

**TESTIMONY**

**OF**

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**OF**

**THE COMMUNITY SERVICE SOCIETY OF NEW YORK**

**AT**

**THE PARTNERSHIP FOR  
UNIVERSAL HEALTH COVERAGE HEARINGS**

**BEFORE**

**GOVERNOR ELIOT SPITZER,  
THE NEW YORK STATE DEPARTMENT OF HEALTH,  
&  
THE NEW YORK STATE DEPARTMENT OF INSURANCE**

**SEPTEMBER 5, 2007  
GLENS FALLS, NEW YORK**

Good day. My name is Elisabeth Ryden Benjamin and I direct the New York State Healthcare Restructuring Initiatives Project at the Community Service Society of New York (“CSS”). On behalf of our Chief Executive Officer and President, David R. Jones, I would like to thank Governor Spitzer, Commissioner Daines and Superintendent Dinallo for their leadership in this area. CSS is delighted that the State is conducting hearings in order to get public comment about how to move towards universal health care coverage in New York State.

CSS has been the leading voice on behalf of low-income New Yorkers for 160 years. Our mission is to identify issues that underlie poverty in New York City and to advocate for systemic changes required to ensure the economic security of working poor and moderate income residents in the nation’s largest city. In doing so, we seek to bring their voices and experiences into the policy conversation. CSS’s research has found that medical issues (disability and temporary illness) are the most common reasons why New Yorkers are out of work.<sup>1</sup> Assuring access to health care has thus become a central focus of our work.

Recent Census data reveals that 14% (2.7 million) of all New Yorkers lack health insurance, despite the fact that we spend more on health care per capita than any other state in the nation.<sup>2</sup> Uninsurance rates are particularly high among adults: 19% of adults in New York (2.2 million) do not have health insurance.<sup>3</sup> Nearly half (48%) of the uninsured have incomes under 200% of the Federal Poverty Line (“FPL”) and nearly one-third (31%) of the uninsured are non-citizens in New York State.

It is well documented that the lack of health insurance hurts individuals, healthcare providers and our greater community. According to the Institute of Medicine (“IOM”), individuals who are uninsured:

- receive too little medical care, too late;
- become sicker and die sooner; and
- receive worse quality of care than their insured counterparts when they are hospitalized.<sup>4</sup>

The IOM has also described the negative consequences upon the larger community when people lack health insurance.<sup>5</sup>

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<sup>1</sup> CSS, “Jobless New Yorkers: An Interim Report from CSS to the United Way,” 2007 (44.5% of unemployed men and 37.5% of unemployed women cited disability and illness/injury as the main reason for being out of work in the past five years).

<sup>2</sup> U.S. Census Bureau, 2007 Current Population Survey.

<sup>3</sup> *Id.*

<sup>4</sup> Institute of Medicine, “Care without Coverage: Too Little, Too Late,” May, 2002.

<sup>5</sup> These consequences include: the erosion of safety net hospitals and health care providers; higher insurance costs as providers spread their unreimbursed costs across alternative payers; increased tax burdens for paying for fragmented health care for the uninsured; hospital and facility closures caused by inadequate reimbursements; weakening of the public health system’s ability to respond to disasters or other emergencies; and an overall strain on the health care system to provide quality care to all community members. *See*, Institute of Medicine, “A Shared Destiny: Effects of Uninsurance on Individual Families and Communities,” March, 2003.

As I will describe in further detail, our groundbreaking research leads CSS to the inexorable conclusion that addressing the statewide need for *affordable* health care coverage is a critical step to ensuring that work is a way out of poverty for New Yorkers.

## **1. CSS Research Indicates that the Lack of Affordable Health Insurance Is a Serious Concern for New Yorkers**

In order to accurately represent the interests of low-income New Yorkers, CSS annually conducts an *Unheard Third* survey of poor and low-income New Yorkers. The “unheard third” represent one-third—roughly 3.4 million residents—of New York City’s voting age population who live in low-income households at or below 200% of FPL. This survey is the only large-scale scientific poll that regularly tracks the concerns and hardships of poor and working poor families in the nation. It also includes a comparison group of moderate- and higher-income New Yorkers with incomes above 200% of FPL in order to identify points of agreement—and divergence—across income groups.

