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HEALTHCARE COMMUNICATION REVIEW

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HEALTHCARE REFORM: WHERE DO YOU STAND?

Where Do *You* Stand on Healthcare Reform? Pg. 1

ON OUR CURRENT SYSTEM

Healthcare Reform: What Are We Leaving Behind? Pg. 1

Best Healthcare in the World? Some Facts and Figures Pg. 3

The Cost of Healthcare: Who Pays For It All? Pg. 4

Deciding Where You Stand: Questions to Ask Yourself Pg. 4

ON THE AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act: An Overview Pg. 5-6

Two Concerns About Health Reform Pg. 7-8

Where To Find Answers to… Pg. 8

ACKNOWLEDGMENTS Pg. 9

General Information About Our Webinars Pg. 10

Where Do *You* Stand on Healthcare Reform?

Where you stand is important. Why? Because the law as passed is not a done deal. Whether you are for or against it, your vote in the 2012 elections can make a difference. Even without challenges to the law as it stands, the law requires that certain elements be reaffirmed in ongoing votes on the budget.

The question becomes then: on what *should* you base your position? We would suggest that it should begin with your personal philosophy of the world and how governments should operate; but it should not end there without you first taking a clear, careful and critical look at the information out there – including the evidence you rely on to support your view.

To do otherwise, makes you less informed in your decisionmaking and, just as making a less informed decision about how to treat your medical condition can work against you, so too can making a less informed decision about where you stand on the enacted healthcare reform. You owe yourself and your family more than that.□

Healthcare Reform: What Are We Leaving Behind?

"No man is an island entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as a manor of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls; it tolls for thee."

From Meditations XVII, by John Donne, 1624

A major problem with our healthcare system has been health insurance and, as we begin to describe here, we have not been individual islands unaffected by the health insurance problems of others. Take the problem of the uninsured. The 2010 Census found that, in 2010, 50.9 million people in the U.S. had no health insurance (up 900,000 from 2009). 80% of them are employed or live with someone who is employed. And, in the past decades, those numbers have climbed regardless of the state of the economy.[1]

Without insurance, access to timely, nip-it-in-the-bud, healthcare services is greatly limited. The uninsured get less preventive care and, when they do seek help for medical problems, it is often late, (after their conditions have progressed), and through the more costly Emergency Departments of hospitals. Treatments, if available, are not only more costly than if their conditions had been found earlier, but are less effective. They are, unfortunately, more likely to die as a result.[2]

That's how it can affect the uninsured. But most, if not all of us, are affected one way or another. One such way, is financially. This is detailed in the article on page 4, but for now, the short answer is that the cost of caring for the uninsured hits us in our own, individual pocketbooks.

See **Leaving Behind**, *on Pg. 2*

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From the Editor

Let me state two things up front. First, the more I learn about the Healthcare Reform enacted in March of 2010, the more impressed with it I am. Second, I'd like nothing better than to be able to bring people around to my view of it. Even so, I realize that not only can reasonable people disagree, but also that reasoned disagreement can be a very good thing! With that in mind, the goal of this issue is to provide readers with information, suggestions and resources so that each can come to a reasoned decision regarding where they stand on the issue of health reform.

To that end, we look at the current system and its affect on the lives of individuals living in the US; on American businesses; and on the US Economy – presenting information that few, on either side of the matter dispute. We then examine the view that ours is the greatest healthcare system in the world, providing facts and figures that compare health outcomes in different countries.

After breaking down who pays for the cost of healthcare, we outline some of the law's key provisions and look at two of the common concerns about it. In 'Where to Find Answers to…" we offer resources for learning more about those and other provisions as well as for checking claims made about them.

As usual, we hope readers find this issue of value.
Be well. *Judith Greenfield*

Leaving Behind, *Continued from Pg. 1*

Studies also show that our businesses suffer economic losses when the uninsured miss work due to sickness and, because the high costs of caring for the uninsured contribute to the overall rising costs of healthcare, our nation's economy suffers as well.[3]

Even the health of some insured can be affected. Why? Evidence suggests that health facilities and professionals in communities with large uninsured populations are often forced to cut back on services (including high tech and emergency care) or just don't set up practices there – limiting care to the insured who also live there.[4]

But those who have health insurance often have their own problems, especially if they develop serious illnesses needing costly treatments and/or are under-insured. Indeed, the Commonwealth fund, has estimated that 25 million adults were underinsured in 2007 – up 60 % from 2003.[5] (At the very least, all too many of us have seen the costs of health insurance premiums rise and co-pays increase while coverage goes down.)

