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SUBMITTED BY:

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Good afternoon. My name is Trilby de Jung and I am the Health Law Attorney for the Empire Justice Center here in Rochester, New York. I also serve on the Steering Committee, of Medicaid Matters, New York.

At Empire Justice we currently have staff attorneys specializing in Health and Medicaid, public benefits (cash assistance, child care, food stamps and child support issues), Supplemental Security Income (SSI) and Social Security Disability (SSD) benefits, education and special 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.

With offices in Rochester, Albany, White Plains and on Long Island, Empire Justice operates as a statewide backup, training and support center for legal services offices statewide. It is this backup and support role that often gives us the perspective to identify trends and patterns in the issues faced by low-income New Yorkers. This is a crucial part of our work – we then address the need for systemic change through tools such as class action litigation, and administrative and legislative advocacy.

We share your sense of urgency about the need for systemic change in the health care system. Despite the advances we have made in our public insurance programs, the Commonwealth Fund still ranks us in the bottom third of the states in terms of avoidable hospital use and costs. We still have 320,000 uninsured children and 1.95 million uninsured adults in New York State.[1] Without reforms to our current system, we will be unable to reduce those numbers, particularly locally, as health insurers continue to increase premiums.

Just last week, Excellus Blue Cross Blue Shield, a major insurance plan here in Rochester, announced another 8.3 percent average rate increase for 2008. Preferred Care, our area's other major health plan, is likely to increase rates significantly as well. According to a survey by the Rochester Business Association, local employers are preparing for an 11 percent increase in rates next year, and only 21 percent plan to absorb the increase without passing cost hikes along to employees. As a result, more and more of New York's families will be unable to afford coverage, and their lives will impacted dramatically. As we all know from a growing body of research, those without insurance tend to be in poorer health, in debt, and experiencing difficulty accessing care.[2]

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[1] A. Cook, D. Miller, and D. Holahan, "Health Insurance Coverage in New York, 2004-2005," United Hospital Fund/Urban Institute, September 2007.
[2] For a summary of the research on the consequences of health insurance gaps, see S. Collins, "Widening Gaps in Health Insurance Coverage in the United States: The Need for Universal Coverage," Invited Testimony before the U.S. House of Representatives, Committee on Ways & Means, November 14, 2007.

Today's hearing poses the fundamental question -- how can New York most effectively reduce the number of uninsured people in our state and approach universal coverage? We see two fundamental directions for reform as essential. First, we need to make improvements to our existing public health programs so that the coverage they promise is truly available to all of those who qualify. Then we can build the new systems we will need to offer meaningful coverage to those currently ineligible for the public programs and unable to afford private products.

Strengthening our Existing Programs

We recently surveyed over 300 families for a 2006 report on Medical Debt in upstate New York.[3] One of the fundamental things we learned was that most uninsured people with debt didn't start out uninsured. They had health insurance at one point and lost it. A recent study by Manatt tells us that half of the people who have Medicaid coverage lose their coverage during the annual recertification process.[4]

It is our sense that while some of those who lose coverage do have increased income or some other event that makes them ineligible for public coverage, many run into administrative barriers, caught up in documentation problems, language barriers or improper case closings. Fair hearings reports tell us that here in Monroe County, only about a third of Medicaid's administrative denials or sanctions that are challenged are upheld.

Another fundamental fact about New York's existing public programs, which I'm sure you all have discussed extensively – 900,000 uninsured New Yorkers, 40% of our uninsured population, are actually eligible for public health insurance.[5] Of course, some of those folks are people who get administratively churned off the programs. But there are also families out there who we fail to reach, who are not coming forward to access coverage and care even though they could.

Clearly, we have work to do in strengthening our public programs if we are serious about universal coverage. We have to make the application and re-certification processes easier for people to navigate and we have to come up with new outreach strategies to reach the eligible but uninsured.

Governor Spitzer has demonstrated a commitment to maximizing access to health insurance coverage in his first year initiatives for simplification of our

[3] "In Sickness and In Health: The Impact of Medical Debt on Upstate New York Consumers," Empire Justice Center, January 2006.
[4] P. Boozang, L. Braslow, and A. Fiori, "Enrollment Churning in Medicaid: Coverage Gaps Undermine the Managed Care System and Continuity of Care for the Chronically Ill," Manatt Health Solutions, December 2006.
[5] D. Holahan, A. Cook, Leslie Powell, "New York's eligible but Uninsured," United Hospital Fund, to be released in December 2007.

public health programs.   These initiatives included reforms to the Medicaid renewal process for adults, such as 12-month continuous eligibility, and self-attestation to income and residence.

These reforms are likely to reduce administrative churning significantly, and we hope to see more progress this session. Specifically, New York needs to move to biennial renewal cycles, expand facilitated enrollment, and eliminate burdensome administrative hurdles that are holdovers from welfare reform with no relevance for health insurance, like the requirements for fingerprinting and drug and alcohol screening.   In order to truly streamline application and renewal processes, we also must eliminate unnecessary distinctions based on age, marital or parental status and disability, which cause people to fall in and out of coverage as they move through life's cycles.

