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**The
Business
Council**

Testimony to

**Senate Finance Committee
Assembly Ways & Mean Committee**

Health & Medicaid Budget Hearing

Presented by

**Kenneth A. Adams
President and CEO**

February 9, 2010



for large employers whose rates will need to increase to subsidize any rate suppression likely to occur in the small business market as a result of the prior approval process; and it will limit product availability designed to meet employers' needs, as insurance companies will do a cost-benefit analysis to support only a limited number of rate filings.

Consider the testimony given last year by the University of Rochester Medical Center at the legislative hearing on prior approval might: "price controls for commercial health insurers that artificially suppress premium rates will lead to their inability to adequately reimburse providers." The testimony went on to say that reinstatement of prior approval will add to the financial instability of hospitals at a time when they have sustained significant state Medicaid reimbursement cuts and ultimately undermine quality health care delivery systems.

Reinstatement of a cumbersome approval process which didn't work in real time when it was in place in the 1990s is hardly the solution to containing health insurance premiums for the commercial market. Government actions such as the \$4.2 billion in health insurance taxes, including \$700 million in new and increased taxes passed as part of last year's state budget, along with the increasing number of insurance mandates continue to add unnecessary and burdensome costs on health insurance premiums and reinstatement of prior approval will merely be one more line on a growing list of "add on" costs to health insurance premiums.

Early Intervention

While the budget seeks to achieve Medicaid savings in the Early Intervention program through a series of recommendations, one particular "savings" proposal is nothing but a cost shift which undermines the whole premise of health insurance rate setting.

While characterized as a way of maximizing commercial insurance reimbursement, in fact the Governor's budget language acknowledges its state-designed and mandated program model is not sustainable and thus, the state can no longer afford it as constructed. You might expect, then, budget language which in fact puts in place some parameters to achieve both cost and quality efficiencies. Instead, the budget shifts this program's burden to insurance carriers and says "you pay!" There is no language which imposes real parameters on the program to get spending under control within a quality construct. The budget language simply moves the cost to a different column – essentially saying "look we reduced state spending" and says that private carriers must reimburse providers of early intervention services regardless of plan benefits and negotiated provider reimbursement rates and regardless of whether that provider is within the health plan's network.

Shifting these costs to private carriers and not allowing them to manage the cost and quality of the delivery of early intervention services within the parameters of a given health plan will result in increased health insurance premiums for all. No one disputes the need for carriers to pay for evidence and clinically based early intervention services – but those services must be managed and they must be provided within the network rules. It is solely because the State did neither of these – managing the services within a cost efficient construct that it finds itself owing a very large bill. A wholesale shift of this program to private insurance

derived from it. We were opposed to last year's increase in the surcharge on hospital-based services as well.

If my theme is beginning to sound familiar -- or if you've heard it from me before -- that's because it is a consistent message: it doesn't matter if it's a 'surcharge', a 'fee', or an 'assessment': it's a tax -- and it's a tax that is passed on ultimately to the end user in the form of higher health insurance premiums. And all of this need for additional revenue points to the challenge facing the Legislature and Governor, particularly as it relates to publicly funded health care spending: the spending is out of control, the program models are not sustainable in their current format, and yet nothing in this budget seeks to transform the delivery system and put it on a sustainable foundation going forward. The gap filling with "revenue raisers" through surcharges such as this reach beyond the notion of a "nuisance": these taxes generate millions of dollars for state coffers from New Yorkers at all levels with privately based health insurance driving up their costs with no concomitant benefit in terms of health care quality or outcome.

Health Care Provider Taxes

This year's budget proposal includes increases in assessments on nursing homes (from 6% to 7%); on inpatient services (from 0.35% to 0.75%) and on home and personal care providers (from 0.35% to 0.7%).

It stands to reason if The Business Council does not support the HCRA surcharge, we do not support the increases in these gross receipts taxes on providers.

This bait and switch by adding and increasing a myriad of fees, surcharges and taxes ultimately drives up employer-provided insurance costs. When the national conversation is about affordable, accessible health care and health insurance, New York's insistence on layering on "hidden" charges on all aspects of the health care delivery system -- from providers to insurers to end users -- takes us in the wrong direction and makes New York less competitive.

In closing if I can leave you with one theme: it is do no more harm. Budgets over the past several years have contributed to increased health insurance premiums for all New Yorkers in accessing employer sponsored health insurance. These budget actions continue to undermine the health care delivery system in New York and ignore the reality of the need for truly transformational policies which will put our system on a sustainable path. Employers need some assurance from their state officials that New York State views health insurance costs as a true factor in whether a company can maintain and grow its workforce, and they need some confidence that state leaders are willing to make the tough choices, rather than shifting more of the burden onto their backs.

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**Testimony of Dr. Danielle Greenberg, PepsiCo Inc.
Before the New York State Joint Legislative Committees
on the 2010-2011 Executive Budget. Health/Medicaid Proposals
February 9, 2010**

Good morning Chairman Kruger, Chairman Farrell and distinguished members of the committee. My name is Dr. Danielle Greenberg.

On behalf of the ten thousand employees who work for PepsiCo, our bottlers and distributors here in New York State, I want to thank you for the opportunity to be here today. New York is our home. PepsiCo's worldwide headquarters are in Westchester County as are the global headquarters of our largest bottler, Pepsi Bottling Group. Our bottlers operate dozens of manufacturing sites and numerous distribution centers serving New Yorkers in every corner of the state. So, I think it's fair to say that the concerns of New York are our concerns.

They are also my personal concerns. I grew up in lower Manhattan, was educated in the state's universities, and raised my own family here in New York. My training is as a behavioral neuroscientist. I served on the faculty of Cornell University Medical College for 15 years, doing research on obesity and the control of food intake. Eight years ago, I joined PepsiCo where I am now a member of the company's Nutrition department.

There is no question that obesity is a serious public health issue. As a leading food and beverage manufacturer, we know we have an essential role to play in helping to find solutions to this complex problem and we are committed to doing our part.

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However, as a scientist whose life's work has been devoted to obesity-related issues, and as a mother of two, I know the solution does not lie in taxing sugared beverages.

Please consider a few facts:

- According to scientists at the National Cancer Institute, calories from soft drinks and other sweetened beverages represent only 5.5 percent of the total calories consumed in the American diet. That means nearly 95 percent of our calories come from other foods and drinks. To address obesity, we need to look much more broadly than just at soft drinks.
- For example, let's consider someone with a daily intake of 3,000 calories – which would be someone who is clearly over-eating. At 5.5 percent of calorie intake, sugared beverages would represent 165 calories per day. Now, let's assume a beverage tax could reduce consumption by 10 to 15 percent. This would equate to between 15 and 25 calories per day. And evidence shows that if calories are cut in one part of the diet, they are often substituted elsewhere so the net calorie impact is likely to be even lower. That is simply not enough to have a meaningful effect on weight loss. (Nutritionists generally recommend cutting 500 calories per day to lose weight.)
- Soft drinks and other sweetened beverages are simply too small a part of the total diet to make a meaningful impact on the obesity problem.
- And data proves this out. Between 2000 and 2008, per capita consumption of sweetened beverages declined 8 percent – while obesity rates continued to rise. Allow me to repeat that point...Americans, including New Yorkers,

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consumed 8 percent less sugared beverages ...yet obesity rates continued to rise.

- The only way to address the multi-faceted problem of obesity is with comprehensive approaches that address both sides of the energy balance equation: that is the calories we consume in our total diet need to balance with the calories we burn through our daily activities and through planned exercise. Weight management is really very simple -- not EASY -- but simple. It's all about energy balance and any solution to the obesity challenge must address both sides of the equation - through education, balanced diets and physical activity.

PepsiCo has long recognized the vital role we can play in these efforts. We have worked for decades now to expand our offerings of low calorie products and to help our consumers make healthier, more informed nutrition choices. Let me give you a few examples.

- Two decades ago, we began acquiring new lines of business – including Quaker Oats, Tropicana, SoBe and Naked Juice – and investing our R&D resources to develop lower-calorie products like Aquafina, G2, Propel Fitness Water, Pepsi Max, Trop 50, and Zero Calorie SoBe Lifewater. This transformation has significantly broadened the range of low calorie choices we give consumers. And, with innovative new products, we're helping make it easier for consumers to make the switch to lower-calorie options.

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- We are also working to raise consumer awareness about calories. Five years ago, we began showing the total number of calories in packages smaller than 1 liter right on our labels. (We didn't do this because we had to. We did it because we knew it would be helpful to our consumers.) About the same time, we launched a consumer website, PepsiProductsFacts.com, that provides detailed nutrition and ingredient information for every product in our beverage portfolio. Today, more than 50,000 people visit that site each month.

- Finally, we are partnering with other organizations inside and outside the food and beverage industries to find and develop solutions. We joined with our industry colleagues to partner with the Clinton Foundation and American Heart Association on childhood obesity initiatives. Through this effort, we have voluntarily removed full-calorie soft drinks from schools and reduced the calories from beverages in schools by over 60%. And PepsiCo's Chairman and CEO Indra Nooyi played a seminal role in forming the Healthy Weight Coalition, a collaboration of more than 40 retailers, food and beverage manufacturers, NGO's and educators committed to help reduce obesity, particularly among children.

- We are changing the nutritional face of our business – and steadily reducing calories in our beverages. In the past five years alone, we have reduced the average number of calories in the beverages we sell by 11 percent.

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And our work continues. We are taking bold steps within our organization to ensure we stay focused on this issue far into the future.

- We are redoubling our R&D efforts under the leadership of a newly hired, Mayo Clinic-trained endocrinologist, recognized for his extraordinary expertise in diabetes and obesity. We've also brought on a top health policy adviser from the WHO to help our senior leaders understand what the health community expects of leaders - like PepsiCo - in the food and beverage industries.
- We've also designed our compensation plans to reward employees for expanding the role of healthy products in our portfolio, literally putting our money where our mouth is, so that creating products that can improve health pays off.

We are a company that encourages nutritionists and scientists like me to make a difference; a place where my colleagues and I are proud to work; and a company that seeks to partner in efforts to find common-sense solutions to complex problems like the one on the table today.

In troubled economic times like these, we can understand the appeal of a tax that purports to produce revenues and promote health. However, there is no scientific or medical evidence that a beverage tax will be effective in reducing obesity. And there is ample reason to believe that such a tax would have drastic economic

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consequences for New Yorkers, putting thousands of well-paying New York jobs at risk, sending sales and jobs to nearby states, and saddling middle class, working people with another tax burden at a time when New Yorkers can least afford it.

We trust that science-based facts and common sense will prevail in finding solutions to the very real challenge of obesity. A sugared beverage tax is a simplistic attempt to solve a complex problem. It may raise revenues but there is no evidence that it will have any effect on obesity.

Thank you very much.

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New York State Vending Association

A State Council of National Automatic Merchandising Association
449B Carlisle Drive, Herndon, Virginia 20170-4607, (703)435-1210, FAX (703)435-6389

Statement of Michael Esposito

President of the New York State Vending Association

On behalf of the New York State Vending Association

Regarding the 2010-2011 Executive Budget Proposal

Before the Joint Legislative Health Committee on February 9th, 2010

Mr. Chairman and members; thank you for the opportunity to appear on behalf of the New York State Vending Association. My name is Michael Esposito and I am a Division Manager-Vending / OCS with Prestige Services, of Clifton Park, New York.

I also serve as the volunteer President of the New York State Vending Association.

Our association represents 65 companies and an estimated 2300 employees in the food and beverage vending industry.

As businesses representing thousands of employees, we share your goal of covering costs of vital state services and protecting the interests of all New Yorkers. In this economy, we all have to make tough choices. For example, in our industry, we are also tightening our belts.

With unemployment high, there are fewer workers in factories and offices. Since there are fewer workers in New York factories, stores and offices, there are less New Yorkers to buy our snacks and beverages.

Many of our vending operator members are actually reporting 10 percent to 20 percent same location sales declines.

Our companies are tightening our belts, reducing overhead, and pinching pennies, just like other small businesses across our great state.

And with this as a backdrop, we are very concerned about one of the options being promoted by some who would arbitrarily tax sweetened beverages as a means of paying for government services.

The proposed tax on soft drinks is the Wrong Public Policy for the following reasons:

1. **This tax won't solve obesity.** Taxing sweetened beverages won't cure our state's problem of obesity. It's important to remember that all calories from food count. The key is energy balance. New Yorkers must better manage calories consumed and calories burned.
2. **Sweetened beverages are not a unique contributor.** There is nothing special about the calories in beverages which cause obesity. In fact, obesity rates are rising while soft drink consumption is declining. Our sedentary life style is as much a factor as our diets. Eating too much and exercising too little causes weight gain and obesity.
3. **Taxes in Vending are Difficult to Implement.** Due to the unique nature of our sales channel, vending has a very difficult time implementing a sale tax increase. Our products are sold in increments of five cents. When a tax is increased by a penny or two or three, we typically are not able to pass along that tax to our customer. Factories, offices and stores often set the prices we can charge for snacks and drinks. So increases are not allowed.

And in all vending locations, in this economy, even if we want, we can't increase our prices. Our sales will decline too much.

4. **Taxes in this economic climate are not the solution.** New Yorkers don't like it when our government officials use taxation to tell them what to eat and drink, even if we agree there is a problem. Voters in Maine repealed a soft drink tax on the ballot last fall. And in response to widespread opposition in New York, Governor Paterson pulled back his proposed tax on soft drinks (last year?).
5. **A tax on beverages is a regressive food tax and hurts families.** We agree with President Obama when he said during the 2008 President campaign: "In an economy like this, the last thing we should be doing is raising taxes on the middle class."
6. **A tax increase could cost jobs.** We are concerned about the economic impact on jobs from such a tax. The added costs from a state tax on beverages put good jobs at risk. Sales will decline. Our margins will continue to be reduced. We cannot operate at a loss, and stay in business.

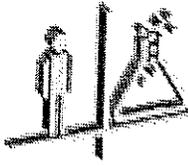
Vending is a productive part of our economy. We don't outsource jobs. We employ a diverse workforce. We are involved in our community. Our companies are becoming greener, and are working to reduce our carbon footprint. Because our customers don't have to drive to purchase a snack, coffee or soda, we are an environmentally friendly retailer. We recognize there is a problem with obesity which is why we created the Balanced for Life, Fit - Pick program in 2004.

But our industry is hurting. We are losing sales, tightening our belts, and struggling to keep our team members employed. Such a tax at this time could really harm our industry, and cost jobs.

I urge the committee to vote against any tax on sweetened drinks at this time.

I appreciate the opportunity to appear before this committee and I look forward to answering your questions.

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AMERICAN COUNCIL
ON SCIENCE AND HEALTH

1405 BROADWAY, 3RD FLOOR, NEW YORK, NY 10017-4868
TOLL FREE: (800) 985-2694 • TELEPHONE: (212) 512-7000 • FAX: (212) 512-4919
www.acsh.org • acsh@acsh.org

Testimony of the American Council on Science and Health

**AT THE JOINT LEGISLATIVE HEARING ON THE 2010-2011
EXECUTIVE BUDGET:
OPPOSITION TO THE PROPOSED BEVERAGE EXCISE TAX**

**Presented before
The Senate Finance Committee
and
The Assembly Committee on Ways and Means**

By:

Ruth Kava Ph.D., R.D.
Senior Nutrition Consultant
American Council on Science and Health

February 9, 2010

As a non-profit, independent public health organization, the American Council on Science and Health provides sound, science-based information on numerous issues that can affect the public's health—including obesity. There have been proposals suggesting that New York State impose a tax on sugar sweetened soft drinks and sports drinks—both to generate revenue and to combat obesity. We appreciate this opportunity to present testimony primarily regarding the purported health effects of the proposed tax on sugar-sweetened sodas and other beverages.

It has been extensively documented that the prevalence of overweight and obesity in the United States has risen dramatically since the 1970s. In 1994 48 states had a prevalence of obesity in adults less than 18%, but only 13 years later no state could make this claim. Indeed by 2007, the prevalence of obesity in 45 states was greater than 22 percent.ⁱ Even more concerning is the fact that obesity in American children and adolescents has also increased alarmingly. National surveys document that for children 6-11 years old, obesity prevalence increased from 6.5% to 17% percent between 1976 and 2006, while for those aged 12-19 years prevalence increased from 5.0% to 17.6%.ⁱⁱ New York State is no exception to these trends. According to the CDC in 1990 less than 10% of adult New Yorkers were obese; by 2008 the prevalence increased to over 24 percent.ⁱⁱⁱ Considering the myriad health problems associated with obesity, such as type 2 diabetes and coronary heart disease, such trends bode ill for the future of public health and the health care system.

Although consumers are constantly bombarded by offers of magical quick fixes for excess weight—from supplements to diets and exercise equipment—experts agree that long-term changes in lifestyle are necessary to treat and prevent obesity and overweight.^{iv} Obesity results from an imbalance between energy consumed in foods and energy burned by metabolic processes and activity. The opportunity for consumption of excess energy has increased over the last few decades as the requirements for activity in work and leisure have declined.^v Thus it is unlikely that altering the consumption of only one type of product will effectively address the obesity problem. Yet in the past few years we have seen regulatory efforts to alter the consumption of various products and ingredients such as certain fats and sugars—at least in part to supposedly decrease the obesity problem. The proposal to tax sugar-sweetened beverages is just the latest example of such an effort.

However, it is unlikely that altering the consumption of only one type of product will

effectively address the obesity problem in New York. Unlike taxation of tobacco products, where high prices may discourage use or prevent experimentation by the young, people cannot just stop eating and drinking. While an increased price might decrease use of one beverage, there is no guarantee or even likelihood that one of equal or greater caloric value will not be substituted. Nor is there any guarantee that a more healthful lifestyle will be adopted.

The science on the relation between consuming sugar-sweetened beverages and body weight is mixed. Some studies have found that reducing consumption can help lower body weight,^{vi} but others fail to find such results initially, or that body weight losses are not maintained over time.^{vii} Clearly, more substantive data are necessary to confirm or deny this putative correlation.^{ix}

The proposed tax supposedly targets “bad” beverages, which feeds into the misapprehension that foods can be easily categorized as “good,” i.e. healthful, or “bad,” unhealthy based on simplistic guidelines. In this case, the sugar content is deemed to be “bad.” Does this mean we should also tax orange juice, which is also high in sugar and has a similar caloric content? Should we also tax foods such as avocados, high in fat and calories, as shown in Table 1? Of course the orange juice and avocados also contribute other nutrients to the diet, but these are irrelevant to a discussion of obesity—which reflects only caloric consumption and utilization.

TABLE 1. Comparison of calories in selected foods*.

FOODS	CALORIES IN SELECTED AMOUNTS
Carbonated Beverage: Cola	93 calories per 8 oz.
Orange Juice	100 calories per 8 oz.
Avocado	91 calories per 2 oz

*Data from Nutrition Analysis Tool, University of Illinois. <http://www.nat.uiuc.edu/> Accessed 2/7/10.

Characterization of foods as “good” or “bad” can also mislead consumers in their efforts to attain or maintain a healthful body weight. When dietary fat was deemed generally unhealthy and a myriad of reduced fat or nonfat products were produced, many

misperceived such foods as weight-loss products. While such foods can be helpful in a weight-loss plan, it is the number of calories that determine their utility—not the grams of fat per se. Similarly, “fast food” has also been demonized as “bad,” and a major cause of obesity, but again this is misleading. It is possible to eat only such foods for an extended period and lose, rather than gain weight—if appropriate selections are made.^x

Further, Governor Paterson suggested that the estimated revenue from such a tax will increase from \$465 million in year one to \$1 billion annually, but this contradicts the supposed purpose of decreasing consumption to prevent obesity.^{xi} How can revenue increase if consumption declines? In short the proposed taxation of sugar-sweetened beverages is highly unlikely to foster a more healthful lifestyle, and may well serve only to confuse consumers about the real causes of obesity.

Thus, the American Council on Science and Health respectfully submits that the proposed taxation of sugar-sweetened beverages will be ineffective in addressing the obesity problem, and should not be advertised as being a useful tool for that purpose

ⁱ CDC's Division of Diabetes Translation. National Diabetes Surveillance System. <http://www.cdc.gov/diabetes/statistics> Accessed 2/01/10.

ⁱⁱ CDC. Childhood overweight and obesity.

<http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/index.htm> Accessed 2/05/10.

ⁱⁱⁱ CDC. U.S. Obesity Trends by State 1985-2008. <http://www.cdc.gov/obesity/data/trends.html> Accessed 2/5/10.

^{iv} CDC. Healthy weight-it's not a diet, it's a lifestyle!

<http://www.cdc.gov/nccdphp/dnpa/healthyweight/index.htm> Accessed 2/5/10.

^v CDC. Overweight and obesity: causes and consequences..

<http://www.cdc.gov/obesity/causes/index.html> Accessed 2/7/10.

^{vi} James J, Thomas P, Cavan D, Kerr D. Preventing childhood obesity by reducing consumption of carbonated drinks: cluster randomized controlled trial. *BMJ*, doi:10.1136/bmj.38077.458438.EE (27 April, 2004)

^{vii} James J, Thomas P, Kerr. Preventing childhood obesity: two year follow-up results from the Christchurch obesity prevention programme in schools (CHOPPS). *BMJ* doi:10.1136/bmj.39342.571806.55.

^{viii} Almiron-Roig E, Drewnowski A. Hunger, thirst, and energy intakes following consumption of caloric beverages. *Physiology & Behavior* 2003; 79:767-773.

^{ix} Allison DB, Mattes RD. Nutritively sweetened beverage consumption and obesity: The need for solid evidence on a fluid issue. *JAMA* 2009;301(3):318-320.

^x Kava R. 2004. 30 Day McDiet: Results are in. American Council on Science and Health.

http://www.acsh.org/news/newsid.963/news_detail.asp Accessed 1/29/09.

^{xi} Whelan E. 2009. New York soda tax: All politics no science. American Council on Science and Health. http://www.acsh.org/factsfears/newsID.1201/news_detail.asp Accessed 1/30/09.

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Testimony of the New York Health Plan Association

to the

**Senate Finance Committee
and the Assembly Ways & Means Committee**

on the subject of
2010-2011 Executive Budget Proposal

February 9, 2010

INTRODUCTION

The New York Health Plan Association (HPA), comprised of 23 health plans that provide comprehensive health care services to nearly seven million New Yorkers, appreciates the opportunity to present its members' views on the Governor's budget proposals. Our member health plans have long partnered with the state in achieving its health care goals, including improved access to quality care in its government programs as well as providing access to care that exceeds national quality benchmarks for commercial enrollees. Our plans include those that offer a full range of health insurance and managed care products (HMO, PPO, POS, etc.), pre-paid health services plans (PHSPs) and managed long term care plans. The New Yorkers who rely on these plans are enrolled through employers, as individuals, or through government sponsored programs — Medicaid Managed Care, Child Health Plus, Family Health Plus and Healthy New York. Accordingly, we appreciate the opportunity to offer our view on the proposed 2010-2011 Executive Budget in relation to its application for health care spending in New York.

FISCAL GIMMICKRY

It is important to note that the nation has spent nearly a year discussing (and continues to debate) how to make health insurance more affordable in order to make coverage available to more people. The Governor's budget proposal, however, does several things that would actually make health insurance less affordable. And, these actions would be on top of the more than \$700 million in new and increased taxes on health care that were included in last year budget. This spending plan would continue the regressive approach.

In addition to this concern, HPA and its member health plans have trouble understanding how certain of the figures in the Governor's spending plan were derived, as well as the basis for some of the proposals called for to achieve the savings envisioned. In our view, the figures are nothing short of budget chicanery.

Let us first look at the proposal to reinstate regulatory authority to the Department of Insurance (DOI) for approval of health insurance premium rates prior to those rates being effective. The Governor and the Division of Budget (DOB) ascribe a \$70 million state share of Medicaid savings for six (6) months of this fiscal year — \$150-\$160 million in 2011-2012 — and yet, no documentation or methodology has been provided as to how this saving is calculated. Lacking a credible explanation, the savings are fictitious and, worse still, misleading as failure to produce those savings will leave the budget with a new \$70 million hole, guaranteeing yet another mid year deficit.

Contrast this questionable proposed savings with the complete absence of any savings attached to the proposed Health Care Reform Act (HCRA) Amnesty program. HPA presented this idea to DOH and DOB, offering two amnesty approaches: 1) DOH would be authorized to negotiate multi-year settlements with payors based upon the findings of a completed HCRA audit and, 2) payors would be permitted to make a lump sum HCRA payment to apply to potential liabilities from as yet, unaudited periods. Similar to an income tax amnesty program, the HCRA Amnesty proposal would be expected to generate immediate revenue to the state. However, the HCRA Amnesty proposal included in the Executive Budget, for some unexplained reason, carries no monetary value. A cynic might wonder whether revenue from the HCRA Amnesty was intended to offset the deceptive Medicaid savings from the prior approval provisions.

REGULATORY APPROVAL OF HEALTH INSURANCE PREMIUM RATES

As stated above, HPA has serious concerns with the proposal to reinstate a prior approval process for health insurance premiums. To begin with, the prior approval application process as presented in the Executive Budget is ill defined, costly and defective.

The department already is unable to handle the existing review of rate filing caseload. According to its own annual report, the Accident and Health Rating Section received 1,394 rate filings and disposed of 1,646 rate filings during 2008 — acknowledging some of the filings were received prior to 2008, indicating an existing backlog already.

Application of the process effective October 2010 for existing rates is unrealistic. If the department is already carrying a backlog, how can it reasonably be expected to process thousands of additional filings to meet the October timeframe?

The Governor's prior approval plan requires both an "objective" 85% minimum loss ratio (MLR) and subjective/discretionary review by DOI. No state has an 85% MLR. More importantly, the value of an objective standard — the MLR — is undercut by the subjective power of DOI to arbitrarily fix rates.

Moreover, applying the 85% MLR standard to all products could prove injurious to state-sponsored insurance programs. Some health plans have sustained annual losses in the state's Medicaid Managed Care and Family Health Plus programs. Continued participation has been possible due to the ability of plans to cross-subsidize these programs from surplus generated by commercial insurance. The proposed 85%

MLR would eliminate plans' ability to use surplus from some products to support these programs.

The prior approval process would enact strict price control of health insurance premiums, thereby undermining the health insurance market in New York. Government price fixing does not work. Price controls will weaken health plan solvency, hurt providers and virtually eliminate innovation and efficiency. At the same time, the proposal ignores the underlying cause of the increase in the cost of health insurance, which is the increase in the actual costs of health care. A report from the centers of Medicaid and Medicare Services just last week showed that the "two primary drivers of growth...are medical prices and utilization," confirming that rising health care costs are driven by increases in underlying medical costs, not health plan administrative costs.

If lawmakers want to explore prior approval, it should be done outside the budget process.

MANDATES

The proposed Executive Budget also includes numerous hidden insurance mandates that shift costs from government to small business and families. Many of these New Yorkers are struggling now to afford the insurance coverage they have. Adding the costs of new mandates will raise premium costs.

The budget's hidden mandates include:

The Timothy's Law subsidy cut — When the Mental Health Parity Law was enacted in 2006, it included a \$100 million subsidy specifically to hold small businesses

harmless from the financial burden that they would face from this new mandate on top of all health insurance mandates and taxes. The insurance department's own findings indicate that this is a reasonable amount needed to offset the additional financial burden. Despite this knowledge, this budget proposal breaks the promise to small business and would reduce the subsidy by \$30 million, which is on top of the \$20 million cut in the December DRP — a 50% reduction in the total subsidy.

Early Intervention — The budget proposes shifting government EI program costs from a broad base — the general fund — to a narrow one — state regulated insurance policies. Large employer self-insured plans, which comprise 50% of the privately insured market in New York, will be exempt from this mandate. The impact of the shit is estimated at \$6 million in 2010-2011 and \$25 million in 2011-2012. Costs that would be added to the premiums of small businesses and individual market, direct pay insured New Yorkers.

PATIENT SERVICE ASSESSMENT

The Executive Budget includes a proposal to expand the HCRA Patient Services Assessment and apply it to physician radiology and office-based surgery. The impact is estimated to be \$25 million in 2010-2011 and \$99 million in 2011-2012.

Whatever it generates, it is simply another tax on premiums, and it is in addition to the more than \$700 million of taxes added in 2009. It is a tax that will be the straw that breaks the camel's back and will force some small businesses and families to drop their coverage.

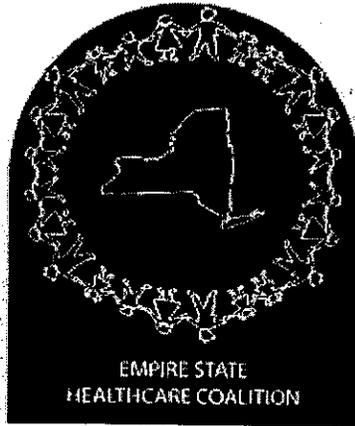
CONCLUSION

The Governor cannot have it both ways: if he proposes new mandates on premiums for EI and Timothy's Law coverage, and expands HCRA taxes, he then can't reasonably be surprised that premiums are increasing; or — even worse — use those increases as justification for prior approval to hold down premiums.

We strongly believe the proposals included in the health department budget will ultimately harm consumers by making health insurance more expensive and less accessible. Diminishing the availability of health care is not in the best interest of New York consumers. HPA urges that you reject this approach.

HPA and its member plans remain committed to working with you and your colleagues on solutions that will increase access of affordable health coverage to more New Yorkers. We thank you for the opportunity to share our views today.

9A



Joint Testimony
of the
Empire State Healthcare Coalition
and the
New York State Association of Health Underwriters
on
Executive Budget Article VII Bill
S.6608 (Budget) / A.9708 (Budget)
Prior Approval/85% Minimum Loss Ratios
& Increased Healthcare Assessments
Submitted before the New York State
Joint Legislative Fiscal Committees
in
Albany, New York
on
February 9, 2010

Good morning Chairmen Kruger and Farrell and distinguished Members of the Senate Finance and Assembly Ways & Means Committees. My name is Richard Fleder. I am a licensed insurance broker and employee benefits specialist. I am President of T&H Group, one of the largest insurance brokers in the country, as well as President and CEO of T&H Benefits, one of the largest employee benefits and consulting firms in the New York metropolitan area based in New York City.

I am the founder and current member of the Steering Committee of the Empire State Healthcare Coalition, LLC, a non-profit association formed by brokers and consultants working to help find solutions to keep healthcare affordable and to reduce the ranks of the uninsured in New York State. I am also a member of the New York State Association of Health Underwriters (NYSAHU), the professional trade

association representing health insurance brokers and producers who support universal coverage in the state by integrating public plans with market-based solutions to improve affordable and accessible health insurance plans for all. I respectfully submit this joint testimony on behalf of both broker organizations.

The distinguished members of the Senate Finance and Assembly Ways & Means Committees may not be aware of the role that brokers, agents and consultants play in representing employers and other insureds. Employers and other insureds are not mandated to utilize a broker, agent or consultant to represent them when designing a benefit program and negotiating with an insurance carrier. Nevertheless, almost all employers and insureds in New York State voluntarily chose to utilize a broker, agent or consultant in these roles. We are uniquely qualified to distinguish the relationship needed between regulators, insurance carriers and insureds!

I come before you today in strong opposition to reinstating prior approval of health insurance premiums and increasing expected minimum loss ratios to 85% as proposed in Part D of S.6608 (Budget) / A.9708 (Budget), which is the subject of this public hearing.

We do not believe that prior approval of health insurance premiums should be implemented. There is an existing rate filing requirement, which we agree should be rigorously enforced. However, the loss ratio formula utilized to determine carrier rates should be amended to include the costs of programs to manage disease and encourage wellness within the claims component and not as a part of expenses. Also the appropriate loss ratio should exclude mandated taxes, fees and assessments as they are not determined by the insurance carrier. Finally, the loss ratio also needs to allow for appropriate capital needs of the carrier as well as an appropriate profit margin.

While it's anyone's guess as to what "healthcare reform" will be passed in Washington this year, the broker community supports eight core principles for achieving comprehensive health care reform:

- reducing long-term growth of health care costs for businesses and government
- protecting families from bankruptcy or debt because of health care costs
- guaranteeing choice of doctors and health plans
- investing in prevention and wellness
- improving patient safety and quality care

- assuring affordable, quality health coverage for all Americans
- maintaining coverage when you change or lose your job
- ending barriers to coverage for people with preexisting medical conditions.

We believe that underlying changes must be made in the delivery of healthcare services in order to make them more affordable and more available to all. Increases in health insurance costs simply reflect the rapid escalation of underlying healthcare expenditures. Insurance is not the only problem – in fact we believe insurance is part of the solution.

Sadly, health insurance is a lightning rod for all of the frustration that New Yorkers and all Americans feel about rising health care costs – but history has shown that price controls simply do not work.

Some of us recall the near insolvency of Empire Blue Cross Blue Shield as the State's health insurer of "last resort," during a time when its rates were kept artificially low by the state. Empire was unable to obtain the capital necessary to remain financially solvent to continue to provide coverage to its policyholders in the individual marketplace.

For a more recent example, we can look at medical malpractice insurance rates. For years, New York State has denied rate increases and, as a result, the medical malpractice carriers now face insolvency.

A parallel analogy can be found nationally in the Medicare system, where appropriate increases in Medicare premiums have not been approved by legislators due to political pressures. This has left Medicare nearly insolvent. This would be untenable if commercial health insurance plans face a similar threat.

One of the major motivations for healthcare reform is increasing competition for carriers. In New York State, in comparison to most states, we are lucky to have multiple carriers compete for clients. Prior approval could possibly lead to decreased competition as carriers are likely to leave parts of the state if not the state entirely.

On the surface, no one would consider rising medical costs a good thing. However, we live longer and more rewarding lives because of advances in medical technology and pharmaceuticals. But more expensive care does not guarantee quality of care. We should support initiatives to improve health outcomes, while reducing medical costs by instituting:

- malpractice reforms
- evidence-based medicine
- best practice guidelines
- pay-for-performance programs
- electronic health and prescription records
- hospital errors reduction programs.

Publicly traded insurance carriers currently realize a profit margin of less than 2% of premium. Although this still creates a substantial profit, our problem is not going to be eliminated with a 2% reduction in cost! Many studies, however, point to lifestyle as the single largest component of healthcare cost increases. Some examples are obesity, sedentary lifestyles, smoking, and drug and alcohol abuse. As an example, 50% of all Americans are considered clinically obese where no other country maintains a level of obesity in excess of 25%!

Medical costs are also rising because of:

- unnecessary or excessive medical tests and screenings (practicing defensive medicine due to tort litigation)
- excess use of high cost medical technology
- overprescribing of drugs
- medical errors and malpractice
- fraudulent claims.

Insurance provides a financing mechanism to help control these cost drivers and to help influence lifestyle choices. Premium discounts and tax credits for employers and other policyholders that offer disease prevention and wellness programs should be considered or expanded.

Increasing Minimum Loss Ratios will adversely affect the creation of innovative health insurance products for consumers, since it will reduce capital for product development. Investments in disease management and wellness programs will also be curtailed, reducing preventative measures and consumer education programs that promote beneficial lifestyle choices in health plan members. In fact, such investments in disease management & prevention, coordination of care, wellness programs, claims adjudication, and fraud & abuse detection, should be moved "above the line" and not be counted against health plan administrative expenses for purposes of calculating Minimum Loss Ratios. The appropriate loss ratio should also exclude mandated taxes, fees and assessments as they are not determined by the insurance carrier. Finally, the loss ratio also needs to allow for

appropriate capital needs of the carrier as well as an appropriate profit margin.

It is imperative that any proposed regulation be redesigned with input from experts that are involved in the details of healthcare everyday!

As licensed insurance brokers and consultants, we represent the employer or other insureds and help keep insurance costs low by conducting specific needs assessments for each client and looking for the most cost-effective solutions for our clients, whether that is conventional insurance, self-insurance or alternative products. We help keep insurance companies and insurance premiums in check by underwriting, reducing and managing an insured's risk.

Minimum Loss Ratios do not provide a standard to measure health insurance value or increased claims payments relative to premiums paid. Conversely, the proposed increase to 85% MLR in all cases will cause rate increases, as carriers will inflate rate filings to offset expected rate reductions by the Insurance Department and the interminable delays in obtaining approvals of filed rates. Moreover, in the midst of the current state agency cutbacks due to the economic recession, the Insurance Department simply does not have enough insurance examiners, attorneys or actuaries to evaluate and process new health rate filings. This will cause carriers to reassess participating in the New York market altogether and may cause some insurers to exit the State.

Increasing Minimum Loss Ratios will reduce competition in New York as insurance carriers will limit the areas within the state they service and may potentially drive insurance carriers away from the state. Reducing competition is obviously not a positive consequence, as it restricts consumer choice, stifles innovation and ultimately raises premiums. The end result: reduced availability and affordability of health insurance in New York.

Health insurance brokers and consultants also function as advocates for the consumer. We help to increase consumer understanding, we help enact programs to encourage better lifestyle choices and better awareness of preventative healthcare and wellness. We also intercede on claim denials by acting as ombudsmen for our clients with carriers, healthcare providers and governmental regulators to assure fairness.

The reduction in the Minimum Loss Ratio will impact our ability to obtain fair compensation to continue to provide these cost-containment services.

It has become clear that the debate in Congress has turned away from healthcare reform and is only focused upon health insurance expansion, with additional taxes to pay for it. Unfortunately, no meaningful healthcare provider reforms or wellness incentives will be forthcoming from Washington, just additional costs.

Therefore, we highly recommend that no action be taken on this legislation for all of the reasons stated above. Also, it should be noted that the federal legislation could materially change the optimal solutions that should be enacted later at the state level.

There is one additional point that I am sure is extremely important to the Senate Finance and Assembly Ways & Means Committees. The enactment of Prior Approval and Minimum Loss Ratios will force both insurers and insureds to strongly consider increased utilization of self-insurance plans. This will create a significant decrease in premium taxes. We believe these laws will actually decrease revenue to the State as opposed to a projected increase in revenue suggested as part of the legislation.

Finally, I would be remiss if I did not also voice our opposition to the increased healthcare assessments contained in Part B of S.6608/A.9708. Doubling the inpatient hospital assessment from 0.35% to 0.75% and the nursing home assessment from 0.35% to 0.70%, increasing the home care assessment from 6% to 7%, extending the 9.63% HCRA surcharge to urgent care clinics, ambulatory surgery centers, and physicians' offices, and reducing the subsidy to small business for mental health parity coverage under Timothy's Law, is simply counterproductive. These assessments will pass through on provider bills, thus raising healthcare costs and health insurance premiums. This would come on top of last year's \$800+ million in increases to the HCRA surcharge and Section 332 assessments.

Studies show that the percentage of health insurance rates in New York directly attributable to State mandated benefits, taxes and assessments, top 50% of premium. The higher healthcare assessments proposed by the Governor will contribute to further premium inflation, and will cause more small businesses and individuals to drop coverage and join the ranks of the uninsured.

Thank you for this opportunity to present the views of the Empire State Healthcare Coalition and the NYS Association of Health Underwriters. Once again let me reiterate our Strong Opposition to S.6608/A.9708, both as to its provisions for prior approval of rates and increasing the Minimum Loss Ratios to 85%, and for increasing healthcare assessments. We should instead be encouraging investments to limit systemic inefficiencies in the delivery of healthcare, reduce cost shifting between private-pay and public plans, and foster behavioral lifestyle improvements in patients.

I stand ready to answer any questions that you or the Committee members may have at this time and welcome the opportunity to provide input in the future.



9-B

500 Patroon Creek Blvd.
Albany, NY 12206-1057
www.cdphp.com

Testimony Prepared for Delivery to the
Joint Legislative Budget Committee –
Health

Dr. John D. Bennett
President and CEO, CDPHP
February 9, 2010

February 9, 2010

TESTIMONY BEFORE THE JOINT LEGISLATIVE BUDGET
COMMITTEE - HEALTH

REGULATORY APPROVAL OF HEALTH INSURANCE PREMIUM
RATES

PRESENTED BY DR. JOHN D. BENNETT, PRESIDENT AND CEO,
CAPITAL DISTRICT PHYSICIAN'S HEALTH PLAN

Thank you Mr. Chairman and members of the committee. My name is John Bennett. I am the President and CEO of Capital District Physician's Health Plan. CDPHP, headquartered here in Albany, celebrated its 25th anniversary last year as a physician-founded and guided not-for-profit health plan. I am a board-certified cardiologist and practiced in New York for approximately 25 years until my appointment as CEO of CDPHP more than a year ago.

Our health plan currently serves members in 24 counties throughout New York State. Nearly 800 employees work at CDPHP and we account for more than \$1 billion in payments annually to physicians, hospitals and other providers for health care services on behalf of our members.

As a not-for-profit health plan, like many others in upstate New York, we seek to provide affordable health insurance for our employer groups, generate a modest 1-2% margin to invest in our operations and provide appropriate reserves to protect our members and the providers that rely upon us for prompt payment. Indeed, nearly 90 cents of every dollar we collect in premium is paid out for health care services.

I am appearing before you today to express my opposition to the Governor's budget proposal seeking the reinstatement of prior approval of all health insurance rate actions. This bill constitutes nothing less than government price fixing of health insurance rates and ignores the competitive marketplace in which we operate, as well as the true drivers of health insurance costs – unit price for hospital services, utilization of health services, mandates, government taxes and assessments, an aging population, and advances in medical technology.

Today, health insurance premiums are set using sound actuarial methods. In the competitive marketplace that CDPHP operates within, we have to set rates that will cover our costs, provide a razor-thin margin, and maintain a price-point that allows us to compete with more than five other health plans that usually bid on the same business that we do. This competition requires us to be precise in our calculations and nimble and flexible to bring products to the market that our employer groups demand.

The Governor's budget seeks to "turn back the clock" to the early 1990's when government controlled an arbitrary process of rate approval that often allowed politics and public popularity to determine adequacy of rates. During this period, health insurance premiums were artificially suppressed and my plan, and many of our competitors, suffered significant financial losses.

Under the Governor's budget proposal, plans faced with arbitrary price controls would be left with no choice but to reduce administrative costs – which would mean layoffs and postponed investment in new technologies, since the other components of our rates, health care services, can not be unilaterally reduced.

