Statement on Universal Healthcare

Student National Medical Association
Health Policy and Legislative Affairs Committee
Statement on Universal Healthcare

Third Revision

Revised and prepared for the Winter 2021 National Leadership Institute BOD Session
January 22-24, 2021
Virtual
By:

Jocelyn McGill, HPLA Committee Member
Aaryn Sophia Toles, HPLA Committee Member
Amber Donald, HPLA FLP Creative Advocacy Fellow
Alankrita Siddula, SNaHP Executive Board Member
Rex Tai, SNaHP Executive Board Member
Marysol Encarnación, SNaHP Inclusivity & Outreach Committee Leader
Justin Anderson, HPLA Committee Chairperson
Eloho E. Akpovi, HPLA Committee Chairperson

Originally authored in 2009 by:
Kari-Claudia Allen, MD
Shamsideen Musa, MD
Brenda Oiyemhonlan, MD
INTRODUCTION

Founded in 1964 by medical students from Howard University School of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation’s oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians. Despite tremendous efforts of the SNMA to achieve health equity for all people, health disparities continue to persist due to a system that is failing millions of Americans. For these reasons, the SNMA supports legislation aimed towards the expansion of healthcare, specifically the development of universal health coverage (UHC) throughout the United States (US). In the spirit of collaboration amongst colleagues in the health professions, SNMA joins Students for a National Health Program (SNaHP) in preparing the following policy statement describing the current state of US healthcare and major proposals toward the goal of UHC.

BACKGROUND

Many factors, including lack of primary care physicians and access to healthcare services, contribute to the health disparities that communities of color experience in the US. The most significant risk factor for victims of poorer health outcomes, including death, is lacking sufficient health insurance. Native Americans, Blacks/African Americans, as well as those residing in rural communities and inner-cities have extremely poor health outcomes – outcomes largely attributable to lack of health insurance or being underinsured – that are more characteristic of a low-resourced (developing) country than a rich, industrialized nation.¹⁻⁴

Prior to the passage of the Patient Protection and Affordable Care Act of 2010 (ACA), it was estimated that nearly 47 million US citizens and legal residents were uninsured, and millions more were underinsured. Minority populations represented the majority of those who lacked health coverage (32.4% Hispanic/Latinx, 20.5% Black/African American, 31.7% American Indian/Alaska Native, and 18.5% Native Hawaiian/Other Pacific Islander) despite making up 18.1%, 13.6%, 1.7%, and 0.4% of the country’s population, respectively.⁵ Following the enactment of the ACA, a net reduction of 20 million uninsured adults by 2016 also yielded improved uninsured rates in communities of color.⁶ However, the burden still falls inequitably on
communities of color who are significantly more likely to also be underinsured despite the newly available access to coverage. Underinsurance means Black Americans are more likely to have past-due medical debt, 31% vs 24% for white Americans. Lack of access and cost barriers has resulted in Black Americans living 3.5 years fewer than white Americans, having 77% higher risk of diabetes, and accounting for more than 40% of patients with HIV. While the gaps in our healthcare system affect individuals of all ages, races/ethnicities, and economic strata, individuals from the lowest income group are at a greater risk of being uninsured and underinsured, predisposing them to higher rates of health complications and financial insecurity exacerbated by the costs of healthcare.

**SCOPE OF THE PROBLEM**

As has been seen in recent history, the state of the American healthcare system is subject to volatility and fluctuations in the economy. All elements of healthcare, from its delivery to the number of individuals insured, have been negatively impacted with spiraling inequality. Increasing premiums, have forced families and individuals who once were insured to drop their coverage, often losing access to their prior provider network and thus continuity of care. Of those that remain on their existing coverage, 28%, or 41 million people, are finding that they are underinsured and thus responsible for deductibles that are as high as 20% of their annual income. Additionally, many individuals in low income communities work multiple part time jobs, which typically do not provide health insurance coverage. The 4% that are currently unemployed are unable to obtain insurance through an employer and thus remain particularly vulnerable to these market changes when purchasing a private plan. This trend has only been exacerbated with the ongoing COVID-19 pandemic, as to date, unemployment rates have reached as high as 14%.

