



# The Health Care Reform Act (HCRA):

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The Need to Restore Accountability to State Taxpayers

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A P R I L 2 0 0 3

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New York State  
Office of the State Comptroller  
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## EXECUTIVE SUMMARY

The Health Care Reform Act (HCRA) provides legislative underpinning for many of the State's health care financing policies. It supports a number of important programs like Graduate Medical Education (GME), bad debt/charity care (BD/CC), Child Health Plus (CHIP), the Elderly Pharmaceutical Insurance Coverage program (EPIC), Family Health Plus (FHP), and many more. HCRA also provides sizable General Fund budget relief (an estimated \$1.6 billion in 2002-03) by supporting programs that used to be or would typically be financed by the General Fund.

HCRA is set to expire on June 30, 2003. The Executive proposes a two-year extension and a number of programmatic changes. In 2003-04, HCRA receipts, based on the Executive's proposal and projections, are estimated to total about \$3.7 billion. The Executive's 2003-04 HCRA revenue includes Tobacco Settlement funds, State and New York City cigarette taxes, proceeds from conversion of Empire Blue Cross Blue Shield to a for-profit health plan, a "covered lives assessment" on each person covered by private insurance, surcharges on hospital and clinic services, and an assessment on inpatient hospital revenue.

The State Department of Health (DOH) has contracted with Excellus Health Plan, Inc. (Excellus or pool administrator) to collect and disburse this revenue from the Professional Education, Health Care Initiatives, Tobacco Control and Insurance Initiatives, and Regional and Statewide Bad Debt/Charity Care pools. Under the previous system that regulated hospital rates, the New York Prospective Hospital Reimbursement Methodology (NYPHRM), most revenues and spending were "off-budget."<sup>1</sup> Most revenues and spending under HCRA are also off-budget. But as HCRA has grown larger in recent years, there have been growing concerns about the off-budget nature of its collections and disbursements:

- The majority of HCRA revenues are collected directly by the pool administrator independent of the traditional state accounting and budget process. Normally the State would collect revenues and the Office of the State Comptroller (OSC) would provide comprehensive monthly accounting of the flow of funds, including revenues and disbursements.
- In State Fiscal Year (SFY) 2001-02, the most recent year for which actual data are available, nearly \$1.7 billion out of \$2.5 billion in HCRA spending was disbursed directly by the pool administrator to health care programs, outside of the traditional contract and budget process. Normally, expenditures are authorized by an appropriation, OSC pre-audits and makes payments, and OSC provides regular and comprehensive accounting of spending.

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<sup>1</sup> Defined as program disbursements that are unappropriated, disbursed directly by the pool administrator, and excluded from the State's financial plan and HCRA revenues that are not reflected in the State's Financial Plan. The only exception to this definition is the Bad Debt and Charity Care pool where the disbursement total is appropriated, but the funds are transferred back to the pools from which the pool administrator issues the checks to health care providers directly.

- OSC reviews HCRA contracts before they are approved, whether are supported by budgeted State funds or are off-budget. But when programs are off-budget, there can be no assurance that OSC receives every contract because the pool administrator, not OSC, writes the checks. Under the traditional contract and budget process, no vendor can be paid unless OSC approves the contract and the payment. No such checks and controls apply to off-budget contracts.
- Furthermore, if funding is split between off-budget and appropriated dollars, OSC cannot audit contract expenditures to assure that the State is paying for services within the terms of the contract, making it difficult to determine the true cost of HCRA programs or to identify how much a particular provider or region within the State is receiving.
- Because many off-budget HCRA grant programs do not require competitive bidding or requests for proposals, OSC is limited in its ability to judge whether a contractor can satisfy contractual requirements and whether a contractor's costs are reasonable.
- Finally, under off-budget contracts, not-for-profit organizations do not benefit from statutory provisions requiring the State to pay interest on late payments for services provided under contracts not promptly executed.

Policymakers have sometimes said that off-budget collections and spending protect important programs from the ups and downs of yearly budgeting. However, the reality is that off-budget actions mask the true level of State-authorized and imposed receipts and spending, which not only results in a loss of accountability to policymakers and taxpayers, but also removes important financial checks and balances that are normally performed by the Office of the State Comptroller.

As HCRA is being extended this session, New York State policymakers should put all HCRA revenues and spending on-budget. State policymakers, taxpayers and not-for-profit organizations would benefit if all HCRA funding streams and allocations were on-budget for the following reasons:

- The State Comptroller could provide lawmakers and the general public with a better accounting of revenues raised as well as what has been spent. Conversely, the State Comptroller would be able to determine what has **not** been spent, and why. Annually, the pool administrator provides information on off-budget revenues and spending but this information is not available to the public, is not presented in a meaningful way for programmatic analysis, and is not released on a regular basis.<sup>2</sup>

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<sup>2</sup> An annual independent audit required by the Public Health Law provides the Legislature and the State Comptroller with only cursory information about specific cash receipts and actual program-specific spending levels. Once a year, OSC reports on HCRA receipts, disbursements and ending balances, based on information provided by Excellus Health Plan, Inc., the pool administrator. In 2001, the Office of the

- The State Comptroller would receive and review **all** HCRA-related contracts, gaining a complete understanding of any given HCRA program. OSC currently reviews DOH contracts supported by off-budget HCRA allocations. But it is unclear if the State Comptroller receives all such contracts.
- Not-for-profit organizations providing services under HCRA programs would benefit from the law requiring the State to pay interest on late payments for services provided under contracts not promptly executed.
- The State Comptroller could collect and distribute funds in the HCRA pools as part of OSC's normal operations. This could save over \$3 million in annual fees<sup>3</sup> paid from HCRA funds to Excellus, the pool administrator, by the State Department of Health. These savings could be invested in new or existing health-care programs.
- Finally, as part of its normal operations, OSC could also perform annual, independent audits of all HCRA receipts and distributions. Currently, the Public Health Law requires the State Department of Health to conduct annual audits of HCRA funds received and distributed by the pool administrator. Under the Public Health Law, the State Department of Health must also contract for an annual independent audit of HCRA "receipts, disbursements, revenues, expenditures, and cash flow of funds" with an independent certified public accountant. However, recent OSC reports examining DOH controls over HCRA surcharge collections and funding for various health care initiatives identified underpayments by hospitals and inadequate DOH documentation practices.

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State Comptroller requested and received from Excellus detailed, program-by-program information on HCRA receipts and disbursements. That information is included in this report. Real-time information about program disbursements would make it easier for the State Comptroller and policymakers to monitor program performance throughout the year.

<sup>3</sup> The pool administrator's fees include up to \$2.5 million in annual personnel expenses. In addition, HCRA funds have paid for the pool administrator's annual expenses for postage, auditing services, management consulting, office rentals, printing, computer hardware and software, photocopying, etc. The Executive proposal to extend HCRA for two years increases annual payments for the pool administrator's personnel expenses by \$1.65 million. The current contract between Excellus and the State calls for \$11.6 million in payments from January 2000 through June 2003.

## BACKGROUND

The Health Care Reform Act (HCRA) of 1996 substantially ended New York's practice of setting hospital reimbursement rates.

