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Citizens' Health Care Working Group
7201 Wisconsin Avenue, Room 575
Bethesda, Maryland 20814

Re: Comments on Interim Recommendations

To the Citizens' Health Care Working Group:

Family Planning Advocates of New York State is pleased to offer comments on the Interim Recommendations of the Citizens' Health Care Working Group.

Family Planning Advocates (FPA) represents the state's family planning providers which include twelve Planned Parenthood affiliates, hospital- and non-hospital-based family planning clinics, and a wide range of other health, community and social service organizations. The entities we represent provide health care to the ever-increasing numbers of low-income New Yorkers in desperate need of health care. Our family planning clinic members provide health care services at 250 sites and are often the only available source of health care for more than 400,000 women and men in New York State.

As long standing providers we have been dedicated both to reducing unnecessary barriers to obtaining public insurance by adopting a model that allows patients to obtain enrollment assistance at the point of service delivery at our health care centers, and to supporting initiatives that seek to ensure all persons have access to comprehensive health insurance coverage, including preventive services for women. To these ends we have supported, for example, expansions of public health insurance eligibility, and passage of a state law which requires coverage of health services and screenings that are vital to women's health.

Our work in representing health providers that provide health care to New York State's large number of uninsured and underinsured persons gives us a unique perspective into the critical importance of addressing the United States' failure to ensure that *all* persons have affordable and comprehensive health insurance as well as access to needed health care services. It is from this experience that we have concluded that any solutions that do not guarantee that all people have access to affordable health insurance coverage that meets their primary, preventive and catastrophic health care needs would be a great disservice.

As advocates for women's health, we are particularly concerned that women's needs for coverage of comprehensive reproductive health care services will be sacrificed for political expediency. It is still a commonplace practice for reproductive health services used by women to be excluded from otherwise comprehensive health insurance plans, a discriminatory practice that results in women paying more for out of pocket health expenses than men. Attempts to address these discriminatory practices are often blocked at the legislative level by political opponents who cite their religious objections to many reproductive health services. The Working Group will undoubtedly receive comments that seek to perpetuate this discriminatory practice. We urge Working Group members to reject the calls of those who would impose one set of religious and moral values on all by excluding from coverage those health care services that a small, but loud, minority of people opposes.

We appreciate the work of the Working Group and urge members to include our suggestions in the final report. We first offer general comments and then comments on specific recommendations.

I. GENERAL COMMENTS

1. *Final Recommendations Should Better Reflect Public Consensus*

We are concerned that the Interim Recommendations seem to deviate from the overwhelming consensus shown by the public's input. People have clearly expressed the desire that health care reform be focused on creating a system in which everyone has coverage for a comprehensive range of health care services that meet needs across the life span. People have conclusively stated that they do not feel we should be accepting "trade offs" in order to guarantee coverage for all, people want health coverage that protects people from financial ruin when catastrophic illness strikes, but they also want coverage for preventive, primary health services without incurring high levels of "cost sharing."

The responses showed significant support for creating a national health plan financed by taxpayers, and an overwhelming rejection that there should be trade-offs in coverage in meeting the goal of creating a health care system that works for all. The results of the Working Group's work are clear: health care in America is in a state of crisis and is failing to meet the needs of far too many people. Those who participated overwhelmingly reject the concept that we need to reduce benefits to ensure increased access. These conclusions did not seem to be fully reflected in the recommendations and we strongly suggest that these conclusions should be better incorporated into the final recommendations.

2. *Final Recommendations Must be Inclusive of Immigrants*

The Working Group recommendations included no mention of providing health care for non-citizens. Perhaps the phrase "all Americans" was intended to be inclusive of all people who live in the United States, and if so, that should be specified. Our providers see large numbers of

patients who are legal residents but are nonetheless not citizens. Legal immigrants pay taxes just as citizens do and should be specifically included in any plan to increase health insurance coverage.

Ensuring that all persons, including immigrants, have access to health care also makes sense from a public health perspective. Communicable diseases--including those preventable by vaccines—do not check for immigration status. Clearly, some health conditions, if left untreated or not prevented, place everyone at risk.

