



**TESTIMONY OF KENNETH E. RASKE, PRESIDENT  
GREATER NEW YORK HOSPITAL ASSOCIATION  
ON THE EXECUTIVE BUDGET PROPOSAL FOR 2006-07 BEFORE THE  
NEW YORK STATE SENATE FINANCE AND ASSEMBLY WAYS AND MEANS  
COMMITTEES**

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Good morning Chairman Johnson, Chairman Farrell, Chairman Hannon, Chairman Gottfried, and other distinguished members of the State Legislature. My name is Kenneth E. Raske, President of the Greater New York Hospital Association (GNYHA). GNYHA represents approximately 250 not-for-profit and public hospitals and continuing care providers in New York and surrounding areas.

I would like to thank you for this opportunity to testify on the Executive Budget proposal for 2006-07. While there is much to commend in the Executive Budget—including the dedication of insurance conversion proceeds and tobacco revenues to the Health Care Reform Act (HCRA) and its important programs, funds for the HEAL New York program for information technology and restructuring, and an increase in funding for the excess medical malpractice insurance pool—I must regretfully but unambiguously state that the Medicaid and HCRA cuts and changes to public programs for the uninsured that are contained in the Executive Budget will, if enacted, dangerously weaken an already financially weak health care system.

The proposed budget would be disastrous for New York's already financially reeling healthcare community and the patients they serve. Hospitals have suffered seven consecutive years of bottom line losses and more than half of New York's nursing homes and certified home health agencies are losing money. The skyrocketing costs of utilities, pharmaceuticals, medical supplies, and malpractice insurance, coupled with the need to invest in emergency preparedness, pandemic readiness, and information technology systems required for patient safety and clinical information linkages, have created huge cost pressures while payments from private payers, Medicaid, and Medicare have been spiraling relentlessly downward.

In addition, the proposed Medicaid cuts are wholly inconsistent with the ongoing work of the Commission on Health Care Facilities in the 21st Century. The Governor and the State Legislature created the Commission precisely because the hospital and nursing home communities are in such dire financial straits, with a rash of haphazard closings and bankruptcies occurring across the State. The Commission's charge is to rationalize the downsizing process and recommend restructuring to ultimately strengthen the hospital and nursing home communities so that they can provide high-quality health care services in a more efficient manner and make necessary capital improvements. In addition, the Legislature and the Governor wisely created the HEAL New York program to help hospitals make the investments necessary to restructure the system and become more efficient. It makes no sense whatsoever to provide funding under HEAL New York while simultaneously slashing Medicaid reimbursements for the very same hospitals. This would be equally true of any funding that may eventually be provided for

restructuring under the Federal-State Health Reform Partnership (F-SHRP) waiver the State is negotiating with the Federal government.

Further, the proposed health care cuts seriously exacerbate the already unacceptable underfunding of Medicaid hospital and nursing home services. Even without these cuts, New York hospitals lose \$1.2 billion annually due to woefully inadequate emergency department and outpatient Medicaid rates. Nursing homes lose \$700 million. Rather than cutting rates, New York State needs new, targeted investments in emergency room, outpatient, and long term care services.

In my testimony today, I will focus on the proposals in the Executive Budget that will have a devastating impact on hospitals and the patients they serve, as well as the benefit cuts that will have a severe impact on the Family Health Plus and Medicaid populations.

I will also focus on critical investments and reforms that we believe must be included in the budget in order to strengthen New York's health care system and enhance the quality and efficiency of the health care provided in our great State. These include investments and reforms to help providers afford the high costs of malpractice insurance; to ensure that communities continue to have access to 24/7 emergency departments; to help hospital workers who lose their jobs as a result of the Commission's recommendations or related actions to find long term re-employment and needed training associated with it; to provide language assistance for those who have limited proficiency in English; to rationalize the unbalanced relationship between insurers and providers; to provide health insurance coverage for all New Yorkers; and to reduce the cost of prescription drugs.

I will first review the context in which I believe the Executive Budget must be considered, including hospitals' financial condition and what I would describe as dangerous structural imbalances in our health care delivery system. I will then discuss the proposed cuts, our recommendations for changes, and urgent priorities for 2006. Separately, Scott C. Amrhein, President of the Continuing Care Leadership Coalition, will discuss our serious concerns about the Executive Budget's long-term care proposals, which we fear would have a devastating impact on our State's nursing homes. Mr. Amrhein will also discuss other long-term care initiatives that we strongly support and would like to work with you to enact this year, including critical investments in nursing home quality improvement and investments in the home health care workforce.

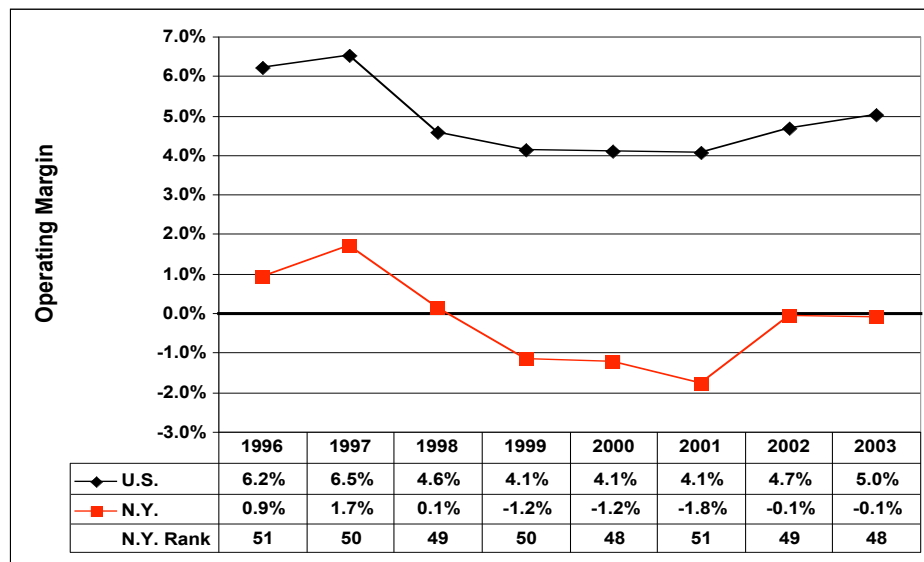
## CONTEXT FOR THE STATE BUDGET

As you know, many changes have been reverberating through our health care delivery and financing system for the past several years. From our perspective, four trends need to be underscored. The first is that hospitals in New York have been precariously underfunded for many years, a trend that is not abating, and this threatens both health care quality and access for residents of our State. The second is that since rate de-regulation in 1997, there has been a growing and dangerous imbalance in the relationship between health plans and hospitals that is reflected in their grossly disparate financial conditions, the administrative costs that have been added to the system, and that is poised for a potentially worse phase as a result of the consolidation of formerly regional health insurers into national mega-plans headquartered outside of New York. The third is the chronic underfunding of Medicaid payments for ambulatory care, and the fourth is the relatively newer phenomenon of niche providers that has emerged as a fundamental de-stabilizer of our health care and hospital system.

### Trend 1. Hospitals in New York are Dangerously Underfunded

Figure 1 below demonstrates that New York hospitals' operating margins continue to be well below the experience of hospitals nationally. The most significant aspect about this information is not how hospitals may have fared in any particular year, but instead is the multi-year trend of persistent losses. Among other things, these continuous losses have disabled our hospitals from re-investing in critical parts of their operations, including information technology, at anywhere near the same rate as their peers nationally.

**Figure 1. Hospital Operating Margins, NYS and United States  
1996-2003**

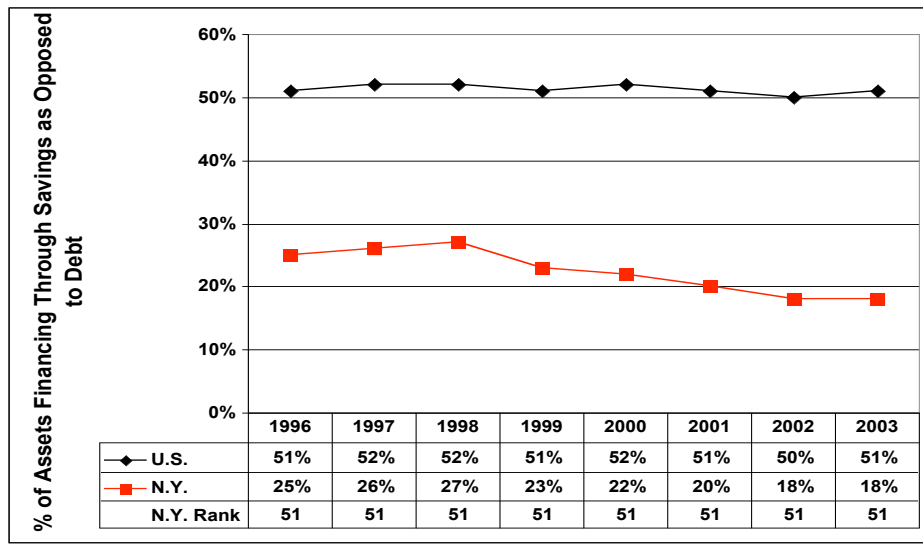


Source: GNYHA analysis of Medicare cost reports.

