THE FISCAL IMPACT OF THE WORLD TRADE CENTER ATTACK ON NEW YORK HOSPITALS

PRELIMINARY ESTIMATE BY THE GREATER NEW YORK HOSPITAL ASSOCIATION OCTOBER 2, 2001

This paper provides a preliminary estimate of the fiscal impact of the terrorist attack on the World Trade Center ("WTC attack") on hospitals in the New York metropolitan area. It also provides the context of the financial condition of the hospitals prior to the day of the attack, September 11, 2001.

The combination of incremental emergency expenses, unreimbursed standby costs, and continuing fiscal impacts on New York City area hospitals resulting from the attacks results in an estimated loss of $340 million. The impact on New York City hospitals is $313 million, or more than double the aggregate net income of these institutions in 1999. These estimates do not include significant cost increases that will be required to meet new security and disaster preparedness standards.

The response of the New York area hospital system to the unprecedented and horrific events of September 11th was one of total dedication to treating and comforting the injured and others in need, as well as responding to the unpredictable demands made upon them by City and State emergency response efforts and the circumstances of the tragedy itself. The importance of a stable, high-quality hospital system that is able immediately to shift and re-program its considerable resources to meet the needs of a full-scale disaster was highlighted by the response of hospitals in the New York area.

Unfortunately, these hospitals already suffered from severe and mounting financial pressures before September 11th, and it is critically important that the costs they incurred as a result of the disaster are fully recognized and reimbursed as soon as possible. This will help to ensure that they can continue to fulfill their patient care missions and to meet the added responsibility of responding to crises in their communities whenever and on whatever scale they may occur.

FISCAL IMPACT OF THE WTC ATTACK

Greater New York Hospital Association (GNYHA) based its estimate of the fiscal impact of the WTC attack on two surveys. The first survey was developed by the New York State Department of Health and compiled by GNYHA (the "volume survey"). It tracked the number of emergency department (ED) visits and admissions to area hospitals by victims of the WTC attack. Area hospitals include private not-for-profit and public hospitals in New York City, Long Island, Westchester County and the Hudson Valley. As of Wednesday, September 26, 2001, 91 hospitals in the metropolitan area had provided about 6,000 ED visits and 500 admissions. The second survey asked metropolitan area

hospitals to record the unreimbursed standby costs and incremental expenses associated with the WTC attack from September 11, 2001 through October 6, 2001 (the "fiscal impact survey"). As of Friday, September 28, 2001, 43 of the 91 hospitals had responded to the fiscal impact survey.[1]

Immediate Impact of the Attack

Significant unreimbursed standby costs were incurred as hospitals abruptly cancelled normal revenue-generating activities in order to create as much capacity as possible for the anticipated victims of the attack. This occurred on Tuesday morning, September 11, 2001, when the New York City Office of Emergency Management (OEM) ***directed*** hospitals to shift to emergency preparedness status. Accordingly, hospitals hurriedly activated their emergency command centers, cancelled all possible elective surgeries, medical admissions, and scheduled procedures, closed ambulatory care clinic services, and transferred or discharged hospitalized patients who could be so handled in order to empty beds and free up service capacity for thousands of trauma and severely injured victims of the attack who were expected to flood area hospitals. New York City area hospitals include many of the most advanced health care institutions in the world, and they essentially turned over a significant portion of their operations to the needs of the disaster so that they would be capable of applying that sophistication to save as many severely injured lives as possible.

Tragically, over the next few days, it became apparent that of the thousands of people trapped by the attack and collapse of the WTC towers, there were almost no survivors. Thus, while hospitals remained on emergency response, beds that were emptied and capacity that was created to respond to the disaster remained largely unused. The disaster response costs incurred by hospitals therefore were not offset by revenue that would normally have been associated with patient care activities. These unreimbursed costs, net of revenue anticipated from re-scheduled admissions and procedures, have created significant and continuing financial hardship for institutions that, as described later in this document, were already suffering from among the poorest financial condition of hospitals in the country. Furthermore, as described below, patient census, particularly in Manhattan, remains depressed.

