

Public Hearing
**Increasing Access to Health Insurance Coverage and Moving Toward Universal
Healthcare Coverage; Defining the Goals and Identifying the Steps**

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**ONONDAGA COUNTY MEDICAL SOCIETY RESPONSE TO ADDRESSING THE
PROBLEM OF THE UNINSURED**

On behalf of the Onondaga County Medical Society (OCMS), we would like to thank you for providing us with an opportunity to explore possible mechanisms which may be employed to address the challenge of how to increase access to medical care in New York State.

The public is worried about the state of health care in the United States today and especially about the rising cost of their own health insurance. Physicians are concerned because to them any system dominated by the managed care industry, which in New York extracts conservatively over a billion dollars in profit from the health care system annually, is broken and in need of a major overhaul.

SCOPE OF THE PROBLEM

The scope and composition of the uninsured population in New York State and the changing demographics of the insurance market demonstrate the multi-faceted, complex nature of the issues which must be considered as the state contemplates actions designed to enhance access to health insurance coverage

OCMS advocates for the political changes necessary to achieve universal coverage.

UNIVERSAL COVERAGE

The goal of universal coverage must be premised upon recognition of the fact that the health care system is a partnership between patients, physicians, hospitals and the State to improve health care and its delivery.

UNIVERSAL HEALTH CARE

Universal health care means health care for all New Yorkers, with access to coverage for the uninsured/underinsured.

If present coverage and access is acceptable, no change in coverage is necessary as long as the insurance offered is compatible with other basic principles enumerated herein.

The Plan 1: Enhance Enrollment of Currently Eligible Uninsured into Public Health Insurance Programs and Simplify Program Eligibility

We must identify and implement strategies to address the problem of that segment of the population (approximately 400,000 children and 870,000 adults) which remains eligible for but not enrolled in publicly-sponsored insurance programs such as Medicaid, Family Health Plus and Child Health Plus.

One such strategy is to USE interface enrollment sites such as schools, emergency rooms, state offices and utility companies. The joint application procedure for many of the programs is a step in the right direction.

Also, OCMS supports expanding eligibility for both CHPlus and FHP. We support the Governor in his request of the Bush administration to reconsider its policy, which in effect will prevent the implementation of legislation enacted as part of the state budget for fiscal year 2007-08 that would require enrollment in the Child Health Plus program of all children in families with income up to 400 percent of the federal poverty level (approximately 70,000 children).

Moreover, streamlining eligibility determinations and the recertification process for these public programs saves time, reduces waste, and most importantly, assures that eligible patients do not lose coverage as a result of unnecessary and excessive bureaucratic hassles.

A) Enhance Reimbursement for Care Provided To Beneficiaries of the Medicaid Program

Since the inception of the state's Medicaid program, the nation's consumer price index has increased 659% and yet only one modest increase has been implemented (in October of 2000) to the Medicaid fee-for-service reimbursement rate for physician services.

This increase, while welcomed and needed, was grossly inadequate to counter the historically low fee structure – particularly when viewed in conjunction with the dramatic increases in the cost of doing business which physicians have experienced.

Without question, New York's Medicaid fees are substantially lower than other government payors, private plans and other states. As an example, Medicaid reimburses an otolaryngologist \$40 for a Fiberoptic laryngoscopy which Medicare reimburses at \$134.67 and Workers' Compensation reimburses at a rate of \$224.46.

While reform of the Medicaid reimbursement structure will not of its own accord redress the problem of the uninsured, fair and reasonable payment enhancement for physicians under the Medicaid program is one of several components of reform which are necessary to assure a sufficient supply of physicians, and to serve the needs of beneficiaries of our publicly sponsored programs including any program which will be established to cover the uninsured/underinsured of New York State.

The Plan 2: A Program Must Be Developed To Enable All New Yorkers, Beginning with the Uninsured/Underinsured, to Purchase Affordable Health Coverage.

