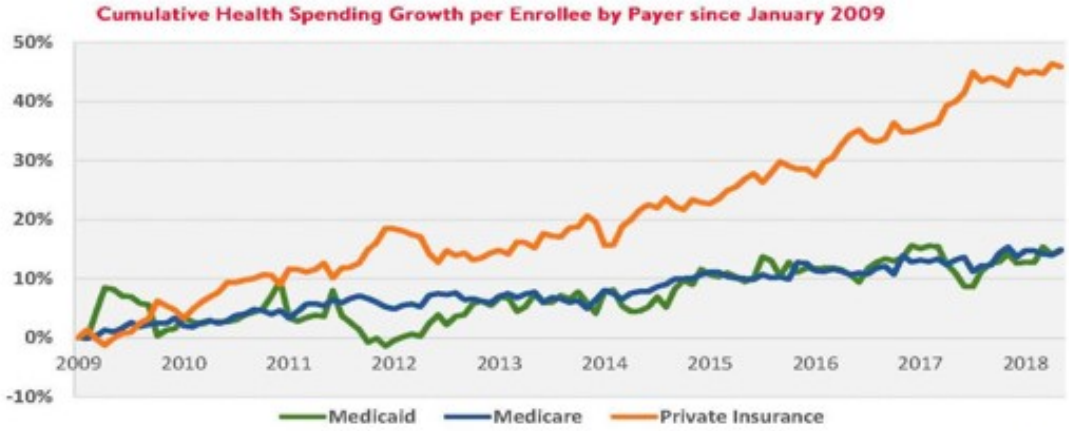
LWV HEALTHY PEOPLE IMPROVED MEDICARE 4 ALL HEALTHY DEMOCRACY

October 22, 2022 *LWV Health Care Reform for the US Caucus Newsletter*

What Does Privatized Health Care Look Like?



Source: "Growth in Spending on Privately Insurance Drives Much of US Health Spending Growth in 2017 and Early 2018", Altarum Institute, https://altarum.org/sites/default/files/uploaded-related-files/Public Private Brief_final.pdf

As shown in the figure above, publicly-funded health care clearly has been able to keep costs lower than private insurance for equivalent or higher value. Like the pressure we have seen to privatize Medicare through Medicare Advantage, ACOs, and DCEs, much of Medicaid has also been turned over to Managed Care Organizations (MCOs). This trend is all the more puzzling since the private corporations make no secret of their stunning financial success that closely mirrors the growth of their health care business with the government, and they are increasingly in the news for abusive business practices, highlighted in the program "How Private Equity Makes Us Sicker."

Private Health Care Companies Got Richer and Richer

United Health and CVS/Aetna leapfrogged into the top 5 spots in the Fortune 500, behind only Walmart, Amazon, and Apple. Cigna made it to #13 spot.

- The government picked up the tab for COVID treatments while insurance corporations continued to collect premiums from workers who didn't lose their jobs as well as payments from Medicare for each MCO enrollee.
- The government paid to fast-track vaccine development from which Big Pharma corporations are profiting.
- The documentary ***Inhospitable*** tells of "non-profit" hospitals which use their tax exemption to add billions of dollars to reserves while soliciting donations and using city resources without significantly "giving back" to the community.

Abusive Corporate Practices Abound in Health Care

- The Oct 8 ***New York Times*** chronicles rampant denials of care, convictions for price-gouging and general anti-competitive behaviors running up prices and veering into "straight up fraud."
- Other sources have uncovered aggressive bill collection targeting even people billed in error.
- The documentary ***Corporation*** dramatizes that it is not just a few "bad apples." Executives are required to put patients over profits or they could lose their jobs.

Can Programs UN-Privatize?

A handful of states have taken Medicaid or Medicare back from private MCOs and had better health outcomes, more physician participation, and lower costs.

Oklahoma and Connecticut replaced their MCO's with a Primary Care Case Management model, a form of "Managed Fee for Service" where the state retains control. CT raised Medicaid payment rates to Medicare levels and still reduced overall costs by 14%.

