Good afternoon, Senators and Assembly Members of the state of New York.

First, thank you for holding this hearing. Given the state of healthcare in this state and country, we believe it is long overdue to have this public conversation. We extend our deep appreciation to the Health Committee Chairs for their leadership on this issue.

My name is Katie Robbins, and I am the Director of the Campaign for New York Health (CNYH), an organization founded to advocate for the right to healthcare in New York State. We firmly believe that a universal, publicly-financed system, or single-payer Medicare-for-All, is the best way to achieve that goal.

Today we are releasing a report titled, "From Coverage to Care, A People's Report on Healthcare in NYS." Over the last two years, volunteers and partner organizations surveyed over 2,400 New Yorkers from across the state, aiming for a sample representative of the state's population in regards to gender, age, race, and geographic distribution.

Our findings were clear. **50% of respondents reported delaying or skipping basic care entirely because of cost.** Even though most people had insurance coverage, they simply couldn't afford it. One third went on to develop more serious complications from not receiving timely care. When health issues aren't dealt with promptly it can lead to worse outcomes, and more costly care.

Our survey with people across the state went further to capture the stress, fear, and reduction in quality of life so many people experience when navigating the healthcare system. That is why we included testimonials from many different New Yorkers who have lived to tell the tale, speaking about their personal experiences with the system:

"Not being able to afford regular dental care cost me my teeth." -- Becca from Elmira

"I didn't have insurance for short periods during my three pregnancies, and the medical debt still follows me today" -- Sara from Buffalo

"I stayed at a job that was emotionally and physically exhausting to keep my health insurance." -- Frances from Brooklyn

"As a registered nurse who performs bedside care in the hospital, I have seen patients delay or refuse healthcare because of cost." - David from Orange Co.

Today, you will hear testimony from powerful and wealthy people and institutions, including the hospital, pharmaceutical, and insurance industries who vehemently oppose the New York Health Act. Unfortunately, these interests are often incompatible with healthcare.

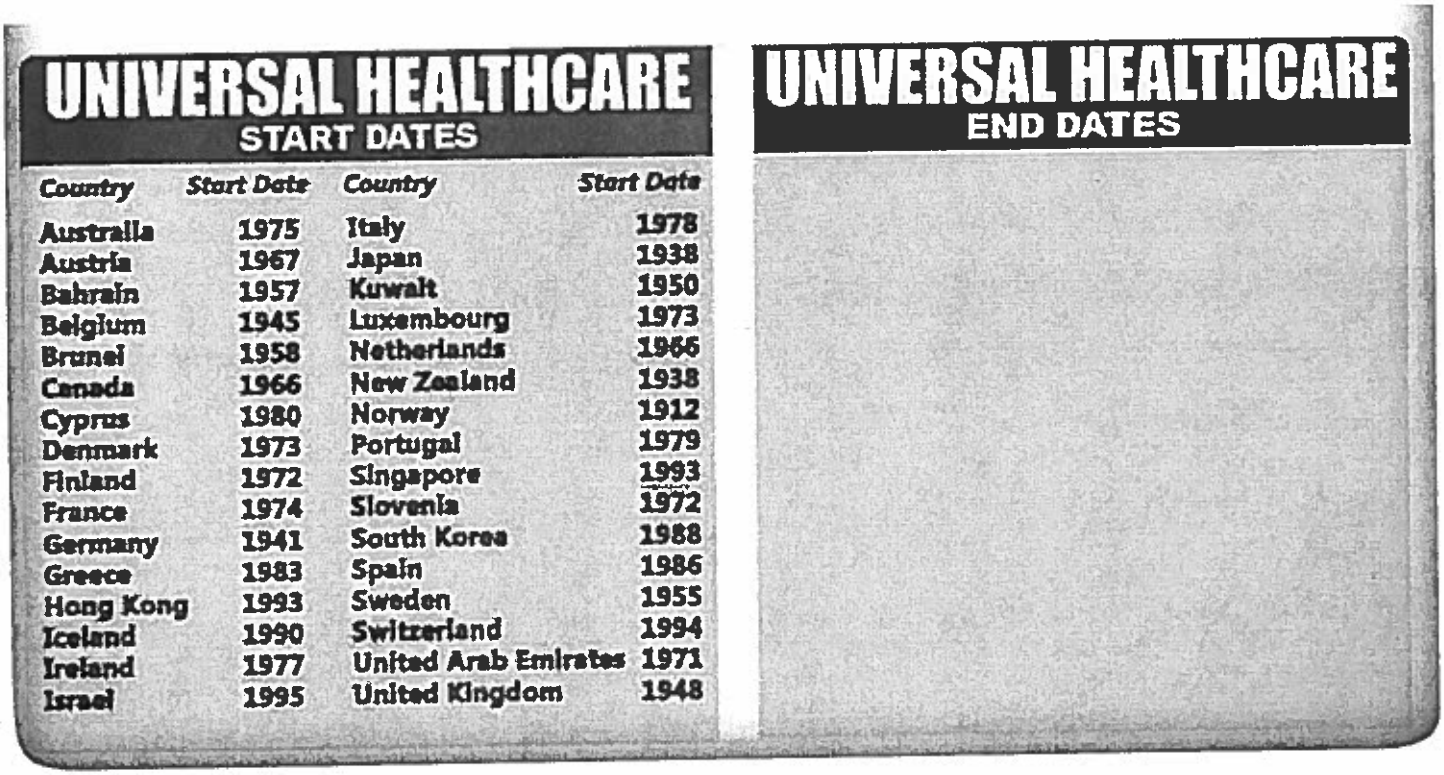
In our study, the vast majority of respondents do not view the current healthcare system favorably. 64% of people felt they do not have a say in decisions about our healthcare system. Overwhelmingly, people believe that believe that healthcare is a human right, and most people support a universal, publicly financed, single-payer system. Frankly, if we didn't have a crisis in our democratic process, we would very likely have such a universal system of guaranteed care in place.

Finally, I am including in my testimony a chart of dates recording when countries around the world implemented their universal healthcare systems. (Yes, we understand that not every country with universal healthcare has the single-payer system we advocate for, which is most similar to Canada, Taiwan, or South Korea. But what all the systems have in common is *strong* government regulation of the healthcare industry -- otherwise you're left with a system like ours that prioritizes profits over the collective health of the citizenry). Most of these healthcare systems were established throughout the middle of the last century. The second chart shows the date universal healthcare systems around the world ended, failed, or were dismantled. If we believe the talking points of our opponents about the dangers of a single-payer system this should surely be an interesting timeline. But in fact you'll see the second chart is

completely blank. No country has ever dismantled their universal healthcare system once it has been established. In fact, these programs prove wildly popular with their citizenry, making it very difficult to dismantle once they are in place.

We ask that lawmakers recognize the extraordinary price we are paying to maintain the status quo, not just in dollars and cents, but the human costs paid in worsening health, quality of life, and too many tragically unnecessary deaths. The legacy of bringing truly universal healthcare to a state like New York is on the table. It's time to pass the New York Health Act.

Thank you.



Listen to Your

Follow Your Hea
Follow Your Hea

NY Hea

Duck & Cover

1950's children were told
"Crawling under the desk will make you safe."
It didn't.

Don't Play "Du
Even Employer-Based Ins

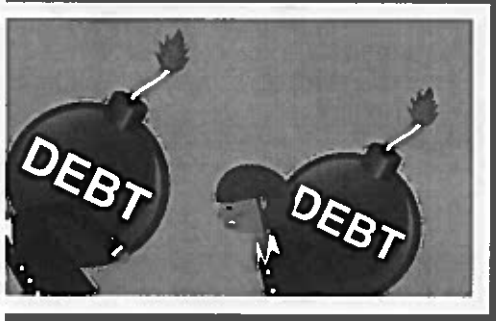
Collected by Dr. Judith B. Estero
Editors of *Healthcare in Am*
for *This Is the Bronx*, publ

Constituents

arts: Save Lives
ds: Save Money

lth Act

Duck & Uncovered



Today we're told
"Employer-based insurance makes you safe."
It doesn't.

ck and Cover"
urance Leaves Us Unsafe

quest and Dr. Barbara L. Estrin
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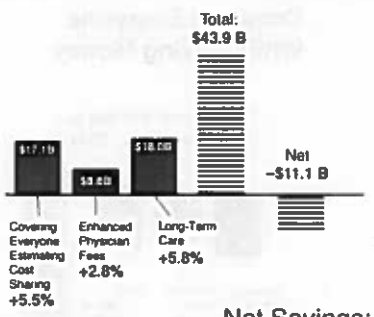
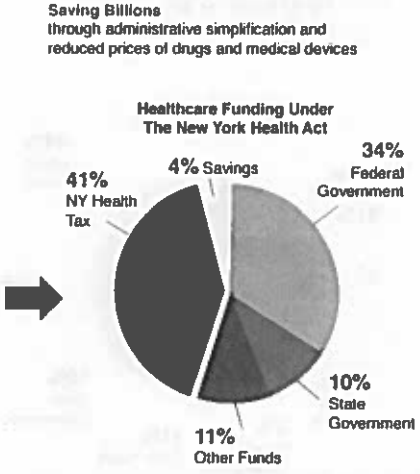


Net Savings:
−3.6%

Total Additional Costs: +14.1%

g v. Funding Under NY Health



h Act, RAND Corporation, August 2018; Leonard Rodberg, ion's Assessment of the NY Health Act, September 2018.

NEW YORK HEALTH ACT (A5248, S3577)

A Single State Fund Providing Comprehensive Benefits

Covers ALL medically necessary care, free choice of provider, no more networks:

- √ primary & specialty care
- √ hospitalization
- √ prescriptions
- √ vision, dental, hearing
- √ long-term care & support services
- √ mental health
- √ substance abuse treatment
- √ reproductive care

Savings: Families, NYS, Municipalities & Counties

For Individuals and Families: 90% will pay less or much less — premiums, deductibles, out-of-pocket costs replaced by a progressive tax that only increases with income, not with medical catastrophe or chronic illness.

For NYS: eliminates administrative waste from insurers and providers; dramatically reduces drug and medical device costs through volume discounts; reduces fraud and controls costs without reducing the quality of care; reduces access inequities across NYS.

Municipalities & Counties will save 15-30% of budget, lowering property taxes:
County Medicaid contributions: eliminated
Healthcare costs for current employees*: reduced substantially
Healthcare costs for in-state retirees*: eliminated
(*including police, firefighters, teachers, librarians, municipal staff, elected reps, etc.)

Healthcare for All of Us

- √ Doctors and nurses, not insurance companies, will decide your care — with you.
- √ Corporate profit will no longer take precedence over your health needs or public health.
- √ Preventive care will be covered — New Yorkers can get care before it's life-threatening.
- √ Long-Term Care will ensure permanently and temporarily disabled NYers — and family who now care for them — get the services they need to lead more productive lives.
- √ Seniors wanting to age at home will have services they need for living in dignity.

Improved NYS Economy

For Businesses: reduces cost, provides a predictable expense, eliminates need for benefits administration, and removes hassle; increases ability to compete for labor and customers, nationally and internationally.

For NYS Economy: improves productivity with healthier workforce; ends "job-lock"; reduces risk for entrepreneurs and start-ups; savings will create 200,000 new jobs.

Let's Not Cover Up the Real Story

The following pages offer stories told by patients, by family members, by physicians.
They usually begin by describing comfortable lives — employed, insured, healthy.

Our current healthcare payment system is broken. Many who interact with it get broken by it.

Medical calamity happens in a moment. Financial and emotional calamity follow.
A vicious cycle begins where illness begets debt, exacerbating ill-health, job-loss,
insurance loss, a downward spiral of unstoppable anguish.

Employer-based insurance isn't working — and it's getting worse:

Sky-rocketing costs have caused employers to reduce the number of covered workers, down 17% since 2000, with less than a third of recent college graduates now offered health benefits. The cost of health benefits exacerbates age discrimination among older workers, and is driving the no-benefits "gig economy," now estimated at 57 million American workers.

Employers have increasingly shifted healthcare costs to employees, with higher employee premium contributions and increased deductibles and co-pays. Since 2000, employer contributions have nearly tripled, while employee contributions have increased almost 5-fold — out-of-pocket deductibles have increased almost as much.

Healthcare costs for family coverage through employment have risen from 13% of the median wage in 2001 to almost 50% today. The average family spends more on premium contributions than on food for a year; more on healthcare premiums plus out-of-pocket than on housing.

Physicians also suffer:

Since 2010, over half of American doctors report symptoms of burn-out — with 10% of critical care and family physicians reporting suicidal ideation. Across the developed world, only German MDs (who also struggle with hundreds of insurance policies) have less career satisfaction than American MDs. Canadian MDs, under single-payer, report satisfaction; they focus on patients, without insurers interfering, without costs threatening lives that doctors have saved.

Our system is changing how doctors practice medicine: few can afford private practice when for-profit insurers offer reimbursement less than Medicare, when billing/reimbursement requires significant office staff and physician time, when doctors carry an average of $200K/year in unpaid debt from insurers. Narrowing networks also reduce continuity of care, making care less personal, less informed. These are reasons why most doctors support a single-payer payment system, like the NY Health Act.

For-profit insurers intrude into our doctor-patient relationships, and harm our health:

Most Americans have a family member who has avoided doctors and skimped on medications; delayed care often requires more complex treatment and critical care. American health metrics, among the worst in the developed world, are worsening. One U.S. demographic has outcomes approaching the globally healthiest and longest-living: seniors who have been on Medicare for at least a decade.

Universal, comprehensive healthcare with no fear of financial ruin helps our seniors get and stay healthy. Medicare offers access to world-class medical care — after a lifetime of less. With regard to Medicare, seniors rejoice (with Maurice Chevalier): "I'm so glad I'm not young anymore."

NY Health Will Cover Eve

Sources of Savings, Add

Covering Everyone While Saving Money

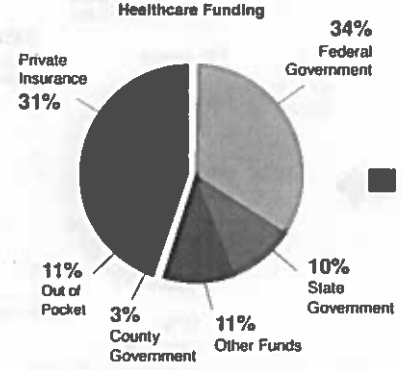
Total projected status quo Spending in 2022: **$311 B**

Total Savings: −17.7%

Current Sources of Funding

The NY Health Tax replaces private insurance, out-of-pocket costs, & county Medicaid costs

Current Sources of Healthcare Funding



Sources: Jodi Liu, et al., *An Assessment of the NY Healt*
Summary and Evaluation of the RAND Corporat

Our Heathcare Heroes

Gary Axelbank, "Mr. Bronx," publisher of *This Is the Bronx* and producer of *Bronx Talk:*
For your generosity in making space for a year of weekly stories delineating "*Healthcare in America,*" and your unfailing commitment to spotlighting healthcare disparities in our borough and state.

Richard Gottfried, For your championing the NY Health Act since 1992, steadfastly advancing and improving this groundbreaking legislation, inspiring us to stay the moral high ground, and thereby bringing victory within reach.

Gustavo Rivera, NY Senator from the Bronx since 2010 and chair of the Health Committee:
For your flair and passionate dedication to erasing health inequity in law and in fact.

Legislative Sponsors: For your courage to do the right thing for constituents.

Katie Robbins, NYH Campaign leader extraordinaire:
For your grace and steel, strategic vision and boundless joy.

NYS Nurses Association: For your 24/7/365 caring when we're at our lowest, for initially advocating single-payer to AM Gottfried, and for 25 years of unwearied efforts to bring quality healthcare to every New Yorker.

PNHP NY Metro Team: each of you joins reason with humanity, and we particularly note,
Dr. Len Rodberg: For your generosity to all comers, exceeded only by your talent for elucidating financial and conceptual complexities pellucidly.
Henry Moss: For your championship of long-term care and your patience when dispelling confusion on details esoteric, technical, and sometimes just plain arbitrary.

NYS Letters Team: the most eloquent, responsive, generous people we know,
Walter Carpenter: For your unflagging advocacy of single-payer in New York — and across the US.
Sarah Outterson-Murphy: For your compassion, organization, and devotion to improving lives.
Ursula Rozum: For your humor, patience, and discipline in mobilizing to make a difference.
Farris Thomas: For your business-savvy, personal insights, and deep moral passion.
Madeline Zevon: For your inexhaustible advocacy and leadership across your county and our state.

