

August 28, 2006

Citizens' Health Care Working Group  
7201 Wisconsin Ave.; # 575  
Bethesda, Md. 20814

RE: Cleveland, Ohio coalition's responses to Interim Recommendations

Dear members of the Citizens Health Care Working Group:

A coalition of groups based in North East Ohio called the "North East Ohio Voices for Health Care", convened by the Universal Health Care Action Network of Ohio (UHCAN Ohio), presents this summary of responses to the Interim Recommendations. Attached are the specific and more extensive comments of several of the groups or individuals, including UHCAN Ohio's. On August 24<sup>th</sup> at Trinity Cathedral in Cleveland the groups convened and presented these statements to representatives of Congressman Dennis Kucinich, Congresswoman Stephanie Tubbs-Jones, and Congressman Sherrod Brown as well as to several state legislators.

We have forwarded a power point which was adapted from the Oklahoma presentation by email. That power point was presented to the assembly of over 70 persons and represents the questions, comments and concerns of the coalition. North East Ohio Voices for Health Care is composed of representatives of UHCAN Ohio, May Dugan Service Center, Jobs with Justice, SEIU, UAW, SPAN Ohio, USW, CPAAHC, Neighborhood Family Practice and some individuals. Comments were presented by those groups as well as the Northeast Ohio Alliance for Hope (NOAH – a faith based organization representing 20 faith communities), St. Vincent's Hospital, University Hospital, LEAP (an organization which advocates for persons with disabilities), and the national organization of UHCAN. Several individuals also spoke.

All persons and groups agreed that universal health care is needed, and sooner rather than later. The comments and concerns of Northeast Ohio Voices for Health Care include the following:

1. The recommendations include several items that are traditionally state, rather than federal, issues, and should be addressed on a state by state basis:
2. Several coalition members felt the process shut out their constituencies or that the questions asked were confusing:
3. Though there was general agreement with many of the recommendations there was concern by many coalition members that the order of implementation was inverted:
4. All agreed that the recommendation on "high medical debt" needs to be refined since experience and research shows that any medical debt may be devastating to low income families, or families with other debt that they must repay:
5. Most felt that there was no real "road map" to universal health care provided:

6. Most felt that the call for a package of 'core benefits' should be a package of 'comprehensive benefits':
7. The Recommendations seem to exclude non-citizens and we would include all residents of the country, as other nations with universal systems do: and,
8. We think your value of shared responsibility best reflects the way in which we should view health care.

The comments of some those who attended were as follows:

**North East Alliance for Hope (NOAH)** – Ann Williams spoke on behalf of NOAH and some of their statements are as follows: As a faith based group we believe everyone has the human and moral right to access to health care. Our faith based organizations deal with health issues of the members every day and “NOAH congregations collectively affirm that in the Citizen’s Health Care Group Interim Recommendations, universal health care should be at the TOP of the list”. Ann shared some personal stories which described how our failing health care system has affected her personally she pointed out the stories she shared illustrate “that the present cost of NOT providing universal health access to health care coverage is, in fact, very high. Our country has the highest health care costs in the world, but we do not have the best outcomes”. (Full statement is attached)

**Sisters of Charity of St. Augustine Health System** – Robin Bachman, Director of Public Policy shared some remarks. As a member of the Catholic Hospital Association we believe in health care for all as a human right. We had our staff participate in the Working Group process and we spent a lot of time on the recommendations to provide health care networks, and to provide better 'end of life' care. We believe in prevention and primary care, and we also believe in the dignity of people and thought the 'end of life' care recommendation was a thoughtful one. (Full statement is attached)

**May Dugan Multi - Service Center** – We work mainly with low income persons who have few or no resources. The Working Group never bothered to come to Cleveland so that population we serve could not participate. It is hard for this population to even identify with some of the phrases used in the Recommendations. For instance 'affordable health care' is usually not affordable to our clientele. Even a \$20 co-pay means not paying for food or rent, for many people. After all what does protection against high costs mean when you can't even pay the rent.

