



# HEALTH CARE AFFORDABILITY IN NEW YORK: A CLOSER LOOK



# HEALTHCARE VALUE HUB

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## INTRODUCTION

Ensuring health care affordability for residents is a challenge faced by many states. Federal policies often take center stage in discussions about the burden of health care costs, however, states also possess the ability to establish a more accessible system through legislation. This report utilizes the 2022 Health Care Affordability State Policy Scorecard, which evaluated states based on their initiatives to ensure reasonably priced health care for their residents in four domains: curbing excessive prices, reducing low-value care, expanding coverage to all residents, and reducing out-of-pocket expenses.

New York earned 42.4 out of 80 possible points on the Scorecard, ranking 15<sup>th</sup> out of 50 states and the District of Columbia.<sup>1</sup> While New York has taken many steps to address health care affordability, a 2022 survey, by PerryUndem concluded that over half (53%) of New Yorkers experienced affordability burdens in the twelve months prior to participating in the survey, such as sacrificing healthcare due to cost (38%), delaying care (19%), and struggling to pay current medical bills (34%).<sup>2</sup>

Considering residents' health care affordability burdens, this report describes New York's performance in addressing high health care costs and provides recommendations for actions policymakers can take to reduce these burdens.



## CURB EXCESS PRICES IN THE SYSTEM

Due to a multitude of factors, most Americans find themselves paying for health care services at rates unrelated to the cost of providing those services. Health care prices are subject to variation across different geographical regions. Even more, prices can vary substantially among health care providers operating within the exact same area. This creates an inconsistent and unpredictable landscape for health care costs, increasing financial burdens and inherent disparities within the health care system.<sup>3</sup> Roughly \$230.7 billion to \$240.5 billion in wasteful spending is associated with excess prices each year.<sup>4</sup>

Health care spending in New York has consistently been among the highest in the country. In 2020, the per capita spending for personal health care in the state was \$14,007. This figure was 37% higher than the national average, which stood at \$10,191. This difference underscores the reality that New York residents bear higher health care financial burdens compared to residents in other parts of the country.<sup>5</sup>

In terms of year-over-year growth, New York's annual average personal health care spending per capita also exceeded the national average. The state's spending grew at a yearly average rate of 6.1%, compared to the national average of 4.3% between 1991 and 2020. This higher growth rate suggests that health care costs in New York are not only high but are also increasing at a faster pace than most other parts of the country.<sup>6</sup> In 2022, New York residents paid (\$8,936) an average of 18% more than the US average (\$7,590) for single, private employee insurance, the highest in nation.<sup>7</sup>

Healthcare spending growth in New York is driven primarily by increases in the *price* of services, not the quantity of services patients are using. Total spending per person in New York on medical care and prescription drugs increased 28% from 2017 to 2021, going from \$6,120 per person to \$7,845 per person. The total average price per service increased 38%, while utilization of services increased by just 12%.<sup>8</sup> Notably, price growth was highest for hospital inpatient services (39% increase from 2017 to 2021) and prescription drugs (17% increase), with less price growth for outpatient services (8% increase) and professional services (14% increase).

Reducing excess pricing within New York can be a complex challenge that requires a multifaceted approach involving various stakeholders, at the state level New York could implement policies to control health care pricing within the health care system.

The policy score included in the Healthcare Value Hub State Policy Scorecard quantifies a state's capability to enhance the affordability of health care. It reviews several key factors including; the existence of an operational all-payer or multi-payer claims database; an established health spending oversight body; a comprehensive all-payer health care expenditure system along with quality benchmarks; and a tool for price transparency.<sup>9</sup>

# HEALTHCARE VALUE HUB

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## ALL-PAYER CLAIMS DATABASE (APCD)

It is imperative to address the escalating private payer prices for health care services to safeguard affordability for consumers, employers, and state governments alike. The journey towards understanding payer prices begins with the creation of an All-Payer Claims Database (APCD). These databases are comprehensive repositories, usually developed by states, which store a wide variety of health care data. This data encompasses claims information from private insurance companies, health benefit programs for state employees, and in certain scenarios, Medicare and Medicaid.

