25TH Anniversary
Physicians for a National Health Program

PNHP
Newsletter
Winter 2012

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

PNHP's 25th Anniversary Meeting in San Francisco is largest ever

Over 380 people, including more than 100 medical students, gathered in San Francisco on Oct. 27 for PNHP's largest meeting ever. In addition to sessions on the health care crisis, financing single payer, health care systems in Canada and Europe, state single-payer campaigns and more, there were ad hoc meetings on grassroots organizing, strategy, and medical student outreach. Next year's meeting will be in Boston, Nov. 2, 2013. Save the date!

Single payer in the news

Late-night comedian Jon Stewart, host of "The Daily Show," has been promoting single payer on the air, e.g. telling the CEO of pizza-maker Papa John's that "if Obama had fought harder for single-payer health care, business owners like you would never have to pay another premium in your lives." Bill Maher of "Real Time with Bill Maher" on HBO, and MSNBC's Rachel Maddow also loudly support single-payer on their shows.

Many PNHPers are keeping up the drumbeat for single payer through media interviews and op-eds. Former PNHP President Dr. Claudia Fegan appeared on MSNBC's "Up with Chris Hayes" while Dr. David Scheiner was on CNBC's "Closing Bell" and Dr. Mary O'Brien was a guest on Current TV's "Viewpoint." Dr. Elizabeth Rosenthal's comments opposing Medicare cuts were picked up by news outlets across the country and a profile of PNHP Senior Health Policy Fellow Dr. Don McCanne ran in the Orange County Register (reprinted on page 23). Dr. James Mitchiner's article, "It's time for single payer" appeared in the ACEP News (reprinted on page 10) while Dr. Ed Weisbart's op-ed "America's health care problems were not fixed by Affordable Care Act," appeared in the St. Louis Post-Dispatch.

PNHP's office helped PNHPers publicize research building the case for single payer on several topics, including on pay-for-performance schemes (reprinted on page 20), health care costs for the elderly in the U.S. and Canada (see page 13), and Medicare overpayments to Medicare Advantage plans (see page 38). Coverage by new media, in particular, was widespread, including by the Washington Post's Wonk blog, Health Affairs blog, WBUR Boston Public Radio CommonHealth blog, Politico Pro, and more. Research led by PNHP board member Dr. Danny McCormick showing that patients covered by public programs in Massachusetts face a wide range of cost-related barriers was covered by several prominent news blogs and highlighted in the JAMA.

States on the move – Vermont, Hawaii and California

PNHPers in Vermont are fighting a media campaign against single payer sponsored by the far-right. Vermont Gov. Peter Shumlin, a strong advocate for that state's "pathway to single payer," was re-elected by a large margin. In Hawaii, PNHPer Dr. Stephen Kemble was recently inaugurated as president of the Hawaii Medical Association after that body passed his resolution in support of single payer. Dr. Kemble is working with the Hawaii Health Authority and others to promote a statewide single-payer plan. California PNHPers are developing a new strategy for single payer now that the Democrats have supermajorities in both houses. Stay tuned!

Single payer gains supporters on the Hill

Three new U.S. Senators are sympathetic to single payer; Tammy Baldwin in Wisconsin, Elizabeth Warren in Massachusetts and Mazie Hirona in Hawaii. Warren was a co-author, with PNHP co-founders Drs. Steffie Woolhandler and David Himmelstein, of two studies of medical bankruptcy, including a 2009 article that found that 60 percent of people bankrupted by medical bills had private insurance. The overwhelming majority of H.R. 676 co-sponsors were re-elected while several new single-payer supporters were elected to the House. Members are encouraged to educate their members of Congress about the need for single-payer national health insurance.

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PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2013

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Membership drive update

Welcome to over 512 physicians and medical students who have joined PNHP in the past year! We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community.

PNHPers in Charleston, S.C., Providence, R.I., St. Louis, Sonoma, Calif., and Memphis, Tenn., are starting new PNHP chapters or expanding existing ones. To get involved in a PNHP chapter near you, see the chapter reports, page 61 or contact Dr. Ida Hellander in the PNHP national office at (312) 782-6006 or Ida@pnhp.org.

PNHP will be hosting exhibits at several medical specialty meetings in 2013, including the American College of Physicians meeting in San Francisco, April 11-13; the American Psychiatric Association, also in San Francisco, May 19-21; and the American Academy of Family Physicians, in San Diego, Sept. 24-28. Volunteer to spend a few hours staffing a booth by dropping a note to Matt@pnhp.org.

What PNHP members can do

1. Learn health policy painlessly. Dr. Don McCanne, PNHP's senior health policy fellow, authors a single-payer "Quote of the Day" highlighting significant new research on the health care crisis and the evidence for single-payer reform. It's like getting a Ph.D. in health policy one e-mail at a time and it's invaluable for keeping up on the latest developments in health policy and politics. Subscribe at www.pnhp.org/qotd. The archives are searchable and contain valuable information on everything from cost containment to international health systems.
2. Give a grand rounds at your hospital on health care reform, or invite another PNHP member to speak at a grand rounds or other hospital forum. Updated slides covering the new health law are available at www.pnhp.org/slideshows (password = adams).To invite another member to speak, call the PNHP national office at (312) 782-6006 or e-mail: info@pnhp.org.
3. Arrange a session on health care reform at the next meeting of your medical or specialty society. Introduce a resolution in support of single payer. Sample resolutions are available online at www.pnhp.org/resolutions.
4. Write an op-ed or letter to the editor for your local newspaper, medical specialty journal, or alumni magazine. Dr. McCanne encourages PNHPers to "recycle" his single-payer "Quote of the Day" messages into letters and op-eds for local publication.
5. Meet with your legislators.

It's easy to add PNHP to your will

Updating your will? Please join PNHP National Coordinator Dr. Quentin Young in adding PNHP to your will. You just add a sentence that says, "I bequeath the following _____ (dollar amount, property, or stocks) to the nonprofit organization Physicians for a National Health Program of Chicago, Illinois. Their FEIN # is 04-2937697 and their mailing address is 29 E. Madison, Suite 602, Chicago, IL 60602."

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

UNINSURED AND UNDERINSURED

▸48.6 million people (15.7 percent of the population) were uninsured in 2011, down slightly from 50 million in 2010, according to the U.S. Census Bureau. Another large Medicaid expansion, along with expanded coverage among 19-25 year olds (see below), accounted for most of the drop among adults. There was no drop among children; in 2011, 7 million children were uninsured, 9.4 percent of all children. The share of Americans with private coverage dropped slightly to 63.9 percent in 2011, continuing a three-decade long trend of diminishing private coverage.

Medicaid, the federal-state program which covers health care for some of the poor and long-term care for the poor elderly, expanded during the recession by another 2.3 million people, to 50.8 million people, 16.5 percent of the population.

The number of uninsured adults aged 19-25 dropped by 539,000 in 2011. About 40 percent of those newly covered obtained insurance through a parent's health plan as a result of the 2010 health law. In 2011, 2.3 million adults aged 19-25 were covered by a parent's plan, while 8.3 million people in this age group (27.7 percent), were uninsured.

Hispanics are significantly more likely to be uninsured (31 percent), than Blacks (19.5 percent), Asians (16.8 percent), or non-Hispanic Whites (11.1 percent). ("Income, Poverty, and Health Insurance Coverage in the United States: 2011" U.S. Census Bureau, September, 2012).

According to the National Center for Health Statistics, 34.2 million people who were uninsured in 2011 were uninsured for more than a year, while 58.7 million people were uninsured at least part of the year. (Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2011, CDC, National Center for Health Statistics).

The Congressional Budget Office raised its estimate of the number of U.S. residents who will remain uninsured in 2016 – two years after the key provisions of the health reform law go into effect - to 36 million (with 30 million uninsured over the longer term) due to the potential for some states to opt out of the Medicaid expansion (CBO, 7/24/12).

▸Many doctors do not accept Medicaid payment, compromising access to care for the poor. Nationally, 31 percent of physicians are not accepting new Medicaid patients, compared to less than 20 percent who are not taking new patients with Medicare or private insurance, according to a study in Health Affairs. Moreover, there is wide variation in Medicaid acceptance by state, from over 95 percent acceptance in Minnesota and Wyoming to lows of 57.1 percent in California and 40.4 percent in New Jersey (Decker et al, Health Affairs, 2012).

▸3.1 to 4 million of the 7 million currently uninsured Californians will remain uninsured in 2019. Three-fourths of them will be U.S. citizens or lawfully present immigrants, and half will be eligible for Medi-Cal or premium subsidies but face barriers to enrollment, such as lack of awareness of the program and an inability to afford their share of the premiums. A high proportion of those remaining uninsured (66 percent) will be Latino; over half (57 percent) will have household incomes at or below 200 percent of the federal poverty level (Lucia et al, "After Millions of Californians Gain Health Coverage under the Affordable Care Act, who will Remain Uninsured?" UC Berkeley Center for Labor Research and Education, Sept. 2012).

▸American Airlines is suing to stop providing health care benefits to about 40,000 retirees. The company has $1.37 billion in retiree health benefit liabilities (Koenigh, "AMR sues retired workers over health benefits," AP, 7/6/12).

Although the proportion of people with employer-based health coverage (55.1 percent) stayed about the same in 2011, the scope of employer-based private health benefits has been shrinking. Almost three-fourths (72 percent) of workers with single coverage had a deductible in 2012, up from about half (52 percent) in 2006. At the same time, the average size of the deductible increased 88 percent, to $1,097.

Almost 27 percent of workers under age 65 with employer-sponsored coverage were enrolled in skimpy, high-deductible health plans (HDHPs) in 2011, up from 15.6 percent in 2007. Including those who gained coverage outside of employment, a total of 29 percent of people under 65 with private coverage have HDHPs, including 19.9 percent who lack a health savings account. One-quarter of workers enrolled in high-deductible health plans have a deductible greater than $2,500. Deductibles and other forms of cost sharing have been shown to reduce access to care, particularly for the poor and sick. ("The Prevalence and Cost of Deductibles in Employer Sponsored Insurance: A View from the 2012 Employer Health Benefit Survey" Kaiser Family Foundation, Nov. 2012).

▸Free birth control dramatically reduced unplanned pregnancies and the abortion rate in a study of more than 9,000 women aged 14-45 in St. Louis. IUDs that are effective at preventing pregnancy but costly ($800 to $1,000 for the device and physician's services) became accessible to the study's high-risk enrollees, along with other forms of birth control. Among teens, the annual birth rate was 6.3 per 1,000, far below the U.S. rate of 34.3 per 1,000. Abortion rates among participants ranged from 4.4 to 7.5 per 1,000, far below the rate of 19.6 per 1,000 women nationwide. While the Affordable Care Act's provisions that eliminate cost sharing on birth control and preventive services for women are commendable, they won't apply to the

estimated 15 million women who will be left uninsured after the bill is implemented ("Free birth control cuts abortion rate dramatically, study finds" NBC News Health, 10/4/12).

SOCIOECONOMIC INEQUALITY

▸Despite the worst economic downturn since the Great Depression and a high poverty rate (15.0 percent), only a small share of the population (1.9 percent) received cash welfare (Temporary Assistance to Needy Families, or TANF) payments in 2010. The TANF program replaced the former cash benefits program, Aid to Families with Dependent Children, under President Clinton, but is so skimpy that most families in poverty (11.8 percent of all families) do not receive it (Wall Street Journal, 1/17/12).

▸In Cook County, Illinois, people living in areas with a median income below $25,000 per year have a life expectancy 14 years below people with a median income greater than $53,000. In Orleans Parish, Louisiana, people living in the poorest Zip code, 70112, have an average life expectancy of 54.5 years, 25.5 years below those living in Zip code 70124, where life expectancy is 80 years (Place Matters for Health in Cook County and Place Matters for Health in Orleans Parish, Joint Center for Political and Economic Studies, 2012).

COSTS

U.S. health care spending for 2012 is estimated to total $2.8 trillion, $8,952 per capita, 17.9 percent of GDP (Keehan et al., Health Affairs, June 2012).

▸The average cost of employer-sponsored health insurance in 2012 was $5,615 for single coverage, with the employee paying $951 of the premium, and $15,745 for family coverage, with the employee paying $4,316. Employer health care costs are expected to rise by 5.3% in 2013 (Wall Street Journal, 10/21/12)

The annual Milliman Medical Index (MMI) measures the total cost of health care for a typical family of four covered by a preferred provider plan (PPO). In 2012, the index exceeded $20,000 for the first time. The cost of health care only (excluding administrative costs and profits of insurers) for a typical family of four in 2012 was $20,728, of which the employer pays about $12,144 while the employee pays $5,114 in premiums and $3,470 in out-of-pocket costs (Milliman Medical Index 2012, www.publications.milliman.com).

MEDICARE

▸According to the Standard and Poor's Healthcare Economic Indices, Medicare's costs per capita rose 2.41 percent between 2011 and 2012 while commercial health insurance costs rose 7.84 percent (S&P Healthcare Economic Indices, March 2012 update).

▸Fewer than 10 percent of Medicare Part D enrollees select the plan that would be most cost-effective for them, according to a study from researchers with the National Bureau of Economic Research. The study, which found that seniors were more sensitive to out-of-pocket premiums than to the overall benefits of the dozens of plans available to them, was designed to find out "how consumers behave in real-world decision situations with a complex, ambiguous structure and high stakes." The results bode poorly for how seniors would fare under a "voucher" program. The study concluded that "our results then do not support the proposition that consumers can make and benefit from good choices in private health insurance markets…." (Heiss et al, "Plan Selection in Medicare Part D," NBER, June 2012).

Medicare beneficiaries are significantly less likely to have problems with access to care and medical bills than are non-elderly adults with employer-based private insurance, according to an analysis by The Commonwealth Fund of a decade of survey data. Medicare beneficiaries are also more satisfied with their insurance than private Medicare Advantage plan enrollees. Only 6 percent of beneficiaries in traditional Medicare rated their insurance as fair or poor in 2010, compared with 15 percent of those with a private Medicare Advantage plan and 20 percent with employer-sponsored coverage. Private Medicare Advantage plan enrollees were less likely to have out-of-pocket costs that exceeded 10 percent of their income than those in traditional Medicare, but more likely to report cost-related access problems (32 vs. 23 percent), perhaps because of the limited networks of private Medicare Advantage plan. (Davis et al, "Medicare Beneficiaries Less Likely to Experience Cost and Access Related Problems than Adults with Private Coverage," Health Affairs, 7/12).

▸Pacificare of Texas, owned by UnitedHealth Group, defrauded Medicare of an estimated $115 million in 2007, or about $1,000 for each of its 118,000 beneficiaries, through "upcoding." An audit of 100 beneficiary risk scores, used to determine payment, found that 43 were invalid. ("Risk Adjustment Data Validation of Payments made to PacifiCare of Texas for Calendar Year 2007," Office of the Inspector General, May 2012).

▸The ACO program of the Centers for Medicare and Medicaid Services had contracts with 154 ACOs as of July. The arrangements can be complicated, and the patients may not know they are in an ACO. For example, the Lakewood IPA in Lakewood, California has a Medicare ACO subsidiary, Premier ACO Physicians Network, which in turn is managed by Coast Healthcare Management. According to Coast's CEO, "Now we find out who the patient is attributed to and track all his or her other doctors and connect them" (Graebner, California Health Report, 7/18/12).

CORPORATE MONEY AND CARE

▸Chicago-based Accretive Health will pay $2.5 million to a patient fund and cease doing business in the state of Minnesota for two years to settle allegations that it violated patient privacy and pursued overly aggressive collection tactics in nonprofit Fairview and North Memorial hospitals. The Fairview CEO

who hired the firm to manage the hospital's "revenue cycle" was also ousted after revelations that Accretive staff were pursuing collections from patients while they were in the emergency room and maternity ward (Snowbeck, Pioneer Press, 7/30/12).

UnitedHealth's CEO rakes in $169.3 million

CEOs at the nation's seven largest private health insurance firms received total pay of $87 million in 2011 (excluding profits on the sale of stock options). By that measure, Cigna CEO David Cordani was the highest paid insurance executive, at $19.1 million, about 94 times the average primary care physician's compensation. The next highest paid CEOs were UnitedHealth Group CEO Stephen Hemsley at $13.4 million, now-ousted WellPoint CEO Angela Braly, $13.3 million, Coventry CEO Allen Wise, $13.0 million, Aetna CEO Mark Bertolini, $10.6 million, Healthnet CEO Jay Gellert, $10.3 million, and Humana CEO Mike McCallister at $7.3 million (Berry, AMedNews, 5/31/12).

Some CEO's made much more. Including profits from exercising stock options ($28.8 million) and the value of "vesting shares" ($12.8 million), UnitedHealth Group's Stephen Hemsley garnered an extra $41.7 million on top of his compensation of $13.4 million for a total of $48.1 million in 2011. In 2010 most of Helmsley's pay also came from the sale of $43.5 million in stock options. His five-year take, according to Forbes: $169.3 million (Forbes, Gravity Defying CEO Compensation, 4/4/12, and Star Tribune, 4/25/12).

Even executives of regional insurers are receiving lavish pay. Patricia Hall, CEO of Health Care Service Corp. (HCSC), a Chicago-based mutual company which operates Blue Cross plans in Illinois and three other states, took home $12.9 million in 2011, of which $11.8 million was a bonus. The ten highest-paid executives at HCSC earned a collective $41.7 million in 2011, up from $25.3 million in 2010 (Wang, "Blue Cross Parents' CEO pay climbs to $12.9 million," 5/15/12).

▸Leonard Schaeffer, former CEO of WellPoint, donated $25 million to establish a health policy center in his name at the University of Southern California, the "Leonard D. Schaeffer Center for Health Policy and Economics." The center's mission includes "promoting value in health spending" and "improving insurance design" but not caring for the uninsured. In 2010 Schaeffer donated $2 million to the Institute of Medicine to "create an endowed executive officer position" and establish the Leonard D. Schaeffer Fund. Judith Salerno, the first Leonard D. Schaeffer Executive Officer of the Institute of Medicine, is co-author of a new book on obesity. While obesity is an important public health concern, a focus on individual behavior and obesity-related health care costs deflects attention from food policy issues and insurers' role in the health care crisis (Full page ad, New York Times, October 30, 2012, and IOM announcement October 11, 2010).

▸The AMA now has a state-by-state 57 page list of $236 million in fines imposed upon health insurers between 1997-2009 on its web site. Fines range from $1,000 to $12 million for everything from failure to pay claims promptly to low reimbursement for out-of-network care. Colorado, New York, and Texas levied the steepest fines (www.ama-assn.org/resources/doc/psa/insurer-fines.pdf accessed on November 13, 2012).

GALLOPING HEALTH CARE CONSOLIDATION

The acceleration in health industry consolidation is driven in part by PPACA, which will expand Medicaid HMOs and allow Medicare HMOs (also known as Medicare Advantage Plans) to continue to thrive. Moreover, Accountable Care Organizations (ACOs) are encouraged by PPACA and have been embraced by private insurers. ACOs put a premium on size, fueling vertical integration (i.e. practices being purchased by hospitals or insurers) as well as horizontal integration such as mergers between insurers or between hospital groups.

PHYSICIANS, INC.

▸The share of physician practices owned by hospitals has exceeded the share owned by physicians since 2008. An estimated 40 percent of primary care physicians and 25 percent of specialists are now employed by hospitals nationally, according to the Medical Group Management Association. In 2014, 75 percent of newly hired physicians are expected to be employed by hospitals, up from 11 percent in 2004 (Hospitals' Race to Employ Physicians, Kocher and Sahni, NEJM 5/12/12, Medscape, 7/9/12).

▸DaVita, the nation's second largest dialysis chain, is buying HealthCare Partners, which operates medical groups, physician networks, and three Medicare ACOs in California, Florida and Nevada, for $3.7 billion. Although DaVita is lobbying CMS to become a renal-disease ACO, the firm's long-range plan is to grow the much larger HealthCare Partners side of the business in new markets "in a capital-efficient way" (Jaimy Lee, Modern Healthcare, 5/26/12).

▸The number of physician-led ACOs grew quickly in 2012, nearly doubling to 70 out of a total of 221, according to a survey by Leavitt Partners. Meanwhile, hospital-led organizations grew by about 20 percent, to 118. A majority of ACOs (153) are contracting with the Medicare Shared Savings Program (MSSP). 29 ACOs are being led by private insurers (although most ACOs have contracts with them) and 4 are being-led by community-based organizations (Hospitals and Health Networks, 11/12)

HOSPITALS, INC.

▸Two investor-owned hospital chains, Universal and Community Health systems, with a combined total of 365 facilities, are growing with help from Wall Street. Both Universal and Community Health buy aging, financially struggling hospitals. They often replace them with newly constructed, modern facilities, which attract the revenue- (and profit-) generating specialists they need.

Universal, which operates 231 acute care hospitals, behavioral

health facilities, and ambulatory surgery centers, opened a replacement hospital for George Washington University in 2003. More recently it has been on a buying spree for private psychiatric hospitals; Universal bought Psychiatric Solutions Inc. the nation's largest chain of psychiatric inpatient facilities, for $3.1 billion in 2010, and Ascend Health Corp., with nine psychiatric facilities, for $517 million in 2011.

Community Health owns 134 hospitals in 29 states, mostly in rural markets. It has purchased 15 hospitals in the past 3 years ("U.S. hospitals find a few defenders on Wall Street," Reuters, 6/21/12).

▸Two giant Catholic health systems, Trinity Health and Catholic Health East, are in merger talks. The combined system will include 82 hospitals and 89 continuing care facilities, home health and hospice programs in 21 states, with combined operating revenues of $13.3 billion annually. They employ over 87,000 people, including 4,100 physicians, and have nearly 2.8 million visits each year (Jenny Gold, "Trinity Health, Catholic Health East Announce Plans To Merge," Kaiser Health News, 10/17/12).

Several deals involving Catholic hospitals trying to merge with secular hospitals have failed due to the church's opposition to abortion, in vitro fertilization, and sterilization. In anticipation of merging, Catholic Healthcare West, which primarily operates in California, Arizona and Nevada, has ended its affiliation with the Catholic Church and changed its name to Dignity Health (Jenny Gold, Kaiser Health News, 10/17/12).

▸Two large nonprofit Michigan health systems are in merger talks, Henry Ford Health System in Detroit and Royal Oak-based Beaumont Health System. The combined system would have $6.4 billion in annual revenue, 10 hospitals and 100 other patient care sites, including a newly built hospital in an affluent Detroit suburb, and a medical school. Two years ago nonprofit Detroit Medical was bought by Vanguard Health Systems of Tennessee for $365 million in cash plus $850 million in capital improvements (Dolan and Rogers, Wall Street Journal, 10/31/12)

INSURERS AT THE PUBLIC TROUGH, MORPHING INTO ACOS

▸Large insurers are on a buying spree to expand their Medicaid and Medicare Advantage business in the wake of the federal health law. As a result, commercial business now accounts for less than half of the nation's four largest insurers' revenue. Revenues from Medicaid have more than doubled since the health law passed, while revenues from Medicare are up one-third.

The insurers are not shy about their plans. As one health analyst told Bloomberg News, "Medicaid is going to be a big growth market for the big health insurers. Fifteen to 20 million lives will be up for grabs in 2014, and WellPoint wants some of those lives." WellPoint recently purchased rival insurer Amerigroup for $4.5 billion to expand its Medicaid business. The combined firm will have Medicaid plans in 19 states.

The largest recent deal is Aetna's purchase of Coventry Health Care, a big insurer that specializes in Medicare Advantage and Medicaid plans, for $5.7 billion. The acquisition will bump the share of Aetna's revenue that comes from government to over 30 percent from 23 percent today. One hedge fund, Greenlight Capital, profited $72 million from the deal.

Leading the expansion into public programs, Cigna paid $3.8 billion for Medicare specialist HealthSpring last year, while UnitedHealth bought XLHealth Corp – a transaction reportedly valued at $2 billion – to expand their role in managing the care of "dual eligibles" people who quality for both Medicare and Medicaid. UnitedHealth's purchase of XLHealth Corp comes on top of their recent three-year, $3.5 billion buying spree to expand their role in Medicaid and Medicare (Saijel Kishan, Bloomberg News, 8/20/12; "Aetna to Acquire Coventry Health Care" Wall Street Journal, 8/20/12; "Insurers Prosper under Overhaul," Bloomberg Government, Appendix 5: Recent large insurer acquisitions, 2012"; "WellPoint to Acquire Amerigroup Amid Health Care Overhaul," New York Times, 7/9/12).

UnitedHealth's Optum takes over risk adjustment for government health exchange

Optum, a subsidiary of UnitedHealth Group, recently purchased Quality Software Services Inc. (QSSI) the government contractor charged with helping to run the federal health insurance exchange. Prior to the purchase, Optum hired Steve Larsen, until recently the top government administrator in charge of drafting the insurance regulations in the federal health law, such as the rules that limit the amount of premium revenue insurers can keep for profit and administrative costs. Optum will be responsible for building the data hub to support key features of the exchange, such as calculating payments for risk adjustment and reallocating federal funds among plans, certifying and decertifying health plans offered on the exchange, and controlling a massive amount of personal social-economic and health information – all of which could give UnitedHealth, the largest subsidiary of UnitedHealth Group and the nation's largest health insurer, unprecedented ability to game the system to its own advantage (Bolton, "Conflict-of-interest concerns raised as Obama races to implement health reform," The Hill, 11/3/12).

▸Insurers are also purchasing physician practices and clinics. They want more control over the cost of health care delivery and, in some cases, to form ACOs. UnitedHealth's Optum subsidiary bought the management arm of Monarch Healthcare, a Pioneer Medicare ACO with 2,300 physicians, last year (California law prohibits insurers from directly employing physicians) for an undisclosed amount. WellPoint paid $800 million for CareMore, a chain of 28 clinics with doctors on staff that specializes in care coordination and intensive treatment to the chronically ill—at a profit. WellPoint plans to open 12 additional CareMore clinics at a cost of $36 million. Humana is getting into the home care business; it purchased SeniorBridge, an in-home care manager with 1,500 providers, for an undisclosed amount, and Concentra, an urgent care and occupational clinic firm, for

$790 million. (Business Insurance, 1/15/12).

▸Minnesota-based insurer HealthPartners is merging with Park Nicollet Health Services to form an ACO-ready firm with about 1,500 doctors, more than 20,000 employees, 5 hospitals and $5 billion in annual revenues (Snowbeck, Pioneer Press, 8/30/12).

▸Insurers are also buying up health information technology firms and private exchanges as those services become increasing central to running ACOs and marketing health plans. WellPoint and UnitedHealth each bought an insurance exchange in late 2011, Bloom Health Corp. and Connextions Inc., respectively.

The consulting firm Towers Watson & Co. is also getting into the exchange business. The firm purchased Extend Health Inc., operator of the largest private Medicare exchange in the United States, for $435 million. ("Towers Watson & Co. to buy largest private Medicare exchange," Reuters, 5/13/12).

UPDATE FROM MASSACHUSETTS – THE MODEL FOR THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

▸Health care premiums in Massachusetts, the model for the PPACA, continue to outpace inflation, with small groups continuing to experience the highest premium rates and increases. In addition, group purchasers are buying coverage with fewer benefits or higher cost sharing, a phenomenon known as "benefit buy-down." "Buy down can result in lower observed premiums, but may reduce access to care or increase out-of-pocket expenditures." ("Mass. Health Care Cost Trends – Premiums and Expenditures," Commonwealth of Massachusetts, HHS, 5/12).

A new survey in Massachusetts found that 40 percent of "sick" adults - those who had a serious illness or injury or had been hospitalized overnight - had "very serious" or "somewhat serious" problems with out-of-pocket costs for medical care. In addition, nearly one-quarter of "sick" adults who have been insured at any time in the past year reported having a problem with their insurer paying a hospital, doctor, or other health care provider in the past year. The survey noted that "some sick adults report having been refused medical care for financial or insurance reasons. Additionally, some sick adults say they did not get needed medical care because they could not afford it. Taken together, these findings suggest that insurance coverage does not protect some Massachusetts residents against the financial hardships of illness, likely reflecting the trend toward higher deductibles and co-payments ("Sick in Massachusetts: Views on health care costs and quality," Harvard/Blue Cross/RWJ poll, June 2012).

▸Jonathan Gruber, an economist who was an adviser on the Massachusetts health reform, admitted at a health care conference in Boston that the reform would not curb costs and asked for more time. "We don't know the answer. We don't know how to fix it now, and we have to experiment and be more patient." Yet, months earlier, in response to Chris Matthews question, "...single payer, is that a better economic deal, with no profit motive?" Gruber conceded that "I think that single payer, if you could start over, I think that single payer has a lot to recommend it, but we can't…" on MSNBC (Politico, 6/3/12).

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

▸Several features of the PPACA go into effect in 2013, including a requirement for easy-to-read plan summaries (which polls as the most popular feature of the legislation), a ceiling on workplace flexible spending accounts of $2,500, and an increase on annual benefit caps of $2 million, up from $1.25 million this year. Caps will be eliminated altogether in 2014 (Wall Street Journal, 10/21/12).

▸Starting in 2014, employers will be allowed to tie 30 percent of the cost of a worker's health insurance plan, an average of $4,500 for a family, or $1,600 for individuals, to perks or penalties for "wellness." The programs must be voluntary and the employer must offer an undefined "reasonable alternative" for those who can't achieve the medical goals. (Julie Appleby, "Employers Tie Financial Rewards, Penalties to Health Tests, Lifestyle Choices," USA Today, 4/2/12)

▸WalMart plans to begin denying health insurance to newly hired employees who work fewer than 30 hours a week. Several other large employers of low-wage workers in the retail, restaurant, and hotel industries are moving towards hiring more part-time workers to avoid the federal health law's mandate that they offer coverage or pay a penalty of $2,000 for each worker starting in 2014. Pillar Hotel and Resorts, which has 210 franchise hotels under the Sheraton and Holiday Inn brands, CKE Restaurants (parent of Hardee's burgers) home retailer Anna's Linens, and Darden restaurants, (parent of Red Lobster and Olive Garden), are either hiring part-time workers to replace full-time employees who left or considering cutting back the hours of full-time staff (HuffPost Business, "WalMart's new healthcare policy shifts burden to Medicaid, Obamacare," 12/3/12); ("Health Care Law Spurs a Shift to Part-Time Workers," Wall Street Journal, 11/4/12).

▸The number of children aged 19-26 enrolled on a parent's health plan increased from 2.3 million in 2011 to 2.9 million in 2012. A Towers Watson survey found that 31 percent of employers are considering reducing their coverage for dependents in 2014 or 2015 (Claxton et al, "Health Benefits in 2012," Health Affairs, Oct. 2012).

