Spring 2022 Newsletter

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

Privatize Medicare? Not on our watch

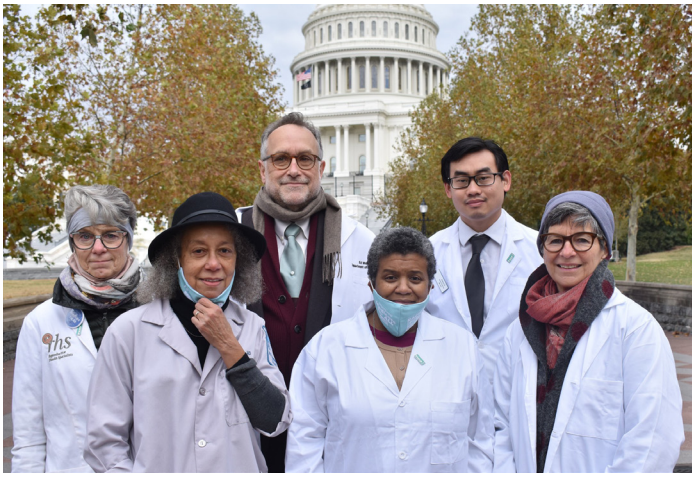
PNHP leads campaign against Direct Contracting

On February 24, the Centers for Medicare and Medicaid Services (CMS) made a stunning announcement: The agency was terminating the controversial Medicare Direct Contracting (DC) program four years ahead of schedule, and "rebranding" the program into a new pilot called ACO REACH.

The announcement came less than three months after a delegation of PNHP physicians and medical students launched a campaign against DC with a press conference at the headquarters of CMS' parent agency, the Department of Health and Human Services. There, PNHP leaders delivered a stack of petitions to HHS Secretary Xavier Becerra, demanding that he immediately end DC and keep Medicare public for future generations.

What is Direct Contracting?

Medicare DC is a pilot program developed during the Trump Administration that would change the way that Traditional Medicare pays for care. Instead of paying providers directly, Medicare pays third-party middlemen called Direct Contracting Entities (DCEs) to "coordinate" beneficiaries' care. DCEs are allowed to keep up to 40% of these payments as profit and overhead, a dangerous incentive to restrict patient care.



PNHP and SNaHP leaders deliver petitions to the Dept. of Health and Human Services, Nov. 30, 2021.

Medicare beneficiaries are automatically enrolled into DCEs without their understanding or consent, and once enrolled, must change primary care providers to opt out. Virtually any type of company can apply to be a DCE, including those owned by commercial insurers, private equity investors, and for-profit dialysis centers. Even though DC is technically a "pilot program," CMS can scale the program up to all of Traditional Medicare without the approval of Congress.

Campaign wins support in Washington

When the physicians traveled to Washington in November, most members of Congress had never even heard of DC. PNHP members and allies quickly met with their representatives and soon won the support of several influential leaders, such as Medicare for All lead sponsor Rep. Pramila Jayapal. In December, Rep. Jayapal and PNHP president Dr. Susan Rogers published an op-ed in The Hill, "The biggest threat to Medicare you've never even heard of," which was shared thousands of times.

In January, Rep. Jayapal and more than 50 Congressional colleagues sent a letter to HHS Sec. Becerra demanding he immediately end the DC program. The campaign then caught the attention of Sen. Elizabeth Warren, who invited Dr. Rogers to speak about Medicare privatization at a Senate Finance committee hearing on Feb. 2.

In the meantime, PNHP members published op-eds and letters-to-the-editor, and campaign leaders gave doz-

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ens of talks and media interviews. By late February, the campaign generated 80 news articles and nearly 50 opinion pieces. In a matter of months, "Direct Contracting" was synonymous with corruption, profiteering, and privatization.

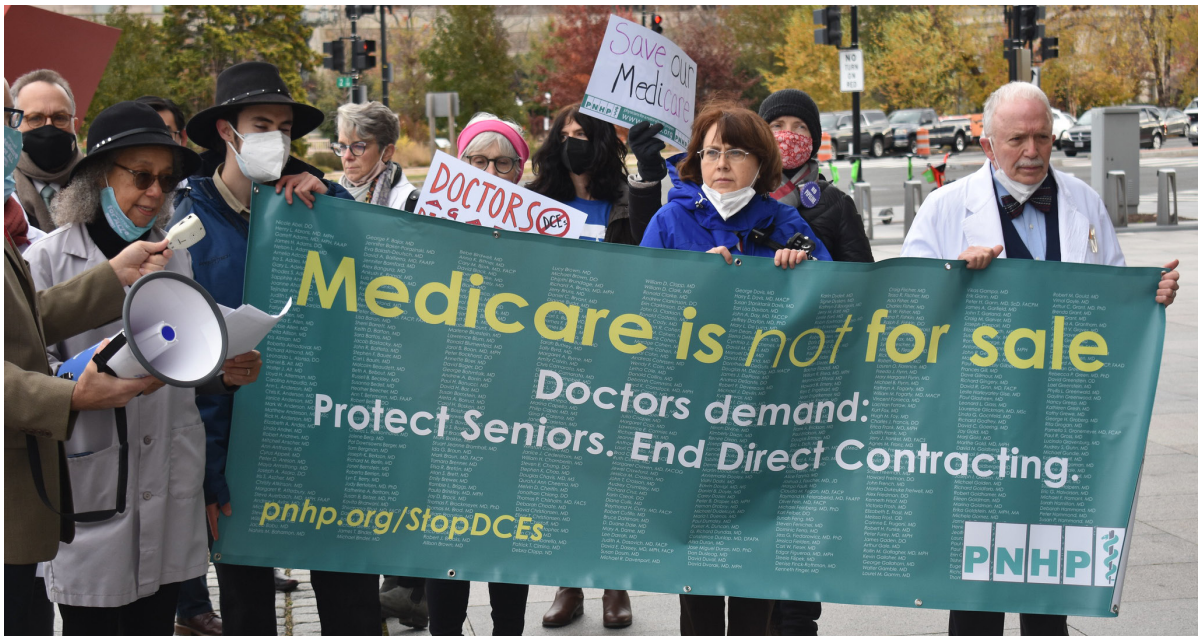
CMS' response to the campaign was to "rebrand" DC into the REACH program. Unfortunately, REACH carries over all the most dangerous aspects of DC, and would continue to allow Wall Street middlemen to profit at the expense of Medicare and its beneficiaries.

PNHP immediately responded to CMS' rebranding with a press statement and video slamming REACH. Less than two weeks later, the campaign sent a letter to CMS and HHS from more than 250 organizations representing health providers, seniors, disabled adults, unions and community groups, demanding an end to REACH and Medicare privatization.

The next phase of the fight against privatization

"The Direct Contracting campaign taught us two important lessons," said PNHP president Dr. Susan Rogers. "First, health justice advocates have incredible power when we educate, organize, and speak out. Second, when Wall Street profiteers get their hands in public programs like Medicare, it's not easy to get them out."

