

Single-Payer Activist Guide



to the Affordable
Care Act

BY HEALTHCARE-NOW!



Healthcare-NOW! is a grassroots organization that addresses the health insurance crisis in the U.S. by educating and advocating for the passage of single-payer healthcare legislation, such as H.R. 676.

We support building the movement necessary to implement a publicly-funded, single-payer healthcare system that is universal, equitable, transparent, accountable, comprehensive, and that removes financial and other barriers to the right to health.

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Table of Contents

Introduction	4
Executive Summary	5
The Fight for Medicaid and Medicare	8
State-by-State Medicaid Expansions	8
Privatization of Medicaid.	10
Sustaining Medicare for the Next Generation	10
Negotiating Medicare Drug Costs	11
Protecting Workers' Access to Care.	13
Employer Responsibility: Delay and Evasion.	13
The Individual Mandate.	14
Rock and a Hard Place: Workers' Eligibility for Public Subsidies	16
Corporate "Wellness" Programs	17
The Threat to Multi-Employer Union Plans	17
The 2018 "Cadillac" Tax on Workers' Benefits	19
Holding Health Insurance Companies Responsible.	20
The Self-Insured and Student Health Plan Loopholes	20
Health Insurers' Profits & Administrative Waste	21
Review of Insurance Premium Hikes	23
Expanding Care for the Marginalized	24
Reproductive Health Care	24
Threats to the Safety Net	25
Immigrant Access to Care	26
Conclusion & Taking Action!.	27
Sources	28
Single-Payer Legislation	32

Introduction

Urgency for national health reform was driven by the reality of a health care system increasingly failing its patients, and costs rising at rates unsustainable for every sector of the economy. The United States, the only wealthy nation allowing for-profit health insurance, was increasingly falling behind countries with publicly financed, universal health care coverage along almost every economic and humanitarian measure.

Following the 2008 elections, some 49 million U.S. residents were uninsured — 16 percent of the population — and more than 25 million were underinsured, without adequate coverage. 45,000 deaths per year were linked directly to lack of health insurance. Yet for all of its poor outcomes, the U.S. health care system was costlier than any other nation's by a large margin: \$7,960 per person in 2009, more than twice the \$3,233 average for OECD countries.

The Patient Protection and Affordable Care Act (frequently referred to as the Affordable Care Act or ACA) was signed into law on March 23, 2010, following a contentious, year-long struggle that mobilized millions of residents. The ACA was the result of a political compromise to mitigate some of the health care system's most glaring shortcomings, but without challenging the commercial health care industry that benefits from it. The law contains important expansions in access

to care, and bans some of the worst excesses of the private health insurance industry, but does little to control the costs of care. Cost control threatens the income of the health care industry, but without it the U.S. healthcare system, along with any access gains, are fundamentally unsustainable.

National health reform represented a missed opportunity to enact the only system of health care capable of providing universal coverage and sustainable costs: single-payer health care, also known as “improved medicare for all.” However, the law and its implementation — by mobilizing communities across the country and creating new public spaces for dialogue about achieving a just and equitable health care system — will generate opportunities to build the grassroots movement for achieving single-payer reform.

This Guide developed by Healthcare-NOW! is not a detailed overview of the ACA, nor a commentary on its overall desirability or undesirability. It is an attempt to identify the most important organizing opportunities that implementation of the ACA will create for building the single-payer movement. This is a guide for organizations and activists who believe that access to health care is a right, basic to human dignity, which must be publicly provided and protected for all. And for those who know we will have to organize to get there.

Executive Summary

The Affordable Care Act is a complex piece of legislation being implemented gradually over the course of a decade, much of it at the discretion of federal agencies. Litigation has challenged several components of the law. The Single-Payer Activist Guide to the Affordable Care Act does not summarize the workings of the law, nor does it address some of the most important aspects of the law. What the Guide does is to identify the contested areas of implementation most likely to create teaching moments, outreach opportunities, or organizing opportunities.

The ACA will create all three types of opportunities at times, but in some states and for some groups it may well be that existing public education, outreach, and organizing strategies are more effective than jumping on the bandwagon of ACA implementation. For others, however, the ACA will create rare openings for activists to reach out to new communities and create a dialogue that should not be missed. We have grouped the major

opportunities that will be created by the ACA into four broad categories: “The Fight for Medicaid and Medicare,” “Protecting Workers’ Access to Care,” “Holding Health Insurance Companies Responsible,” and “Expanding Care for the Marginalized.”

The Fight for Medicaid and Medicare

The ACA contains major provisions affecting the nation’s public health insurance plans. A cornerstone of the law is the expansion of Medicaid to residents up to 138% of the poverty line — an access expansion thrown into uncertainty when the Supreme Court ruled that each state could choose whether to participate in the expansion. Some states are attempting to negotiate a privatized Medicaid expansion, under which Medicaid funds would pay

A NOTE ON STRATEGY

There are three types of opportunity that will be created by the Affordable Care Act:

*A **teaching moment** is an event catching widespread public attention, which creates an opportunity to provide some form of public education around why single-payer reform is the only way to achieve universal and affordable access to care. Public education can take the form of media work (op-eds, letters to the editors, TV and radio interviews, getting reporters to cover a story), emails or newsletters to*



members of an organization, hosting a public forum or a house party, or even targeting a particular group such as legislators with a briefing, fax blast, or emails.

*An **outreach opportunity** is an event creating new openings to reach out to groups of people who are not currently involved in single-payer organizing. This is particularly important for multi-issue groups that may put more time, resources, and manpower into health care issues as the ACA is being implemented than they normally would. The goal of*



outreach is to grow local single-payer coalitions and databases of supporters.

*An **organizing opportunity** is a chance to activate the supporters you already have in an area to leverage some outcome: that may be getting a legislator to support single-payer, a City Council to pass a resolution, an employer to agree to cover workers, or a socially responsible investment fund to drop its investment in for-profit insurers, to list a few examples.*



for private health insurance for eligible residents, driving up costs and padding insurers' profits. For half of the states in the country, Medicaid expansion fights dominate the health policy landscape, and have mobilized large coalitions for single-payer activists to engage with.

The ACA also generated important teaching moments and missed opportunities for Medicare, the one universal, publicly financed health program in the U.S. for seniors and the disabled. Medicare, while universal for seniors, is not able to capture all the savings of a single-payer plan acting as one of many payers in the health care system. For this reason, Medicare's own sustainability is a regular concern, and the ACA attempted to avert a 2018 projected insolvency date by generating new revenues and reducing some costs for the program. Only a true single-payer system is likely to provide even Medicare with long-term sustainability, though.

Lastly, a popular movement to allow Medicare to negotiate lower drug costs with pharmaceutical manufacturers, as all single-payer countries effectively do (as does the Veterans Administration), was derailed during the ACA by pharma lobbying. Efforts to win single-payer negotiating power for Medicare's drug plan are ongoing, and crucial for seniors for whom drug costs are a large financial burden.

Protecting Workers' Access to Care

The ACA will benefit many workers, particularly those who are low-income and not offered health insurance by their employer, who may become eligible for Medicaid coverage or premium subsidies in their state exchange. Other aspects of the law are creating challenges for workers and the labor movement, and creating a double standard privileging employers over their employees.

Lobbying efforts effectively limited employers' responsibilities under the ACA. A small share of employers will be required to offer "affordable" coverage to their workers or face a fine, but this provision was undermined through a one-year delay of its implementation until 2015 and a lenient definition of affordability. A side-effect of unreasonable defini-

tions of affordability is that many employees will also find they are ineligible for premium subsidies in state exchanges, since their employer offers a plan that is deemed affordable for their household.

What sets the ACA apart from earlier health reform laws is the individual mandate, which will require most of the uninsured to obtain health insurance or face a fine on their tax forms. The individual mandate is the law's most unpopular aspect. While all countries with universal coverage require residents to pay into the health care system, they do so through taxes. The mandate on the other hand shifts the cost burden of health care on to lower-income families, and effectively delegates the power of taxation to for-profit health insurance corporations.

Another provision of the law grants employers greater leeway in shifting premiums onto workers if they do not participate in "wellness" programs that in practice often do not improve workers' health or their costs, and function more as cost-shifting mechanisms than wellness incentives.

Two final aspects of the ACA may have far-reaching consequences for workers' access to employer-sponsored insurance. First of these is the ACA's potential impact on multi-employer (or "Taft-Hartley") health insurance plans, common in unionized industries where workers move between employers. Whereas most commercial insurance plans can be offered through the exchanges, and low-income workers can receive subsidies to help purchase them, multi-employer insurance plans are most often the result of contract negotiations between workers and employers and will be excluded from the exchanges — along with the subsidies that accompany them. The plan's administrators expect that many employers in low-wage industries will cease paying into these funds in the expectation that their employees will qualify for subsidized commercial insurance through the exchanges.

Finally, one of the ACA's last provisions to go into effect will be a 40% excise tax on every premium dollar exceeding certain thresholds in 2018. Sometimes inaccurately referred to as a "Cadillac tax," this aspect of the law is most likely to affect plans in states with high premiums (often due to cost of living), and potentially older patients who face discriminatory pricing. Over time the tax will affect large

segments of the insured population, and encourage cost-shifting that discriminates against women, those with chronic illnesses or disabilities, and other groups with higher health care needs.

Holding Health Insurance Companies Responsible

In most developed countries health insurers are barred from profiting off of basic health care coverage, and health insurance is public or non-profit and highly regulated. The ACA leaves the commercial health insurance industry intact, while attempting to rein in some of its worst excesses and to expose (if not control) its rapid cost increases.

