

New York Health Plan Association
Annual Report 2003

Meeting
tomorrow's
challenges
today



H P A



The New York Health Plan Association (HPA) was founded to foster the development of health plans in New York. The HPA is actually two related organizations: the New York Health Plan Association works closely with government to promote quality, cost containment and efficient use of health care resources, and the New York HPA Council conducts educational and public awareness activities.

The membership of the association represents all types of health plans and includes for-profit and non-profit companies. Currently HPA has 17 fully licensed managed care plan members, eight PHSP members and four associate members. (PHSPs are "prepaid health services plans" that largely serve the Medicaid, Child Health Plus and Family Health Plus populations. HPA's associate members include managed long term care plans and preferred provider organizations.)

All HPA member health plans share a commitment to meeting the health care needs of New York State. Plans provide health care protection to the employed population as well as Medicare beneficiaries and people enrolled through the Medicaid Managed Care, Child Health Plus, Family Health Plus and Healthy New York programs. HPA member plans also participate in innovative programs and research that promote the health and well being of New York residents.

Message from the President/Board Chair

The past year was one of transition for health care.

The federal government passed sweeping Medicare reform legislation that represents the most significant change to that program since its inception. At the state level, plans and other health care providers invested significant resources to implement the wide-ranging provisions of the Health Insurance Portability and Accountability Act (HIPAA). In the legislative arena, the state renewed its comprehensive Health Care Reform Act (HCRA).

We also continued to witness emerging trends that suggest future health care models will require greater patient/consumer involvement in the purchasing of services. This desire of premium payers to have diverse product offerings—including consumer driven health plans, health savings accounts, high deductible plans and others—is fueled, in part, by the continuing rise of health care costs, with growth that has outstripped the overall growth of our economy for several consecutive years. In New York, health care costs remain higher than the national average.

While health care costs and developing cost-efficiencies that help to make the most of our health care dollars is important, plans also seek avenues for ensuring and protecting quality in the delivery of health care. To this end, there have been greater collaborative efforts between health plans and their industry peers, with a shared goal of providing New Yorkers a higher quality of care throughout the health care system.

To be sure, many challenges remain. In the area of quality, there is an increased interest in and growing use of “pay for performance” programs that help health plans demonstrate value to payers and maintain excellence of care for members. Plans are also considering a wider array of products and delivery models in their ongoing efforts to provide the care and services consumers desire at an affordable cost. This task, however, is particularly challenging in an environment where an increasing number of government-imposed mandated benefits foster an entitlement mind-set. Constantly seeking to balance access and affordability, one of the greatest challenges remains providing care for New Yorkers who are uninsured—a number that remains stubbornly high despite unprecedented investment in and growth of government-sponsored and subsidized insurance programs.

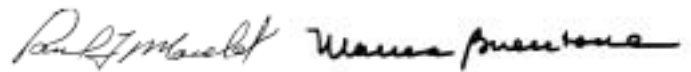
These are the challenges—and opportunities—that helped shape the goals and objectives of the New York Health Plan Association (HPA) and its members through the past year, and that will continue to guide us into the future.



*Paul F. Macielak
President & CEO*



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Continued high cost trends threaten the affordability of health insurance and many consumers' access to care.

The cost of health care in America continues to grow. The good news is that by the end of 2003, health care analysts reported that health care spending growth per privately insured American had slowed in the first half of 2003. However, while growth slowed, the overall 8.5 percent increase in health care spending represented growth that was nearly three times faster than growth in the overall economy during the same period.¹

The slowing of the overall cost trend reflected slower growth in four major categories of health care spending—inpatient hospital care, outpatient care, prescription drugs and physician services. Among these four, prescription drug spending growth slowed the most. The 8.5 percent increase for prescription spending in the first half of 2003 was down nearly 5 percent from the second half of 2002. Also notable, it was the first time since the mid-1990s that the drug costs did not grow at double-digit rates. Spending on physician services increased 6.1 percent during the first half of 2003, but was again the slowest-growing category of health care spending. Meanwhile, although overall spending on hospital care—both inpatient and outpatient—was also down during the first half of 2003, combined hospital spending accounted for nearly 60 percent of the overall growth in

