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NEW YORK: INDIVIDUAL STATE REPORT

**State-Level Field Network Study
of the Implementation of the
Affordable Care Act**

June 2016

**Rockefeller Institute of Government
State University of New York**

The Brookings Institution

**Fels Institute of Government
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Part 1 – Setting the State Context

1.1 Decisions to Date

From the outset, there seemed no question that New York would establish its own state insurance exchange and would expand Medicaid eligibility. The state's affirming intentions were made soon after enactment of the Affordable Care Act (ACA). They were advanced early in the administration of Governor Andrew Cuomo, a Democrat who was elected in 2010. Although the state legislature was divided on the governor's initial proposal to set up a New York insurance exchange, an Executive Order in 2012 overcame partisan objections. The New York exchange and Medicaid expansion were both compatible with the state's prior health reform experiences as well as its political culture.

Early Actions by New York

The earliest evidence of New York's intention to mount a state-based exchange was the successful application in 2010 by the New York Department of Insurance for a federal exchange planning grant of \$1 million. Subsequent federal grants listed below were further confirmation of the intention of state officials to move ahead in implementing the ACA. The establishment of a New York state-based exchange included the following early milestones:

- Cuomo's Executive Order #42 on April 12, 2012, established the New York Health Benefit Exchange. The Executive Order located the exchange within the Department of Health and gave the exchange authority to work with the Department of Financial Services and other agencies to carry out requirements of the Affordable Care Act. The Executive Order also established five regional advisory committees representing Western New York; Central/Finger Lakes; Capital District/Mid-Hudson/Northern New York; New York City/Metro; and Long Island. In July 2012, the governor named Donna Frescatore executive director of the health exchange.¹ Partisanship around the exchange is discussed below.
- Conditional approval in December 2012 by the Department of Health and Human Services (HHS) to establish a state-based marketplace in New York.
- Approval of rates for seventeen carriers seeking to offer coverage through the state-based exchange in July 2013 by the Department of Financial Services.
- Announcement in August 2013 by the state that the online marketplace would be called "NY State of Health" and would be composed of:
 - An individual integrated marketplace offering Medicaid, Child Health Plus (CHP) and Qualified Health Plan (QHP) coverage, and
 - A small business marketplace, the Small Business Health Options Program (SHOP), offering health insurance to employers with fewer than fifty employees.

Partisan Division Around Location of the State Health Exchange

Executive Order #42 was Cuomo's *third* attempt to establish a health exchange. The first was a program bill in 2011 that would locate the exchange in a new, independent public benefit authority. The rationale was that a quasigovernmental authority would have greater flexibility than a state agency to hire and contract. The Democratic majority of the state Assembly supported the program bill; the Republican majority of the state Senate did not.

A second effort was advanced in the 2012-13 executive budget. Again, the Assembly approved, but the Senate majority did not. The Republican Senate opposition seemed grounded in unwillingness by some Republican members to "have anything to do with ... implementing and expediting Obamacare."² Others were generally critical of public authorities, calling them wasteful or overly secretive, with inadequate oversight.³

The third effort, locating the health exchange in the existing Department of Health — Executive Order #42 in April 2012 — was successful. It was a bipartisan solution, acceptable to both

Senate and Assembly leaders. The timing of the agreement was influenced by two factors. One was the short lead time between the Executive Order and October 1, 2013, when the ACA required state health insurance exchanges to commence. The other was the potential for future federal grants to New York to develop the exchange. Before the Executive Order, HHS awarded almost \$88 million to New York to lay the groundwork for an exchange (including, in 2011, an Early Innovator Grant of \$27.4 million to develop an informational technology infrastructure). “Health care groups and Democratic lawmakers [were] growing ... nervous [as federal deadlines passed] that the state could lose the chance to have the federal government shoulder the cost of setting up the exchange,”⁴ *The New York Times* reported. The newspaper characterized the governor’s Executive Order as a “deft healthcare move.” The Executive Order was neither legislatively nor legally challenged subsequently.

Individual Integrated Marketplace Enrollments: Years One – Three

As of February 1, 2016, the NY State of Health exchange completed its first (October 1, 2013 - March 31, 2014), second (November 15, 2014 - February 28, 2015), and third (November 1, 2015 - January 31, 2016) open enrollment periods for individuals. The SHOP offered continuous insurance enrollment throughout the two years for small businesses.

The Urban Institute projected that New York would enroll 1.1 million people into Qualified Health Plans at full implementation of reform: 615,000 individuals and 450,000 small businesses.⁵ This projection did not include public program (Medicaid and Child Health Plus) enrollment estimates. State exchange directors, interpreting three-years to be full ACA phase-in, focused on the individual QHP enrollment estimate of 615,000. In the first, second, and third years, 370,604, 415,352, and 271,964 New Yorkers, respectively, were enrolled in individual Qualified Health Plans. Total QHP enrollment of more than one million individuals over the three years clearly exceeded expectations.⁶

The third open enrollment period for individuals (November 1, 2015 - January 31, 2016) was marked by the addition of a Basic Health Program (BHP), a new option to Medicaid, Qualified Health Plans, and Child Health Plus programs offered on the state exchange. At the end of the 2016 open enrollment period, 379,559 individuals were enrolled in the Essential Plan. They included approximately 250,000 qualified noncitizens transitioned from Medicaid, plus New Yorkers under 200 percent of the federal poverty level. These and other details of the Essential Plan are discussed in the Addendum.⁷

Total individual enrollment on the NY State of Exchange for the first three years was distributed as follows:

	Year 1	Year 2	Year 3
Total Enrollment	960,762	2,143,413	2,833,823
Medicaid	55%	73%	69%
Qualified Health Plans	38%	19%	11%
Child Health Plus	7%	7%	7%
Essential Programs	—	—	13%

Sources: 2014 Enrollment Report; 2015 Enrollment Report; http://www.health.ny.gov/pressreleases/2016/2016-02-23_finalenrollment_2016.htm

SHOP Enrollments: A Brief Update

SHOP enrollments for 2013-14 (as of April 2014) were 3,106 small businesses that offered insurance to nearly 10,000 employees and their dependents.⁸ Small business enrollments in the second year increased, with 3,708 employers offering insurance as of April 2015 to nearly 15,000 employees and their dependents.⁹

Details on the New York SHOP are presented in Part 3 of this report. The individual integrated NY State of Health is the focus of Part 1.2, Part 2, and Part 3 of the report.

1.2 Goal Alignment

New York's affirming responses were consistent with President Barack Obama's goal to "fundamentally reform our health care system, delivering quality care to more Americans while reducing costs for us all."¹⁰

They were also compatible with the state's "paradoxical" progressive and competitive political culture. As I have written elsewhere:

[T]he New York character contains two dominant values: individual entrepreneurship and collective benevolence. New Yorkers generally believe that government should facilitate individual endeavors. At the same time, they have generally shown a spirit of tolerance even though they have not necessarily loved each other.¹¹

In his first State of the State message in January 2011, Cuomo emphasized individual entrepreneurship and efficiency, not benevolent government. He mentioned tax or taxes twenty-one times, mostly to denounce them, and promised to lower them. Further, he asserted, "What made New York the Empire State was not a large government complex. It was a vibrant private sector that was creating great jobs in the state of New York."¹² In addition to reducing the number of state agencies and freezing salaries of state workers, the new governor proposed to reduce Medicaid spending and to limit local property tax increases.

Medicaid Redesign

Within days after his inauguration in January 2011, Cuomo created a Medicaid Redesign Team (MRT) by Executive Order to reorganize and streamline New York's high-cost Medicaid program. High cost, inefficiency, and unacceptable quality of care were the drivers for reform.¹³ Executive Order #5 asserted "compelling public importance [for] the State [to] conduct a fundamental restructuring of its Medicaid program that achieves measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."¹⁴ The Executive Order stipulated a five-year path to fully integrated care management for all Medicaid recipients.

Cuomo appointed twenty-seven members to the MRT, representing hospital systems, health care advocacy and provider associations, state government commissioners, and chairs of legislative health committees. MRT was cochaired by Michael Dowling, president and CEO of North Shore Long Island Jewish Health System, and Dennis Rivera, former president of Local 1199 Service Employees International Union (SEIU), with more than 300,000 health care workers in the New York City area. Jason Helgerson, New York State Medicaid director, was named MRT executive director.

The backdrop to Medicaid redesign was a long history of high Medicaid spending in New York. From 1965 to the present, New York's Medicaid expenditures, both per capita and per enrollee, have been among the highest in the nation. However, its rankings among the states for overall health system quality and for avoidable hospital use and cost contrast unfavorably. The costs of New York's multibillion-dollar Medicaid program are borne by state, county, and federal governments. For a majority of county governments, "Medicaid costs alone account for than half of the entire county tax levy."¹⁵

Predecessors to Medicaid Expansion and the State Marketplace

Before Cuomo's tenure began or his Medicaid Redesign Team initiative got underway, New York made two decisions that logically led to support for Medicaid expansion under the ACA.

The first involved the use of Medicaid Section 1115 waivers by New York prior to the ACA. The state, through a combination of Medicaid and Family Health Plus, covered parents to 150 percent of FPL and single and childless adults to 100 percent of FPL. These actions of New York State to expand Medicaid under waivers were noteworthy. In fact, the subsequent ACA requirement to expand Medicaid to 138 percent of FPL was "not a big deal" given the expansions New York had already achieved through its waivers.¹⁶

New York argued, after the fact, that the federal government should retroactively fund New York's liberalized Medicaid eligibility level. Before final enactment of the Affordable Care Act, a

provision was inserted that allowed “do gooder” states (who expanded Medicaid eligibility under waivers) to receive a higher federal matching rate for the single and childless adults they covered prior to 2014.¹⁷ Ultimately, New York was allowed to receive 75 percent federal medical assistance percentage (FMAP) for single and childless adults under 100 percent of FPL and 100 percent of FMAP for single and childless adults between 100 percent and 138 percent of FPL. By 2020, both groups will receive a federal match at 90 percent.

The other decision, authorized by the state legislature in 2010 and funded in 2011, was to centralize Medicaid eligibility at the state level. The state takeover involved shifting intake to the New York Department of Health away from the state’s fifty-seven county departments of social services and New York City’s Health and Human Services agency. The resulting centralized and computerized process, to be accomplished over five years, was a huge change from inconsistent local intake processes.

Medicaid payments to providers have been centrally administered since 2005 under the eMedNY claims processing system.¹⁸ Centralized determination of Medicaid eligibility for greater efficiency and consistency had long been discussed. In fact, most local social services districts welcomed the shift for all clients (with the exception of elderly and disabled persons) as cost-saving and efficient and, ultimately, as lower property taxes for local taxpayers.

The ACA prompted the shift. A centralized intake function was viewed as an opportunity to develop a system that would facilitate application processing under the state-based exchange. It was consistent with New York’s goal to “maximize uniformity in Medicaid and Exchange programs rules.”¹⁹ Although it made sense for the state to take over Medicaid eligibility, the multiplicity of county intake processes made “centralization a much bigger challenge than anticipated.... In fact, the state takeover was facilitated by the ACA integration of Medicaid, Child Health Plus, and Qualified Health Plans.”²⁰

New York’s centralized Medicaid intake started at the same time as planning for the New York exchange. The challenges to develop a complicated and sophisticated information technology system for centralizing Medicaid eligibility, and at the same time to build an integrated health insurance exchange, were not identical, but they were symbiotic.²¹ New York was one of seven states to receive Early Innovator IT awards. That work, to determine eligibility for public (Medicaid and Child Health Plus) and qualified private insurance plans on the exchange, proceeded in tandem with the state takeover of Medicaid eligibility.

The choices by New York to expand Medicaid, to establish a state health exchange, to centralize Medicaid eligibility, and to redesign Medicaid were consistent with New York’s political culture. Expanding access to both Medicaid and private health insurance was the progressive dimension. Lowering county property taxes by state assumption of Medicaid eligibility — to retain

private sector jobs and attract new investments at local levels – was the competitive one. Maximizing federal dollars for all these purposes was not only smart, it was consistent with long-established practices of New York.²²

Part 2 – Implementation Tasks

2.1 Exchange Priorities

The New York State exchange is housed in the Department of Health (DOH), an agency of the state government. DOH has major responsibility for implementation of the exchange. The Department of Financial Services (DFS), the state insurance regulating agency, also has an important role. Relationships between DOH and DFS were spelled out in the governor's Executive Order #42 (see Part 1.1).

The functions of website development, information systems capability, and program articulation are located and administered in NY State of Health. The Division of External Affairs, Outreach and Marketing oversees the marketing and outreach work of the Marketplace. Assistors (navigators, certified application counselors, and health plan facilitated enrollers) are overseen by the Department of Health Office of Health Insurance Programs. Brokers are overseen by the Marketplace SHOP Division and Department of Financial Services. Outreach "on the ground" by navigators, assistors, and brokers is decentralized under contract with statewide and regional agencies. These functional arrangements within DOH are elaborated in later sections of this report.

