Health

Medicaid

In response to the increasing property tax burden the escalating cost of the State's $44 billion Medicaid Program has placed on local taxpayers, the Executive Budget for State Fiscal Year 2005-06 includes a plan for the State to assume a significant share of the local growth in Medicaid by January 1, 2008. Under the Governor's proposal, counties would not be entirely relieved of any fiscal responsibility for Medicaid; instead their share would be limited to a capped amount. Starting January 1, 2006, Medicaid payments made by local governments would be capped at 3.5 percent growth over 2005 costs, or actual costs, whichever is less. The growth rate would drop to 3.25 percent in 2007 and to 3.0 percent for 2008 and thereafter. In 2008, counties could continue under a cap or they could elect to have the State assume the full local cost of Medicaid in exchange for remitting to the State a calculated percentage of local sales tax revenue. The Executive estimates that this proposal would relieve local taxpayers of more than $2 billion over the next three years.

It is about time that the Governor took real action. In fact, the Governor's plan is very similar to a proposal put forth by the Assembly last year. The Assembly has long recognized the strain Medicaid has placed on county budgets and the need to relieve this pressure. That is why the Assembly, while supporting new Medicaid expansions in the past to improve the quality of care for New York's vulnerable citizenry, has consistently fought to eliminate a local share from these services. The Governor, however, has repeatedly rejected numerous Assembly proposals that would have protected local Medicaid budgets from new costs. In fact, in 1995, as one of his very first Medicaid actions, the Governor rescinded the second phase of an Assembly supported, already enacted two-year plan for the State to assume a larger share of Medicaid managed care and long-term care expenditures. The Governor later succeeded in repealing the first phase of the plan related to managed care as well.

Again, mindful of county costs, the Assembly, in 1999, proposed the Family Health Plus (FHP) Program with no local share. The Governor insisted on implementing the program with a local share, saddling localities with responsibility for 25 percent of the program's expenditures. Had the Governor accepted the Assembly's original proposal, local governments could have saved nearly $700 million to date and avoided frightening increases in local tax levies.

In recognition of the added burden this new program was inflicting on county taxpayers, the Legislature acted last year to assume full takeover of Family Health Plus over two years, starting January 1, 2005. This action was estimated to save localities over $200 million this year and at least twice as much in 2006. In a break from history of saddling localities with higher Medicaid costs, the Governor did not veto this action and counties are beginning to benefit from some relief.

The Governor capitalizes on the Legislature's action by proposing to accelerate full takeover of FHP in upstate counties by three months, moving the start date to October 1, 2005. This proposal would provide an additional $25 million in relief this year, as well as an additional $20 million in Medicaid transitional funding assistance for counties outside New York City. The Governor's spin-up is conditioned on enactment of "the Medicaid cost containment actions proposed in the 2005-06 Executive Budget." It is indeed unfortunate that the price for local fiscal relief must be paid by vulnerable and hardworking Medicaid and Family Health Plus recipients whose health care would be compromised by the proposed cuts.

Proposed cuts to health care are nothing new for this Governor. In nearly every Executive budget since he took office ten years ago, the Governor has proposed egregious cuts to the State's Medicaid Program. For SFY 2005-06, he proposes $2.1 billion (all payors – federal, state, and local shares) in direct cuts and taxes on Medicaid providers. In addition, the Governor proposes over $850 million (all payors) in actions targeted at the poor, the elderly, and the disabled recipients of Medicaid, as well as the working families and adults seeking coverage under Family Health Plus, cuts that will deprive these individuals of needed health care benefits, limit eligibility, restrict access to services and increase out-of-pocket expenses by imposing higher co-pays. In total, the Governor's proposed actions would total about $3.0 billion from health care

The health care industry is the first or second largest employer in nearly every county in the state. This industry is experiencing critical staffing shortages, shortages that ultimately limit access to care and affect the quality of that care. Moreover, workforce shortages can often lead to higher health care costs when consumers are forced to seek more expensive services if access is restricted to less costly alternatives. For example, when access to the personal care and home health services needed by an elderly person to enable such individual to remain in the community are denied due to the inability of providers to meet required staffing levels, this individual may have no alternative but to seek costly institutional care. Ways and Means Committee staff estimates that the health care cuts proposed by the Governor would result in a loss of approximately 45,500 jobs in New York, real jobs held by real people.

