



Do you need health care? Yes

Are you over 65 years old? Yes No

Did you or a spouse pay 10 years of Medicare taxes? Yes No

Do you have money to pay medical co-packet? Yes

Do you need care, dent or hearing? Yes

Are you a kidney dialysis or transplant patient? Yes No

Are you incarcerated? Yes No

Have you been on SSDI for at least 24 months? Yes No

Are you documented resident? Yes No

HUMAN RIGHTS ASSESSMENT OF THE MEDICARE FOR ALL ACT OF 2019

Medicare for All Act of 2019

The Medicare for All Act of 2019 is the most ambitious of several proposed health care reforms currently being considered in Congress. It aims to address two interrelated crises: the denial of care to tens of millions of people each year and the ballooning health care costs weighing down individuals, families, employers, and the whole country.

This assessment evaluates the Act against human rights principles, which obligate governments to guarantee all people's fundamental needs, including health care. They also provide a set of standards against which all policies, systems, and outcomes can be measured. This enables an in-depth analysis of all the key elements of health care proposals and allows the Medicare for All Act to be compared to alternative Medicare and Medicaid buy-in proposals, which NESRI will evaluate in a forthcoming assessment.

WHAT IS THE HUMAN RIGHT TO HEALTH CARE?

Because health care is fundamental to human life, all people have a right to care. This right is enshrined in the Universal Declaration of Human Rights and is widely recognized by the American public.

In order to meet human rights standards, a health care system must realize each of the following principles:

- **UNIVERSALITY:** Everyone must have guaranteed access to comprehensive, quality health care.
- **EQUITY:** Health care resources and services must be distributed according to people's needs without any systemic barriers to access. Everyone must get what they need and contribute what they can.
- **ACCOUNTABILITY:** Government has an obligation to establish a health care system that meets people's medical needs. All public and private actors in the health care system must be held accountable to human rights standards through well-defined public processes.
- **TRANSPARENCY:** The health care system must be open with regard to information, decision-making, and management.
- **PARTICIPATION:** The health care system must enable meaningful public participation in all decisions affecting people's right to health care.

Applying Human Rights Standards to Health Care

Human rights do not require a specific model for financing or delivering care, but they provide essential policy guidance. They require that the health care system's primary goal be the guaranteed provision of medically necessary care to all. Other considerations remain important but from a human rights perspective cannot be used to justify the denial of health care. The human rights framework also places the most marginalized individuals and communities at the center of our locus of concern in policymaking, for only when health care is guaranteed to those who are most marginalized is it protected as a right for everyone.

Recognizing health care as a human right requires us to interrogate all the reasons that people are currently being denied needed care. Evaluating who is denied care and why reveals that although 24 million people are officially counted as "uninsured," far more people—most of whom have insurance—are being denied care.¹ For example:

At least 19 million people fall into the gaps between insurance programs or face barriers to enrollment each year.

- **19 MILLION** people with insurance lose their coverage and become uninsured each year when costs become prohibitive or routine life events make them ineligible.*
- **11 MILLION** undocumented people are denied access to Medicaid, Medicare, and Affordable Care Act subsidies.
- **9 MILLION** people are eligible for Medicaid or CHIP but, due to variable eligibility over time and other challenges with enrollment, remain uninsured.²
- **OVER 5 MILLION** people who moved to the United States face a five-year waiting period for Medicare and Medicaid, and 1.5 million people with disabilities who receive Social Security's Disability Insurance face a two-year Medicaid waiting period.³
- **3.3 MILLION** children are uninsured despite near-universal insurance eligibility.⁴

At least 43 million people who have insurance are denied care every year because their insurance coverage does not meet their needs.

- **43 MILLION** people with insurance have no dental coverage.⁵
- **22 MILLION** people with insurance have no regular eye care coverage.⁶
- **16 MILLION** people over 65 will need nursing home care in the coming years,⁷ yet few people can afford private long-term care insurance or out-of-pocket nursing costs, and inadequate Medicaid funding limits eligibility, staffing ratios, and quality of care.

65 million people who have insurance are priced out of care by deductibles, coinsurance, copayments, and other forms of cost sharing each year.

- **40 MILLION** people must skip a doctor's appointment because of costs.
- **37 MILLION** people must skip taking a prescription because of costs.
- **36 MILLION** people must skip a medical test or treatment because of costs.
- **27 MILLION** people must skip seeing a specialist because of costs.
- **65 MILLION** people must skip at least one of these forms of care because of costs.