Our most recent *Unheard Third* survey, conducted in interviews with 1,551 New York City residents in July and August of 2007, shows that lack of health care and prescription drugs is the biggest worry for the people at 100%-200% of FPL.<sup>6</sup> In addition, our survey finds that more than 9 out of 10 New York City residents, regardless of income, believe that affordable health insurance should be a priority for the federal government.

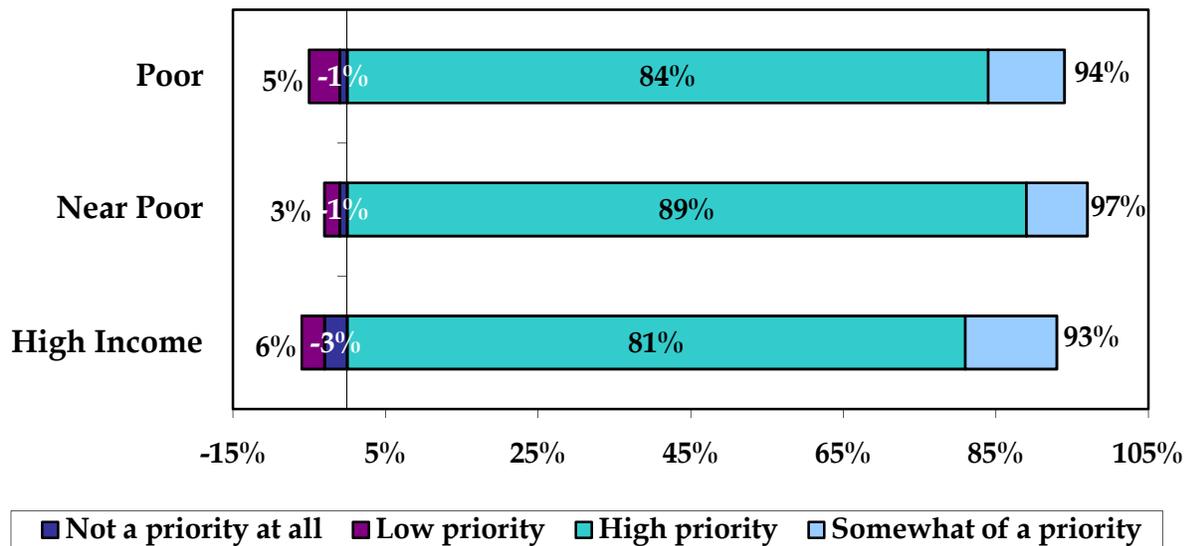
**Katherine, a Brooklyn resident, earns \$17,000 a year. She is self-employed and without insurance. She relies on a free clinic for her health care.**

*“Because we pay taxes for everything and a lot of it—why shouldn’t health care be included in a [State] budget? I make too much money to be a part of the state-issued plans but not enough to pay for it myself. It is not fair—I don’t fit in anywhere.”*

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<sup>6</sup> CSS, Unheard Third 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q18).

**Figure 1 - New Yorkers Believe that Affordable Health Insurance for All Should be a Priority for the Federal Government.**



This year’s *Unheard Third* survey confirms what last week’s Census data reported—fewer and fewer low- and moderate-income individuals are enrolled in employer sponsored health insurance.<sup>7</sup> Our research shows that among workers below 200% of FPL, 55% do *not* receive health insurance for themselves and 67% do *not* receive health insurance for their families through their jobs.<sup>8</sup> As the respondents’ income increases, these numbers improve modestly. For example, fully 32% of the working respondents above 200% of FPL do not receive health insurance through their jobs for themselves and more than one-third—44% of respondents—do not receive health insurance for their families.<sup>9</sup>

Indeed, over the past three years, our *Unheard Third* survey has documented a pronounced decline in the percentage of full-time working poor respondents who report receiving health insurance from their employers (from a high of 58% in 2003-2004 to a low of

