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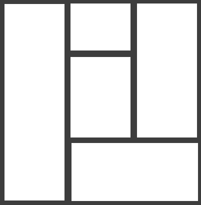

NEW FEDERALISM

HIGHLIGHTS FROM STATE REPORTS

A product of "Assessing the New Federalism," an Urban Institute Program to Assess Changing Social Policies

Health Policy for Low-Income People in New York

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The state of New York has made a substantial commitment to public support of health and social services. The state has by far the largest Medicaid program in the country, with total expenditures of $24 billion in 1995—40 percent more than the next-highest-spending state. More than 3.3 million New Yorkers were enrolled in the Medicaid program in 1995. An additional 447,000 New Yorkers are eligible for Medicaid-equivalent benefits through the Home Relief (general assistance) program. The state has also established a children's health insurance program that covers 124,000 children, with a planned expansion to 251,000 children. Finally, for many years the state has had a bad-debt and charity-care pool, a system of cross-subsidies to hospitals with high uncompensated care burdens from hospitals with fewer nonpaying patients.

Excluding DSH, New York spends more per Medicaid beneficiary than any other state and more than twice the national average on both a per capita and per low-income person basis.

Despite the seeming breadth of the state's public health insurance programs, 16.8 percent of the nonelderly population, or about 3.1 million New Yorkers, are uninsured. There is also evidence that the uninsured population is growing. A relatively low rate of employer-sponsored insurance coverage appears to be a key reason for this trend. A consistent erosion of small-group and individual coverage has occurred in the last few years: There were 160,000 fewer New Yorkers with coverage in the small-group and individual insurance markets in 1995 than in 1992. This decline has taken place despite insurance reforms implemented in 1993.

Characteristics of the State

New York is the third most populous state, with 18.2 million residents. The size of the population is fairly stable; it increased by less than 1 percent between 1990 and 1995, versus a nationwide growth rate of 5.6 percent. New York is heavily urban, with only 9.7 percent of its population living in nonmetropolitan areas, compared with 21.8 percent for the entire country. A somewhat higher-than-average percent of the state's population is elderly, and a somewhat lower-than-average propor-

Table 1
State Characteristics

Sociodemographic	New York	U. S.
Population (1994–95) (in thousands)	18,173	260,202
Percent under 18 (1994–95)	26.0%	26.8%
Percent 65+ (1994–95)	12.8%	12.1%
Percent Hispanic (1994–95)	13.3%	10.7%
Percent Non-Hispanic Black (1994–95)	15.2%	12.5%
Percent Non-Hispanic White (1994–95)	66.7%	72.6%
Percent Non-Hispanic Other (1994–95)	4.9%	4.2%
Percent Noncitizen Immigrant (1996)*	11.9%	6.4%
Percent Nonmetropolitan (1994–95)	9.7%	21.8%
Population Growth (1990–95)	0.8%	5.6%
Economic		
Per Capita Income (1995)	$27,678	$23,208
Percent Change in Per Capita Personal Income (1990–95)	19.7%	21.2%
Unemployment Rate (1996)	6.2%	5.4%
Percent below Poverty (1994)	15.9%	14.3%
Percent Children below Poverty (1994)	24.6%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)	16.8%	15.5%
Percent Medicaid—Nonelderly (1994–95)	14.7%	12.2%
Percent Employer Sponsored—Nonelderly (1994–95)	63.3%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)	5.2%	6.2%
Smokers among Adult Population (1993)	23.5%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)	6.4%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)	7.8	7.6
Premature Death Rate (Years Lost per 1,000) (1993)	60.3	54.4
Violent Crimes per 100,000 (1995)	841.9	684.6
AIDS Cases Reported per 100,000 (1995)	68.4	27.8

Source: Complete list of sources is available in *Health Policy for Low-Income People in New York* (The Urban Institute, 1997).
* Three-year average of the Current Population Survey (CPS) (March 1996–March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship. Please note that these numbers have been corrected since the original printing of this report.

tion is under age 18. The state is racially and ethnically diverse relative to the national profile, and it has a significant immigrant population (table 1).

