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PRAIRIE UNITARIAN UNIVERSALIST SOCIETY

February 6, 1994

HEALTH FOR ALL?

Prelude

Welcome, Julia Bonser, President

Song: Reverence for Life, #11 (Prairie Song Book)

Chalice Lighting

Joys and Sorrows

Responsive Reading: #651, The Body is Humankind

"Problems of Access," Cindy Haq

"Health Care Reform: With or Without Us," Gary Giorgi

Song: We Celebrate the Web of Life, #175

Offering

Introduction of Guest and Visitors

Announcements

Closing Comments

Ask: loans, forgiveness (des. v. other?) – How many actually take advtg. of this? – bel: there's a trade-off

Handout fr. Cindy & Gary's seminar on health care
2-06-94

can we do it adeqtly w/o some govt. controls, oversight?

Perceptions Influencing Reform

health care as a commodity "obscene"

1. Government should have (no/some/the lead) role.

2. Financing should be market driven or managed.

3. Professional groups have (all/many/few/no) answers.

4. Technology is the (problem/solution).
surplus... or lack?

5. The medical system (can/cannot) heal itself. alone?

⑥ We (expect/can't have) everything for nothing. – who decides (or how is it decided) who gets what?

7. We (are/are not) the best.
Define "best."

8. Alternative health care systems (are/are not) part of the equation. alternative
1) what do we mean by "health care"
2) would they be more or less costly?
3) who decides?

9. Abortion (should/ should not) be part of a national health care system.

Health Care Update

By Kathy Boyles

President Clinton's health care proposal (Health Security Act), was introduced in Congress on November 20. The House has finally decided that three committees will handle each health care reform proposal as a "joint" referral - Ways and Means, Energy and Commerce, and Education and Labor. A "joint" referral means that one committee does not have to wait for the other to act. Seven other committees will also have something to say about specific aspects of the bill. The Senate hasn't decided yet how to handle the various health reform bills. *Action Alert:* **Rep. Scott Klug sits on Energy and Commerce; Rep. Gerald Kleczka sits on Ways and Means; Rep. Tom Petri and Rep. Steve Gunderson sits on Education and Labor. These Wisconsin representatives will have early power in decision-making on health care proposals and need to hear what we expect from health care reform! Become informed on health care reform, talk to your congressional representatives! Contact Madison NOW for more detailed information on the specific plans.**

As of early November, the Wisconsin delegation's positions were as follows:

- Single-payer plan (Rep. McDermott's H.R. 1200 and Sen. Wellstone's S.491 - The American Health Security Act) - no Wisconsin member supports this (yet).
- The Clinton Plan (Rep. Gephardt's H.R. 3600 and Sen. Mitchell's S. 1757) Rep. Obey
- Managed Competition Plan (Rep. Cooper's H.R. 3222 and Sen. Breaux's S. 1579) - Reps. Gunderson, Petri, Sensenbrenner and Klug. "Undecideds" - Senators Kohl and Feingold, and Reps. Barca, Kleczka, Barrett and Roth.

As stated in the December issue of Equality NOW, a single-payer plan that provides universal access is the best plan for women and children. The most obvious question is..How can we pay for this? And the obvious answer is... We can't afford not to. Specifically, the McDermott/Wellstone plans start with 1993 costs as a baseline. The plans begin with the assumption that the level of spending will continue, but that it will be allocated in more equitable and sensible ways. While these plans extend health care benefits to millions who do not now have access to the system, this expense should be covered by savings realized from the elimination of 1500 different health care insurance plans from the market. Savings will also occur due to the wider availability of preventative care. (It's much cheaper to prevent the need for expensive medical services with good preventative health programs.) Secondly, single-payer plans would set a "global budget" which would include all health care spending in the nation. The global budget would be allowed to increase only as much as the GNP increases each year. Finally, states would negotiate budgets with providers, including fee-for-service standards, and "capitated rates" for institutions. States would also negotiate with suppliers for drugs and medical supplies and equipment. Once these budgets were set, the providers would be required to accept the state's payment as the full payment. Health care consumers could not be charged additional fees.

Like many other health care professionals, I have been pushing for health care reform for years. If our health care system is not going to be available to everyone, then we shouldn't waste any more time on this topic - nothing short of universal access will reform health care and improve our nation's health.

