

**TESTIMONY OF THE
GREATER NEW YORK HOSPITAL ASSOCIATION
BEFORE THE
NEW YORK STATE ASSEMBLY STANDING COMMITTEES ON
HEALTH, INSURANCE, AND LABOR
ON
HOW TO INCREASE HEALTH INSURANCE COVERAGE
IN NEW YORK STATE
DECEMBER 8, 2006**

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How to Increase Health Insurance Coverage in New York State
December 8, 2006

Good morning Chairman Gottfried, Chairman Grannis, Chairwoman John, and distinguished members of the Assembly Standing Committees on Health, Insurance, and Labor. Thank you for inviting Greater New York Hospital Association (GNYHA) to testify before you on the critically important topic of how to increase health insurance coverage in New York State. I am David Rich, a Senior Vice President at the Greater New York Hospital Association. GNYHA represents nearly 300 not-for-profit and public hospitals and continuing care facilities throughout New York State and other states in the northeast.

Our members have a proud tradition of providing patients access to high-quality care, regardless of their ability to pay. Having no health insurance is extremely troubling and potentially life-threatening, not to mention financially ruinous, for individuals and families alike. This is why our members have always felt a special responsibility and a moral obligation to care for the uninsured sensitively and compassionately. Chairmen Grannis and Gottfried, we were pleased to have worked with you closely last year, as well as with Senator Hannon, on new guidelines for hospital financial assistance policies that will go into affect on January 1, 2007. While many of our members go beyond those guidelines and always have, it is helpful to have minimum State standards that help dispel some of the confusion that was surrounding this important issue for consumers and providers alike. We thank you both for taking our concerns into account throughout that important discussion and debate.

Having said that, I am sure you will agree that hospital financial assistance policies are no solution to the serious problem of the uninsured. Discounts alone are not what people really need: they need stable health insurance coverage that allows them to seek care when they need it so that they do not forgo care for financial reasons while minor, treatable conditions become major, serious, and complicated problems.

As you know, the problem of the uninsured and the underfinancing of care for low-income populations is not only a problem for the uninsured themselves, but is a major driver of the financial distress that is leaving our health care safety net in tatters. Insufficient funding for caring for the uninsured, uncompensated care provided to the Medicaid population, uncompensated care due to health insurer payment abuses, and enrollment barriers that effectively deny coverage for uninsured residents who are eligible for government insurance programs, all present growing and potentially ruinous challenges for voluntary, not-for-profit, and public hospitals in underserved communities throughout New York State. The dire financial condition of hospitals statewide was the reason the State Legislature and the Governor created the Commission on Health Care Facilities in the 21st

Century, to try to manage the hospital closings that have become epidemic across New York State while attempting to maintain access for individuals in vulnerable communities. Our hospital community is in extreme financial difficulty, and the problems of inadequate financing for care for the uninsured and for low-income populations—as well as a relentless drive on the part of health insurers to maximize profits—are among the major reasons why.

Tackling our State's uninsured problem has always been among GNYHA's highest priorities. Throughout the years, we have advanced significant proposals to address this important issue. Most notably, together with 1199 SEIU and the New York State Health Care Campaign, we developed the original blueprint for the Family Health Plus (FHP) program. With the strong leadership of the Assembly and the support of the Senate and Governor, and after a huge public education campaign mounted by GNYHA and 1199 SEIU, FHP was signed into law and now provides health insurance for more than 500,000 working adults. We also spearheaded a campaign, in conjunction with immigrant advocacy groups, to allow legal immigrants access to Medicaid and FHP. Thanks to a favorable court ruling, legal immigrants may now enroll in all of the State's public health insurance programs on the same basis as citizens.

We have also joined forces with 1199 SEIU and members of the State Legislature to advance other proposals for the uninsured; unfortunately, however, these have not yet been enacted. For instance, in January 2004, we proposed the HEAL New York program, which, as originally conceived, would have greatly expanded New York's programs for the uninsured, financed through contributions from employers who do not provide health insurance. Due to concerns about the proposed employer contributions, however, the insurance aspects of our HEAL New York proposal were not enacted. Earlier this year, we supported the Fair Share for Health Care bill, which also would have required contributions from employers. Unfortunately that bill did not become law either.