We also urge the Working Group to address the issue of health care for undocumented immigrants. By some estimates, there are up to 12 million undocumented people in the United States. Many states, including New York, already provide vital health services such as prenatal care and health coverage for children without regard for immigration status. In addition, under federal law, all emergency rooms must provide treatment to anyone who appears with an emergency medical condition. While we understand that this issue is linked to the larger debate over immigration policies, and perhaps not easily settled, it is an inescapable fact that undocumented immigrants will often need and do access health care while in the United States. We cannot ignore the issue of how to provide and pay for health care for this patient population in a debate over comprehensive health care reform.

We urge the Working Groups to ensure that existing programs that provide needed health care services without regard to immigration status are maintained and are more equitably financed so individual providers and communities do not bear all the costs of providing vital health care services to persons who are not in the country legally.

3. *Issues of Reimbursement and Health Insurance Industry Profits must be Addressed*

The analysis and considerations of the Working Group do not adequately address the role of insurance industry profits in the rising costs of health care. For example, in 2005 the 37 independent Blue Cross Blue Shield plans saw their combined net income rise by 15% in a one year period. As reported in *Modern Healthcare*, "the plans' aggregate profits have climbed a total of 853% since 1996, which kicked off six straight years of accelerating average premium increases."[1] We feel that far too much focus is placed on the behavior of patients and not enough on the behavior of those who profit from health care. In order to truly address health care problems, the issue of profits must be grappled with.

A related issue that must also be addressed is the way in which health care services are reimbursed. Providers who serve low income people are finding it increasingly difficult, if not impossible, to offer care due to a failure to adequately fund programs that offer care to the low-income. Many of the providers FPA represents are struggling to provide health care services in the face of increased costs which have not been matched by increased reimbursement rates.

[1] Laura B. Benko, "Transparency has its Limits," *Modern Healthcare*, August 7, 2006.

4. ***The myth that consumer-driven health care will lower health care spending must be dispelled.***

We strongly encourage the Working Group to avoid any recommendations that would lead to a growth of so-called "consumer driven" health plans, or health savings accounts, which require enrollees to pay large co-pays or deductibles. The growing trend of imposing higher co-pays and deductibles is making primary and preventive health care unaffordable for both low income and middle class people, who are often forced to deny themselves needed care.

Research shows that it is unlikely that "consumer driven" health care will result in lower medical costs.[2] According to this model, which has garnered support in some political arenas, individuals will be more prudent consumers of health care if they are aware of health care costs and are responsible for more of their health care costs. However, this is simply unrealistic as the majority of health care spending goes to relatively few people who have high cost medical needs due to complex medical problems.

In fact, studies show that the imposition of high cost sharing actually results in a decline in patients' access to preventive medical care, which can ultimately lead to poorer health outcomes because of delayed diagnosis and treatment.[3] This is not a trend we can support and we urge the Working Group to seek solutions that would not impose high levels of cost sharing on patients.

II. FPA'S POSITIONS ON SPECIFIC RECOMMENDATIONS

***CHCWG Recommendation*:** **Guarantee financial protection against very high health care costs.**

FPA's Position: We agree with the recommendation that we need to find a solution that would guarantee financial protection against very high care costs, and we want to ensure this is a protection that is guaranteed for all individuals and families. We support the recommendation that low income individuals and families have financial protection and hope this means that the Working Group recognizes that it is essential that low-income people continue to have access to no-cost health care. For many low-income people, even costs that seem minimal to some can make health care access unobtainable. We must ensure that low-income people have access to comprehensive, free medical care.

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[2] *See,* Edwin Park, "Health Savings Accounts Unlikely to Significantly Reduce Health Care Spending," Center on Budget and Policy Priorities, June 12, 2006; Leonard E. Burman, "New Healthcare Tax Proposals: Costly and Counterproductive, Tax Policy Center, February 13, 2006; Linda Blumberg, Leonard E. Burman, "Most Households' Medical Expenses Exceed HSA Deductibles," Tax Policy Center, August 16, 2004.

