The COVID-19 Pandemic Starkly Illustrates Why the US Needs Medicare for All

By Sarah K. Weinberg, MD, Editor

This illness, and the virus that causes it, has spread over the entire planet. Despite spending twice as much on health care as other developed countries, the U.S. has had difficulty mounting a mobilizing response appropriate both in speed and in resources. As long-time advocates for a national, publicly funded health care system, two aspects of the U.S. situation come first to mind.

Lack of any control over how health care is delivered and paid for

Without a national system, our government has no way to coordinate the myriad providers of health care across the nation. Some are public, but many are private, both non-profit and very much for-profit. Payment for health care is a tangled mess of tax-funded programs (federal, state, and mixed), private insurers (also with mixed private and tax-funded sources), and a large component of out-of-pocket payments by the sick, whether they can afford it or not. A large number of U.S. residents avoid seeking health care, even when it’s obviously needed, out of fear of the resulting bills – or even damage to their prospects of becoming citizens some day. U.S. residents are also victimized by a near-total lack of price controls, leading to some spectacular price-gouging by drug companies, hospitals, and even some physicians.

Lack of a national public health system

At best, some states exert some overarching control and funding to support more local public health departments. Underfunding is rampant, leaving cities, counties, and states unable to ramp up the personnel and supplies needed for an appropriate response to a pandemic emergency. Locally, our state drew negative national attention when a for-profit nursing home failed to respond promptly to a respiratory disease cluster that turned out to be COVID-19. The incident also revealed lax oversight by the health department charged with assuring competence in nursing home management.

Then there is the inexcusable dismantling by the Trump administration of a federal office in charge of pandemic anticipation and preparedness.

What can we do?

First, each of us can do what we can to help our families and communities deal with the ongoing pandemic: obey shelter-in-
From the President’s Desk

by Marcia Stedman, President

The Rev. Dr. Martin Luther King spoke of “the fierce urgency of now” 57 years ago at the March on Washington for Jobs and Freedom. Now, the fierce urgency brought by the coronavirus pandemic has gripped the entire world. Will the current crisis convince the United States to take action and implement a more equitable model of health care delivery?

The public financing of COVID-19 testing and in some cases, treatment, offers a glimmer of hope.

But, with so many other urgent needs, why should we continue to work toward equity in health care, and why at the state level, when the national need is so great? Here are three reasons.

1. **The primacy of public health.** All around us, many urgent needs are being met with public assistance at an unprecedented level: publicly-funded payments to businesses and individuals in the hope of keeping them afloat; publicly-subsidized housing in now-empty hotel rooms for homeless populations whose past housing options have been sorely inadequate; and public funding for food banks previously supported by private donations. These emergency measures, some at a national level and others at a state level, are needed now in order to safeguard our public health.

2. **States have been at the forefront of innovation** when it comes to policy reform. Recently, we have seen Washington state’s leadership in marriage equality and increasing the minimum wage to $15 per hour, measures which have been replicated in other states and/or federally. This year, Washington passed a law that caps the total out-of-pocket cost for a 30-day supply of insulin at $100 for two years, and establishes the Total Cost of Insulin Work Group which is charged with designing a state-administered drug purchasing entity. We were very encouraged that the bill, prime-sponsored by GOP Rep. Jacqueline Maycumber, had overwhelming bipartisan support, passing 97-1 in the House, and 48-0 with 1 excused in the Senate.

3. As the saying goes, when you have your health, you have everything. Here again, Dr. King said it so well: “**Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.**”

In the time of coronavirus, the fierce urgency of now demands that we take care of each other, because the health of our entire society depends on the health of each one of us. Health is at the heart of all we do. Simply put, it’s the principle of **Everybody In, Nobody Out!**

On behalf of all of us at HCFA-WA, we wish you and your loved ones good health and good cheer in the days and weeks to come, as we look forward to your continued support of our mission: ensuring that health care is available and accessible for all of us here in Washington.

