



Health Care for All-Washington Newsletter

An Information Pipeline for Members and Friends of Health Care for All-Washington

Winter 2018

Social Determinants of Health

by Sarah K. Weinberg, MD, Editor

Gradually, over the past few years, there has been increasing recognition in the world of health care that other aspects of patients' lives are important, sometimes even more important than the care provided directly by health care providers. Much of this issue of the HCFA-WA Newsletter is devoted to this concept.

The term "social determinants of health" was first used by Sir Michael Marmot, a British epidemiologist, in the 1970s. In 2014 he wrote: "Every sector is a health sector. A toxic combination of unfair economic arrangements, poor social qualities and programs and bad governments, are responsible for these inequities in daily life which give rise to avoidable health differences. If we put fairness to the fore, it would reduce variable health inequalities. At the heart of this concern is one of social justice, but evidence really matters."

Summaries of articles follow, touching on these issues along with efforts in cooperation among health care providers and various providers of social services and support.

Cuban medical school trains students in community settings
(see article by Dr. David McLanahan elsewhere in this issue)

Experience of an American living in Sweden – Excerpts from an article that appeared in *Daily Kos* (12/22/17) by Jen Hayden quoting a series of tweets from Allison Gerber:

"Here's what it's like to live in a country with a high effective tax rate and a commitment to spending for the common good. I don't worry that a minor accident, illness, or other bump in the road will derail my family's future or mean that we lose everything. We have excellent health care and social insurance, and the state steps up when we are in a crisis. It's not perfect, of course. There are emergency room wait times and such, just like everywhere else.

"But, for example, I broke the crap out of my foot a while back, in a pretty awful accident involving a zipline. The local hospital in Malmö took a couple of hours to get me through intake, doctors, x-rays, and diagnosis. They sent me home with a soft cast, and instructions to come back in two weeks or so for a hard cast.

"The next day two handsome gentlemen showed up at my apartment. They were from the city's "Hjälpmedel" office, which I hadn't known existed. They take responsibility for providing resources to people with permanent or temporary disabilities....

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



**Health Care is a
Human Right**

Health Care for All-WA Newsletter

Winter 2018

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From the President's Desk

by Marcia Stedman, President.

Annual Meeting Wrap-up

The 2017 HCFA-WA Annual Meeting was a huge success on all counts. We had an opportunity to meet our three new Field Directors, who were introduced by our Program Director, Bevin McLeod. We are thrilled to welcome to our team Carmen Méndez of Yakima, Jessa Lewis of Spokane, and Dale Porter who is organizing voters in southwest Washington. Carmen delivered the keynote address, and provided a view of what we can do to diversify our message. Thanks to the excellent work of Jessa and Bevin, we were able to secure funding pledges at twice the level of last year's Annual Meeting. Of course, the few words spoken by our major donors, Floyd Jones and Alene Moris, might have had something to do with that as well. If you missed the meeting, but want to donate, you can do so easily from the "donate" section of our website: www.healthcareforallwa.org.

During the Turn and Talk segment of the meeting, we met in small groups. As the groups reported back, we heard some exciting and interesting ideas from our state-wide affiliates. My personal favorite, just in time for our rainy season, was the "Everybody In! Nobody Out!" umbrella idea. (These should sell well in all of western Washington!) Overall, the Turn and Talk period received rave reviews, but we also received some good suggestions for making this part of the meeting even better next year. Thanks to everyone who returned their evaluations!

During the business meeting, the membership elected two new Directors of the Board: DW Clark of Spokane and Kelly Powers of Seattle. Kelly was also elected Vice President of the Board. Congratulations to all new and continuing Board members and officers!

We were pleased and honored that Rep. Nicole Macri (D-43) was able to attend. She spoke about her support for the WHST bill and its prospects for a hearing in the House Health Care and Wellness Committee in 2018, which, by the way, look very good. We have also been in conversation with Sen. David Frockt, the prime sponsor of SB 5701, who has indicated he is actively seeking a hearing for the Senate version of the WHST bill before the Senate Health Care Committee in the 2018 session. Stay tuned for developments as the 2018 Legislative Session begins on Tuesday, January 9.

