HEALTHCARE REPORT

Produced by the West Sound for Social Justice
Healthcare Action Team

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This report provides a broad overview of healthcare here in the United State and cites recent data and analysis; all references are footnoted. It was produced for the members of West Sound for Social Justice (WSSJ) by its Healthcare Action Team. The team's approach to this effort was to educate themselves first by asking critical questions and by finding answers those questions, collaborating on their findings, reviewing their progress with WSSJ's Executive Committee, and sharing their work by posting it on WSSJ.org website.

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Introduction.
The nation's health care tab for 2016 was expected to surpass $10,000 per person for the first time, the government said Wednesday. The report from number crunchers at the Department of Health and Human Services projects that health care spending will grow at a faster rate than the national economy over the coming decade. That squeezes the ability of federal and state governments, not to mention employers and average citizens, to pay.

Growth is projected to average 5.8 percent from 2015 to 2025, below the pace before the 2007-2009 economic recession but faster than in recent years that saw health care spending moving in step with modest economic growth. National health expenditures will hit $3.35 trillion this year, which works out to $10,345 for every man, woman and child. The annual increase of 4.8 percent for 2016 is lower than the forecast for the rest of the decade.
A stronger economy, faster growth in medical prices and an aging population are driving the trend. Medicare and Medicaid are expected to grow more rapidly than private insurance as the baby-boom generation ages. By 2025, government at all levels will account for nearly half of health care spending, 47 percent.[1]

Analysis of data from the Organization for Economic Cooperation and Development and other cross-national analyses to compare health care spending, supply, utilization, prices, and health outcomes across 13 high-income countries: Australia, Canada, Denmark, France, Germany, Japan, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. These data predate the major insurance provisions of the Affordable Care Act. In 2013, the U.S. spent far more on health care than these other countries. Higher spending appeared to be largely driven by greater use of medical technology and higher health care prices, rather than more frequent doctor visits or hospital admissions. In contrast, U.S. spending on social services made up a relatively small share of the economy relative to other countries. Despite spending more on health care, Americans had poor health outcomes, including shorter life expectancy and greater prevalence of chronic conditions. [2]

What is healthcare? Wikipedia defines health care as "the maintenance or improvement of health via the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings. Healthcare is delivered by health professionals (providers or practitioners) in allied health professions, chiropractic, physicians, physician associates, dentistry, midwifery, nursing, medicine, optometry, pharmacy, psychology, and other health professions. It includes the work done in providing primary care, secondary care, and tertiary care, as well as in public health."[3]

Healthcare in the United States is provided by many distinct organizations. Health care facilities are largely owned and operated by private sector businesses. 58% of US community hospitals are non-profit, 21% are government owned, and 21% are for-profit.[4] People aged under 67 acquire insurance via their or a family member's employer, by purchasing health insurance on their own, or are uninsured. Health insurance for public sector employees is primarily provided by the government.

[1] http://www.pbs.org/newshour/rundown/new-peak-us-health-care-spending-10345-per-person/
[2] http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective
[3] https://en.wikipedia.org/wiki/Health_care
[4] http://www.aha.org/research/rc/stat-studies/fast-facts.shtml

What is Healthcare Insurance? In the United States, health insurance is any program that helps pay for medical expenses, whether through privately purchased insurance, social insurance or a social welfare program funded by the government.[5] Synonyms for this usage include "health coverage," "health care coverage" and "health benefits."

In a more technical sense, the term is used to describe any form of insurance that provides protection against the costs of medical services. This usage includes private insurance and social insurance programs such as Medicare, which pools resources and spreads the financial risk associated with major medical expenses across the entire population to protect everyone, as well as social welfare programs such as Medicaid and the State Children's Health Insurance Program, which provide assistance to people who cannot afford health coverage.

What is the history of Healthcare Insurance in the U.S.? Private health insurance in the United States began as efforts by hospital and physician providers to deal with the revenue consequences of the Great Depression. The forerunners of managed care plans emerged at the same time as conventional insurance but were subject to serious challenge by physicians, who were concerned about the potential loss of income from the inability to price-discriminate among patients with different demands for care. The growth of health insurance over the middle of the 20th century was spurred primarily by the tax-exempt status of employer-sponsored health insurance. Wage and price controls during World War II, the rise of labor unions, and the declaration of health insurance as a proper focus of collective bargaining were other key factors. Commercial insurers were successful in the insurance market because they introduced experience rating, which allowed them to offer lower priced coverage to groups with lower expected claims experience. The rest of the industry followed suit. The enactment of Medicare in 1965 expanded insurance coverage to older Americans. The current Medicare program reflects the nature of private health insurance in the 1960s. The allowable cost reimbursement system, largely borrowed from the provider designed Blue Cross and Blue Shield plans, entrenched cost-based reimbursement for twenty years. The passage of the Employee Retirement Income Security Act (ERISA) in 1974 led to the growth of self-insured employer health plans and all but ensured competition in the risk-bearing segment of the conventional insurance market. The growth of managed care in the 1980s and 1990s was the result of the introduction of selective contracting as a response to growing healthcare costs. Selective contracting introduced price competition into healthcare markets. Medicaid and Medicare were both dramatically expanded in the 1980s through the 2000s. Medicaid and Children's Health Insurance Plans provided greater eligibility for children under age 19. Medicare was expanded to include prescription drug coverage. The 1990s and 2000s saw consolidation among healthcare providers and a backlash against the utilization management of managed care plans. Both actions undercut the ability of managed care plans to selectively contract. Consumer-driven health plans offering a high-deductible insurance plan and a tax-sheltered health spending account emerged in the mid-2000s and grew to enroll about one-seventh of the insured workforce. The Patient Protection and Affordable Care Act (ACA) of 2010 introduced the requirement that individuals purchase health insurance and expanded the Medicaid program to coverage low-income adults.[6]

