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Center for Independence of the Disabled, NY

HEALTH ADVOCACY AGENDA - 2015

Center for Independence of the Disabled, New York (CIDNY) is a non-profit organization founded in 1978. CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to full participation in the community. In this 25th Anniversary year of the signing of the Americans with Disabilities Act, we are redoubling our efforts towards achieving these goals.

CIDNY helps consumers understand, enroll in and navigate private commercial and public health insurance and free or low-cost coverage alternatives. We advocate informally; file and represent consumers in grievance processes, appeals, and fair hearings; and advocate for optimal coverage, (e.g., sufficient home care hours; medically necessary durable medical equipment; personal care; and prescription drugs).

QUALITY OF COVERAGE

Improving Network Adequacy. Consumers need strong provider networks so that they can have access to the care they need and the providers they rely on. Inadequate and constantly changing networks can lead to interruptions in care, delayed care, and undue harm. Some ways that networks could be strengthened include the following:

- Improving network adequacy requirements – Currently, Qualified Health Plans (QHPs) must include at least two of each required specialist. Required specialists include neurology and neurology surgery, but our members would also like to see subspecialists (such as MS neurologists) required. Networks should also be required to include NCI Cancer Centers and Transplant Centers.
- Now that QHPs have enrollment experience, GPS mapping systems should be used to determine whether a plan has the providers necessary to meet the 30 minute/30 mile time and distance standard.
- Requiring minimum appointment availability standards.
- Requiring QHPs not to drop providers during a plan year – QHPs should only be permitted to remove providers for cause during a plan year.
- Establish a "special enrollment period" for consumers to change QHPs if a provider network or formulary coverage is changed to the detriment of a patient currently in active treatment.
- Extending the 90-day provider transition period for consumers when a QHP drops a provider to the end of contract year, provided the provider agrees to accept the standard payment offered by the QHP.

Re:

Expand External Review. External Review of health plan decisions should be extended to include whether something is a covered benefit, reimbursement levels, cost variation caused by “wellness programs” and adequacy of provider. The external review system should also be opened to large self-insured employer and union plans - both to increase revenue and provide a more consistent system of appeals across the insurance landscape.

Establish a publicly available searchable database of all external review decisions. Currently there is no public database of external review cases. This makes it difficult for consumers and those who assist them to find information about similar cases. New York should ensure transparency in the external review system by establishing a searchable data base for public use. Decisions should be redacted and consumers should be permitted to “opt out” of the data base.

Establish a remediation program for consumers. Although the New York State of Health (NYSOH) marketplace and navigator agencies have done remarkable work in transitioning hundreds of thousands of New Yorkers into new coverage, many consumers, especially those facing unusual circumstances, have been misadvised because of inadequate training of insurance company personnel or others, regarding the coverage options open to them. Some of them have ended up in policies that are inappropriate for their needs when they had the right to better coverage. CIDNY urges the state to set up a remediation program administered by the Department of Financial Services, to enable those who have suffered from such misadvice to switch to the proper coverage retroactively.

Provide Consumers with QHP Quality Information. NYSOH should provide consumers with QHP quality information that uses data such as the number of complaints made proportionate to enrollment in the plan or the number of plan decisions that go to external review and are reversed.

QHPs should be required offer out-of-network coverage. Even with improved network adequacy and external review appeal processes, many consumers would prefer to purchase an out-of-network option that allows them to use out-of-network providers even if at a somewhat increased cost. People paying for vital and often life-saving treatments with trusted providers – HIV and cancer specialists, for example – should retain the right to see these providers without bearing the complete full costs of these services.

Merge the individual direct pay and small group health insurance pools both inside and outside of the NYSOH marketplace. New York still separates its individual and small group insurance markets, both inside and outside of the marketplace. While an individual mandate is bringing new purchasers into the market and has lowered prices, both affordability and choice for individuals would be even more enhanced by a market merger. The ACA requires New York to increase its small group market from 50 to 100 in 2016. This would be a good time to merge our small group and individual markets. It would help ensure an out-of-network option and it would also provide continuity of care during transitions between workplace and individual coverage. Massachusetts offers an example of a successful market merger.

Re:

ACCESSIBILITY OF COVERAGE

The NYSOH marketplace should integrate private commercial coverage and all forms of public coverage, and be capable of enrolling people in the most beneficial program for which they are eligible. For people with disabilities who need comprehensive coverage that meets their needs, it is particularly important that NYSOH do a thorough evaluation of eligibility that takes into consideration disability or diagnosis-related Medicaid, such as Medicaid Buy-in, Medicaid Spenddown, and the Medicaid Cancer Treatment Program. Currently coverage for these programs is not available through NYSOH for these “non-MAGI” populations. NYSOH does ask if a person has a disability determination, is blind, or needs long-term care services, and then refers them to the local Department of Social Services for an actual eligibility determination. An additional question that should also be asked in this section is whether the person has a cancer diagnosis so that they can be considered for the Medicaid Cancer Treatment Program. Navigators and in-person assistors need to be trained to be familiar with disability-related and cancer diagnosis-related Medicaid eligibility so that they can advise people appropriately, pending enrollment functionality for all Medicaid populations through NYSOH.

Consumer Assistance. Navigators, who provide enrollment assistance to consumers, cannot help with post enrollment issues. CIDNY supports a sustainable source of funding to support consumer assistance programs. With so many people who may be new to the world of health insurance enrolling in coverage these services are needed now more than ever. We are advocating that the legislature increase the Administration’s \$2.5 million appropriation to \$5 million for this year.

