



**TESTIMONY OF
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BEFORE THE
HUMAN SERVICES COMMITTEE
Tuesday, March 15, 2011**

**SB 1013, An Act Implementing The Governor's Budget Recommendations
Concerning Human Services**

My name is Stephen Frayne. I am the Senior Vice President, Health Policy of the Connecticut Hospital Association (CHA). I am testifying today in opposition to **SB 1013, An Act Implementing The Governor's Budget Recommendations Concerning Human Services**.

Before outlining our concerns and reasons for opposing this proposed bill, I'd like to talk about the members of the Connecticut Hospital Association—Connecticut's not-for-profit hospitals—and the critical role they play in the health and quality of life of our communities. Our state's hospitals are more than facts and figures, and dollars and cents—hospitals, at their core, are all about people. All of our lives have, in some way, been touched by a hospital: the birth of a child... a life saved by prompt action in an emergency room... the compassionate end-of-life care for someone we love. Or, perhaps, our son, daughter, husband, wife, or friend works for, or is a volunteer at, a Connecticut hospital.

Hospitals are essentially people taking care of people. Each year, the 52,300 people employed in Connecticut's hospitals care for more than 430,000 people admitted to their facilities, treat nearly 1.6 million people in their emergency rooms, and welcome more than 38,000 babies into the world. We provide care to all people regardless of their ability to pay—in fact, every three minutes someone without health insurance comes to a Connecticut hospital in need of inpatient, emergency, or outpatient surgical services. And, we do this 24 hours a day, seven days a week, 365 days a year.

Every day, we see the consequences and health implications for individuals and families who lack access to care and coverage. Our emergency rooms are filled with individuals who cannot find a physician to care for them because they are uninsured or underinsured – or they are Medicaid beneficiaries and few physicians will accept the low rates paid by Medicaid. Our emergency rooms are treating both those who have delayed seeking treatment because of inadequate or no coverage and those who have no other place to go—our hospitals are their healthcare safety net.

Thus, as front line caregivers, Connecticut hospitals are absolutely committed to initiatives that improve access to high quality care and expand health insurance coverage. We stand ready to be partners in solutions to create a system of healthcare coverage that ensures access to care for all residents. Such a system must ensure seamless care that is affordable to individuals and families and is sufficiently financed. The ultimate goal is a healthier Connecticut—this can be accomplished by establishing a healthcare system through which coverage is affordable and sustainable, and access to care is guaranteed.

SB 1013 imposes a hospital tax of 5.5 percent, which increases to the maximum allowable under federal law after September 30, 2011. Let's be clear that this tax is a cut to hospitals—it takes \$267 million from hospitals and, as the administration asserts, “in the aggregate return all the money.” However, this assertion misses the obvious – hospital care for patients occurs locally, not in the aggregate – and when funding for services at the local level is cut, that cut hurts the ability to provide hospital care in that community. Unfortunately, our analysis (attached) shows that the combination of eliminating uncompensated care funds and imposing a hospital tax results in every single hospital in Connecticut experiencing a financial loss—and let's not forget that the ones who lose the most are our communities, our patients, and those who rely on hospitals as their safety net.

Unfortunately the proposed state budget cuts \$83 million in funding from the Uncompensated Care and DSH pools, in addition to the imposition of a 5.5 percent tax on hospitals, and makes a number of other reductions and changes to the Medicaid program that will negatively affect hospitals and the people they serve. In fact, these budget actions threaten hospitals' significant role as today's safety net and seriously jeopardize our ability to invest in tomorrow. Therefore, we would ask that you oppose this bill as it relates to the imposition of the hospital tax and the reduction in hospital funding.

I'm sure, by now, many of you are uncertain what to believe regarding the impact SB 1013 and the state budget would have on hospitals. On the one side, you have the administration suggesting that hospitals will be more than fine because of the increased funding they are receiving from the conversion of State Administered General Assistance (SAGA) to Medicaid for Low Income Adults (MLIA). On the other side, you have hospitals saying no way, not even close—a cut of existing uncompensated funding, plus a tax, will be devastating.

What I would like to do in the time allotted is to provide some clarity on the question about hospitals' financial condition vis à vis SAGA and MLIA and offer more details about the effect that the proposed budget package will have on hospitals.

As many of you may know, for several decades prior to January 1, 2004, the state reimbursed hospitals for services delivered to SAGA patients at the Medicaid rate. In 2003, in response to budget pressures, the legislature enacted some changes to SAGA funding. In brief, the legislature reduced funding for the SAGA program by about 20 percent and capped expenditures for the program but not enrollment. Three caps were established: one for hospital services, another for pharmacy, and another for all other providers, such as Federally Qualified Health Centers, physicians, etc. When the legislature imposed the 20 percent cut and cap on expenditures, the SAGA program covered about 27,500 people.

