Healthcare Association
of New York State

Testimony of the

Healthcare Association of New York State

submitted to the

Joint Public Hearing of the Senate Health and Insurance Committees on Implementation of the New York State of Health

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Thank you for providing the Healthcare Association of New York State (HANYS) with the opportunity to submit testimony to the Senate Health and Insurance Committees' joint public hearing on implementation of the New York State of Health. HANYS represents 500 not-for-profit and public hospitals, health systems, nursing homes, and home care agencies throughout New York State. HANYS appreciates this opportunity to comment on the issues that have emerged as New York implements its Health Benefit Exchange, also called the New York State of Health.

HANYS enthusiastically supports the state's efforts to reduce the number of uninsured by moving forward with establishing the New York State of Health marketplace and thereby helping to make insurance coverage more available to a broader range of the state's population. New York opted to operate a state-based Exchange by Executive Order in April 2012, which presented the state with the enormous challenge of having to build and establish an entirely new entity while meeting tight timeframes and extensive regulatory requirements. We applaud the enormous energy and commitment of the State's staff and the many private sector partners whose efforts have enabled New York State to open the doors to a marketplace that allows individuals and small businesses to comparison shop and enroll in coverage using an innovative electronic interface.

HANYS has made a commitment to assist the state in its efforts to work toward a successful marketplace. We have volunteered to serve as an outreach partner to the Exchange and have acted as an official conduit between the New York State of Health and our hospital members as a central point of access for all information related to the Exchange. We have hosted various education sessions for our members in conjunction with the state staff and we are currently providing Certified Application Counselor (CAC) training, which will allow hospitals to enroll patients in insurance products and increase the number of lives covered by Medicaid and new commercial products.

As the Governor noted in his State of the State address last week, more than 265,000 people have enrolled in coverage through the New York State of Health in either private commercial coverage or Medicaid, with approximately 75% of individuals qualifying for subsidies to assist in reducing premiums[1]. We are hopeful that this increase in access to insurance coverage will benefit patients and providers throughout the State of New York.

Of course, no grand experiment moves forward without having to deal with policy questions, growing pains, and perhaps unintended surprises. We attempt in this brief submission to confine our remarks primarily to these upcoming policy questions, assuming that hard work and the ability to make adjustments will resolve most of the "growing pain" type of concerns.

[1] "Transcript: Governor Cuomo's 2014 State of the State Address," January 9, 2014

No Out-of-Network Benefit

We comment therefore on the surprising revelation, first reported, we believe, in the *New York Post* on October 23, 2013, that there was no plan in the individual market at any metal level tier that offered an out-of-network benefit to consumers[2]. Although HANYS is a member and active participant on the New York Health Benefit Exchange Regional Advisory Committee, we do not recollect there being any discussion about there being no health insurance plans on the Exchange providing out-of-network coverage.

Our concern in this regard is twofold. First, is eliminating out-of-network coverage a good idea? We think not. Payers, providers, and regulators have struggled to find a balance over how to reimburse out-of-network providers when consumers demand and need access to out-of-network treatment options. We understand the impact out-of-network bills have on predictability of costs to insurers and the potential impact on future premium growth. We also see the value of motivating users of health care to stay in-network, when possible, so long as networks are robust and quality providers are available. However, out-of-network benefits arose, for very good reasons, out of consumer pushback against closed panels and gatekeeper Health Maintenance Organizations (HMOs) of the 1990s and became a critical part of point-of-service plans (POS) and preferred provider options (PPO). Moreover, providers were able to vote with their feet and reject inadequate in-network reimbursement – not surprisingly, POS and PPOs became very popular.

We also worry that newly insured purchasers of insurance through the marketplace will not be aware of or understand the financial exposure they may have, should they receive out-of-network services. Hospitals already have grave concerns that the consumer cost share in the lower metal tiered products (bronze and silver) will present enormous burdens to those buying on the Exchange and that hospitals will experience major headaches trying to collect these amounts from patients.

