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On Behalf of National Nurses United

Before the

Senate Committee on the Budget

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Hearing on "Medicare for All: Protecting Health, Saving Lives, Saving Money"

Good morning and thank you, Chairman Sanders, Ranking Member Graham, and members of the committee for holding this critically important hearing today on Medicare for All. My name is Bonnie Castillo. I am a Registered Nurse and Executive Director of National Nurses United (NNU), the largest union and professional association of RNs in the United States. NNU proudly represents over 175,000 members who work as bedside health care professionals.

I'm particularly pleased to be joining you all today on International Nurses Day. I can think of nothing more fitting to commemorate International Nurses Day than by advocating for the quick and urgent transition to a Medicare for All system that would guarantee health care to every person in the United States.

For more than two years, nurses across this country have worked on the frontlines of the Covid-19 pandemic. We have been caring for patients despite atrocious working conditions in which the health and safety of nurses and their families have constantly been put at risk. Nurses continue to bear witness every day to the ravages of this pandemic. We have seen unfathomable levels of death, physical illness, as well as the despair and grief that comes with severe illness and death, particularly when patients are isolated from their loved ones. And we have worked through this pandemic far too often without the protections we need to do our jobs safely.

In my testimony today, I will use the experiences of registered nurses from across the country to illustrate how the current healthcare system is fundamentally unable to provide the therapeutic quality care that our patients need and deserve. By erecting financial barriers to care, it provides starkly disparate care to different people and communities and, for many, provides no care at all. It is also financially inefficient and wasteful for the country as a whole. The only way we can guarantee every person living in this country receives the healthcare they need with a single standard of excellent care is by adopting a single-payer, Medicare for All system.

If it was ever in doubt before, this pandemic has shown that our current profit-driven and fragmented health insurance system does not work. It does not provide quality therapeutic care

to millions of Americans, and it does not value and protect its own health care workers. Critically, the current fragmented system of health insurance is unable to provide the comprehensive pandemic response that we have needed for more than two years.

Why didn't nurses and health care workers get the protections we needed in the pandemic? Because our employers value money over our lives. More than 5,104 nurses and other health care workers have died as a result.

Why didn't we have the emergency stocks of critical medical supplies that we would need in a pandemic? Because the hospital and healthcare industry has long-employed a "just-in-time" supply and personnel model, where they plan their supply chains and staffing based on maximizing profit, not improving and safeguarding patient care.

We have seen high death rates from Covid-19 across the country. The United States population makes up less than five percent of the world's total population, but U.S. Covid-19 fatalities comprise 16 percent of total global Covid-19 fatalities. Our hospitals have been consistently overrun with critically ill patients. There are 30 million people in this country who are uninsured and tens of millions more who are underinsured, who therefore do not get the medical care they need. Without consistent access to high-quality care, including preventive and primary care, our patients are at higher risk of underlying medical conditions, which in turn, puts them at higher risk for severe Covid-19 illness, hospitalization, and death.

We do not have the health care infrastructure we need to effectively respond to this pandemic or prepare for future surges. This is because profit-driven hospital systems have decided where to open and close hospitals based on how much money they can make from the patients in those communities. As a result, rural, low-income, and Black, Indigenous, and people of color (BIPOC) communities lack access to medical care. If our health care infrastructure had been built to provide equitable health care to all communities, our response to the Covid-19 pandemic would have looked very different.

The problems with our health care system far predate this pandemic. For years, nurses have witnessed the preventable tragedies that result from this profit-driven system. Nurses watch as too many patients forgo needed medications, procedures, or care because they cannot afford the costs. They watch as insurance corporations refuse to cover critical care that is required for the health and well-being of patients. Insurers override the professional judgment of licensed health care professionals, and nurses can do little about it when our patients do not get the care that they need. Nurses watch as patients finally come to the hospital emergency room with advanced stages of illness or disease that could have been prevented if they had access to treatment earlier.

The system we have now is beholden to the corporate interests that determine who gets treatment, and what treatment they get. It is deeply inefficient and unsustainable because it prioritizes short-term financial returns rather than long-term investments in our health. This leads to a system that is unaffordable for our country and for our patients. Many patients cannot afford the costs of their care individually, and the country cannot afford the financial burdens of a system with built-in inefficiencies, administrative waste, and needless

profiteering. The Covid-19 pandemic, with nearly one million recorded fatalities in the U.S., has shown clearly that our society cannot afford the consequences this has on public health. Any delay in fundamentally transforming our health care system costs money, but more importantly, we pay with our health and with our lives.

The United States leads the world in health care spending. We spend more money per person on health care than any other nation in the world even though millions of people do not get the health care they need. Instead of providing health care for all people in the U.S., we waste hundreds of billions of dollars each year on unnecessary administrative costs, huge profit margins for corporations, and inefficiencies. Despite paying top dollar for our health care, we get poor results. Our country ranks near the bottom among industrialized nations on many international health indicators, including on critical barometers such as average life expectancy, infant mortality, maternal mortality, and death from preventable diseases. High costs and poor health outcomes persist because access to an insurance plan is not the same as guaranteed health care for all.

The only way to solve the health care crisis in this country, is to enact a single-payer, Medicare for All system.

By moving to a single-payer system, we would transform the profit-driven health insurance system into a health care system that prioritizes patient care. Under the Medicare for All Act of 2022, the existing Medicare program would be improved and then expanded to cover every person living in the United States. Medicare for All would immediately reduce inefficiencies in the current fragmented insurance system by cutting unnecessary administrative expenses associated with billing countless insurance providers, negotiating in-network and out-of-network payments, and fighting against high copays, prior authorization barriers, and unexpected expenses. Medicare for All would also remove the huge amounts of money that are funneled into insurance industry executive pay and corporate profits instead of being spent on our health.

Study after study has shown that a single-payer system is the only way that our country can provide guaranteed health care to all, with comprehensive benefits, while also reducing the amount of money we spend on health care overall. In other words, with Medicare for All, we would get more, cover everyone, pay less, and experience better health care outcomes. Economic analyses have shown that our country would save between two and five trillion dollars over ten years if we implemented a single-payer Medicare for All program.

Medicare for All would save us hundreds of billions of dollars each year by eliminating the administrative complexity and profiteering in our current system and by leveraging our collective buying power under a single-payer to negotiate fairer prices for everyone. Through bulk negotiations, Medicare for All would end high prescription drugs prices. Instead of payments going towards inflated prices, administrative complexity, and health industry profiteering, our health care dollars would be redirected to providing quality patient care.

As a registered nurse, I can envision exactly what Medicare for All would mean for patients in this country. Whenever someone needs medical care, they would see the health care provider of their choice without any worry about financial and insurance barriers to care — about

insurance networks, copayments, deductibles, coinsurance, preauthorization requirements, limits on health care spending, or surprise billing. Every patient would receive the care they need free at the point of service.

We would no longer see patients who could not get lifesaving care because their insurance provider denied them coverage, or because they did not have insurance to begin with. We would no longer see huge numbers of patients who present with severe illness or disease because they could not afford the care they needed months or years earlier. Patients would no longer have to ration their medication.

And for those of us who are health care workers, we would be able to provide medical and nursing care based on our professional judgment, without the interference of insurance companies who are not licensed health care providers and whose interests are in reducing claims to increase returns.

The Medicare for All Act would allow for tangible and practical improvements to health care delivery for registered nurses and other health care workers at hospitals across the country. Importantly, the bill would change the way that hospitals are paid for their services. This payment model would fundamentally shift the profit-motives of hospital corporations and ensure that they focus on patient care while simultaneously investing in their caregiver workforce and protecting worker health and safety.

The Medicare for All Act would pay all institutional providers through a global budget that would allow them to provide quality patient care for their communities. Aligning hospital payments with costs, these global budgets would be tailored to meet and reflect the care and access needs of the patients served by each hospital. Through the global budgeting model, payments would more closely reflect the actual costs of providing health care to patients, and those payments would ensure equity across health care institutions.

Through global budgeting, the Medicare for All program would also use targeted funding to ensure that hospitals are providing for the health and safety of their patients and their health care workforce. For example, the bill explicitly requires that hospitals have the funding necessary for safe nurse-to-patient staffing ratios, for pandemic preparedness costs, for safe patient handling, and for other occupational health and safety programs.

Providers would be accountable for their spending and would no longer be able to overcharge the Medicare program. Importantly, the global budgeting model requires transparency and allows the public to track where our health care dollars are going. We can ensure that rural hospitals and hospitals in underserved areas always get the funding they need to stay open. Providers must also report all relevant data associated with operational costs and justify their spending. With periodic audits and review, providers would be held accountable for their projected spending and the program could monitor whether the provider is meeting program goals and standards.

Importantly, the Medicare for All budget and payment system would greatly improve health equity and would decrease the health disparities we see for rural and low-income communities and for communities of color.

If Medicare for All was in place before the pandemic, we would have been better prepared to respond to Covid-19 with sufficient nurses, doctors, respiratory therapists, and other staff as well as beds, equipment, and medical supplies. The Medicare for All national health budget would also include "a reserve fund to respond to the costs of treating an epidemic, pandemic, natural disaster, or other such health emergency".

If we had a Medicare for All system, health care workers would not needlessly become infected, hospitalized, or die because of the health care industry's reliance on the "just-in-time" supply model. This model, which prioritizes profits over worker health and safety, failed to get health care workers the necessary PPE and other critical medical supplies that would have kept them and their patients safe. Instead, the global budget payments for hospitals and skilled nursing facilities would include funding for infectious disease response preparedness. These facilities would be required to maintain a one-year stockpile of personal protective equipment, and to provide occupational testing and surveillance, medical services for on-the-job infectious disease exposure, and contact tracing.

Medicare for All would not only save money and improve the health of patients, but it would also improve the lives and practice of our healthcare professionals — our doctors, nurses, and other clinicians.

As registered nurses, our primary responsibility is to protect the health and wellbeing of our patients. Our existing health care system does not allow us to do that. We cannot expect a system that is designed to profit off illness, pain, and suffering, to work in the interests of our patients. Medicare for All is the solution we need to ensure that every patient gets the health care they need.

Thank you.

ATTACHMENTS

1. Issue Brief, Medicare for All Act of 2022: The Nurse Staffing Crisis & the Urgent Need for Health Care Redesign

2. Issue Brief, Medicare for All Act of 2022: Covid-19, Future Pandemics & Medicare for All

3. Issue Brief, Medicare for All Act of 2022: Program Design

4. Issue Brief, Medicare for All Act of 2022: Ensuring Access to Care

5. Issue Brief, Medicare for All Act of 2022: Eliminating Health & Health Care Disparities

6. Issue Brief, Medicare for All Act of 2022: Global Budgets & Other Reimbursements

7. Issue Brief: Medicare for All Act of 2022: Cost & Savings Analyses

8. Issue Brief: Medicare for All Act of 2022: Canada, Taiwan & U.S. Comparison

Medicare for All Act of 2022:
The Nurse Staffing Crisis & the Urgent Need for Health Care Redesign

For decades, the hospital and health insurance industries have operated on a model with one goal: maximize net revenue. These profits come at the expense of both patient care as well as worker health and safety — a hospital is not a factory, and health care workers are not machines. Covid-19 has exacerbated the industry-created staffing crisis, which has been decades in the making as health care corporations have deliberately understaffed hospitals to cut costs and prioritize profits over safe working conditions and patient care. Talk of a "nursing shortage" has become ubiquitous during the Covid-19 pandemic. In reality, there is no shortage of nurses in the U.S., only a shortage of nurses willing to risk their licenses or their patients' lives by working in the unsafe conditions that have become prevalent in today's hospital industry.

