HCFA WA

HEALTH CARE FOR ALL EDUCATION FUND

The Medicare Privatizers Keep Coming!

By Sarah K. Weinberg MD, Editor

As we have been trying to use Medicare as a model for a universal health coverage plan for the U.S., there continue to be old and new schemes by various private entities to make profits through special Medicare programs. Conceptually, these schemes are all based on the notion that private industry is always more efficient than government programs. (There's no actual evidence that this is true.)

Starting in the 1970s, Medicare beneficiaries were allowed to enroll in HMOs or PPOs. These privately insured entities then received capitated payments from Medicare in return for taking the risk of providing all the care the beneficiary needed. Initially, since the assumption was that private plans would be more efficient that traditional fee-for-service Medicare, these Medicare + Choice plans (Medicare Part C) were paid 95% of the expected Traditional Medicare cost per patient. By the late 1990s, few private plans remained, as they weren't profitable.

In 2003, mostly thanks to the Medicare Modernization Act, these plans were renamed Medicare Advantage at the same time that Medicare Part D (prescription drug benefit) was added. Around this time, the payment per beneficiary from Medicare (government funds) to the Medicare Advantage (MA) plans (private insurance run) started being adjusted for relative risk for each beneficiary. And so, the gaming began!

For the last 15 years or so, MA plans find plenty of ways to upcode the Risk Adjustment Factors (RAFs) for their beneficiaries. For example, the plan visits the home for a chat with each new enrollee. The nice nurse is there to find "risks" to add to the person's medical chart. The annual wellness visit with the enrollee's physician serves the same purpose, and the physician may literally be paid extra for finding things to add. The net result of this gaming of the system is several billion dollars each year moving from the Medicare Trust Fund (your taxpayer dollars) to the private insurers. It's true that the insurers use some of the extra to improve benefits, but much of it goes into profits and/or high salaries for insurance company executives. This is happening despite the awareness of the Centers for Medicare and Medicaid Services (CMS) of the gaming of the RAFs and their feeble efforts to control the excesses.

And…there's more!

Continued on p 4

Fall

2021

What's inside

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

Fall 2021

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From the President's Desk

by Marcia Stedman, President.

On the Road to Universal Health Care

Thanks to the strong work of HCFA-WA leadership, our advocacy allies, and our Health Care Champions in the legislature, Washington's first permanent Universal Health Care Commission (UHCC) is now being formed. We lobbied hard for the passage of this bill in 2021 and for our amendments to the Pathway to Universal Health Care bill in 2019 that broadened and strengthened the voices on the Universal Health Care Work Group (UHCWG) and made this progress possible. We are gratified that our 25+ years advocating for a body such as the UHCC have succeeded! Soon the Commission will begin developing a universal health care system with a unified financing system that will make comprehensive, affordable and equitable healthcare accessible to all Washingtonians. We look forward to having a voice on the Commission, whether by direct participation or by providing comments during the open public meetings. Watch for news of the meetings in this space and on our website: https://www.healthcareforallwa.org/

Throughout 2021, we went "on the road" with our 2nd Wednesday Speaker Series. The virtual format made state-wide participation easy as we heard from state and national experts on a variety of topics: the UHCWG findings, why the cost of American healthcare is so high, how racism creates health inequities, the 2021 Legislative Health Care Victories, how the Indian Health System works, and how WA is lowering the price of prescription drugs and solving our mental health crisis. If you missed any of these events, or want to watch again, video recordings are available on our website under the Events tab: https://www.healthcareforallwa.org/2nd_wednesday_speaker_series

SAVE THE DATE: In November, our "2nd Wednesday" program moves to the 2nd Saturday, Nov. 13th, from 2-4 p.m. with Stephen Kemble, MD, speaking on "Global Budgeting and Universal Health Care."

Dr. Kemble has a longstanding interest in health care reform. He has been appointed to the Hawaii Health Authority, charged with overall health planning for the State of Hawaii and with designing a universal health care system covering everyone in the State. His experience with Hawaii's system can inform Washington's efforts. A healthcare financing expert, Steve is also a clear and engaging speaker.

Please plan now to join us for an exciting review of our 2021 successes, a look ahead at our plans for 2022, and opportunities to support our ongoing work. The brief business meeting will include votes on our proposed 2022 Budget and the election of Directors and Officers for the coming year. **If you're new to us, please join by Oct. 29th** so you can vote on these important issues. **Two ways to join: online at** https://www.healthcareforallwa.org/donate **or by returning the enclosed remit envelope with your check.**

We look forward to seeing you on Nov. 13th. As always, thank you for your continued support!

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READERS' BOX

[Here you'll find each quarter suggestions on local advocacy work our members can do in their local Congressional or Legislative districts. Also, please send in any local news for universal health coverage in the communities where you live.]

