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The Fiscal Crisis of New York City Voluntary Hospitals

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THE FISCAL CRISIS OF NEW YORK CITY VOLUNTARY HOSPITALS

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In common with virtually every other segment of the total United States economy, the cost of providing health care has been rising at an accelerated pace in recent years.[1] In 1972, the gross total spending on medical care in the country had risen to $83.4 billion from a figure of $17.3 billion in 1955. Hospital care took the largest share of this increase.[2]

In the United States, neither the voluntary hospital nor the voluntary health care institution providing specialized, long-term or other forms of care is a governmental or a profit-making enterprise.[3] Although not officially associated with the government, the voluntary health care institution reflects some of the characteristics of a governmental unit. It is traditionally exempt from taxes (although this is recently showing signs of erosion)[4] and derives increasing propor-

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1. *Soaring Cost of Health Care*, U.S. NEWS & WORLD REP., Jan. 22, 1973, at 28-29.

2. *Id.*

3. Both the traditions of the voluntary hospital and the provisions of the Internal Revenue Code prevent the reorientation of voluntary hospitals to a profit-making status. The Code requires that charitable (and therefore non-taxable) organizations be non-profit. INT. REV. CODE OF 1954, § 501. The traditions of hospitals have been recognized as putting certain duties on them. Wilmington Gen. Hosp. v. Manlove, 54 Del. 15, 174 A.2d 135 (1961). *See* Gold, *Emergency Room Medical Treatment: Right or Privilege?*, 36 ALBANY L. REV. 526 (1972).

4. For example, under Exec. Order No. 12, 98 CITY RECORD 3835 (1970),

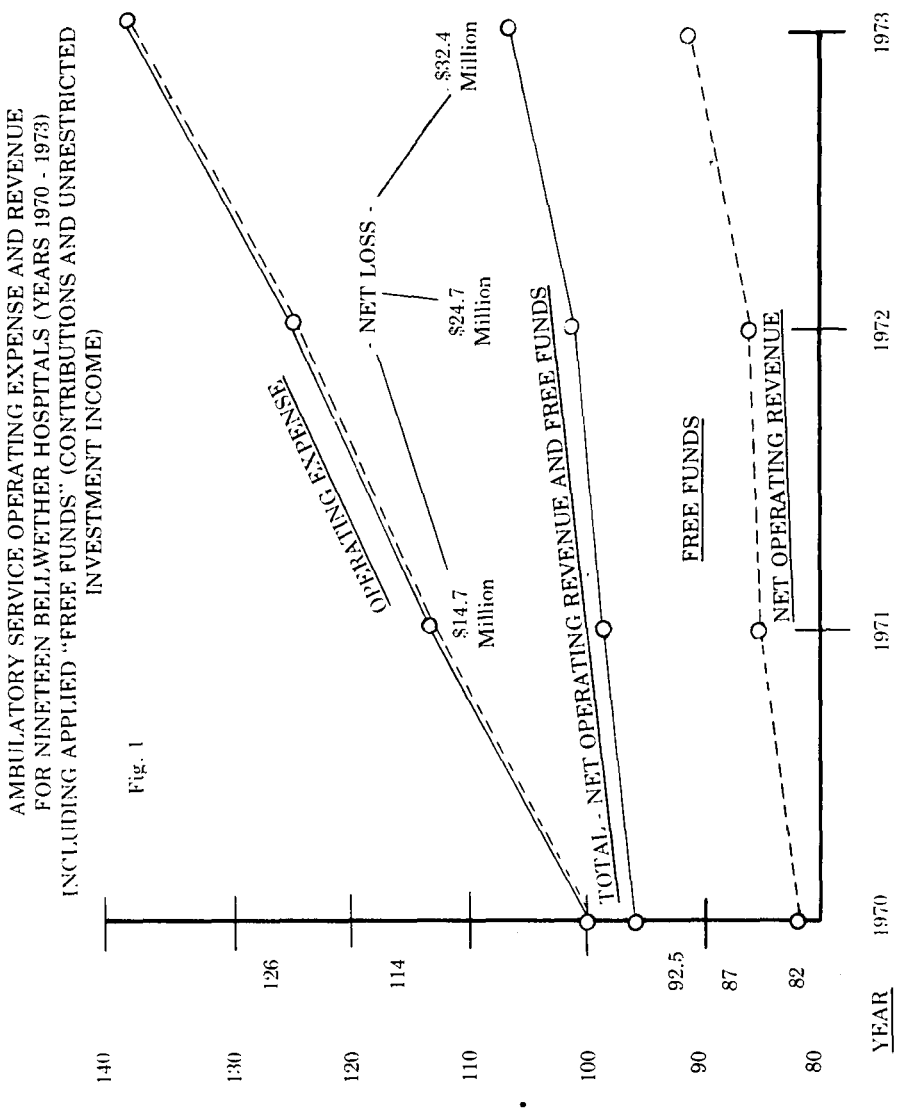

Fig. 1

$'s (Millions)

tions of its revenues from public funds.[5] But these funds are not allotted to a voluntary health care institution in the same way they are to such entities as the Library of Congress or the Department of Sanitation. The funds are instead payment for services rendered to indigents and other eligibles under governmental programs—and most typically at rates far below what it costs to provide those services.

