

Testimony before
Governor Eliot Spitzer, The New York State Department of Health, and
The New York State Department of Insurance
The Partnership for Coverage Hearings

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Good day. My name is Alice Berger. I am the Vice President for Health Care Planning at Planned Parenthood of New York City (PPNYC). I would like to thank Governor Eliot Spitzer and the New York State Departments of Health and Insurance for holding the Partnership for Universal Health Coverage Hearings. We commend Governor Spitzer, Commissioner Daines and Superintendent Dinallo on their leadership on this most important issue.

Planned Parenthood of New York City has been a leader in reproductive health care for over 90 years. Today, as a community-based safety-net provider, Planned Parenthood provides reproductive health care, education and advocacy to clients from throughout New York City. PPNYC is committed to ensuring access to reproductive health care to those who are most in need. In 2006, at our three centers in the Bronx, Brooklyn and Manhattan, we provided reproductive health care and family planning services to more than 45,000 New Yorkers, which translates into more than 80,000 visits. In addition to the health care clients we serve at our centers, we reached 60,000 plus people through our community outreach and education programs and Project Street Beat. The majority of Planned Parenthood's clients are at or below the poverty level, more than one-third use public insurance to pay for their care, and over two-thirds of our clients are women of color.

It is important to note that within our client base, the payer mix has changed. The numbers of uninsured and underinsured patients seeking medical care at our health centers continues to increase each year. Through September of this year, for example, 15% of all comprehensive gynecology visits were paid for via the sliding fee schedule, up 13%, for this same period last year. Similarly, sliding fee visits increased from 13% to 16% of all problem-focused gynecology visits from the first nine months of 2006 to the same period this year. Clearly, there are forces at work making it more difficult for our clients to pay for their care and making it harder for them to qualify for important government programs – including both fee-for-service Medicaid and the Family Planning Benefit Program. We are troubled by this trend, since it has the effect of limiting our ability to meet the needs of the communities we serve.

In addition to the medical services we provide, Planned Parenthood is especially proud of our leadership in expanding access to public insurance programs. At our three health centers, every uninsured client has the opportunity to meet with an Entitlement Counselor to assess his or her eligibility for public insurance and facilitate enrollment into programs that include Medicaid (MA), the Medicaid Family Planning Benefit Program (FPBP), Prenatal Care Assistance Program (PCAP), and Child Health Plus (CHP). In fact, in 2006, PPNYC's Entitlement program assisted nearly 5,000 clients with enrolling into Medicaid and other public insurance programs. We enabled over 1,758 clients to successfully obtain coverage for the Medicaid Family Planning Benefit Program (FPBP), which covers family planning and gynecological services, and 3,072 for pregnant clients applying for PCAP/Medicaid.

I share this background about Planned Parenthood, our services, and our clients because it gives us a unique perspective as a community-based safety-net provider and as a representative of many uninsured New Yorkers. My testimony today will focus on four issues:

1. The importance of covering reproductive health care for all;
2. Roadblocks to enrollment and recertification;
3. The unique coverage needs of adolescents; and
4. The narrow scope of facilitated enrollers for Family Health Plus.

The importance of covering reproductive health care for all

Reproductive health care services, including family planning services, are critical to the health and well-being of the women and families of New York. Expanding the reach of reproductive health services is smart public health strategy and vital to the fiscal health of the state. In fact, when New York State passed the Women's Health and Wellness Act in January 2003, it sent a strong signal that women's health services, including birth control, are basic health care.

- *For many women, reproductive health services are their only link (or first link) to primary care.* Reproductive health care centers, like Planned Parenthood, are on the front lines, providing primary preventive health care for low-income women, men and teens. Whether because of insurance coverage (or lack thereof) or a distrust of the traditional health care system, many clients present at our health centers and on our Mobile Medical Units that would not otherwise seek health care. Planned Parenthood, like other women's health providers, often serve as the portal to both insurance coverage and referral services.
- *Family planning promotes the health of women and babies:* Family planning and access to birth control is about more than preventing unintended pregnancies. It's really about being able to choose if and when to start a family and when to add to a family. It's about being able to provide for the family you already have. Access to contraception is key to helping women and their partners realize their family size goals. When a woman can space her pregnancies, the likelihood of a high-risk pregnancy and low birth-weight baby is reduced and infant health and survival improves. It is hardly surprising that women with private insurance or access to family planning providers are more likely to give birth to healthy babies and to remain healthy themselves
- *Investing in reproductive health services now saves a lot more later:* We know that every dollar spent on family planning services saves at least three dollars in Medicaid costs for prenatal and newborn care. And that's just the start. There are life-long savings that come from preventing complications of untreated sexually transmitted infections (STIs), including HIV, in women and in not having to treat STIs/HIV passed on to babies. Further, there are also enormous savings from the early detection of breast and cervical cancer.