DFS regulates health insurance carriers in New York.²³ This function is carried out by the Health Bureau Division within DFS. Such regulation includes examining financial reports for solvency of insurers, approving policy and contract language, examining timeliness of claims, and setting and approving premium rates for small groups as well as for individuals. DFS is responsible for licensing with SHOP team collaboration pertaining to Marketplace training and certification and broker relations.

Rate-setting may seem the most critical function affecting insurers offering plans on the exchange. However, the range of functions administered by DFS is equally essential. For example, carriers on the exchange who elect to offer the same products off the exchange must do so at the same rates. The ACA stipulated that its requirements were to be folded into the conduct of insurers offering Qualified Health Plans on the marketplace. According to the DFS director of rate review, it was a "ton of work to comply with the ACA requirements" since many of them were not identical with state requirements. For example, information on past claims or prior experience is not used in setting rates for the previously uninsured or newly insured."²⁴

The exchange has substantive priorities that affect administration of various implementation tasks. As articulated by the New York marketplace executive director, they are:

- Improving customer interactions and meeting the needs of a diverse population of potential enrollees;
- Protecting personal information of consumers;
- Ensuring that all Qualified Health Plans include all provider types necessary to deliver the services covered, including hospitals, primary care physicians, specialists, and essential community providers such as Federally Qualified Health Centers;
- Assessing the incremental demand for primary care;
- Enrolling children and families;
- Giving employers flexibility to select plan contributions and options that work best for them.²⁵

2.2 Leadership – Who Governs?

The New York state exchange (NY State of Health) is a separate division of the Department of Health. DFS works in conjunction with the health department, as explained in Section 1 of this report. The organization of NY State of Health is shown in Appendix A.

While this section focuses on leadership *within* the state exchange, the strong commitment of Cuomo to establish a state-based marketplace was critical. The governor's flexibility in locating the exchange within the Department of Health and his subsequent approval for the DOH to expedite hiring new employees (mainly with federal funds) were illustrative of his leadership.²⁶

The leaders featured in this section held key positions when ACA implementation started. With one exception (SHOP director), they continue to hold those positions. They are concentrated in the Department of Health (executive director and deputy director of NY State of Health, Medicaid, SHOP director, and SHOP director of Broker Relations) and in the Department of Financial Services (deputy superintendant and director of rate review in the Health Bureau).

Except for the deputy director of the NY State of Health, who is based in New York City, top management officials are located in Albany, the state capital. Each leader, with two exceptions — SHOP director and SHOP director of Broker Relations — brought strong backgrounds in health policy management and public sector experience to the state marketplace. All served on various interdepartmental (health and financial services) teams that worked “really hard and collaboratively” during “friendly, daily interactions around the exchange” before it was launched on October 1, 2013.²⁷

The leader of NY State of Health is Donna Frescatore. Prior to her appointment as the first executive director of the NY State of Health, Frescatore had long management experience in state government — rising from initial appointment in 1987 in the Department of Civil Service, where she served for eleven years, to the Department of Health in 1998. In 2010, she was appointed New York Medicaid director and deputy commissioner of the office of Health Insurance

Programs. She was appointed to her current position from the Governor's Office, where she was assistant deputy secretary of Health. As leader of the state exchange, Frescatore was lauded in interviews for her expertise, ability to build on past relationships with nonprofit organizations and state agencies, her gradualist and incremental approach to problem-solving, and for setting the tone for collaborative, friendly interactions around the exchange.

Danielle Holahan is deputy director of NY State of Health. Before appointment in 2014 to her present position, Holahan served for three years in the health department's policy and planning division. Holahan brought to the state government health policy analysis skills from eleven years with the United Hospital Fund, New York City, and before that, AARP's Public Policy Institute in Washington, DC. At the United Hospital Fund, she was codirector of its health insurance project. Her report, *Coordinating Medicaid and the Exchange in New York* (2011), positioned her well for a leadership role in NY State of Health.²⁸

Jason Helgerson, New York Medicaid director in the Department of Health, reports directly to the commissioner of Health. Helgerson, appointed to his present position by Cuomo in 2011 as well as executive director of the Medicaid Redesign Team, came to New York from Wisconsin. There, he served as Wisconsin Medicaid director; before that, he was a policy adviser or budget official for the mayor of San Jose, the Milwaukee public school system, and the Milwaukee mayor.

Judith Arnold, director of Medicaid Eligibility and Marketplace Integration, has held various positions in the Department of Health for more than twenty years. Her Medicaid/marketplace portfolio made her a central actor in resolving complex challenges of the integrated state marketplace. Arnold praised the marketplace as "good for the consumer," but also found that integrating "different criteria, different regulations, and different clients was more challenging than anticipated."²⁹ She was a vice president at the Lewin Group in Washington, DC, prior to her work in New York State.

Kelly Smith was director of the New York small business exchange (SHOP) from November 2012 (when she organized the SHOP) to her resignation in 2014 after enrollment was well underway. She brought to the SHOP extensive experience with nonprofit and for-profit organizations in the health insurance field. During the decade prior to her New York government appointment, she was head of the small business market for the Capital Physicians IPA (Albany area). Smith developed a health insurance platform model exchange for the Chamber of Commerce in Saratoga, NY, a model she expanded to Chambers of Commerce in other communities in the Albany Capital District.

Joseph Muldoon was promoted to SHOP director in July 2015. Prior to that, he was director of Broker Relations in the Small Business Health Options Program (SHOP). He was appointed in 2012 to NY State of Health, reporting to Frescatore. Before that, he had

more than thirty years' experience in the private health insurance sector. As a broker representing various health insurers (GHI, UnitedHealth, and Support Services Alliance), he understands the incentives for small business employers to purchase insurance.

Troy Oeschner is deputy superintendant for health at the Department of Financial Services, reporting directly to the superintendant. Before joining DFS, Oeschner served in the Office of the Attorney General for almost fourteen years, most recently as deputy bureau chief in the Health Care Bureau. There he directed litigation against health plans, drug manufacturers, pharmacy benefit managers, doctors and hospitals for illegal and deceptive business practices.

John Powell is director of rate review in the Health Bureau of the Department of Financial Services. He reports to the deputy superintendant. Powell brought considerable experience within the former Department of Insurance to his present position.

The regional councils named in the governor's Executive Order #42 were convened shortly after marketplace implementation began, but not specifically after that. Rather, members of the regional councils are invited when topic-specific conferences (e.g., coverage, outreach, or basic plan elements) are convened.³⁰

There is no oversight board for the state exchange, because it is located within a state government department.

2.3 Staffing

NY State of Health has a staff of 149. Ninety-seven are full-time employees of the exchange, and fifty-two have appointments split between Medicaid and the exchange. They are all government employees. Except for locations in New York City of the ten-person staff of the deputy director and one outreach staff member in Buffalo, there are no local offices of NY State of Health.

Many consultants were involved in building the state exchange. Their services were funded with federal grants that totaled \$575 million for planning and operation of the exchange through the first open enrollment period in 2014. Key consultants included Computer Services Corporation (CSC), Maximus, and Wakely Consulting Group. CSC was the lead developer for the integrated marketplace, as well as for Medicaid eligibility centralization, and continues to have responsibility for operation of the state-based exchange.

The website presents information targeted at individuals and families, employees, employers, brokers, and navigators. Telephone numbers are provided for assistance. Facebook, Twitter, and Google links are provided. CSC, the website contractor, and technicians/operators are all located in Albany.

See Part 4.1 for a discussion of the financing of the exchange after federal funds were no longer available.

2.4 Outreach and Consumer Education

Outreach during the first open enrollment period (2013-14) was largely carried out through activities of statewide and community partnerships. For the second open enrollment period, the state exchange expanded its outreach efforts.

First Open Enrollment Period

Many New York statewide partnerships were established long before the Affordable Care Act. Although their constituent bases differed, they shared a strong interest in how the ACA would play out in New York. Major statewide partnerships representing such diverse interests as consumers, providers, insurers, and business were (and are):

Consumers:

- *Citizen Action Society of New York* (www.citizenactionby.org) is a grassroots organization with eight chapters and affiliates in major cities across the state. A member of HCFANY, Citizen Action takes on such societal issues as “guaranteed quality, affordable health care.”
- *Community Health Advocates (CHA)* (www.communityhealthadvocates.org) with twenty-five partner organizations that help families and small businesses use their health insurance and access health care.
- *Community Service Society of New York (CSS)* (<http://www.cssny.org/>) helps enrolls individuals, families, and small businesses and their employees in free and affordable health insurance statewide. CSS is also the director of the CHA program and a leading member of HCFANY.
- *Empire Justice Center* (<http://www.empirejustice.org>) is a statewide public interest law firm focused on protecting and strengthening the legal rights of poor, disabled or disenfranchised New York residents through advocacy, training and direct civil legal representation.
- *Health Care for All New York Campaign (HCFANY)* (<http://hcfany.org/>), a statewide coalition of over 150 organizations devoted to securing affordable, quality health care for all New Yorkers.

Providers:

- *Greater New York Hospital Corporation* (www.gnyha.org) acts on behalf of nearly 250 hospitals and continuing care facilities in the metropolitan New York area as well as New Jersey, Connecticut, and Rhode Island.
- *Healthcare Association of New York State (HANYS)* (<http://www.hanys.org/>) represents all New York’s hospitals and health systems.

- *Medical Society of the State of New York* (<http://mssny.org/>) represents physicians in advocacy before New York and United States governments.

Insurers:

- *Coalition of New York State Public Health Plans* (<http://www.phspcoalition.com>) represents New York's nonprofit, publicly focused health plans and the safety net populations they serve. Coalition plans serve the majority of children and adults accessing their public insurance coverage through health plans.
- *New York State Conference of BlueCross BlueShield Plans* (<http://www.nysblues.org>) is a partnership of Rochester-based Excellus Blue Cross Blue Shield and New York City-based Empire Blue Cross Blue Shield. Together, the two health insurance plans provide comprehensive health coverage for millions of New Yorkers and provide research and analysis of the cost, access and quality of health care.
- *New York State Health Plan Association* (www.nyhpa.org) speaks for managed care plans across the state that provide comprehensive health services to more than six million New Yorkers.

Business:

- *Business Council of New York State* (www.bcnys.org) represents more than 2,400 private sector employers working to create economic growth and good jobs.
- *Chamber Alliance of New York State (CANYS)* (<http://www.canys.org/>) acts on behalf of Chambers of Commerce around the state.

Funders:

- *The New York State Health Foundation (NYSHealth)* (<http://nyshealthfoundation.org/>) supports projects and community organizations to expand health care coverage.
- *Robert Wood Johnson Foundation* (<http://www.rwjf.org>) is the United States' largest philanthropy focused solely on health. A private foundation, its mission is to improve health and health care for all Americans.

Many of these statewide partnerships were directly involved in funding, outreach, consumer education, and/or personal assistance before or during the open enrollment periods. Several examples of these activities are described in following sections of this report.

In 2013, the Community Service Society of New York (CSS), self-described as “an informed, independent, and unwavering voice for positive action on behalf of more than three million low-income New Yorkers,” convened with HCFANY fourteen well-attended educational events throughout the state for stakeholders, including the organizations just named, who were thirsty for information.³¹

Direct outreach to identify New Yorkers without health insurance and to assist them to enroll on the NY State of Health was decentralized. The state contracted with navigator organizations to provide enrollment assistance; many navigator organizations subcontracted to local community organizations. Outreach efforts were ultimately targeted to lower-income neighborhoods through flyers to community and health agencies; public service advertisements on television, radio, and social media; and word of mouth (see also Appendix B).³²

In addition, the NY State of Health was supported by a Customer Service Center (call center). Tasks performed by the call center included providing information to consumers; processing phone applications from start to finish as well as completing applications that were started in other channels; processing documentation when required to complete an application; and processing applications submitted by mail.³³

The call center, staffed directly or indirectly by linguists of ninety languages led by Spanish and Chinese (Mandarin and Cantonese) speakers, handled over one million calls during the first open enrollment period.³⁴ “Overall, 18 percent of Marketplace enrollees indicated a non-English language as their preferred language,” New York State of Health reported. In addition to the customer service representatives who speak five languages other than English, the language line translation service assisted consumers in ninety-two languages.³⁵

Second Open Enrollment Period

NY State of Health developed several new approaches for the second open enrollment period to enable consumers to better understand and access their health insurance options. They included:

- Plan preview, or anonymous shopping, for individuals to shop for a health plan before starting an application on NY State of Health’s website. The plan preview tool allowed nearly two-and-a-half million individuals to get a premium quote without having to enter personal information and complete an application.³⁶
- Stepped-up efforts to reach more non-English speaking New Yorkers. The exchange added a Spanish version to its website that included an online application, and also translated “key outreach and educational materials into 17 additional languages.”³⁷

Another change in the second open enrollment period was renewal notices by postal mail or electronically between mid-October 2014 and mid-November 2015 to more than 300,000 QHP households enrolled in the NY State of Health in 2014.

