

Single-Payer Activist Guide to the Affordable Care Act

1. Executive Summary
2. Introduction & Background to the ACA
3. The Fight for Medicaid and Medicare
 - State-by-State Medicaid Expansions
 - Privatization of Medicaid
 - Sustaining Medicare for the Next Generation
 - Negotiating Medicare Drug Costs
4. Protecting Workers' Access to Care
 - Employer Responsibility: Delay and Evasion
 - The Myth of Corporate "Wellness" Programs
 - Rock and a Hard Place: Workers' Eligibility for Public Subsidies
 - The Threat to Multi-Employer Union Plans
 - The 2018 "Cadillac" Tax on Workers' Benefits
5. Holding Health Insurance Companies Responsible
 - The Self-Insured and Student Health Plan Loopholes
 - Health Insurers' Profits & Administrative Waste
 - Review of Insurance Premium Hikes
6. Expanding Care for the Marginalized
 - Threats to the Safety Net
 - Immigrant Access to Care
 - Reproductive Health Care and Abortion Coverage
7. Conclusion & Taking Action!

State-by-State Medicaid Expansions

- The Affordable Care Act was written to expand Medicaid to all uninsured people below and just above the poverty line starting in 2014. 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 July 2013, 21 states had voted to oppose expanding their Medicaid programs, while 6 additional states were undecided, disproportionately 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 in all states. In states that do not expand their Medicaid program, this will mean penalizing families for falling below the poverty line.

A key provision of the Affordable Care Act (ACA) would have expanded Medicaid to most uninsured residents below 138% of the federal poverty line (FPL), insuring an estimated additional 21 million by 2022. 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% at its lowest by 2020 and beyond. Even so, twenty-one states were on record in opposition to expanding Medicaid as of June 2013 (sometimes blocked by a Governor or one body of the state legislature). Four additional states remained undecided. These twenty-one states represent 4.9 million uninsured residents who would become eligible for coverage – half of all those who stood to gain insurance coverage under Medicaid expansions nationally. The undecided states represent an additional 1.5 million eligible uninsured uncertain of their eligibility starting in 2014.

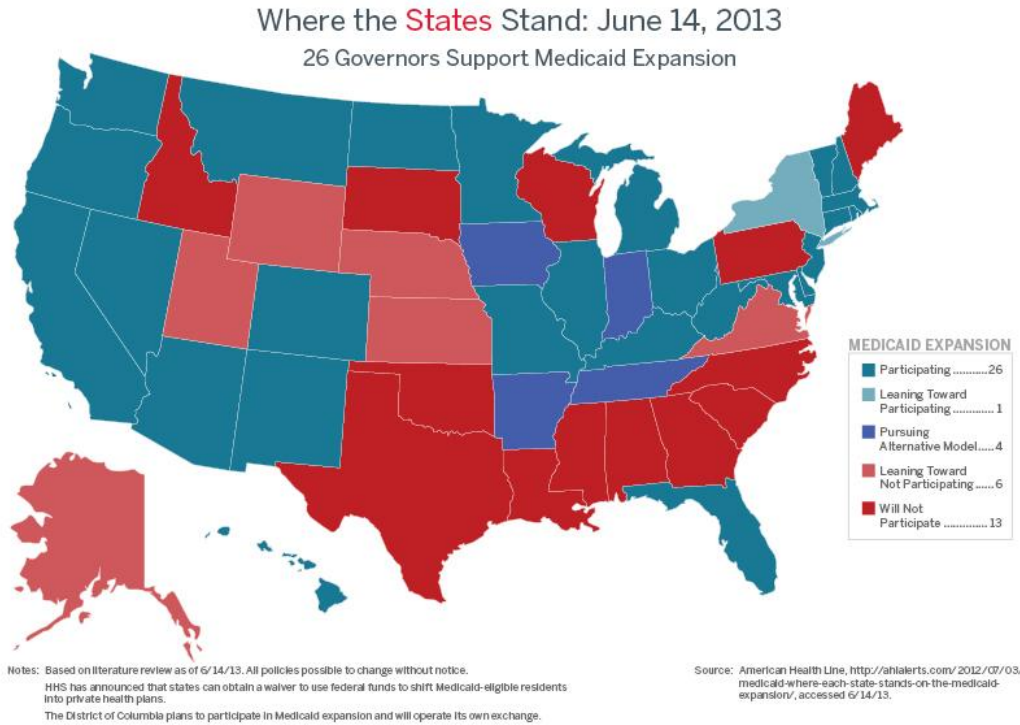
One study looking at only the first 14 states to announce they would not expand Medicaid, found that they would not only forego \$8.4 billion in additional federal funding in 2016, but would see \$1 billion in higher spending on uncompensated care for the uninsured – meaning that failure to expand is likely to hurt state budgets even after states are picking up 10% of the costs of the expansion by 2020.