According to the 2007 Population Survey from the U.S. Bureau of Labor Statistics and the U.S. Census, there are 800,000 uninsured women ages 15-49 currently in New York State. Additionally, there are thousands of women, who although are technically "insured," have extraordinary barriers to overcome in order to access reproductive health care services. For example, in New York State women who belong to religiously-sponsored managed care plans (i.e., Fidelis and CenterCare) have to navigate extraordinary hurdles to obtain basic preventive care. As we move towards universal coverage, we must

insure that valuable public dollars do not continue to fund and expand restrictive entities that impede timely reproductive health care.

As the State considers what level of benefits should be provided, Planned Parenthood urges you to include the full range of reproductive health care services – and not just in name only; there needs to be genuinely easy access.

Roadblocks to enrollment and recertification

As we all know, legislation passed this year that will eventually ease some of the roadblocks to enrollment and streamline the recertification processes. On behalf of our clients, and all eligible New Yorkers, we are grateful for this dramatic philosophic shift that places insurance coverage as a right for all eligible New Yorkers.

We all know that some of the greatest roadblocks to accessing public insurance programs are the onerous documentation requirements. Unfortunately, these enrollment challenges were exacerbated in 2005 when Congress passed the Deficit Reduction Act (DRA), which requires anyone applying for Medicaid to provide original proof of citizenship and identity, rather than previously accepted copies. This requirement has put an additional burden upon those who are eligible in every other category but might not have access to their original birth certificate. In spite of NYS's attempt to minimize the damage with alternate methods of obtaining original documents, many clients across the state, remain wary of the process due to fear of confidentiality breaches. Colleague providers as well as our NYSDOH partners report decreases in FPBP enrollment.

Further, even if we were successful at minimizing the many barriers to initial enrollment, our insurance coverage issues would not be solved – if only it were that easy.

Planned Parenthood applauds Governor Spitzer's commitment to streamline the recertification process. At Planned Parenthood we witness and experience the impact of this onerous process firsthand. Our 10 entitlement counselors dedicate a disproportionate amount of their time assisting clients apply for insurance or more aptly put, "reapply" for insurance. The vast majority of our clients who fall into this category continue to be eligible for the very programs that they were involuntarily disenrolled from. This is especially concerning since as a reproductive health care provider our clients often come to us for time-sensitive services -- their STIs need to be treated, their birth control pill prescription needs to be filled, etc. We provide the service irrespective of their insurance status since that is our mission. However, our clients' periods of uninsuredness do place a great strain on our limited public dollars and in fact, divert those dollars from the clients who are truly ineligible for public insurance.

As our city continues to transform itself, the numbers of immigrant men, women and adolescents continue to rise. Of New York City's 8 million residents in 2000, almost 3 million (2,871,032) were foreign-born. A report issued by the New York City Department of City Planning, *The Newest New Yorkers*, documents a 37.8% increase in the foreign-born population between 1990 and 2000.¹ Due to a number of barriers -- from language access to cultural issues to fears of jeopardizing family member's immigration status -- this new immigrant population is not seeking out available health care coverage even when they are indeed eligible. Our previously mentioned recommendations to streamline enrollment and recertification process will certainly expand access to health insurance to all eligible

¹ New York City Department of City Planning. *The Newest New Yorkers, 2000*. Available at: <http://www.nyc.gov/html/dcp/html/census/nny.shtml>

immigrants. Additionally, we see an urgent need for the State, through its community partners, to expand outreach and education to the immigrant community about their rights to safe and affordable health care, including public insurance programs. For example, even in the case of undocumented immigrants, pregnant women are eligible for New York State's Prenatal Care Assistance Program, children and adolescents are eligible for Child Health Plus B and, and some post-partum undocumented immigrant women are eligible for the Family Planning Extension Program. These programs, although essential, do not solve the overarching problem for large sectors of our state population that are currently excluded from any public insurance programs. We will continue to support NYS in any initiatives that work to close the gap of our fellow New Yorkers.

The unique coverage needs of adolescents

Our collective conversations about insurance coverage in New York State often center on uninsured children and adults. Although these two essential populations constitute a significant portion of the uninsured, we mustn't ignore the State's million plus adolescent population.

At Planned Parenthood we serve thousands of adolescent New Yorkers each year through our health services and our education programs. What we know from our experience is that confidentiality is crucial.