Additionally, 50% of all bankruptcies are medical bankruptcies – filed when, upon getting sick and requiring expensive treatment, patients are dropped by insurance companies, leaving them to foot the bill – a practice prohibited in the new health reform act.

Why would insurance companies do such a thing? The answer reveals yet another problem with health insurance. Many, if not most insurers these days, are private, for-profit corporations with shareholders. As such, their bottom line is providing dividends for those shareholders, even if it means shedding the sickest (and least profitable) patients. In fact, one industry spokesman, interviewed by Steve Kroft in a CBS *60 Minutes* segment, defended his company's dropping of patients by saying:

> *Insurance is a business… It has social functions but it is not social welfare. Governments do social welfare. And insurance is a business, just like the corner delicatessen or the car dealership.*[6]

Question: Who among us can say that they never have or never will find themselves in any of these positions? Probably not many. And that's been a BIG problem!

[1] Search online for "The Economic Impact of the Uninsured,"
[2] Search online for "America's Uninsured Crisis: Consequences for Health and Health Care," Institute of Medicine Report Brief February 2009.
[3] Search online for "How Much is Employee Absenteeism Costing Your Business" by Ira. S. Wolfe.
[4] Search online for: ' 'A Shared Destiny: Community Effects of Uninsurance.'
[5] Visit www.commonwealthfund.org and search for "How Many Are Underinsured?"
[6] Transcript, "Do You Really Want to Know", CBS *60 Minutes*, (April 21, 1996): 8

Best Healthcare in the World? Some Facts and Figures

For years, one of America's claims to greatness has been the healthcare that we offer. And for good reason. Our excellent medical schools draw future doctors from all over the world. Our state-of-the-art trauma and medical centers are able to provide the most complex treatments and surgeries. And these institutions are also the choice of many patients from around the world. Using these measures, then, it seems fair to claim that, at the very least, our healthcare offerings are not surpassed.

That being said, these measures are not enough to support our claim of being the best. One other measure, perhaps *the only other measure* that counts, is how well our offerings serve our populace – more to the point, how healthy, or unhealthy, people living in America are as compared to the health of people in other countries. Fortunately, these comparisons are available at **www.nationmaster.com**. Unfortunately, they show that our claims of being the best fall more in line with claims of the "Emperor's New Clothes." That's because, in many instances, we fall far short of being the best. Indeed, as shown in Table 1, below, the only areas in which we surpass all other countries, are the annual cost per person of healthcare services and our health related GDP. Meaning, we pay more but get less.

About NationMaster

NationMaster is the brainchild of an Australian with a keen interest in facts and figures of different countries. Because he felt that those facts and figures would be more meaningful if they were compared country-to-country, NationMaster was born. Now a resource that is favorably reviewed by the Harvard Business School and the American Library Association among others, the site offers many categories for comparison and provides the sources for all the statistics it posts. To find figures comparing the health prospects of different countries, click on statistics and then on the category of health.

About the Comparisons in Table 1

For our purposes here, we provide just a small sampling of the sets of statistics to be found at NationMaster. And, while their sets of statistics compares many different countries, we are comparing only two others with the U.S. system that is being replaced. Both of those countries provide universal healthcare coverage. One, Canada, uses a government-run program. The other, Germany, uses (highly-regulated) private for-profit and non-profit insurers. Our own past and future systems use a combination of public and private insurers. For those who may wonder if our poor showing in these comparisons may have to do with our large immigrant population, the table below also includes figures comparing the percentage of immigrants in each country. These were found by clicking 'Statistics,' then 'Immigration.' And finally, for each of the statistics listed below, we show how many countries rank better than the US. For a more complete picture, we urge our readers to visit NationMaster and see for themselves.□

Table 1: NationMaster Health Statistics*

	Canada	Germany	US	Of All Compared Countries, # Better Than US
Life Expectancy @ Birth	80.18 yrs	78.93	77.71	35
Life Expectancy: # healthy years	69.9	70.2	67.6	21
Years Lived in Ill Health – Females	10.4	8.9	10.7	26
Years Lived in Ill Health - Males	8.4	6.8	8	22
Circulatory Disease Deaths/100,000	219	292	265	13
Heart Disease Deaths/100,000	94.9	106.1	106.5	13
Spending per person (1998 figures)	$1,939	$2,697	$4,271	All
Total 2004 Health Expenditure: % GDP	9.8%	10.6%	15.4%	All
Percentage of Immigrant Population	18.76	12.31	12.81	Not Available

