CT Health Policy Project
Basics of Health Policy
January 2009

> What looks large from a distance,
> up close ain't never that big.
>
> -- Bob Dylan

Many people believe that health care policy is too complex for the average consumer to understand. While it can be confusing, it is not as challenging as it seems. This is our health policy module for student, intern and volunteer training at the CT Health Policy Project.

There is no need to memorize statistics; health care changes too quickly. They are offered to suggest trends and general themes.

Outline:
A) Public insurance -- Medicare and Medicaid/SCHIP
B) Private insurance
C) The uninsured
D) Health care financing
E) Health care reform prospects
F) Role of states
G) Advocacy –or what busy people can do about all of this

A) Public Insurance

There are two big public health coverage programs in the US – Medicare and Medicaid/SCHIP. While they are both government programs, they are very different in important ways. In addition, CT has a separate program, State Administered General Assistance (SAGA) which is completely funded by the state.

	Medicare	Medicaid/SCHIP
How many Americans are enrolled?	Over 43 million (2008)	Medicaid -- 59 million (2005) SCHIP – 4.4 million (2007)
Who is eligible?	Age 65 and over Disabled Patients with end stage renal disease No income limits	Low income children and families Low income seniors, disabled Children with special health care needs Income limits set by states
Entitlement?	Yes	Yes
Stigma, political clout	No stigma for patients Strong political constituencies Generally seen as an earned benefit	Significant stigma for families, little stigma for seniors Little political strength Often linked to "welfare"
What services are covered?	Hospital care Outpatient care Some preventive care	For children – all "medically necessary care", definition set by states

	Skilled nursing facility Hospice Home health care Optional prescription plan	Hospital care Outpatient care Preventive care Skilled nursing facility Hospice Home health care Prescriptions Family planning Dental Vision Mental health
Who runs the programs?	Federal government through CMS (Centers for Medicare and Medicaid Services)	States with minimal oversight by CMS
Who funds the programs?	Federal	State/federal joint funding
Level of flexibility	Very little	A great deal
How much does it cost consumers annually? (2008)	Most pay $96.40/month with $135 deductible plus 20% coinsurance on many services plus prescription plan costs There is no cap on out-of-pocket expenses	Medicaid – little to nothing SCHIP – cannot exceed 5% of income
How much does it cost per person total?	$7,439 (2004)	Medicaid -- $4,662 (2005) SCHIP -- $1,972 (2007)
Annual rate of increase in per person cost	8.9% vs. 9.9% for private insurance (1970-2004)	6.4% vs. 9.5% for private insurance (2000-2004)
How much does the program cost total?	$374 billion, 13% of total federal spending (2006)	Medicaid -- $317 billion, 8% of federal budget and 18% of state budgets, avg. (2005) SCHIP -- $8.7 billion, about 70% is federal (2007)
How many providers participate in the program?	Almost all	62% (2001)
Are provider rates reasonable? How are they set?	Set to cover costs, set by federal administration Approved by Congress	Set by states, generally low Average 69% of Medicare (2003)
Future prospects	Medicare trust fund will run out of funding in 2018 without intervention	Varies with government budgets – policymakers want to spend on these programs when the economy is good and taxes are up, but that is when there is less pressure on health costs and fewer unemployed/uninsured Constant tension between states and feds over funding
Sources: CMS, Kaiser Family Foundation, State Health Facts Online Accessed 8/25/08, Zuckerman, et al, Changes In Medicaid Physician Fees, 1998– 2003: Implications For Physician Participation, Health Affairs, 6/23/04		

Medicare and Medicaid were created in 1965 under the Social Security Act. Medicare is a social insurance program offering a good scope of health care services to seniors and people with disabilities at all income levels. Medicaid was first created to provide health coverage to people receiving cash assistance or "welfare". It has been expanded over the years to include other low income and working people. Medicaid is also the largest funder of nursing home care for seniors. The State Children's Health Insurance Program (SCHIP) was added to the Social Security Act in 1997 to expand health coverage to children.

Medicare is administered by the federal government alone. Medicare has four parts, each with its own services, consumer costs, funding sources and eligibility rules.

- Part A covers inpatient hospital services
- Part B covers outpatient, physician, home health and preventive services
- Part C, also known as the Medicare Advantage Plan, allows beneficiaries to join managed care plans to receive their health care services
- Part D is the prescription drug benefit delivered through a choice of 1,875 private plans (2007)

Because Medicare doesn't cover some services and includes coinsurance on others, about 10.3 million seniors in the US have supplemental private insurance, Medigap plans, that address some or all of those costs. Some purchase Medigap plans directly, but many receive it as part of retirement benefits. However, the proportion of large firms offering retiree health benefits dropped by half from 1988 to 2006.

Federal Poverty Level (FPL) – to become effective 4/1/09

An archaic standard of what it costs to live in the US, the FPL serves as a benchmark for many income-related programs. Updated every April, the FPL varies by family size.

Family size	2009 Federal Poverty Level
1	$10,830
2	$14,570
3	$18,310
4	$22,050

2009 Federal Poverty Guidelines, US Dept. of Health & Human Services, http://aspe.hhs.gov/poverty/09Poverty.shtml

For comparison, the US Census Bureau found that CT's median household income in 2006/2007 was $64,158.
http://www.census.gov/hhes/www/income/income07/statemhi2.xls

Unlike Medicare, which is available to Americans at all income levels, Medicaid eligibility is generally income limited. Medicaid provides comprehensive health services to low income children and their parents or caretaker relatives, picks up costs and extra services for low-income elderly and people with disabilities, particularly long term care services (including nursing homes) which have limited Medicare coverage. While most providers accept

Medicare, far fewer accept Medicaid despite the fact that the program covers over one in four children and 41% of births in the US; in CT Medicaid covers one in five children and one in four births.