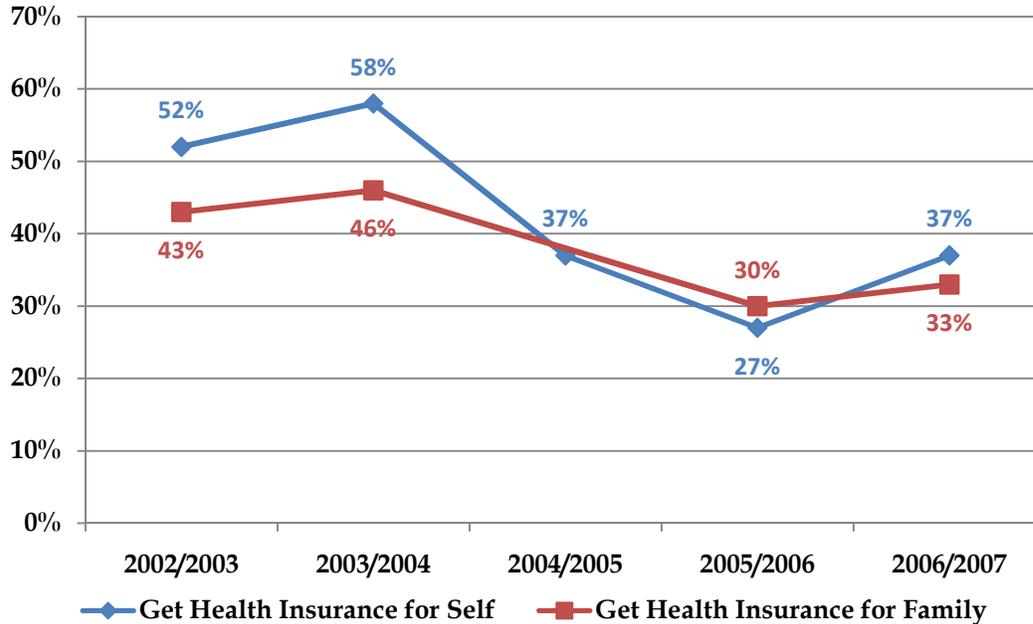
<sup>7</sup> Recent Census data shows that the rate of individuals (overall and of those with income under 200% of FPL) covered through employer-sponsored insurance has consistently decreased since 2004. See, C. DeNavas-Walt, D. B.D. Proctor, & J. Smith, U.S. Census Bureau, Current Population Reports, “Income, Poverty, and Health Insurance Coverage in the United States: 2006,” August, 2007, U.S. Government Printing Office, Washington, D.C., at 20. See also, Editorial, “A Sobering Census Report: Bleak Findings on Health Insurance,” *New York Times*, August 29, 2007.

<sup>8</sup> CSS, *Unheard Third* 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q42).

<sup>9</sup> For those people polled above 200% of FPL, 32% were not offered health insurance for themselves and 44% were not offered health insurance for their families. *Id.*

27% in 2005-2006).<sup>10</sup> This year, we found that that only 37% of full-time working poor people receive health insurance through their jobs.<sup>11</sup>

**Figure 2 - Percent of Poor Full-Time Workers Receiving Employer-Sponsored Insurance.**



\* Sample size for family coverage in 2004/2005 was too small to report.

There is clear evidence that, of those offered employer-sponsored health insurance, fewer employees are enrolling in this coverage due to rising premium costs for employees.<sup>12</sup> Indeed, this year, nearly one out of four low-income New Yorkers told us that they wanted health insurance offered by their employer, but had to decline it because it was unaffordable.<sup>13</sup>

**Louise is a 56-year-old woman earning \$20,000 a year. She lives in Brooklyn and works as a receptionist. She owes \$1,050 on her credit card due to miscellaneous items and medical bills.**

***She said: "My employer coverage is too expensive - I can't remember now how much - just that I couldn't think of getting it."***

<sup>10</sup> CSS, "Unheard Third 2006: Bringing the Voices of Low-Income New Yorkers to the Policy Debate," June, 2007 at 11.

