

Public Hearing
The New York State
Partnership for Coverage
Department of Health Department of Insurance

New York City – October 30, 2007

Testimony of
Rekindling Reform

Good morning and thank you for this opportunity to testify. My name is Robert Padgug and I am testifying on behalf of Rekindling Reform, a nonprofit project sponsored by 72 organizations in the New York City area – academic institutions, professional organizations, civic associations, trade unions, local community groups, and faith organizations (list appended). Rekindling Reform takes part in the debate over a universal, affordable, and high-quality health care system by stimulating informed public discussion and advocacy and by allowing participants to share information and collaborate in the design and implementation of strategies for reform. I am Co-Convener of Rekindling Reform for 2007-2008.

As Sid Socolar, Rekindling’s other Co-Convener, noted on September 5 at the Glens Falls hearing (see attachment), our organization is pleased that the Partnership for Coverage is holding this series of public hearings in order to maximize transparency of, and public participation in, its process. Only a thorough understanding of the options actually available to New York State to achieve universal coverage can lead to a successful outcome of the Partnership and similar processes.

There are, indeed, many possible approaches to health reform, as the numerous proposals that have been put forward at both state and federal levels demonstrate. Not all, however, will adequately achieve the necessary goals of a meaningful health system, including universality of coverage; ease of access to a very broad package of benefits; adequate, equitable, and sustainable financing; simplicity and transparency of operations; low administrative costs and other cost savings; the broadest possible risk sharing; and, finally, but not least in importance, full accountability to the residents of New York.

One approach that would meet all of these goals, as has been pointed out in these hearings and in many other public forums, is a uniform, state-operated and financed, single-payer system. Single-payer systems, whether modeled on Medicare or Medicaid or constructed in another fashion, have already been shown by several state-sponsored studies – the California Health Care Options Project, completed in 2002 is a good example of these¹ – to offer the most coverage at the lowest possible cost. We assume

¹ See California Health and Human Services Agency, *The California Health Care Options Project: Final Report* (prepared for the Health Research and Services Administration. Sacramento, September, 2002. For further information, go to <http://www.rekindlingreform.org> or contact Rekindling Reform, 1
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that at least one, and possibly more, of the approaches that will be studied in greater depth as part of the Partnership and process will be a single-payer plan.

Other approaches are, of course possible, approaches that in some fashion involve a public and private partnership and to some degree build on existing financing systems. We do not intend to suggest here what such systems might look like in detail – the best approaches for New York will hopefully emerge during this process – but we do have informed views about some of the elements, standards, and general approaches that should be included in such plans if they are actually to meet the needs of our state. In general, we have drawn, wherever possible, on the actual policy experience of New York State, insofar as it was at least to some degree successful and continues to offer useful lessons for the present and the future.

Here we think, above all, of such systems as NYPHRM, the New York State Prospective Hospital Reimbursement Methodology, which, from 1983 through 1996, aimed to create and nurture a coordinated, state system of at least inpatient care and financing, whose aims were broad insurance coverage, financial stability for providers, wide availability of services, and significant – and necessary – state regulation of insurers and other payers. For it still seems clear to us that for any reformed health system to be effective, the State of New York must play a central role in its creation, implementation, and operation. In no other way can the activities of very different systemic participants (in particular providers, insurers, employers, unions, individuals, and state and federal governments) with diverse and sometimes conflicting interests, be effectively managed in the public interest.

That said, any realistic system must address several significant issues, including coverage and benefits, financing, cost control and affordability, adequacy of reimbursement for medical providers, and incentives for insurers or other financing agents to act in socially-responsible ways (see the attached Principles for a Universal Health Care System in New York for a full list). If framed appropriately, these issues do not necessarily lead to contradictory solutions with unacceptable “trade-offs” that actually harm large portions of the population. Above all, a substantial benefit package does not automatically have to lead to uncontrollable cost increases. The widespread belief that our population uses “too many” services, however that is defined, is largely inaccurate, and the old insurance shibboleth of “moral hazard” is much over-rated.² Costs do have to be controlled, of course, but that can, at least in large measure, be accomplished partly by controls and regulations internal to the broad financing and administrative structures of a new system and partly by imaginative restructuring of the provider reimbursement and drug purchasing systems.

We, therefore, urge that any reformed system include a state-mandated minimum benefit package that includes increased and improved preventive and primary care, all

² See, most recently John A. Nyman, “American Health Care Policy: Cracks in the Foundations,” *J. Health Politics, Policy, & Law* 32 no. 5 (2007): 769-83.

necessary acute and specialty care, and services for the disabled and others with significant medical-care needs, and must at least be coordinated with an extensive long-term care system, now largely covered by Medicaid alone. In order for services to be widely accessible in actuality, insurers or other financing mechanisms must not be permitted to use medical underwriting or pre-existing condition waiting periods, and copayments or coinsurance must be eliminated entirely or set at very low levels, as in other modern nations. Copayments rarely do more than shift costs and render care unaffordable to those who most need it. High-deductible or similar policies should also be prohibited; these mainly break up coverage pools in undesirable ways and shift costs from the healthy to the sick, precisely the opposite of what health coverage should do.

