Testimony of the New York Health Plan Association

to the

Senate Finance Committee
and the Assembly Ways & Means Committee

on the subject of
FY24 Executive Budget Proposals
on Mental Hygiene

February 16, 2023

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 27 health plans that provide comprehensive health care services to more than eight million fully-insured 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. These partnerships include collaborating on efforts to develop affordable coverage options for individuals, families and small businesses, providing access to care that exceeds national quality benchmarks for both commercial and government program enrollees, and improving access to quality care in its government programs. HPA members include plans that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), public health plans (PHPs) 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 — and through New York's exchange, the NY State of Health (NYSOH).

We appreciate the opportunity to offer our view on the proposed FY24 Executive Budget in relation to its application for spending and policy on mental hygiene priorities, as outlined in A.3007/S.4007, Part II.

PRIVATE RIGHT OF ACTION ON BEHAVIORAL HEALTH – OPPOSE

The FY24 Executive Budget authorizes private rights of action, allowing individuals to sue commercial health plans for alleged mental health parity violations and noncompliance with other provisions of the insurance law related to behavioral health.

Permitting lawsuits against health plans is an ineffective approach to improve access to behavioral health (BH) and substance use disorder (SUD) services. Health plans worked diligently throughout the pandemic – and continue today - to assure access to critical BH and SUD services for members and employees, and health plans have continued to reach out to the Offices of Mental Health (OMH) and Addiction Supports and Services (OASAS) in repeated efforts to address concerns in a meaningful and cooperative manner.

We strongly object to this provision for the reasons outlined below:

- **Multiple meaningful measures already exist to address prohibited mental health coverage practices.** Health plans are subject to both State and federal mental health parity requirements, multiple additional BH and SUD statutory, regulatory and contractual mandates and requirements, as well as oversight from multiple federal and State agencies. New York has strong consumer protection standards related to internal and external appeals processes, and access to BH and SUD treatment, including medications, utilization management activities and more. Both the federal and State governments have broad existing authority to enforce all of these requirements through a number of means, including civil monetary penalties and revocation of licensure. Additionally, the Supreme Court has found health plan liability statutes to be preempted by ERISA, see Aetna Health Inc. v. Davila, 542 U.S. 200 (2004).

  Allowing private rights of action would undermine appropriate and balanced regulatory agency enforcement, and inhibit regulators' ability to shape policy. This would result in inconsistent court rulings, leading to less clarity, not more.

- **Private Rights of Action would lead to higher health care costs for employers, consumers and taxpayers.** Health plans would be forced to insure against potential litigation, raising the cost of coverage to employers, consumers and taxpayers (as this

provision would apply to State employees' health insurance[1]), when affordability should be a larger concern. Moreover, this vaguely written provision leaves open questions regarding who has legal standing to sue, who would bear the cost of litigation, and the rules of liability and burden of proof to win. Clearly, the State understood the potential cost of such litigation, as Medicaid, Child Health Plus and the Essential Plan were purposefully excluded from the provision.

- **Private Rights of Action are an Ineffective Way to Address Concerns with Behavioral Health Care.** This provision would do nothing to expand consumers' access to effective behavioral health services. As other provisions of the FY24 Executive Budget seeking to expand services demonstrate, the State's delivery system is not meeting its residents' needs. For example, the FY22 Enacted Budget authorized the establishment of crisis stabilization services statewide. Two years later, OMH and OASAS still have not implemented a statewide system of such services. In addition, BH and SUD providers struggle to coordinate care across the continuum, and are not subject to any meaningful quality of care or outcome measures. Too few of them have the capacity to enter into value-based arrangements. The private right of action provision does nothing to address any of these issues – or to confront the workforce shortage in BH, the children's BH care crisis or the inadequate infrastructure to appropriately care for individuals in crisis.

HPA urges the Legislature to reject this proposal.

[1] Section 162(1)(b)(i) of the Civil Services Law: requires NYSHIP to comply with "Any and all health insurance coverage mandated by any law, rule or regulation, including but not limited to coverage mandated pursuant to article forty-three of the insurance law."

COVERAGE EXPANSIONS – OPPOSE

The FY24 Executive Budget includes several specific behavioral health related service expansions for commercial health insurance, which would also apply to the NYS Health Insurance Program – *all effective January 1, 2024*, including:

- Sub-acute care in medically monitored residential facilities;
- Mobile crisis intervention;
- Critical time intervention;
- Assertive Community Treatment (ACT) following hospital discharge; and
- School based mental health clinics.