Dr. Rogers noted that PNHP and allies would have to redouble their efforts to end REACH, while also fighting against the growth of Medicare Advantage, the version of Medicare run by commercial insurers for profit. "If we want Medicare for All tomorrow, we must fight to keep Medicare public today," said Dr. Rogers.



PNHP president Dr. Susan Rogers (L, speaking into microphone) leads a delegation of physicians, students, and health justice activists demanding an end to Direct Contracting, Nov, 30, 2021.

Medicare for All support grows in Congress

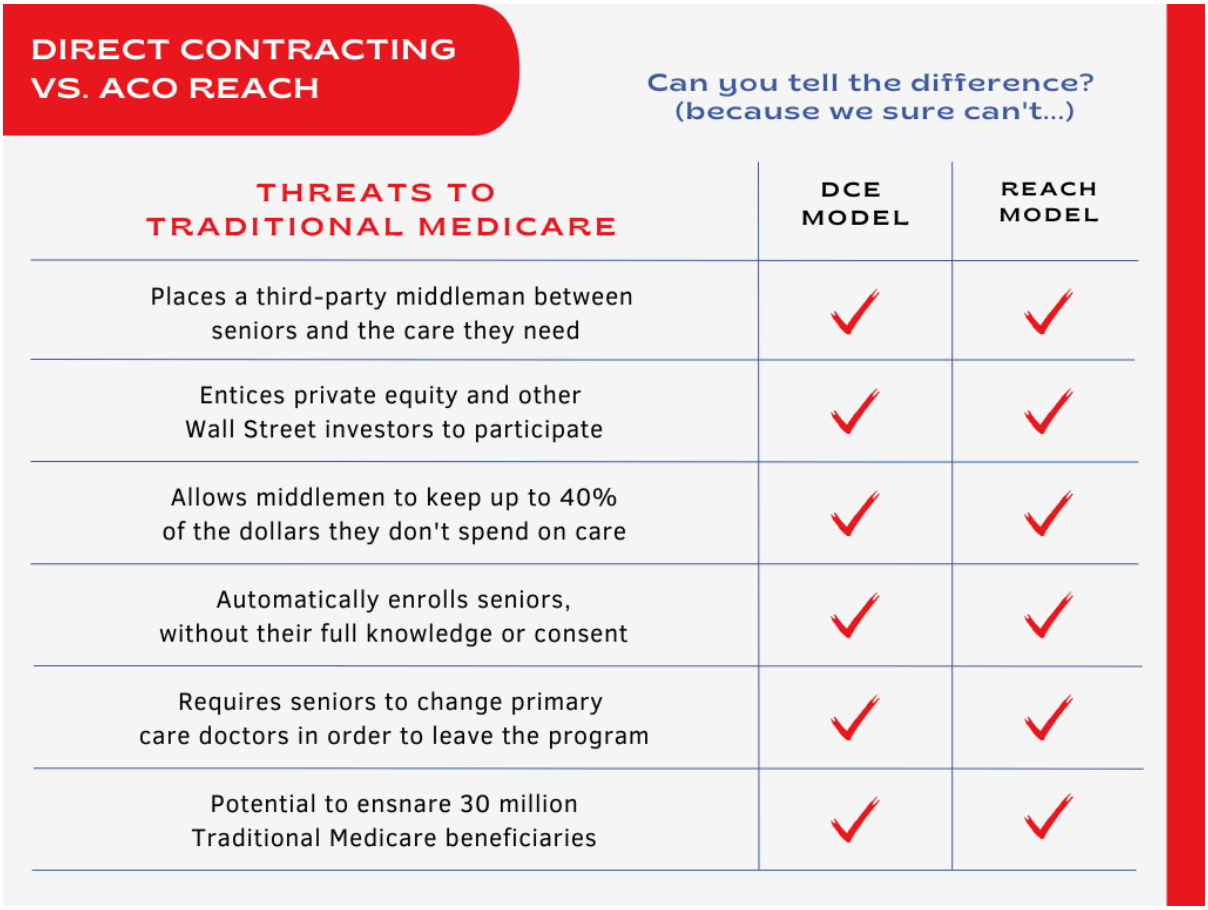
Single-payer advocates across the country have been signing up additional Congressional co-sponsors on H.R. 1976, the Medicare for All Act of 2021. When the bill was introduced by Rep. Pramila Jayapal last March, it had 112 co-sponsors. In the weeks after the introduction, activists quickly signed up another three sponsors (Reps. Mike Quigley of Illinois, Kweisi Mfume of Maryland, and Betty McCollum of Minnesota). Over the summer, two more members of Congress (Reps. Zoe Lofgren of California and Melanie Ann Stansbury of New Mexico) signed on. And in just the last few months, the movement signed up another four co-sponsors (Reps. John Garamendi of California, Shontel Brown of Ohio, Donald Norcross of New Jersey, and Sheila Cherfilus-McCormick of Florida), bringing the total sponsors to 121. In every case, the representatives only signed on after sustained pressure from activists, including phone calls, letters, social media "storms" and public actions. For more information about Medicare for All legislation, visit **pnhp.org/HouseBill**.

CBO: Single Payer is good for the economy

The Congressional Budget Office, the federal agency that provides Congress with economic analysis of proposed laws and policies, just released a powerful report on the potential impact of Medicare for All on the U.S. economy. The CBO concluded that single payer would have several positive impacts on workers and households, as well as the national economy:

- Raise wages as employers would no longer provide health coverage to workers.
- Eliminate households' insurance premiums and most of their out-of-pocket health costs, boosting disposable income.
- Reduce administrative waste in health care, freeing up resources for other sectors of the economy.
- Improve workers' health outcomes, as well as their longevity and labor productivity.
- Create a long-term care program, which would compensate unpaid caregivers or allow them to take on paid work, and increase wages among care workers.

To learn more about this study and the economic impact of Medicare for All, visit **pnhp.org/PayingForIt**.



More state medical societies support Medicare for All

Two more state medical associations have recently joined PNHP's Medical Society Resolutions campaign. In September, PNHP members passed a resolution in the Washington State Medical Association expressing support for "universal access to comprehensive, affordable, high-quality health care … including a publicly-funded national health care program." The resolution passed with 93% of the vote.

