Proposed Positions with Footnotes Explaining Changes

Healthcare (2021) [Underlining indicates new wording]

GOALS

The League of Women Voters of New York State (LWVNYS) believes that everyone should have access to essential physical and behavioral healthcare. New York State has a proper role in the regulation of healthcare and must assure high quality care that is affordable and accessible to all.[1]

Resources should be devoted to health promotion and disease prevention so that people can take active responsibility for their own health. People should have opportunities to participate effectively in decisions regarding their personal health and in healthcare policy decisions. [2]

The League believes that New York State's primary role in healthcare is to assure that quality care is available to all New Yorkers. We believe that the state should provide planning and regulations to assure everyone, including the medically indigent, access to an essential level of quality physical and behavioral healthcare. Cost containment should be an important criterion in developing regulations. Such regulation, however, should not compromise the quality of care or its accessibility.

The League supports regulatory incentives to encourage the development of cost-effective alternative ways of delivering and paying for healthcare, appropriate to all areas of NYS, with coordination across regulatory bodies to avoid undue delays and contradictory, duplicative regulations. Delivery programs may take place in a variety of settings, including the home and online, and must provide quality care, meaning consistent with "standard of care" guidelines, by trained and licensed personnel, staffed adequately to ensure their own and patient safety.[3]

Coordination of services is essential to assure that community needs are met. As public health crises increasingly reveal, NYS should protect the health of its most vulnerable populations, urban and rural,[4] in order to protect the health of everyone. In addition, all programs should be evaluated regularly. Provider reimbursement should include incentives for efficiency and for disease prevention and health promotion activities. Public health, environmental health and research activities should be continued.

Decisions on medical procedures that would prolong life should be made jointly by patient, family, and physician. Patient decisions, including those made prior to need, should be respected.

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[1] In both the Healthcare Position and the Financing Healthcare Position we have substituted *essential* for *basic*, which is newer terminology and reflects current practice.

[2] Similarly, throughout both documents we have substituted *patients* or *people* for *consumers*, reflecting research that medical care does not function like a marketplace.

[3] The new statement about *coordination across regulatory bodies* embodies ideas only implied in the original position. The new statement defining *quality care* reflects LWV NY's work on safe staffing.

[4] Covid-19 hits rural residents harder: "Rural areas tend to have older populations than the national average, with more chronic health conditions that raise the risk of developing more severe cases of COVID-19. They have fewer health care providers and more uninsured residents, meaning residents often wait longer before seeking medical help," June 2020. https://medicalxpress.com/news/2020-06-rural-america-vulnerable-covid-cities.html
Covid-19 kills Blacks, Latinx, Indigenous at triple the rate of whites: "non-Hispanic black persons, Hispanics and Latinos, and American Indians/Alaska Natives…[have] rates of hospitalization or death from COVID-19 [three to five times that of] non-Hispanic white persons," while Indigenous Americans have an age-adjusted hospitalization rate for Covid-19 of 5.6 times that of non-Hispanic White Americans, CDC 6/12/20, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.
"Universal health care is a national security issue," March 2020, "Covid-19 is exposing the dangerously high costs of our incomplete safety net. When people lack adequate health insurance, they don't go to the doctor unless and until they are very ill… rationing access to critical health care resources on the basis of ability to pay is not just unjust, but also bad for public health." https://www.justsecurity.org/69130/universal-health-care-is-a-national-security-issue/
"The root cause of health insecurity [is] the lack of access of the most vulnerable people to essential health services … Ultimately, it's the absence of universal health coverage that is the greatest threat to health security… prevention is not prevention is not only better than cure: it's cheaper," Forward to *WHO 2018 Playbook on Managing Epidemics*. https://www.who.int/emergencies/diseases/managing-epidemics/en/

ESSENTIAL LEVEL OF QUALITY CARE

The League supports uniform eligibility and coverage of essential healthcare services, both physical and behavioral,[5] ideally, including coverage of services such as vision, dental, hearing, and long-term care, through public financing.[6] Access to optional insurance coverage for care not covered by public financing should be available. The League has a strong commitment to an emphasis on preventive care, health education, and appropriate use of primary care services.