In 1971, nearly nine out of every ten of the civilian resident population in the United States were protected by one or more forms of private health insurance—Blue Cross or commercial coverage.[6] The remaining one in ten with no private protection has a considerable proportion of his bills paid by Medicare, Medicaid, Workman's Compensation or public welfare agencies.[7] All of these reimbursement mechanisms, commonly referred to as "third party intermediaries," are contractually obligated to pay hospitals whatever it costs to provide care.[8] Of course, third party agencies attempt to exclude reimbursement for any element of cost they consider inapplicable to their particular category of eligible beneficiaries.

Despite the substantial rise in hospital costs in the past several years,[9] hospitals have succeeded, largely on their own, in reducing

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the City of New York imposed water and sewer taxes on hospitals that had not in the past been taxed. It was only after intense and extended pleas by the Greater New York Hospital Association (GNYHA) that the tax was effectively waived under Exec. Order No. 77. (Apr. 4, 1973).

5. Government funds are supplied to hospitals through such programs as Medicare, Medicaid, Workman's Compensation and Welfare.

6. HEALTH INSURANCE INSTITUTE, 1972-73 SOURCE BOOK OF HEALTH INSURANCE DATA 10-11.

7. The sources of operating revenue for voluntary hospitals in the Greater New York area are estimated by the staff of the GNYHA as follows:

Blue Cross	30% of operating revenue
Medicare	33%
Medicaid	23%
Other Insurance	11%
Private Patients	3%

Unpublished report in the files of the GNYHA.

8. The devices for payment, however, are decidedly different. *See* text accompanying notes 41-44 *infra*.

9. The rise may be noted in the following chart:

the rate of increase.[10] The members of the Greater New York Hospital Association (GNYHA)[11] have established various committees and other procedures to deal with the problem and they have met with some success. As a result of the recommendations of the GNYHA, resource monitoring systems,[12] program costing,[13] coopera-

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AVERAGE PER DIEM INPATIENT COST*
OF HOSPITALS IN LOWER 17 COUNTIES OF
NEW YORK—1967 to 1973

	1967	1968	1969	1970	1971	1972	1973
Average Per Diem Inpatient Cost:			**		**	***	****
VOLUNTARY HOSPITALS							
	$62.18	$73.23	$87.42	$100.85	$114.73	$122.70	$130.04
PROPRIETARY HOSPITALS							
	50.93	58.68	67.27	77.50	88.84	95.62	101.24
ALL HOSPITALS							
	59.63	70.06	83.17	95.83	109.53	117.22	124.21

*nursery costs and days excluded
**subject to further audit
* **estimated
* * **projected

Chart of the Associated Hospital Service of New York in files of GNYHA.

10. *See* note 9 *supra*.

11. The Greater New York Hospital Association is a coordinating agency for the programs of all the major non-profit hospitals, long term and extended care facilities and municipal hospitals in the metropolitan area. Dedicated to serving the health and welfare needs of the community, the Association seeks to advance the interests of its member institutions by building cooperation among them, by assisting them in achieving ever-increasing levels of effective performance, by encouraging essential educational and research endeavors, and by interpreting all these functions to the general public and to allied professional, governmental, and other organizations. The Association also maintains active liaison with groups in related fields interested in improving community health and raising standards of patient care.

12. These involve increasing units of care—the inpatient day, or the outpatient occasion of service—with negligible increases in costs. The systems also involve review of the use of all equipment and other elements of the total operation. Additionally, critical examination is made of the manner in which fiscal and medical staff exercise their responsibility for continuing audits which should question every empty bed and every instance of improper utilization of facilities, service and manpower.

tive programs with other hospitals designed to use existing resources more efficiently,[14] strict budgetary controls,[15] revitalized bad debt procedures and diminished use of private rooms, have been introduced in the member hospitals.[16]

A major device for maximizing the efficient use of hospital resources is ambulatory care. While this approach may diminish actual hospitalization costs, it puts an unaccustomed strain on voluntary hospital finances—a strain not sufficiently diminished by present hospital financing.[17] Ambulatory care is the use of hospital facilities to provide health care to patients who come to the hospital for treatment, but do not stay there. The patient is usually able to walk into a clinic or emergency room and to move from place to place for

13. This device involves the identification and pricing of programs and their related statistics to determine not only the cost of the program, but their effect on over-all unit costs.