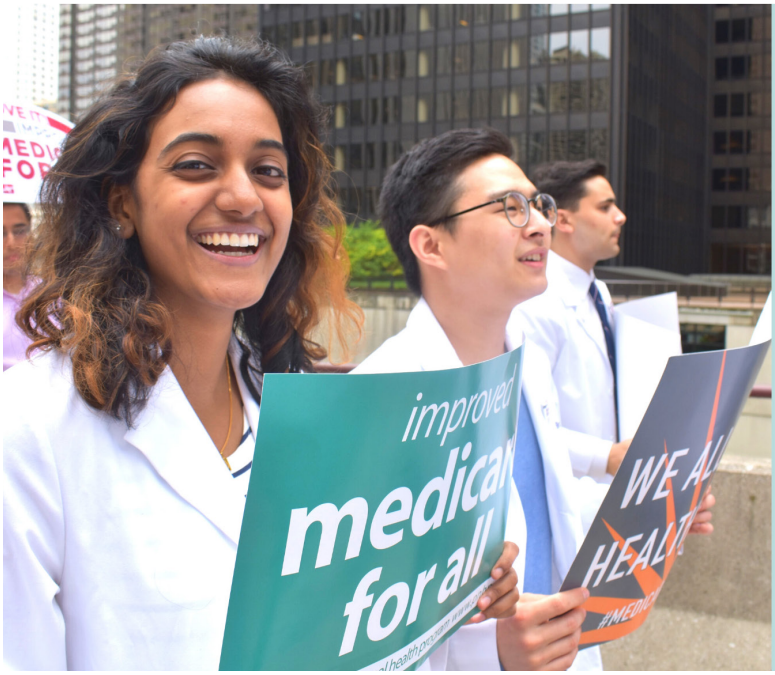
PNHP's Granite State chapter launched their resolution campaign by sending a survey to the New Hampshire Medical Society. They found that 82% of primary care doctors and 66% of specialists support Medicare for All, and similar percentages would support single payer as the official position of the NHMS. Confident in their success, activists submitted a single-payer resolution to the NHMS Council, which passed by an overwhelming majority in March.

Washington State and New Hamphire join Vermont and Hawaii in passing single-payer resolutions in their state medical societies.

Every physician member of PNHP can participate in the Medical Society Resolutions campaign by visiting **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** to get started and connect with other PNHP members in their societies.

PNHP welcomes Dr. Phil Verhoef as President Elect

At the November 2021 Annual Meeting, PNHP's board of directors unanimously elected Phil Verhoef, M.D., Ph.D. as President Elect. He will begin his two-year term as PNHP President in January 2023. Dr. Verhoef, who has been a PNHP member since 2006 and a board member since 2017, received his medical degree and a Ph.D. in pharmacology from Case Western Reserve University, followed by med-peds residency at UCLA. He joined the faculty at the University of Chicago after a fellowship in adult and pediatric critical care, while serving as the president of the Illinois Single Payer Coalition and co-president of PNHP-Illinois. In 2019, Dr. Verhoef moved to Kaiser Permanente in Hawaii, where he serves as an adult/pediatric intensivist and hospitalist and as the associate program director for the internal medicine residency program.



Save the Date!

PNHP 2022 Annual Meeting

Saturday, Nov. 5 in Boston

DATA UPDATE: HEALTH CARE CRISIS BY THE NUMBERS

HEALTH COSTS

Americans delay or skip treatment because of cost: By late 2021, nearly one-third (30%) of Americans reported not seeking treatment for a health problem in the prior three months due to cost, a percentage that tripled since March. One-fifth of adults (21%) reported a member of their household had a health problem worsen after postponing care because of cost. The rate of Americans borrowing money to pay for needed care rose from 7% in December 2020 to 11% in October 2021. An estimated 12.7 million Americans report knowing a friend or family member who died this past year after not receiving treatment because of cost, and Black Americans (8%) are twice as likely to know someone who died as whites (4%). In 2021, many Americans cut back on other necessities to pay for care, including clothing (26%), food (13%) and utilities (8%). *"2021 healthcare in America report," West Health-Gallup, 12/14/2021*

Americans routinely delay or skip needed care: In the past two years, 33% of Americans skipped dental care, 25% delayed a doctor visit or procedure, 24% completely skipped a visit or procedure, 18% avoided going to the hospital or ER, and 15% experienced pain because they could not afford medical care. People with ACA Marketplace plans (78%) were much more likely to report delaying or skipping care due to costs than those with any other type of coverage. *"Healthcare affordability: Majority of adults support significant changes to the health system," Robert Wood Johnson Foundation, August, 2021*

18 million Americans can't afford needed medications: Seven percent of U.S. adults (18 million) were unable to pay for at least one doctor-prescribed medication for their household in early 2021, with higher rates among low-income households. In households earning less than $24,000, almost 20% were unable to pay for medications; for those earning less than $48,000, 18% report skipping pills. About 1 in 10 adults say they've skipped a pill in the prior year to save money. *Witters, In U.S., an Estimated 18 Million Can't Pay for Needed Drugs, Gallup, 9/21/2021*

Nearly one in ten Americans hold medical debt: Roughly 23 million people, or 9% of American adults, owe medical debt, including 11 million who owe more than $2,000 and 3 million who owe more than $10,000. Americans' collective medical debt totaled at least $195 billion in 2019, with people in middle age (35-64) more likely than other adults to report medical debt. Larger shares of people in poor health (21%) and living with a disability (15%) report medical debt, as well as a larger share of Black adults (16%) compared to White (9%), Hispanic (9%), and Asian American (4%) adults. *Rae et al. "The burden of medical debt in the United States," Kaiser Family Foundation, 3/10/2022*

Majority of Americans' debt is medical: In a new survey, roughly 20% of U.S. households report having medical debt, and medical collections tradelines appear on 43 million credit reports. As of mid- 2021, 58% of bills that are in collections and on people's credit records are medical bills. Black Americans are twice as likely (28%) to have past-due medical debt compared to white Americans (17%), and debt is more common in regions that did not expand Medicaid. Medical bills on credit reports can result in reduced access to credit, increased risk of bankruptcy, avoidance of medical care, and difficulty securing employment, even when the bill itself is inaccurate or erroneous. *"Medical Debt Burden in the United States," Consumer Financial Protection Bureau, February 2022*

Medical debt disproportionately impacts the poor: Nearly 80% of medical debt is held by households with zero or negative net worth. Only 9% of medical debt is held by households with between $1 and $104,000 in net worth, and surprisingly, 13% of medical debt is held by households with more than $104,000. Among those with insurance coverage, 26% percent of Black households hold medical debt compared to 16% of non-Black households. Among the uninsured, 35% percent of Black households hold medical debt compared to 26% of non-Black households. *Perry et al., "The racial implications of medical debt: How moving toward universal health care and other reforms can address them," Brookings Institution, 10/5/2021*

High out-of-pocket costs drive up underinsurance in children: Underinsurance for children (lack of continuous and adequate insurance) rose from 31% in 2016 to 34% in 2019 — an additional 2.4 million children — driven primarily by unaffordable out-of-pocket medical expenses. The recent growth of children's underinsurance was driven by those in white and mulitracial households, those considered middle-class (incomes above 200% of poverty), and those with private health insurance. *Yu et al., "Underinsurance among children in the United States," Pediatrics, January 2022*

Despite Medicare, American seniors face financial barriers to care: One in five U.S. seniors (20%) pay more than $2,000 out of pocket for health care services, while most other wealthy nations average 5% or less. In the U.S., 8% of seniors delayed or avoided care in the past year, and 9% skipped medications, compared to 2% or less in countries like Germany and Sweden. *Jacobson, et al., "When costs are a barrier to getting health care: Reports from older adults in the U.S. and other high-income countries,"Commonwealth Fund, 10/01/2021*

