**2017 HEALTH POLICY ADVOCACY AGENDA**

New Yorkers for Accessible Health Coverage (NYFAHC) is a statewide coalition of 53 voluntary health organizations and allied groups who serve and represent people with chronic illnesses and disabilities, including cancer, HIV/AIDS, cognitive impairments, multiple sclerosis and epilepsy. Because the conditions affecting the individuals and families we represent do not discriminate between rich and poor, we advocate for accessible, affordable, comprehensive and accountable health insurance for the privately insured, as well as those in need of access to public insurance programs.

**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 and formularies 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 nuerology and nuerology surgery, but our members would also like to see subspecialists (such as MS nuerologists) required. Networks should also be required to include NCI Cancer Centers and Transplant Centers.
* Requiring minimum appointment availability standards by adopting NYS DOH’s Medicaid appointment availability standards for private insurance plans. Consumers should have the right to go out of network if they cannot get appointments with accessible providers that speak their language within these time frames.
* Requiring QHPs not to drop providers during a plan year – QHPs should only be permitted to remove providers for cause during a plan year.
* Prohibiting plans that are required to offer essential health benefits from dropping drugs from their formularies or adding higher cost sharing or utilization review requirements during a plan year. NYFAHC supports A7707/S5382 which does this.
* 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 transition period to the end of the contract year when networks or formularies change, if the provider agrees to accept the standard payment offered by the QHP. NYFAHC supports A1932 which does this for providers.
* Require plans to meet minimum standards for linguistic diversity and for ADA compliance. Plans need to have providers that are fully accessible and have medical and diagnostic equipment that meets the standards of the access board.

**Out-of-network coverage and services.** 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. The State should require plans to offer out‐of‐network coverage in at least one silver‐level plan and one platinum‐level plan. Health plans could offer such coverage as a rider to insurance policies.

The surprise bill law should be amended to apply to all misrepresentations of network status. The current definition only applies to services that an insured person chooses to receive from a non-participating provider pursuant to a referral by a participating provider. It does not protect people in plans that do not require referrals, even if the out of network provider they choose has misrepresented his or her network status.

**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. 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.

**PATIENT PROTECTIONS**

**Establish a reserve fund.** In the event that carriers begin to fail mid-year a reserve fund should be established the minimize disruptions for consumers.

**Credit consumer payments towards deductibles.** Roll over progress on Maximum Out-of-Pocket payments and deductibles if consumers have to change plans mid-year.

**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. NYFAHC 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.

**Expand External Review.** External Review of health plan decisions should be extended in the following ways:

* Cover more types of health care issues, such as disputes over access to in-network specialists and amounts reimbursed for out-of-network services.
* Cover questions of billing – as opposed to medical determination – such as non-covered services.
* Create a public database of all external review decisions (with privacy protections) that can be accessed to ensure transparency for consumers and advocates.

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. Deisions should be redacted and consumers should be permitted to “opt out” of the data base.

**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 Spendown, 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.

**Create a “Plan Finder”.** Non-Medicare health plans in New York State should have something similar to the national web-based Plan Finder that helps Medicare beneficiaries choose Medicare Advantage and Part D prescription drug plans.

**AFFORDABILITY OF COVERAGE**

**Prior approval.** The Department of Financial Services and the legislature should ensure that New York’s prior approval process remains a strong tool for consumer protection, including:

* Oppose any legislative effort to reduce the discretion of the Department of Financial Services in regard to the regulation of health insurer rate increases, or to limit the ability of consumers and consumer organizations to participate effectively in rate increase proceedings.
* Establish uniform standards and expectations for carrier actuarial memoranda and narrative summaries in prior approval applications.
* Require public disclosure of information regarding claims experience by plans.

**COMPREHENSIVENESS OF COVERAGE**

**Anti-Mandatory Mail Order Drug Legislation.**  NYFAHC 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 decision should not be enitrely 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.