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HCFANY Testimony for Public Hearing on Implementation of the Affordable Care Act before the Senate Committees on Health and Insurance

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Prepared by:
Health Care for All New York

Health Care For All New York (HCFANY) would like to thank the chairs and members of the Senate Insurance Committee and Senate Health Committee for the opportunity to submit our testimony on the implementation of the Affordable Care Act to date. HCFANY is a statewide coalition of over 160 organizations dedicated to winning quality, affordable health coverage for all New Yorkers. We strive to bring consumer voices to the policy conversation, ensuring that the concerns of real New Yorkers are heard and reflected. We also provide expert policy analysis, advocacy, and education on important health policy and coverage issues. For more information on HCFANY, visit us on the web at **www.hcfany.org**.

Everyone in New York State has the right to affordable, comprehensive health care. The NY State of Health is helping us get there.

We are pleased to be able to begin our testimony on a note of commendation. In stark contrast to some other states with state-based exchanges and to states that have relied on the federal exchange, New York has done a remarkably effective job on implementing the Affordable Care Act.

Health Care For All New York
c/o Elisabeth Ryden Benjamin, Community Service Society of New York
105 E. 22nd Street, New York, New York 10010
(212) 614-5461

Through the dedicated efforts of NY State of Health Marketplace officials, regulators in the Department of Health and Department of Financial Services, the insurance plans who write coverage in this State, navigator and consumer assistance agencies, and other stakeholders, hundreds of thousands of New Yorkers have successfully signed up through the NY State of Health website, and the State is resolving any website glitches as they arise.

More than 240,000 New Yorkers enrolled in new health care plans during the first three months of the marketplace. About 175,000 enrolled in private insurance and the remaining 66,000 enrolled in Medicaid. The pace of enrollment has continued with approximately 30,000 additional enrollees in the first ten days of this year. Aggregate enrollment exceeds 270,000. The NY State of Health is on track to meet its 3-year goal of 1.1 million enrolled in new health insurance plans.

New Yorkers and their families are finding more affordable health care on the NYSOH

Premiums for plans on the NY State of Health are overall 53% cheaper than those available to individuals before the launch of the Marketplace. Three of every four individual enrollees will qualify for financial help to purchase insurance. Many individuals who qualify for premium subsidies will also receive assistance with their cost-sharing obligations. We can and must continue to address affordability and quality of coverage by ensuring adequate provider networks, by making out-of-network coverage more fair and transparent, and by setting a long term goal of increasing the Medical Loss Ratio (MLR) in New York State. In addition, we need to protect low- to moderate-income families who may still find the premium costs, even with federal subsidies, unaffordable. We can do so by instituting a Basic Health Program

Basic Health Program

Premium costs may be an unsustainable burden for those at the lower end of the income scale. Forty percent of low- and moderate-income New Yorkers have credit card debt, 26 percent have medical debt, and 32 percent report have no savings at all, leaving these residents with little or no disposable income with which to pay for health insurance.[1] The good news is, under the ACA New York has the option to create a Basic Health Program for consumers between 138 and 200 percent of the Federal Poverty Level. This would offer consumers who qualify a more affordable option, with low or no premium and very low out-of-pocket costs. Thousands of New Yorkers would benefit from this program.

[1] 1. Community Service Society of New York, The Unheard Third Survey, "Hardships and Personal Worries for Low-Income New Yorkers," December 2010, available at http://www.cssny.org/userimages/downloads/UnheardThird2010HardshipsandPersonalWorries.pdf.

For example, take Susan Rumack, who we interviewed during our 2012 Listening Tour[2]:

Susan is a 62 year old Buffalo resident. She is unemployed and has not had insurance since her last job ended. She lives on a small amount of income from shrinking investments, but she still makes too much to be eligible for Medicaid. Susan has been unable to afford individual insurance, from Healthy New York to the New York Bridge plan, so she visits a doctor only in emergencies and does her best to manage her diabetes on her own. Susan told us she hoped New York would create a BHP, because, in her words: "I think it's my best hope for quality health care that I can really afford."

The State could also save money through creating a BHP. The federal government will provide significant funding for this program, which would cover thousands of New Yorkers, such as lawfully present immigrants, who are currently covered with State-only funds. We strongly recommend creating a Basic Health Program in New York State.

Because of consumer assistance, thousands of New Yorkers are receiving the support they need to find and enroll in a plan that is right for them and fits their budget

The State established a network of consumer assisters, called Navigators, to help consumers enroll in the NY State of Health. Over 6,000 individuals have been trained by the State to serve in this role. They offer free, unbiased assistance, as they are not connected to an insurance plan. We should continue to support these vital consumer assistance programs by establishing a sustainable funding stream, while continuing to streamline the program.

