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ISSUE BRIEF

HEALTH CARE IN NEW YORK CITY: UNDERSTANDING AND SHAPING CHANGE

David R. Sandman

New York City's health care system, one of the finest in the world, is in a period of intensive turmoil. A growing proportion of uninsured residents is straining the system's capacity to provide access to care for everyone; in addition, more than a million uninsured families face dire financial consequences should one of their members become seriously ill or injured. Conversion of the city's Medicaid program, one of the nation's largest and most generous, from voluntary to mandatory managed care enrollment offers opportunities to improve care, yet also potentially jeopardizes the quality and accessibility of medical services for low-income residents. In combination, the rising number of uninsured New Yorkers and the shift to Medicaid managed care presents substantial challenges to the city's extensive network of safety net providers, including the Health and Hospitals Corporation, the world's largest public hospital system; academic health centers (AHCs); and community-based health clinics (CHCs).

THE UNINSURED IN NEW YORK CITY

The greatest problem facing the city's health care system may be the large and growing number of residents without health insurance. Twenty-eight percent of working-age adults in New York City ages 18–64, or more than one million men and women, are uninsured—a rate 50 percent higher than that for New York State or the nation.[1] According to Fund-supported analysis, the city has the seventh-largest percentage of uninsured nonelderly (age 64 and younger) residents in the nation's 85 largest urban areas.[2] The number of uninsured people is also growing more rapidly in New York City than in the rest of the country. Twenty percent of the city's nonelderly population was uninsured in 1991, compared with 28 percent in 1996. Over the same time period, the percentage of uninsured people nationwide rose from 16 to 18 percent.[3]

Most uninsured New Yorkers belong to low-income, working families. Forty-two percent live in households with incomes below the federal poverty level, and another third have incomes between poverty and 250 percent of poverty. Working New Yorkers are much less likely to have employer-sponsored insurance than is true nationally: 44 percent of working-age adults in New York City have employer coverage, compared with 63 percent nationally.

Statistics such as these suggest that solutions to the problem of the uninsured cannot rely solely on a strong economy and low unemployment rates, or on approaches that require substantial financial contributions by the uninsured. Fund-supported work shows that financial burdens are staggering for low-income workers whose employers do not provide coverage.[4] Nationally, health insurance premiums would consume an average of 41 percent of all income for a family of four living below twice the federal poverty level. That burden can be even higher in New York City where premiums are among the highest in the country—almost $8,000 a year for a family of four.

New York City's diverse population, including many recent immigrants, also contributes to its high rate of uninsurance. Fifty-six percent of the city's residents were born in foreign countries or are the children of foreign-born parents, and nearly a third of the state's 3.2 million uninsured residents are not citizens.[5] Statewide, 46 percent of non-U.S. citizens were uninsured in 1996, compared with 15

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percent of U.S. citizens.[6] Minority adults in New York City are 50 percent more likely to be uninsured than the city's white, non-Hispanic adults.[7]

Insurance Matters to New Yorkers

The Fund's *Survey of Health Care in New York City* documented the serious health consequences experienced by uninsured residents.[8] Although the city has a more extensive system of public hospitals than anywhere else in the nation and is home to a number of leading academic health centers, the survey found that many uninsured New Yorkers do not receive needed health care. These residents are two to three times more likely than the insured to report health care access problems, to lack preventive care, and to have difficulty paying their medical bills. Seven of 10 uninsured working-age adults lack a regular doctor, and more than a third give negative ratings to the quality of care provided by their doctors.

Urban Health Problems

Lack of insurance and access to care can be especially devastating for patients in large metropolitan areas that bear a disproportionate share of urban health and social problems. New York City has exceptionally high rates of chronic diseases such as asthma and diabetes, of communicable diseases such as HIV/AIDS and tuberculosis, and of health conditions connected to social problems such as substance abuse, homelessness, and mental illness. Childhood asthma, for example, places a major strain on low-income children, their parents, and health care providers in the city: in 1995, 14,504 children were hospitalized for this condition, costly care that could have been avoided had regular and stable primary care been available.[9] New York City children were hospitalized for asthma at more than four times the national rate in 1993, the most recent year for which national data are available.[10]

