

Testimony of the Hunger Action Network of New York State

Mark A. Dunlea, Esq., Executive Director

**To the Joint Budget Hearing of the
Senate Finance Committee and
Assembly Ways and Means Committee
Wednesday February 6, 2008**

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.

Implementing the Findings from the Universal Health Care Studies

We applaud the State Legislature for agreeing last year to add \$200,000 to fund a series of health care studies on how New York can most cost-effectively provide quality health care to all New Yorkers. Since health care represents half of the state budget, it is imperative that we seek to control health care costs while meeting the health needs of all our residents.

It is important that the Legislature ensures that the study process is open and transparent. We urge that the various models that will be studied be made public before they are submitted to the Urban Institute so there is at least some time for public review and input. We also hope that the studies themselves will be released prior to a recommendation being developed so that there is an opportunity for public comment and review.

Whatever universal health care system that is adopted by New York should lower rather than increase costs; this starts with reducing administrative overhead to less than 10%. Patients' care, not profits, should be the focus of our health care system. Increased investments are needed in primary care. 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.

A half dozen states that have already undertaken such studies. Each of their studies concluded that a single payer health care system would do by far the best job: covering all, not just most, of the state's residents while actually lowering costs. Each of the states then decided to do something else because they were unwilling or unable to confront the power of private health insurance, even though insurance only harms our health care system while increasing costs for taxpayers, employers and consumers. Each of the states has so far failed to achieve universal health care or to cut costs.

In appendix II, we outline our concerns about an incremental approach to achieving universal health care. We hope that lawmakers will have the political courage to select the model that is found to save the most money while providing the best health care to all New Yorkers.

The Governor's Health Care Budget is Headed in the Right Direction

The most important health care need in New York is a comprehensive, universal health care system that provides quality health care to all New Yorkers while cutting the present excessive costs of the health care system. While this is missing from the state budget proposals, there are many initiatives in the Governor's proposed health care budget that we strongly support and praise.

We believe that the Governor is on the right track in pushing to put delivery of health care to patients as the primary focus. The Governor is right to call for a long overdue overhaul of the state's payments for health care services to better reflect patients' needs and cost-effective approaches to delivering health care. We support the Governor's efforts to place greater priority – and funding – into primary care, including the Doctors Across New York initiative, to attract more doctors and other health care providers to underserved areas. We support initiatives to ensure adequate staffing by nurses.

We support the Governor's proposal for the state to pick up the federal share for expanding Child Health Plus coverage to 400% of poverty

We hope to see more initiatives by the Governor and the State Legislature to reduce if not eliminate the huge costs and bureaucracy associated with the present system of private health insurance. (Some of these problems are detailed in appendix 2) We support efforts to require prior rate approval of health insurance rate hikes and we like to see a higher standard for medical loss ratios. We support the Governor's proposal to eliminate the various financial incentives that the state provides to HMOs, discounts from state charges that was initially intended to help promote this "developing" industry.

We hope the legislature will add \$5 million in funding for school-based Health Care Centers. The Health Care Reform Act (HCRA) allocates a total of \$10.5 million for SBHCs for core clinical services including primary and preventative health care, mental health services and health education and promotion. This funding should be increased by \$5 million as many underserved communities have identified a need for new centers. Unfortunately, the Governor's budget proposes the same level of funding as last year's Executive Budget, but omits \$675,000 that was added by the Legislature in last year's enacted budget.

Reduce the Cost of Prescription Drugs

We support the Governor's efforts to reduce the cost of prescription drugs.

We strongly support the proposed initiative to create new EPIC Discount Card Program for financially vulnerable persons of any age. The program would have the same income-eligibility levels as EPIC (which according to the web site are \$35,000 or less if single, or \$50,000 or less if married), but would be available to those under the age of 65. This would allow those who have no coverage of any kind, regardless of age, to get a 25-30% discount on prescription drugs, provided they meet the current eligibility requirements of the EPIC program.

Consumers who are uninsured currently pay the highest prices for prescription drugs, because they have no health plan or government program to negotiate on their behalf. This proposed initiative would benefit millions of New Yorkers who currently lack drug coverage and purchase their drugs at retail prices.