QHP enrollees who did not want to change their coverage in 2015 [and/or] ... whose program eligibility was unchanged ... did not have to take any action to remain covered by their health plan in 2015.... As of February 28, 2015, 86 percent of

individuals who were sent renewal notices renewed their coverage for 2015,³⁸ according to NY State of Health.

2.5 Navigational Assistance

Major Sources of Navigational Assistance

Forty-eight organizations were designated as navigator contractors; they brought with them ninety-five affiliated local or regional organizations. New York trained and certified nearly 9,000 individuals to provide free, in-person enrollment assistance to New Yorkers applying for insurance coverage through the marketplace.³⁹

Organizations Involved

The largest navigator contractor with the NY State of Health is Community Service Society New York. CSS was awarded a five-year contract in July 2013 with an August 2013 start date. Operating in sixty-one of the state's sixty-two counties, CSS quickly called on a network of affiliates to cover enrollments in Medicaid, CHIP, and the qualified plans.⁴⁰

As the hub within a "hub and spokes" model, CSS subcontracted with many local affiliated organizations – the spokes. The combination of groups affiliated with CSS was eclectic, including regional organizations (e.g., Adirondack Health Institute), and interest groups (e.g., Chambers of Commerce, Legal Assistance of Western New York).⁴¹

From the largest to the smallest county in New York, multiple NY State of Health enrollment locations were offered. Three examples:

- *Kings County (Brooklyn)*, New York's largest county with population in 2010 of two-and-a-half million, had forty-nine assistor locations in 2013-14 throughout the borough. Brooklyn Perinatal Network was a lead navigator, staffing twenty-two locations through subcontracts with agencies that included Brooklyn Hispanic Chamber of Commerce, Brooklyn Public Library, and Fort Greene SNAP.
- *Monroe County (Rochester)*, an urban county with population of 744,344 in 2010, had eleven locations directly staffed by navigator contractor Community Care Services, Inc., and one location subcontracted by CSS to Legal Assistance of Monroe County.
- *Hamilton County (Adirondacks)*, with the smallest county population in 2010 of 4,836, had two navigators. The Family Counseling Center of Fulton County, Inc., directly staffed four locations, and CSS subcontracted with Adirondack Health Institute to staff a fifth.

Certification

All navigator organizations operate under five-year contracts. Individual navigators and in-person assistors on the individual exchange are recertified annually. Training sessions are offered

throughout the state. In 2013, sessions were conducted by Maximus⁴² during the two months before the exchange was launched. The schedule, according to an observer, was “very/too tight; the presenters talked about what we knew at the same time the exchange was being built.”⁴³ In 2014, new navigators and assistors attended three-day spring training courses; recertification for experienced navigators and assistors was accomplished after webinar training.

There was – and is – heavy reliance on the NY State of Health website for individuals to scan insurance options and to enroll. Training for navigators and assistors is heavily focused on the website. Unfortunately, training for the first open enrollment was largely on paper instruments rather than computers because the website was under construction at the same time the training was offered. That was rectified by hands-on computer training prior to the second open enrollment period.

Capability of Navigational Assistance to Meet Anticipated Needs

The NY State of Health website has functioned smoothly over three years. During the very first three days of operation in October 2013, “The marketplace was overwhelmed by volume (thirty million persons accessing the website). That was quickly remedied, however, by the fourth day when information technology (IT) capacity held in reserve for future Medicaid expansion in the third year was quadrupled.”⁴⁴ Volume, measured in concurrent visitors per peak hour to the website, spiked at the end of December 2013 and at the end of March 2014. “While traffic to the site [was] high, the website ... operated at or above expectations, with an average system response time of 3.48 seconds for each web page,”⁴⁵ NY State of Health said. Even with some technical difficulties and high volume, the state marketplace estimated average enrollment times of forty-five minutes for persons applying for financial assistance and thirty minutes for those who were not.⁴⁶ One personal assistor reflected that “the majority of persons in a diverse population waiting to enroll were patient and happy when the process led to insurance for them.”⁴⁷

The story was different during the second open enrollment period for individuals. In 2014-15, the average time to enroll was considerably lower – under thirty minutes for a single individual in Monroe County and under forty-five minutes for a family. “The website operated at or above expectations, with an average system response time of 2.5 seconds for each web page,” including renewals as well as new enrollments,⁴⁸ according to NY State of Health.

New York exceeded Urban Institute projections for the second open enrollment period of 410,000 QHP enrollees and 2 million QHP and public programs. See the table on page 3.⁴⁹ The combination of a well functioning website, high proportion of renewals in the second year, and increased efficiency of expanded and experience navigational assistance undoubtedly contributed to these results (see Appendix C).

2.6 Interagency and Intergovernmental Relations

2.6(a) Interagency Relations. Bureaucracies are frequently characterized as slow and resistant to change.⁵⁰ That description was contradicted by “really hard work” by *intradepartmental* teams (within the Department of Health) charged with centralizing Medicaid eligibility and building the IT platform for NY State of Health. Several exchange managers commented on the strong work ethic and commitment to these projects for health reform and health insurance exchange integration. As described in Part 2.8, pertinent staff within the Medicaid and exchange divisions of the Department of Health was engaged in the IT build.

Division of responsibility between two state departments for operation of the state exchange created the need for ongoing collaboration. As explained in Part 1.1, the Department of Health and the Department of Financial Services share tasks essential for operation of the integrated exchange. The “biggest worry and source of stress” for SHOP managers in the early implementation process was “the interface with the DFS,” because of its authority over brokers and agents, and regulation of rates of various insurance products.⁵¹ Frescatore’s partnership approach with DFS and insurers worked well to smooth out disagreements over rates. Her practice of meeting monthly with CEOs of the various insurance carriers created trust and led to substantive changes.⁵²

2.6(b) Intergovernmental Relations.

State-Federal Interactions

From 2010 on, New York exchange officials have interacted frequently with federal agencies. During the nearly three years before the state launched its NY State of Health marketplace, New York received multiple grants:

- Exchange Planning grant of \$1 million in 2010.
- Early Innovator Grant of \$27.4 million in 2011 to develop an information technology infrastructure that could be replicated by other states.
- Three federal Level One Establishment grants of \$10.7 million, \$48.5 million, and \$95 million to fund IT systems, expand consumer assistance, redesign the state’s eligibility and enrollment system, and create an all-payer database, hire marketplace executive leadership and staff, develop back-end customer support functions, and conduct consumer outreach and program integration.
- A Level Two Establishment Grant for \$185.2 million in January 2013 to support outreach and marketing, fund IPA training and certification, purchase an accounting system, and support IT development.⁵³

With the addition of an operating grant for the first year of the state exchange, total federal grants to New York through 2014 were estimated at \$575 million.⁵⁴

Since 2014, NY State of Health officials have interacted in regular, ongoing communication with several federal agencies. Characterized by the exchange executive director as “transactional,” the interactions are most frequent with the Centers for Medicare & Medicaid Services (CMS) involving metrics, such as encounter and utilization-of-services data as well as progress on milestones for specific grants. Other federal agencies to which the state reports regularly are the Internal Revenue Service (IRS) about IT security reviews and 1095 tax credits and the Department of Labor (DOL). The state accesses and validates income tax and Social Security data through the federal data hub.⁵⁵

Interstate Relations

After enactment of the ACA, but before final decisions were made about location of the state exchange or expansion of Medicaid, Frescatore, then New York Medicaid director, talked with Medicaid directors and health policy managers from other states. Conversations with officials in Kentucky, Washington, and California involved implementation of health insurance exchanges in those states. New York also contacted officials in Massachusetts and Minnesota, both of which expanded Medicaid eligibility under Medicaid waivers (Section 1115), about retroactive reimbursement under the ACA.

New York officials also benefited from interstate dialogues and technical assistance provided by the Robert Wood Johnson State Reform Assistance Network and the National Academy of State Health Programs.⁵⁶

2.6(c) Federal Coordination. Frescatore has characterized the relationships among CMS, IRS, and DOL as “collaborative” with each other and with New York.⁵⁷ In addition, she commented: “We enjoy open communication with federal agencies and are pleased with the guidance given to us during an interactive learning process ... with ongoing new tasks.”⁵⁸

2.7. QHP Availability and Program Articulation

2.7(a) Qualified Health Plans (QHPs).

2013-14 QHP Enrollments

Over 960,000 New Yorkers enrolled in the state exchange through April 15, 2014. Of that total, 370,604 enrolled in QHPs with or without financial assistance. Seventy-four percent of QHP enrollees were eligible for financial subsidies.

- Such assistance was in the form of tax credits to reduce the cost of premiums for persons whose incomes were at or less than 400 percent of the FPL. (That was for most single adults earning less than \$45,960 and for families of four earning less than \$94,200).
- Cost-sharing reductions that lower copayments, deductibles, and out-of-pocket maximums for most single adults earning less than \$28,725 and for families earning less than \$58,875 who enroll in silver QHPs.⁵⁹

QHP Insurers

Sixteen health insurers qualified for and offered QHP coverage to individuals in the first open enrollment period (2013-14). Health insurance under Medicaid and Child Health Plus was also available for year-round enrollment for those who qualified by income.

The 2014 NY State of Health Open Enrollment Report lists the number and percentage of enrollees in each insurance plan for each of the state's sixty-two counties. The widest geographical distribution is for various insurers doing business as BlueCross/Blue Shield. Geography, however, was not directly correlated with market share of enrollments.

Four insurers each enrolled 10 percent or more QHP enrollees:

- Health Republic Insurance of New York (19 percent)
- Fidelis Care (17 percent)
- MetroPlus Health Plan (15 percent)
- Empire Blue Cross Blue Shield (14 percent)

The remaining 35 percent were spread across twelve insurers, most of whom enrolled 4 percent or fewer QHP enrollees.⁶⁰

2014-15 QHP Insurers and Enrollments

Over two million New Yorkers enrolled in coverage through the state exchange as of February 28, 2015. Of that total, 415,352 enrolled in Qualified Health Plans, with or without financial assistance. This exceeded projected enrollment at the end of the second year.⁶¹

Sixteen health insurers qualified for and offered QHP coverage to individuals in the first open enrollment period (2013-14). Fifteen insurers continued from the first year plus an additional carrier.

Six of the sixteen insurers expanded their individual market-place offerings to additional counties.⁶² Consequently, enrollment was somewhat more evenly distributed across the insurers in 2014-15, with the total of 59 percent (down from 65 percent) for four insurers with largest QHP enrollments. They were:

- Fidelis Care (20 percent)
- Health Republic Insurance of New York (19 percent)
- Healthfirst (10 percent)
- Empire Blue Cross Blue Shield (10 percent)

The remaining 41 percent were spread across twelve insurers, most of whom enrolled higher proportions of QHP enrollees than in the prior year.⁶³

Individual QHPs by Metal Level

Qualified Health Plans were offered through the NY State of Health at four different metal levels. The following table shows the distribution of metal level by premium, out-of-pocket cost (deductible or copayment), and enrollment for the 2013-14 open enrollment period.

Metal Level	Premium	Out of Pocket	Enrollment % of Total
Bronze	Lowest	Highest	19
Silver			55*
Gold			10
Platinum	Highest	Lowest	13
Catastrophic			2

Source: NY State of Health, *2014 Open Enrollment Report*.

* Silver-level plans offer several cost-sharing reductions that reduce out-of-pocket costs, deductibles, and out-of-pocket maximums. American Indians and Alaskan Natives with incomes less than 300 percent of the FPL are eligible for additional cost-sharing reductions at all metal levels. Ten percent of enrollees were in silver-level plans without cost-sharing reductions; the remainder (45 percent) was enrolled in one of three silver level cost-sharing reduction plans.

The distribution by metal level in the 2014-2015 open enrollment period was consistent with that of the prior period.

Metal Level	Premium	Out of Pocket	Enrollment % of Total
Bronze	Lowest	Highest	18
Silver			58*
Gold			10
Platinum	Highest	Lowest	12
Catastrophic			2

Source: NY State of Health, *2015 Open Enrollment Report*.

* Silver-level plans offer several cost-sharing reductions that reduce out-of-pocket costs, deductibles, and out-of-pocket maximums. American Indians and Alaskan Natives with incomes less than 300 percent of the FPL are eligible for additional cost-sharing reductions at all metal levels. Thirteen percent of silver enrollees were in plans without cost-sharing reductions; the remainder in one of three cost-sharing reduction plans.

Stand-Alone Dental Plans

The New York exchange offered stand-alone dental insurance plans (SADP) for consumers whose QHP purchase did not include dental coverage. Such stand-alone plans were available both years with pediatric and/or family coverage. Ten carriers offered a SADP in 2013-14; more than 51,000 consumers (12 percent of enrolled QHP purchasers) enrolled in a SADP that year. In 2014-15, nearly 40,000 consumers – or 9 percent of all QHP purchasers – enrolled in a SADP offered by eleven carriers.⁶⁴

2.7(b) Clearinghouse or Active Purchaser Exchange. New York operates a state insurance exchange that is appropriately classified as *active purchaser*. The Health Bureau of the Department of Financial Services actively sets premium rates with health insurance carriers whose policies and contract language are approved by the bureau. DFS has authority over both small group and individual rates.