A clear consequence of this long term financial stress is displayed in the next figure, which shows the percentage of capital assets that New York hospitals finance with savings earned from their operations as opposed to debt. Of every state and the District of Columbia, New York's

hospitals are the most reliant on debt and the situation is getting worse. Nationally, hospitals have continued to pay for capital investments through a roughly 50-50 combination of savings and borrowing. High performing hospitals in the United States are able to fund 60% or more of their capital projects with savings earned from positive bottom lines.<sup>1</sup> In New York, by contrast, we could only make equity contributions of 25% to pay for our capital investments in 1996, and by 2003 this had worsened to an 18% equity financing contribution rate. This is a tangible consequence of the long term poor profitability of hospitals in our state.

**Figure 2. Equity Financing Ratios, New York and the United States**



Source: GNYHA analysis of Medicare cost reports.

**Trend 2. The Hospital and Health Plan Relationship is Excessively Imbalanced**

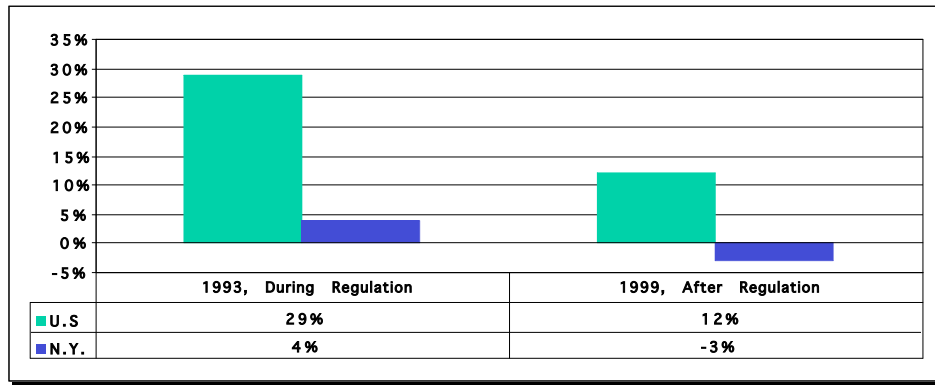
The causes of hospitals’ dismal financial condition are complex. They certainly include the loss of critically important Medicare reimbursement since the passage of the Medicare Balanced Budget Act in 1997, and most recently, Medicare’s disappointing decision to dilute hospital payments in the metropolitan New York City area by deeming three counties in New Jersey to be part of our labor market. We have been vigorously challenging that decision in court, but it has unfortunately already resulted in the near elimination of any inflation increase to hospital Medicare payment rates for 2005 and 2006. However, Medicare cannot be blamed for all of our hospitals’ troubles and for a better understanding we must look closer to home.

Hospital financial troubles are deeply rooted in New York’s unique legacy of regulation and rate-setting. As you know, the regulated payment system that expired in 1996, NYPHRM, established cost-based inpatient rates for Medicaid and Blue Cross. Other private insurance companies were required to pay a fixed “mark-up” of 11% above the Blue Cross rate. This produced breakeven profitability for years before HCRA was enacted. After deregulation in 1997, hospitals’ precariously balanced financial well-being collapsed because health insurers were able to establish negotiated rates by using the old NYPHRM payments as the ceiling. That

<sup>1</sup> The Almanac of Hospital Financial and Operating Indicators, Ingenix, 2004.

is, plans negotiated down from a State-set, cost-based rate rather than from market-set, charge-based payments, as had been the case in other states. In addition, the State was no longer able to rescue ailing hospitals through special rate appeals or revenue enhancements because it no longer controlled most of hospital revenue. The impact of NYPHRM on private payer payments is illustrated by Figure 3, below. In 1993, private payers around the country paid a 29% “mark-up” above hospital costs, but in New York, they only paid 4% above costs due to rate regulation. In 1999, the impact of aggressive managed care expansion around the country dropped the private payer margin to 12% for U.S. hospitals, but in New York, private payers actually paid less than hospital costs.

**Figure 3. Private Payer Payments in Relation to Cost, Pre- and Post-Deregulation**

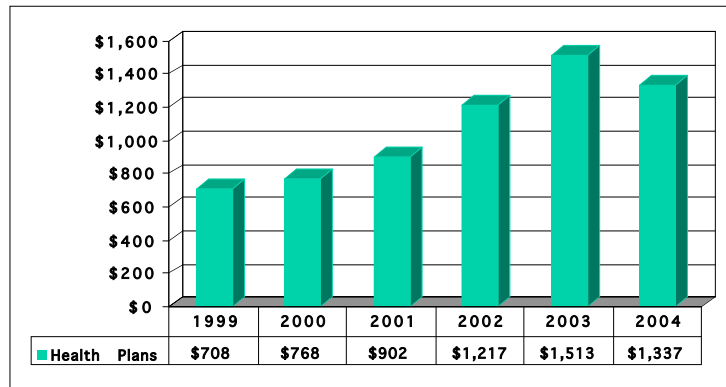


Source: Medicare Payment Assessment Commission (MedPAC).

The market environment has continued to evolve, but hospitals have never been able to make up the substantial lead that was provided out of the starting block to commercial health plans as a result of rate regulation.

This lead is clearly reflected in the disparate profitability of the hospital and health plans sectors. Thus, despite the fact that hospitals have suffered operating losses in every year since the late 1990’s, New York’s health plans have enjoyed growing profitability, rising from \$708 million in 1999 to \$1.4 billion in 2004.

**Figure 4. NYS Private Health Plan Net Profits 1999-2004 (\$ in millions)**



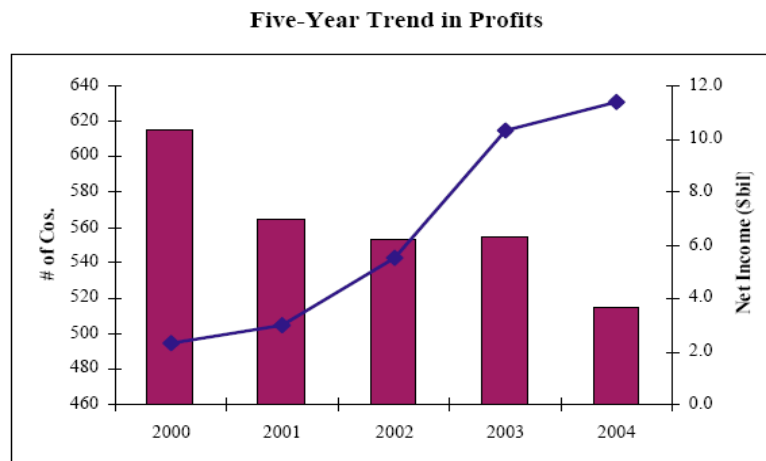
Source: NYS Insurance Department Health Plan Annual Financial Statements (NAIC Statements). Excludes Pre-paid Health Services Plans. Includes HMO, PPO, and indemnity insurance products.

In the past few years, New York has followed the national trend toward payer consolidation and we are seeing formerly regional health plans merge into national, publicly traded mega-payers, some with nationwide enrollments rivaling the entire Medicare program. In 2003, the major payers in the downstate area were Empire, HIP, Oxford, Aetna, GHI, United, and Cigna. In 2006, our major payers will be WellPoint (which just acquired the for-profit Empire), United (which acquired Oxford in 2004 as well as Americhoice, a major Medicaid HMO), HIP-GHI (which announced their merger in 2005), Aetna and Cigna. I would not be surprised if in 2006 we see additional announcements of payer consolidation.

This phenomenon threatens to increase the imbalance between health plans and hospitals because of the enormous resources at the disposal of the mega-plans<sup>2</sup> as well as the loss of regional flexibility and accountability.

As seen from Figure 5, which depicts the growth in health plan profitability nationally as the number of plans has decreased through merger and acquisition, health plan consolidation has been profitable for the plans and will likely continue.

**Figure 5. Health Plan Consolidation Coincides With Increased 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.

An additional troublesome problem confronting hospitals and other health care providers is the increased administrative cost attendant to doing business with health plans at a time when financial resources are increasingly limited. Each plan has disparate rules that change frequently and providers must deal with well over a dozen plans at any given time. As seen in Figure 6, health plans spend about 20% of every premium dollar on their administration and profits and

<sup>2</sup> For example, United and WellPoint each had revenues of about \$33 B through the third quarter of 2005 with net profits of \$2.4 B (7.3% profit margin) and \$1.8 B (5.4%) respectively. Cigna made \$1.4 B, or an 11.3% profit margin, through September 2005, and Aetna made \$1.2 B, or 7.3%. Source: Yahoo! Finance, Section on Health Care Plans.

only about 80% on actual medical care. Unfortunately, the trend has been to spend less on medical care (the medical cost ratio) and more on overhead and profits. Each plan's administrative costs in turn beget huge additional costs for providers, who must be able to comply with *each* plan's unique, ever-changing, and often seemingly arbitrary rules and processes in order to be paid for medical care that they have already provided. The costs to the entire system from the lack of health plan standardization, as well as providers' need to chase payment for services that have already been delivered, are enormous.

**Table 1. Medical Cost Ratios Over Time, Selected Health Plans**

	2000	2001	2002	2003	2004	% Change*
Aetna	87.0	89.8	82.8	78.3	N/A	-10.0
Anthem	84.8	84.6	82.4	80.8	N/A	-4.7
United Health	84.9	84.2	81.5	80.0	N/A	-5.8
WellPoint (excl. Anthem)	80.8	81.5	81.5	80.5	N/A	-0.4
Empire	88.4	88.0	85.0	84.9	85.5	-3.3
GHI	89.0	89.3	89.5	89.6	89.4	0.5
HIP	85.8	83.3	81.4	79.4	80.3	-6.4
Oxford	76.6	78.6	79.0	79.1	80.0	4.5

\* % Change 2000 - 2003 for Aetna, Anthem, United Health and WellPoint; % Change 2000 - 2004 for Empire, GHI, HIP and Oxford.