Most recently, we have joined forces with 1199 SEIU to design an ambitious health insurance reform proposal called Cover NY, which offers a blueprint for achieving universal coverage in our State. Cover NY would expand affordable public and private health insurance programs; subsidize premiums for lower-income individuals who do not have access to affordable coverage; require large businesses to contribute to the public costs of their workers' health care; and, once affordable insurance options are available for all New Yorkers, require all individuals to have insurance, similar to the requirement that all drivers hold car insurance. Inspired, in part, by the bipartisan legislation enacted earlier this year in Massachusetts, Cover NY builds on our State's programs to provide a uniquely New York response to our health system's challenges. I would like to more fully outline the features of Cover NY later in my testimony. But first, I would like to discuss the nature of the uninsured problem in New York.

New York's Uninsured Problem

Our State has a strong tradition of taking care of the health needs of its most vulnerable residents. Programs like Medicaid, Child Health Plus, and Family Health Plus provide a lifeline to millions of New Yorkers who would otherwise be uninsured, and have inspired other states to expand coverage. New York's programs, like Child Health Plus, have served as models for Federal legislation. And

New York's efforts have paid off. According to a Fiscal Policy Institute analysis of U.S. Census Bureau data, New York has bucked national trends throughout this decade by registering a significant drop in the percentage of residents without health insurance, which fell from 16.3% in 2000 to 13.5% in 2005. New York was the only state to see such a decline. This drop in the uninsured rate is almost entirely due to increases in enrollment in public programs, including Medicaid and Family Health Plus. The Assembly Majority in particular should feel proud of this achievement, as it is the Assembly Majority who has most consistently fought for expansions of these programs and against eligibility changes that would have the effect of reducing or slowing enrollment in them.

In spite of these achievements, however, the number of uninsured in our State is unacceptably high. According to the U.S. Census Bureau, nearly 2.6 million New Yorkers were without health insurance in 2005. Most insured New Yorkers obtain coverage through an employer, and an overwhelming proportion of employees who are offered job-based health benefits—90%—accept that coverage. However, like the rest of the country, our employer-based system of health coverage has been steadily eroding over the years. Only 60.2% of New Yorkers had employer-sponsored health coverage in 2005, down from 65% in 2000. In New York City, less than one-half (47%) of the population currently has employer-sponsored coverage. Workers who are not offered affordable coverage through their workplace can rarely afford to purchase insurance on their own. In New York City, for example, the average direct pay policy costs \$7,000 per year, and family coverage averages \$20,000. Clearly, only the highest income workers can afford to purchase private insurance. This is why something must be done.

A Potential Solution: Cover NY

Along with 1199 SEIU, GNYHA has developed a potential solution for you to consider that we have called Cover NY. We offer this proposal not because we believe it is the only solution, but rather because we believe that its elements, which draw from both ends of the ideological spectrum, may form the basis for the necessary compromise that has too long eluded us. Many of the elements include proposals Chairman Gottfried and Chairman Grannis have proposed in the past. We certainly do not view any of the elements as “set in stone,” and would be willing to debate and discuss any or all of them; however, we strongly believe that the time for division has past and that now is the time to get something done.

As I mentioned before, Cover NY is inspired, in part, by the successful effort in Massachusetts earlier this year to enact a universal coverage proposal. It does, however, have a distinctive New York cast, building as it does on our own unique programs and services. The proposal builds on the current system of public and employer-provided private health insurance in New York to make quality health coverage accessible and affordable for all New Yorkers. The plan's guiding principle is that health insurance should be both a *right* for all residents of the State and a *responsibility* shared among businesses, government, and individuals.

The cornerstone of the proposal is an expansion of affordable public and private health insurance programs, including Family Health Plus, Child Health Plus, and Healthy NY. Small businesses with

low-wage workers would receive tax credits to help them purchase coverage for their employees, while large firms would be required to pay a modest assessment for each worker not offered health insurance. Once affordable options are available to everyone, all New Yorkers would be required to have health insurance, similar to the requirement that all drivers have car insurance. However, this requirement would be instituted only if public and private health insurance programs are significantly expanded, and a new safety net subsidy program—established through a system of sliding scale tax credits—is established to protect families from spending more than they can afford for coverage. The proposal also calls for increased financial resources to enhance language assistance services to individuals with limited English proficiency.