Health insurance not only improves access to care, but also ultimately makes a difference in one’s overall health status. Unfortunately, the cost of healthcare and coverage in the US serves as a significant barrier to achieving health. For most, insurance is not always the buffer it should be for those costs, finding themselves burdened by insurmountable medical debt due to underinsurance. Despite the additional 20 million people who now have insurance through the ACA, the national rate of underinsured has been increasing from 23% in 2014 to 29% in 2018. For many of these individuals, the out-of-pocket expenses associated with seeking medical care are unmanageable with rates of bankruptcy and lost income due to healthcare bills remaining
unimproved from before enactment of the ACA.\textsuperscript{17,20-22} In order to avoid the potential financial burden of underinsurance, as many as 60\% of individuals who report difficulty paying their medical bills will avoid or delay care compared to just 11.5\% of those who have no difficulty.\textsuperscript{23}

Death due to treatable conditions accounts for 70\% of the Black-white mortality difference.\textsuperscript{24} This pattern of avoiding medical care is similar to the uninsured population who will only seek medical attention when a preventable illness develops.\textsuperscript{7,20} Thus, neither population is about to gain the health benefits of preventative care. The result is the development of conditions that are much more serious, difficult to treat, and are more expensive in the long term. For example, Hispanic/Latinx patients are twice as likely to suffer amputations and three times as likely to have end stage renal disease due to diabetes.\textsuperscript{25} Patients of color, in particular, are more likely to be enrolled in Medicaid,\textsuperscript{26} and, as a result, suffer from greater restrictions in their access to care. Furthermore, the poor quality of care available to patients of color in community and public hospitals is a direct result of the patient population lacking insurance or being covered by Medicaid. Without a varied payer mix and having to take on the costs of treating patients that come to the emergency room in more serious conditions, public and community hospitals serving minority neighborhoods are often inadequately funded and hence suffer from a lack of resources and staff to provide good quality care, thus impacting health outcomes. As a result, hospitals serving primarily underinsured communities of color are more likely to close down,\textsuperscript{27} such as the closure of Hahnemann in 2019, a renowned 178-year-old safety-net hospital in Philadelphia, PA,\textsuperscript{28} creating healthcare deserts and continuing to restrict access to care.

The US is virtually alone among industrialized nations in having yet to recognize healthcare as a basic human right because it has failed to ratify the International Covenant on Economic, Social and Cultural Rights, an international human rights treaty.\textsuperscript{20,21,29,30} France, Canada, Germany, and the United Kingdom are among many countries who have adopted a universal health coverage (UHC), which is defined by the World Health Organization (WHO) as “means that all people can obtain the health services they need without suffering financial hardship.”\textsuperscript{22} As a result, these countries have extended health coverage to all residents, and subsequently report improved health access and outcomes at a fraction of the cost of what the US spends per capita. Yet, despite spending more on healthcare that any other nation, the US still fares worse in areas of patient satisfaction, number of hospital inpatient days, and quality of care.\textsuperscript{20,29}

For instance, in the US, the infant mortality rate, one of the most sensitive indicators of a nation’s
health, is 5.8 per 1,000 live births, despite spending $9,892 per capita on healthcare. Canada, who has a similar infant mortality rate (4.8 per 1,000 live births), however, historically spends less than half as much ($4,753 per capita). Americans are paying more for their healthcare and getting less out of it.

There is a history of attempts to move towards a UHC model in the US, both at state and federal levels, though at a delicately slow pace. The Social Security Amendments of 1965, which created Medicare and Medicaid, was one such attempt at reducing gaps in access care for US citizens. Thirty-five years later, the ACA was the next and most recent attempt to close the gap at the federal level. Various campaigns have been attempted at the state level to develop UHC programs in recent years, however, none has seen successful legislation toward implementation. In the current political moment, awareness has grown about the remaining inequities and deficits of the current post-ACA healthcare environment, especially when comparing both health outcomes and national health expenditures to other countries that have implemented changes closer to achievement of UHC for their respective citizens. The following sections provide brief case studies on attempts at expanding health access toward UHC in the US, as well as in the peer, high-resource nations of Canada and Taiwan.

