

At the end of all the debates, health reform will need 60 votes in the Senate and a majority in the House. In an ideal world, a bi-partisan majority including Senators Snowe and Collins and other reachable Republicans could support the health reform bill. The Senate bill is a bit stronger on cost containment and the House version covers a somewhat larger share of the uninsured. A bill with the best features of each is within reach.

When I read these bills, I do not recognize the anger that pervades the public commentary from some on the radio and TV talk shows, as the bills are well thought out, well drafted, comprehensive and phased in over time to minimize disruption. The hot button issues for both sides include the public option, Cadillac and millionaire taxes, immigration, deficit spending and abortion. I would like to take this opportunity to shed a little light for those who are interested on these hotly debated issues that will need to be resolved before the matter clears both houses and proceeds to the President's desk.

### **Public Option**

The public option refers to coverage like Medicare (the program for seniors and the disabled). In other words the public option would offer broad choice among participating private doctors and hospitals and a smaller number of public hospitals and clinics.<sup>1</sup> Doctors and other providers are paid on a fee for service basis. Administrative costs are very low (less than 3%). Controls on utilization (how many doctor visits and hospital admissions) are weak, and payment rates to private hospitals and doctors are higher than Medi-Cal (for the poor) and lower than most private insurance plans (through employers or individually purchased).

Both the House and Senate versions of the bill would allow any doctor or hospital to participate in the public plan or not, and reimbursement rates would be established by rate negotiations between the public option plan and individual hospitals and doctors, rather than by applying current Medicare rates.<sup>2</sup> Individuals purchasing through the Exchange (a purchasing pool for the uninsured, for individuals and for small employers) would have a broad choice of private health plans and also the "public option"; no one else can even buy the public option.

The Congressional Budget Office projects that the public option would have minimal enrollment -- about 3-4 million persons or one percent of all Americans -- in the Senate version, six million in the House.<sup>3</sup> It estimates that over a 10-year period, the public option would save about \$3 billion (0.3%) out of the estimated \$900 billion cost of the program. CBO suggests that the public option would not be less costly than private insurance in most markets despite its low administrative costs because private insurers would be far more successful in controlling/reducing unwarranted utilization and would be equally successful at negotiating favorable reimbursement rate with doctors and hospitals.<sup>4</sup> In fact, the public option might be more expensive

as it might attract adverse selection – i.e. those who are sicker and in poorer health may choose the public option.<sup>5</sup> In short, the public option would do neither the terrible damage to private sector insurers predicted by the private insurers and the political right nor produce the miracles of more affordable coverage touted by the left.

There should be some viable compromise among the choices of opt-in, opt-out, triggers and co-ops that would allow opponents and supporters to claim a win without imperiling the bill over this less than consequential issue.<sup>6</sup> One possible compromise would allow the officials operating the Exchange the option to use the public plan in any region where they are not getting competitive bids from local plans and providers due to the absence of local competitors due to natural or artificial local monopolies.<sup>7</sup>

### **Taxes on Cadillac plans**

The Senate bill includes a 40% excise tax on “Cadillac” health plans; the House does not. Labor is strenuously opposed to this tax while many economists from both the left and right believe it is essential to slowing the rise in health spending. The tax is on the incremental cost of coverage above the cost threshold (\$8,500 for an individual or \$23,000 for a family). It is projected by CBO to impact about 20% of policies and reduce premiums by about 10%.<sup>8</sup>

Employment-based health insurance is purchased with a pre-tax dollar that is worth significantly more to wage earners in higher income tax brackets.<sup>9</sup> This tax exclusion is worth on average 30% of the cost of the average employee’s health insurance premium while for higher wage earners, its worth can exceed 50% in a state like California and for low wage earners it is less than 10% of the cost of coverage. The tax exclusion is therefore highly regressive and also one of the reasons that employers and unions might choose in their collective bargaining agreements to increase benefits as opposed to wages. The cost of these tax exclusions (including federal and state income and payroll taxes) is in excess of \$300 billion annually.<sup>10</sup>