Dr. Catherine G. Wolf, 1947-2018, beloved member of our Letters Team, who wrote by using her eyebrow to control a computer: for your courageous, contagious optimism and your righteous advocacy for NY Health, "the most important battle of my life."

Designed by Kelsey Clark
kelseyaclark2@gmail.com

Questions?
NYHA.Esterquest@gmail.com
NYHA.Estrin@gmail.com

May 2019

Healthcare Stories From NYC

1. Financier. Well Insured. Motorcycle Hit Him. Bankrupt
Under NYHA:
   - Medical bankruptcies and debt: eliminated — like peers around the world.
   - Every New Yorker will be fully covered automatically — womb to tomb.

2. Employed & Insured. Pregnancy Complications. No Job. Three Lives at Risk
Under NYHA:
   - Your children will always have healthcare. So will you.
   - Automatic pre-natal and post-partum care will help reverse rising maternal mortality.

3. ER Doctor: For-Profit Insurance Is Not Good Enough or Safe Enough
Under NYHA:
   - ER patients facing death can focus on medical needs, not their wallets.
   - Doctors can save lives, without savaging patient finances.

4. Pre-Existing Conditions. Insidiously Curtailing Careers
Under NYHA:
   - Healthcare costs won't discourage hiring.
   - Older workers may see less age discrimination when job-hunting.

5. Cause of death: For-Profit Insurance. Fortune 100 Fires Chief Litigator
Under NYHA:
   - No one will die waiting for Medicare. No one will die because of losing a job.
   - COBRA payments won't destroy finances.

6. Terrifying Nightmares: "My Wife Will Be Homeless!"
Under NYHA:
   - Hospitalized loved ones can focus on healing, not fearing homelessness.
   - Medical bills won't leave families in debt or struggling with collection agencies.

7. Fully Employed. Got Sick. Lost Job. Lost insurance. Haggled for His Life
Under NYHA:
   - You'll never haggle for your life, like you haggle for a car.
   - Unlike current job-based benefits, you'll be covered. Fully.

8. No Medicare. No Medicaid. NY's Most At-Risk Population: Underserved
Under NYHA:
- Ambulance costs won't leave a broken back on a clinic floor.
- Post-surgery care will decrease suffering and help heal.

9. Small Business Owner: Needs NYHA to Attract Top Talent
Under NYHA:
- Top talent won't be job-locked — you can recruit them.
- Start-ups will have healthcare — even the healthy suffer accidents.

10. Dual-Income. Good Insurance. Lost jobs. Lost Everything
Under NYHA:
- Hard-working NYers who get sick won't face penury.
- Women's health needs will be fully covered.

11. Employer-Based Insurance Threatens My Son's Life
Under NYHA:
- "Continuity of Care" will be the norm, not the dream.
- Changing jobs won't threaten your child's life.

12. Active. Healthy. Sudden Chronic Illness. Formulary Hell. Will I Survive?
Under NYHA:
- Drug prices will no longer extract extortionate profits.
- NYers with chronic diseases will get needed meds; they will remain productive.

13. Delays Updating Insurance. Barely Escaped Bankruptcy
Under NYHA:
- Automatic enrollment in the best plan, always affordable, always there.
- Pre-existing conditions won't dim future job prospects.

14. The Hospital Is "in Network." Surprise! The Doctor Is Not
Under NYHA:
- No surprise bills, no costs at point of service.
- All NY hospitals are "in network," and so are their doctors.

Senator Biaggi: Constant Formulary Changes Worry My Parents

Cost-Sharing Harms Health

My family is typical of many of my constituents in District 34.

Since 2012 when my dad was diagnosed with Parkinson's disease, the number of pills he takes each month has fluctuated depending on how well he's doing. My dad is on my mom's health insurance plan, and adding prescription drugs is very expensive.

So my dad, who is over 65, pays premiums for Medicare Part D for prescription drugs. Even with his health insurance and my mom's, my parents still pay some out-of-pocket costs for my dad's medicine. Each month, pills are changed. One kind of pill can be $500 one month, and $1,400 the next month. A month later, maybe it's $2,000.

My dad has paid close attention to these changes — calling his insurance companies to question costs. He has been told one month it is Schedule 1, the next month it is Schedule 2. Each month it is a different cost share.

So here we have two very smart people, my mom who works in a public hospital in my district and my dad who is a lawyer, having a very difficult time navigating the costs of his prescription drugs.

Now, this is progressive disease and, as time goes on, they know they will have to understand additional things like long-term care and what they can afford. I know we can do so much better. The NYHA will relieve stress for so many families across the state.

Under NYHA: ***We won't face obstacles to getting needed prescriptions.***

Home LTC Kept My Grandfather Alive Longer

High-Quality Long-Term Care Extends Quality Lives

I was fortunate that my grandparents lived until their late eighties and nineties. Watching them age was both wonderful and difficult because differences in their economic status determined the kind of care they were able to access — and, by extension, their quality of life differed. My grandfather had 24-hour care in his home, where he lived until age 97.

> getting good care can extend the length and quality of your life

By contrast, both of my grandmothers went to nursing homes where neither was fed. That may sound crazy, but it's true. The nursing homes did put food in front of them, but both grandmothers had suffered strokes and couldn't use their hands. It was only after several weeks that we learned they were, quite literally, starving. My parents noticed my grandmothers getting thin and moved them from where they were in upstate New York into nearby Bronx nursing homes.

As my family's experience shows, getting good care can extend the length and quality of your life. Despite the challenges we had, my family was lucky to be able to afford the care my grandparents needed. Living at home was a huge positive for my grandfather's mental health and well-being. But homecare often means a family member must stop working or get training. Since long-term care in a New York nursing facility can cost $100,000 per year or more, for most families a nursing home is out of reach until there is no other path but "spending down" all savings.

> We must ... think about the way the policies and laws we pass affect human beings

It is vital that all New Yorkers can age with dignity. We must make sure we are taking care of one another, that we think about the way the policies and laws we pass affect human beings.

Alessandra Biaggi *is State Senator from district 34.*

Under NYHA: ***We'll age at home, with dignity.***

NYC Med Student: Gets "Separate but Equal" Healthcare

I am a 24-year-old medical student in NYC. My overwhelming desire is to heal people, particularly those who are most vulnerable. Our complex healthcare system often fails those who need it most. As both a patient and a future physician I've seen that, even for those with health insurance, access and cost remain problematic.

We actually have separate buildings for patients with private (for profit) and public (Medicaid and Medicare) health insurance at the NYC teaching hospital where I work. Faculty members see patients with private insurance, while a rotating cast of residents (doctors in training) see those with public insurance. Those without health insurance aren't seen at all — unless they go to the student-run clinic, where medical students practice on and treat them.

> even for those with health insurance, access and cost remain problematic

My hospital claims that patients on public and private insurance receive comparable care but, as history has shown us, "separate but equal" is unequal. Patients at the public clinic wait longer for appointments, and their doctors change continually as residents graduate and new doctors in training take over.

Patients who consistently see the same doctor have a distinct advantage over those who don't, those who see a new rotation of physicians each time they are treated or hospitalized. Constant rotation prevents patients from getting the continuity of care required for quality interventions. Inconsistency increases the odds that long-standing conditions are overlooked or ignored, often the difference between life and death. Medicine relies on resident labor as a teaching tool, but this segregated system skews the distribution of resources by income.

Data demonstrates this system creates de facto racial segregation. In NYC, over 80% of patients on Medicaid identify as Black or Latino, while only 30% of privately insured patients do. In practice, this means I can guess whether a patient will receive the higher level of care at the private clinic just by looking at the color of his/her skin.

Sadly, such disparities extend to nearly every aspect of our hospital and medical school. On the OB/GYN service, patients with public insurance are seen on a different floor with fewer amenities than the privately-insured patients. Newborns at the hospital are separated according to insurance status, ensuring that these healthcare inequities are present from each baby's first breath. At the medical school, it's well known that a rotation at the public city hospital means "getting to do more" and having more autonomy when practicing on patients. When I tried to make appointments for my own care, I had a hard time finding physicians at my hospital who accept Medicaid.

> these healthcare inequities are present from each baby's first breath

Being a Medicaid patient meant receiving lower quality of care where I work, so I sought care at a clinic that serves everyone, regardless of insurance status. I am fortunate to be in good health and to have the tools and resources to make informed decisions about my own healthcare; my most vulnerable patients do not.

This unequal system penalizes low-income patients and delivers substandard care to people who desperately need quality medical attention from skilled diagnosticians. Worse, this segregation is entirely legal. Because it is based on health insurance status, not race, hospitals throughout the city segregate patients. While this system has dubious financial benefits, it has very real health consequences.

Our medical school teaches us to value every human life, to treat all patients as equals, care for them with dignity, compassion, and the highest clinical standards; but this system runs contrary to everything we've been taught, undermining it.

> Our medical school teaches us to value every human life ... but this system runs contrary to everything we've been taught, undermining it

This multi-tiered, income-based system isn't fair. It's not fair to patients — or to medical students, who need healthcare to become doctors and who need quality supervision to do right by their current (and future) patients. And it's not fair to doctors who try to give each patient their full attention and best care — regardless of having their fees determined by their patients' income. We need to level the playing field on healthcare — for patients and for providers. NY Health will make a difference.

Serena Castile is a medical student at a major New York teaching hospital.

Under NYHA: **We'll dismantle "separate but NOT equal" healthcare.**

15. Authorizations: Designed to Keep Providers From Patients, Patients From Care
Under NYHA:
- Your provider and you choose your care. No insurer denials.
- All financial obstacles to care: eliminated.

16. Bad Migraine. Scary Prognosis. Insurance Traps. Scarier Debt
Under NYHA:
- No hassles: all insurance traps eliminated.
- If you need the care, it's covered. Rationing based on income will end.

17. Healthcare Costs Destroy Dreams. Discourage Entrepreneurs
Under NYHA:
- Entrepreneurs will flourish, creating 200,000 new jobs.
- Small businesses will have healthcare risks resolved.

18. Sudden Illness. Great Insurance. Months of Stress Over Paperwork and Bills
Under NYHA:
- No hassles on bills, ever — there aren't any.
- Network issues, questions about tests, confusing paperwork — all gone.

19. Med Student. Experiences "Separate but Equal" Healthcare in NYC
Under NYHA
- Eliminating tiered services will begin dismantling "separate but NOT equal."
- Doctors and hospitals won't be paid less for treating lower-income patients.

20. Senator Biaggi: Constant Formulary Changes Worry My Parents: Long Term Care Kept My Grandfather at Home and Alive Longer
Under NYHA:
- We won't face obstacles to getting the prescriptions we need.
- Most of us will be able to age at home — much longer, and with dignity.

Online versions of these stories — and more — are available at thisisthebronx.info/weekday-magazine-healthcare-in-america [Author's Name]

Financier. Well Insured. Motorcycle Hit Him. Bankrupt

My life changed forever on March 31st, 2009: while crossing the street, a speeding motorcycle hit me. The impact sent me flying 25 feet, breaking every bone on my right side, from my clavicle to my toes.

I am grateful to modern medicine to be alive. The trauma was catastrophic. Seven open fractures to my leg, nine broken ribs piercing my lungs, and a broken clavicle. Many surgeries, some more than 14 hours long, rebuilt the right side of my body.

> I was reputed among the best in my field, the subject of two documentaries and a WSJ Column 3 profile

Months of physical therapy and private nurses followed. I had to learn to walk again, to move my arms up and around, to feed and bathe myself. The vascular trauma to my legs was so extensive I have had 11 surgeries on my left leg, the most recent 8 months ago. My world became increasingly small — a world of doctors, therapists, nurses, aides … and more nurses and more therapists.

Where I once found fulfillment in building companies and serving on the boards of numerous organizations, exigency required total focus on caring for wounds and learning basic skills of self care.

Shortly before the accident, my insurance broker arrived with forms to complete. I thought we were maximizing coverage of damn good insurance. I was actually setting unimaginable coverage limits. After the first seven-figures, my insurance ended. Bills continued to arrive, for years. After more bills reached seven digits, I was forced to file for bankruptcy.

> Here I was: bankrupt. I felt shamed

For three decades I'd known myself as a highly regarded professional. I was reputed among the best in my field, the subject of two documentaries and a WSJ Column 3 profile. But here I was: bankrupt. I felt shamed. Slowly, I learned our healthcare system is so broken that two-thirds of bankruptcies are medical.

During this time, I applied for Long-Term Disability. As often happens, my first application was denied. I reapplied. My file was lost — twice. Just before my first court hearing, my attorney was hospitalized with his own medical emergency. When my second hearing date arrived, the Judge was called to another court. Finally, the third date arrived: I was awarded Long-Term Disability.

Naturally, I expected a check. After waiting months and diligently checking with Social Security, the manager of the New York office called the manager of the Chicago office to request an expedited check. It was. Six weeks later. But the size of the award necessitated three installments. Finally, after more than 2 years, my Social Security Disability check was paid in full, most going to overdue medical bills.

The Tom I knew for 50 years is no longer. I am still getting to know the new Tom. Some days feel fragile; other feel strong. The New Tom lives with chronic pain. In my prior life, I served on the boards of social service agencies, always fund-raising. Today, I am a client, and eternally grateful to such organizations and their donors.

> life as we know it can turn in an instant, forever and unalterably changed

I am active in support groups where we help one another navigate this New Normal. Each of us has a full plate of stress, many to the point of overload.

I've learned a few profound truths in my journey:

- First, life as we know it can turn in an instant, forever and unalterably changed.
- Second, healing takes time, financially, emotionally, physically — leaving us in varied stages of preparedness and awkwardness and clumsiness. It takes time to embrace the new you, the new me.
- Third, we are our brother's keeper — we owe it to ourselves and to one another to be there for each other. Most assuredly this includes healthcare.

Worrying about paying for healthcare should never be on anyone's plate. Healthcare is a moral good, not a means for extorting profits.

***Farris "Tom" Thomas**, once a serial entrepreneur and active in philanthropy, is now an active volunteer.*

Sudden Illness. Months of Stress Over Paperwork and Bills

Billing Compounds Serious Health Condition

Ten years ago, on an evening in February, the school where I teach music called to confirm my place on an exciting school trip to China. But I missed the call: I was being rushed to the hospital with a brain infection, soon diagnosed as encephalitis accompanied by a seizure.

I'd come home from school not feeling well. I crawled into bed. My husband was relieved that, for once, I was giving into being sick, so he let me sleep. But the next day, he tried to wake me: my eyes were open but unseeing, I did not respond to anything he said. He called 911. Worried for my life, my elder daughter flew in from Scotland. I was lost in a kind of darkness. Once it seemed likely I would survive, my doctors expected I would need months in the hospital to recover. But I surprised my neurologist by the speed with which I snapped back from the initial symptoms, and I was allowed to go home after ten days.

Encephalitis presents a particularly tricky recovery because the instrument you use to evaluate and interpret yourself and the world is damaged. Emotional recovery took longer than physical and mental functions. Coming to terms with what happened took about 8 years. It is hard to distinguish whether there is permanent damage from work around brain development or even aging.

> I had very good, and very expensive, health insurance

I had very good, and very expensive, health insurance —half paid by my employer and half by me. To give me the best possible chance of recovery, my excellent neurologist referred me for neuro-psych testing with another excellent doctor. Since the hospital took my insurance, we assumed the specialist would. In my very damaged mental state, I didn't ask about payment. It turned out this particular doctor wasn't on my insurance so, after negotiations, the bill for testing was something like $4,500.

Dealing with Recovering, Recovering from Billing

Knowing what a perfectionist and workaholic I am, my neurologist insisted I take the full 3 months of disability leave offered by my school. I was sorry to miss work, and my students missed me, too. But I was grateful for the leave because I needed time to negotiate healthcare payment issues.

While it's hard enough to deal with healthcare bills and insurance companies with a healthy brain, healthcare bills (which don't wait for you to recover) are REALLY difficult with a damaged brain. And the bills wouldn't go away. I still felt confused, like I needed all my strength just to put myself back together. There was a lot of back and forth with the hospital and the insurance company; it was exhausting, stressful, and time-consuming. I remember getting so frustrated that the billing office kept telling me I owed more money than I thought I should. The insurance company and billing office kept bouncing me back and forth.

> And the bills wouldn't go away. I still felt confused … it was exhausting, stressful, and time-consuming

I clearly remember telling an employee in the billing office that I would pay some amount, even though I thought it wasn't fair, if we could just be done with it. They were giving me a runaround about having to check it out, but their supervisor overheard it from another room — and came running in, saying they'd take my money and close the case. My recovery then continued without the added worry of high bills. I returned to work I loved then and continue to enjoy now.

