



Fall 2024 Newsletter

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

Senator Elizabeth Warren Joins Our Fight Against Medicare Advantage

On June 3, PNHP hosted a powerful webinar with special guest Senator Elizabeth Warren, titled “Taking Advantage: How Corporate Health Insurers Harm America’s Seniors.” During the event, Sen. Warren delivered a clear message to all Medicare supporters: So-called “Medicare Advantage” plans are hurting seniors, and the growing movement to reclaim Medicare from corporate profiteers is gaining traction in Washington, D.C. thanks to the work of PNHP and our allies.

Sen. Warren’s appearance at the webinar underscored the urgency of our campaign to protect the health and well-being of seniors across the country. She highlighted the deceptive practices of Medicare Advantage plans, which often limit access to necessary care and prioritize profit over patient needs. The impact of these plans is felt by seniors and physicians alike, with many health-care professionals struggling against unnecessary administrative hurdles and cost-cutting measures imposed by insurers.

In her remarks, Sen. Warren emphasized the growing momentum of our movement and encouraged attendees to keep pressing forward. She called on us to continue sharing stories about how corporate insurers are harming patients and loved ones, to raise awareness about the issue, and to engage with policymakers to demand change.

“Keep going. Keep sharing the stories about how corporate insurers in Medicare Advantage are harming your patients and your loved ones,” Sen. Warren urged. “Keep sounding the alarm about how corporate insurers are making it harder and harder for health care professionals to do their jobs. Call your members of Congress. Let them know why this issue is important to you. Recruit your friends. Recruit your colleagues. Recruit everyone you can to join you in this fight—together. That’s how we will take on the corporate insurers and reclaim our Medicare.”

Sen. Warren’s message resonated deeply with the thousands of attendees who tuned in to the webinar. Her call to action reaffirmed the importance of our efforts and provided renewed energy for our campaign to reclaim Medicare. With the support of policymakers like Sen. Warren, our movement is poised to make significant strides in the coming months.

PNHP’s campaign against Medicare Advantage will continue throughout the open enrollment period (Oct. 15 - Dec. 7) and into next year. Strategizing about our best opportunities to make headway will be a big part of our upcoming annual meeting in Chicago.

If you would like to get involved, please contact National Organizer Mandy Strenz at mandy@pnhp.org.



Register for our Annual Meeting in Chicago today!
More information at pnhp.org/meeting

In this issue:

Medicare Advantage webinar	1
AAP resolution on MA	2
Moral injury project	3
Annual Meeting agenda	4
Meet our new policy specialist	4
Data Update	5
PNHP Chapter Reports	10

PNHP Board of Directors 2024

Executive Committee:

Philip Verhoef, M.D., Ph.D. (HI), President
Diljeet K. Singh, M.D., Dr.P.H. (DC), Vice President
Claudia Fegan, M.D. (IL), Treasurer, National Coordinator
Ed Weisbart, M.D. (MO), Secretary
Susan Rogers, M.D. (IL), Immediate Past President

Regional and At-Large Delegates:

Hugh Foy, M.D. (WA); Stephen Kemble, M.D. (HI); Jonathan Michels (NC); Mary O'Brien, M.D. (NY); Alankrita Olson, M.D. (MD); Peter Orris, M.D., M.P.H. (IL); Carol Paris, M.D. (TN); Jessica Schorr Saxe, M.D. (NC); Eve Shapiro, M.D., M.P.H. (AZ); Sanjeev Sriram, M.D., M.P.H. (MD); Wayne Strouse, M.D. (NY); Brian Yablon, M.D. (MN)

Students for a National Health Program Delegates:

Swathi Bhuma (MD 2025, Chicago Medical School-Rosalind Franklin University); Constance Fontanet (MD 2025, Geisel School of Medicine at Dartmouth); Michael Massey (MD 2024, Northeast Ohio Medical University); James Patrick Waters (MD 2025, Cooper Medical School of Rowan University)

PNHP Staff:

Ken Snyder, executive director; Matthew Petty, deputy director; Lori Clark, Rebecca Delay, and Mandy Strenz, organizing team; Dixon Galvez-Searle and Anika Thota, communications team; Morgan Moore, NY Metro executive director

Contact Information:

29 E. Madison St., # 1412, Chicago, IL 60602 | pnhp.org
P. (312) 782-6006 | F. (312) 782-6007 | info@pnhp.org

AAP's Resolution Marks a Turning Point Against Medicare Advantage

In a landmark decision, the Leadership Council of the American Academy of Pediatrics (AAP) called on the AAP to cease marketing Medicare Advantage plans to members, as outlined in the recent resolution titled "Medicare Advantage: Risky for Pediatricians and All Seniors." This resolution, introduced by PNHP pediatrician members Dr. Robert Vinetz and Dr. Eve Shapiro, sets a powerful example for other organizations to follow.

The resolution addresses a growing concern over private companies treating federally-run health care programs like Medicare and Medicaid as profit centers, often to the detriment of patient care. Medicare Advantage, the for-profit component of Medicare, now serves over 50% of Medicare beneficiaries. This has been achieved through misleading advertising and practices that often lead to narrow networks, excluding more than 70% of doctors in certain counties.

Adopted with an overwhelming 149 to 1 vote, the resolution exhibits the intense concerns among pediatricians regarding the dangers posed by Medicare Advantage plans. The AAP's online comment period saw 66 members express their support, highlighting widespread frustration within the profession. The resolution also benefited from compelling testimony by AAP past president Dr. Jay Berkelhamer.