HANYS' other primary concern is that the elimination of the out-of-network benefit from all products on the Exchange was not transparent and was not a subject of dialogue with us, our members, and the stakeholder community. Indeed, similar to the legislation now being proposed by Senator Kemp Hannon (S.6207), our original expectation was that at least one product on the Exchange would offer an out-of-network benefit and that there would be a "mirror" obligation to offer identical products inside and outside the Exchange. Moreover, the Legislature and Executive Branch have actively considered different pieces of legislation in an attempt to find a balance between the need for consumer access and proper provider reimbursement, yet control unanticipated costs for insurers. There have been various bills proposed that would require disclosures from insurers and providers, provide a dispute resolution mechanism, insulate consumers from liability, and create a method of calculating payment. However, rather than find

[2] "Out-of-network not an option in individual ObamaCare plans" *New York Post*, October 23, 2013

a true legislative solution, we find out-of network coverage simply eliminated on the products offered and in a manner that was not transparent.

We recognize, as we stated above, that time constraints to allow the Exchange to be open in time for January 2014 and the size of this undertaking in the first year undoubtedly inhibited the ability to have a full discussion on various issues, and we hope that the decision to allow products without out-of-network benefits was one of those. We hope, therefore, that The New York State of Health marketplace will re-visit the decision to allow products on the Exchange to exclude an out-of-network benefit and that a discussion about the products to be offered will occur in the coming year.

The Proliferation of Narrow Network Products

The lack of an out-of-network option, of course, can be less problematic when the network being offered is broad and robust. However, many plans offered on the Exchange are providing far narrower networks than those available outside the Exchange. This phenomenon is not unique to New York. Narrow networks are very prevalent in Exchange products throughout the country. According to a December 14, 2013 analysis of 955 plan offerings conducted by the McKinsey Center for U.S. Health System Reform, "Hospital networks: Configurations on the exchanges and their impact on premiums," 70% of the Exchange products offered narrow or ultra-narrow networks of available hospitals.[3] The McKinsey study defines narrow networks as having 30%-69% of an area's 20 largest hospitals not participating and ultra-narrow networks as having at least 70% of an area's 20 largest hospitals not participating.

Narrow panels of providers may allow insurance companies to price Exchange products competitively by virtue of the ability to extract discounts from a limited group of providers being promised volume in return for reduced rate structures. In some instances, legitimate strategic reasons exist for the growth of narrow networks, including consumers and employers willing to select a narrow network in return for lower monthly premiums or reduced out-of-pocket costs. However, it so far appears that many potential purchasers on the Exchange are not aware of the impact of narrow networks when they purchase their plans and do not realize that they may not be able to continue seeing particular physicians or access hospitals traditionally available to them. This potential unwelcome surprise has been exacerbated by unavailability of the marketplace's Web site tool to ascertain with accuracy or specificity which hospital is in-network or view the full panel of participating doctors. Search functions either do not yet fully work or require potential purchasers to attempt to go to a health plan's site and sift through the information there.

HANYS recognizes that narrow networks can be created as the result of a strategic consensus between stakeholders (plans and providers), which serves their community with an innovative

[3] "Less choice, lower premiums" *Modern Healthcare*, August 17, 2013

model that features high quality health services priced affordably for consumers. These narrow network products make sense to us.

What does concern us is the growth of narrow network products that occur when particular hospitals are simply not invited to join. Equally troubling is the exclusion of high quality hospitals that are offered unacceptable levels of reimbursement as a condition of participation or the exclusion of a hospital's physician groups, thus compelling the hospital to walk away. Frankly, because of the paucity of information about what plan networks really look like in terms of participating hospitals and providers, consumers and advocates are mostly guessing about whether particular products on the Exchange marketplace are truly adequate or should be more broad and inclusive. Without far greater transparency, consumers and, for that matter, hospitals trying to negotiate rates in this environment, will continue to struggle to make informed decisions.

An example: In Genesee County, United Memorial Medical Center (UMMC) has been excluded as an "in-network" provider by the insurance company MVP Health Care for its Exchange insurance products. However, UMMC remains a participating provider in MVP's non-Exchange network. In this particular scenario, MVP chose to exclude UMMC from its networks following several attempts by UMMC to negotiate a reimbursement rate structure[4]. This has caused UMMC to advise consumers in Genesee County, who are considering purchasing their health care insurance through the Exchange, to make sure that their physicians and hospital facility were both included in the insurance company's network. UMMC has also deployed application counselors to assist with the process of signing up for health care insurance coverage and to answer questions.

