Testimony of the
Hunger Action Network of New York State

Increasing access to Health Insurance Coverage and Moving Toward Universal Healthcare Coverage; Defining the Goals and Identifying the Steps
To Partnership for Coverage, NYS Health and Insurance Departments
Glens Falls NY September 5, 2007

I am Mark Dunlea, Associate Director of the Hunger Action Network of New York State. Hunger Action, started 25 years ago, is a statewide membership organization of emergency food programs, advocates, faith groups and low-income individuals whose goal is to end hunger in New York State. About 20% of the two million New Yorkers who utilitze the state's 3000 emergency food programs lack health care coverage. High medical bills are a major factor in the demand for emergency food.

The New York Universal Healthcare Options Campaign (NYUHOC) is a four-year-old statewide campaign by more than 250 consumer, faith, health care policy and anti-poverty groups to promote universal health care in New York. Hunger Action Network of New York State and Rekindling Reform are the two statewide coordinators of the campaign.

During 2005, NYUHOC initiated a statewide educational campaign on the benefits doing a cost-benefit analysis of the various ways that the state could provide quality, affordable health care to all New Yorkers. The campaign was co-coordinated by the Hunger Action Network of New York State and Rekindling Reform. It worked closely with Assemblymember Richard Gottfried, chair of the Assembly Health Committee. This was based on similar initiatives in Maryland, Maine, California, Illinois, New Jersey etc. The proposal was endorsed by more than 250 organizations, including the NYS Nurses Association, NYPIRG, 1199 SEIU, NYSUT, NYSPEF, American Medical Student Association (Albany Med and Cornell), Rochester Interfaith Health Coalition, etc.

The Commission proponents organized dozens of forums on the need for universal health care to build support for the Commission. Events took place on Long Island, NYC, Westchester, Albany, Schenectady, Saratoga, Troy, Rochester, Buffalo, Elmira, Ithaca, Syracuse, etc. Literally thousands of New Yorkers have participated in this process. This has also provided us invaluable feedback from consumers, labor, businesses and the faith community as to their hopes and concerns about universal health care.

The Commission proposal passed the State Assembly in 2006 by 135 to 1 and was included in the initial budget passed by the Assembly in 2007. While the Commission itself was not included in the 2007-2008 final budget, $200,000 in funding for the studies was, along with the bill language outlining the study process. Governor Spitzer then went further and established a Task Force to develop a recommendation on how to accomplish universal health care.

We were pleased that after we met with representatives of the Governor and the Departments of Health and Insurance, you have agreed to hold five public hearings before the studies are started to receive input into what universal health care models will be studied. We applaud the Governor's and legislature's commitment to make this an open and transparent process; such openness is critical to its future success. We hope that you will incorporate the other hearings we had included in the Commission bill. We recommend that there be an opportunity for the public to comment on whatever models you decide to study before the study process begins, as well as an opportunity (e.g., hearings) for the public to respond to the studies' findings before the Governor makes his recommendation on how to best move universal health care. We also suggest that you survey consumers to determine their goals for a universal health care system and to identify potential consumer barriers (e.g., application process, co-pays, geographic maldistribution of providers, provider office hours) to achieving universal health care.

We urge you to examine carefully the results of these studies. Governor Spitzer earlier this year articulated a patient first approach to health care, including financing. That is an admirable and much needed goal. Polls show that Americans both support and understand the need for radical reform of our health care system. With so much money on the table in the health care system, the resistance to needed change will be enormous from the special interests and stakeholders. We hope you can focus on what is best for the 18 million New Yorkers who look to your leadership to solve this difficult political problem. For much of the last century, America has had an opportunity every decade or two to resolve our health care crisis through a universal system and every time we failed, most recently in 1993. It is time for us to join the rest of the world in creating a health care system that spends our money wisely while lifting the quality of our health care to that of the rest of the industrial world.

We believe it is also important to educate the public about what you are thinking of in terms of health care for all. While polls show that New Yorkers overwhelmingly support health care for all, they are also concerned about the details. They are concerned about issues such as ability to choose their own health care providers; waiting lines for elective medical procedures; and the role of government in running the health care system. Some fear they could be forced to give up coverage that they have and would prefer to keep. Some of their concerns are due to lack of information or misinformation. Education can help ensure that we have an informed public debate over what is best for our future.

