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There are seven questions that the hearings seek to answer: Should there be one statewide Exchange with adjustments for different regional conditions or do we need separate regional Exchanges? Should there be one combined Exchange for individuals and small businesses or separate Exchanges for each group?

In determining premium cost, should the individual and small group markets be combined, spreading cost and risk over both groups? Should small businesses with more than 50 employees be allowed to participate?

How many different plans should be offered so that consumers have real understandable choices that allow them to make informed choices? Are too many choices bad for consumers? How do we avoid having all sick people grouped in an expensive plan and healthy ones in another?

How do we best use the marketing power of the Exchange as a whole to reduce costs?

The answer to the first four questions is to combine all possibilities in order to have a single entity and minimize administrative costs.

The fifth question (of two parts) is that there should be one comprehensive plan, again to reduce administrative costs both for the exchange and for consumers. Too many choices are bad for consumers when the cost, time, and energy needed to examine and analyze the choices exceeds the marginal benefit of one plan over another.

This also answers the sixth question about avoiding separate plans: unaffordable expensive plans for sick people and affordable plans for healthy people is a contradiction of the purpose of health insurance.

The seventh question begs comparison to proposals for "Medicare for all" or "single payer" negotiation of drug prices.

Since the exchanges are entities of financial administration that are inserted between people and insurance companies, which in turn are entities of financial administration inserted between people and medical care, instead of reducing bureaucratic costs, they increase bureaucratic costs and are not a good idea in the first place. What would be a good idea is to remove the bureaucratic entity that is at the root of the complex, inefficient and costly financial administration of health care – the private-for-profit insurance company - and replace it with "Medicare for all" or a "single payer" system. This conclusion is confirmed by multiple studies of health care financing by the Lewin Group, done in other states, and the study by the Urban Institute, commissioned by New York State. The President of the United States, tens of thousands of doctors, nurses, and health care workers, and millions of Americans know this. They also know that the insurance companies use their financial resources to bribe and blackmail legislatures and executives to maintain the status quo because they make millions and billions of dollars in profits. The President reported to the nation after the compromise legislation was passed that the insurance companies threatened to spend over one-hundred-million dollars on a campaign to defeat "Medicare for all".

With this in mind, it should be understood that the purpose of the policies to be developed by these hearings is to protect people from the insurance companies. The New York Times reported this past week that Health Insurance companies made record profits for the third year in a row, led by United Health Group. The New York Times and the Wall Street Journal reported in 2006 that William McGuire, of United Health Group was paid 1.7 Billion dollars for one year as CEO. It was news in part because the company had illegally back-dated his stock options. We need protection from this kind of practice. We need a "single-payer" financial system like Medicare that has 2% or 3% overhead. New York State, cities, counties, municipalities, agencies, businesses, and individuals would save tens of billions every year.