ACA Implementation—Monitoring and Tracking

New York

Site Visit Report

April 2012

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EXECUTIVE SUMMARY

Despite not yet passing legislation establishing its health insurance exchange, New York has moved ahead to implement the Patient Protection and Affordable Care Act (ACA). The New York legislature passed legislation amending the state's insurance code to meet standards set out in the ACA. Selected as an Early Innovator state by the federal government, New York also has made headway in preparing its information technology system to enroll New Yorkers in the exchange and Medicaid come January 1, 2014. Further, owing to the state's tradition of providing health care to its low-income residents, New York is well positioned to implement ACA Medicaid provisions. New York has made such progress in large measure because it had been "ahead of the mainstream" in health care reform, with many of the provisions included in the ACA already in place in one form or another in the state.

Health Insurance Exchange: Planning and Implementation—Undoubtedly, the most glaring omission in New York's implementation of the ACA is that legislation establishing an exchange is not enacted as of this writing. Governor Cuomo introduced legislation to establish a New York exchange during the 2011 legislative session and a three-way consensus agreement among the governor, the Senate and the Assembly was worked out. The Assembly passed the consensus bill, but the Senate adjourned in June 2011 without voting on it. The exchange legislation failed in part because of the session's last-day vote in favor of same-sex marriage and unexpected resistance to the ACA among some Republican senators.

Since that time, on January 17, 2012, Governor Cuomo released his budget, which included enabling language to establish an exchange, making it almost certain to pass during the 2012 session, according to study informants. The pending legislation calls for creating a public benefit corporation for the exchange and giving it the administrative powers needed to function.

Despite the surprise setback in not having legislation to create an exchange, Governor Cuomo's office is leading a cross-agency effort to ensure that New York is meeting targets for federal certification of a state-run exchange and the state has been awarded a number of exchange-related federal grants, including an Early Innovator grant, a planning grant, and two Level 1 establishment grants. In addition, New York has several exchange-related studies underway and is conducting outreach to industry experts, employer and consumer groups and the public through specially convened meetings.

Even with this groundwork, once a bill passes, New York will need to move quickly to ensure that the exchange is fully operational by October 1, 2013. Going forward, New York will need to make decisions on policy questions such as determining a financing mechanism, authority to engage in active purchasing, standardization of benefits, and the role of navigators, agents and brokers.

Health Insurance Exchange: Enrollment and Subsidy Determinations—New York has made headway in finalizing its vision for exchange and Medicaid eligibility and enrollment processes as well as program integration. It received an Early Innovator federal award in February 2011. Subsequently, New York received additional federal support for activities related to Medicaid eligibility in the context of the exchange. State officials envision that the new eligibility and enrollment system will vertically integrate enrollment across applicant income levels, so that there is "no wrong door" for publicly subsidized or private health insurance, and that eventually it will be horizontally integrated with enrollment and eligibility for social services programs. As of early 2012, New York was in the final stages of the procurement process to select a system integrator contractor.

Insurance Reforms—The New York legislature, nearly unanimously, passed legislation incorporating the ACA's early market reforms during its 2011 session. These reforms were implemented with little fanfare or

controversy, in large part because New York already had most of them on the books, and in some cases exceeded the ACA standards. Industry respondents viewed these early market reforms as requiring only minor policy changes.

The state has little concern about upcoming insurance reforms to go into effect in 2014. Unlike most other states, New York will not need to make dramatic changes to comply. New York is one of only five states that already require insurance companies to guarantee issue coverage to all applicants, regardless of health status. In addition, it has long prohibited individual and small-group market plans from varying premium rates based on occupation, health status, gender, and age. While New York has allowed insurance companies to impose pre-existing condition exclusions on policyholders, legislation passed in 2011 requires them to conform to the federal prohibition on such exclusions by January 1, 2014.

Medicaid Policy—Owing to its long history of providing comprehensive publicly-sponsored insurance programs, New York's ACA Medicaid eligibility expansion will be relatively small and will comprise childless adults with incomes between 100 and 138 percent of poverty. Through its Medicaid and Children's Health Insurance Program (CHIP), New York already covers children and parents up to 138 percent of poverty and childless adults up to 100 percent of poverty. Given that New York's Medicaid program currently provides insurance to more than 5 million individuals, the state feels confident that it has the managed care capacity to absorb individuals who become newly eligible under the ACA.

Whether to implement the Basic Health Program (BHP) is an outstanding policy decision. Many observers saw the benefits of a BHP: It would help with Medicaid "churn", costs would be lower for enrollees than if they were in an exchange plan, and New York would realize savings because legal but not Medicaid qualified immigrants (a population New York currently covers using state-only funds) could be covered with the benefit of federal funding. At the same time, there is concern that if lower income individuals enroll in the BHP, the residual exchange population may be less attractive to health plans because of risk selection and reduced enrollment, potentially jeopardizing plans' participation.

Providers and Insurance Markets—Like other states, New York must contend with general health care market problems as it moves ahead with ACA implementation. A major one for New York is its high-cost health care system, which is dominated by large hospital systems and academic medical centers in New York City and "must-have" hospitals in upstate markets. Because of hospitals' market power, exchange premiums and federal subsidies are likely to be high, all else being equal. Another issue for New York relates to plans that currently dominate the public insurance market in New York City and whether they will participate in the exchange. If they do, it will likely affect exchange premium and subsidies because these plans tend to be lower-cost than commercial plans. This could dampen commercial plans' interest in the exchange. Another issue to watch is a potential tension between New York's rigorous insurance regulation and the need to attract plans to the exchange.

Primary care capacity was generally thought to be sufficient to handle the influx of new Medicaid enrollees, particularly downstate. New York has experienced a recent expansion in Federally Qualified Health Center (FQHC) capacity, adding to its primary care capacity. Further, New York hospitals are buying up physician practices to extend primary care capacity. Concern about specialist capacity upstate was noted, however.

New York's business community has not been heavily engaged in ACA implementation, partly because large business in the state are to a great extent exempt from many of the law's insurance provisions.

Conclusions—New York has been proactive in implementing the ACA and has made considerable progress. Indeed, it continues to push ahead: As this report was going to press, Governor Cuomo on April 12, 2012 issued an executive order to establish a statewide exchange. While New York faces important policy decisions moving ahead, it may have an easier time than other states because it had already addressed many issues as part of its own reform effort, which has been evolving for many years.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses. The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about RWJF's work on coverage, visit visit www.rwjf.org/coverage.

BACKGROUND

Despite not yet passing legislation establishing its Health Insurance Exchange (HIX), New York has moved ahead in meaningful and important ways to implement the ACA. Chief among these: The New York legislature passed, nearly unanimously, legislation amending the state's insurance code to meet standards set out in the ACA. Also in response to the ACA, the state designated a statewide nonprofit carrier to administer the New York Bridge Plan, a temporary high-risk pool for uninsured individuals with health conditions.

New York also has made considerable headway in preparing its information technology (IT) system to enroll New Yorkers in the HIX and Medicaid come January 1, 2014. As part of that effort, state officials from the Department of Health (DOH), the Department of Financial Services (DFS) (which includes the Division of Insurance), and staff from the governor's office have forged strong working relationships and meet at least weekly to discuss IT matters as well as general ACA implementation. New York has secured tens of millions of federal grant dollars to help implement the ACA, and was one of seven states selected as an Early Innovator Grantee.[1] In addition, the state is aggressively pursuing health homes for its Medicaid beneficiaries. Finally, New York health care stakeholders noted that they have been actively engaged in ACA implementation discussions, a process that was described as "rich" and "productive."

New York has made such progress in large measure because it had been "ahead of the mainstream" in health care reform, with many of the reforms included in the ACA being already in place in one form or another in the state: Many of New York's existing insurance laws and regulations surpass some provisions in the ACA. For example, New York statute already provides for community rating of health insurance policies (within geographic regions) and guaranteed issue of health insurance for individuals and small groups. In addition, existing standards in New York's Medicaid program mandate broad coverage—notably, childless adults up to 100 percent of poverty and parents up to 150 percent of poverty are already eligible for Medicaid.

Despite not yet passing legislation establishing its health insurance exchange, New York has moved ahead in meaningful and important ways to implement the ACA.

Undoubtedly, the most glaring omission in the state's implementation of the ACA is that legislation establishing a New York HIX is not yet enacted. During the 2010—2011 legislative session, Governor Andrew M. Cuomo (D) introduced a Program Bill (#12) calling for the creation of a

New York HIX. Negotiations on the bill took place among the Democratic-led Assembly, the Republican-led Senate, and the governor's office with a three-way consensus HIX agreement being "hammered out" among the three parties. The issues that were debated included whether the state's HIX should be an active purchaser and whether the HIX should be statewide or regional. Ultimately, however, the consensus bill only addressed governance and that the HIX would be statewide with regional advisory committees. Virtually all substantive issues were to be studied with recommendations made to the legislature and the governor by April 2012.

Nearly all respondents noted that ultimately New York will have its own HIX, not the default federal exchange.

The Assembly passed the consensus bill, but the Senate adjourned in June 2011 without voting on it. Some Republicans balked at signaling "support of 'Obamacare,'" and the session's last-day vote in favor of same-sex marriage had put "enough of a strain" on some members that they simply "refused to vote [on the HIX] despite the deal with Cuomo and the Assembly."[2] Several respondents explained that while the Cuomo Administration has "embraced" the ACA during its first year, it did not make the HIX enough of a priority in 2011 to see it enacted.

Nearly all respondents, however, noted that ultimately New York will have its own HIX, not the default federal exchange. As one informant put it, there is "a sense of inevitability" about New York having its own HIX, and, moreover, the administration is proceeding as if it is implementing a state HIX. At this juncture, however, New York's legislature will need to contend with many more issues than just HIX governance. As one state informant noted, New York has "a bigger hill to climb" in 2012 because it has to squarely address many policy issues such as whether the HIX is an active purchaser. There is a concern that the basic notion of having a state HIX will get "mushed" together with the policy issues, potentially holding up the legislative process.

Since our site visit in December 2011, Governor Cuomo released his 2012-2013 budget on January 17, 2012, which included enabling language to establish a New York Health Benefit Exchange.[3] Further, in his 2012 State of the State address delivered in January, the governor spoke of the importance of enacting HIX legislation during the current session.[4] Since this address, Governor Cuomo has been cited in the popular press highlighting the benefits of HIXs.[5] The budget bill language seems to be nearly identical to the Assembly-passed consensus bill of June 2011. The pending HIX legislation again focuses on governance issues, creating a public benefit corporation and giving it the administrative powers needed to function. Inclusion in the budget bill makes the HIX provisions almost certain to pass, according to our respondents.

