

Compiled by
The League of Women Voters
of Arizona
2009

Health Care Issues Behind Health Care Reform

@ 2009 by League of Women Voters of Arizona

Printed and bound in the United State of America. All rights reserved.

Permission is automatically given to branches of the League of Women Voters (state or local) to use any or all parts of this tract.

Electronic Transmittal of this document in its entire form is allowed by anyone. No **partial** multiple-page parts of this tract may be reproduced or transmitted in any form or by any means, electronic, mechanical or otherwise, including photocopying, recording or by an information storage and retrieval system without permission in writing from the publishers, **except for** state or local League of Women Voters branches as stated above, **or for briefly quoted passages in review or for educational purposes.**

Although in the compiling of this material every attempt has been made to ensure the accuracy and completeness of the information and appropriate credit, we assume no responsibility for errors, inaccuracies, omissions or any inconsistency herein. Any slights of people or organizations are unintentional.

For information, please contact:

League of Women Voters of Arizona
2510 S. Rural Rd. #102
Tempe, AZ 85282
480.966.9031

Visit:

The League of Women Voters of Arizona at www.lwvaz.org

LWVAZ Health Care Project committee members:

Lois Brechner, BA, MA *	Annette Nunnally, MS
Bonnie Boyce-Wilson, MSW, ACSW	Jessica Mathewson, MBA
Valerie Ellien, Ph.D.	Robyn Prud'homme-Bauer, BS
Terri Farneti, BS	June Ruth, MSPHN
Barbara Klein, MPS, DC *	Kathy Schwarz, Ph.D.
Barbara Litrell, BA	Linda Yee, RN MSN CEN FAEN

*Co-chairs

Many people provided information for this publication. We are grateful for their contributions, and for those of the many organizations and individuals that work so hard on the issue of health care reform.

Note to Reader

Health Care in the US is not a complete failure. It is amazingly good at certain things, such as research and development of new treatments. But the compliments may stop there. We have flaws so great as to cause large chasms getting close to letting the ground crumble beneath our feet. We can not sustain the system and at the same time stand on solid ground.

There are many issues to consider:

- too many people uninsured,
- too many people using expensive ER health care,
- rising costs of treatment in this country,
- rising costs of premiums,
- maintaining choice of providers,
- lack of preventative care,
- insurance companies cherry picking
- and discriminating against preexisting conditions,
- consumers unable to afford out-of pocket expenses,
- companies unable to provide employees insurance,
- small and large companies suffering under 'benefit' costs,
- question of whether we over-test unnecessarily,
- health care lobbyists having more power than public
- pharmaceutical costs not negotiated and higher in US
- quality control issues,
- ever-growing bankruptcies due to illness

No matter what issue you see as a priority, it will be complex. But the longer we wait to solve the issues, the shakier the ground beneath our feet. We need a bridge over the chasm between the wealthy and middle-class/poor; between providers and patients; between those who like their insurance and those who have none; and between those who support the free market to the fullest extent and those who support government involvement.

This booklet is designed to discuss the chasm itself: the problems with the system.

The League of Women Voters of Arizona

TABLE OF CONTENTS

Health Care Issues *Behind* Health Care Reform

Healthcare - The Problem	6
How Does the US Compare with Other Countries	7
Out-of-Pocket Expense	14
Medical Bankruptcies	15
Comparison of Health Care Administrative Costs / Paperwork	16
Where Does US Citizen Stand In the World of Health Care Costs?	22
Health Care Costs for Family of Four	23
Health Care Costs and US Competitiveness	24
CEO's Salaries in the Health Care Industry	27
How Much Do Doctors Earn?	28
What Americans Think of their Health Care	30
Survey of Physician Appointment Wait Times	31
The Truth About Medical Malpractice	34
The Question of Burden to US Health System from Illegal Immigrants	35

The Insured and Uninsured in the US	37
Is Coverage the Only Concern?	39
Preexisting Conditions	40
Are Americans Healthier?	41
Preventive Care	42
Growth of the Aging Population	44
Long-Term Care and Issues	45
10 Key Findings on Long Term Care Needs and Costs	46
Pharmaceutical Issues	47
Americans Have Few Choices When It Comes to Health Insurance	50
Current US Health Care Systems Summarized	53
Comparison of Proposed Plans	54
Glossary	56

Healthcare

The Problem

- ❖ US has the highest health care costs of any industrialized country but falls far behind in quality of care as measured by life expectancy, infant mortality, annual reported deaths due to medical errors, and the high number of preventable deaths.
- ❖ The US also trails other countries when it comes to patient satisfaction and preventive health care.
- ❖ Although the US spends more on health care, more than 46 million Americans are not insured and another 25 million are underinsured. The burden of covering the costs of health care for these two groups is shifted to state Medicaid programs, employer-provided health care and individual policy holders.
- ❖ Cost-sharing – costs to the insured being higher because of uninsured and high usage of expensive Emergency Room services cost most insured US families approximately \$1,000 in higher than necessary premiums annually.
- ❖ Health care costs increased more than 7.8% last year, 2% more than the GDP, and currently exceed \$2.2 trillion. It is estimated that if costs are not contained they will take up 19.5% of the GDP by 2017.
- ❖ Home health care and prescription drug costs have increased at a higher rate than other health care costs.
- ❖ Because of the dilemma of high costs and apparent uneven or low quality of care, health care reform has become a hotly debated topic. There is general agreement that something needs to change, but there is little agreement on what those changes should be. In the past, efforts to reform health care have failed because of the economic interests of the providers and confusion on the part of users. The current system is complex and costly and any change will require an informed and demanding public

Sources:

Keckley, Paul H. and Underwood, Howard. "Reducing costs while Improving the U.S. Health Care System: Health Care Reform Pyramid." Article at:

http://www.deloitte.com/dtt/cda/doc/content/us_chs_ReformPyramid_09.pdf

Health Reform Toolkit, Robert Wood Johnson Foundation. Allhealth.org/Publications/Cost of health care/health care costs toolkit.

The Questions behind the Problem

- ❖ Is health care a privilege or a right?
- ❖ Is health care for everyone a moral imperative?
- ❖ Does health care actually fit the free-market (capitalistic) model?

A COMPARISON OF HEALTH CARE SYSTEMS

The comparisons below are between the United States and countries with some type of 'universal health care.'

Universal health care describes several forms of government action designed to extend access to health care to all of its citizens. Most of the countries below (and others with universal health care) implement universal health care through legislation, regulation and taxation. Usually some costs are borne by the patient at the time of consumption, but the bulk of costs come from a combination of *compulsory* insurance and tax revenues. Some programs are paid for entirely out of tax revenues. In some cases, government involvement also includes directly managing the health care system (socialized). Many countries use such mixed public-private systems to deliver universal health care

JAPAN

Percent change of Gross Domestic Product (GDP) Spent on Health Care - 8.2%

Average Family Premium

The monthly insurance premium is 0-\$435 per household (scaled to annual income), with employers paying more than half.

Co-payments

Co-payments are 30% of the cost of a procedure, but the total amount paid in a month is capped according to income.

System Used to Deliver Care (including Long Term Health Care)

Japan uses a "social insurance" system where all citizens are required to have health insurance, either through their work or privately from a nonprofit, community-based plan. Those who cannot afford premiums receive public assistance.

On April 1, 2000, Japan started a public program of mandatory long-term care insurance. Every person 40 and over with an income must contribute and all older persons with even mild disabilities are eligible regardless of income. The program will cover nearly the full cost of institutional or community-based care, depending on the level of disability. Informal care of the elderly by family members is an important part of Japan's long term care delivery. The largest percentage of the Japanese elderly population live with adult children.

GERMANY

Percent of Gross Domestic Product (GDP) Spent on Health Care - 10.6%

Average Family Premium

Germany's health care system was 77% government-funded and 23% privately funded as of 2004. Monthly premiums are relative to patient's income.

Co-payments

10 euros (about \$15) every 3 months. Some patients, like pregnant women, are exempt.

System Used to Deliver Care (including Long Term Health Care)

The German social insurance approach to long-term care (LTC) financing has addressed a number of problems by:

- Providing universal coverage for services based on level of disability, not income.
- Promoting consumer choice in types of services and setting. Patients can decide whether to be treated at home or in an institution.
- Providing support for home care.
- Developing more uniform standards of quality throughout the country.
- Providing a cash payment to service recipients (begun 1966), who could then use those funds to pay informal caregivers. Their LTC fund may also make pension contributions if an informal caregiver works more than 14 hours per week. LTC is covered half and half by employer and employee and covers cases in which a person is not able to manage his or her daily routine; it is about 2% of a yearly salaried income or pension, with employers matching the contribution of employee

SWITZERLAND

Percent of Gross Domestic Product (GDP) Spent on Health Care - 11.3%

Average Family Premium

Premiums are paid entirely by consumers with government subsidies for low-income citizens. The insured person pays part of the cost of treatment. This is done by means of an annual excess, (or deductible, called the *franchise*), which ranges from \$253 to a maximum of \$2,108, as chosen by the insured person (premiums are adjusted accordingly) and by a charge of 10% of the costs over and above the excess.

Co-payments

10% of the cost of service, up to \$420 per year.

System Used to Deliver Care (including Long Term Health Care)

Insurance is compulsory for all persons residing there (within three months of taking up residence or being born in the country); those not covered are automatically assigned to a company. The government provides assistance to those who cannot afford premiums.

Municipalities are responsible for providing care for the aged. Formal care is provided in old age or disability homes; medical nursing homes; and by informal caregivers. LTC, usually provided by a relative or family member, is an important part of LTC in Switzerland. Swiss cantons are similar to states or districts (with many smaller municipalities within each). The cantons subsidize the construction and running costs of public and certain private nursing homes. SPITEX is a Swiss-German acronym for

domestic aid and day care services outside of the hospital to disabled and frail individuals. Institutional care is financed 1/3 by public support, insurance, and assistance, and 2/3 by individuals. There is no mandatory LTC insurance for the elderly.

UNITED KINGDOM

Percent of Gross Domestic Product (GDP) Spent on Health Care - 8.4%

Average Family Premium

None - funded by taxes.

Co-payments

None for most services; some co-pays for dental care, eyeglasses and 5% of the cost of prescriptions. Young people and the elderly are exempt from all drug co-pays.

System Used to Deliver Care (including Long Term Health Care)

The General Practitioner acts as gatekeeper to the rest of the system; patients must see their GP before going to a specialist. Currently, there is no mandatory LTC insurance costs for the elderly, although considerations for such 'co-pay' arrangements are being considered.

NETHERLANDS

Percent of Gross Domestic Product (GDP) Spent on Health Care - 9.3%

Average Family Premium

The system is 50% financed from payroll taxes paid by the employer to a fund controlled by the Health Regulator; the government contributes an additional 5% to the fund; and the remaining 45% is collected as premiums paid by the insured directly to the insurance company.

System Used to Deliver Care (including Long Term Health Care)

A public/private financing mix of required contribution from the privately insured to the socially insured. Private health insurance (PHI) is the sole source of primary health coverage for a third of the Netherlands' population earning above a set income threshold. Social insurance (together with limited public tax-based financing) is the main source of health coverage for the majority of the population. Most socially insured also purchase supplementary private health coverage. All citizens are eligible for a system of coverage for long-term care and care for the chronically ill. The source of health financing is determined according to the category of health risk, type of illness, as well as income level. A surcharge is paid by the healthier privately insured to the less healthy and elderly coverage market.

In the Netherlands, LTC for elderly people, whether at home or in an institution, is paid out of a compulsory insurance premium levied on the whole population. The 1967 Exceptional Medical Expense Act (AWBZ) covers the medical costs for all chronic care the patient cannot meet through their normal health insurance. Everyone pays premiums, fixed each year, which is about 10% of taxable income. Elderly must contribute to the cost of their care. Personal contributions are income-related.

SWEDEN

Percent of Gross Domestic Product (GDP) Spent on Health Care - 9.2%

Average Family Premium

Patients pay user fees (similar to co-payments in the United States) that are set by county councils. While county councils have discretion in setting user fees, the national government limits the amount of total user fees paid per patient for physician, hospital care, and specialist visits.

System Used to Deliver Care (including Long Term Health Care)

Sweden has a socialized health care system, whereby almost all of the funding comes from government revenue, and most aspects of the health care system, such as hospitals, primary care centers and prescription drugs, are controlled by the government. The state finances the bulk of health care costs, with the patient paying a small nominal fee for examination. The state pays for approximately 95% of medical costs. Most LTC is funded from taxation and supplied by the government. Primary health care and LTC are integrated at the municipal level. Care for the elderly is almost entirely funded from taxes with moderate user fees. Social services are provided to all elderly people on an as needed basis.

CANADA

Percent of Gross Domestic Product (GDP) Spent on Health Care - 10.0%

Average Family Premium

Some provinces charge a small monthly premium for basic coverage; however, most employers pick up the tab for their employees' premiums as a part of a benefit package and the province covers it for people on public assistance or disability. Group plans are cheap enough that even small employers can afford to offer them as a routine benefit.

System Used to Deliver Care (including Long Term Health Care)

Publicly financed and privately delivered, this health system is composed of 10 provincial and 3 territorial health insurance plans. Constitutionally, health care is under the jurisdiction of the provincial governments - not the federal government. The management and delivery of health services is the responsibility of each province or territory; each of them plan, finance, and evaluate the provisions of hospital care, physician and allied health care services, some aspects of prescription care, and public health. The federal government's role in health care financing is to collect the taxes that pay for the bulk of the system, and then transfer it back to the provinces. Each province must ensure that the health care system that it designs meets the conditions of the Canada Health Act.

Canada's national health insurance program, often referred to as "Medicare," is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Instead of having a single national plan, Canada has a national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage. Roles and responsibilities for Canada's health care system are shared between the federal and provincial-territorial governments.

FRANCE

Percent of Gross Domestic Product (GDP) Spent on Health Care - 11.1%

Average Family Premium

A premium is deducted from all employees' pay automatically. An employee pays less than 1% (0.75%) of salary to this insurance, and employer pays an amount up to the value of 12.8% of employee's salary. Those people earning less than \$9,195 per year do not make health insurance payments. The patient must first pay the full bill and is then reimbursed at a later date (in about 10 days). For full reimbursement of health costs, many employees also pay a voluntary premium, up to 2.5% of salary. In addition to payroll contributions, a general social contribution (or social security tax) of 7.5% (known as the CSG or *Contribution Sociale Generalisée*) is levied on employment, general earnings and investment income.

System Used to Deliver Care (including Long Term Health Care)

France has a system of universal health care largely financed by government through a system of national health insurance. Approximately 77% of health expenditures are covered by government.

Most general physicians are in private practice but their incomes are drawn from a publicly funded insurance fund. The government has responsibility for the financial and operational management of health insurance. It generally refunds patients 70% of most health care costs, and 100% in case of costly or long-term ailments. Supplemental coverage may be bought from private insurers, most of which are nonprofit. Coverage is extended to all legal residents in France. There are public hospitals, non-profit independent hospitals (linked to public system), as well as private for-profit hospitals.

The government has two responsibilities in this system:

- Fixing the rate at which medical expenses should be negotiated and fixing the reimbursement rate for medical services.
- Oversee the health-insurance funds to ensure that they are correctly managing the sums they receive, and to ensure oversight of the public hospital network.

