State and National Health Policy

PELI Advanced Course

Physician Leaders Don’t Just Manage Change… They Make It

Coverage, Cost, Access, and Reform: Knowledge is Power

Today’s Agenda

Saturday November 18

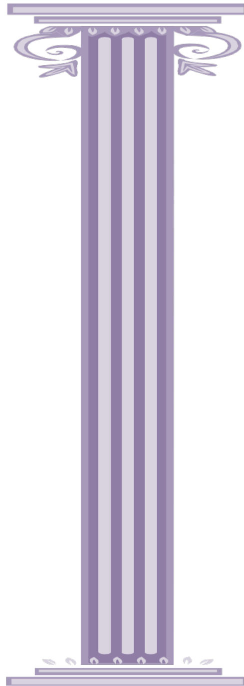
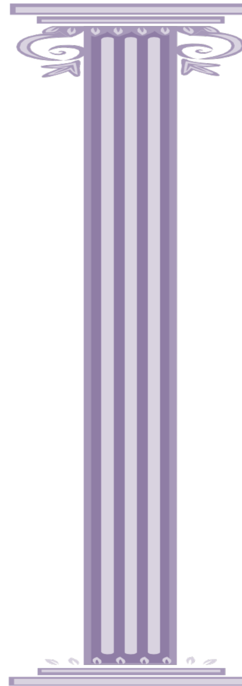
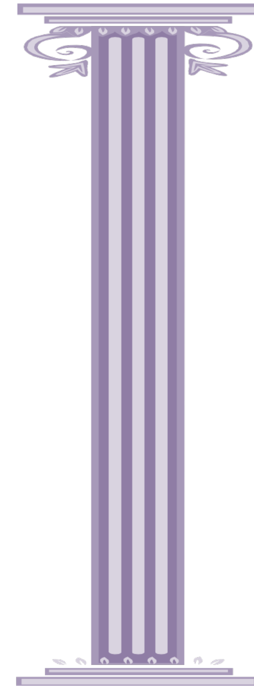
7:00 – 7:30	*Arrival and Breakfast*
7:30 – 8:00	Recap and key lessons from yesterday
8:00 – 9:00	Professor Michael Doonan
9:00 – 9:15	Break
9:15 – 11:00	Professor Michael Doonan
11:00 -11:15	Reflections, Wrap Up
11:15 -11:30	Feedback Survey, What’s Next

Agenda

- Access Quality and Costs
- Universal Health care
- ACA
- Medicare
- Engaging the System

The Three Pillars of Health Insurance

Access | Quality | Cost

Problems with the American Health Care system

- **Cost ---**The highest health care costs in the world.
- **Quality---** We not have the highest lifespan or rank at the top on a number of quality measures.
- **Access---** Some 30 million people are uninsured around 11 percent of the population. Millions with insurance forgo care do to costs or have significant medical debt.

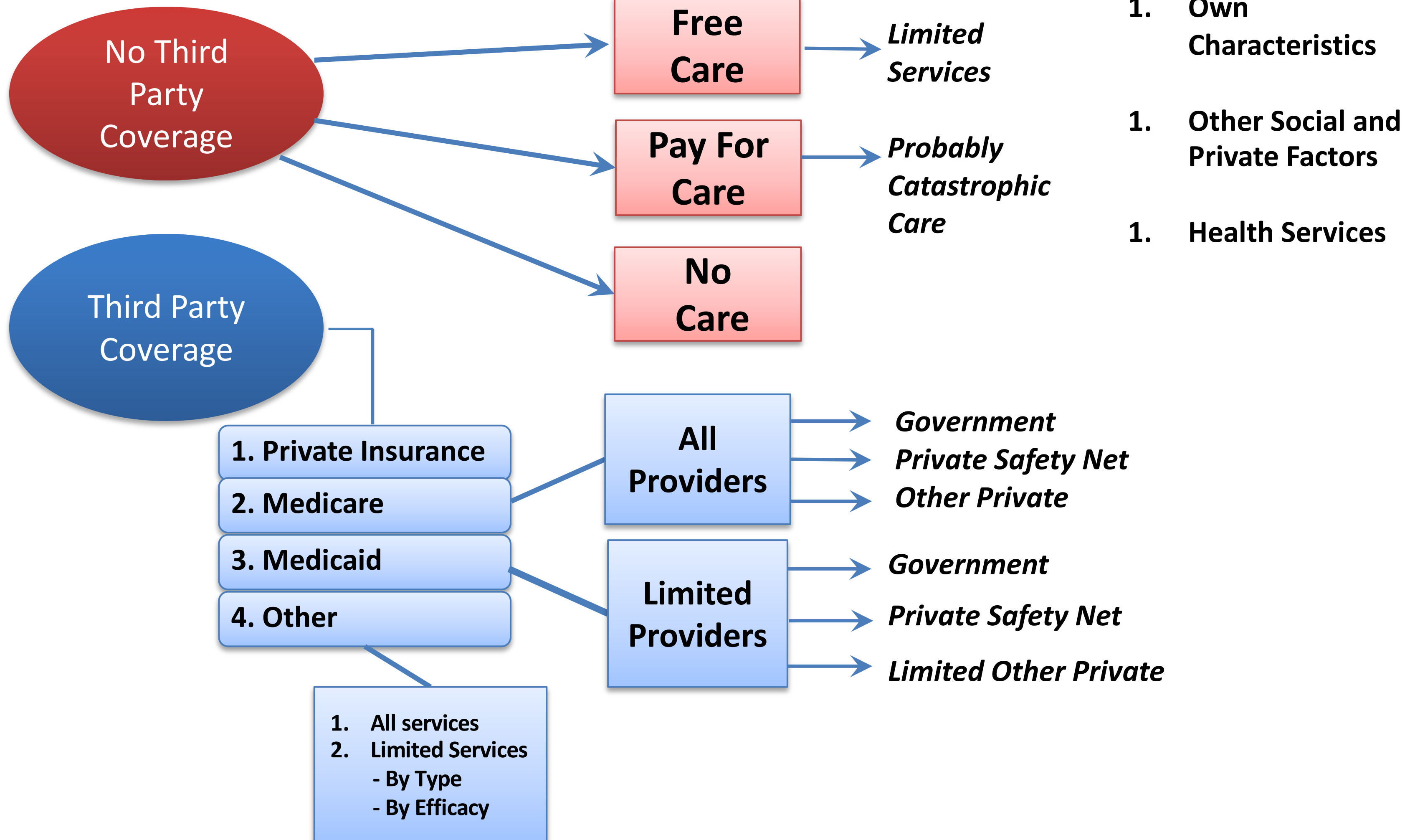
How Medical Care is Paid For In U.S

- Private Insurance
  - From Your Job (Employer Sponsored)
  - Bought By Individuals
- Medicare--- Individuals Over 65 and Disabled
- Medicaid--- Low Income Individuals
  - Child Health,
- Other Public---VA, Defense Dept.
- Out-of- Pocket
- Uninsured---Uncompensated Care

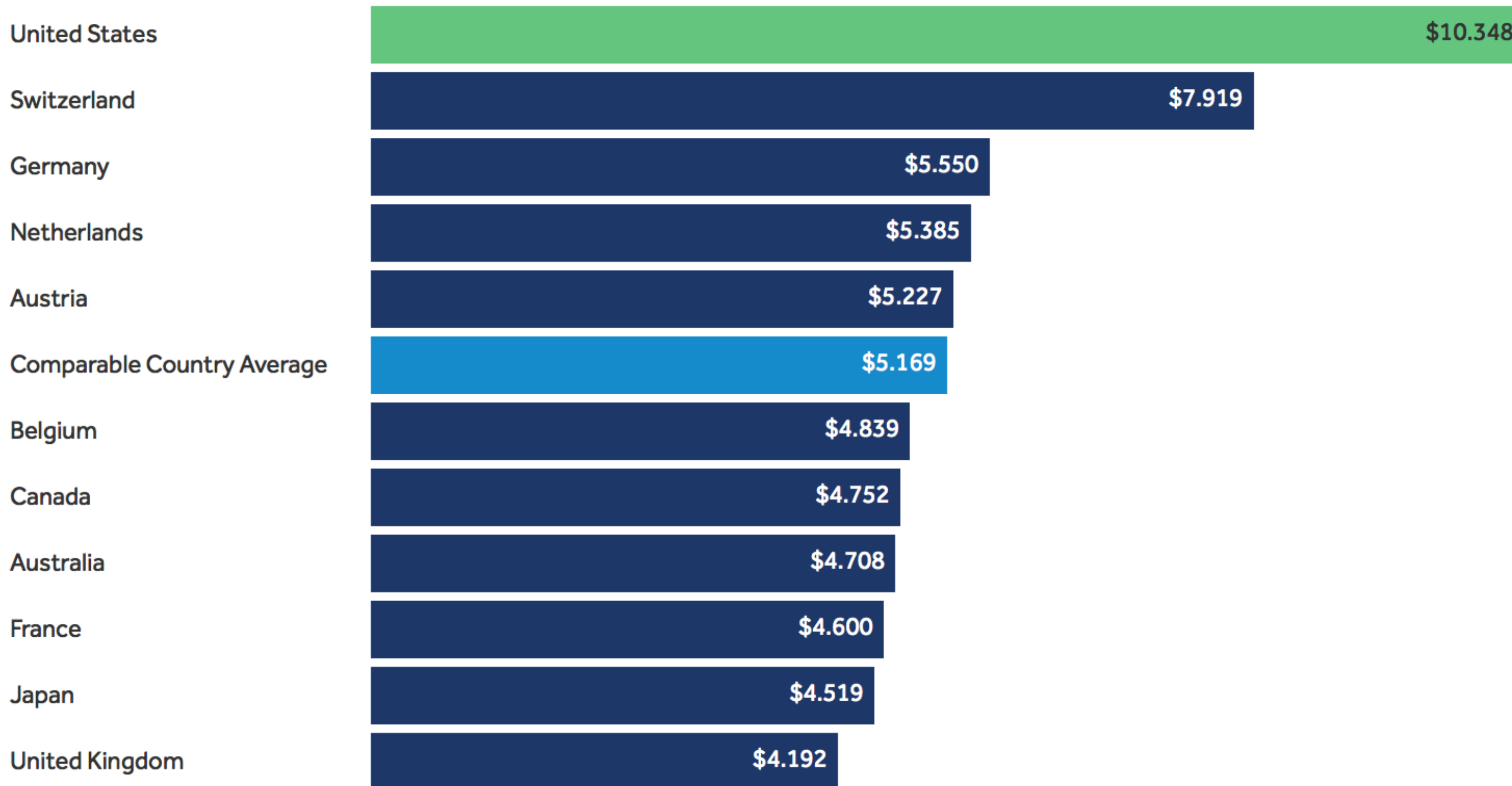
The U.S. Health System

Health Insurance Coverage - Access to Health - Good Health

Insurance Coverage | Access | Good Health



On average, other wealthy countries spend about half as much per person on health than the U.S. spends



Source: Kaiser Family Foundation analysis of data from OECD (2017), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database) (Accessed on March 19, 2017). • Get the data • PNG

Peterson-Kaiser
Health System Tracker

Health Care Spending as a Percentage of Gross Domestic Product (GDP), U.S. Versus Other Countries, 1980–2012

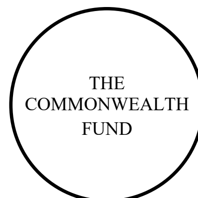
Percent

18
16
14
12
10
8
6
4
2
0

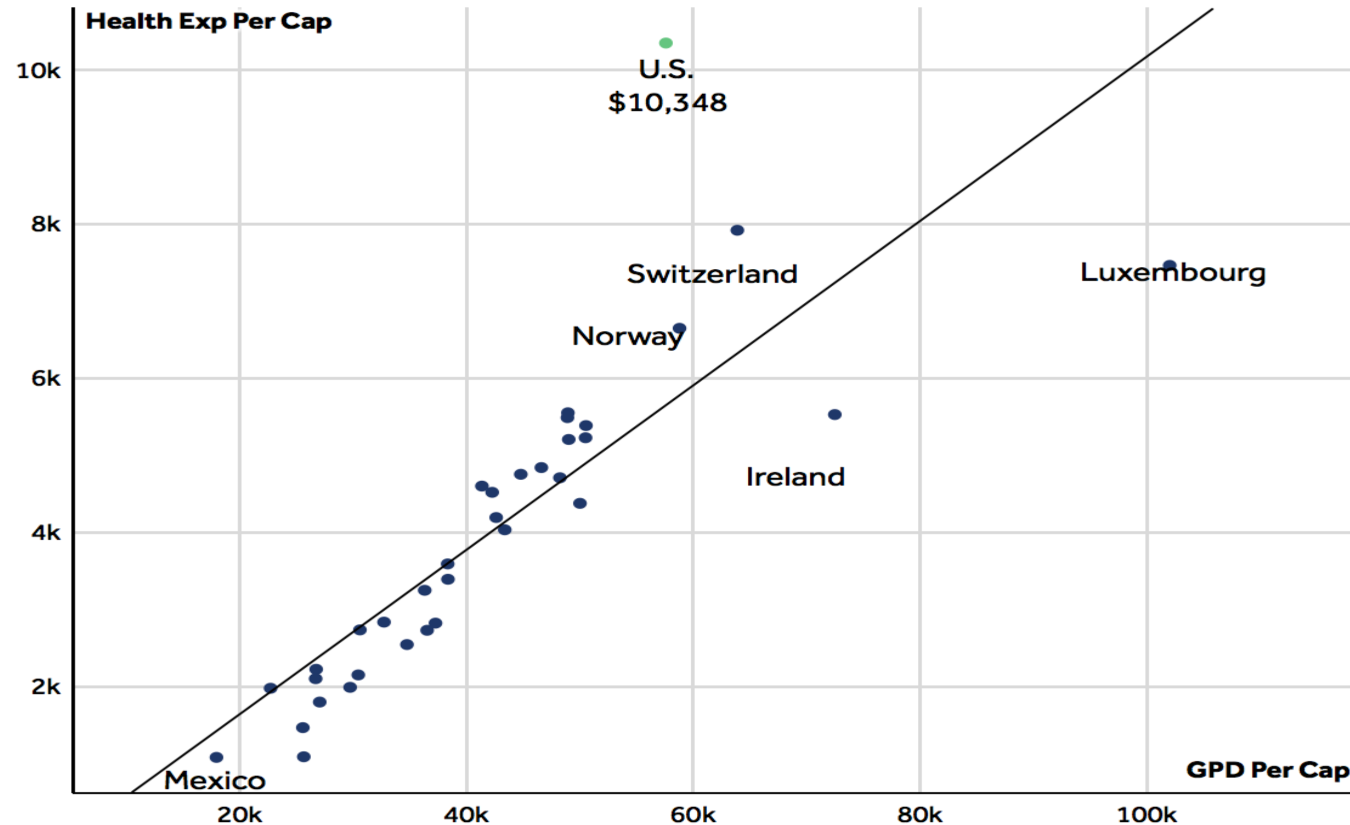
1980 1984 1988 1992 1996 2000 2004 2008 2012

US
NETH
FR
GER
DEN
CAN
SWIZ
NZ
SWE
UK
NOR
AUS
JPN

GDP refers to gross domestic product.
Source: OECD Health Data 2014 (June 2014).