The state is well above average in terms of per capita income. In 1995, the average income of New Yorkers was $27,678, versus $23,208 for the country as a whole. However, the distribution of income is fairly skewed: Despite the state's high per capita income, the percentage of people living below the federal poverty level was above average in 1994—15.9 percent in New York versus 14.3 percent in the United States overall. The state also had a higher-than-average unemployment rate in 1996. Finally, the growth in per capita income was less than the national average between 1990 and 1995 (table 1).

New York faces a number of health problems. In particular, the state has a much higher-than-average number of AIDS cases per 100,000 persons—2.5 times the national average. The state has one of the highest rates of violent crime in the United States, although this rate appears to have declined dramatically in recent years. The premature death rate, which captures years of life lost prematurely for all causes, is also above the national average. New York's low birth-weight and infant mortality rates, however, are comparable to the national averages (table 1).

State and Local Politics

New York is a historically liberal and progressive state, and this has not changed dramatically under Republican governor George Pataki. Governor Pataki has initiated a tax cut phased in over three years and has slowed year-to-year budget growth. However, some of his proposals to reduce health care spending and to reform welfare have not been adopted, in part because of the power and composition of the New York state legislature. The Assembly (lower chamber) is heavily Democratic (96 Democrats versus 54 Republicans) and is more

Table 2
Medicaid Expenditures
by Eligibility Group and Type of Service,
New York and United States
(Expenditures in Millions)

	New York			United States		
	Expenditures	Average Annual Growth		Expenditures	Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Total	**$24,027.4**	**21.1%**	**9.1%**	**$157,872.5**	**27.1%**	**9.9%**
Benefits						
Benefits by Service	$20,608.3	12.6%	11.3%	$133,434.6	18.8%	11.0%
Acute Care	10,467.4	16.3%	16.5%	79,438.5	22.1%	13.0%
Long-Term Care	10,140.9	10.0%	6.8%	53,996.1	14.8%	8.3%
Benefits by Group	$20,608.3	12.6%	11.3%	$133,434.6	18.8%	11.0%
Elderly	$6,962.0	10.7%	4.4%	$40,087.4	16.7%	8.1%
Acute Care	1,259.6	16.3%	14.6%	9,673.7	18.5%	11.9%
Long-Term Care	5,702.4	9.9%	2.6%	30,413.7	16.2%	7.0%
Blind and Disabled	$8,478.2	13.3%	14.6%	$51,379.4	17.7%	12.9%
Acute Care	4,366.3	17.2%	16.8%	29,760.7	22.8%	15.2%
Long-Term Care	4,112.0	10.0%	12.4%	21,618.7	12.3%	10.1%
Adults	$1,760.8	12.1%	14.5%	$16,556.9	20.4%	9.2%
Children	$3,407.2	17.3%	19.3%	$25,410.9	24.3%	13.3%
Disproportionate Share Hospital	$2,916.6	173.7%	-2.2%	$18,988.4	261.5%	2.7%
Administration	$502.5	0.9%	5.2%	$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

representative of low-income populations and of urban areas, particularly New York City, than is the Senate. The Senate tends to represent upstate, rural, and suburban New Yorkers and is heavily Republican (35 Republicans versus 26 Democrats). In sum, the distribution of political power in New York makes it unlikely that any major expansions of social legislation could take place, just as it is unlikely that any major contractions could occur.

New York devolves considerable financial and administrative responsibility to the counties and the City of New York. County governments have an important role in the administration of New York's health and welfare programs. Counties pay 25 percent of the cost of the Temporary Assistance for Needy Families (TANF) program and Medicaid acute-care services and 10 percent for Medicaid long-term care services, much larger shares than in any other state. In return, counties are given substantial administrative flexibility in running the programs. Counties also have an important voice in state legislation. For example, a 1996 proposal to convert Home Relief payments to a block grant to counties was defeated because of county opposition.

