



Greater New York Hospital Association

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Kenneth E. Raske, President

**Testimony of Kenneth E. Raske, President
Greater New York Hospital Association
On the Executive Budget Proposal for 2005-2006 Before the
New York State Senate Finance and Assembly Ways and Means Committees**

January 31, 2005

Good morning Chairman Johnson, Chairman Farrell, 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 2005-2006. While there is much to commend in the Executive Budget—including the extension of the Health Care Reform Act (HCRA) and its important programs and funding for the HEAL New York Bond Act for information technology and restructuring—I must regretfully, but unambiguously, state that the Medicaid cuts, provider taxes, and changes to public programs for the uninsured that are contained in the Executive Budget will, if enacted, destroy New York's health care system.

Elements of New York's health care system need reform. GNYHA has put forward a comprehensive set of reform proposals, including proposals submitted last year to the Senate Medicaid Task Force, chaired by Senator Hannon. The HEAL New York Bond Act is a proposal we put forward with 1199 SEIU that can help achieve critically important reforms and that can help take New York's health care system to a higher level of quality and efficiency.

The Governor's own Working Groups on Acute and Long Term Care Reform strongly supported fundamental restructuring of the system but stressed the importance of maintaining existing funding in the system. Unfortunately, the Executive budget bears no relationship to reform. Its proposals would indiscriminately cut \$1 billion in payments from the hospitals on which all New Yorkers rely; slash more than \$500 million in funding from the nursing homes in which our seniors live; and add significantly to the problem of the uninsured and underinsured by making it more difficult for people to become eligible for Family Health Plus (FHP) and by taking away important benefits for FHP and Medicaid enrollees. These proposals are the antithesis of reform; rather, they will destroy our health care system and must be rejected.

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 FHP and Medicaid populations. I will also focus on the critically important Health Care Reform Act (HCRA), which expires on June 30, 2005, and which

supports essential public benefits provided by hospitals, model health insurance programs such as FHP, Child Health Plus, and EPIC, and other public health and health-related initiatives that have helped make New York's health care system one of the very best in the world. Separately, Scott C. Amrhein, President of the Continuing Care Leadership Coalition, will appear before you later today to discuss our serious concerns about the Executive Budget's long term care proposals, which we fear would decimate our State's nursing homes.

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 and taxes, our recommendations for renewal of the current HCRA program, and describe pressing issues such as medical malpractice costs that we hope may be addressed by HCRA 2005.

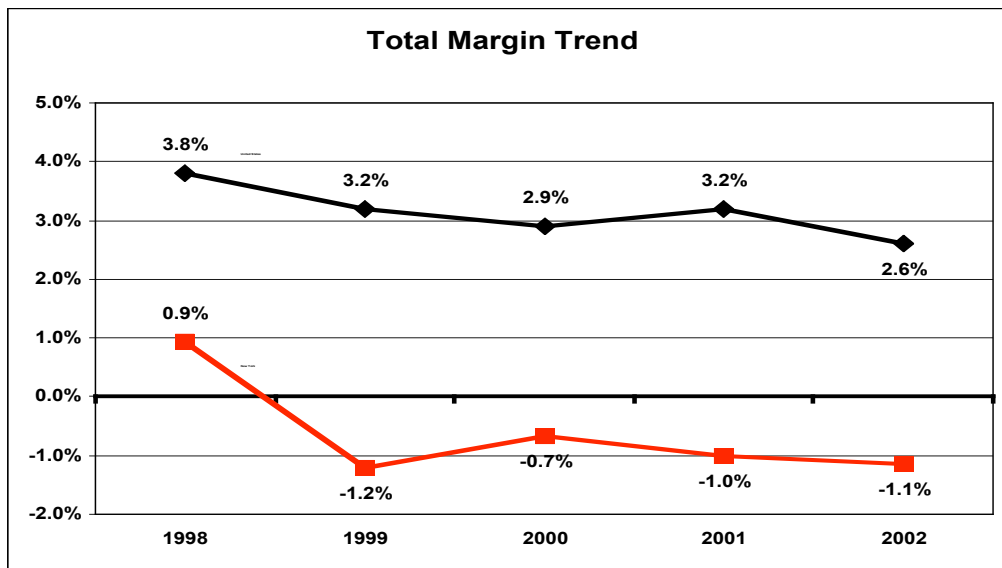
CONTEXT FOR THE STATE BUDGET AND HCRA RENEWAL

As you know, many changes have been reverberating through our health care delivery and financing system for the past several years. From our perspective, three trends need to be underscored. The first is that hospitals in New York are precariously underfunded. The second is that there is an excessive imbalance between the profits of health plans on the one hand, and the losses of hospitals on the other. The third is that the relatively newer phenomenon of niche providers has emerged as a fundamental de-stabilizer of our health care and hospital system.

Hospitals in New York are Dangerously Underfunded

The figure below demonstrates that New York hospitals' bottom line profitability continues to be well below the experience of hospitals nationally. Data from New York hospital cost reports for 2003 are not yet publicly available.

Figure 1. New York Hospitals Have Had Four Straight Years of Bottom-Line Losses



Sources: For U.S. data, the *Almanac of Hospital Financial and Operating Indicators, 2004* (Salt Lake City: Ingenix, 2003). For New York data, the 2002 New York State Institutional Cost Reports (ICRs).

Not surprisingly, hospitals' poor profitability is evidenced in poor cash flow, limited ability to meet current operating and capital obligations, and their over-reliance on debt, rather than equity, to pay for capital improvements and upgrades. This is seen in the table below, which compares New York hospitals' key financial ratios to the national average and ranks the state in comparison to others. New York is among the worst on all of these critical financial measures.

