Senator Bernie Sanders’ Medicare for All Bill (S 1804)  
by Sarah K. Weinberg, MD, Editor

After many months of waiting, Sen. Sanders finally filed his bill “Medicare for All Act of 2017” on September 13. The bill has certainly led to an avalanche of commentary about what it would do, how likely (or unlikely) it is to become law, how to pay for it, and what its effect on the politics of the Democratic Party will be. This article is a summary of the bill, its strengths and weaknesses as seen through the filter of single-payer activists, and how it could be financed.

What does the bill do?

The bill establishes a federally administered national health insurance program based on Medicare and implemented over a four-year phase-in period.

- 1st year: Improves traditional Medicare by adding dental, vision and hearing aids, and eliminates all deductibles under Medicare Parts A, B, and D. Also, the age of eligibility is lowered to 55. An unspecified Medicare Transition plan will be established to provide affordable coverage for all and make sure no one loses coverage. All children from birth to age 18 would be eligible to enroll in Universal Medicare.

- 2nd year: Medicare eligibility age reduced to 45.

- 3rd year: Medicare eligibility age reduced to 35.

- 4th year: Every resident of the U.S. will be eligible and will get a Universal Medicare card to use to receive the health care they need. By this time, there will be no more need for networks; essentially all health professionals and other providers will be participants in the program. Patients can choose their doctors, hospitals and other health providers, and there will be no out-of-pocket costs. The benefits included are quite comprehensive.

The bill anticipates savings in our nation’s $3.2 trillion annual health care expenses from several sources: drastically reduced administrative costs; negotiated fees for health professionals, hospitals, and other providers; negotiated prescription drug, durable medical equipment, and medical device prices.
From the President’s Desk
by Marcia Stedman, President.

Here we grow again! Thanks to a successful summer of fundraising activity, we recently received a generous donation which has enabled us to increase our Program Director’s hours to nearly full time. As a result, you will be hearing much more from and about HCFA-WA in the near future. A case in point is the excellent article in The Stranger, published digitally on Sept. 20th http://www.thestranger.com/news/2017/09/20/25424440/we-can-have-single-payer-in-washington-state-by-2020-if-we-want-it We have also been able to open a search for field organizers in key areas of the state. Beginning with central and southwest Washington, we plan to expand to other areas in the near future. We also have a new part-time Communications Intern, Sydnie Jones, who will keep us active on social media and website updates, and assist with our print and digital publications. And, very soon, when you log onto www.healthcareforallwa.org, you will see our new website.

How have we been able to do all this? We have been following the steps laid out in our Strategic Plan by building relationships with our key allies, meeting with key legislators who sit on the House and Senate health care committees, participating in community events and forums, and speaking to a variety of activist groups that have formed as a result of the direct threats to our health care on the Federal level.

As an organization of volunteers, we depend upon the generosity of our members and supporters. If you are not yet a member, please join today. If you already are a member, check your mailing label on this Newsletter to see if it’s time to renew your membership. We invite you to consider donating an additional amount, either on our website or by mail. We are now ready to accept recurring monthly donations, making it easy to distribute the cost of your donation over an entire year.

The benefits of membership in HCFA-WA include:
• Quarterly Newsletter mailed to your home
• Opportunities for personal meetings with your legislators and Legislative leaders
• Opportunities to meet with other single-payer activists and supporters

Continued on p 5
Outreach Committee Report

By Ruth Knagenhjelm and Jeannie Ernst, Outreach Committee co-chairs

This summer was busy and productive with many opportunities to participate in events and sign up new supporters in different parts of Washington state, often in conjunction with groups such as Whole Washington, the Green Party, and others.

We worked with Democrats in different legislative districts, including tabling at festivals and having HCFA-WA speakers attend their monthly meetings to update their members about our activity and answer their questions about our legislation and “The Path to Single Payer”.

We had members who were on panels to discuss and answer questions after showings of the films “Fix It: Healthcare at the Tipping Point” and “Now Is the Time: Healthcare for Everybody”. We visited Vancouver WA, Port Orchard, Vashon Island, Tacoma, Silverdale, and more. Please do contact us if you would like a speaker or if we can help you – at a house party, a local theater, or even a pizza parlor! We have extra DVDs of “Fix It” to share.

We are currently organizing an event in Burien around October 25. It will be a “Learn More and/or Volunteer” get-together for all the legislative districts in the area. Please contact Jeannie at 206-383-3830 for more details or to let us know you are interested. You can also contact us through the HCFA-WA website: www.healthcareforallwa.org.