Lessons learned in other states tell us that the best way to reach those already eligible is with the message that Medicaid is health insurance, and that is available for all children. The only states that have been able to achieve over 90% enrollment of eligible low-income children, have done so only after raising eligibility levels and marketing the Child Heath Plus (CHP) program as available to all. Our leaders in the Legislature had the vision to take us in that direction by passing last year's expansion of the CHP program to 400% of the federal poverty level.

It is ironic then, that the federal government has denied approval of New York's planned expansion, under the rubric that first we must achieve higher enrollment of children who are already eligible. Indeed many of the grounds advanced for New York's denial amount to poor public health policy, or worse.

We support the Governor's decision to challenge the federal denial in the courts -- we will be filing companion litigation on behalf of families that are being denied access to health insurance for their children as a direct result of the federal government's action. We will also be supporting legislation to expand eligibility for adults as well as children, recognizing that children get coverage when families get coverage.

Initiatives to streamline, simplify and expand existing programs in order to bring eligible but uninsured families into coverage and keep them there, are more than baby steps toward universal coverage. With a full 40% of our uninsured population eligible for public health insurance, and 50% falling out of coverage every renewal period, simplification and streamlining initiatives are crucial building blocks to universal coverage and deserve all of our attention and support.

Building a New System

But what are we building toward as we work to strengthen our existing public programs? At Empire Justice, we believe that a single payer system is the goal that ultimately makes the most sense for our country -- we support that vision on the federal level. But what is the best route for states like New York to take in the meantime?

Let me first say that the path represented by the plan in Massachusetts presents some significant concerns for us. It is our sense that because the plan will utilize an income limit for subsidized coverage and an individual mandate, the plan will inevitably present low-income families with a financial cliff, a sudden, steep increase in cost that will create significant hardship.

In addition, the Massachusetts plan does nothing to raise payments for primary care physicians, without whom there can be little hope of effectively preventing and managing disease. Low-income families are likely to continue facing the same shortages of primary care doctors and dentists, particularly in rural areas of upstate New York.

We are also concerned about whether New York will be able to fashion a health benefit that is sufficiently comprehensive for low-income families if it follows in the footsteps of Massachusetts. Without significant new revenue, existing dollars will inevitably be stretched thin, and benefit packages are likely to be reduced. We have seen that in Massachusetts, hoped for contributions from the business community have not materialized, and the public dollars available for health care for the very low-income are being redistributed to cover larger groups of people.

Because we at Empire Justice are involved in advocating for low-income consumers on a variety of issues, health, housing, food stamps, child care and consumer issues, we understand only too well how precarious existence is for so many families living near the poverty level. The same can be said for those families who have incomes up to 150% of poverty, above which eligibility for public health insurance ends for adults. Benefit reductions for lower income families will mean going without regular preventive care. Those at the edge of the financial cliff will face administrative complexities in applying for subsidized coverage and very difficult choices if income increases even slightly. Under an individual mandate, those who fail to purchase commercial products will be subjected to sanctions.

For these reasons, we are very pleased to note that there is an alternative to the Massachusetts approach for state reform on the horizon, one that we feel contains a lot of the coverage promise inherent in a plan with individual mandates, but avoids the financial cliff and reduction in benefits.

The alternative has been advanced in testimony before this body by the chair of the Assembly Health Committee – Dick Gottfried. As we understand it, Assemblyman Gottfried's plan in essence proposes to open New York's most successful public health program, Family Health Plus, to all New Yorkers, regardless of income level. In one fell swoop, we would eliminate virtually all of the administrative hurdles responsible for churning people out of the programs.

The plan would eliminate premiums and other medical cost sharing for consumers, employers, businesses and local governments alike. All of the considerable spending on insurance premiums and medical cost sharing, by local government, employers and individuals, would instead be converted to a revenue stream to fund the program. Businesses would no longer be subjected to unpredictable and sudden increases in health care costs, like the 8.3 percent increase announced by Excellus last week.

The universality of the plan would provide opportunities not just for administrative simplicity, but also for truly enhanced quality improvement, cost control and health planning. Because all of us would share in the same coverage, consumers' political voice would be unified. And instead of a multitude of employers contracting with health plans, only the state would negotiate and monitor, thereby vastly improving New York's ability to control for quality and cost through contract negotiations. Data systems would be unified and simplified and health planning would become vastly easier, enabling us to construct incentives to bring balance back into primary care and rural settings.

We would want to ensure that under a plan like that advanced by Assemblyman Gottfried, Medicaid's long term care services remain in place for qualified individuals, and that mental health, dental and vision services are adequate. With those caveats, we look forward to further discussion of Assemblyman Gottfried's vision, even as we move forward to put the building blocks for any plan for universal coverage in place by strengthening our existing programs.

Thank you for the opportunity to present testimony about this vitally important topic. Should you have any questions, please do not hesitate to contact me in our Rochester office at 585-295-5722.