



Community Health Care Association of New York State

**Increasing Access to Health Insurance Coverage and
Moving Toward Universal Healthcare Coverage
Public Hearing
September 5, 2007**

Governor Spitzer, Commissioner Daines, Superintendent Dinallo, thank you for the opportunity to testify today. My name is Kate Breslin and I am the Director of Policy at the Community Health Care Association of New York State, CHCANYS. We are extremely grateful and heartened that our State's leaders are reaching out to try to make our health care infrastructure work better for more New Yorkers. You have a challenge ahead of you and we look forward to being a part of the solution.

CHCANYS is New York's primary care association and the statewide association of community health centers. Community, migrant and homeless health centers serve as the family doctor and healthcare home for over 1.1 million New York State residents at more than 425 sites, rural and urban.

- Though we try hard to ensure that people are enrolled in health insurance if they are eligible, 28 percent (324,000 people) of health center patients are uninsured; 43 percent are covered by Medicaid;
- Most (70%) health center patients have family incomes below the federal poverty level; and
- 74 percent of health center patients are racial or ethnic minorities;

According to our mission and our mandate, community health centers are only located in designated underserved communities and they provide access to primary and preventive health care regardless of insurance status or ability to pay. In order for a federally qualified community health center to meet federal expectations, it must create and implement a sliding fee scale, allowing low-income patients without health insurance to pay discounted medical bills in proportion to their income. At a community health center, each patient receives the best and most appropriate care for their needs, regardless of which insurance company is paying the bill.

Health centers offer family medicine as well as comprehensive primary care, including obstetrics and gynecology, pediatrics, dental, laboratory, mental health and substance abuse services. At many health centers, patients can obtain subsidized prescription pharmaceuticals for as little as \$5 or \$10 per prescription.

As we all know, here in the United States, a person's race, ethnicity, and class have a strong bearing on their health care and health outcomes. Community health centers were born out of an idea that this is not the way it has to be. In fact, health centers have documented results in reducing disparities through prevention and management of chronic conditions and have demonstrated the ability to save money *and* offer high quality care.

But still, we've got a problem. Despite a lot of good research and positive remarks from policymakers and the public, primary care is in crisis.

My remarks today focus on three points:

- Coverage matters.
- The primary care infrastructure matters.
- The intersection between the two – coverage and access – is key.

Coverage Matters

Reliable, affordable, comprehensive insurance coverage for all New Yorkers is essential to ensure continuity in primary and preventive care as well as coverage for chronic conditions. People who are both poor and uninsured are more likely to delay needed medical care for chronic diseases, less likely to fill a prescription, and more likely to be hospitalized for a condition that could have been avoided with timely health care. Uninsured persons receive less preventive care, are diagnosed at a more advanced stage of illness and, once diagnosed, tend to receive less therapeutic care and have a higher mortality rate. Lack of insurance leads to higher rates of emergency room use, especially for conditions that could have been treated more successfully in a primary care setting.

Coverage matters for health care providers, too. Gaps in insurance coverage affect safety net providers like community health centers and all health care providers located in and focused on serving our most vulnerable residents. At the same time, the extremely low rates paid by commercial insurers to community health centers and other primary care providers presents a significant and growing problem for health centers across the state. A lack of adequate reimbursement for health care providers who care for growing numbers of both uninsured and commercially insured patients is starving these very providers people rely on for cost-effective care and that the State relies on to ensure access in underserved areas.

We support efforts to attain universal coverage, including expanding Medicaid, Child Health Plus and Family Health Plus coverage and urge the State to take the following actions.

- Continue to simplify eligibility and renewal for public health insurance and undertake aggressive outreach in the Medicaid, Family Health Plus and Child Health Plus programs; this should include an intensive and expansive facilitated enrollment program. Estimates suggest that 70 percent of uninsured children and one-third of uninsured adults are eligible for coverage in one of our public programs.

- Continue to move forward with Governor Spitzer’s stated intent to cover all children. This is an exciting starting point, and we heartily endorse the logical next steps of covering their parents and childless adults, who also suffer the negative effects of lack of insurance.
- Ensure that expansions of our public health insurance programs are affordable to low-income New Yorkers. Cost sharing should be minimized for those with very low-income. Co-payments, co-premiums and high deductibles are not the answer for low-income New Yorkers; people need coverage that they can and will use.

The Primary Care Infrastructure Matters

Coverage is necessary but not sufficient. We need to be concerned about a state where everyone is covered, but access to effective primary health care is limited and the only type of care people can access is the emergency room and costly specialists. Primary care is the front end of our health care system and it is a *part* of the solution to covering everyone. It is the form of care that is the singularly least expensive and most effective in preventing expensive emergency room visits and avoidable hospitalizations and thus reducing health care costs. Despite the well-known benefits of primary care, New York State’s primary care system is uniquely underdeveloped in comparison with its expansive and expensive acute care system. New York ranks 45th among the 50 states in Medicaid spending on primary care, while spending more than any other state on Medicaid overall. We need to readjust; the more a state spends on its primary care system, the less it spends overall. That’s a particularly important message to heed, as a 2004 study found that New York wasted \$1.1 billion dollars on avoidable emergency-room visits.¹ As health care costs grow without associated improvements in outcomes, we can’t afford to ignore primary and preventive care.

