CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
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CONNECTICUT HOSPITAL ASSOCIATION
BEFORE THE
APPROPRIATIONS COMMITTEE
Friday, February 16, 2007

HB 7077, An Act Concerning The State Budget For The Biennium Ending June 30, 2009, And Making Appropriations Therefor

My name is Stephen Frayne and I am Senior Vice President, Health Policy of the Connecticut Hospital Association (CHA). I appreciate the opportunity to testify on behalf of CHA and its members on **HB 7077, An Act Concerning The State Budget For The Biennium Ending June 30, 2009, And Making Appropriations Therefor**.

My testimony today will focus on two aspects of the Administration's budget proposal. First, the funding of a sliding fee scale to help lower-income members pay for the monthly cost of the coverage of the Charter Oak Plan. Second, the Administration's proposal to freeze below cost hospital payments for another two years.

Connecticut hospitals are committed to supporting initiatives that improve access to health insurance coverage for Connecticut residents and reduce the number of uninsured. However, to be successful, initiatives to improve coverage and access to care must adequately finance the healthcare system already providing services to the uninsured and underinsured.

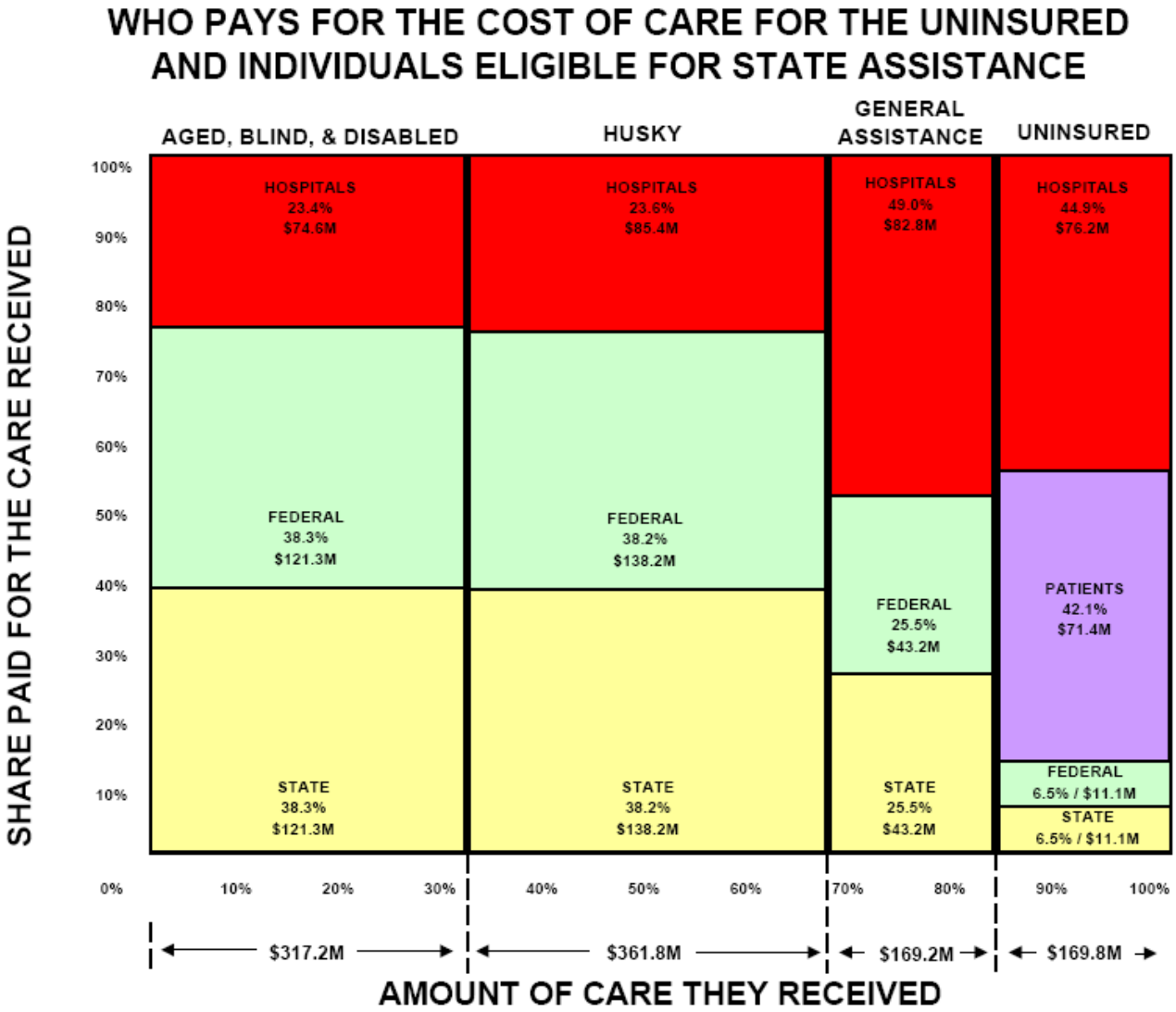
The Administration proposes to adopt a sliding fee scale to help lower-income members pay for the monthly cost of the Charter Oak Plan. The Governor's press release indicates her administration is discussing with CMS the potential for federal funding as outlined in the President's State of the Union address. The President's proposal, called Affordable Choices, cuts existing Medicare payments to safety net hospitals and reroutes the funds to states for use to subsidize premiums.

