PNHP Newsletter Spring 2014

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM • 29 E. MADISON ST., STE 602, CHICAGO, IL • WWW.PNHP.ORG

PNHPers in the news during ACA rollout

The national uproar over the flawed rollout of the Affordable Care Act's federal health exchange website, HealthCare.gov, created an unexpected opportunity to point out that the ACA's problems run much deeper than a few computer "glitches," and that costly administrative complexity is "baked into" the law.

Dr. Ed Weisbart was among the many PNHPers who spoke out about the problems with market-based care and need for single-payer reform. Weisbart was interviewed by Fox News in St. Louis, as well as by several local radio stations. Dr. Caroline Poplin's op-ed calling for improved Medicare for All appeared in Newsday (reprinted on page 13) while Dr. Adam Gaffney's articles were published at Salon.com (see pages 37, 49). Dr. Philip Caper's op-eds appeared in the Bangor Daily News (see page 17) and at Truthout, Dr. Stephen Kemble's op-ed was published by The Honolulu Star-Advertiser, and Dr. Julie Pease's opinion piece appeared in the Sun Journal in Maine.

High-profile figures speak up for single payer

Veteran columnist Mark Shields told PBS' "Inside Washington" there's "a two-word answer" for the ACA's problems: "single payer." Michael Moore endorsed single payer as "the Obamacare we deserve" in an op-ed in The New York Times. Former Secretary of State Colin Powell endorsed single payer at an event for prostate cancer survivors, saying, "I don't see why we can't do what Europe is doing, what Canada is doing, what Korea is doing, what all these other places are doing." John Podesta, a former Clinton (and now Obama) adviser, simply tweeted, "I just enrolled in Medicare. It took me 5 minutes. Single payer anyone?"

Of special note is the recent endorsement of single payer by Dr. Donald Berwick, a former CMS interim chief and internationally respected quality expert currently running for governor of Massachusetts, the state that is the model for the ACA.

Prominent cardiologists, oncologists support single payer

Cleveland Clinic's Dr. Steven Nissen, a past president of the American College of Cardiology, told MedPage Today that "the lack of a single-payer system" is the biggest barrier to his practicing medicine today. "We waste enormous amounts of time and energy dealing with insurance companies, whose major goal is figuring out how not to cover patients," he said. Oncologists Dr. Ray Drasga and Dr. Lawrence Einhorn, a past president of the American Society of Clinical Oncology, are calling upon their colleagues to advocate for single-payer national health insurance. "Our medical system must be oriented toward caregiving, not reward maximizing investors' profits," they write in their feature article in the Journal of Oncology Practice (see page 29).

Single payer bill introduced in Senate

Sen. Bernie Sanders introduced S. 1782, a bill to create a single-payer system administered by the states, on Dec. 10. PNHPers are encouraged to lobby their senators to co-sponsor the bill, particularly known or "should be" single-payer supporters such as Tom Harkin (Iowa), Jay Rockefeller (W.Va.), Tammy Baldwin (Wis.), Martin Heinrich (N.M.), Tom Udall (N.M.), Al Franken (Minn.), Elizabeth Warren (Mass.), and Mazie Hirono (Hawaii). Reps. Joyce Beatty (D-Ohio) and Betty McCollum (D-Minn.) are the most recent co-sponsors of H.R. 676, the single-payer legislation in the House, bringing the total number of co-sponsors to 53. Call the Capitol Switchboard at (202) 224-3121 to be connected to your representative or senator.

In This Issue

Health care crisis by the numbers . . . 3
Medicare's glitch-free rollout . . . 12
Expanding Medicare to all . . . 13
Vermont eyes 2017 . . . 14
Patients and profits . . . 18
Global Amnesia: ACOs . . . 20
Corporate influence on medicine . . . 23
Minority physicians care for majority of underserved . . . 24
Why oncologists should support single payer . . . 28
Republicans' biggest misunderstanding of Obamacare . . . 36
How the GOP's hypocrisy on the ACA will backfire . . . 38
Why Canadians don't understand Ted Cruz . . . 41
International profiles of health care systems, 2013 . . . 42
Doctor with a cure: In remembrence of Dr. Gene Farley . . . 45
Real fix for Obamacare's flaws . . . 46
Sample single-payer resolution for medical societies . . . 48
Price-posting: Another health care cost 'solution' gimmick . . . 49
Your copays are too high . . . 50
Weisbart speech at United Mine Workers rally . . . 53
Market spiral pricing of drugs . . . 54
Chapter reports . . . 57

PNHP Board of Directors, 2014

Officers
Andrew Coates, M.D., F.A.C.P. (NY), **President**
Garrett Adams, M.D., M.P.H. (KY), **Immediate Past President**
Gordon Schiff, M.D. (MA), **Secretary**
Quentin D. Young, M.D., M.A.C.P. (IL), **Treasurer**

Regional and At-Large Delegates
Henry L. Abrons, M.D., M.P.H., (CA)
Pippa C. Abston, M.D., Ph.D., F.A.A.P. (AL)
Philip Caper, M.D., M.S. (ME), Olveen Carrasquillo, M.D., M.P.H. (FL)
Elizabeth Frost, M.D. (MN)
Paul Gorman, M.D., F.A.C.P., F.A.C.M.I. (OR)
David U. Himmelstein, M.D., F.A.C.P. (NY)
Danny McCormick, M.D., M.P.H. (MA), Mary E. O'Brien, M.D. (NY)
Ann Settgast, M.D., D.T.M&H (MN), Diljeet K. Singh, M.D., Dr.P.H. (AZ)
Robert C. Stone, M.D., F.A.C.E.P. (IN)
Arthur J. Sutherland III, M.D., F.A.C.C. (TN)
Stephen F. Tarzynski, M.D., M.P.H., F.A.A.P. (CA)
Steffie Woolhandler, M.D., M.P.H., F.A.C.P. (NY/MA)
Robert L. Zarr, M.D., M.P.H., F.A.A.P. (DC)

Medical Student and Resident Delegates
James Besante (MS3, University of New Mexico)
Joshua Faucher (MS2, Mayo Medical School, Univ of Arizona Law 2014)
Scott Goldberg (MS2, University of Chicago)
Victoria Powell (MS4, Virginia Commonwealth University)
Jessica Reid (MS4, University of Southern California)

Past Presidents
Carolyn Clancy, M.D. (MD); Claudia Fegan, M.D. (IL)
Oliver Fein, M.D. (NY); John Geyman, M.D. (WA)
Robert LeBow, M.D. (deceased, ID); Ana Malinow, M.D. (PA)
Don McCanne, M.D. (CA); Glenn Pearson, M.D. (CO)
Deb Richter, M.D. (VT); Cecile Rose, M.D., M.P.H. (CO)
Jonathon Ross, M.D., M.P.H. (OH); Jeffrey Scavron, M.D. (MA)
Susan Steigerwalt, M.D. (MI)
Isaac Taylor, M.D. (deceased, NC)

Board Advisers
John Bower, M.D. (MS); Aaron Carroll, M.D. (IN)
Margaret Flowers, M.D. (MD); Gerald Frankel, M.D. (TX)
Bree Johnston, M.D., M.P.H. (WA); Rachel Nardin, M.D. (MA);
David McLanahan, M.D. (WA); Karen Palmer, M.P.H. (Canada)
Sal Sandoval, M.D., M.P.H. (CA); Greg Silver, M.D. (FL)
Walter Tsou, M.D., M.P.H. (PA)

Editors: Drs. David Himmelstein, Steffie Woolhandler, Ida Hellander, and Mark Almberg.
National Office Staff: PNHP's headquarters in Chicago is staffed by Matt Petty, executive director; Dr. Ida Hellander, director of policy and programs; Mark Almberg, communications director; Dustin Calliari, technology associate; Angela Fegan, membership associate; and Emily Henkels, national organizer. Local chapter staff include Laurie Wen (New York Metro); Dr. Bill Skeen, Cindy De La Cruz and Keyon Mitchell (California).

Contact information:
29 E. Madison St., Ste 602, Chicago, IL 60602-4406
P. 312-782-6006 ~ F. 312-782-6007
www.pnhp.org ~ info@pnhp.org

ACA rollout compared to Medicare's 1966 launch

The ACA's complexity makes a stark contrast with the ease of implementation of Medicare in 1966. According to Drs. David Himmelstein and Steffie Woolhandler, 19 million people were enrolled in Medicare in 11 months with index cards for less than one-seventh of the cost of setting up the ACA exchanges. (See their Health Affairs blog, page 12)

PNHP lobby day in D.C. – May 22

PNHP will hold its first-ever lobby day in Washington, D.C., on Thursday, May 22, 2014, to build support for single payer and celebrate Medicare's 49th anniversary year. All PNHP members are invited to participate. The lobby day is being co-sponsored by Public Citizen, Healthcare-Now, the Labor Campaign for Single Payer, National Nurses United, and other groups, and will feature an educational program in the morning, lobbying visits in both the House and Senate in the afternoon, and an informal dinner at Busboys and Poets in the evening. To register, drop a note to Dr. Ida Hellander at ida@pnhp.org.

2014 Annual Meeting in New Orleans, Nov. 15

Save the date: PNHP's 2014 Annual Meeting will be held in New Orleans on Saturday, Nov. 15. Our meeting in Boston in November was our largest ever, with over 400 participants, including more than 100 medical students. Among the highlights was a talk by former New England Journal of Medicine editor Dr. Marcia Angell on the urgency of eliminating the profit motive in the delivery of care (see page 18), Vermont Gov. Peter Shumlin's remarks on how that state's "pathway to single payer" is stirring interest in single payer among the nation's governors, and skill-building workshops on organizing a coalition, recruiting new members, and stimulating discussion of single payer in medical societies. A new PNHP slide set for use in grand rounds and other materials from the meeting are available online at bit.ly/1gVBN5R.

Help staff PNHP's booth at ACP, APA, ASCO, or AAFP

PNHP is hosting exhibits at the meetings of American College of Physicians (Orlando, April 10-12), the American Psychiatric Association (New York, May 4-6), the American Society of Clinical Oncology (Chicago, May 31-June 2), and the American Academy of Family Physicians (Washington, Oct. 23-25). If you are going to any of these meetings and can volunteer to help staff the booth, drop a note to Emily Henkels at e.henkels@pnhp.org.

Health care crisis by the numbers:
Data update from the PNHP newsletter editors

UNINSURED AND UNDERINSURED

• 48.0 million Americans, 15.4 percent of the population, were uninsured in 2012, down slightly from 15.7 percent in 2011. The number of uninsured people was not statistically different from 2011, according to the Census Bureau.

Similarly, there was no significant change in the number of uninsured young adults aged 19-25, 8.2 million, in 2012. The effects of an Affordable Care Act (ACA) provision allowing young adults to be covered by a parent's plan, which modestly increased coverage for this group between 2010 and 2011, appear to have plateaued. 6.6 million children (8.9 percent) were uninsured in 2012, including 12.9 percent of children in poverty.

Although Medicare expanded slightly in 2012 with more baby boomers reaching retirement age, Medicaid has covered more people than Medicare (50.9 million vs. 48.9 million) since 2009. 54.9 percent of Americans had employment-based insurance in 2012, down from 64.2 percent in 2000.

Texas had the highest percentage of uninsured, at 24.6 percent, followed by Nevada, New Mexico, and Florida, each of which exceeded 20 percent. 272,000 people in Massachusetts (4.1 percent) were uninsured in 2012. Massachusetts' 2006 health reform is the model for the ACA.

About 8 in 10 of the uninsured are U.S. citizens and 19.7 percent are non-citizens. Uninsured non-citizens include both lawfully present and undocumented immigrants. Undocumented immigrants and legal immigrants residing in the U.S. for less than five years are barred from federally funded health coverage (U.S. Census Bureau, "Income, Poverty and Health Insurance Coverage in the Unites States: 2012," September 2013).

More than half of Americans (57 percent) report delaying or forgoing health care in 2012 due to cost. While 83 percent of the uninsured skipped or delayed care due to cost, so did 54 percent of people with coverage. About 1 in 5 people with insurance reported that their plan did not cover a needed service or that they had a problem with medical bills (Kaiser Family Foundation, September 2013).

• Psychiatrists are significantly less likely to accept insurance (even private insurance) than other physicians. According to a new study, only 55 percent of psychiatrists accepted private insurance in 2010, down from 72 percent in 2005. In contrast, about 89 percent of other physicians accepted private insurance in 2005, down from 93 percent in 2005. The proportion of psychiatrists accepting Medicare (55 percent) and Medicaid (43 percent) in 2010 was also lower compared to other physicians, for whom the acceptance rate was 86 percent for Medicare and 73 percent for Medicaid (Seaman, Reuters, 12/11/13).

As of Jan. 1, 3.9 million people had signed up for Medicaid and 2.1 million people had signed up for private coverage on the ACA's health exchanges (HealthCare.gov and 14 state-based exchanges). The final impact of the ACA on the number of uninsured in 2014 is uncertain as the enrollment period has been extended until March 31 (and indefinitely for people facing certain circumstances, such as a change in family size or hardship); private insurers must receive monthly premium payments from enrollees; the number of enrollees who had coverage last year but are switching to exchange plans is unknown; and more states may choose to expand their Medicaid programs.

The Congressional Budget Office estimated that the number of uninsured Americans would drop by 14 million in 2014. The CBO projected that Medicaid enrollment would increase by 9 million and that another 7 million people would gain private coverage through the exchanges; these gains would be offset by 2 million people losing or switching from their current individual coverage (Congressional Budget Office, May 2013).

High deductibles reduce emergency care, raise subsequent hospitalizations

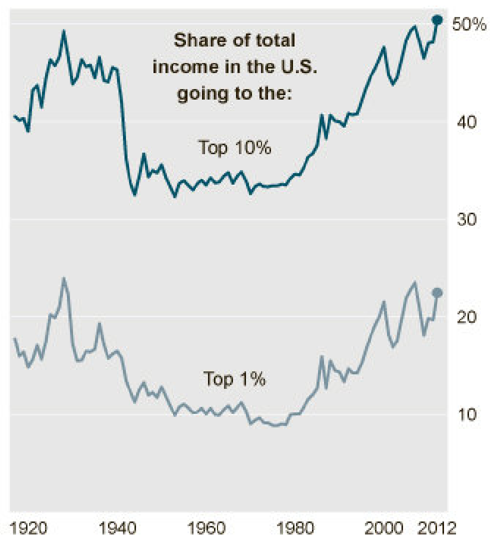
Even patients with severe conditions reduce trips to the emergency department in response to high deductibles. Two recent studies assessed emergency department use among people with high-deductible health plans (HDHPs) compared with patients in HMOs. The first study found that males whose employers switched them from a traditional HMO to a HDHP reduced their utilization of emergency department visits for high-severity indications (conditions clearly warranting an ED visit) by 34.4 percent, even more than they reduced visits for low- and medium-severity indications (down 22 percent). They also experienced a reduction in hospitalizations in year one by 24.2 percent, but this was followed by a 30.1 percent increase in hospitalizations in year two, suggesting that men "put off needed care after their deductible went up, leading to more severe illness requiring hospital care later on" (Kozhimannil, "The impact of high-deductible health plans on men and women: An analysis of emergency department care," Medical Care, August 2013).

A second study found that low socio-economic status enrollees in HDHPs in Massachusetts reacted in a similar way: They reduced high-severity ED visits by 25 percent to 32 percent in the first two years, but their rate of hospitalization eventually rebounded after falling 23 percent in the first year. The findings suggest that initial reductions in high-severity ED visits might have increased the need for subsequent hospitalizations (Wharam, "Low socio-economic status enrollees in high-deductible plans reduced high-severity emergency care," Health Affairs, August 2013).

In contrast, patients who gained Medicaid coverage in the 2008 lottery in Oregon increased their use of the ED by 0.41 visits per person, or 40 percent relative to an average of 1.02 visits per person in the control group over the 18-month study period. ED visits by the newly insured were for a broad range of conditions, some of which could have been treated in a primary care setting. These findings were not unexpected given that the poor tend to be sick and have unmet health needs, especially in the short term after acquiring coverage (Taubman et al., "Medicaid Increases Emergency-Department Use: Evidence from Oregon's Health Insurance Experiment," Science, 1/17/14).

SOCIOECONOMIC INEQUALITY

• In 2012, the share of total income going to the top 10 percent of earners exceeded 50 percent, the highest ever recorded, while the top 1 percent took more than one-fifth of the total income earned by Americans, the same level as before the Great Depression (see chart, below). Overall, the top 1 percent of earners have captured 95 percent of the income gains since the recession ended. The incomes of the other 99 percent plunged 12 percent in the recession and have grown only 0.4 percent since then (Lowrey, "The Rich Get Richer Through the Recovery," New York Times, 9/10/13).



COSTS

• In 2014, U.S. health spending will be $3.1 trillion, $9,697 per capita, 18.3 percent of GDP. This estimate, by the Centers for Medicare and Medicaid Services (CMS), assumes that over 11 million mostly healthy Americans will gain health insurance coverage in 2014, primarily through Medicaid and the health exchanges. Administrative costs for both government and private sector insurance administration are expected to jump in 2014 due to the administrative complexity of the ACA model of reform, to $41.9 billion (up 13 percent from 2013) and $199.4 billion (up 10.8 percent), respectively. Total health spending is projected to rise 6.2 percent per year until 2022, to $5.0 trillion, $14,664 per capita, 19.9 percent of GDP ("National Health Expenditure Projections, 2012-2022," Health Affairs, 9/13/13).

• In 2013, the cost of employer-sponsored health insurance coverage rose to $16,351 for family coverage and $5,884 for individual coverage, up 4 percent over 2012. Workers paid an average of 29 percent of the cost of family coverage ($4,742) and 18 percent of the cost of individual coverage ($1,059). Over 38 percent of workers with individual coverage have an annual deductible of $1,000 or more, up from 34 percent in 2012. Nearly one-third (29 percent) of employers with 5,000 or more employees said they were considering giving workers a fixed sum of money to buy coverage in an online marketplace (or "private exchange"), with workers' responsible for the difference between the value of the voucher and the cost of their coverage ("Employer Health Benefits Annual Survey," Kaiser Family Foundation, 8/20/13).

Since passage of the Parity Act in 2008, spending on in patient mental health and substance abuse care for people under 65 with employer-sponsored coverage has risen only marginally. Mental health spending as a share of total hospital spending grew from 1.8 percent in 2009 to 2.2 percent in 2011; substance-use spending as a share of hospital spending rose from 0.7 percent in 2009 to 1.0 percent in 2011. As a share of the cost of an admission, copayments for mental health treatment and substance abuse treatment (12 percent and 10 percent, respectively) are nearly three times higher than for medical/surgical treatments (4 percent) despite the legislation's requirement of similar coverage for mental health/substance abuse as for medical/surgical treatment. About 60 percent of total mental health spending of $150 billion in 2009 came from public sources, up from 57 percent in 1986. The ACA includes mental health as an "essential benefit," but a government rule on what services must be covered is still pending, and choice of provider is severely limited by plans with "narrow networks" ("Mental Health-Substance Use Services In Hospitals Up After Parity Law," HCCI, 2/27/13; Levit et al., "Federal Spending on Behavioral Health Accelerated During Recession as Individuals Lost Employer Insurance," Health Affairs, May 2013).

• The Milliman benefits consulting firm estimates the average total cost of health care for a typical family of four in an employer-sponsored PPO plan annually. In 2013, the Milliman Medical index reached $22,030, including $12,886 in employer-paid premiums, $5,544 in employee premiums, and out-of-pocket spending of $3,600. In comparison, median household income (not identical to the worker's family, but still instructive) for the most recent year available (2011) was $50,054 (Uwe Reinhardt, Economix, New York Times, 8/30/13).

Large employers shifting workers to high deductible plans, health exchanges

One-third of all large employers (>500 employees) are already taking steps to avoid the “Cadillac tax” that goes into effect in 2018 on plans in excess of $10,200 for an individual or $27,500 for a family. To avoid the tax, many employers are pushing high-deductible, so-called consumer-directed health plans. Nearly three-quarters of large employers (72 percent) now offer at least one high-deductible Consumer Directed Health Plan (CDHP), and nearly one-quarter (22 percent) of employers plan to only offer high-deductible CDHP’s next year, up from 19 percent this year.

Large employers also plan to cut costs by offloading coverage of part-time employees, pre-65 retirees, and COBRA plan participants to the federally subsidized coverage on the health exchanges. Home Depot, Trader Joe’s, and Target are among the large firms that have announced they will no longer provide health insurance to their part-time workers (National Business Group on Health, 8/28/13, “Employers Hold the Line on Health Benefit Costs,” Mercer, 10/1/2013).

MEDICARE

• The number of physicians who agree to take Medicare patients grew from 705,568 in 2012 to 735,041 in 2013 according to CMS. While the number of doctors who decline to take Medicare more than doubled between 2009 and 2012, from 3,700 to 9,539, they are offset by the much larger flow of physicians into Medicare (Diamond, “More Doctors are Quitting Medicare. Is Obamacare Really to Blame?” California Healthline, 8/7/13).

• Medicare premiums for 2014 will stay the same, $104.90 per month. The average premium for enrollees of Medicare Advantage Prescription Drug plans will be $39 per month in 2014, a 14 percent increase from 2013. Some plans are also raising their out-of-pocket limits (The Associated Press, 10/28/13).

The nation’s largest insurer, United Healthcare, is cutting up to 20 percent of the physicians who participate in their Medicare Advantage plans across the U.S., including the entire faculty at Yale’s hospital and medical school. A U.S. district judge issued a restraining order against the firm, temporarily blocking them from dumping 2,200 doctors in Connecticut. United claims it has a unilateral right to terminate a participating physician by “amending” their United Medicare Advantage Plan (Christian, “United Healthcare enjoined from terminating physicians,” Giordano, Halleran & Ciesla, 12/16/13).

• Medicare beneficiaries in fair or poor health spent over twice as much on out-of-pocket costs for health services in 2009 as beneficiaries in good or excellent health, $3,446 vs. $1,643, respectively, according to MedPAC. Having a supplemental plan raised spending on premiums for Medicare beneficiaries in poor health from $1,128 to $3,191 annually, but they still spent a similar amount, $3,382, out of pocket (excluding premiums) for health care (“Health care spending and the Medicare Program,” MedPAC, June 2013).

• Cost-sharing hits black and Hispanic Medicare beneficiaries the hardest, due to their lower median incomes, savings, and home equity. Median per capita income from all sources was lower for black ($15,250) and Hispanic ($13,800) beneficiaries than for white beneficiaries ($24,800) in 2012, a gap that is expected to widen. Per capita savings among black ($11,650) and Hispanic ($12,050) beneficiaries is one-seventh that of white beneficiaries ($85,950). Similarly, a lower percentage of black and Hispanic beneficiaries have at least some home equity (67 percent and 65 percent, respectively) compared to white beneficiaries (85 percent), and the value of that equity was less for black and Hispanic beneficiaries ($53,650 and $67,700, respectively) than for whites ($100,200) in 2012 (“Wide Disparities in the Income and Assets of People on Medicare By Race and Ethnicity: Now and in the Future,” Kaiser Family Foundation, September 2013).

Between 2004 and 2013, the number of Medicare beneficiaries enrolled in costly private Medicare Advantage (MA) plans almost tripled, from 5.3 million to 14.4 million in 2013 (28 percent of all beneficiaries). The plans raise Medicare’s costs by selectively enrolling healthier beneficiaries, gaming the risk adjustment system, and other means. In 2012 alone, private MA plans cost Medicare $34.1 billion more than if their enrollees has stayed in traditional Medicare, or $2,526 per Medicare Advantage enrollee. In 2014, Medicare payments to MA plans are projected to total $154 billion, 26 percent of total Medicare spending (CBO May 2013 Medicare Baseline; Hellander et al., “Medicare overpayments to private plans,” International Journal of Health Services, May 2013).

CORPORATE MONEY AND CARE

• There are 12 new proton-beam therapy centers in the U.S., with 20 more in the works (including two within a 50-mile radius of Baltimore), at a cost of about $230 million per center. Although the beam of protons emitted by the 90-ton cyclotron is more precise than standard radiation and can be useful for rare tumors in the brain, near the eyes, and in children, the main target for the costly technology is the 240,000 men diagnosed with prostate cancer annually, for whom studies have not shown that it is better than standard treatment, although it is much more expensive (“Prostate-Cancer Therapy Comes Under Attack,” Wall Street Journal, 8/28/13).

• Some CEOs of nonprofit hospitals receive lavish pay. In 2009, their average compensation was $595,781 and their median compensation was $404,938. CEOs in the highest 10 percent had average pay of $1.7 million. Some of the most highly paid CEOs (including salary and bonuses) of nonprofits in 2012 included Kaiser Permanente’s George Halvorson ($12.9 million), Providence Health’s John Koster ($10 million), Dignity Health’s Lloyd Dean ($7.1 million), U. Penn. Medical Center’s Jeffrey

Romoff ($9.7 million), Carolinas Health System's Michael Tarwater ($7.5 million), and Advocate Health Care's James Skogsbergh ($5.5 million) (Herman, Becker's Hospital Review, 10/15/13; ABC News, "Chart: Hospital Pay and Incentives," 6/16/13).

Since 2011, when Medicare started to pay dialysis companies a single bundled payment for each patient visit, the dialysis industry has received $530 million to $880 million a year in federal overpayments, audits show. The new bundled payment, intended to eliminate the incentive to over-prescribe epogen, led to a larger drop in the use of epogen and other dialysis drugs than anticipated. Firms' profits soared as they pocketed the difference between the bundled payment and the cost of the drugs, and their executives reaped a windfall. DaVita CEO Kent Thiry was paid $26.8 million in 2012, up 53 percent from 2011. Congress mandated that HHS eliminate the overpayments, and a final rule from HHS is expected soon. In the meantime, the dialysis industry is spending millions on a campaign to fight the cuts (Eric Lipton, "In Congress, A Bid to Undo Dialysis Cuts," New York Times, 8/28/13).

• The Department of Health and Human Services, the Office of the Inspector General, and the Department of Justice allocated $583.6 million to fight fraud and abuse in 2012. They recovered $7.90 for the government for every $1 spent on fraud and abuse control activities between 2010 and 2012, according to the General Accountability Office (Health Care Fraud and Abuse Control Program, GAO, September 2013).

• The number of freestanding for-profit emergency rooms has more than doubled in the past four years to over 400. Some hospital chains are using the facilities to generate admissions to their hospitals. HCA Inc. has seven freestanding ERs in Florida, while Wake Med Health and Hospitals has four facilities in the Raleigh, N.C., area. The metro-Houston area alone has 41 freestanding ERs and 10 more under development, including two that sit adjacent to each other. The chain First Choice Emergency Room owns nine ERs in Houston. Another chain, Emerus Hospital Partners, has started converting its facilities into "micro hospitals" with a few beds for patients needing detox or hospice. The firm is partnering with Baylor Health System to operate eight "micro hospitals" in the Dallas area. Emerus, founded by four emergency medicine physicians in 2006, received $30 million from a venture capital firm in 2011 to expand, with the ultimate goal being to take the firm public. The cost of a visit to a freestanding ER can top $1,000, far higher than costs at a clinic or urgent care center; most of the freestanding ERs don't accept Medicare or Medicaid (Hawkins, "Austin Ventures invests $30 million in emergency room chain," Austin Statesman, 1/18/11; Galewitz, "Wildfire growth of freestanding ERs raises concerns about cost," Kaiser Health News, 7/15/13).

• WellPoint, the nation's second largest health insurer, was fined $1.7 million for exposing health data over the Internet for 612,402 people between October 2009 and March 2010, according to Health and Human Services Department. Since 2009, when HHS started requiring reporting on data breaches, about 27 million people have been affected by major breaches of unencrypted health data (Condon, CBS News, 10/2/13; Reuters, 7/11/13).

• The Florida Department of Corrections, mandated to privatize health services and cut prison health spending by 7 percent, awarded contracts to two firms without looking into their litigation histories. Corizon, awarded a $1.2 billion contract, has been sued for malpractice 660 times in the past five years, including one case in which a jury awarded a 24-year-old patient $1.2 million after he was treated with Tylenol for a back abscess compressing his spine. Corizon also paid a $382,000 fine in Idaho for "failing to meet some of the most basic healthcare requirements" and $1.85 million in Philadelphia for using a front company to pose as a minority-owned business. A second contractor, Pennsylvania-based Wexford Health Services, was awarded a $240 million contract, even though Florida reprimanded the firm in 2002 for poor medical care following the deaths of two inmates. Wexford has paid out $5.7 million to settle 35 malpractice claims since 2008, with about 500 claims outstanding. Arizona terminated its contract with Wexford after an investigation by The Arizona Republic showed the firm was raising costs by skimming the healthier patients and leaving the sicker ones under the state's care (Christensen, "Florida prison healthcare providers sued hundreds of times," Miami Herald, 10/2/13).

• The highest profits in the nursing home industry go not to the homes' operators, but to the hidden, for-profit, investor-owned real estate firms that own and lease out the facilities. Health care "real estate investment trusts" or REITs are growing rapidly, acquiring new properties and aggressively maximizing returns on existing properties, with profits that are double (6-8 percent) the average profit earned by nursing home operators. The three largest firms, with about $60 billion in combined assets and about $6 billion in annual revenues, are HCP, Ventas, and Healthcare REIT (Chart, "10 largest healthcare real estate investment trusts," Modern Healthcare, 9/9/13).

• While the insurance industry is expected to spend $1 billion on advertising promoting the ACA's health exchange plans, Tea Party-inspired groups opposed to Obamacare are also well-financed by corporations. The Freedom Partners Chamber of Commerce, a group linked to Koch Industries, gave over $200 million to nonprofit organizations opposing the ACA in 2012. The largest recipient was the Center to Protect Patient Rights (CPPR), which received $115 million. Run by a political consultant with ties to the Koch brothers, the CPPR lists an Arizona post office box as its address, and distributes funds to groups opposing the ACA. Freedom Partners also gave $5 million to Generation Opportunity, which targets college students. The Koch-financed Americans for Prosperity spent $5.5 million on advertisements against the ACA in just three months in 2013, and expects to spend "tens of millions" of dollars on a multifaceted campaign, including efforts to prevent

states from expanding Medicaid (Stolberg and McIntire, "A federal budget crisis months in the planning," New York Times, 10/5/13).

BIG PHARMA

Drug firms fined billions for illegal marketing

A Johnson & Johnson subsidiary was fined $2.2 billion in civil and criminal penalties by the Department of Justice for aggressively marketing the anti-psychotic medication Risperdal for unapproved uses in the late 1990s and 2000s. In addition to aggressively disseminating false information through its sales representatives, Janssen Pharmaceuticals also paid millions in kickbacks in the form of bogus grants and education payments to the nation's largest nursing home pharmacy, Omnicare. Risperdal annual sales peaked at more than $4.5 billion annually in 2007. The U.S. attorney who prosecuted the case noted that the firm's "promotion of Risperdal for unapproved uses threatened the most vulnerable populations of our society – children, the elderly and those with developmental disabilities." The agreement is the third-largest settlement with a drugmaker in U.S. history.

