10

New York HPA Health Plan Association

Testimony of the New York Health Plan Association

to the

Senate Finance Committee
and the Assembly Ways & Means Committee

on the subject of

2014-2015 Executive Budget Proposal

February 3, 2014

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 23 health plans that provide comprehensive health care services to more than eight million New Yorkers, appreciates the opportunity to present its members' views on the Governor's budget proposals. Our member health plans have long partnered with the state in achieving its health care goals, including improved affordable access to quality care in its government programs as well as providing access to care that exceeds national quality benchmarks for commercial enrollees. Our plans include those that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), public health state plans (PHSPs) and managed long term care (MLTC) plans. The New Yorkers who rely on these plans are enrolled through employers, as individuals, or through government sponsored programs — Medicaid Managed Care, Child Health Plus, Family Health Plus and Healthy New York.

We appreciate the opportunity to offer our view on the proposed 2014-2015 Executive Budget in relation to its application for health care spending in New York.

SHARED GOALS

HPA and its member health plans share a fundamental health care goal with our state lawmakers and policy makers: Providing New Yorkers with affordable access to quality health care.

For more than two decades now, health plans have partnered with New York to provide lower-income New Yorkers access to health care through the Medicaid managed care program. Along with greater access to services in more appropriate settings — shifting care out of hospital emergency departments and providing Medicaid beneficiaries with their own doctors and, thus, with better continuity of care

– health plans have worked tirelessly with the Department of Health to measure and improve the outcome of the care that is provided. Similarly, plans have worked to build on the Medicaid managed care model to provide expanded access to and improved quality of care through the Child Health Plus, Family Health Plus and MLTC programs. Over the past three years, health plans have continued collaborative efforts with the state to implement the Medicaid Redesign Team (MRT) initiatives including the enrollment of new populations and the implementation of the Fully Integrated Duals Advantage (FIDA) initiative.

Likewise, efforts to realize our shared health care goal have extended to the implementation of the New York State of Health (NYSOH), New York's health insurance exchange created under the federal Affordable Care Act (ACA). As you are undoubtedly aware, approximately 330,000 New Yorkers have signed up for health coverage through the NYSOH and New York is held up as a model for state-based exchanges. HPA and its members have worked closely with NYSOH staff on the implementation of this marketplace and continue the collaborative effort to modify and improve it moving forward.

EXECUTIVE BUDGET PROPOSALS

HPA is generally supportive of the Executive Budget. We are pleased to note that it imposes no new taxes, nor increases the level of existing health care taxes and we ask that the Legislature observe the "no new taxes" principle. As we have noted in previous years, the various Health Care Reform Act (HCRA) surcharges and assessments along with other assorted taxes levied on health insurers amount to close to $5 billion a year. This $5B tax equals 5% premium, which has a negative impact on affordability of coverage. Moreover, with the addition of new ACA taxes on both

private and Medicaid premiums, it is more important than ever to hold the line on state taxes on health care.

Beyond the issue of taxes, HPA offers its view on specific provisions in the Executive's proposals.

- Exchange sustainability: The federal ACA requires that state health insurance exchanges be self-sustaining beginning in January 2015. The governor's plan calls for funding the NYSOH from revenue that will result from HCRA funds — specifically patient services assessment monies collected for care provided to those newly insured through the marketplace. This is a smart approach, unlike many other states that rely on new taxes or fees.
- Health IT: The Executive budget provides for "up to" $65 million in 2014-15 from covered lives assessment revenues associated with additional insured individuals for continued operational support for the State Health Information Network of New York (SHIN-NY) as well as other Regional Health Information Organizations (RHIOs). HPA encourages the continued support of these information and data sharing collaboratives — such as the successful Health Information Xchange of New York (HIXNY) here in the Capital Region and the P2 Collaborative in Western New York — without new state taxes.
- Basic Health Plan: As an alternative to health insurance exchanges, the ACA gave states the option of creating a "Basic Health Plan" (BHP) as a means to provide affordable, comprehensive coverage for lower income residents. To date, New York has looked at the issue, using federal grant monies to fund studies into what a New York-specific BHP might look like — the foundation of the benefit package, likely premiums, the potential impact on the populations expected to be enrolled in exchange products — but has not moved beyond the "looking" stage. Part of the