Incremental expenses were incurred in the following areas: disaster-related property loss; incremental labor and overtime; incremental security; emergency supplies, pharmaceuticals, and blood; disaster crisis counseling services; emergency food, housing, and transportation; emergency structural repairs and debris clean up; emergency telecommunications, generators, energy, purchases, and rentals; emergency morgue; and other costs.

[1] The fiscal impact survey asked hospitals to compute financial impacts that their internal accounting systems, which typically are organized in monthly time periods, had not yet summarized. This made survey completion difficult within the short time frame provided. As a result, GNYHA continues to collect survey responses as hospitals are able to complete them.

In order to extrapolate the fiscal impact reported by the responding hospitals to the hospitals with pending surveys (the "pending respondents"), GNYHA classified the universe of 91 hospitals into five tiers based on each hospital's volume of ED visits and admissions associated with the WTC attack. The number of hospitals in each tier is shown in Table 1, with Tier 1 representing hospitals closest to and receiving the highest volume of victims from the WTC.

Table 1. Classification of New York Hospitals Based on WTC Attack-related Volume

Tier 1	3
Tier 2	8
Tier 3	8
Tier 4	20
Tier 5	52

GNYHA computed the survey respondents' unreimbursed standby costs by using revenue losses, net of anticipated reimbursement associated with the rescheduling of admissions and procedures that were cancelled due to the disaster response, as a percentage of baseline revenue. Incremental expenses were calculated as a percentage of baseline expenses. Both percentages were calculated *by tier*. (Baseline revenue and expenses were calculated as 26 days worth of 1999 net patient revenues and total operating expenses as reported on the New York State Institutional Cost Report, Exhibit 26A.) The appropriate percentages were then applied to the pending respondents' baseline revenue and expenses, by tier, in order to estimate their revenue loss and incremental expenses for the 26 days including and following the WTC attack. Table 2 shows the revenue and expense percentages by tier that were applied to the pending respondents.

Table 2. Percentages Used to Derive Unreimbursed Standby Costs and Incremental Expenses of Hospitals With Pending Surveys

	Standby Costs as a % of Net Patient Revenue	Incremental Expense as a % of Total Operating Expense
Tier 1	25.0%	10.0%
Tier 2	12.5%	7.5%
Tier 3	6.3%	5.6%
Tier 4	3.1%	3.1%
Tier 5	1.6%	1.6%

Table 3 summarizes the unreimbursed standby costs and incremental expenses associated with the immediate aftermath of the attack of the 91 affected hospitals in the metropolitan New York area. The unreimbursed standby costs totaled about $92 million and the incremental expenses were about $48 million, for a total incurred cost of $140 million.

Table 3. Unreimbursed Standby Costs and Incremental Expenses Incurred from September 11, 2001 through October 6, 2001

Revenue Loss	$92 Million
Incremental Expenses	$48 Million
Total Cost of WTC Attack	$140 Million

Continuing Impact

There continues to be a significant fiscal impact associated with the WTC attacks. Based upon telephone surveys, GNYHA believes that the hospitals' patient census, which was intentionally lowered starting on September 11 in order to respond to the disaster, has not rebounded, particularly in hospitals in lower Manhattan and upper Brooklyn. The inability of these hospitals to recover lost business has been exacerbated by significant restrictions on patient access resulting from law enforcement and rescue and recovery activities in lower Manhattan, as well as new traffic restrictions imposed on vehicular traffic south of 63rd Street in Manhattan and across bridges and tunnels to and from the outer boroughs. These "strike zone" hospitals therefore are experiencing significant, ongoing threats to their continued financial viability because of unanticipated revenue depression.