What is The Patient Protection and Affordable Care Act? Often shortened to the Affordable Care Act (ACA) and nicknamed Obamacare, is a United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010. Under the act, hospitals and primary physicians would transform their practices

[5] https://www.census.gov/topics/health/health-insurance/about/glossary.html
[6] https://www.ache.org/pubs/Morrisey2253_Chapter_1.pdf

financially, technologically, and clinically to drive better health outcomes, lower costs, and improve their methods of distribution and accessibility.[7]

The Affordable Care Act was designed to increase health insurance quality and affordability, lower the uninsured rate by expanding insurance coverage, and reduce the costs of healthcare. It introduced mechanisms including mandates, subsidies, and insurance exchanges. The law requires insurers to accept all applicants, cover a specific list of conditions, and charge the same rates regardless of pre-existing conditions or sex.[8]

The ACA has caused a significant reduction in the number of people without health insurance, with estimates ranging from 20-24 million additional people covered during 2016.[9] Increases in overall healthcare spending have slowed since the law was implemented, including premiums for employer-based insurance plans.[10] The Congressional Budget Office reported in several studies that the ACA would reduce the budget deficit, and that repealing it would increase the deficit.[11]

The ACA is expected to cover an additional 26 million people by 2024. ACA doesn't eliminate uninsurance in America; instead, it cuts the number of people lacking coverage about in half. Even after Obamacare is fully implemented, budget forecasters still expect that 31 million Americans will lack insurance coverage — a bigger group than the people buying coverage on the exchanges. Our uninsured rate will still be in the double digits, hovering around 11 percent.[12]

What are recent healthcare spending trends (highlights)?

Health Spending by Major Sources of Funds:
• Medicare (20 percent share): Medicare spending grew 4.5 percent to $646.2 billion in 2015, which was a slight deceleration from the 4.8 growth percent in 2014. The slightly slower growth in 2015 was largely attributable to slower growth in Medicare enrollment, which increased 2.7 percent to 54.3 million beneficiaries following 3.1 percent growth in 2014.
• Medicaid (17 percent share): Total Medicaid spending slowed slightly in 2015 to 9.7 percent, but continued the strong growth that began in 2014 (11.6 percent) State and local Medicaid expenditures grew 4.9 percent while Federal Medicaid expenditures increased 12.6 percent in 2015. The increased spending by the federal government was largely driven by newly eligible enrollees under the ACA, which were fully financed by the federal government.
• Private Health Insurance (33 percent share): Total private health insurance expenditures increased 7.2 percent to $1.1 trillion in 2015, faster than the 5.8 percent growth in 2014. The acceleration in 2015 was driven by increased enrollment and strong growth in benefit spending.
• Out-of-Pocket (11 percent share): Out-of-pocket spending grew 2.6 percent in 2015 to $338.1 billion, slightly faster than the growth of 1.4 percent in 2014. The increase in 2015 was influenced by the expansion of insurance coverage and the corresponding drop in the number of individuals without health insurance.

[7] https://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act
[8] http://theweek.com/articles/474219/obamacare-survives-supreme-court-5-takeaways
[9] https://www.cbo.gov/publication/51385
[10] http://files.kff.org/attachment/summary-of-findings-2015-employer-health-benefits-survey
[11] https://www.cbo.gov/publication/49973
[12] http://www.pnhp.org/news/2014/september/8-facts-that-explain-what%E2%80%99s-wrong-with-american-health-care

Health Spending by Type of Sponsor:

• In 2015, the federal government accounted for the largest share of health care spending (29 percent), followed by households (28 percent), private businesses (20 percent), and state and local governments (17 percent).

• Federal government spending on health increased 8.9 percent in 2015 after growing 11.0 percent in 2014, and outpaced all other sponsors of health care in both years. In 2015, the federal government was the largest sponsor of health care at 29 percent, up from 28 percent in 2014 and 26 percent in 2013. The main driver for the increased federal share of health care was the continued enrollment of newly eligible adults into Medicaid, who were fully financed by the federal government (via ACA).

• Health spending by households grew at a rate of 4.7 percent, which was an acceleration from 2.6 percent in 2014. Household spending accounted for 28 percent of health care spending in 2015, unchanged from the year before. The faster growth in spending by households was driven largely by households' contributions to employer-sponsored private insurance premiums.

• State and local government spending increased 4.6 percent in 2015 compared to 3.2 percent growth in 2014. The acceleration was largely driven by faster growth in state and local Medicaid spending which resulted from increased reimbursement rates and an increased effort to expand care in the home and community setting. Overall, state and local government health care spending represented 17 percent of total health care spending in both 2014 and 2015.

• Health care spending financed by private businesses accelerated slightly, increasing 5.3 percent in 2015 compared to 4.7 percent growth in 2014. The private business share of overall health spending has remained fairly steady since 2010, at about 20 percent. [13]

What are some the principle issues associated with ACA?

Why have costs risen so dramatically? According to the World Health Organization (WHO), the United States spent more on health care per capita ($8,608), and more on health care as percentage of its GDP (17%), than any other nation in 2011. 64% of health spending was paid for by the government in 2013, funded via programs such as Medicare, Medicaid, the Children's Health Insurance Program, and the Veterans Health Administration.[14],[15] High costs with mediocre population health outcomes at the national level are compounded by marked disparities across communities, socioeconomic groups, and race and ethnicity groups.[16] National health expenditures are projected to grow 4.7% per person per year from 2016-2025. Public healthcare spending was 29% of federal mandated spending in 1990, 35% in 2000, and is projected to be roughly half in 2025.[17] One of the biggest reasons that healthcare costs have risen is that insurance companies have small profit margins. Health insurance companies are an incredibly easy target for any antipathy towards the American health care system. They're the ones that deny claims for the care that we want, but still charge an always rising premium for their coverage. But here's one fact about insurers that often gets lost in the debate over health care: "their profit margins tend to be relatively small". Yahoo Business estimates that the

