

LWVSD UNIT PRESENTATION, SEPTEMBER, 2009

"HEALTHCARE: HELPING YOU FOLLOW THE DEBATE"

Luncheons

- a) Tuesday, September 22nd - Retired State Senator Sheila Kuehl, "What's So Great About Single Payer Healthcare". She is the author of Single Payer Healthcare bill SB840 which has passed the Legislature twice and been vetoed by the Governor twice and is now SB810 and authored by Sen. Mark Leno. It is being held without action because of the budget shortfall.
- b) Tuesday, October 20th – Prof. Gerald Kominski, "Health Care Reform: Can We Pass the Final Hurdle?". He is a Professor at the UCLA School of Public Health and Associate Director of the UCLA Center for Health Policy Research. Jeff Gordon, M.D. will follow-up with how to become involved in the issues and the political dynamics.

The LWV Position (in part) – see p. 69 of *Impact on Issues*

The League of Women Voters of the U.S. believes that a basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.

Basic Level of Care:

- Prevention of disease
- Health promotion and education
- Primary care
- Acute care
- Long-term care
- Mental health care
- Dental, vision and hearing care are important, but a lower priority

The League favors a national health insurance plan financed through general taxes...As the U.S. moves toward a national health insurance plan, an employer-based system of health care reform that provides universal access is acceptable. The League is opposed to a strictly private market-based model of financing the health care system...and the administration of the health care system solely by the private sector or the states.

Cost Control

- The reduction of administrative costs
- Regional planning for the allocation of personnel, facilities and equipment
- The establishment of maximum levels of public reimbursement to providers
- Malpractice reform
- The use of managed care
- Utilization review of treatment
- Mandatory second opinions before surgery or extensive treatment
- Consumer accountability through deductibles and copayments

LWVUS Advocacy – Supports public option and bulleted items above
LWVC Advocacy – Supports SB 810, Single-payer

Matching Quiz

Universal Health Insurance – Coverage for all residents.

Single Payer/Healthcare for All, CA SB 810 (previously 840)

- Eliminates multiple insurance companies. One government entity designs the plan, collects all fees and premiums, and pays the bills for all residents. This cuts out 20-25% of the current cost of medical services by eliminating administrative overhead of insurance companies and medical providers; this cost savings will cover the uninsured, so the net cost of Single Payer is no more than the net cost today. However, there will be transition costs.
- Establishes a Commissioner and several government entities to set-up the system and run it fairly including public advisory committee and regional planning boards who will identify and prioritize regional health care needs and goals.
- Premiums are based on income or payroll. No co-pays (including the 20% currently in Medicare) or deductibles.
- Free choice of doctors and providers. Includes dental, eye-care, hearing aids, mental health, prescriptions, and other medical services. You are not limited to a network of providers.
- Insurance does not stop if you change jobs (eliminates COBRA)
- Requires electronic record keeping
- Emphasizes prevention and primary health care. Reimburse providers more fairly.

United States National Health Insurance Act, HR676 – Single Payer bill in Congress

Publicly financed, privately delivered, universal

No co-pays or deductibles; no limits or maximum spent per patient

All Americans are eligible

Includes prescription drugs, hearing, dental, vision, chiropractic treatment, mental health services, and long-term care

Choose your physicians, providers, hospitals and clinics

The Quality Affordable Health Choices Act, H.R. 3200 - in the House of

Representatives **Tri-Committee** (Ways & Means, Energy & Commerce, and Education & Labor). Public and private insurance – all Americans and legal immigrants are covered.

- Health Insurance Exchange – A marketplace for individuals and small employers to comparison shop among private and public insurers.
- Guaranteed Coverage – no discrimination for pre-existing conditions or health status. Provides lifetime coverage so that individuals don't max out. Limits the ability of insurance companies to charge higher rates due to health status, gender, or other factors; premiums can vary based only on age, family size, and geography. Health insurance will continue if you are unemployed or change employers.