Dr. Eve Shapiro, reflecting on the resolution, stated, "Our resolution—and the associated organizing effort—can serve as a model for similar advocacy nationwide." She continued, "This vote and the support from our



PNHP Vice President Dr. Diljeet Singh (L) and Sen. Elizabeth Warren talk about the harms imposed by Medicare Advantage insurers during our "Taking Advantage" webinar on June 3.



AAP Past President Dr. Jay Berkelhamer testified in support of our resolution, “Medicare Advantage: Risky for Pediatricians and All Seniors,” on July 12.

pediatrician members not only reflect our frustration but also mark a significant step where the Academy is taking tangible action in response to our concerns.”

Medicare Advantage plans often result in surprise out-of-pocket costs, narrow networks, and delays in care, leading to serious health risks for patients. Additionally, patients are frequently trapped in these plans due to high costs associated with switching back to traditional Medicare. Physicians and hospitals also face significant barriers, including administrative burdens and financial strain from delayed payments.

Through collaborative efforts, PNHP and other groups have been working to alert patients, physicians, and legislators to the risks associated with Medicare Advantage. The resolution by the AAP marks a crucial moment in the ongoing battle against profit-driven Medicare Advantage firms, offering hope for a more equitable and patient-centered health care system.

Resolution 55 - Medicare Advantage: Risky for Pediatricians and All Seniors
Sponsored By: California Chapter 2, Section on Senior Members

RESOLVED, that the Academy inform the AAP Group Insurance Trust that it may not use (or authorize use of) the name of the Academy (*American Academy of Pediatrics*) or the Academy's initials (AAP) in offering, promoting or in any way communicating about Medicare Advantage as an Academy benefit, because Medicare Advantage does not align with the values of the Academy, and be it further

RESOLVED, that the Academy implement an educational program to explain Medicare Advantage vs traditional Medicare for its members facing that consequential decision, and doing so in an unbiased fashion without a vested interest in the outcome.

Edits to the Resolves – Discussion Board
Vote on Resolution – Online Comment Opportunity

To provide testimony: send a chat to the host with your name, AAP role/entity, resolution number and for or against.

American Academy of Pediatrics
www.aap.org

PNHP Launches Moral Injury Project: Survey Development Underway

PNHP is making headway in its ambitious Moral Injury Project, a research initiative funded by the Robert Wood Johnson Foundation to explore how the financialization of the U.S. health care system has impacted physicians and patients alike. This 18-month project, which began with a series of in-depth focus groups, is now advancing into its next phase: the development of a comprehensive survey to further investigate how the profit-driven model of health care contributes to physician burnout, moral injury, and systemic inequities.

Building on Insights from Physician Focus Groups: Over the past several months, PNHP has completed a series of focus groups with physicians from diverse specialties and practice settings. These focus groups provided a critical space for health care professionals to voice their experiences with the growing corporatization of health care and its impact on their ability to provide patient care. Physicians shared stories of frustration and moral conflict as they navigated a system increasingly focused on profits over people, where prior authorization hurdles, restrictive networks, and cost-containment measures undermine their clinical judgment and patient relationships.

The focus groups highlighted the concept of “moral injury,” a term that describes the profound psychological distress physicians experience when they are unable to provide the care they know their patients need due to external constraints. This goes beyond the typical definition of burnout, which often centers on personal resilience or wellness strategies. Instead, moral injury addresses the deeper systemic issues that force physicians to compromise their professional values and ethical obligations.

Physicians also emphasized how these challenges intersect with structural racism, noting that corporate practices, such as limited networks and high co-pays, disproportionately harm marginalized communities. These practices create barriers to care, perpetuating existing health inequities and leaving the most vulnerable patients without adequate access to necessary treatments. The insights gathered from these workshops have been invaluable in shaping the next steps of the project.

Developing a Comprehensive Survey: Building on the findings from the workshops, PNHP has developed a comprehensive survey to gather broader data on the experiences of physicians across the country (pnhp.org/MoralInjurySurvey). The survey was carefully designed to capture quantitative data on how financialization affects physicians’ work, their ability to provide quality care, and their sense of professional fulfillment. It explores how financial pressures contribute to moral injury and burnout, further stratified by specialty, practice environment, and geographic location.

The survey delves into specific questions about the impact of corporate practices—such as prior authorization requirements,

limited networks, and billing pressures—on clinical autonomy and patient care outcomes. Additionally, it seeks to identify patterns of structural racism within these corporate strategies, gathering data on how financialization disproportionately affects communities of color and exacerbates health inequities. The survey's findings will help PNHP further illustrate the systemic problems that need to be addressed to alleviate moral injury and promote health equity.

Next Steps and Broader Research Activities: The survey is just one part of PNHP's larger research agenda. Once the survey is distributed and data collected, PNHP will conduct a series of in-depth interviews with selected physicians to further explore the themes revealed in the survey responses. These interviews will target physicians who serve marginalized communities, providing a deeper understanding of how financialization impacts both providers and patients in settings most affected by structural racism.

Anticipated Outcomes and Goals: The primary goal of PNHP's Moral Injury Project is to produce a comprehensive report by November 2025 that includes actionable recommendations for various stakeholders, including national policymakers, health care advocacy groups, and Oregon's Universal Health Plan Governance Board. This report will provide evidence-based insights into how financialization contributes to moral injury among physicians and perpetuates systemic racism within the health care system. By highlighting both quantitative data and personal narratives from physicians and patients, PNHP aims to shift the current discourse away from ineffective, individual-based solutions like wellness programs to systemic changes that address the root causes of moral injury.

Come to Chicago for PNHP's Annual Meeting!

