SUPPLEMENTAL MATERIAL

T. 6.b.

Healthcare Resolution Goal: Ask Congressional representatives for a full and fair debate on national healthcare reform options, including the solutions offered by "Single-Payer-type" reform such as expanding & improving Medicare for all.

--Resolution passage does not require County expenditures nor staff action other than sending resolution to media and elected representatives.

Reason for Resolution: Nearly uniform agreement exists nationally that healthcare financing and delivery is in crisis with unfavorable and unsustainable quality of outcome and cost trends. Congress needs to appreciate extent of support for a fair debate on healthcare reform options that can improve those outcomes and reduce those cost trends, like "Single-Payer-type" reform. But various Congressional "gate-keepers" – including Chairman of the Sen. Finance Committee – have said "single-payer" is "off the table" or will "not get to first base."

--One example of a "Single-Payer" solution is *Medicare*, enacted in 1964-65, which organizes national financing and administers provider payment according to settled standards. Medicare does not own hospitals or directly employee physicians. Medicare allows free choice of physicians and hospitals and has high levels of enrollee satisfaction. One Federal legislative proposal regarding expanding Medicare is HR676, introduced over 2 years ago which had over 90 sponsors in the last Congress.

--Other examples of "single-payer" solutions include Medicaid or the VA system. The VA system appears to have the extremely high delivery quality outcomes and is leading national innovator in medical information technology.

Impact on County government from passage of resolution:

--Assuming passage of national "Single-Payer-type" reform, County expenditures for healthcare related employee expenses should reduce markedly as a nationally administered financing mechanism replaces current direct financing via private and public premiums and self-insurance.

Example of impact: County budget for 2008-9 has employee healthcare costs approximating $24,754, 450, representing over 33+% of payroll ($72,788,576); under federal HR676 financing provisions, the County as an employer would not have to directly provide health benefits and instead would contribute 3.3% of payroll into the nationally administered system, approximating $2.5 million dollars. This would reduce County costs by approximately $22.2 million dollars.

Justification for having Single-Payer in National Reform Debate:

–Current status of national healthcare delivery is a fragmented "nonsystem" built around more than a thousand private insurance providers. Care providers incur significant administrative overhead in coping with the fragmented insurance processes. System incentives are generally recognized as financially driven and not outcome/quality driven.

