American Cancer Society ☙ Children's Defense Fund/New York ☙
Community Service Society of New York ☙ Make The Road New York ☙ Metro New York Health Care for All Campaign ☙ New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙
Raising Women's Voices for the Health Care We Need ☙
Public Policy and Education Fund of New York/Citizen Action of New York

October 4, 2010

Secretary Kathleen Sebelius
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: OCIIO–9989–NC
P.O. Box 8010
Baltimore, MD 21244–8010.

Dear Secretary Sebelius:

Health Care for All New York (HCFANY) writes to comment on the Patient Protection and Affordable Care Act (ACA) provisions regarding the planning and establishment of state-level exchanges in advance of future rulemaking and grant solicitations. HCFANY is a statewide coalition of more than 100 organizations which seek to achieve affordable, quality health care for all New Yorkers.

Overall, our main concerns regarding implementation of a state Exchange in New York focus on the following seven areas: 1) Creation of a single statewide Exchange to offer affordable comprehensive coverage for all New Yorkers; 2) designating the Exchange as an active purchaser and regulator; 3) maintaining a "no wrong door" policy for the Exchange; 4) maximizing consumer enrollment; 5) establishing a governance structure with strong consumer representation; 6) maximizing and building upon New York's strong public programs; and 7) supporting principles of health equity.

With these seven points in mind, we have addressed the questions most pertinent to New York in the same order as the request for comments notice. Our discussion of the issues facing

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New York in its implementation of its exchange is intended to guide HHS as to the decisions it should make in providing guidance to all of the states.

A. State Exchange Planning and Establishment Grants

Current Progress

(A.1., A.2.) New York is proceeding with the development of a state-based insurance exchange and is in line to have it fully implemented by January 1, 2014. Governor David A. Paterson has appointed a Governor's Health Care Reform Cabinet to manage the implementation of the Patient Protection and Affordable Care Act (PPACA). The Cabinet will advise the Governor and make recommendations on all aspects of federal health reform. State agencies serving in the Cabinet include: the Department of Health, the Department of Insurance, the Division of the Budget, the Department of Civil Service, the Department of Taxation and Finance, the Department of Labor, the Office for Technology, the Office of Temporary and Disability Assistance, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office for the Aging, the Office of the Medicaid Inspector General, and the Office of Children and Family Services. The Deputy Secretary for Human Services, Technology and Operations, Deputy Secretary for Intergovernmental Affairs and Counsel to the Governor also serve in the Cabinet. Although this Cabinet was appointed in May, it appears to stakeholders that New York is at a relatively early stage in its planning process.

In addition to the Cabinet, the Governor has named an external advisory group to ensure stakeholder and public engagement and to advise the Cabinet on the reform provisions. This advisory group includes HCFANY and the following organizations representing consumers, health care providers, businesses, local government, organized labor, health plans, as well as health policy experts: 1199 SEIU, AFL-CIO, Business and Labor Coalition of New York, Business Council of New York State, Centerstate CEO, Chamber Alliance of New York State, Children's Defense Fund, Coalition of New York State Public Health Plans, Community Health Care Association of New York State, Community Service Society, Consumer Directed Choices, Empire Justice Center, Family Planning Advocates, Finger Lakes Health Systems Agency, Greater New York Hospital Association, Healthcare Association of New York State, Hispanic Federation, Medicaid Matters, Medical Society of the State of New York, Medicare Rights Center, National Black Leadership Commission on AIDS, New York Health Plan Association, New York Immigration Coalition, New York State Association of Counties, New York State Association of Health Underwriters, New York State Conference of Blue Cross Plans, New York State Council for Community Behavioral Healthcare, New York State Health Foundation, New Yorkers for Accessible Health Coverage, Office of the Mayor of New York City, P2 Collaborative of Western New York, Partnership for

New York City, Project CHARGE, United Hospital Fund, Visiting Nurse Service of New York, and Young Invincibles.