Patient census in the rest of the metropolitan area, particularly in Manhattan, also has not returned to normal levels. Hospitals appear to be suffering from factors affecting the rest of the local economy, including ongoing traffic restrictions and patient fears or inhibitions about traveling or being incapacitated, but they have been particularly affected because their downturn was intentionally imposed starting on September 11 so that they could be full participants in responding to the disaster. In addition, because patients who have traditionally utilized a number of world-renowned specialty hospitals and academic medical centers in Manhattan come from outside of New York City and even from abroad, the impact of these factors has been particularly harsh.

The revenue loss associated with this downturn in census is about $200 million over the next four months, bringing the fiscal impact up to $340 million.

Finally, hospitals in New York City and the surrounding area anticipate significant increased future expenses to respond to expanded mental health needs in the community, as well as heightened security and disaster preparedness requirements in the hospital. The hospital community will work closely with the State and City governments to respond to mental health needs. With respect to heightened security and disaster preparedness requirements, it is difficult to make estimates until the full range of required and desired responses is known. However, at least two institutions have projected that one-time capital expenses to ensure continued electrical, telephone and computer service, retrofitting to address the threat of biological or chemical contaminants, and other structural changes to ensure continued operations in a disaster, as well as ongoing operating expenses, could be in excess of 5% of current expenses.

CONTEXT FOR THE FISCAL IMPACT

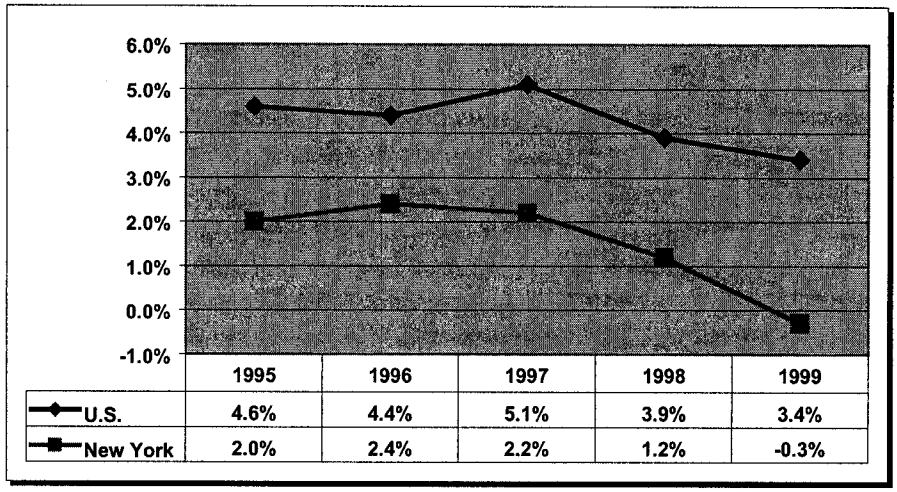
New York City hospitals comprise 92% of the cost incurred as a result of the WTC attack, excluding security and disaster preparedness costs, or $313 million. This amount is more than twice the aggregate net income of New York City hospitals in 1999 of $142 million. While aggregate results for 2000 are not yet available due to the delay in cost report filings, GNYHA surveys have indicated a marked decline in net income for area hospitals.

Since New York hospitals affected by the WTC attack have no financial cushion with which to finance the costs associated with the attack, without immediate financial assistance, they will have to cut vital patient care services, a further assault on the patients and communities served by these hospitals. Furthermore, the hospitals cannot expect an improvement in their financial position, since their distressed condition reflects a series of shocks in recent years and another major shock is expected a year from now in the form of a cut in Medicare indirect medical education (IME) funding of more than $100 million (virtually all of the affected hospitals are teaching hospitals). An urgent legislative priority of GNYHA is to rescind next year's IME cut this year, because the cut would take effect in the fourth quarter of 2002, forcing hospitals to plan program cuts now.

New York Hospitals' Poor Relative Financial Condition

The Center for Healthcare Industry Performance Studies (CHIPS) compares median hospital financial and operating indicators among the states. The financial condition of New York hospitals consistently ranks among the worst in the 50 states. Figure 5 shows New York hospitals' median total margin compared with the U.S. median. New York's 1999 margin of –0.3% ranked 42nd out of 45 states reporting.

