



# Health Care for All-Washington

An Information Pipeline for Members and Friends of Health Care for All-Washington  
Formerly known as HealthCare2000

## “Health Reform” Is Now Law: What Did We Get?

by Sarah K. Weinberg, MD

The Patient Protection and Affordable Care Act signed into law by President Obama in late March is essentially a bundle of health insurance regulations, taxes, fees, and mandates on employers and individuals. Congress and the President intend that this rather chaotic collection will result in an improved environment in which nearly all Americans can obtain more affordable health coverage.

Major Elements (Effective Dates)

**1. Medicaid expansion (2014).** The new law expands Medicaid eligibility to everyone with incomes up to 133% of the Federal Poverty Level (FPL). A family of four earning \$29,000 would qualify.

**2. Insurance regulation (Oct. 2010).** Some regulation of insurance will take effect in 6 months, and some not until 2014. Ending exclusions for pre-existing conditions for children and adding 18-25 year olds to parents’ insurance will go into effect in 6 months. Rescission (canceling insurance) for minor reasons will require proof that the sick person committed fraud. What constitutes “fraud” remains open to court interpretation. Less clear is under what circumstances insurers can still impose lifetime coverage limits between now and 2014.

**3. Insurance regulation (2014).** After this date insurers will not be permitted to deny insurance for pre-existing conditions, cannot impose a waiting period longer than 90 days, cannot impose any lifetime limits, and are limited to a premium ratio spread of 3 to 1 for the oldest to the youngest age groups. (They can charge 1.5 times the usual premium for smokers.)

**4. Employer “mandate” (2014).** Employers with more than 50 employees will face monetary penalties if they do not offer health insurance or if the insurance offered is too skimpy or too expensive for the employee. In businesses with more than 200 employees, employees will be automatically enrolled in the employer’s health insurance plan unless the employee opts out.

**A bundle of regulations, taxes, fees, and mandates.**



**April - June  
2010**

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**Health Care for All - Washington advocates for affordable comprehensive health care coverage for all Washington residents implemented through a unified financing system.**

### **WHAT’S YOUR REACTION?**

See page 4 for a compilation of readers’ responses to the reform bill.

# Health Care for All- Washington

April - June 2010

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# Message from Our President

*Larry Kalb, President,  
HCFA-WA*

Larry Kalb has taken a leave of absence from his position as HCFA-WA President to run for Congress representing Washington's second district. We see this as a win-win situation---whether he winds up in Washington D.C. or returns to his capable leadership of the drive for a true national health insurance plan, our community benefits. We wish him the best of luck.



*Senator Patty Murray addresses health reform supporters in South Park after the bill's passage. KOMO TV photo.*



*By Mary Margaret and Paul Pruitt, Co-Chairs*

### **“Yes we did... and we can do more!”**

“Si se puede” (Yes, we can) is often the chant at rallies and marches for social justice. Hundreds of supporters of the health reform bills celebrated their passage by shouting “YES, WE DID!!!” at a rally held at the Machinist’s Hall in South Park on Sunday March 28”

However, the crowd and speakers also recognized that this occasion is only the “end of the beginning step” and not the completion of achieving affordable, accessible quality health care for everyone. Nevertheless, our state’s elected officials emphasized the positive aspects of the bills:

- **Senator Patty Murray** listed more than a dozen groups in this state that will soon benefit: 92,500 small business owners who will qualify for the tax credit program to help provide health coverage for their employees; 615,337 young people aged 19-25 who will be able to stay on their parents’ health insurance; and 159,000 seniors adversely affected by the Medicare Part D “donut hole” who will get a \$250 rebate this year and more help next year, to name just three groups.
- **Senator Maria Cantwell** lauded the inclusion in the bills of Basic Health Plans modeled on the one Washington has had for several years that can provide coverage for residents between 133% and 200% FPL that will satisfy the requirements of the individual mandate.
- **Representative Jay Inslee** recalled the time, shortly after his marriage, that his wife experienced a “pre-existing condition” – pregnancy – which complicated their getting insurance.
- **Governor Christine Gregoire** promised that her administration plans to “fully implement every word of the health care reforms in the great state of Washington.” She thanked former Governors Booth Gardner and Mike Lowry who worked to pass and to implement the Basic Health Plan introduced by then-state Senator Jim McDermott. She also gave special thanks to the state’s tax payers who, without universal health care in place, have needed to pay for health care for the uninsured.

