VOTER

THE LEAGUE OF WOMEN VOTERS OF CUPERTINO-SUNNYVALE

September 2009 Volume 37 Number 2

In This Issue

FALL KICKOFF MEETING

LUNCH WITH LEAGUE

Saturday, August 22, 2009
11:00 AM – 1:00 PM
Cost: $20.00
RSVP Roberta Hollimon
408-253-6078, lwvcseditor@comcast.net

ARYA Restaurant
19930 Stevens Creek Blvd.
Cupertino, CA 95014
(between Charles Schwab and Scandinavian Designs)
parking in rear

Join us as we start the new League year with:

- lunch
- speakers on the Cupertino Utility Measure and the School Parcel Tax
- preview of League activities in coming year
- announcement of candidate forums
- advocacy on local issues

This is an opportunity to bring friends to let them know about the League and the benefits of becoming a member. RSVP today as seating is limited.

PRESIDENT'S MESSAGE

We have a lot of activities happening and would love to have you join us and bring a friend. Our kick off luncheon is on August 22 at Arya's where we will be discussing two hot topics for some of our local area issues. We also have voter registration events happening at corporations. And with Health Care Reform in high gear, your input to representatives is needed now more than ever. As you know the League stands for quality, affordable health care. Please contact your legislators today! They are being inundated by lobbyists so it's more important than ever to hear from their constituents. Let's remind them we all benefit from good government and suffer from special interest government.

I look forward to seeing you soon.

Elaine Manley, President

IMPLEMENTING REDISTRICTING BY COMMISSION

The League of Women Voters of California (LWVC) is busy making plans to educate League members and the public about implementing Proposition 11, the 2008 initiative that requires an independent citizen commission to draw district lines for the Assembly, Senate, and Board of Equalization. Draft regulations to govern the process of commission selection will be posted soon at www.bsa.ca.gov/redistricting. The League and other redistricting advocates offered suggestions about the regulations and will comment on the proposals. Applications for the commission will be due in late 2009 and early 2010. Local Leagues are encouraged to join in the critical effort to encourage a diverse group of qualified applicants.

At its July meeting, the LWVC board agreed to participate in a proposed collaborative of organizations that would create materials to educate the public on the importance of redistricting and of applying for the commission.

The LWVC also plans to submit applications for funding to the James Irvine Foundation, which has circulated requests for proposals for two phases of redistricting outreach. The first phase will focus on encouraging qualified community members to apply to serve on the redistricting commission. The second phase will center on monitoring the commission's work and encouraging community members to give input to the commission about how they should be represented.

LWVC Update August 2009

Board Briefs

At its July meeting your board:

- Reviewed Directions to the Board from Annual Meeting.
- Learned that LWV Santa Clara County will urge the County Board of Supervisors to use Instant Runoff Voting for their next election.
- Accepted the resignation of Pat Meyering.
- Formed a committee to study the City of Cupertino's Utility User Tax Measure.
- Received board training from our Management Training Advisor, Kathee Tyson.

Membership News

Thank you for renewing your membership: Dorothy Givens, Russell Howard, and Nancy Noto.

Thank you for including a donation with your dues: Marilyn Collins and Leslie Fitch.

Thank you for your donation to the Community Appeal: Hobart Davis.

The Cupertino-Sunnyvale VOTER

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HEALTH CARE REFORM UPDATE: HEALING WHAT AILS US

Summary of July 24 Public Forum

LWV Health Care Reform Since 1989 - Geri Stewart, Social Policy Director, LWV-Palo Alto

Beginning in 1989, the LWVC was the driving force behind LWVUS adopting a national study of health care reform in 1990, which resulted in LWVUS approval of positions in 1993 on which health care action is based today. The four fundamental criteria for reform were the following: **access for all, a basic level of quality care, efficient and economical delivery of care, and an equitable distribution of health care**.

Since 1993, the League has taken action for meaningful health care reform including launching educational forums with the Kaiser Family Foundation and other corporate sponsors, working collaboratively with White House staff and testifying to Congressional committees, including support for a single payer system.

Change We Can Believe in: The International Experience and Health Care Reform – A Case for Single Payer - Dr. Claudia Chaufan, MD, PhD UCSF, California Physicians Alliance (CAPA)

All developed democracies except the United States offer a single payer health care system. Health care is viewed as a service and right of citizenship, not a market driven, for-profit product.

Other developed democracies such as Great Britain, Canada, Japan, Germany and Taiwan pay less percent of their GNP for health care than in the United States, live longer, and have lower infant mortality rates. Necessary services include medical, drugs, dental, vision, mental health care. Patients choose their doctors. Everyone is "In" and pay into a common pool; no one is "Out". Individuals can buy private insurance for services not covered by the public plan. No one is denied coverage for pre-existing conditions; no co-pays, no caps, no paperwork and no one is bankrupted by medical bills.

