



**Testimony of the New York Health Plan Association
to the
Senate Finance Committee
and the Assembly Ways & Means Committee
on the subject of
2018-2019 Executive Budget Proposals on Health Care
February 5, 2019**

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 28 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.

Our member health plans have long partnered 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. 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).

We appreciate the opportunity to offer our view on the proposed 2019-2020 Executive Budget in relation to its application for health care spending in New York.

SUPPORTING UNIVERSAL COVERAGE

Universal Access Commission

In his budget address, Governor Cuomo called for the establishment of a commission to evaluate pathways for achieving "universal access to high quality, affordable health care in New York, and charging this commission to report options to the Governor by December 1, 2019."

HPA and its member plans support the objective of universal coverage. We believe every New Yorker should have access to quality, affordable health coverage. In reality, New York is very close to that goal today.

Since the enactment of the federal Affordable Care Act (ACA) and creation of the NYSOH exchange, New York has cut its uninsured rate in half. Between 2009 and 2017, the percentage of New York's uninsured population has dropped from 11.4 percent to 5.7 percent. That figure is likely to be even lower when the final figures from the 2019 Open Enrollment period are calculated.

New York should be justifiably proud of this accomplishment. It is an achievement that was made possible, in large part, due to the efforts of the health plan community. New York took advantage of provisions under the ACA to expand its already successful Medicaid managed care program. Additionally, the NYSOH marketplace is, by all measures, among the most – if not the most – robust exchange in the nation. A dozen health plans offer private insurance through hundreds of Qualified Health Plan product options, while nine plans offer more than 2,000 products to small employers enrolling through the Small Business (SHOP) Marketplace, and 16 plans participate in the “basic health plan,” known as the Essential Plan, that provides low or no cost coverage to lower income New Yorkers. The Essential Plan has been enormously successful, enrolling more than 740,000 people who do not qualify for Medicaid but still struggle with the costs of private insurance.

Looking at these achievements, it is clear to see that New York is well on its way to universal coverage. We believe that it is possible to close the remaining coverage gap, and feel this is best achieved by focusing on improving what's working and fixing what's not.

New York's efforts to continue expanding coverage should be built upon the following principles:

- Investing in Expanding Coverage — More than six million New Yorkers access their health care through Medicaid managed care, Child Health Plus, or the state's Essential Plan. Building off the existing partnership between government and private health plans, the state should work to enroll individuals who are eligible for coverage but not enrolled and extend access to coverage for immigrant New Yorkers currently ineligible for these programs. This group accounts for about half of the remaining uninsured population. 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.
- Market Based Solutions — 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, including: greater oversight and monitoring of provider mergers so that consolidation does not lead to exorbitant prices; protections for consumers from surprise billing practices for hospitals that do not participate in a health plan's network; and transparency by pharmaceutical companies for increases in their 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.

Establishment of a commission to study options for achieving universal coverage will further support these goals. It is a thoughtful and pragmatic tactic to expanding access to affordable health care coverage to all New Yorkers.

Codifying Provisions of the Affordable Care Act

Before the enactment of the ACA, New York had already taken numerous steps aimed at providing New Yorkers with access to quality, comprehensive health coverage. New York had also already adopted “patient protections,” such as community rating, requiring coverage of individuals with – and prohibiting coverage denial due to – pre-existing health conditions.

Recognizing the significant progress that New York had made in providing access to comprehensive health insurance coverage, and seeking to protect that progress, when the ACA became law and New York was implementing its provisions, New York sought to bring the state’s health insurance rules in line with the requirements of the ACA. This was done largely either through regulatory actions or Executive Order.

The Governor’s budget plan includes numerous provisions to codify the ACA into state statute in order to preserve certain requirements in the event that there are changes in federal law. While HPA supports some of the Governor’s proposals, the proposed language raises several technical issues that require more time to work

through and clarify. As codifying the ACA does not have a fiscal impact, we believe this should be addressed post budget as a stand-alone bill.

HPA opposes the Governor's proposal to grant decisions of the Superintendent of the Department of Financial Services extraordinary deference. Decisions of the Superintendent already are accorded great deference under the "arbitrary and capricious" standard set forth in Article 78 of the CPLR. There is no reason to grant the Superintendent even greater latitude – a standard that does not exist for any other State official.