The health insurance lobby has been effective in limiting these regulations, both in the text of the law and its implementation. Foremost among these loopholes is the exemption of “self-insured” plans from almost all of the ACA’s new regulations. Self-insured plans are employers who act as their own insurance company for covering their workers, meaning that they stand to profit if their workers are healthier than expected, but also take losses if they are costlier than expected. Almost all large employers self-insure, and by 2013 self-insured plans covered a staggering 61% of all insured workers. Self-insured student health plans, in which colleges and universities act as insurers, have been exempted from the rule outlawing annual and lifetime caps on benefits, a particularly common — and dangerous — feature of student health plans.

Health insurance premium hikes were supposed to be limited by two new measures in the ACA, one requiring insurers to spend 80% to 85% of premium dollars on medical spending — designed to limit insurers’ profits and overhead waste — the other requiring large premium rate hikes to be reviewed by state and/or federal regulators. Because of implementation rules allowing insurers to make a number of deductions and exemptions, the ACA has had no impact on total overhead waste in the industry so far. Rate reviews apply only to individual and small employer plans and largely lack teeth — most states can review rate hikes but they cannot challenge them

or prevent them if found to be excessive — but even this level of review can have some impact on prices. Although insurers’ rate filings have not been made very transparent, they will still provide a new tool for single-payer activists to shine a spotlight on the health care system’s unsustainable costs.

Expanding Care for the Marginalized

The ACA will have mixed impacts on socio-economic groups discriminated against by our current health care system. Documented immigrants who are banned from Medicaid coverage until they have lived in the U.S. for five years will become eligible for premium subsidies in the exchanges, but will continue to be excluded from Medicaid. Undocumented immigrants granted DACA status (Deferred Action for Childhood Arrivals) will be ineligible for all of the ACA’s benefits, and undocumented immigrants in particular are likely to be hit hard by safety net cuts.

The ACA will require all insurers to cover contraceptive care, making exceptions for some religious employers. The ACA may have the effect of reducing the number of plans with abortion coverage, though. The vast majority of private insurance currently covers abortion services, but more and more residents will seek care through state exchanges, many of which ban abortion coverage outright and all of which require that abortion services be offered with a separate premium payment.

One of the gravest dangers of the ACA is the cuts to safety-net providers built into the law, which will reduce federal funds for treating the uninsured and underinsured by up to 50% in some states. These cuts are not necessarily proportionate to the expansion of insurance coverage, and in states not expanding Medicaid, they may threaten the financial viability of hospitals serving the most vulnerable, low-income populations.

The Fight for Medicaid and Medicare

The ACA contains major provisions affecting the nation's public health insurance plans. A cornerstone of the law is the expansion of Medicaid to residents up to 138% of the poverty line — an access expansion thrown into uncertainty when the Supreme Court ruled that each state could choose whether to participate in the expansion. Some states are attempting to negotiate a privatized Medicaid expansion, under which Medicaid funds would pay for private health insurance for eligible residents, driving up costs and padding insurers' profits. For half of the states in the country, Medicaid expansion fights dominate the health policy landscape, and have mobilized large coalitions for single-payer activists to engage with.

The ACA also generated important teaching moments and missed opportunities for Medicare, the one universal, publicly financed health program in the U.S. for seniors and the disabled. Medicare, while universal for seniors, is not able to capture all the savings of a single-payer plan acting as one of many payers in the health care system. For this reason, Medicare's own sustainability is a regular concern, and the ACA attempted to avert a 2018 projected insolvency date by generating new revenues and reducing some costs for the program. Only a true single-payer system is likely to provide even Medicare with long-term sustainability, though.

Lastly, a popular movement to allow Medicare to negotiate lower drug costs with pharmaceutical manufacturers, as all single-payer countries effectively do (as does the Veterans Administration), was derailed during the ACA by pharma lobbying. Efforts to win single-payer negotiating power for Medicare's drug plan are ongoing, and crucial for seniors for whom drug costs are a large financial burden.

State-by-State Medicaid Expansions

- ★ The Affordable Care Act was written to expand Medicaid to all uninsured people up to 138% of the poverty line (about \$16k per year for an individual) starting in 2014. However, a 2012 ruling by the Supreme Court struck this portion of the law down, and instead allows individual states to choose whether they wish to expand their Medicaid program.
- ★ As of October 2013, 25 states were not moving forward with Medicaid expansion, primarily in the South and Central U.S.
- ★ The federal law will extend subsidized health coverage, through the Exchanges, to uninsured residents above the poverty line (about \$11,500 a year for individuals) in all states. In states that do not expand their Medicaid program this will lead to chaos and severe penalties for falling below the poverty line.

Medicaid, the nation's safety-net plan for many low-income people, was created in 1965 on the heels of the Civil Rights Movement. Medicaid receives a mix of federal and state funds but is administered by the states. State-based administration has resulted in economically deep and racially-charged inequities between Southern States - facing the legacies of slavery and Jim Crow - as opposed to more expansive Medicaid eligibility and benefits on the coasts and in the North.

The ACA, by expanding Medicaid to all uninsured residents below a uniform poverty threshold, would have covered an additional 21 million uninsured by 2022 and dramatically reduced the geographic inequities in Medicaid coverage that translate into racial and ethnic inequities. A 2012 ruling by the

Supreme Court narrowly — by a single surprise vote from Chief Justice John Roberts — upheld the legality of most of the ACA, but ruled the federal government could not require states to expand their Medicaid programs, instead allowing individual states to choose whether or not to expand Medicaid.

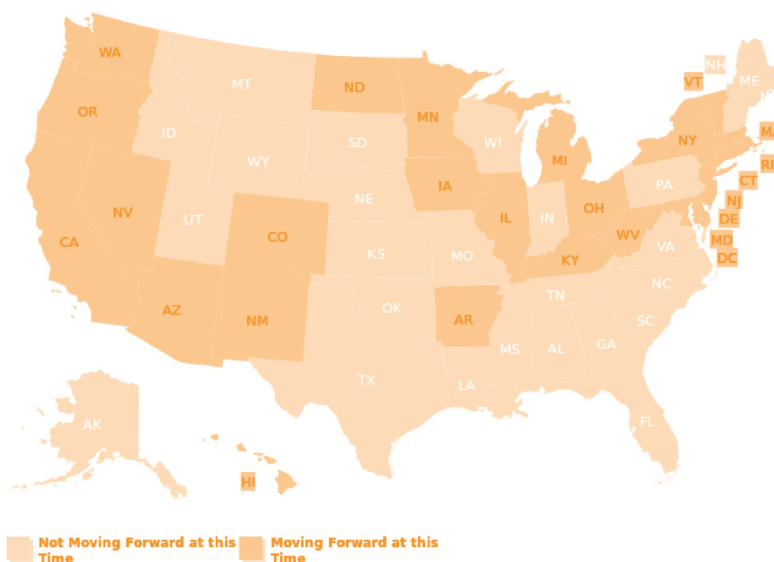
The federal government would pay for 100% of the costs of expansion initially, and 90% of the expansion by 2017 and beyond. Even so, twenty-five states were not moving forward in expanding Medicaid as of October 2013 (sometimes blocked by a Governor or one body of the state legislature), representing more than half of the uninsured who stood to gain insurance coverage under Medicaid expansions nationally.

One study looking at the first 14 states to announce they would not expand Medicaid, found that they would not only forego \$8.4 billion in additional federal funding in 2016, but would see \$1 billion in higher spending on uncompensated care for the uninsured — meaning that expansion saves states money even after they start picking up 10% of the costs by 2017.

The premium tax subsidies offered on a sliding scale to uninsured residents above the poverty line (about \$11.5k per year), but below 400% of poverty (about \$46k per year), will remain a national program. The ACA did not provide for national subsidies for those below 100% of poverty because it was assumed that everyone below that level would be enrolled in Medicaid, that is, until the Supreme Court changed the rules.

The result is a complex nightmare for the uninsured in non-expanding states, where residents will be punished for losing jobs or income, while those with middle incomes will qualify for premium assistance. Congress has not yet offered a remedy for this loss of subsidies for the poorest among us, or the geographic inequities that are now likely to grow wider.

STATUS OF STATE ACTION ON THE MEDICAID EXPANSION DECISION AS OF OCTOBER 22, 2013 (SOURCE: KAISER FAMILY FOUNDATION)



TAKING ACTION



Single-payer advocates can grow their base and activate their members by plugging into Medicaid expansion fights and messaging around the need to establish health care as a public right. Health Care for All Texas, for example, joined the “My Medicaid Matters” coalition in Texas, and helping to organize a rally of thousands in March 2013. Healthcare-NOW! Georgia has similarly joined the Cover Georgia coalition to bring single-payer messaging to Medicaid expansion efforts and build new coalition partners. The Healthy Montana Initiative, The Ohio Alliance for Health Transformation, and other state coalitions are planning to collect enough signatures to put Medicaid expansion on the ballot in 2014, while in Arizona opponents of the Medicaid expansion approved by the legislature and Governor Jan Brewer will attempt to overturn the expansion through a ballot referendum.

Privatization of Medicaid

- ★ Several state Legislatures and Governors have announced their intention to oppose expanding Medicaid to low-income residents and are instead seeking to use this pool of Medicaid money to subsidize private health insurance for the same low-income residents through state exchanges.
- ★ Private insurance on the exchanges costs 50% more than insuring a person under public Medicaid, making this ideological demand an unaffordable giveaway to private insurers.
- ★ These private exchange plans will not cover services required for Medicaid recipients, forcing Medicaid to provide complicated “wraparound” coverage that will require enrollees to have two insurance plans.

In March 2013 the Department of Health and Human Services announced that some states refusing to expand their Medicaid programs may be permitted to use federal Medicaid funds to instead provide “premium assistance” for the purchase of private health insurance through the state exchanges. The first state to consider the “private option” for Medicaid was Arkansas, swiftly followed by Iowa, Indiana, Pennsylvania, and Oklahoma.