- Essential benefits will be set by a new independent Advisory Committee with practicing providers and other health care experts, chaired by the Surgeon General. This will set the minimum quality standard and will include prevention, mental health services, oral health and vision for children, and a cap on money spent on covered services in a year. There will be no rationing of service.
- A **Public Option** will be created which will include several plan levels at different premium rates. It will compete with private plans. It will pay Medicare rates to providers for the first few years. Public Option will be operated by the government like a single payer system or Medicare system. Recently, there is a suggestion from the Republicans that instead of a Public Option, there should be **Healthcare Cooperatives** formed. They are owned by their members including the healthcare providers and need many thousands of members to be viable. They are non-profit. Members vote on such things as healthcare plans offered by the cooperative. Membership is voluntary and is not supported by the government (ie not universal). Cost containment will occur because they are non-profit, can compete with private insurance, and can work to keep their costs down. It may take a few years to establish healthcare cooperatives.
- Sliding Scale Affordability Credits for insurance premiums and cost-sharing available to families of three earning \$73,240 or less (2009 figure).
- Medicaid and Medicare will continue and be improved. and expanded to more people. The donut hole will be eliminated over time. Complete reform of the Sustainable Growth Rate (SGR) formula for reimbursing doctors so doctors are rewarded for successful and efficient care and coordination of services rather than for each procedure. Medicare Advantage will be eliminated.
- Mandatory – Individuals who choose to not obtain coverage will pay a penalty of 2.5% of modified adjusted gross income above a specified level. Employers with payrolls over \$250,000 who choose to contribute rather than cover their employees will pay 8% of payroll. Small employers will be exempt. Employer penalty ranges from 2-8% of payroll. A small business tax credit will be instituted. This is called **Pay or Play**. Insurance companies will have millions of new customers, many of whom will have government subsidies to buy insurance (LA Times, 8/24/09)
- More healthcare providers including primary care doctors will be trained and scholarships will be broadened.
- Emphasis on preventive care.
- States can have their own healthcare system

Sources: House Committees on Ways & Means, Energy & Commerce, Education & Labor. The Henry J. Kaiser Family Foundation.

Cost Containment

Many ideas have arisen of things to be eliminated or reduced; some may not be politically practical (like single payer):

- reduce advertising and marketing
- consolidate forms and rules of various health insurance plans thus reducing billing and paperwork
- switch to evidence based medicine instead of paying doctors for each procedure (in some cases the dr. owns the facility that does the procedure)

- reduce the awards for malpractice suits (and medical tests to protect/support the doctor's diagnosis/treatment)
- increase the number of primary care physicians and reduce the number of specialists
- emphasize preventive medicine
- limit annual increases in premiums
- purchase prescription medicine in bulk with more competitive bidding - savings of \$75 billion for Medicare patients
- eliminate Medicare Advantage or make it competitive- it's too expensive now - savings of \$177 billion
- computerize medical records (has a large initial expense, but is much more efficient)
- charge the same amount for the same procedure in a geographic region; don't pay specialists more to do a procedure that a primary doctor does
- total savings from Medicare/Medicaid revisions is \$622 billion (Kaiser Family Foundation, 7/09).

Evidence Based Medicine

Studies have been done to show the best treatment (including lack of treatment) and the risks and benefits of various treatments. This could be applied to medical decision making. Medical providers could be paid for a whole treatment rather than piecemeal.

Blue Dogs

A group of conservative Democrats who have forced some changes to the bills in Congress.

Massachusetts Healthcare Plan, 2006

- Mandatory for all residents over 18 but people are buying insurance when they need coverage and then dropping it.
- The state grossly under-estimated the number of uninsured (particularly non-English speakers) and thus has gone way beyond cost estimates. It is short 10,000 nurses, for instance. Residents are still going to the emergency room to get timely care. However, the *New York Times* (8/9/09) says that increased costs were expected and budgeted. The federal government is paying half of the increase cost (\$700 million). Due to the recession, Massachusetts has cut back on coverage.
- Penalty for not having healthcare coverage is \$1,068. People who can prove that the state plan is costing them more are not penalized for not joining the state plan.
- They have cut the uninsured to 2.6%. 62,000 have been exempted by the state because they cannot afford the premium and the state doesn't have enough money to subsidize them. Employers are experiencing large premium increases because costs are not controlled.
- The state subsidizes individuals with income under \$32,508 and families of four with income under \$66,168. Many say the premiums are still not affordable.
- No one can be denied. Residents ages 50-64 are being charged higher premiums as they age.

- Critics claim that insurance doesn't guarantee access to care, pointing to long waits for primary care. The cost of care and insurance premiums have continued to rise, but a state commission is work on cutting costs.
- Some believe that the plan is financially unsustainable and doesn't address cost containment, citing continued overuse of expensive high-tech care and an inadequate focus on primary care.
- Unexpectedly, employers have chosen to expand coverage in response to employee demand.

Socialized Medicine – A single-payer system in which the government owns and runs health care facilities and pays the salaries. eg. the VA health care program.