In addition to denying people care, high health care costs and privatized, individualized financing of care forced at least 64 million people—two thirds of whom were insured—into financial hardship. In just a two-year period:

- **64 MILLION** people were forced to use up all of their savings.⁸
- **50 MILLION** people were forced to assume credit card debt.
- **43 MILLION** people were forced to forgo paying for food, heat, or rent.
- **37 MILLION** people were forced to change their education or career plans.

To fulfill the human rights standards of universality and equity, the American health care system must:

- Cover all medically necessary care,
- Eliminate all financial barriers,
- Guarantee full access to the entire population,
- Provide a unified system of insurance that leaves no one out and eliminates inequitable tiers of access, and
- Equitably finance the health care system according to people's ability to pay.

To fulfill the standards of accountability, transparency, and participation, critical decisions about the provision of health care, including who gets care, what care they get, how much health care costs, and who pays what must be made on an individual level by patients' doctors and on a system-wide level through democratic processes that are guided by a clear commitment to meeting human health needs and protecting the public interest.

The American public cannot allow lawmakers to permit profit-driven companies to ration and deny care.

NOTES

* People frequently become ineligible for employer-sponsored health insurance, Medicaid, and other programs because of a job loss, change of employers, changes in work hours, changes in income, divorce, the death of a spouse or parent, aging, leaving school, and giving birth. For poor and working-class people, the problems are compounded. Because 45% percent of Americans do not have enough income or savings to afford a \$500 health care bill, according to the Kaiser Family Foundation, one medical event can set off a chain reaction causing people to lose income, a job, a home, and even custody of their children. And for low-wage workers dealing with variable incomes and work hours, limited internet availability, and other challenges, continual re-enrollment in a new insurance program each time life circumstances change is virtually impossible.

¹ Unless otherwise noted, all statistics on pages 2 and 3 are from the Commonwealth Fund's 2018 Biennial Health Insurance Survey, <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

² Kaiser Family Foundation, "Outreach and Enrollment Strategies for Reaching the Medicaid Eligible but Uninsured Population." <https://www.kff.org/medicaid/issue-brief/outreach-and-enrollment-strategies-for-reaching-the-medicaid-eligible-but-uninsured-population/>

³ Migration Policy Institute, "Legal Immigration to the United States, 1820-Present." <https://www.migrationpolicy.org/programs/data-hub/charts/Annual-Number-of-US-Legal-Permanent-Residents>; Social Security Administration, "Selected Data From Social Security's Disability Program." <https://www.ssa.gov/oact/STATS/dibStat.html>

⁴ National Center for Health Statistics, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-June 2018." <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201811.pdf>

⁵ Commonwealth Fund, "2016 Biennial Health Insurance Survey," <https://www.commonwealthfund.org/publications/surveys/2017/feb/2016-biennial-health-insurance-survey>.

⁶ Ibid.

⁷ Kaiser Family Foundation, "Medicaid's Role in Nursing Home Care." <https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/>

⁸ All statistics in this paragraph are from the Commonwealth Fund's "2018 Biennial Health Insurance Survey," supra note 1.

Human Rights Assessment of the Medicare for All Act of 2019

The Medicare for All Act of 2019 is the strongest Congressional proposal to protect the right to health care in the United States. In the summary assessment below, fully shaded circles indicate full adherence to human rights standards and partially shaded circles indicate room for improvement.

UNIVERSALITY

Everyone must have guaranteed access to comprehensive, quality health care.

STANDARD	ASSESSMENT OF THE MEDICARE FOR ALL ACT
Inclusivity	● Includes and automatically enrolls all U.S. residents. Provides free choice of providers.
Comprehensiveness	● Guarantees comprehensive coverage (including dental, mental health, reproductive, long-term care, and more).
Equal access	● Eliminates gaps and inequities between insurance programs. Eliminates non-medical factors as determinants of access to care. Provides for a swift two-year transition to Medicare for All.
Availability	◐ Monitors medical schools and encourages providers to work in understaffed specialties and geographies. Intervenes where private hospitals and clinics fail to meet health care needs by financing the construction, renovation, and staffing of health care facilities. Should take similar public action where drug companies fail to meet needs.
Adequacy	● Guarantees sufficient financing to meet health needs. Implements and enforces quality control standards.

EQUITY

Health care resources and services must be distributed according to people's needs without any systemic barriers to access. Everyone must get what they need and contribute what they can.

