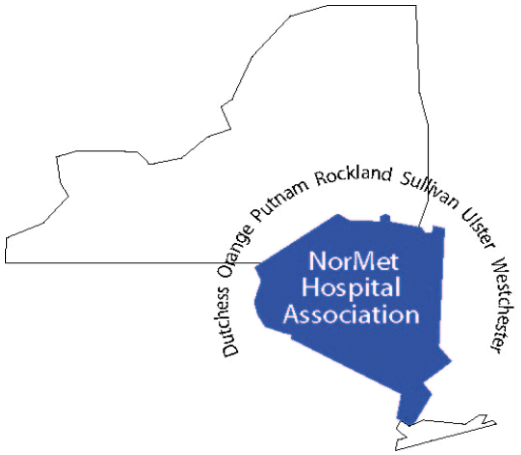
The Need to Rebalance Market Forces for NY Suburban Hospitals and Physicians



Preface

In his recent, highly regarded book, "*The World is Flat,*" Thomas Friedman described the implications of the emergence of a Global Economy. (Friedman, 2005) At one point, he relates a conversation with Jaithirth "Jerry" Rao whose firm in India, MphasiS, pioneered a workflow software program that makes the outsourcing of tax returns cheap and efficient:

> ***"What you are telling me," I said to Rao, "is that no matter what your profession – doctor, lawyer, architect, accountant – if you are an American, you better be good at the touchy-feely service stuff, because anything that can be digitized can be outsourced to either the smartest or the cheapest producer, or both." Rao answered, "Everyone has to focus on what exactly is the value-add."***
>
> - Thomas L. Friedman, "The World is Flat"

Although it is highly digital-dependant, to the individual seeking care, health care is all about touchy-feely stuff. When businesses are thinking about relocating or remaining in an area, or when families consider where to live, they compare things like taxes, security, education, and *health care*; and that means the condition of the local health care infrastructure really matters. If you are a business or family considering the New York metropolitan area suburbs, you have four choices: the Hudson Valley, Long Island, lower Connecticut, and northern New Jersey. For New York suburban hospitals right now, as a result of a series of events over the past decade, market forces have become highly imbalanced in favor of Connecticut and New Jersey. Without correctional intervention of the nature recommended in this White Paper, the Hudson Valley and Long Island - the only two regions with sustained economic and population growth in New York State - will become a less desirable place to conduct business or to live.

NORTHERN METROPOLITAN HOSPITAL ASSOCIATION

& NASSAU SUFFOLK HOSPITAL COUNCIL

THE NEED TO REBALANCE MARKET FORCES FOR SUBURBAN HOSPITALS

Introduction

Hospitals in the suburbs of New York City within New York State provide a wide array of the latest clinical services to the over 5 million residents of Long Island and the seven counties north of New York City, delivering that care with excellence and compassion. They also contribute enormously to the economic vitality of these communities – communities that reside in the only growth regions in the state. The hospitals in these regions employ over 73,000, with an annual payroll of $4.8 billion; they have annual supply purchases of $2.9 billion; and the total economic impact of all their spending on the economy of the two suburban regions is $15.8 billion. Most of the hospitals in these suburban areas are classified as acute care community hospitals, and receive relatively less revenue from graduate medical education, rural and indigent care pools than other hospitals. As a result, the suburban hospitals are disproportionately reliant upon the rates negotiated with commercial for-profit insurers.

Yet, hospitals in the suburbs of New York City face challenges that put them at a significant disadvantage. These suburban hospitals, a mere drive or ferry ride away from Connecticut and New Jersey, receive significantly lower insurance reimbursement rates than hospitals in those two states. In addition to lower reimbursement rates for the same patient services, hospitals in New York State must complete a more expensive and exhaustive application for approval to conduct hospital services than the hospitals in New Jersey, Connecticut and Pennsylvania. Although competition can be a positive motivator, it can be destructive when there is an uneven playing field.