▸Two plans with the same actuarial value (bronze, silver, gold, platinum) on the exchanges starting in 2014 can lead to very different out-of-pocket costs for a given person, according to an analysis by The Commonwealth Fund. While consumers favor plans that appear to have low cost-sharing (and higher actuarial value) because they prefer to minimize risk, there are many other variables that influence out-of-pocket costs, such as the size of the deductible, whether or not some services are covered before

the deductible is met, the amount of co-payments, the amount of coinsurance, the out-of-pocket limit and what qualifies for the limit, patient age, and income-related premium subsidies. The study concludes that "actuarial value … does not pinpoint which plan will produce the best overall value for a particular person" and that even with information about plan benefits, actuarial value, and premiums, "it can be hard for people to choose a plan that best meets their expected medical needs." Given that a recent study found that only 10 percent of seniors were able to choose the most cost-effective Part D plan for drug coverage, that's probably a gross understatement. (Lore et al ,"Choosing the "Best" Plan in a Health Insurance Exchange: Actuarial Value Tells Only Part of the Story," Commonwealth Fund, August 2012).

In NFIB v. Sebelius, the Supreme Court upheld the individual mandate in the Affordable Care Act. The Court concluded the individual requirement to purchase health insurance coverage is constitutional as a tax under the congressional Spending Clause authority, but not under the Commerce Clause. The Court also concluded that it was unconstitutional for the federal government to withhold all of a state's Medicaid funding if they do not expand their Medicaid program to cover all non-elderly individuals with incomes below 133 percent of federal poverty (about $15,000).

As a result of the ruling, states now may opt out of the expansion, although few are expected to as the federal government pays 100 percent of the cost of the Medicaid expansion for the first three years, declining to 90 percent after 2020. As of late-November, eight state Governors were insisting they wouldn't expand their programs. More than half of Americans (56 percent) say the Medicaid program is important to their own family; among low-income Americans it rises to 74 percent (Klein, Washington Post, 7/2/12 and Kaiser Poll, 7/2/12).

▸About 6 million people will pay a total of $7 billion in penalties in 2016 for being uninsured, according to the Congressional Budget Office and the Joint Committee on Taxation. The penalty for lacking health insurance in the federal health law rises to $695 per person (half for children) or 2.5 percent of family income in 2016. Most of the uninsured will not be subject to the penalty, including unauthorized immigrants (who are not subject to the mandate and are prohibited from buying coverage on the exchanges and are ineligible for almost all Medicaid benefits), people with such low incomes that they don't file tax returns, people for whom coverage would cost over 8 percent of their income, members of Indian tribes, or on the grounds of hardship or religious beliefs ("Payments of Penalties for Being Uninsured Under the Affordable Care Act," Congressional Budget Office, 9/19/12).

BIG PHARMA

▸Bristol-Myers Squibb is paying $5.3 billion to acquire diabetes drug maker Amylin Pharmaceuticals Inc. GlaxoSmithKline is buying the biotechnology firm Human Genome Sciences for about $3 billion (Das, Wall Street Journal, 7/16/12).

▸Drug firm Sanofi announced that it would give doctors and hospitals a 50 percent discount on Zaltrap, its $11,000-a-month drug to treat colon cancer, after the drug was rejected from the formulary at Sloan-Kettering Cancer in New York. In an op-ed published in The New York Times, three doctors at Sloan Kettering said the drug was twice as expensive but no more effective than Avastin, and potentially more toxic. The Sloan-Kettering doctors rejected Sanofi's offer, noting that the discount amounted to a kickback to doctors and hospitals, because insurance reimbursement and patient co-pays would still be based on the higher list price, at least for several months (Pollack, New York Times, 11/8/12).

▸Drug giants Novartis is seeking patent protection from India's Supreme Court for their cancer drug Gleevec, which India rejected in 2006. Since 2005 the country has had a law against "evergreening," the practice of firms' seeking patent protection on drugs by reformulating them or changing the delivery system, thereby preventing the introduction of cheaper, non-branded generics. Firms now have to show that new versions of their products are therapeutically more beneficial than earlier versions. India has a thriving generic drug industry that is a major exporter of low-cost medications to the developing world and has helped drive down the cost of HIV medications from $10,000 per patient a year to $150. Besides Glivec, India has rejected patent applications for Gilead Sciences' Viread, an HIV medication, and Roche Holdings' cancer drug Tarceva. If Novartis prevails, it could set a legal precedent that would lead to higher prices on lifesaving medications, putting them out-of-reach for the poor. India is also considering a proposal to have its antitrust regulator review all major pharmaceutical mergers. Foreign drug makers have purchased several Indian pharmaceutical firms in recent years, which could lead to higher prices (Ahmed and Sharma, Wall Street Journal, 8/19/12).

▸Abbott Laboratories will pay $1.6 billion for illegally marketing of the anti-seizure medication Depakote for uses not approved by the Food and Drug Administration (FDA). The company aggressively marketed the drug to nursing homes for agitation in elderly dementia patients. It also marketed the drug for use in the treatment of schizophrenia, even though its own clinical trials showed Depakote provided no benefit (Peter Frost, Chicago Tribune, 5/8/12).

INTERNATIONAL

▸The austerity imposed on Greece by its international creditors has led to damaging cuts in its health system. Previously employers, individuals, and government contributed to a fund to finance universal health care. People who lost their jobs still retained health benefits. Starting in July 2011, Greeks who lose their jobs only retain health benefits for one year. Already half of the 1.2 million long-term unemployed lack coverage, a number that is expected to grow dramatically (Alderman, New York Times, 10/24/12).

▸The firm managing the first privately run hospital in England's National Health Service, Circle LLC, has asked for a bail out after just six months. Hinchingbrooke Hospital incurred losses of 4.1 million British pounds, and dropped significantly in patient satisfaction under Circle, which is headed by a former Goldman Sachs employee. Another hospital run by the firm, Huntingdon Hospital, has cut 46 nursing posts, prompting criticism from the regional director of the Royal College of Nursing (Dorman, "Fury as first privately run NHS hospital racks up 4.1 million pounds loss," People.co.uk, 10/28/12).

A study of income-related inequities in health service utilization in 19 OECD countries found that Americans had both the lowest probability of a doctor's visit (GP or specialist) and the most inequitable horizontal access to care, i.e. the extent to which adults in equal need of physician care have equal utilization. The proportion of adults seeing a doctor in the past 12 months varied from 68 percent in the U.S. to 91 percent in France. In general, across all countries, for the same level of health needs, people with higher incomes were somewhat more likely to visit a specialist or a dentist. The U.S. stood out as the country with the largest disparity between rich and poor, even for primary care visits. In other nations, the scenario for primary care visits was different: people with lower-incomes were just as likely as the affluent to have a doctor visit. Overall, researchers found that the higher the share of public spending on health care, the lower the inequity in doctor visits. (OECD Health Working Paper No. 58, 7/10/12).

▸In comparison to three other industrialized countries (France, Germany, and the U.K.) the U.S. has the highest preventable death rate and made the least progress between 1999 and 2007 in reducing this measure of mortality amenable to medical care. During the study period the overall preventable death rate in the U.S. fell by 17.5 percent (women) to 18.5 percent (men), compared with a decline in the U.K. of 32 percent (women) to 37 percent (men). The lag is most pronounced among Americans under the age of 65, who are more likely to be uninsured and have more problems with access than those over 65. France, Germany and the U.K. all have universal health systems. In 2007 the potentially preventable death rate among U.S. men under age 65 was 69 per 100,000, significantly higher than in the U.K. (53), Germany (50) and France (37). For U.S. women under 65 it was 56 per 100,000, compared with women in the U.K. (46), Germany (40), and France (34).

A 2011 study found that the U.S. ranked last out of 16 countries in deaths that might have been prevented with timely and effective care. Premature death rates in the U.S. were 68 percent higher than in the best performing countries, equivalent to 91,000 excess deaths annually (Nolte et al, "Amenable mortality – Deaths Avoidable Through Health Care – Progress in the U.S. Lags that of Three European Countries," Health Affairs, online 8/29/12 and National Scorecard on U.S. Health System Performance, Commonwealth Fund, October 2011).

Women in the U.S., both with and without insurance, are more likely to go without needed health care because of cost and have greater difficulty paying their medical bills than women in 10 other countries, according to a study by the Commonwealth Fund. The ten nations are Australia, Sweden, Norway, Germany, Canada, France, New Zealand, Switzerland, the Netherlands, and the U.K.

Over 43 percent percent of women in the U.S. reported an access problem such as going without recommended care, not seeing a doctor when sick, or failing to fill prescriptions because of costs in the past year, the highest rate among 11 countries. In the best-performing country, the U.K., only 7 percent of women had access problems. More than three-fourths (77%) of women in the U.S. who had been uninsured during the previous year went without health care because of costs. However, these problems were not confined to the uninsured. Even insured U.S. women reported high rates (32%) of cost-related access problems.

Women in the U.S. were also much more likely than women in other nations to report spending $1,000 or more on out-of-pocket medical expenses (39 percent in the U.S. versus 1 percent in Sweden and 0 percent in the U.K.) and to have problems paying medical bills (26 percent in the U.S. versus 4 percent in Germany and 2 percent in the U.K.). Finally, U.S. women reported the lowest rate of confidence in their ability to afford needed care if seriously ill (52 percent versus 91 percent in the U.K.) (Oceans Apart, Commonwealth Fund, July 2012).

Canadian doctor urges focus on social determinants of health

Drawing upon his experiences as a family physician in the inner city of Saskatoon, rural Saskatchewan, and Mozambique, Canadian family physician Dr. Ryan Meili argues that health delivery too often focuses on treatment of immediate causes and ignores more fundamental conditions that lead to poor health, such as low income, poor education and inadequate social supports. Brought to life by clinical vignettes, "A Healthy Society" explores a number of specific health determinants and ends with a discussion of democratic reforms that could help reshape the way societies organize themselves to create a truly healthy society. Dr. Meili is vice-chair of Canadian Doctors for Medicare.

"A Healthy Society: How a Focus on Health Can Revive Canadian Democracy," Purich Publishing, 2012, Softcover, 144 pages, $22 plus shipping.

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

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It's time for single payer

By James C. Mitchiner, M.D.

"You can always trust the Americans to do the right thing, once they've tried everything else."

Winston Churchill's iconic remark, reportedly issued at the dawn of America's entry into World War II, is equally applicable to the present American health care debate and the crisis that spawned it.

Dr. James Mitchiner

Regardless of whether you are elated or disappointed with June's historic Supreme Court decision upholding the constitutionality of the Affordable Care Act, it is certainly no panacea for the problems facing U.S. health care. Even with the law intact, and despite its best intentions, it will still leave some 25 million uninsured, underinsure millions more, expand the corporatization of health care, and do little to control the escalating costs of care over the long term.

So it's clear we need to do the right thing: the creation of a national, universal, publicly funded health care system, free of the corrupting power of profit-oriented health insurance, and at the same time capable of passing constitutional muster. In short, the right thing is an expanded and improved Medicare-for-All program, otherwise known as single payer.

Don't be so shocked. For the last 30 years, we have tried all the alternatives, and none of them have worked. We have experimented with HMOs, PPOs, high-deductible health plans, health savings accounts, pay-for-performance, capitation, and disease management. These ideas have been promoted in various iterations, often with great fanfare, by public and private payers alike, yet none of them have shown long-term success at bending the cost curve. And the promise of the latest reforms du jour, such as Accountable Care Organizations and Patient-Centered Medical Homes, is speculative at best.

American health care is unique among the world's democracies in that it was never planned in terms of enabling legislation or explicit constitutional authority. As others have stated, our employer-based insurance system, which now covers about 160 million Americans, was an accident of history. Its lineage can be traced to FDR's wage and price control policies during World War II, where employers were permitted to offer workers health insurance in lieu of higher wages as a job inducement.

This benefit has evolved piecemeal into the Rube Goldberg complexity that is contemporary employer-sponsored health insurance, with some 1,200 private plans each doing the same things – medical underwriting, coordination of benefits, claims adjudication and denial, marketing, public relations, lobbying, litigating, and paying shareholder dividends and inflated CEO salaries while forcing individuals to pay a higher share of premiums, increased deductibles, expanded copays, or a combination of all three.

Taken as a whole, private insurers' activities are duplicative, inefficient, wasteful of scarce health care resources, conducive of job lock, and completely misdirected in supporting the 21st-century health care agenda that America needs and deserves.

The objective of the ACA's individual mandate was to remedy a flaw in the market for health insurance: the expectation by the uninsured that the costs of their inevitable illnesses would be benignly transferred to those fortunate to have coverage. If you believe that guaranteed issue and community-rating requires 100% participation in the health insurance market to sustain financial viability, clearly the most efficient mechanism to achieve this is not through an individual mandate, in which the heavy hand of government coerces people to do what they otherwise would not. If the federal government has a professed welfare interest in controlling health care costs, it can – and should – accomplish that goal through a more economically efficient single-payer mechanism.

Taken as a whole, private insurers' activities are... completely misdirected in supporting the 21st-century health care agenda that America needs and deserves.

Given that the primary business objective of a for-profit insurer is to make a profit, the fundamental question we should be asking is this: What is the marginal value of private health insurance? That is, what advantage vis-à-vis a single-payer model like Medicare does our system of private, profit-oriented health insurance convey to patients, providers, and employers? What exactly do private insurers do, above and beyond what Medicare does, that is deserving of their inflated premiums?

To my knowledge, there is no evidence that commercial insurance provides easier access or less hassle-free care, is more cost effective, produces care of higher quality, or has better consumer satisfaction ratings than Medicare (if anyone

(continued from previous page)

has evidence to the contrary, from the peer-reviewed health policy literature, please advise). And according to a recent poll, most Americans prefer to keep Medicare as it is, rather than switching to a premium-support financing mechanism as advocated by Rep. Paul Ryan (R-Wis.). Whatever bad things you can say about our government, at least the Feds are not required to make a profit but are required to answer to all taxpayers, rather than private shareholders who are concerned only with the bottomline.

Under a single-payer system, every American would receive a basic package that would include inpatient and outpatient care, primary care and specialty physician services, emergency care, preventive and restorative care, mental health and substance abuse services, dental care, prescription drugs, home health care, and long-term care. Doctors and other providers would be paid based on a fee-for-service schedule, as negotiated with state governments, with funding coming from progressive payroll taxes paid by both individuals and employers. Quality would be monitored and publicly reported, with financial incentives awarded to providers who followed clinical guidelines endorsed by their medical specialty societies. All services provided would be publicly accountable. Medical decision making at the bedside would be left to the physician.

Conceptually, single payer is imbued with many myths and misconceptions.

Myth #1: Single-Payer Is One-Size-Fits-All

The No. 1 myth – the alpha myth – is that single payer represents a choiceless, one-size-fits-all, government-run health care monopsony. This is a blatant falsehood. Single payer is simply a more efficient and more equitable way of financing health care – and nothing more. By consolidating the administrative functions of insurance, it eliminates bureaucratic duplication and reduces administrative waste, saving time and money for employers, providers, state governments, and consumers alike. It would remove the profit motive from financing care, but not from delivering it. Single payer would efficiently provide for all Americans – regardless of age, health condition, income, or employment status – universal health care that is portable, affordable, equitable, non-terminating, publicly accountable, and funded through progressive taxation, which for the average family would imply a small additional payroll tax that is much less than its current outlay for insurance premiums. A single-payer system would not supplant the private practice of medicine; you could go to a primary care doctor, specialist, hospital, pharmacist, and lab of your choice.

Does anyone seriously believe that purchasing health care services is fundamentally no different from buying a new car or a flat-screen TV?

Myth #2: Canadian Health Care Would Be Bad for America

Americans love to repeat anecdotes about the supposedly lousy medical care our northern neighbors receive from their single-payer system, by demoralized and overworked doctors who work at ill-equipped hospitals with out-of-date technology. This is rubbish. Do Canadians often wait for weeks to see a specialist? Yes. Do Americans also wait? Yes. There is no evidence that Canadians are dropping dead in the streets while waiting for their emergency bypasses or appendectomies, nor is there any evidence that Canadian physicians are emigrating to the U.S. or other countries en masse. Further, there is no evidence that the quality of care in Canada, across the board, is inferior to that practiced in the U.S. Despite comparable rates of smoking and alcoholism, Canadians on average live longer than Americans by more than 2 years, and their infant mortality rate is less than ours. Finally, consider this: Canadians spend much less than we do for health care, both in per-capita dollars and as a percent of GDP, so I have no doubt that if we were to adopt a Canadian-style system and fund it to the tune of $2.6 trillion annually, we would not have 9-month waits for MRIs, even if every one of them was clinically indicated.

Myth #3: Market-Based Medicine Trumps Single Payer

Some argue that our private, market-based system is fundamentally sound, that it should be freed of government regulation and tweaked to promote greater competition based on price, and thus choice of health insurance plans. Really? Does anyone seriously believe that purchasing health care services is fundamentally no different from buying a new car or a flat-screen TV? (If so, I suggest he or she take a course in health economics.) And would anyone seriously believe that Americans want a choice of health insurance, when what they really desire is a choice of doctors and hospitals? What could be more American, more consumer-friendly, and more constitutional than the ability to choose your health care provider based on whatever criteria you deem important? So why not cut out the middleman and let doctors, hospitals, and other providers compete on such things as quality, service, reputation, convenience, and other personal preferences, rather than having private insurers make these choices for us?

Just consider what "The Market" has done for health care in the last 30 years: a steady increase in the number of uninsured; a decrease in the choice of providers; diversion of resources into more profitable hospitals and services; consolidation of HMOs into health care oligopolies; underfunding of less profitable endeavors, such as public health, trauma centers, and mental health services; unaffordable prescription drugs; dissatisfied patients; frustrated physicians; and of course, an inexorably increasing trajectory of health care costs.

Myth #4: Single Payer Would Stop Medical Innovation

To my knowledge, there is no correlation between innovation and a country's method of health care financing. Many technologies and medical advances we now take for granted originated in nations with national health insurance,

for example, CT scans and MRIs (Great Britain), laparoscopic cholecystectomy (Canada), percutaneous coronary angioplasty (Germany), and H. pylori treatment (Australia). The largest single source of funding for medical research in the U.S. is a government agency – the National Institutes of Health – which provided almost $31 billion in funding for medical research in fiscal year 2012. And in terms of per capita drug R&D costs, the U.S. lags behind Britain and Sweden.

Myth #5: Single Payer Is Impossible to Enact Politically

Perhaps this is true – for now. But if social change depended solely on what was politically pragmatic, women would not have achieved the right to vote in 1920, civil rights legislation would not have been enacted in 1964, and Medicare would have failed in 1965. We should always be careful to distinguish between what's desirable and what's doable. The fact that tort reform is certainly desirable, but not politically doable at the present time, has not stopped ACEP from investing significant time and financial resources to advocate for change. Public opinion polls have consistently shown that the level of public support for single-payer is 60% plus. A survey of physicians published 4 years ago showed that single payer garnered 59% support among the 2,193 physicians polled (support among emergency physicians was even higher, at 69%). Despite this, there is no question that moving to a single-payer system will face enormous obstacles. What is needed, as columnist David Lazarus of the Los Angeles Times pointed out, is a "massive infusion of political courage and the willingness to forsake political purity."

But if social change depended solely on what was politically pragmatic... Medicare would have failed in 1965.

Myth #6: We Can't Afford Single-Payer

Given our current system, perhaps the better statement would be "we can't afford not to have single-payer." The most recent financial projections portend no overall decrease in the cost trajectory for health care over the next 8 years, even if the ACA remains intact. Under a single-payer model, a modest increase in taxes would be overshadowed by savings from elimination of insurance premiums, offsets from economies of scale, decreased out-of-pocket payments, and the disappearance of cost-shifting. The annual savings from transforming to a single-payer system are estimated to be $400 billion. If you look at the cost curves for U.S. and Canadian health care, they were identical until the mid-1970s, when Canada's health system was fully implemented. From then on, the curves diverged, with America's climbing much faster than Canada's. When Taiwan converted to single payer in 1995, the costs went up in the first year, as expected, and then leveled off to a reasonable increase of about 3% per year.

What Does This Mean for Emergency Medicine?

Well, consider the ED as a de facto single-payer environment. Patients come to us by choice without needing to first check with their health plan (assuming they have one) to see if their ED visit is covered. We see them without asking them to pay in advance for their ED services, and their care is not predicated on their job, income, or insurance coverage. As emergency physicians, we have more autonomy than our primary care colleagues in terms of making diagnostic and therapeutic decisions without the nonsense of "pre-authorization" or other interference from an insurer who is interested only in the bottom line. While it's nice to be able to make medical decisions without checking on insurance status, it would be even nicer if we actually got paid for every ED patient treated. Private insurance companies simply have no incentive – in fact, it's not at all consistent with their business model – to pay for EMTALA-mandated services provided by out-of-network emergency physicians.

Looking again to Medicare as a single-payer model, consider how we emergency physicians interact with Medicare vs. private insurers. In 29 years of practice, I have never had to seek permission from a CMS official to admit a fee-for-service Medicare patient, have never had a consultant refuse a referral for a Medicare beneficiary, and have never had a pharmacist call me to say the prescription for my Medicare patient was not covered by the formulary. This is not true for some of my patients in managed care plans, including those who were sick enough to be admitted but had to be transferred because my hospital (which the patients self-selected) did not participate in their plan.

Single payer is the only remaining option to simultaneously and synergistically expand access, control costs, preserve choice, and reduce disparities. There is simply no other efficient and constitutionally safe way to do this. Any other proposals are nothing more than tinkering around the edges and based on blind faith that some kind of future financial salvation will somehow save us from the impending health care meltdown. A single-payer, improved Medicare-for-All program would overhaul our dysfunctional health care financing system so that it works best for patients – and for physicians.

Dr. Mitchiner is an emergency physician in Ann Arbor, Mich., a former president of the Washtenaw County (Mich.) Medical Society, and a member of Physicians for a National Health Program.

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RESEARCH LETTER

ONLINE FIRST | HEALTH CARE REFORM

Cost Control in a Parallel Universe: Medicare Spending in the United States and Canada

As the United States was implementing Medicare in 1966, Canada was phasing in its own Medicare program, which covered all Canadians under provincially administered plans. While these provincial plans varied, all incorporated significant payment reforms—global budgeting of hospitals and stringent capital expenditure controls—and banned copayments and deductibles.

Before the mid-1960s, the 2 nations' health care financing systems were similar, and health care costs were comparable.[1] Since then, overall US costs have grown more rapidly, but no study has compared spending for the elderly—the populations covered by Medicare in both nations.

Methods. We obtained official figures for Medicare spending for persons older than 64 years in Canada and the United States for 1971 (when Canadian Medicare became fully operational) through 2009. Since available Canadian data for 1971 through 1979 are less detailed, we focus principally on changes since 1980.

We adjusted Canadian figures for minor changes in government accounting. To avoid distorting time trends, we excluded Medicare Part D (which began in 2006).

We calculated percentage changes in inflation-adjusted spending per elderly enrollee and compared actual US Medicare expenditures in each year since 1980 (and 1971) with the projected level of expenditure had US Medicare spending increased at Canada's rate. See the eAppendix for further details (http://www.archinternmed.com).

Results. US Medicare spending per elderly enrollee rose from $1215 in 1980 to $9446 in 2009 (an inflation-adjusted 198.7% increase). The comparable increase for Canada was 73.0% (from $2141 to $9292). Canada's higher base-year spending reflects its more comprehensive benefits, covering about 80% of seniors' total health costs, vs about 50% in US Medicare.

The **Table** lists actual US Medicare spending from 1980 through 2009 and projected spending and savings had US costs risen at the lower Canadian rate. Projected savings totaled $154.2 billion in 2009 and $2.156 trillion for 1980 through 2009.

Table. Actual and Projected Medicare Spending Characteristics During the Study Period[a]

Year	Actual US Spending	Change From 1980 in Real Per Capita Spending for Persons Older Than 64 Years, %		Projected US Spending if Costs Had Risen at Canadian Rate	Projected US Savings if Costs Had Risen at Canadian Rate
		United States	Canada		
1980	31.0	NA	NA	31.0	NA
1981	37.7	8.3	4.2	34.4	3.4
1982	44.3	17.3	10.6	38.7	5.6
1983	50.0	25.6	12.7	38.9	11.1
1984	55.1	30.5	13.9	40.7	14.5
1985	62.0	38.7	17.5	43.1	18.9
1986	66.8	43.6	19.1	44.5	22.3
1987	71.0	44.2	21.9	50.2	20.8
1988	76.9	47.5	26.3	56.9	20.0
1989	87.3	57.0	28.3	59.7	27.6
1990	96.4	61.6	28.5	64.0	32.4
1991	105.5	66.9	31.0	69.8	35.7
1992	118.1	78.3	31.2	70.4	47.6
1993	130.1	88.0	27.0	67.4	62.7
1994	142.1	98.3	22.4	63.4	78.8
1995	158.6	112.9	19.6	60.8	97.7
1996	172.4	122.8	15.9	59.3	113.1
1997	183.9	131.0	17.6	63.2	120.7
1998	183.2	125.5	23.4	74.0	109.2
1999	181.9	118.3	26.9	83.9	98.0
2000	188.3	116.4	33.6	98.6	89.7
2001	207.7	130.7	39.3	108.1	99.6
2002	223.7	143.0	45.1	116.2	107.5
2003	234.7	146.9	48.2	125.4	109.4
2004	256.1	160.3	54.2	137.5	118.6
2005	277.3	169.2	56.1	149.3	128.0
2006	297.3	175.2	61.0	165.9	131.3
2007	314.8	178.6	63.0	179.7	135.1
2008	344.1	186.1	66.9	201.3	142.8
2009	366.2	198.7	73.0	212.0	154.2
Total, 1980-2009	**4764.3**	198.7	73.0	**2608.3**	**2156.1**

Abbreviation: NA, not applicable.
[a] Unless otherwise indicated, data are reported in billions of US dollars.

Medicare hospital spending per elderly enrollee grew 44.7% in Canada vs 81.9% in the United States. Physician spending grew 100.7% in Canada vs 274.3% in the United States. Hospitals' share of total Medicare spending fell from 49.6% to 41.5% in Canada and from 68.4% to 41.5% in the United States. Spending for other services (eg, home, hospice, and skilled nursing facility care) rose from 3.9% to 23.6% of spending in the United States and from 39.7% to 44.3% in Canada.

For the 1971-2009 period, US costs rose 374.1% vs 126.3% for Canada, and estimated foregone savings were $2.9024 trillion (eFigure).

Comment. Medicare spending has grown nearly 3 times faster in the United States than in Canada since 1980. Had US Medicare costs risen at Canadian rates, rather than a deficit of $17.1 billion in 2009, the Medicare Hospital Trust Fund would have realized a $32.3 billion surplus. Savings on Medicare Part B would have been even larger. By 2009, the $2.156 trillion in excess spending attributable to US Medicare's faster growth was equivalent to more than one-sixth of the national debt.

Several features of Canada's program help constrain costs. First, the single-payer system has simplified administration, holding administrative costs to 16.7% of overall spending vs 31.0% in the United States.[2] Although US Medicare's internal overhead costs are low, it remains one among many payers. Hence providers' administrative costs are inflated by having to deal with a multitude of payers and track eligibility, attribute costs, and bill for individual patients and services.

Second, Canadian hospitals receive prospectively determined global operating budgets, removing incentives to provide unnecessary care while simplifying billing and administration. However, unlike accountable care organization payment schemes in the United States, capital costs are not folded into the global budgets but distributed separately through an explicit health-planning process. Canadian hospitals cannot use operating surpluses to fund new buildings or equipment but must request separate capital appropriations. Hence, they cannot expand by overproviding lucrative services, gaming the payment system through upcoding, avoiding unprofitable patients, or cost shifting.

Third, 51% of Canada's physicians are primary care practitioners vs 32% in the United States.[3] Primary care–centered health systems are generally thriftier.[4] Canada's outpatient fee schedules are also less technology skewed than in the United States.

Fourth, Canada's provincial plans have used their concentrated purchasing power to limit drug and device prices.

Finally, litigation and malpractice costs have remained relatively low in Canada.

Life expectancy at age 65 years is longer and has grown faster in Canada than in the United States since 1980 (and 1971),[5] offering reassurance that cost control has not compromised quality. A meta-analysis suggests that clinical outcomes are, if anything, better for Canadians than for insured Americans.[6]

To some, US Medicare's grim financial health suggests an even grimmer conclusion: it can no longer keep its promise of all needed care for the elderly population.[7] Some would replace it with vouchers that seniors could use to purchase private coverage. Others suggest upending the current payment system by inverting volume-based incentives, offering instead profits to organizations that limit utilization. Yet the efficacy of these drastic solutions remains unproven.[8] Canada's road-tested cost-containment methods offer an alternative.

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Online-Only Material: The eAppendix, eFigure, and eReferences are available at http://www.archinternmed.com.

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HEALTH AFFAIRS

February 15, 2012

Medicare and Commercial Health Insurance : The Fundamental Difference

By Diane Archer and Theodore Marmor

As the debate over Medicare continues in connection to America's fiscal problems, it is critical to understand how Medicare differs from commercial health insurance for working people. There is a fundamental difference between these two types of health insurance plans, one social and one commercial.

The basic difference between Medicare and commercial insurance is that Medicare is designed to absorb risk, serving individuals who have or may have costly and complex medical needs as well as the relatively healthy, whereas commercial insurance is required to protect its business interests by avoiding those most likely to use medical care. That's why Medicare was first enacted. *People over 65 were imable to buy commercial insurance because they use three times more medical services than working people*; it was unaffordable or insurers simply refused to provide it. And now it's simply unrealistic to imagine that commercial insurance companies will change their fundamental business model and work to protect the health and financial security of most Americans.

Medicare's mandate: Medicare is a federally administered insurance program that Americans pay into throughout our working lives and enroll in after they retire or in case of a serious disability. It pools the resources of the entire nation to protect older and disabled Americans from the risk of an unforeseeable financial disaster in the event of an acute illness, an injury, or an expensive chronic condition. All American workers finance the program and all are covered by it once eligible: no one is excluded because of their age, health status, or their income. Meanwhile the program is obligated to pay for all necessary care for the eligible population, wherever they live in the country and whatever else may be true about their history, prospects, and preferences. Medicare only denies claims for medically unnecessary care.

Commercial insurance's mandate: Commercial health insurance, even with regulations, has an entirely different mandate. Its fundamental purpose is commercial. Insurance corporations receive premiums that must fund the costs of their enrollees' health care and administrative costs, as well as profit margins sufficient to allow borrowing in the capital markets. To make that work, insurance firms avoid risk. They are rewarded for avoiding, within the rules of the day, those who are already sick, those likely to become sick, and those whose incomes are relatively low.

In short private insurers must limit the risks they take on in order to survive. And that itself explains a good deal of the behavior that has made commercial health insurance firms unpopular: inclinations to make eligibility difficult for anyone who has or whom they believe is likely to have a costly condition, postpone the payment of claims, quibble about the scope of coverage, and many other behaviors that have filtered into the day to day vocabulary of Americans. The Affordable Care Act takes a good first step at moderating differences and limiting this behavior, but it cannot and does not encourage insurers to pool risk or design plans that attract people with costly conditions as Medicare does.

