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# MEDICARE FOR ALL VS. ALL THE HEALTHCARE THAT EACH CAN AFFORD

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We stand at the crossroads between guaranteeing healthcare to everyone through an improved and expanded Medicare program and leaving increasingly more people at the mercy of the market with legislation such as the American Health Care Act. Now is the time to take on our market-driven system and fight for an improved and expanded Medicare for all.<sup>1</sup>

In contrast to our current system, a Medicare-for-all health plan would provide comprehensive healthcare benefits for all medically appropriate care without regard to income, employment, or health status. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.<sup>2</sup> Payments would be negotiated by representatives of the Medicare-for-all plan and representatives of hospitals, physicians, and other providers. Finally, prescription drugs, medical devices, and other related supplies would be negotiated in bulk for the entire U.S. population at reduced prices. There would be a single standard of excellence in care for all – not bronze for some and platinum for others. People would be free to seek care from any participating healthcare provider. We would receive the care our doctors and nurses determine we need – not what a profit-seeking insurer deems it will cover or deny. Finally, care would be provided without deductibles or copayments thereby easing economic inequality and health disparities.

This paper begins by examining our market-driven healthcare system and the failings of our private insurance system. It includes discussions on why adding a government-run public insurance option to the ACA private insurance marketplaces could not remedy the problems the marketplaces face and on the limitations in care under a market-driven system. Finally, it will examine the major features of a Medicare-for-all system and how our country could provide healthcare as a right, not a privilege.

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## CORPORATE HEALTHCARE AND THE GAMES THAT INSURERS PLAY

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For decades, corporate healthcare has played a major role in defeating attempts to guarantee healthcare for all. The influence of this sector decisively shaped the Affordable Care Act (ACA). In the years leading up to and following the passage of the ACA, 2006 through 2012, the health sector spent \$3.4 billion on lobbying – more than any other sector for four out of seven years and second for the other three.<sup>3</sup> It also contributed a whopping \$709 million in campaign contributions over that same time period.<sup>4</sup> Of this \$709 million, \$332 million went to Republicans, \$304 million went to Democrats (\$23 million to candidate Obama in 2008), and the balance went to outside spending groups. The “investment” in lobbying and campaign contributions paid off. By spending these vast sums, corporate healthcare was able to block measures that would have improved our healthcare system, but interfered with the health industry’s ability to reap enormous profits, and win provisions

that guaranteed increased healthcare industry profits.

Still, in many ways, the ACA was a step forward. Those with pre-existing conditions can no longer be denied coverage and insurers cannot base premiums on health status. The number of uninsured has dropped considerably, with 20.4 million gaining coverage from 2010 to 2016.<sup>5</sup> Unfortunately, the ACA didn’t go far enough. With plans available in the ACA insurance marketplaces requiring cost sharing ranging from 10% to 40%, on top of premiums, cost continues to make it prohibitive for many to access healthcare. Catastrophic plans are even worse. Even though the federal government has been propping up the insurance marketplaces through premium support and cost-sharing subsidies, paid by taxpayers to private insurers, these insurance marketplaces have struggled from the beginning. These struggles have been exacerbated under the current administration.

Some contend that adding a public option to the ACA insurance marketplaces could serve as a corrective to the abuses of the profit-based insurance industry and, perhaps, even be a first step on the road to Medicare for all. The public option plans, as designed by a pair of current congressional bills,<sup>6</sup> would be administered by the federal government, funded by premiums, and have their own provider networks. The public option plans would be offered alongside the private insurance plans in the marketplaces and be subject to the same terms and conditions, including the premium tax credits and cost-sharing reductions as the other metal plans – bronze, silver, gold, and platinum. The idea is that a public option would be able to drive down insurance prices by competing against private health plans as a low-cost option that would not need to spend huge amounts on executive compensation packages, turn a profit, or pay dividends to shareholders.<sup>7</sup> However, the market for health insurance differs dramatically from markets for most goods and services in such a way that increased competition does not necessarily drive down prices. Though the differences are many, consider just two. First, those buying insurance are unable to predict in advance what type of healthcare they may need; even those currently being treated for a health condition may have unanticipated health needs arise. The second and crucial point is that the private insurance business model, which seeks to limit claims paid on policies, conflicts with the very reason most people have for purchasing health insurance, the need for healthcare. Insurers' biggest costs are what they term *medical loss*, or the costs of paying for policyholders' covered healthcare services. Thus, insurers strive to limit how much they pay out in claims for care provided to their enrollees. Health insurers do not focus on maximizing policy sales, but on maximizing sales to individuals who they deem will pay more in premiums than they cost in care. Competition among health insurers amounts to competing to sell policies to healthier individuals (also known as “cherry picking”).

This practice continues under the ACA even with thousands of pages in statutes and related regulations. Studies have documented discriminatory insurance policies on the marketplaces that place key HIV/AIDS, cancer, and multiple sclerosis drugs in the

highest cost-sharing tier in a drug formulary.<sup>8</sup> Selective provider network design offers another means of excluding costly patients. For example, the network may include a limited number of oncologists and other specialists or exclude academic medical centers and cancer treatment centers.<sup>9</sup> Although increased competition generally may lower premiums in some of the ACA insurance marketplaces,<sup>10</sup> the question remains whether a public option would have a sufficient competitive edge over private plans to keep premium rates affordable, particularly when the private insurers game the system.<sup>11</sup> As the public option would not want to replicate the unscrupulous practices of private insurers, it is likely to end up with a great number of costly enrollees that private insurers want to offload, making it nearly impossible for the public option to maintain competitively priced premiums, discrediting the role of the government, and undermining support for public programs such as Medicare and Medicaid.

Moreover, in many areas where the ACA marketplaces are down to a lone insurer, competition is not the problem.<sup>12</sup> Rather, many are losing money as the enrollees are much sicker and costlier.<sup>13</sup> Insurers that remain in these areas have raised their premiums by double digits and, in one case, triple digits.<sup>14</sup> In the four states which dropped down to one insurer in 2017, the increases ranged from 29% to 69%, while cities and counties with a single insurer saw increases ranging from 26% in Anchorage, Alaska to 145% in Phoenix, AZ – which dropped from eight insurers in 2016 to just one in 2017.<sup>15</sup> Recent filings for 2018 indicate further dramatic rate increases.<sup>16</sup> The only solution to bringing down premiums is to broaden the risk pool by inducing those who are younger, healthier, and less costly to enroll. Given the cost and quality of many of the insurance plans in the ACA marketplaces, this would be very challenging even without the sabotage of the current administration. It may prove to be impossible to cover costs while maintaining premiums at a level that enrollees can manage. Without federal premium support, the premiums required to cover the cost of care in these markets would surely outstrip many enrollees' ability to pay and, thus, end in a death spiral. The larger issue here is that even if a public option were the answer to saving the insurance marketplaces, we would still be left with the tiered plan model and 10% to 40% cost sharing or worse, a catastrophic plan.

