



Testimony of the New York Health Plan Association

to the

**Senate Finance Committee
and the Assembly Ways & Means Committee**

**on the subject of
2023 Executive Budget Proposals on Health Care**

February 8, 2022

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 29 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.

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).

Our member health plans have been consistent and reliable partners 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's members remain committed to continuing to work with New York policy makers and lawmakers to support consumers and employers, particularly as New York continues to confront the ongoing challenges of the continuing coronavirus public health crisis.

We appreciate the opportunity to offer our view on the proposed 2023 Executive Budget in relation to its application for health care spending in New York.

Medicaid Managed Care Procurement: Part P (§§ 1-7) – Oppose

For nearly 30 years, New York's managed care plans have been partners with the state, establishing and growing the extremely successful Medicaid managed care program, working together to expand coverage, increase access and improve quality of care. With plans' leadership, New York's Medicaid managed care program routinely meets or exceeds the national average on quality measures and improving patient satisfaction. Today, more than 5.5 million of New York's Medicaid beneficiaries – 78 percent – receive their care through a

Medicaid managed care plan. It is with those 5.5 million New Yorkers in mind that we offer our thoughts about the Medicaid spending plan in the Executive Budget.

The Governor's budget proposal includes a provision – Part P – that would require the Department of Health to procure nearly the entire Medicaid managed care program. The proposal, which includes MMC, MLTC, MAP and HARP, but excludes HIV/SNP plans, directs the Department to select at least two but no more than five plans in each region for the different product lines, with an effective date of October 1, 2023.

This will result in fewer Medicaid managed care plans, limiting choices available to the state's most vulnerable residents. Eliminating health plans from the program will take away options from millions of New Yorkers who rely on these health plans, which could force hundreds of thousands of individuals – maybe more – to select a new plan. The possibility for interruptions in patient care as individuals may be forced to change providers is significant. Often these individuals have multiple health conditions that require coordination of numerous services that include both physical health and mental health care, long-term services and supports, as well as help coordinating social services, such as housing, employment, education, and food access services. The example below illustrates the integrated approach our members take to support-the physical, mental and socioeconomic wellbeing of the individuals served by the Medicaid program.

CARING FOR CONSUMERS: PROVIDING SUPPORT TO REMAIN AT HOME & IN THE COMMUNITY

Mary, an 82-year-old who has multiple sclerosis, osteoporosis and asthma, who requires assistance with toileting, taking medications, preparing meals and transportation to her medical appointments. She's been enrolled in a Medicaid health plan since 2013, which has provided her with personal care assistance services and durable medical equipment supplies so that she's able to remain in her home, despite her health challenges. On the few occasions that *Mary's* needed to go to the hospital, her plan has made sure that the necessary in-home services are in place when she's returned home, and was able to arrange for an in-home COVID vaccine and flu shot at the height of the pandemic. As a result of her health plan, over the last eight years *Mary* has been able to remain at home and in her community.

Executing a procurement of this complexity and magnitude would require a massive reallocation of State resources away from other more important work that needs to be done in the Medicaid program, at a time when the Health Department is already under-resourced.

Efforts to recertify eligibility for more than seven million Medicaid members as the public health emergency ends, and assure continued coverage, expand coverage to new populations, implement better care for Medicare and Medicaid dual members, expand innovative value based payment structures and implement a new 1115 waiver focused on addressing social barriers to health like housing and food insecurity all require the full attention of both the State and the plans and all will suffer because of the procurement.

Further, Part P will undermine the State's goal of promoting health equity as reducing the number of health plans will leave fewer options for Medicaid members, and this will fall disproportionately on minority and underserved populations.

New York's Medicaid program has traditionally emphasized access and patient choice. That is a big reason why New York has successfully enrolled hundreds of thousands of individuals who would otherwise be uninsured. It has also been successful in improving health care outcomes in large part because of the work of the health plans. Limiting the number of health plans will undercut those efforts. The proposal will result in massive disruption to Medicaid recipients but will not produce any savings in the FY23 budget.

Finally, a procurement process to improve the program is not necessary. The State has broad existing contracting authority to make changes to the program, without any of the disruption of a procurement process - including the ability to: define expectations with regard to community investment and participation in 1115 waiver programs and alternative payment arrangements; set clear expectations and define shared metrics for behavioral health, including ongoing progress toward better integration of physical and behavioral health care; implement a quality incentive strategy to promote plan accountability; and swiftly address any issues related to alleged contract violations. Plans are always ready and willing to engage with the State to bring meaningful changes to the program – without the disruption this proposal would bring.