1. Case Studies

1.1. United States: The Patient Protection and Affordable Care Act, 2010

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA). The ACA is one of the biggest overhauls of the US healthcare system since the passage of Medicare and Medicaid in 1965. The ACA included many provisions that increased the insured population in the US by expanding access to healthcare, through Medicaid expansion and Health Benefit Exchanges, and expanding coverage, by abolishing pre-existing conditions, allowing dependent coverage till age 26, and requiring preventative care, in the hopes of controlling healthcare costs and improving the healthcare delivery system. The ACA has helped to insure millions of Americans; however, millions still remain uninsured since its enactment, including 11 million undocumented residents. Insurance plans on the Health Benefit Exchange from the start were low-premium, high-deductible plans within narrow networks that, although offered coverage, left many underinsured. Since 2010 the number of plans offered in certain geographic areas has dwindled, providing fewer options for many people. The ACA has also
incenitized hospital and provider organization consolidation through restructuring of Medicare reimbursement and facilitating creation of Accountable Care Organization (ACOs), resulting in hospitals driving out small competitors and raising prices for patients.\textsuperscript{38}

Nevertheless, the ACA has improved health outcomes while curbing the rising cost of health insurance, a trend predicted to continue should the law remain in place.\textsuperscript{39–42} Subsequent passage of the State-Based Universal Health Care Act, a proposed amendment to the ACA to establish and provide support for state-based universal healthcare systems, could enhance the positive results already seen.\textsuperscript{43} Unfortunately, President Trump and members of Congress have recently attempted to repeal and replace the ACA while only offering alternatives that would result in worse health outcomes.\textsuperscript{44} Though the ACA has proven to not be enough to alleviate all barriers that prevent a portion of citizens from accessing health insurance and healthcare,\textsuperscript{45} legislation that reverts the contributions it has offered to enhancing healthcare access would prove detrimental to the health of all Americans.

1.2. \textit{Canada: The Medical Care Act, 1966}

Canada passed the National Medical Care Insurance Act in 1966, taking a single payer universal coverage format first implemented by the Saskatchewan province to establish a decentralized collection of territorial insurance plans that must meet certain criteria to receive funding. These plans must be comprehensive in coverage, portable across all provinces and territories, universal in terms and conditions, accessible with no costs at point of service and have public administration. However, comprehensive coverage only includes hospital and physician services, leaving out prescription medications, dental, vision, and long-term care. This has resulted in three layers of funding for health services. Layer one is the public services covered by Medicare and paid for through taxation and free at point of service. Layer two is a mix of private and public insurance coverage and hence can involve out-of-pocket costs for prescription drugs, home care, and institutionalized long-term care. Layer three is entirely private and includes dental care, outpatient physiotherapy, and vision care. As a result, 65\% of Canadians have private supplemental health insurance,\textsuperscript{46} while many are without access and pay out-of-pocket for medicines and other care. Yet, prescription medications cost less in Canada compared to the US, due to the bargaining power the Bureau of National Insurance can yield. Canadians have longer life expectancy compared to the US, 82 and 78.7 respectively,\textsuperscript{47} and less disability adjusted life years (DALY) and infant mortality.\textsuperscript{48,49} Financially only 70.9\% of healthcare expenditure is
publicly sourced, similar to the US in some areas, but total healthcare expenditure constitutes 10.4% of Canada’s gross domestic product, compared to 17.7% of the US gross domestic product (GDP). A key factor for this difference is administrative waste, administration accounts for 34.2% of national health expenditure in the US, but only 17% in Canada.

