

**HealthCare**  
Chaplaincy  
Finding Meaning ♦ Bringing Comfort

# **Health Care Reform: A Compendium of Key Issues for Religious Leaders**

**The Rev. Walter J. Smith, S.J., Ph.D.  
President & CEO, HealthCare Chaplaincy  
Partnership of Faith in New York City  
10 September 2009**

# INTRODUCTION

**HealthCare**  
Chaplaincy  
Finding Meaning ♦ Bringing Comfort

## **HEALTH CARE REFORM: AN HISTORICAL CHALLENGE AND MORAL IMPERATIVE**

# Navigating Through the Scylla & Charybdis of National Health Care Reform



- A wonderfully apt image—drawn from Homer’s *Odyssey*—for understanding the *zeitgeist* of the 2009 health care reform legislative process
- The phrase "between Scylla and Charybdis" (or “between a rock and a hard place”) has come to mean being in a state where one is between two dangers and moving away from one will cause you to be in danger from the other
- Translated in terms of health care reform challenges: **Scylla:** what some of us currently have (and many don’t) and increasingly can’t afford; **Charybdis:** how we are proposing to change it and pay for it.

# “It’s déjà vu all over again!”



## HEALTH REFORM DEBATES FOLLOW PATTERNS

- In *The Washington Post* (8/26) Brown University professor James A. Monroe writes that *"every time health reform comes up...the rhetoric runs long, loud, and hysterical. Why so hot? Because big health reforms always play out on three different levels—every one of them a killer."*
- “The debates rest on honest philosophical differences: **Basic rights vs. market competition, communal good vs. private responsibility, government provision vs. private insurance.**”
- The debates, however, also "provoke intense symbols about the state of the nation—barely tethered to the specific proposals at hand: the triumph of socialism, the death of free enterprise, the iron rule of the bureaucrats or the cool murder of innocents.”
- Lastly, "as if all that were not enough, the battle for health reform invariably becomes a battle for political control."

# A FAITH-INSPIRED VISION OF HEALTH CARE



- Many faith leaders see health care reform as an **ethical and religious imperative**
- People of faith envision a society where each person is afforded **health, wholeness and human dignity**
- We envision a system of health care that is **inclusive, accessible, affordable and accountable.**

*Source: <http://www.faithfulreform.org>*

# VISION: INCLUSIVE



- **Health care is a shared responsibility that is grounded in our common humanity. In the bonds of our human family, we are created to be equal. We are guided by a divine will **to treat each person with dignity and to live together as an inclusive community.****
- **Affirming our commitment to the common good, we acknowledge our enduring responsibility to care for one another.**
- **As we recognize that society is whole only when we care for the most vulnerable among us, we are led to discern the human right to health care and wholeness.**
- **Therefore, we are called to act with compassion by sharing our abundant health care resources with everyone.**

# VISION: AFFORDABLE



- Health care must contribute to the common good by being affordable for individuals, families and society as a whole.
- We believe that in the sacred act of creation we are endowed with the talents, wisdom and abundant resources necessary to meet the needs of one another, including the health care needs of all.
- Therefore, in our calling to be faithful stewards, we understand our responsibility to use our health care resources effectively, to administer them efficiently, and to distribute them with equity.

# VISION: ACCESSIBLE



- All persons should have access to health services that provide necessary care and contribute to wellness.
- We believe humanity is sacred and that all persons should benefit from those actions which contribute to our health and wholeness.
- Therefore, we are called to act with justice and love, to ensure that all of us have access to the health care we need in order to live out the fullness of our potential both as individuals and as contributing members of our society.
- We must work together to identify and overcome all barriers to and disparities in such care.

# VISION: ACCOUNTABLE



- **Our health care system must be accountable, offering a quality, equitable and sustainable means of keeping us healthy as individuals and as a community.**
- **We believe that as spiritual and sacred vessels, we are responsible for the care of our bodies to the best of our ability and for the care of one another regardless of individual circumstances.**
- **Therefore, individuals, families, governments, businesses, and the faith community are called to work in partnership for a system that ensures fully-informed, timely, quality and safe care that treats body, mind and spirit.**

# President Obama's Original Goals in Proposing Health Care Reform



- **Insuring all Americans (or nearly everyone)**
- **Restraining the growth of health care costs**
- **Improving quality of care**

# President Obama's Call to Action of Religious Leaders (19 August 2009)



***“I need you to spread the facts, and speak the truth. Time and again, men and women of faith have helped to show us what’s possible when we’re guided by our hopes and not our fears.”***

# The National Challenge

**HealthCare**  
Chaplaincy  
Finding Meaning ♦ Bringing Comfort

## DEFINING THE ISSUES

# The *mise-en-scène* of Health Care Reform



- The health care debate has been mainly focused on patching the biggest hole in the existing system by covering the uninsured.
- That repair may not be sustainable—politically or financially—unless the legislation also moves more boldly to begin building a smarter, more affordable and accessible health care system for the new century.

# President Obama “In His Own Words”

(16 August 2009-NYT)



**“There are 4 main ways the reform we’re promising will provide more stability and security to every American.**

**First, if you don’t have health insurance, you will have a choice of high-quality, affordable coverage for yourself and your family— coverage that will stay with you whether you move, change your job or lose your job.**

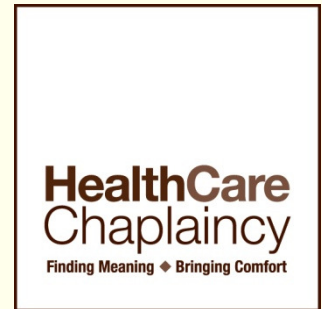
# Pres. Obama (continued)



Second, reform will finally bring skyrocketing health care costs under control, which will mean real savings for families, businesses and our government.

Third, by making Medicare more efficient, we'll be able to ensure that more tax dollars go directly to caring for seniors instead of enriching insurance companies.