- Gov. Inslee signed into law 2SSB 5399 on 13 May 2021 which established Universal Health Care Commission. A 1st step is to thank your state reps. and senators for voting for this bill. To help you out, all the Democrats in both the House and Senate, except Sen. Mark Mullet (5th LD), voted for the bill, and all the Republicans voted against it.
- A second step, in the same email, is to ask them if they will support the WHST if the UHCC includes it when reporting on best alternatives.
- Do let us know what movement there is in your community for the Washington Health Security Trust from letters to the editor or actions taken in your local Democratic Party. Send your thoughts on winning universal health care to: communications@healthcareforallwa.org. Thank you!

Outreach Committee Report

By Ronnie Shure, Chair

Come On Board the Ship to Universal Health Care

It may not seem like smooth sailing to reach the ultimate goal of equitable, high quality, sustainable, affordable, publicly funded, publicly and privately provided health care for all. The winds of change on the national front are weak in some areas. However, there are high pressure fronts advocating for Improved and Expanded Medicare for All, and there are large hot air masses supporting State-based Universal Health Care. Here in Washington state, we are preparing to batten down the hatches for the next wave of health care reform.

Our Second Wednesday Speaker Series has focused on health equity with programs on racial disparities (thank you Amber Lenhart, Heleen Dewey, and Bob Lutz) and tribal health inequities (thank you Vicki Lowe) that have been made worse by the COVID-19 pandemic. We have also been shining the light on the true cost of health care (thank you David Belk). You can watch these presentations on our YouTube channel. Our September presentation featured efforts to lower prescription drug prices by leaders in Washington State, including Donna Sullivan from the Health Care Authority, Janel Jorgensen from the Department of Health, and Jenny Arnold from the Washington State Pharmacy Association. Senator Karen Keiser and Gary Goldbaum helped us inquire about the best pathways to lower prices. Go to our website and click on the YouTube icon to find these presentations.

Our Health Equity Committee is reaching out to bring you the voices of more diverse groups of advocates for improving our health care in Washington state. Consuelo Echeverria is leading a task force to help us understand the needs and the solutions to overcome barriers that our fellow Washingtonians are facing.

Please consider joining our Outreach Committee on teams that are developing our Second Wednesday Speaker Series or Health Equity actions. Rich Lague, Gigi Davidson, Leah Vetter, and I would welcome your participation even for a short-term project. Let me know if you can help us batten down the hatches for this trip. Come on board!

######

Fundraising Committee Report

By Peter Lucas, Chair

The fundraising committee was relatively inactive over the summer and early fall as the members were busy with other HCFA-WA activities such as preparing for the board retreat held in September. Not to mention summer vacations.

We were quite pleased to receive a very large donation in August from a loyal and generous supporter. Now we are well-situated financially to cover our expenses for many months and to fund our lobbyist prior to and during the upcoming legislative session. Now that we have a cushion, we can still greatly benefit from donations in order to build our reserves further and to be in a position to expand our outreach and educational efforts. We would like to get the word out to more Washingtonians and grow grassroots support for universal health care and reforms that address the deficiencies of our highly dysfunctional health care current system.

We decided to postpone the planned individual informational meetings with donors until such time as we can update them on the progress of the Universal Health Care Commission and the legislation likely to be introduced in the 2022 session. So we are now looking at late November or early December as the most opportune dates for these meetings.

As always, we very much appreciate the generous support of you, our members, and encourage you to continue to donate. Recurring monthly donations are especially valued.

Thank you and enjoy the fall colors!

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Medicare privatizers *Continued from p 1*

A new set of schemes actually enabled in the Affordable Care Act, so-called Direct Contracting Entities (DCEs), are coming to your health care neighborhood. These are complicated, but what they do is allow insurance companies to contract with Medicare and then entice their Traditional Medicare enrollees (usually via Medigap policies) into accepting a capitated arrangement. Supposedly there's less RAF gaming, but there are complicated rules that don't do a good job of preventing overpayment by Medicare to the insurer. Nor do the rules prevent the insurer from putting roadblocks (pre-authorization, limited networks, out-of-pocket payment requirements, etc.) in the way when patients need medical care.

Now the ultimate danger

Part of the DCE scheme to get all Medicare enrollees into private plans is the ultimate: move all Traditional Medicare enrollees into a DCE without their permission. This would be done geographically, and the scheme is called GEODCE. Currently, this scheme is on hold, but if it is allowed to go forward it would end Traditional Medicare completely.

As Dr. James Kahn commented from the perspective of Physicians for a National Health Program: "The huge Medicare health insurance ship is headed in the wrong direction. Let's turn the rudder toward traditional Medicare, traditionally implemented, and then on to an improved Medicare for All."