###

Outreach Committee Report

By Ruth Knagenhjelm and Kim Abbey, Outreach Committee members

Outreach activities have increased in many parts of the State in the 4th Quarter of 2017. We even surpassed the Board's goals for 2016-17! During this fall, together with the Legislative Committee, we focused on giving presentations especially in targeted Democratic legislative district organizations where their legislators are on health committees. The hope is to put pressure on legislators to get our bills through committees and up for a vote. Also, we had invitations from many other legislative districts.. We had presentations in the following districts:

September 28th, LDs 23 and 26, at Tacoma's Grand Theater. HCFA WA speakers Peter Lucas and Ken Faber joined with Meaningful Movies to show the film 'Fix It: Healthcare at the Tipping Point' About 20 people joined Board members for the after-movie discussion.

October 2nd, HCFA-WA President Marcia Stedman met with North Seattle Indivisible at their regular house meeting, engaged that group in the campaign to achieve success for Single Payer in our State.

Oct. 14, Presentation to LD 49 Democrats organization in Vancouver, WA.

October 17th, LD 43 invited Ronnie Shure to a lively Panel Discussion with five other participants: 43rd District State Representative, Nicole Macri; Whole Washington, Georgia Davenport; United for Single Payer, Jim Squire; PNHPWW, David McLanahan; Indivisible North Seattle, Jessica Goldman. If you have not yet seen it, we strongly encourage our members to watch a video of that Panel at <https://www.youtube.com/watch?v=dPIJtXqIAuc> The enthusiasm for Single Payer is very clear!

October 28th, LD 33 and 34, Burien branch of King Co. Library. Ruth Knagenhjelm facilitated an Action Workshop.

November 12th. Port Gamble, the "Fix It" film was shown, again with Meaningful Movies co-sponsoring.

November 15th, 5th LD, where all 3 legislators sit on the health committees. Marcia Stedman gave a presentation on the bill.

December 16th, our speaker Peter Lucas presented at the monthly meeting of the West Side Democratic Socialists of America.

We are working with other allied progressive groups to send us requests to the Outreach Committee for more presentations as well. At every presentation more supporters "sign the clipboard" and the database for the campaign grows.

If you know of a group or a theater that is a member of Meaningful Movies in your area, please contact HCFA-WA on our website. We always welcome your ideas for opportunities for presentations on our WHST bill.

HCFA-WA's new Media/Marketing intern, Sydnie Jones, will now help us use our Facebook page and Twitter accounts, as well as email to our database of supporters and members in those LDs, to invite people to these events. You have possibly already noticed that a 'blitz' of Mobilization/Action workshops is showing up in all of HCFA-WA's media methods. There are seven events, all on the same day, January 6, 2018, covering 17 LDs in various parts of the state. These Mobilization events now have a program and script that can be replicated by all members and supporters at house parties, faith-based groups, clubs, and business events. Our Board members are available to train, mentor, and coach any supporters who hope to bring their efforts to this campaign to enact the WHST into law. "

###

Legislative Action Committee

by Ronnie Shure and Kelloy Powers, Legislative Co-Chairs

We are moving into the short 2018 Legislative Session, and we are paraphrasing the words of Patrick Henry --- "I know not what course others may take; but as for me, give me hearings in the Senate and House in order to forward the action on the Washington Health Security Trust to provide health care for every person in our state." Although we do not echo his cry for "liberty or death," we do cry out for a health care system that can save lives for everyone. Now is the time for hearings by the Health Care Committees in both chambers of the Washington state legislature. Now is the time to work closely with legislators and health care authorities in Washington state to provide health care equity for everyone. Now is the time to improve our bill for final approval.

We have set up action team meetings on January 6th in Legislative Districts that have a member on the Health Care Committees. If you were able to join us to review the steps needed for the 2018 Legislative Session, we appreciate your actions. If you were not in a Legislative District that held an action team meeting, there is still a lot that you can do. During the past few months, our Program Director and Field Directors have provided information about health care for all to each Republican and Democratic legislator.

- You can build on that basic information by giving your personal stories and by directly asking your legislators to support our bill. Contact me at action@healthcareforallWA.org if you set up a small group meeting with other members.

- You can check our website closely during this short Legislative Session for announcements of hearings. Watch for last minute alerts! If we paraphrase the words of the American Revolution in this case, you will see one light for hearings in the Senate and two lights for hearings in the House.

- You can tell your friends and neighbors to check our website for announcements of hearings. While they are on our website, you can suggest that they read some of our general Resources or watch some of the short Videos that explain health care for all.