Commercial insurers will always seek to minimize their exposure to risk: It's simply unrealistic to expect commercial insurers to do the job Medicare is already doing. Before Medicare was created in 1965, many argued that the federal government should simply subsidize the purchase of commercial insurance for seniors. But it became clear — even to the industry — that commercial insurers could not find a way to profitably cover older Americans, even with a subsidy. Yet today, some in Congress are embracing the system that was rejected nearly 50 years ago.

The fundamental nature of commercial insurers will undermine any effort to use them to protect the most vulnerable Americans. No matter what regulations are instituted in an attempt to guarantee their good behavior, commercial insurers will still have an incentive to avoid risk, and they will do so insofar as it is possible.

In Massachusetts, where insurers must offer coverage to anyone, plans avoid offering adequate coverage for costly conditions and disguise what they are actually selling. Even heavily regulated Medicare Advantage commercial plans are designed to push people in poor health into traditional Medicare in order to avoid actually paying for care, and they have successfully overcome policies meant to halt this practice. They are also less likely than traditional Medicare to counteract the health care inequalities facing peole of color, people with low incomes, the chronically ill, and the disabled.

Since commercial insurers are not publicly accountable, it is difficult to say exactly how commercial insurers perpetuate these inequalities; their data are proprietary, and they generally keep the payment policies that allow them to remain profitable secret.

(continued on next page)

The Supreme Court ruling on Obamacare: A physician's perspective

By Ann Settgast, M.D.

The day the Affordable Care Act (ACA) was upheld by the Supreme Court was ironic for me as a physician. Two of my patients asked me to prescribe medication for uninsured family members: A mother asked me for an inhaler for her adult son with uncontrolled asthma, and another asked me if I could refill her husband's blood pressure medications for a month or two until he is able to find another job following his lay off. He cannot see his doctor due to his uninsurance.

One might think I felt better at the end of that morning clinic knowing the ACA had been upheld. But, I didn't. You see, even with the ACA in place, we have no reason to believe these two men will obtain access to care. In Minnesota, more than 250,000 will remain uninsured after the ACA's implementation. These Minnesotans will remain invisible like the family members I describe, and some of them may die. After all, uninsurance is a risk factor for preventable death in the United States. However, this is not the only problem. Thousands more will remain underinsured. Any practicing physician can tell stories about underinsurance —we see it when recommendations we make to our insured patients are not taken because the deductible hasn't been met or the co-pay is unaffordable. Minnesota ranks second in the nation for uptake of high-deductible plans, so underinsurance here is alive and well.

I hate to be a spoilsport while many are celebrating the Supreme Court's decision, but the truth is, as a society, we have again sold ourselves short. Here, in this incredibly wealthy nation with vast resources, rather than actually fixing the problem, we will continue to allow patients to forgo needed care because of cost. We have still not joined other wealthy nations in recognizing health care as a human right.

It has been disheartening to hear post-ruling commentary on both sides of the ACA debate because much of it simply isn't true. One politician actually claimed that now the U.S. was joining all other industrialized countries in finally providing universal care … but more than 20 million Americans will be uninsured if the ACA is fully enacted. I need not spell out the blatant falsehood here. I've also heard that now, Americans will not face medical ruin because of healthcare costs. Again, the facts simply belie the statement. The medical bankruptcy rate in Massachusetts did not budge with implementation of the mandate there. That state, now with the lowest uninsurance rate in the nation, also boasts the highest per capita costs. Forcing people to buy skimpy policies that leave them without proper access to care and vulnerable to financial ruin is not meaningful reform. Rather, it is perpetuation of our current dysfunction.

In Minnesota, we can and should hold ourselves to a higher standard. By enacting a single-payer, Medicare-for-All system, we could show the nation what happens when individuals flourish and fulfill their productive potential without the fear of financial ruin should they become ill. By severing our unhealthy relationship with a private insurance industry that amasses great wealth at the expense of sick patients, we can save a tremendous amount of money and actually spend it on health care. The Lewin study, earlier this year, showed us that the administrative simplicity of a single-payer in Minnesota would save our state $4 billion annually while covering everyone with comprehensive care. Now that's a solution I could celebrate.

Ann Settgast is a primary care doctor practicing in St. Paul. She represents Physicians for a National Health Program's Minnesota chapter which now has nearly 1,000 physician and medical student members. This article appeared in Southside Pride (Minneapolis) on Aug. 7, 2012.

(continued from previous page)

Medicare is more cost-effective than commercial insurance: Commercial insurance is less effective than Medicare on any number of metrics. Because Medicare has such an enormous coverage pool, the program has bargaining power that no commercial insurance company can match. On average, Medicare manages to pay 22 percent less than what commercial plans pay for physician services, so the only way those plans could compete would be by offering 22 percent fewer services.

Unsurprisingly, Medicare's per capita costs have risen more slowly than commercial insurers' and are projected to continue doing so. Meanwhile, commercial insurers invest so many resources in *avoiding* paying for actual medical care that their administrative costs are much higher. Commercial insurance meets the health care needs of most working people because most workers most of the time do not need a lot of health care.

Only Medicare is designed to insulate Americans from risk: This essay has laid out the differences between two different ideal types of insurance. The realities of how plans actually work can be substantially more complicated. Medicare hospital insurance (Part A) most fully conforms to the social insurance model, since it is financed by proportional contributions from all citizens, whereas Part B uses general revenue and a yearly premium. Meanwhile regulations can moderate the difference between commercial and social insurance. But nothing can change the underlying reality that programs like Medicare are designed to absorb and broadly distribute risk, protecting everyone, while commercial insurers are designed to select and protect individuals with the fewest needs.

The belief that competition among private health insurance firms can produce cost savings or higher quality care represents the victory of illusion over evidence. We need to let the existing Medicare system do what it already does effectively: insulate Americans from risk, rather than shift risk to the most vulnerable citizens.

The Des Moines Register

July 16, 2012

Head-in-the-sand 'solution' is killing GOP

By Jack Bernard

We Republicans have ourselves to blame for the Affordable Care Act, or Obamacare.

Our reaction to the Clinton health reform proposals in the early 1990s was to have conservative think tanks come up with a free competition model based on expansion of private insurance and Medicaid. That idea became Romneycare, which evolved into Obamacare.

It is our baby, ugly or not.

It is the height of hypocrisy for us now to criticize our own idea unless we have something better to replace it. And, the replacement needs to be comprehensive, not just a series of unacceptable statements and proposals based on doing away with traditional Medicare by turning it into a voucher program and gutting Medicaid by making it into a block grant.

Using vouchers for Medicare just dumps the cost problem into the lap of the powerless patient, rather than the federal government that has clout, making the cost escalation problem worse. The block grants for Medicaid idea just shifts the cost issue onto the states rather than the federal government, which once again solves nothing and only makes things worse.

States will just cut services and people from their Medicaid roles, creating more uninsured. Don't Iowa hospitals serve enough uninsured in their emergency rooms now?

This gets us to what we as Republicans should do: throw out our rule book and be innovative. People my age will remember how we Republicans were 100 percent against recognizing China before Richard Nixon, the anti-communist crusader, came out for it. We must do the same with health care.

There is only one way to control health care costs and insure universal access — and that is by first admitting that the U.S. system has failed and then adopting ideas that have been proven to work elsewhere. We should take a look at how health care is financed and delivered in other developed nations with lower cost and better morbidity and mortality rates.

A Commonwealth Fund study was issued in May 2012 which did just that for 13 countries. The bottom line is that we spend 17.4 percent of our gross national product on health care, far more than other developed nations, which averaged 9.5 percent. Our per-capita spending was $7,960 versus $3,182 for the group as a whole.

Why? One key factor is prices. For example, U.S. pricing on the 30 most commonly prescribed brand name drugs is one-third higher than Canada and double France, both of which have a form of Universal Medicare.

From looking at the international data, if we Republicans really want to dump the Affordable Care Act, the way to go is Medicare for all. Studies show that the nations with universal health care have better overall health care outcomes than we do, not worse.

And, according to the respected Physicians for a National Health Program, www.pnhp.org, yearly savings generated under Medicare for all would be $400 billion. That would go a long way towards paying for universal coverage, versus the Affordable Care Act, which will increase systemic costs because it relies on private insurance.

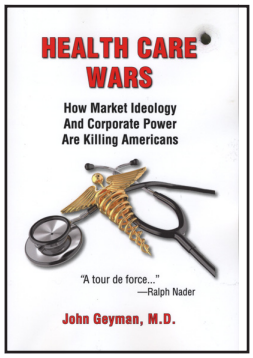
The canard about waiting times to see doctors is just a tactic to scare the public. If you need a knee replacement for a knee that has been going bad for years, waiting a little longer for an operation should not be a major issue for the patient. Despite the scare tactics, no one who needs immediate care in Canada is ever left to sit in a line. In any case, there should be no waiting lists at all here. Canada spends just $4,363 per capita on health care versus our $7,960.

If we Republicans took the Medicare-for-all approach, it would thrust us into the vanguard of reform. Instead of the Democrats stealing our ideas, we could steal theirs. When it was implemented and turned out to be widely accepted, as was Medicare in the 1960s, we would be the party the public would look to for the future.

Of course, there is an alternative. We can stick our heads in the sand and push for infeasible actions. That approach is killing us regarding immigration and will work just as well for health care.

Jack Bernard of Monticello, Ga., is a retired health care executive who worked extensively with Iowa health care providers, including Iowa Health System. He now is a member of the Jasper County (Ga.) Board of Commissioners and Jasper County Board of Health.

'Health Care Wars' by Dr. John Geyman



"Health Care Wars," Dr. Geyman's tenth book on the failing U.S. health system, reveals the corporations and ideology behind our health care crisis and why we need a single-payer system more than ever after the passage of the Affordable Care Act. Dr. Geyman served as chairman of the Department of Family Medicine at the University of Washington School of Medicine in Seattle from 1976 to 1990, and president of PNHP from 2005-2007. He is a member of the Institute of Medicine.

"Health Care Wars: How Market Ideology and Corporate Power are Killing Americans," Copernicus Healthcare, 2012, 227 pages, many tables and figures. Available now at www.pnhp.org/store at the special discounted price of $10.

THE WALL STREET JOURNAL. August 2, 2012

Remember Managed Care? It's Quietly Coming Back

By Anna Wilde Mathews

Under pressure to squeeze out costs, some of the U.S.'s biggest health insurers are quietly erecting more hurdles for patients seeking medical care.

The companies are in many cases reaching back to the 1990s and boosting the use of techniques that antagonized patients and doctors alike.

Today's approaches are tweaked, but may feel familiar to many: Insurers are rolling out plans with more restricted choices of doctors and hospitals, and weighing new requirements for referrals before patients can see specialists.

UnitedHealth Group Inc., Cigna Corp. and others are increasingly requiring doctors to get prior authorization before patients can get certain care such as spinal surgeries.

Earlier versions of these practices were closely identified with the managed-care era of the 90s. They later receded in many parts of the country, as employers switched away from restrictive health-maintenance organizations, and insurers backed off some limits.

Health insurers say today's versions of 1990s strategies are very different, and use new technology to focus closely on improving care as well as reining in expenses.

UnitedHealth, for one, said it is using prior authorization "surgically" to counter "extreme variations in quality and cost." But doctors aren't sure how much things have changed.

"There seems to be a return we're hearing about to some of the old practices that have been very frustrating to physicians," said Jeremy A. Lazarus, president of the American Medical Association.

In its 2012 analysis of medical billing claims, the AMA saw a 23% increase in the share that included an insurer pre-authorization review, to 4.7%. For certain types of procedures, the percentage is far higher, according to athenahealth Inc., which provides electronic health records. Still, the company said, only 4.9% of all the prior authorization requests it processed were denied in 2011.

Today's approaches are tweaked, but may feel familiar to many: Insurers are rolling out plans with more restricted choices of doctors and hospitals, and weighing new requirements for referrals before patients can see specialists.

Erica Swegler, a family physician in Keller, Texas, said the growing number of prior authorizations she has to secure for treatments such as high-tech imaging scans "costs me a tremendous amount of time." The approvals typically take 48 to 72 hours, and sometimes longer if she needs to have a phone conversation with an insurer, she said. "It's a huge headache."

Insurers are responding to pressure from employers to tamp down costs and address evidence of disparities in quality. In recent years, employers have shifted a growing share of the expense of coverage onto workers, and companies are betting employees will accept trade-offs they rejected 15 years ago in order to prevent premiums from jumping even faster.

"This is back to the future," said Eric Grossman, a senior partner at Mercer, a consulting unit of Marsh & McLennan Cos. Employers are interested in "rigorous, aggressive medical management," including prior authorization, as well as limited networks of health-care providers, he said. Some insurers have promised savings of 3% to 5% from narrow-network plans, he said, and reductions of more than 10% if other restrictions are added, including even fewer choices of medical providers, strong pre-authorization, and requirements for patients to get a referral to access specialty care.

Managed-care limits "did slow the growth of costs in the 1990s," said David Cutler, a Harvard University economist. But after consumers and doctors revolted, "managed care got neutered." According to the nonpartisan Kaiser Family Foundation, private health spending flattened in the 1990s, adjusted for inflation, and decreased in one year, 1994, before surging back toward the end of the decade. The foundation's analysts attribute the dip largely to managed-care practices.

In a move widely seen as a symbolic end of the era, UnitedHealth in 1999 said it would stop second-guessing doctors' decisions before treatment, and adopted a "care coordination" process that wasn't supposed to require formal preclearance.

But this spring, UnitedHealth's insurance arm, the nation's biggest, told employers that over the next 18 months, care coordination will generally be replaced by a new "prior authorization" process, according to company documents prepared for clients.

For certain services and tests, including joint replacements and spine surgeries, the documents said, "services determined to be not medically necessary" beforehand wouldn't be covered.

The shift discussed in the documents is aimed at moving to a common standard, and some plans acquired after 1999 were already using forms of prior authorization, a UnitedHealth official said. Insurers also said they are working with doctor groups to smooth the process.

Other insurers are expanding prior authorization in some areas, which they say are targeted narrowly based on patterns of pricey care that doesn't always match medical guidelines.

WellPoint Inc. is developing a program for certain cancer drugs and this fall will start one for tests that diagnose sleep-related conditions. Aetna Inc. said it generally expects to use the process "more in the future, not less."

Cigna started requiring prior authorization for certain back surgeries last year, and is considering procedures in radiation

oncology and cardiology.

"It's very low friction, it's clinical quality, and we lower costs," said Alan Muney, chief medical officer at Cigna, which he said has also in the past eliminated the requirements in some areas.

Care, a health-advocacy firm based in Milwaukee, has seen an uptick in patients like Sandi Kane, a community education director in Shawano, Wis., who says her doctor's office submitted a request for a machine to help treat her sleep apnea in mid-June, and it's been tied up in red tape since then. The administrator of her employer's insurance wanted more documentation for why she needed the pricier model, and she still hasn't gotten an approval, she said.

"There are just so many steps that need to be taken," Ms. Kane said, and she feels caught in the middle between the recommendation of her doctor's office and her plan's rules. Alliance Benefit Group Medical Services Ltd., which administers Ms. Kane's coverage under the Auxiant brand name, said it declined to comment on "individual plan participant matters."

Insurers have been experimenting with smaller provider networks for years, and are now rapidly ramping up, though they continue to simultaneously sell typical broad preferred-provider organization plans. The narrower plans can have closed structures that work like the classic HMOs. But they also have "tiered" designs, with patients facing bigger out-of-pocket charges if they go to providers that aren't in the top category, then even-larger bills if they go completely out of network.

Plans that include fewer medical providers are seen as likely to appeal to people shopping for their own budget-conscious coverage starting in 2014, since consumers may only need to lock in access to their own favored doctors or hospitals, rather than the broadest variety.

Insurers can reduce costs with narrow networks because they can exclude the priciest doctors and hospitals. Also, they can wring rate concessions from medical providers that fear losing patients.

WellPoint is "rolling out a number of narrow and tiered networks" across its markets, said Ken Goulet, executive vice president. These networks involve around 30% to 70% of the company's full list of providers, he said. They will be available in six of WellPoint's 14 states by the end of this year, and are aimed at all of them by January 2014, the company said.

Aetna has long had tiers for specialists, and last year added a new version for hospitals, with the smaller group generally representing 50% to 60% of the insurer's full network. This year it started creating even skinnier—and cheaper—options that generally include just 30% to 40% of Aetna's specialists and hospitals, said Carl King, the company's head of national networks and contracting services. Those will be available in more than 20 markets by the end of next year.

Another 1990s twist, forcing patients to get sign-offs from primary-care doctors before seeing specialists, also may see a comeback. UnitedHealth last year introduced in four states a plan design called "Navigate" that has such a requirement, and the company is expanding it to 16 states this year and more in 2013; the company said it helps build the doctor-patient relationship to "emphasize quality care and more efficient use of care."

WellPoint's Mr. Goulet said his company, which is starting to pay primary-care doctors more to help coordinate care, is also considering more plans with such rules; it already has them in some older HMOs.

Insurers said current versions of old approaches are driven by better information, which helps them focus on improving care, not just saving money. The doctors and hospitals in the narrow networks are selected based on quality measures as well as cost, they say, while data help them ensure they use prior authorization only where it is needed.

"Technology is fundamentally different from what it was in the 1990s," said John Wilson, vice president of analytics at UnitedHealth Group's OptumInsight unit.

Give a grand rounds – or invite a PNHP speaker!

PNHP offers excellent speakers for grand rounds, residency noon conferences and specialty meetings on a variety of topics, including a presentation covering the U.S. health care crisis, the impact of PPACA and the alternative: single-payer national health insurance.

PNHP-delivered grand rounds can assist residency programs in fulfilling ACGME's Systems-based Practice competency requirement.

We have many speakers throughout the U.S. who serve in this capacity (perhaps you're one of them!) or as members of our Speakers Bureau.

Over the past year, several PNHPers participated in whirlwind 2-3 day speaking tours, each with up to a dozen speaking engagements and media interviews arranged by host PNHP chapters and activists.

Dr. David Ansell, author of "County: Life, Death and Politics at Chicago's Public Hospital," gave grand rounds and met with local press on his recent trips to Louisville, Ky., and St. Louis (and is open to doing more!). His visit to Louisville resulted in a profile in the local medical society's magazine.

Dr. David Ansell

Dr. Margaret Flowers' tour of Maine was organized by Dr. Phil Caper and Maine AllCare. Drs. Marcia Angell and Arnold Relman, former editors of the New England Journal of Medicine, gave a number of talks in Portland, Ore. (see article by Dr. Samuel Metz, page 31), while PNHP Past President Dr. Oliver Fein's most recent visit was to Rhode Island to help kick off the new chapter being organized there by Dr. Mark Ryan and others.

Many of our speakers request little or no honoraria unless travel is required. To work with your institution in scheduling a grand rounds, please contact us at (312) 782-6006 or info@pnhp.org.

HEALTH AFFAIRS

October 11, 2012

Will pay for performance backfire?

By Steffie Woolhandler, David Himmelstein and Dan Ariely

Paying for performance (P4P) has strong intuitive appeal. Common sense and rigorous studies tell us that paying more for, say, angioplasties or immunizations yields more of them. So paying doctors and hospitals for better care, not just more of it, seems like a no-brainer. Yet while Medicare and many private insurers are charging ahead with pay-for-performance (P4P), researchers have been unable to show that it benefits patients.

Findings from the new field of behavioral economics may explain these negative results. They challenge the traditional economic view that monetary reward is either the only motivator or is simply additive to intrinsic motivators such as purpose or altruism. Studies have shown that monetary rewards can undermine motivation and worsen performance on cognitively complex and intrinsically rewarding work, suggesting that P4P may backfire.

The Research Record On P4P

Researchers have failed to demonstrate that financial incentives can improve patient outcomes, and not for lack of trying. Reviews of early, mostly small P4P studies found virtually no evidence of global quality improvement; mixed evidence on improvement on incentivized process-based measures; and occasional unintended harms.

Two Cochrane reviews appearing in 2011 reached similarly agnostic conclusions. One overview found that "financial incentives may be effective in changing health care professional practice", but unearthed "no evidence that financial incentives can improve patient outcomes." Another, focused on primary care, found "insufficient evidence to support or not support the use of financial incentives."

The latest findings are no more reassuring. In Britain's massive P4P initiative in primary care, after early apparent success, improvement plateaued for incentivized performance measures and quality deteriorated for non-incentivized measures like continuity of care. Although doctors reported meeting virtually all P4P hypertension targets (including surrogate outcome measures that were incentivized),neither population blood pressures nor hypertension complications fell.

The major U.S. P4P experiment also yielded a null result. In Medicare's Premier Hospital Quality Incentive Demonstration, the 200 participating hospitals' process-of-care quality indicators improved more rapidly than control hospitals' over the first two years, according to one oft-cited study. But differences between P4P and control hospitals had evaporated by five years and patient outcomes didn't improve at all. Incentives specially targeted to low-performing hospitals were also ineffective.

No one has undertaken a large-scale randomized controlled trial (RCT) that might definitively determine the effect of P4P in healthcare setting. However, researchers have completed two trials of the impact of financial incentives on professional performance in education, a milieu with similarities to health care. A $75 million RCT — involving over 200 high-needs New York City schools employing more than 20,000 teachers — offered incentives of up to $3,000 per teacher based on students' test scores, graduation and attendance rates, and the results of learning environment surveys. Notably, most schools opted to pool bonuses among all teachers at the site — the type of institution-level incentives that some P4P proponents advocate. Yet, ". . . incentives . . . did not increase student achievement in any meaningful way. If anything, student achievement declined." And bigger teacher bonuses yield no better results. In a Tennessee RCT, offering middle school mathematics teachers P4P bonuses of up to $15,000 failed to raise standardized test scores.

Of course the absence of proof of P4P's effectiveness does not prove that it's ineffective. But, as with other clinical innovations, the mounting number of null studies should breed skepticism. Moreover,evidence suggests that ubiquitous gaming of quality measurement (e.g. by upcoding diagnoses) may uncouple reward from actual performance; even good people (including doctors and hospital leaders) cheat a little bit when they stand to gain from it, while deceiving themselves into believing they're honest.

Nonetheless enthusiasm for P4P remains strong. Medicare is moving ahead with P4P programs for hospitals, ACO's, HMOs and physicians, and major private insurers are following suit. Even skeptical scholars have focused mostly on technical specification problems, e.g. identifying better performance yardsticks and the right mix of incentives, or fine-tuning risk adjustment. Few have countenanced the possibility that P4P may simply not work in health care.

The Science Of Performance And Reward

The quality improvement literature has pinpointed many causes of quality breeches in medical care: fatigue; poorly designed workflow and care systems; undue commercial influence; knowledge gaps; memory lapses; reliance on inappropriate heuristics; poor interpersonal skills and insufficient teamwork, to name just a few. But "not trying" is rarely cited. Yet P4P implicitly blames lack of motivation for poor quality care.

But even when motivation is the problem, money isn't always the solution. Findings from the new field of behavioral

economics indicate that performance bonuses often backfire, particularly for cognitively challenging work.

Traditionally, economists have viewed extrinsic (i.e. monetary) reward as either the only motivator (Figure 1a), or as simply additive to intrinsic motivators such as purpose, altruism, mastery, or autonomy (Figure 1b). According to this view, higher pay induces better performance. (Figures appear at the end of this post.)

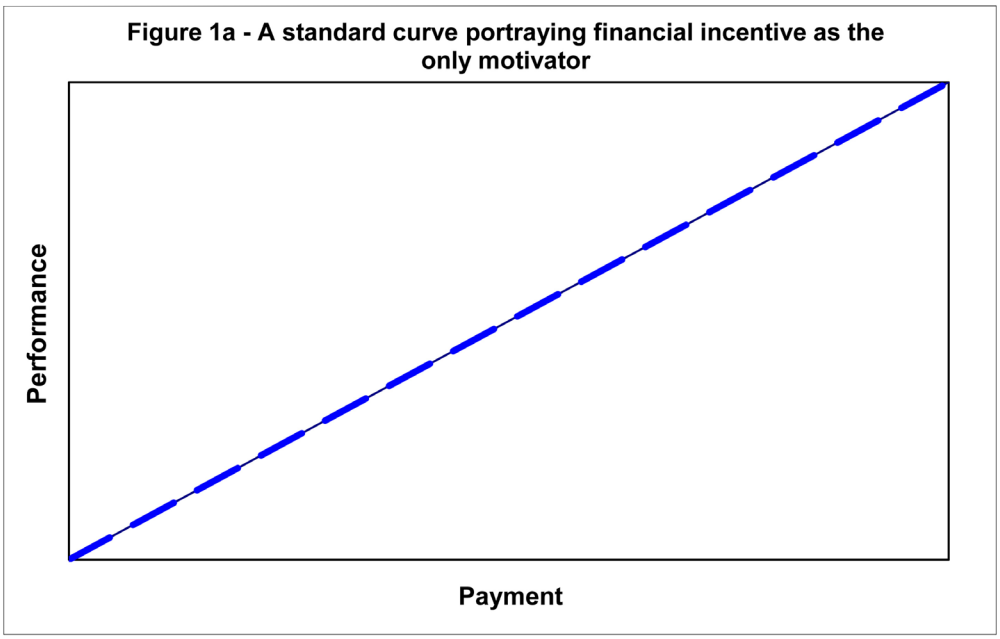
But this simple model of reward-induced performance ignores the complexity of human drive, particularly the role of intrinsic motivation — the desire to perform an activity for its own inherent rewards. Offering your dinner party host a $10 reward for cooking a wonderful meal isn't likely to motivate future invitations.

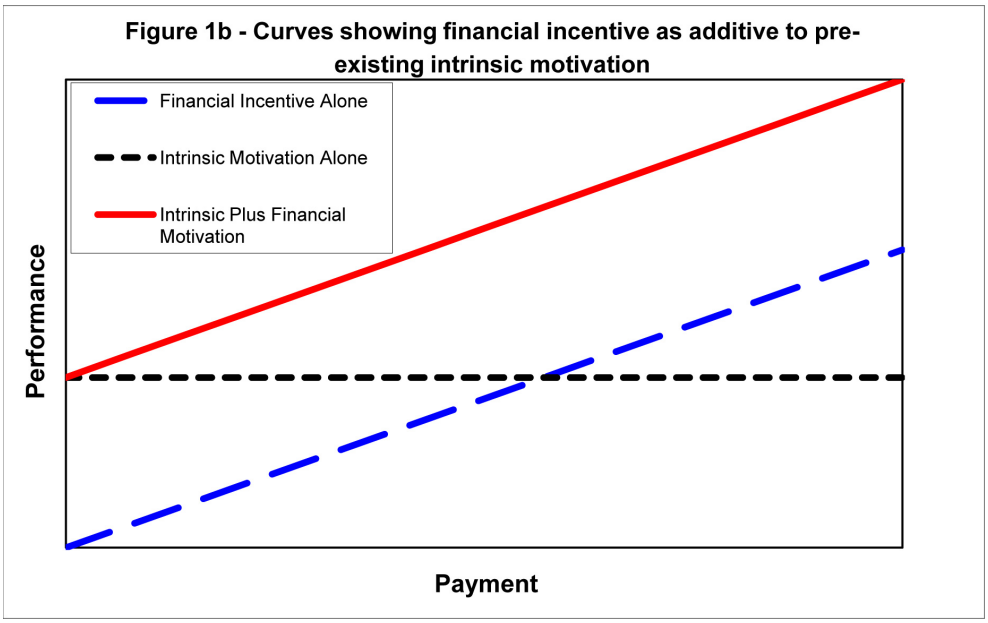
Experimental data documents that financial incentives often "crowd out" intrinsic motivation. For instance, college students will spontaneously play with interesting puzzles, but once they're paid to solve them they lose interest in playing for free.

Among frequent (presumably highly motivated) blood donors, an incentive payment (about $55 in today's dollars) decreased donations in an RCT. In contrast, payments increased donations among those who hadn't donated for years. A Swiss study of volunteer work reached a similar conclusion; unpaid volunteers worked, on average, four hours more monthly than those offered a small payment.

Financial incentives also had untoward consequences in an RCT in Israeli day care centers. In centers that imposed fines on parents for picking up children late, tardiness increased, and remained high even after the fines were eliminated. Fines had transformed promptness from a moral duty to a market transaction governed by price.

Moreover, RCTs have shown that upping the rewards may not overcome motivational crowd-out. In an experiment carried out among MIT students (at semester's end, when many were cash-strapped) those offered up to $300 for solving mathematical puzzles performed much worse than students offered only $30. (In contrast, the highly incentivized students did better on simple tasks requiring only manual effort.) Huge incentives offered to rural villagers in India — equivalent to about half of their annual money income — worsened performance on complex memory and puzzle-solving tasks. High stakes incentives may be distracting, interfering with cognitive focus and creativity.





A meta-analysis summarizing 128 studies indicates that such findings are representative of a consistent body of research.

The conclusions that emerge from the extensive literature on motivational crowd out include:

- Tangible rewards — particularly monetary ones — undermine motivation for tasks that are intrinsically interesting or rewarding, an effect that is quite large.
- Symbolic rewards (e.g. praise or flowers) do not crowd out intrinsic motivation, and may augment it.
- The negative effects of monetary rewards are strongest for complex cognitive tasks.
- Crowding-out effects tend to reduce reciprocity and augment selfish behaviors.
- Crowding-out may spread (both to other tasks and to co-workers), decreasing intrinsic motivation for work not

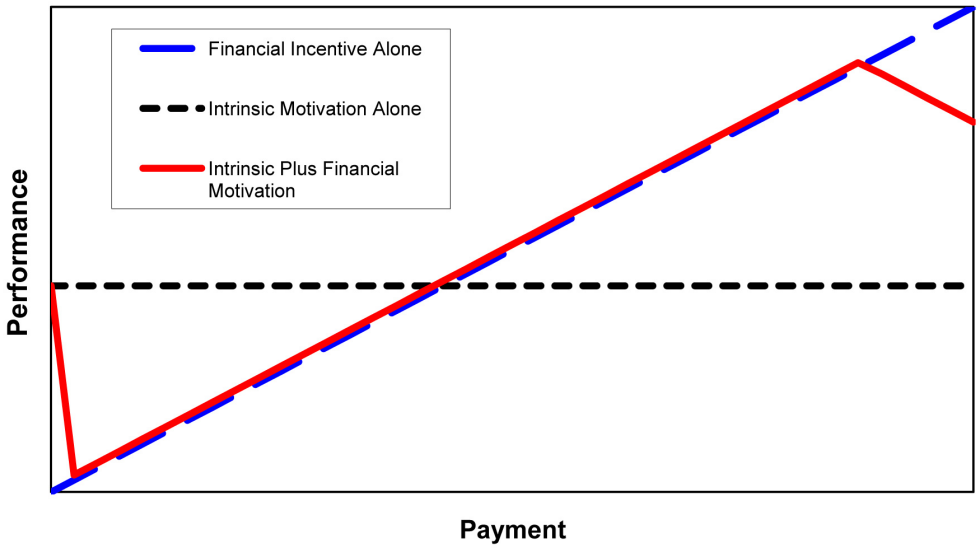
directly incentivized by the monetary rewards.