[13] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf

[14] http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2015.302997

[15] https://www.usnews.com/news/blogs/data-mine/2016/01/22/could-universal-health-care-save-us-taxpayers-money

[16] http://www.annualreviews.org/doi/10.1146/annurev.so.21.080195.002025

[17] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

health-care sector as a whole runs a 15.4 percent profit margin. Health plans, meanwhile, have an average profit margin of 3.2 percent.[18]

What about "Big Pharma"? The Big Pharma sector is being represented by the following fifteen companies as follows:

- Johnson & Johnson: $276 billion (market value)
- Novartis: $273 billion
- Roche: $248 billion
- Pfizer: $212 billion
- Merck: $164 billion
- Sanofi: $134 billion
- Bayer: $123 billion
- Novo-Nordisk: $118 billion
- Bristol-Myers Squibb: $115 billion
- AbbVie: $110 billion
- GlaxoSmithKline: $103 billion
- Eli Lilly: $98 billion
- AstraZeneca: $84 billion
- Teva Pharmaceutical: $59 billion
- Shire: $49 billion

Big Pharma pipelines are enormous, and developing new therapies isn't cheap; luckily for these drug developers new therapies also possess quite a bit of pricing power, which comes in handy when their creators need to recoup their development costs.

According to a 2013 *Forbes* comparison of profit margins in the five primary industrial sectors, pharmaceuticals tied with banks for the highest average profit margin at 19%. This was well ahead of the average profit margin for media stocks, oil & gas companies, and automakers, which produced mid-single-digit profit margins (automakers) to low double-digit profit margins (media). [19]

What are some the key factors that drive increasingly higher prescription drug prices? The "most important factor" that drives prescription drug prices higher in the United States than anywhere else in the world is the existence of government-protected "monopoly" rights for drug manufacturers, researchers at Harvard Medical School report today.

Drug manufacturers in the U.S. set their own prices, and that's not the norm elsewhere in the world. Countries with national health programs have government entities that either negotiate drug prices or decide not to cover drugs whose prices they deem excessive. No similar negotiating happens in the U.S.

We allow "government-protected monopolies" for certain drugs, preventing generics from coming to market to reduce prices. In an effort to promote innovation, the U.S. has a patent system that allows drug manufacturers to remain the sole manufacturer of drugs they've patented for 20 years or more. The FDA also gives drug manufacturers exclusivity for certain products, including those that treat people with rare diseases.

[18] http://www.pnhp.org/news/2014/september/8-facts-that-explain-what%E2%80%99s-wrong-with-american-health-care

[19] https://www.fool.com/investing/value/2015/07/19/7-facts-you-probably-dont-know-about-big-pharma.aspx

The FDA takes a long time to approve generic drugs. Application backlogs at the FDA have led to delays of three or four years before generic manufacturers can win approval to make drugs not protected by patents, the study says.

Sometimes, state laws and other "well-intentioned" federal policies limit generics' abilities to keep costs down. Pharmacists in 26 states are required by law to get patient consent before switching to a generic drug, the authors wrote. This reportedly cost Medicaid $19.8 million dollars in 2006 for just one drug: a statin called simvastatin whose brand name is Zocor. Costs ran higher because pharmacists didn't get patient consent and Medicaid had to pay for the costlier brand name drug even though a cheaper product was available.

Drug prices aren't really justified by R&D. Although drug manufacturers often cite research and development costs when defending high prescription prices, the connection isn't exactly true, Kesselheim and his team found, citing several studies. Most of the time, scientific research that leads to new drugs is funded by the National Institutes of Health via federal grants. If not, it's often funded by venture capital. For example, "sofosbuvir"", a drug that treats hepatitis C, was acquired by Gilead after the original research occurred in academic labs.

"Arguments in defense of maintaining high drug prices to protect the strength of the drug industry misstate its vulnerability," the authors wrote, adding that companies only spend 10% to 20% of their revenue on research and development. "The biotechnology and pharmaceutical sectors have for years been among the very best-performing sectors in the U.S. economy." Instead, the price tags are based on what the market will bear, they wrote

In general, fixing America's drug price problems won't be easy, the study authors concluded. Congressional gridlock and the power of the pharmaceutical lobby would stand in the way of having Medicare negotiate Part D. And leaving that aside, policymakers must find a way to tighten rules and strengthen oversight surrounding patent protections and exclusivity without chilling innovation, Kesselheim said.[20]

Is our current approach efficient and what are some of the impacts associated with rising costs? Demand for health care is growing. The Census Bureau projects that the share of America's population accounted for by people aged 65 or over will expand rapidly, from 13 percent in 2010 to more than 20 percent by 2025. Meanwhile, the Affordable Care Act will bring millions into the health care system. This expansion is putting pressure on government budgets and creating workforce challenges. The Congressional Budget Office estimates that federal outlays for major health programs will account for one-third of the growth in total federal outlays during the next decade—the largest of any major category. To accommodate this growth, the Labor Department projects that demand for health care workers will grow at more than double the rate of the rest of the economy.

Yet, the U.S. health care system is profoundly inefficient. At 16.9 percent of GDP, the United States has the highest total health care expenditures in the developed world—compared with 9.3 percent for the Organization of Economic Co-operation and Development (OECD) as a whole, and 11.8 percent for Netherlands, the second highest spending country. Despite this, health outcomes are often among the worst—the United States ranked 26th out of 40 nations in life expectancy at birth, 32nd out of 37th in adult diabetes, and 22nd out of 33 for ischemic heart disease mortality, 35th out of 40th in childhood obesity and last in adult obesity rates (twice the OECD average).

