JOINT HEARING BEFORE THE NEW YORK STATE
SENATE STANDING COMMITTEE ON HEALTH
AND THE SENATE STANDING COMMITTEE ON INSURANCE

PUBLIC HEARING

NEW YORK STATE OF HEALTH:

A DISCUSSION ON IMPLEMENTATION

Legislative Office Building
Hamilton Hearing Room B
172 State Street
Albany, New York 12247

January 13, 2014
10:00 a.m. to 2:45 p.m.

PRESIDING:

Senator Kemp Hannon
Chairman, NYS Senate Standing Committee on Health

Senator James L. Seward
Chairman, NYS Senate Standing Committee on Insurance

PRESENT:

Senator Greg Ball

Senator Neil D. Breslin

Senator Simcha Felder

Senator Martin J. Golden

Senator Ruth Hassell-Thompson

Senator William J. Larkin, Jr.

Senator Jack M. Martins

Senator Gustavo Rivera (RM)
Senate Standing Committee on Health

SPEAKERS:	PAGE	QUESTIONS
Donna Frescatore Executive Director New York State of Health	10	26
Mary Morse Owner Kwik-Kut Manufacturing	82	96
Pamela Reese Finch Public Relations Consultant Sole Proprietor	82	96
Nick Fitterman, M.D., F.A.C.P. Internist Sole Practitioner	102	129
Andrew Kleinman, M.D. Plastic Surgeon President-Elect of the Medical Society of the State of New York	102	129
Patricia McLaughlin, M.D. Ophthalmologist Sole Practitioner	102	129
Dan Colacino Vice President Rose and Kiernan, Inc.	133	154
Eric P. Nevins President EP Nevins Insurance Agency, Inc.	133	154
Jack Smith Executive Vice President William A. Smith & Son Insurance Agency	133	154
Bob Carey Account Executive Otsego County Chamber of Commerce	158	
Lacey Clarke Deputy Director Freelancers Union Insurance	158	

SPEAKERS (Continued):	PAGE	QUESTIONS
Mark Eagan President & CEO Albany-Colonie Regional Chamber of Commerce	158	
Maurice Isaac Employee Benefits Program Administrator Delaware County Chamber of Commerce	158	
Sean Doolan, Esq. Attorney with Hinman Straub Representing Blue Cross/Blue Shield of New York	180 187 195	184 191 197
Paul Macielak, Esq. CEO, President, and Chairman of the Board Health Plan Association	180 187 195	184 191 197
Elisabeth Benjamin Vice President of Health Initiatives Community Service Society of New York	215	227
James Lytle Attorney Representing Coalition for New York State Public Health Plans	215 232	227 237
Mark Scherzer Attorney Representing Health Care for All New York/New Yorkers for Accessible Health Coverage	215 232	227 237

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SENATOR HANNON: Would you take your seats, please.

SENATOR SEWARD: Good morning, everyone, and welcome to the joint hearing of the Senate Committee on Health and the Senate Committee on Insurance.

I'm very pleased to be joining the Chair of our Health Committee in the Senate, Senator Hannon, and some of his Committee members.

I'm Senator Jim Seward, Chair of the Insurance Committee in the Senate, and we have a number of our members here as well.

We are here this morning to take testimony on the current status of the implementation of the New York State Health Insurance Exchange, as well as the impact of the federal health-care reform, what that impact is having on individuals, families, small businesses, even providers and payers, here in New York State.

And as we listen to testimony and get the current status of, not only the exchange, but the impact of the federal health-care reforms, we hope to be looking at possible State options for filling any gaps and providing any assistance, particularly those who may be negatively impacted, in terms of both their coverage as well as their health care.

Let me say that, at the outset, that in my estimation, when it comes to the exchange, I think New York is doing a good job when compared, certainly, to the federal exchange.

Now, I want to say that I appreciate the job that Donna Frescatore and her team is doing, and appreciate the work of her staff.

They have been very helpful and responsive when my office has called with constituent concerns.

With that said, there are a number of issues, however, that have come to my attention that warrant further discussion.

I also have a number of questions that still need to be answered, that were not answered in response to the letter that Senator Hannon and I sent back in November.

Specifically, I have concerns with those individuals, sole proprietors, and many small business owners who have seen their policies canceled as a result of the federal law.

I have seen numbers here in New York that say that, reportedly, over 100,000 individuals and policies have been impacted with these cancellations here in New York.

What is happening to these individuals in

terms of their coverage and health care?

I've also heard from a number of my constituents, that tell me that the cost of obtaining a new policy is significantly more than they were paying previous to these changes, and, in many cases, is simply not financially feasible for them to continue coverage.

We've also heard from constituents who have actually signed up on the exchange, but to this day, have no verification, no card.

What are they to do if they need to go to the hospital or another provider for their health care?

Most of these individuals are sole proprietors or work for small businesses.

So I'd like to explore whether or not there is any way that the State can assist these individuals.

And, of course, there are many other concerns regarding other aspects of the federal health-care-reform law as well.

And I look forward to hearing everyone's testimony here today.

Senator Hannon.

SENATOR HANNON: Thank you, Senator.

I'll concur with what you've said, and just

note that this -- the statute we're dealing with, the Affordable Care Act, is probably one of the most major policy initiatives we've seen in our lifetime, and, has a number of different aspects. Many of the aspects have focused on the mechanical problems involved.

I would hope that we would get beyond, and start to get beyond, those mechanical problems, important as they may be for people who don't have coverage, and start to look at what the overall purpose has been of ObamaCare, what populations are currently being served, what populations have been missed.

And I'm not talking the national debate. I'm talking here in the state.

We as a Senate have twice expanded Child Health Plus. We helped establish Family Health Plus. We established Healthy NY.

We've looked towards a wider set of coverages for everybody, and the question will be:

Has that been achieved, or, are there steps that the State needs to take, to make sure that both patients are well-treated, well-covered;

And, the providers, there's enough of them, that they're accessible;

That the drugs that are -- people expect, in terms of their modern medical needs, are taken care of.

So those are the things that try to widen the concept of where we're going; not making it a political debate, but looking at it as a policy initiative.

Thank you.

Sir?

SENATOR SEWARD: Senator Breslin.

SENATOR BRESLIN: Thank you very much.

I would concur totally with Senator Hannon that this is a -- an apolitical discussion today to probably the most important piece of health legislation in the last 70 years, and that we should look to:

How it's being achieved in a successful way;

Who we're leaving behind;

Are the providers sufficient? Are they being taken care of, are they being supported?

And I think that this type of hearing can have tremendous success if we look at it in a very objective direct way.

SENATOR HANNON: Senator Rivera.

SENATOR RIVERA: Thank you, Senator Hannon

and Senator Seward as well.

SENATOR BRESLIN: And me.

SENATOR RIVERA: And, of course, Neil as well.

Thank you, Neil.

[Laughter.]

SENATOR RIVERA: I'm -- as a Ranking Member in the Health Committee in the Senate, I can say that I've have a very good working relationship with Senator Hannon, and I think that this is a perfect example of the type of work that can be done when you are asking questions about how policy actually impacts the people of the state of New York.

There are certainly things that the implementation of the Affordable Care Act in New York demonstrates can be done well, as far as, how care actually gets to folks, how folks can get covered.

And I think that there's definitely a lot of successes that we are going to discuss today.

There's also challenges as well.

And I think that, as we have -- as we have been leading in the nation, as it relates to the implementation of the Affordable Care Act, and how to make sure that people get taken care of all

across the state, we should continue to do so.

And the conversations that we're going to have today will, hopefully, lead us down that path.

So, I'm looking forward to the conversations that we will have today, both, about the successes that we've already had, but also about the challenges that we face, going forward.

Thank you, Senator.

SENATOR SEWARD: Well, thank you all for your comments, and let's get started.

And our first panel, representing the New York State of Health, is the executive director, Donna Frescatore.

DONNA FRESCATORE: Good morning, Chairman Hannon, Chairman Seward, other honorable Members of the Committee.

SENATOR HANNON: Would you pull the mic closer to you?

DONNA FRESCATORE: Sure.

Thank you.

I'm Donna Frescatore, executive director of New York State of Health.

As you all know, New York State of Health is New York's official health-plan marketplace under the federal Affordable Care Act. It's a place where

New Yorkers can shop for, compare, and enroll in health insurance.

Since the market's launch in October, well over a quarter of a million people have enrolled in affordable health care through New York State of Health.

Thank you for inviting me here today to tell you about the success of -- the successful launch of our marketplace, and the many New Yorkers who are already receiving affordable health-insurance coverage through the market.

As you know, in April of 2012, Governor Cuomo issued Executive Order 42, establishing a state-based health-insurance exchange in accordance with the federal Affordable Care Act.

The order set in motion an intensive 18-month planning and implementation process that included the input of over 200 individuals across 5 regional committees in our state, the completion of 15 policy studies, and extensive collaboration between our marketplace, our state Medicaid program, and our colleagues at the Department of Financial Services.

In June of 2012, the Department of Health contracted with Computer Sciences Corporation, or, "CSC," to be the single systems integrator

responsible for building and operating the state's marketplace.

We developed an adaptive and flexible system that has proven that it allowed us to identify issues as the system was being built, and to quickly make changes and corrections when they were needed.

On January 31st of 2013, just about a year ago, New York State of Health issued an invitation to all health insurers licensed in New York to be part of our state marketplace.

That invitation went well beyond the federal requirements for health plans that participate in the exchanges.

It required insurers to offer standardized products, it required the products at each metal tier, and, out-of-network benefits were required if the insurer was providing such benefits outside of the exchange.

On October 1st of 2013, we launched New York State of Health's website.

As reported, today, there have been over 2.5 million unique visitors to the site, and they viewed 57 million pages on that website.

The traffic to the website remains high, and it's operating smoothly, with an average response

time of less than 3.8 seconds when a consumer requests a next page or action on the website.

Although the volume remains extraordinarily high, it was even higher in our initial days of implementation, and that resulted in some problematic wait times for consumers.

Our technical team responded quickly, quadrupling the website's processing capacity, and project leadership stayed on site to direct and oversee implementation of these corrective actions.

As a result, on October 5th, just days later, the website performance improved dramatically, and it remains at those levels.

Our call center was also very busy.

Between October 1st and December 24th of 2013, our trained representatives answered over 350,000 calls.

As the deadline for applying for January 2014 coverage approached, call volume more than doubled, from an average of 5500 calls answered every day, to over 15,000, often at a rate of 1500 to 1600 calls answered every hour.

To address the increased wait times for customer service, and to provide better service to our consumers, the customer service center is poised

to add representatives to the phone lines in January and February of this year, as we approach the March 31st enrollment deadline.

New York State Health is committed to improving customer interactions and meeting the needs of potential enrollees.

To date, 75 percent of applications have been submitted by consumers directly through the website; I think a testimony to how the website is working smoothly.

The rate -- remaining 25 percent of applications were submitted by telephone or with the help of a trained assister.

And these assisters include about 570 navigators, over 2500 certified application counselors, and over 3900 licensed insurance brokers in New York who have been certified to work with New York State of Health.

Regardless of the type of assister, each must adhere to strict policies and procedures related to privacy and security of data related to the people they're helping.

Forty-eight organizations serve as navigators throughout state, and bring with them 95 organizations, including thirteen chambers of

commerce, and each individual has completed a three-day training course that's conducted in person, and a written examination.

Like our navigators, our certified application counselors, who are generally employees of hospitals, federally qualified health centers, or health plans provide, provide in-person assistance to individual consumers.

While these counselors must meet the same certification requirements, they are -- they do not receive grant payments from New York State of Health or the department.

Finally, recognizing the very important role that licensed insurance brokers play in New York State in advising small businesses, and, recognizing the assistance that they can provide to individuals as we enroll more people directly in insurance in New York, we have worked extensively with the Department of Financial Services and broker organizations to develop an 8-hour continuing-education course, where licensed insurance brokers can choose to work with the individual marketplace, the small-business marketplace, or both.

Regardless of how consumers apply for

coverage, securing personal data is critical.

In building and deploying the marketplace, the Department of Health has implemented advanced security controls and processes, based on the National Institute of Standards and Technology's guidelines, as well as other regulatory, administrative, technical, and physical safeguards.

These security and privacy controls enable New York State of Health to monitor and continually protect the privacy of information it is required to collect on behalf of the enrollee.

Strong encryptions protect communications to and from the website, and, in addition to standard computer protections in place, which include anti-virus and anti-malware implementation, the website uses both network- and host-intrusion provision mechanisms -- prevention mechanisms to detect and prevent malicious activity.

The marketplace always encourages consumers to protect their personal identification information.

In September, prior to opening the marketplace, New York State of Health issued an alert to consumers, advising them that they should never be charged a fee for assistance to enroll in

the marketplace, that they should only provide information to people they know are certified by the marketplace to help them, and that no one from the marketplace will ever contact them unless they've requested assistance.

Any report of potentially inappropriate activity will be fully investigated by New York State of Health, in conjunction with the Department of Financial Services, when appropriate.

New York State of Health has also established an approval process for those wishing to use the name or logo on their materials or advertisements.

New York's health-plan marketplace is a leader in the nation, and health insurance enrollment through New York State of Health has grown steadily and significantly since first opening October 1st, reaching about 294,000 enrollees as of just midnight yesterday.

But, today, I'd like to tell you a little bit more about the New Yorkers who have enrolled in health insurance effective January 1, 2014, and the types of coverage they've enrolled in.

At the close of business on December 24th, which was the deadline for enrolling for January 1st coverage, 230,624, to be exact, people had enrolled

in the individual marketplace through New York State of Health.

The enrollments include New Yorkers from every county of the state, with the largest percentages from Kings, Queens, Suffolk, Manhattan, Nassau, Westchester, Erie, and Monroe counties.

Of the individual enrollment, the majority, 66 percent, were in qualified health plans; so those are individuals who are qualifying for private coverage through a QHP, as we've come to know them.

Sixteen health insurers are currently certified to offer QHPs through the marketplace, ensuring that consumers all throughout our state have access and choice to different health plans.

Each of the 16 health plans received enrollment for January 2014 coverage.

Additionally, all of our qualified health plans, consistent with federal requirements and with state laws and regulation, cover a whole range of benefits, and, each of the networks must meet pre-established criteria in order for the QHP to be certified on the exchange.

So, QHP networks must include all types of providers necessary to deliver the services, including hospitals, choice of primary-care

physicians, choice of specialty physicians in each specialty type, and essential community providers, such as qualified health centers, among others.

In the event a health-plan member who has enrolled through a QHP demonstrates that they have a need to see a provider that is not part of their health-plan's network, the health plan must approve a referral to an out-of-network provider, and the member will be responsible for only the amount of cost share they would have paid had they used a network provider.

That is a protection through the marketplace that currently exists for HMOs in our state, and, through the marketplace, has been extended to all types of insurers.

We continuously work with other divisions within the Department of Health to assess the incremental demand that new enrollment is going to place on our delivery system; in particular, our primary-care system.

As we conduct that analysis, we will take into consideration the important actions taken by our State Legislature, including the Primary Care Services Corp -- Corporation -- Corp, I'm sorry, loan-repayment program, the Doctors Across New York

programs, and the Health-Force Retraining Initiatives, all of which play a critical role in making certain that all New Yorkers can access primary care.

Of the individuals that enrolled in a qualified health plan, as of December 24th:

53 percent are female, 47 percent are male;

30 percent are under the age of 35;

16 percent are between the ages of 35 and 44;

23 percent between the ages of 45 and 54;

And 31 percent are over age 54.

So that gives you a glimpse into the age distribution in our very first month of enrollment.

Nearly 50 percent of the individuals who enrolled through the marketplace for January 2014 coverage were uninsured at the time of their application.

And that rate of uninsurance, it is higher for those who receive financial assistance through New York State of Health.

And speaking of financial assistance, as projected, about 68 percent of individuals and families who have enrolled in coverage for January received assistance in either -- the form of either federal tax credits or cost-sharing credits;

50 percent eligible for both the tax and cost-sharing credits;

And 18 percent eligible for tax credits only.

The remaining 32 percent of individuals who obtained coverage for January 2014 either had incomes too high to qualify for financial assistance under the federal law, or, they chose not to ask for assistance. Nevertheless, they have benefited from the, approximate, 53 percent reduction in individual premium rates as compared to the rates that were in effect in 2013.

We require every health plan that offers products on the exchange to offer products at the four level -- premium levels -- I'm sorry, plan levels: Platinum, Gold, Silver, and Bronze.

Three variations of the Silver plan are available, under the federal law, for people with incomes below 250 percent of federal poverty level.

Catastrophic plans are also available through the marketplace for people under 30.

I'm pleased to tell you today that for, January 2014:

17 percent of individuals enrolled chose Platinum plans.

12 percent enrolled in Gold plans;

12 in Silver plans;

39 percent in Silver plans with cost-sharing reductions that actually raise the level of benefit and lower their out-of-pocket costs;

And, 18 percent in Bronze plans.

Only 2 percent of enrollees, thus far, have selected catastrophic coverage through the marketplace.

Early results for the first month of coverage under New York State of Health show that it has been effective in reaching all New Yorkers in all areas of the state, at all income levels, and at all ages.

As predicted, New Yorkers are receiving real savings through their marketplace enrollment.

Senator Hannon earlier mentioned the important role of Child Health Plus for children in our state, and we would concur that New York State has clearly been a leader in covering children.

So we're proud to say this morning that, as of close of business on December 24th, an additional 16,750 children enrolled in Child Health Plus through the marketplace.

And, in fact, today, that number has even increased further, and I'm pleased to tell you that about 22,000 children, as of midnight last night,

have joined our Child Health Plus program.

We think that's truly an accomplishment.

The majority of these children are in families that qualify for some subsidies under our state Child Health Plus coverage, because their incomes are at or below 400 percent of federal poverty level.

And, enrollment of children will remain a priority for New York State of Health as we go forward.

Turning now for a minute to the small business marketplace, New York State of Health was one of the only state marketplaces that successfully launched an online marketplace on October 1st of 2013.

Our marketplace gives employers a new option, and the flexibility, to select the contribution rates, the plan options, that they desire for their employees. And it also let's them choose to have a defined contribution program, where they will contribute a predictable amount each month towards coverage, and their employees have flexibility to choose a plan that best meets their needs.

Small businesses in every county of the state elected to provide coverage through the small

business marketplace in January.

In January, over 5,000 employees and dependents were enrolled through New York State of Health, and enrollment continues for coverage effective both in -- February 1st and March 1st.

Platinum-level plans were the most popular choice among our small businesses.

38 percent of them selected a Platinum plan;

28 percent selected Gold.

24 percent selected a Silver plan;

And 10 percent selected Bronze.

New York has built, truly, a one-stop shopping for individuals applying for health-insurance coverage in our state.

As you all know, effective January 1, 2014, New York expanded Medicaid eligibility levels to 138 percent of federal poverty level, making the state eligible for increased federal funding to subsidize both the newly-eligible Medicaid enrollees and our existing childless adults.

Through December 24th, 61,625 individuals enrolled in Medicaid through New York State of Health.

Since New York's eligibility levels already largely met the new federal standard, the expansion

affected single and childless adults whose eligibility had previously been set at 100 percent of federal poverty level under our Family Health Plus program.

The new expansion population, thus far, represents about 20 percent of the 61,000-plus Medicaid enrollees who joined for January 1st coverage.

In summary, the launch of New York State of Health has been an overwhelming success.

We enrolled well over a quarter-million people in health insurance in less than three months, but we know that implementing the marketplace is not a one-time task.

It's a continuous process of operational improvements, of ongoing training, of refining the products that stock the shelves of our marketplace, and, with working one-on-one with consumers and their representatives when they need help or have questions.

Each and every day, the New York State of Health team works to identify and implement modifications that will improve the consumer's experience.

Many of them have already been implemented,

and others are planned in the upcoming weeks and months.

I know that I speak for the entire New York State of Health team when I tell you that we are proud of what's been accomplished, and we are committed to ensuring that New Yorkers have access to affordable, comprehensive health-insurance coverage, and, have the consumer experience they expect and deserve.

Thank you, and I am happy to answer your questions.

SENATOR SEWARD: Thank you very much, Ms. Frescatore.

And, I know we've heard from our two Rankers, Senator Breslin and Senator Gustav [sic] -- but the -- what -- what I'd like to also acknowledge that we have with us, Senator Marty Golden, and Senator Bill Larkin, Senator Jack Martins, Senator Greg Ball, and, Senator Hassell-Thompson has joined us as well.

I had just a few questions for you, and then we'll get -- we'll have some others join in as well.

You mentioned the term "enrolled," in terms of the numbers of individuals and others who have actually enrolled. I assume that means, through

your process at the exchange.

And, can you walk us through, you know, the entire process, you know, enrollment --

DONNA FRESCATORE: Sure.

SENATOR SEWARD: -- and then through that final step of someone actually walking into a provider's door, whether it be a pharmacist or other provider?

And the reason I ask that question, is that we have -- I've had constituents who have contacted me, both, on the Medicaid managed-care enrollee, who had no card or verification. This individual needed insulin, and so they couldn't wait, obviously, when January 1 rolled around, and that was a difficulty.

Thankfully, your -- you know, your staff was able to intervene in that one particular case, and, they're continuing on a fee-for-service basis until that gets straightened out.

And I had another constituent, on the private side, who had signed up with an insurance company, a John Vasalu [ph.] from Cobleskill, who -- he enrolled on November 18th, but he had not received any kind of verification, a card. He talked to his carrier that he had signed up with. They had not heard from the State.

And, his plight was highlighted in the "Albany Business Review" at this -- earlier this morning, and, lo and behold, he -- about an hour ago, he called me and told me he had just received a call -- that he had received, at least over the telephone, a call, with his ID number, and that they would be mailing it today.

So, I think we need to hear from -- these are impressive numbers, in terms of enrollees, but what happens after the enrollment period, in terms of someone actually having coverage, to.

Go out and receive services that are needed?

DONNA FRESCATORE: Certainly.

So, individuals and small businesses can elect to apply for coverage through the website, and about 75 percent of individuals chose that route to apply;

Or, with the assistance of a navigator or an insurance broker, or, in the case of individuals, with a certified application counselor.

Once their application is processed, and individuals get an instantaneous response on what they're eligible for, and what their tax credits will be, if they qualify, they can go on to select their health plan.

The marketplace then sends a transaction to the insurer that the individual selected, and that begins the process of effectuating coverage at the insurer.

All of the insurers, as of Friday, had issued invoices, and most have been issuing identification cards to individuals who enrolled for January coverage, for weeks now, if not months.

We had, of course, a very large volume of enrollments on December 23rd and 24th, the closing days, and some of those invoices and ID cards were -- were -- followed behind that enrollment.

We're glad, certainly, Senator Seward, that your experience with New York State of Health was good when you reported those cases.

Obviously, not everyone would get reported to us.

So what we've done with the insurance companies, is we've worked with them, to make certain that they are issuing identification cards and invoices timely, and, that there are systems in place to work with the health plan and the providers that are affiliated with them, to make certain that anyone who applied for coverage in time for January, and pays their invoice, timely, has coverage

retroactive to January 1st.

SENATOR SEWARD: Do you have a number -- you have the numbers, that you provided us, in terms of the enrollment through your process.

Do we have numbers in terms of who's actually paid their premium and actually have coverage as of today?

DONNA FRESCATORE: You know, as a protection, really, or a safeguard, to consumers, we worked with the insurers that participate in the marketplace, and have agreed upon, what I think about as a rolling 10-day period to pay your invoice, a grace period, which we would typically have in New York.

And so, for many, the very first payment due date that came up would have been January 10th, just last Friday.

But, we will have that kind of information as we move forward.

What we want to make certain is, that if there's been a delay in an individual getting their invoice, through no fault of their own, that they have the same 10-day protection to be able to pay for their premium, and that their coverage is retroactive.

SENATOR SEWARD: You know, under the --

shifting gears, under the federal legislation, as I understand it, the exchange is slated to be financially self-sustaining by January 1st of 2015.

Is that an obtainable goal, do you feel, here in New York?

DONNA FRESCATORE: You're correct.

The federal law and the Governor's executive order requires the exchange or marketplace to be self-sustaining in January 2015. And I think that will be part of the upcoming discussions about state fiscal-year budgets.

SENATOR SEWARD: The -- I wanted to just -- just a question on the relationship between the navigators and our agents and brokers.

The -- as I understand it, perhaps you could share with us, if my understanding is correct, that the navigator is only referring someone to an agent or broker only upon request.