Most impartial observers believe that your study of a single payer health care system will show that it will save significant sums – far more than other approaches - while doing the best job in ensuring 100% health care coverage. That has been the conclusion in the studies conducted for other states (e.g., California, Maine, Colorado, Vermont). We ask that you not dismiss single payer out of hand as being politically unrealistic due to the opposition of some key stakeholders but instead be willing to consider it on its merits and on what is best for our state.

While we look forward to a universal health care proposal by Governor Spitzer in May 2008, we also look forward to working with the Governor and state lawmakers early next year to reduce the number of uninsured by further simplifying access to and increasing eligibility for existing public programs such as Medicaid, Family Health Plus and Child Health Plus. This includes removing barriers to the application process as well as making it easier for employers to use public programs to assist them in ensuring needed health care coverage for their workers. We support the agenda advanced by Medicaid Matters NY, including: completing the delinking of Medicaid and welfare, removing unnecessary barriers such as fingerprinting and drug/alcohol screening; elimination of the asset test for Medicaid and FHP (poor people by definition don't have money and it is administratively cumbersome, a burden on local social service districts, and a significant deterrent); and raise eligibility in FHP to at least 150 percent of poverty so it mirrors parents (even better would be to raise eligibility to the CHP eligibility level).

We support efforts to expand primary, home and community based care. New York needs to invest resources to build capacity within the health delivery system to provide services in a community-based, patient centered, and cost-effective manner. Many consumers want long-term care services that allow them to remain in their homes and part of their neighborhoods. Providing coordinated services in the most integrated setting will not only save dollars, it allows patients to receive high quality care in a dignified manner.

Enact Universal Health Care – for All New Yorkers

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

The most cost-effective, common sense solution is a single payer financing system, similar to Medicare for All. That is the position of the Hunger Action Network of New York State. NYUHOC however does not endorse any one particular approach. Until recently, the campaign has focused on getting the state to initiate a series of universal health care studies. Now that this process has started, we are developing a set of principles that we believe that any universal health care system should achieve. We urge the state to adopt such principles.

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.

Universal Health Care for New York Most Lower – if Not cut – Costs

New York's taxpayers, consumers and employers spend far too much money on a health care system that leaves millions uninsured or with inadequate coverage. We spend a whopping 15.5% of our GNP on health care – far more than any other country – which puts our businesses at a competitive disadvantage in the international marketplace. 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.

According to the 2006 analysis by the Organization for Economic Cooperation and Development, the United States spends an annual $6,102 per person -- more than any other country and more than twice the average of $2,571. Yet Americans have the 22nd highest life expectancy among those nations, at 77.2 years compared with the analysis' average of 77.8 years. People in Japan, the world leader in longevity, live an average of 81.8 years. The report also found that the United States had about 2.5 times the average years of potential life lost due to diabetes: 101 years per 1,000 people compared with the average of 39 years per 1,000 people. Americans had fewer practicing physicians, or 2.4 per 1,000 people, than the average of 3 per 1,000 people. Infant mortality rates have been falling in the United States, but are still higher, at 6.9 deaths per 1,000 live births, compared with less than 3.5 deaths per 1,000 live births in Japan, Iceland, Sweden, Norway and Finland.

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

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

We suggest that you look closely at how to reign in the costs of health administration. According to Public Citizen, "By far, the fastest growing element of cost is wasteful health administration. The number of doctors increased 2.5-fold from 1970 to 2005, largely in proportion to growth in the population. The number of

registered nurses grew a bit more slowly. But the number of health administrators increased 26-fold during the same interval."

The Role of Health Insurance if any in a Universal Health Care System

Universal access to health care should be the goal for New York State, not necessarily universal health care insurance. What New York should be trying to do is to improve the overall quality of health care of the state for all residents while controlling if not reducing costs.

The issue of how to deal with private health insurance is one of the most controversial. Certainly private insurance as we presently know it can not be part of the solution. Insurance is not adding anything of value to our health care system, instead imposing much added costs while often threatening the quality of care and the doctor-patient relationship.

Many observers, especially single payer advocates, feel it should be eliminated, while providing new employment opportunities such in the health care field for existing insurance workers. Others, recognizing the immense political influence of the insurance companies, feel that some role must be carved out for private insurance companies. If the Governor's Task Force does the latter, we hope that you will accept the challenge to figure how you can transform private insurance to eliminate its presently negative role.

