

## PNHP launches Medical Society Resolutions campaign

Even though a majority of physicians now support single-payer reform — with even stronger support among medical students and early-career physicians — the vast majority of professional associations that claim to represent physicians do not support Medicare for All, and in some cases actively oppose it.

The lack of support by organized medicine is a huge problem for the Medicare-for-All movement. Medical societies have enormous influence over health policy at the federal and state level. With the insurance, pharma, and hospital industries spending millions lobbying against single-payer reform, the Medicare-for-All movement needs the full force of organized medicine fighting back.

“We can no longer ignore the elephant in the room: the powerful medical societies standing in the way of reform,” said PNHP president Dr. Susan Rogers. “As the only physician organization dedicated to single payer, PNHP has a responsibility to move the medical profession.”

### What is the Medical Society Resolutions (MSR) Campaign?

Virtually every physician is a member of a local, state, or specialty medical society, and can propose resolutions that determine what policies their society will support (or oppose). The goal of the MSR campaign is to organize colleagues in the medical profession by passing Medicare-

for-All resolutions in every medical society in the U.S.

The MSR campaign follows two years of unprecedented movement towards Medicare for All within organized medicine, much of it led by PNHP members. In 2019, the American Medical Association only narrowly rejected a student-led pro-single payer resolution, then resigned from the anti-single payer Partnership for America’s Health Care Future. In 2020, the American College of Physicians — the largest medical specialty society and second-largest physician group after the AMA — announced its endorsement of Medicare for All. The Society of General Internal Medicine followed suit by endorsing the ACP’s position.

At the state level, the Vermont Medical Society overwhelmingly endorsed a single-payer resolution in November 2020, the second state society to do so after Hawaii. In addition, all the major associations representing medical students and residents have endorsed Medicare for All.

### How to participate in the MSR campaign

Every physician member of PNHP can participate in the MSR campaign by visiting [medicalsocietyresolutions.org](https://medicalsocietyresolutions.org), where they can see if other PNHP members are actively organizing single-payer resolutions in their state, national, or specialty societies; download and edit a sample resolution; and watch recorded workshops on the nuts and bolts of passing resolutions. Interested members can contact [organizer@pnhp.org](mailto:organizer@pnhp.org) to get started and connect with other PNHP members in their societies.



Members of PNHP’s new West Virginia Chapter recruit colleagues at the WV State Medical Association meeting.

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## Kitchen Table Campaign highlights U.S. maternal mortality crisis

The rate of pregnancy-related deaths in the U.S. has nearly tripled in the past 30 years. Besides the U.S., the only other countries with rising maternal mortality rates are Afghanistan and Sudan. Our maternal mortality rate is more than double that of other high-income nations, and our infant mortality rate is 71% higher. Indigenous mothers are twice as likely — and Black mothers 2.5 times more likely — to die from pregnancy complications compared to white mothers.

A majority of pregnancy-related complications and deaths are preventable, caused by health conditions (e.g., diabetes, heart disease, and hypertension) that can be identified, managed, or eliminated with preventive care. But addressing these conditions *before* pregnancy requires a lifetime of regular care, which is out of reach for many Americans — especially people of color — due to costs and insurance barriers.

Band-aid approaches won't solve this crisis. Medicaid, which finances nearly half of U.S. births, starts after a person knows they are pregnant, and ends soon after birth, limiting access to critical prenatal and postpartum care.

By providing lifelong coverage for all health services, Medicare for All is the only plan that would empower patients to prevent, identify, and treat the chronic health conditions that increase risk of pregnancy-related complications and death.

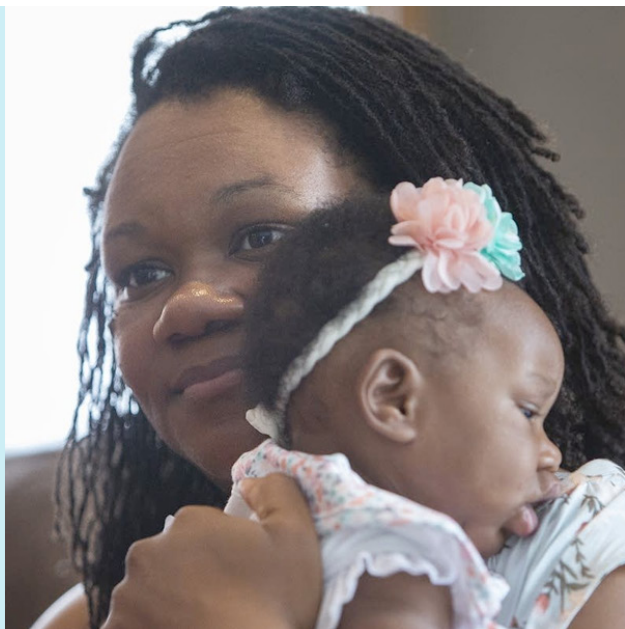
Visit [pnhp.org/maternalmortality](https://pnhp.org/maternalmortality) to explore the Maternal Mortality toolkit, including talking points, handouts, slide set, webinar, videos, podcasts, and a new interactive quiz to test your knowledge. Share these materials online and with your colleagues and communities. To learn more about PNHP's Kitchen Table Campaign, contact [clare@pnhp.org](mailto:clare@pnhp.org).

