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Health Reform in New York State: A Qualitative Analysis of Testimony Provided at Public Hearings

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Project Sponsorship



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NYSHealth is a private foundation dedicated to improving the health of all New Yorkers. NY-SHealth has a three-part mission: expanding health insurance coverage to State residents who cannot afford to purchase their own coverage or whose coverage is inadequate; increasing access to high-quality health care services for underserved people; and improving public and community health by educating New Yorkers about health issues and empowering communities to address them.

About the Authors



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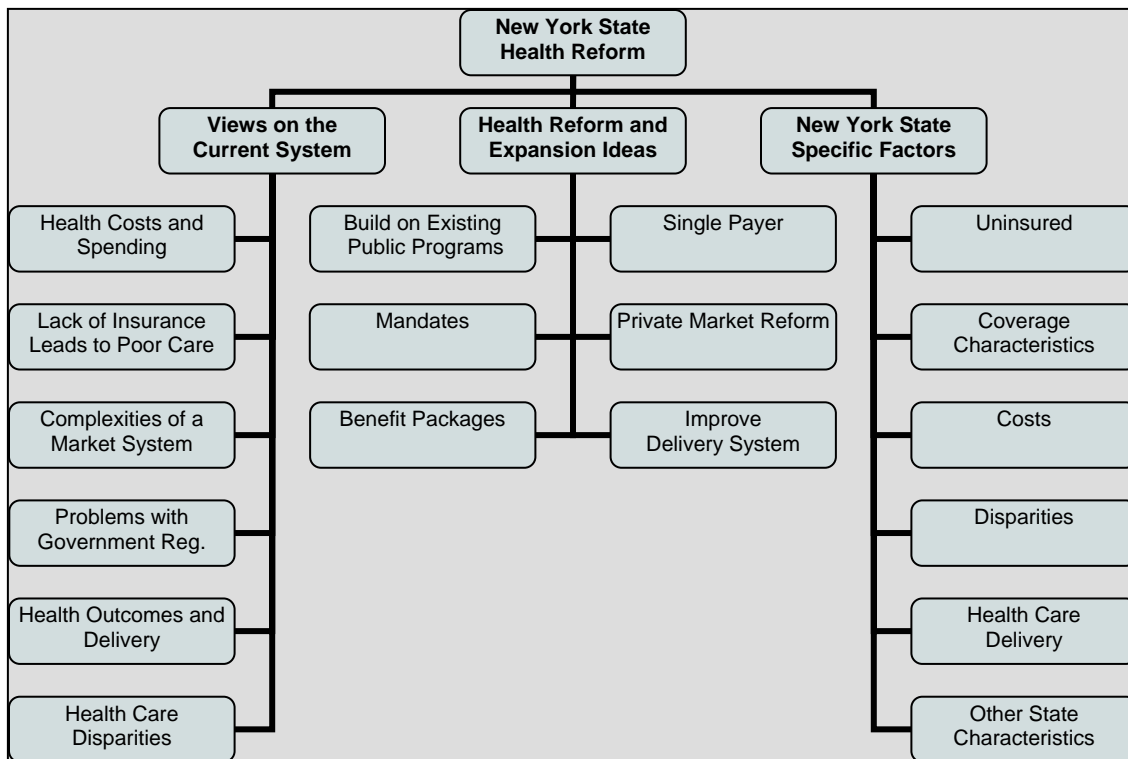
Executive Summary

Over the past two years, there have been several initiatives to garner public opinion and facilitate discussion on health reforms in New York State (NYS). In December 2006, NYS Assembly Representative Richard Gottfried opened a series of three public hearings, “How to Increase Health Insurance Coverage in New York State.” Beginning in September 2007, former Governor Eliot Spitzer introduced the “Partnership for Coverage” hearings, which ultimately included over two-hundred participants in eight sessions. In December 2007 the Manhattan Institute sponsored a conference, “New York’s Uninsured: Looking Back and Moving Forward,” which explored lessons from other states and reform attempts that might be applied to NYS.

This report summarizes the results of our qualitative analysis of verbatim transcripts and written testimony submitted by participants at these events.¹ The report is a summary of the major ideas and themes raised during the hearings and serves as a barometer of the diversity of public views on NYS health reform. The report does not provide a quantitative assessment of public preferences. In addition, we did not validate any of the data, statistics, or facts presented by participants at these hearings.

Using thematic analysis, we classified the testimonies and presentations into three over-arching nodes, which we further stratified into several sub-themes. In Figure 1, we present the conceptual model illustrating the categorization of themes based on the comments by the participants.

Figure 1: Thematic Analysis of Testimony and Presentations at the Three Hearings



Views on the Current System

This category highlights participant views on the current state of health care in New York and nationally. We identified the following major sub-themes:

- **Health Costs and Spending:** The rise in health care costs, health spending, and premiums have affected a wide variety of groups including middle-income families and small business owners.
- **Lack of Insurance Leads to Poor Treatment and Care:** Not having insurance is associated with people foregoing preventative care such as cancer screenings, and relying on emergency rooms for care.
- **Complexities of a Multi-Payer Market-Based System:** There are inefficiencies associated with a voluntary system with multiple payers including bureaucracy and administrative difficulties associated with both commercial insurers and public programs.
- **Problems with Government Regulation and Public Programs:** The current health care system has too much government intervention. Expanding public insurance has resulted in an increased tax burden for consumers and community rating has increased health insurance premiums. Public insurance diminishes consumer choice.
- **Health Outcomes and Delivery:** Characteristics of the health care delivery system in NYS, including physician recruitment and retention, malpractice litigation, and health care reimbursement structures, may lead to diminished health outcomes.
- **Health Care Disparities:** Gaps in health coverage or health insurance stem from factors such as race, age, income, and citizenship status. There is unequal ac-

cess to care and various groups struggle to obtain quality health care.

Health Reform and Expansion Ideas

Major ideas for health reform that emerged from the hearings include suggestions for expanding coverage, minimizing health care disparities, and reducing insurance costs, classified into the following sub-themes:

- **Build on Existing Public Programs:** Expand existing NYS public programs such as Family Health Plus, Child Health Plus and Medicaid. Proposals included expanding Child Health Plus eligibility from 250% to 400% of the federal poverty level, raising Family Health Plus eligibility levels, simplifying and streamlining enrollment and renewal procedures, and establishing an employer or individual buy-in for Family Health Plus.
- **Single Payer:** Establish a single payer health care system, which would produce administrative simplification, lower costs, higher quality care, and more equity and fairness.
- **Mandates:** Individual or employer mandates could expand coverage and lower costs in NYS.
- **Private Market Reforms:** Market-based initiatives such as merging the small group and the non-group market would lower premiums; the state could also provide tax credits to individuals to purchase health insurance and fund a state-wide high risk pool.
- **Benefit Packages:** Benefit design is a critical component of health reform. Some stressed the need for comprehensive benefits packages, including services such as mental health, dental and reproductive services, while others stressed more flexible designs ranging

from high-deductible bare-bones plans to more comprehensive ones.

- ***Improve the Health Care Delivery System:*** Invest more in primary and preventative services, develop better health information technology (HIT), develop global budgeting systems, open additional clinics, improve physician recruitment and retention, and reform the malpractice system.

New York Specific Factors

This category summarizes the major themes that emerged pertaining to data, statistics, and other characteristics that distinguish NYS from other states with respect to health reform. These include:

- Uninsured Characteristics
- Coverage Characteristics and Public Program Structure
- Cost
- Disparities
- Health Care Delivery

Introduction

Enacting sustained and effective substantial health reform in NYS will require the input of many interest groups. In an effort to gain this input and facilitate debate and discussion amongst stakeholders, NYS has held hearings on the issue of reforming its state health care infrastructure. Assembly Representative Richard Gottfried held three hearings entitled “How to Increase Health Insurance Coverage in New York State” via the Assembly Standing Committees on Health, Insurance and Labor. The first took place on December 8, 2006 in Albany, New York and featured seventeen participants. The second took place on March 9, 2007 in New York, New York and featured thirty participants. The third was held in Rochester, New York on April 19, 2007 and featured twelve participants. These participants ranged from prominent health policy experts to health care providers, insurance companies, and health advocates. Each one spoke at the hearings for approximately ten minutes and submitted a written copy of his or her testimony to Assemblyman Gottfried.