I am a strong supporter of the New York Health Act because I want everyone to have healthcare coverage that is as good as (or better than) mine — but without stressful negotiations with bureaucracy, bills, paperwork, prior approvals, negotiations, and the large sums going to "middlemen" that our system requires.

***Judy Fletcher**, who lives in the Bronx, is a violinist, teacher, environmental and political activist.*

Healthcare Costs: Destroy Dreams. Discourage Entrepreneurs

I vividly remember that awful day. August 4th 2014. Lori and I had been married less than a year. She had recently quit her corporate finance job, gone back to school and started her own business. That day she woke up, turned to me, and said, "I can't feel my arms and legs." She was 28 years old.

There is no adequate way to describe the fear, the piercing dread, that washes through you when the woman you love says something like that. I gathered her up and drove to the hospital ER. After admitting her on an outpatient basis, they wheeled her to the radiology department for an MRI. They directed me to the billing department. We thought we had great insurance, just like we thought we were young and healthy, but they wanted $5,000. On the spot. In the moment we were most vulnerable, in the moment my wife's health was most unclear, the system required $5,000. Immediately.

> Part of me wondered maybe we weren't worthy of care if we couldn't pay. I can still feel that panic

I thought there must be some mistake. Naively, I thought they must not have run the insurance card correctly. Run it again, I urged. But, no, they were right — our deductible was $5,000. I had two credit cards in my wallet. The anxiety I felt unnerved me. Part of me was sure they would provide care even if both cards were denied. Part of me wondered maybe we weren't worthy of care if we couldn't pay. I can still feel that panic. Consider: this was despite knowing we had insurance. Good insurance.

Looking back, I know we were lucky. I had two credit cards, and both were paid up. But when "lucky in America" means you have the capacity to accrue potentially vast medical debt, we in America have a serious problem. Two years of struggle followed this initial hospital visit. Two years of doctor visits, late night calls to insurers, everyday battles to demand that the care my wife needed and deserved was the care she got — and two years of debt that almost buried us financially, almost cost our family all we had.

We left New York for New Hampshire and moved in with my Aunt. We were grateful for her help: we couldn't afford medical bills plus credit card bills plus rent on top. Our struggle wasn't unique then. It's not unique now.

Healthcare in America is broken. It's a system that demands people empty their wallets and stress their credit — when they are completely vulnerable, paralyzed with fear, and grievously worried about the fate of someone they love.

Our lawmakers must listen to those who vote for them, rather than the thousands of lobbyists spending millions of dollars to keep the status quo. Healthcare is too expensive. Its cost is destroying too many American families. Yes, of course, it's a moral issue. But it's also a fiscal issue. And an economic issue — for individuals, families, communities, states, and our country.

> When we invest in healthcare, we are investing in America ... big thinkers and small business owners

Families who are struggling every day to pay for food and rent and medical bills are too tired and worried to work on their dreams. How can we expect them to be inventive? Entrepreneurial? To start their own businesses?

When we invest in healthcare, we are investing in America — investing in an America that rewards big thinkers and small business owners, people who start their own business, create new jobs, and build value for our communities. People who fear losing their health coverage, who know that their current job is the only way they can afford insurance, those people don't leave jobs — even if they hate them, even if the health insurance keeps their wages low, even if they yearn to transform their big idea into a business.

> People who fear losing their health coverage... don't leave jobs — even if they hate them, even if health insurance keeps their wages low

The Rand Corporation recently analyzed the NY Health Act, and concluded it would cover every NY resident for less than what NY is currently paying — and that savings would stimulate the NY economy, make NY businesses more competitive, unleash entrepreneurship, raise wages, and create 200,000 more jobs. Our government needs the fiscal prudence of single-payer healthcare. Families need better and more affordable healthcare.

Lawmakers need to hear constituent voices that understand the issues facing ordinary Americans, small business owners, and families. I've seen first-hand a broken system that fails families who are experiencing the scariest weeks and months of their lives. It's time our representatives represent our voices and our future.

Deaglan McEachern *moved from NY back to family in NH after ruinous medical bills; he works in technology and now advocates for universal healthcare.*

Under NYHA: ***Entrepreneurs will flourish, creating 200,000 new jobs.***

Pregnancy Complications. Three Lives at Risk

Part I: My life explodes into healthcare nightmare

Diagnosed with preeclampsia and severe ante-natal depression. Prescription: total bed rest. Here I was, in a high-risk pregnancy that can lead to HELLP syndrome, a life-threatening complication that had almost killed a good friend.

> The idea of leaving my three older children motherless terrified me

I knew American women can and do die from this; it's part of why the US is the only country with rising maternal mortality. I knew I needed medical care to save my baby — and to save my own life. The idea of leaving my three older children motherless terrified me. Rather than giving me medical leave, my school terminated me — which terminated my health insurance, and the health insurance of my children.

- I wasn't eligible for unemployment because I couldn't look for a job: complete bed rest
- I wasn't eligible for (permanent) disability because high-risk pregnancy is temporary (when not lethal)
- I wasn't eligible for COBRA, since my employer didn't process my termination as I asked
- I was scared, and not just for me

Yes, I was in the most dangerous trimester of a high-risk pregnancy, but my tween, recently diagnosed with severe emotional disability and suicidal depression, had just been accepted into an in-patient program. When I lost my health insurance, she was terminated from her program. Her needs were serious, and I had no way to help her.

> I'd like every local, state and national representative to spend a few days waiting among those needing benefits

My desperation for my kids overcame the profound shame deepening my depression: I decided to apply for Medicaid. It was mean-spirited, Byzantine:

- You must apply in person at a local Social Services Office. They open at 8:00 am, give you a number as you enter, and then you wait.
- The line outside forms long before 8:00 a.m. because you need to be at the head of the queue to get a low number. I rushed to leave my kids at school early to arrive before 8:00 am, and never got a low number.
- Because I had to pick up my kids after school, I had to leave at 3:00 pm so I lost my place. They lock the doors at 3:00 or 3:30, so you can't come back. If you leave, you have to return again the next morning.
- Who made these rules? Don't all moms have to care for kids? People who need Social Services for urgent, scary, life-threatening reasons have complicated lives.
- Is it like this to discourage people?

I'd like every local, state and national representative to spend a few days waiting among those needing benefits: every one of us had a story, some far worse than mine. I finally got my Medicaid card at 38 weeks.

> Who made these rules? Don't all moms have to care for kids? People who need Social Services for ... life-threatening reasons have complicated lives

We were all incredibly fortunate that I didn't fall into such a debilitating depression that I couldn't leave my bed, although I came close. In short, as anguishingly horrible as it was, we all survived.

Part II: The nightmare subsides into HC limbo

But, just like life, my story continues — not yet as good as it was before the preeclampsia, but so much better than those three months. I live in a state of uncertainty about both employment and healthcare. To make myself even more attractive — I am gaining additional certification so my school can use me in a greater variety of subjects with a greater variety of students. I like this school, and I love teaching.

With NYHA my termination would not have so desperately worried me about leaving my children orphans. And my daughter could have continued the excellent program she'd entered rather than interrupting it to return to a family in crisis with a mother who was almost as depressed as she was.

Under NY Health, I wouldn't today be so consumed with patching together continuing coverage with as few gaps as possible. Instead, I could focus on doing the best job I can for my students and colleagues. Under NY Health I'll be happy to pay more when my income rises.

Carmen Lyra *is a special education teacher and the mother of four children.*

Under NYHA: ***Your children will always have healthcare. So will you.***

ER Doc: For-Profit Insurance Isn't Good Enough

The CoSt of Heartache

"Stop!" brought life-saving prep to a dead halt.

A woman in her 50s lay on a gurney in the ER where I am an attending physician. I met her EKG before I met her, noting the ominous "tombstone" pattern.

I went to medical school to heal people, not to have financial discussions about indicated care

The woman was pale, sweaty, holding her chest, complaining of crushing pain, and I told her she was "having a heart attack" — a diagnosis I have made over 100 times. We called for a "STEMI Alert" which mobilizes a team to perform a cardiac catheter procedure — saying "STAT" is redundant.

When an EKG shows a heart attack in progress, we live by the mantra "Time is Muscle." Opening that clogged artery in her heart within 90 minutes of the patient entering the ER is the gold standard. While 90 minutes may sound like forever, prepping is not simple: there are no minutes to spare. We stripped her clothes, checked vitals, inserted IVs, drew blood, attached monitors .... Like a pit crew at a racetrack, a swarm of doctors, nurses, and technicians try to beat the clock. The scene may look chaotic, but every person is focused and fast on an essential job — to keep the patient's heart muscle alive, to save her life.

And then came the scream that stopped everything, the entire ER shocked by our emergency cardiac patient shouting, "Stop! Stop!" "I need my phone. I need my insurance card. Are you in my network?!" The team froze. I walked to the head of the gurney. As we made eye contact, she blurted, "I have insurance, but it's a high deductible plan. My spouse passed away. I have a teenaged daughter. I don't know if I can afford this."

In what was likely the most vulnerable moment in her life from a healthcare perspective, she was NOT frightened by what was happening in her body or that, without emergency treatment, she might die — that minutes of delay could cause a lifetime of disability. Her focus was on the cost, about being the only support for her teenaged daughter. The team looked back at me, anxiously eyeing the clock. I can't adequately describe how this situation makes me feel.

When patients bring up cost, especially in such an uncompromisingly emergent condition, where the medical decision is crystal clear, I find myself feeling a deep pit of anger, disgust, and pain in my own heart. Since I first started medical school in 2001, I've known medical bills are the leading cause of personal bankruptcy in America, most with private insurance. It worries me that the care I deliver — and even the lives we save — too often also delivers crippling costs.

I love putting my years of training and clinical experience to work — but when I am focused on saving a patient's future health, I have no additional mental bandwidth. I told her we wanted to keep her alive, that her life was worth saving, that not treating her now could kill her or leave her disabled. I told her there was no way, in this life-threatening situation, where seconds matter, that I could figure out costs. And I assured her the hospital would work with her and her insurer. She let us proceed. The lab inserted a stent.

Medically saving lives can financially ruin them

I went to medical school to heal people, not to have financial discussions about indicated care. But the current state of American healthcare financing has created a double-edged sword: Medically saving lives can financially ruin them.

Our current healthcare system has totally compromised the doctor-patient relationship. It's heart-breaking. And frustrating

I support the NY Health Act, single-payer healthcare — which will cover all essential care for all NY residents — with no payment at point of service. Most doctors agree on this. I need single-payer healthcare so that I can finally tell my patients, and maybe even you who are reading this and might one day be my patient: "Don't worry about the costs. They're covered. You need this treatment ... now." But I can't.

Our current healthcare system has totally compromised the doctor-patient relationship. It's frustrating.

And heart-breaking.

Dr. Daniel Lugassy *is an ER physician at 3 NYC hospitals and a board member, Physicians for a National Health Program NY Metro Chapter. pnhpnymetro.org, nyhcampaign.org*

Under NYHA: **Patients facing death won't focus on their wallets.**

Migraine. Scary Prognosis. Scarier Debt

At age 29, with a blood clot at the base of my brain, I was hospitalized for three days in 2015. I had to be constantly monitored for strokes or seizures so, due to a lack of available hospital beds, I was in the ICU for three straight days.

I initially went to the ER with what I thought was an exceptionally awful, multi-day migraine. When the ER doctor ran into my curtained off area to ask if I had hit my head (I hadn't) because the CT scan demonstrated bleeding, I was terrified. I had to be transported by ambulance to a larger hospital where an MRI could be done on Saturday afternoon.

I was terrified ... neither of us — in our panic — thought to call my insurance company

Nothing like this had ever happened to me or my husband before, so neither of us – in our panic – thought to call my insurance company to obtain pre-authorization for all of the medical services I would need. We didn't know how much would be needed until it was happening!

Since we did not call, and since I had a Blue Cross Blue Shield high-deductible plan, many additional costs fell to me, and I owed far more than my already high deductible of $6,000. After leaving the hospital, I had to continue to take expensive medications to help break down the clot.

Though I was directed to start this treatment the day I was discharged, the hospital had not yet submitted its bills to BCBS; without these, as far as the insurer was concerned, I had not yet met my deductible. I was left with no choice about paying hundreds of out-of-pocket dollars for my medications, on top of my hospital bills.

I was left with no choice about paying hundreds of out-of-pocket dollars for medications, on top of my hospital bills

I have not yet been able to pay the hospital in full, well over two years later. I feel lucky the hospital put me on an extended payment plan, and I am finally close to paying off my original hospital bills. In determining the cause of the blood clot, however, my doctors found a number of underlying factors and possible residual effects that require medical attention and monitoring.

Countless medical appointments, an additional hospital stay, and an ER visit later, my medical debt continues to grow.

I am an attorney in a public interest field (disability rights and advocacy). Though I work hard and love what I do, I do not make what people assume an attorney would. It's hard enough to stay afloat financially without the additional medical expenses. Though I now have better healthcare coverage, I still have significant co-pays and co-insurance.

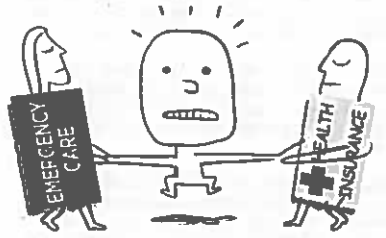
Countless medical appointments, an additional hospital stay, and an ER visit later, my medical debt continues to grow

I worry that the repeal of the Affordable Care Act's individual mandate in the new federal tax bill will leave me with fewer health insurance options — and higher medical bills. Like me, many of us are burdened with significant living expenses and retroactive bills for our student loans.

As a disability-rights attorney, and as a person who now has a pre-existing condition, I see first-hand how the lack of affordable, quality medical care affects people of all walks of life, every day.

A single-payer system is necessary to make sure all New Yorkers are able to continue to lead healthy, productive lives: anyone could have a medical emergency at any moment, and no one deserves to go deep into debt because of it.

Lauren Grace *is a disability rights attorney and advocate. She practices in New York City.*



Under NYHA: **All insurer traps eliminated.**

Prior Authorizations: Designed to Keep Patients From Care

I am a registered nurse working in a doctor's office at a major NYC medical center; my work with patients suffers from having to chase prior authorizations. I am trained to treat patients and certified to do procedures on patients. But whenever the best course of treatment is not on the "formulary" of an insurer (which works with still another company to manage its medication approvals), I spend hours dealing with a convoluted system.

I am not at all sure health insurance is about health

Let me give an example of what was recently required to get a patient the best care possible. This patient cannot take the generic of a specific medication. It makes her ill. She pays a lot of money for her supplemental insurance and needs her insurer to authorize payment, since she cannot afford to buy the medicine. The saga begins, as it often does, when her original prescription was denied at the pharmacy.

I am not sure every doctor's office puts as much effort into this as ours does, leading me to believe that insurance companies purposefully handle their prior authorization process in this way. As you read through the steps listed below, keep in mind that the "benefits" employees I deal with have no medical knowledge, read scripted questions, have no management available at their call centers (for appealing decisions), and have no connection between their company (which manages prior authorizations) and the insurance company.

a lengthy [appeals] process can lead to exacerbation of illness — and even hospitalization ... almost always more expensive than medication

Prior authorizations are themselves obstacles, but having the process be so Byzantine and time-consuming exhausts the doctors offices and causes most doctors to give up. When doctors offices give up, patients usually do something sub-optimal or just go without.

Remember that while we pursue this process, the patient goes without treatment, and a lengthy process can lead to exacerbation of illness — and even hospitalization. Those are almost always more expensive than the medication. The short-sightedness of pre-authorization is astounding.

21 Steps Getting One Patient Needed Medication:

1. I called for prior authorization.
2. That initial call was denied.
3. I was then told the denial was "an accident" and that everything was ok. No progress.
4. I was later told I needed a letter of "medical necessity" which I crafted, detailing the reasons the patient needed the medication and couldn't take the generic. The doctor signed.
5. The prior authorization was denied.
6. I was told the ICD10 code (classification of condition) was incorrect; it wasn't.
7. The company then said I needed an appeal.
8. I faxed the appeal; I have a receipt that it went through.
9. We heard nothing; the secondary company said we needed to call the first insurance company.
10. The insurance company said they didn't know what the secondary company answered.
11. They asked me to fax them again.
12. I did.
13. They didn't immediately see the fax and told the patient (who called) that they didn't have anything.
14. The whole process took six weeks.
15. By the time I called, they had found the appeal.
16. I requested that they expedite the appeal.
17. They said no.
18. I requested to file a complaint. They said "no", only the patient can file a complaint.
19. I requested that the company call the patient with the result.
20. A manager said "no", they cannot flag the system in that way.
21. Finally, the patient was able to get the prescription.