HCFANY strongly supported the inclusion of consumer groups in the advisory group, and we are grateful to see that 12 groups representing consumer interests were appointed to this body. While it is yet to be determined how the advisory group and the implementation team will work together or if the advisory committee will result in a meaningful contribution to the Exchange design, we urge strong continued consumer participation in this process. We recommend additional public measures for input such as town halls and local convening meetings around the state to gather support and input. Further, we suggest that HHS make renewal of Exchange grants to states conditional on demonstration of formal participation by consumer advocates.

Consumer Representation

(A.2.a) New York has not yet established any governance structures or rules for the Exchange. However, HCFANY recommends that the New York Exchange be governed by a state agency or other public entity with strong consumer representation on the board. In Massachusetts, the Connector Board is very small and only includes two consumer representatives (however, even those are only nominally so – an organized labor group and a public health professor). If governance is to be housed in a state department, such as the Department of Insurance, it will need to have an accountable governance structure with strong consumer representation.

Market Merger

(A.3.) Cost is another major consideration that will factor in the design of the Exchange. New York's individual direct-pay insurance market has been in a "death spiral" of adverse selection, due in part to some carriers leaving the market, and rising prices. Merging the individual and small group markets in a single Statewide Exchange will ensure the largest pool possible and the best pricing for consumers. Plans must not be able to sell different products outside the exchange or otherwise dump risk. However, the Exchange must also offer flexibility so that regional plans can participate and pricing can be adjusted to account for regional differences.

It is important to remember as well that the Exchange will not have control over the rules in the outside market. States will continue to set rules for the outside market that could encourage or discourage adverse selection, including marketing of plans. It is important that they receive guidance on how to limit adverse selection, and that they be encouraged to have the same rules both in and out of the Exchange.

Active Purchaser and Regulator

Effective cost containment can only be attained if the Exchange covers a significant share of the market and is able to leverage that share to set high minimum standards, comprehensive

benefits, and aggressively negotiate lower prices and terms with insurers. Much like large employers who are able to select insurers and negotiate contracts in exchange for a large number of new enrollees, the Exchange should be given the role of active purchaser and regulator. This will enable quality plans at affordable prices.

State-funded Safety-net Portal

In addition, it is estimated that up to 1.8 million New Yorkers could remain uninsured even after full implementation of the new law due to a lack of affordable options and the greater cost of living in New York. Opportunities to offer affordable coverage to individuals ineligible to buy in the exchange should be explored, such as a state-funded portal to assist people with safety net options.

Additional Resources

(A.4.) New York's resource needs will factor largely in the structure of the Exchange. New York, like many states, is facing a tough fiscal climate. HHS should assist states with additional financial resources to establish Exchanges.

Existing Infrastructure

(A.4.b.) New York houses several existing resources that could be leveraged as a starting point for Exchange operations and aid the operational transition. A centralized New York State Enrollment Center to serve public insurance enrollees is scheduled to start in 2011 and can likely be rolled into the Exchange. The state also has a strong enrollment network in community-based organizations, facilitated enrollers, public health plan facilitated enrollers, Health Pass, New York City's Office of Citywide Health Insurance Access, and independent insurance brokers.

On-line resources include the New York State Department of Health and Department of Insurance websites. Hudson Health Plan, a managed care organization in New York, has also started an on-line enrollment vehicle for public insurance programs. In addition, New York is home to Community Health Advocates (CHA), one of the largest health care consumer assistance programs in the country. This organization has a rich history in helping consumers with both enrollment and insurance navigation issues.

Despite these positive factors, New York state's legacy IT system is woefully inadequate to the task and the state will have to invest tens of millions of dollars in a new eligibility interface. The state has recently received a $1 million grant from the New York State Health Foundation to assess the existing system and determine what needs to be done to bring it up to speed by 2014. However, significant federal resources must be devoted to addressing the issue of legacy IT systems in New York and other states.

HCFANY recommends that HHS issue guidance to states specifically on design and governance for the Exchanges. States have been given considerable flexibility in this process, and whatever model they choose can dramatically affect the level of adverse selection, size of the risk pool, and governance. It is important that proper assistance be offered on these topics to ensure the viability of the Exchange in each state.

