



# Health Care for All-Washington Newsletter

An informational publication of HCFA Education Fund for health reform advocates

Spring 2019

## First-Ever Medicare for All Hearing in Congress

By Sarah K. Weinberg, MD, Editor

On April 30, 2019, the Rules Committee of the House of Representatives held the first hearing on H.R. 1384, Medicare for All, prime sponsored by Rep. Pramila Jayapal (WA-7). Not having the patience to wade through the entire hearing on video, I have read several reports and commentaries written in the days following the hearing. A summary:

### Positives

- California health reform advocate and patient dying of ALS (Lou Gehrig’s Disease) Ady Barkan provided the most direct and poignant testimony about the need for universal health coverage. He even managed to meet with Speaker Nancy Pelosi beforehand, and she escorted him into the hearing room.
- Barkan stated that objections related to cost of single payer are political, not economic, and that the “richest country in the world” can afford to provide health insurance to its people.
- Rep. Tom Cole, Republican from Oklahoma, commented: “It’s a noble and worthy goal you all share.”
- Opportunity for Democrats to have a serious debate on policy to show how they would govern if they were to win the White House in 2020.
- Many activists, staffers and lawmakers were present, signaling importance. Sen. Bernie Sanders of Vermont also helped organize the hearing.
- Economist Charles Blahous of the Koch-funded Mercatus Center, put the cost of Medicare for All at \$32 trillion over 10 years, but was forced to admit that this figure is “a little more or a little less than we’re currently paying.” “I think that’s fair,” He said. (Note that Blahous’s cost estimate ignores the current system’s expected trajectory, estimated to reach \$6 trillion/year by 2027.)
- Dr. Farzon Nahvi, an emergency room physician, cited cases of patients leaving without treatment or unable to afford the medications prescribed. Some of these patients later returned to be admitted with much more serious consequences as a result.

### Negatives

- As reported by Wendell Potter of Tarbell, the usual FUD (Fear, Uncertainty, Doubt) strategy was on display.
- Grace-Marie Turner of the Galen Institute, a conservative-supported entity, raised concerns about rationing of health care, long wait times and lower quality of care.



### What’s inside

First Congressional MFA hearing.....	1
President’s Message .....	2
Community health centers.....	3
Political Action Committee.....	4
Bits and pieces.....	6
Legislative activism.....	7

**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

Spring 2019

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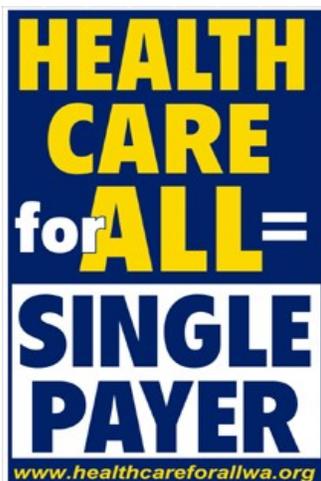
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## From the President's Desk

by Marcia Stedman, President.

### LOUD, PROUD, & VISIBLE

#### Legislation

##### **SB 5822 - Pathway to Universal Health Care**

HCFA-WA and allied organizations testified at public hearings in all relevant committees, leading to inclusion of most of our suggested amendments and passage by the full Senate. The bill was not brought to the House floor for a vote, despite bi-partisan support in both the Health Care and Appropriations Committees. However, funding for the Work Group including the necessary actuarial and financial studies is included in the 2020 budget, and work continues with the Governor's office to issue an additional Executive Order for the Work Group. We will be keeping a close eye on the formation of the Work Group, as well as on the work itself.

##### **HB 1523 - Governor's "Public Option" bill**

HCFA-WA testified at public hearings in all relevant committees but our amendment to include a "true public option" was not adopted. Different versions passed each chamber and were reconciled in Conference. It was signed by Gov. Inslee 5/13/19.