Table 1. The Financial Condition of New York Hospitals is Among the Worst in the United States

	U.S.	New York	NY Rank
Profitability			
Total Margin	2.6%	-1.1%	2d lowest
Liquidity			
Current ratio	2.00	1.30	3d lowest
Days in average payment period	55	77	2d lowest
Capital structure			
Equity financing ratio	55%	32%	2d lowest
Debt service coverage ratio	2.9	1.7	3d lowest

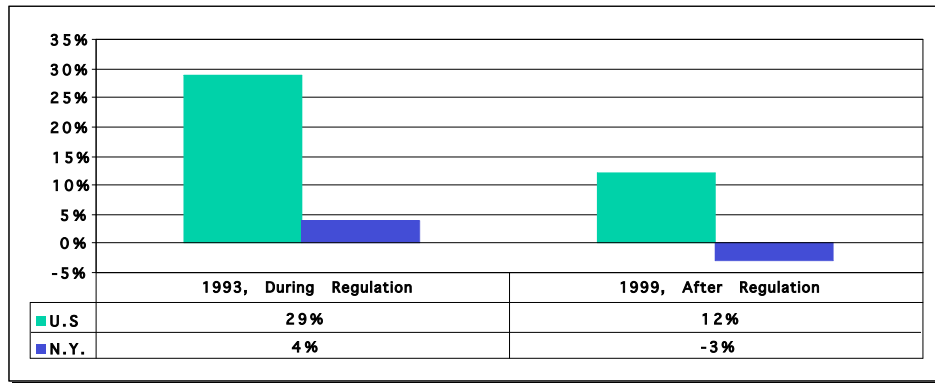
Source: *Almanac of Hospital Financial and Operating Indicators, 2004* (Salt Lake City: Ingenix, 2003).

Hospital and Health Plan Financial Performance is Excessively Imbalanced

The causes of hospitals' dismal financial condition are complex. They certainly include the loss of critically important Medicare reimbursement over time, most recently Medicare's disappointing decision last year to dilute hospital payments in the metropolitan New York City area by deeming three counties in New Jersey to be in our labor market. We are vigorously challenging that decision in court, but it has unfortunately already resulted in the elimination of any inflation increase to hospital Medicare payment rates for 2005.

Hospital distress is also rooted in New York's unique legacy of regulation and rate-setting. As you know, the regulated payment system that expired in 1996, NYPHRM, essentially required cost-based inpatient rates to be paid to hospitals by Medicaid and Blue Cross, with a fixed "mark-up" for other private insurance companies. This produced breakeven profitability for years before HCRA was enacted. With deregulation in 1997, the situation worsened because health plans negotiated new rates with the old cost-based rates as the ceiling, not the floor. In addition, the State was no longer able to adjust hospital revenues through special rate appeals or enhancements to assure that needed community providers remain financially stable. Thus, as seen by the figure below, while private payers paid 4% above cost under the regulated system, their payments actually fell below costs after regulation.

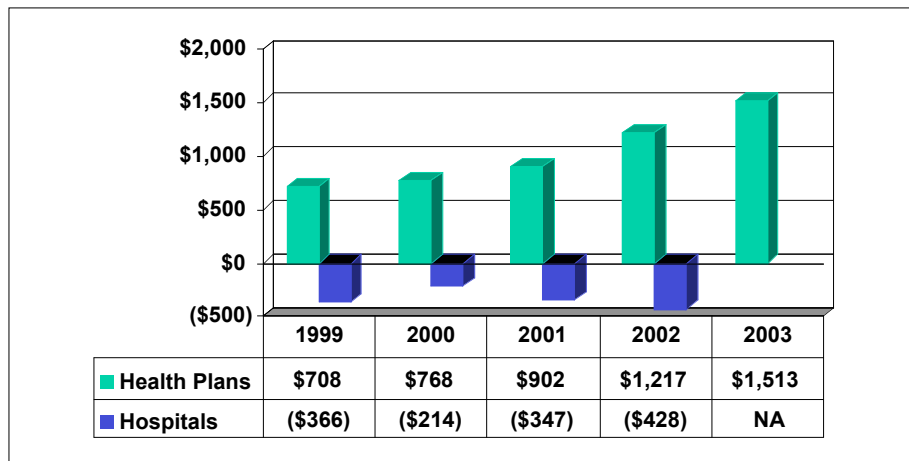
Figure 2. Private Payer Payments in Relation to Cost, Pre- and Post-Deregulation



Source: Medicare Payment Assessment Commission (MedPAC).

This phenomenon has without doubt contributed to the unprecedented growth in private health plan profits since deregulation. Indeed, according to Weiss Ratings, in 2002 (the most recent year for which this information was compiled), health plans in New York State recorded the highest amount of net profits, \$1.2 billion, of any state in the country. California health plans, the second highest group, had profits of \$878.3 million.

Figure 3. NYS Private Health Plan and Hospital Net Income, 1999-2003 (\$ in millions)



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

Our hospitals' poor financial health threatens to degrade what has been one of the finest hospital systems in the country. This would truly be a tragedy for the State and its residents.

Niche Providers Are Further 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 such as legislation proposed by Senator Hannon in 2003-2004 (S.4235), as well as legislation that would require office-based surgery practices to report incidents to the Commissioner of Health introduced by Assembly Member Gottfried (A.5017).

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 the past when I have come before you with grave concerns about hospitals' financial condition, you have asked me whether hospitals have actually closed. The difference between this year and past years is that my testimony now 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 we do not take steps to address this situation now.

Table 2. Acute Care Hospital Closures/Conversions Since 1996 in New York State (Working List)

Hospital	County	Date Acute Care Closed or Converted
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	Announced December 2004

Table 3. Closures of Various Hospital Services and Conversions Since 1996

Hospital	County	Date
Brooklyn Jewish Hospital Division/Interfaith Medical Center	Kings	April 2003, announced closing of obstetrics program
St. Mary's Hospital (Brooklyn)	Kings	October 2003, announced closing of obstetrics program

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

Hospitals in New York State cannot sustain new taxes or Medicaid cuts, and the Governor's proposed cuts to Family Health Plus would be devastating to families and add to the ranks of the uninsured. The Governor's proposed fee-for-service hospital cuts and hospital tax alone would particularly assault New York's teaching hospitals and those that serve large proportions of low income patients.

In order to achieve \$395 million in general fund savings from a new hospital tax and Medicaid fee-for-service cuts, the Executive Budget would impose almost \$1 billion in annualized losses on hospitals. This would be the result of Medicaid rate cuts that would save the State \$200 million but, when combined with local and Federal matching amounts, would multiply to over \$800 million in hospital losses, as well as a \$242 million gross receipts tax. The cuts, each of which is described in detail below, would: Recoup graduate medical education (GME) payments associated with Medicaid managed care patients from as long as nine years ago; re-base and lower the component of teaching hospitals' rates associated with GME; eliminate any increase in payment rates to account for inflation; 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); allow the Commissioner of Health to selectively contract for hospital services and negotiate hospital fee-for-service rates; and apply case management to high cost populations.