Here are the specifics of our proposal.

EXPAND AFFORDABLE HEALTH INSURANCE

Family Health Plus Expansion. All working adults with family incomes less than 200% of the Federal Poverty Level (\$32,200 for a 3-person family) would qualify for Family Health Plus. Eligible individuals would not be required to pay a premium, and assets and other non-income resources would not be taken into account in the determination of eligibility for either Family Health Plus or Medicaid.

Family Health Plus Buy-In. Individuals with incomes above 200% of the Federal Poverty Level may “buy in” to Family Health Plus by paying the full premium, which is considerably less than comparable coverage in the direct pay market (some of these individuals may be eligible for a refundable tax credit to offset the premium).

Public/Employer Partnerships. When it is deemed cost-effective, the State would offer to pay the employee share of the premium of employer-sponsored health insurance for workers and dependents who are offered employer coverage but would otherwise qualify for Family Health Plus and/or Child Health Plus. The State would provide a wrap-around indemnity plan for Family Health Plus and Child Health Plus services not covered by the employer plan. This option is currently available under Medicaid, and it is used frequently in states such as Rhode Island, where the measure has achieved significant cost savings.

Employer Buy-in to Public Programs. Employers would have the option of contributing to Medicaid, Family Health Plus and Child Health Plus on behalf of employees who would otherwise qualify for these programs, in lieu of the workers’ enrollment in the company-provided health plan. The employer would pay the State an amount equal to the amount the employer would have paid under the company’s health insurance plan. This option would also be available to members of union benefit plans.

Union Benefit Fund Participation in Public Programs. Labor/management health benefit funds established through collective bargaining agreements would be allowed to offer Family Health Plus and Child Health Plus to eligible employees and their families, if the coverage is at least as generous, and the cost sharing no more onerous, than Family Health Plus and Child Health Plus benefits and

cost sharing. The State would pay the labor/management health benefit fund the same per-enrollee rate that it would pay a managed care health plan for providing Family Health and Child Health Plus coverage, even if the labor/management benefit fund provides more generous coverage.

Child Health Plus Expansion. Child Health Plus B would be extended to young adults through age 21, at no or very low cost to eligible individuals (with premiums as specified under current law). Young adults through age 21 who earn too much to qualify for coverage would be able to “buy in” to Child Health Plus by paying the full premium. This is an option currently available to children through age 18 who do not qualify for Child Health Plus.

Healthy NY Expansion for Individuals. Individuals with incomes up to 350% of the Federal Poverty Level (\$56,300/3-person family) who do not have an affordable employer health insurance policy available to them would be able to purchase a Healthy NY policy.

Healthy NY Expansion for Groups. Labor/management health benefit funds established through collective bargaining would be permitted to offer Healthy NY coverage to workers. Benefit funds that cover more than 50 FTE employees would be required to have a higher percentage of low-wage workers than the one-third specified in current law, with the percentage rising with the number of individuals covered under the benefit fund plan. The one-year “look back” period would be waived for employers who, through a collective bargaining or otherwise legally enforceable agreement, commit to maintaining health insurance contributions for low-wage workers.

Healthy NY Benefits. Healthy NY policies would be required to cover prescription drugs and mental health and substance abuse treatment at the same level required in the direct pay market. Reinsurance would continue to keep Healthy NY premiums reasonable (Healthy NY premiums are often less than half of premiums for policies purchased in the direct pay market).

Expanded Private Insurance for Young Adults. All private insurance policies (direct pay and employer-sponsored) that include dependent coverage must cover unmarried dependents through age 25.

SMALL BUSINESS TAX CREDIT

All businesses with 50 or fewer employees would receive a tax credit for the purchase of health insurance coverage for their workers if the coverage were at least as generous as an enhanced Healthy NY policy. The maximum credit would be 20%, with the amount proportional to the number of low-wage workers employed by the firm.

