

Testimony of the Hunger Action Network of New York State

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**To the Joint Budget Hearing of the
Senate Finance Committee and
Assembly Ways and Means Committee**

Tuesday February 13, 2007

The Hunger Action Network is a statewide membership organization of direct food providers, advocates and other individuals whose goal is to end hunger and its root causes, including poverty, in New York State. Each week emergency food programs in our state provide food to more than 900,000 New Yorkers.

High health care costs are one of the three major expenses, along with high rent and utility bills, which force individuals to use emergency food programs. Access to health care is directly related to income and race in the United States.

Increase Funding for Emergency Food to \$32.19 million

Hunger Action Network supports several of the initiatives included in Governor Spitzer's proposed budget. We particularly endorse the proposed \$5.15 million increase in funding for the Hunger Prevention and Nutrition Assistance Program.

The Hunger Prevention and Nutrition Assistance Program is a state sponsored grant that provides emergency food programs with funding to obtain nutritional food through the regional Food Banks and the United Way in NYC. HPNAP also has The Operations Support and Equipment grant, which awards emergency food programs up to \$3000 for operations and equipment expenditures. This program is administered by the New York State Department of Health. Funds are provided both through NYS DOH and the TANF block grant.

HPNAP funding has always been a small fraction (e.g., 10%) of the cost of running the state's 3000 emergency food programs, which help feed more than 2 million New Yorkers. However, it has always been important in terms of providing food of high nutritional value than tends not to be received through private donations.

HPNAP was funded at \$22.8 million in 2006-07, a 7 percent decrease from the FY 2002 funding level of \$24.44 million. Despite these recent funding cuts, the need has increased throughout New York State. Between 2002 and 2004, poverty increased by 9 percent in New York.

Hunger Action Network joins with the rest of the state's anti-hunger community in supporting increasing funding for HNPAP by 147 percent over the next five years to a FY 2012 funding level of \$56.3 million. This would keep pace with inflation and the increase incidence of poverty (a 9% hike from 2002 to 2004) . For 2007-08, this means a funding level of \$32.19 million.

Universal Health Care for Children

We support the Governor's proposal to expand income eligibility for Child Health Plus and to reduce the number of uninsured New Yorkers through simplification of the recertification process for Medicaid. However, we wish that the proposal also included simplifying the application process. For instance, we saw a significant increase in the number of eligible individuals able to access the Medicaid program when a simplified process was followed after the 9/11 attacks on the World Trade Center. NY should also

eliminate co-pays for low-income New Yorkers. Even modest co-pays discourage people from seeking necessary health care services. The asset test for Medicaid and Family Health Plus should be eliminated.

We support increased efforts by the government to better assist individuals in obtaining needed medical assistance and care in their own homes rather than being required to move into nursing homes or other institutional settings.

Bulk Purchasing of Prescription Drugs

We support the proposal by Governor Spitzer to save money for taxpayers, consumers, workers and employers by expanding the state's efforts to promote the bulk purchasing of prescription drugs. We hope that the Governor and legislature will go even further than what the Governor has proposed. We support the proposal introduced last session by Assemblymember Gottfried and Senator Golden, including allowing individual New Yorkers to participate in the program.

The rising cost of prescription drugs impacts everyone: those consumers who either have no health insurance coverage whatsoever or have limited coverage that excludes prescription drugs; businesses that provide insurance for their workers that struggle to either absorb the annual inflation in coverage costs or shift it to employees through higher deductibles and/or co-pays, or worse, drop coverage altogether. Taxpayers are impacted as higher prescription drug costs drive up the costs of government sponsored insurance programs such as Medicaid, Family Health Plus, Child Health Plus, EPIC, as well as the costs of state employees' health insurance benefits.

Each year, New York state directly spends over \$2 billion to purchase prescription drugs for state health care programs. New York should leverage its considerable economic power to negotiate lower prices with drug makers. This rational use of the state's market power would help lower inflation in the costs of government-sponsored health insurance programs and state employee health insurance benefits, easing New Yorker's tax burden. A well-designed program would also allow private sector purchasers to opt-in to the program and benefit from lower prices.

New York State should increase funding for Children Environmental Health Centers by \$7 million. A pilot program was established last year through Mt. Sinai. Chronic diseases of environmental origin are an increasing problem for our children. To stem the tide of the chronic disease epidemic in our children, New York should establish a statewide, regionalized children's environmental health system of four to six centers of excellence. While childhood diseases of environmental origin cost Americans \$54.9 billion annually, the startup cost for the centers is less than .01% of the environmentally attributable costs. Chronic diseases among children include asthma, lead poisoning, obesity, cancer, birth defects, injury, mental disability, autism and ADHD, behavioral, learning and psychiatric disorders. At least 28% of developmental disabilities in children are due at least in part to environmental causes. The Centers would help health care providers reduce children's exposures to environmental hazards through education of parents, identification of hazardous exposures, diagnosis and treatment of children, and advocating for prevention.

