

New York State Department of Health and Department of Insurance
Partnership for Universal Health Coverage
Public Hearing
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I'm Theresa Alt from Ithaca, New York. I'm speaking for the Ithaca Local of Democratic Socialists of America.

We know why we're here. We're here because about 2.5 million New Yorkers are uninsured — among 47 million Americans, despite our having the most expensive healthcare in the world. We're here because that Cadillac-priced system gives lackluster results.

You probably think that because I'm a socialist I will be advocating socialized medicine. I won't. It's not that I have anything against it. Socialized medicine is a nationalized system where the government runs the whole healthcare system; doctors, nurses and other medical personnel are paid salaries by the government to do their work. Examples are Cuba and the United Kingdom. In 2003 per capita spending on healthcare in the United Kingdom was less than half that of the United States. Yet British infant mortality is 4.8 per thousand compared to 6.3 per thousand for the United States. British life expectancy at birth is 79.4 years compared to 78.2 years for the United States. So the British outcomes are slightly better than ours. In the film *Sicko* Michael Moore presented the human side of the British system. But, nobody in the United States is proposing a national health system, so that's not what I'm going to talk about.

I am going to talk about some of the systems that *are* currently being proposed in the United States. One type — called “play or pay” — shows up in many versions: the Massachusetts plan that is just now being put into effect, the plans offered by Clinton, Obama and Edwards. These plans all offer a mix of requirements. Larger employers are typically required to insure their workers; those who don't play this game are required to pay toward insuring the uninsured. Individuals who aren't covered by their employers or don't have employers are required to buy their own insurance. There's a pool of tax money to subsidize low-income uninsured individuals. Typically Medicaid and Medicare are left as they are. Typically there is some set of standards that the private insurance plans have to meet.

Now here's the rub. This approach is going to be super-expensive. Providers and insurers both still have all the paperwork of figuring out who's in which insurance plan, what does that plan cover, for how much money? You have the parallel bureaucracies in the different insurance companies as well as the doctors' and hospitals' office workers who deal with the multiple insurance companies. You still have the change to a new insurance company when someone changes jobs. At present about 30% of the money paid for private health insurance typically goes for bureaucracy, advertising and profits. There's not much in these “play or pay” schemes to improve that. Competing companies will try to attract the healthiest clientele and leave the sicker, more expensive ones to the government-funded alternatives, just as they do now. They will continue to try to make

money by denying claims. And to the extent that rules will forbid them from making profits in these ways, they will keep coming back to the government whining that they can't afford to do the job and demanding higher and higher rates. With a requirement on individuals to purchase coverage, that ultimate market mechanism, the ability to walk away and refuse to buy, won't be there as an option to put a limit on prices.

The problem is not that insurance company executives and managers are greedy, evil people — though they may be that. The problem is that as executives and managers of for-profit companies their legal fiduciary duty to the owners and shareholders is to maximize profits. So they do their job and innocent people get hurt. We need a wholly different structure.

Other the plans being proposed are very different from this. These are the so-called single-payer plans. They are not socialized medicine, for doctors can practice independently on a fee for service basis under them. They are, however, socialized health insurance. Examples are HR 676 in Washington — a national plan, and in Albany A 07354 and S 3107 — a statewide plan. Such plans are very cost-effective. It's not hard to see why. All the employee time spent checking on whether a patient is in this plan or that one, what's covered in the specific plan? has he met the deductible? — is not needed. Gone too are the insurance company profits and the advertising aimed at luring customers to this plan or that one. There's no need to go through the signup process again every time you change jobs or every time your income goes up or down. Medicare for all is really simple.

Would adopting Medicare for all be a plunge into the unknown? Not at all. Where Michael Moore really fell down in his movie is in failing to explain that some countries achieve universal coverage without having a national health system. They use single payer national *insurance* coupled with private provision of services. Canada is an example, a useful one, because that country is in other ways so similar to ours. Canada spent \$2998 per capita in 2003 as compared to the United States \$5711. What does the cheap Canadian system do to people's health? Canadian life expectancy at birth is 80.7 years compare to 78.2 years in the United States —two and a half years better in Canada. Canada's infant mortality is 4.8 per thousand live births (like Britain) — again better than the United States' 6.3 per thousand. In short, better outcomes for less money.

What about individual responsibility? Sure, individuals should take responsibility for their health. They should do this by exercising, preparing vegetables for their meals, researching their personal medical problems and discussing treatment options with their doctor free of the fear that they are being steered one way or another for financial rather than medical reasons. Time spent researching competing insurance plans only detracts from such useful activities.

I urge you to go the route of single payer. It's proven; it's cost-effective; it's the ultimate compromise that combines the fairness of government financing and the flexibility of private provision of services.

Now I would like to present a piece of very new information. Let's turn our attention to one particular concern raised in the questions put out by the State for these hearings — #8 What role does preemption under ERISA play? According to Frequently Asked Questions on the Physicians for a National Health Program website this may never have been a real hindrance, but nevertheless things may change. On September 7 of this year a bill was introduced into the U.S Senate — S.2031, It has a companion bill HR.3507 in the US House. It would assist states in experimenting with universal coverage by providing a waiver of ERISA Preemption including Medicare, Medicaid, SCHIP and FEHBP funds to allow states to use such funds in universal health programs. My Congressman, Maurice Hinchey, has cosponsored it.

We can work together to assure that nobody in this state gets left out. Thank you.

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