As with other states, employer-sponsored insurance is the most common type of health coverage in New York. Recent New York State estimates show that in 2011, 57 percent of non-elderly New Yorkers (9.7 million individuals) received health insurance from their employers. Medicaid and other public programs were the next largest insurer, covering about 24 percent of non-elderly residents (4.1 million individuals).[6] An estimated 16 percent of non-elderly New York residents (2.7 million individuals) were uninsured in 2011. If the ACA were fully implemented in 2011, projections estimate that 1.1 million New Yorkers would be enrolled in the HIX, and an additional 500,000 would have Medicaid coverage. About 1.7 million individuals (10 percent of the non-elderly population), however, would remain uninsured. Of the remaining uninsured, 37 percent would be eligible for Medicaid but not enrolled and another 26 percent are estimated to be undocumented immigrants who are not eligible for coverage under the ACA.

HEALTH INSURANCE EXCHANGE: PLANNING AND IMPLEMENTATION

Legislative Developments: HIX Postponed to 2012

In spring 2011, New York had "all the makings of an ahead-of-the-curve state when it came to implementing health reform."[7] HIX legislation seemed inevitable, which would have put New York in the vanguard of states. After earlier discussions, on June 8 the Republican chair of the Senate Insurance Committee introduced a HIX bill, S. 5652-2011.[8] The administration released its version on June13th as Executive Program Bill No. 12.[9] A three-way consensus bill was negotiated among both legislative

houses and the governor's office, which the Assembly passed on June 23.[10] However, unexpected Republican resistance in the Senate prevented even a vote on companion bill S. 5849-2011 in the final hours of the session, as already noted.

Many respondents noted that health care was not a high priority for Governor Cuomo. In the absence of gubernatorial action to convene a special session, authorization for a HIX languished through the balance of 2011. In New York, unpassed legislation "carries over" from one legislative session to the next, and S. 5849 was referred back to committee on January 4, 2012.[11] Governor Cuomo also put the consensus HIX bill's language into the administration's budget bill, released on January 17,[12] where it faces a much easier path to enactment, according to interviewees, but how quickly the legislature will act remains an open question.

The various versions of HIX legislation have shown some distinctions, reflecting differences in opinion between the governor, the Senate, and the Assembly. The governor's bill was more regulatory than the Senate bill, and allowed active purchasing by the HIX. The Assembly bill (which is the consensus bill) now in the governor's 2012-13 budget, is somewhat closer to the Senate version.[13] The Senate bill had dealt mainly with the structure of the HIX and other governance issues, "a minimalist approach" supported by the Business Council of New York.[14] Most substantive issues were to be studied by the HIX, with recommendations made to the governor and legislature for final decision. The consensus bill followed the Senate bill in requiring Senate confirmation of the HIX board chair and in having eight regional advisory committees rather than one statewide committee. The consensus bill also gave the governor somewhat less control over board appointments than the governor's alternative would have done, and similarly reduced the relative share of advisory slots allotted for consumer advocates and providers.

The various versions of HIX legislation have shown some distinctions, reflecting differences in opinion between the governor, the Senate, and the Assembly.

On a number of points, the 2011 HIX consensus bill split the difference between the two prior bills—calling for five regional advisory boards, between the Senate bill's eight and the governor's single board; for 13 studies, between the 18 of the Senate bill and the 9 of the governor's bill;

New York Health Benefit Exchange Act

(passed by Assembly in 2011, pending in Executive Budget for 2012-13)[15]

- HIX to be a public benefit corporation (a state entity but not an administrative agency)
- To cover whole state but with five regional advisory committees
- Governed by a nine-director Board—seven voting members with designated expertises (all appointed by governor, but four from among legislative recommendations), plus two non-voting members of administration—the Commissioner of Health and Superintendent of Financial Services
- Gives the HIX power to make contracts, by-laws, and rules not in conflict with those of agencies
- Confers numerous responsibilities on the HIX, mainly in line with requirements to avoid having a federal HIX
- Lists 13 areas for study and recommendations to the governor and legislative leaders, including essential benefits, large employer participation, active purchasing vs. clearinghouse, and the Basic Health Program Option
- Only legislature may act on the listed areas where HIX recommendations are due
- Creation of the HIX "contingent on sufficient federal financial support to establish and implement" it
- Has provisions for transparency and financial integrity

and setting a due date for studies of April 1, 2012, between the Senate bill's January 1 and the Governor's July 1.

The new 2012 HIX budget bill has now delayed the consensus bill's due dates by four months, to August 1, 2012 (although six months have already elapsed since the Assembly passed the consensus bill). The consensus bill also gave the HIX some new "wiggle room" on timing (maintained in the budget bill), by allowing the HIX to delay any recommendation's due date if relevant federal guidance is lacking.

Key provisions of the budget/consensus bill are presented in the box. Overall, the political process will have the final say on how the HIX is set up and operates; to what extent the legislature will reject or alter recommendations remains to be seen and seems likely to depend upon political developments, as well as the Supreme Court ruling on the ACA expected in June 2012.

Early Operational Progress: Governance and Planning

Through 2011, official progress on HIX governance issues has been minimal, although state officials and planners are moving forward with other aspects of exchange planning. With $1 million in federal HIX planning grant funds, a small but dedicated planning staff has worked with subject matter experts and others in operating agencies to lay much of the foundation for speedy decision-making once governance is finalized.

The main decisions made to date have been to plan for implementation as though the consensus bill still under consideration had already passed.

New York won a Level 1 Establishment grant of $10.7 million in August 2011, applied for additional Level 1 funds at the end of December,[16] and expects shortly to hire a systems integrator to bring its business processes and IT systems close enough to operational readiness during 2012 to win the federal certification that will allow it to run a state rather than a federal exchange (see details below). New York HIX planning also benefits from a remarkable amount of work funded by several New York State foundations.

HIX planning to date has involved regular meetings of agency officials, planners, and the governor's office, notably for the most pressing issues of how to create the administrative/business processes to support HIX operations and the IT infrastructure needed for it to provide a "best in class" user experience.[17] The state has also involved industry experts, business and consumer groups, and other interested parties through specially convened meetings—for example, a discussion on HIX options (April 2011) and risk adjustment (May), on implications for Native Americans (August), as well as five open forums around the state to receive community input (May).[18]

Major Policy Decisions Made

The main decisions made to date have been to plan for implementation as though the consensus bill still under consideration had already passed and to rely heavily on vendors and consultants, outsourcing many issues for study or implementation planning. This last point is consistent with the consensus bill's requirements that the HIX "conduct or cause to be conducted" numerous specified studies. The new budget bill version of the HIX enabling legislation expands the HIX's discretion on studies, specifically allowing it to base recommendations on "any other [completed] study or studies, in whole or in part" in place of its own study.[19]

Other decisions can be said to be virtually certain, even before final HIX legislation. For example, it is almost inconceivable that New York would accept a federally run HIX. "We never considered deferring to the feds. We are New York," said one knowledgeable informant, "Everyone thinks we can do it better." Considering the high level of New York's investment in having designed its own state-run insurance programs like Family Health Plus and Healthy NY, the desire to cater, to some extent, to geographic variations, and the devotion of many advocates to a high level of consumer protections—a state-run HIX seems likely. According to informants, other highly likely policy choices include the following:

- Relying on the DOH to continue regulating managed care quality;
- Relying on the DFS to continue rate review;
- State-run risk adjustment for plan premiums;
- Tighter rating rules than in the ACA; state regulation shows preference for community rating within geographic regions;
- No additional premium subsidies beyond federal level (except for any Basic Health Program, if created); and
- A CO-OP plan from at least one interested group, the freelancers union.[20]

Exchange Policy Studies

1 Essential Benefits	5 **Self-sufficiency**
2 Insurance Market Issues **- Market Merger** **- Group size** **- Benefits Standardization** **- Reinsurance/Risk Adjustment** - Aligning Rules with Outside Market - Definition of Small Group/ Sole Proprietor Outside the Exchange	6 Benchmark Benefits 7 **Integration of Public Health Insurance Programs** 8 Health Savings Account 9 **Role of Navigators** 10 **Role of Insurance Producers, Chambers, Business Associations** 11 Healthy NY and Family/Health Plus Employer Partnership
3 **Basic Health Plan**	12 Large Employer Participation
4 Purchasing Role	13 **Role of Exchange in Decreasing Health Disparities**

Projections indicate that New York's HIX will be considerable in size. Recent estimates suggest that when fully phased, in some 615,000 individuals will be enrolled in the individual HIX and another 453,000 will be enrolled in the Small Business Health Options Program (SHOP).[21]

Major Decisions Not Yet Made

Actually passing legislation to create legal authority for the HIX to operate is the largest open issue. Leaders in the planning effort also cite the several functional capacities that will need to be developed in 2012, along with key policy choices to be made.[22] For the former these include developing a Navigator Program, the SHOP, and eligibility and enrollment processes. The major policy decisions to be made in 2012 include: the selection of HIX board members, determination of small-group size (50 or 100), and establishment of a Qualified Health Plan certification process.

Most of the policy issues are being studied in order to facilitate later decisions. The following table lists 13 such areas, which are categories from the consensus/budget bill. When completed, results of the studies will be presented to the governor and legislature to inform policy decisions.[23] The bolded topics were studies under way at the time of our site visit; in November 2011 a request for proposals was released to conduct studies on unbolded topics.

The table illustrates two main points about the status of New York's HIX. First, planning and information development are very well conceptualized and advanced in execution. Second, there is much left to accomplish before federal readiness is achieved. These are all issues to follow in the future.

Challenges and Controversies

The main challenge apparent at the time of our site visit in early December 2011 was the compressed timeline to make decisions. The main controversy was the unexpected senatorial resistance to the Assembly bill; the differences between the initial bill in the Senate and the governor's bill were resolved quietly, behind the scenes through the consensus bill. The resulting delay seems to have pushed the ability to meet federal deadlines close to the edge of feasibility: "We really need this bill in order to make real headway," said an expert.

The compressed timeline poses several challenges. Hiring staff quickly is very difficult to do under New York's civil service and union rules even in "normal" times. In times of budgetary stringency, hiring freezes the state has been under since 2008, coupled with the desire not to show favoritism towards one area of the state, make it difficult to hire new staff, even for positions funded with HIX grant money.[24] Contracting out is the standard managerial response, but that is also hard to accomplish under state procurement processes. One key informant termed them "truly byzantine," and another said they make managers operate with "one hand tied behind our back."

