CAMPAIGN FOR NEW YORK HEALTH

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To: Joint Legislative Budget Hearing on Health
From: Katie Robbins, Director, Campaign for New York Health (she/her)
Re: Testimony
Date: January 29, 2020
Email: Katie@nyhcampaign.org
Phone: 917-657-4663

Thank you for the opportunity to testify.

I am the Director of the Campaign for New York Health, representing a broad coalition of physicians, nurses, seniors, people with disabilities, businesses, patients, and those who love and care for them in advocating for the right to healthcare in New York State. We advocate for a single-payer healthcare system, such as the NY Health Act [A5248 / S3577], as the most comprehensive and cost-effective model to achieve our goal.

Nearly 200 organizations have joined the Campaign for New York Health in a statement calling for the legislature to "Go Bold On Healthcare in 2020" and pass the New york Health Act, as well as additional reforms to smooth the transition process while implementing the universal system, including: creating a state-sponsored Essential Plan for immigrants ineligible for existing coverage, making private coverage more affordable, supporting more community-based outreach and enrollment assistance, protecting New Yorkers from unfair medical billing practices, and rejecting austerity and the pending cuts to Medicaid.

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When looking for savings in total healthcare costs, the New York Health Act could save upwards of $11 billion dollars, all while providing high quality, comprehensive care to New York residents.[1]

This fall, the Senate and Assembly Health Committees held public hearings across the State on the NY Health Act. Nearly 200 witnesses, and 40 hours of testimony were delivered. Most witnesses spoke about the denials, the delays, the cost barriers, the provider burnout, and the toll in reduced health or in tragic loss of life at the hands of this broken, fragmented system. Very few who weren't profiting from the current system were able to say it was working for them.

In both personal anecdotes and academic research, it is well documented that in the current system many people are priced out of care. Studies have shown over 50% of the population did not get basic care due to cost.[2] Even small copays and fees prevent people from accessing needed care. When people do not get the care they need, delays lead to worsening conditions that become more expensive to treat when the patient finally does seek treatment.

Furthermore, as long we leave Medicaid and the overall healthcare system in the hands of the multi-payer private insurers, we will be left with a fragmented and wasteful healthcare system that drains our dollars to enormous administrative waste, and creates barriers to basic care.

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[1] https://www.rand.org/pubs/research_reports/RR2424.html

[2] https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2759743; https://www.cssny.org/news/entry/new-statewide-healthcare-affordability-survey

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On a national level, administrative costs in the U.S. system are nearly five times as much as the Canadian system.[3] We implore you to look at the most obvious places to find cost savings, as opposed to balancing the budget on the backs of the most vulnerable and their providers. For example, nearly 10 years ago our neighbors in Connecticut found huge cost savings when they kicked private insurers out of their Medicaid system, and instead relied on the state to pay providers directly while keeping administrative costs to 3.2%.[4]

In confronting this budget, the legislature has an historic opportunity before them. With nearly a majority of its members in support of the NY Health Act, the legislature could pass the bill and begin the multi-year implementation process of a universal, guaranteed healthcare system. In fact, the legislature could pass it this year, and the Governor has even publicly pledged to sign it. Once passed, the work of setting the tax brackets for the financing package begins for the next budget cycle. This bold action sends a clear message to New Yorkers that lawmakers are serious about making sure that the healthcare system is a right. That it is truly universal, publicly accountable, fairly financed, and comprehensively covering health needs including the long-term care and support services.

[3] https://annals.org/aim/article-abstract/2758511/health-care-administrative-costs-united-states-canada-2017

[4] https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/HUSKY-Health---Five-Key-Points.pdf?la=en

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Study after study on single-payer and the NY Health Act show that while there will be an increase in taxes only for those with the most wealth in NYS; at least 90% of residents will pay less for healthcare.[5] It would be a huge pay raise for most New Yorkers, stimulating the economy by putting money in people's pockets, creating an estimated 200,000 jobs,[6] and boosting our population health by minimizing the enormous financial barriers people currently face in accessing basic care.