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[5] We use "behavioral health" to mean "the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. The impact of untreated behavioral health conditions on individuals' lives and the cost of health care delivery in the United States is staggering. Persons with any mental illness are more likely to have chronic conditions such as high blood pressure, asthma, diabetes, heart disease and stroke than those without mental illness. And, those individuals are more likely to use hospitalization and emergency room treatment," per HHS sub-agency Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf

[6] 1991 impact called these out as "lower priority" for adults but "essential for children." Today "Essential" under Medicaid requires these for children. Medicare does not cover them, failing seniors. Our new language, still separates them as "preferably" (rather than "supports") to align with the older position, but "ideally" appreciates that seniors live longer, healthier lives when they can eat food, hear conversations, see well enough to navigate safely, like younger Americans. Long-term care is driven by the disabilities community, which seeks to allow members to remain productive — both House and Senate M4A bills include LTC provisions.

HEARING, DENTAL, VISION: "Among Medicare beneficiaries, 75 percent of people who needed a hearing aid did not have one; 70 percent of people who had trouble eating because of their teeth did not go to the dentist in the past year; and 43 percent of people who had trouble seeing did not have an eye exam in the past year. Lack of access was particularly acute for poor beneficiaries." https://www.commonwealthfund.org/publications/issue-briefs/2018/jan/how-medicare-could-provide-dental-vision-and-hearing-care

DENTISTRY: "Older adults are even more affected by poor oral health than their younger counterparts. Very often, seniors have multiple chronic diseases for which they are prescribed a number of medications. Side effects such as dry mouth, inflammation, infections, and mouth sores put them at severe risk for consequences to their oral health, their whole-body health, and quality of life." And "significant link between oral health and systemic diseases such as diabetes, heart disease, reflux, and respiratory infections—and now researchers are even talking about Alzheimer's disease." https://now.tufts.edu/articles/most-seniors-oral-health-goes-uncovered

HEARING: "hearing loss affects one-third of adults over the age of 65 and has a significant impact on health. Those experiencing it are at increased risk for depression, loneliness, and dementia, and may become socially isolated. Hearing loss also affects physical health, putting individuals at higher risk for falls and disability and possibly causing functional limitations such as reduced mobility or balance." https://www.statnews.com/2019/02/27/hearing-aids-medicare-coverage/

VISION "Improved sight, in turn, reduces physical injury and the onset of disabilities." https://money.com/retirement-living-longer-better/

JAYAPAL BILL: " dental and vision services, and long-term care." https://www.congress.gov/bill/116th-congress/house-bill/1384 AND

SANDERS BILL: "(9) Oral health, audiology, and vision services….(13) Home and community-based long-term services. https://www.congress.gov/bill/116th-congress/senate-bill/1129/text - toc-id25c91cb96228483495ad9de0b47b79f8

LONGTERM CARE: "If you don't include long-term supports and services, it cannot be considered a bill that is for all people because it leaves out huge portions of the population, including people with disabilities and aging Americans." https://www.modernhealthcare.com/politics-policy/sanders-medicare-all-expands-long-term-care-benefits

FINANCING OF HEALTHCARE (2021)

As a continuation of the 1985 statement of position on healthcare, a two-year study and consensus on the financing of healthcare was conducted from 1989 to 1991. Following study in 2019-20, this position was updated again in 2021.[7]

The League of Women Voters of New York State (LWVNYS) believes that any proposed healthcare financing system should provide access to essential healthcare at an affordable cost for all New Yorkers, both patients and taxpayers. The League supports the single-payer concept as a viable and desirable approach[8] to implementing League positions on equitable access, affordability, and financial feasibility. In any proposed healthcare financing system, the League favors funding supported in part by broad-based and progressive state taxes on earned and unearned income with health insurance access independent of employment status.

FEDERAL v STATE ROLES

Although the League prefers a healthcare financing system that includes all residents of the United States, in the absence of a federal program that achieves the goals of universal, affordable access to essential health services for New Yorkers, the League supports a healthcare program financed by NYS which includes continuation of federal funding.[9]

FEASIBILITY

The LWVNYS believes the financial feasibility of any single-payer NYS program requires:

- Levels of federal support appropriate for the cost of the program,[10]
- Sufficient cost-savings to be identified so that estimated overall program cost will approximate the cost of current overall health services (all funding sources) or less,[11]
- New state funding from individual taxpayers, employees and businesses to be equitable and progressive to ensure affordability for all,[12]
- A healthcare trust fund managed by the state, that operates in a similarly efficient fashion as Social Security or Medicare trust funds.[13]

COST-CONTROL METHODS

To reduce the impact of any tax increases, healthcare reform should contain costs.[14] The League believes that efficient and economical delivery of care can be enhanced by such cost-control methods as:[15]

- Reduction of administrative costs — both for this insurance plan and for providers,[16]
- Negotiated volume discounts for pharmaceuticals and durable medical equipment to bring prices closer to international levels — or importing of same to reduce costs,[17]
- Regionalization of specialized tertiary services to ensure timely access and quality,[18]

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[7] We estimate the consensus process, likely to begin autumn 2020, will take us into spring 2021.