<sup>11</sup> CSS, Unheard Third 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q42).

<sup>12</sup> Robert Wood Johnson Foundation. "Shifting Ground: Changes in Employer-Sponsored Health Insurance," May, 2006.

<sup>13</sup> CSS, Unheard Third 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q42).

## **2. Massachusetts Is Not the Answer**

Some policy makers have explored the idea of adopting the recently enacted Massachusetts model in New York.<sup>14</sup> We have carefully reviewed this idea, but believe that the conditions in New York are structurally unsuited for this policy solution.

First, and foremost, the Massachusetts model builds on Massachusetts' strength—its employer-sponsored insurance system (“ESI”). According to the Kaiser Family Foundation, Massachusetts ranks eighth among all states to offer ESI to its citizens.<sup>15</sup> Where is New York in that same ranking? Somewhere in the 30s.<sup>16</sup>

Second, a solution that builds upon ESI does not address a second structural issue in New York—we have a larger base of low-wage workers, many of whom do not have health insurance.<sup>17</sup> The composition of uninsured adults in New York is very different from that of Massachusetts. There are 1.8 million low-wage workers in New York, compared with 514,000 in Massachusetts. Uninsured adults in New York State are more likely to live in low-income households and more likely to be immigrants than uninsured adults in Massachusetts.<sup>18</sup> Among low-wage, full-time workers, 37% are uninsured in New York State, compared with 27% in Massachusetts. These workers will have great difficulty turning to employers, with whom they have little bargaining power, to solve their health care needs.

Third, the Massachusetts model is unaffordable for uninsured individuals with moderate incomes. Moderate-income individuals and families who are required to purchase insurance are asked to contribute between 3% and 10% of gross income toward insurance premiums. For example, an individual earning between \$25,000-\$30,000 (250%-300% of FPL) is required to pay nearly 5% of his or her gross income for health insurance premiums; a married couple earning between \$34,000-\$41,000 (250%-300% of FPL) is required to contribute 6%-7% of their gross income; and a family of three earning \$43,000-\$51,000 (250%-300% of FPL) is required to pay nearly 6% of its gross income toward premiums.<sup>19</sup> A recent study of families in Massachusetts finds that nearly half (46%) of families with income between 100% and 300% of FPL cannot afford the monthly premiums proposed under the Massachusetts model. More than half (52%) of families cannot afford the out-of-pocket costs associated with the program.<sup>20</sup>

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<sup>14</sup> See, e.g., United Hospital Fund, “A Blueprint for Universal Health Insurance Coverage in New York,” December, 2006.

<sup>15</sup> Kaiser statehealthfacts.org, 50 State Comparisons: Health Insurance Coverage of the Total Population, states (2004-2005), U.S. (2005) [ranked by “Employer”], available at: [www.statehealthfacts.org](http://www.statehealthfacts.org), (accessed 8/30/07).

<sup>16</sup> *Id.*

<sup>17</sup> For comparison purposes, we define “low-wage” as those with income under 200% of FPL. “Workers” are defined as those who are employed on a full- and part-time basis.

<sup>18</sup> In New York, 48% of the uninsured live in households with income under 200% of FPL, compared with 37% of the uninsured in Massachusetts. Further, 31% of the uninsured in New York are non-citizens, compared with 17% in Massachusetts. See, U.S. Bureau of the Census, Current Population Survey, 2007.

<sup>19</sup> Individuals at higher income levels are required to pay between 8%-10% of gross income for premiums. See, Commonwealth Health Insurance Connector Authority, “Affordability and Premium Schedules,” June, 2007.

<sup>20</sup> Greater Boston Interfaith Organization, “Mandating Health Care Insurance: What is Truly Affordable for Massachusetts’ Families?,” 2007.

Asking New York's near poor and moderate-income residents to spend as much as 5%-10% of their annual income is simply unworkable here.