This year's PNHP Annual Meeting will take place on Saturday, November 16, in Chicago, and it promises to be an engaging and impactful gathering. This year's conference will center on critical issues that are at the heart of PNHP's mission: combating corporate profiteering in Medicare, exploring the impact of moral injury among physicians, and advancing the cause of single-payer Medicare for All. This is not just another meeting; it's a working session where participants will actively contribute to shaping PNHP's campaigns for the year ahead.

Attendees will have the chance to immerse themselves in discussions and workshops that address these crucial topics. The meeting is designed to be interactive, ensuring that every participant leaves with new insights, skills, and a renewed sense of purpose. It's a fantastic opportunity to connect with fellow advocates, learn from experts, and strengthen our collective efforts to drive meaningful change in health care.

Before the Annual Meeting, on Friday, November 15, we will also host the Students for a National Health Program (SNaHP) Summit in Chicago. Scholarships will be available to help cover travel and lodging costs for students and residents. We encourage PNHP members to support this initiative by making a contribution to the Nicholas Skala Student Fund at pnhp.org/SkalaFund.

Online registration is now open! You can secure your spot at our conference, and learn more about our agenda for the day, at pnhp.org/meeting.

Meet Anika Thota, our Policy & Communications Specialist!

Previous Experience: I recently graduated from the University of Illinois at Urbana-Champaign with a Bachelor's in Public Health and Health Administration with a minor in Informatics. I have interned for multiple congressional campaigns writing policy directives for issues such as women's reproductive rights, prescription drug price reform, and mental health access. I have also interned with hospitals and clinics where I focused on studying infant and maternal mortality rates.

What drew you to PNHP? I was drawn to PNHP because of its commitment to advocating for a universal, publicly-funded health care system that prioritizes patients over profits. For me, PNHP's clear, data-driven approach to reform and its focus on health care justice resonate deeply with my own values and vision for a fairer, more equitable system.

What are you looking forward to working on over the next 12 months? I'm looking forward to diving into our Moral Injury Project and our advocacy around Medicare Advantage. I'm excited to help drive meaningful change, whether it's through gathering critical data, influencing policy, or amplifying our message through media and public engagement.

What's a fun fact about yourself? I can list all 50 states in alphabetical order in under one minute!

Connect with Anika at anika@pnhp.org.



DATA UPDATE: HEALTH CARE CRISIS BY THE NUMBERS

BARRIERS TO CARE

High Price of Diabetes Drugs Hurts Low-Income Patients: Drugs like Ozempic and Trulicity are too expensive for low-income patients with diabetes to access effective treatment. These drugs cost approximately \$1,000 per month and they end up being prohibitively expensive for most patients, who are forced to resort to inferior substitutes. Insurance companies insist on prior authorizations that mean many experience delays in care. As the need for these drugs grows, high cost and poor insurance coverage only serve to further exacerbate challenges faced by those most in need. *Renuka Rayasam, “High Price of Popular Diabetes Drugs Deprives Low-Income People of Effective Treatment KFF Health News,” May 21, 2024.*

Big Data Could Bridge Health Care Gaps for U.S. Immigrants: 1 in 8 U.S. residents, or over 40 million people, have great difficulty accessing affordable, high-quality health care due to lack of insurance, language barriers, cultural differences, etc. Uninsurance rates among foreign-born non-citizens reached 50% before the Affordable Care Act. All of these difficulties lead to significant health problems. Using big data from EHRs and claims as well as new data sources (eg, mobile applications) may offer novel ways to better understand access barriers that immigrants face and support new health system strategies. Thus, ethical considerations regarding privacy, inclusion, and transparency are essential for such technologies to not further exacerbate current inequities. *Joseph Kobi, Amida Nchaw Nchaw, Dr. Brian Otieno, “Big Data-Driven Insights for Equitable Healthcare Access and Quality for U.S. Immigrants,” IJRTI, July 2024.*

AI Could Improve Care for Patients with Language Barriers: Interviews with 49 health care professionals revealed that the use of AI could improve care for patients with language barriers, leading to a higher level of care quality, easier access to interpreter services and more capable clinician interactions due to its ability to potentially counteract bias on behalf of clinicians. Health care professionals also identified risks with AI, including concerns about transparency, accuracy, privacy, and stigmatization. *Amelia K. Barwise et al., 2023, “Using artificial intelligence to promote equitable care for inpatients with language barriers and complex medical needs: clinical stakeholder perspectives,” Journal of the American Medical Informatics Association, December 14, 2023.*

Health Spending Growth to Outpace GDP in Next Decade: Health care spending is expected to grow faster than GDP, comprising 19.7% of GDP by 2032 compared with 17.3% in 2012. Private insurance is projected to expand through extended subsidies authorized by the Inflation Reduction Act (IRA), and an additional special enrollment period created for those losing Medicaid coverage. Medicare will gain new drug benefits and price negotiation from 2024 to 2026, as would drug pricing for private insurance itself. Spending growth will outpace economic growth—supported by higher personal health care prices and utilization of services—from 2027 to 2032. *Jacqueline A. Fiore et al., 2024, “National Health Expenditure Projections, 2023–32: Payer Trends Diverge As Pandemic-Related Policies Fade,” Health Affairs, June 12, 2024.*

Barriers to Health Care Access Persist in Rural USA: Almost 51 million people—1/6 of the U.S. population—live in rural regions of the country, and these residents face distinct health care disparities relative to their urban counterparts. Broadband connection is underdeveloped in rural areas, where chronic disease rates are higher and access to digital health care is limited. In addition, rural residents have higher rates of harm resulting from accidents, cardiovascular disease, and suicide. These areas, which contain 17% of all people, saw only 12% of hospitalizations and just 6% of inpatient procedures in 2010. The presence of rural areas without primary care doctors, and the digital divide, compound disparities, making it clear that structural change is needed to eliminate rural health inequities. *N. Douthit, S. Kiv, T. Dwolatzky, S. Biswas, “Exposing Some Important Barriers to Health Care Access in the Rural USA,” ScienceDirect, 2015.*

MEDICARE & MEDICAID ISSUES

Medicaid Enrollment Declines as Continuous Coverage Ends: Medicaid enrollment rose to 94.5 million in April 2023, up by 23 million (32%) from pre-pandemic. From January 2024, renewal outcomes have been reported by states for half of all enrollees: 34% (32.1 million) have had coverage renewed, and 17% (16.2 million) have disenrolled.

