**What Is Wrong With Health Care in America?**

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 During the 2016 election cycle, health care became a hotly debated topic. Many opposed The Affordable Care Act (a.k.a. ACA or ObamaCare) and wanted it repealed and replaced, although most people were not sure with which to replace it. Many others argued that the ACA needed to be fixed, again not supplying any ideas about how to do that. I am old enough to remember what health care was like before the ACA. Back in the mid-1990’s, politicians were screaming about the “health care crisis.” The ACA was supposed to be a “fix” for this “health care crisis”, but it ended up making the problem worse.

 Before we can “fix” the ACA or “repeal and replace” the ACA, we need to do a full scale examination of the problems with the ACA and the health care system that existed before the ACA became law. If we do not identify the health care problems of the last 40+ years, we will never be able to solve the problem and the best we can hope for is a Band-Aid on a gaping problem.

 Upon examination, we can easily identify two major problems with the health care system we have had for the past 60+ years. Most of the minor problems typically fall under one of these two major problems. The two major problems in the American Health Care System are 1) the marriage between healthcare and employment, and 2) insurance for every medical issue, big and small. Although you may not think these are major issues, let me explain each one in depth to show you how these two major flaws and crippling healthcare in America.

**Marriage Between HealthCare and Employment**

1. Employer-Based Insurance Suppresses Wages

According to The Henry J. Kaiser Family Foundation (KFF), 49% of Americans are covered by employer-provided healthcare.[[1]](#footnote-1) According to the official Census, in 2015, 55.7% of the population is covered by employer-based health insurance for some or all of the year.[[2]](#footnote-2) From these two, very reputable and official sources, we can see that about half, or just over half, of the population is covered by employer-based health insurance. This means that these people are getting their health insurance through their employers.

In my experience, most people do not really understand how insurance, and especially employer-based insurance, works. Luckily, since I spent nine years working for a major health insurance company, I have a wealth of experience in this arena and can explain it.

First, you need to understand the players involved and the various contracts involved. As an employee, you have a contract with your employer. The employee provides his or her time, energy, knowledge, skills, education, etc. to the employer for a designated amount of hours per day, week, or month. In return, the employer provides the employee (worker) with compensation (your paycheck) and certain benefits (paid sick time, paid vacation time, health insurance, dental insurance, vision insurance, etc.). The employer (company) also has a contract with the insurance company, which lays out what medical procedures and services will be covered, how much they will be covered for, how much money the employer will provide for the coverage of these services, how much the employer will pay the insurance company for processing (paying and/or denying) the claims (bills) submitted by the medical providers (doctors, hospitals, pharmacies, etc.) and much more. Then there are the contracts between the insurance company and the providers, which detail what is covered, how much is covered, etc. The providers want as much as they can get for the services they provide. The insurance company wants to pay the least. This is hammered out in negotiations.

When the cost of health insurance premiums go up, this cost is passed on to the consumer. If you have employer-based coverage, that cost is going on to your employer and you. When you have insurance through your employer, typically the employer pays a portion of your monthly premium and you pay a portion of your monthly premium through your payroll deductions. What comes out of your paycheck for each pay period usually is NOT the full cost of the premium. It’s just your portion. Typically, employers pay between 70% - 85% of your monthly premium and you pay only 15% - 30% of the premium.3 So, if you are upset about your portion going up, remember that your employer’s portion went up a lot more!

In 2017, the typical family policy costs $18,687 per year in premiums, with the average employer contribution being $13,469 and the average employee contribution being $5,218.[[3]](#footnote-3) This means that the monthly premium is $1557.25, with the employer paying $1,122.41 per month and the employee paying $434.83 per month.

If the health insurance premium goes up by only 10% this year, this means that the total cost will go up by $1,868.70. Ten percent is astronomically low, considering that premiums have risen 34% in 2018.[[4]](#footnote-4) If your employer had intended to give you a $1,000 raise this year (which works out to 48 cent per hour for full time), your employer may instead apply this $1,000 raise to the higher cost of your insurance premiums instead of giving it directly to you. But, that $1,000 raise will not cover all of the increase in premium. So, the remaining $868.70, may be split between you and your employer. So, you will think your employer is not giving you a raise and on top of that, your portion of your premiums (taken out of your paycheck) will go up, resulting in less bring-home pay for you. However, your employer IS giving you a raise, it’s just that it’s going towards the increase in health insurance premiums.