2.7(c) Program Articulation. New York's marketplace is integrated, covering all plans (Medicaid, Child Health Plus, and the QHPs) and income categories. Connections between enrollee characteristics and appropriate insurance programs are calculated through the NY State of Health IT platform.

2.7(d) States That Did Not Expand Medicaid. Not applicable.

2.7(e) Changes in Insurance Markets. Before the Affordable Care Act, the New York individual insurance market was "dysfunctional and adversely selected,"⁶⁵ as one observer put it. That is because very sick people who needed insurance the most dominated the number of covered lives. A "premium death spiral" drove away healthy individuals from the individual market.⁶⁶

These outcomes were surely *not* the intention of advocates of New York health reform in the early 1990s. On the contrary, the New York Health Reform Act of 1992 (HRA) was intended to pave a path for affordable, accessible health care. Governor Mario Cuomo called the legislation a "forerunner of what we'll [be] seeing nationally."⁶⁷

HRA focused on individuals without health benefits from their employer who were forced to shop for insurance on their own in the individual market. To protect them, the state legislature enacted a major overhaul in the individual insurance market. Among the features in the 1992 act were:

- A "guaranteed issue" provision, which prohibited insurance companies from denying coverage to customers, even those with preexisting conditions;
- "Pure community rating" that prohibited insurers from varying premiums based on customers' age or health, another common industry practice;
- Authorization for consumers to buy insurance after they became sick with only a relatively short waiting period. They could also drop it when they no longer needed it; and
- A stipulation in 1995 that all HMOs offer a comprehensive, standardized package of benefits.⁶⁸

Contrary to what some insurers predicted, the New York insurance market did not immediately collapse. However, as the *Los Angeles Times* reported in 2010, "in the ensuing years, more older and sicker New Yorkers bought individual health plans. And premiums shot upward." Between 2001 and 2010, "average premiums for a health plan on the individual market in New York nearly tripled, according to the state Insurance Department. In

some counties it is impossible to buy an individual plan for less than \$12,000 a year.”⁶⁹

A 2009 survey by America’s Health Insurance Plans, an industry group, showed that “average premiums in New York were more than twice those in California and Florida, two other high-cost states.” Some states (Kentucky and Washington) rescinded their new insurance rules in the 1990s “after insurance companies abandoned the state market,” the newspaper reported. In Washington state, “the three largest insurers simply stopped issuing coverage to individuals.”⁷⁰

New York, in contrast, retained both guaranteed issue and pure community rating rules. “But with premiums continuing to climb, the market regulations [were] increasingly becoming an empty promise.”⁷¹ Before the Affordable Care Act, only about 20,000 New Yorkers were covered under the Health Reform Act of 1992.

The last piece to complete health reform in New York was the individual mandate in the ACA. The individual mandate was in large part responsible for an influx of younger, healthier covered lives through NY State of Health, offsetting the high premiums under the 1992 Health Reform Act.

Another explanation for lower premium rates was the inverse relationship between premium increases and changes in market share. Insurers “that implemented significant premium rate increases in 2015 saw decreases in market share between 2014 and 2015 [while] insurers that either decreased their premium rates or only modestly increased rates, saw increases or relative stability in their respective market shares,”⁷² according to NY State of Health.

2.8 Data Systems and Reporting

New York started early to deal with the simultaneous challenges of building the infrastructure for Medicaid centralization and a state marketplace. Such IT efforts incorporated capacity to map distributions of families and children with and without health coverage. Metrics such as encounter and utilization-of-services data, progress on milestones for specific federal grants, and the annual *Open Enrollment Reports* demonstrate New York’s reliance on its IT platform.⁷³

Extending IT capacity was undertaken to enable New York to move ahead on its next priority for health insurance coverage – to identify and focus outreach efforts on specific populations such as Hispanics, African Americans, and young adults, and on geographic areas.

Part 3 – Supplement on Small Business Exchanges

3.1 Organization of Small Business Exchanges

NY State of Health “was one of the only state-based marketplaces to successfully launch [not only an individual, but also] an

online small business marketplace on October 1, 2013,”⁷⁴ Frescatore told lawmakers. Known as the Small Business Options Program (SHOP), it was intended to address the needs of small employers – those with fifty or fewer employees – by offering new options to make covering employees easier and faster.⁷⁵

Background

New York’s early launch of SHOP was informed, in part, by lessons and experience offered from the Small Business Assistance Program (SBAP). Administered by CSS, SBAP was funded by New York State establishment grant funds and the New York State Health Foundation.

SBAP “was a first-in-the-nation program that trained and provided grants to small business-serving organizations to educate New York State small employers about the Affordable Care Act (ACA) and help them with their health insurance problem.... Between 2012 and 2014, SBAP funded 34 small business-serving organizations, including 21 Chambers of Commerce and four Small Business Development Centers. SBAP was administered by the Community Service Society (CSS) which provided funding, training and materials, performed quality assurance, and provided technical assistance to the 34 organizations.”⁷⁶

Implementation Challenges

SHOP, the last department to be built within the exchange, posed particular implementation challenges. One involved the dominance of brokers in the small business insurance market. The other challenge was technological.

Broker Dominance

Unlike the integrated insurance marketplace, where individuals directly consider and select insurance options, a major test for the SHOP was to convince brokers to do business with the small business exchange. Kelly Smith, the first SHOP director, said “brokers control 90 percent of the small business market in New York’s entrenched broker system.”⁷⁷ An exchange official noted that they “are totally independent; they are licensed with companies who provide liability insurance for them.”⁷⁸ Consequently, Smith said, it is easier to do business with 100 brokers than with each employer.⁷⁹ The dominance by brokers is further strengthened because the small business market is community rated. In other words, “there is no financial incentive for employers to go around brokers and shop for coverage on their own,”⁸⁰ Smith said.

Several brokers interviewed for this report commented on the limited attraction of the SHOP for small business owners. One said that access to the SHOP insurance offerings is meaningful only for owners who qualify for tax credits, which he

characterized as “small.” He added that for businesses with fewer than twenty-five employees, “multiple choices within and among Qualified Health Plans (particularly silver plans with several options) and insurers may be confusing for small business owners and their employees.”⁸¹ Another broker viewed the SHOP as an “ineffective middleman between the broker and the small business.... It is far more efficient for a broker representing a small business to deal directly with an insurance carrier.”⁸² The only SHOP incentive of any value to the small business owner, that broker noted, is a tax deduction (on premiums), and even this is attractive to very few small businesses.

The challenge for SHOP success, in Smith’s view, was “to get brokers comfortable.”⁸³ One approach was organizing the New York SHOP around the realities of the broker-dominated system. Brokers or regional sales directors were selected to head the Western, Capital District, Westchester/Long Island, and New York City regions of the state and to concentrate on customer service and broker relationships.

Brokers for the small business exchange are certified every two years. Such certification involves training about the federal exchange as well as NY State of Health. For the first year, “SHOP didn’t create enough opportunities for brokers to come in and play around with the enrollment portal; the portal just wasn’t ready on time,”⁸⁴ Smith said. For the second year, each candidate who already held a state broker license in good standing had to successfully complete a recertification course offered by the SHOP.

Technology Challenge

The second major challenge to implementation of the New York SHOP is technological. The integrated individual marketplace was the primary driver of NY State of Health; Computer Services Corporation was under contract to develop that platform. Small business had to piggyback on the CSC platform with a SHOP software package that CSC then tweaked. Several iterations have been built since then to create what an exchange official called the “most broker-friendly state.”⁸⁵ From a broker’s perspective, however, enrolling for insurance is still cumbersome.

Small Business QHP Availability

Ten insurers offered Qualified Health Plans each year in the SHOP to small businesses with fifty or fewer employees. In the first year, enrollment was open throughout the calendar year, starting on October 1, 2013. Data available for the first year indicate that ten health insurers offered plans to small business owners between October 1, 2013, through April 15, 2014. Over 3,000 small businesses offered insurance to nearly 10,000 employees and their dependents.⁸⁶

As in the individual insurance market, various Blue Cross/Blue Shield insurance carriers were most widely represented

geographically. Four carriers, led by Health Republic Insurance of New York (34 percent), Excellus BlueCross BlueShield (22 percent), Oxford (12 percent), and MVP Health Care (11 percent) had the highest market shares of SHOP enrollees in SHOP.

In the second year, as of April 2015, small business enrollments increased, with 3,708 employers offering insurance to nearly 15,000 employees and their dependents.⁸⁷ Two carriers, led by Health Republic Insurance of New York (35 percent) and Excellus BlueCross BlueShield (27 percent) had the largest market shares.

Why a relatively modest increase in employer participation in New York's SHOP the second year? One explanation, according to a report by the Community Service Society of New York, is that "small employers who hesitated to participate in the first year of the new marketplaces [were late in exploring] the new coverage options available [the second year] in the SHOP Marketplaces."⁸⁸

In New York, SHOP directors drew on their personal experiences as brokers. To attract brokers to SHOP, such "value propositions as multiple plans, a simple billing process (in which employers pay SHOP, which, in turn, pays the various insurance carriers), and no requirements for employer participation or employee contributions" were offered,⁸⁹ an exchange official explained.

The lack of SHOP requirements for employer premium contributions and percentage of employee participation were acknowledged by brokers as attractive to small businesses. However, for small business employers who were hoping to qualify for tax credits and premium deductions, they were not viewed as sufficiently attractive. The value propositions were still not on track to achieving the Urban Institute's early estimate that 450,000 persons would be covered through small business employers in NY State of Health by the third year of ACA implementation.⁹⁰ After two years of experience, New York brokers apparently were not yet comfortable with the SHOP.

New York expanded its definition of small business group in the third year, starting January 2016, from 50 to 100 employees. Although originally intended to be the case in every state as of January 2016, Congress enacted the PACE Act (Protecting Affordable Coverage for Employees) in 2015. PACE kept the original definition of small group at up to fifty employees, but gave states the option of using the expanded definition. Two years earlier, in 2013, New York had passed its own law aligning the original ACA definition of small group. Thus, the PACE Act had no impact on New York's law, and employers with up to 100 employees could use NY State of Health's SHOP exchange.⁹¹ In addition to New York, a few other states — California, Colorado, and Vermont — maintained their original plans to use the expanded small group definition as of January 2016. Enrollment data for the New York SHOP's third year were unavailable as of the release of this report.

Part 4 – Summary Analysis

4.1 Policy Implications

Intergovernmental policy implementation is not a “one and done” process, particularly when the policy involves multiple, new responsibilities for the states. ACA implementation involved many institutions and actors as New York affirmed two major options for states – expansion of Medicaid eligibility and establishment of a state-based marketplace.

Nearly one million individuals successfully enrolled for health insurance on NY State of Health in the first year (2013-14) of operation of the state-based exchange. Enrollment increased impressively twofold in the second year (2014-15) to over 2.1 million.

- Medicaid enrollment accounted for 75 percent of the total; most renewed coverage (see Appendix D).
- Qualified Health Plans were 19 percent of second-year total enrollment. Most QHP enrollees were previously uninsured; three-quarters received insurance subsidies. This suggests they could not afford health insurance before the ACA (see Appendix E).
- Nearly 160,000 children enrolled in Child Health Plus, composing 7 percent of total 2014-15 enrollment.

The SHOP is organizationally part of the NY State of Health exchange (see Appendix A), but differs noticeably from the integrated individual marketplace. SHOP focuses on small businesses, offers different insurance products, and relies on brokers instead of in-person assistors. SHOP enrollment – less than 15,000 employees in the second enrollment year – contrasts greatly with over 2.1 million individual enrollees.

Several factors account for New York’s initial decisions and actions over two years to implement the integrated individual NY State of Health. These factors are leadership, prior experience, and partnerships with stakeholders. They are grounded in the progressive and competitive political culture that defines New York.

The section first focuses on the governor and key administrators of the state-based insurance exchange. They are the major health policy actors within the state government who determined and lead the implementation process. The role of the state legislature is also considered. In the second section, we comment on partnerships between nonprofit agencies and the state government in implementing the ACA.

Leadership by State Government Officials

Newly elected Governor Andrew Cuomo set the pattern for aggressive attention to the actions that followed. In 2011, Cuomo strongly endorsed the establishment of a state-based insurance exchange. After endorsement of his 2012 Executive Order by the Democratic majority of the State Assembly and the Republican majority of the State Senate (see Part 1.1), he moved quickly to

appoint Donna Frescatore, assistant deputy secretary for Health in the Governor's Office, as executive director of NY State of Health. Appointments of key administrative leaders of the exchange, each with a strong background in health policy management, followed.

Based in two departments (Health and Financial Services), key administrators worked collaboratively, efficiently, and very hard for over a year before the state-based exchange opened for business. Integral to success was ongoing interaction between state government leaders and staff of Computer Services Corporation, the lead contractor in the development of the complicated and sophisticated information technology system for the exchange. A clear chain of command under Frescatore's leadership was critical for achieving the scheduled launch of NY State of Health on October 1, 2013.