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, helping to organize a rally of thousands in March 2013. 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.

VISUAL



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[work in progress - keep going]

Privatization of Medicaid

- Several state Legislatures and Governors have announced their intention to oppose expanding Medicaid to low-income residents and are instead asking to use this pool of Medicaid money to subsidize private health insurance coverage for the same low-income residents.
- The Congressional Budget Office estimates that funneling Medicaid funds to private insurers in this way will cost taxpayers 50% more per individual than insuring a person under the traditional Medicaid program, syphoning off public funds for private insurance company profits.
- In some states these privatized Medicaid plans would reimburse physicians at almost half the rate paid by the public Medicaid program, which already maintains extremely low payments to providers, potentially leaving few providers willing to accept patients enrolled in the new programs.

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 a number of other states.

While such arrangements are required by law to be as cost effective as enrolling residents in the public Medicaid program, the Congressional Budget Office estimates that funneling Medicaid funds to private insurers in this way will cost taxpayers 50% more per individual than insuring a person under the traditional Medicaid program, siphoning off public funds for private insurance company profits.

In Florida, which on June 2013 received a federal waiver allowing private insurance companies to administer coverage for roughly 3 million Medicaid enrollees, payment rates to physicians were found to equal only 58% of what the public Medicaid program would pay. Dangerously low provider payment rates mean that fewer and fewer physicians will accept Medicaid patients, 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.

VISUAL

[Map for Medicaid expansion section works for this section as well]

Sustaining Medicare for the Next Generation

- Medicare - the universal, public health plan for seniors age 65 and older - costs less than private health insurance and provides better care, but faces costs rising much more rapidly than under a single-payer system.
- Prior to the Affordable Care Act (ACA), Medicare was projected to become insolvent by 2018.
- The ACA raised new taxes to fund Medicare, and created new physician payment rates to reduce costs, but still left Medicare projected to become insolvent by 2026 or earlier.

Medicare is the only universal, tax-financed healthcare program in the U.S., covering almost all seniors age 65 and above. A 2012 Commonwealth Fund report found that Medicare beneficiaries report better access, better financial protection, and almost half the problems with medical bills of those with private health insurance.

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 much faster than inflation and unsustainable over time. 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 extensive new revenues and cost-saving projects included in the bill have resulted in a new projection of insolvency for 2026, extending the program's life by about 8 years.

Taking Action

Medicare is just one of many public and private payers and cannot realize the administrative savings and financial planning of a true single-payer system. Medicare's costs have risen at twice the rate of Canada's health care spending for seniors since 1980, its administrative costs are three times as high, and Canada's single-payer system covers 79% of seniors' total health care costs, whereas Medicare only manages to cover 51%. Calling for single-payer health reform is the best way to guarantee health security for seniors, and to preserve and expand Medicare for the next generation.

VISUAL

[From HCN's "Save Medicare" flyer - or David & Steffie's graph comparing rising costs for seniors in U.S. vs Canada?]

SOURCES

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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 for lower drug costs.
- Currently, over one thousand Private Drug Plans (PDPs) and Medicare Advantage (MA) plans separately negotiate drug costs for small pools of Medicare beneficiaries, costing between \$230 and \$541 billion more over the 10 years after health reform than if Medicare had negotiated costs like the Veterans Administration does.
- Obama and Congressional Democratic leaders campaigned in 2008 to let Medicare negotiate lower drug costs, but during 2009 instead cut a deal that Pharma would voluntarily reduce Medicare patient's drug costs, and Medicare would continue to be banned from negotiating low costs.

