



PHYSICIANS
FOR A NATIONAL
HEALTH PROGRAM

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Talking points on the Mandate Plans

Overall -

- The plan is completely inadequate in expanding coverage and controlling costs. It is essentially an insurance industry bailout. Most provisions to expand coverage don't even go into effect until 2013, after which it still leaves at least 17 million Americans uninsured.
- The insurance industry hijacked the process: Private insurers get millions of mandatory new customers and about \$600 billion in taxpayer subsidies. This will have the effect of making the health insurance lobby even more powerful, and more able to hijack political processes in the future.
- It forgoes over \$400 billion annually in potential savings on overhead and bureaucracy in the health system - enough to cover all 47 million uninsured - by retaining profit-driven private health insurers instead of replacing them with a streamlined, more efficient, Medicare for All system.
- It makes private health insurance mandatory for middle-income working people, forcing them to buy a defective product. It will become a federal crime to be uninsured, with a penalty of 2.5 percent of income, starting in 2013. Families of very modest means, at 200-400 percent of poverty, will be required to spend an unaffordable 8-12 percent of their incomes on insurance premiums if they don't have employer-sponsored coverage. Since the plan institutionalizes different levels of benefits and allows for skimpy plans (e.g. "bronze"), the mandated insurance may not even cover their health needs.
- We will have a nation of underinsured families and businesses who will be paying money they can hardly afford for health plans that will never meet their needs. Globally, the U.S. economy will continue to be at a competitive disadvantage.
- A Medicaid expansion will cover more low-income Americans, but coverage gains - both in Medicaid and for people receiving tax assistance to buy coverage - will be short-lived because the cost is unsustainable as we've seen in several states that have attempted reform in recent years.
- People in other developed nations all use some form of non-profit national health insurance to get better care for less money. Their

average per capita cost of healthcare is about half what it is in the United States, yet people in Canada and western Europe live about two years longer and have lower infant mortality. As with our traditional Medicare program, they have completely free choice of doctor and hospital. We need to start from scratch with a Medicare-for-all, single-payer approach.

On private insurers

- Private health insurance is an overpriced, defective product, and this plan won't change that. The majority of Americans who face medical bankruptcy start their illness with private health insurance, but are bankrupted anyway by gaps in coverage, like co-payments, deductibles and uncovered services.
- Individuals and families with incomes up to 400 percent of poverty (\$73,240 for a family of 3) are eligible for skimpy subsidies to buy coverage through a new "insurance exchange." Families of very modest means (200-400 percent of poverty) are still responsible for paying an unaffordable 8-12 percent of their income towards health insurance premiums.
- The plan bans denials of coverage based on pre-existing conditions (starting in 2013) and rescissions (retro-active cancellation of coverage) immediately. But insurers are still allowed to deny claims, and two industry whistleblowers (Dr. Linda Peeno and Wendell Potter) have testified before Congress that the industry is now so sophisticated in its ability to deny claims, control care, and cherry-pick that these protections are essentially worthless.
- Similarly, caps on out-of-pocket expenses (at \$5,000 for individuals and \$10,000 for families) don't prevent medical bankruptcy because they don't include expenses for uncovered services.
- Insurers are supposed to spend 85 percent of premiums on care, but experience from Minnesota shows that insurers are able to circumvent this rule easily by categorizing administrative expenses as "clinical" or "quality improvement."

On Medicaid and community health center expansion

- The plan expands Medicaid after 2013 to additional low-income Americans (up to 150 percent of poverty), which is good, but you don't need this plan to expand Medicaid. Also, rising costs, and a lack of funds for Medicaid at the state level, will quickly erode any gains in coverage.
- The plan increases funding for community health centers, which again, is good, but this could be done independently.

- The plan eliminates the Children's Health Insurance Program in 2014, routing the beneficiaries into Medicaid (under 150 percent of poverty) or into the purchase of private coverage), adding hassle and possibly disrupting care arrangements for these children.

On the public option

- The public plan option is a sham. According to the Congressional Budget Office, the premiums will actually be higher than premiums in the private sector, and fewer than 2 percent of Americans will enroll. So the public plan option will be an expensive, tax-funded subsidy to private health insurance, because the public plan option will take the sickest patients off their hands. It won't expand coverage or decrease costs.