#### **Multiple contacts with legislators and staff**

- before and during session
- scheduled and spur-of-the-moment
- together with supporters, organizational allies, and our lobbyist Cindi Laws

#### Communication

**Dynamic Contact** with Members and Supporters

#### **Numerous specific Action Alerts, Blog posts & Facebook posts**

- Direct and focused language, courtesy of Communications Manager Kelly Powers, with links to relevant legislators
- Eye-catching graphics by Sydnie Jones, Communications Specialist

#### Outreach

**HCFA-WA Blitzes** - pre-session

**HCHR Public Forum** – January 26th

**24 presentations statewide in FY 2019 to date:** Oct. 2018-April 2019

#### Teamwork

**HCFA-WA Team and Committee Collaboration**

Fundraising, Communications, Political Action, Spokane Group

**Health Care is a Human Right - WA Campaign** – Kelly Powers & Marcia Stedman integral members of the Steering Committee

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## Role of Community Health Centers in Medicare for All

By Richard Kovar, MD

As the US. continues to struggle with healthcare reform, it is vitally important to prioritize the central role of our nation's community health centers (otherwise known as Federally Qualified Health Centers or FQHCs) and ensure they are not weakened in the process. As the African expression goes... "when elephants dance, the grass gets trampled". The debate regarding Medicare For All brings to the surface the simmering question of whether the FQHCs are a central part of the solution or a 50-year old finger in the dike. I believe it is strongly the former and there must be a win-win going forward.

FQHCs are community-based health centers that serve all people regardless of their zip code or insurance status. They are one of the few federally supported programs that have survived from President Johnson's War on Poverty in the 1960s. From the original two demonstration projects in 1965, they now provide the medical home for some 28 million people in nearly 11,000 communities with 1400 organizations. Historically, most of these communities were ignored by traditional health care systems. They all have patient majority boards of directors. That comes to around 35,000 board members who along with their 160,000 health care professionals will need to be convinced that whatever reform we come up with is in their organization and community's best interest.

FQHCs are by far the largest and most successful primary care system in the U.S., they are located in all 50 states and territories. They specialize in caring for the most vulnerable people in their communities and provide care to people challenged by housing and food insecurity, unemployment, chemical dependency, and language and transportation barriers. While emphasizing prevention, they usually care for sicker, more challenging patients and once connected to care, outcomes are as good or better than the private sector. They value and depend on public/ private partnerships and routinely measure their quality outcomes and cost effectiveness.

It is important to note that FQHCs are successful in large part due to the social or "wrap around" services they provide in the form of multidisciplinary teams. Most integrate medical care with behavioral health and dental care and collaborate closely between these services. There are so many examples that could be described but

let's take the case of diabetes, a disease on track to affect one out of three Americans in the next few decades if we don't figure out how to change our lifestyles. A diabetic patient at a FQHC will receive medical management of their disease that is held to an accountable standard of national guidelines. They are also likely to see a diabetes educator, nutritionist, behavioral health specialist and perhaps a community health worker to try to address some of the socioeconomic disparities that worsen their disease. If they need help with transportation or interpretation in their primary language, that is available. Insurance eligibility and connection to housing support services are usually available. Dental care at the center is frequently the service that improves their diabetes control. Collaboration with local community social services is highly prioritized.

Or consider the example of obstetrical services. All pregnant women are immediately screened for modifiable risk factors, entered into prenatal care in the first trimester, seen by a nutritionist and nurse coordinator and when needed, provided assistance with transportation to appointments, translation, chemical dependency service, mental health support and evaluation and preventive dental care. The incidence of low birthweight babies is considerably lower in health centers than in other systems of care.

At my health center we have a program caring for around 500 people living with HIV disease. The providers who care for these folks are very good, but the case managers and specialized HIV nurses are even better. We are able to document extraordinary quality of care, address comorbidities as well as retain people in care and control the infection at much higher rates than national averages. Only two people have died of HIV disease in the last 13 years and both would not take their medications. Again, I credit our outcomes to the team-based care model.