Finally, not only do private insurers avoid covering the most costly patients, they also attempt to limit care to those they do cover. In a more insidious approach than outright denial, insurers impose clinical practice guidelines and protocols that interfere with physician autonomy by limiting the types of tests and treatments that the insurer will reimburse. Physicians may not be able to order a test because a patient does not meet the criteria in the “guideline” the insurer designates, whether or not the criteria are relevant to a particular patient’s circumstances.<sup>17</sup> In cases where an insurer, hospitals, and physicians work together as a health plan, such as a health maintenance organization (HMO) or an accountable care organization (ACO), care is often limited through the electronic health record (EHR). EHRs go beyond an electronic version of a paper chart that merely records information.<sup>18</sup> Protocols and guidelines, as well as programs to order tests and treatments, can be embedded in the EHR as clinical decision support. Although these software programs may be called clinical decision “support,” and the embedded clinical practice requirements may be called “guidelines,” they often function as hard-and-fast rules that override physicians’ professional judgment as well as limit the full professional practice of nurses and other practitioners that care for patients. As protocols and clinical practice guidelines are about certain percentages of patient populations as a whole, they may not apply to a particular patient. Practitioners must be free to provide care based on their professional judgment about the tests and treatments appropriate for their patient.

All the blame for high premium costs cannot be laid at the feet of insurers, however. Consolidation in hospital and physician practices has also contributed to the increased cost.<sup>19</sup> The rate of increase in hospital consolidation has accelerated in recent years. Since 2009, the number of hospital mergers and acquisitions has doubled and the number of independent community hospitals has dwindled.<sup>20</sup> In 2015, the most recent year for which data is available, only one in three hospitals remained independent.<sup>21</sup> Price gouging in the hospital industry becomes readily apparent by examining charge-to-cost ratios – that is, the relationship between how much a hospital charges compared to its costs. The latest data show

that, on average, hospitals charge 379%, nearly four times, more than an item or service costs. Hospitals that belong to systems have, on average, charge-to-cost ratios that are 53% higher than independent hospitals.<sup>22</sup> Hospitals are quick to say that this is what they charge, but it is not necessarily what they receive in payment. Yet, as insurers typically negotiate rates based on a percentage of what hospitals charge, the more they charge, the higher their profit margin.<sup>23</sup> Unfortunately, the horrifying irony of our current system is that the uninsured pay the highest rates of all.<sup>24</sup>

If there is any doubt that our market-driven healthcare system is failing us, two measures, expenditures and health status, make it clear. Although the United States consistently spends more on healthcare than any other country, it typically has poorer results. The most recent data from the Organisation for Economic Co-operation and Development (OECD),<sup>25</sup> a widely utilized source for making international comparisons, show that the United States spent 16.9% of GDP, nearly twice the average rate of 9% for the 35 member countries.<sup>26</sup> The differences are even greater in the amount we spent per person. At \$9,451, we spent nearly two and half times the \$3,814 average of OECD countries.<sup>27</sup> Yet, despite the amount we spend, the patchwork U.S. “system” leaves 28 million uninsured and millions more underinsured.<sup>28</sup> The result is poorer health and shorter lives. A widely cited study by the Commonwealth Fund comparing the United States to ten other countries ranked the U.S. dead last overall as well as in the categories of healthy lives, cost-related problems to access, equity, and efficiency.<sup>29</sup> A second study, covering 195 countries regarding deaths that were preventable had the patient received “timely and effective medical care,” ranked the U.S. at number 35 on its Health Access and Quality index – in between Estonia and Montenegro.<sup>30</sup> The worst U.S. scores were for lower respiratory infections, ischemic heart disease (coronary heart disease), and chronic kidney disease. Looking strictly at the United States, we find a recent dip in the average life expectancy,<sup>31</sup> a gap of 10 to 15 years in life expectancy between the richest and the poorest among us,<sup>32</sup> and numerous health disparities related to class, race, and sex.



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## MEDICARE FOR ALL: HOW IT WORKS

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Corporate control of healthcare and our misguided faith in the market has resulted in an inefficient, fragmented “system” that leaves millions with little or no access to healthcare. Our current approach treats healthcare as a commodity on a par with other commodities rather than a public good. We have accommodated the failure of the private insurance market by cobbling together the most expensive public-private system the world has ever seen. The shift to a Medicare-for-all plan reorients our system to providing healthcare as a right, not a privilege. It would be a tremendous step toward ending health disparities and would mitigate economic inequality. Finally, recent public opinion polls demonstrate that a strong majority of Americans favor Medicare for all. In December 2015, the Kaiser Health Tracking Poll found:

When asked their opinion, nearly 6 in 10 Americans (58 percent) say they favor the idea of Medicare-for-all, including 34 percent who say they strongly favor it. This is compared to 34 percent who say they oppose it, including 25 percent who strongly oppose it. Opinions vary widely by political party identification, with 8 in 10 Democrats (81 percent) and 6 in 10 independents (60 percent) saying they favor the idea, while 63 percent of Republicans say they oppose it.<sup>33</sup>

A 2017 poll by the Pew Research Center demonstrates that support is growing.

Currently, 60% of Americans say the government should be responsible for ensuring health care coverage for all Americans, compared with 38% who say this should not be the government’s responsibility. The share saying it is the government’s responsibility has increased from 51% last year and now stands at its highest point in nearly a decade.<sup>34</sup>

So what’s stopping us? Supporters of our market-driven model typically sabotage efforts to provide Medicare for all by focusing on how we would pay for it. This is disingenuous. We are already paying

for it; we’re just not receiving it. Approximately two-thirds of U.S. healthcare expenditures already come from taxpayers in the form of federal, state, and local government spending.<sup>35</sup> Healthcare in the U.S. costs more both because of administrative complexity and higher prices, rather than increased utilization. The comparisons of U.S. spending and health outcomes to other countries strongly suggest that there is enough money in our current system to provide healthcare for all, if we spend that money fairly and wisely. The key point is to demonstrate that there is enough money currently being spent on healthcare in the U.S. to provide Medicare for all, rather than specifying particular funding mechanisms.<sup>36</sup>

As mentioned above, we would reap enormous savings by eliminating private insurance company costs such as profits, shareholder dividends, excessive executive compensation, and marketing costs. Additional savings would come from the uniformity in health benefits and in claims and billing processing. Instead of many insurers, each with a variety of health plans and cost-sharing schemes, funding for healthcare would be administered from a single government fund based on a uniform set of benefits.<sup>37</sup> Hospitals, physicians, and other providers would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured. Each of these areas is discussed in more detail below.

