



September 9, 2009

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GENERAL SESSION

September 9, 2009

Program Topic: National Health Care – Legislation Issues

Presented by: National Issues Study Committee

Co-Chairs: Melanie Bowen and Ruby Hammel

Director:

Speakers: Wesley Smith – Director of Public Policy, Salt Lake Chamber of Commerce
Dr. David Sundwall – Executive Director, Utah State Department of Health
Jennifer Cannaday – Regence; Director, Public Policy & Health Information
Rob Ence – Executive Director, AARP Utah

Wesley Smith compared Aesop's "belling the cat" fable to healthcare reform. The mice agree that a bell should be placed around the cat's neck to warn of its approach. They suppose they have their problem solved until one mouse asks, "But, who's going to do it?" The moral is that a solution may be a great idea, but difficult to implement. Mr. Smith suggested the healthcare reform "bell" is cost reduction and wider access.

The Chamber believes market principles should be employed in any solution. Legislation that expands accountability at all levels is necessary for market principles to operate appropriately in health reform. "All levels" means patient, payer, provider, and political leaders. Improved accountability and personal responsibility are essential, as is transparency. Reform should focus on pre-tax dollars, employee choice (to increase personal responsibility), and increasing wellness through healthier lifestyles.

Medicare does not compensate doctors adequately, which shifts the cost to businesses. The Chamber supports tort reform that would lower costs by reducing tests and procedures done simply to shield doctors' liability.

Market principles will control costs in health reform. If people want more of something, that item becomes a growth industry. You get more for less. For example, lasik eye surgery, which isn't covered by health insurance, has been reduced in cost while increasing in quality because people shop for the best deal. If market principles are allowed to work, people will shop for other kinds of health services. Costs will decrease and access increase

Mr. Smith described the Utah Health Exchange, as the "Travelocity" of health care. Employers contribute money to the Health Exchange so employees are not limited to one employer-provided plan. Currently only available to small businesses, the hope is to gradually expand it to the general public.

Dr. David Sundwall spoke of his appointment by Governor John Huntsman, Jr., whose goal in health care was making health insurance available to everyone.

Only 44% of Utah employers offer health insurance. Our state will not be able to compete in the workplace without more affordable

insurance. Personal responsibility is inherent in Utah's tradition and culture, and figures prominently in our health insurance reform debate. Dr. Sundwall continues to see patients one day a week and has noticed those who have health insurance are generally healthier because they seek care sooner.

The Health Dept. has been criticized for being slow, but the state legislature has decreed an incremental approach. Progress is being made, in that Utah Taxpayers can now deduct the cost of insurance from their income. In addition, the Children's Health Insurance program (CHIP) was recently made an entitlement by the Utah legislature.

The Health Ins. Exchange web site (www.exchange.utah.gov) has been designed to connect consumers to the information they need to make informed health insurance choices, and to execute them electronically. The Health Dept. was also charged with setting standards for an additional online, patient approved, database for medical records and information.

Dr. Sundwall noted that 70% of our health care costs are devoted to the last six month of life. Approval is being sought to use federal funds to assist those who don't qualify for Medicaid, but cannot afford private coverage.

Jennifer Cannaday recognized that women have a unique perspective on the health care debate, often being the healthcare decision maker for the family. As complex and overwhelming as the health reform issue is, it comes down to getting the care we need for an affordable price. She supports an incremental approach, since this issue is complex with many competing interests.

The three vital healthcare reform concerns are how to expand access, how to control costs, and how to pay for it. Regence acknowledges there is an insurance policy available for everyone, but affordability is the obstacle. Access will never be achieved unless costs are contained.

Factors impacting healthcare costs include "cost shifting." Medicare and Medicaid pay less than their fair share of the costs (up to 30% less than private insurance pays for the same care). This

adds a hidden tax of \$1000 to in insured family of four.

The insurance industry has separated the consumer from healthcare's true cost. A co-payment doesn't reflect the actual cost of a procedure or drug. Personal health habits also factor in, as complications from obesity, heart disease, cancer and diabetes cost an estimated \$117 billion and drove 27% of the per capita health care spending growth since 1987 to 2001.

Dartmouth College's Institute for Health Policy and Clinical Practice estimates that the U.S. spends \$500 billion annually on unnecessary medical procedures. Technology itself can drive up costs. An X-Ray machine costs \$175,000, a CAT scanner \$1 million, and an MRI machine up to \$3 million. The American consumer expects the best technological diagnoses, which can lead to test duplication. There are also thousands of mandates and regulations on health insurers that impact administrative costs, although many are necessary to insure health care is delivered honestly.

The uninsured, who often use Emergency Rooms as their primary care source, represent another \$165 billion dollars each year which is "cost shifted" to taxpayers and the privately insured.

Ms. Cannaday said 87 cents of each national health care dollar goes to actual health care. The remaining 13 cents goes to administrative costs, of which only 3 cents are profit (or, for a non-profit enterprise like Regence, funds that to be reinvested in the business). In short, medical insurance is not particularly profitable.

