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**New York State Health Policy Research Center**

**Public Policy Forum:  
Ideas for Generating and Sustaining Financing for Health Coverage Initiatives in  
New York State**

**Friday, December 5, 2008**

**Forum Highlights**

**David Sandman, Senior Vice President, NYS Health Foundation**

Between 2004 and 2006, the uninsured rate increased among both adults and children; nearly reversing gains that had been made between 2000 and 2004. In New York State, insurance premiums for family coverage increased 81 percent between 2000 and 2007, while wages increased only 11 percent. The current recession requires that we maintain our efforts to expand coverage and take the longer-term view of economic cycles.

Financing options might include federal financing (leveraged federal funds) through expansion of eligibility levels for public programs and safety net programs.

Funds for financing expansion of health care programs in New York have been denied by the Centers for Medicare & Medicaid Services (CMS), but New York seeks to change federal policy to receive more than \$2 billion in federal matching funds through Child Health Plus.

There are seven primary approaches the state might use to financing health care:

1. *Leveraging federal funds through Medicaid, Family and Child Health Plus* – This is the best option from the state's perspective.
2. *Sin taxes on junk food and cigarettes (e.g., Arkansas taxes soft drinks; Pennsylvania is using lottery funds; New Jersey is using casino funds; etc.)* – These tend to be more politically doable, but the drawbacks are the regressive nature and diminishing returns.
3. *Enrollee cost sharing* – If cost sharing can be done in ways that still make insurance affordable, then this can be a financing option.
4. *Shared responsibility with third party payers.*
5. *Repurposing existing sources* – There is nearly \$1 billion in the indigent care pool that can be redirected; disproportionate share hospital (DSH) payments and graduate medical education (GME) may also be reprogrammed.
6. *Shared responsibility with insurers* – It will be difficult to know how much shared responsibility is the right amount because costs can be passed on to consumers.
7. *Cost containment* – Some of these may more easily achieved than others but in some instances, investments need to be made. The re-programming of existing health care programs is much more difficult in practice than in theory. Of the approaches discussed, the focus should be on raising or redirecting new money and sustaining long-term care.

**John Rodat, Commissioner, Department of Management & Budget, Albany County**

Albany County's annual budget is approaching \$600 million a year. With respect to health care, the county acts as an employer, provider, and financier. For example, it maintains a role in Medicaid enrollment and administration and payment. The county's estimated costs for health care include – within employee health benefits, \$30-35 million in overall health benefits and liability for \$20 million in retiree health benefits (current employees and retirees). This is compared to the \$125-130 million spent on salaries and wages. The county's liability for retiree health benefits is approximately half a billion dollars.

There have been two primary approaches to financing health coverage initiatives: "perfectionist and pragmatist." In the 1960s and '70s a primary goal of pragmatists was expanding Medicaid. In the 1960s a commission established by then Governor Rockefeller proposed seven recommendations to reform the health care system. Six of the recommendations were adopted and still form the basis of much of New York's health policy, such as institutional rate regulation and certificate of need. However, the seventh recommendation, mandated employer-based coverage, was defeated by an alliance of business and organized labor.

Though we were not aware of it at the time, during the 1970s, both the number and percentage of uninsured started to grow. At any given time, one and half million to two million people were estimated to be uninsured over a one year span.

There continues to be active resistance to addressing the number of uninsured. Incremental steps have not solved the problem and costs for health insurance continue to rise. Incrementalism is no longer effective due to the degree of difficulty, overlapping populations and administrative complexity.

**Elisabeth Benjamin, Director, Healthcare Restructuring Initiatives, Community Service Society of NY**

Many people are demanding health reform: A recent Community Services Society poll found that health reform is a critical issue. Voters see reform as inextricably related to the economic crisis because affordability and quality of health care are important for the functioning of small businesses and families.

The state's existing funding streams are too complex, opaque and not accountable to the people they are designed to serve.

