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 28, 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.

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 policy makers and lawmakers to further the efforts to ensure the availability of high quality, affordable health care for all New York consumers and employers.

While Governor Hochul's FY24 Executive Budget contains a number of provisions that will improve New York's health care system, it includes several misguided proposals that ultimately will make health care more expensive and jeopardize the quality of care for all New Yorkers.

We appreciate the opportunity to offer our view on the proposed 2024 Executive Budget in relation to its application for health care spending in New York.

PAY AND PURSUE: PART J – OPPOSE

This proposal would require that hospital claims for emergency services and any resulting inpatient admission be paid ***before*** submitting information needed to determine whether the service or treatment was medically necessary. It includes a lengthy process for when hospitals would be required to submit clinical documentation and protracted timeframes to confirm whether the services were clinically appropriate or the site or level of service was appropriate. If the parties cannot agree whether the service was medically necessary, then the claim would be sent to an independent third party. The proposal would have the potential to result in hundreds of thousands of claims for these services being reviewed and subject to negotiation – even if a procedure was clinically inappropriate, billed improperly or provided in the wrong setting – before health plans would be able to seek a refund of payment. This would have the effect of increasing administrative complexity while consumers wait months before knowing what their cost-sharing will be.

It will fundamentally change the health care financing system in the State, dramatically increase the cost of coverage, and exacerbate the challenge of rising health care costs that New Yorkers face.

Pay and Pursue

Forcing patients, employers, and labor unions to pay for care when it might not be appropriate.

Anti-Consumer • Higher Costs • More Red Tape • Wrong for NY

For hospital emergency services and any resulting inpatient admission:

1. Hospital submits claim to health plan. Health plan has 30 days to pay.

+30 Days

2. Within 30 days of paying the claim, the health plan can request clinical documentation.

+30 Days

3. Hospital has 45 days to submit clinical documentation.

+45 Days

4. Up to 90 days following the receipt of the records, the health plan can request a post payment audit from the joint committee.

+90 Days

5a. The joint committee has 90 days to request clinical documentation from hospital, review the claim, and make a joint determination.

OR

5b. If the hospital fails to provide clinical documentation to the joint committee within 60 days, the services will be deemed not medically necessary. There is no enforceable timeframe for the hospital to repay the health plan.

+? Days

+90 Days

6a. If the joint committee fails to reach a determination, the hospital or health plan may refer the claim to a mutually agreed upon third-party review agent within 5 business days of the end of the 90 day period.

OR

6b. If the joint committee determines the services were not medically necessary, there is no enforceable timeframe for the hospital to repay the health plan, subject to negotiation.

+? Days

OR

6c. If the joint committee determines the services were medically necessary, hospital bills member for cost sharing due.

+5 Days

7. No enforceable time limit by which the third-party review agent must make its determination.

+? Days

8a. If the third-party agent determines there has been an overpayment, the hospital shall refund within 30 days.

OR

8b. If the third-party agent determines services are medically necessary, hospital bills member for cost sharing due.

+30 Days

Of Note:

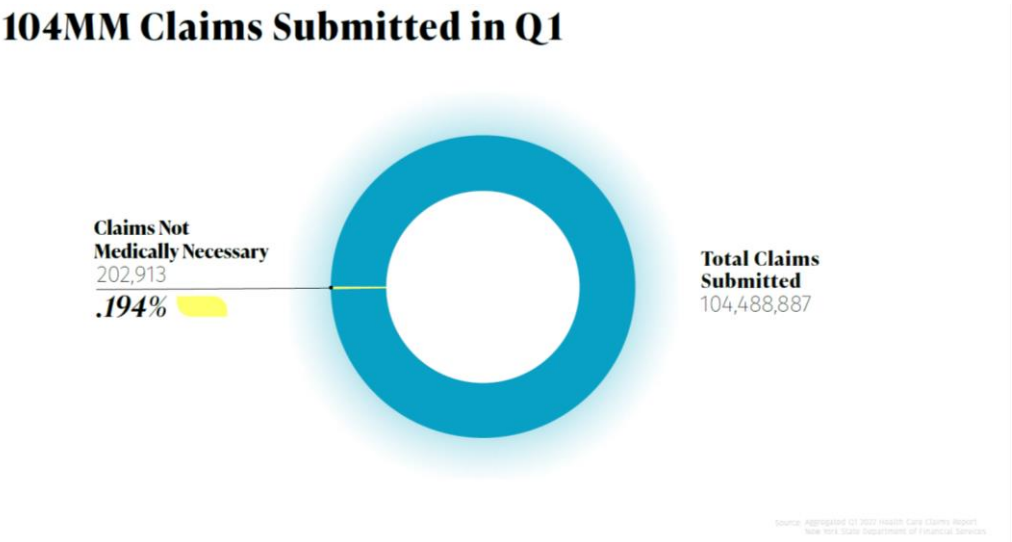
- For *all* claims, a review or audit by the health plan cannot reverse or alter a medically necessity, site of service, or level of care determination.
- For *all* claims, a review or audit of by the health plan cannot downgrade the code of a claim if it has the effect of negating or altering a medical necessity or level of care determination.
- The provisions would take effect on 1/1/24.

