

Submission to the United Nations
Universal Periodic Review of

United States of America

Third Cycle
36th Session of the UPR
Human Rights Council
May 2020

Submitted by: National Lawyers Guild
Contact: International Committee
Contact person: Martha L. Schmidt
Contact person email: martha@MarthaLSchmidt.net
Contact person phone: 206.306.6305
Organization website: <https://www.nlg.org>
Organization established: 1937

and by: International Association of Democratic Lawyers
Contact person: Jeanne Mirer, President
Organization website: <https://www.iadllaw.org/>
Organization established: 1946

and by: People's Action Institute
Contact person: Sondra Youdelman, Campaigns Director
Organization website: <https://peoplesaction.org/institute/>
Organization established: 2016

and by: Rights and Democracy Institute
Contact person: Mary Gerisch, Co-chair, Board of Directors
Organization website: <https://www.rights-democracy.org/>
Organization established: 2015

Organizations submitting this report

The **National Lawyers Guild (NLG)** is the oldest multiracial bar association in the U.S. Its membership includes lawyers, law students, legal workers and jailhouse lawyers in most states of the U.S. It is part of the International Association of Democratic Lawyers (IADL). The NLG works *in service to the people to the end that human rights and the rights of ecosystems are more important than property interests.* (Preamble, NLG Constitution, amended 2018) This report has been prepared by Martha L. Schmidt, LL.M., J.D., a member of the International Committee of the NLG. She volunteers with local and national organizations (Health Over Profits for Everyone, United for Single Payer- Seattle, Health is a Human Right-WA and Physicians for a National Health Program-Western Washington) which advocate for a single payer health care system (national, improved Medicare) for all residents of the U.S.

The **International Association of Democratic Lawyers (IADL)** is an international legal organization with sections and members in more than 50 countries. IADL has consultative status with the UN and is accredited to ECOSOC and UNESCO. It was established to promote international law, understanding among lawyers and their associations and it works to achieve the aims of the UN Charter. The IADL Constitution calls for defending and promoting human and peoples' rights as well as integrating international human rights covenants into the national laws of each country.

People's Action Institute (PAI) is a 501(c)(3) organization with representatives nationwide in the U.S. PAI struggles for the rights of people in our democracy. One of its primary areas of emphasis is health care. PAI believes that people in the U.S. must have: 1) universal access, because health care is a human right and should be affordable and accessible to all, regardless of who you are, where you live, your citizenship status or who you work for; 2) public health care, because we need a public health system that takes power out of the hands of corporations and back into the hands of people; 3) an end to profiteering, because the health care system must serve people not profits; and 4) lower drug prices, because drugs should be subject to government regulations so they can be made affordable for all.

Rights and Democracy Institute (RDI) is a bi-state (Vermont and New Hampshire) 501(c)(3) organization. With allies nationwide, RDI fights for the human rights of people in the U.S. to take back our democracy and defeat corporate greed. RDI seeks to educate the public on human rights and believes that people must name their rights to claim those rights. Health care is one of those rights and is an intersectional issue. RDI believes the U.S. does not have a healthcare system; instead it has an insurance system, which is in violation of the human right to health care. Rights and Democracy promotes health care as a public good, based on principles of participation, equity, transparency and universal access.

The Right to Health

How financing affects the right to health care in the U.S.

Introduction

1. This report discusses obligations under UN Charter Articles 55 and 56; Arts. 2, 3, 25, and 28 of the UDHR; Arts. 2 and 26 of the ICCPR; Art. 5 of the ICERD, as well as the duty of a signatory not to defeat the object and purpose of the ICESCR, including the right to health protected by Article 12. The report critiques the previous Administration's UPR submission, paragraphs 70-73, which claimed that the Patient Protection and Affordable Care Act (PPACA) would significantly address health care discrimination, inequality and equity. Council recommendations during the last review which were supported/noted relating to health, 176.312, 176.314, 176.116, 176.309, 176.311, 176.338, and recommendations noted relating to migrants and health care are discussed. General Comments No. 14 (2000) and No. 22 (2016) of the ESCR Committee on the right to health and reproductive health and the Interim Report of the Special Rapporteur on financing in the context of the right to health, have been consulted for legal authority and recommendations. ***/1/***