With New York Health, those on Medicaid would continue to see generous benefits, but with no out of pocket costs at the point of care, full choice of doctor or hospital, and no longer requiring means testing to spend down their assets to be eligible for long-term care services currently only provided by Medicaid.

Also included in my testimony is a rebuttal to the charge that the NY Health Act cannot be implemented without federal waivers. Should waivers not be forthcoming, the legislation foresees several ways that NY Health can effectively work in concert with the federal programs within a single-payer approach.

In conclusion, I urge you to consider this incredible legacy in the face of these budget challenges and take bold action in 2020: Keep the Medicaid promise and reject austerity, pass the New York Health Act, and the necessary incremental reforms to protect patients as the universal system is being implemented. Thank you.

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[5] http://www.infoshare.org/main/Economic_Analysis_New_York_Health_Act_-_GFriedman_-_April_2015.pdf; https://www.rand.org/pubs/research_reports/RR2424.html; https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003013

[6] https://www.rand.org/pubs/research_reports/RR2424.html

January 8, 2020

Dear Members of the NYS Assembly and Senate,

As advocates for a just and equitable healthcare system for all, **we are calling for bold action in the 2020 state legislative session.**

While the legislature is grappling with a healthcare budget shortfall, it's the residents of New York State who ultimately pay for an unfair and inefficient healthcare system. As we prepare for 2020, we support the following measures to bring guaranteed coverage and affordability in healthcare for all New Yorkers:

- **Pass the New York Health Act**: The New York Health Act **(Gottfried A5248/Rivera S3577)** remains the one piece of legislation that will provide coverage for all residents of New York, while simultaneously lowering total healthcare costs for most individuals and for the state. NYHA is explicitly written to cover all residents, so immigrants currently barred from accessing health insurance would be covered. In 2018, a RAND Corporation study affirmed that NYHA could cover everyone with expanded benefits including long-term care and support services, and still cost less in total healthcare dollars than the status quo. The NYHA should be passed immediately in order to launch the implementation process to achieve our goals of universal, comprehensive and affordable overage.

Passing the New York Health Act in 2020 will start the multi-year process of establishing a universal, single-payer healthcare program. In the meantime, important steps must be taken in this legislative session to expand coverage and address affordability barriers for residents who need relief in the interim:

- **Adopt S.3900/A.5974**, sponsored by Assembly Member Gottfried and Senator Rivera, which **creates a state-funded Essential Plan for immigrants who are ineligible for existing coverage.** This program would be offered to the 246,000 unauthorized immigrants below 200% of the federal poverty level and would cost $532 million.
- **Make coverage more affordable for people.** There are two methods to achieve this goal. The first would be to offer **a state-funded Essential Plan to approximately 120,000 people between 200% and 250% of the federal poverty level.** This would cost around $132 million in the first year. The second option would be **to establish—as California has— additional state subsidies for people between 200% and 400% of the federal poverty level.** This option would make coverage more affordable for approximately 155,000 New Yorkers and cost anywhere between $250 million and $530 million, depending on the generosity of the subsidies.
- **Support more community-based outreach and enrollment assistance to engage the hard-to-reach eligible but uninsured.** New York's current Navigator program is funded at $27.2 million. But these community-based Navigators haven't had a pay raise, or cost-of-living increase, in over six years. The Legislature should supplement these funds, with an extra emphasis on communities that have a disproportionate percentage of the remaining uninsured.
- **Protect New Yorkers from unfair medical billing practices.** S6757/A8639 would eliminate some of these practices by requiring consolidated, clear hospital bills, shorten the time patients can be sued, and capping interest on medical debt to 3 percent. It would also protect consumers from surprise out-of-network bills caused by provider or plan misinformation; protect patients from unfair facility fees; and improve hospital financial assistance for uninsured patients.

- **Reject austerity**. The state must **keep the Medicaid promise and reject harmful cuts that deny coverage or prevent access to care**. State leaders should reorient away from an austerity framework, so that the above health care programs can be fully-funded. Doing so will require creating new sources of revenue that restore progressivity to our state's taxing programs to assure that New York is a just state in which to live and work. The state should also reject the annual growth cap on spending which has unnecessarily starved programs and state agencies of adequate resources to succeed.