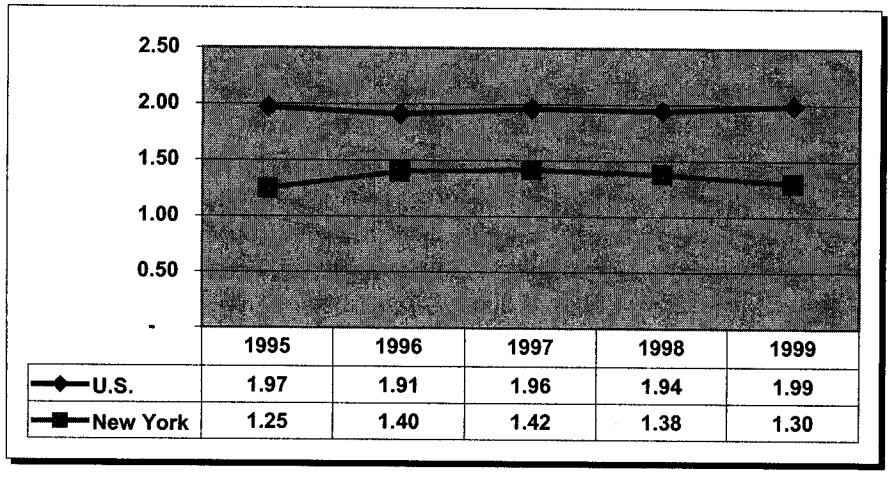
Figure 5. Median Total Margin



	1995	1996	1997	1998	1999
U.S.	4.6%	4.4%	5.1%	3.9%	3.4%
New York	2.0%	2.4%	2.2%	1.2%	-0.3%

The current ratio is the number of dollars held in current assets per dollar of current liabilities. It is the most widely used measure of liquidity. Figure 6 shows New York hospitals' median current ratio compared with the U.S. median. New York's 1999 current ratio of 1.30 ranked 44th out of 45 states reporting.

Figure 6. Median Current Ratio

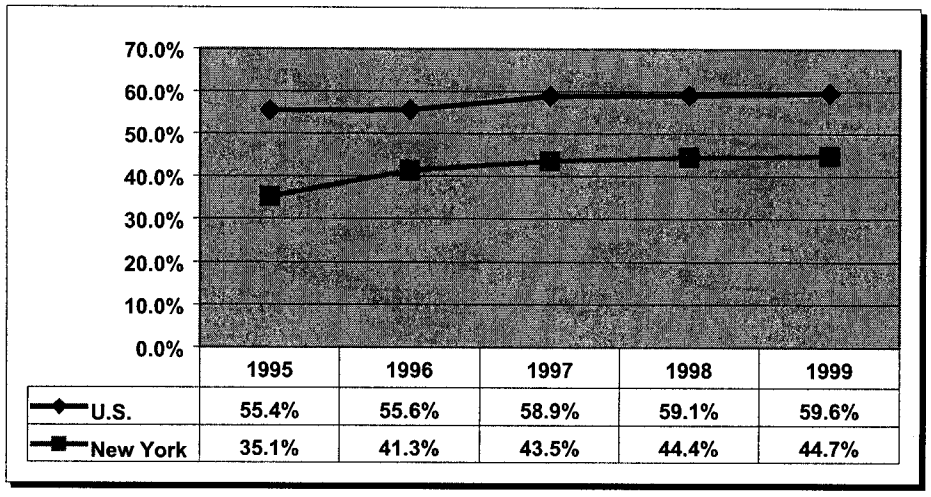


	1995	1996	1997	1998	1999
U.S.	1.97	1.91	1.96	1.94	1.99
New York	1.25	1.40	1.42	1.38	1.30

Source: Center for Healthcare Industry Performance Studies

The equity financing ratio measures the percentage of total assets that has been financed with equity as opposed to debt. It is a common measure of capital structure. Figure 7 shows New York hospitals' median equity financing ratio compared with the U.S. median. New York's 1999 ratio of 45% ranked 42nd out of 45 states reporting.