1.3. Taiwan: National Health Insurance, 1995
Taiwan established their National Health Insurance (NHI) system in 1995 to increase efficiency and justice within the healthcare system at a time when only 57% of Taiwanese had access to care. The NHI is funded by the government, around 23.2%, and by employees and employers at 76.8%. The insured are split into 6 categories and 15 subcategories based on job and income, with the premium paid by the insured ranging from 0% for those that need government subsidies to 100% for those self-employed. There are still nominal co-payments for all services, such as a PCP visit at $1.22, with public assistance available for those that can’t afford co-payments. The NHI provides comprehensive coverage, everything from dental care to traditional Chinese medicine and elderly home care. Adoption of a single-payer system has decreased preventable deaths by 65.9%, has 70% public approval, and now life expectancy is on par with Canada, at 80.2, with lower infant mortality at 3.8. The percentage of GDP spent on healthcare is 6.2%, with administrative overhead only accounting for 2%, markedly better than Canada and the US. In addition, compared to Canada and the US, which utilize multiple electronic medical records (EMR) systems, the NHI has an integrated EMR system that allows patients to carry their medical records in a smart card and allows providers to access their information anywhere in the country.

2. Leading Policy Proposals
Given growing discontent with the current state of healthcare in the US when compared to peer nations across both cost and health outcomes measures, various health advocacy organizations and, more recently, professional physician societies, have begun to speak out in favor of more systematic change to how American healthcare should be funded and delivered. In January 2020, the American College of Physicians (ACP) released an entire supplemental issue of the Annals of Internal Medicine entitled “Envisioning a Better U.S. Healthcare System For All” outlining in a series of policy papers its recommendations on addressing long-standing questions around "ways to achieve universal coverage with improved access to care, reduce per capita healthcare costs and
the rate of growth in spending, reform clinician compensation, and reduce the complexity of our healthcare system.”

The ACP recommended either of two broad systemic solutions that also roughly mirror the leading proposals driving contemporary political discussions of healthcare reform: a “public option” or a “single payer” program. These two programs will be discussed in brief detail in the following sections with regards to how closely they are believed to achieve the overarching goals of providing universal health coverage, improved health outcomes, reductions in healthcare costs that lead to improved patient access to care, and more streamlined administration of medical billing and documentation.

2.1. Single-Payer Healthcare

Calls for a publicly-funded national health insurance plan go back nearly a century, proposed as a solution to the ongoing problem throughout the history of American medicine of prohibitive costs to medical care. Perhaps most notably, upon his inauguration to the US presidency in 1945, Harry Truman made one of his key policy goals to implement a program of healthcare made available to all Americans and to be paid for through a progressive universal payroll tax, as his vision to expand upon the New Deal. However, in the wake of McCarthyism and the Red Scare following World War II, the American Medical Association waged an active lobbying and public relations campaign against Truman’s health plan, striving to defeat what it characterized as government takeover of medicine by souring the American public’s perception of Truman’s health plan and killing it before it ever was put to a vote. Throughout the rest of the 20th century, progressive activists and politicians would continue advocating for the expansion of health access with the ultimate goal of coverage for all, but the major policy victories have entailed piecemeal approaches to expanding access for certain segments of the population in the form of Medicare, Medicaid, and the Affordable Care Act. Alongside the proliferation of employer-sponsored health insurance plans, which has since come to cover just under half, or 49.6%, of the US population, the US can be described to currently have a multi-payer system with a mix of private and public plans, with wide variability between plans both in out-of-pocket costs taking the form of premiums, co-pays, and deductibles, as well as in the range of health services that a given plan covers.