[8] New location for this statement on single-payer: Instead of *acceptable*, which often has a negative connotation, we use the terms *viable and desirable*.

[9] The 1991 LWV NYS position called for the federal government to be the primary funder and determiner of services to be provided, and NYS to have secondary responsibility. Should NYS take the lead, it should determine services and funding until federal government provides at least as much.

[10] In 2020, NYS benefits from federal contributions to Medicare, Medicaid, ACA Exchange subsidies, CHIP, and other programs, particularly those serving the poor, the disabled, those aged 65 and older; if there were significant federal reductions in such funding, maintaining essential health services for all NYS residents might require benefit trade-offs.

[11] Since SP saves so much, seeking to meet or beat current costs appears both pragmatic and politically sensible.

[12] This is largely from current NYS and US positions, which support equitable access for all.

[13] Like Medicare and Social Security taxes collected at the federal level, NYS taxes collected for healthcare need similar protection from non-HC purposes, rational administration, and strategic focus on public health.

[14] Carries forward the 1991 and continuing concern for cost control and healthcare's impact on taxes.

[15] These lines are adjusted from LWV US listing of cost-control methods and LWV NYS language; they build on 30 years of experience. See LWV US position.

[16] From LWV US.

[17] New, responding to dramatic increases in drug prices since 1991:"A Painful Pill to Swallow: US vs Intl Prescription Prices," by Ways & Means Comm Staff, Sept 2019. https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/U.S.%20vs.%20International%20Prescription%20Drug%20Prices_0.pdf

- Evidence-based treatment protocols and drug formularies that include cost/benefit assessments of medical value,[19]
- Malpractice reforms designed both to compensate patients for medical errors and to avoid future errors by encouraging robust quality improvement processes (at individual and systemic levels) and open communications with patients,[20]
- Investment in well-care — such as prevention, family planning, patient education, primary care — to increase health and reduce preventable adverse health events/expenditures,[21]
- Investment in maternal/infant care, chronic disease management, and behavioral healthcare.[22] Provision for short-term and long-term home-care services to reduce institutionalization,[23]
- Innovative payment and record-keeping.[24]

Specific cost-control methods should reflect the most credible, evidence-based research available on how healthcare financing policy affects equitable access to healthcare, overall quality of care for individuals and populations, and total system costs of healthcare and its administration.[25] Methods used should not exacerbate disparities in health outcomes among marginalized New Yorkers.[26]

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[18] From LWV NYS.

[19] Follows from 1991 LWV NYS: "cost/benefit ratio of medical treatments … to contain costs" — the phrase "evidence-based" emerged in 1990's. https://en.wikipedia.org/wiki/Evidence-based_medicine

[20] LWV NYS refers to administrative modification of tort system; language adjusted from LWV US to distinguish effective from ineffective tort reform (e.g., "From Medical Malpractice to Quality Assurance," Frank Sloan, Spring 2008, Issues in Science and Technology: https://issues.org/sloan/).

[21] Language keyed off emphasis on primary care, preventive care, and patient education in LWV NY/US.

[22] Language keyed off emphasis on primary care, preventive care, and patient education in LWV NY/US.

[23] From LWV NY/US.