It is true that some other countries with better and less-expensive health care than we have are multi-payer systems, which can include a role for insurance. But those countries strictly regulate and restrict the role of insurance; here in the US they are allowed to be in the driver's seat while draining away as much as a third of every health care dollar.

As much as 30 cents of every health care dollar is spent on paying for the paperwork, bureaucracy and profit margins of private health insurance companies. A study by the Lewin group of a potential single payer system for California estimated that the state would save $38 billion annually over a ten-year period.
John Sheils of the Lewin Group reports nationally that the health insurers' overhead came to $120 billion last year, of which $40 billion was profit. By comparison, it would cost $54 billion to cover all the uninsured. Dr. Sydney Wolfe of Public Citizen states "At present, insurance company overhead and the paperwork that inflicts on doctors and hospitals wastes more than $350 billion a year, money that could cover the uninsured and eliminate co-payments and deductibles for those who currently have partial coverage."

As Michael Moore's new movie SICKO pointed out, health insurance in America is in itself a fundamental part of the problem. It is hard to see how a root cause of the problem can be a central part of its solution. A Zogby/UPI poll in February found that 42 percent of Americans said their insurer had refused to pay a medical bill. A USA Today/ABC poll in March found one in four Americans had trouble paying for medical care in 2006, although two-thirds of those were insured.

As a Des Moines Register editorial pointed out (March 5, 2007, "Private-sector insurance has been a financial failure in Medicare Advantage plans, where the government subsidizes insurance companies to take over the care of seniors rather than keeping them in less expensive traditional Medicare. According to a study by The Commonwealth Fund, Medicare spent $922 more on each senior in private plans than it would have paid to cover those patients in traditional Medicare in 2005. That's a total of more than 5.2 billion tax dollars that could have been saved or spent elsewhere if seniors would have remained in the basic, government plan." (March 5, 2007: Mandating private health insurance is misguided:
Taxpayer-financed health coverage is a better approach.)

Private health insurance companies spend 20% or more of their revenue on administration, marketing, and profit. By contrast, the public Medicare program covers more than 40 million Americans with a uniform

comprehensive system, and it spends only 3% of its overall cost on administration. (International Journal of Health Services 2005; 35(1): 64-90). The billing, authorization, second-guessing, appeal and other administrative requirements imposed by the private insurance companies on the entire health care system create enormous waste and inefficiency estimated to cost the country more than $300 billion each year. (Woolhandler, Himmelstein NEJM 1991& 1993; Kahn et al Health Affairs 2005)

As a recent op-ed from a doctor from PNHP pointed out, "Because our current non-system is based on insurance companies whose natural market behavior is to compete to cover healthy people while shunning the sick, proposals which preserve our reliance on them are destined for failure:

- "Individual Mandates" (like the much-celebrated Massachusetts plan; see Appendix B) simply force the poor and near-poor to buy overpriced polices that offer grossly inadequate coverage, guaranteeing an epidemic of medical bankruptcies. It will probably be even less successful than the mandate for private auto insurance in achieving universal coverage (14.6% of motorists in states with mandates lack auto insurance.)
- Reforms which force employers to contribute more for coverage just encourage them to cut jobs, wages or other benefits.
- "Consumer-directed" health plans are nothing but a euphemism for substandard coverage, offering families no protection in the event of medical need."

Some groups support allowing individuals to purchase private health insurance outside of a core government-funded health programs as a generally benign way to address concerns related to delays in accessing non-emergency medical operations (e.g., hip replacement). If delays are a problem, a better solution would be to identify and resolve the reasons for the delays (e.g., lack of access to needed equipment, lack of qualified medical personnel, etc.) Private supplemental health insurance doesn't eliminate waiting lists, it just allows wealthier individuals to move to the front, which is generally not a good goal in a democratic society.

The Task Force should examine the apparent negative impact of allowing supplemental insurance in countries that have universal health care. In a July 2, 2007 letter to the editor of the Wall Street Journal, Danielle Martin, the Board Chair of Canadian Doctors for Medicare, pointed out "that unwanted side effective of competitive health care include a drain of highly trained professional from the public system and 'cream skimming' of patients by private clinics who choose the healthiest patients, leaving the most complex to the increasingly overburdened public system. In June 2006, the Canadian Medical Association reviewed all the evidence from other jurisdictions and concluded that private insurance for medically necessary physician and hospital services does not lower costs or improve quality of care; can increase wait times for those who are not privately insured; and could exacerbate human resource shortages in the public system.