Knowledge and experience of the leadership team were essential in planning for the first open enrollment period. Another factor was also in play. That quality was nimbleness, the ability to learn and adapt over time.

NY State of Health opened on time in 2013, but not without some early glitches. With thirty million persons accessing the website in the first three days, volume overwhelmed the marketplace. In addition, technical problems with the new enrollment process resulted in long response times, even with assistants entering data on the website for potential enrollees. The adaptive response by exchange leaders on the fourth day was to release and quadruple IT capacity held in reserve for additional Medicaid expansion planned for the third year.

Ability to learn and adapt also marked planning for the second open enrollment period. The result was a smoother experience than in 2014 for persons enrolling or renewing on the website. Advance planning included approaches such as plan preview, that is anonymous shopping before applying; renewal notices sent electronically or by mail; and more languages available for non-English speakers.

State Legislature

The New York State legislature has generally played a supportive role in the implementation of the ACA. An example of general support by the legislature is a bipartisan, noncontentious bill enacted in March 2014. Approved by both the Assembly and the Senate, this bill authorized a basic health plan in compliance with the Affordable Care Act. The legislation will provide subsidized health coverage on the exchange for residents with annual incomes between 138 to 200 percent of the federal poverty level (see below for more information on the basic health plan).

When differences surfaced between the legislature and the Cuomo administration, they tended to originate with the Republican majority of the state Senate, and centered on state exchange details. Two notable disputes with the Cuomo administration involved location and state funding of the exchange.

- In 2011, the Senate Republican majority opposed the governor's proposal to house the exchange in a new, independent public benefit authority. The disagreement was resolved with bipartisan support of an Executive Order in 2012 locating the health exchange within the Department of Health (see Part 1.1 for elaboration).
- In 2015, when federal funds for operating the NY State of Health were no longer available, the issue was state funding sources. Unlike the just-discussed exchange location, this one involved a challenge to the governor's proposal by a united legislature. The *New York Post* reported that the governor put forward in his executive budget proposal a "\$69 million tax on health insurance policies [about \$25 per policy].... Lawmakers balked, arguing the new tax was counterintuitive to the goal of making health insurance more affordable.... The Republican-led Senate didn't even consider the so-called 'Exchange Tax' in its spending plan. The Democratic-run Assembly initially embraced the tax in its budget proposal but abandoned it during negotiations [with the Senate]."⁹² Effective lobbying by the New York Health Plan Association, on behalf of health insurers (see below), led to agreement by leaders of the Assembly and the Senate. They approved the use of existing state taxes on health insurance premiums (under the State Health Reform Act of 1992) to generate an estimated \$70 million annually to fund exchange operations. That bipartisan legislative agreement was incorporated in the final state budget.⁹³

The Importance of Prior Experience

NY State of Health did not suddenly appear *de novo* on the New York policy landscape. Rather, Medicaid expansion and the state-based individual, integrated insurance marketplace were both logical extensions of initiatives that predated the Affordable Care Act.

New York has long been known for its high-cost Medicaid program; Medicaid is a major driver of spending for both state and county governments.⁹⁴ Under Section 1115 waivers, New York raised the Medicaid eligibility threshold for parents and childless adults. Centralization of Medicaid eligibility at the state level, away from county departments of social services to promote efficiency and decrease local costs, was approved by the state legislature in 2010. And one of Cuomo's earliest actions as governor was to designate a Medicaid Redesign Team to achieve better health outcomes, sustainable cost control, and more administrative efficiency.

Two of these initiatives were directly related to the ACA. Increased Medicaid eligibility standards under Section 1115 waivers turned out to be a precursor to Medicaid expansion under the ACA. Centralization of Medicaid intake at the state level was

undertaken separately, but concurrently with design of the state-based exchange. Finally, Cuomo's Medicaid Redesign Team signified his priority for cost-effective, integrated care management for all Medicaid recipients, a goal consistent with the ACA.

Stakeholder Collaborations

New York's health care interests are multiple, diverse, and well-organized. From the outset, statewide partnership organizations were encouraged to advance their positions on the ACA, dialogue with NY State of Health officials and staff, and members of the state legislature, and engage in outreach efforts to identify and assist individuals to enroll through the state-based exchange. Three statewide organizations – HANYS, HPA, and NYSHealth – exemplify support of the state-based exchange and ongoing dialogue with officials to help to shape exchange details.

The Healthcare Association of New York State (HANYS) is the only statewide hospital and continuing care association in the state. HANYS represents 500 nonprofit and public hospitals, nursing homes, and home care agencies. The organization's initial and continuing responses to the state-based exchange and Cuomo's initiatives to restrain Medicaid costs have been consistently positive.⁹⁵

The New York Health Plan Association (HPA), an organization of twenty-two health plans, provides comprehensive health care services to nearly seven million New Yorkers. HPA leaders testified before the state legislature in 2013 and in 2015 of collaboration with exchange staff on such details as "criteria for qualified health plans; market participation rules; actuarial soundness ... [and] greater access to services in more appropriate settings."⁹⁶ As described above, HPA lobbied actively to fund exchange operations with existing taxes on health insurance policies.

Nonprofit local and statewide organizations were essential partners with NY State of Health, reaching out to uninsured New Yorkers and helping them to enroll online during the first and second open enrollment periods. New York trained and certified nearly 9,000 individuals to provide free, in-person enrollment assistance. They were organized by large as well as small agencies across the state. They ranged from Community Service Society New York, operating in sixty-one of New York's sixty-two counties under a large state navigator contract, to the Adirondack Health Institute, which staffed one location in the state's least-populated county. The participation of these state and local stakeholders was clearly important in the impressive renewal rate of 86 percent in the second individual open enrollment period (see Appendix C).

New York State Health Foundation (NYSHealth) is a continuing collaborator with the New York Department of Health to expedite ACA implementation. The only New York statewide health foundation, it was formed in 2006 after conversion of

nonprofit Empire BlueCross BlueShield to for-profit WellChoice corporation.

To further its mission “to increase health coverage in New York State,” NYSHealth first issued grants to reform Medicaid.⁹⁷ Subsequently, foundation leaders, realizing that “funding effective, but ultimately small-scale projects was not going to have a large impact on the problem of 2.6 million uninsured New Yorkers,” changed course by concentrating on the broader goal of advancing successful implementation of health reform. The foundation subsequently funded seven health reform grants that concentrated on key components (IT, navigator and consumer assistance, eligibility, and enrollment) of the New York exchange.⁹⁸ More recently, NYSHealth has funded grants to train navigators, to support enrollment networks to reach harder-to-reach populations — e.g., lesbian, gay, bisexual, and transgender (LGBT) and low-wage service workers — and to develop health care options for undocumented immigrants.

4.2. Possible Management Changes and Their Policy Consequences

Intergovernmental policy implementation is a continuous process as is speculation about future management changes and policy consequences.

Even so, I am confident to anticipate — at least for the near future — that leaders of ACA implementation in New York will continue to demonstrate both steady and nimble qualities.⁹⁹ Field research covering the first two years of ACA implementation leads to the conclusion that they apply in contemporary New York State.

Steady Leadership

Steadiness or stability implies ongoing commitment to the Affordable Care Act by managers of its implementation in New York. Such commitment is based on two key factors: longevity in current position and prior experiences. Leaders of NY State of Health and of Medicaid expansion have been in place since their initial appointments by Cuomo. Their past experiences in formulating and administering health policy (within the state government, for most) not only point to their individual and collective knowledge, but also their dedicated attention to the complex challenges of the tasks involved.

Nimble Management

Nimbleness implies energetic and timely adaptability to environmental change. Two programs — the federal Delivery System Reform Incentive Payment (DSRIP) and the Basic Health Program — illustrate how New York’s leaders, using federal funds, have taken advantage of recent health system change opportunities.

DSRIP is part of broader federal Section 1115 waivers to support hospitals and other providers with significant funding “to

change how they provide care to Medicaid beneficiaries.”¹⁰⁰ The DSRIP 1115 waiver for New York resulted from protracted negotiations over two years between the Cuomo administration and the Centers for Medicare & Medicaid Services (CMS).¹⁰¹ The settlement, in 2014, was \$8 billion in federal funds from Medicaid Redesign Team savings, to be used by the state as payments from 2015 to 2019 “to provider networks that implement delivery system reform projects and meet accountability metrics.”¹⁰²

In a 2015 study of four states with DSRIP waivers, the Kaiser Family Foundation cited two notable features of the New York waiver:

- The requirement that the state plan integrate DSRIP initiatives into Medicaid managed care “by ensuring 90 percent of managed care payments to providers use value-based methodologies”;¹⁰³ and
- The stipulation that holds the state “accountable at a state-wide level for ensuring that its DISRIP investments are effective.”¹⁰⁴

New York’s leaders in the Medicaid division of the Department of Health exhibited energy and tenacity in pursuing a DSRIP waiver, planning for its implementation, and promoting stronger collaborative relationships among DSRIP providers. Such energy and tenacity reflect back to Cuomo’s creation in 2011 of the Medicaid Redesign Team to lower costs and improve quality.

The ACA Basic Health Program (BHP) — in New York, the Essential Plan) — is an optional addition for states to the individual insurance exchange. New York has the nation’s leading and largest Basic Health Plan. Details of the New York plan, including background, eligibility, and financial benefits to the state, are elaborated in the Addendum, “New York’s Basic Health Program.”

Taking effect on January 1, 2016, it differs from the Qualified Health Plans already on the health exchanges (state-based and federal) in that it is neither a tax credit nor a cost-sharing program. New York residents under sixty-five ineligible for federal Medicaid because of immigrant status or income are eligible for the Essential Plan if their incomes are between 138 percent of the FPL to 200 percent of the FPL.

New York received CMS approval in March 2015 to establish a BHP. The state sought such approval for several reasons.

One was to increase affordability and accessibility to health care for New Yorkers whose incomes are too high to qualify for federal Medicaid, but too low to afford premiums and/or copays for policies offered on the NY State of Health exchange. Monthly premiums will range from zero if income is below 150 percent of the FPL to \$20 for income between 150 percent and 200 percent of the FPL. Cost-sharing charges are also correspondingly low. Participation in the program by eligible persons (largely immigrants residing under color of law and single persons) is estimated to add more than 400,000 enrollees on the state-based exchange.¹⁰⁵

A second reason was the financial advantage to New York. There are no tax or cost-sharing subsidies for the Essential Plan. Instead, the federal government will provide the state with funding “in an amount equal to 95 percent of the amount it would have spent had the individuals who enrolled in the state’s plan enrolled in the Individual Marketplace.”¹⁰⁶ New York will also be advantaged by federal funds for health care to legal immigrants enrolled in New York’s Essential Plan. Federal funds will substitute for state funds that New York has long used state funds to provide health care for persons with permanent residence under color of law (PRUCOL).

All 95 percent federal funds will be paid into a state trust fund managed by the New York Department of Health. Insurance carriers participating in the Essential Plan will receive a monthly capitation payment from DOH for each plan enrollee; they will separately collect applicable insurance payments made by enrollees.

DSRIP and the Essential Plan demonstrate the willingness of NY State of Health leaders to respond to opportunities for more efficient and effective health care. Both programs are compatible with New York’s long-established practice to pursue federal funds and with the central dimensions of the state’s political culture. Substituting federal for state funds – under DSRIP and the Essential Plan – is consistent with competition. So, too, is system redesign under DSRIP for more efficient and effective health care. Expanded health care access under DSRIP and the Essential Plan for persons currently ineligible for Medicaid is consistent with compassion.

Stable and energetic leadership is a central feature in implementation of the Affordable Care Act in New York. New York’s leaders affirmed state options early and subsequently acted to improve access, quality, and cost-savings. They were influenced by past experience and enhanced ACA implementation through partnerships with statewide, nonprofit organizations. There seems every reason to expect such nimble, adaptable, and knowledgeable behavior to continue.

Addendum: New York’s Basic Health Program

Basic Health Program

In March 2015, New York received approval from the Centers for Medicare & Medicaid Services to establish a Basic Health Program (BHP). The BHP is an option for states under Section 1331 (a) of the Affordable Care Act “to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for [federal] Medicaid due to their immigrant status. This coverage is in lieu of Marketplace coverage.”¹⁰⁷

As explained in Part 4.2 of this report, the state exercised this option for two reasons:

- To increase affordability and accessibility to health care for New Yorkers who did not qualify for federal Medicaid and could not afford policies on the state exchange, and
- For financial benefit to New York from federal funds associated with the BHP.

Section 1331 (a) allows states “significant flexibility in how to establish a BHP, [but also stipulates that] “the program ... be coordinated with other insurance affordability programs.”¹⁰⁸

New York’s BHP is known as the Essential Plan (EP). Qualifications for enrollment are straightforward:

- State residency,
- Under age sixty-five,
- Not eligible for federal Medicaid or Child Health Plus,
- Income between 138 and 200 percent of the FPL, or
- Income less than 138 percent of the FPL and not eligible for federal Medicaid due to immigration status.