Ms. Cannaday urged WSLC members to give input on the healthcare debate to their congressional representatives. The Regence website (www.regence.com) offers an easy way to do this. Go to the "Issues and Action" tab and click on "Take Action." In that page, click again on "Take Action" and enter your zip code. There is also a link to a web site that provides further information on health care costs (www.WhatsTheRealCost.org).

Rob Ence said though Utah is different in some ways from the rest of the country, we can learn

from what others are doing. Again, he recommended we all spend the time to become well informed. Misinformation is one of the biggest challenges to any issue. An honest, open debate with correct information is vital to solving problems. AARP is concerned not only about the Seniors it represents, but also their children and grandchildren.

As a nation, we spend twice as much as many industrialized countries, while sometimes receiving less. Healthcare cost is about equally divided between government, corporate and individual expenditures.

Stating that AARP hasn't yet endorsed any of the plans being studied in Congress, Mr. Ence outlined some basic principles AARP believes are important. There needs to be provision for affordable coverage for people between the ages of 50 and 64. Currently, options are limited.

Improvements should be made in the Medicare program. For example, the government is currently paying about 14% more for patients in

the Medicare Advantage program than for those in traditional Medicare. Whatever adjustments are required, the benefits and quality of care should not be cut.

Reform of the payment system that is based on procedures administered rather than quality outcomes could account for considerable savings. Also, follow-up home care could reduce hospital re-admissions. The Medicare program (Part D) should be able to negotiate drug prices with providers, and more use should be made of generics. Finally, as in other types of insurance, everyone should share the cost of health insurance.

Even though market forces are viable and ought to be in our system, health care is not a typical commodity. We don't shop regularly for it, as we do for other items. We need coverage in place when we need it.

Reported by Stuart Gygi

General Session II

Program Topic: National Health Care – Swine Flu Virus

Presented by: National Issues Study Committee

**Co-Chairs: Melanie Bowen and Ruby Hammel
Director:**

**Speaker: Dr. Rachel Herlihy – Deputy State Director of Epidemiology, Utah State
Department of Health**

Dr. Herlihy first presented an overview of the situation this spring with the H1N1 Pandemic and then talked about the plans for fall. The Swine flu was first identified in California in mid-April. It hadn't been seen before in the U.S., so the Centers for Disease Control (CDC) was notified and investigated the new strain. At the same time, reports were coming from Mexico of a severe outbreak of influenza.

It took some time for enough information to be gathered to get a clear picture of the situation in Mexico. Ironically, the most accurate information comes from those who die from the virus. The news media picked up the story quickly, and made it look worse that it turned out to be.

So, what is this new virus all about? Flu virus morphs quickly, requiring a new vaccine each

year. The H1N1 virus is believed to have mutated from four viruses that became one new virus.

Utah's first case was reported in April, originating from a cluster of school children that had been to Mexico for Spring Break. A graph of daily reported cases shows a gradual increase, peaking at 65 new cases by June 1, 2009. There is a similar trend for hospitalizations. The graph for Mexico shows a peak of 675 new reported cases in late April.

The CDC tracks flu carefully from year to year, enabling comparisons. A graph was presented showing the H1N1 outbreak in the spring, as well as the four previous seasons. H1N1 began much later in the season, when previous outbreaks were essentially over. The number of H1N1 cases was in line with previous flu seasons and was, in fact, much smaller than the 2005-2006 season. There were 302 hospitalizations, with 89 severe enough to require confinement to the ICU. There were 18 deaths.

Significantly, 244 cases were patients with underlying medical conditions (asthma, diabetes, neurological disease, obesity, and pregnancy). These conditions were present in H1N1 cases 7 times more frequently than in the general population. Although influenza normally affects the elderly and very young most severely, the reverse is true with H1N1. The elderly are affected very little, with teens and young adults being the most vulnerable.

H1N1 outbreaks were experienced around the world. Australia, New Zealand, Chile and Argentina, being in the southern hemisphere,

experienced both the H1N1 and the normal flu at the same time, which gives us a picture of what to expect here.

The number of infections could be much greater than was experienced this spring. However, the infections were not as severe as the 1918 Pandemic. Will the N1N1 become more severe? Will it be more transmittable? There are many unknowns. In Utah, the State Department of Health has a broad-based surveillance plan which includes onset, severity, risk groups, outpatient infection rates, hospitalizations, school, workplace absenteeism, and pneumonia & influenza deaths. The Utah Public Health Laboratory will do testing to inform community mitigation efforts, clinical management, and to monitor for genetic drift and antiviral resistance.

The use of antiviral medications such as Tamiflu will be used to treat (not prevent) infection in high risk groups such as hospitalized patients, very young children under five, older adults over 65, pregnant women, and people with chronic medical conditions. People should still get the seasonal flu vaccine, which is available now.

The H1N1 vaccine will be available in mid-October to be given to the following groups first: Pregnant women, people who live with or care for children under six, healthcare & emergency medical personnel, people between the ages of 6 months and 24 years and people between 25 and 64 who are at higher risk because of chronic health disorders or compromised immune systems.

Reported by Stuart Gygi

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