

**Testimony of the Hunger Action Network of New York State to the
Joint Hearing of the Senate Finance Committee and Assembly Ways and Means
Committee on the Health Department Budget
Monday, Feb. 2, 2009**

My name is Mark Dunlea and I am Executive Director of the Hunger Action Network of New York State.

The Hunger Action Network helps coordinate the Empire State Economic Security Campaign, which represents more than 200 human service, labor and faith groups. We have attached the health care positions for ES2 for 2009 as attachment 1. We are member of Medicaid Matters New York and support their positions.

Hunger Action helps coordinate Single Payer New York. We support the immediate enactment of a single payer universal health care system – at either the state (S3107 / A7354 in 2008) or national level (HR 676) - that makes quality health care a right for all New Yorkers.

Access to quality, affordable health care is one of the main problems confronting low-income New Yorkers. Many of the 2 million New Yorkers who use emergency food programs annually do so because they have medical bills they are unable to pay. High medical bills remain the single largest reason for bankruptcies in New York State.

We support the proposed \$4.4 million increase in funding for the Hunger Prevention and Nutrition Assistance Program to increase state funding for emergency food programs. We would support an additional increase. The NYC Coalition Against Hunger's annual survey found nearly a 30% increase in the number of people assisted by emergency food programs over the last year; similar increases have been reported statewide. More than 2 million New Yorkers annually receive help from food pantries and soup kitchens. We support dedicating more funding to helping to increase the amount of fresh fruits and vegetables and other foods with high nutritional value through the emergency food program network. We believe that food pantries and soup kitchens should be given a greater role in determining how these funds are spent; presently the NYS DOH listens almost exclusively to the regional Food Banks, which play a critical role in assisting emergency food programs but which do not themselves directly feed hungry New Yorkers.

We support the initiative started under Governor Spitzer to design a state health care system which puts patients first. We understand the critical role that hospitals play in providing health care to New Yorkers but we agree with the administration that Medicaid should not be utilized to enable hospitals to provide subsidies to the private

for profit health insurance companies. The delivery of care to patients is what should drive the state's health care expenditures. At the same times, cuts should be targeted to particular programs to reflect these policy initiatives, not just across the board cuts in hospital funding. We also concerned about cuts to home care. The cuts would result in less access to care for Medicaid beneficiaries who receive care and services in their homes. New York State is overly reliant on institutional sites of care. Home- and community-based services, which are preferred by consumers and are less costly to provide, have been inadequately funded.

We support shifting much-needed Medicaid dollars away from hospitals and toward front-line community care, greatly expanding access to health care for New York's neediest. We support the State's proposals to increase investments in additional ambulatory care to augment hospital, community, mental hygiene and substance abuse clinic rates and support other primary care enhancements. We support the proposal by the Governor to expand Family Health Plus eligibility for adults from 150 percent of the federal poverty level to 200 percent. We support the Governor's proposals – and would go further – to ease enrollment in FHP and CHP through eliminating requirements to conduct face-to-face interviews, finger imaging, and asset tests.

On a related note, we hope that the State legislature will pass the legislation to increase the medical care ratio for insurance companies so that a higher percentage of insurance premiums go to pay for health care services. In addition, we support going back to the system of prior approval of insurance rate hikes.

We also support expanding the state's efforts to save money by increasing the bulk purchasing of prescription drugs. We support entering into cooperative relationships with neighboring states as well as allowing as many organizations, employers and individuals to participate as possible since the larger the pool the bigger the discounts we can obtain and the more money will be saved.

We applaud the Governor for including a ban on pharmaceutical gifts to doctors in his budget proposal. Banning gifts from drug companies to doctors and requiring doctors to publicly disclose any financial relationship with drug companies when conducting seminars could lead to more independent prescribing patterns by physicians. Currently, doctors are pushed into prescribing high-cost, brand name drugs when equally effective, less expensive versions may be available.

We are disappointed that this year's budget lacks any proposals related to universal health care, particularly a single payer system to eliminate the waste, costs and bureaucracy of private for profit health insurance. The State Health and Insurance Departments are now a year late in completing the universal health care studies that the legislature funded at the request of Hunger Action Network and the NY Universal Health Care Options Campaign. At the end we have attached a statement of principles developed through the campaign, which represented more than 250 community, labor, health care and faith organizations. We believe that these principles should be the minimal requirements for any universal health care system. The campaign itself did not expressly endorse single payer, though that was the position of a majority of the groups, including Hunger Action. (We have attached a copy of the principles at the end, along with an op ed about why incremental approaches to universal health care has repeatedly failed in every state that has taken such an approach.)

In addition to the delay, we are concerned that statements made against single payer health care by the Urban Institute, who has been hired to do the studies, raises questions about their objectivity. Single payer advocates have raised a number of concerns about how UI has structured their review of a single payer proposal, starting with their unwillingness to include all residents in such a system. Their failure to do so will significantly understate the potential savings from a single payer system.

With the economy in recession and the state facing a massive budget deficit, a single payer health care for all system is the type of stimulus that we need, lower health care costs for taxpayers, employers and individuals, improving access to quality health care, and creating new jobs. A single payer universal health care would be a strong economic incentive for employers and jobs to relocate to New York. Instead we will continue to spend

far too much money – soon to be one fifth of the gross domestic product – to a health care delivery system that performs far more poorly than other industrial counties.

