



# Health Care for All-Washington Newsletter

An informational publication of HCFA Education Fund for health reform advocates

Winter 2020

## Universal Health Coverage in the US by 2030? Perspectives

By Sarah K. Weinberg, MD, Editor

On December 12, 2012 (12/12/12!) the United Nations passed a resolution urging all nations to work for universal health coverage by 2030. The United States voted for it. All re-committed this year on 12/12/19, now known as International Universal Health Coverage Day. At this time, 7 years after the initial resolution, all high-income nations (except the US) have adopted universal health coverage systems, and many low- and middle-income nations are making good progress. Two recent articles by the Commonwealth Fund examine how some nations got there, and how Americans' values, assessment of the function of the US system, and opinions about improvements affect efforts for reform.

The first article looked at Germany, the Netherlands, and Canada, to see what lessons for the US could be learned from their experience. All three got to universal health coverage gradually over decades, Germany starting in 1883, the Netherlands during German occupation in World War II, and Canada in 1947 in Saskatchewan. Both population segments and health services covered gradually increased. By 2006 (Netherlands) and 2007 (Germany) purchasing insurance became mandatory, and the systems were largely consolidated and tightly regulated. All Canadian provinces had comprehensive public plans by 1972, and the federal government provided partial funding support. Today, all Canadians are automatically enrolled in their province's system.

Note that changes in the US have followed this path, albeit much more slowly. There were general proposals early in the 20th century, followed by encouraging employer-sponsored insurance (ESI) in the 1940s when such plans were exempted from taxes. Then came Medicare and Medicaid in 1965, and the Affordable Care Act (ACA) in 2010. All these actions expanded the number of people covered, provided federal funds, and provided regulations to ensure adequacy of health services covered. It's no secret, however, that the US still has a long way to go to get to truly universal and truly comprehensive health coverage.

The second article summarizes a detailed poll undertaken by the Commonwealth Fund, Harvard's T.H. Chan School of Public Health, and the New York Times. The purpose was to find out more about how people's values interact with their impression of how well the US health care system is working,

Continued on p 5



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### What's inside

Universal care by 2020?.....	1
President's Message .....	2
Health care news items.....	3
Policy Committee Report.....	4
HCFA Spokane.....	5
Outreach Committee Report.....	6
Capitalism and clinics?.....	7
Canadian drug prices.....	8

**Health Care for All- WA advocates for high quality, sustainable, affordable, publicly funded health care**



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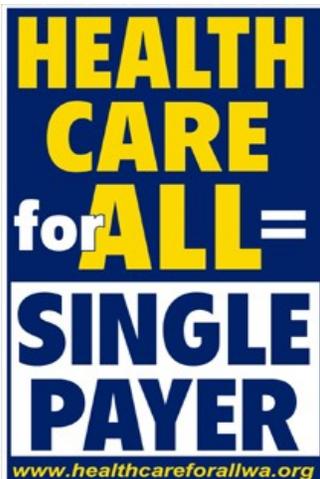
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## From the President's Desk

by Marcia Stedman, President.



Like the Greek god Janus who looks to both the future and the past, HCFA-WA is also looking back at our 2019 successes and ahead to future successes in 2020 as we prepare for 2021.

**In 2019, we made history** when, with the support of members like you, our Pathway to Universal Health Care Bill (SB 5822) was passed by the State Senate, and funding to establish the Universal Health Care Work

Group was added by the House of Representatives. The Work Group has held two meetings so far, with 6 more to follow until mid-October of 2020. By November of 2020, the Work Group will present their recommendation for a universal healthcare system that will be considered in the 2021 Legislative Session.

**But HCFA-WA is not waiting** until then to lower health care costs for our state's residents. In the session interim, we've been working with legislators and staff to draft legislation for 2020 that, if passed into law, would lower prescription drug costs and improve drug affordability for Washington residents. We have heard far too many stories of people playing the dangerous game of healthcare roulette as they ration life-saving drugs like insulin due to its high cost. We can and we must pass this bill in 2020. At press time, the details of the bill were still being worked out, but we expect the finished product to be ready by mid-January. (See Policy Committee Report in this issue.) We will keep you informed via our website, e-bulletins, and Action Alerts.