This brief discusses the link between the intentional profit-maximizing practices of the hospital industry and high rates of nurses leaving the bedside — or leaving the nursing profession altogether — to protect themselves, their nursing licenses, their families, and their patients. Because hospital employers fail to protect nurses on the job and fail to provide nurses with the staff and resources needed for them to give safe, therapeutic care, nurses face profound levels of moral distress, preventable workplace dangers, and job dissatisfaction. Medicare for All is a key solution to this problem; targeted hospital payments for nurse-to-patient staffing ratios and occupational health and safety protections would allow nurses to provide quality patient care in a safe and sustainable environment.

A Shortage of Good Nursing Jobs, Not a Shortage of Nurses

There is no shortage of registered nurses. As of November 6, 2021, the National Council of State Boards of Nursing reported that there are over 4.4 million RNs with active licenses,[1] yet according to the U.S. Bureau of Labor Statistics, there are only 3.2 million people who are employed as RNs, with 1.8 million employed in hospitals.[2] In addition, except for a handful of states, there are sufficient numbers of registered nurses to meet the needs of the country's patients, according to a 2017 U.S. Department of Health and Human Services (HHS) report on the supply and demand of the nursing workforce from 2014 to 2030.[3] Moreover, HHS projected that most states (43) would have surpluses in 2030.[4] Rather, there is a shortage of good permanent nursing jobs where RNs are fully valued for their work at the bedside through safe patient staffing levels, strong union protections, and safe and healthy workplaces.

Importantly, registered nursing can be a pathway to good union jobs for people from Black, Brown, Indigenous, and other communities of color (BIPOC) and other underserved communities, but hiring and educational policies by the hospital industry have restricted the pipeline of nurses from socioeconomically diverse and underserved communities. Although there is no general nursing

[1] National Council of State Boards of Nursing. "Active RN Licenses, A Profile of Nursing Licensure in the U.S." National Council of State Boards of Nursing (2022) (Last updated May 20, 2022). Accessed May 10, 2022. https://www.ncsbn.org/6161.htm. As the National Council of State Boards of Nursing data excludes Michigan RNs, their number of active RN licenses reflects the number of RNs employed in Michigan which is less than the number of RNs licensed in Michigan. National Council of State Boards of Nursing uses Michigan data from U.S. Bureau of Labor Statistics. "May 2020 Occupational Employment and Wages." U.S. Department of Labor (2021). Available at https://www.bls.gov/oes/home.htm.

[2] U.S. Bureau of Labor Statistics. "May 2020 Occupational Employment and Wages." U.S. Department of Labor (2021). Available at https://www.bls.gov/oes/home.htm.

[3] Health Resources and Services Administration. "National and Regional Supply and Demand Projections of the Nursing Workforce: 2014-2030." U.S. Department of Health and Human Services (2017). Accessed on May 10, 2022. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/nchwa-hrsa-nursing-report.pdf.

[4] *Ibid.*

shortage, the lack of racial, ethnic, cultural, linguistic, and socioeconomic diversity within the current nursing workforce reflects the need for increasing the numbers of and support for socioeconomically diverse registered nurses from BIPOC communities and other underserved communities. Racial and socioeconomic diversity within the nursing workforce is crucial for both improving our nation's health and achieving health equity.[5]

How Hospital Industry Practices Drive Nurses Away from the Bedside

To reduce labor costs and to increase profits, the hospital industry deliberately refuses to staff our nation's hospitals with enough nurses to care for patients safely and optimally, harming both nurses and patients in the process. Even before Covid-19, the hospital industry had driven nurses away from direct nursing care at the bedside by adopting policies that result in high patient caseloads and unsafe working conditions, such as the intentional understaffing of units. Understaffing, a deliberate practice in which hospital management does not schedule an adequate number of nurses to safely care for patients in a hospital unit, is driven by a desire to increase hospital profits. Employers do not maintain a robust pool of nurses from which they can increase staffing when patient loads increase, hospitals repeatedly cancel or "call-off" nurses who are scheduled to work and are slow to fill permanent RN positions.

Unsafe staffing levels and poor working conditions make it impossible for nurses to meet their ethical and professional obligations as RNs to provide safe, effective, and therapeutic nursing care. Studies have shown that adequate staffing levels through RN-to-patient ratios result in better patient outcomes, and health and safety programs not only protect workers, but improve the health and safety of patients as well. Further, hospital employers consistently fail to protect nurses from health and safety dangers in the hospital including infectious diseases, workplace violence, and musculoskeletal injury.

Additionally, the hospital industry devalues RNs' professional practice and restricts their autonomy in myriad ways. Most notably, the industry focus on patient satisfaction scores and the routinization that breaks holistic nursing care into discrete tasks have been particularly troublesome for nurses. Both trends are driven by the industry goal of maximizing net revenue and restricts the autonomy nurses have to use their knowledge and experience to care for their patients.

Employers' disregard for and mistreatment of nurses has increased during the pandemic. However, throughout the pandemic, there has been a jarring contradiction between the saccharine and excessive celebration of nurses as heroes for risking their and their families' lives and the utter disregard of nurse safety by the hospital industry. The disposability of nurses during the pandemic can be plainly observed as hospital employers refuse to provide necessary optimal personal protective equipment, mandate endless shifts, refuse sick or quarantine leave and pay, refuse employees Covid-19 tests, demand nurses work even if they have been exposed to Covid-19, and discipline nurses who speak out about unsafe conditions for workers and their patients.[6]

For hospital employers, the Covid-19 pandemic has become the ready excuse to waive their legal duties as employers to protect nurses and other workers who provide essential, life-sustaining labor, and their duty to provide optimal, therapeutic care to their patients. Registered nurses are a critical

[5] National Advisory Council for Nurse Education and Practice. "Achieving Health Equity through Nursing Workforce Diversity." U.S. Department of Health and Human Services (2013). Accessed May 11, 2022. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/nursing/reports/2013-eleventhreport.pdf.

[6] National Nurses United. "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity." National Nurses United (Dec. 2020). Accessed May 10, 2022. https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

public health resource. The pandemic should be a reason to provide them more, not an excuse to provide them less.

In sum, hospital employers' utter disregard for the lives of nurses, their patients, their families, and their professional autonomy during the pandemic has resulted in both a physical and psychological toll on nurses. The failure by hospital employers to staff appropriately and provide the resources needed to provide safe, therapeutic patient care has caused nurses to experience severe moral distress and injury (often incorrectly labeled "burnout"); mental health issues such as stress, anxiety, depression, and post-traumatic stress disorder; and physical exhaustion. As a result, many nurses are leaving the bedside. If hospitals protected nurses with safe working conditions and safe staffing rather than pushing nurses to do more with less, we could keep better retain practicing nurses and bring nurses back to the bedside.

Medicare for All Removes Profit-Driven Insurers from Health Care

The increased corporatization of health care and the continued devaluation of nursing labor can only be addressed by removing the profit motive from health care. Under Medicare for All, we will transform our profit-driven health insurance system into a health care system that prioritizes patient care and, by extension, the nursing profession. Medicare for All would end the fundamental inequality that all systems of private health insurance, as structures organized to maximize corporate profits, are built on.

In a Medicare for All system, no patient will go without necessary and lifesaving preventive care because they can't afford it. Patients will never have to ration their medication. Doctors and nurses will be able to provide care based on their best professional judgment without insurance company interference. We must realign our health care system to meet the needs of patients rather than the aims of the health care industry's bottom line; doing so will improve the working conditions of nurses. Valuing the labor and lives of nurses will increase the number of RNs who choose to remain at the bedside and the number of people who choose to enter the profession.

The Medicare for All Act of 2022 importantly includes explicit provisions to ensure that hospitals and other health care facilities have the funding necessary for safe nurse-to-patient staffing ratios, for optimal staffing levels for physicians and other health care workers, for pandemic preparedness costs, for safe patient handling, and for other occupational health and safety programs.[7] In other words, Medicare for All would curtail health care employers' ability to divert revenue from investments in their caregiving workforce and protecting worker health and safety. Through targeted funding, health care employers would be held accountable for both safe patient care and occupational health and safety. Under the Act, the Office of Health Equity would also be established, which would be responsible for both tracking barriers to health care access resulting from the lack of health care professional staffing and recruitment and would be responsible for implementing policies to address such staffing inequities in our health care system.[8]

Additionally, to end the nurse staffing crisis and to bring nurses back to the bedside, Congress must adopt federal policies that value the vital work of direct patient care RNs and that ensure employers meet their legal obligations to provide safe and healthy workplaces, such as safe staffing standards, optimal workplace safety protections, fair wages, and robust union rights — including conditioning future pandemic relief funding for the hospital industry on implementing nurse retention

[7] Medicare for All Act of 2022 §§ 611(b)(2)(D), 611(d)(1)(A), 611(d)(1)(G).
[8] Medicare for All Act of 2022 § 615.

measures. This unprecedented crisis of the Covid-19 pandemic provides us the opportunity to fight for the protections, pay, and dignity that nurses deserve as well as guaranteed health care for all.

Medicare for All Act of 2022:
Covid-19, Future Pandemics & Medicare for All

As of May 11, 2022, the United States is verging on 1 million confirmed deaths from Covid-19. The Covid-19 pandemic demonstrated just how harmful our profit-driven health care system can be for both patients and our health care workforce. The unfathomably high death, hospitalization, and infection rates during this pandemic were enabled and worsened by a health care system that is fragmented by profit-seeking insurers and that denies care to millions of patients. Although many have become numb to the impact of the Covid-19 pandemic, people continue to be infected, hospitalized, and, in some cases, to die.

The pandemic is a tragedy of avoidable exposures and deaths caused by a lack of preparedness, inadequate hospital capacity and supplies, and uncoordinated, uneven availability of tests, contact tracing, vaccines, treatments, and personal protective equipment (PPE). It also deepened racial and socioeconomic health inequities that have existed for decades, inequities that Black, Indigenous, Latinx, and other communities of color, working class communities, and other underserved communities have experienced for generations and continue to experience daily.

The pandemic is also a tale of utter indifference by employers, particularly health industry employers, and our public health agencies to the health and safety of nurses, doctors, other health care workers, and essential workers who have been risking their lives to keep everyone else safe. Nurses did not have the protections they needed in the pandemic because our profit-driven health care system values profit more than the lives of its workers.