An examination of data surrounding the provision of hospital and health care services, and an exploration of the practices related to payment to hospitals for the services they provide, paints a clear but startling picture of the financial barriers facing hospitals in suburban New York. The New York State Health Care Reform Workgroup noted in November 2004, "Many hospitals are in trouble. With high-profit services increasingly moving to non-hospital settings, hospitals are more and more left to provide for core health needs, which – though essential – do not produce adequate revenue under the current reimbursement system."

Business, economic and policy experts are concluding that the current system must be changed, through legislative action, in order that suburban residents of New York State may offer their families the standard health care they deserve, with the excellence and compassion they have come to expect from their neighborhood hospitals.

We find this data compelling, and ask you to support legislation that strengthens the Health Care backbone of the very communities in which we live, work and play.

The Evolution of Current Hospital Reimbursement Practices

In 1997, New York State adopted the New York Health Care Reform Act (HCRA), allowing insurance providers and hospitals to negotiate insurance reimbursement rates. For several decades prior, New York hospitals were reimbursed based on a rate determined by the State, and included all commercial payers.

This reimbursement process differed radically from reimbursement practices in neighboring states around New York, particularly Connecticut and New Jersey. These States had deregulated for reimbursement many years earlier, and since that time, their hospitals were negotiating rates with commercial for-profit insurers in a more open environment.

When NYPHRM ended in New York, the New York State Department of Health strongly suggested that hospitals start their negotiation with commercial for-profit insurers at the New York

Prospective Hospital Reimbursement Methodology (NYPHRM) rate, which was, at best, near the hospitals' costs, rather than allowing hospitals to begin their negotiations based on prices or their charges.

This requirement of New York hospitals to begin negotiating at cost, rather than at their "list price," represents a sharp departure from common hospital pricing practices around the nation, and was an even more radical departure from price-setting practices among business. As a direct result, hospitals in other states, such as Connecticut and New Jersey, who negotiated from their list price, ended up with significantly higher reimbursement rates than the hospitals in New York who were required to begin negotiations at their cost. The gap created in 1997 has never been effectively overcome.

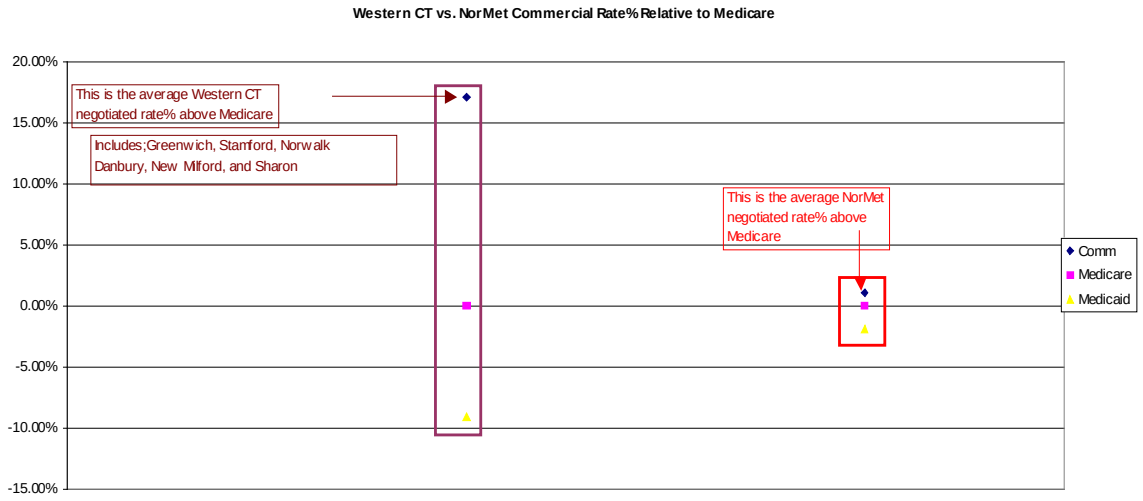
Hospital reimbursement rates in western Connecticut and northern New Jersey hospitals range between 18% and 25% higher than rates for hospitals in the Hudson Valley and Long Island, and even higher in other states. (See Figure 1: Reimbursement Rates for Hospitals in NY Suburbs Significantly Lower than Neighboring Connecticut, and Figure 2: Reimbursement Rates for Hospitals in Suburban NY Significantly Lower than Others in the Nation) The resulting impact of this differential can be summarized most clearly by comparing bottom line results, obtained through the state mandated reports for 2004.