We are disappointed however that the Governor failed to change the rules for the state's elderly pharmaceutical assistance program (EPIC) to allow New Yorkers with severe disabilities that receive SSI and meet the program's income requirements to participate. We hope that the legislature will decide otherwise.

We also support the proposed bulk purchasing initiative, which gives the health commissioner the authority to work with other states to obtain lower prices when buying drugs for public health care programs. New York State should be a smart purchaser for the drugs it buys, and this new initiative will help the state obtain significantly lower prices for the drugs it buys.

The budget does make changes to the preferred drug program and the clinical drug review program to allow for Medicaid cost containment. However, one action in the preferred drug program that would be particularly

troubling to people with mental illness is the elimination of anti-depressants as automatically exempt from the Medicaid preferred drug list.

Medicaid co-pays for brand-name drugs on the PDL would decrease from \$3 to \$1. Unfortunately, this change would not affect dual-eligibles who receive their prescriptions through Medicare Part D plans.

We are deeply concerned about the impact of Medicare Part D on New York's dual-eligible population. High cost-sharing associated with Medicare's Part D prescription drug program place many life-sustaining prescription drugs out of reach of the most vulnerable Medicaid beneficiaries, many of whom take as many as ten prescription drugs per day. MMNY urges the State to reduce co-pays for the dual-eligible population who receive their drugs through Medicare Part D in a manner that is comparable to the rest of the Medicaid population. We also recommend a cap on prescription drug co-pays for the dual eligible population, as they are capped for all other Medicaid beneficiaries.

Hunger Action endorses the positions of Medicaid Matters NY

We applaud the Governor's efforts to expand access to public health benefit programs such as Medicaid, Family Health Plus and Child Health Plus.

We support the proposal to "modernize" the Medicaid utilization threshold program, which presently places an undue limit on the number of services a Medicaid recipient may receive in a year. The new thresholds would be based on clinical evidence, diagnoses and severity of illnesses.

We support the proposal to establish a new enrollment portal permitting the State to directly enroll and renew individuals in Medicaid. The State will operate a single hotline for all public health insurance programs, process certain applications, and eventually operate a telephone renewal process statewide and develop an electronic application. The Budget allocates \$4 million to this project, and gives the Department of Health the authority to contract with a vendor to operate the portal.

We support the increase of \$7.5 million in funding (on top of the current \$15 million) would be provided for facilitated enrollment by community-based organizations. This would mean that more people would get assistance enrolling in public programs in the settings they use everyday in their communities.

We support the Governor's proposal to it easier for consumers to access the Medicaid program, including:

- eliminating the asset test for those eligible for the Medicare Savings Program, contingent on Federal approval;
- aligning the Medicaid and Family Health Plus resource tests;
- eliminating drug and alcohol screening as a condition of eligibility;
- allowing DOH to verify income by accessing information from an applicant's personal income tax returns;
- aligning Medicaid eligibility levels for single adults and childless couples, and eliminating varying county-by-county standards;
- expanding Medicaid coverage for children formerly in foster care from age 18 to age 21; and,
- eliminating the need for reapplication for Medicaid or Family Health Plus when moving from one county to another.

The number of people who are ineligible for Medicaid because of assets is tiny; the administrative headaches associated with the asset test (for both DSS's and for applicants) are horrendous; and many people fail to complete their application because they find the asset documentation requirements completely overwhelming.

Unfortunately, the budget does not eliminate the finger-imaging requirement for single adults and childless couples. We urge the legislature to do so.

The exemption for ‘serious and persistent mental illness’ is being revised in a way that will limit the number of people who are eligible for this exemption from mandatory managed care. This could be troubling for consumers struggling with mental illness.

There are further reforms that we hope the legislature will adopt. We support the establishment of a state-wide network of consumer assistance/navigation so that people are not only provided a Medicaid card, but are also provided with consumer-friendly assistance so they can actually figure out how to use the services they need. We support eliminating the requirement of a face-to-face interview as part of the Medicaid application process. The state should Allow “passive” renewal on a biannual basis where individuals simply have to sign a postcard that indicates that nothing has materially changed in their conditions regarding eligibility for Medicaid. A full renewal review would be conducted on the alternate years.

