New York HPA Health Plan Association

Testimony of the New York Health Plan Association

to the

Senate Finance Committee and the Assembly Ways & Means Committee

on the subject of

2015-2016 Executive Budget Proposal

February 2, 2015

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 28 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, Family Health Plus and 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 2015-2016 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 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 now we are 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). In the first year of operation, nearly one million New Yorkers have signed up for health coverage through the NYSOH and another quarter of a million signed up for coverage that began in January of this year. 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

Exchange sustainability: The federal ACA requires that state health insurance exchanges be self-sustaining beginning in 2015. The Governor's budget plan proposes to add a new tax on premiums to pay for New York's health exchange. HPA strongly objects to this proposal. Imposing a new tax — however "modest" as the Governor presents it —will only make health insurance less affordable for New Yorkers. If affordable health coverage is the goal here in New York, the new 'exchange tax' must be eliminated.

New York currently taxes health insurance, with various Health Care Reform Act (HCRA) surcharges and assessments coupled with other assorted levies on health

insurers totaling more than five billion dollars. This five billion dollar tax equals five percent of premium.

In addition to the HCRA taxes, the ACA imposes an added layer of federal taxes on both private and Medicaid premiums, making it more important than ever to draw a line stopping government from imposing new additional taxes on health insurance premiums. An actuarial study estimated the impact of the ACA health insurance tax alone, which began being assessed in 2014, will amount to more than $13 billion dollars in New York over ten years. This is on top of other ACA taxes such as the prescription drug tax and medical device tax that also increase the base premium of health insurance.

ACA Health Insurance Tax

The estimated ten year impact of the ACA health insurance tax alone, which began being assessed in 2014, will amount to more than $13 billion dollars in New York.

Impact on New Yorkers—Average Increase in Premiums (over 10 years)			
New Yorker Buying Coverage:	**On their own**	**Through a small employer**	**Through a large employer**
Individual	$4,395 over 10 years	$3,661 over 10 years	$2,784 over 10 years
Family	$9,942 over 10 years	$9,046 over 10 years	$7,611 over 10 years
Medicaid health plan costs will increase $2,466 per enrollee over 10 years, adding to the state Medicaid budget.			

Source: "Annual Tax on Insurers Allocated by State", Oliver Wyman, November 2012

It is HPA's view that there is no need for a new premium tax.

Last year the Governor called for funding the NYSOH by dedicating the HCRA taxes collected on New Yorkers newly insured through the NYSOH — specifically patient services assessment monies collected for care provided to those newly insured individuals. HPA supported that proposal as a smart approach as it did not create ***new*** taxes or fees but simply dedicated new revenue from existing HCRA taxes.

Similarly, the HCRA covered lives assessment on those newly insured could be dedicated to fund NYSOH operations. In 2014, nearly one million New Yorkers enrolled for coverage through the NYSOH. Another 225,000 have enrolled already for coverage in 2015. That is 1.2 million newly insured New Yorkers paying existing HCRA taxes. This coupled with any patient services assessment funds should be adequate to eliminate the need for a new exchange tax.

Another potential source of existing funding for NYSOH operations is a shift of some of the indigent care funds found under HCRA. The Governor's budget plan allocates $792 million in HCRA funds to this pool for 2015-2016 — the same amount as in 2014-2015 and ***an increase*** over the 2013-2014 level.

The ACA's purpose was to increase access to coverage, thus reducing the number of uninsured and fewer uninsured would mean less spending on indigent care and bad debt incurred by hospitals caring for the uninsured. New York has reduced its uninsured population. Accordingly, it should be able to reduce the funds allocated to pay for care delivered to the uninsured and use that money for the operation of its successful exchange.

Some other reasons why the exchange tax is bad policy and should be eliminated:

- ***Continuing federal grant funding***: New York's marketplace was established and largely funded over the past two years with funding from federal grants — more than $546 million to date. This includes a new $63 million grant awarded in December of 2014, with the stated purpose being system upgrades and operations to "support the open enrollment period in 2015."

