Retired Public Employees Council of WA

April 4, 2024

Rose Roach
National Coordinator, Labor Campaign for Single Payer
Chair, Health Care for All MN

Here's the PROBLEM...

The U.S. Health Care System in the ...

- **Health Insurers Gave $120 Billion To Shareholders While Denying Your Claim** (The Lever 12/11/24)
- **How Health Insurers Racked Up Billions in Extra Payments From Medicare Advantage** (WSJ 1/2/25)
- **It was stunning. Bipartisan anger aimed at Medicare Advantage care denials** (Politico 11/24/23)
- **Legalized Racketeering; How PBMs Skirt the Law to Rake in Billions** (Health Care Uncovered 10/7/24)
- **UnitedHealth, employer of slain exec Brian Thompson, found to have overcharged some cancer patients for drugs by over 1000 percent** (MSN 1/24)

INVESTING

FINANCE | BANKS | INVESTING | WALL STREET | HEDGE FUNDS | M&A | INS

Goldman Sachs asks in biotech research report: 'Is curing patients a sustainable business model?'

Tae Kim | @firstadopter

Published 3:15 PM ET Wed, 11 April 2018 | Updated 7:20 PM ET Wed, 11 April 2018

CNBC

“The success of its [Gilead’s] hepatitis C franchise has gradually exhausted the available pool of treatable patients. . .In the case of infectious diseases such as hepatitis C, curing existing patients also decreases the number of carriers able to transmit the virus to new patients.”

Vertical Business Relationships Among Insurers, PBMs, Specialty Pharmacies, and Providers, 2024

1. Centene began outsourcing its PBM operations to Express Scripts in 2024. In 2023, Centene rebranded its Envolve Pharmacy Solutions pharmacy benefit subsidiary as Centene Pharmacy Services. In 2022, Prime Therapeutics completed its acquisition of Magellan Rx from Centene.
2. Synergie is a buying group focused on medical benefit drugs. Its ownership includes Blue Cross Blue Shield (BCBS) Association, Prime Therapeutics, Elevance Health, and other independent BCBS health plans.
3. Since 2021, Prime's Blue Cross and Blue Shield plans have had the option to use Express Scripts or AllianceRx Walgreens Pharmacy for mail/specialty pharmacy services. In 2021, Walgreens purchased Prime Therapeutics' 45% ownership interest, so this business had no PBM ownership as of 2022. In 2022, the company was rebranded as AllianceRx Walgreens Pharmacy. In August 2024, AllianceRx Walgreens Pharmacy will become Walgreens Specialty Pharmacy.
4. In 2021, Centene sold a majority stake in its U.S. Medical Management to a group of private equity firms.
5. Since 2020, Prime has sourced formulary rebates via Ascent Health Services. In 2021, Humana began sourcing formulary rebates via Ascent Health Services for its commercial plans.
6. In 2023, Cigna's Evernorth business made a significant minority investment CarepathRx Health System Solutions.
7. Previously known as Evernorth Care Group and Cigna Medical Group.
8. In 2021, Cigna's Evernorth business acquired MDLive.
9. Walgreens owns a majority of VillageMD. In 2022, Cigna invested $2.7 billion for an estimated 14% ownership stake in VillageMD. In 2024, Cigna recorded a $1.8 billion loss on its investment.
10. In 2023, CVS Health completed its acquisitions of Signify Health and Oak Street Health.
11. Previously known as IngenioRx.
12. In 2023, Elevance Health completed its acquisition of BioPlus Specialty Pharmacy from CarepathRx. In 2024, Elevance Health acquired Paragon Healthcare, which operates specialty pharmacies and infusion centers, and Kroger Specialty Pharmacy.
13. Includes CareMore Health and Aspire Health. In 2024, CarelonRx announced a primary care partnership with investment firm Clayton, Dubilier & Rice.
14. In 2021, Partners in Primary Care and Family Physicians Group businesses were rebranded as Centerwell Senior Primary Care.
15. In 2022, Kindred at Home was rebranded as CenterWell Home Health. In 2022, Humana announced an agreement to divest its majority interest in Kindred at Home's Hospice and Personal Care Divisions to Clayton, Dubilier & Rice. Humana also announced plans to close a majority of its SeniorBridge home care locations.

Source: *The 2024 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers*, Exhibit 254. Companies are listed alphabetically by corporate name.


RACISM
is a
Public Health
CRISIS

Managed care was and is ineffective because the diagnosis was wrong: Price versus quantity

- **Since the early 1970s, HMO and privatization advocates have claimed US health care costs are high because doctors order too many services due to the fee-for-service method by which doctors are paid; this has become an accepted this claim without solid evidence to back it up.**
- **Pockets of overuse exist, but documented overuse is not widespread; excessive prices (which reflect administrative costs) for everything (insurance, physician and hospital services, drugs) is the reason US costs are so high.**

It's The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

PROLOGUE: In Fall 1986 *Health Affairs* published the first of nearly two decades' worth of reports summarizing the state of health care spending in industrialized countries that are members of the Organization for Economic Cooperation and Development (OECD). In that first report, featuring 1984 data, the United States led the way in per capita health care spending at $1,637, nearly double the OECD mean of $871 (in purchasing power parities based on the U.S. dollar). In the latest offering, featuring data from 2000, the situation is much the same, although the absolute numbers are much higher (U.S. per capita spending of $4,631, compared with an OECD median of $1,983).

Over the years the OECD has refined its methodology to improve the comparability of data from vastly different health care systems. The analysis published in *Health Affairs* has greatly expanded from those early reports to examine underlying trends in spending differentials and to examine what the different countries get for their health care dollar in terms of population health indicators. In the current report, the authors look in depth at factors contributing to higher health care prices in the United States, which they contend are responsible for much of the difference between the U.S. spending levels and those of the other countries.

Lead author Gerard Anderson has been on the faculty of the Johns Hopkins University since 1983. He is a professor in the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, and serves as that department's associate chair. He holds a doctorate in public policy analysis from the University of Pennsylvania. Uwe Reinhardt is the James Madison Professor of Political Economy at the Woodrow Wilson School, Princeton University. He holds a doctorate in economics from Yale. Peter Hussey is a doctoral candidate in the Department of Health Policy and Management. He serves as a consultant to the OECD Social Policy Division/Health Policy Unit. Research assistant Varduhi Petrosyan is also a doctoral candidate at Hopkins. She will become an assistant professor at American University of Armenia in May 2003.