There are long-standing tensions between New York City and the rest of the state. These tensions existed when there was a Democratic governor and a Democratic mayor of New York City, and they persist today when the governor and mayor are both Republicans. The city generally feels that the state treats it poorly in most resource allocation decisions and that it contributes much more to the state treasury than it receives from the state. The view from upstate New York is that the city is a major beneficiary of state resources because of its large low-income population.

Medicaid

New York's Medicaid program is the largest single item in the state budget when both federal and state funds are taken into account. The program grew faster from 1990 to 1995 than all other expenditure categories in the budget, increasing from 18.5 percent to 34.1 percent of total state expenditures (including federal aid). In 1995 the program spent $10.5 billion on acute care, $10.1 billion on long-term care, and $2.9 billion on disproportionate share hospital (DSH) payments (table 2).

Excluding DSH, New York spends more per Medicaid beneficiary than any other state and more than twice the national average on both a per capita and per low-income person basis. In 1995 New York spent $18,252 per enrollee for the elderly versus $9,738 in the country overall, and $15,062 per enrollee on the blind and disabled versus $8,022 in the country overall. Expenditures per enrollee on nondisabled adults and children were also substantially higher than in the rest of the nation (table 3). This high level of spending reflects a broad benefit package, full-cost reimbursement of hospitals, high nursing home payment rates, and extensive coverage of personal care services. It also reflects the state's efforts to shift services previously funded only by the state into Medicaid to obtain federal matching payments. New York has been one of the most successful states at Medicaid maximization—that is, structuring services to meet Medicaid standards and obtain federal funds.

Table 3
Medicaid Enrollment and Expenditures per Enrollee: Contributions to Total Expenditure Growth

	New York			United States		
		Average Annual Growth			Average Annual Growth	
	1995	1990–92	1992–95	1995	1990–92	1992–95
Elderly						
Total expenditures on benefits (millions)	$6,962.0	10.7%	4.4%	$40,087.4	16.7%	8.1%
Enrollment (thousands)	381.4	1.3%	1.7%	4,116.6	5.1%	3.0%
Expenditures per enrollee	$18,252.0	9.3%	2.7%	$9,738.0	11.0%	5.0%
Blind and Disabled						
Total expenditures on benefits (millions)	$8,478.2	13.3%	14.6%	$51,379.4	17.7%	12.9%
Enrollment (thousands)	562.9	7.8%	9.1%	6,405.2	9.8%	9.5%
Expenditures per enrollee	$15,062.0	5.1%	5.0%	$8,022.0	7.1%	3.1%
Adults						
Total expenditures on benefits (millions)	$1,760.8	12.1%	14.5%	$16,556.9	20.4%	9.2%
Enrollment (thousands)	651.0	6.9%	5.1%	9,584.2	11.5%	4.6%
Expenditures per enrollee	$2,705.0	4.8%	9.0%	$1,728.0	8.0%	4.4%
Children						
Total expenditures on benefits (millions)	$3,407.2	17.3%	19.3%	$25,410.9	24.3%	13.3%
Enrollment (thousands)	1,732.0	6.0%	3.3%	21,566.0	13.1%	4.8%
Expenditures per enrollee	$1,967.0	10.7%	15.4%	$1,178.0	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

New York also has the highest absolute level of DSH payments in the nation.

Although New York's Medicaid expenditures are high, its rate of growth in spending has been somewhat lower than the national average. Between 1990 and 1992, Medicaid spending in New York increased annually by 21.1 percent, versus 27.1 percent for the nation. Between 1992 and 1995, spending grew by 9.1 percent per year, versus 9.9 percent for the nation. New York's slower spending growth is largely attributable to long-term care expenditure trends. Long-term care spending in New York increased by 6.8 percent annually between 1992 and 1995, versus 8.3 percent in the United States over the same period. Acute-care expenditures grew somewhat faster in New York than in the nation from 1992 to 1995, with an average annual increase of 16.5 percent versus 13.0 percent (table 2).