As noted before, other countries do have multi-payer systems but with far more restrictions on insurers. For instance, Germany offers a possible model for those who want to retain the insurance industry but end its ability to profit by pricing out the sick and shifting financial risk onto individuals. (The American Prospect 05.08.07 The Health of Nations, Here's how Canada, France, Britain, Germany, and our own Veterans Health Administration manage to cover everybody at less cost and with better care than we do.)

Co-payments, Deductibles and Individual Mandates Are Barriers to Universal health care coverage

Universal health care means putting an end to forcing consumers to choose between paying for access for health care or paying for other necessities such as food, housing, clothing, or transportation. Discussions about how to make health insurance affordable to everyone are misguided if the goal is universal coverage. Requiring or expecting moderate income New Yorkers to buy subsidized health care will fall short since they lack the funds to do so.

Seventy-five percent of the uninsured are employed, primarily in lower-wage jobs. It is widely recognized that the official poverty rate is understated in New York. Many individuals work in jobs that fail to pay a living wage and have a hard time paying for basic necessities. Forty percent of the 2 million guests who utilize emergency food programs in our state have a job but can't afford to buy food for the entire month.

Recent reforms in other states have included mandating as a last resort that individuals purchase health insurance (e.g., the Massachusetts model, Appendix B) or that the government create subsidized health care insurance programs that individuals can purchase. Both approaches fall far short of universal health care since many moderate income working families do not have the disposable income to make sure purchases. Information about this are include in Appendices B and E. As noted above, all but three states mandate automobile insurance, yet 14.6 percent of America's drivers remained uninsured in 2004.

Nor can we achieve universal health care coverage if we require anything other than a nominal application process (i.e., you live in New York State, you have health care coverage). Otherwise we will see many otherwise eligible New Yorkers being unable to navigate the application process as we already see with programs such as Medicaid, FHP and CHP.

The (Related) Problems of Underinsurance

The problem on focusing on creating "affordable" health care insurance can be seen in the present crisis with underinsurance.

The September 2007 edition of Consumer Reports found that 29 percent of people who had health insurance were "underinsured," with coverage so meager they often postponed medical care because of costs. 49 percent overall, and 43 percent of people with insurance, said they were "somewhat" to "completely" unprepared to cope with a costly medical emergency over the coming year.

Between 2001 and 2005, the percentage of middle-income families - those who earn between $40,000 and $80,000 for a family of four - who had job-based health coverage dropped by 4 percentage points. Half lost benefits because their employers dropped health insurance altogether or quit offering dependent coverage. But 15 percent gave up their employer-based insurance because they could no longer afford the premiums.

But even those who have managed to hang on to insurance have found it more difficult to pay their medical bills. The median household income of respondents who were underinsured was $58,950, well above the U.S. median; 22 percent lived in households making more than $100,000 per year. An explanation isn't difficult to find: Health plans are offloading more and more expenses onto consumers. Co-pays and deductibles have risen steadily in the past several years.

This combination of deductibles and co-pays can quickly add up to serious bills in the case of a major illness. A 2006 study found that 10 percent of insured patients with cancer had out-of-pocket expenses of more than $18,500.

Consumers faced with higher health costs have to find the money somewhere, and many in the Consumer Report found that tough to do. Overall, 37 percent said their health insurance and checking accounts together weren't enough to pay for their medical expenses over the previous year. But 59 percent of underinsured respondents fell in that category. They had to raid their retirement accounts, run up credit-card balances, and borrow from friends and family to pay their medical bills. Twenty-seven percent said they were still in debt to doctors and hospitals, and 3 percent said medical bills had forced them to declare bankruptcy.

Almost 4 in 10 underinsured respondents deferred needed auto or home repairs. Almost 3 in 10 said they made decisions such as changing jobs, postponing retirement, or changing their marital status mainly to preserve access to health insurance.

But the most worrisome result of underinsurance is reduced access the health care itself. Forty-three percent of underinsured respondents said they had postponed going to the doctor because they couldn't afford it, and 28 percent had put off filling prescriptions.