Former Governor’s Spitzer introduced the “Partnership for Coverage,” a series of public hearings aimed at gathering proposals and ideas on increasing access to coverage in New York and determining ways to reform the health care system. From September to December 2007, there were eight hearings in total that took place in Glen Falls, Buffalo, New York, Syracuse, Rochester, Old Westbury, and one which was a call-in hearing. In all, 230 participants appeared at the hearings; they were also asked to submit written copies of their testimony.

The Manhattan Institute held a conference, “New York’s Uninsured: Looking Back and Moving Forward,” on December 11, 2007, examining New York’s health care system and exploring lessons for New York policy

makers. The conference consisted of two panels and a key-note speaker, totaling eight participants, each of whom spoke for approximately ten minutes on the issue of state health reform.

This report summarizes the major themes and issues that emerged in these various hearings [*see Figure 1*], illustrating the diversity of opinions on approaches to improve health insurance coverage in NYS expressed at these events.

Results

Most of the speakers who presented testimony based their recommendations about health reform on a set of views and concerns they had about the current health care system in NYS and in the United States. Testimonies typically began by highlighting specific problems with the current system and using these as a basis for making policy recommendations.

Three major over-arching themes emerged, which we used as a framework. These were:

Views on the Current System: Participant views on the current state of health care in NYS and nationally.

Health Reform and Expansion Ideas: Ideas for health reform.

New York Specific Factors: Statements about the health care system in New York.

We then used these very broad areas as an over-arching framework for subsequent coding. In the following three sections we highlight themes and sub-themes we obtained by mapping the testimonies and transcripts into to the broad groupings listed above.

Views on the Current System

Participants' concerns ranged from the soaring costs of health care and health insurance to the growing number of uninsured and health care disparities.

Major sub-themes include:

- **Health Costs and Spending**
- **Lack of Insurance Leads to Poor Treatment and Care**
- **Complexities of a Market-Based System**
- **Problems with Government Regulation and Public Programs**
- **Health Outcomes and Delivery**
- **Health Care Disparities**

Health Costs and Spending

The issue of high health care costs and rising insurance premiums surfaced numerous times. Many participants noted that the affordability of health care is a major problem for the United States. Cost escalation affects several different groups, including low-to-middle income consumers, workers, and business owners. Many argued that high costs place a strain on overall market competition and the well-being of the economy.

- *One of the things we have to do with health care reform is spend less money. We are charging too much money to the consumers, we are charging too much money to the taxpayers, and we are charging way, way too much money to businesses.*²
- *According to AHRQ's Medical Expenditure Panel Survey, New York has the 11th highest average premium for private sector family coverage. We are the second highest in personal healthcare spending. These spending numbers alone are cause for concern; set against healthcare outcomes they paint a discouraging picture.*³

Burden on Middle Class Individuals and Families. Participants argued that the high costs of medical care and the steady rise of insurance premiums are a burden for middle class individuals and families who neither qualify for public programs nor have the wealth to maintain steady insurance. They often make tradeoffs between purchasing health insurance and other necessities. This may lead to the reduced use of health services, lack of critical and preventative care, and diminished overall health outcomes [*See Lack of Insurance Leads to Poor Treatment and Care*].

- *A person who makes 30,000 dollars a year brings home a little more than 1700 dollars a month. After rent, utilities, and food, how much is this person supposed to be able to afford the 700 dollars average monthly payment for individual market health insurance plans offered in New York?*⁴
- *Those with coverage are struggling to pay premiums, while those without are foregoing primary and preventative health care, which can lead to greater complications and more advance disease states.*⁵

Burden on Businesses. Other participants highlighted the cost strain on business owners, particularly on small businesses. According to them, the rising cost of health insurance makes it increasingly difficult to maintain a profitable enterprise while simultaneously offering comprehensive and affordable employee health benefits.

- *Most small businesspeople I know care very deeply about their workers. We are just frustrated and embattled. Taxes, fees, inspections, forms, penalties, loans, regulations, certifications, paperwork. All of this has to be dealt with on top of running one's business. We are tasked*

*with finding a way to pay fair wages and with providing health care coverage for our employees. This is simply not possible under the current system.*⁶

- *Private insurance linked to employment is decreasing in response to increased premium pricing and competitive business strains.*⁷
- *As health care costs keep escalating, corporate America is strangling and has lost its competitive edge.*⁸

High Medicaid Spending. Many cited the issue of high Medicaid spending not only as a major problem with the current health care system, but also as one of the distinguishing characteristics of New York State. Participants who commented on cost-related initiatives to reform New York State health insurance were often particularly concerned about Medicaid costs and their effect on the state's budget.

- *We now spend more on Medicaid per capita than any other State, about double the national average. Spending more than Texas and Pennsylvania, and Florida all combined. And yet one finds the percentage of uninsured is basically about the national average.*⁹

Lack of Insurance Leads to Poor Treatment and Care

Policy advocates, physicians, and uninsured residents of New York addressed the links between insurance and quality care. They argued that people who are uninsured tend to receive less primary and preventative care, often forego necessary treatment, and ultimately contract more diseases than those that have access to continuous insurance. They noted that lack of insurance may engender more use of hospital emergency rooms rather than primary care, which places greater stress on the physicians in those emergency settings.

Avoidance of Preventative Care. Lack of preventative care, participants noted, may raise health care costs and reduce overall well-being. Many physicians in various specialties pointed out the harm of not having health insurance, whether it was delaying cancer screenings and mammograms among women without coverage, neglecting receiving MRI scans for Multiple Sclerosis, or sacrificing other forms of preventative and primary care. This, according to many participants, is a significant factor generating poor health outcomes in the United States.

- *Uninsured persons receive less preventative care, are diagnosed at a more advanced stage of illness, and once diagnosed, tend to receive less therapeutic care, and have a higher mortality rate.*¹⁰
- *Numerous studies have shown that people who have health insurance and a medical home are more likely to receive key preventative services and screenings such as pap tests, mammograms, and flu shots. And these same studies make it clear that those without insurance tend to skip needed preventative screenings and medical care.*¹¹

Increased Emergency Room Use. The increased use of emergency rooms is another effect of lack of insurance that many addressed during the hearings. Speakers noted that patients who are uninsured or underinsured may be diagnosed with diseases and illnesses at a later stage and seek treatment in emergency rooms for conditions that could have been more appropriately handled in other settings. Several participants argued that this places greater pressure on emergency rooms, increasing waiting times and decreasing outcomes as physicians continue to spend less time with their patients.

- *Emergency rooms are often the settings for the treatment of illnesses or chronic conditions that could have been pre-*

*vented or treated earlier had they been part of a course of care associated with having health insurance.*¹²

Complexities of a Market-Based System

Participants remarked on the inefficiency associated with a multi-tiered, fragmented system. Many were concerned that our system of multiple, competing payers breeds bureaucratic and administrative errors aside from rising insurance premiums [See *Health Costs and Spending*]. They also raised concerns about insurance loading costs and over the growing problem of adverse selection in the voluntary market.

Bureaucracy. Several participants noted that public programs and private insurers all use different forms and rules to determine patient eligibility for insurance, with different standards for paying out claims and reimbursing providers. Consumers at the hearings reported being overwhelmed by the constantly shifting rules and procedures, often claiming that they were too complicated to comprehend. Providers complained about the difficulty in maneuvering through large amounts of insurance paperwork and sorting through reimbursement protocols.