Consistent with the slower-than-average growth of long-term care outlays, expenditures on the elderly grew much more slowly in New York than in the nation from 1990 to 1995. The two components of expenditure growth—enrollment increases and growth in expenditures per enrollee—were both well below the national average for the elderly. On the other hand, spending on the disabled, nondisabled adults, and children grew faster in New York than in the nation. In the case of the blind and disabled, spending increases were driven more by rising enrollment levels than by per-enrollee cost increases. In contrast, for nondisabled adults and children, expenditures per enrollee rose more sharply than did enrollment levels from 1992 to 1995 (table 3).

Despite the slower-than-average growth rates of expenditures for long-term care and the elderly, these expenditure categories continue to comprise larger-than-average segments of New York's Medicaid program. Long-term care accounts for 49 percent of New York's expenditures on services, versus 40 percent for the nation. Further, 34 percent of the state's expenditures are incurred by the elderly (acute and long-term care), versus 30 percent nationally.

New York's Medicaid program has generous eligibility criteria relative to many other states. As a result, its coverage of low-income populations is among the most extensive in the country, with 60 percent of the state's low-income population enrolled versus 49 percent for the nation. Of the state's 3.3 million Medicaid enrollees in 1995, more than half were children. The next-largest group was nondisabled adults, at 20 percent of enrollees (table 3).

Medicaid Managed Care

In an effort to control Medicaid expenditures and better coordinate services, New York has taken significant steps to expand its use of managed care. On July 15, 1997, the state

received approval of a Section 1115 waiver from the Health Care Financing Administration, allowing the state to increase its use of mandatory managed care. The state will be able to expand managed care enrollment from 645,000 to more than 2.4 million Medicaid beneficiaries. The state will not only enroll TANF and related beneficiaries but also go further than virtually any other state in enrolling persons with disabilities. The waiver will also provide federal Medicaid funds for the Home Relief population and for hospitals requiring assistance with the transition to managed care.

Several problems have plagued New York's Medicaid managed care program, even in its voluntary form. These include enrollment procedures, capacity, and rate setting. Many of these problems have occurred in New York City, which accounts for about three-quarters of the state's Medicaid acute care spending. In response to a series of reported abuses by managed care plans in New York City, the state halted direct marketing and enrollment by plans. While the state has reinstated direct enrollment, there is substantially greater oversight of enrollment and marketing practices. New York City is also the center of concern over capacity problems, particularly primary care shortages. Because of low rates of physician participation in Medicaid, ambulatory care is predominantly health center- and hospital-based. There is concern about the ability of managed care to expand rapidly because of limited primary care capacity in some communities.

The state has attempted to reduce managed care rates through competitive bidding. The bidding process appears to have achieved savings of approximately 10 to 12 percent relative to previous rates. Commercial plans and prepaid health service plans (most of which are operated by traditional Medicaid providers) have objected to the low rates that resulted from competitive bidding. In response, the legislature increased capitation rates in New York City by 2 percent and in upstate by 7 percent, and debate on further upward adjustments continues in the legislature.

The state has multiple and occasionally conflicting objectives. It would like to contract with mainstream or commercial health maintenance organizations (HMOs) as well as Medicaid-only plans, increase primary care capacity, provide support to safety net institutions, and regulate managed care organizations aggressively to maintain quality, while at the same time instituting capitation rates that will achieve savings. Needless to say, the state could face serious challenges meeting these objectives.

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The Health Care Market

On January 1, 1997, New York ended its all-payer hospital rate-setting system, permitting insurers and managed care plans to negotiate directly with hospitals. Deregulation occurred because New York's hospital system was increasingly seen as being too costly and as having considerable excess capacity. While the decision to deregulate had widespread support, there was also a consensus that the state should retain its subsidies for charity care and graduate medical education (GME). Under its previous hospital rate-setting system, the state had a complex system of cross-subsidies from financially secure hospitals to those that provided a large amount of charity care. Under the deregulated system, Medicaid will continue to support uncompensated care as it did before. In addition, new assessments were placed on all payments to a broader set of providers and services, including inpatient and outpatient hospital care, diagnostic and treatment centers, and ambulatory surgery centers. The distribution of funds from the pool is also altered, with hospitals providing the largest amount of charity care receiving increased revenues. Funds from the pool will continue to be paid out as Medicaid DSH payments, with federal matching payments coming to the state.