**The United States is a tragic outlier when it comes to large-scale, preventable, and worsening maternal mortality. But it doesn't have to be this way.**

**#SinglePayer #MedicareForAll would provide lifelong health coverage, so health conditions that threaten mothers could be treated well before pregnancy.**

*Motherhood shouldn't be deadly. It's time for a health system that values everybody throughout their lives—Medicare for All.*

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



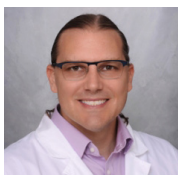
## Meet PNHP's newly elected board members

The newly elected board members will join continuing members Stephen Chao, M.D. (At Large), Mary O'Brien, M.D. (North East), Janine Petito, M.D. (North East), Jessica Schorr Saxe, M.D. (South), Joshua Faucher, M.D., J.D. (North Central), and Eve Shapiro, M.D., M.P.H. (West)

### AT LARGE:

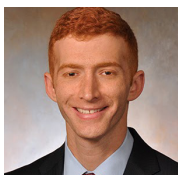


**Sanjeev Sriram, M.D., M.P.H.** completed his M.D. and residency at UCLA, M.P.H at Harvard, and now practices pediatrics in Maryland. He founded the “All Means All” campaign to center racial equity in single payer, and promotes Medicare for All and health equity in national publications and as “Dr. America” for act. TV. As a board member, Dr. Sriram will collaborate with racial justice organizations on strategies to broaden single-payer activism, and expand mentorship and professional development opportunities for students.



**Philip Verhoef, M.D., Ph.D.** completed his M.D. and Ph.D. at Case Western Reserve, med-peds residency at UCLA, and fellowship in critical care at the Univ. of Chicago. He served as president of the IL Single Payer Coalition and co-president of PNHP-IL. Dr. Verhoef works as an intensivist and hospitalist, and associate director for the internal medicine residency program at Kaiser Permanente in Hawaii. As a continuing board member, he will focus on recruiting physicians, especially from diverse and underserved communities.

### NORTH EAST REGION:



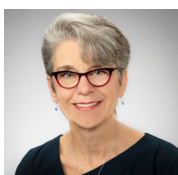
**Scott Goldberg, M.D.** completed his M.D. at Univ. of Chicago Pritzker School of Medicine (launching a SNaHP chapter in 2012) and residency in internal medicine-primary care at UCSF. He serves as an attending physician at Montefiore Medical Center in the Bronx, and an assistant professor at the Albert Einstein College of Medicine. As a board member, Dr. Goldberg will expand PNHP's fundraising and membership, with the goal of shaping the culture of organized medicine around single payer.

### SOUTH REGION:



**Ed Weisbart, M.D.** completed his M.D. at the Univ. of Illinois and family medicine residency at Michigan State. Dr. Weisbart practiced family medicine for 20 years, served as CMO of Express Scripts from 2003-2010, and retired clinically in 2021. He is chair of PNHP-Missouri, where he has delivered more than 600 presentations and dozens of articles on single payer. As a board member, Dr. Weisbart will help PNHP increase its influence within health care policy, and strengthen relationships with adjacent advocacy organizations.

### NORTH CENTRAL REGION:

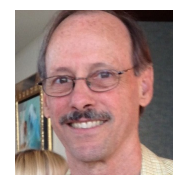


**Judith Albert, M.D.** completed her M.D. at the Univ. of Cincinnati, OB-GYN residency at the Univ. of Pittsburgh and fellowship in reproductive endocrinology at the Univ. of Pennsylvania. Dr. Albert recently retired from 30 years in academic and private practice in Pittsburgh. She co-founded PNHP-Western Pennsylvania and has also been involved in anti-racist organizing. As a board member, Dr. Albert will strengthen PNHP chapters in the region, and build coalitions with unions and anti-racist and anti-poverty organizations.

### WEST REGION:



**Kathleen Healey, M.D.** completed her M.D. at Univ. of Colorado School of Medicine and her residency at the Naval Medical Center in Oakland. She is an otolaryngologist whose career ranged from military service as a flight surgeon, to solo and group practices. Now retired, Dr. Healey serves as co-chair of PNHP-Napa County and PNHP-California. As a board member, Dr. Healey will work to bring more physicians into our movement, and increase PNHP's involvement in organized medicine at all levels.



**Stephen Kemble, M.D.** completed his M.D. at Harvard, and residencies in internal medicine (Queen's Medical Center) and psychiatry (Cambridge Health Alliance). Now semi-retired, he practices part-time in a primary care clinic. Dr. Kemble is past president of the Hawaii Psychiatric Medical Association and the Hawaii Medical Association. As a board member, Dr. Kemble will chair the new PNHP Policy Committee, and help PNHP fight the power of the insurance industry with public education and community organizing.

# DATA UPDATE: HEALTH CARE CRISIS BY THE NUMBERS

## COSTS OF CARE

**Both the insured and uninsured struggle with medical costs:** Nearly one in four (38%) adults had medical bill or debt problems in the last year, including 46% of those on individual/marketplace plans, 34% of those on employer plans, 55% of Black people, and 47% of low-income people; a third of those with debt said they were paying off \$4,000 or more. Among those with medical debt problems, 35% used up all or most of their savings, 35% took on credit card debt, 27% had been unable to pay for necessities like food or rent, 23% delayed education or career plans, and 43% received a lowered credit score. Although uninsured people reported medical bill problems at the highest rates, 64% of those with a medical bill or debt problem said they had been insured at the time. *Collins et al., "Findings from the Commonwealth Fund health care coverage and Covid-19 survey, March–June 2021," Commonwealth Fund, 7/16/2021*

**Americans' medical debt reaches record levels:** An estimated 17.8% of individuals in the U.S. had medical debt in collections in June 2020, for care provided prior to the pandemic. Collection agencies held \$140 billion in unpaid medical bills, up from an estimated \$81 billion in 2016. Between 2009 and 2020, unpaid medical bills became the largest source of debt that Americans owed to collection agencies. Residents of states that did not expand Medicaid owed an average of \$375 more compared to those in expansion states, roughly a 30% increase from the year before Medicaid expansion. People living in the lowest-income ZIP codes owed an average of \$677, compared to \$126 in the highest-income ZIP codes. *Kluender et al., "Medical debt in the U.S., 2009-2020," JAMA, 7/20/2021*