The data indicate that procedural or administrative issues are a leading cause of disenrollment, and this is worrisome for the potential adverse effects of children losing coverage. In December 2023, federal officials issued new guidance to deter procedural disenrollments of children and the HHS Secretary called on nine states who had shown significant decreases in child enrollment to implement further policy options. States have unwound more than 9% overall among Medicaid counterparts, with Idaho down 32% and Maine only 1%. *Robin Rudowitz et al., 2024, "Medicaid: What to Watch in 2024," KFF, January 30, 2024.*

Medicare (dis)Advantages: The federal government is projected to spend about \$2,500 more per beneficiary on Medicare Advantage (MA) in 2024 than it would have under Traditional Medicare (TM). In 2022, 41% of MA enrollees reported access problems related to costs, compared to 35% of TM beneficiaries. In 2024, the same survey found that 12% of MA enrollees could not afford needed care because of copayments or deductibles, compared with 7% in TM. Some factors that may be driving these findings include, but are not limited to, the fact that MA plans can carry with them hidden out-of-pocket costs, network restrictions, and prior authorization requirements. *David Blumenthal, MD, MPP; Gretchen Jacobson, PhD, "How Affordable Is Medicare Advantage?," JAMA, August 28, 2024.*

Medicare Advantage Insurers Influence More Hospital Admissions: A new study by KFF shows that Medicare Advantage plans are responsible for almost 48% of all Medicare inpatient hospital days. The impact on patient choice of care is emphasized and how it can inform health care provider actions. Although these are the plans in which more than half of all Medicare beneficiaries are enrolled, providers argue that MA practices can delay or reduce payment for them, and can lead to financial hardship for physicians and hospitals. And while insurers have benefitted from increased enrollment, they are also contending with higher-than-expected medical expenses, partly as a result of the surge in seniors rushing to seek inpatient procedures post-pandemic. *Bruce Japsen, "Medicare Advantage Insurers Hold Sway Over More Hospital Admissions," Forbes, July 24, 2024.*

High Rate of Medicare Claim Denials Impacts Health Care Providers: To detect and correct inaccurate medical billing, the Centers for Medicare and Medicaid Services (CMS) conducts audits on claims submitted by health care providers. Even after processing more than a billion claims a year (for 60M+ beneficiaries) Medicare still denies many of the properly-submitted claims from providers. Only 1% of these denied claims are appealed, yet 70+% of appealed claims are reversed by a Medicare administrative law judge. It can take providers up to three years to exhaust the labo-

rious appeals process. *Michael Scott Koslow, "Medicare Claim Processing: An Analysis of Perceptions of Lived Experiences by Health Care Executives and Leaders Regarding Medicare Claim Denials," University of Southern California ProQuest Dissertations & Theses, August 2024.*

Mental Health Care Shortage Hits Medicare and Medicaid Enrollees Hard: A report has uncovered the need for more mental health professionals to serve people on Medicare and Medicaid. The study looked at 20 counties that serve more than 130 million enrollees—over 40% of the U.S. population—and across those areas found less than five active mental health providers per 1,000. In certain counties, there are as low as one provider per 1,000 enrollees. This shortage is especially important as it impacts 1 in 4 Medicare recipients who have a mental health or substance use condition. That means people with serious mental illnesses (1 in 3 Tennessee Medicaid enrollees) and those struggling with substance use disorder do not have access to the care they need, from peer support to therapeutic interventions. *Rhithu Chatterjee, "Mental health care is hard to find, especially for people with Medicare or Medicaid," NPR, April 3, 2024.*

Vulnerable Americans Stuck in Medicare-Medicaid Maze Await Solutions: A bipartisan group of senators presented the DUALS Act of 2024, which targets the 12 million Americans eligible for both Medicare and Medicaid and nicknamed "duals." Such eligibility often means having to apply for treatment through two insurance portfolios, each with its own rules and requirements but without coordination, significantly complicating the lives of patients and reducing the effectiveness of treatment. The bill would require all states to provide at least one seamlessly integrated insurance plan to combine Medicare and Medicaid insurance to simplify patient care coordination and reduce costs. According to legislators, the law would streamline services and abolish the necessity for patients to be the intermediaries. *Leslie Walker and Dan Gorenstein, "Vulnerable Americans are stuck in a Medicare-Medicaid maze. Is a fix in sight?," NPR, March 14, 2024.*

Medicare Advantage Payments Exceed Traditional Medicare by 22%: When the two budgets were compared — the Traditional Medicare (TM) budget and a Medicare Advantage (MA) budget — Medicare spent 22% more on MA than TM would have if all of those beneficiaries had been enrolled in Part A, Part B, and Part D. Coding intensity and favorable selection drive much of the differential in payments. *Michael E. Chernew and Paul B. Masi, "Parsing The Debate Around The Medicare Advantage/Traditional Medicare Payment Gap," Health Affairs, March 15, 2024.*