B. Implementation Timeframes and Considerations

(B.1., B.2., B.3.) There are several key implementation tasks that need to be accomplished in order to meet Exchange deadlines. As mentioned in the previous section, the structure of the Exchange, its governance, and its role remain to be decided and implemented. There are several other New York-specific factors that will also need to be reconciled with the formation of the Exchange: New York's existing re-insurance pools (e.g. high-risk pool, Healthy New York pools, actor's pool), pure community rating, and our year-round open-enrollment period.

HCFANY recommends that HHS designate staff to respond to state and stakeholder questions as they arise. Issuance of a more specific timeline would let states know if they are making progress and would allow stakeholders to better measure this progress. Key milestones could include determining the structure of governance and establishing an RFP process for plans, actuaries, web services, etc.

C. State Exchange Operations

Maximize Enrollment

(C.1.) HCFANY has several major considerations in planning for and establishing New York Exchange operations. The idea of "no wrong door" must be central to this design. The Exchange should also be built in a way that is equally effective no matter how consumers choose to access it – through the internet, phone, mail, or in person. Everyone, regardless of means, language spoken, or other status, should be able to use the Exchange to find out what they are eligible for, file for subsidies and exemptions and gain access to public coverage, the Basic Health Plan, or individual or small group coverage. People who are ineligible for private or public products should be able to use a state-only funded section of the Exchange to access state-run charity care coverage (paid for with Bad Debt/Charity Care funding). We see this as NY's opportunity to eliminate the disjointed patchwork system of enrollment in coverage and charity care programs.

The Exchange should also maximize enrollment through strong, closely integrated, Consumer Assistance Programs and Navigators. These programs should work together and with

other state programs to ensure seamless and effective enrollment and navigational assistance to maximize the number of New Yorkers receiving coverage and improve coverage for those who presently have insurance. Nonprofit, advocacy-oriented organizations have a substantial track record in New York and should be leveraged for these functions. Enrollment and coverage information should be simple and standardized.

High quality

We are recommending that the New York Exchange strengthen and build upon New York's strong public programs, including the Basic Health Plan, Medicaid, and Family Health Plus. We are also recommending that the state establish a stand-alone public option. A public option would bring greater competition to the health insurance market, ensure lower prices and higher quality, and provide a backstop should private insurance plans provide inadequate service. According to polling, a majority of Americans supported the creation of a public option, as did both of our Senators in New York. We recommend that HHS issue guidance that explicitly states that public options are permitted as options in state exchanges.

Health equity

It is vital that state exchanges also support principles of health equity and measures should be undertaken to ensure that racial and ethnic disparities in health care are diminished. Health coverage should promote equity based on race, gender, disability, serious illnesses or chronic conditions, language, and immigration status. Statistics on race, ethnicity, sex, primary language, and disability status which illuminate disparities in health care should be developed consistent with the initiatives in the federal statute.

In addition, there several specific ways in which we urge that the regulations guiding establishment of the exchanges promote gender equity by ensuring access to comprehensive reproductive health care:

First, we urge the Department to implement Section 1311(c)(1)(C) of the ACA in a meaningful and robust way, which requires that health plans participating in state-based exchanges contract with essential community providers, which includes women's health centers, HIV/AIDS clinics, community health centers, and public hospitals. Congress identified a number of providers—340B and "340B look-alike" providers—that Exchange-participating health plans must contract with, and the HHS rulemaking should reiterate and emphasize that requirement. Given the unique health care access needs of women, it is especially important that HHS emphasize the importance of requiring Exchange-participating health plans to contract with family planning clinics or women's health centers.

Second, we recommend that in developing criteria for Exchanges to use for certifying,

recertifying or decertifying Qualified Health Plans (QHPs), as required in Section 1311(d)(4), the Department address the special challenges that women sometimes face in finding providers of needed reproductive health services within plan networks. The criteria developed by the Secretary to determine whether a QHP has a sufficient range of providers should take into consideration the fact that some hospitals and clinics may not provide all of the covered services for ethical or religious reasons. In addition, individual providers may refuse to offer covered services. These restrictions may limit access to comprehensive reproductive health services and information about treatment options. An adequate network must include providers that offer all covered services. Moreover, in the event that an enrollee is not able to access the reproductive health services that she needs within the network, the QHP must be required to allow the woman to access services out of network without penalty, including in the case of emergencies.