The Governor’s proposals in the area of managed care raise concern, as MMNY has pointed out. In general, managed care has the potential for improving care for those with complex and chronic conditions. Mandated enrollment presents significant logistical challenges, however, and improvements in health outcomes will only be realized if plans and providers are prepared to truly manage and coordinate the care of our more vulnerable citizens, who will need some navigational assistance to avoid major disruptions in care. Current proposals target the most vulnerable members of the Medicaid population: the dual-eligibles, the SSI population, people with serious and persistent mental illness. The legislature can play an important role in assuring that consumer voices be heard through more aggressive monitoring and oversight of the Medicaid managed care program.

Increase Funding for Nursing Education

Hunger Action supports the inclusion of \$2 million in the Executive Budget to allow expansion of nursing education programs in the SUNY and CUNY systems. However, an even greater investment is needed. We support allocating \$4 million for SUNY nursing education programs and \$4 million for CUNY nursing education programs. These funds should be designated exclusively for either the expansion or the creation of nursing education programs within the SUNY/CUNY system.

The Health Resources Services Administration has predicted that New York State will have a shortage of 17,000 registered nurses by 2010. That shortage is expected to grow to 30,000 by the year 2020. It is estimated that 10,000 registered nurses must graduate each year in New York State to meet workforce demands (HRSA). In 2005, fewer than 7,000 RNs graduated from New York programs. For that same year, the state's Center for Public Health Workforce Studies reported that nursing schools turned away 3,000 qualified applicants.

New York’s nursing programs have limited capacity and continue to turn away an alarming number of qualified applicants at a time when the state’s health care facilities continue to face a worsening nursing shortage. There are clearly not enough programs to educate these prospective nursing students.

We also support \$7.7 million in new money for nursing scholarships to increase entry into the profession.

Other initiatives related to nursing that we support include:

- A \$1.6-million increase in Medicaid payments for care by nurse practitioners in office-based settings.
- Continuation of a scholarship and loan forgiveness program for RNs seeking higher education in order to teach nursing.
- Expansion of Child Health Plus to provide access to health care for all 400,000 children in New York State who lack insurance.

- \$3 million in new state-share Medicaid funding for “nurse-family partnerships,” home visiting programs for at-risk children and pregnant women that have been successful in other states.

Provide \$2.05 Million in Funding for Children Environmental Health 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. 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.

Asthma, Autism, Allergies, Attention deficit/hyperactivity disorder, Leukemia, Pediatric brain cancer, Birth defects, Obesity and Diabetes. These are the major diseases confronting the children of New York today. These diseases are on the rise:

- Asthma rates have tripled in the past three decades. Asthma is now the leading cause of emergency room visits, hospitalizations and school absenteeism.
- One of every six American children has a developmental disorder such as ADHD, dyslexia and mental retardation.
- One in every 150 American children is now diagnosed with autism.
- Primary brain cancer among 0 to 14 year olds increased by nearly 40% from 1975 to 2004, according to the National Cancer Institute.
- Childhood obesity has quadrupled in the past ten years.
- Type 2 diabetes, previously unknown among children, is becoming epidemic.

Synthetic Chemicals in the Environment. Children in New York State are surrounded by unprecedented levels of synthetic chemicals. Most of these chemicals have never been tested for toxicity.

- Today, there are more than 80,000 synthetic chemicals in commercial use, nearly all developed in the past 50 years.
- 2,800 of these are high-volume chemicals, with annual production exceeding 1 million pounds.
- Fewer than 20% of high-volume chemicals have been tested for toxicity to children.
- National surveys conducted by CDC show measurable levels of high-volume chemicals in the bodies of nearly all Americans, including newborn infants.

Evidence is increasing that toxic chemicals in the environment cause disease in children.