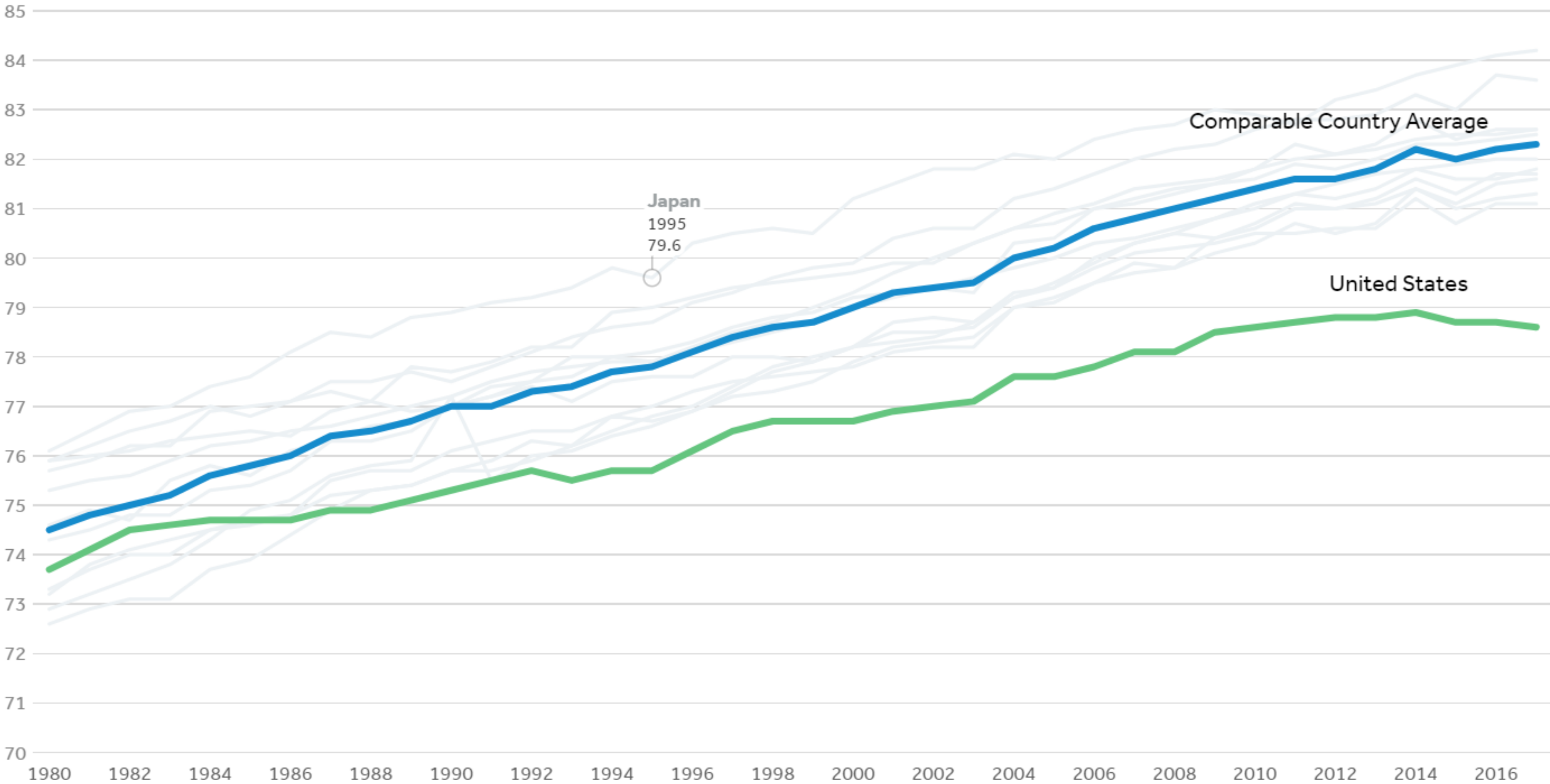


Relative to the size of its wealth, the U.S. spends a disproportionate amount on health care



Source: Kaiser Family Foundation analysis of data from OECD (2017), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). DOI: 10.1787/health-data-en (Accessed on March 19, 2017). • Get the data • PNG

Peterson-Kaiser **Health System Tracker**


Total life expectancy at birth in years, 1980-2017
85
84
83
82
81
80
79
78
77
76
75
74
73
72
71
70
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008
2010
2012
2014
2016
Comparable Country Average
United States
Japan
1995
79.6

Decade By Decade Health Spending in US and OECD Countries as Percent of GDP

- **1970's (limited Growth)—**Regulation in U.S. Spending 1971-1975
- **1980's (Big Growth)---** Very limited Regulation, Expanding Economy and GDP growth with Increased Pvt. Spending
- **1990's (No Growth)---** Era of Managed Care and Limited Govt. Spending
- **2000-2010 (Substantial Growth)---** 2000-2005 Big Growth in Spending After End of Managed Care and then slower growth
- **2010-2015 (Growth After ACA)---** Some Growth in Govt. Spending and Bigger Growth in Pvt. Spending. Limited GDP Growth in All Countries

Health Insurance Coverage of the U.S. Population, 2019

Percentage of Total U.S. Population

Employer	Medicare	Medicaid & CHIP	Direct-purchase	Uninsured	TRICARE	Other public
56.4%	18.1%	17.2%	10.2%	8.0%	2.6%	1.0%

Notes:
Health insurance coverage is based on self-report and categories do not sum to 100% as people may report more than one type of coverage. “Medicare” includes any Medicare coverage. “Direct-purchase” includes coverage purchased directly from an insurance company or through a federal or state marketplace. “TRICARE” refers to coverage under the Military Health System. "Other Public" includes coverage under the Civilian Health and Medical Program of the Department of Veterans Affairs, as well as care provided by the Department of Veterans Affairs and the military.

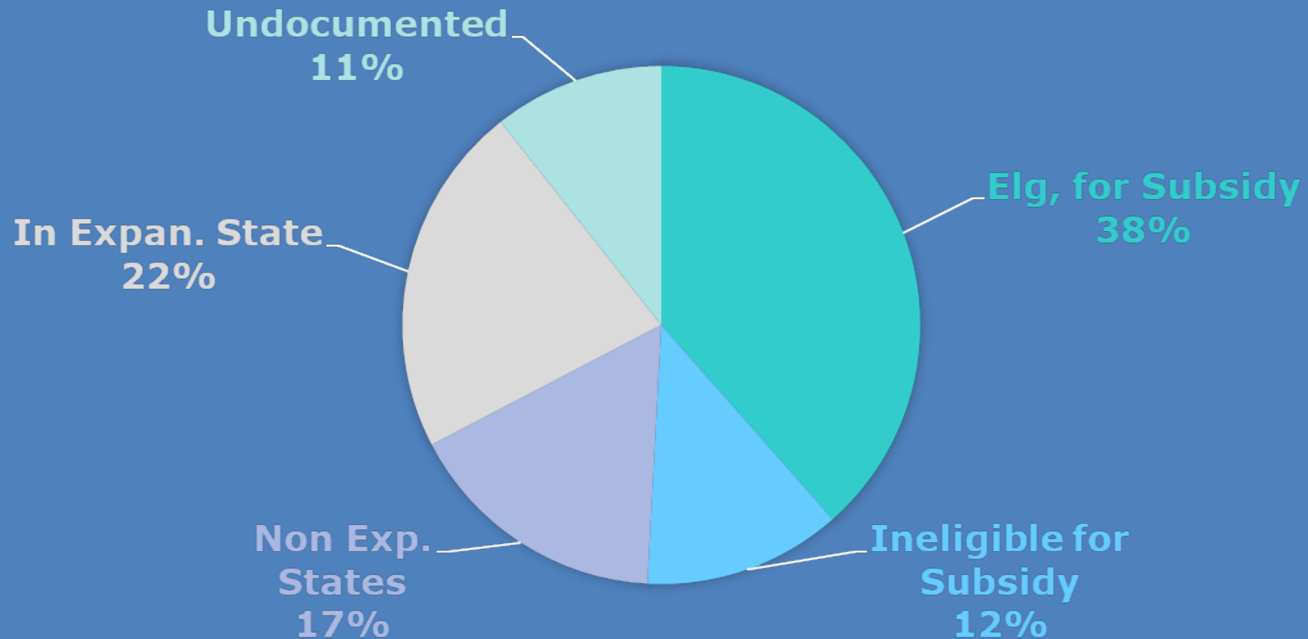
Source:
U.S. Census Bureau. Health Insurance Coverage in the United States: 2019 (2019 data).

Available at:
https://www.census.gov/library/publications/2020/demo/p60-271.html

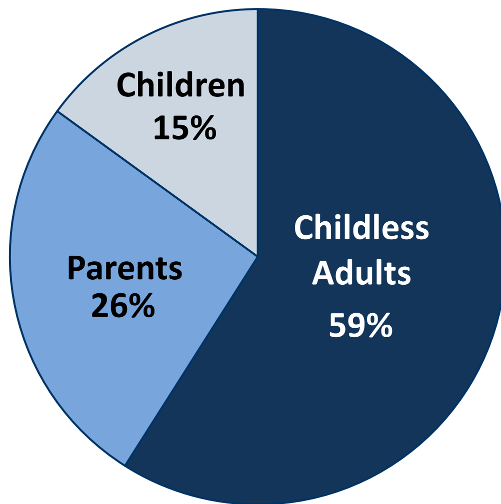
Who *Were (and may still be)* The Uninsured?

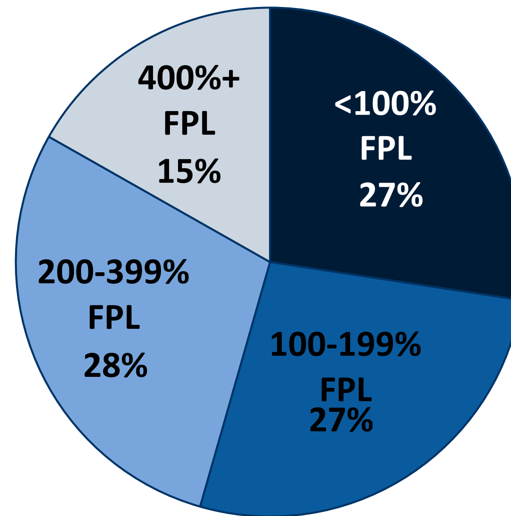
- They Disproportionately Are:
  - Poorer
  - Black or Hispanics
  - Younger
  - Non-Workers or work in marginal jobs with low pay
  - Single
  - Poorer Health
  - Immigrants without documentation
  - -Concentrated in Certain States

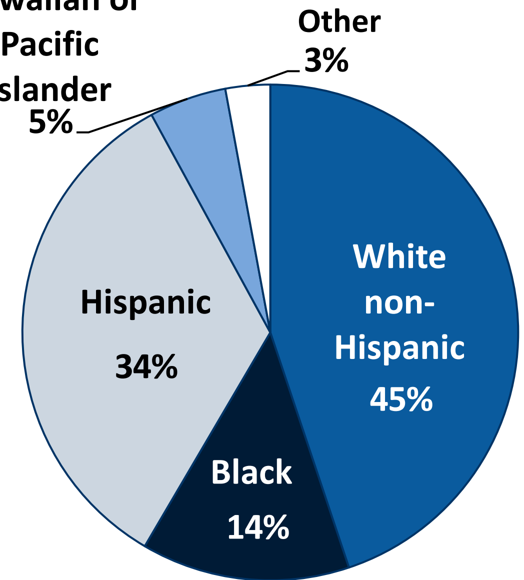
Who Are The Uninsured (2019)



The majority of the uninsured are low-income adults, and more than half are people of color. 2014



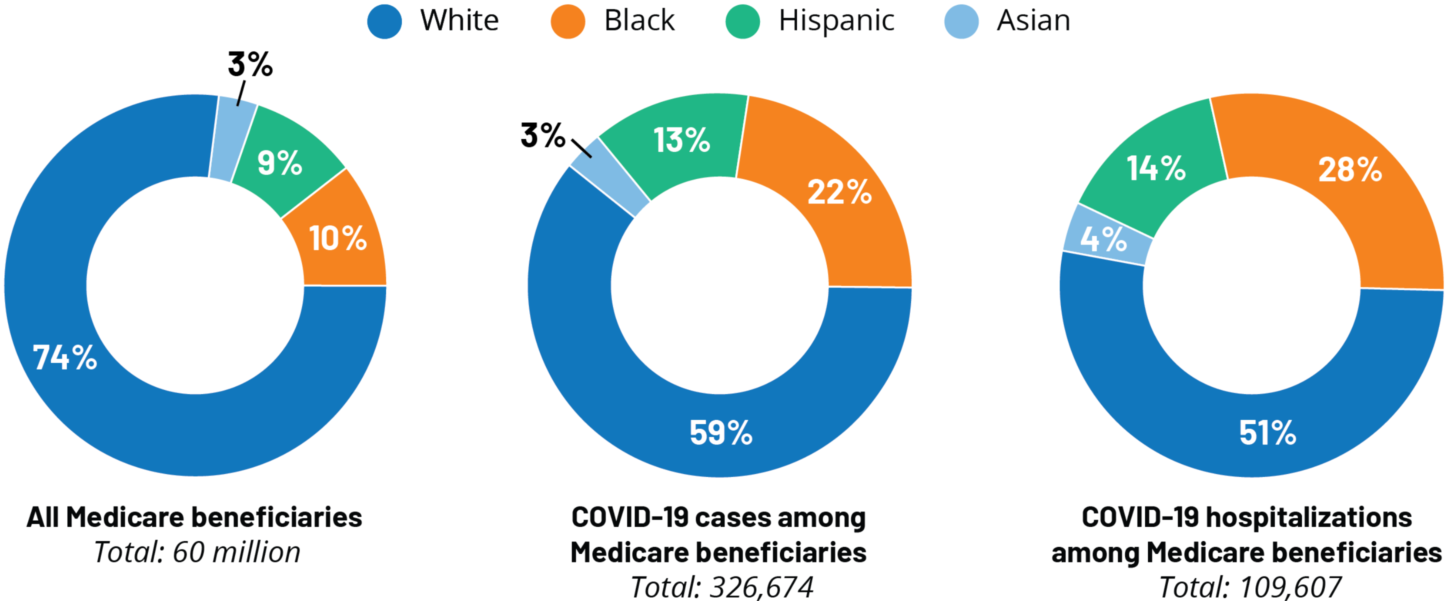




Total = 32.3 Million Uninsured

NOTES: The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,055 in 2014. Data may not total 100% due to rounding.
SOURCE: Kaiser Family Foundation analysis of the 2015 ASEC Supplement to the CPS.

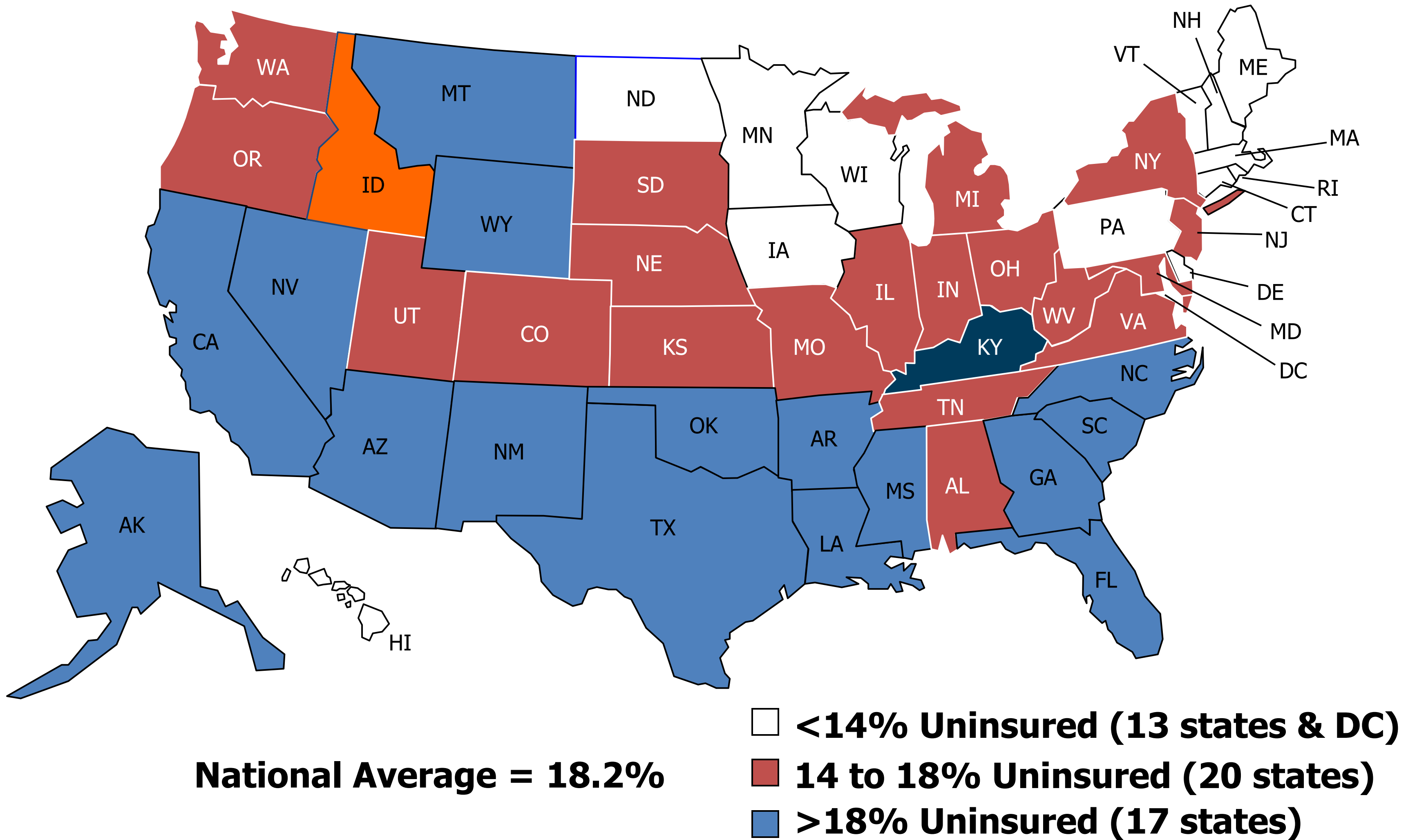
In Medicare, Black and Hispanic Individuals Account for Disproportionate Share of COVID-19 Cases and Hospitalizations



NOTE: Data for other/unknown racial/ethnic groups not shown. Racial/ethnic breakdown based on 2018 data. Data cover claims through 5/16/2020.
SOURCE: KFF analysis of Medicare COVID-19 data released on June 22, 2020, and Medicare enrollment data, 2018.