The data provided by these databases can inform initiatives aiming to curtail excess prices and improve health care efficiency. They can expose potential disparities in health care access and quality, inform the development of more equitable and effective payment models, and help track the impact of health care reforms. Moreover, they could provide insights into the usage patterns of health care services, the prevalence of different health conditions, and the effectiveness of different treatments, which could all contribute to improving patient care and health outcomes.

The New York State Health Connector the state's APCD, collects and analyzes health plan enrollment data, claims and encounter data, provider data, hospital discharge data, and vital statistics mortality data.<sup>10</sup> However, it does not include cost data at the provider level or cost data dated after 2017. It is also important to note that, due to the *Gobeille v. Liberty Mutual* ruling, the New York State Health Connector cannot require employers who provide self-insured plans to submit information to the database. As a result, the state can only ask for voluntary claims submission.<sup>11</sup>

The state has undertaken some efforts to improve the APCD, including consumer interviews and additional research in response to federal hospital price transparency requirements; however, more could be done to improve the efficacy such as encouraging voluntary submission from self-insured plans and expanding the APCD to include cost data at the provider level.

### Recommendations:

- △ [Expand the ACPD to include cost data at the provider level and report this information out on a timely basis.](#)
- △ [Increase the number of voluntary self-insured ERISA health plans included in the APCD by establishing a more efficient process for voluntary submissions.](#)

New York could potentially increase the number of self-insured enrollees included in the APCD by creating a user-friendly, standardized reporting mechanism to reduce the burden on self-insured group health plan administrators. In a 2021 report to the Secretary of Labor, the State All Payer Claims Databases Advisory Committee recommended engaging employers and unions that sponsor self-insured ERISA-covered group health plans to identify real and perceived barriers to submission, and then using this information to create a simplified data submission portal.<sup>12</sup>

## HEALTH SPENDING OVERSIGHT ENTITY

Effectively reducing excessive prices demands a holistic, inter-agency, multi-payer strategy specifically targeting the health care segment of the state's economy. In order to systematically

alleviate the financial strain of health care on state residents (and to provide valuable insights for broader health system transformation initiatives), states require an authoritative body with the mandate to examine various forms of health and social expenditures.<sup>13</sup> This can be achieved through the introduction of a health spending oversight entity, which should have the capacity to identify areas for improvement in terms of the value obtained for each dollar spent, rectify quality deficiencies, and tackle affordability issues faced by residents.

This body could continuously evaluate health care expenditures, actively seeking opportunities for improvement, and ensuring funds are used in a manner that provides the maximum value and highest quality of care for state residents. This approach could help drive systemic changes in the health care landscape, improve the delivery of services, and enhance health outcomes while making health care more financially accessible.

As of 2022, nine states have established comprehensive oversight entities that target all health care spending (Colorado, Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Vermont, and Washington).<sup>14</sup> New York is currently one of seven states that has entities that target narrow forms of spending, such as hospital or drug spending (along with Maine, Maryland, New Hampshire, New York, Ohio, Pennsylvania, and Rhode Island).<sup>15</sup>

New York does not have a comprehensive health spending oversight for all health care spending, but they have the prescription drug cost entity, the Drug Accountability Board (DAB). The DAB incorporates consumer representatives, medical professionals, health economists and pharmaceutical experts to monitor prescription drugs; affordability, value to consumers, price increases, impact on health care insurance premiums, and disproportionately priced compared to its benefits.<sup>16</sup>

## Recommendations:

### △ Establish a Health Spending Oversight Entity to Target All Health Care Spending

New York should establish a health spending oversight entity that targets all forms of health spending; similar to those found in Colorado, Connecticut, Delaware, Massachusetts, Nevada, New Jersey, Oregon, Vermont, and Washington. The entity should be empowered to make legislative recommendations that improve quality of care provision and improve affordability for consumers.