Under the previous system, the New York Prospective Hospital Reimbursement Methodology (NYPHRM), hospitals were reimbursed for services based on rates set by the State Department of Health (DOH). "Public goods" such as hospital bad debt/charity care, Child Health Plus, healthcare coverage pilot programs, and quality improvement grants were funded through statewide and regional bad debt/charity care pools. To support these pools, insurers paid an average of 5.5 percent of their hospital inpatient payments and hospitals paid 1 percent of their inpatient revenues.<sup>4</sup>

Other public goods including primary health care services grants, primary care education and training, and health care planning programs were funded through another pool supported by a percentage of general hospital reimbursable inpatient costs. Various NYPHRM pool reserves also paid for programs to facilitate hospital collaboration, management information systems, global budgeting demonstrations, rural health networks, quality improvement grants, and HIV services for infants and pregnant women. NYPHRM funded graduate medical education through a rate-setting formula, by which teaching hospitals received higher rates of payment than non-teaching hospitals for the identical services.<sup>5</sup>

In Calendar Year 1995, NYPHRM provided \$1.27 billion in institutional subsidies to hospitals and support to other programs for the medically indigent: \$759 million in hospital subsidies for bad debt/charity care and outpatient operating losses; \$420 million for systems development programs including rural health networks and primary care development; and \$89 million for various insurance programs such as Child Health Plus (CHIP).<sup>6</sup>

Medicaid was the source of funding for most (almost \$1 billion worth) of these programs. In order to draw down Federal matching money for hospital bad debt/charity care and outpatient operating losses, the State credited its share to a budgeted state revenue fund, then moved the State and Federal shares back to NYPHRM's regional bad debt/charity care pool, from which hospitals received their funding.

Private insurer add-ons and hospital assessments generated about \$270 million for the various other programs, some of which – emergency medical services training, HIV services for infants and pregnant women, and health care planning - received support from budgeted state revenue funds. Other programs – CHIP, primary health care services, primary care education and training, rural health networks, and quality

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<sup>4</sup> "New York Sets National Precedent in Health Care," Healthcare Association of New York State news release, July 13, 1996.

<sup>5</sup> *Ibid.*

<sup>6</sup> Findings and Recommendations of Governor George E. Pataki's Ad Hoc Task Force on NYPHRM, December 1995

improvement – received their funding directly from off-budget pool resources, not from budgeted state funds.

New York teaching hospitals received nearly \$3 billion in graduate medical payments in 1995: \$1.2 billion from the Federal government in Medicare payments; \$769 million in Medicaid payments through NYPHRM; and \$911 million in payments from private insurers and HMOs through NYPHRM. The State budget provides appropriations for the State and Federal shares of Medicaid. However, the \$911 million in private payments was all off-budget, paid directly from NYPHRM’s medical education pool, not from budgeted State funds.

### **Health Care Reform Act (HCRA) 1996**

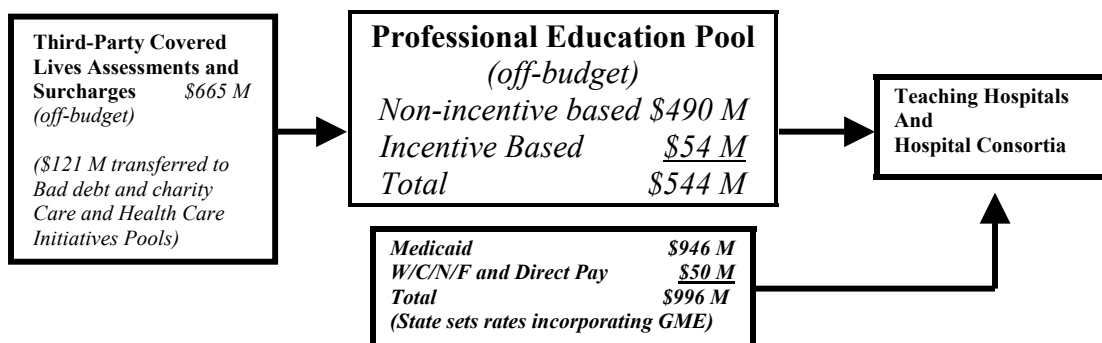
Starting January 1997 and expiring December 1999, HCRA authorized most payors to negotiate their own rates for hospital reimbursement, except that DOH continued to set Medicaid rates for hospital reimbursement while the federal government continued to set Medicare rates for hospital reimbursement. Furthermore, HCRA coupled Workers’ Compensation and No-Fault rates with DOH’s Medicaid rates.

Like NYPHRM, HCRA also established three public goods pools to finance health care for uninsured and low-income working people, support graduate medical education (GME), and fund health care initiatives in primary care, rural health care, quality improvement, and other areas. HCRA generated funding to support the pools by imposing surcharges on the cost of health care services, requiring insurers to pay a fixed amount for each person they cover (known as a “covered lives assessment”), and continuing the 1 percent assessment on hospital inpatient revenue. Funding raised by these surcharges and assessments was collected directly by the pool administrator and flowed into off-budget pools, part of which was then distributed to off-budget health care programs, effectively making the flow of support invisible to the State accounting system.

### **Professional Education Pool**

In Calendar Year 1997, \$544 million in covered lives assessments and surcharges flowed into the off-budget Professional Education Pool supported by private payors that was created by HCRA 1996. This was considerably less than the \$911 million in off-budget funding provided by NYPHRM in 1994 (Figure 1).

## HCRA 1996 Professional Education Pool Calendar Year 1997 Allocation



**FIGURE 1**

In terms of the distribution of the \$544 million, HCRA allocated approximately \$490 million directly from the pool administrator to teaching hospitals to provide partial reimbursement for graduate medical education costs. Distribution of the \$490 million was based on a formula that considers a hospital’s share of all residents in the State and a hospital’s cost per resident as calculated by Medicare. The remaining \$54 million was allocated to hospital consortia and other teaching hospitals that downsized their residency programs by at least 5 percent and had at least 20 percent of their residents in primary care. Teaching hospitals and hospital consortia received similar amounts of HCRA funding in 1998 and 1999.

