Rekindling Reform
Working to Achieve Quality Health Care for All

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HEALTH CARE REFORM: *WHAT NEXT?*

A Position Statement by Rekindling Reform

Several stages of hard work remain before Congress arrives at a single unified bill for its consideration. All five congressional committees of jurisdiction in the Senate and House have completed or nearly completed their separate legislative drafts. The House is already working to merge the drafts of its three committees and produce a bill of its own, and the Senate will shortly be doing likewise with its two committee products.

Rekindling Reform considers the draft developed by the Senate Finance Committee to be on the wrong track in several key respects. Particularly disturbing are its rejection of a public plan option and its insistence on taxing health insurance plans as a mode of financing. Its inadequate funding for consumer subsidies would leave coverage unaffordable for millions of people. Struggles to produce a better bill in the Senate will ensue, first in the effort to meld the Finance Committee bill with that of the HELP Committee and later during the Senate floor debate.

The House leadership is working to resolve differences among its three somewhat acceptable but still far from adequate drafts. Especially noteworthy are their inclusion of a public plan option, their gradual phase-out of overpayments to Medicare Advantage plans, their gradual complete filling of the Medicare Part D drug benefit coverage gap ("doughnut hole"), their substantial reliance on a surtax on high personal incomes to finance premium subsidies, and their requirement for a minimum standard to be satisfied by plans' medical loss ratios (the share of premium revenues that is spent on delivering care). However, no extensions of affordable coverage would start until 2013, extensions would grow at a slow pace over the next five years, and it is unclear when if ever employees of medium or large firms would have access to the public plan. The rate of expansion of affordable coverage, which is very dependent on funding for subsidies, is evidently limited by congressional leaders' reluctance to let the cost of reform exceed $900B over the first decade.

The two bills that Senate and House leaders present for consideration in their respective chambers will be subject to floor debate and amendment, offering opportunities for further revisions, for better or worse. Although the Senate HELP Committee draft may contribute some unique strengths to the eventual Senate bill, the House seems likely to produce a stronger bill than the Senate. Rekindling Reform hopes that this will leave the House in a position of challenging the Senate to accept provisions more in tune with the people's needs.

Rekindling Reform views resistance by the minority party in Congress primarily as a cynical political effort to exploit the difficulties in framing such a complex measure. We believe they

view it as an opportunity to so distort the issues and confuse the American people that they can regain control of Congress and weaken President Obama's ability to govern effectively. That, in turn, would give them the opportunity to send a member of their own party to the White House in 2012. Should they succeed, the prospects for further constructive reform would be dismal.

Rekindling Reform urges all people who view health care as a human right to join together in efforts to shape the legislation before Congress. We recognize that it does not deal with the fundamental contradiction of our country's health care system – its reliance on profit making firms subject to little regulation, firms whose first obligation is to their stockholders, not to the health of their policyholders. Nonetheless, this legislative battle offers opportunities to advance towards health care security for all and to make significant improvements in health care delivery.

Rekindling Reform believes that these key principles should guide Congress in its vital and immediate task of reforming health care coverage:

1. **Everyone should have the peace of mind that comes with guaranteed, affordable, secure coverage for their health care needs**. **Such coverage should be extended to all as soon as possible.**

2. **Everyone should have access to health care practitioners of their choice. To this end, availability of quality care must be expanded.** In particular, access to primary care needs to be enhanced by an increase in the numbers of practitioners engaging in this important work.

3. **Financing health care should be a responsibility borne equitably by the entire society.** It should not fall primarily on the backs of the very people whose insecure or absent coverage is the reason for reform and least of all should it fall on people in immediate need of care.

4. **The option of coverage by a public program should be available to all, and the process of choice should be simple and straightforward. No one should be forced to enroll in a for-profit health insurance plan as a condition for coverage. Without a real public plan option, far more people will view any mandate to buy health coverage as coercive. Ultimately, the nation would be served best by expansion of social insurance.**

5. **Unrestrained prices of health care services and goods make for unsustainable health care. Congress must "bend the curve" of growth of aggregate health care costs.**

6. **Funds allocated and paid for health care coverage should, to the greatest extent possible, be used for health care itself rather than for administration, marketing or profits.**

Following are key provisions that reflect the foregoing principles, provisions that the reform legislation should incorporate:

A. Coverage should be assured for all residents not enrolled in Medicare. Insurance premiums and other charges should be community-rated, with no age-related differences. (With coverage nearly universal, age rated premiums are a variant of preexisting condition exclusion.) To achieve a level playing field, a health insurance exchange should arrange compensatory payments among the participating plans to

balance differences in the plans' risk pools – that is, differences among the plans in terms of the amount of health care that their respective enrolled populations are projected to need.