14. The GNYHA has been active for many years in encouraging the development of shared services, both therapeutic and administrative. Every one of its member institutions is engaged in at least one group puchasing agreement, thereby profiting from joint buying power and passing on savings to its patients. Such possibilities exist in electronic data processing, laundry, radiology, laboratory, purchasing and other ancillary services which may not be utilized at full capacity. The deceleration of the increases in hospital costs brought about by GNYHA and other groups of voluntary hospitals, however, has had an uneven effect on the provision of services tending to inhibit the hospitals in the Greater New York area from initiating new programs and services even though the need for them has perhaps never been more acute. In view of the present budget problems, such conservatism is unavoidable.

15. Many GNYHA member hospitals now function under ground rules which call for prospective budgetary determinations every year keyed to income. Any increase in budget has to remain within the income limit unless some other financing mechanism can be found. Cost of living, merit, and supply cost increases, should they exceed the limit, must necessarily be offset by increased production or cost savings.

16. Part of the success of GNYHA hospitals in decelerating the increases since 1970 is attributable to implementation that year of New York State's Cost Control Law, Law of May 26, 1969, ch. 957 [1969] N.Y. Laws 1429-31, which, in effect, imposed revenue limitations upon GNYHA member institutions.

17. *See* note 29 *infra*.

treatment. This is important since it is an axiom of hospital economics that the treatment of vertical patients is much less expensive than treatment of the patient who is horizontal.[18] Many GNYHA institutions achieve substantial cost savings by offering expanded ambulatory care in clinics or emergency rooms as alternatives to inpatient care. This permits treatment at lower cost without family separation.[19]

Nevertheless, effective ambulatory care still costs money. The salaries of the highly skilled physicians, nurses and technicians who staff the ambulatory care unit must be paid.[20] In fact, the average annual salary in hospitals in this area has nearly doubled in a recent five-year period; in 1965 it was $5,000; by 1970 it had risen to $9,800, and in 1971 it was $10,500.[21]

Moreover, hospitals must have ambulatory facilities available around the clock. These units require sophisticated x-ray and labo-

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18. For example, it is estimated that the average inpatient per diem charge would be around $145 in 1974; at the same time, the average cost of a visit to an outpatient facility will probably be around $45. Unpublished Report in the files of GNYHA.

19. America's first ambulatory care facility was organized as a dispensary in Philadelphia in 1786. *Health Delivery Trends . . . AMBULATORY CARE*, information, Sept., 1973, at 2.

20. As may be noted from the chart below, wages and fringe benefits represent approximately two thirds of the total change in hospital operating costs:

ELEMENTS OF CHANGES IN HOSPITAL COSTS 1970-71

	Voluntary Hospitals	Proprietary Hospitals	Voluntary and Proprietary Combined
1. Changes in Wage Rates	62.7%	49.5%	61.0%
2. Additional employees	19.1	16.5	18.7
3. Additional non-salary costs (including FICA, fringes, etc.)	24.8	30.9	25.4
4. (Reduced) or added cost due to (more) or fewer patient days	(6.6)	3.1	(5.1)

Chart of the Associated Hospital Service in files of GNYHA

21. Presentation of Associated Hospital Service of New York (Blue Cross) to New York State Dep't of Insurance, Dec., 1973.

ratory equipment, monitors, electronic devices, life-saving machines, and supplies of all sorts. Drugs are an additional item—those available today perform wonders but they are increasingly expensive.[22]

Costly though it may be to provide effective outpatient care, it is less expensive than the inpatient variety for several reasons. One of the most obvious is that the outpatient—unlike the inpatient—provides his own food, shelter, and clothing. Moreover, disease that is caught at the early stages, while the patient is still ambulatory, can be more quickly and effectively treated than if it is neglected until the patient must be hospitalized.

In fact, in a classic study conducted in 1958,[23] it was demonstrated that the amount of inpatient hospitalization necessary for people with easy access to ambulatory care was substantially less than that for those without access to such care. This study found that the annual number of hospital admissions for a group insured by the Health Insurance Plan of New York (HIP), which provides ambulatory care services for its members, was 77.4 per 1,000 population as compared with 95.8 per 1,000 for those covered by Blue Cross-Blue Shield, which did not provide such services.[24]

Although ambulatory care is much less expensive than inpatient care, the increasing need for ambulatory care facilities has eliminated the overall savings. As physicians abandon urban areas and their services become less and less accessible to low and middle income patients, increasing numbers of these people have come to rely upon the ambulatory care facilities of voluntary hospitals as their primary source of medical care.[25] A 1971 study,[26] commenting on the trend among physicians to move away from areas where their

22. The consumer price index for "Drugs and Prescriptions" rose over five and one half points from 1967-1972. U.S. Dep't OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 1973, at 67 (1973).

