Training Materials for Cape Care Resolution

Cape Cod Journal, a WOMR interview of Brian O'Malley, MD by Bob Sea is available in VHS and DVD formats

Town Meeting Resolution Text
"Cape Care" Universal Health Care Proposal

Whereas,

Health care coverage has become less affordable and less available to growing numbers of people in our community, despite all efforts to date at both the state and federal level; and

Each person who lacks adequate health care coverage faces increased risks of illness, disability, and premature death. Our region has well above state-average rates of uninsured- and underinsured- people; and

The families of such individuals are faced with growing out-of-pocket costs. These families must now confront the soaring expenses of health coverage, and the worry about bankruptcy or impoverishment in the event of serious illness. Their caregiver stress increases with the need to provide more and more uncovered care; and

Small businesses face the soaring expenses of covering their employees' health premiums, passing some of these costs along to employees in the form of rising premiums and out-of-pocket payments. Our regional predominance of small businesses and self-employed individuals is, understandably, a key factor in the low rates of health care coverage; and

Our Town governments struggle with the costs of health coverage for town employees. We the people are regularly forced to choose among other important and accustomed community services for budget cuts; and

Our community health care providers and institutions are caught in the inescapable financial squeeze of rising administrative costs and declining reimbursements. They are forced to reduce staffing, cut services, or close. Access to care for all they serve is diminished.

And whereas,

These consequences represent losses in quality of life for many (if not all) members of the Cape and Islands community, and a threat to our collective welfare.

Now Therefore:

We petition our County Government to support the development of a proposed regional universal health care program, known as Cape Care, which would, at a minimum, meet these criteria:

- provide broad health care coverage for ALL residents of the Cape and Islands, to improve individual and community health; and
- control health care cost inflation by reducing excessive administrative expenses, as well as through bulk discount purchasing of necessary medications and medical supplies; and
- shape health care delivery to meet community needs for appropriate care, through a representative policy-making board of community members and health care providers; and
- strengthen the ability of our existing network of health care providers and institutions to provide high-quality care, by assuring adequate funding for necessary services.

We call for a public hearing process in Barnstable County, to include analysis of the proposed plan's organization and governance, its expected effects on community health, and its financial modeling, to be initiated by the end of the year 2006.

The Clerk of the Town is instructed to give Notice of Passage of this Resolution to the town's representative to the County Assembly of Delegates, the County Commissioners, and the state and federal Representatives and Senators, within 30 days.

CAPE CARE REPRESENTS

Cape Care represents a proposed, not-for-profit universal health care insurance program, covering all residents of the Cape and Islands for comprehensive, accessible and affordable health care, with free choice of all participating providers.

The model is, essentially, a social insurance system. Access to health care is recognized as a human right, available to all. The parallels with other available services such as Fire and Rescue coverage, libraries, schools, Town recreation areas and others are illustrative of this model.

Cape Care would be professionally administered. It would be governed by a Health Policy Board, representing the community, sharing responsibility with a Medical Advisory Board of health care providers. The Boards would oversee administration and develop policy through a transparent public process. It should be a conscious goal of the health care delivery system, though the mechanism of the Health Policy and Medical Advisory Boards, to facilitate access to all appropriate screening and preventive health services and to provide equitable, high-quality care to all.

Within the Policy Board's mandate to set coverage and reimbursement rates, is the means to assure that the needs of the residents of the region for appropriate medical services are met. This particularly includes the standarization of well-validated preventive health interventions, as well as mental and dental health care coverage. The Board would set the universal benefit package for all enrolled residents, and any extra-cost benefit options. And it would be charged with maintaining adherence to a defined Mission Statement, reflecting the agreed-upon guiding principles of appropriate health care service access.

The essence of the financial basis for the model, is the re-direction of the many health expenditures we now pay, in a variety of taxes, charges and out-of pocket costs (at a higher cost than any system in the world.) Barnstable County, or possbly a new multi-county regional authority , would establish, and oversee, the Community Health Insurance Fund, derived from new revenue stream(s). This would probably include health insurance premiums to build and sustain this fund. Such premiums should be progressive, meaning that the proportion of income directed to health care costs would be lowest for those of least income- the exact reverse of current financing. This would have the effect of increasing disposable income for the individuals and families most in need.

From this Fund, provider claims would be paid via a greatly simplified process. Substantial cost savings are based principally on the reduction in administrative

overhead and the elimination of insurance profit, and are projected to be sufficient to cover all residents (including the current uncovered) with an comprehensive benefit package. In addition, pharmaceutical purchasing will utilize the saving power of volume buying, as well as working with existing buyer networks, to provide a covered formulary as a standard benefit.

Longer-term savings are projected in actual health care expenditures. Our population, covered for access to primary care for preventive and health maintenance services, can be expected to show improvements in public health indicators (i.e. better health!) Such outcomes result in savings both human and financial.

All residents will be covered, independent of employment or means. Employers would have no financial responsibility for the health care of their resident employees.

For those individuals covered under Medicare, MassHealth and similar programs, Cape Care would give them free choice of all affiliated providers, with greater benefits likely as well.

There is no change envisioned, in the ownership or governance of any health care provider- institutional, group, or solo. All health care providers currently certified to receive Medicare, MassHealth (and other) insurances would be eligible to enroll, through a standard Provider credentialling process. With most patients covered by a single, administratively straightforward insurance, providers will experience cost reductions and improved income. And, as the great majority of individuals would be covered by Cape Care, there will be a strong incentive for providers to enroll.