High rates of substance abuse contribute to the prevalence of infectious diseases such as HIV/AIDS. New York City remains a national epicenter for the condition, hosting 17 percent of the nation's AIDS cases but only 3 percent of the nation's population.[11] More than 110,000 New Yorkers have been diagnosed with AIDS, of whom approximately 70,000 have died. Poor metropolitan housing conditions also lead to disease: although the incidence of new tuberculosis cases in the city declined in recent years after aggressive public health interventions, it was five times higher than in the rest of the state in 1996.[12]

Using Information to Develop Understanding and Solutions

Developing an in-depth understanding of the nature of New York City's uninsured problem is essential to forming and evaluating potential responses. One solution to the rising number of uninsured New Yorkers lies in making full use of existing coverage options for low-income residents, especially for children who are covered more extensively by public programs. Nearly 20 percent of children under age 18 in New York City are uninsured and often do not get recommended immunizations or regular pediatric care.[13] However, three-quarters of these children are eligible for but not enrolled in Medicaid or Child Health Plus (CHP), New York State's insurance program for low-income children. This problem could be largely eliminated if outreach and enrollment strategies were more effective.

From Information to Action: Reaching and Enrolling Children in New York City

Fund-supported focus groups with low-income families in the city have been instrumental in generating information about public program enrollment barriers and identifying strategies to increase enrollment.[14] Two projects are actively developing and testing new approaches for reaching and enrolling uninsured children. The Medical and Health Research Association (MHRA) is piloting a model for enrolling children through neighborhood Women, Infants, and Children (WIC) centers in Brooklyn. More than 700 low-income parents have received enrollment assistance under this project and more than 350 children have become insured to date.

With Fund support, the Children's Defense Fund-New York (CDF) is developing another innovative community-based outreach

and enrollment model. To overcome parents' reluctance to visit welfare centers, this model uses trained student volunteers from Columbia University and community groups who are authorized to conduct Medicaid's face-to-face interview to assist families in completing Medicaid applications, gathering supporting documentation, and following up on submitted applications. Approximately 200 parents have filed applications to date in this pilot demonstration.

Connecting People with Coverage Opportunities

Another Fund project also seeks to link a unique group of New York City workers at especially high risk of being uninsured—performing artists—with available sources of insurance coverage. The Actors' Fund, with support from the Fund, the National Endowment for the Arts and others, created the Artists' Health Insurance Resource Center, an Internet site that contains information about unions, guilds, and associations that small arts companies and artists can join to enroll in private group insurance or public programs such as Medicaid and CHP. Launched in December 1998, this New York State database has been used by more than 1,000 individuals to find affordable and comprehensive insurance and now serves as a prototype for other states.

Developing Incremental Approaches to Expand Coverage

In addition to maximizing enrollment in existing coverage programs, reducing New York's uninsured population will require renewed efforts to expand coverage, especially for low-income workers. The national erosion of employer-sponsored coverage has been especially acute in New York City because of its large number of small firms in the service, retail, and entertainment industries—firms that frequently do not provide health insurance benefits. Several Fund projects are developing ways to expand coverage to small employers.

An evaluation of a unique public-private partnership, for example, aims to make coverage more affordable for small firms. Under a new pilot program announced by Mayor Giuliani in his 1999 State of the City address, businesses in East Harlem, Brooklyn, and the Bronx with 50 employees or less will be offered substantially discounted premium rates—approximately $100 per month per person—for a comprehensive benefits package offered by GHI, Inc., a private insurer. Those who sign up will be required to use hospitals and physicians associated with the city's public hospital system. With Fund support, Dr. Stephen Rosenberg of PricewaterhouseCoopers, LLP, is evaluating the pilot program's success in expanding coverage and access to primary care while decreasing reliance on emergency rooms. If the project succeeds, it could be expanded citywide.

New work by Katherine Swartz of the Harvard University School of Public Health also focuses on methods to make coverage more affordable for small employers. This project will produce the first independent evaluation of three programs in New York State that subsidize the purchase of insurance by small businesses and low-income residents. If these programs are successful and could be further strengthened, they could serve as a model for incremental coverage expansion using funding from the anticipated multibillion-dollar national tobacco settlement or other state revenues.