NYC Council Member Urges Support for Retirees Opposing Medicare Advantage Plan: UFT President Michael Mulgrew has withdrawn support from a city effort to force 250,000 municipal retirees into a profit-driven Medicare Advantage plan, and Brooklyn Council Member Shahana Hanif is calling on New York City Council Speaker Adrienne Adams to reopen retiree health care. The Municipal Labor Committee (MLC), which is led by Chair Harry Nespoli, also signaled that it is backing off the plan following legal obstacles that are putting the implementation of it at risk. The Cross-Union Retirees Organizing Committee (CROC) argues that the bill (Intro. 1099) would make health care benefits of retirees permanent law. CROC also captured approximately 150 signatures to urge U.S. Senator Chuck Schumer to protect their health coverage from privatization. *Joe Maniscalco, “NYC Council Member Calls on Colleagues to Listen to Retirees Battling ‘Immoral’ Medicare Advantage Scheme,” Work-Bites, July 16, 2024.*

Advocating for a Single-Payer Health Care System in the U.S.: A real Medicare-for-All system is needed in the U.S. to correct health disparities and result in a coherent health care system. The “Great Unwinding” resulted in 23 million people being unenrolled from Medicaid, most of them children, and most of them losing coverage due to procedural issues. In Medicare, the for-profit insurance scheme that is “Medicare Advantage” covers more than half of enrollees. In 2020, more than 25.6 million Americans overall were without health insurance. Throughout the U.S.—which spends more money per capita on health care than similar nations—gaps in coverage result in “potentially lethal breaches of care.” Alternatively, a single-payer system would feature comprehensive coverage and choice of provider. *Andrew Moss, “The Growing Case for Medicare for All,” MSN, September 16, 2024.*

PHARMA

U.S. Drug Prices Found to Be Nearly Three Times Higher Than Global Average: Drug prices in the U.S. were typically 2.78 times higher than those in 33 other countries in 2022. In its 2023 Drug Price Index, UnitedHealth Group’s Pharmaceutical Medical Committee analyzed the drug prices of 38 advanced nations. Their evaluations found the price gap was most apparent with brand-name drugs, where American prices were four or five times as much as those in other countries. *Samantha Putterman, “For the most part, the US pays double for prescriptions compared with other countries, as Biden says,” PolitiFact, March 4, 2024.*

Biden Says Medicare Drug Price Deal Will Cut Costs by \$7.5 Billion: The White House said Americans will save \$7.5 billion in drug costs in the first year of its program to negotiate prices with pharmaceutical companies—a total that includes government savings and reduced out-of-pocket spending for people with private insurance, too. The White House also hopes to cut Medicare’s net spending by 22% (\$6 billion), as it negotiates with top industry groups, such as Johnson & Johnson and Merck. The assessment said that Medicare patients’ out-of-pocket costs for the 10 negotiated medicines would likely go down by \$1.5 billion a year based on last year’s prices for them. The provisions also cap Medicare patients’ out-of-pocket costs at \$2,000. While the pharmaceutical industry is opposed to the price controls, arguing that they will cut into the funding needed to conduct research and development, the government expects savings of \$100 billion over the next 10 years from broader negotiations involving as many as 50 more drugs. *Oliver Barnes and Lauren Fedor, “Joe Biden hails \$7.5bn savings after striking Big Pharma drug price deal,” Financial Times, August 15, 2024.*

M&As Put Pressure on Pharma Industry: Seismic changes in the health care market are forcing the pharmaceutical industry to adapt to a newly consolidated market of providers. Just 1,500 of over 6,000 U.S. hospitals remain independently operated in the aftermath of a wave of mergers and acquisitions. This consolidation has now moved the balance of power in drug purchasing from physicians to C-suite executives. 50-70% of customer engagement now is happening virtually, so how drug manufacturers engage with customers has changed as well. *Rita Numerof, “The 2024 Outlook For Global Pharma: A Look Ahead,” Forbes, December 28, 2023.*

Pharmaceutical Companies Raised Prices on 775 Drugs in Early 2024:

As many as 775 brand-name drugs have seen their list prices rise this year, with a median increase of 4.5%. Medications such as Ozempic and Mounjaro experienced 3.5% and 4.5% increases, pushing their monthly costs to close to \$970 per month or just over \$1,070, respectively. Four drugs had price hikes surpassing 7.5%: the asthma drug Xolair (Novartis) and GlaxoSmithKline’s Shingrix shingles vaccine were among them. Single-digit percentage jumps came with big dollars attached; Trikafta (Vertex Pharmaceuticals) for cystic fibrosis rose by 5.9% to \$26,546 per 28-day supply, and Skyrizi (AbbVie) for psoriasis went up by 5.8% to \$21,017. *Beth Mole, “Big Pharma hiked the price of 775 drugs this year so far: Report,” Ars Technica, January 19, 2024.*

Physician Payments Linked to Increased Prescriptions of PARP Inhibitors: A study found associations of non-research payments to physicians from pharmaceutical manufacturers with higher rates of prescriptions for some poly (ADP-ribose) polymerase (PARP) inhibitors and Medicare spending in the U.S. Out of 1,686 physicians, 68.7% of them received one or more non-research payments related to certain drugs between 2017 and April or May of this year, when the data were analyzed. Physicians who received payments were more likely to prescribe these medications. *Anju Murayama and Deborah C. Marshall, "Associations between pharmaceutical industry payments to physicians and prescription of PARP inhibitors in the United States," ScienceDirect, February 2024.*

