



Strategies to Cover the Uninsured in New York

Testimony

of the

Healthcare Association of New York State

before the

New York State Insurance Department and

New York State Department of Health

Partnership for Coverage Public Hearing

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Erie County Community College

Buffalo, New York

Thank you, Commissioner Daines and Superintendent Dinallo for providing the Healthcare Association of New York State (HANYYS) the opportunity to testify regarding strategies to achieve universal health insurance coverage in New York State. I am Raymond Sweeney, Executive Vice President of the Healthcare Association of New York State, which represents more than 550 non-profit and public hospitals, health systems, nursing homes, home care agencies, and other health care providers throughout New York State.

I am delighted to be speaking on this important topic today. HANYYS has been a strong supporter of universal coverage for many years and it is deeply gratifying to see state government taking meaningful steps toward that goal—these hearings are an important step.

Expanding access to New York's approximately 2.6 million uninsured residents is a difficult task. The Governor's charge to your two agencies is to develop and recommend coverage strategies by May 31, 2008. Clearly, this is an important step in New York's efforts to ensure affordable access to high quality care for all of our residents. Part of the process includes soliciting public input through this statewide series of hearings.

The Administration has identified a building-block approach to universal coverage, broken into three major stages: 1) covering the approximately 1.3 million uninsured adults and children who are already eligible for a public coverage program; 2) increasing the number of insured children through a Child Health Plus (CHP) income eligibility expansion; and 3) providing coverage to about 1.3 million uninsured residents who are currently not eligible for a public coverage

program. HANYS agrees that it makes sense to structure the state's initiatives to address each of these components of the uninsured, and we will speak to each of them.

COVERING THE UNINSURED BUT ELIGIBLE

Last year, HANYS joined numerous organizations in calling for simplification of Medicaid and Family Health Plus (FHP) enrollment and to improve program retention. In the 2007-2008 state budget, the Administration similarly set forth initial measures to begin streamlining program rules for public coverage programs such as Medicaid and FHP. HANYS supports the Administration's efforts to implement these changes and we recommend that New York further simplify the initial eligibility and recertification processes to maximize use of self-attestation of income/and or resources, and expand state responsibility for validation/verification using state databases, consistent with, but no more stringent than, federal requirements.

Process Simplification and Continuous Enrollment

Every year, eligible New Yorkers forgo enrollment in public programs because of the onerous requirements and excessive documentation needed to apply. Additionally, there is a population of enrolled individuals who involuntarily lose coverage every year because of the burdensome recertification requirements. For New York to successfully move toward universal coverage, we must promote process simplification and continuous enrollment to curb wasteful health care spending and utilization patterns. The Administration and State Legislature correctly began addressing these important issues by enacting two measures in this year's budget.

Changes enacted into law earlier this year, which HANYS supported, allow beneficiaries of Medicaid and FHP to attest to residence and income eligibility at recertification. CHP enrollees can already attest to income at recertification. Further, Medicaid and FHP enrollees are now guaranteed continuous coverage through 12 months from their latest eligibility determination, if they lose eligibility for a reason other than leaving New York State. These are great building blocks, but we need to further ensure simplicity in the enrollment and recertification processes and guard against enrollee “churning.”

HANYS and numerous other organizations are recommending that the state explore changes to Medicaid income eligibility standards. While both CHP and FHP use gross income as the eligibility standard, Medicaid still uses net income. Using gross income instead of net income to define eligibility is much simpler and may enable the program to reach more eligible adults. Additionally, HANYS recommends removing the asset test as an eligibility requirement for Medicaid and FHP.

HANYS recommends that the state consider additional public program changes that are detailed in a 2006 United Hospital Fund/Commonwealth Fund study. One of these changes is to expand FHP income eligibility to 150% of the federal poverty level (FPL) for childless adults. This expansion would align their eligibility with that of parents. The second change would allow for subsidized buy-in to FHP, enabling individuals with incomes between 150% and 300% of FPL to buy into the program with sliding-scale premium assistance. A similar law, which creates employer and labor partnerships for FHP, and was originally proposed as a Governor’s Program Bill, was passed in New York during the 2007 legislative session and signed into law. It gives

employers the option to offer FHP plans by contributing about 70% of premium costs for the higher-earning workers. The state would pick up the premiums for low-wage employees who are income-eligible for FHP. These two components could be part of the shared responsibility model discussed below.

