PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter

Spring 2013

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

Single-payer bills in U.S. House and Senate

Rep. John Conyers Jr., D-Mich., reintroduced H.R. 676, the Expanded and Improved Medicare for All Act, into the 113th session of Congress in February (see news release, page 14). The legislation is based on PNHP's "Proposal of the Physicians Working Group for Single-Payer National Health Insurance" which appeared in the Journal of the American Medical Association. The bill is just 30 pages long and can be found online at www.thomas.gov. Senator Bernie Sanders, I-Vt., will reintroduce single-payer legislation into the Senate later this year.

PNHPers are encouraged to ask their congresspeople to become co-sponsors and to conduct "special orders" for single payer in Congress. During a special order, a representative takes the floor, usually at the end of the day, and makes a speech or reads a letter or article on single payer into the Congressional Record and for transmission by C-SPAN. A sample letter to Congress on special orders is reprinted on page 42.

41 state AFL-CIO chapters endorse H.R. 676

Rhode Island's is the 41st state federation of the AFL-CIO to endorse H.R. 676. The labor group unanimously voted to endorse single payer after a presentation by Dr. J. Mark Ryan on Feb. 25. The remaining state AFL-CIO federations that have not yet signed-on are Hawaii, Illinois, Idaho, Mississippi, New Hampshire, New Mexico, Utah, Louisiana and Virginia. Dr. Ryan (pnhp.ri@gmail.com) is happy to share his slides and insights with others doing outreach to labor groups, as is Kay Tillow, the organizer of a project to garner 1,000 union endorsements for H.R. 676. At this writing, 598 labor organizations have endorsed the bill. For details, see www.unionsforsinglepayer.org.

PNHP members testify at Senate hearing on primary care

Dr. Claudia Fegan, executive medical director of the Cook County Hospital and Health System in Chicago and past president of PNHP, testified before the U.S. Senate HELP Subcommittee on Primary Health and Aging chaired by Sen. Bernie Sanders on Jan. 29. Dr. Andrew Wilper, lead author of a study showing that 45,000 deaths annually are due to uninsurance, also testified at the well-attended hearing; his testimony was picked up by several news outlets. Dr. Fegan noted that "if we would enact a single-payer national health care program, where everyone was entitled to health care as a right, we could focus on delivering to our patients the best care in the world and relieve our physicians of the administrative hassles" they currently face. Their testimony is reprinted starting on page 40.

Lobby days attract students, physicians

From New York to California, Minnesota to Oregon, PNHPers have been enthusiastically turning out to rally for state single-payer legislation while keeping the pressure on for national legislation. New Yorkers, including Dr. Paul Sorum, rallied around the introduction of state Rep. Richard Gottfried's bill in Albany. Over 300 health professional students, physicians, and nurses held a rally and training session for single payer in Sacramento, Calif., despite the Democrats' refusal to introduce a bill this session. In Oregon over 800 people from 40 organizations turned out to lobby for state Rep. Michael Dembrow's single-payer bill. In Minnesota, Dr. Elizabeth Frost and over 60 physicians and medical students paired up to lobby for state Rep. John Marty's Minnesota Health Plan. For details, see the chapter reports, starting on page 62.

Save the date: PNHP 2013 Annual Meeting, Nov. 2, in Boston

The PNHP 2013 Annual Meeting will be held in Boston on Saturday, Nov. 2, at the Seaport Boston Hotel. It will be preceded by PNHP's popular leadership training course on Friday, Nov. 1. Details will be posted soon at www.pnhp.org/meeting.

In This Issue

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2013

National Office Staff: PNHP's headquarters in Chicago is staffed by Dr. Ida Hellander, director of policy and programs; Matt Petty, director of operations; Mark Almberg, communications director; Dustin Calliari, technology associate; and Angela Fegan, membership associate. Local chapter staff include Laurie Wen (New York Metro), Dr. Bill Skeen, Molly Tavella, and Cindy De La Cruz (California).

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PNHP is recipient of a CREDO grant

CREDO, a progressive mobile phone company, has designated PNHP as one of its charitable causes for three of the last six years. CREDO members and online activists rank how the company should allocate its donations among about 40 different groups, so PNHPers with CREDO service should be sure to cast their votes. Aside from CREDO, PNHP is almost entirely supported by members' dues and donations. If you know of other potential grant sources for PNHP, please e-mail us at info@pnhp.org.

Membership drive update

Welcome to over 501 physicians and medical students who have joined PNHP in the past year! PNHP's membership is now up to 18,622. We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community.

PNHP will be hosting exhibits at several medical specialty meetings this year, including those of the American College of Physicians 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. If you can volunteer for a few hours, please drop a note to info@pnhp.org or just stop by.

What PNHP members can do

1. Stay on top of the rapidly changing health reform landscape. 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. The archives are searchable and contain valuable information on everything from Medicare to international health systems. Subscribe at www.pnhp.org/qotd
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 = coates).To invite another member to speak, call PNHP's 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 society or specialty. 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, or even Facebook posts and Tweets.
5. Meet, write or phone your national legislators and encourage them to endorse H.R. 676. The Capitol switchboard is (202) 224-3121.

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

UNINSURED AND UNDERINSURED

• 48.6 million Americans were uninsured during all of 2011, 15.7 percent of the population, according to the most recent data from the Census Bureau. The proportion of young adults aged 19 to 25 who were uninsured declined slightly, from 29.8 percent in 2010 to 27.7 percent in 2011, as a result of the federal reform law's provision that allows young adults to be added to a parent's coverage ("Income, Poverty, and Health Insurance Coverage: 2011," Census Bureau).

• According to new estimates from the Congressional Budget Office, 30 million people will still be uninsured in 2023 ("Effects of the Affordable Care Act on Health Insurance Coverage - February 2013 Baseline," www.cbo.gov/publication/43900 accessed on Feb. 5, 2013).

• The federal reform law may not stop the trend of employers dropping heath care coverage. Big firms may opt to pay the penalty of $2,000 for each full-time worker instead of funding costly plans. In its latest budget projections, the Congressional Budget Office projected that 7 million workers will lose employer coverage between 2013-2022, while the government will collect $13 billion more in revenues from employer fines (Fiscal Times, 2/14/13).

A survey of 800 large and mid-size employers found that 6 percent planned to stop providing health insurance to their workers over the next three to five years, while 28 percent plan to give employees a fixed monetary credit to purchase coverage on the exchanges, shifting the risk of rising premium costs onto workers (Modern Healthcare, 2/28/13).

• An estimated 115,000 women lose private health insurance coverage each year in the months following divorce and about 65,000 of these women become uninsured. The impact of divorce in reducing women's health insurance coverage lasts for more than two years, and compounds the economic losses women experience after divorce. Women insured as dependents on their husbands' employer-based coverage, and those from moderate-income (200-300 percent of the federal poverty limit) families are particularly vulnerable (Lavelle and Smock, "Divorce and women's risk of health insurance loss," Journal of Health and Social Behavior, 11/12/12).

• Tens of thousands of uninsured people with serious illnesses who might have received federal assistance this year will not because of the early closure of the state-based "high-risk pools" created under PPACA. The high-risk pools stopped accepting new enrollees at the end of February, 10 months early, in order to stay within their $5 billion budget. They were intended to function as a bridge until January 2014, when insurers will no longer be able to reject people with pre-existing conditions. About 4,000 people were enrolling every month in the program, which was only available to people who had been denied coverage by an insurer for a pre-existing condition and were uninsured for more than six months. A total of about 135,000 people received coverage at some point during the program, far fewer than the 350,000 expected. The beneficiaries proved far more costly to insure than predicted, as many entered the pools in immediate need of expensive care. "What we've learned through the course of this program is that this is really not a sensible way for the health care system to be run," said Gary Cohen, director of the Department of Health and Human Services' Center for Consumer Information and Insurance Oversight (N.C. Aizenman, "Funding is running low for health insurance in state high risk pools," Washington Post, 2/15/13).

More than one-quarter (26 percent) of all veterans who served in Iraq and Afghanistan are uninsured and aren't part of the Department of Veterans Affairs health system, compared to 10 percent to 16 percent of non-elderly veterans who served in previous periods and 2 percent of elderly veterans, according to an analysis of data from the 2010 National Survey of Veterans. Most WWII and Korean War veterans are elderly and qualify for Medicare coverage. But veterans who left combat operations from recent wars are only eligible for VA health care for five years. After that they only qualify based on service-related medical problems or income-based standards. Previous (2007) research by PNHP members and others has shown that uninsured veterans face problems with access to care similar to those faced by other uninsured Americans (Chris Adams, "Many younger vets among ranks of uninsured," McClatchy Newspapers, 11/19/12).