Courts Dismiss Pharma Challenges to Medicare Drug Price Negotiations: This case is one of several lawsuits filed by drug manufacturers and industry groups challenging the Inflation Reduction Act's Medicare drug price negotiation program. So far, the Biden Administration has prevailed on all of the merits and federal judges have pelted pharma's legal case with doubt. AstraZeneca lost Agilon's diabetes drug Farxiga in the program to negotiation—it had also sued to block that back in March 2024, and a U.S. District Judge ruled against them over Farxiga enforcement being allowed. The judge questioned the company's claims during oral arguments, pointing out that government contracting routinely includes similar terms. The litigation is in its early stages and more of it will develop in the coming months. *Zachary Baron and Sheela Ranganathan, "Setbacks For Pharmaceutical Industry In Challenges To Medicare Drug Price Negotiations," Health Affairs, March 21, 2024.*

HEALTH INEQUITIES

Report Highlights Persistent Racial and Ethnic Inequities in Diabetes Care: Researchers found that the highest prevalence of diabetes by race and ethnicity occurs among American Indian and Alaska Native adults (13.6%), followed by Black (12.1%), Hispanic (11.7%), Asian (9.1%), and white populations at 6.9%. Newer, high-cost medications and diabetic technologies are less likely to be utilized with non-white patients; Black patients with diabetes are hospitalized at nearly three times the rate of white patients; and non-white individuals are much less likely to have a regular source of primary care and to have longer emergency department wait times. Nursing homes with higher concentrations of minority residents have lower staffing levels and are cited more often for care deficiencies. *Megan Lowry, "Little Progress Has Been Made in Closing Racial and Ethnic Gaps in U.S. Health Care; Federal Government Should Act to Fix Structural Inequities," National Academies of Sciences, Engineering, and Medicine, June 26, 2024.*

U.S. Health Care Inequality May Worsen, Experts Warn: People of color are less likely to have insurance than white individuals, and those who lack coverage are impeded from care by serious obstacles. Hospitals that serve a higher proportion of Medicare, Medicaid and uninsured patients often operate on thin margins, forcing closures or removal of services, which impacts minority communities at a greater rate. Mounting prescription drug prices have led many patients to go without essential medications, and new, high-priced treatments may be only feasible for those who can pay cash. These disparities account for the variations in life expectancy among racial, income, and education groups. *Caitlin Owens, "U.S. health care is deeply unequal—and might get worse," Axios, June 21, 2024.*

Children of Color Receive Inferior Health Care Across the U.S.: A report reveals children in the U.S from racial or ethnic minority groups receive care inferior to white children. It also showed that they are less likely to get diagnostic imaging and more likely to suffer problems during and after surgery. In emergency rooms, they wait hours longer and are far less likely to be diagnosed or treated for learning disabilities. The widest differences were in pain control: non-white children are also less likely to get pain medicine for conditions such as broken bones, appendicitis or migraines. *Maria Godoy, "Kids of color get worse health care across the board in the U.S., research finds", NPR, January 18, 2024.*

Racial and Ethnic Disparities Persist in U.S. Health Care Outcomes: This report details serious inequalities by racial and ethnic groups around the country. Compared with white patients, racial and ethnic minorities generally experience worse health status, access to care, and social determinants of health. Nonelderly American Indian or Alaska Native (AIAN) (19%) and Hispanic people (18%) each were more than twice as likely as whites (7%) to be uninsured. Hispanic (40%), Black (38%), and Asian (36%) adults were less likely than white adults (56%) to have received mental health services among the general population of any age within the past year. Black infants and AIAN infants died at least twice the rate of white infants (10.9 per 1,000 and 9.1 per 1,000, respectively) Additionally, the prevalence of food insecurity was more than three times as high among AIAN (24%) and Black children (21%) as among white children (6%). *Nambi Ndugga, Latoya Hill, and Samantha Artiga, "Key Data on Health and Health Care by Race and Ethnicity," KFF, June 11, 2024.*

Rural Patients with Heart Failure Face Worse Outcomes Than Urban Counterparts: This report explores

the differences in care and outcomes for patients with heart failure (HF) residing in the rural versus urban United States. Participants from rural areas had a 19% higher risk of incident HF compared to those from urban settings. Rural patients also have markers for lower quality care, such as lower use of evidence-based medical therapies. Rural patients often have greater exposure to environmental pollutants (e.g. heavy metals), as well. Together, these introduce a 40% heightened risk of cardiovascular disease in rural lives when compared with urban counterparts, showing this phenomenon had adverse effects on public health and health inequities, turning it into a chronic problem. Cayla Pichan and Adam D. DeVore, “Rural and urban hospitals in the United States: does location affect care and outcomes of patients with heart failure?,” *Expert Review of Cardiovascular Therapy*, Published online March 4, 2024.

Health Care Access Disparities Persist Among Marginalized Communities: This report highlights that differences in access to health care among marginalized communities (racial and ethnic minorities, Indigenous people, low-income individuals, new immigrants, LGBTQ+ people, persons with disabilities, and refugees) are persistent and widespread. These disparities are driven by a system of social, economic, and structural determinants, including systemic racism, discrimination to access care, health centers in remote areas, language barriers, and lower levels of literacy related to health. Barriers exist for marginalized communities such as lack of insurance coverage, limited access to primary care services, disparities in treatment and outcomes, and struggles navigating the health care system. The study also found that people with multiple social identities face added barriers to care. While efforts have aimed to tackle these concerns, marked disparities remain, thus warranting combined interventions to prevent and reduce inequity in health across populations. Gracie Williamson, “Healthcare Access Disparities among Marginalized Communities,” *University of Fort Hare*, 2024.

