

ACCESS TO HEALTH CARE

In 1983, the League adopted a comprehensive study of health care in New York State. After considering the cost, payment, delivery of care, and related issues, member consensus provided a position for League action.

HEALTH CARE

Statement of Position

**As announced by the State Board, May 1985 and
revised to reflect State Convention action, 1999**

The League of Women Voters of New York State believes that everyone should have access to basic physical and mental health care. New York State has a proper role in the regulation of health care and must assure high quality care that is affordable and accessible to all. The state should support incentives to foster the development of alternative delivery and payment methods.

More resources should be devoted to health promotion and disease prevention so that consumers can take active responsibility for their own health. Citizens should have more opportunities to participate effectively in decisions regarding their personal health and in health care policy decisions.

The League believes that New York State's primary role in health care is to assure that quality care is available to all New Yorkers. We believe that the state should provide planning and

HEALTH CARE

Statement of Position

As announced by the State Board, May 1985 and
revised to reflect State Convention action, 1999 (continued)

regulations to assure everyone, including the medically indigent, access to a basic level of quality physical and mental health care. Cost containment should be an important criterion in developing regulations. Such regulation, however, should not compromise the quality of care or its accessibility. We support regionalization of specialized tertiary services as a means of providing access while controlling costs.

There should be coordination among regulatory bodies to avoid undue delays and contradictory, duplicative regulations.

The League supports regulatory incentives to encourage the development of alternative ways of delivering and paying for health care. Delivery programs should provide quality care, be cost effective, and be adaptable to different geographical locations. Services may take place in a variety of settings, including the home, and must be staffed by personnel who meet state standards.

Coordination of services is essential to assure that community needs are met. In addition, all programs should be evaluated regularly. Payment methods should be encouraged which include incentives for efficiency and for disease prevention and health promotion activities. Some alternatives, which should be considered for state regulation, include ambulatory surgery, alternative providers, prepayment plans and the issue of professional liability. Activities should be continued in public health, environmental health and research.

Decisions on medical procedures that would prolong life should be made jointly by patient, family, and physician. Patient decisions, including those made prior to need, should be respected. To participate in public discussion of health policy and to share effectively in making policy decisions, consumers must be provided with information on the health care system and on the implications of health policy decisions.

Acting on member support for home care for the frail and disabled, the League supported passage of a law, in 1985, to provide training for family members and friends of those who require care at home.

Since adoption of the Health Care position, the League has lobbied hard for measures that assure access to quality health care, with prenatal and child health care a League legislative priority in 1987. In 1986, the League successfully supported legislation for a prenatal care assistance program and worked again in 1987 for the establishment of a permanent prenatal care assistance program within the New York State Department of Health. Lobbying efforts during 1987 also focused on the inclusion of entitlement to services for pregnant women living at or below 185% of the poverty level. Funding for prenatal care services for women with incomes above the federal poverty level passed in 1989 but not with a full range of services including abortion. In spite of the need for such services, the League

opposed the legislation because Medicaid funding for abortions was not included. Recognizing that early and continuous health care is the first step toward a productive future, the League has been active in supporting bills which would raise income eligibility standards for Medicaid, so that poor children can receive needed health care, and has supported nutrition outreach legislation.

Regarding increased availability of health care services, the League has supported a bill which would encourage physician participation in Medicaid funded maternity services by doubling the reimbursement fee, and a bill which would increase the operation cost component of Medicaid reimbursement to hospitals. The League opposed a Medicaid co-payment bill because it felt the program would be a disincentive to providers to participate in Medicaid and could discourage Medicaid clients from seeking services.

Funding for health planning agencies was continued in 1989 after extensive debate and lobbying. The League supported this legislation under its position of public input and rational allocation of resources. During the budget negotiations for 1995-96, the League lobbied unsuccessfully to restore cuts in funding to the health systems agencies.

In the 1992, legislative session, the League lobbied for legislation which would provide technical assistance to school districts and BOCES in the development of school health care services for pre-school and school age children. This bill died in the Senate Rules committee.

One of the most important legislative proposals the League has lobbied for, beginning with the 1993 session, was the Health Care Facilities Access bill. Passing the Assembly with an overwhelming margin, the bill died that year in the Senate. This legislation is vitally important since it provides access to health care and seeks to protect health care workers from intimidation and harassment. During the 1994-1995 session the John/Cook Facilities Access legislation again passed the Assembly with an overwhelming margin and was held in the Senate Republican conference.

Since the 1994 legislative session, the League has continued to support legislation that would make the funding for school based health services permanent.