The Myth of Universal Health Care and Wait Times

Any universal health care system for NY should avoid excessive wait times. But we need to acknowledge that wait times is already a problem in NY, especially for the uninsured.

As a June 22, 2007 article in Business Week pointed out, "One of the most repeated truisms about the U.S. health-care system is that... American patients at least don't have to endure the long waits for medical care that are considered endemic under single-payer systems such as those in Canada and Britain. But as several surveys and numerous anecdotes show, waiting times in the U.S. are often as bad or worse as those in other industrialized nations…. In addition, 48 million people without insurance do not have ready access to the system. One disturbing study published last year by researchers at the University of California at San Francisco found average waits of 38.2 days to get an appointment with a dermatologist to check out a possibly cancerous mole. "Waiting is definitely a problem in the U.S., especially for basic care," says Karen Davis, president of the nonprofit Commonwealth Fund,. She attributes the delays to a number of factors. Only one-third of U.S. doctors are general or family practitioners, she notes, compared with half in most European countries. Also, only some 40% of doctors have arrangements for after-hours care, making it difficult to see a physician on nights and weekends. As a result, emergency rooms have become fallback systems for routine care.

Paul Krugman of the NY Times added "[T]he Commonwealth Fund found that America ranks near the bottom among advanced countries in terms of how hard it is to get medical attention on short notice... [and] is the worst place ... if you need care after hours or on a weekend…. In Canada and Britain, delays are caused by doctors trying to devote limited medical resources to the most urgent cases. In the United States, they're often caused by insurance companies trying to save money. This can lead to ordeals like the one recently described by Mark Kleiman, a professor at U.C.L.A., who nearly died of cancer because his insurer kept delaying approval for a necessary biopsy. ... [T]here's no question that some Americans who seemingly have good insurance nonetheless die because insurers are trying to hold down their "medical losses" — the industry term for actually having to pay for care. On the other hand, it's true that Americans get hip replacements faster than Canadians. But there's a funny thing about that example, which is used constantly as an argument for the superiority of private health insurance over a government-run system: the large majority of hip replacements in the United States are paid for by, um, Medicare. That's right: the hip-replacement gap is actually a comparison of two government health insurance systems.

"One particularly enduring myth is that Canadians flock to the U.S. to receive health care they can't get in their own country, or that they have to wait too long to receive. A 2002 study looked at admissions of Canadians into U.S. hospitals and other providers of medical procedures commonly wait-listed in Canada, and found ...nothing. If Canadians are swarming the border, they're doing it with an extreme of stealth.

"Our telephone survey of likely U.S. providers of wait-listed services such as advanced imaging and eye procedures strongly suggested that very few Canadians sought care for these services south of the border. Hospital administrative data from states bordering Canadian population centers reinforce this picture. State inpatient discharge data show that most Canadian admissions to these hospitals were unrelated to waiting time

or to leading-edge-technology scenarios commonly associated with cross- border care-seeking arguments. The vast majority of services provided to Canadians were emergency or urgent care, presumably coincidental with travel to the United States for other purposes. They were clearly unrelated either to advanced technologies or to waiting times north of the border. This is consistent with the findings from our previous study in Ontario of provincial plan records of reimbursement for out-of-country use of care. Additional findings from the current study showed that a small amount of cross-border use was related to proximal services, primarily in rural or remote areas where provincial payers have made arrangements to reimburse nearby U.S. providers. Finally, information from a sample of "America's Best hospitals" revealed very few Canadians being seen for the magnet referral services they provide."

Focus More on Preventive Care and Chronic Diseases; restructuring how doctors are paid

Almost everyone says that we have a sick care rather than a health care system in America and that we would save more money if we focused on keeping people healthy rather than trying to cure them once they are sick. Thus New York must make more investments in preventive care and public health programs. Investments in affordable housing programs which would reduce the exposure of New Yorkers, especially children and the elderly, to various environmental health risks would produce perhaps the biggest payback of any health care expenditure.

County Executives routinely point out that 70% of the costs in Medicaid come from treating 30% of the patients. One would hope this would lead the counties and state to focus more on these individuals who have chronic illness. Unfortunately, our health care system doesn't measure up worldwide in controlling chronic diseases, such as diabetes or hypertension. A major factor is that our present payment systems reward doctors for doing procedures, not for managing those chronic conditions. Routine disorders such ad diabetes and hypertension disorders aren't well controlled in American patients at least partially because that insurance payments reward physicians more for procedures such as heart surgery and leg amputations than for preventing those complications.