The import of adolescents' attitudes about confidentiality in health care cannot be emphasized enough. Study after study show that adolescents are more likely to forgo medical care if services are not provided confidentially.^{2,3,4} Thus it is not surprising that, on the flip side, when young people are assured that providers will respect their right to confidentiality, they are more likely to seek care.⁵

Most insurance programs require parental involvement in the eligibility and recertification processes. Private health insurers send "explanation of benefits" letters (EOBs) to the head of household (usually a parent), which impedes the confidentiality protection guaranteed by the NYS minor consent law. Therefore, it's not surprising that many of our young clients who are actually insured under their parent(s), refuse to use that coverage out of fear their privacy will be breached.

As a result, many adolescents remain uninsured but are actually eligible for coverage or cannot use their existing coverage to pay for services. This has the dual effect of both impacting access to core, preventive care for the young person and placing an undue financial hardship on providers who offer care to adolescents regardless of their ability to pay.

New York State has worked to provide adolescents with confidential insurance coverage for certain health care services. When PCAP was established in 1989, there already existed the recognition that any pregnant woman, regardless of age, could apply on their own, and not have to disclose all the family income information. Likewise, in 2002, New York State established the Medicaid Family Planning Benefit Program (FPBP), which provides teens with limited Medicaid coverage for family planning services, STI screening, and HIV testing and counseling. FPBP, built upon the experience of PCAP,

² Cheng TL, Savageau JA, Sattler AL, DeWitt TG. Confidentiality in health care. A survey of knowledge, perceptions, and attitudes among high school students. *JAMA*. 1993; 269: 1404-1407.

³ Ford CA, Bearman PS, Moody J. Forgone health care among adolescents. *JAMA*. 1999; 282:2227-2234

⁴ Ford CA, English A, Sigman G. Confidential health care for adolescents. *Journal of Adolescent Health*. 2004;35:160-167.

⁵ Ford CA, Millstein SG, Halpern-Felsher BL, Irwin CE Jr. Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care. *JAMA*. 1997; 278: 1029-1034.

does not require parental income information in the eligibility process and allows young people to enroll in FPBP on their own. This minimizes a significant barrier and takes a first step in aligning confidentiality concerns with the insurance eligibility process.

FPBP moves toward ensuring young people unfettered access to coverage for some reproductive health care services. However, it's not a magic bullet. It does not include in its benefit package the provision of mental health services. As we all know, rising mental health needs remain one of the most critical and unattended to areas for adolescents in our city. And in spite of the protocol that HRA has implemented here in NYS to mitigate the effects of the DRA, there remain many minors who refuse to go through the enrollment process for fear that their parents will learn that they'd applied for their birth certificate.

In order to significantly decrease the large numbers of young people who are uninsured, underinsured and privately insured but "unable to use," New York State must seek out creative solutions that align young people's fundamental need to be autonomous and access confidential services with insurance eligibility and utilization.

Although confidentiality is particularly significant for young people, we do not want to give the impression that they are the only sector concerned with maintaining privacy. PPNYC knows that adult women also expect that their services will be kept confidential from their family members and sometimes their partners. Oftentimes, confidentiality is at odds even with the best-intentioned expansion plans. We urge the Administration to keep the issues of confidentiality top of mind when working toward universal healthcare coverage in New York State.

Facilitated Enrollment and Family Health Plus

Planned Parenthood, along with scores of other NYS providers have long provided on-site public insurance enrollment to their clients. We have done this through the highly effective "deputized model" that has permitted us to offer insurance screening for PCAP, MA, FPBP and CHP. We work closely with the Human Resources Administration and are the primary enroller for the FPBP.

The one glaring exception to this comprehensive model is Family Health Plus. Due to the restrictive interpretation that only Facilitated Enrollers can enroll into FHP, we have systematically had to refer clients to outside agencies for enrollment into FHP. It makes no sense to screen uninsured clients for all the other programs, but refer out to other agencies when it comes to FHP. Again, clients come to us because they need to access time-sensitive services. Referring them out to obtain FHP is not realistic and in practice rarely happens. This puts an undue burden on our limited public dollars that could be used for those that are legitimately uninsured and perpetuates New Yorkers' uninsuredness. To expand access to health insurance, we must capitalize on the successful model of insurance enrollment and service provision.

Conclusion

Thank you for the opportunity to testify today. We support your initiatives to decrease barriers to insurance coverage and maximize access to health care. We look forward to working together to build a future of affordable, universal health insurance for all New Yorkers. We hope you will call on us if we can be of any more assistance.