And my thought is, would a navigator be able to make such a referral if they thought an individual or a small business's circumstances, you know, let's say, we're beyond, you know, the scope of their, you know, working knowledge, and perhaps they feel that they would need additional expertise of an agent or a broker? Would that be allowed?

Because I think -- the reason I stress that, is many individuals, small businesses, they have had ongoing relationships with agents and brokers who have been there advisors over the years, and, particularly, and with this is -- we're on uncharted waters here with this change that we're seeing, in the -- with the federal health-care changes.

And it would seem to me that some -- the navigators are great in terms of the extent that they can go, but I'd like to see an -- a more seamless role here for the agents and brokers.

Could you just describe how you see that relationship, and, the ease of a navigator turning an individual or a small business, "a client," shall we say, over to an agent or a broker.

DONNA FRESCATORE: Sure.

As part of the planning process and some of the policy work that we did around the very important role of insurance brokers in our insurance markets today, we wanted to be very careful not to disrupt some of those relationships that had pre-existed, you know, the ACA and the exchange for many years.

And that's why we built upon the successful continuing-education programs and the training that

was already in place for insurance brokers in our state.

That said, our expectation for navigators is that, following their training, that they're able to help consumers, both individuals and small businesses.

We have not prohibited navigators from making referrals to insurance brokers when either the individual or small business prefers that, or when it's in their best interests. We obviously want the applicant to have the type of assister that they think best meets their needs.

SENATOR SEWARD: So nobody would prohibit the navigator from simply saying, Well, I think you should talk to an agent or a broker?

Is that what you're saying?

DONNA FRESCATORE: I'm sorry, could you repeat that?

SENATOR SEWARD: Nothing -- you were saying nothing prohibits a navigator from saying, I think you should be talking to an agent or a broker?

DONNA FRESCATORE: No, I'm not aware of anything that would prohibit that.

Nevertheless, our expectation is, that the navigators would be able and capable of assisting --

of assisting all the consumers that they're required to, under their grants and under the federal rules.

We have -- we have not approved standing relationships, where there's always a referral from one navigator to a particular broker. We think it's very important that the applicant's choice of the assister they work with is part of any referral.

SENATOR SEWARD: Thank you.

Senator Hannon.

SENATOR HANNON: A couple of different series of questions.

We -- you've probably heard, or will hear later today, about individuals, especially professionals, who have found it very difficult to find plans that would be successor plans to those that were canceled last year.

I mean, there was a story in "The New York Times" about lawyers and the bar association.

We've received a note from the letter from the Bar Association of the City of New York, that said many of their lawyers there cannot find plans.

We find different situations where replacement of drugs or the replacement of doctors is not able to be done.

And, so, I was very -- I really -- my eyebrows were raised when you said you had -- in your requirements to the insurers, said they should have out-of-network when -- when they offer that someplace else.

And the maybe unexpected consequences of what the rules were for the exchange, was not to have out-of-network allowed in the exchange; but, rather, to cut it down for plans outside the exchange.

And as I think in your testimony, you note that the places where the out-of-network is allowed is basically just in Western New York.

And, so, we have problems with professionals seeking, even if they want to pay, not being able to get products for this.

I think there are questions of people who are changing jobs, and are in between coverage, and because of the lag of getting coverage in New York and the exchange, that's not available; and, yet, they're waiting, 60, 30 days, for a new job.

We have people moving between parts of the state, so that there are different coverage, because we do coverage by region and by county.

So I'm wondering in regard to, what steps can be done to start to look at where we should go with

out-of-network coverage, and whether that be for a physician, hospital, or drugs?

And I could go on.

There's a lot of other anecdotal evidence, but, I mean, you're probably at the crux of getting those type of questions also.

DONNA FRESCATORE: So the rationale for the plan invitation, was that we didn't want consumers to have to, you know, choose between getting their tax credits or financial assistance. And we know that 68 percent or so of the individuals have qualified, at least for January, for that assistance, and out-of-network benefits.

So, thus, we thought there was sort of an equity or leveling of the outside markets and the marketplace or the exchange by having that requirement as part of the plan invitation.

Each of the networks for the plans that certified for the exchange has been subjected to the very same rules that the Department of Health uses to license HMOs in the state. And then there's the added protection of, for all types of insurers, that if the individual demonstrates they don't have a provider that meets their needs, they're held harmless on any additional out-of-pocket costs.

Some plans came to us, their networks weren't quite ready to be certified, because they did not have the required providers in a particular county, and those plans were not certified for offering on the exchange.

You know, that said, we are aware that there are some individuals that would prefer a product with an out-of-network benefit.

We think that, that in the end, that strong, quality plan networks is really the answer for most consumers who need, both, predictability in their out-of-pocket costs, need premiums that are more affordable to them, particularly through the marketplace, when their incomes will typically be below certain levels.

SENATOR HANNON: Are you saying that you feel that the current -- each of the current insurers in the exchange has a network that's adequate?

DONNA FRESCATORE: Yes, each of the -- and it's done on a county-by-county basis, each of the plan networks has been subjected to the same rigorous tests that the Department of Health uses to license an HMO in New York State, to make certain those networks are adequate.

SENATOR HANNON: What about the standards

that the Department of Financial Services uses to license insurers -- health insurers under their certification?

DONNA FRESCATORE: Those as well; although it's my understanding that the Department of Health HMO, because those are generally closed network products, is actually a more rigorous test.

SENATOR HANNON: Rigorous test for providing adequacy? or numbers?

DONNA FRESCATORE: As far as, in terms of, not only the number of providers in the plan network, but, also the choice of providers in the plan network, and other tests.

So, in the -- in situations where a health plan could not demonstrate, to our satisfaction, that they had an adequate network in a particular county, they were not certified for the marketplace.

That would be the same way that an HMO review would work, or an HMO's request for an expansion of service area, through the Department of Health process.

SENATOR HANNON: I had thought, under the executive order, that there was joint governance of the exchange, and things that were the specialty of the Department of Financial Services were done by

them, and things that are specialty of the Department of Health were done by them.

I didn't realize that you were only using adequacy of network under the Department of Health's rules.

DONNA FRESCATORE: The -- there are areas where there was joint review of the applications.

The Department of Health took the lead in the provider-network review for the applications.

But I don't think that, you know, which of the agencies conducted the review has in any way impacted the adequacy of the networks available to the people who enroll through the marketplace.

SENATOR HANNON: Okay, thank you.

We'll continue to look at that.

Let me ask you, since you got into numbers, I just wanted to go through some of the numbers here, because I wasn't aware, until this morning.

You talked about, the total number enrolled in an individual coverage in New York is 230,624, and you said 66 percent of them went into qualified health plans.

So that would be 152,211, if any non-Common Core math works.

[Laughter.]

SENATOR HANNON: So that's 152,000 that are going into non-Medicaid.

I presume the rest of the individuals, this other 78,000, are going into Medicaid?

DONNA FRESCATORE: Some portion of -- those numbers are for the people who enrolled by December 24th.

SENATOR HANNON: I'm just taking it from your statement.

DONNA FRESCATORE: Yeah.

So, there's a portion of those individuals who -- I think your math is absolutely correct.

So, within the 230,624, about 68 percent of them are individuals who enrolled in qualified health plans, either with or without financial assistance.

There's a percentage of those individuals who were children who qualified for CHP, because the marketplace is, likewise, enrolling children in the CHP program if that's the best option for the family.

And then, the remainder, about 27 percent or so, were Medicaid. That's the 61,625.

So we have one front door where individuals apply through the marketplace.

And then, depending on their income, their family composition, if they're eligible for Medicaid, they're enrolled in our state Medicaid program. If their children are eligible for CHP, they're enrolled in CHP.

And if they're eligible to enroll in a QHP, whether they get tax credits or cost-sharing credits, or not, they're enrolled into a QHP product.

That's really the seamless front end that we had envisioned throughout our entire planning process for the state.

We don't say to someone --

SENATOR HANNON: I'm trying to get at some of the numbers.

DONNA FRESCATORE: Okay.

SENATOR HANNON: So that -- we agree that 152,211 went into qualified health plans, which is non-Medicaid.

DONNA FRESCATORE: That's right.

SENATOR HANNON: And then you also, later in your statement, said, half of those never had insurance before, or -- I'm sorry. You said half of those were uninsured.

DONNA FRESCATORE: Half of the individuals

were uninsured.

SENATOR HANNON: Who went into the private plans were uninsured.

DONNA FRESCATORE: That's right.

SENATOR HANNON: So we've now offered, so far, about 70 -- insurance, for people who had previously been uninsured, to 76,000 people?

DONNA FRESCATORE: I think that's the correct logic for the math.

The percent of people who qualified for Medicaid, that were uninsured at the time of application, was slightly higher, but, that's a separate number.

SENATOR HANNON: So, my interesting point to you would be, this state had CHP, Family Health Plus, and Healthy NY.

And the last time I could find numbers for Healthy NY, we had about 170,000, according to their annual report in 2010.

170,000 were enrolled in Healthy NY.

Now, that's individuals and group.

But, my point and my contrast is, that was a significant number of people who had received insurance in this state, and I contrast that with the 76,000 we've just gotten now under the ACA.

DONNA FRESCATORE: So my understanding of the most recent Healthy NY enrollment would be that there were about 88,000 people who bought as individuals or sole proprietors under Healthy NY.

If those individuals completed the application for the marketplace, they, presumably, would respond to a question that they had insurance at the time they applied, and be part of the other --

SENATOR HANNON: Well, I'm just contrasting total numbers of enrollment: 170,000, versus the 76,000.

DONNA FRESCATORE: Yeah, I think that you're applying the percentages correctly, Senator.

I would point out, however, that, you know, the marketplace is truly a new option, and, not all people who will enroll in health insurance will enroll through the marketplace.

Insurers and brokers will work directly with individuals, and small businesses as well, to enroll people in coverage directly.

So I think that's another important component if we were to look more broadly at the number of people, and the transition of insured, from one product through another.

The marketplace is one piece of enrollment.

SENATOR HANNON: Okay.

And in terms of the Medicaid expansion, just the way I looked at the number, where you had 78,000 going into Medicaid, and you said 20 percent of those were as a result of the Medicaid expansion.

So we've enrolled in the Medicaid expansion population, 15,680.

DONNA FRESCATORE: Yeah, the total Medicaid enrollment for January --

SENATOR HANNON: No, this is just the expansion population --

DONNA FRESCATORE: Right.

SENATOR HANNON: -- which was the option the State took under the Affordable Care Act.

DONNA FRESCATORE: Right, so the numbers would be 20 percent of 61,625.

SENATOR HANNON: So it's even smaller than I had. I had 20 percent of the 78,000.

DONNA FRESCATORE: Right.

If -- when we think back to some of the initial projections that were done on enrollment, at full implementation, the expected number of people who would be newly eligible, because Medicaid levels were -- because Medicaid already covered hundreds of

thousands of childless -- single and childless adults in New York, those projections were, that about -- at full implementation, about 75,000 or so people would enroll in Medicaid, over time.

SENATOR HANNON: One point, when I mentioned the bar association, part of their part -- analysis of the Affordable Care Act, was that their -- the definition for an "individual" had changed.

Before, you could get coverage if you were -- there were two people together.

Now, those two people have been split into two individuals, and, the two individuals often wind up paying more than they had been paying before.

Now that had been a change in the New York law, or because of New York law.

And I was just wondering if you have any policy recommendations to go back to where we had been.

DONNA FRESCATORE: So my understanding is, that the way we're determining, or the definition of, "sole proprietor," for the purposes of the marketplace, is consistent with the federal rule, and that we're applying -- we're applying the rules as they're defined in that federal requirement.

SENATOR HANNON: But, still, this state, we

passed legislation in the year -- what'd they call them? -- RHIOs, or -- PEOs" (professional employees' organizations), that allowed people to join and still get the benefit of group rates.

So I'm just wondering where the marketplace is gonna go as we try to find coverage for people who previously had it. And these are not people who are going to get subsidized, they're not going to get tax credits, but they're still looking for products that will offer them the coverage.

And the last thing I have to say is, I've looked for -- I was looking for an -- I understand it's federal, the Spanish website.

You have Spanish materials, but you don't have a Spanish website.

And in terms of the population of New York in need of insurance coverage, we really need to move that forward.

And I wonder, at some point, will you get some good news from the federal government when they will take the rest of what you -- you can only do so much with a website. You need their hub in order to operate.

When are they going to come up with a Spanish website?

DONNA FRESCATORE: We agree, that consumers should have a website that's translated into Spanish.

Excuse me.

We invested, you know, and focused on the technology to launch the marketplace, and, that investment has paid off, because our website never crashed.

There were people who had long wait times, but, people -- it never went down entirely.

And since early October, four days into it, it's been running smoothly, as evidenced by the number of people who are enrolling through the website alone.

We are working on a Spanish website.

And while I can't give you a specific date today, it is something that we agree that should be made available to consumers, and we'll get that done.

SENATOR HANNON: Thank you.

SENATOR RIVERA: First of all, on that last point, (speaking Spanish), very much in agreement with him, as soon as we can have it, that would be excellent.

First will be a brief kind of parochial, and

I'm sure that we'll speak later, because there is a breakdown that you have of where folks have signed up, so I'm sure that if I give you, maybe, a list of ZIP codes from my district, I could have a sense of how many folks have signed up in the Bronx?

DONNA FRESCATORE: We can get you that information.

SENATOR RIVERA: Thank you.

I know that there were -- that we had a -- 2016, the goal was to have 1.1 million folks -- or, the projection, was to have 1.1 million by 2016.

According to the numbers that we just discussed, we're about 294 grand, I think just said.

So I think we're on track to be able to do that; correct?

DONNA FRESCATORE: Yeah, we believe we're on track, and maybe a little ahead of where we thought we would be, based on the projections, at this point.

SENATOR RIVERA: And as far as the population of, you know, quote/unquote, young invincibles; that 35 -- "under 35" folks, according to some of the numbers that you gave, about 30 percent.

So, a third of the folks that have signed up are from this -- from this younger population.

There's been a discussion, nationally, about the fact that there is a need for healthier individuals to be part of the exchange to make sure that it works.

Is that a percentage that, for lack of a better term, is at a healthy percentage to have as the total breakdown of folks that have signed up?

And, do you think that that would be -- that will make the exchange work well?

DONNA FRESCATORE: Yeah, we believe that these early results for January, for the first month -- effective month of coverage, show that there is broad awareness and interest among younger adults in signing up for coverage through the marketplace.

We have, and we will continue our efforts, to reach out to younger adults, to reinforce the value of being insured, of having the, you know, security and protection that insurance affords us.

And we expect that, over time, that number, that percentage, will, in fact, even increase.

SENATOR RIVERA: All right.

That's all I have.

Thank you.

SENATOR SEWARD: Senator Larkin.

SENATOR LARKIN: Good morning, thank you.

A well-prepared document.

I have 309,000 people in my district. If they didn't know anything about health or insurance, they would have said this would be an Academy Award.

And I'm not being insulting, but I'm confused when I look at the state and the federal government, when we're talking about people, like, Let's go on your website.

I have thousands of people who don't have a computer, don't have a website.

I did a survey over this weekend.

Everybody I was asking, the biggest complaint is: I can't have the doctor I want.

"Out-of-network" is not an explained situation.

The other thing I think about is, Friday night, a 73-year-old colonel from the United States Army moving to Florida, said: I got a great policy. It's $175 more than last, but my daughters are very disturbed, because I'm authorized two mammograms a year.

SENATOR SEWARD: That would be interesting.

[Laughter.]

SENATOR LARKIN: Now think about it.

Somebody, along the line, I understand what you're trying to do, and I appreciate it, because I believe health insurance is an necessity, not a nicety.

But I'm concerned that, I think there's money being spent in wrong ways.

We talked about navigators, and all.

I looked at the 900 form of the society of New York, where they're paying their head guys 600,000.

They're going to come up to my district.

That was back in September.

Of course, they haven't found a way to Orange County yet. It's too small of a county.

The other thing is, is the Spanish.

I have a district that has tremendous Spanish-speaking people. Wonderful people.

I have parts of three counties.

Rockland County, they make up for 2,000 of the residents. Most of them are in my district. And they're saying is that, there are inadequate numbers of persons who can translate for them.

Now, you have better books than I do, but I'm telling what the people on the street are saying.

Does anybody know how much we spend on

navigators?

DONNA FRESCATORE: Certainly.

The awards for the navigator program are about $27 million a year.

It supports about 570 or so full-time individuals throughout New York State.

Taking, collectively, the navigators, I can't specifically to Rockland County, but I can get that -- I will get that information for you, Senator Larkin.

Collectively, the navigators speak over 40 different languages, and we've made available a site directory.

You can get it on the website. We understand not everyone has access to the website. You can call and we can get it to people. We can get it to your district offices.

And that directory shows what languages are spoken at what locations, so people can see which navigators.

Additionally, on language access, our customer service center is prepared to assist callers in just about every possible language.

They have over 60, I think 65 or so, representatives who are Spanish-speaking. And, they

use language-line services if they need additional languages or additional resources.

Likewise, our materials are translated into seven different languages, including Spanish.

So far, you know, the call center has handled over 20,000 calls in languages other than English. It's an important feature of the program.

We know the website isn't going to be the answer for everyone, regardless of, you know, their -- of language. It's just not an option for everyone.

SENATOR LARKIN: We realize that, but we're talking about the person on the ground. That -- that's the one person we're trying to get to.

And in my honest opinion, I think our communication is not up to date as it should be.

Remember, the age group, and I can speak for them, because I'm going to be 86 years old in less than 20 days.

But I'm saying, I talked to many, many seniors, and they're confused.

Number one, is the out-of-network.

Number two, is the communications between the individual.

I've had people tell me over the past month

that they've been on a the phone over 12 hours, over a couple of days.

And there's no -- there's something missing.

It could be the person that's telling me the story, versus the person who's receiving it, but something is missing there.

You might not see it when you look at 19 million people, but when I look at 309,000 people that I talk to frequently, not once in a blue moon, the questions are serious.

Out-of-network, no communications, and lack of plans that are not adequate to the individual.

And I thank you for appearing here today.

SENATOR SEWARD: Thank you, Senator Larkin.

Senator Golden.

SENATOR GOLDEN: Thank you.

If you could put your mic a little bit closer to you, please?

DONNA FRESCATORE: Certainly.

SENATOR GOLDEN: Thank you.

The -- I think we're all a little concerned about the out-of-network issue.

And, there was an article back in "The Times," back on October 18th, about a young girl that had a heart issue, 9-year-old D'Andrea.

Miss D'Andrea.

And, she went in, and the hospital told them -- they took their insurance, and, they had no idea, the number of people that were in the operating room, and how many doctors were out-of-network.

And they got additional bills for all of those out-of-network anesthesiologists, out-of-network doctors, and, it was pretty overwhelming.

So, there are two areas here:

One, obviously, is in the -- when there's an emergency and you're put into an emergency situation, and you're going into the emergency room, and whatever doctors are there, obviously, are going to work on you.

There's also the secondary, where you can actually plan to go into a hospital, and you can actually take a look at the doctors that are in your network.

But, we don't have a list of those doctors in the network, do we?

And -- number one.

Number two: How do we go and take care of these different issues, when they go into an

emergency room, or in a planned situation, and there are doctors that go into the operating room or into the -- or the anesthesiologist, that's out-of-network?

How is that being dealt with?

DONNA FRESCATORE: So, thank you, Senator Golden.

The network's information for each of the plans is available. It's on the website.

We've also, since we launched New York State of Health, made a tool available to consumers, as they're applying for coverage, so that they can enter the name of the physician that they desire and they can see the affiliations with different health plans.

In an emergency situation, all of the plans that are certified on the marketplace, consistent with, both, federal, and I think state rules, if a person believes they're having an emergency, they seek care, it doesn't impact their benefit, whether that hospital is participating or not participating.

They're just responsible for -- there's no prior-authorization requirement from the health plan to get those services, and, those services are treated as though they're inpatient.

For scheduled procedures and admissions, these plans generally require the use of an in-network provider, unless the plan has approved an out-of-network referral because the plan can't meet the individual's needs.

SENATOR GOLDEN: So let me -- in an emergency situation, the network would cover it?

Is that what I'm understanding?

DONNA FRESCATORE: In an emergency situation, the provider is -- would be covered. There's no prior authorization, so we don't have people, in emergency situations, where they have to call their health plan, and ask or worry about whether they're seeing a network provider or not.

SENATOR GOLDEN: And in a non-emergency situation, where you have a hospital that's -- any one of them -- NYU, Presbyterian, any one of those hospitals, when you're going in for a serious operation, a heart operation, you can have as many as five, six, seven doctors in the room.

There could be three, four, that are out-of-network.

How would they know?

DONNA FRESCATORE: Again, the networks are available.

We always encourage a consumer to ask the -- their physician whether or not they're in their health plan's network, or not. Or, ask the health plan.

And, you know, I think there have been some particular situations that have been brought to us, questioning whether or not a particular institution or a provider participates in the network.

And when we've been able -- when we've looked at that network data, and, in fact, including the hospital that you raised, the facility does, in fact, participate with some of the plans.

That's something we've made available to consumers while they're picking their plan, because we want them to have that information while they select.

SENATOR GOLDEN: So it would be up to the consumer, if the individual were to go have an operation, and in that operating room, we're looking at six doctors, two anesthesiologists, three nurse practitioners, and then, of course, a whole series of after-care, another series of doctors, that would come in and out of the room over a period of time?

So, it would be up to the provider -- to the individual seeking that insurance, to make sure that

each one of those individuals were in and part of the provider that was being in the network?

DONNA FRESCATORE: It would work as it does today, in today's insurance markets, that --

SENATOR GOLDEN: I'm sorry?

DONNA FRESCATORE: It would -- we would always encourage the consumer to have a discussion with the providers, and, to determine their network affiliation.

That's the same advice we give consumers today outside of the marketplace coverage.

SENATOR GOLDEN: So it would be up to the consumer to make sure they understood, how many doctors and how many people were going to be in the operating room, and how many in after-care, and what your PT would be after that, and how that would be taken care of, which could involve as many as 25 people?

DONNA FRESCATORE: Right.

And that information is also available directly from the health plan on their website.

It should be available from the health plan's customer service staff as well, can answer very specific questions about particular doctors or physical therapists and their participation.

SENATOR GOLDEN: Now, what about these larger hospitals, some of them take one or two plans, three plans, and then you have other networks that, other -- hospitals that take many plans?

Is there any -- anything in process to try to get these hospitals to take more plans? Or is it -- how does that work out?

If you have two hospitals that only take two plans, that, obviously, limits the amount of people that can go into those hospitals that deal with acute cases.

Do we have any way of working with that?

DONNA FRESCATORE: The criteria for approving the plan -- or, certifying the health-plan networks has a requirement for hospitals.

And, depending on the location, I mean, there's some counties in the state where there may be only one hospital.

In other areas, such as in your district, the requirement in the number of hospitals is higher.

But, the agreements between health plans and providers are private contracts, as they are today, and, they are negotiated and changed from time to time.

Also, as you look at the network composition

of each of the plans and the marketplace, it was not our intention, ever, that they be exactly the same; but, rather, that there be some variation in the networks, and, that consumers would have a choice, often at different price points.

SENATOR GOLDEN: The -- just, again, on D'Andrea, Miss D'Andrea, I think they call that "balance billing," right, where the out-of-network makes up the difference on what they were not paid for because they were out-of-network.

Are there other states dealing with the balanced billing?

And, is the federal government have an approach on balanced billing?

And, what are we going to do here in the state of New York, with balanced billing?

Or, do we have a plan to do anything with balanced billing?

DONNA FRESCATORE: You know, I'm not certain that I'm the best person to answer that question.

I think that -- I'm not aware that the federal government has a policy on that.

I think there are some other states that have processes when there is a balanced bill from a provider that's out-of-network.

SENATOR GOLDEN: So they would still be allowed to get their dollars, if they had not done their homework.

Those out-of-network doctors would be able to make up that balance by charging the individual, out-of-pocket.

Correct?

DONNA FRESCATORE: In an out-of-network situation, yes.

The individual would file a claim to the insurer, and there may be an unpaid balance from that bill.

But I'm not -- I don't know I'm not the person to speak to, you know, a survey of the other state policies on that.

SENATOR GOLDEN: Do we have a lot of doctors today starting to opt out of Medicaid and opt of this affordable plan -- affordable health-care plan?