In 2003, HMO profits in New York were $1 billion for the year, but hospital losses were $383 million. Over the past seven years, HMO profits have totaled $3.7 billion, whereas hospitals have lost $2.3 billion. Statewide, hospitals struggle to exist with a -.3% operating margin. (Figure 3: HMOs Profit While Hospitals Lose.)

Health economists recommend a positive operating margin of at least 4% to allow for appropriate investments in technology, training and infrastructure to sustain services. Unfortunately, the low reimbursement rates make it difficult for suburban hospitals to make those investments.

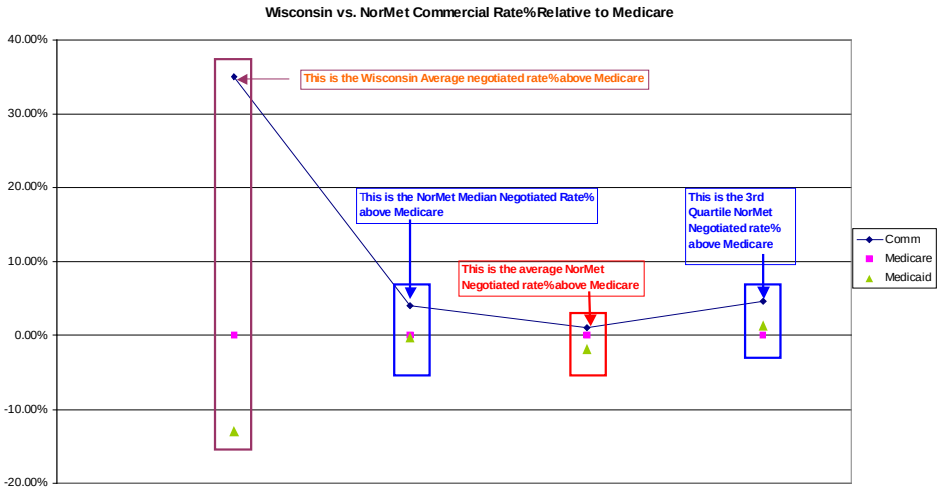
In its final November 17, 2004 report, the New York State Health Care Reform Working Group recommended that, "At a time when many New York health care providers have been struggling financially, many private health insurers are reporting financial success… the relationship between private payers and the financial viability of the health care delivery system needs to be carefully examined… the issue of financial success is inextricably linked to the viability of your health care system. The State needs to study further the issue of the correct balance between the financial success of the insurance sector and the viability of health care providers and take action if it is required."

Fig. 1: Reimbursement Rates for Hospitals in NY Suburbs Significantly Lower than Neighboring Connecticut



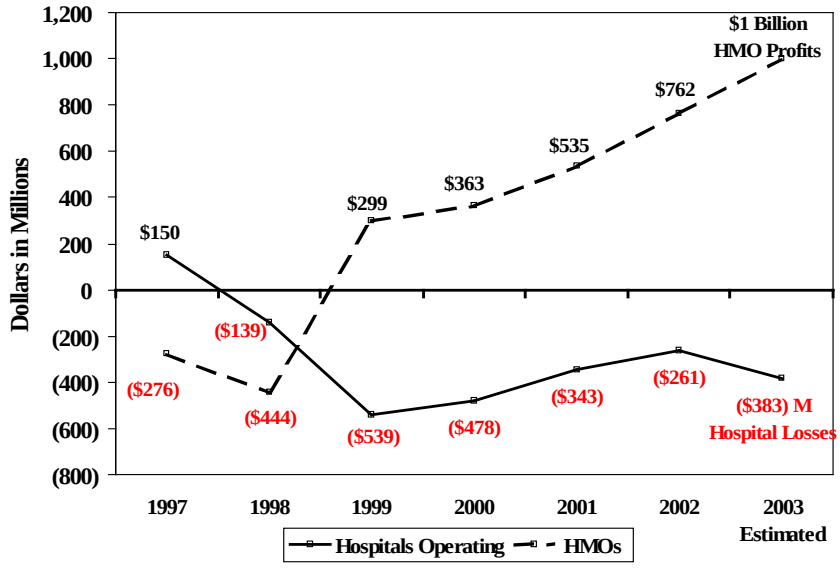
Source: Annual report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2003 Prepared by the State of Connecticut Office of Health Care Access February 2005