• A study of over 60,000 outpatients with coronary artery disease (CAD) found that patients without medical coverage (9.4 percent of the total) were less likely to receive evidence-based medications for CAD than their publicly or privately insured counterparts. Uninsured patients with CAD were 9 percent, 12 percent, and 6 percent less likely to receive treatment with a beta-blocker, an angiotensin converting enzyme inhibitor/angiotensin II receptor blocker (ACE-I/ARB), and lipid-lowering therapy, respectively, than privately insured patients. Patients with public insurance were 9 percent less likely than privately insured patients to be prescribed ACE-I/ARB therapy. (Smolderen et al.,"Treatment Differences by Health Insurance Among Outpatients With Coronary Artery Disease: Insights From the National Cardiovascular Data Registry," J Am Coll Cardiol Jan 2013).

• Uninsured patients are twice as likely to die in the hospital after surgery for a brain tumor as privately insured patients. A nationwide study of 28,581 patients aged 18 to 65 who underwent craniotomy for a brain tumor found that uninsured patients and Medicaid beneficiaries had a higher rate of unadjusted postoperative inpatient mortality (2.6 percent and 2.3 percent, respectively) than privately insured patients (1.3 percent). Differences in overall health did not fully account for this disparity. After adjusting for patient characteristics and stratifying by hospital, among patients with no comorbidity, uninsured patients still had a higher risk of experiencing in-hospital death (hazard ratio, 2.62; 95% CI, 1.11-6.14; P = .03) compared with privately insured patients. After adjustment, the disparity was not conclusively present in Medicaid recipients (hazard ratio, 2.03; 95% CI, 0.97-4.23; P = .06). (Momin et al, "Postoperative Mortality After Surgery for Brain Tumors by Patient Insurance Status in the United States," Arch Surg. 2012;147(11)).

Some employers are creating shell corporations and using bankruptcy court to avoid paying for health care and pensions for their retirees. Peabody Energy, the largest coal-mining company in the world, and Arch Coal, the second-largest mining company, dumped their health and pension obligations for 22,000 retired miners and their spouses into a new corporate entity, Patriot Coal, in 2007 and 2008. Patriot is currently in bankruptcy court trying to limit or discharge $1.37 billion in health and pension obligations to these retirees, 90 percent of whom never worked for Patriot. Peabody paid its CEO Gregory Boyce $10 million in 2011. Patriot is currently seeking court approval to distribute $6 million in bonuses to 225 corporate executives and salaried employees (Macgillis, "Can a coal company get away with breaking promises to workers?" New Republic, 2/19/13).

COSTS

• Health spending for 2012 is estimated to have totaled $2.8 trillion, 17.9 percent of GDP, $8,952 per capita. In 2011, the latest year for which firm figures are available, U.S. health spending was $2.7 trillion, 17.9 percent of GDP, $8,680 per capita. Health care costs rose slowly (3.9 percent) for the third straight year as employers shifted more costs to workers and strapped states limited Medicaid spending (Pear, "Growth of health spending stays low," New York Times, 1/7/13).

• Large California insurers including Aetna, Anthem, and Blue Shield have proposed rate increases of 20 percent to 26 percent on individual and small group policies for 2013. Nonprofit Blue Shield is raising premiums despite having $3.9 billion in reserves, up from $2.2 billion in 2006, three times more than they are required to hold by regulators (Terhune, "Blue Shield of California seeks rate hikes up to 20 percent," Los Angeles Times, 12/13/12).

Employer-sponsored health insurance cost an average of $10,558 per employee in 2012, up 4.1 percent from 2011. The average PPO in-network deductible for an individual increased to $1,427, while the proportion of employers offering skimpy consumer-directed health plans (CDHPs) jumped from 23 percent to 36 percent of employers with 500 or more employees. The average cost of coverage of a CDHP with a health savings account was $7,833 per employee, about 20 percent less than the cost of PPO coverage ("Employers held health benefit cost growth to 4.1 percent in 2012," Mercer, 11/14/12).

MEDICAID

Medicaid coverage just got worse. A new ruling by the Obama administration allows state Medicaid programs to charge higher copayments and premiums for doctors' services, prescription drugs and some types of hospital care, including the "nonemergency use" of emergency rooms, for individuals with incomes over 100 percent of the federal poverty level ($19,090 for a family of three). Under the proposal, a family of three with annual income of $30,000 could be required to pay $1,500 in premiums and copayments. In addition, some states are reducing their Medicaid-benefits to the minimum required by PPACA. For example, Illinois is cutting back on adult dental coverage because the ACA does not require coverage for dental other than extractions. Although physicians will get somewhat higher fees for new Medicaid patients brought in under the PPACA Medicaid expansion rules, they will not be compensated at the higher rate for beneficiaries already in the program, penalizing doctors and safety-net hospitals that have long served the poor. Most states are also letting private firms run their expanded Medicaid programs, even though Medicaid managed care has higher overhead costs, limited provider networks, and has not been shown to reduce costs (see item below). CMS is allowing Arkansas to use all of the Medicaid expansion funds to purchase private policies. Several states are also mandating that dual-eligible elderly and disabled patients, who often have long-standing relationships with several providers, join private HMOs with few specialists and onerous pre-authorization requirements, severely limiting access to care for these vulnerable patients. Simplified Medicaid enrollment has also been delayed. A single streamlined application for Medicaid and subsidies for private enrollment has been put off to Jan. 1, 2015 (Robert Pear, "Many Medicaid patients could face higher fees under a proposed federal policy," 1/24/13).

• A review of the research on Medicaid managed care found little evidence that Medicaid saved money at the national level, and noted that among the few states that appeared to save money,

"the cost savings are primarily due to reductions in provider reimbursement rates rather than managed care techniques." The review, issued by the Robert Wood Johnson Foundation, concluded that the majority of studies that find cost savings due to the implementation of managed care were not peer reviewed and were conducted by consulting firms on behalf of interested parties. There is some evidence that managed care improves access to a usual source of primary care, but most of the research on access focuses on prenatal care, and even this research shows mixed results. In terms of quality and outcomes, studies show that pregnant beneficiaries in managed care do not have healthier babies than their fee-for-service counterparts. The review finds no evidence that managed care will improve quality or reduce costs as a result of enrolling high-need, high-cost beneficiaries (Michael Sparer, "Medicare managed care: Costs, access, and quality of care," RWJ Research Synthesis Report No. 23, 2012).

MEDICARE

Raising the Medicare eligibility age to 67 would have far-reaching economic consequences, costing society as a whole $11.7 billion annually, according to the Kaiser Family Foundation. A plurality of seniors (42 percent) might be able to stay on their employer's insurance, but many more would be faced with buying costly private coverage, or would land on Medicaid rolls or become uninsured. Two-thirds of seniors would pay more for insurance than they would have under Medicare, for a net increase in out-of-pocket costs of $3.7 billion. Employers would spend an additional $4.5 billion a year to keep these workers covered, and Medicaid costs for states would rise by $700 million. The shift of more seniors into the commercial insurance pool would also drive up premiums for the non-elderly. Altogether, the cost to society would be more than double the estimated savings of $5.7 billion to Medicare (Hiltzik, "When government does things better than private enterprise," Los Angeles Times, 12/11/12).

• The PacifiCare Medicare Advantage plan was overpaid by an estimated $424 million in 2007. The California-based insurer was purchased in 2005 by UnitedHealth Group, the nation's largest health insurer. Payments to the plan were calculated by CMS by assigning beneficiaries risk scores based on diagnoses submitted by PacifiCare. An audit by the Inspector General found that 45 percent of beneficiaries' risk scores were invalid. In one case PacifiCare said it should receive enhanced payments for a diagnosis of prostate cancer in a patient whose files indicated suture removal and left shoulder tendonitis (DHHS, OIG, 11/12, "Risk Adjustment Data Validation of Payments Made to PacifiCare of California for Calendar Year 2007").

Three other plans that were audited were also found to have been overpaid in 2007, including UnitedHealth's Texas Medicare Advantage plan ($115 million); Excellus Health Plan of Rochester, New York ($42 million); and Paramount Care, a subsidiary of ProMedica Health in Toledo, Ohio ($18 million) (Carlson, "Amid concerns about overpayments, HHS notes small number of Medicare Advantage Probes," Modern Healthcare, 1/10/13).