* Note: On August 31, 2011, network and cable news reported that, in comparing 45 countries, 41 countries have better infant mortality rates than the U.S. See **http://thechart.blogs.cnn.com/2011/08/31/u-s-ranks-low-for-newborn-survival/?hpt=hp_bn6.** Similar information can be found in the CIA World Factbook whose link is found on Page 10 of this issue.

The Cost of Healthcare: Who Pays For It All?

In 1998, Healthcare spending per person in the United States was $4,271 – more than any other country. By 2008, with higher growth rates in health spending, the U.S.'s per person figure had jumped to $7,530 – with Norway the second highest in per person health spending at $5,003. Given our huge and ever-increasing healthcare costs, one important factor in deciding where one stands on the issue of health reform, is who pays for it all – a question we attempt to answer here.

It seems clear that healthcare costs are shared by individual households in the form of insurance premiums and any out-of-pocket healthcare spending; by taxpayers whose tax dollars provide monies for Government programs such as Medicare, Medicaid and others; by businesses that pay healthcare premiums for their employees; and, finally, by health insurers. If we more carefully follow the money, however, we realize that all is not what it seems – that payments for most, if not all, of that per person health spending can be traced back to our individual households.

Let's begin with the notion of health insurer's share – a notion that is not only incorrect, but one that has contributed to overuse (meaning unnecessary use) of expensive medical tests and procedures. After all, both patients and clinicians typically reason that these wonderful opportunities to diagnose and treat our conditions are there and insurers, not patients, pay the bulk of the costs. In truth, however, health insurers, whether for-profit or nonprofit, need to operate in the black in order to stay in business. For-profit insurers, especially, seek to maximize their profits. They will not absorb the costs of care. They pass it along to all their members in the form of higher premiums, reduced coverage and higher out-of-pocket costs. (As a side note, because tests can provide false positive or negative results, the pursuit of treatments in light of false positive results not only inflates healthcare costs, but also has a great potential for harming patients.[1] But back to the matter of who pays for it all.)

Similarly, businesses that provide health insurance benefits for their employees need to remain in the black in order to survive. Their health expenditures are therefore usually included in the calculations of what to charge for their products and services, which means we become the ones paying those healthcare costs when we purchase those products and services.

In terms of our tax dollars, we pay for every level and form of government health spending, not just the spending described above. We also pay for each government employee's health insurance premiums, for instance.

And what about the costs of treating the uninsured? Who pays those? According to the Kaiser Family Foundation, one third of their medical costs are uncompensated. One-quarter to one third is paid by the uninsured. And the federal government (us) pays much of the rest – around $34 billion in 2004.[2]

Most of that money goes to hospitals to help offset their losses as a result of treating the uninsured. So, yes, insured patients may not pay the full costs of their own care but, with or without health reform, virtually all of the monies paid for healthcare in the U.S. can be traced back to us. That being the case, one question to ask ourselves is whether we prefer to pay in ways that may feel better because the costs are hidden, or in ways that may feel worse because they are seen.□

Deciding Where You Stand: Questions to Ask Yourself

At least four sets of questions may help readers decide where they stand on the issue of healthcare reform. They are:

About Your View of Things
Why do I feel the way I do? What assumptions am I making? Are they correct? Does evidence support them? Have I given full consideration to other views? Have I kept an open mind?

About Different Approaches to Healthcare Coverage
How well do different countries' systems of health coverage work? How do their citizens like these systems? Would they change? What's actually in our new healthcare law?

About Our New System
Is the information (or claim) about our new system accurately stated? If so, is it correctly interpreted – does it mean what people say it means? Are the claims completely or only partly true? What evidence supports them? Does it hold up to scrutiny?

About the Source of the Information
Who is making this claim – someone from the hard Right or Left? Some group? What do others have to say, including those from center Left or Right? What does the person (or group) have to gain by making these claims?

[1] Search online for "One Word Can Save Your Life: No!" by Sharon Begley

[2] Search online for "The Cost of Care for the Uninsured: What Do We Spend, Who Pays, and What Would Full Coverage Add to Medical Spending?"