Organizations like Physicians for a National Health Program (PNHP), which is the parent organization under which statement co-author Students for a National Health Program belongs,
have long argued that this multi-payer mosaic of various private,\textsuperscript{57} for-profit health insurers running parallel to government-funded plans has been a direct contributor to spiraling rates of uninsurance and underinsurance, which has created significant cost barriers to healthcare access that lead to and exacerbate the poor health outcomes that Americans suffer when compared to patients in peer nations.\textsuperscript{58} The major goals of a single payer health program would be to provide universal health coverage to all US residents under the umbrella of a unified government payer, which would gain expanded leverage to set more affordable healthcare and pharmaceutical prices while drastically reducing the amount of non-patient care related spending that currently is extracted away toward administrative overhead, executive compensation, lobbying, and marketing expenses that keeps the private health insurance market afloat. The most commonly proposed mechanism for expanding coverage to all Americans is to enroll everyone into traditional, publicly-funded Medicare, with the added ambitions of eliminating financial barriers to care in the form of cost-sharing and out-of-pocket costs at the point of service, as well as providing expanded health benefits, such as long-term care, vision, dental, and prescriptions into this program, all of which has coalesced politically around the slogan of “Improved Medicare for All.”\textsuperscript{59} It is generally understood that such a single-payer government-funded plan would supplant the existing private employer-sponsored insurance market under the justification that eliminating private insurers would reduce redundancy in the healthcare system and lead to administrative streamlining with associated cost reductions in healthcare delivery; for example, a standard outpatient physician practice could see reduced overhead costs from about 17\% of revenue for private plans to around 2\% if emulating traditional Medicare.\textsuperscript{60} These structural rearrangements to the healthcare economy would stand to benefit healthcare providers by reducing the number of different insurance plans and unique billing standards they must account for, which would reduce expenses attributable to compensation for administrative staff, accounting fees, and legal fees, and simplified billing through a single payer with a single standard for billing and documentation would in turn restore many hours of the practitioner workday back to direct patient care,\textsuperscript{61} rather than devoting clinic time toward documentation and calling insurers in order to meet the demands of the current complex multi-payer system.

As a reflection of growing awareness and political mobilization around this healthcare vision in recent years, various bills have been introduced in Congress supportive of the goals of this “Medicare for All” movement. This includes H.R.1384,\textsuperscript{62} introduced by Representative
Pramila Jayapal (D-WA-07), and S.1129, introduced by Senator Bernie Sanders (I-VT), though each piece of legislation proposes subtle policy and implementation differences from one another that also deviate from recommendations made by advocacy organizations like PNHP. The position of this policy statement is not to endorse any particular piece of legislation but instead to describe the current political landscape of policy proposals, in which it is expedient to conceptualize a shared policy vision described by the term “single payer healthcare” of universal health coverage with comprehensive benefits and elimination of cost-sharing, paid for entirely by the US federal government without duplication of medically warranted services by private parties.

2.2. Public Option

The “public option” or “public choice” model encompasses a spectrum of policy proposals to address existing coverage gaps for currently uninsured Americans, that all share a unifying characteristic of preserving the private insurance market. Such programs attempt to make access to existing public programs like Medicare or Medicaid more feasible for uninsured and underinsured patients with a goal of improved affordability, nationwide portability, and coverage not tied to employment, relative to employer-sponsored options. The pool of patients already covered by employer-sponsored insurance would have the option to choose to enroll in the public insurance plan or remain in their existing plan.

A number of proposals have been recommended for the public option plans to incentivize greater insurance access while keeping out-of-pocket costs as low as possible. One such proposal is a Medicare buy-in option available to all Americans and automatic enrollment for the currently uninsured and newly born, utilizing a system of tax credits, premium subsidies, and out-of-pocket spending caps for low-income families. Other “public option” plans seek to expand the privately delivered Medicare Advantage benefit packages with greater regulatory oversight to keep costs low. Two common goals to these public option proposals are to avoid implementing new tax increases and to attempt to expand federal oversight and negotiating power on pharmaceutical prices.

The public option has a historical basis in the original proposal of the ACA to provide an additional insurance pool for low-income Americans that was eventually scrapped and replaced by state-based Medicaid expansion and the creation of individual marketplace exchanges. Though this umbrella of plans demonstrates potential in expanding coverage to all Americans, the ACP and PNHP note that the insistence on preserving private insurance plans running alongside a public
option poses a number of inherent weaknesses that may limit such a plan’s affordability and quality of care.\textsuperscript{64,65} Public option proponents insist that it would accumulate a large market share so as to outcompete private insurance with public premiums set at lower rates, but private plans could counterbalance this by employing greater selectivity of their beneficiaries and covering only healthy patients who do not require expensive care (sometimes referred to as “cherry picking” of healthy patients), while making the public option the de facto high risk pool of medically complex, costly patients (i.e., “lemon dropping” of sicker patients), which would in turn drive up premium costs for all public option enrollees.\textsuperscript{66} Adding the public option to the existing multi-payer system also retains the current complex, bureaucratic system that creates administrative burden and occupies up to ⅓ of clinicians’ time instead of direct patient care, with none of the downstream cost savings that a single payer system would address via streamlined billing and reduced overhead.