Cadillac plans are defined as those plans that cost in excess of \$8,500 for an individual or \$23,000 for a family as compared to the average plan costs of \$5000 for an individual employee and \$13,000 for family coverage.<sup>11</sup> What makes these plans *Cadillacs* besides the price? First they may include first dollar coverage and gold plated benefits such as spa treatments for Goldman Sachs executives or cosmetic surgery for Hollywood stars.<sup>12</sup> Second they may be plans for primarily unionized older workers in high cost regions, such as Massachusetts or New York.<sup>13</sup> In fact, more extensive benefits to younger workforces in less costly regions of the country would likely escape the tax.

The proposed excise tax applies to only the incremental cost of the plan in excess of the \$8,500 for individuals and \$23,000 for family plans thresholds and these

thresholds are indexed to increase at the rate of the consumer price index plus 1%.<sup>14</sup> It raises \$149 billion in revenues over the ten-year period or nearly 1/6<sup>th</sup> of the total projected costs of health reform.<sup>15</sup> This index is significant, for premium cost inflation rises at a much higher rate compared to CPI meaning more plans could be subject to the tax over time. For this reason, it is one of the most important features in the Senate bill to stem the rise in private insurance premiums.<sup>16</sup>

Labor is opposed because they negotiated for and made important concessions to secure the important benefits that might now be taxed, while some business interests are opposed for similar reasons. In the interests of more cost effective care, this may be a bitter but better cure that each should be supporting, with potential exclusions for those plans whose high cost is primarily due to the age or high risk nature of their workforce (think coal miners, roofers or firefighters).

### **Millionaire taxes**

The House bill contains a 5.4% surcharge on the federal income taxes for those joint filers earning over \$1 million a year. The surcharge applies to the incremental earnings in excess of \$1 million. The Senate bill contains 0.5% increase in the Medicare payroll tax for joint filers' wages in excess of \$250,000 a year.

These are two quite different concepts; let me try to explain. The Senate version<sup>17</sup> would raise \$54 billion over 10 years and the proceeds must be spent on Medicare Part A, which pays for hospital care, not doctor's services. It provides an increase in the individual payroll tax from 1.45% to 1.95% on the incremental wages above \$200,000 a year for an individual and \$250,000 a year for joint filers. This tax does not begin until 2013.

The House version<sup>18</sup> would raise \$460 billion over 10 years. The 5.4% income tax surcharge would apply to taxes on annual income in excess of \$1 million for a couple and \$500,000 for an individual. This applies to all forms of income subject to federal taxes, not just wages and would begin in 2011.

The argument for taxing high earners is that the federal income tax cuts dating back to the '80s have all been tilted to the wealthy and are part of the reason for the very large rise in income inequality in our nation.<sup>19</sup> The argument against is that taxing high earners, while entirely justifiable for rebalancing the budget, has nothing at all to do with health reform, unlike the Cadillac benefits excise tax that will increase incentives to slow the rise in health spending.

### **Immigrants and health reform**

There has been a great deal of confusion and misinformation about coverage for undocumented immigrants under health reform. The House bill excludes subsidized coverage for undocumented immigrants, as does the Senate.<sup>20</sup> Their immigration status is subject to verification with the Department of Homeland Security.<sup>21</sup> The

Senate bill went further than the House and excludes undocumented immigrants from purchasing individual coverage through the Exchange with their own funds and no federal subsidies.<sup>22</sup> Both bills continue the current limitation on federal subsidies for coverage of new legal immigrant adults for the first five years after entry and for undocumented immigrants for all but genuine emergency services.

In California, immigrants from Latin America and Asia are a large and steadily growing share of our workforce who contribute immeasurably to our economic growth; most are legal permanent residents and naturalized citizens, and some (about 20% of California's uninsured) are not.<sup>23</sup> Immigrants are lower users of health services even when they are insured, using care about half as much as do US citizens and long time legal permanent residents.<sup>24</sup>

Immigrants have very high rates of uninsurance both because they work in low wage industries that frequently do not offer coverage, and because many are excluded from Medicaid and CHIP due to federal restrictions.<sup>25</sup> Like uninsured US citizens, long time legal permanent residents will be able to access coverage through the Exchange or Medicaid depending on their incomes. Undocumented and recent legal immigrants can only receive coverage for genuine emergencies through Medicaid.