The US still lacks central medical recordkeeping despite consensus that it is essential. Many doctors' offices still overflow with folders with hand-written records. Fewer American patients get a call from a doctor suggesting they come in for a blood pressure check, and fewer physicians get a computer-generated safety check on potentially toxic drug interactions. While Americans like to pride ourselves on innovation and change, the reality is that we have fallen way behind the curve in information technology. I recently heard a reporter from NPR ask a CEO of an HMO why they hadn't invested in computerized records like the Veterans Administration even though it would save money and lives. His response was that since one in the VA you were in the VA system for your rest of your life, it made sense for the VA to make such and investment even if the savings would happen for 10 to 20 years. With clients changing HMOs on average in five years, they couldn't afford to invest in something that might produce savings only after the patient had left that particular HMO.

A recent NY Times article by Alex Berenson (July 29, 2007) pointed out that since nearly all US doctors are paid piecemeal for each test or procedure they perform, rather than a flat salary, physicians have financial incentives to perform procedures that further drive up overall health care spending. "Doctors are paid little for routine examinations and very little for cognitive services such as researching different treatment options or offering advice to help patients get better without treatment. Primary care doctors and pediatricians, who rarely perform complex procedures, make less than specialists. They are attracting a declining percentage of medical students, and some states are facing a shortage of primary care doctors. Doctors are also paid whether the procedures they perform go well or badly. A doctor may decide to perform a test that costs a total of $4,000 in order to make $800 for himself when a cheaper test might work equally well."

We suggest that the studies evaluate the will study the potential benefits of moving move toward paying doctors fixed salaries, plus bonuses based on the health of the patients they care for. This should also examine how to reduce if not eliminate the costs to individual doctors associated with obtaining medical malpractice insurance.

As our principles of health care reform point it, it is important to ensure that all health care providers receive a living wage and that medical professionals receive compensation that is reflective of their education and training while reducing or eliminating their debt burden.

Our Health Care System Should not be Employer Based

It is an accident of history – the wage controls at the end of WWII – that the US health care system is based on employment. This causes serious problems for workers and employers (businesses, government, nonprofit organizations). A universal health care system in NY should seek to end the connection between employment and health care coverage.

While employer health care mandates for large employers are presently justifiable as corporate accountability, they are not a good comprehensive health care reform. Providing health care to works is beyond the financial means of small employers in various sectors of the economy and expanded mandates could cause significant loss of jobs.

We recognize that employers presently pay a significant share of non-taxpayer health care costs. Thus we probably need to phase out employer contribution over a period of time (e.g., ten years) as we transition to either a progressive income tax, modified payroll tax, or some other financing mechanism.

Employers are not providing healthcare coverage to millions of their employees. Seventy percent of uninsured workers are not even offered health coverage by their employers. Of the rest, 84 percent cite the high cost of health insurance premiums as the reason for declining coverage. Only 55 percent of low-wage workers—those earning under $7 per hour—have access to job-based health care.

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

The Benefits of a Single Payer Health Care System for New York

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

The national staff at Physicians for a National Health Program cites studies that show that a single public payer could save the U.S. more than $350 billion per year. Such a system could have saved New York $23.4 billion in 2003. That’s more than $8,000 per uninsured resident, enough to provide high-quality coverage to everyone

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

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

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

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

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

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

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

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

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

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

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

$1,400 less than that of manufacturing the identical car in the US, primarily because of much higher health costs in this country.

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

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

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

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

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

Single Payer gives the government greater leverage to control costs. A single payer would be able to take advantage of economies of scale and exert greater leverage in bargaining with providers, thereby controlling costs. Recent experiences with both the VHA system and that of Medicare Part D indicate the difference exerting such leverage can make. The Department of Veterans Affairs uses its power as a major purchaser to negotiate prices with pharmaceutical makers. But when the legislation leading to the drug prescription plan (better known as Medicare Part D) was passed, Congress explicitly barred negotiating prices with drug makers. The results of this are now becoming evident: at present, the VA is paying 46% less for the most popular brand-name drugs than the average prices posted by the Medicare plans for the same drugs.