Allowing Medicare to negotiate low drug costs, as the federal Veterans Administration as well as Medicaid currently do, is an easy step to large savings for Medicare. Barack Obama in a well-known campaign ad in 2008 called out Republicans for banning the practice, ending the ad saying that he would "put an end to game playing" like this. Emails later leaked to the New York Times showed that during the national health reform process in 2009, the White House agreed to take Medicare drug negotiation off the table in exchange for pharmaceutical companies voluntarily reducing drug costs for seniors facing gaps in Medicare coverage, and in exchange for PhRMA's public support for the ACA.

Taking Action

Pushing to realize 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 one of the mostly rapidly rising costs in the health care system.

VISUAL

[Graphic showing brand name drug costs in the US vs other countries? Projected savings from negotiations?]

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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 2014 or potentially face financial penalties of \$2,000 to \$3,000 for each full-time employee who is uninsured or offered unaffordable or inadequate coverage. The Obama administration delayed this “play or pay” provision until 2015.
- Employers may attempt to shift from full-time to part-time work to minimize the fines, since there are no penalties for failing to cover part-time employees.
- Employers currently offering health insurance to part-time workers (less than 30 hours) may drop their coverage, since those workers could then become eligible for subsidized insurance through the exchange.

The Affordable Care Act requires employers with 50 or more full-time-equivalent employees to provide “affordable” health plans that provide minimum benefits starting in 2014 or potentially face penalties. The employer fees of \$2,000 to \$3,000 per worker – exempting the first 30 employees - are only triggered if uninsured employees seek subsidized care through 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 fought to undermine the provision further, though. The Obama administration was convinced in July 2013 to unilaterally delay enforcement until 2015, which would fall after the 2014 elections, despite a 2014 implementation date in the text of the ACA. The Congressional Budget Office projects that 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).

The administration also developed a dubious interpretation of “affordable” health insurance. Only the cost of an individual plan can be used in determining affordability, even if an employee must buy a family plan, and it is considered affordable if it amounts to less than 9.5% of the worker’s *household* income. This sets a low affordability bar for employers.

TAKING ACTION

“[T]he law creates an incentive for employers to keep employees’ work hours below 30 hours a week. Numerous employers have begun to cut workers’ hours to avoid this obligation, and many of them are doing so openly... unless you and the Obama Administration enact an equitable fix, the ACA will... destroy the foundation of the 40 hour work week that is the backbone of the American middle class.”
-- Letter to Harry Reid and Nancy Pelosi from the Presidents of the Teamsters, UFCW, and UNITE-HERE

The Myth of 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.
- Large, national studies of wellness programs show that they do not improve the health of enrolled workers by most measures, reduce hospital or emergency room usage, or reduce their health care costs.
- Wellness programs can be extremely intrusive, and primarily allow employers to shift premium costs onto non-participating employees. Despite some regulatory attempts to prevent discriminatory impacts, wellness premium penalties are most likely to impact those facing worse determinants of health, including low-income workers, people of color, and those with chronic illnesses and disabilities, who are less likely to choose to participate.

The Affordable Care Act enables employers to expand on "wellness" programs that were first permitted under a 1996 law. In 2011, sixty percent of employers reported utilizing some form of workplace wellness program. Wellness programs can financially penalize workers with higher premiums if they do not participate in "lifestyle management programs" designed to keep them healthier – these can include mandatory health assessments, blood tests, and urine tests for tobacco usage. These programs are justified as keeping health costs down through prevention, encouraging employees to lose weight, quit smoking, keep up with treatments for lower cholesterol and blood pressure, or even stress management.

