Testimony of the New York Health Plan Association

to the

New York State Assembly Committee on Health
and
the Senate Committee on Health
on the subject of

A.5248/S.3577 – The New York Health Act

November 25, 2019

Introduction

The New York Health Plan Association (HPA), comprises 30 health plans that provide comprehensive health care services to more than eight million fully-insured New Yorkers, and appreciates the opportunity to offer testimony on A.5248/S.3577 – the New York Health Act.

We believe that every New Yorker deserves coverage for high-quality, affordable health care, and our member health plans are committed to continuing to work with state lawmakers, policymakers, and others to achieve the goal of universal coverage. New York has been successful in providing insurance coverage to more than 95 percent of state residents, in large part due to the work of our member health plans in implementing the Affordable Care Act (ACA) and New York's ambitious Medicaid Redesign program.

We recognize that more work is needed to achieve the goal of universal coverage and to address the cost of health care. **However, we oppose the New York Health Act, as it would take away health coverage options currently available to millions of New Yorkers and require massive tax increases.** Instead, we believe the focus should be to build on the current health care infrastructure without disrupting current coverage options for employers and consumers to ensure coverage for all New Yorkers and to make health care more affordable.

Shared Goals

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

For more than two decades, 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 and managed long term care.

HPA member health plans were also instrumental in the implementation of the New York State of Health (NYSOH), New York's health insurance exchange created under the federal ACA. Regularly cited as a model for state-based exchanges, the NYSOH has expanded access to care to nearly 5 million New Yorkers and offered them greater choice of plans and products. The expansion of Medicaid under the ACA coupled with New York's decision to implement a Basic Health Plan – the Essential Plan – means millions of New Yorkers have access to free or very low-cost coverage. For those exchange enrollees not covered by these programs, nearly 60 percent receive subsidies to reduce the cost of premiums and to help defray out-of-pocket costs.

The Value of Managed Care in New York's Health Care System

Historically, when government has looked to expand access to care and coverage, it has turned to health plans and health plans have responded.

At the state level, when New York developed the Medicaid Managed Care program in 1992, key goals were to provide lower-income New Yorkers with better access to health care services by giving this population a "medical home" and, through better and more timely access to care, improve the quality of care and improve the health status of these patients. Promoting 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—helped to provide better continuity of care. In addition to enhancing care coordination and improving overall care outcomes, an added benefit of shifting Medicaid patients away from a fee-for-service (FFS) model and into managed care settings was cost savings for the state.

In 2011, the Medicaid Redesign Team (MRT) was created to move more of the Medicaid population from FFS into managed care — particularly higher risk Medicaid populations such as Supplemental Security Income (SSI) and those with behavioral health concerns who present greater challenges for coordinating and delivering appropriate care and providing case management support services. The MRT sought to expand on the managed care model's ability to provide greater accountability, efficiency and innovation in New York's Medicaid program — things that 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.

Better access to care, enhanced coordination, improved outcomes, and greater accountability were also the goals of the federal government when it created the Medicare Advantage program. These managed care plans provide all the coverage that falls under Medicare Part A (hospital insurance) and Medicare Part B (medical insurance) as well as many things that traditional Medicare doesn't cover. These extras can include vision, hearing and dental benefits, as well as wellness programs and affordable prescription drugs. Not surprisingly, a 2018 poll found that 90 percent of people with Medicare Advantage plans are satisfied with their coverage. In New York, nearly 40 percent of Medicare beneficiaries receive their coverage through a Medicare Advantage plan.

Equally important as the objective of increasing access to coverage is the goal of improving health care outcomes for New Yorkers. Over the past 25 years, health plans have been committed to measuring and improving the outcome of the care provided.

Since 1994, the state has been measuring and reporting on health plan quality. The Department of Health's Quality Assurance Reporting Requirements (QARR) measures how well plans are delivering care in a wide range of areas — including Adult Preventive Care, Behavioral Health, Child and Adolescent Health, Management of Acute and Chronic Conditions, Women's Health and Maternal Care — across the commercial and Medicaid populations. Year after year, New York health plans consistently met or exceeded national benchmarks across measures — especially in Medicaid managed care. Another area that is measured is consumer satisfaction, including satisfaction with providers, care coordination and ability to get needed care quickly. Plans consistently receive high marks in these areas. Similar reporting at the national level from the national Committee for Quality Assurance also shows in New York plans continue to meet or exceed national benchmarks for quality and satisfaction.

Health plans have long been at the forefront of initiatives to identify ways to improve patient care and generally enhance the overall health and well-being of their members and communities. One example is the increasing use of value based payment (VBP) arrangements. The goal of VBP is to improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding a high-value care delivery. Since 2015, New York State has continued to advance its VBP initiative and health plans have collaborated in these efforts.

