

HEALTH CARE

Health Care advocacy in New York State is based both on LWVNYS positions and the positions of LWVUS. (*LWVUS Impact on Issues, 2006-2008, p. 67-70*)

HEALTH CARE POSITIONS IN BRIEF

Support of measures to assure a basic level of quality physical and mental health care for all state residents, including regulatory incentives to encourage development of cost-effective alternative methods of delivery, funding for health promotion and disease prevention programs, and provisions for effective citizen participation in health policy decisions.

Support of measures that enable individuals to assume responsibility for their personal health and to participate in decisions, including termination of extraordinary life-extending procedures.

Support for uniform eligibility and coverage of basic health care costs through public financing. The League supports the single payor concept as an acceptable approach to implementing League positions on equitable access and cost containment.

ACCESS TO HEALTH CARE

In 1983, the League adopted a comprehensive study of health care in New York State. After considering the cost, payment, delivery of care, and related issues, member consensus provided a position for League action.

HEALTH CARE

Statement of Position

**As announced by the State Board, May 1985 and
revised to reflect State Convention action, 1999**

The League of Women Voters of New York State believes that everyone should have access to basic physical and mental health care. New York State has a proper role in the regulation of health care and must assure high quality care that is affordable and accessible to all. The state should support incentives to foster the development of alternative delivery and payment methods.

More resources should be devoted to health promotion and disease prevention so that consumers can take active responsibility for their own health. Citizens should have more opportunities to participate effectively in decisions regarding their personal health and in health care policy decisions.

The League believes that New York State's primary role in health care is to assure that quality care is available to all New Yorkers. We believe that the state should provide planning and

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Statement of Position

As announced by the State Board, May 1985 and
revised to reflect State Convention action, 1999 (continued)

regulations to assure everyone, including the medically indigent, access to a basic level of quality physical and mental health care. Cost containment should be an important criterion in developing regulations. Such regulation, however, should not compromise the quality of care or its accessibility. We support regionalization of specialized tertiary services as a means of providing access while controlling costs.

There should be coordination among regulatory bodies to avoid undue delays and contradictory, duplicative regulations.

The League supports regulatory incentives to encourage the development of alternative ways of delivering and paying for health care. Delivery programs should provide quality care, be cost effective, and be adaptable to different geographical locations. Services may take place in a variety of settings, including the home, and must be staffed by personnel who meet state standards.

Coordination of services is essential to assure that community needs are met. In addition, all programs should be evaluated regularly. Payment methods should be encouraged which include incentives for efficiency and for disease prevention and health promotion activities. Some alternatives, which should be considered for state regulation, include ambulatory surgery, alternative providers, prepayment plans and the issue of professional liability. Activities should be continued in public health, environmental health and research.

Decisions on medical procedures that would prolong life should be made jointly by patient, family, and physician. Patient decisions, including those made prior to need, should be respected. To participate in public discussion of health policy and to share effectively in making policy decisions, consumers must be provided with information on the health care system and on the implications of health policy decisions.

Acting on member support for home care for the frail and disabled, the League supported passage of a law, in 1985, to provide training for family members and friends of those who require care at home.

Since adoption of the Health Care position, the League has lobbied hard for measures that assure access to quality health care, with prenatal and child health care a League legislative priority in 1987. In 1986, the League successfully supported legislation for a prenatal care assistance program and worked again in 1987 for the establishment of a permanent prenatal care assistance program within the New York State Department of Health. Lobbying efforts during 1987 also focused on the inclusion of entitlement to services for pregnant women living at or below 185% of the poverty level. Funding for prenatal care services for women with incomes above the federal poverty level passed in 1989 but not with a full range of services including abortion. In spite of the need for such services, the League

opposed the legislation because Medicaid funding for abortions was not included. Recognizing that early and continuous health care is the first step toward a productive future, the League has been active in supporting bills which would raise income eligibility standards for Medicaid, so that poor children can receive needed health care, and has supported nutrition outreach legislation.