Attracting Plans to the HIX

"How do we attract the plans? We need them," noted a key respondent. "We are not doing a lot yet, [and] we need those conversations." That is hard to do, of course, when the HIX does not yet exist, and clear information about the likely clientele and transparent rules about support is not known. For instance, whether there is to be a Basic Health Program (see discussion below) will affect the composition and attractiveness of the remaining potential customers still seeking coverage in the HIX. And, as a result, it will affect plans' interest in participating in the HIX.

Policy-makers in New York aspire to simplify eligibility determination and enrollment, making consumers' experience with online enrollment be the "Expedia" of Medicaid, as well as other public programs and private plans.

There are some reasons for concern about plan participation, especially outside of metropolitan New York City. In some upstate areas there are only one or two sizeable health plans. Moreover, it is well appreciated

that plan participation in the HIX will be voluntary. This implies that strictures placed upon plans cannot be too harsh from the plans' perspective. At the same time, consumer advocacy groups have a large presence in New York, and there are continuing pressures to maintain or expand consumer protections. Respondents recognized that the state may need to grapple with whether to implement protections that are above the federal minimum standard, such as standardizing benefit design or adding certification criteria for qualified health plans.

HEALTH INSURANCE EXCHANGE: ENROLLMENT AND SUBSIDY DETERMINATION

Exchange Enrollment and Subsidy Determination

While there is still much work to be done, New York State's exchange planning and IT teams are working to ensure that once operational, the exchange will seamlessly determine eligibility and enroll prospective members in the appropriate avenue of insurance coverage. Policy-makers in New York aspire to simplify eligibility determination and enrollment, making consumers' experience with online enrollment be the "Expedia" of Medicaid, as well as other public programs and private plans.

Progress on Eligibility Determinations and Integrated Enrollment

New York considers itself "a longtime leader in eligibility and enrollment policies."[25] The state has substantial experience with expanding access to public coverage. Prior expansions occurred not only in "traditional" public programs, but also in the innovative Healthy NY program, which provides subsidized coverage for individuals and employers. While New York has paved the way in policies to increase eligibility in Medicaid and private coverage, like many states, it currently relies on a legacy IT system to process applications, making enrollment more difficult than the state would like. As in all states, the ACA gives New York the opportunity and the funding to simplify eligibility and enrollment systems, provide excellent consumer assistance, and maximize enrollment in coverage programs. Study respondents explained that these are all activities the state has wanted to pursue for some time but has not had the funding to do so.

It is New York's vision that consumers will be able to use a single portal to explore available health insurance options, apply for eligible programs and subsidies, as well as report changes in personal circumstances. Furthermore, the state envisions that a nearly paperless, IT-based enrollment system will support enrollment in all available plans, guiding each applicant through a process appropriate to their own circumstances in real time. Determining eligibility requires matching applicant information with the appropriate rules governing public programs and subsidies for private coverage, normally accessed through an automated "rules engine."

The state's eagerness to press forward was reflected in its seeking and winning one of only seven Early Innovator federal awards in February 2011.

The state's eagerness to press forward was reflected in its seeking and winning one of only seven Early Innovator federal awards in February 2011. (New York also subsequently sought and received additional federal support through Advanced Planning Documents "to help support activities related to Medicaid eligibility in the context of the integrated Exchange.")[26] At the same, as of December 2011, many of New York's plans for eligibility and subsidy determination were contingent upon the selection of an IT vendor, which as of March 2012 has yet to be announced. While New York certainly has made progress in developing processes for eligibility and enrollment, there is much work left to be done, as respondents readily acknowledged.

Status of IT System Development, Contracting and Vision

New York has laid much of the foundation for an IT system that will process applications for both HIX and newly eligible Medicaid enrollees: Among other things, after receiving legislative authority for an expedited procurement process, New York is nearly ready to select a system integrator contractor.

In developing its request for proposals (RFP), New York elected not to create detailed system requirements. Instead, it included core components in the RFP but also built in for supplements to the contract so it could respond to future federal guidance on ACA IT systems.

It was felt that such a strategy would position the state to handle the "ton of open issues" that will need to be addressed as the federal government continues putting out guidance and regulations.

New York's implementation of the ACA's insurance reforms was aided in many respects by its long history of regulating both the access and adequacy of coverage.

Representatives from the Department of Health (DOH), the Department of Financial Services (DFS) and the Office of Temporary and Disability Assistance (the state agency currently responsible for processing Medicaid eligibility and social services such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP)) have held several sessions in which basic system requirements were developed. By late 2011, New York had created its first version of all the exchange requirements. Informants readily conceded that the exercise was somewhat restricted because of the limited availability of federal guidance and the lack of a state HIX governance structure. Even so, officials felt the system requirement process was "very rich and useful" and puts them in a ready position once the IT landscape becomes clearer.

The vision for New York's IT system is to leverage the considerable advanced technological components of the state's Medicaid Management Information System, referred to as eMedNY. Using both its $27.4 million in federal Early Innovator funds and $10.0 million in enhanced federal Medicaid funding the state recently received to modernize its Medicaid eligibility and enrollment and IT system,[27] New York is using the technical assets of eMedNY (which currently processes payments for about one of every three health care dollars paid in the state) as a platform for the new system.[28]

Given the tight timeframe called for under the ACA, New York officials acknowledge that by October 2013, the date by which the U.S. Department of Health and Human Services (HHS) proposed rules require states to have their eligibility and enrollment systems operational, the new system will likely be able to accommodate only eligibility and enrollment for HIX and newly eligible Medicaid enrollees. Enrollment for current Medicaid beneficiaries will at least initially continue to be processed by New York's existing eligibility and enrollment system. However, the thinking is that current Medicaid enrollees could use the new system but would be "off ramped" to the existing eligibility and enrollment system. State officials envision that the new system will vertically integrate enrollment across applicant income levels, so that there is "no wrong door" for publicly subsidized or private health insurance and, that eventually it will be "horizontally" integrated with enrollment and eligibility for social services programs such as TANF and SNAP.

At the time of our site visit, a major question weighing on New York officials was whether it was feasible for the state to complete all required IT tasks to be ready on "day one." Some were optimistic and felt it was "doable" while others were reserving judgment until the system integrator was on board, at which time the state will get a "reality check" about what absolutely has to be done by January 1, 2014. As one respondent put it, "we don't want to overpromise and under-deliver."

Consumer Information and Outreach

State officials are fully aware that public education, marketing and assistance to individuals and businesses will be essential to maximize enrollment in Medicaid, other public programs, and HIX private plans. To date, substantial effort has gone into *general outreach*, especially through the Consumer Assistance activities. The state has outsourced tasks to the Community Service Society, which is a network of 27 community-based organizations. They have trained community staff and created hotlines to offer consumer education and assistance and reached out to small business organizations, among other things. The Consumer Assistance activities have been continued since the end of that program through use of establishment grant funding that was awarded in August 2011.[29]

State officials have engaged in substantial consultation with stakeholders on ACA policy decisions in order to obtain information and elicit opinions.

State officials have engaged in substantial consultation with stakeholders on ACA policy decisions in order to obtain information and elicit opinions. Representatives of insurance agents and brokers (also called "producers") have been included in many of the ACA-related discussions, and feel as if they are given an opportunity to

be involved in the conversations at the state level. Brokers seem to be the dominant group linking employers to health plans in New York City and environs. In upstate New York, the Chambers of Commerce play a crucial role in informing employers of their health coverage options. The state is making an effort to include them in discussions of how they can continue to provide consumer assistance for the groups they serve in the future.

Is New York Planning Any Further Subsidization of Premiums and Cost-Sharing?

The ACA leaves states free to further subsidize the premium cost for people above Medicaid income levels—that is, use state funds to go beyond the federal premium and cost-sharing subsidies for HIX health plans. In New York, such additional state help for enrollees would likely only occur as an aspect of the BHP. New York, however, has yet to decide whether it will move forward with the creation of a BHP.

INSURANCE REFORMS

The private health insurance market in New York is regulated by the DFS. The DFS regulates three primary types of insurance carriers: health maintenance organizations (HMOs), non-profit insurers, and for-profit plans (also called "commercial" carriers). Each is subject to a slightly different regulatory regime, and the DFS shares authority over HMOs with the New York DOH.[30]

New York's implementation of the ACA's insurance reforms is aided in many respects by its long history of regulating both the access and adequacy of coverage in the individual (also called "direct pay") and small-group markets. Health plans must "guarantee issue" coverage to all individuals and small groups throughout the year, and they cannot vary premiums based on age, health status, occupation, or gender.[31] In general, these market rules have "weathered well" for the small group market, but the absence of a requirement that healthy individuals purchase coverage and the state's robust benefit and rating standards have resulted in significant adverse selection and high premiums in the individual market.[32] For example, the 2012 rate for an individual policy through one carrier in New York City was $1,299/month for an individual and $4,026/month for family coverage.[33] As of 2011, an estimated 1.5 million individuals working in firms with 50 or fewer employees had small-group coverage, but only 145,000 were covered in the individual market, including both the standard individual market and Healthy NY (see below).[34]

Partly in response to a "badly broken" individual market, in 2000 the state created a special subsidized product called Healthy NY in which premiums are moderated through a state-subsidized reinsurance mechanism and limited benefits, and eligibility is limited to small employers, sole proprietors, and employed individuals who have been uninsured for a year and have low or moderate income.[35] Because of fiscal constraints, Healthy NY funding has been flat for the past three years, in spite of increased demand for the program. To mitigate premium increases, the state is now restricting new enrollees to a high-deductible option.[36]

Health plans must "guarantee issue" coverage to all individuals and small groups throughout the year, and they cannot vary premiums based on age, health status, occupation, or gender.

While the small group market is in relatively better shape, respondents identified areas of adverse selection that pose challenges for the traditional small-group risk pool and the viability of the HIX. For example, respondents noted that professional employer organizations (PEOs) are "cycling off" healthy groups from the small-group market. Because these PEOs consider themselves to be self-insured "co-employers" and not associations, to date they have not been subject to New York insurance laws. As a result, they are able to offer lower premiums to their member small employer groups. In addition, more employer groups are considering self-insurance as an option to avoid escalating premiums. A broker respondent noted that, while previously he would never have advised a group smaller than 500 employees to self-insure, he is now recommending that groups with as few as 100 employees self-insure.