YOUR INSURANCE DOESN'T COVER MUCH.
WHAT'S COVERED?
WELL, WHY DON'T YOU TELL ME THE PROBLEM AND I'LL TELL YOU IF IT'S COVERED.
I'M SICK.
NOPE.

MA corporations game the payment model

MedPAC estimates **$83 billion**

PNHP estimates this adds up **to $140 billion** per year

$106 billion of that could be used to improve TM

Ending MA subsidies would make

$83-106 billion

available to improve Medicare.

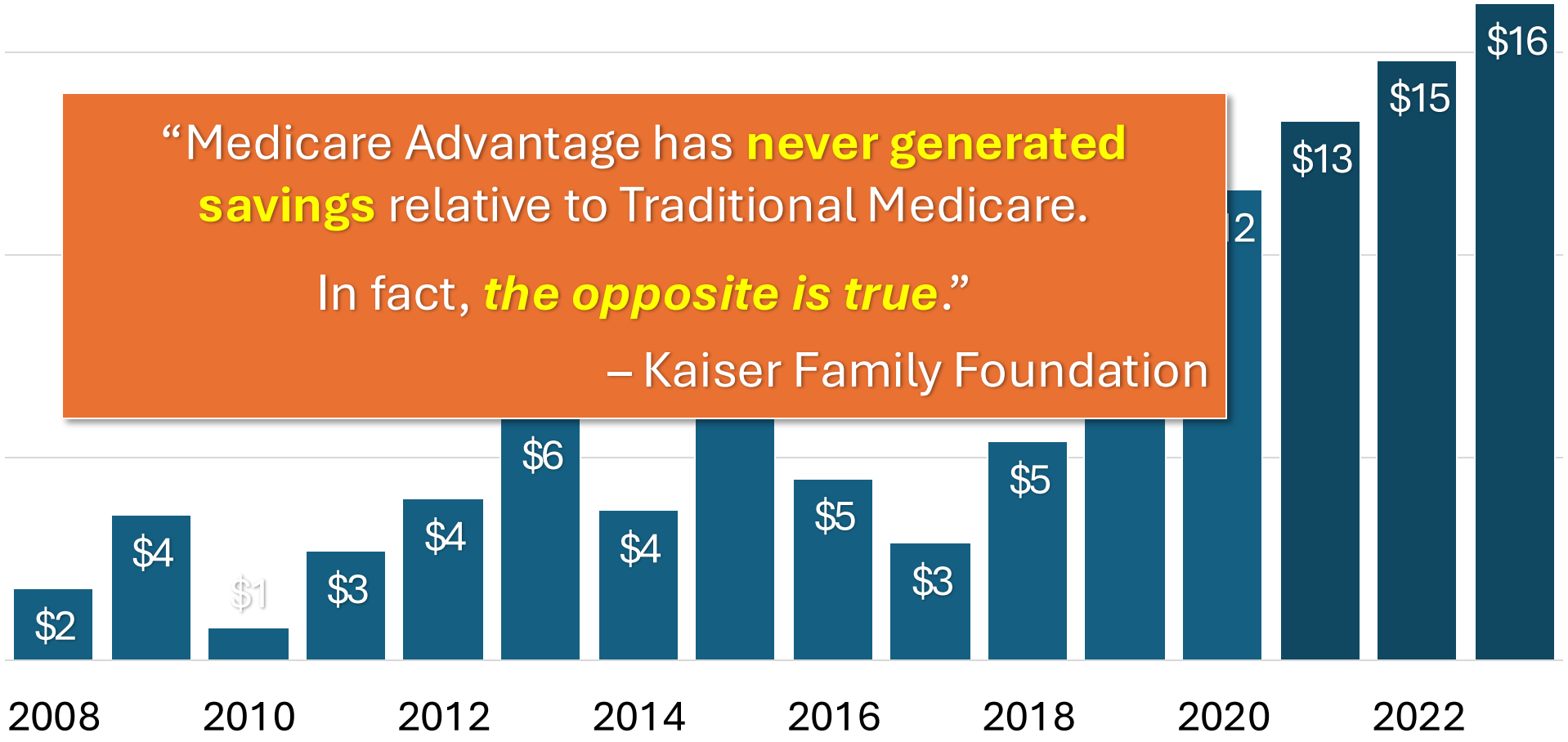
What could we do with those funds?

PNHP's 2023 report on overpayments to Medicare Advantage
https://pnhp.org/system/assets/uploads/2023/09/MAOverpaymentReport_Final.pdf

Uncorrected Medicare Advantage coding intensity

Drains Billions of Dollars from Medicare

$ billions paid to MA plans based on differences in dx coding



"Medicare Advantage has **never generated savings** relative to Traditional Medicare.