- *Our current system breeds errors, requires a separate subsystem to correct those errors, and involves duplicate systems by which the provider and the payer record essentially the same information. Communicating information about coordination of benefits is also extremely inefficient.*¹³
- *Since [my wife's] death and my retirement, I have been attempting to navigate the corporate based health insurance maze as a patient. [...] And I am experienced and can't make it work for me, and if it is hard for me to make the system work for me, imagine what it is for*

*people who haven't spent 50 years in the system. What happens is that a lot of people just give up.*¹⁴

- *One of the reasons the United States spends more and gets less than other modern democracies is a system of mind-boggling complexity and fragmentation. Hundreds of companies offers thousands of policies and benefits packages.*¹⁵

Administrative Excesses. Another concern noted was the amount of revenue that does not get spent directly on health care but on what participants referred to as “administrative waste,” “private insurance loading costs,” or “medical cost ratios.” Speakers used these terms to refer to the funds from premiums that go towards administrative functions, including marketing, company overheads and profits. Participants often complained that these administrative costs were the main drivers of high premiums and decline in the overall insurance rate. Many believed that the high costs harm the overall quality of care, diverting funds from the health delivery system [See *Health Outcomes and Delivery*].

- *It is clear that private insurers' primary product is not insurance, but administrative services, and this has contributed significantly to the waste in our health care spending.*¹⁶
- *Right now, we have such a hodge podge of insurances and public programs that insurance companies spend a large part of their money on marketing, determination of eligibility, and denial of claims.*¹⁷

Adverse Selection and Risk Avoidance. Some participants noted the problem of adverse selection as a major concern. By adverse selection, they referred to individuals or consumers who elect not to purchase health insurance until they feel they will need it.

This may cause insurance companies to search for individuals who are low risk.

- *If you have a voluntary market and you have one with easy access as New York does, it's clear that the people who are going to buy insurance under those circumstances are going to be people who tend to think they're going to need it and young invincible people who may think they're never going to get sick and not going to purchase it.*¹⁸

Problems with Government Regulation and Public Programs

Although many participants found fault with the current, market-based health care system, many others praised markets as the best means of ensuring quality and consumer choice. They argued that increased emphasis on publicly financed health care and market regulation caused high prices and reduced access to health insurance, as well as heavy tax burdens, lack of consumer choice, inefficient community rating, and inappropriate state-mandated benefits.

New York's Large Public Programs. Some participants remarked on New York's already large public insurance system, pointing to programs such as Child Health Plus and Family Health Plus being singled out. They remarked on the high Medicaid spending rate in New York, compared with other states [See *Health Costs and Spending*]. They attributed the problem of New York's uninsured to a lack of adequate private coverage rather than a lack of public programs.

- *If we were to learn from other states, there are many states that have a lower rate of uninsured, a lower portion of their population that's uninsured compared to New York. The characteristics of those states are that they have more people with private coverage, not more individuals on public coverage.*¹⁹

Tax Burden. Many participants noted that increasing taxes to finance expansions of public programs may harm the NYS economy. Some expressed concern over HCRA taxes that are used to finance graduate medical education, charity care, and Medicaid.

- *New York has achieved success in decreasing—or at least stabilizing—the number of uninsured by increasing enrollments in CHP, FHP, Medicaid. Yet with every expansion of government insurance programs, there are costs that are born by taxpayers. Our economy is less diversified and less competitive relative to taxes, so expanding entitlements is challenging to our common goal of seeking job growth.*²⁰
- *So we're taxing people trying to buy insurance and afford it to subsidize other health insurance programs, as well as a number of other public goods, not necessarily health insurance, and it really creates this vicious cycle.*²¹

Community Rating Leads to More Adverse Selection. Presenters noted that community rating laws prohibit insurers from charging different premiums based on factors such as health status and age. Many participants stated that NYS's community rating rules in the individual market contribute to the problem of high insurance premiums. They also argued that community rating increases adverse selection problems.

- *The fact that all small groups and some large groups are subject to a pure community rate means that the premium rate cannot be adjusted for group demographics, industry or health status. In addition to increasing costs, community rating reduces incentives for employers to invest in wellness activities, or to promote healthy lifestyles for employees.*²²

Benefit Mandates. State mandated benefits are services that the legislature decrees insurance companies must include in all policies sold. Participants noted that imposing state-mandated benefits increases health insurance premiums in NY.

- *The purpose of insurance is to protect against rare and uncertain substantial loss, and that the presence of such coverage should not alter individual or group behavior. It becomes clear that these mandates have changed the purpose of insurance and created an inefficient financial funding vehicle for these predictable costs of individuals evaluating their own insurance.*²³
- *In 2003, the Employer Alliance for Affordable Health Care initiated the only study ever undertaken on the cost of New York's mandated services. This report determined that at that time policyholders paid 12.2% more annually to cover the costs of mandates.*²⁴

Consumer Choice. Many participants feared that expanding public programs and emphasizing government regulation would limit choice in the private marketplace. They valued the consumer's ability to pick and choose from a wide variety of benefits packages, providers, and insurance carriers, rather than being limited to a "one-size-fits-all" policy.

- *Representing more than 700,000 members, I can tell you that competition and choice matter. They ensure better service, better products, and better overall quality.*²⁵
- *A value maximizing system creates competition at the individual patient and disease level. The key to that result is a shift from a payer centered system to a consumer centered system.*²⁶

Health Outcomes and Delivery

One of the themes that emerged often during the hearings is that access to coverage is necessary but not sufficient to achieve a better health system. Many asserted that expanding coverage alone would be futile unless accompanied by measures to improve overall health care quality. Participants noted the United States' relatively poor health outcomes compared with other countries.

- *Access to care alone is not enough—it is equally important to focus on the quality of care people receive.*²⁷

Poor Health Outcomes. Participants commented on the poor quality of health care in New York and the United States and the need to address this issue through reform.

- *The quality of American health care is getting poorer, more expensive and less of a guarantee everyday. Our position in overall quality and child mortality among developed nations of the world is shameful.*²⁸
- *Other nations spend half as much as we do and provide quality health care for all their people that is good or better than we do in many respects. It is a critical problem of truly mammoth proportions and we can do better.*²⁹

Focus on Treatment Rather than Preventative Care. One of the reasons cited for poor health outcomes is the tendency of the health care system to focus on the treatment of diseases rather than the care of the patients. Critics of the current system argued that the United States subscribes to a "sick care" system, rather than a "health care" system. Participants pointed to the reimbursement structure that rewards procedures instead of preventative care.

- *In general, office doctors and primary care are no longer going to the hospital.*

*Do you think the hospitalists and the specialists changing daily have a coherent picture of the patient? On the weekend, the hospitalist attempts to cover dozens of patients. What problems are being overlooked?*³⁰

- *Our health care system provides expensive, ineffective care that drives up costs and emphasizes treatment rather than prevention and quality. The U.S. spends more than most countries on health care, yet we trail 47 other nations in life expectancy and we only get approximately half of the recommended level of medical care.*³¹

Loss of Providers / Burden on Physicians.

Physicians at the hearings spoke of growing concerns in the provider community including increased costs of practicing and lack of reimbursement for treating uninsured patients. Safety net program and community health center advocates stated that they received even less reimbursement from commercial insurers and Medicaid. Some complained of the tremendous bureaucracy and paperwork involved in their work, the rising cost of medical malpractice litigation, and the difficulty of managing emergency rooms that have many uninsured patients.

- *A lack of adequate reimbursement for health care providers who care for growing numbers of uninsured patients is starving these very providers that low-income patients rely on for care*³²
- *A widening gap between reimbursement rates received by community health centers from public versus private payers is threatening community health centers' ability to serve commercially insured patients, and is eating away at the limited public resources intended for the uninsured and other public funds.*³³
- *The mountains of paperwork created by such a system place a particular burden*

*on primary care physicians, who already spend increasingly large amounts of time on the largely unreimbursed task of coordinating care for their patients with multiple chronic conditions.*³⁴

- *Multimillion dollar lawsuits in obstetric malpractice cases in New York State are driving older doctors to retire and discouraging new medical students from selecting obstetrics as a field.*³⁵

Health Care Disparities

Speakers noted that in the current health care system access to care is unequal. Participants identified several factors that affect access to and affordability of coverage, including citizenship status, age, race, and work status. Immigrants and non-citizens face both income and language barriers to care. People with non-traditional work arrangements, such as artists, actors, and even adjunct professors at certain NYS universities also have difficulty obtaining coverage and care.