Family Health Plus

The Governor's proposed cuts to the Family Health Plus program exhibits a mean spirited disregard for the plight of the working poor. This program, which was enacted as part of the Health Care Reform Act of 2000 (HCRA 2000), was intended to provide needed health insurance coverage for up to 600,000 uninsured low income adults between the ages of 19 and 64. The program, which began enrolling participants in October 2001, has seen rapid growth over the last three years, but growth has started to slow in recent months. Enrollment in the program is currently at 470,000.

The program's mission may be lost, however, and hundreds of individuals may find themselves once again among the ranks of the uninsured as a result of the Governor's proposed 2005-06 budget. Despite the obvious success of the program and the fact this administration has spent millions of dollars in advertising costs to promote FHP, the Executive budget proposes cuts that would effectively eviscerate the program. The Governor's proposal takes away certain currently covered benefits, depriving program participants access to such vital services as dental, vision, hospice and inpatient and outpatient mental health and alcohol and substance abuse services.

The Governor's proposal unfairly targets working families for actions taken by an employer. For example, the Governor proposes to prohibit enrollment in Family Health Plus to someone who works for a large employer (over 50 employees) even if the employer does not offer health insurance coverage for all employees. The Governor is dooming people/families to going through life without any hope of affordable and accessible health care. Yet another change that would unfairly penalize the worker is the Governor's proposal to remove the current exemption from the waiting period for FHP eligibility for individuals who lose employer coverage due to a reduction in wages or hours by the employer or who drop employer coverage because an increase in the cost of coverage makes it unaffordable.

The Governor also proposes to eliminate facilitated enrollment, an action that is certain to cause hundreds of present enrollees to lose coverage on recertification. Facilitated enrollers provide needed assistance to individuals in both the application and recertification process. Lastly, the Governor proposes steep increases in co-payments for services, an out-of-pocket expense that these individuals cannot afford. Ironically, the Governor proposes accelerating the takeover of the full local share of FHP expenses in upstate counties. Given the proposed cuts to the program, it appears that there may not be much more than the skeletal remains for the State to take over.

Funding Hospital Improvements and Upgrades

The cost of hospitals acquiring new technology and equipment has not only placed a burden on the State's hospitals but it has also helped drive cost increases throughout the healthcare industry. In the SFY 2004-05 budget enacted by the Legislature, $250 million in bonding authority was included to support a capital grant program to provide funding to health care facilities for restructuring and information technology projects. Ten million of this funding was to be reserved for community health centers to support needed improvements to aging infrastructure and technological advancements. Community health centers play a critical role in providing quality health care services in many poor underserved areas upstate as well as in densely populated urban areas downstate. Funding for the entire grant program was vetoed by the Governor.

In the intervening months since the veto, the Governor has obviously rethought his wrong choice. In the Executive Budget for 2005-06 the Governor makes the right choice

by proposing a $1 billion capital program over the next four years to support facility improvement, reconfiguration and consolidation; projects to upgrade information and health care technology; and activities that will improve the operating efficiency of facilities. The Governor finally joins the Legislature in investing in quality health care. He proposes to make $250 million available in 2005-06, including $10 million specifically for community health centers. While health care facilities will welcome the availability of this needed capital funding, it comes with a price tag like so many of the Governor's wrong choices -- monumental cuts in Medicaid that may impede a facility's ability to take advantage of the capital funding.

The Elderly

Long Term Care

Access to quality and appropriate health care is critically important to the more than 2.45 million New Yorkers who are 65 years of age or older. Many of the State's seniors, must struggle daily to make ends meet on fixed incomes and have no recourse but to rely on Medicaid for needed medical care. The elderly, however, use a disproportionately large share of long-term care services. Consequently, cuts and benefits to this sector adversely impact the health care services needed by this vulnerable population.

In the State Fiscal Year (SFY) 2005-06 proposed budget, the Governor recommends cuts and taxes on long term care services that will place even greater financial strain on already stressed nursing homes and home care providers. These actions could force providers to close their doors, thereby denying access to needed services to many frail elderly. Moreover, under the guise of reform of the long-term care system, the Governor proposes changes that would cause many seniors to be deemed ineligible for Medicaid, thereby putting the health care they need at risk. Denying health care to the elderly is the wrong choice.