23. Densen, Balamuth & Shapiro, *Prepaid Medical Care and Hospital Utilization*, 46 HOSPITALS, Mar. 1, 1958, at 50.

24. When deliveries were excluded from the computation, the rates became 59.6 for HIP and 74.3 for Blue Cross-Blue Shield. *Id.*

25. Bodenheimer, *Patterns of American Ambulatory Care*, INQUIRY, Sept., 1970, at 26.

26. L.S. ROSENFELD, AMBULATORY CARE: PLANNING AND ORGANIZATION A4 (1971) (reprinted by U.S. Dep't of Commerce, Nat. Tech. Info. Serv., 1971).

services are most urgently needed, noted that "[p]hysicians have been leaving the slums and younger ones have failed to move in as the older die or retire owing to the lack of financial reward as well as the poor living conditions that slum life affords." Another study concluded that "something like two-thirds of the private practitioners here [New York City] chiefly serve the more affluent half of the population. With the diminishing number of general practitioners in low income neighborhoods, ever larger numbers of people have been relying on hospital staffs for ambulatory as well as in-hospital care."[27]

The ambulatory patient population of any one voluntary hospital's outpatient department will probably represent a cross-section of the area's residents, a microcosm which reflects the end result of society's overall failure to meet the needs of many of its constitutents. These clinics are usually open for limited hours on specified days of the week. The emergency departments, however, must be open and staffed 24 hours a day, 365 days a year, and thus become all-purpose clinics at night.

Strong economic pressures have been placed on urban hospitals by the expansion of demand in the city. Further, most of that demand has been focused on the voluntary hospitals, for an increasing number of individuals who had previously relied on the ambulatory care services of municipal hospitals are turning to voluntary hospitals. Until the advent of Medicare and Medicaid, some 60 percent of outpatient visits were to municipal hospitals. By the end of 1970, their ratio had slipped to a 50-50 sharing of patients. In recent years, the proportion is more nearly in the range of 55 percent using voluntary hospitals and only 45 percent still visiting the municipal institutions.[28]

All of these factors have tended to create a staggering ambulatory care deficit.[29] In 1971 the operating deficit attributable to outpatient

27. N. PIORE & S. SOKAL, A PROFILE OF PHYSICIANS IN THE CITY OF NEW YORK BEFORE MEDICARE & MEDICAID, 1968 (monograph on file in the office of GNYHA).

28. J. LINDSAY, MESSAGE OF THE MAYOR ON THE EXECUTIVE BUDGET FOR 1970-71, at 29.

29. The deficit may be clearly seen from the chart presented at Fig. 1, *supra*. *See also*, Hicks, *Possible Health Crises Resulting from Deficits are Seen by Hospital Official*, N.Y. Times, June 25, 1972, at 26, col. 1;

and emergency care for 19 bellwether hospitals,[30] accounting for approximately 66 percent of all ambulatory visits to New York City voluntary hospitals, totalled twenty-eight million dollars. This figure is estimated to have reached forty-five million in 1972.[31] By projecting these statistics to include all ambulatory care visits, one may reasonably assume total ambulatory care deficits incurred by voluntary hospitals in New York City to be in excess of fifty-five million dollars.

In past years much of these deficits were offset by philanthropy. In 1971, however, contributions and investment income available to the boards of the 19 hospitals amounted to less than half of the twenty-eight million dollar deficit referred to above.[32] The prognosis for 1972 was even bleaker, with contributions likely to amount to no more than one-third of the deficit.[33] Several circumstances account for the diminishing importance of philanthropy in hospital financing. The social and economic structure which existed several decades ago has undergone substantial change.[34] Ever since the thir-

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Voluntary Hospitals are Having Financial Woes, Id., Feb. 4, 1973, at 46, col. 1.

30. The 19 hospitals were: Beekman-Downtown Hospital; Beth Israel Medical Center; The Bronx-Lebanon Hospital Center; The Brookdale Hospital Medical Center; Hospital for Joint Diseases & Medical Center; Jewish Hospital of Brooklyn; Long Island Jewish—Hillside Medical Center; Maimonides Medical Center; Mary Immaculate Hospital Division of the Catholic Medical Center of Brooklyn & Queens, Inc.; Methodist Hospital of Brooklyn; Montefiore Hospital & Medical Center; Mount Sinai Hospital; New York Hospital; The Presbyterian Hospital in the City of New York; The Roosevelt Hospital; St. Luke's Hospital Center; St. Mary's Hospital Division of the Catholic Medical Center of Brooklyn & Queens, Inc.; St. Vincent's Medical Center of Richmond; St. Vincent's Hospital & Medical Center of New York.

31. Unpublished report in the files of GNYHA. *See also* Hicks, *supra* note 29. Several hospitals have practically exhausted available funds. One, in fact, went from a $6.7 million endowment to a $3 million deficit in six recent years in providing ambulatory care service. *Id.*

32. Hicks, *supra* note 29.

33. *Id. See also* Fig. 1, *supra*.