While such arrangements are required by law to be as cost effective as enrolling residents in the public Medicaid program, the Congressional Budget Office estimated that private plans on the exchanges will cost, on average, 50% more than the cost of covering individuals through Medicaid, requiring some creative accounting or potentially very low provider payments to meet the program’s cost effectiveness requirements.

Additionally, privatizing the Medicaid expansion will create bewildering complexity for patients and providers alike, as Medicaid will have to provide “wrap-around” coverage for everyone enrolled in these private plans to provide a range of health services private insurers won’t cover.

Privatized Medicaid expansions under the ACA are different from the older but still ongoing movement

towards “Managed Medicaid” plans, which involve subcontracting administration of Medicaid enrollees to private managed care organizations. In June 2013 Florida received a federal waiver allowing private insurance companies to administer coverage for roughly 3 million Medicaid enrollees, for example. Payment rates to physicians were found to equal only 58% of what the public Medicaid program would pay, threatening access to care even for those nominally insured.

TAKING ACTION



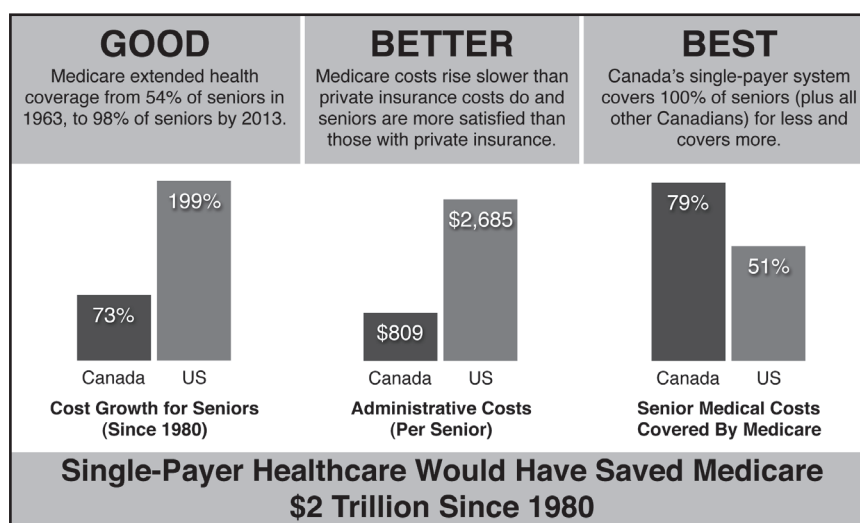
Medicaid privatization is a vivid demonstration of how private health insurance is inefficient, allowing for-profit middlemen to charge more, pay out less for actual health care, and pocket the difference. Single-payer advocates can play an important watch-dog role calling attention to these inefficiencies, high executive salaries, and denial of care rates.

Sustaining Medicare for the Next Generation

- ★ Medicare is one of the most effective health programs in the United States, providing better care than private health insurance with slower cost increases, despite providing virtually universal coverage for the country’s most expensive patients: seniors, those with chronic disabilities, end stage renal disease, and ALS (Lou Gehrig’s disease).
- ★ While more efficient than private health insurance, the Medicare payroll tax remained the same from 1986-2009 at 1.45% leading to a slow erosion of the Trust Fund for hospital care. Just prior to the ACA, this Trust Fund was projected to become insolvent by 2018.
- ★ A major goal of the ACA was to raise new taxes to fund Medicare and create new provider payment rates to reduce costs, but these improvements still left Medicare projected to become insolvent by 2026. Without a true single-payer system, even Medicare’s long-term sustainability may be in jeopardy.

Medicare costs less than private health insurance with better results, but it is not nearly as cost effective as a true single-payer plan that covers everyone and it leaves seniors with too many gaps in their coverage.

Results from this 2012 study show that Canada provides better protection for seniors at a fraction of the cost, making single-payer vital for the future of seniors' health and well-being.



A 2012 Commonwealth Fund report found that Medicare beneficiaries report better access, better financial protection, and almost half the problems with medical bills as those with private health insurance, making it a true financial safety net for a vulnerable population.

Medicare's costs rise 8.3% per year on average, more slowly than the 9.3% per year increase in private health insurance premiums, but still faster than costs rise in countries with single-payer systems. This is because Medicare is a public health insurance plan but not a true single-payer system — it is one of many private and public payers, and unable to relieve providers of astronomical administrative costs. A 2012 study by David Himmelstein and Steffie Woolhandler found that Medicare would have saved \$2 trillion since 1980 if its costs had risen at the same rate as costs for seniors in Canada's single-payer system.

Prior to the Affordable Care Act, the Medicare Trustees projected that the Medicare Trust Fund would become insolvent by 2018. A key goal of the ACA was to guarantee Medicare's sustainability, but new revenues and cost-saving projects included in the bill have resulted in a new projected insolvency date of 2026, extending the program's life by about 8 years. We can continue to raise new revenues to extend Medicare lifespan beyond 2026, but like the employer-sponsored health insurance sector, Medicare will only be sustainable in the long-term with single-payer reform.

TAKING ACTION



Every year on Medicare's anniversary on July 30, Healthcare-NOW! coordinates a national week of action demanding that Congress preserve Medicare for seniors and improve and expand it to the rest of the population. Actions include delivering Medicare birthday cakes to Congresspeople, hosting house parties, viewings of documentaries on Canadian Medicare, rallies, and public outreach campaigns.

You don't need to wait for Medicare's anniversary to take action, though: giving a presentation or hosting a discussion on the ACA and Medicare, as well as the single-payer alternative, is a great way to reach out to organizations representing seniors and those with disabilities, who are often amongst the most active multi-issue organizations supporting single-payer reform. Looking for flyers, slide shows, and presentation notes on this topic? Get in touch with Healthcare-NOW!

Negotiating Medicare Drug Costs

The Medicare Modernization Act of 2003, passed under George Bush, created Medicare Part D, the first prescription drug benefit for Medicare beneficiaries, but prohibited Medicare from negotiating with pharmaceutical manufacturers to lower drug costs.

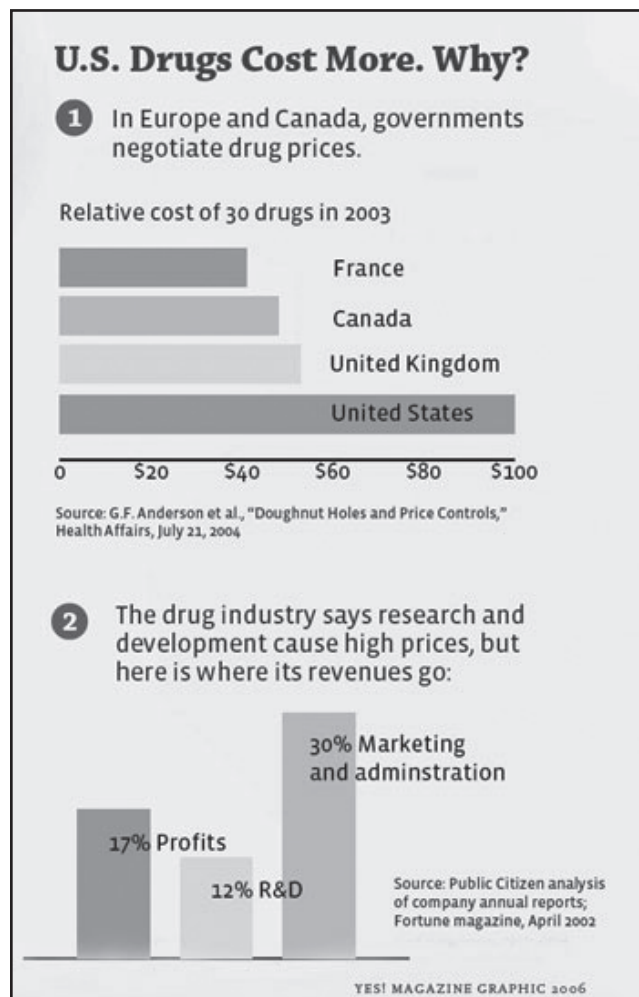
Currently, over three thousand Private Drug Plans and Medicare Advantage plans separately negotiate drug costs. If Medicare collectively negotiated drug costs like the Veterans Administration does, it would have reduced federal spending alone by \$230 to \$541 billion over 10 years.

Through intense lobbying, the pharma industry cut a deal by which it would voluntarily reduce Medicare

patients' drug costs to avoid language in the ACA allowing Medicare to negotiate drug prices. Using the purchasing power of large groups of patients is a central cost control feature of single-payer systems, and the fight to empower Medicare is ongoing.

Allowing Medicare to negotiate or set low drug costs, as the Veterans Administration and Medicaid do, is an easy step to achieve large savings for Medicare, and received significant support during the 2008 elections leading in to national health reform. There is no rationale to justify pharmaceutical companies charging higher prices to U.S. payers - for the same exact drugs - than countries with universal, single-payer plans. This price gouging has been allowed only due to PhRMA's power in Congress, and was left off the table during health reform to buy support from the drug industry.

Seniors and other populations covered by Medicare are more vulnerable than most socio-economic groups to the costs of prescription drugs. One major victory contained in the ACA is the gradual closing of the "donut hole" - the gap in prescription drug coverage under Part D under which Medicare enrollees have to pay the full cost of all drug costs until they hit a catastrophic spending limit. The closing of the donut hole will make rising drug costs increasingly a burden on the financial viability of the Medicare program, and will create pressure to increase co-payments and deductibles.