Now we look forward to the work our Governor, our state legislators, and our Insurance Commissioner Mike Kreidler must do to give our state access to every possible benefit from this first step in a very long journey toward truly universal health care coverage.

## What States Can or Must Do Under the New Law

by Sarah Weinberg, MD, Editor

Required actions: States are expected to set up insurance exchanges for individuals and small groups to purchase insurance. The states must also enforce the new regulations that apply to health insurers. Since Medicaid will be expanded, states are expected to establish education and outreach programs to find and enroll the newly eligible. Meanwhile, states are required to maintain their current Medicaid and CHIP (Children's Health Insurance Program) eligibility standards at least until 2019. For the protection of consumers, states must establish an ombudsman program for people with complaints about private coverage in the individual and small group markets. There are federal grants available to help with the costs of these new responsibilities.

An unusual requirement is that all 50 states must establish a Consumer Operated and Oriented Plan to be offered on the exchange. These co-op plans cannot be run by insurance companies or government entities. \$6 billion is allocated for start-up expenses. It's not clear whether a well established co-op like Group Health Cooperative, which has functioned for years as an insurer in many ways, would qualify.

### Optional programs:

· States may set up Basic Health Programs if they wish by 2014. (This is Sen. Cantwell's contribution, so it should look familiar.) A BHP would cover residents with incomes between 133% and 200% FPL instead of subsidizing premiums for private insurance through the individual exchange.

· States would be permitted to establish more comprehensive plans, but not until 2017. These plans would have to cover every resident, be at least as comprehensive as the plans in the exchange, and not increase the federal deficit. Plans meeting this requirement would get 5-year exemptions from certain federal requirements.

· States would be permitted in 2016 to form "compacts" or groups of states for the purpose of selling insurance based on the laws and regulations of one state to residents of the others. These insurance plans would still have to meet consumer protection and coverage and affordability standards under the new law.

## Readers React to Bills

Nineteen people answered the call in the last newsletter for opinion on the then-pending health reform legislation. Not one thought that the bill as passed by the Senate on 12/24/09 was a good bill. General comments ranged from "It's better than nothing" to "This bill is worse than nothing." Ten people thought it best to pass the bill and hope that Congress will tackle changes to improve the worst parts. Nine people opposed passage of the bill, but three of these didn't actually state a wish to have the bill defeated – they just listed all the things they disliked.

It's clear that our readers in favor of a national single-payer health insurance system were very conflicted by the choice before them between a severely inadequate bill and the consequences of yet another defeat of federal health reform in Congress.

### **Readers' reasons to support passage of the bill**

1. There are a few good provisions in the bill: expanding coverage to the majority of the uninsured and stopping the worst of the insurers' behaviors in denying coverage to people who need it.

2. Allowing the Republicans to defeat President Obama and a Democratic majority in Congress would be a political disaster for the Democrats. Such a defeat would also weaken President Obama in other policy areas, both nationally and internationally – such as economic recovery, international peace issues, justice issues. The likelihood of attaining single-payer national health insurance would hardly be improved by Republican victories in 2010 and 2012.

3. It should be easier to make modifications to this bill in the next few years than to start over, particularly since the Republicans would claim a defeat "proved" that Americans didn't want "government health care" or "socialism", etc.

4. Congress is so influenced by vested interests and greed that we had better take what we can get until we do something serious to lessen the influence of corporate money in our government.

### **Readers' reasons to oppose passage of the bill**

1. The bill is so bad that its failures may set back or destroy the movement for real reform. The long delays before any real changes occur will cause the

(Continued page 5)

(Readers, from page 4)

public to turn against the bill and blame a “government health system” for its failure, lessening the chance for a single-payer plan to be seen as the solution.

2. The bad parts of the bill are so bad that the whole bill should be defeated:

- It won't cover everyone
- No cost controls
- Anti-abortion clauses are intolerable
- The bill completely ignores public opinion
- Taxpayer subsidy of the private insurance industry is intolerable

3. Hoping to fix the bill after passage is naïve.

4. The bill is a product of a corrupt Congress bribed by the health care industry. It is just more of the same – overly complex and inefficient. We need campaign finance reform, lobbying reform, and then we can start over with a single-payer plan.

5. Passage of this bill will be a disaster for the Democrats as the public will turn against them for giving in to the health care industry money-makers. The mandate to buy overpriced underinsurance will be especially unpopular.

6. Too much is being tackled all at once. Start with popular regulation of health insurers. Let states establish single-payer plans. Propose expanding Medicaid and Medicare.



