Lunch & Learn Series:
Healthcare Justice
March 18, 2020
The Shriver Center on Poverty Law fights for economic and racial justice. Over our 50-year history, we have secured hundreds of victories with and for people living in poverty in Illinois and across the country. Today, we litigate, shape policy, and train and convene multi-state networks of lawyers, community leaders, and activists nationwide. Together, we are building a future where all people have equal dignity, respect, and power under the law. Join the fight at povertylaw.org.
Response to COVID-19
Response, Care, and Advocacy for the Communities We Serve

povertylaw.org/pritzkerletter
Today’s Agenda

• What Can Illinois Do to Cover the Remaining Uninsured?
  • Stephanie Altman, Shriver Center on Poverty Law
• Heath Disparities & Insurance Landscape
  • Dr. Susan Rogers, Physicians for a National Health Program
• Moderated Q&A
• Audience Q&A
Stephanie Altman, Director of Healthcare Justice & Senior Director of Policy, Shriver Center on Poverty Law
What Can Illinois Do to Cover the Remaining Uninsured?

Advocacy on State, Local and Federal Fronts to Combat COVID-19
What can we do now to combat COVID-19

- Shriver Center has sent recommendations to the Governor including expanding Medicaid, covering the uninsured, and expediting Medicaid processing.
- We are working with legislators, Congressional delegation members and the state administration to implement emergency policies including Medicaid announcement to cover COVID-19 tests and treatment for uninsured.
- Federal government flexibility on Medicaid to increase funds, eligibility, and coverage.
Gov Pritzker Ran on Medicaid Buy In (“Illinois Cares”) during Campaign
What is a Medicaid Buy-In?

- People use the term “Medicaid buy-in” to describe a wide range of state policies that allow individuals not otherwise eligible for Medicaid to pay to access Medicaid or a Medicaid-like insurance plan.
- States may also use different names – like “public option”
- Core feature of a buy-in is to provide more affordable options to individuals and families by leveraging other state-run programs, such as a state employee health plan or basic health program.
- While buy-in options differ, they utilize the state’s administrative and purchasing power to provide more coverage options and create affordable, quality plans for residents.
Potential Goals for an Illinois Medicaid Buy-in

- Increase health coverage
- Cover undocumented adults
- Introduce more competition
- Lower consumer costs
- Alignment with Marketplace
- Minimize Churn and Disruption
- Road to Single Payer
- Reduce Threat From the Trump Administration (Health Repeal lawsuit, executive orders, etc.)
Resources

• HB4891 has been introduced

• Shriver Center 2020 Policy Agenda:
  https://www.povertylaw.org/article/agenda2020/

• Shriver Center Recommendation on COVID-19
  https://www.povertylaw.org/article/pritzkerletter/
Dr. Susan Rogers, MD, FACP, President-elect of Physicians for a National Health Program
WHY WE NEED MEDICARE FOR ALL

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The economics of medical care in the United States has made poor patients the ones no one wants to treat.
Concentrated poverty is where more than 40% live below the FPL
US Public Spending per Capita for Health Exceeds Total Spending in Other Nations

Note: “Public” includes benefit costs for gvt employees and tax subsidies for private insurance
OECD 2019; NCHS; AJPH 2016;106:449 (updated) – Data are for 2018
Uninsured All Year, 1940-2018

Source: Social Security Bul, HIAA, CPS, and CBO estimate
Uninsured by Race/Ethnicity, 2018

- White Non-Hispanic: 5.4%
- Black: 9.7%
- Hispanic: 17.9%
- Native American: 20.2%
- Asian: 6.8%
Under-insurance Growing

Percent of Adults 19-64 under-insured*

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<td>9%</td>
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Commonwealth Fund Health insurance Surveys 2003-2018

*Under-insurance is defined here as being insured all year, but out-of-pocket expenses were >10% of income (>5% of income if low income) or deductible was >5% of income
Life Expectancy

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OECD, 2019

Note: Data are for 2017 or most recent year available
INEQUITIES

- Black lives are at least 3 yrs shorter
  - Black infant mortality is twice that of white babies
  - Black maternal mortality is 3x white maternal mortality
- Lack of Medicaid expansion left almost ¼ of blacks uninsured
THERE IS LITTLE CHOICE WITH PRIVATE HEALTH INSURANCE

• Private health insurance limits choice to the network of doctors and hospitals with whom they have negotiated contracts and drug benefits

• You pay more to go out of network, end up with surprise bills

• Difficult to determine what your plan offers or what services are covered

• Less than half of those employed have choice of insurance plans which can then change every year
Drug Company Profits

Return on Revenue (%)


Drug Companies  
Fortune 500 Median

Fortune 500 rankings for 1995-2017

Total drug company profits, 2017 = $44.4 billion. Depressed by one-time charges for repatriated profits.
Medicare Would Have Saved $71 Billion Over 6 Years if it Paid VA Prices

Spending for top 50 drugs ($s Billions)

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Millions Lose Private Insurance Every Year

Unknown millions affected

- Quit Job: 40.1
- Fired: 21.9
- Turned 26: 4.5
- Other Job Change: 4.1
- Turned 65: 3.7
- Divorce: 1.5

One in seven firms switch coverage every year; unknown millions affected


Other reasons for involuntary switch: Employer stopped offering coverage; coverage too expensive; policy holder died; hours dropped.
Wasted Money on Bureaucracy

Duke University Hospital System
(3 Hospitals)

957 Hospital Beds
1600 Billing Clerks

Single Payer/Medicare for All

**Comprehensive coverage**
- Preventive services
- Hospital care
- Physician services
- Dental services
- Mental health services
- Medication expenses
- Reproductive health services
- Physical/Occupational Therapy
- Home Care/Nursing home care/Long term care

“All medically necessary services”

No co-pays or deductibles
Single Payer Medicare for All Makes Economic Sense

29 studies: The savings would fund full coverage.

247 economists: “The time is now for Medicare for All.”

“Health care is not a service that follows standard market rules. It should therefore be provided as a public good.”

Public Option = High Costs
IT IS STILL BASED ON PRIVATE INSURANCE

• Less savings than single payer because of **insurers’ overhead**
• Multiple payers = no savings on **billing and administration**
• Private insurers will **tilt the playing field** (as under Medicare Advantage) raising system-wide costs and perpetuating network restrictions, cherry-picking, lemon dropping etc.
• Higher system-wide costs (compared to single payer) assure **political pressure for benefit cuts**
COVID19

- Highlights the reason everyone needs access to healthcare
- Everyone benefits from testing, treatment
- National protection, not piecemeal
For more information

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I'M JUST NOT SEEING ANY GOOD SOLUTIONS.
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- **Total Spending**
  - UK: $4,070
  - Japan: $4,770
  - France: $4,970
  - Canada: $4,970
  - Sweden: $5,450
  - Holland: $5,290
  - Germ: $5,990
  - Switz: $7,320
  - USA: $7,273

- **USA Public**
  - USA Total: $3,847

- **USA Private**
  - USA Total: $11,120

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Return on Revenue (%)

1995
- Drug Companies: 14%
- Fortune 500 Median: 5%

2000
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Take Action Today

• Share our COVID-19 Policy Priorities for Low-Income Communities

• Follow the Shriver Center on Social Media & Share Our Posts

• Ask the Shriver Center or PNHP to Present
  stephaniealtman@povertylaw.org

ADD SUSAN EMAIL

For economic and racial justice