## HEALTH CARE COST GROWTH BENCHMARK

Benchmarks for health care cost growth aim to limit the annual increase in health care expenditure across different sectors. These benchmarks can be designed to focus on various aspects of health spending and may be complemented by quality benchmarks (for instance, as seen in Delaware) and/or spending minimums for essential services such as primary care (like the approach in Connecticut). These supplementary measures are implemented to ensure that efforts to curb spending growth do not compromise the quality of health care services.

Enforcement of these benchmarks varies across states. Some states lack a formal enforcement mechanism and instead depend on public reporting of performance as a way to motivate compliance. Others, however, take a more assertive approach. States like Massachusetts and

Oregon, for example, mandate entities that surpass the benchmark to develop and implement a performance improvement plan to deal with the issue of excessive price growth. These states also possess the authority to levy fines on entities that breach the benchmark.<sup>17</sup>

## Policy in Action

Connecticut's benchmarking approach is novel in that it uses the state's Healthcare Affordability Index to estimate the policy's impact on the number of Connecticut households that will have access to quality health care coverage and be able to meet their basic economic needs. An initial study conducted prior to implementation found that adherence to a cost growth benchmark would grant more than 14,000 additional households access to affordable health care (a six percent increase compared to the number of households with adequate income to afford health care expenses in 2019). The impact of the cost growth benchmark is projected to be even greater among households that purchase coverage through the Marketplace. Notably, Connecticut's benchmark includes targets for increased primary care spending as part of its strategy. The goal of this initiative is to divert more resources towards primary care and avoid the need for costly and complex care resulting from unmet needs. In 2021, the statewide primary care spending met the five percent target (spending 5.1%), but on their own, commercial payers fell short, spending less than four percent.

Cost growth benchmarks are tools in the broader effort to control health care spending and ensure affordability. By creating clear targets for spending, they provide health care entities with concrete goals and help focus efforts to improve efficiency. In turn, these benchmarks, when combined with performance and quality measures, can drive better value in health care, ensuring that cost reductions don't come at the expense of patient care.<sup>18</sup> This multifaceted approach, coupled with an appropriate level of enforcement, has the potential to impact health care cost growth, enhancing the sustainability of health care systems.<sup>19</sup>

New York does not currently have a state benchmarking program. Moving forward, the state should consider implementing one to improve health care cost transparency, identify trends in patient cost-sharing, and drive down consumer costs.

Though evidence on the effectiveness of cost growth benchmarks under varying conditions is still emerging, states are increasingly considering this strategy as a tool to rein in health care spending growth. Including enforcement mechanisms may increase the likelihood of the benchmark's success and quality benchmarks can help ensure that efforts to reduce health care cost growth do not negatively impact health outcomes.

## Recommendations:

### △ Commission a Report on Health Spending

Policymakers should consider commissioning a report specifically within New York's health care market to identify cost drivers in order to develop targeted policy interventions.<sup>20</sup> As more evidence becomes available about the impact of benchmarks in other states, New York policymakers may determine that a cost growth benchmark aligns with New York's health care affordability needs and priorities and can pursue this policy.

## △ Establish an Affordability Index

Policymakers should consider establishing an affordability index for New York households, as Connecticut has.<sup>21</sup> Doing so will enable policymakers to evaluate the effects of various health care policies and reforms (including, but not limited to, a cost growth benchmark) on New York households' ability to maintain quality health care coverage along with their basic economic needs.

