Putting A Face on Health Care  by Kathleen Randall

The stories below put human faces to some of the issues being evaluated in health care today. They represent only a few of the problems with our health care delivery system, but across the state and throughout the nation such problems reverberate with millions of people. Over 47 million people in the country are without health insurance, and it is estimated that another 60 million are underinsured. These numbers will only continue to climb as unemployment grows.

Janice T.

Janice was on Social Security Disability and receiving Medicare. When she was able to return to work, she lost her Medicare, but her job provided health insurance. However, she decided to apply to the state Basic Health program because of her low wages and uncertain employment. By the time she was accepted by Basic Health, she had already left her job and had been without coverage for a number of months. Because her Basic Health Plan did not cover pre-existing conditions for the first six months, Janice had to pay for her own medication to stabilize her condition. Fortunately, she had some savings. When she first enrolled in the Basic Health Plan, it did not require copays or cost shares. Within one year that changed.

Janice had a condition of esotropia or “crossed eye,” complicated by degenerating vision, during this time and was able to have eye surgery that corrected both problems. She had recently had an ankle injury for which physical therapy was recommended, but Basic Health only pays for this when it is post-surgical. The PT assessment cost was $200-$250 and the treatments would be $120 each. She is currently on one medication for which she pays $30 for a 3-months supply. Without coverage her cost would be $450.

Approximately 40,000 Basic Health Plan recipients are in jeopardy of being cut due to our current budget constraints.

Denise T.

Denise had a failed knee replacement back in Denver, Colorado in 2005, which left her disabled and in a great deal of pain. The failure of her knee to heal and its degenerating situation keeps her on General Assistance Unemployable (GA-U). She has tried to go back to work on more than one occasion, but was told she couldn’t take the pain management medication while she was working. Because she was in so much pain, she was unable to continue to work, so was forced to leave that employment and apply for Social Security Disability. Right now, GA-U provides her only income ($339 per month) and benefits other than Food Stamps and subsidized housing. Once she is able to get on Social Security Disability she still has to wait another two years to be able to qualify for Medicare.

GA-U is a program that is in jeopardy of being cut in our state due to budget constraints.

The economy is forcing us to address changes in health care today. We can do better than this. How shall we begin?

ANNUAL MEETING

Thursday, May 21, 2009

$12 Dinner & Registration fee
5:00 P.M. - Registration begins
5:30 P.M. - Call to order
9:00 P.M. - Adjournment

Watch the mail for your Annual Meeting Workbook

INSIDE

Help Wanted/Voter Service Meetings...........................................7
Annual Meeting Information.................................................9
Call to Convention...............................................................11
May Program: Health Care Reform.........................................18
Contents

President's Message .......................................................... 3
Calendar ................................................................................. 4
April Board Briefs ............................................................... 5
Announcements/League News
  Committee Meetings ....................................................... 6
  Help Wanted..................................................................... 7
  Voter Services Meetings............................................... 7
  How To View Forums ................................................... 7
  LWVS to Cosponsor UW Student Forum ................. 7
  Time For Spring Cleaning! ............................................ 8
  Law Day/Civics Ed Forum in Olympia .................... 8
  Mother’s March for Health Care ............................. 8
  Join Us On Facebook!...................................................... 8
  North Central Unit Fundraiser .................................... 8
  Annual Meeting ........................................................... 9
  Education Meeting on Early Learning .................. 9
  LWVWA Good in Gov’t Awards Gala ..................... 10
  A Model for Peace in the Middle East ................. 11
  Call to State Convention ........................................... 11
  LWVUS Arms Control Task Force Recruiting ........ 11

Community News
  Seattle School Board Pres. Talks to League ....... 12
  3/19 King Conservation District Election ...... 12

Action & Advocacy
  Election Verification Network Conference ... 13

National Beat
  Fair Elections Now Act.............................................. 14
  What’s Been Happening in ICE? ....................... 14

Membership
  Membership Report ............................................... 15
  In Memory - Ray Downs ........................................ 15

Features
  Book Review ............................................................. 16
  Editor’s Page ............................................................. 17

Program: Health Care Reform
  Discussion Questions .............................................. 18
  Building a Better Health Care System .............. 19
  LWVUS Quick Facts on Health Care ................ 42
  LWVUS At-Risk Americans .................................. 43

Unit Meetings ............................................................ 44

Board and Committee Contacts ......................... 45

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Seattle, WA 98105
(206) 622-8961
lwvwa@lwvwa.org
www.lwvwa.org

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  User name: lwvwa
  Password: voter

League of Women Voters of the United States
(202) 429-1965
lwv@lwv.org
www.lwv.org

Postal Regulations
The Seattle Voter is published monthly except June and August.

Published periodicals postage paid at Seattle, WA.

Postmaster:
Send address changes to Seattle Voter:
1620 18th Ave, Suite 101
Seattle, WA 98122
Seattle Voter (USPS 052210)
President’s Message

The sun was shining this morning and the daffodils and camellias were beginning to bloom as I carpooled to the League office. I think we have finally reached the end of this trying winter. I also realize that I have reached the end of my term as president of the Seattle League. It has been a very busy time in my life – challenging, rewarding and exhausting – yet it has still been an incredible honor and privilege to serve as president of the Seattle League. We have accomplished many things in the last two years, survived and thrived with a record-setting election season, taken action on important issues and avoided technical disasters with our website and computer system, through a little luck and the technical skill of our technology chair, Karen Lahey.

It seems fitting to me that the last month of my tenure as president will focus on two issues I have worked on for decades, water quality and health care reform. On April 23 the Seattle League will cosponsor a forum at the University of Washington on reclaimed water. The idea of reaching out to students with information on civic engagement came from the League, but the forum was planned and organized by two University students as a senior project, with a little guidance from the League and King County Wastewater Treatment Division. This is an opportunity to bring our successful monthly forum model to a new audience. It is also a chance to venture into new means of outreach by using Facebook to send notice of this forum to students. From my perspective, this is also a great opportunity to introduce the League process and our understanding of civic engagement to a new generation.

Our final forum of the 2008-2009 year will be an update of Health Care Reform. This forum will offer both a national and local perspective on the evolving health care debate. As a child of the 60s I well remember the chant of “health care is a right not a privilege,” and our current debates are not that different, although the cost barrier has escalated beyond our expectations. I encourage you to read the unit material, which includes a 2004 report from the National Coalition on Health Care. The League of Women Voters of the United State (LWVUS) is a member of the coalition and distributed the report at its 2008 convention. The committee planning our forum felt that this report was a good health care reform primer; we have included more recent LWVUS articles to bring it up to date. You will find more information on health care costs and other health issues on the LWVUS website, lwv.org.

It has been a good year; it has been a good term. Thank you for your help and support. It was a pleasure meeting those of you I did not know before and serving as your president. I will leave you in good hands.

Mission Statement
The League of Women Voters of Seattle, a nonpartisan political organization, encourages informed and active participation in government, works to increase understanding of major public policy issues and influences public policy through education and advocacy.
### May

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League Summer Schedule

Summer is a time of transition at the League of Women Voters of Seattle (LWVS). In June, the new board elected at the Annual Meeting in May takes office; the board holds a retreat in July in preparation for the coming year. Most committees take a break in the summer, as do units; meetings resume in September. The last regular Thursday night forum of the LWVS year is presented in May. Even the Voter takes a break; the next issue will be the *Summer Voter*, which comes out in late July. Nevertheless, there are LWVS members who are more active than ever during the summer. If you would like to join them, check the opportunities listed on page seven. In addition, the LWVS office will remain open during the summer months.

April Board Briefs  By Karen Adair, Secretary

*(The Board of Directors of the League of Women Voters of Seattle met on Saturday morning, April 4. This is a brief summary of its work.)*

Membership: LWVS currently has 822 members.

Strategic Planning: The Board accepted the vision statement, priorities, goals and objectives outlined in the plan presented by the strategic planning committee. The new Board, which takes office in June, will refine the plan and decide how and when to accomplish the goals and objectives.

Program: The Board approved the proposed positions of the Water Drainage Study Committee, which will be presented at May’s annual meeting. After reviewing the results of January’s unit program planning responses, the Board decided not to recommend any studies for 2009-2010, but will encourage individuals who wish to organize and present non-recommended studies at the annual meeting.

Annual Meeting: The Board reviewed plans for the annual meeting to be held on May 21. Treasurer Allison Feher presented a proposed budget for the fiscal year 2009-2010. The Board raised the ticket price from $10.00 to $12.00 to cover cost increases for materials and food.

Nominating Committee: Joan Thomas, chair, reported on the committee’s progress in completing a slate of officers and directors to present to the annual meeting in May.

Voter Service: The League will hold an August Primary Election Forum. We will support candidate forums held by units throughout our area. Volunteers are needed for upcoming voter registration and election oversight efforts.

Action: Jayne Freitag-Koontz reported on state action in Olympia and encouraged Board members to read LWVWA Action Alerts. The Social Justice Committee is collecting signatures for Seattle Initiative 100.

Outreach: Maria Brusher reported on many upcoming events and asked members to alert her about any events or groups with which the League should collaborate.

Fundraising: The Ed Fund has sent out invitations for the Spring Fling that will be held on April 26.

State Convention: LWVS has 34 delegate slots at the upcoming State Convention in May. Members who would like to attend should email President Denise Smith or Treasurer Allison Feher.
Committee Meetings

**INTERNATIONAL RELATIONS COMMITTEE**
**DATE:** MONDAY, MAY 4
**MONDAY, JUNE 1**
**TIME:** 12:45–2:45 P.M.
**PLACE:** LEAGUE OFFICE

We will be meeting on the first Mondays in May and June. The May meeting will feature a video on Women in the Developing World; in June we will have a speaker on Mideast negotiations. Anyone interested in participating is welcome; for more information email Ellen Berg (ellenberg@msn.com) or Peggy Saari (peggysaari@comcast.net).

**SOCIAL JUSTICE COMMITTEE**
**DATE:** TUESDAY, MAY 12
**TIME:** 5:30–7:00 P.M.
**PLACE:** LEAGUE OFFICE

**CIVICS EDUCATION COMMITTEE**
**DATE:** THURSDAY, MAY 14
**TIME:** 4:30–6:00 P.M.
**PLACE:** MOSAIC COFFEE HOUSE, 4401 2ND AVE. NE

**TRANSPORTATION COMMITTEE**
**DATE:** TUESDAY, MAY 19
**TIME:** 10:00 A.M. – 12:30 P.M.
**PLACE:** LEAGUE OFFICE

**LAND USE COMMITTEE**
**DATE:** THURSDAY, MAY 28
**TIME:** 12:30–2:30 P.M.
**PLACE:** PARK SHORE BUILDING, 1630 43RD AVE. E (IN MADISON PARK)

NOTE: Please call chair Karen Kane ((206) 329-4848) to confirm the April 30 meeting on Port of Seattle issues; there may be a schedule change. Everyone is welcome to attend Land Use Committee meetings.