U.S. life expectancy plummets, trails other higher-income nations: U.S. life expectancy dropped by 2.27 years in men and 1.61 years in women in 2020, the largest drop of any other middle or high-income country except for Russia. The U.S. drop in life expectancy was driven largely by the deaths of young people. In contrast, in several countries with strong public health and universal coverage — New Zealand, Taiwan, Iceland, South Korea, Norway and Denmark — life expectancy either increased or remained the same. *Islam et al., "Effects of Covid-19 pandemic on life expectancy and premature mortality in 2020: Time series analysis in 37 countries," BMJ, 11/03/2021*

HEALTH INEQUITIES

Maternal mortality crisis grows: The U.S. maternal mortality rate increased by 18% from 2019 to 2020, from 20.1 deaths to 23.8 deaths per 100,000 live births; the 2020 rate is a 37% increase from 2018. Black people had the highest maternal mortality rate (55.3 deaths/100,000 live births), nearly three times higher than white people. The maternal death rate among Hispanic people rose by 44% from 2019 to 2020. The U.S. maternal mortality rate was more than double that of other developed countries. *Hoyert, "Maternal mortality rates in the United States, 2020," National Center for Health Statistics," February 2022*

Latinx/Hispanic Americans have higher rates of preventable cancer: Due to a lack of access to care, Latinx/Hispanic individuals are more likely to suffer from potentially preventable cancers compared to whites. In 2018, 26% of Latinx/Hispanic individuals were uninsured, compared to 9% of whites. Latinx/Hispanic people are more than twice as likely as white people to develop liver cancer or stomach cancer, and are twice as likely to die from those cancers. Compared to white women, Latinas are 32% more likely to get cervical cancer which is almost entirely preventable through screening and vaccination. *Miller et al., "Cancer statistics for the U.S. Hispanic/Latino population, 2021," CA: A Cancer Journal for Clinicians, 9/21/2021*

Inequities plague cancer detection and treatment: The risk of cancer death is 33% higher for Black people and more than 50% higher in Native Americans and Alaska Natives, compared with white people. Even though Black women have a lower rate of breast cancer incidence, they have a 41% higher death rate compared to white women. Breast cancer mortality is also higher in states like Mississippi that did not expand Medicaid and have high levels of poverty. *Seigel et al., "Cancer statistics, 2022," CA: A Cancer Journal for Clinicians, 1/12/2022*

COVERAGE MATTERS

VA care reduces both mortality and health spending: For veterans aged 65 and older, getting emergency care in a Veterans Administration (VA) facility reduced 28-day mortality by 46% and reduced 28-day spending by 21% ($2,598) compared to care in a private facility. *Chan et al., "Is there a VA advantage? Evidence from dually eligible veterans, Working Paper 29765," National Bureau of Economic Research, February 2022*

Veterans died at lower rates in 2020 compared to the general population: In 2020, American veterans faced an excess mortality rate of 13% in 2020, while the U.S. overall had an excess mortality rate of 23% in the same time frame, despite veterans having higher health risks due to age and conditions like hypertension, diabetes, and obesity. Veterans researchers cite "consistent access to health care and the rapid expansion of VHA telemedicine during the pandemic," as the reason. *Feyman et al., "County-level impact of the Covid-19 pandemic on excess mortality among U.S. veterans: A population-based study," The Lancet Regional Health - Americas, 10/30/2021*

Medicaid expansion saves lives: From 2014 to 2018, Medicaid expansion was associated with nearly 12 fewer deaths per 100,000 adults annually; expansion may lead to an overall 3.8% decline in adult deaths each year. The drop in mortality most benefited women and Black people who are more likely to live in poverty than men and non-Black people, respectively. The greatest reduction in mortality was from respiratory and cardiovascular conditions, suggesting that the decrease in mortality is primarily from greater access to preventive care, specialist referrals, and medications. *Lee et al., "Medicaid expansion and variability in mortality in the USA: A national, observational cohort study," The Lancet, 12/2/2021*

Medicare coverage reduces out-of-pocket health spending: Despite a 5% increase in annual medical expenses after 65, older adults' out-of-pocket health costs dropped by 27%, and their rate of catastrophic health expenditures decreased

by 35%, once they enrolled in Medicare at 65. Medicare coverage also led to a 17% reduction in those who delayed seeking care due to cost. *Scott et al., "Changes in out-of-pocket spending and catastrophic health care expenditures associated with Medicare eligibility," JAMA Health Forum, 9/10/2021*

COMMERCIAL HEALTH INSURANCE: A HAZARDOUS PRODUCT

Prior authorization (PA) causes disability and death: In a new survey, nearly all (93%) physicians reported care delays while waiting for insurers to authorize necessary care via PA, and 82% said patients abandoned treatment due to PA struggles with insurers. More than one-third (34%) reported that PA led to a serious adverse event for a patient in their care, such as hospitalization, disability, or even death. *"2021 AMA prior authorization (PA) physician survey," American Medical Association, 2/10/2022*

Americans skip or delay care due to insurance hassles: One quarter (25%) of insured, working-age adults have either postponed or skipped necessary care because of administrative obstacles. Nearly three-quarters of patients (73%) reported undertaking tasks like scheduling, obtaining prior authorizations, and resolving problems with bills and insurance premiums. Nearly half of patients who encountered issues with premium payments, and more than one-third of patients who experienced billing or prior authorization problems, delayed or skipped care. *Kyle and Frakt, "Patient administrative burden in the U.S. health care system," Health Services Research, 9/0/2021*

Insured families can't afford cost sharing: In 2019, average out-of-pocket spending limits in commercial insurance plans (for in-network services) were $7,900 for an individual and $15,800 for a family. However, nearly half (45%) of single-person, non-elderly households did not have the liquid assets to cover more than $2,000 in costs, and nearly two-thirds (63%) could not cover more than $6,000. *Young et al., "Many households do not have enough money to pay cost-sharing in typical private health plans," Kaiser Family Foundation, 3/10/2022*

The cost of job-based insurance is steadily rising: For the nearly 155 million Americans who get health coverage through their jobs, total average annual premiums are now over $22,200 for families, with workers on average paying $5,969 toward the cost of their coverage, and $7,700 for individuals, with workers paying nearly $1,300 towards the cost. *"2021 employer health benefits survey," Kaiser Family Foundation, 11/10/2021*

Employer-plan premiums and deductibles outpace family incomes: Average premiums and deductibles in employer-sponsored health plans climbed to $8,070 in 2020, accounting for 11.6% of the U.S. median household income, up from 9.1% in 2010. Rates were as high as 19% of household income in Mississippi and 18% in New Mexico. Workers with single plans paid about 21% of their premiums; those with family coverage paid 29% of their premiums. *Collins et al., "State trends in employer premiums and deductibles, 2010–2020," The Commonwealth Fund," 1/12/2022*