- Crowding-out is strongest when external rewards are large; perceived as controlling; contingent on very specific task performance; or associated with surveillance, deadlines or threats.

Although none of these studies analyzed physician or hospital performance, most conditions shown to weaken intrinsic motivation are integral to medical P4P.

Finally, as indicated graphically in Figure 1c, motivational crowd-out works in the opposite direction to the standard supply curve, where performance rises with price. The net effect of financial rewards depends on the relative size of the price effect and the crowding-out effect. When crowding-out is modest, the classic economic model underlying P4P holds; you get what you pay for. However, if intrinsic motivation is high and crowding-out is strong, payment may worsen performance.

Figure 1c - Curves showing financial incentive crowding out pre-existing intrinsic motivation.



Contract Theory And P4P

Until recently doctors' and hospitals' payment contracts specified only the general parameters of the exchange (e.g. spend 30 minutes with the patient, or provide a day of ICU care for a heart attack patient). Most details and unexpected contingencies were covered by social and professional norms.

In contrast to these so-called "incomplete contracts", P4P strives to cement the deal with an airtight agreement specifying all deliverables in advance – a more "complete contract". Yet when it comes to contractual detail, more may not be better.

The optimal specificity of contracts has interested economists' at least since Ronald Coase's 1937 paper on the nature of firms — work that was recognized with a Nobel economics prize in 1991 and laid the foundation for Oliver Hart's pioneering work on incomplete contracts.

Coase and Hart noted the exorbitant administrative and legal costs of spelling out and enforcing complete contracts. (Indeed, they posited that these transactional inefficiencies drive entrepreneurs to form firms rather than outsourcing all tasks.) In medicine, the increasing specificity of contracts — a trend that predates P4P — has coincided with a sharp rise in administrative costs.

Costly administration is not the only downside of complete contracts. If something is omitted from an exquisitely detailed agreement there's no presumption of default to goodwill — its happy hunting season. When one of us (DA) asked the Dean of Duke's Law School about its honor code, he replied that it amounted to little more than "don't do anything dishonorable". Lists of rules ("don't raise chickens in your dorm room; don't smoke hashish") implicitly permit everything else.

Moreover, highly prescriptive contracts have a behavioral downside. Because professionals may (correctly) perceive detailed contracts as controlling, such contracts tend to worsen motivational crowd-out. When specifying every detail and contingency isn't possible, as is clearly the case in medicine, itmay be better to rely on professional and social norms.

Conclusions

None can doubt health care's grave quality deficits and cost excesses. As remedy, P4P suggestsmanipulating greed, a fuel that's powered exponential growth in productivity in the overall economy. But Adam Smith, who first recognized greed's awesome power, was also a moral philosopher who believed that commodity production required a parallel public service economy driven by social duty.

Sadly, greed has caused many of the worst abuses within the current system. Injecting different monetary incentives into health care can certainly change it, but not necessarily in the ways that policy makers would plan, much less hope for.

THE ORANGE COUNTY REGISTER

AUGUST 17, 2012

First, do no harm. Second, nationalize

By Teryl Zarnow

It sounds like a golden age in medical care. You went to the doctor and received medical care. You didn't jump through hoops such as prior authorization, referrals, or network providers.

"Insurance didn't interfere," recalls Dr. Don McCanne, who practiced family medicine for 31 years in San Clemente before retiring in 1997. "You just took care of the patient."

Then in the 1990s came the "managed care revolution." Suddenly, he says, the private sector "intruded in the relationship between the physician and the patient."

In his practice, McCanne worked evenings and weekends to treat the poor or undocumented without health insurance. Today he sees the same problems getting worse: Medical costs have soared, and many people still don't have access to health care.

McCanne, now 74, volunteers as a policy fellow for Physicians for a National Health Program (PNHP) where he was a past president. His group favors a single-payer national health program often called "Improved Medicare for All."

It's not socialized medicine, just socialized insurance. I can't decide if the doctor is out of touch with reality or a prophet in blue jeans.

The idea is to take health insurance down to the studs. The Patient Protection and Affordable Health Care Act, which survived a judicial cliffhanger in the Supreme Court, only remodeled the existing structure.

McCanne believes the act corrects several issues, but doesn't go far enough. His group's position is that when the law is fully implemented in 2017, more people will be insured, but under plans that won't provide adequate coverage. Many low-income families could be left out altogether, and medical costs will continue to rise.

"It didn't fix the system," he says.

McCanne describes an alternative that sounds stunning in its simplicity: Everyone would be automatically enrolled in a national health plan at birth. There would be no deductible, no out-of-pocket, no coinsurance, and no networks. It's similar to Canada's national insurance.

"It returns choice to the patient and removes monetary barriers to care."

Doctors and hospitals would deal with only one plan, cutting administrative costs and improving planning. Today, McCanne notes, 31 cents of every health care dollar is spent on administrative costs.

We would pay for this insurance through an employer payroll tax and income tax. Physicians for a National Health Program believes most taxpayers would spend less than they do now.

McCanne doesn't seem like a doctor who could hustle you in and out of his office in seven minutes without making eye contact. He also doesn't seem like a policy wonk.

Dr. Don McCanne

The son of a doctor, he seems like a guy fundamentally offended by the way things work today. Too many uninsured patients came to him too late, ignoring a malady until it has reached a late stage.

"We are the only nation that rations health care based on ability to pay... As a doctor, if someone needs health care, I give them health care. That's just the way it should be."

McCanne's group – a non-partisan think tank that seeks to educate the public about what works and what doesn't work in health reform — believes we won't control health care costs until we reform the way we pay for them. The group estimates a single, national insurance plan could save over $400 billion per year in administrative costs.

McCanne also argues we should stop allowing medical costs to drive families into bankruptcy.

"Half of all personal bankruptcies have medical debt as a contributor and of those ... three-fourths were insured... so insurance is not providing the financial protection it's supposed to."

I see the logic, but isn't it a little naive to think the insurance industry and lawmakers are going to fall into line behind a change simply because it makes sense?

"I'm a pragmatic idealist," he responds. "I'm not for incrementalism, which doesn't work at all. ... Or for supporting legislation because it's what we can get passed....

"We support policy that really works."

In McCanne's upstairs office, underneath the Hippocratic Oath hanging on the wall, is a model of David and Goliath. Against the odds, David scored a knockout.

For the full profile of Dr. McCanne, from which this was excerpted, visit bit.ly/OGaYaF.

5 Myths About Canada's Health Care System

The truth may surprise you about international health care

By Aaron E. Carroll, M.D., M.S.

How does the U.S. health care system stack up against Canada's? You've probably heard allegedly true horror stories about the Canadian system — like 340-day waits for knee replacement surgery, for example.

To separate fact from fiction, Aaron E. Carroll, M.D., the director of the Center for Health Policy and Professionalism Research in Indianapolis, identified the top myths about the two health care systems.

Myth #1: Canadians are flocking to the United States to get medical care.

How many times have you heard that Canadians, frustrated by long wait times and rationing where they live, come to the United States for medical care?

I don't deny that some well-off people might come to the United States for medical care. If I needed a heart or lung transplant, there's no place I'd rather have it done. But for the vast, vast majority of people, that's not happening.

The most comprehensive study I've seen on this topic — it employed three different methodologies, all with solid rationales behind them — was published in the peer-reviewed journal Health Affairs

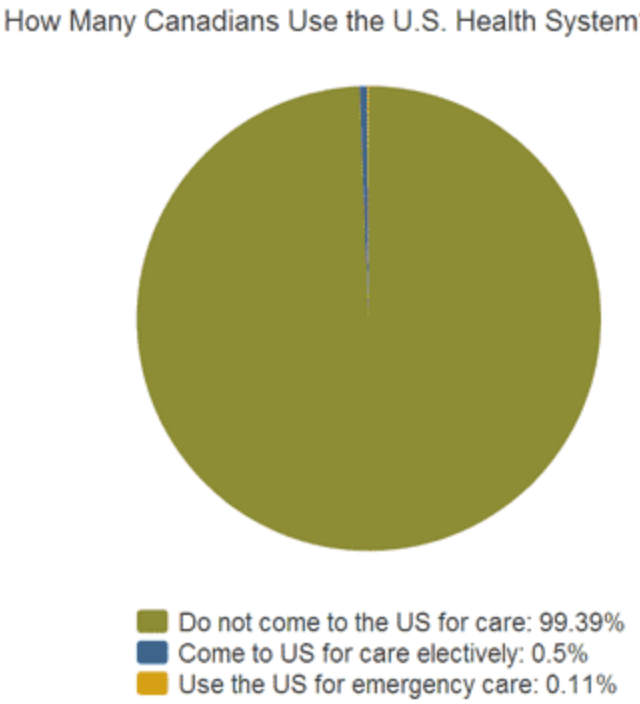
Dr. Aaron Carroll

The authors of the study started by surveying 136 ambulatory care facilities near the U.S.-Canada border in Michigan, New York and Washington. It makes sense that Canadians crossing the border for care would favor places close by, right? It turns out, however, that about 80 percent of such facilities saw, on average, fewer than one Canadian per month; about 40 percent had seen none in the preceding year.

Then, the researchers looked at how many Canadians were discharged over a five-year period from acute-care hospitals in the same three states. They found that more than 80 percent of these hospital visits were for emergency or urgent care (that is, tourists who had to go to the emergency room). Only about 20 percent of the visits were for elective procedures or care.

Next, the authors of the study surveyed America's 20 "best" hospitals — as identified by U.S. News & World Report — on the assumption that if Canadians were going to travel for health care, they would be more likely to go to the best-known and highest-quality facilities. Only one of the 11 hospitals that responded saw more than 60 Canadians in a year. And, again, that included both emergencies and elective care.

Finally, the study's authors examined data from the 18,000 Canadians who participated in the National Population Health Survey. In the previous year, 90 of those 18,000 Canadians had received care in the United States; only 20 of them, however, reported going to the United States expressively for the purpose of obtaining care.



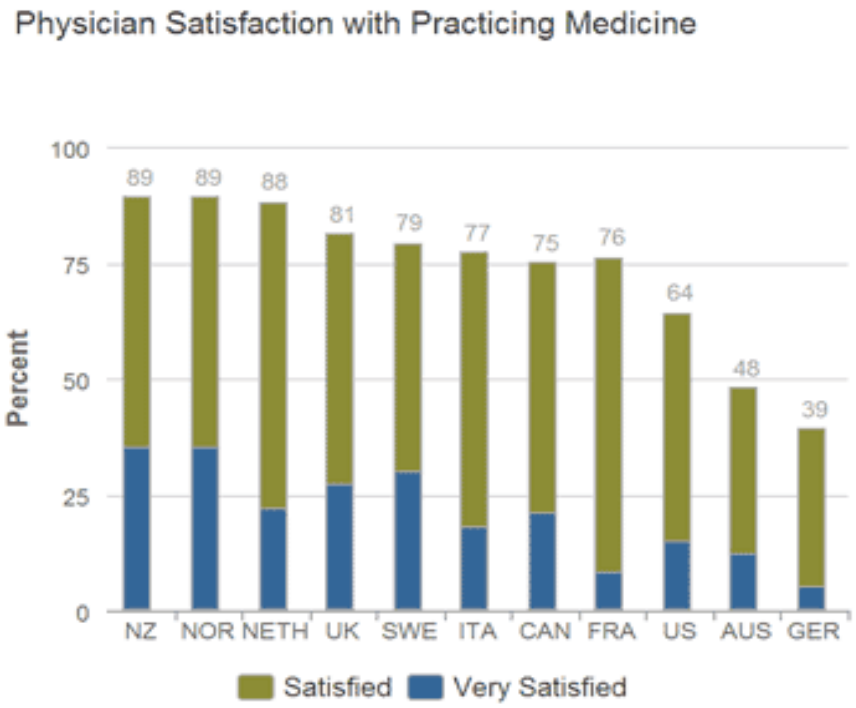
Source: "Phantoms in the Snow: Canadians' Use of Health Care Services in the United States," Health Affairs, May 2002.

Myth #2: Doctors in Canada are flocking to the United States to practice.

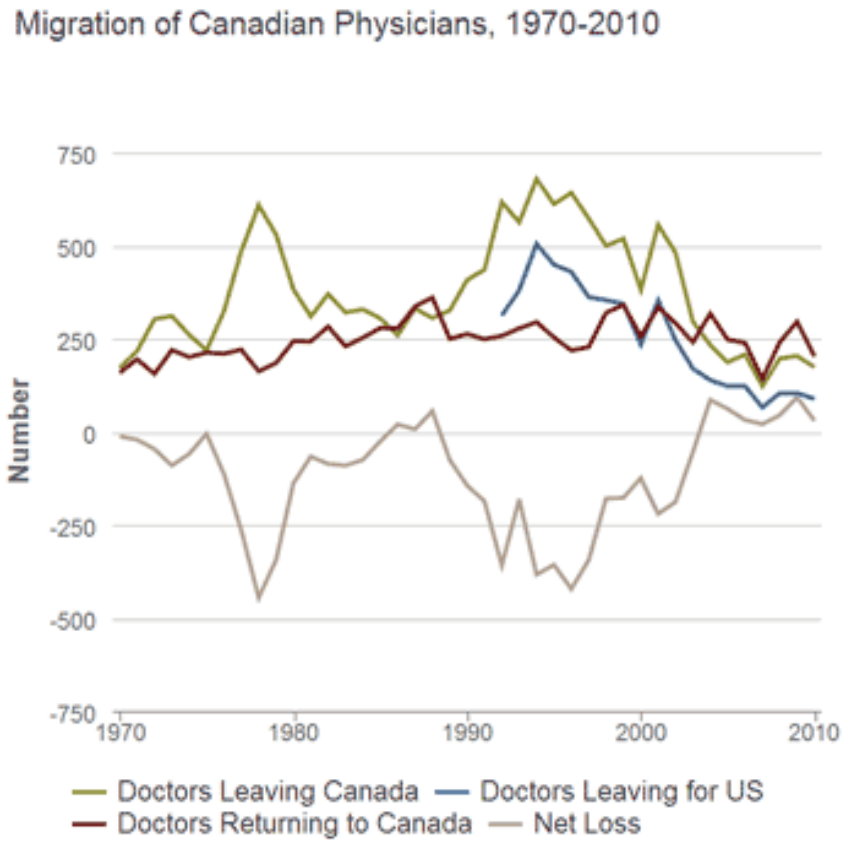
Every time I talk about health care policy with physicians, one inevitably tells me of the doctor he or she knows who ran away from Canada to practice in the United States. Evidently, there's a general perception that practicing medicine in the United States is much more satisfying than in Canada.

Problem is, it's just not so. Consider this chart: (*next page*)

The Canadian Institute for Health Information has been tracking doctors' destinations since 1992. Since then, 60 percent to 70 percent of the physicians who emigrate have headed south of the border. In the mid-1990s, the number of Canadian doctors leaving for the United States spiked at about 400 to 500 a year. But in recent years this number has declined, with only 169 physicians leaving for the States in 2003, 138 in 2004 and 122 both in 2005 and 2006. These numbers represent less than 0.5 percent of all doctors working in Canada.



Source: "2009 International Health Policy Survey of Primary Care Physicians in Eleven Countries," The Commonwealth Fund, November 2009.



Source: Canadian Institute for Health Information

So when emigration "spiked," 400 to 500 doctors were leaving Canada for the United States. There are more than 800,000 physicians in the United States right now, so I'm skeptical that every doctor knows one of those émigrés. But look closely at the tan line in the following chart, which represents the net loss of doctors to Canada.

In 2004, net emigration became net immigration. Let me say that again. More doctors were moving into Canada than were moving out.

Myth #3: Canada rations health care; that's why hip replacements and cataract surgeries happen faster in the United States.

When people want to demonize Canada's health care system — and other single-payer systems, for that matter — they always end up going after rationing, and often hip replacements in particular.

Take Republican Rep. Todd Akin of Missouri, for example. A couple of years ago he took to the House floor to tell his colleagues:

"I just hit 62, and I was just reading that in Canada [if] I got a bad hip I wouldn't be able to get that hip replacement that [Rep. Dan Lungren] got, because I'm too old! I'm an old geezer now and it's not worth a government bureaucrat to pay me to get my hip fixed."

Sigh.

This has been debunked so often, it's tiring. The St. Louis Post-Dispatch, for example, concluded: "At least 63 percent of hip replacements performed in Canada last year [2008] ... were on patients age 65 or older." And more than 1,500 of those, it turned out, were on patients over 85.

The bottom line: Canada doesn't deny hip replacements to older people.

But there's more.

Know who gets most of the hip replacements in the United States? Older people.

Know who pays for care for older people in the United States? Medicare.

Know what Medicare is? A single-payer system.

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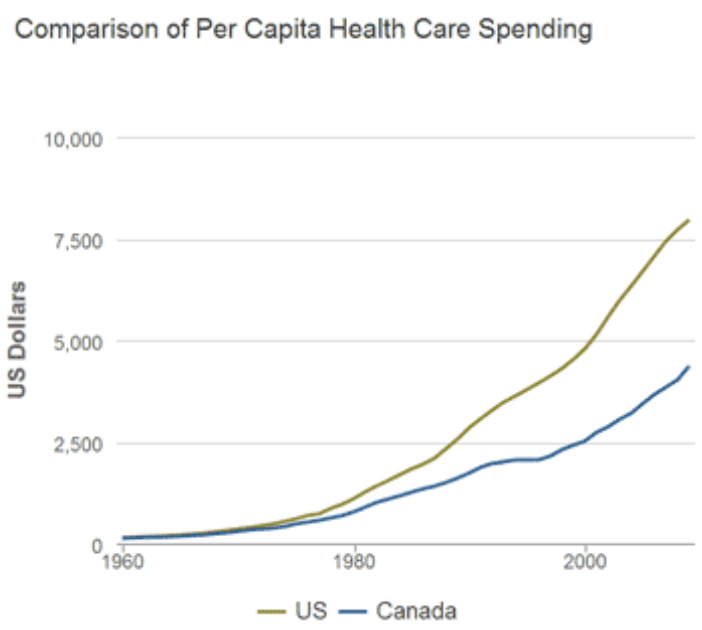
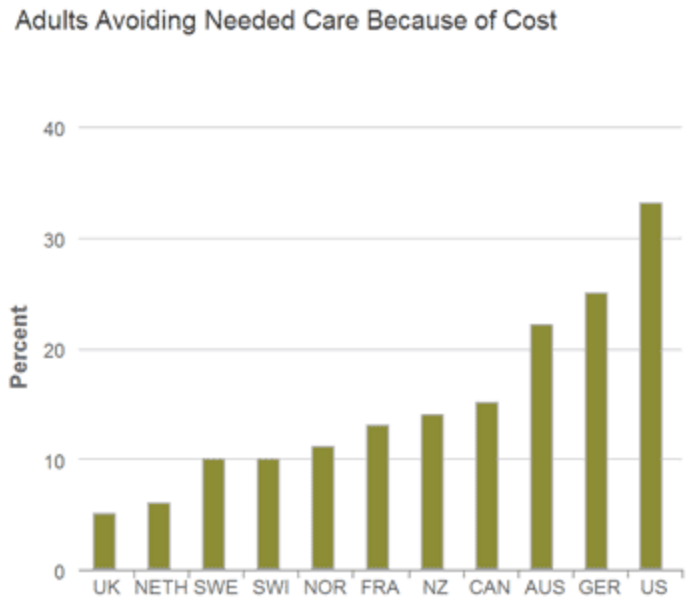


Source: Organisation for Economic Co-operation and Development (OECD)



Source: "How Health Insurance Design Affects Access to Care and Costs, by Income, in Eleven Countries," Health Affairs, November 2010.

Myth #4: Canada has long wait times because it has a single-payer system.

The wait times that Canada might experience are not caused by its being a single-payer system.

Wait times aren't like cancer. We know what causes wait times; we know how to fix them. Spend more money.

Our single-payer system, which is called Medicare (see above), manages not to have the "wait times" issue that Canada's does. There must, therefore, be some other reason for the wait times.

There is, of course. It's this:

In 1966, Canada implemented a single-payer health care system, which is also known as Medicare. Since then, as a country, Canadians have made a conscious decision to hold down costs. One of the ways they do that is by limiting supply, mostly for elective things, which can create wait times. Their outcomes are otherwise comparable to ours.

Please understand, the wait times could be overcome. Canadians could spend more. They don't want to. We can choose to dislike wait times in principle, but they are a byproduct of Canada's choice to be fiscally conservative.

Yes, they chose this. In a rational world, those who are concerned about health care costs and what they mean to the economy might respect that course of action. But instead, they attack the system.

Myth #5: Canada rations health care; the United States doesn't.

This one's a little bit tricky. The truth is, Canada may "ration" by making people wait for some things, but here in the United States we also "ration" — by cost.

An 11-country survey carried out in 2010 by the Commonwealth Fund, a Washington-based health policy foundation, found that adults in the United States are by far the most likely to go without care because of cost. In fact, 42 percent of the Americans surveyed did not express confidence that they would be able to afford health care if seriously ill.

Further, about a third of the Americans surveyed reported that, in the preceding year, they didn't go to the doctor when sick, didn't get recommended care when needed, didn't fill a prescription or skipped doses of medications because of cost.

Finally, about one in five of the Americans surveyed had struggled to pay or were unable to pay their medical bills in the preceding year. That was more than twice the percentage found in any of the other 10 countries.

And remember: We're spending way more on health care than any other country, and for all that money we're getting at best middling results.

So feel free to have a discussion about the relative merits of the U.S. and Canadian health care systems. Just stick to the facts.

The New York Times

July 27, 2012

Taiwan's Progress on Health Care

By Uwe E. Reinhardt

Several years ago I wrote "Humbled in Taiwan," a commentary for The British Medical Journal.

The piece was prompted by a conversation between a health services researcher and the head of health information technology of Taiwan's Bureau of National Health Insurance, which administers Taiwan's single-payer national health insurance system. By that time, virtually all of Taiwan's claims were billed electronically.

In that conversation, the bureau's head of health information technology lamented that some hospitals and physicians in Taiwan still failed to submit fully completed claims forms for encounters with patients within 24 hours of the encounter.

Twenty-four hours?

In the United States, claims settlement for medical procedures under private health insurance can take up to three months; it takes about three weeks for Medicare. As I noted in my commentary for The British Medical Journal, "private health insurance companies in the United States count themselves lucky if high-priced actuaries can tell them in the middle of the year what the carrier ultimately will have to pay the providers of health care for services rendered in the previous year."

Since 1995, Taiwan's 23 million people have enjoyed universal, comprehensive health insurance coverage under its single-payer national health insurance system, which is financed by a mixture of payroll contributions from employers and employees and government subsidies.

The system is administered by the Bureau of National Health Insurance, whose administrative budget absorbs less than 2 percent of the system's total spending for health care benefits. Over all, Taiwan spends about 6.9 percent of its gross domestic product on health care, compared with close to 18 percent spent in the United States. (More detail on the genesis of the system and its modus operandi can be found in this article in Health Affairs and on the bureau's website.)

About two weeks ago, I attended the Europe-Taiwan Health Dialogue, held in Taipei. That two-day conference was sponsored jointly by Taiwan's Department of Health and the European Health Forum Gastein whose European Health Forums are among the leading platforms for discussions on health policy and are attended by participants from around the world. (My travel to the conference, to which I was invited as an academic expert, was underwritten by the Department of Health.)

As an American, I found myself humbled again by a presentation, "Information Technology and Patient-Centered Care – the Case of Taiwan," delivered by Dr. Min-Huei Hsu, director of the Medical Informatics Center of Taiwan's Department of Health.

Dr. Hsu's presentation brought to my mind a chapter on health information, which, as chairman of the New Jersey Commission on Rationalizing Health Care Resources, I wrote for the final report published in January 2008. In that chapter I sketched out the vision for a 21st-century health information system for New Jersey that had emerged from discussion among the commissioners.

Alas, more often than not, the work of such commissions amounts to howling into the wind in our latitudes. It certainly did in that case.

But, in Taiwan, I saw much of such a system in place and fully operating, and mused how long it might take New Jersey, and much of America, for that matter, to come this far.

In Taiwan, the Department of Health, the very active Bureau of Health Promotion, the Centers for Disease Control and other governmental administrative functions are linked in a network that allows a select set of professionals access to its database, under strict controls to secure privacy. Clinics, hospitals and pharmacies are also linked to this central database.

Among other things, this data system allows the guardians of public health to detect quickly the incidence of certain illness that may be infectious, such as severe acute respiratory syndrome, or SARS.

Now in its third year is a clinical interface among health care facilities that already includes half of Taiwan's 500 hospitals. By 2016, all Taiwan's hospitals and 20,000 clinics where physicians practices are to be on this electronic medical record system.

This data system allows physicians in one hospital or clinic to get access to an individual patient's medical record, but only under strict conditions of privacy. The record includes hospital discharge summaries and medical records from outpatient visits, including prescriptions, lab tests and digital images. Such data-sharing among clinicians in different health care facilities or systems is rare in the United States. Again, roughly half of Taiwan's 500 hospitals are already linked in this way, in the system's third year.

To access a patient's file requires that the physician has an authorized digital signature to do so and, more important, that the patient has swiped his or her own, personal electronic smart card through the specialized card reader on every physician's desk, thus authorizing the access.

That card reader has slots for both the patient's and the physician's electronic smart card. It links patient and physician directly to the data center of the Bureau of National Health Insurance at the very time the encounter takes place. Thus it allows the bureau to track health care use virtually in real time and also to monitor the behavior of patients given to excessive doctor shopping.

Touring a rural area, we saw mobile clinics on wheels, equipped with imaging devices (mammography scanners, sonar scanners and X-ray machines) for general check-ups of rural populations in remote areas. In front of the mobile clinics sat young technicians with laptops, linking to the Bureau

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of National Health Insurance data center both patients and physicians, with the latter also having access to the patients' medical records.

The information network also includes electronic kiosks in hospital lobbies; about half of Taiwan's hospitals now feature such kiosks. Using a secure identification card, a patient can make an appointment with a doctor or review her own medical record, including results from tests or scans. To find more about what the test results might indicate, she could use electronic links to explanations. Finally, since all medicines are bar-coded, she might consult the kiosk about the specifics of drugs prescribed for her.

Currently in the field are pilot studies for a national tele-health project for long-term care.

I am sure that there are pockets here and there in the United States with similarly advanced health information technology. Kaiser Permanente, for example, is bound to be as advanced and perhaps even more so. The Veterans Administration is known for its electronic health information system. Some larger health systems and academic health centers may also have highly developed intra-system information systems.

But I wonder how many Americans today can walk up to a multifunction kiosk, find their own medical records, make appointments with doctors and learn there about lab tests and prescription drugs. I wonder how many American doctors today can reach their patients' complete medical records across different health care facilities and systems.

I do not want to romanticize Taiwan health care. Like any health system, it has its share of problems, all the more so because, at only 6.7 percent of G.D.P., the system is underfunded by at least a percentage point or so, using international standards.

I also am persuaded that Taiwan needs a larger supply of doctors. Nor would even Taiwan's health experts assert that their health information system is perfect. It remains a work in progress.

But a national health system must be judged not only by the level of health care it delivers, but by what it offers its citizens for the money they spend on it – by its cost-effectiveness, in professional jargon.

In the United States, the Business Roundtable concluded in a 2010 study that given its high level of spending on health care, the American system shows a 23 percent value gap relative to what Europeans spend and get in return, and a 46 percent value gap relative to spending in Asian countries, including Taiwan, Japan, South Korea and Singapore.

At its best, the American health system probably is unrivaled in the world, staffed by highly trained and hard-working doctors and nurses. For the most part, it boasts luxurious health care facilities.

Oddly and sadly, however, the United States has yet to harvest the full benefits of modern electronic health information. Our nation's engineers and entrepreneurs design smart hardware and software for health care, but we do not seem to use our own products as smartly as do many other countries.

The Healthcare Movie

Highly recommended! This popular, feature-length documentary narrated by actor Kiefer Sutherland explains how the health care systems in Canada and the United States evolved to be so completely different, when about 50 years ago they were essentially the same.

Through a wide spectrum of interviews with Canadian citizens and health policy experts such as Robert Evans and Dr. Michael Rachlis, "The Healthcare Movie" reveals the truth about Canada's single-payer health care, what it has meant to the Canadian people, and what lessons it offers to those of us in the United States.

Directed by Laurie Simons and Terry Sterrenberg, the 65-minute DVD is available for $24.95 plus applicable tax.

Several PNHP chapters have shown the movie and highly recommend it. Watch a trailer here: bit.ly/SxRd4q; order a copy here: bit.ly/YAoi5H. Alternatively, visit healthcaremovie.net.

AMERICAN JOURNAL OF Preventive Medicine

AUGUST 23, 2012

High prevalence of forgoing healthcare for economic reasons in Switzerland: A population-based study in a region with universal health insurance coverage

By I. Guessous, J.M. Gaspoz, J.M. Theler, H. Wolff

Health insurance is compulsory for all citizens in Switzerland and insurance premiums are paid independently of income. Health insurance covers the costs of medical treatment and hospitalization for the insured. The insured person pays part of the cost of treatment: an annual flat deductible, called the franchise, chosen by the insured person (with premiums adjusted accordingly) and a 10% co-pay of the costs up to a stop-loss annual amount of CHF 700 (1CHF≈1$). Between 1099 and 2010, health insurance premiums increased by 77%, coupled with increasing out-of-pocket payments. Increasing out-of-pocket spending may, at least in some settings, reduce the use of clinically important services and drugs to prevent the onset and progression of chronic disease (Paez et al., 2009).

We aimed to determine the characteristics of participants who report forging healthcare and to describe the past 4-year trend for forgoing healthcare for economic reasons.

Abstract

Objective

To investigate the determinants and the 4-year evolution of the forgoing of healthcare for economic reasons in Switzerland.

Method

Population-based survey (2007–2010) of a representative sample aged 35–74 years in the Canton of Geneva, Switzerland. Healthcare forgone, socioeconomic and insurance status, marital status, and presence of dependent children were assessed using standardized methods.

Results

A total of 2601 subjects were included in the analyses. Of the subjects, 13.8% (358/2601) reported having forgone healthcare for economic reasons, with the percentage varying from 3.7% in the group with a monthly income ≥ 13,000CHF (1CHF ≈ 1$) to 30.9% in the group with a monthly income < 3000CHF. In subjects with a monthly income < 3000CHF, the percentage who had forgone healthcare increased from 22.5% in 2007/8 to 34.7% in 2010 (P trend = 0.2). Forgoing healthcare for economic reasons was associated with lower income, female gender, smoking status, lower job position, having dependent children, being divorced and single, paying a higher deductible, and receiving a premium subsidy.

Conclusion

In a Swiss region with universal health insurance coverage, the reported prevalence of forgoing healthcare for economic reasons was high and greatly dependent on socioeconomic factors. Our data suggested an increasing trend among participants with the lowest income.