LARGE EMPLOYER RESPONSIBILITY

Employers with more than 500 workers would be required to pay an assessment equal to the average premium for Family Health Plus (\$250 in 2005) for each employee who works more than 60 hours per month. Employers would receive a credit against the payroll tax obligation for any contribution made to an employee’s health coverage. All proceeds from this assessment would be earmarked to

extend Family Health Plus and Healthy NY to more low-income workers.

INDIVIDUAL RESPONSIBILITY

Individual Requirement. Once existing health insurance programs are expanded, all residents of New York State will be required to enroll in a health insurance plan that provides coverage at least as comprehensive as an enhanced Healthy NY policy with prescription drug coverage or provides the actuarial equivalent of enhanced Healthy NY coverage. This requirement would be phased in over four years.

Premium Assistance. The State will provide refundable tax credits to individuals with incomes up to 400% of the Federal Poverty Level (\$64,400/3-person family) who spend more than 5-7% of their family income out-of-pocket on premiums, according to the following schedule:

Structure of Sliding-Scale Tax Credits

Family Income as % of Federal Poverty Level	Out-of-Pocket Costs Capped at
<200% Poverty Level	5% of family income
200%-300% Poverty Level	6% of family income
300%-400% Poverty Level	7% of family income

Uninsured individuals whose annual income exceeds 400% of the Federal Poverty Level (approximately 400,000 people, or 14% of the currently uninsured) would not be eligible for a subsidy through this program, but they would be able to purchase health insurance at a significant discount over private health insurance through the expanded Family Health Plus and Child Health Plus programs. For example, a 3-person family with one parent and two children earning \$64,400 per year (400% of the Federal Poverty Level) could purchase Family Health Plus and Child Health Plus coverage for approximately \$6,000, or 9% of their annual family income. This compares with a family health insurance policy in New York State, which currently averages more than \$18,000 (28% of income for a family earning \$64,400).

Phase-in. The individual health insurance requirement would be phased in over four years *after* (and only if) Healthy New York and public health insurance programs are expanded and improved, and a mechanism for providing tax credits is implemented.

Enforcement. When the health insurance requirement is fully implemented, all individual tax filers would need to show evidence of health insurance when they file their personal income taxes. Those

without health insurance in the past year would be assessed a premium for the past year plus a modest penalty. Those who do not file income taxes and do not enroll in a health insurance plan will be enrolled in a program when they seek health care services.

Insurance Verification. The State would establish an insurance verification electronic clearinghouse that any health care provider could query to check the source of a patient's insurance coverage.

Outreach. All likely contact points for families and individuals, such as schools and motor vehicle registration, will be engaged in outreach to educate individuals about their responsibility and options available to them.

Enrollment. Individuals without health insurance who present at health care facilities must enroll in a qualified health insurance plan at the point of service. If they do not specify which coverage option they prefer, they will be automatically enrolled in Family Health Plus or Child Health Plus (higher income individuals would pay premiums for this coverage).

STREAMLINE PUBLIC HEALTH INSURANCE PROGRAMS

Continuous Coverage for Adults. Provide 12-month continuous coverage for adults in Medicaid and Family Health Plus, as the State currently provides for children in Child Health Plus A and B.

Biennial Recertification. Require full eligibility reviews on a biennial basis for Medicaid, Child Health Plus A and B, and Family Health Plus. In alternating years, the State would send enrollees a letter that includes their previous eligibility information and a telephone number to call if their economic or family circumstances have changed.

Self-Attestation of Income. Applicants for Medicaid, Child Health Plus A and B, and Family Health Plus would be able to self-attest to their income. The Commissioner would verify the accuracy of income information by matching it against income information contained in databases to which the Commissioner has access. Applicants would have to provide income documentation if the Commissioner discovers a discrepancy that affects eligibility for the public program.

EXPANSION OF LINGUISTIC ACCESS TO HEALTH CARE

Medicaid Reimbursement for Language Assistance Services. Allow health care providers to receive Federal and State Medicaid and State Child Health Insurance (SCHIP) matching funds to support the provision of interpretation and translation services to patients with limited English proficiency. The Federal government gives states the option to obtain Federal Medicaid and SCHIP matching funds for this purpose. Only nine states currently take advantage of this option; New York State is not among them. The 2003 Institute of Medicine report entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* calls for greater resources to be made available by payers (Medicaid, Medicare, health plans) to health care providers to support the provision of language assistance services to patients with limited English proficiency.