[3] *See,* "Paul Fronstin, Ph.D., Sara R. Collins, Ph.D., "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," The Commonwealth Fund, December 2005; Karen Davis, Ph.D., Michelle M. Doty, Ph.D., Alice Ho, "How High Is Too High? Implications of High-Deductible Health Plans," The Commonwealth Fund, April 2005; Emmett B. Keeler, Ph.D., "Effects of Cost Sharing on Use of Medical Services and Health," RAND Corporation, 1992.

In addition, we urge the Working Group to take heed of the comments that increasing numbers of middle income people cannot afford access to primary and preventive care due to the growing trend of shifting health care costs to patients. We agree with the principle that no one should be bankrupted by a medical crisis, but we are also aware that the key to good health is access to preventive care.

***CHCWG Recommendation*: Support integrated community health networks.**

FPA's Position: Providing high quality coordinated care to vulnerable populations is a laudable goal, and FPA's clinics already play an important role in serving as safety net providers to vulnerable people. However, the primary problem faced by clinics is not a lack of coordination, but the inadequate reimbursement rates which make it difficult, if not impossible, to provide the same level of services that privately insured patients can obtain.

We also feel this recommendation fails to take into account the consensus that everyone should have access to a comprehensive range of health benefits. This recommendation seemingly calls for a perpetuation of a two-tiered system in which the low-income obtain a different level of health services than the privately insured and that is not an outcome we can support.

***CHCWG Recommendation*: Promote efforts to improve quality of care and efficiency.**

FPA's Position: FPA certainly supports improving quality and efficiency in health care. Unfortunately, this recommendation overlooks the important role that adequate funding plays in providing quality health care services. Many important sources of revenue that have allowed family planning providers to offer quality care that responds to the needs of patients have not kept up with increased costs and demand for services.

While funding has remained flat, clinics have incurred ever increasing costs for supplies, medications, lab fees and other expenses, including energy costs. For example, the cost of contraceptives has tripled on a per patient basis in the last five years. The older methods are multiplying in cost and the newer, more effective methods are extremely costly. In the first quarter of 2006 the price of one of the most popularly prescribed oral contraceptive increased by 67% since the third quarter of 2005, and the cost of the Nuva Ring contraceptive, a newer method, has increased by 265% since the 4th quarter of 2005. Many women find the new methods of contraception—such as the Nuva Ring or the Patch--easier to use than the birth control pill, making them more likely to use these methods consistently and correctly, factors which help to reduce costly unintended pregnancies, yet the high costs make it impossible for many family planning clinics to offer these products to patients. These increased costs are putting a tremendous strain on clinics' ability to provide care, and are simply unsustainable. It is imperative that efforts to improve quality also include a reformation of healthcare reimbursement policies. Reimbursement rates need to be adequate and reflect the cost of providing quality services.

FPA also urges the Working Group to consider the importance of offering culturally competent care and language access services in providing quality care.[4] The provision of culturally competent practices can improve health outcomes, cost efficiency and patient satisfaction because health providers have better communication and interaction with patients. This allows providers to obtain more specific and complete information upon which to base a diagnosis, which leads to better adherence to treatment plans by patients. A key component of culturally competent care is the availability of language access services for patients with limited English proficiency—a necessary service which many providers struggle to afford. Any recommendations must ensure that language access services are reimbursable.

***CHCWG Recommendation*: It should be public policy that all Americans have affordable health care.**

FPA's Position: We support the goal of ensuring that everyone has access to affordable care, but we must be cognizant of how "affordable" is defined, especially when determining what is affordable for low-income families. The Working Group must consider the input of many who complained of the burden on even middle class families, who are finding the rise in health care costs along with other living expenses, simply too much. Americans recognize the importance of preventive health care and are dissatisfied with the current pattern of more and more costs being passed on to patients. Although a question asked at many community meetings forced people to choose whether they felt insurance was more important to cover everyday medical expenses or to protect against high medical costs, the spoken comments rejected this false distinction. These are both vital aspects to health and we should not need to trade one for the other. People have expressed their opinion that unaffordable co-pays and deductibles is a problem that must be addressed along with the burden that high medical expenses places on many people.
We urge the Working Group to incorporate the public consensus that imposing higher costs on patients through co-pays and deductibles is not affordable and must be stemmed.

