Testimony of the New York Health Plan Association

to the

Senate Finance Committee
and the Assembly Ways & Means Committee

on the subject of

2016-2017 Executive Budget Proposal

January 25, 2016

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 27 health plans that provide comprehensive health care services to more than eight million New Yorkers, appreciates the opportunity to present its members' views on the Governor's budget proposals. Our member health plans have long partnered with the state in achieving its health care goals, including improved affordable access to quality care in its government programs as well as providing access to care that exceeds national quality benchmarks for commercial enrollees. Our plans include those that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), prepaid health services plans (PHSPs) 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, Healthy New York and now, through New York's exchange, the NY State of Health (NYSOH).

We appreciate the opportunity to offer our view on the proposed 2016-2017 Executive Budget in relation to its application for health care spending in New York.

SHARED GOALS

HPA and its member health plans share a fundamental health care goal with our state lawmakers and policy makers: Providing New Yorkers with affordable access to quality health care.

For more than two decades now, health plans have partnered with New York to provide lower-income New Yorkers access to quality health care through the Medicaid managed care program. Along with greater access to services in more appropriate settings — shifting care out of hospital emergency departments and providing Medicaid beneficiaries with their own doctors and, thus, with better continuity of care — health plans have worked with the Department of Health (DOH) to measure and

improve the outcome of the care that is provided. Similarly, plans have worked to build on the Medicaid managed care model to provide expanded access to and improved quality of care through the Child Health Plus, Family Health Plus and MLTC programs. In recent years, health plans have continued collaborative efforts with the state to implement the Medicaid Redesign Team (MRT) initiatives including the enrollment of new populations and the implementation of the Fully Integrated Duals Advantage (FIDA) initiative. And we continue working to undertake the implementation of New York's multi-billion dollar Medicaid waiver, the Delivery System Reform Incentive Payment (DSRIP) program.

As noted above, work to realize our shared health care goal also extends to the NYSOH, New York's health insurance exchange created under the federal Affordable Care Act (ACA). During the first two years of operation, approximately two million New Yorkers have signed up for health coverage through the NYSOH. Since the creation of the state exchange, HPA and its members have worked closely with NYSOH staff on efforts to ensure this marketplace continues as a viable avenue for New Yorkers to obtain affordable coverage.

EXECUTIVE BUDGET PROPOSALS

As we noted when the governor submitted his 2016-2017 budget proposals, we see good news and bad news in his health budget.

At the top of the good news column is that there are no increases to existing taxes and no new taxes. There's no proposal to impose a tax to pay for the NYSOH exchange. There's also no guaranty or insolvency fund tax. A guaranty fund, which hospitals and providers propose to address the losses caused by the failure of the state's Consumer Operated and Oriented Plan (CO-OP) Health Republic as well as future possible solvency concerns, is simply another health care tax, on top of the $5 billion in existing health care taxes. Consumers should not shoulder more taxes that ultimately hurt their ability to purchase coverage.

Also in the good news column, the governor's proposal to require drug cost transparency. It is a good first step to control pharmacy costs and transparency, however, it doesn't go far enough. First, it applies only to the Medicaid pharmacy program. Second, the "transparency" information is available only to the state. We need broader transparency applicable to commercial pharmacy pricing as well. With pharmacy costs as one of the biggest drivers of health care costs overall, consumers need and deserve basic pricing information. As proposed, the governor's transparency provision offers no help for businesses and families trying to make the most informed decisions possible about their health coverage.

Turning to the bad news, HPA and its member plans were disappointed the governor did not address the need for reform of the state's Prior Approval rate setting process. If we learned nothing else from the closure of Health Republic, it showed the failure of state's Prior Approval policy. There has been systemic price suppression by the Department of Financial Services (DFS) over the past several years. Moreover, the suppression is arbitrary, not actuarially based and is directed to achieve a demonstrable level of cuts – in the past two years, DFS's rate announcements have touted the fact that rate increases, on average, have been kept below the growth in health spending. These cuts are proving to be unsustainable and, as we now know, DFS's failure to set adequate rates was a significant contributing factor to the undoing of one health plan and seriously jeopardizes the viability of the exchange and the health care market as a whole. We need reforms that use an objective standard of minimum loss ratios to set rates and a requirement that DFS provide actuarial certification of final rate determinations.

