

SHARED RESPONSIBILITY:

A PRESCRIPTION FOR COMPREHENSIVE HEALTH CARE REFORM IN NEW YORK STATE

EXECUTIVE SUMMARY

THE HEALTHCARE EDUCATION PROJECT



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New York State has embarked on a journey toward a reformed health care system. The State government is setting about the arduous and unprecedented task of closing, restructuring, merging, consolidating, and converting 57 hospitals across the State—fully one quarter of all of the hospitals in New York—as well as adding significantly to New York’s ambulatory and primary care infrastructure.

We estimate that as many as 15,000 personnel will be affected at the 57 hospitals as well as the many nursing homes that were the subject of the Commission’s recommendations. Payers—Medicare, Medicaid, and private insurers—will save \$19 billion in revenue over the next 10 years, as costly inpatient hospital admissions decrease and cost-efficient alternatives to inpatient care replace them. The Medicaid program alone will save \$5.5 billion, \$460 million in the first year. Clearly, this is a major undertaking.

Implementing the Commission’s recommendations constitutes major reform. However, it focuses on just one area: New York’s financially struggling hospitals and nursing homes. Without question, these are the sectors of the health care system that can least afford to shoulder the burden of reform.

If the Commission activity constitutes the only reform of the system, New York’s health care community will still be rife with problems. We will still have too many uninsured New Yorkers; we will still have a Medicaid program in need of reform; we will still have HMOs and insurance companies taking billions of dollars out of New York’s communities through unfair business practices; we will still have pharmaceutical companies and device manufacturers making billions off of New York’s health care system through double-digit percentage mark-ups on their products.

Below is a synopsis of how industry-wide reform can be achieved:

The Uninsured. The new Administration in Albany has pledged to cut the number of uninsured in New York in half over the next four years. While that is a worthy goal, we respectfully submit that more can be done, especially when other states, like Massachusetts, have committed themselves to universal coverage and many publicly traded corporations are making billions of dollars off of New York’s health care.

Programs like Medicaid, Child Health Plus (CHP), and Family Health Plus (FHP) provide a lifeline to millions of New Yorkers who would otherwise be uninsured, and have inspired other states to expand coverage. New York has bucked national trends 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, which is almost entirely due to increases in enrollment in public programs such as Medicaid and FHP.

Despite these achievements, 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, but like the rest of the country, our employer-based system of health coverage has been steadily eroding over the years.

- ***Cover NY.*** The cornerstone of the proposal is an expansion of affordable public and private health insurance programs, including FHP, CHP, 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. The specifics of Cover NY can be found in the Appendix to the accompanying white paper.
- ***Uncompensated Care.*** No discussion of the uninsured in New York State would be complete without mention of the extraordinary amount of care provided by hospitals, hospital clinics, and freestanding clinics 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, 67% of it for outpatient services. 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.

State policymakers should vigorously oppose any attempt to divert critical uncompensated care pool funding to other purposes, unless the diversion is part of a comprehensive strategy to provide guaranteed insurance

coverage for everyone in New York, including New York's sizable population of undocumented residents.

Every single one of the 57 hospitals and dozens of nursing homes that are the subject of the Commission recommendations will be in a state of transition and potential instability, as will their neighboring institutions and the workers they employ. *Thus, it is imperative that the State in no way exacerbate this volatility by enacting new Medicaid or other funding cuts for hospitals, nursing homes, or other safety net providers.*

What is Driving Up Costs in the Medicaid Program? While total spending on New York State's Medicaid program grew 28% from 2000-2004 on an inflation-adjusted basis, spending per beneficiary actually *fell* 7% during those five years! So what accounts for the spending increase? It is due almost entirely to a large increase in the number of beneficiaries: the number of Medicaid beneficiaries grew 38% from 2000-2004.

Looking more closely at spending during that time period will help policymakers determine where to focus reform efforts. For instance, acute care spending, including hospital care, decreased 11% from 2000-2004, in inflation-adjusted dollars. Post-acute care spending, including nursing home care, grew at a relatively modest 13% clip. However, spending on pharmaceuticals increased 40%, the most of any spending category, followed by spending for HMOs, which grew by 28%.