What can be done?

First, we have to be aware of the danger. If you have read this far in my essay, you'll fully understand how complicated, confusing, and deceptive this whole business has become.

Second, we advocates of a single-payer, publicly funded, universal health coverage system need to be more explicit that Medicare may not be the ultimate vehicle to get there. Medicare Advantage for all? Medicare DCEs for all? These would all violate the basic principles of universal coverage: that every American resident must be part of the same risk pool, and that there are no intermediaries siphoning off public funds for private profit.

Third: **Be sure to attend the HCFA-WA Annual Meeting Nov. 13 from 2 – 4 pm to listen to Dr. Stephen Kemble, a Hawaiian psychiatrist, who is very knowledgeable on this subject!**

See you there!

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Corruption, American Style

By Sarah K. Weinberg MD, Editor

Arizona Senator Kyrsten Sinema made the following statements during her 2018 campaign for the Senate: "We need to make health care more affordable, with access to the lowest-cost prescriptions…." On her campaign website she posted the following: "Kyrsten is committed to making sure Arizonans have access to more health care choices, low-cost prescription drugs, and high -quality dependable coverage." In an OpEd piece published in February,2020 she wrote, "Congress must address the cost of prescription drugs."

Then campaign contributions flowed in from Big Pharma, even though Sen. Sinema isn't up for re-election until 2024.

- $121,000 from pharmaceutical-associated PACs in 2019-20. This is double the amount of contributions she received during the 2018 election cycle, and more than she received during her entire congressional career to that point.
- In September, 2021, a group called Center Forward purchased $600,000 worth of television and radio ads touting her "independence" and "a bipartisan leader", likening her to the late Sen. John McCain. It just so happens the Center Forward is heavily bankrolled by several corporate members of PhRMA.

Now Sen. Sinema has informed the Biden administration that she opposed the Democrats' drug pricing plan. She won't even talk to Rep. Ro Khanna, one of the main authors of the Medicare drug pricing bill. She does have plenty of time to talk to business groups opposing the reconciliation bill.

This is how Senators' minds get changed in America!.

#####

Bits and Pieces

US life expectancy in 2020 saw biggest drop since WWII

https://apnews.com/article/science-health-coronavirus-pandemic-fac0863b8c252d21d6f6a22a2e3eab86

For decades, US life expectancy was on the upswing. But that trend stalled in 2015, for several years, before hitting 78 years, 10 months in 2019. Last year, the CDC said, it dropped to about 77 years, 4 months.

Other findings in the new CDC report:

- Hispanic Americans have longer life expectancy than white or Black Americans, but had the largest decline in 2020. The three-year drop was the largest since the CDC started tracking Hispanic life expectancy 15 years ago.
- Black life expectancy dropped nearly three years, to 71 years, 10 months. It has not been that low since 2000.
- White life expectancy fell by roughly 14 months to about 77 years, 7 months. That was the lowest the lowest life expectancy for that population since 2002.
- COVID-19′s role varied by race and ethnicity. The coronavirus was responsible for 90% of the decline in life expectancy among Hispanics, 68% among white people and 59% among Black Americans.
- Life expectancy fell nearly two years for men, but about one year for women, widening a longstanding gap. The CDC estimated life expectancy of 74 years, 6 months for boys vs. 80 years, 2 months for girls.

Unpaid medical debt reaches unimaginable high

https://www.winknews.com/2021/07/21/unpaid-medical-debt-reaches-unimaginable-high/

Nearly 20% of people have a medical debt of around $400, and that debt has been owed long enough to impact their credit.

You know medical debt can get bad. We've brought you stories for years about the pain of trying to pay. "Our deductibles went up every year. Our premiums would go up 200, 300 dollars every year."

Continued on p. 7

Communications Committee Report

By DW Clark, Chair

While in between legislative sessions, the Communications Committee has been posting support for the Universal Health Care Commission with email blasts, our website, YouTube, and other social media. We also work with allied organizations by re-posting many of their messages. On a monthly basis, our committee promotes our 2nd Wednesday Speaker Series with social media, email blasts, and our website. For those who may have missed any of these meetings, we put them up on YouTube the day after the event.

We are in the very beginning of promoting our Annual Meeting, which will be virtual, on Saturday, November 13 from 2:00 to 4:00 pm. **Mark your calendars, and be sure that your membership in HCFA-WA is current by Oct. 29.**

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Policy Committee Report

By Sarah K. Weinberg, MD, editor

After our joyful celebration of passage of SB 5399, establishing a Universal Health Care Commission (UHCC) in Washington state, the summer has now passed without Gov. Inslee making any appointments to the commission. We do know that the governor's health care advisor, Molly Voris has interviewed a few people, but not many from our list. It's not a good sign, but it's too soon to give up hope, both that the UHCC will be appointed, and that it will start to meet before the end of October.