- ***Current spending on navigators is misspent***: NYSOH has allocated $54 million over the past two years ($27 million each for 2013 and 2014) for in-person assistors (IPA) and navigators who are paid to provide application assistance to those enrolling through the marketplace. And yet, according to the NYSOH's 2014 Open Enrollment Report, only nine percent of the nearly one million New

Yorkers who enrolled did so with assistance of these IPA/navigators. That compares to 34 percent of enrollees who received help from Certified Assistance Counselors (CACs) — predominantly staff of health plans and hospitals. Significantly, while both IPA/navigators and CACs receive training to assist potential enrollees, CACs do not receive compensation for these efforts. Given the percentage of people assisted by these two equally trained assistors, it makes more sense to allocate the money being spent on navigators to other NYSOH operations.

- ***Availability of Basic Health Plan funding:*** The ACA gave states the option of creating a "Basic Health Plan" (BHP) as a means to provide affordable, comprehensive coverage for lower income residents and this year's budget plan includes implementation of a BHP for New York. The NYSOH marketplace will be responsible for overseeing the enrollment in the BHP through the exchange. This year's proposal for moving forward with a BHP would have the state move the *Aliessa* population (i.e., lawfully-present immigrants with an immigration status that renders them ineligible for federal financial participation) from Medicaid, for which the state bears 100 percent of the cost of care delivered, to the BHP effective April 1, 2015. Instead of paying 100 percent of the costs for this population, the state will receive 50 percent federal BHP reimbursement, providing New York a projected "savings" of $945 million. A portion of these funds should be used for NYSOH operations instead of imposing a new exchange tax.

HPA questions the idea of a statutory tax to pay for an executive order program. It is bad policy and HPA asks you to reject a statutory tax for a program not in statue.

As a final point on the sustainability of the exchange, HPA would like to address the need for accountability for the NYSOH. With the exception of a "readiness report"

provided to the Legislature in August of 2013 (required as part of the 2013-14 State Budget), announcements of navigator funding and the June 2014 Open Enrollment Report, there has been little information about the operation of New York's exchange. There is a concerning absence of detail about how money is being spent and any mechanisms to provide accountability for that spending. As the Legislature considers the appropriate funding level and mechanisms to ensure sustainability of the NYSOH, HPA encourages you to include provisions that will also ensure for accountability of that spending.

Other budget provisions

Value Based Purchasing: There has been significant attention recently to the concept of value based purchasing or value based payment (VBP) in health care. HPA and its member plans support the goals of VBP — paying providers for quality versus quantity, rewarding value versus volume. Indeed, health plans have been at the forefront of implementing payment reforms that look to achieve these goals. The concern plans have is the number of VBP payment reform initiatives for which their participation is required, in addition to any plan-specific programs, and the coordination of the various efforts.

New York is currently implementing the previously referenced DSRIP program, New York's multi-billion dollar Medicaid waiver initiative, as well as the State Health Innovation Plan (SHIP) program, for which the state recently received $100 million in federal grant monies. Both of these proposals move away from fee-for-service (FFS) reimbursement and expand the use of VBP as part of the effort to promote quality improvements and improved health outcomes. A third New York state program — the Fully Integrated Duals Advantage (FIDA) program designed to provide integrated benefits to people eligible for both Medicare and Medicaid — is likewise using a VBP reimbursement structure. Last week the Centers for Medicare and Medicaid Services

(CMS) announced plans to tie 90 percent of all Medicare FFS payments to some sort of quality or value measure by 2018.

The Governor's budget proposal includes provisions that authorize the Department of Health (DOH) to use VBP methodologies under the DSRIP and other programs. The proposed language, however, is too broad as currently drafted. For instance, the proposed language allows Performing Provider Systems (PPSs) under the DSRIP program to arrange for delivery and provision of health services by contract. The vagueness of this authorizing language raises concern and HPA believes the language should be strengthened to ensure that PPSs not be allowed to directly contract with the state unless they are required to meet the same statutory and regulatory requirements as health plans including reserves and consumer protections. Moreover, the VBP budget language should not be open ended and without provisions for periodic review of impacts on consumers, providers and plans, and rigorous evaluation of the effectiveness of VBPs on access to and improvement in quality of care. The consequences of broad authority without adequate oversight could destabilize the healthcare delivery system.