MANDATED BENEFITS EQUAL MANDATED COSTS

The Governor's Executive Budget proposes the adoption of several new mandated benefits. While undoubtedly well-intentioned, HPA opposes requiring new mandated benefits because this will increase the cost of coverage for consumers and employers, ultimately undermining affordability and leading to some people becoming uninsured.

The primary problem with mandating coverage of specific services is that it disproportionately affects small and medium-sized employers. Mandated benefit bills pertain only to fully-insured policies, which are generally those purchased either by individuals who buy coverage on their own or receive it through a small or medium-sized business. Large companies typically "self-insure" – providing employee health benefits by directly paying health care claims to providers – which are governed by the Federal Employee Retirement Income Security Act (ERISA) and therefore not subject to state-mandated benefits. Forcing employers to include benefits they and their workforce may not want or need exacerbates the challenge they face to find affordable health care options.

The following outlines HPA's concerns with the Governor's Executive Budget proposals:

- Requiring IVF and Fertility Preservation Services Will Increase Costs — The Governor's budget would require large group policies to cover three cycles of in-vitro fertilization (IVF) and expand current New York law requiring coverage of infertility treatments to mandate coverage for fertility preservation for cancer patients in the individual, small group and large group markets. Our member health plans recognize the importance of infertility services. However, when infertility benefits are mandated by the state, utilization of those services goes up. Experience in states that have mandated IVF has shown a significant increase in the use of services. Further, the costs associated with infertility treatment are likely to continue to rise as more technologically advanced treatments are developed, increasing the cost of coverage for all individuals and employers.
- Expanding Behavioral Health Parity and Substance Use Requirements — The Governor's budget would expand the mandate requiring coverage of inpatient treatment for substance use disorders from 14 to 21 days, prohibit prior authorization for medication assisted treatment, limit cost-sharing for outpatient substance use disorders, impose an assessment of \$1.7 million on health plans to fund oversight of parity compliance, and allow the Office of Mental Health (OMH) to review and approve plan medical necessity criteria.

Our member health plans provide comprehensive coverage of a wide array of behavioral health services and work diligently with providers to ensure consumers have access to necessary services that are consistent with the requirements of state and federal mental health parity laws. Further, health plans recognize the impact opioid addiction is having on individuals, their families and our state, providing coverage for a broad range of services — including inpatient and outpatient

treatments — to ensure that all New Yorkers struggling with substance abuse are able to get the care they need in the right setting.

Despite all the steps New York has taken to set rules for what services must be covered, there remains a lack of measures to evaluate the effectiveness of the treatment being provided and whether providers and facilities are following evidence-based standards. Rather than mandating a specific number of days for treatment or imposing restrictions on prior authorization or cost sharing, the state should focus on adopting standards for coordinated care management across the delivery system. Additionally, the state should put in place systems to report on outcomes to ensure that the full range of evidence-based treatment options are available to individuals throughout the continuum of their care. Further, allowing OMH to review and approve plan medical necessity criteria is unnecessary as the Department of Health and the Department of Financial Services already have significant regulatory oversight of health plan activities. Finally, imposing new assessments on health plans to fund oversight activities, on top of the more than \$5 billion in taxes imposed on health insurers, will increase the cost of coverage for employers and consumers without improving care.

RESTRICTIONS ON PHARMACEUTICAL CONTRACTING & PBM REGISTRATION

The Governor's proposed Executive Budget would place restrictions on contracting arrangements between health plans and pharmacy benefit managers (PBMs) and would require registration of PBMs. HPA opposes these provisions for several reasons.

Prescription medications are an important part of medical treatment, but the rapid increase in the prices pharmaceutical companies charge for prescription drugs is a major factor for rising health care costs. The proposals fail to address rising prescription drug prices and, more importantly, are unnecessary as significant oversight of pharmacy benefit management services currently exists. Instead of restricting

reimbursement arrangements and imposing new regulatory requirements, the focus should be on measures that address pharmacy costs more holistically to rein in runaway prescription drug prices.