2. The U.S. continues its pattern of a state not committed to human rights and the right to health. No priority is given to ratification of human rights treaties. No culture of support for human rights as universal, interdependent and indivisible exists, although polls indicate that approximately 70% of the American people believe health care should be a human right and support a single-payer system of national Medicare for all. ***/2/***

3. Areas of concern are policies that adopt hierarchies of rights, deny ESC rights, and a new foreign relations initiative that rejects international human rights standard setting through the UN system. Certain civil rights, such as freedom of religion, have been extended to non-human businesses and privileged over the human right to health care for a vulnerable population, women. ***/3/*** The current Executive Branch apparently rejects the previous Administration's stated commitment that it would treat economic, social and cultural rights as equally important with civil and political rights. In July 2019, a "Commission on Unalienable Rights" was established in the Department of State to promote natural law and natural rights. The commission charter privileges religious rights, and a chair has been selected who believes that requiring health insurers to provide contraceptives violates religious freedom. ***/4/***

4. The present Administration has repeatedly violated health care principles of non-discrimination and equality, universal access, and quality (highest attainable standard of physical and mental health). Examples of retrogression on expansion of health insurance under PPACA include 1) attempts to offer insurance plans of inferior quality that do not meet the statutory minimums; 2) proposing rules and filing cases to condition Medicaid coverage on work requirements under Sec. 1551, or stopping Medicaid expansion (potential loss of access for 22 million people); and 3) promoting discriminatory rules to deny protections, such as Sec. 1557, to individuals who face discrimination in delivery of care on the basis on sex, targeting those who are not cis-

gender, women who need abortions, people who are HIV-positive, people who are LGBTQI, and people who have limited English language proficiency.

Adequate Standard of Living and the Right to Health

5. The standard of living is declining in the U.S and measurements of equality indicate this decline will have an impact on the right to health. U.S. income inequality, as measured by the Gini index, increased from 0.463 in 2017 to 0.482 in 2018, more unequal and inferior to comparator European states and Canada, whose rankings were between .22 and .38. **/5/** The U.S. has a worse Gender Gap Index than comparable states (for 2018, Canada ranked #16, the U.S. #51), a measurement which factors in health, survival, and economic well-being. **/6/** Wealth inequality also reduces universal access and increases inequality in health care because of the private for-profit insurance financing, with numerous coverage gaps. In 2018 the U.S. had the highest wealth inequality of OECD states. It is estimated that 33% of people with income **above** the poverty level are “economically vulnerable.” Economically vulnerable means lacking liquid assets to deal with illness or sudden loss of income by maintaining a poverty level standard of living for at least 3 months. **/7/**

6. The health care (medical care) and welfare systems (income support, long term care) in the U.S. have a negative, synergistic impact on vulnerable people, causing them to become impoverished in order to secure medical services and goods. For disabled individuals with chronic conditions, private insurers and insurance-like affordable care organizations (ACOs) and health maintenance organizations (HMOs) find ways to reduce or refuse care to them because they have greater needs which affect business profits. Federal and state requirements to exhaust assets which are likely to be needed for support in the future, pegging support levels even below the poverty line and reduction of financial support from one program because of a minor but inadequate increase in another program, while demanding voluminous amounts of documentation of all expenses to discourage applications, means that individuals are deprived of an adequate standard of living. It's a life without dignity: “It's not the disease that made me disabled; it's being forced into poverty to pay for medical care and the way the system works to keep me impoverished.” **/8/**

7. African-Americans are a group especially affected by rising uncovered health costs because of wealth and income inequality. White households have 6.5 greater wealth than black households (2016), and income inequality is the main contributor to the wealth gap. **/9/**

8. Higher levels of income inequality coincide with increased mortality for lower income individuals, who are disproportionately female, people of color and minorities, as well as indigenous peoples. Inequality in life expectancy is growing. Men in the 1% highest income group live *14.6 years* longer than the men in lowest 1% income group. Similarly, women in the top 1% income group live *10.1 years* longer than their comparators in the lowest 1%. **/10/** The knowledge of this predictable outcome when setting policy and

passing laws supports a finding that the U.S. is engaged in arbitrary deprivation of the right to life, in violation of Art. 6 of the ICCPR.