New York State should increase funding for Community Health Care Centers (Voluntary Diagnostic and Treatment Center Indigent Care) by \$30 million. Community health centers provide needed health care to patients regardless of insurance status and based on a sliding fee scale. The D&TC Indigent Care Pool provides funds that help health centers and other facilities to cover the costs of the care they provide to uninsured patients. Funding for voluntary D&TC uncompensated care has remained fixed at \$18 million per year since 1996, despite increases in the number of uninsured patients, the number of facilities serving them, and the cost of providing care.

Enact Universal Health Care – for All New Yorkers

Hunger Action Network supports a universal health care system to provide quality, comprehensive health care service to all New Yorkers.

The most cost-effective, common sense solution is a single payer financing system, similar to Medicare for All.

Assuming that the State legislature is not yet ready to take this obvious step, for 2007-08, we support including \$500,000 in the state budget to support the Commission on Universal Health Care as has been introduced by Assemblymember Gottfried. The legislation passed the Assembly 135 to 1 last year. The Commission would oversee independent cost-benefit analysis of the various approaches to providing health care to all New Yorkers.

Universal health care has long been the elephant in the room that too many legislative lawmakers and stakeholders have pretended not to see. The lack of universal health care drives up costs throughout the health care system, starting with forcing expensive hospital emergency rooms to provide care to the uninsured. If one looks at a 12-month span, nearly one out of three New Yorkers go without health insurance for some period of time. Even for those lucky enough to be insured, ever-skimpier private policies helped push an estimated 38,645 New Yorkers into medical bankruptcy in 2004.

New York needs a universal health care system to improve the quality of our health care system; to save money for taxpayers, consumers, businesses and government; and to solve a myriad of other problems. A universal health care system would also help the state resolve other health-related problems such as the high cost of workers compensation, automobile insurance and medical malpractice premiums.

In proposing to freeze the trend factor for the hospital reimbursement rate for Medicaid, Governor Spitzer states that hospitals are using Medicaid to subsidize deep discounts for the private health insurance companies. He correctly argues that we need to ensure that Medicaid dollars are targeted to those assisting our most vulnerable citizens. While we support the Governor's goals in this area, we would prefer a more comprehensive approach to resolving the related problems of the costs of private health insurance and providing medical care to the uninsured. Hospitals provide a critical role in our health system and they need both adequate financial support and strong public policy direction and oversight.

In particular, we support more targeted efforts to eliminate the excessive costs, paperwork, confusion and bureaucracy foisted on our health care system by our present system of private health insurance. Reigning in or eliminating the costs associated with private health insurance is central of any effort to create a cost-effective universal health care system.

We would note that Berger hospital restructuring process was promoted pretty much as “the” way to save money in NY's health care. As Sid Secular of Rekindling Reform (and professor emeritus of the U. of Miami School of Medicine.) has pointed out, “unfortunately, the discussion never tried to analyze the entire range of major factors responsible for NY's high costs. Had it done so it would have found that empty hospital beds are not one of the major factors. I think it would be safe to bet that a FAR larger contribution to costs is the volume of unnecessary services delivered by big teaching hospitals. So how can we account for the Berger process having happened? I think the main factors were eagerness on the part of the financially strong hospitals to reduce competition for patients, eagerness of real estate interests to grab up sites that hospital closings would make available, and the large number of people who fell for the false, unsubstantiated argument that this would be a very good way to save medical care \$\$.”

A single payer health care system, a version of which is used by almost all of the other industrial countries, eliminates the huge waste and paperwork of the private health insurance system. Private insurance uses up as much as thirty cents per dollar; Medicare's administrative costs in comparison are 3%. The thousands of insurance companies and their dueling forms and coverage criteria force doctors on average to hire 2.5 staff people just to deal with the paperwork, further driving up costs. Nationally, it is estimated that a single payer system would save over \$200 billion annually.

As much as 30 cents of every health care dollar is spent on paying for the paperwork, bureaucracy and profit margins of private health insurance companies. A study by the Lewin group of a potential single payer system for California estimated that the state would save \$38 billion annually over a ten-year period.

New York's taxpayers, consumers and employers spend far too much money on a health care system that leaves millions uninsured or with inadequate coverage. Despite having some of the best medical professionals, hospitals and equipment in the world, the U.S lags behind many other countries on basic public health indicators such as life expectancy and infant mortality rates. The World Health Organizations ranks our overall health care system only 37th.

We spend a whopping 15.5% of our GNP on health care – far more than any other country – which puts our businesses at a competitive disadvantage in the international marketplace. The United States is unique among the industrial democracies in that we treat health care as a commodity distributed according to the ability to pay, rather than a social service to be distributed according to need. We spend huge amounts of money to cure people once they are sick, rather than focusing on keeping them healthy. We are ill-served by a health care system that is a serious drain on our economy while providing an inferior product.