Recently, Seattle Mayor Greg Nickels issued a new zoning proposal for City Council and the public’s consideration. The purpose of this Multifamily Code (MFC) Update is to review and revise the design/construction rules that apply to everything from townhouses to condominium towers. The last time this code was thoroughly reviewed was in the 1980s, prior to the creation of our city’s numerous neighborhood plans and Seattle’s Comprehensive Plan.

City Councilmember Sally Clark, chair of the Planning, Land Use and Neighborhoods Committee (PLUNC), has already begun holding public discussions on this new 227-page proposal. According to her latest PLUNC update (available online or through her office), Councilmember Clark is still trying to decide how best to break down this long and technical MFC Update so that its various sections are as accessible and easy to comprehend as possible for the public at large. Over the coming months, her committee wants a broad spectrum of Seattleites to provide meaningful feedback on such questions as: Does this proposal provide enough protection so that new building designs sustain a particular neighborhood’s character? Do proposed changes go far enough to cure current design “ills” (e.g. the oversized, cookie-cutter townhouse developments of past years)? Is there enough accountability to ensure the Department of Planning and Development is responsive to neighborhood concerns?

The Land Use Committee will be following the progress of this proposal over the next year (it undoubtedly will take awhile to go through the public process!), and there will be future opportunities for the LWVS to weigh in on various policy points as the City Council nears a vote(s) on Multifamily Code revisions.
Announcements/League News

HELP WANTED
These are some of the many ways to become involved with the League of Women Voters of Seattle (LWVS).

Voter Registration
The many community events held in the summer provide excellent opportunities to register voters. We need people willing to staff tables at area farmers’ markets and street fairs, as well as festivals such as Hempfest, Juneteenth, Folklife and Bumbershoot. Please call Lindsay at (206) 329-4848 for information about dates, times and training.

Elections Monitoring
The League of Women Voters of Seattle gets many requests to monitor elections for local groups. In order to provide this important community service, we need a list of potential volunteers. This is a good opportunity for those who would rather donate a few hours as their schedules permit than take on a regular commitment. Please contact the League Office at (206) 329-4848 or email Lindsay@seattlelwv.org for more information.

King County Television televises most of the monthly forums presented by the League of Women Voters of Seattle (LWVS); go to www.kingcounty.gov/KCTV.aspx for information. On the left there is a link to the television schedule, which is updated daily. Forums are replayed at specific times during the week and may be viewed on cable channel 22 or online. Some of the recent LWVS forums are also available in the archive and can be watched online. Just click on the “Original Programming” link, then on “Public Forums.”

SEATTLE LEAGUE TO COSPONSOR UW STUDENT FORUM
Date: Thursday, April 23
Time: 4:00–7:00 p.m.
Place: University of Washington HUB, ABC Room

The Seattle League is pleased to team with King County Wastewater Treatment Division and two students in the Community, Environment, and Planning program for undergraduates at the University of Washington to present an educational forum on reclaimed water. The panel presentation, modeled after League monthly forums, was planned and executed by UW students. It will introduce students to the issues surrounding reclaimed water and the King County Reclaimed Water Comprehensive Plan. The League will have a table with information on becoming involved in the county and state process. We encourage you to tell students, friends and relatives at the university about this upcoming event.

If you would like more information about the KC Reclaimed Water Comprehensive plan, go to: www.kingcounty.gov/environment/wastewater/ReclaimedWater.aspx.

**Time for Spring Cleaning!**

It appears that spring has finally arrived and some of you may be taking this time to throw open the windows and clean up from our long winter hibernation. Thanks to John Roberts, former Chair of the Natural Resources Committee, the League has a Hoover vacuum cleaner to be rented out by members and friends to get the deep dust out of carpets. The vacuum is the “Wind tunnel” vacuum with very powerful suction. The vacuum has a red/green light system. When the light shows red, there is still deep dust in the carpet. Keep vacuuming! When the light shows green, the deep dust is out of the carpet. Go on to another area of the carpet and keep vacuuming!

To rent the vacuum, call the League office at (206) 329-4848 to schedule a date. Renters will be asked to provide some identification (such as showing a driver’s license). Cost of rental is five dollars a day, which can be paid when the vacuum is returned. We also will be selling protective face masks at cost. The vacuum cleaner will be sent out with two extra bags, the Hoover instruction booklet, and a one-page instruction sheet from the League. Take advantage of the opportunity to make your home and the League a little “greener”!

**Celebrate Law Day at Civics Education Forum in Olympia**

The League of Women Voters of Washington (LWVWA) is one of many cosponsors of a Civics Education Forum to be presented at the State Capitol on the afternoon of May 1, Law Day. Anyone interested in Civics education in K-12 schools is encouraged to attend. If you plan to attend the best practices showcase or the panel discussion, you are requested to RSVP to Kelly Martin at Kelly.Martin@k12.wa.us.

*Senate Hearing Room 1, Cherberg Building (RSVP)*
1:00 p.m. Showcase of best practices from across the state
2:00 p.m. Panel discussion

*Columbia Room, Legislative Building*
3:00 p.m. Informal Discussion and reception

**Mother’s March For Health Care**

Date: May 30
Time: 12:30
Place: Pratt Park, Central District, Seattle

The League of Women Voters of Washington, as a member of the Healthy Washington Coalition, is among the more than forty organizations that have endorsed the May 30 Mother’s March for Health Care. The march is part of a grassroots national movement for health care reform. For more information, go to www.may30march.org/.

**Join Us On Facebook!**

The League of Women Voters national Ed Fund is now on the social networking site, Facebook—and we need your help to get the word out! If you or friends, loved ones or coworkers already have pages on Facebook, ask them to join our cause at http://apps.facebook.com/causes/view_cause/43588. Not on Facebook yet? Just go to www.facebook.com and follow the simple instructions. Once you’ve confirmed your registration, jump to the League page at http://apps.facebook.com/causes/view_cause/43588. And stay tuned for the forthcoming local LWV Seattle Facebook page!

**North Central Unit Fundraiser**

Date: Saturday, June 6
Time: 9:00 a.m. – 3:00 p.m.
Place: 5025 36th Ave. N.E., Seattle

For its unit fundraiser, the North Central Unit will be holding a yard sale at the home of unit leader Jan Orlando. It will be advertised in the local papers. We would like donations (with the exception of adult clothing) from any one in the League. Donations can be dropped off at the League office or at Jan’s home. It is also possible that items could be picked up. Donations must be received by June 4. If people have questions, want to donate or help, please call Jan at (206) 329-4848.
**Annual Meeting – Thursday, May 21, 2009**

While much of the daily work of the League of Women Voters of Seattle is performed by members of committees or the Board or by a small cadre of other volunteers, every member has a responsibility—every year—to shape the future of League. We are a grassroots organization; members decide what issues we will focus on and what actions we take. Your attendance at the annual meeting is vital to the health of our organization. Please attend. Five percent of the membership is the required quorum, but attendance at the highest level possible helps to forge a League that speaks for all of us.

On the Agenda
5:00 p.m. Registration begins
5:30 Call to order
   - Adoption of new studies and positions
   - Election of new officers and directors
   - Approval of budget for 2009-2010
6:30 Buffet dinner
   - Civics Trivia Contest
   - Carrie Chapman Catt Award
   - 50–year Member Recognition
   - Direction to the Board
   - Education Fund Annual Meeting

Location: Seattle First Baptist Church
1111 Harvard Avenue
Seattle, WA 98122
(Harvard and Seneca on First Hill)

Cost: $12 at the door covers the cost of registration and buffet dinner.

RSVP: Respond to the League office by Tuesday, May 19. Call (206) 329-4848 or email lindsay@seattlelwv.org. This is important because we need to know how many dinners to provide; we cannot guarantee you a dinner if you do not let us know you will be coming.

**Education Meeting on Early Learning**

Date: Friday, June 5
Time: 12:00–1:30 p.m.
Place: League Office

While we heard about state funding for early learning programs in April, in June we will hear about what's happening on the ground. Nina Auerbach, the Executive Director of Thrive by Five, will give us an update on all the activities that the organization supports, including the White Center Early Learning Initiative. Nina has spoken to us in the past as director of Child Care Resources. She is a very informative speaker, so please bring your lunch and join us.

**Diversity Policy**

The League of Women Voters of Seattle (LWVS), in both its values and practices, affirms its beliefs and commitment to diversity and pluralism, which means there shall be no barriers to participation in any activity of the League on the basis of gender, race, creed, age, sexual orientation, national origin or disability.

LWVS recognizes that diverse perspectives are important and necessary for responsible and representative decision-making. LWVS subscribes to the belief that diversity and pluralism are fundamental to the values it upholds and that this inclusiveness enhances the organization’s ability to respond more effectively to changing conditions and needs.

LWVS affirms its commitment to reflecting the diversity of Americans in its membership, board, staff and programs.
Please join the League of Women Voters of Washington

as we present and celebrate

The 2009 Good in Government Awards Gala
Saturday, May 30, 2009, 6:30 - 9:30 PM
Washington State History Museum
1911 Pacific Avenue, Tacoma WA 98402

**THE GOOD IN GOVERNMENT HONOREES**

♫ Senator Rosa Franklin - turning League principles and policies into legislation

♫ The Korean Women’s Association - fostering citizenship and serving the special needs of Asian-Pacific Islander immigrants

♫ The News Tribune - champions of open government and political accountability

♫ “Women’s Votes, Women’s Voices” - In commemoration of the Washington Women’s Suffrage Centennial, this exhibit highlights the historic struggle to secure women’s voting rights in our state.

Dessert and wine reception

6:30 PM  Doors open with the opportunity to tour the exhibit
7:45 PM  Presentation of the Good in Government awards
8:30 PM  Drawing of winners of the LWV Education Fund raffle
9:30 PM  Closing

********************************************************************************************

I am planning to attend the convention as a delegate. I will reserve my place for the Awards Gala through the convention registration process_____ OR: I am reserving NOW at the special delegate-only cost of $20_____.

My guests’ names at the $40 level are:______________

My Name_________________________________________phone____________________
Address___________________________________________________________________

_____ I am sorry I am unable to attend but would like to make a tax-deductible donation to the League’s Education Fund to recognize the honorees and to promote the educational work of the League.