The public option would additionally operate in a largely similar political climate to that which has plagued the ACA over the past decade. By preserving the existing private healthcare industry, the public option would face continual pressure from lobbying groups funded by pharmaceutical companies, hospital groups, professional associations, and HMOs. With up to $225 million of lobbying expenditures spent in 2018 alone from federal races, these lobbying groups dominate political contributions in the health sector for the purpose of maintaining high profit margins in privately-delivered healthcare.\textsuperscript{67} Private gains are often secured at the expense of public programs, which see their payment rates for providers fall and budget allocations kept stagnant relative to high rates of growth in the private market, and pro-private insurance lobbying firms have already begun to signal that they would mobilize to keep public option plans weak and limited in market share,\textsuperscript{68,69} to the point that it could not feasibly outcompete private plans, despite the stated aspirations of public option proponents.

Additional weaknesses and pitfalls of a public option have been covered in more depth elsewhere, but key arguments have been presented on how such a program would start from a difficult foundation of ensuring equitable access in the context of a system that preserves a robust, profitable, and politically powerful private insurance sector.

\textbf{2.3. Cost Effectiveness}

Several studies completed in 2018 were targeted at estimating the price tag of a national health plan. Multiple cost analyses have found that restructuring the health economy to a single payer system
would yield considerable costs savings. Researchers at Yale University modeled a Medicare for All system that estimated a total savings of $450 billion annually, and even more conservative think tanks like the Mercatus Center have estimated savings of $2.054 trillion over 10 years. The majority of the savings come from reducing unnecessary expenditures such as administrative overhead costs from working within a decentralized, multi-payer system and a reallocation of these funds to direct patient care. The cost of healthcare services in the US have also grown faster than inflation, while at the same time are higher than in neighboring countries. For example, a coronary artery bypass graft is 50% more expensive than in Canada.

While public programs (i.e., Medicare, Medicaid, and the Veteran Affairs Health System) only provide coverage for approximately one-third of the US population, public health expenditures account for almost two-thirds of total expenditures due to a complex system of tax subsidies and government regulations overseeing private spending, which, taken together, contribute to a total per-capita cost of US healthcare at $11,120 in 2019, far exceeding the per-capita costs in the next highest-spending country of Switzerland at $7,320 and, by extension, every other nation in the world. It is worth noting that the public share of US per-capita expenditures of $7,273 still exceeds the total amount of spending for nearly every other country, which by extrapolation would suggest that current amounts of US spending is sufficient to provide health insurance to an entire nation’s population, if it could be reallocated more efficiently.

An average American family spends nearly $20,000 a year in insurance premiums, alone. This does not include copays, medications costs, and other hidden insurance deductibles that companies impose. Even the cost for healthy people who give birth averages at about $4,500 for out-of-pocket expenses per birth, with coverage. Another savings benefit would be a reduction of prescription prices that have only exponentially increased over time. A single payer system would allow for the government to negotiate with pharmaceutical companies for lower drug pricing because there would only be one buyer. This restructuring would prevent companies from overcharging on very necessary medications such as the EpiPen. Reducing these costs would save money not only for the country, but for individual patients and families. It is important to note that while this plan would add a total of $32.6 trillion to the federal budget (thereby marginally increasing taxes), this cost is lower than what most Americans already pay for healthcare out of pocket. These increased taxes are therefore offset by Americans no longer needing to purchase health coverage out of their salary.