Highlights

- Forgoing healthcare for economic reasons is frequent in a region of Switzerland.
- This prevalence varies with reported monthly household income category from 3.7% to 30.9%.
- Data suggest an increasing 2007–2010 trend among participants with the lowest income.
- Risk factors include gender, smoking, occupation, children, being divorced, and insurance status.
- Forgoing healthcare is associated with worse self-rated health status.

Switzerland, Greece discussed at PNHP's meeting

PNHP's Annual Meeting in San Francisco, its largest ever, included talks by Beat Ringger, leader of a public employees union in Switzerland, and Dr. Alexis Benos, a Greek physician and international health policy expert, on the status of health care in their respective countries. Dr. Benos' report on the rapidly worsening health crisis in Greece, which he is seen giving above, painted an alarming picture, but concluded with a vivid depiction of the fightback by Greek physicians and other health professionals under the slogan, "Not to serve the greed of some, but the health care needs of all."

The Boston Globe

JUNE 1, 2012

Single Payer health care would save billions for Massachusetts

By David U. Himmelstein and Steffie Woolhandler

The House and Senate health care proposals would set imaginary limits for spending growth enforced by secret "improvement plans" and wrist slaps for hospitals that overcharge; establish tiered payment schemes to consign the poor and middle class to second-tier hospitals and doctors; push most residents of the Commonwealth into HMOs (oops, we forgot, now they're called "accountable care organizations," or ACOs); and wipe out small doctor's offices by "bundling" their pay into ACO payments. Apparently the legislators' theory is that forcing health care providers to consolidate cuts costs. Oligopoly saves money?

Here are six alternative steps the Legislature could take that would actually save money while still preserving care.

- Cut out the middlemen. Why exactly do we pay private insurers 10 cents of every premium dollar? The plan that covers all 13 million residents of the Canadian province of Ontario has overhead of only 1 percent. Adopting that single-payer approach in Massachusetts would save about $2 billion in insurance overhead in 2013 alone.
- Pay hospitals the way we pay fire departments: real global budgets that cover all operating costs, not the per-patient schemes that are masquerading as global payments. Billing, collections, and paperwork consume nearly one quarter of hospitals' revenues. Eliminate billing for individual patients and you'd cut that nearly in half. The savings: about $3 billion in 2013.
- End the medical arms race and enforce real health planning. Hospitals and clinics vie for affluent patients needing lucrative high-tech care. They reap surpluses, a.k.a. profit, which they use to buy fancy machines and superluxe buildings – usually situated where there's already a surplus of such facilities. Inevitably, the surplus facilities induce unnecessary, even harmful overcare. Meanwhile, underserved communities and under-provided services like mental health and substance abuse are starved of investment. Hospital payments should go for patient care, not new buildings. Money for new buildings and technology should flow to a separate fund, and be allocated according to need, not profitability, through a transparent public process. Investing in what's needed instead of what's profitable would save billions and improve care for both the poor and the affluent.
- Right-size the physician work force: more primary care, fewer specialists. Massachusetts hospitals take pride in training super-specialists who go on to provide profitable but often unneeded care (see above). Meanwhile, the primary care shortage persists. The public, through Medicare, already pays for residency training and should use the power of the purse to make hospitals train the doctors that the public needs. And physicians' fee schedules should be altered to assure that best students are attracted to the most needed, important, and difficult fields – primary care – and that doctors make as much for talking to patients as for putting them through a scanner.
- Negotiate drug prices statewide. Canadians pay 40 percent less for drugs than we do because they use single-payer buying power to drive down prices from pharmaceutical companies. Why can't we?
- Cap health executives' incomes. Why should a hospital CEO make more than the president of the United States?

HEALTH AFFAIRS

NOVEMBER 2012

Medical Spending and Global Budgets

By Rachel Nardin, David Himmelstein, and Stephanie Woolhandler

The title of the article by Zirui Song and colleagues (Aug 2012) claims that "The 'Alternative Quality Contract' Based on a Global Budget, Lowered Medical Spending and Improved Quality." But the Alternative Quality Contract (AQC) only lowered spending if you accept the authors' idiosyncratic definition of the term medical spending.

In calculating medical spending, the authors exclude three categories of payments that Blue Cross Blue Shield of Massachusetts made to AQC providers: "surplus payments" to providers who kept fee-for-service billing below targets; bonuses for meeting quality goals; and special payments to support providers' infrastructure to implement the AQC. The authors note, in passing, that these extra payments probably exceeded the "medical savings". Unfortunately, they report no actual figures for the extra payments (although these figures were presumably available to the two coauthors who are executives at Blue Cross Blue Shield). In other words, Blue Cross Blue Shield's total costs under the AQC went up by some undisclosed amount, not down.

Global budget payment strategies are currently being promoted as a way to lower total health costs. The fact that the AQC failed to do this was probably overlooked by many readers and was clearly lost in medical reports of these findings[1] and hence in the policy debate.

The case for global budget payment strategies such as the AQC remains unproven.

Drs. Marcia Angell and Arnold Relman speak out for single payer on visit to Oregon

By Samuel Metz, M.D.

From April 26-28, 2012, Oregon Physicians for a National Health Program and the Mad as Hell Doctors (MAHD, a group that includes PNHP members from Oregon and surrounding states) hosted a very successful visit to our state by Drs. Marcia Angell and Arnold Relman, past editors of the New England Journal of Medicine.

A description of the visit might help other PNHP chapters who want to do something similar, with these, or other, speakers.

Day 1

The initial event was a session at the Oregon Health and Science University, organized primarily by Richard Bruno (OHSU medical student and winner of the Nick Skala Student Activist award at the national PNHP convention) with assistance from other members of the OHSU medical student PNHP chapter. The 100-seat auditorium was packed.

Drs. Angell and Relman then met briefly with Oregon Gov. John Kitzhaber, M.D. and urged him to consider a single-payer program for Oregon.

An event at Legacy Good Samaritan Hospital was also well attended, with about 80 people packed into a small conference room. Dr. Stephen Jones, chair of internal medicine at Legacy Health Systems, was principally responsible.

Day 2

The following day, Angell and Relman participated in two panel discussions along with Cathy Schoen of the Commonwealth Fund and Dr. Bruce Goldberg, director of the Oregon Health Authority.

Day 3

The third day of their visit was highlighted by a single-payer rally at the Majestic Theatre in Corvallis which was attended by about 225 people. This event was organized primarily by Mike Huntington of Corvallis PNHP and MAHD, and Betty Johnson, a longtime single-payer advocate from Mid-Valley Health Care Advocates. Mike and Betty are now key participants in the newly reorganized Health Care for All Oregon.

A fund-raising dinner at my house that evening attracted thirty-five people who listened in rapt attention to Drs. Angell and Relman, who each gave brief presentations then engaged in a long discussion with the audience. Most were senior physicians. Others included a county judge, the head of the port of Portland, and the president of the Oregon State Council for Retired Citizens.

Important results of these events, especially the panels, included raising awareness among non-activist businesspeople of the critical nature of health care reform and the legitimacy of a single-payer option. For many, this was the first time single payer was discussed in a credible, nonpartisan environment.

Another valuable result was the relationship built between those of us who organized these events and a variety of organizations new to single payer who helped with publicity or co-sponsored events, including the Oregon Business Council, multiple neighborhood business organizations, professional organizations for realtors, Project Access Now, and several smaller charitable organizations.

Finally, flyers were sent to each of Oregon's 90 state legislators, leading to several new contacts.

Dr. Marcia Angell

One reason so many organizations collaborated in sending out flyers was, I suspect, that nothing in the panel advertising materials explicitly mentioned single payer. While all of the panel participants and moderators understood the value of single payer (and several are strong advocates), few attendees were aware of this beforehand. This permitted many neutral people to hear about single payer without their attendance showing visible support for the concept.

Lessons from this experience:

- "If you've got what people want, it's easy to sell." In this case, many people drawn to the presentations knew Drs. Angell and Relman only as distinguished senior academic physicians. Featuring recognizable names helped our cause.
- We were fortunate to include Dr. Bruce Goldberg, widely respected as a calm, rational, nonpartisan advocate for Oregon's health care needs. While he did not speak about single payer himself, his presence on stage with single-payer advocates lent prestige to the program.
- The effort to contact a large sample of business organizations was particularly valuable. My contact list now includes many helpful executive directors and program administrators who are on a first name basis with me. When MAHD and PNHP plan their next event, these contacts may open many doors.
- The Saturday rally was the only event designed and billed as a single-payer rally. This served an important need to reward, recharge, and motivate the current advocate population. Over the course of three days our guests spoke to the choir, the pews, and a lot of people just passing by.

What would we plan for Drs. Angell and Relman if we had the opportunity for another visit? Meetings with newspaper editorial boards; meetings with legislators and legislative caucuses; and guest appearances at physician organizations, notably the Oregon Medical Association and the Medical Society of Metropolitan Portland.

Finally, I should note that organizing and attending these events with so many colleagues and community members was truly a pleasure as well as a learning experience. If you have any questions, please feel free to contact me at S@samuelmetz.com.

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Social Responsibility of Physicians

The following address was presented to the "Avoiding Avoidable Care Conference" in Cambridge, Mass., on April 26, 2012.

By Bernard Lown, M.D.

Introduction

Ever since starting clinical practice 62 years ago I have looked forward to this conference. Mercifully, good fortune and good genes enable me to attend. From my earliest days in medicine I have struggled against the prevailing model of health care. My opposition in part was provoked by the growing prevalence of overtreatment. Resort to excessive interventions seemed to be the illegitimate child of technology in the age of market medicine. If more than a half century ago overtreatment was at a trickle pace, it is now at flood tide. Reflecting back on early days, the first overtreatment I encountered was not related to technology. It involved keeping patients with acute MI's at strict bed rest for 4 to 6 weeks. This was a form of medieval torture. It promoted depression, bed sores, intractable constipation, phlebitis, lethal pulmonary embolism and much else. Worse it augmented cardiac ischemia and predisposed to malignant arrhythmias. Physicians were aware of what was transpiring but felt it was necessary to protect patients against cardiac rupture which activity may provoke.

The great Brigham clinician, SA Levine, my teacher and mentor, believed that patients would fare better when nursed in comfortable chairs. Yet he was not ready to challenge established practice. With his backing I launched such a study in 1951. The house staff initially was vehemently opposed, even greeting me with Sig Heil Hitler salutes. Soon they became avid supporters.

Patient improvement was striking. In fact, hospital mortality from acute MI's more than halved, depression diminished, pulmonary emboli nearly vanished, hospitalization was markedly shortened, rehabilitation and resumption of work was hastened. I am not aware of a single cardiovascular measure since then that improved survival of CHD patients as much as this common sense change in medical management. We published two articles on our findings in 1952. They evoked no comments as though reflecting a shameful era best forgotten. One should mention, if only as a historical footnote, that there was not a scintilla of evidence supporting prolonged bed rest. While patients were harmed, doctors profited.

Recognition that new technologies were driving overtreatment became evident with introduction of implanted pacemakers in the 1960's. Compared to colleagues I was implanting about a third as many and inactivating like numbers. Pacemakers though were small cost items compared to what soon followed.

Coronary disease

The problem of overtreatment grew exponentially after Favoloro at the Cleveland clinic opened an innovative terrain by introducing bypass vein grafting. This was followed by technical virtuosities involving angioplasty and later stenting. Within 30 years after Favoloro, the number of revascularizations exceeded a million. Presently a majority of newly minted cardiologists are adept interventionists.

At the same time significant developments were occurring in the medical management of coronary artery disease. These included effective anti hypertensive measures in the 1940's, introduction of beta blockers in the early 1960's, and ever more effective lipid lowering agents thereafter. A profound advance was the recognition that risk factors, largely tethered to life style, accounted for the progression of coronary artery disease (CAD). In a rational social order, preventive medicine would have been the focus of resource allocation and physician concentration. Instead, prodigious investments flowed to halfway technologies.

Dr. Bernard Lown
Courtesy of Lown Cardiovascular Research Foundation

No robust clinical evidence guided the onrush of revascularizations . The Coronary Artery Surgery Study (CASS), the first randomized investigation, published 16 years after Favoloro, provided no comfort for those trumpeting interventions. Instead of being a wake up call alerting to irresponsible overindulgence, coronary procedures continued to escalate.

Lown Clinic

Justification for revascularization is based on claims of increased survival, reduced toll of myocardial infarction and improved quality of life. By the late 1960's I learned that in a majority of patients, CHD was largely stable and did not demand a rush for or even need for revascularization. I was persuaded that investigating this problem would be difficult once patients were hospitalized. As a result I founded the Lown Clinic. Almost immediately we launched a study. We intended to randomize post angiography patients to either revascularization or medical therapy. The study aborted before it began. After patients were

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informed by interventionists and house staff of their coronary anatomy, coached in the lurid prose then and now in use, every patient opted for coronary artery bypass grafting (CABG).

Coronary angiography was a funnel for interventions. Its purpose was largely to guide the operator to the narrowed vessel. To diminish coronary procedures required bypassing coronary angiography. We decided to study patients with multivessel disease over a long time frame without resort to angiography.

During the ensuing 35 years we published four studies in high profile medical journals involving about one thousand patients. Outcome data were remarkably consistent. Cardiac events were extraordinarily low, about 1.0 percent annual mortality rates. Our referral for revascularization increased from 1.1 percent annually during the CABG era to around 5 percent during the stenting era. Since a majority were second opinion patients, nearly all would have been revascularized.

Let me repeat. Over any five year period we referred less than 30 percent of patients with multivessel coronary disease for revascularization.

Our medical management was individually tailored. We rigorously treated risk factors. We encouraged optimism. We addressed social and family problems.

We discussed significant psychosocial stresses. We minimized shuttling patients to other specialists. Foremost, doctors spent much time listening, thereby fostering trust and adherence to prescribed lifestyle changes. We did much for the patient and as little as possible to the patient.

One commonly hears that fear of malpractice litigation is a significant reason for doctors resorting to overtreatment. The Lown Group, with its minimalist approach, should have been deluged with malpractice suits. After all, we deviated from community norms. We did not adhere to the standard of practice prevailing nationwide. Yet during the past forty years we have not had a single malpractice suit for denying a patient with coronary artery disease a revascularization procedure.

We remain a tiny minority voice. Our observations have been ignored by mainstream cardiology. This has not been due to an absence of randomization in our investigations. Large randomized studies from CASS to Courage likewise have had no impact on the scale of interventions.

Health Crisis

Experience of the Lown clinic speaks to the uniformly acknowledged crisis in American health care. Politicians and health policy experts relate the crisis largely to run away costs. In my mind the crisis is far more than fiscal, far deeper than economic. For the past half century doctors have been distancing from patients.

Four points, well known to you, deserve emphasis.

1. Outside the hospital environment one becomes aware that problems bringing someone to a doctor are mostly minor. They largely derive from the rough and tumble of living. They don't augur far advanced disease. These are healed by the passage of time. This is largely the reason that Hippocratic medicine held sway for nearly 2000 years.
2. A carefully taken history and physical exam identify the underlying condition in the overwhelming majority of patients.
3. Much clinical information is epidemiological and statistical. But statistical fact is not the same as individual truth. Data, irrespective of how comprehensive, may not be relevant for the individual patient. Each person is not only different, but different in a unique way.
4. The more time invested by the doctor at the outset, the more cost effective is the encounter and the more satisfied the patient. The number of specialist referrals and requests for technologic procedures are inversely related to the time spent with a patient especially during initial visits.

Sixty years of doctoring has taught me that taking a history, namely listening, is the quintessential part of doctoring. Proper listening is a skill, an art and a core element of medical professionalism. History taking is far more than providing key elements for a diagnosis. It is the basis for nurturing trust. I am persuaded that nothing of science taught to medical students is as difficult to master as is the fine art of listening. Numerous adverse consequences follow if a doctor does not listen. If time is short shrifted, the doctor treats the chief complaint. But the chief complaint is merely an admission ticket and frequently has little to do with what is troubling a patient. If you were a theater critic, it would be foolhardy to write a comment about a play merely from the scanty information on an admission ticket. Yet that is what doctors far too frequently do.

Treating the chief complaint commonly leads to unnecessary and costly interventions. When the chief complaint is unrelated to what truly bothers a patient, whatever medication prescribed will prove ineffective. As a result polypharmacy multiplies as new complaints are assaulted with still more drugs.

The number of specialist referrals and requests for technologic procedures are inversely related to the time spent with a patient especially during initial visits.

When doctors do not spend enough time listening, they become triage officers for specialists, as the patient is reduced to an assemblage of dysfunctional parts each part being served by some expert. Interest in the patient is replaced by preoccupation with disease. The human dimension is leached out from the clinical encounter. Dissatisfaction by the patient with the visit aggravates symptoms and adversely affects outcome. It encourages internet foraging and second opinion shopping.

When a doctor doesn't listen, the focus necessarily shifts to the acute and emergent. Since preventive medicine, though the most cost effective approach to illness, is time intensive, it is largely neglected.

Prevention

The small role allotted to primary prevention is a major deficiency of our dysfunctional health care. Community support for healthy life styles are vastly underfunded. The largest investment goes to chronic illness when manifesting as acute disease. Prevention, the foundation of a sound health system, though honored in preachment, commonly plays second fiddle to the loud drumbeat for hospital focused care. This lacks medical rationale and is devoid of economic sense.

Looking around the globe there are numerous persuasive demonstrations of the effectiveness of government sponsored programs promoting community prevention of cardiovascular disease. In 1972 Finland had the highest CVD mortality rate in the world. The Finnish government sponsored large scale programs educating the public about risk factors. It promoted availability of low-fat dairy products, passed antismoking legislation, and improved nutritional quality of school meals. Within a quarter of a century, CVD mortality in Finland was reduced by 75 percent. Another striking example is what occurred in Poland. In 1990, as the iron curtain toppled, Poland opened trade with the West, increasing import of fruit and vegetables. The government also stopped promoting and subsidizing butter and lard consumption. Within less than a decade CVD mortality dropped by a third.

I am persuaded that doctors devoting time listening to patients and shifting medical traffic to the proven road of prevention would profoundly reduce health care costs. Yet these two measures are largely ignored in the ongoing national debate.

Marketization of Health Care

A major factor accounting for these neglects relates to the dominance of market forces which favor and even compel the industrialization of health care delivery.

An essence of industrialization is reducing cost of production by increasing efficiency, namely, lessening the time to make a widget. Productivity is increased by speeding up assembly lines and replacing costly human labor with technology, especially with robotics. The product, irrespective of how socially necessary or value laden, if not profitable, will not be produced.

Listening was an early casualty. Since listening consumes much time, but is minimally reimbursed, it grew cursory, circumscribed, and frequently completely bypassed. It left patients frustrated and doctors uninformed. The consequences for the health care system are ruinous. Aiming to foster increased productivity, industrialization shifted the focus of the debate to efficiency, to competition, to cost containment. Industrial efficiency is in part obtained by rapid patient through-put during encounters with primary care physicians or during specialist referrals. In such a model of health care doctors are providers, patients are consumer/customers, hospitals are industrial plants and major profit centers.

Medicalization, and overtreatment are an essential part of a market system. As a result patients are morphed into amalgams of dysfunctional parts, with the human dimension commonly shredded in the gears of innovative technologies. The more patients are reduced to widgets, the more amplified is the verbiage that the bed rock of the system is patient centered.

Limitations of Markets in Health Care

Market medicine is organized like any other business to generate profit. Withholding care for those who can not afford it, as well as overtreatment of those with means, are profit maximizers and therefore sound business policy. In order to survive the well intentioned must hew to the competitive pressures of the market or get out of business. This was spelled out by the panjandrum of market theory, the ultimate market triumphalist, Milton Friedman, "Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible." In the business model, like any other business, the major goal is profitability. Good intentions and high sounding principles are incidental. I believe that the market is not a solution. Indeed it is a major part of the problem.

Moral Issues

Market medicine is organized like any other business to generate profit. Withholding care for those who can not afford it, as well as overtreatment of those with means, are profit maximizers and therefore sound business policy.

My objection to market dominated health care is on deeper grounds than economic. In a democratic society health care must be a right, not a privilege. The underlying issues relate to essential moral principles. Medicine is a calling. At the core it is a moral enterprise grounded in a covenant of trust between health professionals and patients. The primary mission of a clinician is to heal, to care, to advocate for the sick and to work for the promotion of everyone's health. Central to the doctor patient relationship is the expectation that patient's needs will be placed first, over and beyond personal interests or the interests of any third party.

There is a moral absolute in medicine to help and never to wrong the patient. No such moral absolute can be found in the marketplace. Caveat emptor, let the buyer beware, is its underlying admonition. The warm and fuzzy rhetoric that "patients come first" is a transparent marketing ploy. For-profit health care is essentially an oxymoron. The moment care is rendered for-profit it is emptied of genuine caring. This moral contradiction is irreparable by any conceivable palliative. We talk of overtreatment as though it was merely an improper financial transaction. Overtreatment harms patients thereby negating the first principle of doctoring, *primum non nocere*.

I am reminded in Herman Melville's Moby Dick; Captain Ahab, experiencing a terrifying moment of illumination, cries out, "All my means are sane; my motives and object mad."

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Where do we go from here?

Any challenge becomes doable when it is shown to be possible. A four minute mile was deemed impossible until Dr. Roger Bannister broke the record. Now it is common-place. So first, the good news. In the present adverse health environment it is still possible to drastically circumscribe overtreatment. For more than 40 years the Lown Clinic has substantially curtailed cardiovascular interventions. The possibility is no longer in question. We have done it!

The bad news relates to the acrimonious partisan health debate now convulsing American politics. When I was in medical school, 70 years ago, universal health insurance seemed a certainty. The Wagner, Murray, Dingell Bill was assured passage through Congress and would have been enacted except for a misbegotten wartime compromise. To maintain a work force in the face of a national wage freeze, industry diverted some wages into health benefits. We are still afflicted with the unintended consequences of that Faustian bargain. We need to get back on the track of history. Medicare has proven to be a remarkable advance in improving health for the elderly. It grants dignity to old age. It operates at lower cost than market driven health systems. Everyone would be covered regardless of employment or health status. It is constitutional.

Half measures will no longer suffice. A single-payer health care embracing the model of Medicare for all deserves to be at the forefront of consideration in addressing what now constitutes close to a fifth of our economy. It would bind our nation, improve health care, contain costs, and lessen moral ambiguities for health workers. A crisis affords an opportunity for deep changes. We should not demure by resorting to creeping partial measures. Self regulation, presumably works among saints. Appeals to our better nature is welcome. History teaches though that curtailing incentives for misdeeds and providing recognition for good outcomes proves far more effective.

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Creating a more just health care delivery system will not solve a host of other vexingly difficult issues. Unless fee for service is replaced, we will not restore the centrality of the patient nor lessen reimbursement driven over treatment.

More is better, or less is better are improper catch phrases. The ultimate litmus is what is best for the uniquely individual patient. In 55 years of practice I recall but a single patient who insisted on having coronary angiography. Fully informed patients, trusting their physicians, do not insist on tests or procedures. In overtreatment the patient is victim not instigator.

Health care with a human face requires drastic restructuring of medical education. Promotion of personal communication skills has to be part of a core curriculum during each of the four years.

Furthermore medical education should be subsidized. Health security is integral to our national security. Among other gains it would reduce the pressure for specialization in order to cope with mammoth student debt.

Beyond the breakdown of health care is a far deeper phenomenon. It relates to the onrushing marketization of all human activities. The result is to denature fundamental human values and tear apart ties that promote communal life. We in the health field, who nurture science for the sake of human health and well being, need to be in the forefront in promoting respect for the dignity of human life. This has to begin with listening to the patient.

One final thought: about three decades ago a small band of doctors contributed to a historic transformation. They spoke out against the stockpiling of nuclear weapons capable of destroying the world many times over. They believed that there is no greater force in modern society than an educated public, aroused and angered to effect change. This Gideon army of passionately committed physicians made millions aware that medicine had nothing to offer in case of nuclear war. They maintained that the two super-powers either lived together or died together. They offered humankind a prescription for survival. The involvement of multitudes in the antinuclear movement compelled governments to serious negotiations which ultimately lifted the Damoclean sword.

At present we physicians are challenged on our home turf. We need to offer people a prescription for health. Each American deserves dignified, person centered, and affordable health care. At the same time we must convince a wide public that our principles embody responsible stewardship of finite national resources. I have always believed that those who see the invisible can do the impossible.

Bernard Lown, M.D., is professor of cardiology emeritus at the Harvard School of Public Health, the inventor of the defibrillator, and the founder of the Lown Cardiovascular Center in Brookline, Mass. A world-renowned peace activist, he was a co-founder of Physicians for Social Responsibility and the International Physicians for the Prevention of Nuclear War, receiving a Nobel Peace Prize in 1985 on behalf of the IPPNW.

Medicare Overpayments to Private Plans, 1985-2012

Shifting seniors to private plans has already cost Medicare $282.6 billion

Ida Hellander, MD, Steffie Woolhandler, MD, MPH, and David Himmelstein, MD

Forthcoming in the International Journal of Health Services

Summary

Previous research has documented Medicare overpayments to the private Medicare Advantage (MA) plans (also known as Medicare Part C or Medicare HMOs) that compete with traditional fee-for-service Medicare. This research has assessed individual categories of overpayment for a single year, or at most a few years. However, no previous study has calculated the total Medicare overpayments to private plans since the inception of the Medicare program.

There are five ways in which private insurers systematically garner excess Medicare Advantage payments from the Medicare program.

Prior to 2004, the selective enrollment of healthier seniors by private plans – what we call "old cherry-picking" – was the major source of excess payments. We conservatively estimate that this old cherry-picking has added $41 billion to Medicare's costs since 1985. Medicare adopted a new risk-adjustment scheme in 2004 based on 70 medical diagnoses ("hierarchical condition categories"), but this scheme has not curbed, and may have increased, private plans' ability to game Medicare's payment system, albeit with a new strategy: now, plans seek to selectively enroll patients who have mild versions of the medical conditions that determine payment. This "new cherry-picking" has added $122.5 billion to Medicare's costs since 2004.

Congress mandated increased payment to private plans in the 2003 Medicare Modernization Act, adding $84.4 billion to the cost of Medicare through 2012.

The Affordable Care Act (ACA) mandated a drop in these overpayments, but a new demonstration project on quality will offset one-third of the reductions called for by the ACA through 2014.

Another major way that private plans are overpaid is by enrolling persons who are eligible for Veterans Health Administration (VA) benefits. The VA has provided $34.8 billion in care to MA enrollees since 1985.

In total, we find that Medicare has overpaid private insurers by $282.6 billion, or 24.4 percent of all MA payments, since 1985. In 2012 alone, we find that MA plans are being overpaid by $34.1 billion, or 6.2 percent of total Medicare spending.

In 2012, 13.5 million Medicare beneficiaries are in private plans, 27 percent of total enrollment. Some proposals would push millions more beneficiaries into private plans (e.g. voucher-type Medicare reform).

Risk adjustment does not and cannot work in the setting of for-profit MA plans, which have a strong financial incentive, and the data and ingenuity, to game whatever payment system Medicare devises. It is time to end Medicare's long experiment with privatization and look toward proven-effective methods for controlling costs and improving coverage.

Background

Commercial health insurance companies have been allowed to market private Medicare plans for three decades, over two-thirds of the duration of the program's existence. The number of enrollees in such plans, now known as Medicare Advantage (MA) plans, has grown rapidly in recent years (Figure 1).

As of mid-2012, 27 percent of all Medicare beneficiaries, 13.5 million people, are enrolled in private MA plans. This year, private plans participating in Medicare will receive an estimated $136.2 billion from Medicare, $10,123 per enrollee. This money is drawn from Medicare Part A (the Hospital Insurance Trust Fund) and Medicare Part B, which in turn are funded primarily by a combination of general revenues, payroll tax contributions and beneficiary premiums.

While there are 3,300 different MA plans, two for-profit firms (UnitedHealth and Humana) enroll about one-third of all Medicare beneficiaries in private plans.

Numerous studies have found that private plans raise Medicare's costs, i.e. that Medicare pays private insurers more in premiums than the MA enrollees would have cost had they stayed

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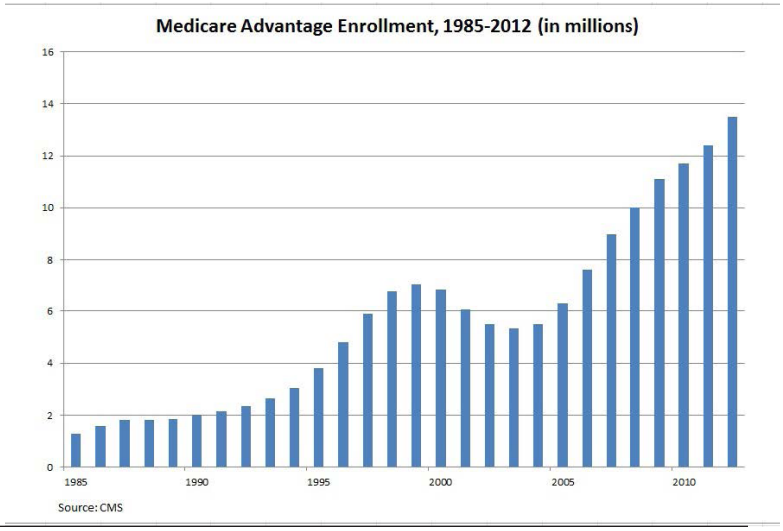
Figure 1



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in traditional (fee-for-service) Medicare. However, private insurers have wielded sufficient political power over the years to resist most calls to end the overpayment – including advice from the Medicare Payment Advisory Commission (MedPAC) in 2001, 2002, 2004 and 2005.

The 2010 Affordable Care Act (ACA) changed the formula Medicare uses to pay the private plans to reduce their overpayment. This change accounts for $145 billion of the $716 billion in Medicare savings projected over the next decade under the ACA. The issue has turned into a political football in the 2012 presidential election.

However, implementation of the ACA's payment reductions has already been undermined by an $8.35 billion demonstration project funded by the Centers for Medicare and Medicaid Services (CMS) that was intended to reward MA plans that provide particularly high-quality care but has awarded bonus payments to virtually all MA plans. These bonuses will offset more than one-third of the ACA's payment reductions between 2012 and 2014. Private Medicare plan en-rollment has grown dramatically since the passage of the ACA, indicating that the private Medicare plans remain highly profitable.

In this report, we review existing evidence on the Medicare overpayment to private plans, and calculate an overall estimate of the cost of such private plans to the taxpayers since 1985.

How does Medicare overpay private plans?

Medicare pays each private plan a fixed amount for each Medicare beneficiary who chooses to enroll in a private plan. The formula for determining this amount has changed several times over the past three decades but MA plans have adapted to each change and have continued to take advantage of overpayments in new ways. Private plans are responsible for covering all care that would be covered by the traditional Medicare program, and may offer additional benefits, such as free eyeglasses.