STANDARD	ASSESSMENT OF THE MEDICARE FOR ALL ACT
Responsiveness to health needs	● Delivers health care according to health needs, adjusting for variation across communities. Guarantees culturally appropriate care. Preserves the Indian Health Service and Veterans Administration to protect tribes' sovereignty and best meet health needs, but should ensure these agencies have adequate funding and accountability.
Elimination of financial barriers	● Eliminates premiums, deductibles, coinsurance, copayments, and out-of-network fees as barriers to care.
Elimination of financial burdens	◐ Eliminates the imposition of medical debt and financial hardship on patients and families. Should propose measures to assist those already burdened by debt.
Equitable financing	◐ Shifts from private financing falling heavily on people who are sick, poor, and middle-income to a unified public financing system. The degree to which equitable financing is achieved will ultimately depend on the progressivity of the tax structure, which the Act does not specify.
Elimination of discrimination and disparities	● Prohibits discriminatory treatment. Eliminates structural discrimination against people with low incomes, non-traditional workers, immigrants, people of color, rural residents, people with chronic illnesses, etc. Finances facilities and staffing in rural and underserved areas. Monitors and addresses health disparities across communities. Eliminates waiting periods and asset tests.
Access to social determinants of health	◐ Provides funding for public health programs. Should enable doctors to prescribe housing, utilities, or other basic needs to a patient when they determine access to such services is necessary to treat the patient's condition. Should also obligate the health care system to interface with social service systems to ensure those needs are met.
Protection of workers' rights	● Requires safe staffing levels at hospitals and clinics. Provides five years of support to workers who are no longer needed to conduct complicated billing and enrollment to transition into new jobs, education, or retirement. Should include additional protections for long-term care workers.

ACCOUNTABILITY

Government has an obligation to establish a health care system that meets people's medical needs. All public and private actors in the health care system must be held accountable to human rights standards through well-defined public processes.

STANDARD	ASSESSMENT OF THE MEDICARE FOR ALL ACT
Primacy of health and public welfare	● Reorients the health care system around a clear goal of meeting patients' health needs by removing insurers as intermediaries, prohibiting providers and manufacturers from extracting profits, eliminating payment schemes pressuring physicians to under-prescribe care, and eliminating pressure on states to cut Medicaid. Shifts decision-making from private companies to doctors and the public. By promoting health and financial security, enhances the wellbeing of individuals, communities, the economy, and democracy.
Deconcentration of anti-democratic power	● Reduces the power of health care corporations to warp legislation and regulatory policy.
Streamlining of administration	● Unifies nearly the entire American health care system under a single publicly financed insurance program, and vastly simplifying administration for providers, patients, and employers.
Cost control	● Halts the inflation of health care prices by publicly negotiating prices with providers, prohibiting profit-making, instituting global budgets for hospitals, establishing drug-cost controls, and streamlining public and private health care billing and administration.
Monitoring and enforcement	● Holds the government and private providers accountable by requiring reporting, establishing accountability and enforcement mechanisms, and creating appeals processes.

TRANSPARENCY

The health care system must be open with regard to information, decision-making, and management.

STANDARD	ASSESSMENT OF THE MEDICARE FOR ALL ACT
Individual access to information	● By unifying health insurance, vastly simplifies the information patients need to successfully navigate the system. Gives patients access to medical records. Should be strengthened by explicitly requiring the government to ensure information on navigating the health care system reaches communities facing language and informational barriers.
Data transparency and reporting	● Requires robust collection, standardization, and reporting of data across the health care system. Should go further by requiring that data be made easily accessible to the public.

PARTICIPATION

The health care system must enable meaningful public participation in all decisions affecting people's right to health care.

STANDARD	ASSESSMENT OF THE MEDICARE FOR ALL ACT
Participation	● The Act was developed with significant community and provider input. It requires the Secretary to consult with provider and patient advocacy organizations, researchers, and public officials to inform policies, a major improvement over private decision-making in insurance markets. It should go farther in creating additional opportunities for communities to participate in assessing health needs, budgeting, monitoring, and accountability.

Full Assessment

UNIVERSALITY

Everyone must have guaranteed access to comprehensive, quality health care.

INCLUSIVITY

- Makes all U.S. residents eligible for and automatically enrolled in coverage.
- Guarantees all residents free choice of providers. (Providers would be allowed to opt out of the program to deliver non-covered services, but given the importance of Medicare for All as the primary source of health care financing, virtually all providers would participate.)