The budget would also seek about \$300 million in State savings by imposing more than \$900 million in all-funds reductions on FHP and Medicaid benefits as well as restrict enrollment in these programs. It would freeze or cut Medicaid managed care and FHP premiums by about \$170 million in order to save \$48 million in State Medicaid funds. The FHP and Medicaid benefits and eligibility cuts would add to hospital losses by creating more uncompensated care, and managed care premium reductions would translate into hospital losses because plans would have to pass these losses onto providers in the form of lower negotiated payments.

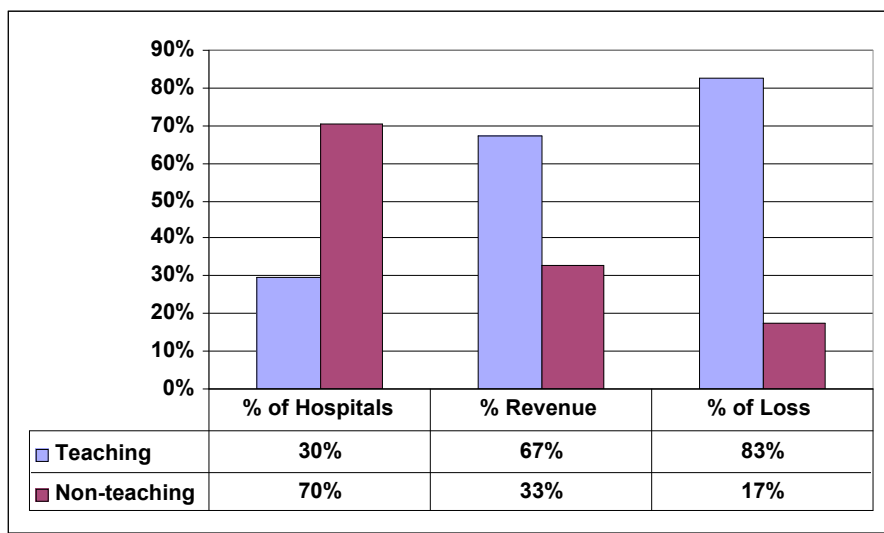
The fiscal impact of the fee-for-service cuts and tax on hospitals is summarized in Table 4 below. The Statewide fiscal impact of individual proposals does not match the estimates provided by the Division of the Budget because we computed them separately based on a comprehensive patient- and hospital-level model. Nonetheless, they are in the same range. In addition, the table does not include proposals that we could not model, including selective

contracting, case management of high cost patients, beneficiary restrictions, or managed care plan premium cuts.

Hospitals		Medicaid Cuts					Other Cuts			Fiscal Impact			
Category	N	%	Trend	Detox	GME Rebasing	Mental Health	Total	GME Takeback	Tax	Total Loss	% of Total Revenue	Total Revenue	% of Revenue
NYS Total	227	100%	(103)	(128)	(88)	(8)	(327)	(253)	(242)	(823)	100%	33,993	-2%
New York City	66	29%	(82)	(105)	(83)	(7)	(277)	(205)	(131)	(614)	75%	18,800	-3%
Rest of State	161	71%	(21)	(23)	(5)	(1)	(51)	(47)	(111)	(209)	25%	15,193	-1%
Very high Medicaid (>=40%)	33	15%	(40)	(49)	(45)	(5)	(139)	(82)	(32)	(252)	31%	4,805	-5%
Major public	12	5%	(26)	(32)	(31)	-	(89)	(58)	(19)	(167)	20%	3,194	-5%
High Medicaid (>=23%)	43	19%	(37)	(52)	(22)	(3)	(114)	(119)	(79)	(313)	38%	10,795	-3%
Low Medicaid (<23%)	152	67%	(26)	(27)	(20)	(1)	(74)	(52)	(132)	(258)	31%	18,473	-1%
Teaching	67	30%	(86)	(94)	(87)	(7)	(274)	(242)	(164)	(680)	83%	22,816	-3%
Non-teaching	160	70%	(18)	(34)	(1)	(1)	(54)	(11)	(78)	(143)	17%	11,177	-1%

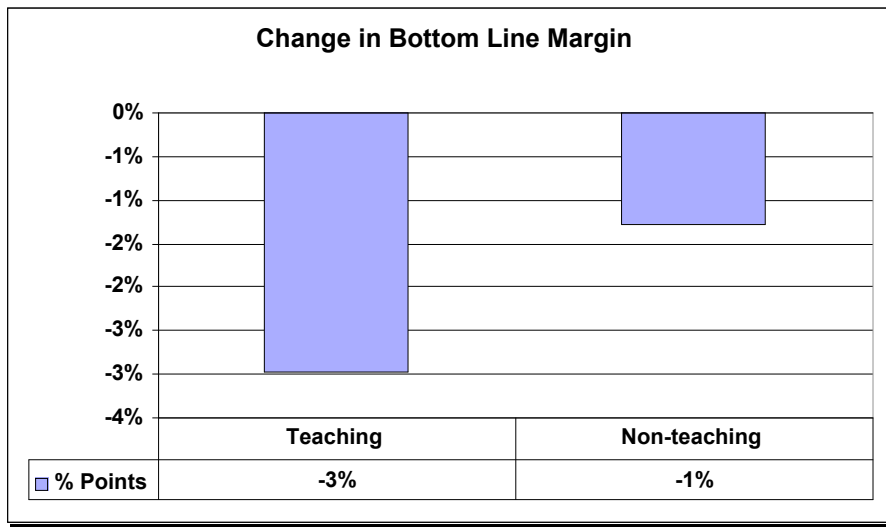
Because more than 40% of the cuts are aimed at GME, and also because they serve high proportions of low income patients, teaching hospitals would bear a wildly disproportionate share of the loss. Thus, our analysis shows that while they comprise 30% of all hospitals in New York State, and 67% of all net patient revenue, teaching hospitals would take 83% of the loss.