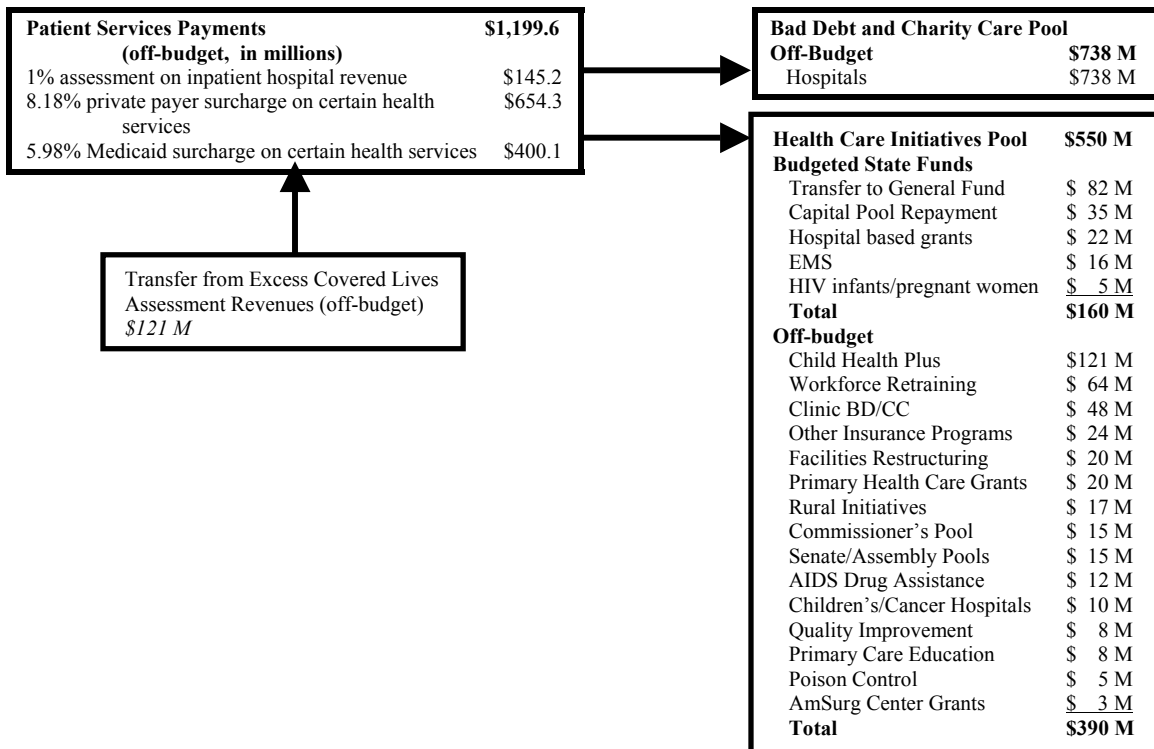
In addition to the professional education pool, teaching hospitals received reimbursement totaling \$996 million for GME through rates paid by the Medicaid and Worker’s Compensation programs. The State and federal shares of Medicaid were appropriated in the State budget and are included in All Funds spending reported by the Office of the State Comptroller. Excess professional education pool funding of \$121 million was transferred to the bad debt/charity care and health care initiatives pools.

## Bad Debt/Charity Care and Health Care Initiatives Pools

The bad debt/charity care and health care initiatives pools created by HCRA 1996 were funded by a 1 percent assessment on inpatient hospital revenues and two surcharges on inpatient services, outpatient services, emergency services, and other hospital and health-related services: 8.18 percent for private payers and 5.98 percent for Medicaid. The pools also received a transfer of \$121 million from the professional education pool.

### HCRA 1996 Bad Debt/Charity Care and Health Care Initiatives Pool Calendar Year 1997 Allocations

FIGURE 2

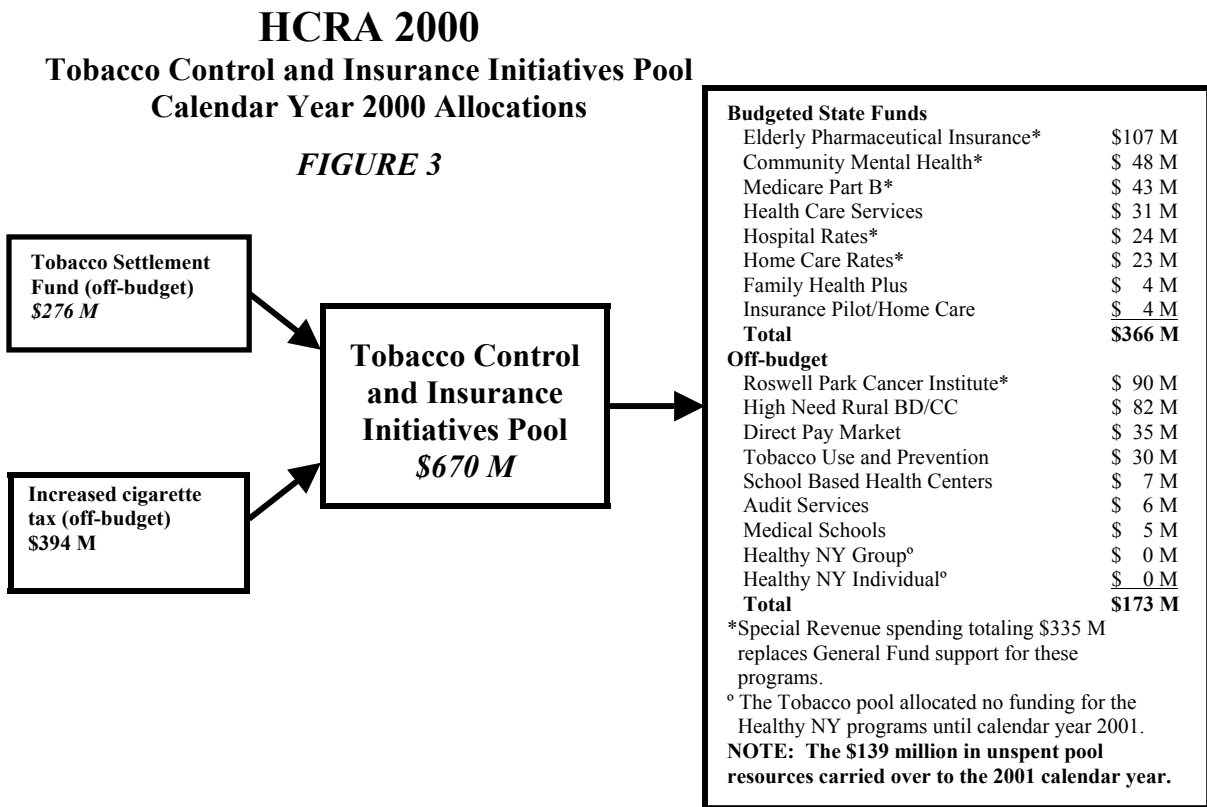


In Calendar Year 1997, the estimated level of bad debt/charity care funding for hospitals was \$738 million. Funding for this off-budget program flowed into the bad debt/charity care pool. It was then transferred to a budgeted State revenue fund. Half of the money transferred was used as a General Fund offset for Medicaid. The other half and Federal matching funds were transferred back to the pool, which then disbursed the funding directly to eligible hospitals. Therefore, although the moneys were appropriated, the checks to healthcare providers are not issued by the Office of the State Comptroller and individual payments to providers are not in the Comptroller's accounting system.

