

THE HEALTHCARE EDUCATION PROJECT



TESTIMONY OF THE

1199 SEIU/ GREATER NEW YORK HOSPITAL ASSOCIATION

HEALTHCARE EDUCATION PROJECT

AT

THE PARTNERSHIP FOR UNIVERSAL HEALTH COVERAGE HEARING

October 30, 2007

**Testimony of
The Healthcare Education Project
George Gresham, President, 1199 SEIU and
Kenneth E. Raske, President, Greater New York Hospital Association
The Partnership for Universal Coverage Hearing
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Good morning Commissioner Daines and Superintendent Dinallo and distinguished hearing officers. This testimony is being presented jointly by George Gresham, President, 1199 SEIU, and Kenneth E. Raske, President of the Greater New York Hospital Association (GNYHA) on behalf of our organizations and the Healthcare Education Project (HEP). We thank you for allowing us to testify before you on the critically important topic of how to increase health insurance coverage in New York State.

1199 SEIU represents approximately 300,000 health care workers and GNYHA represents nearly 300 not-for-profit and public hospitals and continuing care facilities throughout New York State and other states in the northeast.

Our respective members have a proud tradition of providing patients access to high-quality care, regardless of their ability to pay. Hospitals are the ultimate safety net for the uninsured and underinsured in our society and we embrace this role as part of our mission. Not having health insurance for oneself or one's children is one of the most stressful burdens our society imposes on our residents and it leads to under-utilization of needed primary and preventive care. Our members have always felt a special responsibility and a moral obligation to care for the uninsured sensitively and compassionately. To that end, among other things, we were proactive participants in shaping the State's hospital financial assistance law two years ago and have undertaken membership activities to help ensure that it is properly implemented.

We support universal coverage, both in New York and nationally. It is unacceptable that we as a society and nation have been unable to achieve this goal and we are hopeful that the tide is turning. In addition to being morally wrong, the lack of universal coverage also skews the economics of our health care system, including requiring employers who do the right thing and provide insurance to their workforce needing to fund charity care for the employees of firms that do not offer insurance, and imposing the need on hospitals and other safety net providers for explicit subsidies and cost-shifting to other payers in order to try and offset at least some of the cost of uncompensated care. Hospitals in New York are in notoriously poor financial condition, and the extremity of their distress, including bankruptcies and traumatic closures, led to the creation of the Berger Commission two years ago to engage in a planned downsizing of the system. The need for and inadequacy of funds to stem losses from uncompensated care have been a major contributing factor to hospital financial distress.

Throughout the years, we have advanced significant proposals to attain universal coverage. These include development, with the New York State Health Care Campaign, of the original blueprint for the Family Health Plus (FHP) program. After a huge public education campaign mounted by GNYHA and 1199 SEIU, FHP was signed into law and now provides health insurance for more than 500,000 working adults. We also spearheaded a campaign, in conjunction with immigrant advocacy groups, to allow legal immigrants access to Medicaid and FHP. Thanks to a favorable court ruling, legal immigrants may now enroll in all of the State's public health insurance programs on the same basis as citizens.

We have also joined forces to advance other proposals for the uninsured; unfortunately, however, these have not yet been enacted. For instance, in January 2004, we proposed the HEAL New York program, which, as originally conceived, would have greatly expanded New York's programs for the uninsured, financed through contributions from employers who do not provide health insurance. Due to concerns about the proposed employer contributions, however, the insurance aspects of our HEAL New York proposal were not enacted. Last year, we supported the Fair Share for Health Care bill, which also would have required contributions from employers. Unfortunately that bill did not become law either.

We designed an ambitious health insurance reform proposal called Cover NY, which would have expanded affordable public and private health insurance programs; subsidized premiums for lower-income individuals who do not have access to affordable coverage; required large businesses to contribute to the public costs of their workers' health care; and, once affordable insurance options was available for all New Yorkers, required individuals to have insurance. Inspired, in part, by the bipartisan legislation enacted in Massachusetts, Cover NY built on our State's programs to provide a uniquely New York response to our health system's challenges but there are more ideas being circulated today that we think deserve consideration and evaluation. We are extremely pleased that the public conversation about universal coverage is being fostered by these hearings and wish to work with all parties and examine all approaches to identify the right solutions for New York.