An important element of the French insurance system is that the more ill a person becomes, the less they pay. This means that for people with serious or chronic illnesses, the insurance system reimburses them 100 % of expenses, and waives their co-pay charges. This eliminates the problem of bankruptcy or destitution due to illness.

UNITED STATES

Percent of Gross Domestic Product (GDP) Spent on Health Care - 15.3%

Average Family Premium

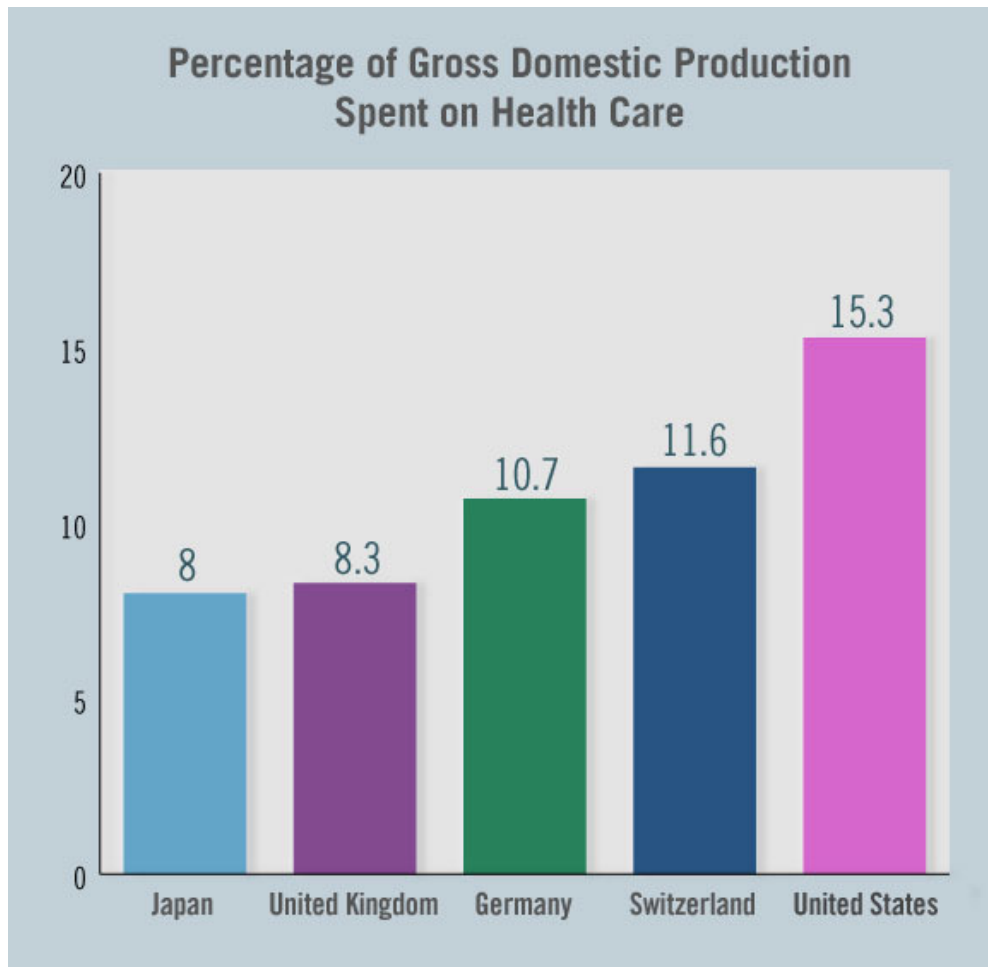
Premiums vary and are controlled by private insurance companies

System Used to Deliver Care (including Long Term Health Care)

Health insurance is one of the main avenues for the payment of medical expenses in the U.S., whether through for-profit insurance premiums, social insurance such as Medicare, or a social welfare program funded by taxation. Individuals unable to obtain insurance through an employer and wishing to be insured have to buy a policy in the individual

private insurance market. This is highly expensive and premiums are typically much higher than for an equivalent policy paid for by an employer.

Additional LTC insurance is necessary for care generally not covered by health insurance, Medicare, or Medicaid. In the US, once a change of health occurs, individual may not be eligible to buy LTC insurance.



These figures are slightly different than the sources in the text and next chart, but maintain similar comparison. Interestingly enough, Japan performs many more tests than the US (almost twice as many MRIs and almost three times as many CT scans) and yet still spends much less in GDP. Health care 'profits' and salaries in Japan are not as high.

Source: Chart draws upon data from a [2007 report](#) by the Organisation for Economic Co-operation and Development (OECD), which collects economic statistics on its 30 member countries. Noted on website for PBS FRONTLINE's episode: **Sick Around the World**

HOW DOES THE U.S. COMPARE TO OTHER COUNTRIES? **OECD HEALTH DATA 2008**

Health Expenditure as a Share of GDP Per Capita Public & Private Expenditure - OECD Countries

Country	% GDP Spent On Health Care	TOTAL HEALTH SPENDING PER CAPITA, PUBLIC & PRIVATE (USD)*
United States	15.3	6714
Switzerland	11.3	4311
France	11.1	3449
Germany	10.6	3371
Canada	10.0	3678
Netherlands	9.3	3391
Sweden	9.2	3202
United Kingdom	8.4	2760
Japan	8.2	2474

*Data are expressed in US dollars adjusted for purchasing power parities (PPPs), which provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalize the cost of a given 'basket' of goods and services in different countries.

Source: OECD Health Data 2008, June 2008

WEBSITE RESOURCES

www.oecd.org/document/25/0,2340,en_2649_33929_2380441_1_1_1_1,00.html

SHA-Based National **Health** Accounts in Thirteen **OECD** Countries, #16

www.NationalCenter.org/NPA555_Sweden-Health_Care.html

Sweden's Single-payer Health System Provides a Warning to Other Nations by David Hogbert, Ph.D., National Policy Analysis, May, 2007

www.Frenchentree.com/fe-health/ Introduction to French Health Care

www.Wikipedia.org/Health_Insurance_in_the_U.S Health Canada

www.hc-sc.gc.ca Canada's Health Care System

<http://www.oecd.org/dataoecd/10/53/33661480.pdf>

OECD Health Working Papers. SHA-Based National Health Accounts in Thirteen OECD Countries: A Comparative Analysis Eva Orosz and David Morgan august 2004 #16

OECD Health Data 2008 www.oecd.org/document

<http://www.aarp.org/acrossthestates> .

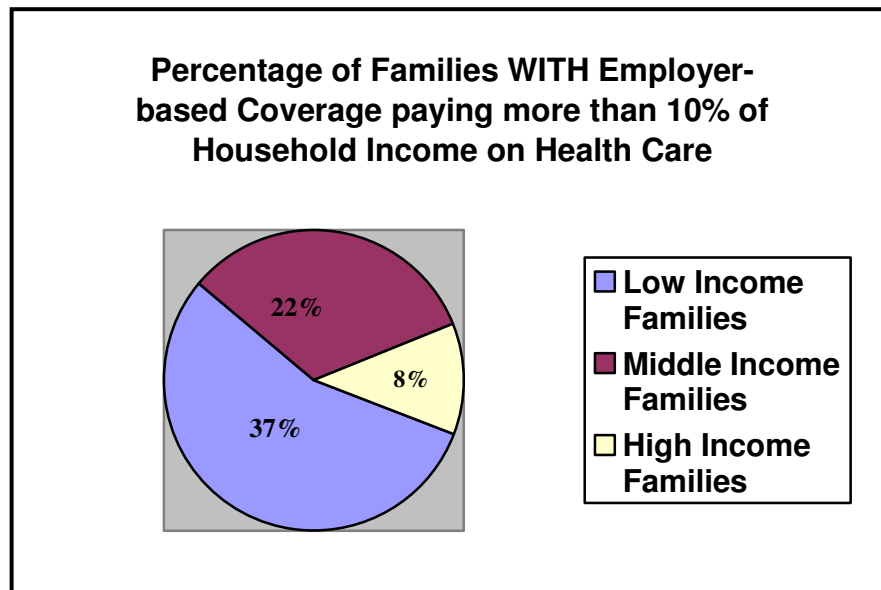
Across the States 2006: Profiles of Long-Term Care and Independent Living, 7th ed., 2006, by Ari Houser, Wendy Fox-Grage, and Mary Jo Gibson. AARP Public Policy Institute, Pub.

OUT-OF POCKET COSTS

The level of total health spending per capita, (public and private) is higher than other countries, as previously seen. What about the spending on health care between socio-economic levels in the United States? Here we look at one segment, those with insurance coverage from employers (so they have insurance and employment) and yet still pay **10% or more** of their income on health care.

US Families WITH Employer based coverage pay significant amounts of income on Health Care.

Out-of-Pocket Costs



Medical Bankruptcy in US Rising: Results of a National Study 2007

Citation:

Medical Bankruptcy in the United States, 2007: Results of a National Study

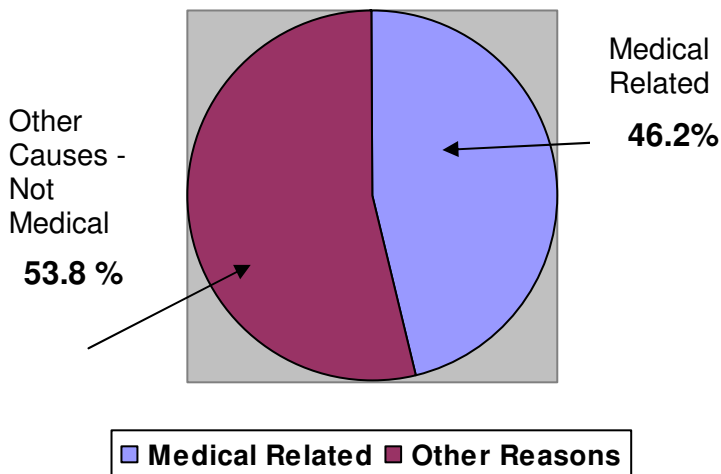
David U. Himmelstein, MD, Deborah Thorne, PhD, Elizabeth Warren, JD, Steffie Woolhandler, MD, MPH. *A Department of Medicine, Cambridge Hospital/Harvard Medical School, Cambridge, Mass; Department of Sociology, Ohio University, Athens; and Harvard Law School, Cambridge, Mass.*

In the **ABSTRACT** of this article, the **BACKGROUND** was stated as follows: "Our 2001 study in 5 states found that medical problems contributed to at least 46.2% of all bankruptcies. Since then, health costs and the numbers of un- and underinsured have increased, and bankruptcy laws have tightened."

In the **CONCLUSION** they state: "Illness and medical bills contribute to a large and increasing share of US bankruptcies."

- 62.1% of all bankruptcies have a medical cause.
- Most medical debtors were well educated and middle class.
- Three quarters had health insurance.
- Share of bankruptcies attributable to medical problems rose by 50% between 2001 & 2007.

2001 Bankruptcy Causes

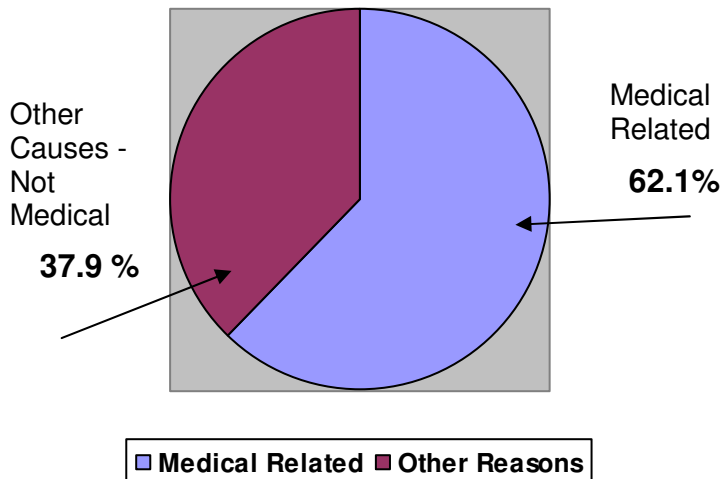


Medical 'causes' used were identical for 2001 and 2007. They included medical problems for self, spouse or family and included loss of significant income due to illness, mortgaged a home to pay medical bill, had medical bills uncollected or problems, some became completely disabled, or lost income having to take time off to care for a family member.

See article for full descriptions.
http://pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

*Percentage based on recent homeowners rather than all debtors.

2007 Bankruptcy Causes



COMPARISON OF HEALTH CARE ADMINISTRATIVE COSTS

“Compared to other countries, the United States does not get value for its health care spending. We spend more but do not receive more services or achieve better outcomes.” Thus begins an article by Drs. David Himmelstein and Steffi Woolhandler.

What is an administrative cost?

- It's the difference between what an insurance company collects from enrollees in premiums and what it pays for their health service claims.
- It pays for claims processing, underwriting, marketing, utilization review, building up reserves, general management, staff salaries and profit.
- It is often shown as a percentage of the premium, and ranges from 5% to 50% or more. For example, if an insurance company pays 20 cents for administrative costs for every premium dollar it collects, then its administrative cost is 20%.

A comparison of administrative costs among private and public insurers

Country	Private (% of premium income)	Public (% of public expenditure on health)
Austria	22% (early 1990s)	3.6% (2000)
Belgium	25.8% (commercial individual) 26.8% (commercial group)	4.8%
France	10%-15% (mutuals) 15%-25% (commercial)	4-8%
Germany	10.2%	5.09% (2000)
Greece	15%-18% (commercial life insurers)	5.1%
Ireland	11.8% (Vhi Healthcare 2001) 5.4% (Vhi Healthcare 1997)	2.8% (1995)
Italy	27.8% (2000)	0.4% (1995)
Luxembourg	10%-12% (mutuals)	5%
Netherlands	12.7%	4.4%
Portugal	c. 25%	-
Spain	c. 13%-15%	5%
United Kingdom	c. 15%	3.5% (1995)
United States	c. 15%	c. 4%

Note: figures for 1999 unless otherwise stated

Source: Mossialos E, Thomson S. "Voluntary health insurance in the European Union: report prepared for the Directorate General for Employment and Social Affairs of the European Commission", available online at: http://europa.eu.int/comm/employment_social/soc-prot/social/index_en.htm. London School of Economics and Political Science, 2002.

Or http://www.euro.who.int/HEN/Syntheses/hcfunding/20040630_9 (Health Evidence Network from WHO)

PAPERWORK and INSURANCE OVERHEAD

In recent years, administrative costs have been the fastest-rising component of health care spending in the US, with a 16.8% increase for private insurers in 2002, up from a 12.5% increase in 2001. The latest estimate shows private insurance administrative costs account for 7% - 20% of total U.S. health care spending (compared with around 3% for the Medicare program).

The cost of private health insurance administrative expenses per enrollee has been rising at an increasing rate, from \$85 in 1986 to \$421 in 2003.