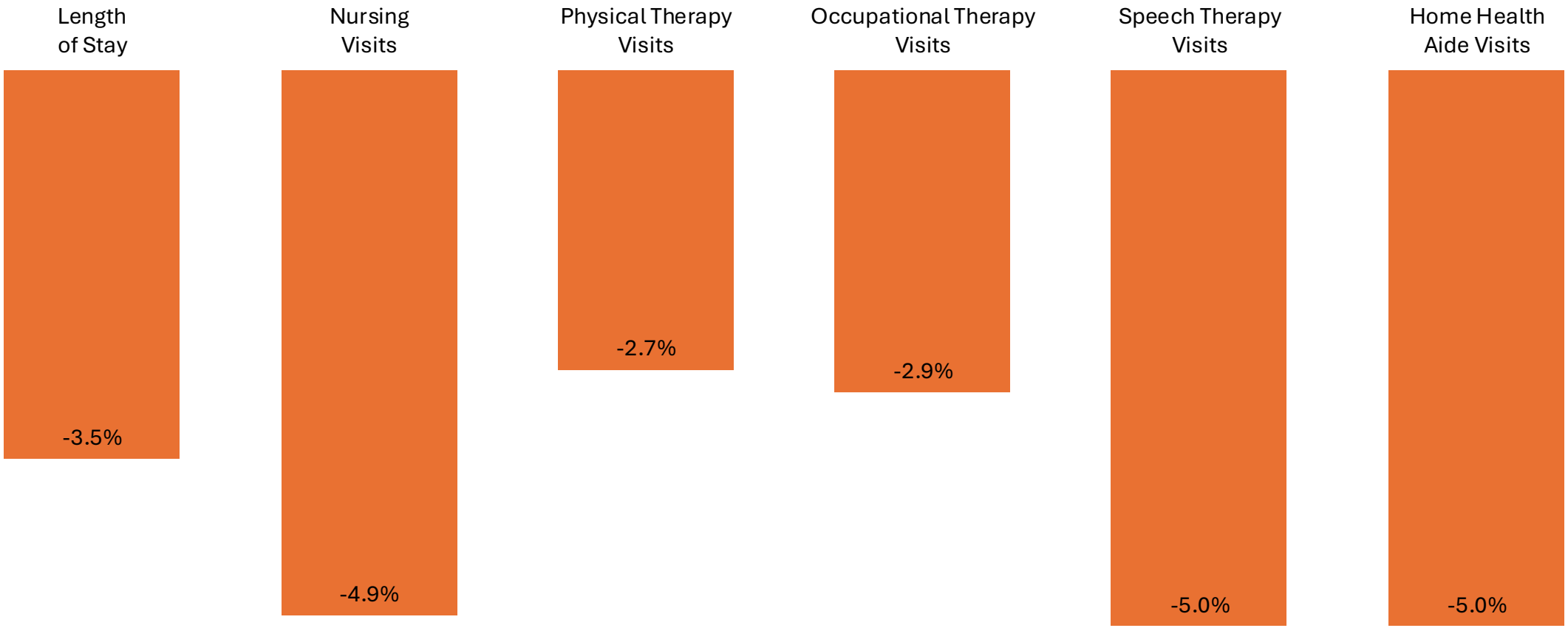
In fact, ***the opposite is true***."

– Kaiser Family Foundation

https://www.medpac.gov/wp-content/uploads/2022/03/03032022_MA_Coding_MedPAC_COMMENT_SEC.pdf
2021-2023 estimates from MedPAC (March 2022)
https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/?utm_campaign=KFF-2021-Medicare&utm_medium=email&_hsmi=2&_hsenc=p2ANqtz--NbWFYepJ3_bF07nVVqdBF1nXFKwXuVn9L66uGcqn5hPdz7Tiot2L7eMwnyN0vSl6Bnbb1hZiyrztywKa3saASppissA&utm_content=2&utm_source=hs_email

Compared to people in Traditional Medicare,

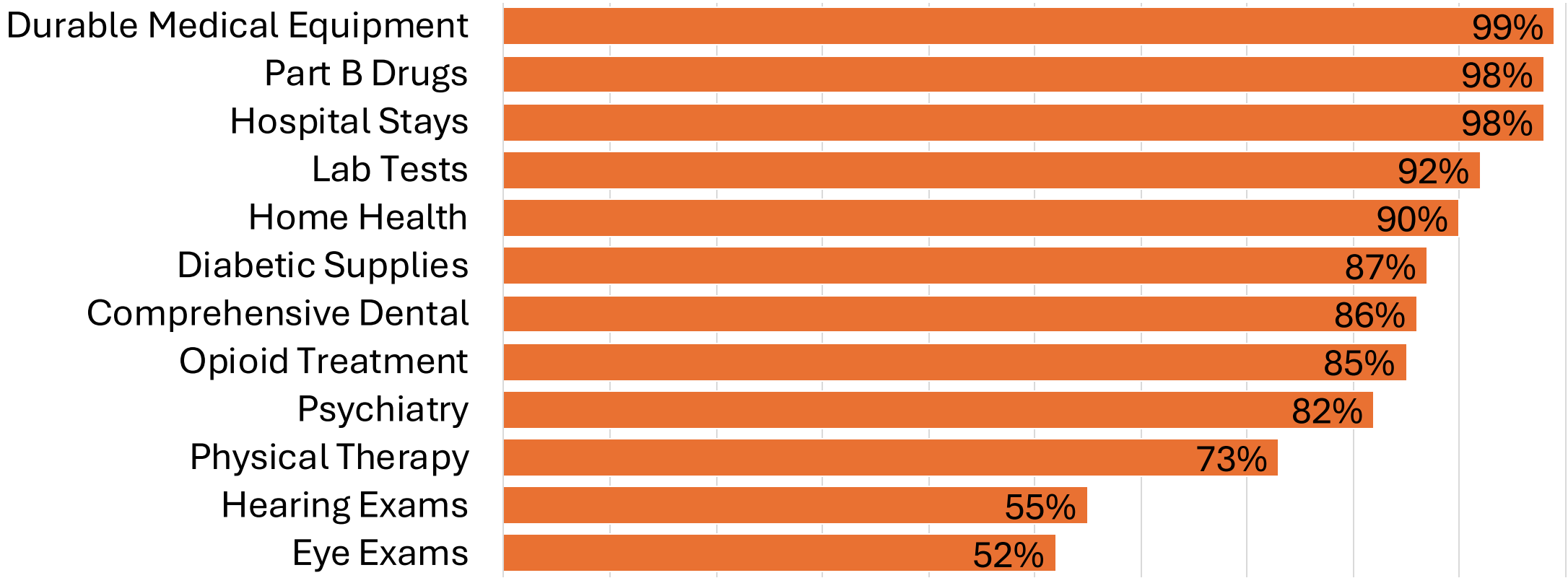
MA Beneficiaries Receive Less Health Care



Data from: Prusynski RA, D'Alonzo A, Johnson MP, Mroz TM, Leland NE. Differences in Home Health Services and Outcomes Between Traditional Medicare and Medicare Advantage. JAMA Health Forum 2024;5(3):e235454. Differences are adjusted.