Employers have not always provided health insurance. In 1942, as World War II was in full swing, the demand for workers climbed sharply because the men were leaving the workforce to go fight in the war, yet there was a larger demand for goods to support the war effort. As employers started raising wages to attract workers from the diminished workforce pool, “Congress passed the Stabilization Act of 1942, which allowed the President to freeze wages and salaries for all of the nation’s workers.”[[5]](#footnote-5) On October 3, 1942, President Franklin Delano Roosevelt signed Executive Order 9250 Establishing the Office of Economic Stabilization.[[6]](#footnote-6) In Title II (Wage and Salary Stabilization Policy), section 1 of this Executive Order, it states:

No increases in wage rates, granted as a result of voluntary agreement, collective bargaining, conciliation, arbitration, or otherwise, and no decreases in wage rates, shall be authorized unless notice of such increases or decreases shall have been filed with the National War Labor Board, and unless the National War Labor Board has approved such increases or decreases.6

There was one loophole in the Stabilization Act, though. It allowed for “insurance and pension benefits” to grow “in a reasonable amount” during the freeze. Since employers could not offer higher wages and salaries to lure workers (and many women) into their companies, the employers offered health insurance as a very sweet benefit. The idea caught on quickly and soon, there was employer-based health insurance from sea to shining sea. Oddly, we are still seeing health insurance being provided in lieu of actual income (see the previous example of raises being used to pay for raising premiums). In the 1940’s employers used health insurance to sweeten the pot because they couldn’t raise wages and now wages are being suppressed because of the health insurance. Oops. I doubt they anticipated the “benefit” becoming a wage “curse”.

1. Health Coverage Costs Fluctuate Wildly When You Change Employers

As we grow in our education, experience, and skills, most of us prefer to advance our careers, whether it would be for higher pay, shortened commute, better location, more challenges, or some other benefit. Very few people would say that they want their first job to be the job they work until retirement. In our effort to advance our paychecks and careers, we often are faced with changing employers (or even leaving employment behind to start our own businesses). However, when we change employers, everything about our health care also changes. First, even if we end up with the same health insurance company, the plan will often be very different concerning copays, coinsurance amounts, deductibles, what’s covered, etc. We definitely will have a new insurance card and policy number. But, that is not all that changes.

When you change employers, your portion of your insurance premium will most likely change. And this is not always a negligible change (from $400 to $450 per month). Often, it can vary wildly, especially if you are leaving a large corporation to work for a smaller, growing company. You could see your $400 per month premium skyrocket to $1400 per month with the company that’s will to give you a $7,000 per year raise but can’t afford to subsidize the health insurance premiums. That’s an additional $1,000 out of your checks each month, or $12,000 per year! Even with the raise, you will see $5,000 per year less! Yikes!

Even in the best of scenarios, where there isn’t much of a change in your health insurance nor the cost to you, there is still a massive problem that may hinder you from taking that fabulous new job – a gap in coverage.

1. Gaps in Coverage When You Change Employers

 Typically, when you leave a job, the coverage you had through that employer continues through the last day of the month you quit. So, if you quit on March 1st, you still have coverage through March 31st. But, if you quit on March 29th, you only have coverage for 2 more days (March 31st). However, most employers require a 90 day probationary period before your coverage kicks in. This means that you could have no coverage for 60 – 90 days, even if you didn’t have a break in employment (started new job the day after your last day at the old job). Now, if you have a spouse and/or children, how eager are you to have your family go without insurance for 60 – 90 days, just to change jobs?

For most families, any one of these problems could be a deal breaker when considering changing employers. This prevents many workers from advancing their careers. Americans are being held back from reaching their full potential when there are barriers to changing jobs, such as raising premiums, drastically fluctuating premiums, and gaps in coverage.

1. Job Change = HealthCare Change / Lack of Portability

With health care being attached to the company or employer, when the employee changes employers, that employee will have a different health plan with the new employer than he or she had with the old employer. You get new insurance cards, new policy numbers, new doctors, new pharmacies, new hospitals, new specialists, and new coverage levels (coinsurance amounts, copays, deductibles, maximum out of pocket amounts, etc). When a patient finds a doctor that he or she likes, that patient wants to continue with that doctor and not be forced to change doctors. We are typically resistant to change, so changing everything about out healthcare every time you change your employer makes it more difficult for people to make positive change in their employment.