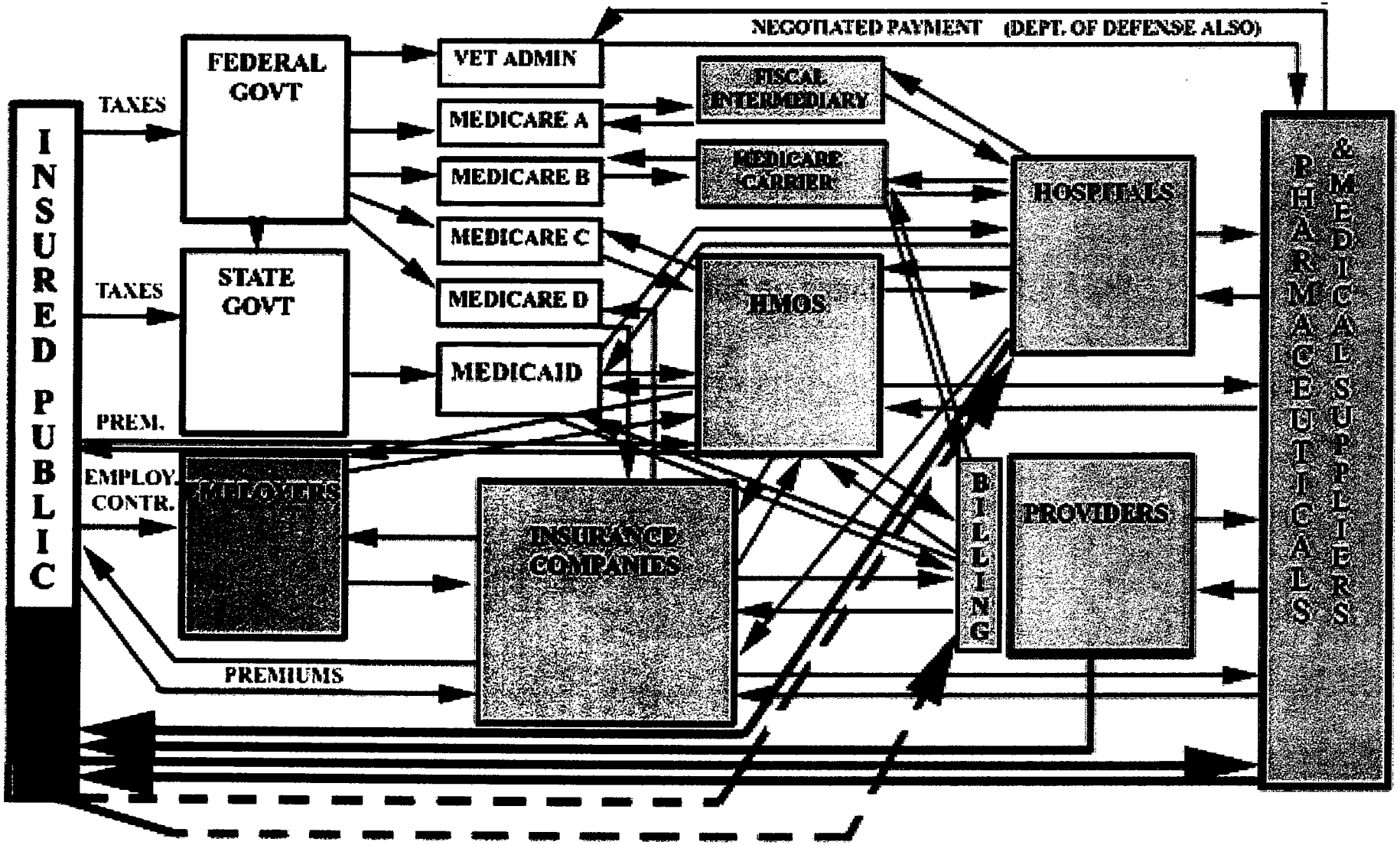
–US outcome ratings in cross-national health comparisons is not high, particularly in view US spending is highest in GDP (17%) or per-capita (now over $8000); example: most of the wealthy industrial democracies' ratios of physicians and hospital beds to population exceed those in the U.S, See, for example, data from Organization for Economic Cooperation and Development, *OECD Health Data, 2004*, 1st edition.

--There is sufficient information showing "single-payer-type" systems such as Medicare or VA have very good quality outcomes or very high administrative overhead efficiencies in contrast to private-sector experience. Expanding existing US "single-payer" structures like Medicare allow for economies of scale and strong negotiating positions vis-a-vis drug and medical appliance manufacturers, and large provider groups. Centralized and accountable authorities can insure the collection of evidence-based information to use in developing more efficient, less costly and higher quality outcomes (one demonstrated success example is VA).

For the above reasons, and more to be presented, "single-payer-type" solutions or structures should be included in the national reform debate so policy-makers and the public might better understand benefits and advantages.

The attached graphs reflect relevant facts pertaining to healthcare financing and costs, the uninsured, and the need for national healthcare reform. We will have other graphs at the presentation.