Unlike Traditional Medicare,

MA Requires Prior Authorization for Care



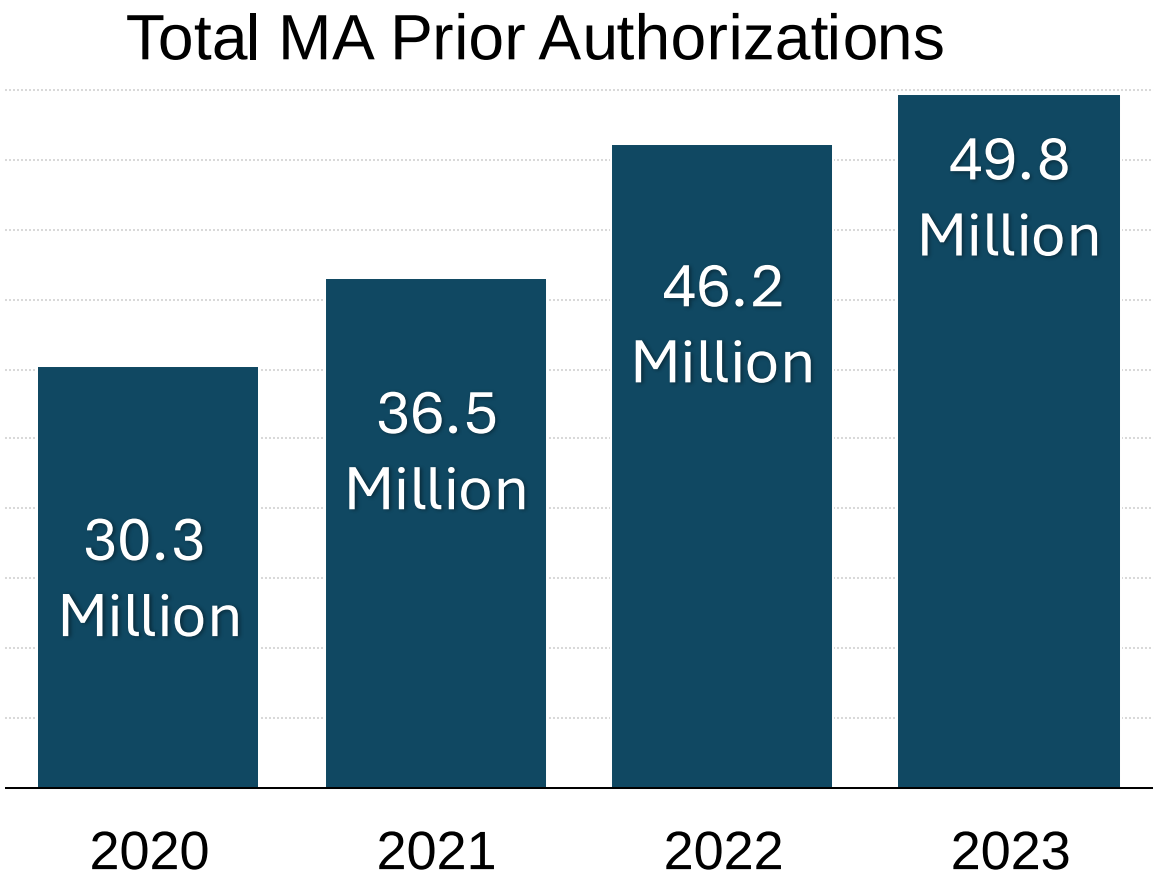
https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/

https://www.kff.org/medicare/issue-brief/use-of-prior-authorization-in-medicare-advantage-exceeded-46-million-requests-in-2022/#:~:text=Virtually%20all%20enrollees%20in%20Medicare,nursing%20facility%20stays%2C%20and%20chemotherapy.

Accessed Aug 31 2024

Unlike traditional Medicare,

MA Is Leaning Into Prior Authorizations



Medicare Advantage	Traditional Medicare
1.8 PAs *per person each year*	**1 PA per *100* *people* *in a year***

Per person data is from 2023 experience
https://www.kff.org/medicare/issue-brief/nearly-50-million-prior-authorization-requests-were-sent-to-medicare-advantage-insurers-in-2023/

Conclusion: Medicare “Advantage” corporations inflict

More Harm Than We’d Realized

Death rates double after some cancer surgeries

MA patients often **blocked from the best** cancer doctors / hospitals

7.3 million people in MA are underinsured

High out-of-pocket costs force people to **avoid and delay needed care**

11.7 million people in MA are in a narrow network

“Insurance” that **excludes most of the physicians** in their county

Up to 20 million hours per year wasted

Medical practice time spent on “Prior Authorizations” **just from MA**

Prior authorizations, narrow networks, underinsurance, and *deaths*.

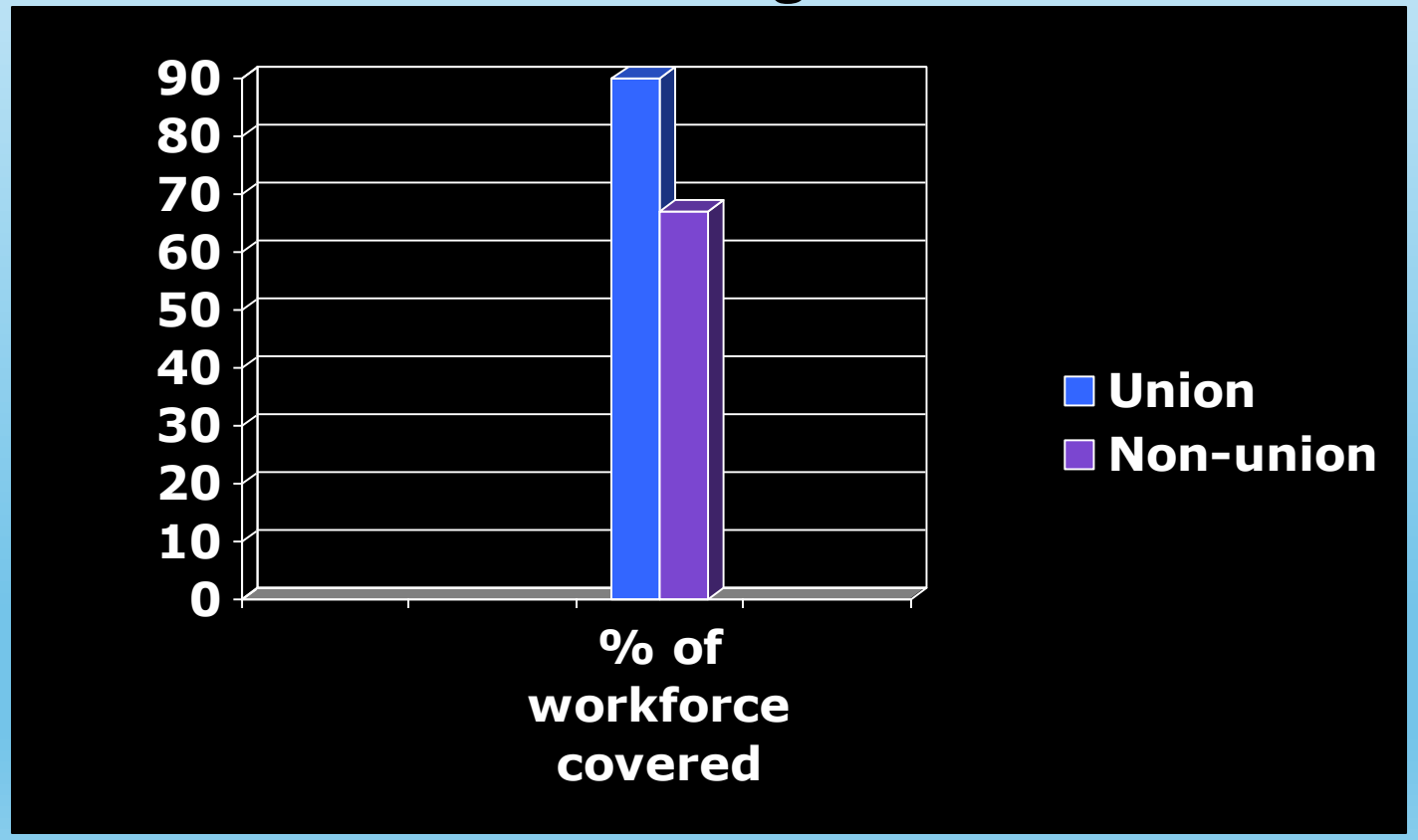
These numbers are all related to each other.