Additionally, this bill would place health plans at the mercy of the “politics of the moment.” By this I mean that rate filings would be viewed by the state through the prism of election-year politics – where state bureaucrats could be pressured by the Governor or the legislature to depress rates derived through actuarially sound methods in order to help a particular candidate or party. Further, although the Governor’s budget proposal does request additional funding for Insurance Department staff, the fact remains that the Department is understaffed and incapable of handling the flow of rate filings that would come with prior approval authority.

Our data indicates that the vast majority of rate filings submitted today under the existing “file and approve” process take months to be reviewed. In fact, even during the 1990’s when the prior process was in place, and DOI had more actuaries on staff, most filings were not approved until either a few days before, or even after, the effective date of the product. This leaves little or no opportunity for health plans to educate employers and members about the products they have available to them – creating chaos in the market and stifling innovation for new products.

Prior approval of rates has not worked in many of the insurance lines in which it has been tried. As a physician, I have seen the dramatic and negative impact price controls have had on medical malpractice insurance – as just one example.

We all agree that the dramatic rises in health care costs that we have seen during the past two decades needs to be addressed, but this bill will not accomplish that difficult task. There are ways to fix the current process, such as restructuring the current fee-for-service payment system to one which rewards quality as opposed to volume.

As the CEO of a not-for-profit health plan that annually ranks among the top health insurers in the nation, I, and 800 employees that serve their customers with aplomb every day, stand ready to work with you in that endeavor. In fact, we have developed a unique patient-centered medical home that couples delivery system reform with payment reform based upon outcomes and quality.

Thank you.

9B



Prepared remarks by David Klein, President and CEO of Excellus BlueCross

BlueShield

Joint Legislative Budget Hearing – Health

February 9, 2010

Good afternoon. I have prepared written comments which will be submitted for your consideration and I will confine my testimony to a brief summary of those comments.

My name is David Klein and I am the chief executive officer of Excellus BlueCross BlueShield, upstate New York's largest not for profit health insurer, and our parent company, The Lifetime Healthcare Companies. With offices spanning across virtually the entire region, Excellus is one of upstate New York's largest employers with over 6,000 employees serving our approximately 1.6 million members. As a not for profit plan, we are committed to three core principles: 1) to assure that as many people as possible in the communities we serve have affordable, dignified, access to needed and effective health care services; 2) we recognize the need and obligation to reach out to all segments of the communities we serve, including the poor, aged and underserved, to enhance their quality of life, including health status; and 3) we are committed to being a nonprofit insurer.

As both a local upstate business and a stakeholder in the health care marketplace, Excellus, like many other plans, has not been immune to difficult times in this economic climate. Over the last several years, we have experienced a drop in enrollment, declining revenue, operating losses, depleting reserves and a reduction in our workforce. Additionally, we have shouldered millions in newly-imposed health insurance taxes, instead of imposing midyear rate increases in vulnerable markets. While I believe the worst may be behind us, we continue to face a number of challenges, not the least of which will be a dramatic change in our market in the event federal health care reform is enacted.

With this challenging environment in mind, there are a number of issues included in the Governor's Budget which are of grave concern and will negatively impact the cost of health insurance. These issues include an increase in the HCRA tax paid by our customers, an Early Intervention mandate that is merely a cost shift of an existing state funded program, and provider Medicaid cuts which will force providers to seek greater reimbursement from the private pay market further driving up the cost of coverage.

While each of those items are of significant concern, I will limit the bulk of my comments to express opposition to the Governor's proposal to reinstate a failed health insurance premium rate-setting mechanism known as "prior approval" and the devastating impact this proposal will have on both health care delivery state-wide and Excellus' role as a large upstate employer.

In a nut shell, "prior approval" grants the Insurance Department the complete unfettered discretion to approve, or disapprove, rate increases in the small group and individual markets. A version of this proposal was in effect prior to 1995, but was repealed, as part of a larger reform initiative, by a unanimous vote of the Legislature.

On its face, this proposal would appear to be an appealing, populist concept. Indeed, while the industry is one of the most heavily regulated in the State, and New York regulates this industry more heavily than any other state in the country, granting the Insurance Department even greater authority to regulate premiums would, on a superficial level, be an effective tool to control costs. Our past experience indicates, however, that this will lead to a number of severely deleterious results, including: 1) an over politicalization of the rate approval process, 2) creating financial instability in the insurance industry, 3) eventual suppression of health care provider reimbursement rates, 4) dramatic fluctuations in approved premiums, 5) an increase in large group rates or union accounts to subsidize the suppressed rates in the regulated market; and 6) extended delays in the approval process leading to retroactive rate approvals that results in a sticker shock on customers.

Each of these negative consequences is well documented and is reflected in my written testimony. In fact, the Assembly Insurance Committee held a public hearing on "prior approval" last year in which each of the above mentioned negative consequences were repeatedly documented when the State had prior approval in the past. Significantly, the vast majority of witnesses appearing at the Assembly Hearing, including hospitals,

business groups, independent insurance agents, or members of the health plan industry, expressed vehement opposition to this proposal.

The basic cause for these negative consequences is the premise that any increase in premiums is unpopular, regardless of whether it is necessary or warranted. No Administration wants to be accused of raising health insurance premiums on an electorate that is already burdened by high costs. This is especially true in a turbulent economic and political climate like we have today. In turn, without an objective, actuarial standard which assesses the cost of care and providing coverage, the subjectivity of the process leads to artificially suppressed rates, or "price controls". That was clearly our experience prior to 1995 and is very similar to the current suppression of rates in medical malpractice insurance.

While the suppressed rates provide short term relief, it merely delays an inevitably large rate increase or contributes to the financial impairment of a health plan. Indeed, we have the benefit of history- under prior approval, we experienced, first hand, severe fluctuations in rates in the late '80s and early '90s, at first being suppressed for a number of years only to be dramatically increased when our Plan faced mounting losses and financial impairment. The results were unpredictability of costs for our customers, reduced provider reimbursement and financial strain on our business.

The common analogy is to a bag of groceries - capping the cost of a bag of groceries without regard to the cost of each item in the bag, may sound attractive, but at some point

someone has to pay. Likewise, artificial price controls inevitably result when you regulate only one component of the cost structure. Using the groceries example, you can not effectively regulate the price of groceries if you don't also regulate the price of the items in the bag - for example, the cost of meat, the trucking industry costs, the meat packing plant, the grocery store overhead, and all of the other players in food production.

Likewise, price fixing health insurance premiums is equally misguided when there is no accompanying control over the actual cost of health care delivery and services consumed.

In contrast to the subjectivity of prior approval, the current process, while by no means perfect, requires plans to set rates using an objective, actuarially-based standard referred to as a medical loss ratio (MLR). At its most basic, MLR is the percentage of a premium dollar spent on claims, such as hospital, prescription drug and medical costs. When determining rates, plans must generate an actuarial projection of the cost of care and ensure rates are such that a minimum standard MLR is achieved. New York's MLR requirements currently exceed the national average in the individual and small group market - 80% as compared to the average 69%, and 75% as compared to the 72% average, respectively. Unless the plan projects that a product will meet these minimum standards, any rate increase is subject to prior approval. Likewise, in the event a plan's experience turns out to be more favorable than the projection and the minimum standard is not achieved, refunds are provided to customers. While there may be a need for improvements, such as accelerating the refunds to customers and clarify ambiguous terms to eliminate potential abuse, the process is highly regulated and can be an effective structure for rate determinations.

In fact, while the Insurance Department has identified twenty-four states that have "prior approval", upon closer examination of each states specific laws, New York's current process, including the oversight provided by the Department to ensure compliance, would result in New York already being considered a "prior approval" state when compared to the process in other states.

As mentioned, I acknowledge that current law is in need of improvement. Instead of reverting back to prior approval, however, a more prudent approach is to look at the current process and make changes to increase regulatory oversight, reduce excess profits, and eliminate the potential gamesmanship by some plans, yet maintain the integrity of an objective analysis. We are certainly prepared to participate in the needed changes to ensure fair and adequate rates in these markets.

In closing, we face incredibly challenging times, both as an employer and a stakeholder in health care. While by no means are we perfect, we have worked to maintain our core principles and also streamline administrative expenses to ensure we maintain adequate reserves and control premium costs. Excellus is proud to be a significant presence in the upstate New York economy and we understand the importance of that role, both as an employer and as a critical member of the health care delivery system. The adoption of prior approval is not only bad public policy, but will threaten our presence as an upstate employer, unnecessarily jeopardize health care jobs and will destabilize an already turbulent marketplace.



Regulatory Approval of Health Insurance Rates: "Prior Approval"

Written Testimony of David Klein, President & CEO of Excellus BlueCross BlueShield, before the Assembly Standing Committee on Insurance

February 9, 2010

This written testimony serves as a supplement to my presentation before the Joint Legislative Budget Hearing on Health. Specifically, I wish to provide additional details and data to underscore our opposition to the Governor's proposal to reinstate a failed health insurance premium rate-setting mechanism known as "prior approval."

Specifically, this proposal would grant the Superintendent of Insurance the complete discretion to set premium rates for individuals and small businesses, irrespective of the actuarial need or justification for appropriate rates. As proposed, this language would provide the Superintendent with a level of authority which has not been granted to any other Superintendent of Insurance through either statute or regulation nationwide. Such unchecked authority will inevitably lead to a return to the politicalization of the premium setting process whereby rates will be artificially suppressed without regard to the underlying components contributing to rising health care costs. If the past is any indication, this, in turn, could lead to a number of deleterious results, including: 1) an inability to maintain adequate reserves; 2) a substantial delay in actuarially justified rate increases; 3) an inability to adequately compensate providers; and 4) a negative impact on our role as a major upstate employer. Moreover, the prior approval process will ultimately threaten the ability of health plans to assure New Yorkers that the coverage they prefer and depend on has been adequately funded, not only for routine services, but for events requiring extraordinary financial backing for sustained periods. Each of these concerns actually occurred when prior approval was in effect and is summarized in greater detail below.

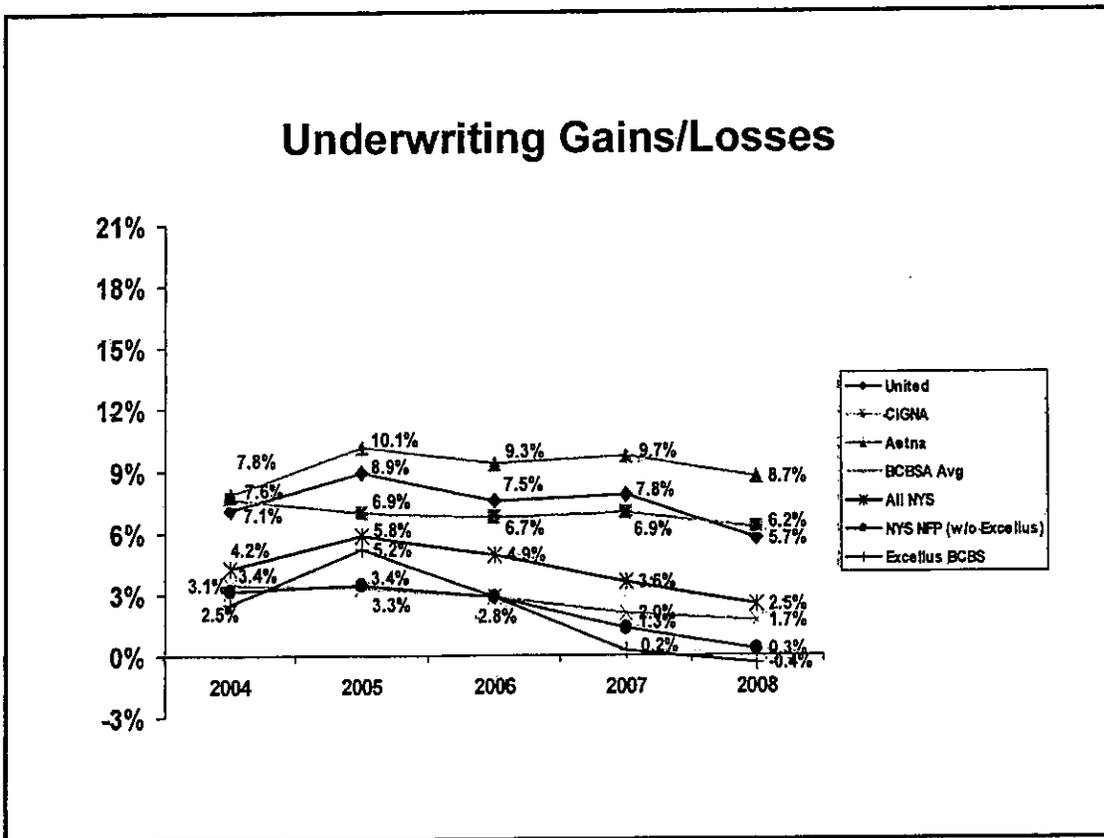
In addition, subjecting one portion of plans' business to price controls will negatively impact other lines of business, such as large labor accounts, as plans will be forced to subsidize rates. Indeed, when prior approval existed prior to 1995, the Insurance Department required a 1% subsidy of large groups to subsidize small group and individual lines of business. This cross subsidization resulted in increased rates on large businesses and jeopardized our retention of that business as large self funded accounts could flee to out of state carriers or third party administrators who are not providing coverage in the small group market.

Artificial suppression of rates by even a small amount can be devastating to health plan finances

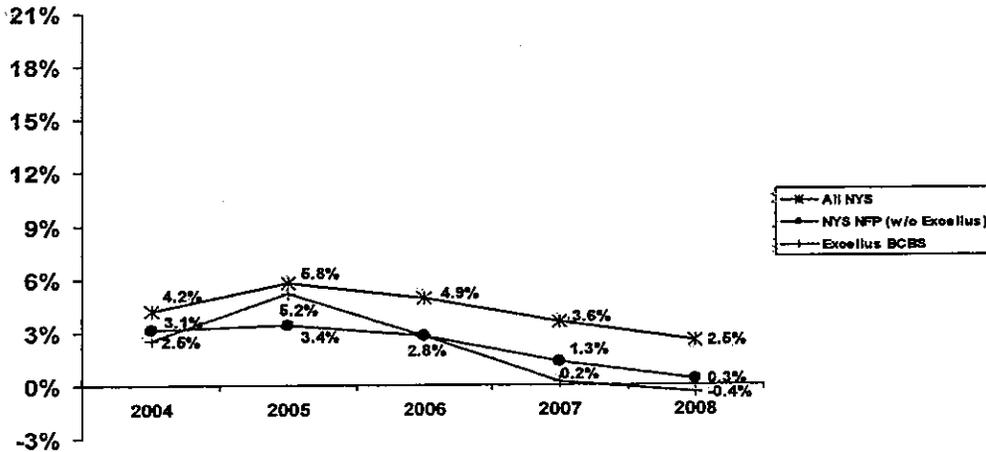
Contrary to public perception, health plans over time live within narrow percents of underwriting gains. A look at the State's own database demonstrates that, in fact, most health insurers in the State suffered deterioration in financial performance during 2008-09, most with loss ratios well in excess of minimums required by law, and many regional not for profit plans actually generated a loss from operations. Operating losses at nonprofits are of particular concern because not for profits do not have access to the capital markets, but instead rely primarily on premiums and investment income. to build our infrastructure, health information technology and other innovations to provide quality services to our customers.

Difficult economic times have also led us to difficult decisions, including, steps to curb administrative spending – including a temporary hiring and promotions freeze, elimination of open positions and an early retirement incentive program – that resulted in a reduction of nearly 530 positions within the health plan or a 13 percent reduction from a fully staffed workforce.

While we believe the worst is behind us, artificially suppressing our rates will severely impact our operations. The effect on plans like ours would be more profound because our underwriting gains don't provide much room for error.



Underwriting Gains/Losses New York State Health Plans



“Unreasonable” and “excessive” -- arbitrary grounds for denial of rates

Under the terms of the legislation, the Superintendent of Insurance would have the power to deny rates if he or she found them to be “unreasonable” or “excessive,” but those terms are extremely broad and subject to political interpretation that could destabilize the entire health insurance industry. No other state in the country bestows upon its Department unlimited authority to determine what constitutes “unreasonable or excessive” as what has been proposed in New York. For example, while New Hampshire law requires that “rates are neither inadequate nor excessive,” the determination is based on whether the rates “bear a reasonable relation to the benefits provided”; thus tying the determination to a quantifiable standard.

Before the existing system was established – commonly misnamed as “File and Use” – the government’s system of prior approval of health insurance premiums dating back to the 1980s and 1990s saw significant swings in rates that had more to do with election cycles than underwriting cycles. Proposed rate hikes during election years tended to be rejected or materially reduced. Later, sticker shock on premium hikes would occur because medical cost and utilization trends continued to grow even though premium rates were suppressed. This practice not only negatively impacted our operations, but also created unpredictability for our customers.

The chart below reflects our own experience with these dramatic fluctuations in premiums:

Date	Increase Requested	Increase Approved
1/1/86	4.8%	1.8%
1/1/87	8.7%	0.7%
4/1/88	20.1%	19.8%
1/1/89	18.3%	17.7%

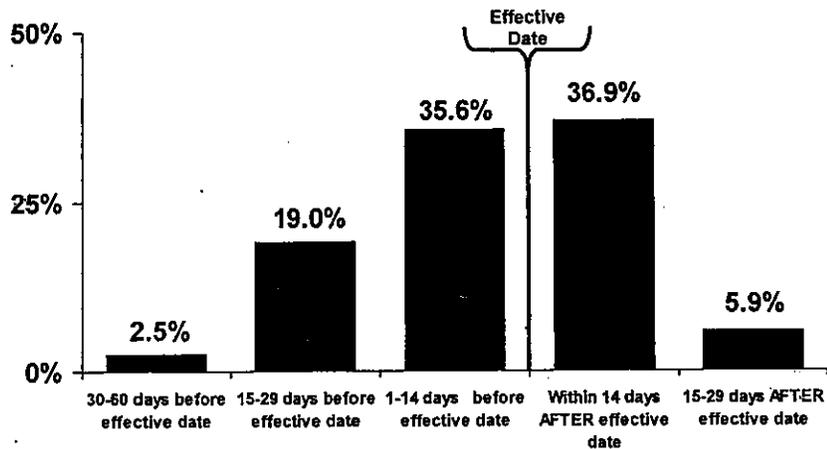
* Excellus rate change request data under prior approval, 1/86-1/89

Prior approval would challenge the capacity of regulators to render timely decisions

Under the prior approval process, health plans experienced long delays in rate approvals, and little, if any ability to prospectively notify members about changes in their rates in the event rates were approved. In reviewing over 200 rate submission applications by the entire industry, NYS Insurance Department Opinion and Decisions regarding rate increase applications and NYS Department of Insurance Press Releases from 1981-99, the average decision came 4 days after the effective date of the rate increase. In contrast, under the current "file and use" process, which sets rates based on an objective actuarially based standard, referred to as a Medical Loss Ratio (MLR) or the percentage of the premium dollar spent on a claim, insurers are required to give members 30 days notice prior to any rate increase. In very few cases were employers and employees given at least 30 days notice under prior approval.

There were significant problems created by the timing of approvals so close to effective dates. Often, employers and their workers would find out at the last minute what was happening with their premium rates that led to a rush in making a host of decisions regarding coinsurance and coordination of spouse coverage, among a variety of other issues.

Timing of NYS Rate Approvals in Relation to Effective Date of New Rates Under "Prior Approval"



Data based on the timing of 236 rate approvals from 1981 to 1999.

The world of health coverage has changed dramatically since prior approval was last in place. Applying prior approval to the vast array of different insurance products now in the market raises serious concerns about whether the Department of Insurance would have the capacity to handle such a review without major delays in getting product and price approvals.

Evidence of insufficient capacity is found in new product approval cycle times currently, so the capacity issue will be magnified several times under a full prior approval system. Only new products are currently subject to prior approval and the current backlog at the department is 7-9 months with some product approvals taking up to two years. The issue is not a matter of inefficiency by the Department. It has much more to do with actuarial staffing shortages, which is a national industry problem.

Prior approval system doesn't work for malpractice coverage

Even the Superintendent of Insurance has stated in the past that our state's system of subjecting medical malpractice carriers to prior approval of malpractice coverage premiums has led to artificial suppression of rates. Medical malpractice coverage in New York State is offered by few carriers. This is unsurprising to anyone in the insurance industry because of the existence of prior approval. One would think that national malpractice carriers would be anxious to enter a marketplace that has among the highest rate of doctors per capita in the country. But between the state's expensive tort system

and its system of prior approval of rates, the downside financial risks of coming here are too great.

1991: Déjà Vu- Why no rate increase despite it being clearly justifiable

EMPIRE INDIVIDUAL MARKET 1991 RATE APPLICATION				
DATE	MLR	NET UNDERWRITING LOSS	RATE INCREASE REQUESTED	RATE INCREASE DECISION
1991	109.1%	\$81,012,261	34%	DENIED
<p>Rate Denial Justification:</p> <p><u>Opinion and Decision of Superintendent Curiale dated October 1, 1991 :</u></p> <p>"I believe the only real solution to the problems of Empire's subscribers and Empire itself is legislation..."</p> <p>Sound Familiar... (Excess Medical Malpractice???)</p>				

Government "cost shifting" highlights another flaw with government price fixing

Numerous studies have emerged showing that the government's Medicare and Medicaid payments to hospitals and doctors for their services have followed trends that often fall below the basic costs of providing care, creating negative margins. Low government reimbursement rates lead to significantly higher costs being shifted to the privately insured in a negotiated marketplace. A national study done by Milliman on this, issued in December 2008, estimated this cost shift adds an estimated 10.6 percent to the average premium for an American family of four.

This issue has also been recognized by many hospital executives in New York, as evidenced by their testimony before the Legislative hearing addressing this topic in June, 2009. For example:

"In 2000, private payer payments average 132.2 percent of hospital costs, thereby offsetting the government shortfall.

Hospital finances and those of other health-care providers are fragile and would be seriously jeopardized if inadequate premium rates prevented private insurers from subsidizing government underpayments. Our concerns with this legislation stem from this dependence on private insurers'

ability to offset the public programs' below-cost reimbursements."

Peter G. Robinson, Vice President and
COO, University of Rochester Medical
Center

"Prior Approval" of Health Insurance Premium Rates: A Nationwide Perspective

State Laws or regulations pertaining to review authority and enforcement of health insurance premium rates substantially differ nationwide. Contrary to the New York State Insurance Department's claim that more than 24 states have "prior approval," it is not as easy as labeling a state regulatory system as either "prior approval" or "file and use." State laws and regulations contain a number of additional factors that affect such a classification including: minimum medical loss ratios (MLRs), deemer provisions and rate bands.

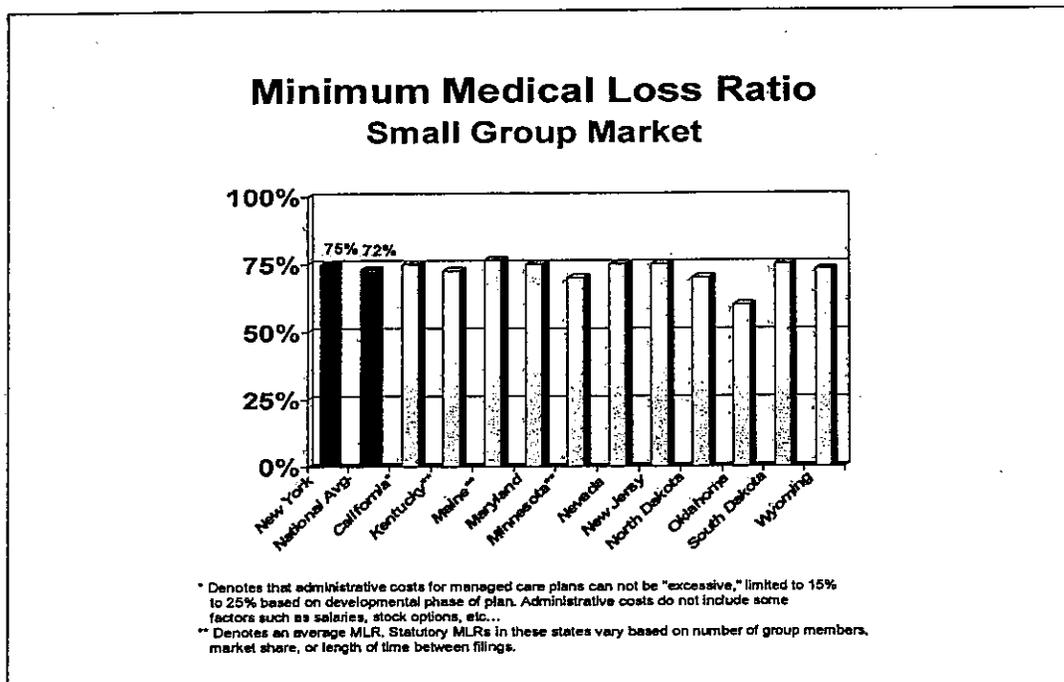
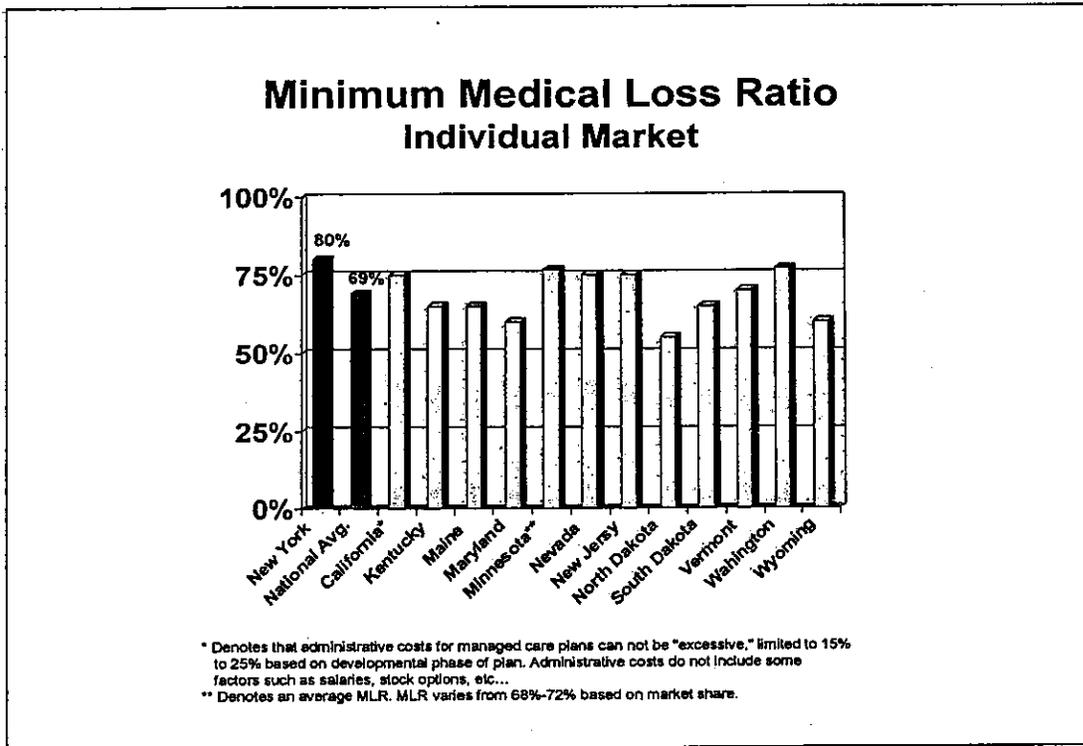
Minimum Medical Loss Ratios (MLRs).

A minimum MLR is a requirement that insurers spend, at least, a specified percentage of premium dollars on the payment of claims for medical care rather than on administration, marketing, and profit.

Both as part of the rate approval process and for ongoing maintenance of rates, many states utilize minimum medical loss ratios in determining appropriate rates. For example, fifteen States, including New York, place statutory MLR requirements on insurers in the Individual and/or the Small Group Markets. The utilization of MLRs in the rate setting process in States that are characterized as having "prior approval," however, varies considerably. For example, in Maine, if an insurer demonstrates that it had a minimum loss ratio of 78 percent over a three year period, the insurer's rate increase is exempt from the prior approval process altogether; while in Minnesota, if the previous year's loss ratio was achieved and the proposed rate increase is accompanied by an actuarial certification, the rate increase is approved based solely on the MLR. Similarly, in Kentucky, if an actuarial certification of the MLR is submitted with the rate application, the proposed rate can be used immediately. In fact, in the seven states that subject insurers to "prior approval," five of these states approve rate increases if an insurer meets a targeted MLR that is comparable to those currently in place in New York. Ironically, in reviewing these varying processes which are characterized as "prior approval", one could argue that New York is already a "prior approval" state.

Moreover, New York is one of only three states that have MLRs that average at or above 75 percent in the Individual Market and one of only seven states with MLRs that average at or above 75 percent in the Small Group Market. No State has an MLR of 85 percent as proposed by the Department. With the exception of Minnesota, which has a complicated

market share test, which may increase a loss ratio under certain circumstances to 82%, New York currently has the highest MLR for the individual market.



- **Deemer Provisions.** A "deemer" provision is traditionally seen in states that are classified as "prior approval." Under "prior approval," filed rates cannot be used until approved by the state insurance department. A deemer provision allows a submitted rate to be used after a specified time period has elapsed without state insurance department notification. Approximately eleven "prior approval" states have deemer provisions.

State	Rates Deemed Approved After
Arkansas	60 days (Ind. Market)
Colorado	60 days (Ind./SG Markets)
Connecticut	30 days (Ind. Market)
D.C.	30 days (Ind./SG Markets)
Kentucky	30 days (Ind. Market)
Maryland	30 days (Ind./SG Markets)
Nebraska	60 days (Ind. Market)
New Mexico	30 days (Ind./SG Markets)
Ohio	30 days (Ind./SG Markets)
South Carolina	30 days (Ind. Market)
Washington	60 Days (Ind./SG Markets)

- **Rate Bands.** A "rate band" is a maximum percentage by which an insurer can seek a rate increase or the maximum percentage by which an insurer can seek a rate increase through "file and use." Increases above the maximum percentage are subject to prior approval or actuarial certification. Seven "prior approval" states currently have statutory "rate bands" that vary in form and from five percent to 40 percent.

State	Rate Band
Colorado	5% (Ind./SG Markets)
Florida	10% (Ind./SG Markets)
Ohio	40% (Ind./SG Markets)
Maryland	10% (Ind./SG Markets)
Nebraska	25% (Ind. Market)
North Dakota	15% (Ind./SG Markets)
Pennsylvania	15% (Ind./SG Markets) (HMOs Only)

Finally, it is important to keep in mind that for the first time in more than a decade, serious discussions are taking place in Washington that could dramatically change the health care landscape. These discussions have included major market reforms that could transform individual and small group health insurance. Placing price controls on health insurance during this time of uncertainty could be disastrous to regional health plans that represent high quality services throughout the state along with tens of thousands of jobs. If regional health plans are weakened, coverage will continue to be sold, but it will occur from national plans with employment bases far from New York's borders.

"Prior Approval" of Health Insurance Rates: A Step Backward from the Current "File and Use" System

The current process, misnamed "file and use", sets rates based on an objective actuarially based standard, referred to as a medical loss ratio (MLR), which is the percentage of the premium dollar spent on claims. The medical loss ratio test measures the components contributing to the cost of coverage, such as hospital costs, prescription drug costs and medical costs.

Under the current system, when a health insurance product is initially designed by a health plan, it needs prior approval by the Department of Insurance to sell it at an initial price. In subsequent years, health plans file their premium increases on those products with the department with certain projected actuarial standards that limit profitability and administrative costs for insurers. Once filed, the health plan may use those new rates. A loss ratio test then compares the MLR to a specified minimum standard. If the experience turns out to be more favorable than the minimum standard, then refunds are provided to our customers. In summary this process provides an objective actuarial standard by which to determine rates.

Competition among health plans on the basis of price is alive and well in New York State, so market forces are already doing what prior approval of rates seeks to do in making sure that price gouging isn't taking place. Employers and their workers don't hesitate to go to competitors if they see better rates.

Reforming the Current Approach

We acknowledge that the current law is in need of improvement and we are committed to working to attain comprehensive reform to the current process by supporting the granting to the State Insurance Department additional powers to punish bad actors and clarify a number of terms which would eliminate any potential for abuse of the current process. Such a proposal would be meaningful reform which would provide a balanced approach to addressing the concerns with the current system, without re-instituting excessive government regulation and endangering the stability of a strong health insurance industry that New Yorkers depend on for their own security.

Specifically, we would recommend the following:

- Clarify the appropriate minimum loss ratio on claims for small businesses and individuals to ensure that the appropriate amount of the premium dollar paid by this vulnerable population is used on health care services.
- Clarify any ambiguous terms and require that all actuarial certifications that accompany rate filings affirm that the filing was prepared in accordance with

generally accepted actuarial principles. This creates additional accountability for health plans to ensure that the data submitted to SID is accurate.

- Require timely refunds to customers so that if rate relief is warranted, customers get the relief quickly. Likewise, ensure that customers are provided adequate notice of any proposed changes in rates.
- Expand the regulatory powers of SID, including the power to suspend a plan's right to use the current process if it has been in noncompliance with current law.

These measures represent a realistic and targeted approach to addressing any deficiencies in the current process without re-implementing the failed "prior approval" system. Given the potential dangers of prior approval, this approach is a viable alternative which addresses shortfalls in the current system, but preserves an actuarially objective process.

While most of the rest of the country is just beginning to discuss market reforms, such as guaranteed issue and community rating, New York adopted these reforms for small groups and individuals over a decade ago. The fact that New York health insurance costs are more than we would like is not a function of having prior approval and price controls on insurance rates. The cost of coverage in New York, particularly for small companies and individuals, is driven by the cost of care in our State, increased State taxes, and mandates that actually drive insurance costs higher and limit options needed for New Yorkers. These are the factors we should focus on to reduce the cost of coverage and build on the positive initiatives New York has taken in reforming our system.





10

**NEW YORK STATE
ASSOCIATION
OF COUNTY
HEALTH OFFICIALS**

“The Voice of Local Public Health in New York State”

**February 9, 2010
Testimony before the Joint Legislative Committee on Health
Regarding the 2010-11 Executive Budget Proposal**

About the New York State Association of County Health Officials (NYSACHO)

NYSACHO's MISSION: To support local health departments in their efforts to provide and improve essential public health services in their communities.

NYSACHO works to:

- **BUILD AND SUSTAIN** local public health infrastructure,
- **PROMOTE AND SUPPORT** efficiency of operation at the local level through enhanced collaboration and alliance building,
- **ADVOCATE FOR** local public health across New York State, and
- **FURTHER** public health priorities by:
 - Promoting and sharing of best practices
 - Providing opportunities for training and resource sharing
 - Developing programs and policies in collaboration with the NYS Department of Health, other state government entities, community-based organizations, the health care community, and educational institutions.
 - Working collaboratively with the New York State Department of Health (NYSDOH), academia and others to address issues of quality, staffing and resources to sustain and enhance the public health workforce.

NYSACHO links together the 58 local health departments that comprise New York's local public health system. Through our members, we work for all New Yorkers to prevent disease and disability, promote health and safety, and protect our residents from risks and threats to our water, food and air supplies, and from other potential health hazards.

As equal partners with the NYSDOH in promoting and protecting the public's health, local health departments apply a population-based approach to building robust communities that provide their residents' with a healthful quality of life. Local health departments emphasize health promotion and disease prevention through a combination of regulatory enforcement, education, oversight, quality assurance and direct services. Evidence-based health promotion and disease prevention are investments in the future and provide the foundation for a strong health care system. An important part of maintaining this foundation is the assurance of a sustained and adequate funding commitment for local public health activities by the state.

NYSACHO seeks to build upon its strong collaborative partnership with the NYSDOH in designing and implementing effective public health policies. As the operational arm of the public health system, local health departments understand the unique needs of their communities. As such, they are necessary voices at the planning table in developing policies that are realistic, effective, and appropriate in scale.

NYSACHO is incorporated as a not-for-profit, non-partisan charitable organization with 501(c)(3) tax exempt status.



February 9, 2010

*Testimony of the New York State Association of County Health Officials (NYSACHO)
before the Joint Legislative Committee on Health regarding the 2010-11 Executive Budget Proposal*

Cynthia Morrow, MD, MPH -- President of the New York State Association of County Health Officials:

Good Morning Senator Kruger, Assemblyman Farrell, Senator Duane, Assemblyman Gottfried and distinguished committee members of both houses. My name is Dr. Cynthia Morrow and I am the Commissioner of Health for Onondaga County and current President of the New York State Association of County Health Officials (NYSACHO). Thank you for the opportunity to present testimony on behalf of my colleagues at all 58 local health departments in New York State.

Today I will briefly present an overview of the current status of local public health in New York State as well as a brief summary of NYSACHO's overall priorities with respect to the proposed budget, and finally I will review specific requests for consideration by this legislature.

Brief background on local public health:

As you are well aware, the national recession continues to cripple the budgets of both state and local government and has already resulted in a loss of funding and staff for local public health. We applaud Governor Paterson for recognizing the critical need to ensure that our state maintains a public health infrastructure that can protect our citizens and promote the health, lives, and safety of New Yorkers.

That being said, the public health safety net has been stretched beyond its limits in all directions. I have been a public health professional for many years. This past year has been one of the most challenging for local health departments. We responded and indeed, are still



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responding, to the global H1N1 pandemic. In early spring 2009, our efforts focused on disease surveillance and public education as we tried to understand the extent of the impact of this new virus and keep the public informed as information rapidly evolved. Over the summer, our efforts focused on preparing to respond to increased disease activity and to planning to receive and rapidly disseminate vaccine once it became available. In the late fall, vaccine became available just as disease activity was peaking and our emphasis shifted to protecting as many people as possible, as quickly as possible through mass vaccination programs across the State. We could not have done this without a coordinated effort with our colleagues at the New York State Department of Health (NYSDOH) and our community partners at the local level.

The reality is there are predictable threats to the public's health, such as tobacco and poor nutrition, and there are more immediate, unpredictable and often frightening threats to our resident's health. For example, just yesterday we heard from colleagues in the Hudson Valley about their response to an ongoing Mumps outbreak. Our ability to rapidly and effectively respond to emerging diseases is in large part attributable to New York's prior commitment to build the basic infrastructure of its local health departments. In today's fiscal environment, we are deeply concerned that this basic infrastructure is at risk and thereby, our ability to protect and promote the health of New Yorkers may be at risk as well.

Summary of the four principles for today's testimony:

The foundation of our testimony today on behalf of local health departments in New York is based on four fundamental principles:



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- **Any further State cuts for local public health programs will mean that many communities will be left without essential public health services.**
- **The State must explore and consider all opportunities to maximize new revenue sources** and allow for increased flexibility and efficiency in delivering public health services. This includes enacting the proposed excise tax on sugar sweetened beverages and the increased tax on cigarettes. It also includes closing loopholes that allow commercial insurers to shirk their responsibility for coverage of early intervention for children with special needs.
- **The prevention of chronic diseases is as essential** today to public health and fiscal well-being in New York State as the prevention of communicable diseases. Again, taxes on sugary beverages and cigarettes are potential weapons in the fight against chronic diseases such as diabetes, heart disease and cancer.
- **New unfunded mandates must be avoided**, and costs for state and federally mandated public health services must not be shifted to the already overburdened local tax base.

NYSACHO urges the legislature to consider the following:

- **Maintain the Current Level of State Aid and State Grant Funding for Local Public Health**

We are pleased that the Governor has recognized the demands on local health department core public health services, as reflected in the appropriation for general public health work in his executive budget. At the same time, we would like to remind you that categorical funding that supports core public health efforts through grants to local health departments for programs, such



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as tuberculosis control or the safe drinking water program, has been significantly reduced over the past two years. Furthermore, this followed a decade of flat funding which had, in effect, resulted in decreased support for these programs. *Any additional erosion of these programs will severely curtail our ability to provide these essential public health services.*

With respect to the State's plans to reduce or shift reimbursement for certain services that have been labeled as "optional," we are happy to see that the governor has acknowledged the need for all communities to have access to home care services by maintaining Article 6 reimbursement for local health departments that are the sole providers of home care in their counties. Since this is an administrative change, we will work with the NYSDOH to arrive at the criteria that determine the appropriate meaning of "sole provider." We are concerned about the impact this change may have on access to care in counties in which there may be other home care service providers, but in which the public certified home health agency (CHHA) provides needed care to the most vulnerable and hard-to-reach populations. The vast majority of local health departments operating public CHHAs are in our smaller, rural communities.

With respect to Medical Examiners, many local health departments are concerned about the proposed shift of funding for this essential service from an entitlement program under the New York State Department of Health (NYSDOH) to an undefined program under the New York State Department of Criminal Justice Services (DCJS). This shift raises significant questions that are not answered in the proposed budget bill language. Although funding for this service is transferred and not reduced in the 2010-11 budget, it is unclear what commitment DCJS will make to fully fund Medical Examiners in the future. If the funding is moved from an entitlement program to a block grant program, sustained funding for Medical Examiners may be jeopardized.



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Furthermore, we feel that it is critical that Medical Examiners, who are responsible for investigating the deaths of persons who might be involved in the criminal justice system or who might be in the custody of state or local government, be independent from law enforcement. We believe that the state should address these concerns before taking a significant step that could potentially have an adverse impact on the effective functioning of Medical Examiners throughout the state.

A final point to consider with regard to changes in the funding of “optional services” is that NYSACHO believes that local health departments should be funded in ways that allow for discretion and flexibility in addressing local public health priorities, which can vary widely from county to county.

- **Realign Fiscal Responsibility for Early Intervention & Preschool Special Education**

NYSACHO strongly supports the reforms put forth in the 2010-2011 Executive Budget for both the Early Intervention and Preschool Special Education programs. Of critical importance are reforms that would ensure that commercial insurance carriers pay for Early Intervention services to the children and families they cover as provided in regulation, and not shift costs to state and local tax payers.

Additionally, we strongly support the cap on the Preschool Special Education local share of costs, with the ultimate goal of transitioning counties from fiscal, administrative and programmatic responsibility for this program altogether, as recommended by the Governor’s special task force in 2008.



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Finally, we continue to be concerned that the appropriation language maintains a 49/51 percent split between the state and counties for funding of the Early Intervention program. This amounts to a cost-shift to local taxpayers, which erodes the original intent that expenses of this mandated program were to be a 50/50 state-local share.