###
Lots to report for the first quarter of 2020!

**Legislative recap and lessons learned**

Three of our core four bills passed, and the main parts of the one that didn’t were included in one that did:

- **HB 2662**, including much of SB 6113, will set up a Total Cost of Insulin Work Group, caps monthly out-of-pocket (OOP) cost for insulin, and allows the Health Care Authority to come up with a scheme for state purchase of insulin for all residents. It was signed by Gov. Inslee just a few days ago.
- **SB 6087** caps the out of pocket cost of insulin at $100/month through 2022. The sunset clause anticipates more long-term action (through HB 2662, for example) by then.
- **SB 6088** passed, but vetoed by Gov. Inslee due to emergency budget restraints, would have established a “prescription drug affordability board”. Although initially aimed only at very expensive drugs, this board would be a step toward more expansive oversight of drug prices as the rest of the developed world already has done.

Three other bills of significance are now law:

- **HB 2457** establishes a Health Care Cost Transparency Board to calculate the total expenditure for health care in our state each year, and set benchmarks for future increases.
- **HB 1608** prohibits any entity from muzzling health professionals from giving complete information. This mostly has to do with stopping religious entities (predominantly Catholic) from ordering their staffs not to offer information on abortions and other medical options that runs counter to Catholic doctrine.
- **HB 2464** limits how much out of pocket can be required at point of sale for prescription drugs. Patients can’t be charged more than the cost of the drug as a “co-payment”, and insurers can’t require the use of a more expensive brand name drug if a cheaper generic is available.

Lessons learned while we had such success:

- Legislators appreciated our “one-pager” information sheets with citations, on why we supported these bills. This approach increased our reputation with legislators.
- We picked good bills to back, at the right time.

Where possible, we worked with legislators from both parties. Even small bipartisan support helped bills gain momentum.

There were some humorous moments, especially when a representative from Canada came all the way from Ottawa to point out that Canadians would not appreciate a US state raiding Canada’s drug supply. He pointed out that Canada has only a tenth of the population that the US does.

Another bill that generated guffaws at the Senate health care committee hearing was the one, called the “medical tourism bill”, that would have set up an insurance company-sponsored scheme for enrollees to travel to BC to buy drugs – all expenses paid!

**After breaking out the champagne, what next?**

The Policy Committee has been mulling over ideas for 2021:

- Another try at the prescription drug affordability board. Maybe by next year the budget will be in better shape.
- Expanding primary care. There was a bill, SB 6413, to develop ways to increase spending on primary care. The bill went nowhere, but it did have a hearing in the Senate. Maybe the experience with COVID-19 could add momentum to the idea of state funding for all primary care. After all, we know that investment in primary care improves outcomes population-wide, and reduces total cost of care.
- Follow-up on bills enacted in 2020. Make sure the state government follows through on work groups and boards in the new laws.
- Global budgeting for hospitals. Apparently Maryland is doing something along these lines, but they already have a system in which all payers pay the same rates for care.
- Add other drugs to the insulin model.
- Shoring up the ACA at the state level. Watch for recommendations to come from the Cascade Care committee set up in 2019.
- Support the Universal Health Care Work Group. Work has stalled due to the COVID-19 pandemic. It is difficult to get the management outfit hired by the Health Care Authority to run the Work Group to think outside the box. Also, any plan(s) chosen by the group need BOTH actuarial analysis AND financing mechanism possibilities.

Despite being housebound, it’s a busy time!

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By Elaine Cox, & Sarah K. Weinberg, Co-Chairs
After a relatively quiet fundraising interlude as we at HCFA-WA focused on our legislative efforts, fundraising has again become a priority for our organization. Funds are needed to support and expand our paid staff, allow us to do more education and outreach, and to maintain our day-to-day operations. We plan to build upon the great successes we had in the 2020 legislative session by shaping policy and legislation in upcoming sessions in Olympia, foremost being our single-payer health coverage proposal, the Washington Health Security Trust. Our passionate and effective lobbyist, Cindi Laws, is now working very closely with the fundraising committee to develop strategies and methods to raise significant donations from members and other individuals as well as unions and foundations. We very much encourage you to support us financially so we can achieve our goal of universal, publicly-funded health coverage for all Washington residents. In this time of the COVID-19 pandemic, that is needed more than ever. Expect to hear directly from us soon!