SOURCE: Lehman Brothers Equity Analysis; New York State NAIC Financial Statements for Empire, GHI, HIP, Oxford.

NOTES: Medical cost ratio is payments to physicians, hospitals, pharmaceutical firms, and other providers and suppliers of medical care services as a percentage of insurance premium revenue.

### **Trend 3. Hospital Ambulatory Care Payments are Underfunded**

Each year, New York's hospitals just about break even on providing Medicaid inpatient services, but lose *\$1.2 billion* providing Medicaid outpatient clinic and emergency department (ED) services. This is because clinic rates and ED visit payments have been capped for more than a decade. Because of the losses associated with these services, we are urging that ED cap be raised, as explained more fully later in my testimony.

As seen in Table 2, below, the Medicaid ED cap on average results in \$200 million in hospital losses per year. From 1999 through 2003, the last year for which cost report data is available, the cap imposed more than *\$1 billion in losses* on New York's hospitals. If the cap is not addressed, then it will impose another \$244 million in losses on an ailing hospital industry in 2006. As noted, hospitals barely break even providing Medicaid inpatient services and the answer therefore cannot be to shift funding from inpatient to outpatient services. Rather, ambulatory services must be funded adequately on their own.

**Table 2. Annual Losses Attributable to the Medicaid ED Cap, 1999-2003**

Year	ED Oper. Cost Per Visit	ED Payment Per Visit	# of Visits	Hospital Gain/(Loss)
1999	\$ 273	\$ 95	1,069,687	\$ (190.4) M
2000	\$ 285	\$ 95	1,021,774	\$ (194.1) M
2001	\$ 298	\$ 95	1,070,862	\$ (217.4) M
2002	\$ 315	\$ 95	1,077,710	\$ (237.1) M
2003	\$ 337	\$ 95	913,231	\$ (221.0) M
Total Loss				<b>\$ (1,060.0) M</b>
2006 (proj.)	\$ 400	\$ 95	800,000	\$ (244.0) M

Cost/visit computed from NYS institutional cost reports; 2006 projected cost/visit and visit volume based on compound annual growth in costs and visits. The reason the number of fee-for-service visits is declining is increasing enrollment in Medicaid managed care.

Inadequate payments for ambulatory care also make it exceedingly difficult to restructure the acute care system, the goal of the Commission on Healthcare Facilities in the 21<sup>st</sup> Century. This is because if it may be possible to close an acute care hospital in a community where inpatient capacity is otherwise sufficient, but only if there is adequate ambulatory care to ensure the community's access to health care services. An example is the replacement of a hospital with a freestanding emergency room in a community that no longer needs a full-service hospital but does need access to emergency services. The problem is that it is not financially feasible to support a freestanding emergency room without other significant subsidies because the ED payment structure is so inadequate. In this regard, the underfunding of the Medicaid emergency department and outpatient clinic system is a formidable obstacle to restructuring the acute care system.

#### **Trend 4. Niche Providers Are De-Stabilizing the System**

Over the last decade, medical advances and changes in reimbursement have shifted services traditionally provided through the inpatient hospital setting into ambulatory settings, including physician offices and freestanding ambulatory service centers. Niche providers, particularly ambulatory surgery centers, create additional costs within the health care system and, at the same time, have a significant negative impact on the clinical operations and financial stability of New York State hospitals. They add to costs because hospital fixed costs already in the system – including capital costs and operating expenditures to care for the uninsured, maintain 24/7 emergency and trauma services, and provide other community benefits – cannot be reduced. The result is that new costs associated with creating non-hospital provider settings are simply additive to total costs in the system. See Uwe E. Reinhardt, *Spending More Through 'Cost Control: Our Obsessive Quest to Gut the Hospital.* (Health Affairs: Vol. 15, No. 2, Summer 1996) 148.

Niche providers also hurt the health care system in the long run by siphoning off profitable procedures for insured patients from community hospitals which the hospitals had relied upon to cross-subsidize money-losing community benefits, such as those outlined above. Needless to

say, niche providers themselves do not provide community services, nor are they subject to the same quality oversight and regulatory reporting requirements as are hospitals.

Since 1998, there has been explosive growth of niche providers within New York State. In that year, 31 ambulatory surgery centers were operating in New York and by 2003, another 84 ambulatory surgery centers had been approved by the Public Health Council of New York State. There are an unknown number of other procedures that have migrated to totally unregulated office-based settings because, other than Medicaid payments that are made for such services, the State does not collect information that would enable it to track this phenomenon in order to evaluate the magnitude, cost, and quality of the services provided.

Thus, GNYHA strongly supports a moratorium on the establishment of additional niche providers in New York State. GNYHA has communicated this position to the DOH Commissioner as well as to the Public Health Council, which has the authority to approve establishment applications.

In addition, we urge the New York State Legislature to enact standards of care for services provided in freestanding ambulatory surgery centers and physician offices to ensure patient safety. We strongly support establishing standards for office-based surgery practices as well as legislation that would require office-based surgery practices to report incidents to the Commissioner of Health.

Finally, we recommend that legislation be enacted to require unregulated providers to submit SPARCS information limited to office-based procedures such as endoscopies so that the State can have information on the extent, nature, and quality of such services.

### **The Hospital System is Deteriorating**

In years past when I came before you with grave concerns about hospitals' financial condition, you asked me whether hospitals have actually closed. Now, for the second year in a row, my testimony contains a list of closed hospitals, closed hospital sites, and hospitals "in flux", i.e., in the stages of closure. This is an unprecedented set of information that is provided to you and it is not a pleasant task. But, it is the result of the imbalances I have described, and there are many hospitals suffering great financial instability that are not on this list but may be by the next time that I come before you if the cuts in the Executive Budget are enacted.

Since I gave you last year's list during last year's budget testimony, you, of course, created the Commission on Health Care Facilities in the 21st Century. As you know, the Commission has begun its work in earnest. GNYHA supported the creation of the Commission, and is working hard to help the Commission by providing data, analyses, and our unique viewpoints. We support the Commission and rational downsizing because, as I have said many times, it is better to have 80 financially healthy hospitals, with the resources to provide quality health care for their communities, than 100 struggling ones. Having said this, downsizing and restructuring must be done in a way that ensures that community needs will continue to be met, that the most vulnerable New Yorkers, including the poor and uninsured, continue to have access to health care services, and to ensure that displaced health care workers are either absorbed by remaining

institutions or retrained for other positions. I discuss the issue of displaced health care workers in more detail later in this testimony.

**Table 3. Acute Care Hospital Closures/Conversions Since 1996 in NYS (Working List)**

<b>Hospital</b>	<b>County</b>	<b>Date Acute Care Closed or Converted</b>
Bronx-Lebanon Hospital Center -Fulton Pavilion (converted to behavioral health)	Bronx	Early 1990's
Staten Island University Hospital South site/North Shore-LIJ (converted primarily to behavioral health; some acute care beds remain)	Richmond	Early 1990's
Mohawk Valley	Herkimer	June 1996
Julia Butterfield	Putnam	June 1996
Jackson Heights – Wyckoff	Queens	December 1996
Little Neck	Queens	December 1996
Leonard Hospital	Rensselaer	April 1997
Samaritan Medical Center – Stone Street Division	Jefferson	December 1997
Union Hospital (now part of St. Barnabas, now a D & T center)	Bronx	January 1998
Salamanca	Cattaraugus	July 1998
Columbus Community Healthcare	Erie	October 1998
Parsons Hospital (Flushing North)	Queens	June 1999
St. Johns Episcopal Community Hospital	Suffolk	June 1999
St. Mary's Hospital	Monroe	November 1999
Massapequa General Hospital Inc.	Nassau	August 2000
Olean General Hospital	Cattaraugus	May 2001
Genesee Hospital (now a clinic)	Monroe	2001
Yonkers General (now part of St. John's Riverside, converted to behavioral health)	Westchester	2002
Brooklyn Jewish Hospital Division of Interfaith Medical Center	Kings	2002
Myers Community Hospital	Wayne	January 2003
Mary McClellan Hospital	Washington	April 2003
Bayley Seton Hospital/Saint Vincent Catholic Medical Centers	Richmond	Announced April 2003
Caledonian Campus/Brooklyn Hospital Ctr	Kings	2003
Island Medical Center (formerly Hempstead)	Nassau	July 2003
Staten Island University Hospital Concord site/North Shore-LIJ	Richmond	September 2003
St. Agnes Hospital	Westchester	October 2003
Sheehan Memorial Hospital (now rehab/detox)	Erie	October 2003
Florence D'Urso Pavilion/Our Lady of Mercy Healthcare System	Bronx	January 2004
Herbert and Nell Singer Division/Beth Israel Medical Center	New York	August 2004
St. Joseph's Hospital/ Saint Vincent Catholic Medical Centers	Queens	October 2004
New York United Hospital Medical Center	Westchester	2005

St. Mary's Hospital	Kings	September 2005
The Hospital, Sidney, NY	Chenango	2005 (converted to SNF)

**Table 4. Bankruptcies**

<b>Hospital</b>	<b>County</b>	<b>Date</b>
St. Vincent Catholic Medical Centers	Kings, New York, Queens, Richmond	2005
Brooklyn Hospital Center	Kings	2005
Brunswick Hospital Center	Suffolk	2005
Parkway Hospital	Queens	2005

## **THE EXECUTIVE BUDGET'S MEDICAID AND FHP PROPOSALS WOULD DEVASTATE NEW YORK'S TEACHING HOSPITALS AND THOSE SERVING LOW INCOME PATIENTS**

Before detailing the devastating impact that the Governor's proposed budget would have on the hospital community and those they serve, I want to note that during 2006, our hospitals will lose \$250 million in annual Medicaid grant funding because of the end of the Community Health Care Conversion Demonstration Project (CHCCDP). This is a program that was part of New York's section 1115 waiver and it has helped hospitals serving the highest proportions of Medicaid and uninsured patients to continue their missions and increase primary care and managed care services to the Medicaid population. We are in the final year of CHCCDP and the loss of these annual funding grants will have a major impact on hospital budgets. Thus, we start the State budget discussions from behind because we will have to cope with the loss of what has been a critically important annual funding source from the Medicaid program.

