

LEGAL AID SOCIETY TESTIMONY

FOR THE NEW YORK STATE

PARTNERSHIP FOR COVERAGE

PUBLIC HEARINGS ON UNIVERSAL HEALTH COVERAGE
SPONSORED BY THE NEW YORK STATE DEPARTMENTS
OF HEALTH AND INSURANCE

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On behalf of the Legal Aid Society, we would like to thank Governor Spitzer, Commissioner Daines, and Superintendent Dinallo for convening these hearings and for their commitment to ensuring access to health care for all New Yorkers.

The Legal Aid Society's Health Law Unit (HLU) operates a state-wide Health Law Helpline and provides assistance to more than a thousand low-income health care consumers and advocates each year. In addition to providing direct representation and advice to consumers, our unit provides training and technical assistance to community-based organizations, legal services providers, and health care providers across the state. HLU staff also participate on steering committees for the New York State Consumer Coalition for Medicare Part D, and the Medicaid Matters New York Managed Care Workgroup. Because of our wide-spread exposure, we are in the unique position of being able to identify the various problems that exist with the current health insurance programs, as well being able to recognize what works well.

HLU clients reflect the diversity of New York. They come to us for help resolving a myriad of problems associated with obtaining health care within our current construct. Some have problems accessing or maintaining public insurance; others have insurance but are unable to navigate the rules governing their coverage so they either lose their coverage or go without care. Many come to us mired in medical debt because they were uninsured or underinsured when they became ill or injured. In most, if not all the cases we encounter, the consumer faces a heavy burden attempting to learn the complicated rules governing the public insurance program and appropriately navigate the system to obtain needed coverage.

We are excited by the discussions taking place throughout our State and appreciate your leadership on this issue. New York has implemented many very good public health insurance initiatives like Family Health Plus for adults, the Medicaid Buy-in Program for Working People with Disabilities and expanding the Child Health Plus eligibility levels. While we agree that it makes sense to use existing public programs as the foundation for Universal Coverage in New York, in order for these benefits not be illusory, the current programs must provide seamless coverage that is easy to access, easy to use, easy to maintain, and meets the needs of all New Yorkers.

Ensuring A Program That Is Easy To Access

We need to make sure that enrollment in current programs is easy to achieve so that low-income workers no longer have to choose between work and health coverage.

After being diagnosed with schizophrenia, Ms. R was on Medicaid and unable to hold a job. After many years of treatment she recovered enough to take a job, but then lost her Medicaid because she earned too much. As a result, she could no longer afford her prescription medication. Ms. R applied for the Medicaid Buy-In for Working People with Disabilities, but it took four months for her enrollment to begin in the program. During

this period without her medications she decompensated and could no longer maintain her job.

The Facilitated Enroller program in New York, which is currently one way to enroll in Medicaid and the only way to enroll in Child Health Plus B, has been both helpful and harmful in New York City. Facilitated Enrollers can be helpful in their presence in diverse locations and at non-standard business hours. They also frequently translate for clients and so increase Medicaid's ability to reach clients who do not speak English. However, the majority of Facilitated Enrollers work for managed care plans, and so sign clients up for their own plans without regard to the fact that a client's doctors may not accept that plan. The benefits of health insurance will be all but non-existent if the client is not able to access needed care, so we urge you to put more resources into language access and expanded hours at local offices. We further suggest increasing community based facilitated enrollment instead of giving money to private companies and their marketing.

Ensuring a Program That Is Easy To Use

For those individuals lucky enough to be enrolled in full fee-for-service Medicaid, all of their benefits are obtained by presenting their Medicaid benefit cards to providers who accept Medicaid. If they receive their care through managed care plans and they are not high-needs users, the process is almost as simple. One exception is that that enrollees use their original Medicaid cards to obtain pharmacy benefits and obtain medical benefits by using the Plan card.

Unfortunately, it is when the care needs become complicated that the system becomes impossible to navigate. Healthy individuals who see a primary doctor once or twice a year rarely have problems. But managed care beneficiaries who use mental health services more than ten times a year are faced with having to learn which services are "carved out" from managed care. If, as often occurs, a patient's managed care doctors do not accept fee-for-service Medicaid, this requires finding a second doctor to provide the carved out services. A patient then must remember which doctor accepts which benefit card, because if the patient shows the wrong card, the patient will likely be told simply that the card is not working and be turned away when the provider assumes the patient's benefits are not active.

If a patient has several specialist providers, the patient must make sure that all of the providers accept the same plan if the patient is to receive uninterrupted care. The option is either to give up one or more of their specialists, or navigate the exemption process. Although the forms look simple, if certain key information is not included, the patient will not receive the exemption. Even worse, it is up to the patient to know how to complete the form successfully and to make sure that the doctors advocate on the patient's behalf.