We commend the Spitzer Administration for its efforts to hasten enrollment in public insurance programs for the estimated 1.3 million uninsured who qualify for such programs and for its efforts to make Family Health Plus (FHP) and Child Health Plus (CHP) in particular available to working people. We are also fully supportive of New York's efforts to eliminate the arbitrary Federal requirements announced this summer that resulted in Federal disapproval of the State's proposed CHP expansion and have, through the PQC initiative described below, created major new forces on the Federal level to ensure that all children in America, including New York, have health insurance.

1199 SEIU and GNYHA became founding partners in May of this year of the Partnership for Quality Care (PQC), a national organization that brings together 1 million healthcare workers and providers who care for more than 45 million patients nationwide. This Partnership is an unprecedented effort of healthcare providers and workers to support healthcare reform at the national level.

As our first initiative, we focused on renewal and expansion of the State Children's Health Insurance Program (SCHIP) because we believe it is a vital first step to ensuring that every American has guaranteed, affordable health care of the highest quality. From July through October, PQC spent approximately \$2 million on a coordinated campaign to pass an SCHIP bill that not only renewed the program, but strengthened it to cover millions more uninsured children, and that would effectively have rolled back the Federal directive that resulted in disapproval of New York's CHP expansion and otherwise would have undermined the program.

This campaign included TV advertisements, print advertisements, radio advertisements in Washington DC and nationwide, in targeted Congressional Districts. Its grassroots activity generated over 20,000 letters and calls to key legislators. PQC also took joint action in support of SCHIP, working with organizations like Families USA and the Catholic Health Association.

We welcome Dr. Daines' prioritization on continuous improvement of quality and patient safety in our hospitals and are pleased that we have been able to work collaboratively – labor and management -- to achieve these goals. Thus, we have collaborated on key initiatives in to improve patient outcomes, improve core measure performance and patient satisfaction, and developing our work force to ensure that staff that work in our health care facilities have the benefit of current training and education in these important areas. If anything, we and our member hospitals have increased their efforts ensure the highest quality of care for our patients. A summary of GNYHA's extensive initiatives to promote quality and a culture of safety in our hospitals is appended to our testimony for your information.

New York's Uninsured Problem

Our State has a strong tradition of taking care of the health needs of its most vulnerable residents. Programs like Medicaid, Child Health Plus, and Family Health Plus provide a lifeline to millions of New Yorkers who would otherwise be uninsured, and have inspired other states to expand coverage. New York's programs, like Child Health Plus, have served as models for Federal legislation. And New York's efforts have paid off. According to a Fiscal Policy Institute analysis of U.S. Census Bureau data, New York has bucked national trends throughout this decade by registering a significant drop in the percentage of residents without health insurance, which fell from 16.3% in 2000 to 13.5% in 2005. New York was the only state to see such a decline. This drop in the uninsured rate is almost entirely due to increases in enrollment in public programs, including Medicaid and Family Health Plus.

In spite of these achievements, however, the number of uninsured in our State is unacceptably high. According to the U.S. Census Bureau, nearly 2.6 million New Yorkers were without health insurance in 2005. Most insured New Yorkers obtain coverage through an employer, and an overwhelming proportion of employees who are offered job-based health benefits — 90% — accept that coverage. However, like the rest of the country, our employer-based system of health coverage has been steadily eroding over the years. Only 60.2% of New Yorkers had employer-sponsored health coverage in 2005, down from 65% in 2000. In New York City, less than one-half (47%) of the population currently has employer-sponsored coverage. Workers who are not offered affordable

coverage through their workplace can rarely afford to purchase insurance on their own. In New York City, for example, the average direct pay policy costs \$7,000 per year, and family coverage averages \$20,000. Clearly, only the highest income workers can afford to purchase private insurance. This is why something must be done.

How Should We Achieve Universal Coverage?

As we noted earlier, more than two years ago, 1199 SEIU and GNYHA developed a proposal to achieve universal coverage that built on the existing system of public and employer-provided private health insurance in New York to make quality health coverage accessible and affordable for all New Yorkers. Our guiding principles were that health insurance should be both a *right* for all residents of the State and a *responsibility* shared among businesses, government, and individuals and our proposal combined elements of government program expansions, modest employer surcharges, and, when it was clear that insurance was affordable, a requirement that all individuals have insurance. The general elements of the approaches that are currently being discussed and proposed through this open hearing process include these blended approaches as well as single payer and government-sponsored systems. Other important building blocks, including reform of the direct pay and small group insurance markets, are also being discussed to make insurance more affordable overall and we particularly welcome these reform efforts as a prerequisite to making insurance affordable prior to any consideration of an individual mandate.