34. Several factors contributed to the relative decline in the proportion of funding available to hospitals through philanthropy. One was undoubtedly a consequence of the catastrophic collapse of the stock market in 1929, and the economic depression which ensued. Another was probably the so-

ties, when Blue Cross hospitalization was launched, hospitals have become increasingly dependent upon revenue from third-party sources,[35] with proportionately less being provided by philanthropy. After the "Blues" demonstrated the feasibility of insuring the payment of hospital bills, the commercial insurance organizations proceeded vigorously to sell this coverage. When Medicare and Medicaid were introduced in the mid-sixties, the predominance of third-party payment in hospital financing became absolute.[36] At the same time, fund-raising to benefit hospitals continued as an important activity, but the climate had changed. After World War II, with the implementation of the Hill-Burton program,[37] philanthropic contributions were directed toward matching contributions mandated by the program for capital construction. Other philanthropic efforts took the form of grants[38] for research and special projects in hospitals.

Recently, bills have been introduced which would substantially eliminate the tax incentives for philanthropic giving.[39] While voluntary health and welfare activities of every kind would suffer greatly from such legislation, voluntary hospitals are likely to be one of the first and most vulnerable victims. Up to now, spokesmen for volun-

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called "confiscatory" taxes introduced during the early years of the New Deal under President Franklin D. Roosevelt. Then, in 1946, the excess profits tax expired and with it a provision which had previously enabled corporations to give 14½ cents per after-tax dollar to philanthropic causes. Smith, *Is Philanthropy Dead*, 46 HOSPITALS, Mar. 1, 1972, at 91.

35. *See* note 7 *supra*.

36. Several other concurrent developments played a role. The idea of patients themselves being helped to assume responsibility for their hospital bills through the pre-payment mechanism was born and caught on in the thirties, and hospitals began to become dependent upon Blue Cross reimbursement as a source of revenue. Capital needs of hospitals expanded tremendously because of technological advances, a general increase in the demand for health services, and the high degree of obsolescence in the industry, with advances in medical science making it necessary for hospitals to have available new machines and devices and highly skilled, expensively salaried technicians to operate them. Hahn, *Hospital Financing in the '70's*, 46 HOSPITALS, March 1, 1972, at 56.

37. Act of Aug. 13, 1946, Ch. 958, 60 Stat. 1040.

38. *Id.*

39. *See, e.g.*, S. 3378, S. 3657; H.R. 1105, H.R. 1106, H.R. 1107, H.R. 1108, H.R. 11862, H.R. 15230, H.R. 15360, 92d Cong., 2d Sess. (1972).

tary health agencies have been successful in discouraging the sponsors of such legislation and in blocking its passage. There is much concern in the hospital community that the clamor for "closing the tax loopholes" may yet result in the passage into law of some measures which will further limit this already drastically reduced source of hospital funding.[40]

The problems of hospital financing have been further compounded by the limited scope of repayment of the third-party intermediaries.[41] One aspect of this problem was pointed out by T. Gordon Young while president of the GNYHA:

> At present, the major third-party reimbursement agencies—Medicare, Medicaid, and Blue Cross—assume responsibility for only the most sharply defined segment of their respective population groupings. Medicare, for example, delineates its share of the total patient load by excluding every element of hospital operation which does not contribute directly and specifically to the care of patients 65 years of age or older, refusing, for example, to make any payment toward the costs of obstetrical services. Medicaid payments are limited to reimbursement solely for care of patients in their rigidly defined income brackets. Blue Cross likewise excludes from its formula a substantial category of inescapable hospital operational costs. The result is that hospitals are left with a body of expenses for which no reimbursement is obtainable at all.[42] This is at the core of the hospitals' monumental, growing deficits and

40. As noted above, a major part of the basic operating deficits of hospitals have been made up by philanthropy. Were this revenue to be eliminated, the overall deficit would be unsupportable. See note 29 *supra* and accompanying text.

41. Community Council of Greater New York, *Pending Federal Tax Proposals Affecting Philanthropic Giving*, Legis. Information Serv. Bull., Aug. 28, 1972.

42. "Take the case of a patient, who happens to have Blue Cross coverage of up to 21 days, but whose income is so low that he is also eligible for Medicaid. During a hospital stay of, say, 18 days, such a patient might require blood and radiation therapy. However, neither of these two types of services is covered by the Blue Cross contract he holds. Yet—and here is the essential point—they cannot be covered by Medicaid either, because Title XIX administrative regulations prescribe that Medicaid benefits may not start until a patient's existing insurance coverage has been 'exhausted.' Since our hypothetical patient still has three days of hospitalization to which he is entitled under his Blue Cross contract, his benefits are not considered 'exhausted' under administrative definitions." Letter from T. Gordon Young (now Administrative Vice-President of the Hospital for Special Surgery) to Tarky Lombardi, Jr., N.Y. State Senator (Oct. 2, 1972) [hereinafter cited as Young Letter] (copy in the files of GNYHA).