- **Re-establish State Funding for Public Health Emergency Preparedness and Response**

While we are cognizant of the reality that now is not the time to ask for any additional funding, we would like to remind the legislature that as a part of last year's state budget actions, state funding for local public health emergency preparedness was eliminated. That cut is carried forward this year. Funding in past years enabled local health departments to build the capacity needed to mount an effective response to a broad range of public health emergencies. That infrastructure was crucial this past year when we were called upon to respond quickly to the global H1N1 pandemic, which struck communities throughout the state. While we know how many people in New York died from complications of H1N1 influenza, it is more difficult to count the numbers of deaths and hospitalizations that were prevented due to our flu education and vaccination campaigns, an effort that was closely and efficiently coordinated with the NYSDOH.

In October 2009, the national watchdog Trust for America's Health indicated that New York State was one of only eight states nationwide that scored a 9 out of 10 in key public health emergency preparedness indicators. This leadership in public health readiness is not something we can take for granted. New York State's funding for local public health preparedness was initially provided to address an erosion of federal dollars in this area.



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This past year, our state and local health departments benefited from an infusion of federal funds to control H1N1. But as this novel influenza ebbs, we cannot count on continued federal funding for the past year's emergency. Without the level of state funding that has been committed to local preparedness in the past, our capacity for emergency response will be compromised. While we are grateful for the federal funding that became available to support our response to the 2009 H1N1 pandemic, the reality is that many of us would not have been able to mount an effective attack against the pandemic without the core infrastructure that has previously been supported with state funding of public health preparedness.

The current crisis in Haiti offers an extreme example of failure to effectively and rapidly execute an emergency response because the basic infrastructure was severely compromised. We must preserve the infrastructure of local health departments in order to protect the health and safety of all New Yorkers from sudden disasters and emerging diseases.

- **Strengthen statewide policies that foster community health and prevent chronic disease through policies that promote good nutrition, physical activity and discourage unhealthy behaviors.**

NYSACHO strongly supports Governor Paterson's proposed establishment of an excise tax on sugar-sweetened beverages and the increase in taxes on cigarettes. These measures will bring in revenue in the short term to ensure that critical government services can be maintained, but more importantly, they are also evidence-based public health interventions that promote healthy behaviors. Environmental and policy changes that support healthier behaviors are



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crucial to the prevention of chronic diseases such as cancer, heart disease, and diabetes that are so costly in the long term—costly both in terms of human suffering and of medical costs.

We believe that the sugar-sweetened beverage tax will have a positive public health impact. The consumption of sugar sweetened beverages accounts for a significant portion of excess calories that have negligible nutritional benefit and that have contributed to the tripling of obesity in children over the past three decades. Reducing consumption of sugar-sweetened beverages by 10 percent could save about 7,400 empty calories per child per year. In addition, increased cigarette taxes are a proven deterrent to tobacco use by adolescents and research shows that adolescents who do not smoke are less likely to become smokers as adults.

On a different note, over the past year, local health departments have worked closely with hospitals and other community partners to complete our Community Health Assessments. In this effort, we focused our plans on the goals within Commissioner Daines' Prevention Agenda Towards the Healthiest State. Throughout this process, we have identified the state and local public health priorities that will improve the health and safety of the residents of our communities. Health costs are so high today that corporations are scrutinizing the health of the workforce and communities when they decide where to locate and invest. In this economic climate, our state's progress toward meeting the goals of the Prevention Agenda could not be more important. We need your support to preserve our basic public health infrastructure if we are to continue to make progress toward becoming the Healthiest State.



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before the Joint Legislative Committee on Health regarding the 2010-11 Executive Budget Proposal*

In closing, an investment in local public health is an investment in the personal health of our families, in the population health of our communities, and in the future economic health of our state. Even in tough times, there are some investments that make sense. Local public health is one of them.

~~HB~~ 10B

Maternity and Early Childhood Foundation

**Testimony to the
Joint Legislative Budget Committee**

February 9, 2010

Joy Griffith
Executive Director
Maternity and Early Childhood Foundation
50 Colvin Avenue
Albany, New York 12206
518-482-0038
www.mecfny.org

Chairman Farrell, Chairman Kruger and Members of the Joint Legislative Budget Committee, my name is Joy Griffith and I am the Executive Director of the Maternity and Early Childhood Foundation.

On behalf of the Board of Directors and the thousands of families we serve, the Maternity & Early Childhood Foundation thanks you for this opportunity to present some vital information about a cost-effective prevention program serving the needs of the most vulnerable in our state.

As you may be aware, funding for the Foundation was eliminated in the Governor's Budget. We strongly urge that this funding be restored to its current level of \$1,198,000. This funding equates to 99 percent of our budget and without it, the programs located in your districts and funded by the Foundation will cease to exist; leaving thousands of families without the help they need and deserve. We believe that a continued investment in the Maternity & Early Childhood Foundation in the 2010-2011 Budget will reap major dividends for the state in the long-term.

The Maternity and Early Childhood Foundation, Inc. (MECF) is a not for profit agency that was started more than 25 years ago through efforts of forward thinking individuals, including members of the New York State Legislature who realized the importance of supporting young parents at a most crucial time- the birth of a child. The agency was founded in 1983 in response to the significant number of teenage mothers and low income single-parent families who were receiving late or no prenatal care and needed support in parenting. Our mission is to ensure a safe and healthy birth of the child and the well-being of the mother by supporting and promoting services to those pregnant and parenting women who are most in need. Those services are provided to fathers and other family members as well.

The Foundation selects programs through a rigorous Request for Proposal process. Funded programs serve young expectant and new parents and are located in high need communities throughout New York State where other community services are often limited or nonexistent. In 2009, the Foundation received approximately \$1.2 million in state funds. With that funding, the Foundation funded 31 programs including five programs in high risk neighborhoods in New York City.

Last year the programs provided services to over 5600 expectant and new parents and their families.

- Of the families served, more than one third of parents were under age 21 at the time of enrollment.
- Over 50% of the parents enroll in the program pre-natally - the best time to make a positive impact on the health of the baby and the mother.

Like many not-for-profit organizations, we have had reductions in state funding over the last few budget cycles, and appreciate the State's fiscal crisis. However, we will be forced to close our doors if our funding is eliminated.

The Governor and the Legislature have always said it supports services for the most vulnerable population – and I can't think of a more vulnerable population than young mothers and infants.

While New York is facing some very serious challenges, we request that you do not forsake the future of New York by eliminating services to our most vulnerable citizens, our children and their struggling parents. Services for young low income expectant and new parents provide a positive support system at a critical time, the birth of a baby. The support we give expectant and new parents will last a lifetime!

Thank you for taking the time to consider our request and for your leadership during these tough times.



Maternity and Early Childhood Foundation

Supporting Quality Services for Vulnerable Expectant and New Parents for Over 25 Years!

“ When it comes to us first time teen parents, we have a lot to learn about being a parent. There are some people that need help but are afraid to ask.”



The Mission of the Maternity & Early Childhood Foundation is to ensure a safe and healthy birth of the child and the well-being of the mother by supporting and promoting services to those pregnant and parenting women who are most in need.

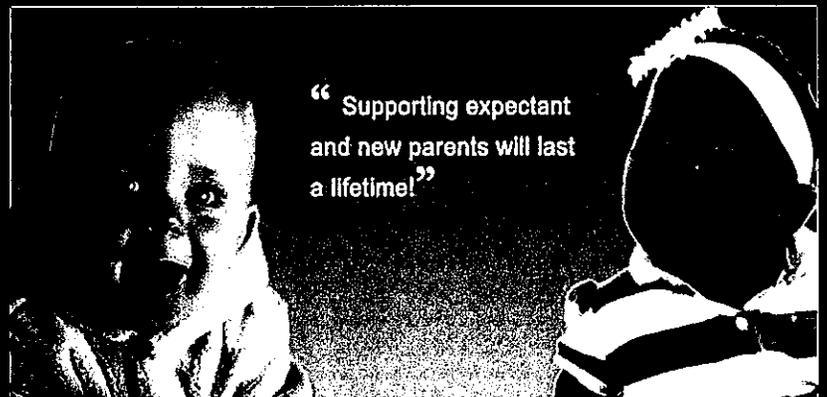
The Maternity & Early Childhood Foundation was founded in 1983 in response to the significant number of teenage mothers and low income single-parent families who were receiving late or no prenatal care and needed information on parenting.

In 2008-09:

- 31 grantees served over 5600 expectant and new parents and family members
- More than one-third of those parents were under age 21 at the time of enrollment.
- 38% of the parents enroll in the program prenatally - the best time to make a positive impact on health of the baby and the mother.
- Most of the families served are living in extreme poverty with unstable housing, lack of transportation and little or no employment.
- 9900 home visits were provided.
- 1595 parents attended parent education workshops.

Funded programs provide a range of needed services including outreach to pregnant women who might not seek prenatal care, assistance with access to health insurance, crisis intervention, parenting skills training, information on baby safety, home visiting and support for education and employment goals.

The Maternity & Early Childhood Foundation provides funds to agencies throughout New York State to promote proper prenatal care, improve birth outcomes, and support positive parenting. Since the Foundation began, grants were awarded to 132 agencies across the state.



“ Supporting expectant and new parents will last a lifetime!”

10A

February 9, 2010

- Testimony of Concerned local New York State Health Officials about the removal of the Medical Examiner's Program from the NYSDOH Budget

- Testimony given before the Joint Legislative Committee on Health regarding the 2010-2011 Executive Budget Proposal

Michael C. Caldwell, MD, MPH – Commissioner of Health for Dutchess County, NY

Representing concerned members of the Hudson Valley Regional Health Officials Network (HVRHON) and other concerned local health officials and medical examiners across New York State.

Good Afternoon. I come before you today to voice the concern of a number of local health officials and medical examiners across our State. Last year, the Governor's budget attempted to completely eliminate the guaranteed 36% funding for our local medical examiner's program. This funding flows from the New York State DOH (NYSDOH) through Article 6 of the Public Health Law and has been in place for decades. Since you know the value of our local medical examiner (ME) programs and you know the need for reliable and sustained support from the State, you chose to reverse this proposal and to reinstate funding for our ME programs.

This year, the Governor is proposing a new funding stream for the Medical Examiner's Program that promises funding for only one year. Unfortunately, missing from the Governor's proposal is the fact that our local ME programs would lose the 36% guaranteed funding currently enjoyed under the present arrangement with the ME programs qualified for Article 6 Public Health Funding. The Governor proposes to move funding for the ME program from the NYSDOH to the Division of Criminal and Justice Services (DCJS). He states that the reason for doing this is that ME work is criminal and forensic in nature and that DCJS would be a better fit for oversight of the ME program. Distinguished legislators, the Governor is dead wrong.

Our Dutchess County Medical Examiner has informed me that less than 10% of ME cases involve the criminal justice system. Medical Examiners can identify at autopsy, cases of unsuspected and undiagnosed infectious or other diseases so that measures can be quickly taken to protect others. Since September 11th and the Anthrax Attacks we have been trying to build stronger partnerships with a number of agencies, including strengthening the ties between public health and our medical examiners. The Governor's proposal is a step backwards, ignoring the value of the closer collaboration that exists with the ME program more directly connected to local health departments. We need to build bridges to improve our operational programs and capacities. All death investigations have public health significance. The ME program belongs with the DOH.

Another concern we have is the appearance of a conflict of interest between the ME program and the DCJS. No one would want to sacrifice a conviction of a criminal due to a perceived controlling of the ME by the criminal justice system. The ME must remain independent, as clearly as possible, in order to assure the maximum benefit to our community. This can only be done by preserving the current system. This can only be done by keeping the ME program connected to our NYSDOH and local health departments across this State.

In summary, the ME program should remain where it is. It is better for the community by preserving and strengthening the bond between public health and the ME and it eliminates the concern about conflict of interest by being directly aligned with the criminal justice community. **It should stay within the NYSDOH budget, eligible for the 36% Article 6 public health funding.** If not, the ME program will inevitably suffer decreases in funding in future years.

(Attached is a copy of a communication written by our Dutchess County Medical Examiner, Dr. Kari Reiber, to Governor Paterson in 2009 which addresses her concerns.)

Dutchess

**Dutchess
County
Department
of Health**

William R. Steinhans
County Executive

Michael C. Caldwell,
MD, MPH
Commissioner

387 Main Street
Poughkeepsie
New York
12601
(845) 486-3400
Fax (845) 486-3447



March 9, 2009

To Governor Patterson and all members of the New York State Assembly and Senate

Medical Examiner Programs in New York State face a 36% budget cut should Governor Patterson's budget recommendations be adopted and State reimbursement to local Health Departments under Article VI for medical examiner services be withdrawn. Although deemed "optional", medical examiner services are in fact mandated by law and essential to countless State agencies that oversee public health and safety. Medical examiner programs will inevitably be forced to curtail services to offset such a drastic loss in funding, and as criminal cases will be given priority, public health and safety will be most severely impacted. As medical examiners have no effective advocacy network, funding from other sources cannot be expected.

Medical examiner systems are mandated by law (1) to investigate the death of any person who dies as a result of "criminal violence, or neglect, or by casualty or by suicide, or suddenly when in apparent health, or when unattended by a physician, or a person confined in a public institution other than a hospital, infirmary or nursing home, or in any suspicious or unusual manner". The duties of the medical examiner include performing postmortem examinations and certifying cause and manner of death, but ultimately the medical examiner's mission is to protect the living. In speaking for the dead, the service provided by the medical examiner is core not only to law enforcement, but to public health and safety as well.

Medical examiner programs provide essential information and documentation to countless State investigative agencies. Work-related fatalities are reported to the NYSDOH Bureau of Occupational Health, motor vehicle fatalities to the State of New York Dept. of Motor Vehicles, inmate fatalities to the NYS Dept. of Corrections, deaths in nursing facilities and rehabilitation programs to Regional Agencies of the NYS Office of Mental Retardation and Developmental Disabilities, and sudden infant deaths to the NYS Center for Sudden Infant Death, to name a few. Medical examiners have been core to SIDS research, back-to-sleep campaigns, infant/adult co-sleeping awareness campaigns, and "don't shake a baby" campaigns, all of which have served to educate the public and prevent senseless infant deaths. Medical examiners work closely with County Departments of Social Services to identify, document, and prosecute cases of abuse and neglect in children, the mentally impaired, and the elderly. Information provided by medical examiners is core to County Departments of Mental Health and Hygiene in monitoring suicide prevention programs. Medical examiners are welcome participants in Fire Death Investigations and provide educational training for paramedics, corrections officers, and law enforcement personnel, to better their understanding of mechanisms and patterns of injury. In this age of political turmoil, medical examiners are in a position to provide infectious disease and bioterrorist agent surveillance should the need arise, and are core to mass fatality planning and emergency preparedness and response. The role of the medical examiner in facilitating groundbreaking advances in scientific research such as DNA technology became clear in the aftermath of the terrorist attacks in September 2001 and the collapse of the WTC.

Medical examiners can identify at autopsy, cases of unsuspected and undiagnosed infectious disease such as tuberculosis, meningitis, or diseases contracted during travel abroad, and report back to local health departments so that measures can be taken to protect others. Medical examiners may be the first to identify a cluster of unusual hospital or community-based deaths, and to alert the appropriate authorities of a potential public health threat. Autopsies performed by medical examiners identify and document injury patterns in vehicular accidents that have led to seat belt laws, airbags, car seats, and other safety measures. Autopsies identify objects, chemical substances, hazardous children's toys, defective baby cribs, inappropriate baby bedding materials, toxins, drugs, therapeutic agents, and other materials that can cause injury, disease or death, so this information can be shared with agencies having the resources to investigate, inform, and take appropriate action. As most deaths investigated by medical examiners are sudden and unexpected, medical examiners are in a unique position to identify real-time trends such as prescription medication and drug abuse, illicit drug adulteration, the recreational use of toxic substances in the teenage population, potentially lethal activities such as the choking game and other nefarious asphyxial activities, and to alert law enforcement agencies, paramedics, hospital staff, and public health officials of the dangers of such behavior. In short, the medical examiner is in a position to recognize hazardous trends and do something about it.

The importance of the medical examiner's contribution to law enforcement is well understood. The bulk of the medical examiner's time and effort is however, dedicated not to law enforcement but to public health and safety. Protecting the public from disease and injury in the long run saves money. By crippling the medical examiner's ability to render these essential services, the proposed budget cuts will ultimately defeat the State's purpose and be less cost effective. On behalf of New York State medical examiners facing these devastating budget cuts, I beg you to reconsider.

Respectfully submitted,

Kari Reiber, MD
Chief Medical Examiner, Dutchess County.

¹ McKinney's Consolidated Laws of New York Annotated County Law, Chapter 11 of the Consolidated Laws, Article 17-A-Coroner, Coroner's Physician and Medical Examiner, NY County § 673.

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Testimony
New York State Legislature Budget-Department of Health Hearing
February 9, 2010
By Ralph Palladino
2nd Vice President AFSCME DC 37 New York

Good day. Local 1549 represents 18,000 Clerical and Administrative employees working for the City of New York. We have over 5,000 members working in the NYC Health and Hospitals Corporation (HHC) and its Medicaid managed care plan, Metro Plus. Those working in HHC facilities include Clerical Associate Levels III & IV who serve as Financial Counselors and Billers, and Client Navigators (many of whom provide interpreter services). At Metro Plus, our members are Enrollment Representatives who enroll eligible uninsured patients onto Medicaid and Medicare programs. We also represent 6,000 Eligibility Specialists who determine Medicaid and Food Stamp eligibility in the NYC Human Resources Administration. Finally, we represent more than 500 clericals in the NYC Department of Health and Mental Hygiene.

A financially viable HHC is vital to maintaining a healthy New York. Our public hospital system, New York State's largest health care safety net, is in serious need of assistance from the State and cannot bear any further cuts in its budget. The Executive Budget could, if enacted, result in a \$78 million to \$94 million cut to HHC - New York City's public hospitals, nursing homes, neighborhood clinics, home care agency and health plan. Over the last three years, state funding to HHC has been cut by \$240 million! HHC has already cut itself down to the bone and will be operating with a projected \$1 billion deficit beginning July 2011. We have seen staffing reduced by over 25% the past 15 years. Services have been consolidated and bed numbers reduced. HHC has re-engineered itself through its Network structures, consolidating administrative and non-direct patient care functions and by retooling its extensive Primary Care operations. Contracting out of services has been reduced. Any further cuts will impact the health of our communities.

Additional cuts to our public hospital system are untenable. HHC facilities are the single largest employers in many New York City communities. These cuts will also have a devastating impact on the economy of some of the City's most underserved communities.

HHC provides approximately one-half of the health care that is provided to uninsured patients in New York State. It costs HHC \$850 million to treat uninsured patients. It is important to note that HHC served more than 451,000 uninsured patients in 2009, an increase of more than 8% from 2007. HHC hospitals also lose approximately \$800 million a year serving Medicaid patients. Nearly \$570 million of that loss is from serving patients enrolled in Medicaid managed care plans. In addition, HHC's Diagnostic and Treatment Centers' costs exceed Medicaid, Medicare and indigent care reimbursement by \$105 million per year. Because there is no state or federal reimbursement for nursing home care for uninsured undocumented immigrants, HHC's nursing homes lose more than \$30 million a year serving this population. HHC provides home care services to uninsured patients and to those who cannot find care elsewhere. Because of this, its home health agency loses \$7 million.

Who else but HHC will treat those most in need in New York City? If you come to nearly any one of our institutions you will feel like you are in the United Nations. New Yorkers of every background, including immigrants (legal or undocumented), fill our halls. This means that extensive multi-lingual services must be provided. Yet there is no reimbursement rate for this service so HHC must also absorb these costs.

Voluntary hospitals across the City are struggling; and every day we hear of more declaring bankruptcy and closing. This places an increased burden on the City's public hospitals. **Where uninsured patients served by those hospitals that close going to go?**

With a projected \$1 billion budget gap beginning in July 2011 and additional cuts in State funding, HHC will have no choice but to make deeper cuts to programs and staffing. There will be a significant negative impact on the health and the economy of the communities that our public hospital system serves. If healthcare workers lose their jobs, they will seek various forms of public assistance and not be able to pay taxes or make purchases short of bare survival needs. It is estimated that for every dollar spent on Medicaid in a community, two dollars are generated into the economy of the local community. In addition, cutting state Medicaid spending results in a loss of federal funds coming to the state. Increase Medicaid spending and you increase federal dollars as income.

Finally, the Governor's proposed premium cut of 1.7% on Medicaid managed care plans would mean a \$15 million cut to HHC's Metro Plus. MetroPlus has more than 380,000 members and has consistently been rated #1 in quality and customer satisfaction based on the New York State Department of Health's indicators. MetroPlus has the lowest administrative costs of any Medicaid managed care plan in the state. And most importantly, MetroPlus reinvests its premium dollars in HHC's hospitals and clinics for preventive and well-care programs, case management services and health education programs. **A \$15 million cut will severely undermine MetroPlus' capacity to staff the very programs that the state encourages for the prevention of unnecessary emergency room use and hospitalization.**

In order to enhance the health of our communities, HHC needs our elected officials to:

1. **Oppose** additional Medicaid cuts on HHC in the State Fiscal Year 2010-11 budget.
2. **Support** extension of the current State authorization for at least the \$300 million in Disproportionate Share Hospital (DSH) funding provided to HHC in last year's State Budget.
 - o DSH funds are used to cover shortfalls in Medicaid and costs of treating uninsured patients. **There is no cost to the State for doing this. The City of New York will provide the matching funds to draw down Federal funds.**
3. **Support** the elimination of the nursing home regional pricing payment system for public nursing homes.
 - o The proposed regional pricing payment system would cut more than \$30 million from HHC's nursing homes while increasing revenues to private for-profit nursing homes!
4. **Push** for use of some of the increased FMAP funds that may come through the federal Jobs Bills to address HHC's \$1 billion budget gap.
5. **Push** for continuation of the Stimulus Bill's 2.5% increase in the State's DSH allotment in the federal Jobs Bills. This could mean \$30 million for HHC.

In order to pay for this funding the state needs to look at:

1. **Support** the proposed taxes on sugary beverages and cigarettes tax;
2. **Further Close Corporate loopholes like cutting the rebate on tax transfers to 80%;**
3. **Taxing the \$98 billion income from the Securities Industry and increasing;**
4. **Increasing the tax rate on upper income brackets.**

11

CHAIN PHARMACY ASSOCIATION OF NEW YORK STATE

1 Commerce Plaza, Suite 402
Albany, NY 12210
Telephone: (518) 465-7330
Facsimile: (518) 465-0273

APTEA Co.

CVS Caremark

Duane Reade, Inc.

Hannaford Brothers Co.

Kinney Drugs, Inc.

Price Chopper Supermarkets

Rite Aid Corporation

Stop & Shop/ Ahold

Target

Tops Markets LLC

Town Total Health

Wakefern

Walgreens

Walmart

Wegmans

Testimony Before:

Senate Finance Committee

Assembly Ways and Means Committee

Tuesday, February 9, 2010

10:00 a.m.

**Hearing Room C, Legislative Office
Building
Albany, NY**

Presented By:

**Steven B. Weingarten, Esq.
Executive Director,
Chain Pharmacy Association of NYS**

Chairmen Kruger and Farrell and Members of the Senate Finance Committee and Assembly Ways and Means Committee, my name is Steve Weingarten and I am the Executive Director of the Chain Pharmacy Association of New York State. We greatly appreciate the opportunity to testify today regarding the Governor's Proposed FY 2010-11 State Budget as it relates to community pharmacy.

First, we would like to express our member companies' appreciation for the past support and leadership of the Senate and Assembly in partially restoring a number of proposed cuts to pharmacy reimbursement over the last two decades.

As background, there are over 4,000 community pharmacies, chain and independent, across New York State which collectively employ over 120,000 full and part-time workers including almost 10,000 pharmacists, and pay almost \$700 million annually in taxes. Nationally, the majority of Medicaid prescriptions – seventy percent – are filled by chain pharmacies. Fair and adequate state Medicaid reimbursement is critical to our membership.

Over \$100 Million in Pharmacy Reimbursement Cuts

The Governor and State Division of Budget have booked significant savings in the FY 2010-11 Executive Budget from federal court settlements with First DataBank (FDB) and MediSpan which took effect on September 26, 2009. The court settlements resulted from allegations that these publishers of prescription drug prices conspired with a drug wholesaler to inflate Average Wholesale Prices (AWPs) during the period of 2001 to 2005. It is important to note that pharmacies were not a party to this court case and no wrongdoing was alleged on the part of pharmacies. However, the result of the court settlements in New York was an almost 4% reduction in pharmacy reimbursements under Medicaid, Elderly Pharmaceutical Insurance Coverage Program (EPIC), Family Health Plus (FHP), Child Health Plus and other public health care programs. This change took effect administratively and reduced pharmacy reimbursement in New York to almost AWP-20% for brand name drugs.

Specifically, the State savings that are being booked in the Executive Budget are as follows:

For FY 2010-11:
\$48.7 million Medicaid
\$2 million EPIC

For FY 2011-12:
\$57 million Medicaid
\$2 million EPIC

Taking into account the federal match on state dollars, the total hit to all of the state's pharmacies is **over \$100 million in FY 2010-11 and over \$120 million in FY 2011-12.** That is a reduction in reimbursement of approximately \$7.54 for every NYS prescription impacted by the settlements (over 4,000 prescription drugs). This cut is simply unsustainable for pharmacies since the reimbursement rate in New York before this cut took effect was already one of the very lowest in the country (AWP-16.25%). In fact, the State's pharmacies had already been forced to sustain over \$100 million in cuts on brand and generic drugs as a result of changes made under Medicaid, EPIC and Family Health Plus in the year 2008 alone. Further, pharmacies were hit with over a dozen cuts

in reimbursement over the last fifteen years in New York, prior to the FDB Settlements that just took effect. These cuts have seriously impacted the financial viability of all pharmacies across the State.

First DataBank/Medi-Span Settlements

As a result of the FDB/Medi-Span settlements, in many instances, Medicaid reimbursement is now less than what it costs the pharmacy to acquire the prescription medications. This greatly affects their ability to provide prescription drugs and services to New York residents.

While the settlements decrease what pharmacies are paid, it does nothing to reduce the cost to pharmacies to purchase prescription drugs. Recognizing that retroactively punishing pharmacies for pricing irregularities perpetrated solely by other entities is counterproductive, the majority of private payers have chosen to adjust their AWP-based reimbursement. **We respectfully seek the assistance of the State Legislature to address these significant cuts in state Medicaid, EPIC and other public health care program reimbursement this year.**

During the summer of 2009, legislation was introduced by Senator Klein and Assemblywoman Destito (S.6146/A.9139) to address this issue. Specifically the bill changes pharmacy reimbursement under Medicaid and other public programs (currently at AWP) to the equivalent in a Wholesale Acquisition Cost (WAC) methodology at the level of reimbursement prior to the settlements taking effect. During a Special session in September, the Senate passed this legislation, which we are sincerely grateful for. Now, we ask for the continued support and assistance of the Senate and Assembly by making this essential change to a WAC reimbursement formula in the final State Budget.

Without State action to move to a WAC methodology, the serious cuts will remain in effect at a very serious cost to the health and welfare of all New Yorkers. Patient access to pharmacy services could be compromised if pharmacies are forced to cutback on services and store hours, layoff workers (which also impacts the economy of the state, particularly upstate) and if some pharmacies are forced to close their doors. Further, some pharmacies may decide that they can no longer participate in the Medicaid program or that they are no longer able to stock needed medications because the reimbursement is lower than their costs.

To date, other state Medicaid programs, such as Vermont, New Jersey, and North Carolina, have acted to adjust pharmacy reimbursement as a result of the FDB settlement. Furthermore, other states like Massachusetts, private payers, and federal government programs have moved to Wholesale Acquisition Cost (WAC) as a benchmark for pharmacy reimbursement. For example, the Department of Defense TRICARE program, which serves over 9 million beneficiaries, including many New York residents, conducted an extensive analysis of benchmark options before moving to WAC-based reimbursement.

It is also important to note that following the federal settlements, First DataBank and Medi-Span have publicly stated on their websites that they will discontinue the publication of all AWP pricing by September 2011. Therefore, New York State *must* move to an alternative methodology prior to that point.

Lastly, it is our understanding that the State has renegotiated its contracts for prescription drug

services under the state employee benefit plan as a result of the FDB-Medi-Span settlements. As part of this renegotiation, the State has agreed to reimburse at an enhanced reimbursement rate preventing the full 4% cut from taking effect. We would ask for parity with this agreement, making an adjustment in the reimbursement rates for the plans that serve the state's low income and underserved (Medicaid, EPIC, FHP and others) in the same manner as for the beneficiaries of the state employee plan.

In sum, in order to ensure stability in pharmacy reimbursement and maintain access to prescription drugs and pharmacy services for all New York residents, **we respectfully urge the State Legislature to include language to move to a reasonable pharmacy reimbursement rate for brand-name drugs for all pharmacies using a WAC methodology under Medicaid and other public programs in the final State Budget.**

Proposed Increase in Co-Payments under Family Health Plus (FHP)

The Executive Budget proposes to increase co-payments under Family Health Plus (FHP) when eligible employers buy-into the program for their employees. Specifically, co-payments for such beneficiaries would be \$15 for brand name drugs and \$5 for generics, as compared to the existing FHP co-pays of \$6 for brands and \$3 for generics.

While our membership is certainly supportive of expanding FHP benefits to more New Yorkers in order to provide for affordable and accessible health care coverage, we are strongly concerned with this proposal because like Medicaid, FHP beneficiaries may refuse to pay their co-payments at point of sale. In fact, the average rate of uncollectible co-payments statewide is 50% (and this rate is much higher in certain parts of the state). In these situations, it is impossible for pharmacies to recoup payments for co-pay losses under both Medicaid and FHP. If the proposed increase in co-pays as part of the FHP buy-in is enacted, pharmacies could lose an additional \$15 per brand prescription and \$5 per generic prescription in uncollectible co-pays. This would further exacerbate and compound the already extremely precarious financial state of pharmacies as discussed above. **For this reason, we ask the State Legislature to reject this proposed increase in FHP co-pays in the final State Budget or to prohibit such FHP beneficiaries from refusing to pay their co-payments, similar to Medicare and private health plans.**

OMIG Auditing Activities Significantly Impact Pharmacies

Finally, the Association would like to bring an issue to your attention that has the potential to cripple New York's chain and independent pharmacy network—auditing activities by the Office of Medicaid Inspector General (OMIG), which have focused on pharmacy administrative mistakes, committed unintentionally. Since 2007, pharmacies have been the focus of intense Medicaid audits by the OMIG and its contingency-based auditing firms, for misunderstandings, clerical, administrative and other errors in pharmacy claim submissions which through the use of extrapolation have resulted in exorbitant fines and payment recoupments per individual audit.

While our members strongly support the OMIG's efforts to catch and punish real Medicaid fraud and abuse, we are extremely concerned that our members have been targeted for such clerical mistakes and errors, instead of the true intent of the Medicaid Fraud statute—prosecuting providers who are defrauding the program with willful intent and negatively impacting patient health and safety.

We ask that the Legislature recognize the financial impact of this auditing activity on community pharmacies and how it only further exacerbates an already financially vulnerable pharmacy network in New York. Further, we ask for your support and assistance with imposing limitations on the OMIG's auditing activities in non-fraud cases, particularly the use of extrapolation and withholds of prospective Medicaid payments during pending audits in non-fraud cases. Such limits would enable the OMIG to refocus on its true mission of addressing real fraud in the system, for which the pharmacy community would like to be partners.

We would again like to thank you for your past support of community pharmacies which has helped to ensure patient access to high quality and preventative pharmacy services throughout New York State. **We appreciate the opportunity to submit our testimony today and look forward to continuing to work with the Legislature to guarantee access to prescription drugs and pharmacy services for all New Yorkers.**

11A

Testimony

for the

**Legislative Budget Hearing
2010-2011 Executive Budget**

Tuesday, February 9, 2010

Hearing Room B, LOB

Respectfully Submitted by:

**Craig M. Burrige, M.S., CAE
Executive Director
Pharmacists Society of the State of New York**

I want to thank the chairs and committee members for this opportunity to provide testimony on behalf of the Pharmacists Society of the State of New York.

The Pharmacists Society has represented New York State's pharmacists and the patient's they serve for over 131 years and we hope to continue that tradition for many more years to come. We feel strongly that our pharmacists have performed their duties as health care providers and patient advocates in the honored tradition of this society and their profession despite the many challenges they have faced over the past several years.

Pharmacy's Own Financial Crisis – The Hidden Cut is Biggest Cut of All!

Each year we come before the Legislature and the Executive and share ideas that have saved or could have saved tens of millions of dollars in the Medicaid and EPIC programs. Nevertheless, in all but one of the past fifteen years, the Executive has proposed drastic cuts in pharmacy reimbursement. You, the Legislature, have restored millions of dollars in cuts that were proposed. In 2008, we suffered the largest cut in NY Medicaid history resulting in a 30% reduction in pharmacy's gross margins for more than 5 million people or 1 in 4 patients. We understand the state's critical fiscal situation and will continue to work with you to help keep down prescription drug prices but our pharmacy network has reached the point of imploding.

The deepest cut to date, one that never had Legislative approval or showed up in this state budget as a cut has been quietly booked as a \$48.7 million "state share" savings in the Executive Budget with an additional \$2 mil. in EPIC savings. This cut was the direct result the First Databank federal lawsuit. A lawsuit, in which pharmacy was not a party, has resulted in an effective additional 55% reduction in

pharmacy's gross margin. (see attachment at the end of this testimony showing the gross margin loss). With the federal match (\$69.3 mil. enhanced FMP), the additional losses to pharmacy's bottom line is a staggering \$118 million and that only includes Medicaid reimbursement losses and not losses from the EPIC, ADAP, Child and Family Health Plus programs that all use the same reimbursement formula.

These are unsustainable losses for community pharmacies, in particular our independents who make up nearly half of this state's pharmacy network. Over 320 independent pharmacies have closed in the past two years and that number will accelerate over the coming months if the reimbursement formula is not fixed.

The Medicaid program continues to gamble and blindly assumes that New Yorkers will continue to have a nearby pharmacy where they will have immediate access to medications they need and access to the pharmacist they know and trust. With the closure of those 320 pharmacies and more than 8,500 pharmacy staff layoffs, pharmacy has come to a crossroads of "barely surviving" or taking the option of just "throwing in the towel" and calling it a day. The job losses in pharmacy belie their actual economic impact on communities. Most pharmacies fill their positions with local individuals living in the community the pharmacy serves. They are well paying jobs. Just 18 months ago, New York had a severe pharmacist shortage as measured by job openings. The job openings severity chart runs from 1.0 to 5.0 with 5.0 being the most severe (University of Minnesota). New York was at 4.8 and in certain areas of the state the pharmacist shortage was worse than the nursing shortage. Today, New York sits at 3.2, reflecting unemployment for pharmacists (lower than 3.5). Our pharmacy school graduates have few if any offers for positions in New York, and many have no choice but to leave the state.

Indications from our wholesalers are that the independent pharmacies – their customers – are slipping deeper and deeper into a financial abyss. Approximately 40% of independents in the NYC-Metropolitan area have fallen 30 days or more behind in paying their wholesalers, and in increasing numbers they are between 90 and 180 days behind. I can assure you, those pharmacies are working off of mainly bare shelves. At the end of December, an independent pharmacy in Brooklyn had to close his doors simply because he could no longer pay his bills. Another independent sold his pharmacy because he could no longer bear to get up each morning, go to his computer to see what checks cleared into his pharmacy account so he could pay his wholesaler that day to restock his shelves. That scenario is being played out week after week across the state.

Access to Certain Medications is Becoming an Issue:

Some branded medications are very expensive to carry in inventory. If it costs a pharmacy \$500 to put a bottle of 100 tablets on the shelf, the pharmacy owner may decide not to stock every dosage level of the medication (i.e. Seroquel). Many high-cost drugs are once a day anti-psychotics and anti-depressants. Every bottle in the inventory can be viewed as a financial risk. The owner gambles that 100 tablets will be dispensed before the expiration date on the container. When that happens, the pharmacy eats the loss. One 30-day prescription at a particular dosage level may be critical for one patient, but if the medication at that dosage is uncommon, it is likely that the product will not be available when the prescription is presented at the pharmacy counter. This is the financial risk that pharmacies take every day. It is a risk they no longer can afford to take, a risk not recognized by Medicaid.

It is now Medicaid policy in New York to reimburse pharmacies at or below the drug acquisition cost plus the dispensing fee of \$3.50, but no more than 80% of the time the pharmacy's fee is \$0.50 because most beneficiaries do not pay the co-pay amount of \$3.00 for a brand-drug prescription. (The state automatically subtracts the \$3.00 co-pay.) So, going forward, patients and prescribers will have fewer medication options and fewer pharmacies participating in Medicaid, EPIC, ADAP, and Child and Family Health Plus programs unless immediate changes are made to the pharmacy reimbursement formula. Furthermore, New York is compelled to change its reimbursement formula because as early as year's end the benchmark Average Wholesale Price (AWP) will no longer be published, a consequence of the settlement in the federal case against First Data Bank.

Medicaid Officials Believe There is No Access Problem

Without so much as offering a single study or survey, we are told that Medicaid officials are not aware of any loss of access to prescription drugs. But the magnitude of pharmacy reimbursement losses since July 1, 2008 should prompt very careful analysis of the access issue. The September 26, 2009 drop in the value of AWP published prices represents an annualized loss of \$120 million from New York's pharmacy sector, combined with more than \$100 million dollars cut from pharmacies in 2008, represents more than \$220 million that comes not from the cost of the drug, but directly from the operating revenue of the state's pharmacies. When we provide specific instances of access problems, they are dismissed as anecdotal. We are asked to conduct surveys. In fact, we have conducted very expensive Cost of Dispensing Surveys in the past, as has the National Community Pharmacy Association. Those study results were dismissed as "biased". Why would we undertake another survey? Where do Medicaid recipients take their complaints? It appears there is no toll free number to call. If a Medicaid

beneficiary calls DOH, the call goes to the main number in Albany. If you are a recently diagnosed mentally-ill homeless person who has a fist full of prescriptions you can't get filled, what do you do? Who do you call? Do you even know who to call? Harlem hospital has 25,000 psychiatric outpatients, many of them enrolled in Medicaid. How many of their ER patients are there because of an access to prescriptions issue? Does Medicaid collect this data? Have hospital costs gone up in the past couple of months? To simply say there is "no access issue" without any empirical evidence is misleading, possibly costly, and potentially dangerous to patients who rely on state-funded programs for their healthcare including prescription medications.

Increasing Co-pays in the Executive Budget

The Executive Budget calls for increasing co-pays to the Family Health Plus "Buy-in" program to \$5 (generics) and \$15 (brands). My question is: Will these co-pays be mandatory? You will recall that Family Health Plus comes under Medicaid rules, and under those rules, service must be provided whether or not the co-payment is made. Given today's marginal pharmacy reimbursement in Medicaid, Family Health Plus and Child Health Plus, an uncollectable co-payment of \$5 or \$15 becomes in effect a very significant provider cut. On a \$100 brand prescription, if the pharmacy does not collect the \$15 co-pay, the state will pay the pharmacy \$13-\$14 less than the acquisition cost of the drug. The \$5 co-pay on a generic prescription is equally problematic. Furthermore, as an operational matter, we question how the state plans to differentiate between categories of FHP enrollees. We respectfully request that the proposed co-pays be made mandatory or that the proposal be withdrawn.

Moving from an AWP-minus based reimbursement to a WAC-Plus formula

Representatives of the Pharmacists Society met with Medicaid officials several years ago to discuss changing the pharmacy reimbursement formula from Average Wholesale Price (AWP) minus a percentage to Wholesale Acquisition Cost (WAC) Plus a percentage. At the time, the change-over would have been budget neutral, and, more importantly, it would have made pharmacy reimbursement policy more transparent. We provided information that showed the conversion equivalent, but our initiative went unanswered. If New York had made the formula conversion back then, we would not be in the dire situation we are in today. The several states that implemented the change to WAC-based pharmacy reimbursement years ago were not affected at all by the First Data Bank settlement that dropped the value of AWP so precipitously, because WAC is a truer, more transparent and reliable reference price. While pharmacy reimbursement policies in New York place pharmacies in jeopardy of closing, pharmacies in every other state are paid a higher product cost allowance and higher dispensing fees. Many have no co-payments.

We once again call upon the legislature in the strongest terms to reject the proposed additional hidden cut to pharmacies participating in Medicaid, EPIC, ADAP, Child Health Plus and Family Health Plus programs by changing the Medicaid formula from an AWP minus 16.25% to WAC plus 4.68%.

Further, we ask that you seriously consider adjusting our 16-year old dispensing fee to \$7.25 (retail) and \$8.00 for pharmacies that provide the specialized unit-of-use packaging that is required by nursing homes and other residential care settings. This fee is consistent with the fees paid in other states that have product cost allowances as low as they are in New York. (See A1118 Destito/S3901 Addabbo.)

Pharmacists and Pharmacies Expand Access to Immunizations, Saving Millions of Healthcare Dollars

Pharmacists offer a unique opportunity for a modest investment that could bring significant returns in healthcare quality and cost-containment. Immunization provides an excellent example. The statute allowing certified pharmacists to immunize adults with flu and pneumococcal vaccine became law in 2008, regulations followed in the fall of 2008, and in 2009, just one year from authorization, more than 2,000 pharmacists have completed the rigorous training process and over 1,500 have are certified as immunizers by the NYS Board of Pharmacy. Preliminary results estimate that between 600,000-700,000 seasonal flu vaccines were administered by pharmacists in 2009 and over 400,000 H1N1 vaccines will have been administered by the end of this month. Although pharmacies were the last to receive the H1N1 vaccine, the convenience factors – evening hours, weekends and no appointments needed – meant that many more New Yorkers will have had access to immunizations. It is also important to note that this expanded access to prevention means millions of dollars in Medicaid cost savings because of fewer ER visits and fewer hospitalizations.