9. A reduction of 10% in inequality could cause mortality of those aged 25-59 to be reduced by 3-9%. **/11/** Reducing inequality by any mechanism of tax redistribution is unlikely. The Tax Cuts and Jobs Act of 2017 which cut corporate tax rates from 35% to 21% is expected to worsen inequality. **/12/**

The Duty to Support the Right to Health by Adequate, Equitable and Sustainable Financing of the Domestic Health Care System

10. The state must ensure that adequate funds are available for health and prioritize funding in the national budgets as well as ensure equitable allocation of health funds and resources. **/13/** Fulfillment of this duty enables a state to realize progressively the right to health. Progressive realization should have already been achieved, considering the size of U.S. GDP and the percentage devoted to health care. The U.S. spent \$3.6 trillion on health care in 2018, of which 67% was derived from taxes. Health spending was 18% of GDP. **/14/**

11. Budgeting choices require a state to ensure maximum available resources are committed to achieve the right to health. Wise targeting so that allocations are made according to need are required. However, the budgeting process has misallocated resources. Some health systems are clearly not sufficiently funded, such as the Indian Health Service (IHS), which serves 2 million indigenous people, and which is funded from discretionary funds. As contrasted with per person annual funding for Medicare (\$11,000) and Medicaid (\$5700), the IHS received a meager \$3700. Funding for the IHS also fails to provide resources to upgrade aging facilities and to attract physicians and practitioners to remote areas, other violations of equity and quality of care. **/15/**

12. Mental health care has been stigmatized and its funding neglected. Suicide was the 10th cause of mortality in 2017, rising every year from 2008. Native Americans and Alaska Natives had the highest rates, and veterans take their lives at the rate of 20 deaths per day. Seniors, who are 12% of the population, accounted for 18% of deaths by suicide. Medicare beneficiaries, among others, are unable to find therapists who will accept Medicare payment. Deaths from overdosing on synthetic opioids increased by 71% **each year** from 2013 to 2017. On 15 August 2019 after two mass killings, the President called for institutionalizing people with mental health problems (“insane” people), rather than addressing violence as a public health problem, as recommended by the Special Rapporteur. **/16/** The VA adopted a public health approach to suicide prevention in January 2019.

Taxation issues in financing health care

13. The multi-payer system of the U.S. is funded from general taxes (with a reliance on income and social security tax) and from out-of-pocket payments by users of health care. These sources and the decline in tax revenues available from corporation tax, as

well as absence of tax from other capital sources raise problems of equity. /17/ Increasing funding from wage earners or from more progressive sources will be necessary to address the needs of an aging population. For some time, the U.S. has had lower effective corporate tax and higher reliance on individual income tax than its OECD comparators.

Privatization and profit incentives

14. The U.S. has a complicated private, multi-payer system (even more so after PPACA) with layers of intermediaries removing profits and creating waste and inefficiencies. Insurance companies as well as quasi-insurers like Accountable Care Organizations (ACOs) and Health Maintenance Organizations (HMOs), hospitals, and monopoly drug companies divert funding away from health care for individuals. The health care system is designed to benefit private business rather than guarantee the human right to health. Some recurring problems noted by the Special Rapporteur apply to the U.S. system: insufficient regulation of private actors (insurers, hospitals, drug companies), failure to prosecute corrupt practices, reliance on out-of-pocket payments by the users of care.

15. Since January 2014 when PPACA went into effect, commodification of health care has increased. Insurance provided by employers continued with little regulation. Other individuals were forced to buy insurance on the exchanges, and subsidies were channeled directly to private insurers. There is an elaborate system of different cost and quality tiers, without transparency about networks and costs of premiums for family members. Older people can be charged 3 times as much as younger people. The statutory regime barely affected the number of 19 to 26 year olds under their parents' insurance because the premiums were so high most families could not afford them. It failed to cap out of pocket spending because Health and Human Services waived this obligation for the insurance companies, although an individual who failed to buy insurance was subject to a penalty.

16. Publicly-funded single payer systems have been opened up to increased waste and risk of fraud. Medicare (serving 8.3 million [2018]) and the Veterans Administration (serving 9 million [2018]) have had their funding siphoned into for-profit parallel systems. Part B Medicare, which has administrative costs of 2%, has been set up to fail in the long run by creation of a parallel privatized system, Part C Medicare Advantage, which has administrative costs of 18%. Medicare has no restrictions on who beneficiaries can consult and offers portability throughout the country. Medicare Advantage, which has restricted networks, and markets extras to healthier, wealthier potential beneficiaries and offers a cap on costs, receives extra funding to guarantee profits to insurance companies and other middlemen. Veterans' health care, which was ranked in 2018 as "equal to or better than private care" /18/ has been undermined by the Mission Act, which changed funding from mandatory to discretionary appropriations and set up a process for sending veterans outside the VA to private facilities, which could cost more than \$100 billion/year. /19/