LINGUISTIC AND CULTURAL ACCESS AND HEALTH LITERACY PROJECTS

Grants to Support Research and Innovation in the Provision of Language Assistance Services, Culturally Competent Care, and Health Literacy Education. Establish grants in New York State to hospitals and other health care providers to design, implement, and evaluate innovative and cost-effective programs, tools, and technologies to improve the delivery of language assistance services to patients with limited English proficiency and to support interventions designed to enhance the provision of culturally competent care and to promote health literacy. Also make State funds available to researchers to evaluate the effect that the provision of culturally and linguistically appropriate care, as well as healthy literacy interventions, have on health outcomes. These provisions are consistent with both the 2003 Institute of Medicine report on health disparities and the 2004 Institute of Medicine report entitled, *Health Literacy: A Prescription to End Confusion*.

Those are the specifics of Cover NY. I would be glad to answer questions any questions you may have on any of the aspects of the proposal.

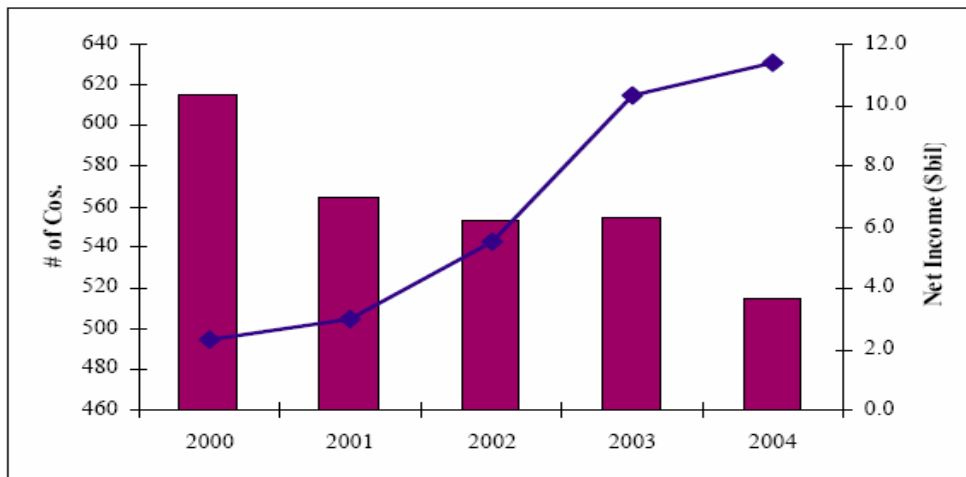
Financing a Universal Coverage Proposal

There are no two ways around the fact that a comprehensive strategy to cover the uninsured in New York State will require new revenues. The current funding provided to hospitals (discussed more fully below) and health centers to help offset the costs of uncompensated care are grossly inadequate to cover even the services provided by those providers let alone to purchase comprehensive health insurance coverage for the 2.6 million uninsured New Yorkers. Besides, any attempt to divert funding for hospitals and health centers for uncompensated care without first guaranteeing coverage for all of New York's uninsured, including its sizable population of undocumented immigrants, would be a disaster for hospitals, health centers, and the patients they serve. It would seriously destabilize an already financially fragile health care delivery system upon which all New Yorker rely. We would strenuously oppose any diversion of uncompensated care funding to finance a partial solution. Instead, the Cover NY program suggests a mix of contributions from employers and individuals; however, we believe other revenues would also be necessary.

One potential source of revenue is the huge windfall profits that have accrued to New York's health insurers in recent years.

Two weeks ago, GNYHA President Ken Raske testified at a joint hearing that Chairmen Grannis and Gottfried held on health plan consolidation and its impact on consumers and providers. At that hearing, Mr. Raske highlighted national trends in health plan consolidation and profitability, depicted in the chart below. It demonstrates clearly that net profits have risen steadily as the number of plans has decreased.