The last category pertains to legally residing noncitizens, including qualified aliens who have been in the United States less than five years and PRUCOLS. PRUCOLS are “non-citizens who are residing in the United States with the knowledge and permission or acquiescence of the Department of Homeland Security and whose departure from the U.S. DHS does not contemplate enforcing.”¹⁰⁹

Legally Residing Noncitizens: Background

In 2010, New York’s population was 19.3 million; this total included 4.3 million immigrants, or 23.5 percent of the population. Of the immigrant residents, 2.2 million were naturalized citizens, 1.4 million lawfully resided in the state, and more than 600,000 were undocumented. In brief, approximately 85 percent of immigrant New Yorkers were either citizens or legal residents as of 2010.¹¹⁰

According to a state exchange official, PRUCOLS are a small subset of noncitizens with incomes less than 138 percent of FPL and not eligible for Medicaid. “The largest group is qualified aliens who have been in the country less than five years.”¹¹¹

The United Hospital Fund reported that 12 percent of New York residents were uninsured in 2010. Noncitizens, however, were more than three times as likely as citizens to lack health insurance.¹¹² “Reasons for the disparity include noncitizens’ higher rate of employment by small businesses that do not offer insurance, an underutilization of public insurance programs owing to a lack of awareness of their rights, concerns about immigrant consequences of accessing such services, and language and other barriers.”¹¹³

Aliessa v. Novello

Federal law imposes a five-year waiting period for federally funded Medicaid benefits for lawful permanent residents. A June 2001 ruling by the New York Court of Appeals, the state's highest court, expanded New York's responsibility beyond federal requirements to provide access to immigrants not covered under federal law. The court ruled in *Aliessa v. Novello* (96 N.Y.2d 418) that the state had violated both its obligation under the New York State Constitution and the Equal Protection Clauses of the state and federal constitutions by limiting access of lawfully residing immigrants to the state's Medicaid program."¹¹⁴ The *Aliessa* decision, in essence, required New York, regardless of federal financial participation, to cover all legally residing nonresidents, including qualified aliens and PRUCOLS.

The *Aliessa* decision originally applied to Medicaid benefits for legally residing noncitizens under the New York Welfare Reform Act of 1997. Subsequent court decisions affirmed access to Family Health Plus, Child Health Plus, and Prenatal Care Assistance programs.¹¹⁵ The final administrative directive was issued by the New York Department of Health (DOH) in December 2004. It stated, for determining eligibility of immigrants for Medicaid, that "only two groups of noncitizens [were] ineligible:

- 'undocumented' immigrants, that is, those [with] no evidence at all of contact with the United States Department of Citizenship and Immigration Service ("CIS"), and
- temporary non-immigrants, lawfully in the United States, but only for a temporary period. This category includes visitors, short term visa holders and foreign students."¹¹⁶

These exceptions were superseded by an expanded definition of lawfully residing in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the ACA. "This definition extended coverage to temporary non-immigrants determined to be residents of the state; in turn, it broadened the population affected by the *Aliessa* decision."¹¹⁷

Enrollment in the Essential Plan

On April 1, 2015, PRUCOLS were transitioned (administratively moved) to the Essential Plan. "They will [then] receive ... coverage through the same [Medicaid] managed care plan through which they are currently enrolled until their eligibility renewal date in 2016."¹¹⁸

Open enrollment began on November 1, 2015. On January 1, 2016, Essential Plan eligibility levels increased to 200 percent of the FPL. "All new applicants with incomes below 200 percent FPL, not eligible for Medicaid or CHIP, under age 65, and without Medicaid Emergency Assistance will be determined eligible for BHP and permitted to select a BHP plan."¹¹⁹ Coverage of BHP services for these groups was effective as of January 2016.

PRUCOLS were a small subset of Essential Plan enrollees. The “vast majority of the enrollees were legal permanent residents with less than five years in the country.”¹²⁰

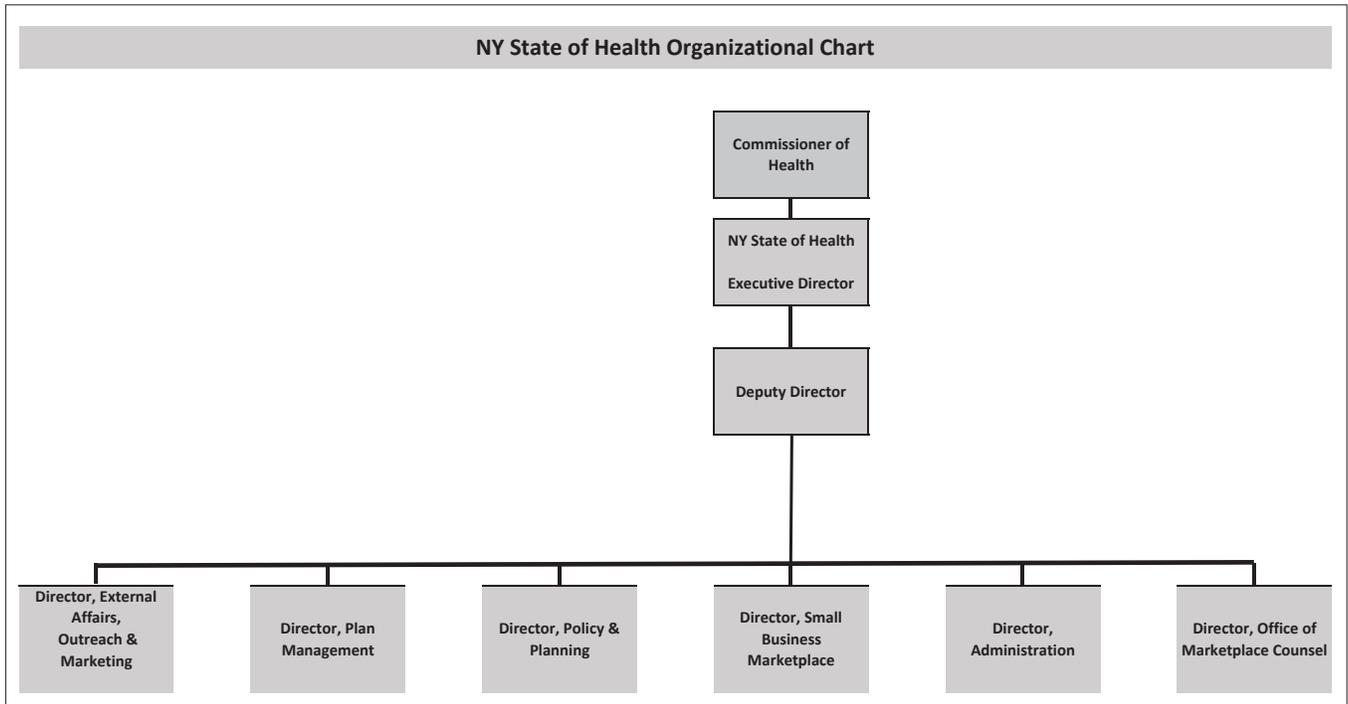
Outreach Efforts

Outreach to qualified aliens in the United States less than five years and PRUCOLS — as well as to younger, uninsured individuals who were eligible for Qualified Health Plans — followed similar approaches as in the first and second open enrollment periods on the state insurance exchange. As explained in this report, navigator organizations worked with local community organizations to identify hard-to-reach populations such as minorities, low-income families, and immigrants. “We always reached for this population” to determine Medicaid or Medicaid Emergency Assistance, according to one navigator program manager.¹²¹ In advance of the third open enrollment period, partnerships with individual community agencies and health networks were expanded. So, too, were advertisements in beauty and barber shops, a new outreach effort encouraged by NY State of Health.

Financial Benefits to New York

New York projected full BHP enrollment of more than 470,000 persons (250,000 PRUCOLs in transition from state-funded Medicaid plus 220,000 individuals renewed or new through open enrollment).¹²² Federal funds to New York — equal to 95 percent of subsidies for BHP enrollees if they had been eligible for coverage on the state marketplace — will be paid into a state trust fund managed by the New York Department of Health. In the 2015-16 state fiscal year (April 1-March 31), the State Medicaid program “is expected to save just over \$1 billion from the transition of lawfully residing non-citizens from Medicaid to the Essential Plan. The savings are expected to decrease to \$804 million with enrollment of the broader essential plan eligible population in 2016-2017.”¹²³

Appendix A NY State of Health Organization



Appendix B Local Outreach Activity Examples

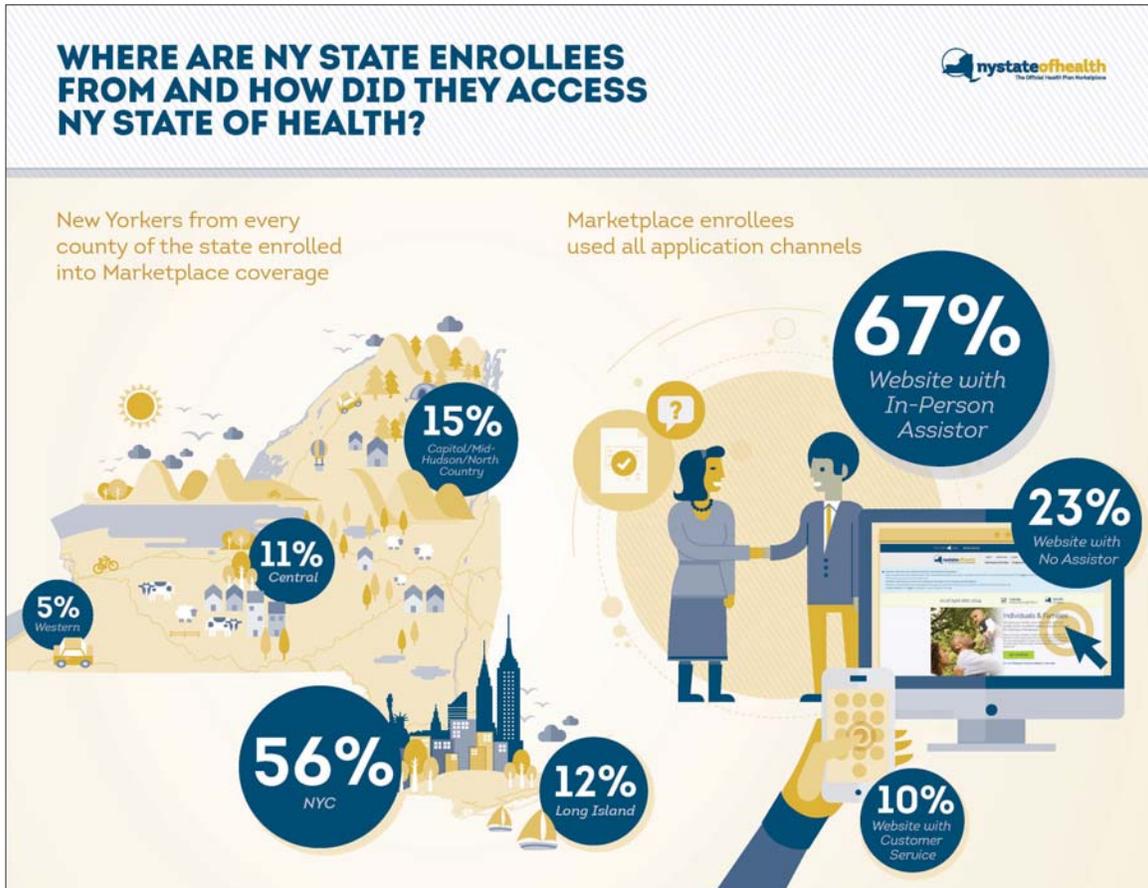


How Can You Continue to Help?