The Patient Protection and Affordable Care Act: An Overview

Details of the Patient Protection and Affordable Care Act, known more simply as the Affordable Care Act (ACA), are a mystery to many, if not most Americans. This overview hopes to begin the unraveling of that mystery. It is primarily drawn from two sources, both of which are highly recommended reading. The first is *Healthcare Reform and American Politics: What Everyone Needs to Know*. In it, Lawrence R. Jacobs and Theda Skocpol not only explain the new law in terms of how it will affect different segments of our population, but also shed a great deal of light on what went on behind the scenes in our nation's capital. The second source is the Kaiser Family Foundation's "Summary of the New Health Reform Law" at **www.kff.org/healthreform/8061.cfm**. This 13-page document, last updated in April 2011, is formatted for easy reading and provides many details, most of which are not included in this overview. The full ACA can be found through the Library of Congress website: **www.thomas.loc.gov**. Links to individual sections of the law, as well as to the full law can also be found at **www.healthcare.gov**.

Designed to be gradually implemented over a 5-year period, the actual achievement of affordable insurance, improved care, and protections for the insured, will depend on how much of the law will still be standing as time goes on.

The Affordable Care Act (ACA)

Signed into law on March 23, 2011, the ACA stays true to the basics of our healthcare system in that it still relies heavily on private insurers as well as on private healthcare professionals and institutions. While it also expands our public assistance programs, such as Medicaid, there is no government takeover of healthcare. Its goals are to make health insurance (and, therefore, healthcare) more affordable; to improve care and to assure better protections from decisions by the health insurance industry. Designed to be gradually implemented over a 5-year period, the actual achievement of these goals will depend on how much of the law will still be standing as time goes on. In this overview, we take a look at some of what the law would mean for our nation's citizens and businesses. Again, details can be found in the above noted sources.

Senior Citizens and Medicare

The new law provides for both an expansion of covered services for senior citizens who have Medicare as well as lowered costs. Provisions include, but are not limited to a large reduction in the cost of medications as a result of greatly reduced prices and, by the end of the decade, Medicare will pay for 75% of all prescription drug costs. In keeping with the law's emphasis on prevention and wellness, recommended preventive services will now be free.

Besides expanded coverage, primary care physicians (family and internal medicine physicians) who treat Medicare subscribers will be paid more. The law also calls for changes in subsidies to Medicare Advantage Plans (HMOs & PPOs) which provide coverage and care for about 25% of Medicare subscribers. Until now, the federal government, has been paying these plans more for that care than they have paid those providing care for patients enrolled in traditional Medicare. Under the ACA, those payments will be changed so as to bring them in line with rates paid for care provided to traditional Medicare enrollees. This will mostly mean reductions in payments to Medicare Advantage Plans and will lead to big savings for the federal government.

Adults Not Yet 65 Years Old (The Non-Elderly)

To make insurance for non-elderly adults more affordable, federal subsidies will help 4 out of 5 individual households pay less for health insurance – even if their insurance premiums go up. Family-of-4 households with incomes of up to $88,200/year (based on 2009 figures) will qualify for subsidies. The Congressional Budget Office expects that there will be a 60% decrease in premium costs for the individual market by 2016 along with a 10% reduction in premium costs for the small group market.[1]

Because a third of non-elderly citizens (in 2009) get the most expensive and least secure health insurance policies through individual and small business markets, the ACA calls for states to set up new insurance marketplaces – Health Benefit Exchanges and Small Business Health Options Programs (SHOP). These exchanges will allow individuals and small businesses to have the same advantages and choices when buying health insurance as employees of large businesses.

Exchanges must have at least two participating insurers, at least one of which must be a nonprofit. These insurers will be required to offer a minimum of a standardized, essential health benefits package that provides a comprehensive set of services; to limit out-of-pocket charges; to provide basic preventive checkups at no extra charge; to not use 'misleading' and confusing fine print; to provide easy-to-understand descriptions of coverage options; and to create a call center, facilitate enrollment, and simplify applications for subsidies.

See **ACA**, *continued on pg. 6*

ACA, *continued from pg. 5*

Those buying insurance through these exchanges will be able to choose from among four levels of coverage, with the difference in each based on the amount of costs covered by their policies (from 60% - 90% of benefits covered). A catastrophic plan will also be available for purchase – albeit only by people up to age 30, who are exempt from the individual mandate to purchase insurance. This plan will require them to pay for all their medical expenses except for those related to a serious accident or illness.