Five-Year Trend in Profits

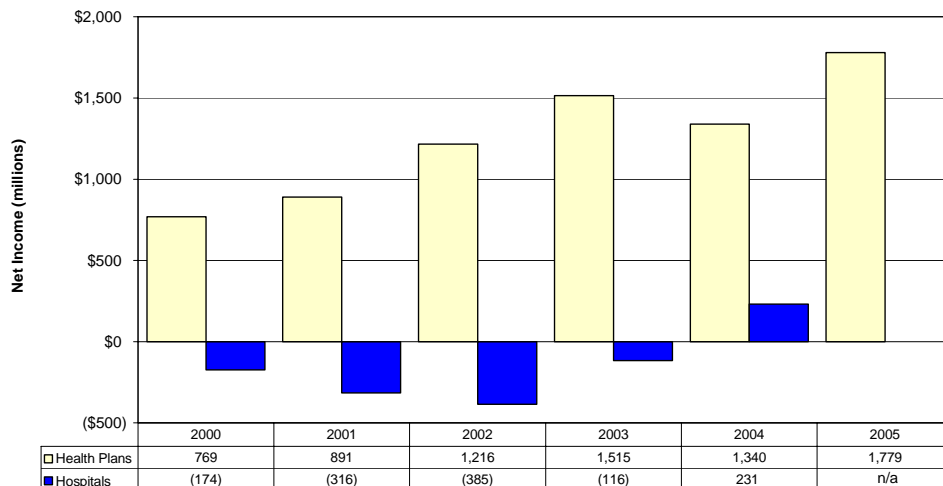


Source: Weiss Ratings, 8/8/05

Notes: Profits for the nation’s HMOs increased 10.7 percent in 2004 to aggregate income of \$11.4 billion compared with \$10.3 billion in 2003. Profits increased more than 80 percent from 2002 to 2003.

Within New York State, the disparity between health plan profits and hospital finances has existed for several years and is growing. The financial picture shown on the table below represents the depletion of health care resources from New York’s communities over time with no discernible improvement in access to or the quality of health care in our State as a result. If anything, hospital quality has suffered from persistent fiscal stress.

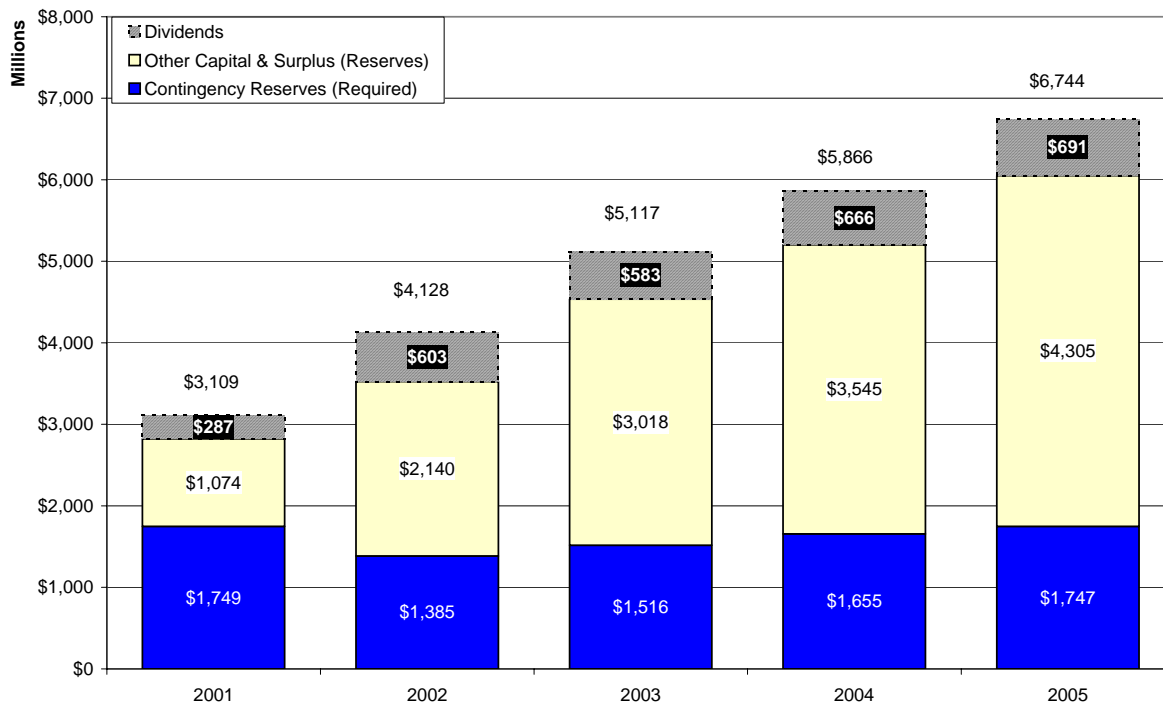
New York State Health Plan and Hospital Financial Condition
Net Income, 2000-2005