For all these reasons, we urge the Legislature to reject this provision.

State Funded Option for Uninsured, Low-Income Immigrants – Support

While HPA supports provisions in the Governor’s budget to expand coverage, we urge policy makers to build on these proposals and go further on efforts to close the coverage gap by providing a State-funded option available for uninsured, low-income immigrants.

Every New Yorker deserves coverage for high-quality, affordable health care. Over the last decade, New York has made remarkable progress in expanding access to health care coverage to millions of residents, achieving near universal health care coverage through the efforts of the state and private sector working together. With less than 5% of state residents uninsured, the State has been particularly successful in providing insurance coverage to New Yorkers and historically has been a national leader when it comes to addressing the health needs of our immigrant community.

Immigrants constitute the third largest group of uninsured New Yorkers, but a large portion of these individuals are not allowed to enroll in federally-funded coverage options because they are undocumented or are lawfully present but remain ineligible for coverage due to their status.

New York currently provides coverage to some members of this population through State-only funding. In their recently released report, *Narrowing New York’s Health Insurance Coverage Gap*, Community Service Society and the Citizens Budget Commission examined a proposal to expand eligibility for low-income immigrants through the creation of a State-only funded EP option that uses the same income eligibility (individuals with incomes below 200% of the Federal Poverty Level (FPL)).

According to the report, of the 245,000 immigrants with incomes below 200% FPL, 154,000 are uninsured. Utilizing moderate enrollment assumptions, the analysis estimated 46,000 newly insured immigrants. Leveraging existing State Emergency Medicaid spending on this population coupled with additional HCRA revenues, the estimated annual net State cost would be \$345MM, along with a reduction of \$19MM in annual uncompensated care costs to hospitals. Other states have taken steps to provide coverage to low-income immigrants,

including California Governor Gavin Newsom, who recently proposed expanding the state's Medicaid program to all immigrants.

Establishing a State-funded program to provide coverage to these individuals would be an important step in furthering the goal of universal coverage in New York.

Coverage Expansion Efforts: PARTS Q, S & U – Support

HPA and its member health plans believe every New Yorker deserves high quality, affordable health care. To that end, plans have worked with lawmakers and policymakers to advance initiatives that help ensure availability of a range of coverage options while also looking for ways to increase access to coverage. Through these efforts, New York has reduced the number of uninsured New Yorkers to a record low 4.7%.¹

Closing the remaining gap is the goal and the Governor's budget includes a number of provisions to reduce the number of uninsured that we support. These include:

- Expanding Essential Plan (EP) eligibility by increasing the FPL cap from 200% to 250% (Part Q);
- Extending postpartum coverage eligibility to one year following the last day of pregnancy in Medicaid (Part S); and
- Eliminating the \$9 monthly premium in the Child Health Plus (CHP) program for eligible children whose family household income is less than 222% of the FPL (Part U).

¹ NY State of Health Announces Record High Enrollment <https://info.nystateofhealth.ny.gov/news/press-release-ny-state-health-announces-record-high-enrollment-more-49-million-new-yorkers>

The following examples illustrate the work that our members take to support individuals and children served by these programs, including investments to address the social determinants of health by tackling the underlying social, economic, and environmental factors that create barriers to better health. This includes programs to improve access to supportive housing, education, employment and food services.

CARING FOR CONSUMERS: CHILD HEALTH PLUS

When *Alicia's* three-year-old daughter, a Child Health Plus member got sick in September 2021, she thought it was just a cold even though her daughter had tested positive for COVID-19 five weeks prior, but experienced no symptoms at the time. Several weeks later the little girl stopped eating and drinking, was extremely fatigued and had a high fever. "Alicia" took her daughter to the hospital where the little girl was admitted to the intensive care unit and diagnosed with multisystem inflammatory syndrome in children, or MIS-C, a condition some children develop after being diagnosed with coronavirus. Doctors quickly got the girl's symptoms under control, and after she was transferred to the pediatric unit, the health plan's nurse care manager stepped in with its Hospital to Home program designed to keep patients and their loved ones informed during and after a hospital stay. A team helps connect patients with resources they may not be aware of, schedules follow up visits when a patient is ready to be discharged, and oftentimes, just lends an ear to those in need. Through this interaction, *Alicia* opened up, explaining that she had missed several weeks of work while caring for her daughter, falling behind on rent and unsure how she would put food on the table or heat her home. The nurse manager and her team sprang into action, connecting the mom with the resources she would need to get back on her feet. The plan's team helped *Alicia* apply for heating assistance and connected her with a local food pantry. They also put her in touch with a local organization that provides emergency financial assistance to families facing medical emergencies.