Racial/Ethnic Disparities. Participants noted that race remains a characteristic that separates those who have health insurance and those who lack it.

- *The problem of lack of insurance intensifies prevalent disparities in health and health care, as person of color in New York are more likely to be uninsured than Caucasians. Of those without health insurance, 25 percent are Hispanics, and 21 percent are African-Americans.*³⁶
- *People of color are sicker and more likely to die in our current health care system because of lack of investment in access, treatment and research in people and communities of color. There is abundant research to support this conclusion.*³⁷

Income Disparities. Many participants noted that most uninsured people are working Americans, whose incomes are too high to qualify for public coverage and too low to make private coverage affordable. They noted that lower-to-moderate income individuals and families forego preventative treatment [See *Lack of Insurance Leads to Poor Treatment and Care*] or rely on safety nets, such as community health centers for their treatment and care.

- *New York City Comptroller, William Thompson, released a landmark report on health disparities, showing that the gap health and health care between rich and poor city residents has unfortunately skyrocketed since 1990. Rates of heart disease, cancer and, particularly, diabetes have struck poor neighborhoods particularly hard in the last 15 years.*³⁸
- *Most (70%) of health center patients have family incomes below the federal poverty level.*³⁹

Age Disparities. Age is another factor associated with the quality of care that people receive and whether or not they remain insured. Most uninsured people are young but the cost burden of uninsurance falls heavily onto older people, near retirement age. Many pointed out the distinct, non-financial barriers to insurance and health care faced by adolescents, a group who often forego primary and preventative care, waiting until their problems escalate before seeking care.

- *We've spoken before about the young invincible and one shouldn't forget how many uninsured Americans are like that despite their depiction on ER or Robin Cook novels. In fact, you find about 50% of the uninsured are between the ages of 18 and 35.*⁴⁰
- *In our conversations, we found that the high cost of insurance predominantly impacted two groups of individuals:*

*those over 55, who are near retirement, or have already retired, and small business owners.*⁴¹

- *Adolescents have the lowest rates of primary care use of any group in the U.S. and are the least likely to have access to health care. Patterns of care of adolescents show that they do not seek routine medical care and often wait until problems become severe before soliciting treatment.*⁴²

Citizenship Status. Another concern voiced by many participants was NYS' large immigrant population, many of whom remain uninsured due to their lack of citizenship and the language barriers in the system.

- *Almost a third of the uninsured in New York are non-citizens, both legal and illegal immigrants. This is so important to understand because if you simply look at public program expansions, many of the Federal Medicaid rules and regulations do not allow you to capture this very significant population and this is a significant uninsured population at all income levels.*⁴³
- *The complexity and onerous nature of enrollment and recertification process that all applicants currently face are particularly acute for immigrants when language obstacles are taken into consideration. They face a distinct set of barriers besides basically the application process and document requirements. Recent studies indicate that while one in twenty children in NYS are uninsured, more than one in four immigrant children in NYC lack health insurance.*⁴⁴

Health Status. Some providers noted that uninsured patients seen by them were typically in worse health than insured patients. They noted that private insurers try to avoid providing coverage for those in poor health.

On the other hand, several participants argued that a majority of the uninsured in New York were in good health and had voluntarily opted out of purchasing costly health insurance.

- *The first rule of health insurance school, the way you make a buck is you cover healthy people and if you are those chronically ill folks, if you're folks at higher risk, go someplace else.*⁴⁵
- *We have actively promoted measures to avoid segmenting the market so that sick people are not isolated.*⁴⁶
- *Ninety percent of the uninsured are in good health.*⁴⁷

Non-Standard Workers. Non-standard workers are people who do not have traditional, full-time working arrangements with a single employer or business. Non-standard workers include those who frequently switch jobs, part-time employees, artists, actors, and adjunct college professors. Many argued that these workers face hardships in maintaining a steady source of insurance coverage and typically pay relatively more for insurance.

- *Of New York City's 3.7 million workers, approximately 31 percent or 1.2 million do not have traditional work arrangements. Many of these non-standard workers experience income insecurity, high mobility, and multiple concurrent employments. In addition, non-standard workers are even less likely than standard workers to be offered health insurance through their employers.*⁴⁸

Table 1: Major Views on the Current System	
Health Costs and Spending	Burden on Individuals Burden on Businesses High Medicaid Spending
Lack of Insurance Leads to Poor Treatment and Care	Avoidance of Preventative Care Increased Emergency Room Use
Complexities of a Market-Based System	Bureaucracy Administrative Excesses Adverse Selection and Risk Avoidance
Problems with Government Regulation and Public Programs	New York's Large Public Programs Increased Tax Burden Community Rating Leads to More Adverse Selection Benefit Mandates Increase Costs Consumer Choice
Health Outcomes and Delivery	Poor Health Outcomes Focus on Treatment Rather than Preventative Care Loss of Providers / Burden on Physicians
Health Care Disparities	Racial/Ethnic Disparities Income Disparities Age Disparities Citizenship Status Health Status Non-Traditional Workers

Health Reform and Expansion Ideas

Drawing from their opinions about the current system, participants at the public hearings went on to provide ideas for expanding coverage in NYS. There was considerable heterogeneity in the proposals put forward. Some emphasized the necessity for a “building block” or incremental approach towards achieving universal coverage. Proponents of this approach tended to focus on the 2006 reforms in Massachusetts. Other participants proposed a more radical overhaul and argued that the state should enact a single payer style system, pointing to various single-payer systems and proposals, such as those in Canada, HR-676 and “Medicare for All”. Other presenters emphasized market-based reforms that would expand private insurance. Many supporters of these initiatives were staunchly opposed to further expansions of public programs. We identified the following major themes.

- **Building on Existing Public Programs**
- **Single Payer**
- **Mandates**
- **Private Market Reforms**
- **Benefit Packages**
- **Improve the Health Care Delivery System**

Build on Existing Public Programs

Many presenters at the hearings focused on the expansion of insurance through New York’s existing public programs, including Family Health Plus (FHP), Child Health Plus (CHP) and Medicaid. Many voiced their agreement with former Governor Spitzer’s expansion ideas or proposed similar measures (varying the public program chosen or the eligibility levels). Some proposed first covering all NYS children by expanding SCHIP eligibility to those below 400% of the federal poverty level (FPL), simplification and streamlining of application and enrollment procedures, increased

facilitated outreach and enrollment, and the enactment of an employer buy-in to FHP.⁴⁹

Expanding Public Program Eligibility Levels. Presenters remarked that the first component of insurance reform should be to expand eligibility levels for existing public programs. Many participants agreed with the Governor’s proposal to expand CHP to 400% while others proposed additional or different means to expand public coverage, for example, by expanding Family Health Plus eligibility levels from 100% to 150% of the FPL for childless adults or by raising Family Health Plus eligibility to 400% of FPL. Others also proposed expanding EPIC to those with disabilities.

- *And yes, we can do the incremental things moving in this direction. To those who say we shouldn’t expand Child Health Plus or Family Health Plus because it preserves private insurance, there’s a lot of people who need that insurance. We need to do that.*⁵⁰
- *And I think we can go one step further, we would suggest that Family Health Plus should be brought up to 400 percent of poverty as well. I think the United Hospital Fund has documented that even if we get to 300 percent of the federal poverty in the Family Health Plus program, that we would take care of 77 percent of our uninsured.*⁵¹
- *And then we would certainly call for the State to expand the State’s EPIC program to all of the disabled. So that all people who rely on Medicare for their medical care can take advantage of the EPIC program, not just senior citizens.*⁵²

Simplifying and Streamlining Public Program Application and Rectification.

Several speakers proposed eliminating public program eligibility procedures that were

complicated or unnecessary. They argued for streamlining and simplifying the application and renewal processes and eliminating barriers to enrollment for existing public programs. Their ideas included extending the enrollment period, allowing participants to attest more simply to changes in their status, establishing statewide databases to store people's status, using the concept of "express lane eligibility," and simplifying the documentation requirements for eligibility. Many also supported expanded outreach and increasing the use of facilitated enrollers as a method for reaching non-citizens and immigrants who face language barriers.