New York's Medicaid program generates more than \$1.2 billion in rebate dollars

Every prescription filled under the Medicaid program generates rebate dollars under provisions of the federal budget enacted in 1990 (OBRA '90). The federal rebate methodology is a mechanism that guarantees the state access to the 'best price' at which any prescription product is sold in the commercial market. These OBRA '90 rebates in SFY 07-08 brought in \$1.127 billion; in SFY 08-09, \$1.240 billion. And it is estimated they will bring in \$1.314 billion in SFY 09-10. The state's share of those rebates is 25% with the counties getting the other 25% to

offset their Medicaid liability to the state. The state's Preferred Drug Program drives still deeper discounts from the "best price." The PDL supplemental rebates accounted for: \$137.6 million in SFY 07-08; \$165.3 million in SFY 08-09 and it is estimated to bring in \$186.2 million by the end of SFY 09-10. These supplemental rebates are *not shared* with the federal government, and they will grow exponentially as more and more drug categories are added to the list of Preferred Drugs. Combined, the supplemental rebates and the OBRA '90 rebates reduce the net cost of prescriptions in Medicaid, EPIC, Child Health Plus and Family Health Plus by approximately 37%. Given this extraordinary revenue stream into the General Revenue Account that reduces the state's cost for prescription drugs to well below market prices, we find it wholly unnecessary and detrimental to the Medicaid program generally that the state's pharmacy providers are continually targeted with reimbursement cuts that bring them to the brink of financial collapse. No other component in the federal or state Medicaid program drives hundreds of millions of dollars into the state's coffers as does pharmacy year after year.

It is also important to note that a percentage of the Medicaid budget, prescription drug costs – reduced by the rebate dollars – is consistently falling. In SFY 2007-08 state's share of spending on the pharmacy benefit was 2.4% of total Medicaid spending, and in SFY 2008-09 it dropped from 2.3% according to the CMS 37 Reports. We estimate that actual drug cost will continue to go down because rebates will increase through 2012 then, as more brand-name/innovator drugs lose their patents in 2011 and 2012, overall drug costs will drop as generics are only 22% of total drug costs. Some of the most expensive drugs in the Medicaid program today will have A-rated generics in place very soon. The state's Medicaid program has cut generic reimbursement to the bone at a time it should consider the

cost-benefit of any incentives to increase the use of generics and, as an added benefit, strengthen the viability of pharmacies that provide jobs and pay taxes.

Independent pharmacies are holding out hope that the Legislature will intervene. So many have already given up, yet even those numbers belie the real crisis that awaits if the budget process doesn't yield favorable results.

Social Security Administration Medicare Part D Asset Rule Changes Could Save New York Millions in EPIC Wrap Around Coverage for Prescription Drugs

Starting this year, approximately 3 to 4 million more seniors will be eligible for Low-Income Subsidies (LIS) due to program changes made by the Social Security Administration with regard to "asset" definitions. Seniors who apply now for LIS help will no longer have to include "life insurance" values or the extra help they receive to pay rent, utilities, etc. We estimate that between 180,000 - 240,000 New York Part D enrollees may now be eligible for LIS assistance if they apply after January 1, 2010.

The state may be the beneficiary of these changes as well. Of the 28,000 EPIC primary enrollees, thousands may be newly eligible for the LIS assistance. As they qualify for LIS, the federal government takes on greater responsibility for their Part D premiums and drug coverage, and EPIC no longer pays their lower Part D co-payments or their drug costs in the 'donut hole.'

Additionally, EPIC has transitioned 11,000 enrollees into Medicare Advantage programs in January, thereby saving the program approximately \$11 million (based on an average drug spend of \$1,000 per enrollee, per year). This transition saves the beneficiaries over \$100.00 per month on their Part B coverage which is

included with the MA-PD plan. We commend the EPIC staff for so diligently looking out for our seniors and making sure that they get the best coverage for the best price.

Medicare Part D Contract Changes Means Big Savings for New Yorkers

Starting with the 2010 Medicare Part D (prescription drug programs), Pharmacy Benefit Managers (PBM) will no longer be able to hide hundreds of millions of dollars in generic drug “spreads” that have pushed seniors prematurely into the coverage gap or what is referred to as the “donut hole”. It was the Pharmacists Society of the State of New York that uncovered the pricing “spreads” on generics, a PBM-enrichment scheme that was well hidden from pharmacies, the federal government, the plans and seniors. PSSNY met with CMS officials and pressed for regulatory changes at the federal level in Part D programs. I personally worked with seniors who hit the ‘donut hole’. I have seen their ‘explanation of benefit’ reports. I have seen evidence that Medicare Part D PBMs forced seniors to pay far more in out of pocket prescription costs than the same PBM paid the pharmacy. I have seen a “spread” as high as nearly \$800 a month. Here in the Capital District one PBM charged \$400 for the same generic prescription it paid the pharmacy just \$12. The pharmacy’s cash price was \$16. What happened to the patient? The patient saved hundreds of dollars a month by paying the cash price to the pharmacy instead of using her Part D card for the remaining 6 months of the year. Because of the change in Medicare Part D regulations that went into effect January 1, 2010, I estimate that approximately 60,000 New York Medicare Part D enrollees will not hit the donut hole or hit it much later in the year and will reap the benefits of PSSNY’s advocacy for regulatory change at the federal level. When the remaining 14,000 EPIC enrollees, who can enroll in a Part D program, they and the state will save millions. This society will continue to monitor the Part D plan’s charges for

generics submitted by their PBMs. Any “spreads” we detect will be passed on to the sponsoring Part D plan and the Office of the Inspector General at CMS.

Transparency for Prescription Benefit Managers – Much needed reform and Significant Cost-Savings for Businesses and Individuals

What surprises me the most is the audacity of the PBMs to keep the Part D plans and most any other prescription drug plan in the country totally in the dark as to what they pay the pharmacy for a drug. Think about it. How would you feel if you bought a new car and the dealer showed you that you saved 50% over suggested retail only to find out that your neighbor bought the same exact car for 35% less? We call upon the Legislature to pass tough PBM Transparency legislation (A2008 Gottfried/S3930 Duane) to make sure that prescription drug plans have all the information they need to make an informed decision on what the “real price” of a drug is. It is not what the PBM says it is. ***The cost of any prescription drug plan should be going down by 2% a year, taking into account the drug price and increases in utilization.*** If it is not going down by 2%, then that plan, the payers and the enrollees are getting ripped-off! It’s that simple.

The State of New York, its municipalities, school districts and the tax payers will save hundreds of millions of dollars annually by shining the light of “transparency” on all PBMs doing business in this state. PBM’s will argue that transparency will increase prescription drug costs. We say, “Prove It!” We have the documentation that demonstrates clearly that PBMs are hiding hundreds of millions of dollars in revenue because they pay pharmacies far less than they are charging the unions, the states and any other purchaser of prescription drugs. Their excessive profits have made them the darlings of Wall Street but their dollars come at the expense of the business, consumers and state and local governments.

Mandatory Mail Order Prescription Plans – Not Cheaper!

PBMs tout mandatory mail order prescription plans as being “cheaper” than retail pharmacy. Mail order “appears” to be less expensive because the PBMs control all of the data and are loath to share what they have. First of all, PBMs collect rebates from the manufacturers. Although they may share some rebate revenues with their clients, rebates also work to their advantage with their mail-order pharmacy subsidiaries. For consumers, PBM’s make rules such as co-payment amounts, ‘preferred’ drugs, quantity limits, or higher co-payments for using local pharmacies. For independent pharmacies, PBM’s control which pharmacies are in the network, how much they will be paid and when, how much medication can be dispensed, whether a 90-day supply of a ‘maintenance’ medication can be obtained locally, when ‘mail order’ is mandatory, etc. Because PBM’s have a financial interest in their mail order pharmacies, they frequently discriminate against local pharmacies and co-payment policies and other rules. PBMs consider much of their data to be ‘proprietary’, allowing them to bill health plans, unions or other self-insurers more for generic drugs than what they paid to the local pharmacies in their network. It is common for PBM’s to pay the pharmacy under one formula and bill the plans under another more costly formula. I have provided some examples of how this works at the end of my written testimony. (It involves “reference pricing” for generics which has NOTHING to do with what the pharmacy is paid. It applies only what PBMs bill the plan.) Patients who pay a percentage of the drug cost as their co-pay, are getting ripped off every time they fill their prescriptions. Out-of-pocket prescription drug co-pays have skyrocketed over the past 10 years, shadowing the ever increasing profits of the Big Three PBMs. I have also included a chart developed by a truly transparent PBM showing the **per day of therapy cost savings** if retail pharmacies were allowed to fill 90-day supplies of maintenance medications over mail order. Community pharmacy is **\$0.53 per day less expense**

then mail order. Now, \$0.53 per day savings doesn't sound like a lot of money but in the 9-month comparison of mail order to community pharmacy, those 950,000 prescriptions totaled more than \$41 million in savings. One large NY-based union (360,000 covered lives) saved over \$50 million in its first year out of its mandatory mail order program and back to community pharmacy under a newer 'transparent' prescription benefit model. The plan absorbed an 8% drug cost increase and 2% increase in utilization that same year which made their actual savings more than \$70 million. Overall, the union experienced a **2% NET** reduction in prescription costs over the previous year of mandatory mail order. This same union expects to save \$210 million over the next three years. (see slides at end of testimony.) Transparency saves money. Mandatory mail order programs are expensive. Access to local pharmacies are a cost-effective alternative to mail order, and access to a local pharmacist both enhances compliance and drives value to the healthcare dollar.

Mail order only prescription drug plans cost this state thousands of jobs and millions in tax revenue based on income and spending. Mail order prescription drug plans account for 28% of all drug expenditures or \$83 billion in 2009. For NYS, total drug expenditures were \$17.76 billion (6% of national total) with \$4.98 billion of that total going to out-of-state mail order pharmacies. New York sends hundreds of millions in tax payer dollars out of the state every year for tax payer-supported prescription drug plans. **(Total U.S. Drug expenditure for 2009 = \$296 billion NYS = 6% of that total or \$17.76 billion.)**

Pharmacists working with municipal unions have saved unions tens of millions of dollars every year. We call upon the Legislature to pass PBM Transparency as a way to save New York taxpayers and employers over **\$1.365 billion annually**, an

amount calculated from the savings on “spreads” on generics. (Avg. estimated overcharges on generics is 35%. Generic drug dollars equals 22% of the total drug spend. \$17.76 bil. X 22% = \$3.90 billion X 35% = \$1.365 billion in savings)

In conclusion, we ask the Legislature:

- 1.) Change the pharmacy reimbursement formula to WAC + 4.68%;
- 2.) Increase dispensing fee in Medicaid, Child Health Plus and Family Health Plus to \$7.25/\$8.00 for special packaging for residential care;
- 3.) Adopt PBM Transparency as the means to save NYS businesses, consumers and taxpayers over \$1.3 billion annually in drug costs;
- 4.) Consider the financial havoc being wrought on NYS-based businesses as it relates to mandatory mail order programs.

Once again, thank you for allowing us this opportunity to testify today. We'll address any questions that you may have at this time.

Supporting Materials

For the

Pharmacists Society of the State of New York, Inc.

2010-2011

Budget Hearing Testimony

February 9, 2010

Example A: Pre-Sept. 26th Medicaid Reimbursement (same drug):

\$100.00	AWP Published Price Pre-Sept. 26 th .
\$ 78.00	Pharmacy Purchase Price with a 22% discount (That's the highest %)
\$ 22.00	"Spread" for pharmacy on acquisition cost of drug
\$ 16.25	NYS Medicaid AWP - 16.25 % discount off AWP (in statute)
\$ 5.75	Gross Margin for pharmacy on drug acquisition cost
\$ 3.50	Medicaid Dispensing fee (Not paid 80% of the time)
\$ 9.25	"gross margin" for that transaction. It's \$6.25 if the dispensing is not paid.

Example A: Post-Sept. 26th Medicaid Reimbursement (same drug):

\$ 95.00	New AWP Published Price (using 120 basis point markup)
\$ 78.00	Pharmacy's drug acquisition cost with a 22% discount
\$ 17.00	"Spread" for pharmacy on acquisition cost of drug
\$ 15.43	NYS Medicaid AWP-16.25% discount off AWP (has a roll-back equivalent of AWP-20.25%)
\$ 1.57	Gross Margin for pharmacy on drug acquisition cost
\$ 3.50	Medicaid dispensing fee (if paid by recipient)
\$ 5.07*	"gross margin" for that transaction. It's \$2.07 if the dispensing fee is not paid.

* This equals a 55% reduction in a pharmacy's gross margin.

Example B: Pre-Sept. 26th Medicaid Reimbursement Using an Avg. Brand Drug Cost

\$177.00	AWP Brand Drug Published Price Pre-Sept. 26 th .
\$138.06	Pharmacy Purchase Price at 22% off AWP
\$ 38.94	"spread" for pharmacy acquisition cost of drug
\$ 28.76	AWP-16.25% - NYS Medicaid reimbursement discount
\$ 10.18	Pharmacy's "gross margin" on drug acquisition
\$ 3.50	Medicaid dispensing fee (paid less then 20% of the time)
\$ 13.68	Pharmacy's "gross margin" if co-pay paid

Example B: Post-Sept. 26th Medicaid Reimbursement Using Avg. Brand Drug Cost

\$168.15	New AWP Published Price Post Sept. 26 th Court Agreement
\$138.06	Pharmacy Purchase Price with a 22% discount
\$ 30.09	"spread" for pharmacy acquisition cost of drug
\$ 27.32	AWP-16.25% 0 NYS Medicaid Discount
\$ 2.77	Pharmacy's "gross margin" on drug acquisition cost
\$ 3.50	Medicaid dispensing fee
\$ 6.77	Pharmacy's "gross margin" if co-pay paid

** Avg. per Rx loss from uncollected co-pays equals \$1.75 for every Medicaid Rx dispensed.

Example:

Community Pharmacy Generic

<p>Drug "A" AWP \$80.00/100 tablets</p> <p>Pharmacy Cost \$0.08</p> <p>Pharmacy MAC \$0.12</p> <p>Payment Formula MAC + \$2.00 =</p> <p>Client Rate AWP – 50%</p>	<p>Pharmacy Paid on 100 Tablets</p> <p>\$0.12 x 100 = \$12.00</p> <p>MAC + \$2.00 = \$14.00</p> <p>Client Pays</p> <p>AWP – 50% =</p> <p>\$80.00 – 50% = \$40.00 + \$2.00</p> <p>or \$42.00</p>
<p>PBM Makes a Spread of:</p> <p>\$42.00 – \$14.00 = <u>\$28.00</u></p>	

Example:
Community Pharmacy Brand

Retail Pharmacy Rate

AWP \$100.00/100 tablets

AWP - 14% + \$2.00 =

\$100.00 - \$14.00 + \$2.00 = \$88.00

Client Rate

AWP \$100.00/100 tablets

AWP - 12% + \$2.50 =

\$100.00 - \$12.00 + \$2.50 = \$90.50

\$2.50 Spread + Rebate Money

Case Studies in Transparency

Case Study #1 – Before Transparency

- **Large Labor Fund (360,000 lives) in NYC with active and retirees throughout the nation, but mostly within the NYC Metropolitan area**
- **Had a “traditional” (margin-based) PBM pricing arrangement**
- **Key Benefit Features:**
 - **Had mandatory mail order with 2x co-pays (fixed-co-pays)**
 - **Had mandatory generics with co-pay penalties**
- **Fund was experiencing a trend of a 15%-20% annual increase (approx. \$20-\$25 million)**

Case Study #1

Post Switch to Transparent PBM

- **Switched to a fully transparent and auditable PBM in 2006 and did not alter their current benefit**
 - **Removed Mandatory Mail Order**
 - **Implemented new 90-day at Retail**

 - **First year in new program, union experienced a net -2% savings despite an 8% increase in drug prices and a 2% increase in member utilization.**

 - **Savings estimated to be \$50 mil.**
 - **Accounts for a previous 15%-20% trending annual cost increases**
-

	Average Pay Class	Total Claim Volume	Total Days of Illness	Total Off-in- Home Pay	Cost Per Day of Illness	Genetic Utilization
MEP Order	89	540,370	48,092,930	\$95,367,736.07	\$1.98	48.4%
Retail Co-pay Supply	90	411,169	37,005,210	\$53,654,772.07	\$1.45	57.5%
Retail Co-pay Pharmacy	24	5,419,450	130,066,800	\$322,113,150.81	\$2.48	59.9%

Based upon Innoviant Book of Business data
 January 1 – September 30, 2007
 Total cost/claim, including member and plan pay

Fact Sheet PBMs and Mail Order

Background

Pharmacy benefit managers (PBMs) are the largely unregulated drug middlemen that administer the prescription drug benefit portion of health insurance plans for private companies, unions, and governments.

Each of the giant PBMs owns a mail order drug company and attempts to drive its customers away from community pharmacy and into the mail order firm it owns. PBMs argue that this saves consumers and plan sponsors money when, in fact, their motivation is higher profits. As the facts below illustrate, patients overwhelmingly prefer filling their prescriptions at a local pharmacy and it is community pharmacy, not mail order, which saves patients and payers money.

The National Community Pharmacists Association strongly opposes efforts by the PBMs to commoditize the prescription benefit and eliminate the important face-to-face relationship between patients and their local community pharmacist by coercing patients into mail order delivery of their prescription medications.

Given the choice, patients prefer their local pharmacy over mail order.

- Given equal copays and days supply, 83% of consumers prefer filling a prescription at their community pharmacy over mail order.¹
- 72% of consumers oppose mandatory mail order.¹
- Almost half (46%) of consumers disagree that mail order is more convenient.¹
- Half of all consumers feel they would be more likely to make mistakes taking medications obtained through mail order.¹
- 71% of consumers indicated they would be concerned about not having the advice and personal attention of their local community pharmacist if they had to obtain medications through mail order.¹
- In a May 24, 2004, press release, Mark B. McClellan, MD, PhD, administrator of the Centers for Medicare & Medicaid Services said, "Four out of five seniors and people with disabilities prefer to buy their drugs from their neighborhood pharmacies, where they can get face-to-face advice and quick access to their medicines from a pharmacist who knows them."
- A *Consumer Reports* survey recommends the use of independent pharmacies, saying "independents are usually far more attuned to your personal needs and total health picture."²
- Congress, which represents the interests of the American people, rejected mandatory mail order provisions for the Medicare Modernization Act of 2003.

(more)

Consumers, payers, and the government pay more and get less when it comes to mail order.

- Based on the top 10 brand drugs and top 10 generic drugs, mail order costs the plan sponsor more than using community pharmacies.³
- Mail order dispenses cost-saving generic drugs only 30% of the time, while community pharmacies dispense generics at least 46% of the time.⁴

PBMs have a financial incentive to push patients to mail order.

- PBMs make an average \$3.50 for every mail order prescription they fill compared to \$1.40 for a prescription filled at their community pharmacy network.⁵

PBMs steer consumers to their own wholly owned mail order facilities by preventing competitors from being able to effectively compete.

- PBMs usually prevent patients from receiving more than a 30-day supply at the pharmacy, while incentivizing 90-day supplies by their own wholly owned mail order firm.
- Community pharmacies are forced into take-it-or-leave-it contracts with the PBMs because they are not legally able to negotiate contracts as a group with PBMs.

PBMs have an incentive to dispense more expensive brand name drugs over cost-saving generics.

- PBMs earn revenues from their own mail order operations and two general sources: administrative fees—including spread pricing—paid by managed care clients and rebates, discounts, and other monies that pharmaceutical manufacturers pay to PBMs to favor the manufacturers' drugs.⁵
- Rebates are typically paid for single-source branded drugs, but not for most generic drugs. PBMs usually retain a portion, and in some cases all, of the rebate dollars that they collect from branded manufacturers, giving PBMs an incentive to sell more single-source branded drugs, even when cheaper and therapeutically similar or identical drugs are available.⁵
- The giant PBM Medco Health Solutions received more than \$3 billion in rebates in 2004 and kept 44% of the rebates instead of passing them along to their clients. The company also received nearly \$180 million in "service" revenues from pharmaceutical manufacturers, which also were not shared with their clients.³
- 38% of Medco Health Solutions revenue comes from its own mail order operations.³
- PBMs with mail order houses profit by repackaging prescription drugs and selling the repackaged goods at higher per unit AWP (average wholesale price) than the manufacturer originally charged. A study found 15 instances when a branded drug was repackaged and sold at a higher per unit price, sometimes by as much as 176%.⁵
- PBM-owned mail order facilities switch to higher-priced drugs more frequently than nonaffiliated mail order facilities.⁵

(more)

Pharmacy Benefit Manager Licensure and Solvency Protection Act

Section 1. Title.

This Act shall be known and cited as the Pharmacy Benefit Manager Licensure and Solvency Protection Act.

Section 2. Purpose and Intent.

The purpose of this Act is to establish standards and criteria for the regulation, solvency and licensing of Pharmacy Benefit Managers. This Act is designed to promote, preserve, and protect the public health, safety, and welfare by and through effective regulation, solvency requirements and licensing of Pharmacy Benefit Managers.

Section 3. Definitions.

For purposes of this Act:

- A. "Board of Pharmacy" or "Board" means the State Board of Pharmacy.
- B. "Commissioner" means the Commissioner of Insurance.
- C. "Covered Entity" means a nonprofit hospital or medical service organization, insurer, health coverage plan or health maintenance organization, a health program administered by the department or the State in the capacity of provider of health coverage; or an employer, labor union or other group of persons organized in the State that provides health coverage to covered individuals who are employed or reside in the State. "Covered entity" does not include a health plan that provides coverage only for accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit health insurance policies and contracts.
- D. "Covered Person" means a member, participant, enrollee, contract holder or policy holder or beneficiary of a covered entity who is provided health coverage by the covered entity. "Covered individual" includes a dependent or other person provided health coverage through a policy, contract or plan for a covered individual.
- E. "Department" means Department of Insurance.
- F. "Health Benefit Plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the cost of health care services including prescription drug benefits.
- G. "Maintenance drug" means a drug prescribed by a practitioner who is licensed to prescribe drugs and used to treat a medical condition for a period greater than 30 days.
- H. "Multi-source drug" means a drug that is stocked and is available from three or more suppliers.
- I. "Pharmacist" means any individual properly licensed as a pharmacist by the Board.

J. "Pharmacist Services" includes drug therapy and other patient-care services provided by a licensed pharmacist intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process as defined in the Rules of the Board. *DRAFTING NOTE: Use "the practice of pharmacy" definition in the state code.*

K. "Pharmacy" means any appropriately licensed place within this state where drugs are dispensed and pharmacist services are provided. *DRAFTING NOTE: Use the definition of "pharmacy" in the state code.*

L. "Pharmacy Benefits Management" means the administration or management of prescription drug benefits provided by a covered entity for the benefit of covered individuals.

M. "Pharmacy Benefits Manager" or "PBM" means a person, business or other entity that performs pharmacy benefits management. The term includes a person or entity acting for a PBM in a contractual or employment relationship in the performance of pharmacy benefits management for a covered entity.

N. "Usual and Customary Price" means the price the pharmacist would have charged a cash paying (not a patient where reimbursement rates are set by a contract) patient for the same services on the same date inclusive of any discounts applicable.

Section 4. Applicability and Scope.

This Act shall apply to a PBM that provides claims processing services, other prescription drug or device services, or both to covered persons who are residents of this state.

Section 5. Certificate of Authority to act as a PBM.

A. No person or organization shall act or operate as a PBM in this state without a valid certificate of authority issued by the Department. The failure of any person to hold such a certificate while acting as a PBM shall subject such person to a fine of not less than \$5,000 or more than \$10,000 for each violation.

B. Each person seeking a certificate of authority to act as a PBM shall file with the Department an application for a certificate of authority upon a form to be furnished by the Department, which application shall include or attach the following:

(1) All basic organizational documents of the PBM, such as the articles of incorporation, articles of association, bylaws, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to those documents.

(2) The names, addresses, official positions and professional qualifications of the individuals who are responsible for the conduct of the affairs of the PBM, including all members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association and any other person who exercises control or influence over the affairs of the PBM.

(3) A Certificate of Compliance issued by the State Board of Pharmacy indicating that the PBM's plan of operation is consistent with the Pharmacy Practice Act and any regulations promulgated thereunder.

(4) Annual statements or reports for the 3 most recent years, or such other information as the Department may require in order to review the current financial condition of the applicant.

(5) If the applicant is not currently acting as a PBM, a statement of the amounts and sources of funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other principals.

(6) The name and address of the agent for service of process in the state.

(7) A detailed description of the claims processing services, pharmacy services, insurance services, other prescription drug or device services, audit procedures for network pharmacies or other administrative services to be provided.

(8) All incentive arrangements or programs such as rebates, discounts, disbursements, or any other similar financial program or arrangement relating to income or consideration received or negotiated, directly or indirectly, with any pharmaceutical company, that relates to prescription drug or device services, including at a minimum information on the formula or other method for calculation and amount of the incentive arrangements, rebates or other disbursements, the identity of the associated drug or device and the dates and amounts of such disbursements.

(9) Such other information as the Commissioner may require.

(10) A filing fee of \$5,000.

C. The applicant shall make available for inspection by the Department copies of all contracts with insurers, pharmaceutical manufacturer or other persons utilizing the services of the PBM for pharmacy benefit management services. Certain contracts are subject to prior approval as provided in Section 10.

D. The Department shall not issue a certificate of authority if it determines that the PBM or any principal thereof is not competent, trustworthy, financially responsible, or of good personal and business reputation or has had an insurance license or pharmacy license denied for cause by any state

E. A PBM shall maintain a fidelity bond equal to at least 10 percent of the amount of the funds handled or managed annually by the PBM. However, the Department may require an amount in excess of \$500,000 but not more than 10 percent of the amount of the funds handled or managed annually by the PBM. A copy shall be provided to the Department.

Section 6. Certificate of Compliance issued by Board of Pharmacy.

A. Each PBM seeking to become licensed in the state must submit its plan of operation for review in a format to be furnished by the Board of Pharmacy.

B. The Board will review the submission in order to determine if it complies with the Pharmacy Practice Act. The Board shall promulgate rules and regulations concerning, but not limited to, the format required, the filing fee, the requirements for re-certification and any other information

that it may require to complete its review. The fees collected shall be used solely for the purpose of regulating PBMs.

C. If the PBM's filing meets with Board approval, it shall be issued a Certificate of Compliance. Subsequent material changes in the plan of operation must be filed with the Board.

Section 7. Disclosure of ownership or affiliation and certain agreements.

A. Each PBM shall disclose to the Department any ownership interest or affiliation of any kind with: any insurance company responsible for providing benefits directly or through reinsurance to any plan for which the PBM provides services; or any parent companies, subsidiaries and other entities or businesses relative to the provision of pharmacy services, other-prescription drug or device services or a pharmaceutical manufacturer.

B. The PBM must notify the Department in writing within five (5) calendar days of any material change in its ownership.

C. Every PBM shall disclose the following agreements:

1. Any agreement with a pharmaceutical manufacturer to favor the manufacturer's products over a competitor's products or to place the manufacturer's drug on the PBM's preferred list or formulary, or to switch the drug prescribed by the patient's health care provider with a drug agreed to by the PBM and the manufacturer;

2. Any agreement with a pharmaceutical manufacturer to share manufacturer rebates and discounts with the PBM or to pay money or other economic benefits to the PBM,

3. Any agreement or practice to bill the health plan for prescription drugs at a cost higher than the PBM pays the pharmacy,

4. Any agreement to share revenue with a mail order or internet pharmacy company and

5. Any agreement to sell prescription drug data including data concerning the prescribing practices of the health care providers in the state.

Section 8. Maintenance of records; access; confidentiality; financial examination.

A. Every PBM shall maintain for the duration of the written agreement and for 2 years thereafter books and records of all transactions between the PBM, insurers, covered persons, pharmacists and pharmacies.

B. The Department shall have access to books and records maintained by the PBM for the purposes of examination, audit and inspection. The information contained in such books and records is confidential. However, the Department may use such information in any proceeding instituted against the PBM or insurer.

C. The Commissioner shall conduct periodic financial examinations of every PBM in this state to ensure an appropriate level of regulatory oversight. The PBM shall pay the cost of the examination which shall be deposited in a special fund to provide all expenses for the regulation, supervision and examination of all entities subject to regulation under this Act.

Section 9. Annual statement and filing fee required.

A. Each authorized PBM shall file with the Department an annual statement on or before March 1st. The statement shall be in such form and contain such matters as the Department prescribes and include the filing fee established by the Department. It must include the total number of persons subject to management by the PBM during the year, number of persons terminated during the year, the number of persons covered at the end of the year and the dollar value of claims processed.

B. The statement shall disclose all incentive arrangements or programs such as rebates, discounts, disbursements, or any other similar financial program or arrangement relating to income or consideration received or negotiated, directly or indirectly, with any pharmaceutical company, that relates to prescription drug or device services, including at a minimum information on the formula or other method for calculation and amount of the incentive arrangements, rebates or other disbursements, the identity of the associated drug or device and the dates and amounts of such disbursements.

Section 10. Contracts; Agreements must be Approved; Prohibited Provisions.

A. No person may act as a PBM without a written agreement between such person and the PBM.

B. A PBM shall not require a pharmacist/pharmacy to participate in one contract in order to participate in another contract. The PBM shall not exclude an otherwise qualified pharmacist/pharmacy from participation in a particular network solely because the pharmacist/pharmacy declined to participate in another plan or network managed by the PBM.

C. The PBM must file a copy with the Department of all contracts/agreements with pharmacies for approval not less than thirty (30) days before the execution of the contract/agreement. The Department shall consult with the Board on the criteria prior to promulgation. The contract shall be deemed approved unless the Department disapproves it within thirty (30) days after it is filed.

D. The written agreement between the insurer and the PBM shall not provide that the pharmacist/pharmacy is responsible for the actions of the insurer or the PBM.

E. All agreements shall provide that when the PBM receives payment for the services of the pharmacist/pharmacy that the PBM shall act as a fiduciary of the pharmacy/pharmacist who provided the services. The PBM shall distribute said funds in accordance with the time frames provided in this Act.

Section 11. Disclosures to Covered Person and Authorization for Substitutions.

A. When the services of a PBM are utilized, the PBM must provide a written notice approved by the insurer to covered persons advising them of the identity of, and relationship between, the PBM, the insured and the covered person.

B. The notice must contain a statement advising the covered person that the PBM is regulated by the Department and has the right to file a complaint, appeal or grievance with the Department concerning the PBM. The notice shall include the toll-free telephone number, mailing address and electronic mail address of the Department.

C. The notice must be written in plain English, using terms that will be generally understood by the prudent layperson and a copy must be provided to the Department and each pharmacist/pharmacy participating in the network.

D. When a PBM requests a substitute prescription for a prescribed drug to a covered individual the following provisions apply:

(1) The PBM may substitute a lower-priced generic and therapeutically equivalent drug for a higher-priced prescribed drug.

(2) With regard to substitutions in which the substitute drug costs more than the prescribed drug, the substitution must be made for medical reasons that benefit the covered individual. If a substitution is being made under this subparagraph, the PBM shall obtain the approval of the prescribing health professional or that person's authorized representative after disclosing to the covered individual the cost of both drugs and any benefit or payment directly or indirectly accruing to the PBM as a result of the substitution and any potential effects on a patient's health and safety including side effects.

(3) The PBM shall transfer in full to the covered entity any benefit or payment received in any form by the PBM as a result of a prescription drug substitution under subparagraph (1) or (2).

Section 12. PBM Responsibilities to the Covered Entity.

A. A PBM shall provide to a covered entity all financial and utilization information requested by the covered entity relating to the provision of benefits to covered individuals through that covered entity and all financial and utilization information relating to services to that covered entity. A PBM providing information under this section may designate that material as confidential. Information designated as confidential by a PBM and provided to a covered entity under this section may not be disclosed by the covered entity to any person without the consent to the PBM, except that disclosure may be made when authorized by a court.

B. A PBM shall disclose to the covered entity all financial terms and arrangements for remuneration of any kind that apply between the PBM and any prescription drug manufacturer or labeler, including, without limitation, rebates, formulary management and drug-switch (substitution) programs, educational support, claims processing and pharmacy network fees that are charged from retail pharmacies and data sales fees.

C. A PBM shall disclose to the covered entity whether there is a difference between the price paid to retail pharmacy and the amount billed to the covered entity for said purchase.

D. The covered entity may audit the PBM's books and records related to the rebates or other information provided in sections A through C.

E. A PBM shall perform its duties exercising good faith and fair dealing toward the covered entity.

Section 13. PBM Responsibilities to Pharmacist/Pharmacy.

A. A pharmacist/pharmacy may not be terminated or penalized by a PBM solely because of filing a complaint, grievance or appeal as permitted under this Act.

B. A pharmacist/pharmacy may not be terminated or penalized because it expresses disagreement with the PBM's decision to deny or limit benefits to a Covered Person or because

the pharmacist/pharmacy assists such Covered Person to seek reconsideration of the PBM's decision or because the pharmacist/pharmacy discusses alternative medications.

C. Prior to the terminating a pharmacy from the network, the PBM must give the pharmacy/pharmacist a written explanation of the reason for the termination at least 30-days prior to the termination date unless the termination is based on the (i) loss of the pharmacy's license to practice pharmacy or cancellation of professional liability insurance or (ii) conviction of fraud.

D. Termination of a contract between a PBM and a pharmacy or pharmacist, or termination of a pharmacy or pharmacist from a PBM's provider network shall not release the PBM from the obligation to make any payment due to the pharmacy or pharmacist for pharmacist services rendered.

Section 14. Medication Reimbursement Costs; Use of Index Required.

PBMs shall use a current and nationally recognized benchmark to base the reimbursement paid to network pharmacies for medications and products. The reimbursement must be determined as follows:

A. For brand (single source) products the Average Wholesale Price (AWP) as listed in First Data Bank (Hearst publications) or Facts & Comparisons (formerly Medispan) correct and current on the date of service provided shall be used as an index.

B. For generic drug (multi-source) products, Maximum Allowable Cost (MAC) shall be established by referencing First Data Bank/Facts & Comparisons Baseline Price (BLP). Only products that are compliant with pharmacy laws as equivalent and generically interchangeable with a Federal FDA Orange Book rating of "A-B" will be reimbursed from a MAC price methodology. If a multi-source product has no BLP price, then it shall be treated as a single source branded drug for the purpose of determining reimbursement.

Section 15. Timely Payments to Pharmacists/Pharmacies; Audits.

A. If a PBM processes claims via electronic review then it shall electronically transmit payment within seven calendar days of said claims transmission to the pharmacist/pharmacy. Specific time limits for the PBM to pay the pharmacist for all other services rendered must be set forth in the Agreement.

B. Within 24 hours of a price increase notification by a manufacturer or supplier, the PBM must adjust its payments to the pharmacist/pharmacy consistent with the price increase.

C. Claims paid by the PBM shall not be retroactively denied or adjusted after seven days from adjudication of such claims except as provided in paragraph D below. In no case shall acknowledgement of eligibility be retroactively reversed.

D. The PBM may retroactively deny or adjust in the event (i) the original claim was submitted fraudulently; (ii) the original claim payment was incorrect because the provider was already paid for services rendered, or (iii) the services were not rendered by the pharmacist/pharmacy.

E. The PBM may not require extrapolation audits as a condition of participating in the contract, network or program.

F. The PBM shall not recoup any monies that it believes are due as a result of the audit by setoff until the pharmacist/pharmacy has the opportunity to review the PBM's findings and concurs with the results. If the parties cannot agree then the audit shall be subject to review by the Board.

Section 16. PBM Prohibited Practices.

A. A PBM shall not intervene in the delivery or transmission of prescriptions from the prescriber to the pharmacist or pharmacy for the purpose of: influencing the prescriber's choice of therapy; influencing the patient's choice of pharmacist or pharmacy; or altering the prescription information, including but not limited to, switching the prescribed drug without the express authorization of the prescriber.

B. No agreement shall mandate that a pharmacist/pharmacy change a covered person's prescription unless the prescribing physician and the covered person authorize the pharmacist to make the change.

C. The insurer and the PBM may not discriminate with respect to participation in the network or reimbursement as to any pharmacist/pharmacy that is acting within the scope of his or her license or certification.

D. The PBM may not transfer a health benefit plan to another payment network unless it receives written authorization from the insurer.

E. No PBM may discriminate when contracting with pharmacies on the basis of co-payments or days of supply. A contract shall apply the same coinsurance, co-payment and deductible to covered drug prescriptions filled by any pharmacy, including a mail order pharmacy or pharmacist who participates in the network.

F. No PBM may discriminate when advertising which pharmacies are participating pharmacies. Any list of participating pharmacies shall be complete and all inclusive.

G. No PBM may mandate basic record keeping by any pharmacist or pharmacy that is more stringent than required by state or federal laws or regulations.

Section 17. Complaint Process.

A. The Department and the Board shall each adopt procedures for formal investigation of complaints concerning the failure of a pharmacy benefits manager to comply with this Act.

B. The Department shall refer a complaint received under this Act to the Board if the complaint involves a professional or patient health or safety issue.

C. The Board shall refer a complaint received under this chapter to the Department if the complaint involves a business or financial issue.

Section 18. Adjustment or settlement of claims; compensation of PBM.

Compensation to a PBM for any claims that the PBM adjusts or settles on behalf of an insurer shall in no way be contingent on claims experience. This section does not prohibit the compensation of a PBM based on total number of claims paid or processed.

Section 19. Regulations.

The Commissioner and the Board may promulgate regulations to carry out the provisions of this Act. The regulations may include the following: definition of terms, use of prescribed forms, reporting requirements, prohibited practices and enforcement procedures. The regulations shall be subject to review in accordance with general rules of administrative rulemaking and review of regulations.

Section 20. Applicability of other laws and regulations. (*DRAFTING NOTE: Use existing code sections to define the enforcement process including, grounds for license revocation, fines, suspension and reinstatement. If the State has an unfair trade practices act and/or a privacy/confidentiality act then this Act should be subject to those provisions. If not then this Act must include prohibitions against discrimination, false and misleading advertising and protections for privacy/confidentiality of covered person information.*)

Section 21. Separability.

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 22. Effective Date.

This Act shall be effective (insert date). In order to continue to do business in this state, a PBM must obtain a Certificate of Authority from the Department within ninety (90) days after the effective date of this Act.

#12



AARP New York State Office

Testimony before the

New York State Legislature

Joint Hearing

Senate Finance and Assembly Ways and Means

Executive Budget Proposal

Health/Medicaid

February 9, 2010

Hearing Room B

Legislative Office Building

Albany, New York

Introduction

Good afternoon Senator Kruger, Assemblyman Farrell and members of the Committee. My name is Neal Lane, I am member of AARP's New York Executive Council. With me today is Bill Ferris, our State Legislative Representative for New York. AARP is a membership organization with over 2.6 million members in New York State. I would like to thank you for allowing us to speak today about AARP's views on the health care portion of the Executive Budget.

I would like to focus our remarks today on three basic areas that are very important to our membership: prescription drug access and affordability, health care access and affordability and home- and community-based long-term care.

Executive Rx Budget Proposals

Major Cut to EPIC

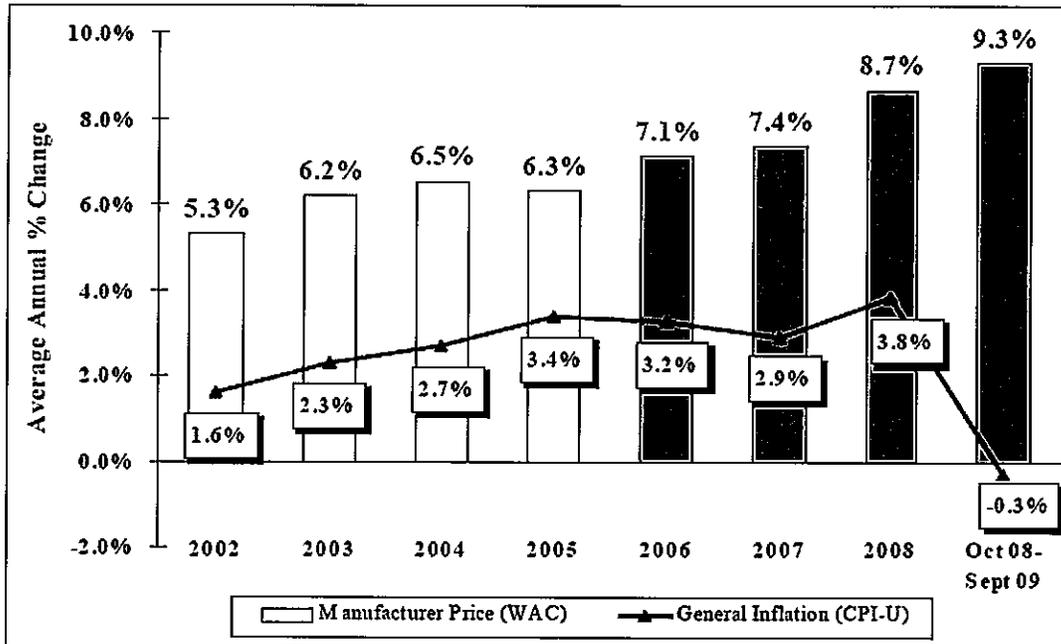
Creating and maintaining access to affordable prescription drugs is a fundamental goal of AARP. For several years, AARP has been tracking the price of prescription drugs through its national *Rx Watchdog* Reports which reveal startling trends in the cost of prescription drugs. According to our *Rx Watchdog* Reports, for the past 8 years, brand name prescription drug costs have been steadily rising from nearly double to triple the rate of inflation.

Numerous health care studies have similar findings and many experts agree that

prescription drug coverage can produce cost offsets from reductions in non-drug services, such as hospitalization and emergency room visits. (See attached AARP Public Policy publication.)

Brand name drugs

Figure 1: Average Annual Percent Change in Manufacturer Prices for Widely Used Brand Name Prescription Drugs Continues to Grow in 2009



Note: Analyses for 2008 and 2009 exclude Zyrtec 10 mg tablets, which began to be sold over-the-counter (that is, without a prescription) in January 2008. Shaded bars indicate years when Medicare Part D was operational.

With that said, it is very upsetting that the Governor is proposing to eliminate the EPIC and Medicaid “wrap around coverage.” The “wrap around” covers prescriptions drugs that Medicare Part D prescription drug plans will not pay for. The Governor’s plan to eliminate the wrap will result in a budget cut of over \$35 million dollars this year and over \$57 million dollars next year in the EPIC program. The impact on the Medicaid program is \$4.3 million dollars this year

and \$5.1 million dollars next year. We respectfully request that the Legislature reject these proposals.

We believe the elimination of the "wrap around coverage" could mean many older adults will not get their medicine and will literally walk away from the pharmacy counter empty handed.

We simply can not let this happen.

