

HANYS

VITAL SIGNS FADING

CLEAR INDICATORS OF A
COLLAPSING HOSPITAL SYSTEM



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Healthcare Association
of New York State

DECEMBER 2008

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INTRODUCTION

The Wall Street crisis of 2008 came as a surprise to most Americans, who are now acutely feeling its consequences. For many years, however, yellow and red warning lights flashed that should have alerted Wall Street insiders, federal regulators, and lawmakers that the meltdown was coming. Yet, no significant precautions were taken to stop the crisis in our financial system.

The same scenario unfolded during the savings and loan scandal and collapse in the 1980s. There were opportunities to heed the warnings and take preemptive action, but the alarms fell mostly on deaf ears.

Today, New York's health care system ominously moves toward a similar systemic calamity—but only if we continue to ignore the key structural problems that threaten the health care services of 19 million New Yorkers. If the breaking point comes, access to emergency and routine health care will be compromised in many communities across the state.

This paper discusses the factors that are eroding the foundation of our health care providers, and each of these factors presents daunting challenges to the health care community. When considered in totality, they represent a tremendous threat to New York's hospitals that must be addressed. How we respond to these warnings will determine the future of health care in New York State. There are two very different paths before us. One path leads to access to high-quality, affordable health care for all, fulfilling a basic human right. The other path leads to a system collapse where health care availability for entire communities would be jeopardized.

It is intended that this document serve as a resounding alarm bell for policymakers, government payers, private insurers, and consumers. Like our nation's financial firms, New York's hospitals, nursing homes, and home care services seem permanent, but are far more fragile than most realize.

IMPACT OF THE WALL STREET COLLAPSE

This year, the nation watched as one by one, financial houses began to crumble. A stunning domino effect devastated our financial sector and some of its most recognized investment banks. Bear Stearns, Morgan Stanley, Goldman Sachs, Lehman Brothers, and Merrill Lynch all succumbed in one way or another, either falling into bankruptcy, being acquired under financial pressures, or completely overhauling their business model.

This collapse and the ongoing national and state fiscal crises have only weakened the already fragile state of most health care facilities across the state. Hospital balance sheets have been hit particularly hard, making it almost impossible for health care providers to access the capital needed to invest in the latest technologies and improve facility infrastructure. The credit and equity crisis further limits access to bonds, and uncertainty exists as to if and when the market will return to functional levels.

Credit agencies have begun downgrading not-for-profit hospitals across the country, and predict rating downgrades will exceed rating upgrades for up to the next 36 months. A recent report published by Fitch Ratings downgraded the U.S. not-for-profit hospital sector from “Stable” to “Negative.”

With the economic downturn expected to continue—or likely worsen—into the foreseeable future, hospitals across the country can expect reduced revenue, continued cost increases, potential for declines or shifts in utilization, and increased uncompensated care—all trends adversely affecting hospitals’ credit profiles and balance sheets.

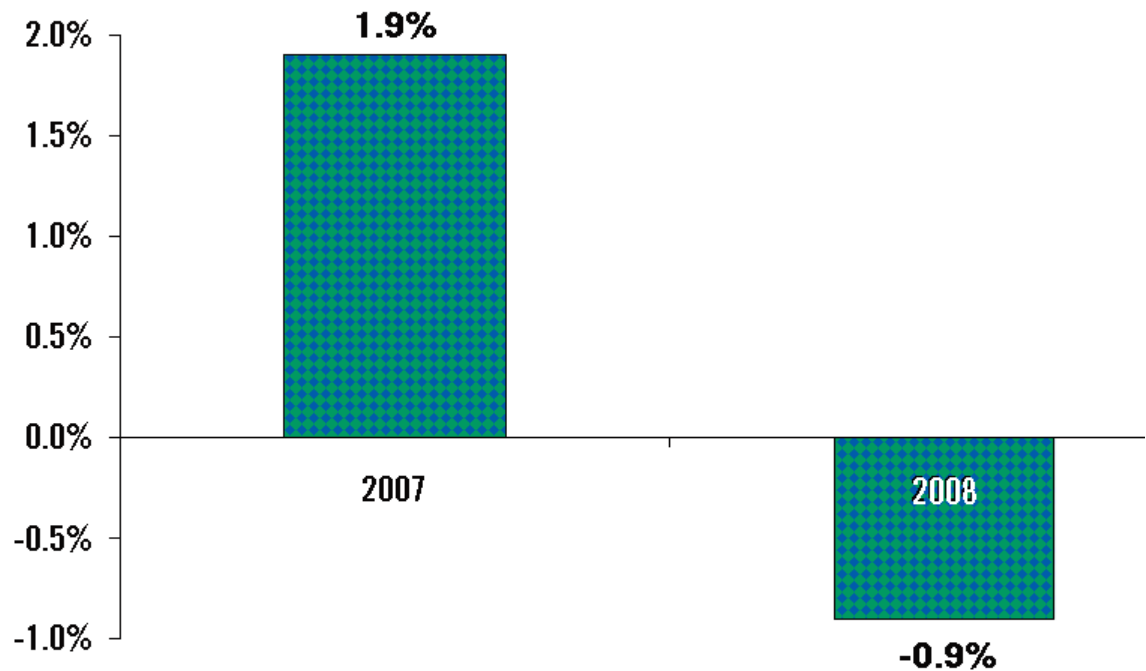
These effects are magnified in hospitals in New York State, as they are already operating with margins well below the national average. The losses on Wall Street have also contributed to state budget deficits in New York in the tens of billions of dollars. As a result, health care providers can anticipate government reimbursement to be constrained. Moving forward, providers must now contend with daunting challenges, including:

- the tightening of credit for both daily operations and desperately needed capital improvements;
- the loss of philanthropy;
- a growing number of uninsured and the associated loss of market-based insurance revenue;
- the loss of business as health care treatments are deferred;
- exploding pension obligations as a result of reduction in asset valuation and the need to divert operating income to meet statutory requirements; and
- serious threats to meeting bond covenants on existing financing due to balance sheet reductions.

In September 2007, New York's statewide hospital bottom line margin was just 1.9%, less than one-third of the national average of 6.8%. Since then, through September 2008, according to a recent HANYS' survey, that margin has fallen to negative 0.9%, further starving providers of essential operating cash and capital funds. When one takes into account that the economic picture has become even more bleak since September, it is certain that hospitals' current balance sheets are even more dismal today than reflected in the survey data provided.