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

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

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

See also appendix C, Myths about Single Payer.

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

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

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

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

A universal health care system would help lower local taxes

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

A Universal Health Care System would lower automobile insurance rates

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

A universal health care system would lower Medical Malpractice Costs

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

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

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

A universal health care system would lower school taxes

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

A Universal health care system would help hospitals

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

A universal health care system would lower prescription drug costs

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

A universal health care system would help doctors

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

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

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

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

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

What's in the New Bill?

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

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

What's Wrong With This Picture?

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

The legislation promises that the uninsured will be offered comprehensive, affordable private health plans, but it offers no specifics. The subsidies in the plan are completely inadequate: To cover the cost of health care for the uninsured, estimated at between $700 million and $4 billion each year, the plan provides a mere $125 million.

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

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

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

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

Appendix C - Some Myths About Single Payer

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

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

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

Myth: People will overutilize the system.

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

Myth: Government programs are wasteful and inefficient.

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

Myth: Universal Health Care Would Be Too Expensive

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

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

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

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

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

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

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

Appendix D – One Approach to the Moral Hazard argument (or you can't have universal health care because people use too much of something good that is free)

The American Prospect Issue Date: 05.08.07 The Health of Nations Here's how Canada, France, Britain, Germany, and our own Veterans Health Administration manage to cover everybody at less cost and with better care than we do. By Ezra Klein

In France, The government provides basic insurance for all citizens, albeit with relatively robust co-pays, and then encourages the population to also purchase supplementary insurance -- which 86 percent do, most of them through employers, with the poor being subsidized by the state. This allows for as high a level of care as an individual is willing to pay for, and may help explain why waiting lines are nearly unknown in France.

France's system is further prized for its high level of choice and responsiveness -- attributes that led the World Health Organization to rank it the finest in the world (America's system came in at No. 37, between Costa Rica and Slovenia). The French can see any doctor or specialist they want, at any time they want, as many times as they want, no referrals or permissions needed. The French hospital system is similarly open. Given all this, the French utilize more care than Americans do, averaging six physician visits a year to our 2.8, and they spend more time in the hospital as well. Yet they still manage to spend half per capita than we do, largely due to lower prices and a focus on preventive care.

That focus is abetted by the French system's innovative response to one of the trickier problems bedeviling health-policy experts: an economic concept called "moral hazard." Moral hazard describes people's tendency to overuse goods or services that offer more marginal benefit without a proportionate marginal cost. Translated into English, you eat more at a buffet because the refills are free, and you use more health care because insurers generally make you pay up front in premiums, rather than at the point of care. The obvious solution is to shift more of the cost away from premiums and into co-pays or deductibles, thus increasing the sensitivity of consumers to the real cost of each unit of care they purchase.

This has been the preferred solution of the right, which has argued for a move toward high-deductible care, in which individuals bear more financial risk and vulnerability. As the thinking goes, this increased exposure to the economic consequences of purchasing care will create savvier health-care consumers, and individuals will use less unnecessary care and demand better prices for what they do use.

Problem is, studies show that individuals are pretty bad at distinguishing necessary care from unnecessary care, and so they tend to cut down on mundane-but-important things like hypertension medicine, which leads to far costlier complications. Moreover, many health problems don't lend themselves to bargain shopping. It's a little tricky to try to negotiate prices from an ambulance gurney.

A wiser approach is to seek to separate cost-effective care from unproven treatments, and align the financial incentives to encourage the former and discourage the latter. The French have addressed this by creating what amounts to a tiered system for treatment reimbursement. As Jonathan Cohn explains in his new book, *Sick*: In order to prevent cost sharing from penalizing people with serious medical problems -- the way Health Savings Accounts threaten to do -- the [French] government limits every individual's out-of-pocket expenses. In addition, the government has identified thirty chronic conditions, such as diabetes and hypertension, for which there is usually no cost sharing, in order to make sure people don't skimp on preventive care that might head off future complications.

The French do the same for pharmaceuticals, which are grouped into one of three classes and reimbursed at 35 percent, 65 percent, or 100 percent of cost, depending on whether data show their use to be cost effective. It's a wise straddle of a tricky problem, and one that other nations would do well to emulate.

