LWV HEALTHY PEOPLE IMPROVED MEDICARE 4 ALL HEALTHY DEMOCRACY

LWV Health Care Reform Interest Group
November 2025 Newsletter

MISSION

To educate and mobilize League members to work toward legislation and other reforms that enact the goals of our LWVUS health care position, with a strong focus on expanded and improved Medicare for All .

Prisons: Main Provider of Mental Health Services in the U.S.

This paradox is one of the starkest indictments of the U.S. mental health system: our largest providers of psychiatric care are jails and prisons — not hospitals, clinics, or community health centers. An explosion of civil rights lawsuits in the 1970s and 1980s, for the first time, required jails and prisons to administer health care to incarcerated populations. Now, Los Angeles County Jail, Rikers Island (NY), and Cook County Jail (IL) are functionally the three largest psychiatric institutions in the United States. People with mental illness are overrepresented in all stages of incarceration; 43% of people in jail and 23% of people in prison have a diagnosed mental-health condition. A national survey found that in some states a person with a serious mental illness was almost twice as likely to be in a jail or prison as they were to be in a hospital.

Clearly, prisons were not designed to be clinical treatment facilities. Their infrastructure is focused more on control than on healing and self-empowerment, and they are not funded sufficiently to offer the comprehensive care that people with serious mental illnesses need. Especially for those with mental illness, just being in prison an acute and chronic stressor, and poses high risk for physical and emotional trauma.

Problems are exacerbated by private correctional healthcare providers, which despite costing communities more, are nearly always less compliant with requirements for care.

Erosion of community supports. The migration of mental health services to prisons and jails reflects the erosion of community mental-health supports, to the point where crisis, confinement, or police involvement have become the default entry points to mental-health care. Families nationwide report the same impossible reality: "The only way my child can get mental-health care is if I call the police."

In addition to addressing concerns for the parents' or patient's safety, Civil Commitment Laws (different in every state), provide for "emergency psychiatric holds" and an evaluation within 3 days rather than the average 3- to 6-month wait for a mental health intake appointment.

Lack of Prevention: In general, America builds crisis systems instead of support systems. The U.S. dramatically underinvests in prevention. Only 5% of mental-health spending goes to prevention or early intervention. Schools, primary-care practices, and community centers lack resources for early detection, routine screenings, or sustained support. Treatment, when available, is delayed until the crisis stage, and then insurers deny behavioral-health claims at twice the rate of physical-health claims.

We propose a **Prevention-First Mental-Health Strategy** for the United States with:

1. Mental-health screening and support in all schools
2. Mobile crisis teams (without police involvement) in every county
3. Mental-health parity with reimbursement reform
4. National workforce expansion for NPs, PAs, LCSWs, peers, and psychologists
5. "Housing-First" tied to mental-health services

The Bottom Line: Political Will: If prisons are our biggest mental-health providers, it's because we built a system that treats illness with punishment instead of care. Mental health outcomes are shaped by housing, wages, education, insurance policy, racial equity, criminal justice decisions, access to care, and above all, political will. Mental health is a political choice.

Submitted by Sharon Goldfarb and Barbara Pearson

Newsletter Staff: ***Barbara Pearson & Candy Birch***

10.26 Attendees

CA — Barbara Commins
CA — Sharon Goldfarb
CA — Jon Li
CA — Anton Prange
CO — Marilyn Ayers
CO — Elaine Branjord
CO — Linda Mahan
CO — Pam Parks
FL — Candy Birch
GA — Sharon Hill
GA — Jackie Killings
KS — Cille King
MD — Margaret Chasson
MA — Barbara Pearson
MI — Maria Woloson
NY — Judy Esterquest
NY — Haley Mack
NC — Wayne Hale
VA — Stephanie Lowenhaupt
VT — Mary Alice Bisbee
VT — Jean Hopkins
VT — Betty Keller
VA — Edwardo Siqueira
WA —Mary Lynne Courtney
WA —Kathryn Lewandowsky