Implementation and Impact of the ACA's Early Market Reforms

For the most part, New York regulators and plans were able to implement the ACA's early market reforms without difficulty. The state legislature easily passed legislation (S.B. 5800; see table below) incorporating the reforms in July 2011, only days before legislators failed to pass the proposed exchange bill.[37] Most respondents noted the early reforms were "not a big deal at all," because New York already had most of them on the books, and in some cases exceeded the federal standards. Industry respondents viewed them as "minor policy changes."

For example, New York law in place prior to the ACA allowed young adults through age 29 to access group coverage through their parent's plan, whereas the ACA provision covers adults up to age 26. However, state respondents did note one important area in which the ACA provision is more protective: the state law was structured as a "COBRA-like" benefit, in which parents could pay the full cost of the premium to keep their adult child on group coverage. Under the ACA's provision, if a plan offers dependent coverage, it cannot vary premiums based on age, so parents adding an adult dependent to their policy cannot be charged more than they would for a younger child.[38] S.B. 5800 incorporates this protection for dependents under age 26, but retains the "COBRA-like" approach for dependents over age 26. In addition, S.B. 5800 amended state law so that young adults no longer have to prove their financial dependence on their parents in order to be eligible for coverage.

Insurance Reforms of S.5800 in New York

- dependent coverage to age 26
- lifetime dollar limits prohibited*
- phased elimination of annual dollar limits*
- no pre-existing condition exclusions for children
- health status not allowable to deny coverage for children
- recommended preventive services to be covered without cost-sharing
- rescission allowable only for fraud or intentional misrepresentation
- primary care physician/pediatrician choice
- direct access to OB/GYNs
- preauthorization and cost-sharing not allowed for emergency services
- internal appeals process required
- independent external review required if internal appeal denied

**for essential health benefits*

Similarly, insurers in New York had little trouble adapting to the federal requirement that they guarantee issue coverage to children under age 19, regardless of health status. New York has had a long-standing requirement that plans guarantee issue policies to all applicants.[39] As a result, the state did not face the same disruptions in its "child only" insurance market as other states.[40]

While some industry observers charge that the DFS is hostile to plans, other respondents applaud the state agency for working with insurers to ensure a "smooth transition" for the ACA's market reforms in 2010. The department developed standardized templates for companies to submit policies for review that could be checked quickly and easily for compliance with the ACA. In addition, DFS respondents expect they will be issuing regulations to provide further guidance to plans on the provisions of S.B. 5800. Department officials express some frustration with the pace and level of guidance provided by their federal partners at HHS. While DFS has been able to help the industry implement the early market reforms with minimal disruption, department officials note that they will need timely and clear answers from HHS on critical questions, such as actuarial values and essential benefits, to ensure that insurers come into compliance with the 2014 reforms with minimal market disruption.

Planning for the Insurance Reforms of 2014

As with the early market reforms, New York has already implemented some of the most significant federal insurance reforms that will become effective January 1, 2014. For example, New York already requires insurers to guarantee issue policies to all individual and small-group applicants, regardless of health status. In addition, the state requires carriers in the individual and small-group markets to charge one base or "community" rate for all subscribers, regardless of age, gender, occupation or health status.[41]

The ACA also includes a provision prohibiting carriers from imposing pre-existing condition exclusions on policies.[42] While New York law allows individual and group policies to contain temporary (12-month) pre-existing condition exclusions, S.B. 5800 amends the code to prohibit this practice beginning January 1, 2014.[43]

One key difference between state law and the ACA is age rating. The ACA allows insurers to charge an older person or small group up to three times the amount they would charge for a younger person or group.[44] New York prohibits plans from varying premiums based on age. State respondents recognize that any effort to relax the rating rules to conform to the federal standard would be considered a "step back" and likely face strong resistance from consumer groups.

New York officials and stakeholders must also respond to recent guidance from HHS regarding the ACA's minimum essential health benefits (EHB). While New York officials were anticipating some controversy over which mandates to maintain and which to repeal, it is possible they could sidestep some of that controversy because of recent guidance issued by HHS. On December 16, 2011, HHS released a bulletin on essential health benefits suggesting that, instead of one national standard for EHB, states may choose among four benchmark options: (1) the largest plan within one of the three largest small group insurance products in the state, (2) any of the three largest state employee health benefit plans, (3) any of the three largest national Federal Employee Health Benefits Plan options, or (4) the largest commercial health maintenance organization operating in the state.[45] If New York officials choose a benchmark plan that already includes existing state benefit mandates, they will be included as part of the minimum EHB and the state will not need to account or pay for them as additional benefits, at least in the short term. The state has submitted comments on the bulletin, urging HHS to provide more flexibility for states to adjust benefits within the chosen benchmark plan to ensure that hey "meet the needs of consumers and ACA's goal of providing meaningful coverage…"[46]

In addition to commenting on the EHB, the state has weighed in extensively with federal regulators on a wide range of proposed rules and sub-regulatory guidance, submitting comments on the proposed summary of benefits and coverage form, the CO-OP program, and proposed rules for the risk adjustment, reinsurance, and risk corridor programs.[47] A recurring theme in these comments is the state's desire for flexibility to maintain or enact stronger consumer protections than the federal minimum standard.

For several years New York regulators and stakeholders have contemplated merging the individual and small-group markets to stabilize premiums in the state's notoriously volatile and high-cost individual market. State respondents note that there has been "a lot of energy" from consumer groups encouraging a market merger. A separate study by the Urban Institute, funded by New York's HIX planning grant, found that health care reform itself would bring about a significant decline in premiums for individual policies, and if the small and individual markets were merged, individual market premiums would experience an additional decline. However, the study anticipates that a merger would result in a small increase (about 1 percent) in premiums in the small-group market.[48]

To date, New York has not made any decisions on whether or when to merge its markets.

Status of the High-Risk Pool

New York did not have a high-risk pool prior to enactment of the ACA, but it established a federal Pre-existing Condition Insurance Program on October 1, 2010. Called the New York Bridge Plan, it is administered by Group Health Incorporated (GHI), a subsidiary of EmblemHealth, and regulated by the DFS. It draws on GHI's exclusive provider network, and offers lower premiums than traditional individual coverage in the state, as shown in the table below.

Monthly Premium Rates: New York Bridge Plan Compared to Sample Individual Market Policies, February 2012

Rate	Individual Market—Standard Indivual Health Plans	New York Bridge Plan
Upstate	$1025-$1398 (Essex County)	$362 (one rate for "upstate")
Downstate	$920-$1367 (New York County)	$421 (one rate for "downstate")

Source: New York Department of Financial Services and New York Bridge Plan.

The benefit package for the Bridge Plan is relatively robust, with no deductible and low cost-sharing. New York received $297 million to establish the Bridge Plan, and enrollment is an estimated 3,014 individuals (as of February 2012), still below the state's projection of 8,000 enrollees.[49] However, Bridge Plan enrollees have had higher than anticipated health care claims, and state officials expect that program funding will be exhausted by the end of 2012. The state is in discussions with HHS about options for continued funding through 2013.

State informants noted that the average cost per member in the Bridge Plan is approximately $2500 per month, although there is considerable variation month to month. They attribute the high costs to a number of factors, including the pent-up demand for health care services from individuals who had been without health insurance for a long time, the robust benefit package, and a marketing strategy that targeted organizations and providers serving individuals with high-cost health conditions. The program has increased its efforts to attract younger, healthier individuals in an attempt to balance the risk pool.

Focus on Affordability: Medical Loss Ratio and Rate Review

Respondents indicated that the federal standards for medical loss ratio (MLR) have had minimal impact on New York insurance companies and producers, in part because

they were subject to state-imposed MLR standards before passage of the ACA.[50] In 2010 the state increased the MLR from 80 to 82 percent for the individual market and from 75 to 82 percent for the small- group market.[51] In addition, most carriers in the state have been reporting MLRs above the federal minimum standard. A 2011 report on New York's private health insurance market notes that the vast majority of health plans meet the new federal standards.[52]

Given this dynamic, state officials saw no need to apply to HHS for an adjustment to the MLR. However, they note two important challenges associated with integrating the federal and state MLR standards. First, under state law the MLR is used by regulators both to prospectively determine the reasonableness of rates and to retrospectively calculate rebates. However, the federal MLR requirement is solely based on a retrospective calculus, in which issuers are required to issue rebates if their prior year's MLR is lower than the minimum threshold. Second, there are important differences in the way issuers must calculate the MLR to meet the federal and state standards. New York regulators have historically defined the MLR as the ratio of claims (numerator) to premiums (denominator). The federal standard allows carriers to include expenditures for "activities that improve health care quality" in the numerator and exclude certain taxes, fees, and assessments in the denominator.[53] The net result of these calculation methods is that the federal minimum of 80 percent is effectively several points lower than the state minimum of 82 percent—an estimated 4 to 5 percentage points lower, according to state respondents.[54]

To address the discrepancies between state and federal law, the DFS issued a Circular Letter to insurers in December 2011.[55] The letter clarifies that for purposes of determining rebates, insurers can calculate their MLR using the federal formula. However, to avoid paying a rebate, they must meet the state's 82 percent threshold for the individual and small-group markets, not the federal threshold of 80 percent. The department further allows insurers to satisfy their state rebate obligations by following the federal rebate and reporting obligations. In other words, the state will not require carriers to calculate a different state MLR or to follow a different set of state procedures.

However, the letter informs carriers that, for the purposes of rate review, the state will continue to use the traditional MLR formula (claims over premiums) in its prospective evaluation of whether rates are unreasonable, excessive, or unfairly discriminatory. In choosing to require adherence to the traditional MLR, the department notes that if insurers were allowed to follow the federal formula, they could generally allow them to report a higher MLR than under the state calculation.[56]

In addition to increasing MLR requirements for health plans in 2010, New York also expanded the DFS's rate review authority. The new state law restored the department's authority to approve, disapprove, or modify changes to health insurance rates before they can be implemented in the individual, small-group, community-rated large group and Medicare Supplement markets (called "prior approval" rate review). Regulators had previously had this authority, but it was taken away during an era of deregulation in the 1990s.[57] The new law also requires a 30-day public comment period on all filed rate requests.

In addition to increasing MLR requirements for health plans in 2010, New York also expanded the DFS's rate review authority.