Figure 7. Median Equity Financing Ratio



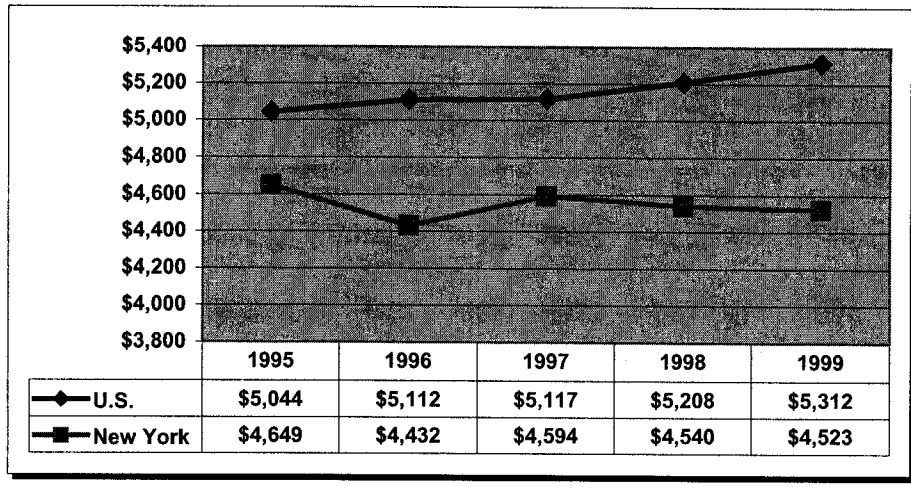
	1995	1996	1997	1998	1999
U.S.	55.4%	55.6%	58.9%	59.1%	59.6%
New York	35.1%	41.3%	43.5%	44.4%	44.7%

Source: Center for Healthcare Industry Performance Studies

New York Hospitals Are Relatively Efficient

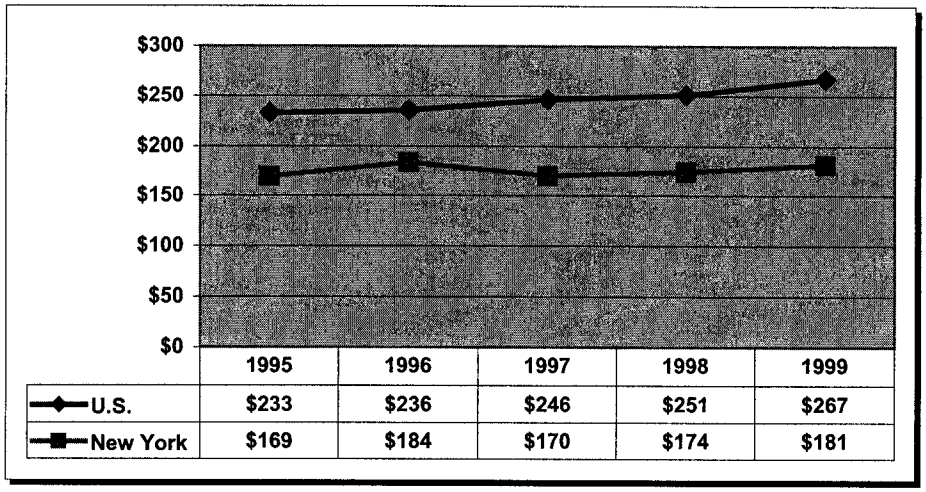
Poor profitability can be a function either of low revenue, high cost, or both. In the case of New York hospitals, the problem is low revenue rather than high cost. According to CHIPS, when median unit costs are adjusted for regional differences in purchasing power and the severity of illness of the patient population, New York hospitals' inpatient and outpatient unit costs are among the lowest in the country. Figure 8 shows New York's median adjusted inpatient cost per discharge compared with the U.S. median, while Figure 9 shows New York's median adjusted outpatient cost per visit compared with the U.S. median. Figures 11 and 12 show New York's median adjusted price per inpatient discharge and price per outpatient visit, respectively, compared with the U.S. medians. New York's median adjusted unit costs and unit prices all rank third lowest in the U.S.