High insurance costs hurt low-income families hardest: Among those with employer coverage, families below 200% of the poverty line spent an average of 10.4% of their income on premiums and medical care, compared to families above 400% of poverty who spent 3.5% of household income on premiums and medical expenses. *Claxton et al., "How affordability of employer coverage varies by family income," Kaiser Family Foundation, 3/10/2022*

ACA Marketplace plans increasingly unaffordable, even for higher earners: For families at 400-600% of poverty ($69,680–$104,520 for a family of two), the premium and deductible for an ACA "Bronze" plan represented 18.3% of income in 2015. By 2019, these costs rose to 26.6% of income. For those aged 55-64 years old, the premium alone is now 18.9% of income. *Jacobs and Hill, "ACA marketplaces became less affordable over time for many middle-class families, especially the near-elderly," Health Affairs, November 2021*

Big insurers dominate most metro area markets: Nearly three-fourths (73%) of U.S. metro areas were highly concentrated insurance markets in 2020, up from 71% in 2014. Fourteen states had one health insurer that controlled at least half of their markets. In 91% of metro areas, at least one insurer had a commercial market share of 30% or greater, and in 46% of areas, a single insurer's share was at least 50%. *"Competition in health insurance: A comprehensive study of U.S. markets," American Medical Association, September 2021*

UnitedHealth profits in the pandemic: During the second year of the pandemic, the nation's largest commercial insurer surpassed revenue and profit projections. UnitedHealth's 2021 revenue was $288 billion, up 12% from 2020, which is triple its revenue from 2010. UH's 2021 operating profit was $24 billion, also up 12% from 2020, and quadruple the level from 2010. While the company is known for insurance, a majority of its revenue ($156 billion) comes from its affiliate Optum, which owns physician practices and specialty pharmacies. *"UnitedHealth Group reports 2021 results," UnitedHealth Group, 1/19/2022*

PRIVATIZING MEDICARE AND MEDICAID

Aetna accused of operating "shadow network" of Medicaid providers: Commercial insurer Aetna, a CVS Health subsidiary, illegally secured contracts with Pennsylvania's Medicaid program by misrepresenting the number of pediatric providers in its network in order to discourage care and increase profits, according to a federal whistleblower lawsuit. The whistleblower found that many of the providers assigned to the company's nearly 100,000 child beneficiaries were either not contracted with Aetna, dead, out of state, or did not treat children. Aetna claimed its lower-than-average screening, diagnostic, and treatment rates were due to parental negligence. *Tepper, "Aetna lied about provider network to win Medicaid contracts, suit alleges," Modern Healthcare," 9/14/2021*

Medicare Advantage (MA) costs taxpayers tens of billions more than Traditional Medicare: Medicare overpaid MA insurers by more than $106 billion from 2010 through 2019, with nearly $34 billion during 2018 and 2019 alone. The overpayments were mostly due to upcoding, or MA plans' fraudulently exaggerating diagnoses to increase patients' risk scores. In 2019, MA risk scores were 19% higher compared to Traditional Medicare. Under current coding rules, spending on MA is expected to increase by $600 billion from 2023 through 2031, with as much as two-thirds of the increase in spending going toward profits for insurance companies. *Schulte, "Medicare Advantage's cost to taxpayers has soared in recent years, research finds," Kaiser Health News, 11/11/2021*

Medicare Advantage (MA) insurers collect billions for unverified diagnoses: In 2016, MA plans' fraudulent "upcoding" — using chart reviews and health risk assessments to increase Medicare risk-adjusted payments — cost the federal government $9.2 billion. The nation's largest insurer, United Healthcare, generated 40% of its risk-adjusted payments, or $3.7 billion, by listing patient conditions unverified through outside medical claims. The top three "upcoded" conditions were vascular disease; major depressive, bipolar and paranoid disorders; and diabetes with chronic complications. *Murrin, "Some Medicare Advantage companies leveraged chart reviews and health risk assessments to disproportionately drive payments," U.S. Department of Health and Human Services, Office of Inspector General, September 2021*

Medicare Advantage (MA) plans cited for not paying for care: Four regional MA plans affiliated with UnitedHealthcare and Anthem have been barred from enrolling new members until 2023 after failing to meet the 85% medical loss ratio threshold for three straight years. The enrollment suspensions affected about 80,000 of UnitedHealth's 7.5 million MA enrollees. *Commins, "Anthem, Unitedhealthcare MA Plans sanctioned for missing MLR threshold," Health Leaders Media, 9/20/2021*

Medicare Advantage (MA) market increasingly concentrated: Six insurers control roughly three-quarters of the MA market: UnitedHealth (7.9 million members), Humana (5.1 million), CVS/Aetna (3.1 million), Anthem (1.9 million), Kaiser Permanente (1.8 million), and Centene (1.4 million). *Herman, "The big Medicare Advantage players keep getting bigger," Axios, 1/19/2022*

HEALTH CARE FOR PROFIT

Private equity flows into health care: Acquisitions by private equity (PE) investors in health care have nearly tripled, from $41.5 billion in 2010 to $119.9 billion in 2019, for a total of approximately $750 billion over the last decade, concentrated in home health, physician practices, and outpatient care. Because PE firms are focused on short-term profits, they tend to prioritize revenue over quality of care and engage in unethical billing practices; they also overburden health care companies with debt, strip their assets, and put them at risk of long-term failure. Experts expect PE investment to increase by 30% to 40% in 2022. *Scheffler et al., "Soaring private equity investment in the healthcare sector: Consolidation accelerated, competition undermined, and patients at risk," American Antitrust Institute and the School of Public Health at UC Berkeley, 5/18/2021*

Physician management companies and private equity drive up costs: Compared to hospitals that did not use physician management companies (PMCs) for their outpatient departments and ambulatory surgery centers, hospitals with PMCs charged 16.5% higher prices; hospitals with PMCs backed by private equity increased costs by 25%. *LaForgia et al., "Association of physician management companies and private equity investment with commercial health care prices paid to anesthesia practitioners," JAMA Internal Medicine, 2/28/2022*

For-profit hospitals avoid unprofitable services: Government-owned and nonprofit hospitals were 9 percentage points and 6.2 percentage points more likely than comparable for-profit hospitals to offer relatively unprofitable services, like psychiatric care, substance abuse treatment, obstetric care, and hospice. For-profits were 32% more likely to offer a profitable service (such as coro-

nary artery bypass grafting surgery) than an unprofitable service, compared to 27.3% for nonprofits and 22.2% for government-owned facilities. *Horwitz and Nichols, "Hospital service offerings still differ substantially by ownership type," Health Affairs, March 2022*