Even though the federal government pays at least half the costs of Medicaid services, states have wide latitude in administering the program, including defining covered benefits, income eligibility levels, costs charged to families, and rates paid to providers. CT is a wealthy state, so Medicaid covers just half our costs. Medicaid regulations are complex, but states can gain permission to bend the rules with state plan amendments and waivers. The processes to gain waivers vary by state, but the federal government generally requires public input into state applications for waivers. In CT, recently passed law (over the Governor's veto) requires legislative approval for all waivers. This is an important opportunity for the public to have input into a critical coverage option for families and seniors and a significant driver of Connecticut's health care economy.

Per person spending in Medicaid varies significantly. Elderly and disabled recipients make up 24% of the Medicaid population, but incur 70% of expenditures nationally. The elderly and people with disabilities have higher per person costs (averaging $11,839 and $13,524 respectively in 2005; $21,522 for seniors and $23,221 for people with disabilities in CT) than children or other adults ($1,617 and $2,102 respectively US; $2,127 for children and $2,421 for adults in CT) mainly due to more intense use of acute and long term care services. Medicaid funds care for six out of ten US nursing home residents. Only 7% of Medicaid recipients use long term care, but they account for 52% of spending. Medicaid spending per person for children and their parents is far lower than under private insurance, and it is growing more slowly.

Medicaid is a critical safety net for low income and working families. A new study found that every 1% increase in the unemployment rate results in an increase in Medicaid/SCHIP enrollment of 1 million, 1.1 million more uninsured and $3.4 billion more in Medicaid/SCHIP spending. Unfortunately, this happens just when state budgets are tight (due to rising unemployment and lower tax revenue) giving them few options to address the problems.

Advocates are very concerned about CT's rising unemployment rate which increases the need for Medicaid just when policymakers are struggling with an estimated $6 billion deficit in the state's upcoming two year budget. This could trigger significant cuts to services and, as health care makes up a huge proportion of the budget, advocates will have to be on defense this year. We expect to see a number of health reform proposals put forward this year, but their prospects are uncertain.

SCHIP was added to the Social Security Act in 1997 in response to concerns about the rising number of uninsured American children. Since SCHIP was enacted, the rate of uninsurance among children living in low income families (200% of the federal poverty level or lower) has dropped from 23% to 14%. CT was the first state to implement an SCHIP program (HUSKY Part B). States receive a higher federal reimbursement for children covered under SCHIP than under Medicaid (CT gets the minimal match at 65%), providing an incentive to states to cover children. Most states run their SCHIP programs together with their Medicaid programs providing similar services, but charging higher income families something for their

care. While CT runs its SCHIP program together with Medicaid for families, the two programs have different benefits, different costs to families and families have different rights. Originally they were linked under the common name, HUSKY, (HUSKY Part A for Medicaid and HUSKY Part B for SCHIP), consumers weren't fooled and learned very quickly the differences between the programs. Unlike Medicaid and Medicare, SCHIP is not an entitlement program – when states run out of their allotted funding, the federal government will not automatically provide more. States are then placed in the difficult position of freezing enrollment for low income children or paying out of tight state budgets. CT has never come close to using all our allotment; funds designated for CT have reverted back to the fed.s to cover states that have run out of money. CT's attempts at outreach have been problematic and largely ineffective.

Optional: Coverage for immigrants
The federal government will not fund Medicaid coverage of legal immigrants who came to the US before 1996 until they have been here five years. Many states, including CT, choose to cover more recent legal immigrants with full state funding. Some states also cover undocumented immigrants with state programs; CT does not. For more, go to http://www.kff.org/uninsured/upload/Health-Coverage-for-Immigrants-Fact-Sheet.pdf

Dual Eligibles-
For impoverished older adults, Medicaid supplements Medicare, creating another eligibility category "dual eligibles" (see http://www.cms.hhs.gov/DualEligible/) Medicare continues to serve as the primary means of health insurance for this group of older adults. While Medicare pays for short-term nursing home care (less than 100 days), Medicaid pays for long-term care (more than 40% of total long-term care). This figure can be deceiving, especially to people who are concerned about the perceived burden of covering impoverished elders. Many believe that middle- and upper-class elders shield their assets in order to qualify for Medicaid, but there is little evidence to support this.

For more info, read http://www.kff.org/medicaid/upload/Medicaid-s-Role-in-Long-Term-Care-Q-A-Fact-Sheet.pdf

For more information –
CMS -- http://www.cms.hhs.gov
Medicare page for consumers -- http://www.medicare.gov
MedPac -- Setting Medicare policy and rates – http://www.medpac.gov
Increasing unemployment linked to increased uninsured and Medicaid/SCHIP enrollment -- http://www.kff.org/medicaid/kcmu042808pkg.cfm
Kaiser Family Foundation (2008).Medicare at a Glance. http://www.kff.org/medicare/1066.cfm
Kaiser Family Foundation (2008). The Medicaid Program at a Glance. http://www.kff.org/medicaid/7235.cfm
Kaiser Family Foundation (2007). State Children's Health Insurance Program (SCHIP) at a Glance. http://www.kff.org/medicaid/7610.cfm

Graduate Medical Education (GME)
The federal government and some states provide a great deal of funding to train new physicians through Medicaid and Medicare payments to teaching hospitals for direct and indirect services.
See http://www.cms.hhs.gov/AcuteInpatientPPS/06_dgme.asp and http://www.cms.hhs.gov/AcuteInpatientPPS/07_ime.asp

B) Private insurance

Most Americans are covered by private insurance -- 202 million in 2007. 88% of those are covered through their own or a family member's employment – a system that is unique in the world and has recently drawn criticism from many stakeholders including consumer, provider and employer groups.