Alice Love *has been a registered nurse for 22 years.*

Under NYHA: **Your provider and you choose your care.**

Pre-Existing Conditions. Insidiously Curtailing Careers

My Dreams Derailed

"Pre-existing condition": healthcare lingo for an illness you have prior to applying for health insurance. According to the Kaiser Family Foundation, over 25% of New Yorkers under age 65 have pre-existing conditions — such as diabetes, cancer (even if cured, cut out, or in remission), high blood pressure, depression, allergies, or anything an insurer chooses.

You may not even know that you have such a condition. I certainly had no idea. My senior year in college, I won a Fulbright fellowship to study *Le Morte d'Arthur* in England. Certification required a medical exam. To my surprise and dismay, the doctor refused to certify me: "I absolutely cannot let you go abroad: you have a heart murmur" (specifically, a "mitral valve prolapse").

In a highly competitive field, universities were chary of hiring someone who might have AIDS

So the death of Arthur became the death of a lifelong dream to study with the famous Malory scholar. Disappointed, I pursued less-specialized graduate study. Over my long academic career, I never again faced a physical exam for any job: Fortunate, because cost calculations can fuel age descrimination.

In 2014, long retired and on Medicare, the murmur became decidedly pronounced. Open heart surgery repaired the valve. Because I had Medicare and a private policy to pay gaps in Medicare coverage, I had no additional costs.

Another's Dreams Derailed

In the 80s, when I was Department Chair at a small college, the academic job market was glutted. Many very qualified people with advanced degrees cobbled together careers as itinerant professors, traveling among several colleges, teaching one or two courses at each, having no health benefits. They hoped for continued good health (and no car crashes).

One day, an extraordinary candidate applied for a sudden part-time opening. His dissertation had won a prize at an Ivy League university. He had published articles in several first-rate journals. He had a contract for a nearly finished book.

His dossier of recommendations praised his work to the skies, except for one troubling sentence. A recognized scholar (in a similar field) spoke highly of the candidate's work, then adding: "A Canadian citizen, Candidate X makes frequent trips home where he sees his doctor and is occasionally hospitalized."

How was this relevant to his scholarship or teaching? I felt a dilemma: Should I violate the confidentiality of the writer? Candidates were not supposed to see these letters. But this non-relevancy suggested the writer bore him some secret animus. In a highly competitive field, universities were chary of hiring someone who might have AIDS.

cost calculations can fuel age discrimination

I took the young scholar out to lunch and asked him about the professor in question. "Oh yes," he said, "we write about the same things." Without revealing anything of substance, I suggested he ask his University Placement Office to remove that letter. The next year, in an even tighter job market, my excellent hire received no fewer than 3 tenure-track offers from major universities. My hunch had been correct.

Young people today continue to make career decisions based on whether (and what quality of) healthcare comes with the employment package.

Else Fisher *is a (mainly) retired professor of Shakespeare.*

Under NYHA: **Healthcare costs won't discourage hiring.**

Cause of Death: For-Profit Insurance. Fortune 100 Fires Litigator

Curable Cancer Kills

I miss my brother. A brilliant trial lawyer, working in the General Counsel's office of a Fortune 100 company, Johnny was abruptly fired just before he turned sixty. I am, of course, biased about this tragic turn of events; Johnny had argued (and prevailed) multiple times before the Supreme Court (and many US Courts of Appeals) and the company's judicial fortunes suffered after he left, not to mention his boss getting fired.

NYC is too expensive to be jobless and still pay rent. Not wanting to die homeless in NYC

He took COBRA. It was jaw-droppingly expensive. He looked for a new job. Age discrimination is real. Prospective employers explained they couldn't pay him what he was worth and they knew he'd jump ship if they offered what they could afford. Never mind that NYC is too expensive to be jobless and still pay rent. Not wanting to die homeless in NYC, Johnny cut back on his expenses, began spending his savings, took Social Security early — and then, after getting a physical, dropped his health insurance.

After the colonoscopy, we argued again. The GI doctor wanted to schedule immediate surgery. "Surgery! Hell, no!" I met him a few days later in the lobby of NY Presbyterian, "5 am! Hell, no," kept him company for the hour of pre-surgery waiting, and hung out in the family lounge — wondering why a 45-minute procedure was taking 2+ hours.

"Cobra is eating my retirement money!"

Then his surgeon arrived, looking sad. He'd removed a "mass the size of a large lemon." Johnny had Stage IV colon cancer. Multiple doctors built a plan. Johnny was scared and said he would do "whatever it takes."

Six months later, after many rounds of chemo, which his oncologist kept saying he'd "failed," Johnny became depressed: it was his "fault" he wasn't better. Johnny, who'd aced every test he'd ever taken, finally came to live with me because he'd failed. I got his company and wit and insight, while he got food and caring. Johnny died a year after that physical. And, no, not because he'd "failed." He shouldn't have died.

I know he shouldn't have gone three years without seeing a doctor

He figured he'd be on Medicare within 3 years. He rationalized that he'd often gone years without a physical. "Nothing bad happened then; nothing bad will happen now. And COBRA is eating my retirement money!"

He began having digestion issues, but put off seeing a doctor because he couldn't afford anything expensive — and "Medicare will kick in soon, and cover whatever they find — and, more likely, whatever they don't find, doing loads of expensive tests."

"Medicare will kick in soon"

Then he turned 65 and got his Medicare card. His physician had retired, so finding a new one took time. He called after the appointment to complain that the new guy was insisting on a colonoscopy, "which sounds nasty." We argued. He made the appointment.

Had Johnny's cancer been diagnosed by a colonoscopy at Stage 0 or 1, he might well be alive today. Even diagnosed at Stage 2 or 3, he might well be alive: Stage 3A has a 5-year survival rate of about 90%.

I miss my brother Johnny. I know he shouldn't have gone three years without seeing a doctor. I also know he wouldn't have been able to afford all the treatment he got without health insurance.

No one should die because seeing a doctor could lead to bankruptcy. Medicare, even with its gaps and flaws, is a godsend for those over 65. We all need "Improved Medicare for All New Yorkers," NY Health, which will save us money, cover us all — and keep brothers like Johnny alive and thriving decades longer.

Johanna Bard *mourning the 45,000 Americans who, like Johnny, die prematurely because of rationed health care, advocates for New York Health and health justice.*

Under NYHA: **No one will die waiting for Medicare.**

The Hospital is "In Network." Surprise! The Doctor Is Not

Surprise! It's a hospital bill!

Eleven p.m. on a Saturday night. My wife and I were returning home from a rare evening out, made possible by our children being away at a summer camp near Sidney, NY. It had been a successful evening: we had discovered a Moroccan-Israeli café on the Upper West Side.

ER doctors are engaged by private contract, the hospital told me

As soon as we walked in the door, the telephone rang. It was the nurse from camp. Our son was OK, he hurried to assure us, but he had injured his finger and the nurse was asking for our permission to take him to the ER of the local hospital. Naturally we agreed. Sidney is 125 miles and a three-hour drive from the Bronx; it would hardly make sense to bring our son all the way home to see a doctor. The camp had our family health insurance information, and the hospital accepted our insurance.

Our son's finger was sprained but not broken; it was taped and he went back to camp. Matter closed. Or so it seemed, until we got a bill for $400 from the ER doctor. (This was in addition to the co-payment to the hospital.)

It seems the hospital accepted our insurance – but the doctor did not. This is something I could not have imagined until I experienced it. Isn't the doctor an inseparable part of the hospital? I asked both the hospital and the camp counselor who accompanied my son for details of what the doctor did to justify this bill. From what I was able to determine, the doctor spoke with my son briefly, sent him for an x-ray, looked at the x-ray results, and bandaged his finger. At most, the doctor may have spent 5 minutes on this case. Let's see: 5 minutes at $400 – that's a rate of $4,800 per hour. Not bad; even more than a lawyer, I think.

Everyone who comes into the hospital has to be seen by the doctor on duty

I asked the hospital why, if the hospital accepted my insurance, I received a bill from the doctor. ER doctors are engaged by private contract, the hospital told me, separate from the hospital's other caregivers. If the doctor is not part of the hospital, I asked, why couldn't my son be seen by a nurse? After all, there was nothing about his case an RN could not take care of.

The hospital's reply: Everyone who comes into the hospital has to be seen by the doctor on duty. In other words, the hospital was having it both ways. Through further research I discovered that two corporations own almost all the medical facilities in a vast area of central New York State.

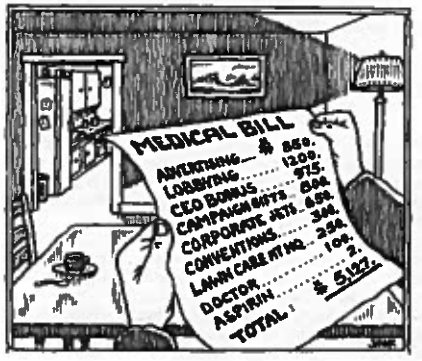
Since then the state passed a law requiring hospitals to inform patients of their billing practices, so patients would not get "surprise" bills.

But the state did not outlaw the practice of billing separately for the doctor. So I guess we can now start figuring out how we'll pay the bill for our illness before we are cured. I do not know if the law requires hospital employees to explain their billing system before they start treating someone who comes in with a heart attack. And if the patient is unconscious, do they have to explain it right away or do they wait until the patient has regained consciousness?

"Perverse" is not too strong a word to describe this healthcare "system"

And of course, when you have a serious emergency where every minute counts, you're not going to go to a hospital farther away because it's cheaper, are you? "Perverse" is not too strong a word to describe this healthcare "system."

Ron Wegsman *is a nonprofit executive and a longtime resident of Kingsbridge and Riverdale.*



Under NYHA: **No surprise bills, no costs at point of service.**

Delays Updating Insurance. Barely Escaped Bankruptcy

This is a story of how Margaret almost lost her life. Our lives together are so intertwined I cannot tell her story without telling mine. It begins, innocently enough, with two mistakes. First, only one of us got a flu shot: me. Margaret thought she didn't need it, because she travels to see family in a warmer climate. Second, we had trouble updating our health insurance because we wanted a joint policy and then thought we had missed the window for enrollment.

Our story began last February when my wife fell terribly ill. After I posted about it on Facebook, as a way of keeping myself sane and getting support from friends, a physician friend I hadn't seen since a HS reunion, 20 years earlier, recommended I get an oximeter to check Margaret's blood oxygen. He told me that if it fell below 90%, to get her to the emergency room by ambulance.

> Her blood oxygen was 85% ... 73% ... 39% ... her care likely cost over half a million dollars

It was 85%. I hustled her into the car to our local ER. She was having trouble walking even a few steps. By the time the ER triaged her, her oxygen was 73% — and they hustled to administer oxygen in various and successively more intrusive ways. At 3am, she was still conscious and told me to go home, that the oxygen mask was working. At 7am, when I returned, the ER coordination physician told me she needed to be put on an ECMO machine — which removes the blood from an artery in the neck, oxygenates it, and returns it directly to the heart. The ECMO is the Hail Mary last resort for breathing issues this serious.

Imagine how I felt, hearing that this machine was her only chance, that my hospital didn't have one (only a few hospitals do), and that she was far too sick to travel. Her blood oxygen was 39%. Our coordinating physician arranged for Montefiore Hospital to send a team of 8 (surgeon, nurses, technicians), who arrived within the hour and performed the surgery with the machine they brought. The surgery took about 90 minutes. As the ECMO began to work, she was up to 45%, and that was the beginning of her long journey back.

Margaret went through so much oxygen deprivation harmed her heart, brain, kidneys and other organs. She was in the ICU for a week —being watched by two nurses 24/7 — and in a coma for a month.

Although ever so much better now, she has not fully recovered and tires easily. Margaret lost her job, and this new pre-existing condition makes finding a new job challenging. Companies are reluctant to hire anyone likely to increase their insurance costs. But, thanks to that magical machine and truly dedicated doctors and nurses from two hospitals, my wife lives.

> Margaret lost her job, and this new pre-existing condition makes finding a new job challenging

Now for the insurance part, equally scary and with an equally happy ending. A doctor told me her care likely cost over half a million dollars. Feeling ill myself, I had tried to apply online for our joint insurance policy, and had gotten stuck with the forms since two policies had to become one. Then, during the height of her illness, I forgot to follow through. It took many calls to the NYC Health Department before I reached an agent, who found our initial application and allowed us, first, to activate the joint policy and, second, date it back to my initial application. The kind agent told me we had 7 days to make the late payment for February before our coverage would be cancelled.

> We might have lost everything — but for the grace of one very kind and patient NYS HD agent

I made the payment — a large sum for us — and we were saved. When I think of what might have been. A half-million-dollar debt would have ruined us. We might have lost everything — but for the grace of one very kind and patient NYS HD agent who took the time to find our file, understood our situation, and made all the coverage happen. I feel very lucky indeed.

I am the executive director for an agency that helps homeless people, providing shelter and advocating for affordable housing for all New Yorkers. Ironically, the poor and homeless in New York receive quite adequate care from Medicaid, but calamity almost took my wife and my future — a sudden, unexpected healthcare calamity, from which my beloved and I barely escaped. NY Health would have prevented many of the anxiety-causing after-effects of my wife's illness.

George Gross *is executive director of an interfaith agency that advocates for the homeless in NYC.*

Under NYHA: *Automatic enrollment in the best plan, always there.*

Terrifying Nightmares: "My Wife Will Be Homeless!"

No! No!" my husband's nightmares — vivid chimeras about his medical bills leaving me bankrupt, without a house, food, or safety — spiked his heart rate and blood pressure, triggered alerts, caused medical staff to race to his bedside. They would find me trying to wake him to reality, as he gripped my hands gasping, "Are you sure all this is covered? I can't have this treatment if you won't be safe."

When fully awake, Michael knew he was lucky, with "Cadillac" insurance. Despite this, we regularly got billed for thousands of dollars. Over five years, I often made calls disputing bills; he was too sick to call.

> My husband worried about needing to borrow money, about dying before disputes were resolved

Sometimes I heard missing "prior authorizations," or his card number had been rejected, or insurance had paid X dollars and he still owed 3X. Then I would call "benefits" and be put on hold, listen to music, get transferred around, constantly asked for the same numbers and dates. Michael would listen from his bed, whispering worried questions. Per his instructions, I kept a notebook of every phone number and person I talked to, and everything they said.

When I'd finally get through to a benefits person who could handle his policy, I'd hear it was covered but the doctor, the hospital, the lab had filed the wrong paperwork.Too many times to count, we received letters from collection agencies, threatening lawsuits, describing punitive finance charges, writing really scary things. I responded to these in writing: "The bill is in dispute. Return it to the provider immediately."

> I always felt terrible when doctors (and nurses) spent time defending medical decisions when they needed (and wanted) to spend time with patients

My husband, a lawyer, would dictate and sign these letters, so he knew how many disputes were in play — and their repercussions. After sending the letter, I would phone whoever sent the bill to collection, and was usually told it had been sent "in error."

My husband worried about needing to borrow money, about dying before disputes were resolved. When home, he was eligible for visiting home healthcare: each new person required a new "intake form," sometimes lasting 2 hours or more. Some of them, heartlessly, required him to answer every question, because "he's the patient, not you."

> His insurers had no qualms about over-ruling his doctors' diagnoses and prescriptions

Never mind that he was drugged, exhausted, too sick to remember every medication or the name and phone number of every doctor. Worse, after every hospitalization, this intake form had to be done anew — there was no way to carry any information over because "things have changed." No they hadn't. The major change was always the date.

Ultimately, Michael's care was "free" — and we were so glad to get good care and to have it covered — but it was not without cost: so many letters, notebooks, and hours, so much effort and stress he could have spent healing. His insurers had no qualms about over-ruling his doctors' diagnoses and prescriptions. His doctors, nurses, and hospital insurance administrators all spent hours on the phone and computers trying to get approvals and permissions, checking billing codes and FDA sites, persuading bureaucrats.

I always felt terrible when doctors (and nurses) spent time defending medical decisions when they needed (and wanted) to spend time with patients. The hassles caused by his Cadillac insurance made life almost as gruesome as his illness. But I know he got superb care despite for-profit insurance, NOT because of it.