**Cost sharing — copayments, coinsurance, and deductibles.** Eliminating patient cost sharing is a first step to achieving health equity and easing the economic inequality that is rife in our country. The very idea of requiring patient cost sharing, also called “out-of-pocket costs,” derives from a market-based approach to healthcare. Those who take this economic approach to providing healthcare argue that people need to “have skin in the game,” meaning that they must have a financial stake in accessing

healthcare, otherwise they will use their health insurance indiscriminately and not just when they truly need it.<sup>38</sup>

Research confirms that even minimal cost-sharing requirements reduce healthcare utilization.<sup>39</sup>

Unfortunately, cost sharing keeps people from seeking both needed and unneeded care.<sup>40</sup> This should not come as a surprise; laypersons cannot be expected to know prior to seeing their healthcare provider whether or not they need medical treatment. As the cost of providing care has increased, costs have been shifted to individuals and families. Imposing higher deductibles, copayments, and coinsurance is a double win for insurers; healthcare utilization drops and they pay less when healthcare is used. Today, millions with health insurance delay seeking healthcare or filling a prescription because of high deductibles, but even copayments can be difficult for many to manage.<sup>41</sup> Those who are sick or low income fare the worst.<sup>42</sup> Thus, eliminating cost sharing reduces both health disparities and economic inequality.<sup>43</sup> Finally, while prompt treatment of injury and illness is reason enough to eliminate cost sharing, in some cases it also reduces the overall cost of treatment.<sup>44</sup>

**Administrative savings.** Administrative savings would come from two primary sources: insurers and providers such as doctors and hospitals.<sup>45</sup> On the insurer side, eliminating private insurance company waste such as profits, shareholder dividends, excessive executive compensation, and marketing costs would produce tremendous savings. Having a single, comprehensive benefits package and a single payer, the federal government, creates uniformity in claims and billing processing. Doctors and hospitals would no longer need large billing departments to manage payments or to pursue collections from the uninsured and the underinsured, nor for preauthorizing tests and treatments or checking drug formularies before prescribing medications. This would produce additional savings that could be redirected to care. Overall, replacing our complex, fragmented health system with its many insurers – each with multiple benefit packages and numerous cost-sharing schemes – would produce savings of 9.3% to 14.7%.<sup>46</sup> Based on projected national health expenditures of more than \$3.5 trillion dollars in 2017, this would amount to \$330 to \$520 billion in administrative savings alone.<sup>47</sup>

**Global budgets.** Hospitals, nursing homes, and similar facilities, as well as home care agencies, would receive a fixed lump-sum annual budget, called a global budget, rather than getting paid separately for each patient’s hospital stay. A global budget, typically

paid out in monthly installments, would reimburse the facilities for all their operating expenses and, under a separate budget, for capital expenses such as new buildings and equipment. The savings would accrue primarily from reduced administrative costs related to billing and insurance. The administrative savings estimated above derive, in part, from global budgeting for hospitals and other healthcare facilities. Multiple studies have documented the savings achieved by using the global budget approach.<sup>48</sup> A recent study of hospital administrative costs in eight countries found that Canada and Scotland, which are paid using global budgets, had the lowest administrative costs at 12.4% and 14.3%, respectively.<sup>49</sup> In contrast, hospitals in the United States, which must manage a far more complex billing system, had the highest administrative costs at 25.3%.

**Capital investment.** A Medicare-for-all program would require approval for investment in expanding medical facilities and major equipment purchases to ensure they are allocated fairly and where needed. The approval process would prioritize capital investment in projects that address medically underserved populations and health disparities related to race, ethnicity, income, or geographic region. This approach contrasts sharply with a market-driven approach which seeks to maximize revenue. For years, hospital corporations have shuttered “underperforming” hospitals in communities with high numbers of uninsured, often reopening them a few miles down the road in areas with better insurance coverage and higher incomes. Most public hospitals, which typically care for the uninsured, on the other hand, have been severely underfunded and stand in need of critical infrastructure and equipment upgrades. Thus, relying on the market has resulted in a maldistribution of healthcare resources from what should be the guiding rationale, providing care to those who need it. Finally, our current system often leaves expensive equipment standing idle. For example, in a profit-seeking healthcare system with hospitals in relatively close proximity to one another, if one hospital purchases an MRI machine, the other area hospitals may feel the need to do so in order to claim the same capabilities as they compete against

each other. In contrast, a Medicare-for-all plan would direct investment in expensive equipment, new hospitals, and medical offices where it is needed, not where corporate healthcare deems most lucrative.

**Bulk purchasing.** The pharmaceutical/health products industry has spent more money lobbying than any other industry every year since 1999. The spending topped out at \$274 million in 2009, with spending at a still sizeable amount of \$246 million in 2016.<sup>50</sup> In addition, the industry has contributed millions to federal campaigns. According to the Center for Responsive Politics: “The pharmaceutical and health products industry ... is consistently near the top when it comes to federal campaign contributions. ... The industry’s political generosity increased in the years leading up to Congress’ passage in 2003 of a Medicare prescription drug benefit.”<sup>51</sup> This appears to have been money well spent. As part of the Medicare Modernization Act of 2003, Congress not only created a Medicare prescription drug benefit, but also prohibited the Health and Human Services Secretary from negotiating prices or creating a formulary of approved prescription drugs.<sup>52</sup> The Center for Responsive Politics also found that “industry spending levels have fluctuated, though they have usually hovered around the \$30 million range... ”<sup>53</sup> That is until 2012, when campaign contributions increased to over \$50 billion and topped out in 2016 at nearly \$60 billion.<sup>54</sup>

A Medicare-for-all plan would negotiate prices on drugs and medical devices for the entire U.S. population.<sup>55</sup> Thus, it would garner far greater bargaining power than our fragmented system of insurers, each competing against each other and seeking to maximize profits. Negotiating with pharmaceutical companies would bring the costs of prescription drugs in this country in line with the rest of the world. A recent study found that this alone would have saved \$113 billion in 2017.<sup>56</sup>

**Primary care.** Research shows that access to primary care, understood as having a usual place of care, continuity over time, care coordination, and a whole-person focus— rather than focusing on a particular disease or body part as specialty care often does – leads to better health.<sup>57</sup> Greater emphasis on primary care lowers overall costs by facilitating earlier intervention in disease processes, staying current with preventive measures, and reducing the

use of emergency departments. Eliminating cost sharing is crucial to meeting these goals.<sup>58</sup>