But not everyone is suffering; many hospital systems and private insurers profited during the pandemic. The hospital industry, despite raking in billions of dollars in federal relief, has continued to knowingly place nurses, doctors, and other health care workers at risk of exposure to Covid-19 without adequate protection. The first year of the Covid-19 pandemic, 2020, was the second most profitable year for the hospital industry ever, with a total net income of almost $92 billion in the U.S. alone.[1] The health insurance industry also continued its trend of skyrocketing profits in 2020, taking in $31 billion in net earnings and increasing profit margins by 3.8%, which represented the highest returns in at least decade.[2]

The comprehensive solution to the failures of our profit-driven health care system during the Covid-19 pandemic is to expeditiously implement Medicare for All. The Covid-19 pandemic gave clear reason for lawmakers to act decisively and with all due urgency to transform our fragmented system of health insurance into a single, government-run insurance system that priorities equitable provision of patient care under a single standard of high-quality care.

The Pandemic Exposes the Fractures in Our Multi-Payer System of Insurance

Millions of families in the United States who were uninsured or underinsured during the past two years of the pandemic delayed or skipped care, both Covid-19 and non-Covid-19 care, because of costs. But foregoing treatment for Covid-19 harms everyone as the virus continues to spread, prolonging

[1] *See* American Hospital Association. "AHA Hospital Statistics Database." *AHA Data & Insights* (Updated 2022). Accessed May 9, 2022. https://www.ahadata.com/aha-hospital-statistics.

[2] American Hospital Association. "NAIC 2020 Health Insurance Industry Analysis Report." National Association of Insurance Commissioners (2021). Accessed May 9, 2022. https://content.naic.org/sites/default/files/inline-files/2020-Annual-Health-Insurance-Industry-Analysis-Report.pdf.

the pandemic and increasing morbidity and mortality. Moreover, because families in the United States have long struggled to afford and access high-quality health care, far too many people in the country have chronic and underlying health conditions which have made them more susceptible to severe Covid-19 illness, hospitalization, and death.

In 2020, during the beginning of the Covid-19 pandemic, one poll found that 68% of adults said that out-of-pocket costs related to treatment would be a factor in their decision on whether to seek treatment for Covid-19.[3] Almost two years later in December 2021, another survey by the Kaiser Family Foundation reported that half of adults in the United States said they delayed or skipped health care or dental care in the past year because of costs, with larger percentages reported by Black, Latinx, or low-income adults.[4] Three in ten (29%) adults reported not taking their medicines as prescribed at some point in the past year because of the cost, nearly half (46%) of insured adults reported difficulty affording their out-of-pocket costs, and one in four (27%) insured adults reported difficulty affording their deductible.

The economic squeeze of the pandemic also fell squarely on working people, particularly working people of color, and resulted in disproportionate losses of job-based health insurance coverage. The Commonwealth Fund estimated that about 14.6 million people lost some or all of their health insurance coverage between February and June 2020 alone.[5] They found that 7.7 million workers lost jobs that provided employer-sponsored insurance, with an additional 6.9 million dependents covered by these employer-sponsored plans. Moreover, the loss of employer-based coverage disproportionately impacted families of color. For example, even accounting for pre-pandemic disparities, Black adults were more likely to experience losses of income or job loss in the first year of the pandemic[6] and, thus, were more likely to be pushed through the enormous gaps of our employer-sponsored health insurance system.

The Pandemic's Disproportionate Impact on Black, Indigenous, People of Color (BIPOC) and Working Families

Covid-19 has forced the United States to finally acknowledge the enduring, destructive, and deadly economic and racial gaps in our health care system and in our society. As SARS-CoV-2 spread across the globe, health care disparities in the United States were exacerbated by our fractured health care system in which different health care providers, health care corporations, and public health care programs do not coordinate with each other. Without universal publicly run health care coverage, there was a failure of strategic planning and preparedness to respond to the pandemic in communities, particularly BIPOC communities and other communities that faced health care disparities before the pandemic.

Although these health and health care disparities have been evident for decades, the racial and ethnic disparities in exposure, severe illness, and death from Covid-19 pandemic brought renewed and widespread attention to the issue. The Centers for Disease Control and Prevention (CDC) found large

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[3] Collins, S. et al. "What are Americans' views on the Coronavirus pandemic? NBC News/Commonwealth Fund Health Care Poll." Commonwealth Fund (March 20, 2020). Accessed May 9, 2022. https://www.commonwealthfund.org/publications/surveys/2020/mar/what-are-americans-views-coronavirus-pandemic.

[4] Kearney, A. et al. "Americans' Challenges with Health Care Costs." Kaiser Family Foundation (Dec. 2021). Accessed May 9, 2022. https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/.

[5] Fronstin, P., Woodbury, S. "How many Americans have lost jobs with employer health coverage during the pandemic?" Commonwealth Fund, Issue Briefs (Oct. 2020). Accessed May 9, 2022. https://www.commonwealthfund.org/publications/issue-briefs/2020/oct/how-many-lost-jobs-employer-coverage-pandemic.

[6] Monte, L., Perez-Lopez, D. "Covid-19 Pandemic Hit Black Households Harder Than White Household Event When Pre-Pandemic Socio-Economic Disparities are Taken into Account." U.S. Census Bureau (Jul. 2021). Accessed May 9, 2022. https://www.census.gov/library/stories/2021/07/how-pandemic-affected-black-and-white-households.html.

disparities in age-adjusted risk of infection, hospitalization, and death for American Indian and Alaska Native (AI/AN), Black, and Latinx people compared to white people.[7] As shown in the chart below, AI/IN people had the largest disparity in cases, hospitalizations, and deaths with Black and Latinx people also having large disparities compared to white people.

Table 1. Selected Statistics Adapted from CDC Covid-19 Age-Adjusted Data (April 2022)[8]

Rate ratios compared to white, non-Hispanic persons	American Indian or Alaska Native, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latinx persons
Cases	1.6x	1.1x	1.5x
Hospitalization	3.1x	2.4x	2.3x
Death	2.1x	1.7x	1.8x

Existing disparities in health for BIPOC communities, reduced access to health care during the pandemic, and greater occupational exposure to the virus all played key roles in the racial and ethnic disparities in Covid-19 infections, hospitalizations, and deaths.[9] BIPOC communities are on average less likely to have health insurance, less likely to see a doctor regularly, and less likely to receive preventive care.[10] Many BIPOC adults were likely to be essential workers exposing themselves day in and day out during the past year. During the pandemic, Latinx, Black, Native American, and Pacific Islander men were the most likely male workers to have frontline occupations, and Vietnamese, Latinx, and Filipinx women were the most likely female workers to hold frontline occupations.[11]

As a result of the long-standing structural racism of our health care system, BIPOC communities were more vulnerable to the devastation of both the virus itself and the economic impact of the pandemic.

Covid-19's Impact on Nurses and Other Health Care Workers

The science of aerosol transmissible disease and occupational safety and health have long taught us how to prevent exposure to airborne diseases, like Covid-19, at work but health care workers have experienced high rates of exposure, infection, and death from Covid-19. Workplace risks of exposure, infection, and death from Covid-19 were unnecessary and preventable. While no national government agency tracks health care worker infections and deaths from Covid-19, as of April 19, 2022, National Nurses United (NNU) has recorded nearly one and a half million health care worker cases and the deaths of at least 5,104 health care workers from Covid-19, with at least 492 deaths of registered nurses

[7] "Hospitalization and Death by Race/Ethnicity." Centers for Disease Control and Prevention (Updated Apr. 29, 2022). Accessed May 9, 2022. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html..

[8] *See ibid*.

[9] *Ibid*. Note that studies have shown that racism directly worsens physical and mental health, rather than only affecting health status indirectly. *See* Singh M. "'Long overdue': lawmakers declare racism a public health emergency." *Guardian* (Jun. 12, 2020). Accessed May 9, 2022. https://www.theguardian.com/society/2020/jun/12/racism-public-health-black-brown-coronavirus.

[10] Ariga, S., Hill, L., Orgera K. "Health Coverage by Race and Ethnicity, 2010-2019." Kaiser Family Foundation (Jul 2021). Accessed May 9, 2022. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/

[11] Goldman, N. et al. "Racial and ethnic differentials in COVID-19-related job exposures by occupational standing in the US." *PLoS One*, 16(9): E0256085 (Sept. 2021). Accessed May 9, 2022. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8409606/.

from Covid-19 in the United States.[12] This is undoubtedly an undercount of health care worker infections and deaths.

Like the impact of Covid-19 overall in the U.S., there have been racial and ethnic disparities in the impacts of Covid-19 for health care workers of color. A recent *Kaiser Health News* and *Guardian* report found that two-thirds of the 3,600 health care worker deaths they were able to identify were health care workers of color.[13] When NNU looked at registered nurse (RN) deaths, we found a disproportionate impact in the deaths of RNs of color. Nearly half of the nurses who have died of Covid-19 were nurses of color, who represent about 24% of the RN workforce. More than 17% of registered nurses who have died from Covid-19 were Black although Black nurses only make up 12% of nurses. And nearly one-quarter of all registered nurses who have died from covid were of Philippine descent, despite making up only 4% of RNs in the U.S.[14]

Health Care Industry "Just-in-Time" Resourcing Results in Lack of Workplace Protections

The hospital industry's "just-in-time" supply and personnel model, which tightly manages inventory and staffing based on short-term financial returns rather than long-term investments and preparedness, has been disastrous during the Covid-19 pandemic.[15] Although infectious disease surges are unpredictable, they are inevitable. Hospitals should have been better prepared, given the initial outbreak in China in late 2019. Yet because employers prioritized profits over preparedness, RNs were forced to choose between staying on the job and caring for their patients, who are also at risk of infection from nurses' lack of PPE,[16] or staying home to protect themselves and their families.

The horror stories from health care workers about the failures of their employers to protect them and their patients were numerous throughout the pandemic. Nurses were forced to go without or to wear PPE manufactured for a single use for days on end. Some nurses were forced to use garbage bags when their employer ran out of surgical gowns.[17] Those who did have access to PPE in the pandemic's early stages generally had to fight for it. Although PPE was a key issue for nurses, it was far from the only issue. Employers also failed to screen and test patients for Covid-19,[18] to notify nurses of a

[12] As tracked by National Nurses United using the methodology outlined in "Sins of Omission: How Government Failures to Track Covid-19 Data Have Led to More Than 3,200 Health Care Worker Deaths and Jeopardize Public Health." National Nurses United (Updated Mar 2021). Accessed May 9, 2022. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0321_Covid19_SinsOfOmission_Data_Report.pdf.

[13] "Lost on the Frontline: Thousands of US healthcare workers have died fighting Covid-19. We count them and investigate why." *Kaiser Health News / The Guardian* (Apr. 2021). Accessed May 9, 2022. https://www.theguardian.com/us-news/ng-interactive/2020/dec/22/lost-on-the-frontline-our-findings-to-date.

[14] National Nurses United. "Sins of Omission: How Government Failures to Track Covid-19 Data Have Led to More Than 3,200 Health Care Worker Deaths and Jeopardize Public Health." National Nurses United (Updated Mar 2021). Accessed May 9, 2022. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/0321_Covid19_SinsOfOmission_Data_Report.pdf.

[15] *See* National Nurses United. "Protecting Our Front Line: Ending the Shortage of Good Nursing Jobs and the Industry-Created Staffing Crisis." National Nurses United (Dec. 2021). Accessed May 9, 2022. https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_StaffingCrisis_ProtectingOurFrontLine_Report_FINAL.pdf.