[24] Based on LWV NYS: "payment methods…incentives for efficiency and for disease prevention," plus new payment and record-keeping issues that have emerged since 1991. These may include, but are not limited to, such things as moving from fee-for-service to "global" payments (e.g., prepayments or capitated payments) to providers, separating payments for capital budgets from payments for operating costs, and ensuring cost-efficiency, portability, and health value of Electronic Health Records (EHR) across all NYS patients and providers. Among the most serious issues to be considered or resolved:

Global payments: Uwe Reinhardt, who designed Taiwan's SP system, recommended "a number of powerful policy instruments to contain costs. The most powerful of these are government-set fee schedules and a global budget system." https://www.healthaffairs.org/do/10.1377/hblog20190206.305164/full/
Maryland received a waiver from the federal govt for a demonstration project on global budgeting: https://dhss.delaware.gov/dhcc/files/globaloverview.pdf At the 5-year mark, MD's All-Payer Model for hospitals found "Medicare beneficiaries had 2.8 percent slower growth in total expenditures ($975 million in savings) …relative to a comparison group." https://www.hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/article/21116405/marylands-allpayer-model-saves-medicare-nearly-1-billion

Electronic Health Records/EHR: "Despite millions of dollars and thousands of hours of doctors' time, patients and their providers often find they have no way to access a patient's full medical history. Here's why it's taking so long." ***https://www.aamc.org/news-insights/electronic-health-records-what-will-it-take-make-them-work***

Portability compromised: the average hospital deals with 16 disparate EHR venders, each a different platform: "implementing, running and maintaining all the different products have created something of mess." https://www.healthcareitnews.com/news/why-ehr-data-interoperability-such-mess-3-charts

Burden on Providers: "The digitization of healthcare promises significant improvement, including more efficient and more personalized care at lower costs, but it has also brought challenges to the industry. Notably, clinicians have reported feeling burdened by the reporting demands of EHRs—responsibilities that take away from their time and focus on patients. **These burdens are so weighty that they've become a chief cause of physician burnout**," because they reduce patient interaction, extend workdays, and create a focus on reimbursement rather than quality of care. https://www.healthcatalyst.com/insights/physician-burnout-EHR-addressing-5-top-burdens

Physician Time: "On average providers spent 4.3 ± 1.3 hours per clinic day using the electronic health record." https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6371357/

"First-year doctors spend 3 times more hours on EHRs than patient care" "Interns spend approximately 13% of their time, or three hours during a 24-hour time period, interacting with patients face-to-face during a typical day, and yet much of that is still spent multitasking," *https://www.fiercehealthcare.com/tech/first-year-doctors-spend-three-times-more-hours-ehrs-than-patient-care*.

[25] Over the past three decades, for example, cost-sharing (e.g., co-pays, deductibles, co-insurance) have been shown to cause people to delay or forgo necessary treatment and preventive services, reducing individual and public health and increasing total healthcare costs; for more. See "Appendix C: Pro/Con on Cost Sharing."

[26] "Rural health disparities are deeply rooted in economic, social, racial, ethnic, geographic, and health workforce factors," 10/2017, https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities ;
"Rural county residents died from the top 5 causes of death more frequently than urban county residents. Many of these deaths were likely preventable…Residents of rural areas in the United States tend to be older and sicker than their urban counterparts. They have higher rates of cigarette smoking, high blood pressure, and obesity... They also have higher rates

PUBLIC PARTICIPATION

The League supports public input as integral to the process for determining health care coverage and funding. To participate in public discussion of health policy and to share effectively in making policy decisions, NYS residents must be provided with information on the health care system and on the implications of health policy decisions.[27]

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of poverty, less access to healthcare, and are less likely to have health insurance" CDC, https://www.cdc.gov/ruralhealth/cause-of-death.html; https://www.ruralhealthinfo.org/topics/rural-health-disparities; "Rural Americans are a population group that experiences significant health disparities … higher incidence of disease and/or disability, increased mortality rates, lower life expectancies, and higher rates of pain and suffering. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities. This inequality is intensified as rural residents are less likely to have employer-provided health insurance coverage, and if they are poor, often are not covered by Medicaid," https://www.ruralhealthinfo.org/topics/rural-health-disparities

Indigenous people are dying at even higher rates (the Navajo Nation recently being the worst "hotspot" in the country) https://www.vox.com/2020/6/11/21286431/coronavirus-arizona-covid-19-cases-deaths-navajo-nation **;**
In rural counties, where 60 million Americans live there may be "no hospitals for hundreds of miles, the result of closures amid crushing financial pressures. Since 2010, 130 rural hospitals have shut their doors," https://www.washingtonpost.com/nation/2020/05/24/coronavirus-rural-america-outbreaks/?arc404=true ;