The President's plan mangles the Robin Hood story. The President's plan essentially steals from one struggling group, hospitals, to give to another struggling group, the uninsured. Funding for a sliding fee scale must be sourced from new State funds, not diverted from existing federal funds to hospitals.

Before I talk about the second issue, hospital rates, I would like to remind you that hospitals are more than facts and figures and dollars and cents—hospitals, at their core, are really people taking care of people. Each year, the 45,000 people employed in Connecticut's hospitals care for more than 400,000 people admitted to their facilities, treat nearly 1.4 million people in their emergency rooms, and welcome more than 43,000 babies into the world. We provide care to all people regardless of their ability to pay—we serve more than 381,000 people in the State who don't have health insurance and nearly one million people enrolled in underfunded state and federal programs. And, we do this 24 hours a day, seven days a week, 365 days a year, but it is taking its toll. Chronic, severe underfunding of state programs results in Connecticut hospitals having to use

approximately $250 million a year from funds that would otherwise be used to hire nurses, buy new equipment, invest in life-saving technology, and make the critical infrastructure improvements that are necessary to enable our hospitals to provide the highest quality care.

As the chart below clearly indicates, every year before a hospital plans a new program, hires another nurse, invests in a quality initiative it must first figure out how to cover the annual $250 million dollars deficit caused by state under-funding of its existing insurance programs. Under current law, this is a never-ending and ever growing deficit. Current law freezes existing rates. The administration proposes to continue to freeze hospital rates for another two years. If successful, the Administration proposal would balloon the annual under-funding of hospitals to more than $310 million by the end of the biennium.



Some of you may be wondering how did things get so messed up? For your convenience, I have attached a synopsis of the last twenty-five years of hospital Medicaid rate setting. At the beginning of the time line, hospitals were paid cost. However, during the last twenty-five years, the combination of freezes, cuts, and repeals of future promises has brought us to the point where we are losing $250 million per year.

What should be done?

A January 16, 2007 New-Haven Register editorial observed the following when commenting on the various options for universal healthcare:

> …state payments to compensate hospitals for the care of the poor fall some $250 million short each year of meeting the hospitals' costs. Even with some of those costs being shifted to those with private insurance, the shortfall has placed some hospitals in financial jeopardy and has diminished investment in new medical technology and patient care systems. The formula for compensating hospitals needs to be revised.
>
> Medicaid, HUSKY and hospital compensation are basic components of the state's health care system. These programs need to be mended before another health care entitlement is considered.

Hospitals need you to decide that investing in their ability to care for Connecticut is a priority. We can do better.

Hospitals need to be paid what it costs to serve individuals enrolled in state programs.

