Venice Neighborhood Council

PO Box 550, Venice, CA 90294 / www.VeniceNC.org
Email: info@VeniceNC.org / Phone or Fax: 310.606.2015

August 21, 2009

Councilmember Bill Rosendahl
City of Los Angeles
200 North Spring Street
Los Angeles, California 90012

Re: National Health Care Reform

Dear Bill:

The Venice Neighborhood Council (VNC) Board of Officers, in a regular meeting August 18, 2009 passed the following motion.

Resolution Requesting the Los Angeles City Council to Support Health Care Reform Efforts in the United States Congress That Includes the "Public Option"

Whereas out -of-control health care costs are projected to rise 70% between 2008 and 2014, reaching 20% of GDP by 2017 and government spending on health care will rise from 6% of GDP today to 15% of GDP by 2040 and,

Whereas the United States spends twice as much on health care as most other industrialized nations (while, according to the World Health Organization, ranking 24th in life expectancy and 37th in health care systems) and therefore US businesses suffer from a competitive disadvantage in world markets due to the fact that insurance premiums for employer based health care have risen 114% in the last decade and,

Whereas around 50 million Americans, nearly 19% of the US population under age 65 are without health insurance and for profit heath insurance providers often attempt to increase profits by delaying payments to insured individuals, denying payments to insured individuals, canceling policies and general abuse of practices such as denial of coverage for pre-existing conditions, denial of coverage for "unapproved procedures and pharmaceuticals," and rejection of insurability due to "uncertain underwriting risks" and,

Whereas the Congress of the United States will be considering several health care reform measures intended to contain health care costs, end the abuses of health insurance companies and provide coverage for all Americans through a combination of existing health insurance plans and a newly created Government provided insurance plan referred to as the "Public Option" (see Appendix for a Summary of the GAO's analysis of these bills)

Venice Neighborhood Council
PO Box 550, Venice, CA 90294 / www.VeniceNC.org
Email: info@VeniceNC.org / Phone or Fax: 310.606.2015

Therefore be it Resolved the Venice Neighborhood Council supports reform efforts in the US Congress that will provide affordable health care coverage to all Americans, including the so-called "Public Option." We therefore encourage the City Council of Los Angeles to pass a

resolution transmitting our support for such reform efforts to the United Stages Congressional Delegation from California and ask the Mayor of Los Angeles to vigorously advocate for such reforms.

Sincerely,

Mike Newhouse
President, Venice Neighborhood Council

Cc: Secretary@venicenc.org

APPENDIX

Summary of GAO's analysis of Health Insurance Coverage Bills

From Congressional Budget Office (CBO) 6/14 Report:
http://www.cbo.gov/ftpdocs/104xx/doc10430/House_Tri-Committee-Rangel.pdf

Key Specifications Related to Health Insurance Coverage

The specifications provided by the tri-committee group would take several steps to increase the number of legal U.S. residents who have health insurance.

Starting in 2013, non-elderly people with income below 133 percent of the federal poverty level (FPL) who were not already eligible for Medicaid would be made eligible for that program, and the federal government would pay all of the costs of covering people who became newly eligible. (States would also be required to maintain their current eligibility levels for Medicaid indefinitely.) In addition, the federal government would establish insurance exchanges throughout the country and, more importantly, would subsidize the purchase of health insurance through those exchanges for individuals and families with income between 133 percent and 400 percent of the federal poverty level, also starting in 2013.

Persons in family	Poverty guideline	133%	400%
1	$10,830	$14,403.90	$43,320
2	14,570	$19,378.10	$58,280
3	18,310	$24,352.30	$73,240
4	22,050	$29,326.50	$88,200
5	25,790	$34,300.70	$103,160

In 2013, the proposal would also establish a requirement for legal residents to obtain insurance and would impose a financial penalty on most people who did not do so (the size of which would generally vary with their income).

