EQUAL Health ◆ *Equitable Quality Universal Affordable*

Equal Policy Brief

Real Health Reform: Positions for Progressives

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What Now

It has been both an exhilarating time for progressives and a bumpy one: the House passed a bill (yay) with a public option (yay). **These are victories for progressives, inside and outside of Congress: we made this happen.**

But House leaders caved at the last minute to an anti-abortion spoiler, the Stupak-Pitts amendment, and dropped a popular provision proposed by Rep. Dennis Kucinich to protect states that opt for single payer systems from lawsuits under ERISA.

Many of us who both support and desperately need health reform are still trying to make sense of the news of the last week. Advocates and the public need to be unified and energized for the final push to get the best possible bill through the Senate and back through the conference committee with the House.

Here are the comprehensive progressive messages we think all Senators need to hear, and why:

1. The House bill is a major achievement. Preserve and expand on its strong points, including the public option.

There is a lot here for access, quality, affordability and cost control, in fact more than there was in any of the bills that passed through the House Committees. The public option is likely to be more robust than the Congressional Budget Office's preliminary projection.

2. We need to advance reproductive rights, not retreat.

The anti-abortion amendment is a real threat and a wake-up call.
We can beat it. Many members who voted "yes" on Stupak are on record as pro-choice.
Pro-choice energy can propel reform forward.

3. Protect single payer states from ERISA lawsuits.

It is important to continue to point this out and to organize for single payer, and against the for-profit private insurance industry States will be a far cry further in the march toward single payer if we can win waivers from federal obstacles including ERISA.

The House is still in play; they will be involved in the conference with the Senate, and will vote again on final passage. Our messages to House members depend on how they voted. (See Tables on p. 8):

1. **Voted Yes on the bill and No on the Stupak Amendment (178 Democrats): Thank you! You're the progressive Democratic majority. Help us win the ERISA waiver, and keep what we've won.**
2. **Voted Yes on the bill and Yes on Stupak: Stick with the bill and stick up for women. [For those historically pro-choice: Shame on you for voting Yes on Stupak]**
3. **Voted No on the bill and No on Stupak: Thanks for opposing Stupak. I'm asking you to stand up for health care reform now and support the bill.**
4. **Voted No on the bill and Yes on Stupak: We need health care reform now, and need our members of Congress to stick up for women. Will you change your vote and stand up for health reform and for women? [For those historically pro-choice: Shame on you for voting Yes on Stupak]**

Read more online at: http://www.centerforpolicyanalysis.org/id62.html

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1. The House bill is a major achievement. Preserve and expand on its strong points, including the public option. There is a lot here for access, quality, affordability and cost control, in fact more than there was in any of the bills that passed through the House Committees. The public option is likely to be more robust than the Congressional Budget Office has projected.

This is all thanks to progressives mobilizing all over the country, inside and outside of Congress. Here are some of our victories:

What's Better In HR 3962, Compared to the Status Quo

Most employers will have to contribute to the cost of health insurance. The U.S. is the only place in the world where people rely primarily on the workplace to get insurance, but we also have no requirement on employers to offer insurance or help pay for it. 130 million people get insurance through work, but another 27 million workers are uninsured.

The bill also requires individuals to buy insurance.
Subsidies for premiums are available to low- and middle-income individuals and families up to 400% of the federal poverty limit, or $88,000 for a family of 4. (See the Center's House Bills and Affordability Tables for details.)

Insurance company abuses will be prohibited. They will no longer be permitted to:
Exclude people with pre-existing conditions, or
Stop paying for your treatment once it turns out your sick.
They will have to spend 85% of our premium dollars on actual health care, not executive bonuses and administration. (This provision sunsets, though, in 2013.)

Quality
Medicare reforms include:
encourage better quality of care,
eliminate copayments for preventive care,
increase the number of primary care providers.
financial incentives for clinician teams

Access
Eligibility now varies widely among states for Medicaid, the federal-state program for low-income people. Most only cover adults if they have certain illnesses or take care of children. The program will now cover all individuals with income up to 150% of the federal poverty level. People with COBRA can keep it until the new exchanges kick in, in 2013. Young people can stay on their parents' plans til age 27.

Costs
Medicare:
Government authority to negotiate for drug prices
Cut Medicare Advantage

Premiums for private plans:
- Authority to reduce exorbitant premiums
- Public option: Pay between Medicare and average of private plans
- Age rating limited to 2:1

Title I-- "immediate reforms" Sec 104: "Sunshine on price gouging by health insurance issuers“
- $1B in grants to help establish this process.
- Starts in 2010

The public plan

The bill establishes health insurance exchanges to help individuals and employers find and purchase health insurance. To be viable, the exchanges must eventually be open to most or all employees.

