

June 2009

PO Box 142
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The Voter



Items of Interest

- What's Happening at Home?
- The 2010 Census Is Around the Corner
- Supreme Court Safeguards Judicial Impartiality
- A Short History of Changes in U.S. Health Care since 1994

Results of the National Popular Vote Compact Study

Washington, DC — On Monday, May 22, the Board of the League of Women Voters of the U.S. approved the following statement, "The LWVUS affirms its support of the direct election of the president and abolition of the Electoral College, but the LWVUS has no position on the National Popular Vote Compact as studied in 2008-2009."

Two criteria were established for a successful consensus study. The requirement for participation by 1/3 of local Leagues was met with participation by 390 of 766 local Leagues (51%).

While the second criterion, the requirement that 2/3 of participating Leagues achieve consensus on the use of the National Popular Vote (NPV) Compact, was not achieved, the study elicited very strong support for the NPV Compact (about 50% in favor). However the remaining 50% were split almost equally between not favoring the NPV Compact or being unable to reach consensus.

Comments from many Leagues reflected: (1) concerns about bias in the questions, (2) the misunderstanding that a choice had to be made between advo-

cating for abolition of the electoral college OR supporting the NPV Compact, and (3) statements that seemed to contradict a given League's responses to the questions.

Based on an analysis of the responses and the comments, the NPV Compact Committee and Program Planning Committee recommended that the LWVUS continue to examine opportunities to achieve the goal of direct election of the president in addition to the unlikely opportunity of abolishing the Electoral College by constitutional amendment.

To put a question on the ballot, petitioners must gather signatures of registered Maine voters equivalent to 10% of the total votes for Governor in the last gubernatorial election.

Secretary of State Issues People's Veto Petition

Augusta, ME - On May 19, Maine's Secretary of State completed work on the master petition for citizens wishing to reject the law to legalize same-sex unions. LD 1020, *An Act to Promote Marriage Equality and Affirm Religious Freedom*, which the League of Women Voters of Maine endorsed, was passed by the Legislature and signed by the Governor on May 6, 2009, and is scheduled to take effect

90 days after the Legislature adjourns.

Citizens wishing to reject the law have until the 90th day to submit petitions containing 55,087 valid signatures to the Secretary of State. If the petitions with sufficient signatures are submitted, then the law will be stayed until a statewide vote on the people's veto.

As of June 1, nearly 5,000 peti-

tions had been distributed to volunteers, who are now gathering signatures in churches, homes and public places.

The proposed ballot question appears on the petition as the following: "Do you want to reject the new law that lets same-sex couples marry and allows individuals and religious groups to refuse to perform these marriages?"



May and June are the months when many Maine communities adopt their budgets.



What's Happening at Home?

Bath, ME - On Wednesday, June 10, the **Bath** City Council gave preliminary approval to a \$14.2 million budget for 2009-10 that would keep the tax rate at \$17.20 per \$1,000 of assessed valuation. If the budget is finally approved on June 24, this will be the first year since 1997 that the tax rate has not increased.

Voters in **Regional School Unit 1** met at Bath Middle School on Tuesday, June 2, to participate in a Town Meeting gathering about the proposed 2009-10 budget of \$25 million. Following the meeting, the proposed budget went to referendum in all five RSU 1 communities on Tuesday, June 9, where it was approved by a margin of 424 to 121.

The budget reflected a nearly 1 percent decrease from the 2008-09 year, as well as a 0.74 percent increase in taxes. The \$16.4 million local contribution was divided among the five communities as follows: Arrowsic, \$485,000, a 13.6 percent increase; Bath, \$7.8 million, a 1.6 percent decrease; Phippsburg, nearly \$3 million, a 0.9 percent increase; West Bath, \$2.5 million, a 3 percent increase; Woolwich, \$2.7 million, a 3.4 percent increase.

On Monday, June 1, the **Brunswick** Town Council approved a \$53.5 million budget for 2009-10, keeping the tax rate at \$22.54 per \$1,000 of assessed valuation. The town budget included a \$36.4 million school

budget, which was ratified by Brunswick voters at referendum on Tuesday, June 9, by a margin of 617 to 128.

On Tuesday, May 26, the **Freeport** Town Council passed a \$9.7 million budget for 2009-10, increasing the tax rate from \$3.11 to \$3.12 per \$1,000 of assessed valuation. The budget passed by a margin of 6 to 1, with Charlotte Bishop in opposition.