Notes: Pancreatic surgery 30-day post-operative mortality rate adjusted odds ratio of 2.0 in MA vs TM;
“Narrow network” defined as excluding more than 70% of physicians in a patient’s county
PNHP.org/HarmsReport

A Labor Perspective

The Union Advantage

Your union membership stands between you and the trend of declining workplace-based health care coverage

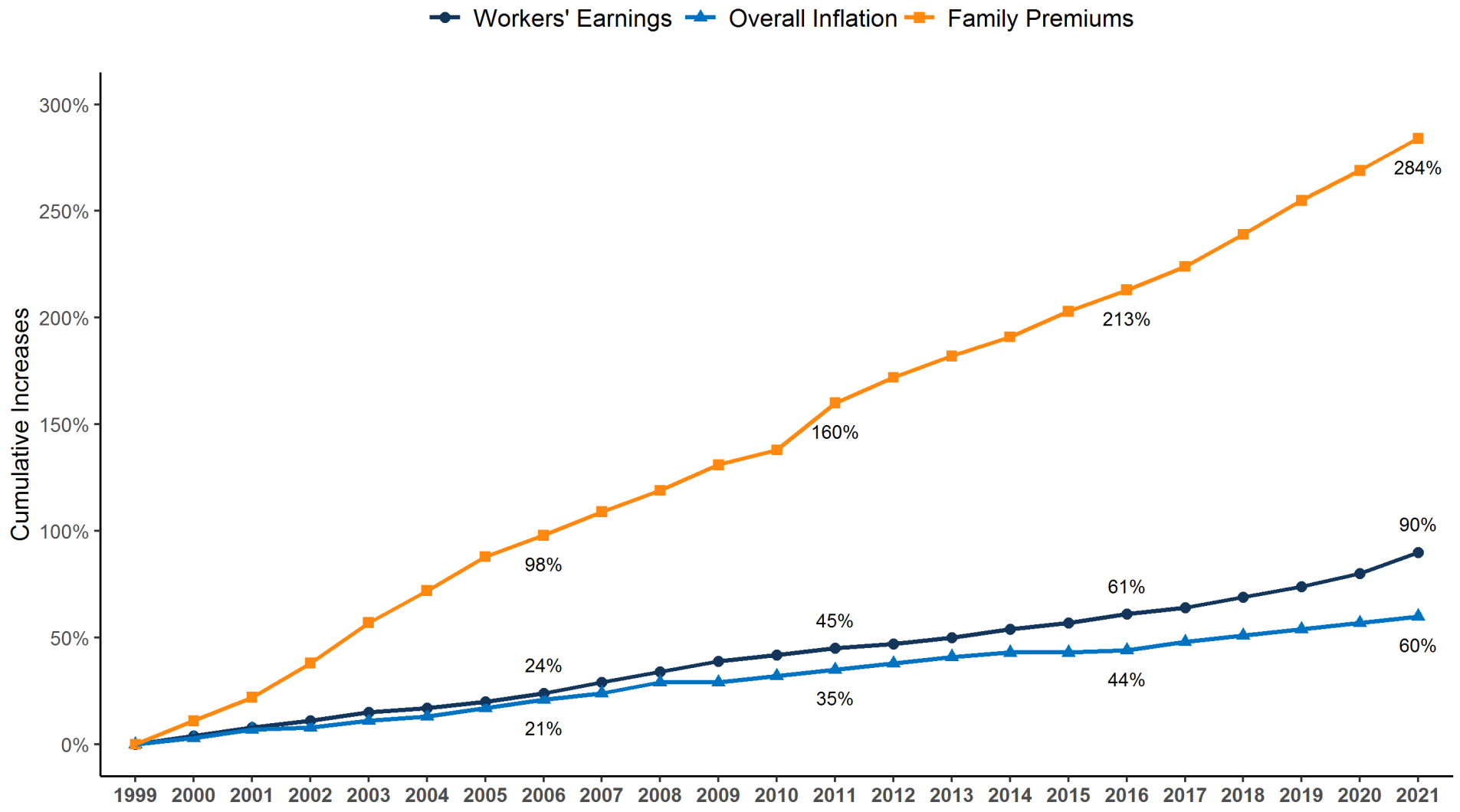


Most Union members receive health benefits through work & have better coverage than other workers, but…

- Even excellent plans don't cover many services (dental, eye care, hearing)
- Employers moving away from providing dependent coverage or paying only costs towards single coverage so additional costs come out of the employee's paycheck
- Huge co-pays, deductibles, & out-of-pocket costs
- Limited choice of providers
- Health Benefits must be negotiated, requiring unions to use most of their bargaining chips on health coverage
- Wage gains often lost to take-backs on health insurance – wage stagnation results