Figure 4. Teaching Hospitals Bear a Disproportionate Share of the Loss Proposed In the Governor’s Budget



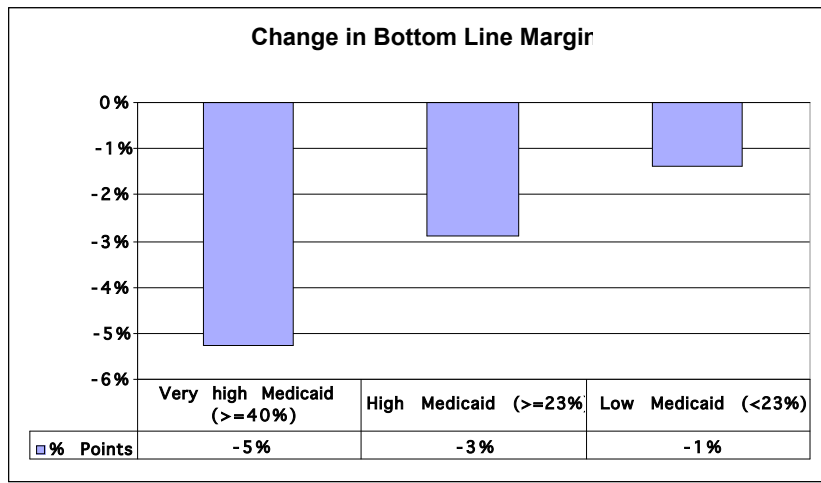
This would translate directly into financial crisis for our State’s teaching hospitals, among the finest in the world, as teaching hospital margins would decrease by 3% if the Governor’s cuts were enacted. In contrast, the margin of non-teaching hospitals would decrease by 1%.

Figure 5. Impact of Governor’s Proposed Cuts on Teaching Hospital Bottom Lines



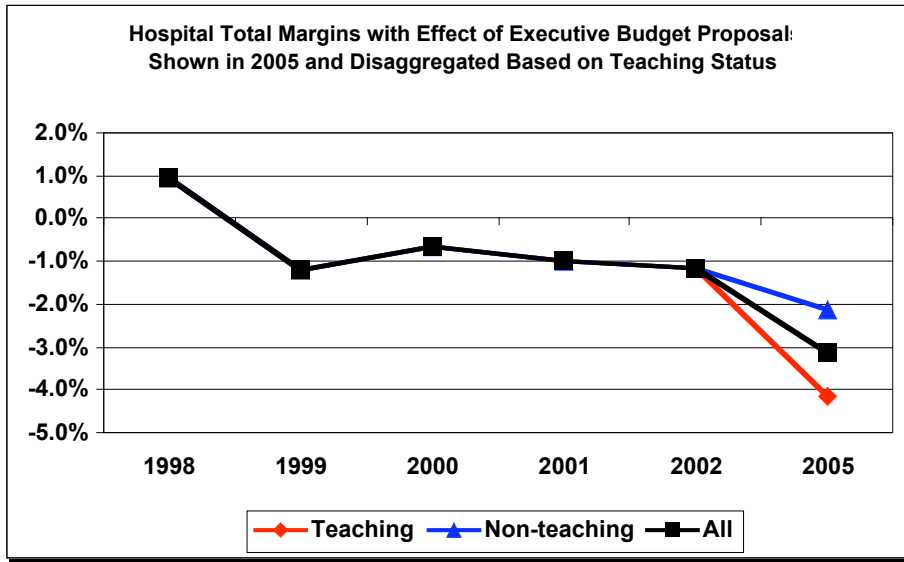
Finally, the cuts would devastate hospitals serving higher proportions of low income patients. Those for which Medicaid comprises more than 40% of total patient revenue would lose, on average, an amount equivalent to 5% of their revenue from all patients, those with Medicaid shares of between 23% and 40% would lose 3% on average, and those with Medicaid shares of less than 23% would lose 1% on average.

Figure 6. Impact of Governor’s Proposed Cuts on Hospitals Serving Low Income Patients



As shown in Figure 1 on page 2, New York’s hospitals have lost money every year since 1999. If the Governor’s proposals were enacted, they would compound these losses and further devastate already negative bottom line margins. The effect of the Executive budget on the total margins of all hospitals, teaching hospitals, and non-teaching hospitals, is illustrated below.

Figure 7. Impact of Executive Budget on New York Hospital Margins



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: **Retroactive Recoupment of GME Case Mix Adjustments**
Hospital Loss: **\$253 million**

Teaching hospitals are paid directly by the New York State Medicaid program for inpatient GME costs related to Medicaid managed care patients. Direct payment for GME costs under Medicaid managed care was enacted in order to ensure that public benefits were appropriately funded in a negotiated rate environment. Thus, a teaching hospital submits two bills every time it provides inpatient care to a Medicaid managed care enrollee, one to the health plan for the negotiated rate amount, and one to the State Medicaid program for the GME amount.

When it made direct GME payments to teaching hospitals from 1996 through 2002, the State adjusted the payments to account for the severity of illness of the patients served, or case mix. This followed its normal practice of adjusting all inpatient payments, including GME, for case mix. An example of how the case mix adjustment changes payment is that if the unadjusted payment amount was \$1000, and the case mix index was 1.1, then the case mix adjusted payment to the hospital would be \$1,100.

For managed care-related GME payments during these years, the State's case mix adjustment was based upon its estimate of the illness severity of all Medicaid patients served by the hospital, whether they were enrolled in managed care plans or not. Beginning in 2003, the State changed this methodology and began to apply the case mix index specific to Medicaid managed care patients. Now, it seeks to adjust the GME case mix it used starting nine years ago, in 1996, up through and including 2002, to match Medicaid managed care discharges and to recoup the difference. This would amount to a staggering \$253 million in teaching hospital losses in one year, including \$205 million in New York City alone.

The State's original plan under mandatory Medicaid managed care was to enroll the vast majority of Medicaid clients into managed care plans on an aggressive schedule, including disabled and chronically ill Medicaid clients who would be served by so-called special needs plans. These enrollees have higher case mix indices because they are more severely ill and medically complex. Using an all-facility Medicaid case mix index to adjust GME payments may have made sense under this plan, under which virtually all Medicaid patients would be enrolled in managed care. However, the State changed its original managed care strategy such that almost all managed care enrollees today are less severely ill patients (e.g., mothers and children). As a result, the case mix index of the Medicaid managed care population tends to be lower than the Medicaid case mix of the entire Medicaid population, which of course includes clients remaining in the fee-for-service system. That is why the proposed recoupments would have such a devastating impact on teaching hospitals.

I strongly urge the Legislature to enact legislation to stop DOH from implementing this retroactive cut, which is the largest proposed by the Governor. Because this cut is not included

in the budget legislation but would instead be implemented administratively, the Legislature will need to add language to the budget to accomplish this important task.