Building on the momentum created by recent coverage expansions for low-income children by extending these efforts to their parents is a high national priority. A new Fund-sponsored analysis by the Center on Budget and Policy Priorities explains how New York State could take advantage of a new opportunity in federal Medicaid rules to expand the program's income eligibility levels to low-income working parents.[15] This expansion, for which the federal government would pay half the costs, could cover hundreds of thousands of low-income New Yorkers.

MEDICAID MANAGED CARE IN NEW YORK CITY

Nearly 1.8 million New York City residents rely on Medicaid for their health insurance coverage, including almost 800,000 children. Nearly all of these beneficiaries, except for those with HIV/AIDS

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and other chronic illnesses, will be required to enroll in managed care over the next several years. Following years of negotiation between New York City, New York State, and the federal government, the first phase of mandatory enrollment will begin in lower Manhattan, parts of Brooklyn, and Staten Island during the summer of 1999. Once completed, New York City will have the largest mandatory Medicaid managed care program in the nation. Approximately 400,000 Medicaid beneficiaries in the city are already voluntarily enrolled in managed care plans.

The conversion of the city's Medicaid program to mandatory managed care has profound implications for beneficiaries, the providers who serve them, health plans, and the entire system of financing and delivering health care in the city. Proponents of Medicaid managed care argue that it can simultaneously decrease program costs and improve the quality of care by linking beneficiaries with regular doctors, emphasizing preventive care, and decreasing reliance on emergency rooms for routine care. Others, however, insist that Medicaid managed care will deprive patients of care in order to save money, that beneficiaries will have difficulty understanding and adapting to a complicated new delivery system, and that increased competition for Medicaid patients, combined with lower provider reimbursement rates, will threaten the financial viability and missions of the city's AHCs and other safety net providers.

The transition to mandatory managed care is occurring simultaneously with a drop in the number of state Medicaid beneficiaries: 384,000 fewer nonelderly individuals in New York were covered by the program in September 1998 than in March 1995, a decrease of approximately 15 percent.[16] Welfare reform efforts and an improved state economy are believed to be major contributors to this decline, although no independent analyses have been conducted in New York.

Assessing the Impact of Medicaid Managed Care

To monitor the impact of Medicaid managed care and other changes in the Medicaid program, the Fund and others have supported work led by the United Hospital Fund (UHF) to analyze the program's evolution and provide officials with "real-time" information needed to make policy and planning decisions. For the last four years, this project has chronicled the development of Medicaid managed care and assembled baseline data with which to make comparisons once mandatory enrollment begins.

Work conducted under the UHF project suggests that voluntary Medicaid managed care thus far has not entirely fulfilled its promise and raises warning signs that the program may encounter greater difficulties under mandatory enrollment. For example, patients who enrolled voluntarily are, as a group, in better health than those who will be mandatorily enrolled. Even with a relatively healthy patient base, however, voluntary managed care has not resulted in substantially altered utilization patterns among enrollees or reduced reliance on emergency rooms.[17] At the same time, the city's ambulatory care providers exhibit a mixed state of readiness to deal with mandatory enrollment: while almost all have at least one managed care contract in effect, many lack sophisticated patient-tracking systems or offer after-hours services, the hallmarks of managed care. Analyses conducted by John Billings of New York University show that although the city has enough providers for the early phases of mandatory enrollment, shortages could occur as enrollment progresses.[18]

Early results from the UHF project have been used to revise the phase-in schedule of mandatory enrollment, to develop guidelines for Primary Care Initiative Awards, and to establish priorities for Community Health Care Conversion Demonstration Projects. The project also identified a number of factors that would support rate increases in payments to managed care plans above those recommended in work commissioned by the Department of Health.