[20] http://time.com/money/4462919/prescription-drug-prices-too-high/

These poor health outcomes drive up costs. One academic study estimates that obesity-related illness accounts for 21 percent of total health care spending, or about 150 percent more per person than for individuals who are not obese. The health care sector also imposes extremely high overhead costs on consumers. A study by consulting firm PwC found that half of all health care spending is "wasteful"—which includes behavioral, clinical, and operational factors for driving up costs.

One way to see these problems is to note the high percentage of administrative workers employed by doctor's offices relative to other industries. Our analysis of Census Bureau data shows that just 42 percent of employees at the average physician's office are health care practitioners while 31 percent are devoted to administrative and office functions, like insurance billing and health records management. By comparison, at the average law firm, 69 percent of employees work in legal occupations and just 22 percent perform administrative tasks. Across all industries, just 13 percent of workers perform administrative functions, and in less regulated advanced service industries—like engineering or computer services—the administrative share of staff is even less.[21]

Health insurance companies, both for-profit and nominally not-for-profit, necessarily always seek to maximize income rather than expand necessary medical services or expand compassion and caring. Their basic functions are business functions consisting of collecting fees (premiums), paying bills, and marketing, which, along with profits, generally consume 20 percent to 25 percent of premiums. Thus the money spent on patient care, the "medical loss ratio" (their term), is generally 80 percent or more of premiums. The ACA legally caps this waste and inefficiency at 20 percent. AHIP (America's Health Insurance Plans) negotiated with the government to allow the plans to count "medical management" as "health care," not administration, for the purposes of calculating the so-called medical loss ratio, MLR. This means health insurance companies can spend unlimited amounts of money on the bureaucracy of managed care, formulary benefits management, "Accountable Care Organizations," pay-for-performance, and other schemes to restrict or deny care or shift insurance risk onto the providers of care, and they can count it all as "health care" for purposes of calculating the MLR.[22]

The most egregious impact of healthcare waste and inefficiencies is financial burden it places on lower wage earning families. As recently as 1981, only 8 percent of families filing for bankruptcy cited medical reasons. By 2010, when the Affordable Care Act was passed, medical bankruptcy was all-to-common. A 2009 study by Himmelstein et al, published in The American Journal of Medicine, revealed that 62.1% of all bankruptcies had a medical cause.[23] The *New York Times* and the Kaiser Family Foundation recently did a survey and found: roughly 20 percent of people under 65 with health insurance nonetheless reported having problems paying their medical bills over the last year. By comparison 53 percent of people without health insurance said the same. The financial vulnerabilities reflect the high cost of health care in the United States, the most expensive place in the world to get sick.[24]

[21] https://www.brookings.edu/research/a-cure-for-health-care-inefficiency-the-value-and-geography-of-venture-capital-in-the-digital-health-sector/

[22] http://www.pnhp.org/news/2014/december/exploring-the-shortcomings-and-fault-lines-of-the-affordable-care-act

[23] http://amjmed.org/under-aca-medical-bankruptcy-continues/

[24] https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html

Why is the quality of healthcare lower than many other advanced industrial nations? The United States life expectancy of 78.4 years at birth, up from 75.2 years in 1990, ranks it 50th among 221 nations[25], and 27th out of the 34 industrialized OECD countries, down from 20th in 1990.[26] Of 17 high-income countries studied by the National Institutes of Health in 2013, the United States had the highest or near-highest prevalence of obesity, car accidents, infant mortality, heart and lung disease, sexually transmitted infections, adolescent pregnancies, injuries, and homicides. On average, a U.S. male can be expected to live almost four fewer years than those in the top-ranked country, though notably Americans aged 75 live longer than those who reach that age in other developed nations. A 2014 survey of the healthcare systems of 11 developed countries found the US healthcare system to be the most expensive and worst-performing in terms of health access, efficiency, and equity.[27]

Why isn't coverage always what it seems? Health insurance providers offer a confusingly different array of plans for employer provided versus self-employed plans. Yet even as many beneficiaries acknowledge that they might not have insurance today without the law, there remains a strong undercurrent of discontent. Though their insurance cards look the same as everyone else's — with names like Liberty and Freedom from insurers like Anthem or United Health — the plans are often very different from those provided to most Americans by their employers. Many of the self- employed say they feel as if they have become second-class patients. Compared with the insurance that companies offer their employees, plans provide less coverage away from patients' home states, require higher patient outlays for medicines and include a more limited number of doctors and hospitals, referred to as a narrow network policy. And while employers tend to offer their workers at least one plan that allows them coverage to visit doctors not in their network, patients buying insurance through ACA exchanges in some states do not have that option, even if they're willing to pay higher premiums. [28]

Why are Healthcare Choices are narrowing? More than half of the insurance products offered on public exchanges under the Affordable Care Act are health maintenance organizations (HMOs) or plans that limit healthcare providers "within a predetermined network," a study by Blue Cross and Blue Shield plans shows. The Blue Cross and Blue Shield Association said HMOs and what it called "exclusive provider organization products" increased to 52% of the health plan offerings on public exchanges for this year compared to 41% in 2015. This is because HMOs generally limit choices to the doctors and hospitals in their networks and exclusive provider organizations work in a similar way to keep costs low, consumers are picking these plans to save money.[29]

What has happened to prescription drugs prices under ACA? The ACA has extended health care coverage to millions of people. But affordability problems remain, most prominently in the area of prescription drugs. Obamacare left the pharmaceutical industry largely unregulated while requiring it to pay for some of the law's increased drug coverage. The Obama administration decided to make a deal with big Pharma to get them to support the legislation,"

