JERICHO newsletter

Fall 2006

Combined Advocacy Efforts Improve Californians' Income and Health

Legislature Passes Minimum Wage, Health Care Coverage

This past year over 5,500 bills were introduced in the state Legislature. After the July recess, committees were still left with over 2000 bills to decide before August 31. Each year JERICHO staff reviews bills based on the priority issues selected through our bi-annual membership survey. This year we started with about 80 bills and winnowed that list down to about 60 for further consideration.

As the session progressed we actively followed about 45 bills that seemed to be the most critical, based on our priority system. The list of bills narrowed even further in the session as we coordinated with the advocacy groups with whom we work to focus our energy on specific bills judged to be either more important, timely, or, with concerted effort, "most likely to succeed."

Governor Signs Minimum Wage Increase

For example, although many of us have been working on the minimum wage increase for several years, forces came together this year that made AB 1835 (*Lieber*) more likely to pass—which it did. Even though we were disappointed not to have "indexing" (rising with inflation) included, we are happy for those Californians who will see their hourly wage increase $0.75 an hour (to $7.50) in January 2007 and another $0.50 in January 2008.

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New Bills Address Needs of Incarcerated Women

In response to the good work of some of our colleagues—the Get on the Bus effort begun by Sister Suzanne Jabro in Los Angeles—Jericho has been involved this year with legislation addressing the unique needs and services of incarcerated women. The correctional system was mostly designed to provide places of incarceration for men and the manner in which the needs of the incarcerated are addressed are also designed with men in mind.

For example, women have different health needs, including pregnancy-related health care. Most women leaving prison will return to their communities within three years. The majority of women in prison have minor children and were the primary caretaker for their children before they were incarcerated and may resume parenting upon release. How women are prepared for reentry has huge consequences on the subsequent upbringing of their children and whether or not their children will sustain severe social, emotional and economic problems and become incarcerated themselves.

Most women inmates had been physically or sexually abused prior to incarceration, resulting in specific barriers to self-sufficiency and success in society. In 2005, more than two-thirds of female inmates were serving sentences for property crimes (i.e., burglary, receiving stolen property, vehicle theft and forgery), drug related offenses or other non-violent crimes.

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Since 1987 JERICHO has engaged the interfaith community throughout California in shaping state public policy that affects individuals and families living in poverty.

JERICHO

Editorial

For the past almost 20 years health care reform has been one of JERICHO's top issues. The fact that we are still so far from it—and some would say worse off than in years past—attests to the difficulties involved in creating a viable "system" out of a mish-mash of programs, services, health plans, etc. that benefit some and not others. Within what I'm calling the "mish-mash" are the various stakeholders whose job it is to protect their part of the network.

Probably the most basic division is between those who believe that the most efficient and cost effective way to approach affordable, universal health care is through a social insurance program—such as Medicare—and those who believe that competition through market forces is the best way to bring down costs and thus increase access. Most of those who believe in market forces also acknowledge government's role in helping those who are most in need.

Unwilling to wait for federal efforts to cover the country's approximately 46 million uninsured, individual states are crafting their own solutions or partial solutions. Some of them are highlighted in this issue. In addition, we have included a broad brush look at how other industrialized countries provide health care.

The next couple of years in California will be important ones in the health care debate as the increasing cost of care is affecting more and more people. This past July, Governor Schwarzenegger convened a Health Affordability Summit—to which JERICHO was an invited participant—to begin a process of defining the elements around which there might be consensus among the various stakeholders. Follow-up meetings with smaller groups and individuals have continued the discussion.

During the same period the state Legislature passed SB 840, sponsored by the California Nurses Association, which would enact a "single payer" system in California wherein all residents would receive services from private health care providers who would be reimbursed for their services by the state. The system, financed mainly through individual and employer taxes, would replace insurance premiums. Existing public dollars would continue to support low-income health services. The Governor has been quoted as saying he will not sign SB 840.

Something must be done to move through the political, financial and programmatic obstacles that prevent reform. JERICHO is committed to discover what ordinary people see as viable solutions.

Many states are looking to the success that Massachusetts had in passing bi-partisan legislation to cover most of its residents. While the elements of the Massachusetts Plan may not all fit California, what is remarkable is that stakeholders met for over two years to arrive at a reasonable consensus.