Regional School Union 5 adopted its first budget - \$23.5 million - on Wednesday, June 3. Seven of the 11 articles passed unanimously. Three articles passed by a margin of 9 to 2, with both Pownal Board members opposed. One article, amended to cut an athletic trainer position, passed by a margin of 6 to 5, with three Freeport members and one Durham member joining the Pownal members to vote in favor.

The budget will affect tax rates in the three communities as follows: Durham, 6.9 percent increase; Freeport, 0.52 percent decrease; Pownal, 26.5 percent increase.

Residents of Pownal are alarmed about the looming tax increase. Although the town is responsible for only 12.6 percent of local RSU 5 funding, declining student enrollment, and increased state property tax valuations have combined to decrease state education funding during a budget year when RSU communities must

pay one-time consolidation costs.

The annual budget meeting is scheduled to take place at Freeport High School on Tuesday, June 16, and voters will cast their ballots on the referendum on Thursday, June 25.

On Wednesday, May 27, several hundred voters at the annual Town Meeting in **Topsham** passed a \$7,841,699 budget for 2009-10, raising the tax rate from \$13.50 to \$13.77 per \$1,000 of assessed valuation.

Voters in **School Administrative District 75** met at Mt. Ararat Middle School on Saturday, May 30, to participate in a Town Meeting gathering about the proposed 2009-10 budget of \$36.3. Following the meeting, the proposed budget went to referendum in all four SAD 75 communities on Tuesday, June 9, where it was approved by a margin of 854 to 376.

The budget reflected a 0.84 percent tax decrease from the 2008-09 year, divided among the four communities as follows: Bowdoin, 0.42 percent increase, Bowdoinham, 1.94 percent increase, Harpswell, 0.52 percent decrease, Topsham, 2.34 percent decrease.

Despite protests from West Harpswell residents, on Thursday, June 11, the Board of Directors of SAD 75 voted to close West Harpswell Elementary School following the 2009-10 school year. Only Harpswell

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The 2010 Census Is Around the Corner

Washington, DC - Article I, Section 2 of the U.S. Constitution mandates a count of residents of the United States every decade. The first Census was conducted in 1790.

The Census 2010 will be a short form, with 10 questions that will take approximately 10 minutes to complete. The census will count all residents living in the United States and ask for name, sex, age, date of birth, race, ethnicity, and familial or

non-familial relationships of all members of households.

Census data is important because: it has an impact on how more than \$300 billion per year in federal and state funding is allocated to communities for neighborhood improvements, public health, education, transportation and more; it is used to apportion seats in the U.S. House of Representatives and to redistrict state legislatures; and it is used to define legisla-

tive districts, school district assignment areas and other important functional areas of government.

The census is like a snapshot that helps define who the nation is. Data about changes in communities are crucial to many planning decisions, such as where to provide services for the elderly, where to build new roads and schools, or where to locate job training centers.



For more information, go to www.lwv.org and search for 2010 Census.

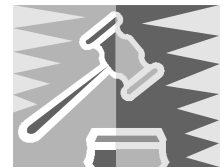
Supreme Court Safeguards Judicial Impartiality

Washington, DC - The 5 to 4 U.S. Supreme Court decision in *Caper-ton v. Massey* "strikes a blow for every American by reinforcing that due process and judicial impartiality will not be compromised for political gain," according to the League of Women Voters of the United States, which joined Common Cause and other nonprofit organizations in an *amicus curiae* brief in that case.

Justice Brent Benjamin of the

Supreme Court of Appeals of West Virginia refused to recuse himself from the appeal of a \$50 million jury verdict, even though the CEO of the lead defendant contributed \$3 million to his campaign for a seat on the court — more than 60% of the total amount spent. After winning election to the court, Justice Benjamin cast the deciding vote in the court's 3-2 decision overturning the verdict.

Writing for the majority, Justice Kennedy concluded, "There is a serious risk of actual bias — based on objective and reasonable perceptions — when a person with a personal stake in a particular case had a significant and disproportionate influence in placing the judge on the case by raising funds or directing the judge's election campaign when the case was pending or imminent."



SAD 75 Board Votes to Close West Harpswell School

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member Jane Meisenbach opposed the action. According to the Board, the school's closure is necessary to provide quality education equitably throughout the district.