## Washington State's Response to the New Health Reform Law

*(By Sarah Weinberg MD, Editor)*

### Office of the Insurance Commissioner (OIC)

Insurance Commissioner Mike Kreidler has already convened Health Care Reform Realization Committee. The Committee has met once, a couple of months ago, and held a teleconference meeting March 24. The next meeting has been postponed until May 26, 2010 to give the staff enough time to digest the 2074 pages of the Patient Protection and Affordable Care Act and the 150 pages of the reconciliation bill (HR 4872). Meetings of this Committee, in general, will be open to the public. Information about these meetings should be available on the OIC website: [www.insurance.wa.gov](http://www.insurance.wa.gov). Barbara Flye is the contact person in the OIC and she can be reached at 360-725-7043 or by email at [barb@oic.wa.gov](mailto:barb@oic.wa.gov) if sufficient information is not on the website.

### Attorney General

The Washington Attorney General, Rob McKenna, has taken action to join Washington with 13 other states in filing a lawsuit challenging the constitutionality of the individual mandate. This action should not be interpreted as favorable to the concept of national health insurance that would automatically cover everyone, although it is amusing to read some of the comments of conservative lawyers writing in support of this challenge:

“Of course, these constitutional impediments [against an individual mandate] can be avoided if Congress is willing to raise corporate and/or income taxes enough to fund fully a new national health system.”

– David B. Rivkin, Jr. & Lee A. Casey, August 2009. (These lawyers served in the Department of Justice under Presidents Reagan and Bush, Sr.)

**5. Individual "mandate" (2014).** By this date individuals will be required to show proof of coverage by a "qualified" health insurance plan or pay a fine with their income tax returns. It is expected that virtually everyone with incomes below 133% FPL will be covered by Medicaid, and that there will be subsidies for those with incomes from 133% to 400% FPL. There are some restrictions on the subsidies, based mainly on whether the individual's employer offers a suitable plan. Only citizens and legal immigrants are eligible for subsidies.

**6. Exchanges (2014).** Each state will have two exchanges that will offer private health insurance plans for purchase: one for individuals and one for small groups. There is some federal funding for the start-up expenses. (See separate article on what states must or can do.) Each exchange must include 2 multistate options approved by the federal Office of Personnel Management (the body that runs the Federal Employees Health Benefits Program). One of these must be a non-profit, and one must not include any coverage for abortions.

**7. Benefits in the plans that will be offered in the exchanges (2014).** The benefit packages will be "not more extensive than typical employee plans", but must meet "essential health benefits" standards. Neither criterion is defined in the legislation. The plans will be tiered from bronze (with an actuarial value of 60%) to platinum (AV 90%). Subsidies will be based on the silver tier (AV 70%). There will also be a catastrophic tier (less than 60% AV) limited to individuals under age 30 or otherwise exempt from the mandate.

**8. Incentives to increase availability of primary care providers (2011-14).** Medicaid payments to primary care physicians will be increased to Medicare rates in 2013-14. Medicare will pay a 10% bonus to primary care physicians, and to primary care physicians and general surgeons practicing in underserved areas. Both programs will last for 5 years from 2011-15. It's not clear whether primary care physicians in underserved areas get a double bonus. All the increased costs will be covered by federal funding.

**9. Help with the Medicare Part D donut hole.** Every year some Medicare beneficiaries with moderately high use of prescription drugs (mostly people with chronic diseases like diabetes) reach a limit on their insurance coverage through Medicare Part D known as the "donut hole". Once a person's drug costs reach about \$2,250, coverage ceases until total costs reach about \$5,000 (the values change each year). Above that level, "catastrophic" coverage kicks in. This sudden requirement for paying 100% of prescription drugs up to about \$2,750 is a terrible burden on many elderly. This law provides some help: a \$250 "rebate" in 2010; a requirement that drug companies give a 50% discount on brand name drugs starting in 2011; and a phase-in of both a decrease in the percentage the beneficiary has to pay from 100% down to 25% and a 75% federal subsidy on the cost of generic drugs; and from 2014-19 a phased-in decrease in the \$5,000 threshold for catastrophic insurance.

**10. \$11 billion allocated for community health centers and the National Health Service Corps.** This provision is designed to help make sure there are providers available to see the newly insured in areas that generally underserved.

#### Minor Elements (Effective Dates)

**1. Subsidized high risk insurance pools for the sick (2010-14).** \$5 billion appropriated to subsidize insurance for the sick at premiums no higher than 4 times the base rate. Insurance through this pool will be available to people uninsured for at least 6 months with pre-existing conditions. Cost sharing will be limited to \$5,950 individual/\$11,900 family per year.