Figure 9. Median Adjusted Cost Per Discharge



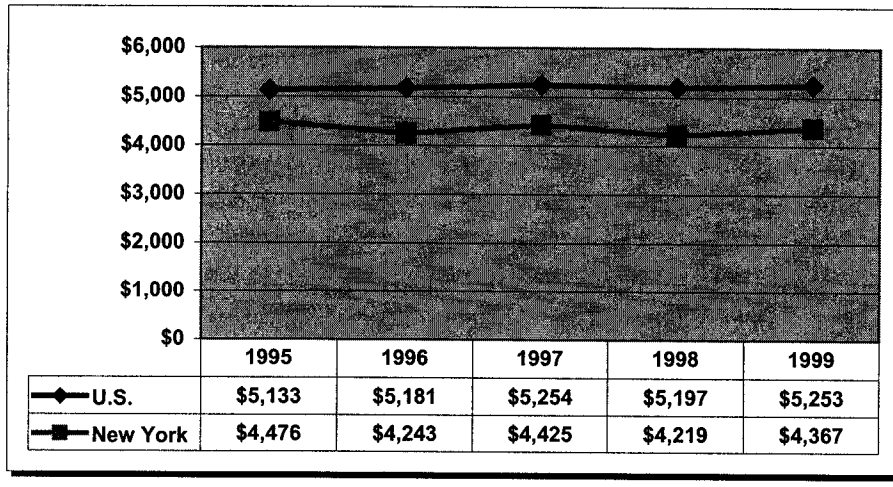
	1995	1996	1997	1998	1999
U.S.	$5,044	$5,112	$5,117	$5,208	$5,312
New York	$4,649	$4,432	$4,594	$4,540	$4,523

Figure 10. Median Adjusted Cost Per Visit



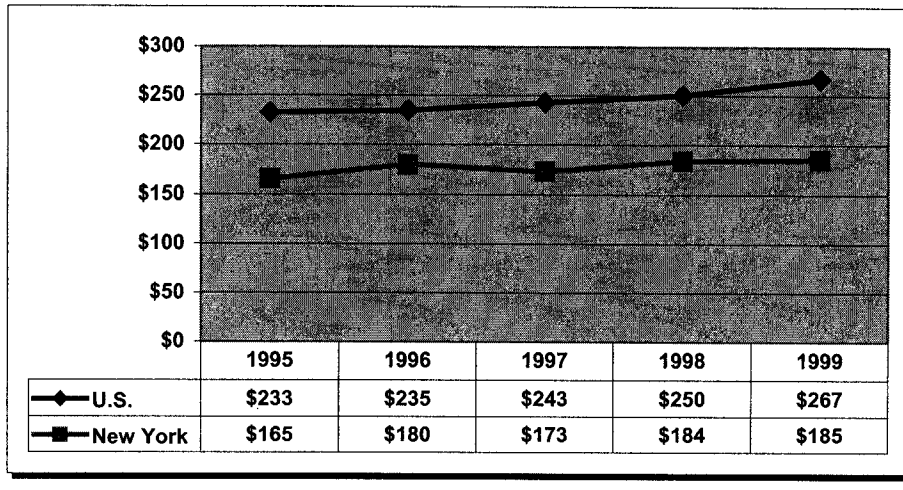
	1995	1996	1997	1998	1999
U.S.	$233	$236	$246	$251	$267
New York	$169	$184	$170	$174	$181

Figure 11. Median Adjusted Net Price Per Discharge



	1995	1996	1997	1998	1999
U.S.	$5,133	$5,181	$5,254	$5,197	$5,253
New York	$4,476	$4,243	$4,425	$4,219	$4,367

Figure 12. Median Adjusted Net Price Per Visit



	1995	1996	1997	1998	1999
U.S.	$233	$235	$243	$250	$267
New York	$165	$180	$173	$184	$185

Source: Center for Healthcare Industry Performance Studies.

