Actions for Cost-Effective Single Payer Health Care for All

- Identify your legislators: **www.vote-smart.org,** 888-vote-smart
- Share with your state & federal legislators the obstacles you face obtaining health coverage / care.
- Become a "citizen lobbyist" (to counter the wealthy insurance & pharmaceutical lobbies). Give legislators and candidates 1-page report summaries at **www.healthcareforallcolorado.org**.
- Organize your group's endorsement of **HR 676** - national single payer health care, and support for the single-payer concept in Colorado draft proposal. (see below).

National Level

Urge Legislators to Rescind Medicare "Reform" (Part D) & Enact National Single Payer Health Care HR676. Direct Email Congress at home page of **www.healthcareforallcolorado.org**

- Urge congressional representatives to support / cosponsor **HR676** for single payer, senators to sponsor a comparable bill.

State Level

Lobby / testify in support of the concept of single-risk-pool Single Payer Health Care.

- Colorado SB 208 in 2006 created a commission comprised of 24 health care providers, consumers and business representatives to hold hearings and make recommendations for improved health care access for all by November 2007.
- SB 208 calls for hearings in each Colorado congressional district (TBA). Testify on behalf of single-payer health care - see draft proposal at **www.healthcareforallcolorado.org**.
- Lobby state legislators to support the concept of cost-effective single-payer health care for all, described in the draft proposal.

Join Health Care for All Colorado in endorsing comprehensive, cost-effective health care that covers all - Public Payer, Private Provider Single-Payer Health Care. 65 percent favor government-guaranteed health coverage even with raised taxes (Pew Poll 5/05)**.**

Want to endorse the federal or state efforts? Need a speaker?
Call 303-277-8306 or 1-866-267-9462. Health Care for All Colorado

State of Colorado Health Care 2006

2006 Colorado Health Report Card The Colorado Health Foundation
Average Grade all Categories: C+
Colorado - partial list of rankings:

- 44th - Inadequate Prenatal Care
- 40th - Low birth-weight babies
- 44th - Vaccination rates for children (19-35 months)
- 44th - Children (0-17) without health insurance
- 22nd - Children (0-17) without a specific source of ongoing primary care
- 38th - Adults (18-64 yrs.) without health insurance
- 21st - Adults (18-64 yrs.) without a specific source of ongoing primary care.

Colorado Center on Law and Policy (CCLP)
Colorado Health Statistics:

- Over 746,000 uninsured & an equal number of under-insured.
- Working adults and their children comprise 80 percent of the medically underserved. Either their employers do not offer insurance, or they cannot afford the cost of employer-provided insurance.
- Colorado ranks in the bottom 5 states in publicly-provided health care coverage of people below the poverty level ("National Survey of America's Families," March 2000). The Colorado assets test for Medicaid eligibility is prohibitive, eliminating health care access for many. A complicated application process and inadequate automated systems render still more without health care access.

COLORADO HEALTH CARE CRISIS
Issues Raised in Testimony - Citizen Health Care Hearings
Denver, Colorado April 21, 2006

1. As insurance premium costs skyrocket, consumers experience decreasing access to health care.

Consumers have paid more for less coverage, as premium rates rose 73% from 2001-2006. One couple reported a monthly premium increase from $420/mo. (2002) to $830/mo. (2006) - excluding deductibles, dental, vision and prescriptions. Another consumer's premium for a high-deductible policy with two exclusions, rose 40% in 2006 alone. Insurance policies are "a form of extortion," she remarked, written for corporate profits on the basis of "risk avoidance, rather than risk sharing,"

2. Private insurers arbitrarily ration care and refuse or delay compensation to providers.

Often HMO decision makers, many not licensed to practice medicine, ration care by denying needed services. Families reported premature deaths, like that of an HIV-positive man with hemophilia, for whom treatments were delayed or denied. The care of a healthy octogenarian who was denied choice of physician under Medicare, was compromised when his HMO reportedly restricted doctor-advised treatment, contributing to his untimely death.