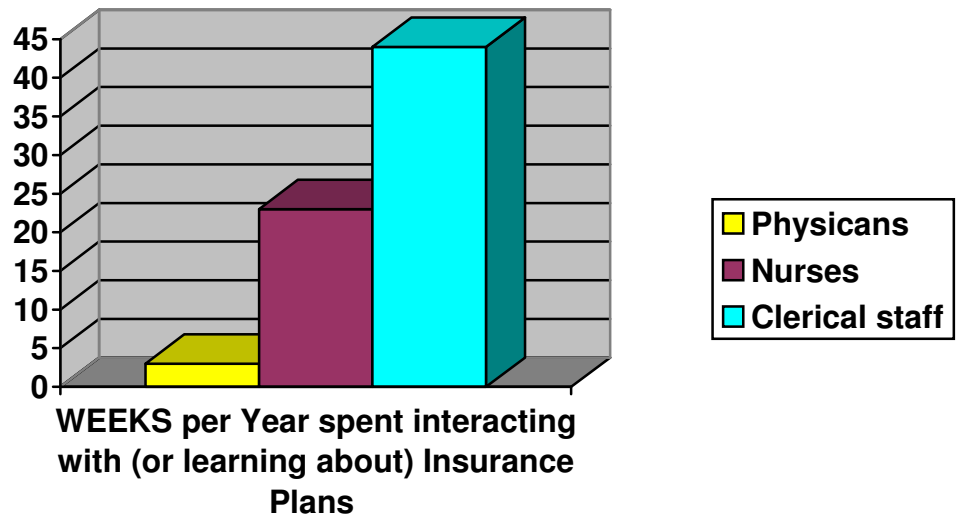
HEALTH EXPENDITURES

The following chart measuring health expenditures in US dollars was prepared by OECD in 2003:

Country	Hospital Spending Per Day	Hospital Spending Per Discharge	Doctors' Income
Australia	998	6264	66,540
Canada	924	8860	100,781
France	561	4270	60,161
Germany	562	5129	104,700
Italy	826	5988	Not provided
Japan	Not provided	7482	70,324
Spain	734	5861	Not provided
Sweden	Not provided	Not provided	40,942
United Kingdom	Not provided	Not provided	42,826
United States	2263	14,095	199,000

According to the study by Lawrence P. Casalino, M.D., Ph.D., of Weill Cornell Medical College and colleagues, physician practices report that overall the costs of interacting with insurance plans is \$31 billion annually and 6.9 percent of all U.S. expenditures for physician and clinical services.

On average, physicians spent three hours a week or nearly three weeks per year on these noted activities (basically paperwork), while nursing staff spent more than 23 weeks per physician per year, and clerical staff spent 44 weeks per physician per year interacting with health plans. More than three out of four of the respondents said the costs of interacting with health plans have increased over the past two years.



"While there are benefits to physician offices' interactions with health plans—which may, for example, help to reduce unnecessary care or the inappropriate use of medication—it would be useful to explore the extent to which these benefits are large enough to justify spending three weeks annually of physician time or one-third of the average primary care physician's compensation on physician practice-health plan interaction," said Casalino. "It would also be useful to explore ways to make the interactions more efficient, both on the health plan side and in physician offices." Note: as stated, and as shown in the chart, these 3 weeks of physician work time indicate 3 weeks every year taken away from direct patient care.

Other study findings include:

- Physicians – especially primary care physicians – in a solo or two-person practice spent significantly more hours interacting with health plans than physicians in practices with 10 or more physicians.
- Across practices, physicians and their staffs spent substantially more time on authorization, formularies, claims and billing and credentialing than they did on submitting quality data or reviewing quality data provided by health plans.

"Because many providers care for patients insured by numerous private and public plans, they must contend with multiple payment schedules, claims forms and credentialing requirements. These complicated requirements create wasteful excess costs and do little to improve the quality of care," said Commonwealth Fund President Karen Davis. "A high performing health care system is possible only with improved coordination and elimination of waste—not only between physicians and insurers but in all parts of the health care delivery system."

"To get to a health care system that is high-quality and delivers better value for everyone, we have to address the skyrocketing price of health care's administrative costs," said Risa Lavizzo-Mourey, M.D., M.B.A., president and CEO of the Robert Wood Johnson Foundation. "Administrative costs will never be zero, but we need to make sure that administrative interactions improve the quality of care by working to make care safer and more efficient and rewarding health care providers who successfully reduce excessive care and provide the right treatment at the right time."

A Closer Look at Billing, Paperwork and Insurance-Related Costs

A separate study, also published online by Health Affairs and co-funded by The Commonwealth Fund and the HCFO, provides an in-depth look at the billing and insurance-related activities performed at a large multi-site, multi-specialty group practice in California to get paid for clinical services. The study found that clinicians spent more than 35 minutes per day performing billing and insurance-related tasks and that these activities also required the equivalent of 0.67 non-clinical full time staff per full-time physician at an annual cost of \$85,276 per physician, representing 10 percent of operating revenue.

The authors note that even though the practice uses an electronic medical record system for billing and clinical record keeping and has implemented extensive automation, the complexity of serving patients covered by hundreds of specific insurance plans, each with different benefits, payment rates and billing procedures, greatly adds to the administrative workload. The challenge of managing these widely varying requirements increase the chance of billing error and dispute and the likelihood of requiring payment follow-up and collections.

"We believe that while minimizing billing and insurance-related administration activities is not the only goal of the health care system reform, standardizing health plan features and processing requirements presents a tremendous opportunity for improving efficiency in a multi-payer health care system," said Julie Sakowski, Ph.D., a senior health services researcher at the Sutter Health Institute for Research and Education.

Provider Overhead: Getting provider bills collected - managing the patient, doctor and insurer payments and reimbursements - cost more than [\\$350 billion](#) in 2007. Industry wide that makes up 15% of all U.S. health care spending and is 20% of all the medical 'benefits' provided. Note; this means that one in every 5 dollars spent on providing medical treatment goes towards bill collection. No other industry has such high costs in collections - only health care - and only in this country. ["Health Care Collections cause Swelling of Bills", Business columnist, Cheryl Hall, Dallas News, February 3, 2008.]

The denial management industry: The Wall Street Journal reports that the “denial-management industry’s rise shows how much of medical spending is consumed by propping up and doing battle over an arcane patchwork of claims systems.” But the costs to those who have their claims denied cannot be calculated, particularly as denied treatment can result in death. These administrative costs are a huge burden for our health care providers.

- U.S. hospitals spend almost a quarter of their budgets on billing and administration.
- Because our system gives **insurers with no medical training** the right of final approval on every prescription, procedure and treatment that a provider recommends, hospitals and physician practices must employ people whose sole job it is to deal with insurers and processing claims denials.
- These payment disputes are costing medical providers and insurers about \$10 billion annually in unnecessary administrative expenses.

Meanwhile, more and more doctors are being driven from geriatric and primary care. Why are these doctors hit harder than specialists? Primary and geriatric doctors rely on preventive care, which requires exhaustive and time-consuming cognitive evaluations that these doctors can’t bill for, rather than the clear-cut procedures insurers favor in our pay-for-service (rather than pay-for-health) system. And who pays when people cannot get the primary preventive care they need? We all do. We may all pay for this problem in uncounted ways and costs, in treatment of uninsured or underinsured once their illness has progressed, in expensive subsidized emergency room care, in personal pain and illness or the emotional tragedy of the death of a loved one. Even those who earn their livings in health care or through health care pay these costs. We all pay.

Lobbying and Overhead: Insurance and drug companies spend a lot on lobbying each year to maintain their power and profits. Supposedly there are two health care lobbyists (excluding those for pharmaceutical companies) for every US Senator and Representative! And during the period of March to July 2009 when most reform options were on the table, it was reported that this number skyrocketed [*National Public Radio*]. All that lobbying is *an administrative expense* that these companies have to make up for in revenues. Think about how much this must contribute to health care costs.

Pharmaceutical and insurance companies as well as their trade associations have a long history of lobbying Congress for many of the laws that shape the drug market today. According to Umang Malhotra in "Solving the American Health Care Crisis" (2009) Health is one of the biggest areas of lobbying efforts and "over \$300 million was spent by lobbyists in 2005" [alone]. From this, he surmises "Money talks! The amount of money spent by lobbyists in influencing Congress and the Executive branch is not helpful in drafting legislation related to health care in America. "

When asked how many lobbyists the pharmaceutical manufacturing industry employs in Washington, D.C., a researcher at the Center for Responsive Politics in D.C. sets the figure at 3,379 - roughly 6 pharmaceutical manufacturing lobbyists for every senator and congressperson. (See more information at the website of the Center for Responsive Politics at www.opensecrets.org about who contributes to which campaigns for federal offices, which federal staffers and employees move through the revolving door to industries, who the "heavy hitter" campaign contributors are, and how much certain industries pay for lobbying.)

Most would agree that the numbers are daunting to ordinary folks. According to Health Care analyst, Brian Klepper (Health Care Blog 4/15/09 Open Secrets.org) last year, health care lobbyists spent nearly a half-billion dollars wooing Congress- "an average of about \$832,000 for each Senator and Representative." Though as Klepper points out, "Of course there's nothing new here. For decades the health care industry has leveraged its money and influence, shaping policy to its own ends."

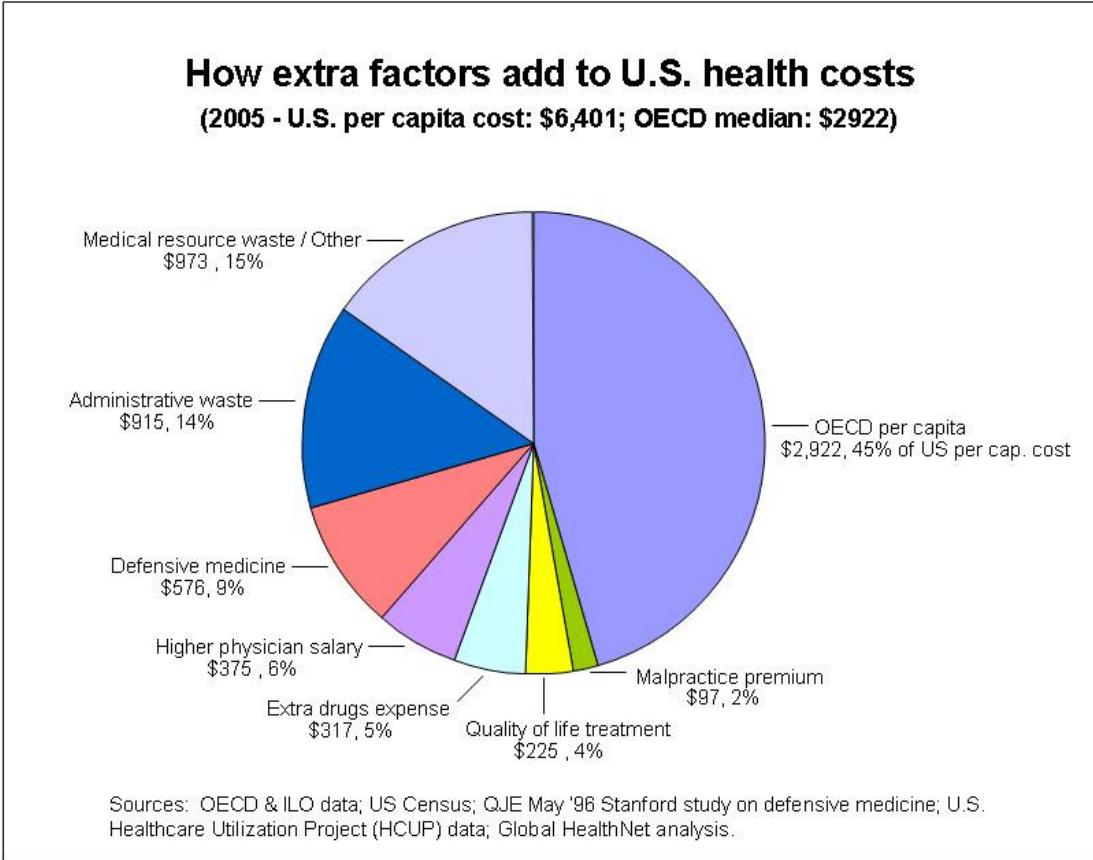
Over 1,000 agents have scurried to lobby congressional committees and administration offices on behalf of drug makers during each of the last two years. (These lobbyists outnumber Federal members of Congress at various rates.) What did they get for their efforts? Success in 2 major goals:

- a government ban on the reimportation of cheaper prescription drugs from other countries;
- the blocking of legislation that would have allowed the federal government to negotiate cheaper prescription drug prices for part D of Medicare.
(Although the pharmaceutical industry *may* have agreed to some long-term cost cuts - with some caveats.)

Insurance and drug companies spending millions of dollars to protect their ability to make billions of dollars is clearly a simple business decision for them. The irony is that if these industries eliminated the administrative costs of paying for a huge full-time staff of professional lobbyists they could lower drug and premium prices while preserving their profits.

Where does the US citizen stand in the world of health care costs?

The full circle below represents the annual health care expenses for an average American. Compare it to the blue section of the circle at upper right. That is the corresponding expense for an average first-world citizen (like a European.) This shows that their health care costs are only 45% of those in the US. The other sections of the circle show the wastes and the excess costs in the US (over and above those in other countries) that make US healthcare so expensive.



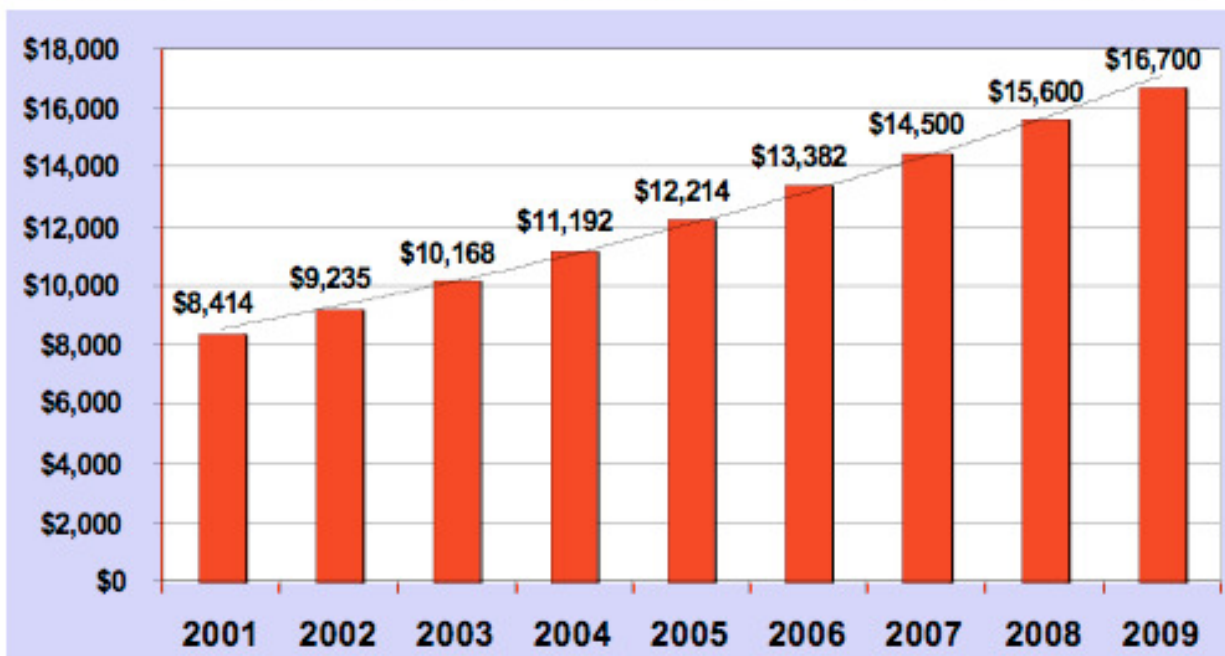
Health Costs for a 'Family of 4'

The well cited figure is that on average Americans spend \$1 on health care out of every \$6 that they earn. That is a huge amount to most individuals and families, a level that cannot be sustained especially as the proportion of earnings spent on health care rises. This 'sixth of what we earn' is particularly high when you consider that we only 'hope we are covered.' With some limited-benefits insurance policies we cannot be sure until it may be too late. A large amount of what we pay in premiums goes to administration.