## HEALTH CARE PRICE TRANSPARENCY TOOLS

There is a variance in the cost of identical health care services across different providers, even within the same geographical vicinity.<sup>22</sup> However, obtaining dependable information about this complex pricing structure poses a significant challenge for both consumers and policymakers.<sup>23</sup> Additionally, a substantial number of health care services are not open for shopping around or comparison. This includes services delivered during emergency situations or in settings where there's a lack of choice regarding treatments or providers.<sup>24</sup>

While it is improbable that patients shopping around will have a significant effect on reducing inflated prices<sup>25</sup>, clear and transparent pricing data can serve as a valuable resource for various stakeholders. Researchers, health insurance providers, regulatory bodies, and legislators can leverage this data to spot outliers and adopt targeted solutions. These could include reference pricing, strategic formation of health care networks, and setting of standardized rates. The effectiveness of such strategies depends on competition among health care providers in the market.

To maximize their potential impact, health care price transparency tools should embody specific characteristics: they should be freely accessible to the public; reflect the rates negotiated between health care providers and insurers; display prices that are specific to each treatment and provider; and couple pricing data with dependable quality metrics. By adopting these principles, these tools can offer consumers the comprehensive information needed to make informed health care decisions.<sup>26</sup>

In June of 2023, New York City Mayor Eric Adams signed legislation to increase hospital and health care price transparency with New York City.<sup>27</sup> The Healthcare Accountability and Protection Act is the first within the nation to establish an office focused on health care accountability, solely for proving data-driven approaches for delivering health care affordability and accountability. The office will provide various state level stakeholders with recommendations to improve the health care affordability burdens in New York City.<sup>28</sup>

## Recommendations:

### △ Establish a statewide office for health care affordability and accountability.

Conducting outreach to inform residents of the tool would be important for making consumers aware of this valuable resource. By increasing public awareness of the tool, more people would have access to price information, leading to more informed health care choices and potentially lower costs. For example, in New Hampshire, market observers testified that, despite limited



public awareness of the price transparency tool, publicly identifying high-priced providers shifted the balance of power towards the state's insurers and narrowed price variation over time.<sup>29</sup>



Low-value care in health care refers to medical treatments, procedures, or tests that fail to deliver health benefit to patients in specific clinical situations. Essentially, it is a form of health care that, when weighed against the potential risks or cost, offers minimal or no tangible positive outcome to the patient's health or wellbeing.<sup>30</sup> Low-value care includes services that offer little to no clinical advantage and contradict the patient's preferences. In these situations, the provided health care services do not contribute towards improving the patient's health nor does it align with the patient's wishes or comfort levels. Such situations could involve unnecessary diagnostic testing, aggressive treatments when palliative care would be preferred, or interventions that have a low chance of success.<sup>31</sup>

Low-value care also involves services performed more out of routine or tradition rather than based on up-to-date, scientific evidence. These are practices that have been carried on for years, perhaps because of established patterns or habits, despite the fact that current medical research might not support their efficacy. This could include prescribing certain medications or carrying out specific procedures, which may have been standard practices in the past, but have since been shown to be ineffective or even potentially harmful.<sup>32</sup>

Therefore, low-value care presents a significant challenge to health care quality and efficiency, as it not only potentially compromises patient outcomes, but also contributes to unnecessary health care spending. By identifying and reducing low-value care, health systems can better allocate their resources to high-value services, leading to improved patient care and greater system sustainability.

## MEASURING LOW-VALUE CARE

Ensuring the provision of high-quality, affordable health care is integral to improving health outcomes and widening access to necessary medical services.<sup>33</sup> Yet, a mounting concern among health policymakers and practitioners is the widespread occurrence of low-value and no-value care. This type of care could potentially harm patients, inflate health care costs, and squander valuable health care resources.<sup>34</sup> The evaluation and measurement of low- and no-value care are pivotal in shedding light on its pervasiveness and effects. By quantifying these aspects of health care, we can gain critical insights into their frequency of provision and the circumstances under which they tend to occur. Such insights can help in the formulation of effective strategies to minimize the incidence of low- and no-value care. With this data-driven approach, policymakers and health care providers can develop and implement strategic interventions to curb the prevalence of low- and no-value care. Consequently, these initiatives could lead to enhanced patient outcomes, cost savings, and a more judicious use of health care resources. This way, the

focus can shift towards delivering care that is truly beneficial, patient-centered, and economically sustainable.