# Pres Obama (concluded)



**Lastly, reform will provide every American with some basic consumer protections that will finally hold insurance companies accountable.**

# Reigning in Health Care Costs



- **Currently, there is nothing in the various reform bills that can rein in uncontrolled inflation of health care costs**
- **They lack significant cost-containment mechanisms**
- **They deal only with federal spending on health care, not total health care spending, or that which patients will pay**

# Will Health Care Reform Make a Real Difference?

## The simple answer is YES !

- If health care reform legislation is enacted, one in six children and non-elderly adults in our country will no longer have to live sicker and risk dying younger because they cannot get needed health care.
- Medical expenses will no longer be a cause of financial ruin for families, individuals, institutions, businesses, and governments.
- All of us will have the quality health care we need regardless of our age, income, race, gender, pre-existing conditions, sexual orientation or place of residence.

# Will it happen?



- As a nation we have never made a national legislative commitment to guarantee needed health care for everyone who lives here.
- We argue about whether we should increase access, reduce costs, add or reduce benefits in public programs, increase income eligibility for public assistance, institute cost controls, improve delivery, and more.
- We seem to lack a moral vision and the political will to use our abundant resources in the service of the common good.

# The Paradox: “We know it’s broken, but we are afraid to fix it”



As Americans, we have a somewhat schizophrenic attitude toward health care

- We know the system is ineffective, frustrating and much too expensive
- We complain about it all the time, yet we can't quite let it go
- Yet, we are afraid to change it

# RESISTANCE TO CHANGE

# Why do some Americans resist health care reform?



## We tend to “romanticize” health care

The clinical discussions of cost-effectiveness, reimbursement rates, insurance exchanges and best practices that go along with the health debate are wholly at odds with our cherished memories of and bonds with the doctor who used to make house calls . . .

Most of us have no earthly idea how much we're paying for health care, which is even more costly than most realize. Thus, we are stunned confronted with reform plans that lay out the costs, not just the new ones, but the existing ones. We get “sticker shock.” It's very hard to evaluate the alternatives being discussed because we don't fully understand how expensive health care already is.

# Is there Consensus on the State of Health Care in America? YES & NO



- People know that health care costs are rising faster than personal incomes and economic growth
- Even the health care insurance industry agrees that much of our health care dollar is being wasted, exposing patients to unnecessary risk
- Overall, Americans favor improving care and generating economic savings by incentivizing best practices
- Nonetheless, there is less support for sweeping health care reform than one might reasonably expect

# Reality Check: The Escalation In Health Care Insurance Premiums In The Last Decade & We Still Resist Change



- Family premiums for employer-sponsored health insurance increased 119% between 1999 and 2008, and they could increase another 94% to an average **\$23,842** per family by 2020, if the current pace of cost growth continues.
- National reforms that slow health care cost increases by 1% to 1.5 % per year (through a public plan or insurance cooperatives or another effective option for controlling both medical outlays and insurance administrative overhead) would yield substantial savings for families and businesses across the country.

# Why do some Americans resist health care reform? (continued)



- It's mostly an accident of history that America has a health-care system in which **employers pay most of the cost of insurance**. Why? Because the government decided to exempt health insurance from wage and price controls during World War II. That meant companies couldn't give raises to attract workers, but could offer health benefits to do so. Then the government decided that neither employers nor employees had to pay payroll taxes on the money spent on health benefits, thereby **enshrining health insurance as the leading employee benefit**.
- Today, there is a **deep fear** of both the notion that individuals would be better off fending for themselves (the conservative impulse) or that the federal government ought to take over the job (the liberal impulse). Those are the two starkest alternatives to the *status quo*, and **both approaches scare people**.

# Why do some Americans resist health care reform? (continued)



- **As a nation, we Americans are deeply cynical about government's ability to do anything right.**
- **To overhaul health care inevitably involves a bigger role for government in, if nothing else, setting standards and policing the market.**
- **Here's where lots of Americans fall off the reform bandwagon.**
- **A survey this summer by the Gallup reported that 36% of their sample expressed confidence in the medical system, ranking it in the middle of the broad range of American institutions that were tested. But a mere 17% said they have confidence in Congress, which is where any health overhaul would be created, putting lawmakers second from the bottom on Gallup's list (just a slight bit above big business).**

# Why do some Americans resist health care reform? (concluded)



- The **health system** isn't just something that provides medical care; it's now also the **largest industry in the land**. It provides more than 14 million jobs, the Bureau of Labor Statistics tells us, and 7 of the 20 fastest-growing occupations are health-related. More than that, health care will generate a staggering **three million new wage and salaried jobs in the next decade or so**, more than any other industry.
- Health firms, drug companies, hospitals and others within the current health-care system have such a big stake in it that they are investing a lot of money defending that stake. In short, problematic as the system may be, **lots of people have a direct economic stake in it**. Any wonder they don't like the idea of a leap into the unknown?

# THE UNITED STATES GOVERNMENT & HEALTH INSURANCE

# The Role of Federal Government in Health Care

- As in all industrialized nations, the U.S. government already plays a large role in the financing, organizing, overseeing—and in some instances—even delivery of health care. **Nonetheless, any proposed health reform legislation would clearly change the *status quo*.** A new policy brief from *Health Affairs* and the Robert Wood Johnson Foundation presents the facts in explaining the implications of the current debate on our health care system. The policy brief explains **three of the key issues** currently attracting attention and sets the record straight on what is true now for patients, payers and providers—and what could change under the health reform legislation being discussed.

Topics covered in the brief are:

1. The Federal Government's role in financing and delivering care;
2. Lowering the rate of growth in Medicare spending; and
3. Advance care planning for serious illness.

Source: Robert Wood Johnson Foundation: *The Role of Federal Government in Health Care: Exploring the Debate Over Advance-Care Planning, Controlling Medicare Spending and the Government's Role in Health Care* (August 2009)

# Health Care Expenditures in the United States

- The US has the most expensive healthcare system in the world. It is almost twice as expensive as every other developed nation.
- The United States leads all industrialized countries in the share of national health care expenditures devoted to health insurance administration.
- The US share is over 30% greater than Germany's and more than three times that of Japan.
- The costs of insurance administration alone in the U.S. health care system totaled nearly \$156 billion in 2007, and that figure is expected to double — to reach \$315 billion — by 2018.
- Administrative costs to provide health care in the US account for 19-25% of all dollars expended in taking care of people.