[25] https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html
[26] https://www.ncbi.nlm.nih.gov/pubmed/23842577
[27] https://www.nap.edu/read/13497/chapter/1
[28] https://www.nytimes.com/2016/05/15/sunday-review/sorry-we-dont-take-obamacare.html
[29] https://www.forbes.com/sites/brucejapsen/2016/01/13/half-of-obamacare-choices-are-hmos-or-narrow-network-plans/#20cfcc077561

he told Morning Consult. Phrama got a number of favorable provisions in the legislation.[30] As a result, Prescription drug costs for Americans under 65 years old are projected to jump 11.6 percent in 2017, or at a quicker pace than the 11.3 percent price increase in 2016, according to consulting firm Segal Consulting. Older Americans won't get much of a break: Their drug costs are projected to rise 9.9 percent next year, compared with 10.9 percent in 2016. By comparison, wages are expected to rise just 2.5 percent in 2017. Drug prices continue to rise faster than either wages or the cost of living, putting a crimp in many household budgets. It's not surprising that four out of five Americans say that drug prices are unreasonable, according to a September poll from the non-partisan Henry J. Kaiser Family Foundation. The unabated price hikes may be even more discouraging to Americans because congressional investigations into drug pricing have done little to alter the pricing trend.[31] The Branded Prescription Drug Fee is one of several new excise taxes included in the Affordable Care Act to help cover fund the federal government's expanded role in the health care system. In fact, it is one of the most significant revenue provisions in the bill, designed to bring in $27 billion of new revenue over ten years. As its name implies, the Branded Prescription Drug Fee is targeted at pharmaceutical companies that sell branded prescription drugs. Unlike most taxes, the Branded Prescription Drug Fee is calculated, not as a percentage of pharmaceutical company's total sales, but in proportion to its share of the branded prescription drugs market. For every year, beginning in 2011, the Affordable Care Act specifies a certain lump sum that the IRS must collect from the branded prescription drug industry. Then, each pharmaceutical company pays a portion of this sum that roughly corresponds to their market share of branded prescription drugs.[32]

What are the key talking points republicans use to denigrate ACA and what is the truth?
1. The individual health insurance market is collapsing. Republicans are right that the individual market that the Affordable Care Act sought to overhaul is having challenges right now. Many insurance companies left the market at the end of 2016 after losing money, which reduced choices for individuals, and five states have only a single insurer providing coverage in 2017. But even with these challenges, the health law's marketplaces, also called exchanges, are providing coverage to more than 10 million Americans. Some analysts say they are far from collapse. Insurance markets also vary a lot by state, said John Ayanian, head of the University of Michigan's Institute for Healthcare Policy and Innovation. "There are a fair number of states where the exchanges are working fairly well, costs are not rising too quickly, and people have a number of choices of health plans," he said. "There are other states where they have just one choice and prices are going up." At the same time, legislation written by Republicans has led to some of the trouble in exchanges. Most directly, Congress limited federal payouts to insurers who encountered higher-than-expected costs in the exchanges. Republicans called the payments "insurance company bailouts," even though similar federal measures have been used in other markets, such as the Medicare drug plans implemented more than a decade ago. Still, the result was that the Department of Health and Human Services was able to provide insurers with only 13 percent of the money they were promised under the law in 2015. That shortfall led directly to the implosion of most of the nonprofit co-op health plans, and some private insurers referenced the shortfalls when they pulled out of the marketplaces this year. Yet when House Energy and Commerce Committee Chairman Greg Walden, R-Ore., noted at

[30] https://morningconsult.com/2016/03/24/why-prescription-drugs-arent-part-of-obamacare/
[31] http://www.cbsnews.com/news/drug-prices-to-rise-12-percent-in-2017/
[32] https://taxfoundation.org/five-years-later-aca-s-branded-prescription-drug-fee-may-have-contributed-rising-drug-prices/

a Feb. 2 hearing that "only five out of the original 23 insurance co-ops remain. … They tried it, it didn't work," he did not mention the loss of the federal payments to cover early losses.

2. Out-of-pocket spending is too high. Out-of-pocket spending is one of voters' top concerns when it comes to health care. The January 2017 monthly tracking poll from the Kaiser Family Foundation found 67 percent of those polled said their top health priority is "lowering the amount individuals pay for health care," followed closely by "lowering the cost of prescription drugs" at 61 percent. (Kaiser Health News is an editorially independent project of the foundation.)
High deductibles — often in the thousands of dollars — have become part of that problem. People who are most angry about the Affordable Care Act, said Chris Jennings, a health official in the Clinton and Obama administrations, "want deductibles lower and more benefits."
But Republicans' most popular proposals for replacing current individual insurance plans — cutting back on required benefits and giving more people access to tax-preferred health savings accounts — would likely increase out-of-pocket spending for those who use health services (although it would be less expensive for people who are healthy all year long).
Letting people buy more bare-bones policies "means insurance doesn't kick in until people have very significant medical bills," said Ayanian.

3. Medicaid patients can't find doctors to treat them. Studies do suggest that low pay (each state sets its own rates) does decrease physician participation in Medicaid, and finding specialty care can be difficult in some parts of the country. But overall the academic literature shows that Medicaid patients have a far easier time, and are far more likely to obtain health care services than people with no insurance. Benjamin Sommers of the Harvard School of Public Health, who has studied the issue, said the idea that patients with Medicaid can't get care comes from looking overall at how many doctors and other providers accept the program's generally lower payments and higher administrative burdens. "But that's not the best way to study this. The best question … is when you talk to the people with coverage and ask them if they can get the care they need." And he said "study after study" shows that "when people get Medicaid, their access to care improves dramatically," including greater use of primary care, preventive screening, and care of chronic conditions. "Even with some potential limitations of provider participation, patients are much better off once they get that [Medicaid] coverage," he said.