**The Insurance Model**

1. Insurance for Every Medical Issue, Whether Big or Small

 After spending nearly a decade in the medical insurance business, I saw the transition from Indemnity plans to HMO and PPO plans. Indemnity plans were the original type of healthcare plans where you pay a premium each month, then when you obtain medical services, you present your insurance card and pay a coinsurance (typically 10%, 15%, 20%, or 25%). The insurance company was responsible for the rest of the bill (less the amount beyond “usual and customary”, which the provider had to “write off” or forgive). Since the patient has to pay a percentage of the cost, people would only go to the doctor when absolutely necessary.

 HMOs, or Health Maintenance Organizations, became popular because they targeted routine care, check-ups, immunizations, and other services that helped to prevent illness and injury. The key was “preventive medicine”. Of course, prevention is the best solution to any health issue. However, this was abused. Growing up in the 1980s and 1990s, it was common for people to go to the doctor for everything. Antibiotics were prescribed for almost everything. This led to the antibiotics taking the place of the body’s natural immune system. People were becoming less capable of fighting illnesses without the use of antibiotics. This resulted in bacteria and viruses mutating into “superbugs”. Stronger antibiotics were needed and eventually developed. In the 21st century, doctors began reducing the amount of antibiotics they prescribed, acknowledging that antibiotics had been overprescribed, suppressed the body’s natural immune system, and contributed to the mutation of “superbugs”.

1. Wasteful Abuse and Hidden Costs

 While the overuse of antibiotics has had a negative impact on society, the cost of health care skyrocketed. With people running to their family physician for every sniffle and cough, the demand for more health care providers climbed. The demand was so high, that providers could increase what they charged and still be secure in the fact that people wouldn’t be swayed by the higher costs. After all, the patient was paying the nominal copay of $10, $15, $20, or the like, regardless of what the provider charged. There are no incentives for the patient to be frugal in his or her use of health care. Quite the contrary. If you pay $200 per month in premiums for a health care plan, you will want to get your money’s worth out of that plan. In you don’t go to the doctor at all that month, you just wasted that $200 in premiums. But, if you go 2 or 3 times that month, you have actually saved a lot of money and the cost of the premium was worth it. So, the consumer is actually encouraged to overuse health care, even when it is not necessary.

 We have all heard doctors say that the best thing for treating a cold is water, rest, and time. Medication may or may not speed up recovery. Going to the doctor for a cold usually results in that very advice, no prescription, and no shot. But, your insurance company may have to fork over $200+ for you to be told to go home, rest, and drink lots of fluids. Was that worth $200? Can you see how the cost of health care has been driven by wasteful spending on unnecessary care? You may not see the impact of health care costs, because you are only charged that nominal copay, but you will eventually see it in higher premiums.

 Most of the time, the patient is not informed of the actual cost that will be charged to the insurance company. Does the patient have a fiduciary duty to the insurance company to go to a reasonably priced provider? No. The patient is not even thinking about the cost, other than the cost of the copay.

 The insurance company was the one being targeted. However, the insurance companies would just raise their premium rates, resulting in the consumers and their employers paying more for the insurance. At first, this did not seem excessive. But over time, it has grown into a crisis. This is a recipe for disaster.

 Let’s take the health care insurance model and apply it to auto insurance. What would happen if auto insurance started covering “preventive” care? Let’s imagine that auto insurance covers tune-ups, oil changes, tire rotations, replacement batteries, replacement tires, and gasoline. You pay $150 per month for the insurance and every time you get gas, you swipe your auto insurance card and then pay $5. Would you only put $10 - $20 of gas in your tank at a time? Of course not! That would be stupid. You would run your vehicle as close to empty as possible, get $60 worth of gas and pay only your $5 copay, right? The most bang for your buck. You would take your vehicle in for tune-ups, oil changes, and tire rotation more frequently, even when it really didn’t need it. The gas stations wouldn’t compete for businesses by keeping prices down. They would continuously increase the cost per gallon. Soon, gas would be $10 per gallon or more. Eventually, the auto insurance company would have no choice but to raise rates. Eventually, we would all be paying $800 per month or more in auto insurance. It would be too expensive for most people and if it continued long enough, people would quit buying auto insurance, putting them at severe risk if something catastrophic happened, like a bad car accident.