Medicaid Provisions: HPA offers the following brief thoughts on various Medicaid provisions included in the Governor's budget proposal.

- ***Medicaid Profit Cap:*** The executive plans to impose an administrative Medicaid profit cap on mainstream managed care (MMC) plans. All of the funds would be reinvested in the Quality Incentive (QI) pool, though no detail is provided on how the cap would be calculated or implemented, or how the QI reinvestment would be structured.

  HPA believes that an arbitrary cap is not an appropriate way to manage plan finances in a risk-based, capitated environment and will be counterproductive to plans' ability to move into a VBP environment and manage the very complex needs of populations being transitioned into managed care in the coming year,

specifically the adult and child behavioral health benefits and populations. While profit is capped, no details exist to address plan losses, year-to-year financial swings, or inclusion or exclusion of revenue generated by QI revenues or VBP premium incentives.

- ***Pharmacy:*** The executive budget includes several statutory and administrative proposals related to the Medicaid pharmacy benefit that would have a combined fiscal savings of more than $119 million. The centerpiece of the Medicaid pharmacy proposals is an effort to leverage rebates from pharmaceutical manufacturers for a total savings from FFS and MMC of $73 million. That amount includes an estimate of $16.9 million in savings achieved by leveraging the total Medicaid pharmacy volume to negate any supplemental rebates. This provision would undercut health plan ability to negotiate supplemental rebates, and thereby potentially increase the cost of the Medicaid pharmacy benefit for plans as the Pharmacy Benefit Managers would lose MMC covered lives to the state. It would also have the ancillary impact of requiring plans to adopt the terms of the state negotiated supplemental rebate in order to achieve the negotiated rebate amount.

- ***Child Health Plus (CHP):*** The Governor's budget includes two CHP proposals HPA believes should be changed.
    - *CHP Rate Reduction* — The executive assumes $70 million in financial plan relief related to increased federal share funding for CHP, effective September 1, 2015. The state should use a portion of this increased federal funding to eliminate the CHP rate reduction enacted in 2010.
    - *Mandatory APG Reimbursement for behavioral health* —The Governor's budget would require that CHP plans pay Medicaid ambulatory payment group (APG) rates for outpatient behavioral health services. HPA believes

this proposal is inappropriate as CHP is a commercial not a Medicaid product. Moreover, it is counterproductive to the move toward value based not volume based reimbursements and will increase costs.

Prior Approval Process: Although not included in the Governor's budget plan, HPA believes the Legislature should take this opportunity to address New York's premium rate setting process, especially in light of the 2015 rate decisions rendered by the Department of Financial Services (DFS).

As many lawmakers may recall, the "prior approval" process that existed before the enactment of the "file and use" system in 1996 was highly susceptible to political influence, not based on sound actuarial principles and compromised the solvency of some insurers. As a result, the Legislature determined to establish an alternative that would depoliticize rate setting and make certain that rate determinations were based on sound actuarial principles. In 2010, when the department proposed reinstituting prior approval, DFS provided assurances to the Legislature — and the industry — that it would not revert to the politicization of rate setting and would instead use a system that would yield actuarially sound rates. The statute adopted expressly requires the superintendent to make decisions "based on sound actuarial assumptions and methods." The statute also requires that the superintendent's decision be provided in writing between 30 and 60 days following the submission of rates.

The 2015 rate setting process was contrary to this statute and resulted in rate decisions that were arbitrary and capricious, and that will ultimately harm consumers by threatening the stability and sustainability of a viable marketplace for coverage in New York. Recent reports about health plans' 2014 losses, which come on top of losses in 2013, bear witness to this threat.

The Legislature must ensure that rate determinations are in writing and reflect the statutory requirement that "the determination of the superintendent shall be supported by sound actuarial assumptions and methods." Plans need independent

actuarial guidance that DFS will rely upon as they prepare rate applications and that the final rate decisions be provided in writing between 30 and 60 days from the date of the rate filing or application.

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.