Fig. 2: Reimbursement Rates for Hospitals in Suburban NY Significantly Lower than Others in the Nation



Source: Wisconsin Hospital Association website www.wipricepoint.org

Figure 3. HMOs Profit While Hospitals Lose



Source: Health Care Association of NYS

Suburban Hospital Operating Margins: Paper Thin for Most, with Some in the Red

An analysis of the 2004 cost reports, filed with NYS Department of Health for all hospitals in the state, shows that 84% of the hospitals in the suburbs from seven counties north of New York City and Long Island, achieved profit margins less than 4%. As previously noted, health economists

recommend a minimum operating margin of 4% to allow for the most basic reinvestment in technology and infrastructure.

The New York State Health Care Reform Workgroup also acknowledged that, "Many hospitals are in trouble. With high-profit services increasingly moving to non-hospital settings, hospitals are more and more left to provide for core health needs, which – though essential – do not produce adequate revenue under the current reimbursement system."

More specifically, these comments from the Workgroup refer to freestanding, for-profit limited service facilities. Such centers usually do not serve the entire community, instead focusing on the well-insured private patients from whom they make substantial profits. They seem to shy away from Medicaid and self-pay/no-pay patients, and those with complex conditions that are not profitable, and leave these patients for the local hospital and not-for-profit community health centers to serve. Many of these for-profit centers are unregulated and have limited quality assurance programs that are in no way comparable to the quality programs at hospitals, that include group peer review, credentials committees, medical boards and independent boards of trustees. The reimbursement they receive from government and commercial for-profit insurers is comparable to what hospitals are paid, although these centers provide only limited services, and usually only during daytime. They leave all complications, and night and weekend programs, to the local hospitals.

The Workgroup also made recommendations to explore and address excess bed capacity within the state, and to better define and attain a more balanced relationship between providers and health insurance companies.

In response to the Workgroup's recommendation to assess and respond to excess bed capacity within New York State, Governor Pataki and the New York State Legislature established the Commission for Health Care Facilities in the 21st Century in the Spring of 2005. The objectives of the Commission are to "ensure that the regional and local supply of hospital and nursing home facilities is best configured to appropriately respond to community needs for high-quality, affordable

and accessible care, with meaningful efficiencies in delivery and financing that promote infrastructure stability."

The Workgroup's conclusion, that attaining a more efficient health care delivery system will be realized only if a more balanced relationship between providers and for-profit insurers is attained, is particularly pertinent for the hospitals in the Hudson Valley. During the February 9, 2006, meeting of the Commission for Health Care Facilities in the 21st Century, Commission Chair Stephen Burger noted that the existing imbalance has been noted frequently, and that this may be the "time to directly address it."

As the Commission pursues its goal of correcting the misalignment of services and needs, they are urged to also find ways to stop all new for-profit facilities from opening unless they meet real community need. Hospitals in New York State must complete extensive Certificate of Need (CON) applications in order to offer services. This CON process is intended to validate the (a) service is needed by the community, and (b) the hospital has the expertise to safely and effectively perform these services. The stated objectives of the CON process are logical, but should be applied to all providers, or modified to enable hospitals to compete with niche providers.