###

2017 New and Renewing Members

July-September 2017

**New**

John & Andrea Adams
John Baumann
Kathryn Carruthers
Cris Currie
Sari Lisa Davison
Lisa Dekker
Kristin Distelhorst
Jessica Felt
Joyce Gorham
Wendy Greenberg
Elizabeth Hanson
Elizabeth & Mike Hively
Wendy & John Indvik
Bert Jackson
Kathryn Keller
Ornie Kerr
Julia Maslach
Paul Merriman
Karen Noble
Paul Oldencamp
Andrea Opolenik
John Pizzo
R. Scott Raber
Diana Schott
Jim Schwing
Cynthia Sears
Claire Siegel
Rich & Lisa Thomas
Teresa Tyler
Leslie Weertman
Judith Zeh
Carolynn Zimmers

**Renewing**

Walter Alt
Jean Brechan
Nancy Corr
Kenneth Fabert
John Geyman
Marshall Goldberg
Marjorie Gray
Paul Grekin
Lee Gresko
Toby Harris
Dana Iorio
Jean & Roger Leed
Alice Litton
Ramona J. Memmer
Janice Ordos
Kelly Powers
Charlton Price
Paul & Mary Margaret Pruitt
EmilyRay
Chuck S. Richards
Elaine & Sidney Smith
James T. Smith
Ernest & Ruth Solowan
Jim Squire
Lounette Templeton
Sarah Weinberg
Robert Weschler
Dave & Jeanette Woodruff

Bits and Pieces

**From the new Director General of the World Health Organization**

Dr. Tedros Adhanom Ghebreyesus, who has been in charge of WHO for just three months, has made it clear that he will push hard on all governments to provide universal health coverage for their residents. “Universal health coverage should be [viewed] as a rights issue” he declared at the Social Good Summit meeting just before the opening of the United Nations General Assembly in New York. Dr. Tedros called on his audience to “talk to your respective governments to come to their senses and to make this happen.”
GET OUT THE VOTE! Washington State
Elections for 2017. Every election counts. Ballots will be mailed out on Friday, October 20th, and they must be returned by Tuesday, November 7th.

Everybody is talking about single-payer health care, from national efforts by Bernie Sanders (S 1804) and John Conyers (HR 676) to the Washington Health Security Trust (HB 1026 and SB 5701) here in our state. If you live in a Legislative District with elections this fall, you can help move the issue of single-payer health care. There is still time to register to vote, so check with your family and friends to make sure they know where and when to register — online by October 9th or in person by October 20th (see https://weiapplets.sos.wa.gov/MyVoteOLVR/MyVoteOLVR). There are elections in the 7th, 31st, 37th, 45th, and 48th Legislative District for state senators and representatives. The following candidates have answered our email survey stating that they support single-payer in Washington State:

7th LD – Karen Hardy – State Senate candidate
7th LD – Susan Swanson – State Representative Pos. 1 candidate
31st LD – Nate Lowry – State Representative Pos. 2 candidate
37th LD – Rebecca Saldana – State Senate candidate
45th LD – Manka Dhingra – State Senate candidate
48th LD – Patty Kuderer – State Senate candidate
48th LD – Vandana Slatter – State Representative Pos. 1

It is not too late to let candidates know that you support single-payer. Every telephone call, every letter, and every email will move us forward.

We are working closely with legislators in preparation for the 2018 Legislative Session. We are planning Action Team meetings in several districts in the next few months in order to prepare each member with key messages and action tools to improve our relationships with legislators. Watch for announcements of the meeting in your area. If any of your legislators are on the health care committee in the Washington State Senate or House, please tell them you want a hearing on the Washington State Health Security Trust in 2018. Now is the time to make appointments with all of our legislators.

We are working closely with the statewide organizations Health Care Is a Human Right Washington Campaign and Working Washington in order to get their endorsement of the WHST. If you are involved in local organizations, we can provide educational materials and programs for them. Now is the time to reach out to groups throughout the state.