## PLEASE JOIN US!

1. Attend the Universal Health Care Work Group meetings or watch them on TVW, and submit your comments, either at the meeting or online at the Work Group's webpage <https://www.hca.wa.gov/about-hca/healthier-washington/universal-health-care-work-group>. The Work Group needs to hear from you. The more stories they hear, the more ready they will be to take the action we need to ensure universal access to health care!
2. Ask your legislators to support and co-sponsor our bill to lower the cost of prescription drugs. Join us at the Capitol this winter to view and/or testify at the public hearings on the bill. Watch for our Action Alerts for up-to-the minute details on time and location.
3. Request a knowledgeable HCFA-WA speaker for your club or group as you build awareness of our winnable goals among your friends and family members.
4. Support our work with a meaningful donation. Your recurring monthly donation – in any amount – is a budget-friendly way to make a difference and sustain our work throughout the coming year: <https://www.healthcareforallwa.org/donations>

**THANK YOU FOR YOUR SUPPORT!**

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## Ten Health Care News Items of 2019

### The Commonwealth Fund 12/23/19

“2019 was a tumultuous year in the world of health care.”

1. **Federal court case on the future of the Affordable Care Act.** The Fifth Circuit Court of Appeals sent the case back to the District Court for further review, delaying the inevitable appeal to the Supreme Court. This leaves the fate of the ACA hanging, perhaps until 2021.

2. **Democratic presidential candidates all propose health reform options.** The plans vary widely, but all would expand the number of Americans with health insurance.

3. **Rise in uninsured. Initial gains in coverage under the ACA have stalled.** In 2018, about 30.4 million people were uninsured, compared to a low of 28.6 million in 2016.

4. **Changes to Medicaid.** States are still tinkering with their Medicaid programs. Arkansas’ work requirement caused at least 17,000 people to lose their Medicaid coverage. A federal judge halted that program. No other state has actually implemented a work requirement, although several are still trying.

5. **Public charge rule.** This rule, by the Trump administration, would label any legal immigrant who receives government assistance a “public charge” and thereby delay or prevent them from advancing to citizenship. The rule can be applied to immigrant parents if their US citizen children receive Medicaid, leading to a dramatic recent increase in the number of uninsured children in the US.

6. **Open enrollment numbers.** 2020 enrollment in health insurance through ACA exchanges is roughly equivalent to 2019.

7. **Outrage over surprise bills.** Although unexpected bills for out-of-network care are not new, their number is increasing, and the bills can be for tens of thousands of dollars. One cause is private equity firms buying specialty physician practices, especially emergency physicians and anesthesiologists, and relying on surprise bills to swell their revenues.

8. **Employer health care coverage becomes more expensive.** Roughly half the US population gets their health insurance through their employers. The cost passed on to employees in premium share and various cost-sharing provisions is rising faster than the US median income.

9. **Tech companies continue inroads into health care.** The management and use of health data can add value to medical services, but the privacy risk of data storage in tech giants’ clouds is serious. Debate: who owns and should control health data?

10. **House passes drug-cost legislation.** The US House of Representatives passed H.R. 3, which would require the government to negotiate the prices of as many as 250 prescription drugs in Medicare. It would also limit annual price hikes, and cap out-of-pocket drug costs for Medicare beneficiaries. The bill is unlikely to be passed in the Senate.

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## Policy Committee Report

*By Sarah K. Weinberg, MD & Elaine Cox, Co-Chairs*

We have been quite active in the months since our Health Care for All – Washington Board Retreat last May, working on getting legislation that would tackle the high cost of prescription drugs in our state. We decided to focus mainly on insulin, for several reasons: it's life-saving for those who are diabetic; pharmaceutical companies have been jacking up the price unreasonably; and the population that needs it is easily identified and is widespread across the state.

If all the insulin and ancillary medications and supplies could be paid for through a state-purchasing plan serving ALL diabetics residing in our state, that would be a real step toward true publicly funded universal health coverage. Our lobbyist, Cindi Laws, talked with several key legislators in Olympia, especially in the Senate, and found that they were already at work on several bills dealing with prescription drug costs.

As the year 2020 begins, there are five bills, all sponsored by Sen. Karen Keiser, that have been pre-filed for the legislative session beginning on January 13.

**SB 6113 Creating a central insulin purchasing program** This bill is the closest to our idea. It would create a large work group to design a purchasing strategy for the (already existing) Northwest Prescription Drug Consortium to act as a single purchaser of insulin for the state. The work group is to submit its report by 12/1/20. What happens after that depends a lot on what the report concludes. We will be advocating for some changes in the composition of the work group. For example, it currently does not include any patients with diabetes or any physicians with experience in treating diabetic patients, and does include multiple members from insurance companies and pharmacies. Watch for an announcement of a hearing on short notice!

**SB 6087 Imposing cost-sharing requirements for coverage of insulin products** The title of this bill is misleading. The main purpose of it is to limit cost-sharing for insulin to no more than \$100/month. It is intended as a bridge until the central insulin purchasing program can be implemented, whereupon it expires.