The U.S. lags behind other countries in both access and health status, and spends far more, partially due to a shortage of primary care physicians.<sup>59</sup> Although estimates differ as to the magnitude of the growing shortfall of primary care physicians, all agree that it is significant. The mid-range projected shortfall in primary care physicians is 7,800 to 32,000 by 2025, increasing to 7,300 to 43,100 by 2030.<sup>60</sup> In addition to this general shortage, many geographic regions and populations are currently suffering due to a severe shortage of primary care physicians. According to the U.S. Health Resources & Services Administration, there are 6,790 health professional shortage areas<sup>61</sup> that need primary care physicians, predominantly in rural and low-income urban communities and among specific population groups within a geographic area such as the homeless, migrant farmworkers, and other groups.<sup>62</sup> Over 69 million people live in a shortage area – more than one in five Americans.<sup>63</sup> More than 10,000 primary care physicians are needed now to provide the care they need.<sup>64</sup>

The market has clearly failed to distribute primary care physicians where they are needed or to fulfill overall demand. A difference in compensation between specialists and primary care providers, coupled with the massive debt many students incur in becoming physicians, has resulted in too few primary care physicians. On average, primary care physicians earn far less than specialists. A recent survey found that average annual full-time physician compensation was \$294,000 with specialist compensation 46% higher than primary care physicians at \$316,000 and \$217,000, respectively.<sup>65</sup> Orthopedic surgeons, at the top of recent compensation surveys, make more than twice as much as family medicine physicians, who are at or near the bottom.<sup>66</sup> A Medicare-for-all program could address these needs, for example, by increasing the number of primary care residencies, scholarships, and loan-repayment programs; targeting education of primary care physicians through dedicated Graduate Medical Education funding; and increasing the reimbursement of primary care physicians.<sup>67</sup> Although none of these ideas is new, a Medicare-for-all program would reorient our healthcare system to put primary



care at the center with a focus on preventive care and early intervention and treatment.

**Physician compensation.** First, to prevent inequity in access and care, physicians who accept payment from the Medicare-for-all plan would be prohibited from also receiving compensation for patient care from private payers, including patients themselves. Second, physicians would be required to accept payment by the Medicare-for-all plan as payment in full. There would still be some physicians who would cater to the wealthy, but there would not be inequity in access or care within the system based on higher reimbursement from private payers or additional fees charged on top of the Medicare-for-all payment rate. Finally, no part of physician compensation would derive from incentives to provide less care such as performance bonuses linked to utilization or profitability.<sup>68</sup>

Representatives of physicians, and other practitioners, would negotiate compensation with representatives of the Medicare-for-all plan. Physicians and their staff would spend far less time on insurance-related administrative matters such as billing and prior authorization for treatment. This decrease in overhead expenses would factor into overall compensation. Compensation would be on either a fee-for-service basis or by a fixed salary, for those working for an organization paid on a per capita basis or operating under a global budget.

The negotiations would also address the difference in compensation between primary care physicians and specialists. This pay inequity lies in undervaluing the cognitive-based services that primary care physicians provide compared to procedure-based services that specialists tend to provide.<sup>69</sup> Unlike surgeons and other specialty physicians who are paid based on the number of procedures they perform and often use complex, expensive equipment, “primary care physicians spend most of their time providing cognitive services, such as acquiring and assimilating information, developing management strategies, coordinating care, and counseling.”<sup>70</sup> While some specialists would still be compensated at higher rates than the primary care generalists, the difference between rates would be reduced.

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## CONCLUSION

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Numerous studies document the many inefficiencies of our “system” and its high financial costs. Likewise, study after study documents our failure to provide healthcare to all those who need it, as well as the vast disparities in health and healthcare in terms of class, race, and sex. Finally, our failure to guarantee healthcare to all exacerbates economic inequality through high out-of-pocket costs for care, medical debt, and bankruptcy.

The reason is clear. As discussed above, a market-driven approach to providing care is based on a business model that fundamentally conflicts with the very reason that people purchase health insurance. Whereas private insurers aim at limiting the amount they “lose” by paying for healthcare, people purchase insurance for the express purpose of accessing healthcare when they need it. A Medicare-for-all program would be accountable to the people, not to shareholders and the bottom line. Rather, it would facilitate the distribution of healthcare resources, such as new facilities and equipment, based on human need, not market share. Compensation for physicians and other healthcare providers would encourage better primary and preventive care. Rural and low-income urban areas would no longer be neglected. Additional resources would be directed to medically underserved areas and populations.

The threat by Congress and the Trump Administration to repeal the ACA makes this a crucial and timely issue. Although the ACA has improved healthcare insurance access, it did so by further entrenching the private insurance industry. Improving our current Medicare system and expanding it to cover everyone is the best solution. If we stand together, we can achieve it.