O'Leary, L. "The Modern Supply Chain is Snapping." *The Atlantic* (Mar. 19, 2020). Accessed May 9, 2022. https://www.theatlantic.com/ideas/archive/2020/03/supply-chainsand-coronavirus/608329/.

[16] Jewett, C. "Patients Went into the Hospital for Care. After Testing Positive There for Covid, Some Never Came Out." *Kaiser Health News* (Nov. 4, 2021). Accessed May 9, 2022. https://khn.org/news/article/hospital-acquired-covid-nosocomial-cases-data-analysis/.

[17] *See*, e.g., Sanchez, T. "Coronavirus: Nurses are Wearing Trash Bags at One Bay Area Hospital Facing a Protective Equipment Shortage." *San Francisco Chronicle* (Apr. 2, 2020). Accessed May 9, 2022. https://www.sfchronicle.com/bayarea/article/Coronavirus-Nurses-are-wearing-trash-bagsat-one-15172777.php.

[18] Jewett, C. "Patients Went into the Hospital for Care. After Testing Positive There for Covid, Some Never Came Out." *Kaiser Health News* (Nov. 4, 2021). Accessed May 9, 2022. https://khn.org/news/article/hospital-acquired-covid-nosocomial-cases-data-analysis/.

Covid-19 exposure,[19] and to provide testing and sick leave while awaiting test results. This is not an exhaustive list of their failings.

As of April 2022, National Nurses United has conducted seven surveys of RNs over the course of the pandemic. We have continuously found that hospital employers fail to prepare for Covid-19 surges and fail to invest the resources necessary to protect nurses and other health care workers from the significant risk of Covid-19.[20] Even two years into the pandemic, National Nurses United's latest survey of RNs, published in April 2022, found that health care employers are still not protecting RNs on the job from Covid-19. Our survey found:

- Only 71.8 percent of hospital RNs reported wearing a respirator for every Covid-positive patient encounter.
- 62 percent of hospital RNs reported having to reuse single-use PPE.
- Only 32 percent of hospital RNs reported that their employer has sufficient PPE stock to protect staff from a rapid Covid surge.
- Less than a quarter (24 percent) of hospital RNs reported that their employer notifies them of Covid-19 exposures in a timely manner.
- 17.8 percent of RNs report that access to testing has declined since the beginning of the pandemic.
- Only 24 percent of hospital RNs reported that their employer has an overflow plan to place additional, trained staff to safely care for Covid patients in isolation.[21]

Intentional Understaffing and Lack of Resources Leads to Moral Injury, Moral Distress, and Emotional Exhaustion for RNs and Other Health Care Workers

With the onset of the pandemic, the hospital industry compounded the issues discussed above by its flagrant refusal to protect nurses from exposure and infection from Covid-19, treating RNs as disposable. Nurses caring for Covid patients experience both high rates of infections and deaths and high rates of acute stress, anxiety, depression, and post-traumatic stress as well as moral distress and moral injury, causing them to leave the bedside at high rates. NNU describes in more detail nurse experiences on the pandemic's front lines, the failures of health care employers to protect nurses and our patients, and the impact on nurses in our report, "Deadly Shame: Redressing the Devaluation of

[19] Gold, J., Hawryluk, M. "Hospital Workers Complain of Minimal Disclosure After COVID Exposures." *Kaiser Health News / The Guardian* (May 13, 2020). Accessed May 9, 2022. https://khn.org/news/hospital-workers-complain-of-minimal-disclosure-after-covid-exposures/.

[20] *See, e.g.*, National Nurses United. "New survey of nurses provides frontline proof of widespread employer, government disregard for nurse and patient safety, mainly through lack of optimal PPE." National Nurses United (May 2020). Accessed May 9, 2022. https://www.nationalnursesunited.org/press/new-survey-results.

National Nurses United. "National nurse survey exposes hospitals' knowing failure to prepare for a Covid-19 surge during flu season." National Nurses United (Nov. 2020). Accessed May 9, 2022. https://www.nationalnursesunited.org/press/national-nurse-survey-4-exposes-hospitals-knowing-failure-prepare-covid-19-surge.

National Nurses United. "National nurse survey reveals that health care employers need to do more to comply with OSHA emergency temporary standard." National Nurses United (Sept. 2021). Accessed May 9, 2022. https://www.nationalnursesunited.org/press/national-nurse-survey-reveals-health-care-employers-need-to-do-more-to-protect-workers.

[21] National Nurses United. "National nurse survey reveals significant increases in unsafe staffing, workplace violence, and moral distress." National Nurses United (Apr. 2022). Accessed May 9, 2022. https://www.nationalnursesunited.org/press/survey-reveals-increases-in-unsafe-staffing-workplace-violence-moral-distress.

Registered Nurse Labor Through Pandemic Equity."[22]

During the pandemic, nurses have experienced high levels of distress due to fears of contracting Covid-19 or infecting their family members. Nurses have also experienced moral distress because crisis standards of care implemented by their employers prevent them from providing optimal patient care. For example, throughout the pandemic, employer policies of PPE rationing have led to care rationing, forcing nurses to provide care in unsafe practice conditions in conflict with their professional obligations to provide safe, therapeutic care to their patients.

Key findings from NNU's most recent survey of RNs demonstrate how the impact of the pandemic and employers' failures to protect nurses are long-lasting beyond the physical toll of Covid-19 infection, hospitalization, and death. From NNU's February and March 2022 survey results, RNs reported the following:

- 66.8 percent of hospital RNs fear they will contract Covid-19.
- Nearly three-quarters (74.6 percent) are afraid they will infect a family member.
- Nearly 60 percent (58.4 percent) are having more difficulty sleeping.
- 83.5 percent feel stressed more often than before the pandemic.
- 77.2 percent feel anxious more often than they did before the pandemic.
- 68.7 percent feel sad or depressed more often than they did before the pandemic.
- More than half (56 percent) feel traumatized by their experiences caring for patients.
- 23 percent sought treatment for a mental health condition related to caring for patients during the pandemic.[23]

Medicare for All is the Solution to Pandemic Readiness and the Future of Public Health

The Covid-19 pandemic provided a clear reason for Congress to act decisively and expediently to end our fragmented system of profit-driven health insurance and implement Medicare for All. With Medicare for All, hospitals and our health care system would have been better prepared to respond to Covid-19 with adequate beds, equipment, and staffing levels needed to respond to the pandemic, and our health care system would have been better coordinated to respond to outbreaks more effectively and to stop them from happening in the first place. As a coordinator of pandemic response, the Medicare for All program also could have been the centralized purchaser of PPE and other supplies rather than having hospitals, counties, and states bid against each other for supplies, driving up costs.

Importantly, Medicare for All would address underlying disparities in health and health access, which greatly contributed to the disparate racial, ethnic, and other impacts of the pandemic. By ensuring health care funding and resources are equitably distributed across the country, historically underfunded safety-net providers would be fully resourced in every community, ultimately reducing and managing chronic conditions that left people more susceptible to Covid-19.

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[22] National Nurses United. "Deadly Shame: Redressing the Devaluation of Registered Nurse Labor Through Pandemic Equity." National Nurses United (Dec. 2020). Accessed May 9, 2022. https://www.nationalnursesunited.org/sites/default/files/nnu/graphics/documents/1220_Covid19_DeadlyShame_PandemicEquity_WhitePaper_FINAL.pdf.

[23] National Nurses United. "National nurse survey reveals significant increases in unsafe staffing, workplace violence, and moral distress." National Nurses United (Apr. 2022). Accessed May 9, 2022. https://www.nationalnursesunited.org/press/survey-reveals-increases-in-unsafe-staffing-workplace-violence-moral-distress.

The Medicare for All Act of 2022 also includes several provisions that are relevant to pandemic readiness and infectious disease response.

Pandemic Preparedness Funding in National Health Budget

The bill requires the Secretary of Health and Human Services to "establish and maintain a reserve fund to respond to the costs of treating an epidemic, pandemic, natural disaster, or other such health emergency" within the national health budget.[24] With Medicare for All, the country would also have more equitably addressed the pandemic and avoided the disproportionate deaths and infections in Native American, Black, and Latinx communities because health care would be accessible to all without financial barriers to care.

PPE Stockpile and Pandemic Preparedness Funding in Hospital Global Budgets

With Medicare for All, our hospitals and health care facilities would have been better prepared to respond to Covid-19 with sufficient nurses, doctors, respiratory therapists, and other staff as well as beds, equipment, and medical supplies. Global budget payments to hospitals and other institutional providers include several provisions related to pandemic preparedness, including funding for "[c]osts for infectious disease response preparedness, including maintenance of a 1-year […] stockpile of personal protective equipment, occupational testing and surveillance, medical services for occupational infectious disease exposure, and contact tracing."[25]

Under Medicare for All, hospitals and other health care facilities would have had reliable funding for supplies and equipment needed to respond to the pandemic. Nurses and other health care workers would not have unnecessarily become infected, been hospitalized, and died from Covid-19 because health care employers failed to provide necessary PPE and other precautions that would have kept them and their patients safe.

Funding for Emergent or Unexpected Infectious Disease Outbreaks

Finally, under Medicare for All, we could have more effectively targeted funding for emergent Covid-19 outbreaks and inequities in pandemic response. The bill includes funding for hospitals in the global budgets provision for costs related to infectious disease outbreaks.[26] The bill also allows hospitals and other health care facilities to request interim funding and additional funding in upcoming budgets, ensuring the Medicare for All program can effectively and quickly direct emergency funds to hospitals based on need due to in community outbreaks.

[24] Medicare for All of 2022 § 601(a)(5).
[25] Medicare for All of 2022 § 611(d)(1)(D)
[26] Medicare for All of 2022 § 611(a)(4)(A)(ii) and Sec. 611(b)(2)(G).

Medicare for All Act of 2022: Program Design

How would the government administer a single-payer health plan?

- **Federal Governance.** The Secretary of the U.S. Department of Health and Human Services (Secretary) would oversee the Medicare for All Program (Program) at the federal level and would be responsible for developing policies, procedures, and regulations to carry it out. In so doing, the Secretary would consult with a broad range of entities including federal agencies, professional organizations, and labor unions. Program accountability measures include requiring the Secretary to provide annual reports to Congress and audits by the U.S. Comptroller General every 5 years.[27]
- **Regional Administration.** The Secretary would establish regional offices and appoint regional directors as well as deputy directors to represent Native American and Alaska Native tribes in each region. The Secretary would incorporate the existing offices of the Centers for Medicare & Medicaid Services (CMS) where possible. The regional directors would be responsible for performing health care needs assessments, recommending changes in provider payments, and establishing quality assurance mechanisms in their respective regions. Finally, the Secretary would appoint a beneficiary ombudsman to receive complaints and grievances and provide assistance to individuals entitled to Program benefits.[28]

Who would be eligible for the plan, and how would people enroll?

- **Four-year eligibility phase-in.** The Program has a four-year transition period. In the first year, persons under the age of 19 and over the age of 55 would be eligible for Medicare. In the second year, persons over the age of 45 would be eligible for Medicare, and in the third year, persons over the age of 35. In the fourth year, all people living in the United States would be eligible for full benefits under the Medicare for All Program.[29]
- **Enrollment.** The Program would include a mechanism for automatic enrollment at birth and upon immigration into the U.S. or attainment of qualified resident status. Eligible individuals would be able to enroll for benefits and obtain a Medicare card in order to receive services under the Program. The Program could build on the current Medicare enrollment system.[30]

What health care services would the plan cover?