New York and the US are already paying for universal health care – we are just not getting it. The amount of funds we spend on Medicaid and Medicare alone is more than any other country spends in total to provide quality health care for all. We don't need more money for health care. We need more health care for the money we are already spending.

Increases in health care costs are a drag on economic growth: they thwart job growth, suppress increases for current workers, weaken the viability of pension funds, and depress the quality of jobs. Rising health care costs are also causing budgetary problems for federal and state governments, who are currently paying over 50% of the US health care bill.

A Zogby International interactive poll of 1,200 New York residents in May 2006 found that by almost 3 to 1 (67.3% to 23.6%), New Yorkers support having the state invest \$500,000 in “a study of the most cost effective ways to provide quality health care for all, looking at models like Canada as well as private sector approaches such as employer mandates, tax credits and Medical Savings Accounts.”

The Hospital Closing Commission Recommends Universal Health Care for New York

Below are some of the comments and recommendations of Commission on Health Care Facilities in the 21st Century on universal health care:

“New York should strive for health coverage that is universal, continuous, affordable to individuals and families, and affordable and sustainable for society at large. New York should study coverage expansion efforts in other states and adopt additional strategies to sustain its recent progress in reducing the number of uninsured New Yorkers.

“The uninsured remains one of the most serious and persistent health care problems both in the nation and New York. The United States is the only wealthy industrialized nation that does not provide universal

health insurance coverage. Nearly one in five non-elderly individuals in the US and NY State lack health care coverage.

”The uninsured face problems accessing needed health care services. Many either do not receive or postpone seeking care due to financial barriers. When they do receive care, it is often episodic and fragmented. Preventable or treatable chronic conditions develop into more complicated and expensive conditions to treat. Compared to insured patients, uninsured patients have less favorable health outcomes and higher rates of complications and deaths. The Institute of Medicine estimates that lack of health insurance causes roughly 18,000 unnecessary deaths very year.

”Uninsured Americans often present to hospital emergency rooms where their care can be uncoordinated and more expensive to deliver. In addition, health care providers bear a substantial burden in providing care for this to the uninsured and indigent. According to the Urban Institute, New York State’s medical providers spent about \$2.8 billion in 2005 on providing care for uninsured New Yorkers. Hospitals provided \$1.8 billion of that care, and physicians accounted for \$412 million. The balance came from health centers, Veterans facilities, and the federal Indian Health Service.”

The lack of universal health care system contributes to a myriad of problems: disparity in receiving health services; increased costs throughout the health care system for government, consumers and employers; high workmen compensation costs; high automobile insurance rates; high medical malpractice costs; increased diversion of individuals with substance abuse and mental health problems into the criminal justice system; high local property taxes; high infant mortality rates etc.

Universal health coverage would also have a salutary effect on labor management relations. Many if not most strikes in the past five years have involved conflicts over health benefits. Universal coverage would defuse this contentious issue, provide benefits independent of employment status, and allow business greater flexibility in whom to hire.

As In Interim Step, Support a Commission to Study Universal Health Care

The Legislative Commission on Health Coverage Reform would help New York develop a long-term, comprehensive and cost-effective solution to the growing costs and complexities of the state’s health care programs, including Medicaid and long term care. The Commission mirrors a successful strategy that has been utilized in other states such as Maine, California and Maryland. States such as Illinois, New Jersey and New Mexico are presently doing commission. The State of Massachusetts recently passed legislation that seeks to provide health care coverage to all residents. In California, the State Legislature recently passed single payer legislation. While the Governor vetoed it, he was forced to propose a comprehensive alternative.

The Commission proposal has been endorsed by more than 250 organizations, including the NYS Nurses Association, NYPIRG, Physicians for a National Health Plan (NY), Rekindling Reform, Hunger Action Network of NYS, 1199 SEIU, Albany County Central Labor Council, Community Service Society, American Medical Student Association (Albany Med and Cornell), Rochester Interfaith Health Coalition, ES2, SENSES, NASW NYS, UJA Federation of NY, Federation of Protestant Welfare Agencies, Public Health Association of NYC, Professional Staff Congress, Congress of Senior Citizens, Metro Health NY, Western NY Health Care Campaign, NYS Health Care Campaign, Citizen Action, Working Families Party, NYSUT, SCAA.

The Commission bill was amended to address concerns raised by Senate Health Committee Chairperson Hannon, such as giving the Governor a strong role in guiding its work. Health care advocates have also suggested that the Legislature impose a deadline of adopting a universal health care system within one year

of the Commission completing the studies. The Commission would also convene two series of regional hearings to receive input and feedback from the public and health care stakeholders.