A retired western slope couple's United Healthcare plan was rejected by all of the providers in their area due to the insurer's inordinate delays in payment. Because the local Montrose hospital is not under this plan, the husband had to travel by ambulance to a hospital in Grand Junction (65 miles away) for heart by-pass surgery. Checkups for his pacemaker and heart condition are a big production. He must begin a month ahead to call New York corporate headquarters to get an "exception" granted for an out-of-network doctor. Though United Health insists that they have doctors in the area, there are none. Doctors who have refused to be in the network continue to be listed, and must repeatedly call or write reiterating that they are not in the network. "Payment is always denied," wrote the wife, requiring the doctor to write a follow-up letter re-stating that an exception was granted for him to treat the patient. Furthermore, many of the husband's heart medications are not covered under this insurer's

11. Rural areas experience even greater compromised access to health care.

More lower-income residents live below the poverty line in rural areas. Businesses tend to be small, limiting employer health coverage. It was reported that the two largest businesses in Montrose County - Russell Stover Candy and Walmart - offer high-deductible policies combined with low wages, making employees dependent on meager public health services. Lack of access to primary preventive care by consumers, including the 1 in 5 non-citizens living in the county, moves more into costly delayed emergency care. The low-income are charged full fee (vs. a lower negotiated fee for the insured). A further disadvantage occurs because county health institutions are not able to offer competitive salaries in order to attract health personnel.

Read / listen to testimony at www.healthcareforallcolorado.org

requiring a change in provider.

8. "Consumer-Driven" health care places an unreasonable burden of responsibility on consumers, whose high-deductible health policies discourage preventive care.

CDHC represents an abdication by private insurers of their responsibility to negotiate global budgets and bulk rates. With high-deductible policies, many consumers pay both deductibles and high monthly premiums. Eligibility for an HSA (Health Savings Account), requires one to qualify for a health plan with an arbitrary deductible amount. One must have available cash to open an HSA, eliminating all but the wealthy. The working poor and uninsured have no chance of opening an HSA account. HSA plans are cited by employers as an excuse to drop coverage for employees.

9. Even the insured experience bankruptcies due to high medical bills. Large medical bills are a significant contributor to 50 % of personal bankruptcies— 75 percent of those have health insurance (Harvard Business School study, 2005).

A woman who required surgery for a broken leg learned too late that her insurance covered only 10% of the costs. She and her husband face over $50,000 in health care bills and the possibility of losing their home and everything they have worked for.

10. Medicare Prescription Drug Reform (Medicare Part D) has compromised access to appropriate medications for many seniors. Many pharmacies face the prospect of bankruptcy due to large numbers of unpaid claims.

A health provider testified that under Medicare Part D, "people everyday are denied medications they need" and choices of the elderly have been stripped. "Dual eligibles" (eligible for both Medicaid and Medicare) have been forced out of Medicaid into private prescription drug programs. Patients take medications that don't work or do without, as private insurers will not pay for certain medications and dictate what doctors can prescribe.

An employee of a long-term care pharmacy reported that it faces potential bankruptcy, with an accumulated $1 million of unpaid claims since Medicare Part D began in 2006.

formulary, requiring him to pay out of pocket.

3. Employment-based insurance is undependable, with tremendous gaps that fail to serve part-time workers, the self-employed, or small businesses - conditions are exacerbated in rural areas.

Employees' health costs rise as employers shift more costs to them. One man testified that he cannot afford his $300/mo. share of employer-provided insurance. Nor do long years of employment guarantee continued coverage. An extremely ill woman who worked for 27 years was fired when she became ill, losing both job and insurance.

COBRA offers employees the chance to retain health coverage for a limited period of time after being terminated or cutting back hours, however the cost is often prohibitive. Cover Colorado, too, carries high deductible costs. High-deductible policies and low wages often push employees into indigent care and other public programs, or into ERs as a last resort for crisis care.

4. "Pre-existing Condition" is a "Catch 22," an open-ended concept denying health coverage to those who need it.

Consumers feel trapped, unable to report health problems or even to change policies for fear they will be rejected for any reason or dropped by their current insurer. Consumers testified that such conditions as systemic lupus, sleep apnea, diabetes, asthma, borderline cholesterol and benign breast mass have disqualified them from coverage. An applicant was told she is ineligible for coverage simply for the fact that she had been turned down by one insurer. A woman from Montrose noted that because insurance coverage is available only to those with spotless medical records, even the employed and healthy are sometimes unable to obtain coverage.

5. Public Programs are underfunded and overburdened.

Different critiques of Medicare and Medicaid have noted that both programs are more likely to pay for expensive crisis care than for preventive care. One recipient testified that Medicaid will deny home care and pay for more expensive nursing home care. Other limitations: Money in the bank or other assets make one ineligible for Medicaid; private insurers reject applications from those who are Medicare-eligible.

