LEAGUE OF WOMEN VOTERS® OF JEFFERSON COUNTY

LWVUS POSITION ON HEALTH CARE

Health Care

Statement of Position on Health Care, as announced by the national board, April 1993 supplemented by concurrence to add Behavioral Health, June 2016 and updated by concurrence at Convention 2022.

The League's Position

GOALS: The League of Women Voters of the United States believes that a basic level of quality health care at an affordable cost should be available to all US residents. Other US health care policy goals should include the 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.

Basic Level of Quality Care

Every US resident 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. Every US resident should have access to affordable, quality in- and out-patient behavioral health care, including needed medications and supportive service that is integrated with, and achieves parity with, physical health care. Dental, vision, and hearing care also are important but lower in priority. The League believes that under any system of health care reform, consumers/patients should be permitted to purchase services or insurance coverage beyond the basic level.

The League supports regulatory incentives to encourage the development of cost-effective alternative ways of delivering and paying for health care. 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. As public health crises increasingly reveal, a health program should protect the health of its most vulnerable populations, urban and rural, in order to protect the health of everyone. In addition, all programs should be evaluated regularly.

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

Financing and Administration

The League favors a national health insurance plan financed through general taxes in place of individual insurance premiums. As the United States moves toward a national health insurance plan, an employer-based system of health care reform that provides universal access is acceptable to the League. The League supports administration of the US health care system either by a combination of the private and public sectors or by a combination of federal, state, and/or regional government agencies.

The League supports the single-payer concept as a viable and desirable approach to implementing League
positions on equitable access, affordability, and financial feasibility. In any proposed health care financing system, the League favors health insurance access independent of employment status.
Although the League prefers a health care 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, the League supports health care programs financed by states which include continuation of federal funding and comply with League principles.
The League is opposed to a strictly private market-based model of financing the health care system. The League is also opposed to the administration of the health care system solely by the private sector or the states.

Taxes

The League supports increased taxes to finance a basic level of health care for all US residents, provided health care reforms contain effective cost-control strategies.

Cost Control

The League believes that efficient and economical delivery of care can be enhanced by cost-control methods. Specific cost-control methods should reflect the most-credible, evidence-based research available on how health care financing policy affects equitable access to health care, overall quality of care for individuals and populations, and total system costs of health care and its administration. Methods used should not exacerbate disparities in health outcomes among marginalized residents.
If they meet the above criteria, cost control methods could include:
- Reduction of administrative costs — both for the insurance program and for providers,
- Negotiated volume discounts for pharmaceuticals and durable medical equipment to bring prices closer to international levels — or importing of same to reduce costs.
- Evidence-based treatment protocols and drug formularies that include cost/benefit assessments of medical value.
- 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.
- Investment in well-care, such as prevention, family planning, patient education, primary care to increase health and reduce preventable adverse health events/expenditures.
- Investment in maternal/infant care, chronic disease management, and behavioral health care.
- Provision for short-term and long-term home-care services to reduce institutionalization.
- Regional planning for the allocation of personnel, facilities, and equipment.
- The establishment of maximum levels of public reimbursement to providers.
- The use of managed care.
- Utilization review of treatment.
- Mandatory second opinions before surgery or extensive treatment.
- Consumer accountability through deductibles and copayments.

Equity Issues

The League believes that health care services could be more equitably distributed by:
- Allocating medical resources to underserved areas.
- Providing for training health care professionals in needed fields of care.
- Standardizing basic levels of service for publicly funded health care programs.
- Requiring insurance plans to use community rating instead of experience rating.
- Establishing insurance pools for small businesses and organizations

Allocation of Resources to Individuals

The League believes that the ability of a patient to pay for services should not be a consideration in the allocation

of health care resources. Limited resources should be allocated based on the following criteria considered together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the treatment, the cost of the procedure, the duration of care, the quality of life of the patient after treatment, and the wishes of the patient and the family.

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 share effectively in making policy decisions, residents must be provided with information on the health care system and the implications of health policy decisions.

Behavioral Health

The League supports:

- Behavioral health as the nationally accepted term that includes both mental illness and substance use disorder.
- Access for all people to affordable, quality in- and out-patient behavioral health care, including needed medications and supportive services.
- Behavioral health care that is integrated with, and achieves parity with, physical health care.
- Early and affordable behavioral health diagnosis and treatment for children and youth from early childhood through adolescence.
- Early and appropriate diagnosis and treatment for children and adolescents that is family-focused and community-based.
- Access to safe and stable housing for people with behavioral health challenges, including those who are chronically homeless.
- Effective re-entry planning and follow-up for people released from both behavioral health hospitalization and the criminal justice system.
- Problem-solving or specialty courts, including mental health and drug courts, in all judicial districts to provide needed treatment and avoid inappropriate entry into the criminal justice system.
- Health education — from early childhood throughout life — that integrates all aspects of social, emotional, and physical health and wellness.
- Efforts to decrease the stigmatization of, and normalize, behavioral health problems and care.

