Summary and County Impact of the

New York Health Care Reform Act of 2000

HCRA 2000

Updated

February 2, 2000

Harold J. Gary, President
Robert R. Gregory, Executive Director

New York State Association of Counties
111 Pine Street
Albany, NY 12207
Tel: 518.465.1473
Fax: 518.465.0506
www.state.ny.us/nysac

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Introduction

The New York Health Care Reform Act of 1996 (HCRA) deregulated inpatient and outpatient hospital rates paid by private insurers as of January 1, 1997. Before HCRA, private payers, except Health Maintenance Organizations (HMOs), were required by state law and regulation to pay reimbursement rates set by the state. HCRA also set up a system to make sure that insurers and HMOs would contribute to the costs of important public initiatives including; graduate medical education, indigent health care and health coverage for children through the Child Health Plus program; and a variety of other health care programs. HCRA was set to expire on December 31, 1999.

The Health Care Reform Act of 2000, or HCRA 2000, replaces the original HCRA and dramatically changes New York's health care system by creating new comprehensive health care insurance programs for the uninsured, while providing for the financing of New York's hospital system. According to the Governor's office, up to one million people who are currently uninsured could be eligible for coverage under the initiatives financed as part of HCRA 2000.

HCRA 2000, negotiated between the Governor and legislative leaders, amidst an intense lobbying campaign by the New York City-based hospital union, Local #1199, has created the largest unfunded mandate to be passed to local government in over a decade. Under HCRA 2000, county governments will be required to pay for 25 percent of the cost of the "Family Health Plus" health insurance program and several other mental health and public health initiatives funded through the Medicaid program.

One of the most serious structural flaws in New York's Medicaid system is that the current funding system distorts the cost-benefit analysis that should accompany every governmental decision. Policy makers in the State government calculate the "costs" of the Medicaid program based on how it will impact the State Budget, rather than the total cost of the program. Funding from counties and the City of New York is implicitly excluded from the cost-benefit calculation. This flaw is particularly apparent in HCRA 2000, as it expands the Medicaid program and the corresponding local cost by implementing the Family Health Plus program and shifts state mental health and other state initiatives into the funding stream. Unfortunately, the cost-benefit analysis will continue to be distorted as long as the state continues to require counties to pay a specified percentage of the Medicaid program.

Highlights

HCRA 2000 amends the Public Health Law, Social Services Law, Insurance Law and various chapter laws to extend the Health Care Reform Act from December 31, 1999 to June 30, 2003. The following are highlights of the major provisions of the bill, with a more detailed analysis of the major components as follows:

- Extends HCRA's system of privately-negotiated rates for non-Medicare payors of hospital inpatient services;
- Creates the "Healthy New York" package that aimed at broadening available health care coverage for the uninsured through the following four components:

    1. Establishes standardized health insurance contracts for small employers (1 to 50 employees) not offering health insurance,

2. Establishes standardized health insurance contracts for individuals who work for an employers who does not offer health insurance, are ineligible for Medicare, or have a net household income equal to 208 percent of the Federal Poverty Level (FPL),
3. Establishes a direct payment "stop-loss" fund to reimburse HMOs for claims under individual direct pay health contracts that run between $20,000 to $100,000 in a year, and
4. Establishes Family Health Plus (FHP), which is an expansion of Medicaid for uninsured adults in a family with a net household income less than ore equal to 150 percent of the Federal Poverty Level (FPL) and for single adults with a net income less than or equal to 100 percent of FPL.

- Imposes an additional 55 cents per pack tax on cigarettes to help finance the HCRA 2000 Agreement. Cigars, chewing and other loose tobacco products are exempt from this tax increase.

- Authorizes the Medicaid payment of health insurance for personal care and home health care workers in New York City, Nassau and Suffolk Counties.

- Establishes the Tobacco Use and Prevention and Control Program through the New York State Department of Health aimed at reducing the use of tobacco.

- Continues and expands the Child Health Plus program.

- Continues prior years Medicaid cost containment measures.

- Includes one new Medicaid cost containment, which will hold the Medicaid trend factor at the rate of inflation.

- Continues and increases bad debt/charity care and indigent care funding for hospitals.

- Maintains the "fixed draw" received by major public hospitals because of their high volume of charity care costs, thus ensuring no reductions over the life of HCRA 2000.