To the extent that the proposals we consider and eventually implement actually involve roles for multiple, competing carriers, private and public, the state should incorporate as many regulations as possible to provide incentives and opportunities for insurers to eliminate much of the high administrative and other costs that are endemic to the current, uncoordinated system. To the extent possible, for example, participating plans should be not-for-profit; the state should nurture its remaining non-profit insurers and, indeed, create new ones to participate in a reformed system. The Insurance Department should resume its full regulatory role by regulating premiums, holding hearings on premium increases, and enforcing (as current pending legislation would do) a reasonable minimum care share (or benefit expense or loss ratio) on all policies, set at 90% of premiums *and* investment income. To ensure that coverage plans do not compete by selecting good risks only, the state should create a mechanism that prospectively or retrospectively adjusts for the health status of the members of insurance and other pools; there already exist many models for such systemic adjustment, including the redistributive pools that were created for the current state-mandated individual and small group plans.

Depending on the plan chosen, the state might also use the provider reimbursement system to provide greater incentives for both insurers and providers to act in socially responsible ways. Any system that alters current reimbursement arrangements would, of course, have to address both institutional and physician services. Physicians, although they are not the recipients of the largest share of health care funding, continue to make most of the decisions regarding medical services utilization. A universal system that provides physicians or other providers with, for example, the equivalent of a “global budget” would provide them with incentives to use resources wisely while leaving medical decisions jointly to them and their patients. We shall have more to say about such reimbursement options in the near future.

The state can further reduce the costs of the system by mandating prompt and administratively simple mechanisms for reimbursement from insurers to providers; by creating a single, “one-stop” and more efficient insurance enrollment system; by implementing malpractice reform (for example, through a no-fault malpractice system); and, in particular, by implementing a new pharmaceutical purchasing system with state-wide, public negotiations with drug companies to ensure that New York plans received

the lowest possible prices, similar to that proposed in recent legislative sessions by Assemblyman Gottfried and Senator Golden.

Rekindling Reform will address additional aspects of health system reform in later hearings and as the Partnership and similar processes unfold. At this point, I would be happy to answer any questions regarding our testimony to date.

REKINDLING REFORM is a non-profit joint project of some 70 organizations in New York. Our mission is to encourage debate and discussion on how our country can best provide affordable health care for all. We base our work in six principles that are the bedrock of our vision as to how American health care should be reconstructed:

- Universal and equitable coverage for all.
- Comprehensive benefits and quality health care providing a full range of services effective in preventing illness and improving health.
- Affordable costs and equitable financing.
- Administrative simplicity and sensibly organized work.
- Accountability to the public that is to be served and to the service providers.
- A strong public health system.

We welcome the diverse views of our sponsors on how these principles should be implemented. We bring people and organizations together to work toward these ends, knowing that reshaping of the health care system will be the product of our combined efforts.

Rekindling Reform Sponsors

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Women's City Club
Working Families Party
Yeshiva University Wurzweiler School of Social Work
* *Steering Committee member*

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

- b) Individual debt for the education of doctors and other health care providers must be substantially reduced.
- c) The burden on providers resulting from the way we try to protect the public from malpractice must be reduced.
- d) 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.

10. 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.

Public Hearing
by
The New York State
Partnership for Coverage
Department of Health Department of Insurance
Glens Falls, NY - September 5, 2007
Testimony of
Rekindling Reform

Thank you for this opportunity to testify. My name is Sid Socolar. I am testifying on behalf of Rekindling Reform, a six-year-old nonprofit project sponsored by 72 organizations in the New York City area – academic institutions, professional organizations, civic associations, trade unions, local community groups and faith communities (list appended). Rekindling Reform seeks the attainment of quality, affordable and accessible health care for all and promotes it by stimulating informed public discussion and advocacy. My position in Rekindling Reform is Co-Convener, a voluntary, rotating office.

Together with the Hunger Action Network of New York State, Rekindling Reform is a coordinator of the New York Universal Healthcare Options Campaign (NYUHOC). The Campaign is a four-year-old statewide effort by more than 250 consumer, faith, health care policy and anti-poverty groups to promote universal health care in New York. I have appended to this testimony NYUHOC's statement of principles for a universal health care system in New York.

During 2005, NYUHOC initiated a statewide educational campaign on the merits of New York's doing a cost-benefit analysis of various ways that the state could provide quality, affordable health care to all New Yorkers. The campaign worked closely with Assemblymember Richard Gottfried, chair of the Assembly Health Committee. The campaign was inspired by similar efforts in Maryland, Maine, Illinois, New Jersey and particularly California. More than 250 organizations endorsed the campaign – organizations including the NYS Nurses Association, NYPIRG, 1199 SEIU, NYSUT, NYSPEF, American Medical Student Association chapters at Albany and Weill Cornell Medical Colleges, Rochester Interfaith Health Coalition, and others.

Considerations of process

Given that achieving universal health care has been a challenging political problem, we judged that the public support needed for New York to adopt any particular model or strategy would best arise out of extensive public engagement with a study of the alternative approaches – that this would lead to an informed public weighing of the options facing the State. That was a key rationale for the Campaign.

We were pleased when the legislature appropriated \$200,000 for an outside study of the options and delighted when Governor Spitzer created the bi-departmental work group (DOH and DOI) that is conducting this series of five hearings over a three-month period. We

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applaud the State's support for a transparent and interactive public process. We urge you not to limit yourselves to 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 90 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.