Millions of New Yorkers are unable to have full access to health care because they lack health coverage. The current system of health coverage undermines the health and financial security of those who lack coverage; imposes increasing financial burdens on employers, taxpayers and individuals who pay for health coverage; unfairly distributes the economic and social costs of health care; and undermines the financial viability of health care providers. The purpose of this legislation is to develop and evaluate options to move NY to a system that will provide or promote health coverage for all and help overcome the problems of the current system.

A legislative commission on health coverage reform would be created to examine, evaluate and make recommendations concerning mechanisms for providing comprehensive, affordable, quality health coverage to all New Yorkers while controlling costs and ensuring freedom of choice for consumers. Options to be examined include: multi-payer; single-payer; tax credits; “pay or play” employer mandates, medical savings accounts; regulatory changes, consumer mandates such as Massachusetts legislation; and extension of existing public insurance programs and/or pooling arrangement. The cost-benefit studies of the options will be conducted by independent qualified institutions in response to RFPs issued by the Commission..

Any universal health care model considered by the Commission would:

- Assure access to comprehensive, affordable core benefits, including preventive, acute and long term health care, for all New York residents and guarantee to residents multiple choices among health care-providing professionals and organizations;
- Maintain and improve the quality of health care services offered to New York residents;
- Provide portability of coverage, regardless of employment status;
- Include cost containment measures and cost analyses;
- Be affordable both by businesses and individuals.

The commission would evaluate the effect of proposals on: (a) advancing the goal of universal health coverage; (b) controlling the cost of health coverage and health care; (c) fairly and equitably distributing the cost of health coverage and health care; (d) the level and distribution of costs as a barrier to health coverage or health care; (e) employers and employment; (f) the special concerns of small businesses; the self-employed and sole-proprietors; collective bargaining arrangements; people with multiple, seasonal or sporadic employment; low-income households; and people who are unemployed, under-employed or unable to work; and, (g) the economic viability of hospitals, community health centers, health care professionals, and other health care providers.

New York Should Adopt a Single Payer Health Care System

A single payer universal health care system would save the most money for taxpayers and consumers. As recently noted in Nation magazine, “Only a government-organized single-payer system can challenge pharmaceutical profiteering and eliminate the huge administrative costs of insurance companies, which compete to limit treatment of seriously ill patients and nickel-and-dime others.” The New York Assembly passed a single payer bill back in 1992.

The Physicians for a National Health Program estimates that a national single payer program would save more than \$200 billion annually. The national staff at PNHP cites studies that show that a single public payer could save the U.S. more than \$350 billion per year. Such a system could have saved New York

\$23.4 billion in 2003. That's more than \$8,000 per uninsured resident, enough to provide high-quality coverage to everyone

Single payer merely means that one entity pays all bills – just like Medicare. Unlike our present health care system, which is increasingly dominated by HMOs, single payer preserves the right of doctors and patients – not insurance clerks – to determine what medical care is provided.

Single-payer refers to one entity acting as administrator, or “payer.” One entity—a government run organization—would collect all health care fees, and pay out all health care costs. Currently, there are tens of thousands of different health care organizations—HMOs, billing agencies, etc. By having so many different payers of health care fees, there is an enormous amount of administrative waste generated in the system.

In a single-payer system, all hospitals, doctors, and other health care providers would bill one entity for their services.

Under single payer, the health care delivery system remains private. The “government” is billed, but doctors remain in private practice. In contrast, a national health service is where the government employs doctors,

All New Yorkers would receive comprehensive medical benefits under single payer – regardless of their employment status or ability to pay. Coverage would include all medically necessary services, including rehabilitative, long-term, and home care; mental health care, prescription drugs, and medical supplies; and preventive and public health measures. Each person would have freedom of choice of doctors and hospitals, unlike our present system where such choices are often dictated by HMOs and insurance clerks. Individuals would receive no bills, and co-payment and deductibles would be eliminated. 90 to 95 percent of people would pay less overall for health care.

Hospital billing would be virtually eliminated. Instead, hospitals would receive an annual lump-sum payment from the government to cover operating expenses—a “global budget.” A separate budget would cover such expenses as hospital expansion, the purchase of technology, marketing, etc.

Doctors would have three options for payment: fee-for-service, salaried positions in hospitals, and salaried positions within group practices or HMOs. Fees would be negotiated between a representative of the fee-for-service practitioners (such as the state medical society) and a state payment board. In most cases, government would serve as administrator, not employer.

One possible financing mechanism is that employers would pay a 7.0 percent payroll tax and employees would pay 2.0 percent, essentially converting premium payments to a health care payroll tax. Existing public expenditures (e.g., Medicaid) would be continued. (The savings of course could allow the state to replace the existing contributions from the counties and NYC.)

Below are some of the rationales for single payer as outlined by Public Citizen.