# Annual Cost of Health Care in America

- The US spent approximately \$2.4 trillion last year (2008) on health care. Of this amount, the total public share (state, federal, local) of this amount was \$1.108 trillion, or about 46% of all national health care spending.
- The Federal share alone (Medicare/Medicaid et al) was \$810.6 billion or 33.7% of total national health spending.
- Add in tax subsidies and the total public share comes to 3/5 of all U.S. health spending.

# Annual Cost of Health Care in America (continued)

- According to the most recent data (August 2009) from PricewaterhouseCoopers' Health Research Institute, about half of that amount (\$1.2 trillion) is waste.
- What accounts for the waste? The report identifies **16 different areas** in which health care dollars are squandered. But in talking to doctors, nurses, hospital groups and patient advocacy groups, **six areas totaling nearly \$500 billion** stand out as issues to be dealt with in health care reform

# Six Major Cost Accelerators in Contemporary US Health Care



## **(1) Too Many Tests**

Doctors ordering tests or procedures not based on need but concern over liability or increasing their income is the biggest waste of health care dollars, costing the system at least \$210 billion a year.

## **(2) Processing Claims**

Inefficient claims processing is the second-biggest area of wasteful expenditure, costing as much as \$210 billion annually

# Cost Accelerators (continued)



## **(3) Ignoring Doctors Orders (up to \$100B)**

Too often patients do not follow the health care protocols recommended by their doctors or adhere to the prescribed medication programs; insurance companies also do not routinely authorize and/or reimburse for evidence-based treatment programs.

## **(4) Ineffective Use of Technology (\$88B)**

Hundreds of billions of dollars can be saved by standardizing procedures and using technology -- something the White House has mentioned as a key to health care reform. Competent use of technology in the health sector will help boost savings, enhance the coordination of care, and reduce medical errors and unnecessary procedures

# Cost Accelerators (concluded)



## **(5) Hospital Readmissions (\$25B)**

Patients (especially elderly patients) discharged too soon because of insurance, bed unavailability, or ageism. Discharged patients also don't fully understand or follow instructions for care after discharge. Complications arise and they are readmitted.

## **(6) Medical Errors (\$17B)**

Processes such as computerized order entry for drugs and use of electronic health records (EHR) could help ensure that patients get the correct dosage of medications in hospitals.

# Apart from politics, where is an informed consensus on health care reform to be found?



- (1) Require that all Americans be insured**
- (2) Provide subsidies (disagreement over how much) for lower-income folks to help them buy insurance; expand Medicaid eligibility**
- (3) Expand marketplace insurance options**
- (4) Create an essential health insurance benefits package for all – defined by federal government**
- (5) Establish some “public option” (new government health insurance plan or not-for-profit health insurance cooperatives) to compete with private insurers**
- (6) Establish stricter insurance regulations that prohibit denials based on pre-existing conditions or charging higher premiums because of medical history or health condition**
- (7) Make Medicare more “lean” and “mean” by rewarding quality care**
- (8) Place greater emphasis on health information technologies, smarter treatment of chronic illness and increased focus on preventive care**

# Containing Costs: Re-engineering the Whole Health Care System



- Congress and the Administration are also trying to determine how to fundamentally re-engineer the entire health care system to lower its long-term cost trajectory.
- Most of the **choices involved are unfamiliar and difficult to quantify**; even CBO resists precise estimates. Yet it is these decisions that will determine whether health reform creates a system that truly "bends the curve" and curtails long-range spending growth.

# Three Pillars of a Reformed Health Care System



Peter Orszag (Director, Office of Management and Budget) has identified three pillars of what he called a *"more-efficient, higher-value, lower-cost health care system."*

**Information** – a world where doctors have computerized access to their patients' health records and can inform their treatment decisions with detailed research on the comparative effectiveness of different options

**A change in financial incentives** – a transition from the current “fee-for-service” model that pays doctors and hospitals for each procedure toward a “bundled system” in which teams of providers share fixed sums for managing a patient's overall health.

**A shift in training priorities** to produce more of the primary care doctors that team-oriented care strategy requires.

# An Administrative Quagmire

- **Physicians spend an average of nearly 3 weeks per year on health-insurance-related activities** –including prior authorization, pharmaceutical formularies, claims and billing, credentialing, contracting, and collecting and reporting quality data.
- In converting time to dollars, **U.S. physician practices spend an average of \$68,274 per physician per year interacting with health plans, or an estimated total of \$31 billion annually**

# How might a comprehensive new plan work?



- **Everyone would be required to have health insurance that was deemed affordable.**
- **Employers would be obligated to offer coverage;**
- **Eligibility for Medicaid and Child Health Insurance Plan (CHIP) would be expanded**
- **New insurance regulations would prevent carriers that sell insurance, whether inside or outside the exchange, from underwriting policies on the basis of health; instead, the regulations would require all carriers to offer policies to anyone who applies.**

# How might a comprehensive new plan work?



- **Premium subsidies** would be available on a sliding scale, based on income.
- Combined with health care system reforms, including changes to the ways in which providers are paid for services it would be possible to achieve near-universal coverage and improve health outcomes while also bending the cost-growth curve.

