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LEAGUE OF WOMEN VOTERS URGES ACTION ON AFFORDABLE HEALTH CHOICES

The League of Women Voters believes that quality, affordable health care should be available to all U.S. residents. Quality health care should include an equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care. The League also believes that all Americans should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care.

Over the years, the League has learned that Americans believe that fairness, responsibility, and access are important values for any health care system and that health care reform can only succeed if it takes all these values into account. As a result, the League has been urging Congress to pass comprehensive health care legislation.

It used to be that having a job meant having health insurance. But as health care costs have skyrocketed and wages have stagnated, fewer employers can offer coverage and fewer employees can afford it when it is offered. In Florida, the number of uninsured 18-64 year-olds who are employed is 1,870,000. This means that 2 out of 3 uninsured 18-64 year-olds are employed! Without health reform, more people will lose their employer-sponsored health insurance due to cost pressures and the weak economy.

In the fall of 1988, Cathy Williams Kerns a member of the Orange County League of Women Voters began to lose the vision in her left eye. The diagnosis was Multiple Sclerosis, a progressive and often disabling disease of the central nervous system.

At first, health care coverage was not a problem, but when Ms. Kerns left her husband's Orlando advertising agency and he retired, they no longer had corporate health insurance coverage. So, Ms. Kerns enrolled in COBRA at a cost of \$1,800 a month and when the COBRA policy expired, she paid \$2,200 a month for a rollover policy.

In May, Ms. Kerns testified before a U.S. Senate Finance Sub-Committee looking into affordable health care. She told them how she has to take 11 medicines a day, including a biologic drug to control MS that has soared in price from \$978 a month 15 years ago to well over \$5,000 per month today; how when her husband was diagnosed with Stage 3 cancer of the esophagus two years ago that, despite being on Medicare and his co-pays, the costs ate into their "dwindling savings"; and how living with MS can cost at least \$30,000 per year for many patients.

"These health care issues apply to all age groups, especially those who, like me, are too young to qualify for Medicare or do not care to fight approximately 2.5 years MS patients must wait to be approved for disability," Kerns testified. "The system needs to stay strong to service future generations and all my fellow baby boomers."

Individuals like Mr. and Mrs. Kerns will benefit from health care reform, and so will many others. Individuals 65 and over covered by Medicare who take a lot of medication, could see significant cost savings under the Reform Bill. There is already an agreement reached with the drug industry to provide 50 percent discounts on brand-name drugs to Medicare Part D beneficiaries who have reached the "doughnut hole" whereby the full cost of the medications must be paid. That is the situation that Mr. Kerns found himself to be in after he retired. The House Reform Bill proposes to gradually phase out the doughnut hole.

Those with insurance – who will be able to keep their insurance under the Reform legislation – will also benefit as Reform will cover most of the uninsured. In turn, that should eliminate the need for hospitals to shift charity care costs to patients who have private insurance.

The actuaries at the Centers for Medicare and Medicaid Services forecast that per capita medical costs are expected to increase 71 percent over the next decade. In 2006, the average cost for a family premium in Florida was \$11,046. In 2009, it rose to \$12,763. By 2019, it is projected that family premiums in Florida will reach \$21,779.

Unless we take serious steps now to reform our health care system—in particular to reduce the rate of growth in health care costs—health insurance coverage will be out of reach for even more individuals than the 52 million Americans who today are uninsured.

Reforming our health care system so that every American is able to afford the coverage they need and deserve is in everyone's best interest.

More information on Health Care Reform and the Charlotte County LWV can be found on www.LWVccfl.com.

FLORIDA HEALTH CARE FACTS

DID YOU KNOW THAT - - - - -

- One way insurance companies limit care is by offering coverage on the individual market that has a weaker benefit package than most employers provide?

Florida requires insurance companies to include 48 benefits in all individual insurance plans, which is higher than the national average of 38. This does not include basic benefits such as cancer screenings and medications, chemotherapy, and maternity services.

- The more broadly insurance companies can define pre-existing conditions, the more conditions they can exclude from coverage, and the less care they will have to pay for?

In Florida, if you had a symptom of a medical condition, even if it went undiagnosed or untreated, it counts as a pre-existing condition. This means that individuals can be

found to have a pre-existing condition based on a symptom for which they never received care.

- It is possible for insurance companies in the vast majority of states to cancel coverage once insurers discover that expensive claims are being made on the policy? In a game of "gotcha," insurers can compare the original application to a policyholder's medical history to find any discrepancy—no matter how small, innocent, or irrelevant—in an effort to cancel coverage.

In Florida, insurers can deny coverage based on health status at the time of application. This means that those individuals who obtain coverage but are found to have omitted a pre-existing condition on their insurance applications can have their coverage canceled, rescinded (retroactively canceled), or limited through a pre-existing condition exclusion.

- Federal law allows rescissions only if an individual obtained their health coverage through "fraud or made an intentional misrepresentation of material fact" in applying for coverage?

State law in Florida requires insurers to prove fraud or intent before rescinding or cancelling coverage, but only after the coverage has been in effect for a number of years. This means that insurers can ration care for individuals who made simple, inadvertent mistakes on insurance applications. Florida gives individuals the right to a formal appeals process if they believe their coverage has been unfairly rescinded or cancelled.