New York HPA Health Plan Association

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March 12, 2021

Hon. Liz Krueger
Chair, Senate Finance Committee
Capitol Building 416C
Albany, NY 12247

Hon. Helene Weinstein
Chair, Assembly Ways and Means Committee
LOB 923
Albany, NY 12248

Hon. Neil Breslin
Chair, Senate Insurance Committee
Capitol Building 430C
Albany NY 12247

Hon Kevin Cahill
Chair, Assembly Insurance Committee
LOB 716
Albany, NY 12248

Hon. Gustavo Rivera
Chair, Senate Health Committee
Capitol Building 502C
Albany, NY 12247

Hon. Richard Gottfried
Chair, Assembly Health Committee
LOB 822
Albany, NY 12248

Dear Senator Krueger, Assemblywoman Weinstein, Senator Breslin, Assemblyman Cahill, Senator Rivera, and Assemblyman Gottfried:

Thank you for the opportunity to present comments during the Joint Legislative Budget Hearing on Health before the Assembly and the Senate on Thursday, February 25, 2021 on the Governor's proposed Health and Mental Hygiene bill (A.3007-A/S.2507-A). As a follow-up to our testimony, the New York Health Plan Association (HPA) would like to respond to several issues raised during the course of the hearing that are outlined below by topic. We appreciate your willingness to continue the dialogue on these important issues and hope to have an opportunity to follow up with you and your staff in the next couple of weeks.

Pay and Pursue

During their testimony, the Greater New York Hospital Association (GNYHA) and the Healthcare Association of New York State (HANYS) requested that legislators consider adopting what is known as "pay and pursue" policies in their one house budget proposals. This proposal would require that hospital claims be paid *before* hospitals submit information needed to determine whether the service or treatment was medically necessary. It would create a new, lengthy and costly negotiation process whereby each medical necessity claim denial would be reviewed and negotiated by health plans and hospitals prior to a health plan being able to pursue a refund from the hospital for any overpayments. Under this construct, with payments already having been made to the hospital, there would be no mutual incentive to resolve disputes on the merits.

Adopting a new pay and pursue process would establish a case-by-case negotiation of each claim denial resulting in a patchwork of inconsistency as to what constitutes medical necessity. Moreover, the process would undermine New York's External Review statute, which allows for a qualified, state certified external review entity to independently determine the appropriateness of care when disagreements arise between health plans and providers. Since its passage in 1997, the external review process has worked well and has been successful in providing an objective means for determining when care is medically necessary.

There is no policy basis or any data to support the necessity for this new approach, which will make it more difficult to ensure that care is clinically appropriate, is performed in the most appropriate site of service, and that providers follow best practices. Further, it creates an incentive for upcoding or conducting unnecessary or duplicative testing and limits the ability to identify medical errors.

Instead, the purpose of this proposal is to simply increase payments to hospital systems, regardless of whether such payments are appropriate. This will result in higher health care costs for consumers, employers, labor unions, the state employee benefit program and the Medicaid program. At a time when you and your colleagues are grappling with the magnitude of the state budget deficit, increasing the cost of hospital care will intensify the fiscal challenges facing the state. Further, pay and pursue will undermine the quality of care and exacerbate the rising cost of health care for all New Yorkers. In short, the hospital association's pay and pursue proposal is nothing more than a financial windfall for hospitals and a huge hidden tax on New York consumers.

Insurance profits during COVID19

Over the course of the hearing, several legislators and witnesses referenced private insurance company profits in 2020. While some plans may have experienced a surplus in the second quarter of 2020 due to the suspension of elective and non-urgent procedures, the resulting reduction in medical utilization merely delayed the delivery of care into the latter half of 2020 and into 2021. Since the third quarter of 2020, health plans have experienced a return to anticipated utilization and, in some instances, increased utilization levels above what was anticipated.

It is important to note that measures exist to limit health plans' annual profits, as New York has one of the nation's most stringent medical loss ratio (MLR) standards for how the premium dollar is spent, requiring health plans to issue rebates if they fail to meet these standards. This protects consumers by ensuring that the bulk of the premium dollar is spent on medical care. These standards will address any unexpected performance gains in 2020 and will ensure that rebates are paid to employers and consumers by June 2021. In the Medicaid program, the state has taken a COVID rate adjustment, which extracted over $1.5 billion from plans at the end of February 2021.

Since the outset of this unprecedented national crisis, HPA's member health plans have been doing their part, working closely with the state and partners in the provider community to combat the coronavirus, ensure patients have access to needed care, and helping employers struggling with the economic impact of this pandemic. Among the steps that our health plans have taken are:

- Eliminating cost-sharing for telehealth services to ensure New Yorkers could access the care they needed while limiting the exposure of hospital personnel and patients to the coronavirus;
- Providing financial support to hospitals and others in the delivery system to mitigate the economic damage the pandemic has inflicted on providers;
- Extending premium grace periods to individuals and small business to help them maintain coverage, as well as providing premium rebates;
- Early in the pandemic, hundreds of health plans' clinical staffs responded to the state's request for doctors, nurses, and nurse practitioners to assist at hospitals and serve on the frontlines as part of New York's COVID-19 response; and
- Donating tens of millions of dollars to nonprofit and human service organizations to support a range of community needs related to the coronavirus.