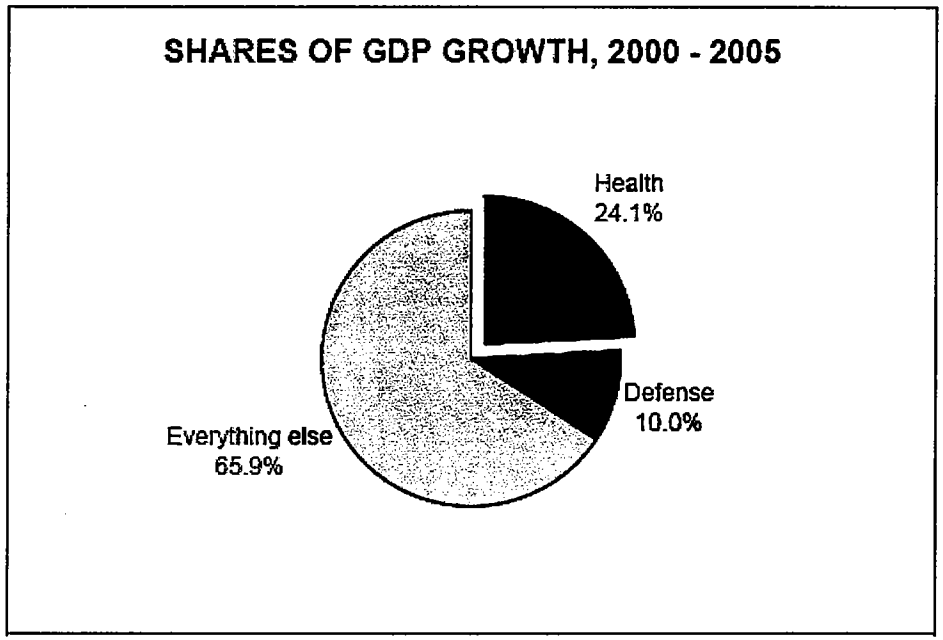
UNITED STATES MULTI-PAYER HEALTH CARE SYSTEM



HIGHEST COST MODERN HEALTH CARE SYSTEM
RATED IN 37TH PLACE BY WORLD HEALTH ORGANIZATION

PRIVATE

HEALTH CARE EATS UP ONE-QUARTER OF GDP GROWTH



GDP in 2005 is expected to be $12.4 trillion, up by $2.6 trillion from $9.8 trillion in 2000. Soaring health care costs have consumed nearly one-quarter of that economic growth.

Alan Sager, PhD and Deborah Socolar, MPH -- 2005
Health Reform Program at the Boston University School of Public Health

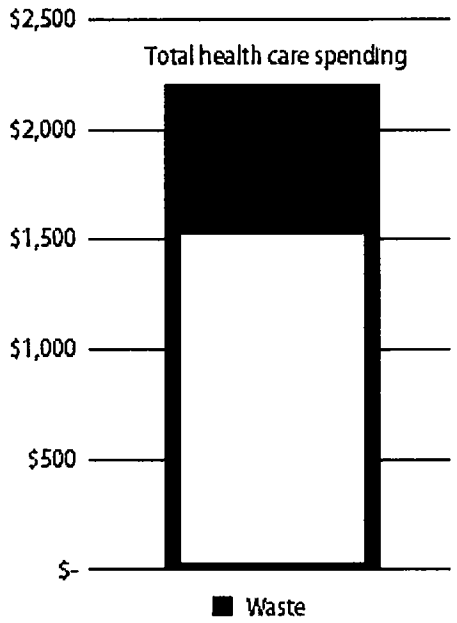
Tax-Financed Health Expenditures, Billions Of Dollars, Selected Years 1965–1999

	1965	1970	1975	1980	1985	1990	1995	1999
National health expenditures (NHE)	$41.0	$73.1	$129.8	$245.8	$426.5	$695.6	$987.0	$1,210.7
Federal government								
Medicare	0.0	7.7	16.3	37.4	71.8	110.2	184.8	213.6
Medicaid	0.0	2.8	7.4	14.5	22.7	42.5	86.2	107.7
Other health programs	4.7	7.0	12.3	19.4	27.6	39.8	52.9	63.5
Public employee health benefits	0.2	0.3	1.2	2.2	4.3	9.2	11.3	13.2
Tax subsidies	1.7	3.5	7.0	19.1	31.3	49.8	75.5	95.4
State/local government								
Medicaid	0.0	2.4	6.0	11.5	18.3	31.1	57.9	79.3
Other health programs	5.5	7.6	12.9	22.0	34.2	58.7	76.4	84.6
Public employee health benefits*	0.3	0.7	2.2	7.6	18.2	33.5	47.1	52.4
Tax subsidies	0.1	0.4	0.9	2.5	4.7	6.9	11.9	14.2
Total tax-financed (billions)	$12.6	$32.4	$66.3	$136.2	$233.1	$383.4	$604.0	$723.8
Tax-financed ($ per capita)	$63	$154	$301	$592	$963	$1,509	$2,254	$2,604
Tax-financed as percent of NHE	30.7%	44.4%	51.0%	55.4%	54.6%	55.1%	61.2%	59.8%

