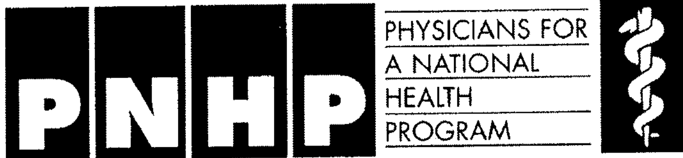
	Senate Finance Committee	Senate HELP Committee	HR 3962 Passed by House
Overall Approach to Providing Insurance Coverage	• Individual mandate • Penalty for employer s that don't provide health benefits • State-based health insurance exchanges; consumer co-ops to compete with private insurers; • Low income tax credits up to 400% of the federal poverty level • Insurance reform: No pre-existing condition exclusion, guaranteed issue and renewal, limits on differences in premium rates • Expand Medicaid to all individuals with incomes up to 133% of the poverty level (phased in over 3 years)	• Individual mandate • Employer mandate • State-based health insurance exchanges with public plan option • Low income subsidies up to 400% of the federal poverty level • Insurance reform: No pre-existing condition exclusion, guaranteed issue and renewal, limits on differences in premium rates • Expand Medicaid to all individuals with incomes up to 150% of the poverty level	• Individual mandate • Employer mandate • National health insurance exchange with public plan option • Low income subsidies up to 400% of the federal poverty level • Insurance reform: No pre-existing condition exclusion, guaranteed issue and renewal, limits on differences in premium rates (up to 2 to 1 for age) • Expand Medicaid to all individuals with incomes up to 150% of the poverty level
Number of Uninsured	• Congressional Budget Office: Around 94 percent of Americans would be covered by 2019 - 29 million more Americans than present, of the remaining uninsured, 1/3 are Illegal immigrants who would not receive coverage and are prohibited from buying on exchange.	• Congressional Budget Office: Settles at approximately 33 million beginning in 2015; at best settles at more than 8 million beginning in 2015, if the government covers all legal residents under 150% of the federal poverty level • Associated Press: "Aims to cover 97 percent of Americans."	• Congressional Budget Office: Covers 36 million uninsured (96% "universal"); • Undocumented workers could purchase insurance through the exchange but not eligible for subsidies.

Costs and Financing over 10 years	• Cost
	  ○ Congressional Budget Office score: $859 billion
	• Revenue/Savings Options
	  ○ Capping health-care benefits tax exclusion at $8,000 for individuals; $21,000 for families
	  ○ $400-500 billion in savings from Medicaid and Medicare, including provider reimbursement reduction, and reduction in payments thru Medicare Advantage.
		• Cost
		  ○ Congressional Budget Office score: $645 billion net cost for insurance coverage portion of the bill
		• Revenue/Savings: No information available
			• Cost
			  ○ Congressional Budget Office score: $1.2 trillion, but with savings reduces federal budget deficit
			• Revenue/Savings
			  ○ 5.4% surtax on high incomes
			  ○ Savings from cuts to Medicare Advantage and reductions in provider reimbursement

Individual Mandate	• All individuals must have insurance that meets minimum coverage standards (some exemptions for hardship)	• All individuals must have insurance that meets minimum coverage standards (some exemptions)	• All individuals must have insurance that meets minimum coverage standards (some exemptions)
Employer Provisions	• Charge employers the cost of subsidies provided by gov't to employees to buy insurance • Temporary small business tax credits	• Employer "Play or Pay" mandate • Small business subsidies	• Employer "Play or Pay" mandate • Small business tax exemption for under $750,000 in annual payroll • If don't provide insurance, pays 8% of payroll as tax (small pays lower rate).
Low-Income Provisions and Subsidies for Individuals	• Medicaid: Expands coverage to parents and childless adults at or below 133% of the federal poverty level, phased in over 3 years • Tax credit for individuals and families with income up to 300% of the federal poverty level to purchase non-group private insurance coverage	• Medicaid: Expands coverage to all individuals with incomes up to 150% of the federal poverty level. • Subsidies: Annual premium credits for those with incomes from 150% to 400% of the federal poverty level on a sliding scale that caps premiums at 1% to 12.5% of income	• Medicaid: expanded to legal residents who are under 65 with family income that does not exceed 133% of the federal poverty level • Subsidies: Sliding scale subsidies for those with family income up to 400% of the federal poverty level. Premiums are limited on a sliding scale to from 1% to 10% of family income. Cost-sharing (does not include premiums) limited to 2% to 30% of costs.
Health Insurance Exchange	• State-based exchanges open only to uninsured individuals and small groups. Individuals could only leave employer-sponsored coverage if the coverage was unaffordable. Co-ops can be created by states to participate in exchange. No public option. • Benefits packages in 4 tiers based on amount of cost-sharing	• State-based "American Health Benefit Gateways" with public option. Open only to uninsured individuals and small groups. Individuals could only leave employer-sponsored coverage if the coverage was unaffordable. • Benefits packages in 3 tiers based on amount of cost-sharing	• National health insurance exchange with public plan option (6 million expected enrollees). Open only to uninsured individuals and very small employers. Other small employers phased in over time. Individuals could only leave employer-sponsored coverage if the coverage was unaffordable. • Low-income subsidies can only be used in the exchange • Benefits packages in 3 tiers based on amount of cost-sharing; 4th tier based on added benefits