Privatization affects public discourse about health care as a human right

17. Increased privatization and delivery of health care on a commodified, for-profit basis stems from a belief in maximizing individual preferences rather than a conviction that individual capabilities need to be enlarged for a person to enjoy healthy well-being. By appeals to individualism, health care as a commodity has been reinforced. Supplying health care continues to be perceived by many as an act of charity in a society of unequal social relations. Although many Americans desire a sensible, efficient single payer system like an improved Medicare for all system, with barriers to universal access at the point of service removed, the attacks on expansion of Medicaid, a means-tested program under PPACA, have created confusion and fear. The public discussion about what kind of health care system promotes human dignity and how we can secure the right to health care has been complicated. The expansion of means-testing, while providing health insurance to more individuals, continued the myth of the need of individuals to prove they are deserving of dignity, and if not deserving, to be denied access. It was and is antithetical to a human rights approach to health, which rests on a social bond of commonality and which increases human dignity by promoting equal freedom in decision-making. The present denial of medical care to immigrant children and families attempting to apply for asylum in the borderlands where the US exercises jurisdiction is a stark example of this conflict over dignity and the human right to health.

Unsustainable for society, unaffordable for families

18. The U.S. percentage of national spending on health care is expected to climb to 20% by 2027. **/20/** The estimated cost over the next decade, 2019-2028, is *\$50 trillion*. **/21/** Health care spending has continued to rise as a percentage of GDP at the same rate since enactment of PPACA. Family coverage insurance premiums rose at the same rate after 2010 as they did before 2010. **/22/** The absence of cost controls and the amount of resources consumed by a multi-payer system that puts profits before health is significant because it means that adequate funds will never be available because they will be diverted. It means that funds will not be pooled into a single pool or several large pools for the most efficient use of resources to benefit all residents of the U.S. The inequitable health outcomes of life expectancy at birth, maternal mortality, infant mortality, and amenable mortality cannot be improved significantly without changing the health financing system.

19. The choices being made in the financing of health care promote economic insecurity of individuals and families as a result of health-related costs. From 2013-2016, of personal bankruptcies, medical problems contributed to 66.5%, medical bills contributed to 58.5%, and illness-related income loss contributed to 44.3%. This was similar to surveys done in 2001 and 2007. There is no evidence that PPACA reduced the proportion of bankruptcies, and expansion of Medicaid by a particular state had no impact on bankruptcies. **/23/**

20. Especially for workers who earn wages below median income, even when their out-of-pocket premium costs don't exceed the 8% cap/individual, the high deductibles

(creeping toward \$5000) and other out-of-pocket expenses, like copays and co-insurance, are barriers preventing them from actually using their health insurance. Other individuals cannot find an affordable health insurance plan in their state or locality, a problem related to the declining number of insurers. Many states have only one or two options on the health insurance exchanges.

21. Affordability is closely tied to equity, including for women, who are poorer than men throughout life. Despite its single payer financing and national pooling, Medicare has an inequitable impact on women. This is because it is funded regressively by imposing out of pocket costs on the individual, a barrier to universal access to all health goods, services and facilities for people over 65, living on fixed retirement income. According to 2016 data, 50% of Medicare beneficiaries spent up to 33% of their Social Security income on health care. Another 23% spent 34-50% of their income on health care. For 50% of beneficiaries, their income was below \$26,000. For 25% of Medicare beneficiaries, their income was below \$15,250. The cost of premiums for Medicare beneficiaries under Part B is forecast to rise by 5% per year for the next 10 years and consume greater portions of seniors' checks. Premiums increased by 195% since 2000. **/24/**

22. Rising suicides of seniors, such as the couple in Ferndale, Washington, in August 2019, are at least in part due to the cost of health care. The Centers for Medicare and Medicaid Services report that Medicare covers only about 65% of costs and costs more than double between the ages of 70 and 90. **/25/**