- **Universal benefits.** Current Medicare benefits would be expanded and improved in order to provide comprehensive health care coverage to all Program enrollees.[31]
- **Comprehensive benefits.** The benefits would include all primary and preventive care; hospital and outpatient services; prescription drugs; dental; vision; audiology; women's reproductive health services; maternity and newborn care; long-term services and supports, including home and community based services and supports; pediatrics, including early and periodic screening, diagnostic, and treatment services; prescription drugs; mental health and substance abuse treatment; laboratory and diagnostic services; emergency services; and more.[32]

[27] Medicare for All Act of 2022 §§ 401-404.
[28] Medicare for All Act of 2022 §§ 401-404.
[29] Medicare for All Act of 2022 §§ 106, 1002.
[30] Medicare for All Act of 2022 § 105.
[31] Medicare for All Act of 2022 §§ 201, 204.
[32] Medicare for All Act of 2022 §§ 201, 204.

What cost sharing, if any, would the plan require?

The plan prohibits cost sharing for all covered benefits. No premiums, deductibles, coinsurance, copayments, or balance billing are allowed except for high- and middle-income families some cost-sharing for prescription drugs may be permitted but capped at $200 per year.[33]

What role would private health insurance have?

The bill allows private health insurance coverage only for benefits that are not covered under the Program but prohibits private health insurance coverage for covered benefits. Because the Program provides comprehensive benefits and coverage, private health insurance is expected to have only a small role (e.g., non-medically necessary care or for international tourists).[34]

What role would other public programs have?

After the four-year transition period, all those receiving health care coverage through Medicare, Medicaid, the State Children's Health Insurance Program, or health marketplaces established under the Patient Protection and Affordable Care Act would be covered by the Medicare for All Program. These programs would sunset. School-related health programs and existing medical benefits or services under the Department of Veteran Affairs and the Indian Health Service would be maintained, though veterans and Native Americans would also be entitled to full Program benefits.[35]

What rules would participating providers be required to follow?

To become a participating provider under the Program, the provider must be eligible to participate and must enter into a participation agreement with the Secretary which includes, as described below, disclosure requirements and other checks on provider participation.[36]

- **Provider qualifications.** Providers are qualified to participate in the Program if they have the requisite license from the state in which they practice and meet minimum provider standards adopted by the Program, including adequate facilities, safe staffing, and patient access. Providers are only eligible to be participating providers for care that they provide directly to individuals.[37]
- **Private contracting limitations.** Participating providers are prohibited from entering into private contracts for covered services with individuals eligible for Program benefits. Any provider that furnishes covered services through a private contract will be ineligible to participate in the Program for one year. Participating providers may enter into private contracts with individuals who are ineligible to enroll in the Program and may enter into contracts with any individual for noncovered services. Disclosure requirements are established for private contracts.[38]
- **Prohibitions on discrimination.** Providers are prohibited from denying benefits, reducing benefits, or otherwise discriminating against patients based on race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions including termination of pregnancy.[39]

[33] Medicare for All Act of 2022 § 202.
[34] Medicare for All Act of 2022 § 107.
[35] Medicare for All Act of 2022 §§ 901, 902.
[36] Medicare for All Act of 2022 § 301.
[37] Medicare for All Act of 2022 § 302.
[38] Medicare for All Act of 2022 § 303.
[39] Medicare for All Act of 2022 §§ 104, 301(b).

- **Prohibition on balance billing.** Participating providers are prohibited from balance billing or otherwise charging a Program enrollee for any covered benefit.[40]
- **Data reporting requirements.** Participating providers are required to furnish information necessary for establishing reimbursements, quality review, and other data reporting, including current data reported under Medicare or state programs, data on costs, quality, outcomes, health equity, and financial data.[41]
- **Application of existing anti-fraud and abuse statutes.** The bill applies existing Medicare and Medicaid measures against provider fraud and abuse to the Program, including prohibitions on self-referrals.[42]
- **Prohibited uses of reimbursements**. To ensure that provider reimbursements are used for the provision of benefits under the Program, the bill prohibits program funds from being used for compensation for any institutional provider employee, contractor, or subcontractor above existing compensation caps established for federal contractors under the Bipartisan Budget Act of 2013.[43]

Who would own the hospitals and employ the providers?

Hospital ownership and provider employment would be unchanged. Thus, most of the health care delivery system would remain in the private sector.

How would a single-payer system pay providers and set payment rates?

- **National Health Budget.** The Secretary would establish a national health budget that would be allocated regionally. Regional allocations would include payments for the region's providers, capital expenditures, special projects, health professional education, administrative expenses, and prevention and public health activities.
- **Institutional Providers & Global Budgeting.** Institutional providers — including hospitals, skilled nursing facilities, and independent dialysis facilities — would negotiate an annual lump sum global operating budget with the regional director which would be paid on a quarterly basis.[44] The global operating budget would be based on:
  - the historical volume of services in the previous 3-year period and provider capacity,
  - the actual expenditures as compared to other providers within the region and normative payment rates to be established,
  - projected changes in volume and type of items and services to be furnished,
  - employee wages,
  - education and prevention programs, and
  - other relevant factors and adjustments.

  Each regional director would review institutional providers' performance on a quarterly basis and determine whether adjustments to the budget are needed, including additional funding needed for unanticipated care for individuals with complex medical needs or for changes in the market.

  Providers would be able to request at any time interim adjustments of their global budget allocation if the provider incurs unanticipated costs or costs out of their control, including natural disasters, outbreaks of epidemics or infectious diseases; unexpected facility or equipment repairs or

[40] Medicare for All Act of 2022 § 202(b), 301(b).
[41] Medicare for All Act of 2022 §§ 301(b), 401(b)(1).
[42] Medicare for All Act of 2022 § 411.
[43] Medicare for All Act of 2022 § 611(b)(4).
[44] Medicare for All Act of 2022 §§ 611-615.

purchases; significant and unexpected increases in pharmaceutical or medical device prices; and unanticipated increases in complex or high-cost patients or care needs. Interim adjustments to provider global budgets would also be made for any reasonable increases in labor costs, including changes in collective bargaining agreements, prevailing wages, or local law.

- **Individual Providers & Group Practices.**[45]
  - **Fee Schedule.** Individual providers, including those in medical group practices, would be paid on a fee-for-service basis using a national fee schedule established by the Secretary. The fee schedule would consider the prevailing rates under Medicare, provider expertise, and the value of the items and services furnished. The bill establishes both a standardized documentation and review process of the relative values of physician services to determine appropriate fee payments and a physician consultation review board to review quality, cost effectiveness, and fair reimbursement of services and items delivered by physicians.
  - **Option for Salaried Payments.** However, as determined by the Secretary, certain group practices and other health care providers with agreements to provide health care services at a specific institutional provider may choose to be paid a salary through such institutional provider's global budget instead of on a fee-for-service basis
- **Addressing Health Inequities and Disparities.**[46]
  - **Office of Health Equity.** The Office of Health Equity would be established within the Department of Health and Human Services to improve services in medically underserved areas and to address health disparities based on race, ethnicity, geography, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length of stay in the U.S., age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, or other socioeconomic status.

    The Director of the Office of Health Equity would develop, coordinate, and promote policies to enhance health equity, including ensuring adequate public funding to address health disparities at the local and State levels and recommending training on cultural competency, increases in the diversity of the health care workforce, and programs to ensure sufficient levels of health care professionals and facilities to address health disparities.
  - **Office of Primary Care.** The Office of Primary Care would be established within the Office of Health Equity to increase access to high-quality primary health care, particularly in medically underserved areas and for underserved populations, and to address health disparities with respect to race, ethnicity, national origin, primary language use, English proficiency status, length of stay in the U.S., age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, or other socioeconomic status.

    The Director of the Office of Primary Care would develop, coordinate, and promote policies on health professional education and training to address primary care health disparities; to increase primary health care practitioners, registered nurses, mid-level practitioners, and dentists; to recommend programs targeted towards Federally Qualified Health Centers, rural health centers, community health centers, and other community-based organizations; and on other programs to address primary care health inequities.

[45] Medicare for All Act of 2022 §§ 611-615.
[46] Medicare for All Act of 2022 §§ 615-616.

How would the single-payer system purchase prescription drugs?

The Secretary would negotiate prices for prescription drugs and establish a formulary system that encourages the use of generic medications to the greatest extent possible.[47]

How would a single-payer system contain health care costs?

Studies have shown that Medicare for All would not only contain costs but would also save the country up to $5.1 trillion over 10 years.[48] Conservative estimates by the Mercatus Center found that the U.S. would save more than $2 trillion over a ten-year period under Medicare for All.[49] Specifically, the Medicare for All Act of 2022 contains costs and produces savings primarily by reducing administrative costs, negotiating prescription drug and medical device prices, and controlling provider payments.

- **Administrative Costs.** Under our current fragmented, multi-payer system, we spend about 31 percent of total health expenditures on administrative costs. This amounted to an estimated $1.1 trillion in 2017.[50] Implementing a single-payer system with a single, comprehensive benefits plan would create uniformity in claims and billing processing. Insurer costs — such as costs associated with care denial and containment, marketing, profit, and executive compensation — would be eliminated. Health care providers would no longer need large billing departments nor have to spend time to manage numerous insurance cost-sharing schemes, collect unpaid bills from the uninsured and the underinsured, or obtain preauthorization for tests and treatments.
- **Prescription Drug and Medical Device Prices.** The Secretary would wield tremendous bargaining power by negotiating on behalf of the entire U.S. population. This would enable the Secretary to drive down costs for prescription drugs and medical devices.
- **Provider Payments.** As the single-payer, the Medicare for All Program would have the power to regulate provider payments. Payment inequities would also be addressed; some providers would see their reimbursement rates reduced[51] while others who are currently undervalued, such as primary care and mental health care professionals, would see their rates increased.
    - **Institutional providers —** Massive consolidation among private hospitals and other institutional providers, as well as the acquisition of physician practices, have enabled some health systems to charge exorbitant prices, while hospitals in rural and underserved areas close and funding for public hospitals dwindles. Under the Program, large conglomerate health systems would see their bargaining power and their ability to extract exorbitant reimbursement rates diminished, while safety-net hospitals would see reimbursement rates increase and funding stabilize.
    - **Health care professionals —** Rates also may change based on the type of medicine a physician or other health care professional practices. The bill addresses a pay inequity that undervalues the cognitive-based services that primary care physicians provide and overvalues

[47] Medicare for All Act of 2022 § 614.

[48] Pollin, R. et al. "Economic Analysis of Medicare for All." Political Economy Research Institute, University of Massachusetts Amherst (Nov. 2018). Accessed May 9, 2022. https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all .

