



# Summer 2021 Newsletter

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM | 29 E. MADISON STREET, SUITE 1412, CHICAGO, IL 60602 | PNHP.ORG

## ***PNHP celebrates new Medicare for All House bill***

On March 17, Reps. Pramila Jayapal (D-Wa.), Debbie Dingell (D-Mich.), and 110 original co-sponsors introduced the Medicare for All Act of 2021 (H.R. 1976). Like previous versions of the Medicare for All Act, H.R. 1976 closely mirrors PNHP's Physicians Proposal for Single-Payer Health Care Reform. It would establish a national health program to cover everybody living in the U.S. for all medically necessary care, including hospitalization and doctor visits; dental, vision, hearing, mental health, and reproductive care, including abortion; long-term care services and supports; ambulatory services; and prescription drugs. Patients could visit the doctor or hospital of their choice, without copays or deductibles. The program would pay independent and small group practice providers on a fee-for-service basis, and fund hospitals and other large facilities with yearly global operating budgets; separate funds would be used for capital improvements. By eliminating the profiteering and waste of commercial insurance, Medicare for All would save \$600 billion per year while expanding coverage to all.

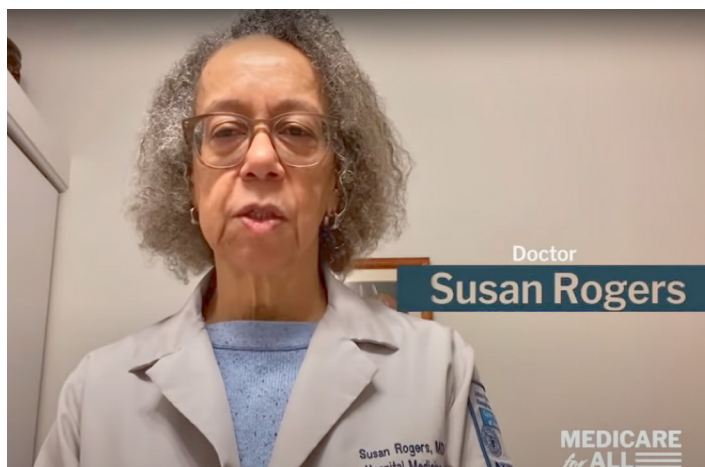
### **What's new in the 2021 bill?**

After months of dialogue with health justice advocates, Rep. Jayapal made some significant new improvements to this year's bill. H.R. 1976 would:

- Protect the national health program by preventing any future administration from reducing or eliminating existing benefits;
- Establish an Office of Health Equity to monitor and eliminate health disparities and promote primary care;
- Increase access to mental health care by including Licensed Marriage and Family Therapists and Licensed Mental Health Counselors as covered providers;
- Improve health services for indigenous peoples with additional funding for the Indian Health Service;
- Expand support for disabled Americans by expanding eligibility for long-term care supports and services;
- Respond to future public health crises by automatically increasing hospitals' global budgets during pandemics or other public health emergencies.

### **What's next for the Medicare for All bill?**

H.R. 1976 has gained three more co-sponsors since its introduction in March, but needs much more support in Congress to move forward. PNHP members can help by educating themselves and their colleagues about the bill, and then urging lawmakers to sign on (or thank those that have already signed). Resources, including summaries, fact sheets, slideshows, and lawmaker contact information, are available at [pnhp.org/HouseBill](https://pnhp.org/HouseBill).



***PNHP President Dr. Susan Rogers speaks at the Medicare for All Act launch event on March 17.***

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## PNHP Board of Directors 2021

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### Students for a National Health Program Board:

Chris Cai (M4, UCSF); Stephen Gurley (M3, Emory); Ashley Lewis (M.D./Ph.D. 2024, NYU); Rachel Madley (Ph.D. 2021, Columbia); Alankrita Siddula (M4, Rush Medical College); Rex Tai (M4, UIC)

### PNHP Staff:

Ken Snyder, executive director; Matthew Petty, deputy director; Clare Fauke and Dixon Galvez-Searle, communications team; Kaytlin Gilbert, national organizer; Bob Lederer, New York Metro chapter executive director

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## 2021 Kitchen Table Campaign

PNHP's Kitchen Table Campaign (KTC) was launched in January of 2020, just as the presidential candidates were fiercely debating their health care proposals. With so many different plans in the mix — from the public option to “Medicare Advantage for All” — PNHP wanted to show voters how single-payer Medicare for All would address the urgent problems that families discussed around the kitchen table. Each KTC toolkit was designed for a general audience, and included handouts, slide shows, webinars, podcasts, videos, social media posts, and sample letters-to-the-editor.

The first phase of KTC focused on surprise billing, racial health inequities, and rural health. During Covid-19, the campaign pivoted to Medicare for All and public health emergencies, and the pandemic's impact on health workers and racial health inequities. Ahead of the November 2020 elections, the KTC issued a Health Care Voters Guide, with a checklist for evaluating candidate health plans.

**PNHP re-launched the KTC in 2021 with a focus on America's mental health crisis.** The campaign explained how commercial insurers discriminate against mental health care by underpaying mental health professionals, limiting patients' choice of provider, and denying coverage for treatments like medication, therapy, and hospitalization. By contrast, Medicare for All would provide comprehensive mental health coverage with free choice of provider.

**This summer, the KTC will explore reproductive health,** highlighting the barriers that patients face in our fractured health system, and how Medicare for All could remove them. PNHP members who wish to get involved in the Kitchen Table Campaign should contact [clare@pnhp.org](mailto:clare@pnhp.org).