SOURCE: Authors' analysis.

* 1999 estimate is from a data source that results in lower estimates than data sources used for earlier years.

U.S. spends over $650 billion per year for treatments that may not improve care



Source: Based on estimates from Dartmouth Institute For Health Policy and Clinical Practice, CMS

DCBS SERVICES

RELEASE

Insurance Division, 350 Winter St. NE, Room 200, Salem, Oregon 97301-3878

For immediate release:
March 6, 2009

For more information:
Cheryl Martinis (503) 947-7213
Public Information Officer

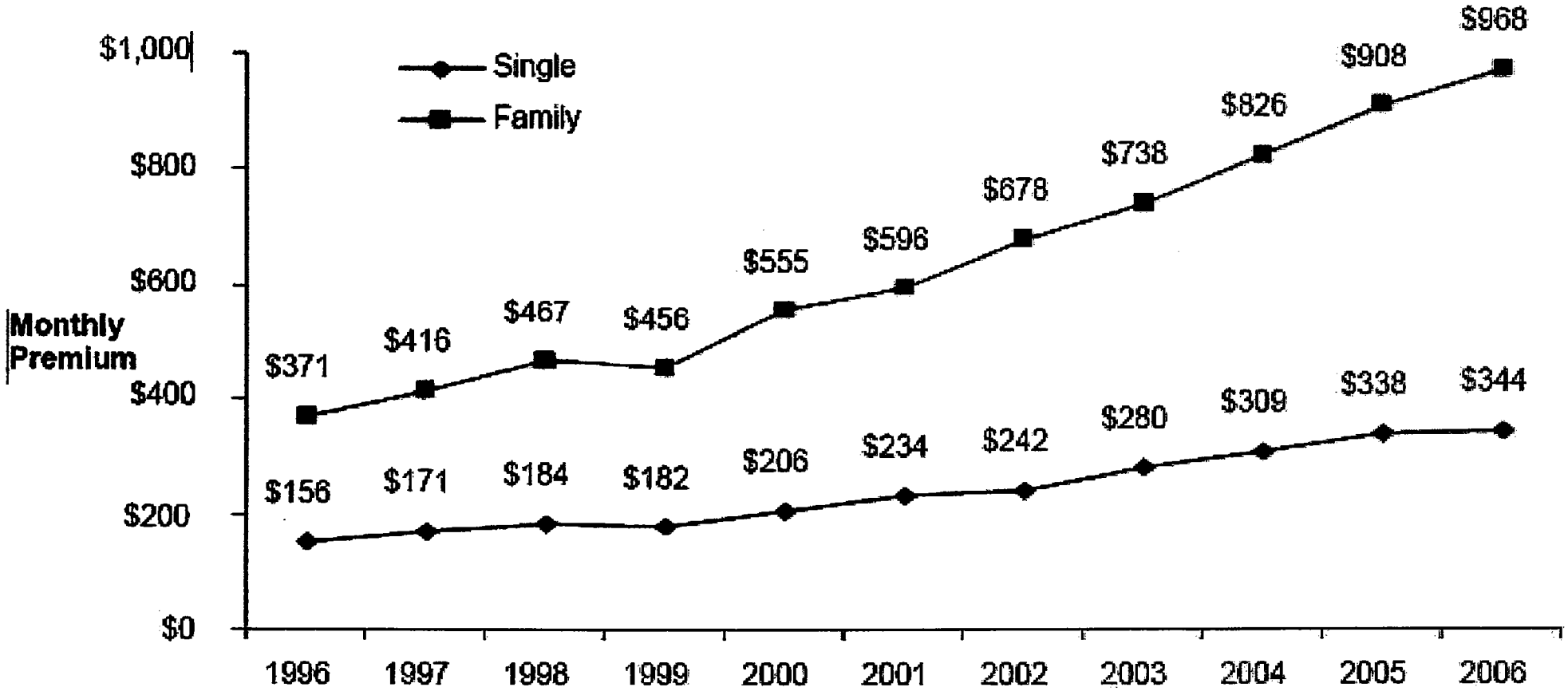
Oregon Insurance Division seeks public comment on health rate request