The categories of systematic overpayment to private plans include:

1. The selective enrollment of healthier beneficiaries before 2004, or what we will call "old cherry-picking." Under the payment formula in effect until 2004, Medicare paid private plans a premium that was risk-adjusted only for a few demographic factors such as age, gender, and disability, whether an enrollee resided in a nursing home and Medicaid eligibility (a proxy for poverty). Hence a healthy 70-year-old man would bring the same premium as his sicker, 70-year-old neighbor. Private plans used marketing, benefit design, enrollment office location, and other techniques to recruit the healthy and discourage sicker seniors from enrolling.

2. Gaming of Medicare's more complex risk-adjustment scheme, known as Hierarchical Condition Categories (HCCs). Since 2004, private plans have been selectively enrolling beneficiaries with very mild cases of the medical conditions included in the HCC risk-adjustment formula; such patients have, on average, substantially lower costs than the risk-adjusted premium payment that Medicare pays the private plan on their behalf. We refer to this as "new cherry-picking."

3. Congressionally-mandated overpayments included in the 2003 Medicare Prescription Drug, Improvement, and Modernization Act (MMA), including duplicate payments for indirect medical education. The provisions that generated this overpayment were tacked onto the MMA after heavy lobbying by the private insurance industry.

4. Bonus payments from the $8.35 billion CMS "Medicare Advantage Quality Bonus Payment Demonstration," an expansion of the $3 billion in quality bonuses contained in the ACA. This demonstration will award bonuses to plans covering more than 90 percent of MA beneficiaries and offset more than one-third of the cuts to MA overpayments mandated by the ACA between 2012 and 2014. According to the General Accountability Office, the demonstration is so poorly designed that it will generate almost no useful findings to improve quality.

5. Duplicate payments for private plan members who receive all or part of their care at VA facilities. Medicare pays the private plan a full premium payment, no matter how much of the patient's care is delivered (and paid for) by the VA. In an extreme case, a senior might receive all care at the VA, making the premium given to the private plan pure profit. In 2009, 8.3 percent of all MA enrollees were enrolled in the VA.

Private plans also garner overpayments through "upcoding," or the practice of intensively recording additional diagnoses in enrollees' charts, making them appear sicker than similarly ill patients in traditional Medicare. Although this might be considered a sixth category of overpayments, CMS is aware of the problem and has started applying a fixed-adjustment for it, reducing MA payments by $2.7 billion in 2010. Although a recent report by the General Accountability Office (GAO) suggests that CMS is continuing to overpay private plans by $1-2 billion, we conservatively excluded upcoding from our calculations, and just focused on the five categories of overpayments above.

Calculating the total Medicare overpayment to private plans

Although MedPAC, the GAO, the Congressional Budget Office, and researchers with The Commonwealth Fund, Urban Institute, and VA have published figures for individual categories of overpayment to private plans (generally for a single year), no previous study has compiled all the sources of overpayments since the beginning of the program.

To calculate total annual spending on private Medicare plans, we obtained figures on Medicare Part A and Part B contributions to private plan premiums between 1966 and 2012 from the CMS' Office of the Actuary, Medicare and Medicaid Cost Estimates Group. We excluded the period between 1966 and 1979 when Medicare Part A spent nothing on private plans, and the

period between 1980 and 1984 when total Medicare spending for private plans (from Part A and Part B) was under $1 billion.

We used published research on Medicare overpayments for each of the five categories of overpayment to calculate excess Medicare spending (in each category) on private plans as a share of total spending on private plans for each year since 1985. Where overpayments were estimated as a share of "Medicare FFS payments," we used data on annual Medicare spending on private plans (which is generally similar and readily available) as a proxy.

Most studies analyzed Medicare overpayments using data from a single year (the "data year") or a few years. For years before and after the data year analyzed, we estimated each category of overpayment based on percentage figures (carried forward or backward) for the closest data year for which estimates were available, then adjusted for temporal changes in total Medicare spending for private plans. Figures are reported in current dollars, i.e. actual dollar costs in the year that the spending was incurred.

We calculated total Medicare overpayments to private insurers since 1985 by summing overpayments in the five categories using the sources described below.

1. A large body of research demonstrates that private plans selectively enroll healthier beneficiaries. Estimates of overpayments due to old cherry-picking prior to 2004 range from 5.7 percent to 74 percent above what it would have cost to care for similar beneficiaries in fee-for-service (FFS) Medicare. We used three conservative, widely cited estimates for our study: an estimate of 5.7 percent using 1992 data by Brown et al. for Mathematica; a peer-reviewed estimate by Riley et al. of 12 percent overpayment using 1994 data; and an estimate by the GAO of 13.2 percent overpayment using 1998 data. We conservatively excluded studies with higher estimates, including a peer-reviewed 1997 study that suggested overpayments due to selective enrollment were 34 percent, and a 1996 study by the Physician Payment Review Commission that suggested overpayments were 37 percent. (Both also found that private plans selectively disenroll sicker beneficiaries, which would further increase plans' overpayment.) Using the three studies cited above, we calculated the amount of the overpayment from the figure for the data year(s) given and the years surrounding it, using the lowest and earliest figure (5.7 percent, 1992 data year) to estimate overpayments back to 1985.

2. We used research by MedPAC to estimate overpayments from 2004 to 2012 related to new cherry-picking, i.e. gaming the complex risk-adjustment scheme. A 2012 MedPAC report using 2007-2008 data found that Medicare beneficiaries who subsequently switch to private plans have 15 percent lower costs than other beneficiaries with a similar risk score. (MedPAC also found that beneficiaries who leave MA plans to return to traditional Medicare have 16 percent higher costs than beneficiaries who stayed in traditional Medicare, a strategy that might be described as "cherry-picking and spitting out the pits.") A National Bureau of Economic Research (NBER) study estimates overpayments of $15 billion to MA plans in 2006 from risk selection and overpayments mandated by the MMA, or a 23.2 percent combined overpayment (personal communication, Ilyana Kuziemko). We used the published MedPAC figure of 15 percent since it was limited to risk selection, but note that the NBER figure is similar (subtracting the 11.2 percent share of mandated overpayments would leave a 12 percent overpayment from new cherry-picking in 2006).

3 and 4. We obtained figures on overpayments mandated by the MMA from two sources. For years between 2003 and 2008, we used research carried out by Brian Biles and colleagues for The Commonwealth Fund. For the years 2009-2012, estimates of the mandated overpayment were available from MedPAC's annual reports on the MA program. MedPAC (appropriately) adjusted its 2012 figure to account for reductions contained in the ACA, and the fourth category of overpayment, demonstration project quality bonuses, which partially offset the ACA reductions.

5. Medicare overpayments for dually eligible VA patients enrolled in private plans have been known to exist for decades. However, they have only recently been quantified by Trivedi et al. at a national level. We calculated overpayments from this source using figures on total VA spending on care for MA enrollees from 2004-2009 as a share of total MA spending duing that period.

Results

Table 1 displays each category of Medicare overpayment to private plans as a percentage of total Medicare payments to private plans for each year since 1985. Overpayments attributable to old cherry-picking ranged from 5.7 percent to 13.2 percent annually between 1985 and 2004. New cherry-picking since 2004 generated annual overpayments of 15 percent of total spending on private plans. Overpayments mandated by Congress rose from 9.9 percent in 2004 to 12 percent in 2010, and then fell to 7 percent in 2012. Overpayments due to care for Medicare private plans' enrollees delivered (and paid for) by the VA were 3 percent annually.

The dollar amounts of overpayments for each category are shown in Table 2. Overpayments nearly doubled with the implementation of the MMA, rising from $6 billion in 2003 to $11 billion in 2004. Prior to 2004 overpayments peaked at $6.4 billion in 2000. The total overpayment was highest in 2009 at $36.2 billion, just before passage of the ACA.

In 2012, the total Medicare overpayment to private plans was $34.1 billion, 25 percent of all payments to private plans, or $2,526 per MA enrollee.

Figure 2 displays the dollar amounts of overpayments in each category since 1985. New cherry-picking, plans' selective enrollment of healthier patients within each risk strata in the HCC risk-adjustment scheme since 2004, is currently the largest category of overpayment, and is responsible for $122.5 billion in overpayments to private plans since 1985.

Table 1

Medicare Overpayments to Private Plans as a Percentage of Fee-for-Service Payments by Category, 1985-2012					
Year	Old Cherry Picking	New Cherry Picking [d]	Congressionally Mandated Overpayments	Care delivered by VA to Private Plan Enrollees[j]	Total Percentage Overpayments
1985	5.7 [a]	NA	NA	3	8.7
1986	5.7 [a]	NA	NA	3	8.7
1987	5.7 [a]	NA	NA	3	8.7
1988	5.7 [a]	NA	NA	3	8.7
1989	5.7 [a]	NA	NA	3	8.7
1990	5.7 [a]	NA	NA	3	8.7
1991	5.7 [a]	NA	NA	3	8.7
1992	5.7 [a]	NA	NA	3	8.7
1993	5.7 [a]	NA	NA	3	8.7
1994	12 [b]	NA	NA	3	15
1995	12 [b]	NA	NA	3	15
1996	12 [b]	NA	NA	3	15
1997	12 [b]	NA	NA	3	15
1998	13.2 [c]	NA	NA	3	16.2
1999	13.2 [c]	NA	NA	3	16.2
2000	13.2 [c]	NA	NA	3	16.2
2001	13.2 [c]	NA	NA	3	16.2
2002	13.2 [c]	NA	NA	3	16.2
2003	13.2 [c]	NA	NA	3	16.2
2004	NA	15	9.9 [e]	3	27.9
2005	NA	15	11.1 [e]	3	29.1
2006	NA	15	11.2 [e]	3	29.2
2007	NA	15	10.1 [e]	3	28.1
2008	NA	15	8.6 [e]	3	26.6
2009	NA	15	14 [f]	3	32
2010	NA	15	12 [g]	3	30
2011	NA	15	10 [h]	3	28
2012	NA	15	7 [i]	3	25

Table 2

Medicare Overpayments to Private Plans by Category, 1985-2012 ($ billions)					
Year	Old Cherry Picking	New Cherry Picking	Congressional Mandated Overpayments	Care delivered by VA to Private Plan Enrollees	Total Percentage Overpayments
1985	0.1	0.0	0.0	0.0	0.1
1986	0.1	0.0	0.0	0.1	0.2
1987	0.2	0.0	0.0	0.1	0.3
1988	0.2	0.0	0.0	0.1	0.3
1989	0.3	0.0	0.0	0.1	0.4
1990	0.3	0.0	0.0	0.2	0.5
1991	0.4	0.0	0.0	0.2	0.5
1992	0.4	0.0	0.0	0.2	0.7
1993	0.5	0.0	0.0	0.3	0.8
1994	1.4	0.0	0.0	0.3	1.7
1995	1.6	0.0	0.0	0.4	2.0
1996	2.6	0.0	0.0	0.6	3.2
1997	3.3	0.0	0.0	0.8	4.1
1998	4.5	0.0	0.0	1.0	5.6
1999	5.1	0.0	0.0	1.2	6.2
2000	5.3	0.0	0.0	1.2	6.4
2001	5.1	0.0	0.0	1.2	6.2
2002	4.8	0.0	0.0	1.1	5.9
2003	4.9	0.0	0.0	1.1	6.0
2004	0.0	5.9	3.9	1.2	11.0
2005	0.0	7.0	5.2	1.4	13.7
2006	0.0	9.7	7.2	1.9	18.8
2007	0.0	11.7	7.9	2.3	21.9
2008	0.0	14.8	8.5	3.0	26.3
2009	0.0	16.9	15.8	3.4	36.2
2010	0.0	17.4	13.9	3.5	34.9
2011	0.0	18.6	12.4	3.7	34.6
2012	0.0	20.4	9.5	4.1	34.1
Total by Category	41.0	122.5	84.4	34.8	282.6

Overpayments mandated by the MMA of 2003, including duplicate payments for indirect medical education, and the first year of quality bonuses to plans as part of a CMS demonstration project on quality, account for $84.4 billion of overpayments to private plans since 1985.

The use of the VA for medical care by MA enrollees accounts for $34.8 billion of total overpayments to private plans, while old cherry-picking (plans' selective enrollment of healthy beneficiaries prior to the adoption of the new risk-adjustment system in 2004) accounts for $41 billion in overpayments to private plans since 1985.

In total, overpayments to private plans have cost taxpayers $282.6 billion since 1985. That amount represents 24.4 percent of total Medicare spending of $1,159.6 billion on private plans between 1985 and 2012.

In 2012 alone, the total Medicare overpayment to private plans will be an estimated $34.1 billion, 25 percent of all payments to private plans, $2,526 per MA enrollee, or 6.2 percent of all Medicare spending.

Private plans and risk adjustment: No contest

Under Medicare's old "demographic" model of risk-adjustment, the most profitable beneficiaries to private plans were those who were the healthiest.

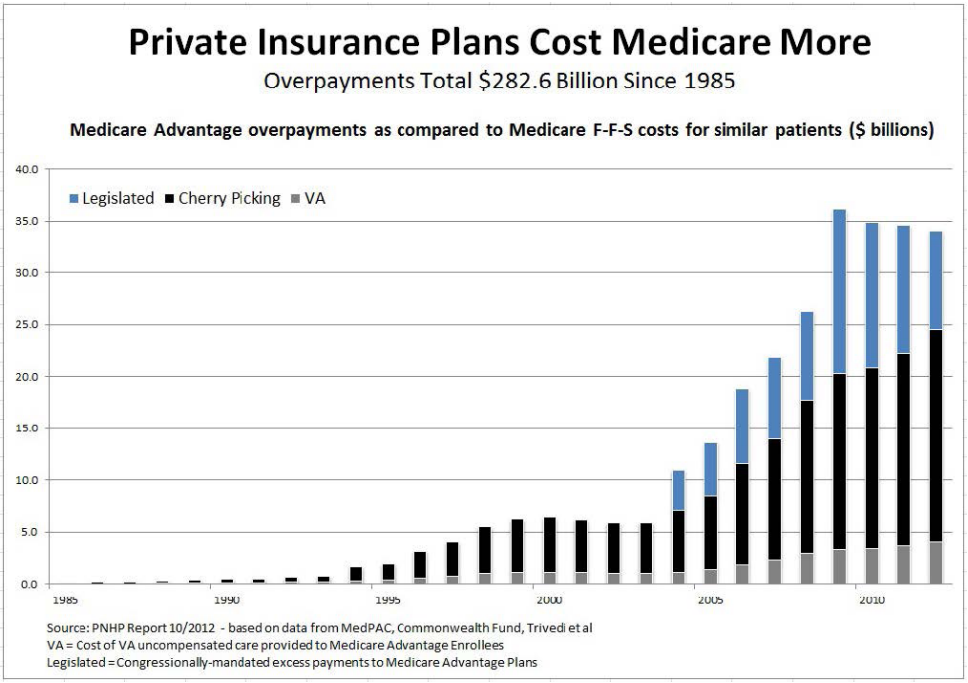
Under Medicare's new risk-adjustment scheme, the most profitable beneficiaries are those with a serious diagnosis (for which the plan receives a higher payment) but who, nonetheless, are actually not very sick (i.e. they have low severity of illness within that diagnosis). While serious cases of diseases like arthritis, diabetes, chronic bronchitis, and prostate cancer increase with age, so do very mild cases that require little or no specific treatment. Private plans have adapted to the HCC risk-adjustment formula by identifying and recruiting beneficiaries with mild cases of medical conditions who are now more profitable to insure than beneficiaries without any diagnoses. Such gaming has been described as "cherry-picking conditional on diagnosis" or "selection along dimensions not included in the risk-adjustment formula."

The example of congestive heart failure (CHF) illustrates how private plans can game the risk-adjustment system. Medicare beneficiaries at the 95th percentile of costliness with CHF had more than $37,000 in Medicare spending in 2008, compared with just $115 in spending for beneficiaries with CHF at the 5th percentile. Despite the cost differences, plans get the same bonus (about 41 percent of the premium for a healthy senior) for each patient who has CHF. Hence, plans can profit by encouraging physicians to perform echocardiogram tests used to diagnose CHF on seniors without symptoms, labeling the patients with this diagnoses when they have such mild cases that their costs of care would not be elevated.

While there are already calls to improve the accuracy of the HCC model, there is no evidence that risk adjustment works or can work in the dynamic reality of profit-seeking health care insurers.

Private plans have powerful financial incentives to design new strategies to game risk adjustment. The plans have access

Figure 2



to much more detail about enrollees' health than does Medicare (i.e. there is information asymmetry), and as mentioned above, very mild cases of chronic conditions are common in the elderly. Each time Medicare adjusts its risk-adjustment formula, private plans will try to compensate by adjusting their cherry-picking. The most interesting part of the 2004 enhancement of Medicare Advantage's risk-adjustment formula is not that plans succeeded in gaming it, but that cherry-picking was at least as common after the enhanced risk adjustment as before.

Without such cherry-picking, it seems unlikely that private plans could compete with traditional Medicare at all. Traditional Medicare is administratively efficient because it enrolls people using the Social Security system and uses a single set of rules and fees to pay doctors and hospitals. Hence, the overhead in traditional Medicare is quite low, under 2 percent, compared to 15 percent in private plans. According to one estimate, overhead per enrollee in 2008 was $147 in traditional Medicare versus $1,450 in private plans. Although private plans' higher overhead doesn't raise our estimate of overpayments, it does imply significantly reduced amounts of clinical care actually delivered to patients by MA plans.

Policy implications

Our findings indicate that the inclusion of private plans in the Medicare program has cost taxpayers $282.6 billion, 24.4 percent of the total amount Medicare has paid private plans since 1985.

Our findings likely underestimate the magnitude of the overpayments. We used low-end estimates to calculate the cost of selective enrollment prior to 2004, and excluded the substantial cost of private plans' disenrollment of beneficiaries who subsequently have higher-than-average costs. With private plans, "the healthy go in, and the sick go out," but our figures only include the first half of that formulation.

We also excluded the cost of the post-2004 upcoding that occurs after the first year of MA enrollment (payments for the first year are based on pre-enrollment data). CMS didn't make its first adjustment for upcoding until 2010, when it reduced MA payments by $2.7 billion. The GAO estimates that Medicare could save another $15 billion over the next decade on upcoding even after CMS' adjustment.

Recent technical and legislative attempts to reduce the two major drivers of overpayments have had little or no impact. The adoption of a new risk-adjustment scheme by Medicare in 2004 has not curbed cherry-picking by private plans, and may have increased it. In 2012 private plans garnered $20.4 billion in overpayments by gaming the risk-adjustment scheme. Reductions in mandated overpayments by the ACA have been partially offset by inappropriate quality bonuses. Hence, the congressionally mandated overpayments fell only modestly this year to $9.5 billion.

In addition, taxpayers pay twice for care provided (and paid for) by the VA for enrollees of private plans. In 2012 the VA will provide an estimated $4.1 billion in care to the 8.3 percent of MA enrollees who are also receiving VA care.

In 2012 alone, we estimate that private insurers are being overpaid $34.1 billion, $2,526 per MA enrollee, 6.2 percent of total Medicare spending this year.

Conclusions

Advocates of market-based Medicare reforms suggest that competition among private plans will induce greater efficiency and result in cost savings. Our findings indicate that the opposite is true. Private plans have drained over $280 billion from Medicare since 1985, most of it in the last 8 years. Increasing private enrollment through voucher-type Medicare reform (as suggested by Republicans) or through quality bonuses and financial incentives to plans to enroll dual-eligible beneficiaries (as enacted by the Obama administration) will almost certainly raise Medicare's costs, not lower them.

Funds wasted on overpayments to private MA plans could instead have been used to improve benefits for seniors, extend the life of the Medicare Trust Fund by more than a decade, or reduce the federal deficit. Private insurers have enriched themselves at the expense of the taxpayers.

It is time to end Medicare's long and costly experiment with privatization. Alternative models of controlling costs that are proven-effective deserve a closer look.

For the full text of this article, including a timeline, endnotes and biographies of the authors, please visit bit.ly/OGaYaF or PNHP's website.

BMJ

ANALYSIS

Pharmaceutical research and development: what do we get for all that money?

Data indicate that the widely touted "innovation crisis" in pharmaceuticals is a myth. The real innovation crisis, say **Donald Light** and **Joel Lexchin**, stems from current incentives that reward companies for developing large numbers of new drugs with few clinical advantages over existing ones

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Since the early 2000s, industry leaders, observers, and policy makers have been declaring that there is an innovation crisis in pharmaceutical research. A 2002 front page investigation by the *Wall Street Journal* reported, "In laboratories around the world, scientists on the hunt for new drugs are coming up dry . . . The $400 billion a year drug industry is suddenly in serious trouble."[1] Four years later, a US Government Accounting Office assessment of new drug development reported that "over the past several years it has become widely recognized throughout the industry that the productivity of its research and development expenditures has been declining."[2] In 2010, Morgan Stanley reported that top executives felt they could not "beat the innovation crisis" and proposed that the best way to deal with "a decade of dismal R&D returns" was for the major companies to stop trying to discover new drugs and buy into discoveries by others.[3] Such reports continue and raise the spectre that the pipeline for new drugs will soon run dry and we will be left to the mercies of whatever ills befall us.[4]

The "innovation crisis" myth

The constant production of reports and articles about the so called innovation crisis rests on the decline in new molecular entities (defined as "an active ingredient that has never been marketed . . . in any form"[5]) since a spike in 1996 that resulted from the clearance of a backlog of applications after large user fees from companies were introduced (fig 1⇓). This decline ended in 2006, when approvals of new molecular entities returned to their long term mean of between 15 and 25 a year (fig 2⇓).[6] Even in 2005, an analysis of the data by a team at Pfizer concluded that the innovation crisis was a myth "which bears no relationship to the true innovation rates of the pharmaceutical industry."[7] So why did the claims and stories not abate?

A subsequent analysis also concluded that the innovation crisis was a myth and added several insights.[8] Based on US Food and Drug Administration records, Munos found that drug companies "have delivered innovation at a constant rate for almost 60 years." The new biologicals have been following the same pattern "in which approvals fluctuate around a constant, low level."[8] These data do not support frequently heard complaints about how hard it is to get any new drug approved. They also mean that neither policies considered to be obstacles to innovation (like the requirement for more extensive clinical testing) nor those regarded as promoting innovation (like faster reviews) have made much difference. Even the biotechnology revolution did not change the rate of approval of new molecular entities, though it changed strategies for drug development.[9] Meanwhile, telling "innovation crisis" stories to politicians and the press serves as a ploy, a strategy to attract a range of government protections from free market, generic competition.[10 11]

The real innovation crisis

More relevant than the absolute number of new drugs brought to the market is the number that represent a therapeutic advance. Although the pharmaceutical industry and its analysts measure innovation in terms of new molecular entities as a stand-in for therapeutically superior new medicines, most have provided only minor clinical advantages over existing treatments.

The preponderance of drugs without significant therapeutic gains dates all the way back to the "golden age" of innovation. Out of 218 drugs approved by the FDA from 1978 to 1989, only 34 (15.6%) were judged as important therapeutic gains.[12] Covering a roughly similar time period (1974-94), the industry's Barral report on all internationally marketed new drugs concluded that only 11% were therapeutically and pharmacologically innovative.[13] Since the mid-1990s, independent reviews have also concluded that about 85-90% of

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all new drugs provide few or no clinical advantages for patients.[14-19]

This small, steady increase in clinically superior drugs contrasts with the FDA granting "priority" review status to 44% of all new drugs from 2000 to 2010.[20] The percentage of drugs with a priority designation began to increase in 1992 when companies started funding the FDA's approval process. Other regulatory agencies have classified far fewer of the same medicines as needing accelerated reviews.[21] Post-market evaluations during the same period are much less generous in assigning significant therapeutic advances to medications.[18 21]

This is the real innovation crisis: pharmaceutical research and development turns out mostly minor variations on existing drugs, and most new drugs are not superior on clinical measures. Although a steady stream of significantly superior new drugs enlarges the medicine chest from which millions benefit, medicines have also produced an epidemic of serious adverse reactions that have added to national healthcare costs.[22]

How much does research and development cost?

Although the pharmaceutical industry emphasises how much money it devotes to discovering new drugs, little of that money actually goes into basic research. Data from companies, the United States National Science Foundation, and government reports indicate that companies have been spending only 1.3% of revenues on basic research to discover new molecules, net of taxpayer subsidies.[23] More than four fifths of all funds for basic research to discover new drugs and vaccines come from public sources.[24] Moreover, despite the industry's frequent claims that the cost of new drug discovery is now $1.3bn (£834m; €1bn),[25] this figure, which comes from the industry supported Tufts Center,[26] has been heavily criticised. Half that total comes from estimating how much profit would have been made if the money had been invested in an index fund of pharmaceutical companies that increased in value 11% a year, compounded over 15 years.[26] While used by finance committees to estimate whether a new venture is worth investing in, these presumed profits (far greater than the rise in the value of pharmaceutical stocks) should not be counted as research and development costs on which profits are to be made. Half of the remaining $0.65bn is paid by taxpayers through company deductions and credits, bringing the estimate down to one quarter of $1.3bn or $0.33bn.[27] The Tufts study authors report that their estimate was done on the most costly fifth of new drugs (those developed in-house), which the authors reported were 3.44 times more costly than the average, reducing the estimate to $90m. The median costs were a third less than the average, or $60m. Deconstructing other inflators would lower the estimate of costs even further.

Hidden business model

How have we reached a situation where so much appears to be spent on research and development, yet only about 1 in 10 newly approved medicines substantially benefits patients? The low bars of being better than placebo, using surrogate endpoints instead of hard clinical outcomes, or being non-inferior to a comparator, allow approval of medicines that may even be less effective or less safe than existing ones. Notable examples include rofecoxib (Vioxx), rosiglitazone (Avandia), gatifloxacin (Tequin), and drotrecogin alfa (Xigris).

Although the industry's vast network of public relations departments and trade associations generate a large volume of stories about the so called innovation crisis, the key role of blockbuster drugs, and the crisis created by "the patent cliff,"[28] the hidden business model of pharmaceuticals centres on turning out scores of minor variations, some of which become market blockbusters. In a series of articles Kalman Applbaum describes how companies use "clinical trial administration, research publication, regulatory lobbying, physician and patient education, drug pricing, advertising, and point-of-use promotion" to create distinct marketing profiles and brand loyalty for their therapeutically similar products.[29] Sales from these drugs generate steady profits throughout the ups and downs of blockbusters coming off patents. For example, although Pfizer lost market exclusivity for atorvastatin, venlafaxine, and other major sellers in 2011, revenues remained steady compared with 2010, and net income rose 21%.[30]

Applbaum contends that marketing has become "the enemy of [real] innovation."[31] This perspective explains why companies think it is worthwhile paying not only for testing new drugs but also for thousands of trials of existing drugs in order to gain approval for new indications and expand the market.[32] This corporate strategy works because marketing departments and large networks of sponsored clinical leaders succeed in persuading doctors to prescribe the new products.[33] An analysis of Canada's pharmaceutical expenditures found that 80% of the increase in its drug budget is spent on new medicines that offer few new benefits.[16] Major contributors included newer hypertension, gastrointestinal, and cholesterol drugs, including atorvastatin, the fifth statin on the Canadian market.

Myth of unsustainable research and development

Complementing the stream of articles about the innovation crisis are those about the costs of research and development being "unsustainable" for the small number of new drugs approved. Both claims serve to justify greater government support and protections from generic competition, such as longer data exclusivity and more taxpayer subsidies. However, although reported research and development costs rose substantially between 1995 and 2010, by $34.2bn, revenues increased six times faster, by $200.4bn.[25] Companies exaggerate costs of development by focusing on their self reported increase in costs and by not mentioning this extraordinary revenue return. Net profits after taxes consistently remain substantially higher than profits for all other Fortune 500 companies.[34]

This hidden business model for pharmaceutical research, sales, and profits has long depended less on the breakthrough research that executives emphasise than on rational actors exploiting ever broader and longer patents and other government protections against normal free market competition. Companies are delighted when research breakthroughs occur, but they do not depend on them, declarations to the contrary notwithstanding. The 1.3% of revenues devoted to discovering new molecules [23] compares with the 25% that an independent analysis estimates is spent on promotion,[35] and gives a ratio of basic research to marketing of 1:19.

Towards more cost effective, safer medicines

What can be done to change the business model of the pharmaceutical industry to focus on more cost effective, safer medicines? The first step should be to stop approving so many new drugs of little therapeutic value. The European Medicines Agency (EMA) does Europe a disservice by approving 74% of

all new applications based on trials designed by the companies, while keeping data about efficacy and safety secret.[36 37] Twenty nine per cent of new biologicals approved by the EMA received safety warnings within the first 10 years on the market,[38] and therapeutically similar drugs by definition have no advantages to offset their unknown risk of increased harm. We need to revive the Norwegian "medical need" clause that limited approval of new drugs to those that offered a therapeutic advantage over existing products.[39] This approach led to Norway having seven non-steroidal anti-inflammatory drugs on the market compared with 22 in the Netherlands.[40] Norway's medical need clause was eliminated in 1996 when it harmonised its drug approval process with that in the EU. EU countries are paying billions more than necessary for drugs that provide little health gain because prices are not being set to reward new drugs in proportion to their added clinical value.

We should also fully fund the EMA and other regulatory agencies with public funds, rather than relying on industry generated user fees, to end industry's capture of its regulator. Finally, we should consider new ways of rewarding innovation directly, such as through the large cash prizes envisioned in US Senate Bill 1137, rather than through the high prices generated by patent protection.[41] The bill proposes the collection of several billion dollars a year from all federal and non-federal health reimbursement and insurance programmes, and a committee would award prizes in proportion to how well new drugs fulfilled unmet clinical needs and constituted real therapeutic gains. Without patents new drugs are immediately open to generic competition, lowering prices, while at the same time innovators are rewarded quickly to innovate again. This approach would save countries billions in healthcare costs and produce real gains in people's health.

Contributors and sources: DWL is professor of comparative health care policy and has published several studies on pharmaceutical policy gathered at www.pharmamyths.net. For his work, he has been selected as a fellow at the Safra Center for Ethics at Harvard University for 2012-13. JRL is the author or coauthor of over 115 peer reviewed articles on all aspects of pharmaceutical policy. The authors made use of their knowledge from their individual and collaborative work on pharmaceutical economics including material from a variety of industry and government publications and their extensive personal libraries. DWL conceived, researched, and wrote the initial draft. JRL researched and revised, making substantial changes.