The proposal would also impose a “play-or-pay” requirement on employers, who would either have to offer qualifying insurance to their employees and contribute a substantial share toward the premiums, or pay a fee to the federal government that would generally equal 8 percent of their payroll. Small employers (those with an annual payroll of less than $250,000) would be exempt from those requirements. As a rule, full-time employees with a qualifying offer of coverage from their employer would not be eligible to obtain subsidies via the exchanges, but an exception to that “firewall” would be allowed for workers who had to pay more than 11 percent of their income for their employer’s insurance. In that case, the employers would have to pay an amount equal to the per-worker fee due for firms subject to the “play-or-pay” penalty. Firms with relatively few employees and relatively low average wages would also be eligible for tax credits to cover up to half of their contributions toward health insurance premiums.

The proposal would also establish a “public plan” available only through the insurance exchanges. That plan would be set up and run by the Secretary of Health and Human Services (HHS). On average, it would pay Medicare rates plus 5 percent to physicians and other practitioners (and those rates would not be determined by the sustainable growth rate formula that is used to set rates for physicians in Medicare but instead would be increased over time using an index of physicians’ input costs). On average, the public plan would pay Medicare rates for hospital and other services and supplies on fee schedules, and negotiated rates for drugs or other items or services not on a fee

schedule. Providers would not be required to participate in the public plan in order to participate in Medicare. (A more detailed summary of the proposal's key provisions is attached.)

Likely Effects of the Proposal The proposal would have significant effects on the number of people who are enrolled in health insurance plans, the sources of that coverage, and the federal budget (as shown in the attached tables).

Effects on Insurance Coverage. Under current law, the number of non-elderly residents (those under age 65) with health insurance coverage will grow from about 217 million in 2010 to about 228 million in 2019, according to CBO's estimates. Over that same period, the number of non-elderly residents without health insurance at any given point in time will grow from approximately 50 million people to about 54 million people—constituting roughly 19 percent of the non-elderly population. Because the Medicare program covers nearly all legal residents over the age of 65, our analysis has focused on the effects of proposals on the non-elderly population.

According to the preliminary analysis conducted by CBO and the JCT staff, once the proposed changes were fully implemented, the number of uninsured people would decline by 35 million to 37 million relative to our projections under current law—leaving about 16 million to 17 million non-elderly residents uninsured.,,,

Components of the Coverage Estimates. Reflecting those calculations, the share of the non-elderly population that is insured would increase from about 81 percent today to about 94 percent under the proposal, CBO estimates. The 16 million to 17 million people remaining uninsured include several million people who would be eligible for Medicaid but who would not enroll in that program. The ranks of the uninsured also include unauthorized immigrants; all together, insured and uninsured unauthorized immigrants make up about 5 percent of the total non-elderly population in our estimates. With unauthorized immigrants excluded from the calculation, nearly 97 percent of legal non-elderly residents are projected to have insurance under the proposal.

Another significant feature of the insurance exchanges is that they would include a public plan that largely pays Medicare-based rates for medical goods and services. CBO estimates that the premiums for that plan would generally be lower than the premiums of the private plans against which it would be competing.

Because all plans offered in the exchanges would vary their premiums to reflect the costs incurred in each area, the difference in premiums between private plans and the public plan would vary geographically—but on average the public plan would be about 10 percent cheaper than a typical private plan offered in the exchanges. That difference in premiums is itself the net effect of differences in the major factors that affect all insurance plans' premiums, including their payment rates to providers, their administrative costs, the degree of benefit management they apply to control spending, and the pool of enrollees they attract (the effects of which would be partly offset by the risk-adjustment provisions described above).

Enrollment in the public plan would also depend on the number of providers who chose to participate in it. Providers would not be required to participate in the public plan in order to participate in Medicare, and CBO assumed that some providers would elect not to participate in the public plan because its payment rates would be lower, on average, than private rates. Even so, CBO's judgment is that a substantial number of providers would elect to participate in the public plan, in part because they would expect a plan run by HHS to attract substantial enrollment. Taking into account both the access to providers in the public plan and the relative premiums its enrollees would pay, CBO estimates that roughly one-third of the people obtaining subsidized coverage through the insurance exchanges would be enrolled in the public plan—so enrollment in that plan would be about 9 million or 10 million once the proposal was fully implemented. Given all of the factors in play, however, that estimate is subject to an unusually high degree of uncertainty.