Hospital Bottom Line Margins

CYTD* September 2007 vs. CYTD September 2008



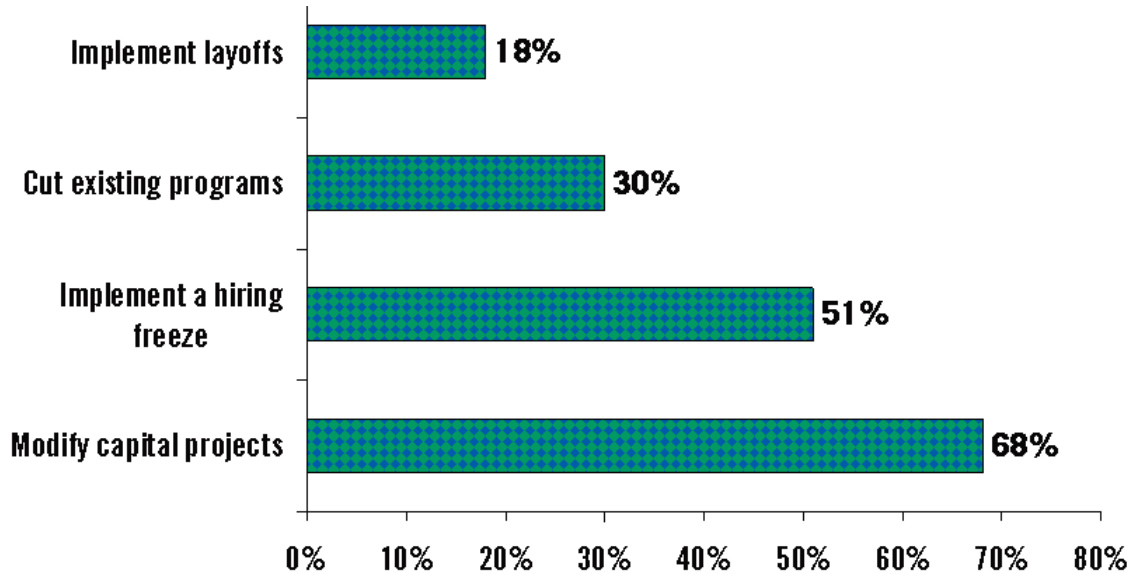
NOTE: Based on reports from 107 hospitals in November 2008 compared to hospitals' results in 2007.

*CYTD = calendar year to date

Meanwhile, the state faces a growing deficit that the Governor seeks to address with massive health care funding cuts—the very opposite of what is necessary to stabilize a clearly destabilized health care system. The federal budget is equally precarious and proposed federal Medicare and Medicaid cuts might not be far behind.

In this environment, providers have little recourse but to begin eliminating services, curtailing or suspending necessary capital and service upgrades, and laying off staff. The recent HANYS survey found a majority of hospitals in New York were already planning such activities, even before Governor Paterson proposes anticipated massive funding cuts in his 2009-2010 Executive Budget.

Percent of Hospitals Making or Considering Changes to Cope With the Current Economic Situation

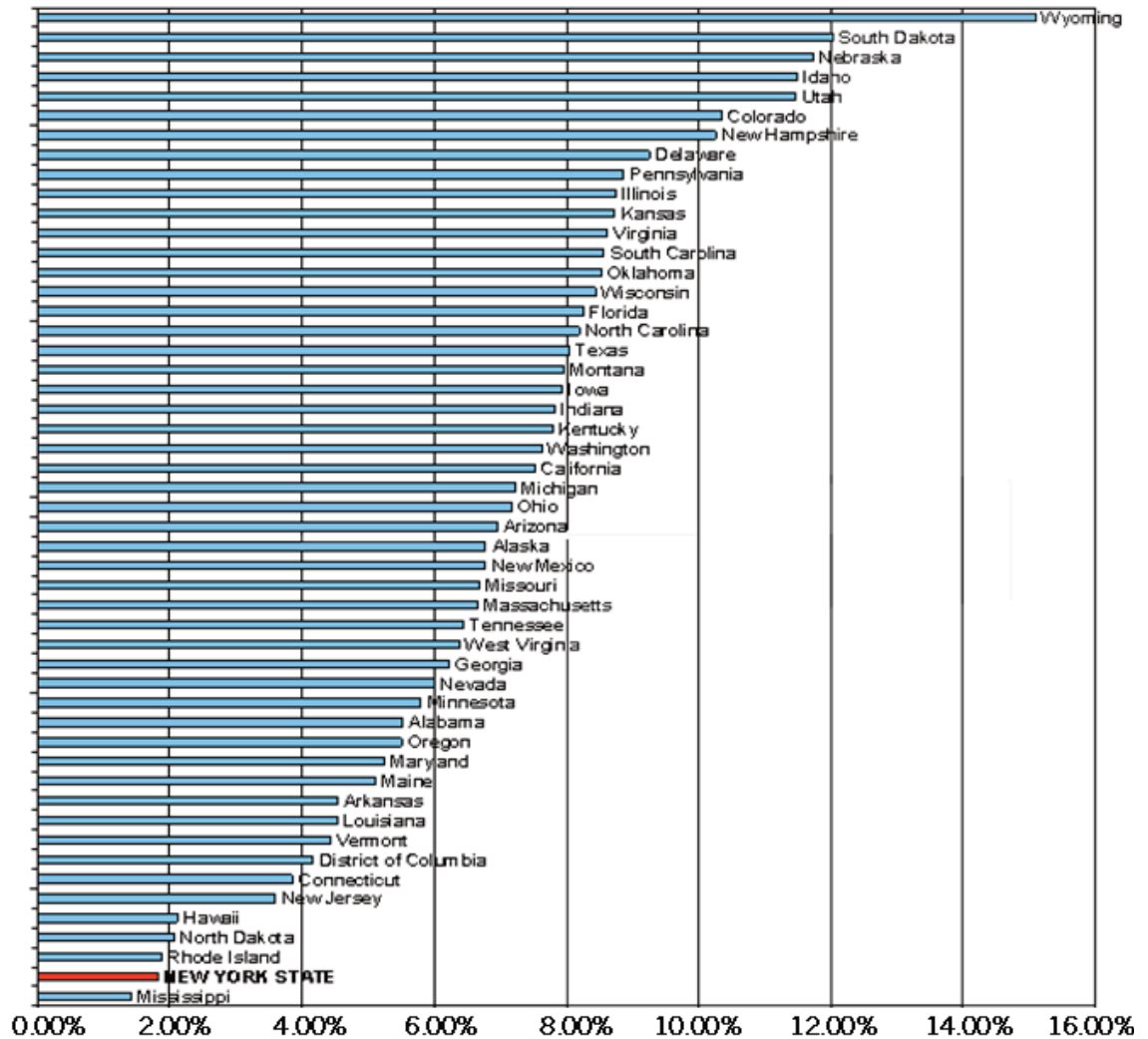


FINANCIAL CONDITION OF NEW YORK'S HOSPITALS COMPARED TO THE NATION

The strains of the Wall Street collapse and economic downturn were especially hard for New York health care providers—because the industry as a whole was already struggling, without margins to draw from, when 2008's harsh fiscal realities surfaced. New York's hospitals are non-profit organizations that reinvest all earnings back into improving patient care. In 2007, the collective operating margin of hospitals in New York State ranked second-worst in the nation, second only to Mississippi. That means our hospitals lack resources to hire staff, build new service capacity, invest in new buildings, and purchase the latest technology.