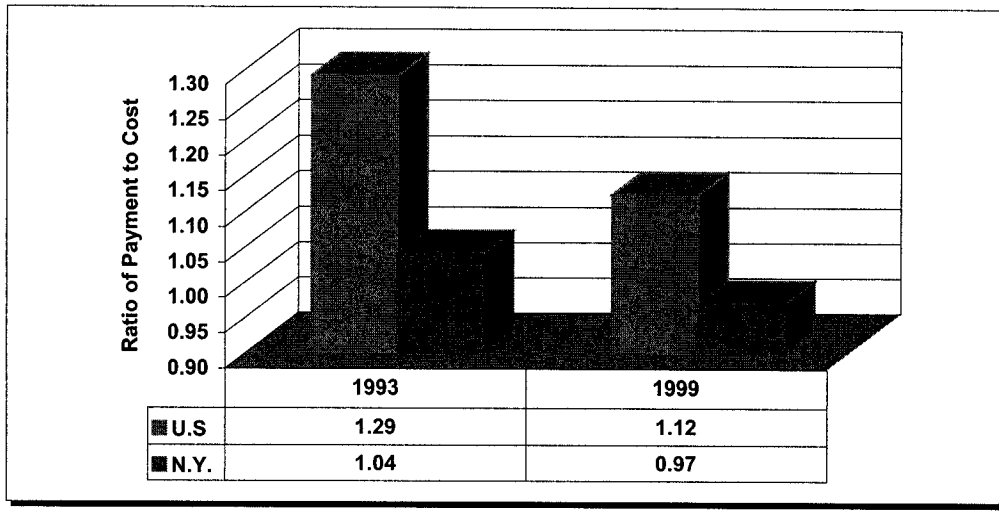
The Revenue Problem

In the 1990s, New York hospitals suffered a series of financial shocks from each major payer group and a marked increase in the uninsured population. In 1995, New York State severely cut Medicaid payments to hospitals, in 1996, the State deregulated private insurer payments to hospitals, and in 1997, the State implemented mandatory enrollment of Medicaid beneficiaries in managed care plans. Also in 1997, through the Balanced Budget Act (BBA), the Federal government severely cut Medicare payments to hospitals, mostly by eliminating or cutting inflation increases, but also by deeply cutting payments for teaching hospitals.

Deregulation was a revenue shock for two reasons. First, New York's former rate setting system kept private payer reimbursement rates barely above cost for 20 years. This was documented regularly by the Medicare Prospective Payment Assessment Commission (ProPAC), which later became the Medicare Payment Advisory Commission (MedPAC). Second, deregulation further reduced payments by introducing late payments and payment denials by managed care companies on a large scale. Under regulation, hospitals had little experience with "day carve-outs," technical denials, and payment delays, but under deregulation, these practices became widespread.

Figure 13 shows the ratio of private sector payments to private sector costs in 1993 and 1999. Prior to deregulation, New York's ratio was the lowest in the U.S.; with the expansion of managed care in the mid-1990s, all hospitals' ratios declined, with New York's persisting in its lower relative position.

Figure 13. Comparative Payment to Cost Ratios



Source: Medicare Payment Advisory Commission.