Regarding increased availability of health care services, the League has supported a bill which would encourage physician participation in Medicaid funded maternity services by doubling the reimbursement fee, and a bill which would increase the operation cost component of Medicaid reimbursement to hospitals. The League opposed a Medicaid co-payment bill because it felt the program would be a disincentive to providers to participate in Medicaid and could discourage Medicaid clients from seeking services.

Funding for health planning agencies was continued in 1989 after extensive debate and lobbying. The League supported this legislation under its position of public input and rational allocation of resources. During the budget negotiations for 1995-96, the League lobbied unsuccessfully to restore cuts in funding to the health systems agencies.

In the 1992, legislative session, the League lobbied for legislation which would provide technical assistance to school districts and BOCES in the development of school health care services for pre-school and school age children. This bill died in the Senate Rules committee.

One of the most important legislative proposals the League has lobbied for, beginning with the 1993 session, was the Health Care Facilities Access bill. Passing the Assembly with an overwhelming margin, the bill died that year in the Senate. This legislation is vitally important since it provides access to health care and seeks to protect health care workers from intimidation and harassment. During the 1994-1995 session the John/Cook Facilities Access legislation again passed the Assembly with an overwhelming margin and was held in the Senate Republican conference.

Since the 1994 legislative session, the League has continued to support legislation that would make the funding for school based health services permanent.

In 2007 legislative session, the League worked to allow for reimbursement of Child Health Plus (CHP) and Family Health Plus (FHP) funding in school based health clinics. This has become a big lift because of the Division of Budget fiscal impact. In the 2008 legislative session, it is anticipated that there will be a push to allow social work reimbursement in these clinics. The League will support this effort.

The League in 1994, successfully supported legislation, to require routine obstetric and gynecologic services offered by Health Maintenance Organizations (HMO's).

The rapid development of managed care entities and market concentration in New York State prompted statewide discussions during the 1995 legislative session on the impact of managed care on the quality and delivery of health care. Legislation and a similar, though not identical bill in the Senate would have set standards and provide protection for consumers and providers.

The League supported this legislation and gave testimony on League position concerning managed care. Dubbed the “Health Care Consumer Bill of Rights,” passed the Assembly but was not addressed by the Senate. Also in the 1995 session, the administration’s proposal to mandate Medicaid managed care prompted action by the state League. Letters were written opposing cuts in Medicaid reimbursement rates to providers and commenting on proposals for reforming the NYS Medicaid program.

In 1996, the League, as a member of two broad based coalitions, The Coalition for Quality and Choice in Managed Care and Health Care Campaign, launched an all-out lobbying effort to secure passage of managed care consumer protection legislation. Because of nonstop lobbying by all sides, the Legislature passed and the governor signed three major pieces of legislation that will significantly impact the way health care is delivered and financed in New York State for years to come. (See additional information under Financing of Health Care.)

Two of the three new laws (Managed Care Consumer Bill of Rights - Chapter 705, Laws of 1996, and Medicaid Managed Care - Chapter 649, Laws of 1996) provide consumers with additional rights and protections in dealing with health insurance companies, particularly managed care organizations. Both laws establish new standards and procedures to improve health care quality and access. These include:

- Disclosure of important information about health insurance plans, such as—benefits provided;
- Costs to enrollees, choosing physicians and medical facilities, the definition of “medical necessity”;
- The right to receive referrals to specialists; use of emergency room services based upon the “prudent layperson” definition;
- Greater regulation of the “utilization review” process; and a timely grievance and appeal process to challenge adverse decisions.

The two new laws also prohibit the infamous “gag clauses”, which insurers have used to keep providers from advocating on behalf of their patients or speaking freely to their patients about treatment options.

Although both laws have much in common, one applies to all insured persons, whereas the other extends protection specifically to Medicaid patients who are enrolled in managed care plans. League worked hard for effective Medicaid managed care protections. We were concerned that, once the federal government approved the states mandatory Medicaid managed care plan, a flood of new enrollees would overwhelm the system and have an adverse impact on Medicaid patients.