League History

Given the growing crisis in health care delivery and financing in the 1990s, the League developed a comprehensive position supporting a health care system that provides access to affordable, quality health care for all Americans and protects patients' rights.

In 1990, LWVUS undertook a two-year study of the funding and delivery of health care in the United States. Phase 1 studied the delivery and policy goals of the US health care system; Phase 2 focused on health care financing and administration. LWVUS announced its initial health care position in April 1992 and the final position in April 1993.

The 2016 Convention updated the position by concurrence to include behavioral health.

The health care position outlines the goals LWVUS believes are fundamental for US health care policy. These include policies that promote access to a basic level of quality care at an affordable cost for all US residents and strong cost-control mechanisms to ensure the efficient and economical delivery of care.

The Meeting Basic Human Needs position also addresses access to health care.

The health care position enumerates services League members believe are of highest priority for a basic level of quality care: the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health care), acute care, long-term care, and mental health care. Dental, vision, and hearing care are recognized as important services but of lower priority when measured against the added cost involved. Comments from numerous state and local Leagues, however, emphasized that these services are essential for children.

To achieve more-equitable distribution of services, the League endorses increasing the availability of resources in medically underserved areas, training providers in needed fields of care, standardizing the services provided under publicly funded health care programs, and insurance reforms.
The LWVUS health care position includes explicit support for strong mechanisms to contain rising health care costs.
Methods to promote the efficient and economical delivery of care in the United States include regional planning for the allocation of resources, reducing administrative costs, reforming the malpractice system, copayments and deductibles, and managed care. In accordance with the position's call for health care at an affordable cost, copayments and deductibles are acceptable cost-containment mechanisms only if they are based on an individual's ability to pay. In addition, cost-containment mechanisms should not interfere with the delivery of quality health care.
The position calls for a national health insurance plan financed through general taxes, commonly known as the "single-payer" approach. The position also supports an employer-based system that provides universal access to health care as an important step toward a national health insurance plan. The League opposes a strictly private market-based model of financing the health care system. Regarding administration of the US health care system, the League supports a combination of private and public sectors or a combination of federal, state, and/or regional agencies. The League supports a general income tax increase to finance national health care reform.
The League strongly believes that, should the allocation of resources become necessary to reform the US health care system, the ability of a patient to pay for services should not be a consideration. In determining how health care resources should be allocated, the League emphasizes the consideration of the following factors, taken together: the urgency of the medical condition, the life expectancy of the patient, the expected outcome of the
treatment, the cost of the procedure, the duration of care, the quality of life of the patient after the treatment, and the wishes of the patient and the family.

As LWVUS was completing Phase 2 of the study, the issue of health care reform was rising to the top of the country's legislative agenda. In April 1993, as soon as the study results were announced, LWVUS met with White House health care officials to present the results of the League's position. Since then, the League has actively participated in the health care debate.

LWVUS testified in fall 1993 before the House Ways and Means Subcommittee on Health, the Energy and
Commerce Committee, and the Education and Labor Committee, calling for comprehensive health care reform based on the League position. The League joined two coalitions — one comprising consumer, business, labor, provider, and senior groups working for comprehensive health care reform, and the other comprising groups supporting the single-payer approach to health care reform.
Throughout 1994, the League actively lobbied in support of comprehensive reform, including universal coverage, cost containment, single-payer or employer mandate, and a strong benefits package. The League emphasized LWVUS support for the inclusion of reproductive health care, including abortion, in any health benefits package.
LWVEF initiated community education efforts on health care issues with the Understanding Health Care Policy Project in the early 1990s. The project provided training and resources for Leagues to conduct broadbased community outreach and education on health care policy issues with the goal of expanding community participation in the public debate. In spring 1994, LWVEF and the Kaiser Family Foundation (KFF) undertook a major citizen education effort, Citizen's Voice for Citizen's Choice: A Campaign for a Public Voice on Health Care Reform. The project delivered objective information on health care reform to millions of Americans across the country through local and state League-sponsored town meetings in major media markets nationwide, involving members of Congress and other leading policy makers and analysts in health care discussions with citizens. In September 1994, LWVEF and KFF held a National Satellite Town Meeting on Health Care Reform. They also undertook a major television advertising promotion of public participation in the health care debate.
In 1997, LWVUS joined 100 national, state, and local organizations in successfully urging Congress to pass strong bipartisan child health care legislation (CHIP). In 1998, LWVUS began working for a Patients'

Bill of Rights, aimed at giving Americans participating in managed care health plans greater access to specialists without going through a gatekeeper, the right to emergency room care using the "reasonably prudent person" standard, and a speedy appeals process when there is a dispute with insurers and other rights.