• CMS announced 106 new Medicare ACO contracts under its shared-savings program as of January 1. These are in addition to the 27 approved last April and 89 approved in July. There are two incentive options in the ACO shared-savings program, including one with potential gains and losses, and the other with smaller potential gains and no losses. So far, all but eight of the ACOs have chosen the payment option with no risk of a loss. Pharmacy giant Walgreens was approved to form three of the new Medicare ACOs (Evans, "CMS announces over 100 new ACO contracts," Modern Healthcare, 1/10/13).

INTERNATIONAL

Health spending per person and as a percentage of gross domestic product fell across the European Union in 2010. The share of GDP devoted to health in Europe averaged 9 percent in 2010, down from a peak of 9.2 percent in 2009. Health spending per capita fell 0.6 percent in 2010 due to the economic recession, compared to an average annual increase of 4.6 percent between 2000 and 2009. This is the first time health spending has fallen in Europe since 1975. Health spending as a share of GDP was highest in the Netherlands (12 percent) in 2010, followed by France and Germany (11.6 percent). Average European Union spending per capita in 2010 was $2,888, with Norway spending the most, $5,528. In comparison, the U.S. spent $8,289 (OECD, "Health at a Glance: Europe 2012," OECD Publishing).

• Despite much higher health spending, Americans die younger and experience higher rates of disease and injury than their peers in 16 other high-income countries, according to a study by the National Research Council and Institute of Medicine. Compared to Australia, Canada, Japan, and many western European countries, the U.S. is at or near the bottom in nine key areas of health: infant mortality and low birth weight; injuries and homicides; teenage pregnancies and sexually transmitted diseases; prevalence of HIV and AIDS; drug-related deaths; obesity and diabetes; heart disease; chronic lung disease; and disability. The health disadvantage among Americans exists across all socio-economic groups and from birth to age 75, but many of the conditions disproportionately affect children and adolescents. The U.S. has the highest infant mortality rate of any high-income country, and also ranks poorly on the proportion of children who live to age 5. U.S. adolescents have the highest rates of teenage pregnancy and are more likely to acquire sexually transmitted diseases. U.S. men ranked last in life expectancy (75.6 years) while Switzerland ranked first (79 years). U.S. women ranked next to last in life expectancy (80.8 years) while Japan ranked first (86 years). Although poverty, inequality, and lack of health insurance play a role, even affluent Americans are in worse health than their international peers (Institute of Medicine, "U.S. Health in International Perspective: Shorter Lives, Poorer Health," 2013).

• It's old but we hadn't seen it. Investor's Business Daily asserted in 2009 that "People such as scientist Stephen Hawking wouldn't have a chance in the U.K., where the National Health Service would say the quality of life of this brilliant man, because of his physical handicaps, is essentially worthless." Dr. Hawking, who has lived and worked in Britain all of his life, responded: "I wouldn't be here today if it were not for the NHS. I have received a large amount of high-quality treatment without which I would not have survived." (Uwe Reinhardt, "Where 'Socialized Medicine' has a U.S. foothold," New York Times, 8/3/12).

CORPORATE MONEY AND CARE

• The number of patients who received Johnson & Johnson's defective mental hip implants who are likely to need a replacement may be three times higher than previously estimated. Johnson & Johnson's internal review of a sample of 554 metal hips implanted through September 2011 found that 37.5 percent were expected to fail and need replacement within five years. In comparison, the replacement rate for other types of hip implants is about 5 percent at five years. About 93,000 of the metal hips were implanted in the U.S. before the firm recalled the hips in August 2010. The British Orthopaedic Association now estimates a failure rate in the U.K. as high as 49 percent after six years (Meier, "Maker aware of 40 percent failure in hip implant," New York Times, 1/22/13).

A new analysis by RAND researchers of the potential impact of electronic health records found scant evidence of savings, discrediting RAND's widely-cited 2005 estimate that EHR would save $81 billion annually, and agreeing with a critique of the 2005 estimate that year by PNHP researchers. Funded by health technology companies like GE and Cerner who profited from its results, the 2005 study helped fuel an explosion in the sale of electronic medical records systems and helped drive the federal government to give billions in incentives to hospitals and doctors to adopt them. In many cases the systems are difficult to use, cannot share patient information with other systems, and are adding hours to the time physicians spend documenting care. They may even raise costs by making it easier for providers to bill more (Abelson and Creswell, "In second look, few savings from digital health records," New York Times, 1/10/13; Himmelstein and Woolhandler, "Hope and Hype," Health Affairs, September 2005).

• Lobbying by firms that sell electronic medical records (EMRs) has paid off handsomely; the industry got a $19 billion boost from incentives for providers to adopt EMRs that were included in the 2009 economic stimulus bill. At Kansas City, Missouri-based Cerner Corporation, spending on lobbying has more than doubled since 2006 to nearly $400,000, and revenues have tripled to $3 billion since 2005. Cerner CEO Neal Patterson received over $21 million in compensation between 2007 and 2011, on top of stock in the firm worth $1 billion. Allscripts' former CEO, Glen Tullman, was health technology adviser to the 2008 Obama campaign and has visited the White House no fewer than seven times since 2009. Sales at Chicago-based Allscripts have more than doubled from $548 million in 2009 to $1.44 billion last year. The legislation cemented the leading positions of Allscripts and Cerner, along with Epic Systems of Verona, Wis. (Creswell, "A digital shift on health data swells profits," New York Times 2/20/13).

HOW HOSPITALS, DRUGMAKERS, AND MEDICAL-DEVICE FIRMS GOUGE PATIENTS

• Time magazine recently published a scathing critique of the health care system by Steven Brill. Among the interesting facts he presented:

- Pharmaceutical, insurance and other health care industries have spent $5.36 billion since 1998 on lobbying in D.C. In comparison, the defense and aerospace industries spent $1.53 billion and the oil and gas industry spent $1.3 billion during the same period.
- The typical new cancer drug coming on the market a decade ago cost about $4,500 per month (in 2012 dollars) but since 2010, the median price has been around $10,000. Two new cancer drugs cost more than $35,000 each per month.
- Drug and device makers mark up their products dramatically for sale to hospitals. The hospitals, including nonprofits, turn around and mark them up again with different prices for Medicare, private insurers, and patients. The resulting price gouging can be astonishing. Genentech can make its cancer drug Rituxan for as little as $300 a dose, but sells it to hospitals for about $3,500 a dose, who may then charge patients more than $13,000.
- Some of the biggest profits are on devices. Medtronic can make a neurostimulator for $4,500 and sell it to a hospital for $19,000, for a gross profit of $14,500 before overhead. The hospital may then charge the patient $49,237.
- Aetna spent $6.9 billion on operating expenses in 2012, about 29 percent of the $23.7 billion the firm paid out in claims. Medicare is very administratively efficient, spending just 1.4 percent of its budget on overhead.
- Many nonprofit hospitals have become hugely profitable. MD Anderson Cancer Center, a nonprofit unit of the University of Texas, had an operating profit of $531 million on revenues of $2.05 billion, for a profit margin of 26 percent in 2011. Montefiore Medical Center in New York had operating profits of $196.8 million on $2,586 billion in revenue, for a profit margin of 8 percent (Steven Brill, "Bitter Pill: Why medical bills are killing us," Time, 2/20/13).

GALLOPING HEALTH CARE CONSOLIDATION

• The Federal Trade Commission is blocking at least four hospital mergers announced in 2012, arguing that they will give the hospitals too much leverage in bargaining with insurers, raising prices. After a long string of losses, the Federal Trade Commission won a landmark case in 2003 against Evanston Northwestern Hospital's merger with Highland Park Hospital. Patient prices jumped 48 percent between the merger in 1998 and 2002, and executives boasted of an extra $24 million in

"revenue enhancements" from being in a better negotiating position with insurers. The FTC required the hospitals to negotiate with insurers separately. Now the FTC is investigating the deals between ProMedica and St. Luke's Hospital in Ohio, Reading Health System and Surgical Institute of Reading in Pennsylvania, OSF HealthCare and Rockford Health System in Illinois, and Phoebe Putney Health System and Palmyra Park Hospital in Georgia. (Karen Cheun-Larivee, "4 FTC-challenged hospital mergers of 2012," 12/20/12)

In 2012 the number of mergers and acquisitions in the health care industry rebounded to a level not seen since 2007. There were 1,063 deals, for a total of $143.3 billion, including 31 deals of $1 billion or more (Irving Levin Associates, Health Care M and A Monthly: 2012).