*"What started as a horrible situation turned out to be such a blessing," said *Alicia*. "The plan was an advocate for me and my family. It didn't matter if I need help financially or emotionally, they were there for me. I always felt like I was talking to a friend."*

Funding for Health Plan COVID Testing Requirements – Support

It is now almost two years since New York issued a state of emergency in response to the coronavirus pandemic. From the very beginning, our member health plans have worked to protect patients, support our partners in the delivery system, and assist employers throughout this global health crisis. Health plans have made sure that New Yorkers have access to needed care, including coverage of diagnostic testing for COVID-19 without any cost-sharing. However, the cost of testing through 2020 and 2021 was not factored into commercial premium rates for those two years and the recent federal requirement that health plans cover the cost of eight over-the-counter (OTC) tests per month per person were not factored into the 2022 premium rates approved last August.

The cost associated with OTC testing is substantial. Based on data collected from health plans, the potential cost impact for the commercial market is estimated to be over \$125MM per month, assuming 50% of the eligible population accesses the full benefit. For the Essential Plan (EP) and Medicaid, the estimated cost is over \$26MM in EP and nearly \$180MM in Medicaid, assuming 50% of the eligible population accesses the full benefit. With the continuation of the federal public health emergency, the extension of enhanced eFMAP funding through June 30, 2022, and the State projecting a General Fund cash balance of \$27.6BB, we would urge the Legislature to utilize a portion of the federal funding provided to New York to offset COVID testing costs to defray the unanticipated costs health plans have incurred.

Invest in Medicaid Managed Care Rates - Support

Managed Care plan rates have been at the bottom of the allowable actuarially sound rate range since January 2020. In addition, plans have sustained hundreds of millions of dollars in cuts where the related “savings” measures did not result in cost reductions to the plans, and in 2021 were subjected to a \$1.5BB COVID rate cut. At the same time, the State expects plans to fully engage in efforts to improve integrated care for Medicare and Medicaid dual members, accelerate and broaden movement to value-based payment arrangements, and participate meaningfully in addressing the social barriers to health, including supportive housing and food security initiatives. Plans have the capacity, ability and desire to do this work, but they cannot make necessary investments while rates continue to be at the bottom of the rate range, and each year brings financial uncertainty and an inability to make annual – or longer term – financial projections as a result of rates and the rate setting process. The State should make an investment to bring plan rates up from the bottom of the rate range.

Caring for Consumers: Timely Post-Partum Care

A NYC plan established a partnership with Mt. Sinai to develop an intervention and payment redesign program to improve timely post-partum visits for low-income, high-risk mothers. The intervention provided education about health conditions (ex: gestational diabetes, and depression), health behaviors (ex: nutrition and exercise), and common postpartum symptoms; taught self-management skills; enhanced social support; and connected patients with community resources.

The payment reform component included a cost sharing arrangement between the plan and the hospital to cover costs related to employing a social worker and community health worker, and financial incentives for completed postpartum visits (as defined by HEDIS guidelines). Eligible members included pregnant women age 18 and over, who spoke Spanish or English and had at least one of the following: gestational diabetes, hypertension, a positive screen for depression, late registration for prenatal care (20 weeks) or residence in a neighborhood designated as high risk for hypertension or diabetes.

Mandated Coverage of Non-Contracted Providers: PART P (§§ 8 & 9) – Oppose

Sections 8 and 9 of Part P mandate that plans participating in Medicaid managed care, the Essential Plan and as Qualified Health Plans on the Marketplace, contract with NCI-designated cancer centers in their service areas, and that the centers agree to the prevailing terms and conditions that plans require of similar providers, including that reimbursement shall be no less than the fee-for-service Medicaid rate applicable to cancer inpatient and outpatient services. This provision is unnecessary as protections already exist to ensure that patients can access the care they need. Health plans strive to make a robust network of qualified providers available to meet the needs of their members, and access to the provider of their choice remains a strong consumer demand for health plan members who expect that their health plans will make all reasonable efforts to reach agreements with providers. Mandating specific types of providers be included in plans' networks without any requirement on the provider to control their costs or meet performance standards will increase the costs for options available on the Marketplace and do nothing to improve the quality of care for individuals enrolled in these plans. Further, this would have the potential to create an incentive for contracted providers to drop out of health plans' networks and establish a dangerous precedent that other providers would seek to follow.