**COVID-19 has turned our mental health crisis into a mental health catastrophe. This is a kitchen table issue for millions of Americans.**

**#SinglePayer #MedicareForAll would provide universal, lifelong coverage for all medically necessary care. Including mental and behavioral health services.**

**Commercial health insurance has been a miserable failure. Medicare for All means mental health care for all.**

**[pnhp.org/KitchenTable](https://pnhp.org/KitchenTable)**



## Spring 2021 Virtual Leadership Training

PNHP hosted its first-ever virtual Leadership Training in late April. While there's no substitute for gathering in person, the program provided activists with a combination of skill-building, strategy, and networking opportunities. All programs were recorded and are available to view at [pnhp.org/OurPractice](https://pnhp.org/OurPractice):

- “Physician Advocacy & Local Organizing” presented by PNHP-IL co-president Dr. Monica Maalouf
- “Organizing a Summit” presented by SNaHP leader Robertha Barnes
- “Talking about Health Insurance 101” presented by PNHP board adviser Dr. Diljeet Singh
- “Organizing a Webinar” presented by Healthcare-NOW! director of communications Stephanie Nakajima
- “Building Relationships with Elected Officials” by PNHP national coordinator Dr. Claudia Fegan
- “Building Bridges across Generations, from Medical Students to Retired Physicians” panel discussion featuring SNaHP leaders Alankrita Siddula and Ashley Lewis in conversation with PNHP leaders Dr. Richard Bruno and Dr. Daniel Lugassy

The Leadership Training keynote address was made by legendary public health advocate Dr. Linda Rae Murray, who reminded activists that the core skills needed to practice medicine are the same skills needed to be effective advocates for health justice. Dr. Murray explained that advocates must always listen, seek new information, and “connect the dots” between different forms of injustice. Physicians in particular, she said, must truly understand the medical system and all its dysfunction before they can work to change it.

## Save the Date!

**PNHP's next Annual Meeting & Leadership Training will be held in person October 22-24 in Denver.**

**Registration details will be posted at [pnhp.org](https://pnhp.org) and emailed to members when they are available.**

## PNHP welcomes new executive director

PNHP welcomes Ken Snyder ([ken@pnhp.org](mailto:ken@pnhp.org)) as executive director. Ken will work closely with PNHP leaders to grow membership and fundraising, and expand organizing and communications capacity. Ken brings 20 years of experience working with community groups, unions, and legislative campaigns. His organizing expertise will be invaluable as PNHP redoubles efforts to organize physicians in support of single payer and strengthen the capacity of PNHP and SNaHP chapters — while advancing PNHP's leadership in developing evidence-based health policy.

PNHP's previous executive director Matthew Petty ([matt@pnhp.org](mailto:matt@pnhp.org)) will assume the role of deputy director and oversee much of PNHP's administration, management, and fundraising. PNHP staff also includes national organizer Kaytlin Gilbert ([kaytlin@pnhp.org](mailto:kaytlin@pnhp.org)) and communications specialists Dixon Galvez-Searle ([dixon@pnhp.org](mailto:dixon@pnhp.org)) and Clare Fauke ([clare@pnhp.org](mailto:clare@pnhp.org)).

## PNHP Board Nominations Open

Nominations for PNHP's Board of Directors are now open, with seats up for election in all regions and for at-large representation. In order to promote an open and transparent process, the Board has not slated candidates in advance, and invites nominations and applicants from members interested in contributing to a diverse Board of Directors.

The following seats are up for election for 2-year terms:

At-large (2 seats) · North East region (1 seat) · South region (1 seat) · North Central region (1 seat) · West region (2 seats)

Nominations and inquiries can be sent to Matt Petty at [matt@pnhp.org](mailto:matt@pnhp.org) by July 15, 2021. Ballots for electronic voting will be circulated in Summer 2021; be sure your current email address is on file with PNHP's office.

## New Chapter Events National Calendar

PNHP and SNaHP chapters found creative ways to continue their advocacy during the pandemic, including webinars and online public forums that reach advocates across the nation. In order to facilitate broader participation, PNHP created a Chapter Events National Calendar ([pnhp.org/events](https://pnhp.org/events)), a tool that allows chapters and allies to share their online events. Chapter leaders are encouraged to submit their virtual events to the PNHP organizing team at [organizer@pnhp.org](mailto:organizer@pnhp.org).



# DATA UPDATE: Health care crisis by the numbers

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## COSTS OF CARE

**Nearly one-fifth (18%) of U.S. adults and 35% of low-income earners say they did not seek treatment for a health problem in the last year due to cost:** An equal number say they could not afford treatment today. This measure is higher among Black adults (29%) and somewhat higher for Hispanic adults (21%) than for whites (16%). In order to pay for care, 12% of Americans have cut back on food; 11% cut back on over-the-counter drugs; and 35% reduced spending on recreation, including 21% of households earning at least \$180,000 per year. *Witters, "In U.S., an estimated 46 million cannot afford needed care," Gallup, 3/31/2021*

**The U.S. has stark disparities in income equality and health care affordability:** In the past year, 38% of U.S. adults skipped needed doctor visits, tests, treatments, or prescriptions because of cost (the percentage rises to 50% among low-income adults); 36% skipped dental care; 22% were unable to pay medical bills. *Doty et al., "Income-related inequalities in affordability and access to primary care in eleven high-income countries," Health Affairs, 12/9/2020*

**Total costs for ACA marketplace plans were 83% higher than Medicaid:** Out-of-pocket spending was 10 times higher in ACA plans vs. Medicaid: \$20.29 vs. \$2.80 for office visits, \$106.21 vs. \$7.27 for emergency visits, and \$6.82 vs. \$2.40 for prescriptions — even after federal cost-sharing reductions. *Allen et al., "Comparison of utilization, costs, and quality of Medicaid vs. subsidized private health insurance for low-income adults," JAMA Network Open, 1/5/2021*

**Cancer care is increasingly unaffordable due to out-of-pocket expenses imposed by commercial insurers:** In 2018, cancer patients paid \$5.6 billion out-of-pocket. Costs vary based on insurance plan: With premiums, deductibles, copays, and coinsurance, cancer patients with ACA-compliant plans paid between \$5,000 and \$12,000 out-of-pocket; and those in short-term plans spent \$52,000 out-of-pocket, mostly due to high deductibles and poor drug coverage. Cancer-caused financial distress falls hardest on young people, people of color, and those with lower incomes and education levels. *"The Costs of Cancer: 2020 Edition," The American Cancer Society Cancer Action Network, October 2020*

**Sixty percent of Americans have been in debt due to medical bills:** 37% of adults currently owe medical debt and 23% have had medical debt in the past; the average debt is between \$5,000 and \$10,000. The top drivers of debt are emergency room visits (39%), doctor visits (28%), sur-

gery (26%), childbirth (22%), and dental care (20%). Nineteen percent say medical debt prevents them from buying a home and 68% say they have lost sleep worrying about it. *Giovanetti, "60% of Americans have been in debt due to medical bills," LendingTree/Qualtrics survey, 3/21/21*