I should note that the Executive has stated that this nine-year old recoupment is required by the State's Medicaid State Plan Amendment (SPA). However, the SPA actually says that any adjustments will be made within two years of a patient's discharge from the hospital, which we believe is a recognition that retroactive take backs of the nature proposed here are exceedingly inappropriate. The funds at issue have long since been spent, and the recoupments would be made from hospitals that treat the sickest and most medically complex Medicaid and other patients. These teaching hospitals also treated large numbers of Medicaid managed care enrollees when the program was new. They suffered lost payments and underpayments resulting from all of the problems associated with any complicated new program, including non-payment resulting from mistakes in eligibility and enrollment information, retroactive enrollment of Medicaid clients into plans that then refused to pay for their prior care, administrative burdens associated with excessive paperwork and denials, inappropriate payment of emergency department triage fees, and similar problems. While we think the two-year adjustment language in the SPA counters the Executive's belief that it *must* do a nine year retroactive recoupment, the Executive also obviously believes that it is administratively empowered to do so if it wishes. That is why legislative intervention to the contrary is essential.

Proposal: Reinstatement of the 0.7% Gross Receipts, or "Sick" Tax
Hospital Loss: \$242 million

The Executive Budget once again proposes reinstating the 0.7% tax on the gross receipts of hospitals, which the State Legislature wisely agreed to phase out in the late 1990s. This tax will cost hospitals in New York State approximately \$242 million. Unlike the nursing home tax, no portion of this tax is reimbursable by the Medicaid program. Our hospitals cannot afford this tax. I strongly urge the State Legislature to once again reject the imposition of new taxes on our financially struggling hospitals.

Proposal: Reduce Reimbursement for Hospital Inpatient Alcohol and Substance Abuse Detoxification Services
Hospital Loss: \$128 million

The Executive Budget would slash funding for inpatient hospital detoxification services by eliminating six "diagnostic related groups", or "DRGs", that are designed for detox patients without other clinical complications. 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.

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 below, 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.

This cut will devastate hospitals that provide substance abuse services and threaten many of them with utter ruin. While over 150 hospitals are affected by this proposal, it is very concentrated, with 34 hospitals having a cut of \$1 million or more each. Teaching hospitals would bear almost 75% of this cut. I strongly urge the Legislature to reject this proposal.

Proposal: Eliminate the Medicaid Trend Factor
Hospital Loss: \$103 million

The Executive Budget proposes eliminating the Medicaid “trend factor”, or inflation adjustment, for calendar year 2005. 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. Skyrocketing pharmaceutical costs, medical supply costs, workforce costs (due to severe workforce shortages), and medical malpractice insurance costs are all 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).

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: \$88 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.

GNYHA 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. As is apparent from the Executive proposal, this approach extracts budget savings from a subset of hospitals while leaving them underpaid for other costs. This cut will severely damage a number of teaching hospitals in the State. The Legislature should reject this proposal in favor of true reform of the Medicaid reimbursement system.

Proposal: Selective Contracting for Hospital Services
Hospital Loss: \$40 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. 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. While the budget documents suggest that this would be limited to certain high-cost services, the actual language in the budget bills 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, we 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.

Proposal: Case Management For High Cost Patients
Hospital Loss: \$46 million

The Executive Budget contemplates more case management for high-cost substance abuse and mental health patients who are covered by the Medicaid program. There is very little detail on this proposal in the Executive Budget documents, yet there is a high savings figure associated with the proposal. GNYHA needs much more detail on this proposal in order to understand how \$46 million on an annualized basis can be cut from hospitals by providing more case management for these populations without severely damaging the inpatient hospital substance abuse and mental health infrastructure.

Proposal: **Eliminate Outpatient Mental Health Day-Night Rates**
Hospital Loss: **\$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. GNYHA urges the Legislature to obtain from the Administration a detailed list of affected institutions so we may better understand the impact of this cut on the hospitals and the patients they serve.

Proposal: **Family Health Plus and Medicaid Benefits and Enrollment Restrictions**
Hospital Loss: **?**

The Executive Budget also proposes major benefit cuts for FHP and Medicaid as well as changes that will make it harder for low-income, uninsured patients to sign up for these important programs. With respect to benefits, the Executive Budget would eliminate from the adult Medicaid benefits package all dental services not provided in a clinic setting and private duty nursing services. In addition, except for adults who are also eligible for Medicare, the Executive would eliminate from the adult Medicaid benefits package podiatry, clinical psychology, and audiology services provided in hospital settings, including outpatient clinics. The Governor proposes major cuts in benefits under Family Health Plus, including eliminating mental health, substance abuse, dental, and podiatry benefits altogether, imposing a \$250 copayment for inpatient hospital services, a \$75 copayment for outpatient surgery services, a \$50 copayment for emergency services that do not result in an inpatient admission, and a \$20 copayment for other services. With respect to eligibility, the Governor would impose new limitations on FHP enrollment by imposing a resource test and denying eligibility to a variety of working New Yorkers, including anyone employed by a company with more than 50 employees, and requiring 12 months of being uninsured before being eligible for enrollment.

The Governor also proposes cutting FHP payments to managed care plans by 4%, and freezing Medicaid managed care and Child Health Plus premiums. The elimination of facilitated enrollment will make it more difficult for eligible residents to receive health insurance, and will also make it impossible for health plans to recertify Medicaid eligibility for vast numbers of persons who in fact qualify for Medicaid but involuntarily lose their Medicaid coverage because of an inability to complete needed paperwork and other reasons. This would result in enrollees falling off and coming back onto enrollment rolls at high rates, causing disruption to families, plans and providers alike.

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, and managed care premium cuts will translate into further hospital losses because plans will be constrained to pass their losses onto their provider networks through lower negotiated rates. Finally, the elimination

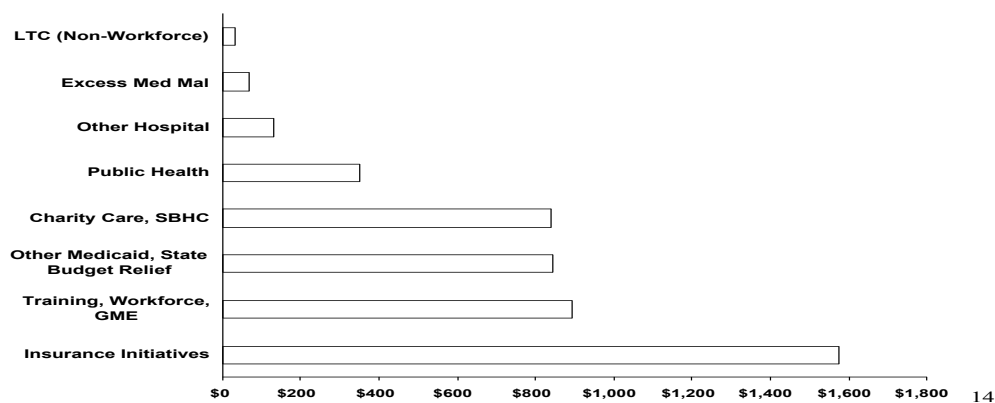
of facilitated enrollment will result in lost continuity of care for hundreds of thousands of Medicaid patients and disruption to the payment and health care delivery system. GNYHA therefore urges the Legislature to reject these changes to our important public health insurance programs.