The public option is proposed as one plan that eligible individuals could choose. It would have lower administrative rates and no profits. It will pay providers a rate between Medicare, and the average of what private plans pay.

Initially only employees of small firms will be eligible to purchase from the exchange, and thus to choose the public option. In subsequent years businesses with up to 100 employees would be required to participate, and even larger firms would likely be authorized. Additional expansions would be partly determined by any "excess of premium growth outside the Exchange.”

Things to fix in the public plan

It still doesn’t start until 2013.

It would pay provider negotiated rates. While there are bands on the rates, paying Medicare plus 5% would be a far more reliable brake on costs.

Enrollment in the public plan is underestimated

A preliminary analysis of the public option by the Congressional Budget Office claimed that the public plan would have higher premiums than private plans, and thus probably only enroll about 6 million people. Comments further projected that it would therefore have little impact on private premiums.

The comments were however preliminary, and very brief, [1] and these assumptions are questionable at best. The key variables are the expectation that the public plan would be less ruthless than private companies in “management of utilization,” that is, denying claims for care. While this is hopefully accurate, the bill allegedly will also curb well-documented insurance company abuses that result in the routine and capricious denial of claims. There is a passing reference to the expectation that the public option would experience adverse selection, but no support for such a projection. If as is more likely public premiums are lower, the public plan will probably attract enrollees who are at least as healthy as private plan members.

2. We need to advance reproductive rights, not retreat.
- The anti-abortion amendment is a real threat and a wake-up call.
- We can beat it. Many members who voted “yes” on Stupak are on record as pro-choice.
- Pro-choice energy can propel reform forward.

The anti-abortion amendment is a real threat and a wake-up call.
The House bill includes the Stupak-Pitts amendment that rolls back women's current legal rights to an abortion. (The full text of the amendment is online at: House Stupak anti-abortion amendment) The amendment says that plans in the health exchange cannot offer to cover abortion, if they enroll any women who will be accepting a federal subsidy.

It also says that plans in the exchange can't use any federal funds for administration related to abortion.

The vast majority of enrollees in the exchanges will be eligible for subsidies, which are available to people with income up to 400% of the federal poverty level, or $44,000 a year for a single person However, the subsidies are graduated depending on income. Most women who use subsidies to pay part of the premium will be paying the majority of the premium cost out of their own pockets, or their employer's.

While the provision appears to offer an out for women who do not accept subsidies, projections are that this separate coverage is unlikely to materialize. According to Jacobs:

> Because the Stupak Amendment bars the subsidization of plan administration activities in connection with prohibited procedures, it can be expected to chill the development of abortion coverage supplements as well as entirely separate plans to non-subsidized women.
>
> Under these circumstances, what is the norm today in the employer-sponsored market – broad coverage of medically indicated abortions – is likely to narrow considerably as the industry seeks to restructure its product design to meet the most restrictive demands… The industry, confronting the challenges of distinguishing between enrollees for a handful of covered procedures and specific conditions, can be expected simply to eliminate certain procedures and conditions from coverage altogether, leaving women and families exposed.

This means that even women who pay entirely out of pocket, or who get employer-paid coverage through the exchange without accepting one cent of public subsidies, will not be able to purchase a health insurance plan that covers abortions through the exchanges.

The Jacobs Institute concludes that adopting the Stupak provisions will radiate a withdrawal from abortion coverage, starting with the exchanges and extending to the rest of the private market.[2] This is a frightening and real scenario, particularly if the public option develops as the lowest cost insurance plan.

There is a related but alternative problem: the absence of abortion coverage will undermine participation in the exchanges, and weaken the public plan.

Pro-choice and pro-reform advocates should join forces to beat back Stupak.

Here is how these provisions would roll back current rights:

There are currently no restrictions on health insurance plans offering to cover abortions. Women covered in health plans through a private sector employer, or who pay out of their own pockets for health care, can use those funds to pay for abortions. The majority of plans now cover abortion.

The Hyde amendment, adopted in the 1970s, prevents the federal government from using public funds to pay for abortions, except where the pregnancy itself threatens the mother's life, or the pregnancy results from rape or incest. This has generally meant that poor women dependent on public programs like Medicaid could not get coverage for abortions. In the 1995, Congress expanded this incursion into reproductive choice and prohibited health insurance plans for federal employees from covering abortion.