- Air pollutants, mold and cigarette smoke contribute to the causation of asthma.
- Lead, mercury, PCBs and organophosphate pesticides are known to cause mental retardation, attention deficit disorder, autism spectrum disorders and learning disabilities.
- Benzene, other solvents and pesticides have been linked to childhood cancer

Most pediatricians and other health care providers have little training in environmental medicine. Pediatricians report that that they commonly see children with diseases of environmental origin, but that they are not comfortable in caring for these children. Only 19.4% of New York State pediatricians have received specific training in environmental history taking.

Chronic disease of environmental origin in children is extremely costly. A 2005 analysis by the Mount Sinai School of Medicine estimates the annual costs of environmental disease in New York’s children to be \$4.65 billion. This included only asthma, cancer and neurodevelopmental disabilities.

Proposed HIP-GHI Conversion

With respect to the proposed HIP-GHI conversion, we oppose the conversion of these two downstate nonprofit insurers into for-profit stockholder owned corporations. For-profit health care increases the diversion of resources out of the health care system into private pockets, and is likely to directly undermine efforts to control costs and expand coverage.

A consultant to New York City has estimated that the HIP-GHI merger alone could drive up health insurance costs for the city by as much as \$200 million per year. This in turn would drive up rates for consumers. Also, after HIP-GHI becomes a for-profit company, it may be quickly sold to a larger insurance company that would result in sharply diminished competition in the downstate market and higher prices for consumers. HIP-GHI might choose to abandon segments of the insurance market that are not profitable, such as the Medicaid program.

In effect, the proposed conversion amounts to a huge hidden tax on health care consumers. Before any decision is made on the proposed conversion, the legislature should hold additional hearings about the potential impacts on consumers, employers and health providers. In addition, the Insurance Department should perform an independent analysis of the impacts of the conversion on premiums and health access around the state, to be completed and published on the Department's web site.

If the state does decide to proceed with conversion, the legislature and governor should put the state's share of the proceeds into a "lock box" to be used for expansion of coverage through the Partnership for Coverage, or similar new coverage expansion initiatives. It is critical that this one-time source of dollars be used effectively to EXPAND coverage, consistent with HIP and GHI's social missions, and not be used to replace existing state obligations to fund health care programs. The money is also a sitting duck for special interests and must be protected for the benefit of the public.

Continue to Expand Mental Health Parity

Arbitrary limits on insurance coverage for mental health services have greatly limited access to care, and to recovery, for many people. Timothy's Law has begun to address this problem with private employee insurance plans, but such limits are still in place in Family Health Plus and Child Health Plus. While we applaud the expansion of eligibility for Child Health Plus, this is raising the ceiling while the foundation still needs work

There is simply no scientific or medical basis for limiting coverage of one organ of the body while covering all of the others, particularly when that very organ – the brain -- is so essential for overall health, as well as for individuals to be contributing members of society. According to a 2003 report of the American Medical Association, the cost in lost productivity to U.S. employers from depression alone is \$44 billion a year.

We urge the legislature to eliminate these arbitrary limits to care, save lives and boost the productivity of many New Yorkers by providing for equal coverage of mental health and chemical dependency services in Family Health Plus and Children's Health Plus. Including language similar to that in S5929/A9354 will bring parity to the mental health benefits in the Child and Family Health Plus programs, effective April 1 so that as employers begin to opt into the programs, they are opting into benefits with parity. If a small rate change is needed to upgrade these benefits, it is not expected to cost more than between 75 cents for Children's Health Plus and \$1.25 for Family Health Plus per member per month, or about \$12 million on a full annual basis, and may well cost less than that.

Increase HPNAP Funding by \$7 million.

We urge an increase of \$7 million in the Hunger Prevention Nutrition Assistance Program (HPNAP) funding for fiscal year 2008-2009. The Governor is proposing to maintain the existing funding at \$28.64 million.

We however support the Governor's proposal to move the \$12 million in additional funding provided by TANF into the Department of Health's funding allocation with the rest of the HPNAP appropriation.

The Food Bank Association and other anti-hunger advocates last year develop a nine year funding restoration and increase effort to restore prior cuts and reflect the increasing rates of poverty and demand for emergency food. This would involved increased the \$22.8 million in state funding to \$56.30 million in 2011-12. We appreciated the \$5.15 million increase in last year's budget by the Governor. In addition, shortly before Thanksgiving, the state released an additional \$5 million in funding to deal with the rising cost of food and the delay in federal funding for emergency food related to the ongoing deliberations over the Farm Bill.