**SPAN Ohio and the UAW** – We support a single payer health insurance system either through HR 676, 'Medicare for All', or through the 'Health Care for All Ohioans Act.' The Recommendations do not adequately deal with the fact that waste and administrative overhead is 40% of our health care dollar at present, while Medicare spends only 3% on overhead. Manufacturing plants would stay in Ohio if we had a single payer plan that would cut their health care costs. Ohio should be out front in the fight for universal health care.

**University Hospital Health System** – There are none of the Interim Recommendations that we, as a provider, disagree with. We believe the Interim Recommendations are a good place to start and the difficulty is how to finance it so it is fair to everyone. We should be focusing on

coverage for every person and we need to speak to the administrative complexity of the present system. We have billing nightmares and the Interim Recommendations may add more complexity. We are also concerned that the 'core benefits' called for may result in different levels of care and we believe in high quality care for everyone.

**Neighborhood Family Practice** -- As an FQHC in Cleveland we believe in health care for all. We have organized a group of uninsured persons to work on reaching that goal. We are angry about our present health care system which is too bureaucratic and too complex to simply 'fix.' It is designed to block people from getting health care. There are lots of ways people can fall 'through the cracks' and fail to have health care or insurance. This is a disgusting situation and embarrassing that the USA, which has so much, has such an unfair health care system.

**Linking Employment, Abilities, and Potential (LEAP)** - LEAP is a non-residential center for independent living. Ongoing access to health care is important to persons with disabilities. We try to get persons with disabilities back into the work force but we often find that they cannot afford health insurance once they find a job. Even work related health insurance is not available often because of pre-existing conditions. The Recommendations completely ignore the issue of 'Long Term Care.' This is also a high cost item and is the 'elephant in the room.' We cannot talk about universal, 'cradle to grave' health care without talking about Long Term Care. We must look at the fragmented delivery system and the health care financing system and make a fundamental paradigm shift. We're not dead yet and we must do something about the cost of Long Term Care. (Full statement is attached)

Several individuals also spoke and their comments are included in the power point. Dr. Tom Pretlow's comments are attached but some of his points bear emphasizing. The Recommendations do not address the shortage of general or family practitioners. Given the amounts of money borrowed by medical students to get their degree, most go into the more lucrative specialties today, leaving society short of internal medicine doctors and other generalists. The reimbursement system makes it worse because providers are asked to spend as little time as possible with each patient to make their business plan work. This shortage is a major problem that will not be solved by implementing these interim recommendations.

We hope these comments are taken in the spirit they are given, to improve on the Interim Recommendations so that meaningful hearings may be held on the issues presented. Thank you for listening to Cleveland.

Very truly yours,

  
Gary Benjamin

Hello, my name is Ann Williams. I am a member of the Northeast Ohio Alliance for Hope, N-O-A-H, also known as NOAH. NOAH is a coalition of faith-based institutions from Cleveland and the surrounding suburbs, working collectively on social justice issues.

Health care is an important issue to the congregations that make up NOAH. We live near some of the best health care facilities in the world. Our area also has top-quality schools for nurses, physicians, and other health care professionals.

Yet we have many people in our area who are among the 46 million Americans who have no health insurance coverage. We have all seen in our congregations the tragedies that result from this lack of adequate health care. Therefore, the NOAH congregations collectively affirm that in the Citizen's Health Care Group Interim Recommendations, universal health care coverage should be at the TOP of the list.

My own family situation illustrates the problem. I have four young adults in my family – 3 adult children and a son-in-law. All of them have worked since they were in high school. Yet until recently, none of them had any health insurance coverage.

This does not even make financial sense. One of my daughters has epilepsy. If my husband and I had not bought her anti-seizure medication for her, she would have been very expensive indeed for the health care system, since she seizes within 24 hours of missing a dose. She would, furthermore, have been completely unable to hold a job or care for herself,

as she normally does when her medication is available to her. Her expenses for hospitalization and disability would have been paid by the taxpaying public.

I also have a cousin who used to own his own small business. His cost for health insurance was high enough that he had to make a choice between investing in his business or buying healthcare coverage. He chose to go without the coverage. He developed diabetes, and did not care for himself properly because of the high cost of care. Even if he had bought health care coverage at this point, it would not have covered his diabetes, which was now a pre-existing condition.

