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 Reauthorization of the Health Care Reform Act
Before the New York State Senate Health and Insurance Committees

January 11, 2005

Good morning, Majority Leader Bruno, Chairman Hannon, Chairman Seward, and other distinguished members of the Senate. 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.

In my testimony today, I will focus on the critically important Health Care Reform Act (HCRA), which expires on June 30, 2005, which supports essential public benefits provided by hospitals, including graduate medical education (GME), financial assistance to the uninsured, and workforce recruitment and retention; model health insurance programs such as Family Health Plus, 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. I will first review the context in which this critical renewal will occur, including hospitals' financial condition and what I would describe as dangerous structural imbalances in our health care delivery system, discuss 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.

I. Context for HCRA Renewal

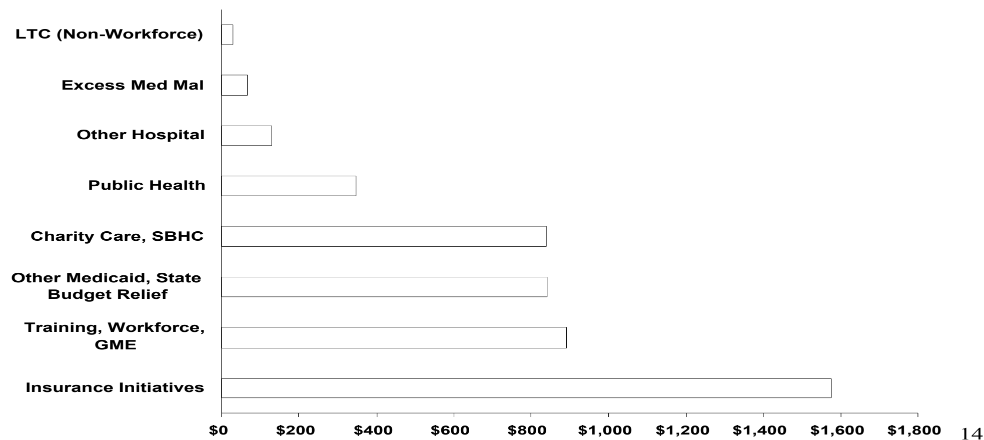
Attached to this testimony is a document we have prepared entitled *Questions and Answers on the Health Care Reform Act*, or HCRA Q&A, that I hope you will find useful in your deliberations. Also attached is a report entitled *Medical Malpractice Insurance Costs and Coverage*, which GNYHA prepared to better understand this complicated issue.

HCRA Has Evolved

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 graduate medical education (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.

HCRA Funding, 2004



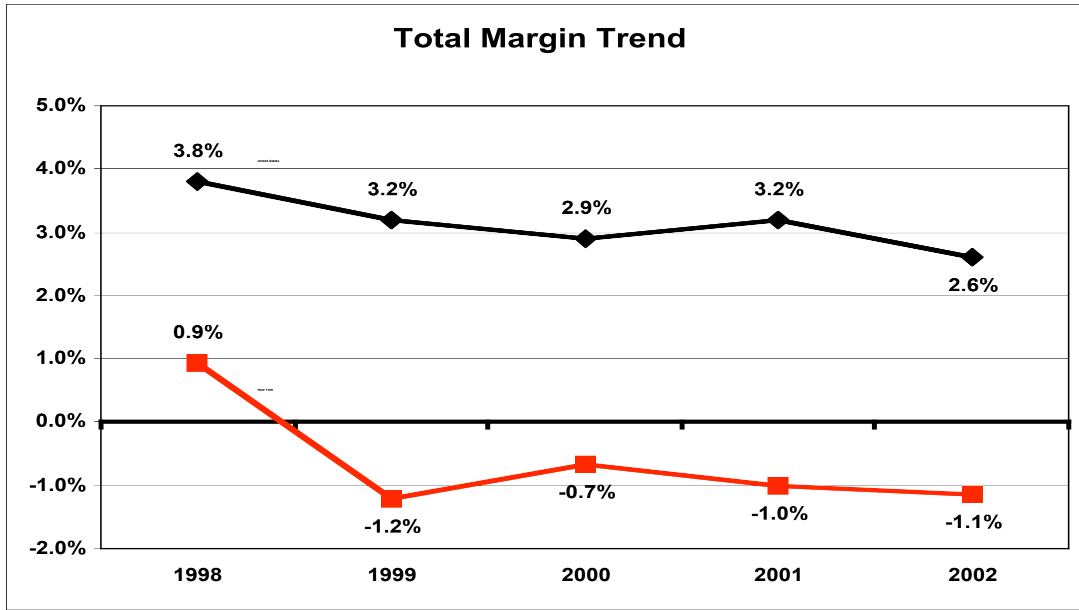
[14]

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.