4. The ACA has reduced jobs. Much of this talking point stems from a report by the Congressional Budget Office in 2014 that projected the nation's workforce would drop by about 2 million jobs due to the health law, as well as anecdotal reports about employers cutting workers hours to avoid triggering the law's requirement that they offer health insurance.
But a careful reading of the CBO report notes that the decline they estimate would be due less to employers cutting back, and more to older workers voluntarily opting to work fewer hours — perhaps because of fears of losing their premium subsidies or their Medicaid eligibility — or retiring because they no longer had to work in order to get health insurance.
It is true that some employers cut worker hours below the 30-hour threshold to avoid the employer coverage requirement.
However, the strengthening economy, including in the health care sector, has shrunk the part-time workforce and expanded full-time employment well beyond the numbers reduced by the Affordable Care Act, according to most analysts. In fact, so many jobs have been created in the industry since the ACA became law that it is becoming a problem itself, because having such a vast chunk of the economy devoted to health care makes it harder to reduce health spending.[33]

[33] http://khn.org/news/a-deep-dive-into-4-gop-talking-points-on-health-care/

What is the 2017 American Heath Care Act (AHCA)?

The House voted on 4 May, 2017 and narrowly passed AHCA legislation that would roll back the Affordable Care Act's expansion of *Medicaid*, eliminate tax penalties for people who do not have *health insurance* and end taxes on certain high-income people, insurers, drug companies and manufacturers of medical devices to finance the current health law. The Senate is now meeting to craft their version of healthcare.

Here is a summary of major provisions of the House bill, the AHCA.

- To help people buy insurance, if they do not have coverage at work or under a government program like Medicare or Medicaid, or through the Department of Veterans Affairs, the **bill would offer $2,000 to $4,000 a year in tax credits**, depending mainly on age. A family could receive up to $14,000 a year in credits. The credits would be reduced for individuals making over $75,000 a year and families making over $150,000

- Under current rules, insurers cannot charge older adults more than three times what they charge young adults for the same coverage. **The House bill would allow them to charge five times as much.** The Congressional Budget Office said this change would reduce premiums for young adults and increase premiums for older Americans.

- The bill would **end Medicaid as an open-ended entitlement to health care** and would put the program on a budget. States would receive an allotment of federal money for each beneficiary, or, as an alternative, they could take the money in a lump sum as a block grant, with fewer federal requirements. **Medicaid cuts would total $880 billion over 10 years.**

- The bill encourages people to maintain "continuous coverage" by **requiring insurers to impose a 30 percent surcharge on premiums** for those who experience a gap in coverage.

- Under the bill, **states could opt out of certain provisions of the Affordable Care Act, including one that requires insurers to provide a minimum set of health benefits**, such as maternity care and emergency services, and another that prohibits them from charging higher premiums based on a person's health status. Insurers would not be allowed to charge higher premiums to sick people unless a state had an alternative mechanism, like a high-risk pool or a reinsurance program, to help provide coverage for people with serious illnesses.

- The bill would **provide states with $138 billion over 10 years that could be used for various purposes like subsidizing premiums**, providing coverage to people with pre-existing conditions and paying for mental health care and the treatment of drug addiction.

Is AHCA is a tax cut for the wealthy? The GOP's Obamacare replacement bill has an identity crisis. It repeals the individual mandate and replaces it with a worse mandate. It preserves the Medicaid expansion just long enough to anger Republicans, but not enough to please Democrats. It replaces Obamacare's subsidies with tax credits that liberals consider impoverishing and conservatives consider unacceptable. In the old days, legislatures used pork to try to please everybody. This bill seems exquisitely designed to please nobody—except for

rich people who want a tax break. Perhaps that's why one of the few groups to praise the bill was Americans for Tax Reform.

Look beyond the bill's quasi-mandate and tax credits, and the Obamacare replacement bill is a $600 billion tax cut, with the benefits going almost entirely to the wealthy. To pay for its spending, Obamacare included several taxes on couples making more than $250,000, like a 3.8 percent surtax on investment income and a 0.9 percent surtax on wages. Last year, those levies brought in about $27 billion, according to Wall Street Journal analysis of IRS data. Repealing them would cost about $275 billion over the next decade; which is to say, it would transfer $275 billion from public-health spending to the richest 1 or 2 percent. Other provisions, like repealing the limit of flexible spending accounts and expanding health savings accounts, will also disproportionately benefit the rich.[34]

In early May of 2017, the House passed legislation entitled American Health Care Act (AHCA). According to the independent Congressional Business Office "score" release 24 May 2017 [35] AHCA will eliminate the healthcare of 23 million Americans; it eliminates funding for Planned Parenthood, it raises premiums for older Americans by as much as 850%; it cuts Medicaid by $880 billion, and it provides the wealthiest Americans nearly a trillion dollar tax cut over the next decade. [36]

What is a universal single payer healthcare system? Single-payer national health insurance, also known as "Medicare for all," is a system in which a single public or quasi-public agency organizes health care financing, but the delivery of care remains largely in private hands. Under a single-payer system, all residents of the U.S. would be covered for all medically necessary services, including doctor, hospital, preventive, long-term care, mental health, reproductive health care, dental, vision, prescription drug and medical supply costs.
The program would be funded by the savings obtained from replacing today's inefficient, profit-oriented, multiple insurance payers with a single streamlined, nonprofit, public payer, and by modest new taxes based on ability to pay. Premiums would disappear; 95 percent of all households would save money. Patients would no longer face financial barriers to care such as co-pays and deductibles, and would regain free choice of doctor and hospital. Doctors would regain autonomy over patient care.
The Expanded and Improved Medicare for All Act, H.R. 676, based on PNHP's AJPH-published Physicians' Proposal, would establish an American single-payer health insurance system.[37]
Funding for H.R. 676 is providing in the Bill as follows:
EC. 211. **OVERVIEW: FUNDING THE MEDICARE FOR ALL PROGRAM.**

(a) IN GENERAL.—The Medicare For All Program is to be funded as provided in subsection (c)(1).