On the national level, Congress and the Executive Branch are still trying to cut the advances in health care for all, even though the public has spoken out against these cuts. Health Care for All – Washington is working closely with national leaders and organizations to provide universal coverage. We are working closely with our single payer allies in other states to work on similar legislation for health care for all across the country. We are working closely with allies here in our state to preserve recent advances in health care reform. You can find these national and state organizations among the Resources on our website. Now is the time to support our national leaders and allies who are calling for Medicare for All and American Health Security.

Now is the time to say Everybody In! Nobody Out!

###

NEW! Communications/Marketing Team

By DW Clark and Jessa Lewis, Co-Chairs

Mission: To help brand and create awareness of HCFA-WA and its mission in order to achieve 100% health care coverage for all Washingtonians through legislative or initiative success by 2020.

Methods: In addition to social media outreach, we will focus on feeding the media with newsworthy information via press releases, phone calls, letters to editors, articles in magazines, and especially earned media through creative and innovative means.

Plans are being made for an event in the downtown Spokane library on January 6, mirroring the events planned west of the mountains. Let's hope for a good turnout!

Questions? Comments? Want to get involved? Contact us: communications@healthcareforallwa.org

2017 New and Renewing Members

October-December 2017

New

Matt Baney
Brandon Bee
Dale Clark
Hugh Clark
Sophia Danenberg
Georgia Davenport
Thea DeYoung
Noel Frame
Nicole Gomez
Marilyn Gray
Marlene Hache
Peter Harrison
Frank Johnson
Robert Kenny
Julie Koch-Michael
Ivan Lewis
Nicole Macri
Fernando Mejia-Ledesma
Beth Nichols
Wendy Noble
Claire Robson
Bernadette Sarszak
David Scott
David Simpson
Summer Stinson

Renewing

Kim Abbey
Richard Bard
Winifred Becker
Elizabeth Blakney
Jessica Bonebright
Ann Brand
Barbara Clark
Christine Clark
Nancy Corr
Susan Eidenschink
Jeannie Ernst
Ken Fabert
Robert Fithian
Judith & Richard Gammon
Alan Greenbaum

Renewing

Marjorie Gillespy
Richard Glass
Marjorie Gray
Deborah Hammond
Carol Hannum
Lisa Henning
Dana Iorio
Helen & Norbert John
Sara Johnson
Floyd Jones
Ron Kaplan
Martha Koester
Ellen Kritzman
Henry Kuharic
Dana Lawrence
Joan Lawson
David Loud
Pamela McDonald
Bevin McLeod
David Merz
Don & Pamela Mitchell
Paul Oldenkamp
Howard Pellett
Judith Perala
Ellen Pierce
Paul & Mary Margaret Pruitt
Chuck S. Richards
Nancy Robinson
Ron Robinson
Belle Shalom
Sue Shaw
Susie Sinclair
Donna Starr
Marcia Stedman
Lounette Templeton
Lynnette Vehrs
Mary Wallon
Charles Weems
John Wolfe
Leslie Zukor

Reinsurance: A Possible ACA Improvement?

By Sarah K. Weinberg, MD, Editor

One idea being floated by some in Congress is reinsurance, otherwise known as stop-loss insurance. The thought is that some form of reinsurance could help to stabilize health insurance premiums by making insurers' costs more predictable. This idea has attracted some support in both parties, and one version of it is in a bill sponsored by Sen. Susan Collins (R-ME) and Bill Nelson (D-FL), S.1835 Lower Premiums Through Reinsurance Act of 2017.

Currently health insurers buy reinsurance on the private market, and it is very expensive and heavily underwritten – which means that the insurance companies selling stop-loss coverage to health insurers often refuse to sell, or charge exorbitant premium, to companies known to have high-cost patients. Administrative costs are high: these plans keep about 23% of their premiums for administration and profits. Some states have public reinsurance programs. These plans are highly variable regarding eligibility rules, payment methods, and financing. The Collins-Nelson bill would provide some federal “seed money” to help states.

A different proposal, put forward in the *Health Affairs* Blog (12/11/17), would be to set up a public national reinsurance program for all private health insurance plans that include key consumer protections. It would set up a per-enrollee medical expense cut-off, say \$500,000. Any insurance company spending more than that for a given patient would be eligible for a percentage reimbursement from the program. Aside from undermining or eliminating the private reinsurance market in health insurance, a national program could set some rules to help control costs, like

assuming Medicare payment rates (or other fixed rates for non-Medicare services), and requiring plans to use evidence-based care management for the patients.