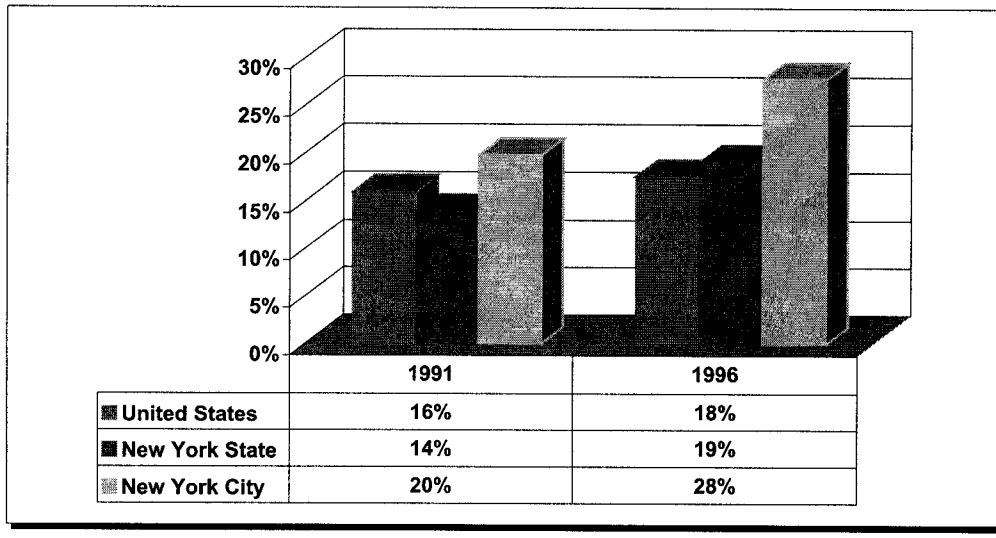
The BBA cut the inflation update for all hospitals and implemented other industry-wide cuts as well. However, the BBA singled out teaching hospitals for a debilitating 30% cut in IME payments. The industry-wide cuts reduced the growth in Medicare payments to hospitals from an expected rate of 16% between 1996 and 2002 to 1%-2%; however, it actually reduced payments to teaching hospitals during that time period. Subsequent legislation restored some of the inflation update to hospitals, but merely postponed the IME cut.

Mounting Cost Pressures

Concurrent with the revenue shocks were several mounting costs pressures. A key pressure was the growth in the non-elderly uninsured population. Figure 14 shows that while the non-elderly uninsured population in New York State was below the national

average in 1991, it exceeded the national average by 1996. Furthermore, by 1996, the non-elderly uninsured population in New York City grew to 28% of the total non-elderly population.

Figure 14. Growth in the Non-elderly Uninsured Population



	1991	1996
United States	16%	18%
New York State	14%	19%
New York City	20%	28%

Source: The United Hospital Fund.

Other cost pressures included soaring pharmaceutical prices, an urgent need to invest in information technology, and severe wage pressure. The need to invest in information technology is urgent in order to comply with new patient privacy rules, to improve management efficiency, and perhaps most importantly, to reduce medical errors, improve the coordination of patient care, and otherwise improve quality.

Wage pressure is a function of a severe labor shortage for nurses and other specialties, including pharmacists and technicians, as well as expiring labor contracts in New York State. Earlier this year, GNYHA conducted a survey that had three principal findings:

- In 2000, New York City had an 8% vacancy rate for nursing staff, including a 13% vacancy rate for nurse managers and aides,
- 48% of vacancies took more than four months to fill, and
- 61% of nurses were more than 40 years old.

These findings are adding market pressure to a labor negotiation that was already intense because of high expectations on the part of the unions stemming from a pattern of recent labor settlements in the 4%-5% range.

CONCLUSION

The financial condition of New York City area hospitals was already poor and deteriorating prior to the shocking and unprecedented terrorist attack on the World Trade

Center on September 11, 2001. Therefore, it is critically important that the costs incurred by New York City area hospitals in responding to the disaster are immediately recognized and reimbursed in full in order to stave off cuts in patient care services, as well as to ensure that these hospitals remain intact and able to respond to crises in their communities whenever and on whatever scale they occur.

In addition, the Federal government should immediately rescind the cut in indirect medical education patients to teaching hospitals that is scheduled to take effect on October 1, 2002, but which is affecting the hospitals' 2002 budget preparation right now.