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The "Public Plan Option": Myths and facts

Myth: A public option will increase choice for patients. Fact: A public plan option will not increase choice of what matters for our health: choice of caregivers and choice in location of care. Patients will still have a limited choice of provider restricted by networks and will pay more to see providers outside of their network. Patients will still have to seek authorization for treatment. The public option will add one more plan to the hundreds of plans that already exist.

Myth: A public option will enable patients to keep their own doctor, regardless of changes in employment or health. Fact: A public plan option does not guarantee patients can keep their doctor regardless of employment or health because it leaves the employer based system of health care provision intact. If an employer chooses to change to a new plan, patients may have to change their doctor or pay higher fees to stay with their doctor. Insurers have strong financial incentives to enroll the healthy while avoiding the sick patients; thus if a patient becomes ill, they still risk losing their employer based insurance.

Myth: A public option will force private health insurers to compete on a level-playing field, especially in limited markets. Fact: The Medicare HMO experience shows private plans undermine fair competition despite regulations. They avoid the expensively ill (called "cherry-picking") and use their marketing power to attract the healthiest patients. Private HMO Medicare also costs 12 to 19% more than traditional Medicare despite having a healthier population. The current Medicare experience combined with experience in many different states that have tried this type of reform shows that public plans are left with the sickest patients and fail due to rising costs while the private insurers continue to collect premiums from the healthiest patients and maintain their high profits.

Myth: A public option will provide everyone with the security that quality, affordable coverage will always be there. Fact: Our health care system is unsustainable. Health care reform that includes a public plan option will add hundreds of billions of additional dollars annually on top of 2.5 trillion dollars, (twice what any nation spends per person). We have vast domestic and international experience with public option schemes, and in no case have they resulted in universal coverage. This is because private insurance companies seek to enhance their profits by screening out sick and unprofitable patients, ultimately relegating most of the sick and costly to the public system, which quickly comes unraveled due to rising costs. Absent effective cost control, any increase in coverage or benefits will quickly be erased by rising costs. In conclusion, a public plan option does not lead toward single payer, but toward the segregation of patients, with profitable ones in private plans and unprofitable ones in the public plan.

Myth: A public option will provide better care to patients by driving innovation in the quality of care physicians provide. Fact: A public plan option would not improve overall quality: (1) it would leave in place the deficiencies that have resulted in very high costs with the poorest health care value of all nations, (2) it would keep intact for-profit, investor-owned hospitals, HMOs and nursing homes that have higher costs and score lower on most measures of quality than their non-profit counterparts, (3) it would add yet another payer to our fragmented system perpetuating challenges to coordinated care, for example, there will still be a need to collect premiums, track enrollment, disenrollment, etc, and hospital/NH payment will still require the an enormous billing apparatus.

What is '**Single Payer**' Health Care versus '**Public Option**' Health Care?