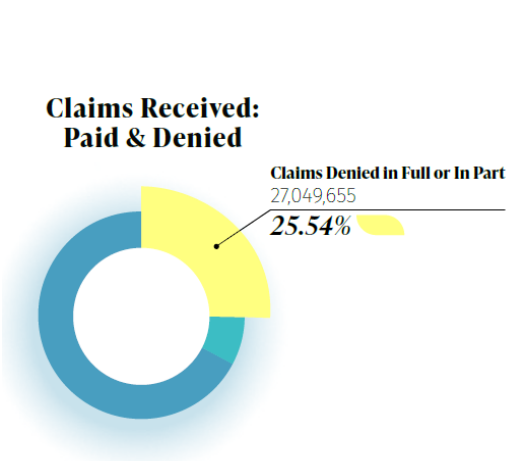
The hospital shall pend any cost sharing and can bill the insured for the cost sharing if the services are determined medically necessary. The member is held harmless for services determined not medically necessary.

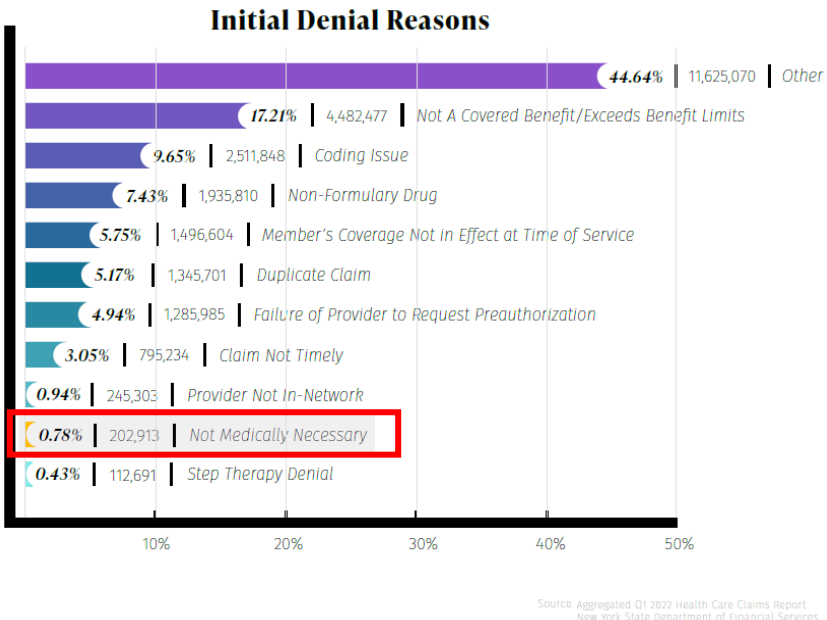
What this means for consumers: Individuals may wait months before they know what they have to pay for the medically necessay services they receive.

Potential Timeframe From Submission of Claim to Determination: **290 Days**

There is no policy basis to support the necessity for this proposal. According to quarterly data that health plans submit to the Department of Financial Services, for Q12022, health plans received more than 104 million claims. Less than two-tenths of 1% of all claims were denied for medically necessity and medical necessity denials accounted for less than 1% of all claim denials. The large majority of denials are due to provider errors, such as coding issues, duplicate claims submitted, the member's coverage was not in effect at the time of service, or the claim was not filed in a timely basis.