 This example may seem ridiculous. But, that is precisely what we have done with health care. When you provide a middle man between the consumer and the provider, the cost becomes irrelevant to the consumer and the provider. The consumer abuses the services. The provider over inflates the costs. The middle man will never be able to control the costs without sacrificing service to the consumer. When we take out the middle man, the consumer and the provider can negotiate a cost reasonable to both of them. That is how the free market system works. It lowers prices to what consumers and providers consider “fair” or the “fair market value”.

 Now, we see health care costs out of control and very few can afford health insurance. In our effort to provide preventive health care and increase the consumers’ quality of life, we ended up making health care unaffordable and unattainable for most Americans. It’s not too late to reverse this course though. We can provide preventive care while controlling costs. It just takes creativity and ingenuity.

1. Retail Medical Care = Inflated Costs

The insurance company is acting as the “middle man” in this process. We pay the insurance company through monthly premiums and the insurance company pays the provider for the services rendered. Of course, the insurance company has to pay for their employees to process (pay or deny) the claims and the customer service agents to take phone calls from patients and providers to check on benefits, coverage, eligibility, and explanations of how a claim was paid or denied. The insurance company also has to pay the managers of those employees and for all the building and operation expenses, so the insurance company has to make more than it pays out. This comes from us, the patients.

To put this in perspective, the insurance company is like a retail store who buys t-shirts from a supplier, or maker. The maker may buy the materials for $2, make the shirt, and charge the retailer $3 for the t-shirt. The added cost is for the time the maker spends turning the fabric into a shirt. That retailer then sells the shirt to you, but for more than the $3 they paid for it because they have to pay their cashiers, stockers, managers, and building expenses to be open for you to come in and buy that t-shirt. You pay $5 for a shirt that would have cost you only $3 if you purchased directly from the maker, or $2 if you made it yourself.

The insurance company is the middle man, or retailer, in the health care industry. By having a middle man, the cost of health care is inflated. To combat this issue, we need a more direct method to limit the middle man and to help drive the cost of health care down to a reasonable level.

1. Limited Care

When you sign up for a health insurance plan (through your employer, self-insurance, Medicaid, or Medicare), you have a set of “preferred providers” or “contracted providers” to choose from. There may be 50 MDs in your town, but only a dozen or so are “contracted providers” with your particular health insurance company. Since you are already paying the premiums for the insurance, you are highly incentivized to choose from that limited list. There are no guarantees that those doctors “contracted” with your health insurance are the best doctors. There are also no guarantees that those doctors charge the most reasonable rates. This leads to you passing up doctors that may provide a substantially higher level of care for a cheaper price, and you end up with a mediocre doctor that charges outrageous prices. How is that better for the patient? Furthermore, why aren’t we rewarding the best doctors with our business?

The insurance model of care is limiting your choices and we, as Americans, love choices and hate having limits on our healthcare options. The insurance model hinders freedom in healthcare. It forces you to choose from a small pool of providers.

Furthermore, we are paying someone else (insurance company) to tell us what types of procedures we can and cannot have. Most of us would prefer to pay for more choices. It seems rather ridiculous to pay someone to dictate how you can spend your health care dollars. Would this work in any other aspect of our lives?

Would you pay me $600 per month for me to dictate what foods for which I will reimburse you? That is ludicrous! Yet, we do that every time we pay health insurance premiums and are told what products and services they will “cover” with that money YOU gave them.

1. Lack of Coverage for Others

For years there has been a debate over how long a child can be covered on his or her parents’ health insurance plan. It used to be up to age 18. Then, it moved to 21 as long as the adult child was still in school and/or dependent. Under ObamaCare, it moved to age 26. But this completely ignores other situations and relationships beyond the parent/child relationship.

A prime example is if your parents have bad insurance or no insurance, you cannot cover them on your insurance. In other words, you cannot use your health care dollars to help out your parents. What if your parents need medication that is not covered on his or her health plan? Why shouldn’t you be able to access your health plan (which you paid for with your money) to assist your parents? Under our current system, that isn’t even an option. You either have to pay with cash, or your parents have to go without.