TAKING ACTION



Realizing the promise of negotiated drug costs for Medicare is likely to be an ongoing effort in the wake of the ACA. The Medicare Prescription Drug Price Negotiation Act, filed by Senator Amy Klobuchar in the Senate and Representative Peter Welch in the House, would allow Medicare to finally negotiate lower drug costs. Countries with single-payer health care systems can negotiate fair drug costs for the entire population, curtailing the mostly rapidly rising cost in the health care system.

A July 2006 edition of YES! Magazine devoted to 'Health Care for All' looked at exorbitant drug prices in the U.S. The same drugs sell for less in countries with universal health care, because they use bulk purchasing power to keep costs reasonable.

Protecting Workers' Access to Care

The ACA will benefit many workers, particularly those who are low-income and not offered health insurance by their employer, who may become eligible for Medicaid coverage or premium subsidies in their state exchange. Other aspects of the law are creating challenges for workers and the labor movement, and creating a double standard privileging employers over their employees.

Lobbying efforts effectively limited employers' responsibilities under the ACA. A small share of employers will be required to offer "affordable" coverage to their workers or face a fine, but this provision was undermined through a one-year delay of its implementation until 2015 and a lenient definition of affordability. A side-effect of unreasonable definitions of affordability is that many employees will also find they are ineligible for premium subsidies in state exchanges, since their employer offers a plan that is deemed affordable for their household.

What sets the ACA apart from earlier health reform laws is the individual mandate, which will require most of the uninsured to obtain health insurance or face a fine on their tax forms. The individual mandate is the law's most unpopular aspect. While all countries with universal coverage require residents to pay into the health care system, they do so through taxes. The mandate on the other hand shifts the cost burden of health care on to lower-income families, and effectively delegates the power of taxation to for-profit health insurance corporations.

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on multi-employer (or "Taft-Hartley") health insurance plans, common in unionized industries where workers move between employers. Whereas most commercial insurance plans can be offered through the exchanges, and low-income workers can receive subsidies to help purchase them, multi-employer insurance plans are most often the result of contract negotiations between workers and employers and will be excluded from the exchanges — along with the subsidies that accompany them. The plan's administrators expect that many employers in low-wage industries will cease paying into these funds in the expectation that their employees will qualify for subsidized commercial insurance through the exchanges.

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Employer Responsibility: Delay and Evasion

- ★ The Affordable Care Act requires large employers to offer health insurance to full-time employees beginning in 2015 (delayed one year under pressure from the business lobby) or potentially face financial penalties.
- ★ Employers may attempt to shift from full-time (>30 hours/week) to part-time work to minimize the fines, since there are no penalties for failing

to cover part-time employees. Small and medium-size employers are exempt from all penalties.

The Affordable Care Act requires employers with the equivalent of 50 full-time employees or more to cover their full-time employees beginning in 2015 or potentially face a financial penalty under a complex formula. Under the formula these employers will be fined \$2,000 per uninsured worker, but are exempt from fines on their first 30 full-time employees. Additionally, employers who offer “unaffordable” coverage (the premium amounting to more than 9.5% of an employee’s household income) or insurance with inadequate benefits, open themselves to even higher fines of \$3,000 per employee if those workers seek out care through the state exchanges.

This employer “play-or-pay” provision is fairly weak to start with: out of 5.7 million employers in the United States, only about 210,000 have more than 50 employees. Furthermore, large businesses are those most likely to already offer health insurance coverage to workers — 94% of businesses with 50 to 199 employees, and 98% of those with 200 or more employees.

The business lobby has successfully won a delay of enforcement from 2014 until 2015. The Congressional Budget Office projects the delay will reduce the number of residents with insurance by 500,000, and will increase the costs of the law by \$12 billion (the RAND Corporation estimates 300,000 and \$11 billion).

TAKING ACTION



The All Unions Committee for Single Payer Health Care - H.R. 676, effectively organized solidarity support for mineworkers at risk of losing their pensions and health care coverage after decades of dangerous workplace environments leaving many with black lung, cancer, and other crippling injuries. Single-payer activists attended mine worker rallies and circulated a petition supporting the workers, while asking workers to “ask your local union to endorse H.R. 676, national single payer health care, so that we can free our health care from corporate control and assure all medically necessary care for everyone.” Sample resolutions are available at <http://unionsforsinglepayer.org>.

The Individual Mandate

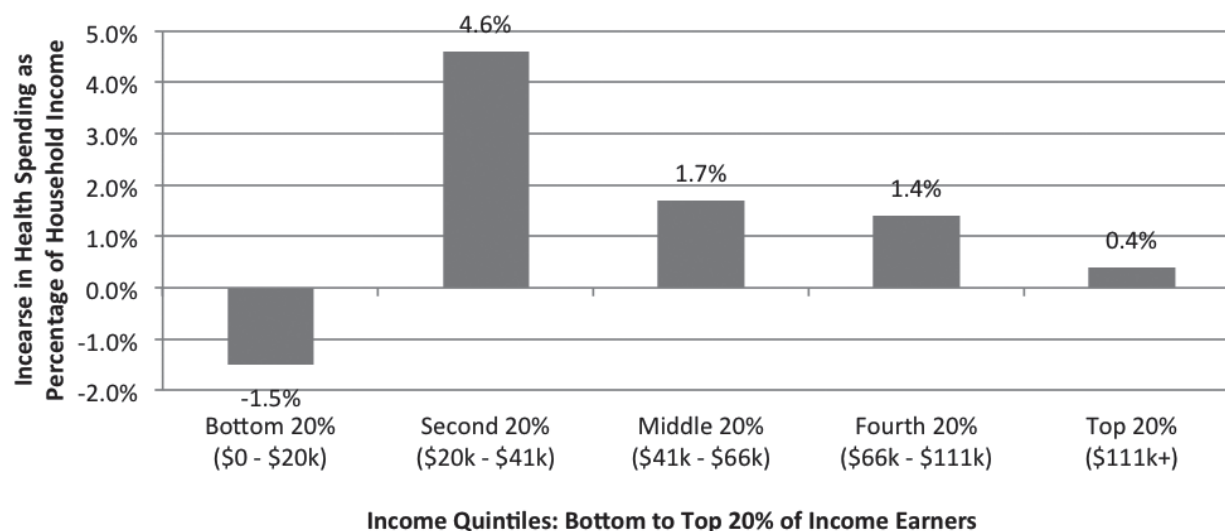
- ★ Starting in 2014 the ACA requires most residents to obtain health insurance coverage, or face a fine when they file their taxes.
- ★ The “individual mandate” concept was developed by conservatives in the 1990s to shift responsibility from employers onto individuals, as an alternative to the Clinton health reform plan. It is unpopular today among all groups, but particularly conservatives.
- ★ Countries with universal health coverage require all residents to pay into the health care system, but do so through payroll and income taxes, whereas the mandate is a regressive “poll tax.” The first individual mandate in Massachusetts placed most new health care costs on lower-income families.

A cornerstone of the ACA is a mandate requiring most residents to obtain health insurance, or face a fine when they file their taxes. The fine starts at \$95 per adult or 1% of income (whichever is greater) for 2014, then increases to \$695 per adult or 2.5% of income by 2016 and beyond. Some are exempted, such as those who do not file taxes, who have religious objections, or who would have to spend more than 8% of their income to purchase a plan. The mandate is the third mechanism - in addition Medicaid expansions and premium subsidies through the exchanges - designed to expand insurance coverage, and it was also a giveaway to health insurance companies who will benefit from the boom in enrollment.

An individual mandate was first proposed by Congressional conservatives in the 1990s as a market-based alternative to the employer mandate included in the Clinton health reform bill. During passage of the ACA, however, it became a primarily Democrat-supported policy. Public opinion polls show that the individual mandate is unpopular, opposed by two-thirds to three-fourths of the public. It is the one aspect of the law without majority support among Democrats, and only 19% of Republicans had a favorable view towards the mandate.

Countries with universal, single-payer health care

INCREASE IN HEALTH CARE SPENDING AFTER MASSACHUSETTS HEALTH REFORM AS A PERCENTAGE OF HOUSEHOLD INCOME, BY INCOME QUINTILES, 2005-2007 (SOURCE: MASS-CARE, 2011)



(Above): The cost of health reform in Massachusetts was paid disproportionately by lower-to-middle-income households, while the wealthy were let off the hook. This is a result of relying on mandates that expand private insurance coverage instead of tax-financed public health insurance.

do require all residents to pay into the health care system, but they do so through taxes - usually payroll and income taxes - under which everyone pays a percentage of their income. The individual mandate, however, acts like a regressive “poll tax.” Although in the United States the term is best known for voting taxes in the South that were used to disenfranchise African American voters, a “poll tax” describes any tax that charges a fixed dollar amount instead of a share of one’s income, which is highly regressive. Moreover, unlike a public tax, the mandate requires residents to purchase health insurance but allows private health insurers to determine premiums with very little oversight, representing a delegation of the state’s powers of taxation to the private sector.

The regressive impact of mandates can be seen in Massachusetts, where families earning \$20,000 to \$40,000 per year - ineligible for free coverage, but required to purchase expensive insurance - paid an astronomical share of their income towards

increased health spending just one year after the individual mandate was instituted there. The wealthiest 20% of the population saw almost no increase in their health care spending.

TAKING ACTION



The unpopularity of the individual mandate provides a teaching opportunity to discuss the impact of private health insurance on income inequality in the United States. Forcing families into the private insurance market — particularly as individual consumers but also as employees — shifts the burden of health care costs onto working class families, and relieves high-income earners of the responsibility to pay a fair share of their income towards the health care system.

Professor Gerald Friedman has conducted an economic impact study of H.R. 676, national single-payer legislation in the House of Representatives, which shows that shifting from private health insurance towards tax-based financing would increase household income for the lowest income earners in the country by almost 20%, and would create savings for 95% of households in the country. Give a talk on who pays for current health reform and the single-payer alternative.