Last year British drugmaker GlaxoSmithKline pleaded guilty and paid $3 billion in fines to settle criminal and civil fines for illegal marketing, failing to report safety data, and false price reporting practices involving several of its medications. In 2009, Pfizer paid $2.3 billion in criminal and civil fines for illegally marketing three medications for off-label uses ("Johnson & Johnson agrees to $2.2 billion fine over Risperdal, Invega, and Natrecor marketing," The Associated Press, 11/4/13).

• The Supreme Court ruled in June 2013 that pharmaceutical companies that pay generic drug manufacturers to delay sales of generic versions of their products ("pay for delay") may be sued for anti-trust violations. According to the Federal Trade Commission, generic versions of as many as 142 brand-name drugs have been delayed by these deals since 2005, costing consumers and taxpayers $3.5 billion each year in higher drug costs. A study of 20 such deals found that they have delayed the introduction of generic drugs an average of five years, and as long as eleven years in the case of Bristol-Myers Squibb's Sinemet CR; that the brand-name drugs cost an average of 10 times more than their generic equivalents, and as much as 33 times more in the case of GlaxoSmithKline's Lamictal ($465 vs. $14 per month); and that pharmaceutical manufacturers reaped an estimated $98 billion in total sales while generic versions were delayed ("Top twenty pay-for-delay drugs," Community Catalyst and Oregon State Public Interest Research Group, July 2013).

• Johnson & Johnson will pay at least $2.5 billion to settle about 7,500 lawsuits related to its defective metal hip implants, but the final settlement may exceed $4 billion. While databases outside the U.S. showed a soaring failure rate for the implants as early as 2008, the firm did not recall the device until 2010. About 93,000 patients received the devices from its DePuy Orthopedics unit starting in 2003, about one-third of them in the United States. Once projected to last 20 years, internal documents showed the hips failed in 37 percent of patients within 4.6 years, a rate eight times higher than many other hip devices. Last year, the failure rate in Australia climbed to 44 percent within seven years (Daniel Acker, Bloomberg News, 11/20/13).

High cancer drug prices probably explain the reduced 10-year survival rates for Chronic Myeloid Leukemia (CML) in the U.S. compared with Sweden, according to international experts in CML. Treatment with Bcr-Abl tyrosine kinase inhibitors (TKIs) reduces annual all-cause mortality in CML to 2 percent versus a historical rate of 10-20 percent, and improves 10-year survival from less than 20 percent to above 80 percent. All five TKIs approved for CML have annual price ranges of $92,000 to $138,000 in the U.S., twice the prices in Europe. In the U.S., five-year survival is only 60 percent, compared with 10-year survival above 80 percent in Sweden (Kantarjian et al., "The price of drugs for CML," Blood, 4/25/13).

GALLOPING TOWARDS OLIGOPOLY

Mergers among hospitals and health systems accelerate

The health care system is rapidly consolidating in the wake of the passage of federal health reform. There were 105 hospital and health system mergers in 2012, more than twice as many as in 2009 ("A wave of hospital mergers," New York Times, 8/12/13).

Mergers involving four huge health systems reduced the number of large, publicly traded hospital corporations from seven to five. Community Health Systems (CHS) paid $3.9 billion to acquire Health Management Associates (HMA), while Tenet paid $4.3 billion to purchase Vanguard Health Systems.

The CHS-HMA deal will create the nation's largest (in terms of number of facilities) hospital chain with 206 mostly non-urban hospitals in 29 states, with a heavy presence in the South, and $18.9 billion in combined revenues.

With the acquisition of Vanguard, Tenet will operate 77 hospitals, 173 ambulatory surgery and outpatient centers, and five health plans with combined revenues of about $15 billion. It will also oversee six accountable care organizations (ACOs). Tenet is paying about $582,000 per bed for Vanguard's four Chicago hospitals, well above the median national price of $450,000 per bed in 2012.

The other three large investor-owned hospital chains are Hospital Corporation of America (162 hospitals, $33.0 billion in revenues), Universal Health Services (23 acute-care hospitals and 197 behavioral health hospitals, $7.0 billion in revenues) and Lifepoint Hospitals (52 hospitals, $3.4 billion in revenues).

Not-for-profit systems are also consolidating. Catholic Health East and Trinity Health finalized their merger earlier this year, creating the second largest not-for-profit health system in the country with 82 hospitals (in 21 states), 89 continuing-care facilities, $12.8 billion in revenues and 87,000 employees, of

which 4,100 are physicians. Only nonprofit Ascension Health, based in St. Louis, is larger, with over 90 hospitals and $16.6 billion in revenues (Crain's Chicago Business, 8/1/13; Crain's Detroit Business, 5/1/13; Herman, "Tenet Closes on $4.3 billion Vanguard Acquisition," MRA Alerts and Updates, 10/2/13; Herman, "56 Statistics on Major For-Profit Hospital Chain Finances," Becker's Hospital Review, 4/5/13).

The health care system in Massachusetts, the state that provided the model for the ACA, is highly consolidated. One insurer, Blue Cross Blue Shield, controls 45 percent of the private insurance market, and just three insurers control 80 percent. 45 percent of all private payments in the state go to doctors working for just three physician groups. Private insurance premiums in Massachusetts rose 9.7 percent between 2009 and 2011, while the value of that coverage shrank 5.1 percent, and deductibles rose 40 percent. The cost of overhead at insurance companies rose 20 percent annually during the same period, to $1.17 billion (Mass. Center for Health Information and Analysis; State House News Services, "Study: Mass. health care costs rise, benefits fall," 8/15/13).

• Seven health systems in New Jersey and Eastern Pennsylvania including 25 hospitals are forming an alliance without merging assets. AllSpire Health Partners, composed of systems with $10.5 billion in combined revenues, will focus on joint purchasing and population health, "starting with the systems' own employees." Similarly, 20 hospitals in Georgia formed Stratus Healthcare, a consortium including 2,000 physicians and 18,700 employees, and three systems in the Philadelphia area formed Lehigh Valley Health Network, a limited liability corporation, to "gain population health management expertise, beginning with managing healthcare benefits for their combined 32,000 employees" (Regional News, Northeast, Modern Healthcare, 9/23/13).

In Idaho, the Federal Trade Commission is suing to reverse the purchase of the state's largest multispecialty physician group, Saltzer Medical Group, by the state's dominant health system, St. Luke's. The FTC says St. Luke's gained an 80 percent market share for adult primary care in Nampa in order to leverage price increases for patients with private coverage. This is the first such deal the FTC has litigated to the courtroom and the outcome is expected to have far-reaching implications (Modern Healthcare, 9/23/13).

• The Cleveland Clinic and the 135-hospital Community Health Systems are expanding their six-month-old alliance. They are in negotiations to acquire the Akron (Ohio) General Health System and the Sharon (Pa.) Regional Health System, and are exploring a "strategic equity partnership" with a 208-bed hospital, Metro Health Corp., near Grand Rapids, Mich. If consummated, the deals will extend CHS' reach into 30 states (Modern Healthcare, 9/23/13).

ACA UPDATE

• Two-thirds of uninsured poor blacks and more than half of uninsured low-wage workers are ineligible for aid under the Affordable Care Act. 26 states – primarily in the South – continue to block the law's Medicaid expansion, leaving a total of 5.2 million people with incomes below the federal poverty line ($19,530 for a family of three) uninsured but ineligible for subsidies on the exchanges because the ACA envisioned that they would be covered by Medicaid. An additional 3.2 million people with incomes between 100 percent and 138 percent of poverty won't receive Medicaid but may buy subsidized coverage on the exchanges. Medicaid has income ceilings as low as $11 a day in some states; the median income ceiling in states blocking expansion is about $5,600 a year for an individual, less than half the federal poverty line ("The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," Kaiser Commission on Medicaid and the Uninsured, October 2013; Tavernise and Gabeloff, "Millions of Poor are Left Uncovered by Health Law," New York Times, 10/2/13).

• Three of the nation's largest insurers – Cigna, UnitedHealthcare, and Aetna – are limiting their participation on the new exchanges, offering plans in just 5, 12, and 14 states, respectively. The firms are avoiding the exchanges for now because they fear that people with costly health needs are more likely to enroll early, reducing profits, despite the administration's promise of risk adjustment and reinsurance programs (Kirchgaessner, Financial Times, 9/4/13).

• In New York as many as 400,000 independent professionals, from physicians to musicians to craftspeople, are losing the group coverage they obtained through their medical society or association, which in many cases provided greater choice of physicians and less cost-sharing than the exchange plans. The ACA prohibits associations from selling insurance because of the risk they will siphon healthy members, who are needed to keep the new health exchanges financially viable (Hartocollis, "With Affordable Care Act, Canceled Policies for New York Professionals," 12/13/13).

• Large businesses are projected to receive an annual $10 billion windfall from the virtual elimination of the COBRA program by Obamacare. COBRA allows employees to keep their employer-sponsored health insurance after leaving a job for up to 18 months, but the worker has to pay the full cost of coverage each month. There were an estimated 2.6 million COBRA beneficiaries in 2011. COBRA enrollees cost their former employer up to twice as much as active workers, because only sicker former-employees tend to enroll but they pay only the average premium. With the availability of subsidies on the exchanges, COBRA is expected to be virtually eliminated as former employees switch to subsidized coverage. However, some COBRA enrollees with chronic health problems are

unlikely to want to switch to exchange plans because such plans have narrow networks of providers and high cost-sharing (Jay Hancock, "Swapping COBRA For Obamacare Likely To Be Windfall For Big Business," Kaiser Health News, 9/23/13).

Insurance regulation won't fix health care crisis

About half of the bronze plans sold in six major cities on the health exchanges require beneficiaries to pay their full deductible before any insurance coverage kicks in. In Dallas, 64 percent of bronze plans require policyholders to meet the full deductible, an average of $5,400 in those plans, before they will cover a doctor's visit or other, non-preventive, care

The ACA intended to ban insurers from excluding patients based on pre-existing conditions. Insurers have responded to the ban by restricting patient choice of doctor to a small pool of doctors and by limiting or excluding coverage of expensive medications needed to treat HIV and other illnesses. While the online marketplace is supposed to facilitate choice of plan by allowing consumers to comparison shop, many plans don't disclose the medications on their formulary or doctors in their networks until patients formally apply for coverage.

Since HHS ruled that churches and other nonprofit religious organizations don't have to cover birth control in employees' health plans, over two dozen courts have ruled that private businesses also have the right to refuse to provide contraceptives. The ACA requires plans to cover preventive care, including contraception, without cost-sharing, including FDA-approved birth control such as levonorgestrel (Plan B emergency contraceptive). Several courts have granted businesses (e.g. Hobby Lobby) injunctions against any fines until the Supreme Court rules on the matter (Julie Appleby, Kaiser Health News, 12/23/13; Pittman, MedPage Today, 12/29/12).

Delays, changes, and rulings affecting the ACA

Although the Republicans tried to repeal Obamacare for three years, and blocked the ACA's Medicaid expansion in 26 states after a June 2012 Supreme Court ruling effectively made the expansion optional, many changes to the law have come from the Obama administration as it grapples with the difficulty of implementing such a complex plan. Ten of the most significant changes made by the White House:

1. Delayed the large-employer mandate by one year to give businesses more time to comply with the bill's reporting requirements. Employers with more than 50 workers will have another year before they must provide coverage for employees working more than 30 hours per week. In the meantime, Target and other large employers have announced they will no longer cover part-time workers.

2. Allowed individual and small-group policies that don't meet the ACA's benefits standard to be retained for another year, pending insurer and state insurance commissioner approval, after technical problems made the HealthCare.gov website inoperable for many weeks after the Oct. 1 launch date.

3. Delayed launching online enrollment through the federal Small Business Health Options Program (SHOP) exchange for one year to avoid technical problems with the roll out like those that plagued HealthCare.gov.

4. Delayed the availability of a streamlined application for both Medicaid and subsidies for private coverage on the exchanges for one year due to the complexity of synching state and federal enrollment data and means testing.

5. Delayed implementation of the limit on out-of-pocket expenses for plans with a separate administrator for drug coverage for one year to give insurers more time to coordinate how they tally out-of-pocket costs. Many of these plans have a separate cap or no limit on out-of-pocket spending for drugs.

6. Eliminated the law's voluntary long-term care insurance component, the CLASS Act, because it was inadequately financed.

7. Granted "quality bonuses" and a "payment adjustment" to Medicare Advantage (MA) plans in 2011 and 2012, respectively, effectively reversing the ACA's cuts of overpayments to MA plans. The additional payments appeased the insurance industry, which ran a multimillion-dollar campaign mobilizing seniors to contact Congress to oppose the ACA's "Medicare cuts."

8. Delayed introduction of the Spanish-language version of HealthCare.gov because it was not ready to launch. CuidadoDeSalud.gov started enrollment over two months behind schedule, and continues to frustrate users with grammatical mistakes and links to forms in English.

9. Gave states permission to charge some Medicaid beneficiaries higher copayments and premiums, up to $1,500 for a family of three making $30,000, and allowed Arkansas, Indiana, and possibly other states to use their federal Medicaid money to purchase private coverage on the exchanges for the very poor to appease GOP governors and get more states to expand Medicaid coverage.

10. Ruled that churches and other nonprofit religious organizations may be exempted from the ACA's mandate that businesses cover birth control in employees' health plans in response to religious opposition to the ACA. The Supreme Court has accepted a case that will decide whether businesses may also choose not to provide these essential benefits.

Many state exchanges frustrate users

Some of the 14 state-based exchanges frustrated users even more than HealthCare.gov. Despite federal grants to Oregon, Maryland, and Vermont totaling nearly half a billion dollars, those states' exchanges experienced some of the worst problems.

After two years and $160 million worth of work, Oregon's exchange was unable to determine if people were eligible for federal subsidies or Medicaid, leaving 400 newly-hired state workers to process paper applications. Using the manual workaround, 20,000 people were enrolled in private insurance, and another 150,000 people were signed-up for the state's Medicaid program by year's end, at an additional administrative cost of several million dollars. As of mid-January, the site had not enrolled a single person (Gray, "Kitzhaber Hires Cover Oregon Examiner," Lund Report, 1/10/14).

In Maryland, a "disastrous" $170 million website crashed

on the first day and continues to have so many bugs that the state considered switching to the federal site, HealthCare.gov. Only about 20,000 people successfully signed up for private coverage in Maryland by the end of December (12 percent of the state's goal by March 31), although 110,000 people enrolled in Medicaid (Johnson, "Maryland Senate committee to again question state official about exchange problems," Washington Post, 1/15/14).

Users initially couldn't get onto Vermont's $168 million, federally-funded exchange, and when they did get on, they couldn't sign up or pay for coverage. After fixes, the website still doesn't give users on-line payment options, and has suffered two privacy breaches. About 20,000 people were finally able to enroll in private coverage through the exchange by year's end; another 30,000 people signed up through their small business employer. Employers with 50 or fewer employees in Vermont are mandated to buy coverage through the exchange, but were allowed to bypass the website and sign up directly with an insurer as the December 24 deadline loomed. Although only two insurers participate in Vermont's program, the annual cost of running the exchange is projected to be $18.4 million. The state is withholding $5.1 million in penalties – the maximum allowable – from the website contractor for missing deadlines (Freese, "2013 Health Care Recap," Vtdigger.org, 12/29/13, Goodnough and Abelson, "Some State Insurance Exchanges Continue to Battle Technical Problems," New York Times, 11/12/13).

POLLS

• A significant proportion of Americans have an unfavorable view of the ACA because it doesn't go far enough to reform the U.S. health care system. 20 percent of Americans said they wanted Congress to expand the law in a CBS News poll in July. A CNN poll in September found that 11 percent opposed the law because it was not liberal enough, while a Kaiser poll earlier that month found that 7 percent of people who had an unfavorable view of the law said the law did not go far enough (Kipicki, "Closer Look at Polls Finds Views of Health Law a Bit Less Negative," New York Times, 10/1/13).

INTERNATIONAL

• New Zealand celebrated the 75th anniversary of its National Health Service, with universal coverage, free care at the point of service, and a salaried physician workforce, on Sept. 14, 2013.

The Society of Family and Community Medicine in Spain is leading the opposition to a law prohibiting undocumented immigrants from obtaining medical care in public facilities unless they are under 18, pregnant, or it is an emergency. In May, a Senegalese immigrant died of TB after being refused treatment at a public hospital. Hundreds of doctors have signed a declaration opposing the law, and several of Spain's 17 regions, which control the provision of health care, have refused to implement it (Cuzin, "Rebel Spanish doctors to keep treating illegal immigrants," AFP, 8/7/12; Ghosh, "Undocumented African Immigrant In Spain Dies After Hospital Refuses Treatment," International Business Times, 5/24/13).

• The next chief executive of the U.K.'s National Health Service, Simon Stevens, spent a decade as a top executive at the largest U.S. private insurance company, UnitedHealth. Stevens previously served as an advisor to Tony Blair, pushing market-based reform. With the NHS facing a £30 billion budget cut, he has announced he will take a 10 percent cut in pay on his 211,000 euro salary "in light of NHS spending pressures." The real question is whether he will use the artificial "crisis" created by large budget cuts to push further privatization and fragmentation of the strained NHS (Toynbee, The Guardian, 10/24/13).

HEALTH SPENDING

EXHIBIT 1

National Health Expenditures (NHE), Aggregate And Per Capita Amounts, Share Of Gross Domestic Product (GDP), And Annual Growth, By Source Of Funds, Calendar Years 2007–12

Source of funds	2007[a]	2008	2009	2010	2011	2012
EXPENDITURE AMOUNT						
NHE, billions	$2,302.9	$2,411.7	$2,504.2	$2,599.0	$2,692.8	$2,793.4
Health consumption expenditures	2,158.7	2,257.3	2,358.0	2,449.6	2,534.9	2,633.4
Out of pocket	293.6	300.7	300.7	305.6	316.1	328.2
Health insurance	1,611.8	1,703.2	1,798.5	1,873.9	1,943.4	2,014.4
Private health insurance	777.7	807.8	833.1	859.6	888.8	917.0
Medicare	432.8	467.9	499.9	520.2	546.2	572.5
Medicaid	326.2	344.9	375.4	398.1	407.7	421.2
Federal	185.8	203.5	248.1	267.5	248.3	237.9
State and local	140.4	141.4	127.3	130.7	159.4	183.3
Other health insurance programs[b]	75.1	82.6	90.2	96.0	100.7	103.8
Other third-party payers and programs and public health activity	253.3	253.4	258.8	270.2	275.4	290.8
Investment	144.2	154.4	146.2	149.4	157.8	160.0
Population (millions)	301.1	303.9	306.5	309.0	311.0	313.3
GDP, billions of dollars	$14,480.3	$14,720.3	$14,417.9	$14,958.3	$15,533.8	$16,244.6
NHE per capita	7,649	7,936	8,170	8,411	8,658	8,915
GDP per capita	48,093	48,437	47,037	48,409	49,944	51,843
Prices (2009 = 100.0)						
Chain-weighted NHE deflator	95.7	97.7	100.0	102.7	105.2	106.9
GDP price index	97.3	99.2	100.0	101.2	103.2	105.0
Real spending						
NHE, billions of chained dollars	$ 2,406	$ 2,469	$ 2,504	$ 2,531	$ 2,561	$ 2,612
GDP, billions of chained dollars	14,877	14,834	14,418	14,779	15,052	15,471
NHE as percent of GDP	15.9	16.4	17.4	17.4	17.3	17.2
ANNUAL GROWTH						
NHE	6.3%	4.7%	3.8%	3.8%	3.6%	3.7%
Health consumption expenditures	6.1	4.6	4.5	3.9	3.5	3.9
Out of pocket	5.9	2.4	−0.0	1.6	3.5	3.8
Health insurance	6.0	5.7	5.6	4.2	3.7	3.7
Private health insurance	5.1	3.9	3.1	3.2	3.4	3.2
Medicare	7.2	8.1	6.8	4.1	5.0	4.8
Medicaid	6.3	5.8	8.8	6.1	2.4	3.3
Federal	6.7	9.6	21.9	7.8	−7.2	−4.2
State and local	5.7	0.7	−10.0	2.7	22.0	15.0
Other health insurance programs[b]	7.4	9.9	9.2	6.4	4.9	3.1
Other third-party payers and programs and public health activity	6.7	0.0	2.1	4.4	1.9	5.6
Investment	9.9	7.1	−5.3	2.2	5.7	1.4
Population	0.9	0.9	0.9	0.8	0.7	0.7
GDP, billions of dollars	4.5	1.7	−2.1	3.7	3.8	4.6
NHE per capita	5.3	3.8	3.0	3.0	2.9	3.0
GDP per capita	3.5	0.7	−2.9	2.9	3.2	3.8
Prices (2009 = 100.0)						
Chain-weighted NHE deflator	3.3	2.0	2.4	2.7	2.4	1.7
GDP price index	2.7	1.9	0.8	1.2	2.0	1.7
Real spending						
NHE, billions of chained dollars	2.9	2.6	1.4	1.1	1.2	2.0
GDP, billions of chained dollars	1.8	−0.3	−2.8	2.5	1.8	2.8

SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and US Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** Definitions, sources, and methods for NHE categories can be found at CMS.gov. National Health Accounts methodology paper, 2012: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 [cited 2014 Jan 6]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf. Numbers may not add to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2006–07. [b]Includes health-related spending for Children's Health Insurance Program (CHIP) Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs.

HealthAffairs Blog

January 2, 2014

Medicare's Rollout vs. Obamacare's Glitches Brew

By David Himmelstein, M.D., and Steffie Woolhandler, M.D., M.P.H.

The smooth and inexpensive rollout of Medicare on July 1, 1966, provides a sharp contrast to the costly chaos of Obamacare. We won't rehearse the chaos part here, just the costs.

As of March 2013, federal grants for Obamacare's state exchanges totaled $3.8 billion. Spending for the federal exchange is harder to pin down because funding has come from multiple accounts, including: the $1 billion Health Insurance Implementation Fund; DHHS' General Departmental Management Account; CMS's Program Management Account; and the Prevention and Public Health Fund. CMS estimates fiscal 2014 spending for the federally-operated exchanges at $2 billion. So it's safe to say that the costs of getting the exchanges up and running, and (hopefully) enrolling 7 million people in the program's first year will exceed $6 billion.

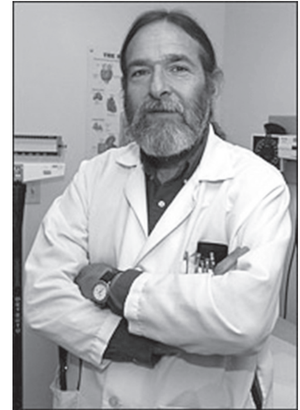
Bear in mind that the exchanges won't actually pay any medical bills, just sign people up for coverage. So billions more in overhead costs will show up on the books of the private insurers and state Medicaid programs that will actually process medical claims.

Back in 1966, Medicare started paying bills for 18.9 million seniors (99 percent of those eligible for coverage) just 11 months after President Johnson signed it into law. Overhead costs for the first year totaled $120 million (equivalent to $867 million in 2013 – all subsequent figures are given in 2013 dollars). But that figure includes the cost of processing medical bills, not just the enrollment costs.

Moreover, Medicare and Medicaid (which was passed at the same time) displaced several smaller federal health assistance programs, saving about $376 million on their overhead costs.

Signing up most of the elderly for Medicare was simple; they were already known to the Social Security Administration, which handled enrollment. To find the rest, the feds sent out mailings to seniors, held local meetings, and asked postal workers, forest rangers and agricultural representatives to help contact people in remote areas. The Office for Economic Opportunity spent $14.5 million to hire 5,000 low-income seniors who went door-to-door in their neighborhoods.

Despite predictions of chaos, and worries that the newly insured seniors would flood the health care system, there were few bottlenecks. Hospitals continued to operate smoothly and no waiting lists materialized. The only real "glitch" was that many hospitals in the Deep South initially refused to integrate their facilities – which Medicare required for certification and payment. But by the end of the first month, 99.5 percent of hospitals had signed on.



Drs. Steffie Woolhandler and David Himmelstein

Obamacare's start-up has been rocky because complexity is "baked in" to the design, just as simplicity was "baked in" to Medicare. Obamacare's exchanges must coordinate thousands of different plans, with premiums, copayments, deductibles and provider networks that vary county-by-county; Medicare offered a single, uniform plan. The exchanges must calculate subsidies for each applicant after first verifying income, family size and immigration status; Medicare offered free hospital coverage, with a minimal ($22) uniform premium for doctor coverage. Instead of setting up a new bureaucracy to collect premiums from millions of enrollees and funnel them to private insurers, Medicare relied on the existing payroll and income tax system to garner funds.

Obamacare's byzantine complexity reflects the contortions required to simultaneously expand coverage and appease private insurers. And private insurers will exact a steep ongoing toll. Medicare's overhead is just 2 percent, vs. an average of 13 percent for private plans (on top of the Exchanges' costs, roughly 3 percent of premiums). A single-payer plan that excluded private insurers could save hundreds of billions in transaction costs.

Medical quality improvement experts often advise hospitals to "avoid workarounds"; fix system defects rather than force doctors and nurses to sidestep problems like faulty equipment, understaffing, or illegible handwritings. This advice is equally valid for health reform. To avoid glitches and wasteful expense, design the system right; eliminate private insurers and cover everyone under a single-payer program.

Drs. David Himmelstein and Steffie Woolhandler are professors at the City University School of Public Health at Hunter College and visiting professors of medicine at Harvard Medical School. They are co-founders of Physicians for a National Health Program.

Newsday

November 14, 2013

Expanding Medicare to all can solve health care disaster

By Caroline Poplin, M.D.

Republicans can hardly believe their good luck.

The Obama administration has once again snatched defeat from the jaws of victory. After successfully holding off Republican efforts to destroy Obamacare by shutting down the government and threatening default, the administration badly bungled the rollout of the crown jewel of health reform: the insurance exchanges. (No surprise to those of us who wrestle with computers daily.) Somehow administration leaders also failed to anticipate the predictable response of insurance companies to a perfect opportunity to raise premiums wholesale, while blaming someone else.

Nevertheless, we need to keep in mind that even as they gleefully tear into the ACA, Republicans have not offered an alternative.

On reflection, however, this is no surprise. Republicans don't see a problem with health care in America. Insurers can sell what they chose to whom they chose; people can select policies they like and can afford, or save their money for other things.

This is how markets work. The only change Republicans would make is deregulation, so insurers and good prospects can find one another more easily across state lines.

As Ronald Reagan said: "Government is not the solution to the problem, government (in this case, the ACA) is the problem." For conservatives, health insurance and health care are ordinary commodities to be traded in the marketplace, just like automobile insurance and automobiles.

But health care is not just another item in the shopping cart. As the African-American spiritual observed, "If living were something that money could buy, the rich would live and the poor would die." And that is where we are in the 21st century. Health care is a matter of life and death. Our medicine is highly effective. Today, we can cure, or treat, diseases that were once fatal - heart attacks, many cancers, even HIV. That is, if you have the money. Today rich Americans live, on average, five years longer than poor citizens.

Nor is health insurance an ordinary insurance product.

Illness today is not evenly distributed across the population. Some 10 percent of people are responsible for 60 percent of health-care costs in the United States. Because most illness continues for many years after diagnosis, these people are easy to identify: patients with multiple sclerosis, congestive heart failure, lymphoma.

No one wants to pay for the sick people - not the insurance companies (particularly if they cannot recover their costs by charging the sick higher premiums), and not healthy customers. We hear this now, as single men and older people complain that to comply with the ACA, they have to pay for maternity benefits that they will never use.

A free market with lots of choices among multiple insurers, risk pools, policies with all sorts of benefits and price structures, allows insurers and healthy individuals to avoid the sick. The less affluent healthy can gamble on inexpensive policies with spotty coverage (useless to the chronically ill): since most people are healthy most of the time, few of them will ever need to test their insurance. (Or they can join large groups of other healthy people working for large employers who provide insurance.) Insurers can charge sick people thousands of dollars a month to cover the cost of their claims, and then some.

The result? The people who need health care the most have the most difficulty getting insurance that covers it. Doesn't this defeat the whole purpose of the exercise? That, however, is the Republican alternative to the ACA. And remember, even before the ACA, things were not stable, but deteriorating: as health costs rose, premiums, co-pays and deductibles were going up, employers were cutting back. Without the ACA, those trends will continue.

The ACA was an effort to preserve a private health insurance market, using regulation to achieve a better result. As we see, this is very complicated.

There is a third option. If everyone is in the same, large, pool, everything medically necessary is covered, insurers are paid merely to process claims, and premiums are scaled to income, there is enough money to cover everyone at reasonable cost without elaborate, expensive, error-prone computer programs and geniuses to run them. People will be able to choose their doctors and hospitals. (And the rich can always buy more if they want.)

A crazy, wild-eyed socialist nightmare? No, this is Medicare, a familiar, popular, competently-run public insurance system that everyone's parents or grandparents rely on. Person-for-person, disease-for-disease, Medicare is the cheapest, most efficient health insurance program in the country. (There is virtue in simplicity.)

Medicare already controls health care costs better than private insurers, and with a few tweaks, could do much more, forcing prices down to the level citizens of every other advanced democracy pay, with no sacrifice in quality.

Given the alternatives, maybe Medicare-for-all deserves a second look.

Caroline Poplin is a physician, attorney and policy analyst in Bethesda, Md. This article was distributed by the McClatchy-Tribune News Service.

ModernHealthcare

October 26, 2013

Vermont eyes 2017 launch of single-payer health plan

By Dave Gram, The Associated Press

MONTPELIER, Vt. – As states open insurance marketplaces amid uncertainty about whether they're a solution for healthcare, Vermont is eyeing a bigger goal, one that more fully embraces a government-funded model.

The state has a planned 2017 launch of the nation's first universal healthcare system, a sort of modified Medicare-for-all that has long been a dream for many liberals.

The plan is especially ambitious in the current atmosphere surrounding healthcare in the United States. Republicans in Congress balked at the federal health overhaul years after it was signed into law. States are still negotiating their terms for implementing it. And some major employers have begun to drastically limit their offerings of employee health insurance, raising questions about the future of the industry altogether.

In such a setting, Vermont's plan looks more and more like an anomaly. It combines universal coverage with new cost controls in an effort to move away from a system in which the more procedures doctors and hospitals perform, the more they get paid, to one in which providers have a set budget to care for a set number of patients.

The result will be healthcare that's "a right and not a privilege," Gov. Peter Shumlin said.

Where some governors have backed off the politically charged topic of healthcare, Shumlin recently surprised many by digging more deeply into it. In an interview with a newspaper's editorial board, he reversed himself somewhat on earlier comments that Vermont would wait to figure out how to pay for the new system. He said he expects a payroll tax to be a main source of funding, giving for the first time a look at how he expects the plan to be paid for.

The reasons tiny Vermont may be ripe for one of the costliest and most closely watched social experiments of its time?

It's the most liberal state in the country, according to Election Day exit polls. Democrats hold the governor's office and big majorities in both houses of the Legislature.

It has a tradition of activism. Several times in recent years, hundreds of people have rallied in Montpelier for a campaign advocating that healthcare is a human right.

It's small. With a population of about 626,000 and just 15 hospitals, all nonprofits, Vermont is seen by policy experts as a manageable place to launch a universal healthcare project.

"Within a state like Vermont, it should be much more possible to actually get all of the stakeholders at the table," said Shana Lavarreda, director of health insurance studies at the University of California at Los Angeles' Center for Health Policy Research.