The organizations signed below are committed to making healthcare justice a reality through these demands in 2020. We encourage legislators to take the pledge with us, and you can find it online at **tinyurl.com/pledge2020**. For more information, please reach out to Max Hadler (mhadler@nyic.org) at Coverage4All or Katie Robbins (katie@nyhcampaign.org) at Campaign for New York Health.

Sincerely,

Campaign for NY Health • Coverage for All • Healthcare for All New York (HCFANY)

Academy of Medical & Public Health Services (AMPHS) • ACT UP/NY • Action Together Long Island (ATLI) • Adhikaar • Adirondack Voters for Change • African Services Committee (ASC) • Arab American Family Support Center • Arts for Peace of Ulster County • Barack Obama Democratic Club of Upper Manhattan • Brooklyn-Queens Long Island Area Health Education Center • Broome-Tioga Green Party • BWICA Educational Fund, Inc. • Callen-Lorde Community Health Center • Capital District Alliance for Universal Health Care• Capital District DSA• Care Packages for the Homeless• Center for Independence of the Disabled, NY• Children's Defense Fund-New York• Chinese - American Planning Council (CPC)• Chinese Progressive Association• Citizen Action of New York• Coalition for Asian American Children and Families (CACF)• Coalition for Economic Justice (CEJ)• Cobblestone Valley Farm• College Democrats of New York• Commission on the Public's Health System• Community Health Care Association of New York State (CHCANYS)• Community Healthcare Network• Community Health Worker Network of Buffalo• Community Service Society of New York• Concerned Citizens For Change• Disabled in Action of Greater Syracuse Inc.• Dsi International Inc• Dutchess County Progressive Action Alliance• East Harlem Health Outreach Partnership• Emerald Isle Immigration Center• Empire Justice Center• Empire State Indivisible• Finger Lakes 4 New York Health• Finger Lakes Community Health• Finger Lakes Rapid Response Network• Forestdale, Inc.• Fort Greene Strategic Neighborhood Action Partnership• Foundation for Integrative AIDS Research (FIAR)• FPWA (Formerly the Federation of Protestant Welfare Agencies)• Gay Asian & Pacific Islander Men of New York (GAPIMNY)• Gay Men's Health Crisis (GMHC)• Geneva Women's Assembly• Grassroots Action NY• Gray Panthers NYC• Greater New York Labor Religion Coalition• HANAC, Inc.• Hand-in-Hand: The Network of Domestic Employers• Harlem/Upper West Side for Bernie• Healthcare Equity Action League of New York (HEAL-NY)• Housing Works• Hudson Valley Chapter of the Campaign for New York Health• The Hepatitis C Mentor and Support Group (HCMSG)• Independent Living Center of the Hudson Valley• Indivisible Harlem• Indivisible Mohawk Valley• Indivisible Nation BK• Indivisible Project• Ithaca Democratic Socialists of America• JFREJ-NYC (Jews for Racial and Economic Justice)• The Korean American Family Service Center• The Korean Community Services of Metropolitan NY, Inc• Labor-Religion Coalition of NYS• Latino Commission on AIDS• League of Women Voters of St. Lawrence County• Leatherstocking Young Farmers Coalition• The Legal Aid Society• The LGBT Community Center• L.I. Poor People's Campaign: A National Call for Moral Revival• Local 930 UAW• Long Island Activists• Lupus and Allied Diseases Association, Inc.• Maison Charles Cleaners• Make the Road New York• ME Action - New York Chapter• Medicaid Matters NY• Mekong NYC• Metro Justice• Metro New York Health Care for All• MinKwon Center for Community Action• Nassau DSA Healthcare Working Group• National Alliance on Mental Illness of NYC (NAMI NYC)• New York 2nd District Democrats• New York Caring Majority• NYC-Democratic Socialists of America (DSA)• NYCD16 Indivisible• New York Doctors• New York Immigration Coalition (NYIC)• New York Indivisible• New York State Academy of Family Physicians• New York StateWide Senior Action Council, Inc.• North Country Access to Health Care Committee• Northwest Bronx Community and Clergy Coalition• Northwest Bronx Indivisible• North Forkers for the Common Good• NYPAN• NYPAN Greene• NYPAN - LIA• New York State Labor-Religion Coalition• New York State Nurses Association (NYSNA)• Nobody Leaves Mid-Hudson• Peace Action of Staten Island• PEER/Progressive East End Reformers• Physicians for a National Health Program - NY Metro Chapter• Polonians Organized to Minister to Our Community, Inc. (POMOC)• Power of 3• Putnam Progressives• Progressive Doctors• PSL-Geneva, NY• Rockland Citizens Action Network• Roxbury Wine and Spirits• Sakhi for South Asian Women• Sarah Lawrence College Democrats• Saratoga Health Committee - Saratoga Progressive Action• Saratoga Immigration Coalition• Show Up LI• South Asian Council for Social Services• South Central Brooklyn United for Progress (formerly NYSD17 for Progress)• Stronger Together Western New York• Students for a National Health Plan (SNaHP) - New York State• Suffolk Progressives• Syracuse Peace Council• Together We Will Long Island• Tompkins County Immigrant Rights Coalition• Transonic Systems Inc.• Treatment Action Group• True Blue NY• UnLocal, Inc.• Uplift Syracuse• Upper West Side Action• Uptown Progressive Action, a NYPAN chapter• WNY Healthcare for All• Western New York Council on Occupational Safety & Health• Women of Reform Judaism of Riverdale Temple•