BURNOUT

Physician Burnout and Intent to Leave High in Key Specialties: A survey found that more than 1/3 of physicians are thinking about retiring, cutting back their hours or leaving the profession altogether, signaling the ongoing toll of physician burnout and job dissatisfaction. 12,400 physicians were polled across 31 states, with 35.7% of all doctors expressing at least a moderate desire to seek different jobs within two years; the rates were even higher among internists (39.1%), family physicians (37.3%), and ob-gyns (34%). Furthermore, 35.9% of physicians intend to

scale back their work hours in the next year. Georgia Garvey, “In 6 Specialties, Desire to Step Away or Scale Back Is Common,” *AMA*, July 23, 2024.

Burnout and Job Satisfaction Among Physicians: 153 physicians and advanced practice providers (APPs) from an academic surgery department were surveyed regarding burnout. According to the survey, 56% of employees said they were feeling burned out, while 48% said they would likely leave the company within three years. However, 61% of respondents claimed to be happy in their roles while 55% said that they were experiencing some form of professional fulfillment. Sally A. Santen, MD, PhD, Kelly S. Lockeman, PhD, Amelia Grover, MD, “Association of Burnout and Other Factors Within Physicians and Advanced Practice Providers in an Academic Surgery Department,” *SageJournals*, June 2, 2024.

Burnout Rates Among Physicians Show Severity and Longevity: In this report, 49% of 9,216 physicians from 29 specialties who were surveyed experienced burnout. Additionally, female physicians are more likely to experience burnout than their male colleagues (56% versus 44%). Although this has decreased some from last year, the duration and severity of burnout persists with 42% saying they’ve been burned out for over two years. 16% of female and 14% of male doctors were pondering leaving the profession altogether—a warning sign of severe burnout. Emergency medicine led among specialties with a burnout rate of 63%. “Physician burnout and depression, in 5 charts,” *Advisory*, January 31, 2024.

Health Care Burnout Crisis Intensifies Despite Medical Advancements: A total of 71,309 doctors quit in 2022 as stress and burnout levels reached a tipping point. The results of the COVID-19 pandemic have exacerbated these problems, and as a result, the CDC has reported more alarming rates of burnout, fatigue, depression, anxiety, and suicidal ideation in clinicians. The article claims that a contributing factor is the fact that Americans are dealing with chronic illnesses at higher rates than ever before (now affecting 60% of the American public). Robert Pearl, “Burnout In US Healthcare: New Data, Surprising Insights,” *Forbes*, November 22, 2023.

Health Systems Must Take Responsibility for Clinician Burnout Solutions: 1 in 5 U.S. physicians intend to leave their practice within two years. In 2021, more than 40% of clinicians reported they were considering leaving the workforce. 72% of 769 clinicians reported that they knew another clinician who intended to leave their field within two years, as of April 2024. Anna Bock, “To Fix Burnout, New Initiatives Go Beyond Worker Resilience and Put Onus on Health Systems,” *JAMA*, May 31, 2024.

PNHP CHAPTER REPORTS

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

In **CALIFORNIA**, members across the state have been working towards reconstituting PNHP-CA and reunifying its chapters, working diligently to create and finalize new guidelines for the organization. In Humboldt County, members have continued to work monthly with the Movement to Eliminate the Privatization of Medicare and placed ads in the booklet for the California Alliance for Retired Americans annual convention. In Santa Barbara, the chapter organized a monthly Health Policy Seminar, with a May 22 session focusing on nursing homes, led by Charlene Harrington, PhD. In addition, in collaboration with Dr. Ana Malinow, Kip Sullivan, and Dr. Corinne Frugoni, they sent a letter to California Health and Human Services Secretary Mark Ghaly addressing the issue of risk adjustment in the Office of Health Care Affordability. In Ventura, Dr. Leslie-Lynn Pawson presented to an audience of 80 community members at the June 22 Justice For All community forum, discussing the effects of Project 2025 on the Affordable Care Act, Medicare, and the movement for single payer. On July 17, Dr. Helen Petroff and Dr. Pawson presented a conference titled “Health Policy Update—What You Need to Know About Medicare Advantage” to residents and faculty at the Northridge Family Medicine Residency Program. Earlier in the year, members submitted a resolution titled “Protect Original Medicare” to the California Academy of Family Physicians (CAFP) All Member Advocacy Meeting. The resolution is currently under review by a CAFPA subcommittee, with a decision pending. *To get involved in California, please contact Lori Clark at lori@pnhp.org.*



Dr. Kitrina Kearfott staffs the Kentuckians for Single Payer Health Care booth at World Fest in Louisville on Aug. 31.

In June, **KENTUCKY** activists made a presentation on Single Payer at the annual meeting of the Kentucky Coalition of Labor Union Women. In late July, Medicare Birthday celebration flyers were distributed at several events, including a John Gage concert, a Frankfort Avenue concert, and the Schnitzelburg Dainty Contest festival. Activists also staffed a booth at World Fest in Louisville over the Labor Day weekend, engaging with attendees on both Saturday and Sunday. *To get involved in Kentucky, please contact Kay Tillow at nursenpo@aol.com.*