Given their overall financial situation, hospitals in New York State cannot sustain new Medicaid cuts, and the Governor's proposed cuts to Family Health Plus (FHP) would be devastating to families and add to the ranks of the uninsured. The Governor's proposed fee-for-service hospital cuts would particularly assault New York's teaching hospitals, public hospitals, and others that serve large numbers of low-income patients.

In order to achieve \$163 million in general fund savings in 2006-07 from hospital Medicaid fee-for-service cuts, the Executive Budget would impose \$431 million in annualized losses on hospitals<sup>3</sup>. The impact of the cuts is much higher than the State savings because hospitals would feel the loss of Federal Medicaid matching funds. The \$431 million estimate includes the ripple effect of Medicaid cuts on workers compensation and no fault insurance rates, which are tied by statute to Medicaid rates, as well as projected payment reductions from the accelerated enrollment of disabled populations into Medicaid managed care and uncompensated care resulting from proposed FHP co-payment increases. I should note that even though there is no way of modeling the impacts, Medicaid fee-for-service cuts also reduce the amounts paid by Medicaid managed care plans, whether by contract or by operation of law, and so the actual impacts are far greater than those described here.

The cuts, each of which is described in detail below, would: eliminate any increase in payment rates to account for inflation; re-base and lower the component of teaching hospitals' rates associated with GME; drastically reduce payment for alcohol and substance abuse inpatient detoxification services; eliminate certain mental health payments for outpatient services dually licensed by the Office of Mental Health (OMH) and the Department of Health (DOH); and allow the Commissioner of Health a freer hand to selectively contract for hospital services and negotiate hospital fee-for-service rates.

The budget would also seek nearly \$47 million in State savings by imposing over \$93 million in all-funds reductions on FHP and Medicaid benefits as well as restrict enrollment in these programs. The FHP and Medicaid benefits and eligibility cuts, besides having a severe and

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<sup>3</sup> All hospital impact numbers are based on estimates provided by the Healthcare Association of New York State.

negative impact on individuals enrolled in these programs, would add to hospital losses by creating more uncompensated care.

These cuts would, furthermore, have a disproportionate impact on the State’s teaching hospitals. Fully 91% of the impact Governor’s proposed rate cuts, not including the ripple effects on other payers or uncompensated care, would fall on teaching institutions. This would devastate the core of New York’s fine hospital system.

**Table 5. Fiscal Impact of the Proposed Executive Budget Cuts, SFY 2006-2007**

Hospitals			Medicaid Cost Containment Measure (\$ in Millions)							
Category	N	% of Total	Trend	GME to Cost	LOS Offset	Detox	Mental Health	ARMS	Total	% of Total
New York State	210	100%	(184.2)	(82.7)	(53.0)	(53.0)	(8.0)	(1.8)	(382.7)	100%
Teaching	105	50%	(162.8)	(79.2)	(50.3)	(48.7)	(6.7)	(1.4)	(349.1)	91%
Major teaching	55	26%	(125.9)	(70.7)	(39.5)	(34.8)	(6.3)	(1.1)	(278.3)	73%
Non-major teaching	50	24%	(36.9)	(8.5)	(10.8)	(13.9)	(0.5)	(0.3)	(70.9)	19%
Non-teaching	105	50%	(21.4)	(3.5)	(2.7)	(4.3)	(1.3)	(0.4)	(33.6)	9%

**Note:** Major teaching hospitals are those with one or more residents for every four beds; minor teaching hospitals are those with fewer than one resident for every four beds.

## DETAILED DESCRIPTION OF PROPOSED CUTS

Below is a detailed description of the Governor’s hospital proposals in order of magnitude and an explanation of why they must be defeated.

**Proposal:** Eliminate the Medicaid Trend Factor  
**Hospital Loss:** \$184 million

The Executive Budget proposes eliminating the 2.5% Medicaid “trend factor”, or inflation adjustment, for calendar year 2006. The Medicaid trend factor, which is based on the consumer price index for urban (CPI-U) consumers rather than that tied to actual medical inflation, is already inadequate to enable Medicaid providers to keep up with the rising costs of caring for Medicaid patients. For example, in 2006, pharmaceutical costs alone are projected to increase between 7% and 9% for outpatient drugs, 9% to 11% for clinic-administered drugs such as chemotherapy, and between 5% and 7% for inpatient drugs, all reflecting a mixture of price increases, volume and mix, and new drugs on the market.<sup>4</sup> Aggressive efforts to negotiate volume discounts from device manufacturers will still result in price increases for medical devices and supplies of much more than 2.5%, in some cases reaching double digits. Workforce costs (due to severe workforce shortages), and medical malpractice insurance costs are also rising much faster than the CPI-U. Thus, while nine-year compound growth in the *medical* CPI-U from 1995 through 2004 was 47%, growth in the CPI-U for *all consumers* used for the Medicaid trend factor was 27.1% (source: U.S. Bureau of Labor Statistics).

<sup>4</sup> American Journal of Health-System Pharmacists, Vol. 63 (January 15, 2006), p. 136.

In the face of chronic underpayment for normal medical inflation, the Executive Budget proposes to deny hospitals even this inadequate inflation update. The Legislature should not only reject the Executive's proposal, it should support replacing the trend factor with an inflation update that truly accounts for the rising costs hospitals are experiencing. At the very least, I urge the Legislature to reject this damaging cut.

**Proposal: Re-base GME Payments**  
**Hospital Loss: \$83 million**

The Executive Budget proposes to slash payments to certain teaching hospitals by updating the cost base for just one component of the hospital rate, namely, the portion that reimburses hospitals for GME. As incredible as it may seem, the inpatient hospital Medicaid reimbursement system was initially developed based on 1981 costs, and while it has been subjected to a variety of adjustments over time, the costs used to develop the rates have never been systematically updated to a more current period. Under this proposal, the Executive would selectively update just the GME component of the rate by comparing projected 2003 costs based on hospitals' 2001 cost reports with actual 2003 Medicaid GME payments. For any hospital for which the Medicaid GME payments exceed Medicaid-related GME costs, Medicaid payments would be cut.

GNVHA has supported a careful analysis of how the entire Medicaid payment system could be updated to more closely reflect current costs and clinical care. However, we strenuously object to the selective updating of portions of the rates, or sub-sets of DRGs as in the detox cut. In the case of the proposed GME cut, a hospital's GME rate component might appear higher than its current costs because it had cut the number of physician residents it was training in the mid- to late-1990's. At that time, there were strong policy directives from both Washington, D.C. and Albany in support of such actions because of the (erroneous) belief that we had a physician surplus. However, any hospital that cut its number of medical residents had to add non-resident patient care staff like nurses and practicing doctors to take over the work that residents formerly had performed. In other words, what had been called GME costs should have been re-labeled additional operating costs because the hospital's total costs of patient care did not necessarily change. The Governor's proposal does not look at total patient care costs and would result instead in a cut to basic patient care. This cut will severely damage a number of teaching hospitals in the State and particularly those that tried to respond to State and Federal policy directives that they reduce the number of residents in training. The Legislature should reject this proposal in favor of true reform of the Medicaid reimbursement system.

**Proposal: Reduce Reimbursement for Hospital Inpatient Alcohol and Substance Abuse Detoxification Services**  
**Hospital Loss: \$53 million**

The Executive Budget would slash funding for inpatient hospital detoxification services by phasing in a much lower per diem rate to replace the current hospital inpatient case payment rate for six detox "diagnostic related groups", or "DRGs", that are designed for detox patients without other clinical complications or who leave against medical advice. These DRG payments would be replaced with a per diem rate based on the amount paid to community-based, non-hospital providers in the region. The community-based provider per diem payment downstate is

\$349; the payment upstate is \$260. The phase-in would work as follows: from April 1, 2006, through December 31, 2006, a hospital would receive the higher of (a) 75% of the case payment rate plus capital and worker recruitment and retention (R&R) add-ons *or* (b) 120% of the per diem rate for community-based detox plus R&R add-ons. In calendar year 2007, the hospital would receive only the higher of (a) 50% of the case payment rate plus capital and R&R add-ons *or* (b) 120% of the per diem rate for community-based detox plus R&R. Beginning in 2008, the Department of Health and the Office of Alcohol and Substance Abuse Services would develop new regulations providing for a new per diem payment.