Turbulent Times: Changes in the Medicaid Health Plan Market

While 19 managed care plans currently participate in the Medicaid program, the program is increasingly dominated by small, nonprofit, provider-sponsored health plans that serve only low-income patients. Health plans sponsored by hospitals

and CHCs now serve 65 percent of the city's Medicaid managed care patients, and enrollment in these plans increased by 31,000 in the last year.[19] Enrollment in traditional health maintenance organizations, however, decreased by 32,000 members last year, and large commercial plans such as Oxford Health Plans and Empire Blue Cross and Blue Shield recently withdrew from the city's Medicaid program. In 1997, 20 of the 21 plans that participated in the Medicaid program lost money.[20]

The Bronx Health Plan and similar organizations are increasingly typical of those serving the city's Medicaid patients. Founded with initial support from the Fund in 1982, this plan was started by several CHCs affiliated with Montefiore Medical Center that sought to convert from a fee-for-service system to a prepaid system of comprehensive health services. The Bronx Health Plan was the first such plan licensed in New York State specifically to serve patients with public insurance coverage. It has served as a model for the state's Medicaid managed care program and as a pilot for state insurance subsidy programs for the uninsured. Today, the Bronx Health Plan has close to 38,000 members in the Bronx and Manhattan and is the city's fifth-largest plan serving the Medicaid population. Its provider network includes more than 450 primary care clinicians working in more than 85 practices and 11 hospitals, and more than 1,500 specialist physicians.

Making Medicaid Managed Care Work: Beneficiary Education

Helping Medicaid managed care achieve its promise is the objective of a model program developed by the Community Service Society of New York (CSS) with support from the Fund. The program educates beneficiaries about choosing a health plan that meets their needs, navigating a complex care system, and obtaining appropriate medical services. Unless Medicaid beneficiaries become knowledgeable managed care consumers, they will not benefit from increased continuity of care, their health care seeking behaviors will not likely change, and cost savings from changes in utilization will not be realized.

CSS developed a curriculum for Medicaid beneficiaries consisting of a low-literacy handbook and participatory workshops that engage them in dialogues with volunteer educators. It also includes training programs for workshop leaders and human service providers who work with beneficiaries at community-based organizations. Recognizing the value of enrollee education, New York State has hired a private broker to conduct Medicaid managed care outreach, education, and enrollment for New York City. The broker's responsibilities will include offering education packets in 18 languages, providing in-person assistance to beneficiaries when necessary, and contracting with community organizations to provide beneficiary education. CSS has also received a multimillion-dollar grant from the City of New York to expand its managed care consumer education activities.

Initially piloted in New York City, the CSS program has become a national model for educating Medicaid populations about managed care. An evaluation of the New York City pilot found that it was effective in raising beneficiaries' knowledge of managed care.[21] As a result, demonstrations are now under way in Los Angeles, Philadelphia, and additional parts of New York City. A Fund-supported evaluation of the CSS model by Sue Kaplan of New York University is finding that the approach developed for the city has broad national applicability and can be tailored to local circumstances.

SAFETY NET PROVIDERS AND ACADEMIC HEALTH CENTERS

New York City has an extensive network of safety net providers and AHCs that provide health care services to low-income, uninsured, and other vulnerable populations. The presence of these providers may account for the finding in the Fund's survey that uninsured New Yorkers have somewhat better access to care than the uninsured nationally.

New York City's Public Hospital System

At the center of the safety net lies a vast municipal hospital system, the Health and Hospitals Corporation (HHC).

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HHC has an annual operating budget of approximately $4.2 billion and consists of 11 acute care hospitals, five diagnostic and treatment centers, 80 family and child health centers, six long-term care facilities, five certified home health agencies, and the MetroPlus Medicaid managed care plan. Annually, patients make approximately 5 million ambulatory care visits to HHC facilities and nearly 1 million emergency room visits. HHC provides a disproportionate share of care to uninsured and Medicaid patients: in 1997, 71 percent of all ambulatory care visits by the uninsured were to HHC facilities, compared with 20 percent to voluntary hospitals and 9 percent to other health centers and clinics.[22] Medicaid accounted for more than half of all HHC inpatient acute care revenues in 1998.[23] City subsidies for HHC have shrunk over time, from $293 million in 1993 to $80 million in 1998.