Recently Congress, in renewing the CHIP program for low-income children, allowed states the option to receive federal matching funds for basic health coverage for new legal immigrant children. It would be very helpful to California residents to expand this precedent to hard working new legal adult immigrants; however this unfortunately is not in either bill.

It would not help US citizens and is in fact counter-productive to close the doors to the Exchange to new legal residents and long time undocumented working residents who want to buy their own coverage and are willing to pay the full cost of it as they are on average, healthier, younger and lower users of services.<sup>26</sup> We should encourage, not discourage, all residents, no matter their immigration status, to purchase coverage to meet their health needs.

### **Deficit reductions**

We must deficit spend very substantially in the short-term to restart our economy. For the longer term, we have to reduce our deficits and return to the budget surpluses of the late Clinton years to pay down the growth in our national debt. We cannot solve the nation's budget problems without slowing the growth in Medicare and Medicaid spending, which are the prime contributors to an unsustainable growth rate in federal spending.<sup>27</sup>

One of the critiques of the reform bills is that they will add to the nation's already large budget deficits; the Congressional Budget Office (CBO) found the opposite. The Senate bill will reduce deficits by \$130 billion over the next 10 years.<sup>28</sup> The House bill is now projected to reduce deficits by \$138 billion over the next 10 years.<sup>29</sup>

The long-term deficit is driven by the projected growth in Medicare and Medicaid and to a lesser extent Social Security.<sup>30</sup> The Senate bill is projected to reduce the rates of growth in federal Medicare costs to 4% per year and 2% per beneficiary per year.<sup>31</sup> These savings are generated in four big ways: 1) reducing the growth rates in payments to hospital, nursing home, hospice, home health and most other Medicare services, 2) reducing the overpayments for Medicare Advantage Plans, 3) redirecting hospital DSH payments as the uninsured are covered, and 4) direct contracting and increased drug rebates from pharmaceutical manufacturers and other medical devices.<sup>32</sup>

What does this all mean? The first change, reducing the reimbursement growth rates is achieved by changing the formulas so that the “market basket” component for hospital, nursing home, hospice and home care wages and salaries assumes that health care worker’s annual productivity grows at the same rate as the rest of the private sector. This saves \$192 billion over ten years in the Senate version and \$228 billion in the House version.<sup>33</sup>

The second change, reducing the overpayments to Medicare Advantage plans, refers to the fact that Medicare Advantage plans are *mistakenly* paid 14% more for their care to Medicare subscribers than the Medicare fee for service system costs for seniors not enrolled in Medicare Advantage (also known as Medicare Part C). As the Medicare Advantage private plans were premised on the assumption that they could deliver care more cost effectively than the public fee for service Medicare could, this particular adjustment is long overdue. The reduction is phased in over three years and saves \$118 billion in the Senate version and \$170 billion in the House version.<sup>34</sup>

The third change, reducing Medicaid and Medicare DSH payments, refers to reducing a hospital subsidy for their bad debts and charity care (uncompensated care) to the uninsured as the uninsured become covered by insurance. This saves \$46 billion in the Senate version and is phased in after the uninsured are covered and hospitals’ uncompensated care to the uninsured is actually reduced.<sup>35</sup>

The fourth set of changes refers to reductions in prescription drug costs, totaling \$42 billion over 10 years in the House version.<sup>36</sup> Part of the prescription drug savings occurs by giving the Secretary of Health and Human Services the ability to negotiate prices with drug manufacturers – a provision that the drug companies strongly oppose and were able to defeat when prescription drug coverage was added for seniors under President Bush. Another part of the savings is achieved by industry rebates on the list (retail) price of their drugs, which savings are then redirected to reduce the donut hole in seniors’ drug coverage over the next 10 years.<sup>37</sup>

## **Abortion**

The Senate and House versions are different. Both bills would pay for abortions that meet the criteria of the Hyde Amendment – i.e. pregnancies resulting from rape,

incest or endangering the life of the mother. Both bills specify that no federal funds shall be used to pay for abortions through the Exchange that exceed the thresholds of the Hyde Amendment. California is one of the states that pay for a full range of abortion services through Medicaid. Both bills require strict sequestration of funds to assure that federal funds are used only for abortions meeting the criteria of the Hyde Amendment.