(Salem) — The Oregon Department of Consumer and Business Services' Insurance Division is seeking public comment on a proposed health insurance rate increase of 19 percent that would affect more than 79,000 Regence BlueCross BlueShield individual plan policyholders.

The proposed 19 percent increase, effective July 1, 2009, would apply to policyholders who renew in July, August, or September. This is the same group that received a 26 percent average rate increase a year ago, following a 16 percent decrease in 2006. Individual plans cover one person or a family and are purchased directly from an insurance company and not provided through an employer.

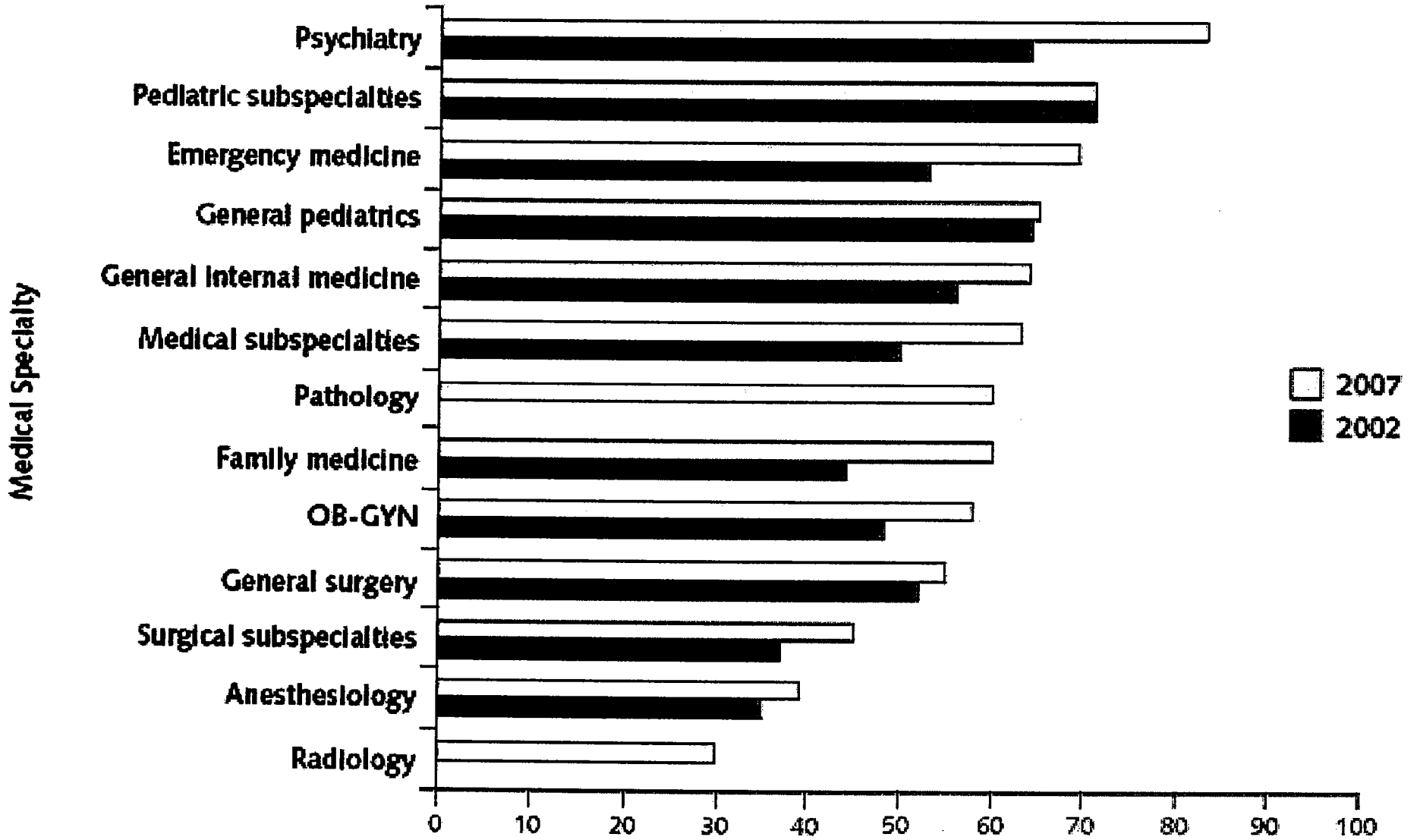
Regence submitted the proposed increase this week. Because of the number of Oregonians involved and the size of the rate request, the Insurance Division is providing a month-long written comment period for anyone who would be affected by the outcome. The division will review comments it receives as part of its rate review