Figure 18

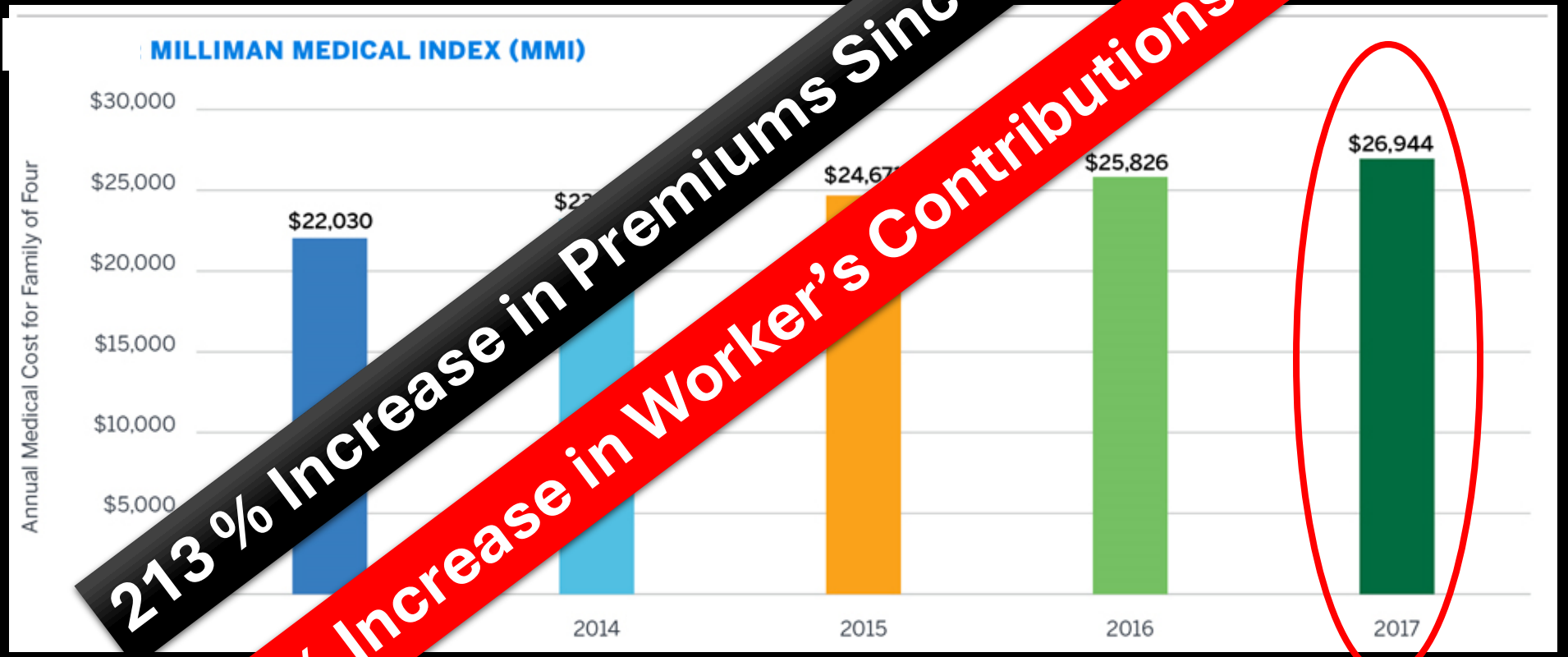
Cumulative Increases in Family Premiums, Inflation, and Workers' Earnings, 1999-2021



SOURCE: KFF Employer Health Benefits Survey, 2018-2021; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1999-2021; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2021.

KFF

Costs to You



213 % Increase in Premiums Since 1999

242 % Increase in Worker's Contributions Since 1999

And then there's this.....

The U.S. Department of Labor estimates that about
one claim in seven made under the employer health plans
that it oversees is initially denied

– about 200 million claims per year.

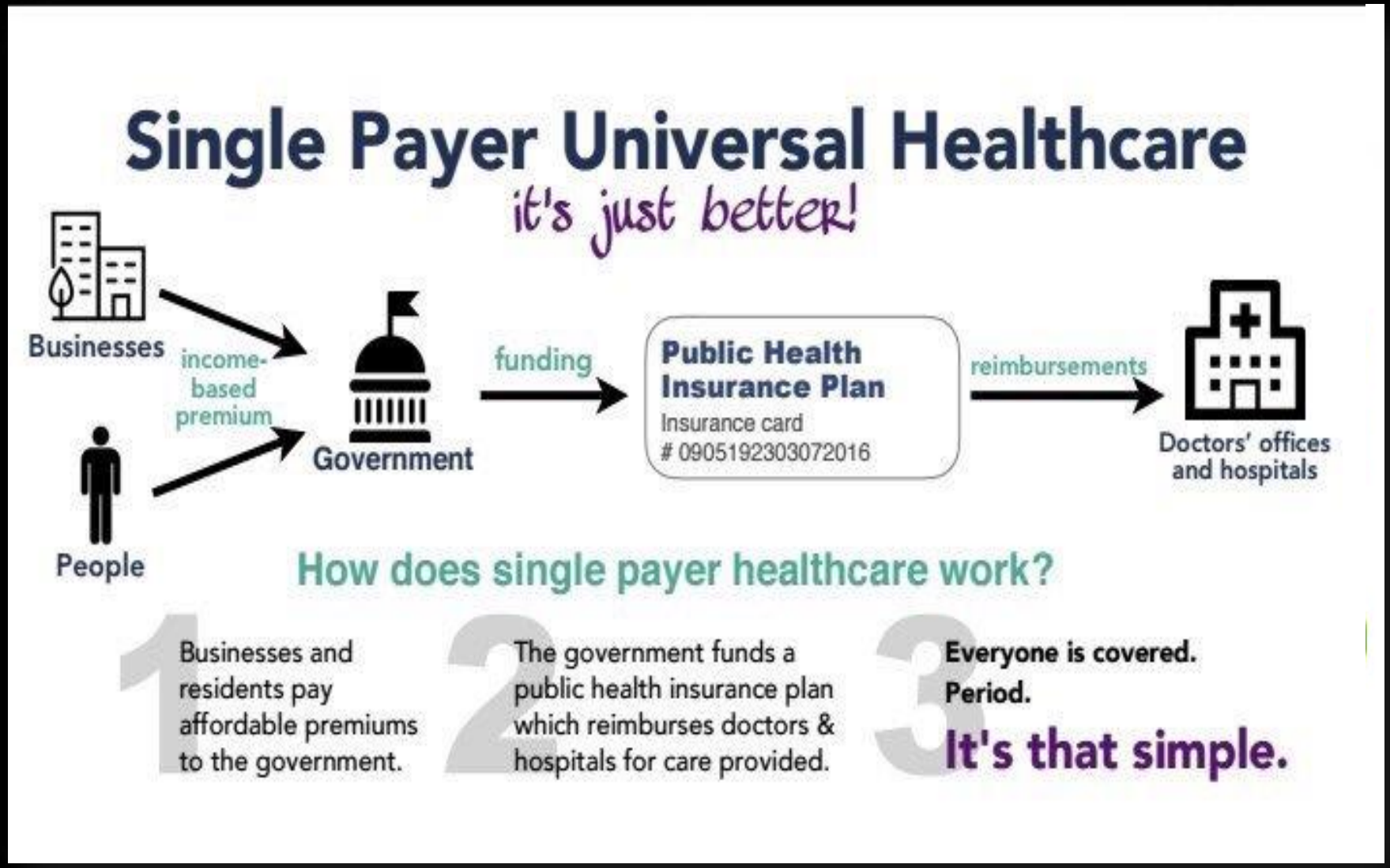
"Insurance companies are playing the odds . . .
They're counting on people not having the stamina to challenge every denied claim,
even when there's a valid medical reason for a drug or treatment being covered."