As noted earlier, we very much welcome the opportunity to work with all parties on evaluating all of the various approaches that are being proposed and to identify the elements that would be most appropriate and workable for New York.

Even Health Care Workers Lack Health Insurance

Our work on the expansion of access to care has been governed by a concern for quality outcomes for all New Yorkers. However, the plight of one constituent group is particularly compelling to our organizations. Throughout our State, thousands of healthcare workers toil everyday on behalf of the elderly and infirmed without the benefit of adequate healthcare coverage for themselves and their dependants.

1199 SEIU represents low wage home health aides who struggle month to month to achieve coverage. They are mostly female, heads of households who earn less than \$8 per hour and they are important members of the community of health care providers. They tend to seniors and the disabled in their homes, take them to doctor appointments, administer medication, monitor vital signs, and groom these patients every day. The continued employment of an aide on a case can directly affect a client's ability and will to live. The simple, sad fact is that the economics of the industry does not permit collective bargaining to make meaningful improvements in health coverage without partnership with the State. Massachusetts has acknowledged that reality in its recently enacted universal coverage law. We hope that decision makers in Albany will recognize this as well. Long-term home care is a growing aspect of healthcare in this country. More needs to be done to assure that dignity is extended to caregivers as well as patients in this relationship.

Financing a Universal Coverage Proposal

Whatever the elements of a final universal coverage proposal might be, we believe we must be sober about the fact that achieving near-universal coverage in New York will cost money; it is unrealistic to think there may be a budget-neutral or near-budget-neutral solution if we simply spend existing funds more wisely. The Urban Institute estimated last October that the cost of additional medical care alone associated with covering the fully uninsured and the part-year uninsured would be \$4.1 billion.¹ Since this figure represents medical spending alone, the cost of *insurance coverage* associated with this \$4.1 billion is likely considerably higher. This is because the medical spending estimates would likely be further augmented by lower out-of-pocket spending by the currently uninsured. In addition, estimates of additional medical spending do not account for the extra costs of actually providing insurance; on average in New York, health plans only spend about 80 cents of every health care dollar on actual health care, with the rest going to administration, marketing, and profits. More optimistically, the United Hospital Fund and the Commonwealth Fund last year estimated that near-universal coverage, achieved through a model that blends employer mandates, government program expansions, and an individual mandate, would cost \$4.1 billion more.² We believe the UHF estimate is a credible minimum.

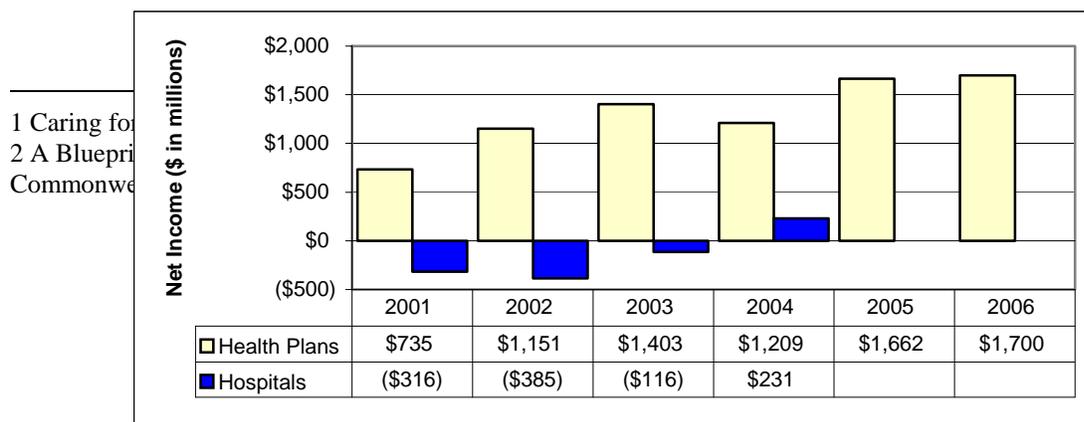
Reforming Our Current System

Whatever the specific details of a universal insurance program might be, we believe the following steps must be taken to reform our current system in order to ensure that any new investments are wise investments.