There are many other conditions treated by FQHC multidisciplinary teams and they are unique to the community needing those services. Whether it is caring for rural farmworkers, homeless individuals or families, prevention of HIV disease, mental illness, treatment of hepatitis C, or opiate use disorder (to name a few), these challenges often require multiple team members to address complex needs that come along with the health disparities of poverty.

*Continued on p 4*

## Political Action Committee

*By Ronnie Shure, Co-Chair*

### WHAT A VICTORY!

We did not get health coverage for all Washington residents this year. However, we did take a big step forward on that path.

The 2018 election brought us new voices for universal health-care; and that election gave new strength to the legislators who have stood for health care as a human right in the past. There was even bipartisan support for several important bills in health-care committees in the House and the Senate. Legislators hear our voices when we get out and vote as we did last November!

We did have a big victory this year. It was a little messy, but we are moving forward on the pathway to universal health-care. It took a lot of small group meetings with new legislators, but we found some very strong voices this year. It took a lot of work with long-time legislative leaders for universal health-care; but we were able to make plans, change directions along the way, and finish with budget approval for a work group to start on

the pathway to universal health-care. We suggested amendments, and we testified at hearings in health-care committees and budget committees and rules committees. We worked with our allies. Our action alerts led to great responses from supporters like you. It was a little chaotic at times, but our consistent message of “Everybody In! Nobody Out!” seemed to pave the way. Each year our voice is getting stronger.

We have a lot of work to do now. We need to support the Health Care Authority who will convene the work group. We need to thank our legislators and support them in moving the work group in the right direction. We need to build more alliances with other advocacy groups. We need to continue the movement for high quality, sustainable, affordable, publicly financed, privately delivered health coverage for all Washington residents.

This victory will help us move forward on the pathway to universal health-care!

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### *Community health centers*

These “wrap around services” are not cheap, but they are cost effective. According to the Congressional Budget Office, a single dollar spent on Medicaid services for a health center patient returns three dollars in savings to the taxpayer. It is important to note that these FQHCs enjoy broad bipartisan support and though they must struggle for reauthorization of funding at the federal level, they keep moving forward.

That brings us to the issue of health care reform in general and Medicare For All in particular. Remembering that health centers enjoy broad bipartisan support, they can’t afford to “bet the farm” on any one proposal that does not ensure their future existence and ability to provide comprehensive primary and preventive care to vulnerable populations. At the present time, the Medicare For All legislation put forward by Senator Sanders does little more than briefly mention health centers and global budgets along with any number of other institutions. There is not a legislative guarantee that a goal of cutting the insurance industry out of the picture would be to strengthen successful primary care systems such as health centers and the model in which they provide care to communities. Any kind of global budget

*Continued from p. 3*

proposal that does not specifically ensure the multidisciplinary team-based care needed by vulnerable populations is unlikely to get the fully engaged support of the safety net.

Representative Jayapal’s bill is significantly better in that it recognizes the role of safety net providers but proposes a global budget process that does not specifically address the long term funding needs of the FQHCs. These clinics receive reimbursement for current Medicaid and Medicare patients based on the cost of providing the care that figures into these team-based services. The budget would need to cover the cost of care for the entire population they serve in a similar manner if a reform proposal was to obtain their backing. A constructive way to do so would be to recognize FQHCs as the largest, most successful, local community based, comprehensive primary health care system in the country that has figured out a way to serve the most difficult to care for people in America. Legislation could then guarantee cost-based reimbursement or a global budget that recognizes FQHCs central, not peripheral role, to ensuring a healthier nation.