**SB 6088 Establishing a prescription drug affordability board** This bill would create a 5-member board of knowledgeable people without any ties to the pharmaceutical industry or benefits management. The board will be tasked with evaluating very expensive drugs and biologics, as well as any that have had their prices jacked up 200% or more recently. Much like the National Institute for Health and Care Excellence (NICE) in the United Kingdom, drugs and biologics chosen for evaluation will be assessed regarding their therapeutic value as compared to other possible treatments as well as cost. The focus will be on setting a maximum price for such drugs/biologics purchased by the state government for its covered population (like state employees, teachers, Medicaid, etc.).

**SB 6110 Importing prescription drugs from Canada** This bill would set up the Health Care Authority to become a licensed wholesaler (or contract with one) to purchase prescription drugs from Canada. Of course, such a program would require federal approval.

**SB 6111 Creating a pharmacy tourism program** (Reading this bill had us rolling on the floor with laughter!) This bill invites insurers to offer a program allowing enrollees to obtain prescription drugs at lower cost outside the US. Such a program must “contract with at least one clinic or pharmacy in a country bordering Washington.” It must also provide reimbursement for necessary transportation and lodging expenses for the participants. The goal is for insurers to encourage enrollees to travel to, um, Canada to save costs by lowering cost-sharing that would apply to purchases in the US.

On this happy note, the Policy Committee, and especially Cindi, will be busy in Olympia for the next month or so.

**Again – be prepared to drop everything to go down to Olympia if/when we have an important hearing!**

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## Coverage by 2020?

*Continued from p. 1*

and their views about how to improve it. An underlying motivation for finding out more from the public is the recognition that any proposed reform must be broadly accepted to be successfully implemented. The results were decidedly mixed.

**Values:** There was strong consensus on what people thought a health care system should do. 93-96% agreed that the system should treat everyone equally regardless of income or race, including almost 80% who view health care as a “right”, and therefore should be equally available regardless of ability to pay.

**Performance of current system:** 84% think the current system fails to treat everyone equally. 49% are unhappy with costs, especially those under age 65, middle income families, and the uninsured. About 25% are dissatisfied when trying to get medical care when it’s needed.

**Government involvement:** This is the area with mixed results. On the one hand, 80% like Medicare, and 61% believe that government regulations are needed to protect the public, but on the other hand 56% believe that something run by the government generally is not run well. Only 44% would prefer a system run mostly or all by the government, while 68% have a favorable view of ESI. Nevertheless, there is majority support for raising taxes on higher income people (59%), and 53% would personally be willing to pay more in taxes to achieve universal health coverage.

**Conclusions:** As the authors in the second article state: “How do we thread the needle on health reform?” Past experience suggests that new programs are greeted with doubt and caution, but gain acceptance eventually after they are implemented. For example, the ACA’s approval

has risen from 42% in 2014 to 53% now. Experience, as least in the three nations described, also suggests that multi-pronged systems can eventually be consolidated by the government into a more coherent, financially stable, whole.

This poll, showing strong egalitarian values and dissatisfaction with the current system’s failure to meet those values, nevertheless doesn’t point to a clear path forward. There is a lack of trust in the government’s ability to solve the problem, although there is general agreement that the government should make sure that everyone has good health coverage.

The final sentence in the second article is not one that those of us who have advocated for a single payer national health insurance plan for decades want to hear – but perhaps we must:

“New public policies that weave together and build on the complementary strengths of the public and private sectors may be especially well aligned with the nuances of American thinking about health care.”

Germany, the Netherlands, Canada, and others have achieved “Everybody In, Nobody Out”. Can we in the US get there by a similar route?

## Endnotes

1. Tikkanen, R. & Fowler, E., *Celebrating International Universal Health Coverage Day: How Three Countries Succeeded, One Step at a Time, in To the Point (The Commonwealth Fund)*, 12/12/19.

2. Schneider, MD, E. C., Shah, A., Lewis, C., & Seerval, S., *Health Care in America: The Values and Experiences That Could Shape Health Reform, The Commonwealth Fund, December, 2019.*

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## Health Care for All Spokane

*By DW Clark, Board Member*

Cris Currie, RN went to Walla Walla early in December for showing of “Fix It” at a Meaningful Movies event at the First Congregational Church there. About 40 people were in attendance, and there was a lively question-and-answer session afterward. Eighteen people signed the HCFA-WA sheet for more information.