B. There should be immediate extension of eligibility for Medicaid to all persons with incomes under 1.5 times FPL, with full federal coverage of the expansion cost. Currently the nationwide average eligibility ceiling is 41% of FPL for jobless parents and 68% for working parents.

C. Congress should enable persons aged 55-64 to buy into Medicare. This is a population whose uninsured members are particularly at risk.

D. **Everyone not enrolled in Medicare should have the choice of coverage by a Medicare-like public plan. Availability of that plan should not be conditioned on any "trigger." All Medicare providers should be in the public plan's provider networks for the first three years, after which they could opt out. Provider payment rates should be based on Medicare rates.**

E. Health coverage affordability cannot be judged in terms of insurance premiums alone. Subsidies are needed to offset the combined total of premiums and other patient payments so that health care costs borne by an individual or family do not exceed a sliding scale percentage of disposable income, a percentage rising from zero at the federal poverty level (FPL) to 12% at 4xFPL.

F. Subsidies for expanded coverage should be financed mainly by income tax surcharges on high incomes but not at all by taxing health insurance plans or benefits.

G. The number of different tiers of coverage offered should be minimized to reduce confusion in use of the insurance exchanges, to reduce people's temptation to under-insure, and to reduce insurers' ability to cherry-pick enrollees.

H. There must be increased provider reimbursement for primary care relative to that for specialty care. Federal supports and incentives must be provided to lead to larger numbers of physicians and nurse practitioners providing primary care, as well as to wider adoption of the accountable care organization or other "medical home" models of practice to assure continuity and coordination of care.

I. The prevailing overpayments to Medicare Advantage (MA) plans should be phased out. The overpayments are at the expense of all Medicare beneficiaries, a population that is no less medically needy than the great majority of MA enrollees. There are, however, certain MA Special Needs Plans with a proven record of effective coordination and delivery of services to particularly frail beneficiaries with complex needs. Rekindling Reform supports provisions of the Senate Finance Committee bill that would maintain supplementary payment to such plans. On another score, if, as has been asserted, there is demonstrable need for special incentives to assure access to providers in rural areas, Rekindling Reform believes that that problem should be addressed separately. Finally, the success of MA plans in luring subscribers by offering dental, optical and/or pharmaceutical benefits highlights serious gaps in traditional Medicare's benefits. Wiser and more humane allocation of the nation's resources would enable filling such gaps.

J. The preventive care, pharmaceutical doughnut-hole closure, and other provisions of H.R.3200 to strengthen Medicare benefits should be included. Beyond their intrinsic value, these added benefits could offset the concerns of many MA beneficiaries about

provisions to phase out overpayments to MA plans and reduce the rates of growth of provider payments to more sustainable levels.

K. Health plans that, in any year, spend less than 90% of their revenues on patient care services should be required to refund the difference to premium-payers.

L. A medical windfall profits tax should be enacted to discourage over-pricing and to husband resources. With a vast expansion of coverage in prospect, there is a real possibility that profit windfalls will be realized by insurers, pharmaceutical firms, and the makers/vendors of medical equipment, devices and supplies.

M. Any health coverage reform legislation adopted should enable state single payer initiatives. To that end, Rekindling Reform supports the Kucinich amendment to the Education and Labor Committee's version of H.R. 3200.

N. There are pressing needs in the area of long term care. Two programs that should be enacted are designed to reduce admissions to and lengths of stay in nursing facilities or intermediate care facilities. One of these programs is the "Independence at Home" pilot project proposed by the House Energy and Commerce Committee. This program would serve Medicare beneficiaries with multiple chronic conditions – persons whose medical care needs currently are generally met only in institutional settings but who would prefer to, and could, live and work in community settings. It would enable them to realize that choice, by providing for home visits for their care. In addition, it could demonstrate what economies such measures can achieve by reducing avoidable hospitalizations. A second program, included in the bill from the Senate HELP Committee and in H.R. 3200, is aimed at persons with functional limitations who, with non-medical services and supports, could maintain community residence. Titled the CLASS Act (Community Living Assistance Services and Supports), it would create a national voluntary insurance program to help pay for these services and supports.

O. Provision for the health of women and families requires full coverage for reproductive health services. Efforts to use health reform to curtail abortion services should be opposed. Rekindling Reform sees such efforts as yet another way to confuse the public and to sabotage health care reform legislation.

P. The federal government should negotiate acquisition prices of pharmaceuticals for all federally funded programs. Private insurance plans that want to get under this umbrella should be able to.

Rekindling Reform appreciates the complexities in enacting legislation. Even under the best of credible legislative outcomes, all who support reforms embodying the foregoing principles and provisions will need to renew this struggle the day after any health coverage reform is signed into law.