In 1997, the League began lobbying efforts early in the legislative session to obtain passage of important provisions of the Managed Care Consumer Bill of Rights that had been eliminated from the comprehensive measure that was passed in 1996. Our priorities for 1997 included:

- Experimental and investigative treatments legislation to improve medical care for the seriously ill;
- Health maintenance organization (HMO) liability, which will hold HMOs liable for the health care decisions they make;

- Establishment of an ombudsman program to assist consumers with their health insurance questions;
- Extension of anti-gag rules to cover health care professionals other than physicians.

Although prospects for passage of these measures looked promising at the beginning of the legislative session and all were passed with bipartisan support in the Assembly, the state Senate took no action on them.

However, the League recorded some notable health care successes. In 1996, media attention focused on the issue of “drive-through” deliveries. Legislation was introduced, which the League supported, requiring insurers to cover a hospital stay of 48 hours for mothers and newborns following a normal vaginal delivery or 72 hours following a caesarian birth. This popular proposal easily passed in both houses and was signed into law.

Similarly, in 1997, legislation was introduced requiring insurers to allow patients and their doctors to decide the length of hospital stay following a mastectomy as well as requiring insurers to pay for reconstructive surgery following a mastectomy. The League lobbied for this legislation, which passed in the legislature and was signed by the governor.

In 1996, the League joined a coalition of health care and environmental groups to lobby for legislation that would require the reporting of publicly accessible data on pesticide use and sales in New York State. The compromise legislation that was enacted also established a health research science board and breast cancer research and education fund.

In 2007, the League supported two measures designed to increase patient access to quality health care. The Nursing Care Quality Protection Act, introduced in the Assembly would require hospital disclosure of levels of nursing and patient care staff and would document the number of adverse hospital incidents. This legislation passed the Assembly. Another bill introduced in the Assembly and supported by the League, would have required the Department of Health to develop minimum nursing levels for nursing homes throughout the day in consultation with an advisory council. This legislation passed the Assembly, but was held in the Senate.

Managed Care Legislation

In 1998 the push for additional managed care consumer protection legislation continued. Two League supported measures were combined into one piece of legislation and signed into law. This legislation created an External Review Board, giving HMO enrollees, the right to appeal an insurer’s decision to deny medical care, including the carrier’s refusal to permit use of experimental or investigational (Clinical trials) treatments. Patients could request action from the independent External Review Board when they had exhausted their insurer’s internal appeals process.

No further legislative action was taken in 1998 or 1999 on other League supported managed care reforms, including HMO liability (now titled the Health Care Accountability Act) or on establishing the Managed Care Consumer Assistance program.

Women's Health Care

In October 1998 all New York was shocked when Dr. Barnett Slepian was shot and killed in his Amherst, NY home. Dr. Slepian was an obstetrician and gynecologist who performed abortions at a Buffalo Women's Clinic. For the seventh year, League, and many other health care advocates, lobbied for much needed Safe Clinic Access legislation and the Assembly quickly passed its bill early in the session. In response to the doctor's murder, Governor Pataki publicly stated his support for such legislation. Although the Senate rejected a companion measure to the Assembly bill, in June 1999 it did pass its own version that incorporated an anti-stalking provision. In the final minutes of the 1999 legislative session, the governor and the Assembly reached a compromise. The law went into effect December 1, 1999.

In 1998 and 1999, the League supported the Women's Health and Wellness Act (WHWA). Many insurers do not cover the most common health problems experienced by women. This act requires health insurers to cover contraceptive drugs and devices, annual pelvic exams and pap smears, annual mammograms for people aged 40 and over, and osteoporosis screening and treatment. In both years, the bill was overwhelmingly approved by the Assembly only to stall in the Senate.

In the 2000 legislative session, the Senate pushed for and was successful in passing an insurance mandate to cover PSA tests for prostate cancer screening. The League supported that legislation, however, we made it clear to the Senate that in failing to pass the WHWA they were continuing to put women's health care at a lower priority.

The League lobbied extensively again in the 2001 session in support of the Women's Health and Wellness Act. Early in the 2001 session, the Senate Majority Leader introduced a bill, which, while mandating coverage of some preventive health services, differs from the Assembly in that it allows insurers to charge co-pays and deductibles. It also includes a loophole, "the religious conscience clause", allowing some employers and insurance plans to deny coverage for contraceptive care. The Senate promptly passed this legislation and the two houses went to conference committee. After three committee meetings, the Assembly appeared to have the momentum so the Majority Leader pulled his members from the committee process.