Health Plans

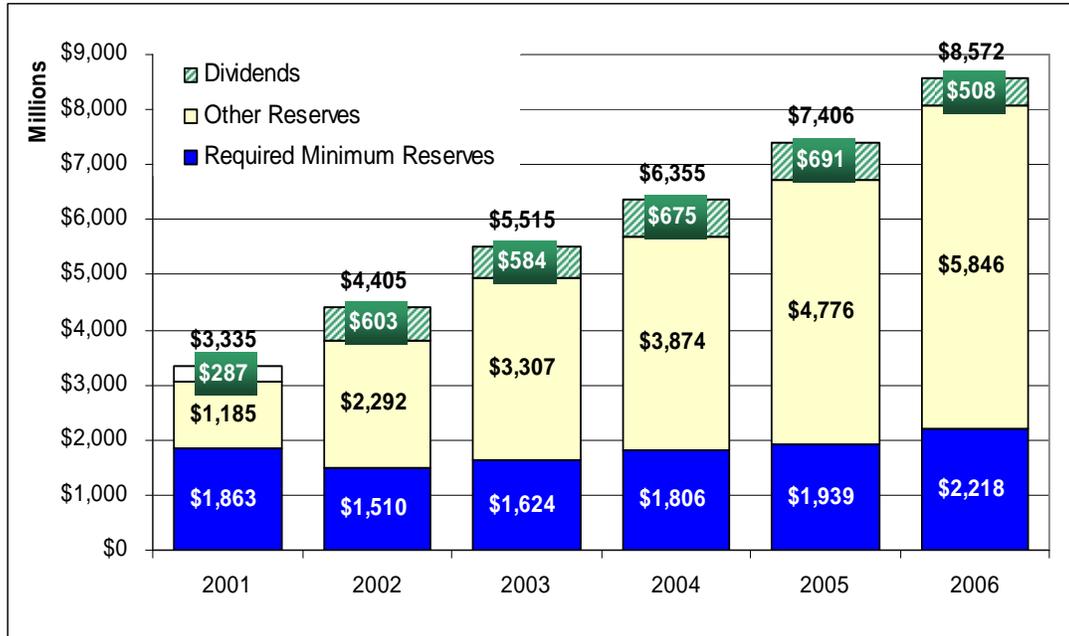
Our current system is unacceptably skewed with respect to the relative profitability of commercial health plans on the one hand and the hospital community on the other. As seen in Figure 1 below, while hospitals have been operating at barely breakeven margins, health plans have enjoyed steadily increasing profits over the past several years, at least in part due to their inadequate payments and payment denials to hospitals. Figure 2 shows that these profits have enriched the coffers of health plans reserves, particularly those left over *after* consideration of dividends to shareholders and minimum reserves required by law. Expanding insurance coverage in this environment would not make wise use of additional public and private investments, much of which would simply wind up further enriching publicly traded national health insurers.

Figure 1. New York State Health Plan and Hospital Financial Performance 2001 - 2006



Source: New York State Hospital Institutional Cost Reports (ICR); National Association of Insurance Commissioners (NAIC) financial statement filings. Excludes Prepaid Health Services Plans (PHSPs).

**Figure 2. Health Plan Reserves
2001 - 2006**



Source: National Association of Insurance Commissioners (NAIC) financial statement filings. Excludes Prepaid Health Services Plans (PHSPs).

Solutions that have been proposed to address this situation include instituting prior approval of health premium increases as well as establishing minimum medical loss ratios (MLR). While we have concerns about plans' ability to "game" the MLR to make it appear that more is being spent on health care services than is actually the case, we support efforts to try and ensure that as much of the health care premium dollar as possible is spent on actual health care versus overhead and profits. However, we have concerns that prior approval may simply result in further pressure on already tenuous provider payments. And, while we have no disagreement with the positive intent behind such proposals, we wonder whether the State has the ability to ensure appropriate spending on medical care in a market-driven economy in which a large portion of covered lives are exempt from State regulation pursuant to the Employee Retirement and Income Security Act (ERISA).

We believe we need to fully explore the following solutions.