## REFERENCES

- <sup>1</sup> This paper will use the phrase “Medicare for all” to mean an improved and expanded version of the current Medicare system. The improvements would include eliminating copayments and coinsurance. The expansion just means that it includes the entire U.S. population rather than just seniors and the disabled.
- <sup>2</sup> The use of the term “single payer” comes from the use of a single fund to pay for healthcare for all.
- <sup>3</sup> Center for Responsive Politics. Influence & Lobbying. (<https://www.opensecrets.org/lobby/>, accessed May 12, 2017). The health sector includes pharmaceuticals/health products, hospitals/nursing homes, health professionals, health services/HMOs and miscellaneous health. Calculations based on data retrieved from online database.
- <sup>4</sup> Center for Responsive Politics. Interest Groups. (<https://www.opensecrets.org/industries/>, accessed May 12, 2017). Calculations based on data retrieved from online database.
- <sup>5</sup> Martinez, M E., Zammiti, E. P., & Cohen, R. A. Division of Health Interview Statistics, National Center for Health Statistics. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2016. (<https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf>, accessed May 15, 2017).
- <sup>6</sup> The two bills, S. 194 and H.R. 635, bills are identical. There is a third, HR 1307, that is similar to the other two, but has far fewer co-sponsors. They can be accessed here: S. 194:<https://www.congress.gov/bill/115th-congress/senate-bill/194/text>, H.R. 635:<https://www.congress.gov/bill/115th-congress/house-bill/635/text>, and H.R. 1307: <https://www.congress.gov/bill/115th-congress/house-bill/1307/text?r=18>
- <sup>7</sup> McArdle, M. (2016, August 19). “Obamacare’s Public Option is No Longer Defensible.” *Bloomberg*. (<https://www.bloomberg.com/view/articles/2016-08-19/obamacare-s-public-option-is-no-longer-defensible>, accessed May 12, 2017).
- <sup>8</sup> Jacobs, D. B., & Sommers, B. D. (2015, January 29). Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace. *New England Journal of Medicine*, 372:399-402. (<http://www.nejm.org/doi/full/10.1056/NEJMp1411376>, accessed April 17, 2017); Avalere. (2015, February 11). Analysis of Prescription Drug Tier Placement and Cost Sharing in Health Insurance Exchange Plan. ([http://go.avalere.com/acton/attachment/12909/f-017c/1/-/-/-/20150211\\_Avalere%20Planscape%202015\\_Class%20Tiering%20Analysis.pdf](http://go.avalere.com/acton/attachment/12909/f-017c/1/-/-/-/20150211_Avalere%20Planscape%202015_Class%20Tiering%20Analysis.pdf), accessed April 17, 2017).
- <sup>9</sup> Gaffney, A., & McCormick, D. (2017, April 8). The Affordable Care Act: implications for health-care equity. *The Lancet*, 389:1442-1452 ([http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(17\)30786-9.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)30786-9.pdf), accessed April 17, 2017); Bertko, J. March 29, 2016. What Risk Adjustment Does — The Perspective of a Health Insurance Actuary Who Relies on It. *Health Affairs Blog*. (<http://healthaffairs.org/blog/2016/03/29/what-risk-adjustment-does-the-perspective-of-a-health-insurance-actuary-who-relies-on-it/>, accessed April 17, 2017).
- <sup>10</sup> Dafny, L., Gruber, J., & Ody, C. (2015). More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. *American Journal of Health Economics*, 1(1):53–81. ([http://www.mitpressjournals.org/doi/pdf/10.1162/AJHE\\_a\\_00003](http://www.mitpressjournals.org/doi/pdf/10.1162/AJHE_a_00003), accessed April 25, 2017).
- <sup>11</sup> Cox, C., Semanskee A., Claxton G., & Levitt, L. (2016, August 17). Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors. Kaiser Family Foundation. (<http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/>, accessed April 20, 2017).
- <sup>12</sup> Reinhardt, U. (2016, August 25). Why are Private Health Insurers Losing Money on Obamacare? *Journal of the American Medical Association Forum*. (<https://newsatjama.jama.com/2016/08/25/jama-forum-why-are-private-health-insurers-losing-money-on-obamacare/>, accessed May 12, 2017); McArdle, M. (2016, August 19). “Obamacare’s Public Option is No Longer Defensible.” *Bloomberg*. (<https://www.bloomberg.com/view/articles/2016-08-19/obamacare-s-public-option-is-no-longer-defensible>, accessed May 12, 2017). Holahan, J., Blumberg, L. J., & Wengle E. (2017, May). “What Characterizes the Marketplaces with One or Two Insurers?” Urban Institute. ([http://www.urban.org/sites/default/files/publication/90211/2001265-what-characterizes-the-marketplaces-with-one-or-two-insurers\\_0.pdf](http://www.urban.org/sites/default/files/publication/90211/2001265-what-characterizes-the-marketplaces-with-one-or-two-insurers_0.pdf), accessed May 22, 2017). The Urban Institute research brief found that markets with larger populations and tended to have more competition, concluding that these areas simply have “less business to compete over.
- <sup>13</sup> Antos, J., & Capretta, J. (2016, October 11). The Future of the ACA’s Exchanges. *Health Affairs Blog*. (<http://healthaffairs.org/blog/2016/10/11/the-future-of-the-acas-exchanges/>, accessed April 20, 2017); Levitt, L. (2017, April 17). Is the Affordable Care Act Imploding? *Journal of the American Medical Association Forum*. (<https://newsatjama.jama.com/2017/04/17/jama-forum-is-the-affordable-care-act-imploding/>, accessed April 20, 2017).
- <sup>14</sup> ASPE. (2016, October 24). Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace. (<https://aspe.hhs.gov/health-plan-choice-and-premiums-2017-health-insurance-marketplace>, accessed May 12, 2017); Cox, C., Long M., Semanskee A., Kamal, R., Claxton G., & Levitt, L. (2016, November 1). 2017 Premium Changes and Insurer Participation in the Affordable Care Act’s Health Insurance Marketplaces. *Kaiser Family Foundation*. (<http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/> (Accessed May 11, 2017). The exception to the double digit increase is Wyoming which was already down to one insurer in 2016. The rate there increased 9%.
- <sup>15</sup> Ibid.
- <sup>16</sup> Livingston, S. (2017, May 10). Health insurers’ proposed 2018 rate hikes are early ‘warning signs.’ *Modern Healthcare*. (<http://www.modernhealthcare.com/article/20170510/NEWS/170519999>, accessed May 13, 2017).

