Submitted 5/17/16
Resolution - Health Care
council mtg

To: Ashland City Council
From: Sandra Coyner
Member, HCAO-Rogue Valley Chapter
Member, Legislative Committee for HCAO
May 17, 2016

Thanks for the opportunity to speak on this request for a ballot initiative referral.

I'll follow up on Paul's comments with two additional general points

First is some more background on why we are asking for this specific resolution at this time.

Second is a question that has come up often here in Ashland—if the study points to universal, single-payer, Medicare-type financing for health care in Oregon, how will it be paid for?

With regard to my first point, how we got here now, I think Ashlanders (and you on the Council) will want to know that HCAO – the state organization that has been working super-diligently on this issue for years-- has done a lot of listening. Members statewide contacted and engaged many stakeholders—hospitals, doctors, nurses, employers, unions, legislators, regular people. We listened to their concerns and to their responses to our ideas. We found broad support for improvement in health care financing. We have talked, many times, with legislators, learning their views and asking their advice on how to proceed. We locally have talked with many Ashland citizens, too, and are heartened by their enthusiasm for improving the health care system.

Last year, in 2015, the state legislature voted to spend actual money to fund the study that is due in 2015, because they think it is a good investment to find out what will be best for Oregon. The Oregon Health Authority, which supervises such studies, among many health-related matters for Oregon, added more money. They are committed. The resolution we are asking you to put on the November ballot gives Ashland citizens a chance to express our support for what the legislature has been doing, conveying to them that we have noticed, and encouraging them to keep on keepin' on. Our timing—asking for this resolution on this November ballot – is optimal for conveying Ashland citizens' support to the legislature for the next full legislative session, in 2017. Other cities are doing the same thing, as local resolutions are coming from Eugene and Corvallis and perhaps other locales as well.

So, in sum, the request we make today comes from a lot of consulting, a lot of listening, a lot of Ashland values, and a lot of good will in Oregon to keep moving on what, as Paul has pointed out, remains an important problem for Oregonians.

Finally, I would like to respond briefly to a question that has been asked a number of times recently in conversations about this issue. The Health Care Study for Oregon asks for the optimal system to achieve health care goals—**universal access, choice of providers**, transparency and **accountability**, **affordability**, minimizing administrative costs and medical efforts, financing that is sufficient, **fair** and sustainable, adequately compensating providers, and including community-based systems.

It is not pre-ordained that this study will recommend a single-payer, Medicare-style system. But every other such study has done so. So why did we ask for an Oregon study? To learn more specifically what would work in **Oregon**, and how Oregonians would pay for it. Other states have done such studies and drafted bills for a single-payer system, and their ideas help us figure out our solutions. Oregon is not alone in seeking improvements in our health care system, and we all learn from each other.

So if it is recommended, how could single-payer be paid for? A lot of fear has been generated around this issue, but a solution is not impossible. The most likely model uses familiar revenue streams but tweaks and renames them. Many Americans get health care insurance through their jobs, with employers paying part and the employees paying part. These revenues can be directed to the single-payer plan through payroll taxes. Unearned income can also be taxed, providing revenue analogous to what people pay for health care through private policies. It's really unfortunate that we can't call such taxes a "health care premium," which is what they will be, but we have to use that dreaded word "taxes," so the payments can be deductible on your 1040. But we're not looking to balloon everybody's income taxes to unheard-of levels.

We're glad to be in Ashland where people care about things like supportive, consultative processes to improve our society, and where people (some at least) always want to know how things will be paid for.

Thanks for your time. Paul and I would be happy to answer any questions you might have.

council mtg Submitted 9/7/16 Resolution - Health Care

Comments in support of:

RESOLUTION OF THE CITY OF ASHLAND, JACKSON COUNTY, OREGON, TO SUBMIT TO ASHLAND ELECTORS AT THE NOVEMBER 8, 2016 GENERAL ELECTION AN ADVISORY QUESTION ON ENCOURAGING THE 2017 OREGON LEGISLATURE TO CREATE A PUBLIC PROCESS TO DESIGN A SYSTEM THAT PROVIDES TIMELY ACCESS TO AFFORDABLE COMPREHENSIVE HEALTH CARE FOR ALL OREGON RESIDENTS, ENSURES CHOICE OF PROVIDER, HAS EFFECTIVE COST CONTROLS, AND FOCUSES ON PREVENTATIVE CARE.

We are here to ask the Council to support placing an advisory resolution on the November 8, 2016 ballot. I want to review some of the ideas about the Legislative intent; renew our focus on the problem of healthcare access; and finally ask you to support placing the resolution on the ballot for the voters of Ashland to judge for themselves.