Single-payer has become increasingly compelling right now, when US businesses are increasingly feeling the pinch of rising health care costs, the number of uninsured continues to rise, the nation is losing its comparative advantage in world markets, hospitals are eager to shed the burden of their “bad debt and charity” pool, and consumers are increasingly baffled by an array of insurers who offer confusion in the guise of ‘choice.’

Publicly financed but privately run health care for all would cost employers far less in taxes than their costs for insurance. Single Payer will enhance the comparative position of the US in the global market. President Bush has repeatedly said that the United States is not reluctant to compete on the international market as long as there is an even playing field. At present, the lack of universal health insurance places the US at a disadvantage vis-à-vis other countries. Companies such as General Motors that have factories in both the US and other countries have learned this lesson well; for example, in 2003 the costs of manufacturing a midsize car in Canada were \$1,400 less than that of manufacturing the identical car in the US, primarily because of much higher health costs in this country.

Single Payer builds on the existing experience. Those who fear that single payer is new and foreign, and therefore untested, need to be reminded that Medicare is, in essence, a single-payer system. For those who are eligible, Medicare is universal and identical, not means-tested, and administered by the government, which acts as a single-payer for hospital and outpatient physician services. Because it did not have to sift and sort the population or cope with a layer of insurers, the rollout of Medicare in 1966 was amazingly smooth. Practically overnight---and without computers--- the program covered services provided by 6,600 hospitals, 250,000 physicians, 1,300 home health agencies, and hundred of nursing homes. By the end of its first year, Medicare had enrolled more than 90% of eligible Americans, a feat that cemented its popularity and redeemed President Johnson's faith in the efficacy of government.

In contrast, Part D of Medicare, which departed from the single-payer model and introduced private insurers, encountered the wrath of consumers who were unable to maneuver the complicated choices required to obtain prescription drug benefits.

Single Payer has significantly lower administrative costs. Studies by both the Congressional Budget Office and the General Accounting Office have repeatedly shown that single-payer universal health care would save significant dollars in administrative costs. As early as 1991, the GAO concluded that if the universal coverage and single-payer features of the Canadian system had been applied in the United States that year, the total savings (then estimated at \$66.9 billion) "would have been more than enough to finance insurance coverage for the millions of American who are currently uninsured."

More recently, estimates published in the International Journal of Health Services conclude that "streamlining administrative overhead to Canadian levels would save approximately \$286 billion in 2002, \$6,940 for each of the 41.2 million Americans who were insured as of 2001. This is substantially more than would be needed to provide full insurance coverage." At present, the US spends 50% to 100% more on administration than countries with single-payer systems.

Single Payer facilitates quality control. Having a single-payer system would create for the United States a comprehensive, accurate, and timely national data base on health service utilization and health outcomes. This would provide information on gaps and disparities or duplication of care, thereby serving as valuable intelligence for decision-making and resource allocation. At present, the closest analogy to this is the Veterans Health Administration (VHA), which has been highly successful in containing costs while providing excellent care. The key to its success is that it is a universal, integrated system: "Because it covers all veterans, the system doesn't need to employ legions of administrative staff to check patients' coverage and demand payment from their insurance companies. Because it's integrated, providing all forms of medical care, it has been able to take the lead in electronic record-keeping and other innovations that reduce costs, ensure effective treatment and help prevent medical errors."

Single Payer gives the government greater leverage to control costs. A single payer would be able to take advantage of economies of scale and exert greater leverage in bargaining with providers, thereby controlling costs. Recent experiences with both the VHA system and that of Medicare Part D indicate the difference exerting such leverage can make. The Department of Veterans Affairs uses its power as a major

purchaser to negotiate prices with pharmaceutical makers. But when the legislation leading to the drug prescription plan (better known as Medicare Part D) was passed, Congress explicitly barred negotiating prices with drug makers. The results of this are now becoming evident: at present, the VA is paying 46% less for the most popular brand-name drugs than the average prices posted by the Medicare plans for the same drugs.

Single Payer promotes greater accountability to the public. One of the key features of the US health care system is its fragmentation. When every player is responsible for only part of the care of part of the population part of the time, there is no overall accountability for how the system functions as whole. Consumers are therefore left wondering who is in charge, and whom they can appeal to when their knowledge is incomplete or their care is inadequate.

The most recent report to Congress of the Medicare Advisory Commission recognizes this: "...perverse payment system incentives, lack of information, and fragmented delivery systems are barriers for full accountability." The creation of a single payer would provide an opportunity for creating a system run by a public trust. Benefits and payments would be decided by the insurer, which would be under the control of a diverse board representing consumers, providers, business and government.

Single Payer fosters transparency in coverage decisions. Single-payer plans have been criticized for "making all sorts of unbearable trade-offs explicit government policy, rather than obscuring them in complexities." Given finite resources, it may not be possible to cover every single treatment, device or pharmaceutical a patient may require or desire. Priorities must be set, and the criteria for these should be transparent and consistently applied.