There is a role for all stakeholders to participate in defining and achieving the solutions that will produce great benefit for citizens, hospitals, providers, businesses, and health insurance companies. For the suburban region, the more critical issue is not closures, but rather a more balanced playing field between providers and health for-profit insurers.

Struggling Hospitals Make Attracting New Business Less Desirable in Suburban New York

Health care policy, regulation and reimbursement impact all citizens, and have a dramatic impact on the ability of businesses to succeed.

"Business leaders are also stakeholders in Health Care. We must run successful businesses and hire the best talent, and that is hard to do without having a strong Health Care system. Hospitals

and physicians are the backbone of this system, and the business community becomes concerned when infrastructure components such as Health Care delivery are threatened. Here, in Westchester, we are facing an access to care problem in light of recent hospital closures and the impasse in contract negotiation between for-profit insurers and physicians," said Bill Mooney, President of the Westchester County Association (WCA), and a retired banker. The Association represents over 400 employers in the county, and identified the crisis as one that "threatens the economic vitality and quality of life in Westchester and beyond."

Out of growing alarm at the financial plight of local hospitals, which collectively are seen by the WCA as a key part of the Lower Hudson Valley's economic engine, the organization formed a Blue Ribbon Task Force to research the issues and develop concrete solutions. At the core of the 'issues' are "large insurance companies' practice of reimbursing – or not – hospitals and physicians for the treatment they provide patients who are supposed to be insured by the companies." (*Journal News, January 30, 2005)*

The Medical Society of the State of New York (MSSNY) noted in their 2006 legislative overview that "business decisions made by managed care executives have produced huge changes within the industry which now seriously threaten patient access to necessary care of high quality." (MSSNY 2006)

The concern of WCA hit an all-time high when the closing of St. Agnes Hospital in White Plains was quickly followed by the closing of United Hospital in Port Chester, and the then growing financial problems at Westchester Medical Center. "A local businessman may be willing to pay higher taxes to be in this region," Mooney said, "but if the infrastructure decays, then I have to think, 'Why am I here? I can go to Greenwich, I can go to Stanford, and not worry about this problem.'" (*Journal News,* January 25, 2006.)

HEALTH CARE REINVESTMENT FUND SUBURBAN DEMONSTRATION PROJECT

As one part of the solution to the hospital crisis, a Health Care Reinvestment Fund is proposed to support advancing the Health Information Technology capabilities of inpatient hospital services in suburban New York State. Significant funding is needed by these hospitals to invest in the hardware, software and training required to sustain the increasing integration of technology with the highest quality of patient care.

Origin of Concept

The Reinvestment Fund is the brainchild of Mooney and the WCA Blue Ribbon Task Force, and is modeled after the Community Reinvestment Act of 1977. Mooney, a banker for 45 years before joining the WCA, recalled those days when banks were "happy to take money from customers for savings accounts, but redlining the very same people when they came asking for loans or mortgages." Under the Health Care Reinvestment Act, insurers would contribute to help hospitals make critical investments in information technology.

Low profit margins of suburban hospitals do not yield the capital required to invest adequately in health information technology. On the other hand, high profit margins of the commercial health for-profit insurers/HMOs in the region have led to a call from business and community stakeholders to reinvest in the communities from which those for-profit insurers profit.

> "As markets become increasingly for-profit, the revenue focus is placed more on commercial product development and profitability and less on community programs… The emergence in New York of Health Care insurance markets that are predominantly for-profit raises significant public policy issues, especially with reference to community benefits and services."
>
> -Treo Solutions, 2002.