Answers to many of the questions are 'qualified' and briefly explained

	Single Payer • Public financing • **Private delivery**	**Public Option** • Individual Financing • **Private Delivery**
Everyone In	Yes	No Can buy into public plan, keep private insurance or be uninsured.
Guaranteed Coverage for Everyone	Yes Paid automatically through taxes	No Not automatic, people have to 'buy in'. Some will be unable to afford.
Choice of Doctors/providers	Yes	Yes
Choice of paying into system	No Mandatory, required by taxes	Yes Can buy public, private or **no** plan
Competition between public & private Ins. companies	No	Yes
Risk of destruction of Insurance Industry	Yes Private ins would be used only for supplemental or special needs Retraining and restructuring required	No Insurance industry protected, perhaps even subsidized for premiums of poor. However, fewer customers in private plans means lower profit margins
'Cherry Picking' (Picking only the most healthy folks to insure – meaning the least costly)	No	Yes Ins. companies have option of picking to insure only those 'less sick' - forces sick into public plan.
Risk pool shared by Everyone	Yes Costs distributed across entire population	No Cost shifted to the sicker of those privately insured and public plan picking up sickest populations
Employment Dependent	No Everyone is in the plan.	No People could choose to stay with an employer's plan or 'buy into' the public plan (employers could do the same).
Discrimination against Pre-existing conditions	No	No (qualified) Discrimination still possible (likely) for those buying private insurance
Plan will help negotiate lower health care delivery costs and lower drug costs	Yes Generally more negotiation power for all services. Bulk purchase / negotiation for pharmaceuticals	Yes (qualified) Competition from private plans reduces number of patients in the public plan thus decreasing public bargaining power from an entire population pool.
Current Legislative and Presidential support	No Few Legislators support this. President Obama supported single payer when a senator but now calls it 'too disruptive.'	Yes Support from president and many Democrats. Many Republican still oppose as "increased government involvement." Claims of 'no Choice of doctors' is a false argument.
Reduced influence of insurance Lobby	Yes	Uncertain Will maintain more influence than with single payer system.
Reducing cost across the entire Health Care System	Yes One holistic system with large pool has greater savings in part due to negotiating power and simplification of administration and paperwork.	No Incremental steps may have other advantages, but nothing specific to create lower costs. More risk of failing to reduce health care costs.

Prepared for League of Women Voters of Arizona by Dr. Barbara Klein (DC; MPS Health Care & Hospital Administration) - 5/09

NATIONAL NURSES
ORGANIZING COMMITTEE

The Polling Is Quite Clear:

The American Public Supports Guaranteed Healthcare on the "Medicare for All" or "Single-Payer" Model

Do you think it is the responsibility of the federal government to make sure all Americans have health care coverage, or is that not the responsibility of the federal government? N=501, MoE ± 5 (Form A)

	IS	IS NOT	UNSURE
11/11-14/07	64%	33%	3%

Gallup Poll. Nov. 11-14, 2007. N=1,014 adults nationwide. MoE ± 3 (for all adults).

Which would you prefer – the current health insurance system in the United States, in which most people get their health insurance from private employers, but some people have no insurance; or a universal health insurance program, in which everyone is covered under a program like Medicare that's run by the government and financed by taxpayers?

CURRENT	UNIVERSAL	NO OPINION
33%	62%	6%

ABC News/Washington Post, Oct. 9-13, 2003, 1000 adults, MoE 3

Which comes closest to your view?

The United States should continue the current health insurance system in which most people get their health insurance from private employers, but some people have no insurance	34%
The United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers	65%
Refused / Not Answered	2%

Do you consider yourself a supporter of a single-payer health care system, that is a national health plan financed by taxpayers in which all Americans would get their insurance from a single government plan, or not?

YES	NO	REFUSED/NOT ANSWERED
54%	44%	2%

Associated Press/Yahoo News Poll, Dec. 14-20, 2007. N=1,821 adults, MoE =2.3

Do you think it's the government's responsibility to make sure that everyone in the United States has adequate health care, or don't you think so?

	THINK IT IS	DON'T THINK SO	UNSURE
All Registered Voters	61%	35%	4%
Republicans	34%	62%	4%
Democrats	81%	16%	3%
Independents	59%	37%	5%

Quinnipiac University Poll. May 8-12, 2008. N=1,745 registered voters nationwide. MoE ± 2.4 (for all registered voters).