"Black people simply are not receiving the same quality of health care that their white counterparts receive, and this second-rate health care is shortening their lives … We have a two-tiered health care system that provides wonderful care to those with private insurance and mediocre care to those without," ABA. 2019, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/;
"The United States is home to stark and persistent racial disparities in health coverage, chronic health conditions, mental health, and mortality. These disparities are not a result of individual or group behavior but decades of systematic inequality in American … health care systems," 5/7/20, https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity/;
"Racial and income equality are too often absent from conversations about health care financing… the current health financing system also reinforces and institutionalizes inequality; unequal care may be viewed as a form of structural racism…" 2015,. http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/;
"Racial Inequity of Coronavirus," July 2020, https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html?referringSource=articleShare: Black and Latino people have been disproportionately affected by the coronavirus in a widespread manner that spans the country, throughout hundreds of counties in urban, suburban and rural areas, and across all age groups…Of Latino people who died, more than a quarter were younger than 60. Among white people who died, only 6 percent were that young.

[27] New wording but maintains substance of transparency and public participation.

CURRENT Position on Health Care (1991)

The League of Women Voters of New York State believes that everyone should have access to basic physical and mental health care. New York State has a proper role in the regulation of health care and must assure high quality care that is affordable and accessible to all. The state should support incentives to foster the development of alternative delivery and payment methods.

More resources should be devoted to health promotion and disease prevention so that consumers can take active responsibility for their own health. Citizens should have more opportunities to participate effectively in decisions regarding their personal health and in health care policy decisions.

The League believes that NEW YORK STATE 's primary role in health care is to assure that quality care is available to all New Yorkers. We believe that the state should provided planning and regulations to assure everyone, including the medically indigent, access to a basic level of quality physical and mental health care. Cost containment should be an important criterion in developing regulations. Such regulation, however, should not compromise the quality of care or its accessibility. We support regionalization of specialized tertiary services as a means of providing access while controlling costs.

There should be coordination among regulatory bodies to avoid undue delays and contradictory, duplicative regulations.

The League supports regulatory incentives to encourage the development of alternative ways of delivering and paying for health care. Delivery programs should provide quality care, be cost effective, and be adaptable to different geographical locations. Services may take place in a variety of settings, including the home, and must be staffed by personnel who meet state standards.

Coordination of services is essential to assure that community needs are met. In addition, all programs should be evaluated regularly. Payment methods should be encouraged which include incentives for efficiency and for disease prevention and health promotion activities. Some alternatives, which should be considered for state regulation, include ambulatory surgery, alternative providers, prepayment plans and the issue of professional liability. Activities should be continued in public health and research.

Decisions on medical procedures that would prolong life should be made jointly by patient, family, and physician. Patient decisions, including those made prior to need, should be respected. To participate in public discussion of health policy and to share effectively in making policy decisions, consumers must be provided with information on the health care system and on the implications of health policy decision.

CURRENT POSITION ON FINANCING OF HEALTH CARE

As announced by the State Board, November 1991

As a continuation of the 1985 statement of position on health care, a two-year study and consensus on the financing of health care was conducted from 1989 to 1991. Major concerns were the financial limitations on access to health care for the uninsured and the underinsured and the escalating cost of health care.

The current financing system which involves public programs with limited eligibility, and private insurance coverage for selected groups and selected health care treatments, does not meet League criteria for access and equity in health care as stated in the position of 1985.

The League of Women Voters of New York State supports uniform eligibility and coverage of basic health care costs through public financing. Access to optional insurance coverage for care beyond the basic level of coverage should be available. Assuming that public funds for health care are limited, the League believes that the scope of services contained in basic coverage and the cost/benefit ratio of medical treatments should be considered in efforts to contain costs. The League has a strong commitment to an emphasis on preventive care, health education, and appropriate use of primary care services.

The Federal government should be the primary vehicle for the financing of health care, determining eligibility for health care services, and determining the scope of services to be provided. The State should assume secondary responsibility in these areas.

The League should ensure that public input is an integral part of the process in determining priorities in health care coverage. Cost containment efforts should precede increased taxes or reallocation of funds from other state programs.

The League supports the single payer concept as an acceptable approach to implementing League positions on equitable access and cost containment.

The League supports the establishment of an administrative system for determining patient compensation as a modification of the tort system related to patient injury.

Overall, the League believes that universal access must be balanced by restrictions in the scope of services, and that the scope of services should be determined by knowledgeable professionals and consumers with administrative and legislative oversight.

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