**Millions of Americans travel to other countries for savings of up to 80% percent on medical treatments:** In 2019, more than 1% of Americans traveling internationally did so for health care, but that figure only accounts for air travel and not those who traveled to Mexico via bus or car. Mexico and Costa Rica are the most popular destinations for dental care, cosmetic surgery, and prescription drugs; Thailand, India, and South Korea attract patients for more complex procedures such as orthopedics, cardiovascular, and cancer treatment. *Yeginsu, "Why medical tourism is drawing patients, even in a pandemic," New York Times, 1/19/2021*

**Health-related fundraisers on GoFundMe have skyrocketed:** Medical fundraisers increased from 42 campaigns in 2010 to nearly 120,000 in 2018, and now account for more than a quarter of all campaigns on the site. In that time, patients requested \$10.2 billion in donations for health costs, and received \$3.6 billion. The most common campaigns were for treatment of cancer, injury, and neurological conditions. *Angral et al., "Evaluation of internet-based crowdsourced fundraising to cover health care costs in the United States," JAMA Network Open, 1/11/2021*

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## DRUG PRICES

**Prescription drug list prices have more than doubled in recent years:** Between 2010 and 2016, the median drug wholesale list price increased by 129% and median insurance payments after rebates and discounts increased by 64%, while median patient out-of-pocket costs increased by 85% for specialty medicines and by 42% for non-specialty drugs. *Yang et al., "Changes in drug list prices and amounts paid by patients and insurers," JAMA Network, 12/9/2020*

**Even a modest increase in out-of-pocket costs will significantly lower medication adherence and increase mortality among patients:** Using data from Medicare, researchers discovered that raising patients' out-of-pocket costs by just \$10 per prescription led to a 23% drop in overall drug consumption, and to a 33% increase in mortality. When faced with higher costs, seniors did not drop "low-value" drugs, but instead cut back life-saving, high-value drugs such as those to lower cholesterol, blood pressure, and blood sug-

ar; and drugs that treat acute exacerbations of emphysema and asthma. Chandra et al., “The health costs of cost-sharing,” *National Bureau of Economic Research Working Paper 28439*, February 2021

**A large number of Americans face financial hardship due to the price of medications:** 36% of patients say they have forgone their medications to pay for essential items and bills; 43% have forgone paying for essential items and bills to afford their medications; and 41% skipped or reduced doses to stretch out their prescription. “2021 Medication Access Report,” *CoverMyMeds*, 1/26/2021

**Drug prices in the U.S. are 256% higher than prices in peer countries:** Among 33 wealthy countries, the U.S. accounted for 58% of revenues, but just 24% of volume. Most of the discrepancy was due to prices for brand name drugs, which in the U.S. averaged 3.44 times higher than prices in other nations. Some of the highest-priced brands treat life-threatening illnesses, Hepatitis C, or cancers. Drug spending in the U.S. jumped by 76% between 2000 and 2017. Mulcahy et al., “International prescription drug price comparisons: Current empirical estimates and comparisons with previous studies,” *RAND Corporation*, 1/28/2021

**Medicare Part D spent more than twice as much on prescription drugs compared to the Dept. of Veterans Affairs:** In a sample of 399 brand-name and generic drugs, the VA paid an average of 54% less per unit than Medicare, even after rebates and discounts; 233 drugs were at least 50% cheaper and 106 were at least 75% cheaper. VA prices were 68% lower than Medicare for the 203 generic drugs (a difference of \$0.19 per unit) and 49% lower for 196 brand-name drugs (a difference of \$4.11 per unit). The price difference is due to the VA’s ability to negotiate drug prices. “Prescription drugs: Department of Veterans Affairs paid about half as much as Medicare Part D for selected drugs in 2017,” *U.S. Government Accountability Office*, 1/14/2021

**Pharmaceutical companies hike their list prices substantially each year, and 2021 is no exception:** More than 100 drug firms raised list prices on 636 drugs in the first week of January, with a median price hike of 5%, more than four times the rate of inflation. For the 19th year in a row, AbbVie raised the price of the world’s best-selling drug, Humira (used to treat autoimmune diseases) by 7.4%. The price for two pens, enough for one month of treatment, is now \$5,968. Contrary to what drug manufacturers argue, two-thirds of Americans pay for some or all of the cost of their medication based on the list price, including 9% of those who are uninsured, 40% with high-deductible plans, and 18% with Medicare. “Pharma raises prices on over 600 drugs to start the new year,” *Patients for Affordable Drugs*, 1/14/2021

## HOW COVERAGE SAVES LIVES & MONEY

**Medicare eligibility means better access to care:** Medicare eligibility at age 65 is associated with a 50.9% reduction in reports of being unable to get necessary care, compared with the percentage at age 64; as well as a 45.3% reduction in not being able to get needed care because of cost. Jacobs, “The impact of Medicare on access to and affordability of health care,” *Health Affairs*, February 2021

**Medicare eligibility is associated with earlier cancer diagnoses and a resulting survival benefit:** Researchers discovered a greater jump in diagnoses for the four most common cancers (lung, breast, colon, and prostate) at the transition from 64 to 65 than at all other age transitions, suggesting that older adults are delaying care until they enroll in Medicare. For example, colon cancer diagnoses increased by just 1-2% each year from 61 to 64, then at 65 jumped to nearly 15%. Diagnosis rates then declined for all cancers in the years following age 65. Compared to uninsured older adults under 65, Medicare-enrolled cancer patients had lower five-year cancer-specific mortality rates. Patel et al., “Cancer diagnoses and survival rise as 65-year-olds become Medicare-eligible,” *Cancer*, 3/29/2021

**Cancer survival post-diagnosis is considerably lower in younger uninsured patients than older Medicare patients:** Uninsured patients ages 60–64 were nearly twice as likely to present with late-stage cancer and were significantly less likely to receive surgery, chemo, or radiotherapy compared to Medicare enrollees ages 66–69, despite lower comorbidity among the younger patients. The younger uninsured patients also had significantly lower five-year survival across cancer types: Five-year survival for late-stage breast or prostate cancer was 5–17% lower than among older Medicare patients. Silvestri et al., “Cancer outcomes among Medicare beneficiaries and their younger uninsured counterparts,” *Health Affairs*, May 2021