DONNA FRESCATORE: You know, we've -- we collect network data for the marketplace. We do -- we've changed that to be quarterly, and with the goal of collecting information from the health plans on a monthly basis, as we move forward here.

And there are some changes, as there are today, in the usual course of business, from month

to month, in the provider network.

But, thus far, what we've seen, you know, overall, is that while there's some adds and some subtracts, that all of the networks exceed all of the adequacy standards that were set forth at certification.

SENATOR GOLDEN: I see a number of doctors, it's in Manhattan; specifically, New York City, they opt out. They have their own special concierge plans today, but you never seen that in the outer boroughs or in Upstate New York.

I see a number of doctors now starting to opt out in my community.

I see that as a problem, coming forward.

You don't see that as a problem here in the state?

DONNA FRESCATORE: Well, you know, we will -- I don't know that I foresee network adequacy as a problem, but, that is -- we will be collecting information quarterly, and then monthly, to be able to see if there's changes in the number of physicians or specialists available to consumers when they enroll in the marketplace coverage, going forward.

SENATOR GOLDEN: Businesses: The --

Senator Hannon had pointed out the number of businesses across the state.

I think, in your testimony, it's around 5,000 businesses have joined.

Are these businesses -- which program are they choosing?

And, are they -- is there a savings here on these small businesses?

And, why is the number so low on small businesses?

DONNA FRESCATORE: The small businesses are -- represent businesses from all over our state.

The small-business marketplace is an option for small businesses.

They still can purchase insurance directly from an insurer, or with the assistance of a broker and the outside market.

There are savings to small businesses through the State, through the small-business marketplace, because it's the only point of access for small-business tax credits.

So, small businesses that meet the federal requirements, they have fewer than 25 employees, an average wage of $50,000 or less, not including the owner's wages, and, that contribute 50 percent

towards the cost of coverage, can qualify for tax credits when they buy through the small-business marketplace.

We expect, over time, that more -- that the enrollment through the small-business marketplace will increase because of the tax credits that are available, and, because the flexibility that's built in, to -- for the employer to make different choices about what they contribute, and what plans their employees have access to.

SENATOR GOLDEN: God forbid any of these tax credits expire, we'd be in serious trouble.

But if you can make it available us to, for the small businesses, to the Committee Chairmen, the number of businesses, the plans they're choosing, and the outreach that's being made to small businesses, and trying to develop that plan.

Last question, and then I'm going to -- because there's other Senators here that want to ask some questions.

I wanted to go into the website, just for a real -- two brief questions.

Has there been any attacks on the websites, and is there any breach?

And, who is liable for that breach?

DONNA FRESCATORE: No, the website is monitored constantly for any particular -- for any possible intrusions.

There have been no breaches to the website, and there's been no known attacks.

SENATOR GOLDEN: And who would be responsible for a breach?

DONNA FRESCATORE: We would -- there's certainly policies and procedures, as well as federal requirements, about notification in the event of a breach.

Those are governed by such regulations as HIPAA.

But, again, we have not seen any breaches, and there's no known attacks on the website.

SENATOR GOLDEN: Thank you very much.

DONNA FRESCATORE: It is monitored constantly.

SENATOR GOLDEN: Thank you for your testimony.

SENATOR SEWARD: Thank you, Senator Golden.

Senator Martins.

SENATOR MARTINS: Hi, how are you?

DONNA FRESCATORE: Hi, Senator.

SENATOR MARTINS: Good morning.

Thanks for your testimony here today.

My questions center around, really, two topics:

One: The number of people who have applied, the number of people who constitute the pool of eligible individuals or families who would qualify for coverage;

And, then, the costs that you spoke to in your testimony.

How many individuals in New York State lost coverage last year?

DONNA FRESCATORE: That's not -- that's not data that we have.

I can walk you through the information that we do have.

Prior to implementation -- prior to the enactment of the Affordable Care Act, New York had already standardized its individual markets; meaning, specifically, our individual direct-pay market and our Healthy NY market.

And we know that, while enrollment fluctuated, from time to time, in those programs, that, prior to the Affordable Care Act, the total enrollment between the two was about 100,000.

So, that's the, approximate, 88,000 or so

that Senator Hannon referenced earlier;

And, an additional 12,000 or so in our individual direct-pay markets.

Because the -- because of the way the tax credits are structured under the federal law, and because we've seen the individual rates in 2014 decrease, on average, 53 percent from their 2013 levels, those individuals, through the marketplace, have affordable options to purchase coverage.

And, in fact, we see throughout the state, many consumers who had coverage, perhaps through Healthy NY, seeing pretty significant reductions in their premiums, from the combination of those two factors: the premium rates going down, and, their ability to access tax credits.

SENATOR MARTINS: I understand, but my point is broader even than that.

You know, when we had this national and state discussion over providing affordable care to everyone, there is a great deal of discussion over the number of individuals and families that did not have coverage, who would be able to, as a result of these efforts, obtain coverage.

And, I want to have a sense from you, as to where we are with regard to those efforts.

Whether those numbers continue static, or whether we've actually been able to provide coverage to individuals and families who previously did not have coverage.

And, how many people today, had coverage, that no longer have coverage as a result of the changes that have been put in place?

Because we do have people who are now without coverage, who did have coverage as recently as a few months ago; correct?

DONNA FRESCATORE: What I can tell you is that, through the marketplace, of the 230,000 people that enrolled, about half of them were uninsured.

So, we are certainly reaching people who did not have insurance, through enrollment in QHPs, as well as our enrollment efforts in our state Medicaid program, where a higher percent -- higher than -- slightly higher than 50 percent of people were not insured.

Because our small-business market in New York was not standardized prior to the ACA, and some 15,000 or so different products were out there, I don't have -- we don't have data that shows how many of those policies were not compliant with the Affordable Care Act.

SENATOR MARTINS: Do you have an estimate as to how many individuals in New York were uninsured prior to the rollout of the Affordable Care Act in New York?

DONNA FRESCATORE: Based on census data that was part of the modeling work that was done by the Urban Institute on behalf of the state, there were about 2.7 million uninsured New Yorkers.

Of those, the expected enrollment, I think this number was mentioned earlier by one of the Senators, we expect that 1.1 million people will enroll through the marketplace by the end of 2016; by December 31, 2016.

So that then gives you some numbers about the total number of uninsured and what the expected enrollment is three years out, which we consider full implementation.

SENATOR MARTINS: So that "2.5 million" figure is probably still about accurate now, isn't it?

DONNA FRESCATORE: Yeah, I don't know that there has been any significant change, based on, you know, census data, to that number, so I think it's fair as an estimate of the uninsured.

SENATOR MARTINS: You've used the statistic,

"53 percent of reduction in premium rates," as compared to those in effect in 2013. You've used that a couple of times so far.

And, I just need some clarity on that because, what's the baseline?

What are we comparing, when you compare, or you say, that there's a "53 percent reduction"?

Because I have heard from a significant number of individuals from my district who have complained about premium increases.

Now, naturally, I expect I'm going to hear from people who are complaining about increases, and I'm not necessarily going to hear from people who have gotten decreases.

But, is that based on a comparison of equivalent coverages, or -- or year to year?

Because, as Senator Larkin mentioned earlier, there are coverages that are now provided that, in the past, perhaps an enrollee would not need, and so the baseline for coverage has increased; thereby, the cost increasing.

That "53 percent" figure is based on, I'm assuming, comparable coverage, year to year, even though, last year, that person may have opted not to have the coverages; correct?

DONNA FRESCATORE: It is based on comparable coverage.

The 53 percent average reduction is the comparison of the individual direct-pay premium rates in effect in 2013, compared to the individual premiums in effect for 2014, for comparable benefits.

SENATOR MARTINS: So if we had individuals who did not choose to have the extensive coverages that are currently afforded under this initiative, they would see their premiums increase, not decrease?

DONNA FRESCATORE: The 53 percent is a comparison of the standardized products that were sold in New York to individuals, to what's available today in the individual market.

So, it's apples to apples.

SENATOR MARTINS: No, I understand, but it doesn't take into account the fact that there are fewer options available to individuals, because the baseline for coverage has actually increased; thereby, forcing them to purchase coverages that they would not have had to have covered or to have used last year; therefore, their actual premiums, money out of their pocket, has actually increased.

Have you seen instances of that?

DONNA FRESCATORE: My understanding is, that for individuals who are purchasing prior to the -- prior to 2014, on the individual market, those -- the products they were buying in the standard market -- standardized marketplace were very comparable to the products that are available to them today.

Because there are so many, over 15,000 products, pre-Affordable Care Act, that were sold in the small-business market, it is more difficult to do that kind of comparison, because it's not really a -- it's not really an apples-to-apples comparison because, just of number of different products that were in the small-business marketplace.

SENATOR MARTINS: You know, what are -- in your view, what are the challenges you have, going forward?

You know, we've heard a lot today about all of the positives, as they are.

What are the challenges, and what are the pitfalls, and what were the hurdles, that you didn't foresee, and you didn't tell us about this morning?

SENATOR LARKIN: Good question.

DONNA FRESCATORE: I think that our -- our challenges are what they've been, really, since we began this process; and that is:

To continue our outreach and education efforts to New Yorkers throughout the state;

To continue to improve the customer experience, on the website, when people call our customer service center, when they work with one of our sisters.

And it's -- as I said earlier, it's an ongoing process. You know, implementation on October 1st, in many ways, was the start of our marketplace, and, it's a continual improvement process that we are fully committed to implementing.

SENATOR MARTINS: One last point:

I think -- earlier you said that, policies, insurance cards, numbers, would be -- identification numbers, would be issued after someone paid their premium, right, and that most of these insurers had not sent out notices for payment until January 10th.

Is there a backlog now?

I mean, is this a significant concern?

Because, if they didn't get their notices for payment until the 10th, this was rolled out January 1st, they have, I'm assuming, a certain

period of time to pay.

Are we dealing with a widespread lack of information being provided to individuals with regard to, access to health insurance, access to the policies that they have, access to identification numbers?

And is there something that can be done to expedite that?

DONNA FRESCATORE: Just as a point of clarification, all invoices were sent out by the 10th, based on information reported by the health plans.

Many of the plans had been sending invoices throughout the course of the last several weeks or months, as they received enrollment information from the marketplace.

So, I just wanted to be clear about that.

Is there safeguards to consumers? People have ten days from when they receive their invoice to make their payment, and make their coverage retroactive.

Most of the health plans have ways to confirm, for providers, that individuals are enrolled in their plans. Some of those processes are telephonic, some are electronic systems; and,

so, those usual processes are in place.

And, again, we will work, and the health plans will work, with anyone who enrolls and pays their premium by the due date. And we're going to be flexible there, to ensure that they have coverage during the month of January if that's what they would want to have.

SENATOR MARTINS: Thank you.

SENATOR SEWARD: Senator Hassell-Thompson.

SENATOR HASSELL-THOMPSON: Yes, thank you.

Just one quick question.

There was -- there was some conversation a little earlier about the role of the facilitator --

SENATOR RIVERA: Navigators.

SENATOR HASSELL-THOMPSON: -- navigators. I'm sorry. And I think that that was part of the question.

Are they, in effect, facilitators, or -- or, really, how does that role play out?

Let me give you an example of what I mean.

Many have us, as electeds, understanding the -- the immigrant population in our districts in the Bronx, for instance, most of us did outreach to many of our organizations, particularly our clergy and other not-for-profit groups, in an attempt to

explain this process to them. And we invited navigators, and others, to explain the program and how it worked.

But I -- but I didn't see any kind of outreach efforts by the State, for instance, to reach out, particularly to our Medicaid population.

And I'm wondering if some of that may account for why the registration in some them is a little slower; or, is that an automatic system?

In other words, you have a list of all the -- all of the Medicaid-eligibles, and so that, automatically, they're sent information.

But what do they do with that information?

How do you ensure that they understand the choices that are available to them?

Who's doing, that, to enhance your ability to reach some of the hard-to-reach in our communities?

DONNA FRESCATORE: So, thank you, Senator.

The role of the navigator is to actually act on behalf of the individual, and help them submit their application.

So, the navigators, the expectation, and what they provide to individuals in the community, is more than just presentations with basic information about how to enroll or where to go to enroll. We

actually expect them to accept the application.

In fact, a number -- a good percentage of applications are handled by navigators, as insurance brokers are assisting individuals as well.

We also have had outreach in communities.

I think that we have been in many communities, if not most, throughout New York State with informational types of forums.

We're always happy to engage with you on those kinds of activities, on a local level.

We've met with many community organizations.

We have met with faith-based leaders in different communities throughout New York, as well as consumer organizations. And we --

SENATOR HASSELL-THOMPSON: But the question is who initiated that?

I mean, is that an expectation that the community initiates that? Does the navigator, you know, initiate that?

And when you say that they do this as a process with the individuals, how do they access the individual?

The individual, obviously, is not going to pick up the phone and call them, because they don't know they exist.

So, you know, how does that work?

DONNA FRESCATORE: So it -- I think it's -- you know, I think, certainly, it's our responsibility in the marketplace to initiate the community outreach, but we also are receptive to others in the community who may want to organize outreach. And we will -- we are happy to participate in that when we can be helpful to that effort.

The navigators do community presentations.

They are in libraries in communities, in health centers throughout communities.

They're in a variety of different locations where people in the community live and work and conduct, really, their daily business and activities.

So, a navigator would be present there.

They're available by appointment, to meet with individuals and process their application for them. Or, they can, you know, meet in a community location as well, and assist consumers.

So that's really the very important role that navigators play in our community.

And we welcome the opportunity to work in communities, along with you as well, to help spread

the word.

SENATOR HASSELL-THOMPSON: Thank you.

Thank you, Chairmen.

SENATOR SEWARD: I know Senator Golden has a follow-up.

SENATOR GOLDEN: One quick backup question.

I just had to go back to the D'Andrea situation again.

And, really, as I sit here and I process this: If you have to be able to get six, seven, eight doctors, medical professionals, into a room, and you have hospitals that only have one or two plans, and, other hospitals, the networks that have four or five, six plans, isn't there a situation that we fear, that we see in other nations, where we have a backup, where you can actually have to be able to get each one of these doctors into that operating room at a specific date, that are in-network, and how many of those doctors are not in-network within those hospitals?

So doesn't that really create a scheduling issue for us and for the state of New York?

DONNA FRESCATORE: I think that it's -- you know, you raise an important point, Senator Golden, that, you know, it's -- and one of the reasons that

we -- you know, we believe that, really working in collaboration with health-care providers and with health plans, we need to build very strong, very robust networks, so that consumers have the protection and the assurance that, when they need a medical service, that they're seeing a physician or other health-care provider that's affiliated with their plan.

We think that in -- you know, in the end, we understand, again, and we are aware, that there's interest in out-of-network benefits.

But we think that the really best answer for most consumers, is to have a plan that has a very robust health-plan network, where they have assurances that the provider's in the network, and they know what their out-of-pocket corresponds are going to be before the service is rendered.

SENATOR GOLDEN: Well, it works only the -- if you're not in an acute situation in one of the larger hospitals that take care of the more serious issues that are presented to families and to individuals.

And what you're going down to are, hospitals that -- doctors that are all hospital employees, then you don't have that problem.

But in the larger sense of, New York City, and around the state of New York, where you have these expert doctors and hospital facilities, getting these people into -- or all of these people into an operating room in a timely fashion for somebody that needs an operation next month, say, I think is going to definitely present a scheduling situation here, not only in this state, but across the nation.

Any further comment on that? No?

DONNA FRESCATORE: No, I don't think so.

SENATOR GOLDEN: Thank you.

SENATOR SEWARD: Well, thank you very much, Donna -- Ms. Frescatore.

DONNA FRESCATORE: Thank you.

SENATOR HANNON: Thank you.

Obviously, we're gonna have lots of conversations.

SENATOR SEWARD: Our next panel are consumers, purchasers of health-insurance coverage; and that is:

Mary Morse, who's owner of Kwik-Kut Manufacturing, a fine small manufacturing facility in Mohawk, New York;

As well as Pamela Reese Finch, a public

relations consultant.

Who would like to go first?

MARY MORSE: Can you hear me?

SENATOR SEWARD: Yes. Just keep close to the mic.

MARY MORSE: All right.

Good morning.

It's still morning.

Okay, I would like to thank today's -- Senator Seward for inviting me here today.

I am a small-business person, probably smaller than most.

I own a manufacturing company, as there are still manufacturers left in New York State.

We have been in the village of Mohawk since 1955, and the company was actually started in the 1940s.

I have provided these little red booklets for you, so you can learn a little bit about the company, and some -- there's also mentioned in there, a few of the other issues that New York State businesses are facing, in addition to the health-care issue.

I've been looking forward to 2014 about like putting a stick in my eye.

There's a lot of changes coming down, especially in taxation.

There's two benefits, in all the years of our company, that we have received from the State of New York:

One is the Empire Zone, which was for manufacturers, which you may or may not know is sunsetting this year. And, my company did receive benefits from that, which we no longer will.

The other one that was, I feel, a little bit of a Godsend for my employees was Healthy NY.

I have kind of a unique situation with employees.

I have three full-time employees, and five employees that are retired and part-time people.

I had a couple of employees that were actually on Family Health Plus.

Back in 2009, they got canceled from that because their son had the nerve to turn 18.

So, because their family became smaller, their income was higher, and they no longer had Family Health Plus.

So Healthy NY, you know, was available.

I didn't have any other plan in my business,

so, I actually let the employees pick which plan they wanted through the Healthy NY plan, and they chose a plan that was a non-prescription plan.

But other than not having prescriptions, I would compare it to any of the Gold plans that are offered on the exchanges today.

They had excellent health-care coverage. The coverage they picked was through Excellus. They could use it anywhere up in our area.

And, I contributed half towards their premium, and deducted the other half from their paycheck.

At the time, in 2009, the premium for that policy was $176.

The -- in 2013, the premium was $226, which I think you will agree is one of the smallest increases of anything in that amount of time.

I also had another employee who was retired, worked for me part-time, and he chose the Healthy NY plan, which he contributed -- he paid the full premium.

When I had to tell these -- with the Affordable Care Act coming along, and I had to tell the employees that they were canceled. We received a cancellation notice.

And, the next thing I got was, which is in your folder, is the policy that was the replacement policy for their Healthy NY policy.

This policy now was $100 more a month. It was loaded with co-pays. It's loaded with out-of-pocket deductibles.

And, not only that, one small paragraph below all the rates was, "If you do not have" -- the policy did not include pediatric dental.

So if they did not have a dental policy somewhere else, this policy was null, void, and a moot point.

Well, I don't, for the life me, know where someone who is a single person, who is 60 years old, and never been married, would have a pediatric dental plan someplace else.

So, that meant that that policy went by the wayside.

The next thing that I -- because I am under the 50 employees and I am not required to offer health insurance, after speaking with my accountant, and, you know, considering what was best for my employees, I had to take the route of not offering health insurance anymore.

I had to just cut them loose and send them

out on their own to the exchanges; and, so, that is what they did.

I have two employees who signed up for -- who -- you know, the other part of my businesses, these are people who make $10 an hour, and the maximum number of hours they work is 32.

We're only open 32 hours.

So that's not a very large paycheck to be, you know, trying to take home.

The only plan that they -- after they went in, a couple of the employees received almost the entire full subsidy that is available. That's -- that's their income is.

And so, after they received, you know, their subsidy notification, as was spoken about, they went in and selected their plans. And the only plan that they could afford is a Fidelis Medicaid-based plan.

I -- you know, I'm very, very fearful for their situation, because I think that this plan has -- it also has very high deductibles, a lot of out-of-pocket expense.

There's a lot of doctors and hospitals that are not accepting Fidelis down around us.

So, on a day-to-day basis, of people who are relatively healthy, they will be perfectly fine, but

if they have a major medical issue, I am very, very concerned about them.

The other gentleman who was retired, he has a cancer situation, where he has to go yearly for a colonoscopy, and usually ends up, for the last five years in a row, has actually had surgery every year.

The plan he had with Healthy NY, he loved it. He never had to pay any money out-of-pocket. He could go see his specialist. He could make timely appointments.

Now he has -- you know, he's also out on his own now.

He is not a destitute person, by any means. He has a good pension from where he retired from.

So, he took -- but he's not a person, of course, who likes to spend more money than he needs to, so he selected a plan that was also around 300-and-some dollars a month, also loaded with a lot of co-pays, also loaded with, you know, high deductibles.

And he has, at this point in time, although all three of these people were signed up on time, I haven't -- didn't check with them today, but as of Thursday, none of them had their insurance cards.

He's had to cancel -- he canceled his colonoscopy, he's canceled his appointment with his cancer doctor, because he felt that he couldn't really go do that without an insurance card.

I did make a phone call to Little Falls Hospital, the head of Little Falls Hospital, which is in the Bassett network, which he would be going to Bassett, and when I asked that gentleman, what is their procedure for the people who may be coming in without their medical cards, he told me that they plug their social security number into a computer and that will tell them if they're covered or not.

So he probably could have gone ahead and done that, but, you know, he didn't think he could.

The other side issue of this, looking at it from a business perspective, is, I have -- because of this, there's no way that I could have kept a health-care plan in my business and afforded to pay for half of the employees' medical insurance, but mostly because they could not have afforded to pay half, their half, because, if I had had a group plan, they would not get a subsidy.

They might end up with a tax credit, but a tax credit means you're waiting to maybe get more money back on your income tax, maybe in -- well, if

you file in January, maybe in April. Or if you file in April, maybe three months after that.

These are people who need money day by day, week by week, you know, to live on.

So, it was a very hard decision for me.

Now my business has lost a tax credit that I got for contributing towards my employees' health insurance.

I feel that I -- and I have taken what I did contribute toward their health insurance and added it into their paycheck, because I just felt -- which I know a lot of small businesses would not, but I felt that was kind of their money, and it was already an expense.

So by adding that into their paycheck, now I'm paying more workers' comp, I'm paying more disability insurance, I'm losing a tax credit.

They're losing -- they're paying more taxes because their -- before their payment was pre-tax in their paycheck, and now it's not. You know, now they've got more money in their paycheck.

So, it kind of remains to be seen what happens next year with this, now that their pay is up.

Their subsidy's gonna go down, so, where is

all that, you know, working out?

And, you know, my hope in coming here today, is that, New York State, which I have to give a lot of credit for in the health-insurance market, because there was Healthy NY, and there is Child Health Plus, and, you know, what's going to happen, you know, with this down the road?

And my hope would be, that something could be worked out for some kind of a subsidy for either -- you know, if there was some kind of a subsidy for me to go back into offering them health care, I would tell them to drop their lousy plans and, you know, get a better one, you know, right away.

But what's killing the price of the plans is, these are three people who, they didn't -- none of them took a prescription. They didn't want a prescription plan. They don't need pediatric dental.

You know, as one of the gentlemen said, there's a lot of things in this health care that we have to pay for that no one's ever going to use.

So, that's kind of my 25 cents.

I'm up, inflation. Used to be two.

[Laughter.]

SENATOR SEWARD: Thank you, Mary.

I know I had a couple of questions, but why don't we have Ms. Finch make her statement, and then we'll see if any of the Senators have questions.

PAMELA REESE FINCH: Thank you very much for the opportunity to be here.

Can you hear me alright?

SENATOR HANNON: Move closer to the mic.

PAMELA REESE FINCH: I appreciate the chance to share my opportunity in dealing with the federal forum issue; and, in particular, New York's health exchanges.

For more than a decade I've been a sole proprietor.

I specialize in public relations and advocacy services, and, I live in Upstate New York, with my two children.

Four years ago, despite making some pretty big changes that would ensure my family's coverage, I lost my health insurance.

Since that time, I have looked into different options; and, so, like a lot of people, I was really excited to see what would become available through the exchanges.

I think what's really important for this discussion is the fact that the term "affordable" is

relative to your situation and your circumstances.

When I come here and speak today, I'm pretty much in the same boat as your community's barber or, you know, your local hairdresser: the average middle-class-family income.

When you first look at the prices through the exchange, some of the premium numbers can be deceiving and look relatively low.

What people don't understand is that there is a greater need now for cost-sharing.

So, while some of the plans may offer, for example, some of the figures I pulled on the Bronze level, had the lowest level at $233, which doesn't look bad until you put it in perspective, that you're paying $100 to see your specialist, that you're paying $50 for your primary-care visit.

So, in essence, you may be paying less in your premiums, but you're still paying the same thing that you were before the federal health-care reform.

I know that when I looked, in my situation, because I am a relatively healthy individual, to purchase health insurance, I would actually be -- pay more than what I currently paid for my regular out-of-pocket costs.