Such a national plan could be paid for through taxes on health insurance plans – perhaps a reformed version of the continually postponed “Cadillac tax” on high-cost policies. By blending the individual market with employer-sponsored insurance, there would be a much broader base to spread the risk, leading to lower premiums.

Arguments against this idea include: dislike of government involvement when there is private reinsurance available; objections by providers who don't like expanding the use of Medicare rates; and single payer advocates who object to keeping private plans at all.

“This meant that they installed a seat in my shower and fitted me out with a wheelchair.... They gave me a crazy grabber stick thing so I could get things from the comfort of my sofa.... All of this was free. They gave me their numbers so I could call if I needed anything else.

“I fooled myself into thinking I was fine to work from home for a couple of days before I realized that the painkillers I was taking were not exactly helping me to do my best work. I called the HR person at my job, and she walked me through how to call out sick (after scolding me for not calling earlier, and for trying to work, which she found ridiculous). I was unpaid for one mysterious “karensdag”, then received the standard 80% of my salary as long as I was out sick – plus a bump up to 90% since I was employed by the state.”

Later, Allison got the hard cast for a while, then went to physical therapy for quite a while. There were some small co-pays along the way, but after \$130 total she got a “free card” for the rest of the year. About a year after the accident, she received \$1,000 from the zipline’s insurance company, as a result of a form the zipline people filled out at the time of the accident. This was intended to cover any incidental expenses – like new shoes with better support and a few taxi rides.

Parkland Center for Clinical Innovation (PCCI) – (From an article by Arthur Allen in *Politico*, 12/18/17) Parkland Hospital in Dallas, TX has a big problem with “frequent flyers”, patients who come to the hospital multiple times each month. These people are nearly all uninsured, mostly homeless, and/or chronically ill. Many of their ER visits could be easily prevented with regular medical care, or housing, or decent food. Over half of the hospital’s budget was spent on uncompensated care.

In 2015, Parkland started PCCI as a joint effort with community services such as homeless shelters and food banks. This grew to a large network of nearly 100 community-based social services around Dallas County, complete with a sophisticated computer system to help with linking patients with a needed service that was available.

The hope is that by the end of 2018 there will be 300 community organizations connected with the network, even expanding it to include the school system, city jail, and the fire department, most of whose calls are health-related.

Says social worker Sheryl Abraham: “We need to have one plan for the patient. When all community organizations and hospitals communicate, we can have one plan, and the entire community can link arms through this technology to quickly facilitate that need for this patient, and something that takes six months to

do we can do in one month, and have a better outcome.”

It has only been two years, but evidence so far shows that PCCI’s network is working. The number of hospital visits by “frequent flyers” has dropped substantially, in some cases by two-thirds or more.

Veterans Administration medical-legal partnerships

– Medical-legal partnerships have been formed at several VA hospitals. This article from *Health Affairs* (12/17 issue) focused on results in four hospitals in Connecticut and New York from 2014-16. They served 950 veterans, handling 1,384 legal issues, averaging 5.4 hours of legal work each. The main issues were: VA benefits, housing, family issues, and consumer issues. They looked specifically at a sample of 148 veterans followed over one year, and found substantial improvement in housing, income, and mental health. Those who received the most services had the most improvement, especially if pre-determined legal goals were met. The conclusion was that medical-legal partnerships within the VA system show real promise in addressing social determinants of mental health.

Health and community consequences of closure of rural hospitals – (from an article by Taylor Blatchford in the *Columbia Missourian* 12/20/17) In Missouri, 43 of 101 rural counties have no hospitals. An additional 26 rural hospitals do not have dedicated obstetric beds. These areas have much higher than average maternal death rates.

(From an article by Tom Crawford in the *Gainesville Times*, 12/20/17) In Georgia, rural hospitals are closing for financial reasons (at least six since 2013), a consequence that might have been avoided had Georgia elected to expand Medicaid under the ACA. Meanwhile, some state legislators formed a Rural Development Council to figure out ways to reverse the flow of people and businesses from rural areas into cities. Their recommendations: tax breaks for those who move to rural areas, subsidies to bring broadband internet capabilities to rural areas, and state aid in recruiting businesses to rural areas. All worthwhile goals.

Reality check: How many companies are going to move to an area with no hospitals – and thus poor access to medical care? By refusing to expand Medicaid, Georgia didn’t receive about \$9 billion in federal matching funds over three years, much of which would have flowed to health professionals and hospitals in rural areas.