Vermont's small size also is often credited with helping preserve its communitarian spirit. People in its towns know one another and are willing to help in times of need.

Gov. Peter Shumlin addresses PNHP's 2013 Annual Meeting

"The key is demography," said University of Vermont political scientist Garrison Nelson. Discussions about health policy "can be handled on a relative face-to-face basis," he said.

And, for better or worse, Vermont has little racial or income diversity, Nelson pointed out.

Then there's the fact that Vermont is close to universal healthcare already. Lavarreda noted that the state became a leader in insuring children in the 1990s. Now 96 percent of Vermont children have coverage, and 91 percent of the overall population does, second only to Massachusetts.

At this stage, no one knows whether state-level universal healthcare will succeed, and it's an open question as to whether Vermont can work as a model for other states.

"Developing a single-payer system for Vermont is a lot easier than in California or Texas or New York state," said U.S. Sen. Bernie Sanders. The independent, frequently described as the only socialist in the Senate, has been pushing for some form of socialized medicine since he was mayor of Burlington 30 years ago.

Vermont's efforts have largely gone unnoticed as the nation focuses on the rollout of the state-based health insurance marketplaces and the disastrous unveiling of healthcare.gov, said Chapin White, a researcher with the Washington-based Center for Studying Health System Change.

"Vermont's thinking about 2017, and the rest of the country is just struggling with 2014 right now," White said.

Even with years to go before Vermont's single-payer plan will be in place, several obstacles remain.

The largest national health insurance industry lobbying group, America's Health Insurance Plans, has warned that the law could limit options for consumers and might not be sustainable.

"The plan could disrupt coverage consumers and employers like and rely on today, limit patients' access to the vital support and assistance health plans provide, and put Vermont taxpayers

(continued on next page)

*(**Vermont**, continued from previous page)*

on the hook for the costs of an unsustainable healthcare system," said AHIP spokesman Robert Zirkelbach.

And questions have also arisen about the expected cost savings of eliminating multiple insurance companies and their different coverage levels and billing styles.

Much of a hospital's billing process is coding to ensure that the right patient is billed the right amount for the right procedure, said Jill Olson, vice president of the Vermont Association of Hospitals and Health Systems. That would continue in a single-payer system.

Vermont also has yet to answer how it will cover everyone. The post-2017 system is not envisioned to include federal employees or those with self-insured employers that assume the risk of their own coverage and are governed by federal law, including IBM, one of the state's largest private employers. It also may not include residents who work for and get insurance through companies headquartered out of state, Olson said.

At least one resident, 73-year-old Gerry Kilcourse, has little patience for the naysayers.

Kilcourse said that when he and wife Kathy bought a hardware store in Plainfield in the early 1980s, they struggled for years to find good, affordable health insurance coverage.

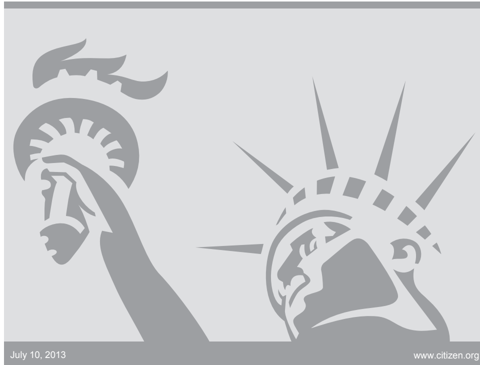
In retirement, Kilcourse has schooled himself on health policy and advocates for universal coverage. He sees healthcare as a public good and likens the current campaign to the 19th-century push in the United States for public schools.

"It should be similar to education, which is publicly funded," Kilcourse said of healthcare. "If we did the same thing for education (as in healthcare), you'd have a number of people being excluded" from public schools.

Shumlin has made it clear the status quo can't hold. As a part owner himself of a small business — a student travel service based in Putney — he has spoken often of the burden that employee health coverage is to such business owners.

At a Chamber of Commerce forum in September, he called the federal health overhaul "a great improvement over the past" but added it "is not the silver bullet that will ... provide universal access and quality healthcare for all Vermonters."

That, he appears to hope, will come in 2017.



A Road Map to 'Single-Payer': How States Can Escape the Clutches of the Private Health Insurance System

A report from Public Citizen

This report outlines the steps needed to develop a health care system that most closely resembles single payer at the state level. It outlines the obstacles and provides guidance on the practical steps that activists and policymakers can take around them. Advocates for state-based single payer plans will find it a useful "road map" for the journey.

It is available for download on Public Citizen's website at:
http://www.citizen.org/documents/road-map-to-single-payer-health-care-report.pdf

Also see "A perspective on national and state single payer efforts," page 40.

Bangor Daily News

November 14, 2013

Health reform's problems run deeper than a glitchy website

By Philip Caper, M.D.

Serious problems with the websites created by the Affordable Care Act continue, and probably will for a long time. Although frantic efforts at incrementally improving them are being made by the Obama administration, and some sites are working better than others, they are a long way from working well.

As I've written before, the causes of the website's problems are far more serious than poor software design. They are baked into the law by its extreme complexity.

There is growing frustration and anger at the administration in Congress from both Democrats and Republicans. Much of it is being expressed by the same people whose hypocrisy and obstructionism is responsible for a failure to do the right thing in the first place. Calls from members of Congress to delay the ACA's implementation or to repeal it entirely will intensify.

Instead of expanding our existing Medicare program, which has been working well for almost 50 years and is our country's most efficient and least intrusive health care financing program, the ACA creates complex new law that perpetuates and reinforces the chaos and confusion of our hodgepodge of public and private insurance programs. Coverage and financial assistance continue to depend on an individual's employment status, income, place of residence, age, conjectures about future health status, and many other factors, some of them subject to change with little or no warning and many impossible to predict.

Smooth implementation of the ACA depends upon the ability of many parts of government and thousands of insurance companies to seamlessly communicate with one another and agree on data drawn from myriad different public and private sources. Some in the health insurance field believe such a task will be difficult or impossible to achieve.

We have to ask ourselves, who are the winners from requiring us to go through the expense and confusion inherent in trying to implement a law of over 2,000 pages? The answer is clear. It's a health insurance industry that profits from complexity and confusion, and providers of pharmaceuticals, medical supplies, devices and services who benefit excessively from the very weak cost controls inherent in our fragmented system of paying for services.

The losers are all the rest of us. The ACA's objective, access to health care for all Americans, could have been accomplished much more easily with far less confusion, expense and complexity.

I talk to a lot of people from across the political spectrum about health care reform. There is a growing consensus that improved Medicare for all is the necessary first step in repairing our badly broken health care system.

Dr. Phil Caper

During a trip to California last week, I ran into House Minority Leader Nancy Pelosi. When I explained to her that while I admired her efforts to reform our health care system, I remain an advocate for "Improved Medicare for All," she responded, "Yes, we should have done single payer."

Perhaps there's still hope. Between Harry Reid's recent comments and Pelosi's epiphany, there seems to be a growing understanding of the problem, and its solution, in some parts of Congress.

But first, we will have to get rid of the obstructionist politicians whose only interest seems to be in preserving a health insurance industry that has become one of the most destructive forces in American society.

That task is up to us.

Physician Philip Caper of Brooklin is a founding board member of Maine AllCare, a nonpartisan, nonprofit group committed to making health care in Maine universal, accessible and affordable for all.

Brush up your grand rounds speaking skills

Could you use a refresher course or some one-on-one coaching before you deliver your next (or first) grand rounds on single payer? We can help. PNHP is developing a series of educational webinars and coaching sessions. For details, contact Dr. Ida Hellander at ida@pnhp.org or call (312) 782-6006.

The New York Times

September 26, 2013

Single Payer, Period

By David Himmelstein, M.D., and Steffie Woolhandler, M.D., M.P.H.

The Department of Health and Human Services' breathless report touts the 53 choices and low premiums available through the new health insurance exchanges. But citizens of other developed nations would laugh at this definition of choice, and the rosy rate quotes hide nasty news for those who aren't forever young.

As The Times reported, the lower than expected rates reflect many insurers' decisions to pare down their provider networks for plans offered through the exchanges. You may have a choice of insurer, but little choice of doctor or hospital. So in Los Angeles, low cost means you're not welcome at the top-ranked hospitals: Cedars Sinai and U.C.L.A.

In the past the uninsured and Medicaid patients traveled in medical steerage – or not at all; private insurance guaranteed a place in first class care. Much of the health law's new private coverage looks a lot like a Medicaid H.M.O. – coverage that restricts and segregates lower-income patients from the affluent. Top-class care is increasingly reserved for the well-to-do.

Canadians or the French or Germans have little or no choice of who pays their medical bills. But they can choose any hospital and any doctor. And they're not socked with the enormous uncovered bills that will still afflict insured Americans. Elsewhere, insurance pretty much covers what you need.

In contrast, plans offered through the exchanges will saddle those who gets sick with hefty deductibles and copayments – $2,000 deductibles and 20 percent copayments thereafter are typical in Massachusetts, the prototype for Obamacare.

If you're too old to twerk the news is even worse. Health and Human Services' news release featured premium costs for a 27-year-old. At that age you can get a Silver plan in New Jersey for $3,030 annually. But for someone 63 the premium is $8,535.

Instead of a menu of 53 skimpy, restrictive plans, a single-payer system would offer Americans unrestricted choice of care and first dollar coverage. By eliminating private insurers' overhead, and the massive paperwork they inflict on doctors and hospitals, we'd save enough to cover the 31 million who will remain uninsured under the Affordable Care Act.

David Himmelstein, M.D., and Steffie Woolhandler, M.D., M.P.H., are professors at the City University School of Public Health at Hunter College and visiting professors at Harvard Medical School.

Health Affairs

November 14, 2013

Administrative Costs And Complexity Of Health Insurance In Eleven Countries, 2012 And 2013

Country	Per capita spending on health insurance administration, 2011[a]	Percent of adults reporting, in the past year: "Spent a lot of time on paperwork or disputes" for medical bills or insurance, 2013[b]	"Insurance denied payment" or "did not pay as much as expected," 2013[b]	Had either difficulty, 2013[b]	Percent of primary care physicians reporting the time they or their staff spend getting patients needed care because of coverage restrictions is a major problem, 2012[c]
AUS	$70	6	15	16	11
CAN	148	5	14	15	23
FRA	277	10	17	23	20
GER	237	8	14	17	41
NETH	199	9	13	19	28
NZ	128	4	6	7	18
NOR	35	7	3	8	12
SWE	55	2	3	4	12
SWI	266	16	16	25	24
UK	—[d]	2	3	4	10
US	606	18	28	32	54

SOURCES See below. **NOTES** Excluding respondents who did not answer the question. Between-country significance tests are shown in online Appendix 8 (see Note 3 in text). [a]Organization for Economic Cooperation and Development, OECD health data 2013 (see Note 16 in text). Australian data from 2010. All data adjusted for differences in cost of living. [b]2013 Commonwealth Fund International Health Policy Survey in Eleven Countries. [c]2012 Commonwealth Fund International Survey of Primary Care Physicians (see Note 12 in text). [d]Not available.

C. Schoen, R. Osborn, D. Squires, and M. M. Doty, "Access, Affordability, and Insurance Complexity Are Often Worse in the United States Compared to 10 Other Countries," Health Affairs Web First, published online Nov. 14, 2013.

Patients and profits

By Marcia Angell, M.D.

The following remarks were presented to participants at PNHP's Annual Meeting in Boston on Nov. 2.

I'm delighted to be here and particularly delighted to be able to help celebrate Quentin Young's 90th birthday. We all know that Quentin is a fearless and indefatigable champion of the sick and downtrodden. But what some of you may not fully appreciate is his historical role in the front lines of the struggle for a better health system, and indeed for a more decent and saner world.

I recently read his memoir, and was astonished at how he managed to be nearly everywhere the good fight was being fought in the last half of the 20th century – not just as a witness, sort of Zelig-like, but as a participant and leader. I won't list his many contributions to important social changes, but I want to mention one.

I recently read Quentin's testimony before the infamous House Un-American Activities Committee in October of 1968. A few words of background: This was in the wake of the horrific police violence unleashed by Chicago Mayor Richard Daley against thousands of anti-Vietnam war protesters in Grant Park, while the 1968 Democratic Convention was underway right across the street. The brutal beatings were witnessed live on television by the entire country.

Not surprisingly, Quentin was right there in the middle of it as chairman of the Medical Committee for Human Rights, which was trying to minister to the injured despite considerable risks to themselves. Afterwards, the House Un-American Activities Committee, known as HUAC, held hearings to try to pin responsibility for the violence on a communist plot. HUAC had terrorized leftists since its founding in 1938, often destroying people's reputations and livelihood. Many who were summoned to appear before it were reluctant to stand up for themselves, often taking the Fifth Amendment to avoid answering questions.

HUAC sure didn't count on Quentin! When he was summoned, and they set out to link him to the Communist Party and discredit the Medical Committee for Human Rights, he refused to hide behind the Fifth Amendment, but instead appealed to the First Amendment, saying it gave him the right to say and believe anything he wanted and associate with whomever he wanted.

He then led HUAC on a merry chase during two days of testimony, outmaneuvering them at every turn. Crafty, really. It was great reading, and I recommend it to all of you. I never thought I'd feel sorry for HUAC, but I almost did. Incidentally, HUAC changed its name the following year.

So it's a real pleasure to wish this great and good man a very happy 90th birthday.

This year also marks the 10th anniversary of the publication in JAMA of the "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance." (In the spirit of full disclosure I should mention that I was on the writing committee, which was led by Steffie Woolhandler, David Himmelstein, and Quentin.) In the proposal, PNHP laid out the details of how

Dr. Marcia Angell

a single-payer system could work in the United States, how it could provide universal care for the same cost as the current system, without the rapid inflation, and how the transition might be accomplished. That proposal became the template for HR 676, introduced by Representative John Conyers the same year, and re-introduced regularly since then.

I recently re-read the JAMA article to see if there were any changes I would make – ten years and hundreds of billions of dollars later, with tens more millions of Americans uninsured or underinsured. I decided it's just as relevant now as it was then, maybe more so. The formal title of HR 676 is The Expanded and Improved Medicare for All Act, which, although clunky as a title, is descriptive. As you know, it essentially calls for extending Medicare to everyone, within a nonprofit delivery system.

This morning, we've heard excellent talks on health policy, including an update on the Massachusetts plan, which explains a lot of pot holes in our roads as health care crowds out all other state responsibilities. And we've heard about the more hopeful Vermont effort to establish a single-payer system. So I'll try not to spend much time duplicating in detail what's already been said. Instead, I'd like to say just a few words about a couple of general points I think are particularly important and worth emphasizing.

First, it's necessary to say again and again that the fundamental problem with our health system is its staggering and uncontrollable costs. Problems with access and coverage stem from that. After all, if money were no object, everyone could have all the health care they wanted. To work long-term, any

reform must target costs. But to target costs, we need to know why they're so high, and there are two quite simple reasons: the investor-owned private insurance industry, and the profit-oriented delivery system.

PNHP has always emphasized the problems created by multiple private insurance companies – hence the term "single payer." And those problems are certainly worth emphasizing. The existence of hundreds of for-profit insurance companies vying to cover the healthy and avoid the sick has created a gigantic game of hot potato. We're the only country in the world with a health system designed to avoid sick people, and when insurers try to do that without explicitly admitting it, it creates enormous overhead costs.

That point is made wonderfully in the cartoon at the back of the recent PNHP Newsletter that shows a doctor saying to his hapless patient, "Uh-oh, your coverage doesn't seem to include illness." This cost-shifting, along with the profits and corporate perks of the industry, is probably wasting around a half trillion dollars this year, although there's no way to calculate health expenditures very precisely. Suffice it to say, it wastes hundreds of billions of dollars a year.

But this refers only to the financing system – the costs of not having a single government payer. What about the delivery system – the hospitals, clinics, and doctors who actually provide the care? I think we don't say enough about the delivery system, which in my view is even more culpable than the financing system.

Here again, we're unique among advanced countries in that we've left the delivery system largely in the hands of profit-maximizing providers. Even institutions that are technically nonprofit behave the same way because they're swimming in the same money-saturated sea. Doctors are paid fee-for-service, and the fees are heavily skewed toward specialist procedures, which is why we have so many specialists doing so many unnecessary and duplicative procedures, often in investor-owned facilities.

It's probably even harder to say how much is wasted in our delivery system, compared with the financing system, but I believe it's probably at least as much – maybe even twice as much. That's why Medicare, for all its virtues, is almost as costly and inflationary as the private system. It uses the same delivery system. The key is to prohibit profits in the delivery of health care. In the 2003 PNHP proposal, that point was made, but I believe it receives too little emphasis. Medicare for all is not enough.

The problem with the Affordable Care Act, which the president is happy to call Obamacare for the time being, is that it doesn't really deal with either of the two underlying reasons for the ever-rising costs and consequent poor quality of our health system – namely, the existence of private insurers, and the profiteering of providers.

Under Obamacare, private insurance companies will still be able to set their own premiums, and since the legislation will pour more money and customers into the industry, that's a recipe for inflation. Most of the regulations to prohibit abuses are fairly easily circumvented, and as the president of the health insurers' trade association once told me, any adverse effect on the companies' bottom line can always be offset by increasing premiums.

As for the delivery system, care will still be provided in for-profit facilities, and doctors will still be paid fee-for-service, and the fees will still be skewed to reward highly paid specialists for doing as many procedures as possible. There is some language in the legislation about determining cost-effective practice and setting up demonstration projects that would pay doctors differently, but nothing specific. It's a promissory note.

Moreover, the law actually forbids tying fees to findings from comparative effectiveness research.

Despite all the hype that Obamacare is the most important piece of social legislation since Medicare, I doubt very much that it will ever be fully implemented as written. It's just too inflationary and also too Byzantine. I'm no techie, but it strikes me that the failure of the HealthCare.gov website has more to do with the mind-boggling complexity of the law than with technological challenges per se. And I don't believe there's any way to make it work by further tinkering.

In recent years, I've grown increasingly sympathetic to a completely nationalized health system in which there is no insurance of any kind. In essence, that would mean extending the Veterans Affairs system to everyone, with hospitals and clinics owned by the federal government, which would pay salaries to doctors. This would be like the UK's original National Health Service. Of course, that would be even harder to achieve than an expanded and improved Medicare system, but it strikes me that it is the simplest system, and it completely separates health care from payment.

The problem with the Affordable Care Act is that it doesn't really deal with either of the two underlying reasons for the ever-rising costs and consequent poor quality of our health system – namely, the existence of private insurers, and the profiteering of providers.

In my view, health care is fundamentally a moral issue, not an economic one. Why should people who are sick or injured have to pay for the privilege? Yet that is what we make them do – as though illness were some consumer product that patients are keen to have. So they pay twice – once in the suffering caused by the illness itself, and then again in the financial costs. To me, that is immoral, a sort of piling on. People who are sick or injured should be able to get the care they need, and money should have nothing to do with it.

My fervent hope is that as the ACA unravels and costs go up, the U.S. will finally be ready to embrace a nonprofit single-payer system that covers everyone, from the president on down. My fear, however, is that Americans will instead conclude that providing universal health care is simply too expensive, and give up on it. The tragedy in that case would be that the country was too insular and too much in the pocket of the health industry to recognize that universal care can be provided relatively cheaply, as other countries have shown.

Dr. Marcia Angell is senior lecturer in social medicine at Harvard Medical School and former editor of the New England Journal of Medicine.

Global Amnesia: Embracing Fee-For-Non-Service—Again

David U. Himmelstein, MD and Steffie Woolhandler, MD, MPH

The City University of New York School of Public Health, New York, NY, USA.

J Gen Intern Med
DOI: 10.1007/s11606-013-2745-1
© Society of General Internal Medicine 2014

Let's hope that Orwell's memory hole remains in good repair. As *1984* fans will recall, that appliance incinerated reminders of things more conveniently forgotten.

Today we need it to cleanse memories of managed care's profit-driven abuses, so we can proceed, unimpeded by history, with accountable care organizations (ACOs) and bundled payment—the linchpin of reforms recommended by the Society of General Internal Medicine (SGIM)'s National Commission on Physician Payment Reform (and endorsed, in this issue of *JGIM*, by Drs. Ho and Sandy[1]).

We support The Commission's calls for rebalancing compensation for cognitive vs. procedure-related work, and reforming the Relative Value Scale Update Committee (RUC) and Medicare's sustainable growth rate (SGR). But its main prescription echoes the 1971 "Health Maintenance Strategy" proposal that ushered in the managed care fiasco.

Back then, Ellwood and colleagues proffered health maintenance organizations (HMOs) as the market-based alternative to national health insurance.[2] They argued that fee-for-service "works against the consumer's interest … the greater the number of contacts and days used, the greater the reward to the provider." Their solution: HMOs paid "a fixed annual fee… The economic incentives of both the provider and the consumer are aligned…[with] A performance reporting system of proven reliability…[providing] accurate information on the comparative performance of alternate sources of health care" and "surveillance of the characteristics of populations served and services provided" to guard against cherry-picking and care denials.

That same year president Nixon made HMOs the centerpiece of his healthcare agenda, because (as captured on tape) "this [HMO strategy] is a private enterprise one… the incentives are toward less medical care, because the less care they give, the more money they make." Employers and insurers soon followed Nixon's lead, and by the mid-1980s, many providers rushed to create their own HMOs.

But egregious abuses followed. Headlines blared; patients sued over vital services denied; and HMO whistle-blowers told horrifying tales of office celebrations triggered when reviewers discovered loopholes allowing the denial of transplants.

Physicians were pressured to withhold care, and to hide that pressure from patients; bonuses of up to $150,000 annually were offered to doctors who minimized specialty referrals, inpatient care, etc.[3] Our protest of those incentives, and a contract provision forbidding their disclosure (a "gag clause") led to "delisting". Award-winning physicians—who often attract unprofitably sick patients—were also delisted. An academic leader admonished physicians: "[We can] no longer tolerate having complex and expensive-to-treat patients encouraged to transfer to our group."[4]

In the end, Americans concluded that fee-for-NON-service was even worse than fee-for-service.

HMOs lived on, but retreated from shifting risk to providers, relying instead on mother-may-I-style cost containment, like pre-authorization.

Now SGIM's Commission has joined the growing policy bandwagon to reanimate the HMO strategy. There are semantic changes—ACO has replaced HMO, and when insurers drop expensive doctors (e.g. the 1,000-member Yale Medical Group[5]), it's called "network optimization" not "delisting". In a new twist on gag clauses, today's ACO patients (e.g. seniors in Medicare's Pioneer ACOs) aren't told they're enrolled. But the diagnosis and prescription are unchanged.

As in 1971, fee-for-service is the culprit. A shift to "bundled payment, capitation, and increased financial risk sharing." is the solution, with "risk adjustment… to avoid physicians and other providers cherry-picking the healthiest patients"; and "quality measures… to assure that evidence-based care is not denied as a cost-saving mechanism."

Twentieth century risk adjustment and quality monitoring were overmatched by HMOs' gaming and deception. Despite additional decades of work to devise bullet-proof risk adjustment, gaming remains so powerful and pervasive that cost and quality rankings are often distorted, or even inverted. No solution is on the horizon.

GAMING TO WIN

Doctors, hospitals and health plans supply diagnoses, the raw material for risk-adjustment algorithms. But diagnoses reflect the aggressiveness of workups and coding, not just

Published online: 07 January 2014

the patient's clinical condition. Under risk-adjusted capitation and bundled payment, making patients look sicker on paper yields higher payments.

Overdiagnosis appears widespread. In high-cost regions, aggressive testing is common and labels patients with more seemingly serious diagnoses.[6] But this apparently greater severity-of-illness is artifactual.[6] How could aggressive testing lead to overdiagnosis? Obtaining echocardiograms on asymptomatic octogenarians would turn up many stiff ventricles, allowing diagnoses of "diastolic congestive heart failure (CHF)". While few such patients would have the grave prognosis and high costs of symptomatic CHF, the diagnosis would boost their risk scores, and hence ACOs' capitation payments (and risk-adjusted outcomes).

"Upcoding" is ubiquitous among hospitals paid diagnosis-related groups (DRG)s (bundled payment per admission) and capitated Medicare Advantage (MA) plans, which use it to extract overpayments of $30 billion annually.[7] Paradoxically, Centers for Medicare & Medicaid Services' (CMS) efforts to refine risk adjustment probably increased gaming-induced overpayments[7]; boosting capitation payment for comorbidities made asymptomatic CHF very profitable. Outright cheating may also be common; an Inspector General's audit found unsupported comorbidities in 45 % of cases.

We've seen first-hand how coding practices impact quality scores. A public hospital where we worked scored poorly on risk-adjusted mortality—42 % above expected. In response, administrators hired consultants to comb charts for ill-described comorbidities and coach interns on wording choices that would boost risk scores; e.g. "hypo-magnesemia" rather than "Mg=1.6" ups the risk score (and DRG payment). Within 6 months, risk-adjusted mortality fell to 14 % *below* expected, and Medicare reimbursement climbed $3 million.

Sadly, the upcoding/overdiagnosis arms race makes such practices mandatory. Our hospital looked bad because it was judged against hospitals that had already adopted coding coaches—we'd encountered them for years at the prosperous medical mecca nearby. Similarly, the 95 % of MA plans that cheated on a quality measure pushed down the rankings of the 5 % that told the truth.[8] In quality measurement, honest guys finish last, as do primary care doctors caring for the poor, the mentally ill and non-English speakers.[9]

Less skillful gaming is one reason that mission-driven providers lose under bundled payment. But even if good-guy ACOs play the seemingly victimless upcoding game, they face daunting odds. Less scrupulous rivals willing to overdiagnose, cherry-pick and skimp on care can outcompete them on price and "quality".

Moreover, giant organizations enjoy a decisive advantage. When one patient can cost millions, deep pockets are essential to assume risk. Even more important, insurers and hospital systems that dominate local markets can extract deals, and hence profits, not available to smaller competitors. The profit-advantage of bigger, more ruthless players makes them more attractive to investors and bondholders, vital sources of the capital needed to expand and modernize.

During the HMO era, many local providers entered the capitated market, but few survived. Undercapitalized, saddled with unprofitable patients and lacking clout to get the best price, some folded; others were swallowed by large national insurers.

Currently, insurers and hospital systems are bulking up. In 45 states one or two insurers now control more than half the market.[10] UnitedHealth bought a Medicare ACO with 2,300 physicians; Wellpoint a chain of clinics; and Humana an in-home care manager with 1,500 providers and an urgent care/occupational health clinic firm. The proportion of office-based physicians employed or closely affiliated with hospitals grew from 41 % in 2000 to 72 % in 2010.[10] In the past 5 years alone, 835 hospitals have merged; today "the typical hospital market . . . has one dominant system [and] two to three smaller systems.".[11] Even the largest cities will soon be left with only a handful (or less) of mega-ACOs.

The SGIM Commission rests its hope for cost control on ACO-type payment. Yet a system dominated by profit-maximizing oligopolies is a perilous route to savings. Moreover, the studies most often cited as evidence that ACO-like contracts bend the cost curve provide scant reassurance; the claimed savings from utilization reductions evaporate after factoring in bonuses providers earned for "shared savings" and "quality".[12,13] In Medicare's demonstration program, upcoding created an illusion of lower costs, but (according to the Congressional Budget Office) virtually no real savings.

PURCHASING VALUE

The Commission's recommendation to pay based on quality seems a no-brainer. But there's reason for skepticism about pay for performance (P4P), even if we could overcome the challenges of upcoding and accurate quality measurement. Doctors' poor performance seldom stems from lack of motivation, and monetary incentives often worsen performance for cognitively complex tasks, especially when preexisting (intrinsic) motivation is high.[14] Rewarding a narrow set of behaviors may distort, rather than improve global quality—the medical equivalent of teaching to the test. Do we really need to make our reimbursement system more complex?

CONCLUSION

Like the SGIM Commission, we rue the toxic incentives of the current fee-for-service system. But in the profit-maximizing milieu of American medicine, capitation risks making things

even worse. "Risk-sharing" too often means that physicians earn bonuses for denying care—a danger perceived by patients, who take a dim view of capitation.[15] Risk-sharing is not simply the inverse of fee-for-service, but of fee splitting, the illegal practice of kickbacks for referrals.

There are many bad ways to pay doctors, and no particularly good ones. Other nations have achieved better outcomes, lower costs and fairer compensation of physicians using a variety of methods: fee-for-service, capitation, and salary; none is clearly best. The common theme isn't mode of payment, but a universal system with regulations that restrain costs and minimize the opportunities for profit and the risk of loss.

Payment reform should focus not on manipulating greed, but on dampening it. Then the real motivations for good doctoring—altruism, social duty, and the glow we feel when we help our patients—can flourish.

Corresponding Author: *David U. Himmelstein, MD; The City University of New York School of Public Health, 255 West 90th Street, New York, NY 10024, USA (e-mail: dhimmels@hunter.cuny.edu).*

REFERENCES

1. **Ho S, Sandy LG.** Getting value from health spending: Going beyond payment reform. J Gen Intern Med doi:10.1007/s11606-013-2687-7.
2. **Elwood PM, Anderson NN, Billings JE, Carlson RJ, Hoagberg EJ, McClure W.** Health maintenance strategy. Med Care. 1971;9:291–298.
3. **Woolhandler S, Himmelstein DU.** Extreme risk: the new corporate proposition for physicians [editorial]. N Engl J Med. 1995;333:1706–1708.
4. Calif. hospital under fire for seeking healthier patients. Modern Healthcare. August 21, 1995:172.
5. **Rosenberg M.** Insurer cuts Medicare plan doctors – Patients left in lurch. Hartford Courant November 15, 2013. Available at: http://articles.courant.com/2013-11-15/news/hc-op-rosenberg-insurer-cuts-doctors-patients-left-20131115_1_primary-care-physicians-medicare-advantage-new-doctor (accessed 11/20/13).
6. **Welch HG, Sharp SM, Gottlieb DJ, Skinner JS, Wennberg JE.** Geographic variation in diagnosis frequency and risk of death among Medicare beneficiaries. JAMA. 2011;305:1113–1118.
7. **Brown J, Duggan M, Kuziemko I, Wollston W.** How does risk selection respond to risk adjustment? Evidence from the Medicare Advantage program. NBER Working Paper No 16977. Cambridge, MA: National Bureau of Economic Research; 2011.
8. **Cooper AL, Kazis LE, Dore DD, Mor V, Trivedi AN.** Underreporting high-risk prescribing among Medicare advantage plans: a cross-sectional analysis. Ann Intern Med. 2013;159:456–462.
9. **Hong CS, Atlas SJ, Chang Y, et al.** Relationship between patient panel characteristics and primary care physician clinical performance rankings. JAMA. 2010;304:1107–1113.
10. **Moses H, Matheson DHM, Dorsey R, George BP, Sadoff D, Yoshimura S.** The anatomy of health care in the United States. JAMA. 2013;310:1946–1963.
11. **Cutler DM, Morton FS.** Hospitals, market share and consolidation. JAMA. 2013;310:1964–1970.
12. **Woolhandler S, Himmelstein DU.** Letter; Savings from the Medicare physician group practice demonstration. JAMA. 2013;309(1):30–31.
13. **Nardin R, Himmelstein DU, Woolhandler S.** Letter: medical spending and global budgets. Health Aff. 2012;31:2592.
14. **Woolhandler S, Ariely D, Himmelstein DU.** Will pay-for-performance backfire? Insights from behavioral economics. Health Affairs blog October 11, 2012. Available at: http://healthaffairs.org/blog/2012/10/11/will-pay-for-performance-backfire-insights-from-behavioral-economics/(accessed December 2, 2013).
15. **Blendon RJ, Benson JM.** The public and the conflict over future Medicare spending. N Engl J Med. 2013;369:1066–1073.