I'm not saying that I'm opposed to the idea of high co-pays or deductibles.

I do feel that personal responsibility is something that's necessary for us all to achieve affordable coverage.

But I'm saying, in terms of dollars and cents, when we look at this from a purely business perspective, if you're asking me to make the decision between my son's braces or paying my self-employment taxes, the health-insurance coverage may be at the shorter end of the list.

When you're looking at people like me, what we're really looking for is ways to reduce the overall health-insurance cost.

I heard a lot of discussion earlier today about the out-of-network people wanting to be able to see physicians who are not part of their network.

I know that I did look at the website, and in order to apply for the plans that were available, I would have to change my doctor; and, frankly, if I could find a plan that fit into my budget, I'd be happy to do that.

For me, it's more about getting access to the basic coverage.

For people who have insurance, and I think

that it was mentioned earlier, there are some kinds of safeguards in place, whether -- you know, that will allow them to receive their medical care.

And I know this isn't what everybody wants to hear, but I think, right now, our focus has to be on giving everyone basic affordable coverage, versus, making it cheaper for those who already have it.

One of the other things I would like to see, as a health-care consumer, is a little bit more, I guess, predictability, in terms of billing.

Because I self-pay for all of my employments, I've had the rather eye-opening experience of really seeing what my providers charge.

The problem with that is, I only get the information after the fact.

Recently, I went to what was a 10-minute visit to my primary-care physician, to take care of a sinus infection, which ultimately cost $283, plus $80 for the generic medicine.

Meanwhile, my gastroenterologist charged $110 for a 15-minute follow-up.

From a consumer's perspective, this type of disparity makes it very hard to budget or get any kind of a real grasp on your health-insurance cost.

And I know that, from my perspective,

I would like to see some type of transparency in knowing beforehand how much I'm going to be charged for that particular visit.

When I meet with my own clients, I know I discuss the job, the expectations, and the costs beforehand.

Likewise, when I take by car to have the tires put on it, I know that my mechanic charges $95 an hour for labor.

What I would like to see, as a consumer, especially one who pays for my services out-of-pocket, is some kind of upfront pricing.

As I said, that's my experience, but, it very much mirrors what I've been told by many other of my colleagues of sole proprietors in my community.

We appreciate the accessibility that's been made from the health-insurance exchange, but right now, what we'd like to see is things that still make it a little bit more affordable.

SENATOR SEWARD: Thank you very much.

I wanted to go back to Mary Morse's testimony.

And we really do appreciate both of you coming here and sharing your real-life experiences which you're going through at the moment.

I just wanted to clarify, in terms of what's happened to your employees who have gone out on the exchange to seek coverage on their own.

Now, they are paying over $300 a month.

Is that with the subsidies?

MARY MORSE: No.

The one that is paying over $300 a month is not getting any subsidy.

SENATOR SEWARD: I see.

MARY MORSE: He receives a good pension.

He's -- actually, he's a Remington retiree.

And the other two are getting almost the maximum subsidy. They're the ones on the Fidelis plan, and they still pay -- they still pay over $100 a month, even with the subsidy taken off.

I'm not sure what the total amount was with the -- I believe it was still almost $400 a month, you know -- well, no. It would have been 350, because they're actually two -- two people on the same policy, because they're a husband and wife.

SENATOR SEWARD: Did you personally, either of you, deal -- go on the exchange and go through that process?

MARY MORSE: I did not.

PAMELA REESE FINCH: I did.

SENATOR SEWARD: You did?

PAMELA REESE FINCH: Yes, I did.

SENATOR SEWARD: And what was your experience?

PAMELA REESE FINCH: The website itself was relatively easy to use.

It was quite a bit more time-consuming than I had expected, but I was able to comprehend the information.

Uhm, it's not as bad as what I've heard the federal government's website would be.

I think our state did a good job with ours.

SENATOR SEWARD: Yeah.

Did -- have either of you, or through -- your employees, did they work with a navigator or an agent or a broker?

MARY MORSE: No, nope, all of my employees actually went through the website, and said they -- you know, they had a very good experience with it.

Actually, they even -- because we need broadband better in this state --

SENATOR SEWARD: That's another important issue.

MARY MORSE: -- one of them was doing it from home. And, probably, they -- I think they got

bounced off about three or four times because of their Internet service, not because of the site. And they said it was very, very easy to go -- once you logged in, they said you had your log-in, and they could go back in. Or if -- and the other gentleman said, a couple of times, he had to go get more information.

And they all had very, very good experiences with the website, I will say that.

SENATOR SEWARD: As I understand both of your statements, just as policymakers, to the best of our capabilities and abilities under this federal law, if we were able to develop a product or process that would -- kind of like the old Healthy NY product, have access to that, and qualified under the federal legislation, that, you would see that as a very attractive option?

MARY MORSE: Absolutely, uh-huh.

PAMELA REESE FINCH: Yes.

MARY MORSE: I think it's just -- you know, it's just one more thing to help business out a little bit.

I -- I -- because I know a lot of business people, I've actually asked around what a lot of them were doing about the health care.

One business person that has been in business his entire life, and, you know, from his parents, on down, he's in his early 50s, and told me the other day that, for the first time in his life, he has no health insurance.

He had a plan through one of the chamber of commerces. That, that plan, you can't have that plan anymore.

So, he said that it increased, you know, four times what he was paying, and he's a single person.

And that's -- that's the story that you hear out there.

Other business people have gone to the high-deductible plans.

And I know one employer has had a high-deductible plan, and he actually pays so much of his employees' out-of-pocket expense, until they get into the -- get into anything else. And he says it comes out cheaper for him than it did when he was paying their premiums.

He just pays their bills.

SENATOR SEWARD: Thank you.

Any other questions?

SENATOR MARTINS: I just have one.

SENATOR SEWARD: Senator Martins.

SENATOR MARTINS: Ms Morse, thank you very much for your testimony.

MARY MORSE: Sure.

SENATOR MARTINS: I just want to follow up on a point you made.

You said something, and I'm going to paraphrase, that you think they'll be okay, but if they need insurance, they may be in trouble, or something along those lines.

MARY MORSE: Well, I -- you know, I just think that looking at the Fidelis plan, you know, just to use that as an example, which is a Medicaid-based plan, there's a lot of hospitals and doctors that do not accept that plan, especially, you know, I'm from, like, the Utica area, you know, up around there.

They -- I made them check with their doctor, and their doctor does accept the plan, so they were okay that they could keep their doctor.

But, when I -- just looking at, you know, $2,500 out-of-pocket, if you're already -- you know, if they already are giving you all this subsidy, and they know that you don't have a lot of money, where are you getting $2,500 out of your pocket?

SENATOR MARTINS: Yeah, but I just wanted to point out, and I think you would agree, that a hope-and-pray is not an alternative. It's not an appropriate health-insurance alternative for what we're talking about here.

MARY MORSE: Yes.

SENATOR MARTINS: You were here for the testimony we heard previously, weren't you?

MARY MORSE: Uh-huh, yes.

SENATOR MARTINS: And you were able to listen to how great the system is, and how wonderful this rollout has been.

MARY MORSE: Uh-huh.

SENATOR MARTINS: But if I've heard anything from both of you, it's that your experiences have been just the opposite, and it's raised far more issues than it has answered.

So, I appreciate your testimony here this morning.

Thank you.

MARY MORSE: Thank you very much.

PAMELA REESE FINCH: Thank you.

SENATOR HANNON: Thank you very much.

SENATOR HANNON: Thank you for being here.

Our next panel will be physicians:

Dr. Nick Fitterman, Dr. Andrew Kleinman, and Dr. Patricia McLaughlin.

Dr. Kleinman, since you're the president-elect of the state medical association, I'll let you go first;

And, Dr. McLaughlin, you can go next;

And, Dr. Fitterman, since you're from that small little health-care system.

DR. ANDREW KLEINMAN: Thank you very much, Senator.

My name is Andrew Kleinman. I'm a practicing plastic surgeon in Rye Brook, New York. And, I am president-elect of the Medical Society of the State of New York.

SENATOR HANNON: Could I just ask one short-term, so we don't have a lot of waiting time in the waiting room, could you not read, but maybe sum up the core points that you want to address?

DR. ANDREW KLEINMAN: I am. Certainly.

Basically what I -- I really want -- I appreciate this opportunity to speak, and I have to say that I think the State has done a very good job in what it's done so far, in terms of rolling out the exchange.

Also, I have to say Donna Frescatore and her

staff have been very open to dialogue with us right from the beginning.

So, I really think they have done a very good job, as far as they can go.

We remain committed to work with them in order to make this work.

Some of our members, politically, were in favor of this, some weren't, but the bottom line is, it is here, and we want to make this work.

The problem that we have, is that having access to insurance coverage is not exactly the same as having access to health care, and that's where our problem -- our problems really lie.

Basically what has happened, is that, with the rollout of this, there have been networks of physicians listed on the websites of the various insurance companies.

Now, first of all, it's very hard to find those lists because you can't access it directly from the website of the New York State of Health.

You have to go into the individual carriers.

Then when we looked at the lists, we saw a number of inaccuracies.

And we actually did a survey of our physicians, and, basically, of the people who

answered the survey, one-third said that they weren't going to participate in the plan. 40 percent said they didn't know if they were on the plans or not.

So we have actually recommended to physicians, go onto the websites and see if you're on the plans. And some of them have a great deal of difficulty even finding out if they're on the plans.

We actually have started calling around to a number of the physicians who have been on the plans, and a number of them have said they are definitely not on the plans.

Some are in the plans because they have an "all products" clause in one of their you contracts, or they're in a rental network. But the ones that are in rental networks that can't opt out, even though they're listed on the plan, have said that they are going to be opting out.

So, therefore, although on paper it looks like the networks are adequate, in reality, the networks indeed might not be adequate.

Also looking on the website, we actually have found a few physicians who aren't even in New York State, and haven't been in New York State for the past year or so.

We did a survey of neurosurgeons in Suffolk County.

One lives in New Jersey, and has for a while; one lives in Albany, and has for a while; so, therefore, they've been included in multiple networks, and they're not.

The -- one of the problems with having physicians participate, is that, although we can't ask directly how much do the networks pay, the physicians supposedly can.

The physicians, in a lot of cases, are having a very hard time finding out what the reimbursement is. Although there are laws in New York, basically, it's been rather difficult to find out.

When the physicians do find out, very often, the reimbursement is significantly lower than it is on any other network within an insurer's -- an insurer's networks.

And, very often, it's significantly lower than even the Medicare rate, which, as most of us know, is already inadequate; so, therefore, it makes it very hard for a physician to remain viable and continue to participate.

In addition to that, there is the "90-day grace period" rule that's going to come into

effect; so, therefore, physicians will be taking care of a lot of patients who actually look like they have insurance, but, in fact, haven't paid their premium.

And that's a federal problem, and I know we can't do anything specific about that.

We are working with the AMA and Congress in order to try to modify that.

We have some suggestions on how at least to notify physicians when a patient is in that grace period. And, if the patient does pay a premium 60 days after the due date, that, at that point, rather than starting over the 30 days again, if we could have reimbursement done a little sooner.

I think what we're asking for is, basically, to, essentially, make it so the networks are adequate, the networks are accurate.

And I think one of the things that we would like to see, is that, in the exchange, a physician actually has to have a contract with the insurance company.

That way, when a patient calls a physician and says, "I'm in X network," the physician will say they take it.

I think one of the problems right now, having

a lot of physicians on the networks who really aren't going to be participating in those plans, is that, if you as a patient go onto the website and say, "Oh, my physician's there; so, therefore, I'm going to sign up for this plan," and then it turns out that's inaccurate, or, as soon as the patient -- as soon as the physician finds out, the physician signs -- you know, basically, opts out of that contract, a patient has, essentially, picked a plan, that they can't see their own physicians.

The other thing that I think we do want to ask for, is some out-of-network coverage.

And, Senator Hannon, we do support your recent bill -- the number is in here somewhere -- requiring companies to offer out-of-network coverage.

And I think it's important to offer out-of-network coverage in the exchange as well, especially with the very limited networks that these companies are going to have for the exchange.

I think it's very important for a patient to have the ability to go out-of-network.

And we think that one of the reasons that almost all of the companies -- in fact, downstate, I think Oxford is the only one that offers

out-of-network at all, and they're only doing it on the small-business exchange.

Nobody is giving it on the individual exchange.

I think part of it is to try to coerce physicians to have to participate in the exchange if they want to see any of these patients.

So, again, I do want to say that, I think they've done a good job signing up patients.

I think there will be a number of patients who continue to sign up.

And our concern, is that the patients should be able to have an adequate network across all specialties, and, should be able to know who is in their network.

Thank you.

SENATOR HANNON: Great summary.

Dr. McLaughlin.

DR. PATRICIA MCLAUGHLIN: Good afternoon.

Thank you for inviting me here today.

I'd like to speak, not only as a physician, but as a small-business person, because, inadvertently, I have been hit twice in this situation, and I think my personal story will have great impact on the problems that are out there.

As a small business, in 2013, my office is in New York City on the Upper East Side, and I had two employees who were qualified for health insurance, and, I paid for their premiums.

We had elected, Empire Blue Cross/Blue Shield called "Total Blue." It was a high-deductible plan.

And I resorted to that back in 2008 when the premium had jumped up to an astronomical number if I didn't take a high-deductible plan.

So once it reached $859 a month per individual, I sought some relief.

Fortunately, I had a brilliant broker, and he gave me the advice to consider one of the high-deductible plans.

That same year, the premium for the same health plan, the same coverage, the same network, decreased from $859 to $300 an individual.

I was thrilled.

Yes, that meant my employees and me all had a $2,000 deductible.

There was the option for an HSA account.

I did as much investigation as I could.

I found a wonderful bank who was very knowledgeable in this, had a long track record, and I set up the health-savings account.

I contributed, not in a health-savings account, but I did contribute towards the deductible for my employees.

They did not want to open up a health-savings account, fearing that the money might be locked in there.

As the years went along, this just renewed every January 1st, and I was thrilled.

I never expected to get a letter at the end of September, telling me that this wonderful plan that covered everything, everything that we needed, was suddenly, because of the ACA, in the letter, not qualified, and was not going to be renewed on January 1st.

Literally, the rug was pulled out from under me.

Now, at the end of a calendar year, running a medical practice, and all the other issues that are involved in end-of-the-year accounting work, I was not pleased to suddenly have to start looking at spreadsheets of other available plans and contemplating the New York State exchange.

I didn't want us to go in as individuals, so I wanted to keep this as a small group.

When I looked at what was available, I wasn't

pleased either.

When the insurance company sent me another letter in a month after the first one, rolling out what was the new concept, the new plan, I was definitely not pleased.

And the reason is, my first plan, which we were paying $483 a month, last year, in the new plan would go down to $470.

That's about a 2.5 percent decrease.

The deductible, however, went up 20 percent, from $2,000 an individual, to $2,500.

The coinsurance stayed the same.

What really disturbed me, was this -- now, was an EPO plan, and that alphabet soup meant "in-network only."

What further upset me, is that this EPO plan in this national insurance company, suddenly, was going to require referrals to see a specialist.

In the history of this company, the EPO network did not require referrals.

So, suddenly, this new plan was targeted to yet another hurdle that one had to jump.

It also mentioned in that letter something that raised grave concern, that I must say I had a bit of an advantage over other, probably, claim

administrators in non-medical businesses.

They were very careful to mention that, as the administrator, I needed to check to see what former doctors I had gone to in, literally, the same network -- EPO and PPO, formally, have the same network of doctors -- that I needed to check, and I needed to tell my employees to check, to make sure that the doctors we had seen were still in-network.

They also went on to state that whatever drugs we were using, the medication network was also changing.

That I couldn't find information to, but the network I did.

So I went onto the website of the insurance company and looked at the network, starting with myself.

After all, I was a participating provider in the EPO and PPO network.

I wasn't there.

I looked at my PCP; he wasn't there.

I asked my secretary what other specialists she went to. There were four; they weren't there.

I asked the other person who worked in my office for her doctors, and they weren't there.

Now, I must say that most of us were using

doctors within the same hospital system, but because of this change, the premium was not the issue.

The network and the access was the issue.

And every single one of us, including my husband who's my dependent, were losing our doctors. 100 percent of our doctors.

I don't think that anything should be designed to cause that destruction, besides what it did to me in chaos in my business.

So I started to look at other plans through a broker.

I must say, that if I did nothing, by default, the insurance company said I would roll into this plan, which should indicate that I would get the new insurance card, because they also mentioned I would have a new insurance ID.

A month after that, I finally got the letter that gave a clue as to why I wasn't in that network.

As per the terms of my contract, they did not feel they needed to extended to me participation in the Affordable Care network or the small-business network that was using the term "pathway."

So they gave the network an actual term, "pathway."

When I went to the website to look at how

many other ophthalmologists, a group that I'm familiar with, being that's my specialty, there were a lot of names in the ZIP code of my office.

I must say, if you looked at that list, there were a few doctors who were either retired or who had moved to another state within the past six months; so, it was not refined.

I think the greater thing that was disturbing, it wasn't in alphabetical order, which made it next to impossible to look at, but, I printed it out, and I must have seen at least 40 to 50 names that were duplicated.

So if they were counting the raw names, it just meant they were in a different office; not that you had more participating providers.

Now, I think it's rather ironic, or a little short-sighted, to use a term in my own field, that if you're going to insure more individuals through the magnitude of the Affordable Care Act and the New York State marketplace exchange, why would you, as an insurance company, be looking to cut back on the participating providers?

I wasn't even asked if I wanted to be in it or not. I was just told, by my contract, I wouldn't be.

Now, on the flip side, there was another insurance company, that I had no knowledge, had put me on the exchange, and I found out about that in the third to fourth week of October, after the website became live, by a patient who had Healthy NY, who found out that he had lost his insurance and needed to search for something.

And he said, "Oh, great, I see you're on the Oxford United."

I said, "Really? They never told me."

And I said, "That's a little peculiar, because I don't have a contract with Oxford to start with."

So after doing a little bit of checking, it turned out that that was an error.

For some reason, that company decided to put the entire Oxford Liberty participating physician group into the Affordable Care Act and the exchanges, probably because, Oxford married United, my name carried over from my United contract, but it was an error. It took about another two to three weeks before my name was removed, along with dozens of other physicians who were similarly misplaced.

Now, in that time, individuals in New York State were deceived.

They may have signed up on the New York marketplace, thinking they were seeing Dr. A, B, and C, who were not there, and should not have been there, and, three weeks later, were taken off.

So, yes, we do need a lot of transparency, because I think that there are mistakes in the provider networks that are unclear.

I can tell you from my own personal experience, I do not relish, and would not tolerate, this limited network.

I have sought out insurance through another carrier. I'm in a pending state.

They have my check; they haven't cashed it.

I'm in flux.

My secretary slipped and fell on the very day that this meeting was canceled last week. She injured her hand.

I didn't know what to tell her to do because, this plan wasn't official, my new plan wasn't official. We were sort of in limbo.

And I even said in my testimony, that I think it was rather negligent on the part of an insurance company, knowing they gave me notice about my plan three months ago, that it was terminated, and I received my insurance card, one of four, on

Saturday.

No one else has received theirs.

My husband should have been in that envelope also, since he was my dependent.

I'm glad it came, though.

I have given 20 copies of this to the staffers before this meeting, because I just brought it up with me today.

Another thing that you must look at, and I beg you to look at from a physician's standpoint, the chaos that is going on right now with patients coming to us, believing that we're in networks that we don't know if we are, asking for care that we don't know if we can truthfully tell them will be covered as part of a network agreement. Or, we can't even be transparent to say what the fee might cost them, other than give them a fair estimate of what that day's results would be.

We won't know, until we've filed this claim a good four weeks from today, what the insurance company's take on this is going to be.

Will it be handled as an in-network participating group, or will it be rejected because we're suddenly not in the panel?

This new insurance ID card couldn't be more

deceptive to a front-desk knowledgeable person in a doctor's office.

It says that I have a PPO plan.

It does not mention the word "EPO."

I have an EPO.

It does not mention that I need a referral.

It does not even give credit to the name of another person, Patricia Ann Foxman, with a phone number. It doesn't even give her the credit of a title of M.D.

I'm assuming she might have been my assigned PCP.

On Saturday, after this came in, I decided to call the phone number.

Lo and behold, the phone number is incorrect.

It tells me it was canceled. It gives me a new phone number.

I call that phone number, I get a completely different physician's office.

Now, I don't know, if I stay in this plan, am I supposed to have this particular person?

Did they just put down the wrong phone number?

Am I just automatically defaulted to the other PCP?

And I'm somebody who understands this.

Please, for the majority of our citizens, the people that we, as physicians, who work so hard to help day in and day out, this is complete chaos.

This is not fair to anyone, mostly the patients.

This is detrimental to the small business of a physician's office.

I am a solo practitioner. I have a fiduciary responsibility to pay my creditors.

If I have people calling up to schedule, in a plan just as mine, telling my front-desk person they have an EPO plan, how am I, as the physician, going to know if I am still the participating physician in the old PPO plans that are serving the larger corporations, the federal government, Blue Cross, the union plans, or am I in this new pathway?

If the patient doesn't even have the card, if the patient doesn't even understand what "pathway" is, they wouldn't be able to tell my secretary at the time of booking the appointment what plan it is.

How can I be transparent when there's such misinformation?

We need so much help.

I know that there's a limited time to talk

about this here, but all I would say to you is, I am so willing to work with you.

Please reach out to me. I have a very good handle on this. I would love to tell you more of the pitfalls.

But the one thing that I completely resent, and don't understand, is the complete elimination of the out-of-network.

That is such an important and critical factor, especially now that I am giving you perfect evidence that these networks are not what they seem.

They are very narrow.

And I have had other physicians call me, because they know of my ability to understand all this, and they say, "I have a full practice. I'm finding out I'm listed as a participating physician. I've had five new phone calls today from patients on the exchange, asking for an appointment as soon as possible."

He said, "I can't fit them in. What am I supposed to do?"

I said, "Either work later, or give them the next available appointment. And, if necessary, send them to the emergency room. I don't know what else you can do."

There is a critical shortage happening here.

And if it's not that an insurance company signed us off, it's, also, that they are paying us a fraction of the Medicare-allowed fee, where we cannot stay in business.

Thank you so much for your time, and I'm so willing to answer questions for you.

SENATOR HANNON: Well, thank you very much.

It actually seems that the majority of the complications that are befuddling your practice are insurance companies, and not the Affordable Care Act.

DR. PATRICIA MCLAUGHLIN: Absolutely.

SENATOR HANNON: Okay.

Now, I'm not going get into it, because I think you've been very clear as to the problems, but I will say one thing:

As a sponsor of at least two bills on out-of-network, that it's much more difficult than it would seem, and especially because you have simply the logical objection, that if you start regulating and mandating out-of-network, what incentive will be left for physicians to join a network?

Now, maybe it would be -- the incentive would

be if they just ran them rationally, instead of the maze that you've had to go through; but, still, that is the logistical legislative problem that we face.

DR. PATRICIA MCLAUGHLIN: Yes, but --

SENATOR HANNON: I thank you very much, and we still have to go to your co-panelist.

Doctor.

DR. NICK FITTERMAN: Thank you.

I'm Nick Fitterman. I'm a practicing internist. I've been practicing for 22 years, beginning of my career in private practice, and, most recently, employed by a large health-care system in our state.

I am here representing the New York State American College of Physicians, the largest medical specialty group in the state, with over 13,000 members.

I want to thank Senators Hannon and Seward for sponsoring these hearings.

Again, as previously said, thanks to staff, Donna Frescatore, and Sherry Tomaski, as they've kept their bi-directional lines of communication open.

And, actually, despite all the horror stories we're hearing, thank all of the administration staff

for these efforts.

There's no doubt that this has helped to improve the health of residents of New York State, and in a Herculean task like this, there will be road bumps; thus, the hearings today.

I am not reading from prepared testimony that we've handed out to you.

I'm going summarize some notes that I took in canvassing my colleagues; most importantly, in canvassing the office managers, the practice managers at many offices, as they had a lot of information on the impact of this; and on a few patient stories.

I'll be brief, because you've heard most of this already.

So the challenges encountered by patients and physicians fall into basically four broad domains that overlap, and you've have heard them:

There's the problems with not having insurance cards and IDs;

Problems with access;

A problem with continuity;

The problem with communication.