In real dollars, what does this look like?

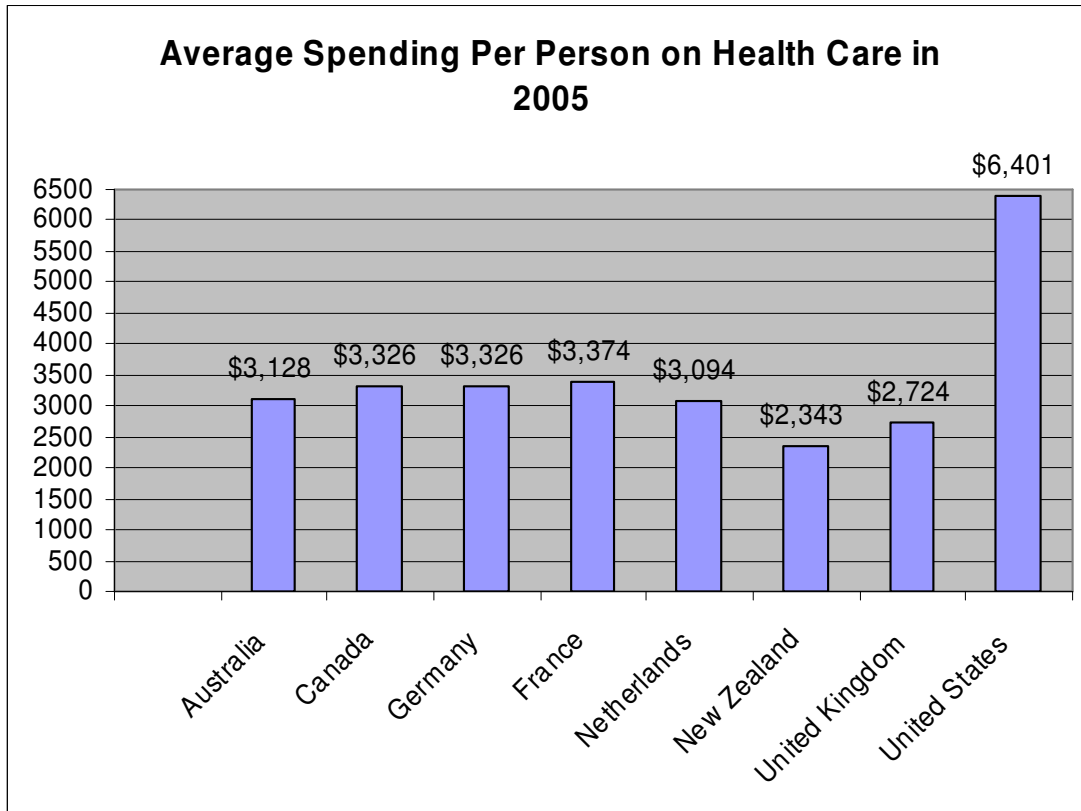
What is the total cost of family spending?

MILLIMAN MEDICAL INDEX (MMI)
Average Annual Medical Cost for a Family of Four
(Employers' and Employees' Premium + Out-of-Pocket Costs)



Source: <http://www.milliman.com/expertise/healthcare/products-tools/mmi/>

Health Care Costs and US Competitiveness



An article in Health Affairs [Toward Higher-Performance Health Systems: Adults' Health Care Experiences In Seven Countries, 2007](#), a survey on healthcare experiences in the US, versus the universal healthcare systems in the UK, the Netherlands, Germany, Australia, New Zealand and Canada. These systems are highly varied, but briefly,

1. the US is a non-universal patchwork of public and private spending; drugs and procedures may be subsidized by insurance
2. The UK is completely single-payer with private care as an option, all drugs and procedures are paid for
3. Canada is single-payer with provinces deciding how health care is spent and strict limits on private care, prescription drugs are heavily subsidized,
4. Australia has a public baseline access to physicians with subsidization of private insurance and option of private care, prescription drugs are heavily subsidized,
5. New Zealand has universal public health care, primary care and prescription drugs are subsidized with some cost sharing, and private care is an option
6. The Netherlands has a system of obligatory private health insurance (like a nationwide Massachusetts system); premiums have a flat rate for all citizens, with subsidies for poorer people who can't afford insurance premiums. Individuals pay for about half, and employers pay for about half; government making up the difference.
7. Germany has a system of mandatory insurance with purchase of access to one of several hundred "sickness funds" paid by employers, there is a private option for those who can afford it, and those who cannot or are unemployed are subsidized by government.

The United States spends more per capita than *any other system* and not by a small amount. We spend almost twice as much as the next nearest spender, Canada, and this without covering all of our citizens. We also spend more of our GDP than any other country, almost twice as much as any other country. Most other countries have a high percentage of patients enrolled with electronic medical records, a system that makes sharing of information between facilities (currently a major cause of redundancy in expenses) more efficient. Note also that universal doesn't require primary care providers to be the gatekeepers. Other systems exist that allow self-referral to specialists.

Most Americans (59.3%) receive their health insurance coverage through an employer (which includes both private as well as civilian public-sector employees) under group coverage, although this percentage is declining. Costs for employer-paid health insurance are rising rapidly: since 2001, premiums for family coverage have increased 78%, while wages have risen 19% and inflation has risen 17%, according to a 2007 study by the Kaiser Family Foundation. Workers with employer-sponsored insurance also contribute; in 2007, the average percentage of premium paid by covered workers is 16% for single coverage and 28% for family coverage. In addition to their premium contributions, most covered workers face additional payments when they use health care services, in the form of deductibles and copayments.

The health care problem in America, while driven in many ways by cost, is not solely a dollars and cents issue. Deeply held values come into play, such as choice, personal security, fairness, and justice. No matter what type of health care reform might be instituted, Americans want to maintain a choice of physicians. Americans are worried about being wiped out financially by medical expenses. They feel taken advantage of by out of control costs for health care and they think it is wrong for some to get care while others don't just because they can't afford it.

According to the Organisation for Economic Cooperation and Development (OECD) (a group made up of the 30 leading industrialized nations), nearly every developed nation can say that all of its citizens have health-care coverage. The United States joins only Turkey and Mexico in the bottom three in terms of lowest share of citizenry that has health-care coverage. All other developed nations cover 97 percent or more of their populations.

The United States spends over 1.9 trillion annually on healthcare expenses, more than any other industrialized country. Researchers at John Hopkins Medical School estimate the U.S. spends 44 percent more per capita than Switzerland, the country with the second highest expenditures and 134% more than the median for member states of the OECD. These costs prompt fears that an increasing number of U.S. businesses will outsource jobs overseas or offshore business operations completely.

The Kaiser Foundation 2008 report notes that health premiums for employer-sponsored health plans have risen 114% in the last decade. At 12%, health care is the most expensive benefit paid by U.S. employers, according to the U.S. Chamber of Commerce.

General Motors, for instance, covers more than 1.1 million employees and former employees, spending roughly \$5.6 billion on healthcare expenses in 2006. GM says that health care costs add between \$1,500 to 2,000 to the sticker price of every automobile it makes. [These figures were from before re-organization of the company.]

It is difficult to quantify the precise effect high health care costs have had so far on the overall U.S. job market. Health care is one of several factors – entrenched union contracts is another – that make doing business in the U.S. expensive, and it's difficult to determine the effects of each factor. Moreover, economists disagree on the number of U.S. jobs that have been lost due to offshoring. It is clear, however that healthcare expenses affect every level of U.S. industry. For large corporations they mean massive "legacy costs" associated with insuring retired employees. For small business owners they can be more devastating.

Elsewhere in the world, healthcare systems are much less reliant on private sector support – and much less expensive.

Taiwan's system is commonly singled out as a model for cost-effectiveness. An article in *Health Affairs* examines Taiwan's National Health Insurance, implemented in 1995, which provides comprehensive universal health coverage to Taiwan's roughly 23 million citizens. Taiwanese are assessed around \$20/month for full health coverage. In contrast, Americans pay roughly \$500/month, according to data in a report by McKinsey. [Interestingly enough, the Taiwan system was based on the US Medicare system.]

According to the Internet Business Solutions Group and Cisco Systems; Healthcare Practice, the amount businesses pay for employee insurance is just one element of their total healthcare costs. Businesses incur a "triple tax." First they pay for insurance programs through health benefits, secondly they indirectly subsidize Medicare and Medicaid and thirdly they subsidize the cost of treating America's underinsured through higher insurance premiums.

Sources:

[Toward Higher-Performance Health Systems: Adults' Health Care Experiences In Seven Countries, 2007](#). Health Affairs
http://scienceblogs.com/denialism/2009/05/what_is_the_cause_of_excess_co.php#more

Health Care Costs and US Competitiveness, article compiled by the Council on Foreign Relations, by Lee Hudson Teslik and Toni Johnson, Staff Writer, Updated March 4, 2009
website reference <http://www.cfr.org/publication/13325>

Alan S. Binder in *Foreign Affairs* cited in the information regarding offshore jobs within the article from Council on Foreign Relations.

"Coping with Cost of Health Care", a National Issues Forums Institute's publication.

CEO Salaries In the Health Care Industry

Source: FierceHealthcare. **Their website description is** "[Healthcare industry, Healthcare news](#) Breaking news, trends, developments and insights in the healthcare industry." They offer a free daily briefing on the healthcare industry. Their website is www.fiercehealthcare.com/ -

It is impossible not to consider salaries (including these multi-million dollar figures) in the administrative overhead of a health care system. Just as the salaries of CEOs in the banking industry were debated and discussed in view of their performance within the failures of that industry, the spiraling increase in health care costs may provoke the same debate.

FierceHealthcare reports the following top 10 CEO salaries for 2008.

CEO	Company	Total Compensation
Ron Williams	Aetna	\$24,300,112.
H. Edward Hanway	CIGNA	\$12,236,740.
Angela Braly	WellPoint	\$9,844,212.
Dale Wolf	Coventry Health Care	\$9,047,469.
Michael Neidorff	Centene	\$8,774,483.
James Carlson	AMERIGROUP	\$5,292,546.
Michael McCallister	Humana	\$4,764,309.
Jay Gellert	Health Net	\$4,425,355.
Richard Barasch	Universal American	\$3,503,702.
Stephen Hemsley	UnitedHealth Group	\$3,241,042.

All of these companies are publicly traded. Listed below are the stock symbols for each of these, where you can easily look up more detailed financial information.

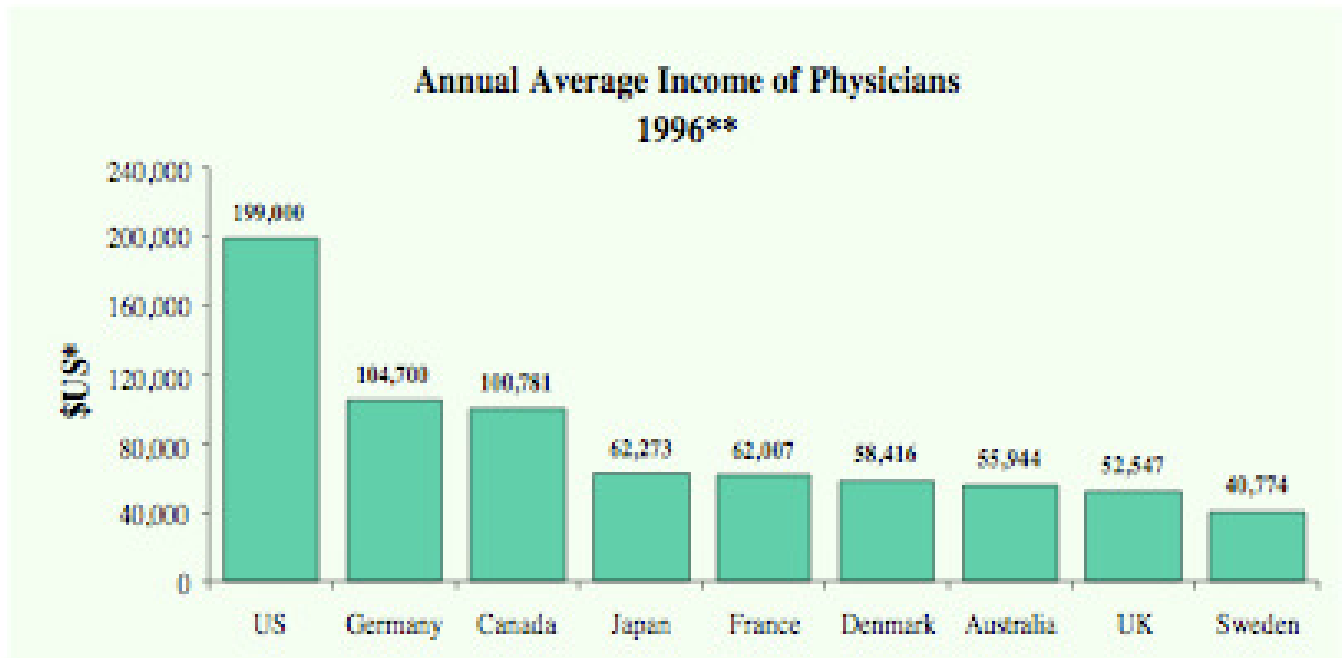
Aetna (AET)
Cigna (CI)
Wellpoint (WLP)
Coventry (CVH)
Centene (CNC)

Amerigroup (AGP)
Humana (HUM)
Healthnet (HNT)
Universal American (UAM)
United Health (UNH)

How Much Do Doctors Earn?

Doctor's salaries are often part of the discussion around health care. Some physicians are worried they will lose their level of payment; others hope for reform that will get insurance companies out of their lives. Like the general population they do not think as a whole.

While these particular figures are over 10 years old, they still offer a frame of reference for comparison between the countries. By international standards when we ask how much our doctor's earn the answer is: a lot. But the free market allows the doctors to strongly support their own interests, as the AMA has done for them for decades. To consider their salaries amidst this debate, here is one look, via an old Ezra Klein posting.



As of 1996, the annual average income of American physicians was:
twice Canada's,
thrice France,
and almost four times the UK.

And yet, the Canadians and French and Brits all live longer than Americans.

Other Details of American Physician Earnings - Salaries by Specialty

Source: Allied Physicians, Delaware

http://www.allied-physicians.com/salary_surveys/physician-salaries-old.htm

There are many organizations which monitor physician compensation. It varies by location. While these numbers are from earlier in the decade and can be assumed to be higher as health care costs have increased, but they may also have taken some minor hits (causing less income) because of the 2008-2009 economic crunch.

Here we provide physician salary surveys conducted by at least 10 sources. They provide a convenient overview of current physician compensation levels listed by medical specialty. The data displayed in the following tables are averages.

Specialty (values in US)	<u>Average</u>
Anesthesiology	203,326
Cardiology	207,690
Emergency Medicine	157,286
Family Practice	122,625
General Surgery	190,273
Internal Medicine	127,366
Neurology	149,309
Ob/Gynecology	204,752
Oncology	173,655
Pathology	175,048
Pediatrics	121,776
Psychiatry	138,267
Radiology	209,150

Details of the 10 sources (themselves averages) creating the above average.