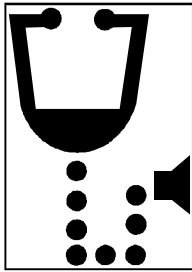
Under Maine's school consolidation statute, Harpswell's vot-

ers must ratify the Board's decision at referendum. However, if Harpswell chooses not to close the school, then the Town will be responsible for paying the potential cost savings, now calculated to be \$184,721 annually, to SAD 75.

Residents of West Harpswell are concerned about a loss of

community following a school closure. They are also concerned that their grade K to 5 students will have much longer bus rides as they are transported from the West Harpswell peninsula across Mountain Road to the Harpswell Islands School on Great Island.





A Short History of Changes in U.S. Health Care since 1994

Washington, DC - The health care system in the United States has undergone major changes since the defeat of President Clinton's effort to create a national plan in 1994. "Over the last few decades, American health care has radically changed. A system that was largely not-for-profit has become a field where the profit motive and market forces affect every decision."¹

The defeat of comprehensive health reform shifted the effort of cost control to the private sector. One major change called managed care promised to control costs, provide good coverage, provide quality health care and eventually cover everyone. Have these promises been kept?

Has Managed Care Controlled Costs?

Before 1995, the great majority of employer plans were traditional indemnity insurance, allowing access to any doctor and paying whatever fee the doctor or hospital required. In 1978, 95 percent of Americans with employer-sponsored coverage had fee-for-service plans. By 1998, only 14 percent were enrolled in such plans.

This decrease was accompanied by an increase in enrollment in a wide variety of managed care insurance plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Point of Service plans (POSs). These plans controlled costs four ways:

- limiting the choice of doctors by paying the total fee only if the physician was in the plan's network;
- requiring patients to see a primary care doctor before obtaining a referral to a specialist;
- requiring prior permission from doctors for admission to hospitals, diagnostic tests or medical procedures; and
- negotiating predetermined fee schedules for physician payment at a discount from the usual fees.

For about five years, the total national expenditure for health care

declined (1993 - 13.7 percent of gross domestic product [GDP]; 1998 - 13.5 percent of GDP).² Analysts disagree about the major cause for this decline. Some say it was due to managed care's effectiveness in controlling costs or marketing strategies that led insurers to underprice their products to expand market share. Others say that it was due to the one-time shift from fee-for-service plans, which cannot be repeated.

In 2004, the National Coalition on Health Care (NCHC)³ reported that premiums and the rate of increase in premiums had escalated since 1998. "What makes recent increases in premiums especially striking is that we have been in a period of low inflation."³

In 2009, the NCHC reported three key facts:

Since 1999, employment-based health insurance premiums have increased 120 percent compared to a cumulative inflation rate of 29 percent and cumulative wage growth of 34 percent during the same period.⁴

Since 2000, the average employee contribution to company-provided health insurance has increased more than 120 percent. The average out-of-pocket costs for deductibles, co-pays for medication and co-insurance for physicians and hospitals rose 115 percent.⁵

Total spending on health care in 2007 was \$2.4 trillion - 17 percent of GDP. "...the United States has \$480 billion in excess spending each year in comparison to Western European nations that have universal health coverage. The costs are mainly associated with excess administrative costs and poorer quality of care."⁶

Have Managed Care Plans Provided Good Coverage?

Most people would define "good coverage" to include preventive, primary, hospital, mental health, dental and vision care as well as prescription drugs - without deductibles and small or no co-pays. Rising costs for health services

have led health insurance companies to market new products to younger and healthier enrollees because risks are low and profits high. Some of these plans have moderate deductibles but limited benefits, e.g., \$10,000 maximum benefit cap. Other plans may have more comprehensive coverage but with high deductibles, e.g., \$5,000 for an individual; \$10,000 for families in-network (double if out-of-network).⁷ Thousands of plans now exist that lower premiums by reducing benefits and raising deductibles and co-pays.

Has the Quality of Care Improved?

In 2004, NCHC reported on "an epidemic of sub-standard care."³

*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.*³

The study went on to say: "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 of 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."³

NCHC also cited a major study by the RAND Corporation.³ "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 re-

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Has Managed Care Worked?

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ceived over a two-year period. Using 439 indicators of quality developed by multi-specialty 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.³ While the Rand study provides an important quality benchmark, without electronic medical records, it is so labor intensive and expensive that it is rarely done and cannot provide an ongoing monitoring of the quality of health care delivery systems to help improve it.