Universality

23. In 2010 at the time of passage of PPACA, 50 million people had no health insurance and it was estimated 44,000 deaths were attributable to that deficiency. In 2018, the estimated total number of individuals without health insurance, not counting children and those over 65, was 28.9 million. About 5.4 million individuals were without health insurance because of their immigration status (this could be for lack of documentation of their own immigration status or fear about other family members). **/26/** The estimated number of deaths attributable to lack of insurance in 2018 was 28,000. **/27/**

24. More people are covered by insurance presently (although this is starting to decline according to September 2019 news releases), but individuals now are experiencing financial distress from "underinsurance," charges for "out of network" care, information about which is not transparent, and gaps in coverage. Although 159.7 million people were covered by employer insurance in 2018 **/28/**, 45% were inadequately insured, the same percentage as were underinsured in 2010. The insurers and employers, whose actions are unregulated by PPACA, maintained their profits by increasing deductibles and pushing other costs onto employees. **/29/**

25. Medicaid and the Children's Health Insurance Program (CHIP) covered about 69.4 million (2018) individuals. **/30/** Of individuals qualifying for Medicaid, within a two-year period 25% are forced out of the program and become uninsured. **/31/** There are about

3 million people who are excluded from Medicaid in 14 states because their states did not expand coverage under PPACA. The U.S. Supreme Court held that states were not required to expand Medicaid to individuals between 100-138% of the poverty level, as PPACA provided. /32/ For the first time in 50 years, Medicaid coverage for health care has been made dependent on work requirements in 9 states, which is likely to have discriminatory effects on vulnerable people, including seniors, vets, people with mental illnesses, women, children, low waged workers, and Native Americans and Alaska Natives, and may deprive over 800,000 people of health care access. /33/

26. PPACA does not cover immigrants. States have the power to cover immigrants through their own funds. Therefore, access to individually-purchased health insurance varies from one state to another. Fewer than half the states offer health care to immigrants.

27. Medicare covers about 59 million beneficiaries over age 65 and continues to be restricted to citizens and immigrants who are lawful permanent residents (LPRs). (Part A, hospital care, is denied to LPRs.) A waiting period of 5 years can be imposed on immigrants. About 8.3 million disabled persons under age 65 are also Medicare beneficiaries. These programs are pegged to social security criteria (attachment to work), so are not fully universal.

Recommendations

28. A public discussion of national single payer health care, such as an improved Medicare system available to all residents in the U.S., should be encouraged. Ample public resources should be made available for this dialogue. A fair, accessible and complete public discussion is needed on the human right to health care.

29. Legislation and financing of a single payer system should be encouraged (bills have been introduced in Congress to cover all residents). By pooling funds, the U.S. could attain the kinds of efficiencies needed to have high quality care while removing barriers to universal access, reducing discrimination and inequality, and improving transparency. In a study done at the University of Massachusetts (2018), the feasibility of such an approach was shown to save between \$5.5 and \$11.8 trillion, with an estimated average of \$6.1 trillion, over a 10-year period. /34/

Endnotes

1/ E/C.12/2000/4 (2000); E/C.12/GC/22 (2016); A/67/302, 13 August 2012

2/ American Barometer Survey conducted by Hill TV and Harris X polling, 10/22/2018. <https://thehill.com/hilltv/what-americas-thinking/412545-70-percent-of-americans-support-medicare-for-all-health-care> (accessed 27 August 2019)

3/ *Burwell v Hobby Lobby Stores, Inc.*, 573 U.S. __, 134 S.Ct.2751 (2014)

4/ Rachel Lopez, "Pompeo's controversial plan to make human rights 'great again'," 25 July 2019, The Hill

5/ America's Health Rankings analysis of U.S. Census Bureau, American Community Survey, United Health Foundation, <https://www.AmericasHealthRankings.org> (accessed 2019)

6/ The Global Gender Gap Report 2018, World Economic Forum, <https://www.wef.ch/gggr18>

7/ Carlotta Balestra and Richard Tonkin, OECD Statistics and Data Directorate, "Inequalities in household wealth across OECD countries: Evidence from the OECD Wealth Distribution Database," Working Paper No. 88, 20 June 2018, [oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC\(2018\)1&docLanguage=En](https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC(2018)1&docLanguage=En)

8/ Personal interview with S.J. (name withheld), a resident of Santa Clara County, CA, an individual who suffers from myalgic encephalomyelitis (ME), 10 September 2019