Rock and a Hard Place: Workers' Eligibility for Public Subsidies

- ★ The ACA will provide subsidies in the form of tax credits to those living between poverty line and 400% of poverty (about \$11.5k and \$46k respectively for an individual) to purchase health insurance through state exchanges starting in 2014.
- ★ Workers who are offered a health plan by their employer are ineligible for subsidized care unless their employer's plan is deemed unaffordable or inadequate. The definition of "unaffordable" may leave many workers unable to afford their workplace coverage, but ineligible for public subsidies.
- ★ Some states with more generous subsidies for low-income residents may be forced to reduce their subsidies to meet the ACA's subsidy schedule.

Offering tax credits towards the purchase of private health insurance is a traditionally conservative proposal — an alternative to expanding public health insurance like Medicaid or Medicare — that became a central feature of the ACA. The program will pay part of the premium cost of plans purchased through state exchanges, providing larger subsidies to members of lower-income households.

The most significant barrier for many uninsured people to access these subsidies may be their own employer. Workers offered a health plan by their employer are ineligible for the subsidies, and a 2013 FamiliesUSA study estimates that 88% of those who would be eligible for partial subsidies will belong to working families.

Workers who are offered "unaffordable" or inadequate coverage by their employers will be able to get subsidized care through state exchanges (resulting in fines for the employer), but the Department of the Treasury announced it would interpret affordability based exclusively on the cost of an individual plan, even for workers who need to purchase a family plan through their workplace. An individual plan will be considered unaffordable only if the premium exceeds



Cooks, custodians, and maintenance workers at the Old Rochester School District in Massachusetts faced a crisis when the school committee attempted to shift 50% of premium costs onto workers. Healthcare-NOW! organized a national online petition to support them, and to educate activists around the country about the dilemmas of workers stuck with employer-sponsored insurance after health reform.

9.5% of the workers' household income (including other income earners in the home). The exchanges, in contrast, will cover all premium costs above 2% of household income for those living at the poverty line, creating a double-standard for affordability in the exchanges and affordability in workplaces.

In rare cases, states may have to cut existing health subsidies for low-income residents. This is the case for Vermont, where a state exchange will replace the existing Catamount and VHAP plans, which will result in lower subsidies for many. The federal government has refused to participate in a hold-harmless measure that would prevent existing enrollees from experiencing cuts.

TAKING ACTION



In March 2013, Healthcare-NOW! launched a national petition to support workers at the Old Rochester School District in Massachusetts. The School District was attempting to shift 50% of health premiums onto employees, which would leave the lowest income workers earning \$2 an hour in take-home pay. With employer-sponsored insurance available they were ineligible for state subsidies, but still required to have insurance by the individual mandate in Massachusetts. Telling workers' stories and creating solidarity campaigns to support them can be a powerful way of illustrating the need for single-payer health reform,

and the high costs of maintaining health care linked to employment.

Corporate “Wellness” Programs

- ★ The Affordable Care Act will allow employers to charge up to 30% higher premiums for employees not participating in corporate wellness programs (50% higher for tobacco cessation programs) starting in 2014. This is an increase from the 20% premium penalty first allowed in 1996.
- ★ While prevention and workplace health and safety is extremely important, the sort of punitive wellness programs being implemented by corporate employers do not improve workers’ health by most measures, and fail to reduce hospital visits, emergency room usage, or health care costs.
- ★ Wellness programs can be extremely intrusive, and primarily allow employers to shift premium costs onto non-participating employees.

The ACA enables employers to expand on wellness programs that were first permitted under a 1996 law. In 2011, 67% of employers offering health benefits also offered some form of workplace wellness program. These programs can financially penalize workers if they do not participate in “lifestyle management programs,” which can include mandatory health assessments, blood tests, and urine tests for tobacco usage.

The labor movement has long fought for workers’ wellness, primarily through occupational safety and health initiatives, with decades of regulatory victories. However, a large 2013 study commissioned by the U.S. Labor Department and Department of Health and Human Services, found that the paternalistic wellness programs being advanced by employers had no statistically significant impact on employees’ health care costs or their use of emergency room or hospital care. The impacts on employees’ health was limited: participation had no impact on cholesterol levels, led to average weight loss of only 1 pound over 3 years, and had notable impacts only on smoking cessation.

The real impact of the new regulation is to allow employers to shift additional costs onto individual workers - a new form of cost-shifting that targets those hesitant to enroll in “lifestyle management,” and employs a blame-the-victim approach to addressing workers’ health problems.

TAKING ACTION



Unionized workers can negotiate to stop wellness programs that are invasive and likely to discriminate against those with the highest health risks. Wellness programs are also being challenged in the courts as violating anti-discrimination laws and workplace privacy laws — none have proven successful yet, but very few suits have emerged so far and none have risen beyond the Court of Appeals.

The Threat to Multi-Employer Union Plans

- ★ Over 26 million U.S. residents receive health coverage through “Taft-Hartley” or multi-employer union plans.
- ★ Union leaders fear that employers will stop paying into Taft-Hartley funds and leave workers to seek care through state exchanges starting in 2014 due to a range of incentives and subsidies provided to insurance plans offered through the exchanges that do not extend to multi-employer plans.

Taft-Hartley plans allow employees who move from employer to employer to receive continuous health coverage that follows them from job to job, and covers them during periods of unemployment. This is particularly common in the construction trades.

Although Taft-Hartley funds are health insurance plans, they cannot be offered through state exchanges, which require participating insurers to accept all applicants (multi-employer plans cover workers in particular industries when they have worked a certain number of hours for the year). Furthermore, small employers can receive significant tax credits by purchasing health coverage for their

workers through state exchanges, but are not eligible for tax credits if they instead pay into a multi-employer plan.

National union leaders predict that the Affordable Care Act will lead many employers to stop paying into Taft-Hartley funds, and push their workers into the state exchanges if their incomes are low enough to qualify for subsidies. Very small employers may stop paying into multi-employer plans and offer insurance through the exchanges, which would not be portable for workers, but would result in large tax credits for the employer (up to 50% of their spending on health care).

TAKING ACTION



Many large national labor unions are up in arms in anticipation of the ACA's full implementation. They have called on the President and Congress to allow workers in multi-employer plans to receive the ACA's subsidies, warned of the dangers of employers shifting towards part-time and casual work, and some have even called for repeal of the ACA. This mobilization provides a teaching moment and an opportunity for single-payer activists to reach out to the labor movement.

MR. PRESIDENT, MULTIEMPLOYER HEALTH PLANS WORK

“And that means that no matter how we reform health care, we will keep this promise: If you like your doctor, you will be able to keep your doctor. Period. If you like your health care plan, you will be able to keep your health care plan. Period. No one will take it away. No matter what. My view is that health care reform should be guided by a simple principle: fix what's broken and build on what works.”

—President Obama, July 16, 2009

WITHOUT ACTION, THE AFFORDABLE CARE ACT THREATENS THESE PLANS

For over 65 years, multiemployer plans have provided affordable, quality coverage to more than 26 million Americans and their families, exemplifying the best bipartisan ideas on health care coverage.

Because it does not recognize the unique nature of multiemployer plans, the Affordable Care Act contains provisions that could undermine this American success story and reduce the number of working families covered and lower the quality of their care.

The Obama administration and Congress must not allow this to happen.

NOW IS THE TIME TO ACT

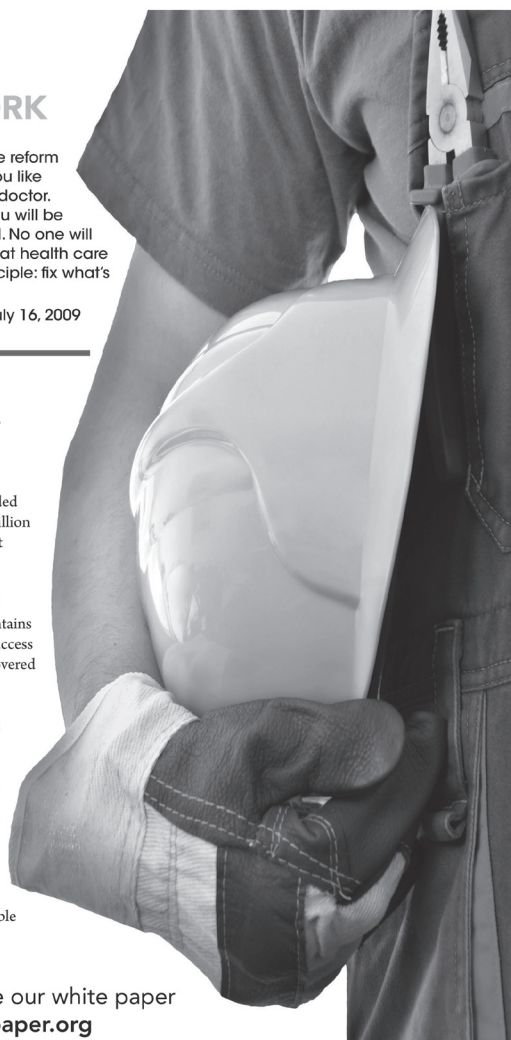
We urge the Obama administration and Congress to take steps that will allow multiemployer plans to continue providing quality coverage as the Affordable Care Act takes full effect.