HCRA RENEWAL PRIORITIES

HCRA was created in conjunction with the deregulation of our inpatient rate-setting system in 1996. As you know, it preserved a portion of the regulated payments that had been paid by private payers that supported selected public benefits such as GME and uncompensated care and pooled these amounts to be distributed to hospitals along side with negotiated rates. Because HCRA supported only a portion of hospital costs in these areas, the intent was that the balance would be addressed through market forces and negotiation. The establishment of public benefits pools has proven to have been a farsighted act by the Legislature and Executive, as it is clear that markets on their own do not support these essential community benefits.

HCRA has also evolved substantially from its origins in 1996 as a \$1.8 billion program funded by hospital and payer taxes to support principally hospital programs to a \$4.7 billion program today whose largest programmatic component provides insurance for the uninsured and underinsured. The funding for HCRA has also become much more complex, with tobacco funds, health plan conversion proceeds, special Federal funds, and others added to the mix. The relative amounts spent on different types of HCRA programs in 2004 are illustrated below.

Figure 8. HCRA Funding, 2004



Source: New York Public Health Law

HCRA's support of GME, charity care, workforce initiatives, restructuring, and related programs continues to be of critical importance to New York's health care providers and the fulfillment of their missions to the community, as is its support of critically important insurance expansions and other essential programs.

Financing: HCRA has been financed through a combination of revenue sources, including proceeds from the State’s legal settlement with tobacco companies; tobacco taxes; assessments on health care services and insurers; a 1% tax on hospital inpatient revenues; and other mechanisms. The State also intends to finance HCRA programs with 95% of the proceeds from the conversion of Empire Blue Cross and Blue Shield from a not-for-profit entity to a publicly traded corporation. Unfortunately, a lawsuit has prevented the State from accessing the Empire conversion funds, placing all of the HCRA programs, including FHP, CHP, and EPIC, at risk of being under-funded.

As part of the HCRA reauthorization, we recommend the following:

- Ensure that HCRA is modified so that the Empire funds are made available as soon as possible and so that the proceeds from future conversions, including the potential conversion of the Health Insurance Plan of New York (HIP), are used to help finance HCRA’s important programs. GNYHA strongly supports the Executive Budget proposal to achieve this end.
- Consider other revenue sources, such as fees or assessments on excess health plan profits and on relatively unregulated health care providers that cherry-pick healthier, paying patients away from hospitals, yet provide none of the charity care or other community services that hospitals provide.

Indigent Care: The State raises funds to finance a portion of the charity care provided by hospitals and health centers through a variety of surcharges and assessments. These surcharges and assessments also help finance a number of other health care programs, including insurance for uninsured New Yorkers. Voluntary and public hospitals receive \$738 million annually in basic uncompensated care funds from the Hospital Indigent Care Pool. Voluntary hospitals receive funding according to a complex methodology that determines each hospital’s need for receiving funds to help cover uncompensated care. As a hospital’s “need” rises—the more charity care its caregivers provide—the percentage of its uncompensated care costs covered by State payments increases as well to provide more funding to hospitals that provide a high proportion of uncompensated care. HCRA 2000 added \$82 million to the pool for rural hospitals as well as for voluntary not-for-profit hospitals whose uncompensated care costs exceeded 4% of total costs, for a total of \$820 million in pool funds. HCRA 2000 also transferred approximately \$27 million in funds, financed from the “covered lives assessment” paid by insurers, from the professional education pool for teaching hospitals to a supplemental indigent care fund for teaching hospitals.

Public hospitals receive a fixed amount from the indigent care pool based upon the amount they received from the State in 1996 for bad debt and charity care. This is supplemented with special Medicaid payments in which county governments (and the City of New York) can participate and which are matched by the Federal government. These so-called inter-governmental transfer (IGT) payments are not available for non-public providers.

According to DOH, on average, HCRA provides funding that covers approximately 50% of the costs incurred by hospitals statewide for providing care for New Yorkers without health insurance. Because the State formula directs more funding to hospitals with higher

uncompensated care costs as a percentage of total costs, the coverage ratio ranges from below 20% to more than 80% for particular hospitals. It should be noted that these coverage ratios do not take into account the 1% tax on inpatient receipts that hospitals pay to help fund the pool; thus, net payments for uncompensated care actually result in significantly lower coverage ratios.

Since 1996, when HCRA was enacted, only the supplemental \$82 million pool for rural and high need hospitals and has been added. The pool allocation has otherwise remained constant.

I wish to underscore that 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 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.

In the past year or so, there has been criticism of hospital financial assistance policies and suggestions for a regulatory response that would impose Statewide requirements on how much free care hospitals must provide and how they are to provide it. By DOH's own calculations, hospitals in New York State have consistently provided a very high level of uncompensated care to insured and underinsured populations. However, though they receive critically important distributions from this publicly funded pool, they still lose 50 cents on average for every dollar of free care they provide even without consideration of the tax they pay to fund the pool. 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, hospitals, beginning in 2003, have been engaging in extensive efforts to update their financial assistance policies and procedures. The hospital community's goal is to identify more accurately when patients are fully uninsured and lack the income to pay, so that hospitals can help patients apply for Medicaid, CHP, or FHP, or apply for the hospital's financial assistance program and, potentially, benefit from discounts before the hospital engages in any collection activities. Thus, the hospital community is trying to strike a balance between the State requirement and intent that reasonable collection efforts be made with respect to patients who have the means to pay before drawing money from the indigent care pool on the one hand, and the need to treat low-income, uninsured New Yorkers with compassion, dignity and respect on the other.