We were also surprised recently to see that rather than providing additional funds as requested for the studies sponsored by the legislature, the NY Health Foundation funded its own studies of the same proposals. The authors of these studies acknowledged that their studies were far less accurate than the state funded studies since they were unable to model individual behavior. So why were public funds wasted on these studies? The NY Health Foundation was created from 5% of the proceeds from the conversion of Blue Shield to a for profit insurance company; we believe that far more of the proceeds should have remained in the nonprofit sector. Similar foundations created in California and Connecticut out of the same process have developed a reputation for supporting progressive approaches to health care reform, including universal health care. We urge the legislature to work with the Governor to reform the NY Health Foundation. The public interest is not presently being served by them.

We oppose the cuts in funding to the Nutrition Outreach and Education Program which helps community based organizations assist households in applying for food stamps.

We oppose the conversion of GHI and HIP into a for-profit insurance company. The president of the Medical Society of the State of New York testified last year that the conversion of the GHI-HIP insurance company would have a negative impact on patient care and payments to physicians. Dr. Robert Goldberg cited examples of previous conversions that resulted in reduced care for patients and reduced fees for providers - despite increased premiums for patients and businesses - so that the companies could generate "enormous profits" for their shareholders. Non-profit status places a cap on administrative spending at 15% of the overall budget, provides oversight on premium increases and restricts access to funding from financial markets (thereby insuring that the overall goal of the company is the provision of healthcare and not the accumulation of profits).

We support the Governor's anti-obesity initiatives, including the soda tax

Governor Paterson has proposed a major anti-obesity initiative to impose a sales tax of 18% sales tax on sugary sodas and juice drinks in order to reduce consumption. He has also made proposals on junk food in schools, calorie-labeling and a ban on trans fats. We support these proposals (including the Healthy Schools Act), though we believe that long term a significant percentage of the tax proceeds should be earmarked for nutrition, anti-obesity or food policy initiatives.

Elie Ward of the American Academy of Pediatrics in New York said that "soda and other sugar-sweetened drinks are the leading single contributor to obesity. Raising the price of this liquid candy will put children and teens on a path to a healthier diet."

Nearly 25 percent of New York's children and 67 percent of adults are overweight or obese, costing \$6.1 billion a year to treat diabetes, heart disease and other obesity-related problems, according to the New York State Healthy Eating and Physical Activity Alliance. One can of soda has the equivalent of 10 teaspoons of sugar. Sugar sweetened beverages are the single leading contributor to obesity and obesity is a leading contributor to disease. Obesity increases the risk of diabetes, heart disease, high blood pressure, stroke, and even cancer which trigger billions of dollars in medical costs each year in New York State.

The anti-obesity initiatives will improve the public's health and help to address the climbing health-care costs. One of every five calories in the American diet is liquid. The nation's single biggest "food" is soda.

Instituting a soda tax is equivalent to the effort in recent decades to stop smoking by hiking the taxes on cigarettes. “Soft drinks are linked to diabetes and obesity in the way that tobacco is to lung cancer,” says Barry Popkin, a nutrition specialist at the University of North Carolina.

One new study estimates that 24 million Americans now have diabetes, more than four times the number in 1980. The total direct and indirect cost to Americans is \$218 billion each year — an average of \$1,900 per American household. Each year, [diabetes contributes](#) to the deaths of more than 200,000 Americans. Part of the solution must come from reforming agriculture so that we stop subsidizing corn that ends up as high fructose corn syrup inside soft drinks.

We support the positions of the StateWide Senior Action with Respect to Protecting the EPIC Program

PROTECT ACCESS TO VITAL PRESCRIPTION DRUGS FOR SENIORS and PEOPLE WITH DISABILITIES

When the Medicare Part D Prescription Drug benefit began in 2006, New York State was a national leader in protecting its most vulnerable seniors and people with disabilities from the huge gaps in Part D coverage. While we applaud New York’s EPIC program for continuing to cover drugs in the Part D “donut hole,” and the Governor’s proposals to protect lower income EPIC members, we oppose elimination of “wrap around” coverage by EPIC and Medicaid when a Part D plan refuses to cover a particular brand-name drug.

Keep Wrap-Around Coverage in Medicaid and EPIC:

- “Dual eligibles” – Poor elderly or disabled persons who have both Medicare and Medicaid must obtain all their medications from a Medicare Part D drug plan. New York must not eliminate the safety net that has, until now, ensured that Medicaid will cover prescriptions just in the following four categories if a Part D plan refuses to cover it: atypical anti-psychotics, anti-depressants, anti-retrovirals used in the treatment of HIV/AIDS, or anti-rejection drugs used for the treatment of organ and tissue transplants. Under federal rules, Part D plans must cover “substantially all” of drugs in these categories anyway. To deny Medicaid for the few medications that fall between the cracks will cause severe medical harm to the most vulnerable people.
 - *REJECT § 42 of the Article VII bill (S 58/A 158)*
- EPIC Wrap -- We support the State’s strong interest in making sure that federal Medicare dollars pay for prescriptions for EPIC members who have Medicare. For that reason, we have not opposed the mandate that all EPIC members who are eligible join a Medicare Part D plan. However, Part D plans are notorious for refusing to pay for brand name drugs they choose not to include on their drug formularies. Last year, New York wisely enacted legislation that required pharmacists to make every effort to work with the EPIC member’s physician to switch to a drug covered by the Part D plan. If this was not possible, the legislation required the EPIC program to pay for the drug while it pursued an appeal seeking coverage. This procedure, just implemented in September 2008, should be given a chance to work and save money. Instead, the Governor proposes simply to *stop* all EPIC coverage for drugs not covered by Part D plans.