Examples of outreach partner activities:

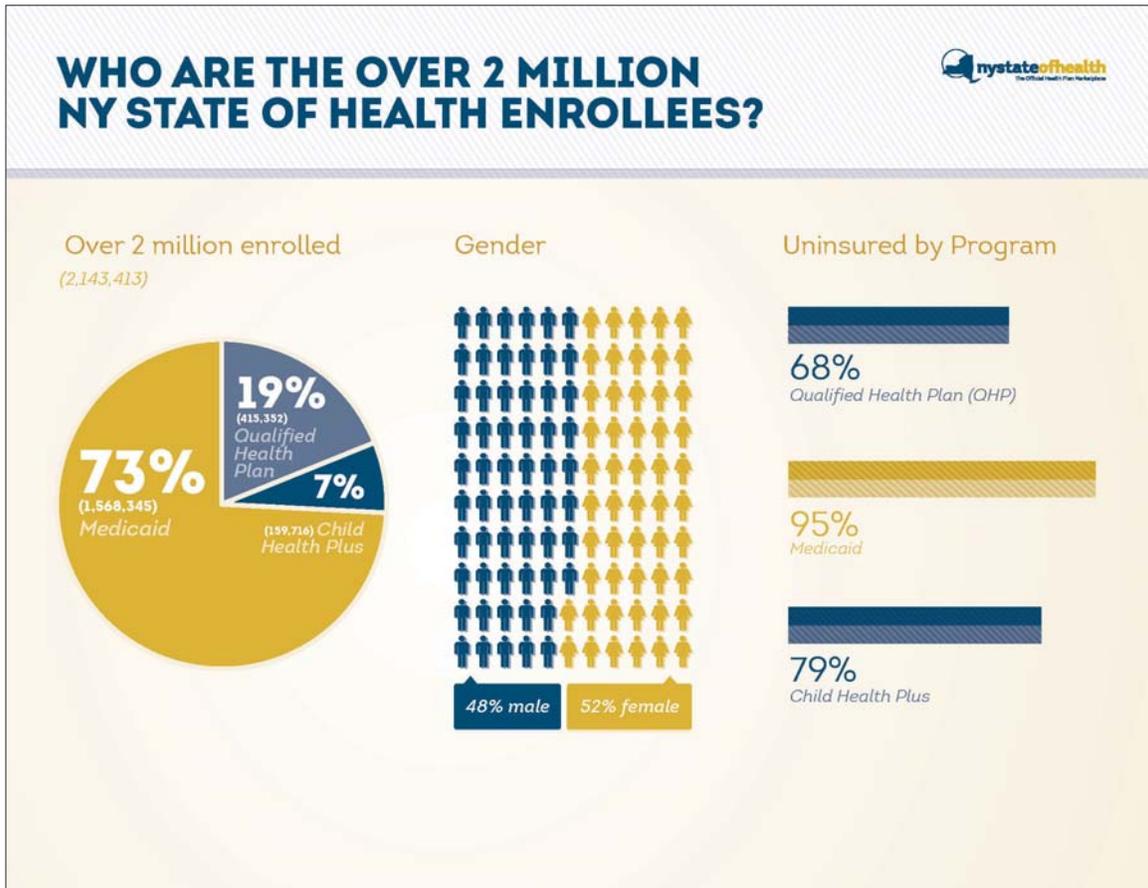
- **Distribute** materials at your events and your locations
- **Include** information in your organization's newsletters
- **Support** online content (e.g. link to our website, like us on Facebook, follow us on Twitter and more)
- **Sponsor** marketplace events in your community
- **Identify** additional outreach partners and share information
- **Drive** New Yorkers to the enrollment website, call center, or a certified Navigator or Broker.

Appendix C NY State of Health Qualified Health Plan Enrollment

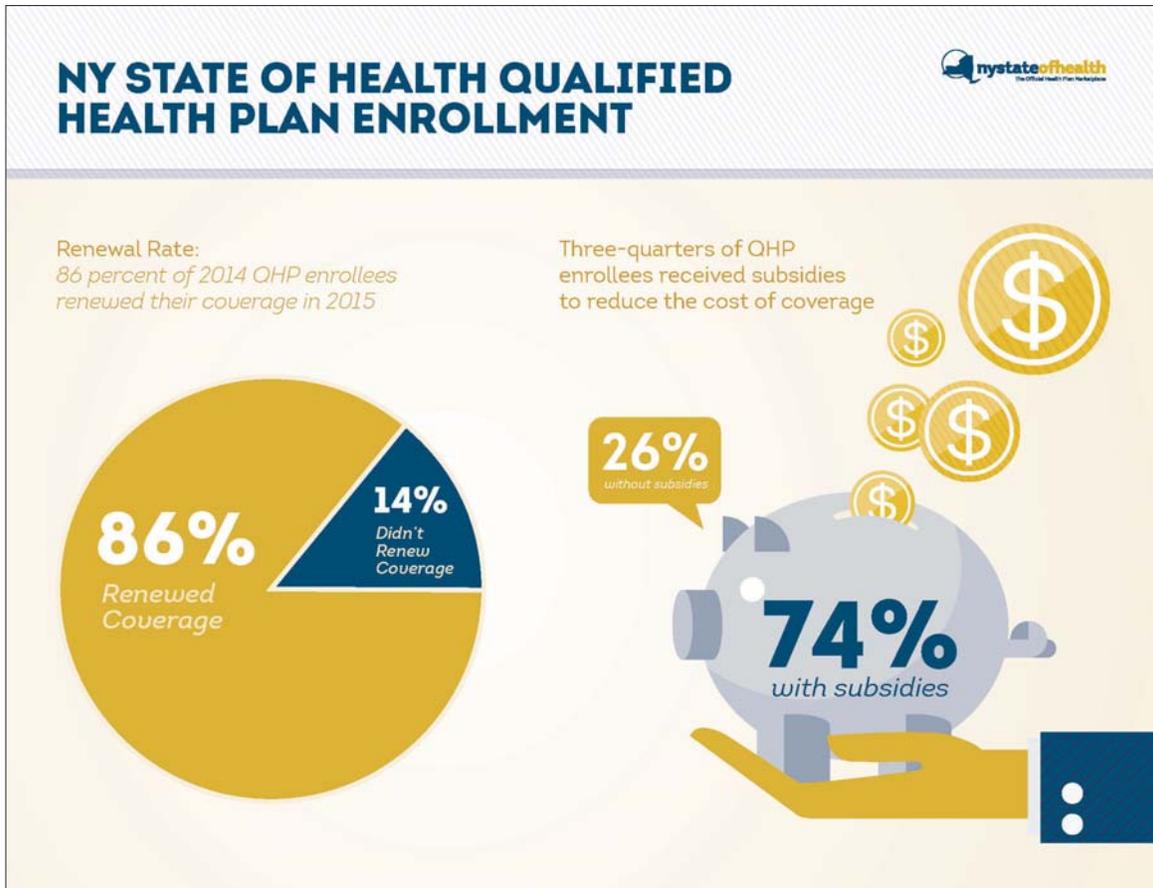


Appendix D NY State of Health

Who Are the Over 2 Million NY State of Health Enrollees?



Appendix E 2015 Qualified Plan Enrollees



Endnotes

- 1 “Governor Cuomo’s Executive Order Number 42,” April 12, 2012, <http://healthbenefitexchange.ny.gov/resource/governor-cuomos-executive-order-number-42>.
- 2 Thomas Kaplan, “G.O.P. Senators in Albany Block Federal Aid to Fulfill Part of Health Law,” *New York Times*, September 11, 2011, <http://www.nytimes.com/2011/09/12/nyregion/republican-senators-in-albany-resist-us-aid-for-health-care-law.html>.
- 3 Public benefit corporations and authorities have been used in New York since the 19th century to evade constitutional debt limits to fund public works projects. They have private as well as public characteristics. Like private corporations, their boards are appointed. They are like government agencies, but exempt from state and local regulations. See the 2004 proposals by State Comptroller Alan Hevesi to reform New York authorities (www.osc.state.ny.us/pubauth/index.htm).
- 4 Kaplan, “G.O.P. Senators in Albany Block Federal Aid to Fulfill Part of Health Law.”
- 5 Projections were based on simulation modeling by the Urban Institute during the marketplace planning process. See Fredric Blavin, Linda J. Blumberg, Matthew Buettgens, and Jeremy Roth, *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State* (Washington, DC: The Urban Institute, March 2012), <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412534-The-Coverage-and-Cost-Effects-of-Implementation-of-the-Affordable-Care-Act-in-New-York-State.PDF>.
- 6 QHP individual enrollee estimates were the focus of state exchange directors because small group (SHOP) estimates were acknowledged to have the highest degree of uncertainty. Correspondence with Danielle Horton, deputy director, NY State of Health, February 22, 2016.
- 7 “NY State of Health Ends 2016 Open Enrollment With More Than 2.8 Million Covered,” NYS Department of Health Press Release, February 23, 2016, https://www.health.ny.gov/press/releases/2016/2016-02-23_final_enrollment_2016.htm.
- 8 *2014 Open Enrollment Report* (Albany: NY State of Health, June 2014), 19, http://info.nystateofhealth.ny.gov/sites/default/files/NYSOH%202014%20Open%20Enrollment%20Report_0.pdf.
- 9 *2015 Open Enrollment Report* (Albany: NY State of Health, July 2015), 29, <http://info.nystateofhealth.ny.gov/sites/default/files/2015%20NYSOH%20Open%20Enrollment%20Report.pdf>.
- 10 “President’s Message” in *A New Era of Responsibility: Renewing America’s Promise* (Washington, DC: U.S. Office of Management and Budget, February 26, 2009), 1-3, https://www.whitehouse.gov/sites/default/files/omb/assets/fy2010_new_era/A_New_Era_of_Responsibility2.pdf.
- 11 See Sarah F. Liebschutz, *New York Politics and Government: Competition and Compassion* (Lincoln: University of Nebraska Press, 1998), Chapter 1, for elaboration of these characteristics of New York’s political culture.
- 12 Danny Hakim and Nicholas Confessore, “Speech Suggests Pro-Business Approach by Cuomo,” *New York Times*, January 6, 2011, <http://www.nytimes.com/2011/01/06/nyregion/06cuomo.html>.
- 13 Governor Cuomo was not the first New York governor to initiate cost containment incentives. “After an overrun by 36 percent of the state government of Medicaid appropriations during the first year (1965-1966), cost containment reforms were advanced on an annual basis” by Governors Hugh Carey, Mario Cuomo, and George Pataki (Liebschutz, *New York Politics and Government*, 1998, 175).
- 14 “Executive Order No. 5: Establishing the Medicaid Redesign Team,” January 5, 2011, <http://www.governor.ny.gov/news/no-5-establishing-medicaid-redesign-team>.
- 15 Ibid.
- 16 Correspondence with Judith Arnold, director of Medicaid Eligibility and Marketplace Integration, NYS Department of Health, May 2, 2016.

- 17 Other “do-gooder” states, California, Minnesota, and Massachusetts, which had liberalized Medicaid eligibility under the Section 1115 waiver, also benefited from the liberalized federal match.
- 18 Danielle Holahan, *Coordinating Medicaid and the Exchange in New York* (New York: United Hospital Fund, 2011), http://www.healthcarereform.ny.gov/research_and_resources/docs/coordinating_medicaid_and_the_exchange_in_new_york.pdf.
- 19 Interview by Michael Sparer and Lawrence Brown with Judith Arnold, Liz Mesa, and Carlos Cuevas, April 7, 2014.
- 20 Interview with Judith Arnold, June 19, 2015.
- 21 Interview with James Intone, deputy secretary for health (2011-13), June 22, 2015.
- 22 See Liebschutz, *New York Politics and Government*, Chapter 12, regarding New York’s creative and aggressive pursuit of federal grants.
- 23 The Department of Financial Services was created at the initiative of Governor Andrew Cuomo and action by the legislature in 2011. Two departments – Insurance and Banking – were consolidated to bring regulatory activity up to date by allowing the new agency to oversee a broader array of financial products and services.
- 24 Interview with John Powell, acting deputy superintendent and director of rate review, NYS Department of Financial Services, June 19, 2015.
- 25 Donna Frescatore, “Testimony Submitted to Senate Standing Committee on Health [and] State Standing Committee on Insurance,” January 13, 2014, <http://info.nystateofhealth.ny.gov/sites/default/files/Donna%20Frescatore%201-13-14%20Testimony.pdf>.
- 26 Interview by Lawrence Brown with Nurav Shah, MD, commissioner of health of New York State, February 14, 2014.
- 27 Many persons interviewed volunteered comments about collegial interactions before and after operation of NY State of Health.
- 28 “United Hospital Fund Report Assesses the Challenges to Integrating New York’s Medicaid Program with a New Health Insurance Exchange,” News Release, United Hospital Fund, May 16, 2011, <http://www.uhfnyc.org/news/880750>.
- 29 Interview with Judith Arnold, June 19, 2015.
- 30 Interview with Donna Frescatore, executive director, NY State of Health, July 24, 2015.
- 31 Interview with Elisabeth Ryden Benjamin, July 1, 2015. CSS draws on its “170-year history of excellence in addressing the root causes of economic disparity through research, advocacy, litigation, and innovative program models that strengthen and benefit all New Yorkers,” www.cssny.org.
- 32 Interview with Kim Wynn, manager, In-Person Assistor/Navigator Program, Coordinated Care Services. Inc., Rochester, NY, May 27, 2015.
- 33 *2014 Enrollment Report*.
- 34 The greatest demand was for Spanish and Mandarin speakers, with 10 percent in 2014 selecting Spanish (rising to 13 percent in 2015) and 4 percent selecting Chinese (Mandarin) in both years.
- 35 *2015 Enrollment Report*, 15.
- 36 *Invitation and Requirements for Insurer Certification and Recertification for Participation in 2016: Qualified Health Plans, Stand-Alone Dental Plans and Basic Health Insurance Plans* (Albany: NY State of Health, April 17, 2015 (Revised), <http://info.nystateofhealth.ny.gov/sites/default/files/2016%20Invitation%20to%20Participate%20in%20NYSOH.pdf>).
- 37 Ibid.
- 38 *2015 Open Enrollment Report*, 8.
- 39 Of the 8,960 application assistors for the 2013-14 open enrollment, 643 were navigators, 3,000 were certified application counselors, and 4,318 were brokers. The numbers of assistors in 2014-15 increased in each

category: 765 navigators, 5,384 certified application and facilitated enrollment counselors, and 5,239 brokers. Sources: *2014 and 2015 Open Enrollment Reports*.