GNYHA has worked extensively with its member hospitals to provide technical assistance in these efforts. 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 is reviewing this proposal to ensure that it provides the flexibility necessary to allow hospitals to provide as much assistance as possible with limited resources.

- GNYHA strongly supports an increase in funding for the Indigent Care Pool, to help New York’s financially struggling hospitals continue to provide care for New York’s 3 million uninsured residents.
- GNYHA strongly opposes any attempt to shift funding from the Indigent Care or high-need pools to fund other programs, including insurance programs, in the absence of universal health insurance coverage.
- GNYHA opposes changes in the Indigent Care and high-need allocation formulas that would shift funding from one set of financially struggling providers to another. We note that the Executive Budget would grant the Commissioner of Health authority to change such formulas without going through the legislative process as has occurred in the past. We strongly oppose the granting of unfettered administrative authority to change the distribution formula in unspecified ways.
- GNYHA recommends that hospitals be allowed to develop their financial assistance policies based upon the needs and characteristics of their individual communities.

Graduate Medical Education (GME): GME is much more than the training of new doctors. The GME “enterprise” involves creating an academic environment within a hospital to enable tomorrow’s physicians and researchers to have access to the broadest and most challenging educational experience possible. Thus, teaching hospitals take on more complex cases than other hospitals to ensure that trainees are exposed to unusual cases. Teaching hospitals must provide a broader range of services, including trauma, burn, transplant, and other complex services in order to ensure that residents are exposed to all of the services that patients may need. Teaching hospitals must purchase the latest technology and stay abreast of the latest procedures, providing ongoing education for both the residents as well as the supervising physicians. It is because of this complex and expensive infrastructure that so much of the nation’s biomedical research occurs in teaching hospitals.

HCRA now provides \$521 million funding for GME through 4 funding streams. The first, \$461.4 million in formula-driven allocations, provides the bulk of GME funding for teaching hospitals (pursuant to the 2004-2005 State budget, \$100 million of these allocations will be made through GME Medicaid rate adjustments for certain institutions). The other funding streams provide \$27 million to teaching hospitals for indigent care, \$31 million for the grants-based GME Incentive Pool program, and \$1.6 million for the Area Health Education Center program, designed to expand community-based medical student training. When HCRA was first enacted in 1996, the pool was funded at a level representing half of 1996 private payer GME payments. It has not been increased since that time for cost inflation and despite the fact that recent independent research reports commissioned by the Federal government are predicting an impending physician shortage. See Federal Council on Graduate Medical Education, *Physician Workforce Policy Guidelines for the U.S., 2000 to 2020*, (Report accepted by Federal COGME, July 28, 2004) and Richard A. Cooper et al., *Economic and Demographic Trends Signal an*

Impending Physician Shortage, (Health Affairs: Vol. 21, No. 1, January/February 2002). These reports call on policymakers and the GME community to take action to increase the supply of practicing physicians so that we can be sure that access is not compromised in the coming years as baby boomers age and begin to need more critical health services. In fact, GME funding was actually cut in HCRA 2000.

- GNYHA strongly supports an increase in funding for the formula-driven portion of the HCRA GME pool for teaching hospitals to account for cost inflation since 1996 and other factors. As mentioned previously, GNYHA strongly opposes the huge GME cuts contained in the Executive Budget's Medicaid proposals, which will decimate our teaching hospitals.

Workforce: Since 1996, HCRA has included a variety of grant programs for worker retraining. In 2004, HCRA authorized the expenditure of \$40 million for a variety of worker retraining programs, although a Request For Proposals for this funding was never finalized. Over the years, HCRA retraining funds have been used to successfully retrain health care workers for new tasks and careers demanded by an ever-changing health care system. Health care providers and union benefit and training programs have worked collaboratively to place workers who have been displaced by conversions, consolidations, and closures of health care facilities in new jobs where health care personnel are critically needed.

- GNYHA strongly supports these programs, urges that the 2004 funding be allocated immediately, and that the programs be re-authorized and expanded as a part of the HCRA reauthorization.

HCRA also contains critical funding for worker recruitment and retention. In January 2002, the Governor and State Legislature, faced with a serious health care workforce shortage and severe financial distress within the health care community, amended HCRA to provide funding for hospitals, nursing homes, personal care providers, community health centers and, later, home health agencies to help them recruit, retain, and retrain health care workers. Specifically, in 2004, HCRA contained approximately \$123.5 million in State funding for hospitals, \$62.5 million for nursing homes, and \$112.4 million for personal care providers. In addition, HCRA provided \$25 million in State funding for nursing homes for nursing home quality improvement. In all, when Federal and local funding is included, in 2004, HCRA provided \$524 million in critical workforce recruitment, retention, and quality funding for hospitals and nursing homes.

- Given the continued increases in workforce costs and the continued workforce shortages, GNYHA strongly supports reauthorizing at least this annual level of funding.
- GNYHA supports converting the quality improvement funds into recruitment and retention funds, using the same formula used for recruitment and retention. GNYHA opposes the Executive Budget's cut in nursing home quality improvement funds for nursing homes.
- GNYHA also supports establishing a recruitment and retention program for certified home health agencies in the reauthorized HCRA legislation.

Insurance Programs: The largest portion of HCRA provides funding for vitally important programs for the uninsured and underinsured, including Child Health Plus (CHP) for low-income children; Family Health Plus (FHP) for low-income parents and other adults; Healthy New York, for small businesses and individual workers; the Elderly Pharmaceutical Insurance Program for seniors; and other programs.

- GNYHA strongly supports streamlining eligibility and enrollment for FHP and Medicaid, to enable more New Yorkers who are eligible for these programs to enroll.
- To reduce inappropriate, involuntary disenrollment of Medicaid managed care beneficiaries, to ensure that Medicaid managed care plans are given the opportunity to properly manage the care of their enrollees, and to cut down on costly emergency room visits, GNYHA supports allowing Medicaid beneficiaries to recertify every two years instead of annually.
- GNYHA also strongly supports funding for facilitated enrollment, and calls for new funding for local social service districts specifically to enable them to “outstation” more Medicaid, FHP, and CHP eligibility workers in hospitals and other provider settings so that more people can be enrolled in these important programs. One way to finance these important initiatives is to ensure that a portion of the revenues from the Attorney General’s eventual settlement with insurance brokers is dedicated to programs for the uninsured and underinsured.
- As mentioned earlier, GNYHA strongly opposes the Executive Budget proposals to impose new costs on FHP and Medicaid enrollees, to limit eligibility, and to reduce benefits.