- Continues graduate Medicaid education funding for hospitals.

- Continues and expands rural health care initiatives.

- Removes the 8.18 percent surcharge from routing laboratory tests, but retains it for most inpatient and outpatient medical services.

Family Health Plus (FHP)

HCRA 2000 expands Medicaid eligibility to cover any adult person (over 19 and under 65) with at least one dependent child under 21 who does not presently receive Medicaid, if such person has a net household income of less than or equal to:

- 120 percent of FPL as of 1/1/2001;
- 135 percent of FPL as of 10/1/2001; or
- 150 percent of FPL as of 10/1/2002

The FPL, determined annually by the U.S. Department of Health and Human Services (DHHS), is commonly used for determining financial eligibility for certain federal programs. The following are the 1999 DHHS Poverty Guidelines, as published in the Federal Register:

Figure 1: 1999 DHHS Poverty Guidelines

Size of Family Unit	48 Contiguous States and D.C.
1	$ 8,240
2	11,060
3	13,880
4	16,770
5	19,250
6	22,340
7	25,160
8	27,980
For each additional person, add	2,820

Under Family Health Plus, using the 1999 FPL, this Medicaid expansion would apply to a four-person family with a household income of approximately $25,000. In addition, Medicaid is also expanded to cover any single adult person who does not presently receive Medicaid, if the adult has a net income less than or equal to 100 percent of the FPL, or $8,240 under the 1999 FPL.

The medical services provided by Family Health Plus are to be delivered under a managed care program, which will have fewer covered services than those currently offered through the Medicaid program. The medical services included in Family Health Plus, include the following:

1. Inpatient health care services;
2. Services of physicians, nurse practitioners and other related professional personnel which are provided on an outpatient or inpatient basis;
3. Laboratory tests;
4. Diagnostic X-rays;
5. Prescription drugs and durable medical equipment;
6. Radiation therapy;
7. Chemotherapy;
8. Hemodialysis;
9. Emergency Room services;
10. Emergency, preventive and routine dental care, to the extent offered by a managed care provider participating in the managed care program, but not including orthodontic and cosmetic surgery;
11. Pre-hospital emergency medical services when provided by an ambulance service;
12. Emergency, preventive and routine vision care;
13. Speech and hearing services;
14. Inpatient and outpatient mental health, alcohol and substance abuse services, as defined by DOH;
15. Family planing services, and
16. Diabetic supplies and equipment.

Since, Family Health Plus is a managed care plan and limits access to only certain providers and provides less coverage than the standard Medicaid package, the state will need to apply for two waivers from the federal government. The implementation of the Family Health Plus program is contingent upon the state receiving these federal waivers.

Unlike the regular Medicaid program, Family Health Plus creates a new enrollment process that allows providers to assist in signing up Medicaid recipients. Under the bill, state approved organizations shall be permitted to assist prospective enrollees in completion of enrollment forms at approved health care provider sites and other approved locations. The only statutory restriction is that a hospital emergency room shall not be an approved enrollment location. The legislation provides that approved organizations shall submit enrollment forms to the local department of social services.

The Senate Finance Committee has estimated that the Family Health Plus program will cost counties $340 million between calendar years 2000-2003. This analysis includes a full annual total in calendar

year 2003, though the Family Health Plus program will end on June 30, 2003. NYSAC concurs with the Senate Finance Committee estimate, for counties will need to budget for a full calendar years impact as part of their 2003 budgets. The following is the county by county estimated losses from the increased local share of the Family Health Plus program:

Figure 2: Est. County Losses from HCRA 2000 - Family Health Plus Program

Estimated Local Medicaid Increase
from Family Health Plus Program
Calendar Year 2001 through 2003
($ in Thousands)