Mrs. A called the HLU after her request for a managed care exemption was denied for the stated reasons that her doctor, a specialist on the faculty of the Department of Anesthesia at a New York City teaching hospital, was not a listed specialist, and because he was in one or more managed care plans. She then forwarded to us the letter that her doctor had written on her behalf. The letter stated that he did not participate in any managed care plan and that he had been successfully been treating her for the past seven years after all previous modalities had failed. It took several calls to Maximus and the doctor's office for HLU staff to confirm that the doctor was not a participant in a health plan, only to find out that the letter written by the doctor that accompanied the application somehow was not in her managed care file. With the intervention of a Maximus supervisor, we faxed the doctor's letter and Maximus granted the exemption.

We are not advocating that Universal Health Coverage not incorporate the use of managed care plans. We are asking that meaningful navigation tools be put in place during enrollment and that care coordination be put in place in appropriate cases so that the most vulnerable patients are not saddled with the burden of coordinating complicated care.

Navigational assistance is also necessary to address billing mistakes that can devastate a family. In the past two years, our unit has eliminated nearly \$800,000 in medical debt for our clients. While clients who were uninsured amassed much of this debt, it is important to point out that more than a third of this debt was attributed to clients with insurance. Under the current system, the burden is on the client to be fluent in the law pertaining to balance billing and the billing of Medicaid patients.

The mother of T, a young boy who received heart surgery called the HLU because she had been receiving notices from a collection agency requesting payment for an unpaid bill incurred prior to T's enrollment in a managed care plan. Since T was on Medicaid fee-for-service at the time the services were provided, he is not responsible for this bill.

When Mrs. K was admitted to a psychiatric hospital, she had limited private health coverage and Medicare. She said that she told staff at the hospital that she had Medicare, but they did not process this information. Although she kept insisting that she had coverage, because of her serious psychiatric illness she was unable to appreciate the seriousness of the matter or to make court appearances and the case against her proceeded. It was not until a judgment was entered against her for \$250,000 that she contacted the HLU. When we presented written proof that she had advised a staff member about her coverage, the hospital vacated the judgment and dismissed the action.

Ensuring a Program That Is Easy To Maintain

Difficulties maintaining coverage make our current system patchwork rather than blanket coverage. Improving our current programs so that they provide seamless coverage will ensure the required stability for universal coverage.

That our current approach to health coverage often results in “band-aid” coverage is illustrated by the numbers of people who fail to recertify for public health programs, despite almost universal continued eligibility. According to a study conducted by Manatt Health Solutions, nearly 50% of public insurance recipients lose their coverage during the annual recertification process. Over 93% of children who fail to recertify for Child Health Plus are still eligible.¹ Most “churn” through the system, reapplying for coverage within a few months. In addition to the gaps in health coverage that consumers experience, churning reduces health plans’ abilities to track chronic conditions and increases administrative costs.²

Under the current system, program eligibility and plan eligibility are not completely coordinated. So when individuals lose coverage due to recertification error – which they often find out when they visit their provider or pharmacy – even if they are lucky enough to get retroactive program coverage to cover some or all of the lag, the plan gap remains.

Ms. X lives in Brooklyn, and was 9 months pregnant when she contacted the HLU after her doctor told her that her health plan card was not active. Ms. X called her plan to find out what was wrong with her coverage and she was told that her underlying Medicaid case was closed because she failed to recertify. Ms. X says that she never received her Medicaid insurance recertification forms in the mail. She didn’t know that she was supposed to have recertified, or that her coverage had lapsed, until she tried to see her obstetrician. The doctor refused to see her unless she paid up front or until her coverage was active again. Ms. X had no money so she missed several important prenatal appointments before her Medicaid case was reopened. In addition to advocating for Medicaid reactivation, HLU staff had to advocate for her health plan coverage to be reinstated immediately. The plan’s original position was that it could not cover Ms. X until the beginning of the next month, effectively ensuring that Ms. X would give birth without seeing her own doctor.

The inability to maintain public coverage affects many aspects of an individual’s life. *Ms. M had a full-time job when she was hit by a car. Following the accident, she was unable to work. Her only income was less than \$800/month in Social Security Disability payments. An income this low leaves no room for error. Ms. M paid her rent on time, until Medicaid erred and her case was closed.. With \$600 in monthly medical expenses, Ms. M fell behind in her rent and faced eviction. She waited 18 months for a Fair Hearing, and, even with our help, she had to pay her own medical expenses for two years.*

Unfortunately, Ms. M’s story is not unique. Studies by the Kaiser Family Foundation and the American College of Physicians/American Society of Internal Medicine show people who are uninsured receive less preventive care than the insured, are diagnosed at more advanced stages of disease, and are more likely to use emergency rooms as their regular source of care.³ Uninsured children are five times more likely than privately insured children to use the emergency room as a regular source of care.⁴

