Latinos for National Health Insurance

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On behalf of Latinos for National Health Insurance, LNHI, I wish to thank Governor Spitzer and Commissioner Daines for their commitment to moving towards universal health coverage in New York. We are extremely thankful to be given this opportunity to provide input on the development of proposals for achieving health system reform. Latinos for National Health Care is a national coalition for equity in health care based in New York. We are composed of leading Latino leaders in health care, labor, government and other sectors. LNHI's mission is to serve as a Latino focused advocacy group to establish a comprehensive, universal, accessible, equitable, permanent and affordable program of health insurance covering every person living in the United States.

Through presentations, publications, and other outreach and advocacy efforts we seek to inform groups and organizations including elected officials of the insurance crisis in the Latino community and the need for comprehensive approach to health insurance coverage based on national health insurance. Our analysis of the latest data from the Census Bureau in NY portrays a very stark picture for Latinos in New York State. Our data shows that in 2006, 23% of all Latinos in NY lacked health coverage versus only 10% of Non-Hispanics Whites. Further of the states 2.7 million uninsured, 764,000 were Latinos. In other words, although Latinos make up only 17% of the population of New York State, they account for nearly 30% of the states uninsured. In contrast NHWs make up 60% of the states' population but only 42% of the uninsured. By ethnic subgroup we find that 15% of Puerto Ricans in NY lack coverage. Most vulnerable are Dominicans and Mexicans with 31% and 45%, respectively, lacking coverage. Further, our analysis of Census data finds that the disparity is most pronounced among Latinos who are non citizens with 46% lacking coverage. Yet even among Latinos who were born in the US, 15% lacked coverage, a rate that is one and a half times greater than NHWs. Nevertheless, the fact that 46% of all uninsured Latinos in NY State are non citizens (390,000 people) suggests that any meaningful attempt at health insurance reform must include addressing the plight of non-citizens. We must also note that disparities are also present for other racial minorities with 20% of Asians and 16% of Non-Hispanic blacks also lacking coverage.

While health insurance is the most important determinant of access to health care, we are well aware that other barriers to care exist such as language barriers, cultural competency, and lack of a diverse workforce to name but a few. Nevertheless, before one addresses all these other barriers, you have to eliminate the primary barrier that is preventing nearly a quarter of all Latinos from accessing the system because they are

uninsured. This is similar to the recommendation by the landmark 2002 Institute of Medicine report on health disparities, which noted that addressing the plight of the uninsured is needs to be the initial and most important step we can take towards eliminating health disparities. Thus we are extremely pleased that the governor and commissioner have made tackling this extremely difficult health disparity issue a priority.

From a disparities framework and in thinking of health insurance reform we believe that the elimination of segregation and unequal access in our health care system should take utmost priority. Today you may hear from a few presenters advocating for market based reforms or so called medical consumerism. The central tenet of such reform proposals is that consumers should be made more sensitive to the price of health care. These policy formulations seek to reduce health expenditures by rationing health care based on ability to pay. Such policies would move us in the opposite direction of our nation's and our state's commitment towards the elimination of health disparities. We hope such approaches would not be central to any health insurance reform approach in NY.

Using the disparities framework we are equally troubled by many of the incremental approaches you will hear about today. As you are well aware, in NY State we essentially have a three tier system. The lowest tier are the uninsured. The highest tier are those having private insurance or national health insurance for elders, known as Medicare. These insurance programs are widely accepted by physicians and hospitals and these groups enjoy the best levels access to health care. In NY 85% of non-Hispanic whites have this highest tier of health care. In contrast, only 50% of Latinos, 66% of blacks and 68% of Asians have such health coverage.

The second tier of our segregated health care system are those covered through the various insurance programs that currently exist serving the poor. These programs including Medicaid and CHIP are critical components of the health care safety net. However, the many hurdles the poor and near poor have to overcome to be able to be insured under these programs and maintain coverage makes these programs a far cry from the stable comprehensive health coverage persons in first tier, such as Medicare beneficiaries, enjoy. Another major flaw in these programs is that they are considered as poverty programs by state and federal legislators and like other such programs, are chronically under-funded. As an example, in NY a private physician providing a comprehensive visit to a new Medicare patient is paid six times as much as when he provides the same service to a Medicaid patient. This forces Medicaid patients in many NY localities, to receive care through the same network of safety net clinics that care for the uninsured. Further, access to sub-specialty care in these settings is often as problematic as it is with the uninsured. As an example, in what is considered by many as one of the best hospitals in New York State, the wait for a Medicaid patient to see a gastroenterologist for a screening colonoscopy is 8 months. In contrast, patients with Medicare could be seen within two weeks in the private offices that are part of the same Medical Center but which do not accept Medicaid patients.