# Health Care Reform

**HealthCare**  
Chaplaincy  
Finding Meaning ♦ Bringing Comfort

## **The Neuralgic Issues:**

# **End of Life Care Counseling**

# End-of-Life Care Facts



- **2.4 million people die in US each year; 25% of these death occur at home. 70% of Americans would like to die at home or in a home-like environment**
- **Projected growth of aging population (65-84) from 2010-20 --- 39%**
- **1.4 million terminally-ill persons are cared for by hospice each year**
- **80% of the people who die each year are served by Medicare**
- **Percentage of dying Medicare patients who elect hospice care = 40%**
- **Medicare payment for hospice care (2007) - \$10B+**
- **Percentage of total Medicare dollars spent in last year of life = 27.4%**
- **96% increase in hospital palliative care programs in US from 2000-2005**

Source: Modern Healthcare (2009)

# The Last Taboo: Talking Honestly About Death & Dying



- There is one subject Americans seem unable to talk about in an honest and rational way: the inevitable decline of old age and death
- We saw this fear surface this past summer in the frenzied public controversy over whether Medicare should pay doctors for end-of-life consultations
- We see it in the unwillingness of Congress to confront those very real long-term care issues that now are unfortunately marginal in the health reform debate

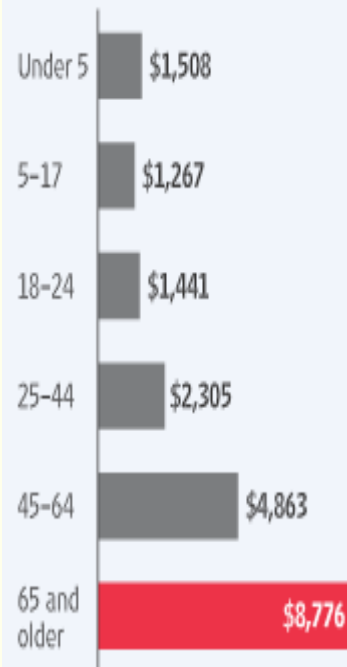
# The Last Taboo (continued)

- 10 million Americans currently need some form of long-term care, either at home, in a nursing or assisted-living facility, or in some other group setting.
- As many as 40 million of us are helping provide this care for family members and friends.
- Mainstream media are terrified of frail old age, yet 2/3 of those 65 and older will need some long-term care before they die, yet we fail to plan for it, either as families or as a society.

# Cost of Aging in America

## Kaiser Family Foundation (2006)

**Cost of Aging**  
Average health-care spending  
in 2006, by age



Source: Kaiser Family Foundation

# The Last Taboo (continued)



- **Members of Congress, not surprisingly, are no different.**
- **When we have raised questions with them and their staff about financing long-term care, or finding new ways to deliver community care, or improving the lot of front-line caregivers, we have gotten a blank stare.**
- **If the idea of a “public option” dies in the final reform bill, it will be occur because of powerful political opposition. But if long-term care issues fade, they will die of neglect. Much like the people these reforms are intended to help.**

# The Last Taboo (concluded)



- **The one aging issue in the health reform debate that has generated plenty of attention: the bizarre fight over whether Medicare should pay for end-of-life counseling. HealthCare Chaplaincy has been working directly with Rep Blumenauer (D-Or) and his staff on this issue.**
- **A seemingly innocuous proposal for reimbursing doctors and other health care professionals (including chaplains) for their time has been described by some as a step toward government "death panels" that will decide whether our loved ones live or die.**
- **It is facile to say this popular opinion is built on ignorance or political demagoguery. But it resonates with many people. That may be because it plays to this same reluctance of Americans to confront frail old age and inevitable death.**
- **Frail old age and death are unfamiliar, so they are fearful & terrifying. The best way to deal with fear is to confront it. That's just what we need to do with long-term care, but I believe it will not be accomplished in this bill.**

# The Controversial End-of-Life Counseling Provision



- **The cost of caring for patients who are near death accounts for a big piece of the government's medical spending. But a furor over a provision for government-paid counseling to plan for end-of-life care is steering lawmakers away from the issue.**
- **The end-of-life counseling provision in the House bill is expected to cost a few billion dollars over the next decade. But health policy experts say it could lower medical spending by reducing end-of-life medical care that patients don't want.**

# End-of-Life Counseling (cont)



- **Opponents say the provision shows that architects of the health-care overhaul want to ration seniors' care. Democratic lawmakers say no part of the House bill calls for rationing care. Physician counseling would be voluntary.**
- **Dumping the counseling provision would thwart a broad effort in recent years by doctors and hospitals to encourage patients to plan for end-of-life care. Advocates say such planning relieves the burden on families and helps doctors know how aggressively to treat those who are very ill.**

# End-of-Life Counseling (conclusion)



- About 5% of Medicare beneficiaries die each year, according to a 2001 study published in *Health Affairs*. But spending during the last year of life accounted for 27.4% of total Medicare spending.
- The Urban Institute, a nonpartisan research center, found that the government could save \$90.8 billion over 10 years by better managing end-of-life care.
- The savings would result from training aimed at discouraging doctors from providing care simply because they would get paid for it, and from having teams at hospitals help terminally ill patients manage their pain (palliative care) once they chose to stop treatment, among other things.

# The Neuralgic Issues:

## The “Single Payer” Proposal

# A Single-Payer National Health Insurance Model



- Although many experts see the value in promoting a “single-payer” model, there is little prospect that a single-payer plan will be approved by Congress; too many people view it negatively as “socialized (rationed) medicine”
- Single-payer national health insurance is a system in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private.
- Despite spending more than twice as much as the rest of the industrialized nations (\$7,129 per capita), the United States performs poorly in comparison on major health indicators such as life expectancy, infant mortality and immunization rates.

# Single-Payer Model (continued)



- Moreover, the other advanced nations provide comprehensive coverage to their entire populations, while the U.S. leaves 45.7 million completely uninsured and millions more inadequately covered.
- The reason we spend more and get less than the rest of the world is because we have a patchwork system of for-profit payers.
- Private insurers necessarily waste health dollars on things that have nothing to do with care: overhead, underwriting, billing, sales and marketing departments as well as huge profits and exorbitant executive pay. Doctors and hospitals must maintain costly administrative staffs to deal with the bureaucracy. Combined, this needless administration consumes one-third (31 percent) of Americans' health dollars.

# Single-Payer Model (continued)

- Single-payer financing is an efficient way to recapture wasted money. The potential savings on paperwork, more than \$350 billion per year, would be enough to provide comprehensive coverage to everyone without paying any more than we already do.
- Under a single-payer system, all Americans would be covered for all medically necessary services, including: doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs. Patients would regain free choice of doctor and hospital, and doctors would regain autonomy over patient care.