1	2	3	4	5	6	7	8	9	10
223,082	228,000	213,400	201,000	262,327	190,000	NA	162,500	180,690	193,612
252,098	NA	204,200	205,900	262,057	182,000	227,921	150,000	186,986	198,045
171,789	171,000	162,800	128,300	174,775	150,000	NA	150,000	152,000	154,911
126,574	116,800	125,600	120,000	132,578	129,000	126,957	100,000	126,838	121,905
206,411	232,700	198,500	164,400	223,764	169,000	213,960	150,000	168,292	175,703
134,897	147,300	131,200	113,000	141,129	130,000	131,205	100,000	126,840	118,086
162,250	NA	147,600	144,000	188,765	166,000	NA	125,000	134,417	126,436
219,829	221,900	209,700	200,000	231,565	NA	214,081	180,000	193,000	184,200
192,055	NA	170,700	155,400	229,184	166,000	NA	120,000	213,731	142,171
202,486	197,300	173,600	150,000	210,070	200,000	NA	130,000	150,761	161,215
130,380	135,400	126,900	110,600	135,000	120,000	120,357	100,000	117,053	121,213
163,446	171,300	167,400	180,000	168,123	199,000	135,682	180,000	173,446	124,465
238,648	NA	219,100	177,714	291,251	175,000	213,316	140,000	189,723	NA

What Americans Think of Their Health Care

Certainly Americans can never be accused of thinking as a monolith. But there are certainly patterns to be seen in recent polls as of summer 2009 regarding the Health Care (HC) issue. Additionally, where some responses indicate conflict it represents the complexity of our current problems.

1. Most Americans (almost 6 in 10) would be willing pay higher taxes to have everyone covered for health care. (4 in 10 said they would be willing to pay as much a \$500 MORE a year).
2. 48% support mandatory requirement that all Americans have HC coverage (as long as public subsidies were available for those who could not afford it).
3. 38% are opposed to a requirement mandating individuals to have coverage.
4. 85% said HC system needed fundamental changing or complete rebuilding.
5. 77% said they were personally very or somewhat satisfied with the quality of their own care. Most were far less satisfied with cost of HC than quality.
6. 18% said Republicans would be better at improving the HC system.
7. 57% said Democrats would be better. [25% of all Republican identified respondents said Democrats would do a better job.]
8. 72% support a government-administered insurance plan (like Medicare for all)
9. 20% said they were opposed to a government plan.
10. Half of those calling themselves Republicans said they would support a public plan
11. 3/4 of those calling themselves Independents said they would support a public plan
12. Almost 90% of those calling themselves Democrats said they would support a public plan.
13. Half thought the government would be better at providing medical coverage than private sector (up from 30% in poll conducted 2007)
14. Almost 60% said government would have more success at keeping down costs compared to private sector (this figure was up from 47% in the 2007 poll).

15. 64% said government should guarantee coverage (a 'safety net')
16. Half to 2/3 (depending on question) worried that government guaranteed health coverage available the would see declines in the own HC quality "considerable unease" about impact of expanded government involvement
17. 34% are very concerned, 34% somewhat concerned that access to care could be limited if government is involved.
18. 33% very concerned and 20% somewhat concerned that they may have to change doctors if government is involved.
[In both 17 and 18 'Republicans' expressed more concern than 'Democrats.')
19. 75% favored requiring private insurers to coverage everyone, without discrimination against pre-existing conditions.
20. 20% support taxing employer-provided health benefits to help pay the cost of coverage for uninsured.
21. Three out of four people believe that unnecessary medical tests are a serious problem and support payment for 'preventative type' services.
22. 87% said it was a serious problem if people could not get tests and needed treated
23. One in four people said someone in their household had cut back on medications because of expense (in last 12 months); one in five said someone had skipped recommended treatment or test.
24. 86% said rising costs posed a serious economic threat – 61% say very serious. (But only about 20% of those WITH insurance said their own costs were a hardship.)
25. About 25% said keeping HC costs down was more important than providing courage to all the uninsured. (Polling in the spring had this number at 40%).

Source:

NY Times / CBS News Poll. Conducted between Jun 12-16, 2009. Poll included 895 adults and had a margin of sampling error of plus or minus 3 percentage points.

In Poll, Wide Support for Government-Run Health

By KEVIN SACK and MARJORIE CONNELLY

Published June 20, 2009

Marina Stefan and Dalia Sussman contributed reporting.

<http://www.nytimes.com/2009/06/21/health/policy/21poll.html>

Raw data is available at:

http://www.cbsnews.com/htdocs/pdf/CBSPOLL_June09a_health_care.pdf?tag=contentMain;contentBody

2009 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES

Extended 'wait times' for health care are often cited as something the American system does not suffer from compared to other countries. Recently, Boston statistics (part of the Massachusetts mandated plan) have been used to augment this argument showing that reform will lead to longer waits. But the waiting times in other countries are infrequently complained about within those countries. Data is not frequently tracked, but one example is listed below (Scottish Information services), which is improving but not outstanding worldwide. Actually, the U.S. does **not** particularly excel in this area.

From September 2008 through March 2009, research associates at Merritt Hawkins & Associates called physician offices in 15 metropolitan areas (Atlanta, Boston, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, Minneapolis, New York, Philadelphia, Portland, San Diego, Seattle, and Washington, D.C.) with the purpose of scheduling a new patient appointment. The survey focused on five medical specialties: cardiology, dermatology, obstetrics-gynecology, orthopedic surgery and family practice.

In each call, research associates asked to be told the first available time for a new patient appointment. Depending on the specialty at issue, they indicated a hypothetical non-emergency reason for the appointment. 1,162 medical offices were contacted. A similar survey was done in 2004, and comparisons were made. No attempt was made to contact the same practices. In 2009, family practice was added to the variety of specialties and therefore no comparison can be made in this specialty to results tabulated in 2004.

		Total Responses	Shortest Time to Appt. Days	Longest Time to Appt Days	Average Time to Appt. Days
Cardiology	2009	216	2.4	48.6	15.5
	2004	278	3.0	65.8	18.8
Dermatology	2009	233	3.4	104.4	22.1
	2004	269	3.3	80.9	24.3
OB-GYN	2009	228	2.5	98.7	27.5
	2004	261	3.0	65.1	23.3
Orthopedic Surgery	2009	192	2.9	59.9	16.8
	2004	254	2.8	43.0	16.9
Family Practice	2009	278	2.47	99.6	20.3

Note: physician-to-population ratios in these metropolitan areas are traditionally some of the highest in the country. If access to physicians in metropolitan areas with a large number of physicians per capita is limited, it may be reasonably inferred that physician access could be more problematic in areas with fewer physicians per capita.

Reference: www.merrithawkins.com

Scottish Wait Times from Information Services Division

Scotland has some of the best health service data in the world. Few other countries have information which combines high quality data, consistency, national coverage and the ability to link data to allow patient based analysis and follow up. Information Services Division (ISD) is Scotland's national organization for health information.

Waiting times & waiting lists (as of March 31st 2009 monthly & quarterly data)

- 97.2% of patients attending Accident and Emergency departments during the quarter ending 31 March 2009 were admitted, discharged or transferred within 4 hours.
- 99.9% of new outpatients seen and 99.9% of inpatients and day cases treated in quarter ending 31 December 2008 had waited less than 18 weeks.
- 98.4% of new outpatients seen and 98.2% of inpatients and day cases treated in quarter ending 31 December 2008 had waited less than 15 weeks.
- As of March 2009, over 99.9% of new outpatients and approximately 99.9% of inpatients and day cases were waiting **less than 15 weeks**. 15 weeks is **the new national standard** that comes into place after March 31 2009 (lower than the previous 18 weeks) and will be the statistic used by NHS Boards to measure performance against Scottish Government waiting times standards from this date.

WAITING TIMES FOR A **NEW OUTPATIENT** APPOINTMENT PATIENTS REFERRED BY A GP OR GDP

Census date							
Indicator	31-Mar-08	30-Jun-08	30-Sep-08	31-Dec-08	31-Jan-09	28-Feb-09	31-Mar-09
Number waiting and available	159 089	175 456	173 363	147 054	141 804	142 860	149 509
Distribution of wait to census date							
<=3 weeks (%)	37.7	38.8	37.1	35.5	46.3	46.1	49.1
3-6 weeks (%)	26.5	25.7	25.5	30.1	19.1	31.4	29.9
6-9 weeks (%)	17.6	16.9	17.0	20.0	19.7	13.8	16.3
9-12 weeks (%)	10.8	11.1	11.7	10.8	11.9	6.6	4.7
12-15 weeks (%)	4.8	5.5	6.8	3.0	2.9	1.9	0.0
15-18 weeks (%)	2.5	1.9	1.9	0.4	0.2	0.2	0.0
Over 18 weeks (%)	0.1	0.0	0.0	0.0	0.0	0.0	0.0

Source: Waiting Times Data Warehouse

http://www.isdscotland.org/isd/CCC_FirstPage.jsp

The Truth About Medical Malpractice

Conventional wisdom holds that the United States is plagued by medical malpractice lawsuits that drive up the cost of health care. The facts do not bear this out, but instead place it in the 'myth' category. The belief that malpractice litigation is a prime cause of rising health care costs is repeated so often that most people believe it. This simply is not the case. Depending on which source you cite, malpractice costs range from only 0.5% to 3% of the total U. S spending on health care.

In the July-August 2005 issue of *Health Affairs*, Gerard F. Anderson, a professor at the Johns Hopkins Bloomberg School of Public Health, and his colleagues calculate that the expense of defending malpractice claims - including awards, legal costs, and underwriting costs - equals less than 0.5% of health care spending. The authors concede that "defensive" medicine, such as tests or procedures ordered primarily to protect medical providers against the risk of being sued, contribute to health spending *possibly more* than the malpractice payments themselves. But they emphasize that this is hard to quantify; seemingly defensive procedures could also be medically appropriate. (Brock, Fred, "Health Care on Less than you Think", Times Books, New York 2006)

According to the Congressional Budget Office, malpractice costs—of which physicians' malpractice premiums are only a part—are less than 3% of the nation's health care spending, and eliminating malpractice costs entirely would have a nearly imperceptible impact on overall costs, (Congressional Budget Office, "Limiting Tort Liability for Medical Malpractice, "January 8, 2004)

One of the often-cited concerns is the potential impact of malpractice premium expense on access to and availability of health services. Anecdotal reports of physicians pulling out of clinical practice or halting certain higher-risk services, such as childbirth labor and delivery, or moving to other parts of the country with lower premiums have been broadly reported by the media. However, there is no solid research on whether the cost of malpractice insurance is the primary factor in these cases. (KaiserEDU.org, March 2003)

The real problem is too much medical malpractice, not too much litigation. Most people do **not** sue, which means that victims, not the health care providers, bear the lion's share of the costs of medical malpractice. Overlaying the whole issue of malpractice costs and litigation is the issue of how to promote patient safety and deter future medical errors. (Institute of Medicine, "*To Err is Human: Building a Safer Health System*")

In addition to the polarized nature of the debate, the issue of medical malpractice is further challenged by the fact that the data available to assess the scope of the problem and the impact of the policies is often lacking or incomplete. For example, malpractice cases that do not result in a jury award because they are settled out of court or dismissed are often not included in the databases that are used in research. There are also very few data sources available to inform the policy discussion. This leaves many stating skepticism about the ability of policymakers to thoroughly evaluate the proposals on the table and could increase the propensity for interest groups to influence debate on these complicated issues. (KaiserEDU.org.)

What is the burden to the U S Health Care System from Illegal Immigrants?

One of the most contentious issues in the immigration debate is whether illegal immigrants create a net loss or a net gain for local, state, and federal government coffers. To answer this question, one needs to know how much illegal immigrants contribute to government through income, sales, property and other taxes, and how much they cost the government by using public services such as education, health care, and law enforcement. Acquiring that information is not easy. It is a political hot-potato and many sources skew their information to suit their philosophical positions. The data in this document represent a range of the available studies on immigrants.

Calculating the costs of illegal immigrants to states and municipalities is as complicated as calculating their fiscal contributions. Many illegal immigrants take advantage of numerous free public services from health care to police and fire protection to schooling for their children. Immigrant advocates say it is hard to make assumptions about how much in public services they consume since some undocumented immigrants are afraid to call the police, go to the hospital, or use other services because they fear being turned over to immigration officials.

As for federal and state public assistance programs, illegal immigrants qualify for some but not all benefits. For example, undocumented immigrants do not qualify for the same benefits that U.S. citizens get with regard to food stamps, cash assistance, and health services. The Congressional Budget Office (CBO) reports that 1986 Medicaid reforms stipulated that immigrants could receive emergency Medicaid for must-have-care situations like childbirth. But "emergency Medicaid covers only those services that are necessary to stabilize a patient; any other services delivered after a patient is stabilized are not covered." They cannot get non-emergency care unless they pay.

Most data about immigrants' interaction with all levels of the health care system continues to be limited. Data on health care costs for illegal immigrants is sketchy because hospitals and community health clinics do not usually ask about patients' legal status. What is known, however, is that adult illegal immigrants tend to be younger and healthier than their legal-resident counterparts, resulting in relatively low levels of health care services. They account for less than 2% of national health care spending. A UCLA study showed that "undocumented immigrants from Mexico and other Latin America countries are 50% less likely than U.S.-born Latinos to use hospital emergency rooms in California. Noncitizens are far less likely to use all types of health care services than citizens. Numerous studies show that immigrant health care costs, including emergency care, are significantly lower than their U S counterparts.

Of course, it is not only the rate of health care use that has people worried—it is the **cost** of use. A 2006 RAND study concluded that in 2000, health care for undocumented immigrants between 18 and 64 years old cost taxpayers about \$11 per household.

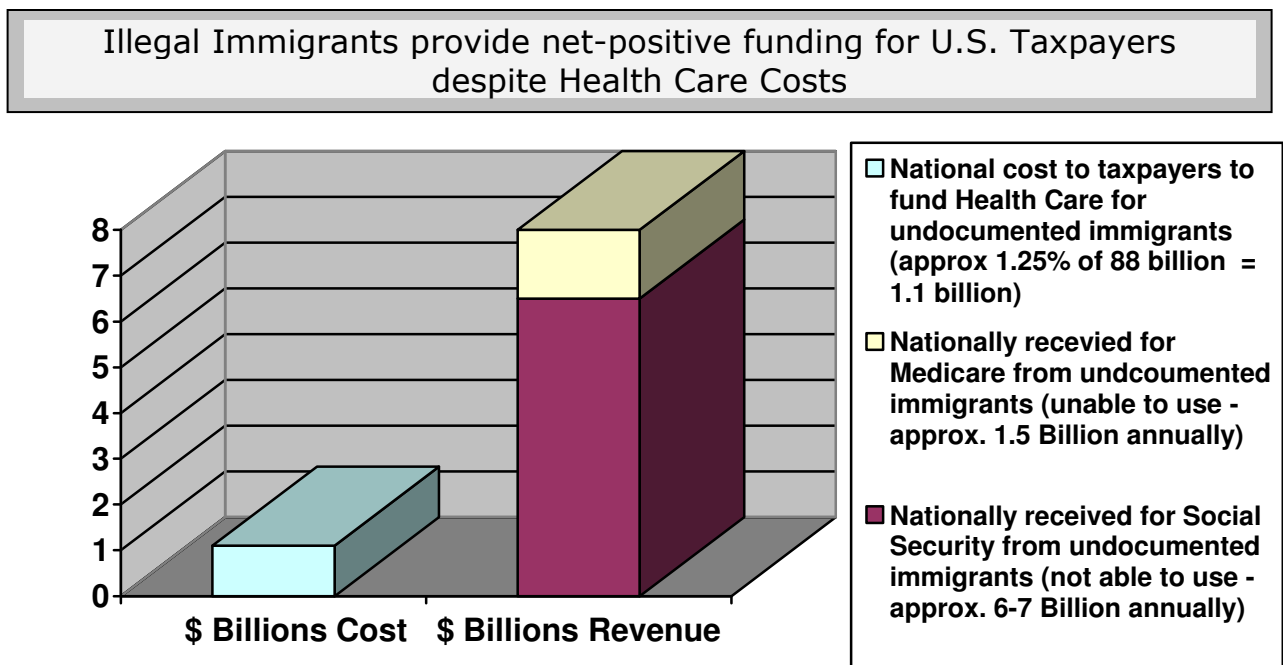
Undocumented adults account for about \$6.4 billion a year in national health care expenses, \$1.1 billion of which is paid from public funds, according to the study by the RAND Corp, a conservative-leaning think tank. The publicly-funded portion represents 1.25% of the total \$88 billion in government funds spent on health care for adults other than seniors during 2000.

