Challenges Facing Our State in Its Pursuit of Health Care for All New Yorkers

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> [This article is adapted from testimony on behalf of Rekindling Reform to the New York State Partnership for Coverage at a September 5, 2007 public hearing. (The Partnership is a joint task force of the NYS Departments of Health and Insurance.) The testimony itself is accessible at http://partnership4coverage.ny.gov/hearings/2007-09-05/.]

The assignment facing the NYS Partnership for Coverage is formidable. Governor Spitzer has charged it with generating development of a plan that assures "access to affordable, high quality medical care for every single New Yorker, reduces the overwhelming and unsustainable cost of healthcare incurred by the public and the state, and avoids the significant implementation problems that have plagued other state efforts in this area,"

To fulfill this assignment, the Partnership process will have to produce a health coverage proposal that is comprehensive, affordable, sustainable, and universal. All who participate in the process need to help develop a shared public understanding and expectation as to what each of these requirements means. Rekindling Reform will be elaborating its views on this multifold challenge. Here are some first thoughts.

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 a sound 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 four year long effort by the NY Universal Healthcare Options Campaign, led jointly by the Hunger Action Network of NYS and Rekindling Reform.

We were pleased when the legislature appropriated $200,000 for an outside study of the options and delighted when Governor Spitzer created the Partnership for Coverage, which is conducting this series of six hearings over a three-month period. We applaud the State's support for a transparent and interactive public process. We urge the Partnership not to limit itself to New York-based information sources, but to seek out testimony from pertinent experts elsewhere as well.

By maximizing transparency and public engagement, the Partnership 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.

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. 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. Cost shifting by employers, governments or insurers to patients is too often cloaked in cost control verbiage. The Partnership can do New Yorkers a service by keeping that distinction clear and explicit in the course of its work.

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. I comment on this further on.

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. Accordingly, neither should a family have to choose between paying for health care and sending a child to college. As to decisions about whether any particular medical service is to be rendered, patients together with their trusted clinicians, not patients alone in consultation with their wallets, should make the decision on whether that service is needed and should be rendered. Of course, we'd have to make sure that the provider payment system doesn't bias the clinician's decisions.

Health insurance regulation

We need stronger consumer protections in the health insurance area:

- The Spitzer administration's call for prior approval of health insurance rates, to replace the current "file and use" procedure, is a great step forward.
- The Department of Insurance should have sufficient resources to audit insurance company compliance with the State's medical loss ratio standards.
- New York should raise the minimum medical loss ratios to 85 percent of a plan's gross income – that is, 85 percent of the aggregate of its premium income and investment earnings.
- 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. Rekindling Reform hopes 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, contributions from workers and their employers finance the pool. Participation is mandatory, so nobody is left out. 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 where each of several employers has a sufficiently big and diverse 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 differ in benefits 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.

Using the term "health insurance" without understanding the difference between these models is sure to lead to confused reasoning and to plans with unanticipated consequences.