Note: Figures do not include Prepaid Health Services Plans (PHSPs)
Source: New York State Hospital Institutional Cost Reports (ICR); New York State Insurance Department, Health Plan Annual Statements (NAIC Statements); data includes commercial PPO, HMO and indemnity.

Another indication of health plan profitability is shown on the table below, which depicts the growth in reserves of the State’s major health plans over time. The health plans represented in this table are the main ones, representing 83% of total premium income, 85% of profits, and 88% of enrollees in the State. You can observe the astounding growth in total surpluses from 2001 to 2005, including surpluses above statutory reserve requirements. A portion of these extra surpluses has been used to pay shareholder dividends, as shown by the top portion of the bars. Thus, in 2005, these plans had \$5 billion in reserves above the statutory minimum, about \$700 million of which were used to pay dividends.

**Growth in Health Plan Capital & Surplus Over Time
2001 - 2005**



Note: Health plans included in this analysis: Aetna; Capital District Physicians Health Plan; Cigna; Empire; Excellus; GHI; HealthNow; HIP; Horizon; Independent Health; Oxford; United (including AmeriChoice); and Wellcare. Together, these plans represent 83% of total NYS premium income, 85% of total NYS net income, and 88% of total NYS enrollee member months. Source: National Association of Insurance Commissioners (NAIC) financial statement filings.

We believe that all organizations require retained earnings for investment in their own growth. However, the amounts above statutory reserves that these plans have accumulated are extraordinary, particularly when juxtaposed against hospitals’ losses. The payers also have a huge amount to gain from the implementation of the recommendations of the Commission on Health Care Facilities in the 21st Century. Our analysis of the savings from the Commission’s recommendations shows that private payers will save **\$6 billion** over the next ten years due to the recommendations. These sectors of the health care system must be asked to participate in health care reform. The Governor-elect has stated as much, and we whole-heartedly agree. ***At a minimum, we are calling for a \$1 billion disgorgement of unnecessary health insurance reserves as well as an ongoing contribution from the payers to help pay for health care reform and to re-invest in communities.*** There is a moral imperative for health plans to re-invest a portion of their profits into the health care system and to re-

invest a portion of the benefits that will accrue to them from the implementation of the Commission's recommendations. Clearly, this is a source of revenue for the health insurance coverage expansions we have discussed here today, as well as a way to help the State meet its current obligations for coverage for low-income New Yorkers.

Further, the Federal government must finally give New York State a fair Medicaid funding formula. New York has the lowest possible Medicaid matching rate. 38 States and the District of Columbia have higher Federal Medicaid matching rates than New York does—despite the fact that, as Senator Daniel Patrick Moynihan pointed out year after year, New York sends billions of dollars more to Washington each year than it receives in return. Increasing the matching rate just 3 percentage points—to the rate currently enjoyed by Nevada, Rhode Island, and Wyoming, but still below the rate received by 34 other states—would increase Federal revenue for New York State by **\$2 billion** annually. This would not nearly correct the inequity between what New York sends to Washington in Federal taxes and what it receives in return—but it would be a start. ***We call on our U.S. Senators and members of the House of Representatives to finally make a fair Medicaid funding formula a reality for New York.*** This Federal funding is critical to our reform efforts.

Uncompensated Care Provided by Hospitals

No discussion of the uninsured in New York State would be complete without a discussion of the extraordinary amount of care provided by hospitals to the poor and uninsured and the importance of continued funding for uncompensated care.