Unfortunately, he has now had a disabling stroke. Although he is still of working age, he now is unable to work, completely disabled, and not able to even get out of bed by himself. All of his savings have been spent on his care. Now, instead of him working and paying his own way, all of his expenses for medical care, housing, food, and other necessities are paid by taxpayers. We know from diabetes research that if he had received adequate diabetes care earlier in his life, it is likely that this could have been avoided.

These are not isolated incidents. There are many similar stories among the families that make up NOAH's congregations. And in recent years, the number of uninsured people in our area has grown because so many large employers have left Cleveland.

**As these stories illustrate, the present cost of NOT providing universal access to health care coverage is, in fact, very high. Our country has the highest health care costs in the world, but we do not have the best outcomes. We should learn from the countries that have better outcomes at a lower price.**

**All other industrialized countries in the world manage to provide universal access to health care coverage, without tying it to employment or health care status, so we know that this is a very achievable goal.**

**The NOAH congregations affirm that universal health care coverage for *ALL* Americans is a top priority for any United States health care policy. This is one situation in which doing the ethically right thing and doing the financially wise thing are one and the same.**

Remarks by Robin Bachman

Sisters of Charity of St. Augustine Health System

August 24, 2006

I would like to thank UHCAN and the partners for convening this forum.

I am with the Sisters of Charity of St. Augustine Health System. We are a family of hospitals, foundations, elder care and outreach organizations in Ohio and South Carolina. Building on 155-plus years of providing health care to this community, the Sisters of Charity of St. Augustine Health System is strongly committed to collaborating with others in assuring access to health care. Individuals have a right to health care as a basic necessity of ones quality of life. Every person is to be respected with the dignity that access to care provides.

We have participated in the Citizens' Health Care Working Group process at the urging of the Catholic Health Association (CHA). We asked our colleagues to take the on-line poll distributed by the Working Group earlier this year. We included information on the Working Group during our Cover the Uninsured Week activities. It has been mentioned in our newsletters and recently, like others across the country, we undertook the public policy exercise of reacting to the recommendations during a staff development luncheon. We shared our staff comments on the interim recommendations of the Citizens' Health Care Working Group with CHA and the Working Group. During our discussions, we spent a great deal of time on the recommendation that called for the "support (of) integrated community health networks." We believe this strongly and strive to be very collaborative in our work. We thought the Group should emphasize preventative health more. And we believed that collaboration among health networks, schools and other social service agencies should be emphasized. For instance, our Building Healthy Communities project at St. Vincent Charity Hospital is a good model. It is an effort to join with

our communities in addressing chronic illnesses like heart disease, cancer, diabetes, and focuses on improving community health and quality of life.

Additionally, we appreciated the Working Group's inclusion of the recommendation: "fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided..." During our discussion we underscored that a setting that offers dignity and comfort does not strain costs.

Thank you again for convening this civic forum!

Dave Ravina

- Saturday 1 April 2006 – politicians – testimony
  1. human suffering
  2. unnecessary deaths
  3. economic impact from lost jobs, to closed businesses
  
- I speak for several organizations, SPAN, UAW
  1. W/regard to interim recommendations:
    - a) The “financing” of the plan is simple, and according to the Congressional Budget Office, and the General Accounting Office of our federal govt. A single payer plan would eliminate the administrative waste, and insure every m w & c in the US at the current level, and would cost the same or less than the present system
    - b) The “core” benefit package by definition is a concern because it implies that that the “affluent” will have better benefits, while under a single payer system everyone could enjoy a consistently high level of benefits at the same or less cost.
    - c) A Single Payer plan would eliminate the need for the community – based health centers serving the vulnerable populations, because everyone would have access to the same high quality care
  
- HB 676 – MEDICARE FOR ALL is the answer, on the National level, but Ohioans can not afford to wait for the political climate in Washington to change.
  
- When Ohio Citizens enact The Health Care For All Ohioans Act, it will have the effect of a State sized HB 676, and as it’s title says provide Health Care to All Ohioans, but it will have an additional impact in that it will serve as an economic development tool because business will come to Ohio & grow in Ohio where their health care costs are controlled. This will lead others states and eventually the federal govt. to follow.