Administration will emphasize simplicity and efficiency. Covered services and benefits would be a uniform package, and undertandable. Claims processing would be much less complex than presently, with no cost-shifting. Based on validated claims submitted to Cape Care, vouchers would direct prompt payment by the Health Insurance Fund to providers. A simple fraud control process would be based on beneficiary verification, of receipt of services paid on their behalf.

The feasibility of this model has been demonstrated in functioning health care systems around the world, and in studies in many states. More care, for all, at a cost less than what we now spend and with much greater control over the content and quality of that care. A model for how it could be better. This is what Cape Care could be. It will be ours to create.

CONSENSUS POINTS

- Health care as a human right
- Comprehensive, accessible and affordable
- Free choice of providers
- Universal, standard benefit-package coverage is the ultimate goal; the process may well proceed incrementally by building from an Island Health Plan (MV) model, based on political feasibility considerations
- Single, not multi-tiered model, is the goal. Consider optional complementary care coverage; out-of-pocket payment for non-covered services
- Governance: not-for-profit
- Professional administration;
- Consider C&I Health District w/ taxing authority
- A universal tax levy will be required to fund the system
- Policy Board- Community and practitioner representation

  Mission statement adherence [will need development]
- Use of coverage and fee schedules as instruments of broader public health policy
- Reduction of administrative overhead and profit is the primary source of new funds to provide coverage to the uninsured and to increase the range of covered services.
- Administrative simplicity stressed; avoid duplication of services, but will need some structure to achieve public health goals and cost containment.
- Utilization review, provider education appropriate tools.
- Info tech may be a facilitating tool; provider expense reductions and care coordination are goals
- Inclusion of pharmaceutical benefit is key.
- Long term care coverage is very desirable as a "selling point"
- Unchanged ownership of existing health care providers. Improving physician satisfaction and retention will be important to buy-in by providers

Cape Care Working Group:

Brian O'Malley, MD; Len Stewart; Robin Rowland, MD; Sheila Vanderhoef; Margie Hansen RN; Merton Bernstein Esq.; Anna Manatis, MD; Wendy Northcross; Rhonnda Tewes; BL Hathaway; Cynthia Mitchell; Patricia Fairchild; Brian Toomey

July 2004

CAPE CARE – Q & A: DECEMBER 2005

What is Cape Care?
Cape Care is a planned self-insurance program for Barnstable County, which will provide universal, tax-funded, health care coverage.

What services will be covered?
The standard package of benefits would most certainly cover all acute medical care, including outpatient, inpatient and emergency care; an expanded preventive care program; laboratory and radiology services; rehabilitation therapies; home care; mental health and substance abuse services; dental care; prescription medications; and equipment and medical supplies. Long-term care coverage will be a critical component in the design of a comprehensive coverage plan.

Who will be covered?
All residents of Barnstable County will be covered for the full range of covered services.

What happens if I'm traveling, and have an illness or injury?
Out-of-network coverage is a standard of almost all insurance coverage, and would be for Cape Care as well.

What about my present insurance coverage?
People with Medicare would have the broader coverage of the Medicare+C program, without the restrictions of provider choice. So would MassHealth-eligible individuals. Most others would find Cape Care less costly than their current commercial insurance plans.

What about choice of health care provider?
All licensed providers will be eligible to provide services and be reimbursed, for the care of any covered resident.

What about employers who provide health insurance benefits?
Employers will no longer be responsible for the health care insurance of their employees. Nor will coverage be tied, in any way, to employment.
These current employer expenses can be redistributed.

What about the Insurance Companies?
They will contract to provide the much-simplified, but still-necessary, claims processing systems which reimburse health care providers. When BC/BS does this for Medicare, they manage 4% administrative costs, . as compared with 25% for their commercial policies.
They will no longer make the decisions about what health care we receive in return for our premiums.

Who will decide about covered health care services?
A Medical Policy Board, composed of, and representative of, participating health care professionals**,** will oversee the quality of health care delivery to all covered residents. They will recommend policies to the Health Policy Board, representing the community at large, which will

carry the responsibility of governance and adherence to the core principles of the Cape Care program.

The Medical Policy Board will develop a standard benefit package; and optional benefits. A preventive health focus must be a core value; this requires adoption of screening standards, and assuring that resources are adequate to achieve goals.

They will recommend and evaluate changes to benefit package, including new technologies, over time.

They will be responsible for formulary development and oversight of pharmaceutical benefits.

They will develop reimbursement schedules for health care services, including modifiers to implement policy goals of preventive care and other services needed to meet identified gaps.

They will recommend health manpower development goals to meet regional care needs.

They will oversee credentialing of all eligible practitioners, and oversee a process of continuous practitioner education.

How is Cape Care financed?

Residents of Massachusetts now spend more per person, over $8,200, than any other place on the planet. Cape Care will greatly reduce the part of this spending which now goes to administrative waste, and uses these savings to cover expanded services for all.

Additionally, preventive care services, which spend now to save health and health care costs later, will be emphasized. Finally, volume discounts for supplies and pharmaceuticals will yield further cost reductions.

