

# **Want Health Care Reform? Public Financing of Campaigns is Essential!**

**If we want real health care reform in this country, we must also support public funding of campaigns. These are two advocacy campaigns that need a political marriage.**

Real progress on many issues – including health care reform – depends on Fair Elections (public campaign financing) – so that decisions by Congress are made in the **public** interest, not skewed by lobbyists and campaign cash from insurance and pharmaceutical corporations.

Right now, money rules the debate. So long as decisions in Congress are shaped by the quid-pro-quo of lavish campaign contributions and spending on lobbying, we are unlikely to achieve affordable single-payer health care for all with comprehensive benefits. Policy debates in Congress are driven by campaign cash and corporate lobbying – rather than by logic or what’s best for all Americans.

Let’s keep in mind: A winning campaign for the U.S. Senate now costs nearly \$10 million. That means raising over \$27,000 every day of the year! Who has that kind of money?

The health insurance industry does. They get it from our premiums (even if paid by employers or by union benefit plans), and from our taxes funneled through federal programs that provide huge revenue streams to for-profit health insurers.

Last year, over \$6.8 billion in profits was reported by just the top three companies alone – UnitedHealth Group (\$2.9 billion), Wellpoint (\$2.5 billion), and Aetna (\$1.4 billion).

Do we think they won’t use any means to keep the gravy train flowing?

The business of these companies depends greatly on Congressional action – and they’ve become expert at extracting favors from Congress.

Most sitting lawmakers want to keep their seats. They need campaign cash to get re-elected – even while they also need constituent votes. So naturally, they play the game – dialing for dollars where the big dollars are.

Corporate America is willing to oblige. In 2008, more than \$550 million was spent on campaign cash and lobbying by health industry corporate players – \$200 million by insurers alone.

It’s mutual back-scratching. Money rolls in; political favors roll out. In effect, lawmaking is for sale to the high bidders – and all Americans pay the price, in higher prices for prescription drugs, skewed public policy, and more.

## **This is why we need to change the system!**

We need public funding of Senate and Congressional campaigns. REAL health care reform – getting it, and keeping it – depends on changing the source of campaign cash, getting rid of “pay-to-play” politics, so that lawmakers listen to voters, not big donors. Of course, we’ll need a robust grassroots movement for this – just as we need for real health care reform.

Fortunately, more and more Americans are learning how public financing of campaigns has changed politics forever in states that offer “Clean Elections” like Maine, Arizona, and recently New Jersey, Connecticut and others.

This year offers a “teachable moment” in many ways. With the bailouts, the economic meltdown brought by a deregulated Wall Street, and now the historic fight over health care reform, it’s a lesson in how our campaign finance laws must change to bring about the promise of a people’s democracy that is not yet fully realized.

If we’re disappointed this year in progress toward affordable health care (even single payer), let’s not be discouraged. Instead, let’s redouble our efforts to get our democracy back – through a game-changer like public financing of campaigns.

# Health Care Reform – Necessary Features in any reform plan from Congress

Any and all health care reform proposals must be designed with the public interest in mind, and not designed by special interests who seek to profit at taxpayer expense.

1. Available to everyone – employers, employee groups, any individual.
2. Unrestricted patient choice of health care providers, including all hospitals, clinics, and services provided and accessible in the community.
3. Comprehensive benefit package, one set of benefits available to everyone – regardless of age, employment status, enrollment group, geography, health status, or any other factor.
4. Guaranteed issue/acceptance: Coverage cannot be denied to anyone for pre-existing conditions, health status, or for any reason.
5. Automatic enrollment and immediate coverage – at the point of first medical visit for anyone without existing insurance, with an opportunity to enroll in a plan of the patient's choosing.
6. Affordable: No barriers to access and use due to financial circumstances; no excessive co-pays or deductibles. Appropriate cost-sharing from employers, individuals, and from public sources and programs such as Medicaid and Medicare.
7. Fair reimbursement to health care providers: Negotiated fair and reasonable compensation to health care providers for services. Global budgeting for hospitals and major clinics/services.
8. Health care providers must be paid directly (as Medicare does), without overhead layers – using a single, efficient public “payer” to pay for services delivered by private health care providers and facilities chosen by the patient. *(This contrasts with a referral or “connector” plan – such as the Federal Employee Benefits Health Plan – that simply enrolls people in existing private insurance plans. A connector scheme is expensive, due to an extra layer of administration to “broker” the arrangement and the expensive overhead of private insurance.)*



Much more information:

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