



Testimony of the New York Health Plan Association

to the

**Senate Finance Committee
and the Assembly Ways & Means Committee**

on the subject of
2017-2018 Executive Budget Proposal

February 16, 2017

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 29 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, including improved access to quality care in its government programs, collaborating on efforts to develop affordable coverage options for individuals, families and small businesses, as well as providing access to care that exceeds national quality benchmarks for both commercial and government program enrollees. Our plans include those 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, Healthy New York and through New York's exchange, the NY State of Health (NYSOH).

We appreciate the opportunity to offer our view on the proposed 2017-2018 Executive Budget in relation to its application for health care spending in New York.

EXECUTIVE BUDGET PROPOSALS

The Governor's 2017-2018 Executive Budget includes a number of initiatives that bear watching in terms of the impact they will have on maintaining a stable health insurance marketplace, particularly as our federal lawmakers consider "repealing and replacing" or "repairing" the Affordable Care Act. The turmoil surrounding the ACA repeal and replace is causing instability and uncertainty for commercial and government programs such as Medicaid. HPA asks the legislature to be mindful of the

current environment as it decides this year's budget and considers legislative proposals during the balance of the session. More specifically, HPA requests that the state take no action to increase health care costs and reduce premium affordability for families and small businesses.

To that end, HPA would like to focus on the following proposals in the Governor's budget plan:

Controlling Prescription Drug Costs

HPA strongly supports the Executive proposal to cap drug prices and capture excess pricing profits in both Medicaid and commercial markets. Pharmacy costs are the fastest increasing costs in health care and in the Medicaid program, where pharmacy costs now exceed in-patient hospitalization costs in the Medicaid managed care premium. Total Medicaid spending on pharmacy grew 54% from fiscal year '13 to fiscal year '17, from \$4.3 billion to \$6.7 billion, with the greatest growth at \$1 billion in the two years following the re-imposition of the "prescriber prevails" policy.

Current law provides a precedent for the Governor's proposal; it allows New York to negotiate additional rebates for high priced Hep C and HIV drugs. This proposal expands on this approach by directing the Drug Utilization Review (DUR) Board to target pharmacy price gouging to protect consumers and the state budget.

Everyone is familiar with Turing Pharmaceuticals and their former CEO Martin Shkreli who raised the price of a drug (Daraprim) that treats infections in AIDS patients by 500% from about \$15 to \$750. Everyone also heard about Mylan Pharmaceuticals that raised the price of its EpiPen from \$100 in 2009 to more than \$600 last year – another 500% increase. And most recently, there's the case of Marathon Pharmaceuticals, which just last week gained U.S. Food and Drug Administration

approval designating a decades-old muscular dystrophy drug (Emflaza) as an orphan drug, thereby allowing it to sell for \$89,000 a year – a price that is 50-to-70 times higher than what it sold for in the U.K. (A few days after first defending the huge price hike, in the face of harsh criticism, Marathon’s corporate leadership announced it would “pause” introduction of the newly designated orphan drug.)

These are only a few examples on a much longer list of egregious price increases drug manufacturers have demanded in the past few years. No other sector of the health care delivery system would be allowed to behave this way. In fact, every other sector has evolved to become more cost effective. The pharmaceutical industry should be no different.

Department of Financial Services Authority

HPA opposes the provisions granting the Superintendent of the Department of Financial Services (DFS) discretion and power to target and sanction “bad actors,” substantially increase penalties and fines for any rule violation, and administratively control plans that are not formally insolvent.

First and foremost, there is no fiscal impact attached to this proposal and it, therefore, should not be considered as part of the state budget financial plan.

Additionally, the language of the components in the proposal lack any safeguards, criteria and standards or adequate due process procedures to protect health plans that would be subject to fines, which this proposal calls for increasing 1,000%, from \$1,000 to \$10,000 per violation. At current fine levels, plans are already incurring fines totaling hundreds of thousands and in some cases millions of dollars for technical or paper violations. (It is worth noting that New York State law permits the Department of Health a maximum fine of \$2,000 per violation for hospital violation that could risk

patient safety and/or cause death.) This proposal could increase fines ten-fold without any requirement to differentiate the magnitude of harm other than at the discretion of the superintendent. At a minimum, a framework is needed to graduate the type, quality and volume of the violations and to create some parameters on otherwise unfettered discretion.