Appendix E - Will Mandatory Health Insurance Work?

by Greg Scandlen, National Center For Policy Analysis
http://www.ncpa.org/pub/ba/ba569/

The latest fad among Republicans is enforcing "personal responsibility" by requiring individuals to buy health insurance. It was enshrined in the recent Massachusetts health reform law, proudly signed by Gov. Mitt Romney and endorsed by a number of conservative, and even libertarian, organizations.

Sounds like a good solution to the problem of growing numbers of people who are uninsured: if people won't buy health insurance voluntarily, pass a law mandating that they buy it anyway. Problem solved.
Well, not quite. How do we know mandatory coverage will work? How do we know it will succeed in getting people who do not currently have health insurance to buy it?

Mandatory versus Voluntary Insurance. Policymakers can get an idea of how well mandatory health insurance would work to reduce the number of uninsured by looking at another type of mandated coverage. Consider:

All but three states mandate automobile insurance, but 14.6 percent of America's drivers remained uninsured in 2004, according to the Insurance Research Council.

No state mandates health insurance, but 17.2 percent of the population lacked health coverage in 2004, according to the Employee Benefit Research Institute.

In 17 states, the uninsured rate for auto is higher than for health.

This is a remarkable finding considering that driving is a voluntary activity and enforcement is relatively easy — making people show proof of insurance when they register their cars. Further, auto coverage is relatively inexpensive, especially since the only part of the coverage mandated in most states is the damage you might do to other people and their property. You are not required to insure for the damage you do to yourself or your own car.

State Participation Rates and Penalties for Noncompliance. The state-by-state breakdown of coverage is even more illuminating when penalties are considered. In some cases the penalty for noncompliance is severe:

In Kentucky an uninsured motorist can be fined $1,000 and 6 months in jail; Wyoming also has a 6 month jail term and a $750 fine. In Louisiana, the driver's car can be impounded for failure to insure. Yet the rate of noncompliance is 12 percent in Kentucky, 11 percent in Wyoming and 10 percent in Louisiana.

On the other hand, some of the least punitive states have the lowest rates of uninsured motorists: New Hampshire has no mandate but its uninsured rate is only 9 percent, well below its rate of noncoverage for health insurance (11.3 percent). Virginia has a mandate but no penalty for noncompliance and its uninsured rate is 10 percent — again, well below the 14.2 percent of the state's population without health coverage.
By contrast, Texas, Nevada and New Mexico levy a fine of only $100 for noncompliance, yet their rates of uninsured motorists are very high (16 percent, 17 percent and 24 percent, respectively); their uninsured rate for health care is even higher — 27.1 percent, 20.5 percent and 24.4 percent.

Reasons for Variation in Coverage. Economists at the National Center for Policy Analysis examined these statistics and found that the average rate of all the states for uninsured motorists was 13.2 percent and 15.7 percent for health insurance. They found that most of the variations between the states for both types of insurance could be explained by two variables: 1) the rate of poverty in the state and 2) the level of health care costs in the state. No other variable was statistically significant.

Specifically, they found: A 10 percent increase in the poverty rate was associated with a 7.4 percent increase in the uninsured rate for auto and a 7.1 percent increase in noninsurance for health.
A 10 percent increase in the cost of health care was associated with an 11 percent decline in the uninsured rate for auto and an 8.5 percent decline for health.

These two variables explained 43 percent of the variation in the health uninsured and 27 percent of the variation in the auto uninsured. Mandatory coverage and no-fault variables, used in the auto regression, and personal income per capita variables, used in both regressions, had no significant effects.

Ineffective Mandates. If the effect of a mandate to buy insurance is small for auto coverage, it will be even less with health coverage. This is because penalties for noncoverage in auto are straightforward, directly connected to the coverage mandated and enforced relatively easily. State-mandated health insurance would be difficult to enforce; and it would be difficult to penalize people for noncompliance. For example, the Massachusetts law will withhold the personal state income tax exemption from people who fail to have proof of insurance; but since many people are not required to pay income taxes, they will be unaffected by the penalty.

Furthermore, health insurance is far more expensive than auto insurance, and for that reason alone the rate of compliance will be less. States may promise to subsidize those who find the expense burdensome, but a subsidy could be provided without the mandate and at far less administrative cost to the state.
But perhaps the biggest lesson from these comparative statistics is the success of a completely voluntary market. Not one state yet mandates health insurance, but people are covered anyway — at virtually the same rate as auto insurance.