My check is enclosed, payable to LWVWA Education Fund: $_________
Please charge my credit card:   Visa___ MasterCard____#____________________________
Exp. Date________ Name as it appears on card___________________________________

Please return payment to the League of Women Voters of Tacoma-Pierce County, 702 Broadway, Suite 105, Tacoma, WA 98402. See www.lwvwa.org for more information about Convention and Good in Government Awards or call 800-419-2596, 206-622-8961. The League of Women Voters of Washington Education Fund is a 501(c)(3) entity of the IRS Code.
A MODEL FOR PEACE IN THE MIDDLE EAST
BY ELLEN BERG, INTERNATIONAL RELATIONS COMMITTEE CHAIR

The International Relations Committee invites you to a talk on June 1 at 12:45 at the League Office. Our speaker, political scientist Bill Taylor, will talk about the negotiating model which has been used unsuccessfully in past Israeli-Palestinian peace talks, and an alternative model which might, indeed, lead to peace.

Taylor’s proposal is based on the Harvard model of negotiation expounded in *Getting to Yes: Negotiating Agreement Without Giving In*, by Roger Fisher, et al. He gained working knowledge of this model during labor negotiations at the Oakton Community College near Chicago, and believes it could be fruitful in the Mideast context.

Bill Taylor was long affiliated with the Seeds of Peace program, which brings youngsters from Israel and Palestine to the U.S. for a summer camp experience in Maine, where they meet and talk with each other, learn tolerance and hone leadership skills. Now he is affiliated with a similar exchange program in Chicago: Hands of Peace. A relatively new Seattleite, Bill teaches about Islam and about the Arab-Israeli conflict at the Lifetime Learning Center.

SEEKING MEMBERS FOR THE LWVUS ARMS CONTROL TASK FORCE

The LWVUS Board of Directors is forming a task force to review the LWVUS position on Arms Control. Board Member Stephanie Johnson is chairing this task force. The task force will be charged with reviewing the position for relevance, usefulness and practical application. LWV members who are interested in this task force and have interest, experience and expertise in the areas of arms control and national security issues are invited to apply to this task force. The application deadline is May 1, 2009.

A detailed description of the work to be done and an application for the task force are available on the LWVUS website, LWV.org. Go to the for members section, and select projects and programs.

CALL TO CONVENTION

The League of Women Voters of Washington (LWVWA) Convention will be held in Tacoma this year from May 29 – 31 at the Hotel Murano. Delegates will be voting on the program, the budget and the leadership of LWVWA for the next two years. There will also be some fun extra events, such as the Good in Government Gala at the Washington State History Museum, where the Washington Women’s Suffrage Centennial Exhibit will be open for viewing, and an opportunity to have lunch in the Hot Shop at the Tacoma Museum of Glass. For more information on the issues to be decided at convention, check the LWVWA website.

The League of Women Voters of Seattle (LWVS) is entitled to send 34 delegates to the convention. The base cost for delegates, which includes hotel, registration and five meals, is $350. LWVS will cover most of the cost; however, since our budget will not cover the full amount, delegates are asked to contribute $50. If you are interested in attending as a delegate, please contact the office. Priority is given to board members, committee chairs, and members with business to bring before the delegates at convention. However, this is a great opportunity for newer members to learn about League and develop leadership skills, so we encourage all who are interested to apply.
Michael DeBell, President of the Seattle School Board, spoke to League members on March 25. He talked on a variety of issues and faced plenty of pointed questions from members in attendance, many of whom are former teachers. Below is a short summary of the key issues:

➢ The Strategic Plan lays out the basis for the work of the Superintendent and the School Board, and Mr. DeBell strongly supports the plan as one that can actually be implemented. The overarching goal of the district is to improve the quality of instruction and to create high performing schools. While desegregation has become a secondary issue, he believes that achieving quality schools and quality education for all students is the ultimate goal of desegregation.

➢ Closing schools was a difficult decision but was based on sound criteria and good rationale. The closures also enabled the School District to reduce overcrowding in the Ravenna and Laurelhurst neighborhoods through the opening of a new K-8 school.

➢ Another issue arising from the Strategic Plan is implementation of a new assessment tool to help teachers assess students and in turn evaluate their own instruction. There are pilot programs in place currently to test the model. This is the beginning of a process to develop quarterly assessments to provide feedback to teachers so that they can evaluate their own instruction and adjust it where necessary.

➢ The state legislature has been looking at new approaches to determining teacher compensation. Most discussed is a system which gets away from seniority or the number of education credits as the basis for compensation. The WEA is opposed to this change, and it appears the issue of teacher evaluation/compensation will not be resolved soon. However, the number of teachers seeking national accreditation has increased significantly over the last few years. The accreditation process is a rigorous one and teachers receive $5000 if they complete the process.

➢ The Budget is the major issue facing the school district right now. The district has reduced costs through school closures, central staff reductions, transportation (by revising bell times), and restructuring of food services. At this time, it is unclear whether federal stimulus money will offset the anticipated reduction in state funding.

➢ The district will be proposing a new assignment plan. A major drawback in making changes is the outdated computer system. The plan will include guaranteed seats for students in their clusters and will define an elementary-middle-high school progression. However, the plan will include choice options. The new plan will be in place for the 2010-11 school year.

What Was That Election On March 19, and Why Didn’t the League Know About It?
by Denise Smith, President

The King Conservation District held their annual board election on March 19 and their executive director reports “the total voter turnout more than doubled the highest turnout numbers in the last five years of King CD elections.” The total number of ballots cast was 2,731. The Seattle League received emails and phone calls about this election, questioning what it was and why we were not providing information to voters. These yearly elections to fill board positions on the all-volunteer five-member board have been held since 1949 and are open to registered voters living within the conservation district boundary.

The King Conservation District is one of 47 conservation districts within Washington State formed after Governor Clarence D. Martin signed legislation creating the Washington State Conservation Commission in 1939. Working with the federal Soil Conservation Service, now known as the National Resources Conservation Service (NRCS), the conservation districts provide education, technical assistance and incentive programs to help private landowners. Their achievements in protecting streams with fencing and native plantings, protecting land from erosion and runoff, improving instream flows, enhancing habitat and promoting conservation practices are noteworthy.

The King Conservation District is funded through a per-parcel assessment fee, the Washington State Conservation Commission and grants from other state and federal programs. Extensive information is available on their website, kingcd.org/index.htm.
According to the district, the March 19 election drew attention because of the increased number of voting centers (13 polling places across the district) and the increased visibility because of voluntary conservation and stewardship efforts. Another factor, and one that generated emails and calls to the League office, was a write-in campaign spread through Facebook and email. The write-in candidate received 43% of the vote, coming in second. From the League perspective this is an important aspect of this election.

Some of our members have voted in this election in past years, and did so this time. Members who are rural residents, master gardeners, land/water stewards or volunteers with King County extension are familiar with King Conservation Districts programs. Residents of rural King County are very familiar with the conservation district. But what should be the League’s role in educating voters about boards and commissions like the Conservation District? This year an election that is barely noticed in urban areas received notoriety because of the write-in campaign. A 60-year-old agency with a long and successful record of accomplishments became the focus of new attention. This is a positive result. However, if the League is to fulfill our mission to encourage informed and active participation and increase understanding of public policy issues, we will have to be more aware of web-based conversations and respond quickly with the unbiased and objective explanation voters have come to expect. We will count on you as League members to let us know about upcoming elections or issues in the cyber community.

Election Verification Network Conference
by Denise Smith, President

Minnesota voters cast three million votes in the 2008 general election. During the recount of the Senatorial campaign by the Minnesota State Canvassing Board there were about 1000 contested ballots and of those only 14 were not able to be resolved. This was one of the many successes from the 2008 election cited by Minnesota Secretary of State Mark Ritchie at the Election Verification Network conference held in Seattle April 2-4. The Seattle League President was one of the 75 invited participants at this year’s conference. Attendees included representatives from the US House of Representatives, the US Election Assistance Commission, civic involvement and voting rights organizations and voting oversight organizations, as well as state and local election administrators, political science and computer science academics, election law specialists and two international representatives. Topics of discussion included the election process, election equipment, and assuring accessible, accurate and verifiable voting. The conference was sponsored by the Quixote Foundation of Seattle, which lists US election integrity— freedom to vote under equitable laws, nondiscriminatory and nonpartisan election administration, and accurate and verifiable vote counts—as a key mission of their organization.

Also in attendance were two members of the League of Women Voters of the United States (LWVUS) Election Audits Task Force, who presented the January 2009 LWV Report on Election Auditing to the group. The report, with its recommended guidelines for election audit and criteria for an election auditing law, is an impressive accomplishment by this task force and one that will assist League members in advocating for reform as well as assist officials responsible for insuring election integrity. The report can be found in the For Members, Projects and Programs section of the LWVUS website (lwv.org). A link to the report appears under Task Forces and Studies on the right side of the page.
Fair Elections Now Act (FENA)
by Jean Carlson, League Member

Campaigning for Congressional electoral seats would be transformed by legislation introduced in both houses of Congress on March 31, 2009. Senators Dick Durbin (D-Ill.) and Arlen Specter (R-Pa.), along with Representatives John Larson (D-Conn.) and Walter Jones (R-N.C.), introduced S 752 and HR 1826, respectively.

These bills would free our elected officials from the campaign money chase and allow them to focus solely on addressing the problems we face as a nation. Under the Act, congressional candidates would run for office using only small contributions and limited Fair Elections funding. Candidates would qualify for these funds by raising a specific number of small contributions from their constituents and agreeing not to accept any large contributions from wealthy interests. Once qualified, candidates would receive a four to one match on their small donations, up to a limit.

Please call Senators Cantwell ((206) 220-6400) and Murray ((206) 553-5545) and your representative in Congress, and urge them to cosponsor the Fair Elections Now Act immediately.

For more information, www.washclean.org has a FairElectionsNowAct link.

What’s Been Happening in ICE?
by Barbara Reid, Co-Chair, Immigration Study Committee

Immigration and Customs Enforcement (ICE) is the Homeland Security agency under which raids into work places and residences are planned and executed. A recent raid took place in Bellingham, WA on February 4, 2009, at Yamato Engine Specialists, where 28 immigrants were arrested and taken to the Tacoma Detention Center. A February, 2009, New York Times article, based on a study by a professor and students at Benjamin N. Cardozo School of Law at Yeshiva University in New York City, gives interesting background information on the changes in targets of ICE raids.

ICE set up fugitive operations teams in 2002 in order to locate and deport immigrants with outstanding deportation orders. In 2003, however, it narrowed the target of raids to those immigrants who had the most serious criminal records in addition to deportation orders. At that time, ICE officials stated that carefully planned raids were focused on locating and bringing in dangerous immigrant fugitives. The agency continued stressing this to Congress through 2006 as the motive for its raids. But by then, the program had changed substantially: the majority of those immigrants arrested had no criminal record, and many did not have deportation orders against them.