County	
Albany	$4,065,682
Allegany	$554,550
Broome	$2,622,517
Cattaraugus	$1,101,637
Cayuga	$897,768
Chautauqua	$1,878,134
Chemung	$1,372,578
Chenango	$560,695
Clinton	$957,875
Columbia	$904,566
Cortland	$576,350
Delaware	$630,839
Dutchess	$2,828,285
Erie	$13,685,578
Essex	$548,295
Franklin	$669,236
Fulton	$996,377
Genesee	$629,785
Greene	$531,400
Hamilton	$54,453
Herkimer	$794,971
Jefferson	$1,211,974
Lewis	$380,718
Livingston	$678,453
Madison	$662,662
Monroe	$10,823,060
Montgomery	$862,471
Nassau	$16,858,055
Niagara	$2,565,674
Oneida	$3,229,492
Onondaga	$6,504,528
Ontario	$959,689
Orange	$4,008,961
Orleans	$489,226
Oswego	$1,366,177
Otsego	$693,324
Putnam	$674,401
Rensselaer	$2,131,661
Rockland	$3,893,465
St. Lawrence	$1,259,608
Saratoga	$1,600,807
Schenectady	$2,357,157
Schoharie	$348,684
Schuyler	$256,708
Seneca	$387,142
Steuben	$1,092,608
Suffolk	$15,898,409
Sullivan	$1,448,998
Tioga	$445,371
Tompkins	$722,285
Ulster	$2,449,343
Warren	$684,610
Washington	$710,223
Wayne	$955,501
Westchester	$13,864,675
Wyoming	$407,007
Yates	$255,303
Rest of State	$140,000,000
New York City	$200,000,000
Total	$340,000,000

Source: Senate Finance Committee

State Subsidies for Small Business and Working Uninsured

HCRA 2000 was designed to encourage small employers to offer health insurance coverage to their employees and to make coverage available to uninsured employees whose employers do not provide group health insurance. To meet the definition of "small employer" and qualify for this subsidy, an employer must have 50 or fewer employees and must have not offered health insurance coverage in the past year. In addition, an employer must have 30 percent of its eligible employees receiving annual wages equal to or less than $30,000. If a qualifying small employer is a sole proprietor, then this sole owner must have a net household income at or below 208 percent of FPL, or approximately $36,000 for a family of four. A qualifying small employer is required, in order to participate, to pay at least 50 percent of the premiums for its employees. An individual qualifies for state subsidy if they don't have Medicare or health insurance and have a net household income at or below 208 percent of FPL, or approximately $36,000 for a four-person household.

The bill stipulates that by January 2001, all HMOs shall offer qualifying health insurance contracts and qualifying individual health insurance contracts, limited to the following benefits:

1. Inpatient hospital services, including daily room and board, special diets, general nursing care, and miscellaneous hospital services and supplies;
2. Outpatient hospital services, including diagnostic and treatment services;
3. Physician services, including diagnostic and treatment services, consultant and referral services, surgical services, anesthesia services, second surgical opinions, and second opinions for cancer treatment;
4. Outpatient surgical facility charges related to a covered surgical procedure;
5. Pre-admission testing;
6. Maternity care;
7. Adult preventive health services;
8. Preventative and primary health care for dependent children, including well visits and immunizations;
9. Equipment, supplies and self-management education for the treatment of diabetes;
10. Diagnostic x-ray and laboratory services;
11. Emergency services;
12. Therapeutic services, including radiological services, chemotherapy and hemodialysis;
13. Blood and blood products furnished in conjunction with surgery or inpatient hospital services; and
14. Prescription drugs obtained at a participating pharmacy.

These benefits can only be provided within the health plans list of approved providers, except for emergency care or where services are not provide through ha plan provider. Co-pays are required for all of these program benefits and deductibles are required for a subset of the program benefits.

To reimburse HMOs for high monetary claims incurred under the state subsidized programs, a "small employer stop loss fund" and a "qualifying individual stop loss fund" will be established. Under the rules, any claims incurred within a year between $30,000 - $100,000 for any one member covered under either of the two programs would be reimbursed at 90 percent of the claimed amount, by the applicable stop loss fund.

State Subsidies for Direct Pay Individuals

Beginning January 1, 2000, HMOs will be eligible to receive reimbursement from a "Direct Payment Stop Loss Fund" for 90 percent of claims incurred between $20,000 and $100,000 in a given calendar year for a member covered under a contract. Claims eligible shall only include claims that have been paid by the HMO no later than March 1st of the year following the year in which the claim incurred.