**Even high-income Americans have trouble paying for care:** In the past year, nearly one in four Americans (38%) said they had trouble accessing health care because of cost, including 27% of high-income earners; 36% skipped health or dental care because of cost, including 21% of high-income earners; 34% said their insurance denied payment for medical care; 22% had serious problems paying or were unable to pay medical bills; and 44% had out-of-pocket medical expenses exceeding \$1,000. *Schneider et al., "Mirror, Mirror 2021 — Reflecting poorly: Health care in the U.S. compared to other high-income countries," Commonwealth Fund, 8/4/2021*

**Providing medications for free leads to greater adherence and cost savings:** In a study of patients in Ontario who reported cost-related non-adherence to medications, providing those medications for free increased patient adherence by 35% and reduced total health spending, including hospitalization, by an average of \$1,222 per patient per year. *Persaud et al., "Adherence at two years with distribution of essential medicines at no charge: The CLEAN Meds randomized clinical trial," PLOS Medicine, 5/21/2021*

## HEALTH INEQUITIES

**U.S. life expectancy drops most for people of color:** Life expectancy in the U.S. decreased by nearly two years between 2018 and 2020, down to 76.9 at the end of 2020 from 78.7 in 2018. However, the declines were more pronounced among Black people, whose life expectancy decreased by 3.3 years, and Latinx/Hispanic people, whose life expectancy decreased by 3.9 years. By comparison, among a group of 16 peer countries, the average decline in life expectancy was 0.22 years (about two-and-a-half months). *Wolf et al., "Effect of the Covid-19 pandemic in 2020 on life expectancy across populations in the USA and other high-income countries: Simulations of provisional mortality data," BMJ, 5/24/2021*

**Life expectancy gap widens between urban and rural communities:** In 2019, the mortality rate in urban areas was nearly 665 deaths per 100,000 people, but in rural areas was 834 deaths per 100,000 people. Over the past 20 years, the life expectancy gap between rural and urban areas grew by 172%. *Cross et al., "Rural-urban disparity in mortality in the U.S. from 1999 to 2019," JAMA Network, 6/8/2021*

**Latinx/Hispanic children in the U.S. are twice as likely to be uninsured:** The uninsured rate for Latinx/Hispanic children in the U.S. reached 9.3% in 2019, compared to an uninsured rate of 4.4% for non-Latinx/Hispanic youth. There is considerable variation in the uninsured rate based on state, ranging from 1.8% uninsured in Massachusetts to 19.2% in Mississippi. The uninsured rate for Latinx/Hispanic children in states that had not expanded Medicaid by 2019 was more than 2.5 times higher than expansion states (14.9% vs. 5.8%). *Whitener and Corcoran, "Getting back on track: A detailed look at health coverage trends for Latino children," Georgetown University Center for Children and Families, 6/8/2021*

**U.S. health spending goes disproportionately to white patients:** The U.S. spends about 15% more on health services for white people than for people of color. Per-person spending for white people averaged \$8,141, compared to \$7,361 for Black people, \$6,025 for Latinx/Hispanic people, and \$4,692 for Asian, Native Hawaiian, and Pacific Islander people. Spending also differed by types of care. For example, compared to the national average, Black people accounted for 26% less spending on outpatient services, but 12% more on emergency or inpatient care, suggesting they are treated for illnesses at more advanced stages. *Dieleman et al., “U.S. health care spending by race and ethnicity, 2002-2016,” JAMA Network, 8/17/2021*

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## COVERAGE MATTERS

**Low-cost care improves colon cancer survival rates, especially for Black patients:** Between 1987 and 2013, colon cancer patients in the U.S. Military Health System (MHS) — where care is provided with few or no financial barriers — had an 18% lower risk of death, and were 10% less likely to be diagnosed in a later phase of the disease, compared to similar patients in the general population. The better survival rates were also more evident among Black patients in the MHS, who were 26% less likely to die of colon cancer than those in the general population. *Lin et al., “Comparison of survival among colon cancer patients in the U.S. Military Health System and patients in the Surveillance, Epidemiology, and End Results (SEER) Program,” Cancer Epidemiology, Biomarkers & Prevention, 6/23/2021*

**Medicare reduces racial disparities in coverage and care:** Eligibility for Medicare was associated with reductions in racial and ethnic disparities in insurance coverage, access to care, and self-reported health, benefiting Black and Latinx/Hispanic people the most. Medicare eligibility shrank disparities in insurance coverage by 53% between Black and white people, and 51% between Latinx/Hispanic and white people. Insurance coverage for Latinx/Hispanic people rose from 77.4% prior to the age of 65 to 91.3% after 65; for Black people, it rose from 86.3% to 95.8%. The proportion of Black and Latinx people who self-reported their health as poor also dropped significantly after they became eligible for Medicare. *Wallace et al., “Changes in racial and ethnic disparities in access to care and health among U.S. adults at age 65 years,” JAMA Internal Medicine, 7/26/2021*

**Workplace “wellness” programs are no substitute for actual health care:** A controlled study of workplace wellness programs — which included modules on nutrition, physical activity, and stress reduction — found that employees at the wellness program worksites had better

self-reported health behaviors (such as attempting to manage their weight), but found no significant differences in self-reported health, clinical markers of health, health care spending or use, absenteeism, tenure, or job performance. A three-year follow up did not yield detectable improvements in clinical, economic, or employment outcomes. *Song and Baicker, “Health and economic outcomes up to three years after a workplace wellness program: A randomized controlled trial,” Health Affairs, June 2021*