The 1977 Federal Deposit Insurance Corporation (FDIC) Community Reinvestment Act required banks to reinvest in community programs that were designed to "help meet the credit needs of the local communities in which they are chartered." (FDIC, 1977)

Mooney's proposal would employ a similar model to HEAL-NY, and would distribute $67 Million to the Hudson Valley and Nassau/Suffolk regions. Health for-profit insurers from these regions would place these dollars in a Health Care Reinvestment Fund to help fund suburban hospitals' IT needs. According to the Commission for Health Care Facilities in the 21st Century,

> *"…currently, hospitals bear almost all the costs of IT investment, while many of the financial benefits such as decreased need for repeat tests, lower readmission rates, and shorter lengths of stay, accrue to those who pay for the care. The technology costs and complexity of cultural changes required to implement the IT agenda are daunting, yet this is a critical pathway to 'the hospital of the future' in its largest sense. Accelerating the forward momentum towards achieving universal adoption will require a shared investment between government, providers, payers, and purchasers."*
>
> "Planning for the Future. Capacity Needs in a Changing Health Care System"
> February 9, 2006, Commission on Health Care Facilities in the 21st Century

Why a Health Care Reinvestment Fund is a Good Deal for All

This proposal promotes a business model that considers the following factors:

- The burden of funding HIT has largely fallen on providers.
- For-profit insurers have operating margins that can support reinvestment in the communities they serve.
- Providers are not immediate direct beneficiaries of HIT investments; yet bear most of the cost of implementation. Numerous studies estimate that it takes many years for providers to obtain a return on their investment in HIT.
- On the other hand, these same studies indicate that health insurers and patients are the most immediate benefactors of Health Information Technology. Insurers for example would obtain an almost immediate return on their investment into the Fund as a result of HIT enhancements that would reduce duplication of tests, adverse drug events, hospital admissions, and streamline back-office activities that account for a substantial portion of their administrative costs.

Distribution of Funding

Hospital inpatient discharges, as reported through the Statewide Planning And Research Cooperative System (SPARCS) 2004 data, would serve as the basis for allocation of the Reinvestment Fund.

Oversight of the Health Care Reinvestment Fund

A multidisciplinary group would be convened to oversee distribution of the Health Care Reinvestment Fund. This Oversight Committee would have representatives from hospitals, business, and health for-profit insurers.

This is proposed as a 4-year demonstration project for the suburban region, with funds available each of the four years.

All Stakeholders and the Community Will Benefit from the Health Care Reinvestment Fund

Physician, hospital, and payor partnerships are crucial to the effective delivery of health care services, and HIT investment can greatly enhance the efficiency of these partnerships. Dollars from the Health Care Reinvestment Fund will be used to help hospitals achieve the Goals identified in July 2004 by the National Coordinator for Health IT:

Goal 1: Inform Clinical practice with the use of electronic health records (EHR)

Goal 2: Interconnect clinicians so that they can exchange health information using advanced and secure electronic communication

Goal 3: Personalize care with consumer-based health records and better information for consumers

Goal 4: Improve public health through advanced bio-surveillance methods and streamlined collection of data for quality measurement and research

Businesses and the consumer in general will benefit from a healthier workforce, with improved data about quality of care, and improved efficiencies in the delivery of care.

However, John Glaser, PhD, Vice President and Chief Information Officer of Partners HealthCare, and Senior Advisor, Deloitte Center for Health Solutions, cautions that these benefits will take time to document, and that there "isn't a demonstrated ROI for the provider who pays for these systems, given the misalignment of financial incentives in the industry." (Deloitte, 2006) He explains:

> *"There's very clear evidence that providers can reduce errors – medication errors and other failure-to-follow-up mistakes. There's very clear evidence that utilization and expenditures on drugs and radiology procedures can be reduced. There's very clear evidence that conformance to care guidelines for those with chronic illnesses is improved. But use of IT as a tool, while contributing to all kinds of care gains, may not add up to an ROI. It's hard to assign a dollar gain to a service improvement. Doing a better job of avoiding an adverse drug effect may have an economic gain for the patient. It may mean an economic gain for the payer, because the patient is not hospitalized. But it may not mean stunning improvement in the provider's margin."*
>
> - John Glaser, PhD, Vice President and Chief Information Officer of Partners HealthCare, and Senior Advisor, Deloitte Center for Health Solutions

Clearly, it is not the providers who most benefit from an investment in health information technology, but rather, the patients and the payors. As such, the payors should be required to contribute to the information systems that most quickly benefit them.