First Policy Principle: Single payer systems share two goals resulting in universal coverage and cost savings: the goal of eliminating financial barriers to health care (health equity); the commitment to the best strategies to control costs:

- **Risk pooling**, (risk is spread over the entire population rather than borne by an individual).
- **Bulk purchasing** (economic scale drives down costs).
- **Cross-subsidizing** (diverse populations—age, gender, sick, well— are in one pool.) Costs are controlled because those who require the most medical care are offset by the majority who are healthy. Twenty percent of the population use 86% of the care. This system is effective only for a large random pool.
- **Non-medical services** are not provided.

Funding of health care systems where emphasis is *Social,* health insurance is of two types:

- **Socialized Insurance**: Funding is public; delivery is private-public partnership. Examples are Taiwan, Canada, Germany.
- **Socialized medicine**: funding is public; delivery is mostly public. Examples are UK, Scandinavia, Spain. Goals are the same: provide universal coverage, eliminate financial barriers to care; reduce cost.

Second Policy Principle:

- **Shared responsibility** (Everyone is covered, but everyone pays into the system)
- **Solidarity** (contributions adjusted to income; everybody is in; no one is out)

If the goal is universal coverage, health care equity, access and affordability, America's "uniquely American solution" is flawed. In contrast to international single payer systems, the American solution divides people into competing insurance plans, spends money on marketing plans, focuses on creating shareholder profits and high CEO salaries, wastes providers time on paperwork rather than providing medical care and results in fewer dollars spent on health care and more on administrative costs. The market driven American system causes the U.S. to spend the most per capita ($5,635 U.S. vs $3,100 Canada) without improved health outcomes or patient satisfaction and leaves 45 million without health coverage.

We have a "window of opportunity" for real health care reform.
Pending Single payer bills:

- California Universal Healthcare Act (SB 810)
- Expanded Medicare for All (HR 676)
- State-level amendment for single payer (Kucinich)

What Problems Are We Trying to Solve?
Giorgio Piccagli, PhD, MPH President, CaPublic Health Association-North

In a nutshell:

The current U.S. health care system does not work for many—45 million Americans are uninsured or one in six. 18 million children are uncovered. 50 million are underinsured or one in three. 60% of current bankruptcies have a health care component and most suffering bankruptcy for medical reasons had insurance. Being insured does not mean having access.

- **Financing does not determine health care**. U.S. health care **costs** are disproportionately higher than other countries. U.S. pays more than double the OECD median; 1.5 times or second highest. U.S. health cost in 2010 is projected to be $2.4 trillion. Health care costs doubled as a percent of gross domestic product (GDP) between 1970-2010 and are expected to rise from 15% to 20% of GDP in the next decade.
- **Fairness** of the financial contribution, the U.S. ranks 54th of 55 nations, according to World Health Organization (WHO).
- **Cost does not equate to quality**. U.S. life expectancy is 78 years, below the industrial world average. U.S. ranks 29th in the world. Cancer/CVD rates are higher than Canada, England and most European countries. Preventable hospital deaths in the U.S. are 100,000/year; preventable deaths among the uninsured are 18,000/year—both higher than developed countries with single payer systems.
- **Problems created by employment-based access** with unemployment rising, employers reducing health benefits packages.
- **Problems created by private insurance-based coverage** include effectiveness, efficiency, medical underwriting, decomposition of the insurance concept. When comparing the administrative costs of private and government-funded care, Medicare costs are 4%, Private Health Insurance is 30% or $217 billion. Patient's out-of-pocket (OOP) costs are 25% or $64.1 billion. Private + OOP = 82% of total administrative costs; Private + OOP = 70% of total Medicare costs.
- **Erosion of the safety net**: gaps in categorical coverage.

Conclusions

- **Problems are not solved by more of the same.** The current private financing and reimbursement system contributes to the problem, not the solution.
- **Where we want to go:** Reforms must be sustainable and deliver universal access to quality care at affordable cost with improved health status for all and eliminate health disparities.
- **If Single Payer is not politically feasible, ask the following questions for a strong public plan:** Available to all? Sustainably affordable? FENBP equivalent benefits? Serves as a model for other plans? Able to influence other plans? Does the system reflect American values that "We hold these truths to be self-evident that all men are created equal…with certain unalienable Rights to Life, Liberty and the pursuit of Happiness." "No one ought to harm another in his life, health, liberty or possessions." MLK, Jr.