DON’T CUT FUNDING OF COMMUNITY-BASED ORGANIZATIONS THAT ASSIST SENIORS and PEOPLE WITH DISABILITIES IN ACCESSING PRESCRIPTION DRUGS THROUGH MEDICARE PART D and RELATED PROGRAMS

Unlike “regular” Medicare, a Medicare beneficiary cannot just bring her Medicare card to the pharmacy to pay for prescription drugs. In order to have drug coverage, Medicare beneficiaries must choose from 61 “stand-

alone” Part D plans and hundreds of “Medicare Advantage” HMO plans, and enroll in a plan in the short six-week annual enrollment period. Choosing a plan requires sophisticated analysis and expertise – the use of an on-line database to identify which plans cover the senior’s particular drugs without onerous “utilization review” criteria that limit access to certain drugs, and comparison of the varied fee structures of the plans – each have different monthly premiums, annual deductibles, and copayment tiers.

Funding for Medicare counseling was already cut 8% during the current Fiscal Year in across-the board state cuts. Now the Governor proposes to cut 50% more in the Appropriations Bill S.54 A.154, pp. 8, 13. The same bill will allocate an additional \$2 million for assistance to EPIC members, but we understand that \$1.5 million of this will go to the county offices on aging. This still leaves substantial cuts for community-based organizations.

EXTEND EPIC TO PEOPLE WITH DISABILITIES UNDER AGE 65 –

Since Medicare Part D has saved New York tens of millions each year by reducing State drug costs, (exact figure?) the State must use some of the savings to extend EPIC coverage to those individuals who are under age 65 who are disabled but don’t yet have Medicare (because of the 24-month waiting period), or who have Medicare and need EPIC during the “donut hole” and other gaps in Part D. Each week we counsel people under age 65 who are forced to forgo taking vital prescriptions for cancer, diabetes, mental illness, heart impairments, etc. because they do not qualify for Medicaid, yet cannot afford these prescriptions.

SUPPORT PROPOSED PROTECTIONS FOR LOW-INCOME EPIC MEMBERS –

- Authorize EPIC to apply for the “Medicare Savings Program” for low income EPIC members. This program is a win-win; an EPIC member approved for the “Medicare Savings Program” automatically qualifies for the full Low Income Subsidy [LIS] for Part D. This saves both the EPIC member and the EPIC program money – there is no deductible or “doughnut hole” for people with the full LIS, so EPIC need not pay for the EPIC member’s drugs during that period. Also, EPIC’s share of the Part D copayment is reduced with the subsidy. As a bonus, the EPIC member saves \$96.40/month, since the Medicaid program picks up the cost of their Medicare Part B premium.

Support § 106 and 112 of the Article VII bill

- Eliminate the annual EPIC fee for members with incomes up to 150 percent of the federal poverty level (FPL), or up to \$1300/month (singles) \$1750/mo (couples). Current fees for these seniors are \$8 to \$194 per year. Until now, EPIC waived the fee only for those with incomes below 135% FPL who had the full Low Income Subsidy.

Support § 109 of the Article VII bill

- Reduce the maximum co-payment for all members in the EPIC Fee Plan to \$15, instead of \$20. EPIC Deductible Plan enrollees will continue to pay current co-payments. This will help the lower income EPIC members, with incomes up to \$20,000/year (singles), \$26,000/year (couples).

Support § 109 of the Article VII bill

SUPPORT OTHER IMPROVEMENTS IN EPIC:

- Allow use of out-of-state mail-order pharmacies that contract with Part D plans. This will allow EPIC members to use the same pharmacy year-round, and to use copayments paid to the out-of-state pharmacy to meet their EPIC deductible, which they could not do before.

Support § 110-111 of the Article VII bill

- Allow the EPIC Panel to establish criteria to disregard certain non-recurring income items when determining EPIC eligibility, to avoid delays in or unfair denials of EPIC eligibility, such as last year

earnings of new retirees, and one-time IRA withdrawals used to meet large medical or living expenses
Support § 104 of the Article VII bill

Continue Efforts to Reform Medicaid, Including Making it Easier to Apply

As noted earlier, we support the general positions of Medicaid Matters New York.

The hospital-centric orientation of our state's health care system denies resources to front-line providers of community-based services that are better positioned to meet the primary and preventive care needs of Medicaid beneficiaries. The creation of the Ambulatory Payment Groups (APGs) methodology was a step toward strengthening the community-based health care infrastructure. New York must continue to reform the way Medicaid pays for care and services to ensure the best health care in the most appropriate and cost-effective setting. Hunger Action joins with consumers and providers across the state to assure adequate funding for community-based services.

We applaud the state's attempt through Doctors Across NY to get health care practitioners to the underserved areas of the state, both urban and rural, and rewarding those providers who practice in needy areas and maintain hours on nights and weekends. We encourage the state to increase funding for this program to sustain it beyond the first year. Additionally, Doctors Across NY should be expanded to include additional providers, such as mid-level practitioners, dentists, and mental health providers.

We support strengthening long-term care services to allow people to live in their homes and remain in their communities. The state must direct resources toward lower-cost, higher-satisfaction home-and community-based long-term care and independent living services. As the state has committed to reforming Medicaid to better provide for the health needs of New Yorkers in a more prudent way, the commitment to reforming long-term care has been unclear.

