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TESTIMONY OF

THE COALITION OF NEW YORK STATE

PUBLIC HEALTH PLANS

ON THE GOVERNOR'S PROPOSED FY 2012-2013 HEALTH AND MEDICAID BUDGET

SUBMITTED BY DENNIS GRAZIANO

TO THE

SENATE AND ASSEMBLY COMMITTEES ON

HEALTH, MEDICAID AND THE AGING

FEBRUARY 8, 2012

Introduction

Thank you for the opportunity to provide testimony on behalf of the Coalition of New York State Public Health Plans (PHP Coalition). My name is Dennis Graziano, and I am testifying in my role as President and CEO of The Monroe Plan for Medical Care and as member of the Coalition.

Established in 1995, the Coalition of New York State Public Health Plans is an important voice for New York's non-profit, publicly-focused health plans and the low-income people we serve. The Coalition currently represents ten plans serving 2.8 million individuals, about three-quarters of all of the children and adults enrolled in New York's Medicaid managed care, Family Health Plus, and Child Health Plus programs. Coalition plans offer decades of experience in delivering high quality services to members who often, otherwise, experience significant barriers to health care.

Today, we would like to comment on how health plans are partnering with the Executive and Legislative leaders to achieve New York's "care management for all" commitment and encourage the Legislature to take advantage of important new coverage mechanisms by establishing a health benefit exchange.

Reigning in Costs While Improving Health Care Quality

Medicaid managed care's partnership with the State grows out of deep-rooted values, goals, and incentives we share. In New York, we know that patients who are the poorest, sickest, hardest to reach, and most expensive to treat are not "the problem" with our health care system; instead, they challenge all of us to provide them with access to a health care system that anticipates and meets their profound health needs. Health plans are meeting this challenge and connecting people who would otherwise fall through the cracks with patient-centered, coordinated, and comprehensive care.

Long before Governor Cuomo brought together key healthcare stakeholders to form the New York Medicaid Redesign Team (MRT) in 2011, the Medicaid managed care model had been a catalyst for positive change in New York's health care delivery system. Recognizing this, the MRT embraced Medicaid managed care as the vehicle to achieve the Governor's stated goal: "measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure."[1] To meet this goal, the State decided to have Medicaid managed care plans enroll new, more complex populations and provide a more comprehensive Medicaid benefit to their members. Health plans have stepped up over the past year to implement these new policies to drive better outcomes and lower costs.

Among these changes, the management of Medicaid drug benefits exemplifies New York's new paradigm for care delivery in Medicaid. Before October 2011, the State experienced runaway drug costs; in addition, some patients had little clinical oversight of prescriptions written by multiple providers, in multiple settings. As a single, accountable entity, managed care

[1] State of New York, Executive Order #5 (January 2011). http://www.governor.ny.gov/executiveorder/5

plans are now able to facilitate information exchange among providers, promote patient-centered care, and contain costs by eliminating duplicative and unnecessary prescriptions. Consequently, New York is expected to exceed its 2011/12 pharmacy State savings target of $50 million and will likely reap annual savings in subsequent years of over $100 million.

In addition to pharmacy benefits, 2011 saw the transition of the personal care and restricted recipients, among other populations, into Medicaid managed care. Plans are also now working closely with the State to prepare for the April 2012 integration of homeless individuals and families, low birth weight babies, and other complex populations that are among the most economically and medically vulnerable in the State. These transitions are not easy and require intense planning and coordination among the plans, consumers, the state, and other health care stakeholders. But, despite aggressive timelines, intensive logistical and technical preparations, and major administrative overhauls, implementation has been remarkably smooth with no widespread disruptions for Medicaid beneficiaries.

Buttressing this transformation is the critical need for setting rates that allow the plans to connect individuals with medically appropriate care while maintaining fiscal stability throughout this entire transition. We've already, unfortunately, seen firsthand, through the pharmacy implementation, that the State's optimistic assumptions on costs are not playing out in the marketplace; plans are currently losing a significant amount of money on the pharmacy benefit. To address this issue, we are urging the Department of Health to work with us to monitor expenses as these and other transitions occur to ensure that rates accurately reflect the true costs of new populations, benefits, and changes in case mix and utilization.