Something must be done to move through the political, financial and programmatic obstacles that prevent reform. JERICHO is committed to educate Californians regarding the current health care reform options and to discover what ordinary people see as viable solutions. Our workshops in early 2007 will collect "grass-roots" reform preferences from a variety of constituents. Our goal is to move the debates in Sacramento towards realistic solutions that benefit the health of all Californians.

Sister Marti McCarthy, SSS

JERICHO Newsletter is published quarterly for members of JERICHO's two organizations.

JERICHO Education for Justice educates faith communities and others about California public policy as it affects poor people.

JERICHO A Voice for Justice through its registered lobbyist in Sacramento and statewide members actively engages in the development of legislation that promotes economic fairness.

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How Other Countries Provide Health Care

France

France offers health care to all legal residents under a social insurance entitlement program. The main fund covers 80% of costs and two smaller funds cover the self employed and agricultural workers. A special fund was implemented in January 2000 to make sure the poor had access to health care as well.

Contributions to the funds come from employer and employee contributions as well as personal income tax. Taxes have increased because of the decrease in wage income over the past few years.

The French have unlimited access to doctors and referrals are not necessary. Patients pay approximately 30% of the cost of a general practitioner doctor visit and 40% of a specialist visit. Many medications are not covered at all or only at a rate of 15%.

Canada

All Canadian citizens are eligible for health care benefits which are paid through individual and corporate income taxes. Each province handles health insurance in its own way. Some provinces supplement with sales tax and lottery proceeds and others by charging health premiums. Federal funding to the provinces is allocated through Canadian Health and Social Transfer.

About 9.5% of the Gross Domestic Product is spent on health care and individually Canadians spend about $3,300 per capita on health care.

All citizens (except prisoners, military personnel and Royal Canadian Mounted Police) attain a provincial health card (immigrants must wait 3 months). For a routine visit, one needs only to present one's card. Currently, there is about 1 primary care doctor for every 1000 Canadians. Specialist and hospital visits require a referral from one's primary care doctor. Dental services, optometrists and prescription medications are not covered under the Canadian health care program.

United Kingdom

All citizens of the United Kingdom receive health care benefits based on need, not ability to pay. The National Health Service (NHS) is funded by individuals through taxes (82%), employer/employee contributions (13%) and user fees (4%) and is managed by the Department of Health.

Basic services are free (e.g. primary care doctor visit, specialist, in-patient care, x-rays)—whereas other costs are out of pocket or are subsidized depending on certain factors (i.e., prescriptions, dental, optical, wigs, and travel). About 10% of the population has private supplemental insurance paid by their employer.

The UK has a "gatekeeper" system wherein everyone must have a General Practitioner (GP) as their primary care doctor—much like HMOs in the US. GPs are paid through capitation—i.e., a small monthly sum per person whether one uses services or not. The average wait to see a specialist is 12 weeks. There is a severe lack of nurses.

Germany

Germany was the first nation to enact mandatory health insurance back in 1983. The system is funded through employer contributions—with half the money coming from an employee's paycheck and half coming from the employer. Participating Germans — about 90% of the country — are enrolled in "sickness funds", some of which are organized by geographical region, some by trade, and some by company. The funds are a mix of private and public entities and are all nonprofit. The funds can't discriminate and can't charge customers at different rates corresponding to their health, age, or lifestyle.

Insurance is mandatory for all Germans with incomes under $40,000. Those above can opt out and secure private insurance, but few do. All told, about 8% of the

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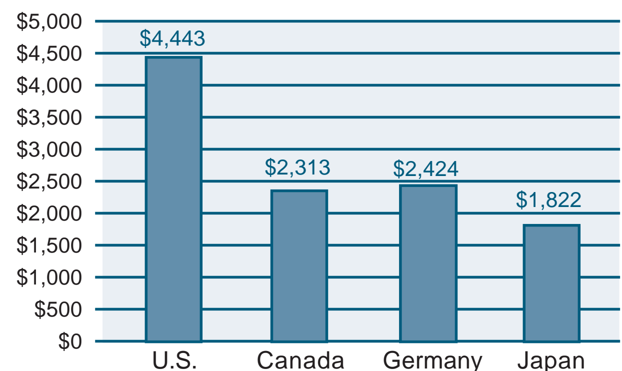
U.S. spends more on health care than any other major industrialized country



How Other Countries Provide Health Care

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country opts out of the sickness funds, and most of them are very wealthy. Private insurers pay doctors at much higher rates, and thus the folks they insure get preferential treatment. About 2% of the country is covered through the armed forces policy, and 2% — mostly the very rich—have no insurance at all.