This advisory resolution for the citizens of Ashland lends support and encouragement to the Oregon State Legislature to continue their work in finding affordable and comprehensive healthcare access to all Oregon residents. The Legislature started this work with a multi-year study to find a system that ensures provider choice; that has effective cost controls; and that focuses on preventive care. The purpose of the resolution before you is to bring attention to Legislature's work; provide an informed citizenry conversation around the healthcare issue; and open up new paths of dialogue to assist in resolving the lingering problems our current healthcare system does not address.

We have improved healthcare access with the passage of the Affordable Care Act (ACA). It has brought attention and created discussions which resolved many issues that faced our citizens. However, we still do not have universal healthcare access. We still leave substantial numbers of families without adequate medical attention. We continue to depend on employers, individuals, and the government to provide the patchwork of coverage that is too expensive for many of us. Competing insurance companies escalate premium costs to small businesses more and more each year; the increase in premiums buys less coverage each year. These small businesses cannot make their budgets from year to year. This causes them to make very hard and difficult human resource decisions. Our citizens are left with partial or non-existent coverage insufficient to prevent economic chaos in their lives. Our medical providers are spending more and more each year on non-productive costs to simply be compensated for the services they provide. Each insurance company has its own rules and will pay only its own rates. It is a very complex but irrational system. But most of all, it is inefficient and expensive. It hurts our business expansions, our governmental stability, and our citizens well-being.

The Legislature has recognized that this crisis has gone beyond political ideology or preference. It impacts both employees and employers. It threatens all of us regardless of our political, social, religious, or philosophical tenets. We all are subject to insurance limits that one major accident or illness can over-spend. The costs are then made up from other sources or extracted through the legal system of bankruptcy. Either way it is harmful to both the medical facility and to the patient.

All of our citizens are not given medical access in an equitable manner. This can lead to higher costs and less successful treatments for some. Our businesses are threatened by unpredictable costs. Even the enterprise of the City of Ashland has its own struggles with the insurance coverage and the ratcheting of insurance costs. The State Legislature study investigates these components and will determine a system that will be the most cost effective, have the most equitable access, and focus on preventive care.

We are asking the Council to support our effort to include the citizens of Ashland in this discussion by authorizing this resolution to be placed on the fall ballot.

Thank you in advance for attention to this matter.

Sincerely submitted,

Paul Fisher, PhD
505 Ashland Street
Ashland, OR 97520
541-261-7315

Submitted 5/17/16
Resolution - Health Care
(council mtg)

For Ashland City Council Meeting Tuesday, May 17, 2016
Words of Dr. Patrick Honsinger

Under the current system, my payers (people who pay me, a primary care doctor) are the insurers of the patients who are paying monthly premiums in the form of cash/income, social security or whatever funds they can come up with to "cover" themselves.

I only get paid to deliver a service (sew-up a wound, open an abscess) or spend face-to-face time with the patient **e**valuating and **m**anaging their health (the so-called "E&M"). This is in the form **Relative Value Units**. The more RVUs a provider can generate, the more money will be reimbursed. If the provider is delivering a procedure (surgery, draining abscesses, doing colonoscopies etc.) the RVU generation is relatively higher and more money is generated for income and business expenses.

Currently, this country is emphasizing "preventative care", trying to implement a cultural change by getting people to change lifestyles, make better choices and live with fewer medical expenses over the course of their lives. *That task is being laid on primary care providers nationwide.*

But with insurance companies paying primary care providers in RVUs, the only way primary care practices (small and large hospital-based practices alike) is to turnover as many RVUs as possible on a given day. Some practices are seeing *patients in 10-15 minute* slots or less per visit to generate enough RVUs to run the business of medicine. One cannot blame insurers for being reluctant to pay providers: naturally, that cuts into profit. So the RVU-generating machine *is kicked into higher gear and patient time is cut more.* Patients are dissatisfied. Providers are dissatisfied.

It fosters me, the provider, to give the patient *Prozac* instead of taking the time to listen to the patient, ask what her stressors are, address and acknowledge difficulties and fully assess his depression. It fosters me to give an opioid to a patient rather than to ask why he hurts, explore what led to the injury and devise an alternative plan to help him manage chronic pain. It hastily pushes me to write a prescription for blood pressure pills and cholesterol pills rather than taking the time to suggest an exercise plan, discuss diet, smoking cessation and weight loss.

Primary care has accepted the challenge of changing the healthcare in this country. However, the American system is driven by a machine that pushes its providers to hastily generate as many RVUs in as short a time as possible. This is how insurance- my payers- promotes the culture. It will never change as long as it's in the equation. There is no such thing as cheap insurance: *we get what we pay for.* I dream of the day there will be one payer for all.

Sincerely,

Ashland Resident **Patrick Honsinger, MD**, Southern Oregon physician