AARP believes this proposal greatly contradicts the assurance made by New York State in the past that EPIC and Medicaid would be there for enrollees when Medicare Part D plans won't pay. New York State should not go back on its commitment to a vulnerable population. The average EPIC enrollee is 78 years old and on four prescriptions. EPIC currently provides coverage to over 320,000 low to middle income seniors. In addition, since the EPIC program was combined with Medicare Part D, it has saved New York more than \$400 million dollars over the last several years. AARP has long supported that some of this savings should be used to expand the EPIC program by lowering the age and raise the income eligibility limits.

Rx Gift Restrictions

Governor proposes to codify the pharmaceutical industry's code of conduct which governs the marketing of their products to physicians. Currently, the industry's

code is voluntary and not overseen or enforced by any state or local authority in New York.

The proposed law would focus on the interactions between pharmaceutical companies and health care professionals and would be enforced by the New York State Department of Health. The proposal would ban any cash payments or cash equivalents, entertainment, sporting event tickets and lavish dinners, as well as require accurate promotional materials that reflect the balance between risks and benefits of industry pharmaceutical products. This code of conduct budget language would exclude prescription drug samples that benefit patients.

Pharmaceutical companies, in many instances, influence physicians to prescribe new, high-cost brand name drugs when equally effective, less expensive versions may be available. In 2002, PhRMA developed a code of conduct to govern their interactions with health care professionals. This code, updated in 2009, is completely voluntary and companies have full discretion whether or not to adopt these standards. If adopted, there is no enforcement on the part of PhRMA, and individual companies simply certify annually that they have policies and procedures in place to foster compliance. It is unclear at this time if any enforcement actions have ever been taken by any company since the code was originally adopted.

We believe the pharmaceutical industry should not have any difficulty complying with this proposal since it is largely their code of conduct language that the Governor has proposed to be codified. If the drug industry is following their code as claimed, this law should have no negative economic impact on New York State or the pharmaceutical industry in any manner.

The evidence is clear: doctors and other health care professionals' prescribing practices are indeed influenced by the elaborate, targeted promotions of the pharmaceutical industry. This marketing promotes the newest, most expensive brand name drugs when equally effective, less expensive drugs may be available.

According to a January 2006 article in the *Journal of the American Medical Association* (JAMA), entitled "Health Industry Practices That Create Conflicts of Interest," approximately 90% of the \$21 billion marketing budget of the pharmaceutical industry continues to be directed at physicians. Additionally, according to an April 2007 article in the *New England Journal of Medicine*, entitled "A National Survey of Physician Industry Relationships," 94% of the surveyed physicians reported having a relationship with pharmaceutical sales representatives and close to 30% of those surveyed received payments from drug companies for consulting and giving lectures.

Evidence-based research should be the guide to prescribing the most effective prescription drugs for patients, not sales pitches, gifts and payments from manufacturers to physicians. Drugs should not be prescribed based on the fact that they are new and heavily promoted, but rather on the basis of their effectiveness and value in treating a disease or condition.

New York has a paramount interest in passing this market reform proposal to eliminate the undue influence pharmaceutical marketers have over prescribing decisions. At a time when the New York State health care budget is under enormous pressure from medical inflation and an ailing economy, this simple, straightforward proposal to reduce financial conflicts of interest will improve medical care for patients and save money for taxpayers who fund prescription drug programs, including Medicaid and EPIC.

We strongly urge you to include this proposal in a final budget.

Executive Health and Long-Term Care Proposals

Medicaid

AARP also believes that Medicaid cuts to institutions and home care as proposed by the Executive budget should be scrutinized very closely to ensure that the ability of nursing homes and home care agencies to deliver quality services is not jeopardized. AARP has been vigorously lobbying the Obama Administration and

Congress for increased FMAP to help New York and other struggling states with their Medicaid costs.

Home Care – Personal Cap

I would also like to highlight the personal care services cap that is included in the Governor's Medicaid cuts. The Budget would require seniors and people with disabilities who need more than 12 hours of Medicaid personal care or Consumer-Directed Personal Assistance Program (CDPAP) aide services per day, on average, to switch to the Managed Long Term Care program, the Nursing Home Transition and Diversion Waiver program, or the Long Term Home Health Care program.

AARP believes that limiting personal care is penny wise and pound foolish. Cutting these services could result in the placement of individuals in an institutional setting at a higher cost, and a greatly diminished quality of life, if the program were restricted.

In addition, this proposal could affect workers as well. Workers will not be able to continue to provide services in the setting of the consumer's choice and there will undoubtedly be significant disruptions in services for the consumers. Does the state really want to limit the available workforce when workforce shortage is frequently identified as a significant problem in long term care?

The attempt to restrict personal care hours is not new; it has been tried numerous times over the years. It is a result of the State's failure to address the problem of over-utilization. We need to confront the problem where it exists instead of capping personal care hours for those individuals for whom these services are necessary and appropriate.

We believe the remedy to this problem, is to have an effective case management component that works with the consumer and their informal supports to developed a person- centered plan of care.

Limiting personal care hours will end up increasing reliance on nursing home care, increase Medicaid expenditures and diminish the quality of life for those who would have otherwise been able to remain in the community.

Nursing Home Quality Pools

The Governor proposes to implement the \$50,000,000 nursing home quality pool that was authorized as part of regional pricing on April 1, 2009. The quality pool would be funded through a redistribution of existing nursing home funding. AARP is in strong support of this proposal and we recommend that the Legislature accept this proposal.

LTC County Nursing Home Demonstration

The Budget proposes a five-county demonstration program that encourages counties to transform their nursing home beds into home and community-based services. This has been a long held position by AARP that the state should invest and create more of a balance between funding for institutional care and home and community-based services that are preferred by the majority of older people. However, we believe that there needs to be some clarifying language added to give priority to home and community based services that are non medical in nature such as social adult day care and supports for families caring for individuals in their home.

Assisted Living

The Governor's budget allows more nursing home beds to be converted to the Assisted Living Program (ALP). This continues the Executive's proposal from last year to eventually convert 5,000 beds. AARP is in full support of New York phasing out excessive institutional beds in favor of community-based assisted living so long as these new beds are not exempted from the NYS Assisted Living Reform Act (ALRA). Currently the ALP, which predominately serves Medicaid eligible people, is *exempt* from the ALRA.

The ALRA is an unprecedented consumer protection law in New York that defines assisted living and establishes strong uniform consumer protections and disclosures for assisted living residents.

AARP strongly believes the Governor's proposals would unintentionally create a two-tiered assisted living system in New York. **Low-income assisted living residents would be governed by an inferior set of rules while non-Medicaid assisted living residents would benefit from the strong consumer protections and disclosures under the ALRA.** These consumer protections include a comprehensive individualized service plan, a uniform residency agreement and the ability of the assisted living resident to age in place.

AARP believes that the consumer protections provided by the ALRA should be available to *all* New Yorkers regardless of where they reside on an economic scale. As you know, New York does not have different standards and protections for residents of nursing homes depending on payment source. Similarly, we believe New York should not have different standards for assisted living.

Thank you again for allowing AARP to testify today on both the negative and positive impacts of the Governor's Health and Medicaid Budget proposals. We would be happy to answer any questions.

Thank You.

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Medicaid **Medicaid Matters New York** *Matters*

TESTIMONY SUBMITTED TO THE NEW YORK STATE LEGISLATURE
Joint Hearing of the Senate Finance and Assembly Ways and Means Committees
February 9, 2010

2010-2011 Executive Budget
Health & Medicaid

My name is Lara Kassel. I am the Coordinator of Medicaid Matters New York (MMNY), a statewide coalition of over 130 organizations representing the interests of those most affected by Medicaid discussions. On behalf of our coalition members and the over four million Medicaid consumers we represent, thank you for the opportunity to address you today.

Medicaid Matters NY sees this year's Executive Budget on Health and Medicaid as a mixed bag. At this time of unprecedented fiscal crisis, the Governor has maintained his commitment to community-based, person-centered services in many ways. He has, however, proposed to save money by making cuts in ways that are unacceptable and incongruous with the "patient first" agenda.

As the voice for New York's Medicaid consumers, MMNY is always concerned about cuts to New York's public insurance programs. However, we have never maintained that any cuts are unacceptable, particularly in this time of economic crisis. Our position is that Medicaid cuts can be accomplished in ways that actually strengthen the program and avoid harm to the low-income New Yorker's that depend on Medicaid to access vital services.

The state's Medicaid expenditures have increased recently, and that is not surprising, given the economic downturn. The state should be as prepared as possible for this type of increase as the fiscal crisis continues. MMNY supports the state's efforts to obtain additional support from the Federal government to sustain the system, while constantly striving to make the system work better by buying quality.

MMNY believes that the way to assure the best possible outcomes in reshaping policy and allocating funds is to include the voices and concerns of Medicaid consumers as part of the discussion. This Administration, as well as Members of the Legislature, has already demonstrated a willingness to work with stakeholders in a spirit of partnership that we hope will continue.

Consumer Access

Making sound policy and balancing budgets only works to the benefit of everyday New Yorkers when consumer priorities are realized. That is the heart and soul of the Medicaid

Matters mission. Along with the Spitzer and Paterson administrations, the Legislature has demonstrated a commitment to the health and safety of consumers in many ways, especially in the face of seemingly insurmountable administrative obstacles. We expect that same commitment will continue in enacting a responsible, accountable budget this year.

The following are items proposed by Governor Paterson in this year's Executive Budget that would directly impact consumers:

Simplification

MMNY has long been a leader in efforts to make the public health insurance application and renewal processes as streamlined as possible. Many key simplifications have already been enacted, and we support the proposals in this year's budget that would take us further in this direction.

Two proposals reduce required documentation, which is incredibly burdensome for consumers to produce at the time of application or renewal.

- Individuals enrolled in community-based long term care would be allowed to attest to their income, residency and resources at recertification. Previous simplification efforts have not included people using long term care, so this is a long-overdue measure.
- Documentation would no longer be required for interest income, as long as the amount does not make the person ineligible for coverage.

Three other proposals authorize the state to take advantage of cross-agency data matching for children and adolescents. Allowing state agencies to share database information would alleviate documentation requirements on the part of consumers and their advocates, making it easier to get and keep coverage.

- Express lane eligibility would authorize the state to automatically enroll a child in Medicaid or Child Health Plus if he or she has already been found to be eligible for another public program with similar eligibility requirements, such as food stamps or subsidized child care.
- The budget would authorize the state to use social security numbers for data matching, easing the burden of showing original documentation for children and adolescents.
- The Department of Health would have another database with which to verify income by working with the Department of Taxation to access tax records.

Any mechanism that makes it easier for the Department to verify that a person is eligible for coverage means that the consumer gets a Medicaid card in their hand more quickly, allowing them to access what they need. We support all of these streamlining proposals in the budget.

Family Health Plus

The Family Health Plus Employer Buy-In has now been made more broadly available. The Governor's budget includes rate-setting provisions to move implementation forward. While we see potential for the program, the budget does not go far enough in achieving affordability. We urge more aggressive action by the state to address high premiums and out-of-pocket costs.

Prescription drugs

State Medicaid law has long exempted certain classes of drugs from the preferred drug program (PDP), thereby prohibiting use of prior authorization as a means of restricting access to any of these types of life-saving medications. The four classes of exempt drugs – antipsychotics, antidepressants, antiretrovirals (HIV treatment), and antirejection drugs (post-organ transplant surgery) – should continue to be broadly available. They are drugs that warrant unmitigated access because of their unique nature.

This year's budget banks a small amount of savings for administrative action the Department of Health plans to take to garner pharmaceutical manufacturer supplemental rebates on the four historically-exempt classes of drugs by adding them to the PDP. These drugs warrant guaranteed unrestricted drug access for the particularly vulnerable people who rely on them.

The budget does not propose to change the law as it relates to prior authorization for these four classes of drugs. It is our concern, however, that moving to attain rebates for these drugs moves us one threatening step closer to requiring that they be subject to prior approval, in order to ensure meaningful rebates in the future. While a "prescriber prevails" process exists in the law for drugs included in the PDP, we know that the process is not foolproof. MMNY is strongly opposed to subjecting any medications within the four classes of exempt drugs to prior approval.

Another pharmacy issue of concern to MMNY is presented by the provisions in the budget that would eliminate the Medicaid and Elderly Pharmaceutical Insurance Coverage program (EPIC) coverage that wraps around Medicare Part D. When the Medicare prescription drug benefit took effect, many people faced barriers when attempting to access medications. Medicaid wraparound coverage was initially much more comprehensive than it is now. In recognition of the gains we have made in helping the elderly and disabled negotiate the complex Part D benefit, New York reduced the Medicaid coverage to the four classes of drugs discussed earlier: antipsychotics, antidepressants, antiretrovirals (HIV treatment), and antirejection drugs (post-organ transplant surgery).

Similarly, the EPIC wraparound coverage has been tooled back as Part D coverage has improved. EPIC no longer functions as a payer of first resort on drugs covered by Part D. Instead, EPIC pays only when a Part D plan denies coverage, and EPIC staff is authorized to pursue Part D plans when they deny payment for EPIC members. EPIC has saved over \$7 million for EPIC members and the EPIC program in the last 18 months through pursuit of Part D

plans. Of appeals initiated by EPIC staff, approximately 1,900 of the initiated appeals have been won.

While the Department maintains that eliminating these already minimal wraparound programs would not affect very many people, the protections they afford to the few they help are critical. MMNY is strongly opposed to realizing savings on the backs of elderly and disabled New Yorkers, and opposes elimination of the Medicaid and EPIC wraparound protection to Medicare Part D.

Physical and occupational therapy and medical supplies

The Governor's budget would require prior approval of physical therapy and occupational therapy. It would also impose additional controls on payment for medical supplies, including incontinence supplies, wheeled mobility products, shoes, diabetic supplies, hearing aids, and oxygen delivery systems.

We oppose these proposed measures to require additional constraints on access to physical therapy, occupational therapy and medical supplies. The Department of Health has indicated that it wishes to restrict access to physical and occupational therapy to those for whom normal functioning would be restored. This means that people with disabilities who require such services to maintain their functioning or prevent development of secondary conditions will not have access to vital supports that underpin their independence. When less expensive services are denied and functioning deteriorates and health is threatened, these individuals will end up requiring hospitalization and institutionalization at far greater expense.

State agency efficiencies

The Office of Taxpayer Accountability Interagency Task Force Eliminations bill includes a provision that would eliminate the Medicaid Managed Care Advisory Review Panel (MMCARP). We understand the Governor's desire to streamline state agency proceedings to save the state money. Maintaining hundreds of task forces, advisory panels and commissions is very costly, and given the state of our economy, it makes sense for the proceedings of some of these bodies to be discontinued, as they may no longer serve a distinct purpose. The MMCARP, however, is not one of those bodies.

The MMCARP is an essential forum for discussions that impact people who must rely on Medicaid managed care for the care and services they need. It is the sole mechanism by which the public garners information about the Department's activities related to managed care, and it serves as an important way for consumers and their advocates to air their concerns about managed care and how it impacts them.

As the state moves the majority of New Yorkers on Medicaid into managed care, it is incumbent upon the Department of Health to maintain the deliberations of the MMCARP. In the last year, the Department has implemented statewide mandatory enrollment for all SSI-

related Medicaid recipients. Many districts struggled with implementation, and through the MMCARP, the state stepped in to monitor and suspend enrollment in several parts of the state. The state is now poised to mandate enrollment of HIV-infected Medicaid consumers, despite concerns about specialty access, provider education, and lack of special needs plans. MMNY is strongly opposed to elimination of the MMCARP at this critical juncture.

Comprehensive benefits

Some have said that in austere budget times, the Medicaid benefit package should be cut. Critics say that the state should not be paying for what Federal Medicaid law terms “optional” Medicaid services. Use of the word “optional” to refer to these services is an unfortunate misnomer. The services considered “optional” are by no means optional to the people who rely on them for their health, safety and independence. The list includes prescription drugs, eyeglasses, dental care, hospice, home-care, medical equipment (like oxygen tanks and wheelchairs), and many other essential provisions.

The state has an inherent obligation to continue to provide a meaningful benefit package under Medicaid. The Governor and the Legislature have long recognized that Medicaid consumers are particularly hard-pressed to pay out of pocket for services that are eliminated, and thus will inevitably go without. Our low-income working families and most vulnerable individuals would suffer long-term consequences as well as more immediate acute care needs as a result. We urge you to maintain New York’s commitment to comprehensive Medicaid coverage.

Increasing the Medicaid fraud target

The Governor’s budget would increase the Medicaid fraud target by \$300 million. It is up to the state to investigate potential fraud in the Medicaid program, and it is prudent for the Office of the Medicaid Inspector General (OMIG) to have broad authority in how to reach the targets set by the Governor and Legislature. However, the OMIG’s unlimited, blanket authority has resulted in particularly difficult and inappropriate audit practices.

Investigations of individual Medicaid beneficiaries lack transparency and reliable procedures. Since they are outside of the fair hearing process, individuals do not have access to the claims against them and are often refused documentation supporting the allegations made against them. Consumers and their advocates have reported abusive treatment by investigators. Language barriers, cultural incompetency and general misunderstanding have led to myriad problems and enormous discrepancies in how individuals are treated by local district investigators. It is understandable that the state has an obligation to go after fraud in the Medicaid program, but people should be treated fairly, equitably and with dignity in investigations. Although these investigations are initiated by local districts, the OMIG sets the tone. Since many individuals who have been investigated were actually eligible or relied on bad advice from a local district or enroller, the imposition of civil penalties should be rejected.

In addition, auditing of providers has become unusually onerous. Community-based clinics, independent living centers, and other providers have reported spending tens of thousands of dollars and innumerable staff hours preparing for and going through OMIG investigations. In some cases, the audits have been dropped mid-stream, so the providers have spent time, money and staff resources for no reason. Going after fraud is important, but draining the resources and energy of community-based, safety-net providers that could be better spent on providing services is inappropriate.

Hospitals and clinics

Governor Paterson's budget reflects the Administration's commitment to making public dollars pay for the best possible health delivery system in New York State, continuing the premise of the "patient first" reimbursement reform agenda. MMNY has strongly supported that agenda from its inception in the 2008-09 state budget because of the goals of efficiency, measured good outcomes, and consumer access:

While this year's budget does not make significant investments to further reform the system, we trust that in less slim budget times, the Governor and the Legislature will resume the commitment to invest in charity care and primary care.

Charity care

MMNY is extraordinarily pleased that the Governor's budget proposes to fund hospital charity care on units of service to the uninsured. This is a marked improvement over what was enacted previously, which is a 90/10 distribution – 90% of funding based on antiquated accounting methods that are not transparent, 10% based on how many uninsured people were actually served. Not only does it make sense for the money to go to hospitals that are serving the patients for whom the pool is intended, but in this tight budget climate, it also makes fiscal sense for the state to be able to accurately track how state dollars are being spent.

As transparency and accountability are built into charity care funding, it is incumbent upon the Department of Health to adequately enforce *Manny's Law*, which stipulates the provision of charity care. We know that as the Department's staff roles shrink, enforcement will become more difficult. However, monitoring is crucial. One example of the need for enforcement is the discrepancy between different types of services provided. Recent data has shown that hospitals provide more uninsured care in the emergency room than in clinics because emergency services are required by the federal Emergency Medical Treatment and Active Labor Act. Clinic services should be as easy to get as emergency services, and they are vitally important for follow-up care after someone has been to an emergency room.

It is unfortunate that the Governor wants to cut hospital charity care funding overall. We understand that the state is in dire fiscal straits, but as the number of uninsured rises, charity care funding should be increased or at the very least sustained.

As we have said time and again, cuts of any sort must be done with an eye toward protecting the health care safety net, the providers that serve high numbers of people who use Medicaid and the uninsured. The Governor's proposed cut to charity care does not do that.

Charity care for clinics was not cut in this year's budget. However, a 2% cut was made to the diagnostic and treatment centers (D&TCs) charity care pool last year. Clinics are often where low-income people turn when they lose their insurance. At a time when the number of uninsured people continues to rise, D&TCs should be supported for continuing to serve the most vulnerable New Yorkers.

Primary care

Significant strides have been made over the past couple of years to improve access to quality primary and preventive care. Moving Medicaid dollars to community-based primary and preventive care by reforming reimbursement methodologies and rewarding quality by providing Medicaid enhancements are major accomplishments. MMNY is pleased that the administration did its best to maintain support for previous investments in this year's budget.

In addition, MMNY supports the Governor's proposal to create 100 new slots for the *Doctors Across New York* program, the goal of which is to provide incentives for physicians to practice in medically-underserved areas throughout the state. The funding would come from a redistribution of the way hospitals are paid for indirect medical education. There would be 50 new slots for physician loan repayment and 50 for grants for physician practice costs.

MMNY has supported the concept of the *Doctors Across New York* program since it was originally proposed because it aims to spend public dollars to provide greater access to health services by New Yorkers across the state. In better budget times, we would advocate for the program to be expanded to cover mid-level practitioners, like nurse practitioners, and specialists, like dentists and psychiatrists.

Long Term Care

MMNY has been an ardent proponent of efforts by the state to make Medicaid payment drive quality, efficiency and value. This administration has slowly begun to see the importance of directing resources toward lower-cost, higher-satisfaction home- and community-based long term services and supports. MMNY has urged commitment to some key principles for achieving meaningful long term care reform, such as:

- Realizing consumer preference for and cost-effectiveness of personal care assistance and consumer-directed services;
- The need to eliminate county-to-county disparities in what is provided by Medicaid; and,
- Recognizing the state's legal obligations under the *Americans with Disabilities Act* and the 1999 Supreme Court *Olmstead* decision.

The Governor's budget abides by these principles in some cases, but wholly violates them in others. The administration has indicated that they must address the growth in spending in Medicaid long term care services without a comparable increase in numbers of people served. However, balancing the budget should not be done at the peril of people's health and independence.

Personal care cap

The Governor has proposed to cap personal care and consumer-directed services at 12 hours per day. Anyone needing more than 12 hours per day would be required to switch to another option – the Nursing Home Transition and Diversion Waiver, the Long Term Home Health Care program, or Managed Long Term Care. MMNY opposes this proposal.

Targeting people with the most significant needs who are already being served in the best, most cost-effective way does not make sense. It threatens the ability for people to stay in the community, rather than turning to nursing facilities because the alternative programs would inherently be inappropriate or unavailable to the people with the most need.

This proposal would be a step backward in achieving the goal of spending Medicaid dollars in the best possible way for the most vulnerable people.

Financial burden of community-based providers

Balancing a state budget during dire fiscal times is no easy task. However, MMNY urges the Governor and the Legislature to avoid cuts that will reduce consumer access to community-based services and supports.

The budget would achieve savings by continuing the elimination of the trend factor which was enacted in the Deficit Reduction Plan in December 2009, and by increasing provider assessments. Governor Paterson has emphasized the importance of access to care and services in the community. Home care and personal care are provided to community residents under their own roofs, allowing them to remain in their homes. If possible, the budget must protect the safety-net long term care providers that serve the frail, the elderly and people with disabilities.

County Long Term Care Financing Demonstration Program

The budget would authorize five counties to participate in this program, which would allow them to reinvest funding from downsized county nursing facilities into community-based options, while guaranteeing care for those for whom community-based options do not exist. MMNY supports this proposal.

This idea indicates that the state knows the importance of spending public funding in the best way possible.

Moving Forward

In closing, MMNY encourages you to help safeguard care and services that are genuinely accessible and comprehensive for all New Yorkers. We recognize that in tough budget times, making the right decisions is not easy. Please consider MMNY and the Medicaid consumers we represent throughout your deliberations, and think of us as partners in your efforts. We are available to you at any time to discuss these matters further, and we thank you for your time.

For more information, please contact Lara Kassel, Coordinator of Medicaid Matters New York at lkassel@cdrnys.org or 518-320-7100.

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Empire Justice Center

Making the law work for all New Yorkers

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**The Senate Finance Committee & the Assembly Ways & Means
Committee
Joint Legislative Hearing on the Executive Budget: Health**

**Albany, New York
February 9, 2010**

**Presented by:
Cathy Roberts
Senior Paralegal**

**Prepared by:
Trilby de Jung, Esq., Health Law Attorney
Geoffrey A. Hale, J.D., Ph.D, Hanna S. Cohn Equal Justice Fellow
Cathy Roberts, Senior Paralegal
Kristin Brown Lilley, Legislative Director**



Good afternoon. My name is Cathy Roberts and I am a senior paralegal who focuses on health and public benefits issues at the Empire Justice Center.

With offices in Rochester, Albany, White Plains and on Long Island, Empire Justice Center provides backup, training and support for the legal services offices across the state that represent low-income New Yorkers. We also undertake policy analysis, legislative and administrative advocacy, provide legal representation to low income New Yorkers on an individual basis and in select class actions to improve the way the law impacts those we serve. Empire Justice employs staff attorneys and paralegals specializing in Health and Medicaid, public benefits, Supplemental Security Income (SSI) and Social Security Disability (SSD) benefits, education, public and subsidized housing, legal issues affecting low income immigrants and people living with HIV and AIDS, consumer law, domestic violence and civil rights.

In our health policy analysis, we look for trends in the problems faced by consumers in public health programs statewide, and identify opportunities for systemic improvements. We then work to make those changes possible through administrative and legislative advocacy, utilizing the courts and class-action litigation as a last resort.

Empire Justice is a steering committee member of both Medicaid Matters NY and the New York State Medicare Part D Consumer Coalition. From this health consumer perspective, there is no question that the Governor's Health Budget moves us in the right direction. Low-income uninsured New Yorkers should see their access to Hospital Financial Assistance increase as changes in funding formulas incentivize hospitals to accept more charity care applications. And low-income persons across New York will see their access to public health coverage improve as a result of proposals to simplify enrollment.

Empire Justice Center fully supports these critically important advances – and applauds the Commissioner and his staff for their creativity in using scarce resources, and their steadfast commitment to putting patients first. We are pleased to see that the budget includes proposals designed to move forward with the Family Health Plus Buy-in program – which holds potential as a bridge between public coverage and affordable private insurance. We caution however, that the budget language regarding the Buy-in does not go far enough. The program will remain out of reach unless premiums can be lowered significantly.

We must also register concern about the Governor's cost savings proposals in the areas of pharmacy services, personal care and fraud recovery. Some of these proposed changes take us in the wrong direction by imposing barriers to medically appropriate care and discouraging enrollment by members of culturally diverse populations.

Finally, we strongly oppose the budget's proposed elimination of the Medicaid Managed Care Advisory Review Panel (MCCARP), one of the few health policy advisory panels with several seats occupied by consumer advocates.

CHARITY CARE

Empire Justice Center enthusiastically supports the Executive Budget's proposal to reform distribution of indigent care or charity care funds, although we are concerned about the overall proposed cut to indigent care of \$286 million. New York still has 2.4 million uninsured New Yorkers; many of these are very low-income people. Inevitably, some face serious health challenges each year and need financial assistance in order to access care from hospitals and other providers. New York's indigent care pool makes it possible for hospitals to respond to this need. We hope that the Governor will revisit funding levels should the need prove to be higher than currently projected.

We are very pleased with the Governor's changes to how the money that remains in the indigent care pool is distributed. As numerous reports have detailed, New York has lacked a transparent and fair system for distributing funds from its indigent care pool. Hospitals utilize complex and variable accounting methods to report their indigent care costs, and are allowed to roll bad debt into the final reports. Last year's budget recognized the hard work of a bi-partisan commission on indigent care reform and required that a portion of the indigent care funding provided in 2009 go out according to a new formula developed by the Commissioner. This year's budget takes us further on the path to enhancing the fairness and accountability of funding for hospital charity care.

This year's budget calls for 100% of the funding for non-major public hospitals to be distributed according to the new formula. The new formula ensures that hospitals are reimbursed according to actual units of care provided to actual uninsured patients. Hospitals that would experience significant funding losses as a result receive payments over several years from a pool set aside for transition needs.

This charity care funding reform accomplishes two very important goals. First, it levels the playing field and ensures fairness in the system. Hospitals will be reimbursed only for services actually provided.

Second, it provides an incentive for hospitals to actually provide charity care. This incentive, unfortunately, is sorely needed. Although New York has had a financial assistance law requiring hospitals to provide charity care for several years now, Empire Justice continues to receive reports, both upstate and on Long Island, of barriers that low-income New Yorkers encounter when they try to access that care.

We hear about unemployed applicants for charity care who are turned away because they have not filed income tax returns and thus cannot prove that they have no income. We hear of applicants with income that, although they provide pay stubs to document the amount of their income, are turned away because they cannot provide several years worth of tax filings. We hear of applicants waiting months for a response to applications they have filed. We hear of applicants who are required to apply for Medicaid before applying for charity care, and thus, face collection actions before their charity care applications are considered. Although we are able to take some of these cases and help applicants overcome the barriers imposed by hospital procedures, we fear that many more people go without help and thus go without financial assistance that they do qualify for and should be receiving.

We urge you to support the Budget's proposed changes to Public Health Law 2907-k and put long overdue reform into our distribution of indigent care funds.

STREAMLINING AND SIMPLIFICATION

In recent years, New York has been on the forefront of streamlining and simplifying enrollment in its public health insurance, helping many low-income families gain access to primary and preventive care in their communities. This year, the Executive Budget capitalizes on opportunities presented by recent federal legislation to maximize efficiency in the enrollment process for children and extends simplifications in paperwork at recertification to more adults.

The budget contains several proposals that encourage inter-agency cooperation to help find and enroll eligible children and reduce documentation requirements. First, the budget allows the Health Department to automatically enroll a child in Medicaid or Child Health Plus if they have been found to be eligible for another similar public benefit program such as food stamps, school meals or subsidized child care. The budget would also allow the Health Department to work with the Department of Taxation to verify an applicant's income through tax records. And finally, although federal law will now require original identity and citizenship documentation for the Child Health Plus program (effective July 1, 2010), the budget would allow for data-matching of such documentation using Social Security numbers.

For adults, the budget extends recertification simplification measures already in place for most recipients to adults who need long-term care services in the community (although not for those needing residential care) by allowing them to attest to income, residency, and resources at recertification. It also allows adults to attest to income generated by interest earnings, provided overall income is within the eligibility levels.

We enthusiastically support these important steps forward in program simplification. We applaud the Governor and the Health Department for continuing to

think proactively and creatively to keep administrative costs down and our children and their parents healthy and productive.

PHARMACY SERVICES

The Governor proposes cutting back on the prescription drug coverage currently in place for low-income elderly and disabled New Yorkers. Currently, both Medicaid and EPIC offer some level of "wrap around" coverage for medically necessary drugs that beneficiaries are unable to access through their Medicare Part D plans. Both of these wrap around programs were more comprehensive during the initial roll-out of the Medicare Part D program. What remains of the wraps continue to provide critical protection for some of the most vulnerable of the medically needy and should not be eliminated.

EPIC wrap

EPIC's wrap will pay for Part D drugs denied by a beneficiary's Part D plan, but only after the treating physician has certified that the drug is medically necessary. EPIC staff are then authorized to pursue appeals on the beneficiary's behalf against the Part D plan and hold the plan accountable for drugs that should have been covered. Since the Part D maximization project went into effect in October 2008, EPIC has successfully pursued over 1,900 "first level" appeals. EPIC's appeals project has generated about \$7.3 million in savings to NYS EPIC and its enrollees.¹

Elimination of the limited Medicaid and EPIC wraps will inevitably harm low-income seniors as well as those eligible for both Medicare and Medicaid by preventing them from receiving medically necessary medications. The Governor proposes this elimination based, in part, on the presumption that Medicare Part D plans now function efficiently and effectively, and are capable of providing the necessary coverage for New York's low-income seniors and other dually eligible Medicaid beneficiaries. Unfortunately, there is no clear indication that Medicare Part D plans have, in the words of the New York State Department of Health, "grown up."² Even with recent improvements, Medicare Part D remains a complicated and confusing program that is difficult for many beneficiaries to navigate. Erroneous denials occur frequently and the appeals process is often poorly understood by beneficiaries. As a result, Part D beneficiaries often forego necessary prescription drugs.

The strength of the EPIC wrap is that it both maintains important consumer protections AND contains a mechanism to pursue the Part D plans for payment. In this way, the EPIC wrap provides an important protection for New York's low-income seniors

¹ Report by Mike Brennan to the Medicare Savings Coalition, December 3, 2009.

² Budget Briefing for Medicaid Consumers, New York State Department of Health, January 25, 2010.

unable to mount successful appeals on their own. In addition, by pursuing appeals against the Part D plans themselves, EPIC ensures that New York State does not inappropriately assume costs that should be borne by the plans.

While CMS has strengthened Part D beneficiaries' rights to "transition" medications (providing temporary coverage of medications for new enrollees and existing enrollees, if the plan changes its formulary), there will still be individuals falling through the cracks if they do not understand how or are unable to navigate the appeals/exception request process so that they can continue receiving their medication after their transition supply ends.

When the Part D plans themselves fail to follow the rules, many, many people are adversely affected. Just one year ago, CMS sanctioned two national plans (both operating in NYS), for recurrent, pervasive contract violations. According to the *Wall Street Journal*, thousands of seniors enrolled in one of the sanctioned plans "found they couldn't fill or renew prescriptions for drugs to treat chronic heart failure, seizures, asthma and other medications," because of systemic computer problems which the plan failed to address.³

The other sanctioned plan, Wellcare, improperly denied prescription drug access to hundreds, if not thousands, of beneficiaries during January 2009, according to CMS. About 800 of the 2,500 complaints CMS received involved "immediate need" cases – usually people out of their medications. In CMS's sanction letter, Wellcare was also cited for substantial violations in their processing of Part D-related appeals, including:

- Failure to properly forward adverse claims decisions to the Independent Review Entity
- Failure to timely notify members about decisions of expedited reconsiderations
- Failure to timely implement successfully appealed decisions
- Failure to correctly distinguish between appeals and grievances.

All of these lapses negatively impacted beneficiaries' ability to attain medically necessary medications.

While CMS did eventually intervene and issue formal sanctions, preventing the plans from enrolling any new members until the violations were corrected, substantial harm had already occurred. Here in New York, Medicaid and EPIC provided a prescription safety net to Wellcare and Wellpoint enrollees caught in this mess. Removal of this vital protection will put vulnerable New Yorkers at risk of similar harm in the future.

³ "Wellpoint penalized for botching drug benefits," *Wall Street Journal*, January 14, 2009.

DOH has justified ending the EPIC wrap under the rationale that EPIC is covering drugs when “clinically effective, lower cost alternatives” are typically on a plan’s Part D formulary. However, EPIC only provides wrap coverage after the Part D plan has denied coverage and the person’s physician has deemed the drug to be medically necessary.

Not only are there wide-spread and well-documented problems associated with specific Part D plans, but the reversal rate of Part D plan denials on the whole suggests that plans frequently deny medically necessary prescription medications that should have been approved in the first place. Data provided to CMS by Maximus, the Part D Independent Review Entity (IRE), confirms that for cases that reach the reconsideration appeal stage and receive a hearing decision on the merits, Maximus reversed the plan’s decisions in 53% of the cases overall, and in 59% of the cases involving a plan’s utilization management requirements. Off-formulary exception requests are granted by Maximus 48% of the time.⁴ This means that plans are improperly denying coverage more than half the time, at least for cases reaching the reconsideration appeal stage -- the third level of appeal. EPIC’s own success rate at winning first level appeals is more illuminating still. Out of more than 2,500 appeals filed since the program’s inception in October 2008, EPIC has won 1,900 of them, or fully 75%.

Medicaid wrap

Medicaid also has wrap coverage, but on a much more limited basis. It covers only four categories of drugs – anti-psychotics, anti-depressants, anti-retrovirals, and anti-rejection drugs. These are medications recognized as critical for severe conditions which are prone to serious complications should treatment be interrupted. The Medicaid wrap provides a critical safety net for our most vulnerable dual eligibles by covering these medications when they are denied by the Part D plan.

DOH has indicated that the Medicaid wrap affects very few beneficiaries (1% or less). It is our understanding that the current Medicaid wrap system does NOT have a Part D maximization component – meaning that the pharmacist can bill Medicaid directly without first having to bill the Part D plan. We believe that maintaining the wrap is critical as a safety net measure, but recommend that Medicaid add edits to the EMEDNY system to ensure that the Part D plan be billed first. Even if relatively few beneficiaries will need to utilize the Medicaid wrap, the potential harm to those beneficiaries is too great if we remove the wrap altogether.

It is crucial that New York maintain its prescription safety net. The current EPIC and Medicaid wrap systems were carefully crafted by the Legislature and the Governor in the past, to ensure important consumer protections and to hold the Part D plans

⁴ “Fact Sheet: Part D Reconsideration Appeals Data – 2007.” Available at: http://www.cms.hhs.gov/MedPrescriptDrugApp/Griev/07_Reconsiderations.asp. (Data is from 2007, the most recent year for which data is available.)

accountable. Don't remove it. If anything, add additional resources to EPIC to allow them to pursue appeals beyond the initial level.

PERSONAL CARE CAP

Empire Justice is very concerned about the proposal in the executive budget to cap the number of hours of personal care available to Medicaid recipients. While we understand the need to restrict home care to that which is medically necessary, we feel this goal is best achieved by careful attention to assessment procedures rather than an across the board cap.

Last year, in response to data demonstrating geographic variance in utilization of personal care, the Health Department developed a pilot program establishing Assessment Centers to assist local districts in standardizing authorization of personal care hours. The pilot will take place in three counties beginning this year and is likely to yield both promising assessment tools, and some understanding of the dynamics underlying county variation. The pilot should be given some time to operate and yield results before an across the board cap is instituted.

The cap proposed this year is 12 hours. It will apply to both recipients of personal care, which is utilized more heavily in New York City, and recipients of Consumer Directed Personal Assistance, which is more common upstate. Unfortunately, the cap is likely to impact those in the community most at risk of institutionalization – elderly and disabled recipients with severe disabilities due to quadriplegia, advanced Parkinson's disease, multiple sclerosis, stroke, Alzheimer's disease and other impairments – who need an aide to attend to them at some point during the night as well as during the day.

The Health Department maintains that Medicaid recipients who have needs beyond the cap will still be able to receive the care they need. The budget proposal would allow more than 12 hours of aid service, but only for enrollees in one of New York's waiver programs. We fear that this solution will not be practical for all of those at risk of institutionalization, for several reasons.

First, none of the waivers that would serve as alternatives allow enrollees to direct their own care in the manner allowed under the Consumer Directed Personal Assistance Program, or CDPAP. CDPAP was established in New York in 1980, and just last year the Legislature expanded the program significantly in recognition of the cost savings benefits involved when consumers take charge of scheduling, training and supervising their aides. The program also achieves cost-savings because it allows aides to provide care otherwise required by nurses under the Nurse Practice Act. CDPAP has been very popular upstate, particularly in Monroe County. The program provides

valuable jobs for relative and friend caretakers of disabled persons, jobs that cannot necessarily be replicated by traditional home care agencies.

Second, not all of those currently using CDPAP or personal care will be able to transition into the waivers because of different limitations inherent in each waiver program. The Lombardi program cannot meet the needs of those who need more than eight hours of aide service per day because an individual cost cap applies to this home and community-based waiver program. The AIDS Home Care program will be accessible only to those individuals who have an HIV/AIDS diagnosis. Managed Long Term Care Programs are financed by capitated payments to managed care organizations, none of which look favorably upon enrolling large numbers of high need members. In fact, advocates report that clients in managed long term care who face increased needs over time tend to switch to the personal care program in order to obtain the care they need.

The budget allows those with needs above the cap two other alternatives. They can receive services through a Certified Home Health Agency (CHHA), or they can transition into the Nursing Home Transition and Diversion Waiver (NHTDW). Here again, the barriers are significant. CHHAs are prohibited by law from billing Medicaid for patients who lack "skilled nursing" needs and instead need help only with activities of daily living. The NHTDW has been haunted by administrative barriers since its inception over two years ago.

To date, very few people are enrolled in the NHTDW program, and in some areas of the state, providers are not available at all. Problems include duplicative approval systems for both providers and consumers at the county and state level, lack of standardized training for providers, redundant and cumbersome paperwork, and extensive delays. The program is capped at 5,000 enrollees. The program was intended to help persons trapped inside nursing homes transition out to the community. Even though the budget purports to set up a state funded NHTDW program for overflow, it runs completely contrary to the purpose of the program to fill slots with persons already succeeding in the community.

In sum, the budget proposal for capping personal care hours does not provide meaningful alternatives for those with high needs and thus places them at risk of institutionalization. As such it not only compromises the state's ability to comply with the U.S. Supreme Court's ruling in *Olmstead*,⁵ it compromises our ability to shift care from expensive institutional settings to the community settings most people prefer.

⁵ *Olmstead v. L.C.*, 527 U.S. 581 (1999), holding that the unnecessary institutionalization of people with disabilities is a form of discrimination prohibited by the Americans with Disabilities Act of 1990 (ADA) and that a public entity must administer services to individuals with disabilities in the most integrated setting appropriate to their needs unless doing so would fundamentally alter the entity's service system.

FRAUD RECOVERY

While we recognize the need to pursue Medicaid fraud and the tremendous fiscal value of large recoveries from high volume providers, we do not support the budget's proposal to add civil penalties to the amounts already recoverable, and are concerned about the potential chilling effect of culturally insensitive investigations that target members of vulnerable communities.

We receive reports of fraud investigations against individuals who are far from fluent in English and have received very little assistance in understanding the questions asked on applications. We receive calls on behalf of recipients facing fraud investigations because of resources that should have been exempt. Others tell us they tried to report changes in income after applying only to be told by district workers to wait for recertification to produce the information. Safety net institutions report aggressive and antagonistic pursuit of recoveries for inadvertent billing-errors in programs like dental clinics, which are desperately needed in many parts of the state.

Too often, individual recipients facing fraud investigations are left in the dark concerning the process. They have no clear idea of the evidence that would be presented against them and what opportunity, if any, they would have to defend themselves. Civil or criminal prosecutions are not well suited to address the due process rights of low-income Medicaid beneficiaries at risk for losing not only their health care services, but their limited financial income and/or freedom as well.

While the state must and should pursue potential fraud by large institutional providers and drug manufacturers, for the most part taxpayer resources should not be directed to pursuit of low-income individuals or safety net providers. If such investigations are undertaken, they must be conducted with appropriate sensitivity to the situation's cultural and financial complexities – or we will drive away the very populations and providers that our Medicaid program should be embracing.