Health plans are also partners in the state's $8 billion Delivery System Reform Incentive Program (DSRIP), an initiative aimed at containing Medicaid costs. The program, which calls for significantly reducing avoidable hospital, relies on managed care to collaborate with hospital systems on system transformation, clinical management and population health improvement. The state has just submitted a waiver application for another $8 billion to extend and expand DSRIP.

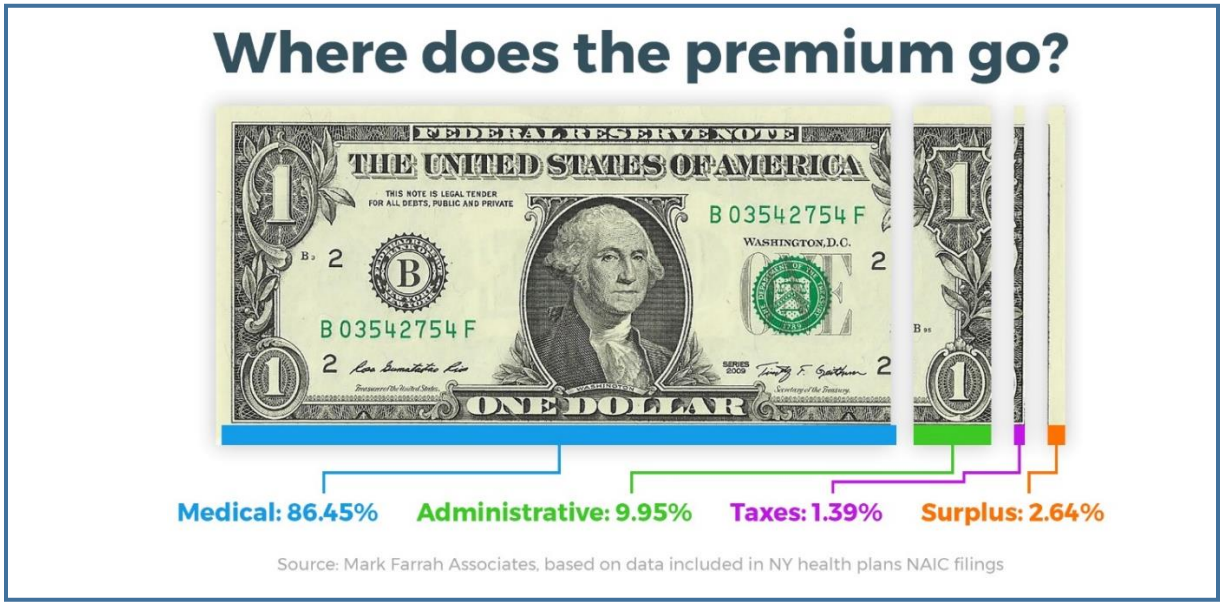
The NY Health Act: Fewer Choices, Longer Wait Times and Diminished Quality

The New York Health Act does not include the processes that are ingrained in managed care systems to measure and improve outcomes. Lacking these proven practices creates serious quality concerns associated with government-run, single payer systems. The evidence demonstrates that these systems fail to provide timely access to high-quality, innovative medical care to all individuals. Often, patients have less access to the latest medical technology and breakthroughs, fewer choices, and longer wait-times to receive basic and specialty care.

The Canadian system — often cited by single payer proponents — offers a good comparison to what is being proposed under the NY Health Act. According to a recent report in the Washington Post, *"Canadians tend to face longer wait times to see specialists or undergo elective procedures, especially hip and knee replacements and cataract surgery. An analysis of 2016 data found 39 percent of Canadians reported waiting at least two months to see a specialist, compared with 6 percent in the United States. Those waits cost Canadians $2.1 billion in lost wages in 2018, with average wait times about 20 weeks from referral to receipt of treatment — 113 percent higher than in 1993."*

The Myth of Administrative Savings

One of the most often used arguments in support of a single payer system is that it would significantly reduce administrative costs. This argument is usually coupled with statements that these costs account for upwards of 30 percent of health insurance premiums. The reality, however, is that federal and state laws restrict what health plans can spend on administrative costs. Currently, for small group and individual policies, health plans are required to spend 82 cents of every premium dollar on medical costs (for large groups, the amount is 85 cents).



Not all things that fall under administrative costs are bad. Administrative costs include a wide range of things such as care management and coordination programs for individuals with chronic conditions, health information technology, quality improvement programs, investments in social determinants of health, and wellness programs. They also include investments in innovations like telehealth and medication adherence, infrastructure to prevent fraud, waste and abuse, and timely claims payment. These programs that improve care and

help save costs are arguably worth the administrative investment. All of this combined accounts for roughly ten percent of the premium.