Barnstable County, or possibly a new multi-county regional authority, would establish, and oversee, new revenue sources. These would probably include health insurance premiums to build and sustain the Community Health Insurance Fund. Such premiums should be progressive, meaning that the proportion of income directed to health care costs would be lowest for those of least income- the exact reverse of current financing. This will have the effect of increasing disposable income for the individuals and families most in need.

How will this affect my health care Provider?

The ownership and management of existing health care providers is unchanged, whether individual physicians or groups, health centers, or institutions. They will simply bill Cape Care for most of the services they provide, just as they now bill Medicare, MassHealth, BC/BS, Harvard Pilgrim, Tufts…and all the others. The greatly reduced complexity will lighten the administrative burden for nearly all providers.

How do health care Providers feel about single-payer health care insurance?

The unsustainable and growing administrative costs of the current financing model are forcing physicians from practice, and closing hospitals. Nearly all recognize the need for fundamental change to bring relief. More and more recognize this model as the only realistic solution.

- these questions were answered by Brian O'Malley, MD

A separate document, "Cape Care Q&A" is updated with much additional information.

Rev. 12/4/05

THE CONCEPT IS CALLED CAPE CARE;

CAPE & ISLANDS HEALTH INSURANCE FOR ALL BECOMING MORE THAN WISHFUL THINKING

To Your Good Health essay ***by Brian O'Malley, MD***

Can you imagine how secure we each would feel, living in a place where we had affordable, comprehensive health insurance, with full freedom of choice of our health care providers? That this insurance covered all acute and chronic care, both inpatient and outpatient, rehabilitation, preventive services, medications, supplies, and even long-term care. And that your family, and all your neighbors, were also covered.

And that, whether you worked for a small or large business, or ran one, or were self-employed, or retired- you would be equally covered. That both you, and your health care providers, would be freed to concentrate on maintaining your health- rather than worrying about the adequacy of your coverage.

In fact, every resident of Cape Cod and the Islands would have just this insurance, if a proposed social insurance program, currently referred to as Cape Care, were to be developed and adopted here.

It would cover all residents of the Cape and Islands with a non-profit health insurance program, governed and administered locally. The existing network of health care providers here on the Cape and Islands would maintain their existing ownership and governance. This program would simply provide a uniform insurance coverage, much like Medicare, for the great majority of their patients.

For people without health care insurance for any part of the year, it would bring the security of access to regular health care services, without barriers. For employed people, the security of coverage, independent of changes in their jobs. For those with coverage, the security of controls on the runaway costs.

And for the health care providers of the region, relief from the enormous paperwork burden- estimated to consume one-third of our income. Relief from the arbitrary coverage denials, the frustrations of the referral and prior approval processes. Relief from the multiple contracting demands of competing insurers.

The reduction in administrative expenses would fund the expanded coverage. Because we already pay in many, many ways for health care-associated costs, new money will not be required. We currently pay an extravagant price for our health care- more, in fact, than any other population on earth. Unfortunately, much of this spending doesn't actually buy any health care. Despite years of patches- futile efforts to cover all the people who remain without health care coverage- this goal remains unaffordable and unattainable.

The Concept is called Cape Care

The administrative costs of the growing tangle of programs amount to as much as 39% of the health care dollar in Massachusetts. Simplified insurance programs – including Medicare itself, and national health insurance programs- operate at 5% or lower overhead. Reduction to this level would save, literally, hundreds of millions of dollars each year for the Cape and Islands. Current health care expenditures and entitlements would be channeled, creating a health care fund that pays for all care. Simplified claims processing and a uniform set of procedures will ensure low operating costs for the system.

In addition to the administrative costs, further savings are expected. Two aspects of this proposed model address significant failings in the current market-based approach.

The power of medications to effectively treat disease is becoming limited by their runaway costs. Practicing physicians confront this dilemma daily. A rational drug formulary, developed with expert guidance and local control, would help control these costs. Instead of forcing each consumer to find and negotiate their own best "deal," volume discounting for both covered medications and Durable Medical Equipment would give us collective strength- and substantial savings.

Finally, the most important cost saving of all, is that achieved by improvement in our collective health by reducing the burden of illness. Preventive health care and early detection services form a cornerstone in this effort. Ongoing care for chronic illness by skilled providers who know the individual patient -does reduce the long-term complications of disease. These services would be covered, and their access facilitated for all.

Information systems would link health care providers. And, taking guidance from the findings of the many in-depth community surveys conducted by the human service agencies of our three water-surrounded counties, our resources would be focused on the key needs of our people. One of the driving concepts is to use coverage as a policy tool to provide the health care services particularly needed in our community.

Groups of dedicated and knowledgeable people have been meeting for almost a year now, shaping and clarifying its vision. The Lighthouse Health Access Alliance, composed of health and human service professionals working on Cape Cod, Martha's Vineyard and Nantucket, has provided an important supporting role in this development. Over the next several years we will begin interim steps to provide health insurance coverage to those with the greatest unmet needs.

We currently envision a 501(c)3 not-for-profit organizational structure, with a Board of Directors, and professional administration. A separate Health Policy Advisory Board, of community representatives and health care providers, would be responsible for setting standards, coverage, preventive health services, etc.

In coming months, we will continue to study the many implications of such a program for the health and the economy of our region. Each and every one of us is a stakeholder in this discussion and this process. It will be up to us to shape it according to our collective vision.

