



Testimony before the New York State Partnership for Coverage

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Good morning. My name is Richard Kirsch, Executive Director of Citizen Action of New York. Citizen Action's mission is to work for economic, social, racial and environmental justice. We have 23,000 members and hundreds of volunteers who work with a professional staff of more than 30 from seven offices in our State, located from Long Island to Buffalo.

For the past 21 years we have actively campaigned for quality, affordable health care for all residents of our State. Citizen Action was active in the effort that established EPIC in 1986. We helped lead the campaign in 1989 that expanded Medicaid eligibility to the poverty level, only to see that coverage erode since it was not indexed to keep up with changes in poverty. We helped win the establishment of Child Health Plus and played a major role in its expansion from a program that provided only outpatient services to children under 13 to the comprehensive program we know today. We worked with Assembly Health Committee Chair Richard Gottfried to write and win Assembly passage in 1992 of New York Health, a public health insurance or "single-payer" bill. Our research affiliate produced the financial analysis for that legislation which led to the design of the financing for the bill. With the collapse of universal health care in 1994, we turned our attention to managed care, playing a major role in writing, passing and then winning enforcement of New York's strong managed care consumer protections. In 1998 we campaigned hard to win establishment of Family Health Plus and last year we helped led the successful campaign to win financial assistance protections for uninsured hospital patients.

We recount this history for two reasons. One, we want you to understand that we bring a longstanding commitment and passion to drive to bring justice to health care in our state and nation. Two, because we hope that what we have learned over the past two decades will be helpful as we move forward together in the coming months and years.

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During the past several months, our local leadership has been in active discussions about what we will recommend to the Governor and other state and federal policy makers on how to achieve quality, affordable health care for our state and nation. You will hear testimony on those recommendations from our local Citizen Action members during the fall. Today, I wanted to discuss with you our view on how to think about the problem and solutions systematically rather than focus on particular solutions. It's important that we have a clear conceptual framework for what kind of solutions will work and what won't. I also wanted to share some broad findings from a very innovative national public opinion research project that I've been part of.

First we need a vision. Then we need an analysis. Then we need a plan, or plans. And finally we need the will to change.

There are two visions of America. One says that we are on our own. The other says that we are all in this together. Creating a health care system that works for all of us must start with the vision that we are all in this together. The failures of our health care system can't be blamed on any one person or group – on business, or government, or individuals. All of us want the same things. We want health care that is affordable – affordable to our families, our businesses our local governments and school districts. We want health security – we don't want to worry that losing a job will also mean losing our health care. Or that we won't be able to take advantage of a new job opportunity because we might not get health insurance. We worry that a serious illness could threaten not just our health, but our family's financial health.

Our businesses are concerned that the next hike in health insurance could make it even more difficult to compete. Our school districts are being forced to raise property taxes to pay for skyrocketing health care costs.

We shouldn't be working for the health care system. Our health care system should work for all of us. All of us, families, businesses in partnership with our government, must join together to make sure that the lack of health care is not an obstacle to achieving the American dream. We need to work together to make sure we have a health care system that works for all of us, guaranteeing economic and family security, a fair system that provides opportunity for all. Together we can build a health care system that provides quality, affordable health care for every one of us.

The vision that we have a common stake in the health care system is underscored by the analysis that health care is not a commodity, it is a public good. It's a public good because access to affordable, quality health care is a human right. It's a public good because we share the air we breathe, the water we drink, the food we eat, the communities we live in. It's a public good because when any one of us is ill and unable to contribute to our society, to work, to learn, to care for family, so many others suffer. Ultimately, we all suffer.

This is exactly the opposite with the view that health care is a private good, a commodity. The conservative diagnosis of the problem with our health care system is very simple and entirely consistent with its broader worldview: health care costs are too high because individuals are not responsible for paying for their own health care. Under this view, when consumers are insulated from paying for coverage they do not act as prudent consumers and use care that is not needed. The solution is consumer driven health care: require consumers to purchase coverage and costs will be lowered as consumers choose the best value – the best quality at the best price.