We also urge the State to collaborate with us in building its program for individuals enrolled in both Medicare and Medicaid (dual eligibles). In New York, there are 700,000 dual eligibles, consuming an estimated 45 percent of Medicaid ($23.4 billion) and 41 percent of Medicare ($11.3 billion) spending. Through better care coordination, New York has a tremendous opportunity to vastly improve the quality of care and quality of life for these beneficiaries and achieve significant operational and financial efficiencies for the State.

Public health plans must play a major role in implementing this new system as we currently serve over 65,000 of these beneficiaries, or 10%, through our Medicare Advantage Special Needs Plans for duals. These enrollees are currently benefiting from managed care – better care coordination, robust provider networks, member services support, quality oversight, among others. An overhaul of this magnitude requires collaboration in the starting block, not at the finish line. Thus, while New York designs its duals program and secures federal authority and resources, health plan expertise must be leveraged from the start in order to ensure a seamless transition for current plan members and ultimately improve outcomes for those who enroll in the future.

As New York outlines ongoing population and benefit integration in the years ahead – particularly in giving plans the responsibility to serve dual eligibles and eventually moving behavioral health services into Medicaid managed care – health plans stand ready to ensure real, measurable progress to reduce immediate and long-term Medicaid costs while upholding and building on exceptional standards of care.

Implementing New Structures to Expand Access to and Continuity of Care

State and federal programs like Medicaid and Medicare are essential to ensuring that the most vulnerable New Yorkers have access to health insurance coverage and health care. But there is more that can and must be done to extend access to affordable coverage to all of our residents. Insurance premiums in our individual, non-group health insurance marketplace are at an all time high, averaging over $1,000 per month, virtually unaffordable for the vast majority of New Yorkers. In addition, New York has the second-highest average monthly premiums in the country for small group single ($554) and family ($1455) coverage[2]; with this market becoming increasingly unprofitable, more insurers are forced to cut their small group market products, increasing the number of working people, and their dependents, who are uninsured.[3]

The State has a unique and unprecedented opportunity to make health insurance coverage more affordable and accessible for New York's small businesses and working families by establishing a Health Benefit Exchange. An Exchange is a transparent insurance marketplace in which individuals and small business can compare and shop for affordable coverage options through a process that is streamlined, standardized, consumer-oriented, and technology enabled. Through a New York Exchange, our residents will be able to access premium subsidies in the form of tax credits to purchase health insurance – these subsidies will make health insurance affordable to many New Yorkers for the first time in their lives. Many of the State's small businesses will also be able to access tax credits by purchasing through the Exchange.

The Executive Budget provides authorization to create an Exchange in New York and outlines the Exchange's functions, organizational form and governance, financial sustainability requirements, and areas of further study to inform design of this new marketplace. The PHP Coalition is committed to the successful design and operation of the Exchange. We believe that New York must be extremely proactive in harnessing this brief window of implementation to be ready to stand up our Exchange in 2014; failure to do so will deny our citizens the full potential benefits of an Exchange, and worse, may jeopardize the State's autonomy and authority to establish an Exchange that is uniquely suited to New York's insurance markets and the needs of our citizens. In short, we all know what the residents of our State need, and we should design and implement our Exchange now, while we have access to funding and time and autonomy to collaborate with stakeholders to do so.

We urge the legislature to provide the authority needed to move forward in establishing the Exchange, drawing down necessary federal funding, and working through the myriad organizational issues critical to its successful implementation. As experts in enrolling, retaining and managing health care for lower-income New Yorkers, public health plans look forward to working with the Legislature and our State agencies to design and participate in an Exchange that will strengthen the continuum of coverage, improve access to and continuity of health insurance, and improve health care for all New Yorkers.

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[2] AHIP, "Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits," http://www.ahipresearch.org/pdfs/SmallGroupReport2011.pdf.