To achieve a long-term care system that works for those who need it, the state must: Continue DOH funding for housing programs to support deinstitutionalization, such as the Nursing Facility Transition and Diversion Medicaid waiver program; Recognize the need for personal care assistance and consumer-directed services; Provide for chronic care coordination, including adequate transition planning; Eliminate county-to-county disparities in what is provided by Medicaid; and Emphasize the commitment to provide care and services in the most-integrated setting.

Oppose Proposal on Prospective Drug Utilization Review for Anti-Psychotics

We agree with the National Alliance for the Mentally Ill of New York State on this issue.

This new provision will stop pharmacists from filling prescriptions ordered by physicians if the prescription does not meet standards developed by the Office of Mental Health. We strongly oppose this initiative.

We are in favor of retroactive drug utilization review which is how the Office of Mental Health is using their standards. When OMH sees that a physician is prescribing more anti-psychotics than the standard, they inform the physician. This is done through their electronic PSYCHES system. We have no problem with this methodology of changing physician practices. However, when doing this prospectively which is proposed, the patient is punished while they wait for a response from the physician.

The Department of Health will tell you they do this with other drugs. However, antipsychotics are not like other drugs. Stopping an anti-psychotic until a doctor can be contacted when a prescription cannot be filled, could cause hallucinations to return causing great harm to a mentally ill patient. The patient could end up in the emergency room or hospital as a result.

Oppose Expanding Medicaid Preferred Drug List to Include Antidepressants

This provision is included in the Deficit Reduction Plan, but the Governor lists NO savings associated for it for the current year. Please reject this proposal.

New York's Medicaid program currently employs a Preferred Drug List (PDL) for certain medications. If a physician wants to prescribe a non-preferred drug, Medicaid reimbursement is denied unless prior authorization is obtained. Currently, antidepressants are exempt from the Preferred Drug List.

Antidepressants are used for a broad range of illnesses, often in combination with other medications. The narrowing of therapeutic options could cause serious consequences for patients and their families, including the discontinuation of therapy, more hospitalizations and suicides.

To say medications are equivalent, according to the National Institute of Mental Health, is not to say they are identical. People have unique responses to psychiatric medications and need more, not fewer, choices. Persons of various heritages, particularly African, Asian and Hispanic, may be affected by genetic differences in drug metabolism that can lead to severe side effects. Options in treatment are critical.

Although Governor Paterson says there are no savings this year and \$3.3 million next year, this latter number does not include all the costs associated with the unintended consequences of switching the medications of thousands of persons with serious mental illness. It is likely that the costs will far exceed the predicted savings. What will happen when the medications of thousands, who have been stabilized on medication regimens that have taken many months or years of trials, changes? According to a May 2007 study published in the American Journal of Psychiatry, almost 20% of patients required an emergency room visit when psychiatric medications were switched. In addition, 11% of patients required hospitalizations.

Why A Single Payer Health Care System Makes the Most Sense for NY – And the Country

America deserve the health benefits offered to the people of every other country in the industrialized world—all medically necessary care and freedom from the fear of economic ruin due to illness. The bottom line is that single payer is the one proposal that guarantees quality, affordable health care to every American. This would also be a great benefit to our economy in our time of crisis, helping to control costs for taxpayers, consumers and employers.

Single payer merely means that one program pays all bills, like Medicare does for senior citizens. It eliminates the paperwork, high administrative costs and profits of the for profit private insurance system. An article in the New England Journal of Medicine concluded the single payer approach would save \$350 billion a year in costs; somewhat smaller savings estimates have been made by the Congressional Budget Office. A study done for the State of California estimated that a state single payer plan would reduce health costs by \$38 billion annually over a ten year period.

In the NYS legislature, 85 members of the State Assembly have sponsored single payer (A7354) and 15 Democratic members of the State Senate (S3107). The Assembly also passed a resolution this year in support of HR 676. Sen. Breslin sponsored a similar resolution in the state Senate but that was not voted upon.

A recent national survey by Indiana University of 2,193 doctors found almost 60% in favor of national health insurance (NHI) -- a 10 percent increase in support since 2002. A March 2007 poll by CBS/ NY Times found that 64 percent of respondents said the government should guarantee health insurance for all; 27 percent said it

should not. An overwhelming majority in the poll said the health care system needed fundamental change or total reorganization.

“America’s health care system is in deep trouble. Nearly 50 million Americans are currently without health insurance, more than 75 million went without insurance for some length of time within the past two years, and tens of millions more have inadequate coverage. More than 18,000 Americans die annually due to a lack of insurance,” stated Mark Dunlea, Executive Director of the Hunger Action Network of NYS. A 2008 study published in the journal *Health Affairs* concluded that as many as 101,000 deaths a year could be prevented by ensuring that all patients receive quality care in a timely manner.

The U. S. spends 16% of gross domestic product (GDP) on health care (\$7,129 per capita), twice what any other industrialized nation spends, yet ranks 37th in performance according to the World Health Organization. We lag behind other industrialized countries in life expectancy and infant mortality. Health care bills cause over 50% of bankruptcies — and three out of four of those bankrupted by medical bills had health insurance.