***CHCWG Recommendation*: Financing Health Care that Works for All Americans**

FPA's position: The public input into these recommendations showed that Americans overwhelmingly see the value in moving toward a system of taxpayer-funded universal health insurance. We do not underestimate the difficulty in achieving such a fundamental transformation and are concerned that the recommendations do not include any points about addressing the inequities in how health care services are currently reimbursed or a call for an open evaluation of the role health insurance industry profits play in the increasing costs of health care. Before we can move toward a universal system, these fundamental questions about the distribution of money must be addressed.

[4] See, *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, U.S. Department of Health and Human Services, March 2001.

CHCWG Recommendation: **Define a "core" benefit package for all Americans.**

FPA's position: We support the recommendation that everyone should have access to health insurance, but we have concerns that this point on defining a core benefit package seems to contemplate a two-tiered system in which some people would have coverage for only a limited, "core" set of health insurance benefits. This type of system does not reflect the overall consensus gleaned from the input of the American people, who have stated clearly they want a system where everyone has access to a comprehensive range of health insurance benefits. We cannot support perpetuating the existing situation where some have coverage for a full range of benefits while others have only limited or no coverage.

It is critically important that any benefit package--particularly if the final recommendation is to offer everyone a barebones, or core benefit package-- include coverage for a comprehensive range of reproductive health services. Women need coverage for a range of reproductive health services that includes abortion, contraception, sterilization, pregnancy and maternity care, screening and treatment for STIs and reproductive cancers. Ensuring access to comprehensive coverage allows women to access those services, medications and contraceptive options that best meet their needs.

Unintended pregnancy is a public health issue that has long-ranging health and financial impacts. Women with unintended pregnancy forego the opportunity to receive pre-conception counseling and are more likely to have low birth weight babies and experience a higher rate of neonatal mortality.[5] Effective use of contraception can help women plan and space their pregnancies, and leads to healthier outcomes. Public health experts project that effective family planning could reduce the rates of low birth weight and infant mortality by 12 percent and 10 percent, respectively.[6] According to the New England Journal of Medicine, "infants conceived 18 to 23 months after a previous live birth had the lowest risks of adverse perinatal outcomes."[7] Health is promoted by controlling the spacing of births. There is no question that when families can plan when and how many children to have, the number of high-risk pregnancies and births are reduced, and infant and child health and survival improves.[8]

We strongly urge the Working Group to resist efforts to restrict coverage for abortion. We believe an important value that should guide this reform of the U.S. health care system is one of respect for the various beliefs of our diverse population. While it is undeniable that many are morally opposed to abortion, it is equally true that many find abortion a morally acceptable option. The only way to respect various religious and moral beliefs in deciding upon health insurance coverage for a diverse population is to refrain from using insurance as a vehicle that allows some to impose their values on all.

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[5] R. Bonoan and J. Gonen, "Promoting Healthy Pregnancies: Counseling and Contraception as the First Step," Washington Business Group on Health, August 2000.
[6] The National Commission to Prevent Infant Mortality, *Troubling Trends: The Health of America's Next Generation*, Washington, DC (1990).
[7] Bao-Ping Zhu, et al., *Effect of the Interval Between Pregnancies on Perinatal Outcomes*, The New England Journal of Medicine, Vol. 340, No. 8 (1999).
[8] Alan Guttmacher Institute, Issues in Brief, *Family Planning Improves Child Survival and Health*, (1998).

Excluding coverage for abortion makes the procedure unattainable for many poor and low-income women, effectively excluding them from the same freedoms that higher income women have to control their reproductive destinies. When low-income women who do not have coverage for abortion must raise money to pay for the procedure, they often divert funds for other vital expenses such as food, rent or utility bills. Although many women may be able to raise the necessary funds, the time it takes causes them to delay the procedure, waiting on average 2 to 3 weeks longer than other women.[9] It is a far better policy option to work to prevent unintended pregnancy rather than target poor women seeking safe, legal medical care. Abortion should be treated as any other medical service and covered in the core set of benefits.

Conclusion

We appreciate this opportunity to provide input on how to devise a health care system that works for all. We look forward to the next stage of this process.

[9] Alan Guttmacher Institute, Issues in Brief, *Revisiting Public Funding of Abortion for Poor Women,* (2000).