Not having cards or ID numbers when they show up for office visits has been frustrating for

patients, has been a burden to the front-office staff in these offices.

The offices do not have a method to go on and check enrollment eligibility.

If the patients don't have their cards, and sometimes even if they do, as we heard, they may not know what the co-pay is, what deductibles are, what the fee schedules are, and it leaves both patients and the providers concerned about potential financial exposure.

More importantly, it limits the capacity of the providers of the docs to help facilitate care.

I hear story after story, where the doctor is saying, "Fine, come on in, let me see the patient," but, then, to facilitate the next step, whether it's an ancillary service or referral to a subspecialist, is next to impossible.

As far as access, the network is not adequate.

We're hearing stories of patients getting coverage, but not being able to see physicians, either because there's an inaccuracy in the listing in the provider network, or there are not -- or the physicians in their region that are in the exchange are full.

And, we're hearing some stories in communities, where physicians are not able to meet the demands of patients that now are insured, that want to be seen and accepted into the practice; yet, in the same community, there are physicians ready, willing, and able to see these patients, but cannot gain access to the provider network.

As far as continuity, again, as we've heard, stories of patients having to -- being assigned a PCP different from the PCP they've had for many years, despite that PCP being in the exchange.

In communication, the common theme that I've heard, that we've heard, in canvassing providers, is lack of communication of the carriers to the provider, letting them know if they're in the exchange; if they're not in the exchange.

For those that have gone on and accessed the site to see if they're in the exchange products, they're having difficulties dealing with the carriers in getting access into their provider network.

Two quick real stories that I came across in doing homework for today's hearings, that I think will summarize this.

First: Middle-aged man, small-business

owner, signs up for a product on the exchange. Presents to his primary-care provider, who he's had for over a decade, with abdominal pain in the first week of January.

He didn't have his card. He didn't have an ID number yet.

The staff -- the front-office staff could not figure out if he was enrolled, and, truly, in what plan, what his co-pays are, or anything like that, but the doc said, as he should, Just come on in, let me take care of him.

He's got belly pain, they suspect diverticulitis.

They had to shop around to four providers to find someone who would do a CAT scan, because they couldn't find out where he could get a CAT scan.

Finally, he wound up in the emergency department of our local community hospital to get that CAT scan.

The man was tolerating oral fluids and meds.

This was an ambulatory condition. No need to get to the ED.

Second case, of a woman in her early 60s, who had a kidney transplant about three years earlier, who had a primary-care provider who had cared for

her for over three decades, who sent her to a tertiary care in the city for her kidney.

They had been -- the transplant team there had been following her for three years.

Transplant teams follow these patients very closely for the remainder of their life, or at least the life of the transplant.

And, now, the provider -- her primary-care provider was in one exchange product. The transplant center is in the another.

No overlap.

So she's forced to choose, who she gonna go with?

I must say that these issues are not all universal, and I did hear some good stories, so, as we moved forward, including physicians having success in gaining access to plans.

But in conclusion:

We urge you to continue to monitor;

Stress the need for an adequate and accurate network of providers;

Continue to stress the need for a provider helpline for each approved plan;

Ask for materials to educate physicians and offices, and the New York ACP stands ready to help

distribute those and spread the message;

For New York State to help lead the way in the 90-day grace period, that needs revision;

And, finally, thank you for allowing me to speak.

SENATOR HANNON: There's little to add.

You've been very comprehensive, and very illustrative, as to some of the problems that are out there, and, really, where the oversight from the Department of Financial Services is for the plan.

There's so much that we've heard before on what the exchange is doing, but none of what the exchange did is negated any of the responsibilities of the Department of Financial Services, and, there's a lot to be done.

The lack of information is incredible, and it's going to result in bad patient care.

SENATOR SEWARD: I have one quick question for you.

What is your experience in terms of the reimbursement levels for participation in a plan in the exchange, versus outside the exchange?

DR. ANDREW KLEINMAN: Well, for obvious legal reasons, we can't actually do a real survey, unfortunately, to find out how everybody is making;

however, we have had a number of physicians call to complain.

And, basically, we have not heard from a single physician, even when we asked, and we sent out surveys, just to see, "How happy are you with the reimbursement?"

Virtually every plan downstate -- upstate, the situation is a little bit different.

But, downstate, almost every plan in the exchange is paying at a lower rate, significantly lower, than other plans in the same -- from the same company.

And as I said, we have heard as low as 45 percent of Medicare, in some cases.

And, as those of you who have been doing this for a while know, the Medicare rate already is so inadequate, in terms of compatibility with staying in practice, that 45 percent of Medicare, basically, for most specialties, is lower than the cost of doing business, so you're actually losing money seeing those patients.

And I just want to answer what Dr. Hannon kind of hypothetically --Senator Hannon, excuse me, hypothetically asked about: What incentive would there to be in-network?

And I think that comes down to a lot of the crux of it.

If the in-network reimbursement was adequate, most people would want to be in-network.

And what has happened is, as networks pay less and less out-of-network, they can lower the reimbursement in-network.

So, essentially, we think it's somewhat coercive to try to keep people in-network.

So, basically, in terms of negotiating, the one thing you have when you're negotiating with an insurance company, is you can walk away.

If you can't see any patients at all if you walk away, then you can't negotiate at all.

DR. PATRICIA MCLAUGHLIN: I'd like to address one other issue.

I agree with the reimbursement.

It personally happened to me, so I was actually relieved that I was mistakenly put on the exchange in this one company, because I would have been put out of business with the reimbursement that they were going to give me.

But, if we look at the Australian system, as far as what you said about out-of-network, there is -- today, the insurance companies do not pay a

reasonable and customary fee.

They are using the Medicare Fee Schedule, and paying a percentage of it for whatever little plans are left that are paying out-of-network.

They are paying 110 percent of Medicare, to 140 percent.

So if a patient chooses, who's lucky enough to have one of those out-of-network plans, chooses to go to an out-of-network doctor, the patient knows that they are not going to get anywhere near the asking fee of that physician.

This actually is a good thing, in a sense, because it will foster a sense of competition between physicians.

So, if you are not in-network, and you are charging more than your colleague down the block, and most of the patients who are using out-of-network choose to go to that person, you will lose your practice, and you will lower your fees.

Competition fosters a lower health-care cost.

Please keep that in mind.

Covering everything from A to Z only increases health-care costs.

There are plenty of studies that state this.

The cost of drugs have become astronomical

ever since managed care has sought to cover the cost of pharmaceuticals.

You need to relook at a lot of this, but I will tell you that I am advocating for out-of-network benefits.

It is essential.

It will not hurt the insurance companies, especially since they have chosen to limit the amount their exposure to a high bill.

It will then be between a negotiation of the patient to the doctor, and that is a good thing.

Thank you.

SENATOR HANNON: Thank you very much.

SENATOR SEWARD: Thank you very much.

SENATOR HANNON: [Inaudible.]

SENATOR SEWARD: Before we call up the next panel, I'd just like to acknowledge that we have, Senator Felder has joined us.

Thank you, Senator.

Our next panel are brokers and agents:

Dan Colacino is vice president of Rose and Kiernan, Inc.;

Erin Nevins, who's president of Nevins Insurance Agency;

And, Jack Smith, who's executive VP of

William A. Smith and Son Insurance Agency.

DAN COLACINO: Good afternoon, Senator.

Senator, thank you again for inviting us, appreciate that.

SENATOR HANNON: You've got to all pull your mics closer.

DAN COLACINO: Real close. Okay.

SENATOR HANNON: Especially because, the rest of them in here, and the sound up here, it's horrible.

DAN COLACINO: Oh, okay. All right.

I'll yell as loud as I can, then.

I'd thank Dr. McLaughlin for giving the brokers a nice plug in her last testimony. We appreciate that.

My name's Dan Colacino. I work for Rose and Kiernan.

I've been there -- I've been working in the insurance industry now for a little over 40 years, so, I've seen everything, from ERISA being implemented, to the Affordable Care Act.

So all the upheavals in the industry, I've seen most of those.

I just want to touch on a few things that haven't been really discussed much today.

We talked about the improvement in rates, and I think the improvement in rates that we've seen has been in the individual market.

As Donna Frescatore had mentioned, the mandated programs in the individual market were horribly expensive.

Individual rates in the individual market were the same as family rates.

So, now, we've seen a significant decrease in those costs.

So for people who are uninsured, unemployed, or who work for an employer who simply doesn't provide insurance, they now have affordable insurance which they didn't even have before.

We'd like to compliment Donna and her staff. They've been very good in reaching out to us, and working with us, as our trade association, helping us to understand and get through some of the roadblocks that existed in the initial part of the rollout.

Yes, there have been some bumps in there, but I think, right now, in general, based on what they've had to deal with, the changing regulations, and so forth, I think, all in all, things have run out pretty well.

And I can say that as a sole proprietor myself.

I work for Rose and Kiernan, but I work part-time these days, so, I'm a sole proprietor, so I don't qualify for benefits. So I had to go through the exchange to buy my own insurance, which I did.

The experience was fine.

I went through the marketplace in, probably, November of this year, and things went fairly well.

I ended up buying off-exchange, which I think is something that we've missed.

The off-exchange market, where the carriers offer the exchange-type programs, not through the exchange, but directly as another resource for people to go to, whether they're individuals or small employers.

I ended up buying off-exchange because the requirements off-exchange for some of those products were a little more flexible.

Although they all had to meet the same metal-level tiers, of the Bronze, Platinum, Gold, and Silver, and so forth, they had a little more flexibility in some of the designs.

So I found a better product off-exchange than

on exchange, actually.

Let me talk a little bit about sole proprietors, because that question had come up earlier.

The sole proprietors lost a lot.

As a sole proprietor, I bought my insurance through the Albany Chamber of Commerce.

Sole proprietors, according to New York law, were allowed to get the group rates, with an increase factor of 15 to 10 percent, which was affordable.

Now, beginning in -- January 1st of this year, of course, "sole proprietors" are now defined by the Affordable Care Act as being in the individual market, because the "group market" is now defined as "2 to 50," and soon to be "2 to 100" in 2016.

I think that was the biggest impact.

There's no evidence that ever showed that sole proprietors are a higher risk than any employer of two or three, so I think sole proprietors have a legitimate place in the group market.

Although, the Affordable Care Act does make mention of the group market size, and I think that's what we went by, trying to follow the

Affordable Care Act guidelines, I think there's ample opportunity for the State to look at legislation that would make -- roll our marketplace back and allow the sole proprietors to enjoy group benefits as well.

We did that before; we allowed sole proprietors to enter the group market a number of years ago, and legislation was written that way, and it also allowed a little bit of a markup for the carriers to do so.

I don't see any reason why we can't do that again.

The states are the place where experimentation are supposed to happen in the insurance marketplaces.

And New York already had a viable market.

I think the Affordable Care Act itself is one that had the biggest impact on us, and it wasn't necessarily a positive impact because of some of the requirements.

And I think somebody mentioned earlier, you were able to buy an insurance product without prescription drugs.

You can't do that now in the individual or small-business market, and you have to meet

essential health benefits or else you pay the individual penalty.

I think there's some opportunity here for us to at least negate some of the impact on the sole-proprietor market, and allow them to buy insurance through the group market as well.

And I think with legislation we can do that one.

I don't think we'd lose any cost -- any revenue-sharing from the federal government. I don't think we'd lose any grants by doing so.

I think it's something we need to seriously look at during this session.

I also want to talk about, we haven't talked it be much at all, the small-business tax credit, because that did come up.

That's something that I think, the anticipated amount of money to be spent on the small-business tax credit was probably in excess of 3 or 4 billion dollars.

I doubt that we've even hit $1 1/2 billion in small-business tax credits nationally.

I think that's because the people don't understand how the small-business tax credit works, even though the IRS has on their website, something

that says "Three simple steps."

There aren't three simple steps to determining whether you have a small-business tax credit. It takes more than that.

It's not that complex that it can't be understood, but I think the communication of it and the understanding of it is something that's been lacking.

Part of my days off, if you will, have been spent instructing employer -- brokers on being able to be certified to sell in the small-business and the individual exchange.

So that's -- I've spent a lot of time talking to brokers about how they can use the small-business tax credit, help them understand it better, to help their clients.

We haven't seen a lot of activity in the shop market.

I'll be honest, I've taught over 400 brokers in the shop and the individual marketplace in certification classes.

I don't think I've talked to anyone who's put anybody through the shop at this point.

Individual exchange, certainly, that works.

I think a lot of them are defaulting to

the -- selling the business directly with the carrier as opposed to going through the shop.

The shop offers some advantages.

The small-business tax credit that Donna mentioned earlier certainly is one of them.

And I think the opportunity to offer multiple carriers and multiple plans is something for employers that's offered through the shop, that you won't get if you sell directly with a carrier.

But I think most of us, right now, are concerned about the complexity of trying to sell through the shop. I don't think it's well understood.

Donna and her staff have agreed to work with us, to run some seminars through the next part of 2014, so we can get our people more comfortable with selling through the shop and using that as well.

Finally, I think you did ask in some of your testimony, about whether the State made the right choice when they adopted not to allow carriers to maintain the same plans that were canceled.

And I think they absolutely did.

And I think the timing of that -- the legality of it being questionable on a federal level, in the first place, but the timing of it was

such, that there was no time for any carrier to get any communication, any rate filings on plans that had, thus, been discontinued.

So I think we absolutely did make the right decision, in deciding not to extended those plans that had been canceled, going into 2014.

We had enough of a road -- we had enough road bumps in 2014 -- January 1st of 2014 without that.

I think that would have added to the confusion.

I think we made the right move by not doing so.

With that, thank you very much for your time.

ERIC P. NEVINS: Hi, my name is Erin Nevins.

I am the owner, founder, and president of my own insurance agency here in Albany, from EP Nevins Insurance Agency.

I'm also the president-elect of the National Association of Health Underwriters local chapter for my industry, as well as a member of the board for the state legislative board for that organization.

Dan actually taught me through that process, and I am certified to sell in the New York State exchange, as well as with small businesses and

individuals and sole proprietors.

What I would like to say is, I thank you very much for the opportunity to be here and speak to you candidly about what is going on.

I think that brokers have a unique perspective that really encompasses almost everything that you heard here today.

Brokers assist members in purchasing insurance.

They work with the providers to ensure that the providers are participating for these members.

And, we help people with their carriers when there's issues that arise from their insurance carriers.

So, the one group of people that actually physically touch almost every piece of health insurance are brokers and agents.

I represent a vast number of individuals, sole proprietors, chambers of commerce that are county wide, as well as small businesses, and that is my specialty with employee benefits. The health insurance is a large portion of that.

I daily speak to sole proprietors and small businesses that are very concerned and very upset about the loss of their previous coverage, from a

few points:

Cost: Not just monthly premium costs, but out-of-pocket costs as well;

And then, also, their access to networks.

I just want to go back to, Senator Martins, you had mentioned something in one of your exchanges with a panelist, about the decrease of insurance costs and the increase in the individual market.

And I want to make a distinction, that, routinely, before 2014, individuals that had no affiliation through a business or a sole proprietorship to -- into the group market, the pricing for individual insurance in our state was extremely high.

The average cost about $900 a month for an individual in the upstate market.

Downstate, of course, is more.

What has happened is, we have adopted the ERISA language that dictates that sole proprietors, and small businesses that are husband/wife joint ventures, have now been forced to now be in the individual marketplace, so, you have increased their pricing to decrease the individual marketplace.

There's a true distinction about what makes up that individual market previous, and going

forward.

And I wanted to make that point to you, because it is a true distinction.

We have -- my agency has spent a long period of time educating employers and sole proprietors about high-deductible health plans, consumer-driven health plans, how to use their insurance to the best of their ability in an economical way, while also putting funding arrangements alongside of it to be able to afford their out of-of-pocket costs.

Those plans in 2013 that we were selling had a 675,000-provider-strong in-network network; now, totally inaccessible to all of these people that were routinely enjoying that network.

I'm not even talking about the out-of-network capability. I'm talking about the in-network.

So, that was a real big hit to that market segment, and, it's hurt every day, because they call our office and they're very upset about it, when they're trying to select new plans that only incorporate, maybe, 23 county service areas with very limited providers, as well as limited prescription drugs at this point.

The cost of those plans that we have been selling and educating and pouring all of our energy

and time into routinely cost about $150 a month in the small-group market/sole proprietor cost.

They have risen to a 50 -- or, a 100 percent increase, to $300, which doesn't sound like much, but you have also increased their out-of-pocket liabilities on the deductibles and out-of-pocket maximums.

So, it's not just the premium that has increased for these people that were going along satisfactorily for the last two or three years, that have really been adjusting their incomes to pay for their out-of-pockets in a different way.

Now they're being hit by the premium as well as increased out-of-pockets.

So, network accessibility and costs associated with the premiums, as well as the out-of-pockets, has been a big, huge impact to these people.

I have a husband-and-wife doctor practice in Dutchess County, engaged in a legitimate business, that are now considered to be in the individual marketplace, and are totally upset and insulted that they cannot have a national network that they previously had had or out-of-network capability.

And, the language in ERISA goes back to

stating that, "husband and wife."

And I don't understand why that has happened, but, just because you're married doesn't mean you're not actively participating in a business.

So, that has been a big, huge problem for that region, as well as broker compensation.

You know, we touch so many people.

We educate people. We help them with claims resolutions. We help them pick a plan. We help them understand the plan.

We do so many things for so many people, and we are compensated by insurance companies, not by the individuals or the constituents that we represent.

But, as this whole thing has unfolded for 2014, routinely, we are no longer compensated on certain products, we are no longer compensated on market segments, of which we were previously compensated.

So all of these sole proprietors and husband-wife joint ventures, if they move to an insurance company that does not compensate for individual plans, we lose compensation, but they're still our clients.

So we're trying to run our businesses and

continue to be a resource.

We have always been a resource for these people, especially now when things are so complicated and confusing, and they really are relying on us to assist them. And now we have to say, Well, I can't help you with this, but I can help you with this.

Of course, we're not going to say that, because we would never practice that way, but, you know, over time, we will have to adjust our business plans to not broker for certain market segments, and that leaves a gaping hole for those people.

Navigators are great, and they're doing what they were asked to do, which is to enroll people.

But, brokers and agents are more than just enrollers. We are consultants to these people.

SENATOR HANNON: We have to hear from Mr. Smith.

ERIC P. NEVINS: Oh, I'm sorry.

Well, I thank you.

SENATOR HANNON: You were great.

I've been trying to cut in, but you didn't even take a breath.

ERIC P. NEVINS: Sorry.

[Laughter.]

ERIC P. NEVINS: Well, I appreciate the opportunity.

SENATOR HANNON: I had asked before that people not read.

I didn't realize you were so passionate that you'd speak longer.

ERIC P. NEVINS: Sorry.

SENATOR HANNON: No, everything you said was very [inaudible].

ERIC P. NEVINS: I put some information in your packets. Please feel free to reach out.

SENATOR HANNON: Thank you.

JACK SMITH: Thank you.

I'm Jack Smith. I'm executive vice president of William A. Smith and Son.

We're a third-generation insurance firm in the Mid-Hudson Valley. We've got offices in Newburgh, Montgomery, and Poughkeepsie.

We work with people on, not only their home and auto and business insurance, but also on their health insurance.

We've got about 1,000 health-insurance clients that are clients of ours with, say, their business insurance, but, also, we have a relationship with the Orange County Chamber of

Commerce. We're a joint-venture partner with them to provide health-insurance advice and sell product to their constituents.

So, what I'm going to talk about comes from that experience.

Much of what I would have normally have said has already been covered, so I'll try to keep it pretty short.

And, I'm also on the board of directors of the Independent Agents and Brokers Association of the State of New York, and speaking on behalf of our members as well.

A couple of things that I just want to reiterate, they've already been touched on, but, the loss of out-of-network coverage is tremendous in our area. A large number of our clients would normally go to New York City for various procedures.

Sloan-Kettering comes to mind, you know, frequently, when somebody finds out they have cancer.

And, you know, with the removal of the out-of-network coverages, they can't do it, you know, and that's when -- when we have to tell people that, when we're explaining to them what the differences are between exchange and non-exchange

products and networks, and so forth, and they find that out, that they feel like they've been let down.

You know, I would say, from the standpoint of our government, whether it be federal or state, I think your constituents feel let down that they lost this.

And it's important that, through the legislation that I know has been introduced, or is in the process of being introduced, that that be put back in, because it's extremely important for people, you know, not only for a situation like cancer, but, also, you know, look at somebody whose child is in college, and maybe is going to school in the University of Connecticut, or someplace like that.

If they don't have network coverage, they've now got to come back to New York State to seek treatment, because they can't see a doctor in Connecticut or Massachusetts or Maine or North Carolina, or wherever they might be going to school.

You know, that hasn't really been talked about at all, but that's, you know, important as well.

You know, also, if you look at business

owners who might spend part of the year, or a couple months of the year, in a different state, again, if their doctors -- if they don't have out-of-network coverage, they're now losing the ability to seek treatment when they're somewhere else, though they are residents of New York and they pay taxes in New York, but they're -- you know, they're losing that ability.

The "sole proprietor" issue has been discussed.

Again, that's -- we've seen that time and time again with our chamber clients.

It's a huge dilemma and it really does need to be fixed.

I won't reiterate what's already been said.

You know, the price of insurance and net cost I think is something that often gets confused. And, while premiums, in some cases, may go down because of these higher deductibles and out-of-network costs, their total cost of health care has not gone down, and I think that's, you know, a big issue.

People are trying to reduce premiums by increasing deductibles and other out of -- you know costs, the cost-share mechanism, and so they're really not decreasing their cost of insurance and

health care when you take all of that into account.

I would say that the shop exchange, the small-business exchange, has not been a great success so far, and because of the reasons that have already been discussed.

Again, we're working with, you know, several hundred to a thousand employers, and I think we've placed one person in the shop exchange, one small business.

So, that really has not, you know, made an impact thus far, and I don't think that was the intent.

I think the intent is for that to make an impact, and for us to be able to place businesses there, so that it does create more coverage for employers.

And, you know, I would say, while the Health Department has done a great job with the exchange in the small amount of time that they had, and the website is phenomenal, there's still work that needs to be done on the back end, which is the transmission of data from the exchange to the carriers.

And that's, I think, some of the issues that we're having, relative to people not having their

ID cards, and, when we try to call a carrier on behalf of a client, and they can't answer our questions because they don't even know they're one of their insureds yet, you know, I think that's probably a technology issue, which I'm sure will be handled down the road, but, you know, that is an impediment at this point in time.

And, really, that's all I have to offer, because everything that I wanted to talk about has, really, already been talked about by so many people today.

SENATOR HANNON: That's the disadvantage of going third.

JACK SMITH: Yeah.

SENATOR SEWARD: Just two quick questions.

The low shop participation, shop-exchange participation, could you just summarize, you know, why that -- in your view, why that is occurring?

JACK SMITH: In our opinion, there's two reasons.

Number one, it's difficult to navigate in a logical way as a broker for a client.

And what I mean by that is, in so many lines of insurance now, there are things called "comparative rating," where we can put data in for

one client and see multiple carriers' information, and then we can talk them through what's what.

That doesn't exist.

I think that's a fairly easy fix, and I think that would help.

As was discussed already, the tax-credit benefits I think are probably confusing, and may not be, you know, fully understood. And, some people just aren't qualifying for them.

I know, in our case, you know, some of the people that we've tried to see if there was a way for them to utilize that, it just hasn't worked out where it's been better and they would want to buy one of those plans, because they would then be losing their out-of-network coverage.

So it's kind of that twofold purpose.

And the out-of-network coverage is also a huge consideration about buying a plan in the shop exchange, because if it doesn't exist, they don't want to, you know, lose what they had.

SENATOR SEWARD: Yeah, it's just -- the product doesn't stack up very well, as compared, yeah.

Just one final question, in terms of the -- your experience with these -- with the navigators,

have you had any experience there?

You know, they -- they do the three-day training, and, without a background check, without any educational background requirements, but they do have the three-day training and they do pass an exam.

What has been your experience, if any, with these navigators -- with navigators?

Who I think have an important role to play, in terms of outreach, but when it comes right down to it, in terms of really advising someone, you know, I think the agents and brokers are in a much better position to do that.

But, can you -- have you had any experience that you can share with us, briefly, in terms of:

Have they overstepped their bounds in any way?

Or, do you think it's a -- have you had any referrals from the navigators?

JACK SMITH: I know, in our situation, we've had no experience with navigators.

ERIC P. NEVINS: I personally have.