Oregon average monthly premiums for private sector employee, 1996-2006



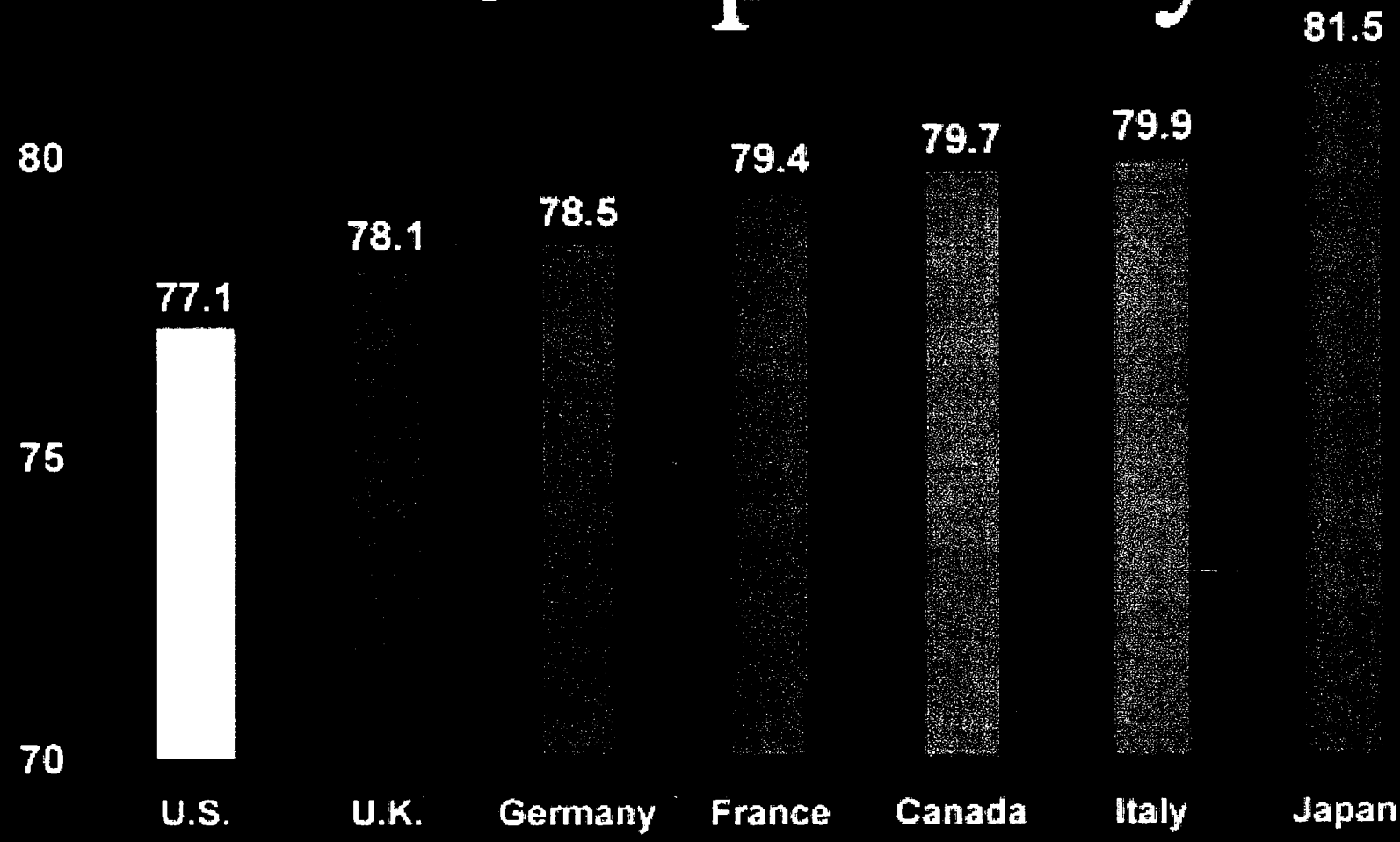
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 1997-2008