Intense lobbying on this issue continued for the rest of the session and during the legislative sessions of 2002 the League had a major women's health care victory. In the closing days of the 2002 session, after much grassroots lobbying by league members and our coalition partners, the Women's Health and Wellness Act was passed by both houses of the legislature and signed into law by the Governor. It went into effect on January 1, 2003. The new law contains all those elements for which the League had lobbied including insurance coverage of contraceptive drugs and devices, annual pelvic exams and pap smears, annual mammograms for woman over forty and osteoporosis screening and treatment. This will have a very real effect on preventive health care for women in New York. Shortly after the law was enacted, the New York State Catholic Conference sued in state court and the law was stayed. The court action extended all the way up to the New York State Court of Appeals. In the court session of 2007, the decision came down that the WHWA was indeed constitutional and the law went into effect immediately. After many years, this is a success for both the League and women's health.

The Uninsured

In keeping with our goal of universal health care, in 1998 and 1999 League focused attention on the growing number of people without health insurance. By 1996, the uninsured in New York had surpassed 3.1 million, a 40% increase from 1991, and the number was continuing to rise.

In 1996, League supported the state's child health insurance program, entitled Child Health Plus (CHP) that offered subsidized health insurance to children of families unable to afford health coverage. In 1998, we supported expansion of this program using new federal funding incentives. As part of its eligibility to receive federal funds, NYS was required to launch an all out effort to enroll children in either the Medicaid or CHP programs. This effort began in the fall of 1999.

Similarly, League examined other proposals to make health insurance affordable for more New York residents. We gave our support to a proposal that would create a "Family Health Plus" program modeled after the CHP insurance plan. (See detailed information on this and the CHP program under FINANCING HEALTH CARE.)

Mental Health Parity

Mental health parity has been a League priority since the 1999 amendment of its 1985 health care position. This issue came to the forefront in 2006, when a constituent (9 year old boy) of a powerful Assemblymember, killed himself. After intense lobbying by the boy's family and awareness statewide the legislature was compelled to pass legislation creating mental health parity in private health insurance. The League supported this legislation. Programs such as Child Health Plus (CHP) and Family Health Plus still remain without mental health parity and must rely on the Medicaid system. It is hoped that the issue of public mental health parity will be addressed in the 2007/2008 budget.

DISEASE PREVENTION AND HEALTH PROMOTION

In 1992, the League actively lobbied for legislation, which would mandate that insurance companies cover annual cervical cytology screening for women aged 18 and older. Legislation to authorize approved organizations within the breast cancer detection and education program to provide early cervical cancer detection and diagnostic services was successfully supported by the League in 1995. This legislation passed the legislature and was signed into law.

The League successfully worked on legislation in the 1994 session that expanded immunizations for vaccine-preventable diseases, Hib, and hepatitis B. This bill passed the legislature and was signed into law.

Anti-Tobacco Legislation

During the 1993 legislative session, the League lobbied successfully for an increase in the excise tax on cigarettes, raising that tax 17 cents per pack. Legislation, known as the PRO-KIDS bill would prohibit smoking on school grounds and other places such as fast food restaurants and day care facilities, which children frequent. It would also ban fixed advertising of tobacco products. A watered-down version of the original bill finally passed the Assembly the day before the legislature recessed; the Senate did not address it. In the 1994 session, the Coalition for a Healthy New York, of which the League is a lead organization, lobbied vigorously for this measure, which passed the Assembly early in the session and was propelled through the Senate by the artful lobbying effort of the Coalition. Signed into law, it took effect September 1, 1994.