The view that health care is a consumer good like any other consumer good and that health care markets work like other markets is pure fantasy, at odds with everything we know about how health care is actually consumed. From an economic analysis, we have the least efficient health care system in the world. Efficiency, in lay terms, is what you get for your money. We spend the most by far and yet not only do we not provide coverage for about one-out-of-six people, our quality lags well behind so many other nations on a host of measures. The reason that we have by far the highest health care costs in the United States, while at the same time having the worst access and among the poorest health outcomes among developed nations, is precisely because our current system largely treats health care as a private commodity. Deepening and accelerating the use of health care as a private good will only raise costs and further reduce access.

We can approach this discussion from many directions. For starters, health care markets are exactly the opposite of the basic economic theory of consumer demand. That theory is based on consumers, who have complete information, creating demand based on their preferences.

In health care, it is not consumers who have the most information and who drive demand. We spend hundreds of thousands of dollars educating doctors and other practitioners so that they can make informed decisions about what the proper supply of health care should be to treat disease. We give the suppliers of health care the legal authority to determine demand: prescribe

tests and medications and undertake medical procedures. While good practitioners listen to their patients, they use their training and experience *and* listening to determine the best course of care – that’s their job. We don’t want consumers to be practicing medicine, particularly when they are using cost as their prime method of determining treatment.

This is not to say that consumers have no role in generating demand. The explosion of drug company consumer advertising is aimed at getting consumers to ask their doctors to prescribe medications, based on the scanty information and slick spins of the ads. Still drug companies spend even more pushing drugs on the doctors who will decide whether to prescribe the medications.

The other part of the economic theory that’s absurd when it comes to health care is the idea of consumers acting from their preferences. Would you prefer cancer to heart disease? If you have cancer would you prefer chemotherapy to radiation? People end up in the health care system quite against their wishes, particularly when it comes to the serious illnesses that are responsible for most health care spending.

Let’s look at some of the aspects of seeing health care as a commodity and how that view raises costs and hurts quality.

The most obvious, a bedrock principle of conservative solutions, is to place more costs directly onto consumers. Doing so doesn’t create more prudent consumers; it raises costs and hurts health outcomes. When consumers put off getting care until medical conditions are further along, the cost of treatment rises. When consumers don’t get preventive and primary care, they end up needing more extensive, expensive care. (This doesn’t count the “external” costs, like lost workdays, family strain, etc). The old adage that “an ounce of prevention is worth a pound of cure” is as true for the health care system as it is for an individual. It is no accident that we already have the highest out-of-pocket costs of any health system in the developed world, and the most costly system.

The same logic applies to decisions not to include coverage for a benefit that’s needed to sustain health. Failing to cover something saves money for the payer but not the system; it simply transfers costs to the person. The most common example is dental coverage; there is ample evidence that people who can’t afford dental care suffer many non-dental, costly health problems and are also much more likely to experience problems getting and keeping a job.

Let's look at the myriad of ways that treating health care as a commodity plays out in our private insurance system. Insurance companies want to maximize their profits in the short term, the length of time they will cover someone, likely to be only a few years if that. They don't have any financial incentive to look at one individual's long term health. So as a CEO of New York's largest health insurance coverage told me some years ago, there is no incentive to cover preventive care since their company has little chance to benefit from the prevention. Of course, there's no incentive to provide good management of chronic care, either if that means attracting and keeping more chronically ill people. There's generally no incentive to cover individuals or groups of individuals who are in poor health, or who are older. It makes much more sense to market to younger, healthier people. If you are stuck with selling to people who most need coverage, then the business logic is to raise premiums and out-of-pocket costs, getting us back to the problems that higher out-of-pocket costs creates in raising system costs and hurting outcomes.