To make the public comment period more meaningful, the DFS worked to post companies' entire rate applications on it website. The DFS faced some strong resistance when it initially proposed this. Most of the major medical carriers in the state argued that much of the information in those filings was proprietary and had to be shielded under "trade secret" protections. They also argued that the filings were too "technical" to be understood by consumers.[58] However, DFS leadership and a coalition of consumer advocates argued that the claims of trade secrets were "overstated," and that consumers needed to see the factors driving premium increases. Regulators also noted that, under the ACA, federal regulators at HHS are now requiring public posting of some of the same information carriers were resisting disclosing in New York. Eventually most of the major carriers in the state withdrew their objections.[59] State officials support their law's requirement of a public comment period and note that the public needs comprehensive information about rate increase requests in order to submit informed comments. As one DFS respondent put it, "as far as ACA is concerned, public disclosure has been a big benefit for rate review."

Insurance industry respondents have noted that the combination of 82 percent MLR and the DFS's authority to disapprove rates could threaten plans' "actuarial soundness." The law, however, gives the DFS the authority to reduce the MLR requirement if there are concerns about

a plan's solvency. Still, some in the industry are concerned about the increasing "squeeze" in terms of rates. In addition, industry representatives believe that carriers may be padding their rate increase requests, noting "everyone says [the DFS] will knock off 5 percent, so if you want 10 percent you need to go in with 15 percent."

DFS officials speculate that the new, rigorous review of rates is causing carriers to winnow their product offerings.

The DFS has benefited from the federal rate review grants authorized under the ACA.[60] The state received a $1 million Cycle I rate review grant in 2010 and used the funds to standardize and streamline rate applications, hire two actuaries, expand the information collected and reviewed in rate filings, and develop a consumer-friendly website with information about rate review, rate filings, and a mechanism to submit public comments.[61] In September 2011, New York received a Cycle II grant award of $4,469,996 to enhance the state's prior approval process. These funds will support expanded data collection and review, allowing the department to disaggregate data by type of coverage and nature of expenditure, as well as compare data across lines of business. The DFS will also be able to revise rate applications to allow submission of the data necessary to certify qualified health plans for the state's insurance exchange, conduct audits to ensure accurate submission of financial and actuarial data, and implement further improvements to its website.[62]

In addition to enhancing the DFS's capacity to conduct a comprehensive rate review program, respondents noted an unanticipated side effect of their expanded authority over rates: a dramatic reduction in the number of policies carriers seek to market. Prior to passage of the state's rate review law, carriers had been allowed to implement rate increases without review or approval of the DFS, so long as they met an MLR threshold (a system called "file and use").[63] State officials noted that under that system, the number of products marketed by carriers "just mushroomed." However, after implementation of prior approval of rates, DFS officials observed carriers discontinuing a number of policies. DFS officials speculate that the new, rigorous review of rates is causing carriers to winnow their product offerings. A number of respondents remarked upon the reduction in the number of products, noting it as a welcome adjustment to a market that had long offered a "dizzying" array of choices among insurance products, many with only minor differences between them.[64] One respondent expressed the hope that it could be a good "catalyst" for the DFS and the industry to move towards more standardized products, both to streamline regulation and aid comparison shopping for consumers.

Last, DFS officials express interest in using rate review to help "bend the medical cost curve" driving up insurance premiums. One respondent notes that they are considering how the commercial rate review process could complement New York's efforts to support a medical homes pilot, as well as early efforts to create accountable care organizations and other projects aimed at coordinating care and linking payment and quality. There are also hopes that a newly funded all-payer claims data base will help them achieve that.

MEDICAID POLICY

New York has a long and rich tradition of providing health care to its low-income residents which is reflected in the state's Medicaid program, the largest in the country. New York Medicaid has among the nation's most expansive eligibility standards, with nearly 5 million individuals each month receiving services through the program. Covering nearly all services allowed by the federal government, New York's Medicaid program is also one of the most extensive programs in terms of benefits, particularly for long-term care services. Reflecting the program's comprehensiveness, in 2008 total New York Medicaid average spending per enrollee was 80 percent higher than the rest of the nation's.[65] Much of this difference is driven by New York's Medicaid spending for long-term care services, which is more than twice what other states spend for these services.[66] Given the scope and depth of the program, Medicaid's role in the New York health care landscape is substantial: It is the single largest payer of health care services in the state, it covers half of all births, and its network includes more than 60,000 health care providers and 20 managed care plans.

Budget Pressures and Medicaid

As it is in many states, New York's Medicaid program is the single largest expenditure item in the state's budget. In the upcoming 2012-13 state fiscal year, New York Medicaid

spending is expected to reach $54 billion (federal and state).[67] Believing that Medicaid was, in the words of one state respondent "not on a path of sustainability," coupled with New York's sagging fiscal situation, Governor Cuomo issued an executive order calling for a major Medicaid redesign effort in January 2011, just days after taking office. Calling the fundamental restructuring of Medicaid a matter "of compelling public importance," Cuomo tasked the redesign team to find ways to reduce program costs and improve quality and efficiency.[68]

Described as being the focus of the Cuomo Administration's 2011-12 health agenda, Medicaid redesign is broken out into two phases. Phase I, where much of the activity to date has occurred, focuses on specific program reforms that could be implemented quickly, within the current 2011-12 fiscal year. Phase II, by contrast, focuses more on longer-term, systemic reforms to Medicaid. Described by one official as a "revolutionary concept" in the state's Medicaid program, the redesign team (which consists of a range of health care stakeholders, from consumer advocates to hospital industry representatives) has met on numerous occasions over the past year and hammered out various ways to reduce program spending.

Governor Cuomo issued an executive order calling for a major Medicaid redesign effort in January 2011.

While Phase I activities entail traditional cost containment strategies (such as provider rate reductions, benefit restrictions, and cost-sharing increases), others involve major changes to New York's Medicaid program.[69] A central one is the wholesale shift to care management for more Medicaid subgroups and services, including health homes for high-cost enrollees, and managed long-term care plans for adults in the community and for dual eligible individuals. Other important managed care Phase I strategies include developing behavioral health managed care plans for services currently not covered by physical health plans and moving personal care services into managed care for some populations. In total, 78 Phase I proposals are being implemented, and as of October 2011 (about half way through the 2011-12 state fiscal year), New York had achieved nearly $600 million in state Medicaid savings, roughly $1.2 billion total (federal and state) savings.[70]

Another central component of the redesign effort was imposing a global state Medicaid spending cap of $15.3 billion for fiscal year 2011-12 and $15.9 billion for fiscal year 2012-13. These caps are in line with the governor's goal of limiting overall state Medicaid spending growth to be no greater than the 10-year rolling average of the long-term medical component of the consumer price index, currently about 4 percent.[71] If state Medicaid spending appears to be heading down a "path of exceeding" the cap, the health commissioner has been given "superpowers" to make program cuts. To keep within the cap, the state needs to cut Medicaid spending by $2.2 billion this fiscal year and another $3.3 billion in the upcoming 2012-2013 fiscal year. Spending is now tracked on a monthly basis and posted on the DOH website—a feature that many respondents noted as having brought a whole new level of transparency to the program.[72]

Moreover, respondents noted that the spending caps made health care stakeholders better understand the fiscal realities of the state's Medicaid program. Hospital industry representatives, for example, explained that hospitals accepted the cap, albeit reluctantly, because the state was dealing with a large budget gap in a weakened economic situation. Hospitals saw the cap as a financial reality and felt they could improve the Medicaid market by encouraging primary care, better managing patients, reducing readmissions, and linking discharged patients to providers. However, for financially troubled hospitals that rely heavily on Medicaid revenue, the spending cap, combined with several years of Medicaid cuts and payment reforms, has greatly increased their already significant financial pressures. Indeed, some of these hospitals are running the risk of closure (see discussion later).

As of August 2011, state analysis showed that Medicaid fee-for-service spending was below projections in many major service categories, including inpatient hospital, emergency room and nursing home care.[73] New York's spending on its Medicaid managed care program, however, was over budget, which was attributed to higher than expected enrollment due to the continued sluggish economy.

While health care industry respondents are taking the Medicaid spending cap very seriously with important and meaningful consequences, they also noted that there was a tacit understanding that if exceptionally large spending growth occurred that was beyond the control of health care providers (e.g., a flu epidemic, a recession or a terrorist attack), the cap would be revisited.

New York intends to pursue with the Centers for Medicare and Medicaid Services the idea of a "shared savings" Section 1115 Medicaid waiver. The rationale behind such a waiver is as follows: Through its redesign efforts, New York is reducing Medicaid costs for the state, as well as for the federal government--savings in which the state believes it should share. Over the next five years, New York estimates that because of its Medicaid redesign activities it will save the federal government at least $18 billion and it would like to "reinvest" some of those federal savings to, among other things, help the state prepare for ACA implementation.

New York's difficult budget situation is also affecting the Medicaid program through its hiring freeze, which as mentioned has been in effect since 2008. Respondents across the board observed that the freeze is a major challenge for state agencies, including the DOH. While informants acknowledged that the addition of federal funds through the Early Innovator grant and HIX grants have helped, these grants alone cannot make up for the shortfall in state staff. For example, there is a 42 percent vacancy rate in the Office of Health Insurance Programs, which is responsible for administering Medicaid, among other programs. Indeed, officials cited the lack of state staff as being one their biggest challenges in completing everyday tasks, as well as in implementing the ACA. In his 2012-13 budget, Governor Cuomo proposes to continue the hiring freeze at least through the upcoming fiscal year.[74]

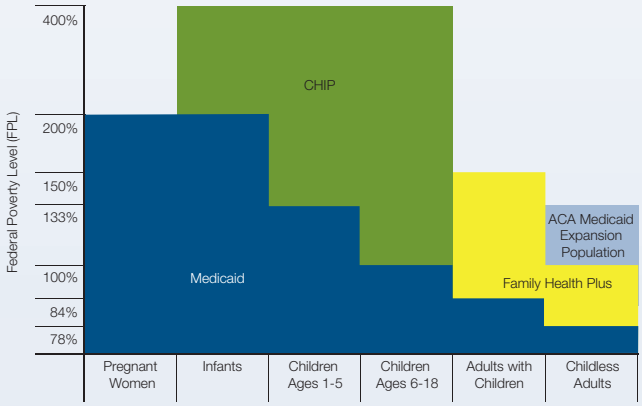
In most states the ACA will bring about a significant expansion in Medicaid enrollment but this is not so in New York.