Young Adults Just Starting Work

The law now allows young adults up to the age of 26 to stay covered under their parents' health insurance policies – whether or not they are in college. And until they can get insurance through their employer or buy it themselves (with help from subsidies), they will be able to enroll in Medicaid (if they have a low annual income of not more than $14,444, based on 2010 figures).

The CBO projects a reduction in the federal budget deficit by about $140 Billion in the first ten years of the ACA, with more deficit reduction in the second decade.

Citizens and Legal Residents Without Health Insurance

With financial aid from the federal government, 16 million uninsured children and adults without children who meet the income eligibility requirements will get insurance through an expansion of Medicaid. And soon after the passage of the law, temporary, national high-risk pools were created for people who were previously unable to get insurance because of pre-existing conditions. In 2014, when private insurers will be barred from denying coverage based on pre-existing conditions, these pools will be discontinued. Premium subsidies will also be available to those who enroll in these temporary high-risk pools.

Businesses

Companies with more than 200 employees will pay new fees to help pay the costs of the ACA and, if they are not already offering health insurance to their employees, they will be required to do so for all workers – although any employee may choose to opt out of work-based coverage. Those companies already providing insurance to employees will see a reduction in those costs. Small businesses with 50 or more employees will have to pay a penalty if they have at least one employee getting a premium tax credit (as a result of getting insurance elsewhere). In that case, companies will be assessed a penalty for each full time worker, excluding the first 30 workers. Small businesses with less than 50 employees are exempt from the requirement to provide insurance and exempt from penalties. Businesses with 25 or less employees that offer health insurance to their employees will get tax credits if they meet certain eligibility requirements.

How Will the New Law Be Paid?

The costs of enacting this new law are huge ($965 Billion), though the Congressional Budget Office projects that future federal expenditures on healthcare will come down from assumed levels – enough to *reduce the federal budget deficit by about $140 Billion during the first ten years of the new program and that we'll see more deficit reduction in the second decade*.[2]

But the bill still needs to be paid and it will be in two ways – first, by using monies saved through cost-containment and reductions in what the federal government would be paying healthcare systems and providers (under the old system) in the many years to come. (For example, monies saved by cutting back on subsidies to Medicare Advantage plans will help pay for the new law's drug benefits.)

The rest (a little more than half) will be paid by taxes and fees imposed on well-to-do businesses and households.[3] Medicare beneficiaries with incomes of $85,000 and higher will be required to pay a premium for Medicare D – prescription drug coverage. And individuals and households earning more than $200,000 and $250,000, respectively, will reportedly pay an average of $560/year more in Medicare taxes, while millionaires should also see an average of $46,000 more per year in new taxes. As well, anyone that frequents tanning salons will be required to pay a 10% tax.

The Individual Mandate

By 2013, an individual mandate to buy minimal essential health insurance coverage will kick in for every U.S. citizen and legal resident. Those who do not get insurance will pay a penalty imposed for each month they don't have coverage. Penalties will start being phased in with the 2014 tax filing for 2013. By 2016, penalties will range from $695 - $2,085 per year OR 2.5% of household income – whichever is greater. Subsequent increases will be tied to cost-of-living adjustments. Exemptions to the mandate include those based on religious objections and unusual financial hardship as well as on populations that include American Indians and undocumented immigrants. States may opt out if they have an alternate way of assuring affordable coverage but, for reasons outlined in the actual law, this controversial provision (or an acceptable alternative) is seen as essential to the ACA's success.[4] □

[1] See Congressional Budget Office analysis at **http://www.cbo.gov/publications/collections/health.cfms**

[2] See Note 1.

[3] See **www.kff.org/healthreform/8061.cfm** for a detailed description of ACA-related tax changes.

[4] See **http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf** pp 243-244.

Two Concerns About Health Reform

1: Socialized Medicine and Rationing of Care

Socialized medicine is defined as:

> "*a system of health care in which all health personnel and health facilities, including doctors and hospitals, work for the government and draw salaries from the government*"[1]

While many don't like the idea of socialized medicine, the primary concern seems to be the rationing of care that occurs in many of these systems – especially upon learning about people in other countries who have to wait for surgeries, expensive tests or are denied medications.