As noted previously, we do not believe a guaranty fund is a good idea – either to address the Health Republic failure or future health plan solvency concerns. While the

hospitals and providers have called for such a fund to help pay for a portion of unpaid claims, a guaranty fund is nothing more than another health care tax that would ultimately add to the cost of health care in New York. And to further tax insurers ignores the significant financial impact the Health Republic collapse had on plans that accepted former Health Republic members on short notice and absorbed the cost of those members' deductibles and out-of-pocket payments. The governor's budget has outlined the expenditure of billions of dollars New York has realized in numerous settlement agreements. In October, the Attorney General announced a settlement agreement releasing $550 million that had been held in an escrow account during a dispute between the state and tobacco companies, and that half of those funds would go to the state. We would support use of some of the approximately $275 million of this tobacco settlement money to address providers' Health Republic claims as alternative to guaranty fund. This would be similar to last year's budget allocation to hospitals of $400 million from one-time monetary settlements. The governor's own fiscal plan language makes the point that one-time resources from monetary settlements funds should be used for one-time purposes — the Health Republic situation fits that description.

Another item under the bad news column is the governor's proposed changes to the state's Early Intervention (EI) program, most of which merely amount to shifting the cost of the program from the state onto insurers and, by extension, New York business and families who are paying the premiums. These are proposals we've seen before and represent bad state policy undercutting traditional managed care tools only for the EI program. Examples of this include: eliminating prior authorization and medical necessity requirements for EI services; mandating that insurers treat all EI providers as in-network even though no contract or credentialing process for the provider exists; mandating insurers to pay for EI services at the higher of the DOH mandated rate or plan negotiated rate regardless of the contracted rate for those services; and indirect

coverage by self-insured plans. Approximately half of commercial coverage is self-insured, which is federally regulated, and for which New York's EI mandate does not apply. Because the mandate would not apply, these individuals would not receive any additional benefits under this proposal. Yet the state is seeking to mandate that plans do the work of identifying all self-insured policies so the state's consultant can further pursue commercial EI payment for these individuals.

Lastly, budget saving proposals for Medicaid managed care appear to be little more than arbitrary efforts to balance the Medicaid global cap — with no program reform purpose and no detail regarding how they would be implemented. It should also be noted that the savings proposals disproportionally hit managed care plans. Almost $290 million is savings is targeted to come from managed care, while Medicaid pharmacy savings are only $120 million and there is no similar savings taken from hospitals or home care providers.

Illustrating the disproportionate impact on Medicaid managed care, a "profit" cap of 3.5% on all Medicaid managed care programs would roll back the success upon which the MRT has been based — care management for all and greater efficiency in the Medicaid program. These funds are not reinvested in managed care to help offset the losses of some plans in the program but, instead are being taken to balance the state's global cap. Moreover, it seems punitive to impose a cap on plans following a year when they invested millions of dollars into programs to improve care to two of the most vulnerable populations in the Medicaid program — Fully Integrated Dual Advantage (FIDA) for dual eligibles and Health And Recovery Plans (HARP) for individuals with serious behavioral health challenges.

In addition, the budget assumes a $40 million state savings based on an audit from the Office of State Comptroller. However, the audit on which savings are based has not

even been released so there is no way to know if the savings target is realistic or accurate. Similarly, $30 million in savings assumed from the Office of the Medicaid Inspector General is on top of the existing target of $300 million. It is ill-defined and arbitrary — and it is unreasonable to administratively take money out of plan premiums in advance for undefined targets.

Finally, for Managed Long Term Care (MLTC) plans, it seems counter-intuitive to add additional services to the MLTC benefit, but carve-out transportation services and state in both cases that the change will improve coordination of care.

CONCLUSION

HPA and its member plans are proud of the role they continue to play in helping New York improve access to affordable health coverage and quality of care for its residents, and plans remain committed to working with you and your colleagues on initiatives that keep New York moving forward on this course. We thank you for the opportunity to share our views today.