[49] Blahous, C. "The Costs of a National Single-Payer Healthcare System." Mercatus Working Paper. Mercatus Center, George Mason University: Arlington, VA (Jul. 2018). Accessed May 9, 2022. https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

[50] Woolhandler, S., Himmelstein, D. "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs." *Ann. Intern. Med.* (2017) 166(8): 587-588. According to the Centers for Medicare and Medicaid Services, national health expenditures was $3,492.1 billion in 2017. Centers for Medicare and Medicaid Services. "National Health Expenditure Accounts (2017)." U.S. Department of Health and Human Services. Accessed May 9, 2022. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html.

[51] As discussed above, reductions in reimbursement rates for the currently high-valued providers that may see decreases in rates would be offset by significant administrative and time savings for the provider.

procedure-based services that specialists tend to provide[52] by establishing a review process of the relative values of physician services to review quality, cost effectiveness, and fair reimbursement of services and items delivered by physicians.[53]

How would a single-payer system be financed?

Current U.S. expenditures provide sufficient funding for the Program, but they must be captured in a new way. Amounts equal to federal expenditures for programs that the bill sunsets — including Medicare, Medicaid, the State Children's Health Insurance Program, and the ACA marketplaces — would be deposited annually into a newly established Universal Medicare Trust Fund. These deposits would be adjusted annually for cost savings resulting from implementation of the Program and for changes in the consumer price index. Although the bill does not specify how the balance of the national expenditures would be financed, there are many options. These could include a corporate gross receipts tax, progressive personal income tax, financial transaction tax, and repealing the corporate tax cuts passed in 2017.[54]

[52] Goodson, J. D. "Patient Protection and Affordable Care Act: Promise and Peril for Primary Care." *Ann Intern Med*. (2010), 152(11):742-744.

[53] Medicare for All Act of 2022 §§ 612-613.

[54] Medicare for All Act of 2022 § 701.

Medicare for All Act of 2022: Ensuring Access to Care

The Medicare for All Act of 2022, which would establish the Medicare for All Program (Program) includes key design features to eliminate barriers to care that occur in our current health system and to ensure that new barriers to care are not created.

Ending Wait Times and Rationing Due to Unaffordability.

- Wait times and rationing occur today under our system of private insurance. Health insurers create financial and administrative barriers to care, including cost-sharing, deductibles, prior authorization, and step therapy, to limit the financial risk to corporate returns. As a result, people delay seeking medical care or filling a prescription because they cannot afford it. Even those who have insurance delay care because they cannot afford the copayments, coinsurance, or deductibles.
- Because financial barriers imposed by premiums, deductibles, and cost-sharing would be eliminated under the Medicare for All Program, delays in care because of affordability, which are common in our current private insurance system and public programs, would no longer occur.

Emphasizing Primary Care and Prevention to Reduce Demand for Emergency or Specialist Care.

- Medicare for All emphasizes primary care and prevention rather than waiting to treat illnesses that must be addressed by a specialist or require hospitalization. With increased access to and use of primary and preventive care, people will be more likely to seek care before their health conditions become severe enough to require the high-cost acute, emergency, or specialty care that currently represents half of the country's health care spending.[1]
- The bill would establish an Office of Primary Care that would focus on increasing the supply of primary care providers — for example, by paying for these providers' medical education — as well as evaluating payments to physicians, including primary care physicians. Doctors would be more likely to enter into primary or family care practices if they were not saddled with massive debt for their education and the gap between primary and specialty care reimbursement narrowed.

Creating Reliable Sources of Funding for Hospitals and Strengthening Our Safety-Net Health Care Institutions.

- The Medicare for All Act of 2022's reimbursement and budget structures are designed to create reliable funding streams for hospitals and other institutional providers. Reimbursing hospitals through global budgeting aligns hospital payments with actual costs. Programming under the Office of Primary Care and Office of Health Equity would be targeted to increase staffing and to improve facility capacity in medically underserved and high social vulnerability index areas.
- Medicare for All would ensure that safety-net health care institutions would be sufficiently funded. Through transparent reimbursement negotiations, the Program would ensure that variations in provider prices are no longer exacerbating health and health care inequality. The Program's global budgeting and reimbursement structure is designed to create reliable and stable funding streams for hospitals and other institutional providers. The Office of Primary Care and Office of Health Equity would establish programs to ensure that safety-net hospitals and other providers in rural and urban underserved areas have sufficient resources and staffing to meet demand in their areas.

[1] *See* Agency for Healthcare Research and Quality. "Medical Expenditure Panel Survey, Total expenditures in millions by condition, United States, 2015." U.S. Department of Health and Human Services (2015).

- In the long-term, Medicare for All will more fairly and effectively distribute care across the system, funding and directing health care resources where they are needed most and where health inequities have been identified. The Program could use Office of Primary Care and Office of Health Equity funds to increase staffing and expand provider capacity in rural or underserved areas. Through global budgeting reviews and adjustments, regional directors can increase funding for hospitals with increases in patient care populations or that need resources to respond to new or emerging public health conditions.

Attracting Provider Participation by Capturing Demand in a Single Patient Pool Under Medicare for All.

- Medicare for All strongly encourages providers to participate in Medicare for All by capturing everyone in the pool of patients and by prohibiting private plans with duplicate coverage. In other words, the Program is designed to capture all health care demand (through comprehensive benefits and no cost-sharing). Operating as a nonparticipating provider would not be a suitable option for the vast majority of providers.

Prohibitions on Private Contracting to Prevent Tiered Access to Care.

- As the Congressional Budget Office noted in its 2019 report on single-payer health system design, wait times may result if a single-payer system allows providers to provide private care or simultaneously see patients with substitutive private plans alongside public plan patients.[2] By limiting both substitutive private plans and private contracting, the Medicare for All Act of 2022 avoids these issues and stops providers from offering two tiers of services where individuals can pay to jump the queue ahead of Medicare for All enrollees.
- Medicare for All also prevents providers from creating tiered waiting lines for care by placing strict limits on when a participating provider can see non-Medicare for All patients and by prohibiting participating providers from entering into private contracts for covered services. If a provider furnishes covered services through a private contract, they will be ineligible to participate in the Medicare for All Program for one year.

Increasing Access to Health Care Professionals.

- The Medicare for All Program directs resources into educating new health care professionals to enter into the system by including in the national budget a component for health professional education expenditures to cover costs associated with clinical education of new health care professionals.
- Under Medicare for All, precious time that doctor, nurses, and other health care providers currently spend on billing, coding, and interacting with health plans would be freed up, allowing providers to do more of what they do best — care for patients. Medicare for All would simplify the administrative process for doctors and other providers by having one payer.

[2] Congressional Budget Office. "Key Design Components and Considerations for Establishing a Single-Pager Health Care System." CBO Publications (May 2019), pp. 13, 23.

Medicare for All Act of 2022: Eliminating Health and Health Care Disparities

Despite spending more on health care per capita than any other country in the world,[1] the United States has extreme health and health care disparities, including disparities related to race, ethnicity, income, gender, and location. The Medicare for All Act of 2022 addresses key contributing factors to health and health care disparities, including health care coverage, access to health care providers and facilities, linguistically and culturally competent care, and quality of care.[2]

The Medicare for All Act of 2022 would begin addressing health and health care disparities by providing universal health care coverage and improving health care access. Unlike our current market-driven system, the Medicare for All Act would ensure access to high quality, therapeutic health care for all individuals in every community in the United States, including rural and urban areas that are currently medically underserved. The Medicare for All Act provides comprehensive health care benefits to all without regard to the ability to pay and without premiums, deductibles, copayments, or other out-of-pocket costs.[3] This would remove the financial and administrative barriers to care created by private insurers seeking to extract profit at the cost of our health.

Currently, many Black, Indigenous, and people of color (BIPOC) and low-income communities face outdated and overcrowded hospitals and clinics, hospital closures, and staffing crises for nurses, doctors, psychologists, and other health care professionals. The Medicare for All Act of 2022 would ensure that our safety-net and critical access hospitals, both rural and urban, are sufficiently resourced and staffed so that all communities are able to promote good health and provide therapeutic care for everyone. Moreover, the Medicare for All Act contains provisions, discussed below, to ensure diversity among health care professionals and improve cultural and linguistic competency across the health care workforce.

The sections below lay out the various provisions in the Medicare for All Act of 2022 that address health and health care disparities.

Non-Discrimination in Health Care Services

The Medicare for All Act of 2022 includes robust protections against discrimination by providers and non-discrimination in the provision of benefits, including prohibitions on discrimination based on "race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions[.]"[4]

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[1] Organization for Economic Cooperation and Development. "Health at a Glance 2021." (2021). Accessed May 9, 2022. https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2021_ae3016b9-en.

[2] Ndugga, N., Artiga, S. "Disparities in Health and Health Care: 5 Key Questions and Answers." Kaiser Family foundation (May 11, 2021). Accessed May 9, 2022. https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/.

[3] There is one exception that allows minimal cost-sharing. The Health and Human Services Secretary may impose copayments for non-preventive prescription medications totaling a maximum of $200 annually for individuals with a household income above 200 percent of the poverty line.

[4] Medicare for All Act of 2022 § 104.

Establishment of the Office of Health Equity

Section 615 would create the Office of Health Equity which would oversees monitoring, tracking, and availability of data regarding:

- the disproportionate burden of disease and death among people of color, [5]
- barriers to health,
- barriers to health care access,
- disparities in quality of care received, and
- disparities in utilization of care.

As the Office of Health Equity would "ensure coordination and collaboration across the programs and activities of the Department of Health and Human Services with respect to ensuring health equity[,]" all of these issues can be addressed by the Medicare for All program as well as other health and social service programs within the Department of Health and Human Services (HHS).[6]

The Office of Health Equity would use the data it collects to establish policies to improve health equity. These policies include ensuring that there are sufficient health care providers and facilities, increasing cultural competency and diversity in the health care workforce, and providing the health care workforce training on implicit bias and ethics. Importantly, the Office of Health Equity would ensure that states and localities have sufficient public health funding to address health disparities.

The Medicare for All Act of 2022 would also establish an Office of Primary Health within the Office of Health Equity to focus on increasing "access to high-quality primary health care, particularly in underserved areas and for underserved populations"[7] as a critical step to addressing health disparities. To meet these goals, the Director of the Office of Primary Health would work with the HHS Secretary to develop policies regarding health professional education to increase the number of primary health care providers and to increase resources for health centers in underserved rural and urban areas.

National Health Budget and Funding Provisions

The Medicare for All Act provides a national health budget and funding provisions that would effectuate the policies and goals established by the Office of Health Equity.[8]

General Principles

- Allocated regionally, the national health budget includes funding for quality assessment; operating expenses; public health and prevention activities; health professional education; and capital expenses such as renovating facilities or building new ones or purchasing major equipment. Health and health care disparities would be considered in funding each of these components.
- Funding would be provided based on regional needs as determined by data and other information

[5] Section 615 of the Medicare for All Act of 2022 requires that data be disaggregated by race, major ethnic group, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length of stay in the United States age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status. The data also allows granular analysis across multiple identities categories to differentiate, for example, among various racial, ethnic, and Tribal groups broken down by sex or sexual orientation. Additionally, the bill provides public access to the data, strong privacy protections.

[6] Medicare for All Act of 2022 § 615.

[7] Medicare for All Act of 2022 § 616. Additional information on underserved areas and populations is discussed below.