MARKET CONDUCT OF HEALTH INSURANCE COMPANIES NEEDS REBALANCING

Health insurance companies/HMOs require employers to pay premiums in advance of coverage, and will not hesitate to drop members for tardy payment of premiums. Yet, for-profit insurers continue to employ several practices that delay, or even deny payment to physicians and hospitals for services that patients need. This conduct enables for-profit insurers to hold onto large fund balances as long as possible, further boosting their large profit margins, while making struggling hospitals and providers hang in limbo, awaiting payment. Current laws are not specific enough and/or do not pose sufficient deterrents to offset the incentive to hold onto the dollars and legislative action is proposed for 2006 to help rebalance the market.

Market Conduct #1: Insurers' Pre-Authorizations Too Narrow & Do Not Permit Medical Judgment for Changes to Benefit Patient Outcome

***Problem**:* When a provider goes through the pre-authorization process, insurers provide the authorization on a very specific level, often to the CPT (Common Procedure Types) code level. This specificity allows little room for divergence from the authorization based on the medical professional's judgment during the procedure, or unexpected patient complications during the procedure. If a different or more extensive procedure is performed without advance notice to the insurer, the entire procedure will often be stalled, or even denied, for payment.

***Resolution**:* Insurers should be mandated to provide presumptive payment, in full, within 30 days of billing date, for the service performed as related to the originally authorized. At a minimum, the original authorized procedure that was performed should be reimbursed to the physician and hospital. Differences can be reconciled after the fact on a quarterly basis. Precertification and authorization criteria need to be more flexible and allow for a degree of clinical judgment, so that providers to give the care the patients most need, without fear of nonpayment.

Market Conduct #2: Code Confusion Delays Patient Approvals for Care and Slows Payment

The Center for Medicare and Medicaid Services (CMS) has established a list of standard CPT codes.

Problem*:* Many insurance companies do not accept the full list of standard CPT codes, and often don't accept the codes used for the patient procedures. In addition, the insurers' lists of acceptable codes will change throughout the year and providers are instructed to refer to the provider manual. Each insurer can currently require use of their independent coding system, resulting in increased likelihood that a physician's or hospital's business office will not be able to track coding for multiple insurers, and that an incorrect code will be used and then rejected by the insurer. This results in further delays in payment to physicians and hospitals, and an increased likelihood that patients will be billed incorrectly for their co-pay.

Resolution*:* Insurers should be required to adhere to the standard set of CPT (Common Procedure Types) codes established by Center for Medicare and Medicaid Services (CMS). Standardization would help streamline the billing and payment process, and result in improved patient care and lower health care costs overall.

Market Conduct #3: Insurers Get Free Ride from New Physicians for as Long as Six Months

Problem*:* Credentialing of newly hired physicians into health insurance plans takes an excessively long time, often six months or more. This excessive wait for insurance company approval prevents hospitals and physicians from billing for care that has been provided by these newly employed physicians. New private practice physicians (not employed by the hospital) also face this economic hardship. As a result, physicians (and hospitals who employ physicians) are unable to recoup reimbursement for care that has been provided. In addition, when claims are

processed by third party payers under these circumstances, the claim is frequently treated as 'out of network,' which generally causes patients to pay more for their care.

Presently, physicians may work in a hospital for six months or longer without either the hospital or the physician being able to bill insurers for their service. Medicare permits physicians to bill retroactively after being credentialed, and we propose that insurance companies (including Medicaid) do the same. Without a Medicare / Medicaid provider ID number, most third party plans will not process application requests, which further delays the approval process.

***Resolution**:* It is reasonable that completed applications be processed promptly (within two months of receipt) by the third party insurer, and that a provider be allowed to retroactively bill and receive payment for all work that was undertaken from the date upon which the application was sent to the third party insurer.

