Information & Disinformation: Guide to Educating the Public about Medicare for All

By Sarah K. Weinberg, MD, Editor

The choice of words and the choice of emphasis makes a lot of difference when talking about Medicare for All with the general public.

“Will provide health coverage for everyone” vs “Will eliminate private insurance”

Even though many, if not a majority, of Americans don’t like their health insurance, the threat of taking it away is still scary to most.

“One guaranteed plan” vs “One government plan”

The disinformation folks take advantage of many people’s skepticism about the government’s ability to do anything right.

“No more private insurance premiums to pay” vs “It will raise taxes”

There is no surer way to scare Americans than to mention raising federal taxes. Completely lost is the message that families won’t have to pay premiums for mostly lousy health insurance any more.

“You can choose your own physician” vs “Your choice of insurance will be taken away”

Again, the disinformation folks emphasize the scariness of taking away choice of insurance, when what people really care about is being able to choose their own doctor and/or hospital. Under Medicare for All, essentially all health providers will be included.

“Coverage will include dental, vision, mental health & long-term care” vs “Eliminates premiums, co-pays and deductibles for everyone”

People are more interested in what the benefits will be than in the cost savings – except for those who have had to use their insurance and had to deal with the “cost-sharing”!

“Will be able to control prescription drug prices”

The disinformation folks haven’t come up with a rejoinder for this big one! They whine about cutting pharmaceutical companies research and development funds, but that claim is not effective.

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From the President’s Desk

by Marcia Stedman, President.

Washington Isn’t Waiting

. . . and neither is Health Care for All-Washington.

As we take time to connect with family and friends during this summer recess, we are also planning our work for the coming year. This year, we have a three-pronged strategy:

1. Participate in and monitor the deliberations of the Universal Health Care Work Group. The Health Care Authority is currently assembling the members of the Work Group, including the actuarial firm that will carry out the economic studies mandated by the Pathway Bill. The meetings of the Work Group will be open to the public, and it is expected that there will be time allotted at each meeting for public comments. We will keep you informed.

2. Advocate for the State Based Universal Health Care Act that is due to be introduced into the U.S. Congress, possibly as early as this fall. Federal support - both financial and regulatory - is critical for the success of our state-based plan. Has your Congressional representative co-sponsored this important legislation? Ask them, and let them know why it’s important to you.

3. Continue working together with key leadership and universal health care champions to develop legislation that will move us closer to providing affordable and accessible healthcare for our state’s residents.

From its incorporation in 1994 as the Washington Single Payer Action Network, through its brief tenure as the initiative campaign known as Health Care 2000, through its 2002 name change to Health Care for All-Washington until today, HCFA-WA has been the leading group in Washington state dedicated to fighting for single-payer healthcare for all Washington residents. Thank you for your continued support of our work

https://www.healthcareforallwa.org/donations

As you continue to enjoy this summer recess, we invite you to stay tuned and visit our website’s blog for updates and articles of interest on both state and Federal actions:

https://www.healthcareforallwa.org/blog

Enjoy your summer, remember to stay hydrated, and get ready for action in the coming months!

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Business Support for Reform of the Health Care System

By Sarah K. Weinberg, MD, Editor

This is the new non-profit joint venture created by Amazon, Berkshire Hathaway, and J.P. Morgan Chase. Led by surgeon and author Atul Gawande, this plan’s goal is to remake the way the employees of these three huge (and wealthy) businesses get their health care. Expectations have been high since the first announcement months ago, but whatever program is being developed is still shrouded in mystery.

Business for Medicare for All

A press release on July 17, 2019 announced the launch of Business for Medicare-for-All to organize business support for the two bills currently in Congress (Sen. Sanders & Rep. Jayapal). More than 1,000 business leaders have joined already. The organization’s website is: businessformedicareforall.org.