Current Proposals: How Can a Public Plan Work?
Deborah LeVeen, PhD, Professor Emerita, SF State

The Gateway plan or Hybrid approach currently under discussion in the Senate HELP and Finance committees is similar to the Massachusetts Healthcare Plan.

- **Criteria of a strong public option**: Comprehensive coverage and affordable for all; high quality and cost effective; fair and sustainable financing; effective cost containment to ensure long-term affordability and fiscal stability.
- **Level Playing Field**: Separate administration for public plan; insurance reforms; **risk adjustment**: transferring funds from plans with healthier enrollees to plans with higher cost enrollees.

General Components:

- **Insurance Exchange:** Eligibility (Who could join?) uninsured individuals, small businesses, (others?) Benefits: comprehensive, limits on cost-sharing; Affordability: income-linked caps on spending, subsidies –up to 3-400% FPL; Choices: existing private plans, possibly new public option.
- **Insurance Market Reforms to ensure access:** Guaranteed eligibility and renewal, no exclusion based on preexisting conditions; Community ratings (gender, age): premiums not based on health status; some standardization of benefit packages, applications, etc.
- **Expansion of existing public programs** (increased eligibility): Medicaid, SCHIP
- **Shared responsibility for financing: Employer Mandate** "play" (offer insurance) or "pay" (pay % of gross into new public program; **Individual Mandate**: compulsory individual participation
- **Cost Containment through a robust public option:** Savings achieved by increased efficiency and quality of care through delivery and payment reforms; possible price negotiations and/or reductions. **Projected outcome:** Lower administrative costs; no marketing, underwriting, profits, high CEO salaries; lower payments for providers and

suppliers; greater savings resulting from payment and delivery system reforms. Lower premiums in public plans (projected 25% lower yields increased enrollment in public plans); lower costs for expanded coverage.

- **Generating price competition on a level playing field among private plans and public option is a more powerful driver for long-term cost-containment than regulation and improvement in quality and efficiency alone. Projected Outcome:** Potential for $3Trillion savings system-wide 2010-2020.

What's on the Table Now? What We Can Do About It?

Ellen Shaffer, PhD MPH,Co-Director, Center for Policy Analysis

- **Health Care in California:** In 2006, 6.6 million uninsured, 20% of nonelderly population; 763,000 children uninsured; 300,000 at risk of losing coverage; Health care spending grows two to three times faster than California economy; health insurance premiums grow significantly faster than overall health care spending.
- **Cost:** Of the $2.5 trillion the U.S. spends annually for health care, 30% is spent on administration and profit; Cost controls are essential to improve coverage, affordability, quality and choice.
- **Single Payer: What is it and why is it controversial?** SP system provides universal coverage, is most cost efficient, contributes to social and economic equity with good health outcomes and provides government the authority to constrain health care spending. Past U.S. Presidents worked unsuccessfully for a single payer system: 1915, Woodrow Wilson; 1935, Franklin Roosevelt; 1949, Harry S. Truman; 1979, Jimmy Carter. In 1965, Lyndon Johnson lead efforts to create MEDICARE, MEDCAID-a single-payer system for those over 65; in 1994, Bill Clinton led passage of SCHIP, a single payer system for children.

Resistance to reform

- **Arguments against reform**: "Better idea is unnecessary" "We have the best system."; using scare tactics-"SP puts government bureaucrats in charge of your health care." "socialism", "SP will result is long waits and rationing of health care; class warfare. Corporate media via advertising, newscasts echo this message.
- **Current system generates huge profits causing vested interests to resist change:** The $2.5 trillion is paid by individuals, employers and government to physicians, insurance industry and pharmaceutical companies for services and products, who in term make major political donations to elected officials.

Movement toward reform: What is under discussion?