Nonprofit insurance CEOs snagged big raises: Across all U.S. health insurers, CEOs received an average 7.5% raise in 2020 compared with 2019. Although nonprofit insurance CEOs were paid less overall than the heads of for-profit insurers, Blue Cross Blue Shield CEOs were more likely to get a substantial raise in 2020. BCBS of Minnesota CEO Craig Samitt got a 109% raise, to $3.3 million; Hawaii Medical Service Association CEO Mark Mugiishi earned a 89.5% raise, to $1.8 million; and Independence Blue Cross's now-retired CEO Dan Hilferty received a 73.6% raise, to $9.9 million. *Tepper, "BCBS CEOs received bigger raises in 2020 than execs at for-profit insurers, report says," Modern Healthcare, 10/12/2021*

PHARMA

Pharma raises prices, spends lavishly on CEOs and ads: A recent Congressional investigation found that from 2016 to 2020, pharmaceutical companies raised the prices of brand-name drugs by 36%, almost four times the rate of inflation. Despite their claims of needing high prices to fund research, drug firms spent heavily on executive salaries and marketing. The 10 largest pharma companies paid their top executives more than $2.2 billion from 2016 to 2020, including nearly $800 million just to their CEOs. AbbVie, Amgen, Novo Nordisk, and Pfizer spent more than $2.6 billion in direct-to-consumer advertising from 2015 to 2018 on just four drugs. *"Drug pricing investigation majority staff report," U.S. House of Representatives Committee on Oversight and Reform, December 2021*

Pharma gifts to doctors lead to higher drug spending: Pharmaceutical company gifts to rheumatologists, through food and beverages or consulting fees, are linked with a higher likelihood of prescribing drugs and higher Medicare spending. For each $100 in food/beverage payments, Medicare reimbursement increased 6% to 44% ($8,000 to $13,000). The increases were particularly high for infliximab and rACTH, where a payment of $100 to a prescriber was associated with increases of approximately $72,000 and $30,000 in Medicare reimbursements, respectively. *Duarte-García et al., "Association between payments by pharmaceutical manufacturers and prescribing behavior in rheumatology," Mayo Clinic Proceedings, 2/01/2022*

Americans spend almost double what the rest of the world combined spends on drugs: The 20 highest-selling drugs generated $158 billion of global revenue in 2020, but due to our high drug prices, U.S. sales represented 64% of that total, or $101 billion. For 17 of the 20 top-selling drugs worldwide, pharmaceutical firms made more money from U.S. sales than from sales to all other countries in the rest of the world combined. Drugs with the highest revenue disparities between the U.S. and the rest of the world include medications for HIV, autoimmune disease, MS, and diabetes. *Claypool and Rizvi, "United we spend: For 20 top-selling drugs worldwide, big pharma revenue from U.S. sales combined exceeded revenue from the rest of the world," Public Citizen, 9/30/2021*

DARK MONEY IN HEALTH CARE

Spending by health industry lobbyists increased in 2021: The Pharmaceutical Research and Manufacturers of America (PhRMA) spent nearly $30 million on lobbying in 2021 — a 16% increase over 2020. Other big spenders include the American Hospital Association, which spent $20.8 million in 2021 versus $18.9 million in 2020; the American Medical Association spent $18.8 million in 2021 (about the same as 2020); and America's Health Insurance Plans, which spent $11.3 million in 2021. Cigna led the lobbying push among individual insurers, increasing its spending by 27% to $9.1 million in 2021 compared with $7.2 million in 2020. *Wilson, "Health interests pour cash into D.C. lobbying," Politico, 1/24/2022*

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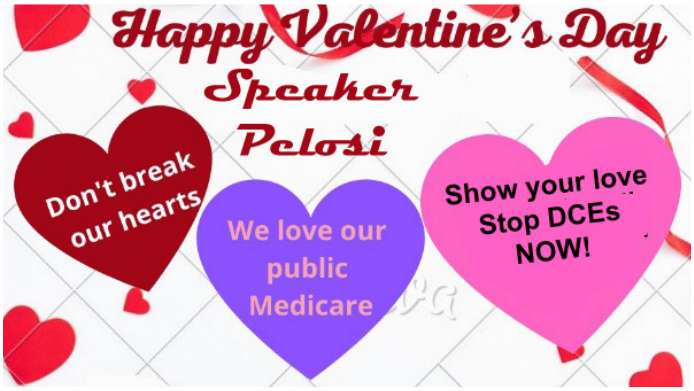
- PNHP members in the news

PNHP CHAPTER REPORTS

To form a chapter in your area, contact organizer@pnhp.org

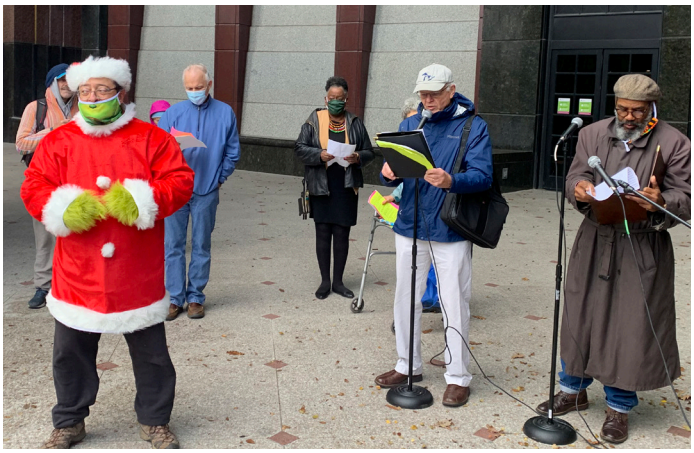
PNHP **CALIFORNIA** worked to pass AB 1400, the state's single-payer bill. PNHP members provided policy recommendations to the bill's sponsor, attended rallies and car caravans, wrote letters and op-eds, and published ads in local newspapers in support of the bill. PNHP members also worked to pass several municipal single-payer resolutions, including the cities of Arcata, Blue Lake, Trinidad, and Eureka; Humboldt County; and the community services Districts of Manila and Willow Creek. California members have been very active in PNHP's campaign to stop Medicare Direct Contracting, organizing a campaign to send hundreds of postcards and emails to Rep. Nancy Pelosi on Valentine's Day in support of Traditional Medicare. *To get involved in California, contact Dr. Corinne Frugoni at cfrugoni@reninet.com.*



Hundreds of members of PNHP California sent postcards and emails to House Speaker Nancy Pelosi on Valentine's Day, urging her to protect Medicare and end Direct Contracting.