A March, 2008 survey of 2,000 American Doctors conducted by the Indiana University School of Medicine found that 59 percent support a "Medicare for All"/single-payer healthcare system

NNOC/CNA: A Voice for Nurses. A Vision for Healthcare.

www.calnurses.org ✦ www.nnoc.net

7/30/08

The Single-Payer Economic Stimulus

New Jobs created by a Single-Payer System
— 2.6 Million

Increased business and public revenues
— $317 Billion

Additional Employee Compensation
— $100 Billion

New Tax Revenues
— $44 Billion

source: "Single-Payer/Medicare for All. An Economic Stimulus Plan for the Nation," IHSP, Jan. 15, 2009

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FREQUENTLY HEARD MYTHS

Single-Payer is socialized medicine

This is not true. Single-Payer is government funded, privately delivered health care. The doctors and other health care professionals are not employees of the government, as with V.A. and other socialized systems, but are private practitioners whose bills would go to the government fund instead of a private health insurer for payment.

The government would interfere with and/or ration health care

Not at all. Now, insurers' profits are their top priority, and in order to protect and maximize those profits, they must pay as little as possible in claims. To this end, insurance company bureaucrats sitting in cubicles dictate whether or how a patients' treatment should proceed.. This does not happen with Medicare and will not happen with an expanded Medicare (single-payer) system. The doctor/patient relationship would not be interfered with by any third party.

Patients' health care decisions would be based on what's best for the country and not the patient

Since treatment is decided by the doctor and patient, there would be no question of "national interest" involved. Now, decisions are based on what's best for the insurer's bottom line, which is not advantageous to the patient.

Doctors will be jailed for treating patients outside the system

This was bogus when Elizabeth McCoy brought it up in 1993 and there is still no truth to this statement. There will be nothing to stop a doctor from treating a patient outside the system, and being paid by the patient, although everyone will be included in the single-payer plan.

Patients are dying while waiting for treatment in countries with national health programs

Misleading. There are some patients who die because their care is delayed. The figure is 110 per 100,000 in the US (not counting people with no access to health care); 103 per 100,000 in the United Kingdom, and 77 per 100,000 inrograms Canada. Dr. Brian Day who criticized the Canadian system in Rick Scott's CPR ads was criticizing only the one system. He preferred the national systems of France, Switzerland and Germany (per Factcheck) and had nothing good to say about our system. In the U.S. at least 22,000 people per year die because they have no access to health care.

Canadians are pouring over the border to get health care in the U.S.

Occasionally a Canadian does come here for treatment. To do this, they must have the money to pay for it up front. Those who come do so because they don't want to wait for elective surgery, such as knee replacements; rarely for life-threatening conditions. There are probably more Americans going to Canada for care; and thousands are now going to third world countries like India, Thailand and Costa Rica for good, affordable health care.

A National program will be mired down in government bureaucracy

The for-profit health insurers spend about 31 cents of every health care dollar on overhead-paper work, marketing, advertising, etc. The Medicare system spends about 3 cents out of every dollar on administrative overhead. The savings would be vast.

GLOSSARY of terms

SINGLE PAYER: Publicly funded, privately delivered health care covering the entire population. Health care is paid for by the taxpayers (as is fire and police protection). The government handles the billing and payments, and can puchase in bulk. The government is the single payer (one payer). The system would function like an expanded and improved version of Medicare and replace the current multi-payer system of private insurance. No co-pays, no deductible, no denials.

UNIVERSAL COVERAGE: Health care for all residents of the US, regardless of age, income, or health status.

SOCIALIZED MEDICINE: A publicly financed, government owned and operated, health care delivery system. Our VA is an example, as is the British system. The government owns the hospitals and physicians are salaried public employees. Single payer is NOT socialized medicine: patients go to the doctor or hospital of their choice.

PROVIDER: A person or hospital providing treatment and care. doctor, therapist, dentist, nurse practitioner, nurse, hospital, clinic, nursing home, lab

MANDATE: A requirement that everyone buy insurance, as in the Massachusetts plan. Low income persons are directed to a subsidized plan which may or not be affordable. Employers must cover their employees or pay a penalty. Private insurers are still involved. The Mass. Plan is having difficulty controlling costs.

PUBLIC INSURANCE: Insurance coverage provided as part of a government program, for example, Medicare and Medicaid, SCHIP.