As we know, insurance companies also have every incentive to delay paying a claim. The longer the claim takes to be paid, the longer the company gets to hold onto its money. And if the claim is never paid, so much the better for the bottom line. Thus we have a huge game of payment delays and cost shifting. The myriad of plans and rules generates high administrative costs in the insurer, and even greater costs that insurers place on doctors, hospitals and other providers forced to try to collect payments from a bewildering array of insurers, each with multiple plans. On top of this, but not counted in the national budget for health expenditures, is the cost to families of wading through a morass of confusing bills and the cost to employers of having to choose between and administer competing health insurance plans.

The fact that health insurance is a commodity, with a price, is also why health care is particularly unaffordable for lower wage workers and their employers. The cost of health insurance is harshly regressive. Under our current employer system, an employee's health premium is the same for the CEO and the secretary, the lawyer and the legal assistant. Think about what this means if you're an employer. If you hire someone at \$100,000 a year, the cost of family health care plan adds 10% to their salary. But if you hire someone in a job that pays \$30,000, health insurance will raise the cost of hiring them by one-third.

The high cost of health insurance for low-and-moderate wage workers creates huge burdens for their employers. And since those employees are likely to not be covered, or to have

to pay a share of the premium which is a big chunk of their wages, it means tremendous financial hardship for those families who already have the toughest time making ends meet.

When we look beyond the insurance industry we see other ways that treating health care as a private good, a commodity, raises costs and often lowers quality:

- We see hospitals duplicating services: e.g. neighboring academic medical centers providing the same, high-tech specialty service, competing for services with the most prestige and biggest price tag. This means duplication of resources and diminishment of quality when there is so much evidence that practice moves towards perfection.
- We see doctors duplicating services offered by hospitals: e.g. the private radiological group that refers patients to its own MRI, across the street from the hospital's MRI.
- We see a prescription drug market that produces prices several times higher in the United States than in other nations, mostly for highly profitable copy-cat drugs with no added therapeutic value compared with much cheaper drugs already available. Every other nation (and our own Veteran's Administration) sets drug prices and considers efficacy.

Treating health care as a commodity also helps explain the poor access and quality in low-income communities and communities of color. When poor people don't have insurance there's no incentive for health insurers to pay attention to health care to their communities or to health care providers to practice in those communities. There's that much less interest in doing research on treatments for people of color. The system does not create financial incentives for paying systemic attention to health care in low-income communities, communities of color and populations of people who are working poor.

The alternative to a system like ours, in which health care is a commodity, is to systemically treat health care as a public good¹.

Generally, we create public goods in two ways. One is to have the public provide the good. The other is to through regulation of private entities. In reforming the health care system, we should do both. In every case, it means thinking about health systems in a different way,

¹ Donald W. Light has studied health care systems in developed nations and identified ten benchmarks that foster a "justice-based" health care system. These benchmarks include: universal participation regardless of health condition, risks and ability to pay; minimizing non-financial barriers; comprehensive and uniform services; equitable financing through community-rated contributions and ability to pay; value through clinical and financial efficiency; public accountability and choice of providers. *Fostering a Justice-based Health Care System*, *Contemporary Sociology*, 1999; 29; 62-74

which will in turn, generate appropriate solutions. Each of the problems I identified above, helps direct us toward those solutions.

Let me give one example, from the issue of hospital payments. In 1991 Citizen Action's research affiliate published a study of hospital global budgeting, based at looking at Quebec's single-payer system and the multi-payer system that then existed in Rochester². What united the two systems was providing hospitals with a predictable amount of revenue, independent of the volume of admissions while at the same time eliminating incentives for redundant technology, clinical services and capital. Both provided mechanisms to determine and direct services to the community's health needs. The details of the systems were very different, as can be expected, but the thinking behind them was closely aligned.

Here's another example. For years, there has been data in New York on huge disparities in Medicaid spending between counties in New York, based on differences in clinical treatment patterns³. But even though this is a huge cost driver with enormous implications for quality, the State has not sought to use the data to attempt to change treatment patterns.

