Good Afternoon, I'm RoseAnn DeMoro, Executive Director of National Nurses United, with 190,000 members, we are the largest organization of registered nurses in the United States.

I'm here to urge you on behalf of patients and their Registered Nurse advocates to demand guaranteed healthcare for all. This is a moral imperative.

As a matter of justice, healthcare – and health itself – is a human right. As a matter of democracy, we demand popular control over not only our individual health, but of the entire healthcare system.

No issue is of greater urgency to nurses. Even with the improvements of the ACA, nurses every day experience the pervasive problems that remain with our broken and dysfunctional healthcare system that compromises their ability to provide the care their patients need and deserve.
They see patients who cut their prescription meds in half or take them every day or never fill prescriptions. They see patients who skip even vital care, from colonoscopies to chemotherapy due to the high out of pocket costs.

Nurses are the last line of defense for all the rampant social ills in our nation that arrive at the hospital bedside, the harmful health effects of poverty, malnutrition, homelessness, unemployment, racism, sexism, and homophobia, and environmental pollution and its disproportionate impact on the low income and communities of color.

It’s why nurses will never stop fighting for a fundamental transformation of our callous, fragmented health care system that remains premised on private profit and ability to pay.

I start with this framework because it is directly counter to that of the health policy briefing put forth by the Clinton campaign.

In that, healthcare as a human right becomes just a “right” to affordable healthcare. If a “right” is conditioned, it is not a right. Besides, who decides what is “affordable?” The multi-billion dollar drug companies, the insurers, the mega-hospital chains?

Our health is not a commodity to be bought and sold in the market.

Inequity is hard-wired into the current healthcare system. We continue to see wide disparities in

access, quality and cost based on gender, race, age, where you live, and what you can afford.

Instead of the systemic changes we need, we are increasingly expected to settle for transparency: more transparent information for consumers. That's a market non-solution to a human problem. And it is not enough.

Patients are not consumers in a healthcare industry – or they shouldn't be.

Yet, the perverted system we have is really an industry based on maximizing revenue through increasing reimbursements to all sectors – corporate hospitals, insurance companies, medical device manufacturers and most of all, big Pharma.

The best technology, the latest cures, and the private rooms go to the wealthy, consistent with the industry model, but something has to give – so in the guise of "efficiency," the industry shifts care to the lowest cost setting, avoiding regulations, and then de-skills professional jobs to serve their profits.

Insurance companies shouldn't dictate care, but they do. They add no value to business, yet skim 30% off the top.

Their business model is so flawed, the insurance companies needed a bailout – first a mandate to

purchase their product AND tax subsidies to make it “affordable,” and they want more!

Apparently, judging by the new tax subsides proposed by the Clinton campaign, they are going to get it!

Nurses oppose the industry model. They believe in a healthcare system that meets patients’ needs based on the moral imperative of caregiving.

The fundamental principle for NNU is a single standard of excellence in safe, therapeutic care in the most appropriate setting. Nurses want the highest skilled caregiver closest to the patient, in a system that enhances professional clinical judgment. That’s a caregiving model.

Much is made of quality in healthcare. What is it?

Nurses know that attention to the individual needs of the patient, not the standardized protocol, is the highest quality care.

A healthcare system based on caregiving addresses far better the majority of Americans’ concerns about healthcare than does building on the failed business model of private health insurance.

What do people care about?

- They want more care not less

- Their premiums, or share of premiums are too high
- Their deductibles and other cost-sharing never stop increasing
- Their drug costs continue to rise
- They worry if their insurance cover the medical care when they are most vulnerable and in need?
- They don’t want to be afraid of being bankrupted if their child, or spouse, or parent goes to the doctor or hospital when they get sick or hurt.

None of American’s concerns can be addressed by increasing transparency – it’s NOT whether they know it, it’s whether they can get it.

Nor will subsidies help - they don’t keep up with costs increasingly shifted to workers. Keeping premiums low by making provider networks narrow has run its course; using co-pays to reduce use is an economic fantasy that harms people.

And yet…those are exactly the policies institutionalized by the Affordable Care Act, and the reform program proposed by the Clinton campaign.

The hidden reality is that tens of millions of Americans remain uninsured or underinsured. It's long past time to bring these people out of the shadows.

It's not good enough to blame Republican governors or the Supreme Court for the 28 million people who remain uninsured. Guaranteed healthcare for all must be a uniform, national obligation that the Democratic Party makes a priority, not a vague concept dependent on the vagaries of which states will pass Medicaid expansion.