Healthcare rationing is defined as:

> *"The limitation of access to or the equitable distribution of medical services, through various gatekeeper controls"* [2]

Some are so concerned about this that, to them, any level of intervention by government makes rationing more likely. For them, the 2010 healthcare reform law does not bode well. Rationing, however, has been a fact of life when it comes to healthcare. It can be found everywhere – even in America. It happens here when access to care is limited by the ability to pay – whether for health insurance or when particular treatments (for insured patients) won't be covered by their insurers.

Rationing has been a fact of life when in comes to healthcare – even in America.

Cost containment is often the driving force behind rationing. For the most part, government's motivation to control costs is driven by an interest in assuring access to healthcare for everyone. For the most part, insurer's motivation to control costs, as acknowledged by House Majority leader, Eric Cantor, is driven by profits.[4] Even so, Cantor believes that rationing by private insurers is preferable to rationing by government.[5]

How then can readers figure out if their concerns about government rationing are valid – if they, too, prefer rationing by businesses to rationing by government? One way would be to look at our government's long-term involvement in healthcare, beginning with Medicare and Medicaid, which rely on private physicians and hospitals. Those who may not be part of these programs might ask those who are how they feel about the care they receive and whether their access to care and the freedom to make their own healthcare decisions is too limited. The same questions can be asked of veterans who receive their healthcare through VA hospitals. As defined above, this ***is*** a socialized medicine program. Its doctors and hospitals work for and are paid by the government. Speak to veterans you know and, if you don't know any, contact your local VFW. Ask its members what they think. In both cases, question as many as you can because, as with anything in life, there will usually be mixed reviews. The more you question, the more likely you'll get a good sense of its general approval rating – whether high or low. This is an important consideration for making an informed decision.

2: The Affordable Care Act will Cut Medicare Services

Claims are being made that the health reform law's planned $500 billion cut in Medicare over the next 10 years will mean cuts in covered services. Even more cuts in services, they claim, will be made by the independent commission, created by the law, whose purpose is to find ways to reduce the growth in Medicare costs. No wonder Medicare beneficiaries are concerned. The question is, how concerned should they be? Will that $500 billion cut mean cuts in covered services? Is that independent commission, the Independent Payment Advisory Board (IPAB), whose recommendations will become policy *unless congress votes otherwise*, something to worry about? Will the policy recommendations of the IPAB's non-elected (and therefore unaccountable) members lead to the rationing of services and reduce access to quality care, as its opponents claim?

With respect to the IPAB, two considerations may help readers decide if they should, or should not, be concerned. The first regards the unaccountability of the commission's non-elected members. This valid point is countered by another valid point – namely, that by not being elected, they are less vulnerable to industry lobbyists whose monies seem to hold great sway with our elected officials. The second consideration is that the law makes a point of stating that the IPAB MAY NOT recommend anything that

> *"would ration care, increase revenues or change benefits, eligibility or Medicare beneficiary cost sharing (including Parts A and B premiums) or would result in a change in the beneficiary premium percentage or low-income subsidies under part D."*[6]

And what about that $500 billion in cuts? Will it reduce services? The answer is 'no' for most and 'maybe' for some. An explanation for this answer will follow here, but details can be found at **www.politifact.com**, a Pulitzer-Prize winning website that investigates many political claims and rates them, on their 'Truth-o-Meter' as being true, pants-on-fire false, or somewhere in-between the two.[7]

To explain the 'no' and 'maybe,' we begin at the beginning. First, the $500 billion cuts are intended to reduce future growth in spending over the next 10 years not covered services. Without these cuts, spending is projected to reach $929 billion in 2020, up from $499 billion in actual spending in 2009.[8] Under the new law, spending will still grow, just more slowly.

See **Concerns**, *on Pg. 8*

Concerns, *continued from Pg. 7*

Second, part of the $500 billion in reduced spending will come from reduced payments to doctors and hospitals for poor quality of care – for example, when preventable hospital readmissions occur. They will, however, be given bonuses for quality care. Other reductions will come from the Medicare Advantage (MA) plans described on page 5. Under the current system, the federal subsidies they've received have been estimated to cost taxpayers 14% more than traditional plans. In part because of these subsidies, MA plans have provided extra coverage (including drug coverage) which traditional Medicare does not cover. And, in some cases, enrollees even pay no premiums.