The health care initiatives pool provided estimated funding of \$550 million in calendar year 1997 for both on- and off-budget spending. Of this amount, \$160 million was included in the State budget as special revenue spending while the remaining \$269 million was not included in the State budget. Specifically, the health care initiatives pool allocated \$82 million for transfer to the General Fund, and supported other health care initiatives including \$22 million for hospital based programs and \$16 million for emergency medical services. Off-budget spending included \$121 million for Child Health Plus, \$64 million for workforce retraining, \$48 million for clinic bad debt/charity care, \$30 million for State Health Commissioner and legislative discretionary pools, and \$24 million for various insurance programs. HCRA 1996 provided roughly similar support for bad debt/charity care and various health care initiatives in the 1998 and 1999 calendar years, except that State support for Child Health Plus became a budgeted expense in SFY 1998-99 in order to draw down Federal matching funds for the program.<sup>7</sup>

## HCRA 2000

The current HCRA 2000, signed into law in December 1999, continued for another three-and-a-half years (until June 30, 2003) the negotiated rate system and pool funding mechanisms supporting bad debt/charity care, graduate medical education and various health care initiatives. However, HCRA 2000 also created a new pool - the



<sup>7</sup> Legislation providing Federal funding for uninsured children through S-CHIP (the State Children's Health Insurance Program) was signed into law during the summer of 1997. HCRA 1996 allocated \$165 million in State funding for CHIP in calendar year 1998 and \$181 million in 1999.

Tobacco Control and Insurance Initiatives pool – and employed two new revenue sources to support it: 1) a portion of the State’s tobacco settlement funds, and 2) a 55-cent per pack increase in the State cigarette tax. Like the assessments and surcharges established by HCRA 1996, these new revenues are not included in the State Budget’s Financial Plan, which is comprised of the General Fund, State Revenue Funds, the Debt Service Fund, and the Capital Projects Fund. While the State Comptroller regularly reports on all State tax receipts, the cigarette tax is the only State tax where a portion of receipts is diverted to an off-budget fund. In addition, tobacco settlement funds are paid to the State Comptroller and pursuant to annual legislation are transferred off-budget for HCRA program purposes. Since neither of these revenues are included in the State’s Financial Plan, this movement of state revenues to HCRA pools adds to the lack of financial plan disclosure, full accounting for State revenues, and (for a portion of Tobacco pool revenue), off-budget spending pursuant to the Health Care Reform Act.

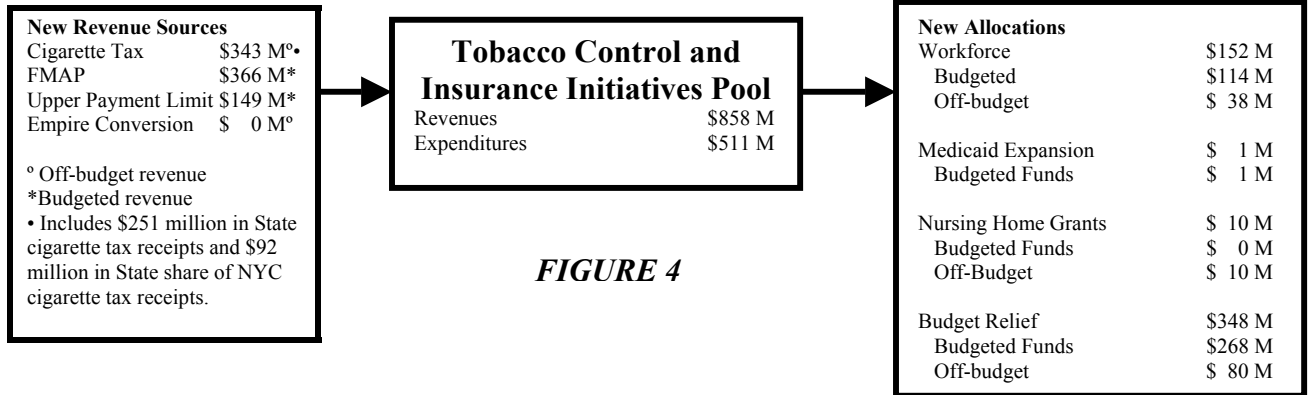
HCRA 2000 also created two new insurance subsidy programs – Family Health Plus and Healthy New York – within the Tobacco Control and Insurance Initiatives pool. In calendar year 2000, the pool allocated \$366 million in budgeted spending, including \$4 million for Family Health Plus. The pool also allocated \$173 million in off-budget spending, but none for Healthy NY until calendar year 2001 when the program began enrollment. HCRA also provided for a significant amount of General Fund relief by shifting to the Tobacco pool approximately \$335 million in support for the Elderly Pharmaceutical Insurance Coverage program, Medicaid payments for Medicare Part B, and the Roswell Park Cancer Institute as well as hospital and home care Medicaid rate increases and expanded community mental health services that would normally be paid for from the General Fund (FIGURE 3).

HCRA 2000 reduced annual graduate medical education spending by \$50 million to \$494 million while it increased basic bad debt/charity care funding for hospitals to \$765 million. HCRA 2000 also provided approximately \$527 million in funding for programs in the Health Care Initiatives pool. In calendar year 2000, the largest allocations from this pool were \$207 million for the State share of the Child Health Plus program and an \$82 million transfer to the General Fund. Other programs funded by the Health Care Initiatives pool included hospital based grants, the State Health Commissioner and legislative discretionary pools, bad debt/charity care for clinics, and workforce retraining. In calendar year 2000, the Health Care Initiatives pool provided approximately \$336 million in budgeted funds and \$191 million in off-budget spending.

### **HCRA 2000 Amendments**

Amendments to HCRA 2000 enacted in January 2002 employed a number of new revenue sources to support increased Medicaid rates designed to increase health care wages and expand Medicaid coverage for women and working people with disabilities (FIGURE 4).

## HCRA 2000 Amendments Estimated Fiscal Impact FY 2002-03 Allocations



Over a three-year time period, the HCRA 2000 amendments anticipated over \$3 billion in new revenue including: \$1 billion in proceeds from Empire BlueCross BlueShield’s conversion to a for-profit insurer; \$1.8 billion from an increase in the State’s Federal Medical Assistance Percentage (FMAP) from 50 to 53 percent; \$789 million by increasing the State’s cigarette tax by 39 cents per pack;<sup>8</sup> \$149 million by increasing the Medicaid upper payment limit to 150 percent for inpatient and outpatient services at public hospitals; and \$100 million by eliminating the scheduled decrease in the covered lives assessment.

The amendments were intended to provide salary increases for non-supervisory workers at health care facilities or supervisory workers who provide direct patient care in hospitals, nursing homes, freestanding clinics, and personal care settings. These funds were also intended to promote financial stability and quality improvement initiatives at financially distressed nursing homes, and provide Medicaid coverage to uninsured and underinsured women diagnosed with breast or cervical cancer and working people with disabilities.

At the same time, over three years, almost \$1 billion of these new resources were to be allocated to pay for programs that were previously supported by the General Fund – such as the Elderly Pharmaceutical Insurance Coverage program, various public health programs, the Roswell Park Cancer Institute, and the Excess Medical Malpractice program. As a result, the funds will not support new health-related programs.

<sup>8</sup> Following passage of the HCRA 2000 amendments in January 2002, the enacted budget for SFY 2002-03 authorized a \$1.42 per pack increase in the cigarette tax in New York City. Because of concerns that the NYC cigarette tax increase may depress NYS cigarette tax receipts, the State receives a portion of the NYC increase (46.5 percent from July 2, 2002 until April 1, 2003; and 46 percent on and after April 1, 2003) and dedicates it to HCRA’s Tobacco Control and Insurance Initiatives pool. In SFY 2002-03, the tax generated \$92 million in revenue for the pool. Coupled with \$251 million in new revenue raised by increasing the State’s cigarette tax, new cigarette tax revenue for SFY 2002-03 totaled \$343 million. Overall, the pool received \$776.6 million in cigarette tax revenue in SFY 2002-03.