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## COMMERCIAL HEALTH INSURANCE: A DANGEROUS AND DEFECTIVE PRODUCT

**High-deductible health plans (HDHP) now the norm:** The majority (51%) of private-sector employees are now enrolled in HDHPs, defined as having a deductible of \$1,350 for an individual and \$2,700 for a family in 2018. HDHP enrollment has grown by 43% over the past five years. *“State health compare,” State Health Access Data Assistance Center, Health Policy and Management Division of the School of Public Health at the University of Minnesota, accessed August 2021*

**High cost-sharing has potentially deadly consequences for lower-income patients:** Among patients who were forced to switch from a low-deductible to a high-deductible health plan (HDHP), patients from low-income neighborhoods had fewer emergency department visits or hospitalizations for nonspecific chest pain, but had more hospitalizations for myocardial infarction (heart attack) after ED diagnosis of nonspecific chest pain. Researchers conclude that HDHPs’ higher out-of-pocket costs lead to potentially negative health implications for lower-income populations. *Chou et al., “Impact of high-deductible health plans on emergency department patients with nonspecific chest pain and their subsequent care,” Circulation, June 2021*

**Patients again saddled with Covid care cost-sharing burden:** Despite record profits and a recent surge in Covid cases, insurers are dropping their Covid-19 cost-sharing waivers. Across the two largest health plans in each state, 72% are no longer waiving out-of-pocket costs for Covid-19 treatment, with another 10% phasing out their waiver policies by the end of October. Almost half these plans ended cost-sharing waivers in April 2021, citing vaccine availability. *Ortaliza et al., “Most private insurers are no longer waiving cost-sharing for Covid-19 treatment,” Kaiser Family Foundation, 8/19/2021*

**Those with commercial insurance face worse access, higher costs than those in public plans:** Compared to people on Medicare, those with employer-sponsored or “marketplace” plans were less satisfied with their care,

less likely to have a personal physician, and more likely to report instability in insurance coverage and difficulty receiving medical care or prescriptions due to cost. Reports of medical debt were more common among people who had employer-sponsored coverage (23.4%) and those with individual commercial plans (22.3%) than individuals covered by Medicare (15.6%) or Medicaid (18.3%). *Wray et al., "Access to care, cost of care, and satisfaction with care among adults with private and public health insurance in the U.S.," JAMA, 6/1/2021*

**Commercial plans save money by denying patient claims:** Insurers offering individual ACA "marketplace" plans denied about 17% of in-network claims (40.4 million) in 2019. Patients almost never appeal claim denials: 0.2% of patients appealed their denials, vs. 99.8% that did not appeal. When patients did appeal, insurers upheld 60% of those denials. Even though patients have the right to request an external review after a claims appeal is denied by the insurer, fewer than one in 20,000 denied claims made it to external review. *Pollitz and McDermott, "Claims denials and appeals in ACA Marketplace plans," Kaiser Family Foundation, 1/20/2021*

**Insurers' "utilization management" schemes cost the health care system \$93 billion per year, with patients paying most of the cost:** Insurers are restricting drug formularies, requiring more stringent prior authorizations, and raising patient cost-sharing requirements for prescriptions. These so-called "utilization management" schemes cost the U.S. health system approximately \$93.3 billion each year for implementing, contesting, and navigation. Insurers spend approximately \$6.0 billion administering utilization management, and drug companies spend approximately \$24.8 billion subsidizing patient copays. However, the biggest costs are borne by patients and doctors: Physicians waste \$26.7 billion on time spent navigating utilization management, and patients spend \$35.8 billion in drug cost sharing, even after copay coupons from manufacturers and charities. The study did not measure the health effects of these schemes, but notes that approximately 20% of prescriptions in the U.S. are never filled. *Howell et al., "Quantifying the economic burden of drug utilization management on payers, manufacturers, physicians, and patients," Health Affairs, August 2021*

**Insurers gobble up provider practices and keep more of patients' premiums:** Commercial insurers are expanding aggressively into care delivery, and get to keep more of the premiums they collect when they also own the providers. Federal law limits insurers' profits to 15-20% of collected premiums, but puts no limits to how much profit a provider can keep. So if an insurer directs enrollees to

insurer-owned providers, the company is able to keep more premium dollars. UnitedHealth, for example, owns commercial insurance plans but also operates Optum-branded surgery centers, physician practices, and specialty pharmacies. In 2021, UnitedHealth expects to earn \$91 billion in "eliminations," an accounting term for revenues that stay within the company, a fourfold increase from 10 years ago. *Herman, "Profits swell when insurers are also your doctors," Axios, 7/16/2021*

**Not all surprise medical bills come from the hospital:** Among large employer health plans in 2018, about half (51%) of emergency and 39% of non-emergency ground ambulance rides included an out-of-network charge for ambulance services, sticking patients with surprise bills. Ambulances bring 3 million privately insured people to an emergency room each year. *Amin et al., "Ground ambulance rides and potential for surprise billing," Peterson-Kaiser Family Foundation Health System Tracker, 6/24/2021*

**Commercial insurers continue pandemic profit streak:** At the mid-point of 2021 — as the U.S. entered another wave of Covid hospitalizations and death — commercial insurers posted massive profits. UnitedHealth led the way with second quarter net profits of \$4.3 billion; CVS Health (Aetna), \$2.8 billion; Anthem, \$1.8 billion; Cigna, \$1.5 billion; and Humana, \$588 million. *Herman, "The vaccine wave kept health care as profitable as ever," Axios, 8/30/2021*

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## PRIVATIZING MEDICARE

**Medicare Advantage drives up Medicare spending:** Medicare spending for enrollees on commercial Medicare Advantage (MA) plans was \$321 higher per person in 2019 than it would have been if enrollees had been covered by traditional Medicare, raising overall Medicare spending by \$7 billion. Between 2021 and 2029, federal spending on payments to MA plans is projected to increase by \$316 billion, from \$348 billion to \$664 billion. *Biniek et al., "Higher and faster growing spending per Medicare Advantage enrollee adds to Medicare's solvency and affordability challenges," Kaiser Family Foundation, 8/17/2021*

**Medicare Advantage plans find ways to dump dying patients:** Commercial Medicare Advantage (MA) plans are finding ways to avoid paying the high costs of end-of-life care. As a result, MA beneficiaries in the last year of life disenrolled to join traditional Medicare at more than twice the rate (5%) of all other MA beneficiaries (2%) in 2017. The U.S. Government Accountability Office found that beneficiaries in the last year of life disenroll because of limitations accessing specialized (and expensive) care under MA.