- **President Obama's Administrative Aims:** Control costs; expand coverage; improve quality/comparative effectiveness; address disparities **BUT** keep what you have; maintain private employment-based health insurance plans and private financing.
- **Five Congressional Committees with legislative proposals**
  Senate: Finance (Baucus) and HELP (Kennedy/Dodd)
  House: Energy and Commerce (Waxman) Eshoo serves; Ways and Means (Starke-Health SubCom)
  Education and Labor (Miller); Speaker Pelosi: House Working Group
- **Insurance Reform:** No pre-existing condition exclusions; no r**escissions**; guaranteed renewability; minimum care share (stop loss) 85%
- **Coverage and financing: Health Insurance Exchange** in 2013; **Individual Mandate**: sliding scales 1-11% of income, affordability credits up to 400% FPL; **Employer Mandate**: pay 72.5% of premium, $750 penalty; max 8% of payroll
- **Cost Control: Similar to Medicare**: Government authority to constrain health care spending; incentives to reorganize delivery system (Team care, primary care; no hospital payments for readmission; prevention, public health measures); Negotiate drug prices (Close Part D "doughnut hole"/gaps or reduce by 50%)
- **Public Plan Option:** Choice within **Health Insurance Exchange**; enrollee can choose a plan like Medicare; gives government authority to constrain spending (lower administrative costs, set reimbursement rates to providers.) Many proposals to weaken public option by delaying when, who may join at what rates.
- **How to pay for health care reform**: Present plans are not budget neutral according to Central Budget Office (CBO); If wring out costs and keep savings, no new funding needed; proposed taxes on wealthy >$350K/yr
- **House Progressive/Quad Caucus:** Will vote for strong **public option**; wanted SP, no more compromises; supports state SP option
- **State Single Payer Option:** Developed in CA; Amendment by Senator Kucinich; passed in committee- 14 Democrats, 13 Republicans

The big question is funding. How do we pay for this? Some analysts believe that if we can contain costs, we can use the savings to cover costs.

- **Can We Win? Is it worth the effort if there is no national single payer plan?** Important to gain ground; continue public education; resist attack machine; pave the way for further future reforms
- **What is Next?** House Committee bills by July 31 (Speaker Pelosi, Rules Committee combine the 3 House committee bills); Senate Finance bill by Aug. 8; House and Senate each vote after Labor Day; Conference to reconcile differences; House and Senate vote to confirm, send to President in fall.

- **Political Tug of War:** House of Reps 435 members, need 218 to win; Democrats = 257; Quad Caucuses: 100 members, Progressive Caucus = 78 members; Black, Hispanic, Asian/Pacific Island American; Blue Dogs + New Democrats = 100 members Blue Dogs: 51 members; New Dems: 69
- **Opportunities for Action**: The message: "Strong public plan; keep state's single payer option". Letters to the editor; sign-on statements; contact Congress: House Speaker Nancy Pelosi; Ed & Labor Chair George Miller; Energy & Commerce Chair Henry Waxman; Senate Finance Chair Max Baucus and President Obama (See handout)
- **Learn more:** http://www.centerforpolicyanalysis.org/ (Website address) Interested parties can join a listserv at - equal@list.equalhealth.info (e-mail address)

Prevention and Health Policy. Marisel Brown, MPH, MBA, Public Health Institute

- **Key Points:** Chronic diseases are preventable; prevention components in current health care reform legislation is a public health milestone; health is a local issue.
- **Determinants of Health and Their Contribution to Premature Death:** Behavioral patterns-40%, Genetics-30%, Socio-economic status-16%, Health care-10%, Environmental exposure-5%
- **HR 3200-America's Affordable Health Choices Act of 2009:** Expansion of community health centers; Prohibition of cost-sharing for preventive services; Creation of community-based programs to deliver prevention and wellness services; Focus on community-based programs and new data collection to address health disparities; funds to strengthen state, local tribal and territorial public health departments and programs.
- **Prevention Works:** Investment of $10/person in community-based prevention could yield more than $2.8 billion in one to two years. Return on investment is .96:1.
- **Prevention is a local issue:** Include good health practices in school policies, worksite practices, business policy, land use policy, transportation policy.

Patient and Physician Needs. Li-hsia Wang, pediatrician (retired)

Problems of the present system in a clinical setting:

- **Equality concerns.** The uninsured are charged at a rate significantly higher than those of the insured, so that those less able to pay are charged more.
- **Current system impedes quick treatment.** The treatment of all patients is delayed 15-20 minutes until eligibility can be checked.
- **Everyone is affected**. The paperwork hassle affects everyone. Denial of services doesn't just affect uninsured. If an uninsured person on a bus or airplane has active TB, even those with good healthcare will be affected.

The American Medical Association represents only 30% of all health care workers, and hence is not the best voice for healthcare. Physicians for a National Health Program (PNHP) has more support among health care workers.

Keeping Hospitals Serving and Solvent. Santa Clara Valley Medical Center: A Local Bellwether for Healthcare Reform.
James Murphy, Director of Planning and Business Development of Santa Clara Valley Health and Hospital Systems

•The Reform Agenda for the National Association of Public Hospitals (NAPH)

- Adequately reimburse health care providers caring for low-income, uninsured and Medicaid patients.
- Coordinate systems of care to improve patient outcomes and lower health care costs.
- Maintain Graduate Medical Education (GME) payments for teaching hospitals in both Medicare and Medicaid.