HCRA 2000 Hospital Financing

The following summarizes the key hospital financing components of HCRA 2000:

Hospital Indigent Care Pool

HCRA 2000 increases from $738 million to $765 million the funds available to partially reimburse hospitals that provide a significant amount of uncompensated care. The $765 million is guaranteed for this purpose and will get priority funding over other HCRA financed programs. The revenues for this pool are generated from the 8.18 percent surcharge of health care services. Under the bill, hospitals must submit reports specifying cots incurred by the hospital and the uncollected amounts that result from providing service to the uninsured, to be eligible for this funding.

In addition, major public hospitals, that had been reimbursed in the past for a higher percentage of their charity care cots because of their high volume of cases, will not receive any reductions in charity care funding over the life of the bill.

8.18 Percent Surcharge

HICRA 2000 repeals the 8.18 percent surcharge on freestanding clinical laboratories and hospital based laboratories, effective October 1, 2000. This action is expected to reduce revenues by $54 million. The 8.18 percent surcharge on all other services under HCRA remains in effect through June 30, 2003.

High Need Indigent Care Adjustment Pool

HICRA 2000 creates a new indigent care payment of "high need" hospitals. A total of $82 million in new resources will be made available to these hospitals, including rural hospitals. With respect to rural hospitals, each hospital will receive a base allocation of $140,000 per year and will be able to receive additional payments prioritized by uncompensated care need.

Graduate Medical Education / Covered Lives Assessment

Graduate Medical Education (GME) is supported by revenues generated by the regionally based covered lives assessment and deposited in the Professional Education Pool. The covered lives assessment will be reduced by $20 million in 2001, $40 million in 2002, and $30 million in 2003. HCRA 2000 decreases the total amount of covered lives assessment dedicated to GME by $50 million, for a total of $494 million annually during 2000, 2001, and 2002. A total of $247 million will be made available in 2003.
The HCRA 2000 legislation also creates three new grant programs to be funded with regional GME pools for the following:

- $10 million for freestanding ambulatory care facilities which train residents in need specialty areas and under served areas;
- $5 million to medical schools that train residents in school-based health centers; and
- $1 million in 2000 and $1,6 million annually thereafter, for the New York State Area Health Education Centers.

Child Heath Plus

HCRA 2000 amends the Child Health Insurance Program, Child Health Plus, by increasing the family income eligibility from 192 percent of the non-farm poverty level, or equivalent to 208 percent of FPL.

Child Health Plus will no longer require that premium payments be made by eligible children who are American Indians or Alaskan Natives.

Anti-Tobacco and Other Initiatives

Tobacco Use Prevention and Control Program

Under HCRA 200, a total of $130 million is committed toward anti-tobacco programs between January 1, 2000 and June 30, 2003. The bill outlines the types of prevention and control activities that would be eligible for funding and include, but are not limited to: community-based programs to reduce and prevent tobacco use through local involvement and partnerships; school-based programs to reduce and prevent tobacco use; marketing and advertising to discourage tobacco use; tobacco cessation programs for youths and adults; special projects to reduce disparities in smoking prevalence among various populations; restriction to access to tobacco products; and any other activity deemed necessary by the Commissioner of Health.

The bill also creates a 17-member Tobacco Prevention and Control Advisory Board with a prescribed appointment process.

Health Insurance Demonstration Projects

HCRA 2000 authorizes the Commissioner of Health to establish a program for Medicaid to pay for health insurance premiums on behalf of personal care and home health workers who reside in cities or counties with populations of 1 million or more (New York City, Nassau County, Suffolk County), and whose employment is irregular or cyclical and whose health insurance is frequently disrupted. Up to $56 million per year can be added to the Medicaid personal care and home health care rates for agencies approved to participate this program. Of the $56 million made available under this Medicaid rate expansion, approximately $28 million represents the federal share, $23 million represents the state share, and at least $5 million will be paid for through the local share of Medicaid.

HCRA 2000 Funding

HCRA 2000 is funded through a number of sources, including the following:

Inpatient Hospital Assessment

Continues the 1 percent assessment on hospital revenues that existed under the NYPHRM system and was continued as part of the 1996 HCRA;

Covered Lives Assessment

Continues the regionally-based covered lives assessment which is imposed on all individual and group health insurance polices

8.18 percent Surcharge

Continues the 8.18 percent surcharge on inpatient and outpatient health care charges, excluding laboratory tests

Tobacco Settlement Proceeds

Dedicates a portion of the state's share of the National Tobaccos Settlement proceeds to HCRA 2000. HCRA 2000 would be allocated $276 million, $305 million, $383 million and $360 million, respectively over the 3.5 year of the bill.