Transitional enrollment problems need to be addressed

Despite these successes, New Yorkers deserve improvements to the enrollment process. Many of the problems lie with individual insurance carriers which apparently have not adequately prepared for a transition of this magnitude. Bills are going out with insufficient time for consumers to pay their premiums. Insurance cards are not being issued in time. Provider networks are confusing: many people are finding it difficult to ascertain the network status of their current providers and to see the provider networks that would be available to them when choosing a plan. Some who had previous coverage, including those with concurrent Medicare coverage and those who had point of service coverage, are encountering obstacles to enrolling in the substitute plans that have been arranged for them. In part, this is because insurance company personnel have not been educated about these programs.

[2] C. Tracy and A. Slagle, "Health Coverage that Works for New Yorkers: Health Care for All New York's 2012 Listening Tour," Community Service Society, June 2013.

We are confident that regulators are addressing these problems, once identified, as fast as they can. But, in some cases the remedies are not coming fast enough. Each insurer should be required to make special personnel available to verify coverage and authorize treatment for new enrollees whose cards have not yet been issued and premiums not yet processed. To the extent that misinformation about rights to enroll in specific coverage has prevented individuals from enrolling in the programs that best suit their needs, the Department of Financial Services should institute a correction program to retroactively enroll them in the programs that were concealed from them or for which they were erroneously told they were ineligible.

Marketplace outreach and enrollment strategies must be inclusive, comprehensive and accessible, and we need increased transparency and consumer engagement

We must continue to take significant steps to ensure that all consumers are adequately informed about the Marketplace and can easily enroll. For example, the NY State of Health should be able to enroll all populations directly, including people with disabilities and certain cancer diagnoses who currently must enroll separately. We must continue to simplify enrollment. More steps should be taken to ensure that the website and informational materials meet the needs of English-language learners and people with disabilities, for example, by translations of the website and written materials into multiple languages. And outreach programs should be comprehensive enough to reach the State's major demographic groups, particularly communities of color, low-income New Yorkers, and immigrants.

New Yorkers need increased transparency as well as additional opportunities to provide input and engage with the NY State of Health. For example, while New York's enrollment numbers are impressive, we don't yet know the makeup of enrollees. Without breaking down enrollment data demographically, we don't know if the ACA is adequately serving New Yorkers of all backgrounds, as well as low-income people. We recommend that the NY State of Health provide monthly public data reports on enrollment, which is broken down by demographic factors such as race/ethnicity, disability status, income, LGBT status and other important factors. The data should also be broken down geographically to ensure that all regions of the state are being served and to pinpoint any gaps in the State's outreach and marketing efforts for the Marketplace. Finally, the Marketplace's existing consumer input processes, including the regional advisory councils, should be enhanced, for example by establishing additional task forces to address priority topics, like reducing health disparities, in more detail. Expansion of public input will not only improve the operations of the Marketplace, but will also increase the likelihood that "hard to reach" populations enroll and benefit from health reform.

Adverse impacts of implementation need to be addressed

Sole Proprietor Coverage

Most New Yorkers whose coverage in the current standardized individual market is being cancelled will find far cheaper premiums in the new market. As noted above, the 53% reduction in premiums resulting from the influx of thousands of new health individuals into the market will benefit them. Other individuals, such as those who have purchased sole proprietor coverage in the past, may see moderate increases in their premiums on NY State of Health. Some of this dislocation is attributable to the removal of preferential rules for their coverage in the past that did not have strong justification. But we believe there are several mechanisms to address the adverse effects on them.

Merging the individual and small group markets

Sole proprietors enjoyed substantial preferences under pre-ACA law. Their premium rates were kept artificially low by a statute mandating sole proprietor coverage be offered at only 15% above small group rates. In contrast, in the standardized individual market premiums were roughly double the small group rate. Further, the market for sole proprietors required, as the ticket to entry, that one show recent work history as a sole proprietor. This excluded seriously ill and disabled people without recent work history. In essence, this was a means of creating a lower risk profile in the sole proprietor market than in the rest of the individual market, based on the sort of health underwriting that New York had otherwise sought to outlaw.

The Affordable Care Act requires that sole proprietors be pooled with the individual market, removing those preferential rules. Given this history, it makes sense that when sole proprietors may see their premiums rise when they move to the individual market. But we should recall that according to a Families USA study,[3] 74% of New Yorkers who are at risk of losing their current individual insurance plans are likely to qualify for financial assistance to pay for the new plans available to them. For those whose coverage is cancelled, and who cannot find equally affordable coverage in the marketplace, the Obama administration has offered a 1-year reprieve from the individual shared responsibility payment. But ultimately we believe the solution to these rising premiums is to merge the individual and small group markets. This will create a single, large risk pool in which insurance cost does not depend on arbitrary differences in employment status, and in which the sole proprietors are not ping-ponged back and forth between two markets, individual and group, with great disparities in premium. They will instead be part of a much larger pool that averages both markets.