What this means for tomorrow is far more disconcerting. New York's hospitals constantly seek out and implement new efficiencies to lower costs and improve patient care, but hospitals are reaching the point where they have no other option than to eliminate valuable health care and community services. If hospital margins continue to shrink, communities across the state will lose access to essential services.

New York State's 2007 Bottom Line Margin is the Second Worst in the Nation



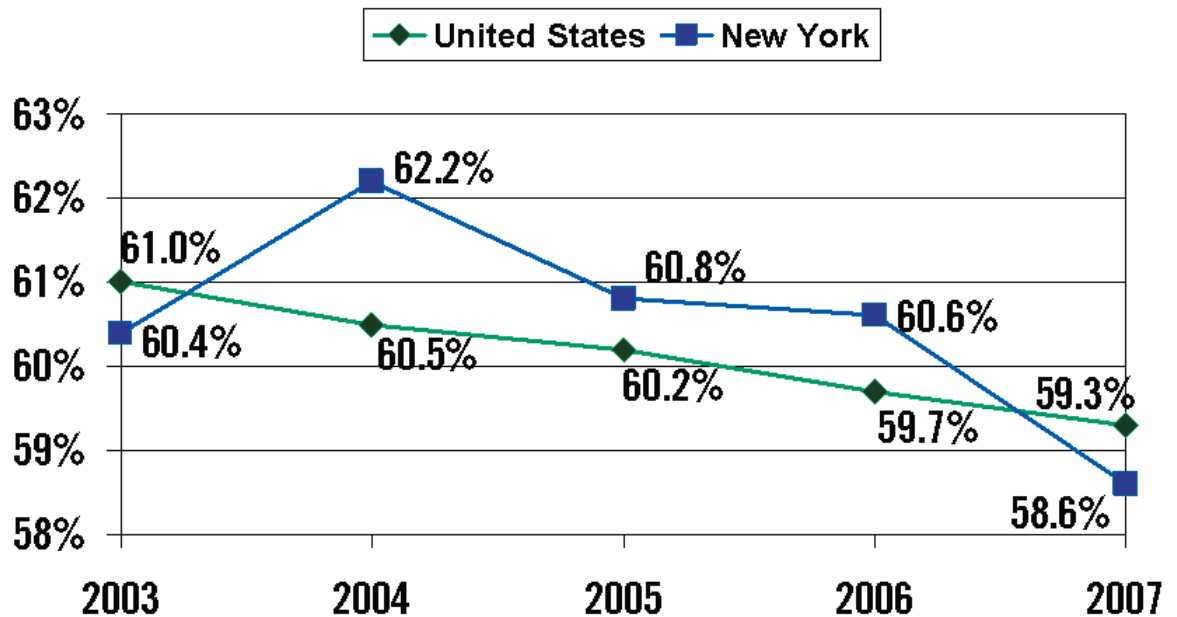
Source: American Hospital Association, "Hospital Statistics 2009"

A TOXIC ENVIRONMENT

The Uninsured and Underinsured

Despite the state's success in launching Child Health Plus and Family Health Plus, and achieving sizeable increases in enrollment, the number of uninsured New Yorkers has been resistant to major reduction. In 2007, 13.2% of New York's population (2.5 million) were uninsured, down from a high of 15.3% (or 2.9 million) in 2002. While the growth in public sector coverage has been impressive, it has been partly offset by reductions in employer-sponsored coverage—and that trend is troubling.

Percent of Population Covered by Employment-Based Health Insurance 2003 to 2007



Source: U.S. Census Bureau, Current Population Survey

The problems associated with the uninsured are varied, including the preventable advancement of illness and disease due to lack of timely access to primary and preventive care, and the high costs associated with treating these illnesses that were identified too late. In total, New York's health care facilities provide more than \$1.6 billion in free care each year, only a portion of which is reimbursed.

The uninsured are a societal problem that affects everyone. The uninsured themselves are most affected; they either deny themselves care, especially preventive care, or spend inordinately high percentages of their household income to access needed services. When that care is finally received, it is often delivered in the most

expensive setting at a time when the disease process has advanced. A recent Commonwealth Fund study found that a staggering 68% of uninsured people went without needed care.

To its credit, the New York State Department of Health has committed to making investments in primary and preventive care. However, while doing so, the Department has created a false choice: in order to make the necessary investments in primary care, we must take resources away from hospitals and acute care services.

The truth is that we must find a way to properly finance primary and preventive care, but not at the expense of hospital acute services. If done properly, investments in primary care will translate into significant savings to the state and to other payers. But if the state's "false choice" is not successful, we simultaneously weaken the acute care system even further.

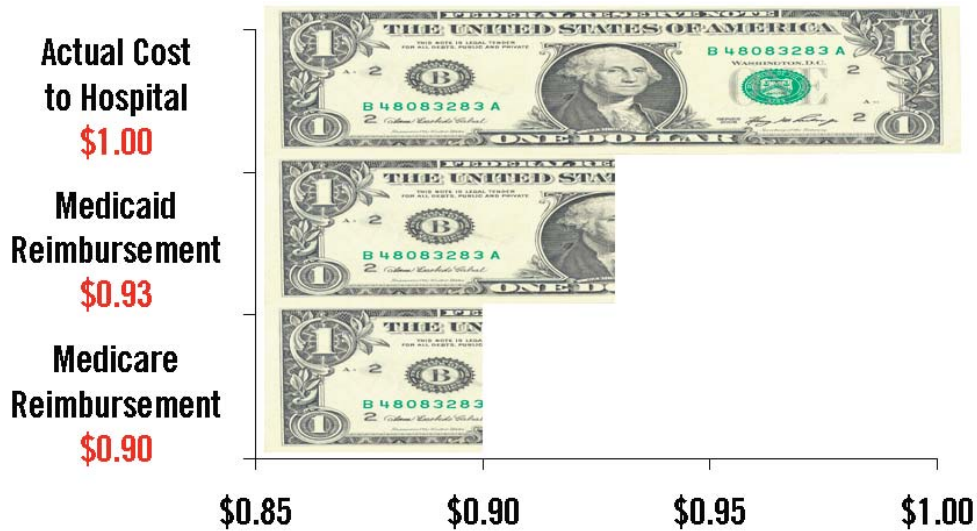
The uninsured disproportionately rely on hospital emergency departments (EDs), and to a lesser degree neighborhood health centers, for their care. Hospital EDs are not the right place to receive primary and preventive care. Those who gain access to care through EDs represent a significant resource drain on hospitals, since most of the care received by uninsured patients is provided at a significant loss to the facility. Hospitals understand and embrace their responsibility to provide access to emergency services without regard to a patient's ability to pay. But that mission comes at a price. It limits providers' ability to make investments in technology and infrastructure that are necessary to keep pace with the evolution of health care services. As a result, we are all impacted by a health system that, from a physical plant, technological, and efficiency standpoint, is falling behind the rest of the nation.