KFF

Uninsured Rates Among Nonelderly by State Before ACA, 2010-2011

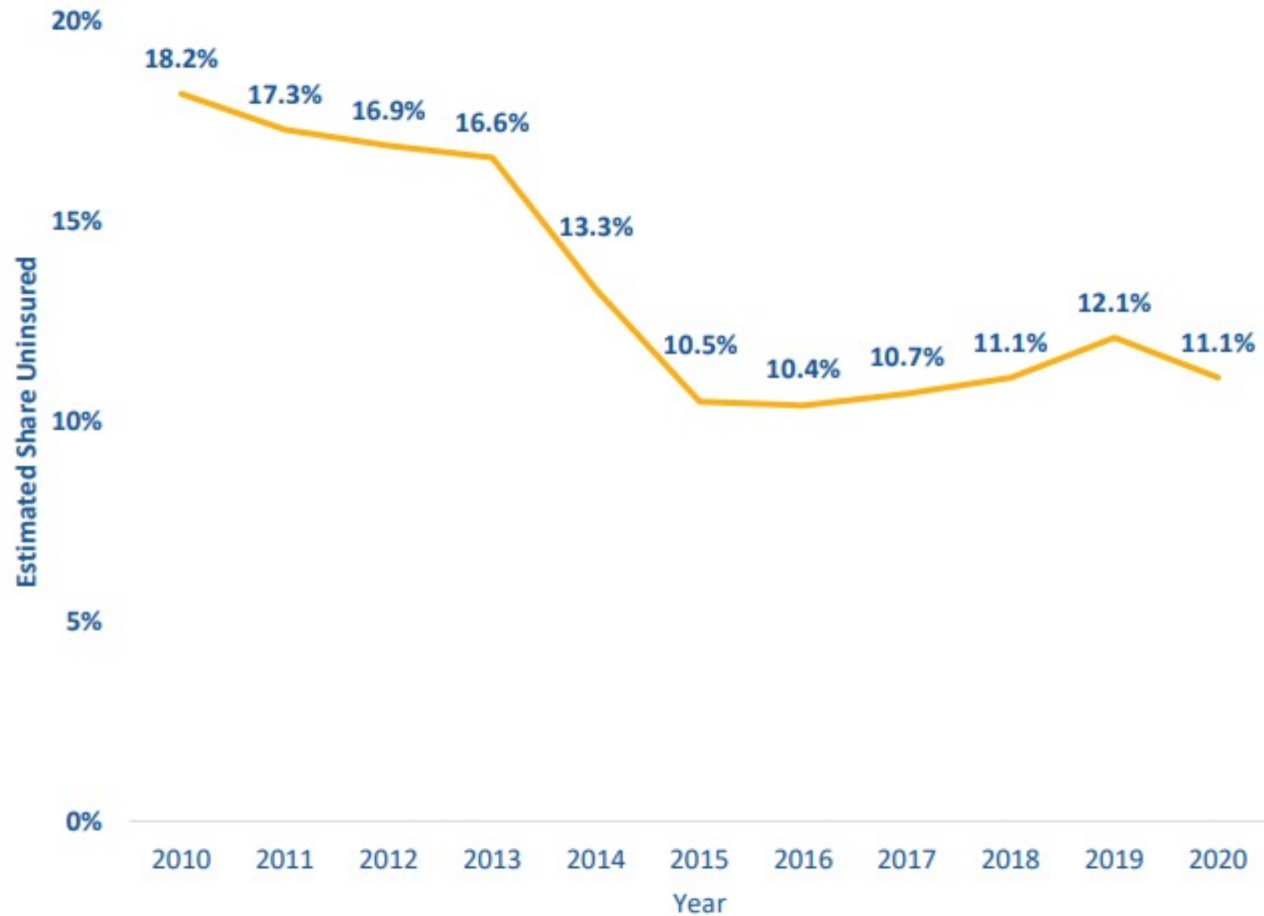


National Average = 18.2%

SOURCE: KCMU/Urban Institute analysis of 2011 and 2012 ASEC Supplement to the CPS (two-year pooled data).

THE HENRY J. KAISER FAMILY FOUNDATION

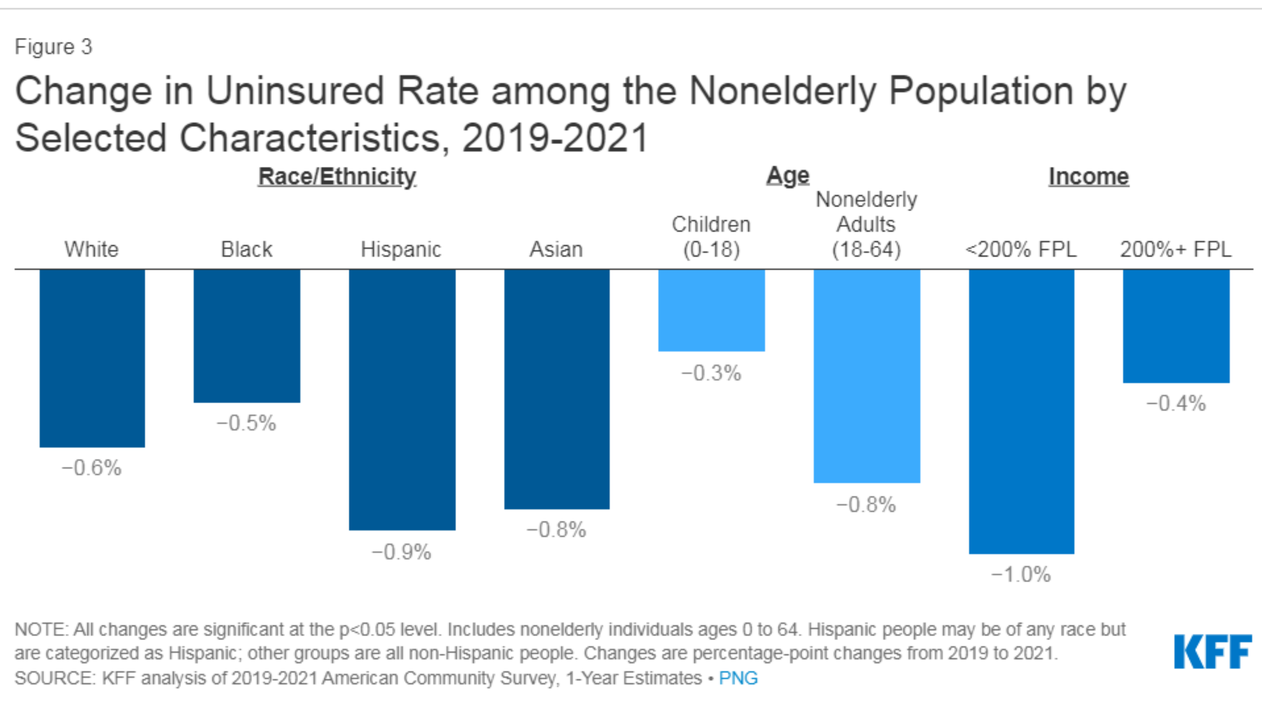
Figure 2. Uninsured Share of U.S. Nonelderly, 2010-2020



Source: Early release of estimates from the National Health Interview Survey, 2018-2020. National Center for Health Statistics. Available from https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm. 2020 estimates are for January-June only.

Location	Children 0-18	Adults 19-64	Total
United States [1]	**5.1%**	**11.3%**	**9.6%**
Maine	4.3%	9.6%	8.3%

Source https://www.kff.org/uninsured/state-indicator/*nonelderly-uninsured-rate-by-age/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D*



Historical Dilemma!

Many American Presidents Tried To Pass Universal Coverage But Failed

- Roosevelt--- Pulled It Back
- Truman
- Johnson---Focused Just on Elderly/Poor
- Nixon
- Carter
- Clinton

Fear Trumps Hope---

"Socialized Medicine" is the kiss of death

Altman Law

Strong support in the country for universal coverage but no consensus on how?

Is Healthcare a Right and Should It Be Guaranteed by Government?

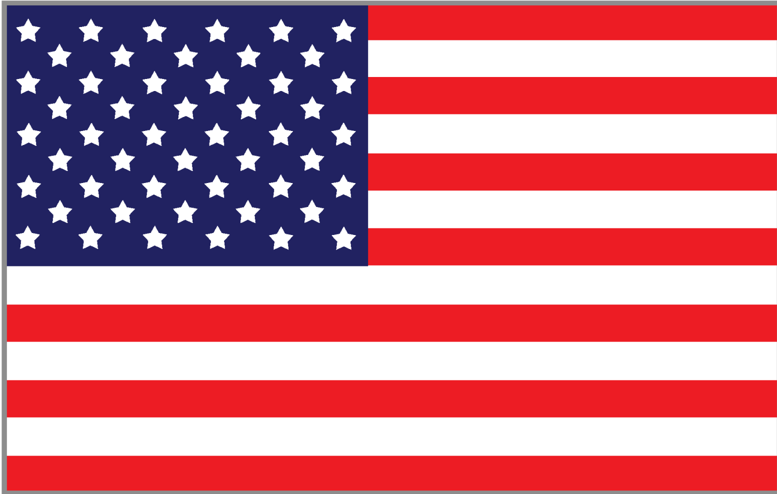
Yes in Most Countries;--- Still Being Debated in U.S. --- Really a Philosophical issue

But Even If Yes---What Is Guaranteed?

Most Countries Guarantee Coverage (Insurance) to Pay Medical Bills But Many Limit Access and Types of Services Covered---Some Require Gov. Care Only at Gov. Facilities, Others Limit Use of Certain Services

Even If Good Access Does or Can Government Guarantee---GOOD HEALTH

US vs. Canada: Cost, Quality, Access



US vs. Canada: Cost, Quality, Access

US is Best

- Cost
- Quality
- Access

Canada falls short

- Cost
- Quality
- Access

Canada is Best

- Cost
- Quality
- Access

U.S. fall short

- Cost
- Quality
- Access

Most Countries Have National Laws To Guarantee Financial Coverage for Healthcare Services Either Directly by Government or Pay for Pvt. Insurance Companies to Provide Such Protection

Such Systems are Often Called "Single Payer" or "Medicare-for-All" Health Insurance Systems

Key Issues In Assessing Pros and Cons of Single Payer System

- Impact of Changing How Revenue Is Collected
  - Change From Premium Based to Tax Based Revenue System
    - Who Pays
    - How Much Is Paid
- Impact on Delivery System and Providers of Care
  - Total Revenue for Healthcare System
  - Services Covered
  - How Payments Are Made
  - Structure of Delivery System
  - Income of Providers
- Role of Government vs Private Insurance Companies

Pros and Cons of a Single Payer Health Insurance System

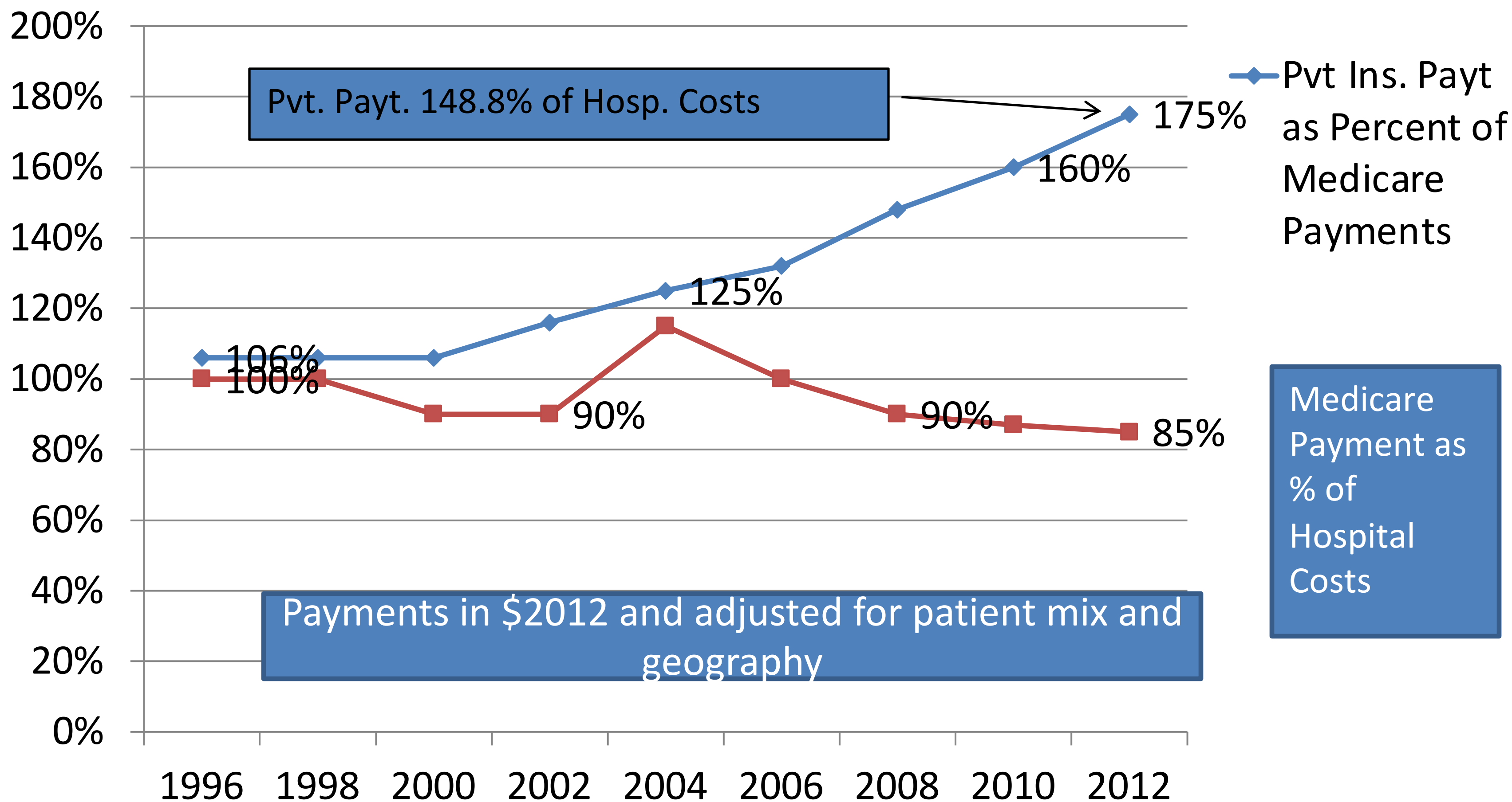
- **Pros**
  - Less expensive to raise funds (government taxing authority) and operate (pay for care) the health system
    - Eliminate health insurance Industry and reduce administrative costs
  - More equitible to use progressive tax system rather than non-income related premiums
  - More equal access to healthcare services
  - Much simpler
  - Can more easily control spending (cost) of system

Pros and Cons of a Single Payer Health Insurance System

Cons

- Negative Implications of a Powerful Government Control System
  - Political issues could influence healthcare resource decisions
  - Require higher tax revenues from upper income groups
- Could take revenue from other needed activities of government
- Require government officials to constantly deal with complicated healthcare problems
- Could underfund services and lead to more upper income groups seeking care privately