3. Public Perception

A 2018 poll by Reuters shows that 70.1% of Americans support a policy of Medicare for All. Another 9.3% of respondents stated that they were not informed enough to decide about their stance on the policy. A majority of both Democrats and Republicans (84.5% and 51.9%,
respectively) support the institution of a Medicare for All plan. These numbers have been steadily increasing over the years, likely due to increased education and the public becoming more comfortable with foreign success in universal healthcare. In the wake of the COVID-19 pandemic and the 2020 elections, multiple polls have also recorded historic highs in levels of favorability for Medicare for All across all political ideologies, when comparing pre-pandemic and post-pandemic levels of support. A greater share of politicians have since adopted public stances supporting Medicare for All, with 118 cosponsors for H.R.1384 in the US House of Representatives and 14 cosponsors of S.1129 in the US Senate. Progressive electoral victories in 2020 have similarly been attributed to public support for Medicare for All in competitive swing districts, relative to more modest outcomes and lost Democratic seats in the House of Representatives among those not endorsing Medicare for All, in an election year characterized by widespread financial uncertainty and an overwhelmed health system amidst a global pandemic.

Medicare for All has likely gained public favor through an emphasis on improved health outcomes at lower cost enjoyed by many current recipients of public health insurance. Recipients of Medicare & insurance Veterans’ Health Administration benefit from the large size of their respective systems, which can set more consistent pricing for various covered health services (for example, the most expensive brand name medications on the VA formulary are capped at an $11/month copayment with even cheaper prices for generic drugs), and various studies have found associated improvements in medication adherence and management of chronic disease; for example, VA insurance has been associated with both reduced racial disparities in cost-related medication adherence between Black/African American and white beneficiaries as well as reduced mortality in prostate cancer, likely related to improved access to screening. Similarly, among elderly Americans of all races, rates of medical uninsurance drop once those age 65 enroll in Medicare, and Black Medicare beneficiaries in particular who suffer from chronic kidney disease but have improved access to dialysis and other forms of coordinated care for cardiovascular comorbidities through Medicare enjoy better survival rates than white CKD patients. While each of these programs faces various difficulties with lower rates of physician compensation and are not as comprehensive as the Medicare for All proposals, they do enjoy popular support among their beneficiaries who have guaranteed lifetime access once enrolled; future health reform toward universal coverage seeks to reproduce these benefits in improved health outcomes with considerable financial savings for all Americans.
STATEMENT OF POSITION AND RECOMMENDATIONS

We, the members of SNMA and SNaHP, jointly recognize the shortcomings of the ailing United States healthcare delivery system. Healthcare in the United States costs too much, covers too little, and excludes too many. The hopelessness and frustration of our communities have impelled us to become advocates for those undeserved and/or harmed by the health insurance market. Our sense of social responsibility deems it necessary for us to provide recommendations and possible solutions to the problem. Therefore, the SNMA and SNaHP recommends that all US citizens and residents should be guaranteed:

1. Universal health insurance coverage regardless of documentation status.
2. A portable, comprehensive benefits package, including prescription drugs, dental care, inpatient/outpatient mental health services, long-term care, optometry services, choice of provider, and more focus on preventive health.
3. Access to the aforementioned health services at minimal cost, ideally free at the point of service. At a minimum, we recommend zero cost sharing for low-income individuals and patients with disability, serious illness, and/or chronic conditions.
4. Increased numbers of culturally humble and committed healthcare workers (i.e., physicians and allied health professionals) to address the needs of underrepresented minorities and vulnerable populations and adequately disseminate health information.
5. Implementation of accountability systems within legal policies such as, the expansion of the State Children's Health Insurance Plan (SCHIP), Medicare, and Medicaid.
REFERENCES


3. Powell DJ, Xirasagar S. Excess deaths among the uninsured before the Affordable Care Act (ACA), and potential post-aca reductions. J Public Heal Manag Pract. 2017;23(3):e18-e27. doi:10.1097/PHH.0000000000000428


18. Soucheray S. US job losses due to COVID-19 highest since Great Depression. CIDRAP -


52. Chen BK, Yang C-Y. Temporal trend analysis of avoidable mortality in Taiwan, 1971-2008: overall progress, with areas for further medical or public health investment. *BMC*


70. Galvani AP, Parpia AS, Foster EM, Singer BH, Fitzpatrick MC. Improving the prognosis