Because Medicare pays MA a fixed fee per enrollee, MA enrollees who switched to traditional fee-for-service Medicare in their last year of life increased Medicare's costs by \$490 million in 2017. *"Medicare Advantage: Beneficiary disenrollments to fee-for-service in last year of life increase Medicare spending," U.S. Government Accountability Office, 6/28/2021*

**Medicare enrollees face cost problems, but fare better in traditional Medicare than Medicare Advantage:** The rate of cost problems was lower among beneficiaries in traditional Medicare (TM) (15%) than in Medicare Advantage (MA) plans (19%). Those with TM plus supplemental coverage (80% of those in TM) had the lowest cost-related problems (12%), but among the remaining 20% of TM enrollees *without* supplemental coverage, 30% reported cost-related problems. Among Black beneficiaries, those in TM had lower cost problems (24%) than those in MA (32%). Across all plans, the rate of cost-related problems was twice as high among Black beneficiaries compared to white beneficiaries (28% vs. 14%), three times higher among beneficiaries in fair or poor self-reported health than among those good health (34% vs. 11%), and 3.5 times higher among beneficiaries under age 65 with long-term disabilities than among those ages 65 and older (42% vs. 12%). *Binieck et al., "Cost-related problems are less common among beneficiaries in traditional Medicare than in Medicare Advantage, mainly due to supplemental coverage," Kaiser Family Foundation, 6/25/2021*

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## HEALTH CARE FOR PROFIT

**Despite the pandemic, health industry CEOs have big paydays:** The CEOs of 178 health care companies collectively made \$3.2 billion in 2020, 31% more than 2019. The CEOs of the six biggest commercial health insurers (Anthem, Centene, Cigna, CVS Health, Humana, United-Health Group) made a combined \$236 million in 2020, a 45% increase over 2019. *Herman, "Health care executive pay soars during pandemic," Axios, 6/14/2021*

**Investors are cashing in on trauma centers:** Investor-owned hospital firms like HCA are rapidly opening "trauma centers," which treat injuries from events like car crashes or gunshots. Trauma centers were once operated mainly by teaching hospitals, but HCA has opened them in 90 of its hospitals and now operates 5% of trauma centers in the U.S. A hospital with a trauma designation can charge "trauma team activation" fees up to \$50,000 per patient for the same care provided in a regular emergency department. *Hancock, "In alleged health care 'money grab,' nation's largest hospital chain cashes in on trauma centers," Kaiser Health News, 6/14/2021*

**High-revenue hospitals more likely to sue their patients:** More than a quarter of the 100 U.S. hospitals with the highest revenues sued patients over unpaid medical bills between 2018 and mid-2020, filing nearly 39,000 court actions (which is likely an undercount since many court records are inaccessible), including lawsuits, wage garnishments, and personal property liens. *McGhee and Chase, "How America's top hospitals hound patients with predatory billing," Axios, 6/14/2021*

**Investor-owned hospitals more likely to inflate prices:** Most hospitals charge more for a procedure than what it costs them, but for-profit facilities take this markup to extremes. The top 100 revenue-generating hospitals charged patients seven times the cost of service, and for-profit hospitals averaged a nearly 12-fold markup. Nine of the 10 top-markup hospitals were investor-owned. While these charges are almost never the actual price paid by insurers, they are used to charge uninsured patients. *McGhee and Chase, "How private hospitals make their money: Massive markups," Axios, 6/14/2021*

**Independent physician practices are now the minority:** By the end of 2020, hospitals and corporations owned half of America's physician practices; nearly 70% of U.S. physicians are now employed by hospitals or corporations like private equity firms and health insurers. In 2019 and 2020, 48,000 physicians quit private practice; of those, more physicians moved to corporate entities than to hospitals. Corporate entities now employ an estimated 20% of all physicians, a 31% increase in the percentage of corporate-employed physicians over two years. *"COVID-19's impact on acquisitions of physician practices and physician employment 2019-2020," Avalere Health, June 2021*

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## PHARMA

**Drug prices are rising at twice the rate of inflation:** While the 2020 rate of inflation was 1.3%, the price of a group of 260 widely used prescription drugs rose by nearly 3% overall since 2019. Over the past 15 years, the price of 65 regularly used brand name drugs rose by nearly 280%, while inflation only rose by 32%. *Purvis and Schondelmeyer, "Rx price watch report: Trends in retail prices of brand name prescription drugs widely used by older Americans, 2006 to 2020," AARP Public Policy Institute, June 2021*

**Medicare drug spending spikes due to prices, not volume:** The amount Medicare spent on drugs dispensed at pharmacies increased 26% from 2013 through 2018. The Medicare Payment Advisory Commission attributed nearly all of the growth in spending to higher prices charged by

pharmaceutical firms rather than an increase in the number of prescriptions filled by beneficiaries. *“Report to the Congress: Medicare and the health care delivery system,” The Medicare Payment Advisory Commission, June 2021*