We have only to imagine the sense of security that could be ours with Cape Care, and believe sufficiently in our ability to succeed, to motivate our labors.

Cape Care Town Meeting Resolution - Process Outline

1. Two coordinators per town
2. Develop a group of 5-6 or more individuals who will support & speak
3. Training for these supporters will be in Cape-wide groups this winter, as well as within each town. Supporting materials including the WOMR video, outlines, and written material will be distributed (*Training Materials for Cape Care*).
4. Collect signatures, submit to Town Clerk in time for Spring Annual Town Meeting (April-May)
5. Meet with Selectmen to seek their endorsement of warrant article.
6. Talk with neighbors to develop understanding, work through concerns.
7. Propose and speak about the resolution at Town Meeting. Speakers should try to cover key issues and main features of Cape Care plan. As few as 4-6 people will present brief perspectives. Local issues keyed to salient advantages are powerful.
8. Publicize each Town Meeting as much as possible, to boost support at other ATM's

THE COSTS AND FUNDING MECHANISMS OF A SINGLE PAYER HEALTH CARE SYSTEM

The theory behind the funding of a Single Payer health care system is to keep the amount of money from each source of funding as close to its present amount as possible during the transition. This will prevent any one group from being a big loser or big winner under Single Payer. Thus the federal and state funding will be maintained at the present level and will increase over time with the rate of inflation. The contribution from private employers is maintained at its present level but decreases percentage-wise over time making the system more and more population-based and less employer-based.

The new individual health care premiums collected by the IRS should not be viewed as an added tax. It should be thought of as a substitution for all the out-of-pocket expenses we pay now including co-pays, deductibles, premiums for individual policies, durable medical goods, and medications that aren't covered currently by insurance. Most people will pay less for the new premium than they do now for all the out-of-pocket expenses because the simplified system will reduce administrative waste and control costs.

SAVINGS

1. **The immediate savings occur because of the simplified system** with one insurance payer that reduces the administrative overhead inherent in the present system of multiple competing payers. The present fragmented system has differing eligibility requirements, relies on claims-based payments, lacks continuity of insurance coverage, and uses up to 39% of health premium money for non-medical purposes (LECG Report)

2. **The second major area of savings is the ability of a Single Payer system to negotiate with pharmaceutical companies for lower prices** and buy in bulk for the entire state. This could achieve the lowering of drug prices to a level more like that of the VA Hospitals'.

3. **The third area of savings occurs because of the ability of a Single Payer system to control costs** which cannot be done in our present fragmented system. A Single Payer system would have an overall budget which would cap total spending, give hospitals and clinic groups a global budget, aid in identifying and reducing unnecessary services, and aid in planning capital expenditures and public health initiatives.

TRANSITIONAL COSTS

Possible ways to cover transition costs include:

1. Federal grants to aid in transition costs. John Tierney is sponsoring a bill that would give grants to 10 states to find new ways to provide universal coverage, comprehensive benefits, quality assurance, and cost-containment.
2. Use of the uncompensated care pool since everyone would be covered.
3. State bonds
4. Major philanthropic grants

Transitional costs are quickly recovered since a Single Payer system saves money!

MASS-CARE
The Massachusetts Campaign for Single Payer Health Care
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(This chart is based on Table 1 in Sager and Socolar, Testimony on Universal Health Care, Health Care Committee, MA General Court, April 1999. The numbers have been updated using total cost projection for 2005[1] and the proportions for each category from the 1999 analysis)

TABLE 1 PROJECTED 2005 MASSACHUSETTS' HEALTH CARE COSTS, WITHOUT REFORM AND WITH SINGLE PAYER REFORM	**COSTS AND SAVINGS ($BILLION)**
BASELINE COST OF CARE FOR MA RESIDENTS 2005, NO REFORM…… Assuming no major reform or policy changes	**$52.7**[1]
ADDED COSTS WITH SINGLE PAYER REFORM …… Cover uninsured Comprehensive benefits for all Data, care coordination, new services for people with disabilities	**+$5.8** **$58.5**
SUBTRACTED SAVINGS WITH SINGLE PAYER REFORM…… Savings in administration of coverage Savings in caregiver administration Savings in more appropriate use of clinical and hospital care Negotiating drug prices; budgeting construction and equipment	**-$ 7.5** **$51.0**
TOTAL COST OF CARE FOR MASSACHUSETTS' RESIDENTS WITH SINGLE PAYER REFORM 2005 ……	**$51.0**
TOTAL SAVINGS FROM BASELINE COST OF CARE FOR MASSACHUSETS' RESIDENTS WITH SINGLE PAYER REFORM 2005	**$1.7**
CHANGES FROM BASELINE COST OF CARE WITH SINGLE PAYER REFORM 2005……..	**-3.2%**

[1]Sager and Socolar, Health Reform Program, Boston University School of Public Health, Feb. 2005, www.healthreforemprogram.org and personal communication Sager and Socolar, based on recently released findings from CMS, May, 2005