As also described on page 5, payments to MA plans will change. In some cases, this may mean increased payments for MA plans. In many, it will mean reduced payments. This, in turn, may cause some MA plans to reduce or eliminate those extra benefits. In other words, cut services. If that should happen, those enrolled in MA plans may lose some of their extra benefits but will still have the same benefits as those who are in traditional Medicare – including the expanded coverage under the new law.

[1] See http://www.medterms.com/script/main/art.asp?articlekey=25521

[2] See http://medical-dictionary.thefreedictionary.com/health+care+rationing

[3] See http://healthcare-economist.com/2008/11/07/us-spends-700-billion-on-unnecessary-medical-tests/

[4] See http://www.kaiserhealthnews.org/daily-reports/2011/may/04/cantor-on-rationing.aspx

[5] See Note 4

[6] See www.kff.org/healthreform/upload/8061.pdf, page 8

[7] See http://www.politifact.com/truth-o-meter/statements/2010/sep/20/60-plus-association/medicare-cuts-health-care-law-will-hurt-seniors-sa/

[8] See Note 7.

Where to Find Answers to…

What do people in countries with universal healthcare think about their healthcare system?

See http://www.gallup.com/poll/122393/oecd-countries-universal-healthcare-gets-high-marks.aspx, for the results of a Gallup poll of citizens in different countries, indicating overall approval ratings for their healthcare systems.

Where else can I find health comparisons of different countries?

For the latest health comparisons of different countries, compiled by our own Central Intelligence Agency, see www.cia.gov/library/publications/the-world-factbook/rankorder/rankorderguide.html

Where can I learn what's already been implemented in the law and how I can benefit from it?

Three different links at www.healthcare.gov can help here: 'Health Care Law & You' (see 'timeline' and 'implementation resources;') 'Get Help Using Insurance' and also 'Find Insurance Options.'

Where can I find what's in the Affordable Care Act?

bears repeating, go to www.healthcare.gov. Click on 'Health Care aw & You' for links that include the law itself (both in its entirety id in sections), the implementation timeline and more.

nd…

ee www.koleyjessen.com/assets/PPACAExecutiveSummary.pdf

Where can I find a simple explanation of the law's effect on Medicare?

http://www.kaiseredu.org/tutorials/Medicare-and-health-reform/player.html

This Kaiser Family Foundation tutorial, which combines video, text and graphs, can be downloaded to your computer.

How can I find out if claims about the law are true or false?

See www.politifact.com. Scroll down the page to learn more about politifact. Then Click on 'Truth-o-Meter,' then 'By Subject,' then 'Health Care.' If you don't see what you're looking for, enter key words in their search box, or contact them and suggest an item – either a claim made by a politician, a TV ad or a chain email. Under the 'How to Contact Us' on their home page, they even express an interest in seeing chain emails.

We Are Pleased to Announce a Special Webinar

"Talking to terminally ill patients and their families – practical guidance for healthcare providers"
By
Guest Presenter
Marcia Levetown, MD

November 10, 2011
2 - 3 pm ET

For Program Description See www.healthcp.org

For General Webinar Information, see Pg. 10

* * *

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ABOUT OUR WEBINARS

At various times throughout the year we will present one-hour webinars (online seminars) for both the general public and health and human service professionals.

NECESSARY EQUIPMENT

All that is needed is a computer, access to the Internet through a cable modem (not dial-up), a phone and an email address.

REGISTRATION

Registration for these programs is via the Internet. A link to register is provided with descriptions. dates and times of each program. Once we are notified of your registration, we will send you a toll-free number to call and a web address for logging on to the webinar website.

PROGRAM FEES & REFUND POLICY

To keep our webinars affordable, we charge $10 for patient education webinars and $29 for most professional education webinars. Full refunds, less a 10% administrative fee will be issued when requested up to two days before the webinar. No refunds will be issued when requested 48 hours or less of the webinar.

PROGRAM TOPICS

FOR THE GENERAL PUBLIC

- Getting the Most Out of Doctor Visits
- Finding, Understand, Discussing Medical Information
- Choosing and Managing Medications
- Advocating for Loved Ones
- And more

FOR HEALTH PROFESSIONALS

- Ethical Considerations When Clinician & Patient Disagree
- Health Literacy: Helping Patients Understand Health Information and Instructions
- Building Cultural Competency
- And topics offered by the occasional guest presenter