# Single-Payer Model



- **Physicians would be paid a fee-for-service according to a negotiated formulary or receive salary from a hospital or nonprofit HMO / group practice. Hospitals would receive a global budget for operating expenses. Health facilities and expensive equipment purchases would be managed by regional health planning boards.**
- **A single-payer system would be financed by eliminating private insurers and recapturing their administrative waste. Modest new taxes would replace premiums and out-of-pocket payments currently paid by individuals and business. Costs would be controlled through negotiated fees, global budgeting and bulk purchasing.**

# Health Care Reform



**Another Neuralgic Issue:**

**The “Public Option”**

# The Public Option:

## Envisioning an Expanded Federal Government Role in Health Insurance



- In lieu of a “single-payer” model, Congress has also been evaluating a “**mixed private-public**” or **government-run health insurance plan** that would compete with private insurance in the new insurance marketplace. These various proposals also have not garnered much political support.
- **A national insurance exchange or gateway**—with new insurance market regulations and a choice of private and public insurance plans— would increase the transparency of insurance products, streamline insurance plan purchase and enrollment, and reduce administrative costs stemming from activities such as underwriting and marketing
- This plan would be financed through premiums rather than taxpayer funding

# How might a “public insurance plan” reduce administrative costs?



- A “public health insurance option” would simplify physician interaction with insurers by applying uniform processes and coverage for its substantial market share
- A “public plan option” could require providers to further automate charting and claims, which would reduce claims denials, ensure coding compliance, and reduce days in accounts receivable
- If standardization could cut such insurance-related overhead in half, the savings would amount to \$15–\$20 billion in savings per year for physicians and \$25–\$40 billion a year for hospitals

# A “Public Plan” and Health Care Cooperatives



Some key Senators (Senator Kent Conrad [D-ND] is one of the leading proponents of health care insurance cooperatives) are proposing **cooperatives** as an alternative to a public health plan. The aim is to provide a health plan in any local market that families can feel is part of the community and always a dependable option.

If Congress wants to provide Americans **access to health co-ops**, it would need to make it possible for **an institution to combine tax-exempt (non-profit) status** with **mutual insurance status**, something health plans cannot do today.

Congress would need to allow mutual health insurance companies to form based on the credit union model. Under this model, Congress would simply grant non-profit status to mutual insurance companies, justified by the "member benefit" they provide.

# Health Insurance Cooperatives (continued)



Health care cooperatives **can work as private entities in a private market** and give another choice to families, but they have to be done right. Here are several principles that must be a part of any co-op model:

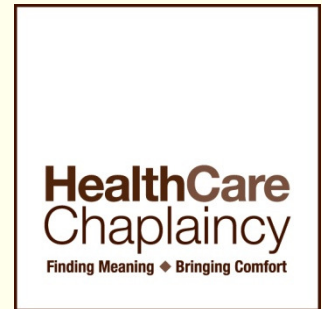
- Cooperatives must be **voluntary**, open to individuals who choose to freely join together without coercion or restraint, and **controlled by its members**, not the government;

# Health Insurance Cooperatives (continued)



- Cooperatives must be **viable on their own** and must not receive anti-competitive government support in any form including assumption of risk, "start-up" capital, or continuous subsidies to the organization--which would turn them into government-preferred public plans;
- Health plans **must be selected only by a co-op's members**, not the government;

# Health Insurance Cooperatives (continued)



**Competitiveness must be based on the member strength of the cooperatives and not on any favored status, including government subsidies, access to government pricing, coverage or coding decisions, or regulatory intervention;**

**Any necessary regulation to keep a level playing field among health plans must be reserved for the states;**

# Health Insurance Cooperatives (continued)



State reforms should **open doors to competition**, including the competition that cooperatives would bring; and

**All individuals**—including those who receive public subsidies and individuals eligible for Medicaid or SCHIP—**should be free to join cooperatives of their choice.**

# Health Insurance Cooperatives (concluded)



The entire basis for lawmakers even pursuing further discussions of the cooperative insurer concept must be to give consumers more options and control within the context of a "level playing field"--with all insurers subject to the same market rules. Under a true consumer-based cooperative, members would have a trusted partner to help them obtain private health insurance coverage for them and their families.

# **The Final Neuralgic Issues:**

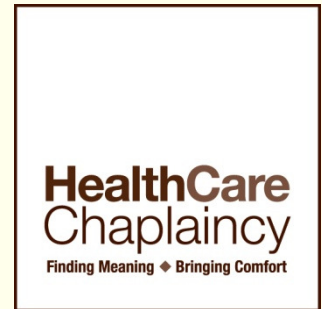
**MEDICARE**

**MEDICAID**

**CHILDREN'S HEALTH INSURANCE PROGRAM**

**(CHIP)**

# MEDICARE & MEDICAID: Core Federal/State Health Care Insurance



- Medicare/Medicaid are **publicly financed health insurance programs** in which the government does not deliver health care directly, but serves as a conduit by collecting money from taxpayers and funneling it through the federal government to private-sector health care providers for offering care.
- In current dollars, the government is spending about **4% of the GNP** (gross national product = nation's overall output of goods & services) or **\$466B**, and this figure is projected to rise to **6% (\$931.9B) in 2019** and by **12% in 2050**.

# MEDICARE / MEDICAID: Managing Growth & Costs

- Much of the projected growth spending for these 2 programs will be driven by growth in per person costs, and not from the aging of the population or other factors.
- Medicare is the largest of these programs, covering 45 million, of whom 38 million are over age 65 and 7 million are disabled.
- About 61 million low-income folks are enrolled in Medicaid, paid by both federal & state funds.

