Testimony

A Pause to Review: The Ongoing Impacts of the COVID-19 Pandemic on Insurance in New York

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Good morning, Chair Cahill, members of the Assembly Standing Committee on Insurance and distinguished members of the Legislature. I am Jeff Gold, senior vice president and special counsel for insurance, managed care and behavioral health for the Healthcare Association of New York State.

On behalf of our statewide member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, thank you for the opportunity to provide testimony on the impact of the COVID-19 pandemic on health insurance and New York's healthcare providers.

The pandemic has stretched our healthcare system to its limit. But one thing has remained clear: hospitals and health systems, the anchors of their communities, have been there for all New Yorkers.

Our hospitals and healthcare workers continue to be the bedrock of the ongoing pandemic response. COVID-19 has highlighted the dedication and bravery of healthcare providers who, facing personal danger, fatigue and shortages of staff and supplies, have worked around the clock to care for patients, striving to keep themselves, their families and co-workers safe.

The pandemic has also put a bright spotlight on longstanding systemic problems including healthcare disparities, workforce shortages, misinformation and supply chain weaknesses. These issues have rightfully gained the attention of media and policymakers. We appreciate this committee's focus on COVID-19's impact on health insurance in New York and are pleased to provide our thoughts on how to address some of the persistent, underlying insurance issues that have been magnified during the pandemic.

Health insurance waivers

During the initial COVID-19 surges, our members needed to quickly make general acute care hospital beds available for higher-need COVID-19 patients, while ensuring the appropriate level of care for other patients, including those recovering from the virus. Hospitals had to urgently modify traditional discharge processes and clinical pathways to optimize personnel, physical plant and other resources.

As COVID-19 cases escalated in March 2020, then Gov. Cuomo declared a state of emergency. The declaration gave the state authority to suspend or modify statutory and regulatory provisions to more quickly and effectively respond to the novel virus outbreak.

Health insurance waivers were implemented via a series of circular letters issued by the Department of Financial Assistance starting in 2020, and have continued into this year.[1] The temporary flexibility these waivers provided significantly assisted hospitals and health systems as they managed the overwhelming influx of patients who needed treatment and care.

The goal of the DFS circular letters was to reduce the administrative burden of health plans' prior authorization requirements and other utilization management tools on an overwhelmed healthcare delivery system. It worked. Removing these hurdles lightened the administrative load for both providers and payers, allowing all to focus on caring for patients and responding to COVID-19.

[1] New York State Department of Financial Services Circular Letter No. 8 (March 20, 2020), Supplement No. 1 to CL 8 (April 22, 2020), Supplement No. 2 to CL 8 (June 26, 2020), Circular Letter No. 10 (May 2, 2020), Circular Letter No. 17 (Dec. 23, 2020); Circular Letter No. 9 (Oct. 27, 2021)

On March 20, 2020, DFS issued Circular Letter No. 8, a landmark action that suspended health plans' requirements for preauthorization for scheduled surgeries and hospital admissions, and concurrent reviews of inpatient hospital services.

Shortly thereafter, DFS issued Supplement No. 1 to CL 8, which extended the suspension of preauthorization and concurrent review requirements to outpatient hospital services. DFS also briefly suspended health plan retrospective reviews and audits until the initial crush of the pandemic had passed. However, in most situations, plans retained the ability to perform retrospective audits to determine if the provided care had been medically necessary and if reimbursement was appropriate.

These administrative waivers, issued under emergency circumstances, have essentially functioned as a pilot program in support of broader and longer-term administrative simplification.

By allowing providers to act swiftly in determining and then providing necessary care to patients, New York's hospitals were able to respond to this crisis in lifesaving ways.

There has been no downside. Removing preauthorization requirements for services did not result in healthcare providers ordering too many tests or over-treating patients. It simply made it easier for patients to get the timely care they needed, an objective to which all involved in the provision of healthcare should aspire.