LA Times, January 17, 2017

When the squeeze comes, **Who Gets Hit The Worst?**

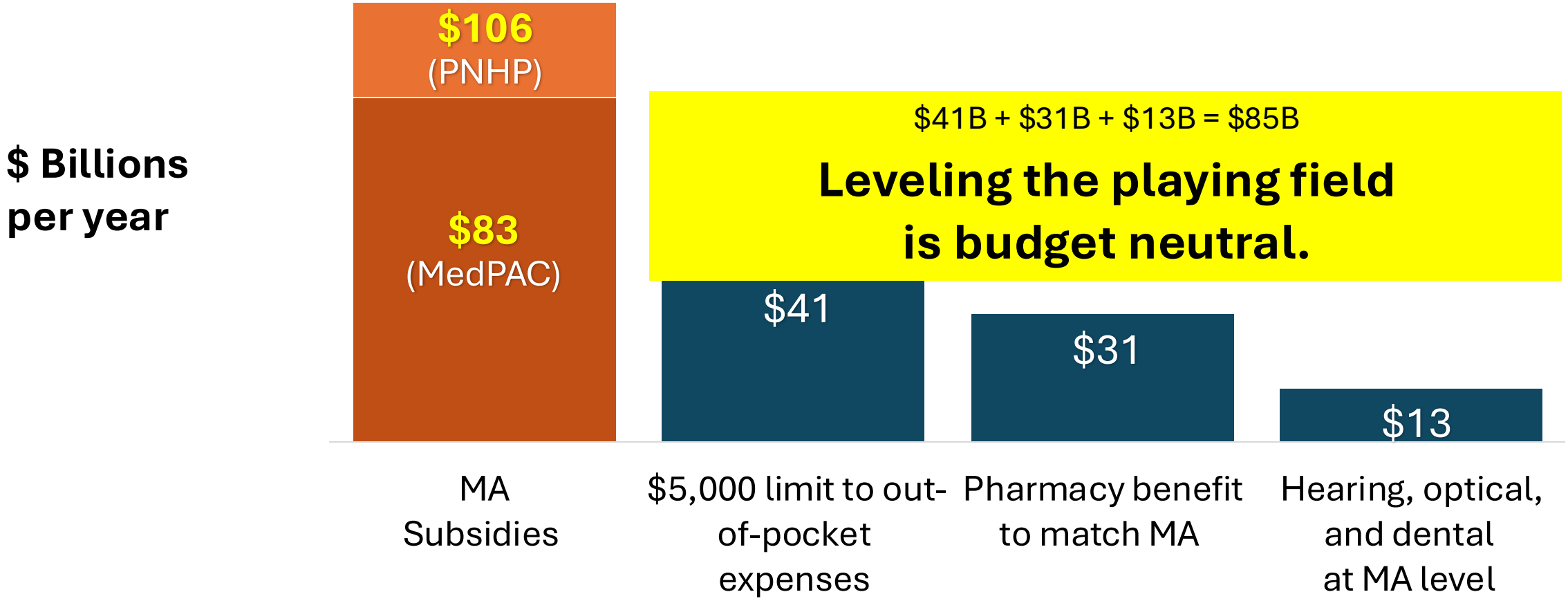
- The most vulnerable and least powerful
  - Retirees get their benefits cut
  - New hires get two-tier wages driving division and undermining unity
  - EVERYONE LOSES!

The Solution



When we reclaim the MA subsidies, we can afford to

Match MA's Benefits in Traditional Medicare



2024 supplemental benefits data updated based on 2022 data from GAO at https://www.gao.gov/assets/d23105527.pdf
Unpublished analysis by Rick Gilfillan MD (former administrator of CMMI)

Reclaim Medicare Coalescence

- Stop further privatization of Medicare
  - Draft “level the playing field legislation”
  - Educate the public on private, corporate Advantage vs public traditional Medicare
  - Pressure Congress to rein in the private insurer’s overpayments
  - Push CMS to hold private insurers accountable with increased transparency on how they spend Medicare dollars

Why Should Labor Support Medicare for All?

- **Don't die younger than we need to - covers everyone**
- **Covers all medical needs, including:**
  - ❖ **Dental, vision, hearing, mental health, prescriptions, long-term care, alcohol & drug treatment**
- **Stop employers from taking away our choice of doctors/facilities - allows patients to choose doctors & hospitals**
- **Reduces costs by cutting administration, *not* denying care**
- **Pay providers in a fair and timely manner**
- **Simple, understandable funding & payment system.**
- **A program to help insurance and healthcare bureaucracy workers with a robust and just transition into new employment**
- **Let's stop wasting money - affordable to all (premiums based on income)**

Every study ever done of a single payer healthcare system has upheld four things to be true and consistent:

1. **It saves money**
2. **It covers everyone**
3. **It improves quality**
4. **It saves lives**

Everything else is **more expensive, wasteful and unhealthy**

Single Payer Medicare for All Delivers

Freedom — End corporate restraints on your personal healthcare decisions; free to choose any doctor, hospital, etc.

Equality — Pathway to end racial bias in the funding and delivery of care. Necessary, albeit not sufficient.