[8] *See* Medicare for All of 2022 §§ 401, 502, 601.

provided by the Office of Health Equity[9] and state-based health care needs assessment reports created "in consultation with public health officials, clinicians, patients, and patient advocates[.]"[10] Funding allocation also would be based on "[d]ifferences in the health status of the populations of the different States, including income and racial characteristics, and other population health inequities[.]"[11]

- Funding would address ways to improve service to medically underserved areas and populations. Medically underserved areas are geographically defined areas (both rural and urban) with a shortage of primary care services. Medically underserved populations are sub-groups of people living within a geographic area that face cultural or linguistic barriers. Examples of a medically underserved population include people who are unhoused, low-income, Medicaid-eligible, Native American, or migrant farm workers.[12] Medically underserved areas and populations are based on their scores on the Index of Medical Underservice which is calculated based on four criteria: the ratio of providers to the population, the percentage of the population with income below the federal poverty level, the percentage of the population over the age of 65, and the infant mortality rate.[13]

Funding for Institutional Providers' Operating Expenses

- The Medicare for All Act of 2022 pays institutional health care providers such as hospitals and affiliated outpatient facilities, skilled nursing facilities, and dialysis centers through global operating budgets that are paid quarterly in a lump sum to cover employee wages and benefits, medical supplies, overhead, and health professional education but would exclude capital expenses such as renovating facilities or building new ones as well as purchasing major equipment.
- The Medicare for All bill prioritizes addressing health care disparities through the provider payment process. As one factor in determining the global budget payment, the Medicare for All Act includes "whether the provider is located in a high social vulnerability index community, zip code, op census track, or is a minority-service provider[.]"[14] It explicitly allows for adjustments to the lump-sum payments for "efforts to decrease health care disparities in rural or medically underserved areas"[15] (defined above). Payments for medically underserved areas or areas with high social vulnerability could include increased funding to hire more staff; pay compensation differentials to attract and retain health care professionals; extend operating hours; improve patient care, education, and prevention programs; or purchase additional medical supplies.

Funding of Provider Capital Expenses

- Funding for capital expenses to purchase, lease, build, or renovate health care facilities or major equipment would be provided based on regional needs as determined by data provided by the Office

[9] In addition to the data collection requirements under Section 615, Sections 401 and 502 contain detailed reporting requirements on health and health care disparities based on race, ethnicity, gender, geography, and socioeconomic status so that funding can be directed where needed.

[10] Medicare for All Act of 2022 § 403(c)(1).

[11] Medicare for All Act of 2022 § 401(b)(2)(I).

[12] Health Resources and Services Administration. "Medically Underserved Areas and Populations (MUA/Ps)." U.S. Department of Health & Human Services (Last reviewed February 2021). Accessed May 9, 2022. https://bhw.hrsa.gov/shortage-designation/muap.

[13] Health Resources and Services Administration. "Scoring Shortage Designations." U.S. Department of Health & Human Services (Last reviewed December 2020). Accessed May 9, 2022. https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring.

[14] Medicare for All Act of 2022 § 611(b)(2)(H). The CDC's social vulnerability index includes four themes: socioeconomic status, race/ethnicity/language, household composition, and housing/transportation. For more information, see: Centers for Disease Control and Prevention. "What is the CDC/ATSDR Social Vulnerability Index?" U.S. Department of Health & Human Services. (Last reviewed August 30, 2021). Accessed May 9, 2022. https://www.atsdr.cdc.gov/placeandhealth/svi/fact_sheet/fact_sheet.html.

[15] Medicare for All Act of 2022 § 611(b)(2)(G)(ii).

of Health Equity[16] and state-based health care needs assessment reports created "in consultation with public health officials, clinicians, patients, and patient advocates[.]"[17]

- Publicly-funded facilities — such as safety net hospitals and clinics — have been seriously underfunded leaving many BIPOC, low-income, and rural communities with overcrowded facilities or no facilities at all. Under the Medicare for All Act, funding for capital expenses would be allocated based on need — with the express aim of reducing, and ultimately eliminating, health care disparities — rather than on maximizing revenue. This creates a strong foundation for publicly funded health care facilities.
- In contrast, current private funding for renovating or building new health care facilities and purchasing major equipment generally is based on whether, and how quickly, the expense will be recouped based on the revenue it generates. Thus, privately owned or funded organizations, even those that are not-for-profit, typically favor investing in affluent suburban and urban neighborhoods where people have more generous health plans and low numbers of uninsured people.

Funding for Health Professional Education

- The bill requires the HHS Secretary to allocate the budget in a way that "ensures that the health professional education expenditure component is sufficient to provide for the amount of health professional education expenditures sufficient to meet the need for covered health care services."
- Funding could be used to provide scholarships for health professionals, loan repayment in exchange for practicing in medically underserved areas or in areas with underserved populations or a shortage of health care professionals, and other programs.

[16] In addition to the data collection requirements under Section 615, Sections 401 and 502 contain detailed reporting requirements on health and health care disparities based on race, ethnicity, gender, geography, and socioeconomic status so that funding can be directed where needed.

[17] Medicare for All Act of 2022 § 403(c)(1).

Medicare for All Act of 2022:
Global Budgets & Other Provider Reimbursements

Medicare for All: Putting Patient Care Over Pocketbooks
The program outlined in the Medicare for All Act of 2022, takes several steps to ensure that providers can focus on patient care rather than on their pocketbooks.

- **Less Time on Billing, More Time for Patients.** Medicare for All would simplify the administrative process for doctors and other providers by having one payer. Precious time that doctors and other health care providers spend on billing, coding, and dealing with health plans would be freed up, allowing providers to do what they do best — care for patients.
- **Negotiating Lower Prices.** Under the Medicare for All Program, health care corporations would no longer be able to overcharge for their services. By leveraging its buying power as the single-payer for health care, the Medicare for All Program would be able to negotiate better, fairer health care prices for everyone. Reimbursement rates for hospitals and doctors will be based on negotiations with the regional directors. Negotiations over health care prices would include prescription drug price negotiations.
- **Health Care Dollars No Longer Line Pockets.** The Medicare for All Program would bar Medicare for All providers from siphoning off health care dollars to line their pockets. The Medicare for All Act of 2022 does so through limits on executive pay and checks on incentives for both underutilization and overutilization. Importantly, provider reimbursements are structured to address health care disparities and to ensure that reimbursements go towards the provision of care.

Global Budgeting for Hospitals & Other Institutional Providers
Under the Medicare for All Act, each hospital and each institutional provider — including skilled nursing facilities, and independent dialysis facilities — will be paid through an institution-specific "global budget".

- **Negotiated Annually.** Each global budget would be negotiated annually between institutional providers and regional directors. Institutional providers would receive a fixed annual allowance, paid and reviewed quarterly, to fund operating expenses related to furnishing health care to Medicare for All enrollees. Major factors included in negotiations are historical volume and costs of care, projected changes in volume and type of care, and wages for all employees, including physicians that work directly for the hospitals. Capital expenditures for costs such as renovating facilities or building new ones would be funded separately.
- **Interim Adjustments.** At any time, an institutional provider can request adjustment to their global budget to account for unanticipated increases in costs, including natural disasters, emergent epidemic conditions or infectious disease outbreaks, unanticipated facility or equipment repairs, unanticipated increases in pharmaceutical or equipment prices, reasonable increases in labor costs, such as changes to collective bargaining agreements, changes in law, or other emergent conditions.
- **Aligning Hospital Reimbursements with Actual Costs.** Global budgeting simplifies the reimbursement system so that payments more closely reflect the actual costs of providing health care to the population served by each hospital and institutional provider.[18] The global budgeting process would allow the Medicare for All program to ensure that providers get the appropriate funding for the health care services that their patients need — providers would be accountable for their spending and would no longer be able to overcharge.

[18] Dredge, R. *Hospital Global Budgeting*. World Bank Health Nutrition and Population Discussion Paper. World Bank (2004), pp. 37-38.

- **Simplification of Hospital Reimbursements.** By eliminating the billing process, global budgets result in administrative simplicity and associated savings for hospitals and other institutional providers. Information necessary to predict annual global budgets — including financial cost data, case mix, and volume of services — is readily available and already captured by hospitals and other institutions.[19] Additionally, this information is already reported to the Centers for Medicare and Medicaid Services in Medicare cost reports.
- **Transparent and Accountable Spending.** Global budgets allow the public to track where our health care dollars are going and to ensure that rural hospitals and hospitals in underserved areas are getting the funding that they need. Providers must report all relevant data associated with operational costs and justify their spending during annual negotiations. With periodic audits and review, providers would be held accountable for their projected spending and the program could monitor whether the provider is meeting program goals and standards. Budget shortfalls, unexpected or emergent public health conditions, or other marginal cost differences between planned and actual health care spending can be addressed through budget adjustments year-over-year or through quarterly reviews.
- **Funding Certainty for Hospitals Serving Vulnerable Communities.** Global budgets can be a blessing to hospitals that serve rural or underserved communities and that currently have inconsistent or undependable funding streams. Global budgets would ensure that our safety-net hospitals that provide care to low-income, rural, and minority communities are sufficiently funded and resourced.
- **International Use of Hospital Global Budgeting.** Many countries with publicly-funded health care — Canada, Scotland, Wales, New Zealand, Australia, Denmark, Sweden, Switzerland, Norway, Iceland, Ireland, and Singapore — use global budgets as key components of their hospital payment methodologies.[20]

Payment Options for Doctors & Medical Group Practices

There are two payment options for doctors and doctor groups under the Medicare for All Act of 2022 — reimbursements based on the Medicare fee schedule or salaries based on negotiated global budgets. The Secretary of the U.S. Department of Health and Human Services would establish a national fee schedule in consultation with doctors and regional directors. Instead of payments based on the national fee schedule, individual providers and group practices could opt to receive salaries through an institutional provider's global budgeting process.

[19] *Id.* at pp.18, 37-38.

[20] *See* Mossialos, E., Tikkanen, R. et al. (Eds.). "International Profiles of Health Care Systems, 2020." The Commonwealth Fund (Dec. 2020). Accessed May 10, 2022. https://www.commonwealthfund.org/sites/default/files/2020-12/International_Profiles_of_Health_Care_Systems_Dec2020.pdf ; Wolfe, P., Moran, D. "Global Budgeting in OECD Countries." *Health Care Fin. Rev.* (1993) Vol 14:3.

Medicare for All Act of 2022: Cost & Savings Analyses

The tables below summarize the findings from three major cost and savings analyses of national implementation of Medicare for All. The first study was conducted by the Congressional Budget Office (CBO).[1] The second study was conducted by Charles Blahous with the Mercatus Center of George Mason University.[2] The third study was conducted by Robert Pollin and his colleagues at the Political Economy Research Institute (PERI) of the University of Massachusetts Amherst.[3] These three studies contain the most rigorous methodologies for analyzing potential savings in addition to increases in cost that would result from implementation of Medicare for All. They all show that a Medicare for All program would produce significant savings over the status quo.