The Senate bill specifies that within the Exchange, there must be plans that offer a complete range of abortion services for those who wish to purchase this package of services and plans offering only abortions that meet the criteria of the Hyde Amendment for those who wish to purchase more limited coverage.

The House bill pursuant to the Stupak Amendment specifies that within the Exchange, no plan (including the public plan) shall offer a complete range of abortion services to anyone who wishes to pay for this option.<sup>38</sup> It then allows individuals to purchase supplemental services for a complete range of abortion services outside the Exchange with contributions from the individuals and/or state or local government, provided there is no federal contribution either directly or indirectly. Finally it specifies that the public plan cannot offer supplemental services for a complete range of abortion services outside the Exchange. In summary, the Stupak amendment adds considerable administrative complexity for an individual who wishes to purchase complete coverage of abortion services with their own funds and bars any direct or indirect federal involvement/assistance.

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<sup>1</sup> In ITUP's reviews of the hospital data, Medicare accounts for a large (44%) share of private non-profit hospital inpatient days and a small (14%) share of public hospital inpatient days in California. Medicare accounts for only 7% of free and community clinic patient visits. Dam and Wulsin, A Summary of Health care Financing for Low Income Individuals in California 1998-2008 (Insure the Uninsured Project, 2008) at [www.itup.org/reports](http://www.itup.org/reports)

<sup>2</sup> Private insurance pays about 20% or more above hospital costs (\$6.4 billion above cost in California hospitals in 2006) while Medicare pays many but not all hospitals at somewhat less than cost (about \$2.4 billion below cost as reported by California hospitals in 2006). A Summary of Health Care Financing for Low Income Individuals in California 1998-2008

<sup>3</sup> Letter from the Congressional Budget Office to Senator Harry Reid (November 18, 2009) and Letter from the Congressional Budget Office to Representative John Dingell (November 6, 2009) at <http://www.cbo.gov>

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> The House version applies to all states. The Senate version gives states the option to pass legislation to "opt out" of the public option. Senator Snowe proposed a

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trigger so that the public option would be implemented in states or the nation where private insurers failed to meet certain benchmarks in controlling costs and enrolling beneficiaries. Senator Conrad proposed coops like the Mayo Clinic, Geisinger in Western Pennsylvania, Group Health Cooperative in Seattle and Intermountain in Utah. The models Senator Conrad is suggesting are consumer governed staff model HMOs, similar to Kaiser Permanente in California, but for the difference in their governance.

<sup>7</sup> Monopolies of local providers occur naturally in small communities with only one hospital and its medical staff. In others, a hospital chain (either non-profit or for profit) has achieved market dominance in a larger metropolitan area. In certain states and in certain regions of California, a single plan has achieved an overwhelming share of the market and the ability to dictate prices and premiums. See Health Care for America Now, Premiums Soaring in Consolidated Health Insurance Market, Lack of Competition Hurts Rural States, Small Business (May, 2009) at <http://healthcareforamericanow.org>

<sup>8</sup> Congressional Budget Office, Letter to Senator Evan Bayh of November 30, 2009 at <http://www.cbo.gov>

<sup>9</sup> Sheils and Haught, The Cost of Tax Exempt Health Benefits in 2004, Health Affairs February 25, 2004 at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.106v1>

<sup>10</sup> Congressional Budget Office, Budget Options Volume 1: Health Care (December, 2008) <http://www.cbo.gov/publications/collections/health.cfm> and Commission on the 21<sup>st</sup> Century Economy (September 2009) at [www.cotce.ca.gov](http://www.cotce.ca.gov). The value of the California personal income tax deduction alone is nearly \$4 billion in 2008-09.

