



WVAHC *Reform News*

West Virginians for Affordable Health Care

Volume 5

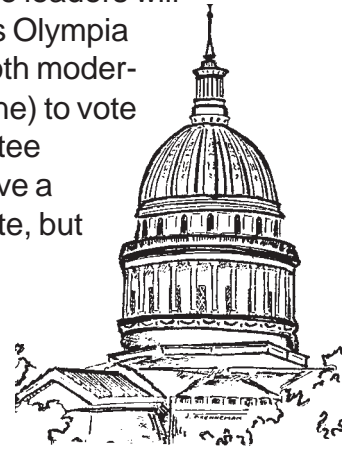
Winter 2010

Issue 1

Senate Passes Health Care Reform *Reconciling House and Senate Versions May Be Difficult*

On Christmas Eve morning, the Senate passed historic health care reform measures. Although passage of the bill required only a simple majority of 51 votes, earlier the Senate needed a 60 vote majority to cut off a threatened Republican filibuster, and they will need 60 votes again when the conference committee report

comes back. In order to get 60 votes all 58 Democrats and the two independents that caucus with the Democrats must vote for the conference committee report, or the Senate leaders will need to convince Senators Olympia Snow or Susan Collins (both moderate Republicans from Maine) to vote for the conference committee report. The House may have a little more room to negotiate, but frankly not much.



Celebration Planned

The differences between the House and Senate versions of health care reform will be difficult to resolve. However, WVAHC expects passage of the reform measures in January or early February, and we are tentatively planning a celebration for Monday, February 15th (President's Day). We will keep you informed of the details as soon as they are finalized. Also, WVAHC will be scheduling a series of town meetings across the state this spring to explain what is in the final version of the bill. The policies are significant and will impact each one of us for decades. If you are interested in helping to organize these town meetings, please contact Perry Bryant at pbryant@wvahc.org or 304-533-7941. Thanks.

Also, please call Senator Jay Rockefeller (202-224-6472), Senator Robert C. Byrd (202-224-3954), Congressman Alan Mollohan (202-225-4172) and Congressman Nick Joe Rahall (202-225-3452) and thank them for voting for meaningful health care reform. They have earned our gratitude. Thanks.

The fall issue of WVAHC's newsletter had a side-by-side comparison of the House and Senate versions of their bill, which continues to be pretty accurate. The only real changes are that the public option is out of the Senate bill, and the House raised its eligibility for Medicaid to 150 percent of the federal poverty level (FPL). The fall issue can be accessed on our web site at www.wvahc.org, and there is a PowerPoint presentation comparing the House and Senate versions on the web site which is up-to-date. This issue of WVAHC's newsletter focuses on the significant differences between the House and Senate versions.

Medicaid

Both the House and the Senate version contain the largest increase in Medicaid eligibility

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in its 45 year history. While Medicaid does a very good job of covering low-income children, currently the program covers very few adults. In West Virginia, for example, an adult must have children and earn less than 35 percent of the FPL, about \$6,400 a year for a family of three. The Senate version would increase Medicaid eligibility to 133 percent of FPL (about \$24,300 for a family of three), and the House would raise eligibility to 150 percent of FPL (about \$27,500 for a family of three).

Congresswoman Shelly Moore Capito has expressed concern about the state match for the expansion of Medicaid. However, under both the House and senate versions the federal government pays for 100% of the expansion the first two years. The House then pays for 91% of the expansion until 2019 and the Senate pays 95%. The state's share — estimated by WVAHC to be approximately \$45 million a year — is modest in relation to the benefits that we receive. Under the Medicaid expansion an estimated 100,000 low-

income West Virginians will receive low-cost, comprehensive health care insurance. That's \$450 a year in state monies for each covered adult.

Health Exchange

Consider the health exchange as an Orbit or Travelocity where small businesses and individuals can go to a web site or call a toll free number and find objective information about health insurance policies. Policies will be standardized so consumers can compare apples to apples and oranges to oranges. All insurance companies will be vetted to insure they have an adequate network of doctors and hospitals, reserve funds large enough to ensure they will be able to pay claims, consumer protection, etc. The health exchange will greatly simplify buying insurance for those who currently have the greatest difficulty in buying insurance: individuals and small businesses.

The House version has a national exchange, while the Senate has either a state or regional exchange. This is a significant difference. Having a national exchange, instead of 50 different exchanges, will provide better consumer protection and increase the purchasing power of those in the exchange. The other major difference is that the House begins the exchange in 2013 and the Senate waits until 2014.