Ensuring a Program That Meets The Needs of All New Yorkers

A poll conducted by New American Media found that only 25% of undocumented immigrants in the United States are currently covered by some form of health insurance.⁵ Lack of health insurance coverage adversely affects both the immigrants and their families. According to an August 2007 *Health Affairs* study while children of immigrants are usually eligible for public health insurance, they are less likely to enroll if their parents are ineligible for public health insurance.⁶ Over eight in ten immigrant families with children are made up of at least one noncitizen parent and at least one child who is a citizen, according to a 2001 report by the Urban Institute. As a result, “the imposition of benefit restrictions for noncitizens tend to spill over to their citizen children,” while “policies intended to extend benefits to noncitizen children are limited in their reach because most children in immigrant families are already citizens.”⁷

Mr. C isn't eligible for Medicaid because of his immigration status. He called Legal Aid's Helpline because he has high blood pressure and wanted to know if he could get health care services somewhere other than an emergency room. He was relieved to know that in New York City he had options, but he also worried that he would need to wait in long lines at a clinic to get care. He stated that he could not afford to miss a day of work to get health care services. Although Mr. C believes it is important to have his high blood pressure checked, he also knows that missing work will cost him his job.

Fortunately for Mr. C, he lives in New York City and can receive health services through the New York City Health and Hospital's Corporation. Through HHC's HHC Options sliding fee scale program, Mr. C can receive ongoing health services for a low fee at a clinic in his borough. While this is good for Mr. C, the ability to receive health care cannot continue to be based on where you happen to live. A young woman in Westchester County was not as lucky. Her advocate contacted the HLU because she needed an eye exam and new glasses and could not find a provider in the city where she lived that accepted Medicaid.

Expansion from Existing Programs

We think expanding healthcare access is important and wise. We want to make sure that the state does it well, and protects the consumer throughout. There is a lot of money in this expansion, and it is entirely possible that companies will be in such a rush to get the money that they will lose sight of the consumer trying to access care.

We want New York State to expand coverage, and we want this coverage to expand from the bottom up and the top down. By covering everyone at a certain income level for free, perhaps up to 250% of the Federal Poverty Level, and requiring small but increasing payments from those at higher levels, we can ensure that everyone in New York can be healthy enough to contribute to improving our communities. Making health benefits something into which employers pay a fixed percentage of an employee's pre-tax income would mean that employees at higher income levels pay for a greater share of our

health costs. Workers at lower incomes need to feel that health insurance is something that is available to them and is affordable enough that it does not pose a burden.

We strongly suggest that New York undertake as much as possible of this health care expansion as an automatic-enrollment government program, like Medicare Parts A and B, rather than through a mandate forcing people to try and understand the offerings of a mishmash of private companies, like Medicare Part D. Over 95% of seniors and disabled people who are eligible for Medicare Parts A and B receive it.⁸ Medicare Parts A and B are opt-out programs, as should be whatever we create in New York. Part D, in contrast, is required or people will face fiscal penalties, yet fewer than 60% of those who are required to select a plan have done so.⁹ Clearly having opt-out coverage enrolls more people. Opt-out coverage would also reduce the waiting time required for your application to be processed. This waiting period is supposed to take between 45 and 90 days in New York, which can be perilous if one is already sick.

It is important that all plans cover the same services, including dental and mental health benefits. Dental benefits are important, especially preventative dental care and dental care that focuses on saving teeth. This benefit should no longer be optional. It's ten times more expensive to cover dental care on an emergency basis than it is to cover those same patients in earlier stages in a dentist's office.¹⁰ Severe tooth decay is responsible for two-thirds of hospital visits by children under six in New York State.¹¹ While low-cost dental clinics do exist, waiting lists are long and clinics are often inaccessible for those in more rural areas. The patchwork of care that we cobble together in New York through existing public health insurance, employer coverage for the few who have it, and charity for the uninsured or underinsured is inadequate.

Yet another benefit of the government approach rather than the private company approach is that it is simpler. We rarely have people calling for help with seeing their doctors on regular Medicaid. People understand the appeals process, finding a doctor is easier, and getting care once you have a doctor is easier in regular Medicaid than in managed care. We know that managed care has a significant presence in New York, so we urge that you at least take some steps to mediate its excesses. The state should mandate that all claims forms and utilization procedures are the same, so that doctors can focus on providing care rather than administrative billing and authorization procedures.