- **California will differ from other states:** MediCal and Valley Care (local) expand coverage, access and utilization; Federal reform, the state budget and waivers promise dramatic changes in funding.
- **Santa Clara Valley Health and Hospital System: "Dedicated to the health of the whole community"** Santa Clara Valley Medical Center: 574-bed teaching hospital, serving 25% of SCC residents; 8 health centers, 830,000 patient visits a year. The medical group has 320 full-time, salaried MDs; Valley Health Plan, 80,000 enrollees; mental, public health depts.; Dept. of Alcohol & Drug Services.
- **Growth in demand for services:** +211% since 1981, +45% since 2000. A care comparison between Valley Med and commercial hospitals is 724/1,000 inpatient vs. commercial plan 181/1,000; emergency room is Valley Med 524/1,000, commercial plan 143/1,000; outpatient is Valley Med 7,860/1,000 vs 5,314/1,000 commercial.
- **California MediCal Waiver Renewal 2010**
- **CA is LAST** among all states for its reimbursement for Medicaid programs; 70 CA hospitals have closed in past 10 years. Hospital fee (tax) was part of Governor's Reform Package; now it is part of a plan to rectify the low rates of California payments for Medicare. However, cuts in pending State budget may cause State to lose or gain $2 Federal dollars for each 41 of State funding.

LEAGUE NEWS

National – The House of Representatives made history last month by passing the American Clean Energy and Security Act of 2009 (ACES), the first both to curb the greenhouse gases that cause climate change and help move our country into a clean energy economy. Instrumental in the successful House passage of the ACES were local Leagues in CA, IN, MI, OH, NM, TX and GA. Lobbying visits across the country have been supported by educational forums held in five communities in California and one in Michigan.

State – There will be six regional workshops this fall. The workshops are designed to inform both League members and the public about what the League does and how it does it. One will be held Saturday, October 24 in Palo Alto. Members are encouraged to attend.

League Websites

National	www.lwv.org
State	www.ca.lwv.org
Bay Area	www.lwvba-ca.org
County	www.scc.ca.lwvnet.org
Local	www.cs.ca.lwvnet.org

Other Websites of Interest

EdSource	www.edsource.org
Great Schools	www.greatschools.net

THE LEAGUE'S ROLE IN CONSTITUTIONAL REFORM

The LWVC expects to play a two-fold role in the constitutional reform effort that is of great interest throughout the state:

- Education for members and the public on why constitutional reform is under consideration and the implications of possible procedures and remedies
- Identification of League positions that should guide our engagement on reforms under consideration

An ad hoc group will be appointed to advise the LWVC board on issues relating to constitutional reform. Educational materials and a leaders' guide will also be developed for local Leagues on both the process and the substance of the reform effort. Watch the LWVC Web site for material, including additional resources, a calendar of activities around the state, and an expected timeframe.

Until the League adopts a position on a process for constitutional reform or on measures that will ultimately go on the ballot, local Leagues can create time in their calendars for education programs and for attendance or sponsorship of community forums on the issue. They should not, however, endorse specific reform efforts that may be under discussion. *LWVC Update August* 2009

CALIFORNIA FAIR ELECTIONS ACT CAMPAIGN IS UNDERWAY

The California Fair Elections Act (CFEA) on the June 2010 ballot would create a pilot project to make available voluntary public financing for candidates running for Secretary of State in 2014 and 2018. Many Leagues and League members worked hard for the passage of AB 583 (Hancock) of 2007-08, the bill that placed CFEA on the ballot. The campaign to pass the CFEA is organizing, and it's time to muster the troops! Please contact advocacy@lwvc.org if you can aid in the effort.

LWVC Update August 2009

Join the League of Women Voters

Membership in the League of Women Voters is open to all men and women of voting age who are U.S. citizens. Others are welcome to join the League as associate members.

Send your check payable to LWVCS to LWV Cupertino-Sunnyvale, P.O. Box 2923, Sunnyvale, CA 94087.

____ $60 Individual member

____ $90 Two members in a household

____ $30 Student

____ Contribution $_____

Telephone: _____

Name: _____

Address: _____

City: _____State:_____ZIP:_____

Email: _____

Checks made out to LWVCS are not tax deductible.

To make a tax-deductible donation, write a separate check to LWVCS EdFund.

CALENDAR

August

Sat 22 11:00 am **Lunch with League**
Arya Restaurant
19930 Stevens Creek Blvd. Cupertino

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THE LEAGUE OF WOMEN VOTERS, a nonpartisan political organization, encourages the informed and active participation of citizens in government, works to increase understanding of major public policy issues, and influences public policy through education and advocacy.

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