Employer-sponsored coverage is paid for in four ways – by workers, by employers, by insurers and by taxpayers. Nationally health insurance premiums grew 5% last year. CT family premiums grew 8.2 times faster than median earnings from 2000 to 2007. The share of those premiums that workers pay grew 10.5 times faster. Health insurance premiums are highest in the Northeast and lowest in the Southern US. In a particularly cruel twist, health insurance premiums at companies with more low income workers average 8% **higher** than at companies with higher income workers. Workers pay for coverage in a variety of ways, all of which are termed "cost sharing" by policymakers. Not all workers pay all these costs, and the costs for workers often vary depending on which benefit plan they choose.

- Premiums – Set monthly amounts, usually deducted from paychecks, not subject to taxes.
- Deductible – Set amount of health care costs that workers must pay before insurance will begin covering costs. Deductibles are generally set (and re-set) annually. 66% of Americans in private coverage plans had a deductible in 2006, averaging $714 for individuals and $1351 for family coverage.
- Copayment (copay) – Flat amounts patients pay for each service. In 2006, 75% of Americans in private coverage had copays averaging $19 for physician visits. Copayments generally vary by service, for instance:
  - Preventive vs. acute care
  - Primary care vs. specialist
  - Generic vs. name brand and formulary vs. non formulary medications
  - By service type -- i.e. dental, vision and in some states mental health services
  - Copays can vary by provider quality or efficiency measures set by the insurer
- Co-insurance – A percentage of service costs that patients must pay. It is not unusual for patients to be responsible for 10% of inpatient hospital costs.
- Annual or lifetime maximum limits – Many policies, especially directly purchased policies, have limits on how much the insurer will cover; patients are responsible for all costs over that amount. These limits are becoming more common. As prices for health care grow, many patients are unaware that they are at risk – patients are often shocked and financially unprepared to learn what $100,000 per year limits doesn't cover.

Private insurance terms to know	
Community rating	A system of insurance pricing found in some states where members in a given area are charged the same rate regardless of age, sex, health history, geography or other personal characteristics. Most states modify community rating systems allowing some variation within categories. CT has modified community rating but only for small group coverage.
Experience rating	A system of insurance pricing based on an individual or group's health history rather than the whole community. CT allows experience rating for large groups and individual policies. This allows insurers to deny coverage or charge very high premiums to individuals with health problems.
Mental health parity	A legal prohibition against charging different costs or offering different coverage for mental care services than for other health services. A federal mental health parity law passed this year, but some states including CT have had stronger laws in place for years.
Cost shifting	The process of shifting costs of caring for patients onto another group. For instance, hospitals are paid less than their costs for patient care under Medicaid and, consequently, charge privately insured patients more for the same services to make up the difference.
Cost sharing	Costs of care borne by workers and patients. There is significant evidence that higher cost sharing, particularly on individual services or medications, reduces utilization and compliance with treatment plans.
Capitation	A flat payment, usually per member per month, paid to insurers by employers (and government) to cover all health care costs. Capitated payments generally vary by at least age, sex and geography. If costs exceed that capitation payment, the insurer loses money and vice versa.
Adverse selection	A theory that people who are at higher risk of needing health care, due to chronic conditions, family history, personal habits, risky jobs, etc., are more likely to purchase health coverage and to assume less financial risk themselves. Insurance companies devote a great deal of resources to avoiding adverse selection and to ensure that they are covering a healthier population.
Moral hazard	A theory that people with insurance alter their behavior because they have coverage, i.e. use more health services than they may need or engage in riskier behavior than they would if they were uninsured.

There is no legal requirement that employers cover any employees except in Hawaii. MA, VT and the City of San Francisco have laws that assess a fee on employers who do not offer coverage to workers and use that revenue to cover uninsured residents (more later when we get to State Health Care Reforms). 44% of employers do not offer health benefits, however that rate varies considerably by firm size. 96% of employers with 50 or more employees offer health benefits, while only 35% of those with ten or fewer employees do (2006).

Even at firms that offer health benefits, only 70% of workers are enrolled. Reasons for turning down employer coverage vary. Workers may not be eligible (part-time or temporary

workers or have not worked for the company long enough to qualify), the coverage may not be affordable, it may not cover what they need, or they may choose to go without coverage.

Insurers and self-insured employers (see below) pay for the costs of care that exceed the payments they collect from workers. Insurers are also required to have large financial reserves, generally held in investments, to cover catastrophic costs of those they insure.

Taxpayers pay a great deal for private insurance, albeit indirectly. Both employers' and workers' share of health premiums are tax-deductible as are consumers' out-of-pocket and premium costs above 7.5% of income. Tax credits at the federal level alone are over $200 billion each year, more than half what the federal government spends on Medicare. People who buy coverage on the individual market do not share equally in these tax breaks. Several proposals to reform the health care system have focused on equalizing the tax benefits of employer-sponsored and directly purchased insurance.

Health insurance has traditionally been regulated at the state level, with one very large exception. Regulation varies significantly between individual policies (few regulations), small groups (most regulated) and large groups (very few regulations). States vary in how they define group size. Other regulations include benefit mandates (i.e. requiring coverage for cancer screenings, contraceptives, or infertility), guaranteed issue and renewal of policies (insurers have to offer anyone who asks a policy and renew it regardless of health history, however there is generally no limit on what they can charge), pre-existing condition exclusions, and direct access to various types of providers. To explore the wide variability in state insurance regulation, go to www.statehealthfactsonline.org, click on Managed Care and Health Insurance.