In addition to PRO-KIDS, the League has worked for a range of anti-smoking legislation designed to promote better public health. The League supported:

- Legislation, which would prohibit the erection or maintenance of billboards advertising tobacco products within 1000 feet of schools. League support has been ongoing since 1994, as these bills have consistently passed the Assembly, but have not been addressed by the Senate.
- Legislation, which would require cigarette manufacturers to disclose the chemical substances used in the manufacture of cigarettes. Passed in Assembly in 1995; no Senate sponsor.
- Legislation allowing the state to recover the cost of Medicaid benefits NYS currently pays for illnesses caused by tobacco products. Introduced late in 1995 session; no action taken; no Senate sponsor.
- Legislation amending Public Health Law and Tax Law allowing local health departments to license tobacco retailers and increase enforcement of current restrictions on access a minor has to tobacco products. It would also create a public health programs fund to provide pro-health messages concerning the health risks of tobacco use. In the 1995 session, League lobbied aggressively and did considerable public relations work around this legislation, known as the "Healthy Children Act," to educate legislators in anticipation of action in future sessions. No Senate sponsor.

In 1996, the League opposed Senate legislation, introduced late in the 1995 session, by the Senate Rules Committee. This legislation referred to as the "Tobacco Industry Relief Act," this legislation would weaken New York State's Clean Indoor Air laws, repeal strong local smoke-free laws in NYC,

Suffolk County and other areas; and would preempt other localities from passing stronger restrictions in the future. This was one-house legislation and the Assembly took no action.

Also in the 1996 and 1997 legislative sessions the League lobbied extensively for passage of legislation which would not only protect children from the dangers of second-hand smoke, but also from the impact of the tobacco industry's advertising efforts to entice teenagers to begin smoking.

The League and the Coalition for A Healthy New York were successful in preventing "preemption" legislation from passing either house of the NYS legislature. Local Leagues, particularly in Erie, Westchester, and Nassau Counties had been successful in passing through their county legislature or through their Health Department stricter anti-smoking measures than the state standard. Suffolk County's law was challenged successfully in court.

Early in 1997, Governor Pataki announced his tobacco control initiative. This multifaceted approach would:

- Improve enforcement of the Adolescent Tobacco Use Prevention Act (ATUPA).
- Ban self-service of tobacco products in groceries and convenient stores.
- Provide for media and education programs.

The Coalition for a Healthy New York encouraged the governor to work with the Coalition to pass legislation with this initiative in it. Unfortunately, no legislation materialized. Legislation called the Healthy Children Act, which incorporated much of the governor's initiatives, was also not addressed.

However, after negotiations with the governor's office by Coalition members, \$2.5 million was added to the 1997-98 state budget for enforcement of ATUPA. Provisions include:

- Spot checks to heighten compliance of vendors selling tobacco products to minors.
- Public education efforts to inform minors of the health hazards of tobacco use.
- An evaluation of the state's efforts to reduce the use of tobacco by minors.

Legislation sponsored in the Assembly to allow the state to recover the costs of Medicaid benefits caused by the use of tobacco products was not reintroduced in 1997 due to class action lawsuits brought by several attorneys general, including NYS Attorney General Dennis Vacco.

During the 1998 legislative session the Assembly passed several pieces of legislation which would; increase penalties for selling to minors, decrease the availability of self-service displays in convenience stores and supermarkets, and restrict billboards within 1000 feet of schools and day care facilities. However, the Senate took no action on any of these bills.

The 1999 legislative session brought new hope for tobacco legislation as the Attorney General's law suit against big tobacco was settled and the prospect of \$25 billion over twenty-five years coming into the state of New York became a reality. As in 1998, anti-tobacco legislation, referred to above, again passed the Assembly, and was not addressed in the Senate.