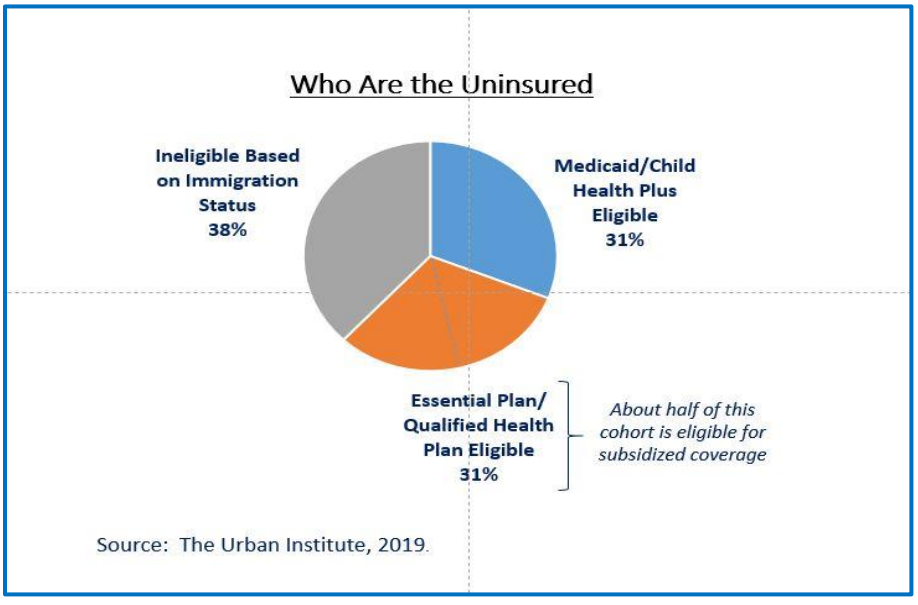
Also included in health plans' administrative costs are the government assessments, taxes, and myriad reporting requirements imposed on plans by the state and federal governments.

The Path to Universal Coverage: Reaching the 5 percent and Making Health Care More Affordable

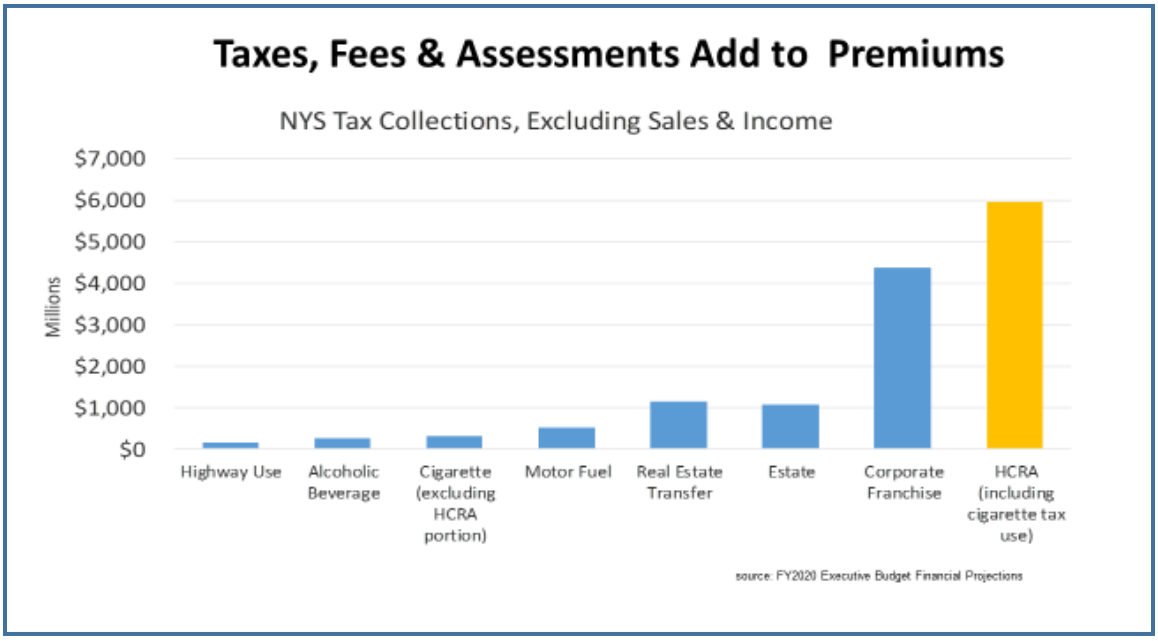
Since the enactment of the federal ACA and creation of the NYSOH exchange, New York has cut its uninsured rate in half. In 2013, more than ten percent of New Yorkers were uninsured. Today, the state's uninsured rate is at its lowest rate ever – 4.7 percent – according to news released earlier this year by the NYSOH, based on recently released data from the federal Centers for Disease Control and Prevention's National Health Interview Survey.