How Has Deregulation Shaped our Health Care System? Three Dangerous Trends
Your notice of today's hearing referred to the many changes in our health care delivery and financing system that have been playing out over the past several years. From our perspective, three trends need to be underscored. The first two trends are portrayed by the charts below: Hospital bottom line margins over time; hospital financial ratios compared to other states; and health plan and hospital profits and losses. These figures show that our hospital system is dangerously underfunded and that the relationship between hospital and health plan financial health has become inappropriately skewed.

The first 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 is not yet publicly available.

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).

Hospitals' poor profitability is, not surprisingly, reflected in their cash flow, their ability to meet current operating and capital obligations, or the degree to which they rely upon debt, rather than equity, financing. This is seen in the chart below, which compares New York hospitals 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.

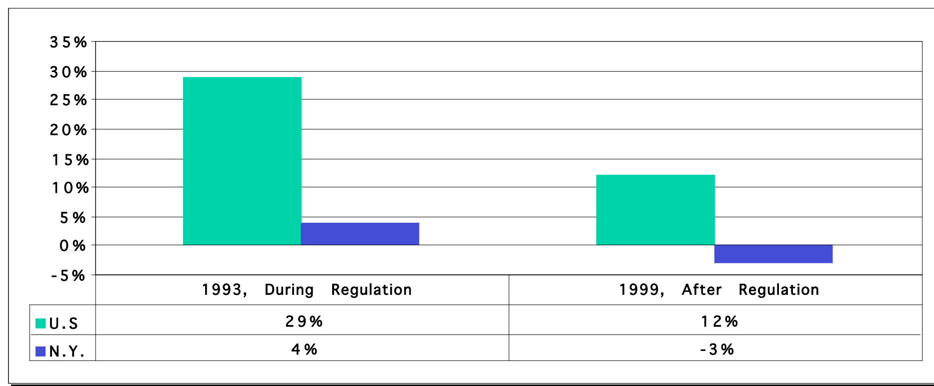
The Financial Condition of New York Hospitals is Among the Worst in the United States

	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).**

The reasons behind this financial situation are complex and include the loss of critically important Medicare reimbursement over time as well as the fact that the legacy of the regulated hospital system was not extinguished by the abandonment of rate-setting. As you know, the

regulated payment system, NYPHRM, essentially paid cost-based inpatient rates to hospitals with a specified "mark-up" for non-Blue Cross plans. This produced breakeven profitability for years before HCRA was enacted. After deregulation, however, 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 is no longer able to adjust hospital revenues through rate appeals or enhancements to assure that needed community providers remain financially stable. Thus, as seen by the graph below, while private payers paid 4% above cost under the regulated system, their payments actually fell below costs after regulation.

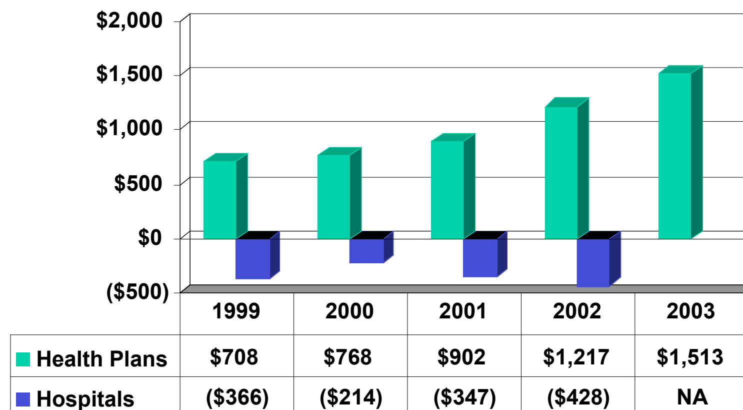


Private Payer Payments in Relation to Cost, Pre- and Post-Deregulation

Source: Medicare Payment Assessment Commission (MedPAC)

This phenomenon has 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, $1.15 billion, of any state in the country. California health plans, the second highest group, had profits of $878.3 million.

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.

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

The third structural imbalance that we wish to identify is the emergence of niche providers. 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 the fixed costs already in the system – including hospital capital and costs associated with providing services to the uninsured and maintaining 24/7 emergency and trauma services, for example – continue to exist, and new costs associated with these new provider settings are simply additive. *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. They 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 services to the uninsured, maintenance of emergency and trauma services, emergency preparedness activities, unprofitable services such as obstetrics, and the like. Needless to say, niche providers themselves do not provide community services, nor are they subject to the same quality and regulatory reporting requirements as are hospitals.

Since 1998, there has been explosive growth of niche providers within New York State. In 1998, 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.

Thus, GNYHA strongly supports a moratorium on the establishment of additional niche providers in New York State pending study of the impact of such providers on hospitals and the health care system as a whole. 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 report on the provision of office-based procedures so that the State can have information on the extent and nature of such services.

Impact on the System. In the past, when we have come before you with grave concerns about hospitals' financial condition, you have asked me whether hospitals have actually closed. Unfortunately, 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 to provide 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 on it by the next time that I come before you next year if we do not take steps to address this situation.