The goal for 2019-20 is to mobilize American business support for Medicare for All while challenging the wasteful status quo. They plan to do the following:

• Sign up 10,000 business owners by January 2021.
• Sign up at least one business owner from every congressional district.
• Publish op-eds from local business owners in newspapers and websites across the U.S.
• Work closely with state business groups and advocate for them among national M4A players.
• Work with elected officials, especially the sponsors of M4A legislation to raise our business voice in Congress.

Wendell Potter is the President, and Richard Master (of Fix It! Fame) is heavily involved.

Discussion

These are, in a way, opposite approaches to the problem of the dysfunctional health care system in the U.S. The first is yet another attempt by the private sector, believing in the superiority of private enterprise, to find a better way, at least for some people (their employees). The second is an acknowledgment that businesses need a government solution for everyone. So far, at least the government solution supporters have a concrete plan. The privatizers have a famous person, but no plan as yet.

Other large businesses are experimenting:
• Walmart is trying primary care clinics
• CVS pharmacy chain is adding health insurance to its pharmaceutical benefits manager business. They plan to develop “health hubs” to focus on improving care for complex patients.
• Venture capital is getting into Medicare Advantage.

Will these private sector efforts actually improve the behavior of, and treatment for, seriously ill people? Or will they merely add more fragmentation, complexity, and confusion? We’ll see.

Meanwhile, HCFA-WA welcomes Business for Medicare for All

Book Review: “Struggling and Dying Under Trumpcare: How We Can Fix This Fiasco”

By John Geyman, MD

On an almost-yearly basis for 17 years, Dr. Geyman has brought readers up to date with how our American health care system is not performing well. Clearly presented over the years, he documents the corporatization of American medicine, the hijacking of reform by the insurance industry that essentially wrote the Affordable Care Act, and how even those protections are unraveling under the Trump administration.

The three sections of Part I document the current poor access to care, the unaffordable costs of care, and how even how quality of care has become unacceptable. Part II delineates how lies, myths, memes, and politics have shattered the safety net that was supposed to enable the poor to access quality health care.

In Part III, Dr. Geyman presents, once again, how a unified national health coverage system could allow the U.S. to work on solutions to all these problems. Yet, as he put it: “Incremental change on health care, in the midst of a heated battle between corporate stakeholders in the status quo and those pushing for real reform, is a trap that comes up every time.” Noting the increased action on Medicare for All in the newly Democratic House of Representatives, Public Citizen commented: “Such a clear surge in support for Medicare for All that our nation is experiencing holds the promise of taking us from worst-to-first when it comes to providing guaranteed access to health care.”

Might that time come in the next couple of years?
Three Recent Articles about Single-Payer Health Care

By Sherry Weinberg, MD, Co-Chair

“Major health reform requires Democratic congressional dominance”, Blumenthal, D, The Hill, 7/19/19.

This article looks at the recent history of efforts, both of the Clinton effort in 1993-94 (failed), and Obama’s Affordable Care Act (passed & implemented). The analysis creates a list of political requirements for the future success of reform efforts:

• Democratic control of the House of Representatives
• Filibuster-proof Democratic control of the Senate (67-vote majority)
• Democratic control of the White House
• President puts health care reform at the very top of the priority list
• President with fine-tuned command of government and understanding of Congress’ arcane byways
• Only the President can speak to the people of the nation to mobilize public opinion in favor of the proposed reform.


This article looks at single-payer legislation actively introduced since 2010 in 20 states. Only one state’s legislature passed such a bill (VT), and later abandoned implementation largely due to the cost of its payroll and income taxes. Beyond achieving universal coverage, these bills seek to control health spending through rate-setting authority and administrative streamlining. They share many common elements:

• Universal eligibility for state residents
• Expansive provider eligibility
• Rate-setting for health services and prescription drugs
• Low or no cost-sharing for patients
• Comprehensive benefits

• Limits on the ability of health insurers (but not employers) to offer coverage that duplicates the single-payer benefits

Several financing strategies are used:

• Consolidate federal funds from Medicare, Medicaid, ACA exchanges, etc., using waiver provisions in the ACA
• Dealing with ERISA – three strategies: 1) levy payroll taxes on employers and income taxes on employees, 2) allow the single-payer plan to pay for all patient care, then recoup those payments from other coverage the patient has, and 3) restrict providers from accepting private-insurer reimbursement

All of these schemes are designed to nudge employers to cease offering private coverage.