Third, we urge the Department to promulgate as soon as practicable Section 1303 implementing regulations establishing "special rules' for the coverage of abortion services in qualified health plans. Such regulations should minimize the burden on insurers and enrollees of complying with the segregated payment structure outlined in the ACA, such as by permitting the use of one instrument (a check or electronic payment) to make both payments. We are concerned that any delays in Section 1303 rulemaking will place additional burdens on insurance plans and will decrease the likelihood that plans will provide coverage of abortion care, in violation of Congress' intent to preserve the coverage individuals currently have.

Fourth, while we do not presently believe New York will follow this path, we would like the Department to make clear that, if a state elects to establish a non-profit entity to operate its Exchange, the non-profit entity must not be permitted to exclude plans on the basis of the coverage the plan provides if it otherwise satisfies the benefit requirements of a qualified health plan as defined under Sections 1302(b) and 1303 and applicable state law. In particular, we urge the Department to ensure that, absent state law as permitted under Section 1303(a), a non-profit Exchange cannot prohibit plans that include coverage of abortion from participation.

Further, we want to call to the Department's attention a potential inadvertent negative side effect for women should a State require insurers to offer the same plans inside and outside the Exchange to discourage adverse selection. Because the ACA created "special rules" for the treatment of abortion coverage, a rule requiring insurers to offer the same coverage inside and outside an Exchange, if applied without exception, could result in far less abortion coverage than Congress or individual states intend. This is particularly true in states that have chosen to ban abortion coverage in state-run Exchanges but have chosen not to ban abortion coverage outside the Exchange. To account for the special rules that govern abortion, we urge the Department to consider an exception to any rule that requires insurers to offer the same plans inside and outside the Exchange for coverage of abortion. Such an exception would allow the Department to address

the serious concerns raised about adverse selection but would do so without running afoul of Congress' intent of preserving insurance coverage of abortion care.

State flexibility

(C.2.) There are certain aspects of Exchange operations or Exchange standards where State flexibility is likely to be particularly important. New York especially needs to retain the ability to ensure its strong consumer protections, including open enrollment, community rating, and benefit mandates. This will often include setting or keeping regulations at levels higher than the federal standards. For example, New York's current medical loss ratio was recently increased to 82%, whereas PPACA specifies that it should be set at 80%. This should be the case for defined benefits as well. Any federal regulation that defines a specific service should be a floor, not a ceiling, for states.

Infrastructure needs

(C.3.) In order to enable the Exchange's important operational functions, New York will need to replace its IT system. As mentioned previously, the old system is inadequate and burdensome, and even a small change can require up to 6 months to reprogram. With the new requirements for the Exchange system, such as transitioning to the MAGI system, NY should look towards streamlining enrollment and eliminating cumbersome or unnecessary federal and local requirements.

(C.4.) This new system should have the capacity to interface with records from both the IRS and the Social Security Administration. The system should allow for seamless transfers of eligibility from one program to another. It should also account for the time lag associated with income data to ensure that consumers are not penalized should their income drop significantly. This system needs to be accessible to navigators and consumer assistance offices (e.g. Health Care For All Massachusetts can access the state public insurance system to enroll people directly on line). The system will also need to capture the race, ethnicity, disability status and language spoken of each enrollee through the Exchange enrollment process in order to determine if/when disparities exist in enrollment, quality of care, etc.

(C.5., C.8.) In rebuilding its IT system and developing the Exchange web portal, New York will have to take special consideration of language access for those with limited or no English proficiency. In addition, the portal should be able to clearly explain the concept of actuarial values, premium costs and out of pocket costs to the consumer - including individual examples of cases and projected cost sharing. We are calling upon our state to convene a special planning group that includes facilitated enrollers, consumer assistance programs, and plan facilitated enrollers to determine what it will take to make the Exchange fully accessible

Premium Rate Review

(C.6.) In reviewing justifications for premium increases from insurers seeking certification as Qualified Health Plans (QHPs), New York will need to consider: the extent to which premium increases will create market instability, whether insurers met the target MLR or had to refund funds to individuals; the extent to which administrative costs were consumed by executive compensation; and the extent to which insurers have engaged in cost reductions without compromising quality of care and outcomes.