Hospital Closures Since 1996 in New York State

Hospital	County	Date Closed
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 of the Bronx	Bronx	January 1998
Salamanca	Cattaraugus	July 1998
Columbus Community Healthcare	Erie	October 1998
St. Johns Episcopal Community Hospital	Suffolk	June 1999
New York Flushing Hospital Medical Center	Queens	June 1999
St. Mary's Hospital	Monroe	November 1999
Massapequa General Hospital Inc.	Nassau	August 2000
Olean General Hospital	Cattaraugus	May 2001
Genesee Hospital	Monroe	May 2001
Myers Community Hospital	Wayne	January 2003
Caledonian Campus/Brooklyn Hospital Center	Kings	March 2003
Jewish Hospital of Brooklyn/Interfaith Medical Center	Kings	April 2003
Mary McClellan Hospital	Washington	April 2003
Island Medical Center	Nassau	July 2003
St. Agnes Hospital	Westchester	October 2003
Florence D'Urso Pavilion/Our Lady of Mercy Healthcare System	Bronx	January 2004
New York United Hospital Medical Center	Westchester	Announced December 2004

II. HCRA Renewal Priorities

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.
- 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 Senate 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.

- 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.
- 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.

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 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.

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.

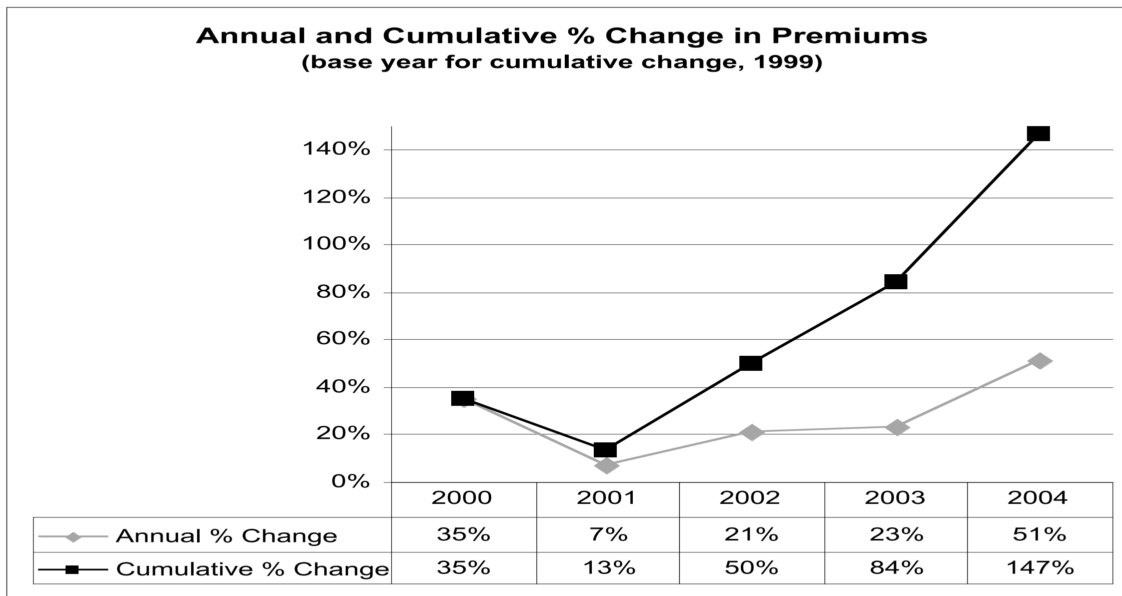
III. New HCRA Priorities

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.

Annual and Cumulative Percent Change in Hospital Malpractice Premiums



	2000	2001	2002	2003	2004
Annual % Change	35%	7%	21%	23%	51%
Cumulative % Change	35%	13%	50%	84%	147%

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.

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.

[a]Premiums reflect occurrence policy rates.

[b]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.

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 announced in his State of the State address last week that he would include the bond act as part of his budget.

- GNYHA looks forward to working with the Governor and the State Legislature to enact the full HEAL New York Bond Act in 2005.

Language Assistance. Hospitals continually strive to provide 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 such a 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. The hospital community's ability to address these challenges is unfortunately significantly limited, however, by a severely under-funded health care system, particularly viewed in the context of the vast number of languages, cultures, and special circumstances that are present in the region. If funding for interpretation and translation services were the only funding need of hospitals, they might be able to identify and secure the resources required for this purpose quite readily. However, hospitals also require significant funding for many other activities essential to serving all of their patients and communities

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. Imposing new or expanded requirements on an already fragile system in order to address an important but very specific problem will not solve the more fundamental financial problems facing health care. Instead, the legislative proposals will only add to the goals and ideals the health care system cannot afford to accomplish.

- 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.

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 Senate to stabilize and improve our health care system.