**2. Insurers required to standardize information for consumers to compare plans (2012).** Federal standards are to be written by 1 year after signing, and the insurers are to be in compliance by 2 years.

**3. Insurers required to standardize claims administration (4/2014).** The hope is that this requirement will reduce administrative waste.

(The next 4 items are discussed in the separate article "What States Can or Must Do under the New Law" on page 4):

(Continued next page)

**4. States permitted to set up Basic Health Programs (2014).**

**5. States permitted to set up more comprehensive plans (2017).**

**6. Interstate “compacts” (2016).**

**7. Cooperatives are required to be established in all 50 states (2013).**

**8. A grab-bag of innovative pilot projects to improve Medicare’s skewed payment incentives (2012 and onward).** There are a lot of sketches of ideas in this category: accountable care organizations; decreased payments to hospitals with high rates of re-admissions or preventable hospital-acquired illnesses; other innovative payment schemes.

**9. Initiatives to promote preventive care and wellness programs (2011).** Several programs provide incentives for employers and others to provide wellness programs. Also most cost-sharing for preventive care is prohibited.

**10. Insurers won’t be able to deduct the cost of executive pay above \$500,000 (2009!!).** Those high-flying executives can still be paid more, but their companies will have to pay taxes on the excess.

### **Financing (Effective Dates)**

**1. Medicare payroll tax increase on those with incomes of \$200,000 individual/\$250,000 couple (2013).** This payroll tax will rise from 1.45% to 2.35% for these high earners.

**2. Surtax on unearned income for “higher income” taxpayers (2013).** The level of investment income at which this 3.8% surtax kicks in is not specified.

**3. Sales tax on indoor tanning (7/2010).** This 10% tax makes getting a tan the latest sin to be taxed!

**4. Regulations regarding tax-deductible expenses from health savings accounts and similar plans (2011-13).** Several minor restrictions will essentially tax certain expenditures from these accounts and limit tax-free contributions to them.

**5. Tax deduction for retiree prescription drug**

**benefit (2013).** Currently companies receive a 28% subsidy toward the cost of providing a prescription drug benefit to their retirees. The companies then have been allowed to deduct the entire cost of that benefit on their tax returns. Under the new law they will only be allowed to deduct the 72% the company actually pays from its own funds.

**6. Threshold for itemized deductions for unreimbursed medical expenses (2013-16).**

Currently people who spend more than 7.5% of their income in out-of-pocket medical expenses can benefit from itemizing their deductions. The threshold will be increased to 10%. Those over age 65 get a reprieve until 2016.

**7. Tax on expensive health insurance plans (2018).**

This tax will be levied on the so-called “Cadillac plans” that have high premiums and presumably higher-than-average benefits. The tax won’t go into effect until 2018, and the threshold is quite high: \$10,200 individual/\$27,500 family annual premium. There are several exceptions: for beneficiaries age 55-64, for those working in hazardous occupations, if medical costs rise faster than expected, etc. The tax is steep: 40% of the value of the plan! It is levied on the insurer, who will be certain to pass it on to the buyer. There are provisions that won’t let health savings account schemes escape the tax.

**8. Fees on insurers, pharmaceutical companies, and medical device sales (2014-19).**

These large fees are structured to collect revenue from these entire industries to support the new law. The yearly amounts vary, but in general the insurers will pay \$8 billion (2014) rising to \$14.3 billion (2018), drug companies will pay \$2.8 billion to \$4.1 billion and back to \$2.8 billion in 2019 and after, and there will be a 2.3% excise tax on sales of medical devices starting in 2013. The insurers will pay more after 2018 depending on the rate of premium growth. Non-profits will be assessed at 50% of the rate of the for-profits, and non-profits that get 80% or more of their business from the poor or disadvantaged will be exempt (Community Health Plans of Washington would be a good example).

**9. Restrictions and reductions in payment to**

(Continued page 9)

# What Would Dennis Do? --- Now We Know

*by Richard Bard, Editor*

In the months leading up to the vote on the now-passed health reform bill, many supporters of universal, single-payer health insurance looked to Ohio Congressman Dennis Kucinich as a rare example of someone willing to stand by his principles. When virtually all other 77 members of Congress' Progressive Caucus who had vowed to vote against the bill if it did not include a public option had given in and voted for the House version, even after the public option had been stripped out of it, Rep. Kucinich alone remained in opposition.