I do broker a large countywide chamber of commerce, and at the onset of this, my chamber president was approached by another group that had

solicited to be the navigator for that region. Had not won the reward yet, but was already meeting with our chamber of commerce, my client.

And, once they did actually receive their award, so, we know who they are.

We've -- we've given many different conferences and forums for all of the chamber members.

They've attended every one of them and taken lots of notes.

And at the onset, I think a lot of brokers were upset. They thought that navigators would be overstepping and taking business from them.

And, actually, it's turned out to be quite the opposite, where we've had some of our clients mosey on over and take a peek at them, and then we're told, "Uh, I think you need a broker," and then referred right back to us.

So, I don't know that they are trained well enough.

I know they know the process on how to enroll somebody, but I don't know that they're trained well enough to understand, and how to explain differences in carrier networks, prescription-drug formularies, and I could go on and on.

I don't think that -- I think that they are just there to specifically get people enrolled.

As far as educating them, I don't think that's part of their task, and I -- so that's ours.

DAN COLACINO: Yeah, my experience has been mostly with hospital-based navigators. I think they were formerly Medicaid-facilitated enrollers, and they moved over, so they were kind of familiar with how the Medicaid program worked, and so forth.

So, we've actually, when we had to refer individuals to a navigator, we would send them to the hospital-based navigators.

And I think they had that -- they had a head start on everybody else because, again, they were Medicaid facilitators and enrollers, and they understood the process to start with. And we're more comfortable than sending them to community-based people right now.

SENATOR SEWARD: Thank you.

Thank you very much for appearing.

SENATOR HANNON: Thanks.

ERIC P. NEVINS: Thank you.

SENATOR SEWARD: Our next panel are small-group insurers:

Bob Carey, who's an account executive of

Otsego County Chamber of Commerce;

Leslie [sic] Clarke, deputy director of Freelancers Union Insurance;

Mark Eagan, president and CEO of the Albany-Colonie Regional Chamber of Commerce;

And, Maurice Isaac, who's employee benefits program administrator of the Delaware County Chamber of Commerce.

And we're going ask Mr. Eagan to lead off this panel.

MARK EAGAN: Good afternoon.

I'm Mark Eagan, president and CEO of the Albany-Colonie Regional Chamber.

We have a membership of 2200 businesses that come from throughout the Capital Region, and they employ about 110,000 area residents.

Appreciate the opportunity, and I commend you for hosting the hearing today, and I appreciate the opportunity to share a little bit of the feedback we received, particularly from the small-business community, within the limitation of the Affordable Care Act in New York.

I guess I'd start by making just a couple of comments about the exchange itself, for businesses who look to use the exchange.

And I would say that, that the first piece of feedback, for those who wanted to, quote/unquote, shop the exchange, we received quite a bit of feedback that they thought it was difficult to window-shop, because they had to go in and set up an account. And I think a lot of them had concern, if they set up an account, were they going to almost be sort of trapped within the portal.

So I think, just as some suggestions on how it can be improved, going forward, if it was easier to see what's available without having to set up an account and go through that formality.

Within our membership, we have a lot of businesses who gather -- gain health insurance through our organization, so, some of my comments will be respective to those folks, and others will be businesses who just gather health insurance from a lot of different places, and feedback that we've received.

First, from the sole proprietors, those who, you know, are independently employed, who get coverage through us:

Many of them were really shocked and angered when they learned that they were no longer considered a business in buying health insurance

when they went to purchase insurance, with the Affordable Care Act.

As you folks know, they are now classified as an individual.

And many of them, you know, called our office and complained, and said, you know: We believe the only reason we were asked to now buy as an individual, is we're helping to subsidize insurance for other individuals. We worked hard to create a business, and we'd like to be able to continue to purchase as a business.

Obviously, when they went to buy it on the individual exchange, most of them experienced significant increases in their premiums.

The other piece that we heard from our sole proprietors, was things that they would discovered as they went through the process, and one of them that we got several calls about was, no out-of-network coverage.

So, whether they're out of state, whether they have their children away at college, they weren't sure how that worked.

And these are, either, they did it through the exchange or they continued to get insurance through our organization.

Also, as you know, we have some new insurance carriers that are offering coverage in New York.

And we're getting some feedback from the -- where a business says they've checked to see, was their current provider going to offer that insurance.

It appeared so, yes, when they went to a website and looked, but then when they actually called it -- the office, they said they don't accept that coverage.

So I don't know if that's still just part of rollout, but that's a frustration that we're hearing from our sole props.

From the small-business community, those who are from 2 to 50 employees, really what we discovered, if they were getting insurance through us now, we mapped them with our carriers to the product that was closest to what they currently had.

As you know, none of the products remained, you know, 100 percent as is.

And we realized that almost all of those businesses, wherever they were suggested, wherever they were mapped to, navigated to, that was the coverage they continued to keep.

So it -- from what we can tell, most of those

businesses didn't even explore looking at the -- the exchange, going to the website or the marketplace.

I don't know if it's because it's the first year and they're not sure what the impact would be for them or what the benefit would be for them or their employees, but it appears most, if they were able to maintain the status quo, that was the route that they elected to do.

So with that, those are my comments, Senator.

Thank you.

SENATOR HANNON: Thank you.

Who would like to go next?

MAURICE ISAAC: Yes, I'll go next, Senator.

I'm Maurice Isaac, with Mang Insurance Agency, and I'm the benefits administrator for the Delaware County Chamber.

And I kind of just wanted to go through my experience, you know, since the exchange opened.

I completed the CE course the Saturday, on September 29th, so I could be one of the first agents eligible for the exchange.

I still did not receive my invitation till October 4th, four days after the exchange opened, even though I qualified and passed all the exams.

In trying to set up my broker's account, it

took five complete days of trial and error with the exchange before I could get that satisfied.

And I got -- finally on the 9th, I got a "Congratulations, your brokerage account is open," with various technical problems.

With the chamber, I've got -- I think, through the two chambers, I have approximately 90 self-employed sole proprietors, that all of their are plans were canceled, so I had to set up meetings throughout the next three months with them.

With them at the help desk, sometimes we waited 45 minutes to reach someone, while the client was sitting with me, because it said -- you know, when you needed help.

There was times where we waited 20 minutes, and the person who answered stated they couldn't help us, we needed to be transferred. And, again, we waited another 20 minutes, with the client sitting there with us.

The help desk has stated at times, that, you know, We would get back to you within 48 hours.

We never heard from them.

When I called back, the help desk says, "Well, do you have a ticket number?"

And I says, "No, I didn't receive a ticket

number. Am I supposed to?"

And they said, "Yes."

So the next time I had an issue, I tried to insist that I get a ticket number, so if I needed to follow up and call back, I had it.

At that time, I was told that we don't -- "We don't issue ticket numbers," in direct compliance to, you know, what I was told the last time.

There was many times where we had programming errors, and the help desk just stated: Look, everyone's having this here, they're having problems. You're gonna have to try again tomorrow. Tell your client, you know, they're gonna have to reschedule an appointment with you.

And these -- some of the clients in Delaware County, it's a huge county, they drove 30, 35 minutes, just to get to me. In inclement weather, you know, and they would have to turn around and drive 30 minutes home, and then back and forth again.

The biggest help-desk issue we had was, on 12/10, it was -- after we put all the information in, it was stated that it could not make a determination.

On the 13th, they finally made a determination that there would be no subsidy.

On 12/16, when we went -- when the client wanted to pursue and get a policy anyways, when we went to confirm and check out, we received an error.

The help desk said, "Keep trying again tomorrow. We're gonna work on it."

Three days later I sent a picture of the problem into the technical support, and, you know, that was on 12/19.

That afternoon, I actually got an e-mail from a regional director of the Department of Health, stating that problem -- that issue was corrected, and that they assigned someone to follow up with me by phone.

She gave me instructions -- they gave me instructions on how to enroll the client further.

I tried that and it did not work.

Eventually, the person called every day, that they assigned to help me, and we could not -- we could not get the coverage put through.

On 12/21, with only two days left to get this client enrolled for January 1st, I resent the error message to technical support and that regional director, stating that we have still been unable to

enroll this client.

And I immediately, from the regional director, received an out-of-office message that says, "I'm going to be out of the office until January 1, 2014. I have a person who is here to help you. Here's their e-mail address, please contact them."

I forwarded the e-mail to that person, and I've never heard from either one of them.

On the 27th I received a phone call from -- the person that was helping me on the phone stated: The problem has finally been corrected, and we did install their plan, but it's not gonna be effective until February 1st.

That was after -- on 12/23, the last day, I enrolled that client directly with a Blue Cross and Blue Shield plan, that they've paid for, and had to, you know, come into the office that day, to make sure they had coverage for January 1st.

Applications that -- on individuals, to date, I put in 58 applications for the exchange, and I've enrolled 49.

Out of the 49, I believe about 10 percent of them were enrolled into Medicaid that qualified for it.

For applications for the shop exchange, I have two, and enrolled -- enrolled one client in the shop exchange.

One client that I had was an individual family that has one child in college, that's 20 years old. They have two children under the age of 19 that are still in high school.

Their eligibility determined that they'd have a $414 a month subsidy on the Silver plan for the complete family.

The premium was $1,370. Their net premium, after the 414, is 955.

And, also, even though they already qualified for a family plan, the exchange notified us that the children under 19 were eligible for Family Health Plus, and were forced to go into Family Force Plus, and they were charged an additional $60 on top of an already-family plan that they're paying.

And we were told that there's no way to circumvent that. Once that they qualified for Child Health Plus, they had to pay the additional funds.

The clients eventually did enroll in that plan to get their subsidy, but are paying $60 extra

even though they're already paying for a family plan.

My clients are mostly small groups, sole proprietors, partnerships, LLCs, and corporations.

One client is an attorney with a newly opened firm less than two years old, and that's a corporation.

This year, she promoted that second attorney to a partner, and now they're equal shareholders. Both are drawing a salary, and, they file a New York 45 quarterly; however, they're now classified as individuals because they're both the owners of the corporation, and now they're required to pay $39 a month more, each, for the same exact plan that's available for small businesses.

This attorney decided and elected not to take the plan, based on that, and has taken the penalty.

With having all small groups, every plan [unintelligible] everyone that I had was canceled, and those clients had to choose a new plan: either move through to the exchange, move to the direct market, or go -- or directly through the carrier.

The President did announce that you were able to keep your existing plan for one more year, our

phone started ringing off the walls.

Clients that we already had moved into new plans and already sent checks in, called up, wanting to move their plans back to their old plans.

And we had to explain to them it wasn't available.

Chamber members, as a whole, were very split on -- some were happy to have our help, and will continue to be members.

Some members stated right out, that they don't need the chamber anymore, and this is the last time we're gonna pay our -- that was -- last year was the last time they're paying their dues and they're not gonna renew their membership.

In summary:

Some clients were very happy. They chose a plan that was better than the one that they had, for the same or less money.

Some clients were determined to be eligible for Medicaid, and were very unhappy and very upset, stating that, you know, "We don't want to be in welfare." And they actually purchased a direct plan outside the exchange and are paying full price.

Some sole proprietors are paying 50 percent more to 100 percent more in premium for less

coverage than they had in their old higher -- high-deductible plans.

SENATOR SEWARD: Thank you.

MAURICE ISAAC: Thank you for this opportunity to share that with you.

SENATOR SEWARD: Thank you very much.

Mr. Carey.

BOB CAREY: Hello, I'm Bob Carey. I'm with the Mang NBT Insurance Agency as well, and, I'm an account executive. And, I am the benefit administrator for the Otsego County Chamber.

I do want to mention that our agency handles five different chambers as benefit administrators.

Maurice is one of them.

And I was asked to come here on behalf of the Otsego County Chamber, to talk about the difficulties and problems, as well as their feelings towards the -- what's been happening within this last year.

The chambers, as a whole, have spent many, many years, in concert with the Legislature here in New York, to create the "sole proprietor" product line, and the "sole proprietor" product line came about because of the input of the chambers, with the State legislators and the Insurance commissioner,

and they created what's called the "Chamber Trust Product." And that Chamber Trust Product did have small-group products, 2 to 50, and it typically had the "sole proprietor" product that was mentioned, that is 10 to 15 percent more.

With the Affordable Care Act, and no reason that -- or, New York didn't do anything to create this, but the Affordable Care Act created the situation where the individual sole proprietor is being moved to the individual market.

What we had discovered when that happened is, within our chambers, anywhere between 25 and 90 percent of chamber revenue on that product line will be lost because of these chamber members moving to the individual market.

So from a chamber's perspective, that was a revenue stream that helped chambers do their good work of promoting small businesses in the community, and the economic-development work that they do, and all the other things.

So, from the chamber's perspective, this law has been a real shot in the arm as far as revenue.

On the small-group side, the executive director of the exchange had mentioned she wasn't sure how many plans were canceled.

I just want to mention that, in our marketplace, 100 percent of all small-group plans were canceled for January 1st, because they did not comply with the essential health benefits.

So, every one of our clients received a letter that their plan was being canceled.

That means every single participant received a letter that their plan was gonna be canceled, and that they would be mapped to a plan that was compliant with the Affordable Care Act.

When the State Legislature -- or, when the Insurance Department and the exchange created the Platinum, Silver, Bronze, and Gold plans, they created standard plans.

And if you study those plans, most small businesses in this state had plans that had deductibles and coinsurance, but they also had co-pays for many items. And those deductibles and coinsurance would only apply to certain circumstances, like hospitalization, or outpatient surgery, and all your other services were co-pay-based.

When the new plans in our marketplace came out, the plans that they were going to be automatically mapped to, and that employer might

have had a $1,000 deductible on their plan; that $1,000 deductible only if you were hospitalized.

That $1,000 deductible in the mapped plan is now in front of all the co-pays, and there are only a handful of plans by one carrier in our marketplace that has co-pays in front of the deductible.

So, it created a tremendous amount of stress in the broker community to reach out to all their clients, to explain that they were being mapped to a plan, and, yes, the premium is less, but all your participants are gonna be subject to this deductible in front of their doctor co-pay.

So, from our perspective, it created a tremendous amount of stress on our staff, on our brokers themselves, and, on our clients, because they didn't understand the products, they didn't understand how they worked, they didn't understand the mandates that they had to have, that they didn't necessarily need.

So from our perspective, although, as mentioned before, the 12,000 people in the direct-pay market received a substantial discount on their premium, but many of the other people are gonna have higher costs, maybe a lower premium, but a lot more out-of-pocket in the plan itself in

cost-shares.

Additionally, I think agencies and chambers, going forward, are going to be reassessing their model as to their staffing, because if we're gonna lose 25 to 90 percent of our revenue stream, we're going to have to work on our staffing as well.

And, so, this has created an additional stress on the industry, to staff properly in a environment where there's more inquiries coming into the agency.

I have some other notes, but I won't touch upon those because they've already been discussed.

Thank you.

SENATOR HANNON: Thank you, Mr. Carey.

And, finally, Ms. Clarke.

LACEY CLARKE: Hi. Thanks for inviting Freelancers Union to testify today.

I'm Lacey Clarke, director of policy for Freelancers Union.

Freelancers Union has been providing health insurance to New Yorkers since about 2001.

For the first several years that we existed, we offered health benefits to independent workers through a portable benefits fund. And then, eventually, we decided to start our own

health-insurance company, rather than simply connecting our members to others' plans.

Freelancers Insurance Company (FIC) was created in 2009 as a demonstration project, with bipartisan support from the New York State Legislature.

It's the first several-purpose health-insurance company to offer independent workers affordable, stable, and portable health insurance, and is wholly owned by Freelancers Union.

FIC aims to provide insurance to the 30 percent of the workforce -- freelancers, consultants, temps, contractors, and the self-employed -- who are excluded from traditional work-based supports.

FIC covers about 25,000 New Yorkers through 5 health plans designed and tailored specifically for freelancers.

In 2012, we launched Freelancers Medical, an innovative patient-centered primary-care program that offers free primary care with zero-dollar co-pays for all visits, free yoga, acupuncture, medication, and other wellness classes.

Enrollment has already surpassed expectations, with more than 3500 members signed up

after only 12 months, and we're excited to open our second location in downtown Manhattan next month.

And despite this new offering, members have seen zero premium increases for two consecutive years.

FIC was created in 2009 before the Affordable Care Act was enacted and greatly changed the health-care marketplace.

In 2012, this Legislature recognized the potential upheaval that the ACA could cause in the individual health-care market, and wisely extended the sunset date for the demonstration project for one year, until the end of 2014, to ensure that FIC members would have a smooth transition during the first year of the health exchanges.

At the end of 2012 and in early 2013, the federal government promulgated numerous rules and regulations in preparation for the ACA's implementation in 2014.

As we followed the events, it became clear that several our very popular health plans would need to be altered at a great expense.

Additionally, more than 70 percent of our members, most of whom are middle-income earners, would not qualify for subsidies on the exchange and

would see significant increases in their monthly premiums.

However, thanks to the forward-thinking of Chairmen Hannon and Seward, this Legislature reaffirmed FIC's ability to continue to offer and to afford both comprehensive plans for these independent workers through the end of 2014.

We are very pleased to report that FIC members have not experienced any disruption in coverage, and 97 percent of members renewed their existing coverage in December for another year.

In addition to FIC, Freelancers Union also owns a health-care technology company that provides back-end services to insurance companies in several states, including New York; New Jersey, whose exchange is run by the federal government; and, Oregon, who runs their own exchange.

Our experience working with both the federal and another state exchange has only highlighted the exemplary work that New York State has done in their exchange and in managing the implementation process.

The New York -- an insurance company we provide consulting services for had very few delays in enrollment. New Yorkers were able to easily enroll on their on exchange -- on exchange plans

from day one, and exchange staff has been well-informed and accessible throughout the process.

While Freelancers Insurance Company does not currently offer health coverage on the New York State exchange, Freelancers Union is committed to ensuring that our members transition smoothly onto the exchange for 2015.

Our focus in the upcoming months will be to educate our members about the exchange offerings and the system in choosing a plan that will best meet their health needs.

We look forward to continuing to work with Donna Frescatore and DFS as we guide members through the enrollment process for 2015.

Thanks.

SENATOR SEWARD: Well, you've had a very complete testimony. All my questions have been answered, except, one for a -- a quick one for Ms. Clarke.

You're absolutely right, you know, through legislation, you know, the Freelance Union was given another year -- the demonstration project was given another year.

Have -- will anything change at the end of 2014, versus the end of 2013?

LACEY CLARKE: Well, it --

SENATOR SEWARD: Other than the fact, you know, in terms of the impact on your -- your members and subscribers?

LACEY CLARKE: Well, we -- our members are currently enrolled in our -- in FIC through the end of 2014.

The demonstration project only lasts through the end of 2014, so, right now, we're -- that's -- we're really involved in trying to figure out what will happen in 2015, and we're really committed to making sure that we get our members onto the exchange.

But it will definitely be a different marketplace for our members in 2015.

SENATOR HANNON: Just a lot of work ahead.

LACEY CLARKE: Exactly.

SENATOR HANNON: Well, thank you very much.

SENATOR SEWARD: Thank you.

SENATOR HANNON: We appreciate it.

SENATOR SEWARD: The next panel is our insurers:

Sean Doolan, Blue Cross/Blue Shield;

Paul Macielak, Health Plan Association.

SENATOR HANNON: Good afternoon.

PAUL MACIELAK, ESQ.: Good afternoon.

SEAN DOOLAN, ESQ.: Good afternoon, yes.

SENATOR HANNON: Who would like to go first?

SEAN DOOLAN, ESQ.: Go ahead.

PAUL MACIELAK, ESQ.: All right.

I guess, after having sat here this morning and listening to a lot of the comments, I mean, from, I think, our perspective on the plan perspective, everybody operated under tight timelines, and continue to operate under tight timelines.

You know, plans have had a deal with major and substantial policy-form changes, rate applications, technical architecture to plug into the exchange. And there have been bumps in the road, and we've heard about some of them.

There's a whole other list of other bumps in the road that we've already had to deal with as we've proceeded.

One such bump has been the federal policies that have changed at the last minute, that have bound the state exchange, which has bound plans, in terms of they're dealing with enrollments.

Extended times for enrollments, extended time periods for payment of premiums, all of those

factors play into the ability of the plan to process the applications, to get out the cards, the premium invoices, et cetera.

Today, as we sit here, we meet with the State, at the CEO level on policy once a month, we meet on legal issues once a week, operations once a week, and the technical-related issues twice a week.

That's an ongoing relationship that's been going on.

In terms of, from our perspective, HPA, we've always said, at the exchange, there were going to be winners and losers.

And you heard a lot about that today, in terms of, you know, how it's rolled out in the marketplace.

Clearly, the Healthy NY population and sole proprietors have taken hits, in terms of, what they had, to what they have today as it's rolled out.

The direct-pay market has had benefits in terms of what their premiums were, to what they are now in the exchange.

Affordability is and continues to be, you know, the theme that we seem to strive for, we know that's what the exchange staff is also looking for,

and we believe that's what the public is looking for, in terms of health insurance.

Whether it's transparency; whether it's trying to address surprise balanced billing, or billing from providers Senator Golden referred to; whether it's dealing with some of the ACA taxes or HCRA taxes that we're all paying; I mean, I think affordability is a key factor.

Now, that has to be juxtaposed, I think, with the tension that exists about access and choice, and we heard a lot today about out-of-network benefits.

So I'm fond of saying there's no free lunch, and that I think is an example of something that you have to confront.

Well, chambers, sole proprietors, Healthy NY people, are concerned about affordability and want the policies to be more affordable.

You have, on the other hand, other people who want out-of-network access and choice, which are going to add costs to the policy.

And that's something I think you need to reconcile.

I think I'll turn it over to Sean to make some more points.

SENATOR HANNON: I would simply point out, the sole proprietors --

(Turns on microphone.)

SENATOR HANNON: I would point out, the sole proprietors are not saying that they got increased, but, somehow, the system was able to take care of them before; and now they're being declared individuals instead of being able to a group of two.

How is it that it -- by making them individuals, the insurance companies are saving and the individuals are paying more?

SEAN DOOLAN, ESQ.: What do they mean, the companies are saving?

PAUL MACIELAK, ESQ.: Did you say the companies are saving?

SENATOR HANNON: Well, you're the ones who just said it costs somebody if you make these changes.

Well, you're -- if the individuals are paying more, then, obviously, the insurance companies are collecting more, so, they're benefiting.

PAUL MACIELAK, ESQ.: Well, I don't necessarily see that as a benefit.

SENATOR HANNON: I would think --

PAUL MACIELAK, ESQ.: If we have to pay --

SENATOR HANNON: I was just --

PAUL MACIELAK, ESQ.: -- additional taxes --

SENATOR HANNON: I was just stating the proposition that you had outlined.

PAUL MACIELAK, ESQ.: Well, if we have to pay additional taxes, like the ACA taxes, that's not something that's benefiting the insurance companies, but that is being imposed on those sole proprietors.

Some of the additional benefits that are mandated by the essential benefit package, that sole proprietors don't like, those aren't benefiting plans either. They are just additional benefits that are made available to the population.

SENATOR HANNON: Then you'd have no problem going back to allowing these husband and wives to be declared a group instead of being two individuals?

SEAN DOOLAN, ESQ.: Yea, unfortunately, that's driven by federal law.

PAUL MACIELAK, ESQ.: It's federal policy, yeah.

SENATOR HANNON: I understand that.

SEAN DOOLAN, ESQ.: No, as a matter of fact, the "sole prop" issue is probably the most perplexing, because they were hit with two things:

Number one, they were moved from the group

market, or a peg off the group market, to the individual market. That was driven exclusively by federal rules.

The second issue is, their product selection, many sole props were in high-deductible plans.

SENATOR HANNON: Excuse me?

SEAN DOOLAN, ESQ.: Many sole proprietors were in high-deductible plans.

By moving them into the individual market; and, in turn, as a result of the changes to -- that were coming down from the federal government, those high-deductible products became more expensive.

So, how to address it?

You know, quite frankly, other than getting at the underlying cost-drivers to coverage overall, unless you had some movement from the federal government to allow them to shift back to the group market, you know, there's nothing, you know, at least on the surface, that can be done.

SENATOR HANNON: What about the fact that, last year, we allowed for the continuation of the professional employee organizations?

How do those members of those differ so much from the two-member groups, in concept?

SEAN DOOLAN, ESQ.: To a great -- the concept

is the same, but the PPOs, and this is actually something I think that they're still waiting for federal guidance on, the change to the "association" law required, if you're a small group or an individual and you go into an association business, you're rated -- you're going to continue to be rated as a small group or as an individual.