**Medicaid expansion is correlated with fewer deaths:** Researchers identified 4,800 fewer deaths per year out of a sample of 3.7 million people living in Medicaid expansion states, or roughly 19,200 fewer deaths over the first four years of Medicaid expansion, compared to the mortality rate pre-expansion. Conversely, in a sample of 3 million people in non-expansion states, researchers identified 15,600 additional deaths over this four year period that could have been avoided if states had expanded coverage. Miller et al., “Medicaid and mortality: New evidence from linked survey and administrative data,” *National Bureau of Economic Research Working Paper 26081*, January 2021

**Medicaid expansion is correlated with improved treatment for colon cancer:** Compared to non-expansion states, patients in Medicaid expansion states had an increase in early (Stage I) diagnoses and were more likely to receive treatment within 30 days. Among surgical patients, expansion correlated with fewer urgent cases and more minimally invasive surgery; Stage IV patients were more likely to receive palliative care. *Hoehn et al., “Association between Medicaid expansion and diagnosis and management of colon cancer,” Journal of the American College of Surgeons, 11/23/2020*

**Children who gained Medicaid coverage in the 1960s enjoyed lifelong health and financial benefits:** Compared to peers who were not enrolled, the first Medicaid cohort (born between 1955 and 1975) were less likely to die young, have a disability, or be unemployed as an adult; improvements in longevity and health added 10 million quality-adjusted life years to this cohort. Medicaid enrollees had less later need for disability and unemployment benefits, saving governments \$200 billion (in 2017 dollars), more than twice the cost of coverage. *Goodman-Bacon, “The long-run effects of childhood insurance coverage: Medicaid implementation, adult health, and labor market outcomes,” Federal Reserve Bank of Minneapolis, October 2020*

**Medicaid expansion is good for hospital finances:** In 2017, hospitals in expansion states saw an average decrease of \$6.4 million on uncompensated care (a 53.3% drop) compared to the pre-expansion period. Uncompensated care comprised 6% of total expenses for hospitals in non-expansion states, double the amount in expansion states. Medicaid expansion had the most impact on operating margins for safety-net and small (fewer than 100 beds) hospitals. *Blavin and Ramos, “Medicaid expansion: Effects on hospital finances and implications for hospitals facing Covid-19 challenges,” Health Affairs, January 2021*

**Excess mortality in the U.S. is higher than peer nations — except for the oldest adults:** Compared to 18 European countries, the U.S. ranked among the worst for excess mortality in working-age adults, resulting in more than 400,000 excess deaths and 13 million years of life lost in 2017, a 64.9% increase since 2000. Excess mortality is most severe for Americans aged 30 to 34, who were three times more likely to die than their European counterparts. However, the U.S. had lower death rates in people aged 85 and older — 97,788 fewer deaths than the European standard; this advantage in older adults (who are covered by Medicare in the U.S.) has only increased since 2000. *Preston and Vierboom, “Excess mortality in the U.S. in the 21st century,” Proceedings of the National Academy of Sciences, 4/20/2021*

## HEALTH INEQUITIES

**Black mortality remains far higher than white mortality in America’s 30 largest cities:** From 2016 to 2018, the national all-cause mortality rate for Black Americans was 24% higher than for whites (960 v. 777 per 100,000), resulting in 74,402 excess Black deaths annually. The mortality rates among Black populations were significantly higher in 29 of America’s 30 biggest cities. Washington, D.C. had the biggest disparity, with a death rate for Black residents that was more than twice as high as for whites. *Benjamins et al., “Comparison of all-cause mortality rates and inequities between Black and white populations across the 30 most populous U.S. cities,” JAMA Network, 1/20/2021*

**The pandemic has exacerbated disparities in life expectancy between white and Black Americans:** Overall life expectancy in the U.S. dropped one full year during the first half of 2020 (from 78.8 years in 2019 to 77.8 years in mid-2020), but with major racial disparities. For white people, life expectancy decreased by 0.8 years (78.8 to 78); but for Black people, life expectancy decreased by 2.7 years (74.7 to 72); White Americans now live an average of six years longer than Black Americans, up from a four-year difference in 2019. *Arias et al., “Provisional life expectancy estimates for January through June, 2020,” National Center for Health Statistics, February 2021*

**More than one in five (21%) adults say they have faced discrimination in the health care system:** 72% of those experienced discrimination more than once. Racial/ethnic discrimination was the most common (17.3%), followed by discrimination based on education or income (12.9%), weight (11.6%), sex (11.4%), and age (9.6%). Of the patients who reported discrimination, 63% were women and 60% had annual household incomes less than \$50,000. *Nong et al., “Patient-reported experiences of discrimination in the U.S. health care system,” JAMA Network Open, 12/15/2020*

**Undocumented immigrants are not an economic burden on safety net facilities such as hospital emergency departments:** Undocumented immigrants used far fewer health services and incurred lower health costs than U.S. citizens. Annual health expenditures were \$1,629 for unauthorized immigrants, compared to \$3,795 for authorized immigrants and \$6,088 for U.S.-born individuals. Nearly half of unauthorized immigrants (47.1%) were uninsured, compared with 15.9% of authorized immigrants and 6.0% of U.S.-born individuals. *Wilson et al., “Comparison of use of health care services and spending for unauthorized immigrants vs. authorized immigrants or U.S. citizens using a machine learning model, JAMA Network, 12/11/2020*



**More than 110 rural hospitals closed since 2013, resulting in longer distances traveled, fewer providers, and less services:** The share of rural hospitals offering general and surgical care dropped from 81% in 2012 to 38% in 2017. After closures, the average distance traveled for inpatient care increased by 20.5 miles; for emergency care, by 20.9 miles; for coronary care, 31.6 miles; and for substance use disorder treatment, nearly 40 miles. From 2012 to 2017, the physician ratio in “closure counties” dropped from a median of 71.2 to 59.7 doctors per 100,000. *“Rural hospital closures: Affected residents had reduced access to health care services,” U.S. Government Accountability Office, December 2020*

**The poverty rate jumped to 11.7% in November 2020, up from 9.3% in June, the biggest increase in 60 years:** Poverty (defined as \$26,200 for a family of four) rose most for Black families (up 3.1 percentage points, or 1.4 million people) and those with high school degrees or less (up 5.1 percentage points, or 5.2 million people), groups who experienced the largest job loss during the pandemic. Households with children have also seen higher increases in poverty: 2.3 million children under 17 have fallen into poverty since June 2020. *Han et al., “Real-time poverty estimates during the Covid-19 pandemic through November 2020,” 12/15/2020*