The reason the US spends more and gets less than the rest of the world is because we have a patchwork system of for-profit payers. Private insurers necessarily waste health dollars on things that have nothing to do with care: overhead, underwriting, billing, sales and marketing departments as well as huge profits and exorbitant executive pay. Doctors and hospitals must maintain costly administrative staffs to deal with the bureaucracy. Combined, this needless administration consumes one-third (31 percent) of Americans’ health dollars.

We’ve done many experiments tweaking private health insurance. It doesn’t work. Two decades of state level reform efforts have demonstrated that mandate plans don’t reduce costs or the number of uninsured. They add bureaucracy and regulation, not healthcare value. We’ve done an experiment with national health insurance. It works. Medicare is not perfect, but Americans with Medicare are happier with their insurance than those with private insurance. Doctors have less hassle getting paid by Medicare than by private insurers

We can’t afford to include bloated administrative overhead and profit in universal coverage. Administrative costs in the for-profit health insurance system consume nearly one-third of our health care spending. We will never have enough money to provide everyone with decent care until we eliminate private insurance, the main source of waste and inadequate coverage. Single payer reduces administrative costs and provides an infrastructure to support chronic disease management, an emphasis on primary care and the use of electronic medical records. The fragmented private insurance system created the perverse incentives which have set us so far behind other countries in these areas. Mandate proposals like Massachusetts preserve the fragmentation.

Among the dozens of groups helping to create Single Payer New York are: New York State Nurses Association, Troy Area Labor Council, Capital District Area Labor Federation, AFL-CIO, Hunger Action Network of New York State, Tompkins County Health Care Task Force, Capital District Alliance for Universal Health Care, Health Care-NOW, Albany Presbytery, various chapters of the Physicians for a National Health Program, League of Women Voters of Saratoga County, Long Island Coalition for a National Health Plan, Rochester Interfaith Health Care Coalition, Green Party of NYS, and New York StateWide Senior Action.

Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, long-term care, mental health, dental, vision, prescription drug and medical supply costs. Patients would regain free choice of doctor and hospital, and doctors would regain autonomy over patient care.

Physicians would be paid fee-for-service according to a negotiated formulary or receive salary from a hospital or nonprofit HMO / group practice. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards.

A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and business. Costs would be controlled through negotiated fees, global budgeting and bulk purchasing.

Attachment 1 – Empire State Economic Security Campaign

AFFORDABLE AND COMPREHENSIVE UNIVERSAL HEALTH CARE COVERAGE

The Challenge

The rising cost of health care is a major concern for all segments of New York. Inadequate coverage, even among persons who are insured, has become a major cause of personal bankruptcies. Medicaid expenditures now represent almost half of the state budget, if we include the federal share.

Even as NY has made progress in increasing enrollment in the various public health benefit programs, the huge numbers of New Yorkers without health insurance—almost one in three in a twelve-month period—are a major factor in our health care costs and in the financial problems facing many hospitals. High health care costs are a major reason in why we have such high auto insurance and worker comp rates in our state.

It is estimated that a single payer national health care program could save as much as \$350 billion a year (New England Journal of Medicine, 2003) by eliminating the system of private health insurance. As much as a third of every health care dollar going through private health insurance goes to pay for their overhead, profits, marketing costs and excessive CEO salaries. Doctors on average have to hire 2.5 staff people just to deal with the conflicting paperwork, rules and bureaucracy of private health insurance.

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. Our overall quality is only ranked 37th by the World Health Organization. US spending on health care is now over 2.1 trillion dollars – nearly \$7,000 per person. This is more than the double the world average of \$2,571. This amounts to 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. Increases in health care costs thwart job growth, suppress increases for current workers, weaken the viability of pension funds, and depress the quality of jobs.

We are the only industrialized country to allow for-profit insurance companies to be middlemen in our health system. In their drive to enroll healthy (and profitable) patients and screen out the sick, private insurance wastes vast sum on billing, marketing, underwriting, utilization review and other activities that enhance profits but divert resources from care and hassle patients and physicians

In 2007, state lawmakers agreed to our proposal to fund a series of cost-benefit studies on the various ways New York could provide health care to all. A single payer system will be one of the approaches studied. Former Governor Eliot Spitzer subsequently appointed a Task Force to oversee the studies, hold public hearings and develop a recommendation for a universal health care system by May 2008. The studies have been delayed. It is expected that the Urban Institute will complete the studies in the fall of 2008. In addition, there is significant interest in universal health care at the national level in the 2008 elections.

During the last two years, former Governor Spitzer correctly pushed to overhaul the state's Medicaid financing to focus more on providing care to patients rather than continuing historical funding patterns that were both obsolete and a reflection of the power of hospitals and others to obtain funding to support their operations. While some progress was made, in most cases the agreements were to phase in new funding patterns over a number of years, raising the potential for this to be revisited.

What the Public Thinks

Public opinion polls have consistently shown strong public support for a universal health care system. For instance, a March 2007 poll by CBS/ NY Times found that 64 percent of the respondents said the government should guarantee health insurance for all; 27 percent said it should not. An overwhelming majority in the poll said the health care system needed fundamental change or total reorganization.

A recent national survey by Indiana University of 2,193 doctors found a solid majority, almost 60 percent, supporting government legislation to establish national health insurance (NHI)—a 10 percent increase in support since 2002. Many labor, community and faith groups have endorsed single payer, including NYS AFL-CIO, Physicians for a National Health Program, NYS State Nurses Association, NYS Academy of Family Physicians, Healthcare Now, Presbyterian Church USA, United Auto Workers and League of Women Voters of NYS.