TABLE 2 DOLLAR SOURCES OF FUNDING CURRENT AND WITH SINGLE PAYER REFORM[1]	ESTIMATED CURRENT SPENDING 2005 ($billion)	WITH SINGLE PAYER REFORM 2005 ($billion)
TOTAL FUNDING NEEDED	**$52.7**[2]	**$51.0** (See Table 1)
CURRENT GOVERNMENT SPENDING both state and federal (about 49% of pre-reform spending)[1,3]	**$25.8**	$**25.8**
EMPLOYER-BASED HEALTH INSURANCE CONTRIBUTIONS (about 31% of pre-reform spending)[3]	**$16.4**	**$16.4**
OTHER PRIVATE INSURANCE (about 3% of pre-reform spending)[1,3]	**$1.6**	**$0**
OUT-OF-POCKET HEALTH EXPENSES co-pays, deductibles, and uncovered medical expenses (about 17% of total health care costs)[1,3]	**$8.9**	**$1.7**
NEW FUNDING FROM OUT-OF-STATE AND NEW MEDICARE FUNDING out of state employers of MA employees (about 3% of pre-reform spending)	**$0**	**$1.7**
NEW INDIVIDUAL HEALTH CARE PREMIUMS and POSSIBLE NEW TAXES on items that cause health problems. System savings help ensure that these figures will be less than current out-of-pocket spending	**$0**	**$5.4**
TOTAL FUNDING	**$52.7**	**$51**

(This chart is based on Table 3 in Sager and Socolar, Testimony on Universal Health Care, Health Care Committee, MA General Court, April 1999. The estimated total funding comes from updated figures from 2005[2] and from Table 1 above. The proportions for the other categories are derived from either the data from Sager and Socolar[1] or from the LECG study commissioned by the MA legislature)[3].

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[1]Updated and modified from Table 3 in Sager and Socolar, Testimony on Universal Health Care, Health Care Committee, MA General Court, April 1999

[2]Personal communication, Sager and Socolar, based on recently released data from CMS, May 2005, and Sager and Socolar Health Reform Program, Boston University School of Public Health, Feb. 2005

[3]The Feasibility of Consolidated Health Care Financing and Streamlined Health Care Delivery in Massachusetts, prepared for the Massachusetts Legislature by LECG, August 2002

MASSACHUSETTS HEALTH CARE TRUST FUND LEGISLATION SUMMARY

Massachusetts Health Care Trust Legislation (S.755)

The Massachusetts Health Care Trust was re-introduced on December 1, 2004.

Below is a list of the current co-sponsors and supporters of:

Massachusetts Health Care Trust Legislation

LEGISLATIVE LEAD SPONSORS:

Senate - Steven Tolman (D-Brighton)

House - Frank Hynes (D-Marshfield)

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SENATE CO-SPONSORS and SUPPORTERS: J Robert Antonioni (D-Leominster); Edward Augustus (D-Worcester); Jarrett Barrios (D-Cambridge) ; Cynthia Creem (D-Newton); Susan Fargo (D-Lincoln); Thomas McGee (D-Lynn); Andrea Nuciforo (D-Pittsfield); Marc Pacheco (D-Taunton); Pamela Resor (D-Acton); Stanley Rosenberg (D-Amherst); Dianne Wilkerson (D)

(12 of 40)

HOUSE CO-SPONSORS and SUPPORTERS: Ruth Balser (D-Newton); Antonio Cabral (D-New Bedford); Mark Carron (D-Southbridge); Edward Connolly (D-Everett); Christopher Donelan (D-Orange); James Eldridge (D-Acton); Michael Festa (D-Melrose); Patricia Jehlen (D-Somerville); Rachel Kaprielian (D-Watertown); Kay Khan (D-Newton); Peter Kocot (D-Northampton); Stephen Kulik (D-Worthington); David Linsky (D-Natick); Jim Marzilli (D-Arlington); Robert Nyman (D-Hanover); Shirley Owens-Hicks (D-Roxbury); Anne Paulsen (D-Belmont); William Pignatelli (D-Lee); Cheryl Rivera (D-Springfield); Byron Rushing (D); John Scibak (D-South Hadley); Carl Sciortino (D-Somerville); Frank Smizik (D-Brookline); Joyce Spiliotis (D-Peabody); Thomas Stanley (D-Waltham); Ellen Story (D-Amherst); David Sullivan (D-Fall River); Benjamin Swan (D-Springfield); Timothy Toomey (D-Cambridge); James Vallee (D-Franklin); Anthony Verga (D-Gloucester); Marty Walz (D-Cambridge); Alice Wolf (D-Cambridge) (33 of 160)

WHAT HEALTH CARE TRUST LEGISLATION (S.755) DOES:

This legislation guarantees every Massachusetts resident first class health care coverage by replacing the current patchwork of public and private health care plans with a uniform and comprehensive health plan. It creates a single public entity called the Health Care Trust to replace all the present public and private bureaucracies. The trust, appointed by the Governor, will have representation from consumers, professionals and government. It will:

1. Oversee the delivery of health care services to Massachusetts's residents, with emphasis on universality, rational and effective allocation of resources, preventive medicine and the need for health care choices to be made by provider and patient.

2. Collect and disburse funds for the purpose of providing comprehensive health care for all residents of the Commonwealth. These funds will derive from current State and Federal expenditures for medical care, additional public and private sources to be proposed by the Trust following completion of a study undertaken by the Legislature and sales taxes on products that tend to increase health costs.

3. Negotiate or set fair and reasonable methods and rates of compensation with providers of medical services and with health care facilities and approve capital expenditures in excess of $500,000.