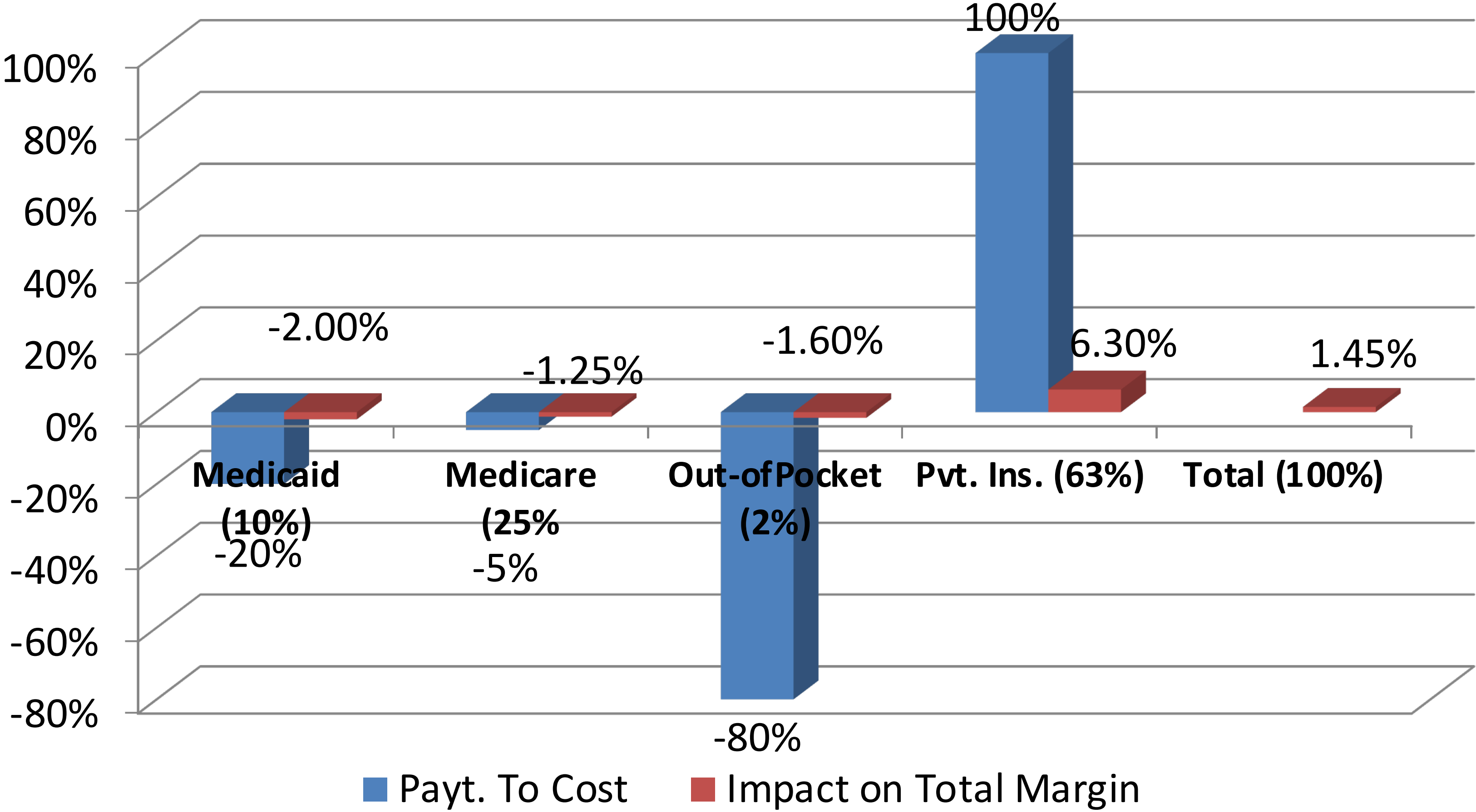
Private Plans Pay Hospitals Significantly More Than Medicare



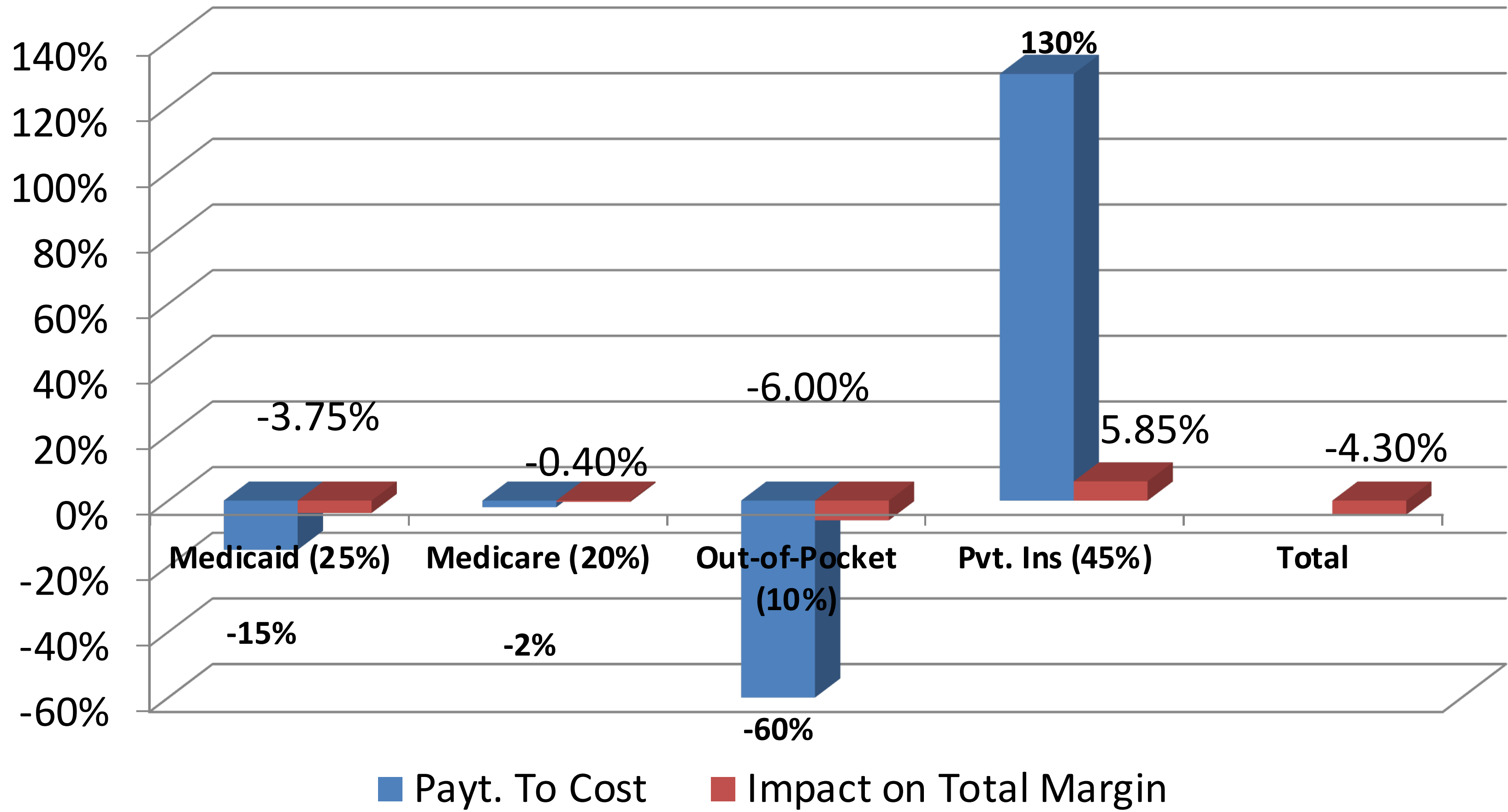
Seiden et al, Health Affairs December 2015

Contribution of Payer Groups to Total Hospital Operating Margin

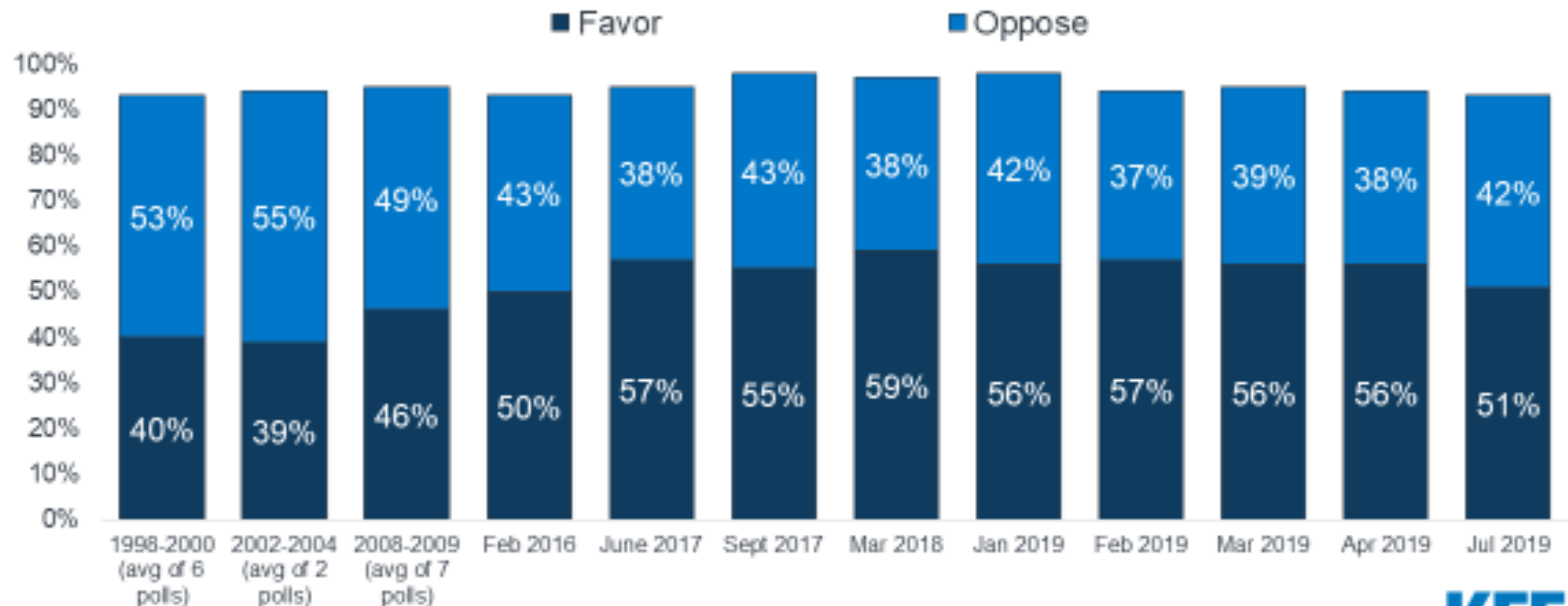
Average Community Hospital



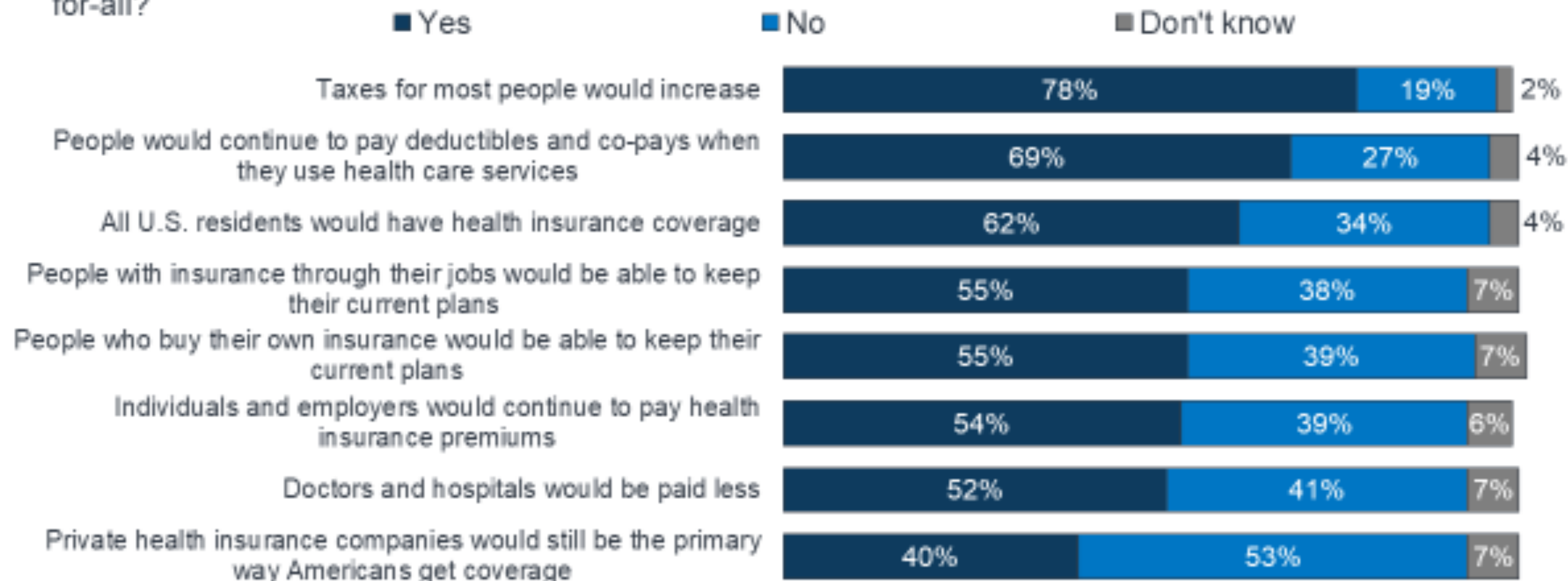
Contribution of Payer Groups to Total Hospital Operating Margin
Safety-Net Hospital



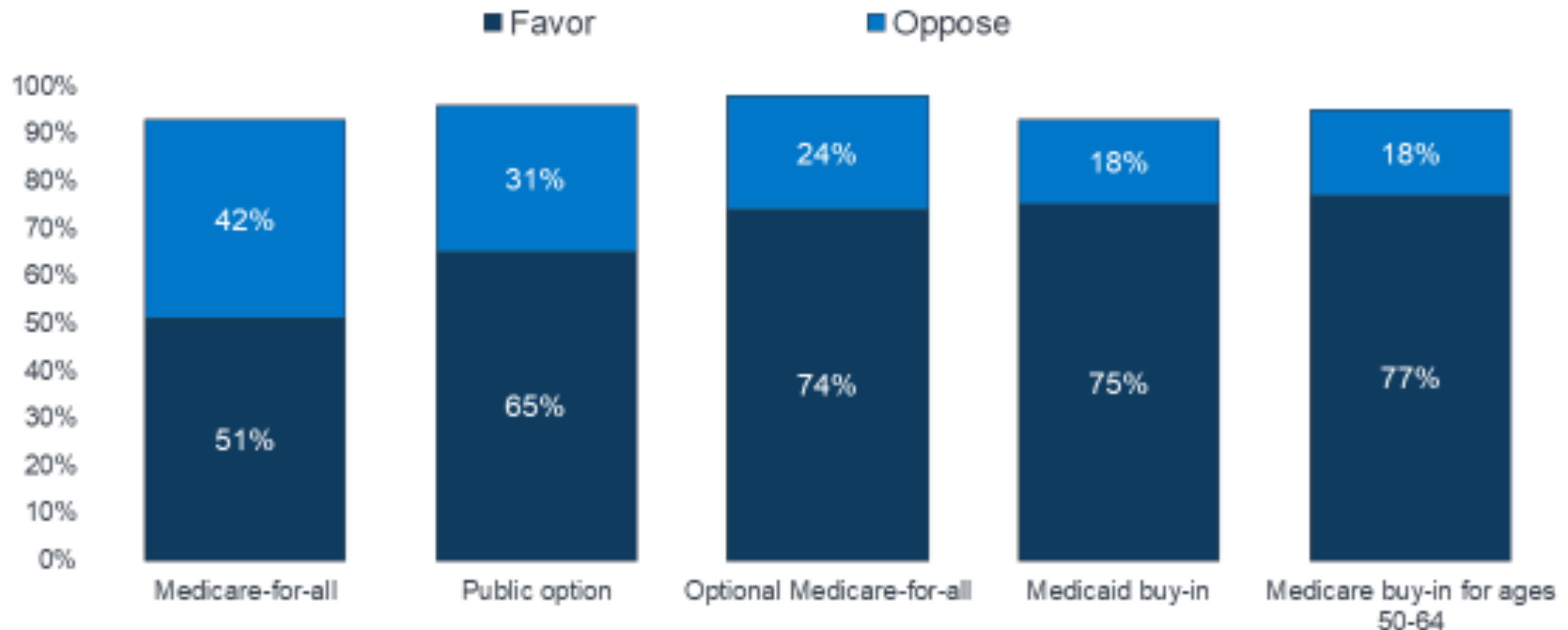
Majority support for single payer



Medicare for All Misunderstood



Incremental change more support



Nevertheless, Obama and Democratic Leadership Chose To Tackle The Issue Again

Options For Universal Coverage

1. Create an All Government-Paid Healthcare Financing System
2. Restructure the Existing Mixed Public/Private System and Maintain Current Tax Preference for Employer
3. Use Tax Credits to Subsidize Coverage

Obama Opted For Option 2

Similar To The Reform Plan of President Nixon and The Romney Plan in Massachusetts

U.S. Reform Builds on Massachusetts Reform Legislation

- Maintains central role of private insurance, but with significant reform
- Government subsidy for low-income to buy private coverage through marketplaces
- Continues tax advantage for employer-subsidized coverage
- Requires all Americans to have coverage
- Expands Medicaid

Massachusetts Reform Driving Forces

- Medicaid waiver renewal, $385 million at risk
- Legislative and gubernatorial leadership
- Coalition of business, hospitals, insurers and consumer advocates
- BCBSMA Foundation's *Roadmap to Coverage* initiative
- Urban Institute report concluded that an individual mandate is essential to anything close to universal coverage

Massachusetts Factors

- Started with relatively low uninsured 10 percent
- History of reform
- Strong stakeholder relationships
- Strong insurance regulation
- Business community engagement
- Coverage before cost containment

Massachusetts Vision

- Shared responsibility
  - Individual
  - Employer
  - Government
- Build upon the existing base
- Shift from safety net to insurance
- Keep stakeholders connected
- Access before cost containment

MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS
Good health. Right around the corner.