New York does not formally measure the amounts of low-value care occurring in the health care system, reflecting an opportunity for improvement. The state may consider using the state-run APCD to conduct an annual review of low-value care. Policymakers may look to Washington state for a blueprint for an effective strategy; the Washington Health Alliance uses the state-run APCD (WA-APCD), managed by the Washington State Health Care Authority, to develop reports exploring the provision of low-value care across the state.<sup>35</sup> Similarly, the Massachusetts Health Policy Commission, the Oregon Health Authority, and the Virginia Center for Health Innovation have all also released reports measuring low-value care in their state using their respective all-payer claims databases.<sup>36,37,38</sup> New York could benefit from a similar initiative to measure and ultimately address low and no-value care, which could be established informally or through legislation.

## Recommendations:

### △ Enact a Multi-Stakeholder Commission to Reduce Low-Value Care.

Measuring and identifying low-value care is an important first step for states to take and should be dovetailed with efforts to reduce its use. Stakeholders should convene to develop actionable steps to eliminate low-value care and to review claims and/or EHR data to identify the prevalence low-value care across the state. The services studied can be identified from medical specialty societies and from other states' efforts.<sup>39,40,41</sup>

## VALIDATED PATIENT SAFETY FOR HOSPITALS

Requiring patient safety reporting for central line-associated bloodstream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI) is a practical option to measure patient safety metrics and potentially mitigate the prevalence of surgical site infections in a state. Most health care facilities in the United States are already required to report the rate of hospital acquired infections (HAIs) and many states currently mandate reporting CLABSI and CAUTI rates (twenty-seven and thirty-six, respectively).<sup>42</sup>

New York requires reporting and validation for CLABSI, but not for CAUTI. In 2005, New York mandated hospital reporting on Hospital-Acquired Infections (HAI).<sup>43</sup> HAI reporting promotes patient safety within in the realm of health care, as it encompasses delivering the right care while aiming to mitigate potential harm or injuries to patients. Errors in medical procedures or adverse events can culminate in severe outcomes such as prolonged hospitalization, long-term disabilities, or even fatal incidents. Furthermore, such episodes can escalate health care costs, not only at the time of the event but also potentially in the future, as the affected individuals may need ongoing care or might end up with permanent disabilities.

Since tracking began in 2007, New York has made improvements to include reporting on a multitude of surgical infections. Initially, the state tracked three different types of surgical infections; however, as of 2020, it now includes eleven variations of different types of central-line associated bloodstream infections (CLABSI).<sup>44</sup>

Promotion of patient safety is not the sole responsibility of one party but demands a joint effort from various stakeholders in the health care field. It involves health care providers, policymakers, and the patients themselves, all working in concert towards a safer health care environment. By making patient safety a top priority, health care systems can ensure the delivery of high-quality care, thereby improving patient outcomes.

## Recommendations:

### △ Mandate validation of CAUTI in the reporting.

While New York currently mandates reporting of CLABSI rates, they should also include CAUTI rates. Expanding validation requirements may improve outcomes in the state. As part of broader efforts to improve patient safety reporting, New York should invest in developing the infrastructure to conduct effective validation, including data cleaning, quality checks, and capacity to contact hospitals to correct data errors. This may help identify which hospitals may need additional supports to address CLABSI and CAUTI rates.



## EXTEND COVERAGE TO ALL RESIDENTS

Individuals without health insurance encounter significant hurdles when it comes to accessing health care services. The primary obstacle is out-of-pocket costs associated with medical care. Without the financial support provided by health insurance, these individuals often bear the full burden of these costs. This high financial burden can act as a deterrent, often preventing them from seeking important preventive care such as regular check-ups, screenings, and immunizations that are vital to maintaining good health.<sup>45</sup> As a result, the uninsured may resort to expensive emergency services.