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### ***Medicare for All Continued from p. 1***

- Ms Turner also worried about an expected shortage of physicians that would be made worse by Medicare for All, and raised the spectre of physicians leaving practice due to low payment schedules.
- Rep. Rob Woodall, Republican from Georgia, would prefer a system that focused on the truly ill, like Barkan, rather than remake the system or divert resources to otherwise healthy families.
- Rep. Debbie Lesko, Republican from Arizona, thought the hearing was a waste of time, and asked if the plan would “provide health care for illegal immigrants.” (Dr. Nahvi pointed out that under the 1986 EMTALA law, undocumented immigrants are already receiving care, whether or not they can pay for it.)
- Rep. Cole dubbed Medicare for All a “socialist proposal”, and “Medicare for None.”

### **Some good quotes and one-liners**

- Barkan: “I needed Medicare for All yesterday. Millions of people need it today. The time to pass this law is now.”
- Rep. Jamie Raskin, Democrat from Maryland: “A basic sense of democratic solidarity is that both the well and the sick should take care of each other.”
- Dr. Nahvi: “Anecdotes aside, we know that single-payer systems in other countries have better outcomes than we do.”
- Dr. Nahvi, referring to a patient who couldn’t afford her antibiotic prescription and went to a pet store to buy antibiotics meant for fish: “I’m worried that there’s a lot of finding problems with the solution, rather than finding solutions to the problem. I never want to see another patient who thinks their best option for medical care is to go to a local pet store.”
- Rep. Donna Shalala, Democrat from Florida, and former secretary of Health and Human Services: “Congress has demonstrated over and over again that they have the backbone to take on big problems, put their arms around it, and try to find a solution. I’m perfectly willing to debate the cost issue and how we’re gonna pay for it. But we’re here because the employee system is deteriorating in front of our eyes.”
- Rep. Shalala: “the notion that an employer-based health care system is still the core solution for health care is dead and gone.”

### **Where does this bill go now?**

While the hearing was in progress, Rep. Jayapal

told reporters that Ways and Means Chair Richard Neal, Democrat from Massachusetts, has agreed to hold a hearing. The date has not yet been set.

Budget Committee Chair John Yarmuth, Democrat from Kentucky, has also said he will hold a hearing, and he earlier requested the Congressional Budget Office report analyzing elements of the bill that was released on May 1. This report does not include a complete analysis of the costs, as there are too many variables left undecided.

Rep. Elijah Cummings, Democrat from Maryland, is chair of the Oversight and Government Reform Committee, which also has jurisdiction. He is a supporter of H.R. 1384, but has not scheduled a hearing.

Even if the bill should pass in the House, it is assumed that it has no chance in the Senate, at least until 2021 after the 2020 elections. Exposure in the House through hearings in multiple committees should be viewed as building momentum for 2021 and beyond.

### **A final note**

Ady Barkan said it best: “My time to deliver this testimony is running out. And, in a much more profound sense, my time to deliver this message to the American people is running out as well. Our time on this earth is the most precious resource we have. A Medicare for All system will save all of us tremendous time. For doctors and nurses and providers, it will mean more time giving high-quality care. And for patients and our families, it will mean less time dealing with a broken health care system and more time doing the things we love, together.”

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## Bits and Pieces

### **Americans going to Canada for health care and pharmaceuticals**

A group of Minnesotans with Type I diabetes recently organized a trip across the border into Canada to purchase life-saving insulin. Members of the group, even though insured, were unable to afford the cost-sharing required or the sky-high price of insulin in the U.S. Apparently, about 25% of Americans with Type I diabetes are dangerously rationing their insulin due to the cost. The Minnesotans traveled to Fort Frances, Ontario, where they were able to purchase their insulin at about 1/10th the cost. Other border towns across Canada have seen an influx of Americans coming to buy needed medications, mainly insulin.

In the US, generic insulin is unavailable. The companies that make insulin keep making tiny changes to keep the patents on their brands from running out. Pressure to do something about excessively expensive drugs is beginning to have an effect: Eli Lilly announced in March, 2019 that it will make a generic insulin available “as soon as possible” at half the current list price for their brand-name version. (That’s still five times the price in Canada.)