The growth of the underinsured population similarly taxes the health care system. The same Commonwealth Fund study found that 14% of adults in America were underinsured. Like the uninsured, the underinsured are less likely to seek care, and if they do, providers are vulnerable to reimbursement gaps when an underinsured person cannot pay their share of the cost for services provided.

Reimbursement Shortfalls

Long-outdated Medicaid and Medicare reimbursement rates and formulae result in billions of dollars in shortfalls for health care providers each year. In fact, according to a recent American Hospital Association study, for every dollar of care provided in New York, Medicare reimburses just 90 cents and Medicaid 93 cents. These losses are unsustainable and erode the entire health care system. In addition, compounding this problem, private insurer reimbursement in New York is the lowest in the nation.

Medicaid and Medicare's Failure to Fully Reimburse Cost



Payers Dominate Care Decisions

The promise of the managed care approach to medicine has yet to be realized. In theory, managed care promised to improve patient care and make the health care delivery system efficient. However, the central emphasis of most private insurance payers has been to manage costs, not care. And instead of added efficiencies and general principles to provide structure, managed care has added a web of administrative burdens requiring an army of staff to process, detracting from actual patient care.

For patients and providers, the reality of managed care has required them to navigate an often incomprehensible maze of rules or process requirements to access needed care. Those complex processing rules frequently result in the denial of payment for medically necessary, covered services because a technical or administrative rule was not followed. Patients are left frustrated by delays or a lack of access to care and unexpected medical bills. Providers are left to explain rules that are not of their making and scrambling to collect payment for medical services they have provided.

The bureaucracy and misdirected focus of managed care, i.e., on profits and not care, has required hospitals to devote scarce resources to the payment process—resources that could have been devoted to providing essential medical care to patients and other community-wide benefits.

Costly, Duplicative, and Misaligned Reporting Requirements

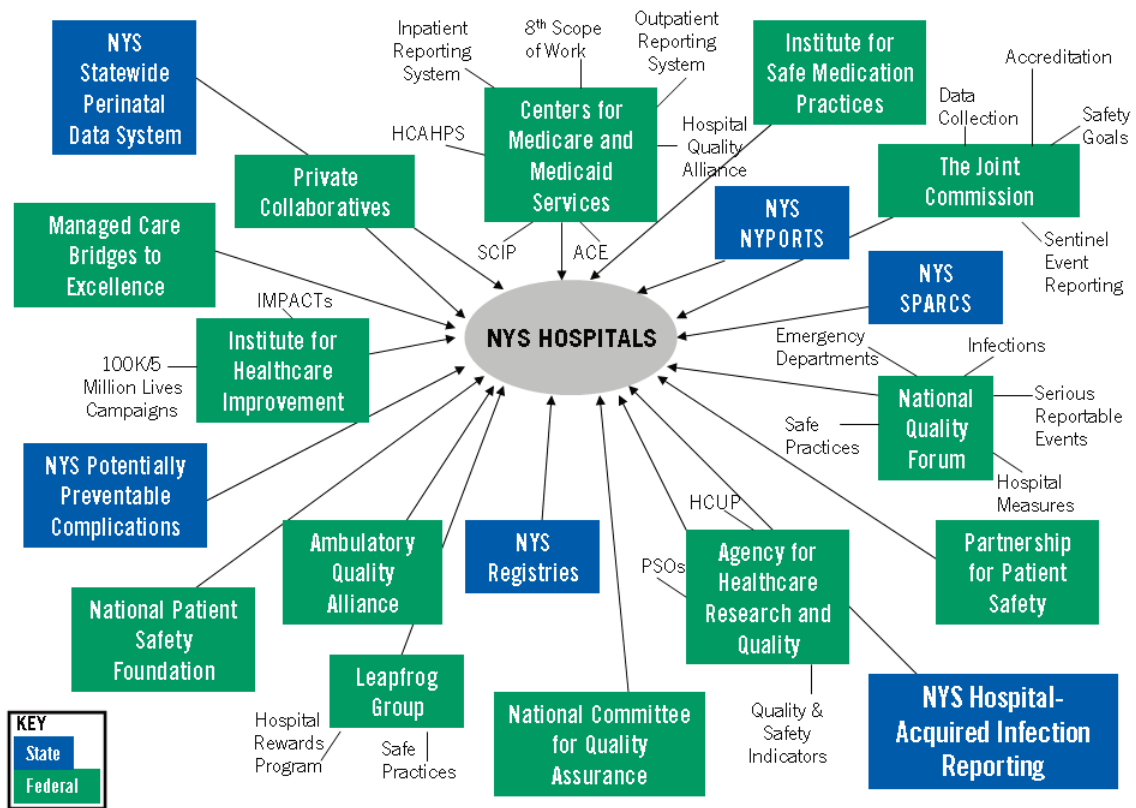
Government entities have linked reimbursement to numerous quality and patient satisfaction measures. Providers support the federal government's quality reporting system because it provides useful, standardized information to the public and to providers, which assists with quality improvement. And providers accept reasonable approaches to increase linkages between quality and reimbursement, if fairly constructed.

However, these requirements, coupled with often duplicative and misaligned requirements from other quality reporting organizations and government agencies, cost providers hundreds of million of dollars in administrative capacity to maintain records and meet filing requirements.

The chart on the next page is an accurate depiction of just the quality data requirements imposed on health care providers. This represents a fraction of the total administrative and governmental requirements that providers must meet. Even more onerous are the reimbursement requirements imposed by state and federal regulators and by private insurance companies.

Whether governmental or private sector, these payments and quality requirements are proposed in isolation, with few attempts to coordinate efforts or avoid duplication. Providers are left to shoulder the cost of growing administrative staffs to meet these ever-growing payment and quality requirements.