- 40 Interview with Elisabeth Ryden Benjamin, July 1, 2015.
- 41 Ibid.
- 42 Maximus, Inc., is a “publicly-traded for-profit corporation that receives government contracts to provide ‘business process services’ to government health and human services agencies,” <http://www.maximus.com/health-insurance-exchanges>.
- 43 Interview with Elisabeth Ryden Benjamin, July 1, 2015.
- 44 Interview with Danielle Holahan, deputy director, NY State of Health, June 1, 2015.
- 45 *2014 Open Enrollment Report*, 17.
- 46 Correspondence with Danielle Horton, February 22, 2016.
- 47 Interview with Kim Wynn, May 27, 2015, citing Monroe and Livingston County experiences.
- 48 *2015 Open Enrollment Report*, p. 27.
- 49 Blavin, Blumberg, Buettgens, and Roth, *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State*.
- 50 See, for example, the mission statement of the Fund for Public Health in New York (FPHNY), a public-private partnership formed by the New York City Health Department: “FPHNY is more nimble and flexible than a government agency can be,” <http://www.fphny.org>.
- 51 Interview by Michael Sparer and Lawrence Brown with Kelly Smith, SHOP director, July 15, 2014.
- 52 Ibid.
- 53 “State Marketplace Profiles: New York,” Henry J. Kaiser Family Foundation, Final Update September 30, 2013, <http://kff.org/health-reform/state-profile/state-exchange-profiles-new-york/>. See footnote 21 re: the Grants Awards List, <http://www.cms.cclio/Resources?Marketplace-Grants/ny.html>.
- 54 Interview with Danielle Holahan, June 1, 2015.
- 55 Interview with Donna Frescatore, July 24, 2015.
- 56 See <http://www.rwjf.org/statenetwork> for papers on technical assistance for developing state marketplaces, as well as effects of Medicaid expansion. See www.nashp.org for information on conferences for state health policy, and resources on health exchanges and Medicaid expansion.
- 57 Interview with Donna Frescatore, July 24, 2015. She also noted the utility of the Federal Data Hub for income tax and Social Security verification.
- 58 Ibid.
- 59 *2014 Open Enrollment Report*, 4.
- 60 *2014 Open Enrollment Report*, 13.
- 61 NY State of Health, *2015 Open Enrollment Report*, p. 7. Projections were based on simulation modeling by the Urban Institute during the Marketplace planning process. See Blavin et al., for Urban Institute projections.
- 62 *2015 Open Enrollment Report*, 19
- 63 *2015 Open Enrollment Report*, 13.
- 64 *2014 Open Enrollment Report*, 15, and *2015 Open Enrollment Report*, 24.
- 65 Interview with Courtney Burke, NYS deputy secretary for health, June 17, 2015. See also Noam N. Levey, “A cautionary tale in healthcare reform,” *Los Angeles Times*, February 21, 2010, <http://articles.latimes.com/2010/feb/21/nation/la-na-health-insurance21-2010feb21>.
- 66 Interview with Danielle Holahan, August 6, 2015.
- 67 Such rules became popular in the early 1990s, as states including New Jersey and Washington contended with insurance companies that were denying coverage to people with preexisting health problems.” See Levey, “A cautionary tale in healthcare reform.”
- 68 Ibid.

- 69 Ibid.
- 70 Ibid.
- 71 Ibid.
- 72 *2015 Open Enrollment Report*, 20.
- 73 See discussions on these aspects of data systems in Parts 1.1, 1.2, 2.3, 2.5, and 2.6 of this report.
- 74 Donna Frescatore, Testimony before the NYS Senate, January 13, 2014.
- 75 Kyle Brittingham, Elisabeth Ryden Benjamin, and Carrie Tracy, *Lessons Learned from the Small Business Assistance Program* (New York: Community Service Society, April 2015), 1, <http://nyshealthfoundation.org/uploads/resources/cssny-lessons-learned-small-business-assistance-2015.pdf>.
- 76 Ibid, 2.
- 77 Interview by Lawrence Brown and Michael Sparer with Kelly Smith, SHOP director, July 15, 2014.
- 78 Interview with Joseph Muldoon, director of Broker Relations, June 18, 2015.
- 79 Interview with Kelly Smith, July 15, 2014.
- 80 Ibid.
- 81 Interview with Michael King, Monroe County Benefits agency owner and certified broker, September 11, 2015.
- 82 Interview with Marc Simmons, Wayne County human resources agency owner and certified broker, August 25, 2015.
- 83 Interview with Kelly Smith, July 15, 2014.
- 84 Ibid.
- 85 Interview with Joseph Muldoon, June 18, 2015.
- 86 *2014 Open Enrollment Report*, 19.
- 87 *2015 Open Enrollment Report*, 29.
- 88 Brittingham, Benjamin, and Tracy, *Lessons Learned from the Small Business Assistance Program*, 18.
- 89 Interview with Joseph Muldoon, June 18, 2005. See also Brittingham, Benjamin, and Tracy, *Lessons Learned from the Small Business Assistance Program*, 1.
- 90 Blavin, Blumberg, Buettgens, and Roth, *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State*, 9.
- 91 Timothy Jost, "CMS Provides FAQ About New Law Allowing States To Keep Original ACA Small-Employer Definition," *Health Affairs Blog*, October 20, 2015, <http://healthaffairs.org/blog/2015/10/20/cms-allows-states-to-keep-original-aca-small-employer-definition-in-the-pace-act>.
- 92 Carl Campanile, "Legislature kills Cuomo's proposed tax on ObamaCare," *New York Post*, March 31, 2015, <http://nypost.com/2015/03/31/legislature-kills-cuomos-proposed-tax-on-obamacare/>.
- 93 HPA's spokesperson said that "revenues from existing state taxes on health insurance – totaling more than \$5 billion and amounting to 5 percent of premiums – could easily cover the cost to operate the New York Health Exchange" (see Ibid). As the pool of newly insured persons increases, so, too, will revenues to support operation of the NY State of Health (see Interview with Donna Frescatore, July 24, 2015).
- 94 See *Medicaid in New York: The Continuing Challenge to Improve Care and Control Costs* (Albany: Office of the State Comptroller, March 2015), https://www.osc.state.ny.us/reports/health/medicaid_2015.pdf. Initiatives by New York governors to contain Medicaid costs date to the 1960s.
- 95 HANYS reacted to the governor's Executive Order establishing the exchange as follows: "The Exchange will benefit the people of New York State and its Hospitals and health care providers by reducing the number of uninsured and underinsured New Yorkers." Healthcare Association of New York State, "Statement by Healthcare Association of New York State President Daniel Sisto On the Governor's Executive Order Establishing a Statewide Health Insurance Exchange," April 12, 2012, http://www.hanys.org/communications/pr/2012/2012-04-12_statewide_health_insurance_exchange.cfm.

- 96 See Testimony of the New York Health Plan Association to the Senate Finance Committee and the Assembly Ways & Means Committee, January 30, 2013 (<https://www.nysenate.gov/sites/default/files/articles/attachments/Written%20Only-%20HPA.pdf>), and to the Assembly Health Committee on January 13, 2015 (<http://www.nyhpa.org/files//Assembly%20Single%20Payer%20hearing%201-13-15.pdf>).
- 97 Interview with Amy Shefrin, program officer for cost and coverage, New York State Health Foundation, June 2, 2015. See also *Making Public Health Insurance Programs Work Better: Partnering with the New York State Department of Health to Reform Medicaid*, NYSHealth Special Report (New York: NYS Health Foundation, April 2011, <http://nyshealthfoundation.org/uploads/resources/public-health-insurance-programs-medicaid-reform-april-2011.pdf>).
- 98 Interview with Amy Shefrin, June 2, 2015. See also Judith Wooldridge, M.A., *Implementing the ACA in New York State: One Statewide Foundation's Approach to Preparing for 2014* (New York: NYS Health Foundation, May 2013), <http://nyshealthfoundation.org/uploads/resources/implementing-aca-statewide-approach-may-2013.pdf>.
- 99 James Madison made the case in Federalist No. 37 for an energetic and stable national government as follows: "Energy in government is essential to that security against external and internal danger, and to that prompt and salutary execution of the laws, which enter into the very definition of good government. Stability in government is essential to national character.... On comparing, however, these valuable ingredients with the vital principles of liberty, we must perceive at once the difficulty of mingling them together in their due proportions." See <http://www.constitution.org/fed/federa37.htm>.
- 100 Introduced originally in California and followed by Texas, Massachusetts, New Jersey, Kansas, and New York, DSRIP programs are a key feature of the dynamic and evolving Medicaid delivery system reform landscape. DSRIP initiatives are part of broader Section 1115 waivers and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries. Originally, DSRIP initiatives were more narrowly focused on funding for safety net hospitals, specifically maintaining supplemental payments for safety net hospitals. Reflecting a growing emphasis at the Centers for Medicare & Medicaid Services (CMS) to strengthen accountability for Medicaid waiver dollars, a defining feature of these waivers is that they require providers – and, recently, states – to meet benchmarks as a condition of receiving Medicaid funds. See Jocelyn Guyer, Naomi Shine, Robin Rudowitz, and Alexandra Gates, *Key Themes From Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States* (Menlo Park: Henry J. Kaiser Family Foundation, April 2015, <http://files.kff.org/attachment/issue-brief-key-themes-from-delivery-system-reform-incentive-payment-dsr-rip-waivers-in-4-states>).
- 101 Ibid.
- 102 Ibid.
- 103 Ibid.
- 104 Ibid.
- 105 Interview with Danielle Holahan, June 1, 2015.
- 106 NY State of Health, "Qualified Health Plans, Stand-Alone Dental Plans and Basic Health Insurance Plans," Last Viewed May 15, 2015.
- 107 "New York Basic Health Program Blueprint," Medicaid.gov, April 2015, 1, www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf.
- 108 Ibid.
- 109 "SI 00501.420 Permanent Residence under Color of Law (PRUCOL) Pre-1996 Legislation," US. Social Security Administration, Effective Dates: 05/25/2012 - Present, <https://secure.ssa.gov/poms.nsf/lnx/0500501420>.
- 110 New York State Immigration Coalition, *Maximizing Health Care Reform for New York's Immigrants* (New York: NYS Health Foundation, February 2013, 8, <http://nyshealthfoundation.org/uploads/resources/maximizing-health-care-reform-new-york-immigrants-february-2013.pdf>).
- 111 Correspondence with Judith Arnold, May 2, 2016.

- 112 Noncitizens include undocumented immigrants, legal permanent residents, and immigrants on temporary visas in the process of adjusting their status. See *Ibid.*, 9. Estimates of insurance coverage are from Danielle Holahan, Allison Cook, and Leslie Powell, *New York's Eligible but Uninsured* (New York: United Hospital Fund, 2008), <http://nyshealthfoundation.org/uploads/resources/new-yorks-eligible-uninsured-august-2008.pdf>.
- 113 New York State Immigration Coalition, *Maximizing Health Care Reform for New York's Immigrants*, 9.
- 114 The New York State Constitution (Article 17, Section 1) states that "The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine." See <https://www.dos.ny.gov/info/pdfs/Constitution.pdf>.
- 115 See Barbara Weiner, "NYS Department of Health Issues Policy on Medicaid Eligibility of Immigrants," Empire Justice Center, December 1, 2004, <http://www.empirejustice.org/issue-areas/immigrant-rights/access-to-public-benefits/access-to-medicaid/nys-department-of-health.html>.
- 116 *Ibid.*
- 117 "Under CHIPRA, the Centers for Medicare and Medicaid provided states an option for federal financial (Medicaid) participation for lawfully residing non-citizen children and pregnant women and also added temporary non-immigrants to the definition of lawfully residing. The ACA then modified the residency requirement to consider temporary non-immigrants as residents. New York had exercised the option to cover children and pregnant women under CHIPRA to receive federal financial participation. Given the ACA change in residency requirements, New York was required under the *Aliessa* to cover temporary non-immigrants that met a New York State residency test in Medicaid with state-only dollars and then in the Basic Health Program once it was effective." Correspondence with Judith Arnold, May 2, 2016.
- 118 "New York Basic Health Program Blueprint," April 2015.
- 119 *Ibid.*, 20.
- 120 *Essential Plan: New York's Basic Health Program. Annual Report to the Governor and Legislature* (Albany, NY: Office of Health Insurance Programs, NYS Department of Health, December 2015), http://www.health.ny.gov/health_care/managed_care/essential/docs/2015-dec_annual_rpt.pdf.
- 121 Interview with Kim Wynn, manager, In-Person Assistor/Navigator Program, Coordinated Care Services, Inc., Rochester, NY, October 14, 2015.
- 122 "Basic Health Program (BHP) Learning Collaborative: BHP Planning & Implementation – State Experiences to Date," PowerPoint Presentation, Medicaid and CHIP MAC Learning Collaboratives, September 2015, 14, <https://www.medicaid.gov/basic-health-program/downloads/bhplc-state-experiences.pdf>.
- 123 *Essential Plan: New York's Basic Health Program. Annual Report to the Governor and Legislature.*