(b) MEDICARE FOR ALL TRUST FUND.—There shall be established a Medicare For All Trust Fund in which funds provided under this section are deposited and from which expenditures under this Act are made.

(c) FUNDING.—

(1) IN GENERAL.—There are appropriated to the Medicare For All Trust Fund amounts sufficient to carry out this Act from the following sources:

[34] https://www.theatlantic.com/business/archive/2017/03/acha-tax-cut/518889/
[35] https://www.cbo.gov/publication/52752
[36] https://www.washingtonpost.com/news/the-fix/wp/2017/05/24/the-three-numbers-you-need-to-understand-the-cbo-report-on-republicans-health-care-bill/?utm_term=.d9cef3dd7b78
[37] http://www.pnhp.org/facts/what-is-single-payer

(A) Existing sources of Federal Government revenues for health care.
(B) Increasing personal income taxes on the top 5 percent income earners.
(C) Instituting a modest and progressive excise tax on payroll and self-employment income.
(D) Instituting a modest tax on unearned income.
(E) Instituting a small tax on stock and bond transactions.
(2) SYSTEM SAVINGS AS A SOURCE OF FINANCING.—Funding otherwise required for the Program is reduced as a result of—
(A) vastly reducing paperwork;
(B) requiring a rational bulk procurement of medications under section 205(a); and
(C) improved access to preventive health care.
(3) ADDITIONAL ANNUAL APPROPRIATIONS TO MEDICARE FOR ALL PROGRAM.—Additional sums are authorized to be appropriated annually as needed to maintain maximum quality, efficiency, and access under the Program.[38]

What are the frequently asked questions and myths about Single Payer Healthcare?

- **Do U.S. doctors support this concept?** Yes. A national survey showed that 59 percent of U.S. physicians support national health insurance, an increase of 10 percentage points from five years before. The survey appeared in the April 2008 edition of Annals of Internal Medicine.
- **Is this 'socialized medicine'?** No. In socialized medicine systems, hospitals are owned by the government and doctors are salaried public employees. Although socialized medicine works well for our Veterans Administration, and has worked well for some countries like England, this is not the same as national health insurance. A single-payer national health program, by contrast, is social insurance like our Medicare.
- **Is there any support for this approach in Congress?** Yes. The Expanded and Improved Medicare for All Act, H.R. 676, is currently in Congress. **The bill would establish an American single-payer health insurance system, publicly financed and privately delivered, that builds on the existing Medicare program.** Polls over the past two decades show that about two-thirds of the U.S. population supports this approach. H.R. 676 was introduced by Rep. John Conyers Jr. of Michigan. It had over 90 co-sponsors in 2010. You can make sure your representative supports H.R. 676 by connecting with them through the Capitol switchboard at (202) 224-3121.
- **Won't we be letting politicians run the health system?** No. Right now, many health decisions are made by corporate executives behind closed doors. Their interest is in profit, not providing care. The result is a dysfunctional health system where 32 million have no insurance, tens of millions more are underinsured, and most are at risk of financial disaster should they become seriously ill. In a single-payer system, medical decisions are made by doctors and patients together, without insurance company interference – the way they should be. No one will go without care.
- **Can we afford universal coverage?** We already pay enough for health care for all – we just don't get it. Americans already have the highest health spending in the world, but we get less care (doctor, hospital, etc.) than people in many other industrialized countries. Because we pay for health care through a patchwork of private insurance companies, about one-third (31 percent) of our health spending goes to administration. Replacing private insurers with a national health program would recover money currently squandered on billing, marketing, underwriting and other activities that sustain insurers'

[38] https://www.congress.gov/bill/115th-congress/house-bill/676/text

profits but divert resources from care. Potential savings from eliminating this waste have been estimated at $400 billion per year. Combined with what we're already spending, this is more than enough to provide comprehensive coverage for everyone.

- **What about Obamacare?** The Affordable Care Act expanded coverage to about 20 million Americans by requiring people to buy private insurance policies (partially subsidizing those policies with government payments to private insurers) and by expanding Medicaid. About 28 million people will still be uninsured in 2026, and tens of millions will remain underinsured. Insurers will continue to strip down policies, maintain restrictive networks, limit and deny care, and increase patients' co-pays, deductibles and other out-of-pocket costs. The law preserves our fragmented financing system, making it impossible to control costs. Adding a "public option" to the ACA marketplaces won't reduce costs or improve access. It just adds another payer to our already fragmented system. And most of the "coops" failed due to adverse selection.
- **Lots of people have good coverage, so shouldn't we build on the existing system?** Our existing system is structurally flawed; patching it up is not a real solution. The insurance industry sells defective products. So like a car with faulty brakes, lots of people who think they have good insurance find that their "coverage" fails when they get sick: three-quarters of the 1 million American families experiencing medical bankruptcy annually have coverage when they fall sick. And all insured Americans continually face premium hikes, rising out-of-pocket costs, and cutbacks in covered services as costs rise. Even those who used to have very good coverage are being forced to give up benefits because of costs. Until we fix the system, things are only going to get worse.
- **Won't national health insurance result in rationing and long waiting lines?** No. It will eliminate the rationing going on today. The U.S. already rations care based on ability to pay: if you can afford care, you get it; if you can't, you don't. At least 30,000 Americans die every year because they don't have health insurance. Many more people skip treatments that their insurance company refuses to cover. That's rationing. Excessive waiting times are often cited by opponents of reform as an inevitable consequence of universal, publicly financed health systems. They are not. Wait times are a function of a health system's capacity and its ability to monitor and manage patient flow. With a single-payer system - one that uses effective management techniques and which is not burdened with the huge administrative costs associated with the private insurance industry - everyone could obtain comprehensive, affordable care in a timely way.
- **Won't our aging population bankrupt the system?** European nations and Japan have higher percentages of elderly citizens than the U.S. does, yet their health systems remain stable with much lower health spending. The lesson is that national health insurance is a critical component of long-term cost control. In addition to freeing up resources by eliminating private insurance waste, single-payer encourages prevention through universal access and supporting less costly home-based long-term care rather than institutionalization. It also saves money by bulk purchasing of pharmaceutical drugs and global budgeting for hospital systems.
- **Won't a publicly financed system stifle medical research?** Most breakthrough research is already publicly financed through the National Institutes of Health (NIH). In fact, according to the NIH web site, of the last 30 Americans to win the Nobel Prize in medicine, 28 were funded directly by the NIH. Many of the most important advances in medicine have come from single-payer nations. Often, private firms enter the picture only after the public has paid for the development and clinical trials of new treatments. The HIV drug AZT is one example. On average, drug companies spend more than half of their revenue on marketing, administration and profits, compared with 13 percent on