Multitude of Quality Data Initiatives and Requirements Confronting Hospitals



Fraud and Abuse

The state government has jumped in as well, ramping up its Medicaid anti-fraud operations. Health care providers support responsible anti-fraud efforts because every dollar fraudulently taken from government health care programs is one less dollar available for patient care.

However, the state has taken an aggressive “guilty until proven innocent” approach in many of its recent provider audit initiatives. Provider claims processing errors and care decisions have been caught in the wide net the state has cast, resulting in millions of dollars of threatened payment recoupments and denials. Moreover, providers are afforded very little opportunity, and even less time, to respond to these allegations, placing an enormous administrative burden on providers to dig through thousands of medical records to produce “proof” that their claims are legitimate.

Real fraud should be rooted out and punished, but honest mistakes and legitimate care decisions are not fraud. A hospital’s first responsibility is to provide care to those in need. Responding to onerous audit initiatives from multiple agencies seriously drains limited resources.

Explosion of Additional Administrative Burdens

Pressures providers face from inadequate reimbursement and increasing utilization demands are exacerbated further by the explosion of administrative demands placed on providers by government and private sector payers. The administrative costs of private insurance and government programs were estimated last year by the U.S. Congressional Research Service to be \$465 billion a year—which does not include billions more in administrative costs borne by health care providers to comply with those requirements.

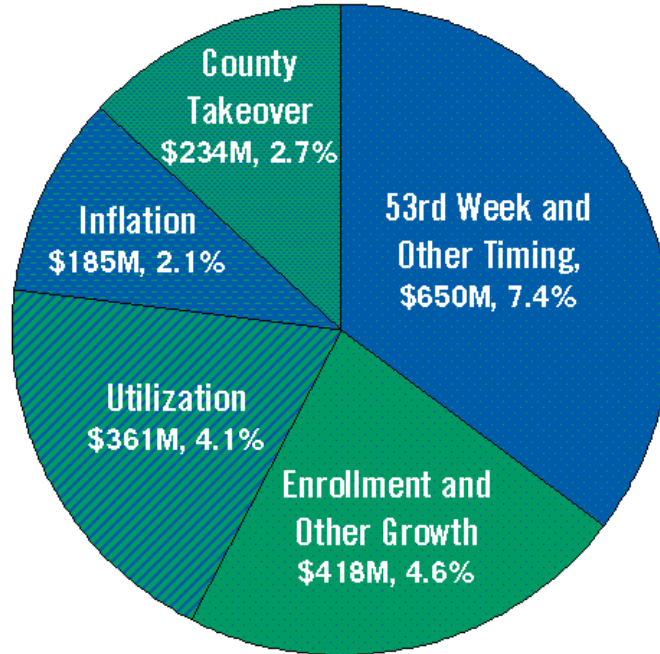
Before medical care is rendered or a claim for medical services is even submitted, providers check a patient's eligibility, benefits, copayment or deductible liability, and seek a managed care plan's authorization to provide the medical care. Once a claim is submitted, health insurers' payment rules are numerous and complex, often not fully disclosed, and constantly revised without sufficient notice to providers. When providers receive less payment than the amount claimed, they are again forced to spend time and resources researching the discrepancy, appealing the error, simply trying to get paid for the medically necessary covered services that already have been rendered.

Government Actions, Utilization Drive Much of Medicaid Spending Growth

The vast majority of Medicaid spending increases represent governmental policy assumptions and choices, as well as the impact of high-cost populations. The state predicts Medicaid spending to increase by 21% next year, yet increases in provider cost inflation account for just 2.1% of that total. The true drivers of Medicaid spending growth are:

- Growth in coverage and enrollment—4.6%
- Increases in utilization—4.1%
- State takeover of the county share of Medicaid costs—2.7%
- Scheduling of 53 weekly payments in the next fiscal year—7.4%

Medicaid Spending Growth Driven by Policy Choices, Enrollment, and Use



New York State Division of Budget's Medicaid Growth Projections of 21% (\$1.8 Billion)

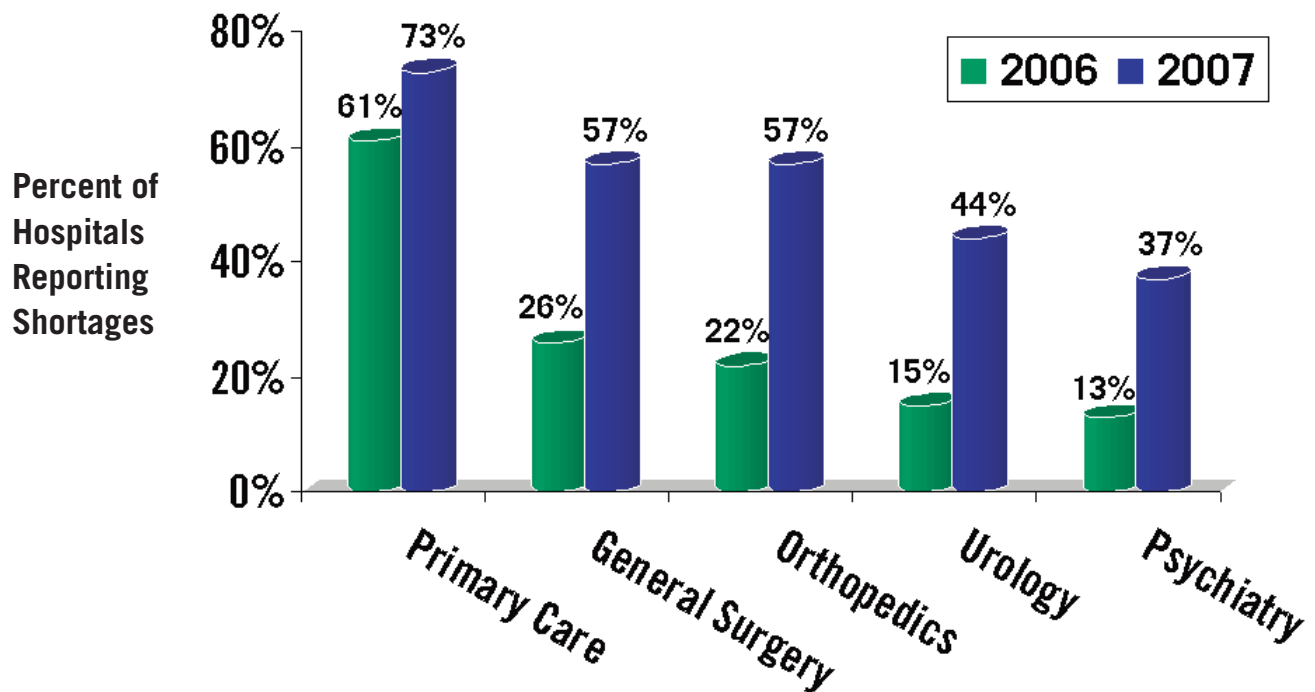
Physician Shortages

The physicians, nurses, and other professionals who staff our hospitals are the heart of our health care system. It is well documented that the health care workforce is aging and replacements for retirees are increasingly hard to find. The challenge of recruiting health care providers to New York is complicated further by the increasingly fragile financial condition of providers.