Following on the heels of the Attorney General's historic federal tobacco settlement in 1999, the League and fellow anti-tobacco advocates had our most successful session ever! Six anti-tobacco bills passed both houses of the legislature and were signed by Governor Pataki. The bills included:

1. The Cigarette Fire Safety Act. NY is the first state to require (by 2003) manufactures to sell self-extinguishing cigarettes. This is widely expected to spur Congress to pass national legislation.
2. Increased penalties for ATUPA violations. This would increase the penalties for retailers who sell cigarettes to minors.
3. License flipping in the event of revocation of cigarette dealers license. This legislation would prevent dealers from "flipping" their licenses to their spouses or other relatives in order to escape revocation of a license when they are guilty of selling tobacco to minors.
4. Limits sale of "Bidis" to tobacco shops. Bidis are specially wrapped cigarettes that taste better than regular cigarettes therefore, they are particularly sellable to teens.
5. Restricts sale of herbal cigarettes by including them among tobacco products in ATUPA.
6. The bootlegging legislation. Although not technically an anti-tobacco bill, this legislation would ban Internet sales of cigarettes. The Indian Nations in N.Y. are expected to fight this new law in court.

The League has continued to work with the Tobacco Coalition in support of measures to restrict the reach and desirability of smoking. In 2006, it supported Governor Pataki's Tobacco Prevention proposals, including a state cigarette tax of \$1 per pack and funding of the state's Tobacco Prevention Program at the \$95 million minimum level recommended by the U.S. Centers for Disease Control and Prevention (CDC). These prevention proposals became part of the 2006/2007 state budget. In 2007, the League again, working with the Tobacco Coalition, supported two bills to further regulate tobacco products. The first, supported by the Assembly would have amended the Public Health Law to prohibit the sale of flavored cigarettes, which appeal primarily to children. This legislation was not addressed by the state Senate. Disclosure of cigarette ingredient legislation has been a focus of Assembly legislation for the last five years beginning in 2000. This legislation consistently passes the Assembly Health Committee, but has not passed the Assembly and has no companion sponsorship in the state Senate. The tobacco industry is still powerful enough to keep this legislation from passing through the entire Assembly or being introduced in the Senate.

The Clean Indoor Air Act 2003

The Clean Indoor Air Act, which bans smoking in ALL restaurants and bars statewide was passed early in the 2003 session and immediately signed into law by the Governor. This law has few exceptions and although patterned after the New York City law it is more stringent. The law took effect on July 24, 2003. The League has lobbied vigorously for this legislation for several years, and sees this new law as the most significant advance in public health in many years. In early December 2003, taking advantage of a loophole in the new law, the NYS Health Department (DOH) issued guidelines for "hardship exemptions" for the forty-three counties where no County Board of Health exists. Local Boards of Health are responsible for issuing these exemptions. In 2004, the League was successfully in opposing legislation that would have partially rolled back the benefits of the *Clean Indoor Air Act of 2003*. This legislation would allow smoking in certain places of public accommodation if they had in operation a state-certified air purification device.

PERSONAL HEALTH DECISION-MAKING

Following the principles that individuals should be responsible for their personal health and should participate with their family and their physicians in decisions regarding it, the League has supported the following legislation:

- In 1989 with extensive League support, a law was passed concerning “do-not-resuscitate” instructions in hospitals and nursing homes. This law was expanded in 1991 to include home and ambulance sites.
- In 1989, the League supported legislation that establishes “living wills.” These instructions relieve family and health care providers of uncertainty should decisions need to be made when a patient is unconscious or incompetent.
- In 1990, the League supported health care proxy legislation, which became law in 1990 and took effect in January 1991. A proxy provides for alternative individuals to make health care decisions on the patient’s behalf.
- In 1995, the League supported the “Family Health Care Decisions Act”, which would allow family members of patients who do not have either a living will or a health care proxy to make decisions affecting their loved ones within specific guidelines.

The Task Force on Life and Law, appointed and funded by former Governor Cuomo in 1985, consisted of prominent physicians, nurses, lawyers, clergy of different faiths and others. The Task Force debated legal and ethical issues in medicine and developed the above referenced legislation. In the 1995-96 Executive budget the Task Force was defunded; it is still in existence with limited funding through the Department of Health.

Family Health Care Decision legislation continued to bubble under the surface through every legislative session. The League will continue to look for opportunities to advance this important legislation.

In the 2006 and 2007 legislation session the Family Health Care Decision, legislation was again introduced in the Assembly. However, major opposition to this legislation by the NYS Catholic Conference, the Conservative Party and the Right to Life Committee continue to hold sway in the NYS Senate. No action was taken.