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Figures

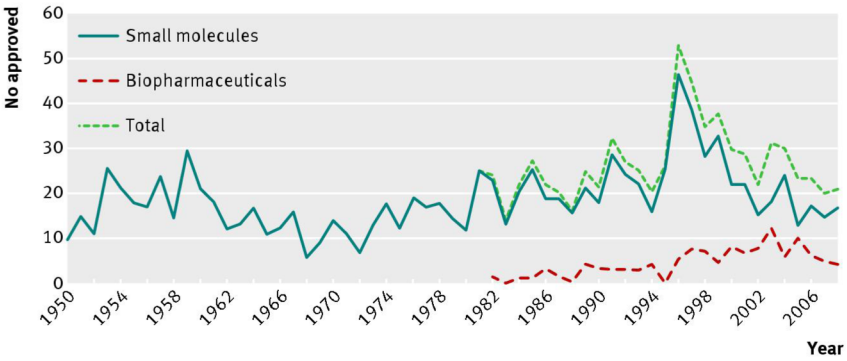


Fig 1 The innovation crisis starting in 1997 is a return to the long term average range of new approvals from an artificial spike caused by political factors[8]

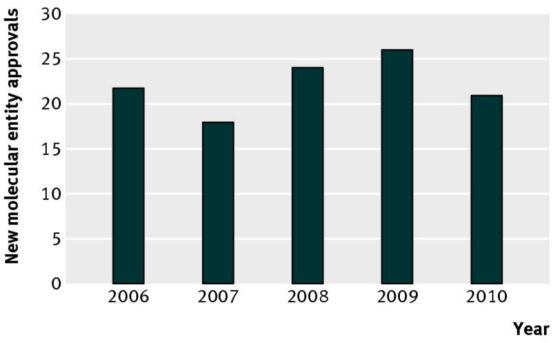


Fig 2 The rate of approval of new molecular entities returned to the long term average range by 2006

"Look, dear - here's a Get Well-or-Else card from the insurance company."

Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care

By Michael K. Gusmano

Access to health care for undocumented immigrants in the U.S. is shaped by several policies and programs at the federal state and local level. This issue brief provides an overview of key federal and state policies.

Are undocumented immigrants eligible for public insurance programs?

With the exception of emergency medical care, undocumented immigrants are not eligible for federally funded public health insurance programs, including Medicare, Medicaid and the Child Health Insurance Program (CHIP).[1]Medicare is a social insurance program that provides health insurance to people age 65 and over, as well as people with permanent disabilities and end-stage renal disease. Medicaid is a means-tested social welfare program that provides health insurance to certain categories of poor people. CHIP, created in 1997, is a block grant program to expand coverage to children in families with incomes that exceed Medicaid eligibility.[2] There is no organized, national program to provide health care for undocumented children. U.S.-born children in mixed-status families may be eligible for Medicaid or CHIP if they qualify on the basis of income and age.

Although federal funds may not be used to provide non-emergency health care to undocumented immigrants, some states and local governments use their own funds to offer coverage to undocumented children.[3] For example, the Healthy Kids program in San Francisco covers uninsured children under the age of 19, including undocumented children.[4] Similarly, the All Kids program Illinois covers all children under the age of 19 who meet program income requirements, regardless of immigration status.[5]

PRUCOL (Permanent Residence Under Color of Law) is a public benefits eligibility category that refers to individuals who are in the U.S. with the knowledge of immigration services and are not likely to be deported.Before the adoption of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,[6] people with PRUCOL status were eligible for Medicaid, but PRWORA eliminated their eligibility with the exception of emergency services. In New York, the State Court of Appeals (Aliessa et al. v. Novello) concluded that denying access to Medicaid violated the equal protection clauses of the New York and U.S. constitutions. As a result, New York provides Medicaid to this population using state funds only.

In about half of the U.S. states, immigrant children under the age of 21 and pregnant woman who have been granted deferred action on their immigration status are allowed to apply for Medicaid and the CHIP or enroll in their state's high risk insurance pool. An exception to this, however, are the so-called "dreamers" – the estimated 1.7 million undocumented teenagers and young adults granted deferred action by the Obama Administration on June 15, 2012.[7] President Obama announced that undocumented immigrants who were brought to the U.S. before they turned 16 and are younger than 30, have been in the country for at least five continuous years, have no criminal history, graduated from a U.S. high school or earned their GED, or honorably discharged from the military will be immune from deportation and can apply for a work permit that will be good for two years with no limits on renewal.On August 28, 2012, the Obama Administration announced that the young people affected by this directive would not meet the definition of being "lawfully present"and would therefore be ineligible for Medicaid, the CHIP and the insurance benefits of the ACA.[8]

How is emergency medical care available to undocumented immigrants?

In 1986 the Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Pub. L. 99–272). The law was designed to provide patients with access to emergency medical care and to prevent hospitals from "dumping" unstable patients that could not afford to pay for their care."[9] Under the law, "any patient arriving at an Emergency Department (ED) in a hospital that participates in the Medicare program must be given an initial screening, and if found to be in need of emergency treatment (or in active labor), must be treated until stable."[10] The law defines an emergency medical condition as a "medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in – (i) [p]lacing the health of the individual … in serious jeopardy; (ii) [s]erious impairment to bodily functions; or (iii) [s]erious dysfunction of any bodily organ part[.]" It requires hospitals covered by the law to provide patients with an emergency medical condition with "an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (EMC) exists." (42 C.F.R 489.24(a)(1)(i)). the medical screening examination "must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations" (42 C.F.R. § 489.24(a)(1)(i)).

Although the law refers specifically to hospitals with an ED, the guidelines from the federal government have applied

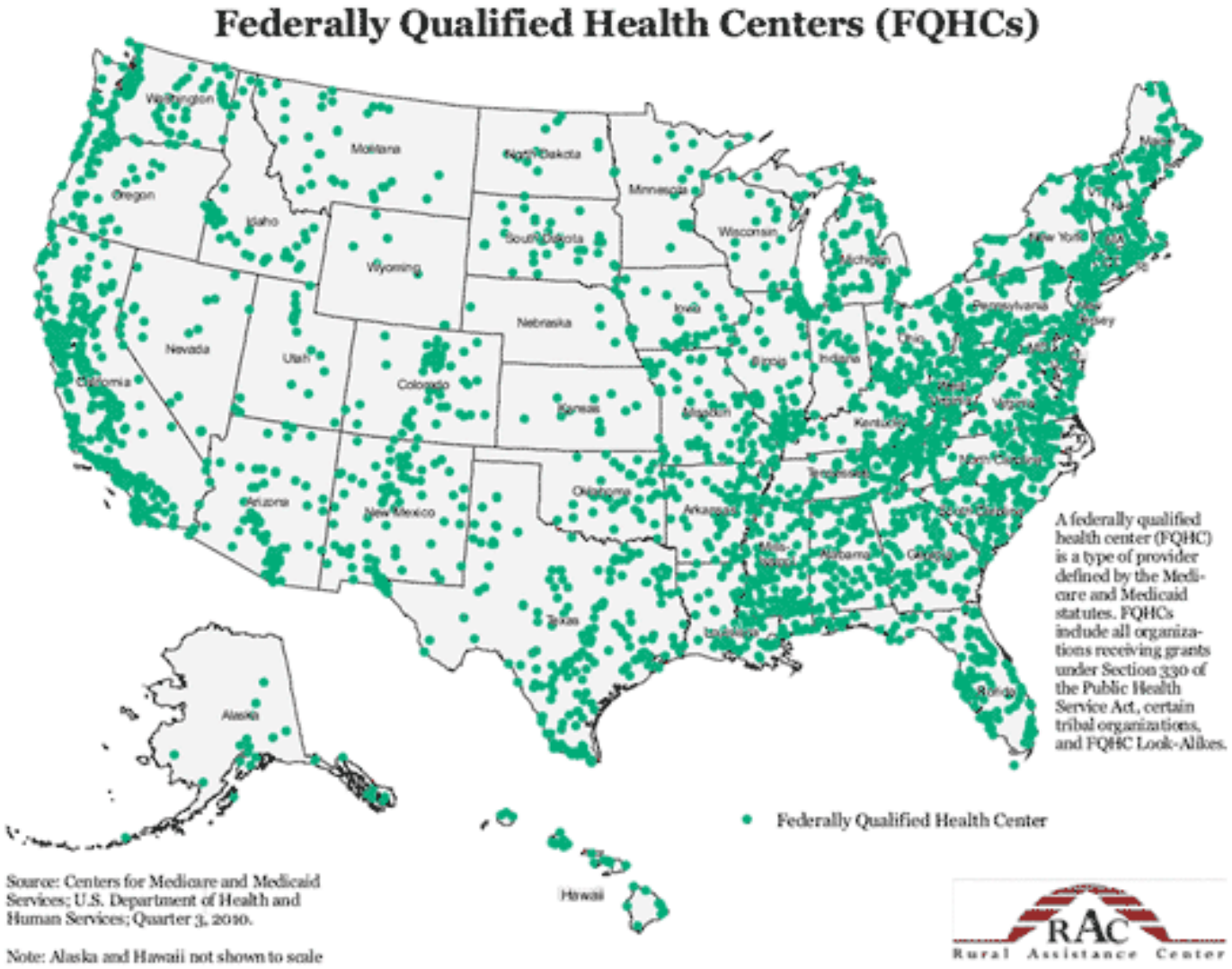
EMTALA requirements to all facilities that participate in the Medicare program and offer emergency services.[11] Met, while EMTALA requires covered hospitals to stabilize patients with emergency medical conditions, it does not require these facilities to provide additional treatment. There is a legal dispute over whether the stabilization requirement in EMTALA continues to apply if a patient has been admitted to the hospital.[12] Decisions by the Fourth, Ninth and Eleventh Circuit Courts held that hospitals have no stabilization duties once patients are admitted,[13] but the Sixth Circuit held the opposite.[14]

In addition to EMTALA, it is also possible for undocumented immigrants to qualify for Medicaid coverage for emergency care. The definition of emergency care and the scope of services available through the Medicaid programs vary by state. For example, in New York State Medicaid for Emergency Care may be used to provide chemotherapy and radiation therapy to undocumented patients with cancer. In New York State, California, and North Carolina, it may be used to provide outpatient dialysis to undocumented patients.[15]

Do undocumented immigrants have access to care through the health care safety net?

To care for the lower income residents, including undocumented immigrants, the U.S. relies on a patchwork "system" of safety-net providers, including public and not-for-profit hospitals, federally qualified community health centers (FQHCs), and migrant health centers. Since the Omnibus Budget Reconciliation Act of 1981, a hospital recognized as "disproportionate share hospital" (DSH) with respect to the percentages of low-income and uninsured patients it treats receives additional payments from Medicaid to support uncompensated care. Congress also required Medicare to allocate DSH funds to hospitals. The DSH programs fund hospital care for uninsured patients. Together, the Medicare and Medicaid DSH programs provide more than $20 billion to qualified hospitals annually, but these programs are scheduled to be reduced significantly under health care reform.[16]

Federally Qualified Health Centers (FQHCs) and Migrant Health Centers are not-for-profit organizations[17] funded by the



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federal Health Resources and Services Administration (HRSA). Both offer comprehensive primary care to vulnerable populations that include Medicaid patients, uninsured patients, and patients in underserved urban, suburban, and rural areas. They provide care regardless of ability to pay, insurance status or immigration status. Both are required to have a board of directors with a majority (at least 51%) of the members from the community served by the center. In addition, both types of health centers are required to use a sliding fee scale. The main difference between them is that migrant health centers are only allowed to serve migrant and seasonal farm workers and their families.*

Federal support for FQHCs increased significantly under the George W. Bush administration and they have received continued support from the Obama administration.[18]Between 1996 and 2010, direct federal funding for FQHCs increased from $750 million to $2.2 billion. As of 2010, there were 1,214 FQHCs operating more than 8,000 service sites.[19] In addition, there were 159 federally funded migrant health center sites, operating more than 700 service sites.[20]

How will the Patient Protection and Affordable Care Act influence access to health care for undocumented immigrants?

The PPACA does not provide undocumented immigrants with eligibility for public insurance programs. Because undocumented immigrants are not regarded as "qualified individuals" under the law, it also does not allow undocumented immigrants to purchase health insurance through the new state health exchanges even if they are able to do so with their own money.[21] Section 1312 of the Act states, "If an individual is not, or is not reasonably expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States, the individual shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange."[22]

Despite these restrictions, the law does include additional funding for the health care safety-net, including an $11 billion increase for FQHCs and the law's expansion of the Medicaid program may provide additional revenue to many FQHCs and other safety-net providers. Yet, the PPACA also calls for an $18 billion dollar reduction in Medicaid DSH payments and a $22 billion reduction in Medicare DSH payments through 2020. The DSH cuts are based on the assumption that hospitals will not need to provide as much charity care once the health reform is implemented. Because undocumented immigrants will not receive public or private insurance coverage under health reform, they are likely to represent a larger percentage of the nation's uninsured population. This raises important question about future political support for the health care safety-net.[23]

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A Major Glitch for Digitized Health-Care Records

By Stephen Soumerai and Ross Koppel

In two years, hundreds of thousands of American physicians and thousands of hospitals that fail to buy and install costly health-care information technologies—such as digital records for prescriptions and patient histories—will face penalties through reduced Medicare and Medicaid payments. At the same time, the government expects to pay out tens of billions of dollars in subsidies and incentives to providers who install these technology programs.

The mandate, part of the 2009 stimulus legislation, was a major goal of health-care information technology lobbyists and their allies in Congress and the White House. The lobbyists promised that these technologies would make medical administration more efficient and lower medical costs by up to $100 billion annually. Many doctors and health-care administrators are wary of such claims—a wariness based on their own experience. An extensive new study indicates that the caution is justified: The savings turn out to be chimerical.

Since 2009, almost a third of health providers, a group that ranges from small private practices to huge hospitals—have installed at least some "health IT" technology. It wasn't cheap. For a major hospital, a full suite of technology products can cost $150 million to $200 million. Implementation—linking and integrating systems, training, data entry and the like—can raise the total bill to $1 billion.

But the software—sold by hundreds of health IT firms—is generally clunky, frustrating, user-unfriendly and inefficient.

Now, a comprehensive evaluation of the scientific literature has confirmed what many researchers suspected: The savings claimed by government agencies and vendors of health IT are little more than hype.

To conduct the study, faculty at McMaster University in Hamilton, Ontario, and its programs for assessment of technology in health—and other research centers, including in the U.S.—sifted through almost 36,000 studies of health IT. The studies included information about highly valued computerized alerts—when drugs are prescribed, for instance—to prevent drug interactions and dosage errors. From among those studies the researchers identified 31 that specifically examined the outcomes in light of the technology's cost-savings claims.

With a few isolated exceptions, the preponderance of evidence shows that the systems had not improved health or saved money.

It is already common knowledge in the health-care industry that a central component of the proposed health IT system—the ability to share patients' health records among doctors, hospitals and labs—has largely failed. The industry could not agree on data standards.

Instead of demanding unified standards, the government has largely left it to the vendors, who declined to cooperate, thereby ensuring years of noncommunication and noncoordination. This likely means billions of dollars for unnecessarily repeated tests and procedures, double-dosing patients and avoidable suffering.

One more item from PNHP's data update:

VA's electronic health record is the low risk option

The VA is changing in the way it develops and updates VistA, the renowned electronic health record (EHR) that helped the government-run system dramatically improve quality. VistA was developed collaboratively over the past 35 years by programmers employed by the VA with the full participation of the medical staff. Today, the VA is poised to move to an open source strategy that will allow developers outside the VA to advance the technology. The VA is a leader in the adoption of EHR, with nearly 100 percent of VA facilities using the VistA system by 1996, compared with only 4 percent of private hospitals that have fully implemented EHRs today. VistA has been implemented in about 3,000 hospitals, clinics, nursing home and physician offices in more than 30 countries (including in all major medical centers in Jordan, after King Abdullah II visited the VA in 2003), and by many community and State hospitals and clinics in the U.S., with implementation costs 12 percent to 35 percent of the cost of proprietary EHR systems. "VistA has proven to be not only the low cost option, but also the 'low risk' option for hospitals" (Maduro, "VA to Invest Billions in Open Source Transition," Open Health News, 5/20/12).

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Health information technology is a tower of Babel, by intent

By Marvin Malek, M.D.

During the 1990s, the VA system was converted from a medical backwater to the forefront of high quality medical care. Ten years earlier, doctors and programmers within the VA system began the pioneering work of developing a software program to be used as a medical record. Ultimately named "Vista," this well-liked software is now used by every clinical worker in the VA system. This linkage of every VA facility in the country with the same, user-friendly software program was the centerpiece of the effort to improve quality of care throughout the VA system.

This effort paid off. In the largest such study yet performed, VA hospitals outranked a large group of private sector hospitals in every area measured, including preventive care, chronic care, patient satisfaction, and treatment of heart disease, while spending 35 percent less than the private sector hospitals.

In 2001, the Institute of Medicine released an influential series of reports documenting the large number of serious medical errors occurring on a daily basis in hospitals and medical practices across the U.S., and they recommended adoption of electronic health records as a key solution. In early 2004, President George Bush set out a landmark federal policy whose goal was to have every Americans' health record be in electronic form by 2014.

But the Institute of Medicine — as well as subsequent federal policy — did not specifically recommend the VA system's route toward computerization: To use a single, popular software language to connect every hospital and doctor's office. Instead, under Bush era policy — which has been continued through the Obama years --- new agencies and programs were created to promote wider private-sector electronic health records adoption. If the late Steve Jobs were forced to use any of these products, he would be appalled at the primitive functionality doctors and nurses are contending with.

Babel, by intent

The 11th chapter of Genesis tells the story of humanity disobeying a commandment of God by building a very tall tower as a symbol of their earthly power. To punish mankind for this disobedience, God "confused the languages of humanity so that they could no longer communicate with each other." As a consequence, the tower at Babel could not be completed.

In health care, we have created our own "Babel" of incompatible medical software products. And this time, we can't blame God.

Federal policy not only failed to encourage all providers to adopt a single software system, but the Office of the National Coordinator of Health IT actually requires state-based agencies to highlight a minimum of two software programs as a condition of receiving federal grant funding.

What should be done: federal policy

How could we have done better? By the year 2000 or so, when the VA's accomplishment was already crystal clear, the federal Department of Health and Human Services should have acted promptly to have the VISTA system adopted at hospitals throughout the country. To their credit, they did open up VISTA as public access, downloadable software available for free to all potential users and even provided technical support.

The VA is in the midst of a major upgrade of their electronic health records. A new Web-based software system (currently referred to as "Aviva") is being designed with superior data-sharing capacity with the major private sector commercial electronic health records systems. The VA is also moving to an open source platform for future updates. With all the computer-related talent in the U.S., it's not hard to imagine teams of programmers working with physicians in all specialties and other health workers to continually upgrade and improve the software. But as long as federal health records policy remains balkanized in the private sector, most patients won't stand to benefit.

What should Vermont do?

The intent of the recently enacted Act 48 health reform legislation is to create a "universal, unified" health care system that provides affordable care to all residents of our state.

A task force should be convened which would include all major providers in the state — including representatives from the Veterans Administration and both university centers — whose goal would be to promote the adoption of a single, cost-effective, user-friendly information system.

If appropriate technical support can be obtained to support the transition, having every provider in the state of Vermont adopt the VA's software system should be considered since it is well-liked by users and available free of charge in the public domain. Since this effort will likely take at least two to three years, it seems reasonable to try to transition to the VA's upgraded "Aviva" system. The state-of-the-art data sharing capacity being built into the new system will facilitate this transition.

If policymakers and leaders in Vermont's health care community set out the goal of creating a unified, cost-effective HIT system for the state of Vermont, this goal can be achieved.

By Emily R. Carrier, Marisa Dowling, and Robert A. Berenson

Hospitals' Geographic Expansion In Quest Of Well-Insured Patients: Will The Outcome Be Better Care, More Cost, Or Both?

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ABSTRACT **The emphasis that hospitals place on cutting-edge technology and niche specialty services to attract physicians and patients has set the stage for health care's most recent competitive trend: an increased level of targeted, geographic service expansion to "capture" well-insured patients. We conducted interviews in twelve US communities in 2010 and found that many hospital systems—some with facilities in geographically undesirable areas—have expanded to compete for better-insured patients by building or buying facilities and physician practices in nearby, more affluent communities. Along with extending services to new markets, these hospital outposts often serve to pull well-insured patients to flagship facilities. The acceleration and expansion of such geographically competitive strategies by hospitals has implications for cost and access. Although payers and competitors contend such strategies will lead to higher costs, hospitals assert the expansions will increase efficiency, increase access, and improve the quality of care provided to patients.**

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Hospital strategies to expand geographic market areas, although not new, have grown and evolved. Generally, the so-called geographic expansion race[1] involves seeking well-insured patients beyond traditional market boundaries, whether in prosperous suburbs or in nearby areas with growing, well-insured populations. To expand, hospital systems add capacity or buy and affiliate with existing providers to shore up referral bases and increase their number of inpatient admissions.

Earlier competitive strategies tended to emphasize marketing to patients and attracting specialists who could build prestigious service lines such as cardiac and cancer care. Although hospitals occasionally looked outside their traditional service areas for growth, such moves were relatively rare.

Briefly, during the zenith of tightly managed care in the early-to-mid-1990s, hospitals faced credible threats of exclusion from insurers' networks if their prices were too high. With that one period of exception, however, hospital competition generally has taken a retail approach—direct marketing to physicians and patients based on the latest technology and amenities—rather than a wholesale approach—direct appeals to payers based on price and one-stop shopping for services.[2]

To win the loyalty of physicians, many hospitals have invested in expensive technology that allows specialists to perform advanced procedures or have offered doctors perks, such as easy access to operating room time.[3] To attract patients, hospitals compete on perceptions of high-quality care and patient convenience and comfort as they add hotel-like amenities.[4,5]

Between 2007 and 2010, the use of strategies that involve expansion outside of traditional service areas grew as a complement to—and in some communities surpassed in importance—strategies involving the development of service lines.

Across the twelve markets followed by the Community Tracking Study, hospitals with sufficient capital have expanded and invested in facilities near well-insured patients, sometimes vying with rivals pursuing similar plans.

Compared with hospital leaders' and market observers' descriptions of this competition in 2005 and 2007, when specialty service lines played a dominant role, more hospitals in 2010 appeared to be pursuing geographic competitive strategies and covered a broader range of approaches, involving not just outpatient or specialty centers and full-service hospitals but also emergency departments.

The implications of geographic competition strategies for cost and access are hotly debated. Payers—insurers and employers—and competing hospitals contend the practice leads to duplicative services and higher costs. However, hospitals contend that their expansion strategies will lead to greater efficiency and improved care. This article describes the evolving use of geographic competition strategies by hospitals and their perceived impact on providers, patients, and payers.

Study Data And Methods

SURVEY SOURCE The Community Tracking Study, conducted by the Center for Studying Health System Change and funded by the Robert Wood Johnson Foundation and the National Institute for Health Care Reform, is a longitudinal study of twelve nationally representative large metropolitan communities visited approximately every two years since 1996. The seventh round of site visits (March–October 2010) involved 539 interviews with local health care leaders in the twelve communities—Boston, MA; Cleveland, OH; Greenville, SC; Indianapolis, IN; Lansing, MI; Little Rock, AR; Miami, FL; northern New Jersey; Orange County, CA; Phoenix, AZ; Seattle, WA; and Syracuse, NY.[6]

INTERVIEW METHODS This paper is based on interviews with leaders of three to four major hospitals in each of the twelve communities, including an independent community hospital in some sites. The leaders were typically the chief executive officer, chief financial officer, and chief medical officer. Also interviewed were leaders of major health plans and four to five physician groups in each community.

Additional interviews were conducted with state policy makers and knowledgeable market observers. Respondents were asked about their own and competitors' strategies during the three years prior to the interview, as well as more recent construction or acquisition of hospitals and physician practices in their market.

ANALYSIS Two researchers conducted each interview; their notes were transcribed, jointly reviewed for validation, then entered into an Atlas.ti database and coded to facilitate review. Results were compared with the findings from previous rounds of interviews in the same communities, which were most recently conducted in 2004–2005 and 2007.

LIMITATIONS This study is based on qualitative interviews conducted in a nationally representative group of large metropolitan areas. We report key developments among leading hospitals and systems in the three years leading up to our visits, as well as the perceptions of market leaders and well-informed observers.

As such, this study aims to present a timely perspective on shifting trends that can influence health care delivery but may be difficult to capture through other measures. However, the precise magnitude of these trends is difficult to quantify—particularly because in several markets they occur in the context of a long history of similar activity.

Study Results

In all twelve markets studied, hospitals employed one or more types of geographic competitive strategy, including buying or building full-service hospitals or freestanding emergency departments, buying or establishing physician practices, and developing a regional presence through emergency medical transport systems. Competitors in some markets employed such strategies for more than three years, while other markets were only beginning to explore them. The hospitals most likely to be pursuing geographic expansion strategies were the dominant systems in local markets.

Among the hospitals using these strategies, the drive to pursue well-insured patients outside of their traditional market boundaries appeared to be heightened by the recession, rather than vulnerable to it. Even as hospital leaders pursued layoffs and contract renegotiations in order to cut operating costs, they often described freezes in construction outside of their traditional market areas as being brief and temporary, when and where these pauses occurred at all.

Phoenix and Indianapolis showed evidence of all of the geographic expansion strategies, while Syracuse and Lansing showed evidence of only one or two. All types of strategies appeared more common in markets where large hospital systems had or were pursuing significant employment of physicians and where service-line strategies were well entrenched.

In keeping with their dominant market positions, hospitals expanding geographically often

had easy access to capital and significant negotiating leverage with private payers to ensure favorable rates and provide a return on hospitals' investments.

FULL-SERVICE HOSPITALS In one strategy, hospitals or systems build new, full-service hospitals outside of their traditional market boundaries and in communities with well-insured populations. Several systems in the rapidly growing Greenville-Spartanburg, South Carolina, area are competing to establish—or maintain—a presence in the more affluent and growing community of Greer, which straddles Greenville and Spartanburg Counties.

The two major systems in the area have both built new hospitals in Greer. The Greenville Hospital System University Medical Center opened Greer Memorial Hospital in 2008, which replaced an older hospital. Also in 2008, the Spartanburg Regional system completed construction of Village Hospital in Greer.

Likewise, Miami's Kendall area, which has high rates of private insurance, has been the focus of hospital competition. The Baptist Health South Florida system opened West Kendall Baptist Hospital in April 2011,[7] less than six miles from the existing HCA East Florida–affiliated Kendall Regional Medical Center.

In other markets, hospitals bought or merged with existing full-service community hospitals rather than construct new ones. In Indianapolis, the largest systems—Indiana University Health and St. Vincent Health—established a presence in smaller cities, circling their core market as both systems moved to build a statewide presence and formalize referral relationships in outlying communities.

Indiana University Health acquired or leased interests in four hospitals within one to two hours' drive of Indianapolis. St. Vincent Health leased hospitals in two communities in the same outer ring. In one case, a community hospital—Dunn Memorial Hospital in Bedford—went back and forth between acquisition offers from Indiana University Health, which already had a hospital in Bedford, and St. Vincent, before settling on St. Vincent. Indiana University Health's Bedford Hospital is a six-minute drive from what is now the St. Vincent Dunn Hospital.

The motivation behind hospitals' expansions may differ. In some cases, such as in Greenville, urban hospitals purchased smaller hospitals at the border of their referral regions to protect relationships in these outlying communities from the incursion of large competitors based in more distant cities.

In other communities, urban hospitals responded to the growth ambitions of smaller, outlying community hospitals. These outlying hospitals may have had informal ties to the larger tertiary care hospitals in urban centers and traditionally would routinely send complicated patients "downtown" for specialty care. However, hospital leaders noted that some of these outlying hospitals strive to provide selected tertiary services in direct competition with their former partners.

A Little Rock hospital system respondent noted that although hospitals in outlying suburban and rural communities used to send tertiary care referrals to Little Rock, many of these hospitals had expanded their services and were now claiming those tertiary care patients for themselves. The Little Rock market itself is notable for high rates of poverty, and tertiary care hospitals in Little Rock historically have benefited from referrals from other communities across the state to bring in more affluent patients.

For example, Little Rock–based Baptist Health bought Stuttgart Memorial Hospital (in Stuttgart, Arkansas, about an hour's drive east of Little Rock) in 2009 and replaced a critical-access hospital in Heber Springs (about an hour's drive north of Little Rock) with a new facility, in part to ensure that those smaller hospitals would not independently develop their own higher-level services or outside referral relationships and to ensure that Baptist Heath's status as a referral center in those communities would remain unchallenged.

EMERGENCY SERVICES

▶ **FREESTANDING EMERGENCY DEPARTMENTS:** Instead of building or acquiring a full-service hospital, some hospital systems built freestanding emergency departments in distant communities, sometimes near competing facilities. The concept of freestanding emergency departments first emerged in the 1970s to meet the needs of rural or underserved communities that could not sustain a full-service hospital but needed timely access to emergency care. Freestanding emergency departments remained a peripheral strategy until recently, when some hospitals and health systems began to tap their potential for expansion into new areas. There are now more than 200 freestanding emergency departments across the United States.[8]

Although early freestanding emergency departments were similar to urgent care centers, many newer facilities offer a range of services usually found in a hospital-based emergency department, up to and including invasive monitoring, intubation and ventilator respiratory support, and circulatory support with vasopressor drugs for critically ill patients. Like hospital-based emergency departments, freestanding departments are generally open round the clock every day.

Freestanding emergency departments are also subject to the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), which requires stabilization of patients experiencing a medical emergency without regard to their ability to pay for care. The freestanding emergency departments also bill for services at the same rates as their hospital-based counterparts.

However, there are several key differences between freestanding and hospital-based emergency departments. The capital costs and institutional commitment required to build a freestanding emergency department are much lower than the costs of building a hospital because operating rooms and inpatient areas are not needed in a freestanding facility. If a patient in a freestanding emergency department requires hospital admission or emergent evaluation by a specialist, the patient must be transferred to a full-service hospital.

Freestanding emergency departments that are part of larger systems can provide stabilizing care and then transfer patients safely to their own affiliated hospitals, even if a competitor's hospital is closer. In this way, freestanding emergency departments can effectively siphon off the emergent care business as well as inpatient admissions from a nearby competitor.

Freestanding emergency departments are a particularly atftractive geographic expansion strategy in the state of Washington, where certificate-of-need rules limit the number of inpatient hospital beds. The certificate-of-need rules are a barrier to building new full-service hospitals, but they do not currently regulate freestanding emergency departments. Legislation was introduced in 2011 to place a moratorium on new freestanding emergency departments in the state, but it remains under consideration in the state legislature.[9]

The Seattle-based Swedish hospital system developed a freestanding emergency department in Issaquah, a rapidly growing suburb that is also the site of a competing hospital's all-hours urgent care clinic. Utilization at the Issaquah facility is high. Swedish also opened two freestanding emergency departments in Mill Creek and Redmond, both fast-growing Seattle suburbs. In Redmond, a competing suburban hospital system plans to build its own freestanding emergency department.

"They feed insured patients [to their own flagships]...and leave the rest to local hospitals. Of course, the [emergency department] can't *not* take care of uninsured patients, but they aren't dealing with uninsured [in the suburbs where they are located]," one Seattle market observer said of hospitals developing freestanding emergency departments.

▶ **EMERGENCY MEDICAL TRANSPORT:** Observers in several communities described strategies in which hospitals drew patients from well-insured communities to their flagship facilities through emergency medical transport systems. Some hospitals marketed themselves to emergency medical services crews to encourage them to transport patients preferentially to their hospitals. Others operated transport programs, including ambulances and helicopters, either as part of the general 911 rotation responding to all emergency calls, or as dedicated transport services facilitating transfers between outlying hospitals and their own facilities.