Federal waivers and the New York Health Act

Errors and distortions in the NYHPA analysis

Summary

The New York Health Plan Association (NYHPA) commissioned an analysis of the impact of federal waiver policy on the ability of the state to implement the New York Health Act (NYHealth). The January 2020 report, by Lanhee Chen of the Hoover Institution and James Capretta of the American Enterprise Institute (AEI), is titled *Current federal health care waiver authorities will not pave the way for the New York Health Act.*

NYHPA represents the health insurance industry in New York and is rightfully concerned that NYHealth will effectively eliminate commercial health insurers from the state. It is not surprising that they asked the Hoover Institution and AEI to produce the analysis. Like the Centers for Medicare and Medicaid Services (CMS) under Trump, these organizations favor private sector solutions and strongly oppose expanding the role of government. It is also not surprising, then, to find distortions and exaggerations in their report.

With respect to federal waivers, they erroneously assert that the legislation seeks to fold Medicare and Medicaid into the New York Health Act which, by ending their entitlement status, would go beyond the scope of the waivers. This is not, however, what the bill intends. The legislation only proposes to seek waivers that would modify payment procedures to allow for a smooth and efficient integration of federal funds into the New York Health Trust. Medicare and Medicaid waivers that were granted to Maryland and Rhode Island, respectively, serve as precedents. In addition, the Senators who added the Section 1332 Innovation Waiver to the Affordable Care Act explicitly intended the waiver to facilitate states who wanted to pursue public option or single-payer programs.

Should waivers not be forthcoming, the legislation foresees several ways that NYHealth can effectively work in concert with the federal programs within a single-payer approach. Contrary to the claims of the NYHPA report authors, these methods are supported by current law.

Federal funds and the New York Health Act

Chen and Capretta imply throughout their report that the goal of NY Health is to fold Medicaid, CHIP, and Medicare into the program. They use phrases like "inclusion of Medicare and Medicaid in the state's single-payer scheme" to suggest that the state is proposing to take over federal programs. They therefore believe that

(A)lthough there is some authority in existing federal law to provide states greater control over existing funding streams, implementing a single-payer program at the state level would require a much broader authority for experimentation than is provided in current law.

With respect to Medicare, in particular, they assert that "Medicare…protects the entitlement rights of its enrollees, which precludes a single-payer design."

However, nowhere in the New York Health Act is there language that would imply that NYHealth seeks to compromise the entitlement status of participants in federal programs. The bill only seeks to facilitate the use of accessible funds to reimburse providers in the most efficient way possible. Providers would be reimbursed entirely by the state, as the single-payer, and the state, with the cooperation of providers, would direct applicable federal funds into the NYHealth Trust Fund. Since NYHealth provider payments will meet or exceed federal levels, with no balance billing, patients and providers would face no obstacles to treatment and reimbursement.