For more information, see our white paper
www.ACAwhitepaper.org

KEEP YOUR PROMISE, LET US KEEP OUR PLANS

Multiemployer Health Plans: Good for Small Business, Good for Working Families

A message from the International Brotherhood of Electrical Workers®



Recent examples include a resolution passed by the Michigan State AFL-CIO recognizing the important gains of the Affordable Care Act, but also its shortcomings, providing “little opportunity to constrain the rapid rise in healthcare costs” and posing “significant challenges to the ability of unions to negotiate decent healthcare coverage for their members and their families.” The initiative “resolves that [the Michigan State AFL-CIO] will continue to fight for healthcare justice until guaranteed, affordable, quality healthcare with a

On July 11, 2013, the International Brotherhood of Electrical Workers (IBEW) ran a full-page ad in D.C.'s Roll Call, calling attention to the threat the ACA poses for multiemployer plans widely relied on by unionized workers. The ACA allows for-profit insurers to receive public subsidies for covering low-income people, and extends tax breaks to small employers for buying them, but non-profit multiemployer plans that are barred from the exchange, making widespread disenrollment likely.

single high standard of comprehensive care is available to everyone in America,” specifically committing the organization to support “H.R. 676, introduced by Rep. Conyers, HR 1200, introduced by Rep. McDermott and S 915 introduced by Sen. Sanders.”

In August 2013 the Labor Campaign for Single Payer Healthcare launched a petition for union members to call on the AFL-CIO to advocate aggressively for single-payer reform in light of the threat the ACA poses to unions’ Taft-Hartley plans, which contributed to effective single-payer resolutions passing the AFL-CIO national convention.

The “Cadillac” Tax on Workers’ Benefits

- ★ Starting in 2018, health insurance plans will face a 40% excise tax on every premium dollar above \$10,200 for individual plans and \$27,500 for family plans.
- ★ Although often referred to as a tax on “cadillac” plans, the high premium plans that will be affected are not those with the most comprehensive benefits, but rather those covering older patients, small business employees, and patients in states with high health care costs.
- ★ The excise tax is already putting pressure on employers and patients to shift towards higher cost sharing.

One of the ACA’s most significant provisions will also be one of the last to be implemented: a whopping 40% excise tax on every health premium dollar exceeding \$10,200 for an individual plan or \$27,500 for a family plan, starting in 2018. These thresholds will rise with general inflation - not medical inflation - after 2018, ensuring that the tax will affect more people, and with steeper fees, each subsequent year.

When initially proposed, President Obama referred to the provision as “penalizing insurance companies who are offering super-gold-plated Cadillac plans.” However, it is inaccurate that the tax singles out comprehensive insurance plans. A 2010 study published in Health Affairs found that only 3.7 percent of the variation in premiums nationally among

family plans could be explained by how good their coverage was.

The ACA allows insurers to charge higher premiums based on geography, age, and whether enrollees are covered by a small employer or no employer, among other factors. A 2012 study by the Pioneer Institute estimated that in Massachusetts, which has among the highest health care costs in the country, more than half of all individuals with employer-sponsored health coverage would be subject to the tax, if premiums continue to rise at traditional rates.

The New York Times reports that already in 2013 employers with premiums on track to exceed the thresholds are shifting towards plans with high deductibles, co-payments, and co-insurance, in an attempt to slow their annual premium growth over the next five years. Accelerating the existing trend towards worse health coverage will not reduce health care costs, but rather shift costs from premium payments to payments at the point of receiving care - which is discriminatory towards groups that use more health care, such as women and those with chronic illnesses or disabilities.



Rising deductibles and co-payments mean shifting costs onto groups with greater medical needs, such as women and those with chronic illnesses and disabilities. Nadina LaSpina (left), a disability rights activist and member of Healthcare-NOW! New York City, has had enough and calls for Medicare for All.

Holding Health Insurance Companies Responsible

In most developed countries health insurers are barred from profiting off of basic health care coverage, and health insurance is public or non-profit and highly regulated. The ACA leaves the commercial health insurance industry intact, while attempting to rein in some of its worst excesses and to expose (if not control) its rapid cost increases.

The health insurance lobby has been effective in limiting these regulations, both in the text of the law and its implementation. Foremost among these loopholes is the exemption of “self-insured” plans from almost all of the ACA’s new regulations. Self-insured plans are employers who act as their own insurance company for covering their workers, meaning that they stand to profit if their workers are healthier than expected, but also take losses if they are costlier than expected. Almost all large employers self-insure, and by 2013 self-insured plans covered a staggering 61% of all insured workers. Self-insured student health plans, in which colleges and universities act as insurers, have been exempted from the rule outlawing annual and lifetime caps on benefits, a particularly common — and dangerous — feature of student health plans.

Health insurance premium hikes were supposed to be limited by two new measures in the ACA, one requiring insurers to spend 80% to 85% of premium dollars on medical spending — designed to limit insurers’ profits and overhead waste - the other requiring large premium rate hikes to be reviewed by state and/or federal regulators. Because of implementation rules allowing insurers to make a number of deductions and exemptions, the ACA has had no impact on total overhead waste in the industry so far. Rate reviews apply only to individual and small employer plans and largely lack teeth — most states can review rate hikes but they cannot challenge them or prevent them if found to be excessive — but

even this level of review can have some impact on prices. Although insurers’ rate filings have not been made very transparent, they will still provide a new tool for single-payer activists to shine a spotlight on the health care system’s unsustainable costs.

The Self-Insured and Student Health Plan Loopholes

- ★ The ACA introduces a number of new regulations on health insurers, requiring coverage of essential health benefits, guaranteed issue to all applicants regardless of pre-existing conditions, limiting deductibles, banning annual and lifetime caps on benefits, and requiring that 80% to 85% of premium dollars go towards medical care instead of overhead.
- ★ “Self-insured” plans - employers acting partially or wholly as their own insurer for workers - are exempt from many of the new regulations, and accounted for 61% of all workers covered by employment-based insurance in 2013.
- ★ One of the key new regulations that does apply to self-insured plans - eliminating annual and lifetime caps on benefits - was not applied to self-funded student health plans, where low caps are particularly common.

The ACA introduced a host of “market reforms” - regulations on health insurance plans - phased in from 2010 through 2014. These reforms included some of the law’s most popular measures, such as

barring insurers from denying coverage based on pre-existing conditions (“guaranteed issue”), extending family coverage to dependents through age 26, disallowing insurers from retroactively dropping coverage of patients (“rescission”), mandating coverage of essential health benefits, limiting deductibles to a maximum of \$2,000 for individual plans and \$4,000 for family plans, a requirement that insurers spend 80% to 85% of their premium income on medical care instead of overhead, and others.

However, “self-insured” plans are exempt from many of these new regulations, and now cover more workers than traditional insurance plans. According to the Kaiser Family Foundation’s annual survey, 61% of workers with employer-sponsored insurance were enrolled in self-funded plans in 2013, up sharply from 44% in 1999. Workers for large employers with 5,000 or more employees were virtually all covered by self-funded plans. The double-standard for traditional insurance and self-insured plans means that more and more employers may choose to self-insure. KFF’s 2013 survey found that 6 percent of employers with traditional insurance planned to self-insure in 2014 in anticipation of the ACA’s new regulations.

Self-insured plans do not have to cover essential health benefits, limit the size of their deductibles, fall under state review of premium rate increases, guarantee issue to all applicants, or devote a certain share of premium dollars towards medical care. Moreover, individual states are prohibited from regulating self-insured plans.

In a surprise ruling from the Department of Health and Human Services, self-funded student health plans offered by colleges and universities were additionally exempted from the ban on annual and lifetime caps on benefits. These caps are particularly common in student health plans, and often dangerously low. Currently very few campuses provide self-funded plans - only thirty nationally - but the ruling deprives students at these campuses of many of the ACA’s protections, and may encourage additional University and College systems to self-insure.

TAKING ACTION



Thousands of students at the University of California have formed a petition asking their administration, which offers self-insured student health plans, to removed annual caps on benefits that would be illegal under the ACA if not for the self-insured student loophole. The San Francisco Chronicle tells the story of Kenya Wheeler, a UC student diagnosed with cancer whose treatment costs exceeded the \$400,000 annual cap on his student health plan, becoming effectively uninsured in the midst of chemotherapy. Under a single-payer plan the cost of health insurance and health care would not be a barrier to higher education for lower-income and middle-income youth.

Health Insurers’ Profits & Administrative Waste

- ★ The Affordable Care Act requires insurance plans to spend a minimum of 80% to 85% of members’ premium dollars on medical care (known as the Medical Loss Ratio). Insurers that spend under this threshold have to refund the difference to their members.
- ★ Insurers refunded \$1.1 billion to their members in 2011 under this provision, and \$504 million in 2012.
- ★ The largest anticipated impact from this provision was insurers reducing their overhead spending, and increasing medical spending, a result that due to loopholes and lenient implementation largely did not materialize except for individuals purchasing insurance directly without employer sponsorship.

The ACA includes a new regulation that requires insurance companies to spend a minimum of 80% of members’ premium dollars on medical care. For plans sold to large employers, the requirement rises to 85% of premiums. Insurers lobbied successfully to build a number of loopholes into enforcement of the law, allowing them to inflate their medical spending by including some spending on qual-

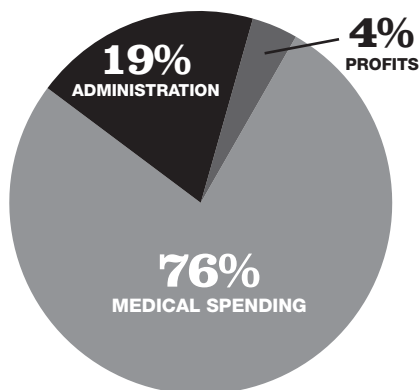
ity improvement initiatives and upgrades to their electronic claims systems, and to deduct the cost of most taxes and fees. High deductible plans and several other categories of insurance were held to lower standards, and a number of states were permitted to lower MLR requirements for individual and small employer plans. The new requirement did result in refunds to members of \$1.1 billion in 2011 and \$504 million in 2012 — but this amounted to less than 0.1% of private insurance revenues.