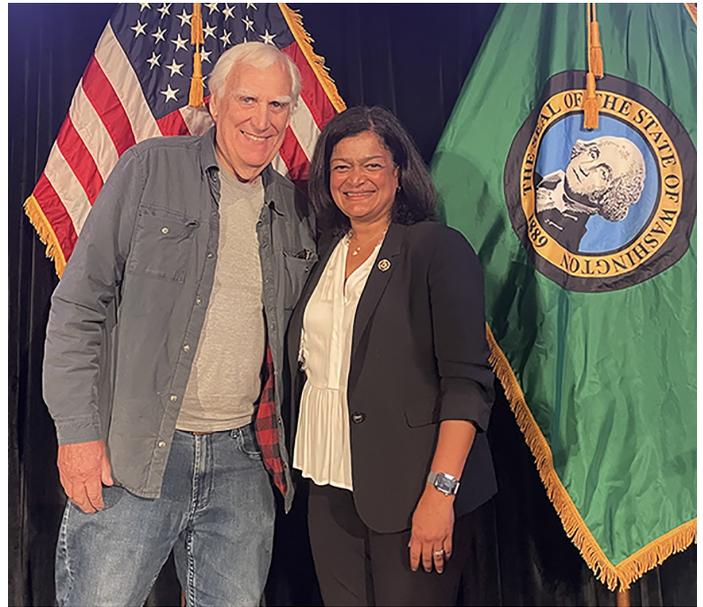
MAINE members successfully promoted and passed another four town resolutions supporting universal health care. They also engaged in ongoing discussions with three out of four federal legislators, focusing on their concerns surrounding Medicare Advantage. One member has organized a group of writers of letters to the editor, with 11 letters published in Maine newspapers since May. *To get involved in Maine, please contact Dr. Henk Goorhuis at henk@maineallcare.org.*

NEW YORK Metro members are strengthening their relationships with rank-and-file union members, and providing support for cross-union collaboration on NY Health Act and Medicare Advantage advocacy. They're also forging new and deeper relationships with local organizations whose missions align, and are collaborating on planning for several fall events and town halls on the NY Health Act. *To get involved in the New York metropolitan area, please contact Morgan Moore at morgan@pnhpnymetro.org.*



Drs. Helen Petroff (L) and Leslie-Lynn Pawson at the California Academy of Family Physicians meeting.

Several Western **NORTH CAROLINA** working group members participated in the June 26 Reclaim Medicare Training hosted by Be a Hero. HCFA-WNC has closely aligned with Reclaim Healthcare WNC to rally alongside Mission Health System nursing and staff against HCA, which took over the system in 2019. Their shared goals include replacing HCA with a non-profit owner dedicated to meeting the healthcare needs of the people in WNC, holding HCA accountable for harmful practices, and restoring best-in-class care throughout Mission Health. On July 19, a screening of the movie “Healing US” was held in Weaverville, NC, alongside a celebration of Medicare’s birthday. The next screening is scheduled for September 30 at the Grail Theatre in Asheville, NC, with several physician members participating in a post-showing panel discussion. *To get involved in Asheville, please contact Kathy Poling at kathy.poling19@gmail.com.*



Dr. David McLanahan (L) meets with Medicare for All lead sponsor Rep. Pramila Jayapal

PNHP **OREGON** members assisted in the creation of a new Students for a National Health Program (SNaHP) chapter at OHSU. They also purchased a table at the Oregon Health Forum fundraiser and sent a letter advocating for single payer to the Oregon Universal Healthcare Governance Board. *To get involved in Oregon, please contact Dr. Samuel Metz at s@samuelmetz.com.*

The **RHODE ISLAND** chapter has been actively meeting with provider advocacy groups and legislators, including members of their federal delegation, to discuss issues related to Medicare Advantage and value-based pricing. A key focus has been raising awareness, as most people remain unaware of the challenges posed by these systems. The chapter’s efforts have centered on education to inform both the public and policymakers about critical issues in the health care landscape. *To get involved in Rhode Island, please contact Dr J. Mark Ryan at pnhp.ri@gmail.com.*

WASHINGTON members played a key role in planning the August 28 “WA Single-Payer Health Care Summit,” which brought together 20 organizations and 40 organizers for a full day of strategizing on how to achieve single-payer health care for everyone in Washington State as well as the federal Improved Medicare for All Act. Rose Roach from the Labor Campaign for Single Payer delivered the keynote address, and Dr. Hugh Foy introduced PNHP-WA to attendees. The team also collaborated with Washington Physicians for Social Responsibility (WPSR) on several “Health Care Not Warfare” community meetings held around the state. Board members spoke at events in Olympia and Seattle. Additionally, members lobbied Congressional representatives and their staff to advocate against the privatization of Medicare. *To get involved in Washington, please contact Dr. David McLanahan at mcltan@comcast.net.*

During the summer of 2024, PNHP members in **WEST VIRGINIA** ramped up their involvement in the “Harms of Medicare Advantage Plans” campaign. They organized turnout for the June 3 webinar and participated in phone banking and national committee meetings to follow up with attendees. Additionally, members joined the national membership building committee and supported the August 28 orientation webinar for new members. Talks on the pitfalls of Medicare Advantage were given to community groups, particularly as the West Virginia University Hospital system launched its statewide Medicare Advantage Plan, “Peak Health.” Active planning and coalition building for the September 30 national Day of Action are in progress. WV-PNHP and People’s Action members also helped design the rally sign for the event, titled “Don’t Give Up Your Red, White, and Blue.” *To get involved in West Virginia, please contact Dr. Dan Doyle at doyleddan348@gmail.com.*



Rally sign for the Sept. 30 Medicare action in West Virginia.

ARE YOU SUFFERING MORAL INJURY?

PNHP IS PARTNERING WITH THE ROBERT WOOD JOHNSON FOUNDATION TO CONDUCT A NATIONWIDE SURVEY OF PHYSICIANS REGARDING FINANCIALIZATION OF HEALTH CARE AND THE BARRIERS THAT PROFIT-DRIVEN MIDDLEMEN PLACE BETWEEN THEM AND THEIR PATIENTS. THIS PROJECT WILL CONCLUDE WITH A COMPREHENSIVE REPORT TO POLICYMAKERS AND MEDICAL PROFESSIONALS IN LATE 2025.

TAKE
OUR
SURVEY