ES2 Policy Recommendations

ES2 supports a universal health care system to provide quality, comprehensive health care service to all New Yorkers. The most common sense solution is a single payer financing system, similar to Medicare for All. (A7354/S3107) This system, used by almost all of the other industrial countries, eliminates the huge waste and paperwork of the private health insurance system.

While the Governor’s Task Force has taken important steps to provide transparency to the study process, concerns remain that both health officials within the Paterson administration and the Urban Institute are biased against single payer, preferring an incremental approach based on increasing enrollment in existing programs and adopting a Massachusetts style mandate for individuals to purchase health insurance if they do not receive it from work or the government.

Whatever universal health care system that is adopted by New York should lower rather than increase costs; administrative overhead should be reduced to less than 10% and a single form for doctor reimbursement should be instituted. Patients’ care, not profits, should be the focus of our health care system. The health care system should be paid for in an equitable way: those with higher incomes should pay a higher proportion of their incomes than those with less. We define universal health care coverage to mean that 100% of residents are covered; requiring even modest premiums and co-pays will prevent many moderate income families from accessing health care.

The 2009-2010 Session

We hope that Governor Paterson will continue the effort to make the delivery of health care to patients the primary focus of state spending. We support placing a greater priority – and funding – into primary care. This includes expanding second year funding for the Doctors Across New York initiative to attract more doctors and other health care providers to underserved areas. DANY should also be expanded to include non-physician providers as well as dental and mental health.

ES2 endorses the positions of Medicaid Matters NY

We support making it easier for consumers to access the Medicaid program, including:

- eliminating the asset test and finger imaging
- electronic submission of applications and renewals
- simplifying enrollment in the Medically Needy program
- expanding eligibility for adults to up to 250% of poverty

MMNY also supports expanding eligibility to EPIC for those with disabilities and putting a cap on dual eligibles’ Medicare Part D Co-Pays. For long term care, NYSDOH should continue funding for housing programs to support deinstitutionalization; emphasize need for personal care assistance and consumer-directed services; increase chronic care coordination, including adequate transition planning; and elimination of county-

to-county disparities.

Reduce Insurance Administrative Costs and Profits. (A7485/S2740) Private insurance has an extremely negative impact upon health care costs and delivery of services. As a short-term step, New York should require prior approval of insurance premium increases. State laws and regulations governing care-share (called “medical loss ratio” in statute and regulations) need to be strengthened and enforced. A7485/S2740 would increase the minimum loss ratio to around 5% to 90% for individual direct payment contracts, and to 85% for small group and small group remittance contracts.

Ban Gifts to Physicians by Drug Companies. Gifts by the pharmaceutical industry are distorting medical decision making and raising costs by giving preference to medicines that may be quite expensive. State legislation in Minnesota has prohibited such gifts over the value of \$50.

Expand Bulk Purchasing of Prescription drugs. We support the further expansion of the bulk purchasing of prescription drugs to reduce costs.

Mental Health Parity. The provisions of Timothy’s Law for coverage to mental health illnesses should be expanded to the state’s FHP and CHP programs.

Children Environmental Health Centers. \$2.05 Million in funding is needed for the Centers. 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.

Attachment 2 - New York Universal Health Care Options Campaign Principles for a Universal Health Care System in New York State

The following principles speak to major concerns and needs of consumers, providers and payers.

1. Health care is a human right. Government must assure that this right is realized. Markets alone cannot.
2. Universality. Universal health care means 100% of the residents have easy access to health care. This means no payments as a pre-condition to receive health care. Equality of access to quality health care should be independent of employment status, gender, sexual orientation, class, race, ethnicity, language, culture, geography, and immigration status.
3. Comprehensiveness. All necessary care, including primary and preventive care, should be covered. As in other countries with advanced industrial economies, care should include mental health, dental, hearing and vision services, rehabilitation, home care, hospice care, and long term care. Services and programs to prevent disease and promote patient wellness and population health must be a major focus of the health delivery system. The system should strive to eliminate health disparities among various communities.
4. Choice a) Consumers have the right to choose any licensed health care providers as their care givers.
 - b) No systemic reform should take away the right of any group to keep their existing coverage if they prefer it.

5. Access. Access to health care needs to be clear and simple, with clarity about scope of coverage. Patients should be free from administrative and logistical obstacles to getting care.

6. Sustainable costs. Overall health care costs must be lowered from present high levels to levels that are sustainable, for consumers and all payers, public and private.

a.) Administrative costs of our health care system must be reduced to the level in existing public health care programs (that is, 3 to 7%) rather than the 20 to 35% levels common in the present private health care system.

b.) Waste, paperwork, and inefficiency throughout the medical care system need to be reduced and integrated electronic record systems introduced.

c.) The system for paying providers should encourage them to deliver the full range of services that are effective in preventing and treating illness and injuries and improving health, but should discourage delivery of other services.

d.) While the role of profit in the health care system should probably be eliminated, at a minimum it must be significantly reduced and carefully regulated.

7. Financing. The health care system should be paid for in an equitable way: those with higher incomes should pay a higher proportion of their incomes than those with less.

8. Working Conditions. Providers and caregivers' work should be organized so that they can serve their patients to the best of their abilities

9. Provider Incomes. All health care workers' incomes should support a decent standard of living. Medical and allied professionals are entitled to a standard of living consistent with their education, training and responsibilities. Payment should be timely.