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## **COMMERCIAL HEALTH INSURANCE: A DANGEROUS AND DEFECTIVE PRODUCT**

**Commercial insurers did little to relax prior authorization (PA) policies during the pandemic, causing delays in care and dangerous outcomes for patients:** In a new survey of providers, nearly all doctors (94%) reported care delays while waiting for PA, and 79% had patients abandon treatment due to PA struggles with insurers. One-third of physicians had a patient suffer a serious medical event as a result of delayed treatment, almost 20% said the delay caused a life-threatening event or hospitalization, and 9% said that PA led to a patient’s disability/permanent bodily damage, birth defect, or death. Physicians said they processed 40 PAs per week, which require 16 hours of additional work time. *“2020 AMA prior authorization (PA) physician survey,” American Medical Association, 4/7/2021*

**Health insurers’ administrative “sludge” costs the economy billions in employee stress, absenteeism, and productivity:** Researchers estimate the cost of the time spent by employees dealing with health insurance representatives was \$21.6 billion, with 53% of that time (worth \$11.4 billion) at work. Workers who spent more time on the phone with their insurer were less satisfied with their workplace, less engaged, more likely to report significant stress and burnout, and more likely to have missed a day or more of work. The absences caused by insurance hassles

cost employers an estimated \$26.4 billion; the productivity loss cost approximately \$95.6 billion. *Pfeffer et al., “Magnitude and effects of ‘sludge’ in benefits administration: How health insurance hassles burden workers and cost employers,” Academy of Management Discoveries, October 2020*

**One out of every six workers whose primary health insurance comes from an employer stay in bad jobs for the health coverage:** Black workers (21%) are more likely to say they would stay in an unwanted job just to keep their health benefits than white workers (14%). The fear of losing coverage is also higher among workers making less than \$48,000 a year. *Witters, “One in six U.S. workers stay in unwanted job for health benefits,” Gallup, 5/6/2021*

**Commercial insurers reported record 2020 profits because enrollees visited hospitals and doctors at much lower levels during the pandemic:** UnitedHealth Group, the nation’s largest insurer, reported 2020 profits of \$15.4 billion. Humana reported a profit of \$4.6 billion, a 40% increase over its 2019 profits of \$3.5 billion. Cigna took in \$8.5 billion in profits, a 66% increase from its 2019 profits of \$5.1 billion. *Burns, “The pandemic one year in: Despite large profits in 2020, health insurers see volatility ahead,” Managed Healthcare Executive, 3/11/2021*

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## **MEDICARE ADVANTAGE & MEDICAID MANAGED CARE**

**Medicare Advantage (MA) increases national health spending:** In 2019, U.S. health costs increased nearly 5% from 2018. While costs increased in nearly all sectors of health care, an outsized spending bump was seen in the MA program run by commercial insurers. MA costs increased 14.5% in 2019, up from an already high 12.6% growth in 2018. Per-capita enrollee spending in MA plans grew 6.3% in 2019, almost three times the 2.4% per capita growth rate of traditional (fee-for-service) Medicare. *Martin et al., “National health care spending in 2019: Steady growth for the fourth consecutive year,” Health Affairs, 12/16/2020*

**2020 was an extremely profitable year for commercial insurers in Medicaid and Medicare:** Commercial insurers in Medicare Advantage (MA) pocketed \$200 in monthly gross margins per enrollee, up from \$139 in 2018. By the end of 2020, 26.4 million people were enrolled in MA plans, up 41.4% from 2017. For Medicaid managed care plans, commercial insurers kept \$71 per enrollee per month in gross margins, up from \$36 in 2018. Last year, 53.9 million people were enrolled in Medicaid managed care plans, which accounts for 69% of all Medicaid enrollees. *Tepper, “Insurers set sights on growth in Medicare Advantage, Medicaid managed care,” Modern Healthcare, 3/6/2021*

**More than 10% of rural seniors in a Medicare Advantage (MA) plan switched to traditional Medicare (TM) between 2010 and 2016:** By contrast, only 1.7% of rural enrollees in TM moved to MA during this period. Switching from MA to TM was driven primarily by low satisfaction with care access, and was most common among MA enrollees who experienced higher costs (e.g., hospitalization or long-term care). Among those requiring more expensive services, rural enrollees were twice as likely to switch from MA to TM as nonrural enrollees (16.8% versus 8.3%), suggesting that limited provider options in rural areas were a major factor for change. *Park et al., “Rural enrollees In Medicare Advantage have substantial rates of switching to traditional Medicare,” Health Affairs, March 2021*

**Medicare Advantage (MA) plans use “chart reviews” to extract more profits from taxpayers:** MA plans receive capitated payments from Medicare based on an enrollee’s number and severity of conditions; but plans are allowed to add conditions not present in claims data (“upcoding”), which increases their risk-adjusted payments. Researchers found that in 2015, MA plans’ chart reviews were associated with a \$2.3 billion increase in payments, a 3.7% increase in Medicare funds to MA plans. Just 10% of plans accounted for 42% of the additional spending attributed to chart review; among these plans, the relative increase in risk score from chart review was 17.2%. *Meyers and Trivedi, “Medicare Advantage chart reviews are associated with billions in additional payments for some plans,” Medical Care, February 2021*

**A Humana Medicare Advantage plan in Florida improperly collected \$200 million in 2015 by overstating how sick patients were:** Certain conditions such as some cancers or uncontrolled diabetes net MA plans more from Medicare because they are costlier to treat, but auditors found that many of these conditions did not match patients’ medical records. For example, in 2015, Medicare overpaid \$4,380 for a patient whose throat cancer had previously been resolved but was still claimed as active by the insurer. *Schulte, “Humana Health plan overcharged Medicare by nearly \$200 million, federal audit finds,” Kaiser Health News, 4/20/2021*

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## HEALTH CARE FOR PROFIT

**2020 CARES Act funds helped wealthy hospitals most, while safety-net hospitals were hemorrhaging:** Funding distribution was based on hospitals’ past revenue and did not account for assets or investments, favoring institutions with wealthier, commercially-insured patients over those whose patients were uninsured or on Medicaid or Medicare. Baylor Scott & White Health, the largest nonprofit hospital system in Texas, accepted \$454 million in relief and laid off 1,200 employees, but reported an \$815 million surplus

in 2020 (\$20 million more than in 2019), and a 7.5% operating (aka profit) margin. UPMC in Pittsburgh accepted a \$460 million bailout and then reported \$2.5 billion more in revenue in 2020 than in 2019, along with an \$836 million operating surplus, partly due to the growth of the health insurance plan the system owns. *Rau and Spolar, “Despite Covid, many wealthy hospitals had a banner year with federal bailout,” Kaiser Health News, 4/5/2021*