In addition, out-of-pocket expenses also make it difficult for uninsured individuals to manage chronic conditions effectively. Regular treatments, medication, and follow-ups necessary for the proper management of chronic diseases can become financially unmanageable, leading to neglect or delay in seeking the necessary care. This neglect can further exacerbate their health condition, leading to a deterioration of their health over time.<sup>46</sup>

The uninsured population is over a million residents within the state of New York as of 2022; with roughly 345,000 being eligible for affordable coverage options such as Medicaid; 421,000 with access to an employer or self-coverage plans but have not enrolled, and about 245,000 uninsured due to immigration status.<sup>47</sup> However, New York has taken steps to broaden its coverage through the expansion of Medicaid and the adoption of a Basic Health Program, (under Section 1331 of the Affordable Care Act). New York may further address the issue by providing insurance coverage for undocumented immigrants and considering innovative strategies to provide high-quality, affordable coverage for individuals who fall into the coverage gap.

New York is one of two states that has a federally funded Basic Health Program (branded as the Essential Plan<sup>TM</sup>), Which offers free, no deductible coverage to individuals up to 200% of the federal poverty level. In 2023, the State filed a 1332 Waiver to expand eligibility up to 250% of the

federal poverty level. The Essential Plan includes, dental and vision and prescription drug coverage.<sup>48</sup> This plan extends to those that may not qualify for Medicaid- individuals who are over-income for Medicaid or who are ineligible for federally-funded Medicaid due to their immigration status.

## IMMIGRANT COVERAGE

New York has several programs dedicated to providing health insurance coverage to immigrants. The state currently offers coverage to all lawfully present immigrants, regardless of their date of entry. It also provides the following coverage to income-eligible immigrants without lawful status: Child Health Plus (up to age 19); Medicaid for pregnant women up to 12 months post-pregnancy; and emergency Medicaid.

Medicaid is also available to income-eligible immigrants at no cost or at a low premium; Deferred Action for Childhood Arrivals (DACA) status. The state's 1332 Waiver seeks to extend The Essential Plan eligibility to DACA residents. Lawfully present immigrants may enroll in The Essential Plan for free for those who do not qualify federally-funded Medicaid.

Beginning January 1, 2024, New York offers Medicaid coverage to seniors aged sixty-five and older regardless of immigration status and, in March 2023, the state began offering expanded post-partum coverage up to twelve-months after delivery. New York has considered legislation that would extend coverage to adult residents of all ages regardless of immigration status but so far these bills have not passed.

In some instances, local legislation has been used to expand coverage. In 2019, New York City started offering undocumented immigrants access to health care through a \$100 million program. Additionally, the state has committed to protecting immigrants seeking coverage assistance from threat of deportation through strict privacy practices that promise to not share citizenship information with federal immigration services.<sup>49</sup>

## Recommendations:

- △ **Allow all income-eligible residents to enroll in The Essential Plan (Basic Health Plan) Medicaid regardless of citizenship status.**

New York can take inspiration from California, which recently expanded Medicaid to all income-eligible residents regardless of citizenship. Alternatively, New York could follow from Colorado and Washington, which obtained a federal 1332 waivers to enable undocumented immigrants to access insurance through the state's exchange. By seeking similar exemptions from federal definitions and regulations, New York can ensure that all its residents, regardless of citizenship, have access to affordable and comprehensive health care options.