Support for government legislation to establish National Health Insurance in 2007 and 2002, by specialty



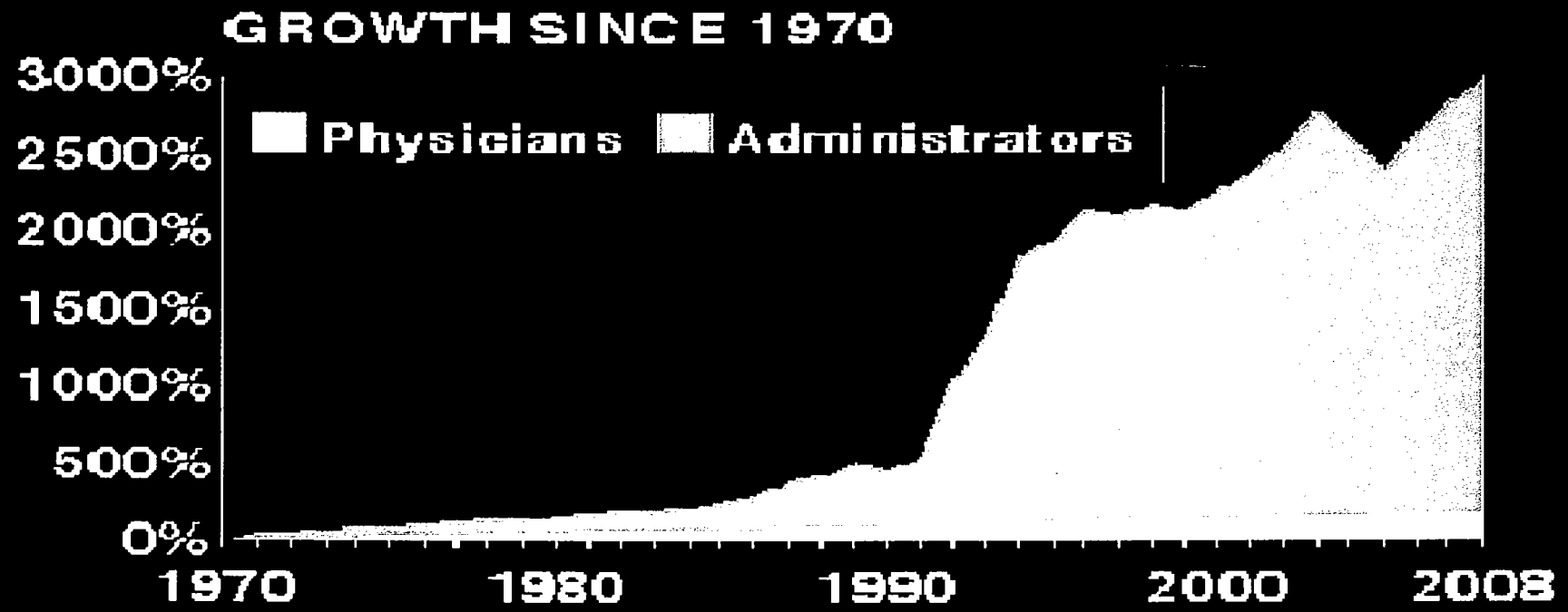
2002 date not available for pathology and radiology because of lack of response –
Annals of Internal Medicine --April, 2008 – Vol 148, No. 7