Provider Taxes in New York's Medicaid Program. Like virtually all states, New York relies on provider taxes to help fund its Medicaid program, including a tax on hospitals, nursing homes and health plans. In a departure from many other states, however, in its current budget year (2011-12) New York relied "very little" on provider taxes to achieve state Medicaid program spending goals. In part this was because New York was "capped [in increasing provider taxes] in some of the key areas for a while" by federal Medicaid provider tax limits but also because the state made the policy decision to try to achieve goals by reducing spending through its redesign effort. New York officials candidly acknowledged that if federal limits on provider taxes were reduced, a policy currently being debated by federal policy-makers, it would certainly pose a problem for the state in financing its share of Medicaid spending.

The ACA and New York Medicaid

In most states the ACA will bring about a significant expansion in Medicaid enrollment but this is not so in New York. Estimates indicate that fewer than 100,000 childless adults will become newly eligible for Medicaid under the ACA.[75] Given that New York currently has about 5 million Medicaid enrollees (non-elderly and elderly) this increase is a "drop in the bucket" in one state official's words. This comparatively small enrollment increase reflects New York's Medicaid eligibility standards being among the most generous in the nation (see figure 1): New York covers children under 5 up to 133 percent of poverty, children aged 6 to 18 up to 100 percent of poverty, pregnant women and infants up to 200 percent of poverty, parents and young adults up to 83 percent of poverty, and nondisabled childless adults up to 78 percent of poverty.

Figure 1: Current New York Medicaid and CHIP Eligibility and Medicaid Expansion under the ACA



In addition, for individuals with somewhat higher incomes, New York operates Family Health Plus, a Medicaid-funded program that operates as part of the state's long-running Section 1115 Partnership Plan waiver. Offering a somewhat more limited package than Medicaid, Family Health Plus provides insurance to parents and young adults (19-20) with incomes up to 150 percent of poverty and childless adults up to 100 percent of poverty. Further, New York's CHIP covers children living in households up to 400 percent of poverty. Owing to the generosity of its Medicaid and CHIP eligibility standards, New York only needs to increase eligibility for childless adults from 100 to 138 percent of poverty to comply with ACA Medicaid eligibility standards.

Current Medicaid-Eligible but Not Enrolled. Although the number of individuals who will become newly eligible for Medicaid under the ACA is modest, New York has a sizable number of individuals currently eligible for Medicaid but not enrolled. One estimate put the number at 1.1 million.[76]

The state is currently estimating that 513,000 individuals would enroll in Medicaid if ACA were fully implemented in 2011.[77] This includes individuals who become newly eligible for Medicaid (see above) as well as individuals currently eligible for Medicaid but not enrolled. The latter group comprises the vast majority of New Yorkers projected to gain Medicaid coverage with reform. Some observers hope that with the new IT system being developed for the ACA and continued efforts to educate individuals that they do not have to be on welfare to get Medicaid (the "hardest nut to crack" in New York), Medicaid-eligible individuals will come forward and "make eligibility levels meaningful." At the same time, respondents fully recognize that if many of the eligible but not enrolled do enroll, it will have important budget implications, because for many of them New York would only receive its regular federal Medicaid match of 50 percent, rather than the enhanced Medicaid match provided by the ACA.

New Medicaid Enrollees. Given that the number of newly eligible Medicaid enrollees under the ACA is fairly limited in New York, the state does not need to significantly expand its eligibility and enrollment processes. Even with expected increased take-up of Medicaid among those currently eligible but not enrolled under reform, combined some 500,000 individuals are estimated to enroll in Medicaid. While large, this number represents only about a 10 percent increase in New York's overall Medicaid enrollment. The DOH sees Medicaid's role in the post-ACA world to be more of "enrollment renewal"—that is, keeping people on the program and providing seamless coverage between Medicaid and the HIX.

While the influx of new Medicaid enrollees because of the ACA is expected to be relatively moderate, respondents readily acknowledged that New York does have eligibility and enrollment challenges and decisions that they face stemming from recent state policy changes and the ACA. An important state policy change is the 2010 legislation that mandates that the DOH "take over" Medicaid eligibility administration from New York's 58 local districts by 2015. While DOH officials believe that centralizing eligibility makes sense for better program efficiency and administration and for Medicaid's interacting with the HIX, the take-over is another task for DOH staff in addition to ACA implementation. Both tasks are challenges in and of themselves, but particularly so given the severely limited staff due to the state hiring freeze.

As of this writing in early 2012, New York has no plans to expand Medicaid coverage in advance of the ACA mandates. State officials said that early expansion has been discussed but there are no plans to pursue this option, primarily because of budget reasons. One official offered that if New York is successful in securing a "shared savings" waiver (see above), early expansion of Medicaid to childless adults from 100 to 138 percent of poverty could be one of the ways New York would reinvest Medicaid redesign savings.

New York also has not made any decisions about whether to move some individuals who are currently eligible for Medicaid but whose incomes exceed the ACA cutoff of 138 percent of poverty to the HIX for coverage in the post-ACA world. Though some respondents observed that New York "is not a state that rolls back eligibility easily," state officials noted that no action has been taken on this partly because the decision is linked to the ongoing debate about whether to adopt the BHP, a new coverage option available under the ACA for individuals with incomes between 139 and 200 percent of poverty who otherwise would be covered under the HIX.

ACA Demonstration Options. New York is taking advantage of several of the ACA's demonstration options designed to test new health care and payment models for Medicaid and Medicare enrollees, including duals. In 2011, New York was one of 15 states selected to receive a planning grant from the federal government to develop an integrated care program for dual eligibles. In addition, the state is actively implementing the health home demonstration, which, at its heart, provides considerable care management funds to hospitals and other organizations to coordinate services for chronically ill and disabled Medicaid enrollees. New York has targeted about 900,000 individuals who could qualify for health home services.[78]

The Basic Health Program Option. Interviewees recognized strong arguments in favor of the BHP, as detailed in an outside analysis.[79] A major one is that the cost of care would be less expensive to individuals with income under 200 percent of poverty in a BHP than in a HIX plan, at little or no cost in state dollars. Operating more like Medicaid than like private insurance could make the BHP less expensive even if costs to enrollees

were kept low to attract high enrollment and if provider payments were raised above Medicaid levels. The exact costs and benefits of the BHP to the state also depends upon which health plans participate in the HIX, as that will influence the relative costs of the HIX and Medicaid (see discussion below).

Having a Medicaid-like BHP would help the state cope with "churning" in and out of Medicaid and would also be less disruptive for enrollees. The state would also benefit by ending some health care subsidies it now pays and instead shifting those costs to federal support for a BHP. Most prominently, New York uses state-only dollars currently to provide health insurance to some 215,000 legal but not Medicaid qualified immigrants who could be covered with federal subsidies under a BHP.[80]

Interviews, however, revealed contrary arguments: A BHP would be administratively very challenging just as creation of the HIX is pushing state capabilities to the limit. A BHP can wait, but the HIX cannot. Another argument against the BHP is that it would take enrollees out of the HIX, which could make the HIX market less attractive to health plans. In addition, some felt that it is better to treat working near-poor individuals more like the rest of the middle class in the HIX than like low-income Medicaid enrollees. Finally, there was the worry that a BHP might not be cheaper if the HIX attracts the mainly healthy uninsured population.

Provider and Plan Capacity in New York's Medicaid Program. There was universal consensus among respondents that managed care plans and hospitals could easily absorb the new Medicaid enrollment expected with implementation of the ACA. To a great extent, this was because with reform New York is looking at incremental expansion on an already robust program infrastructure. As one respondent observed, "New York is driving a $50 billion Medicaid program that is ubiquitous. There is a Medicaid delivery system network everywhere in the state."

Although respondents felt there was sufficient primary care capacity overall, they noted it is often badly distributed.

In contrast to managed care plan and hospital capacity, there were mixed feelings about whether New York has sufficient primary care capacity to care for Medicaid enrollees as well as the general population. Currently, primary care services for New York's low-income population are generally not provided by private physicians. Rather, the low-income are primarily served by providers in diagnostic and treatment clinics, hospital outpatient departments and FQHCs. It is estimated that teaching hospitals alone provide about 65 percent of all primary care clinic visits.

In New York City, study informants expressed little concern about whether in the post-reform world, sufficient primary care capacity would exist. In large measure this was because there is an ample physician supply in the city through its many teaching hospitals and clinics. One respondent also commented that there is a very large supply of foreign medical graduates in New York City, which also helps to mitigate primary care shortages, particularly in neighborhoods with high concentrations of immigrants and racial and ethnic minority populations. Further, New York already has generous Medicaid eligibility criteria and at least in the city, the uninsured have better access to care because of its extensive public hospital system. Thus, increased demand for health care in New York City following reform is likely to be more limited than elsewhere, according to respondents.

Although respondents felt there was sufficient primary care capacity overall, they noted that it is often badly distributed. There are, for example, neighborhoods within Manhattan, Bronx, and Brooklyn where local primary care capacity is very limited. Suburbs of New York City, such as Westchester County which have recently experienced an influx of low-income individuals, were also described as having primary care capacity issues.

More primary care capacity issues were noted by respondents upstate. Compared to New York City, upstate areas have fewer physicians and hospitals do not have the large outpatient departments that are found in New York City hospitals. Further, as in New York City, mal-distribution of physicians is also found in the upstate rustbelt cities and rural areas, where physician recruitment is a challenge, according to respondents. Finally, specialist capacity was noted as being a particular issue in certain areas upstate.

Respondents also noted that expected expansion in FQHCs as provided for by the ACA will further add to New York's primary care capacity. In addition, respondents described both FQHCs and hospital outpatient departments as moving to make better use of nurse practitioners, nurses, and care managers, which will further contribute to capacity.

In addition to federal efforts, several informants noted that over the past several years New York has undertaken efforts to develop primary care capacity in the Medicaid program. For example, New York has increased Medicaid payment rates for pediatricians and OB/GYNs. Now Medicaid payment rates for these physician services are reasonably close to those of Medicare. Further, Medicaid managed care plans often pay physicians better than Medicaid fee-for-service rates, according to respondents. In another policy action, New York Medicaid also pays higher rates for practices meeting medical home standards.

Despite these and other efforts, study informants acknowledged that many private physician practices still do not accept Medicaid, a long-standing national problem. Respondents maintained that increasing Medicaid payments levels further for primary care would not likely change the situation. The lack of private physician participation in Medicaid has made the program very reliant on hospital clinics and FQHCs, especially in New York City.