the potential for disaster which these deficits represent.[43]

Mr. Young has also noted that:

> [I]n May of 1972, the United States Social Security Administration substantially modified its regulations and cost finding methods under the Medicare program. These eliminated from so-called reimbursable expenses those parts of a hospital's cost attributable to delivery rooms. The reasoning is obvious—few Medicare beneficiaries in their sixties are likely to require obstetrical care.
>
> However, when the New York State Department of Health calculates the reimbursement rates it will pay to hospitals under Medicaid, it uses, as a basis for such reimbursenent, all costs incurred by the hospital on behalf of the total patient population. The subsequent Medicaid rate—since it presumes a sharing of costs by other third party payers—only reflects that portion of the hospital's delivery room average costs as determined by the relationship of Medicaid utilization to total utilization. This leaves a substantial portion of those costs uncovered by either Medicare or Medicaid—so the hospital has no choice but to attempt to absorb an essential expense.[44]

The crux of the problem is represented by the portion of the patients not covered by third-party intermediaries who turn to the voluntary hospitals for ambulatory care services. This group is estimated to be 45 percent of the total and falls into three categories. The first consists of those not covered by any form of third-party reimbursement arrangement for ambulatory care services, even though they may hold valid Blue Cross cards (or commercial insurance policies) entitling them to inpatient coverage. The second are the so-called "partial pay population" which is the group of people dropped from the Medicaid rolls as a result of the 1969 cutbacks[45] eliminating those from 21 to 65 years of age or with income or resources in excess of those prescribed. Though no longer eligible for Medicaid, these people must still seek services but are too poor to pay for the costs of their care. Lastly there are the Medicare and Medicaid beneficiaries who are required to pay 20 percent of the

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43. Statement by T. Gordon Young to an Executive Session of the Comm. on Pub. Health of the N.Y. State Legislature, Sept. 15, 1972.

44. Young Letter, *supra* note 42.

45. Act of Dec. 28, 1971, Pub. L. No. 92-223, § 5, 85 Stat. 802. Along with excluding substantial numbers of people from eligibility under the program, a 20 percent co-payment provision was introduced in 1969, which had the effect of discouraging many who were still eligible from seeking care.

charges. Virtually none of this group can do so and the amounts written off thereby must be added to the hospital deficit.[46]

The hospitals' financial situation was further exacerbated by a restrictive application of the Federal Economic Stabilization Program[47] by the New York State Department of Health. The Department administers the Medicaid program in New York, and has adopted a payment mechanism which does not adequately reflect the actual cost of care. Medicaid pays a predetermined rate for services. The Department of Health has construed the six percent price ceiling of the Economic Stabilization plan as applying to Medicaid payments, thus limiting any increase in payments to six percent over the previous year. This interpretation has been somewhat successfully challenged in New York State Supreme Court,[48] but the court's decision will probably be appealed.

New York has made a number of attempts to ameliorate this problem, one of the most promising being the Ambulatory Care Service Program.[49] Since its inception in 1968, the program has

46. In this connection, Charles W. Davidson, executive vice president, St. Luke's Hospital Center, and at the time president of the GNYHA, offered the following comment at a public hearing on April 16, 1971 being conducted by Assemblyman Peter A.A. Berle (D.-Lib., Manhattan): "Our Association has consistently opposed both the concept of mandatory co-insurance in general and the specific requirement that Medicaid eligibles pay 20 percent of the charge for outpatient care. Our reasons perhaps deserve to be restated on this occasion. They are that: 1. Co-payment is inhumane—it discourages poor people from getting the care they need; it deprives expectant mothers of services essential in lowering shockingly high infant mortality rates in disadvantaged areas. 2. Co-payment is counter-productive—by discouraging people from seeking prompt diagnosis and early treatment, when disease is most easily (and inexpensively) curable, it causes neglect, leading to serious illness and lengthy (expensive) hospitalization. 3. Co-payment is impractical—it has been termed an administrative nightmare by social services experts. 4. Co-payment is futile—in most cases, indigent patients do not have, and have no way of getting, the funds to pay the 20% charge. 5. Co-payment is wasteful—it imposes one more burden on administrative costs at a time when hospital financial difficulties are already staggering . . . ."

47. 12 U.S.C.A. § 1904 (Supp. 1973) and Executive Orders issued thereunder.

48. *In re* Presbyterian Hospital, 171 N.Y.L.J. 2 (April 23, 1974).

49. Law of June 22, 1968, ch. 967, [1968] N.Y. Laws 1946-47.

channeled some $62 million into 23 New York City voluntary hospitals which have elected to participate. These monies have helped to defray the cost of providing essential services to medically needy people, but it is estimated that they covered only about a fourth of the cost.[50] Notwithstanding its inadequacies, the value of subsidizing ambulatory care is enormous. The value of such treatment in terms of both efficiency and preventive medicine has already been noted.