Here's how the amendment hamstrings the public plan:

No employer is required to participate in the health exchange, or the public plan that would be part of it. It would be opened up over time to firms with 25 employees or fewer, building up to 100 or more. Presently most insurance plans for both large and small employers offer full coverage of abortions and also pay for complications of abortion. The Jacobs Institute illustrates how these options will be virtually eliminated in the health exchanges for both subsidized and non-subsidized enrollees.

Under these conditions, we conclude that it is both possible and likely that employers and individuals who have any choice in the matter will simply continue to buy their coverage as they do now, outside of the health insurance exchanges. In this case it would remain isolated as a high-risk pool for individuals and self-employed people with no other choices. The number of people choosing the public option from among this limited group could not possibly form the basis of an alternative system that will compete in any effective manner with private sector insurance plans. Certainly employers with female workforces under the age of 45 who offer health insurance would experience demand to select plans that continue to cover the full range of family planning services.

Analyzing the votes: weak support for Stupak, weak opposition to the bill

Progressives have an important stake in assuring that the momentum for meaningful health reform continues. Opponents cannot be permitted to obscure the fact that the fights to maintain reproductive choice, and to win a public plan with significant enrollment, go hand in hand.

It is important to pass a strong health reform bill. It is neither possible nor acceptable to do so at the cost of eroding women's reproductive rights.

64 Democrats voted yes on the abortion ban. All Republicans voted Yes, except Shadegg, who voted "Present."

41 Democrats Voted Yes on the bill and Yes on Stupak.

16 have been pro-choice in the past**.**

23 Democrats voted NO on HR 3962 and YES on Stupak

39 Democrats voted NO on HR 3962. One Republican, Cao, voted yes.

16 also voted No on Stupak.

Most of these No voters declare on their websites that they want something different from the final bill, and intend to change their vote then.

There is clearly room to maneuver here. But advocates for rights will have to make it happen.

3. Protect single payer states from ERISA lawsuits.

It is important to continue to point this out and to organize for single payer, and against the for-profit private insurance industry States will be a far cry further in the march toward single payer if we can win waivers from federal obstacles including ERISA.

See: Center Analysis of ERISA Waiver

The Center for Policy Analysis worked closely with Congressional staff and the California Nurses Association to craft this amendment to health reform legislation, that offers the greatest prospects for single payer supporters.

Why the amendment matters: We need to advance single payer

Some state and local governments that have attempted to expand health care coverage have been successfully challenged in court under the terms of the Employee Retirement Income Security Act of 1974 (ERISA). ERISA pre-empts states from enacting legislation if it is "related to" employee benefit plans. It reserves that right to the federal government. Section 514 of ERISA states that Title V (Administration and Enforcement) and Title IV (Fiduciary Responsibility) of ERISA "shall supercede any and all State laws insofar as they may… relate to any employee benefit plan." There is no provision for an administrative waiver of these rules.

The Kucinich amendment to HR 3200, approved by a recorded vote of the House Education and Labor Committee, would remove this barrier for states that have enacted and signed into law a single payer system. It proposed that the Secretary of Labor, in consultation with the Secretary of Health and Human Services, would be authorized and required to waive the ERISA pre-emption (Sec. 514) for states that have enacted a state single payer system. In this case, the Secretary could decline to grant the waiver only under extraordinary circumstances. The system would have to meet requirements, and the Secretary could revoke the waiver if it fails to do so.

This amendment was not included in HR 3962. It could be included in the final legislation if the Senate adopts a similar provision. The provision would then be considered when the House and Senate conference to determine final language. Both Senators Sanders and Wyden have proposed amendments that would have effects similar to the Kucinich ERISA waiver. It will take strong organizing by progressives to assure that the provision is included.

Conclusion

The drive for significant reform of the health care system is at a turning point. Women, progressives, and the millions who desperately need reform have kept reform alive by mobilizing with unprecedented strength. We have kept the public option alive, and outreasoned the unhinged fringe.

It is time to redouble our organizing, and to demand the platform that will bring home health reform and build coalitions to address the future:

Strong public option! Don't you dare roll back women's rights! Protection from ERISA lawsuits for single payer states

How They voted

41 Democrats Voted Yes on the bill and Yes on Stupak. 16 have been pro-choice in the past
Message: Shame on you for voting Yes on Stupak. Stick with the bill and stick up for women.