- <sup>17</sup> Tritter, J. Q., Lutfey, K., & McKinlay, J. (2014, February 13). What are tests for? The implications of stuttering steps along the US patient pathway. *Social Science & Medicine*, 107: 37–43.
- <sup>18</sup> Office of the National Coordinator for Health Information Technology. Clinical Decision Support. (<https://www.healthit.gov/policy-researchers-implementers/clinical-decision-support-cds>, accessed May 15, 2017).
- <sup>19</sup> Morrisey, M. A., Rivlin, A. M., Nathan, R. P., & Hall, M. A. (2017, February). Five-State Study of ACA Marketplace Competition. The Brookings Institute. (<https://www.brookings.edu/wp-content/uploads/2017/02/summary-report-final.pdf>, accessed April 22, 2017); Dafny, L. (2014, January 16). Hospital Industry Consolidation – Still More to Come? *New England Journal of Medicine*, 370(3):198-199; (<http://www.nejm.org/doi/pdf/10.1056/NEJMp1313948>, accessed April 22, 2017); Cutler, D. M. & Scott Morton, F. (2013, November 13). Hospitals, Market Share, and Consolidation. *Journal of the American Medical Association*, 310(18):1964-1970. doi:10.1001/jama.2013.281675. (<http://jamanetwork.com/journals/jama/fullarticle/1769891>, accessed April 22, 2017); Gaynor, M. & Town, R. (2012, June). The Impact of Hospital Consolidation – Update. Robert Wood Johnson Foundation. ([http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2012/rwjf73261](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261), accessed April 22, 2017).
- <sup>20</sup> Tsai, T. C. & Jha, A. K. (2014, July 2). Hospital Consolidation, Competition, and Quality: Is Bigger Necessarily Better? *Journal of the American Medical Association*, 312(1):29-30. doi:10.1001/jama.2014.469. (<http://jamanetwork.com/journals/jama/fullarticle/1884584>, accessed April 22, 2017).
- <sup>21</sup> American Hospital Association. (1996-2015). AHA Hospital Statistics. The increase over 20 years was 64 percent, with 40 percent in systems in 1996 and 66 percent in 2015.
- <sup>22</sup> Centers for Medicare & Medicaid Services. (2016, December 31). Medicare Cost Reports for Fiscal Year 2015- 2016. Calculations based on report data.
- <sup>23</sup> Institute for Health & Socio-Economic Policy. (2013, May 15). Nurses: Hospital Price Gouging Driving Up Healthcare Costs, Self-Rationing, Medical Bankruptcies. (<http://www.nationalnursesunited.org/press/entry/nurses-hospital-price-gouging-driving-up-healthcare-costs-self-rationing-me/>, accessed April 26, 2017); Batty, M. & Ippolito, B. (2017, April). Mystery of the Chargemaster: Examining The Role of Hospital List Prices in What Patients Actually Pay. *Health Affairs*, 36(4):689-696; doi:10.1377/hlthaff.2016.0986 (<http://content.healthaffairs.org/content/36/4/689.full>, accessed May 1, 2017).
- <sup>24</sup> Ibid.
- <sup>25</sup> Organisation for Economic Co-operation and Development. Members and Partners. (<http://www.oecd.org/about/membersandpartners/>, accessed May 12, 2017). The OECD describes its members as follows: "... our 35 Member countries span the globe, from North and South America to Europe and Asia-Pacific. They include many of the world's most advanced countries but also emerging countries like Mexico, Chile and Turkey." These are the member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israël, Italy, Japan, Korea, Latvia, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, and the United States.
- <sup>26</sup> Organisation for Economic Co-operation and Development. OECD.Stat. (<http://stats.oecd.org>, accessed April 20, 2017) Data are based on estimates and projections; Centers for Medicare & Medicaid Services. (2017, March 21). NHE Fact Sheet. (<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>, accessed April 26, 2017). Although we don't have the actual data for the other OECD countries for 2015, we know that in the U.S. actual costs were even higher than the OECD estimate. The most recent figures on our national health expenditures (NHE) from 2015 the show that NHE grew 5.8% to \$3.2 trillion, or \$9,990 per person, and accounted for 17.8% of Gross Domestic Product (GDP).
- <sup>27</sup> Ibid.
- <sup>28</sup> Martinez, M E., Zammitti, E. P., & Cohen, R. A. Division of Health Interview Statistics, National Center for Health Statistics. Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2016. (<https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201702.pdf>, accessed May 15, 2017).
- <sup>29</sup> Davis, K., Stremikis, K., Schoen, C., & Squires, D. (2014, June 16). Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally. The Commonwealth Fund. (<http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>, accessed May 12, 2017). The other countries included in the study are Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom.
- <sup>30</sup> Barber, R. M., et al. (2017, May 18). Healthcare Access and Quality Index Based on Mortality from Causes Amenable to Personal Health Care in 195 Countries and Territories, 1990–2015: a novel analysis from the Global Burden of Disease Study 2015. *The Lancet*. ([http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)30818-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30818-8/fulltext), accessed May 21, 2017).
- <sup>31</sup> Xu, J., Murphy, S.L., Kochanek, K.D., & Arias, E. (2016, December). Mortality in the United States, 2015. *NCHS*, 267. (<https://www.cdc.gov/nchs/data/databriefs/db267.pdf>, accessed April 21, 2017).
- <sup>32</sup> Chetty R., Stepner M., Abraham S., Lin S., Scuderi B., Turner N., Bergeron A., & Cutler D. (2016, April 26). The Association between Income and Life Expectancy in the United States, 2001-2014. *Journal of the American Medical Association*, 315(16):1750-1766. doi:10.1001/jama.2016.4226 (<http://jamanetwork.com/journals/jama/fullarticle/2513561>, accessed May 11, 2017).
- <sup>33</sup> Di Julio, B., Firth, J., & Brodie, M. Kaiser Health Tracking Poll: December 2015. (2015, December 17). Kaiser Family Foundation. (<http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-december-2015/>, accessed May 26, 2017).