In **ILLINOIS**, as part of the PNHP Medical Society Resolutions Campaign, Dr. Peter Orris submitted a single-payer resolution to the Illinois State Medical Society in December; the chapter will organize to pass the resolution in the coming months. Dr. Pam Gronemeyer is collecting signatures for a Medicare for All ballot proposition in downstate Edwardsville. In November, Dr. Duane Dowell spoke at a "Bans Off Our Bodies" rally for abortion rights, which was endorsed by PNHP-Illinois. *To get involved in Illinois, contact Dr. Anne Scheetz at annescheetz@gmail.com.*

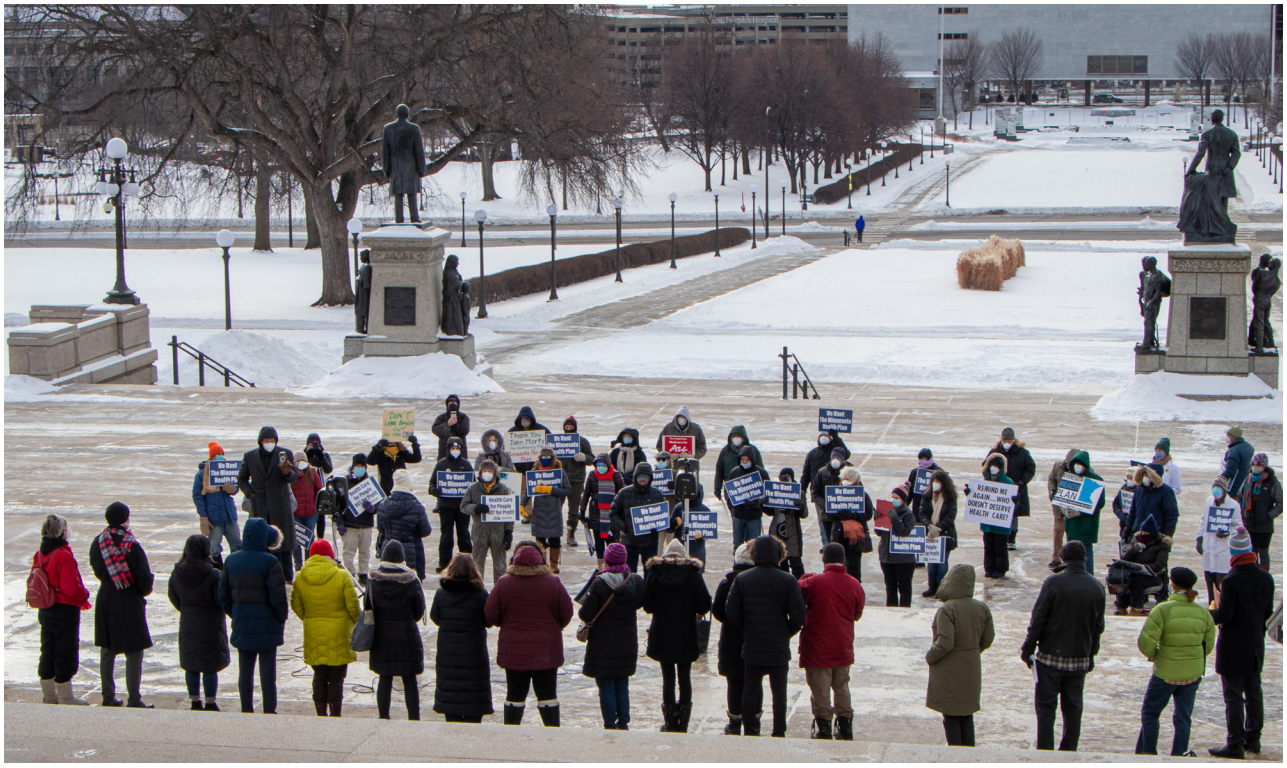
In **KENTUCKY**, PNHP members and allies hosted a rally against Medicare Direct Contracting in front of the Humana Insurance building in downtown Louisville (Humana owns a Medicare Advantage business as well as a Direct Contracting Entity). The event's theme was, "How the Grinch Stole Medicare," and included a visit by the Grinch himself reading an original Dr. Seuss-style poem about the threat of privatization. *To get involved in Kentucky, contact Kay Tillow at nursenpo@aol.com.*



PNHP-Kentucky hosts a Grinch-themed rally against Direct Contracting at Humana's headquarters in Louisville.

PNHP's **MINNESOTA** chapter held their annual meeting in January with nearly 100 members in attendance. The group discussed legislative plans, organizing strategies, and the summer internship, and enjoyed a keynote address from Dr. Rachel Madley, a former SNaHP leader who now works as legislative assistant to Rep. Pramila Jayapal. PNHP and Health Care for All MN braved sub-zero temperatures for a rally at the State Capitol on January 26 to celebrate the formation of the Minnesota Health Plan Caucus, a group of legislators who support single-payer bills in the state House and Senate. In February, the chapter hosted the "Meet the Minnesota Health Plan Caucus" education event, a panel discussion of the Minnesota Health Plan with lead author Sen. John Marty and other caucus leaders to discuss the features of the bill, how to organize to support it, and the anticipated timeline to get it passed. *To get involved in Minnesota, contact pnhpminnesota@gmail.com.*

In **NEW HAMPSHIRE**, PNHP's Granite State chapter sent a survey to the New Hampshire Medical Society, gauging their support for single payer. They found that 82% of primary care doctors and 66% of specialists support Medicare for All, and similar percentages said they would support making single payer the official position of the NHMS. In

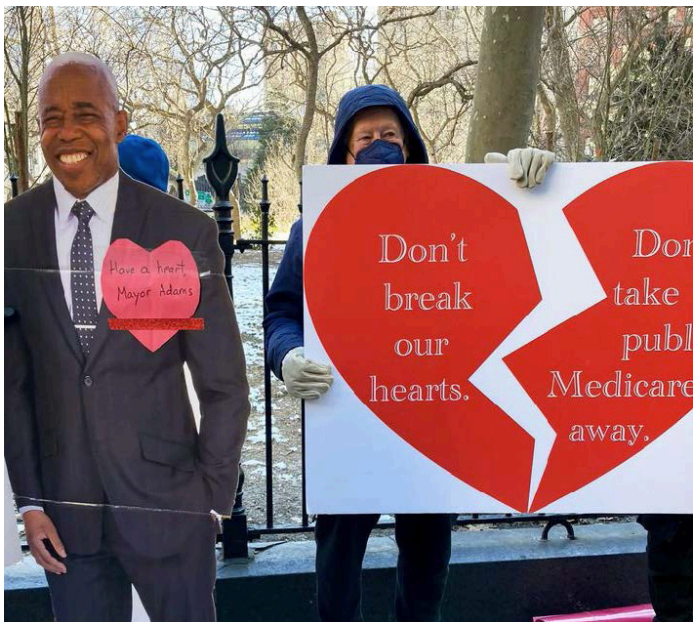


PNHP Minnesota members and allies brave sub-zero temperatures in January to hold a rally for single-payer health care at the state capitol.

response, activists submitted a single-payer resolution to the NHMS Council, which passed in March with an overwhelming majority. PNHP activists and allies also worked to pass a Medicare for All resolution in the City Council of Keene, making it the sixth NH town to pass a MFA resolution in the last two years. *To get involved in New Hampshire, contact Dr. Donald Kollisch at donald.o.kollisch@dartmouth.edu.*