NEXT MEETING | Sunday Nov. 23 | 8:00 p.m. | http://bit.ly/43AiDkN

LWV HEALTHY PEOPLE HEALTHY DEMOCRACY

In Case You Missed It

Oct. 26 — HCR4US meeting video and audio and supplementary materials with Action Links

Oct. 27 — One Payer States hosted Warren George "Designing a Universal Health Plan in 18 Easy Questions"

Oct. 28 — PNHP NY Metro presented a student-led forum "Socialism In the Fight for Universal Healthcare"

Oct. 29 — 1A on NPR discussed "Anti-science Bills Are Being Considered in State Legislatures Across the Country"

Nov. 12 — Medicare Rights Center presented "Medicare, Democracy, and the Future of Health Care: A Conversation with Dr. Dhruv Khullar"

Nov. 13 — LWV Virginia hosted Judy Esterquest and Barbara Pearson to discuss the Privatization Update proposed for adoption at the 2026 LWV National Convention.

Upcoming

Dec. 4, 4:00 p.m. PT / 7:00 p.m. ET — The LWV US Immigration Interest Group discusses "Immigration: Countering Misinformation and Beyond" Click here to join.

Networking

One Payer States
https://www.onepayerstates.org/

National Single Payer
https://nationalsinglepayer.com/

Healthcare Advocacy on Substack
Here's the link.

Physicians for a National Health Program
https://pnhp.org/

Center for Medicare Advocacy
https://www.MedicareAvocacy.org

HCR4US Websites

HCR4US Toolkit:
https://lwvhealthcarereform.org

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

HCR4US Mtg Minutes:
https://tinyurl.com/HCR4US-Minutes-etc

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

The Cruel and Crazy Math of Health Insurance

People other than healthcare wonks have been focused on a tiny health insurance detail: expanded premium tax credits (ePTC) that are expiring. A silver lining to this attention: it makes the public aware of how unsustainable insurance is, and they're questioning if it's even necessary.

The fight over the ePTCs has been fierce, to the point of shutting down the government. You might think they were a major piece of the health care puzzle we all face. In fact, they affect about 24 million people and account for only about $38 billion a year in a $5 trillion industry — less than half of the $71 billion in profit that the seven major insurers made last year alone.

Health care funding since the Affordable Care Act is opaque and makes little sense — as these Canadian and French explainer video clips dramatize for us on Instagram and Tiktok, respectively. Like car insurance, there are premiums, and then a deductible. After the deductible is reached, the company starts to pay out if you make a claim. But in health care, not quite. At this 2nd stage, we're liable for co-pays and "co-insurances." Typical "insurance" kicks in only when your reach your out-of-pocket maximum (OOPM) (if you every do), and the insurer pays your healthcare bills, at least until the end of the year when the process starts again.

These co-payments and co-insurance are thought to give the patient "skin in the game." What is obscured by the complexity of the system is that **the health care insurer has no investment** "in the game." In Rachel's case, her premiums more than covered the minimal role in covering her bills the insurer played, so they had no investment at risk for a "return on investment," only profit (her premium minus their own minimal co-insurance). Their game is not the patient's game: it's to their advantage to deny care and keep prices high.

To illustrate the complexity of what she calls "the Cruel Math of Health Insurance," Rachel Madley of *HEALTH CARE Un-covered* shares the comparison of plans for her family of four in Atlanta. Looking at the plans carefully shows the details of how the decks favor the companies over patients. *(Detailed chart in our Google Drive)*

For this analysis, I have simplified Rachel's expenditures down to the $2000/mo she pays for insulin to answer the following questions: **How would different parameters affect the bottom line? Would the formulas work the same in different states? How much did the insurance actually contribute to medical services, and what percentage of the claims did the patient pay herself?**

The GA plan costs seemed completely outlandish asking Rachel for a $38,000 (bronze) and $55,000 (silver), with the insurer contributing about $8000 to her own much higher amounts. Comparison plans in MA would cost her $5K and $14K less for bronze and silver, with the MA plans contributing about double ($16K) those in GA, based in large part on regulation of deductibles in MA. In neither state would Rachel reach her OOPM; in both states, plan costs averaged about 50% of the average income for the U.S. ($80K/yr).