The federal government also reinforces this segregated system of care by providing additional subsidies through grants or Disproportionate Share Payments for these safety

net providers to see Medicaid patients. This segregationist system is quite effective at ensuring those in the first tier receive a different level of care from those in the second and third tier. Indeed, a recent report by the Bronx Health Reach Coalition extensively described this system of segregated care and unequal access faced by poor and predominantly minority patients and coined the term medical apartheid.

Among the important conclusions were:
• People who are uninsured or publicly insured through Medicaid, Medicaid Managed Care, Family Health Plus and Child Health Plus are often cared for in separate institutions from those who are privately insured.
• Even within health care institutions, separate and unequal systems of care exist. The uninsured, people covered by Medicaid, and sometimes, even those enrolled in Medicaid Managed Care, Family Health Plus and Child Health Plus, receive poorer quality care in different locations, at different times, and by less trained physicians than those who are privately insured.
• When patients are sorted according to their insurance status, this segregated care, or medical apartheid, leads to different health outcomes.

Thus, we are extremely troubled by policy formulations being put forward by many groups who consider themselves advocates of the poor and minorities, proposing to reform our health insurance by extending Medicaid, Medicaid Managed Care, Family Health Plus and Child Health Plus to even more lower income uninsured persons into this second tier of health care. (most of whom are also disproportionately minority). It is quite certain that given a choice, those who advocate for expansions of Medicaid and Medicaid like programs for lower income persons, would themselves chose to the highest tier of health care for themselves and their loved ones. It is thus quite ironic that while most of us in this room would find second tier coverage to be unacceptable for themselves or their families, many feel such coverage is the best we can do for lower income persons. We consider this yet another example of the kind of subtle racism that is so prevalent in many aspects of our health care system. We would strongly urge the governor and commissioner to reject such policy formulations that would further institutionalize segregation and disparities in health care.

In examining the various reform options, LNHI supports those that would equitably provide comprehensive health coverage for all. Single payer health insurance is such a system in which all residents of the state would have equitable coverage. It is often also called an improved Medicare for all. As noted by many of other speakers advocating for single payer insurance in these hearings, there are numerous other advantages for such a system. All residents of the state would have the most choice in selecting their doctor or hospital and no longer be limited to safety net systems that provide care for a large proportion of the uninsured or Medicaid recipients. In addition, the administrative savings from a streamlined program operated similar to Medicare, means that we may be able to cover all residents of the state without increasing our states overall health expenditures. Indeed, single payer is the one universal coverage approach that has been shown repeatedly in national studies and those in other states to not result in increased total health expenditures. We are thus quite concerned, that in specifying that health

reform in NY Sate would proceed using a building-block incremental approach, the Governor has chosen to build on the segregationist and racist system of health insurance that currently exists in our state. Based on testimony he is receiving in these hearings, we would urge the governor and Commissioner to reconsider the merits of a comprehensive approach of single payer coverage that would ensure equitable access to affordable, high quality medical care for every single New Yorker.

LNHI further urges the governor and commissioner to reject health reform proposals that seek to ration health care based on ability to pay as well as those that would place more low income minorities into segregated systems of care. We are keenly aware of political realities. We know that equitable coverage for all residents will be fiercely and vigorously opposed by powerful groups having a vested financial interest in maintaining our discriminatory system of health care. We also know how hard it will for our political leaders to stand up to those forces and take a bold step to eliminate racism and segregation in health coverage in NY. However we believe that at this critical juncture and with capable leadership we do have a unique window.

Martin Luther King once said "of all the forms of inequality, discrimination in health care is the most shocking and inhumane". Dr. King gave his life in his pursuit of ending racism and discrimination. It is our sincere hope that our new political leaders in this great state of New York will find the courage and stamina to take up this fight, and not accept medical apartheid in NY as an acceptable compromise to placate powerful financed interests.

Thank you,

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Speaking in his capacity as
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