In 2007 legislative session, the League worked to allow for reimbursement of Child Health Plus (CHP) and Family Health Plus (FHP) funding in school based health clinics. This has become a big lift because of the Division of Budget fiscal impact. In the 2008 legislative session, it is anticipated that there will be a push to allow social work reimbursement in these clinics. The League will support this effort.

The League in 1994, successfully supported legislation, to require routine obstetric and gynecologic services offered by Health Maintenance Organizations (HMO's).

The rapid development of managed care entities and market concentration in New York State prompted statewide discussions during the 1995 legislative session on the impact of managed care on the quality and delivery of health care. Legislation and a similar, though not identical bill in the Senate would have set standards and provide protection for consumers and providers.

The League supported this legislation and gave testimony on League position concerning managed care. Dubbed the “Health Care Consumer Bill of Rights,” passed the Assembly but was not addressed by the Senate. Also in the 1995 session, the administration’s proposal to mandate Medicaid managed care prompted action by the state League. Letters were written opposing cuts in Medicaid reimbursement rates to providers and commenting on proposals for reforming the NYS Medicaid program.

In 1996, the League, as a member of two broad based coalitions, The Coalition for Quality and Choice in Managed Care and Health Care Campaign, launched an all-out lobbying effort to secure passage of managed care consumer protection legislation. Because of nonstop lobbying by all sides, the Legislature passed and the governor signed three major pieces of legislation that will significantly impact the way health care is delivered and financed in New York State for years to come. (See additional information under Financing of Health Care.)

Two of the three new laws (Managed Care Consumer Bill of Rights - Chapter 705, Laws of 1996, and Medicaid Managed Care - Chapter 649, Laws of 1996) provide consumers with additional rights and protections in dealing with health insurance companies, particularly managed care organizations. Both laws establish new standards and procedures to improve health care quality and access. These include:

- Disclosure of important information about health insurance plans, such as—benefits provided;
- Costs to enrollees, choosing physicians and medical facilities, the definition of “medical necessity”;
- The right to receive referrals to specialists; use of emergency room services based upon the “prudent layperson” definition;
- Greater regulation of the “utilization review” process; and a timely grievance and appeal process to challenge adverse decisions.

The two new laws also prohibit the infamous “gag clauses”, which insurers have used to keep providers from advocating on behalf of their patients or speaking freely to their patients about treatment options.

Although both laws have much in common, one applies to all insured persons, whereas the other extends protection specifically to Medicaid patients who are enrolled in managed care plans. League worked hard for effective Medicaid managed care protections. We were concerned that, once the federal government approved the states mandatory Medicaid managed care plan, a flood of new enrollees would overwhelm the system and have an adverse impact on Medicaid patients.

In 1997, the League began lobbying efforts early in the legislative session to obtain passage of important provisions of the Managed Care Consumer Bill of Rights that had been eliminated from the comprehensive measure that was passed in 1996. Our priorities for 1997 included:

- Experimental and investigative treatments legislation to improve medical care for the seriously ill;
- Health maintenance organization (HMO) liability, which will hold HMOs liable for the health care decisions they make;

- Establishment of an ombudsman program to assist consumers with their health insurance questions;
- Extension of anti-gag rules to cover health care professionals other than physicians.

Although prospects for passage of these measures looked promising at the beginning of the legislative session and all were passed with bipartisan support in the Assembly, the state Senate took no action on them.

However, the League recorded some notable health care successes. In 1996, media attention focused on the issue of “drive-through” deliveries. Legislation was introduced, which the League supported, requiring insurers to cover a hospital stay of 48 hours for mothers and newborns following a normal vaginal delivery or 72 hours following a caesarian birth. This popular proposal easily passed in both houses and was signed into law.

Similarly, in 1997, legislation was introduced requiring insurers to allow patients and their doctors to decide the length of hospital stay following a mastectomy as well as requiring insurers to pay for reconstructive surgery following a mastectomy. The League lobbied for this legislation, which passed in the legislature and was signed by the governor.

In 1996, the League joined a coalition of health care and environmental groups to lobby for legislation that would require the reporting of publicly accessible data on pesticide use and sales in New York State. The compromise legislation that was enacted also established a health research science board and breast cancer research and education fund.

In 2007, the League supported two measures designed to increase patient access to quality health care. The Nursing Care Quality Protection Act, introduced in the Assembly would require hospital disclosure of levels of nursing and patient care staff and would document the number of adverse hospital incidents. This legislation passed the Assembly. Another bill introduced in the Assembly and supported by the League, would have required the Department of Health to develop minimum nursing levels for nursing homes throughout the day in consultation with an advisory council. This legislation passed the Assembly, but was held in the Senate.