Hospitals across New York State report increasing challenges with the recruitment and retention of physicians. In many rural and inner city areas, severe shortages are widespread. Respondents to the *HANYS 2008 Physician Workforce Survey* reported a current need for more than 1,400 physicians outside of New York City alone. The survey revealed that:

- 25% of reporting hospitals had to eliminate or reduce services;
- 55% reported a lack of coverage in the emergency department for certain specialties, forcing patients to be transferred elsewhere; and
- 75% reported having to hire costly temporary staff.

Changes in Reported Physician Shortages From 2006 to 2007



Providers simply cannot offer health care services without trained physicians. Entire communities will increasingly face the loss of services, requiring patients to travel farther to receive necessary care, even in emergencies. Because of these doctor shortages, many facility administrators must spend excessive amounts of time and energy on physician recruitment—often with little success—leaving even less time, energy, and staff resources to attend to a host of other pressing matters.

Explosive Growth in Malpractice Insurance Costs

Exerting even greater fiscal pressure on hospital finances is the ongoing explosive growth in medical malpractice insurance premiums. Virtually every year, malpractice rates skyrocket (up 14% in 2007 alone), driving physicians to other states and out of high-risk practices such as obstetrics/gynecology and neurosurgery. In fact, it is not unusual to see annual premiums as high as \$200,000 or more for a single physician—levels that are simply unsustainable.

Moreover, malpractice costs are compounded, since both physicians and hospitals are compelled to obtain costly coverage. The high cost of malpractice has exacerbated physician shortages in many areas of the state and discouraged countless practitioners from establishing practices here. Moreover, exorbitant premiums paid by hospitals have had a profoundly negative impact on the availability of resources necessary to meet basic operational demands.

Millions of dollars wasted on an irrational and grossly ineffective malpractice system would be far better spent on core hospital functions, such as adding or augmenting essential services, addressing staffing shortages, and investing in health care information technology.

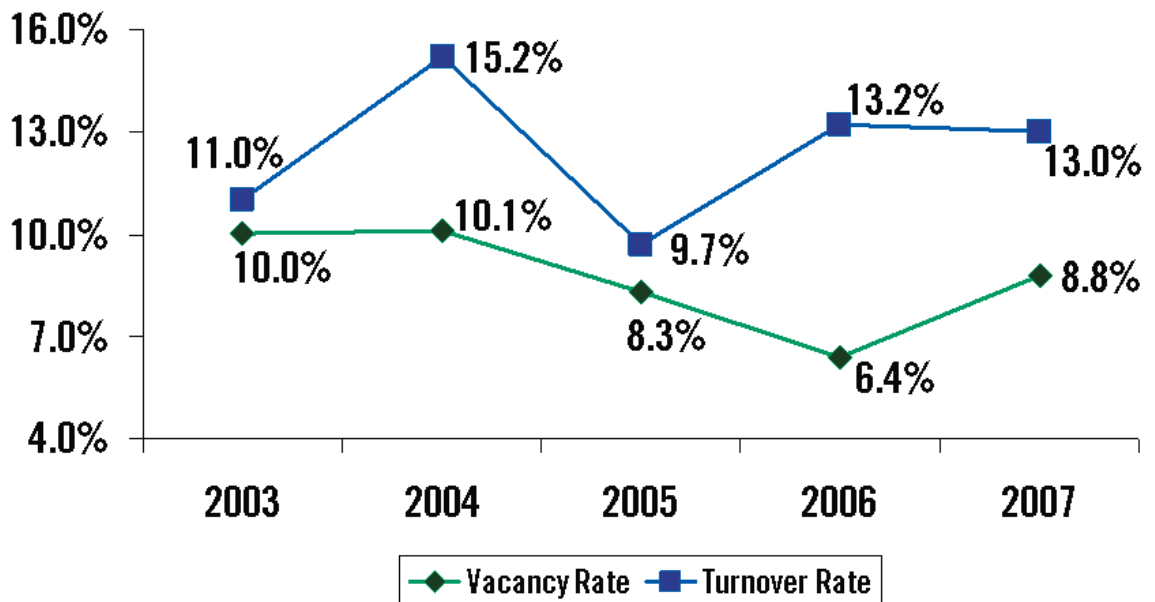
Nursing and Allied Professional Shortages

Registered nurses represent the largest single health profession in the state and nation. New York State hospitals report a vacancy rate of 8.8%, which is slightly higher than the national rate of 8.5%. However, according to the Bureau of Health Professions of Health Resources and Services Administration (HRSA), there is a projected widening gap between national nurse supply and demand of approximately 750,000 nurses by 2020. In New York State, this projected shortfall is 37,000 registered nurses (RNs) by 2015.