- <sup>34</sup> Bialik, K. More Americans Say Government Should Ensure Health Care Coverage. Pew Research Center. (<http://www.pewresearch.org/fact-tank/2017/01/13/more-americans-say-government-should-ensure-health-care-coverage/>, accessed May 26, 2017).
- <sup>35</sup> Himmelstein, D. U. & Woolhandler, Steffie. (2016, March). The Current and Projected Taxpayer Shares of US Health Costs. *American Journal of Public Health*, 106(3):449-452. (<http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2015.302997>, accessed May 11, 2017). This figure includes the money spent to purchase private health insurance for public sector employees and tax expenditures to subsidize employer-sponsored health insurance in the private sector.
- <sup>36</sup> Some of the savings discussed below would enable federal dollars to go further in providing care. The balance would need to be allocated through the federal budget and, if needed to expand coverage, captured through progressive taxation.
- <sup>37</sup> To prevent tiered care, insurers, including employers who self-insure, would be prohibited from providing coverage for benefits provided by the Medicare-for-all plan, but could offer supplemental insurance. Typically, temporary assistance for up to five years would be provided to workers displaced by the change.
- <sup>38</sup> Brook, R. H., Keeler, E. B., Lohr, K. N., Newhouse, J. P., Ware, J. E., Rogers, W. H., Davies, A. R., Sherbourne, C. D., Goldberg, G. A., Camp, P., Kamberg, C., Leibowitz, A., Keeseey, J., & Reboussin, D. (2006). The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. RAND Corporation. ([https://www.rand.org/pubs/research\\_briefs/RB9174.html](https://www.rand.org/pubs/research_briefs/RB9174.html), accessed May 16, 2017); Hoffman, B.A. (2006, Winter). Restraining the Health Care Consumer. *Social Science History*, 30:4 doi: 10.1215/01455532-2006-007
- <sup>39</sup> Hoffman, B.A. (2006, Winter). Restraining the Health Care Consumer. *Social Science History*, 30:4 doi: 10.1215/01455532-2006-007; Trivedi, A. N., Rakowski, W., & Ayanian, J. Z. (2008, January 24). Effect of Cost Sharing on Screening Mammography in Medicare Health Plans. *New England Journal of Medicine*, 358:375-383. (<http://www.nejm.org/doi/pdf/10.1056/NEJMSa070929>, accessed May 16, 2017); Howard, D. H., Guy, G. P. Jr., & Ekwueme, D. (2014, October 9). "Eliminating Cost-Sharing Requirements for Colon Cancer Screening in Medicare." *Cancer*. (<http://onlinelibrary.wiley.com/doi/10.1002/cncr.29093/full>, accessed May 1, 2017). Some have argued for a sliding scale for cost-sharing based on income and no cost-sharing for certain types of preventive care (the ACA has no cost-sharing for certain preventive care measures). But requiring any type of cost sharing would undermine the uniformity that enables much of the administrative savings discussed above.
- <sup>40</sup> Brook, R. H., Keeler, E. B., Lohr, K. N., Newhouse, J. P., Ware, J. E., Rogers, W. H., Davies, A. R., Sherbourne, C. D., Goldberg, G. A., Camp, P., Kamberg, C., Leibowitz, A., Keeseey, J., & Reboussin, D. (2006). The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. RAND Corporation. ([https://www.rand.org/pubs/research\\_briefs/RB9174.html](https://www.rand.org/pubs/research_briefs/RB9174.html), accessed May 16, 2017).
- <sup>41</sup> Ibid.; Collins, S. R., Gunja, M., Doty, M. M., & Beutel, S. (2015, November). How High Is America's Health Care Cost Burden? Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, July– August 2015. The Commonwealth Fund. (<http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/how-high-health-care-burden>, accessed May 16, 2017). Among privately insured adults ages 19-64: 43% of those across all income groups found paying deductibles either "very difficult or impossible" or "somewhat difficult" and 17% of those across all income groups found paying copayments either "very difficult or impossible" or "somewhat difficult."
- <sup>42</sup> Osborn, R., Squires, D., Doty, M. M., Sarnak, D. O., & Schneider, E. C. (2010). In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care. *Health Affairs*, 29(5):766-772. (<http://content.healthaffairs.org/content/35/12/2327>, accessed May 16, 2017); Brook, R. H., Keeler, E. B., Lohr, K. N., Newhouse, J. P., Ware, J. E., Rogers, W. H., Davies, A. R., Sherbourne, C. D., Goldberg, G. A., Camp, P., Kamberg, C., Leibowitz, A., Keeseey, J., & Reboussin, D. (2006). The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate. RAND Corporation. ([https://www.rand.org/pubs/research\\_briefs/RB9174.html](https://www.rand.org/pubs/research_briefs/RB9174.html), accessed May 16, 2017); Hoffman, B.A. (2006, Winter). Restraining the Health Care Consumer. *Social Science History*, 30:4 doi:10.1215/01455532-2006-007
- <sup>43</sup> For deep discussion of these issues see the Lancet series, America: Equity and Equality in Health. (2017, April 8). (<http://www.thelancet.com/series/america-equity-equality-in-health>, last accessed May 23, 2017.)
- <sup>44</sup> Goldman, D. P., Joyce, G. F., & Karaca-Mandic, P. (2006). Cutting Drug Co-Payments for Sicker Patients on Cholesterol-Lowering Drugs Could Save a Billion Dollars Every Year. RAND Corporation. ([https://www.rand.org/pubs/research\\_briefs/RB9169/index1.html](https://www.rand.org/pubs/research_briefs/RB9169/index1.html), accessed May 16, 2017); Chandra, A., Gruber, J., & McKnight, R. (2010). Patient Cost-Sharing and Hospitalization Offsets in the Elderly. *The American Economic Review*, 100(1):193–213. <http://doi.org/10.1257/aer.100.1.193> (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2982192/>, accessed May 16, 2017).
- <sup>45</sup> There would also be insurance-related administrative savings for employers that are not captured here.
- <sup>46</sup> Berwick, D.M. & Hackbarth, A.D. (2012). Eliminating Waste in US Health Care. *Journal of the American Medical Association*, 307(14):1513-1516. <http://dx.doi.org/10.1001/jama.2012.362>. (<http://jamanetwork.com/journals/jama/fullarticle/1148376>, accessed May 16); Jiwani, A., Himmelstein, D., Woolhandler, S., & Kahn, J. G. (2014). Billing and Insurance-Related Administrative Costs in United States' Health Care: Synthesis of Micro-Costing Evidence. *BMC Health Services Research* 14(556). Percentages calculated based on data in the articles. These are mid-range savings; the larger number comes from the Jiwani, et al. article.
- <sup>47</sup> Centers for Medicare & Medicaid Services. (2017, March 21). NHE Fact Sheet. (<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>, accessed April 26, 2017).