The addition of these specific services to statutory language is unnecessary. Mental health parity ensures coverage of BH services at levels that are consistent with the coverage provided for medical services and this is reflected in model contract provisions developed for plans by the Department of Financial Services (DFS). Some of these services are vaguely defined. For example, ACT includes such services as "vocational training" and "community linkages" which would not typically fall within the scope of covered services within a health insurance program. Pursuant to federal law, the State would have an obligation to offset the cost of these new mandates within individual and small group policies eligible for Affordable Care Act subsidies although the budget does not appear to account for this. Moreover, we are concerned with a statutory coverage effective date of January 1, 2024, when availability of the additional services for all plan enrollees by that time is questionable. As noted above, in the FY22 enacted budget (passed in April 2021), OMH and OASAS mandated coverage for crisis stabilization centers, effective January 1, 2022. Almost two years later, crisis stabilization services are not available statewide and there is no timeline to achieve statewide availability.

HPA is not opposed to an expansion of available services to address BH and SUD needs, or to the development of services to fill long-standing gaps in the continuum of care overseen by OMH and OASAS. We are opposed to statutory change as the path to get there. **We urge the Legislature to reject these statutory coverage expansion mandates and instead work with**

OMH and OASAS to provide timelines for when each of the planned service expansions will be operational.

LIMITATIONS ON UTILIZATION MANAGEMENT – OPPOSE

The FY24 Executive Budget also includes a provision to preclude plans from doing prior authorization, or concurrent review for the first 30 days of an inpatient psychiatric hospital stay for individuals 18 years of age or over. This provision will make coordination of care and care transitions more difficult, create a disincentive for providers to communicate with plans, and is likely to lead to longer lengths of stay than necessary. When the State imposed a similar requirement for 14 days of inpatient SUD treatment in 2016, plan data indicated that the length of stay consolidated around 13 days – to allow providers to avoid engaging with plans in concurrent review. Before the 14-day mandate, discharges were equally distributed around seven, 14, 21 and 28 days – indicating that plans were authorizing care as needed – whether for less ***or more*** than 14 days.

HPA urges the Legislature to reject the elimination of prior authorization and limitation on concurrent review for adult psychiatric inpatient stays. Rather than expanding the mandated number of days for inpatient psychiatric treatment, the State should focus on developing standards for coordinated care management across the delivery system, in collaboration with plans and providers. The State should require providers to communicate with the plan throughout the inpatient stay and begin to engage in a discharge planning process with the plan well in advance of the member's discharge from inpatient care – to assure that the member receives the most appropriate next level of treatment upon discharge from inpatient treatment. In addition, despite all the steps New York has taken to set rules for what services must be covered, there remains a lack of outcome measures to evaluate the effectiveness of the treatment being provided and whether providers and facilities are following evidence-based standards. In the coming year, the State should put in place systems to publicly report on provider outcomes to monitor the quality of care being provided and ensure that the full range of evidence-based treatment options are available to individuals throughout the continuum of their care. Plans must be involved from the beginning of the hospitalization to ensure that

children and adults, and their families, receive the most appropriate care across the continuum.

MENTAL HEALTH NETWORK ADEQUACY EXPANSION – OPPOSE

The FY24 Executive Budget proposes an expansion of network adequacy standards under the Insurance law for mental health. Plans share the State's concerns that individuals are not always able to access behavioral health care in a timely manner – especially in light of the pandemic's impact on the need for BH and SUD care - and work diligently to get members the care they need. Plans gain nothing by failing to provide members with evidence-based, necessary care – whether medical or behavioral – and are well aware of the cost impact on the medical side of not addressing members' behavioral health needs. However, issues of access will not be resolved by imposing more rigorous behavioral health network adequacy standards on plans, since the underlying issues with the delivery systems are far more complicated, involving provider issues and State policy. Expanded network adequacy standards will not address the behavioral health workforce crisis or insufficient provider capacity, nor will they improve the quality of care provided. **HPA urges the Legislature to reject these provisions.**

CONCLUSION

HPA and its member plans are at the forefront of integrating physical and behavioral health care. Plans remain committed to working with you and your colleagues on initiatives and strategies that help ensure New York individuals, families and businesses continue to have access to high-quality, affordable health insurance.

We thank you for the opportunity to share our views today.