The benefit of PPOs is that they could rate them as a large group, even though there was no connection between the individual and the small group.

Whether the federal law -- and that -- again, that change in state law to applicable associations was driven from the federal government.

To the extent -- and I think this is, you know, clarification that's still needed from the federal government, to the extent that that same rule applies to PPOs, then, they're going to run into the exact same problem.

SENATOR HANNON: You wanted to start.

SEAN DOOLAN, ESQ.: Thank you.

I will just touch on a few global issues, in terms of how things have gone, and then, perhaps, we can jump into some of the individual questions.

To echo Paul, you know, this -- you could not

underestimate --

SENATOR HANNON: What I think we failed to do, this is being webcast, and we failed to have you do one essential thing: Identify yourselves for the people who are on the other end of the TV camera.

SEAN DOOLAN, ESQ.: He's Paul Macielak, CEO of the Health Plan Association, chairman of the board, and president.

I am Sean Doolan with Hinman Straub, representing the Blue Cross plans of New York.

SENATOR HANNON: Thank you. I'm sorry.

SEAN DOOLAN, ESQ.: No, thank you.

This has been a transformational period for the plans.

The focus today has really been on the individual and small-group market vis-a-vis the exchange.

In reality, virtually every policy, whether it be coverage policy or plan policy, whether it be actuarial, whether it be underwriting, or whether it be sales, have gone through dramatic changes and implemented in a short time period.

You know, as Paul had mentioned, there have been challenges, certainly, not the least of which has been a change in the paradigm of oversight.

Insurance has traditionally been a state-regulated business, with the exception of ERISA or self-funded plans.

Now, obviously, many of the rules are being driven by the federal government on a blanketed perspective, not taking into consideration where each individual state has been in the past or what their ground rules are today.

Adapting and changing to that has been incredibly challenging, not to mention the operational issues around the exchange.

Historically, the business of insurance is really between the broker, at least with small groups, the plan, and the group.

Inserting the exchange into that with individuals is just simply enrollment from the individual to the plan.

Inserting the exchange into that process, where the exchange is the front end of enrollment without the plan's ability to do enrollment themselves, has been, you know, not only from an IT perspective, but just operationalizing it, an incredibly challenging endeavor.

And, you know, in terms of recommendations at the end, you know, perhaps there are some areas for

improvement there.

The exchange staff, you know, certainly led by Donna, the level of collaboration to all stakeholders, you know, really is unprecedented, and has been remarkable.

Paul went through, you know, the somewhat daily contacts we have with them.

You know, certainly, we agree on issues as frequently as we disagree, but, the dialogue, whether it be with Donna, her staff, the DFS, and other stakeholders, you know, has been, you know, truly helpful in trying to facilitate this process.

In terms of your initial question, Senator, "Has the implementation of the ACA accomplished its goal?" -- and I think Paul touched on, and the broker panel before touched on, the key issue of affordability -- I think you have to look at the shop and individual exchanges differently.

Certainly, the individual exchange, simply by putting in more products and greater selection to what was historically a broken system, is an improvement.

You know, that said, there were a number of assumptions that went into the price-setting process.

Typically, through the prior approval, there are a limited number of assumptions: utilization, trend, being the two prominent ones.

This process was a little bit more speculative, so to speak, in that, there was an anticipated level of uninsured people, the young invincibles, becoming enrolled.

Likewise, there was morbidity factors: How many groups were dropping coverage, and those individuals go -- healthy individuals going into the exchange?

I think it remains to be seen whether those projections will ultimately prove to be true.

And as a matter of fact, you know, as we head into 2014 and 2015 rates, you know, we will be submitting -- because of the prior approval process, we will be submitting rates, you know, in the first quarter, April, perhaps May at the latest, with very limited experience to ascertain whether those assumptions were spot on, or whether the number of healthy individuals that came into the pools were either overestimated or underestimated.

SENATOR HANNON: Given the number of types of policies that have sharply decreased because of the whole nature of change --

SEAN DOOLAN, ESQ.: Yeah.

SENATOR HANNON: -- should you have to submit your rates that early?

Or, should you at least, on a one-time basis, be given greater time to get some experience, and then -- because, arguably, they're -- the time frame was set when there were forty, fifty thousand types of policies, many of them were almost me-toos, but, still, they don't have to look at all of them?

SEAN DOOLAN, ESQ.: Yeah, I mean, you've got two timelines.

You've got the prior-approval timeline, you know, which we've talked about, which is laborious.

I mean, there's a 60-day notice of proposed rates, there's a review period, and then there's an additional 60 days at the back end, prior to being implemented.

You know, there's an additional time period for the department to request more time.

You know, that alone is about 150- to 180-day process.

Compounding things -- so that takes you, you know, at a minimum, to, you know, May or June.

Compounding and accelerating that timeline is the recertification of the plans to participate in

the exchange, which the department and the exchange has actually given us some additional flexibility, but it's still resulting in the submission of rates, you know, in, you know, April or May.

And I think that, again, the plans submit the rates, say, May 1, but they begin to develop the rates on April 1, and, it gives them, essentially, three months worth of experience to determine whether they have a healthy pool, a sick pool, and whether any of the assumptions from last year's prior-approval process were accurate or not.

SENATOR HANNON: I'm just saying, for both of those timelines, it seems to be that experience would be a great valuable asset to have for actuarial projections, for adequacy network projections, to see what type of flexibility needs to be given. And it's -- those are self-imposed deadlines, both by the department and the exchange.

SEAN DOOLAN, ESQ.: Yeah. Yeah, I agree, I agree.

PAUL MACIELAK, ESQ.: We --

SEAN DOOLAN, ESQ.: And one other -- I'm sorry, Paul.

One other huge variable in this, is risk adjustment, which will be coming down again from the

federal government.

There were simulations done by the department, that were somewhat controversial, and that some plans agreed with them, some plans disagreed with them. Those, likewise, were built into the rate.

That risk-adjustment model has still yet to be promulgated by -- fully promulgated by the federal government.

So, again, another variable that could have a dramatic impact on premium.

SENATOR HANNON: But how could they do a risk adjustment until they know the actuarial makeup, the demographic makeup --

SEAN DOOLAN, ESQ.: Exactly.

SENATOR HANNON: -- of the insured pool?

SEAN DOOLAN, ESQ.: Exactly.

PAUL MACIELAK, ESQ.: Only to model. I mean, it's -- what it was based on was some assumptions.

I mean, we've operated, to date, on a lot of assumptions, and that's been part of the rate setting.

And while you've had a number of new plans enter into marketplace, you have had a few other plans sit on the sidelines, because I think there

was a fear about rates, fear about, you know, what the mix was of who was going to enroll, and what the pent-up demand was, and what some the utilization would be.

SEAN DOOLAN, ESQ.: So back to the two worlds, you have the individual market, which we talked about, which definitely has promising features.

On the flip side, I think you've heard pretty loud and clear, there has not been a lot for small business in the ACA.

You have additional benefits, number one, which, obviously, lead to the increased cost in coverage.

You have a very narrow tax-credit band that clearly is not providing a sufficient number -- incentive for businesses to participate in the exchange.

Likewise, that tax credit, under federal law, lasts only two years.

And so you have -- and you have additional taxes.

The ACA tax, the research task, that was enacted last year. You know, the issue about self-financing, which you talked about, or touched

on earlier, Senator, in terms of paying for the exchange in 2015.

And going forward, to me, that is, you know, especially since there is no mandate for the small-group market, addressing the affordability of small-group coverage will be critical.

The other issues, in terms of lessons learned, you know, going forward, uhm -- and I -- actually, one more other issue on the shop that I think has been an impediment, that the State, actually, we disagreed with them on, and the State actually had flexibility in this regard:

One of impediments to the shop is, instead of a group enrolling in the shop, or enrolling for all of their employers -- employees, rather, which was certainly the initial guidance from the federal government -- the initial guidance from the federal government is, the group could pick the metal level, but each individual employee would pick the company.

So whether it be Empire, Aetna, Oxford, that complexity, which I think recognized pretty early on by the federal government, and they allowed the states to simply stick with the current process, which is, a group can enroll all of their members, not only selecting the metal tier, but the

individual plan.

I think between the broker community and the plans, that became a pretty significant impediment to enrollment in the shop, which I think you do have the control to modify.

SENATOR HANNON: State law? Federal law?

SEAN DOOLAN, ESQ.: State law.

The federal law modified it by giving states flexibility to allow for group enrollment.

The State decided to stick with individual employee selection.

So they're with -- they're -- and I think, frankly, that would make the shop, you know, perhaps, going forward, a more attractive marketplace.

SENATOR HANNON: I think there needs to be a full assessment of how corporations and small corporations are going to be looking forward in 2015.

SEAN DOOLAN, ESQ.: Sure.

SENATOR HANNON: Because the federal government suspended part of the rules for the large corporations --

SEAN DOOLAN, ESQ.: Right.

SENATOR HANNON: -- and then changed around

some of the rules for the small.

So, if there's anything with the market, they've screwed it up.

SEAN DOOLAN, ESQ.: Right.

In terms of -- and this actually touches on, I think, in terms of looking forward, an area to improve, you know, the operations of the exchange, as I said, you know, the plans have had, you know, a fairly significant challenge.

There have been mistakes.

A lot of the front-end issues that Donna touched on, that the State experienced in October and November, both in terms of enrollment, but just consumer access to the website, you know, obviously, the plans to -- start to experience in December and January with actual enrollment.

So the same high volume, not necessarily high volume in enrollment, but high volume in terms of questions, and in terms of customer service.

You know, likewise, there is somewhat of a natural barrier between the actual enrollment process and the plan's role.

The plan, under the current construct, has very little role in the actual enrollment of whether it be a group or an individual on the exchange.

That is handled exclusively by the exchange, with assistance from, primarily, the navigators, but also brokers.

To the extent that there is -- the plans can play a greater role in actually facilitating enrollment, either having access to the exchange's web portal and enrolling people through the plan's web portal, or having the ability to directly enroll with the exchange.

SENATOR HANNON: Do you mean, letting the plans who have been doing enrollment for decades actually do the enrollment?

SEAN DOOLAN, ESQ.: Correct.

SENATOR HANNON: Well, it seems to me, that if you're not getting a subsidy or a tax credit, or you're not going on Medicaid, there's no reason to have the exchange do the qualification and all that.

Why not just go directly to a plan?

SEAN DOOLAN, ESQ.: Right.

It -- certainly, at a minimum, having greater visibility.

I mean, one of the challenges we had in operationalizing things were, in order to get access to the exchange, you had to begin the application process.

So the plans, just validating logos, validating that the information is correct, they'd have to be a dummy applicant, so to speak; as opposed to having greater visibility, and to the -- at least on their own information, to ensure accuracy.

Again, hindsight being 20/20, I think that's something that could be looked at to be corrected, going forward.

In terms of some of the individual issues that have been raised, you know, I know, earlier on, there was a question about multi-lingual participation, that I think both Senator Rivera and Senator Larkin raised.

Actually, there's an obligation on the plans, to the extent that there is greater than 10 percent of a particular ethnicity, whether it be Spanish-speaking, whether it be Asian, whether it be, even in Rockland County, Yiddish or Orthodox Jewish, there is a requirement that the plans provide enrollment data for -- or, enrollment applications, as well as backup data, in that particular language.

You know, likewise, a number of plans, you know, certainly Empire in the city being one of the

more prominent, has gone through an outreach to the Spanish populations in the Bronx, in Brooklyn, in Queens, to facilitate and educate them on the enrollment process.

But, certainly, more can be done, and having the multi-lingual website is a big start.

In terms of the networks --

SENATOR HANNON: My point on multi-lingual was, that they have information in other languages, but there's not enrollment, so that if you were to go through the enrollment process, you need to know English.

SEAN DOOLAN, ESQ.: Right.

No, absolutely. Absolutely.

In terms of networks, certainly a lot of lessons to be learned.

There are a number of issues there.

You know, in terms of network submissions, and that the networks that the plans used to apply for the exchange, many -- each plan varied.

Many plans, a number of upstate plans, for example, simply use their commercial network.

So a provider, not knowing whether they're on the exchange or not on the exchange, frankly, might not know, because the plan is simply using their

commercial network. And, the contract that they have with the provider covers all products -- all commercial products.

Some plans used a variation of their commercial network. Some plans built an exchange-only network.

Based on the contracts with providers, they were to be notified of their, either, option to accept new rates or new terms and conditions, or not.

In terms of --

SENATOR HANNON: Well, that sounds well enough, but you were here to hear Dr. McLaughlin describe, both as an individual and as a practitioner, the attempt to find out who is in which plan, when, and how to prove it.

So I would think that there's a large mountain to go up right now for all the health insurers in this state, because of all of the changes to try --

SEAN DOOLAN, ESQ.: Yeah, and my only point is, I think it varied, depending on the approach that the plan had taken.

You had also asked about network adequacy.

SENATOR HANNON: Well, let me go back to it.

This is, Dr. McLaughlin was the Upper East Side. Hardly the rural part of America.

In fact, if I recall, it's probably one of richest parts of America; and, still, she was pretty articulate about the amount of confusion that exists.

PAUL MACIELAK, ESQ.: It still goes back to what Sean was saying: Depending on what model the plan pursued, it didn't matter what part of the state you were in. It mattered what the plan model was that they pursued.

That created, I think, some of confusion.

SENATOR HANNON: I know, and the problem was not the exchange. The problem is, your memberships.

SEAN DOOLAN, ESQ.: Yeah, I think, again, you know, starting with the exchange, you know, and I think that they would acknowledge this is an area for improvement.

The consumer's ability to determine the providers in each plan's network is not a single provider point-and-click methodology, as opposed to getting full visibility into the entire plan network.

Likewise, from the plans' end, I think that they can and should do a better job of transparency

on their own web pages, in terms of which plans are in the network.

PAUL MACIELAK, ESQ.: Right, but I think that was, both were a reflection of the time.

The time-compressed period that plans had to submit their proposed networks, have DOH, DFS, do the review and certify, or come back with what deficiencies were to have corrected, that it was that compressed.

I think that, in part, feeds to some of the confusion we're hearing about today.

SENATOR HANNON: I think there was a lot more need for the plans, and, in fact, probably the exchange, to allow people to put in their providers and find out if anybody meets them.

Likewise for drugs, likewise for clinics, likewise for hospitals.

It is -- the entire onus is on an incredible maze of the consumer, or potential consumer, to try to figure out who's where.

But I would simply -- I would simply think, go back and listen to what Dr. McLaughlin said. That's -- it's a lot more complicated than it's ever been before.

SEAN DOOLAN, ESQ.: Yeah, and I think to

Paul's point, I mean, both, in the defense of the exchange operationalizing their platform and the plans developing those networks in a short time frame, and negotiating contracts in a short time frame, continues to be a work in progress.

SENATOR HANNON: This goes back to your other point: I think there's more time needed to plan for next year.

SEAN DOOLAN, ESQ.: Correct.

In terms of the network adequacy review, I think you had mentioned, DFS versus DOH.

In reality, today, the DOH process is far more robust and comprehensive.

The DFS process, really, is limited to a fairly minimalist approach.

And I think deferring it to DOH, and the DOH review process, while more cumbersome, and has actually been -- there's been a quite a bit of give-and-take between the plans.

And DOH, from a consumer's perspective, in terms of determining network adequacy, was the appropriate approach.

SENATOR HANNON: Well, that may be true, but the point is, for the consumer in New York, you have a problem with adequacy of a network, you make your

complaint to the Department of Financial Services.

What the Department of Health is doing, is simply regulating the HMOs that are Medicaid HMOs, and, that's a whole different process.

SEAN DOOLAN, ESQ.: Actually, DOH determines network adequacy for commercial HMOs as well.

So, they basically took that commercial HMO network-adequacy standards and imposed them on insurance products.

So, again, it actually required the plans, on their insurance products that had closed networks, to raise the bar.

In terms of other changes that were made, again, going from HMO, to insurance, and I think Donna had touched on this, there were a number of consumer protections that exist in the HMO market, that, as a result of the contracting with plans, have been extended to the insurance market; whether it be allowing a member to go out-of-network for emergency services. Or, for that matter, an APO product, allowing a member to go out-of-network, to the extent that there is not an appropriate and available provider in-network to provide those services.

So, incrementally, I think they tried to

raise the standards.

Clearly, more needs to be done, especially in terms of, you know, participating providers and network adequacy.

And, whether it's updating them on a more timely basis, whether it's greater transparency, you know, the key, I think, from a policymaker's perspective --

SENATOR HANNON: All of which is obviated by the fact, if they've made these skinny networks, that -- and don't allow for going outside of network, that it doesn't matter about the rules for out-of-network, and, that the "adequacy" has had a new definition.

SEAN DOOLAN, ESQ.: Yeah, and I was going to get to the out-of-network issue, so, just to segue there, you know, because, obviously, that's been a dominant theme here.

Even prior to the implementation of the ACA, the marketplace has been moving away from out-of-network coverage, for two reasons:

You know, number one, pure affordability.

And, having out-of-network benefits regardless of which benchmark you were using, whether it's UCR, a percentage of Medicare, or a

plan's own fee schedule, was becoming cost-prohibitive. And the pricing, and you see it in the large-group market as well, the pricing was really being skewed, because only those groups or individuals that were accessing, or needed to have out-of-network providers, were purchasing the coverage; thereby, driving up the price.

The other issue, you know, which, frankly, I think Senator Martins talked on, and, actually, Dr. McLaughlin referenced, was the balanced-billing process; where, if you're in-network, you have a contract between the plan and the physician or the hospital, that is payment full.

If you're out-of-network, the plan pays their out-of-network reimbursement rate. Since there is no contract, the provider then turns around and balance-bills the member whatever that particular provider desires.

Now, Dr. McLaughlin said that that, frankly, was, you know, an admirable process: let the provider negotiate with the consumer.

Frankly, from a customer-service perspective and a public-policy perspective, I would think you'd want the member out of the middle, and not to get hit with that surprise bill.

You know, likewise, the example that Senator Golden walked through, unfortunately, that is a very common scenario, where you have the member go to a participating hospital, they think they're in-network. The surgeon is a participating provider, but the anesthesiologist or some other specialist is non-par; the hidden provider.

They think that they've played by the rules, and they get hit with the balance bill.

Greater transparency in terms of the physician, because they'll -- should know, you know, who's providing the services. The hospital should know which -- whether they're par or not, which plans they participate with.

Greater access to consumers of which providers are par, and which are -- which plans they participate with and which they don't, is a major step in the right direction, in terms of reform, that would go a long way.

You know, in terms of, you know, the mandate of having an out-of-network benefit, again, you know, with the digestion of these benefits today, and, likewise, even if you handled it through a rider type of scenario, the groups that would purchase that rider are only those groups that would

utilize the coverage; and that, in turn, would make it cost-prohibitive.

So, from the plan's perspective, having a mandate, whether it be on the exchange or off the exchange, of an out-of-network benefit, which doesn't hold the consumer harmless, number one; which doesn't have that greater transparency and ultimately leads to increased costs; goes completely contrary to the goals that we're trying to accomplish in terms of affordability.

SENATOR HANNON: Doesn't answer the question.

The -- I did put a bill in, for requiring an out-of-network rider, but without any limitation as costs.

So if people really want that, is what they want to design their policy, let them pay for it.

PAUL MACIELAK, ESQ.: Well, the other related issue to that is, that rider we have to get approved by the DFS division. And I'm not sure that, you know, what would be requested, what we believe would be the market price, would get clearance through the DFS process, in terms of the prior approval.

So that would be a concern, as we had seen, actually, in the other direct-pay market, particularly on the point-of-service product, what

some of the costs were, what some of the rate requests were, versus, what was approved.

So, that, that would be a concern.

SENATOR HANNON: Good point.

SENATOR SEWARD: I had one question.

And it's been an interesting discussion here. You've covered a lot of issues.

But I had one question regarding the -- your view of the transfer of debt and information once, you know, someone has enrolled on the exchange and selected a plan, that the delay in getting the verification and the cards and ID numbers out, you know, we've run into many, many examples of where that has been a great delay.

And, of course, the premium payment also.

How -- how prompt has the State been in terms of providing the plans with information, in terms of who has enrolled in their plans; and, thus, you start the process for billing and setting up the account?

SEAN DOOLAN, ESQ.: Yeah, I mean, I would say in a condensed time period, you know, they have done a good job.

Part of the issue was, you know, each plan needed to go through a testing process, an IT

testing process, to make sure that the enrollment fields and the actual enrollment, on what they call the "834 form," matches up with the plan's process.

They went through that process and standardizing it all amongst all of the plans.

That, obviously, was in a very short time period.

The transfer of the files began, you know, roughly, in December. It went through December.

So, in a very tight time frame, sure, they met all their milestones, but then it made it very difficult for the plans to turn around and meet their milestones.

And, you know, that being said, the plans have had challenges.

You know, the way the process is unfolding, is that the plan gets the enrollment, they confirm enrollment, and then they send out a bill.

They send out a bill, they get premium payment back. The member, at that point, is technically enrolled, but doesn't have an ID card.

You know, typically, this happens in, you know, November -- October, November, and December, so by the time January 1 rolls around, they've got the card in hand.

Here, we're trying to do everything almost simultaneously.

To adjust to that and address that issue, the plans have done a couple of different things.

Number one, given consumers the ability to download a temporary ID card off the web;

And, number two, give providers -- and this actually came up on the provider panel, give providers access to their provider web portal with the plan, to determine whether an individual is enrolled or not.

That's the concept.

Obviously, there are a lot of challenges.

You know, when you have thousands of people trying to download temporary ID cards, you run into bumps.

I think the fact that all the invoices, to Donna's point, have gone out by the end of last week, the process should start to improve.

We still have challenges ahead, though.

PAUL MACIELAK, ESQ.: And I would just echo what John said, but I think the data flow from the State to the plans, really, was as good as they could do, in terms of the bulk of it.

As we went through the process, and we would

see in our weekly calls, we would see glitches, and you would see, you know, a field that wasn't identified, or a particular family status that would have knocked somebody out of coverage, so the 834 wouldn't have been complete or would have been rejected.

Those type of things came up, and we continue to work through those kind of bumps.

SEAN DOOLAN, ESQ.: Yeah, and, obviously, as the federal rules changed, you know, in December, you know, that threw an additional monkey wrench in resources.

And the perfect example, is this ability to purchase catastrophic coverage --

PAUL MACIELAK, ESQ.: Right.

SEAN DOOLAN, ESQ.: -- you know, which came down from the federal government.

The only catastrophic policy available is on exchange.

And as I mentioned earlier, since the plans have no ability to enroll, they pointed to the exchange to facilitate enrollment.

While the exchange needed to verify whether the individual was getting a federal waiver, and got it punted back to the plans, and then the plans,

ultimately, are now, at least in this limited circumstance, are allowed the ability to enroll based on this.

But this all went down, you know, the last ten days of the year. And, to operationalize it was, obviously, challenging.

SENATOR HANNON: Yeah.

SENATOR SEWARD: Thank you.

SENATOR HANNON: Thank you very much.

SENATOR SEWARD: Our final panel, on public health advocates and insurers:

Elisabeth Benjamin, who's the vice president of health initiatives at Community Service Society of New York;

James Lytle, Coalition of the New York State Public Health Plans;

And, Mark Scherzer, health plan -- excuse me, Health Care for All New York/New Yorkers for Accessible Health Coverage.

We're going to ask Jim Lytle to go first.

JAMES LYTLE, ESQ.: All right.

Well -- and I will be very brief.

I think my client sort of bridges the two last panels. They are the Coalition of New York State Public Health Plans, which are the

Medicaid mainstream plans in the state, not-for-profit provider-sponsored plans, responsible for enrolling 2.7 million people in the Medicaid program.

Four of the plans in our coalition made the decision to become active participants on the exchange, which we felt was extremely important, particularly for those individuals who may be transitioning, from time to time, from Medicaid to commercial insurance. And these four plans are now part of the exchange, including some of the plans that have been referenced earlier today: Fidelis, Health First, and others.

The -- how successful they've been on the exchange remains to be seen.

Today's "Crain's Health Pulse" has more data than I've seen, but, Metro Plus, the city health and hospitals corporation plan reports about 23,000 individuals have enrolled in their plan through the exchange.

There are -- many of the issues that the insurers just discussed are shared by the plans that we represent.