It’s clear that the threat of ERISA pre-emption creates formidable legal uncertainties for state-based single-payer proposals that would not exist for a federal single-payer plan. But states can be laboratories of change, as Massachusetts was for the ACA, and Saskatchewan was for Canada’s Medicare. The article concludes by advocating reform of ERISA by narrowing its pre-emption provisions or adding a waiver. Not mentioned, unfortunately, is the State-Based Universal Health Care bill (SBUHUC) that was in the last Congress and is promised again in this session “soon”.


This article enlarges on former Vice President Joe Biden’s plan that claims that universal coverage would not require the elimination of a private insurance market. The article focuses on Germany, the Netherlands, and Switzerland, who use a system of highly regulated private insurance to cover all their residents at much lower cost compared to the US Highlights of these plans:

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Single payer Articles  (Continued from p. 4)

- Standardized benefits
- Limits on what people have to pay out-of-pocket – Germany limits such payment to 2% of income
- Required universal enrollment in health insurance
- Either the tax system pays the premiums, or there are subsidies for lower income families

Not mentioned is that these three nations still spend well above the average even for nations with high GDP/capita numbers. In fact, were it not for the U.S., Switzerland would really stand out as spending much more.

Yes, it is possible to provide universal health coverage through private insurance, it’s just inefficient as compared to a true single-payer system.

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Insulin Too Expensive? Try Canada

*By Sarah K. Weinberg, MD, Editor*

While the US news is full of Congress members arguing over whether or not to allow the government to negotiate drug prices for Medicare beneficiaries, Sen. Bernie Sanders (I-VT) escorted a group of families of diabetics to Windsor, ON (20 minutes drive from Detroit) to buy insulin. The average price of a single vial of insulin in the U.S. is $340, but the exact same drug is $30 in Canada. The families stocked up – one bought a 6 months supply for $1,000 that would have cost $10,000 at home. Families told stories of cutting or skipping doses, not paying their electricity bill, etc. all to try to keep enough insulin for their diabetic family member to survive.

Our treasurer, Dana Iorio, with his new treasure, Mai Carmela Iorio-Truong, born 7/6/19.
Following the annual Board Retreat of HCFA-WA, what was the Political Action Committee (and named the Legislative Committee before that) has subdivided into a Lobbying Team and a Policy Committee. We encourage any active member of HCFA-WA who is interested in working on policy to contact either Sherry at weinbergsk@msn.com or Elaine Cox at laineypc@outlook.com.

Planning for 2019-20

We spent quite a bit of time discussing the role of the Policy Committee. Its major responsibility will be writing or implementing the policy needs of the strategic plan. However, the 2019-20 updated strategic plan has not yet been finalized.

Following the progress of the Work Group authorized by the final state budget will be important. Once its membership has been determined, it should begin meetings around the end of July. Its meetings will be open to the public, and Dr. Hal Stockbridge plans to attend as many as possible. (At least he lives in Olympia!) Our committee may be a resource for the Work Group as it explores possible routes to universal health coverage.

Another concept under investigation is the possibility of working on a state bill to control pharmaceutical prices. How to do this in a way that advances a single payer approach is not certain. The committee will be looking at what our state government is already doing, what other states are doing, what proposals are being considered in other states, and how other nations handle pharmaceutical prices.

Conclusion

At this time, there is no conclusion – only a starting effort to continue forward momentum toward a single payer universal health coverage system in our state on the way to national health coverage.

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Educating the Public

(Continued from p. 1)

“Medicare for All expands a program that already works” vs “Let’s keep what’s working”

Emphasize that Medicare for All really IS what is working in our dysfunctional health care system.

“A simplified single system will provide the most savings” vs “How about a public option?”