In appropriating funds to the program, however, the City was caught between two sets of conflicting pressures. Community representatives took the position that hospitals should supply the best quality of care, including, but not limited to such amenities as full-time directors of ambulatory care, preferably with an ethnic minority background, bilingual staff personnel, appointment systems and the like. Hospitals, on the other hand, while agreeing that these features were long overdue, had to explain that they simply could not be provided unless funds with which to purchase equipment and pay salaries became available. At the same time, requests for funds were being made by organizations of policemen, firemen, teachers, sanitationmen, and categories of workers also providing essential services. The City was, therefore, compelled to balance conflicting demands and cut the available pie into relatively smaller segments. Thus the Ambulatory Care Services Program was launched with a severely limited operating budget.

This program, designed to ease financial pressures on hospitals caused by ambulatory care services, had a diametrically opposite effect. On the one hand, as explained above, the City failed to provide sufficient funds to implement the program fully; on the other hand, the hospitals have been under strong City pressures to upgrade levels of service provided—pressures which have had the effect of adding to costs.

A number of possible mechanisms to ameliorate the problems extant in ambulatory care in New York have been suggested. At the present time section 2807 of the Public Health Law establishes the mechanisms for repayment of hospital costs by Blue Cross.[51] The

50. Report of the Staff of GNYHA, in the files of the GNYHA.

51. N.Y. PUB. HEALTH LAW § 2807(3) (McKinney Supp. 1973). Blue Cross is regulated by Article nine-c of the Insurance Law. N.Y. INS. LAW §§ 250-60 (McKinney Supp. 1973).

law provides that the Commissioner of Health should approve hospital rates in accordance with established criteria.[52] Nowhere does the law mandate that the loss incurred in providing the community with ambulatory care services be considered in determining the payments that Blue Cross will make to hospitals. In prior years, when Blue Cross and the hospitals negotiated directly concerning ambulatory care, without the requirement of the Commissioner's approval, the loss incurred in providing ambulatory care was included in determining the payment Blue Cross would make to the hospitals. However, since 1971, this essential cost of doing business has been excluded from the formulation. Prior to 1972, Blue Cross would make an estimate as to the percentage of patients insured by Blue Cross who were using the hospital's inpatient facilities.[53] Blue Cross would then pay the hospital a portion of the ambulatory service deficit based on the percentage of Blue Cross inpatients using the facility. Thus, if it were determined that 50 percent of those using inpatient facilities were Blue Cross clients, and the ambulatory care deficit were $100,000, Blue Cross would pay $50,000.

Since the amendments to section 2807,[54] this is no longer true. Under the present regulations, the Commissioner does not include the ambulatory deficit—the cost of ambulatory care, in approving the rate.[55] Were this to change, and such an inclusion mandated, a

52. N.Y. PUB. HEALTH LAW § 606 (McKinney 1971).

53. As a rule, hospitals are not repaid by Blue Cross item by item for the expenses incurred in treatment of covered patients. Instead, the numbers of patients and related costs are estimated by Blue Cross and an all-inclusive rate is determined for each day of service rendered by the hospital.

54. N.Y. PUB. HEALTH LAW § 2807 (McKinney Supp. 1973).

55. *Id.* This section reads, in relevant part, as follows: "2. Payments for hospital service and health-related service, including home health service, made by the government agencies or corporations organized and operating in accordance with article nine-c of the insurance law shall be at rates approved by the state director of the budget in the case of government agencies and approved by the superintendent of insurance in the case of corporations organized and operating under article nine-c of the insurance law. . . . 3. Prior to the approval of such rates, the commissioner shall determine and certify to the superintendent of insurance and the state director of the budget that the proposed rate schedules for payments for hospital and health-related service, including home health service, are reasonably related to the costs of efficient production of such service. In making such certification, the commissioner shall take into considera-

significant portion of the deficit would be eliminated. The inclusion of the cost of providing ambulatory care would, of course be passed on to the consumer, but this would cause only a minimal increase in insurance rates.

At the same time one must remember that the cost of ambulatory care is less than that of inpatient care.[56] Hypothetically the increased use of outpatient facilities will supplant some of the demand for hospitalization, thereby decreasing overall hospital costs. Thus the initial outlay for ambulatory care may very well result in lowering of insurance rates in the future. Moreover, outpatient treatment is likely to catch disease at the early stages, when it is quickly, easily, and relatively inexpensively, curable. The same logic applies to a possible requirement that all insurers in New York State provide at least a minimum range of ambulatory service benefits.[57]

The Public Health Law also allows the state to match city payments to hospitals providing ambulatory care.[58] The statute contemplates a state-city sharing of the ambulatory care deficit. Under

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tion the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital or agency is located, the rate of increase or decrease of the economy in the area in which the hospital or agency is located, costs of hospitals or agencies of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of inhospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research, those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service or home health service, and allowances for costs which are not specifically identified." *Id.*

56. *See* note 18 *supra.*

57. This approach was noted by then-Comptroller Abraham D. Beame in a speech given at a luncheon of the Greater New York Hospital Association, Feb. 1, 1973. He said "[t]he Federal government may soon have to assume greater responsibility for this problem of clinic costs. We may either see some form of direct subsidy to take care of such clinic deficits, or we may see some form of national health insurance put into effect."