**U.S. hospitals charge an average of \$417 for every \$100 of their actual costs:** The “markups,” which have more than doubled over the past 20 years, caused hospital profits to skyrocket by 411% from 1999 to 2017. The markups are led by for-profit hospitals: 95 of the 100 hospitals with the highest markups are investor-owned; all 100 are owned by hospital systems, as opposed to independent community hospitals. For-profit HCA Healthcare owns 53 of the top 100 markup hospitals, including the hospital with the highest charge-to-cost ratio, Poinciana Medical Center in Florida, whose charge-to-cost ratio is 1,808%. *“Fleeing Patients: Hospitals charge patients more than four times the cost of care,” National Nurses United, November 2020*

**HCA Healthcare was also found to have netted \$1.6 billion from excessive E.R. admissions:** A new analysis found the investor-owned hospital chain admits far more Medicare patients who visit its emergency departments compared to the national average. This practice of unnecessary admissions may have netted HCA excess Medicare payments of \$1.6 billion since 2009. *Banow, “Shareholder group calls out HCA for alleged excessive emergency department admissions,” Modern Healthcare, 3/2/2021*

**Hospitals are invoking a century-old liens law to bypass insurance — especially Medicaid — and sue patients for the full cost of care:** Since Medicaid typically pays less than commercial insurance, hospitals found that in the case of car accidents (where an insurance settlement was expected), it was more lucrative to bypass Medicaid and place a lien on patients’ accident settlements. For one patient, the hospital should have billed Medicaid for \$2,500, but instead placed a lien for \$12,856 — the “sticker price” charged to uninsured patients. The practice is so lucrative that some hospitals hire investigators to scan police accident reports in search of patients who might have been in a crash. *Kliff and Silver-Greenberg, “How rich hospitals profit from patients in car crashes,” New York Times, 2/1/2021*

**High staff turnover in for-profit nursing homes contributed to patient deaths during the pandemic:** Nursing homes accounted for more than one-third of all Covid-19 deaths in the U.S., and high staff turnover rates made it harder for facilities to implement strong infection controls. Researchers found the average annual turnover rate was



128%, with some facilities experiencing turnover that exceeded 300%. Turnover rates were much higher at for-profit institutions and those owned by chains. *Gandhi et al., “High nursing staff turnover in nursing homes offers important quality information,” Health Affairs, March 2021*

**When private equity (PE) firms acquire nursing homes, patients die more often:** PE investment in nursing homes has exploded, from \$5 billion in 2000 to more than \$100 billion in 2018. Going to a PE-owned nursing home increased mortality for patients by 10% against the average. Researchers estimate that 20,150 lives of Medicare enrollees (about 1,000 deaths per year on average) were lost due to PE ownership of nursing homes from 2000 to 2017. PE-owned facilities tend to reduce staffing by 1.4%, as well as reduce the number of hours that frontline nurses spend providing basic but critically important patient services such as bed turning and infection prevention. PE facilities were 50% more likely to use antipsychotic drugs, which are associated with higher mortality in elderly people. *Gupta et al., “Does private equity investment in healthcare benefit patients? Evidence from nursing homes,” National Bureau of Economic Research Working Paper 28474, February 2021*

**Executives at the companies fighting hardest against Medicare for All earned more in compensation in 2020 than any other year:** Despite the pandemic, the CEOs of insurance, pharma, and investor-owned hospitals made record income, largely due to the value of their stocks. David Cordani of Cigna made \$79 million (six times as much as 2019), and \$73 million of that came from stock. Dave Ricks of Eli Lilly made \$68 million (twice as much as 2019), \$58 million from stock. Sam Hazen of the HCA Healthcare hospital chain made \$84 million (four times as much as 2019), with \$66 million from stock. In 2019, the CEOs of 179 leading health care companies collectively took home \$2.5 billion, an amount that is four times what the Centers for Disease Control and Prevention were allocated to study and prepare for all “emerging and zoonotic infectious diseases.” *Herman, “Health giants disclose hefty pandemic year paydays for top executives,” Axios, 3/23/2021; and “Health care CEO pay outstrips infectious disease research,” Axios, 6/1/2020*

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## DARK MONEY IN HEALTH CARE

**Financial disclosures by the industry front group “Partnership for America’s Health Care Future” shows how much the industry spends to block health care reform:** In 2019, the group raised more than \$55 million and spent roughly \$20 million, ending the year with \$36 million in assets, according to its tax return. During the 2020 Democratic presidential primaries, the Partnership spent \$4.5 million on television ads attacking Medicare for All, and

continues to spend millions to block a public option in Colorado. *Sirota and Perez, “The establishment is gearing up against even a public option,” Jacobin, 12/9/2020*

**Insurers spent record amounts lobbying Congress as Democrats crafted new Covid relief bills in early 2021:** America’s Health Insurance Plans spent \$3.9 million on lobbying in the first quarter of 2021, a 7% increase over the same period last year and the most AHIP has ever spent in a first quarter. The nonprofit Kaiser Foundation Health Plan spent \$2 million lobbying in the first quarter of 2021, a 200% increase from the same time last year. Centene, which runs multiple Medicaid managed care, ACA, and Medicare Advantage plans, spent \$1.4 million lobbying in the 1Q 2021, an 80% increase from 2020. *Hellmann, “Insurers spent more on lobbying as Congress debated ACA and COBRA subsidies,” Modern Healthcare, 4/20/2021*

**Pharma increased its political spending by 6.3% in the first quarter of 2021:** Drug and health product manufacturers, along with their national association, spent a combined \$92 million to lobby the federal government from January through March; pharma’s spending was more than double what was spent by the second-highest-spending industry, electronics. There are currently 1,270 registered lobbyists for pharmaceuticals and health products, more than two lobbyists for every member of Congress. *“Industry Profile: Pharmaceuticals/Health Products,” Center for Responsive Politics, April 2021*