Expectations were that the largest savings would come from insurers reducing their overhead spend-

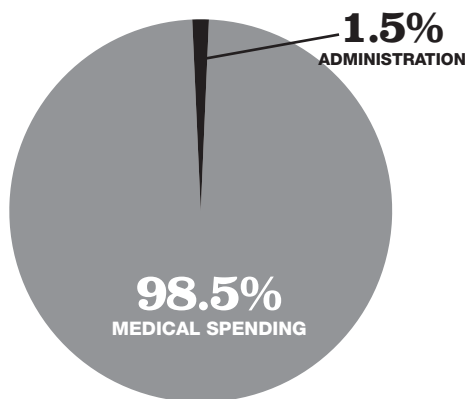
ing to avoid the rebates, redirecting administrative funds or profits towards medical spending, and passing on the savings in the form of lower premiums. This does appear to have happened for those purchasing individual insurance directly (without an employer): a Commonwealth Fund report found that medical spending for direct-purchase plans increased 3.3%, and administrative spending and profits fell between 2010 and 2011. These plans account for less than 10 percent of the population, though. For those with employment-based insurance, administrative costs did fall slightly but they were offset by an equal increase in profits, resulting in no improvement in medical spending.

The U.S. National Health Expenditure Accounts reported no change in the share of premiums devoted to medical spending for the private health insurance industry. This is because so many private insurance plans were exempted from the MLR requirements - particularly self-insured employer plans, which accounted for 61% of all covered workers in 2013 — and medical spending requirements were low enough that most insurers were already in compliance, even before deductions were allowed.

Top 5 For-Profit Insurers (2012)



Medicare (2012)



Private health insurance is a wasteful, inefficient means of covering patients. Less than 2% of Medicare's costs go towards overhead, whereas the largest for-profit insurers wasted 23% of every premium dollar on bureaucracy and profits, leaving little for medical care.

TAKING ACTION



In 2011 every insurer in every state was, for the first time, required to publish the extent to which they waste subscribers' premiums on non-medical costs (albeit with a very problematic definition of medical costs). This is powerful evidence that private insurers are middlemen pocketing a large share of our health care dollars without adding value to the health care system. You can look up the "Medical Loss Ratios" and the fines paid out by insurers in your state by searching for "List of Health Insurers Owing Rebates in 2012" (or subsequent year). To calculate the medical spending that for-profit insurers report to their shareholders — which is lower than what they report to the government — look up an insurer's Form 10-K annual reports filed with the Securities and Exchange Commission, using the SEC's EDGAR database (<http://www.sec.gov/edgar.shtml>).

A good way to put pressure on for-profit insurers, and educate the public about how they siphon off health care dollars for profits and administrative waste, is to get

involved with the Divestment Campaign for Health Care. The Divestment Campaign seeks to get institutional investors - such as municipalities, unions, colleges and universities, and socially responsible investment funds - to pull their money out of for-profit health insurer stocks, as it is unethical to profit by reducing medical spending. Divestment activists have moved the Presbyterian Church to consider divesting from health insurance, and succeeded in getting TIAA-CREF, the country's largest public employee pension fund, to drop a large health insurer from its socially responsible investment fund. To get involved, go to <http://healthcarenotwealthcare.us/>

Review of Insurance Premium Hikes

- ★ The ACA requires health insurers to file “Rate Filing Justifications” every time they propose to increase premiums. Increases above 10% must be reviewed, either by states or the federal government.
- ★ States have the option of implementing a “prior approval” process that gives them the power to reject premium hikes, and even rate review without teeth gives advocates a tool to shame insurers for putting profits over patients.

The ACA will require every health insurance company to justify annual premium hikes by filing financial data with the Department of Health and Human Services and participating state agencies. The requirement only applies to individual and small employer plans though. Premium hikes of 10% or more will trigger a mandatory “rate review” process starting in 2012 (states have the option to set lower thresholds in subsequent years), but the reviews have only the power of publicly shaming insurers - not the power of striking down proposed premium increases - unless a state chooses to implement a “prior approval” process.

More than half of states had prior approval before implementation of the ACA. The ACA created funding for a range of states to expand their use of rate review and prior approval. The extent to which states actually use this leverage varies drastically, though.

There is considerable anecdotal evidence that states committing resources to independently evaluate proposed premium increases are sometimes able to challenge the actuarial claims of insurers - who often “pad their numbers” — and can shame insurers into reducing rate hikes.

TAKE ACTION



The new “Rate Filing Justification” forms insurers must submit to the federal and state governments, as well as the requirement for some form of public comment period, will be a potential tool for single-payer organizers to highlight exorbitant rate hikes by insurers, and to contrast the spiraling costs of our commercial health care system with the cost control that single-payer health care would offer. Rate review filings are not as transparent as they should be, but filings for each insurance company by state are being posted at <https://data.healthcare.gov/>

Public review of unaffordable rate increases is a good opportunity to organize teach-ins, public forums, or presentations to community groups on how single-payer would impact health care costs in the U.S. You can now use data from a study by Gerald Friedman, economist at the University of Massachusetts-Amherst, which analyzed the economic impact of implementing H.R. 676, the Improved Medicare for All legislation in the House, and there are a wealth of slide shows available from Physicians for a National Health Program and Healthcare-NOW! for use as model single-payer talks.

Expanding Care for the Marginalized

The ACA will have mixed impacts on socio-economic groups discriminated against by our current health care system. Documented immigrants who are banned from Medicaid coverage until they have lived in the U.S. for five years will become eligible for premium subsidies in the exchanges, but will continue to be excluded from Medicaid. Undocumented immigrants granted DACA status (Deferred Action for Childhood Arrivals) will be ineligible for all of the ACA's benefits, and undocumented immigrants in particular are likely to be hit hard by safety net cuts.

The ACA will require all insurers to cover contraceptive care, making exceptions for some religious employers. The ACA may have the effect of reducing the number of plans with abortion coverage, though. The vast majority of private insurance currently covers abortion services, but more and more residents will seek care through state exchanges, many of which ban abortion coverage outright and all of which require that abortion services be offered with a separate premium payment.

One of the gravest dangers of the ACA is the cuts to safety-net providers built into the law, which will reduce federal funds for treating the uninsured and underinsured by up to 50% in some states. These cuts are not necessarily proportionate to the expansion of insurance coverage, and in states not expanding Medicaid, they may threaten the financial viability of hospitals serving the most vulnerable, low-income populations.

Reproductive Health Care

★ The ACA requires all health insurance plans to cover “preventive care and screenings” without cost sharing, including birth control. Exemptions have been made for certain religious organizations.

- ★ Consistent with the existing “Hyde amendment,” the ACA will not permit subsidized health plans offered through state exchanges to include abortion coverage, unless a separate premium is charged for an optional abortion benefit.
- ★ States have the option of banning abortion coverage in their exchange altogether, an option 23 states have adopted.

One significant impact of the ACA is its requirement that all health insurance plans cover a range of preventive services without co-payments or deductibles, as determined by the Health Resources and Services Administration (HRSA). In 2011, the HRSA determined that this rule includes FDA-approved contraceptives, sterilization, and counseling, on the grounds that planned pregnancy positively impacts the health of parents and children. In August 2011 the administration issued rules that only churches and church-operated organizations would be allowed to opt-out, but not religious universities, hospitals, charities, or other non-profit organizations. In the face of intense lobbying and litigation, the administration arrived at a final rule in June 2013 that will allow such religious employers to opt-out of paying for contraceptive services for employees, but in such cases the insurer will be required to offer and pay for contraception for those employees.

The ACA follows the existing Hyde Amendment rule in prohibiting any federal funds from paying for abortion coverage, whether through Medicaid or the new premium tax subsidies offered through the exchanges. Prior to passage of the ACA, states were already empowered to limit abortion coverage among private insurers. By 2013 eight states had banned abortion coverage altogether and eighteen states excluded it from coverage of public employees.

Following the ACA, a record twenty-three states voted to bar abortion coverage in state exchanges —

even if subscribers are willing to pay for it with a separate premium. Most of the state bills implementing this ban do not include exemptions for women facing serious or even life-threatening injuries from pregnancy.

87% of employer-based insurance plans cover abortion services. The wave of state-based prohibitions combined with the growing number of residents who will rely on coverage through state exchanges may lead to a national decline in access for lower-income women.

Threats to the Safety Net

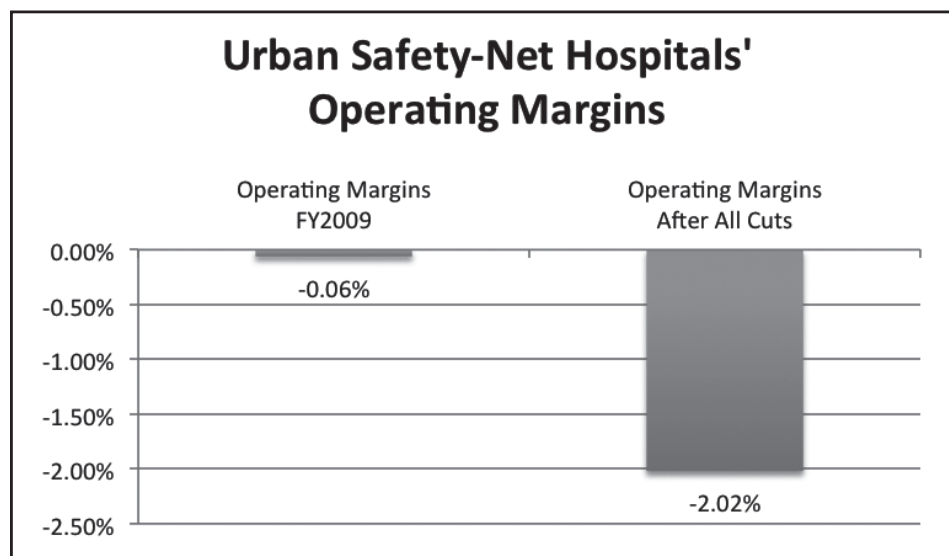
- ★ The ACA will cut safety net payments to hospitals and health centers for treating the uninsured and underinsured by 25% or 50%, depending on the state.
- ★ For many providers, these cuts will be deeper than their reduction in uninsured and underinsured patients, particularly in states where Medicaid is not expanded.
- ★ Safety net cuts may lead to a financial crisis for providers serving the most vulnerable populations, and lead them to avoid caring for unprofitable patients.