Based on a questionnaire completed by 2,543 adults in 65 Los Angeles neighborhoods, nearly 22% of illegal immigrants have health insurance, which covered about \$362 million in costs in 2000; and immigrants paid \$321 million for health care out-of-pocket. Other studies show that more than two-fifths (44%) of noncitizens were without health insurance in 2005, despite a strong immigrant presence in the work force. Only 38% of noncitizens have employer-based health insurance, compared to 62% of citizens.

The other side of the equation is that undocumented immigrants pay taxes. Health care costs are mitigated because they are much smaller compared to economic benefits. The CBO reports that in 2004, undocumented immigrants in Iowa paid \$45.5 million in state income taxes and \$70.9 million in sales taxes. New Mexico collected \$69 million in income, property and sales taxes from undocumented immigrants in 2006. Immigrant payment of sales taxes is especially important because it reimburses state and local governments. A 2007 study on immigrants in Arkansas found that the positive economic impact of Arkansas' 100,000 immigrants (51% undocumented) on the state economy was nearly \$3 billion. A Texas Comptroller study found that the 1.4 million undocumented immigrants living in Texas in 2005 contributed \$17.7 billion to the state economy.

At the national level, a bigger population means a bigger tax base: undocumented immigrants annually bolster Social Security with a \$7 billion subsidy. Undocumented immigrants also pay into Medicare payroll taxes, even though they do not qualify for Medicare. In 2002, the Social Security Administration noted that nine million filed W-2s landed in the suspense file, accounting for \$56 billion in earnings. This suspense file is mainly attributed to undocumented immigrants. The file's continued growth generates \$6 to \$7 billion in Social Security tax revenue and an additional \$1.5 billion in Medicare taxes annually.

Concerns that illegal immigrants are placing an undue burden on the U S system as a whole are unsubstantiated. The public cost of immigration is not in health care. Care for undocumented immigrants represents a tiny fraction of the nation's health care burden.



The Uninsured

- It is estimated that there are 45.7 million people in the United States who are uninsured. This estimate covers those who do not qualify for government-provided health insurance, those who are not provided health insurance by an employer, or those who cannot afford, or cannot qualify or who choose not to purchase private health insurance.
- 52 million or 89% of those who look for individual health insurance do not get it because of costs or are turned down
- 13.7% of those who apply for individual health insurance are denied coverage because of pre-existing conditions (i.e. **medical underwriting** *).
- Many people who have serious health conditions do not apply for insurance because they expect to be turned down; they are not included in this figure.
- 1% of all individual policies are cancelled and/or their claims denied because the insurer determines that the insured provided incomplete or incorrect information when applying for insurance (**rescission**).
- Denial of coverage increases with age from 5% for people 18 and under to nearly 33% for people ages 60-64.⁷ Among those who obtained coverage, 22% were quoted higher rates; this also increases with age so that by age 40 almost half of the applicants are either denied coverage or are required to pay higher rates (**adverse selection** ++)

* **Medical underwriting** refers to the practice of requiring people who apply for health or life insurance to provide medical or health information to the insurer; it is a method used to estimate potential health risks in a pool of insured members. The information is then used to determine whether to provide or deny coverage and to set premium rates.

++ **Adverse Selection**-charging higher premiums to people with increased health risks (i.e., they "price differentiate") or limit or deny coverage to individuals at high risk.

What are the costs of the uninsured to others?

- The costs of providing health care to the uninsured is covered by those who are insured (**cost shifting**) - by \$34 billion for public coverage and \$69 billion for private coverage in 2001 dollars.
- The average family with insurance pays an extra \$1000 per year in premiums to pay for the health care of the uninsured and an individual with coverage pays approximately \$470 per year.
- A Kaiser Family Foundation report estimated that a 1% increase in the unemployment rate would increase Medicaid and SCHIP enrollment by 1 million and increase the number of uninsured by 1.1 million.

Sources:

Teresa Chovan, Hannah Yoo and Tom Wildsmith, *"Individual Health Insurance: A Comprehensive Survey of Affordability, Access and Benefits,"* America's Health Insurance Plans, August 2005.

Tan Dorny, Garrett Bowen, John Holohan and Aimee Williams, *"Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses,"* Kaiser Family Foundation, April 2008

http://en.wikipedia.org/w/index.php?title=Health_Care_in_the_United_States&printable=yes

Insured and Uninsured In the United States

US Population:	305 Million
Medicare & Medicaid	86 Million
Employed & Insured	130 Million
Employed & Uninsured	23 Million
Unemployed (7%)	10 Million
Children without Insurance (20%)	15 Million
Total Uninsured	48 Million

* www.bls.gov/news.release/archives/empsit_09072007.pdf

The insured

Those who are insured are covered under company plans, individual plans, and government plans.

Coverage	How	Percentage
Yes	Employer Provided	60.4
Yes	Privately Acquired	9.2
Yes	Medicaid	12.4
Yes	Medicare	13.7
Yes	Military and other	3.5
NO	Uninsured	13.7%

Is coverage our only concern?

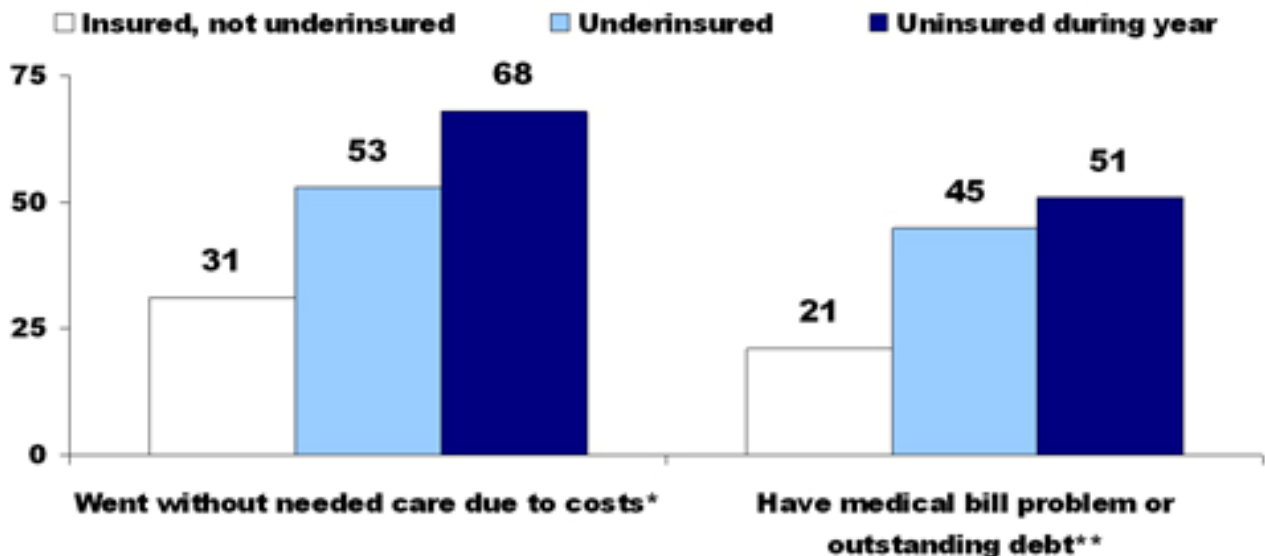
Or do we need to consider a goal of high-quality care, and improved outcomes for health —not just coverage?

We need strategies for an inclusive and higher-performing, high-value health system.

Is the question how do we Cover everyone with insurance, or how do we deliver Health CARE to everyone.

Underinsured and Uninsured Adults at High Risk of Going Without Needed Care and Financial Stress

Percent of adults (ages 19–64)



Many underinsured (as well as uninsured) adults did not fill prescription; skipped recommended medical test, treatment or follow-up, had a medical problem but did not visit doctor; or did not get needed specialist care because of costs. . .“had problems paying medical bills; changed way of life to pay medical bills; or contracted by a collection agency for inability to pay medical bills.”

Data: 2007 Commonwealth Fund Biennial Health Insurance Survey.

Source:

* Summarized from: *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*. June 10, 2008 | Volume 102

Authors: Cathy Schoen, M.S., Sara R. Collins, Ph.D., Jennifer L. Kriss, and Michelle M. Doty, Ph.D.

Journal: *Health Affairs* Web Exclusive, June 10, 2008:w298–w309

Summary Writer(s): Deborah Lorber

Pre-existing conditions

- Diseases that can prevent an individual from getting insurance include arthritis, cancer, heart disease, etc., and often less serious conditions, such as smoking, being over-weight or under-weight, and old sports injuries.
- A pre-existing condition not only affects whether or not someone can purchase health coverage but it discriminates against holders by canceling policies after they have filed claims or by setting higher premiums.
- Underwriting can also prevent people with minor and treatable conditions from obtaining other forms of individual or family coverage such as disability income and long-term care insurance.
- It is estimated that 13% of the people who apply for individual health insurance are denied coverage due to pre-existing conditions (medical underwriting)
- Another 1% of the policies for individual health insurance are cancelled annually because the insurer determines that incomplete or incorrect health status information was submitted when the individual applied for insurance (rescission).
- Denial of coverage increases with age from 5% to those 18 and younger to nearly 33% for people ages 60-64.
- Among those who obtained coverage, 22% were quoted higher rates; this also increases with age so that by age 40 almost half of the applicants are either denied coverage or are required to pay higher rates.
- The U.S. is the only industrialized country that does not have a universal government sponsored health plan; as a result, it is the only country that allows for medical underwriting or rescission.

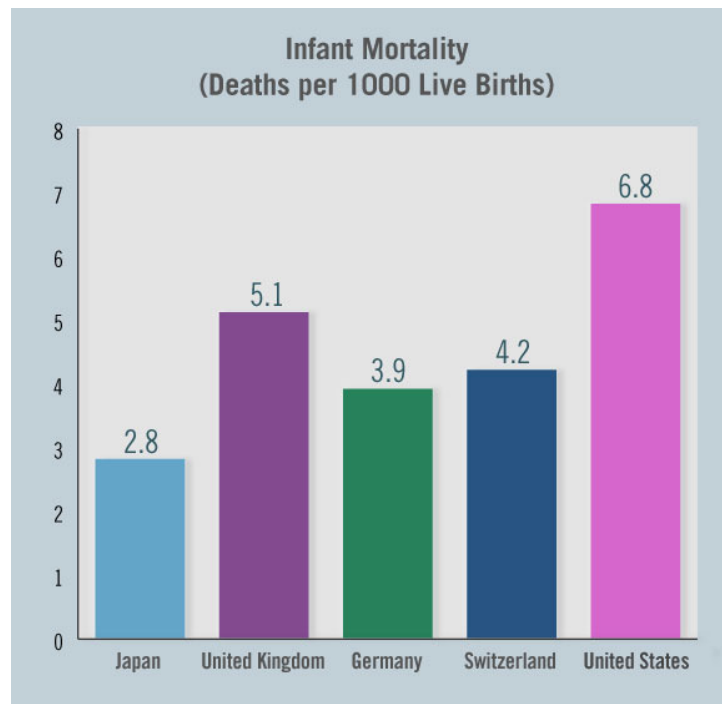
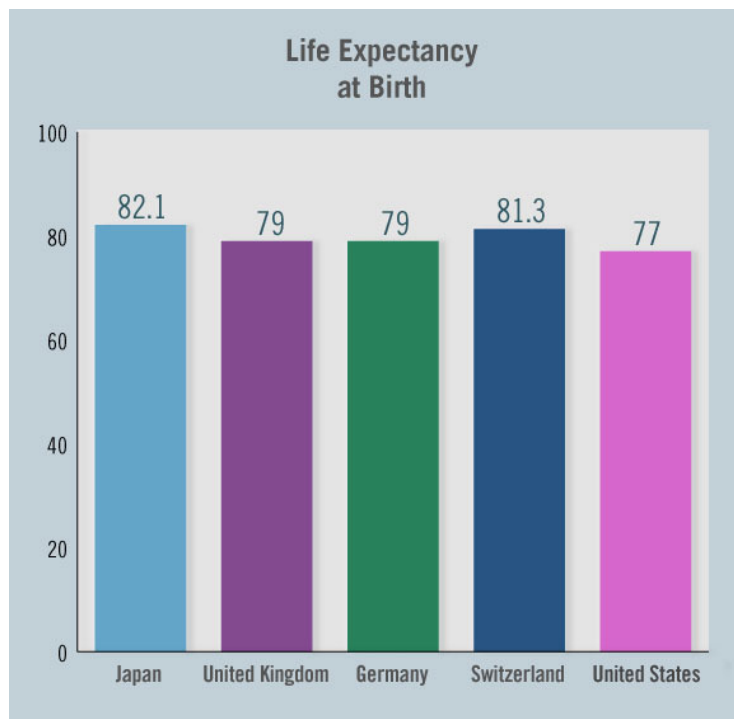
Sources:

Robert Blendon; Minah Kim and John M Benson. *"The Public Versus the World Health Organization on Health System Performance."* Health Affairs, May/June 2001

"Risk Classification in Individually Purchased Voluntary Medical Expense Insurance," American Academy of Actuaries, February 1999.

Are Americans Healthier?

Neither statistics for life expectancy nor infant survival rates say we have better health. Instead our rates are not good. While these charts compare our poor standing with just a few countries, adding less-well off countries does NOT improve our standing much.



Source:

Chart draws upon data from a [2007 report](#) by the Organisation for Economic Co-operation and Development (OECD), which collects economic statistics on its 30 member countries. Noted on website for PBS FRONTLINE's episode: **Sick Around the World**.

Preventive Care

Preventive care involves public health, diagnostic testing and life-style. Of these three, public health (clean water, food inspections, vaccinations, etc.) has done more to extend life expectancy than any of the others. When we refer to preventive care, we are usually referring to diagnostic testing to assess acute problems or avoid more serious problems. These measures have increased longevity with the result that more people are living with chronic health conditions, such as, diabetes, cardiovascular diseases, cancer and chronic respiratory conditions, all conditions that are greatly affected by smoking, alcohol abuse, obesity, poor nutrition and other life-style habits.

According to recent surveys, 72% of large companies now provide coverage for preventive care which includes early diagnostics: annual physicals, mammograms, prostate screenings, etc. but advice to reduce health risks; by improving diets, getting more physical exercise, reducing substance use and abuse is less common. Health care models should promote healthy living as well as diagnostics as part of any preventive health care plan.