PRIVATE INSURANCE: Insurance purchased from a for-profit (Humana, WellPoint, United Health) or non-profit insurance company. The for-profit insurers must answer to shareholders. .

MEDICAID: A federal/state health insurance program which covers low-income individuals who meet variable and changing state eligibility requirements. A company such as Passport operates as an HMO for Medicaid.

MEDICARE: A federal insurance program providing health care benefits for the elderly and disabled. It has four parts:

- Part A Hospitalization insurance
- Part B Supplementary medical insurance (covers tests, and other items not covered by A).
  Medigap policies sold by private insurers to pay for items not covered (gaps) in Original Medicare.
- Part C Medicare Advantage (privatized) plans. These plans vary in their offerings. It is recommended that applicants read pp 33-42 of the Medicare &You 2007 Handbook.
- Part D Prescription drug coverage (privatized)

MEDICARE ADVANTAGE: Private health plans subsidized by Medicare (that is, taxpayers are paying a percentage of the costs), authorized by Medicare legislation in 2003.

HMO: Health Maintenance Organization: Organizations which provide a broad range of services, to clients. Treatment is usually coordinated by primary care physicians on a prepaid basis for enrollees. These can be for-profit (Humana) or non-profit (Kaiser Permanente). Also called "managed care" organizations. HMOs claim that they control costs. .

PPO: A group of physicians or providers in a PPO panel/group agree to accept set discounted fees in exchange for the practice-building opportunity of being listed as a "preferred provider." Insurers usually promote PPOs as being economical because the patient is treated "in-network."

EMPLOYER-BASED INSURANCE: A voluntary system dating back to the 1940s whereby employers have provided health insurance coverage to their employees. It was originally provided as "perk" when wages were frozen. It has become very expensive for employers and employees. Premiums can often be excluded from taxes.

PRE-EXISTING CONDITION: A medical condition which pre-dates application for private insurance, often used to deny coverage.

FEE-FOR-SERVICE (FFS): A common method of reimbursement for health services provided by a doctor, lab or hospital-- such as by visit, procedure, laboratory test or imaging study.

HIGH-RISK POOL: Insurance pools established by some states to help people who have been denied coverage in the individual market. These patients gain coverage by pooling risk with those is a similar precarious situtation.

HIGH-DEDUCTIBLE INSURANCE PLANS (HDHI): Plans offered by private insurers with high cost-sharing requirements, including annual deductibles of up to $10,000. High deductibles are often associated with Health Savings Accounts. Increasingly, insurers are shifting costs to the consumer.

HEALTH SAVINGS ACCOUNTS (HSAs): Authorized in 2003 by the Medicare Modernization Act, employer and employee contributions to these accounts are tax-free when accompanied by high deductible insurance policies. HSAs provide investment opportunities for the healthy, but are of little benefit to people with significant medical expenses. Few low-wage workers can afford such savings accounts and the high deductible keeps them from seeking preventive care.

AHIP (AMERICA'S HEALTH INSURANCE PLANS): A national trade group representing about 1,300 private insurance companies, each selling multiple plans.

DISEASE MANAGEMENT: Being discussed by policy makers/legislators as a means of reining in health care costs and improving quality of care for chronic diseases sucha s diabetes. A for-profit DM industry has emerged, started by the drug industry, which attempts to provide patient education and patient self-management often through nurse advisors in distant call centers. Treatment is not necessarlily integrated with primary care.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985):
Means by which people who lose or change jobs may contiue their insurance coverage by paying the premium (the employer's contribution as well as the employee's. This coverage may be continued for 18 months. Those recently unemployed are finding COBRA unaffordable.

CO-PAYMENT: A fee charged directly to patients whenever they seek health services or drug prescriptions, regardless of insurance coverage..

CO-INSURANCE: The amount you may be required to pay after you pay any plan deductibles. In the original Medicare Plan this is a percentage (like 20 %) of the Medicare approved amount. You have to pay this ammount after you pay the deductible for Part A and/or Part B. This is a worrisome new addition to Medicare and other insurance plans. Patients can find they are underinsured—may not anticipate the extra "coinsurance" bill.

Prepared by H. Seiler and C. Tvaroh. Please let us know if you see errors.
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As for the "donut hole' we aren't even going to try to explain that!