All three studies show that the savings produced by Medicare for All would exceed increases in cost resulting from universal health care coverage. Findings in Blahous' analysis demonstrate that Medicare for All could result in $2.1 trillion in savings over 10 years in National Health Expenditures (Table 1).[4] Pollin's analysis found that Medicare for All would result in $5.1 trillion in savings over ten years (Table 1).[5] Unfortunately, the CBO does not calculate savings for a 10-year period. The CBO projects 1-year savings of $317 billion in 2030, Blahous projects 1-year savings of $93 billion in 2022, and Pollin projects 1-year savings of $310 billion in 2017.

Table 2 shows increases and savings for a 1-year period based on the largest expenditure categories. The major driver of increased costs is increased utilization of health care when everyone is insured and cost-sharing is dramatically reduced. The major areas for savings result from reductions in administrative costs, payments to providers, and prescription drugs. The CBO study finds that there could be a $583 billion increase in costs as a result of increased health care utilization, but Medicare for All would also capture $900 billion in savings in administration and reduced payment rates for providers (Table 2).[6] Blahous' study demonstrates that although Medicare for All would increase health care demand by $435 billion, the program would also produce $528 billion in savings on administration, pharmaceutical payments, and provider rates (Table 2).[7] Pollin's findings show that although there could be, on the high-end, a $390 billion increase in costs as a result of an increase in health care utilization, Medicare for All would also capture $643 billion in savings in administration, pharmaceutical payments, and provider rates (Table 2).[8]

A second, recently published CBO study found that, under a Medicare for All health care system, people would live longer and be more productive as their health improved and workers' wages would increase as employers shifted savings from money previously spent on health insurance to wages.[9] Furthermore, long-term supports and services benefits (LTSS) would reduce household out-of-pocket costs, increase wages for workers in providing LTSS care, and allow family members currently proving

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[1] CBO's Single-Payer Health Care Systems Team. "How CBO Analyzes the Costs of Proposals for Single-Payer HealthCare Systems That Are Based on Medicare's Fee-for-Service Program." Working Paper 2020-08. Congressional Budget Office (Dec. 2020). Accessed May 10, 2022. https://www.cbo.gov/publication/56811.

[2] Blahous, C. "The Costs of a National Single-Payer Healthcare System." Mercatus Center, George Mason University (2018). Accessed May 10, 2022. https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

[3] Pollin, R. et al. "Economic Analysis of Medicare for All." Political Economy Research Institute (PERI), University of Massachusetts Amherst (2018). Accessed May 10, 2022. https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all.

[4] Blahous (2018) at p. 7 (Summing projected National Health Expenditures for 2022-2031 from Table 2).

[5] Pollin (2018) at p. 3, 125-26.

[6] CBO's Single-Payer Health Care Systems Team (2020).

[7] *See* Blahous (2018) at p. 4 (Table 1).

[8] *See* Pollin (2018) at pp. 40-44 (adjusting percentages to reflect percentage savings of national health expenditures).

[9] Jaeger, N. "Economic Effects of Five Illustrative Single-Payer Health Care Systems." Working Paper 2022-02. Congressional Budget Office (Feb. 2022). Accessed May 10, 2022. https://www.cbo.gov/publication/57637.

care to work more hours in their paid jobs.[10] Finally, the CBO study found that reducing administrative costs, which Table 2 shows as the single largest category of savings from Medicare for All, would shift financial resources to other sectors and increase productivity across the economy.[11]

Table 1. Projected Savings in National Health Expenditures: CBO, Blahous, & Pollin

	CBO	Blahous	Pollin
Projected Savings MFA (10 Years) in National Health Expenditures	**NA**	**$2.1 Trillion+**	**$5.1 Trillion***
Years	NA	2022-2031	2017-2026
Projected Savings MFA (First Year) in National Health Expenditures	**$317 Billion^**	**$93 Billion++**	**$310 Billion**
Year	2030	2022	2017

^ The CBO study analyzed five different single-payer scenarios that differed in the provider payment rates and cost-sharing requirements; one included the costs of long-term supports and services (LTSS). The numbers in the tables below come from combining Option 3, which had lower provider payment rates and lower cost-sharing, with the additional costs for LTSS provided in Option 5.

\+ Calculated from Blahous' projected changes in health care spending between 2022 to 2031, in the aggregate, (decrease of $482 billion) summed with administrative cost savings, in the aggregate, for that same period ($1.572 trillion). *See* Blahous, at p. 7, in Table 2 for both figures.

++ Calculated from Blahous' projected changes in health care spending for 2022 ($10 billion) summed with administrative cost savings for 2022 ($83 billion). *See* Blahous, at p. 7, in Table 2 for both figures.

* The Pollin study used Health Consumption Expenditures and the CBO and Blahous studies used National Health Expenditures. To ensure compatibility in comparing the data, percentages from the Pollin Study were adjusted to reflect National Health Expenditures. *See* Pollin, p. 22, for explanation on use of Health Consumption Expenditures.

[10] *Ibid.*
[11] *Ibid.*

Table 2. Major Categories of Projected Increases and Savings in National Health Expenditures: CBO, Blahous, & Pollin

	CBO^ (2030)	Blahous+ (2022)	Pollin* (2017)
Increases in National Health Expenditures due to Increased Access to Health Care under Medicare for All			
Projected Increase in Utilization/Demand	$583 Billion	$435 Billion	$390 Billion
Percentage Increase in Utilization/Demand	8.79%	9.50%	11.73%*
Savings in National Health Expenditures due to Medicare for All			
Administrative Savings	$411 Billion	$83 Billion	$327 Billion
Percentage	5.69%	1.66%++	8.80%*
Reduced Provider Payment Rates	$489 Billion	$384 Billion	$102 Billion
Percentage	6.78%	7.68%++	2.74%*
Drug Savings	NA^^	$61 Billion	$214 Billion
Percentage	NA	1.22%++	5.77%*

^ The CBO study analyzed five different single-payer scenarios that differed in the provider payment rates and cost-sharing requirements; one included the costs of long-term supports and services (LTSS). The numbers in the tables below come from combining Option 3, which had lower provider payment rates and lower cost-sharing, with the additional costs for LTSS provided in Option 5.

^^ The CBO includes drug savings in the reduced provider payment rates.

\+ *See* Blahous' projected increases in utilization/demand for 2022, at p. 4, Table 1.

++ Percentage calculations based on spending after introduction of Medicare for All, which includes Blahous' currently projected National Health Expenditures for 2022 ($4,562 billion), p. 7, Table 2, plus Blahous' projected increases in utilization/demand for 2022 ($435 billion), p. 4, Table 1.

* The Pollin study used Health Consumption Expenditures and the CBO and Blahous studies used National Health Expenditures. To ensure compatibility in comparing the data, percentages from the Pollin Study were adjusted to reflect National Health Expenditures. *See* Pollin, p. 22, for explanation on use of Health Consumption Expenditures.

** Projected National Health Expenditure savings in Table 1 are slightly different than total savings minus increases in Table 2 because of rounding in the Pollin Study.

Medicare for All Act of 2022: Canada, Taiwan & U.S. Comparison

Two international examples of single-payer programs — Canada's Medicare program and Taiwan's National Health Insurance program — are detailed below in comparison to U.S. health spending and costs (Table 1) and to the system design of the Medicare for All Act of 2022. The most recent year with health expenditure and administrative cost data from all three countries is 2017.

The single-payer health systems of Canada and Taiwan are most similar in design to the single-payer program proposed under the Medicare for All Act of 2022. Similar to the United States, Canada and Taiwan both have a mix of publicly and privately delivered health care.

Table 1. Health Care Spending & Insurance Administrative Cost Comparison: Canada, Taiwan & U.S. (2017)

	Canada	Taiwan	U.S.
Total Spending on Health, % of total national GDP (2017)	10.8%*	6.1%**	16.8%*
Mean Spending on health per capita, PPPUSD	$5,138*	$3,047**	$10,106*
Insurance administrative costs,* by percentage**	3.0% of total national health spending*	0.77% of NHI budget**	8.0% of total national health spending* 13% of private insurer spending** 7% of traditional Medicare and Medicare Advantage spending combined** 1.1% of traditional Medicare spending alone**

* Organization for Economic Cooperation and Development. "OECD Health Statistics 2021." OECD Stat (Updated Dec. 2021), available at http://www.oecd.org/els/health-systems/health-data.htm.

** Cheng, Tsung-Mei. "Health Care Spending in the US and Taiwan: A Response to *It's Still the Prices, Stupid, And a Tribute to Uwe Reinhardt*." *Health Affairs* (Feb. 2019), available at https://www.healthaffairs.org/do/10.1377/hblog20190206.305164/full/.

*** Health care providers also incur substantial billing and insurance administrative costs that are not included in these figures.

Table 2. Program Design Comparison: Canada, Taiwan & Medicare for All Act[1]

Design Feature	Canada	Taiwan	U.S.
Program Name	Medicare	National Health Insurance (NHI)	Medicare for All (MFA)
Level of Administration	Provincial or territorial government	National government	National government; regional subdivisions responsible for allocation of funds and negotiations with providers
Eligibility			
Universal coverage	Yes	Yes	Yes
Separate public programs for certain groups other than military	Yes	No	Yes. Although veterans and American Indians/Alaskan Natives may receive services through the Veterans Health Administration or Indian Health Services, respectively, they may also enroll in MFA.
Mandated Benefits Package			
Hospital and physicians' services	Yes	Yes	Yes
Outpatient prescription drugs	No	Yes	Yes
Long-Term Services and Supports (LTSS)	No	Has a "Long-Term Care 2.0" plan to fully cover comprehensive home- and community-based care under NHI by 2026. Home-based care programs are currently being rolled out to expand coverage.	Yes, with a prioritization of home- and community-based services.
Dental, vision, and mental health services	No	Yes. Also, includes Chinese medicine, and home nursing care.	Yes
Private Health Insurance			
Supplemental	Yes	Yes, plays a non-substantive role; used primarily as a cash benefit for private rooms, co-pays, etc., and not used for coverage of services with the exception of long-term care.	Permitted for services not overlapping with Medicare for All, which would be extremely limited given the comprehensive benefits of the program.
Substitutive	No	No	No

[1] Information compiled from: Congressional Budget Office. "Key Design Components and Considerations for Establishing a Single-Payer Health Care System." CBO Publications (May 1, 2019), available at https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf; and Mossialos, E., Tikkanen, R. et al. (Eds.). "International Profiles of Health Care Systems, 2020." The Commonwealth Fund (Dec. 2020). Accessed May 10, 2022. https://www.commonwealthfund.org/sites/default/files/2020-12/International_Profiles_of_Health_Care_Systems_Dec2020.pdf.

Design Feature	Canada	Taiwan	U.S.
Other types of private insurance	No	No	No
Participating Provider Rules			
Balance billing allowed	No	No	No
Payments from private-pay patients for covered services	No	No	No
Hospitals			
Primary ownership	Mixed	Private	Private
Primary payment method	Global budget	FFS with overall hospital sector global budget	Global budget
Primary Care Physicians			
Primary employment	Private	Private	Private
Primary payment method	FFS	FFS with overall primary care global budget	FFS with option to elect salaried reimbursement through hospital global budgeting.
Outpatient Specialist Physicians			
Primary employment	Private	Private	Private
Primary payment method	FFS	Salary	FFS with option to elect salaried reimbursement through hospital global budgeting.