How might it to do this? Well, let me give you an example from Great Britain's health service, in which physicians received bonuses for using information systems to improve outcomes in their practices.

The size of New York's public investment in health care and the strong regulatory history in the State, means that we have many tools at hand to make these kinds of changes. In the area of health insurance, we can establish a public health insurance program in which individuals directly or through their employer can enroll. We can address the problem of the crippling regressivity of health premiums by basing premium payments in the public program on earnings instead of a fixed charge per person. Doing so would dramatically lower the cost to business of providing health coverage for low-and-middle income workers and to their low-and-middle-income employees. It's the same we pay for Social Security and for retirement benefits. It makes great sense for health care.

We can also demand much more of our publicly-paid for but privately run programs such as Medicaid, Family Health Plus and Child Health Plus. We already mandate coverage and beneficiary costs – removing two tools that insurers use to increase profits at the expense of

² Hospital Global Budgeting: A Key to Health Care Reform, Public Policy and Education Fund of New York, 1993.

³ The Geography of Medicaid Spending, Signalhealth, 2003.

patients. We can pay much more attention to insurer expenses, to patient access, to provider networks, to being sure that the public dollars are improving patient and community care.

We can take the protections we now have in the small group market of community rating and guaranteed issue and expand that to all markets, creating a larger pool and reducing incentives to game the system for the large group market.

We can choose to invest our public dollars in communities of color and low-income communities, working to create equitable access and treatment, by including this criteria in each of our public investment decisions.

Whatever changes you recommend to the Governor will have to pass the hardest test, the ability to hold the public will to change, in the face of well-financed attacks. Before concluding this morning, I'd like to take a few moments to give you some insights from an innovative public opinion research project that I've been involved during the last two years. The project, run by the Herndon Alliance, has taken an in depth look at American public opinion on health care reform. The first year of findings are available to the public at Herndonalliance.org. Once the second phase is done, which will be this fall, I'll arrange for a thorough briefing for the Partnership for Coverage staff. That data will also be available publicly. Here are the most important lessons to take from what we've found so far

- People take health care very personally. As a result, the health care debate fundamentally changes when the discussion moves from the problem to the solution. When you address particular solutions, people's first concern is how it will impact them and the fear that it will hurt their access to affordable, quality coverage. So it is very important to frame solutions that reassure people about the impact on them personally.
- People have mixed feelings about government. They understand that only government can protect them against the insurance industry, drug industry and other powerful forces. They want government as a watchdog and rule setter. But they are concerned about government's ability to effectively provide health care and generally skeptical about government's efficiency.
- People want choice and control, although not competition. They strongly value choice of health care provider. Choice puts them in control, while competition is about maximizing profits, at their expense.

➤ People want an American solution, as they will want a New York solution if the State is to act. And since any solution that we come up will be by definition a New York solution, we should trumpet that proudly.

We should be proud of the progress we have made in New York in lowering the number of uninsured through the establishment and expansion of public health insurance coverage. But we should be mindful that despite these gains, we have millions of uninsured and skyrocketing costs pressure throughout the system. There is a limit to what we can accomplish without tackling the systemic problems. Unlike other Governors who have focused only on expanding coverage, Governor Spitzer has made it clear we must expand coverage and control costs systemically. Doing so the right way will improve quality.

The Governor has committed to building blocks for reform. If the building is to stand, it must rest on a foundation that sees health care as a public good. Each block must rest on that foundation, or the building will crumble. As we work with you and the Governor and other like-minded New Yorkers over the next months and years, we will bring to each recommendation and proposal that same test: does this establish health care as a public good or is it based on market-based solutions which will cause the structure to collapse.

We will also ask whether the proposals can be explained to the public in a way that reassures them about change, that appeals to their hopes and aspirations and quiets their fears.

In the end, winning real health care reform will require a clear vision, a persistent, strategic energy and a belief in the miracle of change.