**Direct advertising leads to increases in Medicare spending on expensive drugs:** Pharma manufacturers spend about \$6 billion each year on consumer advertising. The highest ad spenders were AbbVie’s rheumatoid arthritis drug Humira at \$1.4 billion; Pfizer’s neuropathic pain drug Lyrica at \$913 million; and Eli Lilly’s Type 2 diabetes drug Trulicity at \$655 million. Between 2016 and 2018, nearly 60% of Medicare Parts B and D beneficiary spending (\$324 billion) went to drugs advertised directly to consumers. Advertised drugs accounted for 8% of total Medicare Part D drugs used but 57% of drug spending. Among the top 10 drugs with the highest Medicare expenditures, four were also among the top 10 drugs in ad spending in 2018. *“Prescription drugs: Medicare spending on drugs with direct-to-consumer advertising,” Government Accountability Office Report to U.S. Senate Committee on the Judiciary, May 2021*

**Pharma payments to doctors are associated with increased prescribing of more expensive insulin:** An analysis of Medicare claims found that more than 51,800 physicians received industry payments worth \$22.3 million in 2016. The following year, those physicians wrote, on average, 135 prescriptions for more expensive long-acting insulin, compared with 77 prescriptions written by doctors who did not receive industry payments. The larger number of prescriptions resulted in an average Medicare Part D claim of \$300, which was \$71 more than claims generated by doctors who did not receive payments. *Inoue et al., “Association between industry payments and prescriptions of long-acting insulin: An observational study with propensity score matching,” PLOS Medicine, 6/1/2021*

**Pharma spends more on dividends and stock buybacks than research and development:** The 14 largest drugmakers spent \$577 billion on stock buybacks and dividends from 2016 through 2020, which was \$56 billion more than was spent on R&D during the same time. In fact, some of the spending categorized as “research and development” was spent “researching” ways to suppress competition — especially from generics — such as filing hundreds of new but very minor patents on older drugs. *“Drug pricing investigation: Industry spending on buybacks, dividends, and executive compensation,” U.S. House of Representatives Committee on Oversight and Reform, July 2021*

**Some of the biggest patient advocacy groups take millions from drug companies, but hide those relationships:** All but one of the 15 most prominent patient ad-

vocacy organizations — including the American Cancer Society, American Diabetes Association, American Heart Association, and American Lung Association — fail to fully disclose the amount of drug industry funding they receive, and 12 of the 15 leading groups also have representation from the pharmaceutical industry on their boards. One of the groups, the International Myeloma Foundation, received 57% of its funding (\$11.5 million) from just two pharmaceutical companies. Researchers found that many of these same groups “appear unable or unwilling to take positions on consumer issues such as lowering prescription drug prices that might anger their drug corporation funders.” *“The hidden hand: Big pharma’s influence on patient advocacy groups,” Patients for Affordable Drugs, 6/30/2021*

**Pharma keeps prices high by buying off lawmakers:** Nearly every attempt to lower drug prices in states has failed. Not surprisingly, more than one-third of state legislators in the U.S. (at least 2,467) took pharmaceutical industry contributions in the last two years. In Louisiana, 84% of lawmakers took cash from pharma during the 2020 election cycle; in California it was 82%; in Illinois, 76%; and in Oregon, 66%. The industry spent slightly more on Democrats (\$4.5 million) than on Republicans (\$4.4 million). *Facher, “Pharma funded more than 2,400 state lawmaker campaigns in 2020, new STAT analysis finds,” STAT, 6/9/2021*

**Pharma throws cash at Dems who fight Medicare drug negotiations:** In May, Rep. Scott Peters (D-Calif.) tried to block a bill allowing Medicare to negotiate drug prices. Over the next two days, Rep. Peters received \$19,600 from the pharma industry, including \$5,800 from Pfizer CEO Albert Bourla, \$5,000 from Eli Lilly CEO David Ricks, \$2,900 from Bristol Myers Squibb CEO Giovanni Caforio, \$2,900 from Merck CEO Ken Frazier, and three \$1,000 checks from PhRMA lobbyists. Rep. Peters took in \$66,400 from the industry between May 4 and June 30. *Cohrs, “Pharma CEOs, lobbyists showered Democrat with cash after his attempt to torpedo Pelosi’s drug pricing bill,” STAT, 7/20/2021*

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The Digital Edition includes more than  
**200 pages** of bonus content:

- 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)

In **CALIFORNIA**, four physician members met with state Senator Monique Limón in July, sharing stories about patients who could have been helped by a single-payer plan. Sen. Limón is a member of the senate health committee. PNHP-CA members participated in several actions this summer, including a rally at the state capitol in support of the Healthy California Now bill, a rally demanding Gov. Newsom lead the way on single payer, a delegation to the national March for Medicare for All in Los Angeles, and an event celebrating Medicare's birthday and demanding Medicare for All. *To get involved in California, contact Dr. Kathleen Healey at [khealey.ent@gmail.com](mailto:khealey.ent@gmail.com).*



**PNHP-CA members rally for single payer at the state capitol in June.**

**ILLINOIS** members have given several single-payer presentations this summer. Shannon Rotolo, PharmD, a founder of Pharmacists for Single Payer, discussed pharma issues on a Healthcare-NOW! podcast, and was quoted in the Journal of the American Pharmacists Association. Dr. Pam Gronemeyer spoke on journalist Ben Joravsky's podcast, and at the Chicago March for Medicare for All. Dr. Anne Scheetz spoke to the LaSalle Democratic Central Committee and on a panel sponsored by Chicago Jobs with Justice. Chapter members participated in a vigil for global vaccine access; a Medicare for All rally at the office of Rep. Raja Krishnamoorthi; and a campaign by the Jesse Brown VA Medical Center's Clinical Committee for Black Lives, urging the VA to end the use of race-based algorithms in kidney function calculations. *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 found that many seniors who switch back to Traditional Medicare from a commercial Medicare Advantage plan are not protected from being denied a Medigap plan, or charged more, because of pre-existing conditions such as age, health status, claims experience, or medical condition. Dr. Eugene Shively proposed and successfully passed a resolution at the August meeting of the Kentucky Medical Association calling on the state legislature to end Medigap discrimination. Chapter members also helped to organize the Louisville March for Medicare for All in July, earning local media coverage. *To get involved in Kentucky, contact Kay Tillow at [nursenpo@aol.com](mailto:nursenpo@aol.com).*