## HCRA 2003 Proposal

In January 2003, the Executive proposed to extend HCRA 2000 for two additional years. The proposal dedicates \$8.7 billion for health care programs from July 2003 through June 2005, and includes \$786 million in program cuts and fee increases as well as \$943 million in other revenue actions to offset \$649 million in new spending. Many of the revenue actions are non-recurring. Much of the new spending is designed to provide General Fund budget relief.

### HCRA 2003 PROPOSAL - ACTIONS BY STATE FISCAL YEAR (\$ in millions)

	SFY 2003-04	SFY 2004-05	4/05 – 6/05	Total
<b>Cost Containment</b>				
Shift eligible children from MA to CHIP	42	120	30	192
Roll back Family Health Plus eligibility	20	34	10	64
Manage annual FHP premium increases	19	65	16	100
EPIC/pharmacy cost containment	34	65	19	118
EPIC/increase fees by 10 percent	4	4	1	9
Reduce certain program allocations	62	62	15	139
Reduce Roswell subsidy	5	5	1	11
Federalize clinic bad debt/charity care	27	36	9	72
Lower State share/hospital-clinic workforce	32	39	10	81
<b>Subtotal</b>	<b>245</b>	<b>430</b>	<b>111</b>	<b>786</b>
<b>Revenue Actions</b>				
Tobacco securitization	0	(420)	(427)	(847)
Additional conversion proceeds – Empire	83	300	300	683
Additional conversion proceeds – Other	0	0	200	200
Increase payor surcharges to 8.85/6.47 percent	20	80	21	121
Increase covered lives assessment	9	35	17	61
Amnesty program	30	10	5	45
Dedicate Federal CHCCDP funds	0	350	0	350
Program Federal FEMA World Trade Center funds	0	330	0	330
<b>Subtotal</b>	<b>142</b>	<b>685</b>	<b>116</b>	<b>943</b>
<b>SUBTOTAL – RESOURCES</b>	<b>387</b>	<b>1,115</b>	<b>227</b>	<b>1,729</b>
<b>New Spending</b>				
General Fund Offloads	(214)	(351)	(72)	(637)
Adult Homes Initiative	(4)	(6)	(2)	(12)
<b>Subtotal</b>	<b>(218)</b>	<b>(357)</b>	<b>(74)</b>	<b>(649)</b>
<b>NET PROPOSED CHANGE</b>	<b>169</b>	<b>758</b>	<b>153</b>	<b>1,080</b>

Taken together, using Executive projections, these proposed cuts and fee increases, revenue actions and new spending generate over \$1 billion in additional funding for HCRA from July 2003 through June 2005. However, in SFY 2003-04, proposed baseline HCRA spending exceeds anticipated HCRA revenue by almost \$450 million.

**HCRA Anticipated Revenue versus Proposed Spending for SFY 2003-04**

<b>Pool(s)</b>	<b>Anticipated Receipts (in Millions)</b>	<b>Proposed Allocations (in Millions)</b>	<b>Difference (in Millions)</b>
Bad Debt/Charity Care and Health Care Initiatives	\$1,571	\$1,477	\$94
Professional Education <sup>9</sup>	\$494	\$494	\$0
Tobacco Control and Insurance Initiatives	\$1,626	\$2,166	(\$540)
<b>Totals</b>	<b>\$3,691</b>	<b>\$4,137</b>	<b>(\$446)</b>

In SFY 2004-05, the Executive anticipates \$4.2 billion in total HCRA spending and nearly \$4.2 billion in total HCRA revenue. For the first three months of SFY 2005-06, the Executive anticipates \$1.1 billion in total HCRA spending and \$1.5 billion in total HCRA revenue.

To fill the gap in SFY 2003-04, the Executive may be planning to use a portion of existing HCRA cash balances, assuming the Legislature adopts a proposal to provide DOH with the flexibility to “cash-manage” HCRA pools. Current law requires DOH to pay back cash balances that are “borrowed” from HCRA pools dedicated to one purpose to meet the funding obligations of other HCRA programs. The Executive proposes to authorize the agency to “utilize,” but not pay back, HCRA cash balances in order to ensure appropriate funding levels for HCRA programs. The Division of the Budget (DOB) says DOH needs this authority to avoid de-funding certain programs in order to fully fund others that are, by law, higher priority. However, granting such authority makes DOH less accountable to policymakers, payors into the pools, providers and the general public, particularly if DOH controls policy decisions regarding funding reductions to programs.

One program that could be susceptible to reductions is Child Health Plus (CHIP), the State’s popular program to subsidize health insurance coverage for children of low-income families. The Executive’s HCRA proposal ends “guaranteed” funding for CHIP, which has been in place since 2000. In SFY 2003-04, the Executive proposes to allocate \$415 million for CHIP, but adds language that would fund the program “up to” that amount, creating the potential for funding reductions.

**HCRA Funding for CHIP since SFY 1999-2000**

**(in Millions)**

	<b>1999-2000</b>	<b>2000-01</b>	<b>2001-02</b>	<b>2002-03 (estimated)</b>	<b>2003-04 (proposed)</b>
CHIP State Funds	\$154	\$267	\$325	\$398	\$415

<sup>9</sup> Anticipated receipts do not include a \$205 million transfer of excess Covered Lives Assessment revenue to the Health Care Initiatives pool.

If CHIP allocations are insufficient to cover program costs, the Executive also proposes to “**allow**” instead of “**require**” the Commissioner of Health to transfer funds from other HCRA pools to provide full program funding, thereby eliminating any guarantee that the program will be fully funded.<sup>10</sup>

By the end of June 2003, when the current Health Care Reform Act expires, it has been reported that the Executive anticipates about \$560 million in unencumbered HCRA cash balances, even after forgiving a \$200 million loan to the General Fund in 2002-03. The Executive proposes to forgive the loan by allocating its liability to prior year HCRA allocations determined to be unnecessary<sup>11</sup>, including:

- \$127 million from Healthy New York<sup>12</sup> group program allocations that are not needed due to slower than anticipated enrollment;
- \$48 million from the Healthy New York<sup>11</sup> individual program;
- \$8 million from the hospital-based grants program;
- \$7 million from the emergency medical services training account;
- \$5.8 million from the primary health care services grant program; and
- \$4.2 million from the Small Business Health Insurance Partnership program.

#### **SFY 2001-02 HCRA Actual Collections and Distributions:**

The State Department of Health contracts with a pool administrator, Excellus Health Plan, Inc., to collect and distribute funds in the HCRA pools. Once a year, OSC reports on HCRA receipts, disbursements and ending balances, based on information provided by Excellus.