## RATE REVIEW

Rate review refers to the process that insurance regulators use to approve or deny proposed premium rate increases for health insurance.<sup>50</sup> The goal of rate review is to hold insurance carriers accountable for justifying their proposed rate increases and disapprove any that are unjustified. New York has seen an effective rate review process, classified by the Centers for Medicare & Medicaid Services (CMS), but does not incorporate affordability into its process.<sup>5152</sup>

New York's rate review process is the regulatory framework designed to ensure that health care insurance companies have justified and reasonable pricing for insurance premiums. The rate review system is controlled by the New York State Department of financial services, they hold the authority under prior approval, to not only approve, but also modify or reject proposed insurance rate increases.<sup>53</sup>

## Policy in Action

Rhode Island's affordability standards include four criteria that insurers must meet in order to have their rates approved: increased spending on primary care; adoption of the patient-centered medical home model; supporting the state's health information exchange; and working towards comprehensive payment reform, which include a cap of inflation, plus 1%, in insurers' negotiated prices with hospitals. This rate review process applies to large group market plans as well as the individual and small group markets. A 2019 study found a net reduction in spending by an average of \$55 per enrollee.

## Recommendations:

### △ Incorporate Affordability Criteria into the State's Rate Review Process

New York should develop affordability criteria into its rate review process to inform and guide whether rate change proposals are reasonable and affordable for consumers. Doing so could reduce the number of uninsured residents and amount of medical debt in New York by making health insurance more accessible and affordable.

By evaluating insurance based on affordability criteria such as income levels and premium tax credits, New York's regulators can hold insurance companies accountable for the affordability of their products. Examples of affordability criteria may include factoring in cost of living and inflation alongside health care expenses. Stakeholders may also find it helpful to review the National Academy for State Health Policy's Rate Review Toolkit to survey examples of affordability criteria, accessible through [this link](#).<sup>54</sup> This approach will ensure that the rate review process not only evaluates proposed rate increases but also considers the impact of these increases on consumers.



## MAKE OUT-OF-POCKET COSTS AFFORDABLE

Ensuring access to essential medical care regardless of the cost is a pivotal concern in health care. In New York, out-of-pocket health care expenses pose a substantial financial strain on residents, often resulting in debt and financial instability. Such high costs become even more detrimental when imposed on individuals suffering from chronic diseases, as they require more continuous medical attention, medications, and various health services.<sup>55</sup>

The cumulative costs for frequent medical provider visits can escalate rapidly, pushing individuals to make tough decisions between getting required medical care and managing other basic needs such as food and shelter. Moreover, the burden of high out-of-pocket expenses could deter individuals from pursuing preventative measures or early interventions. This delay can accelerate the deterioration of various health conditions, leading to more advanced and expensive treatments in the future.

In the 2022 Affordability Scorecard, New York had a policy score of 10 out of 10 possible points, reflecting their policies intended to reduce out-of-pocket costs for residents. However, even with these policies in place, residents still suffer with affordability and high cost associated with health care plans and services. New York scored a 5.2 out of 10 possible points in outcome scoring, due to affordability burdens still being prominent, 23% of adults faced an affordability burden: not getting needed care due to cost (7%), delaying care due to cost (7%), changing medication due to cost (9%), problems paying medical bills (13%) or being uninsured due to cost (78% of the uninsured population).<sup>56</sup>

### **Federal Policy Impact on State Policy Note:**

The No Surprises Act is a federal law that aims to protect patients from surprise medical bills, which occur when patients receive unexpected bills from out-of-network health care providers. Under this law, patients who receive emergency care from out-of-network providers or are unknowingly treated by out-of-network providers during an in-network procedure will only be required to pay their in-network cost-sharing amounts (such as deductibles, copayments, and coinsurance), and out-of-network providers will be prohibited from billing patients for the remainder of the cost.

The No Surprises Act is intended to protect patients from unexpected financial burdens resulting from surprise medical bills, and to ensure that health care providers are fairly compensated for their services. The law went into effect on January 1, 2022, and applies to most health plans, including employer-sponsored plans, individual plans, and plans sold on the Affordable Care Act exchanges.