Insurance expansions can also be financed with existing funds via reforms: New York spends more per capita on health — \$126 billion — than any other state. Despite this, 2.5 million people (13 percent of the population) remain uninsured. New York rarely has top health outcomes and a good percentage of New Yorkers have trouble getting basic medical care such as prescriptions, due to a lack of insurance or money. New York needs to focus on current and potential sources of revenues and expenditures, as well as finding the best methods of financing health reform and spending. The methods should be transparent, accountable, and optimally use state resources. Major financing mechanisms might include:

- *Reform Medicaid* – Improve administrative simplification; continue reimbursement restructuring; and support primary care and quality-based reimbursement. Shift money from inpatient care to ambulatory care — the State Department of Health says that New York is overpaying inpatient care by \$600 million, although hospitals refute this by saying their 2008 budgets resulted in \$395 million in losses and would not be able to take any more inpatient cuts. Also reform graduate medical education (GME) and the base years that are used to estimate reimbursement rates.
- *Reform and re-direct funds in the Health Care Reform Act (HCRA)* – HCRA includes three different pools: indigent care; tobacco funds; and professional education. HCRA's funding sources include the covered lives assessment (which insurers and consumers pay); tobacco taxes and settlement; HCRA surcharges on payers (which hospitals pay); the Community Health Care Conversion Demo Project; and conversion monies. The general funds ("off-loading") from HCRA amount to \$116-150 billion per year, which would help with health care expenses. Hospital indigent care pools total \$847 million, and are untraceable to individual patients. The 2008 budget reforms call for at least

10 percent transparency and patient traceability. Other relative hospital programs, such as hospital-based grants, expend \$22 million, and the health facility restructuring program expends \$20 million. Workforce recruitment and retention (WRR), based on a 2008 formula, is 50 percent based on 1999 payroll and 50 percent based on Medicaid inpatient discharges. Some of the current WRR allocations (utilizing F-SHRP) are:

- voluntary hospitals: \$262 million
  - public hospitals: \$49 million
  - personal care in New York City: \$136 million (including FMAP)
    - Healthy NY allocates \$103 million for individual Healthy NY programs and \$103 million for group Healthy NY programs. The Federal-State Health Reform Partnership (F-SHRP) program matched these funds so another \$206 million could be redirected toward coverage initiatives. Graduate medical education under HCRA was originally allocated based on 1997 figures and no new teaching programs can access these funds (allocation is \$331 million, plus FMAP). GME is a complicated allocation system that should be more transparent.
- *Malpractice reform* – Excess medical malpractice insurance amounts to approximately \$130 million, which helps hospitals to pay for insurance over a certain amount; malpractice reform could free up these funds.

There are potential sources of new revenue

- *Increasing the Federal Medical Assistance Percentage (FMAP)* – Congress may propose increasing FMAP, which could result in roughly \$4 billion more in Medicaid funding for New York State. Governor Paterson’s proposal pushes an FMAP increase of 5 percent until 2011. Health advocates strongly support an FMAP increase, and arguments dictate FMAP funding should be spent on health, not filling budget gaps.
- *Using Medicaid waivers for more federal assistance* – Medicaid waivers to fund public insurance expansions hold an estimated \$24 billion in unspent savings. Estimates suggest maximum federal support (up to 400 percent of the federal poverty level) would yield \$1.69 billion (with a state share of \$2.8 billion) for 1.3 million enrollees. The waivers could offer the State Children’s Health Insurance Program (SCHIP) support for a Child Health Plus (CHP) expansion, covering young adults up to age 25. Other waiver ideas include the renegotiation of the F-SHRP waiver to pay for coverage expansions.
- *Increase the personal income tax (PIT)* – The rationale for this action is that middle- and low-income people pay nearly twice as much in taxes as the top one percent of earners. The PIT brackets for the millionaires’ tax and from the Working Families Party proposal should be reassessed.
- *Use other tax increases* – Use the Bigger Better Bottle Bill (\$218 million per year), increase cigarette and alcohol taxes, and tax cell phones.

