

Hello. My name is Gaen Hooley. I am a registered nurse and a member of the New York State Nurses Association, the American Nurses Association.

The American Nurses Association and the New York State Nurses Association believe that health care is a basic human right. Forty four million Americans do not do not have health insurance and tens of millions more are underinsured.

The current healthcare structure in New York is fundamentally flawed. Significant disparities and gaps in coverage are inherent in a system where the majority of patients are covered by diverse employer health plans and where private, for-profit insurance companies drive fee schedules that seldom reflect the actual expenses of services rendered.

Because of this patchwork system, New Yorkers who have health coverage may be denied care that is excluded from their policy packages or unavailable from their network providers. Thousands of patients who have insufficient or no health insurance coverage often find the cost of care to be prohibitive. Patients are increasingly foregoing necessary health care or are clogging emergency rooms for otherwise preventable or primary care issues. It has been demonstrated in national studies that health coverage based on private, for-profit insurance companies is extremely expensive and does not improve the quality of health care.

I am fortunate to have health insurance for my family provided by my employer. Throughout my career I have been covered by number of different health insurance plans; a traditional Blue Cross/Blue Shield plan, a Health Maintenance Organization – with Independent Health, a Preferred Provider Organization (PPO) – with Empire BC/BS and now a Health Reimbursement Arrangements (HRA) through BC/BS. Each of these plan types has their own obstacles to overcome in terms ease of use by consumer. I have often had claims denied by the insurance company that were covered benefits. I am an educated consumer, I know and understand my benefits. I know what is covered and what is not. I know and understand that certain types of care

require a “pre-certification” by my insurance company or payment will be denied. Therefore I know enough to call the insurance company and object to a denied claim. I know that I have a right to appeal a denied claim. Each and every time I make that call regarding a denied claim I recall the movie *The Rainmaker* ([1997](#)), based on a John Grisham book, directed by [Francis Ford Coppola](#), starring Matt Damon. Do you recall the story line? A poor family denied health insurance coverage for their son diagnosed with leukemia, his treatment considered by the insurance company to be “experimental.” His parents win the lawsuit against the insurance company but their son dies. The testimony in the movie was that claims clerks were instructed by the insurance company to automatically deny the claim. Is that what my insurance company is trying to do? How often do consumers question a denial or process an appeal?

The other thought that crosses my mind when I call regarding a denial of benefits is of the elderly, extremely ill or poorly educated consumers; the people that due to their illness do not have the energy to make the calls necessary or those that do not understand their benefits. When they receive their explanation of benefits and the claim is denied who helps them understand whether or not the claim was legitimately denied. How many just assume the denial is correct and pay the bill?

Let me give you a couple of quick examples of my experiences:

- My husband has emphysema. A little more than a year ago, his symptoms increased. He had a persistent cough, increased shortness of breath, frequent headaches and fatigue. Our physician prescribed a Chest Cat Scan to rule out lung cancer. Cat scans require pre-certification with my health care plan. I was present as the clerical staff at our physician’s office attempted to get the approval from my insurance carrier, repeating the diagnosis and symptoms, the clerical person on the other end of the phone could not approve the CT, based on her predetermined protocol criteria.

It took the physician's assistant to personally get on the phone and explain my husband's history and the rationale for the order to gain approval. Who is the medical practitioner? The physician? The physician's assistant? The advanced practice nurse or the clerk at the insurance company?

- My daughter saw her primary physician for a sick call in January of this year. The claim was denied. I received a bill for \$219, for a doctor's office visit. When I inquired to the insurance company the reason for the denial I was told the visit was coded as if she was seen only by a medical resident. The coding was incorrect. The attending physician also saw her. I called Kaleida Health, both the physician's office and the billing department. I was assured the visit would be re-coded correctly. Kaleida then billed a different insurance company, not once but twice. Each time I called to inform them they billed the wrong company and gave them the correct information. Finally they billed my company, but the code was not corrected and the claim was again denied. It was only in the past week that the claim was correctly processed. My final cost for this visit was ZERO. But the time and energy I spent to get the insurance company to pay the claim and the Health care provider to code it correctly was significant. How many consumers would have just assumed for some reason the visit was not a covered benefit? How much time was consumed by the clerical staff at Kaleida Health and my insurance company? We all pay for this time in our health care costs and insurance premiums.

- Many years ago when my oldest daughter was in college we were covered by a HMO. I attended the informational meetings provided by the HMO to understand the benefits before signing on with that plan. My daughter would be attending college away from home, I needed to know she would be covered. When she fell at school and broke her wrist the emergency care was indeed covered. However, the HMO denied the after care and physical

therapy stating she should have received that care at home, it was not an emergency. Now was that reasonable?