While the budget proposals seek to add more discretionary powers to fine, sanction and control health plans, HPA continues to advocate for objective standards in the premium rate setting process to curtail the suppression of actuarially sound rates. The objective of maintaining a strong and stable marketplace to ensure New Yorkers continue to have access to quality, affordable health insurance coverage requires adequate premiums.

Reforming New York's Health Care Reform Act

HPA opposes mere extension of New York's Health Care Reform Act (HCRA) and recommends that reform be included.

HCRA began 20 years ago as an effort to bring market-driven change and efficiency to New York's hospital industry. When it was created, HCRA included mechanisms to fund "public goods" being provided by the hospital community – namely bad debt and charity care reflecting costs incurred by hospitals for provided care to people who were uninsured, and graduate medical education related to costs incurred by hospitals training future doctors. While everyone agreed about the importance of these public goods, the two pools, funded through assessments and surcharges on health plans and medical services, were intended to provide a transition period for the hospital industry and were supposed to be phased out over time. Not only have they not been phased out – or even reduced – over time, these surcharges, which are nothing less than taxes

on every health insurance policy purchased in New York, have continued to grow and now total more than \$4 billion annually.

According to a recent report from the Empire Center, HCRA taxes increase health insurance premiums by more than 6% in New York City and undercut premium affordability. To quote the report, “by making health insurance less affordable, HCRA taxes work at cross purposes with the policy goal of moving toward universal coverage.”

At a minimum, HPA believes the recommendations of the HCRA modernization task force should be built into the HCRA extension, starting with the recommendation to improve quarterly reporting to make revenue and expense information more transparent and understandable to stakeholders – and to ensure that pool administrator reporting ties more closely to state financial plan reporting. The HCRA Modernization Task Force should be extended and specifically directed to review the programmatic expenditures of HCRA which has strayed from its historical roots. The original legislative intent of HCRA still remains applicable today, but implementation has strayed far from the intent, to where more than two-thirds of HCRA revenue goes to support what would otherwise be General Fund Medicaid expenditures.

The Legislature should carefully review the indigent care pool funding formula and the six year long “transition adjustment” of funds, which seems to have precluded safety net hospitals that provide the most indigent care from getting the funding they need while protecting those institutions whose need is less. If funding is allocated where it is needed, it could reduce the demand for additional resources to be used to “bail out” these financially vulnerable hospitals.

Medicaid Reforms

HPA urges legislative action to reform the DOH administrative actions in the Medicaid program and amend the MRT blueprint.

The quality initiative cuts in the mainstream Medicaid managed care (\$40 million) and MLTC programs (\$30 million) are philosophically at odds with the state goal of incenting improvements in health care quality measurement and the broader effort to move health care reimbursement to a value-based program which rewards efficiency and quality.

Additionally, the state should consider implementing a moratorium on the carve-in of additional populations and benefits into the Medicaid managed care program. These include: the nursing home transition diversion (NHTD) and traumatic brain injury (TBI) waiver programs; children's behavioral health services and certain populations of children; school based health centers; blood clotting factors for hemophilia; and any new services to be added as part of the community first choice option (CFCO). At this time we believe it is illogical to continue moving ever more populations into the Medicaid managed care program in light of the federal uncertainty concerning the type and level of Medicaid funding,

Early Intervention

HPA opposes the Early Intervention proposal.

New York State continues to try and fit a program for individuals with developmental disabilities into a health insurance medical model. While we do not argue the value of Early Intervention (EI) services, the majority of the services fall under educational programs and are not medical in nature.

These are proposals we've seen before, and that we've raised concerns about before. The proposals merely amount to shifting the cost of the EI program from the state onto

insurers and, by extension, New York business and families who are paying the premiums. It should also be noted that as with any state-mandated benefits, the coverage applies only to state-regulated policies. Approximately half of commercial coverage in New York is self-insured, which is federally regulated, and for which New York's EI mandate does not apply. Because the mandate would not apply, these individuals would not receive any additional benefits under this proposal. Yet the state is seeking to mandate that plans do the work of identifying all self-insured policies so the state's consultant can further pursue commercial EI payment for these individuals.

The legislature should reject these budget proposals and instead insure that the Early Intervention Coordinating Council is fully appointed and operational to help develop realistic, meaningful changes in the EI program.

CONCLUSION

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, and plans remain committed to working with you and your colleagues on initiatives that keep New York moving forward on this course. We thank you for the opportunity to share our views today.