Finally, the Massachusetts model depends on an insurance mandate—or a requirement that people sign up for insurance—in order to succeed. CSS believes that mandates do not work. Experience from the auto insurance context, a form of insurance far easier to acquire than health coverage, has revealed the deficiencies of mandates. For example, for nearly 40 years, California has mandated every driver to carry auto insurance. The result? Approximately 15% of Californian car owners are estimated to be uninsured.<sup>21</sup> Mandates are also extraordinarily difficult to implement, as the experience in Massachusetts shows.<sup>22</sup> Finally, the availability of insurance in theory does not always translate into accessibility in practice. Multiple studies have documented the barriers associated with enrollment in public health insurance programs.<sup>23</sup>

**A 55-year-old participant at a workshop sponsored at the Community Service Society who earns \$28,000 a year expressed his concern about the Massachusetts mandate to purchase health insurance coverage:**

*“If you cannot afford a car you don't buy one—everyone needs health coverage but if it's is not affordably priced, it should not be imposed.”*

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<sup>21</sup> Los Angeles Times, “State Crackdown on Uninsured Drivers,” December 6, 2006.

<sup>22</sup> Editorial, “Massachusetts Universal Care Plan Faces Hurdles,” New York Times, July 1, 2007.

<sup>23</sup> G. Kenney & J. Haley, “Why Aren't More Uninsured Children Enrolled in Medicaid or SCHIP?,” The Urban Institute, May, 2001; K. Kronebusch & B. Elbel, “Simplifying Children's Medicaid and SCHIP,” Health Affairs, 23, No. 3 (2004): 233–246; J. Haley & G. Kenney, “Low-Income Uninsured Children with Special Health Care Needs: Why Aren't They Enrolled in Public Health Insurance Programs?” Pediatrics, January, 2007: 119: 60 – 68; D. Horner & B. Morrow, “Opening Doorways to Health Care for Children: Ten Steps to Ensure Eligible but Uninsured Children Get Health Insurance,” Kaiser Family Foundation, April 2006; K. Kronebusch & B. Elbel, “Simplifying Children's Medicaid and SCHIP,” Health Affairs, Vol. 23, No. 3, 2004.

### **3. Crafting a New York Solution for New York's Uninsured Residents**

CSS believes that New York State must craft a New York solution—one that builds on our strengths and meets the needs of those who are weakest.

This fall, CSS will release a proposal that seeks to build on the success of Child Health Plus and Family Health Plus. Our proposal leverages the State's enormous purchasing power to walk the eligibility rules and cost sharing requirements from the Child Health Plus/Family Health Plus Programs to adults and children up to 500% of poverty.<sup>24</sup> The proposal will also explore the costs of expanding the recently enacted employer- and union buy-in to the Family Health Plus program. In short, our proposal will seek to offer high-quality, affordable insurance accessible to all of New York's residents.

There are important reasons why New York State should seriously explore our proposal to build upon New York's strong public programs.

First, contrary to Massachusetts, New York's strength is not rooted in ESI. Instead, our strength is our highly regarded publicly-sponsored insurance programs. Our Child Health Plus program was the first established children's health insurance program in the nation and led to a national solution to the problem of high rates of uninsurance among the nation's low-income children—the federal SCHIP program. Our network of public programs, Child Health Plus, Family Health Plus, the Prenatal Care Assistance Program and Medicaid, serve as an important foundation for a universal health insurance solution.<sup>25</sup>

Second, it is significant that these programs are already highly regarded by New Yorkers. Our research shows that 73% of New Yorkers support expanding government health insurance like Child Health Plus and Family Health Plus to cover more of the uninsured, even if it means raising taxes.<sup>26</sup> This strength even holds when we use the often disparaged term “Medicaid” instead of Child Health Plus and Family Health Plus. Fully 67% of New Yorkers at all income levels favored expanding Medicaid to cover more of the uninsured, even it means raising taxes.<sup>27</sup>