In **NEW YORK**, PNHP-NY Metro has built working groups to implement chapter advocacy projects including Medicare privatization, the single-payer New York Health Act, and recruitment of doctors and other health workers into the movement. The chapter has worked hard to block the city's scheme to move 250,000 municipal retirees into a Medicare Advantage plan by holding educational webinars; writing and distributing detailed analyses of the financial impact on retirees and health inequities; submitting an affidavit supporting a lawsuit; and supporting a retiree resistance group that held several rallies against the mayor's decision. In March, a judge rejected the city's plan, although the ruling is being appealed. NY-Metro continues to hold online monthly forums on topics like Direct Contracting and Medicare privatization, and how to fight back against high prescription drug prices. *To get involved in NY-Metro, please contact Executive Director Bob Lederer at bob@pnhpnymetro.org.*

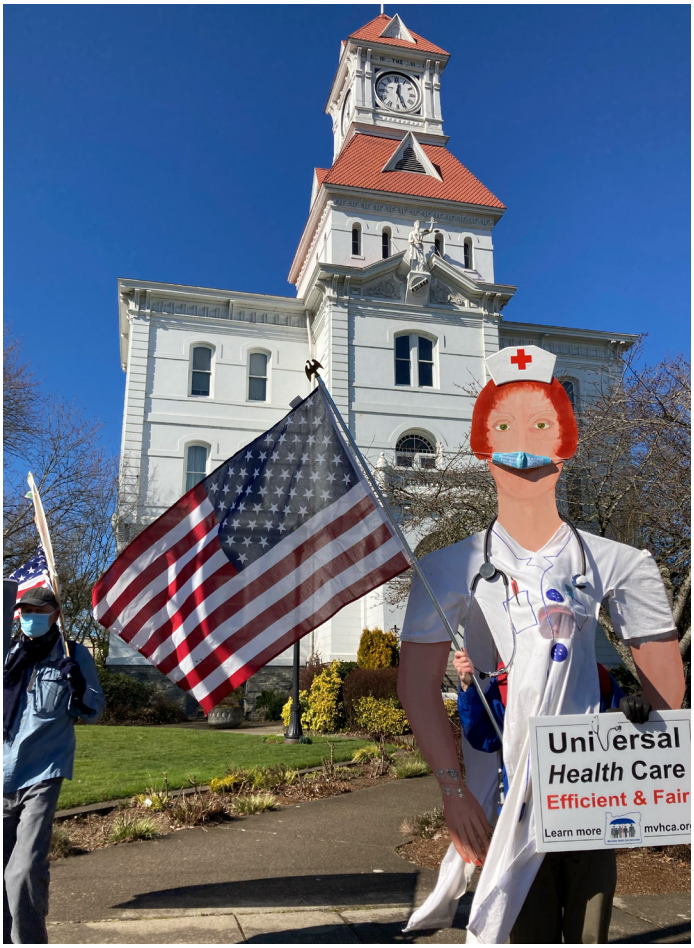
In **NORTH CAROLINA**, Health Care Justice NC members helped persuade Rep. Alma Adams to sign the Congressional sign-on letter against Medicare Direct Contracting, which was released in January. The chapter has developed a strong relationship with Rep. Adams and her staff over the years. *To get involved in Health Care Justice NC, contact Dr. Jessica Schorr Saxe at jessica.schorr.saxe@gmail.com.*



PNHP NY-Metro supports municipal retirees' fight against the city's attempt to move them from Traditional Medicare into a commercial Medicare Advantage plan.

Members of **Health Care for All Western North Carolina** (HCFA-WNC) in Asheville have been active in the campaign against Medicare Direct Contracting. Members held a watch party for PNHP President Dr. Susan Rogers' testimony at the Senate Finance Committee in February, gathered signatures for the Direct Contracting Petition, and recruited local groups to sign onto PNHP's organizational sign-on letter to HHS Sec. Becerra. *To get involved in HCFA-WNC, contact Terry Hash at theresamhash@gmail.com.*

In **OHIO**, PNHP members and allies organized a car caravan in Columbus, where dozens of activists urged Congresswoman Joyce Beatty to sign onto H.R. 1976, The Medicare for All Act. Activists amplified the pressure with an ad targeting Rep. Beatty in the *Columbus Dispatch.* Allies organized similar events on the same day in three other cities in Ohio, targeting members of Congress who had not signed on to H.R. 1976. *To get involved in Ohio, contact Dr. Jim Binder at jamesbinder3@gmail.com.*



Dr. Mike Huntington of PNHP Oregon in puppet gear at a Medicare-for-All rally at the Benton County Courthouse.

In **OREGON**, the PNHP chapter is holding weekly "Conversations with Candidates" health policy forums for candidates running for governor and Congress. Sixteen candidates have agreed to be interviewed, and each forum attracts more than 50 audience participants. Chapter members have also been active in rallies across the state for Medicare for All. *To get involved in Oregon, contact Dr. Peter Mahr at peter.n.mahr@gmail.com.*

In **VERMONT**, PNHP members collaborated with multiple health care activists to send a letter to CMS and to the Vermont Attorney General regarding OneCare, a state program similar to Medicare Direct Contracting/REACH. Chapter leaders also met with several candidates to discuss their positions on Medicare for All, including staff representing U.S. Senator Patrick Leahy and Rep. Peter Welch, as well as Lieutenant Governor Molly Gray, and State Senators Becca Balint and Kesha Ram-Hinsdale. The PNHP New England coalition is once again hosting a summer internship for medical students. This spring, they interviewed and selected students for the 2022 session, which will include students from New Jersey, Arizona, Louisiana, Florida, and New York. *To get involved in Vermont, contact Dr. Betty Keller at bjkellermd@gmail.com.*

In **WASHINGTON**, chapter members met with key staff of their Congressional representatives, including Sen. Patty Murray, Sen. Maria Cantwell, and Rep. Susan DelBene, asking them to support Medicare for All and oppose Medicare Direct Contracting and privatization. Chapter leaders signed ten Washington State organizations onto the anti-Direct Contracting sign-on letter that was sent to HHS Sec. Becerra in early March. PNHP members also worked to pass a resolution in the Washington State Medical Association expressing support for "universal access to comprehensive, affordable, high-quality health care … including a publicly-funded national health care program." The resolution passed with 93% of the vote. *To get involved in Washington, contact Dr. McLanahan at mcltan@comcast.net.*

In **WISCONSIN**, the Linda and Gene Farley chapter has been active in PNHP's campaign against Medicare Direct Contracting. In early February, the chapter hosted Dr. Ana Malinow to speak about DCEs with many allied organizations at the Wisconsin Health Matters coalition meeting. After the forum, several groups signed onto PNHP's organizational letter to HHS Sec. Becerra. Chapter leaders also met with their Congressional representatives to educate them on Direct Contracting and Medicare privatization. *To get involved in Wisconsin, contact wisconsin.pnhp@gmail.com.*

Sign and share our anti-privatization petition at pnhp.org/REACHPetition