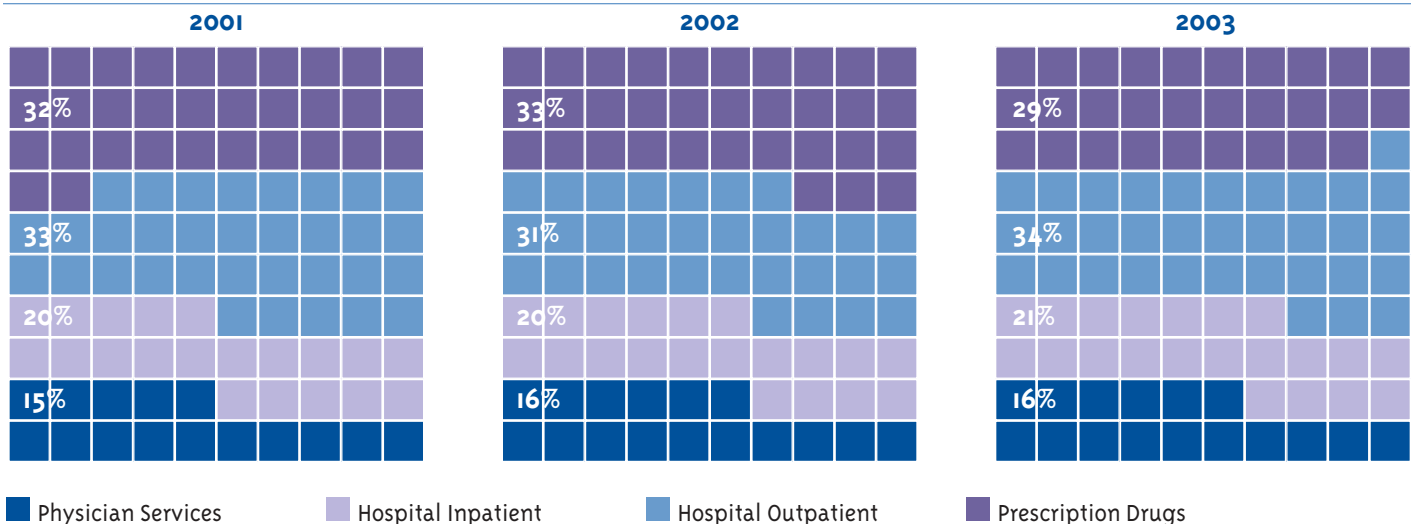
Cost of Care

health care spending. Outpatient care remains the fastest-growing category of health care spending, increasing by 12.9 percent in the first half of 2003 and accounting for 37 percent of the overall spending growth. Spending on inpatient care grew 7.6 percent during the same period, representing 22 percent of overall health care spending, during the first half of 2003.²

What does all this mean in the real world? Continued high cost trends threaten the affordability of health insurance and many consumers' access to care. Recent surveys of employers found them bracing for health care premium increases of between 10 percent and 14 percent in 2004. While some experts expect that, like spending, the increases may slow, the cost of health care remains a critical or significant concern to 96 percent of CEOs and senior executives.³

New York is being particularly hard hit by the trend of increasing health care costs. Personal health care spending in New York rose more than 43 percent from 1991 to 1998, with per capita health care spending exceeding the national average by more than 25 percent. A recent report from the Department of Health and Human Services' Centers for Medicare and Medicaid Services showed residents throughout the Northeast spend more on personal health

SHARES OF OVERALL HEALTH CARE SPENDING GROWTH 2001-2003¹



care than those in Western states like Utah, Idaho and Arizona. Researchers say key reasons for this are higher incomes and greater costs in urban areas, with another significant factor being more concentrated populations in cities that are able to support teaching hospitals and other specialized facilities that can cost more.⁴ Given this explanation, it should come as no great surprise that New York, with its large number of teaching hospitals and academic medical centers, spends more for health care than the rest of the nation.

There are numerous forces beyond general inflation that are driving the increases in health care costs. Increased consumer demand coupled with higher prices for hospitals and other provider services as well as higher drug costs are the major factors. Other factors that contribute to the rise in health care costs include an increasing number of mandated benefits and growing government regulation as well as rising litigation costs and fraud. A recent report conducted by PricewaterhouseCoopers found that litigation, mandates and fraud and abuse added \$18 billion to national health care spending in 2001.⁵

While it is a simple fact that good health care is expensive—hospitals equipped with advanced technology and highly trained professionals are

essential to providing patients with the right diagnoses and care, while new drugs are helping to treat an amazing array of medical problems more effectively—it is also true that ever escalating costs threaten access to that care. As rising costs increasingly jeopardize affordability, it raises questions as to whether every hospital needs every newest technology and all the latest programs or whether this duplication is an unwise allocation of our precious health care dollars.

Insured consumers have been largely protected from cost increases because employers have paid a disproportionate share of rising premiums. But, with a slowing economy, this is expected to change. Already many employers are increasing cost sharing—asking employees to pay a larger share of their premiums or raising co-payments for prescription drugs, hospital care and physician services. Increasingly the impact of health cost increases is being felt by all—employers struggling to provide health benefits and working New York families who find it harder to afford insurance at all.

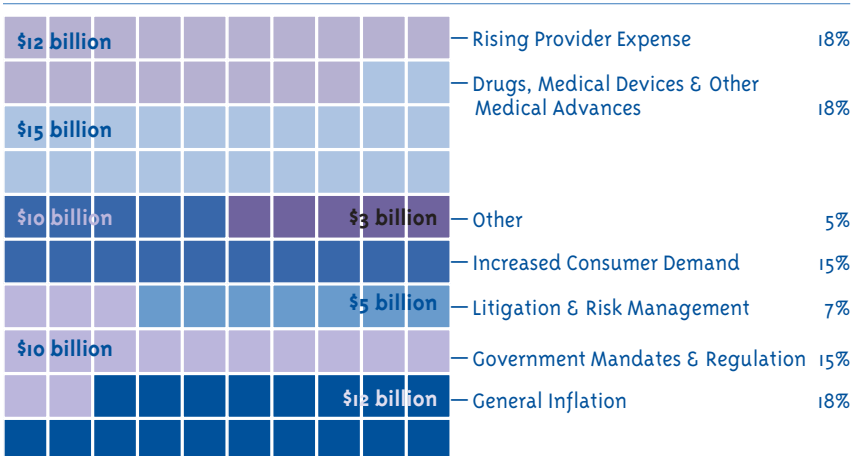
New research shows New Yorkers are more likely than the rest of the nation to lack health insurance. Analysis of Census Bureau data by the United Hospital Fund found the ranks of the uninsured in New York increased from 1995 to 2000, even as the number of people lacking health insurance nationwide decreased. The