The state must continue to improve the seamlessness of the system. There is no existing mechanism in New York to ensure a seamless transition between programs like CHP A and CHP B. The Children's Defense Fund estimates that between 16,000 and 33,000 children lost insurance coverage in 2005 due to this transition. We believe that enhanced use of state databases and utilization of information technology can improve the seamlessness of New York's health and welfare systems.

HANYS recommends that the state explore the use of Express Lane Eligibility. Express Lane strategies use existing government programs operating in New York State to identify and enroll low-income uninsured into the state's Medicaid or CHP program. These strategies offer real potential for retaining enrollees and capturing previously eligible but uninsured individuals, but the state must compare eligibility standards and participation rules between programs.

The state should consider linking government-subsidized programs. An example would be linking the Medicaid recertification process to the enrollment process for CHP and FHP. When a recipient loses eligibility for Medicaid, he or she could be automatically transferred from a plan's Medicaid managed care program to the plan's CHP or FHP program, for which he or she was deemed eligible, maintaining continuity of care with the same primary care provider and plan.

Similarly, when a child ages out of CHP eligibility (age 19), the plan should be responsible for determining FHP eligibility and, where eligible, should automatically transfer the enrollee to that plan's FHP program. HANYS recommends considering a uniform duration of coverage for public program enrollees with one renewal date per family.

Re-enrollment costs are substantial and time-consuming, highlighting the importance of the recently enacted provision to guarantee coverage through 12 months. However, New York State should go one step further and also pursue a federal waiver for continuous eligibility of up to two years for Medicaid, CHP, and FHP.

Outreach

Unfortunately, making programs available—even popular ones like CHP and FHP—is not enough to ensure coverage for all who are eligible. Outreach is a necessary and important complement to a simplified application process. The effectiveness of using facilitated enrollers has been demonstrated in the CHP program. HANYS recommends the state provide funding to expand use of facilitated enrollers for all programs, including expanding partnerships with community-based organizations, providers, and others. Facilitated enrollment programs are successful at increasing access to community-based application assistance, which is a positive step toward coverage for all New Yorkers.

Grant-funded facilitated enrollers have proven effective in outreach efforts. To build upon past work and continue enhancing outreach, we must expand our efforts by using volunteers and

hospital auxiliaries in this capacity. HANYS recommends training volunteers, including hospital auxiliaries, to maximize workforce resources in this important effort.

CHILD HEALTH PLUS INCOME ELIGIBILITY EXPANSION

Universal coverage discussions should begin with insuring all children. Children across New York and the nation must have affordable access to quality care. Last year, HANYS recommended increasing income eligibility for CHP B to at least be consistent with the highest income eligibility standard in the nation (350% of FPL).

In the 2007-2008 state budget, the Governor proposed and the Legislature endorsed an even higher standard—increasing CHP income eligibility to 400% of FPL—a proposal that HANYS supported. This proposal required federal approval, which was recently denied. Political and ideological differences in Congress over the future of health care in the U.S. have complicated the reauthorization of the State Children’s Health Insurance Program (SCHIP), which expires on September 30. This has, in turn, complicated states’ efforts to increase coverage to more uninsured children. A new policy implemented by the Centers for Medicare and Medicaid Services (CMS) requires states to limit SCHIP enrollment to 250% of FPL unless they meet three primary conditions: (1) cover at least 95% of children living below 200% of FPL in either Medicaid or SCHIP within a year; (2) address private coverage crowd-out by imposing a 12-month waiting period on any new enrollees over 250% of FPL; and (3) impose cost-sharing requirements in approximation to the cost of private coverage. HANYS supports the state in challenging CMS’ attempts to limit state prerogatives in crafting a children’s health insurance program consistent with state needs and circumstances. HANYS is strongly advocating for a

reauthorization of SCHIP that allows New York to continue to grow its program and insure more children through an income eligibility expansion.

Federal financial participation is crucial and HANYS also recommends continued pursuit of a longer term goal: expanding the federal match for Medicaid—either the Federal Medical Assistance Percentage (FMAP) generally, or increase the match for all children enrolled in Medicaid to the same level as SCHIP (65% federal financial participation)—to guarantee adequate funding for programs serving New York’s children.

NEW COVERAGE STRATEGIES

Finding the right bridge between publicly funded coverage and private coverage for the remaining 1.3 million New Yorkers is the challenge. Of course, this is not just a state issue—it is a national issue affecting 47 million people that demands a national solution. While there is reason to be optimistic because of growing interest in finding a national consensus, it is clear that states remain the primary and immediate proving ground for testing options. New York State has a unique opportunity to add its views and ideas to help shape the national agenda—as we did with Child Health Plus and Family Health Plus.