WHY WE NEED THIS BILL NOW:

> Massachusetts spends more on health care than any other state in the U.S., yet over a million of our residents have no health insurance or are underinsured! We already spend enough on health care in the Commonwealth to provide quality care for all of our residents. Under this bill, money that currently goes to administrative costs such as paperwork, marketing and profits would be spent on providing care. In 1987 we had 368,000 uninsured in Massachusetts, in 1997 that figure stood at 755,000. The number of uninsured more than doubled despite the fact that we added over 140,000 to the public rolls.

> We currently pay for health care many times over. As taxpayers, we pay for the public programs that make up almost half of direct health care spending. We pay for tax subsidies for employers who offer health insurance, whether our own employer offers coverage or not. As individuals, if we get employer-based coverage, we pay our share of the premium, and, on average, earn about 20% less than we would otherwise to cover the employer's share. Then we pay cash out of pocket for co-pays and deductibles. Businesses and individuals who buy liability insurance (auto, homeowners, product) pay for health care coverage for the people hurt, regardless of whether those people already have coverage -- only insurance companies benefit from this duplicative arrangement.

> By replacing private dollars with public ones and making funding of health care more equitable, most individuals and Massachusetts businesses would, on average, pay no

more than they do now for health care. Coordinating funding through a single payer (Health Care Trust) will save enough in administrative costs to pay for the health care needs of all Massachusetts residents. Over time, savings from planning and positive changes in service delivery could also save.

> Unlike our present health care system, the system created by this bill allows patients real choice. They can pick their provider or elect to enroll in HMOs. Care decisions will be made by patient and provider together with the goal of maximizing health rather than by insurance companies trying to maximize profits. Peer review, utilization review and capital spending approval requirements will prevent inappropriate uses of resources.

SUPPORTERS OF THE BILL –

Massachusetts's voters have consistently supported a universal single payer health care system like the one to be created by this bill. A 1986 referendum directing the State Legislature to call on the US Congress to enact a national health care program was approved by more than 66% of the voters statewide. A subsequent universal single payer referendum in 1994 was approved by over half of the voters in eight voting districts. In 1998, the voters in three legislative districts overwhelmingly approved a referendum question calling for a single payer health care system. Another local referendum was overwhelmingly approved in 1999, and three in 2000. A long list of organizations and groups support a single payer health care system including the Mass Public Health Association, Mass Senior Action Council, United Auto Workers CAP Council, League of Women Voters, Unitarian Universalists, Latino Health Institute, Mass Nurses Association, and many others. MASS-CARE is the umbrella organization whose purpose is to develop and build grass roots support for such a system.

MASS-CARE
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COMPARISON OF SINGLE PAYER WITH HEALTH CARE BILLS OF GOVERNOR ROMNEY, SENATORS TRAVAGLINI & MOORE

USING THE INSTITUTE OF MEDICINE'S 5 PRINCIPLES TO GUIDE EXPANSION OF COVERAGE

1. ***Health coverage should be universal.***

SINGLE PAYER – S755	SENATOR MOORE – S 738	SENATOR TRAVAGLINI - S 2042	GOVERNOR ROMNEY
Will cover all MA citizens. No employer mandate	**Will not cover everyone. Has employer mandate to provide health insurance for employees**	**Will not cover everyone.** Hopes to cover half of the uninsured in two years**. No employer mandate.** Will fund a study on the feasibility of a mandate for all individuals to buy health insurance.	**Will not cover everyone. No employer mandate.**

2. ***Health care should be continuous.***

SINGLE PAYER	SENATOR MOORE	SENATOR TRAVAGLINI	GOVERNOR ROMNEY
It is continuous.	**Not continuous.** Insurance policies from Commercial insurance companies are mostly job dependent, thus any loss or change in job may cause loss or change in health coverage.	**Not continuous for the same reason as Senator Moore's bill**.	**Not continuous for the same reason as Senator Moore's bill,** but Gov. Romney's plan does allow for subsidies for low cost insurance policies for six months while the unemployed look for jobs and during the waiting period before insurance at a new job kicks in.

3. ***Health care coverage should be affordable to individuals and families.***

SINGLE PAYER	SENATOR MOORE	SENATOR TRAVAGLINI	GOVERNOR ROMNEY
Health care coverage is affordable because it is paid by: **a**. income premiums (taxes) that would be less expensive for most people than out-of-pocket medical expenses that people currently pay **b.** federal and state monies from existing programs such as Medicare and Medicaid, **c.** employers' contributions. There are **no** co-pays, deductibles, health insurance premiums, or significant out-of-pocket expenses that would be barriers to health care access. **There are no means tests, all MA residents are eligible.**	**Health care coverage may not be affordable** because this plan relies on the commercial insurance industry and people will still have to pay insurance premiums, co-pays, and deductibles that make policies unaffordable. Even though the state will subsidize part of the cost of the health premiums for low wage earners, health insurance will still be too costly for many families to afford and the costs are likely to rise faster than the health premium subsidies. This plan also expands Medicaid.	**Health care coverage may not be affordable** because this plan relies on the commercial insurance companies to provide "affordable" health insurance policies. People will still have to pay insurance premiums, co-pays, and deductibles that often make policies unaffordable. This plan will offer a tax deduction for health savings accounts and subsidize employees' premiums who earn up to 300% of FPL. It will expand Medicaid to cover all the people who are currently eligible and require insurance companies to cover young adults up to age 25.	**Health care coverage may not be affordable** because this plan relies on the commercial insurance companies to provide "affordable" health insurance. The insurance industry will not be able to make a profit on low cost insurance unless the benefits are limited and the deductibles and co-pays are high, (bare bones policies). High deductibles and co-pays often are barriers to low income people seeking preventative and maintenance care. Gov. Romney plans to expand Medicaid to cover all the people who are currently eligible. `This will require significant outreach money.