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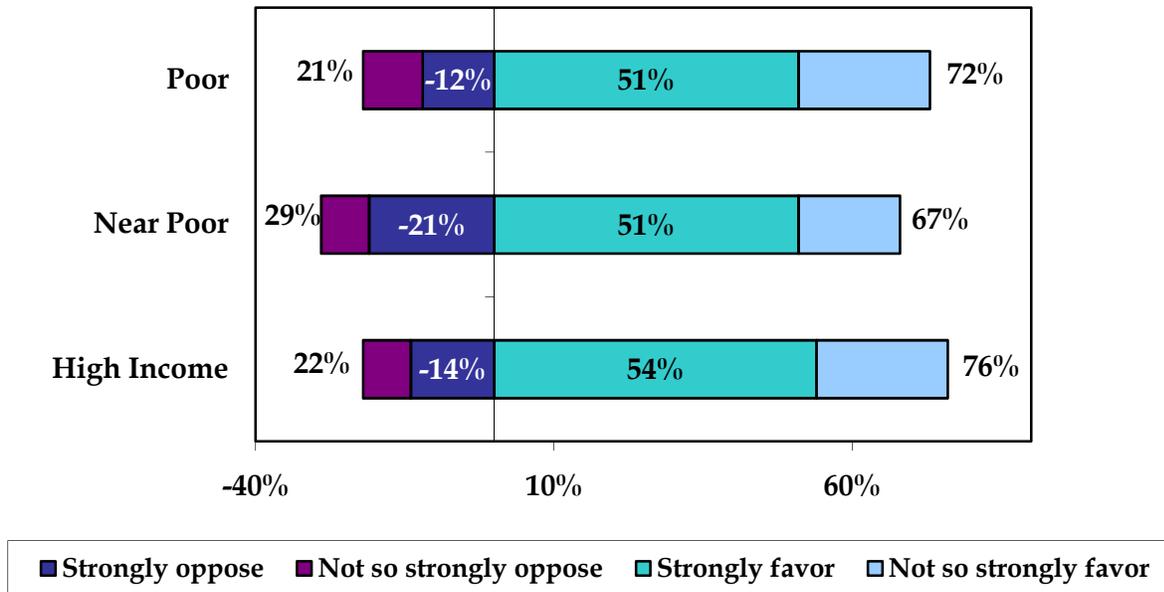
<sup>24</sup> The CSS proposal seeks to extend the residency rules of Child Health Plus to cover all New York State residents, regardless of immigration status. This component of our proposal has public support. Fully 60% of New Yorkers believe that a state health insurance program should cover all state residents, regardless of immigration status. *See* CSS Unheard Third 2007 poll of 1,551 New York City Residents, conducted in July-August 2007, by Lake Research Partners (Q53).

<sup>25</sup> According to Kaiser statehealthfacts.org, New York State ranks fifth in the nation for percentage of population receiving health insurance coverage under Medicaid. Kaiser statehealthfacts.org, 50 State Comparisons: Health Insurance Coverage of the Total Population, states (2004-2005), U.S. (2005) [ranked by “Medicaid”], available at [www.statehealthfacts.org](http://www.statehealthfacts.org), (accessed 8/30/07).

<sup>26</sup> CSS, Unheard Third 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q51).

<sup>27</sup> *Id.* (Q49).

**Figure 3 - New Yorkers Favor Expanding Child Health Plus and Family Health Plus to Cover the Uninsured, Even if it Means Raising Taxes.**