The major exception to state regulation of insurance is self-insured or ERISA plans. Self insurance is the practice by most large employers of assuming all the financial risk for worker health benefits. Many self-insured employers hire insurance companies to administer health benefits, but the insurer does not take any financial risk for workers' health care needs. Consequently, many Americans are unaware that their employer is self-insuring and that they are not protected by state regulations. The Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from regulating self-insured health plans. ERISA plans are subject to the much weaker consumer protections in federal law. 56% of US employees with health benefits are in self-insured plans; 50.5% of CT workers are in self-employed plans (2006).

There have been numerous proposals at the federal level to pre-empt all state regulation of health insurance and replace it with far weaker federal protections. These proposals have been unsuccessful to date, however they are strongly supported by small business groups. For more on these proposals, go to
http://www.cthealthpolicy.org/briefs/issue_brief_25.pdf.

For more information --
Kaiser Family Foundation's annual Employer Health Benefits Survey (2008)
http://ehbs.kff.org
Tax subsidies for health insurance -- http://www.kff.org/insurance/7779.cfm

Premiums vs. Paychecks: A Growing Burden for Connecticut's Workers, Families USA, September 2008 -- http://www.familiesusa.org/assets/pdfs/premiums-vs-paychecks-2008/connecticut.pdf
Kaiser Family Foundation How Health Coverage Works: A Primer -- http://www.kff.org/insurance/7766.cfm

C) The Uninsured

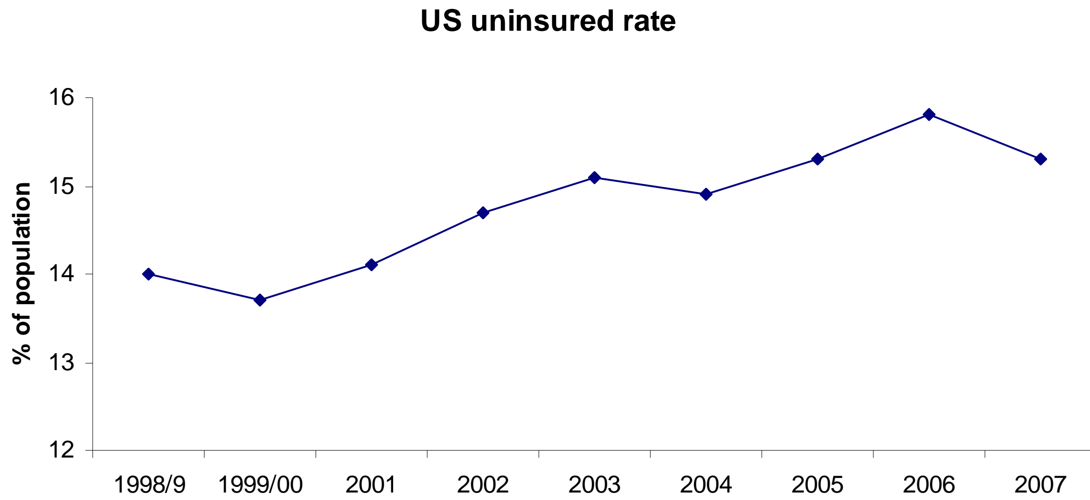
45,657,000 Americans went without any health coverage last year – 15.3% of us. 325,000 CT residents lacked health coverage in 2007 – 9.4% of us.

Myth: Uninsured people don't buy health insurance because they don't think they need it.
Truth: The vast majority are uninsured because they can't afford it or they are not eligible for coverage at work and can't get individual coverage. Only 1.5% of the uninsured report that the main reason they are uninsured is because they don't think they need it.

Who are the uninsured?

- Three out of four uninsured adults is working.
- One in four has a family income under $25,000/year, another 21% have incomes between $25,000 and $50,000; less than 8% have family incomes over $75,000.
- 65% do not have a college degree.
- More likely to be self-employed, part-time and temporary workers.
- Half the uninsured are between the ages of 18 and 34 years.
- Hispanics are three times and blacks twice as likely to be uninsured as white Americans.
- About half of non-citizens are uninsured, but they are not a large proportion of the total uninsured as they constitute a small fraction of the total population.
- The uninsured rate varies significantly by geography – between states and even within communities.
- Many are in poor health; one in five uninsured adults has a chronic condition.
- Most uninsured adults are not eligible for Medicaid – Medicaid is mainly available to families with children, pregnant women, seniors and people with disabilities.

And things are getting worse.



Why is the rate of uninsured Americans rising?

- Health care premiums are rising more than twice as fast as wages.
- Total family premiums have doubled since 2000 and are now more than a full-time minimum-wage worker makes in a year.
- Premiums are expected to rise 8% this year and by double digits from 2010 on.
- 56% of uninsured Americans are not offered benefits at work and another 14% are not eligible.
- Job creation has been heavier in small businesses and the service sector – the least likely to offer health benefits.
- More employers are hiring part-time workers; only 35% of CT part-time workers are eligible for health benefits
- Between 2004 and 2006, the number of uninsured increased by 3.4 million despite the improving economy; employer sponsored insurance rates failed to recover from the economic slump of 2000 to 2004.
- Medicaid expansions did not reach young adults who are generally not eligible and the most likely to be uninsured.

How does it matter if people aren't uninsured?

- It's not healthy to be uninsured.
    - The uninsured are seven times more likely to forgo needed health care because of cost.
    - They are six times more likely not to fill a prescription due to cost.
    - The Institute of Medicine estimated that 18,000 Americans died in 2000 because they were uninsured.
- It's not cheap to be uninsured.
    - Over 14% of the uninsured spend over 10% of their income on health care.
    - One third of the uninsured report cutting back on other basic needs such as food and heat to pay medical bills.