In 1998, LWVEF again partnered with KFF and state and local Leagues on a citizen education project, this time focused on Medicare reform, patients' bill of rights, and other health care issues. In the first phase, more than 6,500 citizens participated in focus groups, community dialogues, and public meetings. Their views were reflected in How Americans Talk About Medicare Reform: The Public Voice, presented to the National Bipartisan Commission on the Future of Medicare in March 1999. In spring 2000, LWVEF and KFF developed and distributed two guides, Join the Debate: Your Guide to Health Issues in the 2000 Election and A Leader's Handbook for Holding Community Dialogues. The project focused on five issues under debate in the election: the uninsured, managed care and patients' rights, Medicare reform, prescription drug coverage, and long-term care.

In the late '90s, LWVUS lobbied in support of a strong Patients' Bill of Rights. Despite close votes in 2000, Senate opponents continued to block passage. At Convention 2000, League delegates lobbied their members of Congress to pass a strong, comprehensive Patients' Bill of Rights, but it was shelved as the 2000 election drew near.

In the 108th Congress (2003 – 2005), the League lobbied in support of the Health Care Access Resolution. In 2003, the League opposed the Medicare Prescription Drug bill, which the President signed into law, because of provisions that undermined universal coverage in Medicare.

In May 2006, the League urged senators to oppose the *Health Insurance Marketplace Modernization and Affordability*
Act (HIMMA), which purported to expand health care coverage, while limiting critical consumer protections provided in many states.

From 2007 through 2009, the League urged reauthorization of the State Children's Health Insurance Program (SCHIP), which in 2007 provided health care coverage to six million low-income children; the efforts were rewarded with reauthorization in early 2009.

In 2010, after two decades of work to ensure access to affordable, quality health care for all Americans and protect patients' rights, the League celebrated success when the *Affordable Care Act* (ACA) was signed into law. The League remains vigilant considering current efforts to repeal or diminish the law in Congress and the courts.

In the 112th Congress (2011 – 2013), the League continued to fight attempts to repeal the ACA and to limit provisions that provide health and reproductive services for women. State Leagues began to work with their legislatures to implement the ACA, and LWVUS signed on to an amicus brief in the challenge to the *Affordable Care Act*, which was upheld by the US Supreme Court.

In 2013, as opposition to the ACA was raised in the legislative, regulatory, and judicial processes, LWVUS submitted comments opposing religious exemptions for contraceptive services. This debate continued in the courts, and the League joined with other concerned organizations opposing broad religious exemptions to the requirement that all insurance plans provide access to contraception as basic care in the 2014 Supreme Court case of *Burwell v. Hobby Lobby Stores*.

Judicial action continued in 2015 as supporters including the League submitted an amicus brief in the case of *Burwell v. King*, which challenged the availability of tax subsidies for people who purchase health insurance on a marketplace administered by the federal government. The ACA gave states a choice not to administer their own marketplaces. The brief outlined how tax subsidies are essential to women's health and critical to the ACA's continued viability.

The League continued to support implementation of the ACA at the state level and expansion of the Medicaid program, as provided by the ACA. The League also continued its strong support for continued funding of CHIP.

The League opposed several attempts by Congress to repeal the *Affordable Care Act* in the 115th Congress (2017– 2019), including the Graham-Cassidy Plan, the *Better Reconciliation Act*, and the *American Health Care Act*. The League activated grassroots supporters and the LWVUS Lobby Corps on these efforts and was a key member of the coalition that worked to stop passage of a final bill in the US Senate.

The League also opposed attempts in Congress to destabilize the health care market by defunding cost-sharing reduction payments. And the League worked to spread awareness about the open enrollment period after decision by the executive branch to decrease the outreach budget, limit sign-up during the ACA open enrollment period, and reduce funding for the Navigator program.

Following the 2018 election, the League urged congressional leadership to pursue an agenda that ensures that the best health and health care are equally accessible and affordable to all in the 116th session of Congress (2019 –2021).

In 2020, as Congress began to address the crisis caused by the COVID pandemic, the League joined other
organizations asking the House and Senate to pass legislation that provided state and local aid for essential
services. Along with public health advocacy groups expressing grave concerns regarding the US Government's decision to terminate relations with the World Health Organization (WHO)

In early 2021, LWVUS joined an amicus brief in support of plaintiffs in a trio of US Supreme Court cases challenging the imposition of work requirements on Medicaid recipients. We joined LWVTN in contacting the Director of the Centers for Medicare and Medicaid Services (CMS) opposing the approval of a Medicaid block grant in Tennessee that would limit the state's ability to provide access to critical healthcare.

The League lobbied Congress in 2022 to take action to improve health care affordability and address health inequities impacting women and families.

At Convention 2022, delegates concurred with the LWVNY Health Care update, amending the LWVUS Health Position to include updated criteria for evidence-based cost control measures that don't exacerbate DEI disparities, highlight the need for access to healthcare for underserved areas, patients, and populations to improve both equity and public health, and make LWV support for single payer explicit, including allowing states or regions to enact universal health programs that meet certain criteria. The new position also supports separating access to health care from employment, expanding delivery options, ensuring safe staffing, centering the decisions of patients including decisions made prior to need, regular evaluation of health programs, and public participation in determining health care funding and coverage.

Impact on Issues, 2022-2024, pgs. 137-143.