- Health plans should be required to engage in community reinvestment.** This concept was created by the Westchester County Association, an association of business leaders concerned with the damage being caused to the local health care infrastructure and economy by health plan payment practices, underpayments to doctors and hospitals, and excessive profits. The concept was modeled on similar requirements imposed on banking corporations that made significant profits and yet failed to support the local communities that made those

profits possible. Health plans should be required to disgorge some portion of the profits and reserves they have built up over the years as a result of increased premiums and their failure to pay for medically necessary care rendered by hospitals and other providers. Community reinvestment should be used to support initiatives that benefit the health care of the community, including investments in information technology, quality and patient safety.

- **Market practices should be reformed.** It is time to rein in the current Wild West environment of arbitrary payer practices by following the general principles that hospitals, physicians, and other providers should be paid for medically necessary services, and that payment should be made with a minimum of hassle and administrative cost to the system.
- **Specific reforms that should be considered include at least the following:**
 - Limit or eliminate payers' ability to make technical payment denials for medically necessary services because, for example, a hospital failed to make a phone call on time.
 - Ensure that, if a provider requests in advance whether a payer will pay for a scheduled service, that the payer provide it with an answer, and if the answer is "yes," that it actually pays.
 - Ensure that health plans maintain up-to-date records of subscribers' eligibility and benefits coverage so that when they tell a provider that a patient is enrolled and covered, they will stick by that assurance.
 - Require greater transparency in the hospital and physician "quality and efficiency" rankings that payers are providing to consumers by requiring greater disclosure of data sources and methodologies; separating "grades" for low cost from those related to quality rather than blending them; require application and disclosure of appropriate risk adjustment methodologies; and require regular communication of the findings of the payers' data analysis to providers so that they can be assessed and discussed.
 - Require health plans to publicly disclose how many payment denials they are issuing for medical necessity and alleged failure to fulfill the plan's administrative rules, the rate of overturning these denials on appeal, and dollar impacts of these actions.
 - Relieve patients of the responsibility for paying the bills for non-contracted provider services.
 - Make improvements to the prompt pay law and external appeals process.
 - Prohibit plans from constantly changing their "administrative requirements" in a way that increases administrative costs as well as technical denials for appropriate medical care.
 - Require health plans to participate in the collection of amounts owed for services for high deductible/high cost-sharing benefits plans.
 - Toughen up State oversight and penalties related to payer breaches of law and regulation.
 - Address the market power imbalance between a handful of national insurance companies on the one hand and hospitals and physicians on the other.

- Eliminate certain contracting practices.
- Standardize plan administrative practices (see below).

Administrative Costs Associated with Health Insurance

Our current system of health care insurance is completely broken when it comes to the amount of arbitrary, wasteful, and burdensome costs fostered by a lack of standards and standardization governing health plan administrative requirements. This topic is directly related to the question, “How are we going to pay for insurance expansions?” We need to fix this system if we are going to expand enrollment into it.

From a provider perspective, one of the most discouraging and oppressive hallmarks of our health insurance system today is the administrative burden resulting from unique and often arbitrary health plan policies, particularly those dictating the technical hoops through which a provider must jump in order to be paid for a medically necessary service. While some of these requirements may have originated from legitimate purposes, for example, the desire to know when a subscriber has been admitted for inpatient care so that health plan case management resources can supplement hospital discharge planning, they have evolved into a dizzying array of rules, processes, and procedures that do not recognize how hospitals actually operate, are changed at the whim of the health plan outside of the contracting process, and result in inappropriate payment denials for medically necessary care that has already been provided.

Since providers do business with many health plans, which in turn sub-contract lines of business such as mental health, radiology, laboratory services, and so forth to other companies that have their own unique protocols, providers may be dealing with 50 different sets of unique administrative requirements at any given point in time and trying to contact as many or more entities for care approvals, even under one health plan umbrella. It is difficult to convey how complicated it has become for providers to be paid, but the reality is that health plans are each spending enormous sums on fashioning and implementing their own unique protocols, that these sums are multiplied many times by providers trying to accommodate them, and that payment denials resulting from the inevitable inability to keep up have contributed to hospital financial distress. This system is simply broken and we are diverting precious dollars that could be used for patient care and improved access to faxing, telephoning, appealing, chasing, arguing, and just trying to contact a live person at the health plans to be paid appropriately.