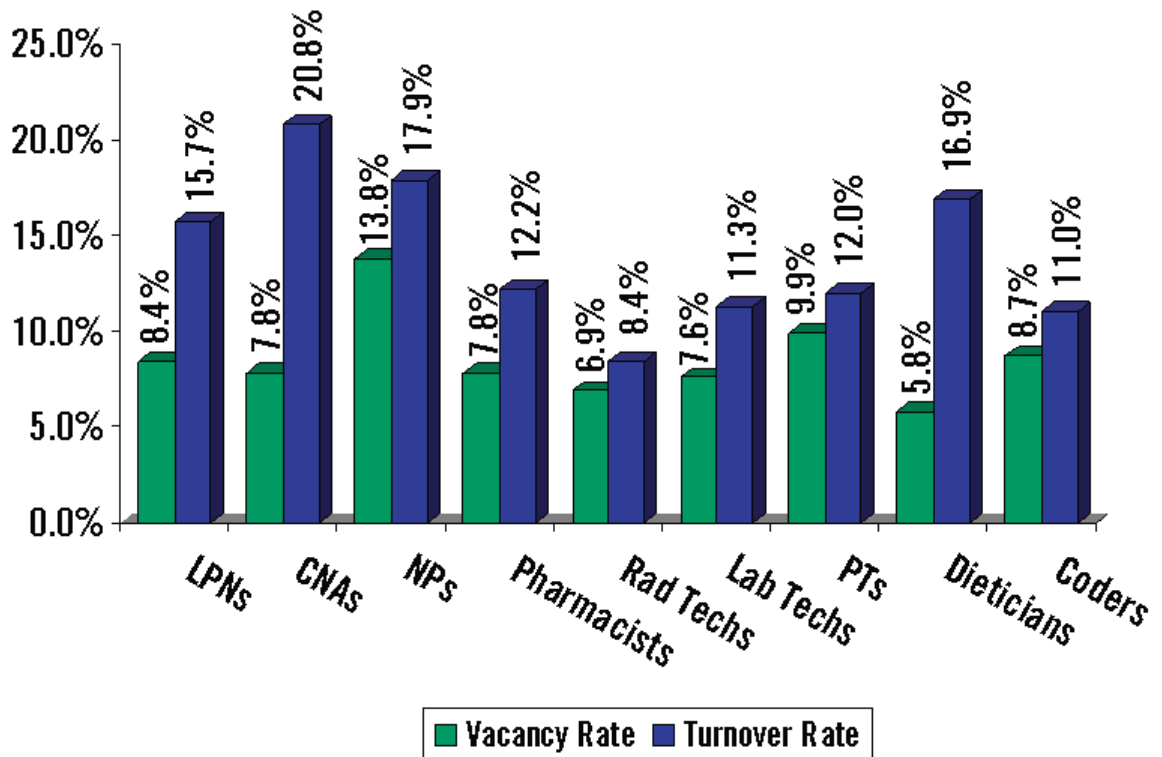
While the nursing and physician shortages have attracted the most attention, shortages of other allied health professionals including pharmacists, coders, various medical technicians and therapists, and other clinical workers are beginning to reach crisis levels. According to the Department of Labor, the total number of jobs needed in health care is expected to grow 18% by 2012—more than twice the rate of growth of all other occupations. In 2006, 11.4% of jobs in New York State were in health care, compared to 8.7% nationally.

These shortages further tax providers' ability to offer comprehensive, and often, basic health care services.

Statewide Registered Nurse Vacancy and Turnover Rates 2003-2007



2007 Allied Health Professionals Vacancy and Turnover Rates



HOW PROVIDERS STRUGGLE TO ADAPT AND COPE

The challenging environment is by no means a recent occurrence. In fact, for decades, health care providers have increasingly been compelled to provide more services and care for more patients and residents, with proportionately less funding.

Few other sectors of our economy have responded as aggressively and effectively as the health care provider sector in finding the efficiencies necessary to survive revenue shortfalls.

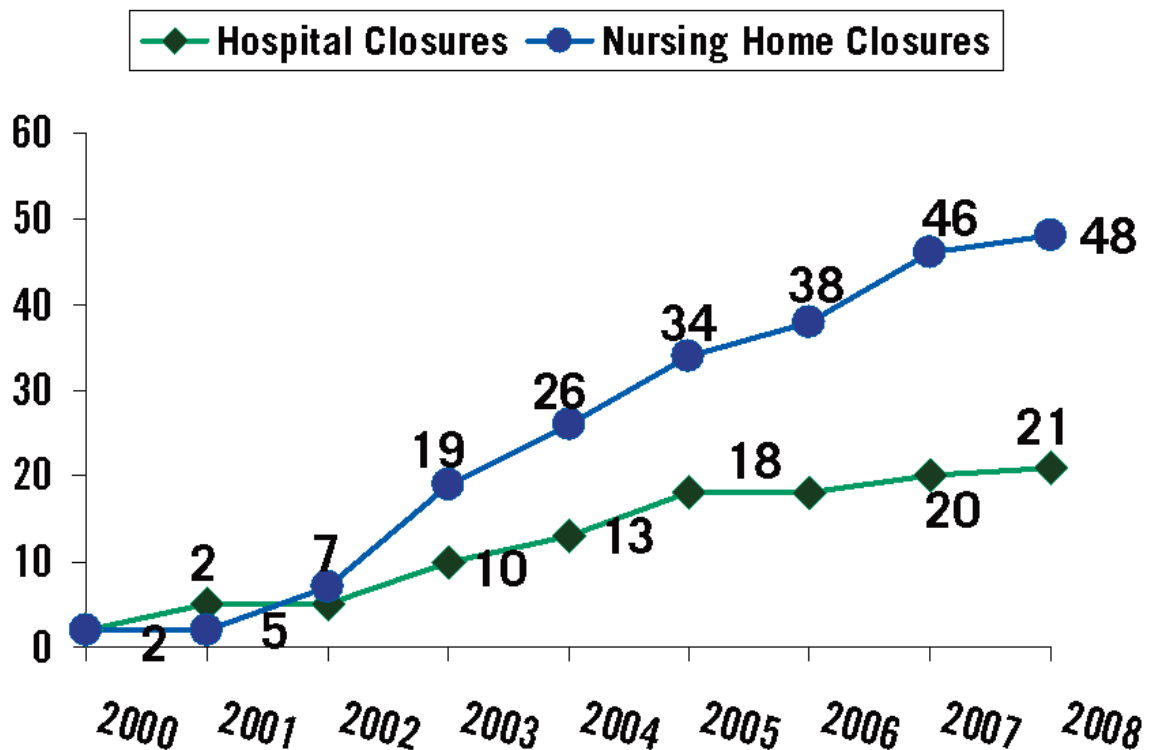
Providers have created thousands of joint agreements and mergers among and between cooperative and even competitive entities, and are looking to creative solutions such as partnering in non-traditional ways to best care for their communities. Tertiary hospitals have linked with their rural counterparts via telemedicine to provide state-of-the-art stroke care to residents in the most remote areas of the state. Rural hospitals increasingly are employing primary care practitioners and offering practice support to secure a stable health care system for their communities, where reimbursement often fails to cover the costs of preventive and primary care.

Other providers focusing on the continuum of care have worked with private entities to develop low-cost housing, supported by nearby health care services, for seniors and others with limited incomes and resources. In some cases, providers have fought efforts by state policymakers to force cuts in programs, reaching out to neighboring facilities for support in maintaining important services, such as obstetrics, especially when patients would face transportation obstacles and other challenges if forced to travel too far for their care. Even in the most competitive markets, hospitals have joined forces to support community health activities, such as mobile dental vans, geared specifically toward treating under-served communities.

Hospitals have not undertaken these efforts to sustain a profitable business model (New York hospitals are not-for-profit organizations)—they have done these things to protect core health care services, including emergency services, primary care, obstetrics/gynecology, inpatient care, diagnostic and treatment and surgical services, and many others.