The agency modified its rules to drop the requirement that 75 percent or higher of those picked up in raids must have criminal records, and to allow teams to include nonfugitives in their quotas. A directive increased the annual quota to one thousand immigrants for each of 104 teams engaging in raids. At first, “collateral arrests” (those immigrants on the scene who were not targets of the raid, but were undocumented) were not to count toward the quota. Nine months later, however, a new directive allowed these nonfugitive arrests to be included. The result was that in 2007 fugitives with criminal records dropped to an astonishing low of nine percent of the total immigrants picked up during raids.

Janet Napolitano, Homeland Security Secretary in the Obama administration, stated that she had not known about the Bellingham raid before it took place, has called for an investigation into it, and has placed a moratorium on ICE raids. At this writing, all 28 of those detained in the Bellingham raid have reportedly been released. We certainly should applaud these actions.

Both Secretary Napolitano and President Obama have pushed for action to be taken against the employers of undocumented immigrants, rather than against the immigrants themselves. Does one interpret this as a change in direction, or as a patching of our often contradictory immigration policy? It is early in this administration to draw conclusions.

The League of Women Voters adopted new positions on national immigration policy in 2008. The positions call for a path to legalization for undocumented immigrants as well as a moratorium on deportation of those undocumented immigrants without criminal records. Current ICE policy clearly goes against our national positions.
MEMBERSHIP DONORS
A very warm thank you to our members who have contributed to the League of Women Voters of Seattle by making a donation in addition to the payment of their dues or by renewing at a higher level. These are Carol Fuller, Margaret Vance, Dorothy Cyra and Rosealma Smith. Their additional contributions help to support the work of the League, including memberships for others at lower fees. We also thank members Bobbe Bridge, Lee Van Divort and Theline Cramer, who have generously renewed at the contributing level.

OUR NUMBERS
The membership count for the LWVS is currently 823. We have five members who will be acknowledged at the annual meeting for reaching the 50-year mark in commitment to the League of Women Voters!! Be sure to attend the meeting to find out who they are and join in the rousing and well-deserved ovations they will receive.

ONE LAST CHANCE
The final forum of the 2008/2009 year will be held on May 7, and the topic is one of interest to everyone inside and outside of the League: health care reform. Here is “one last chance” for you to invite guests to attend a forum with you this year and find out what the League is up to these days. If you’ve been attending the forums over the last year, you know the valuable education you’ve received on a range of topics. Share the wealth. The summer months will soon be upon us and we will have a brief hiatus. If you can’t attend and/or bring someone in May, think about all of the friends and neighbors you’ll encounter once the sunny days are here again—share the benefits of League and your experiences with them. After summer vacation, come back refreshed and with a new face to introduce to the League.

NEW MEMBER PROFILED
Diana Pritkin was a new face at the March Get to Know League dinner. She is a retired administrative assistant and secretary to an elementary school principal. New to Seattle, Diana received her education at the College of the City of New York in business, and includes public speaking, singing, hiking and swimming among her interests. Before relocating to Seattle, she led a busy life in Norwalk, Connecticut. Her activities included membership in the Democratic ward and service as treasurer and board member for the Norwalk library and golf course. In addition, Diana has been Vice President of the National Council of Jewish Women in Norwalk, Vice President of the South Norwalk Council for the Arts, and a Justice of the Peace!

She is not new to the League of Women Voters and was a member for a short time in Norwalk. She’s been reintroduced to the League by Carol Goldenberg and wants to learn about Seattle and state politics; she would like to help where she can. Welcome, Diana—we can always use your talents and put your willingness to work...to work!

In Memory - Ray Downs
BY CAROL GOlDENBERG

The Seattle League of Women Voters lost a supportive friend and member when Ray Downs died on March 27. He and his wife, Vicky, moved to Seattle in 1999 after living for 40 years in Japan, where Ray served as a teacher and headmaster at The American School in Japan and Vicky was librarian. Since 1997, Ray lived with a brain tumor, but with Vicky’s help he was able to participate in many shared activities and commitments. Ray and Vicky took great pleasure in making their lovely home available to League Events, including the annual Great Decisions discussion groups, Spring Fling, meetings, parties and receptions. Ray was a gracious host, ready with a warm smile. While caring for Ray, Vicky made many special contributions to the League. Her timely monthly book reviews have enriched the Voter. The International Relations and Economics and Taxation Committees have benefited from her participation.

Vicky has inspired us with the grace with which she has sustained a meaningful and dignified life for Ray and managed her many contributions to the League. Our sympathy is with Vicky and her family.
When *The Noonday Demon* won the National Book Award in 2001, I quickly bought and read it. My sister suffered from clinical depression all her life, and I hoped to understand something of the problems she’s had to deal with. I learned a great deal.

Many kinds of sickness can be helped by a combination of accurate diagnosis, appropriate medication and good care. However, unlike patients who suffer from appendicitis or the measles and are likely to receive perfectly adequate care, only “about 6% of the total depressed population” receives adequate treatment. Of that small group, “many will ultimately go off their medications, usually because of side effects,” leaving “between 1 and 2 percent who get really optimal treatment.” This is especially shocking because depression is “…an illness that can usually be well-controlled with relatively inexpensive medication [and few] serious side-effects.”

Here in Seattle a social worker told me that many homeless are alcoholics with mental diseases. According to Solomon “most depressed substance abusers have two linked illnesses running concurrently, each of which requires treatment…” He says the popular idea that we have to get the person off substances before paying attention to the depression is ludicrous. We now know, as Soloman says, if “you are addicted, it doesn’t matter how you got there, you have a disease with a life of its own.” It helps to deal with each of them at the same time, as these two diseases tend to feed on each other. I hope we’ve been doing that in Seattle!

The most memorable section of the book for me has been Solomon’s picture of depression itself. He says it’s like a small leaf rising from a crack in the sidewalk, climbing up one’s foot, ankle and leg and onward irrevocably to the head. There it enters into the brain and quickly takes over. Reading that, I realized as never before how brave and stalwart my sister has been. I can understand her occasional odd behavior better and now have infinitely more compassion for the depressives who are homeless here.

Solomon explains why my sister was able to control her depression starting in the late 60s and 70s. He writes that impressive changes in medication for depressives appeared at about that time. Though the poor and ill-educated have not been able to share adequately in the enormous strides in medical care, Solomon notes what progress has been made.

This book covers a great many aspects of clinical depression, including the personal, political, scientific and historical. It is wonderfully informative and even offers hope for the future. An index makes this a useful resource.

The opinions in this review are personal and do not represent those of the LWV.
A Good Reade
by Beatrice Crane, Voter Editor

If, like me, you like your light reading on the heavy side, a little Victorian melodrama mixed with social criticism, do try Charles Reade. Reade (1814-1884) is best known for The Cloister and the Hearth, which I have to admit that I have not yet read. But some of his lesser-known novels are delightful, not so much for their plots as for their digressions.

Take A Woman-Hater, for instance. About a third of the way into the book, the hero finds a young woman fainting from hunger on a park bench. He persuades her to allow him to give her a meal, and she then tells him her history. She is a recently qualified doctor; she received her degree in France after undergoing difficulties which are detailed in the course of several chapters. Reade rather disarmingly informs the reader that he has not introduced this character just to rant about the need to support female doctors; she is important to the plot. And, in fact, she does have a connection to the main story. But as he often does, Reade lets his secondary theme take over for a good portion of the book, and returns to it at the end, as he puts in a plug for educating and employing women.

In large part because of such digressions, Reade’s novels are artistically lacking. Still, they are good reads. In It Is Never Too Late to Mend, the subject is prison abuses. Reade, as always, has done his homework, and his accounts of the tortures inflicted on prisoners in the name of a scientific system are convincing and gripping. They also have very little to do with the basic plot, just provide diversion and a minor role for the heroine while the hero is off in Australia trying to make enough money to come home and marry her.

Another aspect of Reade’s appeal is his tendency to create strong female characters—or women who reveal their capacities when given the opportunity. In Foul Play, the hero and heroine are wrecked together on a desert island. The heroine is consumptive, and not expected to live. But the hero falls ill, and she has to exert herself to keep them both fed and sheltered. She walks miles a day, she lifts heavy loads, and by the time they are rescued she is strong and healthy.

You may have to go to some effort to find these books, unless you have access to a university library—though Seattle Public Library does have a copy of Foul Play. They can all be downloaded on the internet, or found in secondhand editions. But especially if you enjoy learning about social history by way of fiction, you will find the search worthwhile.

Do you have a book that you would like to recommend to fellow League members?

Send a brief description, with title and author’s name, to votereditor@seattlelwv.org. Recommendations will be printed as space allows.
May Program: Health Care Reform

HEALTH CARE FORUM MAY 7, 2009

DISCUSSION QUESTIONS

1. Do you have health insurance?
2. Do you receive health care through Medicare or another publicly funded system such as public employees benefit program, Veterans Administration, Retired Military or Medicaid?
3. Do you or does someone you know use the following services and are these services covered by insurance?
   - Preventive care
   - Routine health coverage
   - Mental health coverage
   - Alcohol or substance abuse counseling
   - Dental
   - Vision
   - Medical equipment
   - Prescription medication
   - Alternative health care
   - Rehabilitation or physical therapy
4. Are you satisfied with your health insurance?
   A) Have you or has someone you know experienced difficulty paying insurance premiums or deductibles? If so, what did you/they do?
   B) Have you or has someone you know experienced having service denied?
   C) Have you or has someone you know continued employment or obtained a job with a specific employer primarily to keep insurance coverage?
5. Discuss your priorities for a National Health care policy (i.e. universal coverage, employer-based, child coverage, single payer, accessibility, prescription drug and/or alternative treatment coverage).

The League of Women Voters of the United States has a Health Care Education Task Force and Health Care Discussion Group. We encourage you to follow this on www.lwv.org.

We also invite you to join the League of Women Voters of Seattle Health Care Reform Discussion Group which meets at the Seattle League office every other Monday at noon. Call the League office at (206) 329-4848 for more information.
Building a Better Health Care System

SPECIFICATIONS FOR REFORM

A Report from the National Coalition on Health Care

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Former President Jimmy Carter
Former President Gerald R. Ford

CO-CHAIRMEN
The Honorable Paul G. Rogers
The Honorable Robert D. Ray

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Mark A. Goldberg

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Preface

The United States is on the cusp of a major new debate — a necessary debate — about the future of our health care system.