Employees are insured automatically if their income is below $40,000. Others included are students, disabled, pensioners, and farmers. Employees pay 13.9% of their income for health insurance unless they earn below a set income—in which case they pay one half of that percentage and the employer pays the other half.

If someone loses his or her job or retires, coverage through the fund continues. The employer continues to pay its half and the government pays the individual's portion.

Most members must pay a modest percentage or contribution towards doctor visits, prescription drugs, in-patient hospital care, treatment, etc. Those that are exempt from these contributions are children under 18, poor, war victims, unemployed and the disabled. An entity called "Concerted Action" comprised of representatives from the nation's health care providers, sickness funds, employers, unions and government sets guidelines for fees and rates.

Germans spend 10.7 of their Gross Domestic Product on health care.

Japan

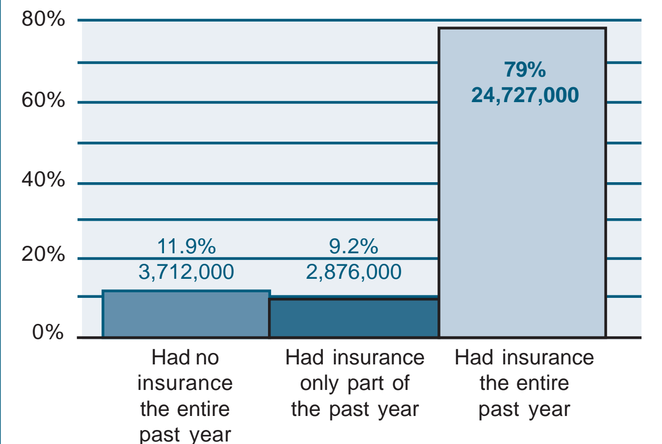
Only legal status citizens are eligible for the Japan health care program—Employee Health Insurance (EHI) —which covers those employed with medium to large companies, national or local government or private schools. A government managed program covers employees of small businesses. Premiums are based on monthly salary—half is paid by the employer and half by the employee. The average payment is 4% of an employee's salary.

National Health Insurance (NHI) covers workers in agriculture, forestry or fisheries and self employed or un-employed and seniors over 70. This is funded by a compulsory premium from the self employed and contributions from the EHI to cover retirees. Any further amount comes from the general revenue.

There are no restrictions regarding hospital or physician choice and no pre-authorization requirements. Payment for hospital and clinics are on a fee-for-service basis. A co-pay under EHI is 20% of hospital costs and 30% for outpatient care. A co-pay is needed for medication. There is a cost ceiling for all other things. The co-pay under NHI is 30% for all mentioned above, and also has a cost ceiling after which one receives full coverage.

Japanese spend 7.6 of the GDP on health care.

Any time during the past year without health insurance



Source: 2003 California Health Interview Survey www.CHIS.ucla.edu

...And Across the Nation

Maine

In 2003, Maine passed the Dirigo Health Reform Act that set the goal of universal coverage by 2009. Employers pay 60% of the premium for each employee, with employees paying a portion. Insurers are assessed and a "savings offset payment" was developed to quantify and capture the savings generated to fund expansion of publicly-funded coverage. Cost controls and quality improvements were negotiated with hospitals and the insurance companies that agreed to participate. Subsidies are used for those earning less than 300% FPL.

New York City and Suffolk County, NY

This model was developed as a direct response to Wal-Mart's limited participation in health coverage. This "fair share" program requires grocers and "big box" stores to contribute between $2.50

to $3.00 for every hour worked by employees. The benefit does not dictate what kind of coverage the employee must have, but does require a minimum level of spending.

Maryland

Another "fair share" model was passed by the state's legislature after over-riding the Governor's veto in 2005. This employer mandate is directed at employers of 10,000 or more—of which Wal-Mart is the only qualifying business of this size in Maryland. A qualifying employer must spend at least 8% of payroll on health coverage. Currently, some non-qualifying employers pay as little as 3% of payroll for health coverage. Maryland is the first state to pass a Fair Share Health Care Act in the nation.

