NEXT STEPS

The U.S. Supreme Court has upheld the Affordable Care Act, but medical care will still be out of reach for millions of Americans. Learn how the law leaves the private insurance system unchanged, and how expanding Medicare for all is the only solution that works. BY CHARLES IDELSON
Now that the United States Supreme Court has upheld the 2010 Affordable Care Act, it’s a good time to revisit what the law does and does not do, and what’s next on the agenda for advocates of more comprehensive healthcare reform.

At its best, the law will help some people who have been unable to get health coverage, primarily through the expansion of Medicaid and some of the insurance reforms, assist seniors to pay for prescription drugs, and provides important financial help for community health programs.

But the law does little to control healthcare costs for families and individuals, is not universal, leaves big loopholes in the insurance reforms, and is a huge windfall for insurance companies, hospitals, and pharmaceutical corporations.

Overall, the law reinforces, protects, and expands the reach of the private insurance system. Even its most progressive element, the Medicaid expansion, was undermined by the court decision allowing individual states to opt out, which could substantially reduce the law’s promise of expanded coverage.

As NNU Co-President Karen Higgins, RN, who was on the steps of the Supreme Court when the decision was announced, said, “Nurses experience the crisis our patients continue to endure every day. That’s the reason we will continue to work for reform that is universal, that doesn’t bankrupt families or leave patients in the often cruel hands of merciless insurance companies.” That reform is called an expanded and improved Medicare for all.

There are several key provisions of the ACA, most of which are to be phased in by 2014.

Probably the most controversial part of the law so far has been the individual mandate, which means that those who currently have no health insurance, for example, through their employer or covered by a government-funded program like Medicare, Medicaid, or the VA, will be required to buy private insurance. Failure to comply will result in a tax (as redefined by the Supreme Court) amounting to $695 a year or 2.5 percent of an individual’s income, whichever is greater. Subsidies are supposed to be provided for people with incomes of up to 400 percent above the poverty line to buy insurance. New state health insurance exchanges will be set up to offer choices.

The ACA also offers a few “benefits” that will add some more people to the ranks of the insured. People with incomes up to 133 percent above the poverty line will have access to Medicaid, a provision accounting for more than half of the additional people who will now have health coverage. That Medicaid expansion comes with a big caveat, however. The court allowed states opposed to the Medicaid expansion to opt out. A number of states are threatening to do so. And young adults up to age 26 can now remain on their parents’ health plans, a provision already in effect.

The law bars some of the most notorious insurance abuses, including denying coverage because of preexisting conditions, rescissions (dropping coverage when you become sick), and annual and lifetime caps on coverage. Insurers are also supposed to provide rebates to consumers if they spend more than 20 percent of their revenue on administrative costs. Insurance plans will also be required to include preventative care (e.g. mammograms, vaccinations, colonoscopies, physicals) with no co-pay, by 2018. Medicare will now include an annual physical and no co-pays for preventive services. And the law provides for significant increases in funding for community health centers, one of the best provisions of all,
which was added late in the Congressional debate at the insistence of Sen. Bernie Sanders.

On prescription drug coverage for those on Medicare, the ACA helps shrink the “donut hole” in coverage, but does not eliminate it. The Bush administration program of prescription drug coverage for Medicare recipients through a private supplemental program left a huge coverage gap with large out-of-pocket costs for seniors. The ACA reduces the gap, by about 40 percent, which has produced important savings for millions of seniors, but does not solve the entire problem.

Finally, small businesses, which pay far more than big companies if they offer health benefits, will get tax credits of up to 50 percent of
the cost of premiums for offering health insurance to their workers, a provision already in effect.

But on many fundamental levels, the law falls woefully short and fails to rein in health insurers. Insurance companies, drug companies, and hospitals will still largely be able to charge what they want. Restrictions on premium rate increases and out-of-pocket costs are limited and will likely be ineffective. The probable result: a continuation of bankruptcies linked to high medical bills and many people, including those forced to buy insurance, skipping needed care because of high out-of-pocket costs.

Furthermore, insurance companies will still be able to deny medical treatment, diagnostic procedures, and referrals, making excuses by citing such care as “experimental,” or “not medically justified.” They will be able to dictate the order of tests and course of treatment. Recourses for patients will remain weak. And you can bet insurance companies will spend a lot of money on lawyers and claims adjustors who will be experts at finding loopholes in the new law.

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Many Already on Board For Medicare For All

On Jan. 25, Carolyn Trovao knew she was having a heart attack. Yet the 61-year-old Fresno, Calif. woman lay on her living room floor with crushing chest pain, afraid to go to the emergency room because she knew that, because she had no health insurance, getting medical help would ruin her financially and potentially kick her unemployed son out on the streets.

“I actually stayed at home for 16 hours suffering chest pains, praying that I would die because I was afraid that my son would be left homeless,” said Trovao. “I do have insurance to pay off my mortgage, so at least if I died, he would at least have a home.”

Passing in and out of consciousness, Trovao eventually couldn’t stand the pain anymore and her 23-year-old son, who lives with her, convinced her to go to the hospital.

Trovao is still alive today, but now saddled with a $135,000 hospital bill that she has no resources to pay. The reason she didn’t have insurance coverage in the first place after she retired from her 15-year position with Aetna (yes, she used to work for a health insurer, advising brokers about Aetna policies no less) was because she could not afford the $1,300 per month COBRA premiums.