Many of DFS' actions to waive or modify preauthorization requirements are consistent with the goals of the DFS Administrative Simplification Workgroup, which submitted its final report to the Legislature in October 2021.[2]

HANYS participated in the workgroup and remains a longstanding advocate for reducing unnecessary administrative burdens and removing barriers to care. **HANYS strongly supports measures to reduce the use of preauthorization requirements, particularly for procedures that are routinely approved by plans.**

Standardized emergency-related waivers

The DFS waivers have proven invaluable in the pandemic battle. But having healthcare providers, insurers and the state negotiate the provisions and terms of these waivers on the fly in the midst of a crisis was sub-optimal.

Our member hospitals' number one mission is to provide care. If the state declares an emergency related to a disaster that impacts the provision or receipt of care, a mechanism should exist to trigger a waiver of requirements that impede a hospital's ability to provide that care. **HANYS supports standing rules for the state to call upon to waive administrative requirements when the state declares a disaster emergency.**

[2] Report of New York's Healthcare Administrative Simplification Workgroup (Oct. 3, 2021)

Telehealth

The pandemic cemented telehealth as an important component of our healthcare infrastructure. Telehealth provides access to healthcare services for patients who may be unable to receive in-person care due to geographic limitations in underserved areas, provider shortages or restricted patient mobility.

Over the last two years, struggling providers have invested scarce resources into telehealth equipment, staff training and telehealth infrastructure to expand offerings and meet growing demand.

Recognizing the importance of telehealth for expanding and ensuring access to care, this year's enacted state budget requires telehealth payment parity: reimbursement for telehealth services must be equal to rates paid for comparable in-person services.

Telehealth payment parity will strengthen the state's telehealth infrastructure, expand the availability of telehealth services offered to patients and enable providers to sustain their investments in telehealth.

HANYS and our members are grateful telehealth parity was included in the final budget and we support making these provisions permanent. However, New York should go a step further to ensure that all healthcare providers, when appropriate, are authorized to provide telehealth services. **HANYS recommends expanding the definition of "telehealth provider" to include any provider who can legally provide healthcare in New York (A.9467-A).**

Administrative simplification

The DFS circular letters provided critically needed relief from administrative requirements during emergency circumstances. HANYS believes the Legislature should consider adopting additional measures that would promote ongoing and permanent simplification.

Under current law, when a healthcare provider submits a request for coverage of services for a health plan's enrollee, a lack of response from the health plan within statutory timeframes results in a claim denial. Allowing plans to deny services by simply not making a determination creates an incentive for insurers to delay or ignore claim submissions and wrongly shifts the burden to the provider to appeal such denials.

HANYS supports statutory modifications that would treat the failure of a plan to respond to a timely claim submission as an approval rather than a denial (S.6920).

HANYS also urges this committee to consider reasonable limits on the audit practices of some health plans. It is standard practice for health plans or their vendors to initiate audits to review claims for fraud or errors. However, the scope and breadth of audits that occur after the final adjudication of a claim is problematic. These types of audits often reverse or override a medical necessity or level of care decision after the determination and payment have been decided with finality under New York's Prompt Payment Law.

HANYS recommends prohibiting plans from reopening medical necessity decisions or level of care determinations during an audit.

Conclusion

Since the start of the pandemic, our healthcare professionals have provided lifesaving care amid extremely difficult, arduous circumstances, often putting themselves and loved ones at risk. The pandemic has shown our strength and resilience. It has also highlighted longstanding problems in New York's healthcare system.

The endless churn of insurance document requests, preauthorizations, reviews, audits, phone calls and faxes wastes precious healthcare resources and is a detriment to payers, providers and patients.

HANYS urges this committee to support an agenda that protects patient choice and access to care, while decreasing administrative burdens and costs borne by both providers and payers.

HANYS is committed to working with state government and all healthcare stakeholders as we pursue our common goal: ensuring that the highest quality care is accessible and affordable to all New Yorkers. We appreciate the support of the Legislature and this committee and look forward to continuing the progress we have made together.