**Pharma funneled millions to prominent dark money groups that pushed industry-friendly messages in the last election:** In 2019, the Pharmaceutical Research and Manufacturers of America, or “PhRMA,” raised nearly \$527 million (a \$68 million increase from 2018) and spent \$506 million. The group’s largest political donation (\$4.5 million) went to the American Action Network, a dark-money group that launched several multi-million dollar ad campaigns opposing the drug pricing proposals of both Pres. Trump and House Democrats. In 2019, PhRMA gave \$1.6 million to Center Forward, a dark-money group aligned with moderate “Blue Dog” Democrats. *Evers-Hillstrom, “Pharma lobby poured millions into ‘dark money’ groups influencing 2020 election,” Center for Responsive Politics, 12/8/2020*

**Read the PNHP Newsletter Digital Edition at [pnhp.org/Summer2021Newsletter](https://pnhp.org/Summer2021Newsletter)**

The Digital Edition includes:

- Links to Data Update sources
- Research Roundup of new studies
- PNHP members in the news

# PNHP Chapter Reports

To form a chapter in your area, contact [organizer@pnhp.org](mailto:organizer@pnhp.org)

**PNHP-CALIFORNIA** endorsed A.B. 1400, the single-payer California Guaranteed Health Care for All bill, as well as H.R. 1976 in the U.S. House. The Santa Barbara chapter held several events to pressure elected officials to support these bills, including a caravan of 40 cars carrying Medicare-for-All signs in February, and a march to the offices of state legislators Monique Limón and Steve Bennett in April. Members also helped circulate a statewide petition demanding that Gov. Newsom apply for federal waivers allowing the state to implement single payer. At the local level, chapters in Chico, Sonoma, and Santa Barbara successfully passed Medicare-for-All resolutions in their city councils. PNHP-CA just welcomed a chapter of Students for a National Health Program (SNaHP) at the new Kaiser Permanente Bernard J. Tyson School of Medicine in Pasadena. *To get involved in California, contact Dr. Kathleen Healey at [khealey.ent@gmail.com](mailto:khealey.ent@gmail.com).*

In January, **PNHP-COLORADO** collaborated with SNaHP leaders at the University of Colorado to host a forum called, “Medicare for All 101.” PNHP-CO co-directors Drs. Rick Bieser and Cecile Rose were the keynote speakers at the “Beyond the ACA” forum sponsored by Health Care for All Colorado. PNHP members are also active in the statewide “Push to Pass” coalition which is pushing the state’s Congressional delegation to support emergency Medicare coverage for the unemployed and a permanent Medicare-for-All program. The coalition recently met with staff members for Rep. Diana DeGette, and Sens. John Hickenlooper and Michael Bennet. *To get involved in Colorado, contact Dr. Bieser at [rbieser@gmail.com](mailto:rbieser@gmail.com).*

In **ILLINOIS**, PNHP and SNaHP members are part of a coalition that won over two new co-sponsors for H.R. 1976, the Medicare for All Act of 2021. Rep. Mike Quigley signed on for the first time after years of pressure from local activists, and newly elected Rep. Marie Newman signed on after defeating a Democratic incumbent who refused to support single payer. SNaHP students Paul Ehrlich and Alankrita Siddula met with Rep. Newman in April to encourage her to provide more leadership for Medicare for All among her colleagues. PNHP Illinois also supports “Save Our VA,” a campaign that works to improve benefits and oppose privatization, union busting, and facility closures at Veterans’ Health facilities. *To get involved in Illinois, contact Dr. Anne Scheetz at [annescheetz@gmail.com](mailto:annescheetz@gmail.com).*

In **KENTUCKY**, Kentuckians for Single Payer Health Care is working to protect seniors from being charged more or denied a “Medigap” policy because of pre-existing conditions. Many seniors who enroll in Medicare Advantage (MA) plans run by commercial insurers later switch to traditional Medicare because of MA’s narrow networks and hidden costs. But when seniors switched back to Medicare, they are often denied coverage for supplemental Medigap policies due to pre-existing health conditions. KSPHC is trying to pass a state bill that would forbid commercial insurers from denying coverage based on age, health status, past claims, or medical condition. In addition to their work on Medigap plans, chapter leaders have spoken at several events, including a hearing at a church in Louisville and a meeting of residents in internal medicine. *To get involved in Kentucky, contact Kay Tillow at [nursenpo@aol.com](mailto:nursenpo@aol.com).*



**In California, dozens of single-payer activists gather for a Medicare for All march at the Santa Barbara Courthouse on April 17.**





**Medical students Paul Ehrlich (L) and Alankrita Siddula (R) meet with Rep. Marie Newman on April 1 in Chicago.**

**MAINE** AllCare has recently formed a nonprofit called Maine Health Care Action. In January, MHCA launched a ballot initiative that would direct the state legislature to “create a bill that ensures comprehensive, publicly funded, privately delivered health care for every Maine citizen.” The resolve language has already been accepted by the Secretary of State and needs 63,067 signatures to appear on the ballot in November of 2022. In 2021, chapter members passed Medicare-for-All resolutions in the towns of Brooklin, Surry, Tremont, Brooksville, and Bar Harbor, in addition to the five municipal resolutions passed in 2020. *To get involved in Maine, contact [info@maineallcare.org](mailto:info@maineallcare.org).*

**PNHP-MINNESOTA** celebrated Black History Month by partnering with Health Care for All Minnesota and the Minnesota Nurses Association to host a February screening and discussion of “The Power to Heal.” In April, the chapter hosted a presentation on the economics of single payer by health economist Dr. John Nyman, who explained that six leading studies all conclude that Medicare for All can save money while expanding coverage. Dr. Nyman was also a key advisor to PNHP-MN interns Conor Nath and Preetiya Seka, who analyzed numerous single-payer financing studies during the summer of 2020, and whose conclusions can be read at [pnhp.org/PayingForIt](http://pnhp.org/PayingForIt). *To get involved in Minnesota, contact [pnhpminnesota@gmail.com](mailto:pnhpminnesota@gmail.com).*

**PNHP-MISSOURI** is working with local consumer groups to develop a campaign about the hazards of the Medicare Advantage (MA) program run by commercial insurers. The campaign will focus on the lack of consumer protections, guaranteed issue, and community rating for Medigap plans, which create a trap for seniors who join MA. The coalition is pursuing a grant to fund an actuarial analysis, professional message development, and the launch of an education campaign. *To get involved in Missouri, contact Dr. Ed Weisbart at [pnhpMO@gmail.com](mailto:pnhpMO@gmail.com).*