How Has Canada Controlled Costs?

1. Lower administrative costs via single payer - 16.7% of total health spending vs. 31.0% in the U.S.
2. Lump-sum, global budgets for hopitals
3. Stringent controls on capital spending for new buildings and expensive new equipment
4. Single buyer purchasing reins in drug/device prices
5. Low litigation and malpractice costs
6. Emphasis on primary care
7. Exclusion of private insurers - private plans overcharged U.S. Medicare by $34 billion in 2012

Source: Himmelstein and Woolhandler, "Cost Control in a Parallel Universe," Archives of Internal Medicine, December 2012

WAMC NORTHEAST PUBLIC RADIO

November 8, 2013

Physicians, patients must partner to eliminate profiteering from caregiving

By Andrew D. Coates, M.D., F.A.C.P.

Physicians tend to be a conservative group, in the sense that we're cautious when it comes to new ideas. For example, I find myself very reluctant to prescribe medications that have been on the market for only a few months or a short year or two, no matter what benefit their manufacturer's claim they offer. Caution seems a better practice when it comes to our patients, especially if hundreds of millions have used a traditional treatment without harm, while the new medication in question is so slickly advertised.

Over the last couple of years, medicine as a profession has stood on the shore of a kind of health-systems continental drift. As a profession, we doctors have tried to keep doing what we have been doing, perhaps with a belief that our coastal province will eventually come (back) under our individual control.

It is almost as if we would so prefer to embrace a sedimentary but predictable process, a layering of generations of responsibility within our profession, measured in geological time, that we are loathe to try to decipher our own experience.

Beneath the surface, the continent of medical care is being subsumed into the continent of corporate power and profit. A few aspects of what we can do for patients have been uplifted, but most have been subsumed and driven deep underground or else sheared in half or even pulverized into pieces. The impact of these changes upon caring for patients comes not over a geological epoch but over a short decade or two. It is a worldwide process that now touches nearly every physician and nurse in the United States.

While a few physicians have taken the opportunity to do well, rather than good, most of us head to work with the motivation that we can improve the health, and thus entire lives, of other human beings. If there are a few who have cashed in on business schemes and then gone on, for example to CEO work, those doctors remain the exception, not the rule, in our profession. Most of us head early to the office or clinic or hospital, and often keep extra hours at our work.

Physicians see the work of our profession as a call to service to humanity. Corporate executives in the giant health care enterprises that dominate our country see us quite differently. They see us not so much in a profession, but in a "position."

These corporate "positions" are roles defined by the needs of the institution and its financial viability, not the talents, dedication or human qualities of individual caregivers. Similarly, patients are seen not for their needs but for the revenue stream they will provide. The plate tectonics metaphor makes sense to me because underneath it all, deep underground, lies a great collision of human values.

Will corporate medicine succeed in "profitizing" the caregiving relationship? Dr. Julian Tudor Hart, the great British physician, put forward a thesis that the doctor-patient relationship is a productive partnership. Together we work toward a product that has great value to ourselves personally as well as the society as a whole, the health of an individual. This fundamental character of caregiving may be seen as a human enterprise, but clearly it does not and cannot lend itself to the immediate extraction of profit.

This contradiction is a problem for corporations. It is even more of a problem for patients. And it is a problem for the profession of medicine. The effort to extract a profit from the doctor-patient relationship amounts to an effort to end it as a productive partnership and re-establish it as an adversarial money-driven contest.

The cause of profiteering from the care of human beings has been pushed further along by the Affordable Care Act. A new wave of corporate health care investment and conglomeration has been unleashed. In turn, we find a new escalation of user fees, co-pays, co-insurance, high deductibles, in-network fees and out-of-network fees. And with the tangle of unintelligible rules and fees, the prevalence of underinsurance – the phenomenon of having health insurance that doesn't cover our health needs – is growing.

To capture revenue, health care corporations add administrators, finance experts, deal-makers and supervisors in a mushrooming byzantine bureaucracy. Patients simply try to hold on to their bank accounts. And physicians now begin to see a struggle to hold on to our profession. True to our conservative nature, and skeptical of the changes afoot, physicians want to get back to caregiving. The patients want the same. I believe we physicians need to partner with our patients, not only in the exam room, the operating room and at the bedside.

With earth-shaking changes altering the landscape of health care, to protect our hard-earned ability to provide truly expert care to our patients, the most conservative thing medicine as a profession can do is to start from the health needs of our patients – as individuals and as a population. We must partner with our patients to demand that our democracy provide its people with a health system without user fees, publicly pre-paid, so that every patient's necessary care is freely available – for each and all.

Dr. Andrew Coates practices internal medicine in Upstate New York. He is president of Physicians for a National Health Program. An archive of his WAMC broadcasts is available at wamc.org/term/andrew-coates.

RESEARCH LETTER

Minority Physicians' Role in the Care of Underserved Patients: Diversifying the Physician Workforce May Be Key in Addressing Health Disparities

Disparities in access to care persist despite efforts to improve care for underserved patients: racial and ethnic minorities, the uninsured, the poor, Medicaid recipients, and non-English speakers.[1] A shortage of physicians practicing in communities where disadvantaged patients live is a major contributor.[2]

Minority and non-English-speaking populations in the United States have grown markedly during the past 2 decades,[3] and minorities may be a majority by 2050. While the Patient Protection and Affordable Care Act will expand insurance coverage for low-income, uninsured individuals, concern remains about the supply of physicians to care for these newly insured populations.

Related article

If nonwhite physicians care for a large proportion of the underserved, then increasing the racial and ethnic diversity of the physician workforce may help. A prior nationally representative study indicated that in 1987, nonwhite physicians disproportionately cared for underserved and sicker patients[4]; to our knowledge, these data have not been updated since. Given the demographic changes and impending implementation of the Patient Protection and Affordable Care Act, this question has renewed relevance.

Methods | We performed a cross-sectional analysis of 7070 adults in the 2010 Medical Expenditure Panel Survey who identified a medical provider (not a facility) as their usual source of care. We calculated unadjusted odds ratios to estimate the likelihood of having a nonwhite physician for patients who were racial and ethnic minorities, low income, Medicaid enrollees, uninsured, and non-English home language speakers. We then adjusted these odds ratios for physician sex, office type, geographic region, and metropolitan statistical area status by applying multiple logistic regression models. Last, we compared self-reported health status and health care use for patients of minority and non-Hispanic white physicians using χ^2 tests. National estimates were calculated with weights provided by the Medical Expenditure Panel Survey. Institutional review board approval was waived.

Table 1. Unadjusted Association Between Disadvantaged Population and Receipt of Care From White vs Black, Hispanic, and Asian Physicians, Medical Expenditure Panel Survey, 2010

Patient Characteristic	No. (%) Millions of Patients With a White Physician	No. (%) Millions of Patients With a Black Physician	Unadjusted Odds Ratio (95% CI)[a]	Millions of Patients With a Hispanic Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[b]	Millions of Patients With an Asian Physician, No. (%)	Unadjusted Odds Ratio (95% CI)[c]
All patients	62.2 (100.0)	3.3 (100.0)		5.9 (100.0)		9.8 (100.0)	
Non-Hispanic whites	53.2 (86.8)	1.1 (34.7)	1 [Reference]	2.4 (41.5)	1 [Reference]	5.2 (53.7)	1 [Reference]
Minorities	9.0 (13.2)	2.2 (65.3)	12.30 (8.30-18.00)	3.5 (58.5)	8.20 (5.98-11.23)	4.6 (46.3)	5.40 (4.16-6.99)
Black, non-Hispanic	4.1 (7.1)	1.9 (63.9)	23.24 (16.28-33.17)	0.5 (16.8)	2.65 (1.81-3.87)	1.0 (16.3)	2.56 (1.90-3.44)
Hispanic	3.1 (5.5)	0.1 (5.3)	0.96 (0.49-1.88)	2.7 (52.6)	19.04 (13.47-26.93)	1.1 (17.7)	3.68 (2.62-5.18)
Asian	0.9 (1.7)	0.1 (5.1)	3.06 (1.15-8.17)	0.3 (9.0)	5.63 (2.67 -11.86)	2.3 (31.2)	25.73 (16.92 -39.13)
Other	0.9 (1.7)	0.1 (7.4)	4.60 (1.78-11.94)	0.02 (1.1)	0.61 (0.17 -2.15)	0.2 (3.8)	2.25 (1.19-4.25)
Income							
High/middle	48.9 (78.5)	2.1 (64.5)	1 [Reference]	3.9 (65.5)	1 [Reference]	7.0 (70.9)	1 [Reference]
Low	13.4 (21.5)	1.2 (35.5)	2.03 (1.46-2.75)	2.1 (34.5)	1.92 (1.44-2.55)	2.8 (29.1)	1.49 (1.23-1.81)
Medicaid							
None	54.8 (93.2)	2.5 (78.4)	1 [Reference]	4.4 (81.8)	1 [Reference]	7.9 (85.2)	1 [Reference]
Medicaid	4.0 (6.8)	0.7 (21.6)	3.75 (2.72-5.18)	1.0 (18.2)	3.04 (2.29-4.04)	1.4 (14.8)	2.38 (1.85-3.06)
Any health insurance	58.8 (94.3)	3.1 (95.2)	1 [Reference]	5.4 (90.1)	1 [Reference]	9.3 (94.0)	1 [Reference]
Uninsured	3.5 (5.7)	0.1 (4.8)	0.83 (0.49-1.41)	0.6 (9.9)	1.83 (1.30-2.57)	0.6 (6.0)	1.07 (0.78-1.47)
English home language	60.6 (97.3)	3.2 (96.8)	1 [Reference]	3.9 (66.7)	1 [Reference]	7.9 (80.4)	1 [Reference]
Non-English home language	1.7 (2.7)	0.1 (3.2)	1.18 (0.51-2.69)	2.1 (33.4)	17.83 (12.80-24.82)	1.9 (19.6)	8.69 (6.19-12.19)

[a] Odds of patients in a demographic group reporting a black physician relative to non-Hispanic white patients reporting a black physician.

[b] Odds of patients in a demographic group reporting a Hispanic physician relative to non-Hispanic white patients reporting a Hispanic physician.

[c] Odds of patients in a demographic group reporting an Asian physician relative to non-Hispanic white patients reporting an Asian physician.

Copyright 2013 American Medical Association. All rights reserved.

Table 2. Health Status and Health Care Use of Patients Seen by White, Black, Hispanic, and Asian Physicians, Medical Expenditure Panel Survey, 2010

Patient Characteristic	No. (%)		P Value for Comparison Between Black and White Physicians	Millions of Patients With a Hispanic Physician, No. (%)	P Value for Comparison Between Hispanic and White Physicians	Millions of Patients With an Asian Physician, No. (%)	P Value for Comparison Between Asian and White Physicians
	Millions of Patients With a White Physician	Millions of Patients With a Black Physician					
Health status							
Body mass index ≥30[a]	19.0 (31.6)	1.0 (44.2)	<.001	2.0 (34.7)	.38	2.0 (26.0)	<.001
Smokes	9.0 (15.3)	0.5 (16.4)	.53	0.8 (13.7)	.003	1.3 (14.8)	.002
Reports limitations[b]	19.0 (31.6)	1.2 (38.1)	.27	1.5 (25.2)	.004	2.9 (30.9)	.02
Fair or poor health	9.0 (14.8)	0.7 (21.3)	.05	1.1 (18.3)	<.001	1.8 (18.0)	.04
≥2 Medical conditions reported	29.0 (46.4)	1.8 (53.3)	.43	2.5 (41.1)	.03	4.9 (49.8)	.15
Use							
≥2 Emergency department visits in past 12 mo	2.0 (3.7)	0.2 (7.1)	.03	0.1 (2.4)	.26	0.4 (4.4)	.72
≥2 Hospital discharges in past 12 mo	1.5 (2.4)	0.1 (4.2)	.21	0.1 (1.9)	.37	0.2 (1.8)	.29

[a] Calculated as weight in kilograms divided by height in meters squared.

[b] Describes limitations in physical activity, sensory functions, instrumental activities of daily living, or activities of daily living.

Results | Nonwhite physicians cared for 53.5% of minority and 70.4% of non-English-speaking patients. In unadjusted (**Table 1**) and adjusted (data not shown) analyses, patients from underserved groups (except uninsured patients) were significantly more likely to see nonwhite physicians than white physicians. Patients of black, Hispanic, and Asian physicians were more likely to have Medicaid; patients of Hispanic physicians were more likely to be uninsured.

Higher proportions of black physicians' patients were obese, had self-reported fair or poor health, and used the emergency department. For patients of Asian and Hispanic physicians, several health status measures were better than those of patients of white physicians, but self-reported fair or poor health was worse (**Table 2**).

Discussion | Nonwhite physicians provide a disproportionate share of care to underserved populations. Hence, increasing the racial and ethnic diversity of the physician workforce may be key to meeting national goals to eliminate health disparities.[5]

Our findings do not argue for buttressing de facto medical segregation or denigrate the efforts of nonminority physicians who care for the disadvantaged. Nonetheless, it is clear that the preferences of physicians in choosing practice settings and of patients in choosing physicians combine to create an outsized role for minority physicians caring for the disadvantaged.

It is worrisome that there has been little growth in the proportion of physicians who are black or Hispanic relative to their population size,[6] despite support for workforce diversification from the Institute of Medicine and the Association of American Medical Colleges. More robust policies aimed at recruitment of racial and ethnic minorities into medical school are likely needed. Building a physician workforce that is more representative of the US population would likely help address inequalities in health and health care.

Study limitations include assignment of physician race based on patient report and lack of information on physician characteristics such as age, postgraduate year, and foreign graduate status. Also, our findings are not generalizable to those without a usual source of care.

Lyndonna M. Marrast, MD
Leah Zallman, MD, MPH
Steffie Woolhandler, MD, MPH
David H. Bor, MD
Danny McCormick, MD, MPH

Author Affiliations: Department of Medicine, Cambridge Health Alliance, Harvard Medical School, Cambridge, Massachusetts (Marrast, Bor, McCormick); Institute for Community Health, Cambridge Health Alliance, Cambridge, Massachusetts (Zallman); City University of New York School of Public Health at Hunter College, New York (Woolhandler).

Corresponding Author: Lyndonna M. Marrast, MD, Cambridge Health Alliance, 1493 Cambridge St, Cambridge, MA 02139 (lmarrast@challiance.org).

Published Online: December 30, 2013.
doi:10.1001/jamainternmed.2013.12756.

Author Contributions: Dr Marrast had full access to all the data in the study and takes full responsibility for the integrity of the data and the accuracy of the data analysis.
Study concept and design: Zallman, Woolhandler, Bor, McCormick.
Acquisition of data: Marrast.
Analysis and interpretation of data: All authors.
Drafting of the manuscript: Marrast, Bor, McCormick.
Critical revision of the manuscript for important intellectual content: Marrast, Zallman, Woolhandler, McCormick.
Statistical analysis: Marrast, McCormick.
Administrative, technical, and material support: Zallman, Bor, McCormick.
Study supervision: Zallman, Woolhandler, Bor, McCormick.

Conflict of Interest Disclosures: None reported.

Funding/Support: This study was supported by grants T32 HP10251 and T32 HP12706 from the Health Resources and Services Administration and the Ryoichi Sasakawa Fellowship Fund (Dr Marrast) and by grant 4 D34HP16868-03-03 from the Harvard Medical School Center of Excellence in Minority Health and Health Disparities, sponsored by Health Resources and Services Administration (Dr Zallman). No other disclosures were reported.

Role of the Sponsor: The Health Resources and Services Administration had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Previous Presentations: This paper was presented at the New England Regional Society of General Internal Medicine (SGIM) meeting; March 8, 2013;

Additional matter and references can be found on page 27.

Invited Commentary

Taking Diversity Seriously: The Merits of Increasing Minority Representation in Medicine

For decades, efforts to increase the presence of underrepresented minority (URM) groups in the physician workforce have received widespread endorsement. Actual progress in diversifying our profession, however, has been disappointing. The disconnect between vocal support and visible results has been due, at least in part, to a pervasive but often unspoken belief that diversity is an "extra," a secondary consideration when selecting future members of our profession. Diversity would be nice, we believe, as long as it does not require trade-offs in more important factors, particularly academic achievement, as measured by science grades and standardized test scores. With that mind-set, lower average grades and scores among URM students, blamed on inequitable primary and secondary education, provides an easy excuse to shrug our shoulders on the issue of diversity.

This complacency, of course, is not universal. Many people work tirelessly to increase minority representation in medicine, convinced that diversity is more than an extra. Their conviction is supported by several arguments. The *educational benefits* argument stipulates that a more diverse student body engenders a more robust learning environment that results in more thoughtful, open-minded, and humanistic physicians.[1] The *relationship benefits* argument is based on evidence that in our still-racialized society, some minority patients prefer and have better interactions with physicians from their own background.[2] The *representative workforce* argument recognizes that an institution that includes people from a given racial or ethnic community may seem more trustworthy and approachable to members of that community. The *social justice* argument—the frequently unacknowledged "elephant in the room"—holds our profession accountable for the discriminatory and exclusionary policies that for many years kept minority individuals from achieving the privileged status of becoming a physician.

Perhaps the most pragmatic case for increasing URM representation in medicine is the *service commitment* argument. In the 1980s, scholars examining the practice patterns of graduates from various medical schools reported that minority graduates were disproportionately serving minority and underserved communities.[3] In 1995, a landmark study reported data from a national survey, confirming that minority physicians cared for poor, sick, and uninsured Americans at significantly higher rates than their nonminority counterparts.[4] Numerous studies subsequently validated these findings, demonstrating that URM medical students expressed a greater commitment to serve the underserved and were more likely than others to fulfill that commitment.[3] In this issue of *JAMA Internal Medicine*, a study by Marrast and colleagues[5] shows us that what was true a quarter century ago is still true today: minority physicians play a vital role in providing access to medical care where it is needed most.

The evidence base demonstrating the benefits of increasing minority representation in medicine is stronger than for most other criteria used in medical school admissions, including science grades and test scores, which most studies have shown to predict only future science grades and test scores. Yet still we treat racial and ethnic diversity as a secondary consideration. Part of the problem is that we automatically attribute minority students' service orientation to their socioeconomic status (SES). We do not believe that one's race, per se, should confer disadvantage, and so we assume that minority students' empathy for the less fortunate comes from their own experience of socioeconomic disadvantage. We then consider SES, rather than race, to be the legitimate factor to evaluate in determining who has experienced disadvantage and who is likely to serve the underserved. It makes more sense and feels more comfortable.

Studies of service commitment, however, have shown that, compared with race, SES is a relatively weak predictor of medical students' going on to serve the underserved. In fact, URM students from the *highest* SES categories serve the underserved at greater rates than do white students from the *lowest* SES groups.[3] One possible reason for this finding is that SES changes over time, while race does not. In becoming a physician, a student from a poor or working-class upbringing moves quickly into a higher social tier and is no longer a member of a disadvantaged class. Race, however, confers more durable disadvantage. Underrepresented minority students and physicians, regardless of SES, do not escape the experience of discrimination, negative stereotyping, and exclusion. They must continuously deal with the unfairness of a racial hierarchy that, although officially abolished, remains deeply embedded in our social fabric and unconscious attitudes.

The increasing health care needs of our aging population and the expansion of health insurance coverage to previously uninsured Americans have prompted efforts to rapidly augment our physician workforce. Simply training more physicians, however, will not meet our needs. We should be deliberately selecting and training physicians who will go into undersupplied specialties (eg, primary care), serve vulnerable patient populations (eg, the poor and disabled), and practice in underserved communities (eg, inner-city and rural areas). Meeting these needs will require a strategic approach. One important and evidence-based strategy is to train more URM physicians. Underrepresented minority status is more predictive of serving the underserved than SES, rural or urban upbringing, or participation in the National Health Service Corps, a federal program providing financial incentives for health professionals to work in underserved areas.[3] Increasing URM representation in medicine will not only help meet our public health needs but will also have the

Copyright 2013 American Medical Association. All rights reserved.

added benefits of producing a more robust learning environment in medical schools, as well as a more trustworthy and culturally competent physician workforce. Perhaps most important, it will fulfill our moral obligation to address the injustices that made URM groups underrepresented in the first place.

Somnath Saha, MD, MPH

Author Affiliation: Section of General Internal Medicine, Portland VA Medical Center, Portland, Oregon.

Corresponding Author: Somnath Saha, MD, MPH, Section of General Internal Medicine, Portland VA Medical Center, 3710 SW US Veterans Hospital Rd, Portland, OR 97239 (sahas@ohsu.edu).

Published Online: December 30, 2013. doi:10.1001/jamainternmed.2013.12736.

Conflict of Interest Disclosures: None reported.

Funding/Support: Dr Saha is supported by the Department of Veterans Affairs.

Disclaimer: The views expressed in this article are those of the author and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States government.

1. Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *JAMA*. 2008;300(10):1135-1145.

2. Saha S, Shipman S. *The Rationale for Diversity in the Health Professions: A Review of the Evidence.* Washington, DC: Health Resources & Services Administration, US Dept of Health & Human Services; October 2006.

3. Saha S, Shipman SA. Race-neutral versus race-conscious workforce policy to improve access to care. *Health Aff (Millwood)*. 2008;27(1):234-245.

4. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA*. 1995;273(19):1515-1520.

5. Marrast LM, Zallman L, Woolhandler S, Bor DH, McCormick D. Minority physicians' role in the care of underserved patients: diversifying the physician workforce may be key in addressing health disparities. *JAMA Intern Med*. doi:10.1001/jamainternmed.2013.12756.

Minority Physicians' Role in the Care of Underserved Patients, *continued from page 25*

New Haven, Connecticut, and at the 34th annual SGIM national meeting; April 24, 2013; Denver, Colorado.

Additional Contributions: David U. Himmelstein, MD (City University of New York School of Public Health at Hunter College), helped conceive the study idea and assisted with data analysis. He did not receive financial compensation for the role he played in the project.

1. Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare.* Washington, DC: National Academies Press; 2003.

2. Komaromy M, Grumbach K, Drake M, et al. The role of black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med*. 1996;334(20):1305-1310.

3. Humes KR, Jones NA, Ramirez RR. United States Census: overview of race and Hispanic origin: 2010. http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf. Accessed August 6, 2013.

4. Moy E, Bartman BA. Physician race and care of minority and medically indigent patients. *JAMA*. 1995;273(19):1515-1520.

5. National Prevention Council. *National Prevention Strategy*. Washington, DC: US Dept of Health and Human Services, Office of the Surgeon General; 2011. http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf. Accessed August 15, 2013.

6. Diversity in the Physician Workforce. *Facts and Figures 2010*. Washington, DC: Association of American Medical Colleges; 2010. https://www.aamc.org/data/. Accessed January 20, 2013.

JOURNAL OF ONCOLOGY PRACTICE®

January 17, 2014

Why Oncologists Should Support Single-Payer National Health Insurance

By Ray E. Drasga, MD, and Lawrence H. Einhorn, MD

St Clare Clinic for the Indigent, Crown Point; and Indiana University School of Medicine, Indianapolis, IN

Oncologists face growing difficulties in caring for patients because of the rising cost of treatment coupled with the high prevalence of uninsurance and underinsurance. A diagnosis of cancer is often the single most catastrophic health care event in an individual's life. The stress of the situation increases exponentially when patients realize the burden of cost on themselves and their families.

Oncologists face the dilemma of advising a treatment schema that the patient can afford. Therapies may need to be compromised as a result of the patient's inability to pay. Patients often present with more advanced disease because they have never had cancer screenings because of a lack of insurance or concerns about cost. Meanwhile, the prices of cancer-related drugs are rising sharply, prompting some oncologists to sound the alarm.[1]

Different insurance plans have their own procedures for use review and benefit determinations, making it difficult for providers to interpret whether cancer treatment will be covered. The average patient finds it frustrating to navigate the bureaucracy with his or her life and financial security on the line. This article will outline the scope of these issues and offer an evidence-based case for single-payer national health insurance.

Situation Today

In 2011, US health spending was approximately $2.7 trillion and accounted for 17.9% of the gross domestic product.[2] Despite spending more, the United States ranks last of 16 developed countries in deaths that might have been prevented with timely and effective medical care.[3]

Cancer care accounts for at least 5% of total health care spending.[4] One survey showed one third of nonelderly insured patients with incomes of less than $75,000 did not have enough money to pay for medical care.[5] Another found that among uninsured patients with cancer, 27% said they went without care or delayed care for cancer.[6] A study of nonelderly patients with cancer found that 13.4% spent at least 20% of their income on health care costs compared with 4.4% of patients without cancer or chronic disease.[7]

According to the Census Bureau, 48.6 million people in the United States were uninsured in 2011—15.7% of the population.[8] Although the Patient Protection and Affordable Care Act (ACA) is expected to reduce this number in coming years, the Congressional Budget Office estimates that the law will nevertheless leave 31 million Americans uninsured in 2023.[9]

The problem of underinsurance, or insufficient coverage, is also expected to persist, if not worsen.[10] Insurance plans with limited networks of providers, along with high deductibles, copays, and out-of-pocket costs, are making underinsurance the new normal. The most affordable plans on the state health exchanges, the bronze and silver plans, leave 30% or 40% of health care costs, respectively, to be paid by policyholders.[11]

Single-Payer Insurance

Single-payer systems are systems in which a single public or quasipublic agency handles all health care financing. Delivery of care may remain in public or private hands, depending on the particular system.

The single-payer program we endorse is basically an improved Medicare for all. It would resemble the current arrangement in Canada in many ways. It would provide universal, comprehensive coverage with free choice of providers. All medical care would be covered, including provider visits, hospital care, prescription drugs, and rehabilitation. Copayments, deductibles, insurance premiums, and out-of-pocket expenses would be eliminated.

A single insurance plan for each region of the country would be administered by a public agency. This agency, which would be composed of elected or appointed laypersons and medical experts, would set health care policies and organize financing, decide benefits and establish the drug formulary, and have the power to negotiate prices for drugs and supplies and to negotiate fees with providers and hospitals. It would also be responsible for planning and new technology. Clinical decisions would be made by the physician and patient within that general framework. No longer would private insurance companies be in a position to decide, behind the scenes, what they will or will not cover.

The public agency would manage the plan and the health care budget in a transparent way. The allocation of available health resources (ie, rationing) would be guided by medical considerations, not on the basis of meeting corporate requirements for a return on investment or on the basis of a patient's ability to pay, the dominant forms of rationing in the United States today.

Financing the system could be accomplished by a mix of payroll and income taxes. Funds from Medicare and Medicaid would be retained. Several fiscal studies of single-payer national health insurance have shown that any increased tax burden on US households would be more than offset by the elimination of

insurance premiums and out-of-pocket costs for health care.[12,13] This would be a fair and sustainable solution.

Case for Single-Payer System

Administrative savings. Administrative overhead, including the enormous burden insurers impose on physicians and hospitals, consumes 31% of every health care dollar in the United States, double what Canada spends.[14] Although Canada has a single insurance plan in each province, in the United States, there are hundreds of insurance companies and thousands of different private plans. Every insurance company has departments for marketing, eligibility determination, claims processing, and use review, along with profits to fund. As a result, private insurance overhead averages 14% of premiums, compared with the traditional overhead of Medicare of just 1.4%.[15]

Overhead accounts for more than one quarter of all hospital spending in the United States because of the need to generate itemized per-patient bills for a plethora of plans and haggle over how much insurers will pay.[16] In contrast, Canadian hospitals are paid once a month and do not even have US-style billing departments.

Physician reimbursement is also much simpler under a single-payer system. In the United States, multispecialty group practices spend 13.9% of revenues for billing- and insurance-related overhead.[17] A recent study showed the United States spends 4× as much on billing and administration per physician as Canada does.[18]

Changing to a single-payer system like that in Canada would slash spending on insurance overhead as well as provider overhead, saving approximately $380 billion annually,[14,19] money that could be redirected to patient care. The savings would be enough to cover all of the uninsured and to eliminate copays and deductibles for everyone else.

Numerous state and national studies have shown that savings achieved from slashing bureaucracy with a single-payer system would be more than enough to provide comprehensive coverage for everyone with what we are currently spending on an inadequate system, including studies from the General Accountability Office, the Congressional Budget Office, and the Lewin Group, a consulting firm recently acquired by United-Health Group.[20-22]

No other reform can slash overhead and generate this level of savings on administrative bloat. In contrast, in Massachusetts, the model for the ACA, the health exchange adds 4% to the cost of plans.[23]

Medical bankruptcies. A 2009 study found illness and medical bills were linked to 62.1% of the 1.4 million bankruptcies filed by families that year.[24] The uninsured were not the only patients affected. In fact, 78% of the individuals whose illness led to bankruptcy had health insurance at the onset of their illness, but it was inadequate or lost when the beneficiary could no longer work because of the illness.

Among bankrupted families, average out-of-pocket medical costs incurred since the onset of illness totaled $17,943; for patients with neurologic disorders, it rose to $34,167. In comparison, a 2008 study found that the median net household financial assets for insured families with incomes more than 300% of the poverty level was $5,700; the figure for uninsured households in the same income category was $100.[25] Another recent study showed that people with cancer diagnoses have a 2.65× higher rate of bankruptcy than people without such diagnoses.[26] The Massachusetts experience suggests that there will be no reduction in the rate of medical bankruptcy under the ACA.[27]

Being uninsured is bad for your health. Having no insurance is associated with a 1.40 hazard ratio for mortality compared with those with insurance.[28] The uninsured have a higher risk of death when compared with the privately insured, even after taking into account socioeconomic status, health behaviors, and baseline health. This translates into approximately 44,000 preventable deaths in the United States per year. Uninsured patients with cancer are 1.6× more likely to die within 5 years than their insured counterparts, according to a 2008 study by American Cancer Society researchers.[29]

Most health care in the United States is already taxpayer financed. The United States already has the highest taxpayer expenditure for health care in the world; however, it fails to deliver comprehensive care to everyone. Approximately 60% of US health care costs are publicly financed if taxpayer-paid premiums for private coverage for federal, state, and local government employees are included. In fact, US public spending on health care alone is more than what other developed countries spend from both public and private sources. In other words, we are already "paying for national health insurance and not getting it."[30pXXXX] Because they insure the healthiest segment of the population (age < 65 years, nondisabled, active workers), private businesses pay just 20% of the national health care tab.[31]

A single-payer system would also make financing health care more equitable. Currently, the poor and those with expensive illnesses like cancer pay a higher proportion of their incomes for health care than their wealthier counterparts.