Illinois

In November 2005 the Health Care for All Children Act was passed. It is funded by the state's general fund and will cover doctor visits, hospital stays, medications, vision, and dental. It expanded health care to 250,000 uninsured children beginning July 2006.

Massachusetts

This bi-partisan health care reform package couples an employer mandate (supported by Democrats) with an individual mandate to buy "affordable" insurance (supported by Republicans). It expands Medicaid through a combination of re-allocated safety net money, revenue growth and employer assessments. Employers must provide coverage or pay $295 per uninsured worker into a state program. Benefits and much of the implementation have not yet been determined since this was just passed in April.

Vermont

In May, Vermont became the first state inspired by Massachusetts to pass comprehensive health reform. It is funded by a tobacco tax which begins October 1 together with money from the general fund and a $375 fee which employers will pay per uninsured worker. The health plan extends a subsidy to the uninsured whose income is below 300% FPL. Providers would be reimbursed at 110% of Medicaid and Medicare. The aim of the reform is to control costs by curtailing cost-shifting and also through a new insurance product to improve the health management of people with chronic illnesses.

Legislature Passes Minimum Wage, Health Care Coverage

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Health Bills Signed, Others Waiting

As we go to press the Governor has signed several bills that affect children's health. Three bills would make smoother processes for enrollment in public programs and others would better assist children with complicated medical problems and support the development of 500 school-based health clinics.

Of significance is the passage of SB 840 (*Kuehl*) on partisan lines and the Governor's statement that he would not sign it. SB 840 would create a statewide health care system that puts all Californians into one insurance pool to share the risk and redirect dollars currently going to administrative costs in private insurance programs. SB 840 contains the content of the plan but has left the financing details for a later time.

The Governor vetoed a bill that would have required very large employers to provide for their employees health care.

We are still waiting the outcome of other health-related, housing and public benefit bills. **Final results will be posted on our website on October 1.**

New Bills Address Needs of Incarcerated Women

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The legislature passed AB 2917 (*Liu*) to specifically address the needs of incarcerated women by establishing a Gender Responsive Strategies Commission (GRSC) that will evaluate the conditions of female offenders in the California Correctional System and make recommendations to assist the California Department of Corrections and Rehabilitation in developing gender responsive strategies for women in prison.

AB 2066 (*Lieber*) focused on providing comprehensive rehabilitative services to help women transition successfully into the community upon release—giving them a chance to be healthy, and productive members of society and improving the future of their families. This bill did not pass and will most likely be reintroduced next session.

Please note the change in JERICHO's e-mail and website addresses:
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November Ballot Measures Explained

Once again Californians will face a daunting ballot in November as they decide on thirteen measures. Eight of the propositions qualified for the ballot by securing enough signatures, and five bond measures were placed on the ballot after being passed by the state Legislature and signed by the Governor.

For the past three years JERICHO has developed questions to consider when making your decision on each measure. **This year we will post them on our website beginning October 12.** Anyone who cannot access the website may call the office for a hard copy.

We are also facilitating a limited number of ballot measure workshops this year. You may call the office to see if there is an October workshop in your area. If your group would like to host a health care reform workshop or if you want JERICHO staff to speak at one of your events, please call the office at 916-441-0387 or e-mail at jericho@jerichoCA.org

Passion to Serve, Power to Transform

The Valley Interfaith Council, Progressive Christians Uniting, and Interfaith Communities United for Justice and Peace are co-sponsoring an action and advocacy workshop focused on inspiring and equipping clergy and laypersons in starting, or expanding, social justice ministries within congregations. Panelists, practical, "how-to" workshops and a wide range of faith-based peace and justice resources will equip local congregations. **The event will be held Sunday, October 22nd, 1:30-5:00, at St. Michael and All Angels Episcopal Church in Studio City, (San Fernando Valley) CA.** Suggested Donation: $10.00 ($5.00 for students). Childcare will be available. For more information, or to request a registration form, contact: Virginia Classick, vclassick@aol.com, or 818-225-0410.

If your group would like to host a health care reform workshop or if you want JERICHO staff to speak at one of your events, please call the office at 916-441-0387 or e-mail at jericho@ jerichoCA.org

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