Leading Causes of Preventable Deaths Annually in US

Smoking	435,000 (18.1%)
Overweight and Obesity	111,909 – 365000 (4.6 – 15.2%)
Alcohol	85,000 (3.5%)
Infectious diseases	75,000 (3.1)
Toxins	55,000 (2.3%)
Auto accidents	43,000 (1.8%)
Firearms	29,000 (1.2%)
STDs	20,000 (.8%)

WHO.int/mediacentre/fs172/en/index factsheets

Preventive Care in the U.S.

- According to recent surveys, 72% of large companies are providing complete coverage of preventive care, compared to 55% in 2008.
- Most frequently covered services are annual physicals, mammograms, routine gynecological exams, prostate screenings, flu shots and colonoscopies.
- In the U.S., 38% of all deaths are due to preventable factors (tobacco use, poor nutrition, lack of exercise and alcohol use).
- It is estimated that there are approximately 75,000 to 101,000 preventable deaths in the U.S. each year.
- In 2002-03, the US ranked in last place among industrialized countries in amenable (i.e. treatable) deaths.
- A national survey reports that the effects of the bad economy effects healthy activities, as follows:
 - 57% report the economy has affected their ability to take care of their health
 - 32% report changes to save money (miss appointments, skip meds, skip dentist)
 - 25% cancelled gym memberships
 - 42% changed eating habits to save money (fewer fruits and vegetables)

The table below represents the frequency of risk factors for every 100 employees in this country (DHHS)

Risk Factor	Per 100 employees
Cardiovascular disease	27
High blood pressure	24
High cholesterol	50+
Overweight by 20% or more	26
Heavy drinkers	10
Do not get adequate exercise	59
Suffer from stress	44

Children and Prevention

Accidents are the leading cause of death in children 9 - 18 years of age. The top five worldwide unintentional injuries in children are as follows:

Cause	Number of deaths resulting
Motor vehicle collisions	260,000 per year
Drowning	175,000 per year
Burns	96,000 per year
Falls	47,000 per year
Toxins	45,000 per year

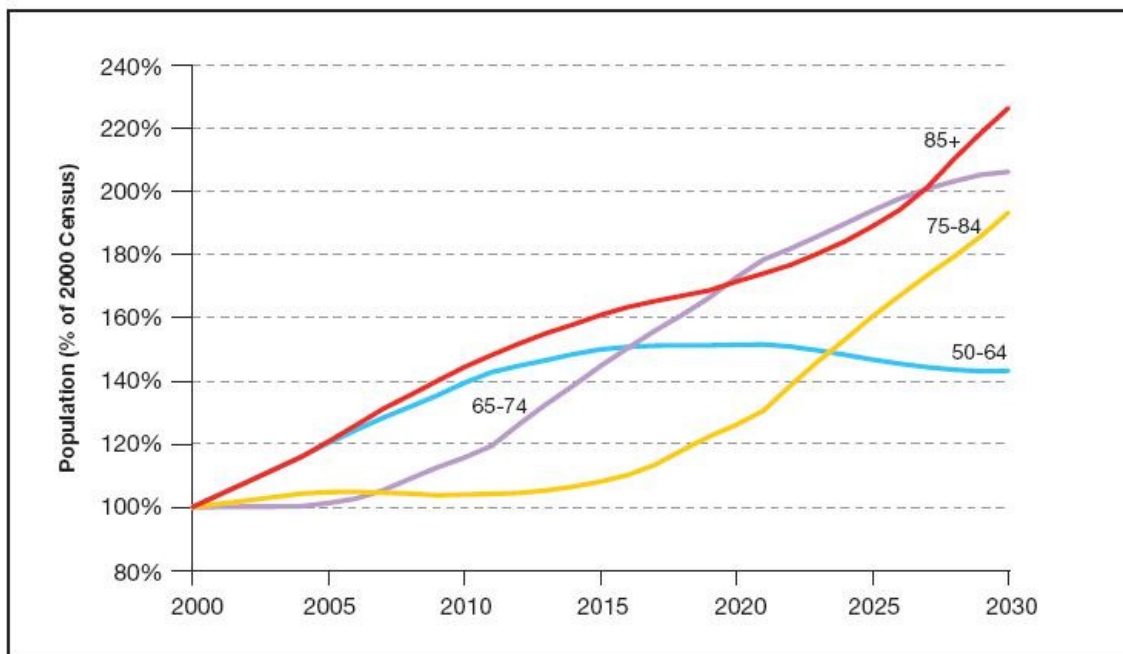
GROWTH OF THE AGING POPULATION

The projection is that the U.S. will have a growing population of older folks to consider within our Health Care system as the years progress. The U.S. health care delivery system and the dollars that we spend on it have to be considered realistically as we recognize this growing population of older people. Prevention and quality life-style changes may be vitally important to keep health care costs down. However, the delivery of care for illness, injuries, diagnostic testing, chronic disease and long-term care have to be viewed through the lens of a population which is not only growing, but one that is statically growing older as well.

Source: This chart is from the AARP publication "Across the States: Profiles of Long-Term Care and Independent Living" by Ari Houser, Wendy Fox-Grage, Mary Jo Gibson (eighth edition, 2009).

The most recent editions of *Across the States* can be found at <http://www.aarp.org/acrossthestates>

**Projected Growth in the Older Population in United States
as a Percentage of 2000 Census, by Age Group, 2000-2030**



LONG TERM CARE AND ISSUES

Long-Term Health Care

From 2007 to 2030, the population age 65 and over is projected to grow more than 4 times as fast as the population as a whole. Aging of the baby boomers will be responsible for most of this increase. Because people are living longer, the growth in the population age 85 or older is expected to increase by 74% between 2007 and 2030. Demand for long-term services will increase as a result of age-related disabilities and the need for assistance with activities of daily living.

The older population is financially and socially diverse. The demand for long-term care services is driven by social and economic factors like income, education, assets, marital status and the availability of family or friends to provide care. Geography also plays a role in demand for care, in that home and community-based services are scarcer in rural and non-metropolitan areas.

Although Medicaid is the largest payer of long-term care services, the foundation of long-term care in the US is family caregivers. Family caregivers help to contain health and long-term care costs by delaying or preventing the use of nursing homes and hospital care. Family caregivers are essential to the financing and delivery of long-term care. For such family members, this is an added health care expense that is rarely seen as such, or calculated into health care spending.

People with disabilities have a number of service needs which are costly. In the U.S. the individual has the primary responsibility for paying for long-term services. Medicare only pays the cost of a minimal stay in long-term care, and Medicaid will only pay for services once the individual's assets and income are depleted.

10 Key Findings Of Long Term Care Needs and Cost Considerations

AARP Public Policy Institute presents a list of **10 key findings** from state and national data that they cite as “critical” when we consider policymaking, dollar issues and future plans to improve the lives of those who will need long term care.

Source: This list is from the AARP publication “Across the States: Profiles of Long-Term Care and Independent Living” by Ari Houser, Wendy Fox-Grage, Mary Jo Gibson (eighth edition, 2009).

The most recent editions of *Across the States* can be found at <http://www.aarp.org/acrossthestates>

1.	The population age 85 or older – the age group that is most likely to need long-term care services – is growing at a dramatic rate.
2.	The older population is more racially and ethnically diverse than ever before.
3.	The older population is financially and socially diverse.
4.	Family caregivers are the main providers of long-term care services in all states.
5.	Older people with disabilities have a growing array of service options, but the services are costly and can deplete the life savings of older households.
6.	Nursing facility residents, beds, and occupancy rates have remained nearly constant over the last five years, despite an increase in the older population.
7.	The bulk of Medicaid long-term care dollars go to nursing homes rather than home and community-based services.
8.	The number of older people and adults with physical disabilities receiving Medicaid-funded home and community-based services has increased over the past five years.
9.	Long-term care spending is not the primary cause of Medicaid spending growth.
10.	On average, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based settings for every person in a nursing facility.

Types and Uses of Pharmaceutical and Medical Device Promotional Tools

There are a variety of methods that pharmaceutical and medical device manufacturers use to influence the prescribing physician. Techniques do vary by country, but generally include:

- Sales Representatives
 - Also called “detailing.” Sales Representatives visit prescribing physicians and engage the doctor in a one-to-one conversation on their products or drop off product samples and information. Sales Representatives are generally very well trained about the relevant disease state and the benefits of the products they represent. They are also proficient in general sales strategies and techniques.
- Gifts
 - Pharmaceutical and medical device companies offer doctors a variety of gifts to encourage them to prescribe particular products more frequently. Gifts can range from pens and paper branded with the product name to more expensive items including dinners and trips (see Continuing Medical Education below). Some studies have shown that even the smallest gift can be effective in making the doctor feel the need to reciprocate.
- Continuing Medical Education (CME)
 - Physicians have to update their medical training and as public funds for CME have fallen, pharmaceutical and medical device companies have stepped in. Physicians can earn CME credits by attending industry-sponsored training events which might include dinners with speakers, trips with time set aside for workshops or seminars on a disease state, meetings and conferences with educational components, etc. Some critics question the independence of the information that manufacturers provide during these events.
- Opinion leaders
 - Manufacturers know that doctors are influenced by credible colleagues and therefore make an effort to persuade key opinion leaders about the benefits of their products.
 - Most reputable medical journals have guidelines requiring a physician submitting a paper for publishing to acknowledge the source of their financial support, but these guidelines are not always strictly adhered to.

- Disease awareness campaigns
 - Disease awareness campaigns aim to raise awareness about a medical condition and encourage people to take preventative action and/or seek treatment. These campaigns can be delivered in a variety of ways: print and TV advertising, web, direct or e-mail marketing, etc. Critics have accused the pharmaceutical manufacturers of using these campaigns to increase sales by associating their company with the condition or by associating their product with the medical condition through product placement.

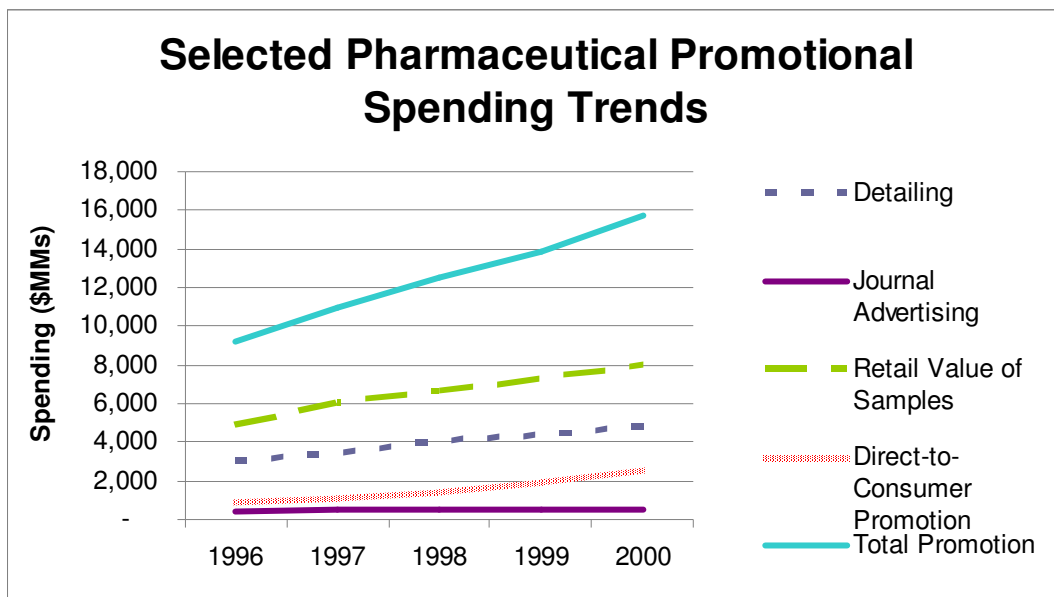
- Advertisements
 - Medical journals contain advertisements targeted toward prescribing physicians. Most countries have guidelines about what the ad can and cannot say but the guidelines and levels of enforcement vary greatly.
 - Only two countries, the US and New Zealand, permit direct to consumer advertising (DTCA) of pharmaceuticals.
 - In the US, where DTCA has been allowed since 2000, the number of prescriptions per person has risen dramatically since 2000. Spending on prescriptions also increased.
 - In Canada and the European Union, there is pressure from both the media and pharmaceutical manufacturers to water down or remove the current ban on DTCA.
 - In Europe, manufacturers want a greater role in giving information to patients and have talked about sponsoring a pharmaceutical TV channel. Critics believe this would be advertising in everything but name. An attempt by pharmaceutical manufacturers to remove the European ban was defeated in 2002.

¹ Sources:

http://marketingoverdose.org/index.php?option=com_content&task=view&id=37&Itemid=51#6
http://marketingoverdose.org/index.php?option=com_content&task=view&id=37&Itemid=51#10

Impact of Direct to Consumer Advertising (DTCA) on Physician Prescribing Behavior

- Supporters argue that DTCA provides up-to-date information and educates consumers about conditions of which they may not have been aware.
- Critics believe that pharmaceutical manufacturers are not the best source of unbiased information about medical conditions or the benefits/drawbacks of potential treatments. Critics also believe that DTCA drives up the cost of healthcare.
- Studies to date have been inconclusive about the role of DTCA on patient and physician behavior.
 - Results of one study did suggest that: “DTCA appears to affect whether someone receives medication, whereas detailing affects which medication they receive.”



	1996	1997	1998	1999	2000
<i>Detailing</i>	3,010	3,365	4,057	4,320	4,803
<i>Journal Advertising</i>	459	510	498	470	484
<i>Retail Value of Samples</i>	4,904	6,047	6,602	7,230	7,954
	791	1,069	1,317	1,848	2,467
<i>Total Promotion</i>	9,164	10,991	12,474	13,868	15,708

¹ ["Effects of Direct-to-Consumer Advertising on Medication Choice: the Case of Antidepressants,"](#) *Journal of Public Policy and Marketing*, 23(2):115-127, Fall 2004 (J.M. Donohue and E.R. Berndt). This research found that DTCA for antidepressants has little impact on drug choice, while detailing (promotional visits to physicians) has a substantial impact. The researchers cite other studies that found that DTCA motivates individuals to visit their physicians for previously untreated conditions. The researchers conclude that DTCA appears to affect whether someone receives medication, while detailing affects which medication they receive.

Americans have **FEW CHOICES** when it comes to health insurance

Americans have limited choice because many insurance markets are dominated by only a handful of firms. This concentration limits employers' and families' health insurance options as well as the care they receive.

"The table [on next page] shows that in many states insurance markets are dominated by only one or two insurance carriers. In at least 21 states, one carrier controls more than half the market. More than half of the market is controlled by two carriers in at least 39 states. In 2007, a survey conducted by the American Medical Association found that in more than 95 percent of insurance markets, a single commercial carrier controlled at least 30 percent of the insurance market."