Financial Impact of the ACA on New York Medicaid. At present, DOH officials believe that the net fiscal impact of the ACA on New York is positive—that is, the state will see more federal dollars under reform than it would have otherwise. This is in large part because, as discussed above, the state already covers non-disabled childless adults up to 100 percent of poverty. Under the ACA New York will receive a so-called Expansion State federal match of 75 percent (rather than its current 50 percent match) for non-disabled childless adults; by 2020 the match for this group will increase to 90 percent where it will remain.[81] As of the end of 2011, nearly 1 million nondisabled childless adults with incomes less than 100 percent of poverty were enrolled in Medicaid, so the savings will be sizable. Balancing these savings will be the new costs for newly eligible nondisabled childless adults between 100 and 138 percent of poverty, but the state share for this population will be only 10 percent by 2020. In addition, to the extent that New York enrolls more individuals who are currently Medicaid eligible but not enrolled under reform than it would have otherwise, these will be additional reform-related costs for the state.

Other ways New York will save money under the ACA include the enhanced CHIP federal match, which will increase from 65 to 88 percent in 2015. Another potential way New York could save money (as discussed above) is to transition parents with incomes between 138 and 150 percent of poverty from Medicaid to the HIX. Finally, the ACA offers many opportunities for states to participate in demonstrations and receive an enhanced federal match for a wide range of activities. Among others, New York is aggressively pursuing health homes and an integrated managed care waiver program for dual enrollees—that is, Medicaid beneficiaries also enrolled in Medicare.

New York does not see much opportunity to roll more state-only health-related services into Medicaid to obtain a federal match. As one official noted, "New York has made an art form out of Medicaid-izing services. We pushed the envelope."

PROVIDER AND INSURANCE MARKETS

Once health reform is launched and individuals gain insurance coverage, the success or failure of reform in New York, as in all states, will greatly depend on the response of health care providers and insurers. How they react will directly affect coverage, access to care, premiums, subsidy costs, and ultimately the sustainability of health reform.

The New York insurance market is bifurcated between commercial insurers, as well as several nonprofit plans and prepaid health services plans.

Health Insurance Market

The New York insurance market is bifurcated between commercial insurers (including Empire, United, GHI-HIP (now called EmblemHealth), and Aetna, as well as several nonprofit plans upstate) and prepaid health services plans (PHSPs), which are largely provider-sponsored nonprofit managed care plans that play a major role in the government program market (including Medicaid, Family Health Plus and Child Health Plus). There are several commercial insurers upstate, usually two to three in every region, but in some areas more. While these insurers serve the small and large group markets, they have avoided the individual market. Currently, consumers in the individual market can only purchase HMO products. In a departure from many other state Medicaid managed

care programs, several commercial plans participate in New York's Medicaid program, particularly in upstate areas. In large measure this is because Medicaid is such a larger insurer, covering one in four New Yorkers, which makes it attractive to commercial insurers. In fact, upstate, commercial plans are far more dominant in the Medicaid market than PHSPs. While commercial insurers are also important in Medicaid downstate, PHSPs dominate this market, enrolling about 70 percent of Medicaid lives in the New York City metropolitan area.

Unlike in the New York City metropolitan area, most upstate plans do not have a choice about whether to contract with particular hospitals.

Commercial insurers have broad networks, contracting with most hospitals and private practice physicians in a given geographic area. Insurers have been hesitant to date to limit their hospital networks, even though at least downstate, a plan could establish a strong provider network with excellent hospitals that excludes some hospitals. One respondent suggested that downstate plans have adopted the strategy of contracting with all hospitals because they want to have large networks for marketing purposes but also because they want to avoid paying additional charges for out-of-network emergency admissions. Occasionally, plans have threatened to exclude some hospitals and impose tiered networks during contract negotiations but insurers and providers have always reached accommodation, at least to date. Plans' threat of exclusion combined with New York's generally high health care costs put some limit on hospitals pricing power. With an improving economy, however, hospitals ability and willingness to exert their substantial market and pricing power may change.

In metropolitan areas outside of New York City (such as Rochester and Buffalo) insurers also must contend with hospitals' market power. In most of these cities there are fewer insurers (compared to the New York City area) but there are also "must-have" hospitals that plans view as being essential to have as part of their provider network. Thus, unlike in New York City metropolitan area, most upstate plans do not have a choice about whether to contract with particular hospitals.

PHSPs are sponsored primarily by hospitals but in some cases FQHCs are the sponsors. The largest PHSPs are HealthFirst, HealthPlus, MetroPlus, and Fidelis. PHSPs typically contract with most local hospitals. PHSPs pay hospitals somewhat better than the Medicaid fee-for-service program, especially for ambulatory care, but they still pay less than commercial plans for Medicaid patients. Nonetheless, most hospitals in New York City participate in Medicaid simply because it comprises such a large part of the market. In contrast, upstate, health plans have less leverage with the dominant hospitals, which affects their hospital payments levels.

To date, large national Medicaid for-profit plans have not entered the New York market in a significant way. The exception is Amerigroup, which operates in New York City and is in the process of buying Health Plus, a major PHSP in the city.

The link between many Medicaid plans and New York hospitals has not been without its consequences. The basic intent of managed care is to increase primary care and reduce emergency department use and inpatient care. However, since so many of the plans participating in New York's Medicaid managed care program are hospital-sponsored, this movement of care out of hospitals has not occurred. Further, most hospital-sponsored plans, primarily PHSPs in New York City, are heavily institutional-based and do not have a lot of contracts with office-based physicians. Thus to a very great extent, New York's Medicaid managed care program continues to rely strongly on hospitals to provide care to program enrollees, particularly in the downstate area. In the upstate area, this reliance is less evident because plans are able to contract more with private physicians.

Plan Participation in the Exchange. Whether commercial plans or PHSPs will participate in New York's HIX is not known at this time. Potentially, the PHSPs could be very competitive in the HIX market in New York City, particularly the non-group exchange. PHSPs, however, would likely have to pay hospitals and doctors somewhat more than they do currently under Medicaid. If PHSPs come into the HIX, it could be difficult for commercial plans to compete because HIX participants would have to pay the marginal cost of the more expensive plans, likely the commercial plans. Commercial plans, however, would probably respond by more aggressively negotiating with providers thereby lowering premiums. In short, if PHSPs participated in the New York City HIX market the outcome is uncertain but a very competitive market could result.

At the same time, participating in the HIX could be difficult for PHSPs. The HIX market will be different from

the Medicaid market, especially the small group market. Currently, PHSP members are largely individuals enrolled in Medicaid and other public programs. Respondents suggest that there may be some flexibility on insurance requirements for PHSPs to participate in the HIX in that coverage provided through the HIX could be subsidized and thus could be interpreted as a publicly-sponsored program. Another alternative is that PHSPs could simply convert their existing licenses to HMO licenses. Requirements are roughly the same. Most PHSPs have broad networks throughout New York City, both doctors and hospitals, and thus they have capacity to expand to meet the needs of the HIX.

It is likely that the structure of the HIX market will differ upstate and downstate. As described above, in the Medicaid program commercial plans are relatively more dominant upstate, whereas downstate PHSPs dominate the Medicaid market. Upstate, commercial plans will likely dominate the HIX market. To the extent these plans have difficulty negotiating with the must-have providers in different localities, HIX plan premiums and subsidy costs will be higher than expected. In contrast, if PHSPs compete effectively in the HIX downstate, premiums and subsidy costs could be less than if they do not.

If New York adopts a BHP, uncertain as of this writing in February 2012, this could segment the low-income market. PHSPs could serve BHP participants and commercial insurers' higher-income subsidized exchange participants. Respondents suggested that this segmentation could occur both upstate and downstate.

New York's Hospital Market

New York's health care system is expensive, primarily because large hospital systems dominate inpatient care services and much of outpatient care services. New York hospitals face high labor and real estate costs as well as the costs associated with the world-class graduate medical education programs they sponsor, particularly in New York City. Largely driven by hospital costs, New York City is one of the most costly health care markets in the United States. The state remains very hospital-centric.

New York's hospital industry is made up of several large systems, both downstate and upstate. In the New York City metropolitan area, there is the Health and Hospitals Corporation (HHC), which consists of 11 local public hospitals in New York City. There is the New York Presbyterian System, which is a combination of New York Hospital and Columbia Presbyterian Hospital. Together, these hospitals have affiliations with other hospitals in other boroughs of New York City. In contrast, Mount Sinai Hospital and New York University Hospital are academic medical centers that are largely independent. New York University, however, is located next to Bellevue Hospital (part of the HHC system), and its residents provide care to low-income patients being treated at Bellevue. The Continuum system, which may merge with New York University, includes Beth Israel, St. Luke's, and Roosevelt. Montefiore Hospital is a major hospital in the Bronx. The NorthShore-LIJHealth System, whose facilities are located largely on Long Island, is another major system which recently purchased the Lenox Hill Hospital in Manhattan. Upstate, there are major hospital systems such as Bassett Health Care in Cooperstown, Strong Memorial in Rochester, and Great Lakes System in Erie County.

New York City's hospital market is now divided into hospitals that are part of extremely strong systems and independent hospitals, some of which are strong and some of which are on the verge of bankruptcy.

New York City's major hospital systems over the past several years have purchased a large number of middle-tier hospitals—that is, reasonably profitable hospitals with a commercial payer base. New York City's hospital market is now divided into hospitals that are part of extremely strong systems (often associated with academic centers) and independent hospitals, some of which are strong and some of which are on the verge of bankruptcy. According to respondents, most, but not all of the smaller independent hospitals in New York City without an affiliation to a large system or a commercial patient base are struggling. Indeed, three smaller independent hospitals in Brooklyn are near bankruptcy. Respondents observed that there is no incentive for one of the larger hospital systems to purchase these failing hospitals because their patient base is largely comprised of Medicare, Medicaid, and uninsured patients and few commercial patients. Some rationalization of the situation, likely involving mergers and hospital closures, seems imminent, according to informants. Because it is the principal safety net system in New York, HHC is in a similarly stressed financial position. HHC, however, receives significant funding from the city and state, as well as a lot of disproportionate share hospital (DSH) payments from both Medicare and Medicaid.

Consistent with national trends, New York hospitals are starting to buy up physician practices to extend primary care capacity, in part to meet expanding demand. Consolidation is occurring more aggressively for some hospitals than others. The NorthShore system in Long Island has been active in this area, as has the Strong Memorial System in Rochester. Montefiore Hospital in New York City has many salaried physicians who provide many ambulatory care services. Hospitals are also purchasing physician practices in smaller cities across the state. Other hospitals, including such prominent ones as New York University and New York Presbyterian are not pursuing this strategy.