Cigarette Tax Increase

An increase of 55 cents per pack, effective March 1, 2000, which will raise New York's per pack tax to $1.11

The following table details the projected state revenues dedicated to HCRA 2000:

Figure 3: State Revenues Dedicated to HCRA 2000

HCRA 2000 Projected Revenues
($ in Millions)

Source of Funding	2000	2001	2002	Through 6/30/03	3.5 Year Total
Inpatient Hospital Assessment (1%)	$157	$157	$157	$80	$551
8.18 Percent Surcharge on Health Care Services	$894	$854	$854	$426	$3,028
Covered Lives Assessment	$690	$670	$650	$315	$2,325
Tobacco Setlement Proceeds	$276	$305	$383	$360	$1,324
Cigarette Tax Increase	$394	$445	$428	$207	$1,474
Total HCRA 2000 Revenues	$2,411	$2,431	$2,472	$1,388	$8,702

Source: NYSDOB

State Budget Savings through HCRA 2000

Included with HCRA 2000, is a plan to generate substantial state budget relief by shifting $2.8 billion in state costs previously funded through the state general fund, to the dedicated HCRA revenue stream. This includes the following programs: Elderly Pharmaceutical Insurance Program (EPIC), state subsidies for the Roswell Park Cancer Institute, and many other NYS Department of Health programs, including HIV/AIDS program funding and breast cancer screening.

In addition, HCRA 2000 included an agreement to continue existing Medicaid cost containment provisions that have been in effect since 1995. This will preserve both state and local savings that previously accrued to the state and local budgets, but does not offer any new Medicaid relief. As part of this agreement, the state has agreed not to seek any additional Medicaid cuts to hospitals, nursing homes, and home care providers over the next three years, except for one new initiative that would limit the inflationary increase or "trend factor" for hospitals, nursing homes and home care providers, to the rate of inflation. Excessive Medicaid growth will continue to be a local budgetary concern.

Also included is a plan to use $87 million in HCRA funding to implement the Governor's $125 million expanded mental health children and adult service initiative announced in November. Counties will be expected to pick up over $28 million in Medicaid local share associated with these new mental health programs over the life of the bill.

Overall, the state will realize net general fund budget savings totaling $2.840 billion or $399 million, $384 million, $392 million, and $422 million, respectively over the next four state fiscal years beginning in sfy 200-01.

County Cost Increases through HCRA 2000

Due to the state's decision to expand HCRA 2000 under the current Medicaid formula, counties will be required to fund substantial increases in the Medicaid program over the next four years. The Senate Finance Committee estimates that the Family Health Plus program will conservatively increase local Medicaid costs by $340 million over the next four full calendar years. Also, increased local Medicaid costs related to the expansion of mental health initiatives and other demonstration projects will increase mandated local spending.

State leaders have argued that because of the re-authorization of prior years Medicaid cost containment savings and the counties receipt of revenue from the National Tobacco Settlement, that counties experience a net financial benefit from HCRA 2000. State leaders estimate that this net local benefit to be approximately $612 million over the life of the legislation. NYSAC disagrees with this assessment of HCRA 2000.

An important component within the HCRA 2000 legislation is the continuation of existing Medicaid cost containment. Counties and New York City have benefited greatly from the Medicaid cost containment, originally adopted in the 1995-96 state budget. This cost containment has reduced the double-digit annual growth rates experienced by counties in the early 1990's. Though we are grateful that the Governor was able to convince the Senate and Assembly to lock in the prior year's Medicaid cost containment, we do not agree that the cost avoidance provided through these provisions justifies the adding of new program costs to the county Medicaid base

Also, the state leaders estimates use the local portion of the National Tobacco Settlement as an offset to the local costs associated with HCRA 2000. Counties were named a party in the National Tobacco Settlement Agreement, and were to receive these funds as a way to compensate the local taxpayers who have borne the growth of Medicaid over the past decade. County officials would rather apply their portion of the tobacco proceeds to property tax relief and local initiatives, than fund the states expansion of the Medicaid program. This cost should rightfully be borne by the state, with its far broader ability to raise revenues, and not through yet another unfunded mandate.