As the legislative process unfolded and the public option component was gradually and inexorably weakened until it finally evaporated, those who staunchly continued to believe in a true public national health plan like that proposed in HR 676, co-authored by Congressman Kucinich along with Michigan's John Conyers, grew even more disillusioned. Congress seemed increasingly preoccupied by corporate pressure and the strident abusive opposition coming from the minority on the far right. Surely it would be better to dump what had become a travesty of continuing subsidy for private insurance, and devote the energy of reform toward getting a respectable hearing for 676. In his uncompromising stance, Rep. Kucinich seemed the champion of this view.

And then he switched. What happened? Did relentless pressure from the President and the leadership of the House finally change his mind? Did he truly come to believe the bill wasn't so bad after all?

A statement featured on his web site more or less takes the latter view. The law, he says, is a starting point. Its weaknesses can be strengthened, its faults repaired, its holes filled. Meanwhile, we can work to give more support to states who want to institute single payer plans of their own.

But in an interview given to *Esquire* later in March, just before the final vote, Rep. Kucinich suggests other factors were in play. He came, he says, to see the vote as make or break not only for health reform but for the Obama presidency and any hope it might have for further progressive action. With Congressional Republicans united in contemptuous opposition, with many gloatingly foretelling the end of the President's effectiveness, with the chance that one more Democrat's "no" vote could push the bill—and the White House's future—into oblivion, Rep. Kucinich decided to attend to the larger picture.

One other consideration entered into his decision, and that was the judgment that starting over and working for a better solution had no reasonable chance of success. "If the bill were to go down, this whole discussion about anything we might hope to do in health care in the future is not going to happen in this generation," he told *Esquire*. "We had to wait sixteen years after the demise of the Clinton plan to come to this moment. . . the temperature that's been raised in the body politic over this bill, the characterizations of the bill in a debate that's been quite distorted - all of those things argue against bringing up another health care bill in the near future if this bill were to go down."

In the end, Rep. Kucinich's vote was based on hope—not only for a chance to improve the plan that has become law, but for the Administration that backed it.

# We Need Your Help!

**Health Care for All—Washington**, despite being an all-volunteer organization, relies on membership dues and donations to promote the cause effectively. Please join in helping to make our movement even stronger.

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("Reform", from page 7)

**private Medicare Advantage (MA) plans.** There is a complex schedule of reductions on the one hand, and incentive bonuses on the other that will apply to these plans. Total payments cannot exceed current levels. There will be penalties for MA plans that spend less than 85% of premiums on actual health care. MA plans can't impose cost sharing that is higher than it would be in the fee for service traditional Medicare plan.

**10. Medicare Part B premiums for seniors with high incomes.** For the last few years seniors with incomes (including tax-exempt interest and dividends) above \$85,000 individual/\$170,000 couple have paid additional monthly premiums for Medicare Part B (outpatient care) coverage. This program will continue at present levels at least through 2019.

**11. Medicare Independent Payment Advisory Board.** This Board is to make recommendations to slow increases in costs of Medicare if these costs are deemed to be rising faster than they should. However, the Board is expressly prohibited from making recommendations that would ration care, increase revenue, change benefits or eligibility, change cost-sharing, or change premiums for Part B. Hospitals and hospices would be exempt from recommended payment reductions through 2019, and clinical laboratories for one year. The Board is also supposed to make recommendations to lower the nation's overall health care expenditures (while preserving quality of care) starting in 2015.

**12. Medicare payments to safety net hospitals (2014).** Hospitals that see a large number of uninsured patients and provide a lot of charity (uncompensated) care have been receiving extra payments from Medicare to help cover this cost. These payments will be cut by 75% under the new law. The justification for this provision is that nearly everyone will be insured, so the extra payments to cover uncompensated care won't be needed nearly as much. There are provisions for adjusting the payments after 2014 to reflect the amount of charity care actually given.

(Most of this information is from a comparison spread sheet available on the Kaiser Family Foundation website – [www.kff.org](http://www.kff.org) – and includes changes made in the reconciliation package passed by Congress 3/25/10.)

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dba HealthCare 2000, and Washington Single-Payer Action Network

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## More Pics from the Seattle Post-Passage Gathering



*Tireless campaigner Marcelus Owens, shown here watching President Obama sign the reform bill into law, was in attendance at the Seattle rally. White House photo*



*Supporters waiting for the oratory to begin. Howard Martin photo*