ACA Passed Because

- Stakeholders engagement
- New idea from Massachusetts
- Built off the base of existing system
- Put more money in the system
- Didn't substantially address costs
- Dem control of House and Senate
- Nancy Pelosi

Lessons From Massachusetts

- Major reform can happen in our political system!
- Bipartisan
- Keep stakeholders close and part of the process
- Build off the base of the current system
- Share responsibility
- Access first can pressure movement on cost and quality
- Give some of the hard questions to a board

Lessons From Clinton Failure

- Changed the way all Americans received care (fear trumped hope)
- Didn't keep stakeholders close
- Not bipartisan/no super majority
- Alienated key Congressional leaders
- Provided detailed plan that was hard to explain
- Did not act fast

National Reform?

- Partisan (Problematic)
- Expand on the base of existing system
- Health care exchanges (Market based or government control?
- Mandates? (everyone doing their share or government telling you what you must do?)
- Focused on access but still high costs and quality concerns

Major Components of Original Reform Law

- Expanded Coverage ---25-30 Million
  - 50% Medicaid (Expand to All up to 138% of Poverty)
  - 50% Marketplaces (Most subsidized (133-400% of Poverty).
    - Operated by States or federal government
- Require all individuals to obtain coverage
  - Tax penalty
  - Employer penalty for not offering coverage
- Private Insurance Reform
  - No preexisting condition exclusion
  - Limited age bans (3 to 1)
  - Limits on administrative costs
  - Tax on very high cost plans (Cadillac tax)

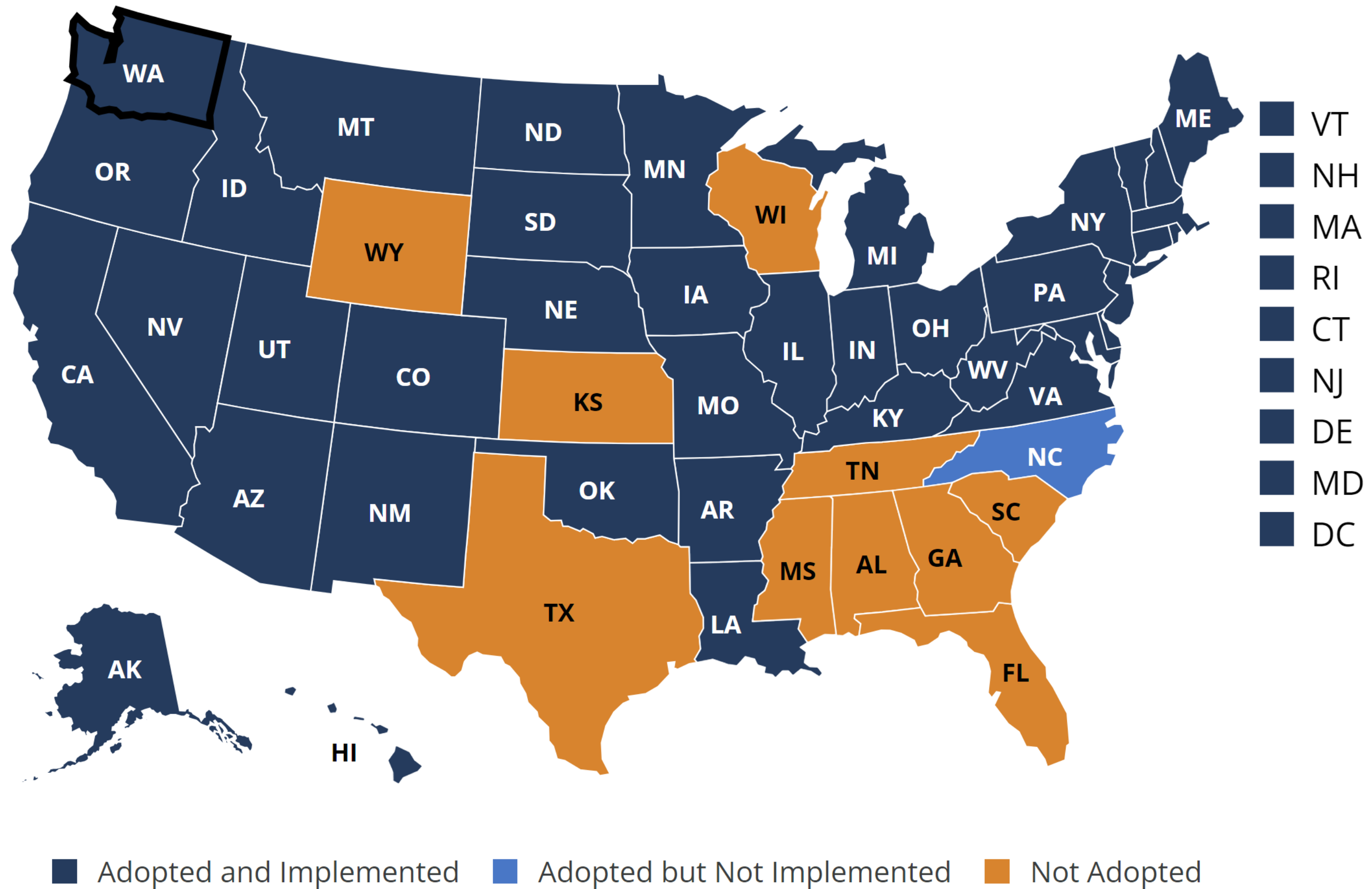
Major Components of Original Reform Law

- Allow people to say on parents plan until age 26
- Eliminate gender as well as health status differences
- Weak employer mandate pushed off
- Establish essential benefits
- Medicare
  - Reduced Subsidy for Medicare Advantage plans
  - Higher Tax Payments for high income individuals
  - Lower Medicare Payments to Hospitals
  - Eliminated coinsurance for some preventive services

Supreme Court Ruled---

ACA is Constitutional But States Can Chose Not To Expand Medicaid Coverage

Current Status of State Medicaid Expansion Decisions

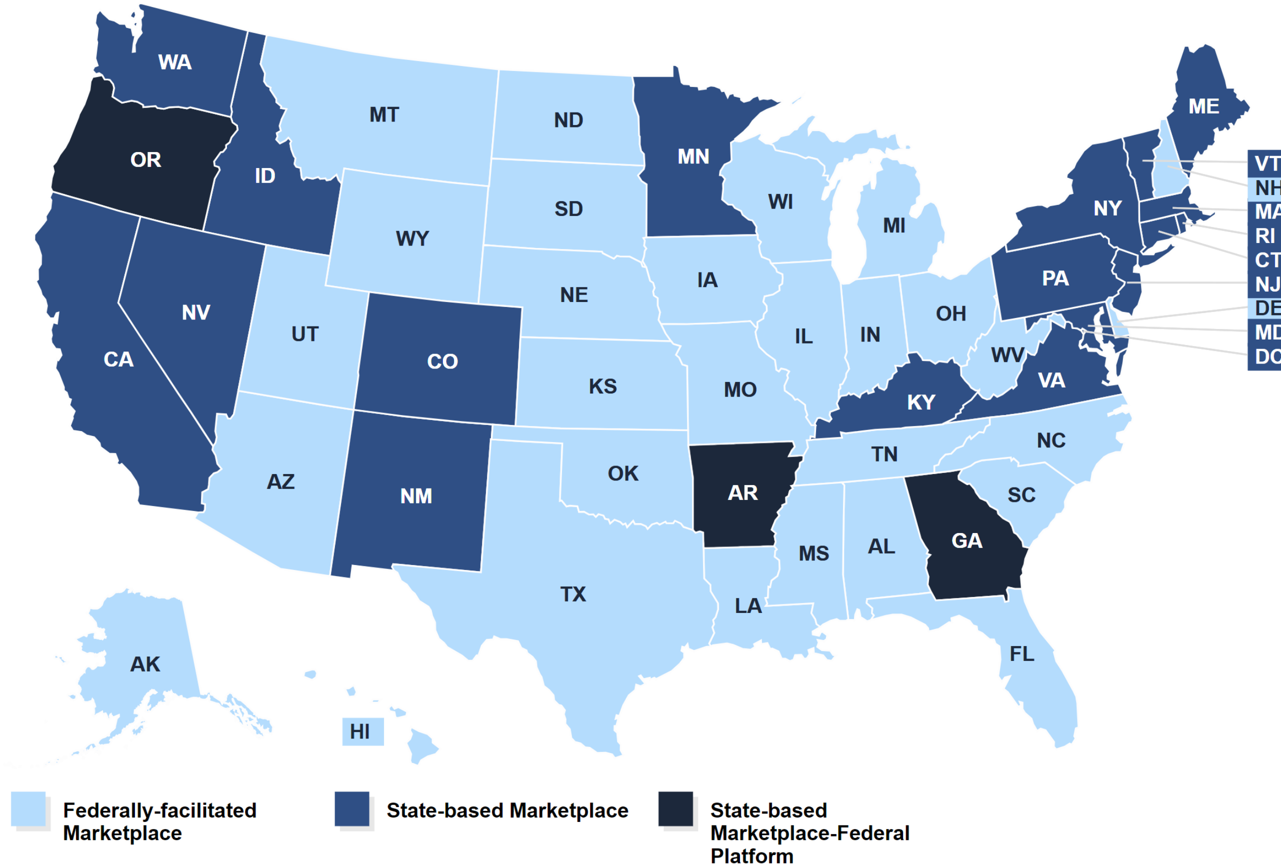


https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

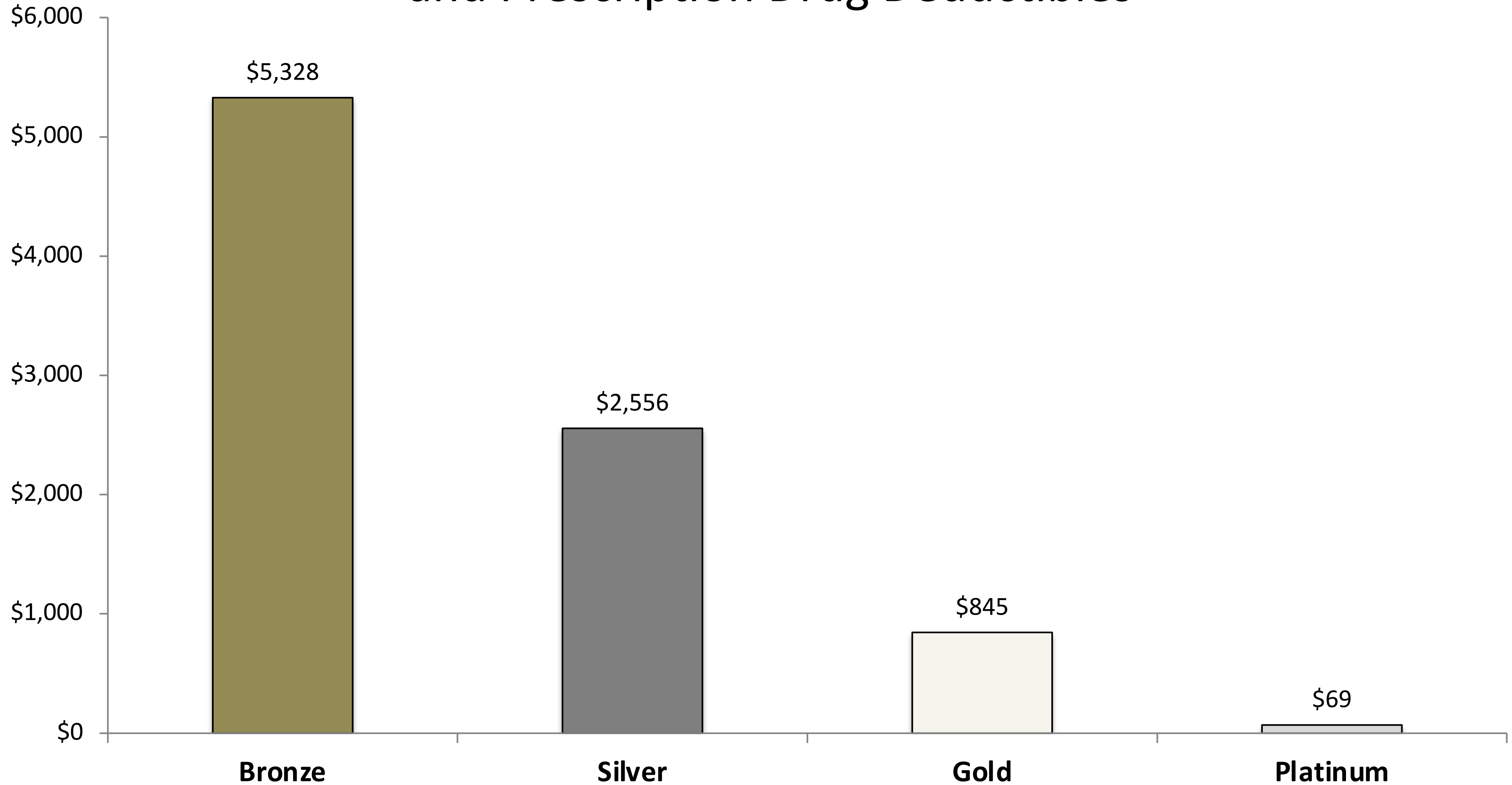
ACA Established State Insurance Marketplaces

- For-Profit, Not-for-Profit and Co-op Ins. Plans Allowed
- Many Run By Federal Government
- Separate Marketplaces for Individuals and Small Businesses
- Plans Must Have Acceptable Coverage
- Different Type of Plans
  - Platinum, Gold, Silver, Bronze (Related to Relationship to % of Actuarial Cost Covered By Plan (Silver 70%)
  - Silver--- Low Income Receive Tax Subsidy
- High Deductible Plans for Young
- Plans Can Have Co-Ins. And Limited Networks

ACA State based Marketplaces



https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?activeTab=map¤tTimeframe=0&selectedDistributions=marketplace-type&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D


Average Medical Deductible, in Plans with Combined Medical and Prescription Drug Deductibles
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
$5,328
$2,556
$845
$69
Bronze
Silver
Gold
Platinum

Core Functions of a Marketplace

- Certify, recertify plans
- Website Portal
- Toll-free hotline
- Present plan benefit options in a standardized format
- Provide information on Medicaid, CHIP, Medicare and other subsidized options
- Calculate subsidies
- Certify exemption from the individual mandate
- Ultimate rate plan value based on cost and quality

What Else?