On the employer-mandate

- Starting in 2013, employers with payrolls over \$500,000 are required to provide coverage and pay a share of the premiums (72.5 % for individual, 65% for family coverage) or pay an 8 percent payroll tax.
- Employers are not required to meet benefit standards until 2018, but even then are only required to help fund the "lowest cost plan" that meets the "essential benefits package," and so may offer very skimpy coverage. The "basic plan" on the insurance exchange, for example, is only required to cover 70 percent of benefit costs. As there are no cost controls, coverage will deteriorate further, leading to a rise in underinsurance nationwide.
- Millions of working Americans will continue to lack coverage. In Hawaii, which has had an employer mandate since the 1970's, many employers circumvent the requirement by hiring part-time employees or using consultants. Also, small businesses are not required to provide coverage (but receive a paltry tax credit for two years if they do).

On the insurance exchange and tax subsidies

- The plan creates a national insurance exchange, a marketplace where individuals and small business would go (after 2013) to buy insurance. If you have subsidized coverage, you would have to buy your insurance through the exchange. Like the "Connector" in Massachusetts, the exchange will add another layer of bureaucracy to the health system, and an additional 4 percent overhead to every health plan.
- Subsidies for low-income people to purchase coverage will be hopelessly complex, requiring verification of income, citizenship, employer size, etc.

- Millions will have their subsidies change as they change or lose jobs. Imagine finding a job, losing your insurance subsidy, then being laid off your job and applying for a subsidy all within a year. How would this work?

On evidence that this plan won't reduce the number of uninsured or control costs

- The coverage gains from the plan won't last. What's happened in the past when bills like this have passed in the states is that they run out of money very quickly, healthcare is simply unaffordable, and then you start to see the coverage expansions cut back. The subsidies shrink, the Medicaid shrinks, and then you're back at square one, where you've spent a lot of money and not made any progress. And we've seen this over and over in the United States—in Massachusetts in 1988, in Oregon in 1992, in Washington 1993—passed bills virtually identical to what's being passed in the House right now, and there was no durable improvement in the number of uninsured in those states. Healthcare was not affordable ten years after those bills were passed.
- The Massachusetts plan is the model for this bill. Massachusetts expanded Medicaid (which again, is good, but you don't need this plan to expand Medicaid) and passed an individual mandate that makes it illegal to refuse to purchase private health insurance. The fine is up to \$1,068. The plan has been very expensive. The state has opted to pay for that by taking money from safety net clinics and hospitals, so that safety net providers that care for immigrants, the mentally ill, people with substance abuse, that provide primary care, they've seen their funds shrunken, so that money could be handed over to purchase insurance policies.

On the anti-abortion provisions

- The plan applies restrictions to policies sold through the insurance exchange to undermine women's rights. It creates an insurance exchange, a marketplace where you would go to buy your insurance. If you have subsidized coverage, you would have to buy your insurance through the exchange. And any insurance plan purchased through the exchange would have to exclude coverage of abortion. So, for the first time, Congress has stepped in and said that even with your own money, with private money, it's illegal for insurance to cover abortion. It's a tremendous step backwards for women's rights.

On prescription drug costs

- It fails to lower drug costs for the majority of Americans and those unable to afford expensive medications. Drugmakers have raised wholesale prices on brand name drugs by 9 percent this year alone in anticipation of reform.
- Biotech firms receive a windfall 12 year patent on new drugs.
- A very small share of the population, Medicare recipients who are in the doughnut hole, will receive a discount on brand-name medications.
- The doughnut hole is reduced in size until it is eliminated in 2019.
- Overall, the pharmaceutical industry is thrilled with the bill, and Wall Street has rewarded them by driving up the value of their stocks.

On undocumented immigrants

- Requires verification of citizenship to apply for subsidies for the purchase of insurance. Thus, the plan mandates that non-citizens buy insurance, but leaves it unaffordable for them.

Medicare Advantage Plans

- The plan phases out overpayments to Medicare Advantage plans. It also requires them to spend at least 85 percent of premiums on care, but as shown in states like Massachusetts, insurers can easily circumvent this rule.

Summary of commendable features - some may not make it into final bill

- Medicaid expansion (delayed until 2013) to about 10 million people
- Increased funding for community health centers (to double capacity over time) and other community programs like home visiting programs.
- Increased funding for primary care health professional education
- Phasing out of doughnut hole in Medicare prescription drug plan by 2019 and Medicare Advantage plan overpayments
- Eliminating pre-existing conditions (2013) and rescissions (2010)
- Extending health benefit tax benefits available to married couples to domestic partners
- Extending parental coverage to children aged 26-27
- Progressive tax on the wealthy for funding instead of taxing health plans that are comprehensive (so-called "Cadillac" plans)