4. ***The health insurance strategy should be affordable and sustainable for society.***

SINGLE PAYER	SENATOR MOORE	SENATOR TRAVAGLINI	GOVERNOR ROMNEY
Single payer SAVES money – It costs less than our present system. It is sustainable for the long term **because it eliminates huge administrative waste inherent in the commercial insurance industry, controls costs with a budget, uses bulk purchasing power for prescription drugs, plans for efficient use of health resource needs, and initiates public health programs to**	**This plan will add more costs to our system without universal coverage**. It calls for money to expand Mass Health, pay for health insurance subsidies for low income workers, a reinsurance program, increased payments for providers, and increasing the Insurance Partnership program. The plan has large administrative costs due to means testing, eligibility requirements, and a complex system. **It mandates the commercial insurance industry to provide health insurance coverage or pay into the system.** Administrative	**This plan will add more costs to the system without universal coverage.** The costs include: reforming the Insurance Partnership, a tax deduction for Health Savings Accounts, increasing Medicaid rates for hospitals, doctors, and health centers, new reinsurance pool, and expansion of Medicaid enrollment. The plan has large administrative costs due to means testing, eligibility requirements, and a complex system. **It relies on the commercial insurance industry to provide "affordable" health insurance coverage.** Administrative and market-	**Gov. Romney states that no new money will be needed to fund his system, but his plans include items that require more money.** He plans to enroll 106,000 eligible people into Medicaid. He plans to use the free care pool to pay for care for the chronically unemployed and the working poor in a network of clinics and community health centers. His plan facilitates the pre-tax payment of health premiums with his new Commonwealth Exchange. **The plan relies on the commercial insurance industry to**

promote a healthy MA. Most importantly it is accountable to the citizens of MA and will be flexible enough to change as our health care needs change.	and market-driven costs make the commercial insurance system much more expensive than a Single Payer system, (25% vs. 10%). **There are no significant cost control capabilities other than using public health programs to keep MA citizens healthy.**	driven costs make the commercial insurance system more expensive than a Single Payer system, (25% vs. 10%). **It controls costs by promoting preventive health programs and long term insurance, free-rider surcharge on employers and employees, and a website that compares cost and quality of care**	**provide "bare bones" health insurance policies.** High administrative and market driven costs make the commercial insurance system much more expensive than a Single Payer system, (25% vs. 10%). **The plan controls costs by tightly regulating expenditures for the poor.**

5. ***Health insurance should enhance health and well-being by promoting access to high quality care that is effective, efficient, safe, timely, patient-centered, and equitable.***

SINGLE PAYER	SENATOR MOORE	SENATOR TRAVAGLINI	GOVERNOR ROMNEY
Will allow **unlimited choice of provider, simplified efficient administration**, a Quality Council to improve safety, and direct input from patients into making the system user-friendly. What really sets Single Payer apart is that it is the fairest and most equitable plan because **every citizen of MA will have the same comprehensive policy which is not based on ability to pay, but on need of care.**	**Choice of provider will remain limited by the insurance plan offered by employer or by the patient's income**. The plan is complex and difficult for patients to understand**, it is not patient-centered or equitable because the plan is based on ability to pay and not on medical need.** The MA Health Quality and Cost Council will oversee safety issues.	**Choice of provider will remain limited by the insurance plan offered by the employer or by the patient's income**. The plan is complex and difficult for patients to understand, **it is not patient-centered or equitable for the same reasons as Sen. Moore's bill.** A Health Care Quality and Costs Information Board will provide cost and quality information about hospitals and doctors through an internet website.	**Choice of provider will remain limited by the insurance plan offered by employer or by the patient's income category**. The Safety Net Care plan will restrict patients' choice to designated health care centers or clinics potentially causing patients to lose their usual health care providers. The plan is complex and difficult for patients to understand, **not patient-centered or equitable because the plan is based on ability to pay and not on medical need.** Quality control limited to certifying the "bare bones" policies put out by the insurance companies.

KEY DIFFERENCES BETWEEN THE HEALTH CARE REFORM BILLS

The most important differences between the Tolman-Hynes Single Payer (Health Care Trust Bill S 755) and Senator Moore's, Senator Travaglini's, and Gov. Romney's bills are:

a. <u>The Single Payer is the most ethical plan</u> because it gives patients access to medical care on the basis of medical need and not by ability to pay. In other words, in Single Payer <u>everybody's in, nobody's out.</u> If you are a resident of MA you can get the care you need no matter what your financial status.

b. <u>In Single Payer the same comprehensive plan is available to all MA residents</u> and it covers all care that is medically necessary. There are no bare bones policies, no caps on benefits, or exclusions for mental health, preventive care, or previous illness.