United Hospital Fund study found one in six New York State residents does not have health insurance. The research also found that African-American and Hispanic New Yorkers are more likely to be uninsured and, although the majority of those without insurance are citizens, non-citizens are more than three times as likely to be uninsured.⁶

While a majority of those with health insurance are covered by employer-sponsored plans, most of those without health coverage are also working. In fact, 64 percent of the uninsured in New York work full-time or are children of full-time workers. Nearly 90 percent of uninsured workers are either not eligible for or not offered their employer's insurance, with the vast majority of that number—78 percent—not offered insurance.⁷

There is no magic cure for the rapidly rising cost of health care. Controlling costs requires a cooperative effort and recognition by all—providers, employers, consumers and government leaders—that the amount of money we have to spend on health care is finite. By acknowledging our resources are limited and by spending money more wisely, we can achieve a shared goal of improving the quality of health care in New York, while keeping it affordable for all New Yorkers.

THE FACTORS DRIVING RISING COSTS IN HEALTHCARE 2001-2002⁵



¹"Tracking Health Care Costs: Trends Slow in First Half of 2003", Center for Studying Health Systems Change, December 2003

²Ibid.

³"Health Care Expectations: Future Strategy and Direction 2004", Hewitt Associates LLC.

⁴Department of Health and Human Services' Centers for Medicare and Medicaid Services, July 2002.

⁵"The Factors Fueling Rising Healthcare Costs", PricewaterhouseCoopers report for the American Association of Health Plans, April 2002.

⁶"Health Insurance Coverage in New York, 2000", United Hospital Fund, September 2002.

⁷Ibid.

⁸New York State data extrapolated from: National Center for Health Statistics (2002), Prevalence, 2001: Lifetime asthma diagnosis, current asthma, and asthma attack prevalence.



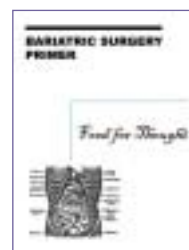
Improving Quality

Obesity Surgery

As the prevalence of overweight and obesity in the U.S. has increased dramatically, there has been a similar increase in the number of patients seeking and receiving treatment including various types of surgical treatments.

These procedures, collectively known as bariatric surgery, have been increasing in number. Between 1998 and 2002, the number grew five-fold and it is estimated that in 2004, some 145,000 bariatric surgeries will be performed. Despite this dramatic increase in the number of procedures, there is little information available about their safety and efficacy. The obesity surgery project, also funded by a Department of Health grant, created a partnership between nine health plans and a dozen of the leading bariatric surgeons in New York state for the purpose of developing and disseminating a "best practices" set of guidelines for the evaluation of patients suitable for surgery, as well as pre- and post-operative care of bariatric patients, and information about the training qualifications and experience of surgeons performing the surgery.

To compliment the practice guidelines, a separate Obesity Surgery Primer, "Food For Thought", was also developed. The primer, providing an overview of the growing problem of obesity and other related health issues as well as plain language explanations about various surgical procedures, potential risks and other helpful information, is intended to assist health care providers and individuals considering surgery.



Appropriate Antibiotic Use

Through a state Department of Health-funded grant, the Health Plan Association and several health plans partnered with provider organizations and the Council for Affordable Quality Healthcare (CAQH) to develop the *Save Antibiotic Strength New York* (SASNY) campaign. The project seeks to educate the public and health care provider community about the problem of drug resistant bacteria and to reduce the inappropriate use of antibiotics. Complicating the problem is the fact that providers are often faced with diagnostic uncertainty that makes it very difficult to definitively rule out a bacterial component to an infection. In its effort to educate providers and the public and raise awareness of the problem, the SASNY project developed a Website that offers numerous materials and resources for providers and their patients about viruses, bacteria and antibiotic resistance.

The project also produced a CD Rom "tool kit" packed with resources designed to assist providers with diagnosis and help educate patients about when antibiotics are effective (against bacteria) and when they are not (against viruses). The CD Rom tool kit features information about:

- Practice tips and guidelines for diagnosing and treating pharyngitis (strep throat) and bronchitis;
- Patient education materials, including CDC and New York State Department of Health fact sheets and "viral prescription pads";
- Printable office posters and flyers; and
- Summary and other materials on the principles of appropriate antibiotic use.

The Tool Kits were mailed to more than 16,000 primary care providers in New York in time for the cold and flu season. To help determine the effectiveness of the educational effort, members of the SASNY coalition will be comparing diagnosis and prescription patterns.