The federal reform law is driving a "renaissance" in hospital mergers that makes the wave of hospital consolidation in the mid-1990s "pale in comparison," according to corporate lawyers who specialize in the health sector. There were 94 hospital or health system mergers in 2012, on top of 92 in 2011, 77 in 2010, and 53 in 2009. Analysts expect the hospital merger wave to keep rising for at least five years. Hospital acquisitions (or "alignments") of physician groups is equally, if not more, intense. 54 percent of physician practices were owned by hospitals in 2012, up from 22 percent a decade ago, according to a McKinsey survey. (Strom, "Hospital mergers get caught between reform, competition," Chicago Lawyer, 12/1/12)

• The insurance industry in the U.S. is highly consolidated. In 70 percent of the 385 metropolitan areas studied by the American Medical Association, the insurance market is rated "highly concentrated" based on Federal Trade Commission guidelines and there is a significant absence of competition. In two-thirds of metropolitan areas, one health insurer had an HMO, PPO, or POS market share of 50 percent or greater. In ten states, a single insurer accounted for a majority share of the health insurance market: Alabama, Hawaii, Michigan, Delaware, Alaska, North Dakota, South Carolina, Rhode Island, Wyoming, and Nebraska ("New AMA study finds anticompetitive market conditions are common across managed care plans," AMA, 11/28/12).

• Over the past 7 years, private equity firms have invested more than $2.2 billion in substance abuse treatment and behavioral health companies in 62 deals. Addiction treatment companies are attractive because their profit margins can exceed 20 percent. In 2006, Bain Capital paid $723 million for CRC Health Corp, the largest U.S. provider of methadone treatment, with 57 clinics in 15 states that generated $123 million in 2011 revenue. In the four states where it has its most patients – Ind., W.Va., Calif. and Ore. – it provides take-home packages, ranging from one dose to as many as 30, more often than other clinics. The indiscriminate use of take-home dosing has led to infant deaths and drug-dealing. Since Jan. 1, 2009, CRC's clinics have failed to meet staffing standards more than 50 times, have been cited 80 times for failing to document adequate counseling, and have received more than 1,000 deficiency notices. CRC's recovery division, which includes the methadone clinics and other substance abuse treatment facilities, reported earnings of 35 percent of revenue for the first three quarters of 2012. In addition, CRC has paid Bain about $15.4 million in management fees and $7.2 million in fees related to the merger since 2006. Mitt Romney, Bain's co-founder, owns more than $1 million worth of a Bain fund that holds most of CRC's shares. 52.8 percent of the 1,200 U.S. methadone clinics are for-profit (Freedberg, "Drug users turn death dealers as methadone from Bain hits street," Bloomberg.com, 2/8/13).

A growing number of hospital systems are starting their own insurance plans, aiming to capitalize on the trend towards ACOs encouraged by the ACA. In 2010, about 10 percent of community hospitals owned, or were part of systems that owned, health plans, according to the American Hospital Association.

Two Atlanta hospital systems, Piedmont Healthcare and WellStar Health System, with 10 hospitals and hundreds of affiliated doctors, are starting a jointly owned insurer that will sell plans to employers and Medicare recipients, and possibly on the health exchange, starting in 2014. North Shore-Long Island Jewish Health System aims to start a plan to offer on New York's health exchange. California's Sutter Health, Indiana University Health, and MedStar Health in Baltimore are all starting or expanding insurance operations.

It works the other way too, with health insurers buying hospitals. Highmark, a health insurer based in Pittsburgh, is buying West Penn Allegheny Health System, Premier Medical Associates and Jefferson Regional Medical Center. Highmark said it is likely to buy more hospitals and practices in the area (Mathews, "Hospital systems branch out as insurers," Wall Street Journal, 12/17/12).

HOSPITALS, INC.

• Health care has been transformed from its charitable roots into a profit-seeking industry. For-profits now operate 84 percent of home health care agencies and 85 percent of dialysis clinics. For-profits operate 96 percent of the nation's outpatient surgery centers, a sector that has grown by more than a third since 2004. Hospice care has evolved into a $14 billion business, run mostly for-profit. Over three-fourths of nursing home revenues go to for-profit nursing homes. The exception has been hospitals, where nonprofits and government-operated facilities had 88 percent of revenues in 2010 (MedPac 2012).

• Private equity firm Cerberus Capital Management, which once owned Chrysler, bought the six-hospital Caritas Christi Health Care System, of Boston, renamed it Steward Health Care System and turned it into a for-profit operation. St. Louis-based Ascension Health, the nation's largest Catholic health system with $15.5 billion in annual revenues, is partnering with private equity firm Oak Hill Ventures to acquire distressed Catholic hospitals. They took over Alexian Brothers Health System in Chicago last year. (Strom, "Hospital mergers get caught between

reform, competition," Chicago Lawyer, 12/1/12)

• The Health Care Foundation of Greater Kansas City won a $162 million judgment against HCA for not spending what it had promised on capital improvements to the formerly nonprofit Health Midwest hospitals after HCA bought them for $1.13 billion in 2003. HCA had promised to make $450 million in capital improvements and to provide more than $650 million in charity care in the Kansas City area (Stafford, "Judge says HCA broke spending promises," The Kansas City Star, 1/24/13).

HCA, which controls 163 hospitals from New Hampshire to California, was bought by three private equity firms – including Bain Capital – in late 2006. Critical to HCA's success has been its ability to garner more income by billing much more aggressively. HCA's net income was $2.47 billion when it went up for sale in the largest-ever private-equity backed IPO in 2011. Bain reaped a $750 million windfall from the deal, a ten-fold profit on its original $64 million investment. Bain's pay out included a $460 million, or 30 percent commission, for buying and selling the company, a $62 million management fee charged to HCA, a $58 million transaction fee and a $76 million management fee charged to its investors. In addition to the cash payouts, both Bain and its fund investors received sizable equity stakes in HCA. Bain's success has inspired 35 buyouts of hospitals or chains of facilities in the last two and half years by private equity firms (Peter Waldman, Bloomberg.com, 12/31/12; Kosman, "Bain's huge HCA IPO gain" New York Post, 3/11/11).

MILLIONAIRE HOSPITAL CEOS

• Thirty-two nonprofit hospital CEOs in California each received compensation of over $1 million in 2010, up from 19 in 2007. In 2010, George Halvorson of Kaiser Permanente was the highest paid at $7.74 million. Thomas Priselac, CEO of Cedars-Sinai Medical Center in Los Angeles, received $2.77 million, down from $3.9 million in 2009. 14 administrators at New York City's Memorial Sloan-Kettering Cancer Center are paid over $500,000 each, including six executives who make over $1 million. Montefiore Medical Center in New York pays several executives well over $1 million. In North Carolina, where eight health systems dominate the state's delivery system, at least 25 hospital executives have received annual compensation exceeding $1 million. Marna Borgstrom, CEO of Yale New Haven Health System, earned $2.5 million, 58 percent more than the $1.6 million paid to the President of Yale University (California Health News, 2/14/13; "Million-dollar hospital executives in North Carolina," Charlotteobserver.com 4/21/12, from the investigative series "Prognosis: Profits").

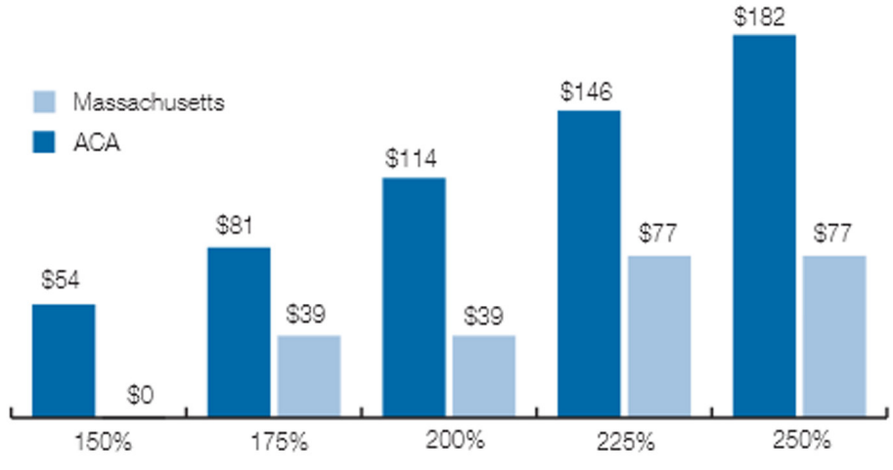
SKIMPY COVERAGE UNDER THE ACA

• Some employers are justifying shifting a larger share of health care costs to employees as "resetting" the actuarial value of their plans at the minimum level required by the ACA, 60 percent of eligible health plan expenses, according to an annual survey of employer health benefits by Mercer. Currently, most employer-based coverage has an actuarial value over 80 percent (Anderson, "Employer health benefit cost increases lowest in 15 years" www.healthcarefinancenews.com, 11/20/12).