**Comments for the Citizens Health Care Working Group**  
**Presented 8/24/06-Town Hall Meeting of the NEO Voices for Health Care Coalition**  
**Prepared by-Deborah Nebel, Director of Public Policy, Linking Employment,**  
**Abilities & Potential (LEAP), Cleveland, Ohio**

My name is Deborah Nebel and I am the Director of Public Policy for Linking Employment, Abilities & Potential, a non residential Center for Independent Living. We serve people with all types of disability regardless of age. All of our services promote self-sufficiency and focus on providing persons with disabilities the tools that they need to reduce their dependence on public systems. The vast majorities of the consumers that we serve are poor and unemployed and cannot purchase services to promote their independence. Or they face significant systemic barriers to access the complete range of services that they need to live in the community.

No where is this more apparent then in the area of ongoing access to health care coverage and the sometimes daily nursing, personal care assistance and supportive services that people need to live as independently as possible with a either a chronic medical, life long psychological or developmental condition or disability. Persons with disabilities are basically shut out of the private health care insurance market. More often then not, when they do obtain a job or re-enter the workforce they are without health care benefits or are offered coverage that is simply not affordable. Many persons with disabilities have had to fight for years to receive a disability determination that eventually entitles them to Medicare or if they are low-income enough to Medicaid coverage. Having access to ongoing health care coverage is so important to persons with disabilities that LEAP has a whole program called Benefits Planning, Assistance and Outreach which helps people understand the impact that going to work will have on primarily their health care benefit.

So it is absolutely astonishing to me to read the interim recommendations of the working group and see basically no serious discussion or acknowledgement between the need to address the overall health care crisis and the need to reform the way we as a country finance and deliver long term care to our aging population and persons with disabilities. One only needs to look at the Medicaid "crisis" in Ohio to know that the increase in how we spend our public health care dollars is not primarily due to an increased caseload but on the increased cost of health care, especially for institutionalized care and prescription drugs and the expanded use of Medicaid dollars to pay for alcohol and drug addiction, mental illness, mental retardation and developmental disabilities (health care issues often not adequately addressed by our current employer based/insurance system).

How can we seriously talk about what health care benefits and services should be provided, or where the American public wants health care delivered when we are ignoring the "long term care" elephant in the room? For many years, I was a Long Term Care Ombudsman and my mantra was "who pays" determines where "one stays" to receive care and also determines "what services one will actually receive." How can we hold as a value that all Americans will have access to a set of core health care services across the continuum of care throughout the lifespan (cradle to grave) and not acknowledge directly the institutional bias that still exists in the care we provide to those aging and persons of all ages living with disabilities? If will not be enough to restructure end of life care—which in itself is a good recommendation—because that only deals primarily with access to appropriate care by those making informed decisions when faced with incurable conditions or the natural process of eventual physical failure and mortality. It does not do justice to the unique health care and personal care challenges faced

by persons with disabilities of any age, who in the words of the grassroots consumer advocacy group ADAPT, constantly remind this society "that we are not dead yet".

If we are to address the oxymoron that is our fragmented health care system, we must tackle head on how all of our US health care coverage (preventative, acute, long-term and palliative) should be financed and decide how we all will participate in that "shared social responsibility". It is important that one of the recommendations is that no one in America should be impoverished by health care costs. (But even that will require a complete paradigm shift in our thinking about the use of public health care dollars because that is exactly what we currently ask of persons with disabilities and the elderly--that they impoverish themselves before they qualify for long term care.) Protecting individuals and families from catastrophic health care cost is a way of sharing the risk of the human condition but it will not address the out of control problem of rising costs and how we choose to spend the resources that we as a country have and whether we have the political will to act on the belief that "health and health care are fundamental to the well-being of the American people.



**UHCAN Ohio Comments on Interim Recommendations of the Citizens Health Care Working Group**

August 23, 2006

By Cathy J. Levine, JD, Executive Director

UHCAN Ohio is a statewide non-profit organization working throughout Ohio for high quality, affordable, accessible health care for all Ohioans, through education, empowering people and organizations, and public policy work.