- Only one in four uninsured adults with incomes under 200% of the federal poverty level receives free medical care.
  - Most are charged two to four times what public programs pay for services.
  - Half of US bankruptcies are a result of high medical bills.
  - 18% of the uninsured report being contacted by a collection agency in the past year over unpaid medical bills.
- It's not good for communities where many people are uninsured.
  - Taxpayers fund 75% of the cost of care for the uninsured -- $43 billion this year.
  - Communities with high numbers of uninsured have fewer health care resources including fewer hospital beds and are less likely to offer trauma and burn care.
  - Public health hazards of large numbers of people who do not have access to regular health care.

However, it is very important to note that coverage does not guarantee access to care. It is estimated that in 2007 in addition to the 46 million uninsured, there were 25 million underinsured Americans, up 60% from 2003. Underinsurance is defined as spending more than 10% of income on health care or having a deductible that exceeds 5% of income. Underinsured Americans face similar challenges accessing and paying for care as the uninsured. 53% of underinsured Americans report missing needed care, in comparison to only 31% of the insured. Almost half the underinsured report difficulty paying bills, being contacted by a collections agency or changing their way of life to pay medical bills. Many take on loans, mortgages or credit card debt to pay for health care.

As the number of uninsured and underinsured grows and the burden on the US health care system and economy increases, proposals to address the problem multiply. Later, we will explore the reforms being implemented in three leading states.

1) Individual mandates – Health insurance works by spreading the costs of care for those who need it over a large population including the majority of us who are lucky enough to be healthy. An individual mandate is a legal requirement that everyone purchase coverage, not allowing healthy people to game the system and only purchase coverage when they become sick. Unfortunately, there is little evidence that it will work as planned and could have damaging unintended consequences, would incur large enforcement costs and divert attention from constructive health system reforms. For more on individual mandates and CT go to http://www.cthealthpolicy.org/pdfs/200812_issue_paper.pdf.
2) Expand Medicaid/SCHIP income eligibility limits – The lure of matching federal funding makes this a popular option for states. Medicaid and SCHIP programs include comprehensive benefit packages at historically low per person costs making this even more attractive. These expansions have been very effective in expanding coverage and access to care for low income families and children.
   a. Allow the uninsured to buy into Medicaid/SCHIP – Recently implemented in CT, the Charter Oak Plan allows individuals who have been uninsured for six months to purchase coverage through the same HMOs as the state's HUSKY plan. There are deductibles, copays, premiums and coinsurance for

Charter Oak members, with subsidies for low income applicants. The six month exclusion is designed to avoid "crowd out", a concern that people (or businesses that employ them) will drop private coverage to purchase Charter Oak.

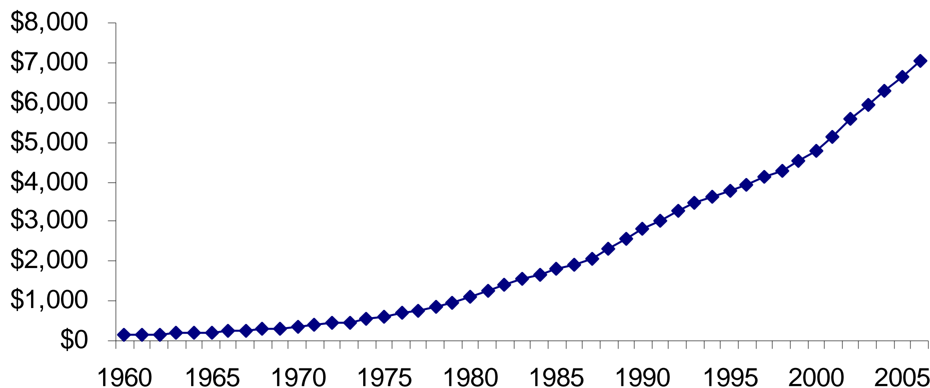
3) Tax credits – Popular with free market advocates, this option gives businesses (often small businesses) and/or individuals credits against taxes to purchase private coverage. Tax credits have not been successful in the past – as uninsured individuals tend to be low-income, tax liability is not a salient issue, and fairness dictates that credits be applied to the 56% of businesses that already offer health benefits, creating large expenses that do not improve coverage rates.
4) Pooling – The idea is to pool the risk of a large number of uninsured, usually together with large insured populations, to spread financial risk and administrative costs providing more stability and affordability. Pooling has a mixed record of success of modestly reducing costs and expanding availability in some cases.
5) Bare bones policies – Mandated insurance benefits and regulations are often blamed for increasing the costs of coverage, particularly favored by the insurance industry. Proposals to exempt some policies from mandated services have been implemented in some states. Unfortunately these minimal plans have not reduced costs much and are not popular with consumers.
6) Consumer directed health plans (CDHPs) – Price insensitivity of consumers for the cost of health services has been blamed for rising prices. When patients pay the same $25 copay each for services with costs that may vary from $50 to $500 depending on the provider, economists are concerned that consumers have no incentive to make the most efficient choice. CDHPs combine high deductible coverage with Health Savings Accounts (HSAs) that force consumers to pay out of pocket for most routine health costs, at least partially with a tax-free account, but protects them from catastrophic expenses. Early research suggests that CDHPs provide some savings, but are most attractive to higher income, healthier consumers – not those who have the most trouble getting coverage.
7) Safety net expansions – The idea here is to ignore coverage and build more places for the uninsured to access affordable, quality care directly. Safety net providers are those institutions and providers who provide care to anyone, regardless of ability to pay. Most offer subsidies for low income patients. This has broad support across the ideological spectrum.
8) Employer mandate – A requirement that employers offer health benefits, usually with exemptions for small businesses. MD's employer mandate was overturned in federal court as violating ERISA. The only state with an employer mandate currently is Hawaii, which received an exemption in the ERISA law when it passed. As you will see under State Reforms below, to avoid ERISA some states have created assessments (taxes) on employers who do not offer health benefits and used that funding to cover the uninsured. Those arrangements have not yet been tested in court.
9) Single payer – This proposal would integrate the entire US health care system under one governmental payer supported by taxes. The proposal could mirror Medicare for everyone or the Canadian or British systems.