All of us need a simpler, more user-friendly, less costly payment system. It's one reason why single-payer NY Health will be better. Doctors will diagnose and prescribe according to evidence-based protocols defined by doctors — and get paid, promptly. All the time now spent arguing? Newly available for patient care. And my darling husband — and your loved ones — won't worry about bankrupting their families, or leaving them homeless because of unpaid medical bills. They can concentrate on getting well.

Judith Lieben *lost her husband after 580 days of hospitalization. In his honor, she advocates for NY Health — to eliminate financial obstacles to healthcare for all New Yorkers.*

Under NYHA: *Loved ones can focus on healing, not fearing homelessness.*

Got Sick. Lost Job. Lost Insurance. Haggled for His Life

I almost died eleven years ago. Initially, I had a job with insurance, but illness cost me my job. Losing my job cost me my insurance. Not being able to afford healthcare almost killed me. My story is a vicious, like-threatening cycle. I've learned that hundreds of thousands of Americans have similar stories.

now my job didn't include health insurance. Not all jobs do, even some that recruit you with promises of health insurance

A few years earlier, I had my first episode of biliary duct obstruction and didn't get so sick. My insurance company paid $1,500 for a cholecystectomy and, after weeks of recovery, I was almost back to normal, living my life and doing my job, but now my job didn't include health insurance. Not all jobs do, even some that recruit you with promises of health insurance.

So there I was eleven years ago, working every day. Then I got really sick — intense bloating, jaundice, a fanatical itching that kept me from sleeping for four months. It was constant every hour of every day. Non-stop. I was in such misery. I lost weight. I was hollowed out.

One friend said I looked like a "dead man walking." The hospital told me $20,000 for the same treatment they'd charged the insurer $1,500 for a few years earlier. I was dumbfounded. Why was the cost so high for me when I no longer had health insurance? $1,500 would have been difficult, but $20,000 was unimaginable. I wondered, should I just give up and die?

$20,000 was unimaginable... Should I just give up and die?

I told the hospital administrator that the grave was beckoning since I didn't have $20,000. Suddenly, the price became $13,800. This was still an unimaginable sum, but I found it inconceivable to be bargaining for my life. Was I in a parallel universe?

I dissociated: from the inside I was terrified and miserable; from the outside I couldn't fathom the absurdity. Can you imagine bargaining for your life the way you haggle for a used car?

I was in constant itching agony and couldn't fathom how $1.5K could become $20K could become $13.8K. As I turned yellower and yellower over the weeks, the price finally dropped to $8,000 — I'd negotiated the price of my own life down 65%. Is this free-market healthcare? Is this being a savvy healthcare consumer?

I wasn't trying to be a good capitalist, much less a knowledgeable consumer. I simply wanted to save my life, but I felt demeaned. This is why I support NY Health — Improved Medicare for All New Yorkers.

Only in the U.S. do healthcare costs lead to financial ruin, bankruptcy, or death. Every other developed country has universal healthcare; everyone is covered; lack of wealth doesn't prevent care. About 45,000 Americans die each year because cost prevents life-saving medical care.

I wasn't trying to be a good capitalist ... I simply wanted to save my life

Even with insurance, high-dollar deductibles keep people from early, easily treatable diagnoses. When others, also insured, get seriously ill, pre-authorization delays and benefit denials force them to face ruinous out-of-pocket costs. Many, like me without much in savings, not wanting to impoverish our families, forego treatment — and die.

NY Health will remove financial obstacles to care. If you lose your job because of illness, you'll still be able to see a doctor and get treatment.

Many ... not wanting to impoverish our families, forego treatment — and die

You won't ever hear that you need to find $20,000 — or $13,800, or $8,000 or even $1,500 — for a routine procedure that prevents death. When you have a job, you'll pay a progressive tax. If you lose that job, you won't lose healthcare. Your children won't lose their healthcare; they'll be covered because they're children. Families will worry about loved ones getting better, not about going broke.

Walter Carpenter *works in the tourist industry and now advocates every day for single-payer NYHA.*

Under NYHA: ***You'll never haggle for your life, like you haggle for a car.***

Sudden Chronic Illness. Formulary Hell. Will I Survive?

This story may not have a happy ending because my insurance company is denying prior authorization for a medication my doctor wants me to have. My doctor is arguing assiduously on my behalf — but without success. But let me begin at the beginning.

I am very active. I run, walk, bike, do Yoga, eat healthily and, until Passover of 2010, considered myself entirely healthy. As my friends and colleagues can testify, nothing stops me. But during the holiday, I suddenly became ill. I had uncontrolled rectal bleeding, diarrhea, bad cramping and sore muscles, not to mention serious headache and chills. I remember suffering through the first part of the eight-day event with an uncontrollable bladder, embarrassment and pain. At the time, my family had been attending Chabad of Riverdale.

The Rabbi's father-in-law was a very kind and seasoned physician. He diagnosed me after services one day and was concerned. He said I needed to get tested. His review of my symptoms and diet suggested some kind of lower intestinal malady. I had never been really sick before and so this all came as a shock.

The appointments took forever, the costs sky-rocketed, and the meds were ineffective

After the holiday I began searching for a GI. I received many referrals. A large local practice diagnosed me with ulcerative colitis (UC), an inflammatory bowel disease that mainly affects the lining of the large intestine (colon). This autoimmune disease has a relapsing-remitting course, which means that periods of flare-ups are followed by periods of remission.

Nearly one million people suffer from this disease. At the moment, there's no medical cure for UC. Radical surgery causes other problems. From day one, the illness was difficult for me. The appointments took forever, the costs sky-rocketed, and the meds were ineffective. The doctors never really listened to my complaints or had enough time really to help me get to where I could be.

After two years, six flares, and three colonoscopies, I was totally miserable. My entire body became inflamed: ankle swells, back pain and chest muscle flares and pain. I endured weight swings, losing 15 pounds, then bloating and big weight gains. Most important, my GHI insurance does not cover the best medicines, which are very expensive.

On my salary and with family obligations, I cannot afford medications that might help me more than the ones I am on. Like so many others with long-lasting conditions, I am stricken both by the illness and by its increasing financial burden: a vicious circle because anxiety increases the symptoms.

Our health system makes chronic health disorders difficult to treat — because insurance doesn't cover the optimal treatment

I am also unhappy at the impact the UC has on my independence and mobility. During flares, I have to know the location of every restroom in the City. I am terrified if I get a cramp and must use facilities in neighborhoods with no public toilet. As a community social worker who travels a great deal, I experience the toll of a disease which affects my energy level.

Our health system makes chronic health disorders difficult to treat — because insurance doesn't cover the optimal treatment. Those with chronic diseases and without infinite financial resources must continue to suffer unexpected flare-ups. One watches advertisements for miracle cures, like the one for Hepatitis C, where the course of treatment is $94,000, and one wonders, even if there is a cure for UC, will I be able to afford it?

"Little more than 1 percent of GDP assigned to health could cover it all." -Uwe Reinhardt

We need big pharma to work for us, to stop spending one third of its budget on advertising, and to be able to negotiate fair and equitable prices so that all Americans can have the right to good health. We need a health system that will keep us healthy at a price we can all afford.

As healthcare economist Uwe Reinhardt argued: "The issue of universal coverage is not a matter of economics. Little more than 1 percent of GDP assigned to health could cover it all. It is a matter of soul."

David Knapp *directs a program (under the auspices of the NYC Department of Aging) to assist older adults to live independently.*

Under NYHA: ***Drug prices will no longer extract extortionate profits.***

Employer-Based Insurance Threatens My Son's Life

My nine-year-old son desperately needs NYS to pass the New York Health Act.

Seven years ago, my perfectly healthy and typically developing almost-three-year-old son woke up having a seizure. He was admitted to our neighborhood hospital where over the next week and a half we watched him lose his ability to walk, talk, swallow, focus his eyes, and reliably breathe. He was eventually diagnosed with anti-NMDA receptor encephalitis.

When my husband was changing jobs, moving our son to the new policy would have threatened his life

About two months into his hospitalization, the hospital billing office began asking why I was choosing out-of-network providers: our insurance had contracts with the hospital, not the doctors. But I never had any choice of any in-patient provider: my son was seen by whoever happened to be on service.

Bills had been sent to collections for non-payment that I didn't even know about. For months, I had held bedside vigil for my son as he teetered between life and death. I was told he was eligible for institutional Medicaid, but enrolling him required my going to the midtown offices. I refused to leave my son's bedside while he was in such a critical state. That initial hospitalization lasted 15 continuous months, between three different hospitals each with different insurance contracts, causing more billing and payment complications. Eventually, we began giving hospital-level care at home.

each change creates potential for — and has caused — mistakes and disruptions, putting him through unnecessary suffering

The fight to get everything we need to keep our son alive, and to avoid bankruptcy, is daily and draining. We can only use the preferred providers who have contracts with our insurance company, an ever-evolving list that changes with contract negotiations.

Each time our insurer discontinues contracts with providers, we scramble to find new ones and to restart complicated processes of doctors' orders, prior authorizations, and insurance approvals. When my husband was changing jobs, moving our son to the new policy would have threatened his life.

We ended up using COBRA benefit to keep our son on the policy we had when he first got sick, and his eligibility for that expires in the coming year. We still do not know how to ensure our son's safety, indeed his viability, during the transition to a new employment-based primary policy.

While still 100% dependent for all activities of daily life, in the seven years since the onset of his illness, my son has relearned to walk with assistance, he has developed a communication system using vocalizations, eye gaze, and his right hand, and, to my joy, he can now eat by mouth. He goes to an amazing NYC public neighborhood school and thrives in an inclusion class. He is determined and funny, courageous and frustrated, and outsmarts everyone who underestimates him or his intelligence based on his medical condition and resulting limited motor control.

My son has an upcoming surgery. The day before Thanksgiving, I was informed he might not have the same surgical team that has performed three prior surgeries on him at the hospital that has managed his complex case for the last seven years, due to contract negotiations between the hospital and the insurance company. I was terrified my son's care would suffer because of this.

It is grueling. It is senseless. It is designed to enhance the profits of insurance companies

The contract negotiations ultimately ended in an agreement and this specific crisis was averted, but what I am describing here is maddening. It is grueling. It is senseless. It is designed to enhance the profits of insurance companies and other money-motivated medical cost-inflators. There is absolutely no sense in my son's changing doctors, nurses, suppliers, and hospitals due to contract negotiations between profit-motivated entities, or changes in insurance policies once his COBRA eligibility expires. Each change creates potential for — and has actually caused — mistakes and disruptions to his care, putting him through unnecessary suffering and ultimately making his care more expensive to the system as a whole.

Like many diseases, our son's unpredictable illness could happen to anyone, at any time.

Sandra Joy Stein *is a writer and educational consultant.*

Under NYHA: ***"Continuity of Care" will be the norm, not the dream.***

NY's Most At-Risk Population: Underserved

Part I: Workplace Accidents

A perfect storm led to a workplace injury that should never have happened. I was an administrative clerk for a kitchen serving 1500 meals a day. October 15, 1990: the baker and the meat inventory clerk called in sick.

Assigned the baker duties, I mixed bread pudding for the day's dessert. To put it in the oven, I squeezed between the oven and a tall double-stack of boxes, left there by John, the grudging meat clerk replacement. I twisted to open the oven and slide in the trays; then squeezed back between the oven and the boxes of meat.

At 1.30 pm, the fresh meat had been sitting beside the hot oven for three hours. Envision: boxes of meat that hadn't been interlocked to stabilize their weight, boxes haphazardly side-by-side in two six-foot stacks.

my sciatic notch broke. I awoke unattended on our health clinic floor — no ambulance

When I went to open the oven, pull out the trays, twist around, and head to the cooling tables, the meat boxes toppled, bombarding my lower back and legs.

I must have screamed bloody murder, as I was knocked to the floor by 600 pounds of meat in 50- to-100-pound boxes. I remember searing pain, not noticing breaks to my foot, leg, and ankle, because the traumatic hit to my lower back obliterated all rational thought. I lost consciousness from pain as my sciatic notch broke.

I awoke unattended on our health clinic floor — no ambulance was called, no one stayed with me. You see, this particular workplace differs from the commercial kitchen you've likely imagined. No one said "No" to my Boss: she could put you in solitary confinement for disobedience.

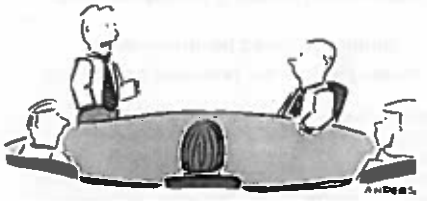
Part 2: Healthcare: We All Need It

The kitchen is in Bedford Hills Correctional Facility, part of the NYS penal system. I had a life sentence (possible parole after 25 years), for fighting back in self-protection within a domestic violence (DV) relationship. I suffered beatings for more years than is easily imaginable. I now know that 90% of Bedford's female inmates have been physically or sexually abused prior to incarceration; that prison reform advocates report women who kill their abusers have 25% higher conviction rates — and they get far harsher sentences — than men who kill their female partners or men who kill in self-defense. In the U.S., white females who kill a white person can expect a sentence of 10-30 years (with earlier parole)—white female DV victims who kill in self-defense are predictably sentenced, like me, for life.

Today, a NY court that follows current sentencing guidelines (not all do) could charge me with second-degree self-defense manslaughter and perhaps sentence me to 1-5 years, given the facts in my case. If that had happened, I would never have experienced those badly stacked boxes of beef, and all the misery that followed.

Another difference: healthcare in prison is not like healthcare on the outside. What was called our prison "hospital" was only a simple clinic with nurses and minimal supplies. Calling ambulances didn't happen because it meant an unnecessary expense, a slew of additional reports, and possibly an investigation into mishandling inmates. I was left on the clinic floor for the next shift to deal with because the prison didn't want to incur overtime charges, and the guards didn't want to waste family time by writing overtime reports.

Continued on page 9



"To cut costs, we're doing away with health insurance in favor of an apple a day."

Under NYHA: ***Ambulance costs won't leave a broken back on a clinic floor.***

Continued from page 8

The next shift hoisted me into a prison van and seated me, shackled, upright on my sciatic break without a seat belt. The 15-minutes of bouncing and sliding on my spinal injuries, en route to a public hospital, meant wracking nerve pain that was beyond excruciating. For years, care was hit or miss. After returning from one of seven surgeries following this accident, my bloodied hospital bandages needed changing. The prison hospital staff ignored them. My friend conspired to give us a moment alone — telling the guards I was returning to the cell block and telling the nurses that the guards had called to say the cell block was prepared for me.

> Calling ambulances didn't happen because it meant a slew of additional reports, and possibly an investigation

As she pushed my wheelchair out of the prison clinic, she grabbed whatever bandages, gauze, and cleansing solution we could reach, stuffed them in my lap, and covered me with a blanket. Another time, we ran out of bandages and opened sanitary napkins to serve as replacements. One learns to survive to heal.

Part III: My Past Frees (and Focuses) My Present

I was released and paroled a year ago, having worked hard for others during my years inside: serving as the Episcopal Rector's assistant; teaching ESL classes, beginner math, and English to inmates in the prison school; serving as a prison paralegal.

I was lucky, and those efforts helped me land a job on the outside, working with a criminal defense attorney. I am grateful to have Medicaid, and to have freedom. I fear nothing. Hearing a judge rip me from my life with a sentence of 25-to-life, meaning no chance of parole for 25 years, forced me into facing every day without fear. What more could I lose, ever?

> Medicaid gives us a chance to begin again as equals

I support NY Health. Personally it will give me dental care not covered by Medicaid. Mainly because Medicaid gives us all a chance to begin again as equals, even those of us who served more than their time.

***Karen Thomas** was a schoolteacher, owned a delicatessen, and was imprisoned for DV homicide in 1982 at age 34.5. She was released after 34.5 years.*

Small Business Owner: Needs NYHA to Attract Top Talent

Healthcare costs affect me every day: first, as the owner of a small business in NYC, and, second, as one of the thousands who deferred healthcare treatment for fear of bankruptcy.

In my small business, I see how employer-based health insurance creates job-lock for first-class candidates. Those with the best qualifications are often stuck in dead-end jobs: they cannot afford to lose their expensive benefits package by jumping ship to me.

> employer-based health insurance creates job-lock for first-class candidates

I am always juggling the costs of growing my business with the costs of providing competitive insurance. Recently, I found a superb candidate from Austria who does not require insurance — so I am relieved of high-cost deductibles and other administrative payroll expenses.