ELIMINATION OF MMCARP

Empire Justice Center strongly opposes the executive budget proposal to eliminate the Medicaid Managed Care Advisory Review Panel, known as MMCARP. While we understand the need to consolidate functions and eliminate unnecessary commissions whenever possible, the timing could not be worse for elimination of one of the few standing advisory panels that includes consumer advocates as members.

New York is aggressively expanding requirements for all Medicaid recipients to enroll in Managed Care. Last year we saw the expansion of mandatory managed care for all SSI-related Medicaid recipients, a population that is either elderly or disabled and thus presents special challenges in terms of negotiating the complexities of Medicaid

managed care – a system in which specialty networks can vary considerably, key services, such as mental health and pharmacy are carved out, and where enrollees must choose a plan or face auto-enrollment.

Changes to the program continue at a relatively rapid pace, and MMCARP has provided a critical means of communicating these changes to the constituents of the members of the panels, both plans and consumers, as well as a means for questions and concerns to be relayed to Health Department Staff.

For example, the Center for Medicare and Medicaid Services (CMS) has just approved addition of persons with HIV to New York's mandatory managed care program. While the Health Department has not yet identified a date for implementation of this newest expansion of the program, consumer populations are concerned about the lack of Special Needs Plans for those with HIV, and the lack of provider networks in many areas of the state.

This past year several upstate counties and New York City experienced extremely high auto-assignment rates for individuals with disabilities newly mandated into managed care. Fifteen counties experienced rates in excess of 20%, the highest level considered acceptable by CMS. More than half of those counties reached auto-assignment levels of over 30%. High auto-enrollment rates are an indication that county outreach to consumers needing to choose a managed care plan are far from successful. Auto-enrollment also indicates a lack of consumer awareness and involvement in transitioning into managed care, which makes disruptions in services and even coverage far more likely.

MMCARP responded to these high auto-enrollment rates by requesting information and investigation, which led to intervention by the Department of Health and suspension of auto-assignment in several counties. While the Health Department has been very responsive to requests from MMCARP members, and has worked hard to bring down auto-enrollment rates, mechanisms for ensuring this accountability would have to be re-invented were MMCARP to be dissolved.

Looking forward, we can hope to see more innovative service delivery options integrated into New York's Medicaid managed care program, such as the promising Medical Homes initiative currently under development. Such initiatives present a more proactive role for MMCARP. The panel's unique partnership of plan representatives, provider organizations, consumer advocates and Health Department staff have no other mechanism for working together to develop policies for managing care in New York's Medicaid-related programs.

While we would not oppose some changes to the statute that created MMCARP in order to ensure fresh representation and perhaps more realistic output, we would

very much oppose complete elimination of a panel-so important for consumer education and input into state policy initiatives.

Conclusion

Thank you for the opportunity to present testimony about the Governor's Executive Budget Proposal for FY 2010-2011. Should you have any questions, please do not hesitate to contact Cathy Roberts in our Albany office at 518-462-6831, x112, or Trilby de Jung in our Rochester office at 585-295-5722.



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TESTIMONY

OF

JOAN SIEGEL

SENIOR POLICY ASSOCIATE FOR HEALTH AND MENTAL HEALTH

PRESENTED TO THE

NEW YORK STATE SENATE FINANCE COMMITTEE

AND

NEW YORK STATE ASSEMBLY COMMITTEE ON WAYS AND MEANS

REGARDING THE

NEW YORK STATE EXECUTIVE BUDGET PROPOSALS FOR

DEPARTMENT OF HEALTH

STATE FISCAL YEAR 2010-2011

FEBRUARY 9, 2010



Good Morning. My name is Joan Siegel and I am the Senior Policy Associate for Health and Mental Health at Citizens' Committee for Children of New York (CCC). CCC is a 66-year-old privately supported, independent, multi-issue child advocacy organization. CCC does not accept or receive public resources nor do we provide direct service or represent a sector or workforce. For 66 years CCC has undertaken public policy research, community education and advocacy activities to draw attention to what is or is not for working for children in New York and to advance budget, legislative, and policy priorities—all with the goal of ensuring that children are healthy, housed, educated and safe. I would like to thank Chairman Farrell and Chairman Kruger and members of the Assembly Ways and Means and Senate Finance Committees for this opportunity to testify on the Governor's Executive Budget for Fiscal Year 2010-2011.

It is clear that New York's troubled economy and staggering budget deficit demand long-term structural budget changes and not short-term fixes. That said, while all New Yorkers are reeling from the downturn, few are likely to be hit harder than poor children and their families. We must not allow this year's budget to eliminate the safety net that is needed to ensure a generation of vulnerable New Yorkers reach their full potential.

Governor Paterson's \$134 billion Executive Budget proposes to close a \$7.6 billion gap by raising revenue and reducing state expenditures. While the budget protects many essential programs for children and families, we urge you to negotiate an Adopted Budget that goes further to ensure that needed investments in programs that produce positive outcomes for children, are maintained in these difficult economic times.

We urge the legislature to negotiate a budget that uses fairness as a guiding principle and considers the effectiveness of programs to make deliberative choices about where the expense side of the budget needs to be reduced. For example, instead of zeroing out all programs currently funded by TANF dollars, we urge you to look at those programs individually and restore those that are cost-effective and produce outcomes that will save the state money in the long-run—including home visiting programs, alternative to detention and incarceration programs, the Advantage After School Program, Summer Youth Employment, child welfare preventive services, and homelessness prevention services. All of these programs have

demonstrated that they are effective at preventing more costly interventions later such as special education, foster care, juvenile detention and the need to live in homeless shelters.

We also ask the State Legislature to work with the Governor and Metropolitan Transportation Authority (MTA) to prioritize the restoration of state subsidies for free student MetroCards. Without this critical student resource, the 584,000 city students who receive free or half-fare MetroCards would all receive half-fare cards beginning next September and be responsible for paying the full fare in September 2011. This adds up to an additional expense of nearly \$700 per student in a school year.¹ This cut would disproportionately impact low-income students and families as well as families with multiple school-age children who may already be struggling to meet the ever-increasing cost of living in New York City. Most alarmingly, these cuts place students who are already at-risk for truancy and dropping out in greater jeopardy of being disconnected from the school system altogether, by taking away a basic resource that supports full attendance and positive school engagement.

Fairness also requires that the State's 2010-2011 Budget is not balanced by shifting costs to counties in general, and New York City specifically. Mayor Bloomberg has estimated that the Executive Budget would impose \$1.3 billion in cuts and New York City and lead to almost 19,000 layoffs to a workforce providing critical services to New York City residents. Please do not forget that this is a very difficult budget year not only for the State but for the counties as well - it is unfair and disingenuous for the State to balance its budget by shifting costs for essential services to the counties. CCC urges the State Legislature and the Governor to negotiate a budget that maintains a balance of shared responsibility so that counties are not forced to cut essential services. We strongly urge you to reconsider proposals that would eliminate New York City's AIM (the only county for whom this is proposed), shift \$51 million in mandatory summer special education costs, and shift \$55 million for adult homeless shelters.

¹ In 2008, the cost of the student \$239 million MetroCard subsidy program was shared between the city and state at \$46 and \$45 million respectively. In 2009 however, the state share fell to \$6 million. "Students See Hard Future If Free Fares Are Ended." New York Times, December 17, 2009.

In addition, we urge you to support revenue-generating proposals, particularly those that will improve the health and well-being of New Yorkers. CCC strongly supports imposing an excise tax on sugar-sweetened beverages as a means to take a critical step towards addressing childhood obesity and the associated illnesses such as diabetes and heart disease. In addition, we support increasing the tax on cigarettes by \$1 per pack, which is estimated to prevent 100,000 children from becoming smokers. We also urge you to consider increasing the excise tax on beer, a beverage often marketed to youth and a contributor to alcohol-related illnesses and addictions.

Turning to proposals related to the **Health** budget, CCC is pleased that the Governor's Proposed State Budget for 2010-11 protects many critical health services for children including expanding Child Health Plus (CHP) benefits to include medically necessary orthodontia and changing insurance law so that Early Intervention is considered medically necessary and therefore reimbursable by insurance companies. The monies collected under this last proposal will be substantial; according to the Governor's plan private insurance companies pay only 2% of the total gross E.I. costs (about \$13 million) even though 44% of children receiving E.I. services have private insurance coverage

On the other hand, the Executive Budget includes several proposals that will have long-term negative impacts on the health and well-being of New York's Children. We urge the legislature to negotiate a budget with the Governor that rejects the following proposals:

- **Imposing a quarterly parent fee for Early Intervention (EI) services for families.** CCC believes that there should be no parental fee and if there must be one, then the income threshold for the parent fee should be increased from the proposed 250% of the federal poverty limit to 400% of the federal poverty limit. Research demonstrates that every dollar invested in early childhood programs produces \$3.78-\$17.07 return in savings, due to decreased crime, decreased child abuse and neglect, and decreased need for special education or reliance on public assistance. Given these outcomes, it is in the state's best interest to ensure that infants and toddlers with needs have access to Early Intervention at the earliest possible age and that parents, in particular the poor and working poor, do not face barriers to accessing these services. CCC does not want any infant or toddler to lose out on these critical, life-changing services because his/her

parents are strapped for funds during the economic downturn. Pursuant to the Article VII bill, if a parent did not pay the fee for a quarter, the infant or toddler would not only lose the services, but also eligibility. This means that should a family's economic situation change and a parent's capacity to pay change, the eligibility process would need to be started all over again, thereby establishing an unacceptable barrier to care.

- **Requiring early intervention providers who receive payments of more than \$500,000 to bill third party payors** prior to seeking payment from localities, including New York City. Since individual service providers are inexperienced at doing this, they may not bill correctly (resulting in less money or no money to offset Medicaid costs). Insurance and Medicaid billing are complex processes – some government agencies have entire units devoted to this matter. This proposal is unduly burdensome on providers, would delay funds and thus hinder the providers' ability to provide services to children. The projected savings is minimal (\$0.4 million for 2010-11 and \$1.7 million in 2011-12), but will have significant ramifications on access to services for children.

Finally, we are concerned about children's continued access to clinic based mental health services as it relates to Medicaid. Publicly funded community-based mental health clinics are the first intervention in the lives of persons with mental health needs and more serious emotional disturbance and the only means of accessible services for the poor and moderate income New Yorkers. Typically clinics serve a wide mix of clients who have services covered under Medicaid fee-for-service, Medicaid managed care, and commercial insurance. Historically, payment rates for mental health services under all these coverage options have not kept pace with the actual cost of care and to make up for deficit financing, the state has used COPS add ons to keep clinics whole. The clinic rate restructuring effort underway would improve the rate for Medicaid fee-for-service patients, while phasing out the COPS payment add ons. Make no mistake, Medicaid managed care plans and commercial insurance rates also need to be dramatically improved upon if clinics are to survive this transition. Regrettably for children, the continued disparity in rates across fee-for-service Medicaid, Medicaid managed care plans, and commercial insurance also contradicts the intent of mental health parity in Timothy's Law. CCC is bringing this issue to the legislature's attention so that managed care and commercial insurance rates are addressed as clinic restructuring moves forward. It is essential that clinic rate

restructuring does not result in children losing access to services needed for mental health treatment.

In closing, we ask the Assembly and the Senate to negotiate a budget with the Governor that protects our youngest New Yorkers from paying for this economic downturn for the rest of their lives. While we appreciate that very difficult choices about revenue increases and expense reductions that need to be made, we urge you to protect the services that will ultimately be less costly to the children of today and the taxpayers of tomorrow.

Thank you for the opportunity to testify.



NYFAHC



841 Broadway #301
New York, NY 10003

646/442-4184 Tel
212/674-5619 TTY

212/254-5953 Fax
NYFAHC@CIDNY.org

New Yorkers For Accessible Health Coverage

13D

Member Organizations

American Association of Kidney Patients,
New York chapter
American Cancer Society
American Diabetes Association
Brain Tumor Foundation
Cancer Care
Care for the Homeless
The Center for Independence of the Disabled, NY
Cystic Fibrosis Foundation, Greater New York
chapter
Disabled in Action of Metropolitan New York
Epilepsy Foundation of Greater New York
Gay Men's Health Crisis
Hemophilia Association of New York
Huntington's Disease Society of America, New
York and Long Island chapters
Interagency Council of Mental Retardation and
Developmental Disabilities
Leukemia & Lymphoma Society, New York City
chapter
Mental Health Association of New York City
Mental Health Association of Westchester County
National Alliance for the Mentally Ill -
New York State
National Aphasia Association
National Marfan Association
National Multiple Sclerosis Society, Capital,
Long Island, New York City, Southern,
and Upstate chapters
New York AIDS Coalition
New York Association of Psychiatric
Rehabilitation Services
SHARE: Self-Help for Women with Breast and
Ovarian Cancers
SLE Foundation
West Islip Breast Cancer Coalition for Long Island

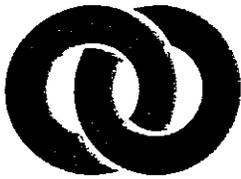
Cooperating Organizations
Alliance of Resident Theaters of New York
Brooklynwide Interagency Council of the Aging
Citizen Action of New York
Commission on the Public's Health System
Community Healthcare Network
Community Service Society
Dance Theater Workshop
Greater New York Labor-Religion Coalition
Institute for Puerto Rican and Hispanic Elderly
Joint Public Affairs Committee for Older Adults
Lambda Legal Defense and Education Fund
Long Island Progressive Coalition
Medicare Rights Center
Metro New York Health Care for All Campaign
National Association of Social Workers,
New York City chapter
New York State Health Care Campaign
New York State Nurses Association
New York State Psychological Association
New York Statewide Senior Action Council
Senior Services
Society for Hospital Social Work Directors,
Metropolitan New York chapter
South Fork Community Health Initiative
William F. Ryan Community Health-Center

Testimony to the Joint Budget Hearing of the Senate
Finance Committee and Assembly Ways and Means
Committee on the Executive Budget - Health Care

February 9, 2010

Testimony By:
Heidi Siegfried, Esq.
Director of Health Policy
Center for Independence of the Disabled
Program Director
New Yorkers for Accessible Health Coverage





Good Afternoon. My name is Heidi Siegfried and this testimony is submitted on behalf of New Yorkers for Accessible Health Coverage (NYFAHC) a statewide coalition of 53 voluntary health organizations and allied groups who serve and represent people with chronic illnesses and disabilities, including cancer, HIV/AIDS, cognitive impairments, multiple sclerosis and epilepsy. NYFAHC is a project of Center for the Independence of the Disabled, NY. We appreciate the opportunity to share with you our thoughts about the New York State's Executive Budget Proposal and our recommendations.

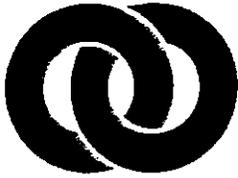
Because the conditions affecting the individuals and families we represent do not discriminate between rich and poor, we advocate for accessible, affordable, comprehensive and accountable health insurance for the privately insured, as well as those in need of access to public insurance programs. In 2010, with New Yorkers continuing to lose employer based coverage and turning to the direct pay market and public coverage, it is even more critical that the seriously ill and disabled have access to the coverage required to maintain life and health. Unfortunately, there are SFY 2011 proposals that will shift costs to people with serious illnesses disabilities who can ill afford them. Some proposals, while appearing neutral on their face, will have the result of encouraging people with disabilities to seek services in less integrated and more costly settings: emergency rooms, hospitals and nursing homes. These proposals are certainly in conflict with the Governor's "patients' first" agenda. They risk undermining the State's ability to comply with federal civil rights law. They will also undermine the State's efforts to achieve savings.

PROTECT ACCESS TO PRIVATE HEALTH COVERAGE

NYFAHC strongly supports the prior approval proposal included in the Executive Budget. This proposal would: (1) restore the authority of the state Superintendent of Insurance to approve health insurance premium rates by eliminating the ability of health plans to increase health premiums by simply filing a rate increase and using it (the alternate "file and use system"); (2) restore public hearings prior to approval when the aggregate increase in premium for that policy form is more than 10%; (3) increase the minimum "medical loss ratio" to 85% for individual direct pay and small group markets from 80% and 75% respectively.

NYFAHC supports the proposed "medical loss ratio" increase to 85%, but requests that the legislature adopt a "medical loss ratio" of 90% for individual policies. This would create an objective standard that would force insurers to operate under simulated market conditions, improving efficiency and lowering premiums for all New Yorkers. Even a 90% "medical loss ratio" still permits 10% of premiums to cover administrative expenses and profits.

Significantly, these changes will protect consumers and businesses from unduly burdensome rate increases. But more importantly, they will cap rate



increases *before* they take effect, preventing increases that could force consumers who are most in need from dropping their coverage.

The Governor has estimated that this proposal will reduce health insurance premium increases by 3% and prevent approximately 45,000 people from losing their insurance and moving into available public health insurance programs for an annualized savings of \$150 million.

While restoring prior approval and increasing the medical loss ratios are an important first step to addressing the crisis in the direct pay market, the disaster in the direct pay market requires additional intervention. New York's direct pay market has plummeted from over 100,000 in 2000 to an less than 40,000 today due to premiums that have become unaffordable. The principle reason is that the stabilization (reinsurance) pools set up to offset the effects of high cost medical claims have been underfunded, and now cover less than 40% of claims eligible for reimbursement. While medical costs have increased steadily and this market has experienced an ever-increasing concentration of people with high cost medical claims, funding has not been increased since 2003.

The Governor's budget unacceptably perpetuates this decreased level of funding, while continuing to support another program, Healthy New York, which has a limited benefit package, which does not meet the needs of people with serious illnesses or disabilities. The direct pay market provides comprehensive coverage for those needs. NYFAHC believes that the Healthy NY and direct pay reinsurance pools should at the very least be aggregated and then shared equally between the two markets.

Another way to protect the individual market would be to merge it with the small group market. NYFAHC supports a merger of the direct pay and small group markets which has been estimated to reduce individual premiums by more than 35% and raise small group premiums by 3%. We believe this is a necessary stop gap measure to keep the market functioning.

PROTECT ACCESS TO PUBLIC HEALTH COVERAGE

Reject the proposal to cap Personal Care and Consumer Directed Care.

The Executive Budget proposes to limit personal care services to 12 hours per day and to shoehorn recipients requiring services in excess of this cap into managed care programs which have not been designed for them. The State anticipates that this will affect 5,000 frail elderly and severely disabled individuals and save \$30 million in 2011 with annualized savings of \$48.7 million. NYFAHC is concerned that implementation will lead to disruption of care and backlogs of applications. Service gaps during a transition could force people into nursing homes. Currently, 5,000 of the 73,000 individuals receiving home care or CDPAP home care have such severe disabilities due to advanced Parkinson's disease, multiple sclerosis, stroke, Alzheimer's disease, quadriplegia and other disabilities, that they need assistance day and night. They are medically stable, but need personal care.

New Yorkers For Accessible Health Coverage



services to help them to go to the bathroom, administer a nebulizer, turn over in bed to prevent deadly pressure sores that require hospitalization, or stay safe when they wake up at night.

New York State proposes to transfer these people to alternative programs that will simply not be able to meet their needs: (i) Certified home health agencies will not accept these individuals because they lack a skilled medical need; (ii) the long-term home health care program cannot meet the demands of those who need more than 8 hours of service because of the individual cap (75% of the cost a nursing home for each enrollee) that applies to this program; (iii) AIDS home care is available only to those with an AIDS diagnosis; (iv) managed long-term care plans are incented by their capitated rate structure to avoid enrolling people with higher health needs and to deny services to those enrolled; (v) the nursing home transition and diversion waiver's development has been stymied by cumbersome provider and consumer paperwork related to enrollment and service and enrollment of so many high need individuals would exceed the aggregate cost cap required by federal law and the Governor's proposal to supplement the waiver with state funds would both negate cost savings and may not be approved by CMS. These options are simply not a viable solution.

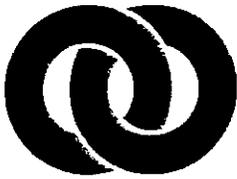
New York State instituted a demonstration program last year, the Long Term Care Assessment Centers to replace county assessment and enrollment operations. The law mandated the new centers to begin operations for new applicants after January 1, 2010, but that implementation has been delayed while the Department extended its deadline to respond to its Request for Proposals beyond October 15, 2009. This demonstration should be given an opportunity to show that it can identify over-utilization and substitute an appropriate level of service before experimenting statewide on thousands of vulnerable people who could be harmed by limiting care.

The State's proposal risks censure by the courts for failure to comply with the U.S. Supreme Court's 1999 Olmstead ruling. This decision held that individuals with disabilities must be served in the most integrated setting. New York has already been found to be in violation of federal law in another matter and has failed to develop an Olmstead plan.

ENCOURAGE ENROLLMENT IN PUBLIC HEALTH CARE COVERAGE

Support proposals to reduce documentation requirements.

Two Executive Budget proposals reduce required documentation, which is incredibly burdensome for consumers to produce, at the time of application or renewal. Documentation would no longer be required for interest income, as long as the amount does not make the person ineligible for coverage. Individuals enrolled in community-based long term care would be allowed to attest to their income, residency and resources at recertification. Previous simplification efforts have not included people using long term care, so this is a long-overdue measure.



Eliminate the asset test for the SSI population applying to Medicaid and seeking community Medicaid. The State has taken many actions to ease the community Medicaid application process for families and children. Unfortunately, people with disabilities and seniors have been left behind in this effort. This is an omission that the State should correct.

Expand the facilitated enrollment program for Medicaid to SSI-related applicants through community-based disability serving organizations. For those without disabilities, the facilitated enrollment program is an invaluable resource for low-income individuals and families attempting to navigate the health insurance maze. However, facilitated enrollers are prohibited by contract from preparing SSI-related Medicaid applications and lack the expertise and the community connections to assist people with disabilities. This important navigational assistance should not be denied to those who would benefit most. Easing access to coverage in this way would surely decrease the cost of uninsured care borne by State taxpayers.

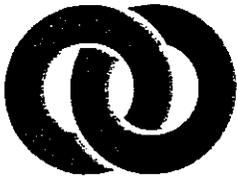
PROTECT ACCESS TO HEALTH COVERAGE

Reject additional constraints on access to physical therapy, occupational therapy, and medical supplies.

The Executive Budget proposes requiring prior approval of physical and occupational therapy for a savings of \$3.5 million and additional controls on payment for medical supplies including: incontinence supplies, wheeled mobility products, shoes, diabetic needle supplies, hearing aids and oxygen delivery systems. This means that people with disabilities and serious illnesses who require such services to maintain their functioning or prevent development of secondary conditions might not have access to or have only delayed access to vital supports that underpin their independence. When less expensive services are denied and functioning deteriorates and health is threatened, these individuals will end up requiring hospitalization and institutionalization at greater expense to New York's taxpayers.

Retain the exemption for four classes of drugs from preferred drug list (anti-rejection drugs; anti-psychotics; anti-depressants; antiretrovirals).

The Executive Budget proposes savings related to pharmaceutical manufacturing supplemental rebates on four classes of drugs that it would add to the preferred drug list. We support State efforts to seek rebates, but recommend rejection of these proposals. These drugs would continue to be exempt from prior authorization, for now. However, this action brings the State closer to subjecting the drugs to prior approval. The State should not remove the protection that has ensured that people with psychiatric disabilities, those with AIDS and transplant recipients will be able to obtain drugs that meet their needs. It can be difficult to establish which drug will benefit an individual and it can be dangerous to attempt to switch individuals from a therapy that is effective to one that has both been tested and failed or whose effect is unknown. New York should not risk the lives of these individuals.



Reject elimination of EPIC and limited Medicaid wrap around to Medicare Part D Drug coverage.

The proposed budget provides that the EPIC Part D wrap-around will no longer cover the cost of drugs for seniors who are EPIC-eligible when no payment or reimbursement is made by a Medicare Part D plan. This means that if a patient's Part D plan changes its drug formulary mid-year or a patient is prescribed a new drug that is not on the formulary they could experience a gap in coverage and go without the medication. While we agree that Part D coverage should be maximized, the better way to do this is to continue the EPIC program which files appeals on behalf of their members for people, whose Part D plan denies a drug, coordinating with the prescribing physician when clinical information is required. Since its inception on October 1, 2008, over 1900 positive determinations have saved the state over \$7 m. This figure does not include the projected savings on refills and new prescriptions for the same drug. Older New Yorkers with disabilities and serious illnesses depend upon EPIC for life-saving drugs. Eliminating Medicare Part D wraparound coverage is putting those who need drug coverage the most at risk.

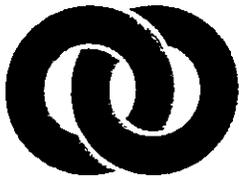
Medicaid provides limited wrap around coverage to Part D plans to lower income people with disabilities for four categories of drugs – atypical antipsychotics, antidepressants, anti-retrovirals used to treat HIV/AIDS and anti-rejection drugs used by organ and tissue transplant recipients -- when a Medicare prescription plan refuses to pay for them. It is difficult for people with depression to find a medication or combination of medications that works for them. Once they have found an effective regime, switching medications would mean that some would fall back into depression and be at risk of becoming so discouraged that they stop all medication, or even commit suicide. Any one on immunosuppressive medications should not change from one generic to another or from brand to generic or generic to brand without doctor's approval and supervision. For many seniors and people with disabilities, these drugs are essential to managing their care and it is unacceptable to eliminate this coverage. People with disabilities and serious illnesses are often not in a position to pursue an appeal process or may not be able to get the help of their treatment providers in doing so. A better way to maximize Part D coverage would be to provide appeals assistance to dual-eligible's denied coverage by their Part D plan. NYFAHC oppose these changes to EPIC and Medicaid Part D wraps. It is unacceptable to eliminate this coverage.

EXPAND ELIGIBILITY FOR PUBLIC HEALTH CARE COVERAGE

Implement Family Health Plus Employer Buy-In.

The Family Health Plus Employer Buy-In has now been made more broadly available. The Governor's budget includes rate-setting provisions to move implementation forward. While we see potential for the program, the budget does not go far enough in achieving affordability. We urge more aggressive action by the state to address high premiums and out-of-pocket costs.

Expand New York State's EPIC program to cover people with disabilities under the age of 65. Medicare Part D demands high cost-sharing by enrollees, and each plan has its own list of approved medications, New Yorkers For Accessible Health Coverage



leaving out some that are essential to certain consumers. For Medicare beneficiaries over age 65, the state's Elderly Pharmaceutical Insurance Coverage (EPIC) plan fills in these gaps. However, disabled beneficiaries under age 65 continue to be left out of EPIC. This denies them the protection they need from the high-cost-sharing and limited selection of medications in the Medicare drug benefit. EPIC should be expanded to people under 65 who have SSDI (making them eligible for Medicare) and meet current EPIC income eligibility levels. While EPIC is one of New York's great success stories, its exclusion of people with disabilities is an injustice that must be corrected. The combination of high prescription drug needs, low incomes, and lack of alternative coverage puts people with disabilities at great risk.

Oversight

Reject proposal to eliminate Medicaid Managed Care Advisory Review Panel.

DOH is proposing to eliminate the legislatively-created oversight body for the State's Medicaid HMO program at a critical moment. Auto-assignment rates for people with disabilities who rely on SSI are high. This means that they don't have the information or ability to select a plan and aren't getting sufficient help to do so. When people with disabilities are assigned to a plan instead of selecting one, their relationships with doctors and other providers can be disrupted. They become disconnected with care and the quality of their care suffers. Mandatory enrollment for people with psychiatric disabilities has just occurred and mandatory enrollment of people with HIV/AIDS is about to occur. Public oversight has been an important way to address problems with the program.

Thank you for your time and consideration.

13B

Testimony of The Legal Aid Society

On

THE 2010 - 2011 EXECUTIVE BUDGET

TOPIC: HEALTH/MEDICAID

Presented before:

**The Senate Finance Committee
and
The Assembly Committee on Ways and Means**



MAKING THE CASE FOR HUMANITY

**Presented by:
Lisa Sbrana
Supervising Attorney
The Legal Aid Society Health Law Unit**

February 9, 2010

The Legal Aid Society appreciates the opportunity to testify at this hearing on funding for critical Health and Medicaid services in the 2010 - 2011 Executive Budget.

The Society's Health Law Unit operates a State-wide Helpline that assists hundreds of New Yorkers in need of health care services or health insurance coverage, and those mired in medical debt. As the economy has worsened, we have experienced a 40 percent increase in the numbers of New Yorkers seeking help with health care problems.

In addition to providing direct client assistance, our unit provides technical assistance and training to advocates and consumers throughout the state. We are active members of coalitions raising consumer concerns including Medicaid Matters New York and the Statewide Consumer Coalition on Medicare Part D. We also participate in workgroups on Medicaid streamlining and simplification, Medicaid managed care, and Charity Care.

The Legal Aid Society recognizes the gravity of the fiscal crisis facing our State. We greatly appreciate the commitment of the Governor and the Legislature to maintain, and where possible to increase, access to both health insurance and health care services. We thank the Governor and the Legislature for continuing to lead the nation in the provision of public health insurance to low-income New Yorkers.

We are here today in support of several proposals in the Executive budget that continue the State's efforts to remove barriers and increase access to health care. We are also here today to highlight our concerns regarding proposals in the Governor's budget that diminish access to health care coverage and services.

Streamlining and Simplification

In these very challenging times, we appreciate the Governor's continued commitment to easing administrative barriers to enrollment in New York's public health insurance programs and his commitment to ensuring that all eligible New Yorkers can easily enroll in public programs.

We urge the adoption of the following proposals in the Executive Budget:

- Express Lane Eligibility provisions allowed under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Adopting these provisions will allow the state to make important modifications to existing systems so that children will not experience gaps in coverage if their parents' income changes and they must be transferred between Medicaid and Child Health Plus. Express Lane will also allow enrollment of children in Medicaid based on their receipt of food stamps.
- Data matching with the Social Security Administration to satisfy citizenship and identity requirements for children in Medicaid and Child Health Plus. This CHIPRA provision removes the burden on parents to produce documents proving their children's citizenship and identity when they enroll in Medicaid or Child Health Plus.

- Self-attestation of interest income. Currently individuals must provide proof of interest income when they apply for public health insurance programs. Since the Department has authority to match with the necessary data bases on these accounts, it is no longer necessary and unduly burdensome to require paper documentation from recipients.
- Extend self-attestation of income, resources and residency at renewal to community Medicaid recipients receiving long-term care service services in the community. Self-attestation is already in place for all other community Medicaid recipients, extending this to individuals receiving community-based long term care services reduces administrative burdens for local districts and recipients.

Primary and Preventative Care

We were pleased to see the Governor's continued commitment to primary and preventative care through rate reform and by investing in high need yet underserved practice areas. We urge the Legislature to support the proposed allocation to the Obstetrical Access and Quality program and funding for additional physician slots for the Doctors Across New York program. Both of these programs provide much needed care to underserved areas.

Early Intervention Fee Proposal

We are disappointed that the Executive Budget once again contains a proposal to impose fees on parents whose children receive Early Intervention services. The imposition of fees would be detrimental to all New York families, and would be particularly devastating for children in foster care.

For decades, New York State has provided Early Intervention services at no cost to families, in recognition of the fact that it is a cost effective program. Evidence has shown that children with developmental delays and disabilities who receive Early Intervention services need fewer special education services later in life, are retained in grade less often, and in some cases, are indistinguishable from non-disabled classmates years after intervention.¹ Conversely, if children do not receive needed services at an early age, they are more likely to require additional special education services or more restrictive classrooms when they do arrive at school. They are also likely to require additional years to complete school, and are less likely to become productive working adults – all of which ultimately result in higher costs to the public.

The proposed legislation would require families to provide documentation of income and to pay a sliding scale fee prior to receiving services. The proposed fees range from \$180 to \$2,160 per year per child, and would be applicable to any family making more than 250% of the federal poverty level (approximately \$46,000 for a family of three.) The fee structure is such that low and middle income families would likely be forced to choose between spending their limited income on critical Early Intervention services or

¹ See, e.g., <http://www.kidsource.com/kidsource/content/early.intervention.html>.

on other basic necessities, such as food, clothing and shelter. Furthermore, families who are not able to provide proof of income will be required to pay the highest amount on the sliding scale. This would have a disproportionate effect on children in foster care, children whose families are homeless, and children of undocumented immigrants.

The Legal Aid Society represents the majority of children in foster care in New York City, many of whom are eligible for Early Intervention services. In many cases, parents are minimally involved in their children's lives, making it difficult – if not impossible – to obtain proof of parental income and payment of quarterly fees. If this legislation were to become law, many of the state's most vulnerable foster children would lose access to Early Intervention services. Additionally, the proposed fee would deter individuals from serving as foster or adoptive parents for children with special needs.

We urge the Legislature to reject the Early Intervention fee proposal in its entirety. If, however, the legislature chooses to move forward with imposing a fee for Early Intervention services, the proposed legislation should be amended to include an exemption for children in foster care. Other states, including Arizona, Connecticut, New Jersey, Texas and Massachusetts, that require parent fees have included such exemptions in their state laws, regulations and policies.

Hospital Financial Assistance Law

Although we were disappointed to see a \$286 million dollar reduction in the Charity Care pool, we applaud the Governor's commitment to continuing to implement reforms that ensure that uninsured patients benefit from the State's Charity Care funds.

New York State distributes close to \$850 million annually to hospitals throughout the state for the provision of services to uninsured patients. Since January 1, 2007, hospitals have been required to inform uninsured patients that they may be eligible for financial assistance with their hospital bills. Implementing this law was an important first step to guaranteeing that these funds are actually used to provide services to the uninsured. However with few Department of Health staff dedicated to the enforcement of this provision, many low-income uninsured patients continue to be denied access to these funds. The reforms proposed by the Governor will require hospitals to actually provide financial assistance to uninsured patients before they receive allocations from the State's fund.

Currently only 10% of the funds distributed to hospitals to provide care for the uninsured are distributed based on actual units of service to uninsured patients. This year's Executive budget proposes to require 100% of the funds to be distributed to hospitals based on actual units of service provided to uninsured patients. Even with New York's strong commitment to providing health insurance coverage, we only provide coverage to adults with children up to 150% of the federal poverty level (\$1822 per month for a parent and one child) and adults without children are only covered to 100% of the FPL (\$1215 per month for a couple). The charity care rules require that these funds assist

New York residents with income up to 300% of the federal poverty level. With 2.4 million New Yorkers currently uninsured and increasing numbers of New Yorkers facing periods of unemployment, it is critical that they not be forced into debt based on unexpected health needs. Requiring charity care funds to be issued to hospitals based on actual care provided makes sense from a programmatic perspective – the Department will be able to track how the money is spent and it makes fiscal sense because the funds will go to hospitals providing care to uninsured patients. We urge the adoption of this proposal.

Medicaid Prescription Drug Program

We applaud the Governor's decision to preserve access to critical medications for Medicaid recipients by maintaining their exemption from utilization requirements. With these protections in place, we support the Governor's proposal to extend the Department's authority to negotiate prices with drug manufactures to four currently excluded classes of medications – 1) atypical anti-psychotics for treatment of psychiatric conditions like schizophrenia, acute mania and psychotic agitation, 2) anti-depressants, 3) anti-retrovirals for the treatment of HIV/AIDS and 4) anti-rejection medications for recipients of organ and tissue transplants through the Supplemental Rebate program.

Elderly Pharmaceutical Insurance Coverage (EPIC)

EPIC currently provides vital protection to low-income seniors enrolled in Medicare Part D. It is no secret that navigating Medicare Part D has been difficult for enrollees across the nation. Consequently, the current EPIC program which wraps around Part D is critical to ensuring that seniors do not leave the pharmacy without their prescriptions. The Governor's Executive budget proposes to eliminate this protection by removing the EPIC wraparound benefit. We think that this is a mistake.

To prevent Medicare Part D plans from shifting costs to EPIC, the Legislature gave the EPIC program authority to file appeals of denials by Part D plans on behalf of EPIC enrollees. EPIC has only filing appeals since October 2008 and it has recovered \$7,300,000 in costs based on incorrect denials by Part D plans. EPIC has won more than 65% of the appeals filed. Instead of eliminating EPIC's wraparound benefit, EPIC should continue to maximize Medicare Part D by recovering funds expended based on incorrect denials by the Part D plans.

Medicaid Wrap-around benefit to Medicare Part D

The Governor's Executive budget proposes to eliminate the limited wrap-around benefit for Medicaid beneficiaries who also have Medicare Part D. New York currently provides Medicaid wrap-around coverage for Medicare Part D for the same four classes of medications (atypical anti-psychotics for treatment of psychiatric conditions like schizophrenia, acute mania and psychotic agitation, anti-depressants, anti-retrovirals for the treatment of HIV/AIDS, and anti-rejection medications for recipients of organ and tissue transplants) that the Governor continued exempting from utilization requirements for the general Medicaid population. This exemption makes sense for regular Medicaid

recipients and continuing wrap around coverage makes sense for those who are dually eligible for the same reason - maintaining a treatment regimen and access to these medications is critical to the health of the recipients who need them.

While we understand that achieving cost-savings is critical in this fiscal crisis, they must be achieved responsibly and should not place critically ill New Yorkers in jeopardy. Rather than risk the health of beneficiaries requiring these four classes of critical medications, the Department should put necessary systems changes in place to ensure that Medicaid is the payer of last resort. These changes would allow the Medicaid program to track Part D plan denials and establish the reasons for them. It would also ensure that Medicaid, as is the procedure with all other third-party payers including Medicare Parts A & B, must be billed only after the third-party payer denies payment. In addition, the Medicaid program should act on beneficiaries' behalf in the same manner as the EPIC program and recover the costs to the program by appealing incorrect denials by Part D plans.

Personal Care Services should not be capped

It is disappointing to see the Governor's Executive budget proposal capping Medicaid personal care and Consumer Directed Personal Assistance Program (CDPAP) services at 12 hours per day. We urge the Legislature to reject this proposal.

According to the Department of Health, the Governor's proposal will affect approximately 5000 recipients across the state. Close to 90% of these recipients live in New York City and about 1000 throughout the State receive their services through CDPAP. Individuals in receipt of these services have severe disabilities and require extensive assistance throughout the day and night because of conditions like multiple sclerosis, Parkinson's disease, stroke, quadriplegia, Alzheimer's disease and other impairments.

While the Administration has worked to ease the administrative burdens of operating the Medicaid program and to increase access by removing barriers to coverage experienced by applicants and recipients, people with disabilities have largely been left out of these advancements. Some examples of this disparity are last year's budget elimination of the resource test for all recipients except those in the SSI-related category of coverage. Similarly most Medicaid recipients can now attest to resources, but not those who require long term care services. Ironically, programs that have been adopted specifically to assist individuals with disabilities like the Medicaid Buy-In Program for Working People with Disabilities are difficult to access and to maintain. Although not a Medicaid program, similar disparities are seen in the State's prescription assistance program, called the Elderly Prescription Insurance Coverage program (EPIC) tells the story. EPIC provides assistance to low-income Medicare recipients who are 65 or older, but does not help recipients under the age of 65 who receive Medicare because of a disability.

The proposed options for those in need of more than 12 hours of care are not viable. Although the long term home health program, also known as the Lombardi program, is a

very good program for many people, it is unclear why it has been offered as an option in this context. The Lombardi program has an individual cost cap that limits the current number of hours to recipients to about eight hours per day so by definition it cannot meet the needs of people who require more than 12 hours of services per day. Similarly, the AIDS Home Care Program will only be available to those recipients who have the necessary diagnosis to receive benefits under the program. Implementation of the Nursing Home Transition and Diversion waiver has been very slow. Approximately 30 people have been enrolled in New York City and only 300 people have been enrolled statewide since its inception almost two years ago. Although the Governor proposes to pay for individuals who do not meet the federal criteria for this program with State only funds, funding does not address the barriers currently experienced in this program which are largely related to lack of provider capacity. Finally, managed long term care plans are offered as a means to obtain more than 12 hours of care. However, since these plans receive a capitated rate they currently avoid enrolling high need recipients like those in need of more than 12 hours of service per day. While the Department has indicated that it will be increasing this rate it will never be at the level required to actually cover these services which means that there is a financial incentive for the plans to reduce hours.

This proposal effectively reverses the slow progress New York has made in coming into compliance with the 1999 United States Supreme Court decision in Olmstead v. L.C. which found that under the Americans with Disabilities Act (ADA) services must be provided in the most appropriate setting to the person's needs. While it may be possible for some recipients in receipt of personal care services to add CHHA services to remain exempt from this proposal it will be impossible for those in the consumer directed services program. Limiting consumer directed services to 12 hours per day would effectively eliminate the services that currently allow more than 1000 consumers with disabilities to live in the community. We urge the Legislature to reject this proposal.

Medicaid Managed Care Consumer Advisory Review Panel

We strongly disagree with the Governor's decision to eliminate the MMCARP. This body provides critical oversight to the State's Medicaid managed care and Family Health Plus program. As the State continues to move additional populations into managed care, the mission of the MMCARP as defined in the Social Services Law to determine whether there is sufficient capacity to meet the needs of enrollees, to review enrollment and auto-assignment rates and to monitor rollouts of new populations continues.

A continuing problem with the rollout of mandatory enrollment for individuals with disabilities is auto-assignment. An individual is auto-assigned into a managed care plan if they fail to respond to the mandatory mailings sent by the local district which tell them that they must choose a managed care plan. Failing to respond does not always mean that the person chose not to answer. It often means they did not get the mailing or that they did not understand what they were supposed to do.

This past year eight upstate counties had auto-assignment rates for individuals with disabilities in excess of 30% and seven were in excess of 20%. However, it was not until the MMCARP began requesting information on this issue that the Department began investigating the local districts to determine the cause of the problem. As a result of these investigations the Department suspended auto-assignment in five counties. Three counties are suspended currently – Albany, Erie and Monroe. In addition, the Department is awaiting final approval from the Center for Medicare and Medicaid Services to mandate enrollment of individuals currently exempt because they are HIV+. The danger of auto-assignment is the disruption of ongoing treatment, for individuals with HIV on complicated drug regimens disruption in treatment could be devastating. It is critical that MMCARP be actively involved in the oversight of this process. Finally, as discussed above, this year's budget proposes enrollment of individuals in need of more than 12 hours of personal care services in managed long term care plans which if adopted will require considerable monitoring.

As increasingly vulnerable populations face enrollment in managed care plans, the importance of MMCARP a body that contains voices from all parties – health plans, consumers and providers - is critical. We urge the Legislature to reject this proposal.