However, not all of the coping strategies have been successful. When all other options have been exhausted, providers have been compelled to make very painful decisions—chief among them is the outright closure of a facility. Since 2000 alone, 21 hospitals and 48 nursing homes have closed across New York, leaving many communities burdened with greater travel distances to obtain care, and more vulnerable to having insufficient capacity to manage natural disasters, mass casualty accidents, and severe illness outbreaks.

New York State Hospital and Nursing Home Closures 2000-2008, Cumulative



Additionally, as government payers (Medicaid and Medicare) have continually failed to adequately reimburse the true cost of care, providers have been compelled to shift costs to other payers, primarily the business community, through their employee health insurance premiums, even as health insurance companies record billions in annual profits.

But it is not just health care providers that are shorted by both the government's failure to adequately reimburse and by the tremendous excess revenue appetites of the health maintenance organizations. The business and health care communities would be wise to recognize their shared interest and join together to demand a realistic and equitable reimbursement system.

CONSEQUENCES OF INACTION

Boards of trustees and health care providers will have very few options as this fiscal landscape deteriorates further. They will be compelled to forego medical advancements, eliminate services, reduce staff, or all three. The government's choices will be no less stark: eliminate services covered by Medicaid and Medicare, reduce the number of people eligible to receive them, or continue to pay providers less than cost. All of these options are untenable to the responsible health care administrator and policymaker, but all are potentially inevitable if we do not shift our health care system to better models of care and a more rational, efficient, and sustainable reimbursement structure.

Loss of Essential Health Services

If we fail to act now, the hospital and nursing home closures that we have seen over the last eight years will continue, and more and more communities will be forced to contend with no care, or traveling even longer distances to access basic and critical care. Those facilities that can survive will be compelled to eliminate a host of critical community health services and thousands of jobs, putting untold lives and livelihoods at risk.

In addition, more and more physicians will drop out of the Medicaid and Medicare system to stay in practice, leaving more vulnerable communities without the critical hospital and non-hospital health care services they need.

This is not a fallacy. We have already begun to see indications of reductions to critical community and preventive services such as breast cancer screening programs, which save lives and money.

CONCLUSION

We take our health care facilities and providers for granted, just as we did the dozens of banks, mortgage lenders, and trading houses that have been consumed in current and past financial crises. In each case, the warning signs that foreshadowed these collapses went unheeded, resulting in the loss of millions of jobs and homes, and the loss of financial security for millions more families and retirees across the state and nation.

Yet, those losses will pale in comparison to what we might endure if we allow our health system to similarly collapse. It will not be the loss of jobs or 401(k) plans that we lament. If we fail to act to address these core issues, it will be the loss of life that we mourn, and the loss of health and vitality for all of us who might one day need the services of a health care system that, due to our collective neglect, is no longer able to provide needed care.

The warning signs are clear:

- insufficient reimbursement from government payers and insurance companies;
- ever-escalating costs for labor, pharmaceuticals, energy, technology, etc.;
- the debilitating and costly impact of the uninsured;
- payers, not providers, drive care decisions;
- the explosion of administrative burdens;
- crippling malpractice costs;
- vast physician and nursing shortages;
- a growing population in need of services;
- an aging infrastructure;
- the exorbitant negative impact of the financial crisis; and
- the failure of government both in Albany and in Washington to propose long-term, systemic solutions to any of the above.

The confluence of these critical indicators can no longer be ignored.

IS THERE A WAY OUT?

Yes, but not a quick or easy way. It is vital to the well-being of New York State's citizens, communities, and local economies that comprehensive structural reforms are undertaken to ensure that hospitals can withstand the coming crises and continue to provide the same high level of service patients expect and deserve while remaining the economic engines of their respective regions.

HANYS works with federal and state officials at all levels of government to address the complex issues facing health care providers. In the face of today's devastating economic climate, identifying and implementing effective policies is critical to the future of New York's hospitals. It is more critical than ever that policymakers address effective recommendations, including:

Expand coverage for the uninsured—Health care providers have long recognized the critical need to provide coverage to the uninsured, and achieving universal coverage has been an ongoing component of HANYS' advocacy efforts. It is critical that measures to provide coverage are characterized by shared responsibility between government, employers, payers, and individuals, while all stakeholders acknowledge and understand the overall cost of covering millions of uninsured New Yorkers.

Provide all people with access to primary care—Increasing access to primary care keeps people healthier, lessens the strain on an overtaxed acute care system, and reduces health care costs by preventing avoidable ED visits and hospitalizations. Investments—that do not come at the expense of the acute care system—must be made to ensure the appropriate development of primary care, which should include a better alignment between reimbursement and the cost of providing those services.

Encourage efficient, high-quality care—Integrating clinical care across providers and settings fosters collaboration and, as a result, improves the quality and efficiency of care. Clinical integration enables hospitals to perform well in pay-for-performance initiatives, improves the quality of care and efficiency for independent providers, and provides a vehicle for a hospital to work more closely with members of its medical staff.

Ensure that every payer contributes its fair share of reasonable costs—Chronic under-funding is simply a policy of cost-shifting to the private sector—government should pay its fair share.

Medical malpractice insurance reform—A cap on non-economic damages is the foundation of real reform; however, passage of such a measure is unlikely at this time. HANYS therefore has joined with numerous other organizations and associations to urge the adoption of efforts including: establishing a medical indemnity fund to fairly compensate neurologically impaired newborns and others outside the tort system; providing premium relief for physicians; reforming rules associated with “expert” witnesses; and incentivizing quality improvement initiatives, among others.

Increase access to affordable capital—The ability of hospitals to access affordable capital is essential to providing the best possible service and care. To achieve quality improvements, update aging infrastructure, enhance emergency preparedness capabilities, or implement other critical projects, low-cost, low-hassle financing needs to be available so that hospitals can maintain their level of care, and properly meet patients' demands. HANYS continues to urge policymakers to preserve avenues to affordable financing and develop new programs that create even more options to obtain low-interest funding.

Make sound investments in health care technology—Health information technology in hospitals and health systems has been proven to dramatically reduce medical errors, improve the quality of care, and increase efficiency. Providing hospitals with the resources to implement widespread sharing of electronic health information across hospitals, physician offices, pharmacies, and other stakeholders could improve the coordination of care and lead to better health outcomes.

These and other measures to solidify our health care system are no longer merely topics of discussion. They are necessary steps to ensure the survival of our industry. We must all acknowledge and understand the dire consequences of our collective failure to prevent what is an entirely preventable social crisis. We must act immediately.



HEALTHCARE ASSOCIATION OF NEW YORK STATE

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