From 1971 to 1996, New York had an all-payer hospital rate-setting system. There seems to be little interest, and perhaps little need, to return to an all-payer-system, given the revenue constraints imposed on most hospitals through the state Medicaid spending caps, Medicare cuts, and difficulty in passing costs on to commercial payers. Respondents suggest that even hospitals with market clout are at least currently reluctant to exploit their power, recognizing the state's weakened economy and that premiums paid by employers are very high. Given the revenue constraints, hospitals face the need to become more efficient and develop models that reduce readmissions, keep patients from going to emergency rooms, avoid unnecessary tests, and so on. It is not clear, however, whether hospitals will use of their significant market power more aggressively once the economy strengthens.

New York Hospitals and the ACA. As discussed earlier, New York's Medicaid expansion under the ACA will be relatively small and thus will not have a substantial effect on the state's hospitals. In contrast, the million or so individuals newly covered in the HIX will add to the demand for hospital services. While on balance, the HIX coverage expansion should help offset the Medicare payment cuts included in the ACA, individual hospitals, particularly those with a large Medicare patient base, may face financial difficulties. The ACA Medicare rate cuts will reduce a hospital's revenue in proportion to the number of Medicare patients it serves. While some hospitals with large Medicare patient shares may be able to offset lost Medicare revenue with new revenue from newly insured HIX enrollees, some may not.

Respondents also expressed concern that the loss of Medicaid DSH payments will affect hospitals, particularly HHC. DSH payments give financial support to hospitals that provide care to large numbers of Medicaid and uninsured patients. In 2010, federal DSH funds totaled $11 billion, with New York receiving $1.6 billion of those funds. Under reform, federal DSH payments for the nation will be cut $0.5 billion in 2014; DSH allotments will be cut annually to a $5.6 billion reduction in 2019. Then federal DSH allotments will rise slightly to $7 billion in 2020 and thereafter. New York estimates that between 2014 and 2020, the state will lose nearly $2.6 billion in Medicaid DSH payments.[82] The rationale behind reducing DSH funding is that post-reform the need for these payments will be less. However, as discussed above, New York estimates that about 1.7 million non-elderly individuals will remain uninsured under reform, with 26 percent of whom are undocumented immigrants who are excluded from coverage by the ACA.[83] Another sizable component of the remaining uninsured are individuals eligible for Medicaid but not enrolled in the program. If it proves difficult to reach and enroll these individuals, the fear is that the level of new Medicaid revenues will be insufficient to offset DSH reductions.

Underinsurance is another concern for hospitals in the post-ACA world. Respondents worry that many HIX enrollees will purchase a bronze health plan and, as a result, will have high deductibles and significant out-of-pocket costs, costs that they may not be able to pay and that hospitals will have to absorb.

New York's Business Community and the ACA

At least to date, respondents observed that New York's business community has not been heavily engaged in health reform implementation. In part, respondents explained that large businesses with corporate headquarters in New York are to a great extent exempt from many of the insurance provisions in the ACA. Small businesses, by contrast, must address them.

While smaller businesses regard the metropolitan New York area as having robust competition and plenty of health insurance choices, upstate there are fewer options, making it more difficult for small employers to obtain insurance for their workers. Smaller businesses also have concerns about affordability: Insurance policies in New York's small-group market are expensive, in large part because of the high cost of care in the state as well as high distribution costs for carriers. While New York is still considered to have a competitive insurance market compared to other states, there has been ongoing market consolidation among carriers in all market segments, including small group.[84] In addition, seemingly because of difficulty in navigating and dealing with the risks in the market, in late 2011 Empire Blue Cross-Blue Shield,

announced that it was limiting its role in New York's small-group market. New York's small group market appears to be contracting, which will introduce new challenges for small businesses. If the ACA can offer business owners lower-cost premiums than they currently have or if human resource costs associated with managing health insurance for their employees are reduced, then they will be likely support the new law. Otherwise they probably will not.

CONCLUSIONS

Owing to its long history in providing generous publicly-sponsored insurance programs and being on the vanguard in pushing reform in its private insurance market, New York had already implemented many of the changes mandated in the ACA. The state's Medicaid program, for example, currently covers parents with incomes up to 150 percent of poverty and childless adults up to 100 percent of poverty. Further, nearly all of the ACA's early market reforms, implemented in 2010, were already part of New York law and required only minor legislative changes in order to grant the full scope of consumer protections. A bill (S.B. 5800) implementing these reforms passed almost unanimously during the 2011 legislative session.

Even so, New York has faced some challenges in moving forward with the ACA. Most notable is the absence of state legislation to create a HIX in New York, a surprise setback. Despite this, Governor Cuomo's office is leading a cross-agency effort to ensure that New York is meeting targets for federal certification of a state-run HIX, and the state has applied for and been awarded a number of HIX-related federal grants, including an Early Innovator grant, a planning grant, and two Level 1 establishment grants.

As part of that effort, New York is making considerable headway in finalizing its vision for HIX and Medicaid eligibility and enrollment and program integration during 2011. State policy-makers understand very well that enrolling people into health coverage is the reason for having an exchange. Accordingly, eligibility and enrollment have received a great deal of policy attention. In addition, New York had several HIX-related studies underway at the time of our visit in December 2011. The state is also conducting outreach to industry experts, employer and consumer groups, and the public through specially convened meetings.

Observers fully expect that the New York HIX legislation will pass during the current session because enabling language for the HIX was included in the governor's budget submission of January 2012. Despite the considerable groundwork laid by state planners, once a bill passes, New York will need to move very quickly to ensure that the HIX is fully operational by October 1, 2013. Indeed, several key respondents cited resulting time pressure as perhaps the greatest challenge faced by reform. There are, however, some likely outcomes, such as relying on the existing state regulatory structure to perform key plan management functions (i.e., assessing health plan quality, performing rate review), establishing a state-run risk adjustment program, and retaining New York's long-time prohibition on age rating. Going forward with HIX development, New York will need to make decisions on critical policy questions such as determining a financing mechanism, authority to engage in active purchasing, standardization of benefits, and the role of Navigators, agents, and brokers.

While all has not been completely smooth sailing, New York has been proactive in implementing the ACA and has made considerable progress.

Respondents generally expressed little concern about the upcoming array of insurance reforms to go into effect in 2014. Unlike most other states, New York will not need to make dramatic changes to comply with these reforms. New York is one of only five states that already require insurance companies to guarantee issue coverage to all applicants, regardless of health status. And it has long prohibited individual and small group market plans from varying premium rates based on occupation, health status, gender, and age. While New York has allowed insurance companies to impose pre-existing condition exclusions on policyholders, SB 5800 requires them to conform to the federal prohibition on such exclusions by January 1, 2014. In addition, prior to enactment of the ACA, New York passed a law expanded its authority to review and approve rates, and imposed an MLR standard that exceeds the federal minimum required by the ACA.

Given New York's generous Medicaid eligibility standards, the ACA will have comparatively little impact on program enrollment. Fewer than 100,000 childless adults are projected to become newly eligible for Medicaid under reform. In addition, individuals currently eligible for Medicaid

but not enrolled are expected to take-up Medicaid coverage under reform. Combining these two groups, recent estimates are that about 500,000 New Yorkers would enroll in Medicaid if reform were implemented in 2011. While this is a large number, because of the size of New York's Medicaid program, state officials were confident that the state has sufficient managed care to them. Primary care capacity was also generally thought to be sufficient to handle the influx of new Medicaid enrollees, particularly downstate. New York has experienced a recent expansion in FQHC capacity because of funding through the Bush administration and the ACA, which has added to primary care provider supply. Some concern about specialist capacity upstate was noted.

Whether to establish of a BHP is an outstanding policy decision, and is currently being debated by New York health care stakeholders. Many observers saw the benefits of a BHP: It would help with Medicaid churn, costs would be lower for enrollees than if they were in a HIX plan, and the state would realize some savings because legal but not Medicaid-qualified immigrants (a population to which New York provides coverage using state funds only) could be covered with the benefit of federal funding.

At the same time, many opposing arguments were put forward. Perhaps most compelling is that if individuals are enrolling in the BHP rather than the HIX, health plans may be less inclined to participate in the HIX because of risk selection concerns and of reduced enrollment.

Also related to plan participation in the HIX is whether PHSPs, primarily provider-sponsored health plans that dominate the public insurance market in the New York City area, will participate in the HIX. If PHSPs do participate, it will likely affect premiums and subsidies because they tend to be lower-cost than commercial plans. An upshot of PHSPs taking part in the HIX is that commercial plans would have to compete more aggressively on premiums. The result could be a downward pressure on premiums, which potentially could dampen commercial plans' interest in participating in the HIX. While PHSPs are also found in upstate New York they do not dominate the Medicaid market the way they do in the New York City area. Thus there is less likelihood of such an intense competition developing between commercial plans and PHSPs for HIX enrollees upstate. Overlaying the matter of whether PHSPs participate in the HIX, another issue to watch is a potential tension between New York's rigorous insurance regulation and attracting health plans into the HIX.

Like other states, New York must contend with general health care market problems as it moves ahead with implementation of health reform. A major one for New York is its high cost health care system, one that is dominated by large hospital systems and academic medical centers in New York City and "must-have" hospitals in upstate markets. Because of hospitals' market power, HIX premiums are likely to be high as will be federal subsidies, all else being equal.

While all has not been completely smooth sailing, New York has been proactive in implementing the ACA and has made considerable progress. Indeed, it continues to push ahead: As this report was going to press, Governor Cuomo on April 12, 2012 issued an executive order to establish a statewide exchange. While New York faces important policy decisions moving ahead, it may have an easier time than other states because it had already addressed many issues as part of its own reform effort, which has been evolving for many years.

About the Authors and Acknowledgements

Teresa A. Coughlin and Randall R. Bovbjerg are senior fellows in the Urban Institute's Health Policy Center. Shanna Rifkin is a research assistant with the center. Sabrina Corlette is a research professor at the Georgetown University Health Policy Institute-Center on Health Insurance Reforms. The authors thank the many New York government officials and health care stakeholders for their time and insights. This report would not have been possible without them. In particular, we are grateful for the contributions of staff from the governor's office, New York State Department of Health, and the New York State Department of Financial Services. Finally, a thank-you is extended to John Holahan, Kevin Lucia, and Linda Blumberg for their comments and input to the study and the report.

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The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace.

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