Source: American Medical Association, "2007 Update: Competition in Health Insurance, A Comprehensive Study of US Markets": 2007

Most American insurance markets dominated by one or two large companies

State	Health insurer with largest market share	Market share %	Health Insurer with second largest market share	Market share %	Combined market share % of top two insurers
Alabama	Blue Cross Blue Shield AL	83%	Health Choice	5%	88%
Alaska	Premera Blue Cross	60%	Aetna Inc.	35%	95%
Arizona	Blue Cross Blue Shield AZ	43%	UnitedHealth Group Inc.	22%	65%
Arkansas	Blue Cross Blue Shield AR	75%	UnitedHealth Group Inc.	6%	81%
California	Kaiser Permanente	24%	WellPoint Inc. (BCBS)	20%	44%
Colorado	WellPoint Inc. (BCBS)	29%	UnitedHealth Group Inc.	24%	53%
Connecticut	WellPoint Inc. (BCBS)	55%	Health Net Inc.	11%	66%
Delaware	CareFirst Blue Cross Blue Shield	42%	Coventry Health Care Inc.	23%	65%
District of Columbia	Data Unavailable				
Florida	Blue Cross Blue Shield FL	30%	Aetna Inc.	15%	45%
Georgia	WellPoint Inc. (BCBS)	61%	UnitedHealth Group Inc.	8%	69%
Hawaii	Blue Cross Blue Shield HI	78%	Kaiser Permanente	20%	98%
Idaho	Blue Cross of ID	46%	Regence BS of Idaho	29%	75%
Illinois	HCSC (Blue Cross Blue Shield)	47%	WellPoint Inc. (BCBS)	22%	69%
Indiana	WellPoint Inc. (BCBS)	60%	M*Plan (HealthCare Group)	15%	75%
Iowa	Wellmark BC and BS	71%	UnitedHealth Group Inc.	9%	80%
Kansas	WellPoint Inc. (BCBS)	59%	Health Partners	10%	69%
Kentucky	Data Unavailable				
Louisiana	Blue Cross Blue Shield LA	61%	UnitedHealth Group Inc.	13%	74%
Maine	WellPoint Inc. (BCBS)	78%	Aetna Inc.	10%	88%
Maryland	CareFirst Blue Cross Blue Shield	52%	UnitedHealth Group Inc.	19%	71%
Massachusetts	Blue Cross Blue Shield MA	50%	Tufts Health Plan	17%	67%
Michigan	Blue Cross Blue Shield MI	65%	Henry Ford Health System	8%	73%
Minnesota	Blue Cross Blue Shield MN	50%	Medica	26%	76%
Mississippi	Data Unavailable				
Missouri	WellPoint Inc. (BCBS)	68%	UnitedHealth Group Inc.	11%	79%
Montana	Blue Cross Blue Shield MT	75%	New West Health Services	10%	85%
Nebraska	Blue Cross Blue Shield NE	44%	UnitedHealth Group Inc.	25%	69%
Nevada	Sierra Health	29%	WellPoint Inc. (BCBS)	28%	57%
New Hampshire	WellPoint Inc. (BCBS)	51%	CIGNA Corp.	24%	75%
New Jersey	Horizon Blue Cross Blue Shield	34%	Aetna Inc.	25%	59%
New Mexico	HCSC (Blue Cross Blue Shield)	35%	Presbyterian Hlth	30%	65%
New York	GHI	26%	WellPoint Inc. (Empire BCBS)	21%	47%
North Carolina	Blue Cross Blue Shield NC	53%	UnitedHealth Group Inc.	20%	73%
North Dakota	Data Unavailable				
Ohio	WellPoint Inc. (BCBS)	41%	Medical Mutual of Ohio	17%	58%
Oklahoma	BCBS OK	45%	CommunityCare	26%	71%
Oregon	Providence Health & Services	25%	Regence Blue Cross Blue Shield	23%	48%
Pennsylvania	Data Unavailable				
Rhode Island	Blue Cross Blue Shield RI	79%	UnitedHealth Group Inc.	16%	95%
South Carolina	Blue Cross Blue Shield SC	66%	CIGNA Corp.	9%	75%
South Dakota	Data Unavailable				
Tennessee	Blue Cross Blue Shield TN	50%	Total Choice	12%	62%
Texas	HCSC (Blue Cross Blue Shield)	39%	Aetna Inc.	20%	59%
Utah	Regence Blue Cross Blue Shield	47%	Intermountain Healthcare	21%	68%
Vermont	Blue Cross Blue Shield VT	77%	CIGNA Corp.	13%	90%
Virginia	WellPoint Inc. (BCBS)	50%	Aetna Inc.	11%	61%
Washington	Premera Blue Cross	38%	Regence Blue Shield	23%	61%
West Virginia	Data Unavailable				
Wisconsin	Data Unavailable				
Wyoming	Blue Cross Blue Shield WY	70%	UnitedHealth Group Inc.	15%	85%

Source: Health Care for America Now, available at http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isl1.pdf.

Health Plan Enrollment - Market Share Data

Top 25 U.S. Health Plans, Ranked by Total Medical Enrollment* (as of December 2008)

Company	2008 Enrollment
UnitedHealth Group, Inc.	32,702,445
WellPoint, Inc.	30,622,381
Aetna, Inc.	16,318,625
Health Care Service Corporation	12,218,623
CIGNA HealthCare, Inc.	9,922,135
Kaiser Permanente	8,532,951
Humana, Inc.	8,486,913
Health Net, Inc.	6,180,395
Highmark, Inc.	5,182,186
Blue Cross Blue Shield of Michigan	5,011,359
Coventry Health Care, Inc.	4,762,000
EmblemHealth, Inc. (aka HIP Health Plan of NY)	4,035,710
Medical Mutual of Ohio	3,929,677
WellCare Group of Companies	3,537,777
Independence Blue Cross	3,480,168
Blue Shield of California	3,474,951
Horizon Blue Cross Blue Shield	3,149,279
CareFirst, Inc.	3,044,880
Blue Cross Blue Shield of Massachusetts	3,012,396
Blue Cross and Blue Shield of Alabama	2,971,869
BlueCross BlueShield of Tennessee	2,907,762
Blue Cross Blue Shield of North Carolina	2,789,587
Blue Cross and Blue Shield of Florida, Inc.	2,675,923
Regence Group, The	2,545,973
Blue Cross Blue Shield of Minnesota	2,483,968

*Includes medical enrollment in all models of fully insured and self-insured health plans; does not include specialty benefit enrollment.
 see [AIS's Directory of Health Plans: 2009](#) for complete listing. ©2009 Atlantic Information Services.

Current US Health Care Systems Summarized

Most Americans have group health insurance which they obtain through their employer or their spouse's employer. Employers select a provider or providers which are 'For-Profit' insurers. Currently 130 million Americans are covered in this **employer based system**. They lose their insurance for themselves or their families if they lose their job, a significant problem during times of increased unemployment.

Other US forms of healthcare include:

Medicare - a federal entitlement program providing coverage to 45 million people, which is publicly funded and privately delivered. The government collects taxes for payment, but individuals retain choice of independent doctors and hospitals. Medicare insures people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.

Military Health Care and Indian Health Services - the **only** examples of socialized medicine supported by the U.S. government. Each of these programs pays for all care given by the providers they employ and the facilities they run.

Medicaid - a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines.

Children's Health Insurance Program - a federal-state program that provides coverage for uninsured low-income children who are not eligible for Medicaid.

Federal Employee Health Benefits Program (FEHBP) - federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organization plans. There are more than 170 plans offered with varying costs, benefits and features.

The above programs make up our current system, one which most experts see as 'unsustainable.' Before we look at options for change, we need to understand why the reform is needed. The bulk of this booklet has pointed out these reasons for change in detail. President Obama has stated that the cost of doing nothing is not acceptable. According to AARP research and analysis, that opinion is backed by the numbers.

In 2008, the AARP Public Policy Institute, put out a paper entitled: **The Costs Of Doing Nothing: What's at Stake without Health Care Reform.**" This can be seen at: http://assets.aarp.org/rgcenter/health/m7_nothing.pdf

Comparison of Proposed Plans

There is an excellent, detailed side-by-side comparison of all of the plans at www.kff.org/healthreform/sidebyside.cfm which is updated regularly by the Henry J. Kaiser Family Foundation website.

Another good source is the new "Hot Legislation" page on the 'Rand Compare' site at http://www.randcompare.org/proposals/federal/hot_legislation. This is from the Rand Corporation and has all the latest on what is going on in Congress; you can also get copies most bills or summaries.

The Single Payer Plan

Discussions of this approach, modeled after Medicare, have included the following features

- automatic coverage for life for everyone, regardless of job loss or change
- comprehensive services for all medically necessary care, including prescription drugs, dental, vision, mental health, and long term care
- choice of doctor and hospital
- low administrative costs

In brief, this program would be publicly funded and privately delivered; with the federal government as sole payer for services delivered by independent doctors and hospitals.

The Public Plan Option

Understanding the Public Plan Option

Simply stated, if you don't have coverage from your employer, you can choose from a menu of health insurance products that includes a range of private health plans as well as a public insurance plan provided on the same terms nationwide. It is still insurance that you purchase the same way you would purchase other private insurance.

Key Features

- Provides a range of health insurance products including a public insurance plan for people under 65 who do not have employer-based health insurance,
- Modeled after Medicare
- Provides quality, affordable care through a broad network of private providers
- Promotes healthy competition between public and private health insurance alternatives
- Spurs improved quality of care

How Would the Currently Proposed Public Plan Work

- Initiates a National Health Insurance Exchange - a supermarket of public and private plans allowing consumers to comparison shop for the policy that best suits their needs
- Retains employment-based insurance in which employers continue to help pay premiums for privately purchased coverage
- Requires employer contributions to the exchange for those who do not offer health coverage ("play or pay")
- Continues coverage for those currently covered by existing public programs (Medicaid, CHIPRA)
- Operates under rules that apply to private and public plans ("level playing field")

In Brief, the function of a public plan would be to:

- provide a backup to citizens through availability on similar terms throughout US;
- provide a benchmark for all insurance to improve quality and efficiency of care
- provide a backstop - control costs resulting from the insurance provider consolidation that has driven up prices

These functions are not met by Health Care Cooperatives, HMO's, or PPO's

Public Plan vs. Health Care Cooperatives

Health Care Cooperative would allow consumers, states, or other groups to purchase health care for its members. One example is the Group Health Cooperative of Puget Sound which operates as a tightly managed health maintenance organization paying doctors on a salaried basis. This type of decentralized model could not meet the necessary functions of public plan described above.

Health Reform and Pharmaceuticals

Of the 10 congressional proposals (as of July 11, 2009), only 4 specifically include prescription drug coverage. These include: HR 15 (Representative Dingell); S 703 (Senator B. Sanders); HR 193 (Representative Stark); and HR 676 (Representative Conyers). ***(Since proposals are still being revised, this could change)***

There have also been other arrangements discussed whereby the pharmaceutical companies would make concessions on this matter (and on the cost of drugs within the Medicare Part D 'donut-hole'), presumably so they will not be 'forced' to make even greater concessions due to more strict reforms.

Sources:

1. Bredensteiner, Sue. *Understanding Healthy Competition: How To Structure Public Health Insurance Plan Choice To Ensure Risk-Sharing, Cost Control and Quality Improvement*. Retrieved 6/20/2009 from: www.lwv.org/AM/Template.cfm?Section=Health_Care1&TEMPLATE=/CM/ContentDisplay.cfm&CON
2. Hacker, Jacob S. *Un-Cooperative: The Trouble with Conrad's Compromise*. The New Republic. http://blogs.tnr.com/tnr/blogs/the_treatment/archive/2009/6/14/hacker.aspx

Glossary of Key Health Reform Terms

Abridged from: Kaiser Family Foundation,
www.kff.org/healthreform/upload/7909.pdf

As Congress discussed the elements of reform, the proposals that emerged have been as complex as the problems they seek to fix—45 million uninsured, skyrocketing health care costs, increasingly limited access to care, and lackluster quality. This glossary is intended to serve as a resource for understanding the concepts included in health reform proposals. It provides simple and straightforward definitions of key terms that have become part of the health reform debate.

Adverse Selection: People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

COBRA: When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and December 31, 2009.

Cost Containment: A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency in the health care system.

Cost-Sharing: A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

Cost Shifting: Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

Electronic Health Record/Electronic Medical Records: Computerized records of a patient's health information including medical, demographic, and administrative data. This record can be created and stored within one health care organization or it can be shared across health care organizations and delivery sites.

Employer Mandate: An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Employer Pay-or-Play: An approach that would require employers to offer and pay for health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund. The fund would provide a source of financing for coverage for those who do not have employment-based coverage. Currently, two states, Massachusetts and Vermont, and the City of San Francisco impose pay-or play requirements on employers.

Entitlement Program: Federal programs, such as Medicare and Medicaid, for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require

legislation. The Federal government is required to spend the funds necessary to provide benefits for individuals in these programs, unlike discretionary programs for which spending is set by Congress through the appropriations process. Enrollment in these programs cannot be capped and neither states nor the federal government may establish waiting lists.

Federal Employee Health Benefits

Program (FEHBP): A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organization plans. There are more than 170 plans offered; a combination of national plans, agency-specific plans, and more than 150 HMOs serving only specific geographic regions.

The various plans compete for enrollment as employees can compare the costs, benefits, and features of different plans.

Fee-for-Service: A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient's insurance carrier for reimbursement.

Guarantee Issue/Renewal: Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason.

Health Insurance Exchange/Connector: A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006.

High-Risk Pool: State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. As of early 2009, high-risk pools operate in 34 states but vary by who is eligible, cost sharing requirements, availability of premium subsidies, and funding sources.

Individual Mandate: A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

Lifetime Benefit Maximum: A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy.

Long-Term Care: Services that include those needed by people to live independently in the community, such as home health and personal care, as well as services provided in institutional settings such as nursing homes. Medicaid is the primary payer for long-term care. Many of these services are not covered by Medicare or private insurance.

Managed Care: A health delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as "gatekeepers" and manage the care their patients receive.

Portability of Coverage: Rules allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.

Pre-existing Condition Exclusions: An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.

Premium Subsidies: A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income.

Primary Care Provider: A provider, usually a physician specializing in internal medicine, family practice, or pediatrics (but can also be a nurse practitioner, physician assistant or even a health care clinic), who is responsible for providing primary care and coordinating other necessary health care services for patients.

Purchasing Pool: Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Reinsurance: Reinsurance is insurance for insurance companies and employers that self-insure their employees' medical costs. Through government-funded reinsurance programs, federal or state governments pay for a portion of the high costs experienced by insurers. By limiting insurers' exposure to very high health costs, reinsurance programs enable insurers to lower the premiums they charge to employers and individuals. This

type of program is a form of subsidy to the insurer that lowers the premium cost for all purchasers. The Healthy New York program and the Healthcare Group of Arizona are examples of state reinsurance programs.

Risk Adjustment: The process of increasing or reducing payments to health plans to reflect higher or lower than expected spending. Risk adjusting is designed to compensate health plans that enroll an older and sicker population as a way to discourage plans from selecting only healthier enrollees.

Socialized Medicine: A health care system in which the government operates and administers health care facilities and employs health care professionals.

Tax Credit: A tax credit is an amount that a person/family can subtract from the amount of income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax they would otherwise owe.

Tax Deduction: A deduction is an amount that a person/family can subtract from their adjusted gross income when calculating the amount of tax that they owe. Generally, people who itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums, that exceed 7.5% of their adjusted gross income.

Underinsured: People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

Universal Coverage: A system that provides health coverage to all Americans. A mechanism for achieving universal coverage (or near-universal coverage) under several current health reform proposals is the individual mandate. Single payer proposals would also provide universal coverage.

Visit us at www.lwvaz.org

For the League of Women Voters of the United States visit www.lwv.org