Justice — Progressively paid for, comprehensive insurance for *everybody in* America, regardless of race, ethnicity, income, wealth, employment

Security — Always have, cradle to grave, regardless of changes in job or other life circumstance.

Medicare for All National Coalition

2025 opportunities for action

- Continuation of UHG claims denial stories
- Medicaid cuts;
- ACA subsidy cuts; Advantage overpayments;
- July 30th is the 60th anniversary of Medicare;
- Pharma drug pricing negotiations;
- Reintroduction of the Medicare for All Act in the spring

It's the 21st century civil rights issue and labor must help lead the movement to achieve it!

For economic & moral reasons, we have no choice.

Do we have the courage & persistence to pass truly universal health care?

Unions in other countries…

Have figured out that they can't keep their own health care benefits without everyone having health care.

By advocating for all, they keep health care for themselves.

Final Takeaways

Change is coming to the U.S. health care system. It's imperative that the labor movement be prepared to shape the change to serve our members and all working people.

The $4.5 trillion we currently spend on healthcare could be used to pay for a system based on humane principles.

Improved Medicare for All would take healthcare off the bargaining table allowing us to use our bargaining power to improve wages, pensions, and working conditions.

In the last 40 years, the ultra-rich have robbed working people of trillions of dollars of wealth that we created. Medicare for All is one way to take some of that back and give us a pay raise.

If we're going to make such a massive change in our healthcare system, we need to ensure that workers in healthcare, healthcare administration, and the insurance industry are protected.

Does Improved Medicare for All sound too good to be true? That's why opponents spend tens of millions to attack the bill.

Taking the Labor Movement to the forefront in the fight for single payer healthcare, because it's time to take healthcare off the bargaining table

Rose Roach

rose.roachLCSP@outlook.com

Labor Campaign for Single Payer

https://www.laborforsinglepayer.org

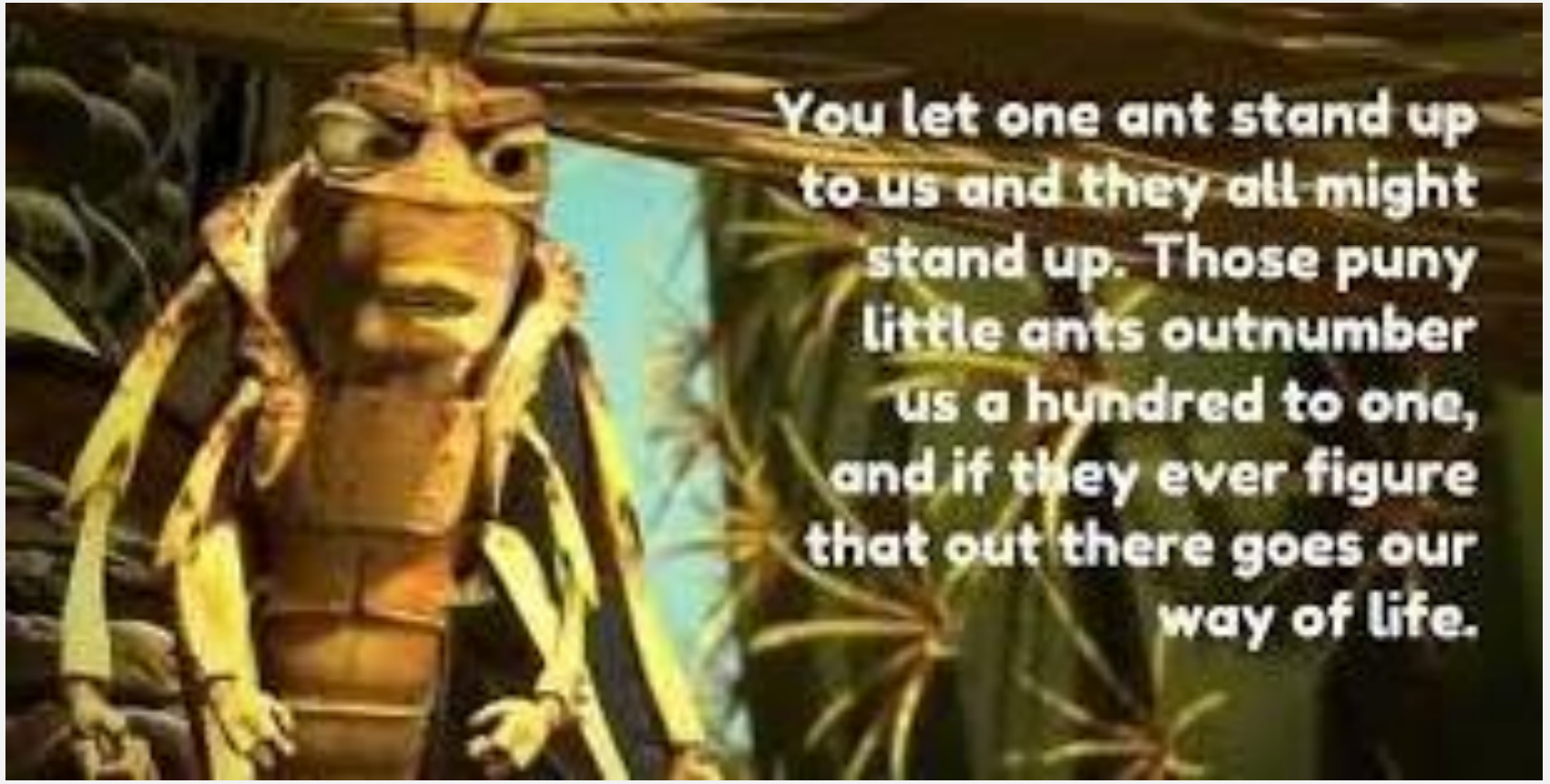
Published briefing papers and created toolkits

Papers:

- Impact of the Affordable Care Act on Bargaining
- Workers Compensation
- Multi-Employer Plans ("Taft Hartley plans")
- Why Corporations Don't Support Single Payer
- Online newsletter *Labor Health News*
- *Medicare Advantage: What Unions Need to Know*

Toolkits:

- GASB/FASB Rules and Their Impact on Retiree Healthcare
- ACO-REACH Program Undermining Medicare
- Abortion Access and the Right to Healthcare


You let one ant stand up to us and they all might stand up. Those puny little ants outnumber us a hundred to one, and if they ever figure that out there goes our way of life.

Questions