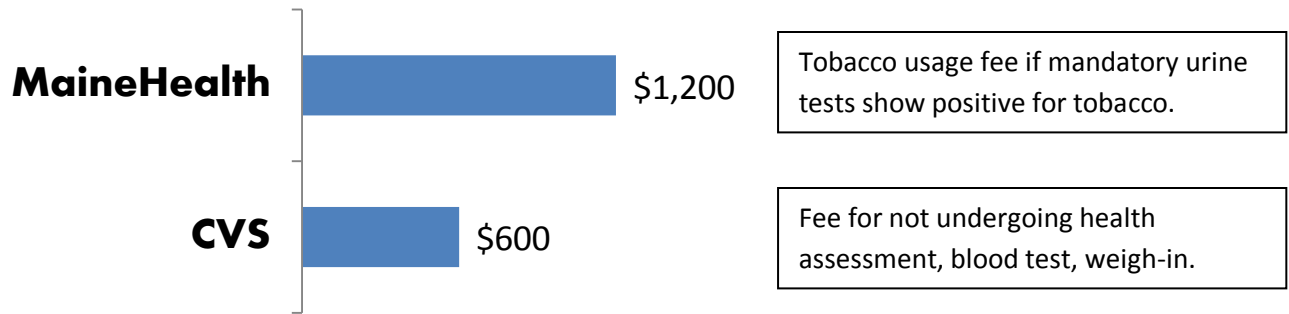
In reality wellness programs achieve few if any of these stated objectives. A large 2013 study by the RAND Corporation, commissioned by the U.S. Labor Department and Department of Health and Human Services, confirmed what earlier studies had found: wellness programs had no statistically significant impact on employees' health care costs or their use of emergency room or hospital care. The impacts on employees' health was limited to non-existent: 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.

VISUAL



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

- The Affordable Care Act (ACA) will provide subsidies in the form of tax credits to those living above the poverty line up to four times poverty 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 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 appears to be 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, which implemented health reform in 2006. 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. 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.

Visual

[Images of the Old Rochester workers, maybe of the change.org petition total?]

Sources

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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 modest periods of unemployment. This is particularly common in the construction trades. For workers, portable health benefits that employers pay into is often what sets unionized work apart from non-union hiring halls.

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 unionized industries when they have worked a certain number of hours for the year). Furthermore, small employers can receive large 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

The Presidents of three national unions that rely heavily on multi-employer plans – the Teamsters, United Food and Commercial Workers, and UNITE-HERE – have written a letter to Democratic leadership in Congress demanding that subsidies be extended to workers with Taft-Hartley health plans. The International Brotherhood of Electrical Workers took out an ad in D.C.’s *Roll Call* calling on the President to make good on his promise that those with insurance they like can keep it, by saving Taft-Hartley plans. The Labor Campaign for Single Payer Healthcare launched a petition in August 2013 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.

VISUAL

[IBEW ad? May be too big...]

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 high cost sharing.

One of the Affordable Care Act'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 plans, 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, despite being commonly referred to as the "Cadillac Tax" in the press, 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 comprehensive 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.

VISUAL

[No obvious visual for this one...]

SOURCES

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The Self-Insured and Student Health Plan Loopholes

- The Affordable Care Act (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 percent of all workers covered by employment-based insurance in 2010.
- 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 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 ("recession"), 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 reported plans 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 under federal law.

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 example 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.

VISUAL

Photo of Kenya Wheeler from the San Fransicso Chronicle.



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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 for 2011 under this provision, and are scheduled to refund about \$500 million for 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 Affordable Care Act (ACA) includes a new regulation that requires insurance companies to spend a minimum of 80% of members' premium dollar on medical care. For plans sold to large employers, the requirement rises to 85% of premiums. Despite a number of loopholes, and a lenient interpretation of what counts towards premiums and medical spending, the new requirement did result in significant refunds being issued to members in 2011 (totaling \$1.1 billion) and to a lesser degree in 2012 (\$500 million).

Expectations were that the largest savings would come from insurers reducing their overhead spending, redirecting administrative funds or profits towards medical spending, and pass 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 as a whole between 2010 and 2011 (87.7% in both years). In part this is because so many private insurance plans were exempted from the MLR requirements - particularly self-insured employer plans, which accounted for 60% of all covered workers in 2011.