## SURPRISE MEDICAL BILLS

Surprise medical bills (balance bills), occur when patients receive unexpected invoices from out-of-network providers when they believed they were receiving in-network care. This can occur in emergency situations, or when a patient is being treated at an in-network facility but are provided

services from an out-of-network provider (such as an anesthesiologist or laboratory technician) while there. These surprise bills can create significant financial burdens for patients, leading to debt and financial insecurity.<sup>57</sup>

## Recommendations:

### △ Extend protections for emergency services provided at urgent care facilities.

Expanding protections to cover emergency services provided at urgent care facilities in New York is crucial to address the financial burden and insecurity that surprise medical bills can create for patients. Urgent care facilities are becoming an increasingly popular option for patients seeking medical care for non-life-threatening conditions, and without adequate protections patients can be vulnerable to receiving surprise bills from out-of-network providers.<sup>58</sup> Including urgent care facilities in the state's patient protection laws would ensure that patients are not financially burdened for seeking medical care in emergency situations and promote greater financial security for patients in New York.

## REDUCE COST-SHARING

Health care costs have been a growing concern for many Americans in recent years. While the Affordable Care Act (ACA) requires most health plans to cover preventive services without cost sharing, many Americans still struggle to afford necessary care.

### Federal Policy Impact on State Policy Note:

The Inflation Reduction Act addresses prescription drug affordability through a variety of provisions. Among other provisions, the federal legislation limits monthly cost-sharing among Medicare beneficiaries for insulin to \$35 a month. The bill also eliminates cost sharing for vaccines and caps out-of-pocket spending for Americans enrolled in Medicare Part D, which provides catastrophic coverage for high out-of-pocket drug costs.

New York currently has cost-sharing reductions for residents that are enrolled in “silver level” plans within the state. To qualify individuals and families must have incomes between 200% and 250% of the Federal Poverty Level.<sup>59</sup>

Accumulator adjustment programs prevent copay assistance that may be available for expensive drugs to count towards an individual's deductible. These programs prevent consumers from applying cost-sharing assistance resources (e.g., manufacturer coupons) towards their deductible, which disproportionately affects people with rare, complex, and chronic diseases.<sup>60</sup> Federal bipartisan legislation prohibiting copay accumulator adjustment programs is currently pending (S.1375/H.R.830); however, New York has legislation which requires insurers to apply all copayments made towards an individual's annual deductible.

### Recommendations:

- △ **Cap monthly out-of-pocket costs for an expanded number of specialty drugs.**

Capping monthly out-of-pocket costs for specialty drugs will ensure that patients with chronic and complex conditions can afford the necessary treatments without facing exorbitant costs. This is particularly important given the high cost of specialty drugs, which can exceed thousands of dollars per month. The state has already enacted legislation to reduce cost-sharing for some prescription drugs but should also consider expanding the number of eligible prescriptions to ensure greater access.

### STANDARD PLAN DESIGN

Standard plan designs simplify health care coverage by providing standardized benefits across all participating insurers. To date, nine states and the District of Columbia require that Marketplace insurers offer standard plans.<sup>61</sup> New York’s offers two standardized health plans through its state-based marketplace, The NY State of Health.<sup>62</sup> New York also limits non standardized plans on the marketplace, to two. Standardized plans all cover the same benefits but differ with different cost-sharing of premium and out-of-pocket cost. The difference is the name of the carrier and the carriers’ networks. New York also minimizes the annual deductible and applies it to most covered plan benefits, unlike most states.<sup>63</sup>

### CONCLUSION

New York has taken many steps to improve the affordability of care, however, many residents still experience affordability burdens. Policymakers and other stakeholders should pursue the recommended strategies to address this burden, to enhance health outcomes, diminish inequalities, and to create a promising future of affordable health care in New York.

**ABOUT THE ALTARUM HEALTHCARE VALUE HUB**

With support from the Robert Wood Johnson Foundation, the Healthcare Value Hub provides free, timely information about the policies and practices that address high healthcare costs and poor quality, bringing better value to consumers. The Hub is part of Altarum, a nonprofit organization with the mission of creating a better, more sustainable future for all Americans by applying research-based and field-tested solutions that transform our systems of health and healthcare.

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