Lowering Prescription Drug Costs. To lower the cost of Medicaid prescription drugs, the State should:

- strengthen the Medicaid preferred drug list
- more aggressively reduce pharmaceutical costs by seeking an exemption from the Federal Medicaid "best price" requirement
- evaluate eliminating the Medicaid managed care pharmacy "carve-out"
- maximize use of the 340B program for other State-funded pharmaceutical programs

Reform the Medicaid Managed Care Program. The State's Medicaid managed care program can be a much more cost-efficient, quality program. For starters, the State should reevaluate and improve its Medicaid managed care disease management activities and lower Medicaid managed care administrative costs.

End the Unfair Treatment of New York Due to the Federal Medicaid Matching Rate Formula. 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—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. We call on our U.S. Senators and members of the House of Representatives—many of whom have assumed leadership positions in the new Congress—to finally make a fair Medicaid funding formula a reality for New York.

The Growing Power of the Insurers. New York has seen significant changes over the past several years in the number and nature of health insurers serving the area. The disparity between the high profits of New York health plans and the poor financial condition of New York's hospitals is well known and getting worse. Consolidation has exacerbated this situation because it has given health insurers increased market power with which to compel providers *and consumers* to accept contracts that may have inappropriate terms and payment rates and to be forced to endure arbitrary, and possibly actionable, payment practices.

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

- ***Health Plans Should Pay for Medically Necessary Services.*** Health plans *must* pay appropriately for care and the State should require payment for medically necessary care. Right now, payment for pre-approved, concurrently reviewed, medically necessary care is often denied or only partially paid.
- ***Negotiation with Health Plans.*** We believe that more flexibility is needed to recognize different types of provider alliances for purposes of relating to health plans. Traditional anti-trust analysis has permitted the consolidation of large health plan purchasers as being pro-competitive but has frowned on many configurations of provider alliances. We do not believe these analyses are well suited to health care.
- ***State Regulation.*** We recommend that State regulatory and oversight powers be strengthened and exercised in a way that includes consideration of the importance of the health care provider infrastructure

to the health of the State's citizens and the impact that plan actions have on that infrastructure. We believe that current enforcement powers and agency resources are insufficient for this task.

Prescription Drugs. Spending on prescriptions drugs by the New York State Medicaid program per beneficiary grew 40% between 2000 and 2004. By contrast, the cost of acute care services per beneficiary, including hospital care, actually declined 11%. Clearly, the State could do much more to control the cost of prescription drugs.

Medical Devices. Medical devices, which include many different products, including stents, pacemakers, artificial joints, and orthopedic screws, are extremely overpriced. A recent analysis of the financials of the major U.S. device makers reveals that their self-reported gross profits—defined as revenues from sales minus costs of products sold—exceeded \$61 billion in 2005. The gross profit margin on products sold exceeded 65%. In other words, consumers—primarily hospitals, doctors, and their patients—are paying a 65% mark-up on every device sold. Because New York State represents 8.2% of national health care spending, it is reasonable to assume that *over \$4 billion of the gross profits for these medical device manufacturers are generated by New Yorkers alone.*

This overpricing has a significant impact on New York's health care system. New York's financially fragile hospitals clearly cannot afford to pay more than is necessary for critical supplies, and surely cannot continue to afford device mark-ups of nearly 60%—especially considering that total hospital Medicare and Medicaid payments for many services are less than the cost to the hospital of the device *alone*. Without question, reducing the over \$4 billion New Yorkers contribute annually to the device makers' gross profits would help New York create a more cost-efficient system.

Medical Liability. The old paradigm of doctors blaming trial lawyers and trial lawyers blaming bad doctors and hospitals has stymied any forward progress on the issue of the rising cost of medical malpractice insurance. In the meantime, costs have been soaring. A survey of GNYHA members showed that their malpractice insurance costs had risen 147% between 2000 and 2004. To break through the old logjam, we clearly need a "third way." We have come up with a proposal that we think provides a strong incentive to drive quality improvement while, at the same time, reforming the legal system. Basically, we are saying that both sides in the debate are right: the legal system is failing patients and providers, and quality does need to be improved. So let's have the State set up a rigorous quality improvement program that, if followed by providers, entitles

individual providers in the program to certain protections in court. Non-participating providers would still operate under the system we have now. Certain particularly egregious “never events” would not be protected. We combined this proposal with a time-limited State funding pool to provide relief in the short term, until the program could become fully operational and have a true impact on premium costs.

Specifically, hospitals and physicians can enjoy the benefits of a dramatically reformed medical malpractice insurance and tort reform system, but only if they voluntarily create a culture of safety within their institutions and physician practices that is evidenced by implementation of voluntary, aggressive, institution-wide medical error reduction, patient safety, and infection control programs.