This cut will be devastating for hospitals that provide detox services, and, worse, will be devastating for the patients in need of these services. Even without clinical complications, there are a variety of reasons that a physician may strongly recommend inpatient detox as more clinically appropriate than outpatient care, based on a patient's clinical profile and history. Not all patients can appropriately be served in non-hospital settings. In addition, alcohol detoxification and detoxification for benzodiazepine addiction can have many clinical effects. Thus, many patients are best served in the inpatient setting, supervised by clinicians.

The low "community based" reimbursement rates proposed by the Executive Budget also do not take into account overhead costs and other expenses for hospital services such as emergency department standby costs, trauma and burn center costs, uncompensated care, costs of emergency preparedness, etc. that are not provided by community detox providers. As with the GME re-basing cut, described above, this proposal would selectively pick out one type of payment, slash it, and fail to readjust the rest of the payment system to account for the changed payment methodology. That is, if payments for inpatient detox are essentially eliminated, the fixed and other infrastructure costs that ripple through all other DRGs should be adjusted in a recalibration of payments. The Executive proposal of course would not do this but would simply perform one half of the equation.

The hospital community recognizes that a number of questions and concerns have been raised about the inpatient detox system in New York State. Indeed, GNYHA along with other associations have been working with the State to identify reforms of the current system to ensure that Medicaid beneficiaries in need of detox receive the appropriate level of care and also to ensure that the system is not abused. We will soon be sharing with the State Legislature and the Governor's office a proposal that we believe will eliminate the inappropriate use and over-use of inpatient detox services, create hospital alternatives to inpatient detox, and implement mechanisms to ensure that detox truly leads to outpatient drug treatment. We were heartened that the Governor included in the Executive Budget proposal a demonstration project along these lines, and expressed interest in working with us during the 30-day amendment period on alternatives to reimbursement rate cuts. We look forward to working with the Governor and the Legislature on proposals that will truly improve the care for New Yorkers suffering from drug and alcohol addiction. In the meantime, reimbursement rate cuts will not solve any problems, exacerbate the problems already plaguing financially struggling hospitals, and should be rejected by the State Legislature.

**Proposal: Eliminate Length of Stay Offset (LOS) in Volume Adjustment**  
**Hospital Loss: \$53 million**

The Executive Budget would cut hospital rates by eliminating the so-called length of stay (LOS) offset in the Medicaid volume adjustment. By way of background, the volume adjustment is a vestige of the old all-payer rate-setting system under which Medicaid reduces the operating component of a hospital's rate when its total volume of patients increases above a certain threshold. The theory behind this was that full hospitals can operate more efficiently and that their variable costs per case are lower. A hospital that would otherwise receive a payment cut because its business had increased, however, could avoid the negative adjustment if its LOS decreased, thus, essentially, getting "credit" for operating more efficiently. The Executive Budget proposes eliminating the LOS "offset" or "credit", thus subjecting hospitals that have increased the number of patients they treat *and* become more efficient by reducing the average length of stay to a reimbursement rate cut. This cut makes no sense, and penalizes hospitals precisely because they have attracted more patients and increased efficiency.

The volume adjustment may have made sense in a totally regulated environment where the well being of providers and the communities they served was determined by State government. However, today the fates of providers and their patients are in the hands of the market, where health plans increasingly control access and payments for commercial, Medicaid, and Medicare patients. In this environment, the volume adjustment cut actually hurts hospitals that are competing effectively for more patients through better quality, patient service, and reduced LOS. Because it has no rational place in a market-driven health care environment, we urge that the negative volume adjustment be eliminated.

I will note that the volume adjustment works both ways. That is, Medicaid will increase the payments of hospitals that are losing patients as a way to help them meet their fixed costs. The hospitals that receive these so-called positive volume adjustments may serve vulnerable communities and their missions should be protected. We believe it is important to know how many and which hospitals are actually receiving positive adjustments and believe that negative adjustments may far out-weigh the positive at this time. We urge that the negative volume adjustment be eliminated but that appropriate support be continued for hospitals that may be receiving positive adjustments.

**Proposal: Cut the Health Workforce Retraining Initiative Grant Program**  
**Hospital, Worker Loss: \$32 million**

The Executive Budget proposes to cut the HCRA workforce retraining initiative grant program in half, for a cut of \$32 million. This is the worst possible time to cut this program. As previously discussed, hospitals and nursing homes across the State have been closing, restructuring, downsizing, and laying off workers. In addition, the Commission on Health Care Facilities in the 21st Century is working on recommendations for further downsizing. The last thing the State should do at such a time is cut funding for workforce retraining, which has been used to great effect to help place displaced health care workers, help them train for new positions, upgrade their skills, and, generally, improve the quality of care received in hospitals and nursing homes throughout the State. Rather than cutting workforce retraining dollars, the State needs a new

strategy for investing in the workforce. Later in this testimony I will discuss a new proposal for your consideration that we have developed jointly with 1199 SEIU to help displaced health care workers make the transition to new employment.

**Proposal: Selective Contracting for Hospital Services**  
**Hospital Loss: \$ ? million**

The Executive Budget would grant the Commissioner of Health virtually unlimited discretion to negotiate inpatient reimbursement rates for certain services that she would designate, going back on a hard-fought compromise passed in the 2005-06 budget. Hospitals that did not successfully negotiate lower rates of payment would be barred from billing Medicaid for the designated services, unless the Medicaid patient was admitted due to an emergency or the hospital gained prior approval from the State. The Executive's proposal allows the Commissioner to designate any services she sees fit. The bill would allow her to do so through a request-for-proposals (RFP) process, or to waive the State's RFP requirements. A Federal waiver of clients' rights to freedom of choice of providers would be required to implement this proposal. GNYHA is very concerned that this proposal is a way of allowing the Commissioner of Health to implement hospital Medicaid reimbursement rate cuts without having to go through the Legislature, as is currently the case. While we would be willing to discuss alternative payment models, and worked with the Legislature and the Governor's office last year on what we think was a common-sense compromise, we continue to think that granting such broad discretion to the Commissioner is unwise and circumvents the legislative process. GNYHA strongly urges the Legislature to reject this proposal as put forward in the Executive Budget. Because the Division of the Budget ascribed no Medicaid savings to this proposal, the Legislature could reject the selective contracting amendments without having to "buy back" any savings associated with this provision.

**Proposal: Eliminate Outpatient Mental Health Day-Night Rates and ARMS**  
**Hospital Loss: \$9.8 million**

According to State officials, there are 10 hospitals in the State with outpatient mental health programs that are duly licensed by the Department of Health and the Office of Mental Health and that receive a so-called day-night rate add-on for certain outpatient mental health services. Under this proposal, payments to these programs would be reduced the Medicaid outpatient rate, which is \$67.50 per visit, rather than paying the higher rate currently in effect. This proposal would cost these hospitals \$8 million annually. In addition, the Alternative Rate Methodology System, or ARMS, which is used to reimburse 7 hospitals in the State for outpatient mental health services they provide, would be eliminated. The ARMS proposal would cut these hospitals by \$1.8 million per year. GNYHA urges the Legislature to reject these cuts.

**Proposal: Family Health Plus and Medicaid Enrollment Restrictions**  
**Hospital Loss: \$15 million**

The Executive budget would shift hundreds of millions of dollars in costs to Medicaid beneficiaries through increased co-payments, eligibility changes, and benefit reductions, placing

an enormous burden on an extremely vulnerable low-income population. GNYHA strongly oppose these changes. The proposals include:

- Increasing the Family Health Plus (FHP) co-payment for non-emergency ER services from \$3 to \$25;
- Making co-payments “mandatory” by allowing providers to decline services to patients who refuse to make a co-payment;
- Eliminating eligibility for FHP for employees in firms with more than 100 employees, thus adding to the uninsured problem in the State;
- Eliminating the six-month guarantee of eligibility for Medicaid managed care and FHP enrollees, thus denying health insurance and disrupting continuity of care; and
- Implementing a look-back penalty for home health care services

GNYHA strongly opposes all of these cuts, which will add to the number of uninsured New Yorkers and make our population significantly less healthy by cutting off access to essential services. A substantial portion of the proposed FHP copayment requirements can be expected to translate into hospital bad debt because patients will be unable to pay. The Executive budget proposal to give providers the ability to turn patients away if they are unable to pay a co-payment is not the answer; we are unlikely to deny services on this basis, particularly in the ER. GNYHA therefore urges the Legislature to reject these changes to our important public health insurance programs.

Rather than add to the number of uninsured and increase out-of-pocket health care costs for low-income New Yorkers, GNYHA and our partner, 1199 SEIU, will be offering for your consideration a comprehensive health insurance coverage proposal that we call “Cover New York.” This 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 would receive tax credits to help them purchase coverage for their employees, while the State’s largest 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. We expect to have the details of the proposal ironed out within the next few weeks and look forward to sharing it with you.

## HCRA AMENDMENTS

The Executive Budget proposes a number of changes to the Health Care Reform Act (HCRA). As previously mentioned, one change GNYHA strongly opposes is to cut desperately needed worker retraining funds by \$32 million annually. This cut comes at a time when the State, through the Commission on Health Care Facilities in the 21<sup>st</sup> Century, is looking to downsize and restructure the hospital and nursing home communities, which has the potential to displace thousands of health care workers who will be in dire need of placement, training, and retraining services. This cut must not only be rejected, but new investments will be needed in worker placement, training, and retraining services. 1199 SEIU and GNYHA look forward to working with the Governor and the State Legislature on a displaced health care worker initiative for inclusion in the final 2006-07 State budget, which we discuss later in this testimony.