Life Expectancy



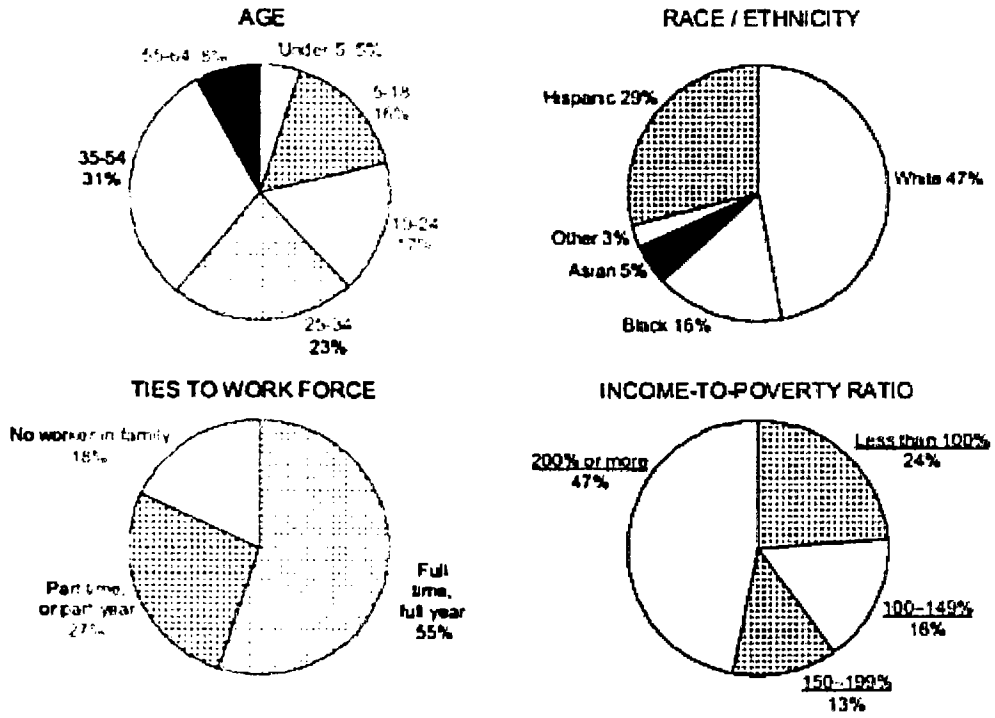
US has fallen to 42nd, below Cuba, AP 8/12/07; graph: OECD, 2004

Growth of Physicians and Administrators 1970-2008



Source: Bureau of Labor Statistics; NCHS; and analysis of CPS

Figure 5.1 **Characteristics of the Uninsured Population Under Age 65, 2002** (age and race/ethnicity)



Source: U.S. House, Ways and Means (2003, p. C42).

"The economics of U.S. health care policy" By Frank W. Musgrave, p,96