HIV/AIDS

In 1994, legislation was introduced by Assemblywoman Mayersohn and Senator Velella, which would unblind the newborn sero-prevalence test for HIV. Although unblinding would indicate the possible HIV status of newborns, it would disclose the absolute HIV status of the mother. The League opposed this legislation on the basis that it violates the right of individuals to make their own health care decisions. More importantly, we believed such a punitive measure would have a negative impact on promising new treatment programs that were reducing the rate of HIV transmission from infected mothers to their newborns. Therefore, the League actively supported legislation in the Senate that would mandate prenatal HIV counseling and voluntary HIV testing. This legislation did not pass in either house of the legislature.

In 1995 League wrote in support of a program, recommended by the Centers for Disease Control and implemented by the NYS Department of Health, that combined counseling and voluntary HIV testing with an aggressive AZT treatment program for HIV infected pregnant women. Once again, legislation opposed by the League and many health care providers and women's groups was introduced by Assemblywoman Mayersohn and Senator Velella to unblind the newborn HIV test. This bill passed in the Senate but was held by Assembly Speaker Silver.

In 1996, the Assembly Health Committee was pressured by the Assembly leadership to release the Mayersohn HIV Newborn Screening bill from Committee. This bill would give the Commissioner of Health authority to disclose the results of the newborn HIV test whether or not permission was given by the mother. Once out of Committee, this mandatory HIV testing bill passed both houses and was signed into law. In restating our opposition to the legislation and its implementing regulations, League argued (unsuccessfully) that the voluntary program already in place was working and that the prenatal HIV transmission rate was decreasing as predicted.

In 1998, League actively supported HIV name reporting/partner notification legislation. League recognized that the voluntary system of partner notification was not working. Notification had long played a role in controlling syphilis and gonorrhea and we agreed that HIV/AIDS should not be exempt from this life-saving practice. Primary prevention was paramount. The final version of the bill created a name-based surveillance system and a universal partner notification system. It gave public health workers primary responsibility for notifying the partners of HIV positive individuals. The legislation included safeguards that were essential for League support. These included: voluntary compliance; no criminal penalties for noncompliance; continuous anonymous testing option; creating protocols in cases of domestic violence; and, confidentiality of HIV individuals during the notification process. The legislation was passed by the legislature and signed into law by Governor Pataki.

FINANCING OF HEALTH CARE

The 1985 position did not adequately address priorities and trade-offs among cost, access, and quality. Delegates to the 1989 Convention adopted a two-year study of current and alternative methods of financing health care in New York State.

FINANCING OF HEALTH CARE

Statement of Position

As announced by the State Board, November 1991

As a continuation of the 1985 statement of position on health care, a two-year study and consensus on the financing of health care was conducted from 1989 to 1991. Major concerns were the financial limitations on access to health care for the uninsured and the underinsured and the escalating cost of health care.

The current financing system which involves public programs with limited eligibility, and private insurance coverage for selected groups and selected health care treatments, does not meet League criteria for access and equity in health care as stated in the position of 1985.

The League of Women Voters of New York State supports uniform eligibility and coverage of basic health care costs through public financing. Access to optional insurance coverage for care beyond the basic level of coverage should be available. Assuming that public funds for health care are limited, the League believes that the scope of services contained in basic coverage and the cost/benefit ratio of medical treatments should be considered in efforts to contain costs. The League has a strong commitment to an emphasis on preventive care, health education, and appropriate use of primary care services.

The Federal government should be the primary vehicle for the financing of health care, determining eligibility for health care services, and determining the scope of services to be provided. The State should assume secondary responsibility in these areas.

The League should ensure that public input is an integral part of the process in determining priorities in health care coverage.

Cost containment efforts should precede increased taxes or reallocation of funds from other state programs.

FINANCING OF HEALTH CARE

Statement of Position

As announced by the State Board, November 1991

(continued)

Cost containment efforts should precede increased taxes or reallocation of funds from other state programs.

The League supports the single payor concept as an acceptable approach to implementing League positions on equitable access and cost containment.

The League supports the establishment of an administrative system for determining patient compensation as a modification of the tort system related to patient injury.