In 1993 and 1994, our nation had such a debate — in Congress, the press, and the polity — about a variety of proposals, from many quarters, for health care reform. Political leaders in both parties agreed that the problems confronting health care then — in particular, rising costs and increasing numbers of Americans without health insurance — constituted a genuine crisis and warranted an urgent policy response. That debate ended without legislative action. The health care system was not reformed, its problems remained unchecked, and the sense of urgency that had animated and permeated the debate dissipated.

The system-wide problems that triggered an intense national debate more than a decade ago are larger now than ever. The growth of these problems has overwhelmed incremental measures meant to alleviate them. If we needed comprehensive health care reform in 1993 and 1994 — and we did — we need it even more today.

The recommendations for comprehensive reform that you are about to read come not from a single organization or interest, not even from one sector of American society. They were developed, in a year of study and deliberations, by the National Coalition on Health Care, which brings together many interests and sectors. The Coalition is an organization of organizations — of nearly one hundred of America’s largest businesses, unions, health care providers, associations of religious congregations, pension and health funds, insurers, and groups representing patients and consumers. Collectively, the Coalition is the nation’s largest and broadest alliance working for the achievement of comprehensive health care reform. Our members represent — as employees, members, or congregants — at least 150 million Americans. They speak for a cross-section — and a majority — of our population.
The organizations that belong to the Coalition are united by their commitment to the pursuit of five principles or goals for a reformed health care system:

- Health Care Coverage for All
- Cost Management
- Improvement of Health Care Quality and Safety
- Equitable Financing
- Simplified Administration.

The Coalition is rigorously non-partisan. Its honorary co-chairmen are former Presidents George H.W. Bush, Jimmy Carter, and Gerald R. Ford. Its co-chairmen are former Iowa Governor Robert D. Ray, a Republican, and former Florida Congressman Paul G. Rogers, a Democrat. Our members believe that an effective response to the crisis in American health care is urgently needed and that it will require leadership from both political parties and a willingness to compromise across ideological, economic, and social divides.

It is in that spirit that we offer a series of interconnected specifications for reform. This brief document does not describe one plan, one potential course of action. Instead, it sets out objectives for reform, criteria by which alternative proposals can be assessed, and options for policymakers and the public to consider. Our hope is that these specifications will help to accelerate and frame a renewed national debate about how to build a better American health care system — and that they will help to embolden political leaders to act soon.

The specifications summarized here are tough, thorough, and ambitious. Our members have set aside their preconceptions and predispositions in order to forge a consensus document. Individual members may have different first preferences on some of the items addressed, but they recognize that for progress to be possible, a compelling national interest — in the assurance of excellent and affordable health care for all Americans, in the creation of a health care system that can serve us all well in the decades to come — has to be given precedence over narrow self-interest. They are unified in believing that these specifications represent a sound and sensible set of concepts and precepts for a public-private partnership to reform American health care.
That these recommendations were developed by such a diverse and large aggregation of powerful organizations — representing such a broad swath of our economy and society — should be heartening to those who had given up on the prospects for policy responses commensurate with the scope of the challenges we face. We should not be resigned to settling for small steps forward — not when the problems of the health care system are growing by leaps and bounds.

We need systemic, and rapid, reform.
Our Ailing Health Care System
THE URGENT NEED FOR COMPREHENSIVE REFORM

The American health care system is bedeviled by three huge and interlocking problems, any one of which would be reason enough for alarm: rapidly escalating costs; a huge and growing number of Americans without any health coverage; and an epidemic of substandard care.

Rapidly Escalating Costs

Health insurance premiums are now rising at high, and accelerating, rates. Not only premiums themselves, but the rate of increase in premiums, has jumped every year since 1998. The increase last year — 13.9 percent — was nearly four times the increase in 1998. To put last year’s premium surge into context: In 1993, when political leaders in both parties declared that the health care system faced a financial crisis because of rising costs, health insurance premiums increased by an average of 8.5 percent.

What makes recent increases in premiums especially striking is that we have been in a period of low inflation. When we consider premiums in real terms — that is, net of increases in the Consumer Price Index — the rate of rise is even steeper. Last year’s real increase of 11.7 percent was more than five times the 2.3 percent real increase in 1998 and more than double the 5.1 percent real increase in 1993.

Looking ahead, a variety of independent studies and surveys anticipate that premiums will continue to increase at double-digit rates over the next several years. The Coalition projects that the average annual premium for employer-sponsored family health coverage will surge to $14,545 in 2006 — more than $5,000 higher than last year’s average premium of $9,068 and more than double the average premium of $7,053 in 2001.
These increases are making it more difficult for businesses to continue to provide health coverage for their employees and retirees. In addition, individuals and families are finding it more difficult to pay their share of the cost of employer-sponsored coverage or, for those who are not offered coverage by employers and are not eligible for public programs, to purchase health insurance themselves in the non-group market.

It is clear that Americans are worried about rising health care costs — not as an abstraction or as an issue for politicians to contend over, but as a problem that could affect them personally and profoundly. In a recent Harris Poll conducted for the Coalition, respondents were asked whether they expected that in 2008 “the number of people like you [emphasis added] who won’t be able to afford the medical care they need will be bigger or smaller than it is today.” Seventy-eight percent said that they expected that number would be bigger; only 17 percent said that they anticipated that the number would decline. This sense of foreboding — of vulnerability to rising health care costs — is widespread; it is shared by those with health insurance and without it, by middle-income and lower-income Americans, by Republicans and Democrats.

The escalation of health care costs is not only a health care issue; it is also a major national economic problem. As these costs rise, they eat into corporate margins, reducing the capacity of firms across the economy to grow their businesses by investing in research, new plant and equipment, and product development. Health care cost increases slow the rate of job growth by making it more expensive for firms to add new workers. They suppress wage increases for existing workers by driving up total compensation costs. They compromise the viability and vitality of pension funds and offset increases in pension benefits for retirees. And double-digit premium increases — on top of what are already the highest per-worker health care costs in the world — put American firms at a steep and growing disadvantage in global markets, where they must compete against companies with much lower health care costs.

Sharply escalating health care costs have become the single most contentious issue in collective bargaining, with huge stakes and consequences for business and labor. For example, this issue precipitated a grocery industry strike in Southern California that lasted five months. During that period, three major companies lost a
total of more than $1.5 billion in sales. Sixty thousand workers lost hundreds of millions of dollars in wages, and many of them also lost their homes and life savings. The strike was about a problem — surging health care costs — too big, and too pervasive, for either side to control. And we can expect more discord over health care costs — and more losses and more pain — until we address this problem through changes in public policy.

Senior corporate executives know how important this problem is to their businesses going forward. Hewett Associates recently conducted a survey of chief executive officers, chief financial officers, and chief human resource officers at 648 large companies across the country. When asked about the impact of rising health care costs on overall corporate costs, 96 percent of these senior executives said this was an issue of significant or critical concern. Ninety-one percent expressed significant or critical concern about the impact of rising health care costs on employees.

Rising health care costs are also producing severe long-term federal budgetary problems. The Treasury Department, the Congressional
Budget Office, and the General Accounting Office have warned that anticipated increases in Medicare and Medicaid obligations under current law will generate tens of trillions of dollars in unfunded liabilities in the coming decades. According to Comptroller General David Walker, those increases will be “unsustainable.” He projects that by 2050, Medicare and Medicaid combined will consume more than double their current share of the gross domestic product.

Overall, the United States spends much more on health care than any other nation. According to the Centers for Medicare and Medicaid Services, national health expenditures in the United States will reach $2.6 trillion in 2010 — more than double the total in the year 2000. On a per capita basis, health care costs in the United States are more than twice the median level for the 30 industrialized nations in the Organization for Economic Cooperation and Development (OECD) — even though 15 percent of our population has no health coverage at all (and even though the health outcomes associated with our higher spending are no better and, by some measures, worse than outcomes in nations that spend much less).

**A Huge and Growing Number of Americans Without Any Health Coverage**

According to the most recent official figures from the U.S. Census Bureau, the number of Americans without health insurance rose to 43.6 million in 2002. That total reflected the largest year-to-year increase in the ranks of the uninsured — a jump of 2.4 million — since 1987. On the basis of several recent national surveys of employers and health plans about expected increases in premiums for employer-sponsored coverage, in combination with econometric studies that have modeled the relationship between premium increases and increases in the incidence of uninsurance, the Coalition projects that the number of uninsured Americans will reach 51.2 to 53.7 million in 2006. This would amount to an addition of at least 10 million Americans to the ranks of the uninsured since 2001.

Even these numbers, as dramatic and troubling as they are, do not capture the real scope of the uninsurance problem in America. Nearly 82 million Americans — 32 percent of the non-elderly population — spent at least a portion of 2002 or 2003 without coverage. Of these, nearly half — about 38 million — lived in
households with annual incomes of more than $37,000; 13.5 million were in families with annual incomes in excess of $74,000. And, as polls make clear, the sense of vulnerability to the potential loss of insurance is shared by tens of millions of other Americans who have managed to retain coverage in recent years.

The impacts of uninsurance on the uninsured are clear and severe. First, the uninsured receive less health care than those with coverage. In a survey last year by the Kaiser Family Foundation, 47 percent of those without health insurance said that they had postponed seeking care within the past twelve months because of costs and 35 percent said that they had needed care but had not been able to obtain it at all. (These circumstances were reported by 15 and 9 percent of insured respondents.) Second, the uninsured who did not receive care when they needed it suffered as a consequence, with 47 percent reporting that they had incurred a painful temporary disability and 19 percent reporting that they had experienced a long-term disability. Half of the uninsured who failed to obtain needed care said that they were able to spend significantly less time at important activities as a result. Third, the uninsured must live each day in financial as well as physical jeopardy, knowing that if they are injured or contract a serious disease, they either will not able to obtain care — or will be forced to liquidate their savings or possessions to pay for it.

As a practical matter, because those without insurance receive less care — and receive it later — than those with coverage, they are on average less healthy and less able to function effectively in their daily lives. And, sadly, their risk of mortality is 25 percent higher than it would be if they had health insurance.

The impacts of uninsurance are not confined to the uninsured. First, family members, neighbors, and colleagues at work are adversely affected by the incapacities that befall the uninsured. Second, as the number of uninsured Americans increases, so does the cost-shift for uncompensated care built into the insurance premiums of those who purchase coverage. Third, the high incidence of uninsurance generates losses throughout the economy, due mainly to the lower productivity of uninsured (and, on average, less healthy and functional) workers. The Institute of Medicine has estimated that total economic losses attributable to uninsurance amount to between $65 billion and $130 billion per year.
The HR Policy Association, which represents senior human resources officers at 200 of the nation’s largest companies, puts the annual cost of reduced productivity alone at between $87 billion and $126 billion.