The Executive also proposes dedicating new funding to HCRA, including all funds from health care insurance company conversions, and funds from an increase in the Statewide cigarette tax. GNYHA strongly supports dedicating all of these funds to important health care programs. None of these funds should be diverted to the general fund for non-health care purposes.

Several HCRA provisions in the Executive Budget we strongly support include funding of HEAL New York (although we do not support the diversion of \$25 million to Roswell Park Cancer Center); new guidelines for hospitals to follow when designing financial assistance policies; and an increase in the excess medical malpractice pool, to ensure against the collapse of the excess market. With regard to HEAL New York, we also support additional language to add flexibility for the Department of Health and the Dormitory Authority to enable them to implement the program in a more efficient and timely manner. To date, the State has had difficulty releasing desperately needed HEAL New York restructuring dollars due to restrictive language in the original statute.

With regard to hospital financial assistance policies, about which there has been much publicity and debate, I wish to underscore the following points.

First, the \$850 million available in HCRA hospital indigent care pool payments only covers half of hospitals' uncompensated care costs (not charges) as calculated by the Department of Health (DOH). This has been the case for several years now. Second, the amount that hospitals receive from the pool depends on the amount of free care they provide. However, the pool on average covers only 50 cents of every dollar they expend. Put another way, for every extra dollar of free care they provide, the best the average hospital can do is to lose 50 cents.<sup>5</sup> And third, as a limited, taxpayer funded pool that was created as a payer of last resort, hospitals have to balance the need to try and assist all patients who may need help paying their bills with taking responsible steps to ensure that withdrawals from the pool are justified.

All of our member hospitals expend significant resources assisting patients to apply for available insurance, especially Medicaid. They have trained units of Medicaid eligibility specialists who

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<sup>5</sup> Because of the pool formulas, the 50% coverage ratio is an average. Some hospitals receive as little as 10% of their costs, and some receive more than 80%. The coverage ratio is not tied to the absolute dollar value of free care but, rather, the proportion of total costs that are free care costs.

quickly assess whether a patient is likely to qualify, and they help patients and their families complete the complicated Medicaid application process. Hospital eligibility workers' expertise in this area is reflected by the high enrollment rate they achieve for patients they assist. They do this because full insurance is better for the patient as well as for the provider, and also reduces the draw on limited pool dollars.

Over the past two years, despite the fact that hospitals have been incurring \$1.6 billion each year in free care costs, there has been criticism of the lack of transparency in the way that hospitals apply their financial assistance policies and suggestions for a regulatory response that would impose Statewide or local requirements on how much free care hospitals must provide and how they are to provide it. We have been very concerned about mandates to provide even more free care since this would impose even greater losses on hospitals that may be ill-prepared to absorb them. The crisis of the uninsured is not a problem created by hospitals, and hospitals alone, even with partial funding from HCRA, cannot solve it. That is why we have been a strong partner with the Legislature and State in supporting insurance expansions.

The State Legislature designed the indigent care pool to be a payer of last resort, after normal collection efforts common to any business have been exhausted. Despite this, for the past several years hospitals have been engaging in extensive efforts to update their financial assistance policies and procedures. The hospital community's goal is to continue to identify and assist patients who might be eligible for coverage from Medicaid in particular to apply for enrollment, to update their financial assistance policies to take account of clarifications in Federal Medicare law as to permissible discounts and also the needs of their communities, and to provide greater consistency and standardization in the way that they administer their policies. They have accomplished this in different ways and at least some portion of the variation is attributable to the characteristics and needs of uninsured and underinsured patients who use their facilities as well as their administrative resources. Some hospitals have developed processes to try and handle financial assistance requests internally, for example, while others have proactively turned to their collection agencies to administer the Medicaid eligibility and financial assistance application process. With limited resources, hospitals are trying to be responsive to their communities and to act responsibly when drawing down capped HCRA pool dollars.

GNYHA has worked extensively with its member hospitals to provide technical assistance in these efforts. As noted, what we have discovered is that hospital policies vary to a certain degree in response to community demographics as well as hospital operations. We believe that member hospitals have been extremely responsive to the call for greater clarity and precision in their financial assistance approaches, and that the variation in their approaches reflects innovation intended to meet the particular needs of their communities. In the Executive Budget, there is a provision requiring hospitals to implement financial assistance plans as a pre-requisite for receiving funds from the pool. GNYHA supports this proposal, and is committed to working with the Governor and the State Legislature to enact State guidelines for financial assistance policies that ensure that the uninsured are treated with dignity and respect while providing the flexibility necessary to allow hospitals to provide as much assistance as possible within limited resources.

## NEW PRIORITIES AND INITIATIVES

### *Medical Malpractice Costs*

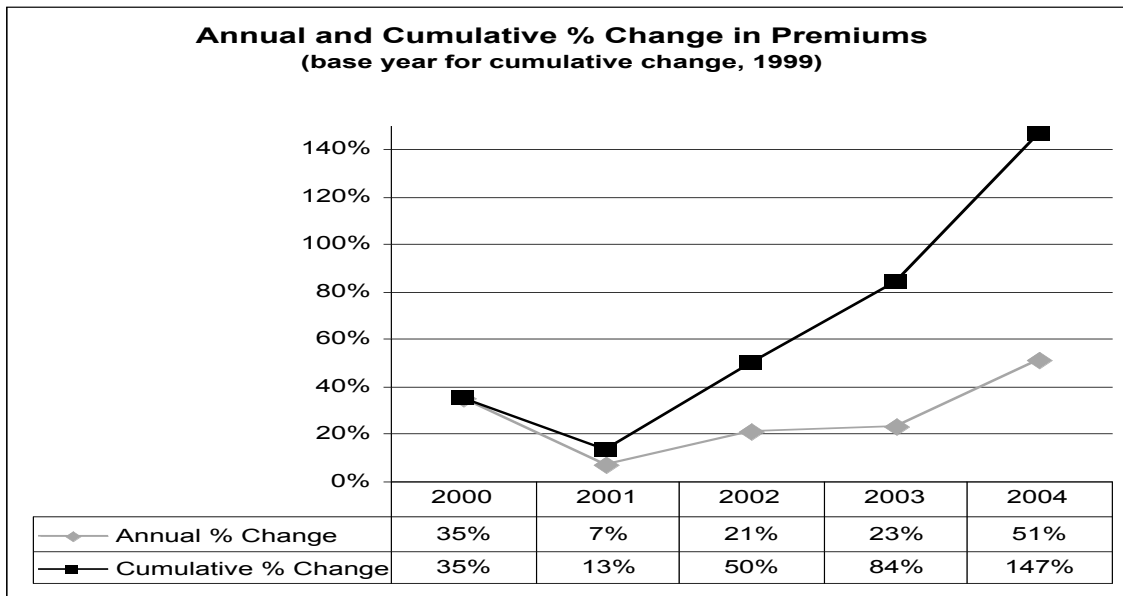
Liability insurance costs for hospitals and physicians have increased dramatically in recent years, making it difficult for health care providers to continue to provide critical services for their communities. To understand this complicated issue better, GNYHA conducted a comprehensive literature review on the subject and conducted surveys of member hospitals' premium and coverage experience from the period 1999–2004.

The GNYHA survey of hospitals in the downstate New York region showed that hospitals have experienced average annual malpractice insurance premium increases of 27% per year from 1999 through 2004, or 147% cumulatively. The study findings indicate that Medicare and Medicaid fail to reimburse New York hospitals adequately for the malpractice portion of their costs. While hospitals experienced average premium increases of 27%, the medical malpractice insurance component of the Medicare update increase by only 6.2%. Malpractice premium costs are not considered at all by Medicaid, which uses the consumer price index to update hospital rates.

Our survey respondents represented 36% of Statewide hospital operating expenses. If the study hospitals' malpractice costs expressed as a percentage of operating expenses were extrapolated to all hospitals in New York State, hospital malpractice premium costs would be estimated at close to \$1 billion annually.

Anecdotally, hospitals also reported to GNYHA that maternity services were becoming less and less affordable to provide, due to a combination of low reimbursements and high medical malpractice costs. In addition, a number of hospitals in New York State announced their intention to discontinue the provision of maternity services altogether. To find out just how unaffordable the provision of maternity services had become for hospitals in New York City, GNYHA conducted an in-depth analysis of hospital costs reports to determine whether hospitals were losing money providing maternity services. Strikingly, GNYHA learned from this analysis that virtually all—86%—of hospitals in New York City that provide maternity services lost money on those services in 2003. The aggregate losses amounted to \$195 million. If it were not for the ability to cross-subsidize from other, better-reimbursed services, hospitals would not be able to provide maternity services at all, leaving their communities without vital services. This also explains why so many financially failing hospitals discontinue providing maternity services as a precursor to closing their doors altogether.

**Figure 6. Annual and Cumulative Percent Change in Hospital Malpractice Premiums**



Source: GNYHA 2004 Medical Malpractice Survey. Note: Hospitals with self-funded plans may over-reserve in one year and then take money out the following year as a correction. One of the hospital respondents experienced a large correction in the 2000-2001 period.