In short, HANYS supports a multi-participatory approach to covering the 1.3 million New Yorkers who remain ineligible for or uncovered by existing programs—a plan involving shared responsibilities for government, employers/payers, and individuals.

The blended approach adopted in Massachusetts is perhaps the most immediately relevant model on which to begin a discussion of what might work in New York. Besides its proximity, Massachusetts shares many similar characteristics with New York, including political, economic, and social demographics. Most important, we have the opportunity to observe and learn what works and what does not from the Massachusetts implementation process. However, despite the similarities, there are also significant variations in the characteristics of the uninsured between the states that necessitate that we find our own blend for sharing responsibilities among stakeholders.

Massachusetts is, of course, only one example of a shared-responsibility model. Several other states are considering variations on the approach and we will note California's efforts below. Moreover, many of the current Presidential candidates—notably New York's Senator Hillary Clinton—have offered proposals that embody elements of shared responsibility. The United Hospital Fund also provides an excellent analytical framework and modeling information on a range of options that will be invaluable for an informed discussion.

The point is that there is a range of possibilities to consider in crafting a unique New York plan. What is needed is a consensus-building process that involves all the stakeholders—government, providers, employers, payers, and consumers—and that allows a full exploration of options around the principle of shared responsibility. HANYS remains committed to support and participate in such a process.

One word about what we think is not “inside the boundaries” of a shared responsibility discussion. On either end of the spectrum are (1) the single-payer approach and (2) voluntary, tax credit-only approaches (relying on high-deductible plans). While the single-payer approach offers a promise of reducing administrative overhead of a complex, multi-payer system, we do not consider it a viable option for a state to consider in isolation and it is a political non-starter at the national level. At the other end of the spectrum, high-deductible plans attempt to address the problem of the high cost of insurance, but do so at the expense of exposing segments of the population (e.g., those with chronic conditions) to difficult and expensive choices. Neither of these approaches are viable for New York.

Massachusetts

Massachusetts’ health care reform legislation blends major components, including coverage mandates for individuals and employers, expanding Medicaid, enacting health insurance market reforms, and creating an independent public entity to facilitate the purchase of health insurance products. HANYS supports the concept of shared responsibility embodied in that plan.

Individuals over the age of 18 are required to carry coverage. Failure to secure coverage results in penalties enforced through the tax system. To ensure that employers are participating in the financing of health care, the legislation creates a “fair share contribution” of \$295 per employee that every employer with 11 or more full-time equivalents (FTEs) must pay if it does not contribute to health care. Additionally, a “free rider surcharge” is assessed to employers that do not provide coverage if an employee or dependent uses state-funded uncompensated care three or more times, or if the company as a whole has more than five total occurrences in the year. The

surcharge is 10% to 100% of the cost to the state for services provided and is triggered when these costs exceed \$50,000 in the aggregate.

The law also includes an integral role for government. Family income eligibility for the Massachusetts Medicaid program was increased to 300% of FPL for children, while also increasing enrollment caps for several other public programs. The law includes a substantial increase in Medicaid provider rates for hospitals and physicians. A new program was created that offers subsidized and non-subsidized private insurance products on a sliding-scale basis. The subsidized products are offered exclusively for the first three years by Medicaid contracted managed care organizations (MCOs), and the non-subsidized products through private plans. An independent public entity, known as the Connector, was created to function as an intermediary between health insurance plans and individuals and small businesses. In addition to administering the new subsidized program, key functions of the Connector include approving health plans, certifying/ensuring that these are affordable and creditable coverage options, creating enrollment procedures, determining subsidies, and publishing rates and products. The Connector also allows individuals to purchase coverage pre-tax and ensures portability by permitting employees to keep the same insurance if they change jobs.

Several proposals for insurance market reform are included in the law. The non-group and small group markets were merged—an action that the Massachusetts Legislature predicts will result in a 20% reduction in individual premiums. And, a variation on community rating was incorporated for younger populations (from age 19 to 26) to provide more affordable coverage for younger workers.