The NYHealth bill asserts that it will seek any and all federal waivers that can facilitate the efficient movement of funds through the new program. It also states that if such waivers are not forthcoming, it will simply operate within the current framework.

Federal waivers

CMS has waiver options available through Medicaid (Section 1115), Medicare (CMMI and Section 402A), and the Affordable Care Act (ACA) (Section 1332). Chen and Capretta claim that none of these waivers would allow funds to flow into a single-payer system. They assert this, however, using a flawed understanding of how NYHealth would work. As noted, the state can be the single payer without needing to challenge the statutory integrity of any federal program. There have been, in fact, numerous systemic payment reforms that have been permitted through waivers. As long as a payment reform does not increase spending by the federal government and does not compromise quality of care, waivers can generally be awarded, outright or on a demonstration basis. Importantly, these types of waivers affect only the flow of funds, not the operation of the programs or delivery of care.

The waiver issued for Maryland's "all-payer" Medicare rate setting program is a case in point. In addition to unifying payment for hospitals, the Maryland waiver authorizes global budgeting for hospitals, thus simplifying the reimbursement process, and Maryland is now expanding the waiver to include non-hospital providers. NYHealth could request a similar waiver but with a different formula. There is nothing in federal law that precludes such a waiver. Its aim would be to simplify claims processing and provider reimbursement, not to absorb the Medicare program.

Chen and Capretta claim that, should NYHealth set provider rates higher than current levels through such a scheme, it would automatically trigger increased federal spending, violating a guardrail for waivers. This is puzzling. They appear to ignore the fact that New York, like several other states, already uses its own funds to supplement the federal share and could certainly do so without forcing increased spending by CMS.

A similar strategy is reflected in the Rhode Island Medicaid "global waiver" where the state negotiated a five-year Medicaid budget with CMS with caps on total federal spending. The state gained flexibility in how it spends federal money and CMS gets the benefit of knowing that the state will stay within a reasonable spending limit. The waiver was recently reapproved by the

Trump administration. A waiver for NYHealth would not use Rhode Island's managed care structure, but there is no statutory basis for excluding such a waiver under fee for service or any other payment system.

If meeting quality and access standards is a requirement, the NYHealth sponsors are confident that the standards would be met. NYHealth offers a superior set of benefits for Medicare recipients including long-term care, with no cost-sharing, no limited networks, and no greater prior authorization requirements than in Medicare. It also will reimburse primary care physicians and others for providing care coordination.

With respect to ACA Section 1332 innovation waivers, Chen and Capretta claim that this type of waiver only applies to that small portion of federal funds associated with potential pass-through reimbursable tax credits and certain subsidies. But they conveniently fail to note that Section 1332(a)(5) makes a public option possible through a Coordinated Waiver Process wherein "the secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under Title XVII (Medicare), XIX (Medicaid) and XXI (CHIP) of the Social Security Act and any other federal law relating to the provision of health care items or services." This section permits a state to submit a single application for a waiver "under any or all of such provisions."

Section 1332 was added to the ACA through the efforts of Senator Ron Wyden of Oregon, a senior member of the Senate Health Committee. Oregon, at the time was exploring the possibility of developing a state public option or single-payer program. He intended Section 1332 to facilitate such possibilities.

Chen and Capretta expose their real agenda, though, by noting that the Trump administration issued new guidance for Section 1332 waivers in 2018, looking more favorably on waiver requests that "promote private market coverage" and "consumer-driven health care", and unfavorably upon waiver requests that expand public programs. This is evidence that Chen and Capretta understand the intent of Congress in the original legislation and guidance, but, with Trump, aim to block public programs.

The only statutory requirement for approval of a 1332 waiver is that certain "guardrail" conditions be met. The system should 1- have benefits at least as comprehensive as those mandated by the ACA; 2- not increase the financial burden on enrollees, 3- not increase the number of residents who do not enroll; and 4- not increase costs for the federal government.