HCFANY recommends that HHS issue guidance on ways to maximize enrollment in the Exchange, including ways to streamline integration of existing programs, and transition to a MAGI system in the short time frame. Guidance should also be issued that explicitly states that public options are permitted in state exchanges.

D. Qualified Health Plans (QHPs)

(D.1., D.2.) New York has several major considerations that will need to be taken into account in certifying QHP's under the exchange. For example, ratios of upheld complaints/appeals, ratios of decisions reversed on external appeal, levels of executive compensation, measures results on the New York State Quality Assurance Reporting Requirements (QARR), and health equity data. While the state currently has good standards in place for HMO certifications, it will need to develop similar standards for EPOs to address network adequacy issues. New York and HHS need to address out-of-network billing issues as part of the certification process as well.

(D.2.a., D.2.b.) Health plans participating in the Exchange should be required to have adequate provider networks. There are several issues that New York needs to consider in relation to setting standards on choice of providers and information on the availability of providers. We recommend that the Exchange authority use the Medicaid standard of at least 3 primary care physicians within ½ hour on public transportation, board certification of provider lists, in-network Centers of Excellence, and appropriate doctor/specialist to patient ratios. In addition, there should be vigorous enforcement of marketing standards for QHP's. Content needs to be scrutinized to minimize false information in advertising. Minimum federal marketing standards should be established, with the ability of states to establish stronger standards if they meet the needs of state residents. Consideration should also be made for health equity and reduction of "cherry-picking" in marketing approaches.

(D.3., D.3.a., D.3.b.) In order to facilitate a sufficient mix of QHP's in the Exchanges, New York should consider mandating that insurers selling plans in New York participate in the

Exchange as a condition of doing business. Any insurer who is selling outside of the Exchange must only be selling to individuals who are ineligible to purchase within the Exchange or offer products that are identical to those in the Exchange (see, however, our earlier comments in section C regarding abortion coverage).

The ACA also prohibits plans from employing benefit designs that have the effect of discouraging people with significant health needs from enrolling. This is not an uncommon practice among insurers and it will be important that HHS set minimum standards for this requirement, and encourage states to effectively monitor plans to ensure that they are complying. States should also be encouraged to collect and track data on how plan benefit design may be affecting patient mix over time (using data gleaned from premium rate review and risk adjustment programs, for example) in order to detect whether changes in benefit design are provoking adverse selection among plans.

These requirements, along with a requirement to standardize products or the presence of a public plan could affect the participation of plans in the Exchange. If a procurement process is needed, it must be streamlined. This function could perhaps be housed in a separate section of comptroller's office in order to maintain fast-track for QHPs.

(D.5.) Two factors will be key in establishing minimum requirements for the actuarial value/level of coverage in New York: the definition of medical versus administrative costs, and the aim to limit out-of-pocket exposure for consumers.

(D.7., D.8.) With respect to the option of offering coverage under qualified nonprofit co-op plans, this is not a route that New York is likely to pursue. Co-op plans are unlikely to work in New York as most of our non-profit plans have converted to for-profit. Sadly, this seems an obsolete business model. However, the participation of multi-state plans in a New York Exchange is a possibility and we are recommending that the state should consider several factors when establishing standards for this: willingness to comply with New York's rules, the period of open enrollment, and New York's strong consumer protections – benefit mandates, community rating, and our managed care patient bill of rights.

(D.9.) Lastly, New York is actively considering the Basic Health Plan (BHP) as a vehicle to roll its existing Family Health Plus (FHP) program back to 133% of the Federal Poverty Level, and to have a new FHP-like product under BHP option.

HCFANY recommends that guidance be issued on how states can foster competition within plans based on value, price, network, and quality ratings, rather than through destructive risk segmentation.

E. Quality

(E.1., E.1.c., E.2) New York has an established insurance plan quality rating system called Quality Assurance Reporting Requirements (QARR) which successfully uses pay-for-performance incentives in our public insurance programs.[1] HCFANY recommends that New York's QARR system be built upon in developing a corresponding rating system for QHPs in the Exchange. However, health equity needs to be added to and explicitly addressed in the measures. New York will also need flexibility to go above federal quality standards for health plans, as the QARR program already utilizes measures above the federal quality standards set forth by the National Committee for Quality Assurance (NCQA).