For more information –
CT Health Policy Project brief on the uninsured --
http://www.cthealthpolicy.org/briefs/issue_brief_45.pdf
Kaiser Family Foundation Uninsured Primer
http://www.kff.org/uninsured/7451.cfm
US Census – latest numbers – this is the gold standard for measuring the uninsured
http://www.census.gov/prod/2008pubs/p60-235.pdf
Commonwealth Fund on the underinsured
http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=688615

Racial and ethnic disparities --
Racial and ethnic minorities in the US are more likely to suffer poor health and difficulty accessing care, even within income categories. While minorities are more likely to be uninsured, other factors are also significant. For more on these factors and the effects, go to http://www.kff.org/minorityhealth/6069.cfm

D) Health Care Financing

America's health care system financing is expensive and fragmented with payers seeking to shift costs onto each other. In 2007 Americans averaged $7,421 per person on health care; that amount is up 50 fold since 1960.



Source: CMS National Health Expenditure Accounts,
http://www.cms.hhs.gov/NationalHealthExpendData

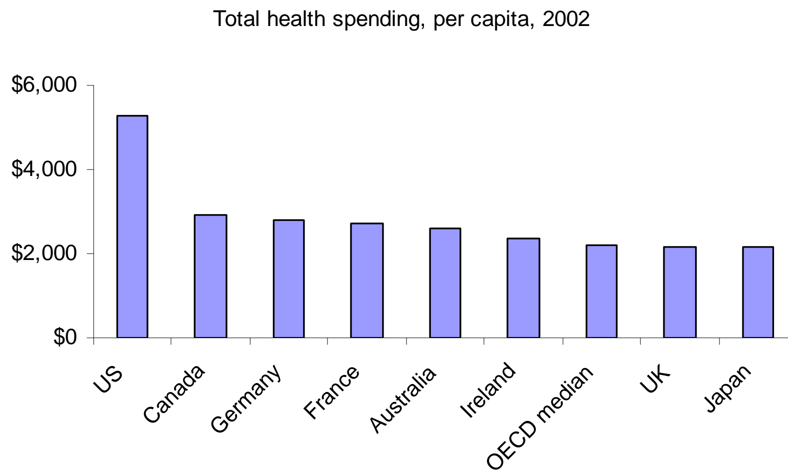
A small proportion of Americans account for a large share of health care spending. Almost half of US health care spending was used to treat only 5% of Americans with health

expenses over $13,387 in 2004. Seniors average seven times the spending of children per year. Women average 31% more health care spending in a year than men.

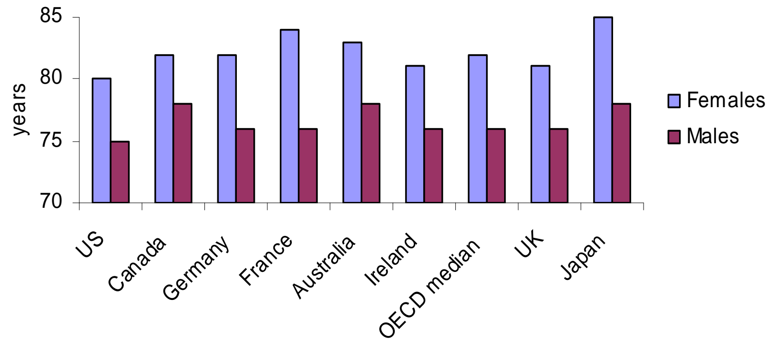
Why is health care so expensive?

- Because we choose to spend more on health care – wealthier countries can afford to spend more and health is highly valued by consumers
- The US population is getting older but this often-cited factor is estimated to account for only 2% of the increase in health care spending
- The rising incidence of chronic diseases is a significant driver of health costs. Obesity alone accounted for 27% of the rise in per capita health spending from 1987 to 2001.
- According to the Congressional Budget Office, the major driver of rising health costs, accounting for 38 to 65% of rising costs, is improving technologies and services. Some medical advances are critical to improving health outcomes but some have little or no clinical value. As yet, there is no generally accepted methodology to determine which are cost effective and should be adopted.

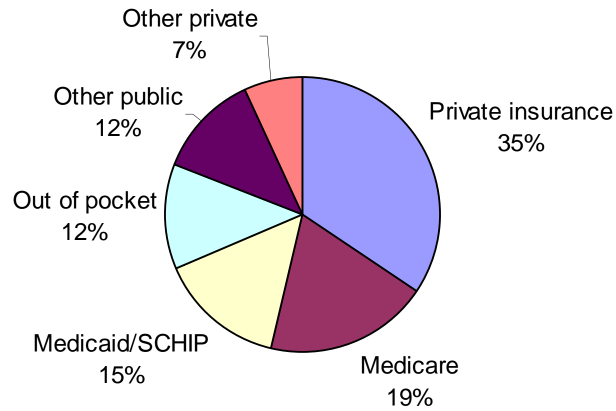
Americans spend more per person for health care than any other country. 16.2% of our economy is devoted to health care. That share is rising and expected to reach 19.5% by 2017, far higher than in other developed countries. Economists are concerned that we cannot sustain that trend without compromising other areas of the economy.



Many Americans feel that although we pay more than other countries that we have the best health care system in the world. In some respects that is true, but overall our health outcomes do not match the rest of the world in important respects.