Yielding to the demands of Senator Joe Lieberman, who threatened to vote against the entire bill unless the "public option" was dropped from the exchange, the Senate adopted an intriguing alternative to the public option. The Office of Personnel Management — the agency that operates the federal employees health insurance benefits program — must offer 2 multi-state health plans through the exchange. One of these plans must be non-profit. If the Office of Personnel Management is successful in negotiating significant discounts, and they have been successful for federal employees, this proposal could have as



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much effect as the weak public option that was being considered by both the House and the Senate.

Employer Responsibility

During the last decade there has been a slow, steady decline in the number of employers that offer health insurance. Employer sponsored insurance (ESI) has gone from 69 percent in 2000 to 60 percent in 2009. The House version of employer responsibility reverses this trend, while the Senate version continues the reduction in ESI. The House has an employer mandate. Large employers either have to provide their employees with health insurance (and pay at least 72.5% of the single employee's premiums and 65% of the family coverage) or pay a penalty of 8% of payroll. This provision results in an addition 6 million Americans getting employer sponsored health care over the next decade.

The Senate's approach, called a free rider amendment, has no employer mandate. If large companies (those with more than 50 full time employees) do not provide their employees with health insurance, and if one of their employees goes to the exchange and gets subsidized health insurance coverage, then and only then will the employer face a penalty of \$750/year for each full time employees. This proposal results in 5 million fewer Americans with ESI within a decade. However, if the conference committee adopted a real employer mandate, it will mean the loss of Senator Olympia Snow, and probably Senators Joe Lieberman and Ben Nelson, who is a former insurance executive.

The difference between the House and Senate version? Coverage for 11 million Americans, so this provision is extremely important.

Individual Mandate and Subsidies for Moderate and Middle Income Families

Both the House and the Senate versions require those without private insurance, or employer sponsored insurance, or public insurance (Medicare, Medicaid, etc.) to purchase health insurance. Many who are required to purchase insurance can obtain subsidies in the exchange. For those who earn more than Medicaid and up to 400 percent of the FPL which is \$43,300 for an individual and \$88,200 for a family of four, will receive subsidies on a sliding scale in order to make their premiums affordable. The House version provides higher subsidies for those earning just above Medicaid eligibility, while the Senate provides more generous subsidies for those earning 300 to 400 percent of the FPL. Both the House and the Senate offer additional assistance to offset the cost of deductibles and co-payments, although the Senate version only provides assistance to those earning less than 200% of the FPL. And both the House and the Senate set out of pocket maximums, which is the total amount that an individual or family would have to spend on deductibles and co-payments, The House version has lower out-of-pocket maximums than the Senate version.

The House and Senate have significant differences in the amount of money spent on subsidies. While the Senate spends \$436 billion over ten years, the House spends \$602 billion over 10 years: a \$166 billion difference, which is huge. These levels of subsidies will be one of the most important compromises reached in the conference committee, and will determine whether the health insurance that people are required to purchase is affordable.

Insurance Reform

Almost all of the insurance reforms have been agreed upon. Beginning in 2013 (House version) or 2014 (Senate) there will be no more pre-exist-

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ing exclusions, no more discriminatory premiums for women, no more rescissions where an insurance company drops your policy because you get sick and use it, and no more lifetime limits. Insurance companies would be prohibited from charging you higher premiums based on your health, although they can charge tobacco users more. One major area of disagreement is that the House allows insurance companies to charge older Americans 2 times what they charge younger people, while the Senate allows a charge of three times the percentage of the premiums charged young adults.

The other difference in insurance reform involves “medical loss ratios.” A medical loss ratio is the amount that an insurance company collects, compared to the amount they spend on paying claims. The House bill requires insurance companies to have at least an 85% medical loss ratio (they must spend at least 85% of the premiums that they collect on paying claims, and no more than 15 percent on administrative cost, advertising, profits, etc.) or provide a rebate to their customers. The Senate bill only requires an 85% medical loss ratio for large business, and an 80% medical loss ratio for small businesses and individuals. This is one of the most important insurance reform that Congress is considering.

Financing

The Senate and House bills finance reform in very different ways. The House relies heavily on a surcharge of 5.4% on individuals earning more than \$500,000 and couples earning more than \$1 million a year. This proposal generates \$460 billion over ten years (all revenues are over ten years). The Senate increases Medicaid taxes on individuals earning more than \$200,000 and couples earning more than \$250,000. This produces \$87 billion. The most significant tax increase in the Senate version is a 40% excise tax on high premium insurance products, those costing more than \$8,000 a year for a single policy and \$23,000 a year for a family policy. This tax on

“Cadillac” plans is vigorously opposed by labor organizations, but supported by the Obama Administration.