In **NEW HAMPSHIRE**, the Granite State PNHP chapter worked with local activists to introduce Medicare-for-All resolutions in two towns, one of which passed successfully. Chapter leaders have also given single-payer presentations to a number of Rotary groups in the state. This summer, the chapter is collaborating with colleagues in Vermont to once again sponsor an internship for medical students. *To get involved in New Hampshire, contact Dr. Donald Kollisch at [Donald.O.Kollisch@dartmouth.edu](mailto:Donald.O.Kollisch@dartmouth.edu).*

PNHP members in **NEW YORK** are working to pass the single-payer New York Health Act, which was introduced this year with majority support in both the House and the Senate. On March 23, the NY Metro chapter held a Health Worker, Student, and Resident Virtual Lobby Day, where activists attended workshops and met with state legislators and their staff. The chapter continues to hold online forums on health care justice topics. January’s forum on systemic racism in medicine, called “Unequal Treatment: The Unjust Death of Dr. Susan Moore,” included prominent speakers Drs. Mary Bassett, Mary Charlson, and Camara Phyllis Jones, who discussed the importance of demanding institutional accountability for change. The forum in March explored how a state single-payer program would spur an equitable economic recovery from the pandemic. *To get involved in New York, contact NY Metro Executive Director Bob Lederer at [info@pnhpnymetro.org](mailto:info@pnhpnymetro.org).*



**NY Metro's January forum, “Unequal Treatment: The Unjust Death of Dr. Susan Moore,” addresses racism in medicine.**

In **NORTH CAROLINA**, Members of Health Care Justice NC in Charlotte met with Rep. Alma Adams ahead of the introduction of the 2021 Medicare for All Act in the House. They encouraged her to be an original co-sponsor of the bill and to broaden her advocacy for single payer. Chapter leaders also met with a member of the Mecklenburg County Commission to discuss a proposal for restorative justice in Charlotte as well as a county resolution for Medicare for All. The area’s SNaHP members continue to produce short videos that can be viewed at [newimprovedmedicareforall.org](http://newimprovedmedicareforall.org). *To get involved in Health Care Justice NC, contact Dr. Jessica Schorr Saxe at [jessica.schorr.saxe@gmail.com](mailto:jessica.schorr.saxe@gmail.com).*





**Members of Health Care Justice NC meet with Rep. Alma Adams to discuss her support for the Medicare for All Act.**

Members of **Health Care for All NC** held a Human Rights Day press conference on December 10. Speakers from PNHP, the National Domestic Workers Alliance, Charlotte City Workers Union, the NC Council of Churches, and the NC Medicare for All Coalition discussed the effects of the pandemic and demanded Medicare for All. The coalition then held a series of “Medical Bill Burns” in Charlotte, Asheville, and Durham where participants burned their medical bills and shared health care horror stories; the burn events were covered by several local news outlets. *To get involved in Health Care for All NC, contact Jonathan Michels at [jonscottmichels@gmail.com](mailto:jonscottmichels@gmail.com).*

**Healthcare For All Western North Carolina** launched a YouTube channel to share local health care stories, as well as a webpage with resources to fight racism. The chapter is working to pass a Medicare-for-All resolution in the Asheville city council, and forming a broader coalition with other groups such as the Sunrise Movement, the Poor People’s Campaign, and NNU. *To get involved in HCFA-WNC, contact Terry Hash at [theresamhash@gmail.com](mailto:theresamhash@gmail.com).*

**OREGON** PNHP members serve on the OR Universal Care Task Force, and Dr. Samuel Metz has developed a financing plan for a potential state single-payer system. In April, Dr. Metz debated Michael Cannon of the Cato Institute at the Oregon Health Forum event, “Single Payer vs. Free Market.” In Corvallis, members are organizing town halls on how to fund universal health care in Oregon and the U.S., and on racial inequities in health. *To get involved in Oregon, contact Dr. Peter Mahr at [peter.n.mahr@gmail.com](mailto:peter.n.mahr@gmail.com).*

In **PENNSYLVANIA**, members of SNaHP and PNHP Western PA organized a flu vaccine clinic for striking steelworkers who had lost their health coverage. In April,

the chapter sponsored PNHP’s webinar, “Addressing Racial Inequity in Healthcare.” *To get involved in Western PA, contact Dr. Judy Albert at [jalbertpgh@gmail.com](mailto:jalbertpgh@gmail.com).*

In **Philadelphia**, Dr. Walter Tsou discussed health care as a public good at the Progressive Democrats of America national meeting in January. In March, PNHP members met with the chief of staff for Rep. Dwight Evans to urge his support for H.R. 176. Then in April, members of PNHP, Healthcare-NOW!, the Labor Campaign for Single Payer, and Philly DSA organized a social media and phone call “zap,” directed at three Philadelphia-area members of Congress who have yet to sponsor H.R. 176. *To get involved in Philadelphia, contact Dr. Tsou at [walter.tsou@verizon.net](mailto:walter.tsou@verizon.net).*

In November, the **VERMONT** Medical Society (VMS) endorsed a single-payer resolution introduced by PNHP-VT vice president Dr. Jane Katz Field. VMS is the second state medical society after Hawaii to endorse single-payer. Members also helped pass Vermont’s first Medicare-for-All municipal resolution in Putney. PNHP and SNaHP leaders met with Sen. Bernie Sanders’ legislative assistant, urging him to align his bill more closely to the House version and include global budgets for hospitals. The chapter is expanding its summer internship and seeks speakers and trainers from June 14 to July 16. *To get involved in Vermont, contact Dr. Betty Keller at [bjkellerm@gmail.com](mailto:bjkellerm@gmail.com).*

PNHP Western **WASHINGTON** changed its name to “PNHP Washington” to encourage participation across the state. Aside from monthly Zoom forums on health care topics, chapter leaders are involved in efforts to achieve universal coverage in the state. PNHP-WA president Dr. Sherry Weinberg is helping to develop legislation for the Work Group for Universal Health Care; PNHP-WA coordinator Dr. David McLanahan is a leader in the Health Care is a Human Right coalition, which promotes both state and national Medicare for All. *To get involved in Washington, contact Dr. McLanahan at [mcltan@comcast.net](mailto:mcltan@comcast.net).*



**NC Medicare for All Coalition members toss their medical bills in the fire during the “Medical Bill Burn” in December.**