There has been increased focus in recent years on the need to improve the quality of care delivered in various settings throughout health care system. The Institute of Medicine (IOM), with its ongoing reports both highlighting shortcomings and providing roadmaps for enhancing health care quality, has been a major impetus for numerous quality improvement initiatives. Over the past several years, the managed care community in New York has become increasingly involved in quality improvement efforts. Many of the initiatives center around the design and dissemination of evidence-based clinical guidelines and best practice information. By encouraging the use of clinical guidelines and best practices, health plans seek to affect the delivery of care in ways that will result in higher quality of care and improved health outcomes. The following is a summary of some of the key cooperative initiatives undertaken by HPA, its member plans and other stakeholders in New York's health care system.



www.sasny.org

SASNY MEMBERS

- Capital District Physicians' Health Plan
- Council for Affordable Quality Healthcare
- Empire Blue Cross Blue Shield
- Health Net
- Independent Health
- Medical Society of the State of New York
- MVP Health Care
- New York Academy of Family Physicians
- New York Chapter, American College of Physicians, Inc.
- New York Health Plan Association Council
- Oxford Health Plans
- Vytra Health Plans

Asthma

Asthma is a serious public health problem in New York as well as the rest of the nation. This chronic inflammatory disorder of the airways affects more than 17 million Americans including more than one million adults and 250,000 children in New York.⁸ Total Medicaid health care expenditures for people with asthma in New York State exceeded \$1 billion in fiscal year 2000.⁹

In recognition of this growing public health problem, the state Department of Health convened an expert panel in late fall of 2002 to come up with a statewide guideline for the treatment of asthma. The panel was comprised of several health plan medical directors, representatives from various physician specialty societies (pediatrics, family practice, internists and the Medical Society of the State of New York) and included many recognized experts in the field of allergy and pulmonology. After a series of meetings and much discussion, consensus was reached and the panel approved the guideline, which is consistent with the current National Institutes of Health (NIH) Asthma Guideline. The guideline was released in October of 2003 and distributed to more than 20,000 health care providers across New York.

Tobacco Cessation

Concerned about health problems caused by and related to smoking and tobacco use, health plans have long sought to educate their members and the general public about the dangers of smoking, and to help members who do smoke quit. As the U.S. approaches the 40th anniversary of the Surgeon General's report that declared smoking and secondhand smoke bad for our health, we can look back at the progress that's been made in reducing smoking in our society. However, more than 23 percent of adult New Yorkers still smoke, so more needs to be done to bring those numbers down.

To assist plan providers, the HPA medical directors this past fall endorsed a common smoking cessation guideline and provider guide aimed at helping patients become tobacco free. The cessation guideline, an evidence-based tool based on the *Treating Tobacco Use and Dependence Clinical Practice Guideline* published in 2000 by the U.S. Public Health Service, and the provider guide, adapted with permission from a guide originally developed by the Canadian Council for Tobacco Control, were distributed to all HPA member plans, with plans promoting the tools to participating providers. The materials were also mailed to nearly 20,000 providers—including primary care, internal medicine and family practice physicians, obstetrician/gynecologists, pediatricians, and pulmonologists—around New York.



Diabetes

HPA member plans have endorsed and promote the use of a common guideline for the diagnosis and treatment of diabetes. The goals of a standard diabetes care guideline, which is under continual review and is updated as needed, include the alleviation of confusion that can exist when clinicians receive multiple directives from different plans and improvement in the quality of care for patients with a chronic condition that requires coordination of services among a number of providers to best manage and treat the disease. Use of the standard guidelines was pioneered by the Westchester New York Diabetes Coalition, which continues its efforts to imple-



ment processes that promote the coordination of care among providers for diabetes patients.

In 2003 the coalition launched a new effort to improve care for patients with diabetes through the implementation of diabetes patient registries in private practice settings. The patient registries function as a decision support and tracking system that can aid physicians in adhering to recommended guidelines and protocols, and monitor patient progress. More than 100 physicians and health care providers attended a WNYDC organized Continuing Medical Education dinner on the benefits of adhering to clinical practice guidelines and were invited to participate in the registry project initiative.

OBESITY SURGERY PROJECT MEMBERS

- Affinity Health Plan
- AmeriChoice
- Capital District Physicians' Health Plan
- Fidelis Care New York
- Health Net
- HIP Health Plan of New York
- Hudson Health Plan
- Independent Health
- MVP Health Care
- NY Health Plan Association Council
- Oxford Health Plans

⁹ New York State Department of Health (2002), Claim Detail/Special Reporting System, Office of Medicaid Management.

Improving Quality

Credentialing

Working with the Council for Affordable Quality Healthcare (CAQH), the Health Plan Association is seeking better systems to credential providers. Credentialing can be a burden for any medical practice. To help reduce the burden, CAQH, a not-for-profit alliance of leading health plans and networks, developed a service called Universal Credentialing DataSource that greatly streamlines the process and creates a win-win solution for plans and practices. In New York, it is estimated that 600 providers join the system each month and, to date, there are 10,000 registered providers. Nationwide, 86,700 physicians are now registered with the system and by the end of 2004 the Universal Credentialing DataSource initiative will be launched in every state.

HIXNY

The Health Information Xchange of New York (HIXNY) is a non-profit cooperative alliance between the New York Health Plan Association and the Iroquois Healthcare Alliance, which represents 56 hospitals and health care facilities in a 28 county area in upstate New York. The objective of this alliance is to identify areas of non-competitive cooperation between regional health plans and providers that would provide mutual benefit and improve the quality and efficiency of health care delivery throughout New York. After working to create a regional provider-payer consortia to collaborate on implementation of federally mandated electronic transactions in compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), the HIXNY group is exploring quality improvement through payer-provider data analysis and realigned reimbursement incentives.

