Testimony of the New York Health Plan Association

to the

Senate Finance Committee
and the Assembly Ways & Means Committee

on the subject of
2025-26 Executive Budget Proposals on Health Care

February 11, 2025

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 23 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. Plans have also supported and participated in New York's ongoing efforts to address and eliminate long-standing racial and ethnic disparities, working on multi-faceted strategies to build an equitable health care system. Plans strongly support the state's Medicaid 1115 Health Equity Reform waiver, which invests significant resources into efforts to eliminate disparities, and in which plans have a major role. HPA's members remain committed to continuing to work with policy makers and lawmakers to further the efforts to promote health care equity and ensure the availability of high quality, affordable health care for all New York consumers and employers.

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, nearly five million of New York's Medicaid beneficiaries — approximately 70% — receive their care through a Medicaid managed care plan.

We recognize the uncertainty facing New York presented by the threat of deep cuts in federal funding for the Medicaid program and the challenges that could create in budget discussions. HPA and our members in concert with consumers, frontline caregivers, providers, insurers, business, and local government are steadfast in our shared dedication to protecting, preserving, and strengthening New York's Medicaid program.

Further, a major policy change enacted in the current fiscal year budget (FY25), and scheduled to be implemented on April 1, 2025, is the transition to a single fiscal intermediary (FI) in the consumer directed personal assistance services (CDPAS) program. The transition is taking place in an extremely short timeframe. Our primary concern has been – and continues to be – avoiding any disruption to the care of approximately 250,000 members who rely on CDPAS to remain independent. A smooth transition requires that all parties – DOH, the state's contractor, PPL, and the plans – work together to assure that all CDPAS members are registered with PPL, and that all the members' personal assistants (PAs) are also registered in PPL's system, so they can continue to provide services and be paid on and after April 1, 2025. Plans are making every effort to work collaboratively with the state and PPL to assure that members continue to receive their CDPAS services as the implementation date gets closer and expect to continue to work with the state and PPL once the implementation is underway.

Our specific comments on the Executive Budget and HPA's requests are as follows:

Funding for the Medicaid Quality Incentive (QI) Program — Support

We were pleased to see that Governor Hochul's Executive Budget included funding for New York's Quality Incentive (QI) Program. In past years, funding for this program has been reduced or eliminated, and the Legislature has thankfully restored some funds to support this important program.

The QI Program has been vital in enhancing the quality of care for individuals in Medicaid, supporting a broad range of initiatives between health plans and their provider partners to address racial and ethnic disparities in care and improve health outcomes for underserved populations across the state. Sustainable funding is critical to building on these efforts and we urge your continued support and further investment in the FY26 budget to fully fund the program.

The Executive Budget utilizes a portion of the proceeds from the MCO tax to provide $50 million state share funding for the Mainstream Medicaid Quality Incentive Program. We ask the Legislature to provide $300 million state share in the final FY26 budget for the QI Program.

This program, which has been in place for more than two decades, has a proven track record of improving the quality of care for the Medicaid population and helping to address the social factors that create barriers to equitable care for residents.

Initiatives supported by the QI Program include:

- Screening for post-natal depression and connecting these mothers with therapy as well as other health services and social supports in New York City;
- Providing diabetes management tools and education to help high risk, non-compliant patients lower their A1C levels and improve medication adherence;
- Assisting homeless members with a history of long-term substance abuse to successfully maintain sobriety, manage their medical care, avoid inpatient treatment, and help them secure housing in the Bronx; and

- Providing new parents in the Capital Region with educational information and resources, as well as a new baby "welcome package."

Quality funding is directly invested back into the community, with plans using QI Program dollars to partner with providers and community organizations on programs that benefit low-income New Yorkers. The success of the programs that receive funding is closely monitored and health plans are measured on performance metrics that the State sets. Plans only receive incentive funding for achieving results that meet or exceed these metrics.

We appreciate that the Legislature has consistently supported this program by including funding in the final budget to sustain the vital services of the QI Program. **Increasing the proposed funding in the FY26 budget to $300 million will help preserve and enhance these critical programs and maintain the ongoing efforts to eliminate disparities and deliver high-quality, equitable care to the state's most vulnerable residents.**

Additionally, to ensure continued progress on improving equity, eliminating disparities and incentivize ongoing health care reforms, it is imperative that the QI Program be adequately and consistently funded. Codifying this program in statute would be an important step to protect the QI Program and initiatives it supports. **HPA strongly encourages the inclusion of legislation (A2044) in each house's one-house budget proposals to establish the Medicaid QI Program in statute.**

Excluding Medicaid from the Independent Dispute Resolution (IDR) Process — Support

Part E of the Health and Mental Hygiene Article VII bill would exempt Medicaid from the Independent Review (IDR) process. The State's IDR process is intended to protect patients when there is an out-of-network emergency service or a surprise bill from a nonparticipating provider and resolve disputes between a provider and health plan over whether the provider's fee or the health plan's payment is more reasonable.

Exempting Medicaid from the IDR process is appropriate for two reasons. First, members are already protected from balance bills when out-of-network reimbursement disputes arise. Second, when a nonparticipating provider uses the IDR process for a Medicaid member, it can result in significantly higher costs than what Medicaid pays for services, enabling providers to increase their reimbursement at the expense of taxpayers. This is because in determining whether the provider's billed charges or the plan's Medicaid rate is more reasonable, the entity reviewing the dispute compares the two rates to the 80th percentile of the rate paid for the service according to FAIR Health. When the provider's billed charges are closer to the FAIR Health rate than the Medicaid rates, the existing statutory setup has the result of driving the decision to choose the provider's billed charges as more reasonable, as the current process does not take into account differences in payments between commercial and Medicaid payors.