research and development. Negotiating lower prices will allow Americans to afford drugs without hurting research.[39]

Why is universal health care, which is commonplace around the world, so hard to achieve in the United States?

Why are we unable to overcome a market-based system that leads to a hundred thousand unnecessary deaths each year? Corporate interests in maintaining this system are powerful, as is a culture of competition and consumption that sees health as a personal choice rather than a human right. The odds against universal health care advocates are long: What does it take to turn a market commodity into a public good, and dismantle an entire industry along the way?
For the past few years, as the limitations of the Affordable Care Act were becoming increasingly clear, a mass people's movement in the small state of Vermont paved the way for universal health care, winning the passage of a 2011 law that mandated the state to financed its health system publicly and equitably and guarantee access to care for all. Yet as the governor's recent about-face illustrates, the task at hand remains challenging. It is not a new task, as Dr. Martin Luther King Jr.'s 1967 speech, "America's Chief Moral Dilemma," reminds us: "It didn't cost the nation anything to integrate lunch counters; no expenses were involved; no taxes were involved. [...] Now we are dealing with issues that will cost the nation something in terms of billions of dollars. [...] We are now dealing with issues that will demand a radical redistribution of economic and political power."

Dr. King was envisioning ending poverty and ensuring economic and social rights for all, including people of color who were — and still are — most affected by economic injustice, and he predicted strong resistance from the powers that be. Half a century later, progress toward this vision has been halting at best, and resistance is enduring to this day. The country is currently experiencing the largest concentration of wealth since the 1930s and the biggest income inequality gap since the late 1970s, with inequitable financing of health care directly contributing to this injustice. In the private health insurance system, low-income people pay proportionally more for health care than the wealthy, while receiving lower value insurance plans. One in three people in the U.S. struggle with medical bills, while insurance executives are raking in billion-dollar compensation packets. This inequitable market-based system — with its different and unequal insurance products, different and unequal prices for health services, and different and unequal access to doctors — is both unjust and unsustainable.

Public, tax-based financing of health care would take an important step toward realizing Dr. King's vision by ensuring both universal access to care and equity in the payment for care. Moreover, it could free up resources for other public services, since universal health care is about sharing costs more equitably, not raising new money. To situate this in Dr. King's frame, radical health care reform is about economic redistribution through taxes, not about raising extra billions of dollars.[40]

Conclusion.

Public outrage over the AHCA is strong. The continuing rise of healthcare costs coupled with the potential loss of Medicare and Medicaid funding, means there are very real threats to

[39] http://www.pnhp.org/facts/single-payer-resources

[40] http://www.huffingtonpost.com/anja-rudiger/universal-health-care_b_6973164.html

Other references:

women's healthcare (Planned Parenthood), the elderly, those mental health issues, and those with addictions. The 2018 elections offer the best chance to reverse who controls both the House and Senate paving the way the U.S. to ultimately adopt a universal, single payer healthcare system. The Expanded and Improved Medicare for All Act, H.R. 676, based on Physicians for a National Health Program, American Journal for Public Health-published Physicians' Proposal, would establish an American single-payer health insurance system. Under a single-payer system, most medical care would be paid for by the Government of the United States based on modest tax increases, ending the need for private health insurance and premiums, and likely recasting private insurance companies as providing purely supplemental coverage, to be used when non-essential care is sought. Spending less per capita and achieving better health outcomes can be accomplished by eliminating non value added waste within our current system and by better controlling costs including the skyrocketing costs of prescription drugs. A single payer health system is the best route forward for an equitable healthcare system for all Americans.

What is the critical path forward for making a Universal, Single Payer Healthcare system a reality?

1. **Defeat current GOP repeal and replace legislation**. We'll need to stay tuned in the continuing dialog and we need to immediately rebut Republican misinformation. We have to be respectfully forceful and vocal in holding accountable our Members of Congress. Letters, phone calls, and faxes help us. We should link virtually "Indivisible Groups" and other Resistance Groups in Republican controlled districts on a local, regional and national basis.
2. **Support local, regional, and national Universal, Single Payer Health Care public engagement dialog**. We'll need get the message and fact based information out well as dispel myths and misinformation regarding Single Payer Healthcare.
3. **Support all efforts to flip local, State, and National House and Senate in the 2018 election cycle by endorsing progressive candidates that support Universal, Single Payer Health Care.** Ensure our members understand which candidates are supportive and which are not. We'll need to attend political rallies for candidates. On an individual basis we must be prepare to endorse.
4. **Overturn Citizen United; get dark money out of politics**. We'll need to take aim and call out big monied political interests and lobbyists. We'll have to support a constitutional amendment that overturns Citizens United.
5. **Defeat GOP in the 2020 presidential elections with a Social Democratic candidate (Bernie Sanders).** We'll need to help get the vote out. As individuals, we'll need to support the best candidate that has our interests at heart.

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