In addition, in early 2004, the GNYHA/1199/SEIU Healthcare Education Project proposed the Healthcare Equity and Access Law for all New Yorkers, or HEAL New York. Under HEAL New York, all employers who do not provide health insurance coverage for their employees would be required to pay a sliding-scale assessment to the State, both as an incentive to provide health insurance, but also to provide revenue to help the State expand health insurance coverage for the uninsured. Specifically, revenue from the HEAL New York assessment would be used to streamline eligibility and increase enrollment in FHP; increase the eligibility level for FHP for childless adults to 150% of the Federal poverty level to match the eligibility level of parents; allow small businesses to buy into FHP on behalf of their employees; reduce the cost of health insurance by providing tax credits and tax cuts for small businesses that provide health insurance for their employees; improve the Healthy New York program so that more businesses can participate; and other reforms.

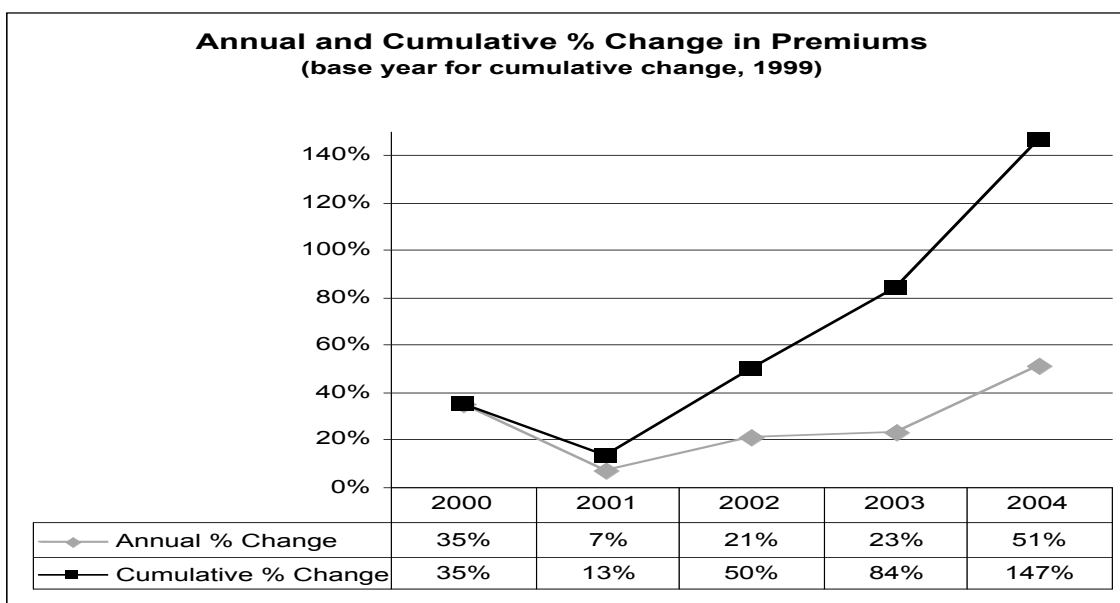
- GNYHA urges the enactment of the HEAL New York program. A more comprehensive summary of the HEAL New York program can be found on GNYHA’s web site at www.gnyha.org.

NEW HCRA PRIORITIES

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. 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.

Figure 9. 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.

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.

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

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

^aPremiums reflect occurrence policy rates.

^bPremium 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.

HEAL New York Bond Program for Restructuring and Information Technology: To address the dire financial situation of the health care system in New York as well as the critical need for information technology to improve health care quality, the Healthcare Education Project proposed the HEAL New York Bond program in early 2004. The proposal contained short, intermediate, and long-term solutions to improve the financial circumstances of hospitals and the quality of the entire healthcare system. \$1 billion worth of bonds would be issued over time to fund the restructuring of the system as well as health care information technology to improve patient safety and efficiency. In addition, HCRA funds would be reprogrammed to meet the immediate needs of financially troubled institutions. Critically important worker retraining funds would also be provided to help displaced workers and improve customer service and quality care at institutions experiencing a drop in patient volume.

- The Legislature responded by creating a new \$250 million capital program as part of the 2004-2005 budget, as well as a \$28 million pool to help meet the immediate needs of needed health care providers and programs in financial trouble. The Governor's Health Care Reform Working Group Report, issued in November 2004, the Working Group proposed a similar program and Governor Pataki included funding for the program at a level of \$1 billion over four years in the Executive Budget. GNYHA is extremely pleased by the support shown by the Legislature and the Governor, and urges enactment of this extremely important program.

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. However, several legislative proposals have been considered by the Legislature that would impose unrealistic and duplicative standards on hospitals to provide language assistance services. State regulation

requires hospitals to provide skilled interpreters within specific time frames. There are also existing Federal requirements under the Social Security Act and under the U.S. Department of Health and Human Services Office of Civil Rights. We do not believe that imposing new or expanded requirements on a financially fragile health care system is the answer.

- 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's new Advisory Task Force on Diversity in Health Care Leadership looks forward to participating in this effort.
- GNYHA also supports dedicated funding for language assistance services.

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 handling of retroactive eligibility terminations, administrative payment denials, coordination of benefits, access to post-acute care services, and the like. These would not address 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.

One trend that bears comment is the emergence of high deductible health plans. These are being developed as a response to the movement toward health savings accounts (HSAs) and other consumer-directed insurance models. These plans will require hospitals, physicians, and other providers to recover significant payment amounts from patients that, in the past, would have been collectible from the health insurer. However, current contracts – both in their terms and rates of payment – have been built from traditional product offerings that offer a certain level of administrative efficiency because the deductible and copayment is relatively modest. In order to ensure that hospitals and insurers act with the best interests of consumers, products with high patient cost sharing should be considered new insurance products subject to separate description and contract discussions with providers. Absent such treatment, there will be attempts to sweep these new products into current negotiated rates which, as noted, were agreed to upon the assumption that the cost of collection was minimal. In addition, we strongly recommend that plans wishing to offer high deductible health plans be required to provide clear and accurate information needed by providers prior to the delivery of services as to the amount of the deductible still outstanding and other prerequisites for full payment. If this information is not provided or it is not reliable, providers and consumers will be ill-served because billing will have to be pursued after services are rendered, and collection will be more difficult for all parties. Such information exists within payer systems but its complete and accurate transmission is not necessarily a high priority.

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.