COMPREHENSIVENESS

- Guarantees comprehensive coverage of all medically necessary care including primary and preventative care, inpatient and outpatient hospital care, ambulatory and emergency care, prescription drugs and devices, mental health and substance abuse treatment, laboratory and diagnostic services, comprehensive reproductive care including abortions, pediatrics, oral health care, audiology, optometry, rehabilitative services, dietary and nutritional therapies, podiatric care, medical transportation, early screening and diagnosis, and the full spectrum of long-term care services, with a default to home-based services that allow people to stay in their own homes.
- Finances capital expenditures to ensure availability of comprehensive services in all geographies, with designate funding for rural and medically underserved areas.
- Creates a presumption in instances in which care is not automatically covered (as with certain alternative and experimental treatments and medicines) that doctors should exercise professional judgment on behalf the of their patients. It also establishes mechanisms for patients and doctors to appeal non-coverage and for the Secretary of Health and Human Services and States to expand coverage.

EQUAL ACCESS

- Pools risks and benefits across all of society, thereby achieving superior health outcomes at lower cost, ending the segregation of sicker and poorer people into separate insurance pools with inferior health care access than healthier, wealthier populations, and eliminating eligibility, enrollment, and coverage gaps

between programs. (Only the Indian Health Service and Veterans Administration would remain separate.)

- Bases access on medical needs, not nature of employment, ability to pay, place of residence, immigration status, family structure, age, or any other factor.
- Creates a swift two-year transition into Medicare for All, ensuring that human health needs are met as soon as possible. One year after passage, all people under 19 and over 54 years old would be automatically enrolled, and everyone else would have the option of remaining on their existing insurance plan or buying into Medicare for All for one year at a 90% actuarial rate, with subsidies available to people with low and moderate incomes. Two years after passage, all insurance programs would be rolled into the Medicare for All system and all remaining U.S. residents would be automatically enrolled. Measures would be put in place throughout the transition to assure a smooth process, especially for people with disabilities, complex medical needs, or chronic conditions and people who are hospitalized during the transition.

AVAILABILITY

- Establishes an Office of Primary Health Care to coordinate health professional education policy and goals; monitor the number and specialty of individuals being educated and trained; increase the number of primary care practitioners, registered nurses, midlevel practitioners and dentists; recommend training and technical assistance; and identify rural and underserved areas with unmet needs.
- Ensures that all regions have health care facilities by providing public financing in rural and other areas underserved by private hospitals and clinics.
- Should take similar public action in instances where drug companies fail to meet needs, such as by steering public research dollars toward treatments for medical conditions receiving inadequate attention, reforming patent law, putting publicly funded research in the public domain, and establishing an Office of Drug Manufacturing to manufacture generic drugs that pharmaceutical companies are not producing and selling affordably.

ADEQUACY

- Meets all human medical needs by assessing health needs annually and raising the tax revenue needed to meet those needs, thereby eliminating denials of care resulting from inadequate financing.
- Leaves States and medical provider associations the authority to set, monitor, and enforce professional

standards. To ensure universally high-quality care, establishes national minimum standards including requirements for facilities, services, staffing ratios, training, and wait times; monitors disparities across racial, socioeconomic, gender, and geographic groups; and requires federal action to address disparities.

EQUITY

Health care resources and services must be distributed according to people's needs without any systemic barriers to access. Everyone must get what they need and contribute what they can.

RESPONSIVENESS TO HEALTH NEEDS

- In health needs assessments, data collection, and reporting, requires attention to different health needs, outcomes, and disparities across racial, gender, geographic, and socioeconomic groups. To equitably improve outcomes in marginalized and underserved communities, allocates resources according to communities' needs and establishes baseline quality-of-care standards for health care facilities and services.
- Supports the needs of specific communities by providing culturally appropriate care for all communities and providing medical transportation to people with disabilities and low-income people who have limited mobility.
- Preserves the Indian Health Service and Veterans Administration in order to honor Native American and Alaska Native tribes' sovereignty and to best meet the health needs of indigenous communities and veterans. The Act should allocate sufficient funding for these agencies to meet health needs and implement accountability mechanisms to ensure effective administration and delivery of care.

people with chronic diseases, people with disabilities, elders, and family and friends who support them.

- Should propose measures to assist people who have already been forced into medical debt by the current health insurance system.