**An Epidemic of Sub-Standard Care**

The American health care system provides excellent care to many of its patients much of the time, but, on the evidence, not to enough of its patients enough of the time. As a series of landmark reports from the Institute of Medicine has documented, there is in our health care system what the Institute terms a “quality chasm” — a wide gulf between the care that patients should receive and the care that is actually delivered.

Despite the heightened attention and effort devoted to improving the quality of care in recent years, that chasm endures. Six years ago, in a report prepared for the Coalition, a team of researchers at RAND offered this summary of an extensive review of the literature evaluating health care quality:

![Number of Uninsured Americans](chart.png)

*Number of Uninsured Americans (in millions)*

- **2001**: 41.2
- **2003**: 43.6
- **2006 (Projected)**: 51.2 to 53.7

*Source: Adapted from Henry E. Simmons and Mark A. Goldberg, *Charting the Cost of Inaction*, National Coalition on Health Care, 2003, p.5.*
The dominant finding of our review is that for most care that has been studied, there are large gaps between the care that people should receive and the care they do receive. This is true for all three types of care [preventive, acute, and chronic]. It is true whether one looks at overuse or underuse. It is true in different types of care facilities and for different types of health insurance. It is true for all age groups, from children to the elderly.

A major new RAND study makes clear just how vast those gaps remain. Researchers examined the medical records of random samples of thousands of patients across twelve metropolitan areas and evaluated the care that these patients received over a two-year period. Using 439 indicators of quality developed by multispecialty expert panels, the analysts found that participants in the study received only 54.9 percent of recommended care — a proportion that varied little across the categories of preventive, acute, and chronic care.

Mismatches of this magnitude between ideal and actual practices would not be tolerated in most industries. Why are they permitted to persist in health care, where they cost lives and produce pain and suffering?

The Institute of Medicine has estimated that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals. That range of projections does not include the 88,000 deaths that, according to the Centers for Disease Control and Prevention, occur because of infections contracted during hospitalization, nor, obviously, does it include deaths due to preventable medical errors in settings other than hospitals. Dr. David Lawrence, the former chairman and chief executive officer of Kaiser Permanente, has calculated that mistakes in the use of medical technologies, across all settings of care, account for at least 400,000 deaths each year, of which about two-thirds can be attributed to preventable “health care accidents.” And, Dr. Lawrence adds,

These numbers do not include the impact of failing to treat what we know how to treat. Nor do they include the impact of overzealous use of the care. Were fatalities from these additional sources added to those from accidents, the number of deaths would climb significantly.
The Coalition believes that the United States needs to mount an all-out effort to combat this hidden epidemic — now, before millions of more Americans die needlessly from the ministrations of a health care system that they turn to for help, not harm.

Health care quality is also an enormous cost issue. Dr. Lucian Leape of the Harvard School of Public Health observed, in an earlier report issued by the Coalition on medical errors, that serious preventable injuries due to sub-standard care can cost hundreds of thousands of dollars each. These numbers add up — and represent a huge opportunity to save money as well as lives. According to Dr. Donald Berwick, president of the Institute for Healthcare Improvement and a faculty member at Harvard Medical School,

> Improvements in American health care are both feasible and can contribute to substantial, double-digit reductions in the total costs of care. Even with modest assumptions about defect rates in health care, total cost reductions of nearly 30 percent below current levels should be attainable while improving the overall quality of health care.

A study conducted for the Midwest Business Group on Health by two research organizations, the Juran Institute and the Severyn Group, reached a similar conclusion: that “30 percent of all direct health care outlays today are the result of poor-quality care, consisting primarily of overuse, underuse, and waste.”

With annual health care spending in America now exceeding $1.6 trillion, these estimates from Dr. Berwick and the Juran/Severyen study point to potential savings of more than half a trillion dollars a year. That prospect alone should provide more than enough incentive — if the potential to save lives were not already a sufficiently compelling reason — for Americans to demand improvements in the quality of their care.
What Must Be Done
SPECIFICATIONS FOR REFORM

As noted above, the Coalition’s specifications for reform reflect a consensus among our member organizations. Before turning to the specifications themselves, we would make three points:

**Health care reform must be a national priority.**
Comprehensive health care reform is long overdue. Every year that reform is delayed, tens of millions of Americans live in peril, without health insurance; millions are harmed, and hundreds of thousands die needlessly, because of sub-standard care; and health care costs continue to spiral ever upwards.

The Coalition’s specifications are meant not just to encourage and help to frame a national debate about health care reform, but to create momentum for the passage of legislation. These specifications are an expression of operational intent: Our member organizations are determined to work with other organizations and with policymakers in both parties to secure the reforms described here. Yes, we need a vigorous debate about health care policy — but what we really need is action, and soon.

**Health care reform must be systemic.**
The Coalition’s specifications were developed not as a shopping list of potential stand-alone initiatives, but as a linked series of targets, criteria, and options — meant to be adopted concurrently and to work together.

The vast American health care sector is exquisitely and elaborately interconnected. Partial or piecemeal reforms, even those conceived and implemented with the best of intentions, can produce unanticipated adverse consequences far from the focus or locus of those targeted reforms.
For example, a dramatic expansion of access, implemented without accompanying measures to improve quality and manage costs, could produce an overloaded health care system that delivers worse care (albeit to more people) at higher costs. Similarly, constraints on costs (and reimbursements for care), pursued in isolation, could compromise both access and quality.

A system is a set of institutions and processes that function together to achieve defined objectives. The Coalition’s specifications were designed to serve multiple goals simultaneously. We began our development of recommendations by agreeing on five core principles for reform (which appear below as section headings for our specifications). Then, as our deliberations proceeded, we continuously revisited and recalibrated our recommendations to make sure that the individual components fused together into a sensible systemic strategy.

We believe that a systemic approach can increase not only the substantive coherence of reform, but also its political feasibility. Thus, if constraints on health care cost increases were proposed in isolation, providers might understandably anticipate that their revenues going forward would be diminished. By contrast, if those same constraints were conjoined in a systemic strategy with an assurance of coverage for all Americans and financing for their care, providers would receive payment for care that they now provide, with little or no compensation, to uninsured patients.

Health care reform must be system-wide.

The Coalition is calling for system-wide reforms, not for changes that would apply to only some payers, patients, or providers. Unless reform is system-wide, gains in some sectors or for some groups are likely to be offset by losses elsewhere.

There is, in addition to this practical consideration, another compelling argument for making certain that reform is system-wide. America is already a nation of health care haves and have-nots. Reform should aim to assure that all Americans receive excellent health care and are able to enjoy the quality of life and peace of mind for which such care is essential. Piecemeal reform that helps some categories of people to the detriment of others would not take us closer to an optimal health care system and could actually make it harder to attain.
We should move forward together. Let us begin by specifying where we want to go:

**PRINCIPLE 1**

*Health Care Coverage for All*

Every American* should have health care coverage, as defined below, and access to the services covered. Participation should be mandatory. The goal of health care coverage for all Americans should be achieved within two to three years after the passage of enabling legislation. We recognize that this is an ambitious timetable, but lives, and the quality of lives, are at stake.

Coverage should encompass medically necessary, comprehensive care, including emergency care, acute care, prescription drugs, early detection and screening, preventive care, care for chronic conditions, and end-of-life care. Pre-existing conditions should not be excluded from coverage. The details of the core benefit package, within each of the categories noted, should be consistent with best medical practices and should be adjusted over time, as science and technology advance and as the understanding of best practices evolves. Enrollees should be guaranteed the right to timely appeal of denials of coverage for particular services — first through internal review processes and then through independent external review processes.

Individuals or their employers should be able to purchase supplemental coverage — that is, coverage beyond the core benefit package.

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* We recognize that a more precise delineation of the application of this principle would require the consideration of issues — regarding immigration policy and its enforcement — beyond the ambit of our deliberations about health care reform. In light of the importance of health care and, therefore, health care coverage as predicates and safeguards for physical and financial well-being, we hope that policymakers will be more, rather than less, inclusive.
The Coalition has identified a range of viable options for insuring all Americans:

- employer mandates (supplemented with individual mandates as necessary).
- expansion (and perhaps consolidation) of existing public programs that cover subsets of the uninsured (such as the State Children’s Health Insurance Program).
- creation of new programs targeted at subsets of the uninsured.
- establishment of a universal publicly financed program.

Legislation incorporating any, or a combination, of these mechanisms

- should include adequate subsidies for those who are less affluent.
- should assure continuity of coverage for those who move from one form or context of coverage to another.
- should facilitate enrollment by all those eligible for coverage.
- should require individuals to establish — for example, by appending documentation to their annual tax returns — that they have coverage.

Group purchasing is more efficient and more equitable than disaggregated purchasing. Therefore, the Coalition recommends against relying on individual mandates and individuated purchasing as the sole or central mechanisms in a national strategy to achieve coverage for all Americans.

The Coalition also recommends against reliance on a sub-national strategy in which individual states would be responsible for devising and passing legislation to attain coverage for their own citizens. We recognize, however, that progress can and should be made in individual states pending the passage of national legislation to cover all Americans.
**PRINCIPLE 2**

**Cost Management**

Average annual percentage increases in the health care costs and insurance premiums associated with the core benefit package should be brought into approximate equivalence with annual percentage increases in per-capita gross domestic product. Cost management measures should be designed to achieve that goal within five years after the enactment of legislation. (The Coalition recognizes that unusual discontinuities, such as epidemics or the emergence of revolutionary new medical technologies with benefits that clearly outweigh costs, may warrant short-term cost or premium increases that exceed the rate of growth of per-capita gross domestic product.) In addition, cost management should serve the longer-term goal of increasing the value generated by health care expenditures — that is, the health benefits that accrue to patients from any given level of spending.

Cost management must be a multi-faceted undertaking. It must incorporate a mix of more and better information and incentives for patients, providers, and purchasers; a commitment to improving the quality and outcomes of care, as described below; an increased emphasis on prevention and early detection of disease; the accelerated development of an integrated national information technology infrastructure for health care; and steps to modernize and simplify the administration, and dramatically reduce the administrative costs, of the health care system.

The urgent need for relief from rapidly rising costs also requires the establishment of constraints as soon as practicable after the passage of legislation. These constraints should take two forms: rates for reimbursing providers for episodes of care encompassed by the core benefit package and, only after those rates take effect, limitations on increases in insurance premiums for the coverage defined by that package.

An independent board, chartered and overseen by Congress, should be responsible for establishing and administering these measures and for calibrating rates and limitations that keep increases in costs and premiums in alignment with defined annual targets. (This board, which would also be responsible for
coordinating efforts to improve the quality of care, is described in more detail below in the specifications regarding Principle 3.)