Medicaid Managed Care Ombudsperson Program. In December the state established a Medicaid Managed Care ombudsperson program called Independent Consumer Advocacy Network ((ICAN) for people receiving long term care services for more than 120 days in mainstream managed care, Managed Long Term Care, and the Fully Integrated Duals Advantage (FIDA) program, CIDNY supports the Governor’s provision of an additional \$5 m. in the 2015 -2016 Executive Budget for Ombudsperson program services. Understanding and navigating these new ways of accessing care can be difficult making these services critical to the success of this new care delivery.

AFFORDABILITY OF COVERAGE

Basic Health Program. CIDNY supports the implementation of the Basic Health Program which would provide coverage for people between 138% of federal poverty level (income at which non-disability related adults become ineligible for Medicaid), as well as lawfully present immigrants not eligible for federal Medicaid funding, up to 200% of the FPL which is 23,340 or a single individual and \$47,700 for a family of four in the 2015 benefit year. These people are eligible for premium subsidies, but that can amount to 6.34% of their income for the second lowest silver plan or more if they need a plan with higher actuarial value. A Basic Health Program will provide more affordable coverage and will generate approximately \$300 million in annual fiscal savings for the State. Because federal funds cannot be used to administer the program CIDNY supports an appropriation to administer the program.

Re:

CIDNY also urges the legislature to provide state funding to make sure that higher income PRUCOL immigrants can be included in the BHP as they are in Medicaid and consistent with past practices under the Family Health Plus program

Finally, the State should consider taking the additional step of covering undocumented immigrants in the program as all New Yorkers deserve affordable, quality health coverage.

Preserve spousal and parental refusal. The Governor's Budget again proposes to eliminate the longstanding right of "spousal/parental" refusal for children with severe illnesses, low-income seniors and people with disabilities who need Medicaid to help with long term care costs and Medicare out-of-pocket costs. The "refusal": will only be honored and Medicaid granted if a parent lives apart from his or her sick child, or a "well" spouse lives apart from or divorces his or her ill spouse. CIDNY opposes denying Medicaid to these vulnerable groups; the projected cost savings from this action may not be realized, and in fact the increased insecurity of these consumers and their families may cause further health care and social costs that have not been included in the budget assumptions.

COMPREHENSIVENESS OF COVERAGE

CIDNY strongly opposes eliminating Provider Prevalis. This proposal would repeal an important patient protection in the Medicaid It would amend fee-for-service Medicaid provisions to eliminate prescriber prevails for drugs not on the preferred drug list. A prescriber, with clinical expertise and knowledge of his or her individual patient, should have the final say to be able to override the preferred drug list for atypical anti-psychotics, as well as anti-depressant, anti-retroviral, anti-rejection, seizure, endocrine, hematologic, and immunosuppressant therapeutic classes. People with disabilities often have chronic conditions that require a complex combination of medications. Different individuals may have very different responses to different drugs in the same class. Sometimes only a particular drug is effective or alternative drugs may have unacceptable side effects. Disrupting the continuity of care can result in detrimental or life threatening consequences and can actually lead to more medical complications, expensive hospitalizations, emergency room use, and higher health costs. It can also discourage consumers from continuing with needed treatment due to uncomfortable side effects or because drug failure erodes their trust in medication. Prescribers are in the best position to make decisions about what drug therapies are best for their patients. CIDNY urges the State to recognize the importance of specific prescription drug combinations and protect Provider Prevalis.

CIDNY supports "Step Therapy" legislation that would allow for a prescriber override. People with disabilities and serious illnesses often have chronic conditions that require a complex combination of medications. Sometimes only a particular drug is effective or alternative drugs may have unacceptable side effects. Sometimes a drug that has been helpful will lose its effectiveness. CIDNY supports passage of legislation that would add a new article to the insurance law which gives prescribers access to a clear and convenient process to override step therapy and "fail first" restrictions when medically in the best interests of the patient. The prescriber's

Re:

treatment decisions would prevail when, in his or her professional judgment, the preferred treatment of the QHP or its Pharmacy Benefit Manager is expected to be ineffective or cause an adverse reaction or other harm to the covered person. The legislation would also limit the duration of a step therapy protocol to the period deemed necessary by the prescribing physician or health care professional to determine its effectiveness, or a period of thirty days.

Anti-Mandatory Mail Order Drug Legislation. CIDNY strongly supports passage of legislation that is necessary to clarify and strengthen current law to ensure that consumers can have the choice of accessing their covered medications from a local pharmacy or by mail order. This legislation would better define terms and remove provisions in current law that have served to impose extra requirements on network community pharmacies as a precondition for providing covered medications otherwise available by mail order. Consumers are the ones who should decide whether to receive medications by mail or from a local pharmacy. This decision should not be left up to an insurance company.

20-visit limit on Medicaid Physical Therapy, Occupational Therapy, and Speech Therapy should be subject to an override. The Medicaid Redesign Team adopted the recommendations of its Basic Benefit Review Workgroup that included the principle that decisions on the Medicaid Benefit package would be based on evidence derived from an assessment of effectiveness, benefits, harms, and costs. Arbitrary visit limits may not make sense, and discriminate against people with disabilities. People who have a stroke may need more than 20 physical therapy visits to regain the function of walking. Already, we have seen a person subjected to this limit who required surgery as a result, and then was unable to get the recommended post operative physical therapy due to the limit. Some people may experience depression when they are unable to gain or regain function that may require therapy or prescription drug treatment. Medicare provides for an override, and Medicaid Utilization Thresholds which have been used in New York have provided a procedure for a physician override. Such a procedure should be implemented with these limits.