Now, health plans are working with the state, local governments, and the delivery system to provide information to the public on the importance of the COVID-19 vaccines and that they will be able to receive a vaccination at no cost. We are proud of the work of our members in response to this crisis and will continue to be constructive partners to combat this disease.

Early Intervention
During the hearing, several legislators discussed changing the payment structure for early intervention (EI) services as a local aid relief measure. While we understand the state's desire to reduce their and the counties' costs of the early intervention program, we are concerned with shifting those costs to privately insured individuals, small businesses and union benefit funds as it adds to their health care costs.

Health plans currently pay for medically necessary EI services that are evidence-based, clinically appropriate and provided within the network rules. As part of the FY2012-2013 budget, the state designated health plans as the first payer for early intervention services, requiring municipalities and the state to split the cost of any non-medical services not initially covered by the health plan. The state established an early intervention fiscal agent (SFA) to manage submission of claims. The state specified, in guidance released in March of 2013, that "any claims which are denied by an insurer for reasons beyond the provider's control (such as lack of medical necessity, service not covered, visit limits or service caps reached, etc.) will be paid by municipalities through the SFA at State established rates for the Early Intervention Program."[1]

Since 2013, health plans have worked with the fiscal agent and paid claims relating to the medical benefit. During the hearing, some witnesses suggested imposing a covered lives assessment on insurers to pay for developmental or educational non-medical services. HPA opposes this approach as it will drive up the cost of health insurance premiums for employers, consumers and union benefit funds.

Further, transitioning to a covered lives assessment to move the cost of early intervention services from the state and municipalities onto commercial coverage does nothing to improve the quality or efficacy of services provided to children, or assure they are evidence-based and necessary. Shifting early intervention costs without making meaningful reforms to ensure that the services are appropriate is nothing more than a huge hidden tax on the cost of health coverage for employers and consumers. Ultimately, this would blur the line of what has traditionally been covered by health plans by requiring payment for services that are largely developmental or educational in nature. Rather than pushing the cost of early intervention services onto health insurance, the state should be reviewing and aligning the early intervention fiscal agent contract to account for unfulfilled obligations, and reviewing utilization of services in the program to assure that benefits provided are evidence-based.

Mental Health Parity
During the hearing, some witnesses raised issues regarding the rate of denial of mental health and substance use disorder claims. In response, we reviewed the publicly available data on the Department of Financial Services' (DFS) website. Based on the independent information, we disagree with the assertion that there is a high rate of claims denied for these services.

State data indicates that health plan members have access to needed mental health and substance abuse services. Health plans process hundreds of millions of claims annually and from 2019-2020 and 2021 so far, combined just 10,308 went through the external appeals process; 1,246, or 12%, of these relating to mental health or substance use disorder claims. Of the 1,246 claims sent to external review, only 475 claims were upheld as denials. With nearly, 11 million fully insured New York residents eligible to access the external appeals process, this is an extremely small fraction of a percent of overall claims, far smaller than those cited during the budget hearing.

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1 https://www.health.ny.gov/community/infants_children/early_intervention/docs/provider_agreement_clarification_q_and_a.pdf

2019-2020	Total	Upheld	Partially Upheld	Overturned
All External Appeals	10,308	6116	176	4016
MH Appeals	570	232	44	294
%	6%	40.7%	7.7%	51.5%
Substance Abuse	676	243	11	422
%	7%	35.9%	1.6%	62.4%

Source: Department of Financial Services website

Our member health plans are committed to ensuring that New Yorkers are able to get the care they need, and place a high priority to making available extensive networks of qualified providers to meet the behavioral health and substance abuse needs of patients. Plans take seriously their obligations to abide by parity requirements. There is significant oversight and ongoing reporting of health plan compliance with state and federal mental health parity laws by a broad range of state agencies, including the Office of Addiction and Substance Abuse Services and the Office of Mental Health, as well as the Departments of Health and Financial Services. We are unaware of any reporting or evidence to indicate that plans are not fulfilling their obligations.

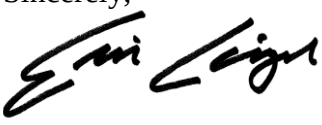
Telehealth

Many legislators and witnesses expressed support for the Governor's proposal to expand access to telehealth services and we are supportive of several provisions in the Executive's budget as noted in our written testimony. In response to the pandemic, health plans have expanded the types of services available through telehealth and other innovative technologies that support remote care and are committed to building on these efforts to improve the quality and availability of health care throughout the state.

While we support expanding access to telemedicine, the bill is silent on reimbursement rates. The use of technology in other industries has ultimately benefitted consumers through greater productivity, increased efficiency and lower costs, and health plans and employers already are implementing telemedicine services. Requiring the same reimbursement as an in-office visit would eliminate any potential savings for individuals and employers. HPA urges the Legislature to allow plans the flexibility to set rates as appropriate, rather than require payment parity with an in-office visit.

Thank you again for providing HPA with an opportunity to offer testimony at the February 25 Joint Legislative Budget hearing and to submit this response to discussions held during the course of this hearing. I look forward to an opportunity to meet with you and your staff in the coming weeks to continue this dialogue. In the meantime, if you have any questions or need additional information on the issues outlined in this letter, please do not hesitate to have your staff contact me at 518-462-2293 or elinzer@nyhpa.org.

Sincerely,



Eric Linzer
President and Chief Executive Officer