# Medicare: Blessing or Curse?



- Medicare is both a blessing and a curse. The curse, however, is not Medicare, but our continually escalating and uncontrollable health care costs in America
- The core problem is our health care system that pushes up costs by rewarding inefficiency, causes unbelievable waste, pushes over-medication, provides inadequate prevention, over-uses emergency rooms because many uninsured people can't afford regular doctor checkups, and spends billions on advertising and marketing seeking to enroll healthy people and avoid sick ones.
- To fix Medicare, the government has to slow the rate of growth of medical costs — including having some kind of public option when it comes to choosing insurance plans under an emerging universal health insurance bill.
- With a public option, the government can use its bargaining power with drug companies and suppliers of medical services to reduce prices and keep competitive pressure on private insurers to trim costs yet provide effective medical outcomes

# MEDICARE / MEDICAID: Reform Goals



The overall goal in the proposed reform legislation is to:

- Reduce overall growth of Medicare
- Curb waste (and fraud) in the system
- Pay physicians more

# The New “R” Word in Health Care Reform: Rationing



- Political scientist Harold Laswell once described politics as “Who Gets What, When, & How” and that's where the healthcare debate is going now.
- And so, the word “rationing” has crept into the health care reform debate.
- Wittgenstein insisted that *"The meaning is the use"* and he urged us to look at ordinary language ("language games") to find out the meaning of concepts.
- The term "rationing" was never evoked when transportation policy severely curtailed air service to rural airports. It was not employed when welfare reform (and cutbacks) were introduced. We don't talk about "rationing" when it comes to organ transplants, although allocation there is sometimes a life-and-death decision.
- *The "R" word is, almost inevitably, a term used to invoke the specter of some approaching terror.* Those who advocate reform can never win as long as that are suspected of promoting something like what the "R" word threatens.
- *The debate over reallocating money is a necessary and serious one.* Whenever the "R" word is introduced, it serves to paralyze serious thinking, excites fear and naturally engages resistance.

# Educating Seniors About How Reform Could Help Older Americans



## A current (Sept 09) HHS memo outlines reasons seniors need reform:

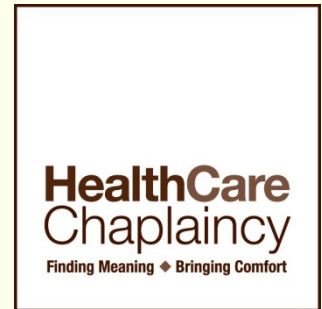
- **Increasingly high out-of-pocket costs for Medicare beneficiaries to pay for drugs and medical services could be lowered if comprehensive reform brought down the overall growth in health-care spending**
- **Comprehensive reform could benefit seniors indirectly. Uninsured Americans, who typically get less routine medical care, are sicker once they become eligible for Medicare, increasing costs for everyone in the program**
- **Unfortunately, these nuanced points are not easily translated into sound bites, further evidence of why the public-relations battle with seniors is so complex.**
- **Bottom-line: Seniors are confused.**

# Assessing the Impact of Cost-Savings in Medicare



- **Seniors could be the net losers under bills approved by three House committees this past summer, and currently under review**
- **The legislation proposes to trim \$563 billion out of Medicare's growth rate over the next 10 years while pumping in about \$320 billion**
- **Without any changes, the program is expected to cost about \$6.4 trillion over the same period**

# Medicare: Savings for Whom?



- **Several independent policy analysts say most of the proposed savings to Medicare affect providers, rather than beneficiaries.**
- **Discounts for prescription drugs, higher reimbursements for many doctors and elimination of co-payments for preventive services are some of the ideas advocates applauded.**

# Medicare: Who Pays the Differences? Federal Government or the States?



- **Senate Finance Committee negotiators are focusing on how to expand Medicaid as part of a health care overhaul without breaking the budgets of states that fund the costly program jointly with the federal government. Unless Congress funds a mandatory expansion in Medicaid eligibility exclusively with federal funds, any change that covers more people would hit state budgets hard.**
- **Unlike the federal government, states must balance their budgets every year—and virtually all of them are struggling to do so in the midst of the ongoing deep recession. Many have been cutting, not expanding, their Medicaid rolls.**
- **Currently, the federal government picks up about 57% of the cost on average, although the exact amount varies from state to state. There has long been tension between states and the federal government over who should carry more of the burden. Many states complain that Medicaid is fast devouring their budgets; they spend about 15% of their budgets on Medicaid, on average.**

# Cutting Medicare or Preserving Medicare?



- To help finance coverage for the uninsured, **Congress expects to extract huge savings out of Medicare**, the program for older Americans and the disabled. These savings would pay nearly 40 percent of the bills' cost.
- The legislation would **trim Medicare payments for most services**, as an incentive for hospitals and other health care providers to become more efficient. The providers make a plausible case that the cutbacks could inadvertently reduce beneficiaries' access to some types of care.
- The President told AARP last month that *"Nobody is talking about reducing Medicare benefits. All the savings would come from measures to eliminate waste and inefficiency in Medicare."* As an example, he cited duplicative tests ordered by different doctors for the same patient.
- But some proposals could affect beneficiaries. The major bills in Congress would **cut more than \$150 billion over 10 years** from federal payments to private health plans that care for more than 10 million Medicare beneficiaries.

# Who Pays? (continued)



- **Medicaid eligibility is set by states, with certain federal core requirements. Enrollment is frequently restricted to people with incomes below the poverty level—about \$22,000 for a family of four in 2009. On average, parents covered by Medicaid have incomes at **68%** of the poverty level or below, according to the Kaiser Family Foundation.**
- **The proposed legislation envisions a large Medicaid expansion as part of their health care overhaul to cover millions of low-income people who do not qualify under current law and either do not have access to private insurance or cannot afford it.**

# Who Pays? (continued)



- **Childless adults are generally ineligible – except those in nursing homes whose long-term care is paid by Medicaid once all personal resources have been exhausted.**
  
- **The Senate Finance Committee is considering expanding Medicaid to cover families earning up to 133% of the poverty level, or about \$29,300 in 2009. It is not clear if the committee would allow more childless adults to qualify for the program.**