[3] Crain's New York (January 2012), http://www.crainsnewyork.com/article/20120108/SMALLBIZ/301089987

To these ends, the PHP Coalition also supports the creation of a Basic Health Program (BHP) in New York. A BHP would provide affordable and comprehensive coverage for adults whose incomes fall below 200% of the Federal Poverty Level who would otherwise face a steep cost-sharing cliff between Medicaid and plans offered through the Exchange. A BHP would provide consistent and stable coverage for low-income families who may otherwise face a "split" in provider networks, policies, procedures, and cost-sharing as adults receive coverage through an Exchange and children remain in Medicaid and/or CHIP. A BHP minimizes the risk of coverage breaks for individuals that can lead to extremely harmful effects on their health and on the entire health care system.

The Coalition acknowledges there are many design, implementation, and sustainability questions that remain with respect to developing a New York Basic Health Program; thoughtfully assessing and addressing these issues is critical to ensuring that a BHP is the right option for New York, and that its design is tailored to the State's goals and needs.

A New York State Exchange and Basic Health Program provide unprecedented opportunities to expand affordable health coverage to all New Yorkers. The PHP Coalition is dedicated to working collaboratively with the State and other stakeholders to help leverage these opportunities to the benefit of all New Yorkers.

Conclusion

Thank you for the opportunity to provide testimony on these critical issues. We look forward to continue partnering with the Legislature to ensure that a strong and stable health coverage and health care system is in place that not only serves the growing number of New Yorkers that rely on it, but that reflects and enhances the collective vitality of the entire State.

MEMBERS OF THE COALITION OF NEW YORK STATE PUBLIC HEALTH PLANS

PLAN	AFFILIATED ORGANIZATIONS	SERVICE AREAS
Affinity Health Plan	*Primary care provider organizations with representation on the Board of Directors*: Morris Heights Health Center, Charles B. Wang Health Center, Urban Health Plan, and Institute for Family Health	New York City and Nassau, Orange, Rockland, Suffolk, and Westchester Counties
Amida Care	HIV Special Needs Plan founded and owned by Harlem United, HELP/PSI, Inc., Housing Works, Acacia Network, St. Mary's, and VillageCare	Bronx, Kings, New York, and Richmond Counties
Fidelis Care New York (The New York State Catholic Health Plan)	Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic healthcare providers	New York City and 53 other counties[1]
Healthfirst	Hospitals in all counties in which the plan operates[2]	New York City and Nassau and Suffolk Counties
Health Plus	Lutheran Medical Center	New York City and Nassau County
Hudson Health Plan	Open Door Family Medical Centers, Hudson River Community Health	Dutchess, Orange, Rockland, Sullivan, Ulster, and Westchester Counties
MetroPlus Health Plan	New York City Health and Hospitals Corporation	Bronx, Kings, New York, and Queens Counties
The Monroe Plan for Medical Care	The Monroe Plan for Medical Care is an independent, not-for-profit managed care organization that has a contract with Excellus BlueCross BlueShield to manage their Medicaid, Family Health Plus, and Child Health Plus products	Broome, Cayuga, Chemung, Chenango, Clinton, Cortland, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orleans, Oswego, Otsego, Schuyler, Seneca, Steuben, St. Lawrence, Tioga, Tompkins, Wayne, and Yates Counties
Neighborhood Health Providers	Brookdale Hospital and Medical Center, Jamaica Hospital Medical Center	New York City and Suffolk County
Total Care (Syracuse PHSP)	Syracuse Community Health Center	Cortland, Onondaga, Oswego, and Tompkins Counties

[1] Albany, Allegany, Broome, Cattaraugus, Cayuga, Chautauqua, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Ostego, Oswego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St Lawrence, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester and Wyoming Counties.

[2] Beth Israel Medical Center, Bronx-Lebanon Hospital Center, The Brooklyn Hospital Center, Elmhurst Hospital Center, Interfaith Medical Center, Jamaica Hospital Medical Center, Maimonides Medical Center, Montefiore Medical Center, Mount Sinai Hospital, New York City Health and Hospitals Corporation, New York Downtown Hospital, North Shore – LIJ Health System, the NuHealth System, Staten Island University Hospital, St. Barnabas Hospital, St. John's Episcopal Hospital, St. Luke's-Roosevelt Hospital Center, Stony Brook University Hospital, and SUNY Downstate Medical Center