A) Governance:

- 1) In our opinion the governance of the plan should reflect as much autonomy from the political process as possible.
- 2) An entity should be created which operates separately from the State but subject to rules and regulations set up by the State.
- 3) The program should be administrated under the auspices of a stand alone organization with its own administrative staff.
- 4) There must be proper oversight to guard against corruption, cost shifting, misuse of funds and overpayment to executive employees of the plans authorized to underwrite the coverage provided under this program. A limit on program administrative costs, advertising, and profit to a level more commensurate with publicly administered health plans such as Medicare or Medicaid, or those in our neighbor country to the north, must be obtained.

B) Program Structure:

- 1) All New Yorkers must, at least, obtain basic health coverage. This should be effectuated through a mandate upon individuals to purchase insurance. This is a personal mandate, as the young and healthy must be involved.
- 2) Every New Yorker also should be offered the opportunity to purchase this basic health coverage.
- 3) For the uninsured or underinsured, there must be income dependent subsidization with perhaps those families at under 100% of the federal poverty level receiving a total subsidy and the remainder of the uninsured/underinsured receiving a sliding scale subsidy of partial subsidization and/or low cost insurance in families or individuals with income up to 400% of the federal poverty limit.

Subsidization, coupled with insurance changes to introduce affordability such as widening the base of covered persons, is important. In our opinion, a widened base may produce a modest premium reduction for all.
- 4) This plan must include an HSA, high deductible health plan, associated with catastrophic insurance.
- 5) Coverage offered through this program should be portable within the State.

6) There should be disincentives for those who do not purchase health coverage. The specific mechanism for enforcement of the mandate, whether it is a tax penalty or a fine, must be sufficient to assure compliance.

7) The members of the OCMS are opposed to an employer mandate.

8) Simplicity, such as Gap Insurance for Medicare, should also be pursued as an alternative to the complexity of the current system and preserve choice.

9) New York must be ready to roll its system into any national plan which may evolve so as to take advantage of:

- a. Tax relief and/or credits which may be advanceable and refundable
- b. Individual ownership
- c. National portability
- d. Resultant attenuations of restrictive federal law

10) New York's health coverage program for the uninsured/underinsured must provide equitable coverage and benefits, similar to programs adopted in other states such as Massachusetts.

Universal parameters, with a single tier of insurance and one benefit package for those receiving a public program, are critical so as to reduce the associated administrative burden. Simplicity must replace the complexity of the current system.

11) Insurance renewal should be guaranteed for as long as necessary. A patient should be able to slip seamlessly into the plan when necessary. There should be no administrative waste on either end with regard to issuance.

C) Infrastructure:

1) The community physician and hospital must be recognized as the base to any health plan and must be funded appropriately.

2) The present infrastructure should be used wherever possible. Where there is a community or hospital based health clinic, these facilities should be strengthened. These existing clinics and any new ones formed should continue to be a delivery site of health care. An appeal should be made to the physician community at large, including medical students and residents, to provide care focused on primary and preventive services in such clinics. To enhance interest in such service, service contracts between those physicians and the state should be executed which provide for tuition rebates; loan forgiveness; and medical liability indemnification through the state and appropriate annual salary. An appropriate schedule is affixed.

3) Recognition must be given to the fact that without participation by the community physician and the hospital no solution for coverage of the uninsured/underinsured will work. The community physicians and the community hospital's present difficulty with payments, forced added overhead expense, and insurmountable medical liability premiums must be recognized and solved as an integral part of this effort.

4) A long term view is necessary.

The Plan 3: Additional Health System Reforms

OCMS supports the imposition of a minimum medical loss ratio (MMLR) which assures an adequate investment of payor revenue in the provision of medical care. In our opinion, we should seek to allocate at least 95% of all revenue for reimbursement of health care providers, including physicians, for patient care.

Until such time as it becomes no longer necessary, there should be the enactment of a prior approval rate process which will assure that the rate structure implemented will afford adequate resources to support the provision of necessary medical care and treatment.

Insurance cards, including those for self-funded corporate plans, should be dated with the date of issue and termination and specify all coverage limitations and cost sharing requirements.