- Marketplaces can’t set premiums
- But insurers have to justify rate hikes
- State agency, quasi-public authority or non-profit agency can run marketplaces
- Geographically exclusive
- State-based marketplaces federal or state run
- Regulations on exchanges give states far more flexibility than I read in the law

ACA Marketplace Subsidies

- Federal Copayment Subsidy
  - 100% to 250% of Federal Poverty Level
  - Must Buy a Silver Plan Type of Coverage
- In Those States That Have Not Expanded Coverage
  - Could Fall in Gap Between State Level FPL and 100%.
    - No Medicaid and No Subsidy
- Biggest Problem for Individuals Above 250%
  - Required Coverage Often Better Than Previous Plan and Much More Expensive
  - Few Allowed To Keep Old Plan

Maine Marketplace

- Shifted from Federal to state based
  - Hybrid state oversees marketing outreach and feds enrollment
  - 55,000 covered down from 70,000 in 2019 (Maine expanded Medicaid that year)
  - Community Health Options, Harvard Pilgrim Health Care, and Anthem Blue Cross and Blue Shield of Maine
  - $2 million in new funding for outreach enrollment
- Federal increase in subsidies mean 25 percent of enrollees monthly premiums $10 or less

https://www.mainecahc.org/maine-launching-state-run-health-insurance-marketplace-for-2022-enrollment/

Important Changes In Private Insurance Market Incorporated In ACA

Impact of ACA Insurance Changes On Premiums

- Depends on where you live and your specific characteristics
  - Young healthy people generally pay more and get better coverage
    - Except those who are heavily subsidized
  - Employees in firms that had limited coverage pay more
- Some states (New York) saw lower individual premiums because they already restricted discrimination for pre-existing conditions and/or age.

Where Are We Today

Most Americans Now Support Most If Not All of ACA Provisions:-In The Past Over 50% Opposed

ACA Take Away

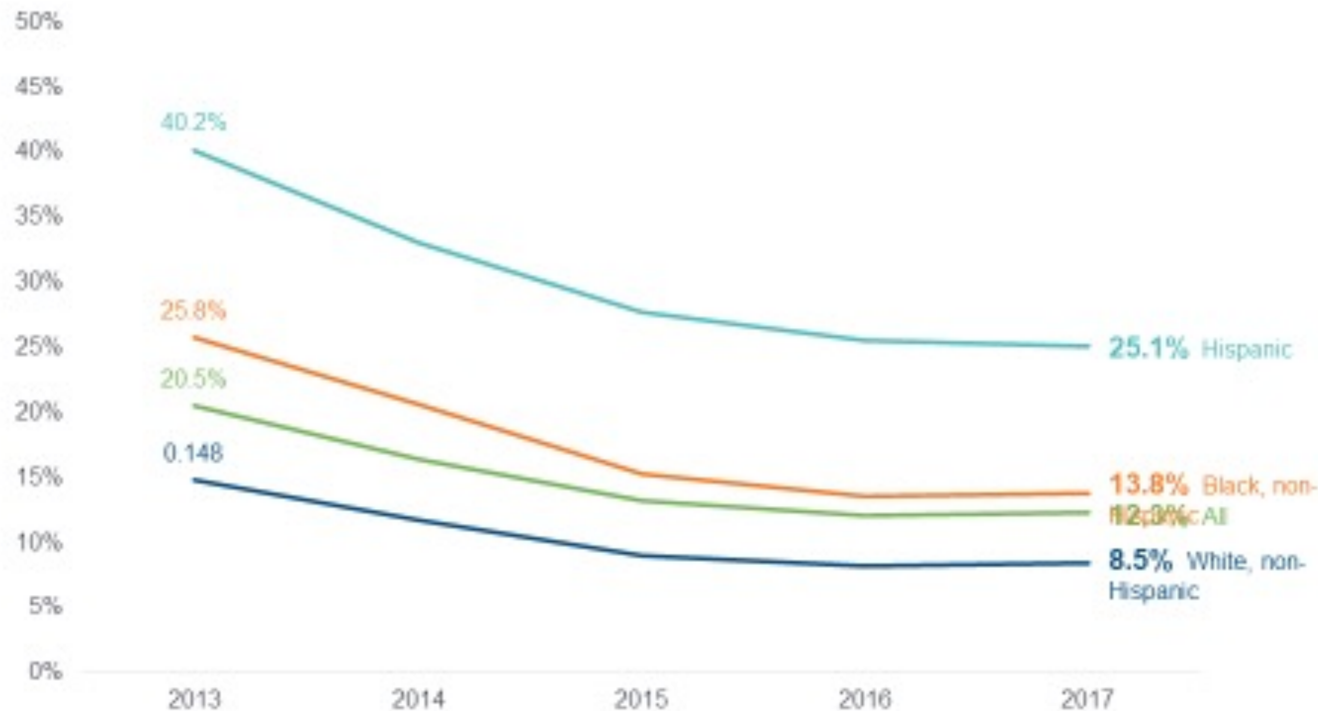
- Number of uninsured are down
- Racial and ethnic disparities have been reduced
- Health care costs were not addressed
- Additional subsidies will lead to greater reductions in the number of uninsured
- Still complicated
- Still political and gains are not protected

Racial and Ethnic Disparities

- Nonelderly adults uninsured decline by 40 percent from 2013 to 2017 (20.5 percent to 12.3 percent)
- The coverage gap between blacks and whites declined from 11.0 percentage to 5.3 percent.
- The coverage gap between Hispanics and non-Hispanic whites dropped from 25.4 percent to 16.6 percent.

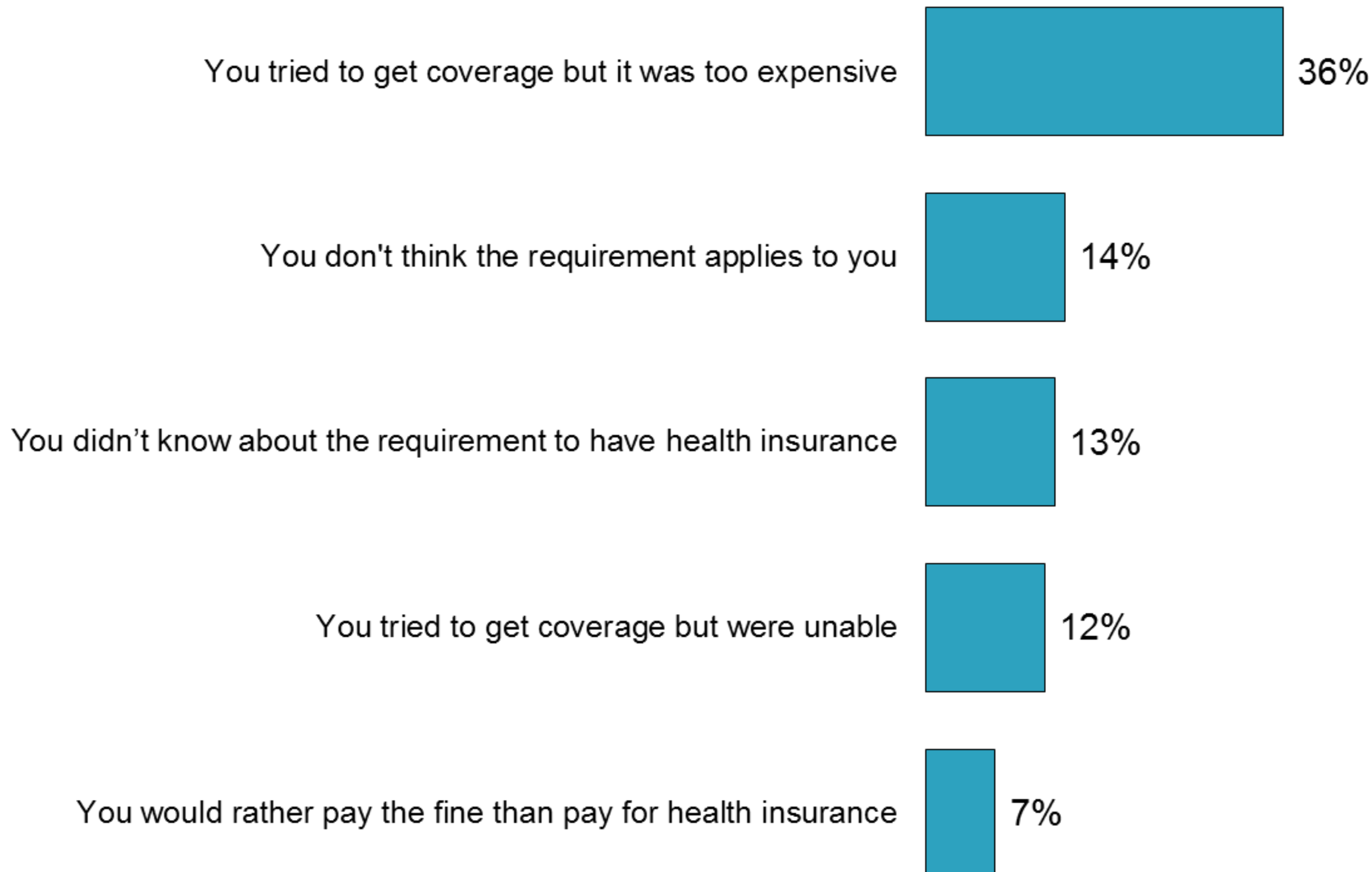
https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/did-ACA-reduce-racial-ethnic-disparities-coverage

ACA Disparities Reduction



Cost Is Main Barrier For Uninsured

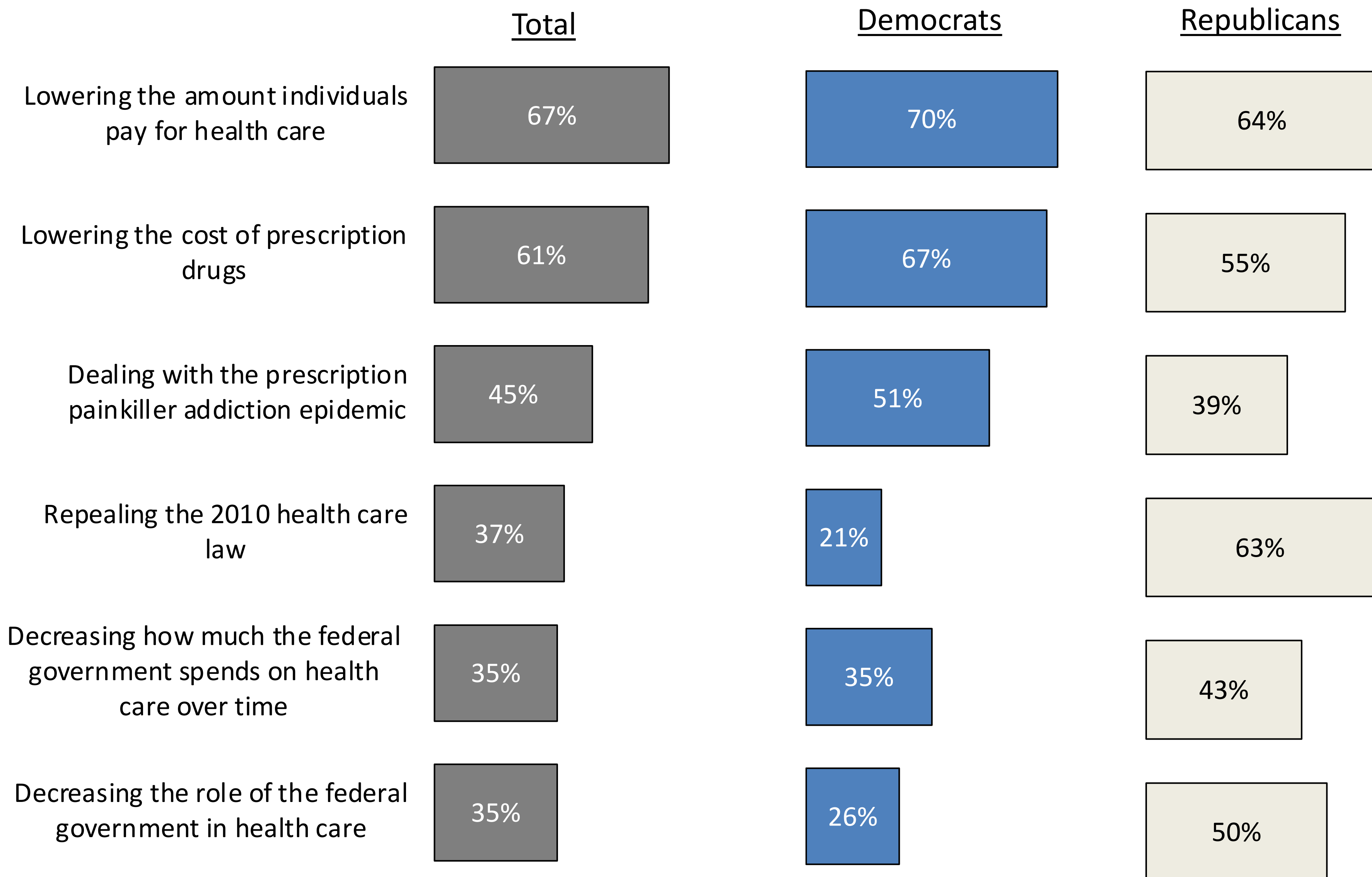
AMONG THE UNINSURED AGES 18-64: As you may know, the health care law requires nearly all Americans to have health insurance this year or else pay a fine. Which of the following comes closest to why you personally have not gotten health insurance this year?



NOTE: Some other reason (vol.) and Don't know/Refused responses not shown.

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted April 15-21, 2014)

Percent who say each is a top priority:



Presidential Elections Matter

State Elections Matter

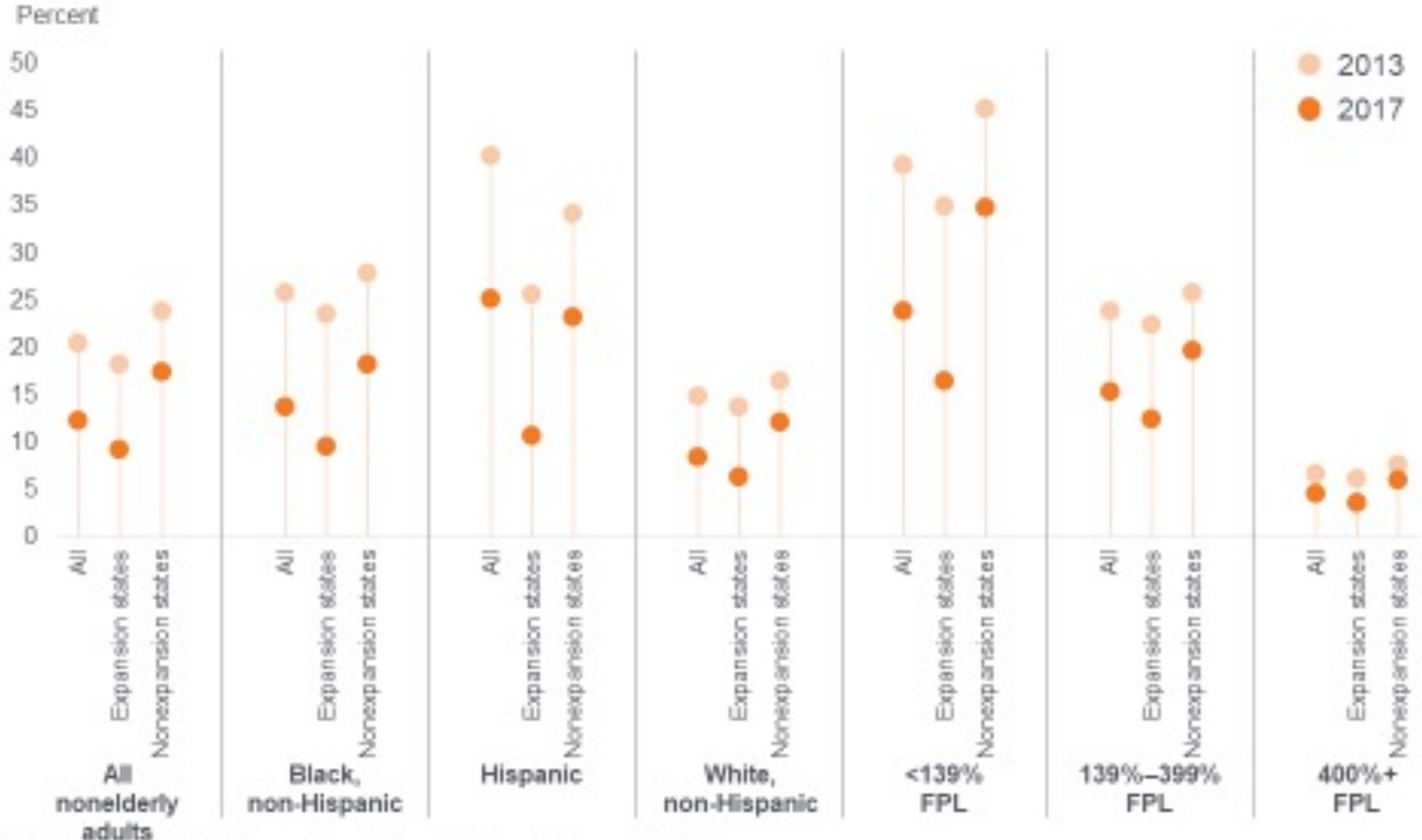
Trump Repeal Action

- Elimination of cost sharing subsidies
- Elimination of individual mandate enforcement
- Reduction in advertising
- Reduced open enrollment period
- Encourage Cross State Plans
- Planned Parenthood funding prohibition