- *Of great concern is that nearly one half of the uninsured in New York State are eligible for existing publicly sponsored health insurance. Specifically, 400,000 uninsured children and 900,000 uninsured adults are eligible for Medicaid, Family Health Plus, or Child Health Plus, but they are not currently enrolled. As Governor Spitzer has emphasized, this is unacceptable.*⁵³
- *Evidence shows that there is a direct correlation between ease of application and enrollment procedures and participation in health insurance programs.*⁵⁴
- *Based on a study of states who allow for self-attestation of income, the states who verified their income before determining eligibility universally reported low error rates, and thereby protected their program integrity.*⁵⁵
- *Administrative barriers make it difficult for people who are eligible for coverage in public health insurance programs to get and stay enrolled in these programs. Both New York and New Jersey could streamline their eligibility and renewal processes to ensure a coordinated, comprehensive approach to care, and expand their investment in facilitated enrollment.*⁵⁶
- *Clearly facilitated enrollment is one of the most effective tools we have for finding and enrolling the most hard to reach children and families. An expansion of this highly successful program will help us reach even further into our communities to find those who are eligible yet uninsured.*⁵⁷

Buy-In to Public Programs. Many participants advocated a buy-in mechanism for public programs. Employers and individuals could purchase coverage in one of the existing public programs, such as Family Health Plus, at subsidized rates with sliding scale premiums.

- *We will be including the employer buy in bill in our budget legislation, which would enable an employer to purchase Medicaid Managed Care, Family Health Plus, Child Health Plus, for the employer's workers or to offer that to its workers, and those workers who are income eligible would receive it as a subsidized rate, those workers who are not income eligible, the employer with or without worker participation would be paying the regular premium.*⁵⁸
- *We also believe there ought to be some retooling of the premium level. Today it's an all-or-nothing. If you're eligible, you're in. If you have a dollar over the cap, you're out. We think there ought to be some glide-path transition, to make it more accessible to people to still access the program.*⁵⁹
- *The employer and the employee have a positive reason to align themselves with the [buy-in] plan. The buy-in by the stakeholders is fine, because each has something it considers worthwhile.*⁶⁰

Single Payer

For many presenting at the hearings, achieving universal coverage in NYS incrementally through public program expansion meant maintaining a system characterized by many flaws and inefficiencies. These participants proposed converting the current system of multiple payers, including public programs and commercial insurers, to a system with one single payer. Many advocates of a single payer system expressed their belief that health care should be a fundamental human right. They argued that viewing access to health care as a commodity, as the current system does, is the reason we have so many uninsured as well as a major cause of the disparities which exist in the current system. Single payer supporters pointed to the Canadian health care system or to European countries that have achieved universal coverage at a lower cost than the current system in the United States. They highlighted the ability of those systems to lower costs, improve quality of care, and reduce bureaucracy. Several noted that a single payer system would essentially resemble Medicare, but be expanded to include all individuals within NYS.

Advantage over Expanding the Current System. Participants noted that one of the main benefits of a single payer system is its administrative simplicity. They argued that a single payer system would reduce the administrative waste and allow the system to operate with fewer rules and procedures, and less bureaucracy than a system with multiple commercial insurers.

- *Anything other than a universal system would be a commitment to a fragmented, overly-costly, unsafe, an un-American, multi-tiered caste system of health care. Medicare for All should be our number one public health priority.*⁶¹
- *Moving to a single payer system will get rid of the multiple rules and procedures, and eliminate enrollment and eligibility*

*problems. Based on the single payer in Canada, we could reduce administrative costs by 10-15% of total health spending or \$10 billion - \$15 billion.*⁶²

- *Streamlining payment through a single nonprofit payer could save more than \$350 billion per year, enough to provide comprehensive, high quality coverage for all Americans. While Medicare operates with less than 3% overhead, HMOs have 15% to 30% overhead.*⁶³
- *So, how would it work if we had single payer? Well if you came to me, I would send you to the doctor I want to send you to. I would write prescriptions on this one formulary that our insurance single payer health plan gives us. It's simple. The administrator that we deal with, all these headaches, it reverts back to a form of health care that is personalized.*⁶⁴

Quality Care. Advocates argued that a single payer system can improve the quality of health care. Funds saved through reduced administrative costs could be channeled towards preventative care and health promotion programs. Coverage under a single payer system would be comprehensive, including preventative care, prescription drugs, cancer screenings, etc. Hospitals operating under a global budgeting system would have the ability to account for and track costs more easily.

- *Under a single payer model, coverage for disease prevention and health promotion programs and services will also make good economic sense. Private health insurers are not motivated to achieve long-term benefits in health status, especially with the employer-based system.*⁶⁵
- *Think of everybody getting seen when they need to be seen—preventative care instead of waiting and waiting, often un-*

*til it is way too late to be diagnosed and treated—the current plight of almost 50 million of us.*⁶⁶

- *A single payer system would align us with all of America’s major western industrial rivals.*⁶⁷

Business Viability. Advocates argued that a single payer system would facilitate business by making the workforce more competitive and reducing unnecessary costs.

- *A single payer, with its more effective cost control mechanisms, means that annual medical care inflation will be better controlled, slowing down the rapid increases in health care costs, which will help to make businesses more competitive.*⁶⁸
- *Workers who have health care would not be forced to choose between paying living costs and debt, and having health insurance. If we were to classify this in more strict economic terms, health care costs are a tax on workers’ wages; they prevent more of their income from entering the economy as a whole.*⁶⁹

Public Support. Advocates noted that while single payer enjoys considerable support among the general public, it has garnered little support from policymakers. They felt that the political influence of large corporations such as the pharmaceutical and insurance industry were major obstacles to the single payer plan.

- *In a recent survey of 600 registered New York State voters, nearly half support replacing private health insurance with universal public insurance.*⁷⁰

Mandates

Two types of mandates were addressed frequently: an individual mandate, which would require all New Yorkers to obtain

coverage; and an employer mandate, which would impose an assessment either per worker or on employer payroll that would provide an incentive for business owners to provide coverage for their workers or contribute significantly towards the cost of workers’ health insurance.

Individual Mandates. Proponents of individual mandates argued that requiring individuals to purchase health insurance would both expand coverage and diminish the adverse selection problem that currently exists, lowering premiums.

- *Well I submit to you first of all that mandates are required to make everyone pay their fair share. The uninsured are quite a diverse population and the poster child tends to be the low income population and struggling but at least 10%, maybe 20%, maybe 30% of the uninsured are actually fairly high income and they could afford to buy health insurance now and are choosing not to. Those are the free riders.*⁷¹
- *Aetna was the first national insurer to support an individual coverage requirement that would require all Americans to possess a basic level of health insurance. If properly structured, this common-sense approach would require those who can afford health care coverage to purchase it, while providing subsidies from broad-based funding mechanisms for those who qualify for free or reduced coverage.*⁷²
- *An individual mandate responds to legitimate concerns from those who are covered that those who do not have health insurance still receive medical services when needed, while the costs for those services are being passed on to those with health insurance.*⁷³

Employer Requirements. Several participants at the hearings spoke in favor of an assess-

ment on employers who do not provide coverage to their workers. Such an employer mandate would encourage more employers to offer health coverage to their workers or would collect more funds that could be used to finance coverage.

- *If every employer were required to provide health insurance, then no employers could ride for free. Fairly soon the market would work itself out. Companies could again charge enough to cover their costs.*⁷⁴
- *The debate really provided an opportunity to engage the employer community about their ongoing role in the private insurance system. And to sort of say, look for better or worse you guys have a role to play and let's figure this thing out rather than allowing the employer community to continue to step away from it under a voluntary program that currently exists.*⁷⁵

Private Market Reforms

Some participants at the hearings argued that private insurance should be expanded and be made more easily available to the uninsured. Some favored initiatives such as an insurance “exchange” or “connector” that would offer subsidized rates and information on various plans; others recommended funding high-risk pools; and some thought insurance premiums should be regulated.