It was, I suppose, in some ways, an even greater challenge for some of the plans in our

coalition, because this was the first time they ever had to submit premium proposals, and go through this sort of more commercial side of selling insurance than they had previously done in providing Medicaid managed care, Family Health Plus, and children -- Child Health Plus insurance.

One of the things that the plans are particularly proud of is their experience in facilitating enrollment, in helping folks navigate their way into health insurance, which they've done for decades, or almost decades.

And, on the Medicaid side, they're pleased that the State continues to believe in the facilitated enrollment program, and the plans have used their resources and their experience, particularly in reaching out to populations that are -- have been more vulnerable and less capable of accessing health care, to try to make sure that, whether it's language barriers or other barriers, that information was provided as much as possible.

I would note, in comments of one of the individuals from a small business who was worried about their Fidelis coverage of one of their employees, I think there's a presumption that the -- those plans that have historically provided Medicaid

coverage are -- present networks or present an array of services to the people who are enrolled in their plans, that are somehow less than what they may find in the commercial market.

They're subject to the same tests, subject to the same assessments, by the Department of Health, as Sean was just testifying.

And, I think that sort of a best-kept secret in New York is going to be how robust some of these Medicaid managed-care plans, or historic Medicaid-plans networks, actually are.

We appreciate there are issues about out-of-network coverage.

I know that the Senator has scheduled another hearing on that subject.

I think, in general, we think it's a little too soon to tell exactly how significant those barriers may be, but, it is something, particularly the provider-sponsored plans are sensitive to and are interested in exploring further with you.

We -- one of the points that you made on the hearing announcement was the importance of access to primary care, and whether we have a primary-care infrastructure robust enough to meet the needs of the exchange.

We pride ourselves, the plans do, on their ability to build strong primary care networks, relying on the historic primary-care infrastructure of the state, many of whom were founded by community health centers.

And -- but, we continue to work with the State on issues like patient-centered medical homes and health homes, to build an even stronger primary-care infrastructure.

And with that I'll let the -- my consumer colleagues take it from there.

SENATOR HANNON: You talked so slow.

JAMES LYTLE, ESQ.: I'm sorry? I talk so slow?

I was trying to see if I could actually be briefer than Mr. Doolan, so, I was doing my best.

SENATOR HANNON: Now, now for a real slow-talker.

Ms. Benjamin.

ELISABETH BENJAMIN: Sure.

First of all, I want to thank you both very much for letting me come and testify -- or, inviting me to testify today.

Thank you, Senator Seward.

Thank you, Senator Hannon.

I also really want to thank the staff of the exchange, and, actually, the larger health-delivery community.

I think the plans, the providers, the docs, we've all -- the consumers, we've all really tried to pull together and make this process, this very, very significant transition, work as best as possible for the consumers, and the State of New York, along with elected officials.

And, it's been a really exciting, and sometimes crazy-making period, but, it's been really, you know, a real honor to be part of this whole process.

And I think it's a real testament to how hard we all are trying to work and communicate with each other, that it has gone as smoothly for New York.

I think probably smoother in New York than anywhere else in the country.

And, you know, there's a lot of great people all really trying to pull together.

SENATOR HANNON: As incredible as it seems, I read this morning, that there is one exchange, maybe there's more, in the nation that's not even open yet.

ELISABETH BENJAMIN: Yeah. Vermont is not

doing well, as I understand it from my colleagues there.

You know, Oregon is still having a tough time.

It's really troublesome.

But, New York is not -- I mean, really, New York has an exemplary exchange. And, especially because we do this one-stop shopping that I think Donna was trying to talk about.

You know, we really are trying to do small group, and public insurance, and the qualified health plans, all in one house.

And from the consumers' perspective, that's incredibly helpful, because we do have consumers that are trying to sort through which bucket they should be following -- falling in, and our exchange actually does make it very easy to figure that out.

But, I'll just try to be brief.

You know, Community Services Society, one of these old philanthropies, has been around for many, many years. 170 years in New York.

We both do -- we have the largest state navigator program. We're in 61 out of 62 counties through our network of 38 community-based organizations and chambers of commerce and

business-serving groups.

It's a robust network, we're really proud of it.

We also -- so that's for our enrollment services, but we also work to help people, post eligibility, post enrollment, through the state Consumer Assistance Program, our community health-advocates program, try to navigate when glitches do arrive, after having been enrolled in coverage.

So, I'd like to talk about both of those programs, super briefly, because I know you guys, I can't believe you're still sitting there, Senator Seward.

My hat's off to you.

But, anyway, so, I'll go fast.

I noticed there were some questions in the hearing about: "What are navigators?" And, "How is it working?"

Navigators, under the Affordable Care Act, are designed to sort of be distinct from brokers in the sense that, we're neutral. We do not receive commissions from carriers.

I would say that's our biggest distinction.

We are supposed to be culturally competent.

We're supposed to have many multi-lingual capacity.

I think the idea was, that we would really be sort of local trusted groups.

And I think, in New York, we've really achieved that. There are 48 lead navigator agencies.

So, like me, I have 47 lead agencies that are companions.

Under my network, I have another 38 chambers and community-based groups.

So, we really do try to be in all communities in the state of New York.

And, I'm pleased to report, and maybe Donna touched upon this, there are at least two navigator groups in every single county of New York State, with 572 full-time equivalent-trained navigators.

We've all gone through three-day intensive trainings. We're pretty -- you know, on a variety of topics.

You know, privacy is security. I think you've touched about that, is a very important part of our training.

In order to -- I mean, I can talk about all the protections in the exchange itself, to make sure that our -- you know, anything we have access to is

kept very secure.

And, I can get into that if you want to.

The navigators are really helpful in rural communities where, you know, you only have dial-up. A navigator group can come in and really help people that are in rural areas.

A lot of us are former facilitated enrollers. We're really, really comfortable at working people through eligibility systems.

And, you know, I can go through our activities, but I'm going to try to be short because I'm cognizant of time.

I think the importance of navigators is not to be underestimated in the wake of a recent "Health Affairs" article that came out two weeks -- about a month ago, but it's in this month's "Health Affairs" article, that says, 60 percent of Americans do not understand basic insurance concepts.

We're talking about deductibles, co-insurance, co-payments.

And navigators really are there to help people understand:

What's in the net -- what's a net -- in-network?

What's out-of-network?

You know, what's in a formulary?

How do co-payments work?

What are these tiers?

Cost-sharings: How a cost-sharing reduction can actually be sort of like a -- I like to think of it as an upgrade. An airline upgrade.

So, kind of walking through these concepts with people.

And, you know, after we help enroll people, they're incredibly and intensely gratified.

We had one woman say, you know: Health care's what I wanted for coverage, and I have it.

And, I have so many stories of people that have -- we have helped enroll in coverage, that are so very, very pleased to have it, and really feel like the New York State of Health has offered them an extraordinary option.

I think, just turning -- pivoting for a second, the Community Service Society, along with our partners at the Medicare Rights Center, Empire Justice Center, and the Legal Aid Society, have administered, traditionally, the state Consumer Assistance Program for the last three years, under Section 1002 of the Affordable

Care Act.

Thank you very much, in the past, you all have helped us secure dry appropriations, so that when federal consumer-assistance program funding has come through, we've been able to access that.

And, I would just encourage you all to continue to find a sustainable source of funding for that program.

We are experiencing boomerang clients; clients who, after enrollment, come back and have questions, and need help kind of getting through their new systems of care.

It is a new system.

People need help getting through it.

They need help with prior approval, they need -- or, prior authorization.

They need help with, you know, random bills.

They need help, you know, as they sort of get used to coverage.

And, I would really encourage you all to continue your support in the past for that program.

It's an exciting program.

At its height, we were able to serve 65,000 consumers a year.

I know, for the help line, we run the

help-line component of that Consumer Assistance Program, and our call volume has gone up, from around 125 calls a week, to over 600 calls a week, and we are struggling, with a cobbling together, you know, attorneys, paralegals, and a lot of volunteers that we train to handle that call volume.

So, your continued support would be incredibly, you know, well received from our end.

I can answer more questions if you want, but I was trying to be brief, because I know you guys have been here for a while.

SENATOR HANNON: Earlier today, Senator Larkin was talking about finding out the navigator in his -- one of his counties.

ELISABETH BENJAMIN: Uh-huh.

SENATOR HANNON: So I just, while you were talking, and I didn't have much time, because you talked fast --

ELISABETH BENJAMIN: I'm sorry.

SENATOR HANNON: -- I went to the state health site, and looked -- I started to look for navigators, and to see if I could find out a navigator in my home county.

ELISABETH BENJAMIN: Nassau.

SENATOR HANNON: I couldn't find it.

I did find out there's an application process to become a navigator.

ELISABETH BENJAMIN: You mean on the state website? I'm surprised.

SENATOR HANNON: I'm on the state website.

ELISABETH BENJAMIN: Oh, well, I mean, I know that --

SENATOR HANNON: Then I went to the "Search," and I went to search for "navigators," I came back to what I already had.

Then I went to the "Search," "Nassau County Navigators" and it just stopped.

So, the point is, I'm Joe Jones. I'm in the county of Suffolk. I'm interested. I can't figure it out. So, where do I go to find a navigator, and how do I access the list of navigators?

ELISABETH BENJAMIN: Sure.

You go onto website, you're there now, it says "Get Help." There's a "Get Help" button.

And then you can -- you'll be able to get -- you type in, there's a "search" function, by county.

I've done it a lot, 'cause I, you know, have to help clients select myself, actually, as a navigator.

I personally have done over 65 enrollments in

the last, 2, 2 1/2 months. And, it's been really fun to kind of do the process with people.

And exciting, actually.

I mean, to be able to get people coverage has been sort of the --

SENATOR SEWARD: You mean, after the hearing, you'll be able to help --

ELISABETH BENJAMIN: Yeah, I'll do it.

I mean, it's really -- you can appoint me, Kemp. I can be your navigator.

[Laughter.]

ELISABETH BENJAMIN: But it is doable.

And then, also, as you're going there through the application, you can stop, on the left-hand side, it says "Get a Navigator," and you can go that way, too, if you're doing --

I mean, I wish I had -- I can show you on my iPad, afterwards.

Kemp?

Senator Hannon?

We've lost him.

SENATOR HANNON: So, three times I've put in the search for "navigator." The first two --

ELISABETH BENJAMIN: Not the "Search" function.

It says -- when you're on the home page, it says "Get Help."

Do you see that?

SENATOR HANNON: No, it's -- yeah, but there's a "Search" function.

What would do you -- what would you do with a "Search" function, ignore it?

ELISABETH BENJAMIN: Well, I think --

SENATOR HANNON: So I push -- the third time I pushed "navigator," I got, it does show you, someplace, there's site locations for New York State Health, and it also got me to the DEC navigator.

ELISABETH BENJAMIN: Okay, no, no.

SENATOR HANNON: And it got me to the New York City Department of Health and Mental Hygiene.

ELISABETH BENJAMIN: But you're in the -- can you just go back to the home page?

If you go to the home page, and it says, "Individuals and Families," you click on that, and then it says "Get Help."

SENATOR HANNON: I do websites a lot.

ELISABETH BENJAMIN: Okay.

SENATOR HANNON: I buy a lot of things.

ELISABETH BENJAMIN: Uh-huh.

SENATOR HANNON: It's not a great website.

ELISABETH BENJAMIN: You know, I would disagree.

I mean, because, I think --

SENATOR HANNON: The point is, there's no list.

Why can't there be a list of navigator, by county?

ELISABETH BENJAMIN: I think there is a list of navigator, by county, but I will show it to you.

It's hard to describe without knowing exactly where you are.

But, if you go under "Individual" -- on the home page, you go to "Individuals and Families," it says "Get Help." There's a little blue box in the middle of the page. It's pretty prominent.

SENATOR HANNON: You know, I saw it before, but why would you have "Search," and then "Get Help"?

ELISABETH BENJAMIN: I mean, I think -- well, you know, I don't design websites, so...

I would suggest that you talk to the exchange about --

SENATOR HANNON: And under "Get Help," it says "Site Locations"; but why have "Search"?

ELISABETH BENJAMIN: I'm sorry?

SENATOR HANNON: It says -- yes, I can see now that it came up "Navigator Site Locations."

ELISABETH BENJAMIN: So you got it?

SENATOR HANNON: And then you gotta go to another page to find out lists.

It's still clunky.

ELISABETH BENJAMIN: Yeah.

SENATOR HANNON: It's still clunky.

You know?

ELISABETH BENJAMIN: I mean, I think everybody was working really fast to get it up, and it's -- you know, it's a lot to do on a little time.

SENATOR HANNON: All right.

SENATOR SEWARD: Mark?

MARK SCHERZER, ESQ.: Thank you, Senator Hannon and Senator Seward for the invitation.

I'm not going spend your precious time echoing everything Elisabeth said, except to say, I echo everything Elisabeth said about how wonderfully the exchange staff had performed, and the other regulatory agencies, and the stakeholders, working together to make this work.

I'm talking on behalf of Health Care for All

New York, which is a -- represents over 160 organizations.

We're dedicated to winning quality, affordable health coverage for all in New York, and we've been very anxious to see the ACA implementation work smoothly.

We talked about affordability earlier.

We're completely convinced that, certainly, was -- within the design of the ACA, that those who would be most helped with affordability are at the lowest end, above Medicaid, on the income scale. And we know they've been the ones who are -- been most likely to be uninsured, because of cost considerations.

They're the ones who are certainly going to see a lot of benefit.

We have talked a lot today about the, maybe, decreased premiums but increased cost-sharing, and, whether that really is an improvement in affordability.

I think one thing we haven't focus on at all, and we ought to acknowledge, is that the ACA builds in an out-of-pocket maximum into all policies, that includes your co-payments, something that never really existed before.

So, someone who's a big user of health care, every time they went to the specialist it would be a $50 co-pay, $50 co-pay, $50 co-pay. Even if you went every day, it never stopped.

That -- now it stops. Now there is an out-of-pocket maximum, which protects people at the back end who face serious health conditions.

That's an element of affordability that is a tremendous improvement, from the standpoint of people who face big medical bills.

I'm -- I heard, with great interest, the person from Kwik-Kut Manufacturing earlier, though, who talked about how she was very concerned, that if she had bought a tax-credit policy as a group, that her employees still could not afford their 50 percent of even a small premium at the level of people who are earning sixteen, seventeen thousand dollars a year.

She's similarly concerned about them going into the exchange, because, can they afford a $100-a-month premium that they'll be asked to pay, along -- you know, that they haven't been asked to pay in the past?

And we recognize, fully, that that's a significant issue of affordability for people in

that income bracket.

We think the State does have an excellent remedy for the affordability in that -- from that perspective; and that is to enact the basic health plan, which we urge you strongly to consider, which would enable coverage for people between 138 and 200 percent of poverty level.

It would, actually, likely save the State money because it would bring in federal funds for certain classes of immigrants that the State has been paying for, of a State-only money, to date.

And, it would put people in the -- in that income bracket, that -- those Kwik-Kut employees, in a no-premium and very low co-payment situation.

That's a way to address affordability that's well within your discretion to do, and we strongly urge your consideration for doing it.

We think there -- we've heard a lot about transitional enrollment problems that need to be addressed, today.

And, Senator Hannon, I think you pointed out earlier, a lot of those are not really problems of the exchange, or state officials. They're problems at the plans.

And we think that there are -- you know, we

could talk a lot about specific remedies for different things, like billing, and whatever, but we strongly suggest that plans be required to set up some point people who have to respond immediately to these consumer problems of, say, identifying whether you're in the plan or not, immediately.

We also would like to see a remediation program enacted.

So, for people who have received misadvice, very often, insurance-company employees, about what they have the right to enroll in and what they don't have the right to enroll in, if they can show that they're in the -- ended up in the wrong place because of that misadvice, there's some retroactive correction system in place for them to take advantage of.

I've -- I'll rely on my written testimony for the rest of what I had to say, except for going into some detail on the two topics that have most consumed us this morning: Sole proprietor -- the sole-proprietor coverage, and the issue, out-of-network coverage, which are closely interrelated.

I think I come at this from a slightly different perspective regarding the sole

proprietors, because we've heard a lot to suggest that there's something unfair about treating sole proprietors as individuals rather than as businesses.

And while there be issues about the two-person firm, that happen to be married to one another, not qualifying as a small group, it's really hard for me to see why it's unfair for an individual who happens to have a business, being treated very differently from an individual who, for example, may once have had a business, but has become disabled by illness and no longer can operate that business.

Why is it unfair to put those together as individuals in a market, and not -- not -- and treat them differently from small groups, if you have those two categories of coverage?

And, I'm going to come back to that, "if you have those two categories of coverage," because I think it's important --

SENATOR HANNON: There's -- because the answer is -- "Why?" -- is because we, earlier this year, ratified the PEOs, which allow individuals to join these organizations.

And, conceptually, I don't know the

difference between individuals in those organizations, and the individuals who were part of the two-person group.

MARK SCHERZER, ESQ.: Well, and I think -- but you -- Senator Hannon, I think the question is: Why are any of these individuals different from any other individuals?

I think you could view our traditional approach to the sole-proprietor coverage as having provided artificial price protection to sole proprietors who were pegged at 15 percent above the group rate, no matter what the sole proprietor experience was.

SENATOR HANNON: And that gets you into the philosophy of, why does anybody get anything less than total equality?

But --

MARK SCHERZER, ESQ.: Well, and that's the -- I think that's exciting [unintelligible] --

SENATOR HANNON: -- [unintelligible] that people with risky behaviors should not be getting away with the same time type of premium that people who lead exemplary, healthy lives.

MARK SCHERZER, ESQ.: But -- well, we're not necessarily talking about whether people who have

cancer, or whatever, have led risky lives.

Sometimes it's just the luck of the draw whether you get ill or not.

SENATOR HANNON: I'm not going to name them, but, those -- that's an illness.

There are people who have risky behaviors who endanger themselves; and, therefore, greater medical costs.

And, should everybody else be subsiding them?

MARK SCHERZER, ESQ.: Okay, well, I -- let's -- I think that's a big philosophical question.

I'd like to look at a practical solution to the problem of sole proprietors, which is within our grasp.

I would disagree with Dan Colacino who said earlier that you could roll back the practice in New York to define "sole proprietors" as businesses rather than individuals.

I think the ACA dictates they must be viewed as individuals.

But I think what we can do is --

SENATOR HANNON: There are ways that you can do it.

I mean, we were -- we looked at the

freelancers, and thought that that was unfair to pull the rug out from under that group.

So, yet, we allowed the others to have rug pulled out from under that group.

MARK SCHERZER, ESQ.: I -- we have two --

SENATOR HANNON: So the point is, how do you go forward and try to find things for people?

And then there's the other part of it is: Will the people who want to pay, now that they're single, find something they -- that's worthwhile of their purchase?

MARK SCHERZER, ESQ.: And I think we need to talk about both of those issues, as opposed to price and the out-of-network access. And they're both solvable, we believe.

The "price issue," the fair way to resolve it, we believe, and which something we've advocated for for several years now, is merging the individual and small-group markets, which the ACA permits states to do. That's absolutely within your purview to do.

And, it's something that Massachusetts did as part of its reform. For risk purposes, it has merged the two markets.

That way, is it a question of: Whether

you're a two-person firm or a one-person firm? Is it, whether you're a firm or not a firm?

It all becomes irrelevant. Everyone is in the same risk pool.

Merging the markets is, we think, the solution to fairness in pricing without ping-ponging the sole proprietors back and forth between the high-cost individual market and the low-cost group market.

That seems to me to be somewhat intuitive, that we can average them out, by -- and not have any questions of what's fair and what's not, by just saying everyone's in the same pool.

With respect to out-of-network coverage, first of all, I think we should recognize that there is nothing in the ACA that dictated that New York had to abolish its requirement that plans offer out-of-network coverage to individuals.

One of the great advantages of having colleges with winter break, is that I've had a wonderful intern with me for the last week and a half, Alec Tevevo [ph.] from Haverford College, who I tasked with surveying the other states and what's available in the individual markets.

And a copy of his report is annexed to my

testimony here.

He found with relative ease, that individual coverage with out-of-network benefits is relatively available in 47 states and the District of Columbia.

It's only New York, New Hampshire, and, we think Massachusetts, although we're not sure, that don't have that available to individuals.

So, there is nothing in the ACA that says that you can't have out-of-network coverage in the individual market.

And, Senator Hannon --

SENATOR HANNON: Okay, but, I agree, and I know there's not there.

It's the tendency to -- two things: Save costs, and, to try to go after people who were making some outrageous billing under out-of-network.

MARK SCHERZER, ESQ.: Well, and you have to view, first of all, I mean, there's two separate questions here, because the question of out-of-network surprise bills is something you need to deal with with general legislation.

That's something that people are, you know, not protected from, even though, for example, we have the exchange negotiating with plans, to say, if someone doesn't have an adequate expert in-network,

they get to go out-of-network for it.

You're right, that could be an elusory protection, both, because you have to fight your plan; but also because, if you're in the EPO market outside the exchange, you don't have that protection still.

There are a lot of -- there are millions of people in the state who don't have that protection, no matter what you do in the context of the exchange, or the implementation of the Affordable Care Act.

That's just a question of state law that the Legislature needs to resolve.

SENATOR HANNON: Just a question.

MARK SCHERZER, ESQ.: Just a question.

[Laughter.]

MARK SCHERZER, ESQ.: And we think, that Assemblymember Cahill actually has some interesting thoughts he's been given to, how to set a price benchmark, that we think may -- we -- may be able to sort of thread the needle between where the plans are and where the doctors are on what the cost ought to be when people are stuck with surprise out-of-network bills, and that has to be arbitrated.

You're absolutely right, Senator Hannon,

though, that the price on a rider can be separately set, so that it's a voluntary thing. It's not going to affect the base price within the market if you do require that that be offered.

I think the other issue that guided the decision not to have out-of-network coverage in our new market, was the desire to get the PHSPs into the marketplace -- into the exchange marketplace, and, the concern of the health plans, that if the PHSPs were in, and they didn't know how to do out-of-network coverage, and they didn't have to do out-of-network coverage, then the health insurers would be sort of the magnets for the adverse risk that wanted to buy the out-of-network coverage.

We think the resolution there is two-fold:

One is, you give a transitional period to the PHSPs, to learn how to do the out-of-network coverage;

And, second, that you do more robust risk adjustment in the meantime so that nobody gets stuck with disproportionate risk.

For the sole proprietors who, in the immediate term, have lost out-of-network coverage that they had, and can't replace it, you have an easy fix in the short term.

The easy fix is, that, in order to protect the individuals in the direct-pay market, who had out-of-network coverage, and were about to lose it at the end of last session, you enacted a law that grandfathered them, allowed them to buy a rider on a Platinum plan, in the out-of-network -- out-of-exchange marketplace.

You could allow the sole proprietors who are now going into the individual market to buy that very same pre-existing product.

There's no, like, startup effort here required. It's there; just allow them to buy it, too.

That would be a quick fix for those who are losing coverage right now.

The longer-term bill, along the lines that you have proposed, we think is a very good way to go.

There may need to be, again, issues addressing what -- 'cause you're, as I understand 6207, it addresses just the Article 43s and the Article 32s.

There may be other categories that need to be transitioned into that in order to make it work in a fair way.

So, I think that there needs to be consideration given there.

But, we think the fix is, to a lot of these problems, are within your legislative control, and, we welcome the chance to discuss them with you further.

SENATOR HANNON: Well, thank you.

And I found it.

[Laughter.]

SENATOR HANNON: But, it actually went off the -- it got locked in to -- just went off to another site.

But the third time, it was right there.

ELISABETH BENJAMIN: Good, I'm glad you found it.

I mean, because -- and we have, I think, four colleagues, four of our subcontractors, are in Nassau County, Senator Hannon.

SENATOR HANNON: No, I can see it. It's on the list.

ELISABETH BENJAMIN: Yeah, so we have -- not to mention, you know, the other navigators.

SENATOR HANNON: Thank you.

ELISABETH BENJAMIN: Thank you both for hanging in there.

I'm completely impressed that you guys stayed there.

Thank you very much.

SENATOR SEWARD: Well, thank you very much.

We've had an interesting and insightful hearing, and we'll continue to, not only monitor, but be involved in these issues.

Thank you.

ELISABETH BENJAMIN: Thank you.

(Whereupon, at approximately 2:30 p.m., the joint public hearing held before the New York State Senate Standing Committee on Health and the Senate Standing Committee on Insurance concluded, and adjourned.)

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