reason for this is the lack of federal guidance related to the BHP. The 2014-2015 Executive Budget proposal takes a modest step forward, including a provision to "establish" a BHP. HPA commends this cautious approach. For close to two years, the state, health insurers, providers, consumers and others have been working diligently to implement the NYSOH marketplace. The initial enrollment period for this new coverage option remains open until March 31st. We believe our focus should continue on the NYSOH before shifting to a new program, especially without much needed federal guidance and a state calculation of the costs and potential savings.

- Living Wage for Nursing Home Workers: The provision in the Executive's plan that establishes standard rates of compensation — a living wage — for nursing home employees raises some concerns, particularly in that it requires that managed care contracts support this standard wage but offers no guarantee that government will recognize the contract requirement and support it with adequate rates. Too often government mandates are not fully funded. The recent living wage for Home Care workers is an example of a state mandate not 100% paid for, with the balance expected from providers and plans. Government must guaranty 100% funding of the nursing home worker living wage proposal.
- Global Cap Dividend: A provision in the Executive budget authorizes the distribution of savings achieved under the Medicaid Global Cap to be distributed proportionately among providers and health care plans. On its face, this sounds like a win for all involved. However, the potential of a dividend is undercut by the addition of living wage payments to nursing home workers along with the existing home care living wage rule. Additionally, the proposal states that up to half of the dividend can be segregated to pay vital access providers. This program expenditure undercuts the goal of medical savings as a result from improved efficiency, and may reward the inefficient.

- Out-of-Network: Although not outlined in the Health and Medicaid section of the budget plan, the Executive nonetheless did include provisions designed to address an ongoing area of concern in health care — access to and payment of services delivered by out-of-network (OON) providers. The provisions include: Requirements for OON health care providers to provide cost estimates for services rendered to patients *if requested*; protections to hold consumers harmless from "surprise bills"; creation of a dispute resolution process to mediate OON claims payment disagreements; requirements for insurers to provide access to OON health care providers if the insurer does not have a network provider with training and experience to meet the insured's needs; and requirements for insurers that offer an OON option for group policies to "make available" another OON option that covers "at least 70% of usual and customary costs," with that calculation based on the FAIR Health database.

HPA and its member health plans have wrestled with the challenge of finding a balance that ensures patients have access to OON services when needed while also protecting all patients from being subject to surprise bills and exorbitant balance bills. To this end, many the goals of the Executive's proposals are laudable and we support the efforts to ensure greater transparency of health care prices as well as those to provide expanded consumer protections for consumers against OON emergency room and surprise bills through a reasonable arbitration mechanism.

But, as is often the case, the devil is in the details and some of the governor's proposals do not go far enough while others go too far.

For example, for true transparency, consumers need to know not only the plan's reimbursement methodology for OON services, but they also need to know what the doctor's charges will be. As proposed, doctors are required to disclose the price of their services only on request. The same requirement for disclosure should apply to both plan and provider.

As proposed, plans are concerned about the potential of rate suppression by the Department of Financial Services (DFS). Because of the added costs incurred when a consumer goes to a provider outside the plan network, OON products are, by definition, more expensive. DFS's prior approval authority has the potential to lead to price suppression in a desire to ensure the OON make available pricing is attractive. This could result in OON rates being inadequate and, in turn, consumers subsidizing OON products sought by only a few.

Plans are also concerned — and the legislature should be as well — with a provision in the Executive's proposal that gives the DFS Superintendent unlimited discretion to change the OON law to mandate additional options through regulatory power. If this proposal is adopted, it will occur after extensive negotiations among consumers, providers and plans with legislative input. Any change to add new options should likewise be subject to legislative input.

CONCLUSION

The Governor's proposed health care budget provides a thoughtful roadmap for New York to continue its course to improving access to affordable health coverage and quality of care for its residents. HPA and its member plans are proud of the role they have played in these efforts and remain committed to working with you and your colleagues on initiatives that keep New York moving forward on this course. We thank you for the opportunity to share our views today.