If the state does not obtain new funds, it has a moral imperative to revisit its current expenditures and redirect them to coverage. We are in an economic crisis statewide, as well as nationally. The answer that there is “no money for health care reform” is not acceptable.

**Ray Sweeney, Executive Vice President, Healthcare Association of NYS**

States have been more active in health reform because of a lack of federal action. Massachusetts is the best example of a state that has taken action in health reform.

The U.S. spends \$2.3 trillion on health care, so there should be enough money for financing coverage initiatives. New York may be able to use variations on the Massachusetts health model as outlined in the United Hospital Fund's Blueprint for coverage.

There is a lot in savings that can be generated for financing.

There should be shared responsibility in financing: a billion dollars in federal funds; \$600 million in employer savings; and \$1.1 billion in play-or-pay costs, which becomes eight percent the responsibility of family income and includes individualized savings (depends on enrollee).

The recent budget proposal had \$1.8 billion in health care cuts (nurses, hospitals, etc.). The cuts are not any easier with the \$14-15 billion budget gap. A solution will have to be to substitute state savings with alternate forms of initiatives and funding. Some substitutions may include the SCHIP reauthorization in April 2009, which will include additional funding to invest in program expansion, and indigent care funding.

The federal government is trying to arrive to a national solution, and if they fail, the federal government will encourage states to use their own reform strategies, so New York should be prepared to engage in reform.

**Sean Doolan, Counsel, New York Conference of Blue Cross and Blue Shield Plans**

Funding sources for health care are not always used for coverage expansions, but rather for plugging budget shortfalls. There is a disconnect between raising taxes on insurers on one side and providing subsidies on the other.

Financing sources are likely to include customers paying premiums, health plans, providers, and the government.

Small businesses are experiencing economic hardship and competition, and should not be asked to pay more for health care.

Health plans already are highly taxed; alternatives must be considered. While alternatives continue to be explored, the hospital discharge tax is a heavy 8.95 percent on the low-income family.

What can be done?

- Short-term cost containment is an option, but such plans need to be structured.
- The uninsured usually are government program eligible, but not enrolled — and need to be.
- Costs on the individual market need to be cut between 20 percent and 50 percent. Introducing new products into the market for populations such as young adults and the terminally ill would help.
- These changes can be done in the short-term as a bridge to universal coverage.

**Charles Brecher, Research Director, Citizens Budget Commission**

There is no new money for health care. New taxes are implemented to cover budget gaps — and there are big budget gaps. There is a temporary surcharge on income tax to cover gaps in New York City, but there are other places where savings can generate financing for coverage:

- There is already a lot of money in long-term care. Medicaid funded long-term care cannot be designed to fund care for the middle class — it must be reformed.
- Personal care services in New York are much higher than in other states, and need to be rationalized.
- Health insurance for public employees is built on cost-sharing on premiums, and the amount has not been sufficient. There could be more cost-sharing.
- Graduate medical education is over subsidized in New York. The state pays for the training of a disproportionate share of physicians who subsidize the rest of the country. Different types of doctors are needed — more primary care doctors need to be trained.

**Paul Sorum, MD, Chairman, Physicians for National Health Program, Capital District**

A single payer system is the way New York should finance health care. This system can enable all New Yorkers to be insured. The first principle of a single payer system relies on comprehensive coverage for all; the second principle details public financing as transparent, broad-based and equitable; and the third principle simply states one state, one plan.

Single payer savings decrease administrative costs, allow negotiation of lower prices with health companies, restrain reimbursements, provide the ability to shift resources to primary care and the ability to enforce single set of quality improvement rules (providers are then willing to cooperate).

Additional taxes in a single payer proposal include an income surcharge of one percent of any annual income above \$200,000. Self-employed business tax on net income is 10 percent (\$100,000 annual). The payroll tax provides the remaining necessary income with \$10,000 annual income floor and no ceiling.

Current proposals for reforming Medicaid inpatient reimbursement should redirect money to primary care.

*Views expressed by the authors do not necessarily reflect the opinions or official position of the State University of New York, the Rockefeller Institute, or its funders.*