The board could also develop capitated rates for particular categories of care (for example, care for patients with specified chronic diseases) to encourage coordinated, integrated, and efficient provision of care in those categories.

A national strategy for cost management should also incorporate the following elements: First, it should make health insurance premiums more readily comparable by requiring insurers to establish explicitly separate premiums for the core benefit package and for any supplemental coverage they offer. Second, it should include a rational mechanism for increasing the cost-effectiveness of capital spending. Third, it should incorporate cost-sharing and other tools to provide incentives for patients to make appropriate choices about health maintenance and health care and for reducing both overuse and underuse of care. To assure that the use of such tools does not block access to needed care, subsidies or exemptions should be provided for those who are less affluent.

PRINCIPLE 3

Improvement of Health Care Quality and Safety

A comprehensive and concerted national effort should be launched and sustained, with dramatically more public funding than has been previously available for this purpose, to improve the quality and safety of American health care.

Some progress has been made, in both the public and private sectors, on initiatives to help reduce medical errors and improve quality, but we need to do much more, much faster, across the entire health care system. A system-wide effort to improve quality should increase investment in the generation of information — about effectiveness and cost-effectiveness — to improve recommendations and choices among options for care. It should develop and make widely available measurements — of process and outcomes quality — to facilitate choices among plans and providers by payers and consumers. It should be designed to reduce vari-
ability, across regions and providers, in patterns of practice — and, more generally, to improve the consistency of such patterns with best practices. It should seek to link payments for care to the measured quality of care.

In addition, a national quality-improvement effort should accelerate the development of an integrated national information technology infrastructure for the health care system. This infrastructure should include protocols for electronic patient records, prescription ordering, and billing; standards to protect privacy; a process for updating protocols and standards to reflect experience and technological advances; and mechanisms to incentivize and provide capital for the upfront investments necessary to build, and build out, the infrastructure.

These mechanisms to encourage investments in automated clinical information systems — and in further integration and coordination of the delivery of care — could include supplemental payments, changes in tax policy, programs to provide long-term low-interest loans to qualifying providers and provider organizations, and targeted grant programs.

This concerted national effort to improve the quality of health care in America should be coordinated by the new independent national board — with members drawn equally from the public and private sectors to reflect and reinforce a public-private partnership for improved quality. This board would be chartered and overseen by Congress.

The new board should be responsible for coordinating the development and refinement of national practice guidelines. The guidelines should be based on reviews, by panels of leading health care professionals, of research that has been conducted on the impacts of alternative technologies and procedures. These panels should collaborate with and leverage the work of professional societies, provider organizations, health plans, universities, companies and industry associations, patient groups, payers, and other organizations. For technologies and procedures about which additional data are needed for the development of guidelines, new studies and assessments should be funded by the board. The board should assure that guidelines are continually updated as new data — on current and new technologies and procedures — become available.
The board should also be responsible for disseminating national practice guidelines and measures of process and outcomes quality to those who deliver, pay for, or receive care. It is vital not only that more and better information be developed, but that it be encapsulated and communicated broadly so that it can be acted on.

The practice guidelines issued by the board could be adduced in malpractice cases as evidence of what is considered best medical practice. Conformance to these guidelines should help to protect medical professionals from frivolous or marginal lawsuits. Use of the guidelines, the development of an information technology infrastructure that includes computerized prescription ordering and electronic patient records, and the ready availability of measures throughout the system of process and outcomes quality should over time work to reduce the incidence of medical errors and malpractice and to protect the safety of patients.

As noted above, the core benefit package should not be static. The board should periodically review the components of that package and adjust them as needed to reflect changes in national practice guidelines.

**PRINCIPLE 4**

*Equitable Financing*

Reform should seek to reduce or eliminate cost-shifting across categories of insurance programs and payers, both public and private, and to make the distribution of financial burdens more equitable.

The Coalition has identified a range of mechanisms or sources that could be used, individually or in combination, to fund the program costs of the initiatives described here, including the costs of assuring coverage for all Americans:

- general revenues.
- earmarked taxes and/or fees.
- contributions required from employers.
- contributions required from individuals and families (including co-payments, deductibles, and contributions toward premiums).
Financial obligations should be gradated, or subsidies provided, based on relative ability to pay for less affluent individuals, families, and employers.

**PRINCIPLE 5**

*Simplified Administration*

The United States spends more than any other nation — nearly $300 billion per year — to administer its health care system. And as the complexity of our system continues to increase, so too does the associated administrative outlay. According to the Centers for Medicare and Medicaid Services, just one category of administrative expenses — those incurred by private health insurers — rose 52 percent between 1999 and 2002, from $237 to $360 per person covered.

The complexity of the American health care system confuses and frustrates patients, payers, and providers. In addition, because it reduces the transparency of transactions and the comparability of performance and cost data, it also undermines accountability and the capacity of health care markets to function efficiently.

The mechanisms and initiatives recommended in these specifications would produce a streamlined, rationalized health care system — one that would be more efficient (and less costly), less cumbersome and perplexing, and safer. We can, and we should, reduce unproductive inconsistencies across the system. We can, and we should, more fully leverage in health care the capacities of available information and communications technologies — capacities that have improved productivity and performance in so many other sectors of the American economy.

For example, the assurance of coverage for all Americans and the establishment of a core benefit package would create a consistent set of ground rules and understandings for patients, payers, and providers — reducing the variations that now draw time and resources away from the protection and advancement of health. The creation, at long last, of an integrated national information technology infrastructure for health care — including electronic
patient records, prescription ordering, and billing — would not only decrease administrative complexity and costs, but help to reduce medical errors, protect the safety of patients, and improve outcomes. (At present, only 10 percent of health care providers use computerized medical records and ordering — this in a health care system that is the most advanced in the world in its generation, adoption, and use of purely medical technologies.) Similarly, the development and application of national practice guidelines would simultaneously reduce complexity and variability and improve the quality of care for millions of patients.

The expensive administrative complications of our current health care system are not productive uses of our scarce resources. We would be better off saving some of the money we now spend just to administer our system — or investing that money in new technologies or organizational innovations that would improve the health of the American people.
Conclusion

The members of the National Coalition on Health Care are determined to work for comprehensive reform of the American health care system. We offer these specifications for reform as an agenda — an urgent agenda — for action. We close with two observations.

First, we would emphasize again our conviction that reform must be systemic and system-wide. The problems of our health care system — and the principles that guided our development of specifications for reform — are so closely interrelated that they must all be addressed at the same time. One-dimensional reform will not work.

Consider: Unless we improve the quality of care, we will not be able to manage costs or afford universal coverage. Unless we manage costs effectively, we will not be able to achieve equitable financing or cover all Americans. And unless we assure coverage for everybody, we will be unable to make the system less complex, establish a level playing field without cost-shifting, or create a truly competitive health care marketplace. (In fact, many of those who first advanced the market-based reform hypothesis called managed competition warned that a market for health care cannot function efficiently or effectively in the absence of mandatory universal coverage and government oversight.)

Second, the status quo — clearly, undeniably — is not working. It leaves tens of millions of Americans with no health insurance at all. It allows costs to skyrocket year after year, putting coverage out of reach for millions of Americans and compromising the vitality of our economy and its capacity to create and sustain jobs. And it jeopardizes the safety of patients because of widespread sub-standard care.

The status quo is not acceptable. It is time — it is past time — to change it. The readers of this report can have a tremendous impact on the prospects for reform and the shape of reform. We hope that you will work with us in this important effort.
Quick Facts On Health Care Costs

• Total health spending in the U.S. reached $2.1 trillion in 2007 – or $7,026 per capita.

• By 2016, total health spending is projected to rise to $4.2 trillion.

• Between 2005 – 2006, total health spending increased 6.7 percent, more than double the rate of the 2.9 percent increase in overall economic growth.

• Total health spending remained relatively constant at about 16 percent of gross domestic product from 2003 – 2006, but is projected to increase to 19.5 percent by 2017.

• Spending for home health care increased at a faster pace from 2005 – 2006 (9.9 percent) than any other category of health spending; however, its impact is limited because it accounts overall for only 2.5 percent of total health spending.

• Yearly prescription drug spending growth accelerated in 2006 to 8.5 percent from a low of 5.8 percent in 2005, in part because of full implementation of Medicare Part D.

• Between 2006 and 2007, premiums for health coverage offered by employers increased 6.1 percent, the fourth straight year of declines in the rate of premium growth, from a peak of 13.9 percent in 2003. Even so, this was more than twice the rate of growth in the Consumer Price Index.

• Of every dollar spent on health services in the U.S. in 2006, 46 cents came directly from government sources.

• Costs for program administration and the net cost of private health insurance were about 7 percent of total health spending in the U.S. in 2006 and grew 8.8 percent, a marked increase over the 3.6 percent rise in 2005.

This list (without the original endnotes) is from “AReporter’s Toolkit: Health Care Costs” (an Alliance for Health Reform Toolkit produced with support from the Robert Wood Johnson Foundation) and is reproduced here courtesy of the Alliance for Health Care. The entire toolkit can be found at http://www.allhealth.org/Publications/Cost_of_health_care/health_care_costs_toolkit.asp#keyfacts.

Resource provided by the LWVUS Health Care Education Task Force, 2009.
Data from multiple sources agree that in 2007, 47 million Americans (15.6 percent of the total U.S. population) lacked any kind of health insurance coverage. When these numbers are adjusted for age (excluding those 65 years and older), the uninsured percentage of the population rises to 17.9 percent. Moreover, it is estimated that 25 million adults under age 65 were underinsured during 2007, despite having insurance all year. In total, 42 percent of all adults (86.7 million) were either uninsured or underinsured during 2007.

Putting a face on persons who were uninsured or underinsured during 2007 and 2008:

- **Age:** One of three people under age 65 were uninsured for some or all of 2007 and 2008; of the total uninsured population, 60.1 million were adults (between 19 and 64 years of age)
- **Duration:** Among the underinsured/uninsured, 74.5 percent were uninsured for nine or more months and one-quarter were uninsured the entire 24 months
- **Employment status:** 80 percent of individuals who were uninsured were in working families and only 16 percent were not in the labor force (due to disabilities, chronic illness, or serving as family caregivers)
- **Income:** Nearly 60 percent were in families with incomes below the federal poverty level (FPL: $21,200/year for a family of four); 52 percent with incomes between 100 to 200 percent of FPL went without health insurance in 2007/2008
- **Racial and Ethnic origin:** 55 percent of Hispanics/Latinos, 40.3 percent of African Americans and 34 percent of other racial or ethnic minorities had no health insurance in 2007/2008, compared to 25.8 percent of whites. While racial and ethnic minorities are more likely to be uninsured, whites accounted for 49.8 percent of the uninsured
- **Age breakdown:** The likelihood of being uninsured declines with age; 49.5 percent of those 19 – 24 years old, 36.3 percent of those 25 – 44 years old, 32.5 percent of those 45 – 54 years old and 21.2 percent of those 55 – 64 years old were uninsured over this two-year time period. The 55- to 64-year-old age group consumes more health care on average than younger adults.