“That’s what happens to people,” said Trovao. “I never thought that I’d lay there and want to die, but I have to be honest with you, I’d have rather died than leave my son homeless.” She said the hospital recently called about payment, but she has no idea how she will settle that debt.

Trovao’s situation is just one of the many distressing stories that NNU nurses and staff members heard and documented during their three-week bus tour across California this summer as part of NNU’s campaign to expand and improve the Medicare system to cover everybody.

Dubbed the “Healthcare Express,” the bus left San Diego on June 19 and crisscrossed the state, making stops in more than 18 cities. At each stop, nurses offered basic health screenings to community members instinctively understood the need for Medicare to be expanded to cover everyone regardless of age.

Registered nurses met all kinds of patients, from those who have lost their jobs and insurance so can no longer afford their medications, to those who had not seen a doctor or nurse in more than a decade.

Many of the registered nurse volunteers had their own stories to tell. One RN is supporting 10 relatives on just her salary. Only her immediate family has health insurance. Another RN, Joan Potts, recently lost her insurance when she lost her job. Her husband, who is diabetic, depended on her coverage and is not able to get individual insurance because of his preexisting condition, so is not able to seek medical care. Based on her previous year’s salary, they make too much money to qualify for Medicaid. They are now considering a divorce so that he can access some kind of government aid.

“He suffers every day and I know there is medical help for him, but it’s unattainable. We just can’t afford it,” said Potts. “I’ve come to realize that healthcare shouldn’t be a luxury. There’s good people out there suffering needlessly and they’re dying needlessly. Unfortunately, it took something like this to happen to me to make me realize that this needs to stop. We need to have healthcare for everybody.”

Find out more about NNU’s Medicare for All campaign and what you can do to help at NursesHealAmerica.org. —Lucia Hwang

To see video interviews from the Medicare for All bus tour, please visit youtube.com/calnurses.

crackdowns on insurance abuses. For example, insurers can create new marketing techniques to cherry-pick whom they cover despite the ban on denials for people with preexisting conditions. The law also permits insurers to charge more based on age and for those who fail “wellness” programs because they have diabetes, high blood pressure, high cholesterol readings, or other medical conditions. Insurers will continue to be able to rescind coverage due to “fraud or intentional misrepresentation” - the main pretext they use now.

The law also simply fails to provide universal coverage. Before the court decision, the non-partisan Congressional Budget Office estimated up to 27 million people would be left without health coverage under the ACA, mostly people who will still not be able to afford to buy private insurance. However, the court decision permitting states to reject the Medicaid expansion could cause the number left out to jump by as much as several million more. The principle of “all the healthcare you can afford” remains in effect, as the insurance market is divided into multiple risk pools and multiple plans offering different levels of coverage based on price.

For the first time, the law will tax health benefits beginning in 2013. The main target is comprehensive coverage. The inevitable result will be fewer employers offering good health benefits, and far more people pushed into plans with reduced coverage and significantly higher co-pays, deductibles, and other large out-of-pocket costs.

For registered nurses, the law promotes IT systems in healthcare, many of which are wasteful and have been used by many employers to erode RN clinical judgment and promote dubious standardized protocols and other efficiency measures. Budget pressures will drive these delivery system changes, under the guise of “improving quality.” The law also encourages the use of dubious “patient satisfaction” schemes, such as scripting and rounding, that typically undermine nursing practice by linking them to hospital reimbursements. For more on what’s wrong with these schemes, see the October 2010 issue of National Nurse.

Ultimately, what the ACA accomplishes is create a windfall for health corporations: Billions of dollars in additional profits for insurance companies, through the individual mandate and taxpayer-funded subsidies to buy private insurance; for drug companies, whose support for the ACA was negotiated by blocking the ability of the federal government to negotiate bulk purchasing discounts; and hospitals, which will get millions of new customers and higher
reimbursements. All of which will further strengthen a healthcare system already too focused on profits rather than patient need.

“Medicare is far more effective than the broken private system in controlling costs and the waste that goes to insurance paperwork and profits, and it is universally popular, even among those who bitterly opposed the Obama law,” said Higgins. “Let’s open it up to everyone. No one should have to wait to be 65 to be guaranteed healthcare.”

NNU will continue to work at both the state and national levels for guaranteed healthcare through expanded Medicare. More than a dozen states have active single-payer movements, and the ACA does allow state waivers in 2017 to expand beyond the ACA; activists are pushing to move the waiver date up to 2014.

Nationally, nurses will work with a broad array of existing healthcare and community activists to improve Medicare through such steps as ending the creeping privatization of administration and services, increasing funding, and expanding Medicare as more people see a need to solve, once and for all, a patient care crisis that will not end with the Supreme Court decision.

Charles Idelson is communications director of National Nurses United.

RATIOS AT RISK
(Continued from page 11)

hospital upper management get this? Perhaps if the CEO was a registered nurse, not a businessman with an MBA, things might be better.”

NNU members and staff across the country hear stories like these every day. It’s the reason why NNU has sponsored national legislation S. 992, introduced by California Sen. Barbara Boxer, and H.R. 2187 by Illinois Rep. Jan Schakowsky and state bills from Nevada to Florida.

It’s why nurses in California, with the solidarity and support of nurses throughout the United States, will never accept a return to the days when California patients had to call 911 from their hospital beds to get help and be silent in the face of the latest insidious threat to the hard-won law to protect patients. And no joint venture of a corrupted labor leader with the hospital industry can change that.

RoseAnn DeMoro is executive director of National Nurses United.