Tens of millions more remain under- insured – unable to get the care they need even if they have health insurance. Insurance is not care, and useless if you can't get medical treatment when you get sick or face bankruptcy or the terrible choice of paying for care or paying for your housing costs or food for your family.

In January, the New York Times and Kaiser Family Foundation, reported that at least 20 percent of people under age 65 *with health insurance* have problems paying their medical bills -- 63 percent of those said they used up all or most of their savings; 42 percent took on an extra job or more work hours; 14 percent moved or took in roommates; 11 percent turned to charity.

The Miami Herald recently reported about the widespread problem of “balanced billing” which results in unexpected medical bills for patients *with insurance*. It occurs when a physician or other health care provider bills a patient for the difference between what the insurer paid and what the provider charged.
Politico reported in May that many consumers who signed up for insurance plans through the ACA market exchanges will be slammed with double digit premium increases on November 1st by insurance companies who kept their initial charges lower in the first year of the ACA exchanges so they could maximize the number of new paying customers.

Those bills are expected to hit one week before the election. Think that might be on the mind of some voters right before they go to the polls?

Instead of re-committing to the commitment of Democratic Presidents Franklin Delano Roosevelt and Harry Truman for a national health care system from cradle to grave, we hear Secretary Clinton proposing incremental ACA reforms to:

- Block “unreasonable” or “excessive” premium rate increases
- Restrict out of network co-pays to in-network amount for in-hospital care

- Provide transparent information for consumers to choose a health plan
- Monitor changing industry landscape regarding mergers and acquisitions
- Investigate mergers or business practices that could harm consumers

First, what is an “excessive” or “unreasonable” premium increase? Aren’t health insurance companies inherently unreasonable and excessive in their exploitation of human misery?

Second, out of network costs is a massive loophole in the system that their warehouses full of accountants know very well how to exploit. The Los Angeles Times reported in March, for example, that growing number of patients with insurance are getting surprise bills even when they go to in-network hospitals because of the hospital contracting with out-of-network physician groups for surgeries and other procedures.

Third, more information for consumers to shop for a plan is not the same as getting the care you need from a provider of your choice.

California Healthline reported in March that scores of families who signed up for ACA plans under Covered California have had their insurance

coverage suddenly dumped by insurers, even when they are fully paid up.

Apparently no one can figure out why this occurring. But people are either dumped into Medicaid or, as occurring across the nation when insurers make sudden changes in their plan offerings, told they should just “shop around” for another plan.

– As if picking out a health insurance plan, with all the arcane paperwork, fine print, confusing options on what is covered, how much your out of pocket costs are, what providers are in your network, and what unlisted surprises you will get with your medical bills is as simple as deciding which breakfast cereal to buy in the grocery store.

Fourth, investigating mergers is not the same as stopping them. That is precisely the market consolidation encouraged by the formation of Accountable Care Organizations and the continuing anti-trust exemptions for the healthcare industry that contribute to higher healthcare costs.

We hardly need to “investigate” mergers. The evidence is already in.

Drug companies merge to avoid taxes, insurers merge to grab market share, and private equity

companies operate hospitals so they can access their capital reserves, such as workers' pensions.

A new University of Southern California study shows that hospital prices in two of California's largest health systems were 25 percent higher than at other hospitals around the state – directly attributed to hospital mergers**.**

A recent study by the National Bureau of Economic Research found that private insurance prices are at least 15% higher in less competitive markets.

This is an industry out of control that will not be "reformed" but must be transformed!

We need a healthcare system that:

- Replaces rising premiums with a progressive, national financing program,
- Ensures there is no additional cost to access care when you need it
- Provides comprehensive benefits not based on the size of your premium
- Guarantees complete choice of provider – one card, like a Medicaid card – that you can present to any hospital, any surgery center, any clinic, any doctor, any medical lab, any specialist, private or public, whenever and wherever you need it.

- That means NO mergers or acquisitions for profit or market share

Alleged reforms of the private insurance market cannot compare to the benefits of providing social insurance. Here's what Secretary Clinton proposes in her health care policy brief:

- Tax credit for "excessive" out-of-pocket costs
- Limit Family costs to 8.5% of income for premiums
- Allow family members on employer plans more easily
- Delivery system reform that rewards value & quality to reduce costs
- Demand lower drug costs for working families and seniors

None of these changes alleviate the primary concern of Americans that they can not get the care they need. These market reforms only serve to strengthen the healthcare industry grip on our health rather than save patients' lives.