In the time between January 1, 2004, and March 31, 2010, several things happened. First, the number of individuals enrolled in SAGA grew by 61 percent to 44,200. Second, the caps on pharmacy and all non-hospital providers were effectively removed, resulting in those providers being paid the Medicaid rate without reduction. Third, the cap on hospital services remained in force and didn't grow to keep pace with the increase in enrollment—as a consequence, the hospital payment reduction for SAGA patients grew from 20 percent of Medicaid to nearly 60 percent of Medicaid in 2010. By 2009, hospital losses on care they provided for SAGA patients were nearly \$150 million per year.

Last year, the legislature and the Rell administration converted SAGA patients to MLIA primarily to address the state deficit—this action led to nearly \$40 million per year in federal funding being leveraged to help address the state budget gap. However, to obtain the \$40 million in federal funds, the state could no longer pay hospitals and other providers less than the Medicaid rate for services. Thus, the budget anticipated an increase in funding for hospital services of about \$66 million per year to bring payment for SAGA hospital medical services up to the amount required by Medicaid. The previous administration and the legislature were willing to make that investment and expand Medicaid entitlement—in particular, because, even **after** accounting for the increased expenditures for hospitals and others totaling about \$91 million per year, the state deficit would be reduced by about \$40 million per year.

There were and are three key benefits to moving SAGA into Medicaid: patients were helped because access to needed medical care for this population improved; the state benefited because making all state expenditures for SAGA eligible for a federal match helped reduce the state deficit; and hospitals were helped because their losses for serving SAGA patients were moderated slightly.

To help put hospital losses in context, below is a table that shows Medicaid enrollment and hospital losses serving Medicaid patients. As can be seen from the table, enrollment in Medicaid and SAGA and their related hospital losses have been growing exponentially, and will continue to do so. By 2014, the low-end estimate is that hospital losses will more than double to \$749 million per year. The high-end estimate is that hospital losses will nearly triple to \$924 million per year. The low-end estimate assumes enrollment in Medicaid stays right about where it is today – those leaving the program as they regain jobs with employer-sponsored insurance are replaced with those who join because of expanded eligibility. The high-end estimate assumes enrollment around 664,000 – no reduction in current enrollment due to a jobless recovery and an addition due to expanded eligibility. Neither result is sustainable.

	Enrollment				Hospital Losses		
	SAGA	FFS	MCO	Total	FFS + MCO	SAGA	Total
2004	27,509	93,699	298,328	419,536	\$(130,638,000)	\$(74,309,000)	\$(204,947,000)
2009	37,288	104,610	331,213	473,111	\$(211,538,000)	\$(145,726,000)	\$(357,264,000)
1/2011	59,652	106,947	391,054	557,653			
2014				538,000 to 664,000			\$(749,000,000) to \$(924,451,000)

It is not appropriate or fair to suggest that paying hospitals the Medicaid rate for MLIA patients should be counted as an increase or that hospitals can well afford to absorb cuts – particularly when one considers that paying the Medicaid rate for MLIA patients was done primarily as way to help reduce the state deficit.

We are grateful that the losses we were experiencing in the SAGA program have shrunk somewhat and proud to have been part of an effort to help reduce the state deficit. However, we don't believe either of these can or should be used as justification for the proposed budget package of cuts and taxes that will negatively impact hospitals. These budget cuts include:

- eliminating \$83 million in funds for the Uncompensated Care and Disproportionate Share pools.
- cutting \$1.1 million in funding for certain hospital outpatient services.
- reducing non-emergency dental services for adults under Medicaid. This \$9.8 million will impact hospitals that may be the community's only dental provider that accepts Medicaid patients.
- imposing cost sharing requirements for certain individuals receiving Medicaid services. The accompanying \$8.3 million reduction in state funding will also negatively impact hospitals.
- reducing grants from the Department of Mental Health and Addition Services for uncompensated care in FQHCs.
- eliminating funding for the LifeStar program.

In our opinion, we can and should do better. We have outlined in the [\(attached\)](#) Medicaid Modernization brief an alternative approach that improves the care and value for patients, reduces the state deficit, materially reduces the cost shift to Connecticut businesses and workers, and makes it possible for Connecticut hospitals to remain strong and viable in their role as Connecticut's healthcare safety net.

Thank you for considering our position.