Cost containment. For any reform to work, it needs to control the rising cost of health care, or any coverage expansions will be short lived. ACA does not include any cost-control measures proven to be effective. It launches an experiment in reviving the health maintenance organization (HMO) model of the 1990s—accountable care organizations (ACOs)—but there is no evidence that ACOs will be any more effective than HMOs were in containing costs.[32,33]

The most significant test of the ACO concept was the Medicare multiyear, 10-site physician group practice demonstration, which initially reported apparent savings of 1%, but on closer scrutiny, no actual savings were seen after taking into account diagnosis-coding differences.[34] Furthermore, the increase in consolidation among hospitals, physician groups, and other providers under the ACA is likely to increase costs.[35]

A recent study found that compared with the Canadian single-payer system, Medicare spending in the United States on the elderly has grown nearly 3× faster since 1980.[36] Although

traditional Medicare has a low administrative overhead, it is not a true single-payer system, because it coexists with many other private and public insurance plans. A hospital still has to do itemized, per-patient billing, and physicians still have to deal with onerous use review and different rules of multiple plans.[15]

Quality of care. Despite higher spending, the United States ranked sixth of seven countries in terms of quality in a 2010 cross-national study by the Commonwealth Fund, with only average performance on effectiveness and patient centeredness and low performance on safety and coordination.[37]

In terms of outcomes, the United States consistently ranks poorly in infant and maternal mortality, deaths resulting from asthma, and poor kidney and liver transplantation outcomes, but it does relatively well in some types of cancer care. A study of care in five countries (United States, United Kingdom, Canada, New Zealand, and Australia) in 21 areas found that the Untied States did well in breast cancer survival and had the highest screening rate for cervical cancer, but it ranked behind Australia and New Zealand in the treatment of non-Hodgkin lymphoma.[38]

Although superior survival rates in the United States for breast cancer and, in other studies, prostate cancer, may seem like a bright spot in our international performance, these may be artifacts of earlier diagnosis (lead-time bias) for these particular cancers or of excess diagnosis and treatment of cancer that would never have led to clinical disease.[39] On the other hand, uninsured patients with nearly every type of cancer present at later stages of diagnosis and have higher mortality rates.[40]

The biggest improvement the United States could make in improving the quality of care for cancer and other illnesses would be to assure universal access to treatment with no financial barriers to care.[41,42]

Investor ownership compromises care. During the past two decades, the US health care delivery system has undergone a transformation from its historic charitable roots to an investor-owned business. For-profit, investor-owned hospitals have higher spending on overhead than nonprofit hospitals, as well as higher costs.[14] Comprehensive literature reviews published in 2004 and 2002 found that for-profit hospitals cost 19% more and had 1% to 2% higher death rates than nonprofit institutions.[43,44] A more recent study of 3,229 hospitals found that the so-called best hospitals—those in the highest quartile of quality performance and lowest quartile of risk-adjusted costs—were more likely to have nonprofit status.[45]

For-profit nursing homes are higher priced and have lower quality of care.[46,47] For-profit hospices, which are soaring, are paid more per patient than nonprofit hospices because of an average longer length of stay, and they seem to seek out patients with diagnoses like dementia, for whom care is less costly to provide than patients with cancer.[48] They are less likely to provide palliative radiotherapy, a symptom reliever for patients with cancer.[49]

Physician incomes. On the basis of the Canadian experience, average physician incomes would remain approximately the same. Primary care physicians would likely make more, whereas specialist incomes may decline, narrowing the gap in incomes by specialty somewhat.[50] On the other hand, a single-payer system would reduce practice overhead and the time oncologists have to spend dealing with insurance and use review and allow more time for focusing on the delivery of high-quality clinical care to patients.

Drugs and Medical Devices

The cost of medications in the United States is higher than in any other developed country. The consulting firm McKinsey estimated that pharmaceutical prices in the United States are 50% higher than in Europe for the same medications, and 118% higher because of the more expensive US mix of drugs.[51]

Although drug companies claim their high US prices are needed to cover their research costs, they only spend 13% of their revenues on research and development compared with a much higher 31% on marketing and 20% on profit.[52] Lower drug prices would not jeopardize drug innovation. Most true innovations in therapeutics (as opposed to so-called me-too drugs that are slightly different versions of existing drugs) stem from publicly financed research.[53]

The Veterans Health Administration (VA) obtains a 40% discount on medications by negotiating prices with pharmaceutical firms and buying drugs in bulk. In contrast, Medicare is banned by law from negotiating prices with drug companies, and private Part D Medicare plans are far less effective than the VA at controlling drug costs.[54]

The cost of a new cancer drug has increased to a median price of $10,000 per month since 2010, and some drugs cost much more. Two drugs were priced at $35,000 per month.[55] Markups of drugs by hospitals and providers also can dramatically increase the prices of these drugs, particularly where insurance coverage is skimpy or absent.

Transition to Single-Payer Insurance

The transition to a single-payer system from our current financing arrangements will be challenging. It could be gradually implemented on a state-by-state basis, starting with one or two states, to lessen the administrative burdens.

At the same time, it is important to remember that Medicare was fully operational after only 1 year of its enactment, using paper records. Upgrading and expanding Medicare to cover everyone would be a fairly straightforward process, and legislation in Congress has been introduced outlining what such a plan could look like.[56]

Patients would register only one time and be covered by national health insurance for life. Investor-owned hospitals and clinics could be purchased by the public plan and be converted to nonprofits. People working in the private insurance industry would be entitled to retraining and placement. Many could work in new jobs in the single-payer system. Retraining and placement would only cost a fraction of the administrative savings from the transition to a single-payer system.

Congress will need to adopt such a law. The political obstacles, particularly opposition from lobbyists and other actors

representing the interests of the private health insurance industry, the multinational drug companies, investor-owned hospitals, and other large, for-profit providers in the US system, will undoubtedly be formidable. However, the widely recognized economic unsustainability of our present arrangements, combined with an appreciation of the proven ability of broad-based social movements in the United States to change existing power relationships (eg, women's suffrage and civil rights movements), suggests such a shift is achievable. In this connection, it is worth noting that surveys of the public and of physicians in the past two decades have shown that an improved Medicare for all approach enjoys solid majority support.[57,58]

The US path to a single-payer system will no doubt be unique. Canada started with only one province in 1946, and others followed later. The National Health Service in the United Kingdom was created in the wake of World War II and the attendant economic hardship. Taiwan swiftly converted to a single-payer system in 1995 without major difficulties.

Discussion

Cancer leaves a patient in his or her most vulnerable state not only physically but financially. Oncologists are in a unique position to champion the cause of improving access to care for patients with cancer and easing the financial burden they and their families face.

With ACA now the law of the land, and its retention of the private insurance industry at the center of the health system, the trend toward high-deductible health plans, underinsurance, and cost shifting to patients will almost certainly worsen.[59] Years of private-sector solutions have failed. There needs to be a major paradigm shift in our approach to funding health care in the United States.

How can we ethically and with dignity provide equal access to all patients with cancer while still controlling cost? Instead of an expensive, exclusionary, for-profit, market-based system that siphons off nearly one third of every health care dollar to bureaucracy in the quest for profit, we need a streamlined, efficient, nonprofit system based on human needs to provide high-quality care to every person: single-payer national health insurance.

In conclusion, because ACA will fail to remedy the problems of the uninsured, the underinsured, rising costs, and growing corporate control over caregiving, we cannot in good conscience stand by and remain silent. Life is short, especially for some patients with cancer; they need help now. We call on the American Society of Clinical Oncology (ASCO) to advocate for a single-payer national health insurance program. Our medical system must be oriented toward caregiving, not toward maximizing investors' profits.

Is this concept too idealistic to become a political reality? We think not. Because a single-payer system is a sensible and realistic solution, we believe its achievement is possible with sufficient understanding among the public and their elected representatives.

All of our patients deserve dignity. It is our moral and ethical obligation as physicians to advocate for universal access to health care. Oncologists, working in conjunction with ASCO, are well positioned to educate legislators about single-payer national health insurance. The time to start is now.

Authors' Disclosures of Potential Conflicts of Interest
The author(s) indicated no potential conflicts of interest.

Author Contributions
Conception and design: All authors

Collection and assembly of data: Ray E. Drasga

Data analysis and interpretation: All authors

Manuscript writing: All authors

Final approval of manuscript: All authors

Corresponding author: Ray E. Drasga, MD, 60 East Monroe St, Unit 6801, Chicago, IL 60603; e-mail: red1123@icloud.com.

DOI: 10.1200/JOP.2013.001160; published online ahead of print at jop.ascopubs.org.

**

References

1. Cavallo J: Oncologists speak out against the high cost of cancer drugs. http://ascopost.com/issues/august-15,-2013/oncologists-speak-out-against-the-high-cost-of-cancer-drugs.aspx

2. Hartman M, Martin AB, Benson J, et al: National health spending In 2011: Overall growth remains low, but some payers and services show signs of acceleration. Health Aff (Millwood) 32:87-99, 2013

3. Nolte E, McKee M: Variations in amenable mortality: Trends in 16 high-income nations. Health Policy 103:47-52, 2011

4. Agency for Healthcare Research and Quality: Chart 4: The five most costly conditions as a percentage of total health expenditures—United States, 2002. http://www.ahrq.gov/research/findings/factsheets/costs/expriach/expriach4.html

5. USA Today, Kaiser Family Foundation, Harvard School of Public Health: Health care costs survey. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7371.pdf

6. USA Today, Kaiser Family Foundation, Harvard School of Public Health: National survey of households affected by cancer. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7591.pdf

7. Bernard DS, Farr SL, Fang Z: National estimates of out-of-pocket health care expenditure burdens among nonelderly adults with cancer: 2001 to 2008. J Clin Oncol 29:2821-2826, 2011

8. DeNavas-Walt C, Proctor BD, Smith JC: Income, poverty, and health insurance coverage in the United States: 2011. http://www.census.gov/prod/2012pubs/p60-243.pdf

9. Congressional Budget Office: Table 1: CBO's May 2013 estimate of the effects of the Affordable Care Act on health insurance coverage. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

10. Woolhandler S, Himmelstein DU: Life or debt: Underinsurance in America. J Gen Intern Med 28:1122-1124, 2013

11. Kaiser Family Foundation: Focus on Health Reform: What the actuarial values in the Affordable Care Act mean. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf

12. Rasell E: An equitable way to pay for universal coverage. Int J Health Serv 29:179-188, 1999

13. Friedman G: Funding HR 676: The expanded and improved Medicare for All Act: How we can afford a national single-payer health plan. http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf

14. Woolhandler S, Campbell T, Himmelstein DU: Costs of health care administration in the United States and Canada. N Engl J Med 349:768-775, 2003

15. Sullivan K: How to think clearly about Medicare administrative costs: Data sources and measurement. J Health Polit Policy Law 38:479-504, 2013

16. Woolhandler S, Himmelstein DU: Costs of care and administration at for-profit and other hospitals in the United States. N Engl J Med 336:769-774, 1997

17. Kahn JG, Kronick R, Kreger M, et al: The cost of health insurance administration in California: Estimates for insurers, physicians, and hospitals. Health Aff (Millwood) 24:1629-1639, 2005

18. Morra D, Nicholson S, Levinson W, et al: US physician practices versus Canadians: Spending nearly four times as much money interacting with payers. Health Aff (Millwood) 30:1443-1450, 2011

19. Woolhandler S: Cutting health costs by reducing the bureaucracy. New York Times, November 20, 2011:A28

20. US General Accounting Office: Canadian health insurance: Lessons for the United States. http://archive.gao.gov/d20t9/144039.pdf

21. Congressional Budget Office: Universal health insurance coverage using Medicare's payment rates. http://www.cbo.gov/ftpdocs/76xx/doc7652/91-CBO-039.pdf

22. Sheils JF, Haught RA: The Health Care for All Californians Act: Cost and economic impacts analysis. http://www.lewin.com/publications/Publication/161

23. Ways to reduce the cost of health insurance for employers, employees and their families. Hearing before the Subcommittee on Health, Employment, Labor and Pensions of the Committee on Education and Labor, 111th Cong, 1st Sess, April 23, 2009

24. Himmelstein DU, Thorne D, Warren E, et al: Medical bankruptcy in the United States, 2007: Results of a national study. Am J Med 122:741-746, 2009

25. Jacobs PD, Claxton G: Comparing the assets of uninsured households to cost sharing under high-deductible health plans. Health Aff (Millwood) 27:w214-w221, 2008

26. Ramsey S, Blough D, Kirchhoff, et al: Washington state cancer patients found to be at greater risk for bankruptcy than people without a cancer diagnosis. Health Aff (Millwood) 32:1143-1152, 2013

27. Himmelstein DU, Thorne D, Woolhandler S: Medical bankruptcy in Massachusetts: Has health reform made a difference? Am J Med 124:224-228, 2011

28. Wilper AP, Woolhandler S, Lasser KE, et al: Health insurance and mortality in US adults. Am J Public Health 99:2289-2295, 2009

29. Ward E, Halpern M, Schrag N, et al: Association of insurance with cancer care utilization and outcomes. CA Cancer J Clin 58:9-31, 2008

30. Woolhandler S, Himmelstein DU: Paying for national health insurance: And not getting it. Health Aff (Millwood) 21:88-98, 2002

31. Carrasquillo O, Himmelstein DU, Woolhandler S, et al: A reappraisal of private employers' role in providing health insurance. N Engl J Med 340:109-114, 1999

32. Marmor T, Oberlander J: From HMOs to ACOs: The quest for the holy grail in U.S. health policy. J Gen Intern Med 27:1215-1218, 2012

33. Berenson RA: Shared savings program for accountable care organizations: A bridge to nowhere? Am J Manag Care 16:721-726, 2010

34. Iglehart JK: Assessing an ACO prototype: Medicare's physician group practice demonstration. N Engl J Med 364:198-200, 2011

35. Creswell J, Abelson R: New laws and rising costs create a surge of supersizing hospitals. New York Times, August 12, 2013:B1

36. Himmelstein DU, Woolhandler S: Cost control in a parallel universe: Medicare spending in the United States and Canada. Arch Intern Med 172:1764-1766, 2012

37. Davis K, Schoen C, Stremikis K: Mirror, mirror on the wall: How the performance of the US health care system compares internationally, 2010 update. http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?page=all

38. Hussey PS, Anderson GF, Osborn R, et al: How does the quality of care compare in five countries? Health Aff (Millwood) 23:89-99, 2004

39. Welch HG, Schwartz LM, Woloshin S: Are increasing 5-year survival rates evidence of success against cancer? JAMA 283:2975-2978, 2000

40. Halpern MT, Ward EM, Pavluck AL, et al: Association of insurance status and ethnicity with cancer stage at diagnosis for 12 cancer sites: A retrospective analysis. Lancet Oncol 9:222-231, 2008

41. Schiff GD, Bindman AB, Brennan TA: A better-quality alternative: Single-payer national health system reform—Physicians for a national health program quality of care working group. JAMA 272:803-8, 1994

42. Woolhandler S, Himmelstein DU, Angell M: Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. JAMA 290:798-805, 2003

43. Devereaux PJ, Heels-Ansdell D, Lacchetti C, et al: Payments for care at private for-profit and private not-for-profit hospitals: A systematic review and meta-analysis. CMAJ 170:1817-1824, 2004

44. Devereaux PJ, Choi PT, Lacchetti C, et al: A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. CMAJ 166:1399-1406, 2002

45. Jha AK, Orav EJ, Epstein AM: Low-quality, high-cost hospitals, mainly in South, care for sharply higher shares of elderly black, Hispanic, and Medicaid patients Health Aff (Millwood) 30:1904-1911, 2011

46. Harrington C, Woolhandler S, Mullan J, et al: Does investor ownership of nursing homes compromise the quality of care? Am J Public Health 91:1452-1455, 2001

47. Comondore VR, Devereaux PJ, Zhou Q, et al: Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. BMJ 339: b2732, 2009

48. Wachterman MW, Marcantonio ER, Davis RB, et al: Association of hospice agency profit status with patient diagnosis, location of care, and length of stay. JAMA 305:472-479, 2011

49. McCue MJ, Thompson JM: Operational and financial performance of newly established hospices. J Hosp Palliat Care 23:259-266, 2006

50. Duffin J: The impact of single-payer health care on physician income in Canada, 1850-2005. Am J Public Health 101:1198-1208, 2011

51. Farrell D, Jensen E, Kocher B, et al: Accounting for the cost of US health care: A new look at why Americans spend more. http://www.mckinsey.com/insights/health_systems_and_services/accounting_for_the_cost_of_us_health_care

52. Light DW, Warburton RN: Extraordinary claims require extraordinary evidence. J Health Econ 24:1030-1033, 2005

53. Light DW, Lexchin J: Foreign free riders and the high price of US medicines. BMJ 331:958-960, 2005

54. Frakt AB, Pizer SD, Feldman R: Should Medicare adopt the Veterans Health Administration formulary? Health Econ 21:485-495, 2012

55. Bach PB, Saltz LB, Wittes RE: In cancer care, cost matters. New York Times, October 15, 2012:A25

56. Expanded and Improved Medicare for All Act, HR 676, 113th Congress, 1st Sess, 2013. http://beta.congress.gov/bill/113th-congress/house-bill/676?q=hr+676

57. Sullivan K: Two-thirds of Americans support Medicare for all. http://www.pnhp.org/sites/default/files/docs/2011/Kip-Sullivan-Two-thirds-support-medicare-for-all.pdf

58. Carroll AE, Ackerman RT: Support for national health insurance among U.S. physicians: 5 years later. Ann Intern Med 148:566-756, 2008

59. Himmelstein DU, Woolhandler S: Obama's reform: No cure for what ails us. BMJ 340:c1778, 2010

Copyright © 2013 by American Society of Clinical Oncology

Hartford Courant.

November 15, 2013

Insurer cuts Medicare-plan doctors - Patients left in lurch

By Miranda Rosenberg

While most Americans have been focusing on the recent problems surrounding the rollout of the new HealthCare.gov website, another health insurance story has been largely overlooked. Last month, just as Medicare's open enrollment period was set to begin, UnitedHealthcare dropped thousands of physicians nationwide, including thousands in Connecticut, from its Medicare Advantage programs without an explanation.

Who are these physicians and why were they dismissed from United's Medicare Advantage plans en masse without being dropped from any of United's commercial programs? Company executives remain notably tight-lipped despite public inquiries from physicians, newspapers and lawmakers. Connecticut's five-member congressional delegation and attorney general have become involved. Based on the information available, it is clear that the company's end goal is to unload its sickest, costliest patients.

Typically insurance companies entice patients to join by including large networks of highly regarded providers. United's doctor drop, however, accomplished almost the exact opposite, wiping out entire services in some areas and removing the most talented physicians from the network.

Many of the physicians in question carry United's premium designation, the company's official recognition of excellence in "quality of care and cost efficiency." In Florida, United dropped an estimated 45 percent of its Medicare Advantage provider network, including the nationally renowned Moffitt Cancer Center in Tampa. United also dropped the only nephrologists in Connecticut's greater New Britain area as well as the entire Yale Medical Group, which represents more than 1,000 physicians on the faculty of the Yale School of Medicine. It is not only specialists that United is targeting — more than a third of the 2,250 physicians dropped in Connecticut are primary care providers.

What does this mean for patients? Thousands of senior citizens now must either find new in-network physicians, enroll with a different company's Medicare Advantage plan, or go back into traditional Medicare before open enrollment ends on December 7th.

Finding a new doctor can be challenging because many doctors, especially primary care physicians, either do not accept new patients or have long waiting times for new patient appointments. Many of our nation's seniors have complicated, ongoing health problems and complex medical histories — they cannot afford to wait months to see a new doctor. Their current physicians are familiar with their health needs; abruptly changing doctors only serves to disrupt their care.

The healthiest patients who rarely need medical care are more profitable for United; these patients may not have developed strong physician-patient relationships. Patients undergoing costly, long-term treatments such as dialysis and chemotherapy, however, are more likely to choose to leave United's Medicare Advantage programs in order to stay in the care of their current physicians.

When Medicare Advantage programs debuted, they tended to attract younger, healthier patients. Now that those patients are getting older and sicker, the cost of their care is increasing, pushing United to look for a way to remove them selectively from their coverage programs.

When Medicare Advantage programs debuted, they tended to attract younger, healthier patients. Now that those patients are getting older and sicker, the cost of their care is increasing, pushing United to look for a way to remove them selectively from their coverage programs.

If managed care is meant to represent successful health maintenance, however, then the patients United has been covering for the past decade should be healthier than average. United should enact policies that aim to retain these policyholders rather than drop physicians in order to encourage the patients to go elsewhere for coverage. Getting expensive patients to leave the United network enables United to maximize its own revenue and protect its 2014 projected earnings, but it comes at the expense of the other insurers and traditional Medicare which will be forced to absorb this high-cost patient population.

Ultimately, what United has done is enact a back-door plan to unload the sickest, costliest patients and put the financial burden back onto traditional Medicare and other health insurance companies.

Miranda Rosenberg of Philadelphia is a first year student at the Perelman School of Medicine at the University of Pennsylvania with a research focus on health policy.

JAMA®
The Journal of the American Medical Association

September 25, 2013

A PIECE OF MY MIND

Crossing Boundaries—Violation or Obligation?

Gordon D. Schiff, MD
Center for Patient Safety Research and Practice, Division of General Internal Medicine, Brigham and Women's Hospital; and Harvard Medical School, Boston, Massachusetts.

Corresponding Author: Gordon D. Schiff, MD (gschiff@partners.org).

Section Editor: Roxanne K. Young, Associate Senior Editor.

It is 5 PM on Friday afternoon. After 2 hours on the telephone trying (and failing) to get her insurance plan to pay for her medication refill, I reached into my pocket and handed the patient $30 so she could fill the prescription. It seemed both kinder and more honest than sending her away saying, "I'm sorry I can't help you." While I hardly expected a commendation for such a simple act of kindness, I was completely surprised to find myself being reprimanded for my "unprofessional boundary-crossing behavior" after the resident I was supervising shared this incident with the clinic directors. This allegation of an ethics violation was not only personally painful; it also raised important, controversial, and timely questions about appropriate professional roles.

After more than three decades as a general internist at a Midwest public hospital, I joined the staff of an academic medical center in Boston. While the public hospitals' patients were predominantly poor and uninsured, the academic center had both a different patient-mix and, to my surprise, a different culture and different norms related to "professional-patient boundaries." Actions my public hospital colleagues and I regularly took to help needy patients were questioned as inappropriate and unprofessional. Indeed, informal polls I've recently conducted at conferences in several hospitals comparing views and practices showed that there were dramatic differences in physicians' views on the acceptability of, for example, helping patients pay for medications, assisting unemployed patients in finding jobs, or, in a situation where there were no better alternatives, giving a patient a ride home. Some physicians (in all settings) considered these acts acceptable and had done so themselves, although these views and behaviors were much more common in public hospital settings. Other physicians felt these acts represented a violation of proper and needed professional boundaries.

Physicians must indeed respect certain boundaries. A growing literature and guidelines have admonished physicians and other health professionals to strictly respect boundaries to avoid improper expectations, dependency, legal liabilities, and confusion of personal and professional relationships. Most concerning were data documenting sexual relationships between physicians (often psychiatrists) and their patients.[1] In reaction to such abuses, medical societies and regulatory bodies established codes that strictly—and appropriately—proscribe sexual or other relationships that may exploit patients' vulnerability and trust.

However, some interpretations of these restrictions risk constructing a misguided model—one that discourages physicians from humanly caring for and about their patients. This new paradigm risks encouraging detached, arms-length, uncaring relationships. When do "boundaries" become barriers to meaningful caring relationships?[2] And will such bounded thinking serve to rationalize abdication of our professional and personal responsibilities to humanely respond to patient suffering and underlying injustices?

While I had rarely paid for a patient's medication as I did on that Friday afternoon (medications had been free at the public hospital clinic), in this situation it seemed reasonable and appropriate. Various ethics and conflict of interest rules prohibiting physicians from having "financial relationships" with patients may be appropriate when it comes to physicians *taking* or *soliciting* money from patients. But what about the propriety of *giving* money to a needy patient in this particular situation? While other alternatives such as using a special fund might be preferable, when I found that no such fund existed at my hospital (and the drug insurance plan denied coverage due to a technical glitch in the patient's enrollment), was it wrong to personally help a patient in such a moment of need?

Everything we do in medicine has risks. Whether prescribing a medication or performing surgery, we, in consultation with the patient and family, must weigh potential benefits and risks. When considering reaching out to help patients in need, possible adverse effects should be weighed against the benefits in that particular context and situation. Potential risks include, for example, the possibility that patients would divert money to instead buy street drugs or alcohol; that patients might come to expect, or depend on, or demand such help in the future; liability risks if one had a car crash when driving a patient home; diverting time and attention from other patients; that acts of kindness would be misinterpreted by patients as requiring reciprocal favors. In addition, time and energies required for professionals to carry out and sustain these extended-caring acts can further stress already overburdened physicians and other professionals.

In weighing such risks, however, we need to be clear *whose risks* we are considering. Many of these risks are actually more risks to physicians, rather than to patients. Thus, those insisting on stricter boundaries need to rethink what they mean by "limits." Who are those limits designed to protect? Are "limits" protecting the patient, or are they protecting us—protecting our time or even protecting our consciences, allowing us to avoid painful questions of inequality or taking needed moral action? While there is nothing inherently wrong with protecting caregivers against overwhelming time demands or burnout, let's not pretend we are imposing limits for patients rather than our own best interests.

The American Medical Association's Code of Medical Ethics states: "The practice of medicine ... is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. ... The

relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest ... and to advocate for their patients' welfare."[3] The type of caring relationships embodied in this statement, and the kindness I believe most patients and physicians yearn for, has been pejoratively dubbed "nostalgic professionalism." This outmoded model of professionalism, it is argued, needs to be replaced by a more dispassionate business-like model where limitations and boundaries are more circumscribed and it is clear that we are not our patients' friends, neighbors, or personal advocates for issues beyond their medical problems. Short of avoiding caring for poor patients entirely or not being part of the community in which our patients live and work (both unfortunately not rare), personal engagement with patients as people, not just as "clients" or "consumers," is inevitable, and even desirable.[4] For many of us (particularly primary care physicians), more than any P4P (pay-for-performance) financial incentives, our most fulfilling rewards and professional satisfactions come from having meaningful relationships with our patients, as well as our ability to broadly ameliorate their problems and suffering.[5] Of course we have to make daily compromises with reality, especially the realities of suffering and hardships poor and underserved patients face—problems we obviously can't personally cure. Nonetheless, we should try within the limitations of our time, resources, and abilities to help where we can.

The real danger of personal engagement is not that we further complicate already complicated relationships with our patients by doing too much. Rather it is that of tokenism—of doing too little and feeling satisfied and excused from addressing the social and economic injustices that underlie poor patients' suffering. It is here we have to be mindful of the fundamental distinction between charity and solidarity.[6] Yes, we need to be charitable in every way possible, but we also need to stand alongside our patients in striving for a fairer, more caring world. If physicians want to stand aloof, addressing only the biomedical problems, ignoring and seemingly indifferent to the social circumstances of our patients, then patient/relation-centered medical homes are likely to feel more like gated communities than places where people live and work together. Fortunately, the two strands of genuine "caring DNA" are closely intertwined. Collective advocacy for societal change and personal advocacy and helping of individual patients cross-fertilize and nourish each other. Minimizing barriers for professionals and patients working together for this shared agenda represents true patient-centered medical care.

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for the Disclosure of Potential Conflicts of Interest and none were reported.

1. Gabbard GO, Nadelson C. Professional boundaries in the physician-patient relationship [published correction appears in *JAMA*. 1995;274(17):1346]. *JAMA*. 1995;273(18):1445-1449.

2. Gutheil TG, Gabbard GO. Misuses and misunderstandings of boundary theory in clinical and regulatory settings. *Am J Psychiatry*. 1998;155(3):409-414.

3. American Medical Association. Opinion 10.015. The patient-physician relationship. Code of Medical Ethics. 2008-2009. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion10015.page.

4. Berwick DM. What "patient-centered" should mean: confessions of an extremist. *Health Aff (Millwood)*. 2009;28(4):w555-w565.

5. Brown S, Gunderman RB. Viewpoint: enhancing the professional fulfillment of physicians. *Acad Med*. 2006;81(6):577-582.

6. Galeano E, Posada JG, Fried M. *Upside Down: A Primer for the Looking-Glass World.* New York, NY: Picador USA; 2001.

SALON

October 10, 2013

Republicans' biggest misunderstanding about Obamacare

By Adam Gaffney, M.D.

The right hates the new healthcare law because they think its reach will be universal. The problem is the opposite.

The battle for universal healthcare is not over. This is not because of the reason you might suspect – that Republicans will obstinately endeavor to obstruct Obamacare in every way they can (though that seems to be the case). Instead, even after the smoke clears from the government shutdown (presumably with the law intact), the battle over universal healthcare will still not be over, but for a more fundamental reason: Obamacare, whatever its advantages (and despite the right's worst fears), does not create a system of universal healthcare.

Now first, to be clear, this is not to say that Obama's Affordable Care Act won't help many people. The uninsured who become eligible for coverage through the expansion of Medicaid, for example, will of course be better off – assuming they don't live in one of the 20 or more states that have callously elected to deny them this potentially lifesaving opportunity. Additionally, many uninsured who were previously unable to afford private health insurance may now be able to do so, for instance through the new income-based premium subsidies. And most of us will benefit from many of the law's insurance reforms, like the one that prevents insurers' from denying us coverage because we are sick.

First, on a basic level, the ACA is not universal healthcare because though it will reduce uninsurance, it won't provide universal coverage.

And at the same time, have no doubt: The various Republican alternatives for American healthcare would be disastrous. Consider the most recent GOP healthcare proposal H.R. 3121, which would gut state insurance regulations, eliminate popular ACA reforms like the ban on "preexisting conditions," end the Medicaid expansion, and provide tax benefits that would preferentially benefit the wealthy, among other unhelpful proposals that would do nothing to help the uninsured. Conservative "consumer-driven" healthcare dreams, more generally, would in truth be nightmares, radically furthering the transformation of healthcare into yet another commodity, bought by "consumers" in proportion to their means, not provided to patients on the basis of their needs.

Yet these facts don't change the fundamental fact that the ACA will not create what so many of us want, what the right so fervently fears, and – most important – what so many people really need: true universal healthcare. Why?

First, on a basic level, the ACA is not universal healthcare because though it will reduce uninsurance, it won't provide universal coverage. According to the Congressional Budget Office's May 2013 estimates, even by 2020 some 30 million Americans will be left uninsured under the ACA, a number that can only be partially attributed to intransigent Republican state governments that have blocked the expansion of Medicaid in their states.

But even putting aside those 30 million people, the ACA is insufficient because it will not deliver what most of us think of as universal healthcare: a system of equitable and comprehensive care for all, with full protection against the cost of illness. Indeed, on the contrary, underway already is a "quiet revolution" in American healthcare, in the words of Dr. Drew Altman of the Kaiser Foundation, that moves us "from more comprehensive to less comprehensive" health insurance, with patients paying more and more out of pocket every time they get sick. Ironically, even with the ACA going into full effect, "the vision of insurance that they've [conservatives] always favored," as Altman told the New York Times, "with more skin in the game, is the one that's coming to dominate in the marketplace."