In **MAINE**, after hundreds of hours of testimony, meetings, and the production of educational materials for legislators, the legislature passed the Maine Health Care Act, which authorizes the state to request waivers from the federal government to implement a state universal health program, and requires that after the implementation of such waivers, the governor appoint a board to design the state plan. PNHP members participated in the March for Medicare for All in Portland, earning media coverage from one TV station and two of Maine's largest newspapers. PNHPers in Maine are also gathering signatures for a ballot initiative directing the state legislature to establish a universal health care system in the state. *To get involved in Maine, contact Dr. Henk Goorhuis at [henk@maineallcare.org](mailto:henk@maineallcare.org).*



**Dr. Julie Pease and state Rep. Poppy Arford speak at a Medicare for All rally in Portland, Maine.**

PNHP-MINNESOTA hosted a workshop in July on passing local government resolutions in support of Medicare for All. Participants heard from health care activists around the state working on active resolution campaigns, as well as those looking to start new campaigns. *To get involved in Minnesota, contact [pnhpminnesota@gmail.com](mailto:pnhpminnesota@gmail.com).*

PNHP’s NEW JERSEY chapter hosted a planning session in June to discuss organizing strategies to win national Medicare for All. Speakers included U.S. Rep. Bonnie Watson Coleman, who is vice-chair of the Congressional Progressive Caucus. *To get involved in New Jersey, contact Dr. William Thar at [wethar@gmail.com](mailto:wethar@gmail.com).*



**Members of Health Care for All Western NC picket in solidarity with striking NNU nurses at Mission Hospital.**



**Actor Susan Sarandon and PNHP-NY Metro board member Dr. Steve Auerbach march for Medicare for All in July.**

In NEW YORK, PNHP’s NY-Metro chapter is continuing to focus on organizing around the New York Health Act, which was introduced this year with majority support in both the Assembly and the Senate. Organizing tactics included social media campaigns, a series of in-person rallies outside of the offices of targeted legislators, along with a large rally and “die-in” civil disobedience outside of the state capitol building. This spring and summer, the chapter also focused on fighting a move by New York City to shift its public union retirees over to a Medicare Advantage plan. PNHP-NY Metro and the NY Statewide Senior Action Council worked with concerned union members, providing them with tools to coordinate the larger group of retirees interested in the fight, and by hosting two informational forums about the proposed change and how it would affect retirees. *To get involved in New York, contact NY Metro Executive Director Bob Lederer at [info@pnhpnymetro.org](mailto:info@pnhpnymetro.org).*

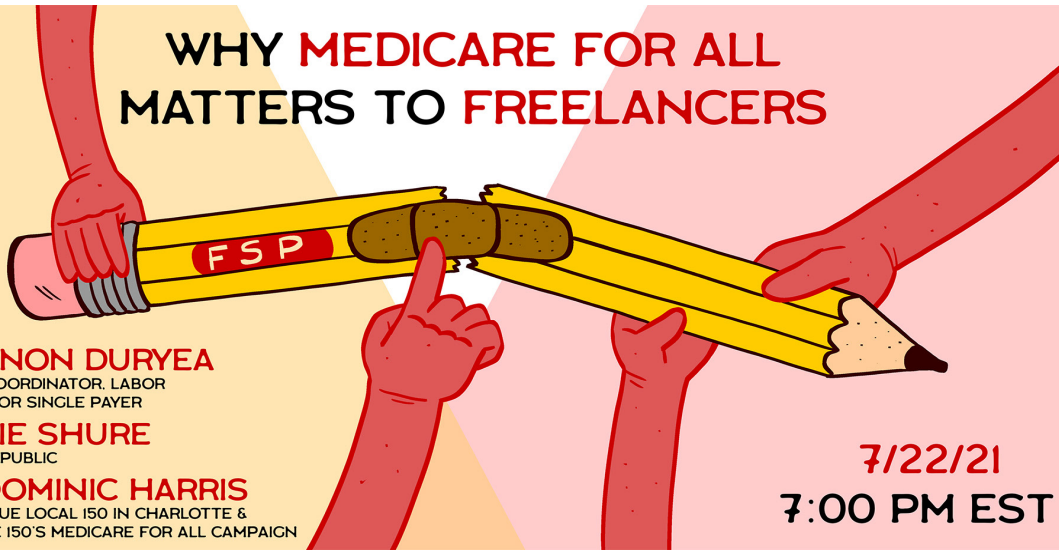
Members of Health Care for All Western North Carolina (HCFA-WNC) in Asheville presented a Medicare for All resolution to the Asheville City Council and the Buncombe County Commission. Members also picketed in solidarity with NNU nurses at Mission Hospital, who were organizing for a new contract. HCFA-WNC joined with six other groups to plan and sponsor a March for Medicare for All which attracted more than 100 marchers. *To get involved in HCFA-WNC, contact Terry Hash at [theresamhash@gmail.com](mailto:theresamhash@gmail.com).*



**Health Care for All Western NC members help lead the March for Medicare for All in Asheville.**

Health Care for All-NC co-hosted a teach-in with the National Writers Union’s Freelance Solidarity Project about why Medicare for All matters to freelance workers, and how they can support it. Panelists included Rhiannon Duryea, national coordinator for the Labor Campaign for Single Payer; Natalie Shure, a writer for The New Republic; and Dominic Harris, president of UE Local 150 and chair of UE 150’s Medicare for All campaign. PNHP is working with the writers’ union to draft a resolution in support of Medicare for All. *To get involved in Health Care for All NC, contact Jonathan Michels at [jonscottmichels@gmail.com](mailto:jonscottmichels@gmail.com).*