What if you wanted to help out a friend with his or her prescription cost? You do not have the option of helping others out, even if you have far superior coverage than they do. We need to be able to have a plan that allows us to use our health care dollars for the loved ones we wish to help.

With our current system, each adult or couple is autonomous from all others. There’s no sense of community in our current health care model.

And why are we arbitrarily picking the age 26. For some families, the adult child who is 22, is already married and has a child of his or her own. For other families, the 29 year old adult child may be disabled enough to still be dependent on the parents. We need more flexibility that makes it possible for each family to determine what is best for their particular family, without arbitrary numbers that are meant to make everyone the same. We need healthcare that is as diverse as the American family.

1. Delay in Payment for Providers

When a patient goes to a doctor for care, the doctor performs services for the patient on that day, only getting the copay from the patient on that day. Then the doctor has to submit a claim for payment to the patient’s insurance company. The insurance company has a time frame to process (pay or deny) that claim. The doctor will not get paid for that service for at least 2 – 6 months. There are very few industries where this “delayed payment” occurs. If you ran a business, you would want payment up front before you render services. Think about McDonald’s. They will not even entertain the ridiculous notion of giving you food for a promise of payment months into the future. Yet, we expect our doctors to wait for payment. This is unfair to the providers who had to pay a lot of money for specialized education and training so that they could provide those services. We need a system that pays providers at the time of service, rather than payment being delayed for months at a time.

1. Providers Need More Staff

Since providers need to submit “claims” to insurance companies to get reimbursement for products and services rendered, the provider often has to employ a full time person just to handle all that additional paperwork. These people are called medical billing specialists, with medical coding training. The provider, or doctor, needs to pay that person, which means the doctor has to charge more for his or her services to cover that additional employee.

**Medicaid**

1. Discrimination

When a person is approved for Medicaid, due to having a low income, Medicaid provides the covered person with a “medical card”, similar to an insurance card received when you sign up for any other insurance. The problem is that it clearly states “Medicaid”, or the specific Medicaid program name, on the card itself. This is highly problematic because when the Medicaid recipient presents the “Medicaid” card to a provider, the provider immediately knows that the patient is a Medicaid recipient and therefore, poor. The provider often treats Medicaid patients different than patients with some other form of insurance. The providers sometimes treat the Medicaid patient as “less important” than other patients. This is a form of discrimination, and it is often difficult to prove.

1. Fraud, Waste, and Abuse

Just as with the employer-sponsored health care, people do not exercise frugality when someone else is picking up the tab. This leads to needless office visits, prescriptions, and tests. The patient isn’t thinking about the taxpayers that will have to pay for these unnecessary services. When we are spending someone else’s money, we tend to be more extravagant and less frugal. This leads to fraud, waste, and abuse.

In March 2018, the U.S. Department of Health & Human Services, Office of Inspector General provided its report “Medicaid Fraud Control Units Fiscal Year 2017 Annual Report”. In it, they report that there were $1.8 Billion recovered for Medicaid Fraud.[[7]](#footnote-7) This is just the amount recovered. The actual amount is more likely much higher. Even if that amount was the total amount of fraud, that’s $1.8 Billion of your tax money being wasted on fraudulent claims. That’s not a nominal amount.

1. Limited Providers

There are many providers that refuse to take Medicaid recipients. This narrows the list of providers for the patient to choose from and this limits the patients’ choice of providers. Everyone, regardless of their employment status or economic status, should have access to all available providers. The limited amount of providers often results in Medicaid patients only having access to subpar providers. Many of the top doctors and facilities do not accept Medicaid patients, which leads to further discrimination.

1. Higher Costs for More Restricted Care

One of the worst things we can ever do is throw more money at healthcare while we continue to receive further and further limitations being imposed. Why pay more for less coverage? The American spirit is one of frugality. We all want the best for the least cost. Currently, we are receiving fewer and fewer options as our costs continue to rise. That is backwards. Certainly, we can provide much better options at reduced costs.