Managed Care Legislation

In 1998 the push for additional managed care consumer protection legislation continued. Two League supported measures were combined into one piece of legislation and signed into law. This legislation created an External Review Board, giving HMO enrollees, the right to appeal an insurer’s decision to deny medical care, including the carrier’s refusal to permit use of experimental or investigational (Clinical trials) treatments. Patients could request action from the independent External Review Board when they had exhausted their insurer’s internal appeals process.

No further legislative action was taken in 1998 or 1999 on other League supported managed care reforms, including HMO liability (now titled the Health Care Accountability Act) or on establishing the Managed Care Consumer Assistance program.

Women's Health Care

In October 1998 all New York was shocked when Dr. Barnett Slepian was shot and killed in his Amherst, NY home. Dr. Slepian was an obstetrician and gynecologist who performed abortions at a Buffalo Women's Clinic. For the seventh year, League, and many other health care advocates, lobbied for much needed Safe Clinic Access legislation and the Assembly quickly passed its bill early in the session. In response to the doctor's murder, Governor Pataki publicly stated his support for such legislation. Although the Senate rejected a companion measure to the Assembly bill, in June 1999 it did pass its own version that incorporated an anti-stalking provision. In the final minutes of the 1999 legislative session, the governor and the Assembly reached a compromise. The law went into effect December 1, 1999.

In 1998 and 1999, the League supported the Women's Health and Wellness Act (WHWA). Many insurers do not cover the most common health problems experienced by women. This act requires health insurers to cover contraceptive drugs and devices, annual pelvic exams and pap smears, annual mammograms for people aged 40 and over, and osteoporosis screening and treatment. In both years, the bill was overwhelmingly approved by the Assembly only to stall in the Senate.

In the 2000 legislative session, the Senate pushed for and was successful in passing an insurance mandate to cover PSA tests for prostate cancer screening. The League supported that legislation, however, we made it clear to the Senate that in failing to pass the WHWA they were continuing to put women's health care at a lower priority.

The League lobbied extensively again in the 2001 session in support of the Women's Health and Wellness Act. Early in the 2001 session, the Senate Majority Leader introduced a bill, which, while mandating coverage of some preventive health services, differs from the Assembly in that it allows insurers to charge co-pays and deductibles. It also includes a loophole, "the religious conscience clause", allowing some employers and insurance plans to deny coverage for contraceptive care. The Senate promptly passed this legislation and the two houses went to conference committee. After three committee meetings, the Assembly appeared to have the momentum so the Majority Leader pulled his members from the committee process.

Intense lobbying on this issue continued for the rest of the session and during the legislative sessions of 2002 the League had a major women's health care victory. In the closing days of the 2002 session, after much grassroots lobbying by league members and our coalition partners, the Women's Health and Wellness Act was passed by both houses of the legislature and signed into law by the Governor. It went into effect on January 1, 2003. The new law contains all those elements for which the League had lobbied including insurance coverage of contraceptive drugs and devices, annual pelvic exams and pap smears, annual mammograms for woman over forty and osteoporosis screening and treatment. This will have a very real effect on preventive health care for women in New York. Shortly after the law was enacted, the New York State Catholic Conference sued in state court and the law was stayed. The court action extended all the way up to the New York State Court of Appeals. In the court session of 2007, the decision came down that the WHWA was indeed constitutional and the law went into effect immediately. After many years, this is a success for both the League and women's health.

The Uninsured

In keeping with our goal of universal health care, in 1998 and 1999 League focused attention on the growing number of people without health insurance. By 1996, the uninsured in New York had surpassed 3.1 million, a 40% increase from 1991, and the number was continuing to rise.

In 1996, League supported the state's child health insurance program, entitled Child Health Plus (CHP) that offered subsidized health insurance to children of families unable to afford health coverage. In 1998, we supported expansion of this program using new federal funding incentives. As part of its eligibility to receive federal funds, NYS was required to launch an all out effort to enroll children in either the Medicaid or CHP programs. This effort began in the fall of 1999.

Similarly, League examined other proposals to make health insurance affordable for more New York residents. We gave our support to a proposal that would create a "Family Health Plus" program modeled after the CHP insurance plan. (See detailed information on this and the CHP program under FINANCING HEALTH CARE.)

Mental Health Parity

Mental health parity has been a League priority since the 1999 amendment of its 1985 health care position. This issue came to the forefront in 2006, when a constituent (9 year old boy) of a powerful Assemblymember, killed himself. After intense lobbying by the boy's family and awareness statewide the legislature was compelled to pass legislation creating mental health parity in private health insurance. The League supported this legislation. Programs such as Child Health Plus (CHP) and Family Health Plus still remain without mental health parity and must rely on the Medicaid system. It is hoped that the issue of public mental health parity will be addressed in the 2007/2008 budget.