

## Testimony for December 5, 2007

I am Mary Dewar, RN, retired nurse educator from Adelphi University, who has had 24 years of nursing experience in China, Angola, Zimbabwe, and Ghana, and president of the Long Island Coalition for a National Health Plan. I appear here today as representative of the latter group. We have been in existence for 25 years trying to educate, advocate and lobby for universal health care, single payer insurance. We represent a number of Long Island agencies including the Retired teachers, the grey Panthers, the League of Women Voters, the Long Island Council of Churches,

You have heard many times about the number of uninsured in New York of which 300,000 are on Long Island. You know about overcrowded emergency rooms. You may also know about the many who are uninsured for parts of a year due to change of jobs or being dropped by an insurance company for maxing out of allowed insurance claims as happens often in cancer treatment.

You may also know about the underinsured who have insurance but who are denied care by their agency for many treatments and for many different reasons. They are left with medical expenses to pay out of pocket in addition to paying the insurance premiums. You also know about the “doughnut hole” in the Medical Modernization Act, Part D of Medicare into which many elderly fall as early as March of a given year if they have heavy prescription drug expenses causing them to choose between food and medicine for they cannot afford both.

For those who have insurance, especially through their employers, many are being dropped or are feeling insecure that they may be dropped. Their companies cannot afford the expense any longer or are going out of business. They visit their families in other parts of the country and find that any health care need treated while away is “out of service” and becomes an out-of-pocket expense. Their choice of doctors is the choice of the employer in choosing the insurance company for his/her firm. The employer may change his health insurance company in any year and all the employees may have to change doctors for each company carries its own “bank” of doctors.

Therefore it has been our belief that the way to get quality health care to all those living in New York is to set up a single payer system that will provide the following advantages.

**Universality-** “Everybody in, nobody out” Every person living in the USA would receive a health care card, not unlike the Social Security Card that would have a number that would identify a person in any health care facility. This would give the consumer access to health care wherever he/she might be. There would be no primary questions about health insurance. The provider can start with the consumer’s health problem. Think of the improvement in interpersonal relations, the famed doctor-patient relationship, when the provider looks at the consumer and says, “How can I help you today?” instead of “What insurance do you have and give us your cards to xerox.” or “You have no insurance? Well then, go to the emergency room in the county hospital. We do not handle the uninsured.” Or “Your insurance card is not valid here. We do not handle clients from that insurance company.”

Again, the provider would no longer need a bank of secretaries to fill out applications and

bill 1500 different insurers for treatment given or proposed. Toronto General Hospital in Toronto, Canada, hires three persons to handle insurance papers while a similar-sized hospital on Long Island hires 300 for the same purpose. Think of the saving to hospitals and providers in paperwork and employees to do the paperwork.

Universal insurance would spread the risk pool to all persons in one pool, the healthy and the chronically ill. That is the *raison-d'être* of insurance that spreading the risk reduces the cost.

At present the healthy are often not in the system or are cherry-picked for the HMO's and the chronically ill are in a public risk pool which becomes unbearably expensive for it is made up of those who cost the system the most. The sick pay for the sick and the healthy go "scot free". And the public agency like traditional Medicare finds itself financially strapped. We need to move away from a philosophy of every man for himself to one of "we are our brother's keeper", a community that cares for all of its members.

Mandated purchase of health insurance as a way to universal health care supposes a philosophy of everyone for himself. Find your own way to buy health insurance and if you are offered a cheap policy ( one that you can afford ) you will also receive cheap care ( few benefits with large deductibles and co-payments) which will cost you more in the long run than no insurance. This is what Massachusetts is trying and others are contemplating. It is not the way to being inclusive of all. That is watered down insurance that costs more than the benefits.

**Portability-** With single payer everyone has insurance all the time, not tied to an employer, nor a local insurance company. That means that wherever you are in the USA you can obtain health care under your insurance plan. It will be good anywhere at any time. No one is tied to a job because of the health insurance.

**Choice-** This word has been used by many for many different purposes. In single payer, choice means that the consumer has a choice of doctors, hospitals, clinics without restriction. This is what consumers want. They do not want to be restricted to a specific bank of providers that may change as often as every year depending on the company the employer negotiates with. Choice of insurer is extolled as choice by politicians and some few of the more affluent may want this but those on lower incomes want insurance and if it allows them choice of providers that is sufficient.

**Comprehensive benefits.-** Benefits must be enough to cover all basic needs including vision, hearing, dental services, mental health, rehabilitation, home care, hospice care, long term care and population-focused services (i.e. public health). It must be uniform for everyone and have no exclusions for pre-existing conditions. To make this work even better, there should be developed over time evidence-based outcomes that suggest that certain treatments are the most effective way to treat certain health problems so that effective treatments become more uniformly used.

**Wellness care-** With universal insurance a great emphasis can be placed on healthy life styles and preventive care including screening. Primary care would become more essential and specialists less necessary. Since there is a shortage of primary care physicians now, there will have to be an increase in the training of primary care physicians initially both to take up the present slack and to prepare for a greater number of people using primary care. This specialty needs to be made more "sexy", if I can use such a word, so that it appeals to medical students

more than specialties which is not the present case. It also needs to be rewarded (salary) comparably with specialist salaries.

**Access-** Access to care needs to be clear and simple. There should be a standard form for all that is short. There should not be administrative and logistic obstacles to care. Funding must be sufficient to supply the necessary number and quality of facilities so that access is possible even in present underserved areas; e.g. inner city and rural areas.

**Accountability-** There needs to be a system for evaluating or auditing services provided annually. In addition there needs to be privacy protection and grievance procedures set up.

**Costs-** Can costs be reduced in a single payer system. Yes, they can although not initially

1. Paper work will be simplified to very few forms saving about 4 billion a year nationally ( work that out for NYS.)
2. Greater use of informatic technology so that patient records are available to doctors and tests do not need to be repeated
3. Global budgeting for providers using present statistics on budgetary needs would eliminate unnecessary testing and procedures done to increase income ( the present payment system)
4. Elimination of profits, shareholders, large CEO salaries, marketing fees and a high care-sharing ( medical-loss ratio) will reduce costs. Administrative costs can be reduced to 3-7% of the budget. Present private agencies have administrative costs amounting to 20-30% of their budgets.

5. According to Tim Joseph, chairman of the Tompkins County Legislature, in an article he wrote in the Times Union on November 4, he points out that there are a lot of hidden costs in offices of the government. For example in the Office of the Aging inordinate amounts of time are taken up by personnel helping people deal with the complications of Medicare, Part D, finding programs to assist people in navigating the health care system, fighting insurance company denials, sorting out who is going to pay for health care, negotiating in union contracts for the health care benefits, Two thirds of negotiating time goes to sorting out health care problems. Hours of staff time go to developing and publicizing discount prescription cards to reduce costs for the consumer. A consultant is usually hired to work out a suitable health care plan for the county agency staff.

These are only some of the hidden costs to government agencies at county and state levels that would be eliminated by a single payer system making workers for government more productive for other things.

6. The Lewin Group , a non-partisan research agency, prepared a study for the state of Colorado on 4 alternative proposals for health care reform. Only the single payer model covered everyone without exception and saved money, as much as 1.4 billion. I attach the summary version of a much longer analysis to this paper.

Therefore, we of the Long Island Coalition for a National Health Plan feel that the single payer model with the government as the payer is the most beneficial, most inclusive, most cost-efficient way to deliver health care.

We thank you for this opportunity to present our views and wish you great success in providing the NY State government with the data it needs to form legislation for more effective health care coverage in New York State.