EQUITABLE FINANCING

- Replaces private financing with an entirely public, tax-financed health insurance model that ensures that everyone's medical needs are met.
- Eliminates inequitable premiums and out-of-pocket costs, which fall most heavily on people with severe illnesses and working-class, and middle-class people.
- Ends the inequitable distribution of public resources and subsidies across programs (notably including subsidies for high-income workers' private insurance plans). Instead raises the revenue needed to meet everyone's needs and steers the greatest resources to communities with the greatest health needs.
- Does not include a specific tax proposal for financing the bill. If Medicare for All were financed through a combination of progressive income, wealth, and payroll taxes, as advocates have proposed, the vast majority of Americans would receive significantly more robust health care coverage and guaranteed protection against costly medical bills at similar or lower costs than they pay for health care now. At the same time, the wealthiest would pay a significantly higher share, and income and wealth inequality would diminish. The extent to which Medicare for All advances equity in financing however, will ultimately depend on the specifics of the plan.

ELIMINATION OF FINANCIAL BARRIERS

- Eliminates all premiums and deductibles, coinsurance, copayments, out-of-network fees, and other cost sharing, thereby eliminating financial barriers to care. This would ensure that health care is based on medical need, not financial circumstances.

ELIMINATION OF FINANCIAL BURDENS

- Puts an end to the imposition of medical debt and financial hardship on patients and their families. The elimination of pay-for-access medicine and the financing of long-term care would especially benefit

ELIMINATION OF DISCRIMINATION AND DISPARITIES

- Explicitly prohibits discrimination “on the basis of race, color, national origin, age, disability, marital status, immigration status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy).”
- By eliminating tiers of insurance coverage and access, eliminates structural discrimination against people with low incomes; non-traditional workers; people with frequent changes in income, employment, and/or place of residence; immigrants; people with specific medical conditions (chronic illnesses, mental health needs, addiction, reproductive care, dental care, etc.); and people too young for Medicare, among others.
- Monitors racial, gender, geographic, and socioeconomic disparities, steers funding to communities with greater needs, and sets and enforces quality-control standards.
- Eliminates years-long waiting periods that prevent people with disabilities and documented immigrants from getting health care through Medicaid or Medicare, and eliminates asset tests for people with disabilities.

ACCESS TO SOCIAL DETERMINANTS OF HEALTH

- Establishes a fund for health needs arising from epidemics, pandemics, natural disasters, and other

health emergencies, and provides funds for prevention and public health. Maintains funding for existing public health programs and directs the Secretary of Health and Human Services to integrate these programs with Medicare for All.

- Should enable doctors to prescribe housing, utilities, or other basic needs to a patient when they determine access to such services is necessary to treat the patient’s condition, and should obligate the health care system to interface with other social systems to ensure those needs are met.

PROTECTION OF WORKERS’ RIGHTS

- Requires hospitals and other providers to maintain safe nursing and staffing levels.
- Provides five years of financing to help dislocated workers transition out of billing, administration, and other jobs that are no longer needed in a simplified, streamlined insurance system. Includes direct funding for income replacement, retirement benefits, job training, and education.
- Should provide additional protections for long-term care workers in both institutional and home-based care settings such as minimum wages, reliable scheduling, better safety standards, and protections of workers’ right to unionize without obstruction by employers.

ACCOUNTABILITY

Government has an obligation to establish a health care system that meets people’s medical needs. All public and private actors in the health care system must be held accountable to human rights standards through well-defined public processes.

PRIMACY OF HEALTH AND PUBLIC WELFARE

- Reorients the health care system around a clear goal of meeting human health needs, and established mechanisms to hold public administrators and all medical providers accountable to this goal.
- Eliminates insurance companies’ role as gatekeepers who ration patients’ access to essential care. This shifts decisions on who gets care and what care is delivered from private insurance companies to doctors (for individual patients’ treatment) and to democratic processes involving public administrators, medical professionals, and public health experts (for the health care system as a whole).

- Publicly negotiates payments with all hospitals, clinics, physicians, and other providers, thus establishing health care prices in a democratic, transparent process designed to serve the public interest rather than a private process controlled by companies with a pecuniary interest in driving up prices.
- Clearly directs physicians to meet patients’ health needs, requires them to report all financial interests in drugs and treatments they prescribe, and eliminates “value-based payments,” a business practice that insurance and hospital companies use to incentivize physicians to restrict patients’ care.
- By placing full responsibility for meeting health needs on the federal government, removes budgetary

incentives for States to restrict Medicaid eligibility and coverage. Only allows States to take actions that further expand eligibility and coverage.

