

Testimony
by
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THE PROBLEM: To be effective, insurance must include all members of the group that may need to be compensated. In the case of health insurance, we must insure not just those who are sick, but those who are healthy so that the risk can be spread over the entire group.

In our current health care system, the most likely to need to call on their insurance for help—i.e. the elderly and disabled—are grouped in Medicare and Medicaid. Meanwhile, the healthiest segments of the population are insured privately, usually through an employer. Most pay at least part of their premiums through payroll deductions. We need to bring all segments of our population together under a single umbrella for our insurance system to be effective. Which umbrella should it be—public or private?

It is a fallacy, widely believed, that employers pay for the majority of health care in this country. In fact, their share is about 20%. The other 80% is paid for by you and me. Don't believe it? Consider your pay stub. Check "Fed. Withholding". Your federal taxes pay for health insurance for all federal employees, the VA system, and military medical care. "NY Withholding": Your state taxes pay for health care for state employees. Get out your property tax bill. When you pay your school taxes, you are paying for insurance for teachers, administrators, and support staff. County and city taxes? Right. Insurance for all those city and county employees. Except for the VA and the military, all this health care is purchased from private insurance companies. Back to your pay stub. Under "FICA MC" you will find a small deduction for Medicare. Medicare and Medicaid are the only government health insurance paid directly by taxes. Altogether, all levels of government—i.e. you and I--pay for 60% of the health care provided in this country.

But you said 80%. What happened to the other 20%? Check that pay stub again. Most of us pay a portion of the premiums for our health insurance. Then, before the insurance company pays a dime, you have to pay a Deductible. Once you have met your deductible, you have to make Co-Pays to your providers. Then there are Out of Pocket Expenses. This may include your medications. For those with no insurance (47 million nationwide and 2.5 million in New York) ALL expenses are out of pocket. For the additional estimated 40-70 million under insured, huge deductibles make their policies useless except for catastrophic illness. Add all these up and you have 20% of the health care bill.

There are other problems associated with employer provided private insurance. If you are a part time worker, you may not qualify for your employer's plan. If you have a "pre-existing condition," you may be refused

coverage altogether or be charged higher premiums than healthier members of the plan. If you become too ill to continue working, your insurance will be discontinued when you most need it. (75% of people declaring bankruptcy because of medical bills were insured when they became ill). This results in a continuing winnowing of the pool of the insured, with the elimination of the ill and inclusion of the well—an obvious advantage to the insurance company. If you do lose your job, you have the right to continue with your health plan for eighteen months through COBRA. You have to pay all the premiums yourself, but you at least have health insurance. I did the math on my wife's insurance plan through her employer. The policy costs \$13700.42, of which we pay about 10%. Of course that is a GROUP rate. If we were to take over the payments, it would be considerably more. Should she lose her job, it is fair to say that there would be 47 million and two uninsured citizens in the country.

No, I take that back. Make it 47 million and one. I have a Medicare card and none of the problems noted above apply to Medicare. It follows you from job to job—whether part or full time. It is not discontinued if you lose your job or are too ill to continue working. Your premiums are not based on the seriousness of your illness and you are not refused for “pre-existing conditions.”

So which umbrella? Public or private? Unfortunately, we can no longer afford private insurance. Several studies of the insurance industry have concluded that companies offering medical insurance are responsible for overhead costs amounting to 31%. This means that for each dollar you send to the company, only 69 cents is actually spent on health care. The rest goes to profits, marketing, sometimes outrageous executive salaries, and a huge army of employees deciding whether to pay your claim or not. In the last 30 years, while physician numbers in this country have doubled, the number of administrative workers in the medical insurance industry has increased nearly thirty fold. Similar increases in hospitals and doctor's offices contribute greatly to the overhead costs associated with private insurance. By contrast, overhead expenses for the Medicare program amount to 3%.

Let's put some numbers to the above statistics. We spend in this country over 2 TRILLION dollars on health care each year. That's a 2 with twelve zeros after it. Thirty percent of that number is 600 BILLION dollars (a 6 with eleven zeros after it). If we could save that amount of health care dollars, we could easily insure every citizen in the country and have enough left over to pay for all their medications and long term care.

A SOLUTION: Our present system has demonstrably failed in cost containment, access to care, and in population health outcomes and should be replaced with a single payer system. Studies have been done of the health care systems in California (twice), Connecticut, Delaware, Georgia, Maine, Maryland, Massachusetts (twice), Minnesota, Missouri, New Mexico, Rhode Island, and Vermont. In each case, the conclusion was that the state could save substantial amounts by switching to a single payer system of reimbursement. What happened to those studies? We know about the California and Massachusetts decisions. They have decided to try and force all citizens of the states to purchase private insurance. If you refuse (or can't afford it) you will be fined. To make the policies "affordable" they will have to be stripped to the bare bones and/or have huge deductibles.

Let's not follow California or Massachusetts. Let's not tweak Medicaid, give tax credits or subsidies for private insurance, or enlarge Healthy New York. It's time for New York to lead again. We are a microcosm of the rest of the nation. Our 2.5 million uninsured are the same proportion as the 47 million are to the country. As a nation and a state we are already way behind the rest of the industrialized world. Our employer based system is unique in the world and it fails those who need it most. The time for single payer has come. We can act now or we can go on adding another million uninsured every year and wait for the entire system to implode. Let's be proactive and not let that happen.