PPO/Preferred Provider Organization – A healthcare delivery system where the insurer and/or the employer provide healthcare coverage at a discount through contracts with health providers. Patients have a choice of doctors from a list provided by the insurance company and sometimes do not have to go through a "gate-keeper" primary care doctor for a referral. The insurance company sets the premium (which is a little higher than that of an HMO) and approves procedures and coverage. It reduces the provider's payment significantly from that billed. The patient usually pays a co-payment.

HMO/Health Maintenance Organization – A healthcare delivery system where there is a provider network with a primary care doctor who also acts as a gate-keeper. There is usually no coverage outside the network except for emergencies. There are no claim forms because patients pay a small standard co-pay plus their premium. Prescription drugs and eye care are usually covered. There is more emphasis on prevention. They often use electronic record keeping. Patients are more likely to have routine things done by medical personnel other than doctors.

Medicare

Who is Eligible?

- People 65 years and older (37 million) if they have paid into Social Security for at least ten years.
- People under 65 years old with certain disabilities (7 million).
- People with end-stage renal disease requiring dialysis or a kidney transplant.
- A total of 14 percent of Americans.

Part A & B & D

- Part A – hospital inpatient services, short-term skilled nursing home care, hospice
- Part B – medically necessary services including doctors, outpatient care, some preventative services, ambulance, outpatient surgery, blood, chiropractic and mental health services, emergency room, durable medical equipment, home health nursing services, and physical and occupational therapy. PPO or HMO.
- Part D – Prescription Drug Coverage – largely privately run, many choices. Coverage varies according to the cost of prescription drugs. People with expenses for prescription medicine between \$2,700 and \$6,154 per year have no help from Medicare. This is called the **donut hole**. Those over \$6,154 have 95% paid by Medicare and those with prescription medicine between \$295 and \$2,700 have 75% paid by Medicare. Coverage by Medicare or a comparable private plan is

required for those on Medicare.

Who Pays?

- U.S. Government (from Social Security funds) – this source is shrinking to the point where doctors are dropping out of the program; San Diego Co. is classified as rural and does not get the correct formula for the higher cost of living here (SDUT, 1/29/08).
- Part A is funded by a tax on earnings paid equally by employers and workers.
- Premium from client for Part B & D – deducted from Social Security check – based on income. From 2000-2007, Part B premiums doubled and far surpass the increases in the Social Security cost-of-living adjustments (21 percent in the same period).
- Parts B & D also receive funds from general tax revenues (Federal) and from states.
- Co-payment (20% of discounted medical bill plus deductible) by client.

Medi-gap Insurance - Private companies provide supplemental coverage for the 20% not covered by Medicare – client is charged a premium and probably has a deductible. Many people with Medicare also pay for Medi-Gap so they are fully insured or they belong to a HMO.

Medicare Advantage Programs (Part C)

Includes benefits from Parts A and B. May include prescriptions, vision, hearing, dental, and health & wellness programs. Deductible, premium, and co-payment are usually part of the program, but Medi-Gap is not needed. Medicare contributes 12% more to providers for Part C patients than it does to providers of Part A & B patients (AARP Bulletin, 11/2007). Provided by private health insurance companies approved by Medicare. Studies have shown that the increased cost to Medicare is not paying off in improved healthcare.

Medicaid (in CA it is called Medi-Cal) - An entitlement program that provides medical care for 58 million people (especially children) with limited income funded by the Federal and State governments jointly. Some groups of people, such as non-disabled adults without dependent children, regardless of how poor they are do not receive Medicaid coverage. Some people qualify for both Medicare and Medicaid. Includes nursing home, prescriptions, mental health, substance abuse treatments, long-term care, and home health care. Care is not as timely or as thorough (specialists are dropping out of the program) due to low state funding. Doctors receive half of what they get from treating Medicare patients. Added to their costs is a lot of paperwork. Rules and coverage vary by state. Some people with large medical expenses become Medicaid eligible over time; the minimum asset level is very low and has not been raised.

State Children's Health Insurance Program (SCHIP)

States provide health coverage to 6 million low-income children with family incomes too high to qualify for Medicaid but too low to afford private health insurance. Federal funding is sent to states and is based on a fixed allocation each year, not by services provided.

Federal Employees Health Benefits Program (FEHBP)

Health insurance program for 8 million federal workers, retirees, and their dependents. 284 HMO and PPO plans from which to choose in 2007. Allows for group purchasing.

Veterans Health Administration (VHA)

Health services for 7.7 million out of 24 million living veterans who enroll. Managed care (HMO) which includes nursing homes. Senior veterans have Medicare and VHA. Service is prioritized based on military injury and income.