Compare these figures to the MA state-based SINGLE PAYER plan outlined in the Medicare for All bills: comprehensive coverage with no deductibles or out-or-pocket craziness would cost an employee roughly 2 or 2.5% of wages. At $80K, that would be $1600 or $2000/yr, not $38,000/yr. Why are we supporting Fortune-500 profits? *Barbara Pearson*

Article Archive

Recent Articles of Interest Related to Healthcare Reform

Hold down the CTRL key and click on the hyperlinks to access the articles.

Oct. 22, 2025 **Common Dreams**

"Universal Healthcare Will Save Lives...and Could Save the Democratic Party"

By Diljeet K. Singh

"As the only wealthy country without universal health coverage, sticking to our current system is truly not "politically feasible." Democratic leaders need to understand and embrace Americans' desire for change."

Nov.6, 2025 **HEALTH CARE un-covered**

"Where Do Our Health Insurance Premiums Go?"

By Rachel Madley, PhD

"Big Insurance has hauled in $500B in profits since 2014— enough to cover extending the enhanced ACA subsidies and leave $150B — yet it's gone to shareholders and executive bonuses instead of patients."

Nov. 11, 2025 **Becker Hospital Review**

"FAH president concerned healthcare is 'moving in the opposite direction'"

By Alan Condon

"The most urgent warning stems from the One Big Beautiful Bill Act, which would cause hospital revenues to decrease by about $4.5 trillion and lead to $1.2 trillion in reduced spending, according to the Congressional Budget Office. Medicaid spending is set to decrease by nearly $1 trillion, with the number of uninsured individuals projected to grow by 19 million by 2034."

Nov. 12, 2025 **Your Local Epidemiologist**

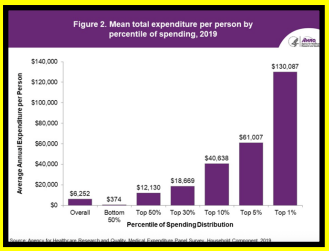
"Five Ways Our Health Care System Has Become Utterly Insane"

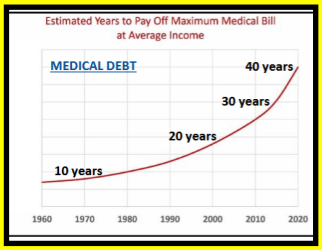
By Katelyn Jetelina and Hayden Rooke-Ley

Health Justice Monitor commentators Don McCanne and Jim Kahn say "This essay is a terrific primer for them. It's an insightful status check on the unhealthy state of our health system. Impression (a medical term): Imbalanced, with excess money and a care deficit – especially for those short on money. High costs and poor performance make it obvious that we need a transformed approach. Treatment plan: Radical shift from money focus to medical care. "

High Stakes. Worth the Risk?

Given the convoluted and cruel insurance math Rachel Madley introduced us to on page 2 of this newsletter, it really seems like the expiring tax credits have pushed commercial health insurance over the cliff. Who can or would buy $8000 (or even $16,000) worth of coverage for $38,000, let alone $55,000? It is really tempting to say, "Forget it, I'll take my chances." After all, in this chart from AHRQ on the left, the bar on the far right represents 1% of the population. That is, it's a very small percentage of people unlucky enough to incur catastrophic medical bills in any given year. But group statistics don't tell anything about what will happen to an individual. The graph on the right from a colleague shows his calculation that a maximally bad healthcare episode (if we didn't die from it), could take as much as 40 years (one's whole career!) to pay off. The stakes are too high.





Insurance that pools everyone's risk is the only rational approach. Luckily, plans for just that have been worked out in all the developing countries of the world (except the U.S.) and even the U.S. has bills pending that could take care of us all for far less than we're spending already. As AOC says, "If we had Medicare for All, you could simply go to the doctor." *Submitted by Barbara Pearson*