10. Encouraging Provider Responsiveness to New York's Needs

a.) Individual debt for the education of doctors and other health care providers must be substantially reduced.

b.) The burden on providers resulting from the way we try to protect the public from malpractice must be reduced.

c.) There should be incentives (rather than the present financial disincentive) to encourage an adequate distribution of medical professionals, both geographically, in relation to local needs, and among primary care and the several specialties.

11. Public Accountability and Transparency. To become more responsive to individual, family and community needs, the system must enable patients, providers, and communities to provide input. Its leaders and managers must be accountable to the communities it serves. The system's policies and rules – and the way they are made – must be transparent.

Attachment 3 - Can Incrementalism Be the Path to Universal Health Care?

By Mark Dunlea, Hunger Action Network of NYS

Governor Spitzer and state lawmakers seek an evidence-based plan that will bring comprehensive health care to all of the people of New York State, a result that almost everyone would like to see.

Unfortunately, the Spitzer administration, along with many health care reformers, continually assert, without providing any evidence, that the best way to universal health care is a series of incremental steps that build upon

existing programs to bring targeted populations of the uninsured into the “health care” system.

Incrementalists argue that the public opinion polls showing overwhelming public support - not just for a comprehensive government universal health care financing system but also for radical reform - are misleading. They contend that if one digs deeper, one finds that those with health insurance (“those who actually vote”) would rather keep the shrinking (and often already inadequate) coverage they have than see the entire system changed. They murmur that it is not “politically feasible” for our leaders to stand up to the power of the private health insurance industry and big pharma. They redefine the public’s desire for choice in doctors to hospitals to instead be choice among which insurance company to contract with. They confuse access to comprehensive health care with expanding health insurance.

Yet the experience in the various states that have tried a variety of “incremental approaches” objectively shows that it will not work. “Bold, new experiments in moving our state to universal health care” have invariably withered away over time, often in only a few years.

For instance, the media coverage over the new “universal” health care system in Massachusetts generally failed to mention similar pronouncements from Governor Dukakis two decades previously that fell apart in a few years. Because Massachusetts expanded its subsidies for insurance premiums for low-income people, over 160,000 of those eligible signed up this year. But only 7% of the nearly 250,000 who must buy unsubsidized insurance -- or face a fine of \$2,000 in 2008 -- purchased private health insurance this year. Thus the plan will end its first year at least \$147 million over budget, with Massachusetts preparing to cut payments to doctors and hospitals and ramp up out-of-pocket costs for patients. And nearly 500,000 in Massachusetts remain uninsured. Yet the leading Democratic Presidential contenders now embrace Massachusetts’ mandate for individual purchase of health insurance.

Maine’s patchwork approach to universal health care - the Dirigo plan – is not working. Nor have the plans in Vermont, Minnesota, Washington and Oregon. Tennessee’s noteworthy TennCare program to help the poor and uninsured is in the process of being dismantled. NY has added targeted programs such as Child Health Plus and Family Health Plus yet more than 5 million New Yorkers annually lack health insurance.

This fall Vermont launched "Catamount Health," a plan to cover all Vermonters by subsidizing private health insurance from MVP and Blue Cross Blue Shield with a combination of tobacco tax money, Medicaid money and new taxes on employers who don't offer health insurance. But as the plan takes its first steps, the inadequate insurance for those who have it, with soaring co-pays, huge deductibles and unaffordable prescription drugs has put the crisis in health care back into the legislative agenda for 2008, front and center.

In contrast, the experiences in the rest of the industrial world provide ample evidence that a comprehensive approach to universal health care will succeed. Not only do the other major industrial countries spend far less on health care than we do, they cover everyone with better health outcomes, even though we have among the best medical professionals, infrastructure and equipment in the world.

Incremental approaches evade the fundamental problems that are causing the ongoing crisis in our health care system. Real change requires addressing the entire structure of financing -- in which employer-based private health insurance dominates. Without facing this, the problem of costs cannot be solved. Most of the money spent on health care in New York comes from government (federal and state) spending, yet private health insurance dominates the system. As Governor Spitzer has pointed out, NY’s system of health care financing is often not directly tied to the services being provided, its complexity and irrationality a result of the backroom deal making at the State Capitol.

Incremental approaches have done little to nothing to control costs, while adding more people to the system, thus causing more financial strain on both the government and private sectors, especially in bad economic

times. The various stakeholders such as hospitals and insurance companies often actually extract more resources as a result of the political negotiations over expanding access to health care (i.e., ok, you can cover more people but we need to extract higher payments in exchange).

Costs increase over time as health care costs in general continue to rise above the rate of inflation and more people utilize the new programs. Thus states find that they simply cannot afford incremental improvement, and so they must manage an incremental retreat. They end up pushing the costs of the health crisis problem back onto individuals by raising premiums, co-pays and deductibles, through roadblocks to limit participation in government programs and by whittling away at health services.

Perhaps the most fundamental difference between the US and the rest of the industrial world is that we allow health care to be treated as a commodity that is bought and sold on the open market, with the profit motive as a major factor. Access to health care is often based on the ability to pay rather than on need. The profit motive propels the US towards a “sick care” system, even though it is more expensive to cure people once they are ill rather than keeping them healthy. Incremental approaches fail to address these basic problems.