Pay and Pursue would make it more difficult to ensure that care is safe and effective, and that providers follow best practices, creating incentives for providers to order unnecessary and duplicative procedures and tests and discouraging efforts to transition the system to value-based payment arrangements.

Moreover, there is no evidence to support the hospitals' argument that health plan review of claims is contributing to hospital fiscal and workforce challenges. Rather, the proposal would require employers, labor unions and consumers to pay for unnecessary – and potentially unsafe – services. Pay and Pursue would simply increase payments to hospital systems in the short run, making health care more expensive for residents, businesses, union benefit funds, the State Employee Benefit program and the Medicaid program, and it would do nothing to address the workforce shortage.

The Administration projects this proposal would cost the State $7.7M in FY24 and nearly $32M in subsequent years. <u>However, this cost estimate relates only to Medicaid and does not take into account the impact on the New York State Health Insurance Program (NYSHIP), which would result in millions in additional costs.</u> The Legislature should reject this proposal.

PRIVATE RIGHT OF ACTION ON BEHAVIORAL HEALTH: PART II, SUBPART D – OPPOSE

This provision in the 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 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 themselves against costly 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. The only party to benefit from this provision will be trial attorneys, eager to see expanded liability. Moreover, this vaguely written provision leaves open questions regarding who has legal standing to sue, who would

[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."

bear the cost of litigation, and what are the rules of liability and burden of proof to win. Further, there is no language to limit frivolous litigation. **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. Individuals' inability to access appropriate BH or SUD care most often has nothing to do with any action on the part of a health plan. 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 are still years away from implementing 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 quality of care or outcome measures in any meaningful way. 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. It is merely a distraction from the work that needs to be done collaboratively with health plans in all those areas and more.

  We believe that the private right of action provision in the FY24 Executive Budget would be a costly and ineffective way to address the challenges the State faces with the behavioral health delivery system, and that meaningful oversight and enforcement options exist, making this provision unnecessary and excessively burdensome.

Additionally, Part II would expand the type of mandated behavioral health services commercial plans are required to cover, mandate that mobile crisis intervention and school-based mental health center services are covered regardless of whether they are in a plan's network, and prohibit prior authorization for inpatient psychiatric hospital stays and concurrent review of those stays for 30 days for adults. Prior authorization is an important tool to protect patients from unnecessary and potentially harmful care. For example, it is utilized to help ensure that facilities are able to provide services to meet the member's needs. Eliminating prior authorization and limiting concurrent review will inhibit plans' ability to coordinate care and treatment for members, and assure that members are connected to appropriate levels of care upon discharge. The proposal would also require the Superintendent to develop new network adequacy standards for behavioral health.

Finally, there are no fiscal implications for the State budget. For all these reason, the Legislature should reject this proposal.

SITE OF SERVICE REVIEW: PART L – OPPOSE

A provision in the Executive Budget purports to establish a process for site of service utilization review determinations for services performed at a hospital-based outpatient clinic rather than a freestanding ambulatory surgical center. However, the actual language regarding requirements for site of service clinical review criteria is written in such a way that it will steer patients toward hospital-based centers, increasing the number of procedures that take place in more expensive hospital settings.

Data show that over the past decade, minimally invasive surgical procedures that were once performed on an inpatient basis have shifted to outpatient facilities. This shift has occurred because ambulatory surgery centers and certain office-based sites provide safe and effective sites of care to perform certain routine, non-urgent screenings and procedures.

One plan looked at data for more than six million routine outpatient procedures performed in hospital outpatient departments, finding only 10% of procedures were for complex patients, and that 56% of the procedures for non-complex patients could be performed at ambulatory surgical centers within a short distance of the patient's home. Convenience and greater choice and flexibility in scheduling for patients is a key reason why consumers report high satisfaction with care delivered in ambulatory surgical centers.