Comparison, continued

Feature*	Administration plan	Single-payer plan	Market-oriented plan
Cost-control features	Caps on insurance premiums and Medicaid/Medicare spending; controls on care through guidelines and limitations	National budget tied to gross domestic product; limits on drug prices and capital spending; controls on care through guidelines and limitations	Thrift incentives for patients, tort reform (see below)
Cost-containment incentives for patients	$10 copayment in most cases; deductibles in fee-for-service plans; no other incentives	No copayments, deductibles, or other incentives	Tax-free medical savings accounts provide incentive to spend sparingly; unspent funds can be used for non-medical purposes, subject to taxation
Cost-containment incentives for physicians	Capitation limits incentive to provide best care	Fee-for-service approach may mean little incentive for restraint	Direct payments by patients (through medical savings accounts) provide incentive for competitive pricing and better service
Probability of general tax increases	High, according to most observers	Plan explicitly calls for increases	Some increase may be necessary to provide care for poor
Physician payment method	For most, capitation or salary set by health plans, though price-controlled fee-for-service plans may be allowed	States to pay on fee-for-service basis, with fees based on RBRVS, or by capitation in managed-care plans	Little change from present
Practice guidelines	Establishment of guidelines by panels and committees is obvious throughout plan	Federal panel to develop guidelines to be used in state quality reviews	Medical decisions left to physicians
Tort reform	Patients must use alternative dispute resolution process, but can go to court if they dislike result and if independent physician agrees claim has merit; attorney fees limited to 1/3 of damage award (current practice)	None	Loser in court must pay winner's legal costs; $250,000 cap on noneconomic damages; lawyers' contingency fees capped at 25%; no punitive damages against makers of drugs approved by FDA
Rationing	Guarantee of universal care makes virtually certain	Virtually certain, as in Canadian system	Unlikely

RBRVS, resource-based relative value scale.
*All plans have provisions for administrative streamlining and protecting insurance coverage for job changers and persons with preexisting conditions.

sicians and the concept of a fee-for-service system, but would put these fees under government control and impose other guidelines and controls to keep costs within the mandated national and local budgets.

Under the single-payer plan, the government would collect higher taxes to take the place of insurance premiums, copayments, and deductibles. The plan

continued

A comparison of three healthcare reform plans

Feature*	Administration plan	Single-payer plan	Market-oriented plan
General approach	Employers required to provide insurance and pay 80% of cost; they buy coverage through regional or corporate alliances (pools) that seek best rates. Networks of providers compete for business. Self-employed and jobless get coverage through regional pools	Single-payer, Canadian-style system: universal, comprehensive care is financed by federal government and managed by states	Employers must offer, but not pay for, insurance; employees choose either conventional plan, managed care, or tax-free medical savings account they can use to buy their own insurance and pay out-of-pocket costs. Also expands deductibility of insurance costs for those who pay their own, and makes it easier for small businesses and organizations to form insurance pools
Who is covered?	Everyone	Everyone	More people likely to be covered than at present, but insurance not a legal obligation. However, financially able must buy insurance to qualify for federal assistance
Benefit package	Federally mandated	Federally mandated	No government standard
Responsibility	Employer (mandated by government)	Government	Individual
Provisions for the poor	Medicaid buys coverage through regional pools	All are covered, with no out-of-pocket cost	Federal credits to pay for insurance covering preventive care and major expenses (for low-income persons ineligible for Medicaid)
Other subsidies	Working poor to get help paying premiums, copayments, and deductibles; small employers get some help paying insurance costs	Entire plan paid by taxes	Persons with preexisting conditions receive subsidies to cover insurance costs more than 50% higher than average
How much government?	Seven-member national board, with advisory committees and complex bureaucracy, manages entire system by setting global budget, premium caps, and benefits; states regulate provider networks (health plans)	Seven-member national board governs system with help of advisory committees; states manage operation under federal rules	Apparently little increase
Money sources	Mandatory premium payments by employers (about 80%, up to 7.9% of payroll) and employees (up to 20%), $10 copayments, shift of Medicaid/Medicare costs to health alliances, increase in cigarette tax, benefit cuts for federal workers	7.9% payroll tax; increases in personal and corporate income taxes; increase in Medicare premiums and taxable portion of Social Security benefits; taxes replace insurance premiums and out-of-pocket costs	Employer and individual contributions; reductions in growth of Medicare and Medicaid costs; taxes on employee benefits above certain levels