Insurance Exchange or Connector. Several participants mentioned the concept of an insurance connector. Like the Connector that is part of the Massachusetts plan, this institution would serve as a marketplace where consumers could compare various health plans and select one. The Connector might also administer subsidies.

- *Massachusetts calls it a connector that would administer the subsidies associated with that buy in. It would then, in*

*effect, create a marketplace in which other products could be offered at group rates to individuals beyond the 300 percent poverty level.*⁷⁶

- *So you put in three pieces of information: your age, your size of household you're buying for, and your zip code. And we have 42 options for you approved by a competitive bidding process, making it easier for you as a shopper to say, “Gee, I want gold. I want virtually no cost sharing and the highest premiums. Show me my options.” And up pop the three lowest priced options side by side.*⁷⁷

Tax Credits and Tax Deductibility. Some participants suggested that the government offer tax incentives to those who purchase insurance in the non-group market.

- *I think the key to making U.S. health care work better in general is to put the money back in the hands of the families. A lot of things have to go on. The way I would do that would be to repeal the exclusion of employer sponsored insurance, provide a tax credit that's twenty five hundred for the individual, five thousand for a family, and that would be available for purchase in both the employer and non-employer markets.*⁷⁸
- *Society should provide coverage for those people with little or no income assets. It is necessary for us as a society to make care available to all. This can be best accomplished by giving tax credits and where necessary refundable tax credits to those in need.*⁷⁹

HCRA Taxes. Participants recommended eliminating or reducing the HCRA taxes on voluntary health insurance. Participants argued that these taxes, intended primarily to fund hospital bad debt and charity care, lead to increases in private insurance premiums.

- *New York imposes significant surcharges, or taxes, that are incorporated into the premium rates and paid by health insurers. These include Graduate Medical Education (GME), Bad Debt and Charity, and HCRA Small Group Demographic Surcharges. These taxes add a significant amount to the premium rates each year and, if reduced, would make rates more affordable.*⁸⁰

Risk Pools. A statewide, high-risk pool was advocated as another mechanism to increase access to health insurance for people with significant health care expenses. Proponents suggested the establishment of a non-profit association that would provide insurance for residents of the state with pre-existing conditions that made it hard to buy coverage. Other participants suggested additional means of pooling, such as separately creating new risk pools in the direct pay market and varying community rating slightly based on certain health risk factors.

- *All New Yorkers should have some form of health care insurance that guarantees them appropriate treatment if their medical situation changes. A statewide risk pool should be established for those with pre-existing conditions, so that status can never again be used to exclude individuals.*⁸¹
- *We propose creating a new risk pool for Direct Pay consumers. To facilitate creation of the pool, we propose using the administrative structure of the state employee/retiree plan (NYSHIP).*⁸²

Reinsurance. Reinsurance pools were suggested by several participants as mechanisms to help spread the cost of high risk individuals and families among insurance carriers. Under reinsurance, claims that exceeded some predetermined threshold would be transferred to the pool, which would assume any further risk for these high-cost individuals. Blue Cross, Blue Shield, for ex-

ample, proposed implementing a stop-loss program to reimburse health plans for payments that exceed \$20,000.

- *A critical piece to enhance the affordability of coverage [...] is redeployment of existing subsidies used for hospital bad debt and charity care and the Healthy NY Program, along with perhaps additional sources of revenue, into a new stop-loss pool for claims exceeding \$20,000.*⁸³
- *The key to creating affordability in the direct market is the significant increase in amounts allocated by HCRA to cover all currently eligible high cost claims. The stop loss pool needs to be fully funded, requiring an additional increase to at least \$100 million.*⁸⁴

Merge Small Group and Non-group Markets. Some participants recommended following the Massachusetts reform by merging the NYS small group and non-group markets. They argued that merging the markets would create one large pool, thus lowering costs for those with greater medical needs.

- *We would recommend that the state merge the small group and individual markets. This step alone would dramatically reduce premium rates for individuals, but it would also increase rates for small groups.*⁸⁵

Section 125 Plans. Some participants suggested that employers be required to offer Section 125 plans, which would allow employees to purchase coverage with pre-tax dollars.

- *We need to make sure that people have access to tax free health insurance through a Section 125 plan through their employer, and encourage as many employers as possible to offer health insurance. What's interesting is if you'll look at employers who simply offer and pay a*

*very small share of the premium, the vast majority of employees enroll—its' a very efficient way for them to get health insurance.*⁸⁶

Reform Healthy New York for Small Businesses. Many participants suggested several reforms to the existing Healthy New York program to increase access and lower costs. These suggestions included expanding income eligibility limits and adjusting required employer contributions for the program.

- *Remove the requirement that employers contribute 50% or more of the monthly premium for full-time employees. In addition to eliminating a suggested contribution amount for some employers, this change will allow small businesses that cannot afford to contribute to health benefits to make Healthy NY available to employees and allow them to pay the entire premium on a pre-tax basis.*⁸⁷
- *Help equalize access to Healthy NY for New York City's businesses by adjusting the income eligibility levels to reflect regional variations in the cost of living and doing business.*⁸⁸

Regulating the Private Insurance Market. Many participants argued that more regulation of insurance, rather than less, was needed to control costs and ensure quality. One suggestion often mentioned was to regulate medical loss ratios (the amount that insurance companies spend on paying claims for medical care). Many suggested raising New York's current medical loss ratio requirement in the small group market from 75 percent to 80 or 85 percent. Others proposed increasing the ratios in the direct pay market from 80 percent to 85 or 90 percent. Another suggestion was to re-establish rate hearings throughout NYS, so that increases in premiums in the direct pay market would be publicly vetted.

- *Establish a minimum loss ratio for direct pay products at 85 percent.*⁸⁹
- *The Insurance Department should resume its full regulatory role by regulating premiums, holding hearings on premium increases, and enforcing (as current pending legislation would do) a reasonable minimum care share (or benefit expense or loss ratio) on all policies, set at 90% of premiums and investment income.*⁹⁰
- *Prior to the year 2000, New York required public hearings on rate increase proposals in the direct pay market of more than 10 percent. This law helped to deter insurance companies from continuing raising rates 20 or 30 percent per year, as they currently do. Legislation introduced in '06, in both the Assembly and Senate would have reinstated rate hearings when premium increases exceeded 5 percent as proposed for the direct pay market.*⁹¹

Benefit Packages

One of the major complaints about proposals that would reduce the cost of insurance was that the term “affordable coverage” was often synonymous with “bare-bones” plans, high co-payments, high deductibles, and less comprehensive benefits. Many participants emphasized the importance of providing comprehensive coverage. Others, however, stressed the significance of design flexibility and consumer choice in benefit design.

Mandate Comprehensive Coverage. Many participants at the hearings emphasized the importance of providing comprehensive coverage to all residents of NYS, suggesting that a required benefit package include preventative care, mental health, rehabilitative care, reproductive care, and prescription drug coverage. Participants acknowledged that comprehensive coverage would be

costly, but argued that only this type of coverage would be appropriate.

- *Other states that are looking to provide universal health insurance are proposing bare bones and high deductible that are not appropriate for people living with chronic illnesses and people living on low incomes. Plans that do not offer comprehensive coverage, including prescription drug coverage, mental health services, physical therapy and other such benefits are not options for people living with chronic illnesses.*⁹²
- *Health insurance must provide the full range of health benefits to meet people's needs. All health coverage should include a standard for health benefits that covers what people need to keep healthy and to be treated when they are ill, including preventative services and treatment needed by those with serious and chronic conditions. We want to be sure that everyone gets the same benefits that you and other government employees have.*⁹³
- *Any reformed system should include a state-mandated minimum benefits package, including increased and improved preventative and primary care, all necessary acute and specialty care, and services for the disabled and others with significant medical-care needs, and must at least be coordinated with an extensive, long-term care system, now largely covered by Medicaid alone.*⁹⁴

Minimize Cost-Sharing. Many participants noted that high cost-sharing impeded access to care. Several participants proposed adjusting the cost-sharing structure according to income or minimizing co-payments and deductibles.