The data clearly show, for instance, that with each passing year, more and more of the insured are already paying higher and higher deductibles, co-pays, and co-insurance whenever they actually need to use their expensive insurance (despite unsurprising evidence that rising out-of-pocket expenses can deter people from seeking needed medical care). In another disturbing trend, major employers – including Walgreens, Sears and Darden restaurants – seem to be moving away from "fixed benefit" health insurance to "fixed contribution" plans, in which employees receive a lump sum to buy a healthcare plan, with no guarantee that these contributions will keep up with the cost of health insurance in future years. It should be noted that this "quiet revolution" toward higher out-of-pocket expenses and more limited benefits is not of the ACA's making. At the same time, however, the ACA will do little to reverse it (and, in the case of the new excise tax on "Cadillac" healthcare plans, may even exacerbate it).

Meanwhile, for those not insured by their employer and who buy health insurance on the state exchanges that opened on Oct. 1, "underinsurance" may very well become the norm. The plans on the exchanges will be offered in tiers, with the lowest level – the Bronze plan – only required to have an actuarial value of 60 percent (that is to say, the percent of your average annual healthcare expenses that insurance actually pays for), with out-of-pocket annual expenses (after

(continued on next page)

*(**Gaffney**, continued from previous page)*

your premium is paid) reaching as high as $12,700 a year for families (depending on income). Moreover, to keep premiums in check, many of these plans will have significantly limited networks of doctors and hospitals, bringing back memories of 1990s managed care. In Missouri, for instance, the Anthem BlueCross BlueShield Plans sold on the exchange will exclude one of the state's top hospital systems, thereby denying access to the state's primary academic medical center and its prominent children's hospital.

Finally, the ACA most likely won't significantly bend the overall cost curve of healthcare, mainly because it will more or less leave our existing, fragmented and inefficient system in place. According to the most recent projections, for instance, once the economy recovers, the rate of growth of national health expenditures is expected to rebound to about 6 percent annually. This is better than in some previous years, and in an expanding economy in which growth was being distributed throughout the pay scale, might be entirely acceptable. But insofar as these rising costs continue to be passed on to the average working person – while at the same time gains in economic growth continue to accrue solely to the most affluent among us – these rising expenses will simply translate into tighter and tighter household budgets, and therefore even more inequality.

So while what the right says about Obamacare is generally wrong, paranoid or both, and though their own proposals would clearly make things much worse, we can't pretend that Obamacare will create universal healthcare in the sense that most of us imagine it.

So while what the right says about Obamacare is generally wrong, paranoid or both, and though their own proposals would clearly make things much worse, we can't pretend that Obamacare will create universal healthcare in the sense that most of us imagine it. We won't have, that is to say, truly comprehensive healthcare for all, with free choice of doctor and hospital, and without a "sickness tax" in the form of out-of-pocket expenses every time we become ill.

What would a system of true universal healthcare look like? The most feasible and best-studied system for the United States is a form of national health insurance called "single payer," in which care would be provided by the same mixture of private and public hospitals and physicians that is already in place, but in which a single entity – the government – insures everyone in the country. Medicare is one example of an existing single-payer system, but under a national single-payer system, everyone – not only the elderly – would be covered. Uninsurance would thereby be finally, and entirely, eliminated.

From a quality perspective, the evidence suggests that universal systems perform better – not worse, as is frequently alleged. A January 2013 report from the National Research Council, for instance, showed that the U.S. has essentially the worst health outcomes among 16 wealthy "peer nations," despite spending about twice as much on healthcare.

Such a system would have other advantages as well. For instance, it would drastically reduce our massive and rising expenditure on healthcare administration, which in 1999 accounted for an estimated 31 percent of all healthcare spending in the U.S., as opposed to a mere 7 percent in Canada. This difference is the predictable result of our highly complex and fragmented system of billing and insurance, which is particularly a problem of the private health insurance industry, which has such additional costs as product design, marketing and profits. Indeed, as much as 85 percent of excess spending on "health administration and insurance" is attributable to the private health insurance system. How, exactly, the health insurance industry contributes to actual healthcare – putting aside its extracting role as unnecessary middleman – remains among the great mysteries of the modern age.

The potential windfall from simplifying this mess could therefore be enormous. According to one recent study, a single-payer system could save the federal government about $592 billion a year. These savings could be used to pay for the cost of eliminating both uninsurance and underinsurance, with everyone receiving comprehensive healthcare without onerous co-pays and deductibles every time they got sick.

Such a system might sound like a dream for some, but it's not only a dream worth fighting for, but also one that can – with time and determination – be won. The fight for universal healthcare, it is clear, is still far from over: A new stage of that fight, in fact, has only just begun.

Adam Gaffney is a physician and writer in Massachusetts.

SALON

October 28, 2013

Here's how GOP Obamacare hypocrisy backfires

By Michael Lind

GOP base doesn't understand that the right wants to turn Medicare, Social Security and more into a very similar program.

The smartest thing yet written about the botched rollout of the Affordable Care Act's federal exchange program is a post by Mike Konczal of the Roosevelt Institute at his "Rortybomb" blog at Next New Deal. Konczal makes two points, each of which deserves careful pondering.

The first point is that to some degree the problems with the website have been caused by the overly complicated design of Obamacare itself. Instead of being a simple, universal program like Social Security or Medicare, the Affordable Care Act system is designed as if to illustrate Steven Teles' notion of "kludgeocracy" or needless, counterproductive complexity in public policy. By using means-testing to vary subsidies among individuals and by trying to match individuals with private insurance companies, the ACA requires far more information about people who try to sign up than do simpler public programs like Social Security and Medicare. If Congress had passed Medicare for All, the left's preferred simple, universal alternative to the kludgeocratic ACA mess, signing up would have been a lot easier and the potential for website snafus correspondingly less.

The worst features of Obamacare are the very features that conservatives want to impose on all federal social policy: means-testing, a major role for the states, and subsidies to private providers instead of direct public provision of health or retirement benefits.

Konczal's second point is even more important – the worst features of Obamacare are the very features that conservatives want to impose on all federal social policy: means-testing, a major role for the states, and subsidies to private providers instead of direct public provision of health or retirement benefits. This is not surprising, because Obamacare's models are right-wing models – the Heritage Foundation's healthcare plan in the 1990s and Mitt Romney's "Romneycare" in Massachusetts.

This point is worth dwelling on. Conservatives want all social insurance to look like Obamacare. The radical right would like to replace Social Security with an Obamacare-like system, in which mandates or incentives pressure Americans to steer money into tax-favored savings accounts like 401(k)s and to purchase annuities at retirement, with means-tested subsidies to help the poor make their private purchases. And most conservative and libertarian plans for healthcare for the elderly involve replacing Medicare with a totally new system designed along the lines of Obamacare, with similar mandates or incentives to compel the elderly to buy private health insurance from for-profit corporations.

If you don't like Obamacare, you should really, really hate the proposed conservative alternatives to Social Security and Medicare. Konczal writes:

"Conservatives in particular think this website has broad implications for liberalism as a philosophical and political project. I think it does, but for the exact opposite reasons: it highlights the problems inherent in the move to a neoliberal form of governance and social insurance, while demonstrating the superiorities in the older, New Deal form of liberalism. This point is floating out there, and it turns out to be a major problem for conservatives as well, so let's make it clear and explicit here."

Building on an insightful discussion of public policy by means of subsidies or "coupons" published by the New America Foundation's Next Social Contract initiative, Konczal contrasts the indirect, market-based, state-based neoliberal/conservative approach to social insurance that inspired Obamacare with the kind of universal federal social insurance preferred by liberals in the tradition of FDR and LBJ:

"So this tells a story. Let's refer to these features of social insurance, which are also playing a major role in the rollout problems, as 'Category A.' Now, what would the opposite of this look like? Let's define the opposite of this as 'Category B' social insurance. And let's take these two categories and chart them out."

Konczal speculates that the flaws of Obamacare may undermine public support for proposed conservative replacements of Social Security and Medicare:

"However, the smarter conservatives who are thinking several moves ahead (e.g. Ross Douthat) understand that this failed rollout is a significant problem for conservatives. Because if all the problems are driven by means-testing, state-level decisions and privatization of social insurance, the fact that the core conservative plan for social insurance is focused like a laser beam on means-testing, block-granting and privatization is a rather large problem. As Ezra Klein notes, 'Paul Ryan's health-care plan – and his Medicare plan – would also require the government to run online insurance marketplaces.' Additionally, the Medicaid expansion is working well where it is being implemented, and the ACA is perhaps even bending the cost curve of Medicare, the two paths forward that

(continued on next page)

*(**Lind**, continued from previous page)*

conservatives don't want to take."

Will the flaws of Obamacare really hurt the right and help center-left supporters of universal social insurance? I doubt it.

To begin with, this implies a willingness of the right to acknowledge that Obamacare, in its design, is essentially a conservative program, not a traditional liberal one. But we have just been through a presidential campaign in which Mitt Romney, who as governor of Massachusetts presided over the creation of the most important model for Obamacare, rejected any comparison of Romneycare with Obamacare. What is more, instead of agreeing with Konczal that the flaws of Obamacare are shared by most conservative entitlement reform proposals, conservatives are likely simply to denounce Obamacare as "socialism" or "collectivism" while promoting their own, Obamacare-like replacements for Social Security and Medicare, with blithe indifference to their own inconsistency.

If Obamacare – built on means-testing, privatizing and decentralization to the states – is treated by progressives as the greatest liberal public policy success in the last half-century, then how will progressives be able to argue against proposals by conservative Republicans and center-right neoliberal Democrats to means-test, privatize and decentralize Social Security and Medicare in the years ahead?

Nor are progressives likely to press the point in present or future debates. Unlike conservatives, who are right-wingers first and Republicans second, all too many progressives put loyalty to the Democratic Party – most of whose politicians, including Obama, are not economic progressives – above fidelity to a consistent progressive economic philosophy. These partisan Democratic spinmeisters are now treating Obamacare, not as an essentially conservative program that is better than nothing, but as something it is not – namely, a great victory of progressive public policy on the scale of Social Security and Medicare.

In doing so, progressive defenders of Obamacare may inadvertently be digging the graves of Social Security and Medicare.

If Obamacare – built on means-testing, privatizing and decentralization to the states – is treated by progressives as the greatest liberal public policy success in the last half-century, then how will progressives be able to argue against proposals by conservative Republicans and center-right neoliberal Democrats to means-test, privatize and decentralize Social Security and Medicare in the years ahead?

I predict that it is only a matter of time before conservatives and Wall Street-backed "New Democrats" begin to argue that, with Obamacare in place, it makes no sense to have two separate healthcare systems for the middle class – Obamacare for working-age Americans, Medicare for retired Americans. They will suggest, in a great bipartisan chorus: Let's get rid of Medicare, in favor of Lifelong Obamacare! Let's require the elderly to keep purchasing private insurance until they die!

I'm sure a number of token "centrist" Democrats will be found, in due time, to support the replacement of Medicare by Lifelong Obamacare. And with neoliberal Democratic supporters of the proposal as cover, the overclass centrists of the corporate media will begin pushing for Lifelong Obamacare as the sober, responsible, "adult" policy in one unsigned editorial after another.

Once Medicare has been abolished in favor of Lifelong Obamacare, perhaps by a future neoliberal Democratic president like Clinton and Obama, Social Security won't last very long.

The conservative Republicans and centrist Democrats will argue that the success of Obamacare, in both its initial version and the new and improved Lifelong Obamacare version, proves that a fee-based, means-tested, privatized and state-based system is superior to the universal, federal, tax-based Social Security program enacted nearly a century ago in the Dark Age known as the New Deal. We will be told that, in a world with computers and globalization and apps or whatever, simple, universal, one-size-fits all social insurance is obsolete. In the "new economy," public policy needs to offer as many baffling choices as airlines or gyms, like the ridiculous bronze, silver, gold and platinum plans of Obamacare.

At some point in the future, the right will introduce a plan to replace Social Security with a system of individual mandates and fines to compel working-age Americans to invest in for-profit Wall Street mutual funds during one's working years, and to compel them to buy annuities from for-profit money managers at retirement (which with the help of centrist Democrats will be postponed to 70 or beyond). The genuine progressives will respond with a defense of Social Security. Whereupon the faux-progressives, the neoliberal heirs of Carter, Clinton and Obama, will reject the option of preserving Social Security – why, that's crazy left-wing radical talk! – but insist that the subsidies for the poorest of the elderly be slightly increased, as the price for their adoption of the conservative plan to destroy Social Security. Throughout the process, the right-wing Republicans and neoliberal Democrats will ask, "How can progressives object to means-testing, privatization and 50 state programs, when those are the very features of the Obamacare system that our friends on the left celebrate as a great achievement?"

Think about it, progressives. The real "suicide caucus" may consist of those on the center-left who, by passionately defending the Affordable Care Act rather than holding their noses, are unwittingly reinforcing the legitimacy of the right's long-term strategy of repealing the greatest achievements of American liberalism.

Michael Lind is the author of "Land of Promise: An Economic History of the United States" and co-founder of the New America Foundation.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

A perspective on national and state single-payer efforts

By Steffie Woolhandler, M.D., and David Himmelstein, M.D.

Virtually all single-payer supporters aspire to a nationwide reform. Absent a national solution, many regions with the gravest problems in access to care will lag further and further behind. Living in New York or Massachusetts doesn't lessen our sense of responsibility for millions in the Deep South and other "red state" areas for whom national legislation is the only realistic option for health care progress.

Yet with the Congress currently tied in knots, prospects for the passage of a national single-payer bill are dim for the next few years. Meanwhile, in a number of states the political environment offers more openings for single-payer work, in no small part due to years of work by local PNHP members and other activists. These efforts are educating and pressuring many state legislators, and even governors, to embrace single payer – at least rhetorically. We outline below our views of the opportunities and obstacles to state-based work.

Opportunities

1. In some locales, the apparently lower bar to state single-payer legislation is facilitating mobilization of activists who might be daunted by the scale and seemingly dim prospects for congressional action.
2. State-based efforts empower local leadership. Such local leadership is critical to development of a nationwide movement.
3. Media outlets are often more willing to cover state-based efforts, both because they view such efforts as more feasible and because attention to local issues and personalities is a central focus of local media.
4. State legislators and local politicians who become single-payer supporters influence, and sometimes themselves become, U.S. representatives and senators.
5. State programs can be tailored to address local problems, e.g. thorny rural health issues.
6. Some feel that a state program may avoid some of baggage of Washington-based lobbying and rule making. The Affordable Care Act, flawed from the outset, has been further compromised in HHS' rule-making process, which has bent to corporate pressures.
7. Many point to the Saskatchewan example of state- (or province-) level reform that served as a springboard to national legislation.

Obstacles

1. Federal waivers are required to include Medicare, Medicaid and SCHIP enrollees in a state single payer. While HHS can grant Medicaid and SCHIP waivers, an act of Congress is required for a Medicare waiver.
2. Leaving Medicare outside of the single-payer funding stream makes it impossible to realize many cost savings possible under a true single-payer reform. Hospitals can't be paid global budgets, precluding the elimination of their wasteful per-patient billing apparatus; health planning via control of new capital investments is obstructed; and Medicare-paid, for-profit HMOs, dialysis facilities, hospices, home care agencies, etc., will continue to distort the system.
3. Waivers are not without risk. We fear that conservative forces in red states may take advantage of loosened federal restrictions on Medicaid, and particularly Medicare, to further undermine these programs. For instance, while Massachusetts was able to secure a progressive Medicaid waiver to help fund care of the uninsured, Arkansas took advantage of this process to fully privatize its Medicaid program.
4. It's not clear how – absent an act of Congress – a state program could fully integrate federal workers and military personnel and retirees covered by Tricare. As with Medicare, maintaining these separate funding streams sacrifices most administrative cost savings.
5. In some states, many people cross state borders to work and get medical care, greatly complicating the design of state-based programs.
6. The political power of corporations is highly portable. While national insurers, drug firms and billionaire conservative activists often stand back in earlier stages of state single-payer efforts, as a state moves closer to implementation we can expect a massive influx of outside funding for efforts to disrupt it. Hence, the advantage of a locally progressive political climate is likely to erode as a movement gets closer to binding legislation.
7. State (but not federal) programs must skirt the federal ERISA law that prohibits state regulation of employee benefits, i.e. to ban private coverage that duplicates the single-payer coverage. Such duplicate private coverage erodes political support for continued adequate funding of the public system, and encourages the development of two-class care.
8. While the Saskatchewan example is inspiring, its applicability in the U.S. context is questionable. The division of powers under the Canadian constitution reserves most responsibility for health care to the provinces; the Canadian federal government exercises leverage almost exclusively by offering the provinces funding. Hence, Saskatchewan faced few federal hurdles to implementation.
9. Applying the term "single payer" to a state program compromised by corporate and federal government interference risks sullying the public image of such reform.

In sum, we believe that state-level work offers a valuable opportunity to educate and mobilize for single payer. But we're also convinced that a fully workable state program is not possible without explicit congressional endorsement, or at least acquiescence. Hence a continuing focus on national-level work is essential, not only to save Texas, but to allow real progress in Vermont.

The Washington Post

September 25, 2013

Canadians don't understand Ted Cruz's health care battle

By Matt Miller

When you're being forced to endure another rabid Sen. Ted Cruz (R-Texas) soliloquy on Obamacare's threat to human freedom, it's easy to forget how absurd our health care debate seems to the rest of the civilized world. That's why it's bracing to check in with red-blooded, high testosterone capitalists north of the border in Canada – business leaders who love Canada's single-payer system (a regime far to the "left" of Obamacare) and see it as perfectly consistent with free-market capitalism.

Take David Beatty, a 70-year-old Toronto native who ran food processing giant Weston Foods and a holding company called the Gardiner Group during a career that has included service on more than 30 corporate boards and a recent appointment to the Order of Canada, one of the nation's highest honors. By temperament and demeanor, Beatty is the kind of tough-minded, suffer-no-fools wealth creator who conservatives typically cheer.

Yet over breakfast in Toronto not long ago, Beatty told me how baffled he and Canadian business colleagues are when they listen to the U.S. health care debate. He cherishes Canada's single-payer system for its quality and cost-effectiveness (Canada boasts much lower costs per person than the United States). And don't get him started on the system's administrative simplicity – you just show your card at the point of service, and that's it. Though he's a well-to-do man who can pay for whatever care he wants, Beatty told me he's relied on the system just as ordinary Canadians do, including for a recent knee replacement operation. The one time he went outside the system was to pay extra for a physical therapist closer to his home than the one to which he'd been assigned.

It's just "common sense" in Beatty's view that government takes the lead in assuring basic health security for its citizens. He's amazed at the contortions of the debate in the United States, and wonders why big U.S. companies "want to be in the business of providing health care anyway" ("that's a government function," he says simply). Beatty also marvels at the way the U.S. regime's dysfunction comes to dominate everyday conversation. He shakes his head recalling how much time and passion American friends devoted one evening to comparing notes on their various supplemental Medicare plans. Talk about your sparkling dinner conversation.

Roger Martin, another Toronto native and avowed capitalist, spent years as a senior partner at the consulting firm Monitor before becoming dean of the Rotman School of Management at the University of Toronto, where he recently completed a 15-year stint. He advises U.S. corporate icons like Proctor & Gamble and Steelcase. He lived in the United States for years and has experienced both systems firsthand.

Martin told me that Canada's lower spending, better outcomes and universal coverage make it superior by definition. Plus, it's "incredibly hassle-free." In the United States every time he took his kids in for an earache his wife spent hours fighting with the health plan or filling out reams of paperwork. In Canada, he says, "the entire administrative cost is pulling your card out of your pocket, giving it to them and putting it back."

There's more. Canadian divisions of multinational firms love Canada's system because when they bid on projects they have no health costs to load in. Also, there's no crazy "job lock" as with the employer-based system in the United States – where people with (say) a sick child cling to their job for fear of being pronounced uninsurable. His peers, he says, view the U.S. debate as "ideological and not based on economics."

"The whole single-payer thing just makes sense," Martin adds. "You don't spend time trying to shift costs." It's hardly perfect: a few folks go to the United States to jump the line on certain elective procedures, and Canada, like others, free rides on American's investment in pharmaceutical innovation (funded by higher U.S. drug prices). But, he adds, "I literally have a hard time thinking of what would be better than a single-payer system."

The moral of the story? Don't let the rants of cynical demagogues like Cruz confuse you – it is entirely possible to be a freedom-loving capitalist and also believe in a strong government role in health care. Remember, Obamacare features a much smaller such role than does Canada's approach – or England's, where Margaret Thatcher would have been chased from office for proposing anything as radically conservative as the Affordable Care Act.

One well-known billionaire told me a few years back that the right answer for the United States was single payer for basic coverage, with the ability for folks to buy additional private supplements atop that. But he won't say this in public; the gang at the club just wouldn't understand. Maybe when U.S. business leaders muster the common sense of their Canadian counterparts, they'll deliver the message the Ted Cruzes of the world need to hear: sit down and shut up.

Matt Miller writes a weekly column on economic and other domestic policy issues. He is a senior fellow at the Center for American Progress and a commentator on public radio. Hes served as a senior adviser at the White House Office of Management and Budget from 1993 to 1995.

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

International Profiles of Health Care Systems, 2013, published November 2013

Table 1. Health Care System Financing and Coverage in Fourteen Countries

	HEALTH SYSTEM AND PUBLIC/PRIVATE INSURANCE ROLE			BENEFIT DESIGN	
	Government Role	**Public System Financing**	**Private Insurance Role** (Core Benefits; Cost-Sharing; Noncovered Benefits; Private Facilities or Amenities; Substitute for Public Insurance)	**Caps on Cost-Sharing**	**Exemptions and Low-Income Protection**
Australia	Regionally administered, joint (national & state) public hospital funding; universal public medical insurance program (Medicare)	General tax revenue; earmarked income tax	~50% buy coverage for private hospital costs & noncovered benefits	No. Safety nets include 80% OOP rebate if physician costs exceed AUS$1,222 [US$1,160]	Low-income and older people: Lower cost-sharing; lower OOP maximum before 80% subsidy
Canada	Regionally administered universal public insurance program (Medicare)	Provincial/federal tax revenue	~67% buy coverage for noncovered benefits	No	No cost-sharing for Medicare services. Some cost-sharing exemptions for non-Medicare services, e.g., drugs outside hospital; varies by province
Denmark	National health service	Earmarked income tax	~55% buy coverage for cost-sharing, noncovered benefits, or access to private facilities	No. Decreasing copayments with higher drug OOP spending	Drug OOP cap for chronically ill (DKK 3,410 [US$617]); financial assistance for low-income and terminally ill people
England	National health service	General tax revenue (includes employment-related insurance contributions)	~11% buy for private facilities mainly for elective surgery and consultations with specialists	No general cap for OOP. Prepayment certificate with £2 [US$3.20] per week ceiling for those needing a large number of prescription drugs.	Drug cost-sharing exemption for low-income, older people, children, pregnant women and new mothers, and some disabled/chronically ill. Financial assistance with transport costs available to people on low incomes.
France	Statutory health insurance system, with all SHI insurers incorporated into single national exchange	Employer/employee earmarked income and payroll tax; general tax revenue, earmarked taxes	~90% buy or receive government vouchers for cost-sharing; some noncovered benefits	No. €50 [US$67] cap on deductibles for consultations and services	Exemption for low-income, chronically ill and disabled, and children
Germany	Statutory health insurance system, with 134 competing SHI insurers ("sickness funds" in a national exchange); high income can opt out for private coverage	Employer/employee earmarked payroll tax; general tax revenue	Cost-sharing + amenities (~20%); Substitute: 10% opt-out of SHI system for private coverage only	Yes. 2% income; 1% income for chronically ill + low-income people	Children exempt
Italy	National health service	National earmarked corporate and value-added taxes; general tax revenue and regional tax revenue	~15% buy coverage for access to private facilities and amenities	No. €46.15 [$59 USD] copayment on outpatient care; limited copayment (regional rates) on drugs	Exemptions for low-income older people/ children, pregnant women, chronic conditions/disabilities, rare diseases
Japan	Statutory health insurance system, with approx. 3,500 noncompeting public, quasi-public, and employer-based insurers	General tax revenue; insurance contributions	Majority buy coverage for cash benefits/ cost-sharing	No. Coinsurance reduced to 1% after 80,100 yen [$999 USD] monthly cap	Low-income monthly OOP ceiling: 35,400 yen [$441 USD]; reduced cost-sharing for young children and older people
Netherlands	Statutory health insurance system, with universally mandated private insurance (national exchange)	Earmarked payroll tax; community-rated insurance premiums; general tax revenue	Private plans provide universal core benefits; 90% buy for noncovered benefits	No. But annual deductible of €350 [US$472] covers most cost-sharing	Children exempt from cost-sharing; premium subsidies for low-income
New Zealand	National health service	General tax revenue	~33% buy for cost-sharing, access to specialists, and elective surgery in private hospitals	No. Subsidies after 12 doctor visits/20 prescriptions in past year	Lower cost-sharing for low-income, some chronic conditions, Maori and Pacific Islanders; young children mostly exempt
Norway	National health service	General tax revenue	<10% holds VHI, mainly bought by employers for providing employees quicker access	Yes. Main cost sharing ceiling is NOK 2,040 [US$342]	Exemptions for children <16 years somatic, <18 years psychiatric, pregnant women, and for some communicable diseases (STDs)
Sweden	National health service	General tax revenue	<5% buy for private facilities	Yes. SEK 1100 [US$169] for health services & SEK 2200 [US$337] for drugs	Exemption for children and pregnant women
Switzerland	Statutory health insurance system, with universally mandated private insurance (regional exchanges)	Community-rated insurance premiums; general tax revenue	Private plans provide universal core benefits; majority buy private plans for noncovered benefits and amenities	Yes. 700 CHF [US$768] max after deductible	Income-related premium assistance (30% receive); some assistance for low-income; some exemptions for children, pregnant women
United States*	Medicare: age 65+, some disabled; Medicaid: some low-income (most under age 65 covered by private insurance; 16% of population uninsured)	Medicare: payroll tax, premiums, federal tax revenue; Medicaid: federal, state tax revenue	Primary private insurance covers 56% of population (employer-based and individual); supplementary for Medicare	No	Low-income: Medicaid; older people and some disabled on Medicare

* Prior to January 1, 2014.

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

International Profiles of Health Care Systems, 2013, published November 2013

Table 2. Selected Health Care System Indicators for Fourteen Countries

		Australia	Canada	Denmark	France	Germany	Italy	Japan	Netherlands	New Zealand	Norway	Sweden	Switzerland	United Kingdom	United States
Population, 2011	Total Population (1,000,000s of people)	22.323	34.484	5.571	65.161	81.373	60.724	127.799	16.718	4.404	4.952	9.447	7.912	61.760	311.588
	Percentage of Population Over Age 65	13.7%	14.7%	17.1%	17.1%	20.7%	21.0%	23.3%	15.9%	13.3%	15.2%	19.3%	17.1%	16.2%	13.2%
Spending, 2011 unless otherwise noted	Percentage of GDP Spent on Health Care	8.9%	11.2%	11.1%	11.6%	11.3%	9.2%	9.6%a	11.9%	10.3%	9.3%	9.5%	11.0%	9.4%	17.7%
	Health Care Spending per Capita[d]	$3,800[a]	$4,522	$4,485	$4,118	$4,495	$3,012	$3,213a	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508
	Average Annual Growth Rate of Real Health Care Spending per Capita, 2000–2011	2.74%	3.0%	2.7%	1.8%	2.1%	1.2%	3.0%c	4.7%	3.8%	2.4%	3.1%	1.8%	4.0%	3.0%
	Out-of-Pocket Health Care Spending per Capita[d]	$733[a]	$666	$593	$307	$593	$542	$464a	n/a	$348	n/a	$635	$1,455	$338	$987
	Hospital Spending per Capita[d]	$1,532	$1,298	$1,960	$1,409	$1,304	n/a	$1,484a	$1,589	$1,242	$1,981	$1,704	$2,030	n/a	$2,730
	Spending on Pharmaceuticals per Capita[d]	$587	$752	$300	$641	$633	$487	$652a	$479	$298	$388	$474	$531	n/a	$995
Physicians, 2011 unless otherwise noted	Number of Practicing Physicians per 1,000 Population	3.31	n/a	3.48[b]	3.07	3.84	4.1	2.21a	n/a	2.64	3.72	3.86[a]	3.83	2.81	2.46
	Average Annual Number of Physician Visits per Capita	6.7	7.4[a]	4.6[a]	6.8	9.7	n/a	13.1a	6.6	n/a	5.2[b]	3.0	n/a	5.0[b]	4.1[b]
Hospital Spending, Utilization, and Capacity, 2011 unless otherwise noted	Number of Acute Care Hospital Beds per 1,000 Population	3.38	1.73	2.87	3.43	5.33	2.75	7.95	3.33	2.61	2.40	2.01	3.03	2.41	2.56
	Hospital Spending per Discharged[d]	$9,611[a]	$15,433[a]	$11,374	$8,363	$5,339	n/a	n/a	$13,025	$8,478	$11,306	$9,894	$11,968	n/a	$21,018[a]
	Hospital Discharge per 1,000 Population	159	82	172	169	244	129	111	122	147	175	163	170	136	125
	Average Length of Stay for Acute Care (days)	5.0[a]	7.7[a]	n/a	5.1	7.9	6.8	17.9	5.8	5.6	4.5[a]	5.1	6.5	6.5	5.4
Medical Technology, 2011 unless otherwise noted	Magnetic Resonance Imaging (MRI) Machines per Million Population	5.7	8.5	15.4	7.5	n/a	23.7	46.9	12.9	11.1	n/a	n/a	n/a	5.9	31.5
	MRI Exams per 1,000 Population	24.1	49.8	61.5	67.5	95.2[b]	n/a	n/a	49.9	n/a	n/a	n/a	n/a	n/a	102.7
IT, 2012	Physicians' Use of EMRs (% of Primary Care Physicians)[f]	92.0%	56%	n/a	67%	82%	n/a	n/a	98%	97%	98%	88%	41%	97%	69%
Health Risk Factors, 2011 unless otherwise noted	Percentage of Adults Who Report Being Daily Smokers	15.1%	15.7%	20.0%	23.3%	21.9%	22.5%	20.1%	20.8%	n/a	17.0%	13.1%	n/a	19.6%	14.8%
	Obesity Prevalence (BMI >30)	28.3%	25.4%	13.4%	12.9%	14.7%	10.0%e	4.1%	11.4%	27.8%	n/a	11.0%	n/a	24.8%	36.5%

Source: OECD Health Data 2013 (June) unless otherwise noted.
[a] 2010.
[b] 2009.
[c] 2000–2010.
[d] Adjusted for differences in the cost of living (PPP; purchasing power parity adjustment).
[e] Self-reported as opposed to measured data.
[f] Source: 2012 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

Table 4. Provider Organization and Payment in Twelve Countries

	Provider Ownership		Provider Payment		Primary Care Role	
	Primary Care	Hospitals	Primary Care Payment	Hospital Payment	Registration with GP Required	Gatekeeping
Australia	Private	Public (~67% of beds), private (~33%)	FFS	Global budgets + case-based payment in public hospitals (includes physician costs); FFS in private hospitals	No	Yes
Canada	Private	Mostly private not-for-profit or public; some private-for-profit	Mostly FFS, but some alternatives (e.g. capitation)	Global budgets + case-based payment in some provinces (does not include physician costs)	Not generally, but yes for some capitation models	Incentives, varying across provinces: e.g., in Ontario, specialist physicians have higher fees for patients who have been referred by their GP
Denmark	Private	Almost all public	Mix capitation/FFS	Global budgets + case-based payment (includes physician costs)	Yes (for 98% of population)	Yes (for 98% of population)
England	Mainly private (most GPs are self-employed or partners in privately owned practices)	Mostly public, some private	Mix capitation/FFS/P4P; salary payments for a minority (the salaried GPs are employees of private group practices, not of the NHS)	Mainly case-based payments plus service contracts. All include physician costs, drug costs, etc.	Yes	Yes
France	Private	Mostly public or private not-for-profit, some private for-profit	Mix FFS/P4P/flat 40€ bonus per year per patient with chronic disease and regional agreements for salaried GPs	Mainly case-based payments (includes physician costs) + non-activity-based grants for education, research, etc.	Yes (may be with a specialist or GP; in practice over 95% are with GPs)	National incentives: higher cost-sharing for visits and prescriptions without a referral from the gatekeeper
Germany	Private	Public (~50% of beds); private nonprofit (~33%); private for-profit (~17%)	FFS	Global budgets + case-based payment (includes physician costs)	No	In some sickness fund programs
Italy	Private (primary care providers (i.e., GPs and pediatricians) are self-employed)	Mostly public, some private	Mix capitation/FFS	Global budgets + case-based payment (includes physician costs)	Yes	Yes
Japan	Mostly private	Private nonprofit (~55% of beds) and public	Most FFS, some per-case daily or monthly payments	Case-based per diem payments+FFS or FFS (includes physician costs)	No	No
Netherlands	Private	Mostly private, nonprofit	Mix capitation/FFS	Global budgets + case-based payment (include physician costs)	Yes	Yes
New Zealand	Private	Mostly public, some private	Mix capitation/FFS	Global budgets + case-based payment (includes physician costs)	Yes (for 96% of population)	Yes
Norway	Private	Almost all public	Mixed income from municipal contracts, user-charges (in accordance with cost-sharing caps) and government sponsored FFS payments	Global budgets + case-based payment (40% of DRG; includes physician costs)	Yes	Yes
Sweden	Mixed	Almost all public	Mix capitation/FFS/P4P	Global budgets + case-based payment (includes physician costs)	Yes (except Stockholm)	Some incentives
Switzerland	Private	Mostly public, some private	Most FFS, but some capitation	National diagnosis related groups (Swiss DRG) payment system for (somatic) acute inpatient care	No	Free access (without referral) to specialists unless enrolled in a gatekeeping managed care plan
United States	Private	Mix of nonprofit (~70% of beds), public (~15%), and for-profit (~15%)	Most FFS, some capitation with private plans	Per diem and case-based payment (usually does not include physician costs)	No	In some insurance programs

The Nation.