(E.1.a.) The Exchange will be tasked with both explaining plan cost and quality and also allowing consumers to compare plans on these points. In order to help consumers understand the implications of their plan choices, the Exchange should be able to provide examples of typical scenarios under each plan choice available. For example, it should be able to describe the estimated financial exposure and quality ratings related to common diagnoses, like diabetes or cancer, under each plan available. Consumers should also be given information to allow them to compare plans on compliance issues, such as MLR, rate increases, or reported profits.

HCFANY recommends that guidance or regulations be issued on how to present quality data and plan information in a way that is most useful to consumers.

G. Enrollment and Eligibility

(G.1.) NY is a year round open enrollment state, and this should be maintained. If open enrollment is to be limited, the initial period should be very long and we should adopt liberal policy on special enrollment periods (consistent with our Health NY program), including death of spouse, loss of job, divorce, etc.

(G.2., G.3.) Having online enrollment will necessitate radically simplified applications in order to ensure that they can be completed without assistance, if necessary. This will mean that many of the federal Medicaid statute requirements beyond essential categories required to

[1] Brenson et. al., "Evaluating the New York State Medicaid Managed Care Quality Improvement Incentive Program," Urban Institute, February 2007.

determine eligibility will need to be eliminated, and in the need to provide physical documents to verify various eligibility categories will have to be reduced.

HCFANY has recommended that New York adopt a single, radically simplified application for all programs. This is the single best strategy to successfully enroll and retain the highest number of individuals – those who are eligible for tax credits and cost-sharing reductions, those who are eligible for public programs, and those not eligible for either.

Further, everyone needs to have access to and be able to use health insurance, regardless of language spoken or if they purchase insurance in or outside of the Exchange. In this respect, HCFANY recommends that HHS issue language access requirements for all insurers. For group plans, this should include written translation whenever the lower of five percent or 500 enrollees are literate in the same non-English language. For individual plans, written translation should be required whenever five percent of a county's population is literate in the same non-English language. For all plans, oral interpretation and translation should be required on an as-needed basis for all enrollees, as well as clear information on the availability of these services at no cost.

HCFANY recommends that guidance be issued on how to transition to online enrollment at a statewide capacity. New York, like many states, still operates on a largely paper-based system and information and resources on how to ease this transition is greatly needed. We also recommend that HHS issue language access requirements for insurers, including the standards listed above, to ensure that health insurance accessibility is maximized in each state.

H. Outreach

(H.1.) New York has several outlets available to educate and perform outreach to consumers on the new health reform provision: a social marketing campaign that closely works with community groups and grassroots facilitated enrollers, navigators, safety-net providers etc., a strong Consumer Assistance Program (e.g. Community health Advocates) which provides individual assistance, training sessions, one-pagers, educational presentations, a helpline, website, etc., and close coordination with stakeholders (e.g. HCFANY, Medicaid Matters NY, and local chambers of commerce).

(H.2.) Moving forward, we recommend that navigator programs be closely coordinated and included with state programs, to ensure that consumers are provided effective enrollment and navigational assistance. Nonprofit, advocacy-oriented organizations have a substantial track record

in New York in both the facilitated enrollment and consumer assistance arena and should be leveraged for these functions. The increased regulation of brokers also needs to be explored.

HCFANY recommends that HHS provide examples of outreach strategies for states based on target populations and special needs. This guidance should encourage states to utilize existing grassroots networks and community-based organizations, alongside state-based efforts.