c. <u>Senator Moore's, Senator Travaglini's, and Gov. Romney's plans are trying to find ways to cover the part of the population that is uninsured</u>. There have been many attempts to define the uninsured and find incremental ways to cover them. Yet the percentage of the population that is uninsured nationally has actually slowly increased from 13.7% in 1987 to 17.2% in 2002 and the total number of uninsured has increased from 29.5 million to 43.3million over that same time period. Each new plan that is enacted to cover the uninsured adds its own bureaucracy, eligibility requirements, and expenses so that the system becomes complex, confusing, and costly. Yet there always remains a group of people who don't meet the eligibility criteria for coverage. THE CONCEPT THAT INCREMENTAL REFORMS CAN ACHIEVE UNIVERSAL HEALTH COVERAGE DOES NOT WORK!

d. <u>Single Payer is simple administratively, is efficient, and saves money.</u>

e. <u>Senator Moore's, Senator Travaglini's, and Gov. Romney's plans rely on the commercial insurance industry</u> to provide affordable insurance. Single Payer does not allow commercial insurance companies to offer coverage for the items that are covered by the Health Care Trust, which keeps the system simple and efficient. The insurance companies waste up to 33% of their health care premium money on non-medical expenses that add significant cost to the health care system.

f. <u>Single Payer is the only plan for reform that can effectively control costs</u>. Cost control measures include a budget, negotiated lowered prescription drug prices, bulk purchasing, elimination of administrative waste, and making clinical care more efficient. None of the other plans has effective cost control measures.

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MASSACHUSETTS PHYSICIANS' OPEN LETTER ON HEALTH CARE REFORM

November 1, 2005

Dear Governor Romney, Speaker DiMasi and Senate President Travaglini:

We urge you to abandon your ill-conceived proposals for health care reform and to adopt, instead, a single payer program of universal coverage for the Commonwealth.

As physicians and health professionals, we witness the heavy toll of unnecessary suffering endured by patients who delay care and even forego vital treatment due to costs. While the uninsured bear the heaviest burden, many with insurance also find care unaffordable due to co-payments, deductibles and restrictions on coverage. Reforms should address the grave problems of both groups.

Your plans to loosen regulations on health insurance, allowing ever-skimpier coverage, would perpetrate a cruel hoax. Such cut-rate policies would cost families thousands of dollars yet offer miserly care and little protection from financial ruin in the face of serious illness. Many who currently enjoy adequate coverage would doubtless be forced into plans with gaping holes and onerous restrictions on choice. If there is one thing worse than being uninsured it's paying dearly for worthless coverage.

Your view that we can achieve universal coverage by forcing people to buy themselves insurance ignores the most basic facts about who is uninsured. Only 12.4% of the 748,000 uninsured in our state are both young enough to qualify for low-premium plans (under age 35) and affluent enough (family incomes greater than 499% of poverty) to readily afford them. Yet even this 12.4% figure may be too high if insurers are allowed to charge higher premiums for persons with health problems; only half of uninsured persons in those age and income categories report that they are in "excellent health" (The statistics in this paragraph were obtained by analyses of data that the Census Bureau collected on Massachusetts residents in March 2005).

Proposals to raid the existing free care pool in order to partially subsidize cut-rate policies would actually worsen the plight of many who are currently uninsured. Under such reforms, patients now eligible for free or low-cost services would often face greater restrictions on care and higher out-of-pocket costs. The only real winners would be the private insurers who would surely gain millions from the sale of near-useless policies.

Replaying Dukakis' failed employer mandate, i.e. making employers pony up more money for coverage, will not lead to universal coverage. As Dukakis found, relentlessly rising health costs quickly stir rebellion among powerful employers, making the program unsustainable.

While we welcome the expansion of Medicaid as a stopgap measure to cover more poor families, we know that this strategy ultimately leads to a dead end. Inevitably, the next economic downturn will bring a flood of additional families pushed onto the Medicaid rolls just as state tax revenues fall. As in the past, Medicaid will be cut when the need is greatest.

In contrast, a single payer reform would create a stable long-term financing mechanism for

health care. It could cut costs by streamlining health care paperwork, making universal, comprehensive coverage affordable. The Commonwealth's three largest private insurers spend more than $1.3 billion annually on billing, marketing, high executive salaries and other administrative costs. That's ten times as much overhead per enrollee as Canada's national health insurance program. And hospitals and doctors spend billions more fighting with insurers over payments for each aspirin tablet, x-ray and doctor's visit. If we cut bureaucracy to Canada's levels we could save at least 14% of current health expenditures, enough to cover all of the uninsured in Massachusetts and to improve coverage for the rest of our patients as well.

And single payer is popular. Sixty-two percent of Massachusetts doctors support it (according to a recent study in the Archives of Internal Medicine), joining the Massachusetts Nurses Association and dozens of other labor, seniors and consumer groups.

We recognize that a single payer reform threatens the multi-billion dollar insurance industry, and would force down the high profits enjoyed by drug companies. But such interests must not be placed ahead of the health of the people of Massachusetts. Only a single payer system can assure universal and comprehensive coverage at an affordable price. The people of the Commonwealth deserve no less.

Sincerely,

Nancee Bershof, M.D., Greenfield
J. Wesley Boyd, M.D., Cambridge
John Day, M.D., Boston
Tina Furcolo, D.O., Springfield
Kathleen Grandison, M.D., Shelburne Falls
Audrey Guhn, M.D., Springfield
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