The individual mandate became effective July 1. More than 155,000 of the roughly 550,000 previously uninsured residents signed up for coverage, but the bulk of those are in the new, highly subsidized plans. About 15,000 enrolled in private, non-subsidized plans. However, Massachusetts' officials estimated about 160,000 residents needed to sign up for the non-subsidized plans for the state to reach its goal of near-universal coverage. More than 200,000 Massachusetts residents missed the deadline and are currently without insurance. While very early in the implementation process, it remains to be seen whether the “carrot/stick” approach to mandating coverage will work.

New York and Massachusetts

Demographic differences and differences in the makeup of the uninsured populations in New York State and Massachusetts limit the direct applicability of the Massachusetts plan to New York, but the applicability in New York State of the underlying philosophy guiding the Massachusetts initiative warrants serious discussion.

Massachusetts was successful in developing a proposal because it relied on building a consensus between representatives across all stakeholders. HANYS believes a similar consensus-building approach is needed in New York State.

When discussing a Massachusetts-like plan in New York, consider these differences:

- New York has a larger share of low-income residents than Massachusetts.

	<100% FPL	100%-200% FPL	>200% FPL
New York	20%	19%	62%
Massachusetts	14%	16%	70%

- Low-income individuals represent a greater share of the uninsured in New York.

	<100% FPL	100%-200% FPL	>200% FPL
New York	36%	26%	37%
Massachusetts	29%	29%	43%

Other key differences:

- Seventeen percent of the non-elderly population in New York is uninsured, compared to 13% for Massachusetts.
- Forty-five percent of the uninsured in New York are eligible for existing public programs, compared to 23% in Massachusetts.
- Twenty-one percent of the uninsured in New York have income above 300% of FPL, compared to 40% in Massachusetts.

- Seventy-three percent of firms with 10 to 24 employees and 89% of firms with 25 to 99 employees in New York offered health insurance coverage, compared to 81% and 95% in Massachusetts, respectively.
- Non-citizens account for roughly 10% of the non-elderly population in New York State. Nearly one-third of this population is uninsured. This population, which is heavily concentrated in New York City (77%), is difficult to track and, thus, difficult to enroll into coverage programs.

Employers

The Massachusetts plan includes a very modest, \$295 per employee assessment, plus a “free rider surcharge” on employers who do not provide coverage for their workers. The need to find an affordable contribution level, particularly for small employers, has to be balanced against several competing concerns: (1) to encourage employers to directly provide coverage; (2) to discourage “crowd out”—the possibility of dropping coverage and paying the assessment; and (3) the cost implications on the public sector or individuals for their share of the system. It remains to be seen whether Massachusetts’ blend of responsibilities works as intended or expected.

A 2006 report from the United Hospital Fund and the Commonwealth Fund details two employer mandate scenarios for New York: a pay-or-play scenario and a modest employer assessment, similar to the Massachusetts model.

The pay-or-play scenario assesses employers with ten or more workers an 8% payroll contribution. Employers providing coverage and contributing at least 60% of the premium are given tax credits to offset the payroll contribution. This policy itself would provide coverage to 130,000 previously uninsured. The report finds that this approach would raise \$1 billion in revenue to help offset the cost of other reform and would result in more employers continuing to offer coverage directly, compared to the assessment scenario.

In the alternative model, the employer assessment is assumed to be \$400 per employee. This assessment would raise about \$400 million in revenues to help offset the state's cost of coverage expansions. The report concludes that \$400 per worker is not large enough to create an incentive for previously non-providing employers to begin offering coverage, and thus would have no direct impact on private sector coverage rates—all the growth would have to come from a public or publicly-subsidized coverage expansion.

Health care reform and universal coverage are also on the agenda in California—a state with which New York is always compared. California Governor Arnold Schwarzenegger is currently negotiating a universal coverage plan with the California Legislature. Governor Schwarzenegger's original plan proposed a pay-or-play scenario that would assess non-providing employers 4% of payroll. A separate coverage plan was passed by the California Legislature, which the Governor has threatened to veto. Under this plan, non-providing employers, through a pay-or-play approach, would be required to pay 7.5% of wages for employee health care expenditures.

HANYS does not have a specific recommendation with respect to the correct contribution level for employers versus the public sector or individual mandate for New York State. The range of options seems to be framed by the Massachusetts approach, on the modest end, to one based on a percent of payroll (say 7 to 8%) on the higher end. HANYS believes that the appropriate level can be determined through consensus-building and compromise.