Ms. J needed physical therapy after she hurt her ankle. Her doctor requested prior approval for physical therapy in February of 2007. When he did not receive a response, Ms. J assumed the request was denied and continued to limp and further strain her ankle. The doctor requested the services again in July of 2007. In October, Ms. J still had no response so she contacted the HLU. We called the doctor, got a copy of the form the he had submitted to the insurance company, and called the company. Because the doctor had submitted the prior approval request on his own letterhead rather than the company's own specific physical therapy prior approval form, the company had ignored his request for services. We were able to get the doctor a copy of the correct form, which he resubmitted and the service was approved.

In whatever program New York creates, we need to make sure that people's rights are respected and protected. Having a telephone number through which representatives can answer questions is fantastic, but what if the people on the telephone give you inaccurate information? Or what if you try to file a complaint by telephone—how can you follow up on it? New York's new coverage system should include a hotline through which representatives are empowered to take action on people's cases. Each hotline call and caller should be given an ID number so that callers can make reference to those numbers in future interactions.

We are concerned that private companies will take advantage of New Yorkers, particularly the most vulnerable among us. We want to share with you an example of a client who did everything right, and still got hurt.

Mr. M is an 87-year-old veteran living upstate with his 86-year-old wife on a fixed income. He gets most of his medications from the VA, but spends \$7,000 yearly on a Medicare Part D prescription drug plan for the drugs that the VA doesn't cover. A representative of a new Medicare Advantage plan came to his senior center and promised he could save half of that money by switching to a new plan. Mr. M signed up to receive further information after the representative assured Mr. M that he understood Mr. M was only agreeing to receive further information, and that he wasn't signing up for the plan. The next week, Mr. M had heart trouble and ended up in the hospital for three weeks. After leaving the hospital he found that he had been enrolled in the new plan, that he had bills of over \$100,000, and that none of his prescriptions were covered. Mr. M managed to get back into his old plan and most of those bills disappeared, but it is horrible to hear Mr. M express the shame he feels over having been tricked into this plan, and how terrified he and his wife were when they saw those bills.

We must create protections for people like Mr. M, with appeals, an Office of Patient Rights, fraud protection measures, and ombudsmen charged with responding to the concerns of New Yorkers. We need to make the process of getting a doctor and accessing health care transparent, to keep us free from mountains of paperwork and concentrate instead on getting healthy and back to work to help keep our state strong.

Something is seriously wrong with a system that requires a lawyer to obtain needed health care.

New York has a chance to show the rest of the country that expanding coverage is practical and smart. We look forward to working with you on this vitally important issue. Thank you.

¹ Patricia Boozang, Laura Braslow, and Anthony Fiori, "Enrollment Churning in Medicaid: Coverage Gaps Undermine the Managed Care System and Continuity of Care for the Chronically Ill," *Manatt Health Solutions*. New York State Coalition of Prepaid Health Services Plans, December 2006, 6.

² “Enrollment Churning in Medicaid,” 7.

³ *Sicker and Poorer: Consequences of Being Uninsured*, Kaiser Commission on Medicaid and the Uninsured (2002); *No Health Insurance? It’s Enough to Make You Sick: Latino Community at Risk*, American College of Physicians/American Society of Internal Medicine (March 2000).

⁴ *No Health Insurance? It’s Enough to Make You Sick: Latino Community at Risk*.

⁵ “Historic Poll of Undocumented Immigrants From Latin America,” New America Media, Poll, Posted: Jun 21, 2007. Available:

http://news.newamericamedia.org/news/view_article.html?article_id=5f47289d59c786e1f07c3eb69707b8a

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⁶ J.L. Hudson and T.M. Seldon, “Children’s Eligibility and Coverage: Recent Trends and a Look Ahead.” *Health Affairs* web exclusive, August 16, 2007.

⁷ Michael Fix, Wendy Zimmermann & Jeffrey S. Passel, *The Integration of Immigrant Families In the United States*. Washington, DC: Urban Institute, July 2001.

⁸ “Medicare Part D Enrollment Numbers,” February 16, 2006. Medicare Rights Center. Available: http://www.medicarerights.org/policy_enrollment_brief022006.pdf

⁹ In June of 2006, only 22.5 million Medicare beneficiaries, or 52%, had prescription drug coverage out of a total of 43 million Medicare beneficiaries. From “Medicare Fact Sheet: The Medicare Prescription Drug Benefit,” The Henry J. Kaiser Family Foundation (Washington, D.C.: November 2006), 2.

¹⁰ Pettinato Erika, Webb Michael, Seale N. Sue. “A comparison of Medicaid reimbursement for non-definitive pediatric dental treatment in the emergency room versus periodic preventive care”. *Pediatric Dentistry* 2000: 22(6), pp.463-468.

¹¹ “Early Childhood Caries-related Visits to Hospitals for Ambulatory Surgery in New York State,” Wadhawan, Kumar, Badner, Green, *Journal of Public Health Dentistry* Vol 63 No.1, Winter 2003, 47-51.