Another important component of the effort to improve quality of care is related to improving systems of communication, record keeping and general streamlining of the systems that run the health care system. To this end, HPA and member plans participate in ongoing collaborative initiatives involving technology development that will enhance information sharing to promote an overall improved health care system.

Cultural Competence

In recent years, various reports have highlighted disparities in care delivered to racial and ethnic minorities, with those disparities resulting in lower quality of health care than for non-minorities, even when access-related factors are equal. Studies have found that poor communications with culturally diverse populations often contribute to unequal treatment by reducing these populations' access to services. Stereotyping and bias on the part of the health care providers can play a role as well. Recognizing these problems, and wanting to help reduce disparities in this area, the New York Health Plan Association and three member health plans have collaborated with the Center for Immigrant Health (CIH), New York University School of Medicine, on a cultural competence project. A Department of Health Quality Improvement in Managed Care grant funds the project.

The purpose of the cultural competence grant is two-fold: to improve the level of cultural competence among health plan staff who are in direct contact with members and their primary care provider networks; and to develop patient

empowerment tools so that immigrant and/or minority members can improve in their ability to access care. To achieve these goals, participating plans first identified the geographic areas for intervention within the five boroughs of New York by examining claims data that identified zip codes that indicated poor utilization of the health care system, including few well visits, no primary care visits and high emergency room usage. The project then sought to engage primary care physicians and health plan staff serving the targeted zip codes through trainings to improve the level of cultural sensitivity. The cultural competence trainings were customized to reflect the populations in the target zip codes and to the needs of direct service clinical and non-clinical health plan staff and primary care providers (PCPs). Along with the training, plan staff and providers received a tailored resource guide. The second project strategy was designed to help address the cultural diversity of patients through development of patient empowerment tools (PETs). These tools, including various reference guides and language access cards, were developed and translated into four target languages (Spanish, Chinese, Russian and Haitian/Creole) in addition to English. The PETs, disseminated in identified communities, are designed to educate members/patients about preventive health practices such as annual well visits, screenings and immunizations. In addition to screening and immunization schedules developed for patient reference, language access cards were designed for non-English speaking patients to assist them in asking for translation services. A review of plan data will help determine utilization of the tools and allow for an evaluation of which were most effective in aiding the minority patient population in accessing health care services and improving communications with providers and plan staff.

CULTURAL COMPETENCE PROJECT MEMBERS

- AmeriChoice/UnitedHealthcare of NY
- Capital District Physicians' Health Plan
- Fidelis Care New York
- Neighborhood Health Providers



Plan efforts

With their focus on prevention and intervention, health plans have been at the forefront of initiatives to identify ways to improve patient care and generally enhance the overall health and well being of their members and communities. Recognizing that New York’s health plans are engaged in a wide array of innovative programs, the New York Health Plan Association created the Health Plan Achievement Awards to publicly acknowledging plans’ outstanding efforts and spread the word about these programs.

There was a tremendous response for the first ever Health Plan Achievement Awards program, with eleven plans submitting a total of 23 programs for consideration. There were two categories for the awards. The Health Plan Patient Care Improvement Initiative looked at programs developed by a health plan to initiate improved patient care within its membership. The Health Plan Community Leadership Award focused on programs demonstrating excellence by a health plan in addressing community needs.

Top honors in the patient care improvement category went to GHI (Group Health Incorporated) for its “Positive Actions Towards Health”—or PATH—program that targets patient-level interventions with the goal of detecting and reducing gaps between evidence-based clinical care and actual care provided to patients. Hudson Health Plan’s Prenatal Care Initiative, which successfully standardized the data collection process, resulting in more accurate and complete reporting of prenatal care, received first place in the community leadership category.

Because of the high caliber of the programs and the close scoring by the judges, second place award winners in each category were also recognized. For patient care, HIP Health Plan of New York was recognized for its Geriatric Case

Management Program that seeks to improve or maintain functional status of Medicare+Choice members, facilitate the delivery of health care services and enhance quality of life for these members. Oxford Health Plan’s Asian Initiative, which after identifying an underserved Chinese

population, created a special program in the heart of Chinatown to provide appropriate health information and health care services, and ultimately improved care delivered to this population, received second place for community leadership.

