

New York-based information sources, but to seek out testimony from pertinent experts elsewhere as well.

By maximizing transparency and public engagement, the State can minimize the risk that special interests will distort the process. After the outside study, once the executive branch develops recommendations, it will be important to have another set of hearings to help the State refine those recommendations. To win public support, there will need to be clear justification for the choices made.

Apart from comments at this time on five matters, Rekindling Reform will reserve other remarks for your October 30 hearing, in New York City.

Centrality of cost control

The amount that we as a nation spend on health care per person is high as compared with other wealthy developed countries, and our health care spending keeps growing faster than the economy overall. This leads to ever rising numbers of uninsured and underinsured. Rekindling Reform emphasizes that if New York is to move toward universal coverage in ways that will be sustainable over time, the State cannot simply plan on dealing with those who are currently uninsured and underinsured. It must recognize and address (1) the *ongoing* erosion of job-based coverage and (2) the continuing rise in the costs of coverage and care in all parts of the health care system.

Public discussion of health system cost control confuses people when, as often happens, it fails to distinguish between cost control and cost shifting. Who pays and the overall costs of providing coverage and care are different matters. Cost shifting by employers or insurers to patients is too often cloaked in cost control verbiage. You can do New Yorkers a service by insisting that the distinction is always respected in these hearings.

Rekindling Reform suggests that the explanation for higher costs in New York and other high cost states reflects mainly an overabundance of specialist practitioners together with a critical shortage of primary care practitioners. High costs result because of the set of incentives and pressures under which the practitioners work:

- An initial heavy burden of personal debt due to the extraordinary cost of medical education and training
- The high cost of liability insurance coverage that arises from the way we have chosen to protect the public from the consequences of malpractice
- The perverse incentives of a provider payment system that rewards providers according to the volume of procedures performed on each patient.

New York, if it wished, could develop a pilot project aiming, over a period of years, to bring these factors under control. A successful pilot could become the basis for state-wide systemic reform. That in turn would open the way for changing the main focus of New York's medical culture from high-cost acute/tertiary/inpatient care to lower-cost primary care in community-based (ambulatory) settings, with an emphasis on prevention.

A contributing cost factor that is less location-specific is the failure of the State to use its bargaining power to reduce prescription drug prices for New Yorkers. Rekindling Reform has

supported and continues to support legislation that could enable the State to negotiate pharmaceutical prices on behalf of a very large proportion of New Yorkers.

Another significant cost factor is health insurance profits. We'll make some recommendations on this.

How not to achieve affordable health insurance premiums

If the State is not careful, a quest for affordable coverage for uninsured New Yorkers could lead to replacing uninsurance and/or good coverage with under-insurance. This could result either from settling on a bare-bones benefit package or from imposition of cost sharing in the form of co-pays or co-insurance. Such cost-sharing is as likely to be a barrier to needed care as it is to unnecessary care. No family should have to choose between paying for the health care it needs and paying for other necessities of life. Should a family be forced to choose between paying for health care and sending a child to college? Rekindling Reform thinks not. Decision on whether patients should receive a needed medical service should be made jointly by patients and their trusted clinicians, not by the patients alone in consultation with their wallets. Of course, we'd need to make sure that the provider payment system doesn't bias the clinician's decisions.

Health insurance regulation

Rekindling Reform supports strengthening consumer protections in the health insurance area:

- We applaud the Spitzer administration's call for prior approval of health insurance rates, to replace the current "file and use" procedure.
- Further, the Department of Insurance should be given the resources to audit insurance company compliance with the State's medical loss ratio standards.
- We recommend raising minimum medical loss ratios to 85 percent of a plan's gross income.
- With respect to claims payment, we encourage the State to study a recent suggestion by economist Dean Baker, co-director of the Center for Economic and Policy Research. Baker has proposed that "health insurers must pay claims unless they can show a deliberate act of fraud on the part of the beneficiary. In other words, unless the insurance company can show that the insuree deliberately lied or concealed information, they must pay the claim."

Commercial insurance vs. social insurance

The Partnership for Coverage asks for comments on the respective advantages and disadvantages of single-payer and multi-payer models. We hope to bring expertise to bear on this question at a later hearing but it occurs to us that a more fundamental distinction that you could help the public understand first is the difference between social insurance and commercial insurance.

The social insurance model: the citizens of a state or nation decide that, to get financial protection against a set of shared risks, they will set up a common pool. Typically, the pool is financed by contributions from workers and their employers. Participation is mandatory, so nobody is excluded. Contributions are according to workers' earnings, and participation means entitlement to a common defined benefit. The sense of entitlement is associated with a sense of

mutual ownership of the pool. In a nation in which each of several employers has a big enough work force, those employers and their respective work forces could each operate what is essentially a social insurance pool under common regulatory standards. Other countries can show us a variety of implementations of the social insurance principle.

The commercial insurance model: a corporation sets up a pool as a business operation, with a view to deriving profit. Typically, several insurers compete for customers, offering insurance “products” that vary in benefit according to the premium charged. Depending on the regulatory environment, the insurers may or may not be required to accept all applicants, and may or may not discriminate in the premium levels charged. However, the insurers, accountable to their corporate investors, use selective marketing strategies to maximize profit. They compete largely by avoiding higher risk customers. In principle, regulation could minimize selective marketing but there has been little experience with that.

A possibility for federal help

Both houses of Congress have passed bills that would reauthorize and substantially expand the State Child Health Insurance program. They await reconciliation. The House bill, more generous in respect to SCHIP expansion than the Senate’s, also includes multiple provisions that would protect and substantially strengthen Medicare. It includes the most comprehensive and extensive improvement in protections for persons with low incomes in nearly 20 years. Among other things, it would eliminate the “doughnut hole” in prescription drug coverage for Medicare beneficiaries living on less than \$15,312 a year. Rekindling Reform urges the State to ask its two senators, in particular, as well as its representatives in the House, to press for the House bill’s provisions to prevail in the reconciliation process.

Thank you for your attention.

New York Universal Health Care Options Campaign

Principles for a Universal Health Care System in New York State

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

1. Health care is a human right. Government must assure that this right is realized. Markets alone cannot.

2. Universality. Universal health care means 100% of the residents have easy access to affordable 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. Affordability relates to premium payments as well as to conditions for utilizing benefits.

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.

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