Need for an Insurance Intermediary/Program Cost

The United Hospital Fund/Commonwealth Fund study analyzed the value of a purchasing mechanism similar to that employed in Massachusetts. Enrollees in this entity, referred to as the Insurance Exchange, would be charged a pooled group rate and two forms of income-related subsidies would be made available for FHP: a sliding scale premium subsidy for those below 300% of FPL, and premium contribution caps based on income level.

The report determines that an individual mandate with auto-enrollment is required to achieve universal coverage. Everyone in New York State would be required to purchase coverage, and those who do not voluntarily enroll into coverage would be auto-enrolled into coverage for which they are eligible and charged the premium owed. This mandate would be enforced through the tax system.

Applying the program changes with an individual mandate and an Insurance Exchange, regardless of the employer-related approach (pay-or-play or per worker assessment), would result in a 98% coverage rate—reaching 2.4 million of the 2.8 million that this report uses as the total uninsured population. The overall net cost would total \$4.1 billion. This is a reasonable

projection of the cost of adding coverage for more than two million New Yorkers. It is important to be clear, up front, that an investment will be needed and how it will be shared.

This work done by United Hospital Fund/Commonwealth Fund is an important starting point for discussions related to universal coverage in New York. HANYS supports the recommendations related to public program changes, as well as the shared responsibility approach set forth in this study. HANYS further believes that a consensus-building panel of stakeholders will be successful in determining the right combination of mandates, program expansions, and relative responsibilities for government, employers, and individuals.

RESPONSIBLE PAYER REFORMS

As we move toward universal coverage within a framework that includes managed care, it is crucial that we address lingering problems with managed care practices that limit access to care and proper payment for care. Achieving successful universal coverage requires that managed care organizations (MCOs) provide responsible access to and payment for needed medical care.

HANYS continues to strongly advocate for payer accountability and managed care reform. Achievement of reform will help to ensure that health care consumers are provided the benefits they deserve and providers receive timely and adequate reimbursement for the medical services they provide. HANYS was pleased to be a part of the 2007 managed care reform negotiations that resulted in Chapter 451 of the Laws of 2007. This important consensus-driven reform is a direct result of a paradigm shift led and directed by the departments of health and insurance, whereby all stakeholders were brought together to work out the points of contention between

payers and providers. We congratulate and thank the agencies as well as the New York State Legislature for driving and achieving a fair, reasonable, and balanced package of reform initiatives.

HANYS is particularly pleased with the major breakthroughs regarding the obligations of health plans that preauthorize services. According to the new law, MCOs are required to pay for pre-authorized services, except under limited circumstances; MCOs will share the financial risk, under certain circumstances, of claims denied when an insured person is determined to be ineligible for coverage; and MCOs are prohibited from denying an additional surgical or invasive procedure that is provided at the same time as a pre-authorized surgical procedure solely on the basis that the pre-authorization is lacking for that additional procedure. HANYS was also encouraged by the inclusion of an additional right to an external appeal for denied requests for out-of-network treatment.

Despite this significant progress, however, there is still much more to be done. The following proposals are among HANYS' highest advocacy priorities for 2008.

Protect Consumers' Health Care Benefits

HANYS has identified a number of health insurance practices that may—intentionally or unintentionally—discourage providers from exercising the right to contract, or prevent consumers from using a broader or more expensive benefit than MCOs must offer.

As shown by the public discussion of the Oxford Health Plans, Inc. out-of-network coverage practices,¹ some health plans treat hospitalizations at a facility with which a plan has a contract as out-of-network, merely because the treating doctor is an out-of-network physician. This apparently undisclosed practice (in at least Oxford's case) results in patients finding they are responsible for an unexpected and costly portion of the hospital bill that would normally be covered at an in-network hospital. Moreover, it results in an unearned benefit to the plan because it only pays a percentage of a discounted in-network rate the plan negotiated in its contract with the hospital and then requires the member to pay the remainder of the amount owed. Payers should be prohibited from changing in-network hospital coverage to out-of-network based on treating physician status.

A new managed care practice is emerging in which health insurers prohibit consumers from authorizing direct reimbursement from their insurer to an out-of-network provider. All insurance policies should permit assignment of rights (including reimbursement) to an out-of-network provider.

Eliminate Administrative Denials

In the absence of demonstrable evidence of a plan's inability to manage the care provided to an insured person, a plan should not be able to deny claims for medically necessary, covered services based on a technical error by the provider.