2003 HPA HEALTH PLAN ACHIEVEMENT AWARD SUBMISSIONS

HEALTH PLAN PATIENT CARE IMPROVEMENT INITIATIVE

PROGRAM	PLAN
Weigh 2 Be	CDPHP
Smoking Cessation	CDPHP
Pressure Wise	CDPHP
Peak Asthma Performance	CDPHP
Palliative Care Services	Elderplan
“PATH”—Positive Actions Toward Health	GHI
Diabetes Health Management Program	HealthNow
Diabetic Foot Ulcer Management	HIP Health Plan of NY
Healthy Living with Chronic Conditions	HIP Health Plan of NY
Geriatric Case Management	HIP Health Plan of NY
Increasing Primary Care Services for Special Care Adults	Hudson Health Plan
Independent Health Physician Incentive Project: Diabetes	Independent Health
MVP Back Care Program	MVP Health Care
Living with Diabetes & Diabetes Best Practices Programs	Oxford Health Plans
Tobacco Free Teens	Vytra Health Plans

HEALTH PLAN COMMUNITY LEADERSHIP AWARD

PROGRAM	PLAN
Leap and Learn Health Choices	BCBS Western NY
Walking Works: The Blue Program for a Healthier America	BCBS Western NY/ BlueShield of NENY
Care for the Caregiver Initiative	HIP Health Plan of NY
Partnership: Clara Barton HS for Health Professionals & HIP	HIP Health Plan of NY
Prenatal Care Initiative	Hudson Health Plan
Asian Initiative	Oxford Health Plans
“You’re in Charge”: Improving Wellness in Older Adults	Preferred Care
SPF—Summer Protection For 2003	Vytra Health Plans

Quality Efforts: Performance measures

Health plans have long made data on performance available to consumers. For years, plans have not only “measured” the quality of care and services provided to its members, but they have also offered consumers reports on those measures and how plans perform against national standards.

The National Committee for Quality Assurance (NCQA), an independent, non-profit organization, is recognized as a leader in setting national standards for measuring and monitoring quality in managed care. NCQA developed demanding reporting requirements designed to examine health plan performance in delivering quality of care and services. Data from these performance examinations are collected and then publicly reported. Health plans have widely embraced this voluntary quality performance evaluation tool and, to date, managed care is the only sector in health care that publicly opens itself to scrutiny through the reporting of data.

Health plans in New York also report data similar to NCQA’s measures to the New York State Department of Health, known as the Quality Assurance Reporting Requirements (QARR).

This reporting is not voluntary, but mandatory for New York plans. The data collected is independently audited and then compared to national standards, or benchmarks, to measure plan performance in terms of how well it does in providing both care and service to its members. Data can also be used to compare plan performance over time. Benchmarks measuring care provided to members show New York health plans score equal to or better than the national average on every measure for which there is comparable national data. In terms of service, which generally represent measures of consumer satisfaction with their plans, New York plans perform equal to or better than the national average. Moreover, the most recent reports including the *NCQA State of Health Care Quality*¹⁰ report, the *2002 New York State Managed Care Plan Performance Report*¹¹ and the fifth annual *New York State HMO Report Card* from the Health Accountability Foundation all show that New York’s health plans, as a general rule, continue to improve the quality of care provided to New Yorkers from year to year.



Preventive Measures	NYS PLAN AVERAGE	NATIONAL AVERAGE
Childhood Immunizations	87%	80%
Early Prenatal Care	88%	85%
Cervical Cancer Screening	81%	80%
Breast Cancer Screening	74%	76%
Beta Blocker After Heart Attack	94%	93%
Follow-up Hospitalization/Mental Illness	77%	—
Cholesterol Management/People with Heart Disease	94%	93%
Control of Blood Pressure	62%	53%
Appropriate Medications for Asthma	68%	65%
Eye Exams/People with Diabetes	56%	52%
Elevated Blood Sugar/People with Diabetes*	31%	37%

* Lower number is preferable

Access to Care/Service	NYS PLAN AVERAGE	NATIONAL AVERAGE
Problems Getting Care*	19%	23%
Problem with the Plan*	35%	—
High Rating for Plan	65%	62%
High Rating for Personal Doctor or Nurse	76%	75%
Board Certification Rate	85%	80%
Percentage of Providers Staying with Plan	93%	92%

* Lower number is preferable

¹⁰ *State of Health Care Quality: 2002*, National Committee for Quality Assurance (NCQA), September 2002.

¹¹ *2001 New York State Managed Care Plan Performance Report*, July 2002.

Sources: New York State Managed Care Performance 2003 (NY Department of Health); NYS HMO Report Card 2003 (*New York State Health Accountability Foundation*)

Expanding Access

Much is made of the quality of health care in our nation. However, the highest quality measures mean nothing to the person who cannot access health care services because they cannot afford health insurance.

The problem of the uninsured is not a new one, nor is it one that has been overlooked. Despite the attention focused on the problem, it continues to worsen. The federal government estimates that nearly 44 million Americans—a number that includes nearly 3 million New Yorkers—lack coverage of any kind for an entire year and other research shows that tens of millions more Americans go without health coverage for shorter periods of time.

The increase in the number of uninsured can be directly tied to a decline in employer-sponsored health insurance coverage. In New York, 63 percent of the population under the age of 65 had employer-sponsored health coverage in 2002, down from 65 percent 2000.¹² As the price of health insurance has continued to rise in recent years, more employers are faced with tough decisions as they seek to offset the rising costs. In the worst-case scenario, many employers are being forced to drop coverage for workers all together. Other strategies considered include reducing benefits, increasing employees' deductibles or co-insurance, or increasing employees' share of premiums—which in turn causes some employees to opt out of the employer-offered plans. In numerous surveys and polls, the high cost of insurance is the most often cited reason people who are uninsured give when asked why they don't have coverage.