Telehealth Reimbursement Parity: Part V – Recommend Technical Changes

The Executive Budget includes a proposal that would require telehealth visits to be reimbursed at the same rate as an in person visit. We recommend revisions to this provision, described below.

The promise of telehealth has long been promoted as a way to lower the costs of health care services and has helped to ensure that patients are able to access care during the current pandemic. However, requiring the same reimbursement level as an in-office visit would eliminate any potential savings for individuals and employers. Further, telehealth is not appropriate for all health care services. For example, surgery, sensitive examinations, and some specialties including rheumatology and ophthalmology may not be appropriately delivered via telehealth. Imposing mandated reimbursement levels for telehealth also is contrary to efforts to move the delivery system away from a fee-for-service based structure and toward value-based arrangements. Efforts to expand telehealth should focus on addressing the barriers, specifically the lack of access to broadband and ensuring patients are comfortable with the technology and have the knowledge to use it. Mandating specific reimbursement rates does nothing to address those challenges and only further increases the cost of coverage.

Restoration of the Quality Pools – Support

New York has been a national leader in delivering high-quality care to its Medicaid beneficiaries. This is largely a result of efforts by managed care plans and their provider partners. The Medicaid Managed Care Quality Incentive Program is an essential resource in advancing quality in Medicaid as it rewards managed care plans for the quality of care that they deliver to New Yorkers covered by Medicaid. The measures incentivized by the quality program are at the core of health disparities experienced by low-income communities and people of color and have been essential to New York State's achievement of better health outcomes for underserved populations. We are encouraged by the Executive's investment in the incentive program and support the restoration of funding included by the Governor.

State Alignment with the Federal No Surprises Act: Part AA – Support in Part

The 2020 Federal No Surprises Act (NSA) included in the Federal Consolidated Appropriations Act of 2021 provides federal consumer protections against surprise billing, limits out of network cost sharing and establishes continuity of care and health plan ID card requirements. Part AA is designed to align New York consumer protections with the NSA.

We support the provisions in Subpart A related to adding the median in-network rate as a consideration in the State for the out-of-network dispute resolution process. This is an important component to protect consumers and employers from the market distortions caused by surprise billing and restrain costs for patients. Use of the median in-network rate is in line with the Federal Interim Final Rules on the NSA that qualifying payment amounts (QPA) “should be the primary factor considered by independent dispute resolution (IDR) entities” and that the QPA is the median of the contracted rates between plans and providers.

We also generally support Subpart B, which largely aligns New York’s existing laws with the rules required under the federal NSA on issues related to disclosure of provider directory information as well as disclosure requirements of patient protections related to emergency and surprise bills.

Subpart C seeks to implement several recommendations of the Health Care Administrative Simplification Workgroup (ASW). Established under the FY2020 Budget, and with a report issued this past October, the goal of the workgroup was to advance proposals that would help simplify administrative processes and issues to foster greater communication and cooperation between health care providers and insurers, which will ultimately allow the health care system to provide better care for consumers. HPA participated in the workgroup and views the recommendations set forth in the report as a good blue print to help New York realize those goals. However, work on many of the implementation details of the recommendations is ongoing. Therefore, we do not feel it is appropriate to include the Subpart C provisions in the State Budget. Moreover, these proposals have no budget implications. For these reason, we urge the Legislature to remove the Subpart C provisions.

Coverage for Abortion Services: Part R – Recommending Technical Changes

Part R of the Executive Budget plan codifies much of existing state regulation that requires health plans to provide coverage for abortions. However, the proposal includes a provision that could require out-of-network abortions be provided without member cost-sharing except for high deductible plans. This conflicts with current state regulations that require coverage without cost-sharing only for in-network providers. Part R should be revised to align with current regulations, and make it clear that cost-sharing is not prohibited in instances where an out-of-network provider is utilized.

CONCLUSION

HPA and its member plans remain focused on the task of preserving the highest quality of care in the Medicaid program and protecting New York's most vulnerable citizens while also helping New York improve access to affordable health coverage and quality of care for its residents. We remain committed to continuing to work with you and your colleagues on efforts to strengthen our health care system and help ensure New York individuals, families and employers continue to have access to high-quality, affordable health insurance.

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