[3] : http://www.familiesusa.org/ACA-individual-market/#About

Out-of-network Coverage

When sole proprietors were moved from the small group to the individual market they lost more than a price advantage. They also lost access to out-of-network coverage. The frustration expressed by sole proprietors echoes that of individuals who also had access to out of network coverage in our direct pay market until this year. This loss has nothing to do with the Affordable Care Act. Rather, it is the result of an unfortunate policy choice which New York made that affects the individual market generally.

Nothing in the ACA restricts insurers from out-of-network coverage in the individual market. Indeed, we have confirmed through a survey of other states, a copy of which is annexed[4], that point of service, PPO, or even indemnity coverage, all of which reimburse for services outside the insurer's network, are broadly available in at least 47 states and the District of Columbia. The only states where we have not been able to confirm the sale of such coverage in the individual market are Massachusetts and New Hampshire.

New York, which has for decades been a leader in protecting consumer rights in health insurance, should not now become an unfortunate outlier. We recognize that the administration and the Legislature acted out of good motives last year when they abolished the requirement that HMO's offer individual point of service coverage. Their intent was to reduce premiums, to encourage Private Health Services Plans (PHSP) that did not customarily offer such benefits to participate in the NY State of Health, and to maintain an even playing field between commercial plans and the PHSPs. But we believe that decision was nonetheless ill-advised. It removed a consumer protection that is important to many people who are willing to pay more for the freedom to choose an appropriate specialist rather than fight with their health plan for an out-of-network exception. Due to this decision, very few plans on or off NY State of Health offer out-of-network coverage; none at all in downstate New York.

The goals the State sought to achieve by removing the requirement for out-of-network coverage can be achieved through other means. Out-of-network riders can be separately priced in a way that does not adversely affect the affordability of the basic insurance product. PHSPs can be given a transitional period to develop the mechanisms for out-of-network payment. The even playing field can be maintained through more robust risk adjustment. The problems of adverse selection are substantially diminished when there is a mandate for all individuals to purchase coverage.

[4] Out of Network Coverage in the Individual Health Insurance Market: A National Survey, January 10, 2014. We are indebted to intern Alec DeVivo, Haverford 2014, for performing the survey and writing the report.

We also recognize that commercial insurers may now experience out-of-network coverage as a major headache, in that there are so many disputes over the level of out-of-network reimbursement. The consumer who is rendered a surprise bill by an out-of-network anesthesiologist she has never met, after surgery by an in-network doctor at an in-network hospital, will naturally be dismayed and furious when her insurer fails to cover that unexpected bill in full. The consumer who recently got preauthorization for an out-of-network stereotactic radiosurgery of the brain and was reimbursed just 4% of the billed amount of over $80,000, an amount less than one eighth of the amount the Fair Health data base said was the usual and customary charge for that service, based on a fee schedule that was not previously disclosed to him, was bound to be upset with his health plan. But the remedy for this headache is not abolition of out-of-network coverage. It is legislation that New York failed to pass last year and must reconsider this term: that is, to ensure disclosure to consumers of network status of providers and of fees charged, to ensure adequacy of networks across all plans in the market so as to reduce the need for out-of-network services, and to institute an arbitration process directly between health plan and providers over surprise out-of-network fees which takes consumers out of the middle, and makes them responsible only for their in-network copayments.

To reinstate out-of-network coverage, we would suggest a two-stage approach. First, enact immediately effective legislation to allow all sole proprietors, individuals coming off COBRA, and others who are losing their out-of-network coverage, to purchase the riders that have already been developed for individuals who were losing Direct Pay point of service coverage. Second, pass a law along the lines of Senator Hannon's bill, S. 6207, requiring insurers and, after a transitional period, PHSPs, to offer optional out-of-network coverage along with their basic coverage.

A combination of the Basic Health Program, market merger, network adequacy rules, protection from surprise out-of-network bills, and a mandate to offer optional out-of-network coverage will go a long way to ensuring that the coverage New Yorkers obtain under the Affordable Care Act will cover them fully when the face serious health challenges. And our recommendations in regard to inclusive, comprehensive and accessible, outreach and enrollment strategies, affordability and transparency will significantly enhance the number of New Yorkers that will benefit from health reform.

We thank you again for the opportunity to offer this testimony.

Mark Scherzer
Legislative Counsel, New Yorkers for Accessible Health Coverage
Co-Chair, Policy Committee, Health Care for All New York