• Premiums on the ACA exchanges will be higher than they are in Massachusetts. In that state, individuals at 150 percent of poverty pay no premiums, and those between 175 percent and 250 percent of poverty pay monthly premiums of $39 to $77 (see Figure 1). Low premiums have contributed to reducing that state's uninsured rate by half. In contrast, their low-income counterparts on the ACA exchanges will pay between $54 and $182 monthly (Stan Dorn, "The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States," Urban Institute, March 2011).

• Vermonters currently in state-subsidized Catamount and VHAP health insurance programs, slated to end in 2014, will face sharp increases in their health care costs under the ACA. The ACA mandates that low-income individuals pay premiums on a sliding scale based on income, from 4 percent of income (at 150 percent of poverty), to 6.3 percent (at 200 percent of poverty), to 9.5 percent (at 300 and above), while enrollees in Vermont's programs paid only nominal fees for their care (Stein, "Administration cuts low-income subsidy for health exchange" 2/7/13, Vtdigger.org).

Figure 1. Minimum monthly premium payments for a single adult at various FPL levels, 2010: ACA versus Massachusetts CommCare



Source: Massachusetts Commonwealth Connector 2010.[21]

A quantitative assessment of ACA underinsurance

One of the major flaws of the Affordable Care Act is that underinsurance will become the new standard for health insurance in the United States. A new report from the Kaiser Family Foundation demonstrates how the most common plans that will be purchased in the state insurance exchanges will fall well below the coverage that most people have today.

The cheapest plans in the exchanges – bronze plans with an actuarial value of 60% (i.e. patient pays an average of 40% of covered costs) – will have deductibles estimated at $4,375 for an individual ($8,750 for families) with coinsurance of 20% (the patient pays 20% of the amount over the deductible). According to the estimates the deductible can be reduced to $3,475 for an individual but then the patient faces a staggering coinsurance of 40%.

Because of the availability of income-indexed subsidies, it is likely that silver plans with an actuarial value of 70% will be the most commonly selected plans among low-income families eligible for the subsidies. These are still well below the typical employer-sponsored plans which have an average actuarial value of 82%. Kaiser estimates that the deductible for the silver plans would be $2,050 for an individual with a 20% coinsurance rate. The deductible could be reduced to $650 but, again, the coinsurance rate would increase to 40%.

Subsidies would assist those with lower incomes, but for this population even the most modest out-of-pocket cost sharing expenses can create financial barriers to care. As income increases, the subsidies diminish and eventually phase out altogether. The 2014 limit for maximum out-of-pocket spending will be $6,350 for an individual or $12,700 for a family (on top of the portion of the premium that must also be paid). These income-adjusted increases in cost sharing will still be excessive for most individuals and families with significant health problems and with all of the other financial problems that often are associated with ill health.

This commentary is from PNHP Senior Health Policy Fellow Dr. Don McCanne's Quote of the Day, a daily health policy update on the single-payer health care reform movement. To subscribe, visit http://www.pnhp.org/qotd.

• Group purchasers in Massachusetts are buying health plans with fewer benefits or higher cost sharing, a trend known as "benefit buy-down." Benefit buy-down makes it appear that premium inflation has slowed, when it has merely shifted costs to patients and/or reduced access to care ("Massachusetts Health Care Cost Trends," Mass. Health and Human Services, 5/12).

• Underinsurance in the form of lack of choice of doctor and the potential for large out-of-network medical bills is expected to surge next year. HMO-like plans with tightly controlled networks of providers are expected to play a prominent role on the exchanges, where individuals and small businesses will shop for coverage starting Oct. 1 for coverage beginning Jan. 1, 2014. Nearly one-quarter (23 percent) of large employers offered narrow network policies this year, up from 14 percent in 2011, according to a benefit survey by Mercer. Insurers like such plans because they attract young and healthy enrollees, while discouraging enrollment by people with medical problems who want to keep their current providers (Julie Appleby, "HMO-like plans may be poised to make comeback in online insurance markets," 1/22/13).

THE ACA – FAILING TO FIX THE INSURANCE MARKET

Along with 100,000 people in the federal high risk pool, more than 200,000 people in older, state-run high risk pools are likely to be dumped into the health exchanges as soon as they open in 2014. To avoid rate shock, HHS has set aside $20 billion for a reinsurance pool that will make payments to plans for high-cost patients (defined as over $60,000 per year), but state high-risk pools aren't eligible for the money. As a result, the state pools, which had planned to transition their beneficiaries into the exchanges slowly, now must act quickly. The reinsurance program is front-loaded, $10 billion in the first year, $6 billion in the second year, and $4 billion in the third year. The reinsurance fund and risk-adjustment scheme developed by HHS is not expected by economists to be large enough to prevent premiums from rising for young healthy people. It also won't help patients with serious medical needs who face higher cost-sharing in the exchanges (Brett Norman, "States rethink high-risk pool plans," Politico.com 1/29/13).

• Federal officials are worried that small and medium-size employers, particularly those with younger and healthier workforces, may opt out of the health exchanges and decide to self-insure (that is, pay the medical bills of their employees directly). If so, premiums for employers buying coverage on the exchanges will rise.

Self-insurance is no longer limited to very large companies. With health care costs skyrocketing, the proportion of private sector workers with health coverage in self-insured plans rose to 59 percent in 2011, up from 41 percent in 1998. Now, small and medium-sized employers see self-insurance as a way to avoid the ACA's mandated benefits.

As of Jan. 1, 2014, the ACA makes it less risky for small employers to self-insure. If it turns out an employee becomes expensively ill, the employer can still go back to traditional coverage because of new rules mandating insurers accept all enrollees. But those rules don't apply to firms that sell "stop-loss" insurance that protects self-insured employers against very large claims, say $50,000 to $100,000 per person; they can continue to deny coverage for certain conditions or individual workers. Moreover, some insurers are now offering lower limit stop-loss coverage that makes "self insurance" attractive to even very small firms with young healthy workers. Meanwhile, small firms with older and sicker workforces are less likely to self-insure, leading to adverse selection on the health exchanges.

State insurance commissioners from California to New Jersey complain that intense marketing of stop-loss coverage to employers with young and healthy workforces is already under way (Robert Pear, "Some Employers Could Opt Out of Insurance Market, Raising Others' Costs," New York Times, 2/17/13).

• The $6 billion corporate wellness industry also got a big boost from the ACA. Beginning in 2014, employers may use up to 30 percent of the total amount of employees' health insurance premiums (50 percent at the discretion of the secretary of Health and Human Services) to provide outcome-based wellness incentives, such as premium rebates, lower cost-sharing, and extra benefits. The wellness provisions in the ACA were inspired, in part, by Safeway, which claimed that its wellness initiative flattened health care cost inflation between 2005 and 2009. In fact, Safeway's wellness initiative didn't start until 2008, too late to account for the change, and costs rose afterwards. Moreover, only 11,000 of the firm's 200,000 employees participated in the program (Al Lewis and Vic Khanna, "Is it time to re-examine workplace wellness 'get well quick' schemes?" healthaffairs.org/blog, 1/16/13).

NURSING HOMES, INC.

• 78 percent of $105 billion in nursing home revenues went to for-profit nursing homes in 2010, up from 72 percent in 2002. Investor-owned nursing homes average a 20 percent profit margin on Medicare patients (compared to 9 percent for nonprofit operators) according to MedPac, and are nearly twice as likely as nonprofits to bill Medicare at the highest rate for patients of similar ages and diagnoses. According to an investigation by the Inspector General's Office at HHS, 30 percent of claims sampled from for-profit homes were deemed improper, compared to 12 percent from nonprofits. The 10 largest nursing home chains employed 37 percent fewer registered nurses per patient day between 2003 and 2008 than nonprofits.