**Medicare**

1. Double Charging for Premiums

People work for decades, with a portion of their paychecks going to fund Medicare. You pay into Medicare for decades, but once you sign up for Social Security and start receiving Social Security, they take out your “portion” of your “premium” for the Medicare. How is it you have been paying these “premiums” for decades and still have to pay for it when you are retired and on a fixed income. This is a form of double paying. By the time a person reaches retirement and Social Security age, their Medicare premiums should be considered paid in full. This is akin to charging the elderly for something they already paid for.

1. Unsustainability

Our own government claims that Medicare is not sustainable as it is. “The estimated depletion date for the HI [hospital insurance (Medicare Part A)] trust fund is 2026, 3 years earlier than in last year’s report.”[[8]](#footnote-8) We keep having problems with the sustainability of Medicare, especially with a growing need for Medicare. As medical advancements as made, our elderly are living longer lives, translating into more years spent on Medicare. We need to ensure Medicare is sustainable for all of our elderly from retirement to death, regardless of whether that is 2 years or more than 40 years.

**Conclusions**

We need to torpedo the health care industry (cabal) in American and rebuild it into a truly American system of health care. We can do this. As Americans, our ability to think, and dream, of ideas no one else has ever dared to think or dream up, is infinite. We can come up with a health care system that benefits employers, employees, patients, and providers. We can invent a health care system that provides preventive medicine while preventing abuse. We can balance the interests of everyone, while allowing everyone to contribute to the determination of health care costs. We can have a system that allows the free market system to bring costs to a market sustainable level (not too high, not too low). We can make everyone happy and healthy. We can take care of our poor, disabled, and elderly, while reducing costs for everyone and increasing quality. That is the American way – best in the world and at the most reasonable price! Let’s solve this problem together!

1. The Henry J. Kaiser Family Foundation (KFF), Health Insurance Coverage of the Total Population (2017), <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, Accessed January 12, 2018. [↑](#footnote-ref-1)
2. United States Census Bureau, Barnett, Jessica C. & Vornovitsky, Marina S., Health Insurance Coverage in the United States: 2015, Issued September 2016, <https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf>, page 1 (page 7 if opened in PDF), third bullet point that starts “In 2015, private health insurance…”, Accessed January 12, 2018. [↑](#footnote-ref-2)
3. The Henry J. Kaiser Family Foundation (KFF), <https://www.kff.org/other/state-indicator/family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, Accessed January 12, 2018. [↑](#footnote-ref-3)
4. Avalere, Pearson, Caroline F., Carpenter, Elizabeth, and Sloan, Chris, Silver Exchange Premiums Rise 34% on Average in 2018, October 25, 2017, <http://avalere.com/expertise/managed-care/insights/silver-exchange-premiums-rise-34-on-average-in-2018>, Accessed January 12, 2018. [↑](#footnote-ref-4)
5. Chicago Tribune, Mihm, Stephen, Employer-Based Health Care Was a Wartime Accident, February 24, 2017, <http://www.chicagotribune.com/news/opinion/commentary/ct-obamacare-health-care-employers-20170224-story.html>, Accessed January 12, 2018 [↑](#footnote-ref-5)
6. The American Presidency Project, Franklin D. Roosevelt, Executive Order 9250 Establishing the Office of Economic Stabilization, October 3, 1942, <https://www.presidency.ucsb.edu/documents/executive-order-9250-establishing-the-office-economic-stabilization>, Accessed August, 11, 2018. [↑](#footnote-ref-6)
7. U.S. Department of Health & Human Services, Office of Inspector General, Murrin, Suzanne, Deputy Inspector General, Medicaid Fraud Control Units Fiscal Year 2017 Annual Report, March 2018, OEI-09-18-00180, <https://oig.hhs.gov/oei/reports/oei-09-18-00180.pdf>, accessed October 7, 2018. [↑](#footnote-ref-7)
8. Centers for Medicare & Medicaid Services, Mnuchin, Steven T. (Secretary of the Treasury), Acosta, R. Alexander (Secretary of Labor), Azar II, Alex M. (Secretary of Health and Human Services), Berryhill, Nancy A. (Acting Commissioner of Social Security), and Verma, MPH, Seema (Administrator, Centers for Medicare & Medicaid Services), transmitted on Jun 5, 2018, 2018 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf>, page 7 (page 13 if downloaded in PDF). [↑](#footnote-ref-8)