Medicaid Fraud

The Governor proposes to place increased emphasis on fraud enforcement, including the imposition of civil penalties in Medicaid fraud investigations. While we in no way condone Medicaid fraud, we strongly oppose this proposal. During the past two years our office has assisted more than 80 individuals under investigation for fraud and have saved our clients more than \$400,000 in alleged overpayments. Although these cases are not investigated by the Office of the Medicaid Inspector General (OMIG), granting OMIG the right to impose civil penalties sets the wrong tone for all investigations across the state.

The investigations we have seen lack transparency and a reliable process. In many cases clients have come to us because they have been told by the district that they owe the Medicaid program thousands of dollars, but the agency refuses to provide any documentation of what they owe or why. Since these investigations are outside of the fair hearing process, clients do not have access to the evidence the investigation is based on. In many cases clients come to us not knowing what the claim is against them, why the agency says they owe money or how much they supposedly owe.

We have found that investigators often allege fraud without analyzing the case. Investigators lack training in complicated Medicaid budgeting rules and only drop investigations after our office provides them with copies of the rules. Our office has represented clients who appear to have resources that make them ineligible for coverage, but a review of the eligibility rules has shown the resources are actually exempt for Medicaid eligibility.

The cases we see are not the ones that are featured in the Daily News or The New York Times. Our clients do not have homes in the Hamptons or grand apartments on the

Upper Eastside. They are low-wage workers who cycle in and out of work or struggle to hold down multiple jobs. Many do not speak English. Some are from low-income mixed status immigrant families where family members with social security numbers help those less fortunate by holding savings in their bank account or by pooling their money to buy a property that provides rental income to multiple generations of a family. These acts of unity unwittingly expose our clients to fraud investigations. Our clients complete health insurance applications and disclose their resources, but not the resources they hold for relatives because that money is not theirs even though it is held in a bank account bearing their name.

Often clients who do not speak English must rely on an oral translation of the application form. Incomplete translations and miscommunications result in clients who are fully eligible for Medicaid or Family Health Plus being investigated for fraud because they receive Medicaid coverage in the district. In other cases, clients are penalized for receiving bad advice from local districts. We have clients who attempt to report changes in eligibility at the time they occur but are told by local district workers to wait and report these changes when it is time to recertify their case. Generally the client does not know this is bad advice until they receive notice of a fraud investigation.

These cases are egregious for so many reasons, but the most important is the chilling effect they are having for potential applicants. At a time of high unemployment and increased poverty our limited state funds should be directed towards the provision of services not increasing fraud investigations.

Conclusion

We are extremely grateful to the members of the Assembly and Senate for your leadership and ongoing commitment to expand access to health insurance coverage and access to health care services. As the economic crisis worsens, we look forward to working with you to ensure that New Yorkers are able to obtain medical services.

From: Ben G Szaro
130 North Pine Avenue
Albany, NY 12203
February 8, 2010

14

To: Assemblyman Herman D. Farrell, Jr.
Chair, Ways and Means Committee
923 Legislative Office Building
Albany, NY 12248

re: NY Spinal Cord Injury Research Program funding

Dear Assemblyman Farrell:

I am writing concerning Governor Paterson's proposal to end funding for the Spinal Cord Injury Research Program (SCIRP) administered by the NYS Department of Health (Chapter 338, Laws of 1998). Notwithstanding the fact that without the funding of such research, there is little hope of relief for people suffering from this injury and their families, the funding of this program is a wise investment for New York. Ending it can only be described as shortsighted.

I have been on the faculty at the University at Albany for 19 years and am now a Professor in the Department of Biological Sciences.

Several years ago, I applied for and received a two year IDEA grant, which cost the program \$180,000. This money was largely spent in the state of New York, thereby helping to fund New York State businesses and jobs:

- 1) It funded the PhD research and support stipend of a PhD student, Kurt Gibbs, who is now finishing his PhD and will be continuing to work as a researcher in spinal cord injury.
- 2) Much of the remaining money was spent with the University at Albany's Center for Functional Genomics in Rensselaer, NY and with local scientific suppliers, including Krackeler Scientific of Albany, NY.
- 3) Its overhead (\$30,000, termed indirect costs) went directly to support SUNY and its mission.
- 4) The moneys paid to these individuals and institutions in turn was spent mostly locally, helping to boost the economy of New York State even further.
- 5) I recently included data that was generated with resources from this grant in support of my application to the National Science Foundation for a \$480,000 three year grant, which I was recently informed will be paid. Where else can your money earn 267%?

Because prior to receiving this grant, I was not directly involved in spinal cord injury research, my involvement in this field is still growing. We have only just submitted our major findings for publication; once they are out, I intend to apply for additional funding to continue the work. Thus, the initial investment made by SICRP in this work should continue to grow.

I am sure you are well aware of the maxim: "Teach a man to fish and you feed him for a day; teach him how to fish and you feed him for a lifetime". I have devoted my career to being that teacher. This program has helped to provide the boat, rod, reel, and bait for these efforts, and ending it is tantamount to asking us to fish with our bare hands.

Thank you for your help.

Sincerely,
Ben G Szaro, PhD
Professor of Biological Sciences



New York Neural Stem Cell Institute
Regenerative Research Foundation

14

Testimony, NYS Senate

Tuesday February 9th 2010

New York State Spinal Cord Injury Research Program (SCIRP)

Sally Temple
Scientific Director
New York Neural Stem Cell Institute
One Discovery Drive
Rensselaer NY 12144
USA

phone: 518 694 8188; 518 694 8190;
fax: 518 694 8187

Summary: The NYS spinal cord injury program (SCIRP) is a successful research program that is developing treatments for injured patients, creating high tech jobs and bringing in leveraged funding from out of state. Most importantly, it offers to those courageous patients, their families and caregivers, precious hope for new treatments. The SCIRP is not funded from tax dollars, but from traffic ticket surcharges. Yet, while other NYS research programs are being reduced, SCIRP is slated for elimination. On behalf of the community of spinal cord injury researchers, I urge you to vote against terminating this valuable research program.

I thank Senator Kruger and Assemblyman Farrell for the opportunity to speak today.

My name is Sally Temple, I am the Scientific Director of the New York Neural Stem Cell Institute, an independent non-profit research center focused on regenerative therapies for nervous system repair, including spinal cord injury. I am speaking as a researcher in the spinal cord injury field and as an 8-year recipient of funding from the New York State Spinal Cord Injury Research Program or 'SCIRP'.

The SCIRP was established a decade ago thanks to the efforts of our own courageous Paul Richter, a NY state trooper paralyzed in the line of duty. SCIRP is funded using money from surcharges imposed on motorists who are convicted of moving traffic violations, it is not funded by tax dollars. The funding source is fitting, as many devastating spinal injuries come from motor vehicle accidents. If this program is eliminated it will turn back a decade of hard work and investment that NYS has made to become a world leader in biomedical and nanoscience research. SCIRP has put NYS on the map for spinal cord injury research, we don't want to lose this strong strategic position.

The SCIRP is an effective investment – this money is largely spent locally, boosting the NYS economy. In turn, the money has generated a substantial return in out-of-state dollars. For example, Dr Joseph Francis from SUNY Downstate medical center received 650 thousand dollars from SCIRP grants and used these to develop a successful 12.8 million dollar federal DARPA (Defense Advanced Research Projects) contract. The SCIRP program has led to hundreds of high tech research jobs and is a magnet that brings researchers into the state. It has generated numerous patents that are being developed towards therapies for spinal cord injured patients. SCIRP funding feeds local biotech. For example, Acorda Therapeutics, a Hawthorn NY company founded to cure spinal cord injury received early support from a SCIRP award. Their subsequent research on nerve conduction led to FDA approval for Ampyra for multiple sclerosis, this January, estimated to be a 1 Billion dollar per year drug. If the SCIRP is terminated, this valuable pipeline from research to biotech will dry up.

For our work, SCIRP helped us establish a research institute in Rensselaer NY where now 40 scientists are pursuing high-tech solutions to nervous system repair. It supported creative work from our laboratories leading to the recognition of a MacArthur award, which brings national attention to NYS biomedical research. A SCIRP award enabled us and Rensselaer Polytechnic Institute scientists to develop a nano delivered candidate drug for spinal cord injury. We now need to complete laboratory studies to move this promising finding towards human clinical trials, and without SCIRP we likely won't be able to do it. The fruit will wither on the vine.

Current treatments for spinal cord injury are outdated, yet over the past few years there have been huge technological advances. You see these every day in the computing technologies that have advanced all aspects of our lives. That same level of technological breakthrough has occurred in the medical research world. These regenerative therapies include bone marrow, heart, cornea and skin transplantation. We are in the best position we have ever been in to produce new therapies for spinal cord injured patients. Yet to do this, we need continued, stable investment in research. On behalf of the community of spinal cord injury researchers, I urge you to vote against terminating this valuable, nationally respected and sorely needed research program.

14A



**ARTHRITIS FOUNDATION CHAPTERS IN NEW YORK STATE:
LONG ISLAND CHAPTER • NEW YORK CHAPTER
NORTHEASTERN NEW YORK CHAPTER • UPSTATE NEW YORK CHAPTER**

NEW YORK STATE SENATE COMMITTEE ON HEALTH

**PUBLIC HEARING TESTIMONY
ON
FISCAL YEAR 2011 EXECUTIVE BUDGET**

FEBRUARY 9, 2010

Presented By:
Victoria M. Rizzo, LCSW-R, Ph.D.
Program Evaluation Consultant,
Arthritis Foundation New York Chapters
&
Assistant Professor &
Hartford Geriatric Social Work Faculty Scholar
Columbia University School of Social Work

On Behalf of:
Arthritis Foundation, Inc., New York State Chapters

Senator Thomas K. Duane, Chairman of the Senate Committee on Health and members of the committee, I thank you for the opportunity to testify today on behalf of the Arthritis Foundation New York State Chapters to request your support for the restoration of \$246,000 for arthritis programs in the FY2011 New York State Executive Budget. This critical funding would support the Arthritis Foundation's continued statewide efforts to expand the capacity of arthritis disease management and education programs to all residents of New York State. In this testimony, I will answer the following questions: 1) Why are disease management programs critically important for NYS residents diagnosed with arthritis? 2) What positive impact do disease management programs funded by New York State Government have on our state's citizens? 3) Why is it imperative that this funding be restored in the FY2011 New York State Executive Budget?

1. Why are disease management programs critically important for NYS residents diagnosed with arthritis?

Arthritis is one of the most common chronic diseases in the United States (U.S.), affecting 46 million adults. Furthermore, arthritis is the leading chronic illness cause of self-reported disability, with 16 million adults reporting activity limitations due to arthritis in 2002 (Hootman & Helmick, 2006). Nationally, arthritis is estimated to cost \$51 billion a year in direct medical costs and is responsible for 750,000 hospitalizations and 36 million outpatient physician visits each year (CDC, 2006a). In New York State (NYS), 57% of adults 65 years of age and older and 39% of individuals between the ages of 45 and 64 reported a doctor diagnosis of arthritis (U.S. Department of Health & Human Services, Centers for Disease Control & Prevention, National Center for Chronic Disease Prevention & Health Promotion, 2007). Arthritis among New Yorkers leads to retirement due to disability and the utilization of health care and long term care services that could be avoided and/or delayed as a result of successful self-management of arthritis.

The National Arthritis Action Plan (Arthritis Foundation, Association of State and Territorial Health Officials, and Centers for Disease Control and Prevention, 1999) and *Healthy People 2010* (U.S. Department of Health and Human Services, 2000) identify arthritis as a major public health issue that can be addressed using prevention, education, and research strategies. These documents identify physical exercise and disease management programs as empirically tested, effective means to increase individuals' knowledge of arthritis and self-efficacy in managing their disease while decreasing symptoms of arthritis, such as pain and stiffness, symptoms of depression, and social isolation. Furthermore, these programs have been shown to have a positive impact on health care utilization and costs for individuals who participate when compared to those who do not participate (For a review of disease management programs for arthritis, see Anderson, 1991; Lorig, et al., 2001; Brady et al., 2003; Boutaugh, 2003; Hootman & Minor, 2005; Lorig, Hurwicz, Sobel, Hobbs, & Ritter, 2005; & Schoster et al., 2005). Lastly, evidence suggests that these disease management programs are effective across populations of individuals with arthritis (Lorig, Gonzalez, & Ritter, 1999; Lorig, Ritter & Gonzalez, 2003). With support from the New York State legislature and the Governor's office, the Arthritis Foundation chapters in New York State have had success in building capacity to deliver these effective disease management programs to all residents across the state.

2. What positive impact do disease management programs funded by New York State have on our state's citizens?

Since 2002, the New York Chapters of the Arthritis Foundation - Long Island Chapter (Melville), New York Chapter (Manhattan), Northeastern New York Chapter (Albany), and the Upstate New York Chapter (Rochester) - have worked together to effectively build the statewide capacity of arthritis programs. Over the past eight years, these program efforts have made an enormous impact on the 4 million state residents with arthritis: improving the availability of nationally-developed, evidence-based

disease management programs and increasing public awareness of arthritis.

By March 31, 2010, nearly \$2 million in New York State funding will have enabled the Chapters to:

- Train more than 1,400 course instructors and certify 17 master trainers
- Offer more than 1,400 free disease management programs at hundreds of community sites throughout the state, reaching nearly 25,000 people with arthritis
- Achieve outstanding documented health outcomes for program participants
- Reach more than 10,000 New Yorkers with an array of public education and awareness programs
- Distribute marketing brochures, *A Hands-on Guide to Controlling Your Arthritis Pain* and *Living Life to the Fullest*, at health fairs, libraries, community centers, etc. throughout New York State.

The findings of the annual evaluations of these statewide programs that I have conducted reveal statistically significant program benefits in the areas of daily activities, changes in arthritis symptoms, general arthritis knowledge, attitudes and beliefs about exercise and the ability to self-manage arthritis symptoms, and level of depression among course participants. In addition, more than 75% of respondents have indicated their intention to make changes in their arthritis care as a result of course participation. These programs as previously stated have also been shown by Kate Lorig, RN, DrPH at the Stanford Arthritis Center to have sustained health benefits while reducing health care costs through the reduction of hospitalization and physician visits. In reports commissioned by the National Coalition on Care Coordination (N3C), Brown (2009) and Berenson and Howell (2009) identified disease management programs as one of three intervention models shown to be effective in improving (or maintaining) the quality of life, health status and functional status of Medicare beneficiaries while reducing emergency room visits, hospitalizations, nursing home admissions and the costs of overall care. As the baby boomers age and the number of dually eligible seniors (meaning those receiving Medicare and Medicaid) increases, disease management programs hold promise for positively impacting the lives of New York residents, while also containing health care and long term care costs in this state.

3) Why is it imperative that this funding be restored in the FY2011 New York State Executive Budget?

As all of us know, the global economic crisis, and the crisis in the U.S. banking and housing industries has had significant financial implications for state, county, and local government budgets. As a result of local budget cuts due to current financial difficulties at the local level, the Arthritis Foundation's programs provided at senior centers, community centers, naturally occurring retirement communities—to name just a few—across the state as a result of the executive budget funding we have received in the past are often the only programs provided to individuals with arthritis.

Because of the longstanding support of New York State, the Chapters have made tremendous headway in bringing urgently needed resources to New Yorkers with arthritis. Based on this success, it is clear that there is a critical need for continued state funding to support the Chapters' statewide efforts. Restoring the \$246,000 allocation will enable the Chapters to continue to expand the capacity for disease management programs and examine the effectiveness of these programs in New York State. If this funding is eliminated, thousands of New Yorkers will not have access to these free arthritis programs, and community sites statewide will lose the capacity to provide arthritis programs to those they serve.

Thank you for your attention to this important initiative to enhance New Yorkers' access to arthritis disease management services. It has been a privilege to testify before this committee.

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(14 B) Submitting only



CURE - NOT CARE®

SPINAL CORD SOCIETY

An International Society for cure research and treatment of spinal cord injury and related problems

Paul Richter, NYS Chapter Coordinator
24 Davis Avenue • Albany, NY 12203 • (518) 458-2141

To: NYS Senate Finance Committee Members and
NYS Assembly Ways and Means Committee Members
Public Hearing, Hearing Room B
Legislative Office Building, Albany, NY
From: Paul Richter
Subject: Governor Paterson's 2010-11 Executive Budget proposals to terminate the Spinal Cord Injury
Research Board (SCIRB) and to phase out the Spinal Cord Injury Research Program (SCIRP)
Date: February 9, 2010

It is an honor to appear before this distinguished committee today.

My name is Paul Richter, currently residing in Albany, NY. I am the NYS Chapter Coordinator of the Spinal Cord Society, an unpaid member of the NYS Spinal Cord Injury Research Board and a former New York State Police Zone Sergeant retired on disability as a result of being shot three times while on duty during a traffic stop. I am here today to urge you **NOT TO SUPPORT** Governor Paterson's 2010-11 Executive Budget proposals to terminate the Spinal Cord Injury Research Board (SCIRB) and to phase out the Spinal Cord Injury Research Program (SCIRP).

I am accompanied today by:

- Mr. Michael DiScipio, a former Albany County corrections officer who is paralyzed from the neck down as the result of a back yard swimming pool accident almost ten years ago.
- Mr. Terry O'Neill, Esq., Director of the Constantine Institute and former counsel to former Assemblyman Ed Griffith who sponsored the SCIRP program.
- Dr. Allen Carl, M.D., surgeon, Professor of Orthopedics and Pediatrics, Albany Medical College, Albany
- Lorne Mendell, Ph.D., an M.I.T. graduate, a distinguished Professor of Neurobiology and Behavior at the State University of New York at Stony Brook, NY, and currently the chairman of the Spinal Cord Injury Research Board (SCIRB).

The shooting incident took place on September 30, 1973, at about 2AM in Lake Placid, NY, one of the .22 caliber bullets damaged my spinal cord in the neck/shoulder area causing me to fall to the ground paralyzed from the neck down. The two perpetrators fled the scene and were eventually captured. With good fortune, excellent medical treatment, rehab at Sunnyview Hospital and support from my family, friends and the State Police I regained enough function thankfully to ambulate with a leg brace and cane. I had to retire from the State Police, and begin living a new and different life with my wife and six young children. Because of the life altering changes, not only personal but for our loved ones caused by spinal cord injury (sci) paralysis, and being blessed to have regained so much body function, I began to advocate for a cure of this devastating injury caused paralysis. That was 37 years ago.

In 1998 I had an idea to create a state spinal cord injury research program that would be focused on finding a cure and funded by a surcharge imposed on motorists convicted of moving traffic violations. It is the disregard of these moving traffic laws by auto/motorcycle operators that cause the majority of the spinal cord injuries in NYS. I contacted Mr. O'Neill, staff person of Assemblyman Griffith and Mr. Bob Farley, staff person of Senator Vincent Leibell to present my idea for their consideration and sponsorship. The spinal cord injury community in NYS were so pleased to learn that these two forward looking legislators agreed to sponsor the "Spinal Cord Injury Research Board" and the resulting research program. A ground swell of citizen political activity across NYS resulted in the unanimous passage of this legislation in both houses in record time, less that 6 months from date of introduction until it was signed into law on July 14, 1998 at the NYU Medical Center by then Governor George Pataki (NYS Chapter 338, Laws of 1998, as amended by Chapter 612, Laws of 1999). Present at the bill signing was Christopher Reeve, and New York City police officer Steven McDonald, also a gunshot victim and confined to a wheelchair.

At the same time, a special revenue fund was established for these surcharge funds, known as the "Spinal Cord Injury Research Trust Fund":

§ 5. Article VI of the state finance law is amended by adding a new section 99-f to read as follows:

§ 99-f. Spinal cord injury research trust fund.

1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a special revenue fund to be known as the "spinal cord injury research trust fund."
2. The fund shall consist of all monies appropriated for its purpose, all monies required by this section or any other provision of law to be paid into or credited to such fund, and monies in an amount not to exceed eight million five hundred thousand dollars collected by the mandatory surcharges imposed pursuant to subdivision one of section eighteen hundred nine of the vehicle and traffic law. Nothing contained herein shall prevent the department of health from receiving grants, gifts or bequests for the purposes of the fund as defined in this section and depositing them into the fund according to law.
3. Monies of the fund, when allocated, shall be available for administrative costs of the spinal cord injury research board established pursuant to title four of article two of the public health law and for funding spinal cord injury research projects administered by such board.
4. Monies shall be payable from the fund on the audit and warrant of the state comptroller on vouchers approved and certified by the commissioner of health.

§ 6. This act shall take effect January 1, 1999.

It is my opinion as well as many of our supporters that the mission of the Board and research program to find a cure for spinal cord injury paralysis remains incomplete and leads to greater medical costs associated with these injuries. The Legislature clearly intended to fund this program \$8.5M per year based on surcharges from convictions of moving traffic violations. I can assure you that the level of convictions has not precipitously dropped as such infractions occur in the millions within the state annually.

The following only scratches the surface of the many accomplishments achieved by these programs since enacted ten years ago:

- **approved funding for more than \$54 million in research awards in NYS--which many recipients have leveraged to bring into NYS many more millions from NIH and private foundations.**
- **the fund has earned over \$5.5 million in interest.**
- **created hundreds of good jobs in the medical research field, thereby encouraging new post grads to enter the field of sci research.**
- **creating the Spinal Cord Injury Center of Research Excellence (CORE), which is made up of researchers and support staff at eleven institutions across the state, from New York City to Buffalo.**
- **this program is a high tech job magnet - local institutes are now able to attract excellent spinal cord researchers from other states who want to move here to take advantage of this NYS funding opportunity.**
- **lest we forget that this program provides ""HOPE"" for those paralyzed by a spinal cord injury.**

Christopher Reeve's prediction "that those suffering from sci and I will stand up from our wheelchairs and walk away from them forever" did not come true in time for our great champion, but I still believe in his great dream. When that happens, New York will have been part of that tremendous effort—if we act now to prevent bureaucratic short-sightedness from killing it.

The trust fund revenues from surcharges currently supports the salaries, benefits, travel and supplies for four (4) full time state employees who are assigned to handle administrative duties of this program, it costs New York State TAXPAYERS NOTHING. The SCRIB and SCRIP are long term investments to find a cure for spinal cord injury paralysis thus reducing the taxpayer cost for care on average of \$300,000 per year, multiply that by 100 patients = \$30,000,000 per year. There are many thousands of such disabled people across the State of New York.

I know that my friend Christopher Reeve would join me in asking you to please, DO NOT SUPPORT the governor's proposals to terminate this one of a kind NYS Spinal Cord Injury Research Board and phase out the Spinal Cord Injury Research Program.

Respectfully submitted,

Paul Richter
Paul Richter

From: bjb08@health.state.ny.us
To: lorne.mendell@sunysb.edu, alcsar@nycap.rr.com, bsk0909@aol.com,
prichter05@aol.com, davisandtrotta@taconic.net, wolpaw@wadsworth.org,
brookemellison@gmail.com, dfaber@aecom.yu.edu, gary_paige@urmc.rochester.edu,
jason_huang@urmc.rochester.edu, astein3@nshs.edu, meg2008@columbia.edu
CC: ldr01@health.state.ny.us, mlr06@health.state.ny.us, tka03@health.state.ny.us,
met03@health.state.ny.us
Sent: 1/21/2010 4:55:43 P.M. Eastern Standard Time
Subj: Governor's Budget Proposal - Impact on SCIRB

Hello -

* The Commissioner of Health has asked that we notify you that the Governor's Executive Budget for 2010-2011 proposes the elimination of the Spinal Cord Injury Research Board, effective April 1, 2010. As a cost-saving measure, it is one of several programs that are proposed to be eliminated or consolidated.

As we currently understand it, the proposal is to phase out the program. Thus, the budget proposes the reappropriation of unspent funds from past years to support executed contracts.

While the official role of the board would be eliminated under the Governor's proposed budget, the Department certainly expects to continue to reach out to you for input as we close out the program. Due to the close proximity of the April 9 meeting to the start of the new fiscal year, please continue to hold the date for the April 9 meeting. We will advise you as soon as possible regarding our ability to convene.

Thank you for your continued support.

In service,
Bonnie

Bonnie Jo Brautigam
Director, Extramural Grants Administration
Wadsworth Center/NYSDOH
Room D-350, Empire State Plaza
PO Box 509
Dock J, P1 Level (for courier delivery only)
Albany, NY 12201-0509 (12237 for courier delivery only)
brautig@wadsworth.org
518-474-7002 (office phone)
518-486-2191 (fax)

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=

Davis & Trotta

From: <Prichter05@aol.com>
To: <davisandtrotta@taconic.net>
Sent: Monday, February 08, 2010 12:38 PM
Subject: Reduce or Eliminate Public Health Programs.

need
40 copies to go with my cover letter
10 copies , one for copy i will read from, 9 for media

i have 2 more items to send--then i will call you in about one hr about how i would like these stapled together in what order thks

PLEASE UNDER LINE OR HIGHLIGHT BELOW IN FIRST BULLET PARA>>>while contracts for spinal cord research (\$6.7 million) would be phased out.
////////////////////////////////////below for submission////////////////////////////////////

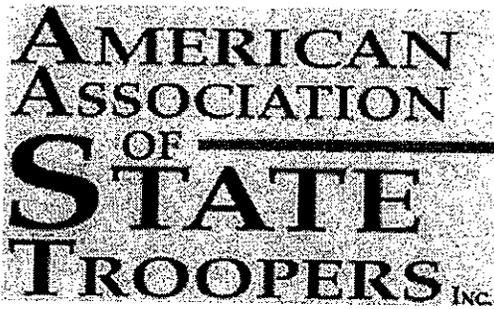
Public Health and Aging Programs

The Department of Health and the State Office for the Aging administer a number of programs that support New York's public health and senior care systems. The budget achieves savings by reforming the Elderly Pharmaceutical Insurance Coverage (EPIC) program, the Early Intervention (EI) program, and the General Public Health Work (GPHW) program; consolidating various public health programs; reducing spending on programs less central to agency core mission programs; and other operational and administrative efficiencies. These actions would save \$104.2 million in 2010-11 and \$187.3 million in 2011-12.

- **Reduce or Eliminate Public Health Programs.** Spending on Infertility (\$1.5 million – including \$1.3 million in HCRA savings) and Red Cross emergency preparedness (\$0.9 million) would be reduced by 50 percent; while contracts for spinal cord research (\$6.7 million) would be phased out. Funding for the following programs that are less essential to DOH's core mission would be eliminated: Eating Disorders (\$1.7 million); Maternal and Early Childhood Foundation (\$0.9 million); Arthritis Foundation (\$0.2 million); Interim Lead Safe Housing (\$0.1 million); Translational Neurological Research (\$0.1 million); and various education and outreach programs (\$2.0 million). (2010-11 Savings: \$14.2 million; 2011-12 Savings: \$21.5 million)
- **Reduce Spending for Senior Services.** Spending would be eliminated for the Patients' Rights and Advocacy Hotline Project (\$0.1 million) and Congregate Services Initiative (\$0.6 million). (2010-11 Savings: \$0.7 million; 2011-12 Savings: \$0.7 million)
- **Additional Agency Reductions.** The Executive Budget recommends an additional \$29.6 million reduction to the operations of the Department of Health, and \$0.3 million for the State Office for the Aging. The agencies would manage these reductions through a broad range of savings actions, including: strict limits on staffing; energy conservation; purchases of vehicles, supplies, equipment, and contracts for technology and other services; and the development of shared services. (2010-11 Savings: \$29.9 million; 2011- 12 Savings: \$22.3 million)

////////////////////////////////////

5



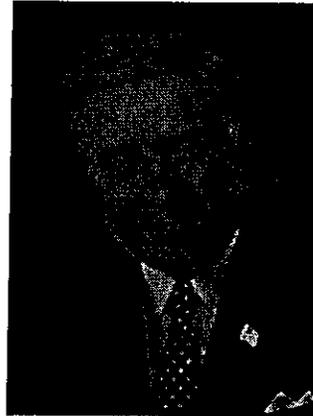
"Providing benefits and services to America's state troopers since 1989"



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Retired New York trooper pioneers spinal cord injury research

Near fatal gunshot wound left him paralyzed



Retired New York Trooper and AAST Member Paul Richter

On a late-night traffic check in Lake Placid on September 30, 1973, Paul Richter was working as a New York State Police trooper when he was shot in the neck with a .22 caliber gun, leaving him paralyzed from the neck down. He has since dedicated much of his life to spinal cord injury research.

On July 14, 1998, a bill was passed realizing Richter's initiative to establish a spinal cord injury research fund. With its broad grassroots support, including a mass letter-writing campaign across the state, the bill passed unanimously in a brief nine months, becoming the first law of its kind in the nation. Major legislation typically takes three to seven years to get passed.

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Richter literally could have walked away from the devastation of spinal cord injury after regaining the ability to walk with a cane. Today he considers himself lucky.

"I couldn't turn my back on other spinal cord injury victims who aren't as fortunate as me to regain the ability to move and walk," Richter said. "My injury and extensive rehabilitation were for a reason. I can now use my situation to help find a cure."



Christopher Reeve, pictured right with Richter, was among those who helped get the bill passed to establish a spinal cord injury research fund in New York state.

Friends and connections, eventually including the late actor Christopher Reeve, paralyzed after a fall from a horse, provided invaluable support along the way to help get the bill passed, a law which provides \$8.5 million a year for spinal cord injury research. The bill passed with no lobbyists – grassroots only.

In 1977 Richter joined the Spinal Cord Society, whose function is to raise money to fund research to find a cure for spinal cord injury paralysis. He is now the New York state chapter coordinator of the group, which is comprised solely of volunteers. Richter also serves on the New York State Spinal Cord Injury Research board and takes a keen interest in the research efforts that his bill makes possible, including the Center of Research Excellence.

7

Research money is dispensed in the form of grants, requests which are submitted to a review board administered through the New York State Department of Health.

Richter has been recognized many times for his work. On June 3 the Burke Rehabilitation Hospital and Burke Medical Research Institute in White Plains, N.Y., honored Richter as the research recipient of the Burke Award, the highest honor bestowed by Burke and its board of directors. The award is presented to an individual or group for strength in overcoming a disability for the development of science and research regarding disability, and for contributions made to the development of rehabilitation.

Thank you, Paul Richter, for your clear vision and unyielding efforts in this life-changing field.

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Common food dye may hold promise in treating spinal cord injury

A common food additive that gives M&Ms and Gatorade their blue tint may offer promise for preventing the additional -- and serious -- secondary damage that immediately follows a traumatic injury to the spinal cord. In an article published online today in the Proceedings of the National Academy of Sciences, researchers report that the compound Brilliant Blue G (BBG) stops the cascade of molecular events that cause secondary damage to the spinal cord in the hours following a [spinal cord injury](#), an injury known to expand the injured area in the spinal cord and permanently worsen the paralysis for patients.

This research builds on landmark laboratory

findings first reported five years ago by researchers at the University of Rochester Medical Center. In the August 2004 cover story of *Nature Medicine*, scientists detailed how ATP, the vital energy source that keeps our body's cells alive, quickly pours into the area surrounding a spinal cord injury shortly after it occurs, and paradoxically kills off what are otherwise healthy and uninjured cells.

This surprising discovery marked a milestone in establishing how secondary injury occurs in spinal cord patients. It also laid out a potential way to stop secondary spinal injury, by using oxidized ATP, a compound known to block ATP's effects. Rats with damaged spinal cords who received an injection of oxidized ATP were shown to recover much of their limb function, to the point of being able to walk again, ambulating effectively if not gracefully.

Now, scientists detail the clearing of yet another hurdle in moving this research closer from bench to bedside by successfully identifying a compound that could be administered systemically to achieve the same benefit. Previously, the team needed to inject a compound directly into the injured spinal cord area to achieve its results.

"While we achieved great results when oxidized ATP was injected directly into the spinal cord, this method would not be practical for use with spinal cord-injured patients," said lead researcher Maiken Nedergaard, M.D., D.M.Sc., professor of Neurosurgery and director of the Center for Translational Neuromedicine at the University of Rochester Medical Center. "First, no one wants to put a needle into a spinal cord that has just been severely injured, so we knew we needed to find another way to quickly deliver an agent that would stop ATP from killing healthy motor neurons. Second, the compound we initially used, oxidized ATP, cannot be injected into the bloodstream because of its dangerous side effects."

Nedergaard cautions that while this body of work offers a promising new way of treating spinal cord injury, it is still years away from possible application in patients. In addition, any potential treatments would only be helpful to people who have just suffered a spinal cord injury, not for patients whose injury is more than a day old. Just as clot-busting agents can help patients who have had a stroke or heart attack who get to an emergency room within a few hours, so a compound that could stem the damage from ATP might help patients who have had a spinal cord injury and are treated immediately.

Too Much of a Good Thing

While ATP is usually considered to be helpful to our bodies -- after all, it's the main source of energy for all of our body's cells -- Nedergaard was the first to uncover its darker side in the spinal cord. Immediately after a spinal cord injury occurs, ATP surges to the damaged area, at levels hundreds of times higher than normal. It is this glut of ATP that over-stimulates neurons and causes them to die from metabolic stress.

Neurons in the spinal cord are so susceptible to ATP because of a molecule known as "the death receptor." Scientists know that the receptor -- called P2X7 -- plays a role in regulating the deaths of immune cells such as macrophages, but in 2004, Nedergaard's team discovered that P2X7 also is carried in abundance by neurons in the spinal cord. P2X7 allows ATP to latch onto motor neurons and send them the flood of signals that cause their deaths, worsening the spinal cord injury and resulting paralysis.

So the team set its sights on finding a compound that not only would prevent ATP from attaching to P2X7, but could be delivered intravenously. In a fluke, Nedergaard discovered that BBG, a known P2X7R antagonist, is both structurally and functionally equivalent to the commonly used FD&C blue dye No. 1. Approved by the Food and Drug Administration as a food additive in 1982, more than 1 million pounds of this dye are consumed yearly in the U.S.; each day, the average American ingests 16 mgs. of FD&C blue dye No. 1.

"Because BBG is so similar to this commonly used blue food dye, we felt that if it had the same potency in stopping the secondary injury as oxidized ATP, but with none of its side effects, then it might be great potential treatment for cord injury," Nedergaard said.

The team was not disappointed. An intravenous injection of BBG proved to significantly reduce secondary injury in spinal cord-injured rats, who improved to the point of being able to walk, though with a limp. Rats that had not received the BBG solution never regained the ability to walk. There was one side effect: Rats who were injected

with BBG temporarily had a blue tinge to their skin.

Nedergaard's long-time collaborator on this and other projects, chair of the University of Rochester Department of Neurology Steven Goldman, M.D., Ph.D., adds, "We have no effective treatment now for patients who have an acute spinal cord injury. Our hope is that this work will lead to a practical, safe agent that can be given to patients shortly after injury, for the purpose of decreasing the secondary damage that we have to otherwise expect."

Nedergaard and Goldman believe that further laboratory testing will be needed to test the safety of BBG and related agents before human clinical trials could begin. Nonetheless, the investigators are optimistic that with sufficient study, strategies like this could yield new treatments for acute spinal cord injuries within the next several years.

Other authors from the University of Rochester Medical Center include Weiguo Peng, Maria L. Cotrina, Xiaoning Han, Hongmei Yu, Lane Bekar, Livnat Blum, Takahiro Takano, and Guo-Feng Tia.

The research was supported by the New York State Spinal Cord Injury program, the Miriam and Sheldon Adelson Medical Research Foundation, and grants from the National Institutes of Health.

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Same blue dye in M&Ms linked to reducing spine injury

- Story Highlights
- Researchers find way to reduce secondary damage caused by spinal injuries
- Compound BBG is similar to blue food dye used in sweets, sports drinks
- Only side effect of intravenous injection was that it turned test rats blue
- Researchers are planning to apply to the FDA for permission for human tests

(CNN) – The same blue food dye found in M&Ms and Gatorade could be used to reduce damage caused by spine injuries, offering a better chance of recovery, according to new research.

Researchers at the University of Rochester Medical Center found that when they injected the compound Brilliant Blue G (BBG) into rats suffering spinal cord injuries, the rodents were able to walk again, albeit with a limp.

The only side effect was that the treated mice temporarily turned blue.

The results of the study, published in the "Proceedings of the National Academy of Sciences," build on research conducted by the same center five years ago.

In August 2004, scientists revealed how Adenosine triphosphate, which is known as ATP and described as the "energy currency of life," surges to the spinal cord soon after injury occurs.

Researchers found that the sudden influx of ATP killed off healthy cells, making the initial injury far worse. But when they injected oxidized ATP into the injury, it was found to block the effect of ATP, allowing the injured rats to recover and walk again.

"While we achieved great results when oxidized ATP was injected directly into the spinal cord, this method would not be practical for use with spinal cord-injured patients," said lead researcher Maiken Nedergaard, professor of Neurosurgery and director of the Center for Translational Neuromedicine at the University of Rochester Medical Center.

"First, no one wants to put a needle into a spinal cord that has just been severely injured, so we knew we needed to find another way to quickly deliver an agent that would stop ATP from killing healthy motor neurons. Second, the compound we initially used, oxidized ATP, cannot be injected into the bloodstream because of its dangerous side effects."

Back in 2004, Nedergaard's team discovered that the spinal cord was rich in a molecule called P2X7, which is also known as "the death receptor" for its ability to allow ATP to latch onto motor neurons and send the signals which eventually kill them.

Nedergaard knew that BBG could thwart the function of P2X7, and its similarity to a blue food dye approved by the Food and Drug Administration (FDA) in 1982 gave her the confidence to test it intravenously.

It worked. The rats given BBG immediately after their injury could walk again with a limp. Those that didn't receive a dose never regained their mobility.

Nedergaard told CNN that there is currently no standard treatment for patients with spinal injury when they reach the hospital emergency room.

"Right now we only treat 15 percent of the patients we receive with steroids and many hospitals question if that even works for that 15 percent; it's a very moderate benefit to only a subset of patients. So right now 85 percent of patients are untreated," she said.

Nedergaard said the research team isn't claiming that BBG can cure spinal injuries, instead that it offers a potential improvement in

patients' condition.

"Even a moderate improvement in functional performance of the patient is a big, big event for these patients," she said. "They can control their bladder. If they can just take small steps instead of sitting in a wheelchair all the time, it's a tremendous benefit for these patients," she added.

The dose must be administered immediately after the injury, before additional tissue dies as a result of the initial injury.

Researchers are currently pulling together an application to be lodged with the FDA to stage the first clinical trials of BBG on human patients.

"Our hope is that this work will lead to a practical, safe agent that can be given to patients shortly after injury, for the purpose of decreasing the secondary damage that we have to otherwise expect," said Steven Goldman, Chair of the University of Rochester Department of Neurology.

Find this article at:

<http://www.cnn.com/2009/HEALTH/07/28/spinal.injury.blue.dye/index.html>

Check the box to include the list of links referenced in the article.

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#14

Testimony, NYS Senate

Tuesday, February 9th, 2010

New York State Spinal Cord Injury Research Program (SCIRP)

Mark Noble, Ph.D.

Professor of Genetics, Neurology, Neurobiology and Anatomy
University of Rochester Medical Center
Co-Director, NYS Center of Research Excellence in Spinal Cord Injury
Phone: 585 273 1448
Email: mark_noble@urmc.rochester.edu

Rajiv Ratan, M.D., Ph.D.,

Burke Professor of Neurology and Neuroscience
Weill Medical College of Cornell University
Executive Director, Burke-Cornell Medical Research Institute
Director, NYS Center of Research Excellence in Spinal Cord Injury
Phone: 914-597-2851
Email: rrr2001@med.cornell.edu

**The Honorable Senator Kruger
The Honorable Assemblyman Farrell**

Dear Distinguished Leaders of New York:

We are having these discussions because we are in an economic crisis. Thus, let us stress that maintaining SCIRP funding is not just good economics. It is great economics.

This funding creates jobs, and it creates good jobs. The average grant award creates 5 or more job slots. People employed on these grants are trained for high tech jobs, and add to the skilled labor force we need to build both academic and corporate science in New York.

This funding brings money into New York State, and brings prestige to the state. SCIRP funding has enabled New York State researchers to attract millions of dollars in funds from the US government, from private foundations and from donors. It attracts scientists to New York to work, and these scientists also bring in external funding. Discoveries supported by SCIRP frequently are covered in newspapers around the world. Moreover, this program has enabled us to integrate the work of laboratories across the country in an effort headed here in New York State.

This funding aids biotechnology development. I am fortunate to be a founding member of the scientific advisory board of Acorda Therapeutics, one of a small number of New York State biotechnology companies with an FDA-approved drug, 4-aminopyridine, soon to be in the marketplace. SCIRP funding to Acorda has been critical in supporting discoveries now in the developmental pipeline.

This funding has enabled us to take people off the medical rolls and get them back to work. People like Nancy Lieberman. When I met Nancy, she was in one of our New York City hospitals because of cervical spinal cord injuries. She had no use of her legs and arm movement limited literally to inches. Her doctor told her that this was all she ever would have. I told her this was wrong. She started taking 4-aminopyridine from a compounding pharmacist – the drug that Acorda will soon be selling – and it helped relieve her pain. She enrolled in the SCIRP-funded robotics program at the Burke Neuromedicine Institute. In an email from Nancy this morning, she said tell them about “ what this program means to me, how it has directly and profoundly aided in my rehabilitation from a devastating injury, and how the robots have added significantly to my ability to return to work. Explain how I have a very demanding job as a mergers specialist and acquisition/corporate law partner in a major New York law firm (Skadden Arps) and I would never be able to productively function if I did not have the use of my arms, which I now have due to the robots.”

Assigning a value to what is widely agreed to be an essential part of a quality of life is impossible because these activities are priceless-ask anyone who is paralyzed. Dr. Ratan and I want to share with you our excitement that the funding generated by the pioneering legislation of Paul Richter has been utilized for path-breaking research on spinal cord injury and has provided remarkable return on investment. Already, two people who could not move their arms to feed themselves, brush their teeth, or answer the phone are now able to do so-in one case seven years after his injury. And these people are working! In addition to these tangible human benefits, the Center run by Dr. Ratan and I has set the table to attract millions of dollars in federal funding to New York; trained more than 40 young graduate students and Ph.D. post-doctoral fellows; and filed a dozen new patent applications on drugs and other therapies that can move rapidly to clinical testing and which provide a foundation for still more biotechnology development.