Looking ahead, we are listing items we think the legislature should deal with in the 2022 session:

- Another try at the prescription drug affordability board
- Expanding primary care. There was a bill in 2020. SB 6413, to increase spending on primary care. The bill went nowhere, although it did have a hearing. Our experience with COVID-19 might add momentum to the idea that the state should fund all primary care. After all, it has been shown that investment in primary care improves population health and reduces total health care costs.
- Follow up on legislation passed in 2019, 2020, and 2021. Pressure our state government to follow through with work groups, boards, and commissions that are now law.
- Add other prescription drugs to the insulin model legislation passed in 2021.
- Support the UHCC once it is appointed and starts meeting. Prepare to present the Washington Health Security Trust bill to the commission at an appropriate time. Assist the UHCC in finding funding models and securing federal cooperation.
- Continue to press at the national level for the State-Based Universal Health Care bill that will make it much easier to capture the federal health care funds that come to our state through multiple means.

As we work with state policy makers and legislators, we will keep in mind some lessons learned during our successful 2021 session:

- Legislators really appreciated our "one-pager" information sheets, complete with citations, on why we were supporting individual bills. This approach increased our reputation with legislators.
- We picked good bills to back at the right time. (Yes, there's some luck involved!)
- Where possible, we worked with legislators from both parties. Even a small amount of bipartisan support helped bills gain momentum.

Meanwhile, we are holding our breath waiting to see what happens with the UHCC**. Attend our HCFA-WA Annual Meeting on Zoom, Nov. 13, 2 – 4 pm.** We're sure to know more by then!

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Join Now for 2021!
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_____

$_____Contributions to **HCFA Education Fund,** a 501(c)3, are tax deductible.

$_____Contributions to **Health Care For All-WA,** a 501(c)4, go for vital organizational growth, but are **not** tax deductible.

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Thank you for your support.

Health Care For All-WA
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Bits and Pieces

Continued from p. 4

Medical debt is much higher than originally thought. Americans owe $140 billion in unpaid medical bills that have been turned over to collection agencies.

"If you're getting a phone call or a debt collector knocking on your door, more often than not now, it's because of an unpaid medical bill," said Neale Mahoney, a professor of economics at Stanford University.

"What we found is that medical debt levels are about three times higher in the Deep South in the United States than in other regions," he said. There, the average amount of unpaid medical debt listed on a credit report is a whopping $677. If you live in the Northeast, it's $167.
Original article published in JAMA 7/20/21.

Providing medications for free leads to greater adherence and cost-savings, study shows

https://www.eurekalert.org/news-releases/901106

Two years into the study, adherence to all

(Continued on p. 8)

Photo taken by Connie Rock at the July 24 Medicare for All march from Westlake to Seattle Center. Sherry Weinberg and Chris Covert-Bowlds, both physicians and HCFA-WA Board

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Bits and Pieces

Continued from p 7

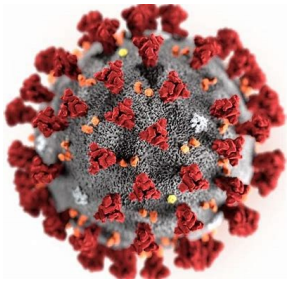
appropriate prescribed medicines was 35 per cent higher in the free distribution group compared with the group that had usual access to medications. ***Free distribution of medication also showed to reduce healthcare costs, including hospitalization, by an average of $1,222 per patient per year.***

"The cost savings are substantial, but they are less important than people simply being able to afford taking lifesaving medications," said Dr. Nav Persaud, a scientist at the Li Ka Shing Knowledge Institute of St. Michael's and lead author of the study.

"This is the first study of providing people with free access to a comprehensive set of medicines, and hopefully it will be the last one needed before policy changes," said Dr. Persaud, who is also a family physician at St. Michael's Hospital.

In June 2019, the Advisory Council on the Implementation of National Pharmacare recommended a universal, single-payer, public pharmacare, estimating such a program would save Canada an estimated $5 billion per year..

Medicare Advantage plans find ways to dump dying patients.



https://www.gao.gov/products/gao-21-482

Commercial Medicare Advantage (MA) plans are finding ways to avoid paying the high costs of end-of-life care. As a result, MA beneficiaries in the last year of life disenrolled to join traditional Medicare at more than twice the rate (5%) of all other MA beneficiaries (2%) in 2017. The U.S. Government Accountability Office found that beneficiaries in the last year of life disenroll because of limitations accessing specialized (and expensive) care under MA. Because Medicare pays MA a fixed fee per enrollee, MA enrollees who switched to traditional fee-for-service Medicare in their last year of life increased Medicare's costs by $490 million in 2017. "

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