An analysis of Institutional Cost Reports shows that hospitals in New York State provided \$1.8 billion in uncompensated care to the uninsured in 2004. The same analysis reveals that New York's hospitals provided \$1.5 billion in uncompensated care to the Medicaid population, mainly for outpatient, clinic, and emergency services for which payment rates do not nearly cover the cost of care. Thus, hospitals provided \$3.3 billion in uncompensated care in 2004.

The Federal, State, and local governments provide support to help partially defray the costs of uncompensated care in a variety of ways. For instance, New York State has established the Indigent Care Pool (known colloquially as the “bad debt and charity care pool”), which provides \$847 million annually to hospitals to offset the costs of bad debt and charity care, funded by the State and Federal governments. Because hospitals themselves provide over a quarter of the funding for the pool through a 1% tax on gross receipts (which, in 2005 raised \$218 million), the actual net benefit to hospitals of this pool is approximately \$629 million, or a little more than a third of the \$1.8 billion hospitals provide in uncompensated care for the uninsured. For voluntary hospitals, payments from the pool are based on eligible uncompensated care costs from two years prior to the payment year. The payment distribution formula recognizes increasing amounts of uncompensated care costs, and provides a greater amount of support to hospitals that have higher percentages of total operating costs attributed to uncompensated care. In other words, the payments are skewed toward hospitals whose operating budgets contain higher percentages of uncompensated care. Public hospital payments from the pool are fixed at the amount received by the public hospitals in 1996. Public hospitals are provided additional support through indigent care adjustments, upper payment limit

supplements, and other payments provided by Federal and local governments.

According to an analysis of New York State Department of Health data and 2003 Institutional Cost Reports, New York City hospitals paid 59% of the 1% tax statewide, and received 75% of the after-tax Indigent Care pool payments, a reflection of the greater proportion of uncompensated care provided by hospitals in the City to the considerable number of low-income and uninsured residents here. (The percentage of after-tax pool payments received by hospitals in the City, though high, was still less than the percentage of uncompensated care they provide statewide). New York City's non-public, non-academic medical centers provided 34% of the tax revenue and received 55% of the after-tax payments from the pool; New York City's non-public academic medical centers contributed 14% of the tax revenue and received 7% of after-tax pool payments; and New York City's public hospitals, including SUNY, paid 11% of the tax statewide and received 13% of the after-tax pool payments.

Despite the obvious inadequacy of the funding provided to help hospitals cover the costs of uncompensated care, the funding is critically important. Without it, hospitals, whose bottom line margins are already slim to non-existent, would be in even worse financial shape and hospitals that provide high proportions of care to the uninsured would be devastated, with consequences not just for the uninsured they serve but for their entire communities. Just as the funding is inadequate to cover hospital uncompensated care costs, it is also grossly inadequate to fund health insurance coverage for the State's 2.6 million uninsured residents. According to a recent study by the Urban Institute, entitled *Caring for the Uninsured in New York*, the incremental cost of medical care services utilized if all of the uninsured in New York State were covered by health insurance would be over \$4 billion annually, with the actual cost of providing insurance much greater. Clearly, an \$847 million pool, that provides only \$629 million in net funding to hospitals, will hardly make a dent in the number of uninsured New Yorkers, if converted to insurance payments, and such a diversion will cripple New York's hospitals. Even shifting a portion of the pools to pay for coverage expansion would have a devastating impact on the safety net provided by hospitals. Dollars taken from the pools to pay for coverage would inevitably end up diverted into HMO profits, HMO administrative costs and other parts of the health care system. Consequently, the reduction in pool payments would far outstrip any benefit to hospitals from a marginal increase in insurance coverage and the financial health of safety net hospitals would be further eroded.

Thus, GNYHA would strongly oppose any attempt to divert critical Indigent Care pool funding to other purposes, unless the diversion coincides with the implementation of a comprehensive program that guarantees insurance coverage for everyone in New York, including New York's sizable population of undocumented residents.

Conclusion

The problem of the uninsured in New York State must be solved. Without solving it, we cannot hope to achieve the improvements in quality of care and public health outcomes that we must achieve in order to make New York what it should be: a place where the population is healthier than anywhere else on earth. We look forward to working with you in the coming months on this important issue.

Thank you again for your attention to GNYHA's testimony.