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Check our Chair Marcia Stedman’s great LTE in the Seattle Times—https://www.seattletimes.com/opinion/letters-to-the-editor/business-and-health-competitiveness/

In reference to Boeing’s claim that Canadian airplane manufacturer Bombardier sold its airplanes in the U.S. at less than fair market value, due to government subsidies [“Big win for Boeing: U.S. slaps Canadian competitor,” Sept. 27, A1]:

Every business located in a country with a government-sponsored universal health care system has a pricing advantage when it comes to selling their products on the U.S. market. With health care provided to everyone as a public good and guaranteed by the government, businesses in Canada and 35 other developed countries of the world do not have to add the cost of employee health-care benefits to their pricing structure. They can be more competitive because basic human needs are taken care of by society, not by businesses. Such a system could continue to be privately delivered. Only its administration would be handled by a government entity, such as Medicare is now.

It’s time for American businesses to understand this and support universal health care in the U.S. If they did so, they could eliminate one of the costs that currently place their products at a competitive disadvantage with those of their counterparts abroad.

Marcia Stedman, Bothell
Republican ACA Repeal Graham-Cassidy Bill in a Nutshell

by Sarah K. Weinberg, MD, Editor

(It looks like this bill will be a footnote in history by the time this newsletter is issued.)

In a third attempt to “repeal and replace” the ACA, this slightly modified version of the Senate’s Better Care and Reconciliation Act (BCRA) is, if anything, even worse than its two predecessors. The bill keeps most of the provisions nibbling away at the patient protections of the ACA, and adds an even more draconian attack on Medicaid and ACA premium subsidies, not only shifting them to block grants to states, but also doing so in a way to take funds from states that expanded Medicaid under the ACA and give more to states that did not do so. And after 2026, all bets are off.

Although this bill appears dead, never doubt its possible zombie re-appearance. Should it become law, there will be time for more detailed analysis in a future issue of our newsletter.

Announcements

Washington Community Action Network annual awards breakfast

As in past years, Washington CAN will hold its annual social justice awards breakfast in October. The date this year is October 26, from 7:30 to 9:00 am. The location is the IAM District 751 Union Hall at 9125 15th Place S., Seattle, WA 98108. HCFA-WA and PNHPWW are sharing a table with ten seats. The expected donation is $60 if you want to reimburse either organization for its contribution. This event is a nice gathering of social progressives each year. Come if you can!

HCFA-WA’s Annual Meeting, November 4 at Horizon House

HCFA-WA will hold its Annual Meeting on Saturday, Nov. 4 at Horizon House, 900 University St., Seattle, one block north of Virginia Mason Hospital. Registration will start at 12:30 pm, and the meeting will begin at 1:00 pm. We encourage each of you to come and be a part of this year’s learning and discussions – there is so much going on regarding health reform this year! The event is open to the public and free of charge. Light refreshments will be served.

President’s desk

• Invitations to public events and forums
• The opportunity to make a difference for the public good
• The right to vote at our Annual Membership Meeting

Save the date! Annual Membership Meeting – Sat., Nov. 4th – Horizon House, 900 University Street, Seattle, WA - 1:00-4:00 p.m. (registration opens at 12:30 p.m.)

In addition to hearing from a prominent state legislator, you will have an opportunity to learn about our Strategic Plan and meet other activists. This event is free and open to the public. Light refreshments will be provided. During the business meeting, we will be electing officers and at least one new member of the Board of Directors. We will also be voting on an amendment to our Bylaws (see announcement in this issue). Please plan now to attend. I hope to see you there.

###
The intent is to shift the focus of the U.S. health care system from profit-seeking to caring for the health care needs of people living in the U.S.

Strengths

- Universal health coverage after 4 years – Everybody In, Nobody Out!
- Comprehensive coverage – all medically necessary care
- No cost sharing when receiving care
- Free choice of doctor, hospital, etc.
- Ability to control costs

All of these strengths have been successful in other developed nations’ health care systems.

Weaknesses (room for improvement?)

- The small co-payments for some prescription drugs should be eliminated. Studies have shown that even small co-pays discourage patients from getting needed medications, leading to worse health effects. The administrative costs of collecting co-pays is likely to exceed the funds brought in, making co-pays just a penalty for the patient. Negotiated prices should be more effective in keeping drug costs reasonable.
- Long-term care is not included, but is only covered by Medicaid for those patients who are impoverished. A program for long-term care coverage should be added to Universal Medicare in the future. (My guess is that it was left out because it is a huge expense.)
- Use global budgeting for hospitals and other large provider groups or organizations. This approach reduces administration costs, and also is better at encouraging large providers to care for everyone seeking their services and not cherry-pick the patients that would generate the highest fees.
- Separate capital budgets from operating expenses for hospitals and large provider groups. Expansions, remodeling, advertising, etc. would be budgeted separately and subject to assessment of a community’s need for more facilities.
- For-profit entities are not prohibited, but they should be phased out. Currently, for-profit providers provide inferior care and have higher mortality rates than non-profit entities.
- The Veterans Administration health system and the Indian Health Service are left out. They should be incorporated into Universal Medicare in the future.