Instead, an Improved Medicare for All system would enhance clinical professional judgment, control costs, guarantee healthcare based on need,

and get rid of the financial barriers to care to guarantee access to care:

- Progressive taxation, including a tax on Wall Street speculation, that would replace insurance premiums
- Price controls on drugs, hospital charges, needed medical supplies, lab tests and the rest of health care industry price gouging
- Elimination of profits, marketing costs, and waste
- Strict budgets for hospitals, based on actual cost of delivery of patient care
- Negotiated fees and payments to providers
- No co-pays, co-insurance, deductibles, out of network charges, or other surprise medical bills

These are the elements of a single-payer or Improved Medicare for All system. It is a public solution, not a public option.

The public option would:

- Fund taxpayer subsidies to advertise for insurance companies
- Allow undocumented families to buy-into private health plans

- Work with governors for states to establish widely varied public option plans
- Allow people 55-65 to pay a premium for Medicare coverage

Why would we believe that this insurance option, especially when it is overloaded with the older and sicker patients the private insurers avoid, will operate any differently?

Inevitably the result will be narrow networks, high deductibles, and ever escalating co-pays and other inflated out-of-pocket costs.

If anything, it could undermine support for a public solution, which would be truly universal - not leaving millions uninsured and underinsured.

Improved Medicare for All means:

- Everybody In, Nobody Out
- Automatic enrollment
- State-based administration that can bring more local control
- Availability of supplemental benefit programs
- Lower costs through public leverage to control prices, progressive financing and one universal, national risk pool

Such an approach has two big advantages:

- It actually solves the problems Americans experience most
- It is popular. 58% of Americans support Medicare for All in a recent Gallup poll.

Every other industrialized country has figured this out. They spend less for care and get more in return.

Stop blaming patients for using too much care – the U.S. has an average length of stay in hospitals shorter than the OECD average, we go to the doctor less than the OECD average, and trail behind most of the OECD countries in a wide array of patient outcomes, from infant mortality to life expectancy.

It’s not over-utilization that drives up U.S. healthcare costs. It’s because prices are high, driven by the ever escalating demand for profits. It takes the leverage and power of a “single-payer,” like Medicare, to limit prices.

And we cannot stop there.

Much is also made of healthcare “disparities.” In fact, that is a dry term for a harsh reality – socio-economic status is the leading determinant of health status.

We need a comprehensive approach to meeting human needs – accessible housing, quality public education, living wage jobs of at least $15/hour; secure retirement, ending mass incarceration, and HIV/AIDS, and creating a sustainable economy based on climate justice. Only then can we achieve health care justice and effectively challenge ill-health based on injustice and inequality.

Americans do not believe we use too much healthcare. They worry about the cruel financial barriers to care. They fear they are not going to get the healthcare they need. They are right. America's nurses say we must guarantee healthcare. The Democratic Party platform must say it: we demand Improved Medicare for All!

With your indulgence, I'd like to briefly note two other health-related issues the platform should address.

The power of finance capital as it further extends control over the health care industry will increase inequality. Poor health is not a social disparity; it is inherent in the industry model. It must be addressed at the system level.

That requires reducing the power of Wall Street. We can decrease inequality if we effectively confront Wall Street greed by implementing a tiny sales

tax, a financial transaction tax, on the buying and selling of stocks and other financial instruments.

Practically everybody else pays sales tax, why not traders who buy and sell millions and billions– we could raise up to $300 billion a year to fund not only help fund universal healthcare, but many other critical human needs.

Put it in the platform – a commitment to enact a robust tax on Wall Street speculation, what we call the Robin Hood tax. If we can tax shoes, we can certainly tax Wall Street.

Second, we urge the Democratic Party to include in its platform an unequivocal opposition to the Trans Pacific Partnership.

The final text of the pact announced last October only reinforced our opposition.

In TPP Intellectual Property Chapter, Article 18, we are particularly appalled at monopoly pricing protections for giant pharmaceutical firms that could be a death sentence for countless patients in need of affordable medications around the world and the expansion of the ability of corporate giants to use corporate tribunals to seek to overturn public health and safety laws.

When the final agreement was first announced last month, initial reports suggested a major

“compromise” by the U.S. in reducing monopoly pricing rules for drug giants from 12 years, what the U.S. had first demanded, to 5 years, particularly for biologic medications, drugs derived from living organisms.

But the final text shows those rules littered with loopholes, allowing the U.S. to pressure TPP signers to expand the monopoly control – and their inflated prices – for eight years or longer, according to a review by the Citizens Trade Campaign.

Patent exclusivity rules, that affect when cheaper, generic versions of high priced name brand drugs, can go on the market, can produce long delays in access to affordable medicines, under the TPP.

The TPP can not be fixed. It should be defeated, period. Our health should never be for sale.