<sup>11</sup> HR 3590

<sup>12</sup> Reed Abelson, A Tax on Cadillac Health Plans May Also Hit the Chevys, New York Times, September 20, 2009 at <http://www.nytimes.com/2009/09/21/health/policy/21insure.html>

<sup>13</sup> Ibid.

<sup>14</sup> HR 3590

<sup>15</sup> Congressional Budget Office, Letter to Senator Evan Bayh of November 30, 2009 and Letter from the Congressional Budget Office to Senator Harry Reid (November 18, 2009).

<sup>16</sup> Ibid. The response to the excise tax by plans and subscribers is projected to decrease premiums by 9-12% for the 19% of private insurance plans subject to the tax in 2016. Overall, CBO projects that large employer premiums would fall from 0-3% due to the reforms, that small employer premiums would change between a 1% increase to a 2% decline due to the reform, and that individually purchased premiums would increase by 10 to 13% due to the increase in covered benefits for individuals. Fifty-seven percent of those purchasing individual coverage would be subsidized by on average 55-59% of their premiums. Twelve percent of small businesses would be subsidized by on average 8-11% of their premiums. Some commentators are much less enthusiastic about the impacts of the Cadillac excise tax. See Gabel et al, Taxing Cadillac Health Plans May produce Chevy Results,

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Health Affairs (December 3, 2009) at

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.2008.0430>

<sup>17</sup> HR 3590; Letter from the CBO to Senator Harry Reid (November 18, 2009)

<sup>18</sup> HR 3962; Letter from the CBO to Representative John Dingell (November 6, 2009)

<sup>19</sup> See Gordon, Robert and Dew-Becker, Ian, Controversies about the Rise of American Inequality, National Bureau of Economic Research Working Paper 13982 (May, 2008) at [www.nber.org/digest/dec08/w13982.html](http://www.nber.org/digest/dec08/w13982.html) for a thorough analysis of all the causes of rising economic inequality.

<sup>20</sup> HR 3962 and HR 3590

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.

<sup>23</sup> California and Health Reform: Some Background Facts (Insure the Uninsured Project, September 2, 2009) and Health Reform: a California Perspective (Insure the Uninsured Project, September 3, 2009) at

<http://www.itup.org/workgroups/regionalworkgroups/DC/DC.html>

See also presentation of Al Hernandez-Santana, Latino Coalition for a Healthy California to ITUP Central Valley Regional Workgroup (September 24, 2009) at [www.itup.org/workgroups/regionalworkgroups/CentralValley/CentralValley.html](http://www.itup.org/workgroups/regionalworkgroups/CentralValley/CentralValley.html)

<sup>24</sup> Ibid.

<sup>25</sup> Ibid.

<sup>26</sup> Ibid.

<sup>27</sup> See Congressional Budget Office, Budget Options Volume 1: Health Care (December, 2008) <http://www.cbo.gov/publications/collections/health.cfm> and

<sup>28</sup> Letter from the CBO to Senator Harry Reid (November 18, 2009)

<sup>29</sup> Letter from the Congressional Budget Office to Representative John Dingell (November 20, 2009) revising the net budgetary impact of HR 3962

<sup>30</sup> Congressional Budget Office, Budget Options Volume 1: Health Care

<sup>31</sup> Letter from CBO to Senator Harry Reid (November 18, 2009)

<sup>32</sup> Ibid.

<sup>33</sup> Letter from CBO to Senator Harry Reid and Letter from CBO to Representative John Dingell (November 6, 2009)

<sup>34</sup> Ibid.

<sup>35</sup> Ibid.

<sup>36</sup> Letter from the CBO to Senator Harry Reid

<sup>37</sup> Letter from the CBO to Representative John Dingell (November 6, 2009)

<sup>38</sup> HR 3962 §265 as amended by Representative Bart Stupak of Michigan