> "Medical costs are the tapeworm of American economic competitiveness." -Warren Buffet

Cash was really scarce when I started my company, so I did not have insurance for two years. Fortunately, I faced no life-threatening conditions. But emergency treatment and 12 stitches for a cut to my forehead caused me to choose between the high costs of seeing a plastic surgeon — and possible bankruptcy — or living with a permanent scar. That's a pretty dire consequence for 12-stitches.

Whenever I look in the mirror or a customer looks at me, I remember the dread of not having healthcare. I agree with Warren Buffet who said, "Medical costs are the tapeworm of American economic competitiveness."

***John Rodney**, is a successful entrepreneur, growing his second start-up.*

Under NYHA: ***Top talent won't be job-locked — you can recruit them.***

Dual-Income. Lost Jobs, Lost Everything

I am living proof that even the hardest-working, most educated people can lose it all in a matter of months. I went from earning $225K a year to less than $21,000 now. After losing my 60-hour-a-week, high-pressure corporate communications job in NYC and having COBRA expire, I signed up on the Affordable Care Exchange, paying for my disabled husband's and my coverage with savings.

Sadly, neither the psychiatrist nor the psychologist I saw regularly for chronic depression was covered under any of the Exchange plans, so we paid out of pocket. In my early 50s, I was having little success finding another job, which exacerbated my depression. Then my husband was diagnosed with PTSD after being violently assaulted, so he too began seeing a psychologist on a weekly basis.

In 2016, our healthcare bills exceeded $40,000, quickly draining our savings so that we had to sell our NYC home and relocate to a cheaper location in the Hudson Valley. It is terrifying to know that losing your job and needing critical health services can rapidly deplete all the financial resources you've worked years to accrue. Having health insurance tied to employment makes losing a job not only scary, but potentially life-threatening.

> In 2016, our healthcare bills exceeded $40,000, quickly draining our savings

As our current income is so low (I've still yet to find a new full-time position, so am now working as a freelance content developer and ghostwriter), we recently qualified for Medicaid. It has been a true lifesaver given my husband's illness and my own chronic condition. We are most grateful to have Medicaid coverage through the expanded program under Obamacare, but there are gaps that mean we don't get the essential care we need.

First, Medicaid doesn't provide chiropractic coverage. I was born with a reverse curvature of the neck, a condition made more painful by spending hours on a computer every day writing. My husband sustained a serious spinal injury 15 years ago which left him partially disabled, in pain, and unable to work.

Because my salary was once so high and I had health coverage through work, he never qualified for disability coverage. Now we can't afford to pay for chiropractic care on our own — so we just deal with being in pain all the time. To add insult to injury, provider networks keep changing, so we find ourselves forced to change doctors all too often — even if the ones we originally had were most qualified to treat us. It's also problematic that coverage for mental health professionals often doesn't extend beyond just community or hospital clinics, so the best therapists for a particular diagnosis are often out of reach.

> Having health insurance tied to employment makes losing a job ... potentially life-threatening

And then there are the many gaps in women's health issues: I suffer from a rare gynecological condition that required my consulting with a specialist who wasn't covered by my insurance.

When I had a job, I never worried about my healthcare or my husband's. Now I worry constantly about our worsening health and our worsening finances. NY Health would make such a difference to our lives.

***Sonya Haifa** spent 25+ years as a PR and Corporate Communications professional. Her fiction and creative nonfiction have appeared in more than 30 literary*

Under NYHA: ***Hard-working NYers who get sick won't face penury.***

NEW YORK HEALTH ACT

Savings and Spending Under the New York Health Act FAQ

Introduction: The New York Health Act (NYHA) will generate enormous savings by replacing the marketing, bureaucracy, and profits of insurance companies with a single publicly-accountable plan, as well as by negotiating fair prices with drug companies. Data from the RAND study shows that NYHA, while covering everyone, including long-term care, and eliminating all deductibles and copays, will save more than $11 billion in 2022 and even more in future years. By distributing the tax burden fairly based on ability to pay and having capital gains and other taxable investment income contribute to its cost, 90% of New Yorkers will see substantial savings in their spending for health care.

How Much Will the Average Person Save and Pay under the NY Health Act?

New Yorkers will save billions of dollars by not paying rising premiums, deductibles, co-pays, out-of-network charges, and long-term care costs (home care, nursing home care). We'll save tens of billions by cutting out insurance company bureaucracy and profit, lowering doctor and hospital administrative costs, and negotiating lower drug prices.

The lower cost of the single payer system will be funded by existing Medicare and Medicaid and other public funds, along with a progressively graduated tax on payroll and taxable non-payroll (investment) income. The employer will pay at least 80% of the payroll tax; the employee no more than 20%. A self-employed person would pay the full payroll tax. All New Yorkers, including children, will be covered, whether they are working or not.

The NYHA provides that the first $25,000 of a person's annual income will not be taxed. The bill does not specify other income brackets and rates, which would be set shortly before the plan is ready to be implemented.

We can, with reasonably high accuracy, estimate what the average working New Yorker will spend under the New York Health Act single payer legislation. Over 80% of New Yorkers earn less than $100,000 per year. For that significant majority of New Yorkers, here is what they will pay in New York Health taxes, based on the results of the RAND report and a Summary and Evaluation of that report (see below):

Annual Income	Employee		Employer		Self-employed	
	Tax	Effective rate	Tax	Effective rate	Tax	Effective rate
$25,000	$0	0%	$0	0%	$0	0%
$50,000	$900	1.8%	$3,600	7.2%	$4,500	9%
$75,000	$1,800	2.4%	$7,200	9.6%	$9,000	12%
$100,000	$2,700	2.7%	$10,800	10.8%	$13,500	13.5%

For any income below $100,000, the maximum tax can be calculated as follows:

1. Subtract $25,000 from the income.
2. For employees/employers/self-employed, multiply the result by 0.036/0.144/0.18.

Higher-income persons will pay proportionately more, as tax rates rise in accord with a progressively-graduated tax schedule. These taxes will raise the funds described below.

Note: The New York Health tax is a tax on individuals, not households or families. As an example, the median household income in New York State is $65,000; if that income is earned by two employed people making $32,500 each, their total New York Health tax will be less than $540.

Compare all these numbers with what people spend today: The average family health insurance coverage in New York State costs $21,000, and the average deductible is $3,200.

What Will Overall Savings and Spending be under the New York Health Act?

Getting rid of insurance company bureaucracy and profits will save New Yorkers over $20 billion. We will save over $16 billion we now pay to doctors, hospitals and other providers for the administrative costs of fighting with insurance companies. Under NY Health, we could cut drug prices over $18 billion with the bargaining power of 20 million consumers. That's over $55 billion a year. The New York Health Act would use the savings to pay for health care and put money back into New Yorkers' pockets.

NY Health would pay health care providers more than Medicare and Medicaid now pay, because the rates would be required to be related to the cost of delivering the service and sufficient to assure an adequate supply of the service, and unpaid care would now be paid.

For patients, NY Health would also cover what we now spend on deductibles, co-pays, out-of-network charges, and out-of-pocket spending for long-term care.

Table 1. Savings & Additional spending – in $ billions

Savings	
Reduced insurance company bureaucracy and profit	20.4
Reduced health care provider administrative costs	16.3
Reduced prices for prescription drugs	18.6
TOTAL SAVINGS	**55.3**
Additional spending	
Covering the uninsured & eliminating deductibles, copays, out-of-network charges	17.1
Improved provider payments	8.8
Long-term care – shifting unpaid care to paid	18.0
TOTAL ADDED SPENDING	**43.9**
NET SAVINGS	**11.4**

See also Figure 1. See the RAND study and a Summary and Evaluation of the RAND Report for further details on this table and what follows. [1]

[1] www.rand.org/content/dam/rand/pubs/research_reports/RR2400/RR2424/RAND_RR2424.pdf; www.infoshare.org/main/Summary_and_Evaluation_of_the_RAND_report_-_LRodberg.pdf

What does Long-term Care (Long-term Services and Supports) Add to the Cost of the New York Health Act?

Today in New York, spending on LTSS is $22 billion by government (primarily Medicaid) and $11 billion private spending (insurance plus out-of-pocket) -- totaling $33 billion. The RAND study estimates that people in New York provide about $31 billion in unpaid home care (generally provided by a family member, usually a woman), and assumes that a portion of current unpaid home care will be replaced by paid home care under NYH, costing $18 billion. Therefore, the new public spending on LTSS under NYH would be $11 billion plus $18 billion, totaling $29 billion.

Table 2. Long-term care – in $ billions

Current government spending for LTSS	22.0
Spending shifted to NY Health:	
Current insurance spending for LTSS	4.0
Current out-of-pocket spending for LTSS	7.0
Unpaid home care shifted to paid care	18.0
TOTAL NY HEALTH SPENDING FOR LTSS	**$29.0**

How Much Revenue Must be Raised by the NY Health tax?

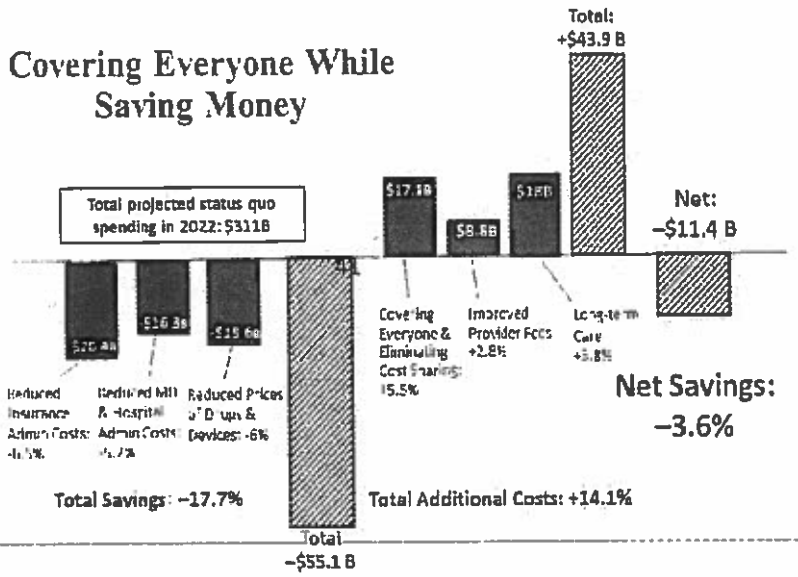
New York Health will replace current spending by New Yorkers: $131 billion we now spend on premiums (employer and employee share, individual coverage, Medicare Part B premiums, etc.), $29 billion in out-of-pocket costs (deductibles, co-pays, out-of-network charges, paying for long-term care, etc.). It would cover the $8.9 billion cost of the local share of Medicaid. This current spending totals $169.3 billion. Table 1 shows that NY Health saves $11.4 billion in current spending. Taking account of these savings, the NY Health tax will need to raise $157.9 billion. See also Figure 2.

Table 3. Revenue needed from NY Health Tax

Current spending replaced by NY Health	
Insurance premiums (employment-based, individual, Medicare Part B, etc.)	$131.5
Out-of-pocket spending	28.9
Medicaid local share	8.9
TOTAL	**169.3**
Net savings from Table 1	**-11.4**
Revenue to be raised by NY Health tax	**157.9**

Figure 1

Sources of Savings, Added Costs, and Net Savings



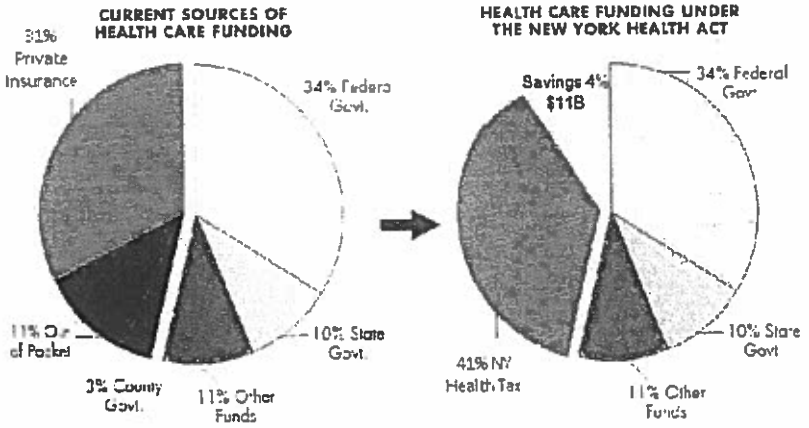
Sources: Jodi Liu, et al., *An Assessment of the NY Health Act*, RAND Corporation, August 2018
Leonard Rodberg, *Summary and Evaluation of the RAND Corporation's Assessment of the NY Health Act*, September 2018.

Figure 2

Current Sources of Funding vs. Funding under the New York Health Act

The NY Health tax replaces
private insurance, out-of-pocket costs, & county Medicaid costs

Saving billions
through administrative simplification and reduced prices of drugs and medical devices



Sources: Jodi Liu, et al, *An Assessment of the NY Health Act* (RAND Corporation, August 2018);
Leonard Rodberg, *Summary and Evaluation of the RAND Corporation's Assessment* (September 2018).

How the New York Health Act Works in Tables and Figures

1. Where New Yorkers Currently Get Their Coverage Today

Source of coverage	Population (millions)[1]
Employment-based private insurance	9.4
Individual (non-group) insurance	1.8
Medicaid, Essential Plan & CHIP	4.3
Medicare & VA	2.4
Dual Medicaid and Medicare	1.0
Uninsured	1.2
Total	20.1

[1]Data from Jodi Liu et al, *et al*, *An Assessment of the NY Health Act* (RAND Corporation, August 2018), 2022 projection.

2. How the Cost of Private-sector Employer-based Health Insurance in New York has Grown

	2008	2017	Percent Increase
Average premium			
Single coverage	$4,638	$7,309	57.6%
Family coverage	$12,824	$21,317	66.2%
Average employee share of premium			
Single coverage	$947	$1,568	65.6%
Family coverage	$3,376	$5,878	74.1%
Deductible			
Percent of employees with deductibles	46.6%	75.2%	61.4%
Average single deductible	$732	$1,687	130.5%
Average family deductible	$1,524	$3,226	111.7%

Note: General inflation between 2008 and 2017 was 15%.

Source: Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, DHHS, Washington, DC, 2018
https://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2

3. Savings under the New York Health Act:
Comparison with Status Quo Spending on Health Care Services

Expenditures ($2022 Billions)

	Status Quo	NYHA	Change	Percent Change
Health care services				
Medical care	163.3	182.5[1]	19.2	11.8%
Prescription drugs & devices	48.1	36.2	-11.9	-24.7%
Nondurable medical products[2]	6.0	6.0	0.0	0.0%
Long-term care (paid)	38.0	56.0[3]	18.0	47.4%
Long-term care (unpaid)	*[31.0]*	*[13.0]*	*[-18.0]*	*[-58.0%]*
Total health care services	**255.4**	**280.7**	**25.3**	**9.9%**
Administration				
Health plan administration	28.5	8.3	-20.2	-70.9%
Provider administration	26.4	10.1	-16.3	-61.7%
State financial administration	0.6	0.6	0.0	0.0%
Employer health benefit admin	0.2	0.0	-0.2	-100.0%
Total administration	**55.7**	**19.0**	**-36.7**	**-65.9%**
Total health care spending	**311.2**	**299.7**	**-11.4**	**-3.7%**

[1] Includes increased utilization (per RAND report) and improved provider fees

[2] NYHA could negotiate lower prices (not included in RAND report)

[3] Includes universal long-term care

4. How Health Care Is Paid for Today, and How It Would Be Paid for under the New York Health Act
Expenditures ($2022 Billions)

Source of Health Care Spending	Status Quo	NYHA	Change
Federal govt (Medicare, Medicaid, ACA, etc.)	120.5	120.5	0
State & local govt (Medicaid, etc.)	34.1	25.2[1]	-8.9
Employer-based private insurance	84.8		-84.8
Individual (non-group private insurance)	10.4		-10.4
Other miscellaneous premiums[2]	27.8		-27.8
Medicare Part B premiums[3]	8.5		-8.5
NYHA payroll tax[4]		102.0	102.0
NYHA non-payroll tax[4]		55.9	55.9
Out-of-pocket payments	33.5	4.6	-28.9
Total health care spending	**319.6**	**308.2**	**-11.4**

[1]Local share of Medicaid removed and paid for by NYHA tax

[2]Includes Medigap, Essential Plan, CHIP premiums

[3]Paid to the Federal government and thus not reflected in Table 2 health care service spending

[4]NY Health tax replaces private insurance premiums, out-of-pocket costs, and other premiums. It pays for improved provider fees, Medicaid local share, Medicare Part B premiums, and universal long-term care.