## Outreach Committee Report

By Erica Grall-Nealious & Ronnie Shure, Co-Chairs

### MAKE A NEW YEAR'S RESOLUTION FOR 2020

Join one of our Zoom meetings on January 22nd, 23rd, or 25th

Maya Angelou gave us the best New Year's resolution when she said "If you don't like something, change it." We are learning that nobody likes being controlled by their health-care insurance. Let's add to the second part of her quotation to say "If you can't change it immediately, help the community change their frustration into action steps to provide health-care coverage for everybody in our community." Let us move the action forward by keeping involved. Everybody in! Nobody out!

Please join us for an on-line Zoom meeting to hear updates of health-care legislation and the next steps that are needed to forward the action in this short, 60-day legislative session. Our lobbyist, Cindi Laws, has been working closely with legislators who will be proposing bills in 2020. You can meet the HCFA-WA teams on-line --- our Outreach Committee, our Policy Team, our Lobbying Team, and many of our Board members. You can also meet other health-care advocates from across Washington state. We will present the updates at 3 different times, so that you can join us at the most convenient time for you.

- Wednesday evening, January 22, 2020, 7:30-8:30 pm, or
- Thursday afternoon, January 23, 2020, 3:30-4:30 pm, or
- Saturday morning, January 25, 2020, 11:00 am – 12:00 noon

We will give a short presentation and give you plenty of time to ask questions through the

Chat line. Please choose a meeting using the computer links or telephone numbers below (or check our e-Bulletin or website [www.healthcareforallwa.org](http://www.healthcareforallwa.org) .

**Time: Jan 22, 2020  
07:30 PM Pacific Time (US and Canada)**

**Join Zoom Meeting**  
<https://zoom.us/j/728892923>

**Meeting ID: 728 892 923**

**Time: Jan 23, 2020  
03:30 PM Pacific Time (US and Canada)**

**Join Zoom Meeting**  
<https://zoom.us/j/993575356>

**Meeting ID: 993 575 356**

**Time: Jan 25, 2020  
11:00 AM Pacific Time (US and Canada)**

**Join Zoom Meeting**  
<https://zoom.us/j/407310029>

**Meeting ID: 407 310 029**

If you prefer to use your phone:  
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**Pharmacies, Insurers, Venture Capitalists... Primary Care Clinics?**

*By Sarah K. Weinberg, MD, Editor*

An end-of-the-year article in Market Watch described the moves by some pharmacy chains, insurers, and even a venture capital firm to open medical clinics, especially close to pharmacies. Similar to the Zoom clinics that opened in Portland and now Seattle, these clinics function as primary care facilities in the sense that they encourage people to walk in off the street for convenient treatment – a front door to health care.

The focus of these clinics is making money. In the case of insurer-owned facilities, the goal is to keep costs down by minimizing the use of specialists or hospitals. In the case of pharmacy-owned facilities, the goal is to generate prescriptions to be filled in the nearby pharmacy. In the case of venture capitalists, the goal is allow primary care providers to attract patients with good insurance or cash and minimize administration costs by owning dozens of clinics.

There are now hundreds of these clinics in the US, and many more are expected to open in 2020. Don't expect

to see an actual physician (MD or DO) in these clinics, unless the PA or RN or pharmacist is concerned. The physician's name will be on the prescription, however! Continuity of care? Forget that!  
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**Richard McMaster, business owner & supporter of single payer, speaking at Single Payer Strategy Conference in Portland, Oct. 18, 2019**

# Health Care for All-Washington

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## **Canadian Government Works to Control Prescription Drug Prices**

*By Sarah K. Weinberg, MD, Editor*

In 1987, Canada set up the Patented Medicine Prices Review Board (PMPRB), using a “basket” of prices in other nations to establish reasonable prices in Canadian pharmacies. The system has not been successful in that Canadians rank third among developed nations, and pay an average of 25% more than the average of these nations. In addition, the government is designing a national drug coverage benefit, National Pharmacare, and needs to get better control of prices to make this benefit affordable.

In August, 2019, significant changes were made to the Patented Medicines Regulations to help PMPRB bring prices down, both to help Canadians now, and to prepare for National Pharmacare in the future. The changes:

- Removed the U.S. & Switzerland, the two nations with the highest prices and less consolidated health care systems, from the “basket” of other nations’ prices.
- PMPRB will use actual market prices, not inflated “sticker” prices.
- PMPRB will evaluate whether the price of the drug reflects its value for patients.

These changes alone are expected to save Canadians CAD 13.2 billion over 10 years. If a given drug is determined by PMPRB to be priced excessively high, the Board can demand that the patent holder reduce the price at which the drug is sold.

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