State and Representative	Approval Rating from Planned Parenthood (%)	Approval Rating from National Right to Life (%)
Berry, Marion, Arkansas, 1st		
Snyder, Vic, Arkansas 2nd	83	
Baca, Joe, California, 43rd	100	
Cardoza, Dennis, California, 18th	67	
Costa, Jim, California, 20th	80	
Salazar, John T., Colorado, 3rd		
Bishop Jr., Sanford D., Georgia, 2nd	69	20
Costello, Jerry, Illinois, 12th		
Lipinski, Daniel, Illinois, 3rd		
Donnelly, Joe, Indiana, 2nd		
Ellsworth, Brad, Indiana, 8th		
Hill, Baron, Indiana, 9th	71	14
Michaud, Michael, Maine, 2nd	71	0
Lynch, Stephen F., Massachusetts, 9th		
Neal, Richard E., Massachusetts, 2nd	77	0
Kildee, Dale, Michigan, 5th		
Stupak, Bart, Michigan, 1st		
Oberstar, James L., Minnesota, 8th		
Etheridge, Bob, North Carolina, 2nd		
Pomeroy, Earl, North Dakota, At-Large	69	16
Driehaus, Steve, Ohio, 1st		
Kaptur, Marcy, Ohio, 9th		
Ryan, Tim, Ohio, 17th		
Space, Zachary T., Ohio, 18th	100	
Wilson, Charles A., Ohio, 6th		
Carney, Christopher P., Pennsylvania, 10th	100	14
Dahlkemper, Kathy, Pennsylvania, 3rd		
Doyle, Mike, Pennsylvania, 14th		
Kanjorski, Paul E., Pennsylvania, 11th		
Murtha, John, Pennsylvania, 12th		
Langevin, Jim, Rhode Island, 2nd		
Spratt, John, South Carolina, 5th	67	0
Cooper, Jim, Tennessee, 5th	71	0
Cuellar, Henry, Texas, 28th		
Ortiz, Solomon P., Texas, 27th		
Reyes, Silvestre, Texas, 16th	83	
Rodriguez, Ciro, Texas, 23rd	100	
Perriello, Tom, Virginia, 5th		
Obey, David R., Wisconsin, 7th	69	0
Mollohan, Alan B., West Virginia, 1st		
Rahall, Nick, West Virginia, 3rd		

16 Democrats Voted No on the Bill and No on Stupak
Thanks for opposing Stupak. Let's talk about the bill.

Markey, Betsy, Colorado, 4th
Boyd, Allen, Florida, 2nd
Kosmas, Suzanne M., Florida, 24th
Minnick, Walt, Idaho, 1st
Kratovil, Jr., Frank M., Maryland, 1st
Adler, John, New Jersey, 3rd
Massa, Eric J.J., New York, 29th
McMahon, Michael E., New York, 13th
Murphy, Scott, New York, 20th
Kissell, Larry, North Carolina, 8th
Kucinich, Dennis J., Ohio, 10th
Herseth Sandlin, Stephanie, South Dakota, At-Large

Edwards, Chet, Texas, 17th
Boucher, Rick, Virginia, 9th
Nye III, Glenn C., Virginia, 2nd
Baird, Brian, Washington, 3rd

23 Democrats voted NO on HR 3962 and YES on Stupak. Possible messages:
1. We need health care reform now, and need our members of Congress to stick up for women. Will you change your vote and stand up for health reform and for women?
[For those historically pro-choice: Shame on you for voting Yes on Stupak]
2. Shame on you. Change your votes or we'll see you in the primaries.

Jason Altmire
John Adler
Rick Boucher
Allen Boyd
Brian Baird
John Barrow
Dan Boren
John Boccieri
Bobby Bright
Ben Chandler
Travis Childers
Lincoln Davis
Artur Davis
Chet Edwards
Bart Gordon
Parker Griffith
Tim Holden
Stephanie Herseth Sandlin
Dennis J. Kucinich
Larry Kissell
Suzanne Kosmas
Frank Kratovil Jr.
Mike McIntyre
Jim Matheson
Jim Marshall
Charlie Melancon
Betsy Markey
Eric Massa
Michael E. McMahon
Walt Minnick
Scott Murphy
Glenn Nye
Collin C. Peterson
Mike Ross
Ike Skelton
Heath Shuler
John Tanner
Gene Taylor
Harry Teague

[1] Preliminary Analysis of HR 3962. Congressional Budget Office to Chairman Charges Rangel, October 29, 2009. http://www.cbo.gov/ftpdocs/106xx/doc10688/hr3962Rangel.pdf. Here's the entire discussion:

> "Under the proposal, certain employers could allow all of their workers to choose among the plans available in the exchanges, but those enrollees would not be eligible to receive subsidies via the exchanges (and thus are shown in Table 2 as enrollees in employment-based coverage rather than as exchange enrollees). CBO and JCT expect that approximately 9 million people would obtain coverage in that way in 2019, bringing the total number of people enrolled in exchange plans to about 30 million in that year. Roughly one-fifth of the people purchasing coverage through the exchanges would enroll in the public plan, meaning that total enrollment in that plan would be about 6 million.
>
> "That estimate of enrollment reflects CBO's assessment that a public plan paying negotiated rates would attract a broad network of providers but would typically have premiums that are somewhat higher than the average premiums for the private plans in the exchanges. The rates the public plan pays to providers would, on average, probably be comparable to the rates paid by private insurers participating in the exchanges. The public plan would have lower administrative costs than those private plans but would probably engage in less management of utilization by its enrollees and attract a less healthy pool of enrollees. (The effects of that "adverse selection" on the public plan's premiums would be only partially offset by the "risk adjustment" procedures that would apply to all plans operating in the exchanges.)"

[2] Sara Rosenbaum, Lara Cartwright-Smith, Ross Margulies, Susan Wood, D. Richard Mauery. An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions. November 16, 2009.

Here's how the amendment would shut down access to abortion, according to the Jacobs Institute:

> *Industry-wide impact that will shift the standard of coverage for medically indicated abortions for all women:* In view of how the health benefit services industry operates and how insurance product design responds to broad regulatory intervention aimed at reshaping product content, we conclude that the treatment exclusions required under the Stupak/Pitts Amendment will have an industry-wide effect, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health insurance exchange.
>
> As a result, Stupak/Pitts can be expected to move the industry away from current norms of coverage for medically indicated abortions. In combination with the Hyde Amendment, Stupak/Pitts will impose a coverage exclusion for medically indicated abortions on such a widespread basis that the health benefit services industry can be expected to recalibrate product design downward across the board in order to accommodate the exclusion in selected markets.
> <u>Impact on currently uninsured women and women who are employees (or spouses or dependents of employees) of small businesses</u>
> To the extent that small employers migrate into the exchange system (as envisioned), the impact on employer-sponsored abortion coverage could be considerable as smaller employers that now regularly include abortion coverage in their plans move into a market in which similar plans may no longer be available unless specially marketed either as more comprehensive plans or as more limited plans linked to

an abortion supplement. Simply put, the market for these women is highly speculative. Because the bills contemplate opening the exchange to employer plans of increasing size over the years, the impact of the Stupak/Pitts Amendment on women with employer-sponsored coverage could be dramatic, especially since there is no indication that companies would develop comprehensive or supplemental products that cover a wider range of medically indicated abortions.

Women would be able to buy a separate "rider" that covers abortion only. The chances would seem to be slim that an insurance company would offer a plan to cover unexpected pregnancies, or that many women would have the funds or emotional temperament to plan for an unplanned pregnancy by buying insurance.

> *Supplemental insurance*. Because the Stupak Amendment bars the subsidization of plan administration activities in connection with prohibited procedures, it can be expected to chill the development of abortion coverage supplements as well as entirely separate plans to non-subsidized women.
>
> Under these circumstances, what is the norm today in the employer-sponsored market – broad coverage of medically indicated abortions – is likely to narrow considerably as the industry seeks to restructure its product design to meet the most restrictive demands. If this consequence flows, then the industry, confronting the challenges of distinguishing between enrollees for a handful of covered procedures and specific conditions, can be expected simply to eliminate certain procedures and conditions from coverage altogether, leaving women and families exposed.

Conclusion. Jacobs concludes that:

> The Stupak/Pitts Amendment is intended to reach only a specific part of the market. But the cumulative effect of the provision, in combination with existing federal laws governing Medicaid and federal employee health benefits (as well as the law of certain states) inevitably can be expected to move the entire health benefits industry away from its current inclusive coverage norms and toward a new norm of exclusion. The provisions of the legislation, as well as the technical challenges that arise in benefits administration, militate against the creation of a supplemental coverage market. Thus, if the result of national health reform is to move millions of women into a market that operates subject to the exclusion, then it is fair to predict that the entire market for coverage ultimately will be affected as a product tipping point is reached and virtually no supplemental market appears.
>
> In addition, given past experience and the sanctions that arise from a violation, it is reasonable to predict that in interpreting and applying the exclusion, health plan administrators will err on the side of coverage denial. This is because the legal risks associated with coverage determination are all on the side of incorrectly awarding coverage, not erroneously denying it. This balancing of risks can be expected to lead insurers to calibrate coverage determinations in a way that works against women whose medical conditions ultimately lead to an abortion that they never willingly sought.