Additionally, because there is no out-of-network benefit available in the Exchange, consumers may be forced to decide between facing potentially high out-of-pocket expenses to receive out of network services or to choose a different provider within the network.

Too Soon to Tell

While we have high hopes for the New York State of Health marketplace, we continue to study other potential concerns:

- **Adverse selection**: This would occur if the more healthy population selects a lower-priced plan option while the less healthy chooses the more comprehensive plan option. Since the Affordable Care Act (ACA) allows the state to maintain an insurance market outside the Exchange, the state must be careful that one market does not become the equivalent of a high risk pool. This would happen if one market featured more stripped-down plan designs while the other offers more robust options[5].

[4] "UMMC 'excluded' from MVP Exchange Network" *The Daily News*, December 20, 2013

[5] "Adverse Selection Issues and Health Insurance Exchanges Under the Affordable Care Act" National Association of Insurance Commissioners, 2011

- **Collecting Out-of-Pocket Cost Shares**: It is axiomatic in the hospital world, that collecting dollars from patients after services have been rendered is hard work. Bad debt is only one aspect of the difficulty – the energy and staff time spent chasing these dollars is also "expensive." With increased cost shares, especially if consumers opt for lower metal tier products, providers worry about increased bad debt and having to devote even greater energy and resources to collection activity.

- **Self-Sustainability by 2015**: ACA requires the state's Exchange to be financially self-sufficient by January 2015. The state is tasked with determining a reliable funding source for the New York State of Health, which does not depend on the state's general fund. This issue must be addressed during the upcoming 2014 legislative session to meet the federal deadline.

- **Basic Health Program (BHP):** ACA allows states to provide an alternative to receiving health coverage through the Exchange by allowing states to use federal tax subsidies to help cover low-income individuals whose income is too high to qualify for Medicaid. However, CMS postponed implementation until 2015. The state must decide whether to offer BHP as a possible policy option in 2016. HANYS and other provider groups emphasized the need for adequate provider networks and reimbursement to ensure access for BHP enrollees.

- **Potential Churning Between Exchange Products and Medicaid:** In the past, people would lose Medicaid eligibility due to temporary income spikes and would re-enroll when income levels dropped. People who churn out of Medicaid would become uninsured. Now, as a result of the Exchange, many individuals who churn out of Medicaid will become eligible for insurance subsidies in the New York State of Health. We are pleased that individuals who become ineligible for Medicaid will have more affordable options and will maintain health coverage. However, patients who enroll and re-enroll at several points in a year may select plans run by different companies, with different networks, and may not be able to continue seeing their same doctor or hospital. This will affect the overall quality of service delivered and may interrupt care for vulnerable patients.

- **Grace Period Coverage:** Health plans are required to provide enrollees who are delinquent on their premium payment, a grace period of three consecutive months. During the grace period, plans must pay all claims for services provided during the first month of the grace period but are allowed to pend claims during the second and third month. In response to this federal regulation, the U.S. Department of Health and Human Services (HHS) has heard several questions and concerns related to how this will negatively affect the hospital and provider community. HANYS is concerned that providers will likely not be compensated for services provided to patients during the last two months of the grace period, which will increase provider uncompensated care costs. Grace period coverage raises additional questions about whether third-parties such as hospitals should be able, either directly or through charitable foundations, to pay lapsed premiums and restore coverage. Allowing third parties to make such payment would help reduce the number of uninsured thereby expanding access to health care services and

at the same time, potentially reduce provider uncompensated care cost. However, initial HHS guidance suggests reluctance, at least at the federal level, to allow such payments to be made.

Conclusion

At a time when providers, health plans, and other stakeholders are being asked to be more transparent regarding cost information and reimbursement, we hope that there are more open discussions about out-of-network products and network adequacy in the coming year. We assume that it will be easier to ascertain which providers are participating in particular products and that this type of information becomes readily accessible. We hope that our hospitals will be able to participate in plan products and receive fair and adequate reimbursement for their services.

We recognize the great strides that have been taken to launch the New York State of Health marketplace and look to be part of a continuing dialogue to address the many questions that loom. We respectfully thank the Senate Health and Insurance committees for the opportunity to submit testimony.