- *Research has shown over the years the adverse consequences of cost-sharing. It deters people from getting care. It de-*

*ters people from signing up for health insurance.*⁹⁵

- *Cost Sharing should be minimized for those with very low income. Co-payments, co-premiums, and high deductibles are not the answer for low-income New Yorkers. People need coverage they can use.*⁹⁶

Standardized Benefit Designs and Flexible Plans. Other participants suggested keeping benefit design flexible by setting only minimal benefit standards and then allowing people to choose additional policies. Such benefit flexibility would be valuable to small businesses who sought lower cost coverage for their employees.

- *An incremental step towards universal coverage might be to offer a base insurance product, with a benefit design that reflects evidence based medicine and achieves a level of affordability that may be more sustainable. The basic plan would cover the following: Preventative services with minimal or no co-payments; care for chronic conditions, subject only to reasonable co-payments; acute services subject to co-payments and deductibles; most other services subject to co-payments and deductibles, with an ability to purchase additional coverage and pricing options for these services.*⁹⁷
- *Create more standard benefit designs that range from lower-priced consumer-directed health plans to more comprehensive designs to improve options in the individual market. Each product would be offered on an open enrollment basis and community rated separately. The concept here is to provide consumers the ability to comparison shop and have a wider array of benefit choices.*⁹⁸
- *Allow more flexibility in plan design and covered benefits. Small businesses that*

currently provide coverage should have more health benefit choices available to them—ranging from standardized plans that include all State mandated benefits to those with more basic coverage, such as Healthy NY and Brooklyn Health-Works.⁹⁹

Improve the Health Care Delivery System

Although the focus of these three sets of hearings was on health insurance, many participants argued that expanding health insurance coverage was of secondary importance compared to improving the overall health care delivery system in NYS [See *Health Outcomes and Delivery*]. Many discussed strategies to improve the quality of health care in NYS and the health of NYS residents.

Invest in Preventative, Long-Term, and Primary Care. Participants suggested taking steps to encourage residents to establish a medical home and to develop a network of primary care providers in New York State.

- *Expand primary, home and community-based care. New York needs to invest resources to build capacity within the health delivery system to provide services in a community-based, patient-centered and cost-effective manner. Many consumers want long-term care services that allow them to remain in their homes and part of their neighborhoods. Providing coordinated services in the most integrated setting will not only save dollars, it allows patients to receive high quality care in a dignified manner.*¹⁰⁰

Additional Clinics and Health Centers. Another proposal was to open additional clinics or to provide incentives for new or experienced physicians to work at clinics and centers in underserved areas of NYS.

- *We should consider opening up clinics in every borough, from 5 p.m. to 9 p.m., no major procedures should be carried out on the premises. They would be referred to hospitals. Create a medic corps, similar to our peace corps, with young newly licensed doctors getting service from one to two years in these neighborhood clinics and given government assistance to pay down their student loans. What a great human experience these doctors would receive.*¹⁰¹

Physician Recruitment and Retention. Several providers at the hearings urged state officials to improve conditions in order to attract more physicians to NYS. They shared their concerns about increasing physician attrition due to low reimbursements by insurance companies, rising medical malpractice costs and bureaucratic complexities.

- *The physician population is not the same as it was twenty years ago. The age level is different. To encourage more physicians to come into New York State, which is the solution to your problem, is something that would be wonderful for us.*¹⁰²
- *If New York wants to stop the hemorrhage of doctors, it will need to assure us and ensure that we will also be protected and compensated for our dedication, diligence and attention.*¹⁰³

Health Information Technology (HIT). Many presenters called for an increased emphasis on HIT, which could enhance the health care delivery system and promote better health outcomes. They noted the benefits of HIT in allowing for the secure and efficient exchange of health information between consumers and providers and in storing medical records and streamlining health care processes.

- *Expanding our use of health information technology is critical to achieving our*

goal of improving quality care and health outcomes. Our health care system continues to rely on antiquated methods.¹⁰⁴

- The widespread adoption of innovative technologies like electronic prescribing and electronic medical records should be encouraged throughout New York.¹⁰⁵

Table 2: Major Health Reform and Expansion Ideas

Build on Existing Public Programs	Expand Public Program Eligibility Levels Simplifying and Streamlining Public Program Application and Recertification Buy-In to Public Programs
Single Payer	Advantage over Expanding Current System Quality Care Business Viability Public Support
Mandates	Individual Mandate Employer Requirements
Private Market Reforms	Insurance Exchange or Connector Tax Credits HCRA Taxes Risk Pools Reinsurance Merge Markets Section 125 Plans Healthy NY Reform Regulate Private Insurance Market
Benefit Packages	Mandate Comprehensive Coverage Minimize Cost-Sharing Standardized Minimum Benefits with Flexible Plans
Improve the Health Care Delivery System	Invest in Preventative, Long-Term and Primary Care Open Additional Clinics and Health Centers Physician Recruitment and Retention Health Information Technology (HIT)

New York Specific Factors

As we previously noted, the purpose of the “Improving the Analysis of Health Insurance Expansion Options for New York State” project is to analyze, both qualitatively and quantitatively, meaningful and lasting options to expand health insurance coverage in NYS. In the next phase of the project we will be conducting quantitative modeling of various reform proposals for NYS. Thus, in reviewing and coding the transcripts and testimony, we were particularly interested in identifying statements about features of the NYS health care that set it apart from other states. Below, we list facts noted by participants about the NYS health care system.

Uninsured Characteristics

- 2.6 million New Yorkers lack health coverage.¹⁰⁶
- Of the 2.6 million lacking insurance, about 450,000 are children. About 350,000 are already eligible for Medicaid or Child Health Plus.¹⁰⁷
- 1.3 million are uninsured because coverage is unaffordable, or because residents require assistance to obtain public coverage.¹⁰⁸
- New York has higher rates of insurance than the national average.¹⁰⁹
- The number of uninsured non-elderly New York City residents decreased from 1.7 million in 2002-2003 to 1.5 million in 2003-2004. From 2003-2003 to 2003-2004, the number of uninsured children in New York decreased from 289,000 to 240,000. This was primarily due to an increase in the number of public program enrollees. Between 2002 and 2007, public health insurance enrollment in New York City increased by almost 755,000.¹¹⁰
- The majority of uninsured workers in New York City are employed by small businesses.¹¹¹
- New York State has a larger share of low-income uninsured people than Massachusetts.¹¹²

Coverage Characteristics and Public Program Structure

- New York City has a broad spectrum of public programs, including Medicaid, Child Health Plus, and Family Health plus, which have so far succeeded in enrolling many uninsured people.¹¹³
- In 2004, the number of individuals covered by employer sponsored insurance dropped to 61% (down 1% from the previous year), while the percentage of individuals covered in public programs dramatically increased from 15% to 19% in just two years.¹¹⁴
- New York State has a lower rate of people receiving employer sponsored insurance than does Massachusetts. In addition, New York has had less success with its public programs—it has a larger eligible but uninsured population.¹¹⁵
- New York’s Medicaid program is already large. It is as large as the programs in Texas, Florida and Pennsylvania combined.¹¹⁶
- There are many states with a lower uninsured rate than New York. The characteristics of those states are that they have more people with private coverage, not more people with public coverage.¹¹⁷
- There are eleven states with a lower rate of uninsurance among children than New York. Nine of these have SCHIP eligibility levels below New York’s.¹¹⁸
- People under the age of 65 who have a disability or chronic illness do not have access to prescription drug coverage through the EPIC program. This is unlike Massachusetts, New Jersey, Connecticut and 12 other states across the country, which do cover both the disabled and the aged in State drug coverage programs.¹¹⁹

Costs

- Medicaid costs in New York are among the highest in the nation, and New York has a very broad-based public financing system for safety net programs.¹²⁰

- New York State now spends more on Medicaid per capita than any other state, and double the national average.¹²¹
- New York has the second highest average monthly premium for family coverage at small businesses.¹²²