Overall, the League believes that universal access must be balanced by restrictions in the scope of services, and that the scope of services should be determined by knowledgeable professionals and consumers with administrative and legislative oversight.

Hospital case-based reimbursement passed in 1987 and was the focus of legislative hearings on the "hospital crisis in New York State," due partly to the increasing demand for services caused by AIDS and drug abuse. The League supported the legislation with reservations and testified at the hearings. Before 1987, reimbursement was on a per-diem basis.

During the 1992 legislative session, the League supported legislation in the Assembly known as "community rating" which would require health maintenance organizations accept individuals in small groups on an open enrollment basis. It passed the legislature, was signed into law, and went into effect in April 1993.

Of great concern in the 1993 session was the New York Prospective Hospital Reimbursement Methodology (NYPHRM V). This legislation sets the reimbursement rates for hospitals and health care facilities. NYPHRM has been consistently extended and is currently the statute under which hospital reimbursement is determined.

In 1996, the state ended its 13-year-old hospital rate setting system, the New York Prospective Hospital Reimbursement Methodology (NYPHRM), and enacted the Health Care Reform Act (Chapter 639, Laws of 1996) to take its place.

The Health Care Reform Act (HCRA) of 1996, that replaced NYPHRM, sought to control rising health care costs by encouraging market competition. No longer protected by the state's hospital rate setting system, health facilities would now bargain directly with insurers for services. However, HCRA continued programs to safeguard public access to health care including, notably, funding for graduate medical education, bad debt and charity care, and the Child Health Plus program.

As originally created, the state's Child Health Plus (CHP) program was an innovative but limited program offering subsidized health insurance to the children of low-income families. In 1997, the Federal Government passed Title XXI, or the State Children's Health Insurance Program (SCHIP), a 10-year, \$50 billion federal effort to develop state health insurance programs for children. Together with other child and health advocates, League supported expansion of the state's existing CHP program to make use of these federal funds. In 1998, the CHP program was greatly improved by offering dental, vision and hearing benefits, and mental health and substance abuse services. It increased eligibility to age 19, increased income eligibility, and reduced cost of coverage for families. As part of the state/federal partnership, NY is required to identify eligible children and to enroll them in the appropriate insurance programs, either Medicaid or CHP.

The League worked closely with other consumer-oriented organizations to ensure the inclusion of Family Health Plus, a subsidized health insurance program for working adults based on the state's successful Child Health Plus program, as part of HCRA 2000.

HCRA expired June 30, 2003, and was reauthorized. Pressure from the SEIU 1199 and other health advocates HCRA funds continued to include both Child Health Plus and Family Health Plus. Money derived from securitization of the tobacco funds were used to fill budget gaps.

Legislative activity between 2003 and 2005 surrounded the health care funding in the state budget. In 2003, the Assembly introduced numerous measures including Child Health Plan (CHP) and Family Health Plus (FHP). These measures would expand insurance coverage. Although the League has supported such measures, they have gone nowhere. The League continues to support expansion of measures that make health care accessible and affordable for additional New Yorkers.

The League believes that New York State has a proper role in the regulation of health care and must assure high quality care that is affordable and accessible to all. Historically, since 1965, New York State through Medicaid began its most formal role in providing public health care for individuals and families with low income and resources. In 2000, with the passage of the Health Care Reform Act (HCRA), New York State substantially increased its role in public health care by subsidizing programs for the underinsured through such programs as Family Health Plus, Child Health Plus, and Medicaid. Since 2000, HCRA has been renewed in 2003 and 2005 and will be up for renewal in 2007.

In January 2007, Governor Spitzer announced his plan to increase access to uninsured New York children by increasing eligibility for subsidized coverage to families with incomes up to 400 percent of the federal poverty level thereby extending coverage to nearly all of the 400,000 currently uninsured children in New York under age 19. In August 2007, because President Bush had announced new regulations for the State Child Health Insurance Plan (SCHIP) the Governor's efforts for expansion were impeded. In October 2007, New York and five other states were prepared to sue the federal government to block the new rules.