Restricting contracting arrangements does nothing to address rising prescription drug prices
Rising prescription drug costs are driven by increases in the prices pharmaceutical manufacturers charge for drugs and this change will not automatically result in lower costs. It is unclear how the state intends to realize the \$86.6 million in Medicaid savings. Regardless of the type of payment arrangement, current health plans contracts with PBMs may already incorporate the intended savings, as a result of trade-offs in the procurement and negotiating process. Health plans are concerned that the Governor's proposal will result in a rate cut without providing them with the ability to manage the impact of this policy change, and policymakers have taken away many of the tools health plans would use to contain rising drug prices, such as step therapy.

Limiting the amounts paid to PBMs does nothing to change the prices drug companies charge
In a market where there are virtually no controls over the prices or price increases that pharmaceutical manufacturers charge and with prescription drugs continuing to be the largest part of the Medicaid managed care premium, spread pricing developed as a way to incentivize PBMs to negotiate the best price possible for prescription drugs. Limiting contracting arrangements to a one-size-fits-all approach will limit innovative program designs health plans and PBMs can undertake to contain drug spending.

Pharmacy benefit management services are already highly regulated
Significant oversight of pharmacy spending already exists through DOH, the Office of the Medicaid Inspector General (OMIG), and the Department of Financial Services (DFS). The Medicaid contract requires health plans to submit quarterly reports specific to their PBMs, including the amounts paid by the plan to the PBM for pharmaceutical

services by category, the amounts paid for each prescription drug, and the amounts paid for administrative services. OMIG's Pharmacy Review Project Team reviews payments from PBMs to network pharmacies to ensure compliance with federal and state regulations, contract requirements, and the pharmacy benefit component in the mainstream managed care program. In the commercial market, health plans are required to submit significant amounts of information to DFS on pharmacy costs as part of the annual rate review process. While the information submitted as part of the licensure process is to be deemed confidential, the provision leaves it to the DFS Superintendent's discretion on whether the information can be publicly disclosed. The potential that discounts and other sensitive information could be disclosed has the potential to lead to higher prices as the Federal Trade Commission has warned that "whenever competitors know the actual prices charged by other firms, tacit collusion, and thus higher prices, may be more likely."

These proposals are unnecessary. They would add unnecessary, duplicative new provisions over pharmacy benefit management services, and will lead to higher costs in New York's health insurance market and under the Medicaid Global Cap. There is no indication that the clients of PBMs lack accurate information on the price and quality of the services that they receive. Focusing on PBMs and restricting their payment arrangements will not improve market outcomes and are a distraction from the real issue regarding prescription drug costs — the unchecked high prices and price increases of drugs.

NO MEDICAID CUTS WITHOUT REFORM

The Governor's budget proposal includes a number of Medicaid provisions that purport to save the program hundreds of millions of dollars in FY20. However, simply cutting premiums paid to Medicaid plans without related reforms is shortsighted and could ultimately undermine the program's integrity and jeopardize the care of the

vulnerable populations that rely on the services provided by HPA's member plans. Overall, the state's intention to reduce plans' premium funding before any savings have actually accrued leaves us with serious concerns regarding the adequacy of the rates.

When NY pioneered the idea of Medicaid managed care in the 1980s, health plans answered the call to reshape a system that too often had patients going to emergency rooms or Medicaid "mills" for routine or unnecessary care. With health plans as partners, the doors to hundreds of thousands of doctors offices were opened and Medicaid patients had, many for the first time, a doctor who knew them and their children – they had a medical home. Improving access to care helped improve quality of care, as is demonstrated by data collected by DOH in its annual quality reports.

At the beginning of this decade, when Governor Cuomo called for a major redesign of the Medicaid program to expand and improve services to the states most vulnerable populations, managed care was again the path to achieve this goal. Once again, plans partnered with the state. The commitment of the health plan community continues today. The central concept of the Governor's Medicaid Redesign process was "care management for all." Nearly every population and benefit has been transitioned INTO managed care – in recognition of the fact that the state couldn't effectively manage the program directly. Since 2011, transitions into Medicaid managed care have included the pharmacy benefit, behavioral health and substance use disorder services and mandatory managed care enrollment for those receiving more than 120 days of long term care supports and services – just to name a few. Between January 2011 and January 2019, Medicaid managed care enrollment in New York State has grown from about 2.9 million to 4.7 million – over 60 percent.