- <sup>48</sup> Himmelstein, D. U., Jun, M., Busse, R., Chevreul, K., Geissler, A., Jeurissen, P., Thomson, S., Vinet, M. & Woolhandler, S. D. (2014). A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far. *Health Affairs* 33(9):1586-1594. doi: 10.1377/hlthaff.2013.1327 (<http://content.healthaffairs.org/content/33/9/1586.full.pdf+html>, accessed May 4, 2017); Patel, A., Rajkumar, R., Colmers, J. M., Kinzer, D., Conway, P. H., & Sharfstein, J. M. (2015, November 12) Maryland's Global Hospital Budgets — Preliminary Results from an All-Payer Model. *New England Journal of Medicine*, 373(20):1899-1901. (<http://www.nejm.org/doi/pdf/10.1056/NEJMp1508037>, accessed May 4, 2017), Hsiao, W. C., Knight, A. G., Kappel, S., & Done, N. (2011). What Other States Can Learn From Vermont's Bold Experiment: Embracing a Single-Payer Health Care Financing System. *Health Affairs*, 30(7):1232-1241. doi: 10.1377/hlthaff.2011.0515 (<http://content.healthaffairs.org/content/30/7/1232.full.pdf+html>, accessed May 4, 2017).
- <sup>49</sup> Himmelstein, D. U., Jun, M., Busse, R., Chevreul, K., Geissler, A., Jeurissen, P., Thomson, S., Vinet, M. & Woolhandler, S. D. (2014). A Comparison of Hospital Administrative Costs in Eight Nations: US Costs Exceed All Others by Far. *Health Affairs* 33(9):1586-1594. doi: 10.1377/hlthaff.2013.1327 (<http://content.healthaffairs.org/content/33/9/1586.full.pdf+html>, accessed May 4, 2017).
- <sup>50</sup> Center for Responsive Politics. Pharmaceuticals/Health Products Industry Profile. (<https://www.opensecrets.org/lobby/indusclient.php?id=H04>, accessed May 19, 2017).
- <sup>51</sup> Center for Responsive Politics. Pharmaceuticals/Health Products Industry: Background. (2015, August). (<https://www.opensecrets.org/industries/background.php?ind=H04++>, accessed May 19, 2017).
- <sup>52</sup> Cubanski, J. & Neuman, T. (2017, January 23). Searching for Savings in Medicare Drug Price Negotiations. Kaiser Family Foundation. (<http://kff.org/medicare/issue-brief/searching-for-savings-in-medicare-drug-price-negotiations/>, accessed May 19, 2017).
- <sup>53</sup> Center for Responsive Politics. Pharmaceuticals/Health Products Industry: Background. (2015, August). (<https://www.opensecrets.org/industries/background.php?ind=H04++>, accessed May 19, 2017).
- <sup>54</sup> Center for Responsive Politics. Pharmaceuticals/Health Products: Long-Term Contribution Trends. (<https://www.opensecrets.org/industries/totals.php?cycle=2014&ind=H04>, accessed May 23, 2017).
- <sup>55</sup> Medicare for all legislation would include repealing the prohibition of negotiating drug prices.
- <sup>56</sup> Woolhandler, S. & Himmelstein, D. U. (2017, April 18). Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs. *Annals of Internal Medicine*, 166(8):587-588. DOI: 10.7326/M17-0302 (<http://annals.org/aim/article/2605414/single-payer-reform-only-way-fulfill-president-s-pledge-more>, accessed May 19, 2017).
- <sup>57</sup> Chang, C.-H., Stukel, T. A., Flood, A. B., & Goodman, D. C. (2011). Primary Care Physician Workforce and Medicare Beneficiaries' Health Outcomes. *The Journal of the American Medical Association*, 305(20):2096–2104. <http://doi.org/10.1001/jama.2011.665> (<http://jamanetwork.com/journals/jama/fullarticle/900155>, accessed May 17, 2017); Osborn, R., Squires, D., Doty, M. M., Sarnak, D. O., & Schneider, E. C. In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care. (2010). *Health Affairs*, 29(5):766-772. (<http://content.healthaffairs.org/content/35/12/2327.full>, accessed May 16, 2017); Starfield, B., Shi, L., & Macinko, J. (2005, September) Contribution of Primary Care to Health Systems and Health. *Milbank Quarterly*, 83(3):457-502. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/>, accessed May 17, 2017).
- <sup>58</sup> Osborn, R., Squires, D., Doty, M. M., Sarnak, D. O., & Schneider, E. C. (2010). In New Survey of Eleven Countries, US Adults Still Struggle with Access to and Affordability of Health Care. *Health Affairs*, 29(5):766-772. (<http://content.healthaffairs.org/content/35/12/2327.full>, accessed May 16, 2017).
- <sup>59</sup> Ibid.; Institute of Medicine. (2013, January 9). U.S. Health in International Perspective Shorter Lives, Poorer Health. The National Academies Press. (<https://www.nap.edu/catalog/13497/us-health-in-international-perspective-shorter-lives-poorer-health>, accessed May 17, 2017).
- <sup>60</sup> IHS Markit. (2017). The Complexities of Physician Supply and Demand: Projections from 2015 to 2030. Prepared for the Association of American Medical Colleges. ([https://aamc-black.global.ssl.fastly.net/production/media/filer\\_public/a5/c3/a5c3d565-14ec-48fb-974b-99fafaecb00/aamc\\_projections\\_update\\_2017.pdf](https://aamc-black.global.ssl.fastly.net/production/media/filer_public/a5/c3/a5c3d565-14ec-48fb-974b-99fafaecb00/aamc_projections_update_2017.pdf), accessed May 21, 2017); U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. (2013, November). Projecting the Supply and Demand for Primary Care Practitioners through 2020. U.S. Department of Health and Human Services. (<https://bhwh.hrsa.gov/sites/default/files/bhw/nchwa/projectingprimarycare.pdf>, accessed May 17, 2017). This study projects a shortfall of 20, 400 in 2020; Petterson, S. M., Liaw, W. R., Phillips, R. L., Rabin, D. L., Meyers, D. S., & Bazemore, A. W. (2012). Projecting US Primary Care Physician Workforce Needs: 2010-2025. *Annals of Internal Medicine*, 10(6):503-509. doi:10.1370/afm.1431. (<http://www.annfam.org/content/10/6/503.full.pdf>, accessed May 17, 2017). This study projects a shortfall of nearly 52,000 by 2025.
- <sup>61</sup> Bureau of Health Workforce, Health Resources & Services Administration, U.S. Department of Health & Human Services. (2017, May 23). Table 1. Health Professional Shortage Areas: Number, Population, and Additional Practitioners Needed for Geographic Areas, Population Groups, and Facilities as of May 23, 2017. ([https://ersrs.hrsa.gov/ReportServer?/HGDW\\_Reports/BCD\\_HPSA/BCD\\_HPSA\\_SCR50\\_Smry\\_HTML&rc:Toolbar=false](https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry_HTML&rc:Toolbar=false), accessed May 23, 2017).
- <sup>62</sup> Bureau of Health Workforce, Health Resources & Services Administration, U.S. Department of Health & Human Services. Health Professional Shortage Areas. (2016, October). Health Professional Shortage Areas (HPSAs). (<https://bhwh.hrsa.gov/shortage-designation/hpsas>, accessed May 18, 2017).
- <sup>63</sup> Bureau of Health Workforce, Health Resources & Services Administration, U.S. Department of Health & Human Services. (2017, May 23). Table 1. Health Professional Shortage Areas:



Number, Population, and Additional Practitioners Needed for Geographic Areas, Population Groups, and Facilities as of May 23, 2017.

<sup>64</sup> Ibid.

<sup>65</sup> Grisham, S. (2017, April 5). Medscape Physician Compensation Report 2017. *Medscape*. (<http://www.medscape.com/slideshow/compensation-2017-overview-6008547>, accessed May 22, 2017).

<sup>66</sup> Ibid.; Zimmerman, B. (2017, January 26). 2017 Statistics on Physician Compensation. *Becker's Hospital Review*. (<http://www.beckershospitalreview.com/compensation-issues/2017-statistics-on-physician-compensation-2017.html>, accessed May 22, 2017); Conn, J. (2016, July 16). Competition for New Docs Pushing Pay Higher. *Modern Healthcare*. (<http://www.modernhealthcare.com/article/20160716/MAGAZINE/307169981>, accessed May 22, 2017); Medical Group Management Association. (2015). Trends in Physician Compensation. (<http://www.mgma.com/industry-data/research-and-studies-overview/survey-infographics/trends-in-physician-compensation>, accessed May 22, 2017). Other primary care providers such as internists and pediatricians also rank low in compensation surveys.

<sup>67</sup> Sanders, Bernard. (2013, January 29). Primary Care Access: 30 Million Patients and 10 Months to Go: Who Provide Will Their Primary Care. (<https://www.sanders.senate.gov/imo/media/doc/PrimaryCareAccessReport.pdf>, accessed May 18, 2017).

<sup>68</sup> The Working Group on Single-Payer Program Design. "Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform." ([http://www.pnhp.org/beyond\\_aca/Physicians\\_Proposal.pdf](http://www.pnhp.org/beyond_aca/Physicians_Proposal.pdf), accessed May 22, 2017). This proposal also identifies ways to address concerns that fee-for-service payments inappropriately drives up utilization such as "monitoring for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on low-value medical interventions."

<sup>69</sup> Goodson, J. D. (2010, June 1). Patient Protection and Affordable Care Act: Promise and Peril for Primary Care. *Annals of Internal Medicine*, 152(11):742-744. doi: 10.7326/0003-4819-152-11-201006010-00249 (<http://annals.org/aim/article/745811/patient-protection-affordable-care-act-promise-peril-primary-care>, accessed May 18, 2017).

<sup>70</sup> Ibid.