Life Care, based in Cleveland, Tenn., has 230 facilities with 30,000 beds, making it the nation's third-largest nursing home chain. The firm is accused of billing Medicare for unnecessary and sometimes harmful treatments at its nursing homes between 2006 and 2012. Skilled Healthcare Group (SKH) which operates 75 U.S. sites, was the subject of a class-action lawsuit that led to a $63 million settlement last year. The jury found that the company failed to meet the minimum nursing requirement on more than 1.2 million patient days between 2003 and 2009 (Waldman, "For-profit nursing homes lead in overcharging while care suffers," Bloomberg.com, 12/31/12).

BIG PHARMA

• Liz Fowler, the former WellPoint executive who drafted the ACA as a congressional staffer to Sen. Max Baucus and moved to the White House to oversee the early stages of its implementation, is leaving the Obama administration to take a senior position with drugmaker Johnson & Johnson. In addition to giving a huge boost to private health insurers, the ACA was a windfall for Big Pharma. The legislation keeps U.S. drug prices the highest in the world by continuing to bar Americans from re-importing drugs at lower, European or Canadian prices, and prohibits Medicare from negotiating pharmaceutical prices with the industry, as the VA and other nations do (Glen Greenwald, "Obamacare architect leaves White House for pharmaceutical industry job," The Guardian, 12/5/12).

The world's largest biotechnology firm, Amgen, agreed to pay $762 million in criminal fines and civil penalties after pleading guilty in federal court to improper marketing of its anemia drug Aranesp. Federal prosecutors said the firm was "pursuing profits at the risk of patient safety."

Less than two weeks after being subject to one of the largest criminal fines in U.S. history, Amgen, which has 74 lobbyists in D.C., received a two-year reprieve from having its drug Sensipar hit by Medicare cost controls. The delay, worth about $500 million in extra Medicare payments to the firm, was in a clause tucked into year-end budget legislation. An investigation by The New York Times exposed Amgen's deep political and financial ties to three powerful senators with major influence over Medicare payment policy – Republican Minority Leader Mitch McConnell, Democratic Sen. Max Baucus, chair of the Senate Finance Committee, and that committee's ranking Republican, Orrin Hatch. Both Baucus and McConnell have former chiefs of staff who now lobby for Amgen, and a former health policy analyst for Amgen is now a top aide to Hatch. Although Amgen was not mentioned by name in the loophole, the news that it had been tucked into the fiscal cliff deal "was so welcome that the company's chief executive quickly relayed it to investment analysts" (Terhune, "Amgen pleads guilty, to settle misbranding case for $762 million," Los Angeles Times, 12/18/12; Lipton and Sack, "Fiscal Footnote: Big Senate Gift to Drug Maker," The New York Times, 1/19/13).

• The six biggest U.S. drugmakers avoided paying $7.05 billion in U.S. taxes last year by shifting their profits overseas, almost double the amount they saved using the same strategy 10 years earlier, according to data compiled by Bloomberg news.

For years, multinationals such as Pfizer Inc., Merck & Co. and Johnson & Johnson have been moving ownership of patents and trademarks to subsidiaries in low- or no-tax countries. This has allowed drug companies to skirt paying U.S. taxes on their sales of these products unless the money is returned home.

Merck and J&J were the biggest drug company winners in 2012 with savings of about $2 billion each attributable to the strategy, according to regulatory filings. Pfizer reported having $73 billion abroad, Abbott Laboratories $40 billion and Bristol-Myers Squibb Co. and Eli Lilly Co. $21 billion each. The reports by the six drugmakers were filed in February (Drew Armstrong, "Overseas tax savings for U.S. drugmakers under threat," Bloomberg.com, 3/11/13).

PNHP presence on Facebook and Twitter on upswing

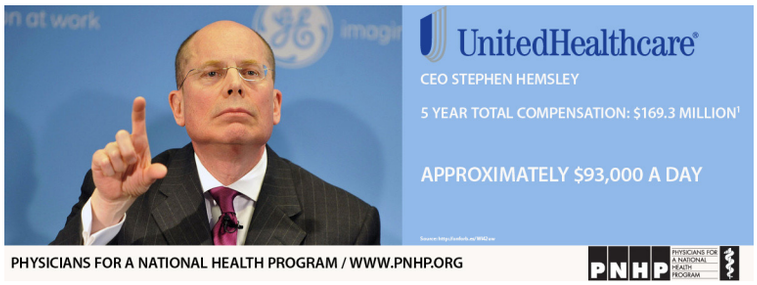
While PNHP has been engaging with its supporters on Facebook for several years now, the extent and quality of that engagement has definitely been rising over the past year.

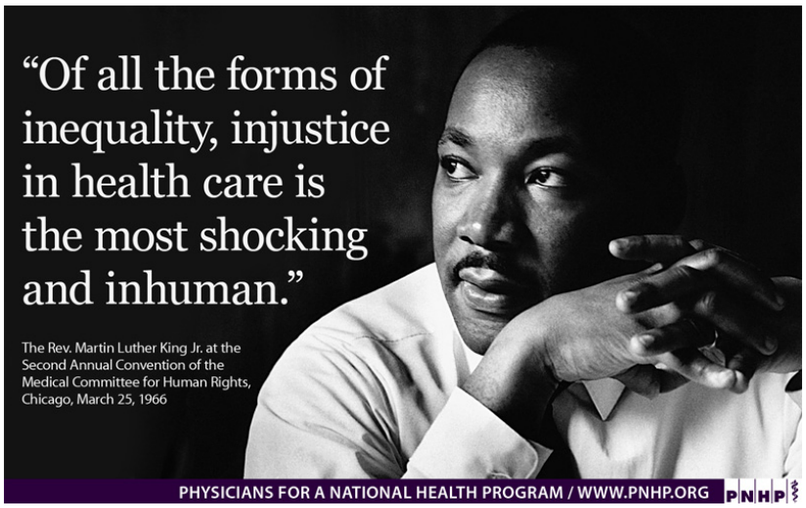
Thanks in large part to the steady posting by our national staff of provocative infographics and links to lively, stirring articles, the number of people who "like" PNHP's Facebook page has grown from around 5,000 in early 2012 to over 11,000 today.

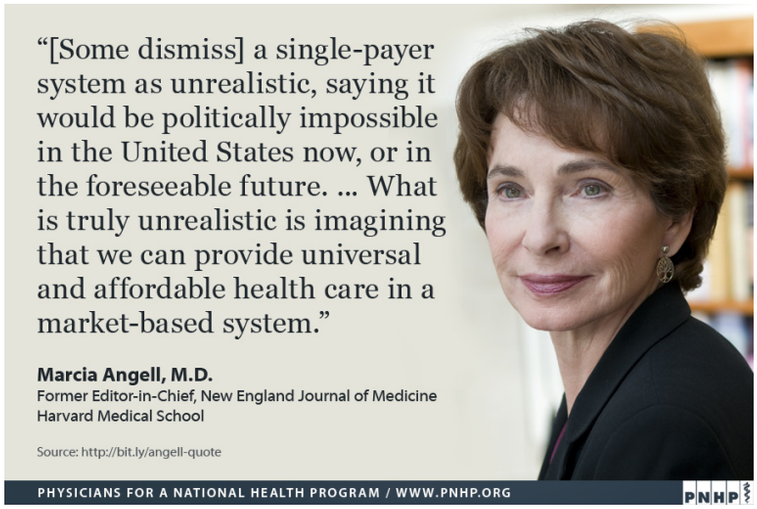
Dustin Calliari, our technology associate and webmaster, has spearheaded this effort, much as Dave Howell, our previous webmaster, did before him.

If you're on Facebook and haven't already "liked" PNHP, please do so today. And when you see a new post by us, please comment on and share our content with your friends and colleagues. A sampling of our posts appears below.

We're also becoming more engaged with Twitter, where we have 2,000 followers and are growing. Please follow and retweet us there, too!







THE LANCET

The art of medicine

Caregiving as moral experience

Everyone who has been in love or built a family knows that there are things, essential things, that money can't buy. Patients with serious illness and their network of caregivers know this too, because those things that really matter to us are threatened and must be defended. And many clinicians, reflecting on what is at stake in health care not only for patients but for themselves, know the same thing: the market has an important role in health-care financing and health systems reform, but it should not reach into those quintessentials of caregiving that speak to what is most deeply human in medicine and in living. This is the moral limit of an economic paradigm. Or at least it should be.