Abortion

This is the one issue with the potential to derail the health care debate. Unlike most issues where a compromise can be reached, finding an acceptable compromise on abortion has been elusive. House Democrats thought that they had an “abortion neutral” provision — one that neither promoted abortion nor restricted abortion rights. Federal funds (the subsidies for moderate and middle income families in the exchange) would be separated from private premiums paid for insurance coverage. These separated federal funds could only be used to fund abortion under the current provisions: rape, incest or to protect the life of the mother. Rep. Bart Stupak (D-Michigan) convinced 42 House Democrats to oppose passage of the health care reform bill, which was enough to kill the bill, unless his amendment was adopted. The Stupak amendment essentially prohibits any plan in the exchange from offering abortion services. It was adopted on the House floor.

Senate Democrats tried the same approach, an abortion neutral provision. Senator Ben Nelson refused to support ending the Republican filibuster unless an amendment was added that also restricted abortions. His amendment required those who wanted abortion services to write a separate check for this procedure. These monies would have to be kept in separate checking accounts by insurance companies. Additionally, states could opt out, and prohibit any insurance company from offering abortion services in their state’s exchange. This amendment was adopted in order to obtain the 60th vote and end the filibuster.

As the two bills go to conference committee there is no easy solution to this issue. For unlike most Americans who are in the middle of this issue, most members of Congress are deeply polarized on abortion.

Payment Reform Leads to Better Health Care and Reduced Costs

One of the most important health care reforms has received little attention. This reform goes by the very simple name of “payment reform”. It may sound simple, but it is very important.

Doctors and hospitals are paid on a fee for service arrangement. Every time they provide a service the insurance company pays them a fee. The more services they provide, the more fees they receive. It doesn’t matter if there are improved outcomes for their patients. It only matters how many procedures the doctor or hospital perform. None of us can afford a system that ignores quality and only rewards quantity. It’s insane, and it’s eating our lunch.

Critics of the reforms being debated in Congress say that only pilot projects on payment reform are being proposed. But one pilot project on payment reform is paying real dividends, and it’s occurring right here in West Virginia. The results are better patient care with reduced costs.

Here’s the story: About a year ago Craig Robinson, the CEO of Cabin Creek Clinic, approached Ted Cheatham, Director of PEIA, and suggested that Cabin Creek forgo their fee for service arrangement, and take a capitated fee — a flat dollar amount for each PEIA patient. If a PEIA patient came in once a month or ten times a month, PEIA would not pay anything more than the flat fee.

The capitated fee was set high enough so that Cabin Creek could hire a care coordinator to coordinate the care of the PEIA patients, and work intensively with patients with chronic illnesses like diabetes. In this medical home, physicians concentrate on treating their patients, while the care coordinator educates diabetic, for example, on how they can effectively control their blood sugar.

The health improvements, just nine months into this pilot project, are impressive. For example, now most diabetic PEIA patients (83%) have had their cholesterol checked in the last twelve months,

and the number of these patients with high levels of “bad” cholesterol has been reduced by 20 percent. The percentage of PEIA patients between the age of 50 and 80 who have had a colorectal screen in the last 12 months was below 60 percent when the pilot started in March. It’s now 76 percent.

These and other improvements occurred while Cabin Creek Clinic was saving PEIA money. Over a six month period Cabin Creek saved PEIA almost \$44,000, while improving the health of those covered. That’s a modest savings for PEIA, but the pilot project only has 340 participants. Imagine the savings if all West Virginia doctors were paid a capitated fee, and were rewarded for improvements in health care provided to their patients.

To be honest, Cabin Creek Clinic has some advantages that many physician offices don’t have. Cabin Creek has electronic medical records. With a few clicks on their computer, they can tell how many diabetics have had the blood sugar checked in the last year. Most physician offices can’t replicate this. Cabin Creek has experience in disease management, and they were willing to invest in training to turn a pharmacy technician into a care coordinator. And they have leadership at all levels. A “we can do better” attitude permeates the entire organization. Finally, they have a partner in PEIA that is willing to work with Cabin Creek for the shared goal of quality improvement and cost containment.

While the debate in Washington has focused on a public option and the costs of national reform, it has been the collaborative work between PEIA and Cabin Creek that has produced what all Americans really need in health care reform: better outcomes and reduced cost. We should be paying much more attention to payment reform, and Washington would be well advised to pay close attention to the results of payment reform occurring here in Kanawha County.

Membership Form

West Virginians for Affordable Health Care

Yes, I want to help reform health care and help with an aggressive public education campaign to educate people about the benefits of the reform package.

Enclosed is my contribution for \$50____ \$75____ \$100____

Name: _____

Street Address: _____

City: _____ State: _____ Zip _____

Email Address : _____

(Please print clearly)

I would like to volunteer for WVAHC. Please contact me.

Please return your membership form to:

WVAHC, 1544 Lee Street, Charleston, West Virginia 25311.

--Thank you!