The dilemma of covering the uninsured persists because there is no consensus on the best way to address the problem. Health plans want to be a part of the solution and have worked to

find viable health care alternatives for this population, with many plans developing a variety of products designs. These efforts are an attempt to offer consumers flexibility and better meet the specific needs of different marketplaces.

Additionally, health plans are teaming up with government on a variety of innovative programs designed to expand health care coverage to more New Yorkers. Partnering with the state, the New York Health Plan Association and its member plans have helped to provide coverage of health care for hundreds of thousands of New York residents who would otherwise be without insurance. Through New York's Medicaid Managed Care program, the model Child Health Plus program or Family Health Plus, aimed at extending health care to hundreds of thousands of lower income New Yorkers, and Healthy New York, a program designed to help small businesses offer health insurance to their workers, plans and the state are working together to help New Yorkers access needed health care services. Plans also strive to serve those with highly specialized needs such as our aging population through the development of managed long term care plans and those New Yorkers with chronic health care concerns and high health care costs who rely on the state's program of standardized health insurance for individuals.

Health plans are teaming up with government on innovative programs designed to expand health care coverage to more New Yorkers.

¹² "Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2002", U.S. Census Bureau Current Population Survey, Annual Social and Economic Supplement, November 2003.

Healthy New York

As health insurance premiums continue to experience double-digit increases for several years running, affordable health coverage continues to be a top concern for employers across the country and New York. As noted previously, New York employers faced with continually increasing health care costs are asking their workers to pay more of the costs of health insurance benefits. But too often and for too many employers, especially small businesses, the cost of insurance remains out of reach.

The Healthy New York program was developed to encourage small employers to offer health insurance coverage to their employees and their dependents, and to help make that coverage affordable by subsidizing the cost of premiums. Small employers that don't currently provide health benefits and uninsured employed individuals are eligible to purchase Healthy New York coverage which offers standardized benefits—providing comprehensive coverage but with some limitations on required benefits that help to reduce the overall cost of the insurance. Now in its third year, the program continues to grow at a steady pace. By the end of 2003, nearly 40,000 New Yorkers were enrolled in the program.

Expanding Access

Child Health Plus

New York's nationally recognized Child Health Plus program has been providing wide-ranging health services to children for more than a decade. Managed care plans across the state are responsible for providing health care services to close to 4,000,000 New York children. A total of 30 managed care plans participate in Child Health Plus.

Family Health Plus

As with Child Health Plus, health plans across New York are key partners in the Family Health Plus program. Coverage is available for adults between the ages of 19 and 64 who do not have health insurance—either on their own or through their employers—but have incomes too high to qualify for Medicaid, and is offered at no cost to single adults, couples without children and parents with limited incomes. Modeled on Child Health Plus, the program provides comprehensive coverage, including prevention, primary care, hospitalization, prescriptions and other services.

Medicaid Managed Care

New York's health plans have long served the state's Medicaid population, with some plans providing health care services to Medicaid beneficiaries even before New York established the landmark Medicaid Managed Care program in 1992. Since the start of the program, Medicaid Managed Care enrollment has grown significantly and by the end of 2003, close to two million New Yorkers covered by Medicaid were members of health plans.

Key goals when New York lawmakers created the Medicaid Managed Care program in 1992 were to provide lower-income New Yorkers, many of them minorities, with better access to health care services by giving this population a "medical home" and, through better and more timely access to care, improve the quality of care and improve the health status of these patients.

Data collected by the Department of Health show these goals are being met. Access to health care services has improved for all age groups over time. Part of this is due to improved availability of providers through managed care networks, with more pediatricians, OB/GYNs, internists and family practice providers available to Medicaid managed care members than providers serving Medicaid fee-for-service patients.

Medicaid Managed Care

Measures of childhood and adolescent care:

- Childhood immunizations (ages 0-2) increased from 57% in 1995 to 78% in 2002, a 37% increase.
- Screening for lead poisoning increased from 64% in 1994 to 74% in 2002, a 13% increase.
- Well-child visits for children up to 15 months of age increased from 48% in 1999 to 72% in 2002, a 50% increase, while well-child visits for children 3-6 years of age increased from 69% in 1999 to 81% in 2002, a 17% increase. Adolescent well-child visits increased from 41% to 71%, a 73% increase during the same period.
- Providing appropriate asthma medications to children ages 5-17 increased from 50% to 58%, a 16% increase from 1999 to 2002.

Measures of care for women:

- Cervical cancer screening increased from 43% in 1994 to 71% in 2002, a 65% increase.
- Breast cancer screening increased from 50% in 1994 to 64% in 2002, a 28% increase.
- Prenatal care in the 1st trimester increased from 57% in 1995 to 78% in 2002, an 37% increase, while postpartum care increased from 44% in 1997 to 63% in 2002, a 43% increase.

Measures of care for adults with chronic conditions:

- Providing appropriate medications for adults with asthma increased from 61% in 1999 to 68% in 2002, an 11% increase.
- For diabetes patients, hemoglobin A1C testing increased from 69% in 1998 to 80% in 2002, a 16% increase, while those diabetes patients with poorly controlled hemoglobin A1C decreased from 60% to 45%, a 33% decrease.

New York's individual market represents the "Catch-22" of health care.