58. N.Y. PUB. HEALTH LAW §§ 378(c), 606, 608(1)(b) (McKinney 1971).

this legislative scheme a deficit of $100,000 would be paid for by assessing the state and city equally. Ideally, the law should work well—hospitals are to inform the city of their deficit and the city is to pay half. The state then matches the city's contribution and pays the other half. However, this scheme works only if the city in fact pays its half. In the past several years, the city has begun making allocations to the hospitals without reference to the hospitals' losses. Thus, instead of paying half of the loss, the city often contributes substantially less. Because the state will only match what the city appropriates, the hospitals are left with a large deficit.

The legislation, however, would work far more efficiently if this approach were altered so as to provide that the state pay the hospitals directly, and that the city match state allocations rather than the other way around. Under this proposal the state would pay the full outpatient deficit directly to the hospitals. The state would then collect an amount equal to one half of the deficit from the city. This could be accomplished by the usual means of direct repayment by the city, or, if the local governments were recalcitrant, repayment could be enforced by a deduction from state aid to the city.

A number of other adjustments are also possible. Section 608 of the Public Health Law[59] might be expanded to allow reimbursement by the state of up to seventy-five percent of ambulatory care expenses. At the same time, direct or indirect subsidies to hospitals or a subvention of clinic and emergency room losses would provide a major offset to hospital deficits and may, in fact, provide a stimulus for the widening of ambulatory services in the state.

Another approach which could be taken would be for the legislature to establish a broader category of medical indigency specifically related to ambulatory care. At present, Medicaid, which is known as Title XIX of the Social Security Act,[60] generally pays medical bills for services rendered to those defined as eligible under the statute.[61] Under provisions of the present law, the state may establish income eligibility levels no higher than 133 percent above public assistance levels. Thus, the medical bills of persons classified as indigent according to this State and Federal income eligibility determination will be paid for by Medicaid. (Some services, how-

59. *Id.* § 608.
60. 42 U.S.C.A. §§ 1396-96(i) (Supp. 1973).
61. *Id.*

ever, require a 20 percent co-payment to be made by the person receiving the services.)

If the state were to create a new category involving a broader medical indigency level for ambulatory care, the scope of Medicaid coverage could then be extended. Such broader coverage would take into consideration the relationship between a patient's ambulatory care bill and his income. If the person's bill were above a predetermined percentage of his income, the person would be considered medically indigent and in this manner would qualify for benefits under the expanded program. Such an approach would be no different from current New York State provisions which consider catastrophic costs of illness as related to inpatient services and therefore eligible for coverage.

Creating a new category of medical indigency would be a boon to the great majority of middle class persons who can be economically destroyed by huge hospital bills. Further, because these large fees are beyond the economic reach of many middle class Americans, they go unpaid—resulting in deficits for the hospitals. A category of medical indigency would serve to protect the middle class and diminish the deficits resulting from their inability to pay. Such a change would not appreciably increase the cost of Social Security for individuals and would, at the same time, provide real security to those who pay most of its bills—the middle class. Given the changing patterns in the delivery of medical care discussed earlier in this article, *i.e.*, the increased use of and need for ambulatory care facilities, this would appear to be a sensible approach.

Other solutions may suggest themselves, but something must be done promptly to avoid an inevitable next step—the reduction or elimination of ambulatory care services of city voluntary hospitals entirely except for those able to pay the full costs, or those for whom the costs are covered by a third party. One hospital has already taken this step.[62] If other institutions followed suit, substantial numbers of citizens would be deprived of access to essential care, since New York City's municipal hospitals could not possibly begin to pick up the tremendous additional burden which would be thrust upon them.

In the last analysis, any move by government, or by any other

62. Hicks, *1 Billion Asked for 20 City Hospitals*, N.Y. Times, Jan. 5, 1973, at 35, col. 5.

force, in the direction of cultivating and expanding the concept of ambulatory care is likely to produce substantial dividends for the total community. The principle of ambulatory care is to provide prompt diagnosis and early treatment of conditions at the stage where they are quickly and relatively easily curable. The beneficiaries at the initial stages of such a program are likely to be low-income patients, simply by virtue of the fact that present ambulatory programs are presently heavily patronized by such patients. But there is nothing about the effectiveness of ambulatory care which need necessarily be restricted to low-income groups. Middle and upper-income patients have just as much to gain by the increased availability of this form of health care.