In Greenville, an observer described hospitals that are "wooing the EMS" through improvement of the rooms where emergency medical service workers rest and complete paperwork after transporting patients to the hospital and by offering educational lecture series. In northern New Jersey, hospitals encouraged referrals from hospitals in other communities through extensive transport programs, including helicopters, and established "green-light" policies designed to encourage community hospitals to request transfers to their facilities for complex services.

AMBULATORY PHYSICIAN PRACTICES Hospital systems also are increasingly building ambulatory care facilities in new geographic areas, especially where well-insured people live, and buying or forming physician practices to staff them. Such moves enable hospital systems to increase market share by drawing referrals to support current or planned inpatient facilities (sometimes located on the same site as the physician practices), increasing referrals of complex cases to their flagship tertiary care hospitals, and strengthening service lines.[10]

In creating practices in new areas, a system can take two approaches: employ local, previously independent physicians, or relocate physicians already employed or affiliated with the system from other, more established markets. In an example of the first approach, Cleveland's University Hospitals built physician offices in Concord Township and Twinsburg, fast-growing affluent areas outside the city, and recruited local physicians to the new offices.

In contrast, the Cleveland Clinic uses employed physicians to staff new facilities in outlying areas—a practice noted as disruptive by local practitioners but with advantages from a system perspective. Cleveland Clinic is "taking cookie-cutter outpatient buildings, almost always by the freeways, and placing their own salaried docs there and disrupting practices of individual doctors that have been practicing there for a while," a market observer said. "This has to be

creating major turmoil.... [The system's] bet was to create their own network and not have to deal with individual [local] doctors."

In some communities, hospitals are purchasing and affiliating with providers in selected high-growth, highly insured areas. For example, the Spartanburg Regional system in South Carolina recently purchased the last remaining independent primary care physician practice in Greer, where the area's two major systems compete vigorously.

Markets Pursue Combination Of Strategies

Most markets develop some combination of competitive approaches. The following are examples of how these strategies have evolved in three communities.

PHOENIX The Phoenix market includes several hospital systems that are complementing their service-line strategies with an emphasis on geographic expansion, often targeting a ring of suburbs approximately an hour's drive from downtown Phoenix. Catholic Healthcare West expanded to a high-growth area with the opening of Mercy Gilbert Medical Center in 2006, approximately forty minutes southeast of the system's flagship Phoenix hospital.

Rival system Banner Health, the largest Phoenix hospital system, expanded in the same direction with the 2010 opening of Banner Ironwood Medical Center in Queen Creek. Banner Health also acquired the Arizona Medical Clinic, a multispecialty practice with more than 100 physicians oriented toward caring for Medicare patients, in 2007, as part of a larger strategy to expand northwest of Phoenix into the West Valley.

Banner followed the Arizona Medical Clinic purchase in 2008 by buying Sun Health's two hospitals, also northwest of Phoenix, establishing Banner as a valleywide provider. Banner competitor Abrazo recently opened a freestanding emergency department in Peoria, also northwest of Phoenix. The pace of construction across the market has recently slowed, however, as population growth slows and hospitals reconsider planned expansions in light of expected diminished reimbursement from public and private payers.

INDIANAPOLIS The four main Indianapolis hospital systems are continuing to build and buy hospitals as well as to expand through freestanding emergency departments and ambulatory sites, primarily north of downtown. Observers termed it an "Exit 10 strategy," in which systems compete for dominance in the growing, well-insured area off Exit 10 on Interstate 69.

Indiana University Health is building Saxony Hospital at this exit in the town of Fishers, near St. Vincent Health's freestanding emergency department, also just off Exit 10 and a two-minute drive from Community Health Network's Pavilion Saxony, an ambulatory care center. In nearby Carmel, St. Francis Health's planned outpatient, specialty, and short-stay inpatient medical center will be only a three-minute drive from St. Vincent Carmel Hospital.[11]

"I think [capacity] is enough to meet demand, but it is maybe not distributed best by location," a market observer said. "The growth in the suburbs is for convenience and certainly relates to deals with doctors in those areas."

CLEVELAND In Cleveland, the two major systems—Cleveland Clinic and University Hospitals—are continuing to build new hospitals in growing, affluent suburbs, as well as continuing to expand their ambulatory presence there.

In February 2011, University Hospitals opened Ahuja Medical Center, a new full-service hospital in Beachwood, an eight-minute drive from Cleveland Clinic's Beachwood Family Health and Surgery Center.[12] University Hospitals also has opened freestanding outpatient medical centers, including one in Twinsburg with an emergency department linked to Ahuja Medical Center.

Cleveland Clinic purchased the former Medina General Hospital in Medina, a smaller city about forty-five minutes from Cleveland. The hospital is a few blocks from University Hospitals' Medina outpatient and urgent care center, which opened in April 2010.[13] Hospital leaders explicitly described these developing networks as "hub-and-spoke" models aimed at keeping the care of less complex cases in lower-cost community facilities and filling beds in the tertiary care flagship hospitals with complex patients requiring higher levels of care.

Cleveland Clinic also is expanding its reach through its emergency medical service transport system. One executive at a competing hospital noted that its claim to transport patients suffering from a severe form of heart attack to a cardiac catheterization lab more quickly than more distant competitors went by the wayside when the "Cleveland Clinic let [people] know that they'd send out a chopper."

However, not all areas are targets for growth. Cleveland Clinic recently closed Huron Hospital, a struggling safety-net facility in the poor community of East Cleveland, opening a smaller family health center at the site instead.

For Some Markets, Different Paths

In other communities, hospitals are developing different strategies for growth that do not in-

volve construction or acquisitions in affluent communities. In northern New Jersey, historically a market with a surplus of beds, two of the largest hospital systems are already based in affluent suburbs rather than urban centers. These systems are seeking to draw patients to existing facilities.

Atlantic Health System is ramping up marketing to become known for "outcomes" and to be a "destination hospital." St. Barnabas is working with local emergency medical services squads to simplify patient drop-off and to attract the squads back to their hospitals. Between 2007 and 2010, Atlantic purchased a medical transport service, including ambulance and helicopter service, to transport patients to its hospitals.

Two communities appeared relatively unaffected by geographic expansion pressures. In Lansing and Syracuse, there were few reports of outlying suburban communities or small cities becoming targets for expanding systems, although one Lansing system is pursuing hospital purchases and employment of physicians in surrounding rural areas. This may reflect the relatively small, geographically isolated nature of these markets and their lack of growth.

In fact, in Syracuse, city hospitals reported a surprising increase in patient volumes in recent years, which they attributed to increased referrals from outlying suburban and rural areas after a hospital in an adjacent community closed.

Implications Of Expansion For The Cost Of Care

It is too early to tell what impact hospitals' geographic expansions will have on patients' access to care in different communities, the quality of care, and costs. In theory, hospitals' expansion strategies could both increase and decrease health care spending.

Providers, payers, and policy makers differ on the likely results of the geographic dimension to hospital competition. Payers raise the specter of higher costs, while some providers point to potential benefits to patients in terms of greater access and higher-quality care that is coordinated throughout a large integrated system. Other providers—often those that are not expanding themselves—echo payers' concerns.

Payers' and policy makers' most commonly cited concerns were that new and potentially unneeded capacity will raise costs. Hospitals frequently countered that their expansions are necessary and sometimes overdue responses to population shifts and that cost increases reflect their efforts to provide high-quality care, not the cost of financing their expansions. In each case, market participants' views regarding geographic expansion strategies reflect what they stand to gain or lose.

PAYERS' CONCERNS OVER RISING PRICES From a payer perspective, hospital geographic expansion strategies are likely to promote competition for relatively affluent, insured patients, but not necessarily price competition. Expansions can affect expenditures in a variety of ways.

First, the construction or acquisition of new capacity can raise costs. Second, the presence of unneeded capacity may encourage higher utilization through supplier-induced demand. Third, expansions that increase the number of providers employed by or affiliated with a hospital system, or strengthen the systems' presence in key communities, can increase providers' leverage in negotiations with insurers, allowing them to raise prices.

Over the past two decades, the nature of hospital competition has evolved. Because hospital competition rarely involves price—save for the managed care era, when hospitals briefly competed on price to win inclusion in insurance networks—and instead focuses on wooing physicians and patients with technology and amenities, the result is what has sometimes been described as a "medical arms race."[2]

In communities like Indianapolis, where for decades major hospital systems each occupied separate geographic markets, observers argued that their relative isolation protected hospitals from competition and allowed them to drive up prices. As these systems now establish beachheads in each others' territories and compete directly over turf in new communities, greater proximity might be expected to encourage price competition and lower costs.

However, several observers said, the opposite has proved true: Growing hospital systems are using the market power accrued through size and reputation to finance more expansions by raising (not lowering) prices. "There is an unbelievable amount of building. They are building hospitals right next to each other; it is pretty amazing," said an Indianapolis insurer representative regarding new suburban facilities, explaining why premium costs will be affected. "They have to pay for them; someone must fill them up."

Mirroring concerns about the expansion of system-affiliated hospitals, system-affiliated physician practices promote increased leverage for both the system and physicians because systems can bargain as a bloc. As one Seattle health plan respondent said, two of the largest systems "have developed quite a regional network of primary care physicians, and that strengthens their hand in the market and also their referrals." This phenomenon also has been linked to rising costs

in Boston, where large systems have purchased physician practices and outpatient facilities in surrounding suburbs.[14]

Many of the hospitals engaging in what may be a new chapter in the medical arms race are already "must-have" hospitals with considerable market power. Increasing their geographic reach may bring more patients into these hospital systems, further increasing their leverage over health plans to command higher payment rates.[15]

Suburban hospitals that had hoped to expand independently may see their plans thwarted by the arrival of large systems. "Academic medical centers are competing [with community hospitals] with bold moves out there [in the suburbs]," said one Boston respondent. "It's very much a message of 'join or die.'"

OPPORTUNITIES FOR PROVIDERS TO MEET GROWING DEMAND Providers' stance on expansions depended in large part on their own plans. Many hospital respondents contended that their expansions provided access to needed services or extended the high quality of care delivered in their systems to a wider range of providers and patients. At the same time, they often decried competitors' construction and acquisitions as heedless growth.

In Cleveland, representatives of the two largest systems criticized each other's growth strategies in nearly identical terms. "To be honest, I have no idea how other systems are going to be able to sustain what they are growing. It is irrational to me. For us, we are in a different situation," said a leader of one system. "We don't build empty buildings and spend years to fill them up with doctors," said a leader of the other system. "That is what our competitors do."

Implications For Access To Care

How will geographic expansion strategies affect patients? For patients in well-insured communities, expansion may improve the coordination of care they receive, given the way acquisition and construction of new affiliated facilities may increase ties between outlying community hospitals and flagship tertiary care hospitals.

Expansion also may increase these patients' access to services. In many cases, this enhanced access may simply add convenience, but for time-dependent conditions, such as heart attack or stroke, rapid access to care can be life-saving. However, this benefit must be weighed against the issue of creating more outlets to provide volume-dependent services that encourage overuse and may dilute quality.

The situation of patients in poorer communities, where many are uninsured or have public coverage, is unlikely to improve. If their population is growing, lack of investment in these communities—because of more lucrative opportunities elsewhere—could limit access when hospitals close struggling facilities to focus on more successful ventures.

Not only could the inner-city poor, who still have access to the flagship hospitals as well as traditional safety-net facilities, be affected; so could the suburban poor, who may have difficulty reaching inner-city facilities yet be far from new suburban alternatives. As state budgets are cut, however, safety-net providers might not be able to shoulder the costs of expanding services and physical plants to meet this additional need of poor patients from the suburbs.[16]

Hospitals in urban areas may find themselves pushed into an exclusively safety net–oriented role. Indeed, this shift may drive hospitals in competitive markets to consider expansion activities.

A Phoenix hospital leader described the challenges when competitors pursue geographic expansion: "What we are seeing is these hospitals on the perimeter of the market are really starting to take some of the population. As a downtown hospital, we are a destination center. Patients have to skip other hospitals to come here. You see a strong service-line focus here. It is hard to compete with [outlying] hospitals with their brand-new, pretty general services. That [outlying] population is not coming here anymore [for routine care]. So our mix has changed. We are becoming more and more a Medicaid hospital."

Implications For Policy

Hospitals' geographic expansion strategies can affect the cost, quality, and availability of care, although a complex array of market-specific factors will influence the outcomes in individual communities. Payers' approaches to reimbursement will play a major role in shaping the impact of geographic expansion for the quality and cost of health care.

As the recent slowing of construction in Phoenix suggests, hospital systems remain sensitive to market signals. Some systems may struggle with delayed aftereffects of the recession, but many have remained financially strong and anticipate continued growth.

Public and private payers' adoption of payment reforms or the development of accountable care organizations and bundled payments, rather than decreasing utilization, may shift these hospitals' goals toward increasing efficiency within their existing facilities instead of continuing their expansion strategies. Under a system dominated by continuing fee-for-service

reimbursement, however, tighter integration within must-have provider systems would simply give these systems more clout as they grow.

Although hospital system leaders assert that expansion will allow them to provide better access to high-quality care, there is evidence that these systems' geographic range and capabilities may increase their leverage in negotiations with payers in ways that are not addressed by conventional antitrust laws.[15]

Although hospital geographic expansion competition appears to be a spontaneous response to market opportunities created as well-insured populations shift, policy also can influence competitive strategies. For example, Seattle-area hospitals' aggressive construction of freestanding emergency departments probably reflects, in part, the current exclusion of these facilities from the state's certificate-of-need regulations. Regulations governing accountable care organizations and other aspects of health reform will shape hospitals' competitive strategies as well.

Policy and payment changes may determine the direction of systems' future growth. Approaches such as locating near consumers with commercial insurance, creating additional entry points for those consumers to use their locations, and consolidating to increase market leverage are all strategies consistent with market competition, which for decades has been the operative model that governs health care provider behavior. Indeed, these strategies are natural choices for firms competing to secure their market position.

Often, hospitals act for understandable defensive reasons: for example, to broaden their geographic reach to include relatively more well-insured patients in their patient mix. At the same time, in many circumstances such self-interested, competitive behavior may create excess capacity and raise health care costs that are ultimately borne by consumers in the form of increased health insurance premiums.

In short, health care providers' market imperative to grow may conflict with other mission and policy goals. As our study shows, this tension persists and remains unresolved. ■

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"I'M prepared to suffer the slings and arrows of misfortune, but my health plan doesn't cover that."

Chapter Reports, Winter 2012

In **California,** PNHPers are laying the groundwork for the "Campaign for a Healthy California," a five-year campaign to win a state single-payer plan, S.B. 810. They are speaking, organizing, forming new chapters (in Humboldt/El Norte and Santa Rosa) and coalition-building with unions, medical students and grassroots groups. "The Healthcare Movie," narrated by Kiefer Sutherland, was screened over the summer; the film, featuring interviews with Canadians about their health system, is a useful tool for initiating discussions about health care reform with lay audiences. Activists are networking with an eye toward involving more celebrities like Sutherland in the movement for single payer. In October, PNHP California hosted a reception and chapter meeting at the PNHP Annual Meeting in San Francisco; Drs. Paul Song, Bill Skeen and Hank Abrons were featured speakers. Shearer Student Fellow Cindy De La Cruz is educating and organizing medical students for their upcoming Lobby Day in Sacramento. Contact the chapter at (510) 590-9691, info@pnhpcalifornia.org, www.pnhpcalifornia.org.

California medical students, including PNHP California's Shearer Student Fellow Cindy De La Cruz (third from left), were well represented at PNHP's Annual Meeting in San Francisco, Oct. 27. (Photo: Molly Tavella)

In **Colorado,** PNHP members are active in speaking, coalition-building, and promoting state single-payer legislation. In contrast to the 2010 federal reform law, single payer would cover all Coloradans while costing less than any other type of reform, according to a 2007 fiscal study by The Lewin Group. Contact Dr. Elinor Christiansen at drelinorc@gmail.com.

In **Hawaii,** PNHPer Dr. Stephen Kemble was recently inaugurated as the president of the Hawaii Medical Association. He testified against the AMA's endorsement of "premium support" reform for Medicare at their delegates meeting in Honolulu, and is working tirelessly with the Hawaii Health Authority to promote steps toward a statewide single-payer plan. A top priority is ending the state's failed experiment with Medicaid managed care, something that may be possible even as Gov. Neil Abercrombie's Health Transformation Task Force focuses on implementing the Affordable Care Act. Hawaii recently elected a second pro-single-payer senator, Dr. Mazie Hirona, joining Sen. Daniel Inouye. Dr. Kemble and Dr. Leslie Gise, a psychiatrist in Maui who is active in educating the psychiatric community about single payer, spoke at the PNHP Annual Meeting in San Francisco. Contact Dr. Kemble at sbkemble@hawaii.rr.com.

Illinois PNHPers have been active in outreach to medical students, working with labor on the Hyatt hotel boycott, and speaking at events both across and outside the state. Chapter organizer Dr. Anne Scheetz, Dr. Susan Rogers and others hosted a successful event in Chicago on race, health care and health care reform featuring PNHP member Dr. David Ansell and law professor Dorothy Roberts of Northwestern University. They raised $2,000 to support the regional conferences of the Latino Medical Student Association and the National Medical Student Association, demonstrating PNHP's support for physicians-in-training of color and at the same time educating them about single-payer health care. Dr. Ansell and Dr. Philip Verhoef spoke at the LMSA earlier this year. Dr. Ansell has also traveled out of state for several jam-packed speaking and media tours arranged by local PNHP chapters and others around his book "County" and the need for single-payer reform. Activists are also involved with the boycott of Hyatt hotels for their anti-labor practices, including management threats to curtail workers' health care coverage (see hyatthurts.org). Dr. Pam Gronemeyer is working with a new group of single-payer activists in the Springfield area. Dr. David Gill, a longtime PNHP member, narrowly lost his race for Congress in the 13th CD of Illinois. Contact Dr. Scheetz at anneschеetz@gmail.com.

In **Indiana,** Dr. Rob Stone, Karen Stone, Dr. Jonathan Walker and other PNHPers are active in taking on Indianapolis-based insurer WellPoint, along with speaking, media outreach, and grassroots organizing with Hoosiers for a Commonsense Health Plan (HCHP). PNHP President Dr. Garrett Adams and Dr. Quentin Young joined Indiana PNHPers for a protest at WellPoint's annual shareholders meeting. Dr. Walker is a frequent op-ed contributor to the Fort Wayne Journal Gazette. Dr. Stone is nurturing the movement to divest from health insurance companies; activists have been pursuing the issue with the Presbyterian Church and the pension fund TIAA-CREF, while building ties with firms involved in socially responsible investing. The nonpartisan HCHP held community meetings on health care reform in the run-up to the election. Contact Dr. Rob Stone at grostone@gmail.com.

In **Maine,** PNHP members are active in speaking and media outreach. Dr. Phil Caper is a frequent op-ed contributor to the Bangor Daily News. The chapter hosted Dr. Margaret Flowers for a successful series of speaking and media events in May, including pediatric grand rounds at Maine Medical Center, along with an official unveiling of painted portraits of her and Dr. Quentin Young by Robert Shetterly, an artist who has created a gallery of similar portraits under the title "Americans Who Tell the Truth." The chapter is fighting the governor's proposed

Medicaid cuts. Eighty percent of physicians statewide now work for corporations (one in each of the four major geographic service areas). See www.maineallcare.org or contact Dr. Phil Caper at pcpcaper21@gmail.com.

In **Maryland,** the PNHP chapter is active in education, organizing, and grassroots outreach. The chapter released an economic impact study on a statewide single-payer plan by economist Gerald Friedman of the University of Massachusetts, Amherst earlier this year. The study showed that Maryland could cover everyone and save $6 billion annually, or over $1,000 per resident. Friedman visited the state for two days of meetings, media interviews, and speaking, including a presentation at the Maryland chapter's annual meeting, which drew 100 people. Dr. Eric Naumburg is working on the chapter's "Healthcare is a human right" campaign in conjunction with the United Workers and Healthcare-Now in Maryland; the campaign, patterned after a similar Vermont effort, recently hired its first organizer and is making great strides. Funding for the organizer and the fiscal study was generously donated by chapter members. Contact Dr. Eric Naumburg at enaumburg@hotmail.com.

In **Minnesota,** PNHPers are active in speaking, recruiting new members, outreach to medical students, lobbying and coalition-building. About 65 physicians and medical students participated in this year's annual Lobby Day. They visited about 50 lawmakers and shared the findings of The Lewin Group's fiscal study of a single-payer system in Minnesota showing that it would cover everyone and save $189.5 billion between 2014-2023 (Lewin is owned by Minnetonka-based UnitedHealth Group). Chapter co-chairs Dr. Elizabeth Frost and Dr. Ann Settgast are frequent speakers and presented a workshop on effective chapter organizing at the last two national PNHP meetings. Dr. Settgast spoke to the Minnesota Urological Society. Contact Dr. Ann Settgast at settg001@umn.edu or Dr. Elizabeth Frost at libbess@gmail.com.

In **Missouri,** PNHPers Dr. Ed Weisbart, Linda Lieb, and others established a new chapter of PNHP in St. Louis on March 5. Since then they've been working non-stop, doing networking, arranging grand rounds and other talks for speakers, publishing articles, and meeting with editorial boards. The chapter hosted author Dr. David Ansell for an ambitious and successful series of events recently, including grand rounds and media interviews. Earlier this year PNHP President Garrett Adams and Dr. Carol Paris visited to speak at the medical school, participate in editorial board meetings, and more. The chapter now has 157 physicians and 43 medical students on its e-mail list and 59 "likes" on its Facebook page. Contact Dr. Ed Weisbart at edweisbart@gmail.com.

In **New Jersey,** PNHPers are stepping up their activities, including more frequent public speaking, working with the grassroots single-payer group Healthcare-Now on the campaign for divestment from private insurance companies, publicizing the benefits of single-payer reform for state and local government budgets, and holding regular phone conferences and general membership meetings. Contact Dr. Wink Dillaway at w.dillaway@gmail.com.

Dr. Daniel Lugassy of N.Y. Metro PNHP speaks at a rally on the steps of City Hall in New York City on Nov. 16 to demand that Mayor Bloomberg do more to address the acute health needs of Hurricane Sandy survivors. The action was co-sponsored by the N.Y.S. Nurses Association and other groups. PNHP members were among those who went door-to-door in the stricken areas looking for vulnerable, home-bound patients; they also helped out at makeshift clinics set up by volunteers. (Photo: Laurie Wen)

The **New York Metro** chapter of PNHP has had a very active year from Occupy Wall Street to a Lobby Day in Albany, and from an ambitious medical student summit to relief work after Hurricane Sandy. PNHPers participated in demonstrations against hospital closings with the "Healthcare for the 99% Working Group" of Occupy. The chapter hosted a well-attended speakers training and Lobby Day in support of Assemblyman Richard Gottfried's state single-payer bill earlier this year. Executive Director Laurie Wen gave an advocacy training session to Montefiore Medical Center physicians and other health professionals. Over 50 medical students from 16 medical schools participated in the Northeast Regional Single-Payer Student Summit on Sept. 22 in New York City; Robin Lunge, from Vermont, was the keynote speaker. The chapter has started a student advocacy fund with a matching grant from the Pierson Foundation. Dr. Mary O'Brien spoke out at the TIAA-CREF shareholder's meeting to urge them to divest from health insurance companies. Finally, Dr. Elizabeth Rosenthal's interview by AP video opposing Medicare cuts was circulated widely in the mainstream media and on the Internet. Contact Laurie Wen at laurie@pnhpnymetro.org.

The **N.Y. Capital District** chapter of PNHP is active in speaking, lobbying, and especially medical student outreach. Incoming PNHP president Dr. Andy Coates is a frequent speaker to

students at the Albany Medical College. Five students from the school attended the regional medical student summit in New York. Fourth-year medical student Danielle Alexander helped organize and lead meetings for students at PNHP's national headquarters in Chicago and at the PNHP Annual Meeting. Third-year student Megan Ash and others set up tables at the school to educate students and faculty about single payer. Contact Dr. Coates at esquincle@verizon.net.

Dr. Andrew Coates, incoming president, PNHP

In **North Carolina,** Dr. Jessica Schorr-Saxe hosted a reception in Charlotte with Rep. John Conyers Jr., the lead sponsor of H.R. 676, during the Democratic National Convention. The event drew 70 people and helped build ties among single-payer advocates in the area. The chapter also hosted an event with Dr. Oliver Fein at the APHA mid-year meeting that drew a receptive audience of about 40 people. The chapter is looking at legislative initiatives such as a state bill that would set up a commission to study the benefits of going to a single-payer health care system. In the short term, expanding Medicaid to the full extent the 2010 health law allows is a top priority. Contact Dr. Jonathon Kotch at jonathan_kotch@unc.edu.

In **Oregon,** PNHP members are helping to build a new coalition, Health Care for All Oregon, which now has over 50 member groups. They are organizing under the slogan "Health care is a human right" and raised $10,000 to hire an organizer at a fund-raiser attended by over 600 people. They are hoping to reach into the more conservative parts of the state. The chapter hosted former New England Journal of Medicine editors Drs. Marcia Angell and Arnold Relman for a series of meetings with physician groups and public events earlier this year (for details on the visit, including lessons learned from organizing their tour, see article by Dr. Sam Metz, this issue). They also hosted Cigna whistleblower Wendell Potter. The chapter received positive feedback from a screening of "The Healthcare Movie" at a local theater. Contact Dr. Mike Huntington at mchuntington@comcast.net.

In **Pennsylvania,** Dr. Ana Malinow participated in a meeting with Leo Gerard, president of the United Steel Workers, earlier this year. Also participating in the very positive discussion were Drs. Andy Coates and Ida Hellander. Dr. Walter Tsou is a frequent speaker to medical professionals and grassroots groups; he attended the fifth anniversary celebration for Michael Moore's film "Sicko" and has a new presentation on single payer as the solution to the "fiscal cliff." Contact Dr. Tsou at macman2@aol.com.

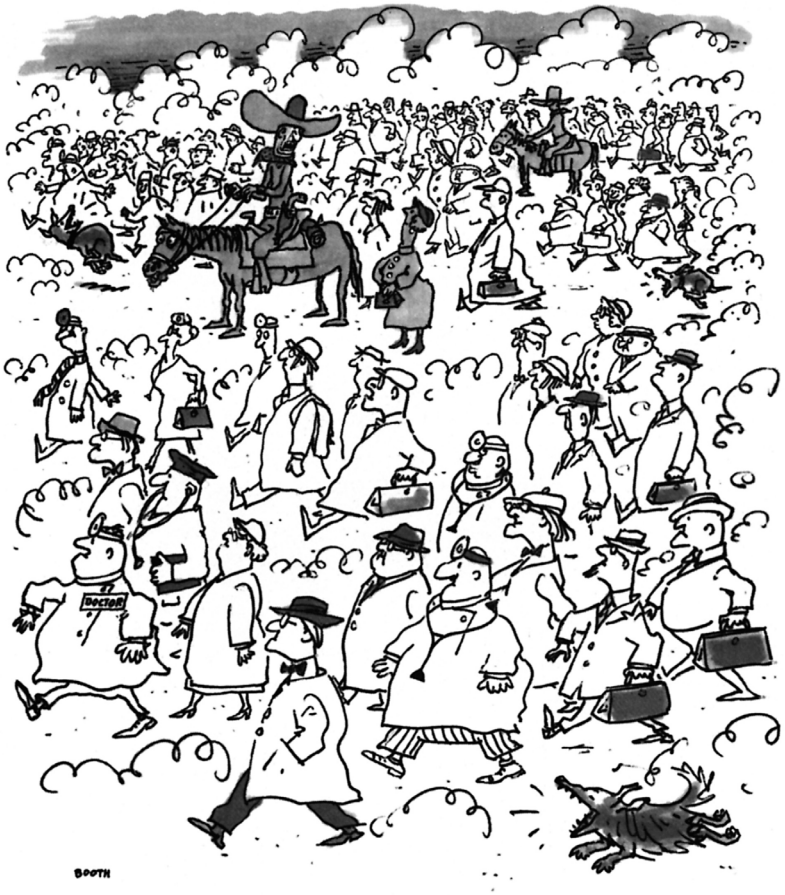
In **Rhode Island,** PNHPe members organized a jam-packed series of talks and meetings for former PNHP President Dr. Oliver Fein's visit in October. Among the many events was a lecture at Brown University Medical School, a grand rounds (simulcast to a second hospital), meetings with state health officials, and a luncheon with Brown medical students. The new chapter is eager to follow up on the success of Dr. Fein's visit with more activities. Contact Dr. Mark Ryan at pnhp.ri@gmail.com.

In **South Carolina,** David Ball and 15 other PNHPers officially launched Health Care for All – South Carolina, the newest chapter of PNHP. After just two chapter meetings they are off to a great start, with an ambitious program of networking, speaking, and recruiting in the works. Contact David Ball at davidball47@gmail.com.

In **Tennessee,** Dr. Arthur Sutherland has been crossing the state to speak and form local chapters of single-payer advocates. He made a successful six-day tour of eastern Tennessee and neighboring states with Dr. Garrett Adams, visiting Knoxville, Bristol, Kingsport, Johnson City and Chattanooga, among other cities, and delivering grand rounds at the University of Tennessee, Knoxville, and at the Bristol Regional Medical Center. Their itinerary also included meetings with medical students, a presentation at the Tennessee Academy of Family Physicians, and several media interviews in Chattanooga. Nashville physician Dr. Diana Reed's book "The Other End of the Stethoscope" ends with push for single payer. She has received some local and national media attention. Contact Dr. Sutherland at asutherland523@gmail.com.

In **Vermont,** PNHP members are fighting back against an anti-single-payer media campaign. Single-payer activists in PNHP and with Vermont Health Care for All have assembled a "rapid responder" team of about 30 people to counter misleading, anti-single-payer articles and broadcasts with letters to the editor, etc. SEIU donated $100,000 toward a media effort in support of single payer and the initial ads on TV and radio have been very strong. Gov. Peter Shumlin was re-elected and is committed to seeing the "pathway to single payer" legislation (Act 48) that was passed in 2010 go forward. The financing plan for Vermont's health law is scheduled to be announced in January. Contact Dr. Anna Carey at peggycareyster@gmail.com.

In **Washington,** Dr. James Squire and other PNHPers are involved in grassroots organizing efforts using the theme "Health care is a human right" to promote single payer. The chapter held a public meeting that was attended by about 800 people earlier this year. Speakers included journalist Amy Goodman of Democracy Now, Rep. Jim McDermott, D-Wash., Dr. Quentin Young, PNHP's national coordinator, and Teresa Mosqueda of the Washington State Labor Council and Healthy Washington Coalition. Contact Dr. Jim Squire at squirsky@earthlink.net.



"The Discount Physicians' Network is moving two thousand head up to Dodge City, Ma'am."

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