Funding

First and foremost it’s important to remember that the U.S. is spending $3.2 trillion per year under the current system. Around 65% of that sum, over $2 trillion, is already paid through various tax-supported government programs. Much of the total spending is wasteful and could be sharply reduced in a Universal Medicare system: unnecessary administrative expenses, exorbitant prices charged by providers, profiteering prices for prescription drugs, high prices for durable medical equipment and medical devices, etc. Studies have estimated $500 billion in administrative savings, and $113 billion in lower drug costs alone, which would reduce the amount of additional tax revenue (over the $2 trillion already being spent by tax dollars) to about $600 billion per year.

Remember also that residents of the U.S. would no longer have to pay private health insurance premiums, deductibles, and co-payments, but would pay increased taxes instead. A progressive tax system would mean that all but the very wealthy would pay less for health coverage than they are currently paying under the present system.

Funding options

- 7.5% payroll tax paid by employers, with provisions to cover the 4-year transition and to exempt small businesses with less than $2 million yearly payroll.
- 4% “premium” on household income. Because of the standard deduction, families of four making less than $29,000 a year would pay nothing.
- Eliminate several tax breaks that would no longer be needed, mainly the one that allows employers to deduct their cost of providing private health insurance for their employees.

Taken together, these three funding options could raise about $1.06 trillion per year. Another approach would be to reform the personal income tax system to make it more progressive:
• Raise marginal income tax rates on incomes above $250,000 in graduated steps to a ceiling of 52% on incomes above $10 million (just 16,700 households in 2014).
• Tax investment income the same as income from work, at least for households with income above $250,000.
• Limit tax deductions for the wealthy. Taken together, these federal income tax changes would raise about $180 billion per year.

Additional tax changes that mainly affect the wealthy:
• Make the estate tax more progressive by exempting the first $3.5 million ($7 million for a married couple) and change the tax rate from a flat 40% in graduated steps to 50% for estates over $50 million (plus an additional 10% surcharge if the estate is over $500 million). This plan would also close some loopholes used to lower estate valuation, but increase existing protections for farmland and conservation. ($24.9 billion per year)
• Establish a wealth tax on the top 0.1%. The tax would be 1% annually on a household’s net worth exceeding $21 million. The tax would only be paid on the amount exceeding $21 million. ($130 billion per year)
• Close the Gingrich-Edwards loophole that allows some individual business owners to avoid paying the existing 3.8% tax on earned income. ($24.7 billion per year)

Taken together, these changes in taxes on the wealthy would bring in $202.4 billion per year, plus the one-time repatriation tax of $767 billion. Overall, the income and related wealth taxes would raise $382.4 billion per year plus the one-time $767 billion.

If all these taxes and fees were implemented, they would raise an estimated $16.2 trillion dollars over 10 years, or $1.6 trillion dollars per year. Assuming that the taxes currently supporting the $2 trillion already being spent by federal health programs remain unchanged, $1.6 trillion per year should be ample to cover the amount now being paid through private insurance premiums and out-of-pocket expenditures. And that’s without taking into account the $600+ billion per year in savings available to a Universal Medicare program.

WOW!!! Let’s go – MEDICARE FOR ALL!

###

**Sanders Medicare for All**  
Continued from p 6

- One-time tax on currently held offshore profits. ($767 billion paid once)
- Fee imposed on large financial institutions with assets currently amounting to 56% of our entire GDP. ($11.7 billion per year)
- Disallow corporate accounting gimmicks that hide profits. ($11.2 billion per year)

Bits and Pieces

**How to handle overpriced imaging procedures**

Prices for MRIs and CT scans are more expensive in hospitals and outpatient departments than in free-standing facilities. Both Medicare and Anthem, a private insurer, are taking steps to deal with this problem. Their different approaches illustrate the difference between a patient-oriented system and a for-profit business system.

Medicare set regulations that no longer allow higher charges for hospital-owned facilities, meaning that patients can go where it’s convenient related to other care they are receiving, and Medicare will not be overcharged. (This policy also reduces the incentive for hospitals to buy up small clinics in order to be able to charge more for these imaging studies.)