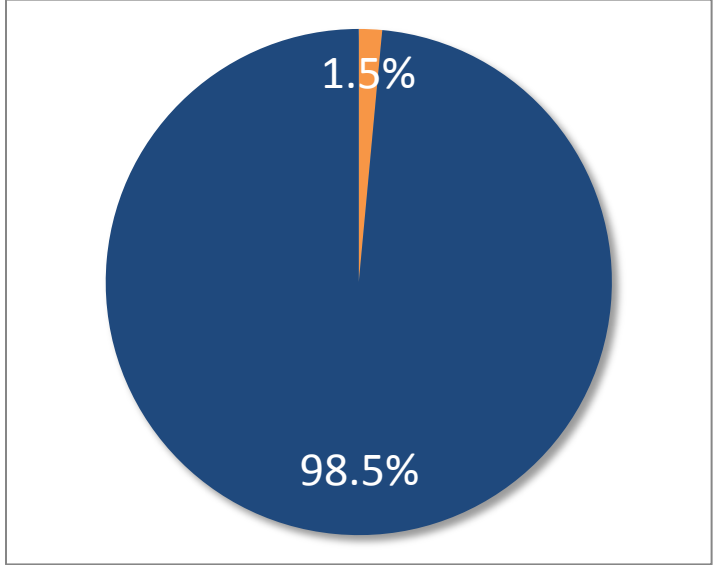
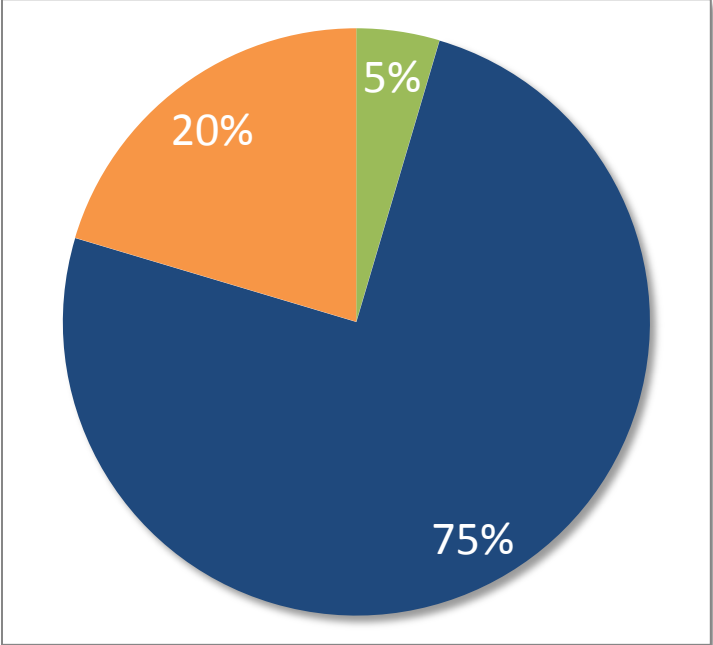
Taking Action

Starting in 2011 every insurer in every state will, for the first time, be required to publish the extent to which they waste subscribers' premiums on non-medical costs. This is powerful data for making the case that private insurers are primarily 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). Medicare spends more than 98% of total costs on medical reimbursement, as do most universal single-payer plans. Can you imagine the rebate to consumers of switching to a Medicare for All system with that kind of low overhead and no profits? You do the math - and publish the results!

Visuals

[Pie charts comparing overhead at Top 5 For-Profit Insurers and Medicare]



Review of Insurance Premium Hikes

- The Affordable Care Act (ACA) requires health insurers to file "Rate Filing Justifications" every time they propose to increase premiums.
- Every premium increase above 10% has to be reviewed, either by states or the federal government.
- Rate review don't allow the government to block unreasonable premium increases, but states have the option of implementing a "prior approval" process that does give them the power to reject premium hikes, and even rate review without teeth has been shown to reduce premiums somewhat.