Fundraising Committee Report

By Peter Lucas, MD, Co-Chair

Now’s the time ! ! !

The COVID-19 is a deafening wake-up call to the inadequacy of health care availability and access in America, and the neglect of our public health system. There are major deficiencies in our public health system, and huge barriers to health care for individuals.

“More than two-thirds of respondents (68%) said that potential out-of-pocket costs would be very or somewhat important in their decision to seek care if they had symptoms of the coronavirus.” NBC News/Commonwealth Fund Health Care Poll, March 20, 2020.

When profits come first, the health system’s needs take a back seat. Health Care for All – Washington has long advocated for universal access and coverage of health care. Our mission is high quality, sustainable, affordable, publicly finances, privately delivered health coverage for all Washington residents.

The best way to protect each other in a pandemic is to ensure that everyone can get health care when they need it. Strong and committed financial support is crucial to our mission.

Join us today with a CONTRIBUTION that demonstrates the value you place on achieving universal health coverage in our state.

Everybody in, nobody out ! ! !
COVID-19  
Continued from p. 1
place restrictions, wear masks when out of the house, help neighbors who are in more fragile health with things like grocery shopping, seek testing if symptomatic, but only go to the hospital if short of breath…. Then, we can raise our voices about the need for a national, publicly funded health care system in two ways’
1. Call for immediate government coverage for every resident who needs medical care related to COVID-19
2. Call for support for enacting and implementing a plan to move to a true national health coverage system over the next few years (“few” meaning less than 5 years) that will include every man, woman, and child living in the U.S. “Medicare for All” is a handy slogan, but a true universal plan needs to be more complete than Medicare and with better funding.

Let this crisis be a wake-up call for all of us: EVERYBODY IN, NOBODY OUT!

Report form Eastern Washington

By Chris Currie, RN

Two items from the 4/6/20 Spokesman-Review:

A local columnist Shawn Vestal had two full pages describing how he thought life after the virus might look. For example, he stated that “there may be a rethinking of relationship between the individual and government on matters of health care.” He also quoted Larry Cebula, a professor of history at Eastern Washington University, “as millions lose their jobs, they are also losing health care coverage – which is likely to put more wind in the sails of proposals such as ‘Medicare for All’.”

https://www.spokesman.com/stories/2020/apr/05/shawn-vestal-will-anything-ever-be-the-same-again/

Rural hospitals are being slammed again. The Pullman Regional Hospital announced that it is cutting all hourly and salary employees’ pay by 25% for the next 60 days. The hospital does not qualify for government assistance through the CARES Act nor through the state. Its only option is to rely on short term loans and donations. If Medicare for All were in place, this would not be happening.


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I visited Taiwan in 2011, about 15 years after that nation implemented a national health system (NHI) similar to Canada and U.S. Medicare. The transition apparently went smoothly, although about 10 years in it became necessary to raise the payroll tax a couple of percentage points. How has Taiwan’s health system handled the new coronavirus threat?

**Preparation for future epidemics**

Taiwan reacted after the 2003 SARS epidemic by setting up a governmental structure to swing into action if/when another disaster or epidemic came along. Some of the things they used would be unlikely to be accepted by Americans:

- Established a National Health Command Center (NHCC) with several subunits, including a Central Epidemic Command Center (NECC)
- Set up a mechanism to integrate health information in the NHI’s database with immigration and customs information from people entering the country’s ports or airports.