Biden Reversed Trump

- Reinstated cost sharing subsidies
- Increased advertising
- Expanded open enrollment period
- Prohibited exemptions from essential benefit requirements
- Limited wavers to sidestep the law

More coverage less disparities in expansion states

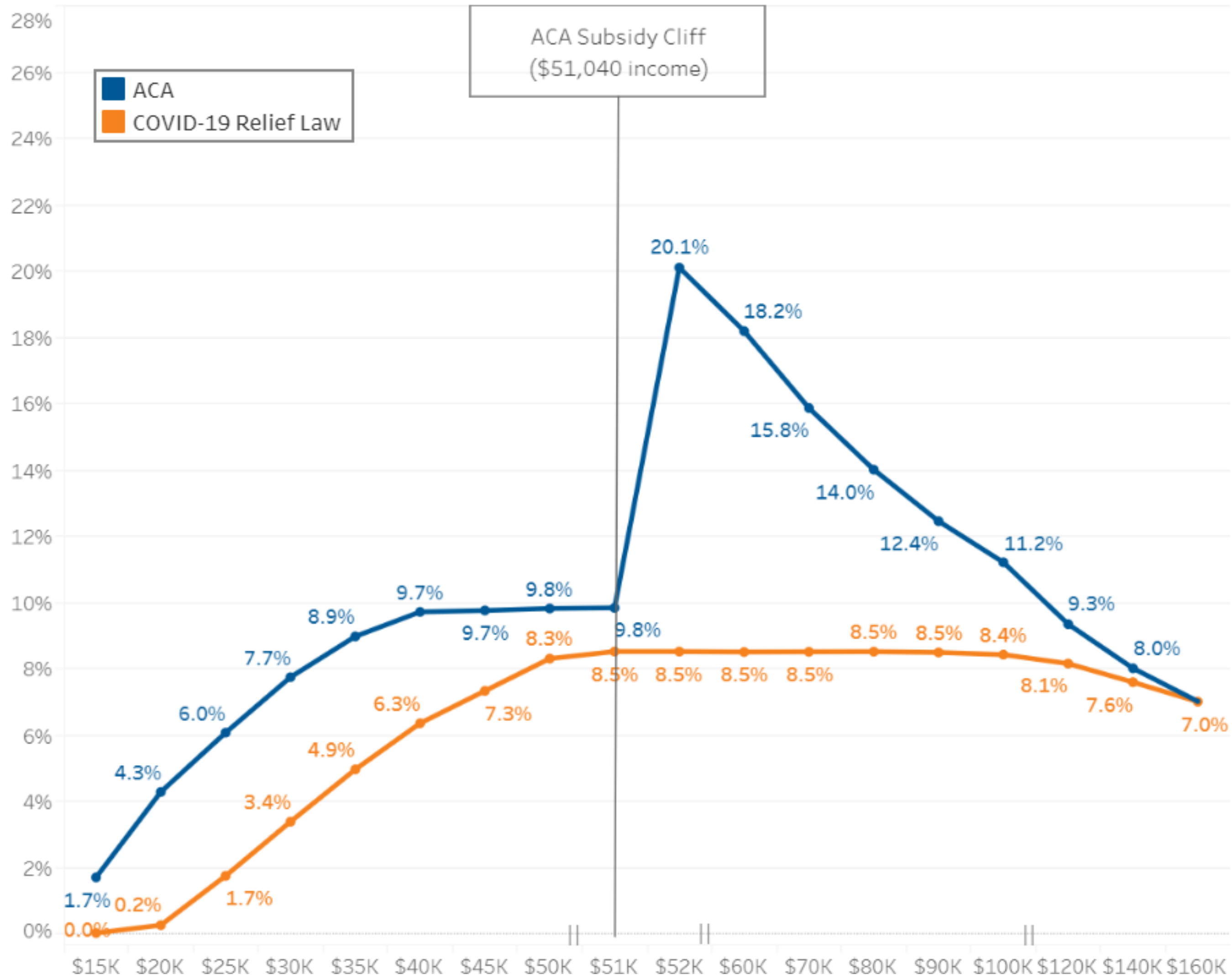


The American Rescue Plan Act of 2021

Key Provisions Designed To Reduce Uninsured, Make Health Insurance More Affordable and Expand Medicaid Coverage

Key Healthcare Provisions of American Rescue Act of 2021

- Increased Subsidies for Individuals Earning Between 100% and 400% of Poverty.
- Those Earning Between 100-150% of Poverty ($12,700-$19,050) Pay No Premium*
- Limited Premiums For Those Earning More Than 400% of Poverty ($51,040) to 8.5% of Income*
- If Individual receives unemployment compensation a portion of income is not counted in determining eligibility for subsidies*.
- Individuals Receiving COBRA coverage Would Receive a Subsidy of 100% of Premiums (April-September 2021)
- No Reduction in Cost-Sharing for Market-Based Health Plan
- States That Have Not Yet Agreed to ACA Medicaid Coverage Would Get Added Subsidies for Basic Medicaid Spending If Expand Medicaid Coverage Under ACA Rules (Added 5% to Existing Matching Rate for 2 Yrs. After Expansion)



ACA Subsidy Cliff
($51,040 income)
ACA
COVID-19 Relief Law
28%
26%
24%
22%
20%
18%
16%
14%
12%
10%
8%
6%
4%
2%
0%
20.1%
18.2%
15.8%
14.0%
12.4%
11.2%
9.3%
8.0%
9.8%
9.8%
9.7%
9.7%
8.9%
7.7%
6.0%
4.3%
1.7%
0.2%
0.0%
1.7%
3.4%
4.9%
6.3%
7.3%
8.3%
8.5%
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8.5%
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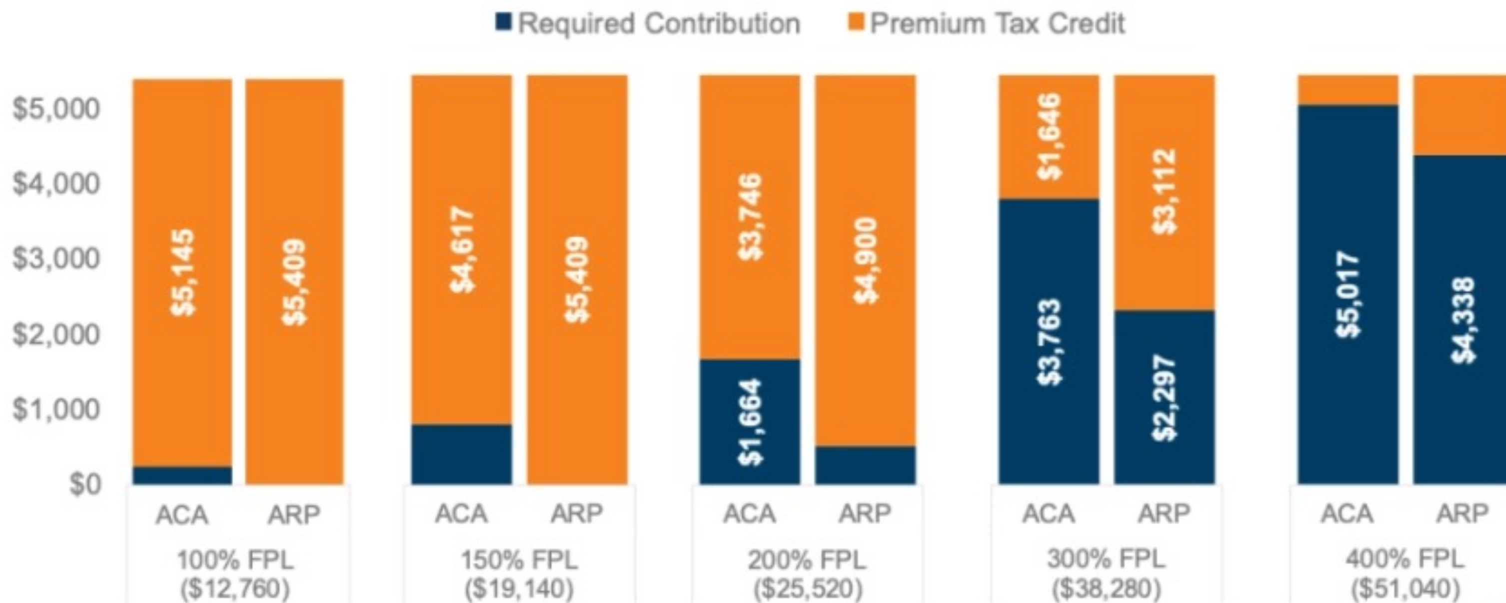
8.4%
8.1%
7.6%
7.0%
$15K
$20K
$25K
$30K
$35K
$40K
$45K
$50K
$51K
$52K
$60K
$70K
$80K
$90K
$100K
$120K
$140K
$160K

It Matters

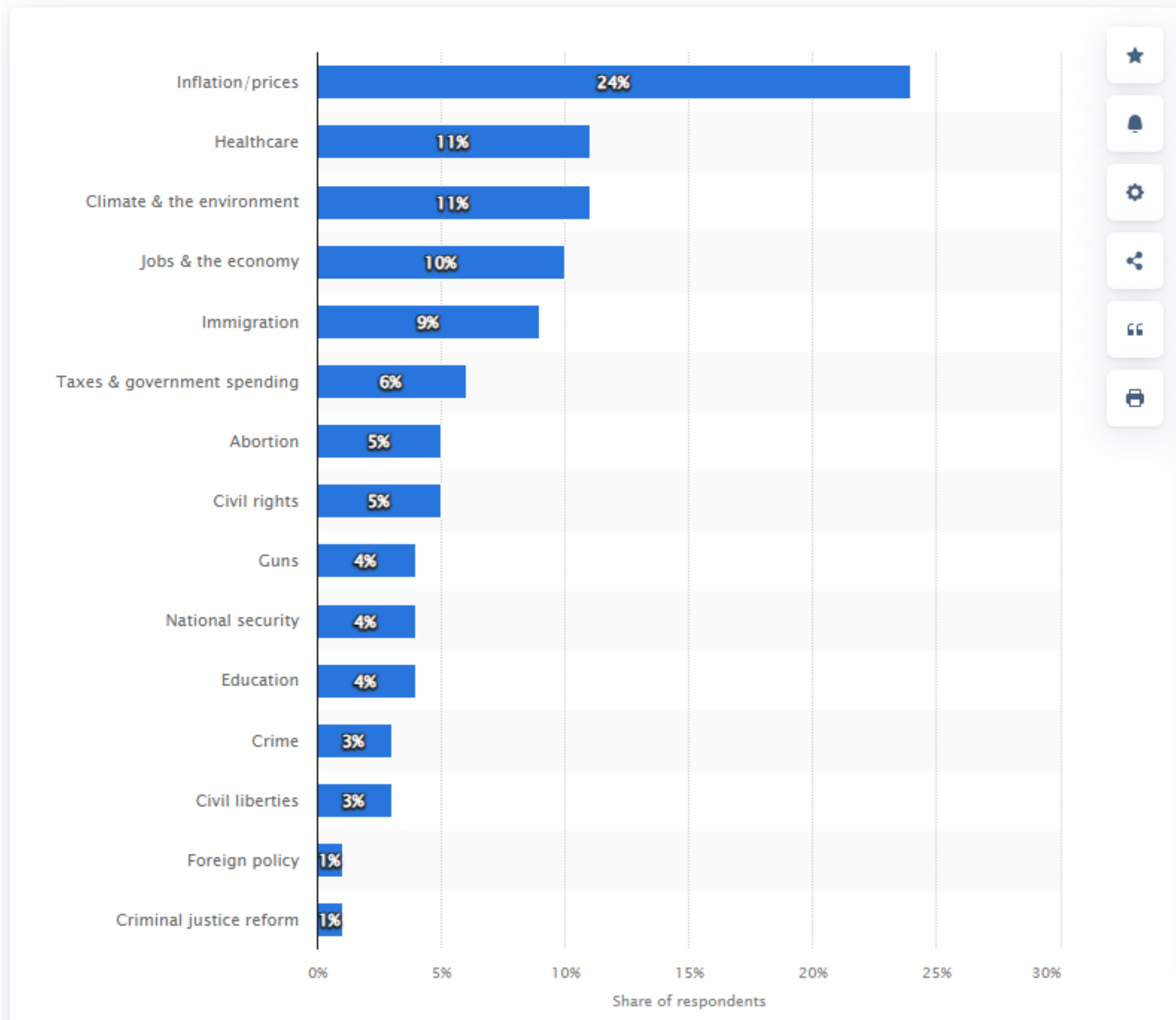


Recovery Act Could Lower Uninsured by 3 to 5 Million

Reductions of Uninsured Could Be Even Higher If Most Non-Expansion States Decide to Expand

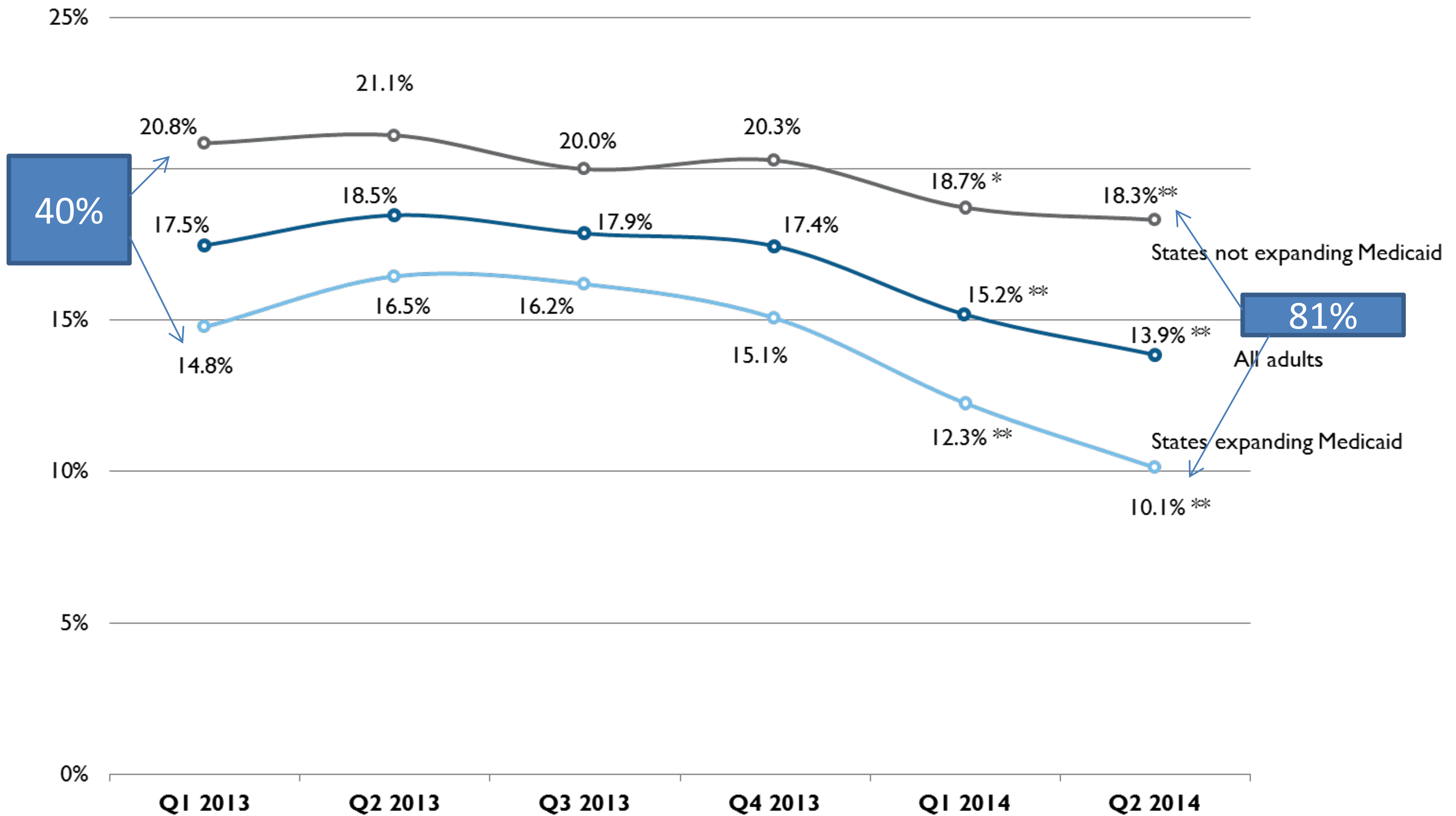
The American Rescue Plan Premium Subsidies Were Extended by the Inflation Reduction Act Through 2025