New York City's Academic Health Centers

New York City is home to some of the world's leading AHCs, including 33 voluntary major teaching hospitals. In addition to their research and teaching missions, these 33 hospitals are an important source of care to the city's Medicaid and uninsured populations and rely heavily on publicly financed insurance programs. In 1997, one-third of their discharges were Medicaid patients, and combined Medicaid and Medicare fee-for-service payments accounted for approximately 58 percent of their revenues.[24] Bad debt and charity care costs for these hospitals increased steadily from 1995 to 1997. The city's AHCs also provide a significant amount of physician services to public hospitals through affiliation agreements, although these arrangements have changed considerably in recent years.[25]

New York City's Community Health Centers

CHCs are another crucial part of the city's health care safety net. More than 22 of these centers provide care to a patient base comprised of roughly half Medicaid patients and 30 percent uninsured patients. In addition to primary care, these centers often provide pediatric and adolescent health services, OB-GYN services, dentistry, health education, and enabling services such as interpretation, transportation, and referrals to specialty care and social services. CHCs have been recognized for their expertise in providing culturally competent care that is sensitive to the needs of low-income, low-literacy, and ethnically diverse patients.[26]

The Primary Care Development Corporation (PCDC) has played an important role in building capacity for the delivery of primary care services in underserved New York City neighborhoods. PCDC was established in 1993 as a unique public-private partnership with support from the Fund, other private and corporate foundations, and the city, which provided a $17 million revolving loan fund. PCDC provides low-interest loans, project management, and technical assistance to nonprofit health care providers to build and operate health centers in neighborhoods that lack adequate primary care resources. Since its inception, PCDC has arranged approximately $100 million in financing for 27 new primary care centers, 19 of which are completed and in operation. Combined, these centers have added capacity for more than 770,000 new primary care visits annually. PCDC-financed facilities repay their construction loans with patient revenues, primarily from those with Medicaid or CHP coverage.

Challenges to New York City's Health Care System

The future of the city's health care providers and their historical mission to provide care regardless of patients' ability to pay is uncertain. Safety net facilities are simultaneously experiencing a decline of paying patients and growth in their uninsured patient populations. Managed care has increased competition among providers for Medicaid patients who provide the lion's share of revenue for safety net providers and a significant source of revenue to AHCs, while reducing reimbursement rates so that funds traditionally used to subsidize care for the uninsured are shrinking. At the same time, deregulation of hospital payment rates has set off an intense period of mergers and affiliations among the city's providers, which could cause

considerable financial instability in essential health care institutions.[27]

Fiscal pressures on safety net providers and AHCs are likely to intensify because of changes in federal and state policies. HHC projects a loss of $100 million over four years as mandatory Medicaid managed care is implemented and as Medicaid and Medicare reimbursement rates are reduced.[28] It is estimated that Medicare hospital payment reductions enacted in the federal Balanced Budget Act of 1997 will reduce baseline Medicare revenues by 13 percent at New York hospitals by 2002, which will reduce overall baseline net patient revenues by approximately 4 percent.[29] Reductions in federal and state funding for public goods such as graduate medical education and the disproportionate share program, which provides subsidies to hospitals with large Medicaid populations, will take an especially heavy toll in New York City. In addition, the state significantly reduced Medicaid hospital reimbursement rates in 1996 and 1997, and current state funding for uncompensated care does not fully reimburse providers for care to the uninsured.[30] And though the state Medicaid managed care program provides $1.25 billion over five years in transitional funding to hospitals that serve at least 20 percent Medicaid or uninsured patients, almost no funds are currently available to similarly support CHCs during the conversion to mandatory enrollment.

CONCLUSION

New Yorkers' access to quality health care is at risk because of eroding insurance coverage, changes in the financing and delivery of Medicaid, the growth of managed care, and stresses on safety net providers and AHCs. Any further increases in the city's uninsured population are likely to strain its capacity to serve those in need. Other trends, including growing income disparities among residents, welfare-to-work efforts, and ongoing waves of new immigration, could place additional pressure on the local health care system.

Public and private sector leaders face considerable challenges in preserving New York's longstanding commitment to health care for all its residents. Private foundations have a unique ability to provide crucial early support so that new approaches to service delivery can be developed, implemented, and evaluated for their effectiveness. Initiatives started with foundation support can then serve as the basis for public policies and actions that align financial incentives with the provision of high-quality and accessible care. Efforts such as those by the Bronx Health Plan, CSS, and PCDC exemplify how creative approaches begun with foundation dollars can be sustained and expanded with subsequent support from the government and private resources.

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One East 75th Street
New York, NY 10021-2692

Tel: 212.606.3800
Fax: 212.606.3500
E-mail: cmwf@cmwf.org
http://www.cmwf.org

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