Because ERISA prevents the state from regulating self-insured plans, we advocate for a two-pronged, state and federal approach which seeks administrative simplification on the state level with concomitant reform on the federal level.

Individual health responsibility for patients to avoid chronic disease is essential. While this may not save up front costs, the increase in value by a program that achieves this may be immeasurable. Obesity, hypertension, smoking, excess alcohol consumption and diseases which may be related to lifestyle improprieties must be addressed. Quality and effectiveness of medical treatment is the central consideration. Quality bench marks such as those promulgated by the physician consortium and by the AMA can be used to effectuate clinical care improvement and enhanced quality for all.

Conclusion. The number of persons without health insurance coverage in New York State will continue to grow unless action is taken to address this escalating health crisis. The Onondaga Medical Society believes that this problem must be addressed through a multifaceted approach, which would at a minimum include:

- 1) Enhanced enrollment of currently eligible uninsured into public health insurance programs
- 2) Simplified program eligibility requirements for existing publicly sponsored coverage programs
- 3) Enhanced reimbursement for care provided to beneficiaries of the Medicaid program
- 4) Development of a program to enable the uninsured/underinsured to purchase affordable health coverage
- 5) Imposition of an individual mandate to purchase affordable health coverage
- 6) Recognition that it is the physician and hospital that are the base of the program

We stand ready to assist you in your consideration of strategies to address this most important health policy issue.

Attachment A- Comparison of New York's Medicaid Fees to Other Payors and States

New York Medicaid Fees Compared to Other Payors and State Programs							
			NYS M'caid doctors' office	Medicare*	W/C**	Kentucky	Florida
Psychiatry	90801	Initial diagnostic evaluation	\$ 45.00	\$ 175.50	\$ 218.35	\$ 85.01	\$ 84.13
	90807	Psychotherapy 45-50 minutes	\$ 54.00	\$ 120.14	\$ 156.33	\$ 73.50	\$ 57.95
	90862	Pharmacologic management	\$ 22.50	\$ 59.83	\$ 74.11	\$ 39.02	\$ 28.66
Otolaryngology	42825	Tonsillectomy	\$ 60.00	\$ 335.74	\$ 748.96	\$ 173.02	\$ 152.68
	31575	Fiberoptic laryngoscopy	\$ 40.00	\$ 152.05	\$ 224.46	\$ 78.25	\$ 67.51
Urology	52000	Cystoscopy	\$ 17.00	\$ 315.37	\$ 235.91	\$ 98.06	\$ 152.68
	55700	Prostate Bx	\$ 20.00	\$ 243.26	\$ 267.98	\$ 89.95	\$ 93.47
Pediatrics	99291	Critical care (PICU) 99293	\$ 25.00	\$ 247.59	\$ 285.78	\$ 147.84	\$ 118.61
	99292	Critical care (30 min.) 99294	\$ 12.50	\$ 127.52	\$ 142.89	\$ 71.86	\$ 60.86
E&M	99202	E&M, new, minor	\$ 30.00	\$ 76.75	\$ 61.43	\$ 35.29	\$ 33.85
	99214	E&M, established, moderate	\$ 30.00	\$ 97.91	\$ 71.49	\$ 41.97	\$ 43.20

	99215	E&M, established, high	\$ 30.00	\$ 142.12	\$ 114.33	\$ 66.39	\$ 63.31
Prepared by the Division of Socio-Medical Economics							
			* All Medicare fees are based on Par rate for Loc. 1 w/o site of service differential				
			** All WC fees are = WC Loc. 4				

Attachment B: Suggested programs for recruiting physicians to the infrastructure.

- 1) Tuition rebates for medical students indicating desire to join such program.**
- 2) State reduction of medical school debt by a formula which forgives some medical school debt for each year of service. A minimum of \$30,000/per year to be applied to medical school debt is appropriate. This will bring stability to the physician work force.**
- 3) A salary should be given which is a living wage.**
- 4) Medical liability indemnification through the state.**
- 5) A work contract for a minimum of four years.**