- Safeguards the American economy and democracy by promoting health security and financial security, improving public health, eliminating costly medical bills, allowing people to change jobs and leave relationships without losing insurance, reducing paperwork and cost burdens on patients, providers, and employers, streamlining public administration, and ending the influence of health insurers over electoral campaigns and lawmaking.

DECONCENTRATION OF ANTI-DEMOCRATIC POWER

- By removing insurance companies as intermediaries and requiring providers and manufacturers to operate as nonprofits, reduces the political power of health care corporations to warp federal and state legislation and regulatory policy in ways that deny access to care, shift costs onto patients, employers, and the public, and shrink the sphere of public decision-making.

STREAMLINING OF ADMINISTRATION

- Minimizes administrative costs and complexity by freeing providers from handling costly billing for multiple insurers, freeing employers from the burden of providing health insurance, freeing patients from enrollment, eligibility, and billing burdens, and merging nearly all public insurance programs and subsidies into a single public Medicare for All Program.
- Merges Medicare, Medicaid, TRICARE, the Federal Employees Health Benefits Program, employer-sponsored insurance, Affordable Care Act subsidies and marketplaces, and individual insurance plans covering medically necessary care into Medicare for All.

COST CONTROL

- Achieves huge savings by eliminating needless administration, marketing, and profits generated by private insurance companies; reducing providers' administrative costs through a unified national billing system; freeing employers from managing insurance plans; merging federal and state health administration into a unified system built on existing Medicare infrastructure, which currently incurs overhead costs of just 3%; and tracking data on utilization, spending, and other metrics to improve administrative efficiencies over time.
- Takes public action to restrain the increasing costs of hospital and clinic bills, drugs, medical devices, specialists, and treatments by prohibiting providers

and manufacturers from extracting profits from public payments; monitoring provider spending patterns; requiring physicians to disclose financial interests in all drugs and treatments they prescribe; requiring the federal government to negotiate prices paid to physicians, hospitals, clinics, and drug, medical device, and biomedical manufacturers; implementing global budgets for all hospitals; and introducing drug formularies, a preference for generics, and other drug-purchasing reforms.

- Shifts the decision-making power over the cost of care to the public sphere by setting up price negotiations between the government, providers and manufacturers each year. This transparent, democratic public process would give providers and manufacturers ample voice and participation, but would protect the public welfare by ensuring that health care prices do not continue to spiral out of control.

MONITORING AND ENFORCEMENT

- Establishes procedures for patients to appeal determinations of coverage and noncoverage, physician determinations that care is not medically necessary, discrimination, or any other aspect of the health care system.
- Holds providers accountable by allowing patients appeals, instituting whistleblower protections, and establishing and evaluating national minimal standards on adequacy and quality of care, safe staffing ratios, continuity of care, wait times, and other matters. Requires hospitals to report data on inpatient discharge, emergency departments, community benefit activities, staffing ratios, workers' wages and hours, health information technology, and patient outcomes. Requires physicians to report "reasonably required" information to the Department of Health & Human Services including data on quality standards, payments received, and any financial interests they hold in drugs or treatments they prescribe.
- Holds the Department of Health and Human Services accountable by requiring reports to Congress, audits by the Comptroller General, and reports by the federal Center for Clinical Standards and Quality. Requires the Secretary of Health and Human Services to implement the Center's recommendations.
- Requires system-wide data collection and monitoring to minimize both underutilization and overutilization of care and services.
- Requires the Secretary to monitor health disparities across geographies and populations and to shift funding to areas of higher need.

TRANSPARENCY

The health care system must be open with regard to information, decision-making, and management.

INDIVIDUAL ACCESS TO INFORMATION

- Makes it far more possible, due to the simplicity of the unified insurance system, for everyone to have access to the information they need to navigate the health care system.
- Requires patients to be given access to their medical records.
- Should require the government to ensure that information on transitioning to and navigating the Medicare for All reaches communities facing the most information barriers, such as non-English speakers,

people without internet access, and people who are homeless or otherwise lack a permanent residence.

DATA TRANSPARENCY AND REPORTING

- Establishes a national database and uniform reporting requirements to standardize data.
- Should explicitly require that data be made easily accessible to researchers and the public, such as through a user-friendly online data portal.