On behalf of the board and members of UHCAN Ohio, I commend the Citizens Health Care Working Group members and staff for its efforts to gather input from policy experts and Americans alike on health care reform. The Interim Recommendations demonstrate that members listened to input from community meetings. The recommendations, if implemented, would move the US closer to health care reform. In that context, I am offering comments aimed at strengthening the final recommendations.

**1. The order of the recommendations is puzzling; the recommendation that "It should be public policy that all Americans have affordable health care" should be the overall recommendation, with the other recommendations being elements of the overall goal. Clear consensus exists among participants in CHCWG and in the public on the desire for a system that provides comprehensive, quality coverage, as described in the discussion with detail and clarity. Widespread support was expressed for a "national health plan, financed by taxpayers, in which all Americans would get their health insurance," for comprehensive benefits for everyone, and for action soon.**

The other recommendations cannot be implemented adequately without providing coverage for everyone in a nationally coordinated health care system. The lack of consensus on whether the system guarantees health care or provides everyone with health insurance is secondary, reflects confusion among even ardent supporters of universal health coverage, and is not worth acknowledging.

**2. The recommendation to guarantee financial protection should extend beyond "very high" health costs. Many studies show that even modest medical debt can destabilize a family's finances, leading to housing loss, avoidance of needed health care, and other well-documented consequences of medical debt. Lower-income working people do not have excess income to cover more than nominal cost-sharing. Individuals should not be "free to purchase the policy that suits their needs best." People need coverage with cost-sharing limited to affordable amounts. The CHCWG poll question asked us to choose, as the single purpose of coverage, between health care and protection against high costs. That poll question, like others, contained assumptions that should not be included in a poll seeking people's views.**

The proposal to provide catastrophic coverage to all will be meaningless to people who cannot afford preventative care or care to manage acute or chronic health conditions. High-deductible insurance shifts the costs of health care onto the individual. Instead, everyone should have coverage that provides a core set of benefits designed to ensure that they receive the right care at the right time in the right setting.



**3. The support of integrated community health networks is a good one but those networks should be for all patients, regardless of income and include private, nonprofit and public providers. All primary care providers should be part of a network that, like the Federally Qualified Health Centers, has protocols for treating chronic health conditions based on evidence-based best practice and performance measures, to ensure that patients receive the correct annual screenings and treatment.**

**The networks should also extend culturally competent care with consistent quality from FQHCs to private physician practices, in order to improve quality for all and reduce unnecessary health care spending by providing evidence-based care.**

**These networks could also be the basis for making affordable prescription drugs available to all. The FQHCs receive low prices for their patients. Those 340(b) prices should be made available universally.**

**4. The Interim Recommendations do not adequately address the need to reduce wasteful spending in health care. We need strategies for eliminating high profit-making in health care. If we are going to provide coverage to everyone that is affordable to individuals and society, we cannot allow today's unregulated profit-taking from health care from a variety of industries. For example, we need to develop legislation to reduce prescription drug spending, by using evidence-based formularies, encouraging bulk purchasing, allowing the federal government to negotiate directly with the pharmaceutical companies for Medicare beneficiaries, and controlling industry marketing practices. We need regional health planning to eliminate construction and expansion of health care facilities and high-tech equipment that offer duplicative services, because these drive up health care spending. Columbus, Ohio does not need 3 heart hospitals!**

**The recommendation to promote efforts to improve quality of care and efficiency is vitally important, but we have to make sure that the evidence-based best practice become the national standard of care. We need strategies to reduce our shameful medical error rate and improve health outcomes. Provision of health care should be paid for based on outcomes, not on the number of procedures performed on patients.**

**5. Financing of health care has to be based on shared responsibility, so that all employers should be contributing to employee health care costs, unless we make the national decision to eliminate employer-sponsored health care and seek revenues through another means. We need a larger national investment in health coverage and in health improvement. On the state and national level, health care should be financed through a fair, progressive, and diversified tax structure. Massive tax cuts for wealthier Americans, in the past six years, undermine the ability of the federal government to invest adequately in fixing the health care system. The federal government should make federal financial incentives available to states so that states can become laboratories for reform and develop state-specific reforms designed for their particular environments.**

**Thank you for considering these comments.**

**Respectfully submitted,  
Cathy J. Levine, JD  
Executive Director  
UHCAN Ohio**