

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.

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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.

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Statement of Position

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(continued)

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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.