# WHY MEDICARE FOR ALL MATTERS TO FREELANCERS



**WITH:**  
**RHIANNON DURYEA**  
 NATIONAL COORDINATOR, LABOR CAMPAIGN FOR SINGLE PAYER  
**NATALIE SHURE**  
 THE NEW REPUBLIC  
**AND DOMINIC HARRIS**  
 PRESIDENT, UE LOCAL 150 IN CHARLOTTE & CHAIR OF UE 150'S MEDICARE FOR ALL CAMPAIGN

**7/22/21**  
**7:00 PM EST**

**Health Care for All-NC joined with union allies to host a teach-in for freelance writers about why Medicare for All matters and how they can fight for it.**

**Health Care Justice NC** — PNHP’s chapter in Charlotte — led several presentations on the topic of the pandemic, health inequities, and Medicare for All to the Atrium Health System pediatric residents, the staff of the Charlotte Center for Legal Advocacy, and to Duke University’s African-American Covid Taskforce Meeting. After a vote by the board, chapter members have been contacting their elected representatives to advocate for improvements to traditional Medicare, including lowering eligibility age to 60, coverage for dental, vision, and hearing care, a cap on out-of-pocket expenses, and allowing Medicare to negotiate drug prices. *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).*



**Board members of Health Care Justice NC hold a farewell dinner for graduating SNaHP leaders from University of North Carolina and Queens University of Charlotte.**

Members of PNHP **OREGON** helped to organize a March for Medicare for All rally in July. The chapter has also joined PNHP’s Medical Society Resolutions Campaign, with the goal of passing resolutions in local chapters of internal medicine and pediatrics specialty societies. Dr. Paul Gorman is helping to organize a new chapter of Students for a National Health Program at Oregon Health and Science University. *To get involved in Oregon, contact Dr. Peter Mahr at [peter.n.mahr@gmail.com](mailto:peter.n.mahr@gmail.com).*



**Dr. Judy Albert speaks to the Pittsburgh March for Medicare for All in July.**

In **PENNSYLVANIA**, PNHP’s Western Pennsylvania chapter continues to ally with the local labor movement, and recently visited striking members of the United Steelworkers to build solidarity. The chapter also sponsored the Pittsburgh March for Medicare for All in July, which attracted about 100 single-payer activists. *To get involved in Western PA, contact Dr. Judy Albert at [jalbertpgh@gmail.com](mailto:jalbertpgh@gmail.com)*

Members of PNHP's **Philadelphia** chapter met with the chief of staff for Rep. Dwight Evans to learn why he doesn't support H.R. 176, even though he endorsed previous single-payer bills. The chapter will use his response to strategize next steps in their campaign to win support from all members of the area's Congressional delegation. *To get involved in Philadelphia, contact Dr. Walter Tsou at [walter.tsou@verizon.net](mailto:walter.tsou@verizon.net).*

In **TENNESSEE**, PNHP's State of Franklin chapter (eastern Tennessee and southwest Virginia) holds monthly meetings focused on developing single-payer messages that appeal to conservative audiences. In the past year, guest speakers included PNHP past president Dr. Carol Paris and former insurance executive Wendell Potter. Members have also published multiple op-eds and letters to editors in local media, and joined in coalition with other non-physician groups fighting for Medicare for All. *To get involved in Tennessee, contact Dr. Bob Funke at [r\\_funke@charter.net](mailto:r_funke@charter.net) or Dr. Robin Feierabend at [robin@firerobin.net](mailto:robin@firerobin.net).*



*In Austin, Texas, Dr. Paul Ehrlich thanks Rep. Lloyd Doggett for co-sponsoring the Medicare for All Act of 2021.*



*PNHP summer interns enjoy a night together in New York.*

PNHP chapters in **VERMONT** and **NEW HAMPSHIRE** completed their sixth annual summer internship program (online), with 14 rising second-year medical students. Topics included the history of the health system, the business model of the insurance industry, organizing students, physicians and chapters, utilizing traditional and social media, and messages for legislators and the public. *To get involved in Vermont, contact Dr. Betty Keller at [bjkellermd@gmail.com](mailto:bjkellermd@gmail.com).*

In **WASHINGTON**, PNHP members held a session on incremental change in the struggle for single payer. The chapter helped organize the March for Medicare for All in Seattle, and facilitated a greeting from Rep. Pramila Jayapal. Members hung Medicare for All banners over Seattle freeways on several occasions. *To get involved in Washington, contact Dr. David McLanahan at [mcltan@comcast.net](mailto:mcltan@comcast.net).*

PNHP welcomes a new chapter in **WEST VIRGINIA**. Since forming in January 2021, members launched the first SNaHP chapter in WV, as well as a "55 STRONG" campaign to recruit a PNHP member in each of the state's 55 counties. They are also actively recruiting in the West Virginia State Medical Association and working on Medicare for All municipal resolutions. *To get involved in West Virginia, contact Dr. Daniel Doyle at [doyledan348@gmail.com](mailto:doyledan348@gmail.com).*



## Annual Meeting goes virtual

The 2021 Annual Meeting will now be held in a virtual online format on **Friday, Oct. 22** (evening) and **Saturday, Oct. 23** (mid-day), with Leadership Training workshops the week of Oct. 18. Speakers include labor leader **José La Luz** and Medicare for All advocate **Dr. Abdul El-Sayed**, along with a health policy update from **Dr. Adam Gaffney**. Visit [pnhp.org/meeting](https://pnhp.org/meeting) for agenda and registration details.