The ACA will require every health insurance company to justify annual premium hikes by filing select financial data with the Department of Health and Human Services and, if they chose to engage in rate review, state agencies as well. Only 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 used prior approval prior to implementation of the ACA, but only for plans sold to individuals and small-employers. 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 often able to challenge the actuarial claims of insurers - who often "pad their numbers" - and even without prior approval 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 that some form of public comment period be created, 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 single-payer health care would offer.

To look up rate review filings of insurance companies in your state, visit: <https://data.healthcare.gov/>

Each insurance plan must submit a 'Rate Increase Summary' with an overview of the costs they face, from which they claim to justify their proposed rate increase, as well as a written explanation justifying the rate increase.

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Threats to the Safety Net

- The Affordable Care Act (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, which 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 and not designed to protect providers who continue to serve high numbers of uninsured and underinsured. 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 the low-income at all.

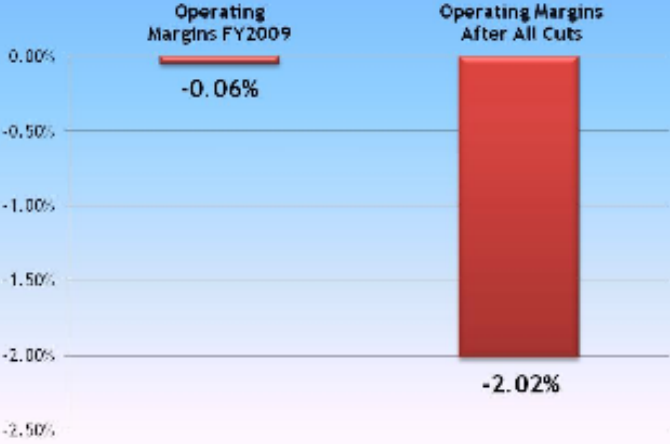
One offsetting benefit of the ACA for safety-net providers is a significant increase in Medicaid rates paid to physicians for certain types of primary care. Medicaid payment rates are generally set by the states, and in 2012 averaged only 66% of Medicare rates for the same care. The ACA requires Medicaid,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

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

VISUAL

[Graph from the National Association of Urban Hospitals - <http://www.nauh.org/research/raw/98.html>]

Urban Safety-Net Hospitals' Operating Margins



Immigrant Access to Care

- The Affordable Care Act (ACA) safety net cuts will particularly impact immigrants, many of whom will be ineligible for the ACA's Medicaid expansions.
- 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" status will be treated as undocumented, and excluded from all of the ACA's benefits.

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 above).

One important expansion for documented immigrants is the ACA's premium subsidies in state exchanges. These subsidies will partially subsidize health plans for those earning more than the poverty line but less than four times poverty (from \$11,490 to \$45,960 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 - counterintuitively rendering them ineligible for subsidies.

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 undocumented residents who had 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.

Voices of Health Reform

A September 2013 article by The Seattle Post tells the story of Likos Afkas, a Micronesia native living in Washington state. Micronesia residents suffer from high cancer rates and other health problems due to U.S. nuclear testing on the island during the Cold War. Micronesia 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.

[Photo of Likos Afkas from The Seattle Times.]



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Reproductive Health Care and Abortion Coverage

- The Affordable Care Act (ACA) requires all health insurance plans to cover “preventive care and screenings” without cost sharing, which was determined by the Health Resources and Services Administration to include birth control.
- The Obama administration initially exempted “religious organizations” from providing contraceptive coverage, including only churches but not religious hospitals, universities, or other employers. In the face of protest and litigation, the administration backed off this ruling temporarily, and the final rule is still contested.
- 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 further limiting or banning abortion coverage in plans offered in their exchange, an option

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. From the start the administration intended to create some form of exemption for religious employers who object to contraception, but in August 2011 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. Many states have taken this limitation further: Prior to passage of the ACA, states were already empowered to ban coverage of abortion services, which in 2013 eight states prohibited for all private insurance coverage and eighteen states prohibited for public employees. Following the ACA, a record twenty-three states voted to bar any abortion coverage in state exchanges – even if subscribers pay for it with a separate premium. Most of these state bills do not include exemptions for women facing serious or even life-threatening injuries.

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

Sources

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