By definition, incremental approaches fall far short of universal coverage. The incremental approach also mistakenly often defines “universal” as everyone having access to health insurance, when what we need is a system that offers comprehensive _care_ to all. Having everyone “in” one system provides a variety of ways to save costs, both within and without the health care system (e.g., reduction in costs impacted by health care such as workers’ comp and automobile insurance.)

Take for instance computerized medical records, something that everyone agrees we need. In a fragmented for-profit system individual “players” such as HMOs won’t make such common-sense investments since the immediate bottom line, not the long-term interests of the patient or society, prevail. In contrast, a true universal health care system will need to build in incentives for the use of computerized records, in order to allow medical providers demonstrate their efforts to keep the population healthy and to systematically address areas of high cost such as chronic illnesses.

The incremental approach often underestimates the number of uninsured and the problems they face. Every one has heard there are 47 million uninsured in America but few realize that the Census Bureau defines that number by those who lack insurance for the entire year. Perhaps twice as many go without health insurance for some time during any one-year. Thus it is impossible for a program that expands subsidies for private insurance to offer true health security to those who unexpectedly find themselves uninsured.

Further, those who are uninsured but live in medically under-served areas may finally find a way to pay for health care, for instance under New York's Family Health Plus, but that fact by itself will not necessarily bring health care facilities or providers any closer to their door. And they may remain unable to find doctors in their communities willing to accept the reimbursement rates provided (e.g., Medicaid for certain services such as dental care.)

Then there is the problem of people who have inadequate insurance. A 2003 Commonwealth study estimated that 16 million adults have inadequate insurance. In September 2007 Consumer Reports found that 29 percent of people with health insurance have coverage so meager they often avoid necessary medical care because of costs, that 43 percent of people with insurance feel unprepared to cope with a costly medical emergency, and that 20 percent were so dissatisfied with their HMO or PPO that they hoped to switch plans.

Worse, most people don’t realize they have inadequate insurance until they need it. Private insurance companies increase their profits by denying services to those they insure. As a result, high health care bills now account for a majority of bankruptcy filings, yet 3 out of 4 such individuals had health insurance when they become ill.

Thus at least a third of the American population suffers from a lack of adequate health insurance.

Incremental efforts, by definition, fail to offer comprehensive health solutions. We need a plan for health care that will provide all necessary medical care. This means emergency, primary and preventive care, necessary specialty care including prenatal care, acute hospital care, rehabilitative services, home care, nursing home care, dental care, mental health care, eye care. Look at nursing home care. Medicaid is in crisis, entangling our nursing homes and our county governments. Incremental expansions may be much more likely to exacerbate than to alleviate such problems.

Most experts who study health care admit that a single payer Medicare for all Style program does best at achieving the goals of providing quality, affordable health care to all. Single payer means one entity pays all bills but it doesn't run the delivery system (e.g., doctors, hospitals). Single payer proposals, by eliminating the cost and bureaucracy of private health insurance, manage to bring everyone in while actually saving costs. Single payer has been rated best by every state that has undertaken the comprehensive cost-benefit analyses of universal health care that New York is presently starting. The single payer proposals are almost always the only ones that meet the goal of actually bringing the entire population into the health care system (i.e., universal coverage.)

Yet many elected officials and health care reformers contend that single payer is not politically feasible, largely due to the opposition of special interests starting with the private health insurance companies that would no longer be needed. Many argue that the massive amounts of money spent by the insurance industry to defeat the Clinton health care plan in 1994, highlighted by their Harry and Louise ads, shows that they can't be defeated. This argument however ignores that Clinton explicitly rejected a single payer approach, deciding instead to try to buy the support of the various stakeholders by throwing money at them in her proposal. The result was so complex and convoluted that many single payer advocates agreed that it should be defeated. The lesson arguably is not that a single payer proposal has no chance but rather that half-baked, flawed incremental approaches are doomed to failure.

Proponents of incrementalism tend to avoid the reality that the special interests oppose many of their proposals anyway, since most involve a reduction of their market share and funding. So right from the start incrementalists have weakened the impact of potential reforms without receiving any concessions in return from the major opponents. Incrementalists accommodate rather than resolve the fundamentally negative impact of private health insurance on health care delivery; indeed, the "reforms" that have been enacted have invariably strengthened rather than curtailed private insurance companies. Incrementalism unfortunately also undercuts the momentum for more comprehensive, effective reforms.

Others argue that moving to a single payer system - despite its positive impacts across the board on issues such as cost, coverage, access, choice, etc. - would be too disruptive, starting with the hospitals, doctors and insurance companies.. More "time" is needed to allow everyone to "adjust" to the new reality. However, little evidence has been presented to back up this assertion.

It should be noted that a number of industrial countries do have multipayer systems. What they don't have is our system of private health insurance, where doctors are forced to navigate a maze of companies, many of them for profit, with their own rules and paperwork. As much as a third of every health care dollar touched by private insurance firms goes to pay for their existence, paperwork and profit. In America, despite the fact that more than 60% of health care costs are now paid directly for by the government (e.g., Medicare and Medicaid), we allow private health insurance to dictate much of the terms of the health care system. In all other industrial countries, the health care system is determined through their system of representative democracy. If private insurance is allowed, it plays a minor supplemental role, operating under strict rules determined by the government, with no role for profit.

The chorus of calls for incremental reform has fallen badly out of tune with respect to what the people of New York want for their health care system and hopelessly out of tempo with what people need for their personal health and security. When Governor Spitzer weighs the evidence he will find that only a single payer system can provide affordable, comprehensive health care for all New Yorkers.