5. Savings and Additional Spending under the New York Health Act

Savings	$2022B
Reduced health plan admin costs & profit	20.4
Reduced provider admin costs	16.3
Reduce prices of drugs & devices	18.6
Total savings[1]	**55.3**
Additional spending	
Covering the uninsured & elimination of cost-sharing	17.1
Improved provider fees	8.8
Long-term care	18.0
Total additional spending	**43.9**
Net savings	**11.4**

[1] NYHA could achieve additional savings through reduction in fraud and waste. RAND did not provide an estimate of potential savings; Friedman estimated at least $5B in savings.

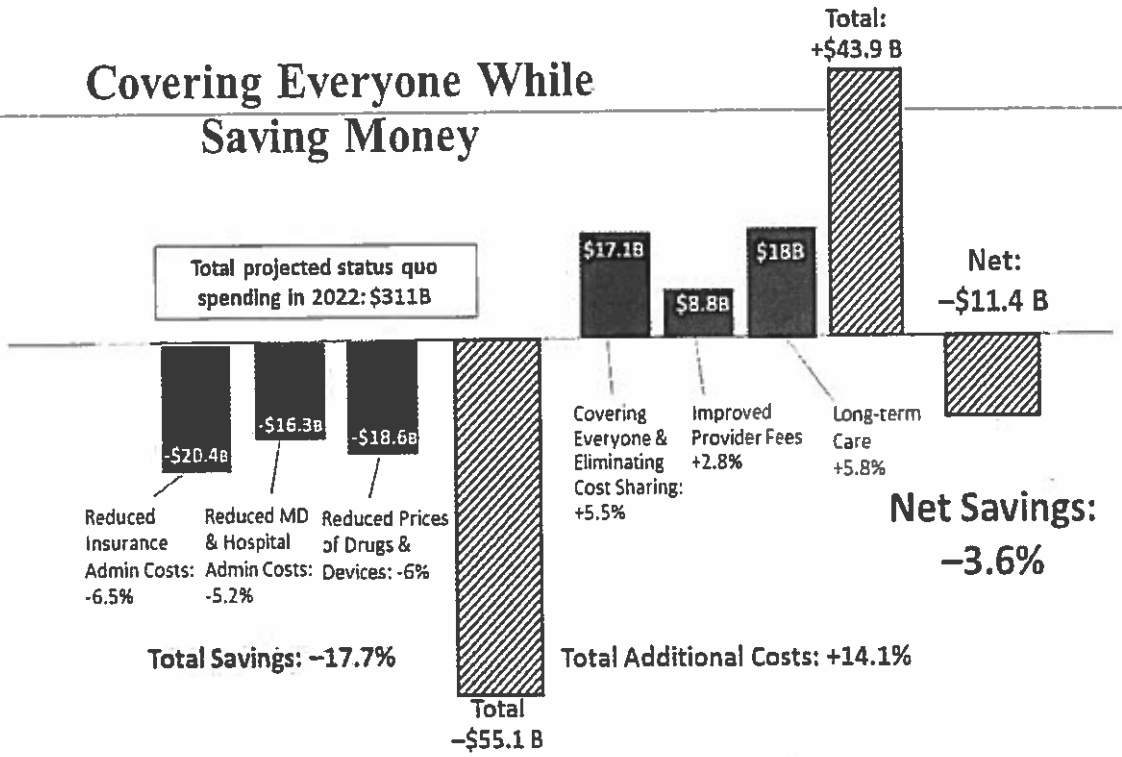
6. One Proposed Effective Payroll and Non-payroll Tax Rates under the New York Health Act[1]

Income	NYHA Effective Rate
$25,000	0.0%
$50,000	6.9%
$75,000	10.2%
$100,000	12.2%
$200,000	16.9%
$400,000	20.8%

Note: Average health care spending today at all income levels, including premiums paid by individuals, out-of-pocket payments (including the cost of long-term care), tax payments supporting health care programs, and premiums paid by employers (forgone wages), is over 20% of household income. See Jodi Liu, *et al, An Assessment of the NY Health Act* (RAND Corporation, August 2018), especially Fig. 5.4 and Appendix B.

[1] Marginal tax rates: <$25,000: 0%; $25,000-$49,999: 13.8%; $50,000-$74,999: 16.9%; $75,000-$99,999: 18.4%; $100,000-$199,999: 21.6%; $200,000 or more: 24.6%. See L. Rodberg, *Summary and Evaluation of the RAND Corporation's Assessment of the NY Health Act* (September 2018). Section 9.

Sources of Savings, Added Costs, and Net Savings



Sources: Jodi Liu, *et al.*, *An Assessment of the NY Health Act*, RAND Corporation, August 2018
Leonard Rodberg, *Summary and Evaluation of the RAND Corporation's Assessment of the NY Health Act*, September 2018.

Current Sources of Funding
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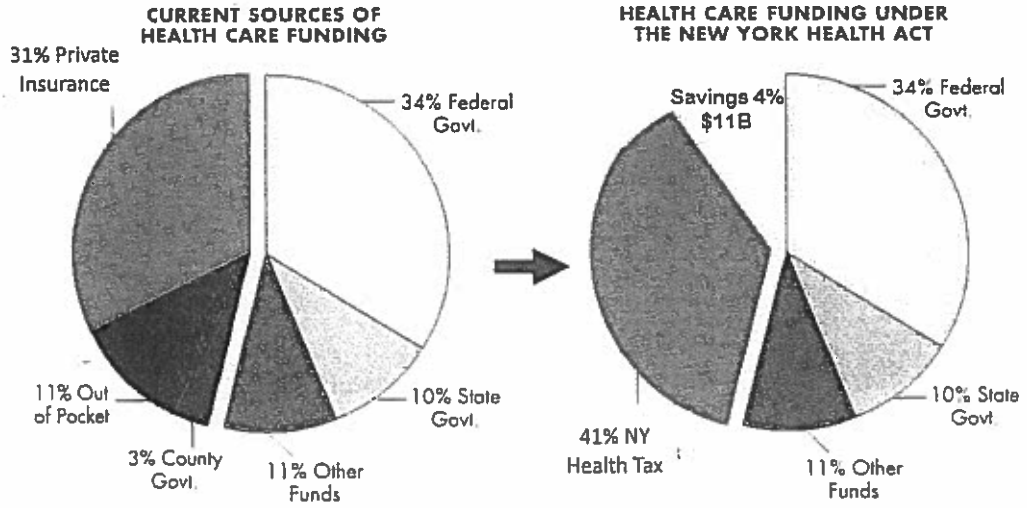
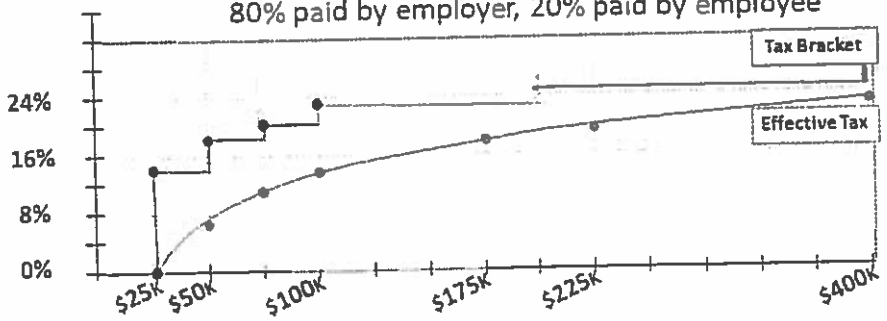


Sources: Jodi Liu, *et al, An Assessment of the NY Health Act* (RAND Corporation, August 2018);
Leonard Rodberg, *Summary and Evaluation of the RAND Corporation's Assessment* (September 2018).

Progressively Graduated Taxes under the New York Health Act

Paying for NY Health through Payroll & Non-Payroll Tax

80% paid by employer, 20% paid by employee



Wages & Salary & Taxable Investment Income

	Income/ year	Effective Tax	Employee Pays (20%)/year	Employer Pays (80%)/year	Non-Payroll (investor pays)
A	$50K	6.9%	$690	$2,760	$3,450
B	$100K	12.3%	$2,455	$9,820	$12,275
C	$175K	16.3%	$5,695	$23,475	$28,475
D	$225K	17.8%	$8,005	$32,020	$40,025
E	$400K	20.8%	$16,615	$66,460	$83,075

Sources: Jodi Liu, *et al*, *An Assessment of the NY Health Act* (RAND Corporation, August 2018).
Leonard Rodberg, *Summary and Evaluation of the RAND Corporation's Assessment of the NY Health Act* (September 2018).

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NEW YORK HEALTH ACT

Federal Waivers FAQ

Q: In order to efficiently integrate federal funds into the new system, the New York Health program will seek waivers from the federal government that will bypass ordinary federal reimbursement rules and enable bulk transfer of funds based on global budget projections. What options are available should such waivers not be forthcoming?

A: Over half the funds that provide and administer health care services in New York comes from federal and federal-state public programs. These include Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Affordable Care Act (ACA) tax credits.

The New York Health Act (NY Health) explicitly provides that the Commissioner of Health will seek federal waivers needed to smoothly and efficiently integrate these funds into the NY Health trust fund (See the bill Introduction and Section 5109).

Medicaid and CHIP

States manage and partially fund the Medicaid and CHIP programs. Matching funds are provided by the federal government. Currently, federal funding is conditional upon verifying the eligibility of each Medicaid and CHIP participant and assuring the validity of each individual service transition. New York would seek a waiver to allow funds to be received, in bulk, based upon past receipts and estimates of future eligibility and costs, bypassing the need for case-by-case, fee-by-fee verification. This would be similar to the global funding waiver currently in effect for Rhode Island's Medicaid program.

New York already has a number of approved Medicaid waivers that allow New York to provide services that are not part of original Medicaid including, among others, long-term care services in the home and community and certain behavioral health and addiction services. These waivers would be expected to continue, along with others in effect, or under development, that allow integrative managed care approaches and capitated payment methods that move away from the less efficient fee-for-service model.

Medicare

The Medicare program does not have state-based "waivers", but it does have "demonstration projects" as defined by the 1967 and 1972 amendments to the Social Security Act which can potentially serve the same purpose. These are intended to promote research that might assist Congress and the Department of Health and Human Services (HHS) in designing reforms that would increase the efficiency and cost-effectiveness of the Medicare program, without

compromising health care quality. These reforms could include changes in payment methodology that would allow for seamless articulation of the Medicare program with NY Health.

Most projects were expected to be proposed initially by Congress and HHS, and managed and evaluated by the Center for Medicare and Medicaid Services (CMS). The legislation was not designed to support state-specific operational program reforms, although the research has led to some innovative technical improvements and a few state-based operational waivers, such as one that allows Maryland to establish uniform pricing, and, more recently, global budgeting, for all hospitals. Maryland is now seeking to extend its Medicare pricing policy to physician reimbursement.

The Maryland waiver shows that significant changes in payment methods in a state are treated by CMS as aligning with the intent of the original Medicare legislation.

Medicare Advantage may be used if a Medicare waiver is unavailable

Alternative payment mechanisms such as Medicare Advantage (MA) are available if a waiver were not to be granted. In 1973, Congress codified federal rules for provider collectives that offered services on a capitated basis, and Medicare was authorized to develop demonstration projects that would allow such HMOs to manage services for older adults. This became the basis for the Medicare Part C (Medicare Choice+) legislation in the Balanced Budget Act of 1997 and the Medicare Advantage legislation in 2003. Although nearly all MA organizations have been private, usually for-profit, the 1973 law refers to "public or private" entities that could be authorized by the federal government to be providers for such programs.

Over 38% of Medicare recipients were enrolled in MA programs in New York as of 2017. Such programs typically offer an expanded set of benefits, usually optical, dental, and hearing, along with a prescription drug component. The MA organizations typically reduce their expenditures by offering only a narrow network of providers, by requiring substantial co-pays, and sometimes by requiring a premium add-on.

A public or quasi-public entity serving as an MA plan could ease the way toward integrating Medicare into NY Health. Medicare recipients in New York State would be considered to be part of the state's MA plan. They would, of course, receive the same comprehensive benefits as everyone else. The federal government already uses capitated payments for such plans, replacing inefficient fee-for-service reimbursements. This would help to smoothly integrate federal funds into the NY Health trust fund, if a waiver (or demonstration project) could not be negotiated.

Since this would be a new situation, there are issues that might arise. The original Medicare Advantage amendments were intended to encourage health marketplace competition to drive down premiums and allow consumers a broader range of health plan choices. A state MA plan

would be part of the single-payer plan that eliminates competition for basic comprehensive health insurance. NY Health will, of course, reduce health care spending and allow for total freedom of choice of provider. Comprehensive benefits will cover everything covered by MA plans, and more, with no cost-sharing.

New York's dual-eligible plan already incorporates Medicare Advantage

The ACA was designed to help states implement innovative health insurance reforms. One major goal was to find ways to integrate Medicaid and Medicare for so-called "dual-eligible" patients, including long-term care. In 2008, dual-eligibles constituted only 20 percent of Medicare beneficiaries nationally but 31 percent of Medicare spending. They constituted 15 percent of Medicaid beneficiaries but 39 percent of Medicaid spending.

Section 2602 of the ACA set up a Federal Coordinated Health Care Office, reporting to the administrator of CMS. Among the purposes of the office are to more effectively integrate benefits under Medicare and Medicaid for dual-eligibles, simplify the processing of claims, and improve care continuity and the quality of health and long-term care services. The new office, in effect, becomes the waiver vehicle through which Medicare is integrated with Medicaid into a single payment stream managed by states.

New York is one of 17 states authorized to carry out such a demonstration project. It is called Fully-Integrated Duals Advantage (FIDA) and is part of the state's Medicaid Redesign Team reform effort launched in 2012. Although New York already had two small integrated programs, including the Program for All-inclusive Care for the Elderly, or PACE, the FIDA initiative aimed to eventually include all dual-eligibles and become part of the ongoing effort of New York to transition Medicaid recipients into managed care and managed long-term care environments where, in theory, costs can be managed and quality improved.

The new federal office uses the MA program to carry out its integration efforts. New York's FIDA initiative was set up as a set of MA plans using private insurance organizations to manage the demonstration project. Medicare payments are made according to the MA model.

Medicare wrap-around

As a fallback option, a state could set up a Medigap plan, or other plan, that would "wrap around" traditional Medicare. Such a plan would run parallel to Medicare as it currently exists and provide any needed extra payments to providers. While such an approach would limit administrative savings for the state government, since providers would still have to submit bills to the Medicare program, an efficient electronic claims processing system could minimize the additional administrative effort by providers.

There are also provisions under Section 1395kk of the Medicare law that allow the federal government to hire contractors to maintain data and administer benefits under certain conditions. A state or state-related entity could qualify as such a contractor and thus could process Medicare claims as well as claims made directly to NY Health.

ACA Innovation waivers can bypass ACA requirements

The Affordable Care Act Section 1332 offers innovation waivers that allow a state to opt out of ACA requirements (for instance, the requirement to create a "marketplace" to offer private insurance plans) in order to introduce new approaches that could address substantive areas of health insurance policy and/or technical areas such as data collection and claims processing.

The waiver option was included in the ACA on a bi-partisan basis because it could cover approaches that were of interest to both conservative and liberal members of congress. The discussion leading up to the enactment of the law explicitly included single-payer options, and the state of Vermont submitted a 1332 waiver request for the single-payer legislation it passed in 2011 (the request was withdrawn when the governor tabled the plan.).

In order for a 1332 waiver to pass muster, the new system must offer benefits at least as comprehensive and as affordable as would have been the case without the waiver, and it must cover at least as many residents. In addition, the state must present a ten-year budget that demonstrates that the system will not add to the federal deficit. The NY Health program would readily meet these "guardrail" provisions.

At a minimum, an innovation waiver will allow a state to receive ACA premium tax credit funds directly and in bulk form rather than for each individual service fee. A waiver can also allow a state to develop uniform pricing and innovative claims processing systems. NY Health will likely use a single "back office" to manage payments to providers to limit administrative expense.

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NEW YORK
HEALTH ACT

The "ERISA Problem" FAQ

Q: The federal Employee Retirement Income Security Act (ERISA) was passed in 1974 to provide security and uniformity across the nation for pension, health, and other benefits provided by employers. ERISA declares that the federal government has priority in governing such plans, and states cannot establish laws or programs that regulate or otherwise impact such plans. Does the New York Health Act violate the provisions of ERISA?