While subsidies for GME were also retained, the amount of direct GME support was reduced by $400 million. Under the new system, GME is partly funded through an assessment on Medicaid payments and/or private payers' covered lives, and partly through negotiations between providers and payers. The assessment on insured lives was set at a level that will guarantee about 80 percent of previous payments for GME, including Medicare. Hospitals must now reduce GME spending or negotiate with insurers for rates that are sufficient to cover their costs for GME.

The general expectation was that the financially stable academic medical centers would do well in a competitive market, in part because they have substantial market power and because they will continue to receive some subsidies for GME. However, community hospitals without a substantial base of privately insured patients could be in serious trouble. There was some concern that many of these community hospitals would have difficulty continuing to provide care to the growing uninsured population despite the resources they receive from the bad-debt and charity-care pool.

Managed care was relatively slow to enter New York, in part because of the state's regulatory environment. Managed care is now growing rapidly, and growth is expected to accelerate with the end of rate setting. New York has considerable excess capacity in its hospital system and a large supply of physicians, especially specialists, providing managed care plans the opportunity to negotiate aggressively. On the other hand, the state has moved to increase regulation in the HMO market. Legislation restricting managed care practices was enacted as the result of efforts by consumer groups and the Medical Society of the State of New York.

Health Insurance Reforms

New York enacted substantial reforms of its small-group and individual insurance markets in 1993, including open enrollment and community rating. The principal impact of these reforms was on commercial insurers, as HMOs and Empire Blue Cross already had open enrollment and community rating by law. Following the 1993 reforms, premiums of commercial plans increased sharply at first and have continued to increase at double-digit rates; meanwhile, enrollment in these plans has declined. HMOs as a whole reduced the scope of their benefit packages in an effort to avoid high-risk enrollees and consequently have kept their premiums low and their enrollment levels high. As before the 1993 reforms, Empire Blue Cross generally insures the worst risks; it has experienced substantial increases in premiums and declines in enrollment.

Across all types of plans in the state, there was a loss of enrollment of about 27 percent in the individual market and 4 percent in the small-group market between 1992—before implementation of the legislation—and 1995. Although the decline in coverage in the small-group market was roughly consistent with changes occurring elsewhere in the country, the decline in the individual market was greater than that shown in national data.

The Health Care System in New York City

The health care system in New York City is confronting the shifts in state policy and market forces described above as well as other changes. These changes include the deregulation of the hospital rate-setting system, reduced city support for the public hospital system, rapid expansion of Medicaid managed care, and Medicare payment reforms, particularly those affecting graduate medical education. Many health care providers in the city are under financial pressure. Providers generally face lower managed care rates and, consequently, a growing need to reduce costs while attempting to remain attractive to patients. The larger academic medical centers are actively engaging in mergers and network development to increase their efficiency and market power when negotiating with managed care plans. Most community hospitals see their ability to affiliate with the larger teaching hospitals as essential to their survival. Safety net providers are actively seeking affiliations with physicians and ambulatory care centers. Few hospitals have closed, but almost all are experiencing declines in utilization. Both public and private hospitals are concerned about the city's reduction in support for its public hospitals and the possible effect on their ability to continue serving the uninsured.

There are no plans to expand Medicaid enrollment, and the rolls could fall as a consequence of welfare reform. If the number of uninsured New Yorkers continues to grow, the revenues from the bad-debt and charity-care pool could become inadequate.