New York should be justifiably proud of this accomplishment. Looking at these achievements, it is clear to see that New York is well on its way to universal coverage. So in a goal of getting everyone covered, why throw all of this away? We believe that it is possible to get all New Yorkers covered by taking the following steps:

- Investing in Expanding Coverage — According to an 2019 report by the Urban Institute, today roughly half of the 1.1 million New Yorkers who lack coverage are already eligible for free or low-cost coverage through public programs like Medicaid, Child Health Plus, and the Essential Plan—or are eligible for tax credits to reduce premiums and cost-sharing for the Qualified Health Plans available from New York State of Health. Reaching out aggressively to enroll these individuals and, where available, maximizing federal funding would be a major step forward in closing the uninsured gap.



- Stabilizing the Individual Market — The state should make subsidies available to consumers who are not eligible to access federal subsidies or tax credits and adopt an individual mandate to promote a stable marketplace.
- Providing Greater Market Flexibility — The state should build on the existing employer-based system by giving businesses and consumers more health insurance options. Measures should include greater regulatory flexibility in health plan benefit design that will allow for a broader choice of affordable health plan products, including measures that promote wellness and reward consumers who seek care from high-quality, cost-effective providers.
- Addressing Underlying Health Care Costs — Health insurance premiums and the prices charged for medical services and prescription drugs are inextricably linked. New York should take steps to ensure that employers and consumers are getting value for the prices being charged. Approaches should include: greater oversight and monitoring of provider mergers so that consolidation does not lead to exorbitant prices; and transparency by pharmaceutical companies for increases in their prescription drug prices.
- Making Better Use of Existing Health Care Dollars — Nearly $5 billion in various taxes, surcharges, and fees are imposed on health insurance, representing the third largest source of state revenue behind the sales and income taxes. The state should promote the most efficient use of these funds and reallocate some of this revenue to assist consumers in accessing coverage.



Massive Tax Increases: New York's Widening Budget Gap

Last year's independent analysis by the RAND Corp. for the New York State Health Foundation estimated more than $139 billion in new taxes would be needed in 2022 and $210 billion in 2031 to fund the New York Health Act. This number climbs to nearly $250 billion when you factor in the addition of long term care, which was not included in the RAND estimates. These estimates are predicated on assumptions that are likely hard to achieve:

- First, that the state would receive the necessary federal waivers, which is doubtful in light of CMS Administrator Seema Verma's statements that CMS would likely deny waivers from states to launch single payment systems.
- A second assumption is that the state would be able to regulate provider rates and drug prices, which RAND noted was "highly uncertain and depend on providers' bargaining power."
- The analysis also noted that New York would need to increase taxes even further if the projected savings from cutting prices paid to providers don't materialize or if wealthier New Yorkers and/or New York businesses abandon the state. Unshackle Upstate recently released results of a survey of businesses citing single payer as a huge concern and said that all respondents knew "at least one business" that had left New York for more welcoming economic climates.

Another factor that must be considered is New York's existing budget challenges. In recent weeks, state officials acknowledged a significant — and potentially growing — gap in the state's Medicaid budget. According to the mid-year financial report released just this past Friday by the state Division of Budget, New York's Medicaid spending is on track to exceed statutory limits by more than $4.3 billion for the fiscal year that ends March 31. The Administration is already discussing the possibility of drastic cuts to Medicaid spending over the next five months to address the problem.

The fiscal challenges in Medicaid raise questions about how the state would handle similar shortfalls under the New York Health Act, and how it would affect the health care of all New Yorkers. Will it result in payment cuts to providers? Will there have to be restrictions in services and coverage benefits? Will there be mid-year tax increases? Or will it be a combination of all of these?

Conclusion

Rather than continuing to devote attention to creating a one-size-fits-all, government-run system that would take away options currently available to seniors and other state residents, and require massive tax increases, the focus needs to be on efforts to build on New York's achievements to date, and to further expand coverage, address costs and improve quality without disrupting current coverage options for employers and consumers.

HPA and its member plans support the objective of universal coverage, and New York is very close to achieving that goal. Our plans are proud of the role they have played in helping the state achieve this success and continue to be committed to working with you and your colleagues to close the remaining gap and ensure that all New York individuals, families and business have access to high-quality, affordable health care coverage.

We thank you for the opportunity to share our views today.