### **Will New York be the first state to pass single-payer health coverage?**

(from The Nation, May 2, 2019) In the past, New York’s legislature fell a few votes short in the Senate, controlled by Republicans. After the 2018 elections, Democrats are in the majority in both houses, and Gov. Cuomo is a Democrat. But now, Democrats in the Senate want to hold more hearings, even though the bill has been before them for about 30 years. Former “strong” supporters are now concerned that now is not the time without the elusive waiver. It’s easy to enact cost-free Democratic priorities, but those that require money.... Cuomo worries that the rich will flee New York if they have to pay higher taxes. He has called for yet another commission to study health care. Unions are also not united in support. Few New York Democrats actively oppose the NY Health Act, but it won’t pass until they’re willing to fight for it.

“Single-payer legislation has been studied, debated, proposed, and refined for three-quarters of a

century. The only question left is how to make lawmakers do it.”

### **It’s the prices, stupid!**

It’s well known that prices for medical care, especially hospital care, in the U.S. are the highest in the world. To understand a major reason, we’ll have to dive into the weeds. Ready?

Our private insurance system, especially the employer-sponsored (ESI) part, depends on negotiations between insurers and hospitals to determine what insurers will pay for services provided to their enrollees, usually employees with ESI. In recent years, hospitals have formed huge conglomerates, insisting on high prices to be included in an insurer’s network. The insurers shrug, and pass the high cost back to the employer, who then passes the cost on to the employee via higher premiums, higher deductibles, higher co-pays, and narrow networks. Note that the actual money comes out of the employee’s pocket, one way or another, so there’s no incentive for the hospitals, insurers, or employers to offer or insist on lower prices. It’s so bad now that the average prices insurers pay to hospitals is now over 200% of what Medicare pays for the same services.

Worse, insurers actually have an incentive to allow for high prices. The more that insurers pay, the higher their medical loss ratio (MLR), meaning that the amount left of the total premium paid for insurer administration and profit is higher also. Talk about bargaining in bad faith!

Medicare for All legislation focuses on using global budgets for hospital payment to cover their actual operating costs plus a cushion. Money for hospital capital improvements would be allocated separately according to community needs.

### **ACA Protections Now in State Law**

One important item passed in the 2019 legislative session was adding the protections for people buying health insurance that are in the ACA to our state’s law. Washington joins 10 other states in taking this step in case the ACA is dismantled, either by Congress or by federal courts. There are 8 basic protections:

*Continued on p 8*

Join Now for 2019!  
Health Care for All – Washington

**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 \_\_\_\_\_

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**Thank you for your support.**

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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](mailto: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?

# Health Care for All-Washington

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## Bits and Pieces

*Continued from p. 6*

- Guaranteed issue – insurers not allowed to refuse to sell a policy to a willing buyer.
- Community rating – insurers must use an overall rating system for the community, and are not allowed to raise rates for certain people.
- Ban on exclusion of coverage for pre-existing conditions.
- List of essential health benefits that must be included in coverage package.
- Limits on the amount of cost-sharing by enrollees.
- Ban on annual or life-time limits of coverage.
- Preventive services must be covered without cost-sharing.
- No discrimination based on age, disability status, or expected life span.

At least 14 other states are considering adding some or all of these protections to their state laws.

### **Long term care trust passed in state legislature**

On March 26, 2019, the Washington State legislature passed 2SHB 1087, the Long-Term Care Trust Act. (It was signed by Gov. Inslee on May 13.) Much like the Washington Health Security Trust bills over the last 20 years, this Act establishes a 21-member commission to set up and run a trust fund to provide long-term care services to eligible Washingtonians. The program is to be funded through employee payroll deductions, initially set at 0.58% of wages. It is anticipated that the first payments will start in 2025, and initial payroll deductions will begin in 2022, allowing 3 years to build up a sufficient balance. Initially, there will be a maximum lifetime benefit of \$36,500, but it will be adjusted as the Consumer Price Index increases.

**Washington State leads the nation with the first tax-supported long-term care coverage plan!!**

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