See also appendix C, Myths about Single Payer.

Why is Our Present Health Care so Expensive and Ineffective?

Other countries have figured out how to provide higher-quality coverage to all their citizens for far less than we spend. Recent studies have detailed how Brits and Canadians have lower rates of nearly every chronic disease and enjoy superior access to care. An exhaustive 2004 study of 21 international health quality indicators in 5 countries found that – despite double the outlay on health care – the U.S. performed noticeably better on only two.

How can the U.S. spend so much more and get so much less? Anyone who has ever had to deal with the nightmarish paperwork of giant insurance companies already knows the answer: it's our reliance on private insurers. Insurance companies stay profitable by keeping those who actually need health care from getting it. To do this, they erect a giant, expensive bureaucracy whose only purpose is to fight claims, issue denials, and screen out the sick. They consume care dollars, but their main output is unnecessary paperwork headaches. It affects everybody: doctors and hospitals must maintain costly staffs just to deal with insurance hassles, and businesses are saddled with the burden of administering their own health benefits. In total, this administrative waste consumes nearly one-third of our health spending.

Research has shown that streamlining payment through a single public payer could save the U.S. more than \$350 billion per year. Such a system could have saved New York \$23.4 billion in 2003. That's more than \$8,000 per uninsured resident, enough to provide high-quality coverage to everyone. Everybody would be covered for all medically necessary services, including doctor, hospital, long-term, mental health, dental and vision care. All prescription drugs would also be covered. Patients would have free choice of doctor and hospital, and physicians would be unleashed from corporate dictates over patient care.

Much hysteria has been printed about alleged “rationing” of care in other nations. The truth is that the U.S. rations care more harshly than any other country. According to the Institute of Medicine’s most conservative data, 18,000 Americans die every year due to lack of insurance. Millions more go without need care due to cost. Now that’s rationing. What’s more, Canadians don’t even wait very long for care. The median wait time for non-emergency, elective surgery was 4.0 weeks in 2005. Service was so fast that in a recent survey only 3.5 percent of Canadians reported feeling they waited too long for care. Considering we spend twice what they do, a U.S. system should be able to eliminate waits entirely.

Our Health Care System Should not be Employer Based

It is an accident of history – the wage controls at the end of WWII – that the US health care system is based on employment. This causes serious problems for workers and businesses. The solution to our health care crisis is to end the connection between employment and health care coverage.

Employer health care mandates are justifiable as corporate accountability. They are not a good comprehensive health care reform.

Employers are not providing healthcare coverage to millions of their employees. 85 percent of those without health coverage are in families with working parents. Seventy percent of uninsured workers are not even offered health coverage by their employers. Of the rest, 84 percent cite the high cost of health insurance premiums as the reason for declining coverage. Only 55 percent of low-wage workers—those earning under \$7 per hour—have access to job-based health care.

A 2003 Commonwealth Fund/Health Research and Educational Trust survey of 576 New York State firms found that, in order to manage rising health costs, employers are increasing the share of the insurance premium that employees pay, delaying the start of benefits, and increasing cost-sharing at the point of service. This has enabled employers to preserve health benefits, but has raised costs for workers and their families. On average, workers' contributions for family coverage rose 54 percent, from \$1,392 per year in 2001 to \$2,148 per year in 2003. During that time period, fewer workers selected family coverage.

Because of gaps in insurance coverage, only 60% of women who ought to have routine mammograms have this potentially life-saving procedure. A recent Kaiser Family Foundation study indicated that 20% of those surveyed skipped or reduced dosage of needed medications because they could not afford prescription drugs. This figure translates into more than twenty millions Americans.

The Massachusetts Model is not Good for NY

Nearly everyone, regardless of ideology, agrees that reform to establish universal coverage is necessary. But the most important question is “how,” and here not all proposals are created equal. Because our current non-system is based on insurance companies whose natural market behavior is to compete to cover healthy people while shunning the sick, proposals which preserve our reliance on them are destined for failure:

- “Individual Mandates” (like the much-celebrated Massachusetts plan) simply force the poor and near-poor to buy overpriced policies that offer grossly inadequate coverage, guaranteeing an epidemic of medical bankruptcies.
- Reforms which force employers to contribute more for coverage just encourage them to cut jobs, wages or other benefits.
- “Consumer-directed” health plans are nothing but a euphemism for substandard coverage, offering families no protection in the event of medical need.

The recent health care expansion in Massachusetts will fail to provide universal health care. Let's not forget a similar announcement twenty years ago just before Governor Dukakis started his run for President. That plan imploded within two years and today there are 250,000 more uninsured residents than when the "breakthrough" was announced.