9/ Dionissi Aliprantis and Daniel Carroll, "What is Behind the Persistence of the Racial Wealth Gap?" Economic Commentary No. 2019-03, 28 February 2019, Federal Reserve Bank of Cleveland, [clevelandfed.org/newsroom-and-events/publications/economic-commentary/2019-economic-commentaries/ec-201903-what-is-behind-the-persistence-of-the-racial-wealth-gap.aspx](https://www.clevelandfed.org/newsroom-and-events/publications/economic-commentary/2019-economic-commentaries/ec-201903-what-is-behind-the-persistence-of-the-racial-wealth-gap.aspx)

10/ Raj Chetty and others, "The Association between Income and Life Expectancy in the United States, 2001-2014," Journal of the American Medical Association, 315(16)(2016):1750-1766, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4866586/> (accessed 2019). See also GAO Report, Retirement Security-Income and Wealth Disparities Continue Through Old Age, GAO-19-587, study of individuals born between 1931-1941, released 8 September 2019 (commissioned by Senator Sanders), confirming mortality disparity between lowest and highest income quintiles.

11/ America's Health Rankings analysis of U.S. Census Bureau, American Community Survey, United Health Foundation, <https://www.AmericasHealthRankings.org> (accessed 2019)

12/ Suresh Nallareddy, Ethan Rouen and Juan Carlos Suárez Serrato, "Corporate Tax Cuts Increase Income Inequality," Working Paper 18-101, Harvard Business School, 2018, hbs.edu/faculty/Publication%20Files/18-101%20Rouen%20Corporate%20Tax%20Cuts_0a4626be-774c-4b9a-8f96-d27e5f317aad.pdf

13/ Interim report of the Special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 13 August 2012, A/67/302

14/ Andrea Witte, www.ConnectTheDotsUSA.com

Slide: “Despite ACA Improvements, U.S. Healthcare is Complex, Costly & Cruel,” updated 6/1/19 (sources omitted)

15/ Andrew Siddons, **Roll Call**, 5 March 2018 (accessed 2019), statement attributed to Ron Shaw, President, Association of American Indian Physicians

16/ Recommendations of the Special Rapporteur on the highest attainable standard of mental health. A/HRC/41/34 (June-July 2019)

17/ Special Rapporteur’s Report on financing, op. cit.

18/ Rebecca Anhang Price et al., “Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings,” *Journal of General Internal Medicine*, E pub April 2018, and www.RAND.org

19/ Commission on Care Report to Congress, 2016, Veterans for Peace

20/ Public Citizen, *The Case for Medicare for All*, 2019

21/ Andrea Witte, op. cit.

22/ Kip Sullivan, JD and Stephen Soumerai, ScD, “No, Obamacare Did Not Lower U.S. Health Costs,” July 29, 2019, <https://www.medpagetoday.com/publichealthpolicy/healthpolicy/81275>

23/ “Medical Bankruptcy: Still Common Despite the Affordable Care Act,” by David U. Himmelstein, Robert M. Lawless, Deborah Thorne, Pamela Foohey, and Steffie Woolhandler, *American Journal of Public Health*, March 1, 2019 (online Feb. 6, 2019), DOI: 10.2105/AJPH.2018.304901

At least 530,000 people go bankrupt annually as a result of health care costs. See Andrea Witte, op. cit.

24/ Mary Johnson, “How Low Inflation and Rising Medicare Costs Threaten Social Security Benefit Growth,” *Senior Citizens League*, Special Report, March 2018

25/ Marisa Iati, “Couple dead in apparent murder-suicide left notes saying they couldn’t afford medical care, police say,” *Washington Post*, 10 August 2019, <https://www.washingtonpost.com/nation/2019/08/10/couple-dead-apparent-murder-suicide-left-notes-saying-they-couldnt-afford-medical-care-police-say/>

26/ Congressional Budget Office, “Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018”

27/ Andrea Witte, op. cit.

28/ Congressional Budget Office (CBO), op. cit.

29/ Sara R. Collins, Herman K. Bhupal, Michelle M.Doty, “Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps but more Underinsured,” 7 February 2019, Commonwealth Fund

30/ CBO, op. cit.

31/ Collins et al., op. cit.

32/ *Nat’l Fed. of Ind. Bus. v. Sibelius*, 576 U.S. 519 (2012)

33/ Center on Budget and Policy Priorities reports, 2019

34/ Gerald Friedman, Ph.D., Yes, we can have improved Medicare for all, 11 December 2018, www.pnhp.org