May 28, 2019
Chairman Gustavo Rivera
Chairman Richard Gottfried
Legislative Office Building – Hearing Room B
198 State St, Albany, NY 12210

Dear Chairman Gottfried, Chairman Rivera and members of the Health Committees,

My name is Cheryl Cashin and I live on Shelter Island, NY. I am submitting testimony today on behalf of the group Progressive East End Reformers (PEER), a chapter of New York's Progressive Action Network (NYPAN), to express our strong support for the NY Health Act. I am a health care co-facilitator for the group, which represents hundreds of NY residents and has been actively engaged with progressive issues on Long Island. In the health care group we have been dedicated to community education about and enthusiastic advocacy for the NY Health Act. I would also like to share my perspective with you today as a PhD health economist who has worked in health systems financing for more than 25 years. Over that time, I have provided technical assistance and advised governments of more than 20 countries on financing of health systems.

All of the countries where I work are committed to making high-quality health care accessible to their populations without financial hardship for families. Most of these countries have to do that with a fraction of the resources we have available in the U.S. Not one of these countries has considered doing that through the private health insurance industry. There is a good reason for that—they see that the for-profit layer in the U.S. health system consumes 18 cents of every dollar we spend[1] but we do not get value in return for that. The consequences are that we spend more per person on health care than any country in the world ($10,739 per person in 2018), and health spending consumes almost 18% of our economy, also the highest in the world.[2] But our outcomes are worse and worsening. Just one of many examples--according to the most recent World Bank data, 47 countries do a better job avoiding maternal mortality than the United States. Some of those are high-income countries like Canada and Germany. But women also have a greater chance of dying in childbirth in the U.S. than in Kazakhstan, Slovenia, Saudi Arabia, and Libya.[3]

Why does spending more and more money on health care not bring us better outcomes? Of course there are many reasons for this, but the one that I would like to focus on, and that relates most closely to my work, is that the promise of for-profit health insurance to bring innovation, efficiency and responsiveness to consumers has failed to deliver.

The innovation by private insurers has been to find new and better ways to deny care, shift costs, and restrict access to providers. The Affordable Care Act was the best attempt that I have seen to expand coverage and reduce the out-of-pocket burden of health care costs for Americans, while keeping our

[1] https://www.ahip.org/health-care-dollar/
[2] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html
[3] https://databank.worldbank.org/data/reports.aspx?source=world-development-indicators#

private insurance system intact. This experience has shown us that it is impossible to have both. We now have a mountain of research from objective think tanks like the Kaiser Family Foundation and the Commonwealth Fund that shows just how successful the private insurers have been in making profits by eroding coverage, even with the regulations imposed by the Affordable Care Act. Even when you think you have good coverage, there is no guarantee your insurance company will approve the care your doctor has recommended or already provided. Claims denials are at an average of 20% of all in-network claims in some parts of the system.[4] Have you heard of the actual paid position within some insurance companies "Denial Nurse"?[5] The former medical director of Aetna, the insurance company covering me and my family and 23 million other Americans, admitted under oath last year that he never looked at patients' records when deciding whether to approve or deny care.[6]

On the personal side, I am surrounded every day on Eastern Long Island by people I care about paying higher premiums and deductibles, having fewer and less clear benefits, less choice of provider, traveling further and further for an in-network provider, experiencing more denials and surprise bills. Most tragically, a dear East Hampton friend died last year a week before his 65th birthday waiting to be eligible for Medicare to get treatment for his heart condition. And an increasing number of plans no longer include our local community hospital in their networks. My brother had to travel an hour for a hernia operation in January because Southampton hospital is no longer in his network. In the countries where I work in Asia and Africa, traveling an hour to a hospital is considered an access barrier that needs to be fixed. My colleagues in other countries ask me why we do not consider all of this a human rights abuse. I do.

Why do I think a publicly funded single payer system can do better? Because I have seen up close what other countries are able to do. I know the idea of a single government agency managing the health expenditure on behalf of all NY residents may feel like a scary leap—will the agency function effectively and efficiently? Will it be wasteful or corrupt? Will it be responsive to consumers? A large part of my professional work is with single-payer agencies in Asia and Africa. These agencies are by no means perfect. There is a lot of work to do. But I have seen many examples of innovation and responsiveness in these agencies more so than in other parts of those health systems.

Part of that comes with the system-wide view these agencies have, which allows them to manage the health of the population proactively rather than simply paying the bills for treating illness. In single-payer systems there are real incentives and mechanisms to invest in and pay for prevention and community management of chronic diseases. These incentives do not exist for our private insurers.

When I worked in Ghana in West Africa, for example, the single payer agency was able to look at utilization data across the system and identify gaps in access to primary health care. There are now pilot activities to form networks of clinics and community-based providers to close access gaps. The system-wide information and purchasing power can be used to create coherent incentives for providers through

[4] https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/
[5] https://khn.org/news/coverage-denied-medicaid-patients-suffer-as-layers-of-private-companies-profit/
[6] https://www.cnn.com/2018/02/11/health/aetna-california-investigation/index.html

unified payment systems, drastically reduce administrative costs, and orient the whole system toward more efficient use of resources. I am working now in Indonesia, which has a population close to that of the U.S., where the single-payer agency is developing innovative payment models to improve community-based prevention, diagnosis and treatment to reduce costly unnecessary hospitalizations. These agencies negotiate with providers, and especially pharmaceutical companies, to manage the costs of the system. In Vietnam, the single-payer agency manages expenditures of the entire system every year through a sophisticated combination of expenditure caps, negotiation with providers, and activity-based payment for services. If government purchasing agencies in Ghana, Indonesia, and Vietnam can work hard to be innovative and responsive to their populations and also be efficient, I am sure that an agency in NY with all of our resources can rise to the task.

I would like to make a final point about the technical quality of the NY Health Act, as I am sometimes asked to comment on such bills for other countries in the course of my work. I have read the bill carefully. There are still questions--for example, how to fine-tune the revenue plan to uphold the commitment to a fair and progressively funded system. But I can say that when I teach health financing in the global courses of the World Health Organization and the World Bank this fall, as I have been doing for many years, I will use the NY Health Act, and hopefully law, as a teaching example of best practice. I will do that with great pride in my state.

Let us face the facts. The U.S. is no longer a world leader in health care. We are falling further and further behind, while countries far less wealthy than we are surpass us with innovative universal publicly funded systems, while spending far less. NY state has the resources to implement a single payer system and lead the country toward joining the rest of the world with an efficient, high-quality, **humane** health care system.

Sincerely,

Cheryl Cashin, Ph.D.
Managing Director, Results for Development
Co-Facilitator, PEER/NYPAN Health Care Group