Additionally, these nonhospital sites are usually less expensive, and thus provide cost savings. The same plan data looking at where procedures were performed found that shifting outpatient procedures for non-complex commercially insured individuals to ambulatory surgical centers would reduce spending by 59% and save consumers $684 on average per outpatient procedure.

Additional data supports the goal of aligning payment rates for certain services across sites where patients receive outpatient care — including hospital outpatient facilities, ambulatory surgical centers, and freestanding physician offices—often referred to as "site-neutral payment," showing such alignment can provide significant cost efficiencies. According to the Medicare Payment Advisory Commission (MedPAC) June 2022 report to Congress[2], expanding site-neutral payment policies in Medicare could generate an estimated $6.6 billion in annual savings for Medicare and taxpayers as well as $1.7 billion in lower cost-sharing for Medicare beneficiaries. The report went on to note that effects for the commercial market are likely even greater.

The main beneficiaries of care delivered in hospital outpatient centers are the hospitals that own the facilities. Increasing the number of procedures performed in hospital-based settings will result in higher costs for consumers, without any increase in quality of care or improved outcomes.

[2] MedPAC: Medicare and the Health Care Delivery System; https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/

As there are no fiscal implications for the State budget, we urge the Legislature to reject this proposal.

GUARANTY FUND: PART Y, SUBPART D – OPPOSE

The Governor's proposal would add commercial health insurers to the guaranty fund already established for life insurers in New York State; notably, Medicaid, CHIP, and Essential Plan products are excluded from this requirement. As such, this proposal is a pure policy consideration with no fiscal impact to the State. With respect to the commercial insurance market, as proposed, health insurers would pay 50% of the total guaranty fund to cover potential insolvency events for products and policies that are largely written by life insurance carriers. In addition, a guaranty fund already exists in New York to support life insurers who offer such policies. At a time when the number one concern for health insurance is affordability, adding additional costs to health insurance products, is not in the best interests of New Yorkers.

The Department of Financial Services (DFS) seeks to justify the proposal because the NAIC model has been adopted by other states. However, New York State has its own requirements to ensure a stable health insurance market that other states do not have, including prior approval of health insurance rates. Specifically, health insurers doing business in New York State must submit an annual rate package to the Department for approval. DFS's approval process is meant to ensure that rates are actuarially sound and are sufficient to support the benefit package. With approval of sound rates, the State does not have to fear a potential insolvency. In addition, health insurers are required to have significant reserve funds to adequately cover for adverse outcomes. Accordingly, there is no need for a guaranty fund to guard against insolvency.

With no fiscal implication, this should not be considered as part of the FY24 budget.

MEDICAID PROVISIONS

For the past three decades, 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% — receive their care through a Medicaid managed care plan. It is with those New Yorkers in mind that we offer our thoughts about provisions in the Executive Budget related to Medicaid spending.

- **Reverse the Pharmacy Carve Out:** The Governor's budget proceeds with the carve-out of the Medicaid pharmacy benefit from managed care and into the State's fee-for-service program. The carve-out is projected to save the State $410 million in the upcoming fiscal year. Yet, after factoring additional funding included in the budget directed to federally qualified health centers (FQHCs), Ryan White clinics and hospitals, the carve-out is projected to save just $42 million. These savings estimates are open to debate. A December 2022 analysis by Wakely Consulting for HPA and the Coalition of NY State Public Health Plans found that *the carve-out will actually add significant new costs* to the Medicaid program. The analysis projected that the carve-out will increase annual New York State-specific expenditures by more than $235 million, increasing costs for the Medicaid program by $1.1 billion over five years.

  The budget also provides no methodology or timing for the payment of "reinvestment" funds to safety net providers, who will be negatively affected by the massive funding cuts on day one. Community health centers in California have not seen any reinvestment funds nearly a year after the state implemented its pharmacy carve-out policy.

Additionally, the carve-out will have a negative impact on the coordination of care for Medicaid enrollees, especially those with chronic illnesses requiring the management of multiple medications and other care. **As the carve-out is projected to generate minimal savings for the State and adversely affect patients and safety net providers, we urge the Legislature to reject this proposal.**

- **Restore the Quality Pools — Administrative:** New York has been a national leader in delivering high-quality care to its Medicaid beneficiaries – largely as 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 the more than five million New Yorkers covered by Medicaid. The measures incentivized by the quality program are aimed at addressing the core causes 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. Medicaid quality incentive funding has been repeatedly cut over the past several years and faces total elimination again in the FY24 Executive Budget. The proposed cut, including $60 million for mainstream Medicaid managed care plans and $51.8 million for MLTCs, comes at a time when the State expects plans to do more to address health equity and reduce disparities.