“Safety-net providers” are hospitals, health centers, and physicians serving low-income and vulnerable

communities, characterized by a large share of uninsured, underinsured, and publicly insured patients. For survival, safety net providers rely on adequate rates for treating Medicare and Medicaid patients, as well as “disproportionate share hospital” (DSH) payments that are paid by the federal government to reimburse hospitals for the cost of treating the uninsured and underinsured. The ACA may negatively impact two of these revenue streams for safety-net providers, potentially putting health care facilities serving the most at-risk populations in danger financially.

Starting in 2014, the ACA will cut DSH payments to states by 25% or 50%, depending on whether the state had previously been treating larger or smaller uninsured populations. Although the cuts are based on the assumption that increased insurance coverage will reduce the need for DSH payments for treating the uninsured, the formula for cuts is arbitrary. States that do not expand their Medicaid programs face a particularly dire situation in which DSH payments may be cut by 50%, with no expansion of coverage for low-income uninsured people.

One offsetting benefit of the ACA for safety-net providers is a significant increase in Medicaid rates paid to physicians for certain types of primary care. Medicaid payment rates are generally set by the states, and in 2012 averaged only 66% of Medicare rates. The ACA requires Medicaid, starting in 2013, to pay Medicare rates for certain categories of primary care.



The National Association of Urban Hospitals issued a September 2012 report warning of potentially dire impacts from the ACA's safety-net cuts. Urban safety-net hospitals, already taking losses on average for serving the most vulnerable patients, may be pushed into insolvency by the ACA.

In Massachusetts, where a similar health reform law was passed in 2006, cuts to the safety net resulted in catastrophic losses for the state's two largest safety net hospitals, leading both to cut services and personnel and one to seek a buyer due to sustained financial losses.

TAKING ACTION



The Western Pennsylvania Coalition for Single-Payer Healthcare joined with members of the Braddock, PA community in the formation of "Save Our Community Hospitals" when UPMC announced in October 2009 the imminent closing of UPMC Braddock Hospital, which was demolished in 2010. At the same time, UPMC built and opened a brand new hospital in a middle-class neighborhood in Monroeville, PA, less than one mile from a competitor's hospital. Braddock was a thriving steel-town 30 years ago and today is a struggling, mostly African-American community outside of Pittsburgh. Tony Buba, chair of SOCH and a filmmaker who grew up in Braddock, documented the struggle to save the hospital in "We are Alive! The Fight to Save Braddock Hospital" (2012).

Immigrant Access to Care

- ★ The ACA's safety net cuts will particularly impact immigrants, many of whom will be ineligible for Medicaid and premium subsidies.
- ★ The ACA will make subsidies available to documented immigrants traditionally barred from Medicaid, if they are above the poverty line.
- ★ Undocumented immigrants will be barred from the state exchanges, even if they are not receiving public subsidies.
- ★ Immigrants granted "Deferred Action for Childhood Arrivals" (DACA) status, frequently referred to as "Dreamers," will be treated as undocumented and excluded from all of the ACA's benefits.

Voices of Health Reform

A September 2013 article by The Seattle Post tells the story of Likos Afkas, a Micronesian native living in Washington state. Micronesian residents suffer from high cancer rates and other health problems due to U.S. nuclear testing on the island during the Cold War. Micronesian citizens are legally permitted to reside on the island, but without U.S. citizenship.

Afkas, who moved to Washington in 2012 diagnosed with kidney failure, is barred from Medicaid eligibility for another 4 years, does not have enough work credits to be eligible for Medicare disability coverage, and does not make enough income to qualify for subsidized coverage in the exchange starting in 2014.

The ACA will have a mixed impact on immigrant communities' access to care. A 1996 law blocked federal Medicaid funding for documented immigrants until they have been residents for five years, with some exceptions made for refugees, asylees, and members of the military. This means that all undocumented immigrants and many documented immigrants will not benefit from Medicaid expansions in states that opt to expand Medicaid, but they will disproportionately bear the brunt of safety net cuts (see box above).

One important expansion for documented immigrants is the ACA's premium subsidies in state exchanges. These subsidies will partially subsidize health insurance for those earning more than the poverty line but less than four times poverty (about \$11.5k to \$46k for an individual in 2013), and will be available to all documented immigrants, including those falling under the 5 year bar. This will create a double standard for recent documented immigrants depending on their income, though, penalizing those who fall below the poverty line.

Undocumented immigrants will continue to remain ineligible for Medicaid and all public subsidies, and in an unexpected move the Centers for Medicare and Medicaid Services passed a rule also barring “Dreamers” who have been granted “Deferred Action for Childhood Arrivals” (DACA) status. DACA was created by Homeland Security under the Obama administration to prevent the deportation of young undocumented immigrants who had been brought to the United States as children, often through no choice of their own.

TAKING ACTION



The 2006 Massachusetts health reform on which the ACA was modeled initially included coverage for documented immigrants falling under the 5 year bar, which had to be funded entirely out of the state budget. When the health law ran into financial shortfalls in 2009, the state legislature voted to disenroll all 30,000 immigrants in the program with less than 5 years residency. Massachusetts Physicians for a National Health Program collected signatures from 500 physicians in the state, calling for single-payer reform and to “fully restore funding for the 30,000 immigrants who face imminent exclusion.” PNHP then co-hosted a press conference at the State House, joined by speakers from the Committees of Interns and Residents, the National Association of Social Workers, the Massachusetts Nurses Association, American Friends Service Committee, and SEIU 615, a local union representing janitors and many working immigrants’ families, to oppose the cuts and call for comprehensive reform.

Conclusion

In the Affordable Care Act we did not get the health reform we deserve — single-payer or improved medicare for all — but the reform we did get will mobilize millions attempting to realize the promises of reform and achieve equitable access to health care for all. The ACA represents a challenge, with the potential to marginalize single-payer advocates, but also a series of organizing opportunities to grow the movement. It is up to us to ensure that the ACA serves as a sail and not an anchor for achieving the only proven, humane system of care.

This Guide attempts to identify some of the new organizing opportunities the ACA is creating, and encourages single-payer advocates to think strategically about leveraging the implementation process as a series of teaching moments and opportunities to broaden their networks.

TAKE ACTION!

Would you like to get involved but you're not sure how, or you'd like to receive some national support, or bounce ideas off a Healthcare-NOW! organizer? We're here to help you!

Visit our web-site: www.healthcare-now.org

Email us: ben@healthcare-now.org

Call us: 215-732-2131

Or make a donation to support our work! You can donate online at www.healthcare-now.org, or send a check or money-order to Healthcare-NOW!, 1315 Spruce St., Philadelphia, PA 19107. Make your check out to “IFCO/Healthcare-NOW!” for tax-deductible donations.

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Single-Payer Legislation

We will only achieve national, single-payer reform through legislation, and that means building legislative leadership and support as well as growing the grassroots movement. You can organize a delegation to visit your Congresspeople or state legislators. Petitions, post cards and letters are also effective and will help to build your contact list for further work. There are two single-payer bills in Congress: H.R. 676, which has had over 90 co-sponsors in the House at times, and the American Health Security Act, the only single-payer bill in the Senate (with a companion piece of legislation filed under the same name in the House). In some states campaigns to enact state single-payer legislation are also very active. Moving legislators to support single-payer legislation can be a satisfying victory for local activists and a good litmus test of the single-payer movement's effectiveness in a district.

The Expanded & Improved Medicare For All Act, H.R. 676

Introduced by Representative John Conyers, the Expanded & Improved Medicare For All Act establishes a unique American national universal health insurance program. The bill would create a publicly financed, privately delivered healthcare system that uses the already existing Medicare program by expanding and improving it to all U.S. residents, and all residents living in U.S. territories. The goal of the legislation is to ensure that everyone will have access, guaranteed by law, to the highest quality and most cost effective healthcare services regardless of their employment, income, or healthcare status.

The American Health Security Act

Introduced by Representative Jim McDermott in the House and Senator Bernie Sanders in the Senate, the American Health Security Act would provide federal guidelines and strong minimum standards for states to administer single-payer health care programs.

State Single-Payer Legislation

State-level single-payer legislation has been introduced in 26 states at one time or another, and many state campaigns are currently very active, such as in New York, Massachusetts, Pennsylvania, California, Minnesota, Oregon and elsewhere. Vermont has introduced and passed legislation that instructs the state to develop a complete single-payer implementation plan and put it into effect after receiving necessary federal waivers. Contact Healthcare-NOW! if you would like to be put in touch with state single-payer efforts in your area.

TAKE ACTION: GET INVOLVED!

Healthcare-NOW! is a grassroots organization that addresses the health insurance crisis in the U.S. by educating and advocating for the passage of single-payer healthcare legislation, such as H.R. 676.

We support building the movement necessary to implement a publicly-funded, single-payer healthcare system that is universal, equitable, transparent, accountable, comprehensive, and that removes financial and other barriers to the right to health.

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