Maryland Medicare switched to an "All-Payer model with global hospital budgeting" which is not deprivatized but has some characteristics of public M4A plans. A regulatory commission set uniform payments within hospitals for commercial, Medicare and Medicaid patients, lowering total care costs. Its savings are 3 times those of CMMI's ACO programs.

The ACA granted ALL Libby, MT residents, regardless of age, access to Medicare after an environmental disaster.

(Barbara Pearson)

NEXT MEETING
Sunday, Oct. 30 8:00 p.m. ET

Register at
https://tinyurl.com/HCR4US-Oct30

TENTATIVE AGENDA:
Intros for New Attendees—Announcements—Legislative Actions—Newsletter—Break-out Sessions

In Case You Missed It

- Medicare 4 All Congressional Caucus 9/20/22 with Reps. Jayapal & Dingell
- Better and Cheaper - The Colorado Health Care Cost Analysis Task Force with journalist TR Reid & hospital exec Bob Smith

Behavioral Health Affinity Group: Update on 988 Suicide and Crisis Lifeline Rollout

Good news from Health and Human Services! On September 9 they reported that calls to the new 988 number increased 45% over last year at the same time. Calls also were answered more quickly, 42 seconds vs. 2½ minutes. Counselors on the average spent almost 19 minutes speaking, chatting, or texting with contacts. Calls to suicide prevention lifeline rose 45% after changeover to 988 number. (*Mary Lynne Courtney)*

Websites

HCR4US Youtube Channel: https://www.youtube.com/c/LWVHealthCareReform

HCR4US Web-Contact Form: tinyurl.com/Contact-LWV-HCR-4US

HCR4US Google Drive: https://tinyurl.com/HCR4US-Minutes-Materials

HCR4US Toolkit: https://lwvhealthcarereform.org

HCR4US : *Dedicated to educating and mobilizing League members to work toward legislation that enacts the goals of our LWVUS health care position*
Newsletter Committee: *Barbara Pearson, Jon Li, Candy Birch, Kathy Yen, Tom Cherry*

New State of Our Art: Oregon's Plan for Universal Care

Oregon was the best prepared to implement Obamacare when it became law in 2010. However, the legislature has given up on Obamacare and has written a law to create a Task Force on Universal Health Care. The Task Force's "novel" waiver contract channels previously committed federal funds into a single account, utilizing funds from Medicare, Medicaid, Children's Health and other programs.

Principles: choice of provider, provider participation, medical necessity is community- and provider- driven, continuous and evidence-based coverage.

Eligibility: all people who live in Oregon

Covered Benefits: More benefit categories than the ACA, Medicare, or the current Oregon Health Plan for Medicaid; increased funding for behavioral health.

Long-Term Service and Support: maintain current level of support provided by Medicaid and explore options; Medicare recipients would have expanded coverage.

Providers: All health professionals, MDs, RNs, behavioral health, traditional health and other health care professionals; priority given to a more diverse workforce compatible with the community being served in various parts of the state.

Reimbursement: Providers are paid directly, rates set by region to account for different health needs and costs; private health insurance would be limited to things not included in the Plan. Capitation, a set amount paid for each enrolled person, is not allowed.

Employment status: Cuts the link between employment and health insurance.

Social Determinants of Health: Plan savings should include allocations to address housing, transportation, child care, social service and other social challenges.

American Indians Included: Nine federally-recognized tribes of Oregon members as well as tribal providers will have the choice to enroll in the Plan.

Payment by Consumers for Care: Patients will not pay when receiving care; no co-pays and no deductibles. People will pay new taxes based on their ability to pay. All covered services will be fully paid by the Plan.

The Plan's unique proposal accommodates the restrictions to a "state plan" built into the federal Employee Retirement Income Security Act of 1974, which pre-empts state regulation of employee benefits, leaving a narrow pathway for states to integrate employers and employees into a single payer system.

Next Steps: The Task Force recommends that Oregon's 2023 Legislative Assembly establish a governing board to design a Governing Board with a variety of health professionals and community voices to implement the Plan.

(Jon Li)

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