For all ethnic and racial groups, lower-income families and individuals were more likely to be uninsured than lower-income whites. This disparity continues even as incomes rise in all groups.

There is a marked increase in the number of adults having difficulty paying medical bills – the most visible consequence of the weakening in insurance coverage. In 2007, 41 percent of adults (72 million people) reported problems paying medical bills, faced bill collectors or were in debt for medical care, up from 34 percent or 58 million in 2005. The majority had insurance at the time these bills were incurred – well in advance of the economic downturn.

1 All statistics above and below are from http://www.familiesusa.org/resources/publications/reports/americans-at-risk-findings.html


Janis McMillen (LWVUS Board member and LWVKS) is chair of the LWVUS Health Care Education Task Force.

Produced by the LWVUS Health Care Education Task Force, 2009.
<table>
<thead>
<tr>
<th>Unit Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday, May 11, 2009</strong></td>
</tr>
<tr>
<td><strong>SOUTHERN</strong></td>
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<tr>
<td>Sam Scharff</td>
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<td><strong>ISSAQUAH EVENING</strong></td>
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<td>Ann Thornton</td>
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<td><strong>FIRST HILL</strong></td>
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<td>Jeannette Kahlenberg</td>
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<td><strong>CAPITOL HILL/MONTLAKE</strong></td>
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<tr>
<td>Jan O’Connor</td>
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<tr>
<td>Vicky Downs</td>
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<td><strong>Tuesday, May 12, 2009</strong></td>
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<tr>
<td><strong>BELLEVUE</strong></td>
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<td>Bonnie Rimawi</td>
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<td><strong>WEST SEATTLE DAY</strong></td>
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<td>Lucy Gaskill-Gaddis</td>
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<td><strong>WEST SEATTLE EVE</strong></td>
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<td>Barbara O’Steen</td>
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<td>Helen St. John</td>
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<tr>
<td><strong>Wednesday, May 13, 2009</strong></td>
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<tr>
<td><strong>VIEW RIDGE</strong></td>
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<tr>
<td>Gail Winberg</td>
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<td><strong>MAGNOLIA/QUEEN ANNE/BALLARD EVE</strong></td>
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<tr>
<td>Bettina Hosler</td>
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<td><strong>Thursday, May 14, 2009</strong></td>
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<td><strong>NORTH CENTRAL</strong></td>
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<td>Jan Orlando</td>
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<td>Gail Shurgot</td>
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<td><strong>MERCER ISLAND</strong></td>
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<td>Martha Jordan</td>
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<tr>
<td><strong>SHORELINE</strong></td>
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<td>Juliet Beard</td>
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<td><strong>UNIVERSITY HOUSE – WALLINGFORD</strong></td>
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<td>Mary Slotnick</td>
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<td>Marilyn Paulson</td>
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<td><strong>ISSAQUAH</strong></td>
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<td>Margaret Austin</td>
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<td>Jocelyn Marchisio</td>
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<td><strong>Saturday, May 16, 2009</strong></td>
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<tr>
<td>Joan Peterson</td>
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<tr>
<td>Shirley Gerstenberger</td>
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<tr>
<td><strong>Monday, May 18, 2009</strong></td>
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<td><strong>KIRKLAND/REDMOND - NOTE DIFFERENT DATE!</strong></td>
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<tr>
<td>Patti Catalano</td>
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<td>Gerry Williams</td>
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<tr>
<td><strong>Wednesday, May 20, 2009</strong></td>
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<tr>
<td><strong>NORTH KING COUNTY (LAKE FOREST PARK) - NEW!!!</strong></td>
</tr>
<tr>
<td>Judy Bevington</td>
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## Board & Committee Contacts

<table>
<thead>
<tr>
<th>Term</th>
<th>Executive Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007–2009</td>
<td><em>President</em> Denise D. Smith <a href="mailto:president@seattlelwv.org">president@seattlelwv.org</a></td>
</tr>
<tr>
<td>2008–2009</td>
<td><em>1st V.P. Membership</em> Kitty Mahon <a href="mailto:membership@seattlelwv.org">membership@seattlelwv.org</a></td>
</tr>
<tr>
<td>2008–2010</td>
<td>2nd V.P. Program Nora Leech <a href="mailto:nleech2002@yahoo.com">nleech2002@yahoo.com</a></td>
</tr>
<tr>
<td>2008–2010</td>
<td><em>3rd V.P. Voter Service</em> Sarah Luthens <a href="mailto:voterservice@seattlelwv.org">voterservice@seattlelwv.org</a></td>
</tr>
<tr>
<td>2007–2009</td>
<td>4th V.P. Action Jayne Freitag-Koontz <a href="mailto:jfkoontz@comcast.net">jfkoontz@comcast.net</a></td>
</tr>
<tr>
<td>2008–2009</td>
<td>Secretary Karen Adair <a href="mailto:adairk@seanet.com">adairk@seanet.com</a></td>
</tr>
<tr>
<td>2008–2010</td>
<td>Treasurer Allison Feher <a href="mailto:treasurer@seattlelwv.org">treasurer@seattlelwv.org</a></td>
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<tr>
<th>Term</th>
<th>Directors</th>
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<tbody>
<tr>
<td>2008–2010</td>
<td>Outreach Maria Brusher <a href="mailto:outreach@seattlelwv.org">outreach@seattlelwv.org</a></td>
</tr>
<tr>
<td>2007–2009</td>
<td>Unit Coordinator Patti Catalano <a href="mailto:partimusic@comcast.net">partimusic@comcast.net</a></td>
</tr>
<tr>
<td>2007–2009</td>
<td>Voter Editor Beatrice Crane <a href="mailto:votereditor@seattlelwv.org">votereditor@seattlelwv.org</a></td>
</tr>
<tr>
<td>2007–2008</td>
<td>Civics Education Jaclyn Wall <a href="mailto:speakingstrategies@hotmail.com">speakingstrategies@hotmail.com</a></td>
</tr>
<tr>
<td>2007–2009</td>
<td>Observer Corps Anita Warmflash <a href="mailto:ansky2@comcast.net">ansky2@comcast.net</a></td>
</tr>
<tr>
<td>2008–2009</td>
<td>Director Christal Wood <a href="mailto:gimme_steam@hotmail.com">gimme_steam@hotmail.com</a></td>
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<thead>
<tr>
<th>Term</th>
<th>Education Fund Board</th>
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<tbody>
<tr>
<td>2008–2009</td>
<td>President Betty Sullivan <a href="mailto:jaybetty2@msn.com">jaybetty2@msn.com</a></td>
</tr>
<tr>
<td>2008–2010</td>
<td>Vice President Dorothy Y. Sale <a href="mailto:saledy@comcast.net">saledy@comcast.net</a></td>
</tr>
<tr>
<td>2007–2009</td>
<td>Treasurer Lisa Peterson</td>
</tr>
<tr>
<td>2008–2010</td>
<td>Secretary Lucy Gaskill-Gaddis <a href="mailto:terrylucy2u@comcast.net">terrylucy2u@comcast.net</a></td>
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<thead>
<tr>
<th>Off-Board Positions</th>
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<tbody>
<tr>
<td>CIS Coordinator Cynthia Howe <a href="mailto:howe.john@comcast.net">howe.john@comcast.net</a></td>
</tr>
<tr>
<td>Fund Development Victoria Bennett <a href="mailto:funddevelopment@seattlelwv.org">funddevelopment@seattlelwv.org</a></td>
</tr>
<tr>
<td>Technology Oversight Karen Lahey <a href="mailto:karen@laheyfamily.org">karen@laheyfamily.org</a></td>
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<thead>
<tr>
<th>Committees</th>
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<tbody>
<tr>
<td>Civics Education Jaclyn Wall <a href="mailto:speakingstrategies@hotmail.com">speakingstrategies@hotmail.com</a></td>
</tr>
<tr>
<td>Economics &amp; Taxation Nora Leech <a href="mailto:nleech2002@yahoo.com">nleech2002@yahoo.com</a></td>
</tr>
<tr>
<td>Education Lucy Gaskill-Gaddis <a href="mailto:terrylucy2u@comcast.net">terrylucy2u@comcast.net</a></td>
</tr>
<tr>
<td>Social Justice Committee Vanessa Soriano Power <a href="mailto:vanessa.power@gmail.com">vanessa.power@gmail.com</a></td>
</tr>
<tr>
<td>Immigration Study Co-chair Annette Holcomb <a href="mailto:anholc@earthlink.net">anholc@earthlink.net</a></td>
</tr>
<tr>
<td>Immigration Study Co-chair Barbara Reid <a href="mailto:barbereid@yahoo.com">barbereid@yahoo.com</a></td>
</tr>
<tr>
<td>International Relations Ellen Berg <a href="mailto:ellenzberg@msn.com">ellenzberg@msn.com</a></td>
</tr>
<tr>
<td>Land Use Karen Kane <a href="mailto:kanek@iopener.net">kanek@iopener.net</a></td>
</tr>
<tr>
<td>Transportation Linnea Hirst <a href="mailto:LWVquilter@comcast.net">LWVquilter@comcast.net</a></td>
</tr>
<tr>
<td>Port Study Linda Brown <a href="mailto:brownlj@comcast.net">brownlj@comcast.net</a></td>
</tr>
<tr>
<td>Privatization Study Nora Leech <a href="mailto:nleech2002@yahoo.com">nleech2002@yahoo.com</a></td>
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* Indicates LWVS Board Representative on the Education Fund Board
May Forum

The Current State of Health Care & Health Care Reform: A National & Local Perspective

Speakers:
Robert Crittenden, MD, MPH - Executive Director of the Herndon Alliance and a Faculty Member in the University of Washington Departments of Family Medicine and Health Services
David Loud, Community Liaison for Health Care for US Congressman Jim McDermott, MD
Jonathan Seib, MPA, JD, Executive Policy Advisor on Health Care, Governor’s Executive Policy Office

Thursday, May 7, 2009
7:30-9:00 p.m.
Briefing for discussion leaders at 6:30 p.m.

Location:
Seattle First Baptist Church - 1111 Harvard Avenue (Harvard & Seneca)

All forums are free and open to the public.