Market Conduct #4: Patient Insurance-ID Cards Incomplete and Unclear

***Problem**:* Each insurance company is unique in the way that they describe their products, and patients' identification cards often do not clearly describe the plan the patient belongs to, the specific address to mail claims, or other information needed so that patients can access appropriate care. The incomplete information on cards also contributes to providers uncertainty about services the patient's plan covers, necessary for both effective health care decisions by the patient and proper billing by the hospitals and physicians. When bills are transmitted with the incorrect coverage type, or to the wrong location, it can take weeks to discover the error, resulting in lost time and money.

***Resolution**:* Standardized insurance ID cards that clearly identify, at a minimum, a patient's:

- Coverage
- Product line (Medicare, Medicaid, PPO, HMO, etc.)
- Co-payment amounts
- Billing address and contact phone number

- Electronic Submission information

Market Conduct #5: Health Insurance Companies Retroactively Deny Patient Services They Previously Approved

Problem: Some insurance companies provide only verbal approvals of requests for pre-certification and authorization, and then question or deny the service once it has been completed, resulting in patients, physicians and hospitals absorbing costs for services the insurer once approved.

Resolution: Verbal approvals and denials should be followed by a hard copy sent via facsimile or e-mail, or posted on the insurer's website so that the physicians and/or hospitals can print the approval. Such approvals should also be binding.

Market Conduct #6: Insurers Change Billing Procedures & Covered Services without Notifying Physicians or Hospitals

Problem: Procedural changes are made on an ongoing basis, but often the insurers give providers no advance notice, or notice is given after the change has taken place. This results in delays in payment, or in costs for services already performed being unexpectedly absorbed by the providers and patients.

Resolution: Providers must be notified in writing 90 days in advance of the effective date for any changes to the manual, as well as any other changes related to medical management, billing procedures, and reimbursement.

Market Conduct #7: Insurers Retroactively Require Refunds from Providers for Services Performed Years Past

Problem: There is currently no statutory limit on how far back in time an insurance company can go to demand a refund. In addition, insurers are free to make recoveries with no notice or

approval from the provider. These refunds have been required of providers for services conducted nearly a decade ago.

Resolution: Insurers should be required to identify overpayments within 60 days. Also, providers be informed of intended recoveries and given the opportunity to verify that that they are valid.

Market Conduct #8: Electronic communications – A One-Way Street for Insurers When It Comes to Critical Mental Health Services

Problem: Too many health insurance claims and billing are still handled via the most lengthy means possible: cumbersome paperwork delivered via traditional mail. This delays approvals and billing, resulting in a delay of services for patients, and in delayed reimbursement for providers. More than in most other aspects of Health Care, mental health services are still reliant upon this antiquated system.

Resolution: Health insurers should be required to process related approvals and billing electronically, as most insurers do with the majority of other aspects of the Health Care system.

Market Conduct #9: Insurers Merge, Further Increasing Negotiating Power While Providers Struggle Under Anti-Trust Regulation Requiring Independent Negotiation with Huge Insurers

Problem: Under current anti-trust regulation, physicians and hospitals are unable to negotiate effectively with huge managed care companies for adequate reimbursement and inclusion of clinical services under a plan and contract.

Resolution: Providers – hospitals and physicians alike – need the ability to negotiate more effectively. Safe harbor language should be incorporated into state and federal antitrust laws to allow health care providers greater collective negotiating ability.

Market Conduct #10: Health Insurers Have a Significant Information Advantage That Hurts Providers and Employers

Problem: Because the information filing requirements for hospitals and health insurers are vastly different, the health insurers are afforded a significant negotiating advantage. NYS requires hospitals to annually file detailed financial and clinical data related to all phases of a hospital's operation. This information is publicly available on a hospital-specific basis. Conversely, filing requirements of for-profit health insurers are minimal, and do not contain the level of detail to provide hospitals with information about rates in contiguous states, or with rates by region within the state.

Resolution: Begin to restore market balance by equalizing the level of information available to both parties. For-profit health insurers should be required to annually report average rate information from a contiguous state for any county in that state located less than 10 miles from the NYS borders. Within NYS, health insurers should be required to annually report average premium and reimbursement rate information by "HSA Region."

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