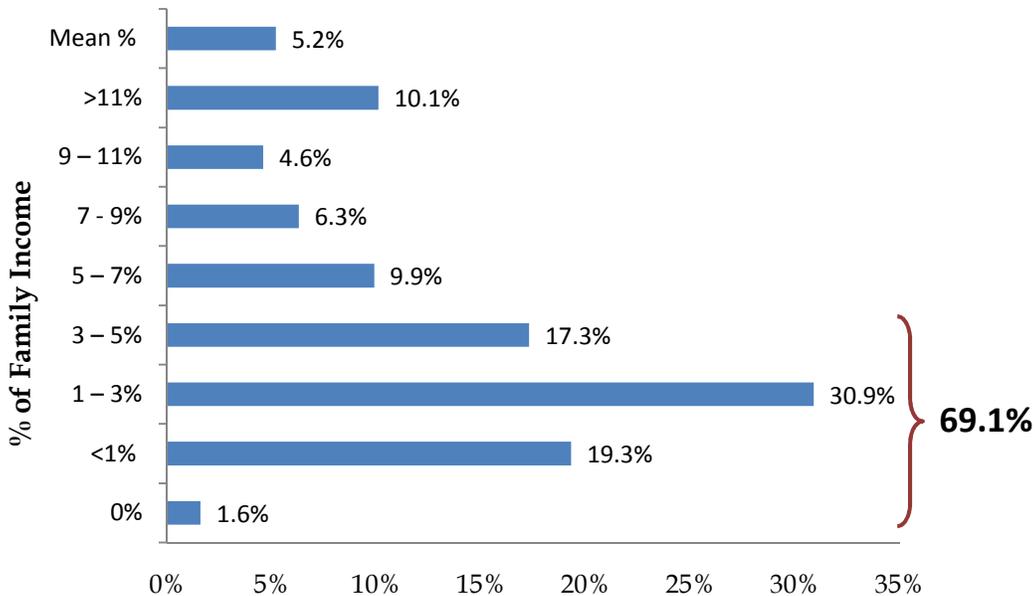
Third, CSS believes that extending these programs at a premium basis between 1% and 5% of a family’s gross income is fair and affordable for the vast majority of New Yorkers. This belief based on observable health insurance behavior in our region.

Using a well-regarded national data set known as the Medical Expenditure Panel Survey, CSS carefully analyzed how people are currently acquiring health coverage.<sup>28</sup> We find that most families with one or more workers between 150%-500% of FPL are both offered (76%) and accept (75%) ESI. Our analysis leads us to believe that most people opt into ESI because it is affordable. For example, the vast majority of families between 150%-500% of FPL who have ESI (78%) contribute \$200 a month or less for health insurance for their family coverage. Singles pay even less: 80% pay less than \$100 a month towards their individual coverage. Accordingly, our data find that the vast majority of families (almost 70%) spend less than 5% of their income on medical costs.<sup>29</sup>

<sup>28</sup> The Medical Expenditure Panel Survey, Household Component (MEPS-HC), is a source of data on health insurance coverage and enrollee costs. Using data from the 2002, 2003 and 2004 MEPS-HC (Panel 6 Round 3, Panel 7 Round 1, Panel 8 Round 1 and Panel 9 Round 1) of individuals and families residing in the Northeast Census region (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) we have developed initial findings on patterns of offer and take-up of ESI and enrollee premium contributions by FPL, for individual adults and for families, as appropriate.

<sup>29</sup> CSS, “Findings from MEPS-HC on Offers and Take-Up of Employer-Sponsored Insurance and Premium Contributions by Federal Poverty Level,” unpublished, August 2007.

**Figure 4 - Family Medical Expenses as Percent of Family Income (Total Population).**



Fourth, CSS believes cost-sharing must be kept low to ensure access. Research indicates that cost-sharing has a deleterious impact on low-income health care consumers, and that even modest cost-sharing discourages people from seeking necessary health care services.<sup>30</sup> CSS’s survey of New Yorkers finds that people at the lowest income, those below 200% of FPL, have almost no savings: 41% report having less than \$100 in savings; half (50%) report having less than \$500.<sup>31</sup> With resources at these low levels, even modest cost-sharing for health care is a serious deterrent to accessing care. In fact, findings from the Rand Health Insurance Experiment indicate that the imposition of co-payments led to a worsening of health status and reduced the likelihood that both adults and children would receive highly effective medical care. The adverse effect of cost-sharing was stronger in the lower income group studied.<sup>32</sup>

Affordability is a concern not only when considering cost-sharing, but also in thinking about what a low-wage worker can afford to contribute to the cost of coverage. A full-time worker earning the minimum wage earns less than \$15,000 per year. Data from the Self-Sufficiency Standard for the City of New York make it starkly clear that for many New Yorkers,

<sup>30</sup> See, e.g., Ku, L. and Wachino, V., “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings,” Center on Budget and Policy Priorities, July 7, 2005 (metastudy on adverse impact of cost-sharing on low-income populations); RAND, “The Health Insurance Experiment: A Classic RAND Study Speaks to the Health Care Reform Debate,” 2006; B. Stuart & C. Zacker, “Who Bears the Burden of Medicaid Drug Copayment Policies?,” *Health Affairs*, 18(2):201-12, 1999.