Many proponents of a single payer system believe that the savings that could be garnered from the elimination of this wasteful, duplicative paper chase would go a long – if not the entire -- way to pay for universal coverage. Whether or not there are enough savings to pay for universal coverage, a middle road that relies on our current system of private health plans would include the following elements:

- In consultation with interested stakeholders, including providers and health plans, the State should promulgate one set of simple standards for the administration of government managed care programs, including Medicaid managed care, FHP, CHP, Healthy New York,

and any associated expansions that focus on ensuring that there is payment for medically necessary services with a minimum of hassle and red tape. This is particularly important in discussions about expanding existing government programs to enroll more people.

- Pursuant to reforms that would expand enrollment in private health plans, the State should at a minimum standardize:
 - Benefits and cost-sharing, similar to Medicare supplemental policies, for expansion products
 - Administrative processes and requirements in the areas of pre-authorization, eligibility verification, notification, concurrent and retrospective medical reviews, prompt payment and coordination of benefits, minimum standards for DRG validation, appeals processes, and other processes related to service and payment.
- Require any health plan, and particularly those wishing to participate in new business opportunities associated with insurance expansions, to commit to electronic connectivity through participation in industry standards-setting efforts committed to implementation of electronic transactions described by the Health Insurance Portability and Affordability Act (HIPAA) and related interactions. The purpose of such organizations is to ensure that the adage “garbage in, garbage out” does not forever doom the efforts of providers and health plans committed to electronic commerce by collaboratively developing Federally-compliant minimum code sets with proven business value that can be applied uniformly across the industry. Currently, health plans are more likely to have implemented HIPAA solutions that are unique to them and this is a barrier to full implementation across the spectrum of our health care system.³

We believe these and related steps would significantly lower the cost of providing universal coverage and promote greater fairness and equity in payments for medically necessary services.

Hospital Indigent Care Pool Funding

We have not failed to notice that a proposed source of funding for insurance expansion in numerous proposals is the Hospital Indigent Care (BDCC) Pool, whether through a reduction in Health Care Reform Act surcharges or other mechanisms.

³ An example of such an organization is Linxus, a voluntary standards-setting group for which GNYHA is the project manager and which currently includes 24 hospitals, more than 6,000 physicians, five out of the six largest commercial health plans in the downstate region, Medicaid managed care plans and the Medicaid fee-for-service program (ex officio). Linxus participants are committed to refinement of existing HIPAA transactions and electronic connectivity solutions that deliver business value, e.g., obviating the need for a provider to pick up a telephone to call the payer as well as the need for the payer to respond to that call. Linxus works in close coordination with national standards-setting organizations to ensure that the solutions it identifies are meaningful to national payers, which comprise such a large part of the health plan market today.

The HCRA pool is currently funded at \$847 million, which covers about half of reported hospital uncompensated care. \$708 million of the pool is the sole State source for private, not-for-profit hospitals' uncompensated care losses and \$139 million supports public hospitals uncompensated care. The vast majority of public hospital funding for these purposes comes from other sources unique to the public sector. Hospitals themselves contribute in excess of \$200 million per year through a tax on inpatient revenues to fund the pool.

The pool's current design is the subject of examination by a Technical Advisory Committee called for by last year's budget legislation and will be the subject of a report by Commissioner Daines in December. We have appreciated the opportunity to share our perspectives with the TAC and Department of Health staff and to offer our recommendations on ways to make pool funding more transparent and equitable.

With respect to the BDCC pool, we believe it is imperative in any coverage expansion initiative to observe the following principles:

- Under no circumstances should the pool funding level be reduced unless and until there is demonstrated reduction in the amount of uncompensated care provided by hospitals as a result of the transition to insurance expansion.
- The pool must continue to cover unpaid cost-sharing amounts for patients who have insurance. Today, the pool provides necessary support for the underinsured because insurance policies often carry high deductibles, large cost-sharing requirements, limited benefits, restrictive provider networks, or all of the above. The evidence is in that under universal insurance efforts, these benefit designs will become more, not less, prevalent. Everyone might have an insurance card, which is a good and important thing, but that card will not pay for everything and in many cases it might not pay for very much at all.

In Massachusetts, where the universal coverage program is actually rolling out, there is concrete information about the high cost-sharing required by the unsubsidized new individual market insurance products that are being offered as part of the coverage expansion initiative.