  The Department of Health's own 2020-2021 report on the Medicaid quality incentive program states the following:

  "Rates of performance in Medicaid managed care have increased steadily over the last decade. New York State Medicaid plans have demonstrated a high level of care compared to national averages, and for many domains of care the gap in performance between commercial and Medicaid managed care has been decreasing since the Quality Incentive Program was

implemented. The use of financial incentives has proven successful in engaging Medicaid managed care plans in developing infrastructure, programs, and resources to promote high quality care. Incorporating financial incentives that tie payment directly to quality is an important approach to improving the quality of care, holds health plans accountable for the care they provide, and rewards those who invest in processes that improve care. State Medicaid programs have steadily increased the use of financial incentives or pay-for-performance (P4P) mechanisms in their payment systems."

Plans use quality incentive funding to support:

- Awards to providers linked to their performance, like provider bonuses to incentivize physician offices or community health centers to reach out to a patient missing a preventive service, like a mammogram.
- Funding to pay primary care and behavioral health providers more than is supported by the Medicaid premiums.
- Investments to test innovative care models. Like using maternal care navigators to improve care coordination and follow-up for high-risk mothers.
- Support for social determinants of health interventions, like food as medicine and housing coordinators.
- Flu vaccines for homebound MLTC members.

Examples of how health plans utilize these funds include:

CARING FOR CONSUMERS: QUALITY INCENTIVES SUPPORT EFFORTS TO ADDRESS SDOH

Marie*, 63 years old and suffering from a host of mental and physical health complications, had experienced homelessness for almost four years. After being evicted from an assisted living facility and ending up in the hospital, her plan was able to connect her to support services and resources including peer support services and community-based psychiatric treatment and rehabilitation. The plan also helped her with crisis residential services and housing interviews that eventually led to meaningful housing stability she hadn't experienced in years.

Will* has severe asthma, but because of transportation issues, he wasn't able to see his providers regularly. After ending up in the emergency room twice and then being admitted, his plan worked with him and his primary care provider to ensure he sought care before it became a crisis. The plan also met with the family to help the family become more knowledgeable about Will's condition and how to avoid triggers, as well as to ensure access to the transportation he need get to regular appointments. All these steps helped and Will did not have a single ER visit in 2021.

CARING FOR CONSUMERS: QUALITY INCENTIVES SUPPORT SERVICES FOR THE MOST VULNERABLE NEW YORKERS

Just 59 years old, Howard* is not your typical MLTC member. However, because he suffers from numerous chronic disorders, Howard has significant care needs. When as a result of diabetic ulcers Howard had three toes amputated, his physician prescribed home care and topical oxygen therapy for the wound — life-altering treatment that literally saved both of his feet.

Mary*, an 82-year-old who has multiple sclerosis, osteoporosis and asthma, has been enrolled in a MLTC plan since 2013. Because her plan has provided her with personal care assistance services and durable medical equipment supplies, she's able to remain in her home, despite her various health challenges. On the few occasions that Mary has 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.

The elimination of the quality incentive funding has a direct impact on the delivery system, resulting in corresponding cuts in plan payments to providers, negatively affecting the State's Medicaid quality rankings and stalling statewide efforts to move toward value-based payment. Without funding for this program, Medicaid members are more likely to fall through the cracks because Medicaid plans and their providers will lose resources as well as a clear incentive to focus on the measures of greatest significance to the population.

We urge the Legislature to reject the Governor's proposal to cut the Medicaid managed care quality program and to fully restore this funding, and request that the Legislature codify this program in statute.