Increases in HPNAP (including that just realized) will better enable us to combat the ever increasing reality of hunger and poverty. America's Second Harvest estimates that 14.6% of New Yorkers (2003-2005) live in poverty; 10.4% live in food insecurity (choosing between food and other costs of living). Half of the over 2 million who seek food assistance in this state each year are children.

The Need for a Medicare for All Universal Health Care System

The rising cost of health care is a major concern for all segments of New York

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.

The repeated failure of fragmented, bandaid, go-slow approaches to universal health care is ample evidence that an incremental approach is unlikely to succeed in New York (see appendix two.)

A single payer, Medicare for All, 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. A recent study found that a state single payer system just in California would save \$30 billion annually.

While the United States has very skilled health providers, our health care system performs poorly, with its overall quality only ranked 37th by the World Health Organization. The US spends an annual \$6,102 per person -- more than any other country and more than twice the 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. 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.

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.

Inadequate coverage, even among persons who are insured, has become a major cause of personal bankruptcies. Medicaid expenditures now represent (if we include the federal share) almost half of the state budget.

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. Rising health care costs are a major burden on all employers and are increasingly the main reason for labor-management disputes.

Appendix I - Ten Problems with the Private Health Insurance System

1. Profit before health care. Private health insurance companies make more money when they prevent consumers from receiving care. Health care is just another product for sale. Access is based on ability to pay. Health care needs to be regarded as a right whose implementation is a major social responsibility..
2. High Administrative Costs. As much as 20 to 35 cents of each health care dollar processed by private health insurance goes to pay for its profits and administrative costs. Premiums are raised regardless of patients' ability to pay.
3. Creation of paperwork and confusion. Consumers and doctors can't figure out what is covered. A doctor on average has to hire 2.5 staff people to fill out insurance forms and to try to figure out what medical services are covered by the various insurance programs.
4. Excessive Role in Health Policy. The private health insurance industry, whose primary accountability is to corporate shareholders, has too much power over the health care system. They dictate how our health care resources are spent, what medical services are available, and how doctors and hospitals are financed. Their power makes it difficult to regulate the health care system.
5. Undercuts social insurance – or shared responsibility. Private insurers carve up the risk pool, appeal to people's individual self-interest ("Why should the young and healthy pay for people who are sick?"), and undermine social solidarity.
6. Restricts choice. Private health insurance unduly restricts what doctors and other medical providers consumers can use. They add a third level of approval for treatment in many cases. Changing jobs or employment status often requires people to change their health providers.
7. Employer Based. Private health insurance is primarily financed through employers (i.e., almost 90%), which creates many problems. This historical accident stems from wage and price controls during WWII. Workers become "locked" into their job, since they often can't carry their policy to their next job, and may be denied coverage at their new job due to "pre-existing conditions." Health insurance is very expensive for small businesses.
8. Excludes the sick. Private Insurance companies make more money by covering those who are healthy and likely to remain so. They invariably excludes pre-existing medical conditions
9. Coverage often inadequate. Being insured does not guarantee access to health care nor coverage for services received. Most people with insurance don't know the scope of the coverage. They may not learn this until the insurance company rejects coverage when they seek medical treatment. Three of five (62%) of all adults with medical bills or debt problems said they or their family member were insured at the time the debt was incurred.
10. High costs for workers and employers. The annual premium that a health insurer charges an employer for a health plan covering a family of four averaged \$11,500 in 2006. As costs rise, employers feel pressure to pass on more of the costs to their employees. Workers contributed nearly \$3,000 each, or 10 percent more than they did in 2005 .The annual premiums for family coverage totally eclipsed the gross earnings for a full-time,

minimum-wage worker (\$10,712). Health insurance expenses are the fastest growing cost component for employers. Health insurance costs will overtake profits by 2008.

Appendix II – Can Incrementalism Be a Path to Universal Health Care

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.