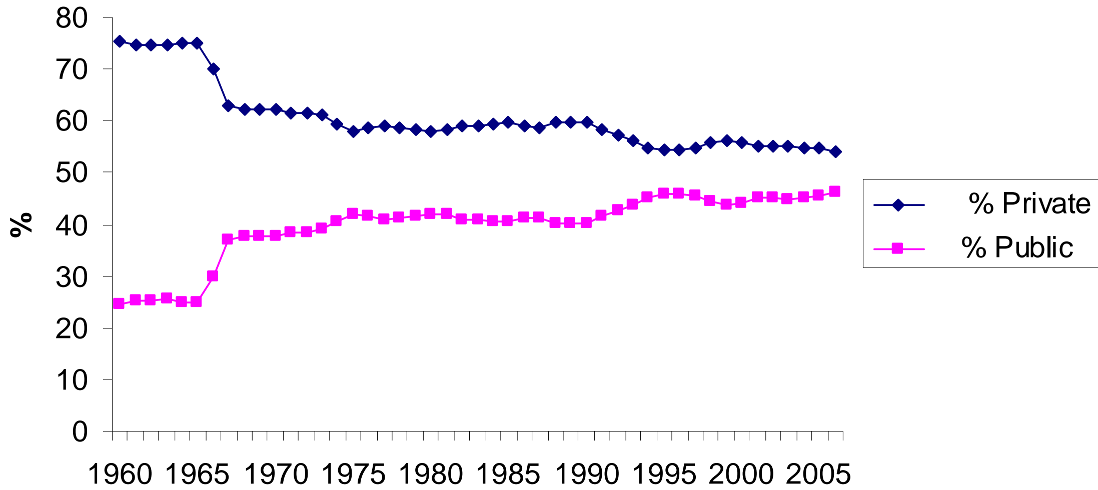


In 2006 America spent just over $2.1 trillion on health care. Where did it come from?

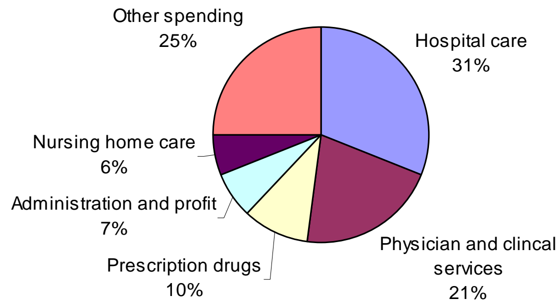


Source: CMS, National Health Accounts, 2006

Over the years, the proportion of health care paid for with tax dollars has grown significantly and private funding has
fallen.



Where did our health care dollar go?



Source: CMS, National Health Accounts, 2006

What proposals are being considered to reduce the growth in health care spending?

- Evidence based medicine.
- Wellness, disease management programs and other consumer incentives for healthy living.
- Electronic medical records and information sharing.
- Improving provider effectiveness – i.e. pay for performance.

- Consumer Directed Health Care (see above) and other means to make consumers sensitive to health care prices, to reduce demand for services.
- Policies to assess cost benefit of new technologies before adoption.
- Reducing geographic differences in treatment that do not affect quality of care.
- Re-aligning payment incentives to emphasize prevention, primary care and care management and away from episodic, expensive, acute care services.

For more information --
KFF primer on health care costs -- http://www.kff.org/insurance/7670.cfm
CMS—National Health Accounts -- http://www.cms.hhs.gov/NationalHealthExpendData
K. Thorpe et. al., *The Impact of Obesity on Rising Medical Spending*, Health Affairs Web Exclusive, 10/20/04,
http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.480v1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Thorpe&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT
Commonwealth Fund on international comparisons of preventable deaths --
http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=640980

E) Health Care Reform Prospects

> We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of the Nation.
>
> - President Harry Truman, Special Message to the Congress Recommending a Comprehensive Health Program, Nov. 19, 1945

After many years of gridlock and no progress on health reform nationally, there is renewed hope with the new administration. Numerous national health reform proposals are gaining traction. At this point, there has been no clear plan but there are hints. In his campaign, President Obama favored a public-private mixed model allowing Americans who are happy with their coverage to keep it but offering a publicly regulated but privately administered alternative as well. He also favored expansions of successful public programs such as SCHIP. Recently Congress has passed a moderate expansion of SCHIP, previously vetoed by President Bush and President Obama has indicated that he will sign it. Details of the rest of the plan are still unknown including levels of subsidy for low income Americans, employer and individual responsibilities, comprehensiveness and structure of the plan(s).

More reading on prospects for national health reform:
J Oberlander, Great Expectations – The Obama Administration and Health Care Reform, *NEJM*, 1/22/09, http://content.nejm.org/cgi/content/full/360/4/321

Sen. Max Baucus' plan for health care reform
http://finance.senate.gov/healthreform2009/home.html

Tom Daschle, Critical: What We Can Do About the Health-Care Crisis, St. Martin's Press, 2008, http://www.amazon.com/Critical-What-About-Health-Care-Crisis/dp/0312383010/ref=pd_bbs_sr_1?ie=UTF8&s=books&qid=1227117431&sr=8-1

In the absence of progress to reform the health care system at the federal level, some states have been developing and implementing reforms of their own. Massachusetts, Maine and Vermont are leaders in these reforms. All three states have long histories of strong public support prioritizing health care issues and important earlier initiatives to cover the uninsured.