Prescription Drugs

For many elderly, the taking of multiple medications is an essential part of their daily regimen in order to maintain good health. The Governor, however, proposes to raise pharmacy co-payments for Medicaid and Medicaid Managed Care recipients, increasing out-of-pocket expenses for this already needy population. Such increases, no matter how slight, could put undo strain on the already limited income available to these seniors and force them to forego needed medications. Denying needed medicine is the wrong choice.

Federal Medicare Prescription Drug, Improvement and Modernization Act of 2003

On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (H.R. 1). This law creates Medicare Part D, a new program that provides prescription drug coverage for Medicare beneficiaries that will take effect on January 1, 2006. Enrollment in the new prescription drug benefit will be voluntary, except for the dually eligible population who must participate in the program. (Dual eligibles are individuals who are both Medicare and Medicaid eligible, i.e., poor elderly and the disabled.) Drug benefits will be provided through approved, private stand-alone prescription drug plans (PDP's) or Medicare Advantage Prescription Drug Plans (MA-PD's), which are comprehensive plans consisting of a drug benefit along with Medicare Part A and Part B benefits. Participating Medicare beneficiaries will pay an average premium of $35 per month and an annual deductible of $250 for prescription drug coverage in the first year. On average, beneficiaries will be required to pay for 25 percent

of their annual prescription costs under $2,250, and 100 percent of their costs from $2,250 to $5,100 per year (known as the "donut hole"). Medicare will cover 95 percent of costs over $5,100 annually. There will be premium and cost sharing assistance for those members under 150 percent of the Federal Poverty Level.

The new program raises many issues for New York State, including among other things, how it will interact with the State's Elderly Pharmaceutical Insurance Coverage (EPIC) Program, the amount of savings to the State from implementation of the Federal program, and the impact of the program on the dually eligible population who will lose Medicaid prescription drug benefits under the new law. Policymakers must face the challenge of insuring optimal coordination between the State's EPIC Program and the new federal program in order to maximize fully the federal financial benefit of the new law while preserving access to critically needed drugs for seniors and the disabled. The new Medicare drug benefit is limited and involves a large amount of cost sharing. It will also have limitations on the formulary lists available and the pharmacies that can participate in the plan. These limitations and requirements could have a negative effect on the quality and access that New Yorkers have come to expect. Moreover, Medicare Part D does not allow Medicaid dollars to be used to supplement the drug benefit so any plan to provide additional coverage must come solely from State taxpayers.

It appears that the dually eligible elderly and disabled will be the group most adversely affected by the implementation of Medicare Part D. As the new federal law prohibits federal Medicaid wraparound of any drug benefits, these individuals will have access to fewer drugs and will face higher cost sharing based on more stringent co-payment requirements. Nor can they expect any help from EPIC because the dually eligible elderly and disabled are not eligible for EPIC. Although advocates for the aging and disabled communities strongly urged that any State savings in the EPIC Program from the implementation of Medicare Part D be reinvested in an expansion of EPIC to include the dually eligible elderly and disabled, the Governor's proposed budget does not provide for this relief. The dually eligible elderly and disabled are fearful that the new federal law will deny them access to the drugs they need, which could be disastrous to their quality of life. An expansion of the EPIC program to the dually eligible elderly and disabled would help to alleviate these concerns.

Community Services

When elderly individuals are unable to access needed community-based services, they are often forced to rely on more costly services in institutional settings, such as nursing homes. In his State of the State address, the Governor asserted that during this Session, we should "give even more seniors and their families access to a wider variety of long-term care options." Towards this end, the Governor proposes an increase in the Expanded In-Home Services for the Elderly (EISEP) Program and the Community Services for the Elderly (CSE) Program. These are important community-based programs that assist low-income elderly to remain as independent as possible for as long as possible, thereby

avoiding costly institutional care. The Governor also proposes a new $10 million initiative, "Access to Home" to assist the elderly and disabled in making modifications to their homes that would enable them to stay in the community instead of seeking more costly institutional care. Regrettably, the good effects of these proposals are mitigated by the previously discussed cuts to long-term care that may serve to deny seniors access to the services they may ultimately need.