Last year, OSC requested and received more detailed information from Excellus. The following analysis is the first publicly released accounting of actual spending versus allocations provided in the law. According to this analysis, the Bad Debt/Charity Care, Professional Education, and Health Care Initiatives pools began SFY 2001-02 with a cash balance of \$822 million and ended the year with a cash balance of \$943 million, after distributions of more than \$1.8 billion for more than 30 HCRA-funded programs and activities. (FIGURE 5)

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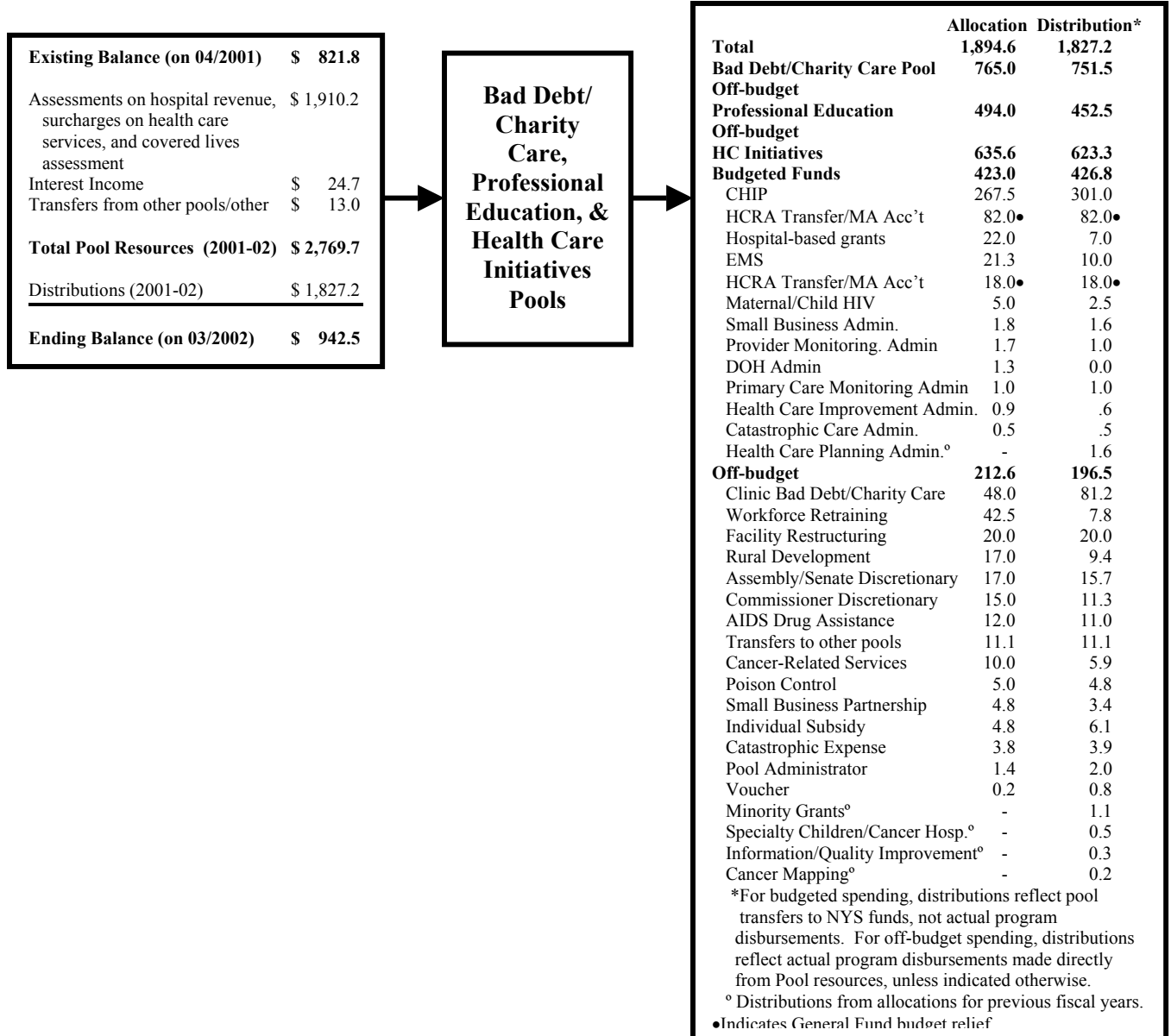
<sup>10</sup> Page 79, lines 4-13, Article VII Health and Mental Hygiene Bill (S.1408/A.2108).

<sup>11</sup> Memorandum in Support, Article VII Health and Mental Hygiene Bill (S.1408/S.2108)

<sup>12</sup> Healthy New York is a state sponsored program offered through health maintenance organizations and other approved insurers that aims to increase access to health insurance for employees of small businesses with 50 or fewer employees, working uninsured individuals whose employers do not provide health insurance coverage, and eligible individual proprietors. The State helps to subsidize the cost of the insurance by assuming all of the payment for selected high-cost claims.

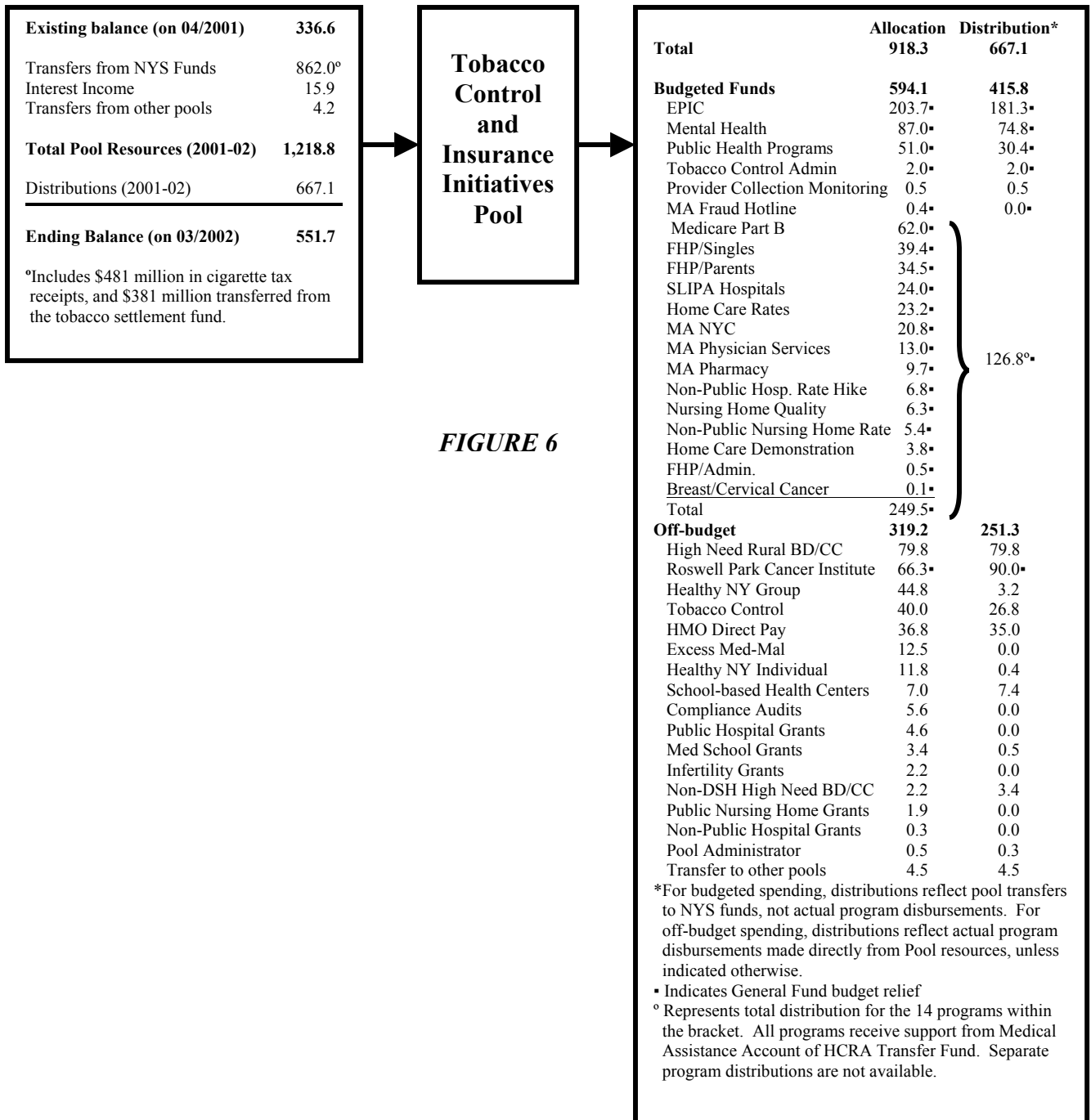
**HCRA 2000 ANALYSIS**  
**Bad Debt/Charity Care, Professional**  
**Education, & Health Care Initiatives Pools**  
**SFY 2001-02 Results (in millions)**