Once again, the real winners in Massachusetts are those with the most political clout – and campaign contributions. The law ends up providing far more funds to the hospitals and insurance companies than it does to providing health care to the working poor. At best, it will promote the expansion of private health insurance policies that will impose huge deductibles while failing to cover many basic health needs. And Governor Romney, lining up for his own presidential run, vetoed the provision that required employers to make a small annual payment if they failed to cover their workers (he argued the payment was too small to make any difference but opposed a larger payment).

See additional info in Appendix B.

Appendix A - **Universal Health Care would help solve other problems in NY**

Any universal health care system would achieve significant savings across the board – for government, consumers, employers, hospitals. A single payer universal health care system - would save the most money for taxpayers and consumers

A universal health care system eliminates the large cost shifts resulting from providing care to the uninsured

As many as one in three New Yorkers under the age of 65 are uninsured at some point in any one year period. They often end up using hospital emergency rooms to receive treatment.

A universal health care system would help lower local taxes

One of the principal reasons why New York has such high local property taxes is that counties and NYC are required to pay up to 25% of the cost of the Medicaid program. Depending on how a universal health care system was structured, it could significantly relieve the financial burdens on local government to pay for health care. It would also reduce the cost of providing care to their own workers.

A Universal Health Care System would lower automobile insurance rates

New York has the second highest auto insurance premiums in the state. Much of the premiums go to pay for bodily injury. These payments would be substantially eliminated with a universal health care system since everyone's health care costs would already be covered.

A universal health care system would lower Medical Malpractice Costs

A significant portion of any medical malpractice awards goes to ensure that the long-term care needs of the victims. This would be already covered by a universal health care system.

Workers Compensation Costs would be reduced through a universal Health Care system

A significant portion of workers comp awards go to pay for health care costs. This would now be already covered.

A universal health care system would lower school taxes

Like all employers, school districts would see the costs for providing health care to their employees reduced. Health care is often the second biggest expense for schools are salaries.

A Universal health care system would help hospitals

Many hospitals, especially those serving low-income communities, are under severe financial strain due to having to provide emergency room treatment to the uninsured. Universal health care would ensure that hospitals get paid for all such treatment. It would also permit re-instituting regional planning to limit purchase of costly equipment that not every hospital in a region needs to have and would enable pooled purchasing of medical equipment and supplies.

A universal health care system would lower prescription drug costs

Costs would be reduced through a built in bulk-purchasing program

A universal health care system would help doctors

Doctors would see reduced paperwork and could concentrate on providing care to their patients. Doctors have to hire an additional 2.5 staff persons on average to just to deal with the paperwork from private insurance companies.

Appendix B - Massachusetts Health Plan a Poor Choice for New York

Statement by Leonard Rodberg, PhD, NY Metro Chapter of Physicians for a National Health Program. This statement is based on the earlier statement prepared by David Himmelstein and Steffie Woolhandler, on materials from the Mass. Chapter of PNHP (available at www.pnhp.org), and on material prepared by Alan Sager and Debbie Socolar of Boston University's Health Reform Program (www.healthreformprogram.org).

The health insurance package passed by the Massachusetts legislature several days ago has been touted by its advocates as providing “universal health insurance coverage” for the citizens of that state. Some, including William Weld, the former governor of Massachusetts now seeking that position in this state, has proposed the Massachusetts plan as a model for New York. This would be a serious mistake. The Massachusetts plan gives new money to insurance companies and large medical centers, but it will do little for the nearly 750,000 citizens of that state who lack insurance today.

The Massachusetts plan is a cruel hoax. As long as the wasteful and unnecessary private insurance companies are kept in the system, costs will continue to rise and the numbers of uninsured will climb as well.

What's in the New Bill?

The new bill includes three key provisions meant to expand coverage. First, it would modestly expand Medicaid eligibility. Second, it would offer subsidies for the purchase of private coverage to low-income individuals and families, though the size of the subsidies has yet to be determined. Finally, those making more than three times the poverty income (about \$30,000 for a single person) would have to buy their own coverage or pay a fine to the state.

To help make coverage more affordable, a new state agency will connect people with the private insurance plans that sell the coverage, and allow people to use pre-tax dollars to purchase coverage (a tax break that mostly helps affluent tax payers who are in high tax brackets). This new agency is also supposed to help design affordable plans. Businesses that employ more than 10 people and fail to provide health insurance will be assessed a fee (not more than \$295) to help subsidize care. Additionally, hospitals won a rate hike assuring them better payments from state programs.

What's Wrong With This Picture?

The linchpin of the plan is the assumption that uninsured people will be able to find affordable health plans. A typical group policy in Massachusetts costs about \$4500 annually for an individual and more than \$11,000 for family coverage. A wealthy uninsured person could afford that but few of the uninsured can.