November 11, 2013

IN MEMORY OF GENE AND LINDA FARLEY

A doctor with a cure: 'Medicare for All'

By John Nichols

Gene Farley and I shared a deep affection for Tommy Douglas, the Baptist preacher-turned-statesman who as the leader of Saskatchewan's Cooperative Commonwealth Federation established the framework for what would become Canada's single-payer national health care system.

Douglas, who is often recalled as "the Greatest Canadian," had a congenial style that belied his determination to address social and economic injustices he knew to be immoral. "The inescapable fact," he argued, "is that when we build a society based on greed, selfishness, and ruthless competition, the fruits we can expect to reap are economic insecurity at home and international discord abroad."

Paraphrasing Tennyson, Douglas roused Canadians with a promise: "Courage, my friends; 'tis not too late to build a better world." That line always came to mind when I was with Gene, who died Friday at 86.

Gene was an internationally renowned physician, an originator of family practice residency programs and innovative public-health initiatives who finished a distinguished academic career as chair of the Department of Family Medicine at the University of Wisconsin.

Yet, his great passion was as a "build a better world" campaigner. The man who proudly recalled joining the March on Washington for Jobs and Freedom in 1963 was still marching for those same causes in 2013.

With his beloved wife, Dr. Linda Farley, Gene devoted two decades of "retirement" to advancing a broad justice vision that – after Linda's death in 2009 – could be seen in the remarkable ecological, agricultural and community-building work of the Linda & Gene Farley Center for Peace, Justice and Sustainability.

Because of their professional background, Gene and Linda focused particularly on advancing the cause of universal health care. With their longtime friend Dr. Quentin Young, they were early and enthusiastic leaders of the "Physicians for a National Health Program" movement, which for decades has encouraged U.S. leaders to develop "an expanded and improved version of Medicare (to) cover every American for all necessary medical care."

The man who refused offers of prestigious international positions because he felt a duty to carry on the battle to reform the U.S. health care system knew understood the challenge of seeking that reform at a time "when society is going toward selfish extremes… when (governments) pay anything to build up the military but don't want to give to the social good." Still, he remained "fantastically optimistic." And that optimism was often rewarded – especially with the 2012 election of his friend and ally Tammy Baldwin as the junior senator from Wisconsin.

Amber Arnold - Wisconsin State Journal

Dr. Gene Farley

Though Farley warned that the Affordable Care Act, with its deference to insurance companies, was more complicated and costly than need be, he hoped that the passage of the act would serve as an important step on the road to a creating a single-payer system in the United States. As we traveled in eastern Canada together last month – on a Nation Cruise where Gene delighted in comparing notes with his dear friends Dr. Michael Klein and Bonnie Sherr Klein – we spoke a good deal about the difficulty of implementing what has come to be known as "Obamacare."

Yet, Gene, "fantastically optimistic" as ever, recalled that Canada went through decades of bitter wrangling before finally establishing a universal health care system that delivers longer life expectancy more efficiently and at a lower cost than the American system. "We have to be patient, but we have to be determined," he said, explaining that the establishment of the principle of "health care as a right" is not just a medical mission, not even an economic or social responsibility.

It is, Gene said, "about morality."

Canada came to recognize that morality, embracing the vision of Tommy Douglas.

And it is right and necessary to expect that America will come to recognize that morality, embracing the vision of Gene Farley.

John Nichols is Washington correspondent for The Nation and associate editor of The Capital Times (Madison, Wis.).

theguardian

November 27, 2013

The real fix for Obamacare's flaws: Medicare for all

By RoseAnn DeMoro

There's no reason to rollback the progress the ACA has made. But we should go all the way and dump the for-profit system.

Lost amidst the well-chronicled travails of the Affordable Care Act rollout are the long-term effects of people struggling to get the health coverage they need without going bankrupt.

If that sounds familiar, it's because that's been the main story line of the US healthcare system for several decades. Sadly, little has changed.

Still, with all the ACA's highly publicized snafus, and less discussed systemic flaws, there's no reason to welcome the cynical efforts to repeal or defund the law by politicians whose only alternative is more of the same callous, existing market-based healthcare system.

US nurses oppose the rollback and appreciate that several million Americans who are now uninsured may finally get coverage, principally through the expansion of Medicaid, or access to private insurance they've been denied because of their prior health status.

At the same time, nurses will never stop campaigning for a fundamental transformation to a more humane single-payer, expanded Medicare for all system not based on ability to pay and obeisance to the policy confines of insurance claims adjustors.

Website delays – the most unwelcome news for computer acolytes since the tech boom crashed – are not the biggest problem with the ACA, as will become increasingly apparent long after the signup headaches are a distant memory.

What prompted the ACA was a rapidly escalating healthcare nightmare, seen in 50 million uninsured, medical bills plunging millions into un-payable debt or bankruptcy, long delays in access to care, and record numbers skipping needed treatment due to cost.

The main culprit was our profit-focused system, with rising profiteering by a massive health care industry, and an increasing number of employers dropping coverage or just dumping more costs onto workers.

The ACA tackles some of the most egregious inequities: lack of access for many of the working poor who will now be eligible for Medicaid or subsidies to offset some of their costs for buying private insurance through the exchanges, a crackdown on several especially notorious insurance abuses, and encouragement of preventive care.

But the law actually further entrenches the insurance-based system through the requirement that uncovered individuals buy private insurance. It's also chock full of loopholes.

Some consumers who have made it through the website labyrinth have found confusing choices among plans which vary widely in both premium and out of pocket costs even with the subsidies, a pass through of public funds to the private insurers.

The minimum benefits are also somewhat illusory. Insurance companies have decades of experience at gaming the system and warehouses full of experts to design ways to limit coverage options.

The ACA allows insurers to cherry pick healthier enrollees by the way benefit packages are designed, and as a Washington Post article noted on 21 November, consumers are discovering insurers are restricting their choice of doctors and excluding many top ranked hospitals from their approved "network".

The wide disparity between the healthcare you need, what your policy will cover, and what the insurer will actually pay for remains.

Far less reported is what registered nurses increasingly see – financial incentives within the ACA for hospitals to prematurely push patients out of hospitals to cheaper, less regulated settings or back to their homes. It also encourages shifting more care delivery from nurses and doctors to robots and other technology that undermines individual patient care, and that may work no better than the dysfunctional ACA websites.

Is there an alternative? Most other developed nations have discovered it, a single-payer or national healthcare system.

Without the imperative of prioritizing profits over care, Medicare for all streamlines the administrative waste and complex insurance billing operations endemic to private insurance. That waste is a major reason why the US has more than double the per capita cost of healthcare of other developed nations, yet lower life expectancies than many.

Medicare for all eliminates the multi-tiered health plans that plague both the individual and group insurance markets that are tied to the girth of your wallet not your need for care. Class, gender, and racial disparities in access and quality of care vanish under Medicare for all.

It's beyond time that we stop vilifying government and perpetuating a corporatized healthcare system that has abandoned so many. We can, with a system of Medicare for all, we can cut healthcare costs and promote a much more humane society.

RoseAnn DeMoro is executive director of National Nurses United, the leading union of registered nurses in the U.S., with 156,000 members. She also serves as national vice-president and executive board member of the AFL-CIO.

From DeMoro, “The Real Fix for Obamacare’s flaws, The Guardian”

Comparison between Single Payer and the ACA

Medicare for All / Single Payer	The Affordable Care Act
Universal--everyone is covered.	Not universal. Even after 9 years, 31 million people will still be uninsured.
Not employment based. Everyone has access to the same coverage and benefits, whether employed or not.	Employment based. Wide variance in costs and covered benefits for those with employer-paid benefits. As insurance costs skyrocket, more employers drop coverage or shift more costs to workers.
Single standard of excellent care for all, independent of ability to pay.	Multi-tiered plans in the ACA exchanges with big differences in premiums and out-of-pocket costs. Public subsidies available to offset some, but not all, costs.
Comprehensive benefits, no restrictions on covered benefits based on insurance company prerogatives.	Minimum set of benefits required, but insurers can still design plans to cherry-pick healthier enrollees, have a wider latitude in what they cover and many pretexts for denying claims.
Free to use any provider and/or facility.	Limited to provider networks, insurers may still charge much higher fees for going to doctors outside of network, and exclude some top-tier hospitals.
Single goverment payer facilitates adminstrative simplicity and cost savings by eliminating complex billing systems.	Administrative complexity because of numerous insurers and payers and emphasis on profits, administrative costs far higher than for Medicare.
Supports bulk-purchasing of drugs and medical devices.	Fragmented purchasing of drugs and medical devices, government barred from negotiating lower drug prices.
Cost savings would equal more money for medical care (comprehensive benefits).	Diverts money that could be used for healthcare to insurers and administrative waste.

Sample Resolution in Support of Single-Payer National Health Insurance

WHEREAS, 48 million Americans lacked health insurance in 2012[1], and an estimated 31 million Americans will remain uninsured in 2023[2], and

WHEREAS, the United States ranks last out of 19 high-income countries in preventing deaths amenable to medical care before age 75[3], and

WHEREAS, underinsurance is growing as many patients are forced into insurance plans with high-deductibles (> $1,000) and narrow networks of providers[4], and

WHEREAS, the United States spends twice as much per capita on health care as the average of wealthy nations that provide universal coverage[5], and

WHEREAS, medical bills contribute to 62% of all personal bankruptcies,[6] and medical bankruptcy did not fall in Massachusetts after that state's implementation of reform in 2006[7], and

WHEREAS, 75% of people bankrupted by medical bills had private insurance at the onset of illness or injury, and

WHEREAS, private insurance companies consume, on average, 13% of premiums in overhead compared to fee-for-service Medicare's overhead of under 2%[8], and

WHEREAS, providers are forced to spend tens of billions more dealing with insurers' billing and documentation requirements[9], bringing total administrative costs to 31% of U.S. health spending, compared to 16.7% in Canada[10], and

WHEREAS, the U.S. could save over $380 billion annually on administrative costs with a single-payer system[11], and

WHEREAS, the savings from slashing bureaucracy would be enough to cover all of the uninsured and eliminate cost sharing for everyone else[12], and

WHEREAS, a single-payer system could control costs through proven-effective mechanisms such as global budgets for hospitals and negotiated drug prices[13], thereby making health care financing sustainable, and

WHEREAS, a single-payer reform would reduce malpractice lawsuits and insurance costs because injured patients would not have to sue for coverage of future medical expenses, and

WHEREAS, a single-payer system would facilitate health planning, directing capital funds to build and expand health facilities where they are needed, rather than being driven by the dictates of the market, and

WHEREAS, a single-payer reform would dramatically reduce, although not eliminate, health disparities. The passage of Medicare in 1965 led to the rapid desegregation of 99.6% of U.S. hospitals[14], and

WHEREAS, a single-payer system would allow patients to freely choose their doctors, give physicians a choice of practice setting, and protect the doctor-patient relationship, and

WHEREAS, there is single-payer legislation in both houses of Congress, H.R. 676 and S. 1782, and

WHEREAS, Vermont passed legislation in 2011 to create a "pathway to single payer" in that state starting in 2017, the soonest allowed under federal law, and many other state legislatures are considering similar legislation, therefore

BE IT RESOLVED that ________________ express its support for universal access to comprehensive, affordable, high-quality health care through single-payer national health insurance, including single-payer legislation at the state level.

References

1. "Income, Poverty and Health Insurance Coverage in the U.S.: 2012," U.S. Census Bureau, September 2013.
2. CBO's "Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," May 2013.
3. Nolte E, Ph.D., and McKee CM, M.D., "Measuring the Health of Nations: Updating an Earlier Analysis," Health Affairs, January/February 2008.
4. Kaiser Family Foundation/Health Research & Educational Trust (HRET) 2013 Employer Health Benefits Survey.
5. Woolhandler S, M.D., et al. "Paying for National Health Insurance – And Not Getting It," Health Affairs 21(4); July/August 2002.
6. Himmelstein DU, M.D., et al., "Illness and Injury as Contributors to Bankruptcy," Health Affairs Web Exclusive, Feb. 2, 2005.
7. Himmelstein DU, et al., "Medical bankruptcy in Massachusetts: Has health reform made a difference?" American Journal of Medicine, March 2011.
8. Sullivan K, J.D., "How to Think Clearly about Medicare Administrative Costs: Data Sources and Measurement," Journal of Health Politics, Policy and Law, Feb.15, 2013.
9. Morra D, M.D., et al., "U.S. Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers," Health Affairs, August 2011.
10. Woolhandler S. "Cutting Health Costs by Reducing the Bureaucracy," New York Times, Nov. 20, 2011.
11. Woolhandler S, et al., "Costs of Health Administration in the U.S. and Canada," NEJM 349(8), Sept. 21, 2003.
12. Friedman G, Ph.D., "Funding H.R. 676: The Expanded and Improved Medicare for All Act. How we can afford a national single-payer health plan," July 31, 2013, online at www.pnhp.org
13. Marmor T, Ph.D., and Oberlander J, Ph.D., "From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy," Journal of General Internal Medicine, March 13, 2012 (online).
14. Himmelstein DU, and Woolhandler S, "Medicare's Rollout vs. Obamacare's Glitches Brew," Health Affairs blog, Jan. 2, 2014.

Download this resolution at http://www.pnhp.org/sampleresolution.pdf.

August 2, 2013

Price-posting: Oh look! Another health care cost 'solution' gimmick

By Victoria Powell, MS4

The Surgery Center of Oklahoma has been in the spotlight recently because of its decision to post all of its prices for its procedures online. This has been heralded as increasing transparency in health care costs and implicitly demonizes other hospitals in the area that haven't followed suit, like traditional academic centers.

Why haven't hospitals done this a long time ago, so the uninsured can bargain shop for their knee replacement instead of being stuck with a huge bill they'll have to go into bankruptcy to afford? It's an attractive idea, especially when presented as oversimplified as it has been to the public.

In isolation, price-posting is just another market-based artifice, more zeitgeist of our accelerating entrenchment in our broken, healthcare-as-commodity model than any real solution. Nothing illustrates it better than this quote in the New York Times opinion piece from the co-founder of the Surgery Center himself: "Patients are holding plane tickets to Oklahoma City and printing out our prices, and leveraging better deals in their local markets."

HOLD UP DOC. There are a few BIG assumptions here:

1. The medical procedure you need is known to you in advance – that is, it isn't an emergency.
2. You have the ability to pay SOMETHING, but either don't have insurance or lack specific coverage for the procedure, etc.
3. You are physically and mentally able to bargain shop for the health care you need. There are many people who need health care services who aren't able to do this – people with dementia requiring long-term care, a person in a coma from a car accident, a person with a debilitating psychiatric problem – it's not hard to bring examples to mind.

We find that what this really represents is a very specific marketing tactic to a targeted audience – mostly healthy people who need elective surgery to improve their quality of life. Clearly a very important demographic, but it's by no means representative of everyone seeking health care.

This approach might works for certain places, like outpatient surgery centers, because they don't have to deal with people who can't pay. They can throw their hands up and say, "Don't blame us! This is a fair deal. Our prices are listed with no small print – pay or don't receive services." These are not hospitals – they are centers that offer specific, non-comprehensive services.

Meanwhile, other hospitals in the area, like Oklahoma University Medical Center, take care of people who can't pay.

The NYT opinion piece basically sums up the problem of health care costs as a lack of knowledge on the part of the consumer. That IS a problem, but the real problem is summed up simply in one word: profit.

Victoria Powell

When there is a market-based health care system like there is now, we get comical (but tragic!) comparisons like the NYT piece where finding cheap airline tickets through Kayak is used as analogy to "shopping" for health care.

Anyone without a stake in the current system, any American that needs life-saving services, anyone with the presence of mind to take a step back and examine things in context will see this is just. another. tired. gimmick.

The beginning of a real solution to the health care cost problem requires the following steps, in order:

1. Recognize every single person's fundamental vulnerability to disease and death, THEN
2. Affirm health care as a human right, NOT a commodity that is only available to those that can afford it, THEN
3. Change the system into an "Ultimate Public Utility" model – because it's something that we ALL benefit from, and are (mostly) unable to predict when we will require, THEN
4. Realize that a publicly funded, Single Payer model – improved Medicare for everyone – is the NECESSARY BUT NOT SUFFICIENT next step.

I've noticed some Single Payer advocates start to falter when they present Single Payer as the ipso facto solution for every healthcare-related problem. It will not be like that. Very little will change for the average person if we just decide tomorrow to extend Medicare to cover everyone. A Single Payer system's REAL power is providing the ONLY framework that will allow us to collate our bloated, fragmented system into one that can be examined and systematically changed in response to population needs. More fundamentally, it is the only one in which population needs can be accurately assessed in the absence of profiteering. It will be a quicker, more centralized, more responsive system because it is structured to be resistant to conflicts of interest. The goal of a Single Payer system is to provide necessary health care to everyone, NOT quibble about piecemeal, temporary gimmicks like price-posting.

Victoria Powell is a 4th-year med student at Virginia Commonwealth University in Richmond, Va.

SALON

August 5, 2013

Your doctor copays are too high!

By Adam Gaffney, M.D.

We've chosen a cost-sharing system of high-deductible health care. Here's why it's grossly unfair to Americans.

Until recently, the high-deductible health insurance plan – pay less up front, and more when you get sick – was something of a novelty product, marketed to the young and healthy. Now, however, high-deductibles are rapidly going mainstream – whether for young or old, professionals or poor alike.

Let's say that you are in the market for a health insurance plan for your family. Perusing the choices on United Health's website, you play it safe, avoid the plan labeled "high-deductible," and settle on the company's "comprehensive plan," so-called "Copay Select."

You expect a hefty annual premium, but are surprised to learn that after the premium is paid, you will still have a sizable deductible – money to be paid out-of-pocket for services ranging from lab tests to surgery – starting at $1,000 and ranging up to $12,500 per year. You may then be susceptible to "co-insurance" – additional out-of-pocket expenses of up to 30 percent of your medical bills –with maximums reaching as high as $10,000 per year. Then there are copays for visits to the doctor, as well as four "tiers" of cost sharing for prescription drugs.

Realizing that such expenses might turn a medical illness into a financial catastrophe, you consider waiting to 2014, when you can buy health insurance through the new exchanges created under the Affordable Care Act (ACA). You would, however, be disappointed to learn that the mid-level "silver" plans offered on the exchange are only required to cover 70 percent of your annual health care expenses. Out-of-pocket "cost-sharing" – in the form of copays, deductibles, or co-insurance – could go as high as $12,700 a year for your family, depending on your income.

Now those fortunate enough to have insurance through their employer might hope to be free from this phenomenon. The protection, however, is only partial, as plans in the employer market have been trending in a similar direction for years. Between 2006 and 2012, for instance, the percentage of covered workers with a deductible of $1,000 or more tripled, as did those with a deductible of more than $2,000.

Even those sufficiently impoverished to be eligible for public assistance are not immune: in January, the administration moved to allow states to charge Medicaid patients higher copayments for drugs, emergency room use and doctor's visits.

Welcome to Copay Country.

To understand the origins of this new era of "cost-sharing," we have to look back to the 1970s, when the rising costs of American health care became for the first time the predominant concern of policymakers.

Dr. Adam Gaffney

During that decade, accelerating health care inflation was superimposed on economy wide-stagflation, a situation that only got worse after the expiration of Nixon's health care sector price controls in 1974. From 1970 to 1980 health care spending jumped from $75 billion to $256 billion, an increase from 7.2 percent to 9.2 percent of GDP. The health care cost crisis was born.

The idea of "cost sharing" is neither a new idea, nor a universal one. Nixon's 1971 health care plan, for instance, featured deductibles and copayments as well as a cap on annual expenses. The British National Health Service, conversely, has since its inception made health care free at the point of service.

Those who support cost sharing argue that it reduces overall health care spending by deterring patients from seeking unnecessary health care, or – more recently – by pursuing less expensive care from competing providers. Those who oppose cost sharing, on the other hand, argue that the incentive to save could also serve as a disincentive to seek care, as well as a financial liability for many working-class families.

To address these concerns, in the late 1970s the federal government funded the "Rand Health Insurance Experiment," a difficult-to-perform study that has not been repeated, and which continues to inform discussions on the topic today. The experiment assigned – at random – 3,958 people aged 14 to 61 to one of four categories of health insurance: a "free plan" with no cost sharing, and three other plans with variable degrees of cost-sharing in the form of copays, deductibles and co-insurance.

Some of the results were predictable. Those who had to pay each time they used health care, for instance, used less of it, making about a third-fewer visits to the doctor and being hospitalized about a third less. But notably, for the group as a whole, such cost sharing didn't seem to worsen overall health outcomes. The experiment has subsequently been used to argue that there was a potential free lunch to be had: cost sharing could decrease overall spending, and no one would get hurt in the process.

(continued on next page)

*(**Gaffney**, continued from previous page)*

Of course, there was some fine print. First, even at the time of publication, when the researchers looked specifically at the group of patients with low income and elevated health risks, the results were concerning: within this group, those who were in the cost sharing plans, as compared to the free plans, had worse vision as well as higher blood pressure. In fact, the researchers calculated that they had an increased risk of dying as a result of cost sharing.

Furthermore, later evaluations demonstrated that while cost sharing clearly reduced health care usage, it reduced both "appropriate care" (for instance, effective care for acute conditions) and "inappropriate care," not a surprising fact given that patients generally trust the advice of their physicians, and are usually not equipped to decide which care is necessary and which is dispensable.

More modern research on cost sharing has raised even more concerns. When it comes to prescription drugs, for instance, a 2007 study in the Journal of the American Medical Association demonstrated that cost sharing results in lower rates of medication usage, with worse adherence to prescribed regimens. Additionally, those with higher cost sharing seemed to use more non-drug medical services – in particular patients with heart failure and schizophrenia – suggesting that not taking medications might be increasing medical costs in other ways.

Cost sharing frequently also puts individuals and families in extremely unenviable situations: should I go for the follow-up CT scan and make sure that some small growth isn't developing into a cancer, or should I pay my rent? A 2011 study published in the journal Health Affairs looked at the effect of "high-deductible plans" (defined as plans with a $1,000 or more deductible) on families in which one member was chronically ill.

Almost half of the families with a high-deductible plan – more than double that of families in traditional plans – had substantial financial burdens, such as having difficulty paying basic bills or having to set up payment plans. Cost sharing may also cause some families to avoid care altogether: a 2012 study published by some of the same researchers demonstrated that high-deductible plans were associated with an increase in delayed or forgone care, both for adults and children.

Cost sharing, it is becoming increasingly clear, may not be a free lunch after all, particularly for those who have to pay for it.

But putting aside the empiric data for a moment, there is also something deeply counterintuitive about the underlying logic of cost sharing: that someone who is sick – frequently operating under significant physical, psychological, or financial constraints – will be able to impartially dissect the rationale for his or her doctor's recommendations, parse the nuances of the frequently controversial and incomplete medical evidence, and safely decline only the unneeded medical interventions. That the same individual – so the theory goes – will simultaneously engage in a lifelong hunt for high-quality but bargain-priced deals among competing groups of laboratories, doctors, pharmacies, drug-manufacturers, hospitals, dialysis providers, imaging centers, and medical supply companies.

Such an expectation is – to put it modestly – entirely unrealistic. But even worse, it is grossly unfair to the sick patient.

Regardless, unless things change, the future promises only more and more cost sharing. In addition to the trends already in place, in 2018 another provision of the ACA will go into effect – a 40 percent excise tax on high-cost insurance plans, defined as family plans costing more than $27,500, or individual plans costing more than $10,200. These are no doubt very expensive plans by today's dollars, and if this provision went into effect today, few would be affected. But over the years, as a result of continued health sector inflation, more and more plans will begin to hit that ceiling. And when they do, it will not be in the employer's or insurer's interest for them to go any higher: further increases in the cost of care will simply take the form of more and more cost sharing. As the New York Times reported in May, many companies are already increasing copays and deductibles now, so that they can remain below the threshold when 2018 hits.

Understanding the logic of this tax is crucial: its purpose is not to raise revenue, but to contain costs by limiting the scope of benefits under these so-called "cadillac plans." But the problem is that costs are contained only by dumping more of the price of care onto us when we get sick, forcing us to either decline care, or theoretically to find cheaper alternatives.

The logic of cost sharing is therefore essentially the logic of health care consumerism, increasingly a dominant mantra in political and health policy circles. Make the patient a consumer, and the system will be saved.

Yet, the United States already has more health care "consumerism" and cost sharing than other developed countries – and yet we have much higher costs. The truth is that there are safer and better-proven methods of cost control that we could employ, and which wouldn't involve making a patient pay every time he or she gets sick.

We could, for instance, allow Medicare to directly bargain with drug companies over prescription drug prices, as other wealthy countries already do: by one estimate, the savings from this reform alone could range from $230 to $541 billion over ten years.

More ambitiously, we could work towards a "single payer system," which could save billions through reduced administrative and clerical expenditures, while allowing costs to be directly controlled through global budgets and fee schedules. Gerald Friedman, an economist at the University of Massachusetts at Amherst, recently estimated the savings of such a system at $592 billion annually.

At the same time, we are of course obliged to continue to move away from procedures and tests with high cost and little health benefit, both through physician and patient education.

But rather than borrow these and other ideas from better performing health care systems, we are only making our system more and more like itself.

"Copay Country," in other words, is not an inevitability – it is a choice. But is it really the country we want to become?

Adam Gaffney is a physician and writer in Massachusetts.

Canadian HealthcareNetwork.ca

August 1, 2013

Canadians should beware of Americans bearing 'activity-based funding'

By Johnathan Ross, M.D.

Many American physicians, myself included, support single-payer national health insurance, with global budgets for hospital care. A single, publicly accountable payer, coupled with global hospital budgets, are tools needed to assure cost control in health care systems.

But I was recently reminded by one of my Canadian colleagues that some American "reforms" are getting a hearing north of the border. One of these is that hospitals should be paid by case-based activity fees rather than global budgets.

In the U.S., we bundle clinically similar care into diagnosis related groups (DRGs), and the money follows the patient. We pay hospitals according to the fee assigned to each DRG. I would advise extreme caution and careful assessment of the implications for cost, quality, access, equity and efficiency before adopting this hospital funding model.

In Canada, I'm told you call this "activity-based funding" or ABF. Depending where you live, this method of funding may be called patient-focused funding, payment by results, volume-based funding, service-base funding, case-mix funding, or prospective payment system. But no matter what you call it, ABF has serious side effects.

One of the dangers is that ABF can be used to "game the system." When you pay hospitals according to diagnosis, the incentive is to increase or otherwise modify your diagnosis so your hospital will make more money. And that's exactly what happened when the United States implemented ABF for U.S. Medicare patients.

Here in the States, we have a small army of nurses reviewing every case in hospital to remind us to use special words just the right way so we can get more money for each case, regardless of whether we have done anything different in managing our patients.

For example, it is not enough to say that patient has lost weight and looks ill. Instead physicians must use the term "malnourished." It's even better if you order a blood test to prove the obvious, even if that test does not change the diet ordered for the patient, or your case management.

The incentive is to list all of the diagnoses you can possibly list for every patient, as some of these will increase the payment even if it does not change your management one bit. These are "complicating conditions" and can increase payment even if they change none of your orders or tests.

All day, every day, nurses are caring for charts rather than for patients at every U.S. hospital. This is what activity-based funding will buy you.

Of course, there will also be pressure to discharge patients sicker and quicker in order to create more cases. You can expect that you will need added extended care rehabilitation beds. There will be demand for added bricks and mortar to build rehab facilities for patients who could more efficiently spend another few days in a hospital bed getting rehabilitation before going straight home. This transfer makes no sense at all unless you already happen to have excess empty rehab beds in a community. It also diverts the patient to a facility where the patient's physician team does not regularly visit. If physician care is still needed during the rehab stay, the access to those physicians will be impaired, disrupting continuity of care.

Your length of hospital stay will decrease, but the added costly days will just happen in a different costly building, with another costly set of therapists, working under another costly set of administrators.

If the hospitals game the codes upward, then you need another army of regulators to catch them and code them back down. This version of the popular video arcade game, "Whack-a-Mole," continues in U.S. hospitals to this day. There is now a large hospital bureaucracy whose job it is to up-code the severity of illness of Medicare patients and another large Medicare bureaucracy trying to figure out how to stop the hospitals from gaming the system.

The game of up-coding has been getting significant attention in the U.S. press, where the extreme disparities in hospital costs and insurance payments are making headlines. Surely, Canadians wouldn't want this administrative nightmare in their own health care system.