Examples include:

- The Blue Cross Blue Shield of Massachusetts Bronze Plan geared toward older uninsured individuals, with *35% coinsurance for hospital stays*.
- The Harvard Pilgrim Bronze Plan, with a \$1500 individual/\$3,000 family deductible and a 20% co-insurance requirement for hospital care.
- Neighborhood Health Plan's Bronze Plan with a \$2,000/\$4,000 deductible and 20% inpatient hospital cost sharing.

The Young Adult Plan designed for younger uninsured persons include these offerings:

- The Blue Cross Blue Shield of Massachusetts Essential Blue YA Plan has a 30%-60% cost-sharing requirement, a \$250-\$350 emergency room visit co-payment, and 30%-60% cost-sharing for outpatient surgery, with a \$5,000 annual out-of-pocket maximum.
- The Harvard Pilgrim Pulse Plan carries a \$2,000 annual individual deductible, a \$5,000 cap on out-of-pocket expenses, and a \$50,000 annual benefit maximum, 20% cost-sharing after the deductible for inpatient hospital care, \$250/emergency room visit, and 20% cost-sharing after deductible for outpatient surgery.
- The Tufts Health Plan Advantage HMO Select Young Adult Plan has a \$2,000 deductible, \$5,000 out-of-pocket maximum, \$50,000 annual benefit cap, a \$200/emergency room visit fee, and a \$250 pharmacy deductible.

These plans are not dissimilar from some commercial products that we have begun to hear about in New York that are aimed at the uninsured. For example, we recently became aware of a new product being offered by a commercial insurer as part of its Preferred Provider Organization (PPO) product that has a \$20,000 annual maximum benefit.

Obviously, some insurance is better than none, but we would characterize these products, whether offered in Massachusetts or driven by the market as in New York, as “almost insurance.” This is a new kind of health insurance that would leave a potentially very significant portion of health care costs as the patient’s responsibility.

High cost-sharing and capped benefits plans will pose tremendous challenges to hospitals and other providers with respect to collecting amounts that are the patient’s responsibility, whether it is a \$2,000 deductible 35% coinsurance for a hospital stay, or payment for services above an annual maximum. These high dollar responsibilities will absolutely generate requests for fee-scaling and uncompensated care that hospitals will and should grant pursuant to their own financial assistance policies, which in turn are guided by minimum State law requirements for fee-scaling any service offered by the hospital to an eligible patient.

Unpaid cost-sharing amounts therefore must continue to be eligible for coverage from the hospital indigent care pool on the same basis as all other uncompensated care costs.

Where Does Medicaid Financing Fit In?

There are at least two important priorities that should be mentioned with respect to our Medicaid program and universal coverage.

New York’s Medicaid program is the largest in the country in terms of total dollars spent (\$47

billion) and second largest in terms of people enrolled (more than 4 million). There is no question that decades of conscious State policy to maximize Federal participation in what would otherwise have been State-only health care expenditures, as well as New York's history of appropriately generous eligibility and benefits design, have produced a large program. While there is a need to better align spending within New York's Medicaid budget, the overall size of our program does reflect funding maximization strategies over the past two decades, not gross inefficiency, profligate spending, or overly generous eligibility standards.