But we live in a truly confused age. The market model seems to have infiltrated so thoroughly into human lives and medicine that in certain circles—policy making and analysis, hospital and clinic administration, and even clinical work—economic rationality with its imperative of containing costs and maximising efficiency has come to mute the moral, emotional, religious, and aesthetic expressions of patients and caregivers. Most take it for granted and accept its implications. Models from economic psychology, behavioural economics, and business studies, based on the narrowest calculations of what a "rational" person would choose as most cost-effective, are now routinely applied to clinical decision making and the organisation of care. They model the choices available to patients and their family members as if they were sufficient for the torturous experience at end-of-life, the routine frustrating crises that constitute caregiving for neurodegenerative conditions, the admixture of desperation that depression brings to disabling heart disease and cancers, and the emotional turmoil and challenge of serious childhood disabilities. Such models, pace the claims to the contrary of health policy experts and programme administrators, are themselves value-laden, and, once introduced, warp the context of health care—a kind of gravitational field that attracts the instrumental and distorts the human.

Professionals and laypeople may rail against the hubris of the market model in caregiving, and yet in current debates over health-care reform in the USA, the UK, China, and many other countries, neither the voices of clinical professionals nor those of family caregivers are invited or adequately heard, let alone carry equal weight. This is not just an issue of the corrosive effect of unbridled capitalism on human values which Karl Marx inveighed against, albeit it is partly that. It is also a stunning failure of people who have "skin in the game", which means pretty nearly all of us, to adequately articulate and champion an alternative. In caregiving, I believe there is an alternative that makes the case for the limits of markets and also offers a different vision. Caregiving is one of the foundational moral meanings and practices in human experience everywhere: it defines human value and resists crude reduction to counting and costing.

Consider how central caregiving is to what it means to be human. Caregiving is an indelible part of relations between partners, the raising of children, and response to the infirmities of aged parents and grandparents. It is, of course, the very definition of how families and friendship networks cope with sickness or disability among their own. And there is an ancient lineage to caregiving across historical periods and societies. Nursing, medicine, and the allied health disciplines justify their status as healing professions by underlining their professional commitment to caregiving. Religions respond to suffering with rituals that animate caregiving in both social and subjective realms. All cultures have elaborate systems of healing and ideas about illness and its courses and treatment that are enacted in the care of the sick. Of course, the sensibility of caregiving extends well beyond medicine to stewardship of the environment, support for the welfare of the poor, and to the building of political institutions and processes that advance basic human interests.

To be sure, the moral distance between stated values and actual practices is substantial. Over the past several years, when I have delivered lectures at medical schools and health science centres, I have explained to the audience that, given how little in the way of financial, time-in-the-curricula, and other resources most medical schools devote to the principles, values, and practice of caregiving, perhaps we should allow medical schools to remove caregiving as a goal of medical education and restrict the curriculum to technical clinical competence and biomedical knowledge. The response to this suggestion is usually a passionate defence by those in the audience of how important caregiving is to medicine, and I adduce to their own sense of purpose and meaning. So in light of this seeming paradox—medicine invests little in caregiving, yet it is core to health professionals' motivations and identity—how should we think of caregiving?

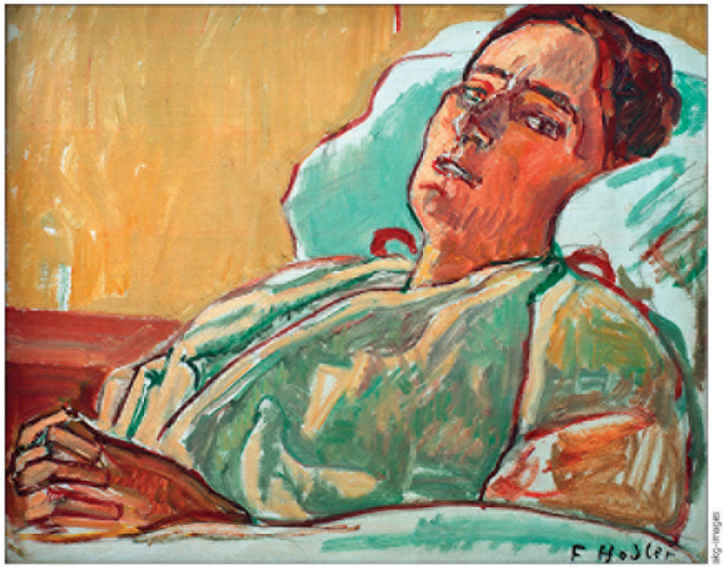
For family members, close friends, the sufferers themselves, and professionals, caregiving turns on the amelioration of pain and suffering. Practical assistance with activities of daily living—feeding, bathing, ambulating, toileting—is a basic component, as are protection and emotional support. For physicians, in particular, diagnosis, prognosis, treatment, and rehabilitation can be done in ways that emphasise their human as well as their technical aspects, both of which are part of caregiving. But here I wish to emphasise the moral face of caregiving. Acknowledgment of the personhood of sufferers and affirmation of their condition and struggle have long been recognised as the most basic and sustaining of

moral acts, whether among the friendship and kin network or in patient-physician and other professional relationships. The laying on of hands, empathic witnessing, listening to the illness narrative, and providing moral solidarity through sustained engagement and responsibility over the course of chronic illness and in the terminal period are all core moral tasks in caregiving. Theorists of caregiving have also identified "presence"—being there, existentially, even when nothing practical can be done and hope itself is eclipsed—as central to the giving of care. And it is also important in care receiving, because caregiving is almost always a deeply interpersonal, relational practice that resonates with the most troubling preoccupations of both carer and sufferer about living, about self, and about dignity.

In anthropological terms, caregiving centres on a different kind of reciprocity than financial exchanges—albeit it can be both. It is closer to gift giving and receiving among people whose relationships really matter. The person receiving care shares her experience and story as a gift with the caregiver, in reciprocation for the practical things that need doing along with a sensibility akin to love. What is exchanged is the moral responsibility, emotional sensibility, and social capital of the relationship. The exchange changes the subjectivity of both the caregiver and the person receiving care. The terms "taking care" and "caring" imply cultivation of the person and the relationship through practices of attending, enacting, supporting, and collaborating. What is at stake is doing good, for others and for oneself, if need be, despite the emotional and material cost. Indeed, the rewards—unvoiced or explicit—can be transformative, going to the heart of who we are and what we can offer, or endure.

Inasmuch as caregiving (and receiving) is done by individuals who themselves are complex and divided and who inhabit local worlds that are also plural and divided, it needs to be understood as a process that is affected by emotional, political, and economic realities. But that does not mean that the market is more fundamental than caregiving. They are often entangled to be sure, but they are also distinctive ways of being human as well as different visions of who we are.

The great failure of contemporary medicine to promote caregiving as an existential practice and moral vision that resists reduction to the market model or the clarion call of efficiency has diminished professionals, patients, and family caregivers alike. It has enabled a noisy and ubiquitous market to all but silence different motives, ideals, hopes, and behaviours that must be expressed, because they are as much who we are as economic rationality. If caregiving is absent from the political and economic discourse on health care, then nothing but institutional and monetary issues seem to matter. Even questions of "quality" in health care become distorted. What counts as "evidence", then, is an absence of presence. Caregiving with its central commitments to doing good to others and to oneself becomes invisible and is left out of the debates on policies and programmes. And the result is that all of us are demeaned and the profession of medicine and the processes of health care are transmuted into something that is hollowed of its humanity and moral value. And yet throughout health organisations, in medical wards, in clinics, in ambulances and emergency facilities, in managers' offices, in endless meetings, clinical conferences, and quality-of-life care committees are individuals for whom the calling and the passion for caregiving is alive. They know the power of a touch, true listening, the quiet satisfaction of making a difference. The system is not the people (mostly) in it.



akg-images

Ferdinand Hodler, *Valentine Gode-Darel in Illness* (1914)

This is a call, therefore, for a serious discussion about caregiving and a reconsideration of its place in medical education, medical practice, and medical research, on the one side, and its significance for patients, families, and communities, on the other. Nor should this discussion be restricted to health care. Once we open the door to the democratic implications of caregiving as moral and political practices, so much of the rest of our world from leadership to governance and from domestic to foreign affairs becomes a matter not just of markets, regulations, and security concerns, but of how we can enact care as humankind's shared project.

