
**Testimony of the New York Health Plan Association**

**to the**

# Assembly Health Committee

**on the subject of**

## "New York Health Act" Proposal

**January 13, 2015**

## INTRODUCTION

The New York Health Plan Association (HPA), comprised of 23 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.), public health state 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, Family Health Plus and Healthy New York.

We appreciate the opportunity to offer our view on the proposed New York Health Act.

## 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 on efforts to expand access to and improve quality of care to New Yorkers. These partnerships include initiatives to provide lower-income New Yorkers access to health care through the Medicaid managed care program and other government-sponsored programs such as Child Health Plus, Family Health Plus and MLTC. There was also

partnership on the Healthy New York program designed to give small businesses, sole proprietors and individuals access to affordable, comprehensive health care.

By extending coverage to millions of New Yorkers, these programs have promoted greater access to services in more appropriate settings—shifting care out of hospital emergency departments and providing many of those covered with their own doctors for the first time—and helped to provide better continuity of care. Additionally, health plans have worked tirelessly with the Department of Health to measure and improve the outcome of the care provided.

Over the past three years, health plans have continued collaborative efforts with the state to implement the Medicaid Redesign Team (MRT). The key goal of the MRT is to shift Medicaid away from a fee-for-service (FFS) model and move beneficiaries into managed care settings. And the reason for this shift is to provide greater accountability, efficiency and innovation in New York's Medicaid program, things the FFS had failed to do. One example of the success of this strategy is the savings New York has realized with the MRT initiative that put the pharmacy benefit back under the managed care benefit package. That one step alone has generated state savings of $500 million—five times the estimated $100 million annual savings projected.

Other MRT stratagems include the enrollment of new higher-needs populations into managed care—i.e., the homeless, behavioral health patients—and the implementation of the Fully Integrated Duals Advantage (FIDA) initiative. By using managed care systems to provide the care needs of these populations, New York seeks to enhance care coordination and improve overall care outcomes.

Likewise, efforts to realize our shared health care goal have extended to the implementation of the New York State of Health (NYSOH), New York's health insurance exchange created under the federal Affordable Care Act (ACA). The NYSOH has expanded access to care to New Yorkers and offered them greater choice of plans and products. Subsidies to reduce the cost of premiums and to help defray out-of-

pocket costs have helped ensure affordability. The ACA's essential health benefit package ensures a standard level of benefits and quality measures offer protections to this group of new health care consumers. As you are undoubtedly aware, approximately one million New Yorkers have signed up for health coverage through the NYSOH in its first year of operation and New York is held up as a model for state-based exchanges.

This year, New York is moving forward with the implementation of the Basic Health Plan (BHP). The 2015-2016 Executive Budget is expected to include both funding for the program as well as savings—estimated at $300 million—that will be realized from moving a small number of Medicaid beneficiaries (approximately 250K *Aliessa* enrollees) into new BHP managed care plans.

**NEW YORK HEALTH ACT AND SINGLE PAYER SYSTEMS**

The New York Health Plan Association (HPA), whose member health plans have partnered with the state, feels strongly this legislation is bad medicine for New York.

The bill promises a universal health care system where everyone and everything would be covered, and the system would magically pay for it all. There is a vast chasm between this idealized world and reality, and this proposal lacks any infrastructure to bridge it.

- ***Flawed Funding***

The proposal would fund coverage using federal monies now used for Medicare as well as federal and state dollars that go to Medicaid, Family Health Plus and Child Health Plus, coupled with additional state taxes.

At both the federal and state levels, Medicare and Medicaid are increasing the use of private sector managed care to provide for a growing number of beneficiaries including various special needs populations. It's the cornerstone of the Cuomo Administration's

Medicaid Redesign Team program and, at the federal level, the commercial Medicare Advantage program. The goal—and reality—of expanded managed care is more comprehensive care that leads to improved quality outcomes while also realizing the highest value for every Medicaid and Medicare dollar.

In New York, more than one million seniors have chosen a Medicare Advantage plan over FFS Medicare. These Medicare Advantage plans offer broader benefits, better coordination of care and innovative programs designed specifically for this population.

The idea to take the money currently used for Medicare would destroy Medicare as we know it, disrupting the health care delivery system for nearly three million elderly and chronically disabled New Yorkers (including the one million plus in Medicare Advantage plans).