Adding another plan to an already complicated system won’t save any money. Besides, the private insurers will quickly figure out how to shift the most expensive patients to the public plan, and keep the relatively healthy (read: profitable) enrollees. They already do this with the Medicare Advantage plans.

These suggestions may help you when you explain Medicare for All to your friends, neighbors, and colleagues. Some other important rejoinders to disinformation don’t fit the above format, but should be kept in mind:

- “No one should go bankrupt to save their life” – having a major illness, even with “good” insurance, is a major cause of personal bankruptcies in the U.S. Such bankruptcies simply don’t happen in nations with national universal coverage systems.

- “The for-profit health care and health insurance industries will be essentially eliminated” – health insurance will be reduced to coverage of non-essential care, meaning that insurance companies will have to shift to other lines of insurance. For-profit hospitals and surgery centers will be put on budgets that will essentially require them to become non-profit.

But, most of all, keep talking about Medicare for All, and why you support it!
Yes, I'll join to work for high quality, sustainable, affordable, publicly-funded health care for ALL Washington residents

Circle how you can help: Speaking/ Fundraising/ Phoning/ Demonstrations/ Writing/
Action Teams/ Meet with legislators/ Online & Social Media/ Other_____________________

$______Contributions to HCFA Education Fund, a 501(c)3, are tax deductible.
$______Contributions to Health Care For All-WA, a 501(c)4, go for vital organizational growth, but are not tax deductible.

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Thank you for your support.
Health Care For All-WA
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Info@healthcareforallwa.org ; www.healthcareforallwa.org

Please become a health care activist in your LD

Every two years HCFA-WA sets up constituent visits with legislators in each LD across the state. This effort can use your energy and skills. For more information, contact us at action@healthcareforallWA.org. Give us your LD number and a phone number to contact you. To help support our work this fall, here are some questions for you:

• Do you know your legislators, or do they know you?
• Can you make appointments with any of them for a meeting?
• Can you recommend a place in your LD where neighbors can meet to talk about the latest developments in advocating for universal health coverage before the meetings?
• Are you free to do any calling of other HCFA-WA supporters in your LD?
• Are you interested in hosting a house party for friends or neighbors for an update on universal health coverage in our state?
Check your label for the date of your last contribution. Renew your membership now for 2019

The “Cadillac Tax”

*By Sarah K. Weinberg, MD, Editor*

“Cadillac Tax” is a nickname for a tax that was written into the ACA when it was passed in 2010. It’s a 40% tax on the cost of health insurance policies above a set price. The initial purpose was two-fold: 1) to encourage cheaper plans offered by employers and unions, and 2) to offset the costs to the federal government of the subsidies for individual plans purchased on the exchanges. It was touted as a method to control the constantly rising costs of health care by having plans with more enrollee cost-sharing thereby decreasing utilization of health care. This idea was based on the premise that a major driver of costly health care in the U.S. is over-utilization of unnecessary care. The tax has actually never taken effect, as it has been postponed twice – from its initial start date of 2018 to the current one of 2022.

The tax has been unpopular with both Republicans and Democrats, and now the House of Representatives just voted overwhelmingly to repeal it. No concern has been shown about the increase in the deficit that will result. Whether the Senate will also vote on the issue is not known at this time.

There are some fundamental flaws with the tax:

--It’s not just the wealthy who would be affected – teachers, state workers, and people living where health care costs are high (like Alaska) would also be subject to the tax.

--As health care costs continue to rise faster than inflation, increasing numbers of employer plans would cross the threshold. The Kaiser Family Foundation estimated that 21% of employers would be affected in 2022, rising to 46% by 2030.

Even though the tax has not gone into effect, the threat of it is one factor in the eviscerating of the quality of health insurance coverage over the past several years.

It’s a reminder that the main cost drivers are lack of control over hospital and drug prices, not over-utilization. Universal health coverage proposals like Medicare for All would be a much fairer and more effective way to control health care costs – and would help everyone!