If you want to use financial incentives to change behavior in health care, you need to be clear about what you want. How about rewarding staying within budget without patients feeling a loss of access to needed care or reduced quality? How about rewarding providers for reducing the number of premature deaths related to treatable illness? Canadians should ask themselves what they want before implementing activity-based funding.

Winston Churchill is rumored to have said, "You can always count on the Americans to do the right thing … after they have exhausted all the other possibilities." I would beware of American consultants bearing gifts such as case-based payments for hospitals as a cost-saving idea. Count your blessings, Canadians, and get to work improving the effective system that you have!

Dr. Johnathon Ross is past-president of Physicians for a National Health Program, a U.S. physician organization that supports Medicare for all. He teaches and practices primary care internal medicine at a 500-bed teaching hospital in Toledo, Ohio.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

September 24, 2013

Mine workers are fighting for our health care and basic human rights

By Ed Weisbart, M.D.

The following are the prepared remarks of Dr. Ed Weisbart for a speech he delivered to a rally sponsored by the United Mine Workers of America in St. Louis on Sept. 24.

Some of my colleagues have asked me why a physician organization would be participating in a labor rally. Let me explain this.

I am here today because of a 57-year-old woman having what she knew to be her second heart attack. Instead of going to the emergency room as most people would, she went home to die rather than risk a $50,000 hospital bill. She knew that a huge medical bill would mean bankruptcy and eviction, but that if she just died at home her mortgage insurance would pay the house off and her son would have a place to live.

I am here today because of my 32-year-old diabetic patient who can only afford to take his insulin three days a week. Without his insulin he'll need dialysis in two to three years. Only at that point, when his illness becomes a catastrophe, will our system start to pay for his care, including his dialysis, at $70,000 per year. And, by the way, his insulin.

This is like seeing a small leak in your roof and waiting for it to cave in before doing anything about it. I'll bet there are even more striking parallels in coal mining.

I am here today because of the 64-year-old grandmother whose blood pressure had been well controlled for many years but now it's 180/115. I asked her what had changed, and she told me she was on her final eviction notice and could no longer pay her rent, buy food for the three grandchildren living with her, and also continue to buy her medications. She said she cannot permit her grandchildren to be homeless. She asked me, "So, Dr. Weisbart, how long can I live without taking my medications?"

I never want to hear that question again.

Every year, 1 out of 3 Americans goes without medical care because of the high cost. Most of them have medical insurance.

Every day, over 100 Americans die because of not having insurance. No one in the rest of the modern world dies from this.

Every American is one illness away from bankruptcy. You have a job, you have insurance, you get sick, you're unable to work so you lose your job, you lose your insurance, with no way to pay your medical bills you declare bankruptcy, and the rest of us are on the hook for these outstanding debts. 62 percent of bankruptcies are triggered by medical expenses, and 78 percent of them had insurance at the beginning of the illness.

These problems make a mockery of the notion of "American exceptionalism." We are now the exception in the modern world, in the worst possible way. We are the only place where a diabetic can't afford his life-saving insulin, where a working mother would choose to die rather than burden her family with a hospital bill, and where a grandmother would need to trade her health for her grandchildren's roof.

Gary Otten

Dr. Ed Weisbart

This is not the United States of America that I believe in. This is not the American Dream. And this is not the United States of America that labor built.

You have built a nation where child labor is nearly unthinkable, where decent working conditions are the law of the land, and where workers expect – and demand – a living wage.

You have joined the struggle to build a nation where health care is a human right, where this right is not on the negotiating table to be traded against a decent living wage, and where the rich can't get richer by blocking your ability to get your medicine, to see your doctor, and to have your life saved in a hospital.

You have joined the struggle for single-payer health care.

My organization, Physicians for a National Health Program, believes the solution to our crisis is right before us: Medicare. It's not perfect today, but almost every senior would fight long and hard to keep it. Let's improve Medicare and provide that to each and every American, no matter their age or background.

There's a bill in Congress, Rep. John Conyers' H.R. 676, the "Expanded and Improved Medicare for All Act," that would do exactly this. It's got 48 co-sponsors and growing. We need such law – urgently. Please, ask your U.S. congressional representative to co-sponsor H.R. 676.

With everybody in, and with nobody out, health care would finally become the human right we know it to be.

Thank you for your struggle. You are fighting for your right to health care, you are fighting for my right to health care, and you are fighting for every single American's basic human rights.

Physicians for a National Health Program is honored to walk beside you.

Dr. Ed Weisbart is the chair and a founding member of the Missouri chapter of Physicians for a National Health Program.

Cancer

Market Spiral Pricing of Cancer Drugs

Donald W . Light, PhD[1]; and Hagop Kantarjian, MD[2]

Every patient with cancer or another life-threatening disease wants the most effective treatment, but drug prices have become staggering. Twelve of the 13 new cancer drugs approved last year were priced above $100,000 annually (Table 1), and a 20% copayment makes them unaffordable, even for well-insured patients.[1]

What determines the escalating prices of cancer drugs? Pharmaceutical experts often cite the high research costs and the benefit or added value of the new cancer drug. We believe that neither argument is well-founded and that pharmaceutical companies may be using a third strategy: constantly raising prices on last year's drugs and then pricing new ones above the new market price level; this is known as the Market Spiral Pricing Strategy.

The industry-sponsored estimate of average research costs to get a drug to market is $1.3 billion, including the cost of failures.[2,3] Such estimates may be significantly inflated:[4]

- First, half of this industry estimate is not research costs, but a high estimate of profits that companies would have made if they had not invested in research in the first place. There are good reasons for subtracting these "profits foregone" as not real research costs, which brings the average down from $1.3 billion to $650 million.
- Second, taxpayers subsidize about half of company research through various credits and deductions (though companies make sure no one can get an accurate figure). This brings the average cost down to $325 million.
- Third, this industry estimate was made on the most costly fifth of new drugs and then misattributed to all drugs. Correcting for this brings the average down by 30%, to $230 million.
- Fourth, a few costly projects always distort the average cost; therefore one should use the median, which is 26% less than the average. The average is now down to $170 million.
- Fifth, there is no accurate estimate of basic research to discover new drugs because it varies so much; so an unverifiable high estimate was added that made up at least a third of the total. More than 84% of all basic research for discovering new drugs comes from the public, who also bear all the high risk.[5] After deducting taxpayer subsidies, companies spend only about 1.3% of revenues on basic research and the rest on developing minor variations or testing.[6] Removing that basic-research inflator brings the net median corporate research costs down to just $125 million (plus the variable costs of basic research).

Although such calculations are subject to unknown variables or factors that could alter the final estimates, the statement that "it costs $1 billion to develop a drug to market," which has been repeated so often that it is accepted as a solid truth, is in fact a significant overestimate. Andrew Witty, chief executive officer of GlaxoSmithKline, stated in a recent health care conference in London (March 2013) that the $1 billion cost to develop a drug is "one of the great myths of the industry."[7]

In the case of cancer drugs, most of the basic research and many clinical trials are paid by the National Cancer Institute and foundations, all free to companies. Further, clinical trials in cancer are smaller and shorter than trials for other diseases, so trial costs should be smaller too.[8] In sum, there is no credible evidence that the net costs of the major companies for cancer research are not lower than research costs for other drugs. Consequently, cancer drugs should be priced lower .

The added-value argument for unaffordable prices is not supported by objective data. Most new cancer drugs provide few or no clinical advantages over existing ones. Only one of the 12 new anticancer drugs approved in 2012 provides survival gains that last more than 2 months (Table 1).

Corresponding author: Donald W. Light, PhD, Edmond J. Safra Center for Ethics, Harvard University, 124 Mount Auburn Street, Suite 520N, Cambridge, MA 02138; dlight@ethics.harvard.edu

[1]Edmond J. Safra Center for Ethics, Harvard University, Cambridge, Massachusetts; and [2]Leukemia Department, University of Texas MD Anderson Cancer Center, Houston, Texas

DOI: 10.1002/cncr.28321, **Received:** June 11, 2013; **Revised:** July 18, 2013; **Accepted:** July 22, 2013, **Published online** September 3, 2013 in Wiley Online Library (wileyonlinelibrary.com)

TABLE 1. Prices of Anticancer Drugs Approved by the Food and Drug Administration in 2012

Drug (Trade Name; Company)	Indication	Approval Basis	Dose	Monthly or Per-Cycle Cost
Axitinib (Inlyta; Pfizer)	Metastatic renal cell carcinoma	2-mo PFS benefit compared to sorafenib	5 mg orally twice daily (can be increased to 10 mg orally twice daily)	$10,584 (up to $21,168)/mo
Enzalutamide (Xtandi; Astellas)	Metastatic prostate cancer	5-mo OS benefit compared to placebo	160 mg orally daily	$8,940/mo
Ziv-aflibercept (Zaltrap; Sanofi-Aventis)	Metastatic colorectal cancer	1.5-mo OS benefit compared to placebo (combined with chemotherapy)	4 mg/kg IV every 2 weeks	$15,360/mo (two 200-mg vials per dose; 80 kg)
Regorafenib (Stivarga; Bayer)	Metastatic colorectal cancer	1.4-mo OS benefit compared to placebo	160 mg orally daily for 21 of 28 days	$11,220/mo
Pertuzumab (Perjeta; Genentech)	Metastatic breast cancer	6-mo PFS benefit compared to placebo (combined with chemoimmunotherapy)	420 mg IV every 3 weeks (maintenance dose)	$4,890/3 weeks
Cabozantinib (Cometriq; Exelixis)	Metastatic medullary thyroid cancer	7-mo PFS benefit compared to placebo	140 mg orally daily	$11,880/mo
Vismodegib (Erivedge; Genentech)	Basal cell carcinoma	Objective response rate	150 mg orally daily	$9,000/mo
Carfilzomib (Kyprolis; Onyx)	Multiple myeloma	Objective response rate	20 mg/m^2 on days 1, 2, 8, 9, 15, and 16 every 28 days	$11,937/mo (1.8 m^2)
Bosutinib (Bosulif; Pfizer)	Chronic myeloid leukemia	Objective response rate	500 mg orally daily	$9,817/mo
Ponatinib (Iclusig; ARIAD)	Chronic myeloid leukemia	Objective response rate	45 mg orally daily	$12,900/mo
Omacetaxine (Synribo; Teva)	Chronic myeloid leukemia	Objective response rate	1.25 mg/m^2 subcutaneously every 12 hours for 14 days per month until hematologic response	$28,056/mo for 14-day cycles; $14,028/mo for 7-day cycles (1.8 m^2)
Vincristine sulfate liposome (Marqibo; Talon)	Acute lymphoid leukemia	Objective response rate	2.25 mg/m^2 IV weekly	≈$12,000/cycle
Glucarpidase (Voraxase; BTG International)	Methotrexate toxicity	Rapid and sustained clinically important in plasma methotrexate concentration	50 units/kg	$108,000 (80 kg)

Abbreviations: IV, intravenous; OS, overall survival; PFS, progression-free survival.

Some economic experts argue that, in a free-market economy, pricing is based on "what the market will bear," which will, in the long run, settle prices at reasonable levels. However, there appears to be no free-market forces, but rather what seems to be monopoly rights to charge similarly high prices, even when several cancer drugs are available for the same cancer indication. Although 90% of oncologists state they would prescribe a cheaper drug for their patient if there are 2 drugs of similar efficacy and toxicity profiles, there are not enough drug price sensitivities (or differences) to allow oncologists or patients to select drugs based on costs savings.

In the past 5 years, companies have doubled the prices for cancer drugs, and have increased prices every year on older drugs rather than reduce them.[9] Other countries do not allow such increases.

Market spiral pricing impoverishes desperate patients, strapped taxpayers, and struggling employers. It threatens universal access to critical care for patients facing death. Congressional hearings on spiraling prices for specialist drugs, based on the myths of greater added value and unsustainable research costs, are badly needed. In fact, the dollars that companies have put into research over the past 15 years have generated 6 times more revenues.[10] Independent studies show that companies recover all costs and make a reasonable profit at Canadian and European prices, but still charge Americans twice as much or more.[4]

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 included legislation prohibiting Medicare from negotiating drug prices.[11] This legislation, probably influenced by the pharmaceutical lobby, contributed to high drug prices and, when implemented in 2006, was associated with an immediate increase in pharmaceutical company profits.[12] An analysis by Dean Baker, a well-known economist, suggested that allowing Medicare to negotiate drug prices could save $40 billion to $80 billion annually.[13] Congress should eliminate the prohibition against Medicare negotiating discount prices on drugs; this could save the health care industry billions of dollars annually and avoid a lot of grief for patients.[11,13] Congress should also prevent companies from delaying access to generic drugs, which would not only relieve millions of patients, but would also save on average $80 billion to $100 billion annually, and would foster more innovation, because patents generate more innovation by ending, not by perpetuating, monopoly pricing. Oncologists would then be able to treat their patients with drugs they can afford.

CONFLICT OF INTEREST DISCLOSURE

Dr. Light has received a consultant fee from Redburn Ltd. (UK), and has received speaker fees from PNHP (Physicians for a National Health Plan). Dr. Kantarjian made no disclosure.

REFERENCES

1. Kantarjian HM, Fojo T, Mathisen M, Zwelling LA. Cancer drugs in the United States: *Justum Pretium*--The just price. *J Clin Oncol.* 2013;doi:10.1200/JCO.2013.49.1845.
2. DiMasi JA, Hansen RW, Grabowski HG. The price of innovation: new estimates of drug development costs. *J Health Econ.* 2003;22: 151-185.
3. Vernon JA, Golec JH, Dimasi JA. Drug development costs when financial risk is measured using the Fama-French three-factor model. *Health Econ.* 2010;19:1002-1005.
4. Light DW, Warburton RN. Demythologizing the high cost of pharmaceutical research. *Biosocieties.* 2011;6:1-17.
5. Light DW. Basic research funds to discover important new drugs: who contributes how much? In: Burke MA, ed. *Monitoring the Financial Flows for Health Research 2005: Behind the Global Numbers*. Geneva, Switzerland: Global Forum for Health Research; 2006:27-43.
6. Light DW, Lexchin J. Foreign free riders and the high price of US medicines. *BMJ.* 2005;331:958-960.
7. Silverman, E. Quote of the...Year? $1B Drug Cost Is 'A Myth'. *Pharmalot.* http://www.pharmalive.com/quote-year-1b-drug-cost-myth. Posted March 18, 2013. Accessed July 17, 2013.
8. Keyhani S, Diener-West M, Powe N. Do drug prices reflect development time and government investment? *Med Care.* 2005;43: 753-762.
9. Schondelmeyer S, Purvis L. Rx Price Watch Report, March 2012: Trends in Retail Prices of Prescription Drugs Widely Used by Medicare Beneficiaries 2005 to 2009. Washington, DC: American Association of Retired Persons; 2012.
10. Light D, Lexchin J. Pharmaceutical R&D - what do we get for all that money? *BMJ.* 2012;344:e4348
11. O'Sullivan J, Chaikind H, Tilson S, Boulanger J, Morgan P. Specialists and analyst in social legislation. Domestic social policy division. CRS report for Congress: Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Updated December 6, 2004. Washington, DC: Library of Congress. http://royce.house.gov/uploadedfiles/overview%20of%20medicare.pdf. Accessed July 17, 2013.
12. Rome E. Big pharma CEOs rake in $1.57 billion in pay. Huff Post Business. 2013. http://www.huffingtonpost.com/ethan-rome/big-pharma-ceo-pay_b_3236641.html. Accessed July 17, 2013.
13. Baker D.The savings from an Efficient Medicare Prescription Drug Plan.Center for Economic and Policy Research. http://www.cepr.net/documents/efficient_medicare_2006_01.pdf. Accessed July 17, 2013.

Laurie Wen (left) and New York medical students at PNHP's Annual Meeting.

Third Student Summit, Chicago, April 12

The PNHP student board members are happy to announce the third annual PNHP Student Summit on Saturday, April 12, at Northwestern University - Feinberg School of Medicine in Chicago. The student movement to organize for single payer is growing at a breakneck speed, and this year's summit is anticipated to be the largest to date. The conference is designed and led by the medical students themselves, and will feature both introductory and advanced skill-building workshops for single-payer advocacy. Housing during the summit will be provided at Hostelling International in the Chicago Loop. Registration is $30 and opens on February 3rd.

PNHP members are asked to "sponsor a student" to attend this important gathering of new single-payer advocates. $100 covers a student's registration fee, housing, and meals during the summit. A $200 donation will cover a student's flights to and from the summit. To donate, please go to pnhp.org/skalafund.

For more information, contact Emily Henkels at e.henkels@pnhp.org.

Chapter Reports

In **California**, PNHP members participated in a Los Angeles rally commemorating the 50th anniversary of Dr. Martin Luther King's 1963 march. Shearer Student Fellow Keyon Mitchell was a featured speaker. PNHP California members also participated in a visit to Rep. Alan Lowenthal that resulted in his becoming a co-sponsor of H.R. 676. The state now has seven chapters, including a newly reactivated chapter in Sacramento. In December, PNHP California participated once again in the annual South Los Angeles Health & Human Rights conference at St. John's Well Child and Family Center. The event drew about 200 participants. Keyon Mitchell has pioneered a new form of engaging medical students in PNHP through a weekly Twitter Chat series. Anyone can participate in the Twitter Chats, which focus on a specific aspect of single payer. They take place each week on Sunday at 7 p.m. Pacific time. PNHP members are welcome to contact Keyon at keyon@pnhp.org to learn more.

In the **District of Columbia**, undergraduate student Kaylen Larson produced a 7-minute film under the guidance of Dr. Robert Zarr called "cureALL." The video premiered on YouTube and received over 3,000 views in its first week. The online video, which aims to introduce the concept of single payer to new audiences through social media, has been shared widely through Facebook and Twitter. It's already being used to educate student and community audiences to. You can view "cureALL" at bit.ly/1hAu4gp. To learn more about the project, contact Dr. Zarr at rlzarr@yahoo.com.

PNHP **Illinois** members were very active in speaking engagements throughout the fall and winter. In August, Dr. Claudia Fegan participated in a student-organized debate at the University of Illinois – Chicago School of Medicine with the president-elect of the American Medical Association, a representative from the Chicago Medical Society, and a representative from Doctors for America. Dr. Phil Verhoef participated in a similar debate in a community setting. PNHP members made over a dozen presentations to community and medical organizations. Illinois members also organized to give compelling testimony in support of reversing cuts to Medicaid prescription drug coverage. Chapter leader Dr. Anne Scheetz, in addition to Drs. Kathy Bottum, Phil Verhoef, and Henry Palmer, gave oral and written testimony, and Dr. David Ansell organized ACP support. The chapter brought the one-man play "Mercy Killers" for several performances in the Chicago area and facilitated lively discussions afterward. Drs. Pam Gronemeyer and Oscar Sierra had an exhibitor table at the Region II Student National Medical Student Association 2013 conference. The table was sponsored by PNHP-IL's special fund to support medical-student-of-color organizations. Finally, PNHP Illinois welcomes a new student chapter at Rush Medical School. To hear more about the chapter's current projects, contact Dr. Scheetz at annescheetz@gmail.com

In **Indiana**, PNHP welcomes a new chapter of Hoosiers for a Commonsense Health Plan (HCHP) in the city of Lafayette. Chapter leader Dr. Rob Stone and others participated in several tabling events and grassroots outreach. HCHP was part of a large coalition of organizations in the state that held a rally at the Indiana Statehouse on Nov. 19, calling on lawmakers to support the expansion of Medicaid. Chapter members look forward to another large event in the capital early in the new year. For details or to become involved, contact Dr. Stone at grostone@gmail.com.

In **Maryland**, Dr. Eric Naumburg reports that the PNHP chapter has joined forces with two other groups, United Workers and Healthcare-Now Maryland, to organize a Healthcare is a Right Campaign coalition in the state. The coalition has seven active chapters that meet monthly or bi-weekly. The coalition sponsored its first statewide rally in October. The rally in Baltimore included a marching band and street theater, and garnered media coverage in The Baltimore Sun, a local TV station and The Real News Network. The coalition has established a leadership council of 12 people to plan activities in 2014, including community forums where candidates for office will be invited and asked about their position on health care as a human right. For more information, contact Dr. Naumburg at enaumburg@hotmail.com.

Eric Foster

Dr. Claudia Fegan makes a point during a debate with AMA President-elect Dr. Robert Wah.

The **Massachusetts** PNHP chapter was instrumental in building attendance for the largest-ever Annual Meeting this past November. The recruitment efforts of Drs. Gordy Schiff and Mardge Cohen also helped inspire the formation of new medical student chapters at Boston University and the University of Massachusetts at Worcester. PNHP members at those institutions who want to help support the new student groups are encouraged to reach out to the national office at info@pnhp.org. Just before the PNHP Annual Meeting, Mass-Care and the Massachusetts chapter of PNHP hosted a successful joint fundraising event featuring Noam Chomsky and Dr. Arnold Relmam as speakers. The chapter will host guest speaker Dr. Donald Berwick at its first meeting of 2014

in January. Dr. Berwick, the former head of CMS and a current Massachusetts gubernatorial candidate, has recently spoken out in support of a single-payer system. To get involved in the Boston chapter of PNHP, please contact Dr. Rachel Nardin at rnardin40@gmail.com.

In **Minnesota**, chapter co-chair Dr. Inge De Becker reports that PNHP members have been doing educational outreach and working closely with allies in the Minnesota Legislature, including state Sen. John Marty. She reports that the chapter helped organize events in the Twin Cities for journalist T.R. Reid in September, drawing a crowd of more than 200. Eric Jackson, a second-year medical student at the Mayo Clinic, organized an event at the school for Reid, drawing an impressive turnout of almost 100 people. The chapter has also worked with professional animator Ben Pohl to create an addictive 1-minute video about single-payer organizing in Minnesota, written by Drs. Laurel Gamm and David Dvorak. You can see the clip by visiting the PNHP Minnesota Facebook page or www.pnhpminnesota.org. For more details, contact Dr. De Becker at ingepnhp@gmail.com.

Students from Mayo Clinic with T.R. Reid.

In **Missouri,** chapter chair Dr. Ed Weisbart reports that the state chapter had an outstanding year. Chapter members Drs. Mark Krasnoff, Bill Fogarty, Robert Edmond, Tom Lieb and others spoke to over 55 physician, student, and community groups in 2013, reaching over 1,900 Missourians directly. Many of the invitations were secured by Tom Flanagan. Dr. Weisbart spoke to a rally of 3,000 United Mine Workers of American (UMWA) members who were fighting Peabody Coal in bankruptcy court over health and pension benefits. (The UMWA emerged victorious.) The chapter is also active in media outreach, giving eight radio interviews and one TV interview last year. Drs. Steve Keithahn and Carole McArthur are building the chapter's presence in Kansas City and Columbia, respectively; the chapter, whose e-mail list now boasts 969 contacts, is planning a speaking tour by economist Gerald Friedman; a speaker's training; and outreach to the American College of Physician Executives this spring. For details, contact Dr. Ed Weisbart at pnhpstl@gmail.com or see the chapter website at www.pnhpstl.org.

The **New Hampshire** PNHP chapter continues to grow and has recently welcomed five new members. Steering Committee members are active developing a speakers bureau, a New Hampshire-specific slide set for presentations, and social media projects, and are drafting a single-payer bill to bring to the Legislature. To get active in New Hampshire or learn more, contact Dr. Donald Kollisch at donald.o.kollisch@dartmouth.edu.

PNHP **New Jersey** has seen its busiest year to date. Members have made over 30 presentations to community and medical audiences. Chapter leader Dr. Wink Dillaway reports that the chapter is starting a new website, has built a speakers bureau of six physicians, and has revamped its collaboration with medical students. They are currently a key group in a coalition to promote single-payer legislation in New Jersey. To become involved in the PNHP New Jersey chapter, contact Dr. Dillaway at w.dillaway@gmail.com.

In **New Mexico**, third-year medical student and PNHP board member James Besante's presentation to the state AFL-CIO resulted in their official endorsement of H.R. 676. New Mexico is the 44th state AFL-CIO to endorse single payer. For details, contact James Besante at jamesbesante@gmail.com.

The **New York Metro** chapter has been active through the fall and winter with both regular and special projects. In October, the chapter had its annual retreat, during which members planned priorities for the upcoming year. The New York Metro chapter has been working to get more of its congressional delegation signed up as co-sponsors of H.R. 676, resulting in Reps. Carolyn Maloney and Jose Serrano becoming co-sponsors. Members are also working to get congressional support for H.R. 1102, which would permit Medicare to negotiate with drug companies for lower pharmaceutical prices. The chapter has joined a coalition that opposes cuts in Social Security and Medicare, the "No Bad Grand Bargain Coalition." The coalition's activities have included visits to members of Congress. Some of the chapter's recent successful monthly forums featured a panel on the impending closure of more hospitals in Brooklyn, speakers on the New York and Vermont exchanges, and a presentation from medical historian Ted Brown, whose recent book presents a history of health reform through cartoons. Recently, the chapter also co-hosted a labor breakfast with Rep. John Conyers and Phil Donahue, along with Progressive Democrats of New York and the city's Labor Council. In December, the New York Metro chapter's annual membership meeting drew about 50 people, and elected six new board members. For more details, contact Laurie Wen at laurie@pnhpnymetro.org.

The Healthcare Justice chapter in **Charlotte, North Carolina**, has been recruiting new volunteers to help its work. Dr. Jessica Saxe reports that most of the chapter's activity has focused on Medicaid expansion, which the state continues to reject. In December, chapter members participated in a forum co-sponsored with the Charlotte League of Women Voters on health reform, at which the audience was shown a short version

of "The Healthcare Movie." Several people from the very receptive audience volunteered to get active for health reform. For more information, contact Dr. Saxe at jsaxe@earthlink.net.

In **Rhode Island**, students from Brown University's Alpert Medical School attended the 2013 PNHP Annual meeting in Boston and were inspired to organize a new student chapter. The students had their first event, a showing of "The Healthcare Movie," in December. Dr. J. Mark Ryan is their faculty sponsor. For more information or to get involved in Rhode Island, contact Dr. Ryan at pnhp.ri@gmail.com.

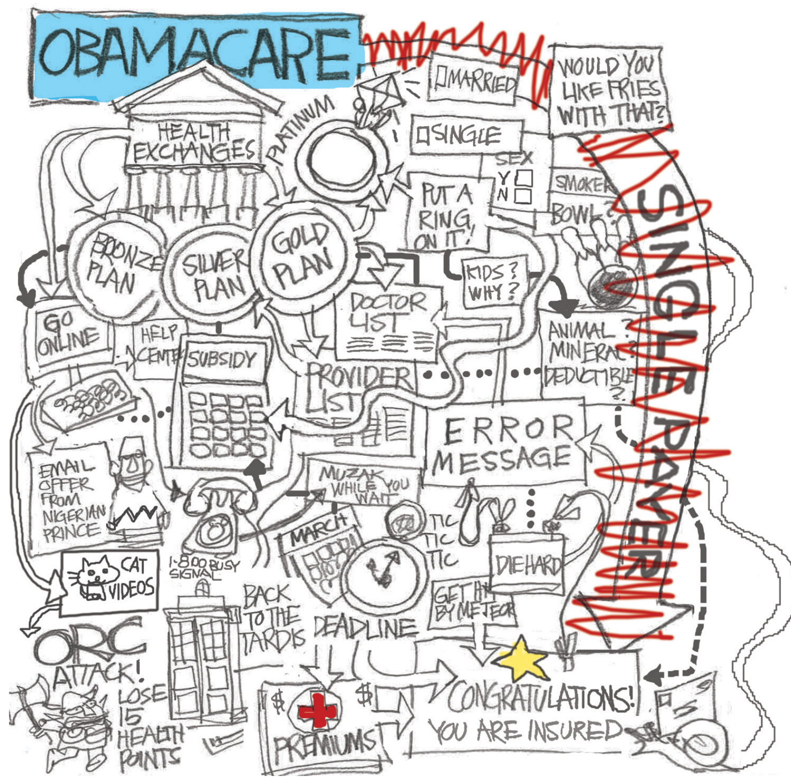
In September, Health Care for All **South Carolina** participated in a forum at the University of South Carolina. The forum was co-sponsored by the USC Colleges of Medicine, Nursing, Pharmacy, and Social Work, as well as the Arnold School of Public Health. The chapter is continuing to build its ranks state-wide. Chapter activist David Ball, RN, has been educating his colleagues about single payer in the U.S. Air Force while on deployment in Afghanistan. To become involved with Health Care for All South Carolina, write to Dr. David Keely at davidkeelymd@comporium.net.

In **Tennessee**, state coordinator Dr. Art Sutherland made several presentations on single payer throughout the fall, including at the University of Memphis School of Public Health, and at Vanderbilt's "Politics of Health" conference. Dr. Sutherland, along with colleagues Dr. Jim Powers and Dr. Garrett Adams, spoke at a plenary session at the annual Healthcare-NOW strategy conference in Nashville in October. Dr. Sutherland also received the Quentin Young Health Activist Award at the 2013 PNHP Annual Meeting in Boston. Two new members of PNHP Tennessee attended the Leadership Training Institute ahead of the Annual Meeting, and are hoping to use the skills gained there to organize an emerging Chattanooga chapter. Dr. Sutherland reports that he plans to get a new local chapter started in the Knoxville/Oak Ridge area in East Tennessee. Physicians living in the area are encouraged to get involved. For details on how to plug in, please contact Dr. Sutherland at asutherland523@gmail.com.

PNHP's **Western Washington** chapter has been instrumental in organizing a new coalition for a Health Care is a Human Right campaign. The new coalition has had two successful planning meetings with participants from almost 20 organizations. Western Washington chapter member Mark Hickling has been working on a video project to be used in single-payer activism in the state. The chapter also continues its successful monthly Skype-in speaker program, featuring guests such as Sergio España from the Maryland Healthcare is a Human Right campaign, Laurie Wen, executive director of the New York Metro PNHP chapter, and Emily Henkels, national organizer of PNHP. Finally, Health Care for All Washington had its annual meeting in November with Dr. John Geyman as speaker. For details on organizing projects in Washington, contact Dr. David McLanahan at pnhp.westernwashington@comcast.net.

Members of the Linda and Gene Farley PNHP Chapter with Sen. Bernie Sanders at Fighting BobFest in September.

In **Wisconsin**, members of the Linda and Gene Farley Chapter of PNHP in Madison mourn the loss of visionary leader Dr. Gene Farley on Nov. 8. Dr. Farley was the co-founder, with his spouse Linda, of the Wisconsin PNHP chapter and a champion of many progressive causes. The chapter is continuing Dr. Farley's dedication to universal, single-payer health care through educational events in the state, including a presentation in the fall from Dr. Claudia Fegan and a tabling event at the Fighting BobFest, an annual progressive fair whose keynote speaker this year was Sen. Bernie Sanders. For more information, contact Dr. Melissa Stiles at wisconsin.pnhp@gmail.com.



THE SIMPLE GOP PLAN FOR THE UNINSURED

NON-PROFIT ORG
U.S. POSTAGE PAID
PHYSICIANS FOR A
NATIONAL HEALTH
PROGRAM

29 E. Madison St., Suite 602
Chicago, IL 60602-4406

Phone: (312) 782-6006
Fax: (312) 782-6007
info@pnhp.org
www.pnhp.org

Address Service Requested