# MEDICARE / MEDICAID

## WHO ELSE CAN HELP REDUCE COSTS?

### Other Non-enforceable or “Scorable” Commitments at Cost Reductions



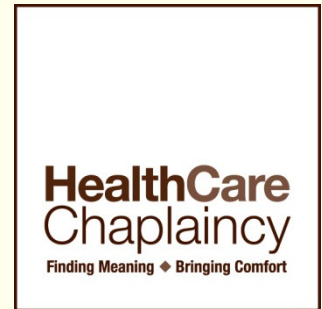
- **Hospitals, health insurance companies, medical equipment suppliers have committed to work to lower overall rate of national health spending growth by 1.5% per year over the next 10 years (savings = \$2 trillion)**
- **American Hospital Association - \$155B in Medicare savings over 10 years**
- **Pharmaceuticals – make drugs available at 50% discount to Medicare beneficiaries**

# Children's Health Insurance Program (CHIP, 1997)



**CHIP is a federal/state supported program that covers roughly 7 million children whose families generally have low-to-moderate incomes, but not so low as to qualify for Medicaid**

# The U.S. GOVERNMENT: MAJOR HEALTH INSURANCE BENEFIT PROVIDER



- As an employer, the government is paying a large share of the health care costs for almost 9 million federal employees and their dependents
- The government also pays for the health benefits of those who have worked for the government (active & retired military personnel & their families)
- The Veterans Health Administration (a part of the Veterans Administration) is caring for 7.8 million of the 25 millions US veterans
- Indian Health Service provides health care for approximately 1.9 million Native Americans.

# U.S. GOVERNMENT: Current Role as Health Care Insurer



- The federal government already holds sway over the health care system through Medicare, Medicaid and various insurance programs for children, veterans, military personnel and other federal employees.
- The federal government will account for 35% of the expected \$2.5 trillion in health spending in 2009, and that does not include subsidies built into the tax code.

# CONCLUDING OBSERVATIONS

## WHO WILL BENEFIT FROM HEALTH CARE REFORM?

# Who will benefit from Health Care Reform?

## EVERYONE WILL BENEFIT

### *PHYSICIANS*

- Health care professionals could spend more time in patient care, thereby increasing their levels of job satisfaction and improving patients' experiences with the health care system.

### *EMPLOYERS*

- Employers, particularly small employers, would benefit from the increased transparency and streamlined enrollment offered by the exchange and from the lower premiums enabled by lower administrative costs.
- Such cost reductions would be especially helpful in the context of a requirement that employers provide coverage for their employees or pay a fine or tax.

# Everyone Benefits . . .



## *INDIVIDUALS*

- Individuals would see lower premiums.
- Individuals would have simpler interactions with the health care system, resulting from increased portability of coverage, greater transparency in the market, guaranteed issue, and standardization of benefits (leading to fewer claims denials).

## *FEDERAL GOVERNMENT AND THE STATES*

- State and federal governments would benefit from the portability of coverage, the decreased churning among low-income individuals and families, and the greatly reduced costs of running high-risk pools.

# Are we really satisfied with the *status quo* of US health care and health care insurance?



- **84% of Americans (Zogby, 2009) who have health care insurance are satisfied with their health care, although 79% believe rising health care costs are hurting businesses**
- **The people who like their health plans the most are the people who use them the least!**
- **Despite anecdotal claims of high dissatisfaction among those who live in countries with universal healthcare, the reality is that, with the exception of Italy, Americans, in general, are less satisfied with their healthcare than are the citizens of every other developed nation, including England, France, Germany, and Canada**

# Is the US the Best Medical System in the World?



The New York Times (8/26) editorial:

- "Critics of President Obama's push for healthcare reform have been whipping up fear that proposed changes will destroy our 'world's best' medical system and make it like supposedly inferior systems elsewhere.
- The emptiness of those claims became apparent recently when researchers from the Urban Institute released a report analyzing studies that have compared the clinical effectiveness and quality of care in the United States with the care dispensed in other advanced nations. ... The bottom line was unmistakable. The analysts found no support for the claim routinely made by politicians that American healthcare is the best in the world and no hard evidence of any particular area in which American healthcare is truly exceptional."

# WHAT ABOUT THE UNINSURED IN NEW YORK CITY AND NEW YORK STATE?



- Adults represent the overwhelming majority of the uninsured in both New York State (**15%** of the population of the State) and New York City (**18%** of the population of the City of New York).
- An estimated **2.1 million adults** (86%) are uninsured in New York State, and just under **1.3 million** (97%) of these adults reside in New York City. Statewide, about **350,000 children** (14%) are uninsured, **170,000** (13%) of whom live in New York City.

# Documented & Undocumented Uninsured Non-Citizens



- Nearly **30%** of the state's uninsured are non-citizens. Eight out of ten uninsured persons are low-wage workers or their dependents. **An estimated 1 million (or 44%)** of uninsured New Yorkers are eligible for public coverage but are not enrolled.
- Documented non-citizens face **barriers to enrollment** in public programs, including the fear that applying for coverage or enrollment may adversely affect their ability to gain citizenship, and they have **access issues** related to language. (Undocumented non-citizen adults face these barriers as well as additional eligibility obstacles.)

# Who Can Afford to Pay the Premiums?



- **Between 2001 and 2007, an increasing share of adults with private insurance—whether employer-based coverage or individual market plan—spent a large amount of their income on premiums and out-of-pocket medical costs, were underinsured, and/or avoided needed health care because of costs.**
- **Those with coverage obtained in the individual market were the most affected. Over the last three years, nearly three-quarters of people who tried to buy coverage in this market never actually purchased a plan, either because they could not find one that fit their needs or that they could afford, or because they were turned down due to a preexisting condition.**
- **Even people enrolled in employer-based plans are *spending larger amounts of their income on health care and curtailing their use of needed services to save money.* The findings underscore the *need for an expansion of affordable health insurance options,* particularly during a time of mounting job losses.**
- *Source: The Commonwealth Fund (July 2009)*

# What's at Stake?



- **The stakes are enormous**
- **Health care represents 17% of the US economy**
- **Market stakeholders are pulling out all the stops in their lobbying and advertising efforts to make sure that their markets aren't bothered too much.**