Most important issue for voters in the United States in 2023



The Affordable Care Act Substantially Reduced The Number and Percentage of Americans Without Health Insurance

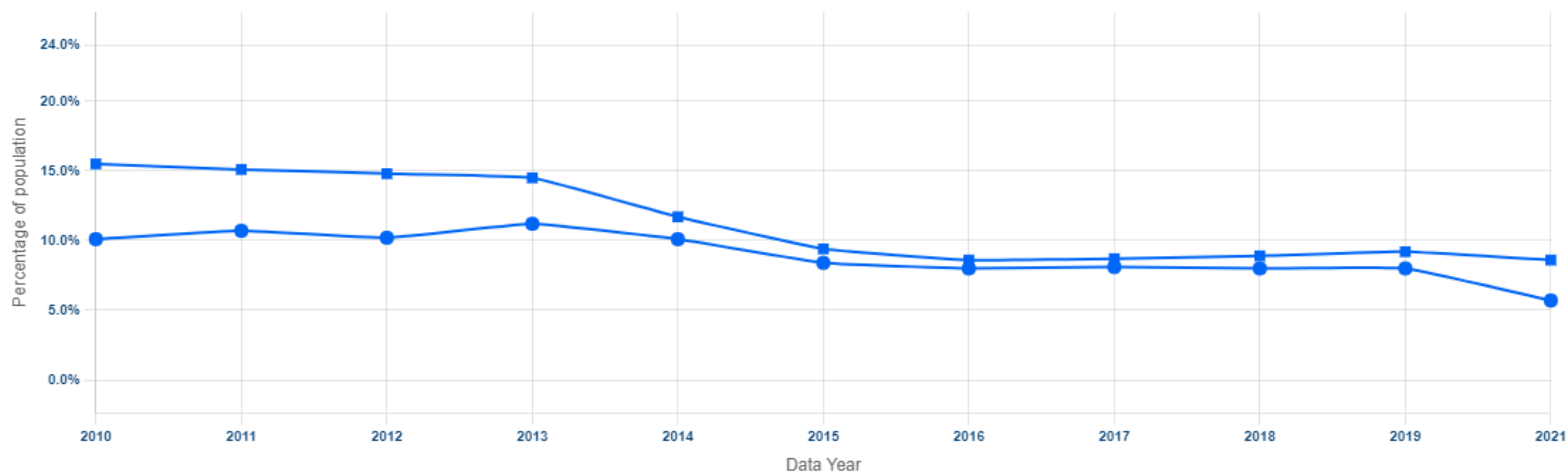
Trends in Uninsurance for Nonelderly Adults from Q1 2013 to Q2 2014



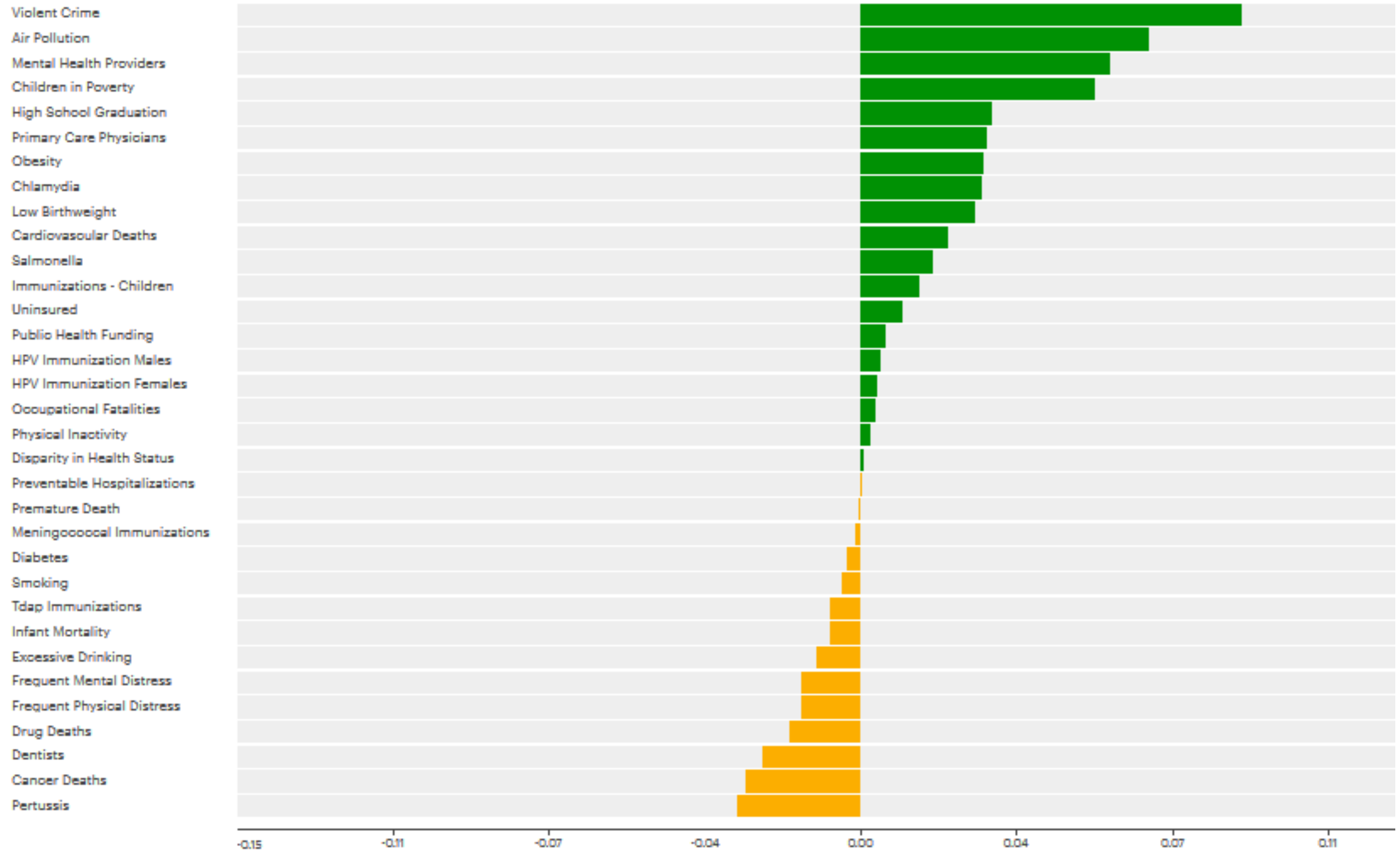
Source: Health Reform Monitoring Survey, quarter 1 2013 through quarter 2 2014.
Note: Estimates are regression adjusted.
*/** Estimate differs significantly from quarter 3 2013 at the .05/.01 level, using two-tailed tests.

Uninsured Trends

Percentage of population not covered by private or public health insurance



Maine 5.7% uninsured U.S. 8.6%



https://www.americashealthrankings.org/explore/annual/measure/HealthInsurance/state/ME

Maine

OVERALL RANK: 12

STRENGTHS

- Low racial disparity in premature death rates
- High prevalence of having a dedicated health care provider
- Low levels of air pollution

CHALLENGES

- High prevalence of multiple chronic conditions
- High Black/white residential segregation
- High prevalence of physical inactivity

HIGHLIGHTS

- Food insecurity decreased 42% from 16.4% to 9.5% of households between 2014-2016 and 2019-2021.
- Uninsured decreased 29% from 8.0% to 5.7% of the population between 2019 and 2021.
- Frequent mental distress increased 21% from 12.6% to 15.2% of adults between 2020 and 2021.

https://www.americashealthrankings.org/explore/annual/measure/HealthInsurance/state/ME

Since Passage of The Affordable Care Act (ACA or Obamacare) Number and Percentage of Americans Without Health Insurance Has Fallen and Coverage Under Medicaid Increases

Medicare

In 1965 Federal Government Pass Major Health Legislation Creating Medicare Part A, Medicare Part B and Medicaid

Structure of Medicare Program

1965

- Part A: Hospital Care, Nursing Home, Home Health, Renal (Paid from Trust Fund)
- Part B: Out Patient Care and Labs (Premium and General Revenues)

Beginning In 1980's

- Part C: Medicare Advantage—Includes Benefits of A&B; (Paid from Trust Fund and General Revenues plus Premium)

2003

- Part D: Prescription Drugs—(Paid from General Revenues and Premiums)

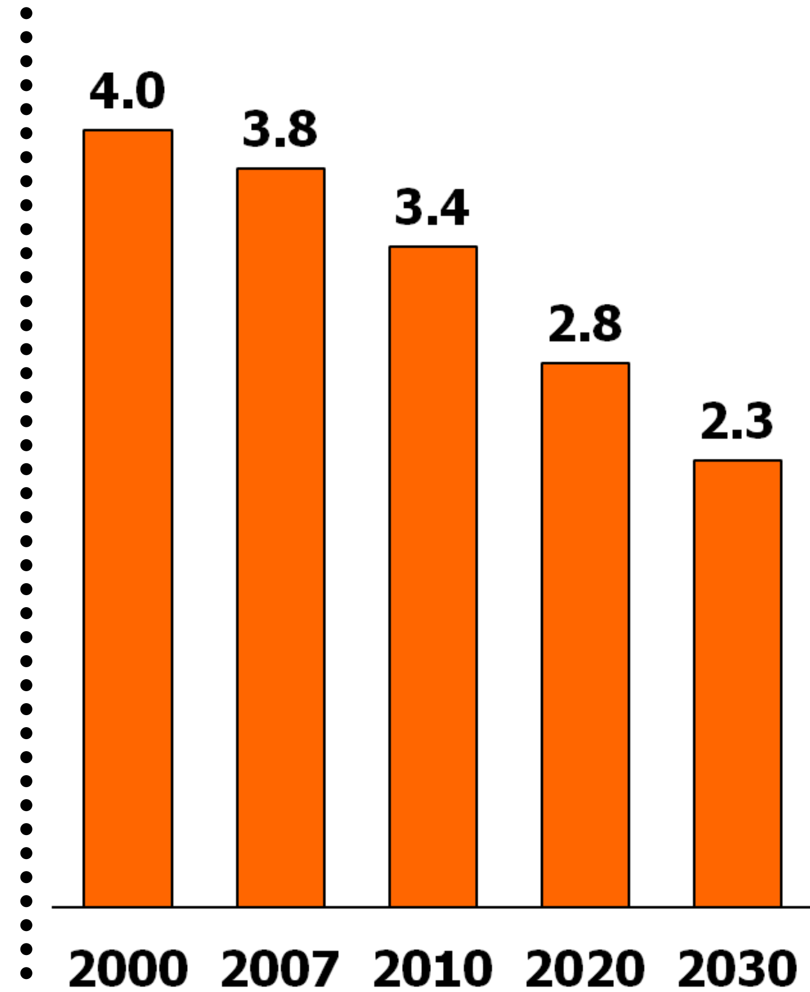
Medicare Part A: Trust Fund Financing

1. Current Working Generation Pay Into a Trust Fund to Pay for Healthcare Services of Previous Generation
    - Tax Rate of **2.9%** of wages (Individuals With Incomes over $200,000 and Families Over $250,000 pay **3.8%**
2. Important to Have Many More Workers than Retirees (see next slide)

Historical and Projected Number of Medicare Beneficiaries and Number of Workers Per Beneficiary

Number of Beneficiaries (in millions)

1966	1970	1990	2000	2010	2020	2030
19	20	34	40	47	64	80



SOURCE: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Structure of Medicare Program

- Part A (Hospital Insurance Program)
  - Designed to cover hospital and related institutional acute care services
  - All individuals automatically eligible if paid into Medicare trust fund for ten or more years (40 quarters) and have reached age 65, plus limited number of disabled and people with end-stage renal disease
  - Administered by federal government through private intermediaries
  - **For Hospital Care:** patient pays one day deductible and 1/8 day coinsurance 61-90 days; lifetime reserve of 60 days (1/4 day coinsurance)

Structure of Medicare Program

- Part A (Continued)
  - **For Skilled Nursing Facility:** only for post-hospital skilled nursing and rehabilitation services
  - Within 30 days of a hospital stay of at least three days
  - No coinsurance 1-20 days; 21-100 days, $99 per day coinsurance
  - **For Home Health Care**: 100 days under Part A with no coinsurance
  - **For Hospice Care**: Terminally ill patients with prognosis of six months or less to live

Structure of Medicare Program

- **Part B (Supplementary Medical Insurance)**
  - Pays for physician and other medical services
  - Financed by a 25% beneficiary premium and annual federal appropriations for the rest
    - Individuals With incomes of $200,000 and families with incomes of $250,000 pay higher proportion
  - Patients pay $100 annual deductible and 20% coinsurance
  - Some physicians (that do not take assignment) may charge up to an additional 15% of approved rate paid by beneficiary or Medigap policy

Medicare Advantage **(Part C)**

- Alternative to receiving benefits under Parts A, B and D from Gov't
  - Receive benefits from Pvt. Ins. with Gov't paying plans at capitated rate
  - Payments to Pvt. Ins. plans vary by region (county) and by the expected medical use of beneficiary
    - Age
    - Whether in institution
    - Index of How Sick Beneficiary Is

The Medicare Prescription Drug Plan **(Part D)**

- Initial Coverage of Prescription Drugs
  - $420 Premium/$250 Deductible
  - 25% Coinsurance $250-$2200
  - No coverage $2201-$5100
  - Individuals with income above $80,000 pay higher premium for Part D coverage; those below $12,123 pay no premium
  - Create a senior Medicare drug discount card
  - Coverage **must** be sold by private insurance companies or HMOs (unless none available in area)
  - Govt. **Cannot Regulate Pres. Drug Prices** or Re-import Drugs From Other Countries

Medicare is a lot more expensive and complicated that you thought!

"…premiums for Medicare Part B (which covers doctors' visits) for 2022 would rise 14.5 percent, one of the biggest jumps in the program's history. That will take the standard monthly premium to $170.10 from $148.50."

https://www.nytimes.com/2021/11/19/business/inflation-retirement-savings.html

What does this analysis mean for contemporary policy?

- Medicare for all
- Public Option
- Expanded subsidies
- Cost control
- Prescription drug cost control
- Medicare trust fund insolvency
- Surprise billing

Take away

- Complex non system health care system
- Bias towards incremental change
- Change is possible
- Engagement is essential
- State actions can have outsized influence
- Elections matter

What can you do?

- Work through associations
- Engage with elected officials
- Write op eds or letters to the editor
- Testify before the Maine state legislature
- Elected officials should know your name
- Contribute to campaigns
- Run for public office

What's Next? Session 3 – January 25 – 27, 2024

Content Overview: Conflict Resolution & Negotiation, Navigating Power & Politics in Health Care

Heller Faculty: Joel Cutcher-Gershenfeld

DANIEL HANLEY CENTER for HEALTH LEADERSHIP