Additionally, sponsors presume providers will accept reimbursement at government set levels. Doctors and hospitals already argue Medicaid and Medicare reimbursement doesn't cover their costs and these providers expect government program losses to be paid for by shifting costs to private commercial insurance payments.

For the "additional taxes," sponsors suggest increased personal income tax and a surcharge on business income taxes or a payroll tax. Just last month Vermont Governor Peter Shumlin revealed that his plan to create a single payer system there would have required an 11.5 percent payroll tax on businesses and a surcharge on individuals' income of up to 9.5 percent. In the face of those staggering numbers, the governor pulled the plug on his single payer effort, citing the negative impact the cost to fund it plan would have on the state's economy.

These taxes would be on top of the more than $4.8 billion in Health Care Reform Act (HCRA) surcharges and other taxes New York currently assesses on health insurance. New York Health Act plan fails to take these assessments into account, as well as the many programs funded by the HCRA taxes. The need to pay for New York hospitals'

bad debt and charity care, the graduate medical training of thousands of doctors, and numerous other programs—i.e., AIDS Drugs Assistance Program, workforce retraining—would not disappear.

Another oversight of the proposal is the fact that New York has no authority over almost seven million New Yorkers covered by self-insured plans—approximately 36 percent of New York's insured population. Not only would the legislation force these people to give up coverage they have and presumably like, they would impose new taxes on their income and payrolls to pay for it.

- ***No Control Over Costs***

Health care premiums are driven primarily by the underlying cost of medical care and not health plans administrative costs and profits. Under the ACA, health plans must operate under a medical loss ratio (MLR) that limits what they can spend on administrative costs. The MLR caps any expense that does not go directly to pay for medical care or is not included on a pre-approved list of "activities that improve health care quality," and sets a cap on health plans' profits, salaries, and marketing costs. In New York, the MLR is stricter than the federal ACA level—82 percent versus the federal MLR or 80 percent—and plans' "administrative costs" include the previously mentioned HCRA surcharges and other taxes.

Except by setting government limits on prices, the proposal does nothing to realign myriad factors that contribute to our current escalating health care costs. Failing to take any steps to reign in utilization or rising hospital and drug costs, price controls will have the undesired effect of virtually eliminating innovation and efficiency.

- ***No Quality Improvement Guarantee***

The bill also promises to promote improved quality of, and access to, health care services and improved clinical outcomes, with no mechanisms to deliver the promises.

Meanwhile, it disregards current tools—the Healthcare Effectiveness Data and Information Set (HEDIS) and New York's Quality Assurance Reporting Requirements (QARR)—that are proven systems that both measure and report quality, and have track records of improving quality of care delivered over time. Notably:

- The annual *State of Health Care Quality Report* from the National Committee on Quality Assurance (NCQA) looks at the status of care in the nation's health care system as delivered by managed care plans. The 2014 report showed almost half of NCQA's quality measures show significant, long-term improvement.
- New York's annual QARR reports indicate the quality of care provided by New York managed care plans is consistently meeting or exceeding national averages. Moreover, the data show differences between Medicaid and commercial managed care plans has continued to diminish.
- Similarly, a study published in the December 11, 2014 issue of the *New England Journal of Medicine* looked at Medicare Advantage data from 2006 to 2011 and found disparities related to blood pressure, cholesterol, and glucose were eliminated in certain Western states as a result of plans' disease management programs.

- ***Negative Economic Impact for New York***

As noted previously, increasing both individuals' person income tax and businesses' payroll taxes would strike a devastating blow to the state's economy. That jab would be followed by an equally hard punch by eliminating tens of thousands of jobs in the health insurance industry.

Not only do plans provide good jobs and pay hundreds of millions in state and local taxes, but they are also community-based companies that invest in those communities, supporting other organizations and making charitable contributions. Health plan

employees are part of the fabric of their neighborhoods and patronize local businesses and merchants, further benefiting the local economy. New York's health plans and their employees make a positive impact on New York's bottom line each year and this proposal not only ignores this but would undo it.

## CONCLUSION

HPA and its member plans are proud of the role they have played in New York's ongoing efforts to improve access to affordable health coverage and quality of care for its residents, and 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.