

## **LONG ISLAND HEALTH ACCESS MONITORING PROJECT**

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### **TESTIMONY PRESENTED TO THE “PARTNERSHIP FOR COVERAGE” PUBLIC HEARING JOINTLY CONVENED BY THE OFFICE OF THE GOVERNOR, THE NEW YORK STATE DEPARTMENT OF HEALTH AND THE NEW YORK STATE DEPARTMENT OF INSURANCE**

December 5, 2007  
Old Westbury, NY

Good afternoon/morning. My name is Donna Kass. I co-direct the L.I. Health Access Monitoring Project together with Dr. Rosemarie Guercia. This testimony has been prepared by both of us and we would like to thank you for this opportunity to speak on healthcare reform.

We are an all volunteer, not for profit organization created in direct response to the growing crisis of uninsurance. Our mission is to expand and improve access to healthcare for the uninsured and underinsured population on Long Island. We have worked with hospitals trying to encourage them to better fulfill their statutory obligation to provide charity care to indigent patients. This work convinced us that changes in the law were needed. Our efforts led to the adoption of charity care laws in Nassau & Suffolk counties and significantly contributed to the adoption last year, of New York State's Hospital Financial Assistance law. (subdivision 9A § 2807-k). But even this law is not enough. Patient dumping continues to be an all too frequent occurrence at our hospitals.

I am going to address primarily item #3 in the Public Hearing Notice which asks what steps should be taken to improve quality, deliver cost-effective care and eliminate unnecessary utilization of health services.

HRSA has identified 33 medically underserved communities in Nassau county, most of them in low income communities. They contrast sharply with the more affluent communities that have well insured populations and a CAT scan on every corner. Physicians' free standing diagnostic and surgical centers abound in the richer areas and drain off paying patients from area hospitals. These facilities are for profit corporations and they give no free care. This overabundance is the result of an absence of planning and regulation. The mushrooming of high technology began after the Health Systems Agency was defunded and it has continued unabated. Investment in excess services leads to their increased use and increased costs. Ways must be found to reign in and redirect growth. Please consider a return to local input into the CON process.

There are 156,000 uninsured people in Nassau County. These individuals are without a regular source of care. They create costly inefficiencies in the delivery of care, through a skewed use of emergency rooms in lieu of primary care and through an increased use of hospital beds for ambulatory sensitive conditions. Their neglect of chronic conditions often leads to long term institutionalization. Unless we can change that, we will never reduce costs. So we need to find a way to give the uninsured a medical home. The city of San Francisco has found a way to do it for all of their uninsured residents and ultimately plans to open this innovative program to everyone, including business. As I understand it, they are redirecting existing streams of money and also charging some premiums. We should explore ways of emulating them. The long term benefits will be tremendous.

Meanwhile our existing safety net is inadequate and needs to be strengthened. Hours of operation at ambulatory care centers are often limited to weekdays with very few evening hours. This imposes a hardship on working people and especially on parents who need their sick child seen early in the morning before going to work, or lose a day's pay. The scope of services offered is limited. The clinics lack specialty services, such as orthopedics, dermatology and cardiology. Basic tests like lab work and X-rays often require a trip to another site. Medications for the most part are not provided. Dental care is the single greatest unmet healthcare need on L.I. yet we have community clinics that don't provide any dental care and none of the dental care offered is free. There is a lack of vision care and a lack of behavioral services, particularly for children and teens. This is exacerbated by a shortage of bi-lingual providers. To improve outcomes, the State needs to ensure that every ambulatory care facility provides obstetrical and gynecological care.

We need to expand the use of health educators. Perhaps they should be made part and parcel of every insurance plan including our public insurance. People need to be educated on how to take care of themselves and how to appropriately use the healthcare system. We especially need to educate people with chronic diseases on how to manage their illness. The State needs to promote increased screening for cardio-vascular diseases, diabetes and cancer. Early detection and treatment will result in cost savings and help people maintain their quality of life.

We need to invest in public health nurses who will teach young mothers how to care for their low birth weight infants. The return on this will be a lowered infant mortality rate. We have heard anecdotal stories of infants being given soda pop in their bottles, not out of neglect by their teenage mothers, but out of a lack of knowledge on how to help a baby thrive. At the other end of this spectrum is the need for nurses to make visits to the elderly. Patients who have either insufficient or no services available to them at home, are frequently moved into institutional settings which are more costly and certainly less desirable for many.

For these efforts to be successful we need to take into account cultural differences. Recommended changes in behavior will not be followed if ethnic preferences are not taken into account. This is a case of penny wise and pound foolish. The State should mandate regular training of providers in cultural competency.

Our communities are diverse and we live in a multilingual society. Therefore all informational and educational material should be available in languages commonly used by the target population.

We need to be pro-active in reducing health care disparities. Nassau County's infant mortality rates are hugely divergent between communities, as are percentages of people with diabetes, hypertension, cardiovascular disease and certain cancers. Money invested in reducing these disparities will save a lot more in the long run than the initial investment will cost.