Medical care for incarcerated prisoners—(From *Health Affairs* Blog 12/21/17) The 2.17 million Americans in US prisons have disproportionately high rates of chronic disease, infectious disease, substance use disorder, dental disease, and serious

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Social determinants of health ‘ *Continued from p 6*

mental illness. Yet, US prisoners have a constitutional right to medical care. In an effort to train future health professionals to meet the needs of this population, several institutions in Boston collaborated in a project to provide needed care and to expose students in their fields to the effects of incarceration on health.

Started in 2014, the Crimson Care Collaborative, a network of student-faculty clinics led by the Stoeckle Center for Primary Care Innovation at the Massachusetts General Hospital, partnered with the Suffolk County Sheriff's Department to operate a weekly clinic in the Suffolk County Jail. Several teams of student trainees and supervising faculty provided care in several ways; 1) medical care for chronic illnesses, 2) dental care, 3) mental health care, 4) health education, and 5) help for inmates nearing release to enroll in Medicaid. Essential to this work were huddles before each clinic discussing the various needs of the patients to be seen, and huddles after the clinic to discuss highlights and particular challenges.

The next step for the Collaborative will be to facilitate inmates' return to their communities upon release, and linking them to resources there. Students who have participated generally show increased awareness of the effects of incarceration, and many express interest in continuing to work with this population in, or after release from, prison. Some have returned as medical resident preceptors. As the number of graduates increases, the Collaborative plans to assess the impact on students' career choices.

(From an OpEd by Nicholas Turner & Jeremy Travis in the *New York Times*, 8/6/15) The authors report on a delegation of people concerned about the US criminal justice system to visit some prisons in Germany and observe their conditions. "What we saw was astonishing."

Male inmates wore their own clothes, lived in private cells, each with its own separate bathroom. They decorated their cells as they wished, including plants, family photos, and colorful linens from home. Each had his own phone. They all had access to communal kitchens where they could cook their own meals, using wages earned in vocational programs to buy groceries.

A comparison between German and American criminal justice:

- Core values: accountability and rehabilitation vs retribution and punishment
- Rate of incarceration: 8/10,000 vs 60/10,000
- Much shorter sentences in Germany – few more than 15 years; 70% less than 2 years
- Solitary confinement rare, generally just a few days, never more than 4 weeks; compare with months or years as is common in the US
- Training of corrections officers: two years, highly selective application process vs just a few months, and labor shortages
- Recidivism: corrections staff ask themselves what they could have done better vs extra punishment for the released inmate who failed.

Historically, the German prison system reflects the national reaction of shame after the horrors of the Holocaust, whereas the US system reflects slavery's long shadow and today's persistent racism.

State performance rankings in long-term services and support (LTSS) – (From *Health Affairs* Blog, 12/11/17) AARP has devised a scoring system (scorecard) to evaluate how well states are doing in providing long-term services and support for their residents. **At last, some good news: Washington State ranks #1 overall!**

Our state is strong in state funding for home-based care support, participant-directed services, and availability of assisted living and residential care facilities. Our weakest areas are in employment of people with disabilities (ages 18-64) as compared with the non-disabled, and affordability of services, both home-based and institutional.

###



Graduate of Cuban Medical School at PNHPWW Monthly Meeting

By David McLanahan, MD, Coordinator of PNHPWW

At the December 2017 monthly meeting of Physicians for a National Health Program Western Washington (PNHPWW), Xochitl Garcia, MD, a graduate of the Latin American School of Medicine (ELAM) in Havana, Cuba, presented a film “Dare to Dream” about US medical students training in Cuba. She also led a lengthy discussion after the 30-minute film. ELAM is the largest medical school in the world.

Considering the continuing bad news about the current state of, and future threats to, our health care system, it was very nice to hear some good news about an influx of dedicated, socially conscious physicians who work for health care for all.

The film shows several US students at ELAM who are receiving a free medical school education provided by the Cuban government. Several students talk about their backgrounds and why they chose to leap the barriers the US government has placed between the two countries to receive medical training that will allow them to serve the needs of their communities. ELAM is working to revolutionize health care on a global level, having graduated more than 26,000 doctors from underserved areas around the world.

US applicants for ELAM are selected by the Pastors for Peace organization from underserved areas in the US with the understanding that after graduation they will use their new medical skills to serve underserved communities back home. These young Americans are very inspiring, as is their understanding that many of the barriers to medical care, as well as the social determinants of health, are largely political and will require a commitment from all of us to transform our medical system to make “health care is a human right” real for all Americans.