Anthem, on the other hand, announced that it will not cover imaging in hospital-owned facilities, but requires patients to go find a free-standing imaging center for needed studies, whether or not that center can communicate the results easily with the patients’ physicians. This can be a considerable burden on a sick patient with extensive treatment needs.
(Dr. Atul Gawande is a Boston surgeon who has written several books about health policy and how health care systems function, although his most recent book, a best-seller, is “Being Mortal”, about facing the end of life in the 21st century. He also writes frequently in The New Yorker. This article being reviewed was published in the October 2, 2017 issue.)

Dr. Gawande approaches this question whether health care is a right in an unusual way: he visited Athens, Ohio, the town where he grew up, and interviewed quite a few people there, both friends from childhood and others he met now. The town, in the Appalachian foothills, is where “[t]he battle over whether to repeal, replace, or repair the Affordable Care Act …continues to rage now.”

Using conversations he had with residents, Dr. Gawande brings to life several of the issues Americans are struggling with regarding the best way to handle access to, and affordability of, health care in today’s U.S.:

- Deserving vs undeserving: should people “be judged by how they treat the least of our society” or, “I work really hard. I deserve a little more than the guy who sits around.” (Both quotes are from “Maria”, wrestling with the moral conflict.)

- Several interviewees said their views changed after they survived life-threatening illnesses that also were very expensive. One, now working in the city’s water treatment plant observed: “People don’t think about their water, but we can’t live without it”. He now understands that both a safe water supply and health care should be a government responsibility.

- Medicare as it is now vs expanding Medicare to cover everyone: “We all pay in for [Medicare], and we all benefit.”

This view makes the argument “less about a universal right than about a universal agreement on how much we give and how much we get.”

Dr. Gawande continues with an examination of the history of the U.S. government’s involvement with health care issues. In the late 18th century, health care was too primitive to make much of a difference to life or liberty, and was ignored by the Constitution. That began to change in 1801 when Edward Jenner developed a smallpox vaccine from cowpox. President Jefferson “arranged for the vaccination of 200 relatives, neighbors, and slaves at Monticello.” How that played out with government involvement in the U.S. vs in Europe is worth reading the article to find out!

“The fact that public vaccination programs eventually became ubiquitous (even if it took generations) might tell us something about the ultimate direction of our history – the direction in which we are still slowly, fitfully creeping.”

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Sarah K. Weinberg, MD, Editor
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.  
$____ total

  Suggested contribution $35_____ $ 50 _____ $100______ Other $________

___Check ___Visa___ MasterCard #___________________________ Exp. Date_______

Name: __________________________________________________________________
Address __________________________________________________________________
Phone ___________ Email__________________________________________________
Legislative District ______                                        Monthly email bulletins __Yes __ No

Thank you for your support.  
**Health Care For All-WA**  
PO Box 30506 Seattle, WA 98113-0506 (707)742-3292  
Info@healthcareforallwa.org ; www.healthcareforallwa.org

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**Welcome to Sydnie Jones!**

Sydnie Jones is HCFA-WA’s new communications intern. She has a background in sports and advocacy writing. Her analysis of sexism and domestic violence in mixed martial arts brought industry-wide attention to the issue, reaching disparate audiences. She brings that same ability to the communications team at HCFA-WA.

Sydnie was born and raised in Alaska, studied English at the University of New Orleans, and ultimately graduated with a BFA from the Art Institute of Seattle. Since graduation, advocacy writing has been a constant for her, and interning for HCFA-WA marks her first foray into non-profit work.

Sydnie is also writing a novel and spends her spare time training Brazilian jiu jitsu.
Check your label for the date of your last contribution. Renew your membership now for 2017

**Amendment to HCFA-WA By-Laws for Annual meeting Vote**

*At the Annual Meeting of the membership of Health Care for All – Washington we will be voting on an amendment to our By-Laws. The current language:*

Article V: BOARD OF DIRECTORS: HCFA-WA shall be governed by a Board of Directors consisting of officers of the Corporation (President, Vice President, Secretary and Treasurer), and up to twelve Directors at Large, to include the chairs of the Standing Committees, and one director chosen annually by each duly adopted chapter.

The term of HCFA-WA President will be for two years, and the term of Past President will be for one year, during which s/he may serve on any Standing Committee, ex officio. [adopted 11/16]

The proposed amendment would add a third sentence to Article V: “As of November 2018, the term of office for all officers of the Corporation (President, Vice President, Secretary, Treasurer) shall be two years.”

###