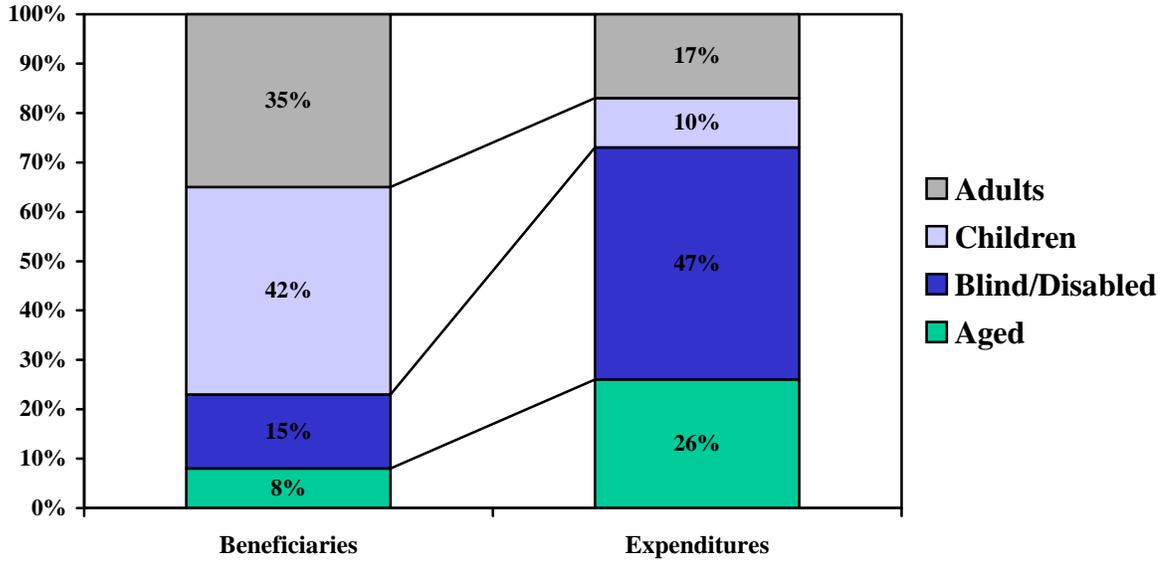
Hospital outpatient departments provided 46 million ambulatory care visits in 2004, 17 million of which were for primary care services. The population served by hospital outpatient clinics is largely poor and uninsured; two-thirds of all visits, for example, were provided to Medicaid or uninsured patients. Hospital outpatient capacity is therefore a critically important part of the provider infrastructure for any insurance expansion.

Unfortunately, Medicaid payment rates for ambulatory care services are abysmally below, having been frozen at a capped level that covers only half of actual hospital costs. They are much lower than rates for comparable services at freestanding health centers, which fortunately follow more of a cost-based reimbursement methodology though they, too, have been frozen. Hospitals therefore must cross-subsidize losses from Medicaid outpatient services with higher payments from other payers wherever possible, and where it is less possible, hospitals experience severe financial losses.

This long-standing underfunding has hurt the primary and specialty ambulatory care system and must be addressed in its own right and certainly as a part of expanding government programs. If it is not, there will be no way to ensure that there is sufficient and high quality ambulatory care capacity available to cover potentially millions more covered lives. Hospitals welcome the opportunity to use needed funding for ambulatory services to enhance and improve the delivery of such services and the quality of patients' experiences.

With respect to the perception that New York's Medicaid is inappropriately large and inefficient, as seen in Figure 3 below, the problems are not with the delivery of acute care services to non-disabled adults and children. Indeed, almost three-quarters of New York's Medicaid spending is devoted to about one-quarter of Medicaid enrollees who are aged, blind, and disabled. The biggest challenge for New York's Medicaid program is presented by the legitimate complexity of caring for the most vulnerable residents of our State, including persons with co-occurring behavioral, substance abuse, and medical conditions; persons with mental retardation and developmental disabilities; and the elderly who require nursing home and long term care, among others. There are no quick fixes here and we have appreciated working with the State on approaches to programs that might result in better care management of these vulnerable populations. But, we should exercise caution in pointing to our "large" Medicaid program and somehow believing that we can shift spending around to pay for a large insurance expansion.

Figure 3.
73% of Medicaid Program Spending is for 23% of Enrollees



Notes: Beneficiaries are unique counts of beneficiaries using services. Beneficiary counts and expenditure amounts are exclusive of the following eligibility categories: Children w/ Unemployed Parents, Unemployed Adults, Foster Children, and Breast and Cervical Cancer Act beneficiaries due to minimal effect on the distribution figures.

Source: Center for Medicare and Medicaid Services: Medicaid Statistical Information System (MSIS) report.

Delivery Model

We believe that in exploring insurance expansion models, we should do everything possible to encourage the development and use of provider delivery systems and provider-sponsored health insurance vehicles. This is because at the end of the day, providers, not insurance companies, manage care, and those providers that succeed should be at the front line of State strategies to expand coverage. This would be a direct means to improve the quality and coordination of care at a price that reflects efficiency and quality under public and not-for-profit auspices.

Conclusion

The problem of the uninsured in New York State must be solved. Without solving it, we cannot hope to achieve the improvements in quality of care and public health outcomes that we must achieve in order to make New York what it should be: a place where the population is healthier than anywhere else on earth. We look forward to working with you in the coming months on this important issue. Thank you again for your attention to our joint testimony.