We also found that, despite New York's best efforts to ensure affordable malpractice coverage to physicians, including through the excess malpractice pool now funded as part of HCRA, physicians face staggering premiums in many specialties and in areas of the state.

**Table 6. Physician Medical Malpractice Premiums by Specialty and Geographic Region for \$1 Million per Incident, \$3 Million Aggregate Coverage, 2004–05**

Territory	Specialty Class <sup>a</sup>		
	Neurosurgery	Obstetrics/ Gynecology	Internal Medicine <sup>b</sup>
<b>1</b> New York, Orange, Rockland, Sullivan, Westchester	\$160,213	\$97,663	\$18,316
<b>2</b> Bronx, Kings, Queens, Richmond	\$190,042	\$115,847	\$21,726
<b>3</b> Nassau, Suffolk	\$207,050	\$126,214	\$23,671
<b>4</b> Columbia, Dutchess, Greene, Putnam, Ulster	\$98,347	\$59,951	\$11,243
<b>5</b> Erie, Niagara	\$61,810	\$37,678	\$7,066
<b>6</b> Livingston, Monroe, Ontario, Seneca, Wayne, Yates	\$43,514	\$26,526	\$4,975
<b>0</b> All other counties	\$58,366	\$35,579	\$6,673

Source: Medical Liability Mutual Insurance Company

Note: Physicians must purchase an additional \$300,000 per incident, \$900,000 in aggregate to participate in the excess pool, which is described in greater detail below. The cost of this additional coverage is 6% of the premium shown in this table.

<sup>a</sup>Premiums reflect occurrence policy rates.

<sup>b</sup>Premium Class 13.

The malpractice insurance crisis has been exacerbated by the fact that New York’s insurers’, according to the National Association of Insurance Commissioners (NAIC), have the fourth worst loss experience of any State in the country, paying out, on average, \$1.44 in claims and expenses for every \$1.00 collected in premiums. In the past four years, two of the six companies offering physician coverage in New York became insolvent and two more stopped offering specific lines of coverage. However, the solution is not to allow them to charge more, because this would only make insurance more unaffordable than it already is.

The malpractice crisis appears to be affecting patients’ access to services as obstetrician/gynecologists (OB/GYNs) report that they have stopped or decreased the amount or nature of obstetrical care they perform because they fear malpractice exposure. In New York, the number of OB/GYNs per 100,000 population caring for patients decreased by 4.1% from 1998 to 2002, while the number of patient care physicians overall per 100,000 population declined by 1.5%. It is for these reasons and more that New York is one of 20 states listed by the American Medical Association as having a medical malpractice crisis.

GNYHA strongly supports the enactment of measures to ease the crisis in medical malpractice insurance costs. Last year, along with the Medical Society of the State of New York, the American College of Obstetricians and Gynecologists, 1199 SEIU, and the New York State Trial Lawyers Association, GNYHA proposed a State funding pool to help hospitals and physicians afford the increasing costs of malpractice insurance. We look forward to working with the Governor and the State Legislature on this proposal and others to ease this worsening crisis.

### ***Emergency Department Costs***

Medicaid payments for hospital emergency department (ED) visits have been capped since the early 1990's at \$95 per visit plus Medicaid's share of capital expenses. While hospitals barely break even on Medicaid inpatient services, the ED cap has been a consistent and major source of hospital financial losses and a major source of hospital financial distress. It should be eliminated or, at a minimum, raised to the average cost per visit in 2006. And, because inpatient payments just about cover patient care costs, the answer is not to shift money from inpatient services to the ED. Rather, ED payments must be adequate on their own to cover the costs of these vitally important services.

As was seen earlier in Table 2, which is reproduced below, the Medicaid ED cap on average results in *\$200 million in losses* on hospitals per year. From 1999 through 2003, the last year for which cost report data is available, the cap imposed more than *\$1 billion in losses* on New York's hospitals. If the cap is not addressed, then it will impose *another \$244 million in losses* on an ailing hospital industry in 2006.

**Table 2. Annual Losses Attributable to the Medicaid ED Cap, 1999-2003**

Year	ED Oper. Cost Per Visit	ED Payment Per Visit	# of Visits	Hospital Gain/(Loss)
1999	\$ 273	\$ 95	1,069,687	\$ (190.4) M
2000	\$ 285	\$ 95	1,021,774	\$ (194.1) M
2001	\$ 298	\$ 95	1,070,862	\$ (217.4) M
2002	\$ 315	\$ 95	1,077,710	\$ (237.1) M
2003	\$ 337	\$ 95	913,231	\$ (221.0) M
Total Loss				<b>\$ (1,060.0) M</b>
2006 (proj.)	\$ 400	\$ 95	800,000	\$ (244.0) M

Cost/visit computed from NYS institutional cost reports; 2006 projected cost/visit and visit volume based on compound annual growth in costs and visits. The reason the number of fee-for-service visits is declining is increasing enrollment in Medicaid managed care.

Hospital emergency departments provide essential services for their communities and are the ultimate safety net. They provide life-saving services day after day to all persons regardless of their ability to pay and are the difference between life and death for those stricken by serious illness or accidents. They cannot choose their patients, and cannot turn them away. As the front line of any natural or man-made disaster, they have become indispensable parts of the front line of emergency preparedness, relied upon to detect biological events as well as treat the victims of disaster. As hospitals generally suffer extreme financial distress, resulting, among other things,

in closure and bankruptcy, the system can ill afford to continue imposing losses of the magnitude imposed by the Medicaid ED cap.

Therefore, the ED cap should be eliminated and payments should be made at cost, or it should be re-set at projected average 2006 costs per visit of up to \$400. The annual fiscal impact on the State General Fund in 2006 of raising the cap to \$400 would be \$122 M.

### ***Assistance for Displaced Health Care Workers***

The Commission on Health Care Facilities in the 21<sup>st</sup> Century (“Commission”) has been statutorily charged with issuing recommendations by the end of 2006 to consolidate and restructure the acute care hospital system in New York State. This work will result in the closure of hospital beds and possibly whole institutions as well as changes in hospital missions from acute to ambulatory care, for example. The Commissioner of Health is directed to implement the Commission’s recommendations by the middle of 2008, or about 18 months after the recommendations are issued at the end of this year.

The Commission will fashion its recommendations in a way that avoids compromising access to care by ensuring that remaining hospital and other provider capacity is adequate. However, it is not within the Commission’s ability to address the needs of the displaced and laid-off health care workforce at hospitals that are restructured. Depending on the degree of hospital overcapacity ultimately identified for action by the Commission, job displacement could be significant and amount to thousands of jobs in a relatively short period of time.

Unlike the hospital closures that have occurred around the State to date, the Commission’s work is intended to result in the planned downsizing of the system, which in turn will produce a “bulge” in the number of workers who are laid off in a relatively short period of time. This “bulge” will be too large for the system to absorb through normal staff turnover. A separate legislative initiative therefore is required to ensure that this workforce, which possesses years of valuable healthcare expertise and commitment to patients, is appropriately re-absorbed into the healthcare system and that displaced workers receive appropriate job placement and training services to ensure that outcome. To accomplish this, temporary hiring incentives are needed to support displaced worker placement services, salaries, benefits, and training needs for a transitional period so that financially strapped hospitals will be able to handle the one-time spike in the number of workers in this situation. After a transition period, normal attrition rates and workforce patterns will smooth out the “bulge” and permit re-employed workers to be absorbed organically into the workforce.

The hiring incentives that should be implemented should focus on clinical, technical, and other patient care staff who work in positions that are not in short supply, as well as lower skill level service, clerical, maintenance, and security guard workers. We do not include management, clinical staff in short supply, and technical positions in short supply because of their greater access to re-employment opportunities. Because experience with closures to date demonstrates that the great majority of displaced workers will also benefit from job placement and counseling services, however, we believe that these basic job transition services should be provided to all displaced workers.

New York has a history of investing in the health care workforce as a way to ensure excellence in the health care system. Examples include:

- The Health Care Reform Act (HCRA) provides worker retraining grants to qualified entities
- Worker Recruitment and Retention add-ons to Medicaid rates ensure that hospitals and nursing homes can recruit and retain qualified staff
- About 20% of Community Health Care Conversion Demonstration Program (CHCCDP) funding under New York's section 1115 waiver was dedicated to training programs to assist workers to make the transition to a managed care environment
- The Hospital Closure Incentive Program (HCIP) provides a small Medicaid rate adjustment for hospitals that hire workers who lose their jobs as a result of hospital closures.

**Potential Job Losses.** The Commission has indicated that it believes the acute care hospital system is too large. Estimates of excess beds have ranged from as many as 18,000 in original DOH estimates based upon observations of average daily census (ADC) to 7,000 in hospital industry analyses that have focused on peak patient census. There is an average of almost 4.8 full-time equivalent (FTE) non-management hospital employees per bed reported on hospital reports. If between 7,000 and 10,000 beds Statewide are closed, this could result in the displacement of between 33,000 to 48,000 non-management employees. Within this range there is a smaller number of workers who should be eligible for hiring incentives including salary and benefit support and short and longer-term training.

GNYHA and 1199 SEIU will be offering for your consideration a proposal to address the problems outlined above. The proposal will provide placement and counseling services to all workers who lose their jobs as a result of the activities of the Commission, and provide incentives for hospitals that hire displaced workers. The proposal will also provide for training of laid off workers in connection with a new job offer.