Managed Long Term Care

It is a well-documented fact that Americans are living longer and, as they age, their health care needs are changing. Similarly, there is a growing number of Americans with various disabilities, with more and more of them choosing to live in an independent environment. In response, our health care system is changing to offer more care options to these growing populations.

In New York, the managed long term care program has greatly expanded the health care options available to our aging and disabled populations. Established in 1997, the program allowed for the creation of special health care plans to oversee the specialized health care needs of these populations. By coordinating and arranging for the long term care and acute care needs of their members, managed long term care plans offer an alternative model of care delivery for the frail, elderly population, as well as for people over the age of 21 who have chronic disabilities. The managed long term care program allows providers to offer a variety of services in a flexible way, thereby enabling those individuals in need of long term care to remain in the community. Like the populations they serve, enrollment in these programs continues to grow and at the end of 2003, more than 10,000 New Yorkers are being cared for by New York's managed long term care plans. As the demand for these plans and the need for services increases, HPA and its managed long term care plan members remain committed to the program and to working with state leaders to ensure managed long term care remains a viable care alternative in the future.

Individual Market

New York was among the first states in the nation to adopt legislation giving individuals who are not offered benefits by an employer or who are self-employed the ability to purchase health care on their own. HPA and the managed care community supported this landmark health care policy as well as legislation designed to expand New York's individual market, giving consumers more options and greater flexibility through two standardized comprehensive managed care plan packages: a health maintenance organization (HMO) product and a point-of-service (POS) alternative.

Approximately 140,000 New Yorkers obtain their health care coverage in the individual/direct pay market. This is less than one percent of New York's total population.

New York's individual market represents the "Catch-22" of health care. The standardized products have an extremely generous benefit package, as required by law. In addition, the

co-payments and co-insurance mechanisms have not changed in nearly a decade, resulting in extremely high cost for this coverage. Consumers who continue purchasing the standardized individual coverage generally have chronic health care concerns and high health care costs—the very reason they need insurance. So, despite the products' high premiums, the cost of coverage is still below the actual cost of services each person needs. Meanwhile, health plans continue to experience significant losses and are forced to seek higher premiums and that, in turn, acts as a purchasing disincentive to healthier individuals who nonetheless need coverage. HPA continues seeking solutions to the affordability paradox of New York's individual market that would help reduce the cost burden on chronically ill New Yorkers who so desperately need health care coverage while also making the individual market benefits more attractive to healthier consumers.





Looking to the future— Policy directions for tomorrow

The past decade has been one of tremendous change in our health care system. Looking ahead, 2003 gave hints of even more changes on the horizon, with many of the emerging trends suggesting greater patient/consumer involvement in our future health care models.

Health plans have historically demonstrated the willingness and ability to adapt to meet marketplace demands. Managed care plans of the early and mid-1990s responded to the desires of employers to slow rapidly rising health care costs by limiting patients' choice of physicians and hospitals, requiring prior approval for certain services. Those actions worked, as witnessed by a dramatic slowing of the growth of the cost of health care, with health care premiums rising by low single digits for several years in a row.

However, the actions also produced a powerful backlash—from both consumers and providers—particularly as the employers looked to managed care plans to control costs and the number of people enrolled in plans reached significant market penetration around the country. At the same time, the economic boom and tight labor market of the late 1990s had employers competing to attract and retain workers and, to do so, many responded to their employees' desires by moving away from insurance coverage with limited provider choice and extensive care restrictions. Health plans likewise responded, expanding provider networks and easing restrictions on care by eliminating primary care physician (PCP) gate keeping and prior approvals for specialty referrals and many tests and procedures. The impact of these changes was sharp increases in the cost of health care and health coverage. With fewer checks and balances, but with consumers still insulated by managed care's relatively low co-payments or co-insurance, utilization began to increase and premiums once again started rising by double digits.

Now, seeking to respond to consumers' wishes for greater choice while still being mindful of the bottom line of the em-

ployers paying the bills, health plans are looking in new directions; developing new products that provide consumers with more control over how they access and use health care while also encouraging them to weigh the costs and benefits of those decisions. One new product, tiered-provider networks, replaces the network restrictions common in tightly managed care plans with financial incentives that encourage patients to use more cost-efficient providers. Similarly, health plans also are offering customized product approaches that provide employers and consumers with more limited and structured choices over benefit design and out-of-pocket costs. Also in development are so-called "consumer-driven" products that combine a personal health care spending account with a high-deductible health plan.

Likewise, the industry is working with government on health care alternatives that might better fit the needs of consumers and businesses. At the federal level, the Medicare Modernization Act of 2003 created health savings accounts (HSAs). In New York, the managed long term care program and a new product being piloted for those dually eligible for Medicare and Medicaid seek to address the needs of the state's aging population. Proposed New York legislation explores creating new low-cost "Freedom Policies" that would work in conjunction with tax-free HSAs, as well as expanding existing health care tax credits and enhancing state-supported programs. The efforts are aimed at encouraging more small businesses to provide health insurance for their employees and making coverage more affordable for individual purchasers. Although these programs are still in the earliest stages of development, many consumers clearly indicate the new approaches offer new opportunities that they will closely consider. Health plans are certain to respond with products and needed information that will enable consumers to play a more active role in seeking health care coverage that best fits their needs.

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