Disparities

- Two-thirds of the uninsured are from low-income families, and approximately 38% are families with incomes less than 100% of the federal poverty level.¹²³
- Most of the growth in the number of uninsured was from low-income families.¹²⁴
- Persons of color in New York are more likely to be uninsured than Caucasians.
- Of those without health insurance, 25% are Hispanics and 21% are African-Americans.¹²⁵
- Of the 1.2 million uninsured adults in New York City, 400 to 600,000 fall into overlapping categories of low-wage, non-standard and undocumented workers.¹²⁶
- Buffalo is the second poorest city in the nation, according to new estimates by the U.S. Census Bureau. Nearly 30% of its residents are considered poor.¹²⁷
- Almost a third of the uninsured in New York are non-citizens, both legal and illegal immigrants. Many are not eligible for coverage under federal Medicaid rules.¹²⁸
- Recent studies indicate that while one in twenty children in NYS are uninsured, more than one in four immigrant children in NYC lack health insurance.¹²⁹
- In New York State, fewer than 40 percent of uninsured women got annual mammograms in 2004, in contrast to more than 60 percent of those with insurance. Black and Hispanic women overall had rates of 55 percent.¹³⁰
- 39 percent of low-income New Yorkers do not even have a hundred dollars in savings. Over half have less than five hundred dollars.¹³¹

- Immigrants, refugees, and their families comprise a large and growing percentage of New York State residents. More than one in five New Yorkers are foreign born and more than 100,000 international immigrants settle in New York every year.¹³²

Health Care Delivery and Quality

- In New York City, the Health and Hospitals Corporation has had electronic medical records for some time, whereas nationally only about 10 to 15% of hospitals use electronic health records.¹³³
- There is a difference between health care in upstate New York and downstate. The upstate system uses community based physicians, community oriented hospitals, and referral centers. Downstate, there are more hospital clinics, staff physicians, faculty practice physicians, and a significant academic and specialty presence.¹³⁴

Other State Characteristics

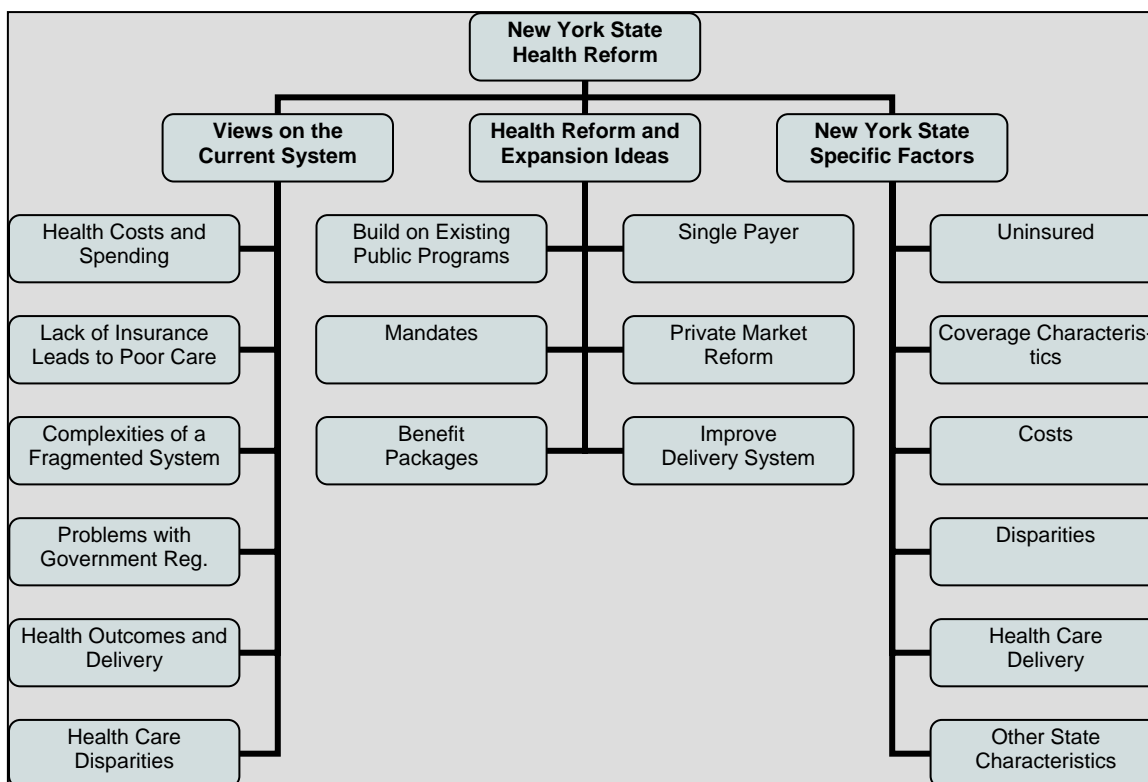
- In a poll conducted of 600 registered New York voters in October 2006 by Pace University, New York Magazine, WCBS 2 News, and WNYC, nearly half supported replacing private health insurance with universal public insurance.¹³⁵
- About 97 percent of the approximately 365,000 businesses in New York City are small, meaning they have fewer than 50 employees, and almost 86 percent of small businesses have fewer than 10 employees.¹³⁶
- Of New York City's 3.7 million workers, approximately 31% or 1.2 million are in non-traditional work arrangements. Many of these non-standard workers experience income insecurity, high mobility, and multiple concurrent employments. Non-standard workers are even less likely than standard workers to be offered health insurance through their employers¹³⁷

Conclusion

The three sets of hearings and conferences sponsored by Gottfried, Spitzer and the Manhattan Institute captured a wide array of public opinions on health care reform. Although the participants came from very diverse backgrounds (including health care providers, advocacy groups, policy analysts, insurance industry representatives, economists and health care consumers), there was overwhelming consensus that health care in NYS is in need of substantial change. All presenters agreed that policymakers need to make health insurance reform a priority in NYS. The positions put forward by participants also suggest such reform must rest upon the core tenets of access, affordability, and quality. While most presenters agreed

on these as tenets of reform, they put forward quite varied and often contradictory opinions and policy prescriptions on how health insurance expansions should proceed. This diversity is summarized in the figure below.

We hope that by summarizing nearly a dozen days worth of testimony and presentations, our report will better inform policymakers of the great variety of opinions which exist within NYS. Given the lack of consensus on a specific approach, the obvious challenge will be for policymakers to successfully translate these varied opinions into specific policy formulations.



Methods

We obtained written transcripts of all three of the Gottfried Assembly Committee hearings as well as the Manhattan Institute conference. For the Spitzer “Partnership for Coverage” hearings we obtained the testimony submitted by each participant that is available through the State website.¹³⁸ As speakers at these hearings were limited to ten minutes, the written testimony we use was often more detailed than what was presented orally. We imported the available transcripts and testimonies into qualitative analysis software, N Vivo 7. We then conducted thematic content analysis of the transcribed text to systematically identify the themes and the relationships among these documents. In the analysis, we used an open coding approach to identify these major themes and generate a broad list of codes. A more focused coding scheme was then used to establish variations within the broader codes as well as more specific codes within each theme. Once we had generated the final list of codes, these were applied to the transcript text file in order to compare the extent to which a theme occurred across sets of narrative text. In this report we present our findings grouped into the major themes and codes and include transcribed text that was representative of each coding point.

This report is a summary of the major ideas that were raised during the hearings and is meant to be viewed as a depiction of diverse and varied public views within NYS. While we note some of the most common themes and issues which emerged, we do not provide a quantitative tally of speakers expressing a specific concern or numbers of persons expressing support for a particular insurance reform option. This is because the hearings and conferences were not designed to serve such a survey or polling function. Instead they were established to obtain input, which is what we summarize in our report. Readers should also be aware that the transcripts and testimonies were our only source of data for the report. Thus, we have not attempted to validate any of the statistics or facts provided at these hearings and this needs to be taken into account in our presentation of transcribed text.

Notes

¹ These are available for the public on the “Partnership for Coverage” website,

<http://www.partnership4coverage.ny.gov>.

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