GNYHA looks forward to working with the Legislature and the Governor on this important initiative.

### ***Language Assistance***

The not-for-profit, charitable and public hospitals in GNYHA's membership are committed to serving the health care needs of their communities. This commitment includes providing meaningful access to high quality care for the communities that they serve, regardless of the languages that they speak, the cultures from which they may come, or the disabilities they may have. Indeed, it is the mission of hospitals to provide high quality care to their communities, and they undertake extensive efforts to ensure they are doing so. However, there is no place in the world that is as culturally and linguistically diverse as is the New York City region. That fact makes New York City rich as a community, but it also presents significant challenges for the entire region, and particularly health care, as communities seek to meet the needs of this diverse population.

Hospitals currently provide interpretation and translation services to persons with limited English proficiency, through the use of staff interpreters, bilingual staff trained in interpretation, contracts with outside interpreter and translation services, use of telephone interpretation systems, and through the use of trained volunteers. However, because of the vast numbers of languages, cultures, and special circumstances present in the region, GNYHA's members continually seek ways to expand the language services they offer.

GNYHA strongly supports the expansion of language access services. Numerous studies have documented that language discordance poses a barrier to health care.

GNYHA proposes a collaborative effort to identify low-cost, but meaningful ways to address the needs of New York's diverse population and appropriate funding to assist with these important efforts. GNYHA also supports dedicated funding for language assistance services. For instance, GNYHA strongly supports legislation to permit the State to draw down Federal Medicaid reimbursement for interpretation and translation services to assist providers in their provision of interpretation services for Medicaid eligible individuals. We also support increased cultural and linguistic resources and best practices support from the New York State Department of Health, including additional templates of standard health care forms determined to be vital to patient care, including informed consent and advance directives, translated into the most common languages in communities in New York State.

### ***Rationalizing Payer-Provider Dynamics***

As noted earlier, we believe there is an alarming imbalance between hospital financial condition on the one hand and payer profits on the other that does not well serve New York's health care system and communities. The dynamics behind these trends may be beyond the scope of this hearing, but I note that GNYHA supports a variety of reforms to standardize and rationalize hospital and payer interactions, such as assuring payment for medically necessary services and standardizing plan administrative practices. These would not directly remedy the skewed financial relationship but would seek to reduce administrative overhead and inappropriate payment reductions by clarifying certain rules of engagement regarding health insurance. We would be very pleased to have the opportunity to discuss these issues with the Senate and Assembly in order to implement needed relief.

### ***Reducing the Cost of Prescription Drugs***

On a national level, spending on prescription drugs grew 14.3% in 2000-2002, 10.2% in 2003, and 8.2% in 2004 to \$188.5 billion. A recent decline in the growth rate has been attributed to shifts in utilization of cheaper generic and over-the-counter alternatives; increased mail-order dispensing of drugs; and decreased utilization of some drugs due to safety concerns (*Wall Street Journal* 01/10/2006).

Though trends in the last two years have contributed to a modest decrease in the growth rate, total U.S. spending on prescription drugs has remained at a steady 11% of aggregate health spending since 1999 and is one of the fastest growing components of health spending, increasing

at double digit rates from 1995 to 2003 (*The Henry J. Kaiser Family Foundation, November 2005*).

Contributing factors include increased prescription drug utilization; price inflation of retail prescription drug prices; and increased prescription drug spending on newer, higher-priced brand name drugs (*The Henry J. Kaiser Family Foundation, November 2005*).

One measure benefit plans have to gain control over members' prescription drug spending is to sign-up with commercial Pharmacy Benefit Managers (PBM). By utilizing PBM's (Medco, ExpressScripts, AdvancePCS, etc.) preferred drug lists (PDL), benefit plans achieve savings from: (1) the PBM's negotiated discount on PDL drugs, and (2) their members choosing cheaper generic and over-the-counter alternatives in the PDL to costly branded drugs.

Some common practices among the commercial PBM industry though, conflict with a benefit plan's ability to gain most possible savings from a PDL. First, the PBMs negotiated discounts for drugs on its PDL are not transparent to the benefit plans. Some share of the PBM's negotiated discounts is reserved for profits, but the percentage reserved on specific drugs is unknown to the plans; this lack of transparency does not serve the benefit plans best interests.

Second, and related to a lack of transparency, is drugs included on a PDL are not always the most cost effective alternative for a benefit plan. In exchange for discounts on certain PDL drugs, manufacturers may negotiate with PBMs to keep certain (more expensive) branded drugs on a PDL, even when a cheaper alternative drug that is as clinically effective should be included on the PDL. Managers of benefit plans are often left to review drugs included in a PDL, to demand (or customize) a PDL with known cheaper alternative drugs. Because each plan must do this on their own, potential savings are not realized by all benefit plans.

Another means for delivering savings on prescription-drug costs is through state response. Some states (Maine, Georgia, etc.) are using their purchasing clout to negotiate better price discounts, and/or are partnering with other states to form larger purchasing pools (National Medicaid Pooling Initiative), and/or are working collaboratively with private group plans to establish voluntary purchasing pools within their states. Similar to the purchasing power of PBMs, these pooling of members enable the states to gain purchasing clout directly with manufacturers to negotiate price discounts.

So far there has been little progress to coordinate NY State programs (such as EPIC, state employees, state prison employees, and OMH), New York State Medicaid, union benefit funds, and other employer sponsored benefit plans to pool New York's collective prescription drug purchasing power.

In NY State Medicaid alone, prescription drug spending rose from \$1.7 billion in 1999 to \$3.8 billion in 2004. This ranks highest among all states and is second in prescription drug spending per Medicaid beneficiary (*New York Times 11/26/2005*). With recent Part D changes for dual eligibles, there may also be negative aspects in the negotiating dynamic for the state with decreased drug spending, further weakening its leverage.

Among the State programs - EPIC, state employees, prison employees, and OMH - and other group plans, including unions, around New York, groups are separately negotiating their own employees' drug benefits with for-profit PBM. This includes each group's utilization of unique PDL with generic or over-the-counter equivalents and negotiated group discounts, to help control their own employees' prescription drug costs.

***Component 1: Establish a PBM with state oversight that any state program and private not-for-profit group plans can voluntarily join, to manage prescription drug benefits (includes possibly adding Medicaid covered lives).***

The proposal requires formation of a Pharmacy Benefit Manager (PBM) program that is open to state programs (i.e. EPIC, state employees, state prison employees, and OMH) and not-for-profit groups. Through state oversight, the plans would yield greater savings than current practice of contracting separately with commercial PBMs.

Specifically, the program would require: (1) management of the preferred drug list (PDL) to ensure that it is clinically effective for a broad demographic of the participating membership; (2) selection of a PBM to administer the plan.

Management and oversight of this program requires the state to form an Advisory Committee consisting of clinical experts, employer advocates, consumer advocates, and state representatives. The Advisory Committee will decide drugs that should be included on the PDL, monitor the clinical effectiveness of PDL drugs, and maintain the manufacturer's pricing of PDL drugs.

The proposal also requires the state either to select a plan administrator for the program through RFP, or to establish a state controlled PBM that will: manage price negotiations with manufacturers; establish mail order dispensing options; and contract drug dispensing terms with retail pharmacies. If a PBM is selected through RFP to administer the program, versus a state controlled PBM, it must be not-for-profit and agree to disclose the discounted prices of PDL drugs negotiated with manufacturers to the Advisory Committee.

The advantage to state oversight versus purchasing plans through commercial PBMs is significantly improved transparency. The benefit plans will be able to monitor negotiated discounts and accrue savings to its membership; these negotiated savings are currently unknown to the plans, because commercial PBMs keep this as a share of profits. State oversight will also ensure inclusion of drugs on the PDL that are the most cost effective; this avoids conflicts of interest, where manufacturers negotiate with commercial PBMs to include more costly branded drugs on their PDL in exchange for discounts on other drugs.

Finally, assuming legal barriers could be resolved, the proposal would also include NYS Medicaid joining this PBM program. A key benefit to Medicaid joining is it enables the state to harness and enhance Medicaid's purchasing power through pooling together with the state programs (EPIC, state employees, state prison employees, and OMH) and private not-for-profit group benefit plans. This is an additional benefit to the state as a counter-measure to losing

leverage from eventual decline in drug spending of dual eligibles switching to the federal Part D program.

***Component 2: Create state law that requires drug manufacturers to offer not-for-profit plan sponsors prices on PDL drugs indexed to Medicaid statutory rebates.***

This proposal requires change to state law, where drug manufacturers are required to offer drug discounts indexed to Medicaid's statutory rebates to not-for-profit plan sponsors. The proposal is based on a rebate system that manufacturers already follow for Medicaid members; the practice ensures that states get best prices on drugs negotiated in the open market.

The new state law would require manufacturers to make rebated drug prices available to not-for-profit plan sponsors in NY by using the same rebate calculations they use for Medicaid, but at a percentage (index) below Medicaid's discount price (i.e. benefit plan pays Medicaid's discounted price + some percentage).

The indexed prices would create drug cost savings similar to the Medicaid program for not-for-profit plan sponsors, but not give equivalent price discounts to Medicaid. An index should be used to create enough savings so the benefit plans have a viable alternative to commercial PBMs.

Thank you for the opportunity to present this testimony to you this morning. GNYHA looks forward to working with the Legislature and the Governor to stabilize and improve our health care system.