<sup>31</sup> CSS, Unheard Third 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q83).

<sup>32</sup> J. Gruber, “The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond,” Henry J. Kaiser Family Foundation, October, 2006.

not only is there no slack in their budget, but in fact they wind up short every month.<sup>33</sup> This leads to painful trade-offs between paying rent, utilities, and food. Consider the case of Abby, profiled in the box below, who at first glance may not seem to require a government subsidy for health insurance.

**Abby is a 46 year-old woman living in Manhattan. She is a freelance writer earning \$36,000 a year. She wrote:**

*"I cannot keep up with my current monthly bills as it is. I juggle which bills I will pay each month. Rent is a must - others I pay as I can but I am usually left with literally \$20-\$50 per month for transportation and leisure activities. If I am really responsible and pay as many bills as I can each month I have \$50-\$100 left over for food and literally no money after..."*

*"I should add that I have no 401K, no savings, and no family support whatsoever."*

*"Honestly, I think that right now I have no margin for error in my budget. I cannot imagine paying more than \$25 a month for health insurance and even that would be a hardship... I think that for those with children, families to support back home and those who work minimum wage jobs and/or fall into the category of working poor (too "rich" for subsidies but too poor to make ends meet) any monthly requirement would be egregious."*

Despite the fact that low- and moderate-income New Yorkers have so little disposable income, CSS has found that New Yorkers value health insurance. We found that 62% of those with incomes below 200% of FPL would favor paying \$25 a month for health coverage.<sup>34</sup> Amongst the higher-income New Yorkers we surveyed, we found that 52% of those polled above 200% of FPL favored paying as much as \$200 a month towards family health coverage. Again, as the price for coverage increased, the popularity of the proposal dropped, with only

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<sup>33</sup> Women's Center for Education and Career Advancement, "The Self-Sufficiency Standard for the City of New York 2004," January, 2005.

<sup>34</sup> CSS, Unheard Third 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q54). This number drops significantly as the price for coverage goes up. Only 48% of New Yorkers favored paying as much as \$75 a month for insurance coverage *Id.* at (Q55).

35% of higher income respondents favoring paying as much as \$400 per month for family coverage.<sup>35</sup>

#### **4. CSS's Future Work on Universal Health Care**

CSS's work in this area is continuing at a rapid pace over the next few months in three disparate areas.

First, we continue to work with Manatt Health Solutions to formulate the contours and costs of our proposal to expand Child Health Plus and Family Health Plus at subsidized rates to New Yorkers up to 500% of FPL.

Second, with our colleagues at the Public Policy and Education Fund, we are conducting a convenience sample of several hundred families throughout New York State. This sample consists of running small health insurance "affordability workshops" with insured and uninsured New Yorkers at all income levels. To date, we have conducted 112 interviews in Manhattan, Brooklyn and Queens—and a few of their voices have been highlighted in this testimony. This month, we will conduct another hundred or so interviews of New Yorkers who live on Long Island, the Hudson Valley, Western New York (Buffalo and Rochester), and Binghamton. From these interviews we will generate qualitative data about family budgets, the cost of health care around the State, and learn more about how our State's residents react to various universal coverage proposals.

Finally, this fall CSS will conduct a targeted survey of New Yorkers with Lake Research Partners. This survey will seek to learn more about what constitutes affordable universal health care in New York by reaching out to people below 200%, between 200%-400% and above 400% of FPL in four regions (urban downstate, suburban downstate, urban upstate and rural upstate).

We hope you will permit us to return before this panel to present our findings and our proposal for achieving universal health coverage in New York to you.

Thank you for providing me with the opportunity to testify today.

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<sup>35</sup> CSS, Unheard Third 2007 poll of 1,551 New York City residents conducted in July-August 2007 by Lake Research Partners (Q57).