Nurses' guide to single-payer reform

Definition of 'affordable' a key issue in new Mass. health care reform law

By Sandy Eaton, RN

The September issue of the *Massachusetts Nurse* published excerpts from Richard Kirsch's assessment of this year's Massachusetts "universal" health insurance bill ("If Wishes Were Horses: The False Promise of the Massachusetts Health Plan"). This assessment was written shortly after the April 12 Faneuil Hall signing ceremony, presided over by Gov. Mitt Romney and attended by nearly every "suit" in the state's extensive health care industry. Since April, some clarity has begun to emerge.

Chapter 58's complexity and its silence on the meaning of several key terms have stoked ongoing struggles to leverage its impact on various competing interests: corporate "stakeholders" versus those communities and individuals to whom so much had been promised. The two-year extension of the state's Medicaid waiver, worth $378 million per year, was subsequently approved by the Bush administration.

The Commonwealth Health Insurance Connector was established and its board filled with appointments by the attorney general and the governor, with an executive director drawn from the commercial health insurance industry. The Connector's charge is to broker "affordable" health insurance "products" so that coverage is within everyone's reach. As such, it must define what affordable means in this context.

Four existing managed care plans through which Mass Health, our state's Medicaid plan, is administered have been approved for this expanded role: Fallon Community Health Plan, Neighborhood Health Plan, HealthNet and Network Health. There's been some passing discussion of adding a fifth plan as well. Individuals and families earning below the federal poverty line will be covered at no cost to them.

The newly-created Commonwealth Care fund will receive employer assessments and dispense subsidies to individuals whose earnings fall between 100 and 300 percent of the federal poverty level - for an adult the range is $9,800 a year to $26,400 per year and for a family of two adults it's $13,300 to $39,600. For a family of two adults and one child, it's $16,600 a year to $49,800 per year.

Proposed "affordable" contributions under the current four plans range from 1.7 percent (or $18 monthly) to 4.7 percent ($106 a month) of income for individuals, and from 2.1 percent ($36 to $48 a month) to 6.3 percent ($240 a month) for families.

The only new source of revenue for these subsidies is the $295 per employee per year from employers of eleven or more workers who fail to show that they are making a "fair and reasonable" contribution to their employees' coverage. The Romney administration's Division of Health Care Finance and Policy held hearings to define "fair and reasonable." Employers and trade associations were heavily represented, with minimal representation from labor at these poorly advertised meetings. Employer representatives argued that any contribution that an employer makes toward employee coverage should be counted as "fair and reasonable," while spokespeople for groups associated with the ACT! petition campaign argued for a minimum standard of a 50% premium contribution. (The representative of the Associated Industries of Massachusetts claimed that the "any contribution" definition was the common understanding of those forging the compromise bill behind the scenes at the State House in March. Of course those discussions were off the record and of little weight now.)

The Romney administration has now issued its official standard: In order to avoid the $295 assessment, employers must show that at least one-quarter of their employees are enrolled in a company-sponsored health plan, or employers must offer to pay at least one-third of the cost of an individual employee's premium. (Among companies that still contribute to insurance premiums, employers pay 84% of premium costs for individuals and 74% for families. This low-ball standard of one third is widely predicted to become a strong disincentive for employers to maintain health insurance plans, complicating contract negotiations in organized workplaces and sowing additional insecurity elsewhere.)

This past July, the Affordable Coverage Today! (or ACT!) coalition chose not to file the final round of voters' signatures to place their question on the November ballot, thus weakening themselves in the ensuing battles around affordability and adequate employer funding, trusting instead to work within the "delicate compromise" that had been brokered behind closed doors in March by Partners Healthcare and Blue Cross-Blue Shield of Massachusetts. A week later the Legislature sent to study the healthcare constitutional amendment proposal that would have provided the impetus to march forward toward affordable, universal coverage. Hence, no healthcare question will appear on this November's ballot.

Upcoming deadlines:

Oct. 1: The "fair and reasonable" rules set by the Romney Administration's Division of Health Care Finance and Policy for require companies with 11 or more full-time equivalent employees to pay the assessment if they do not meet one of two "fair and reasonable" standards. Companies will avoid the assessment if at least 25 percent of full-time employees are enrolled in the company's

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Health care reform: an issue for women, an issue for nurses

By Catherine DeLorey, RN, DrPH
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Nurses have always been advocates for the health of society, and as we struggle for an adequate health care system nurses are at the forefront as change agents, organizers and decision makers.

With almost 95 percent of nurses in the U.S. being women, the issue of health care reform and women is of particular interest to nurses, as advocates and as women.