Venice Neighborhood Council
PO Box 550, Venice, CA 90294 / www.VeniceNC.org
Email: info@VeniceNC.org / Phone or Fax: 310.606.2015

A Summary of the Specifications for Health Insurance Coverage Provided by the House Tri-Committee Group

July 14, 2009

- **The proposal's major provisions—including the establishment of an individual mandate to obtain insurance, an expansion of eligibility for the Medicaid program, and the creation of new insurance exchanges through which certain people could purchase subsidized coverage—would be implemented beginning in 2013.**
- **All legal residents would be required to enroll in a health insurance plan meeting certain minimum standards or face a tax penalty (described below)**. Individuals not required to file a tax return would be exempt from the penalty; exemptions for hardship and other reasons would be determined by a new and independent federal agency overseeing the health insurance exchanges (also described below).
- **The penalty assessed on people** who would be subject to the mandate but did not obtain insurance would equal 2.5 percent of the difference between their adjusted gross income (modified to include tax-exempt interest and certain other sources of income) and the tax filing threshold. The amount of the penalty could not exceed the national average premium for plans offered in the exchanges.
- **New health insurance policies sold in the individual and group insurance markets would be subject to several requirements** regarding their availability and benefits. Insurers would be required to issue policies to all applicants and could not limit coverage for people with preexisting medical conditions. In addition, premiums for a given plan could not vary because of enrollees' health but could vary because of their age by a factor of two (under a system known as adjusted community rating). Individual policies that were purchased before 2013 and maintained continuously thereafter would be "grandfathered," meaning that they would not have to conform to the new rules but would still fulfill the individual mandate. Existing group policies would have to conform to the new rules by 2017.
- **In order to fulfill the individual mandate, policies that were not grandfathered would have to cover a broadly specified minimum benefit package** (which was assumed to have the same scope of benefits as seen in a typical employer-sponsored plan) and would have to have a minimum actuarial value of 70 percent and a limit on out-of-pocket costs no greater than $5,000 for individual coverage and $10,000 for family coverage. (A health insurance plan's actuarial value reflects the share of costs for covered services paid by the plan.) After 2013, the maximum levels of those out-of-pocket caps would be indexed to general inflation.
- **The proposal would establish a national exchange through which certain individuals and employers could purchase health insurance**; states could also opt to operate their own exchanges (either one per state or one covering several states). All insurance plans sold through an exchange would be required to cover the "basic" benefit package described above. "Enhanced" plans would have an actuarial value of 85 percent, and "premium" plans would have an actuarial value of 95 percent.
- **Except as specified below, individuals and families who enroll in exchange plans and have income between 133 percent and 400 percent of the federal poverty level (FPL) would be eligible for premium subsidies and cost-sharing subsidies** (see table below). Federal premium subsidies in a given area would be tied to the average premium of the three lowest-cost plans providing basic coverage in the exchange in that area. The subsidies would limit an enrollee's contribution to a percentage of income ranging from 1.5 percent to 11.0 percent (see table); those caps would not be indexed over time. The federal government would fully fund cost-sharing subsidies, which would increase the actuarial value of enrollees' coverage to specified tiers based on income.

Subsidy Tier	Start of Tier		End of Tier		Actuarial Value of Coverage in Tier
	Income Relative to the FPL	Premium Cap as Share of Income	Income Relative to the FPL	Premium Cap as Share of Income	
1	133	1.5	150	3	97
2	150	3	200	5	93
3	200	5	250	7	85
4	250	7	300	9	78
5	300	9	350	10	72
6	350	10	400	11	70