Maine -- Passed in June 2003, the Dirigo Health Plan has provided about 29,000 Maine residents with affordable, comprehensive health coverage. Maine has a long political history of addressing health coverage for everyone. Dirigo is a public-private pool providing affordable, comprehensive coverage for individuals and small businesses through a private, non-profit HMO on a sliding fee scale. Maine includes neither an employer nor an individual mandate. Dirigo is part of a larger reform agenda including cost containment, quality improvement, insurance market reforms, Medicaid expansions, and access to care. The plan includes strong disease management and health promotion initiatives. The plan is funded by premiums paid by consumers, state taxes, federal matching funds, and assessments on insurers from the savings resulting from insuring more state residents. Dirigo reforms saved Maine $44 million in health care spending in the first year. For more go to, www.dirigohealth.com.

Massachusetts – Prompted by the potential loss of $385 million in federal funding, in April 2006 Massachusetts passed initial reforms designed to cover as many state residents as possible through a state regulated private pool. As a result of reforms, the uninsured rate in Massachusetts dropped from 13% to 2.6% (summer 2008). The state created the Commonwealth Health Insurance Connector to organize affordable insurance options. Other reforms included Medicaid expansions, increases in provider rates, insurance market reforms, premium subsidies for low income residents, and an assessment on employers who do not cover workers. MA is the only state to date with an individual mandate. Last year the state passed new reforms to contain health care costs and increased taxes on cigarettes to fund the reforms. For more, go to www.**ma**ss.gov/dhcfp

Vermont – Passed in May 2006, Vermont's reforms built on a Medicaid waiver giving the state flexibility in plan design and enhanced financing. Catamount Health provides state regulated private insurance options for uninsured residents with sliding scale premiums. VT also includes a strong emphasis on managing chronic illness for all state residents, not limited to Catamount Health Plan members. Vermont includes an assessment on employers who do not cover workers, but no individual mandate as yet. VT also increased cigarette taxes to fund the reforms. Reforms also include healthy lifestyle insurance discounts, free immunizations for all state residents, and a significant investment in health information technology. As of November 2008, Green Mountain Care (including Catamount Health) had 7,378 members. For more information go to http://hcr.vermont.gov.

For a comparison of the three states' reforms go to http://www.cthealthpolicy.org/briefs/issue_brief_27.pdf.

Kaiser Family Foundation Approaches to Covering the Uninsured –

http://www.kff.org/uninsured/7795.cfm

F) Role of States in Health Care

Responsibility for health care policy is predominantly at the state and federal levels of government. But states have a special role being closer to providers and consumers, closer to local health care systems and culture. Advocates can have enormous impact in state level policymaking, because state capitols are closer, have fewer state policy staff who then have to rely on community resources and information sources, and state elected officials are more accessible than federal representatives.

States have critical roles in policymaking including:

- License and regulate health care providers and institutions.
- Limit expansions and reductions in size and services provided by health care institutions.
- Finance and administer health care for large numbers of residents. Between Medicaid, state employees and retirees, corrections and safety net programs state governments are generally the largest purchaser of health care in their states.
- Regulate environmental health hazards and standards.
- Fund and administer public health programs.
- Set policy and administer important federal health programs such as Medicaid, Title V and health related block grants.
- Fund and administer safety net programs.
- Educate and subsidize the education of health workers in public schools and universities.
- Regulate health insurance and insurers.
- Regulate and fund local health departments.
- Coordinate and fund electronic health interoperability standards and initiatives.

For more reading –
The Commonwealth Fund on states' roles in high performing health systems --
http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=676496
And
http://www.commonwealthfund.org/statescorecard/

G) Advocacy – So what are busy citizens supposed to do with all this? How do you make a difference?
It's far easier than you imagine.

First, **VOTE**. It's often said -- if you don't vote, you don't get to complain. For a small sample of how important health care was in last year's Presidential race, go to http://www.health08.org/.

Next, get involved. There are dozens of advocacy groups to join, newsletters to sign up for, websites and blogs to visit – there is no lack of resources. Finding one that fits your needs,

your values and your interests can be a challenge, but keep at it. If you aren't happy with a group's focus, pay your dues and move up into leadership.
You can also have enormous impact by being appointed to state policymaking councils and task forces. Most have openings and it is not difficult to get appointed. But once you become a member, it is critical that you show up and stay active in the work; don't just consider it a resume-builder.

Some general tips on advocacy:

- It's all about relationships. Think about the long term and meet them where they are. It's about their point of view, not your own.
- Be polite. These are busy people with a lot of demands on their time and attention.
- Be brief. Get your message down to an elevator ride.
- Be helpful. Find out what they need – votes, research, information, an invitation to your next event, etc.
- Be patient. It is rare that a bill or program passes the first year it is proposed. And generally that is a good thing. The world works pretty well – it should be hard to change the rules.
- Your issue is a priority for you, but it isn't for everyone. This includes policymakers, lobbyists and other advocates.
- Be prepared. Have numbers to justify your position, but stories of people who are affected and the impact of your issue are far more compelling.
- Be persistent. Always follow through. Nothing is more effective. This is the secret weapon of advocacy.

Things to understand:

- The difference between elected officials, political appointees and civil-service style bureaucrats. They all have important roles, but respond to different constituencies.
- You cannot underestimate the importance of staff. They generally outlast legislators, they are full time when most state legislators aren't. They have the luxury of immersing themselves in issue areas. Policymakers rely on and trust their staffs. They can be your best ally.
- Research the system to learn what you really need. Passing a bill is a waste of time if what you really need is money in a program, or a change in regulation, or if the bill you pass never gets implemented. Think with the end in mind.
- Consider public opinion. Getting press attention to your issue helps drive policymaking.

For a state health advocacy toolbox including processes and tools for legislative and administrative advocacy, budget, coalitions, and media, go to http://www.cthealthpolicy.org/toolbox.

Now you have all the tools – go make the world a better, healthier place.