Long-Term Care

New York state supports a large long-term care industry through its Medicaid program. Expenditures for nursing home care ($4.6 billion in 1995) and home care ($2.7 billion in 1995) together account for about one-third of total Medicaid expenditures. Personal care is an optional home care program under Medicaid that provides assistance for dependencies in activities of daily living—not medical services. New York's use of the personal care benefit is by far the largest in the country. Despite widespread concerns over the scope of the personal care benefit as well as the perceived prevalence of asset divestment to qualify for Medicaid, current efforts to constrain Medicaid long-term care expenditures have focused on freezing payment rates for nursing homes and maximizing Medicare revenues for both nursing homes and home care.

Provision of long-term care for persons with mental health problems has been characterized by a shift in the locus of services from institutions to community-based alternatives. The type of care provided has also changed. The focus is now on rehabilitation rather than custodial care. Medicaid maximization has been an important trend in the financing of New York's mental health program. Approximately 60 percent of the mental health budget of $4 billion is financed by Medicaid, including funding of state psychiatric hospitals through DSH. The impetus to deinstitutionalize is moderated by the potential loss of DSH payments and the fact that some community care services are not covered by Medicaid.

New York's program for persons with mental retardation and developmental disabilities is also characterized by a strong emphasis on community-based care. The census of large, state-operated developmental institutions declined 44 percent between 1990 and 1994. The state operates a Medicaid home and community-based services waiver for the developmentally disabled population, which serves 27,000 clients. Although New York operates some programs for the developmentally disabled with state funding only, the majority of services qualify for federal Medicaid matching funds.

Challenges for the Future

New York has a highly sophisticated and expensive health care system, with a large supply of hospitals, nursing homes, and medical and surgical specialists. The state has by far the

largest Medicaid program in the country, as well as large Home Relief medical benefits and an expanding health insurance program for children. It has enacted comprehensive reforms of its small-group and individual insurance markets and deregulated its hospital payment system while retaining the system's support for financing uncompensated care.

Despite these efforts, the state faces a number of challenges. The percentage of the nonelderly population without health insurance is greater than the national average, and it is growing. This may be due in part to a decline in coverage in the small-group and individual insurance markets despite insurance reforms enacted by the state earlier in the decade. Moreover, there are no plans to expand Medicaid enrollment, and the rolls could fall as a consequence of welfare reform. If the number of uninsured New Yorkers continues to grow, the revenues from the bad-debt and charity-care pool could become inadequate.

Another issue is whether the state can sustain its high level of spending on Medicaid, including its costly commitment to long-term care services. Most recent cost-containment efforts have centered on hospital and nursing home rate reductions and the expansion of managed care, not on curtailing enrollment and benefits. It is unclear, at this point, whether the state will be successful in achieving major savings through managed care. Its Section 1115 waiver program must address issues ranging from potential marketing and enrollment abuses to ensuring sufficient primary care capacity, particularly in New York City, as well as meet the multiple and somewhat conflicting objectives outlined above.

The insurance and hospital markets in New York are undergoing major changes. Hospital deregulation is expected to lead to the expansion of commercial HMOs in the state, and HMOs should continue to develop because of excess provider capacity. In anticipation of hospital deregulation and the growing power of HMOs, hospitals are moving rapidly to form various kinds of affiliations, mergers, and joint ventures. A key issue is how such strategies will affect these entities' ability to successfully bargain with managed care organizations. What will be the impact of their success or failure on hospital utilization and system cost?

Other challenges revolve around New York's powerful academic medical centers. Some question whether teaching hospitals will retain enough market power to be able to finance their graduate medical education programs. There is concern that the market will become so competitive that teaching hospitals and other public and nonprofit hospitals will come to see uncompensated care as a cost they can no longer afford. The issue is whether enough of the hospitals that serve low-income populations will be able to survive in an increasingly competitive system.

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There are two *Highlights* for each state. The *Highlights* that focus on health cover Medicaid, other public insurance programs, the health care marketplace, and the role of public providers. The income support and social services *Highlights* look at basic income support programs, employment and training programs, child care, child support enforcement, and the last-resort safety net. The *Highlights* capture policies in place and planned in 1996 and early 1997. To receive the full-length reports on which the *Highlights* are based, contact the Urban Institute.

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