Reform needs to address women

Health care reform needs to address the special health needs of women. As more than 52 percent of the population, women are the major consumers of health services. Women are also the majority of health care givers and the traditional caretakers of family health.

Gaps and inequities in the health care system greatly affect women, especially women of color. Women are more likely to be under-insured because they are disproportionately represented among low-wage workers or work in industries that don't offer benefits, and women are frequently dependent on their husbands for coverage.

Health care reform is important for women, because women:

- Make 58 percent more visits each year to primary care physicians than do men
- Are more likely than men to take at least one prescription drug on a daily basis
- Have greater annual health expenses than men ($2,453 vs. $2,316)
- Pay a greater proportion of their health care expenses out of pocket (19 percent vs. 16 percent)
- Work in positions that are 15 percent less likely to be offered job-based health insurance
- Are 20 percent more likely than uninsured men to have trouble obtaining health care
- Are more than twice as likely as men to receive employer-based health coverage as "dependents" through their spouses' insurance (26 percent vs. 11 percent)

Uninsured in rural areas

In addition to the issues relevant to all women, minority women—especially Latinas—have difficulties in accessing adequate health care. Thirty-four per cent of Latinas and 21 percent of black women are uninsured, versus 13 percent of whites. For immigrant women, difficulties accessing health care are compounded by language and cultural barriers.

The rate of being uninsured in rural areas is 20 percent higher than in urban areas. Even with insurance, the lack of health care options means that rural women often have difficulties accessing appropriate care.

Recently there have been significant changes to Medicaid that have the potential to reshape program coverage for the nearly 19 million low-income women, who make up approximately 70 percent of Medicaid's adult beneficiaries.

Medicare—the closest thing in the U.S. to universal health care access plan - covering nearly all seniors—serves women disproportionately. Fully 56 percent of Medicare recipients are women.

Reproductive health

In planning health care reform, we know there is no health security for women without protecting the full range of women's reproductive services. Reproductive health rights mean that women have the right to get pregnant when they want to, the right to a healthy pregnancy, and the right to a healthy baby.

In addition, the following principles are essential to any reform proposal:

- Universal access to quality care
- Comprehensive health benefits
- Availability of women's health care from a variety of providers
- Care provided in a variety of settings
- System accountability to women
- Full health information for women to make own health decisions

As we plan for the future, the only way we will achieve an adequate health system for women is for women to work together to have their voices heard. Some ways this is being done include:

- The National Women's Health Network (at nwhn.org) includes health care reform in its long-term goals.
- The Avery Institute for Social Change (www.averyinstitute.org), coordinated by Byllie Avery, convened a national meeting of women's health advocates to establish a consensus on women and universal health care.
- The Maryland Women's Coalition for Health Care Reform (information via *askasper@aol.com*) formed in November 2005, as a confederation of women in Maryland to support efforts already underway to bring comprehensive health care to all.
- Women's Universal Health Initiative (www.wuhi.org) is a national organi-

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health plan and the company is making a contribution to it. If companies fail that test, they may still avoid the assessment by offering to pay at least 33 percent of an individual's insurance premium.

Oct. 2: That's when the state was supposed to start enrolling to the poorest residents—those making less than the federal minimum wage of about $9,800 a year for an single adult - into the new Commonwealth Care insurance program.

Jan. 1, 2007: The four designated insurance providers (Fallon Community Health Plan, Neighborhood Health Plan, HealthNet and Network Health) begin offering state-subsidized plans to those earning up to three times the federal poverty level.

By next spring, insurers are expected to be offering lower-cost private health plans for those who earn more than three times the federal poverty rate but who aren't already covered.

July 1, 2007: Everyone in Massachusetts is required to have some form of health insurance coverage or face a series of increasing tax penalties.

Please feel free to bring questions about the impact of Chapter 58 to MASS-CARE @ 617-723-7001 or info@masscare.org. The MASS-CARE Web site, www.masscare.org, carries news of developments in the fight for a just healthcare system, as well as suggestions on ways to get more deeply involved. ■

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zation dedicated to building diverse communities of women working for health care reform. They publish a quarterly e-newsletter on women and health care reform.

Of the 17 million women who are uninsured, more than 67 percent did not seek health care because they could not afford it. We should all be concerned about this and its implications for the family and society. (See chart at right.)

Only in a system that guarantees access to affordable, comprehensive health care for everyone can we resolve these disparities in health care experienced by women. Nurses must continue in the struggle for health care reform, highlighting its special importance for women. ■