These are all important investments for New York State. This is where we finally are, and now is not the time to cut the legs out from under this program. Given the moral and financial mandates of SCIRP funding for people in New York and around the world, we can see no tenable argument to eliminate this support.

Finally, consider Paul Richter, and other officers and soldiers who can't walk because they literally took a bullet for our citizens. Walking away from them cannot be the right answer.

Professor Mark Noble, Ph.D., Univ. Rochester Med. Ctr., Co-Director, NYS Center of Research Excellence in Spinal Cord Injury (P: 585 273 1448; mark_noble@urmc.rochester.edu)

Professor Rajiv Ratan, M.D., Ph.D., Director, Burke Neuromedicine Institute, Director, NYS Center of Research Excellence in Spinal Cord Injury (P: 914-597-2851; rrr2001@med.cornell.edu)

Children's Hospital of New York at New York-Presbyterian Hospital
Columbia University Medical Center

#14
HARKNESS PAVILION, FIFTH FLOOR
180 FORT WASHINGTON AVENUE
NEW YORK, NY 10032-3791

Jason Carmel, MD, PhD
Division of Pediatric Neurology
Departments of Neurology and Pediatrics
College of Physicians & Surgeons of Columbia University

February 4, 2010

Dear Governor Patterson,

I am writing to express my bitter disappointment that you have proposed to eliminate the Spinal Cord Injury Research Program (SCIRP) in your recent budget proposal. I am a neurologist and neuroscientist at Columbia University studying recovery of movement after spinal cord injury, among other conditions. I also have a twin brother, David Carmel, who has a spinal cord injury. So I write to you as a researcher who knows the potential of the work that has been funded, as a doctor who is frustrated by the limited treatments for my patients with spinal cord injuries, and as a close family member who knows the terrible toll such injuries on those who suffer their effects. Please do not cut this vital funding.

As a researcher, I can see the progress that is being made towards recovery of function in animal models of spinal cord injury. We need the funding to be able to translate these exciting results into treatments that can actually help people with spinal cord injuries. The NY SCIRP funds a significant portion of the research nationwide devoted to spinal cord injury. Without the SCIRP treatments that help rats recover the ability to walk, urinate independently, and regain sexual function cannot be brought to people who desperately need them. I am currently very limited in what I can do to help my patient's with spinal cord injuries. This research has the very real potential to help people recover lost function, not just make do with their limited capabilities.

This program is budget neutral because it raises all of the funds through a surcharge on moving violations. This makes sense since over 50% of people with spinal cord injuries are hurt in motor vehicle accidents. The money was created specifically for this program and should remain for this program instead of being shunted to other expenses for which they were not intended. This is not simply an accounting issue; it is a moral issue. Please do the right thing and devote the money to its intended purpose.

By continuing this program you will keep researchers like me in the state and recruit others to join this very promising program. It leverages the NY State funding by advancing research that then qualifies for NIH and other grants. The program makes New York an exciting place to do recovery research and to practice medicine. It also restores the hope that science can help reverse paralysis in people like my brother David. Please, continue to invest in this important program, in the talented researchers who do the work, and in the real possibility for meaningful recovery for David and thousands of others like him

Thank you,

Jason Carmel, MD, PhD

**Testimony by Dr. Lorne Mendell to the Senate Finance Committee
Albany, New York
February 9, 2010**

#14

My name is Dr. Lorne M. Mendell. I am Distinguished Professor of Neurobiology and Behavior at Stony Brook University where I have worked for 30 years, 20 of them as Chair of my department. I have also served as President of the Society for Neuroscience, which has a membership of 40,000 scientists and clinicians in the US and throughout the world. I testify here as a private citizen. At the same time, I have been a member of the Spinal Cord Injury Research Board (SCIRB) for the past 6 years, and have been its Chair for the past 3 years. Thus, I believe that I am qualified to tell you of the value of this Program.

I think that we would all agree that spinal cord injury is among the most debilitating of conditions. The afflicted lose their independence and suffer a severe decline in quality of life. They become paralyzed, they lose normal urinary, bowel, and sexual function, and they suffer other severe disabilities. With current care, many individuals live for many years with these devastating problems. At present, about one million Americans suffer paralysis due to spinal cord damage, tens of thousands in New York alone. Each year, several hundred additional New Yorkers suffer a spinal cord injury. A new population of spinal cord injured people for whom we bear special responsibility consists of our military personnel returning from Iraq and Afghanistan. Spinal cord injury represents a large burden on the public health care system. The life time expense for a 25-year old with a high-level injury is estimated to be as much as \$3,000,000.

The importance of improving the lives of spinal cord injured people and enabling them to return as productive members of society is reflected in the fact that several states (Kentucky, Florida, California, and New Jersey, among others) have spinal cord injury research programs. New York's Spinal Cord Injury Research Program (SCIRP) is the largest, most prominent, and most widely respected of these, and features a very rigorous reviewing process. Each proposal is reviewed in detail and scored by an independent board of experts drawn from outside the state, and the evaluation of each proposal is presented to the Spinal Cord Injury Research Board. We discuss the reviews and fund only those grants that are likely to produce new knowledge that can help improve the lives of people with spinal cord injuries. We fund fewer than 50% of the proposals received. We also use the reviews to evaluate the program as a whole and to set policy. We believe this system is choosing wisely because so many of our recipients have been able to leverage their SCIRP funding to obtain grants and contracts from agencies outside the state, for example, the National Institutes of Health, the Veterans Administration, the Department of Defense, etc.

By law the SCIRP is funded by a surcharge on fines for Moving Violations, and so it is not a drain on state tax funds. Most of the recipients have obtained results from their SCIRP funding that enabled them to obtain further funding from the Federal government and from other non-NY sources. Our data show substantial leverage of SCIRP funding: it has brought about 50% more funds than were spent by SCIRP. Furthermore, both SCIRP funds and these additional outside funds support salaries for many scientists and other staff at our universities, hospitals and research institutes and have brought about 75 new professionals into New York State. Thus, we should think of SCIRP as an investment, not an expense. It is an investment that improves the lives of people with spinal cord injuries, attracts to considerable additional funding to New York, increases the jobs available to New Yorkers, and brings new scientists, clinicians, and other professionals into New York.

In summary, SCIRP funds do not come from tax dollars, are invested in jobs, are leveraged to bring in much more money than New York spends on the program, and are resulting in new knowledge that improves the lives of our citizens. All of these are hallmarks of a successful program that deserves to be continued. We trust that you will agree with this evaluation of the New York State Spinal Cord Injury Research Program and will ensure that it continues to exist.

Submitting 01104

MICHAEL J. DI SCIPIO
86 JONES DRIVE
SCHENECTADY, N.Y. 12309

To: New York State Senate Finance Committee Members
and
New York State Assembly Ways and Means Committee Members

Good afternoon Senators and Assembly persons, my name is Michael Di Scipio and I am a former Albany County Sheriff's Department Corrections Officer currently residing in the Town of Colonie.

I want to thank you for giving me the opportunity to speak before you today about Governor Paterson's executive budget 2010-2011 which proposes to terminate the Spinal Cord Injury Research Board and phase out the Spinal Cord Injury Research Program.

On July 3, 1999, I had a tragic diving accident leaving me paralyzed from the chest down. Since, my life has drastically changed as well as my children's, my loved ones, and my communities. Each and every day is a struggle where I need twenty-four hour care, seven days a week, three-hundred sixty-five days a year. The daily struggles that we go through each and every day I would not wish upon any human being. That is why I have become an advocate and supporter for research in finding a cure for this devastating injury.

The New York State Spinal Cord Injury Research Board / Research Program was signed into law on July 14, 1998 by Governor George Pataki, its mission is to fund cutting edge cure directed research in New York State such as that of distinguished researcher Dr. Sally Temple. Through the hard work and dedication of Paul Richter, Christopher Reeve, Terry O'Neill, and so many others plus the sponsorship by Senator Vincent Leibell and Assemblyman Ed Griffith made this program a reality. This program raises approximately \$8.5 million per year through surcharges imposed on motorists that are convicted of moving traffic violations and **not tax dollars**. It does not contribute towards New York State's budget deficit in any way, shape or form, it is a self sustaining program. This program is so successful that it attracts world renowned researchers and their staffing to New York State.

I believe this funding can ultimately lead to a cure getting tens of thousands of New Yorkers who suffer from paralysis out of our wheelchairs to lead a normal, productive life again.

New York State needs to remain in the forefront and not fall behind with this kind of research that is why this program is so important. I am urging you today **not to support** Governor Paterson's budget proposals for terminating / phasing out of the Spinal Cord Injury Research Board / Research Program that will ultimately help lead to the cure we are desperately seeking.

I again thank you for this opportunity to speak here today and know that you will do the right thing.

Respectfully submitted,

/s/ Michael J. Di Scipio

Michael J. Di Scipio
86 Jones Drive
Schenectady, NY 12309
518-248-4202
mdiscip2@nycap.rr.com

EMPIRE STATE PRIDE AGENDA



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Jonathan Lang
Empire State Pride Agenda
Written Testimony
Joint Legislative Public Hearing on Health/Medicaid
February 9, 2010

Thank you and good afternoon. My name is Jonathan Lang and I am the Network Director at the Empire State Pride Agenda. The Pride Agenda is New York's statewide lesbian, gay, bisexual and transgender civil rights and advocacy organization. We are very proud to coordinate the NYS LGBT Health and Human Services Network, on whose behalf I appear today.

The Network is a coalition of 54 non-profit organizations across New York State providing a wide range of non-HIV community-based services to LGBT New Yorkers. Since its creation in the mid-90s, the Network has grown into a sophisticated and diverse statewide coalition capable of delivering cost-efficient preventative and supportive services to hundreds of thousands of LGBT New Yorkers and our families. In fact, in one year alone – 2008 -- the Network's member organizations provided services to over 800,000 New Yorkers in all of New York State's 62 counties.

Some of the crucial services that Network organizations provide include:

- Health and wellness programs including primary and preventative health care;
- Mental health treatment and family counseling;
- Domestic violence and sexual assault services;
- Crime victim assistance;
- Homeless youth services; and
- Alcohol and substance abuse prevention.

In the spring of 2009, the Pride Agenda published an assessment of LGBT health and human services needs in New York State. For the first time, New York State has clear, scientific data that identifies the unmet needs of LGBT New Yorkers. Some of the findings of the needs assessment are startling:

- For something as fundamental as receiving basic health care, 40% of LGBT New Yorkers say there are not enough health professionals who are adequately trained and competent to deliver healthcare to LGBT patients.
- 14% of LGBT people, and fully one-third of transgender New Yorkers, are or have been homeless at one time.

- 13% of LGBT New Yorkers have been victims of a homophobic or transphobic sexual or physical assault severe enough to require medical care. The rate is even higher for people of color: 19% for Black LGBT New Yorkers and 20% for Latino.
- Social isolation is a significant problem for LGBT people, with two-thirds of rural LGBT residents saying they feel isolated from others, and over half of LGBT seniors saying they sometimes or always lack companionship.

These findings indicate what LGBT communities have always known anecdotally: LGBT communities face a staggeringly wide array of unique health-related problems. Disproportionately affected by a host of issues including mental health, substance abuse, homelessness, social isolation and hate violence, LGBT communities are placed at a severe disadvantage due to the lack of culturally competent healthcare and social services.

Like many other New Yorkers, the LGBT community is being tested in unimaginable ways by the economic downturn. Organizations that serve the LGBT community are struggling to accommodate a flood of clients, especially from historically marginalized groups such as seniors, youth and people of color. Emergency housing and meals, legal advice, foreclosure counseling and workforce development are just a few examples of the types of services that LGBT New Yorkers are seeking out in greater numbers.

Despite facing a sharp increase in demand for services with stagnant or even shrinking resources, Network organizations have remained resilient, resourceful and innovative in the face of a very challenging environment. Following the example of New York's state agencies, Network organizations are focusing on core mission programming that will effectively reach their target populations. With limited staff and funds, Network organizations are relying on creativity and sheer determination to provide services to so many. Over half of the 54 organizations in the Network operate on an annual budget of \$500,000 or less. 25% are either run entirely by volunteers or employee only one staff member. Falling back on the Network's greatest strength—collaboration—member organizations are working together to share resources, minimize costs and maximize impact.

But innovation and collaboration can only go so far. At some point, doing more with less becomes doing less with less. Network organizations have answered the cry for services from LGBT communities, and are providing them every day. They are stretched to their limits and need New York State to stand with them on the frontlines as they meet the needs of some of New York's most marginalized citizens.

New York State has long supported the Network because of its proven ability to provide culturally competent services in a highly cost-efficient manner that stretches every state dollar to its fullest. Network organizations are providing services that are responsive to the needs of their communities and that prevent hundreds of thousands of New Yorkers from utilizing more costly health care services that will increase our state's deficit. Because of this, New York State's relatively small investment in the Network has actually saved the State an immeasurable amount of money in the medium and long-term.

The facts and figures are clear and irrefutable: Regardless of the economic climate—and in some cases because of it—the needs of the LGBT community in New York State are profound. The State has a responsibility and a constitutional mandate to address the needs of some of its more vulnerable citizens. Even in tough times, New York can not neglect the needs of the hundreds of thousands of LGBT New Yorkers who continue to face stigma and discrimination when accessing even the most basic forms of health care. In these times of economic uncertainty, New York State must continue its decade-long investment in the Network by continuing to provide public support for the invaluable services that the Network collectively provides.

We hope that as the Governor and the Legislature contemplate how to address the state's economic troubles that they keep in mind the implications — in terms of public health, the health of the economy and, yes, equality and fairness — of cutting invaluable funding for these low-cost, preventative services provided by the Network's community based organizations. On behalf of the Network, I am asking that the 2010-2011 State Budget include adequate funding from both the Executive and the Legislature to help ensure that LGBT New Yorkers get their fair share from their government and continue to have access to safe, quality health care and human services. Thank you.

#16

February 9, 2010

ACTS Response to Governor's Early Intervention budget proposals:

I want to thank the members of the New York State legislature for allowing me to speak on behalf of Professional Agencies for Children's Therapy Services (ACTS) in regard to the Governor's recently proposed budget initiatives for the NYS Early Intervention Program.

My name is John Calderon, Board Member and Secretary of ACTS.

ACTS is an association of 21 provider Agencies of Early Intervention and Pre School Special Education services. ACTS Agencies serve disabled children from Orange county south through Westchester, New York City and Long Island in a "natural environment" home and community based setting.

Our model is fully compliant with both NYS and Federal requirements that early intervention services should be provided in a "natural environment". The New York State Early Intervention Performance Plan states "Early Intervention services and supports should be provided in settings where typical children live, learn, and play with activities that address children's needs built into the child's and families typical routines, such as mealtime, bath time, or play time". The Federal definition of the natural environment states in part C of IDEA "settings that are natural or normal for the child's age peers and who have no disabilities" (34 CFR 303.18.

1 In 2009 ACTS Agencies served an aggregate total of 41,302
2 children in Early Intervention and Special Education Pre School
3 programs in New York State. The 33,643 Early Intervention
4 children ACTS Agencies served last year represents approximately
5 48 % of all New York State children served in the Early
6 Intervention program.

7

8 ACTS is acutely aware and concerned about the New York State
9 budget shortfall. This is why ACTS Agencies have proposed
10 administrative initiatives to the Department of Health that we
11 estimate will save New York State \$46 Million dollars in fiscal
12 year 2011/2012 and forward. Our proposal will save money
13 without putting providers of “natural environment” home and
14 community base early intervention services in fiscal jeopardy and
15 without resorting to parent co-pays.

16

17 In contrast, the Department of Health and Governor’s budget
18 include proposals that would save \$66 Million dollars by
19 significantly reducing the reimbursement rate to “natural
20 environment” Home and Community Base Early Intervention
21 providers, and by shifting the burden of billing Medicaid and
22 private insurance to the Provider community and by instituting
23 parent co- pays.

24

25 Although the Department of Health has refused to disclose the
26 exact terms of its “interim rate proposal”, ACTS projects that the
27 Department will propose reducing the reimbursement rate to
28 “natural environment” Home and Community Base Early
29 Intervention providers by at least 10% or approximately
30 \$60Million State wide. Factoring inflation, early intervention
31 reimbursement is 45% less today then when the program began in
32 1994. Reductions at the magnitude to be proposed by the
33 Department of Health will put providers of “natural environment”
34 home and community based services in financial jeopardy.

35

1 The Department of Health also proposes to shift a significant
2 amount of funding in their “interim rate proposal” to a small group
3 of providers that serve children in a segregated, non-natural
4 environment. This interim rate proposal was done without
5 consulting the Reimbursement Advisory Panel (RAP) which was
6 formed to review rate methodology in the Early Intervention
7 program.

8
9 Part C of IDEA stipulates that “to the maximum extent
10 appropriate to the needs of the child, Early Intervention services
11 must be provided in natural environments including the home and
12 community settings in which children without disabilities
13 participate.” (34 CFR 303.12 (b)). Additionally, a federally funded
14 outcome study several years ago in NYS measuring parent
15 satisfaction with Early Intervention services found parents were
16 highly satisfied with service outcomes. Most of these parents
17 received home and community based services for their children.
18 Most recently, a study was published in the Journal of the
19 American Academy of Pediatrics, Nov 30, 2009, measuring the
20 effects of ABA services within Early Intervention provided in a
21 home and community based setting. home and community based
22 intervention resulted in children gaining 17 points in IQ scores
23 resulting in greater than 1 standard deviation improvement with
24 additional significant gains in adaptive behavior.

25
26 A loss of provider capacity in “natural environment” home and
27 community based services with an increase in segregated non-
28 natural environment services is against current New York State
29 policy, Federal regulations, parents’ wishes and best clinical
30 practices. The Department of Health “interim rate proposal” can
31 cause New York State to lose Federal funding of Part C early
32 intervention due to Federal regulations that require children to be
33 served in a natural environment. We urge the legislature to speak
34 out against this dangerous interim rate proposal.

1 The Governor has proposed that 80 Agencies that serve
2 approximately 68% of the children in the NYS early intervention
3 program bill Medicaid before seeking reimbursement from
4 Counties. The Department of Health estimates savings associated
5 with this proposal will result in a savings of only \$1.7 Million
6 dollars in fiscal year 2011/2012. The Governor and the
7 Department of Health acknowledge that Counties have been
8 unsuccessful collecting all billing due from Medicaid. ACTS
9 estimates that the amount Agencies will be unable to collect
10 through Medicaid billing will result in a loss of approximately \$20-
11 \$30 million dollars to these Agencies. A loss of this magnitude
12 will result in the financial collapse of the Agencies that serve the
13 majority of early intervention children. In order to avert a collapse
14 of the provider community, ACTS urges the legislature not to
15 consider any legislation that would require early intervention
16 providers to bill Medicaid before seeking reimbursement from the
17 Counties.

18
19 The Governor has proposed modifying section 3235-a of the NYS
20 insurance law in order to compel private insurance not to deny
21 claims for early intervention services. This legislation would also
22 require 80 Agencies that serve approximately 68% of the children
23 in the NYS early intervention program to bill private insurance
24 before seeking reimbursement from Counties.

25
26 ACTS is in favor of legislation requiring insurance companies to
27 reimburse the Counties for early intervention services but only if
28 the Counties continue to be responsible for the billing and
29 collection function. We strongly object to the section of the
30 legislation that would require provider Agencies to bill private
31 insurance prior to billing and seeking reimbursement from the
32 Counties. The Governor and the Department of Health are aware
33 that Counties have had significant challenges collecting all billing
34 due from private insurance. Since 2003, these governmental
35 entities have had the infrastructure, resources and expertise to bill

1 private insurance. Provider Agencies do not have the
2 infrastructure, staff nor expertise to perform this labor intensive
3 and complex function. It is not uncommon for Counties not to
4 know what billing issues have caused private insurance rejections
5 for 180 days or longer. Since most Counties have billing rules that
6 would prohibit Provider Agencies from billing them after 90 days,
7 recoupment of denied private insurance claims would be
8 impossible. ACTS estimates that the shortfall to Provider Agencies
9 may be as much as \$20,000,000 State wide per year. Shifting an
10 enormous financial shortfall to Provider Agencies with even less
11 resources than governmental entities will cause Provider Agencies
12 to collapse.

13 ○
14 ACTS opposes the establishment of parent co-pays in the NYS
15 Early Intervention program.

16
17 These costs, although pro-rated will place an undue hardship on
18 working parents with disabled children who already have
19 increased costs due to the disabilities exhibited by their children.
20 The caregivers and parents of disabled children in NYS should not
21 be required to pay a tax to have their children's disabilities treated.
22 Children of NYS should be treated humanely, not taxed for their
23 disabilities.

24
25 On behalf of ACTS member Agencies, I thank the members of the
26 legislature for considering our comments regarding the Governor's
27 proposed budget initiatives for the NYS Early Intervention
28 Program.

29
30
31

Department of Health Budget Proposal \$ in Millions	ACTS Budget Proposal \$ in millions	
Enroll providers into Medicaid	\$1.70	\$0
NYS to Bill Private Insurance	\$24.60	\$24.60
Parent Fee	\$13.60	\$0
Evaluation protocols	\$3.30	\$3.30
Speech protocols	\$5.80	\$5.80
Use of ABA para-professionals	\$5.90	0
Provider Audits	\$1.00	\$1.00
DOH Interim Revision to rates	\$9.80	\$0.00
20% rate reduction to independent contractors that contract directly with Counties	\$0	\$6.00
Eliminate bus transportation	\$0	\$5.00
Projected 2011/2012 savings	<u>\$65.70</u>	<u>\$46</u>
=====G32	=====	=====

Membership of Professional Agencies for Children Therapy Services (ACTS)
As of 2/6/2010

Valley Consultants
Up wee Grow
O'Connell & Selig
All About Kids
Therapy Center for Children
Metro Therapy
Sunny Days
Cooper Kids Therapy
Kidz Therapy
New York Therapy Placement Services
TheraCare of New York
First Steps
Children Speech and Rehabilitation
MK Salomon Associates
Infant and Toddlers Intervention
Kadletz and Associates
Challenge Early Intervention Program
Bilinguals, Inc.
Kinderwide
Personal Touch Early Intervention
Designing Futures



**New York State Senate and Assembly
Joint Session on Health for the
FY 2010-2011 Executive Budget
February 9, 2010**

**Supportive Housing Network of New York
Ted Houghton, Executive Director**

Good morning. My name is Ted Houghton, and I am the Executive Director of the Supportive Housing Network of New York. The Network represents over 180 nonprofit providers and developers who operate nearly 40,000 supportive housing units throughout New York State, the largest supportive housing membership organization in the country.

Supportive housing – affordable apartments linked to on-site services – is the cost-effective and humane way to provide stable homes to individuals and families who have difficulty finding and maintaining housing. The people we house and serve – people with mental illness, HIV/AIDS, substance abuse, and other barriers to independence – are typically frequent users of expensive emergency services like shelters, hospitals, prisons and psychiatric centers. Because placement into supportive housing has been proven to reduce use of these services, supportive housing saves state taxpayers' money, often far more than what was spent building, operating and providing services in the housing. This has been proven, time and time again, by dozens of peer-reviewed academic studies.

Supportive housing's cost-savings arguments are particularly compelling when we are housing people with HIV/AIDS. When placed in housing linked to services, residents' T-cell counts go up, and viral loads go down. Hospitalizations are averted, or made more brief. Other barriers to independence, from mental illness to substance abuse to weak job histories, can be addressed with housing-based services.

The consistent service interventions deliver better quality care for far less than other more intensive, emergency settings. For example, one supportive housing residence, operated by Network member Harlem United, houses and serves only individuals with AIDS who have been certified eligible for nursing home care.

Placing them into this supportive housing residence offers a far better quality of life to tenants, while still providing appropriate support and care. Importantly, it saves the public a stunning \$103,000 a year for each resident who avoids placement into a nursing home. It is an extraordinary achievement.

As a result of supportive housing's long track record of success, today we have over 40,000 units of supportive housing in New York, spread throughout the state, from the Canadian border to the tip of Long Island. The AIDS Institute funds the services to a key subset of these 40,000 apartments, through two budget lines: Operational Support for AIDS Housing (OSAH) and NY/NY III service funds:

Operational Support for AIDS Housing (OSAH) – In the Governor's budget proposal, OSAH funding is transferred from the DOH AIDS Institute to the Office of Temporary and Disability Assistance (OTDA). We support this move, as the funding helps defray the cost of operating residences built with OTDA capital dollars. However, the transfer is accompanied by a cut of 10%, from \$1.092 million to \$983,000. We ask the committee to weigh in with your colleagues to restore this cut to a program that has long been supported by this committee.

NY/NY III Service Funds – These DOH AIDS Institute funds pay for services in new supportive housing units developed by a City-State initiative to create 9,000 more supportive housing units in 10 years. Under this initiative, called the New York/New York III Agreement, the AIDS Institute committed to pay for half the cost of providing services in 1,000 new units for people living with HIV/AIDS. These State funds leverage a like amount of City funding from the New York City HIV/AIDS Services Administration (HASA).

Today, thanks to the AIDS Institute and its counterpart agency in New York City, 521 formerly homeless people living with HIV/AIDS – most with additional disabilities – are now housed. Over the course of the next year, five more buildings will open with 55 units set aside for this vulnerable population.

The AIDS Institute has yet to release information about the amounts in individual budget lines for the SFY10-11 executive budget. We hope that the AIDS Institute follows the lead of other State agencies that are signatories to the agreement and fully funds services to existing and new units at \$6.626 million.

Thus far in the executive budget, three other State agencies that are NY/NY III signatories – the Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and the Office for Children and Family Services – have maintained their commitment to funding the operating and services costs for units created for their respective populations in the NY/NY III Agreement. They understand that abiding by the City-State agreement leverages enormous amounts of City and federal capital and expense budget dollars that would otherwise be

lost. They understand that investment in more supportive housing units helps them reduce other State spending on emergency interventions, like hospitals, shelters and prisons. In order to achieve this leverage and cost savings, NY/NY III funding is one of these agencies' few budget lines that continues to grow each year.

While other agencies have funded NY/NY III services, we still need to confirm that DOH AIDS Institute has fully funded these services this year. Last year the DOH AIDS Institute budget for NY/NY III fell short of the need by \$1.3 million. Without a last-minute restoration by the Legislature, at least two residences that opened this year would have had to forfeit their units set aside for people living with HIV/AIDS.

To cover the operating and service funding for all 521 existing NY/NY III AIDS units and the 55 units opening this fiscal year, the AIDS Institute needs \$6.626 million, an increase of \$968,000 over last years' budget.

We applaud the Legislature's recent action in passing the bill to limit rent charges to people with HIV/AIDS who live in subsidized housing to 30% of their incomes. We urge you to ensure that this budget allows people living with HIV/AIDS to still get access to the medicines they need to remain healthy. And we ask that you do all you can to protect the safety net for poor New Yorkers during this most difficult time. Most importantly, we ask that you protect the relatively small amount of service funding necessary to operate supportive housing for people living with HIV/AIDS safely and effectively.

We will follow up with the Health Committee as soon as the DOH AIDS Institute budget details are made known. We hope that there will be sufficient funding in this years' budget for all of the units that require services. If this is not the case, we hope we can count on the Health Committee to ensure that when the final budget is passed, the AIDS Institute has \$6.626 million for New York/New York III housing.

Thank you for this opportunity to testify.

Respectfully submitted by:

Ted Houghton

Executive Director

Supportive Housing Network of New York

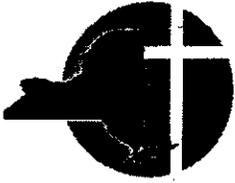
247 West 37th Street

New York, NY 10018

(646) 619-9641

thoughton@shnny.org

www.shnny.org



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NEW YORK STATE CATHOLIC CONFERENCE

465 State Street • Albany, NY 12203-1004 • Tel. (518) 434-6195 • Fax (518) 434-9796
www.nyscatholic.org

RICHARD E. BARNES
Executive Director

Testimony of the
New York State Catholic Conference

Presented by
Ron Guglielmo
Director for Health Care

Before the
Joint Fiscal Committees
Regarding the
Health and Medicaid Budget

February 9, 2010



Introduction

The New York State Catholic Conference represents the Bishops of New York State in public policy matters. Our Catholic tradition compels us to actively participate in the civic life of the community, to uphold the dignity of every individual, and to serve and advocate for those most in need. As the Catholic Conference has testified in the past, everyone deserves health care as a right consistent with their dignity, everyone needs health care to lead healthy and productive lives, and society has an obligation to provide access to health care to everyone, especially to the vulnerable aged, the disabled, and the poor.

The Catholic Church's health care ministry represents the largest single not-for-profit provider sector in the state, and provides approximately 10 percent of health care services statewide, in communities large and small throughout New York. The Church is also the largest provider of human services, with more than 700 programs and human services agencies located throughout the state. The broad spectrum of our service provision affords us a unique perspective to view the breadth of need throughout our state.

Mission-based health care providers play a unique role in the provision of health care services throughout the state. In particular, faith-based providers often operate with limited resources in areas serving the greatest need and provide services that other institutions are unable or unwilling to provide. In this regard, Catholic and other faith-based providers are uniquely suited, through their broad service networks of inter-related institutions and service agencies, to address the full spectrum of community needs, in partnership with the state, over the continuum of health and social services.

Our concerns are twofold: Access to health care is critical to the health and well-being of millions of New Yorkers, particularly in a weakened economy; and a financially robust health care infrastructure—whether Catholic-sponsored or sponsored by other entities—must be maintained to provide the health care services needed in every community in this state. Against these two broad concerns, the budget before you contains proposals which are encouraging in some respects and worrisome in others.

Reduced Revenues for Health Care Providers

The sluggish economy continues to place growing demands on health-care services, as evidenced by increased Medicaid caseloads—particularly for behavioral health services—and increased use of hospital emergency rooms. In addition, the cumulative effect of nearly \$4 billion in revenue losses and assessments on providers just in the last two years, on top of repeated smaller but no less debilitating cuts over more than a decade, has, as all can see, taken its toll.

It is precisely during periods of economic stress that the state's safety net services must be maintained. Indeed, even in the best of economic times, many low- and moderate-income individuals need assistance to afford the basic necessities, including health care. That need is found in every community even in good economic times, and it is growing as the prolonged economic slump continues.

Formula-driven cuts such as those before you have been proposed repeatedly for over a decade. The Legislature has on many occasions rightly rejected them, and for good reason. Patients do not present in the hospital emergency room by formula. Hospitalizations and surgeries are not necessitated by formula. And costs which cannot be controlled internally certainly are not governed by formula. These cuts may provide short-term budgetary savings to the state, but they will also have significant lasting consequences. In the short run, they merely weaken the ability of our health care institutions to effectively respond to the growing and rapidly changing nature of our communities' health care needs. And in the long-run, they fail to provide an adequate investment in the health care infrastructure necessary to nurture a long-term environment of efficiently provided quality health care for all our citizens. Without adequate recognition of increasing costs that remain largely outside the control of any provider, a facility's revenue base cannot hope to keep pace and provide sufficient resources to support the provision of necessary health care in their communities.

Budget reductions must take into account the needs of our most vulnerable neighbors and the crucial role these safety net services play in maintaining their health and dignity as other resources available to them are reduced or eliminated and as their jobs, other financial resources, and health care coverage are threatened. Providers in communities with the greatest need are

often the most adversely affected. For any provider struggling and committed to serving in our poorest communities, remaining “competitive within its market” is not an option.

And yet, the budget would cut revenue for health care providers at all levels—hospitals, nursing homes, and home care agencies—through reduced payments and increased assessments totaling nearly \$1 billion. Our preliminary estimate points to a loss of approximately \$22 million in revenue for the state’s 28 Catholic hospitals; approximately \$19 million for our 52 nursing homes; and approximately \$12 million for our home care agencies and programs. Cuts of this magnitude cannot be absorbed without drastic reductions in service provision. In addition, as access to health care becomes more limited due to cost and the loss of jobs and employment-related health coverage, imposition of provider assessments and additional surcharges on insurers can only make health care costs higher still, forcing even greater numbers of individuals into the ranks of the uninsured.

Ironically, in a struggling economy with flat job growth, the health care provider sector is one of the most robust sectors of our economy. Catholic hospitals alone provide \$9.5 billion in economic benefit to their communities and employ nearly 70,000 people.

Let us be clear: Just as we all rightly view cuts in education funding as cuts to students’ education, and not as cuts to schools, we must surely view cuts in health funding not as cuts to providers but as cuts to patients’ health care. Reduced revenues for providers will mean reduced levels of service, unmet staffing needs, elimination of marginal services, delay of capital investment in technology—ironically, including health information technology which can reduce expenses and increase efficiency over time.

The current heightened focus on both the real and the perceived surplus in the state’s institutional capacity belies the need for a systematic, ongoing approach to planning which incorporates analysis of need with availability and commitment of financial resources. In this regard, the yearly struggle faced by hospitals, nursing homes, home- and community-based providers, and physicians to maintain adequate revenue streams demonstrates the underlying need for an integrated approach to support the continuum of health care delivery.

Enhanced Access to Health Insurance Coverage and Service Efficiency

Your efforts over the last few years to extend affordable health care coverage to all of the state's children has served as a model for the nation, and the success of New York's Child Health Plus program is a testament to the state's commitment to the health and well-being of the young members of our community. Provisions before you to implement "Express Lane" enrollment and to further simplify the documentation requirements and enhance public databank matching for enrollment in Child Health Plus and Medicaid Managed Care are welcomed.

However, the proposal to reduce premiums for Medicaid Managed Care and Family Health Plus by 1.7 percent will place greater pressure on plans to adequately provide services to their enrollees. In addition, proposed co-pays in the Family Health Plus buy-in program will make such coverage less affordable to the low- and moderate-income individuals for whom the program was established. With the outcome of federal health care reform uncertain at this time, retrenchment in state supports for subsidized health insurance programs will jeopardize the ability of these individuals to access comprehensive health care through affordable coverage options.

With regard to rationalizing the delivery of home- and community-based services, the proposal to authorize joint case management of waiver services is a step in the right direction, and we commend it to you for your consideration. We believe that more can be done to enhance the delivery of services to the frail elderly and the disabled beyond waiver services, as discussed below.

The Particular Needs of the Frail Elderly and the Disabled

In contemporary American society, our elderly population too often is treated either as a problem or—equally troubling—as an afterthought. Even our public policies can overlook the needs of our oldest and frailest members to whom we owe such a debt. We have made great strides in our treatment of these valuable members of our community through the years, but, sadly, budgetary crises and other factors often lead to unfortunate cuts in services that severely impede that progress. As Catholic health care providers, we see an urgent need for a fresh look at how we are meeting our responsibilities to our elderly population and for adjustments in policies to better serve them.

The state's Catholic bishops have long emphasized this concern and call for a strengthening of the partnership of service between the state and the faith-based and not-for-profit long-term care provider community, which has been a hallmark of our society's commitment to fulfill the needs of our frailest and most vulnerable neighbors.

Demographic trends indicate that the elderly constitute a large and growing segment of the population in the nation and New York. Current methods of health care delivery—along with the delivery of ancillary services needed by the frail elderly—are but one of many factors contributing to the pressure on the long-term care delivery system. As seniors live longer, they face increasingly complex and costly health problems. At the same time, changing attitudes are placing greater emphasis on the ability of seniors to remain in their homes and communities rather than to retreat into institutions.

These factors, along with growing competition for ever-dwindling public financing, have contributed to a steady decline in the state's financial commitment to long-term care, especially to not-for-profit institutions' role in providing for the needs of the state's frail elderly, the poor, and the disabled.

As the state's Catholic bishops noted in their March 2005 pastoral letter on society's responsibility to the poor and vulnerable entitled *Restoring the Covenant*, a partnership of service between the state and the faith-based and not-for-profit long-term care provider community has been a hallmark of our society's commitment to fulfill the needs of our frailest and most vulnerable neighbors.

In its haste to realize budgetary savings in the short run, the state has rationalized a dismantling of the institutional delivery infrastructure and has based its current policy on formula-driven reimbursement and needs methodologies devoid of an acknowledgment of the impact such actions have on affected individuals.

Current trends notwithstanding, the need continues for a robust and financially stable institutional infrastructure to deliver long-term care services to our frailest and most vulnerable elderly, for whom home- and community-based services are not a realistic alternative. The desire to receive services at home or in the community is justifiable when it is the most

appropriate setting for those in need of service, but institutional long-term care is, and will remain, an essential component of a complete health care delivery system.

With these factors in mind, we believe that certain core principles must be applied to the evolving development of long-term care policy:

- Through dialogue with communities of interest, develop a coherent vision, principles and policies for the care of our frail elderly and other dependent populations and adopt specific programs for moving toward that vision.
- Clearly establish and organize the state's accountability for protecting and securing the lives and well being of the frail elderly and other dependent populations.
- Reaffirm the state's historic partnership with voluntary and faith-based agencies in providing care and services to those in our communities who are most vulnerable and unable to care for themselves.
- Commit to a system of Medicaid reimbursement that will pay for the necessary and reasonable costs of long-term care services that will meet acceptable standards for quality of life as well as quality of care.

In keeping with these principles, we recommend that the following policy initiatives for your consideration:

- Require a comprehensive care plan for every nursing home-eligible individual—developed with the participation of the affected individuals and their families—which reflects the full range of human needs, including spiritual fulfillment, and which takes into consideration the availability of institutional and home- and community-based services appropriate to the needs of each such individual.
- Develop plans related to the decertification of nursing home beds and the substitution of additional assisted living beds or any other form of home- and community-based care. These plans must take into account the circumstances of the populations to be affected and the specific circumstances of the affected individuals and their families, the availability and capacity of institutional and home- and community-based service

providers in the affected area, and the supply of trained health care workers. Such plans should also ensure that every individual has access to appropriate care and should provide priority access to employment opportunities in home- and community-based-care for affected health care workers.

- Establish a standing interagency long-term care planning committee consisting of leadership and appropriate staff from the Department of Health, the Office for the Aging, and the Department of Housing and Community Renewal, as well as providers and consumer groups, which would make recommendations to policy makers and regulators on how to best meet long-term care needs.
- Recognize the importance to care recipients, their families and care providers of the role of spiritual support in their daily lives.

Providing Life-affirming Health Care

Maternity and Early Childhood Foundation

The Executive Budget completely eliminates funding for the Maternity & Early Childhood Foundation, Inc. (MECF), which funds projects throughout the state that provide vital health and social services to pregnant and parenting young women and their infants. The elimination of this funding will devastate a program that has proven to be cost-effective in promoting early pre-natal care and healthy lifestyles for low-income pregnant and parenting mothers, and in preventing serious subsequent health problems and future dependency on the public assistance and foster care systems. Investing in programs like MECF will enhance the health, well-being and dignity of those served and save New York State in the long-term. We strongly urge the Legislature to restore the \$1.2 million appropriation for the Maternity & Early Childhood Foundation.

Stem Cell Research

The Executive Budget contains \$44.8 million for the Empire State Stem Cell Fund, consistent with a ten-year commitment outlined in the 2007-2008 State Budget. Projects funded by the Empire State Stem Cell Board are highly controversial and have flowed to research requiring the destruction of human embryos for their stem cells. Most recently, the Stem Cell Board decided, with no direct legislative approval or oversight, to allow funding to be used to

financially compensate women for the harvesting of their eggs for research—an extreme policy which no other state in the union allows. In addition, the Board is currently contemplating the ethical and policy implications of animal-human “chimera” research, and could decide that research involving the integration of human and non-human cells would be eligible for Stem Cell Board grants. Numerous opportunities exist for promising ethical stem-cell research, and we urge the Legislature, as we have in the past, to limit scarce research resources to ethical non-embryonic stem cell projects.

Medicaid Abortion Funding

Funding for abortion through the medical assistance program remains in the 2010-2011 State Budget. We urge the Legislature to mirror the federal Hyde Amendment’s restrictions on abortion funding. Limiting funding for abortion to cases of reported rape or incest and cases in which the life of the mother is threatened by a continued pregnancy would save the state the vast majority of the approximately \$45 million spent on abortion each year through the Medicaid program.

Conclusion

Make no mistake: As we and others have repeatedly said over the last decade, reductions of this magnitude will result in a loss of health care services for our poorest neighbors, especially for the frail elderly and the disabled. The responsibility to balance the state budget must not be placed on those least able to shoulder the burden, especially when their need for health services—always an issue even in the best of times—is growing. Indeed, those least able to bear the brunt of the state’s budget deficit should be disproportionately sheltered from its ill effects.

Without adequate access to care, our citizens cannot hope to live healthy and productive lives. Without adequate compensation, health care facilities cannot provide services needed in every community in this state. We urge you to take the long view, to look past the opportunity for short-term formula-driven savings, and to work collaboratively with the health care provider community to develop long-term savings based on sound strategic investment.

We urge you, therefore, to restore adequate payments to providers to maintain needed health care services for all; to continuing the development of home- and community-based

services so seniors can receive necessary care while remaining in their homes among family and friends; and to maintain the hard-won gains in access to affordable health care coverage.

All of us, and especially our most needy fellow New Yorkers, deserve a health care system that is appropriately and adequately funded, and we urge you to reject easy fixes to these difficult circumstances.

We stand ready to work with all policy makers and our faith-based and not-for-profit colleagues to fashion cost-effective and compassionate policies which will ensure the dignity of our most vulnerable fellow New Yorkers.



Testimony to the Budget Hearing on Health and Medicaid

In years past, my testimony has outlined basic questions about AIDS policy and science raised by scientists and medical doctors.

Last year, ten of those questions, along with an explanatory presentation, were sent to the federal Health and Human Services Department, seeking answers or resolutions.

As is apparent from the correspondence, virtually none of the questions can be answered.

Nonetheless, federal and state governments continue to spend tens of billions on AIDS. In the case of New York, roughly 3% of the state budget, while school aid is slashed.

Here is just one of the questions that cannot be answered: Why do criteria for a positive HIV test, unlike any other medical test, differ by geography, so that someone testing positive in Africa may not be positive in New York?

The full correspondence to and from HHS is at www.aidspetition.org/Questions.

Recently, HIV co-discoverer Montagnier stated¹ that a healthy immune system can get rid of HIV. If general health measures can remove HIV, why are we spending billions on toxic drug treatments?

It really is time for serious scrutiny of AIDS policy and spending.

Sincerely,
Frank Stoppenbach

96 Rokeby Road
Red Hook, NY 12571

Member, The Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis

February 9, 2010

¹ <http://thepertgroup.com/HON/LMNexus.html>