Therefore, we recommend that at a minimum the State redirect investment to communities of need, and develop incentives for providers to relocate.

The cost of drugs and supplies must be controlled through bulk purchasing or a similar arrangement. Let's get real about what we are prescribing for people. As long as glucose test strips cost \$ 55.00 for a box of 50 we cannot expect any but the wealthiest diabetics to use them.

And while we are on the subject of money we need to talk about insurance premiums. They range from a low of \$ 900/per month for a family plan with HIP to a high of \$5000/month with MD NY. Yet according to the N.Y.S. Health Accountability Foundation (tables appended) patient satisfaction and ease of getting needed care is pretty much the same. Accordingly, insurance premiums need to be regulated and the profit loss ratio reigned in to more closely resemble the administrative costs of Medicare and Medicaid.

Healthcare cannot continue to be treated as a market good. It is a necessary public good and therefore has to be held to a different standard. An income of \$10,000/yr. disqualifies a single person from receiving MA, but is not nearly enough to pay for rent, food, clothing and transportation on L.I. let alone for insurance premiums.

We conclude by stating that the public would be best served if the State instituted a publicly administered, publicly funded insurance program that would cover all residents of New York. A single payer system. Such a system would create unique opportunities for the control of costs by allowing the state to negotiate fees, to set global budgets for institutions and to purchase drugs in bulk. It would create a reliable program that would guarantee health care security to all, regardless of age, economic status or medical circumstance.

Thank you for your attention.



**HMOs: Monthly Premiums (Nassau County, NY)**

Monthly premium rates ("list prices") for standard individual and family HMO plans. Rates may vary depending on the month in which you enroll. To verify the rates listed below, please call the HMO directly. These rates are updated monthly.

**HMO Standard Premium individual HMO Standard Premium family**

		
<a href="#">Aetna</a>	 \$822.38	 \$2,444.20
<a href="#">CIGNA</a>	\$783.40	\$2,350.18
<a href="#">Empire</a>	\$759.49	\$2,278.47
<a href="#">GHI HMO</a>	\$1,260.62	\$3,214.58
<a href="#">HIP</a>	\$501.75 <sup>*</sup>	\$933.56 <sup>*</sup>
<a href="#">Health Net</a>	\$894.93	\$2,515.62
<a href="#">MD NY</a>	\$1,737.57	\$5,038.94
<a href="#">Oxford</a>	\$711.66	\$2,134.98

**Footnotes**

\* \$233.39 per child, maximum of \$933.56 for 4 or more children

Due to differences in sample size, there are instances where plans with similar percentage scores differ in how significantly they vary from the statewide average. Cost and quality measure information represent just two factors that should go into the selection or evaluation of a health plan. No single measure is indicative of an organization's overall performance. Use this information to begin a discussion with your family doctor and call the insurance company to ask questions.



# Health Care Report Card

aboutthehealthquality.org

## HMOs: Customer Satisfaction (Nassau County, NY)

This page shows how well health plans are doing on a selection of questions from a customer satisfaction survey (CAHPS). Data are from 2005.

	Customer service 	Getting care quickly 	Getting needed care 	Health plan rating 
<a href="#">Aetna</a>	Not significantly better or worse than state average 	Not significantly better or worse than state average 	Not significantly better or worse than state average 	Not significantly better or worse than state average 
<a href="#">CIGNA</a>	Not significantly better or worse than state average 	Significantly worse than state average 	Significantly worse than state average 	Not significantly better or worse than state average 
<a href="#">Empire</a>	Not significantly better or worse than state average 	Not significantly better or worse than state average 	Not significantly better or worse than state average 	Not significantly better or worse than state average 
<a href="#">GHI HMO</a>	Significantly worse than state average 	Not significantly better or worse than state average 	Significantly worse than state average 	Significantly worse than state average 
<a href="#">HIP</a>	Not significantly better or worse than state average 	Significantly worse than state average 	Significantly worse than state average 	Not significantly better or worse than state average 
<a href="#">Health Net</a>	Significantly worse than state average 	Not significantly better or worse than state average 	Significantly worse than state average 	Not significantly better or worse than state average 
<a href="#">MD NY</a>	Not significantly	Significantly worse	Not significantly	Significantly worse

	Customer service 	Getting care quickly 	Getting needed care 	Health plan rating 
	better or worse than state average 	than state average 	better or worse than state average 	than state average 
<a href="#">Oxford</a>	Not significantly better or worse than state average 	Significantly worse than state average 	Not significantly better or worse than state average 	Significantly worse than state average 
	<a href="#">[show details]</a>			

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### Legend

-  Significantly better than state average or 100%
-  Not significantly better or worse than state average
-  Significantly worse than state average
-  Data not available or too few cases to evaluate
-  Performance significantly improved from a year ago
-  Performance did not change significantly from a year ago
-  Performance significantly declined from a year ago
-  Yearly change information not available

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