Investing in our primary care infrastructure will lower costs and improve outcomes. Data from around the world show that with a strong community-based, primary care infrastructure, unnecessary hospitalizations and associated costs can be averted, overall health status can be improved and disparities can be reduced.^{2,3,4,5}

New York should ensure that all New Yorkers, including those without health insurance, are able to access a primary care home. This entails:

- Investing state dollars in expanding primary health care, so that people have access to high quality, lower cost options.
- Investing state dollars in strengthening health information technology at the community-based and primary care levels, to support care management and outcomes tracking.

There remain large areas of the state with severe shortages of primary health care. Even with the best coverage, if there are no primary care doctors or if patients must wait for months for an appointment or risk ending up in an emergency room, we will not see improvement in outcomes.

The Intersection Between Coverage and Infrastructure is Crucial

Coverage has to be done right if we want better outcomes. Even with the best of intentions, if health care providers are not paid or reimbursed enough to remain financially viable, they will need to close their doors and we'll all lose. Primary care remains a sector that is seriously under-reimbursed, which has implications for the primary care infrastructure's viability in terms of capital and workforce.

To ensure that health centers are effectively positioned to maximize care, federal law requires state Medicaid programs to pay health centers for the services they provide at a cost-based rate. This federal requirement helps to ensure that health centers do not incur losses when they care for Medicaid patients.

The situation is different when it comes to payments from commercial payers. Some community health centers, many of them located in rural areas including the Adirondacks, serve a significant number of patients with private/commercial health insurance. It is estimated that between 20 and 30 percent of CHC patients in New York State have private coverage and in some centers, the number is equal to half or more. A widening gap between reimbursement rates received by community health centers from public versus private payers is threatening community health centers' ability to serve commercially insured patients, and is eating away at the limited public resources intended for the uninsured and other public funds. In addition, health centers frequently have contracts with numerous (15+) commercial payers, which brings substantial administrative burdens that take resources away from patient care. These administrative burdens include credentialing, preauthorization requirements and the multitude of different plan incentives.

Several community health centers – in rural and urban areas -- are being hobbled by the extremely low payments they receive when they provide care for commercially insured patients. In an environment where large and powerful commercial insurance companies negotiate rates with stand-alone providers in underserved communities, health centers end up on the short end, accepting whatever payments they can get from the commercial plans, rather than turning those patients away. Health centers are put in the untenable situation of choosing to accept a particular insurance plan, despite payments that do not cover the cost of care or telling the patient, who may not have other viable options, that they do not accept that insurance. There is particular irony in this situation, since the primary and preventive care provided at community health centers, even when fully reimbursed, saves money and yields better results in the long run. Yet there is no strong incentive for a commercial plan to cover the costs associated with providing high quality primary care when there is a significant likelihood that the insured person will be covered by another carrier in a few years.

New York's health centers care for a growing number of uninsured patients each year; the number of uninsured persons served by New York State's community health centers increased by 59 percent between 1996 and 2006. During that time, the amount of funding in the pool that helps to cover this care remained flat, threatening the centers' ability to serve those in need and remain financially viable. Recent legislative action results in approximately 30 percent of care for the uninsured being covered, still grossly inadequate to cover costs, but an improvement.

Until we achieve universal coverage, there will be uninsured New Yorkers who require access to primary care. It makes more sense to serve them in community health centers than in emergency rooms. As we continue to work toward universal coverage, the State needs to

- Increase funding for the diagnostic and treatment center indigent care pool. As hospitals reconfigure their services and convert facilities to D&TCs, more facilities will draw from the fixed D&TC pool. This will only exacerbate an already intolerable primary care indigent care funding shortfall for primary care providers. We need to ensure the viability of the safety net so that all New Yorkers have access to appropriate care.

As New York designs a new health coverage and access infrastructure that aims to ensure that the health care system is affordable and accessible, we need to also address the viability of the people and institutions providing the care. Our system for paying for health care needs to be examined and addressed in a comprehensive way (not just Medicaid) to ensure that payers actually pay for the costs of providing care. We look to our policy leaders for

- Comprehensive, all payer reimbursement reform to ensure the stability of our safety net.

We appreciate the opportunity to be heard today and, even more, to continue to participate in New York’s endeavor to rationalize our health care infrastructure and delivery system through coverage and access. We look forward to continuing to work together with our policy leaders to improve, stabilize and strengthen our ability to deliver high quality health care to all New Yorkers.

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¹ National Association of Community Health Centers, *2006 Access to Community Health Databook*, New York (2006).

² Rosenbaum, Shin, Whittington, *Laying the Foundation: Health System Reform in New York State and the Primary Care Imperative*, 8, citing Epstein, “The Role of Public Clinics in Preventable Hospitalization among Vulnerable Populations,” *Health Services Research*, 2001, 32:2, 405-420.

³ *Id.* at 9 (literature review).

⁴ Institute of Medicine, *Primary Care: America’s Health Care in a New Era*, 1996, 62.

⁵ Starfield, Shi, Macinko, *Contribution of Primary Care to Health Systems and Health*, *The Milbank Quarterly*, v.83, n.3, 2005.