**First word of the coming epidemic**

Using this structure, when the Taiwan government heard on 12/31/19 the World Health Organization (WHO) announce the Wuhan outbreak of pneumonia of unknown cause, they immediately sent officials to board planes coming in from Wuhan and check all passengers for symptoms before de-planing and going through immigration and customs. By 1/5/20, the checks were expanded to anyone who had been to Wuhan in the previous 14 days. On 1/20/20 the NECC was activated.

Now officials were able to control the border, identify cases using integrated data, quarantine appropriate people, proactively search for cases. This data integration allowed officials to send an alert to a provider during a medical visit to consider COVID-19 if the person was considered at risk. (No HIPAA in Taiwan!) They were now authorized to allocate resources, issue reassurance and education information, and negotiate with other countries. As a result, there were only 10 cases of COVID-19 documented as of 2/24/20. This was a great success in a nation of 23 million citizens, of whom over a million live and work regularly inside China, with a great deal of travel between the two.

Three months later

This article so far is based on a report in the Journal of the American Medical Association, published on 2/24/20. But then something must have changed. I found information as of 4/6/20 that Taiwan now has 373 cases and 5 deaths. Their curve looks a lot like other nations throughout the world, with a sharp increase starting around 3/14/20. That said, their rate of 16.2/million is well below others (the U.S. is at 1,111/million, for example).

Note: I have not been able to find an explanation, but I did send an email to the author of the JAMA article asking if he knew anything. I have not heard back from him at this time.

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Bits and Pieces

Americans Borrowed $88 Billion to Pay for Health Care Last Year, Survey Finds

Americans borrowed an estimated $88 billion over the last year to pay for health care, according to a survey released on Tuesday by Gallup and the nonprofit West Health.

The survey also found that one in four Americans have skipped treatment because of the cost, and that nearly half fear bankruptcy in the event of a health emergency.

There was a partisan divide when respondents were asked whether they believed that the American health care system is among the best in the world: Among Republicans, 67 percent of respondents said they believed so; that number was 38 percent among Democrats.

Employer-Sponsored Family Health Premiums Eat Up Almost a Third of Household Income
https://gritpost.com/employer-sponsored-premiums-income/

For many workers, one benefit offered is health insurance for the worker, paid by the company, with the option to extend coverage to a worker’s family for a monthly premium. This is the most common form of health insurance in the U.S., according to a study from the University of Pennsylvania’s Leonard Davis Institute of Health Economics and United States of Care. That study also shows the premium for family insurance is sometimes one of the biggest sucks on a family’s household income.

In all 50 states, the premium on employer-sponsored health insurance is never less than 24.4% of a family’s household income (Minnesota), and goes as high as 37.1%

Continued on p 8
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Bits and Pieces

Continued from p. 7

(Louisiana). On average, the family premium comes out to around 30% of an employee’s check. This is likely due to the fact that the increase in employer-sponsored health premiums outpaced income growth in 46 states.

“In 2016, the national health care cost burden was 30%, representing average premiums of $17,710 and median income of $59,039,” the study read. “Between 2010 and 2016, the average health care cost burden increased from 28% to 30% nationally, with premiums growing faster than incomes (27.7% vs 19.8%). The burden increased in all but four states, including the District of Columbia.”

With family premiums taking up an average of 30% of monthly household income, that would make health insurance premiums just about as expensive as rent. The U.S. Department of Housing and Urban Development states that for a renter to be considered “rent-burdened,” he or she would have to pay more than 30% of their income in rent. This means most Americans are, on average, paying as much for employer-sponsored healthcare as rent-burdened tenants.

Single mother goes from traffic stop to bench warrant to jail over unpaid medical bill: 'It just isn't right'


“I have no felonies or anything on my record,” she recalled. “I didn’t know what was going on.”

The officer returned to her minivan and asked her step out of it. Why? There was a warrant for her arrest, she was told. It’s from a civil case in 2014 when she failed to appear in court for an unpaid ambulance bill.

“Sorry ma’am,” the officer replied.

Latronica was handcuffed behind her vehicle, which was impounded.  

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