NYHealth easily meets these conditions.

In 2019, over a dozen states began considering laws for establishing a public option through a Medicaid buy-in. They anticipate using Section 1332 and Section 1115 waivers to implement these options. With the expectation that they would meet the guardrail provisions, they are ready to challenge the new guidance of Trump's CMS.

Chen and Capretta are also concerned about existing New York 1115 waivers, some of which provide extra services to specific groups of recipients. They say that NYHealth would have to make accommodations for these populations, "one more reason why it would be impossible to actually subsume Medicaid into the larger single-payer scheme." Yet, such accommodations would be administrative in nature and easily carried out within the current New York Medicaid system operated by the state.

While the issues identified by Chen and Capretta show that the 1332 and 1115 waiver laws might make administering the New York Health Act more cumbersome, their rhetoric gives the reader the impression that the obstacles would be a show stopper. That's hardly the case.

NY Health without waivers: Status quo options

The New York Health Act states that, should waivers not be forthcoming, NYHealth would work within the status quo:

> The legislature intends that federal waivers and approvals be sought where they will improve the administration of the New York Health program, but the legislature intends that the program be implemented even in the absence of such waivers or approvals...If any necessary waiver or approval is not obtained, the state shall use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally-matched health programs and federal health programs in New York Health. Thus, even where other programs such as Medicaid or Medicare may contribute to paying for care, it is the goal of this legislation that the coverage will be delivered by New York Health and, as much as possible, the multiple sources of funding will be pooled with other New York Health funds and not be apparent to New York Health members or participating providers.

To facilitate the incorporation of Medicare funds, NYHealth may opt to apply to become or sponsor an HMO that would work like a Medicare Advantage plan. In 1973, Congress codified federal rules for provider collectives that offered services on a capitated basis, and Medicare was authorized to develop demonstration projects that would allow such HMOs to manage services for older adults. This became the basis for the Medicare Part C (Medicare Choice+) legislation in the Balanced Budget Act of 1997 and the Medicare Advantage (MA) legislation in 2003. Although MA organizations are private, usually for-profit, the 1973 law refers to "public or private" HMOs that could be authorized by the federal government to manage programs that serve Medicare and Medicaid enrollees.

Such a public or quasi-public entity could ease the integration of federal funds. The federal government already uses capitated payments for such plans, replacing fee-for-service reimbursements. This would help to smoothly integrate the federal funds. In addition, Section 1109 of the proposed legislation requires that NYHealth applicants also apply for any federal program for which they are eligible so that federal funds become available to the state.

Chen and Capretta disingenuously suggest that such a plan would struggle to compete with existing MA offerings, fight to recruit providers, and take on "substantial insurance risk". That would be simply untrue. There would be little or no competition since the NYHealth plan would be a far better plan by all measures. If a current recipient preferred her current MA plan to the NYHealth plan, despite the NYHealth plan having basically no network restrictions, no cost-sharing, and a far better benefit package, including long-term care, which no current MA plan has, she could keep it. NYHealth is also committed to being premium-free and intends to reimburse Parts B and D premiums to Medicare recipients.

As a fallback option, NYHealth could "wrap around" traditional Medicare. Such a plan would run parallel to Medicare as it currently exists and provide any needed extra payments to providers. While such an approach would limit administrative savings, since providers would still have to submit bills to the Medicare program, an efficient electronic claims processing system could minimize the additional administrative effort. There are also provisions under Section 1395kk of the Medicare law that allow the federal government to hire contractors to maintain data and administer benefits under certain conditions. A state or state-related entity could qualify as such a contractor and further unify the claims administration system.

Conclusion

The sponsors of the New York Health Act are fully aware of the potential conflicts that might arise when trying to interact with federal programs and have carefully considered the options available through waiver programs or work-arounds. Rather than engaging in a constructive discussion of potential strategies, the aim of the NYHPA brief is to create confusion and fear among legislators, health care professionals, and the public. Through omissions, distortions, and factual errors, the authors work not in the interest of letting New Yorkers understand the options before them, but to protect their funders, the commercial health insurers of New York.