Medicaid and Medicare reimbursements have been continually cut, prompting providers to refuse to accept new patients, thus decreasing consumers' choice of providers. With yet another 4% cut in reimbursements in 2005, a consumer testified that doctors have begun to require patients to pay full price at time of service and to wait for partial reimbursement by Medicare. Patients who cannot pay in advance are asked to find another doctor, a further obstacle to obtaining preventive care.

Consumers are charged a penalty for signing up "late" for Medicare Part B, as well as Medicare Part D - the additional cost makes it unaffordable to some. A woman on Social Security Disability since 1985 testified that she has Medicare Part A for inpatient hospital expenses, but no coverage for doctor bills, outpatient hospital, lab tests, etc.

A provider cited 30% cuts in state funding for mental health and substance abuse in 2001. Consequently, many uninsured who cannot access mental health care end up in prison (at $65/day vs. $14/day for community treatment) or in emergency rooms (at 3-5 times the cost of primary care). Another provider testified that because the Colorado CBMS system wrongly dropped Medicaid-eligible patients, they were denied referrals for surgery or specialty care. At her Denver-area clinic, less than 10% of all uninsured referrals to specialists are seen; and only 50% of cancer patients receive treatment or specialty care (most who do are covered by Medicaid or Medicare).

She cited a Catch-22: Specialists will not see patients without more tests; tests won't be done until they are seen by a specialist. Caught in the middle, one patient raised $400 as down-payment for a recommended CT scan. A dispute over the type of treatment he required led to his rejection for treatment. Denied surgery, he was forced to resort to ER visits to be re-hydrated because he could not eat or drink much. Family and friends are now fundraising to pay for a surgical consult and surgery. Treatment up front, including surgery, would cost less and permit patients to return to work. Denied surgery/specialty care, some end up on disability for two years until they can qualify for Medicaid to pay for surgery. Some are permanently disabled, forced onto Medicaid and disability for a lifetime.

COBRA & Cover Colorado are stopgap measures, too expensive for many. At 50% of her income, the cost of Cover Colorado was out of reach for a part-time worker. A woman existing on $1,000/mo of social security survivor benefits would have to pay Cover Colorado $900/mo. Another woman who paid $250/mo. + deductibles in 2000 paid $11,000 out of pocket for a "high-risk" pregnancy in 2001.

A doctor testified that working at Stout St. Clinic for the homeless is like working in a foreign country, with inequality growing every day. He notes that a poor woman with breast cancer in Colorado does not qualify for surgery until her cancer spreads beyond the breast. Nationwide, 50 people die every day due to lack of health coverage. Furthermore, he said, everyday in Colorado people are discharged from hospitals to die, with no medications or follow-up.

6. Shifting burden and costs contributes to the downward spiral of health care and the closure of medical facilities such as emergency rooms and psychiatric treatment units.

As more under- and uninsured are denied primary preventive care and forced to seek delayed crisis care, emergency and trauma centers have become overwhelmed by unpaid debt, leading to closure of many emergency facilities over the past decade.

St. Anthony Hospital closed its psychiatric unit January 1, 2006. A shortage of psychiatric beds pushes psych patients into ERs. Emergency room care does not provide preventive or follow-up care, or needed medications. Referral options for the uninsured have decreased, as their numbers have increased. Lack of funding also leads to referral agencies closing their doors.

7. Providers' time and resources are consumed by dealing with requirements and paperwork of multiple insurers.

Much time is wasted following up with insurance companies. Each insurer has different authorization procedures, claims, billing, formularies, etc. Providers must hire people just to deal with complex paperwork. One provider reported spending 6% of her income on a billing service. Each provider must submit complex paperwork to each insurer for periodic re-credentialing. Patient care is further disrupted when employers change coverage, as often as every year, frequently

Cosponsors, Single-Payer Federal Bill HR 676:
Over 70 U.S. House members

A Few of the Growing Numbers of Endorsers:
- National Older Women's League
- 160+ Union Organizations
- National Education Association
- Physicians for a National Health Program

"We must tirelessly advocate for [single-payer universal health reform]. As the health care crisis extends and mushrooms, with more and more Americans without adequate coverage, the opportunity for such change will come at national, state, and local levels. And we must be there as advocates for our patients."

American Psychiatric Association President Steven Sharfstein
(APA News, 6/16/06)

www.healthcareforallcolorado.org

Summary Report of Health Care Issues

***

Citizen-Organized Health Care Hearings

Denver, Colorado   April 2006

Current Status of Colorado Health Care Access
&
Proposed Actions to Achieve Health Care for All