J. Consumer Experience

(J.1., J.2.) New York should use a simple layout and language when designing the online interchange for the Exchange. Language should also be standardized across insurance options in order to avoid confusion. Special care should be taken for non-native English speakers or low-literacy consumers. Community-based organizations who are a trusted presence in the communities they serve will be essential to reaching individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency. Access should be made available in multiple languages and with definitions of terms available. In addition, the women's health centers and family planning clinics that provide safe, trusted, confidential reproductive health care to millions of women and men each year should be actively involved in informing their clients about the exchange and helping to enroll them in appropriate programs

Information that consumers will find useful in determining which plan to choose includes premium cost, schedule of co-pays, benefits, actuarial value (with explanations and examples), provider networks (including specialists and provider lookup), current customer satisfaction ratings from the Consumer Assessment of Healthcare Providers and Services (CAHPS) , and additional quality ratings from the Healthcare Effectiveness Data and Information Set (HEDIS), QARR, or other sources.

(J.3.) (J.4.) Regulation of all health insurance products should ideally be the purview of one single state agency in each state. In addition, consumer protection standards should be uniform across products (e.g. HMO, EPO, PPO). It is also important that consumer complaint efforts of different agencies be effectively coordinated if there is not a single state agency to accept complaints. If a multi-venue complaints system continues, it should be uniformly collected and reported through a single portal at the state or Exchange. This will allow for a more rapid response on reporting, addressing, or troubleshooting problems, particularly if provided by a consumer assistance program operating at a grassroots level. Problems that are location-specific are more likely to get lost in a larger information capture area and in particular will more greatly benefit from local-level data collection.

HCFANY recommends that HHS issue specific guidance on how to organize a feedback loop that maximizes efficiency. The consumer is the central basis for the Exchange, so a system of information gathering and timely response to consumer needs will be integral to its functioning.

K. Employer Participation

(K.1., K.2., K.3., K.4.) Employers looking to participate in the Exchange will have several factors to consider when making that decision: cost, simplicity of navigation within the Exchange, ease of enrollment, employee verification requirements for enrollment, transition and comparability with current plan, and eligibility for tax credits. Employers should also be able to buy a package (or set a contribution amount), and employees should have the option to self-fund the purchase of a higher level product if they wish to. Employers should also have good assistance available to facilitate the use of business tax credits.

HCFANY recommends that HHS issue guidance encouraging the use of the largest pool possible in determining the employer size limit (e.g. 100 employees) for participation in the Exchange.

L. Risk Adjustment, Reinsurance, and Risk Corridors

(L.1., L.2., L.3., L.5., L.7., L.6., L.8., L.10.) The New York State Department of Insurance is likely to fulfill the role of an "applicable reinsurance entity" as defined in the ACA. New York uses reinsurance for our direct-pay market and our Healthy NY product, and should be able to seamlessly integrate a temporary reinsurance program with our direct-pay reinsurance. Our reinsurance program has worked well in our Healthy NY product, where individuals are deemed high-risk or high-cost based on annual claims amounts. It is unclear how this will continue under the ACA and New York needs to exercise caution when implementing multiple risk selection mitigation strategies at once so as to not risk duplicate reimbursement for the same risk. Implementation of New York's risk adjustment in the private market has not been as successful and traditionally has been underfunded.

HCFANY recommends that HHS issue guidance on how to integrate the temporary reinsurance with existing state programs.

M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

(M.3.) Unique costs and benefits will affect New Yorkers based on the design, flexibility, and substance of the provisions mandated by the ACA. Women will be at a severe detriment if the two-check system is left intact. New Yorkers as a whole will be at a disadvantage if the State has to weaken its strong consumer protections (i.e. benefit mandates, community rating, etc.) in order to comply with the law.

At the same time, if New York can effectively pool the individual and small group markets both inside and outside of the Exchange, consumers will be greatly benefited and prices will be better kept under control. Similarly, if the Exchange authority can require plans to offer equal products both in and outside of the exchange, and negotiate lower costs, consumers will benefit. Equally important is if public products can be fully integrated into the Exchange. This will ensure that every New Yorker who needs coverage will be able to go to a single place to find it. Thoughtful design of the exchange offers extraordinary opportunities to improve access to health insurance, and these should be harnessed to the fullest extent possible.

Thank you for considering our comments. If you have any questions, please contact Elisabeth Benjamin at ebenjamin@cssny.org or at (212) 614-5461 or Arianne Garza at agarza@cssny.org, or (212) 614-5541.

Sincerely,

Elisabeth Benjamin, MSPH, JD
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Community Service Society of New York