Many of the Governor's proposals impact the Managed Long Term Care program. While we are pleased to see that the state worked with plans in developing needed

reforms, we have serious concerns with the Governor's budget proposal that would take substantial savings — \$268 million worth — “up front.” This would be achieved by reducing plan premiums before any reforms are implemented and possibly leaving plans with little or no ability to actually recover savings depending on how and when these proposals are implemented. The following are specific proposals for which we have concerns:

- Limitation on Fiscal Intermediaries — The Governor's proposals authorize DOH to limit the number of fiscal intermediaries (FIs) in the consumer directed personal assistance program (CDPAP) by entering into a contract or contracts without a competitive bid or RFP process. The state would also limit reimbursement to FIs to a per member per month (PMPM) reimbursement so that FIs do not increase their reimbursement by increasing the number of hours a member receives.

We believe that CDPAP is an essential part of the long term care continuum. We also believe that limiting the number of FIs and using a PMPM based reimbursement is necessary to maintain the integrity of the program. However, we are concerned about how the initiative will be operationalized and how the \$150 million in savings will impact plans when it will be taken out of the premium as assumed savings before any actual change occurs.

- Regulatory Amendment — In the same way, while we support regulatory changes that would give plans greater flexibility to manage personal care utilization and build plans of care that include multiple services to meet a member's needs, we believe it is inappropriate to take \$50 million out of plan premiums up front when the impact of any regulatory change won't be realized until well after April 1, 2019.
- State Office for the Aging “Private Pay” Program — We support the Governor's proposal to expand services under the state office for the Aging (SOFA) in an effort

to divert people from enrolling in Medicaid. We believe this valuable idea is worth trying. However, we do not believe that it is appropriate or fair to take \$68 million out of plan premiums based on assumptions of savings that have not yet accrued — and may not accrue.

Other Medicaid Proposals

- Office of Medicaid Inspector General (OMIG) – The FY20 Executive Budget includes several statutory provisions related to OMIG. These include that monies paid by DOH to plans, including MLTCs, are deemed a payment by the state’s Medicaid program and authorizing OMIG to review plans compliance with contractual program integrity requirements as well as penalizing plans for up to two percent of the administrative component of the premium if OMIG finds a plan out of compliance. The proposal indicates that where the state is “unsuccessful” in recovering improper payments from subcontractors or providers, OMIG may require the plan to recover the payment. We oppose giving OMIG authority to impose penalties of up to two percent of the administrative component of the premium. All plans strive to be in full compliance with all contract provisions and we have no reason to believe that such a punitive approach is necessary. OMIG has failed to evolve from dealing with a fee-for-service Medicaid system to one based on managed care. Their inefficient pursuit of “back-end recoveries” fails to recognize that the managed care plans capture inappropriate payments before they happen. Plans also disagree with the proposal that would require them to report to OMIG every provider who may have made an inadvertent error such as accidentally submitting a duplicate claim.
- Pharmacy — The Governor’s budget calls for the elimination of “prescriber prevails” from both fee-for-service (FFS) and managed care when the justification is not clinically supported. HPA supports this proposal as these policies that enable

prescribers to override a plan's formulary without justification increase the cost of the Medicaid pharmacy benefit and have a direct impact on the Medicaid global cap, which in turn threatens hospital and physician reimbursement in Medicaid. Prescriber prevails is a boon to pharmaceutical manufacturers and removes one of the few cost containment tools plans have at a time when in the MMC reimbursement rate of pharmacy costs are greater than inpatient hospital costs.

CONCLUSION

We recognize the importance of many of the policy ideas raised by the Governor in his budget proposals. A number of them — codifying the ACA, providing coverage of certain fertility treatments, improving behavioral and maternal health — all deserve further discussion, but in a context outside of the budget making process. We look forward to contributing to those conversations.

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. Plans remain committed to working with you and your colleagues on initiatives and strategies that help ensure New York individuals, families and business continue to have access to high-quality, affordable health insurance.

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