- **Reject Managed Long-Term Care (MLTC) Changes — Part I:** The proposal would establish performance standards and enrollment thresholds for the MLTC program and provide the Department of Health (DOH) with the authority to "procure" (put out a competitive bid) the program beginning in October 2024 if the standards and thresholds are not met. The enrollment thresholds are arbitrary, could not be achieved by any upstate-based plan, and would create massive disruption statewide for the Medicaid program's most vulnerable enrollees -- even before there could be a procurement process.

  The FY23 Executive Budget proposal included a provision that would have required the Department to procure nearly the entire Medicaid managed care program. The Legislature rejected that proposal and included a requirement that DOH select an independent contractor to prepare a report by October 31, 2022, with recommendations on the status of services offered by Medicaid managed care plans that contract with the State. The report has not been issued and the Department should not be authorized to move forward with this proposal without more careful deliberation. The MLTC market continues to consolidate, and could proceed in the same direction in an orderly manner, with appropriate incentives, instead of unworkable, disruptive proposals. **We ask the Legislature to reject Part I.**

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

At 102, Nicola* has been a member of her Medicaid plan since 2007 when it was the Lombardi program – a predecessor of New York's MLTC program. When Lombardi was being phased out in 2013, she made the decision to transition into her plan's MLTC program because she loved her care management team and the services that were provided. She did not want to experience any changes or disruption then, and felt strongly about staying with the plan and the team she trusts. Nicola suffers from numerous chronic conditions, including diabetes, high blood pressure and osteoarthritis, and her care manager ensures that she receives the services and support necessary. Legally blind – and with no family – Nicola relies completely on the care manager who has been by her side for more than 9 years.

OTHER PROVISIONS

The FY24 Executive Budget contains provisions that will improve New York's health care system. HPA supports the following proposals in the Governor's budget:

- **Essential Plan Program Changes: Part H and Administrative — Support**

The FY24 Executive Budget proposes language related to the Essential Plan (EP) to support the State's recent Section 1332 (of the Affordable Care Act) "State Innovation Plan" waiver application to the Centers for Medicare and Medicaid Services (CMS). The application seeks to implement provisions of the FY23 enacted budget to expand eligibility for the EP from 200% to 250% of the federal poverty level (FPL). The expansion will make comprehensive coverage more affordable for individuals up to 250% of the FPL, and increase the overall number of individuals with coverage. It is projected that if the waiver is approved, about 25,000 more New Yorkers will get coverage under the EP. **HPA supports the provision and the State's 1332 waiver application. HPA also continues to support efforts to achieve universal coverage for all New Yorkers, including undocumented immigrants, who are the last remaining population for which comprehensive coverage is unavailable.**

- **Prescription Drug Pricing Transparency: Part Y, Subpart B —Support**

The Prescription Drug Price and Supply Chain Transparency Act provision in the FY24 Executive Budget would prevent drug manufacturers or wholesalers from charging a price increase on the wholesale acquisition cost (WAC), average wholesale price (AWP) or other metric without first reporting the proposed price increase to DFS. Information to be reported would include the name of the drug(s), the existing price and proposed increase, the effective date of the increase, and the justification for the increase. The proposal also requires a 120-day notice in advance of a price increase and imposes a sliding scale fee for each report based on the level of the price increase and whether it takes place between January 1 and January 31 or after January 31. The Department

would be required to publish a report of price increases within 15 business days of receiving notice.

Prescription drug prices have skyrocketed in recent years and remain one of the primary costs driving up health insurance premiums. Each year drug manufacturers significantly hike the price on hundreds of much needed medications, with no advance notice of the increases. Moreover, too often there is no correlation between the excessive price increases and clinical improvements.

It is critical that policymakers take steps to protect consumers and employers from out-of-control drug costs. While the 2020-2021 enacted budget included a requirement for DFS to create a Drug Accountability Board and gave the Superintendent the ability to elect to investigate when prescription drug costs increases over 50% in a calendar year, the budget language did not address prior notification for impending price increases. By providing greater oversight of pricing and ensuring consumers get advance notice of increases, this provision would be an important step in holding drug companies accountable for the exorbitant prices they charge. **HPA supports the Prescription Drug Price and Supply Chain Transparency Act proposal in the Governor's Budget.**

CONCLUSION

HPA and its member plans remain focused on making health care more affordable for consumers, families and employers, not increasing their costs. 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.