*FIGURE 5*



According to further analysis of these data, the Tobacco Control and Insurance Initiatives pool began SFY 2001-02 with a balance of \$337 million and ended the year with a balance of \$552 million, after distributions of almost \$667 million to more than 30 health care programs and activities.

### HCRA 2000 ANALYSIS Tobacco Control and Insurance Initiatives Pool SFY 2001-02 Results (in millions)



## OSC Audits

In addition to the previous analysis, the Office of the State Comptroller has conducted two audits of HCRA initiatives. The first audit,<sup>13</sup> released in May 2000, examined State Department of Health controls over HCRA surcharge and assessment collections and found underpayments at certain hospitals. OSC recommended greater use of available technologies – such as electronic data interchange and forms processing software – to improve the collection process.

A second audit,<sup>14</sup> released in November 2002, examined State Department of Health controls over funding for various health care initiatives. While the disbursements examined were generally accurate and authorized, OSC auditors could not complete all audit tests because the State Department of Health did not provide some of the documentation requested. OSC recommended improvements in the Department's documentation practices.

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<sup>13</sup> Health Care Reform Act Surcharge Collections, Report Number 2000-F-33

<sup>14</sup> Health Care Initiatives Pool Disbursements, Report Number 2001-S-43.

## ISSUES DISCUSSION

As policymakers consider extending HCRA for two additional years, they should address three areas of concern:

- The growing utilization of “off-budget” allocations as well as the existence of large cash balances and the lack of public reporting raise important issues of oversight and accountability. In many cases, taxes and revenues have been increased, yet the associated programmatic spending has not occurred;<sup>15</sup>
- As the State’s reliance on HCRA funds to pay for traditional General Fund programs grows, so too does pressure to maintain full funding for a vast number of HCRA initiatives. Furthermore, General Fund budget relief artificially deflates the level of taxpayer supported spending and hides additional revenues by circumventing the traditional budget process; and
- The use of non-recurring revenues jeopardizes the integrity and stability of HCRA in the out-years.

### Oversight and Accountability

One of the most pressing issues involving HCRA is the lack of oversight and accountability for off-budget revenues flowing into and out of HCRA pools to various health-care programs. Off-budget actions effectively mask the true level of State authorized and imposed receipts and spending. Not only does this result in a loss of accountability to taxpayers, but by removing these transactions from the State budget process, it also removes important financial checks and balances that are normally performed by the State Comptroller.

As the following chart indicates, off-budget revenues flowing into HCRA pools have grown dramatically since calendar year 1997, nearly doubling by calendar year 2004, under the Executive’s HCRA proposal. In CY 2004, it appears that the only budgeted revenues come from the Federal Emergency Management Agency to cover expenses related to the World Trade Center tragedy, including Disaster Relief Medicaid, and Federal funds related to the State’s Medicaid Managed Care waiver program.

Since 1997, off-budget distributions have grown by 10 percent. The dramatic increase in budgeted distributions reflects increased Medicaid rates funding the

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<sup>15</sup> In February 2002, Citizen Action of New York delivered “broken hearts” to the Governor and members of the State Legislature because “only a small fraction of those promised health insurance” actually received coverage, two years after policymakers raised cigarette taxes to provide health insurance for one million uninsured New Yorkers. A report prepared by Citizen Action found that “almost a billion dollars of new cigarette taxes were collected based on authorization in the Health Care Reform Act of 2000,” but only 15,000 people had been enrolled in two new health insurance programs (Family Health Plus and Healthy New York) also authorized by HCRA 2000. In the report, Citizen Action of New York Executive Director Richard Kirsch concluded that, “The money’s already been collected. It’s time to use the money for what it was intended – providing health coverage to the uninsured.”

recruitment and retention of hospital, nursing home, clinic and personal care workers (HCRA 2002 amendments), increased support for EPIC, and CHIP and the Executive proposed Medicaid pharmacy swap.

**HCRA REVENUES AND DISTRIBUTIONS (in billions)**

	<b>CY 1997</b>	<b>CY 1999</b>	<b>CY 2000</b>	<b>CY 2004 (Proposed)</b>
<b>Revenues</b>	<b>\$1.865 B</b>	<b>\$1.894 B</b>	<b>\$2.456 B</b>	<b>\$4,071 B</b>
Budgeted Funds	0	0	0	\$0.510 B
Off-Budget	\$1.865 B	\$1.894 B	\$2.456 B	\$3.561 B
<b>Distributions</b>	<b>\$1.832 B</b>	<b>\$1.721 B</b>	<b>\$2.325 B</b>	<b>\$4.275 B</b>
Budgeted Funds	\$0.160 B	\$0.332 B	\$0.620 B	\$2.413 B
Off-Budget	\$1,672 B	\$1.389 B	\$1.705 B	\$1.862 B

The State Comptroller reviews DOH and all other State contracts before they are signed, whether they are funded off-budget or by appropriated dollars. But when contracts are funded by off-budget allocations, there can be no assurance that OSC receives every contract because the pool administrator, not OSC, writes the checks. Under the traditional contract and budget process, no vendor can be paid unless OSC approves the contract and the payment. No such checks and controls apply to off-budget contracts.

Nor can the State Comptroller estimate an off-budget program's total value or identify how much a particular provider or region within the State is receiving, much less audit contract expenditures to provide assurances that the State is paying for services consistent with contract terms.