# Aggressive Lobbying



- Drug makers, hospitals and insurers are continuing to pour millions of dollars into lobbying, as health care reform legislation is being **hoping to limit the damage to their bottom line** debated.
- Health care special interests [Pharmaceutical Research and Manufacturers of America (PhRMA), AMA, America's Health Insurance Plans (AHIP), Blue Cross and Blue Shield Association, MetLife Group, etc.] and their lobbyists have been **spending money at the rate of approximately \$1.5 million a day for the past 9 months.**

# How will it eventually play out in Congress?

Source:

*Wall Street Journal* (Jonathan Weisman and Naftali Bendavid, August 20, 2009)

## Splitting the Bill

Senate Democrats are weighing whether to split health legislation into two parts. Here's how it might work:

### 1st part

Under 'reconciliation' process for budget items, requires 51 votes to pass.

- Federal subsidies to buy insurance
- Expansion of Medicaid
- New taxes to pay for these items

### 2nd part

Requires 60 votes to overcome filibuster

- Require most Americans to have health insurance or pay fine
- Prohibit insurers from rejecting customers over pre-existing conditions
- Cap out-of-pocket expenses

### Gray area

Unclear whether in first or second part

- Establish public health-insurance plan or nonprofit co-operatives to compete with private insurers
- Set up 'exchanges' where people can comparison-shop for insurance.

# Crystal Ball Prediction



- **Some consensus will emerge and I think some legislation will pass and be signed into law, but it may turn out to be more of an engine tune-up than an engine overhaul**
  
- **Nonetheless, I think we'll have the biggest health care legislation since 1965, but I don't think it will be as sweeping as earlier Congressional efforts seemed to predict**

# Health Care Reform



## EPILOGUE

### Health Care Reform An Historical/Political Science Perspective

# Health Care Reform: The Long View On Social Reform In The US



- **Health care reform 'glide path' would be on a well-traveled route. What's a glide path? It means that rather than hold out for a new wall-to-wall national medical insurance system, the Obama administration might settle for something less with the hope that it will serve as a kind of sculptor's armature on which to build a more comprehensive program in the future.**
- **Half-measures, later augmented, have been the story of most important policy changes in U.S. history, including The Social Security Act of 1935, which was designed to be just the beginning of a broader social safety net that would include national health insurance. But the struggle to get the old-age and survivors' benefits was so arduous that President Franklin Roosevelt concluded that he had done all he could and left it to his successors to broaden the coverage.**
- **This task fell to President Harry Truman, who fought in vain to get Congress to enact the program that came to be known as Medicare. Adding policy clay to the armature proved impossible for Truman and the next Democratic president, John F. Kennedy.**
- **1965, 30 years after the original Social Security Act was passed, that President Lyndon Johnson flew to Independence, Mo., to present Medicare card No. 1 to an 81-year-old Truman.**

Ross K. Baker (USA Today 8/26/09)

# Health Care Reform: The Long View On Social Reform In The US (continued)



- **Presidents can come up with grand designs to radically alter social policy in the USA, but these architects have always had to console themselves with a half-finished building.**

## **Civil rights**

- **The modern history of civil rights legislation follows the same intermittent course. A bill was introduced during the Eisenhower administration that dealt mainly with the right of African Americans to vote in the segregated South. By the time the bill got to Eisenhower's desk, it had been filibustered in a record-breaking talkathon on the floor of the Senate by Strom Thurmond of South Carolina and was largely toothless. But, significantly, it was the first piece of legislation bearing the words "civil rights" that Congress had enacted since 1875. Even Clarence Mitchell, a leader of the NAACP, declared the bill important because "it had been assumed Congress could not and would not pass any civil rights legislation."**
- **Why have so many statutory structures been cellar holes or framing and only later dry-walled, roofed and insulated? The most basic cause is the power of organized interest groups in American politics. There is nothing sinister or conspiratorial about doctors or insurance companies or pharmaceutical firms acting to shape or even kill legislation. To avoid this inevitable clash in the early 1990s, the Clinton White House excluded these groups and learned to its eternal grief that the interest groups cannot be excluded. If they are shut out, their powers of retribution are awesome.**

# Health Care Reform: The Long View On Social Reform In The US (concluded)

## Social Security

- If it is any consolation to President Obama as he and his allies fan out through the country to make their case, one of his predecessors, Roosevelt, found himself in a campaign to defend the Social Security Act that was to go into force on Jan. 1, 1937, with the first taxes being withheld from American workers.
- With Roosevelt facing re-election in 1936, the Republican National Committee hit upon a strategy to discredit Social Security – and with it FDR. Republicans campaigned with the accusation that the government would withhold the payroll tax and workers would never get it back at retirement. Social Security was only a promise, the GOP alleged.
- More ominously, Republicans charged that Social Security was a totalitarian plot to snoop into the private lives of Americans. One newspaper featured a stainless steel dog tag that all American workers enrolled in Social Security would supposedly be forced to wear. Workers found their pay envelopes stuffed with anti-Roosevelt and anti-Social Security leaflets.
- Accusations of a power grab by big government in 1936 are remarkably similar to those being used today.
- Given the need to satisfy myriad conflicting interests, dissent in his own party and outright opposition by the GOP, Obama will likely have to settle for a health insurance program less far-reaching than what he has sought. But if he looks upon the watered-down plan not as a setback but merely a down payment on a more ambitious approach to national insurance, he should just declare victory and be comforted by the fact that it is the nature of such changes to proceed incrementally.

*Ross K. Baker is a political science professor at Rutgers University.*



**Administrative Center**

315 East 62nd Street, 4th Floor  
New York, NY 10065-7767  
Phone: (212) 644-1111  
Fax: (212) 758-9959

**Program Center**

307 East 60th Street  
New York, NY 10022-1505  
Phone: (212) 644-1111  
Fax: (212) 486-1440

[healthcarechaplaincy.org](http://healthcarechaplaincy.org)