CASE STUDY

Medicaid member was admitted to a downstate, nonparticipating facility for emergency back surgery. Surgery was performed by an out-of-network provider. Because of the nonparticipating status of both the facility and the provider, the plan paid the provider's claim at 100% of the Medicaid fee schedule, but the provider disputed the reimbursement rate, submitting a bill more than 200 times higher than the Medicaid rate.

- **Provider's Billed Charges:** $566,319
- **Medicaid Paid Amount:** $2,807
- **80th Percentile Fair Health:** $357,489

The IDR rendered a decision that the provider was owed an additional payment of $511,396.

- **Final Judgment Award Amount:** $514,169, with the plan required to pay this amount despite the charges being well in excess of the amount Medicaid reimburses for this procedure.

Providers utilizing the IDR process often are not primary care physicians but rather those in high cost specialties such as neurology/neurosurgery, orthopedics/ortho surgery, anesthesiology, cardiology, and thoracic surgery. The current structure has created a loophole

that providers use to exploit the Medicaid system, incentivizing high priced providers to remain out-of-network to charge exorbitantly higher rates, while providing no benefit to patients and increasing costs for taxpayers. New York should not allow providers to intentionally stay out-of-network and then refuse the Medicaid rate. **We urge the Legislature to support the inclusion of this provision in the final enacted budget.**

Increased DOH Contract and Performance Penalties — Oppose

Part E also includes language that would authorize the Department of Health (DOH) to penalize health plans for contract and performance standard noncompliance, with penalties from $250 – $25,000 per violation dependent on the severity and at the sole discretion of the Commissioner. Under the Medicaid managed care program, DOH and each individual health plan enters into a model contract defining the obligations of the parties to provide benefits to Medicaid enrollees. The Department already has ample authority to seek redress for both contractual and regulatory violations and the proposed penalties are unnecessary. Last year's Executive Budget proposal included a similar provision that HPA opposed and the Legislature rejected. **We urge the Legislature to continue to reject this proposal.**

Commercial Compliance Monitoring of Behavioral Health Services — Changes Proposed

The FY 2025 Enacted Budget established a new requirement that New York State-regulated commercial insurers reimburse certain providers licensed by the Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) at or above the Medicaid rate for outpatient behavioral health services. The FY 2026 Executive Budget provides $1 million for additional staff to monitor compliance with the new law.

Health plans worked closely with the Department of Financial Services (DFS) and OMH and OASAS to implement these requirements in advance of the January 1, 2025 effective date in an effort to ensure as smooth a transition as possible. Despite health plans requesting specific data and support from the State, operational challenges persist. HPA has advocated

for OMH and OASAS to create a fee schedule for each service subject to the mandate – rather than a complicated set of calculations plans must make manually for multiple service combinations. Instituting a fee schedule would simplify the process and reduce billing disputes, decreasing administrative complexity for health plans and ensuring providers are paid the expected amount. HPA and our plans are also committed to continuing to work collaboratively with both the State and the providers to address issues as they arise going forward. **Rather than increasing funding for commercial compliance monitoring, provisions should be included in the final FY26 budget directing OMH to establish a fee schedule, utilizing the Medicaid rates, for outpatient behavioral health services.**

Transparency of Prescription Drug Rebates — Oppose

Provisions in the Executive Budget (TED Part Z) would require licensed Pharmacy Benefit Managers (PBMs) to annually publish a report on their websites containing detailed information on rebate contracts. In addition to outlining the specific aggregated data required for disclosure in each PBM's annual report and defining what constitutes a "rebate contract," it also requires that a copy of each PBM's annual report be filed with DFS and DOH.

This provision has the potential to encourage anti-competitive behavior among pharmaceutical manufacturers, who would be able to see every detail of the rebates their competitors offer. This does nothing to provide meaningful information for consumers on their prescription drug costs and does nothing to address the high cost of prescription drugs. Instead, it will likely lead to tacit collusion among drug companies enabling them to decrease rebates while continuing to charge high prices, increasing costs for consumers and employers without providing any meaningful benefit.

Further, New York adopted legislation in 20222 to regulate the operation of PBMs, which included extensive disclosure and reporting requirements. The law also charged DFS with developing regulations for these new rules and requirements and those regulations were

finalized in late November 2024. Given the recent adoption of this sweeping regulation, acting to mandate additional reporting requirements – on top of reporting that has not yet completed a full year's cycle – is premature at the least. **We urge the Legislature to reject this proposal in the final budget.**

Interstate Nurse Licensure Compacts — Support

Part W of the Executive's budget includes language that would enable New York to join the Interstate Licensure Compacts for registered nurses and licensed practical nurses. This will make it easier for registered nurses and licensed practical nurses licensed in other states to practice in New York, which is a step forward in addressing the problem of provider shortages – particularly in the areas of primary care and behavioral health. **We urge the Legislature to include this proposal in the final budget.**

CONCLUSION

We thank you for the opportunity to share our views today and look forward to continued discussions with you and your colleagues on these and other health care related provisions in the FY26 state budget.