Another problem associated with off-budget HCRA allocations is the non-competitive nature of many of the off-budget contracts awarded under the program. Because many off-budget HCRA grant programs do not require competitive bidding or requests for proposals, the State Comptroller and the general public are limited in their ability to judge whether a contractor can satisfy contractual requirements and whether a contractor's costs are reasonable. Finally, under off-budget contracts, not-for-profit organizations do not benefit from statutory provisions requiring the State to pay interest on late payments for services provided under contracts not promptly executed.

In an effort to provide more accountability and better tracking of all State contracts, the State Comptroller is in the final stages of implementing a new contract management system that will code all HCRA-related contracts OSC receives.

This is a positive step that can be implemented administratively within OSC. However, this new system is not the solution to the State's off-budget collection and

spending problems. It will not provide assurances that OSC has received all HCRA contracts – off-budget or not – for approval, nor will it help the State Comptroller track expenditures against contract terms. However, if all HCRA revenue streams and allocations were brought on-budget, the State Comptroller and other interested parties would have a much better accounting of revenues raised as well as what has been spent. Conversely, the State Comptroller would be able to determine what has not been spent and why.

The large cash balances that carry over from year to year are symptoms of the problem. DOH’s annual independent audit provides DOB and the Legislature with only cursory information about the pools’ cash receipts and disbursements. The audit provides overall balances by pool, but no information about specific cash receipts and actual program-specific spending levels. Once a year, OSC reports on HCRA receipts, disbursements and ending balances, based on information provided by Excellus Health Plan, Inc., the pool administrator. In 2001, the Office of the State Comptroller requested and received from Excellus detailed program-by-program information on HCRA receipts and disbursements. That information is included in this report. However, real-time information (at least monthly and sometime more frequently) about program disbursements would ease policymakers’ struggle to monitor program performance as well as analyze seemingly arbitrary proposals to reduce unspent prior year allocations.

Bringing HCRA collections and allocations on-budget could also save money because, as part of its normal operations, OSC could perform the functions of the administrator that is receiving over \$3 million a year in HCRA resources to collect and distribute the funds in the HCRA pools. OSC could also perform annual, independent audits of all HCRA receipts and distributions. Current law requires the State Department of Health to conduct annual audits of HCRA accounts and to hire a certified public accountant to perform an annual independent audit of HCRA “receipts, disbursements, revenues, expenditures, and cash flow of funds.” But recent OSC reports examining DOH controls over HCRA surcharge collections and funding for various health care initiatives identified underpayments by hospitals and inadequate DOH documentation practices.

### **General Fund Budget Relief**

The State Constitution requires the Executive to submit an Executive Budget that is balanced in the General Fund, which receives most of the State’s tax revenue and accounts for spending on programs that are not supported directly by dedicated fees and revenues. In recent years, the Health Care Reform Act has played a larger role in achieving budget balance by diverting large amounts of General Fund spending to HCRA special revenue accounts. Moving General Fund programs not directly supported by dedicated fees and revenues to HCRA hides the true level of spending and spending growth in state supported programs.

The following chart shows the rapid increase in off-loads to the Health Care Reform Act to achieve General Fund budget relief. Most of the increase is attributable to

financing a portion of the State’s Medicaid program associated with the 2002 HCRA amendments designed to increase wages for health care workers, increased support for EPIC and the proposed Medicaid pharmacy swap.

**Estimated HCRA-Related General Fund Budget Relief from SFY 2000-01 to SFY 2003-04  
(in Millions)**

	<b>2000-01</b>	<b>2001-02</b>	<b>2002-03</b>	<b>2003-04</b>
HCRA Transfer Fund <sup>16</sup>	\$246	\$335	\$1,159	\$1,510
EPIC <sup>17</sup>	\$137	\$181	\$378	\$409
Roswell Park Cancer Institute	\$83	\$90	\$84	\$82
<b>Total</b>	<b>\$466</b>	<b>\$606</b>	<b>\$1,621</b>	<b>\$2,001</b>

**Non-Recurring Funding Sources**

The Executive’s HCRA proposal relies on non-recurring funding sources to support HCRA programs through June 2005.

One of those non-recurring funding sources involves the conversion of Empire BlueCross BlueShield to a for-profit health plan known as WellChoice. Policymakers originally estimated upwards of \$1 billion in proceeds from the conversion, which results in the issuance of stock expected to be redeemed over three years, beginning in 2003. HCRA receives 95 percent of the proceeds with the remainder going to a charitable foundation.

Estimates of conversion proceeds rose to almost \$2 billion last Fall when the initial public offering of WellChoice stock was priced higher than expected, at \$25 per share. The Executive’s current HCRA proposal reflects those estimates and anticipates upwards of \$1.7 billion in revenue from the conversion through June 2005. However, if WellChoice stock is sold for less than \$25 per share, HCRA’s share would be correspondingly lower. On April 9, 2003, WellChoice stock was selling for about \$22 per share, although it has traded as low at \$17.65.

Another concern about the Empire conversion is pending litigation<sup>18</sup> that currently prevents the proceeds from flowing to HCRA at all. The outcome of this litigation as

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<sup>16</sup> The HCRA Transfer Fund is supported by transfers from HCRA’s Tobacco Control and Insurance Initiatives Pool and is used primarily to finance a portion of the State’s Medicaid program, including the expansion of programs such as Family Health Plus.

<sup>17</sup> EPIC is partially funded by revenues authorized in HCRA.

well as continued softness in the stock market also raise concerns about the Executive's proposal to generate \$200 million for HCRA from additional for-profit conversions.

The Executive's HCRA proposal also relies on approximately \$700 million in non-recurring revenue from the Federal government. Over the past five years, under the Community Health Care Conversion Demonstration Project (CHCCDP), the State has spent a total of \$1.25 billion in Federal aid on New York hospitals transitioning to managed care. The Executive's proposal to spend \$350 million in new, non-recurring Federal CHCCDP funds on HCRA programs is a departure from past practice and may be met with strong opposition from hospitals that need the money to balance their own budgets. The State is also counting on \$330 million in non-recurring funding from the Federal Emergency Management Agency (FEMA) for HCRA programs. The funding is for the costs the State incurred in responding to the World Trade Center tragedy, including \$170 million to pay for Disaster Relief Medicaid, the temporary public health insurance program created after 9/11.

## **HCRA RECOMMENDATIONS**

- Eliminate off-budget pools and program expenditures. The growing use of off-budget accounts for public resources diminishes accountability and oversight. It is difficult to track revenues and spending that do not go through the regular budget.
- If off-budget receipts and distributions are not eliminated, require DOH's HCRA pool administrator, currently Excellus Health Plan, Inc., to provide the State Comptroller with pool receipts, disbursements by program/purpose, identification of transfers between pools, and ending cash and investment balances, no later than 45 days after the close of the State's fiscal year.
- Limit using HCRA revenues to supplant existing General Fund spending. Using HCRA resources for General Fund budget relief drains funding that could have been used to address some of the State's most pressing health-related problems.
- Minimize reliance on non-recurring revenue sources. Questionable financing arrangements could lead to unfunded or under-funded programs.

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<sup>18</sup> Consumers Union of U.S., Inc., et al. v. The State of New York, et al. Supreme Court of the State of New York, County of New York, Index Number 118699/02.



This report was prepared by the State Comptroller's  
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