Hospitals need you to block diverting federal dollars paid to support safety net hospitals.

For additional information, contact CHA Government Relations at (203) 294-7310.

Synopsis of 25 Years of Cuts and Freezes

Year	Change	Comment
1982	**Paid actual cost for inpatient and emergency room care**	**No loss providing services**
	Clinic care was paid at actual cost capped at 150% of the cost for a physician office visit.	**No loss providing services**
1984	PA 84-367: Changed payment from actual to reasonable cost of an efficient provider.	Cut
	Added payments for Inpatient Administrative days	Increase not implemented
1985	PA 85-482: Reduced the amount allowable for clinic from reasonable cost capped at 150% of the physician fee schedule to 116% of the physician fee schedule.	Cut
1987	PA 87-27: Removed from allowable cost expenses related to supporting or opposing unionization.	Cut
	PA 87-516: Permitted the Commissioner to pay more for clinic to DSH hospitals up to 175% of physician fee.	Increase not implemented
1988	PA 88-156: Permitted the Commissioner to pay more than reasonable cost for DSH hospitals.	Increase not implemented
1989	PA 89-297: Reduced Emergency room payment for non-emergency use of the emergency room to the clinic rate.	Cut
1991	PA 91-8: Capped the increase in the clinic rate to no more than CPI changes, froze current ED rates except those that decreased.	Cut and Freeze
	Reduced by the most recent Medical CPI payments for those outpatient services paid on a cost basis.	Cut
1992	PA 92-16: Froze the ED rates for another year except those that decreased.	Freeze
1994	PA 94-5: Reduced by the most recent Medical CPI payments for those outpatient services paid on a cost basis.	Cut
	Froze the ED rates for another year except those that decreased.	Freeze
	Required a fee schedule to be developed for all outpatient services effective 1/1/1995, froze the fee schedule for 18 months, then required it to be increased to reflect the cost of services.	Cut and Freeze
1995	PA 95-306: Limited the application of AND enhanced payments to instances when the patient is not eligible for Medicare.	Cut
1998	PA 98-131: Beginning 10/1/1998, stopped pegging the annual	

Year	Change	Comment
	inpatient inflation increase to Medicare and set it at 3% per annum thereafter.....	Cut
1999	PA 99-279: Repealed the 3% inpatient adjustment for all years after 10/1/1998 - granting no increase thereafter.	Cut
	Repealed outpatient fee schedule updates for 1999 and 2000.	Cut
2001	Repealed taxes.....	Increase
	PA 01-3: Increased outpatient fees by 10.5%.....	No new dollars; funded by Reduction to Uncompensated Care Pool
	Increased inpatient to a minimum of 62.5% of cost. If above the minimum no increase. Froze the rates for 2002 and 2003.	No new dollars; funded by Reduction to Uncompensated Care Pool
2003	PA 03-3: Extended outpatient rate freeze through 2005.....	Freeze
	Extended inpatient rate freeze to 2004 and 2005.....	Freeze
2004	PA 04-258: Set minimum inpatient target for 4/1/05 at 3,750, 4/1/06 at $4,000, 4/1/07 at $4,250; inpatient rates remain frozen if above minimum.	Increase
	Cut SAGA by $20 million per year.	Cut
2005	PA 05-280: Delayed increasing the 2006 and 2007 minimum inpatient target for six months.	Freeze
	Cut DSH by $10 million per year.	Cut
2006	PA 06-188: Repealed the 2007 $4,250 minimum inpatient target.	Cut
	Permitted an inpatient increase for 2006 for institutions not eligible for minimum.....	Increase not implemented
	Permitted an increase for outpatient clinic rates.	Increase
	Permitted an increase for outpatient MRI rates.	Increase not implemented
	Permitted an increase for outpatient CT SCAN rates.	Increase not implemented
	Permitted an increase for outpatient ED rates.	Increase
2007	**Rates frozen in perpetuity**.....	**Loss providing service $250 Million** **Loss grows by more than $30 Million per year**