Are We Moving Toward Coverage for Everyone?

In 1994 there were 39 million uninsured people;⁸ in 2002 43.6 million uninsured people;⁹ in 2003 45.0 million;⁹ in 2004 45.8 million;⁹ in 2006 46 million;¹⁰ in 2007 45.7 million.¹⁰ It is estimated that there will be from 48 to 50 million uninsured people in 2009.

As the costs rise, more businesses drop their health care benefits. The percentage of people (workers and dependents) with employment-based health insurance has dropped from 70 percent in 1987 to 62 percent in 2007. This is the lowest level of employment-based insurance coverage in more than a decade.¹¹

As more people lose jobs that provided coverage, the number of uninsured people continues to rise. More people would be uninsured but for publicly funded insurance such as Medicaid and SCHIP (State Children's Health Insurance Program).¹⁰

Even with some early and temporary gains in reducing costs, the managed care model in the private sector has not stopped the deterioration of this nation's health care.

The Transformation of Health Insurance Companies

Beginning in 1995, non-profit health insurance companies gradually transformed into for-profit com-

panies, selling shares on the stock market to raise capital that could be used to expand market share by buying other insurance companies. In 1988, ten top insurers covered 27 percent of all insured Americans. Today, four publicly traded corporations — WellPoint, Inc., United Health Group, Aetna, Inc., and Cigna — dominate the market, covering 85 million people, or almost half of all Americans with private insurance.¹²

One result of this change is that insurance companies have become responsible to shareholders to maintain profit margins. The "medical loss ratio" is the insurance companies' term for the amount of money a company pays for health services. Reducing the amount paid for services increases profit, which is often translated into higher value for the company stock.

Four major ways that insurance companies manage risk and reduce their medical loss ratios are: 1) reducing covered services; 2) raising deductibles and co-pays; 3) refusing coverage for pre-existing conditions; and 4) marketing to the young and the healthy ("cherry picking"). "Even non-profits such as Blue Shield of California are obliged to follow prevailing market practices or be swamped with the highest-cost customers."¹³

In the individual market, another method of keeping medical losses down is to cancel customers who insurers say did not qualify for coverage in the first place. "Several insurance companies have established departments dedicated to reviewing applications of customers who file costly medical claims. The goal is to discover evidence that the clients failed to disclose pre-existing conditions when they applied. Insurers cite these omissions as grounds to cancel policies retroactively, a process known as rescission."¹³

For example, Health Net, Inc., a nation-wide insurer with 6.7 million members avoided spending \$35.5 million by cancelling the policies of 1,600 California customers over 6 years. Health Net paid bonuses to

an employee based, in part, on how many policies she cancelled.¹³

Private Health Insurers: Managing Money, Not Health Care

The development of Health Savings Accounts (HSAs) is rooted in the notion that health care expenses are rising in part because most Americans who receive health coverage as an employment benefit have no idea how much their care actually costs. The argument continues: if people paid more out of their own pockets, they would become more frugal and discriminating in their choice of doctors, hospitals and medications.¹⁴

In 1996, Congress approved a program providing tax relief for medical savings accounts. In 2003, the contribution limits were raised and indexed to inflation (in 2008 — \$2,900 for individuals; \$5,800 for couples). Under the rules, contributions to HSAs are tax-exempt, as are their investment gains. Withdrawals are also tax-exempt if they are used for qualified medical expenses. Over time, an HSA balance could grow to hundreds of thousands of dollars because the money can carry over year after year indefinitely.

Commercial banks, seeing the opportunity to collect fees for managing the account and transaction fees for investing the funds, jumped into the business. Medical insurers rushed to open their own banks. WellPoint, Inc., the nation's largest health insurance company, tried to convince the Federal Reserve Board that financial services was its core business. When questioned about its mail-order pharmacy and its program for managing chronic diseases, which were overseen by WellPoint doctors and nurses, WellPoint convinced the Fed that those activities were merely "complementary" to its main business — financial services. It pledged to limit them to less than 5 percent of total revenue.¹⁴

"That a medical insurer would agree to keep a lid on healthcare expendi-



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Managing Money, Not Health Care

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tures so it could get approval to open a bank illustrates a fundamental change in the industry: Insurers are moving away from their traditional role of pooling health risks and are reinventing themselves as money managers – providers of financial vehicles through which consumers pay for their own healthcare."¹⁴

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