The legislation promises that the uninsured will be offered comprehensive, affordable private health plans, but it offers no specifics. The subsidies in the plan are completely inadequate: To cover the cost of health

care for the uninsured, estimated at between \$700 million and \$4 billion each year, the plan provides a mere \$125 million.

The only way to get cheaper plans in this situation will be to strip down the coverage, boost copayments and deductibles, remove services from coverage, etc. Governor Romney has suggested an insurance policy costing \$2400 per year per person (or \$9600 for a family of four) but has offered no details on this proposed policy. In neighboring New Hampshire a policy costing \$2484 is available for a single 30-year-old non-smoking woman and offering the following coverage:

- \$1000 deductible before insurance pays anything
- 20% co-payment on covered services for the next \$5000
- Inpatient mental health capped at \$2500 each year
- Outpatient mental health 50% of charges (including drugs), maximum \$40 per day
- No coverage for routine preventive care, gynecologic exams, or maternity care

Such a plan would not protect people from huge bills if they were to become seriously ill. Hence, the requirement that the uninsured purchase coverage will either require them to pay money they don't have or buy nearly-worthless, stripped-down policies that represent coverage in name only.

Equally important, the legislation will do nothing to contain the skyrocketing costs of care. Indeed, it gives new infusions of cash to hospitals and private insurers. Predictably, continually rising costs will force more and more employers to drop coverage, while state coffers will be drained by the continuing cost increases in Medicaid and the subsidies promised in the reform legislation. This program is simply not sustainable over the long or even medium term.

Appendix C - Some Myths About Single Payer

Myth: The government would dictate how physicians practice medicine.

In countries with a national health insurance system, physicians are rarely questioned about their medical practices (and usually only in cases of expected fraud). Compare it to today's system, where doctors routinely have to ask an insurance company permission to perform procedures, prescribe certain medications, or run certain tests to help their patients.

Myth: Waits for services would be extremely long.

In countries with NHI, urgent care is always provided immediately. Other countries do experience some waits for elective procedures (like cataract removal), but maintaining the US's same level of health expenditures (twice as much as the next-highest country), waits would be much shorter or even non-existent.

There would be no lines under a universal health care system in the United States because we have about a 30% oversupply of medical equipment and surgeons, whereas demand would increase about 15%

Myth: People will overutilize the system.

Most estimates do indicate that there would be some increased utilization of the system (mostly from the 42 million people that are currently uninsured and therefore not receiving adequate health care), however the staggering savings from a single-payer system would easily compensate for this. (And remember, doctors still control most health care utilization. Patients don't receive prescriptions or tests because they want them; they receive them because their doctors have deemed them appropriate.)

Myth: Government programs are wasteful and inefficient.

Some are better than others, just as some businesses are better than others. Just to name a few of the most successful and helpful: the National Institutes of Health, the Centers for Disease Control, and Social Security. Even consider Medicare, the government program for the elderly; its overhead is approximately 3%, while in private insurance companies, overhead and profits add up to 15-25%.

Myth: Universal Health Care Would Be Too Expensive

The United States spends at least 40% more per capita on health care than any other industrialized country with universal health care. Federal studies by the Congressional Budget Office and the General Accounting office show that single payer universal health care would save 100 to 200 Billion dollars per year despite covering all the uninsured and increasing health care benefits. The United States spends 50 to 100% more on administration than single payer systems. By lowering these administrative costs the United States would have the ability to provide universal health care, without managed care, increase benefits and still save money

Myth: A single payer system Would Result In Government Control And Intrusion Into Health Care Resulting In Loss Of Freedom Of Choice

There would be free choice of health care providers under a single payer universal health care system, unlike our current managed care system in which people are forced to see providers on the insurer's panel to obtain medical benefits. There would be no management of care under a single payer system unlike the current managed care system which mandates insurer preapproval for services thus undercutting patient confidentiality and taking health care decisions away from the health care provider and consumer

Myth: Universal Health Care Is Socialized Medicine And Would Be Unacceptable To The Public

Single payer universal health care is not socialized medicine. It is health care payment system, not a health care delivery system. Health care providers would be in fee for service practice, and would not be employees of the government, which would be socialized medicine. Repeated national and state polls have shown that between 60 and 75% of Americans would like a publicly financed, universal health care system

Myth: The Problems With The US Health Care System Are Being Solved and Are Best Solved By Private Corporate Managed Care Medicine because they are the most efficient

Private for profit corporation are the least efficient deliverer of health care. They spend between 20 and 30% of premiums on administration and profits. The public sector is the most efficient. Medicare spends 3% on administration. The same procedure in the same hospital the year after conversion from not-for profit to for-profit costs in between 20 to 35% more. Health care costs in the United States grew more in the United States under managed care in 1990 to 1996 than any other industrialized nation with single payer universal health care. 80% of citizens and 71% of doctors believe that managed care has caused quality of care to be compromised.