Dr. Garcia is a Mexican-American from Los Angeles, and graduated from ELAM in 2014. She has worked extensively as a community physician in Mexico, and is coordinator for a medical volunteer team of Mexican graduates from ELAM working in the state of Oaxaca. In Yakima, she worked in a free clinic as a volunteer physician with mostly Spanish-speaking Mexican migrant farm workers. She is applying to family medicine

residency programs in Washington State where she plans to continue working with underserved Americans and the migrant community. She is a lifetime advocate for universal health coverage.

Dr. Garcia talked about her experience at ELAM and how its graduates are providing health care in 60 countries around the world, particularly in needy areas of Africa and Central/South America. She described how Cuba dispatched the first experienced medical teams to work in Africa to fight the ebola virus outbreak, to Haiti after hurricanes and earthquakes caused immense damage and suffering, and even volunteered to send teams to Louisiana after hurricane Katrina and to Puerto Rico after the recent devastating hurricane Maria. The offers were repeatedly ignored by the US State Department.

ELAM has openings for more US students. Pastors for Peace in New York City coordinates recruiting and works to support the students during the six years of medical school. One of the goals of “Dare to Dream” is to help with recruitment of students who would like to consider a career in medicine but who are put off by the immense costs of a medical education in the US.

You can watch the trailer for free, and the whole film for \$2.99 at <https://vimeo.com/ondemand/dare2dreamcuba>.

PNHPWW has some connections to Cuban health:

- Our chapter was founded in 2005 after Drs. Hugh Foy and David McLanahan visited Cuba as part of a delegation to look at Cuba’s health care system, meeting with Health Ministry officials and Cuban physicians in their various hospitals and community clinics, as well as visiting ELAM. During the trip, PNHP’s then-National Coordinator Dr. Quentin Young challenged the two Seattleites about why such a “progressive” city did not have a PNHP chapter.
- We held several events to raise funds for Ramon Bernal, who graduated from ELAM in 2013, and Sol Bockelie, who is now a second-year student there.

###

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What's Likely in 2018?

By Sarah K. Weinberg, MD, Editor

Nationally

In Congress, House Speaker Paul Ryan (R-WI) has made it clear that he would like to cut Medicaid, Medicare, and perhaps Social Security in response to the increase in the deficit due to the tax cuts just enacted. Other Republicans in the House have been more muted. In the Senate, Majority Leader Mitch McConnell (R-KY) does not plan to go along with such cuts, but hasn't come up with any health-related proposal yet.

The Trump administration states its intent to undermine the ACA through regulations and enforcement or lack thereof.

Washington State

With very narrow margins, Democrats will be in charge of both houses of the legislature. There is reason to hope that there will be a hearing in the Senate's health care committee, and maybe also in the House's parallel committee. However, there is a lot of work to do to get ready for the possibility of federal cooperation starting in 2021 if there is a new presidential administration. (See the article about Gov. Shumlin's advice elsewhere in this issue.)

Health Care for All-Washington

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Former Vermont Governor Shumlin: Advice for Single Payer Advocates

By Sarah K. Weinberg, MD, Editor

As reported in the *Sacramento Bee* on 12/14/17, former Governor Peter Shumlin spoke at length at a health care hearing in Los Angeles about what caused him to abandon (hopefully temporarily) the effort for single payer health care in Vermont three years ago. He outlined a political and legislative strategy and listed pre-conditions that he thinks must be met before a state's effort to set up a single payer system can be successful. "I would write a bill that sets very clear goal posts that you have to meet, before your public financing kicks in." This process takes time and political clout.

Shumlin's specific advice

- Single payer is the goal.
- Tackle costs first. Taxes to pay for health care must rise if health care costs rise, so control of costs is essential to win support for those taxes.
- Reform how providers are paid, moving away from fee-for-service. He likes ACOs as promoting value-based payments.
- Regulate private insurance first, then it will be easier to move to a public system.
- Federal cooperation is required due to the ACA. Vermont got a waiver that allows Green Mountain Care to pool all federal and private payments into one outcomes-based payment system. Unfortunately for other states, that means waiting three years for a new president more willing to work with them.
- Meanwhile, use state funds to improve the ACA. Examples: expand subsidies, include the undocumented in Medicaid, and open Medicaid to the wider public as a state-run insurance option.
- The more the current administration and Congress harm the ACA, the more public support for single payer will increase.