- **Eligibility for subsidies would be determined on the basis of adjusted gross income** (modified to include tax-exempt interest and certain other types of income). Participants would have to provide information from their prior-year tax return during a fall open-enrollment period for coverage during the next calendar year (for example, tax return data on income received in 2011 would be provided when applying in the fall of 2012 for subsidies to be received in 2013). Each exchange would be given authority to obtain such information about taxpayers from the Internal Revenue Service as necessary to verify the information provided on income from the prior year. Individuals who did not qualify for a subsidy on the basis of their prior-year income would be allowed to apply for a subsidy on the basis of specified changes in their circumstances. Individuals receiving subsidies would be required to report changes in income and family composition during the year and, if changes occurred, would have their eligibility redetermined.
- **People not enrolled in other coverage would be allowed to purchase insurance in an exchange at their own expense.** Employers meeting specified size requirements would also be allowed to let their workers choose any of the plans available in the exchange (in which case, the workers would not receive subsidies via the exchange but would be subsidized by the tax exclusion for employment-based policies that exists under current law).
- **A "public plan," run by the Department of Health and Human Services, would be offered through the exchanges.** That plan would pay Medicare rates plus 5 percent for physicians and other practitioners (and those rates would not be determined by the sustainable growth rate formula used in Medicare but instead were assumed to grow with the Medicare economic index); Medicare rates for hospitals and other services and supplies that are on fee schedules; and negotiated rates for drugs and other items and services that are not on a fee schedule. Medicare providers would not be required to participate in the public plan.
- **Eligibility for the Medicaid program would be expanded to all non-elderly individuals and families with income at or below 133 percent of the FPL**. The federal government would pay 100 percent of the costs of newly eligible enrollees. States would be required to maintain their current eligibility levels for existing groups indefinitely. The federal government would fully subsidize the cost for some parents and childless adults who are currently covered by Medicaid under existing waivers that expand coverage. People eligible for Medicaid could not receive subsidies via an exchange.
- **Newborns who would otherwise be uninsured would be automatically enrolled in Medicaid for 60 days** (with the federal government paying 100 percent of their costs during that period), at which point there would be a determination of their eligibility for Medicaid or for subsidies provided through an exchange.

- **Medicaid payment rates for primary care services would be increased to 80 percent of Medicare rates in 2010, 90 percent in 2011, and 100 percent beginning in 2012**. The federal government would pay 100 percent of the cost of those increases.
- **There would be a maintenance-of-effort requirement for the Children's Health Insurance Program through 2013, at which point the program would be terminated.**
- **Firms with an annual employee payroll above $250,000 would be subject to a "play-orpay" requirement.** Employers could "play" by offering coverage that meets the minimum benefit standards described above and making a minimum contribution toward the premiums (72.5 percent for individual premiums and 65 percent for family premiums). Firms that do not meet those requirements would be subject to a payroll tax, with the rate depending on their annual payroll, as follows: 2 percent, for firms with a payroll between $250,000 and $300,000; 4 percent, for firms with a payroll between $300,000 and $350,000; 6 percent, for firms with a payroll between $350,000 and $400,000; and 8 percent, for firms with a payroll above $400,000. Employers could choose to "play" for full-time employees and "pay" for part-time employees and could also make separate 4 elections for separate lines of business. Employers offering coverage would also be required to automatically enroll workers in single coverage.
- **In 2013, full-time employees with an offer of employer-sponsored insurance would not be permitted to receive subsidies via an exchange (under an approach known as a "firewall"**). Thereafter, those employees could receive the subsidies only if their contribution for that coverage was deemed unaffordable—which would be defined as exceeding 11 percent of their income. Part-time employees could receive the subsidies with no restrictions. Beginning in 2014, employers offering coverage would be required to pay the exchange a percentage of their average payroll per worker for each employee obtaining coverage with the exchange. The percentage would be the same one that applied if the firm was subject to the play-or-pay penalty (and thus would vary with the firm's total payroll, as described above).
- **A tax credit for small employers would be available.** It would be permanent, not advanceable or refundable, and would phase out as employers' size and average wages increased. The smallest firms with average wages below $20,000 would receive a credit equal to 50 percent of the employer's share of premiums. The credit would phase out for employers with between 10 and 25 employees and average wages between $20,000 and $40,000 and would not be available for workers with wages above $80,000; those wage amounts would be indexed to the consumer price index.