PARTICIPATION

The health care system must enable meaningful public participation in all decisions affecting people's right to health care.

- The Medicare for All Act of 2019 was developed with significant participation by labor and community organizations representing nurses, physicians, and patients. It was also built on the policy framework established by HR 676, a long-standing piece of legislation that incorporated contributions from a wide range of stakeholders over the years.
- Requires the Secretary of Health and Human Services to "consult with Federal agencies, Indian tribes and urban Indian health organizations, and private entities, such as labor organizations representing health care workers, professional societies, national associations, nationally recognized associations of health care experts, medical schools and academic centers, consumer groups, and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this Act." This is a major improvement over the status quo, where critical decisions about the health care system are made by private health care companies.
- Establishes an advisory commission on long-term care involving people with disabilities and elders, organizations representing the gender, racial and economic diversity of these communities, providers, disability rights organizations, organized labor, and researchers.
- Involves patient advocacy organizations, physicians, registered nurses, pharmacists, and other health care professionals in the development of the drug formulary.
- Retains existing state-level regulation of professional licensing and standards of practice, which retains significant participation by medical professionals in developing and enforcing standards of care.
- Requires the Secretary to "consult with communities and advocacy organizations of persons living with disabilities as well as other patient advocacy organizations to ensure that the transition buy-in takes into account the continuity of care for persons with disabilities, complex medical needs, or chronic conditions."
- The Act should go farther in creating opportunities for everyday people to participate in health needs assessments, budgeting processes, and monitoring, evaluation, and accountability processes, such as by involving communities in determining how their health needs are met (through clinics, home-based services, schools, etc.), implementing participatory budgeting practices; and identifying, developing, and implementing complementary social supports and community institutions to promote health.

Conclusion

The United States has a human rights obligation to guarantee health care to everyone within its borders, and as the wealthiest country in the world, has every ability to do so. Though it is true that even the United States does not have unlimited resources, the primary problem driving the health care crisis is not a lack of resources—we spend far more than any other country on health care already—but the way in which the costs and benefits of the health care system are inequitably distributed across the population. By treating health care as a commodity rather than as a human right and public good, the multi-payer insurance system and for-profit delivery system deny tens of millions of people needed care and impose enormous financial burdens on the entire country.

Though human rights do not require a specific financing or delivery system, they do require that quality, comprehensive health care is universally available to all, that care is delivered equitably according to individual and community health needs, that health care costs are apportioned equitably according to people's ability to pay, and that the whole system is run democratically by operationalizing the principles of accountability, transparency, and participation. The existing health care system falls far short of meeting each of these criteria.

Measured against human rights standards, the Medicare for All Act of 2019 is by far the strongest health care proposal being considered by Congress. If implemented as written and financed progressively, it would guarantee health care as a public good freely available to all, provide financial security, improve national health outcomes, and limit the continued growth in the nation's health care costs. It would close coverage gaps between insurance programs, abolish coverage limitations, narrow networks, and cost barriers, and eliminate inequitable tiers of coverage that allocate different levels of health care access not on the basis of medical need, but on discriminatory non-medical factors such as income, wealth, employment, age, and immigration status. It would shift health care decision-making from private health care companies to doctors and public, democratic processes. And by including the entire population in a unified program, it would protect public health insurance programs against future political attacks commonly waged against non-universal means-tested social insurance programs.

The Medicare for All Act of 2019 sets a new standard for universally and equitably guaranteeing health care as a human right in the United States.

NESRI NATIONAL ECONOMIC & SOCIAL RIGHTS INITIATIVE

Human Needs | Human Rights

Our Mission

In partnership with communities, NESRI works to build a broad movement for economic and social rights, including health, housing, education, and work with dignity. Based on the principle that fundamental human needs create human rights obligations on the part of the government and private sector, NESRI advocates for public policies that guarantee the universal and equitable fulfillment of these rights in the United States.

Our Role

NESRI partners with community organizations to elevate their voices, strengthen their campaigns, and effect change. Working in a participatory way and guided by human rights principles, whether we take action on the ground, foster coalition building, or offer broader analysis, we are accountable to decisions made collectively with our partners and grassroots leadership.

Through our collaborations, NESRI gives national impact to local actions by developing replicable and scalable models and spreading them across the country. We bring an inclusive human rights approach that builds power, shifts narratives and debates, and changes policies by putting people's experiences at the center and bridging divisions between issues and communities.

www.nesri.org