Remember I said she was away at college. The insurance company expected her to travel home 1 ½ - 2 hours each way for after care and physical therapy several days per week?

When was she to attend class and do her homework?

Following appeal the HMO paid the bills, but in the interim the doctor's office had made a report of non payment which appeared in a negative light when I went to refinance my mortgage 3 years later.

My current Health Reimbursement Arrangements, includes high deductibles; \$4000 for family coverage in network, of which the employer contributes the first \$3000, leaving \$1,000 deductible for the me the insured individual. These deductibles must be met before the insurance kicks in. Therefore all costs, including the costs of prescriptions are paid in full for the first \$4,000 in each calendar year. Then the insurance, co-insurance and co-pays kick in. Maximum annual out of pocket is \$9,000 for a family in network, but if your family requires care out of network the maximum annual out of pocket cost doubles at \$18,000!!!! Does anyone on this panel or in the audience think this is reasonable? How many middle class New Yorkers/Americans have \$9,000 - \$18,000 extra each year to spend on health care – this in addition to premiums already paid to the insurance company, in my instant case approximately \$1,000/month for family coverage.

I am one of the fortunate ones. I have health insurance. It is becoming more and more difficult for workers to maintain this benefit as it becomes more and more costly to our employers. Every year since **1965** health care expenditures have risen 2 -4 times the rate of economy wide inflation! We have seen double digit increases in premiums for last several years.

We must as a state and a nation address this issue. We cannot afford to continue in the same direction. Each year millions of Americans and New Yorkers including our children go without health care. They do not receive any preventative screening or

testing. They put off seeking care when they are ill because they cannot afford to pay the costs. By the time they are seen in the health care system they are often very ill requiring hospitalization.

As I was preparing for this testimony the following came across my desk. It is not a local report, it is from New York City, but I suspect our local data would be very similar.

Last Thursday, New York City Comptroller William Thompson released a landmark report on health disparities showing that the gap health and health care between rich and poor city residents has unfortunately skyrocketed since 1990. Rates of heart disease, cancer and, particularly, diabetes have struck poor neighborhoods particularly hard in the last 15 years, the comptroller found.

Preventable or manageable diseases Comptroller Thompson found to be dramatically rising in low-income neighborhoods include:

\* **Diabetes** : The total number of diabetes hospitalizations in the city increased by 82.9 percent from 1990 to 2005, the comptroller found. During that same period, diabetes hospitalization rates more than doubled in five low income neighborhoods (Hunts Point-Mott Haven, Highbridge-Morrisania, Crotons-Tremont, East Harlem, and Fordham-Bronx Park).

\* **Heart Disease** : From 1990 to 2005, the heart disease hospitalization rate rose in 34 of 42 neighborhoods, according to Thompson, with the largest increases (in excess of 40 percent) in eight mostly low income neighborhoods.

\* **Cancer** : Thompson noted that from 1995 to 2005, the number of cancer deaths in New York City dropped 11.7 percent. The cancer mortality rate increased in only eight of the 42 New York City neighborhoods, including the low income neighborhoods of Hunts Point-Mott Haven, Crotona-Tremont, East Harlem, and Williamsburg-Bushwick.

A huge part of the solution to the rising rates of hospitalization and death from these three diseases, according to Thompson is: Increasing primary and preventive care capacity and currently meager reimbursement rates. "Simply stated, providing primary and preventive care saves lives and money, and is key to

reducing disparities,” Thompson said. “Research studies have firmly established a positive correlation between the availability and utilization of primary and preventive health care in a neighborhood and the health of a neighborhood’s residents.”

The full report can be found here:

[http://www.comptroller.nyc.gov/bureaus/opm/reports/09-27-07\\_health-wealth-report.pdf](http://www.comptroller.nyc.gov/bureaus/opm/reports/09-27-07_health-wealth-report.pdf)

Articles appeared in the New York Times, the New York Post, the New York Daily Times, the New York Sun and the Associated Press regarding this report. I think it clearly demonstrates what I have been trying to say here today.

We must establish a policy that guarantees health care access that is comprehensive, quality, affordable, culturally competent and community based. We can no longer afford to discriminate based on income, employment status, age, health, race or culture.

Thank you for the opportunity to speak today. The governor’s commitment to health care is definitely a step in the right direction but I hope we will take the necessary steps toward universal health care as a nation, not only as New York State.