A: The New York Health Act (NYHA) does not regulate employer-provided health benefits, nor does it direct employers to provide, or not provide, any particular benefits. All employers must pay the state-wide taxes that fund and make possible the NY Health program, but employers are free to maintain, limit, or eliminate their existing programs.

Insurers that provide coverage for employer-based health insurance plans are regulated by state insurance laws and regulations. However, what plans are offered by employers, and the extent of coverage they offer, cannot be regulated by states. That is, federal preemption governs in that case. (Note: Plans offered by employers that self-insure and take on risk themselves are not considered insurance plans and are not subject to state regulation of any kind. They may bypass state health care laws, regulations, and certain direct taxes.).

The federal ERISA law can potentially preempt any state rule such as NYHA that "impacts" such plans in any way. This would have a significant effect on the new program, since currently, millions of workers in New York State get their health insurance benefits through employer-provided plans.

NY Health will be better than any plan provided by an employer. Such plans usually require significant cost-sharing, that is, they have large deductibles and co-pays. They also typically have limited networks and benefits that are less comprehensive than those of NY Health. Companies must also incur expenses managing such plans or contracting with a management service to oversee them.

Federal law does not prevent a state from taxing businesses and employees, as long as the taxes are broadly based and not intended to force actions by such employers. These taxes could include

those aiming to improve health care for all state residents. Under NYHA,, all employers will be paying such a tax on behalf of their New York employees to help fund the NY Health program.

It would be expected, therefore, that most companies would no longer include their New York resident employees in their health plans, since these employees will automatically qualify for the new state health insurance program that will be both superior and less costly. However, NYHA would not require them to stop offering their own program if they so desired.

The federal ERISA law is vaguely worded, and conflicting legal rulings make it unclear what might be considered an action by the state that would "impact" an employer plan. Some might argue that the NY Health tax, while itself legal, would, in effect, be forcing an employer to abandon its program in the state. Opponents of NY Health might well launch a law suit claiming that ERISA preempts the new law because of its "impact" on employers.

Following the advice of legal experts on ERISA, the language of the NY Health Act is explicitly framed to avoid ERISA challenges, including an offer of tax credits that would wholly reimburse employers, and their employees, for taxes paid on behalf of employees who live out of state but work in New York [see Section 4(2)(e)(ii)]. Should a challenge still occur, the bill's sponsors are confident that, based upon a clear interpretation of legislative intent and past federal rulings, NY Health will prevail. Should any part of the bill be ruled in violation of ERISA, an accommodation that would exempt some employers, while inefficient and costly, would still leave NY Health as a viable program and in the best interest of the vast majority of New Yorkers.

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NEW YORK HEALTH ACT

Wait Times FAQ

Q: Canada, the UK, and other countries are often held up as model single-payer health care systems, yet we persistently hear of long wait times for appointments and services. Is this what we can expect from a single-payer system?

A: Numerous careful studies have found that the insurance and financing system is not responsible for long wait times. Excessive wait times can be found in all systems, single-payer or multi-payer, public, mixed, or private, and can occur within systems by region, state, province, county, municipality, or even individual medical facility or practice. The most important factors affecting wait times include physician shortages, limited hospital facilities, funding constraints, and poor patient flow management.

The "wait time issue" is important. No one should have to suffer pain and anxiety while waiting for diagnosis or treatment, or be forced to remain away from work or school for unnecessarily long periods. Nor should they be placed at increased risk of death or disability.

The Organization for Economic Cooperation and Development (OECD), a grouping of the major industrial countries, has undertaken extensive studies of their health care systems, including variations in wait times. All of these system but that of the US provide universal coverage with comprehensive financing and rich data sources. In all of them, government has a major role in the health system, so waiting times for elective procedures have often become a contentious political issue. In 2001-04, many of them were concerned about waiting times, and OECD began reviewing policies for reducing waiting times.

A major study completed in 2013, Waiting Time Politics in the Health Sector: What Works?, evaluated what progress had been made in that period. Not surprisingly, they found that countries that spend more on health care, had increased their supply of physicians, and had greater hospital capacity experienced shorter waiting times. In some cases, they had adopted waiting time guarantees or targets to place pressure on those working in these systems, and these incentives were effective when they were enforced.

Most important, these studies found that it was these capacity and budget factors, not the nature of a country's health care financing system, that determined the existence and length of any delay for receiving care.

There has recently been great concern about excessive wait times in Veterans Administration facilities. An independent assessment conducted for the American Legion found that "wait

times at the VA for new patient primary and specialty care are shorter than wait times reported in focused studies of the private sector." Overall, the report concluded, "VA wait times do not seem to be substantially worse than non-VA waits."

Emergency services

With respect to potentially life-threatening emergencies, all advanced countries use specially designed and tested triage systems to ensure that high priority emergency room (ER) admissions are treated immediately upon patient arrival in cases needing resuscitation, and in less than an hour in cases considered of "emergent" or "urgent" acuity. Under most conditions, high priority wait time targets are met in the vast majority of cases in all advanced countries.

If target times are not met, there are usually external reasons. In rural hospitals it might be due to travel time for surgical specialists. In heavily-used urban hospitals, delays are often a function of temporary or, in extreme cases, chronic ER crowding. Recent cutbacks in National Health Service funding in England, as another example, have affected ER wait times.

Crowding is especially prevalent in ERs that serve large numbers of patients who do not have true emergency problems. In a 2013 Commonwealth Fund study involving 11 advanced nations, the US had the largest percentage of such patients, due primarily to inadequate or no insurance.

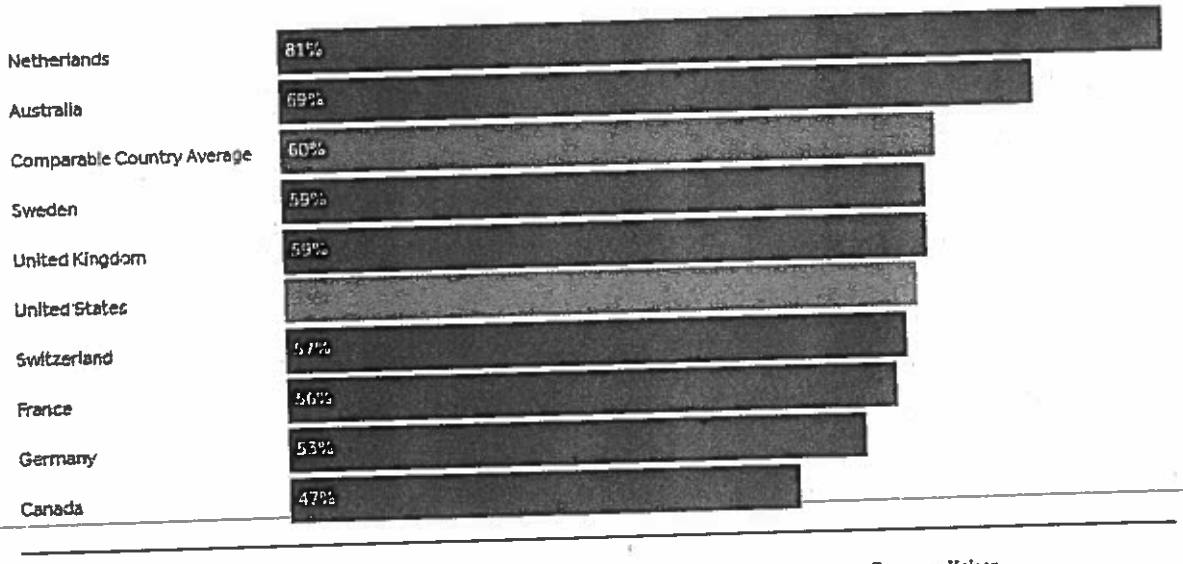
The same study showed that the US and Canada had among the largest percentage of non-urgent ER admissions due to difficulties getting appointments with primary care physicians. Yet France, Australia, and the UK, all with universal health care systems, single-payer and multi-payer, had 40-60% fewer such admissions. Germany and The Netherlands, also with government-regulated universal systems, reported the overall percentage of ER use at only 25-35% of that of ERs in Canada and the US

Wait times for emergency services can vary widely among countries, and among regions and hospitals within countries. There is no correlation based on national financing system. Single-payer countries are among the best and the worst with respect to ER wait time. After years of improvement, the National Health Service in England, for example, has experienced a recent worsening of ER wait times, while the nearly identical program in Northern Ireland recently reported that 95% of ER patients get a triage assessment within 8 minutes and are seen by a medical professional within 29 minutes, both excellent results.

Wait times to see a primary care physician when sick

As noted above, a major reason for crowded ERs is a person's inability to get an appointment with a primary care physician to treat an acute condition which is not a true emergency. A 2016, 11-nation Commonwealth Fund survey found the following results for adults "able to get same-day/next-day appointment when sick."

Percent of adults who made a same-day or next day appointment when needed care, 2016



Source: 2016 Commonwealth Fund International Health Policy Survey • Get the data • PNG

Peterson-Kaiser
Health System Tracker

Same-day or next-day access to primary care in Canada and the US is below the 11-nation average, yet one has a public single-payer health insurance system and the other a private market-based system. The fully nationalized UK system does better than both. In any case, there is little difference among these countries having very different financing systems.

Managing patient flow is of critical importance in meeting wait time goals and there are many aspects to this management. Limited physician networks in the private US system are a typical source of long wait times. Physicians refusing Medicaid patients create long delays in the US public system as well, affecting wait times for the poor and driving them into emergency rooms. The single-payer Medicare system in the US, on the other hand, has fewer network restrictions and better primary care wait time results, on average, than both private and Medicaid patients.

The availability of evening and weekend hours can mitigate wait time problems as can the availability of urgent care walk-in clinics. Increased use of nurse practitioners and physician assistants can address wait time problems in areas with physician shortages or long travel times.

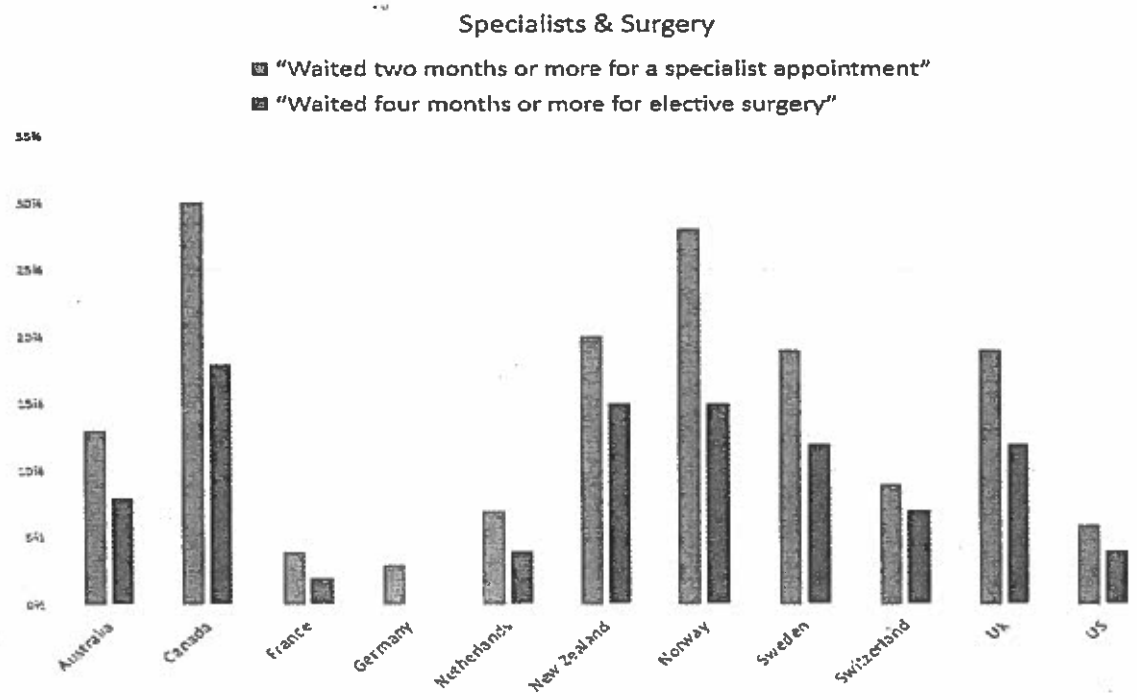
Countries, regions within countries, and individual facilities and practices vary widely in their ability to manage patient flow. The variation cuts across all modes of health insurance financing.

Wait times for non-urgent care and elective procedures

Many of the complaints involving Canadian, British, and other single-payer or multi-payer universal systems relate to care that is not urgent or involves elective procedures. This could be first-time visits with a new provider, annual check-ups and screenings, visits to specialists, or non-urgent or elective surgery such as hip and knee replacement or cataract surgery. Long wait times in these situations can be a direct product of patient flow management as providers prioritize care for those with more immediate needs, or can result from physician supply constraints due to many of the same factors as described above.

Following years of steadily improving service including reduced wait times, the Canadian Medicare and English National Health Service systems have experienced substantial increases in wait times for non-urgent services since the recent recession. This has generated public discontent and a barrage of press stories describing some of the worst cases. As a result, public officials have prioritized the issue, and both systems have begun using improved patient flow management systems coupled with penalties or rewards for meeting, or failing to meet, the targets. More importantly, targeted spending has increased in response to public concern about the problem.

Here are the data from the 2016 Commonwealth Fund study relating to non-urgent wait times:



The US fares better in this category than Canada and England and even Norway and Sweden, and much has been made of this fact. However, the universal social insurance systems of France, Germany, and the Netherlands fare just as well as the US

The New York Health Act and wait times

The New York Health Act will remove many of the sources of long wait times in the US. There will be no limited provider networks, and providers will no longer discriminate against Medicaid and Medicare patients, since reimbursement rates will be standardized. There will be no barriers to provider choice, creating a greater range of options, especially in urban areas with greater concentrations of providers.

With reduced paperwork and administrative burden, providers will have more time to devote to patient care and the management of patient flow. This will be especially important in the face of the expected increase in utilization of health care services. Hospitals, too, will be relieved of an administrative burden and be able to devote more resources to patient services.

In the longer run, NY Health planners will be able to work with the Governor and the Commissioner of Health to increase the supply of providers in rural areas and to provide the necessary capital for expanding patient care facilities and diagnostic technology where it is needed.

Sources:

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New York Health Act (A 5248, S3577)

Dear Senators and Assembly Members,

The twenty stories collected in this book are typical of the nearly fifty we've published over the past year for *This Is the Bronx*.

They tell stories of family members, friends, and neighbors — people representative of your constituents who suffer under our current broken healthcare payment system, people who have told pollsters that healthcare continues to be their most urgent election issue.

Most of these stories are about people who thought their job-based insurance would keep them safe. It didn't. It can't. The current multi-payer private-insurance system has a business model that prioritizes profits over patient health, too opaque to manage or improve. Few New Yorkers have any idea how vulnerable we are.

We are vulnerable because healthcare costs are consuming our economy: about 12% of GDP 20 years ago; almost 18% today; projected to hit 32% within a decade. In 2000, the cost of family coverage through employment was 13% of the median wage. Today, it is 50% of the median wage.

The average family spends more on premium contributions than on food for a year; more on healthcare premiums plus out-of-pocket health expenses than on housing. Because employers can't afford it either, they are shifting an increasing share of costs to employees and reducing the number of covered workers (down 17% since 2000). By discouraging routine medical care, these uncontrolled costs torpedo our public health.

We are volunteers working to pass the New York Health Act, so that all but the wealthiest New Yorkers will spend less for healthcare and, finally, to control costs by cutting at least 17% of wasteful spending that benefits no one's health, that frustrates physicians, that reduces their clinical time with patients.

Even more important than monetary savings, however, will be the security of having all financial obstacles to care removed — improving public health, increasing productivity, and strengthening families. New Yorkers, like those in these stories, will no longer have to choose between seeing a doctor and paying rent, filling prescriptions for chronic disease and buying food, halting an ER doctor's life-saving treatment for a heart attack and impoverishing their family.

We hope that you — as you read these stories — will hear echoes of people you know. Almost every family has a story similar to these. Enacting NY Health will allow NYS to lead our nation — demonstrating that American exceptionalism doesn't require poor health outcomes at unsustainable prices. Like Tommy Douglas in Saskatchewan, we can light the way to universal, comprehensive, affordable healthcare.

Thank you for listening to your constituents.

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