¹ Richard Perez-Pena, *When Choice of Doctors Drives Up Other Bills*, NY Times, 9/11/06

Limit Refund Demands

Currently, there are no statutory limits, requirements, or prohibitions on the timing or scope of refund demands, or “take-backs,” issued by health plans to hospitals. Health plans should have no more than two years from the payment of a claim to demand a refund. In addition, health plans should limit the circumstances under which take-backs can occur to billing/coding errors or fraud. In all circumstances, providers must have the right to appeal a plan’s demand for a refund.

Enhance New York’s Prompt Payment Law

Under New York’s current Prompt Payment Law, insurers are required to adhere to certain deadlines and make timely payment of claims. In the interest of supporting and encouraging provider investment in technology, plans should be compelled, as they are in other states², to pay electronic claims within a shortened timeframe.

Coordinate Benefits

HANYS has helped to draft and continues to support an insurance regulation now pending before the State Insurance Department Healthcare Roundtable that would address coordination of benefits issues. While not yet promulgated, the regulation would outline how to resolve the disagreement over which payer is primarily responsible to pay a claim, including requiring payers to coordinate benefits among other payers without taking back paid claims or denying claims based upon plans’ refusal to accept the medical necessity determination of another plan.

² N.H. Rev Stat. Ann. §420-J:8-a (15 days); Fla. Stat. §641.3155 (20 days); Haw. Rev. Stat. §431:13-108;431:13-201 (15 days)

Enhance Utilization Review Law

Currently, New York law establishes timeframes in which utilization review agents must make adverse determinations. However, the law should be enhanced to protect consumers and providers by deeming the failure to make a utilization review decision within the stated time to be an approved claim and not an adverse determination.

Reduce Administrative Burden for Emergency Department (ED) Visits

To avoid the burden and cost associated with supplying medical records for all ED visits, commercial health plans should be required to consider certain factors in applying the “prudent layperson” standard when determining whether the medical care provided was for emergency medical services, such as the time of day or the day of the week.

Ensure Fair Contracting

As insurers in New York merge, providers have increasingly less bargaining power and little recourse to dispute unfair contract provisions autonomously imposed after the fact. The state should mandate that insurer contracts require notice of and mutual agreement to material changes in an insurer’s policies.

These legislative reform proposals are intended to improve the current system and prohibit inappropriate health insurance practices or payment methods. Strengthening and improving existing laws regulating the health insurance industry will restore the balance of negotiating power between providers and payers, will ensure providers are paid for the medical services they

render and, most importantly, ensure all New Yorkers benefit from enactment of this reform that will enhance access to quality health care.

COMMUNITY REINVESTMENT FUNDING

The ongoing need to provide better health care to all New Yorkers is a shared responsibility among providers, business, health insurers, and health maintenance organizations (HMOs). At the same time, additional funding is needed to improve the provision of health services in communities, including improvements in quality, workforce, infrastructure, and efficiency. Requiring payers to reinvest in health care will benefit communities across the state.

HANYS helped develop legislation that has been introduced in both the Assembly and Senate that would accomplish this objective. Introduced by Assemblymember Bradley and Senator Hannon, A.8704/S.6056 would help ensure that health care reinvestment becomes an equitably shared responsibility across all major payers. Currently, state and federal government, and providers are playing their part in the financing of health care operations and infrastructure improvements. This community reinvestment fund would provide the necessary mechanism to guarantee third-party payer accountability and ensure that communities continue to have access to the highest quality care.

Specifically, this legislation would enhance statutorily imposed medical loss ratios—a measure of the percent of a premium dollar spent on actual patient care services versus administrative costs or profits. Payers that fail to meet the new higher ratio would pay the difference between the current ratio and the new threshold into a community reinvestment fund. The funds collected

from these payments would be utilized to improve the quality of care provided to patients in our communities. Decisions about funding would be made on a regional basis in order to meet the priorities and needs of local communities.

HANYS urges your consideration of this initiative.

CONCLUSION

HANYS applauds your efforts to address this critical issue and looks forward to a continuing dialogue and to working in partnership with you as we strive to achieve universal coverage in New York State. There is real opportunity for the Administration to positively affect access and coverage in New York State, and HANYS wishes to help.

A consensus-building process that involves representatives from government, providers, employers, payers, and consumers is needed. We must explore options that are crafted around the principle of shared responsibility. Together, we can find solutions to the obstacles that have limited previous coverage strategies in New York and across the country.

Thank you for giving HANYS the opportunity to testify at this important hearing.