

LEGISLATIVE ALERT: SPEAK OUT NOW ON SENATE HEALTH CARE REFORM PROPOSAL

On March 23, the Senate's proposed version of health care reform (H. 861) was released. Contrary to popular belief, the Senate proposal does not pare back the House plan, makes more people eligible for benefits, is constructed in a way that will seriously erode the private insurance market, and does not compromise with the Governor on important points.

We believe the proposed Senate version could greatly damage the existing private health insurance market and our health care system of non-profit hospitals and practicing physicians.

There is momentum for this Senate proposal built on a misperception in the press and in the State House that it is a moderate, pared-back proposal that compromises with the Governor. That is simply not the case. We need to convince the Senate to actually pare the proposal back, and find a compromise with the Governor, in order to resolve the health care reform debate once and for all.

If you agree with our assessment after reading the analysis below, please voice your concerns as soon as possible to your Senators and local press. Here's what you can do:

- Call the editor of your local paper and express concern that there is a misconception that the Senate version is moderate, pared-back and compromises with the governor.
- Write a letter to the editor saying the same; include a couple of examples from below about the problems with the Senate proposal.
- Leave a message for your Senators by calling the Sgt. at Arms at 802-828-2228. You can either leave your phone number for a call back, or leave a message --- for example, that you, as a (business owner; community leader; hospital trustee; etc), are concerned about the scope of the Senate leadership proposal on health care reform

Here are some of the impacts of the proposed Senate version (draft 1.1 March 22) on employers and employees:

The Growing Cost Shift

1. **The Senate proposal increases the cost shift by allowing people with private insurance to move into the low-paying Catamount Plan.** Private insurers reimburse hospitals and doctors at significantly higher rates than government plans. When people drop private insurance and move into lower paying government plans, cost shifting to the remaining private payers increases, at the same time the private pool to absorb the shift is shrinking.
2. **The Senate proposal does not cover hospital care. Instead, their bill requires hospitals and hospital-affiliated physicians to provide free care to everyone whose income is below 200% of poverty.** Also, hospitals and their affiliated physicians will be limited to a sliding scale fee schedule for what they can charge anyone between 200% and 350% (\$70,000/family of 4) of poverty, and out-of-pocket for this group is capped at \$2,000.

How does the Senate expect these unreimbursed costs to be covered? **The Senate proposal specifically codifies into law the existing cost shift to private insurance that currently helps pay for charity care.** Adding to the problem is that the Senate plan makes more people "eligible" for free care by law, without putting any new money into the system.

3. **By treating the current cost shift for charity care as a “source” of revenue, the Senate proposes to do what the legislature refused to accept in the Governor’s plan last year: creating a premium tax to pay for a new plan for the uninsured.** (This is not called a “premium tax” in the bill; it is called “Hospital Default Insurance Program.” – p. 44, Draft 1.1.)
4. Because the Senate’s Catamount plan provides no revenue for hospital care, when people drop insurance plans to join the cheaper Catamount, **there will be far less revenue for the hospitals, but hospitals are expected to provide the same services, probably to more people.**
5. The Senate proposal provides **no new revenue to restore last year’s \$16 million cut to hospitals (which was cost shifted into private insurance rates), and provides no new revenue to reduce the historical cost shift,** now totaling \$59 million a year for hospitals alone. (Call 802-864-6787 for our fact sheet on Medicaid Cost Shift for your Hospital Service Area.)
6. *In 2006, the total Vermont Medicaid hospital cost shift exceeded the total federal Medicare hospital cost shift for the first time in history.* Not surprisingly, this cost shift is one of the primary reasons that health insurance in Vermont is becoming unaffordable. **But instead of attacking the cost shift, this proposal creates a new government plan, and “funds” it with existing cost shift.**

The Impact on Private Insurance

1. The Senate proposal allows currently insuring employers to switch from private coverage to the state plan, where premiums are artificially low because hospital care isn’t paid for and providers are underpaid. **Non-profit and for-profit insurance carriers, whose benefits and rates are regulated, cannot possibly compete with Catamount plan rates.**
2. **The Catamount plan could actually attract employers with the highest risk employees,** because it will either eliminate or limit their exposure for hospital costs.
3. The proposal **continues to shift costs from Medicaid onto private insurance, and adds new Catamount cost shifts, while reducing the pool of insured.**
4. Only employer-sponsored plans as rich as Catamount Health will qualify for employee premium subsidies under the Senate proposal. **Because few employers can afford these \$5,000+/year plans, few, if any, will qualify for these needed premium subsidies.**
5. As premiums grow due to the growing cost shift, more employers will move to Catamount, for lower premiums, lower hospital exposure and to qualify their employees for subsidies. **The entire cost shift will be borne by those remaining in the private market.**
6. **In the worst case (but not groundless) scenario, our remaining three carriers leave the state, self-insured employers shift to Catamount, and Catamount will be the only coverage available. But then there will be no one paying the cost shifts that are required to keep all the state government plans – Medicaid, VHAP and Catamount – afloat, because they all depend on cost shifting. (This is called “the death spiral.”)**

Providers would have no where to go to make up the difference between the cost of care they are required to deliver, and what state plans are funded to pay. And there will be no carriers for employers and employees to move back to, if the state plans are eliminated or severely cut.

If any of this worries you, we list at the beginning some simple steps you can take to be heard.