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Further reading

Canguilhem G. Writings on medicine. Translated by Stefanos Geroulanos, Todd Meyers. New York: Fordham University Press, 2012

Kleinman A. The illness narratives. New York: Basic Books, 1988

Kleinman A. What really matters. Oxford and New York: Oxford University Press, 2006

Mol A. The logic of care. New York: Routledge, 2008

Sandel MJ. What money can't buy. New York: Farrar, Straus and Giroux, 2012

Tronto J. Moral boundaries: a political argument for an ethics of care. New York: Routledge, 1993

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Doctors group hails reintroduction of Medicare-for-all bill

FOR IMMEDIATE RELEASE
February 14, 2013

Single-payer health program would cover all 50 million uninsured, upgrade everyone's benefits and save $400 billion annually on bureaucracy, physicians say

A national physicians group today hailed the reintroduction of a federal bill that would upgrade the Medicare program and swiftly expand it to cover the entire population.

The "Expanded and Improved Medicare for All Act," H.R. 676, introduced by Rep. John Conyers Jr., D-Mich., and 37 other House members, would replace today's welter of private health insurance companies with a single, streamlined public agency that would pay all medical claims, much like Medicare works for seniors today.

Proponents say the publicly financed plan would vastly simplify how the nation pays for care, improve patient health, restore free choice of physician, and yield substantial savings for individuals, families and businesses.

"The evidence is clear: an improved-Medicare-for-all program is the most equitable and cost-effective way to assure that everyone, without exception, gets high-quality care," said Dr. Andrew Coates, president of Physicians for a National Health Program, a nonprofit research and advocacy group of 18,000 doctors nationwide. "Nothing less will do the job."

"A single-payer program would assure truly universal coverage, cover all necessary services, and knock down the growing financial barriers to care – high premiums, co-pays, deductibles and coinsurance – that my patients are running up against, often with calamitous results," he said.

Coates, an Albany, N.Y.-based internist, continued: "Such a plan would save over $400 billion a year currently wasted on private-insurance-related bureaucracy, paperwork and marketing – money that should be used to care for patients. Such a program would also have the financial muscle to negotiate with drug and medical suppliers for lower prices, and would further save money through lump-sum budgeting for hospitals.

"In short," he said, "the enactment of Rep. Conyers' bill would take us much further than the 2010 health law, which despite its modest benefits will not be able to control costs and which the Congressional Budget Office estimates will still leave 30 million people uninsured in 2023.

"Surveys have repeatedly shown that about two-thirds of the public supports a Medicare-for-all approach," Coates said. "And a recent survey of physicians shows that a solid majority now favor government legislation to create national health insurance."

"As a doctor who sees hard-pressed patients every day, I can tell you that the need for fundamental health care reform has never been greater," he said. "It's time to stop putting the interests of private insurance companies and Big Pharma over patient needs. It's time to adopt a single-payer, improved-Medicare-for-all program in the United States."

Initial co-sponsors of H.R. 676 as of March 22

The follow members of the U.S. House are the initial co-sponsors of Rep. John Conyers' Expanded and Improved Medicare for All Act, H.R. 676, in the 113th Congress. If your congressperson is not on this list, please call the Capitol switchboard at (866) 220-0044, ask for your representative's office, and then ask him or her to become a co-sponsor.

Nadler (NY)
Schakowsky (IL)
Pingree (ME)
Grijalva (AZ)
Ellison (MN)
Hank Johnson (GA)
Eddie Bernice Johnson (TX)
Takano (CA)
Holmes-Norton (DC)
Lofgren (CA)
Rangel (NY)
Moore (WI)
Chu (CA)
Al Green (TX)
Farr (CA)
McGovern (MA)
Welch (VT)
Clarke (NY)
Lee (CA)
Nolan (MN)
Pocan (WI)
Doyle (PA)
Engel (NY)
Gutierrez (IL)
Frederica Wilson (FL)
Cohen (TN)
Edwards (MD)
McDermott (WA)
Clay (MO)
Huffman (CA)
Roybal-Allard (CA)
Cummings (MD)
Yarmuth (KY)
George Miller (CA)
Honda (CA)
Christiansen (VI)
Rush (IL)
Hastings (FL)

For more information about the legislation, visit PNHP's home page and click on the box that features the bill.

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Setting the record straight on Medicare's overhead costs

Traditional Medicare's administrative costs were only 1% in 2010, but if you roll in the private insurers' Medicare plans, that figure jumps to 6%, says new study

FOR IMMEDIATE RELEASE

February 20, 2013

The traditional Medicare program allocates only 1 percent of total spending to overhead compared with 6 percent when the privatized portion of Medicare, known as Medicare Advantage, is included, according to a study in the June 2013 issue of the Journal of Health Politics, Policy and Law.

The 1 percent figure includes all types of non-medical spending by the Centers for Medicare and Medicaid Services plus other federal agencies, such as the IRS, that support the Medicare program, and is based on data contained in the latest report of the Medicare trustees. The 6 percent figure, on the other hand, is based on data contained in the latest National Health Expenditure Accounts (NHEA) report.

The journal article, written by Minneapolis-based researcher Kip Sullivan, finds that the gap between the two measures has been growing over the last two decades as enrollment in private Medicare plans has risen.

"The high administrative costs of the privatized portion of Medicare are no surprise," says Sullivan. "What's surprising is that the high administrative costs of the Medicare private insurance companies haven't provoked a debate about whether spending more money on insurance industry overhead is a good use of scarce tax revenues."

According to Sullivan, the low attention given to this issue is caused in part by confusion about Medicare's overhead costs.

"The confusion is due partly to the existence of two government reports," says Sullivan, "and partly to claims by critics of Medicare that the government fails to report all of Medicare's overhead costs." The paper addresses both sources of confusion.

The article explains the difference between the yardstick used by the trustees and the one used by the NHEA and concludes both are accurate. The trustees' measure counts as overhead only those administrative expenditures that support the traditional fee-for-service Medicare program, in which approximately three-fourths of all Medicare beneficiaries are enrolled. The NHEA measure takes the trustees' measure and adds to it the overhead of insurance companies that participate in Medicare Advantage and that sell stand-alone Part D drug coverage.

"The issue isn't whether one yardstick is more accurate than the other," Sullivan explains. "The issue is when it's appropriate to use one measure instead of the other."

The 1 percent figure is the one that should be used to analyze several hotly debated health reform issues, including whether to expand traditional Medicare to all Americans and whether to turn Medicare over to the insurance industry, either by expanding the Medicare Advantage program of by converting Medicare to a voucher program as Rep. Paul Ryan has proposed.

"Total spending for any type of insurer, public or private, consists of medical and administrative expenditures," explains Sullivan. "If you want to know whether Medicare would cost more or less if it were turned over to insurance companies, you first have to determine what Medicare spends on medical care and administration and you have to do the same for the health insurance industry."

The proper yardstick to use to measure Medicare's overhead in analyses of issues such as these would be the trustees' measure – 1 percent. The average overhead of the health insurance industry is approximately 20 percent, he said.

The large difference between traditional Medicare's overhead and that of the insurance industry has caused some conservative critics of Medicare to assert that the federal government is ignoring numerous administrative expenditures incurred by various federal agencies that should be attributed to Medicare.

Sullivan's paper, "How to think clearly about Medicare administrative costs: Data sources and measurement," describes this criticism as the second major source of confusion about Medicare's overhead. Sullivan's study reports that the 1 percent figure includes all appropriate administrative expenses incurred on Medicare's behalf, including those by the IRS, the Social Security Administration, and the FBI, as well as the cost of numerous pilot projects that Congress orders CMS to conduct.

Sullivan's notes that many liberals are also confused about what Medicare's overhead costs are. "With so much confusion on both sides of the political spectrum, it's fair to say a useful debate about whether to expand or contract the traditional Medicare program has yet to take place in this country," he said.

Sullivan is a lawyer and member of the Minnesota chapter of Physicians for a National Health Program, which had no role in funding the study.

THE HUFFINGTON POST

January 24, 2013

The Affordable Care Act: What to Expect in 2013

By John Geyman, M.D.

The Affordable Care Act (ACA), crafted in large part by corporate stakeholders who are themselves responsible for the high costs of U.S. health care, is more secure with President Obama's win last November. But regrettably, the law will fail to control costs or prices, will not provide universal access to care, and at best will provide low-value, high-premium "insurance" that will still make essential health care unaffordable for many millions of patients and families.

The ACA's fundamental flaw is that it props up an inefficient and exploitative private health insurance industry while not recognizing that deregulated markets can't fix systemic problems of access, costs, quality, equity, accountability and sustainability.

President Obama gained an impressive victory, and Democrats have held control of the Senate. Most importantly, corporate money, power, lies and deception on the right have not prevailed. But of course, the Republican-controlled House is likely to bring continued political gridlock. Overemphasis on austerity and deficit control threaten Medicare, Medicaid and safety net programs.

Going forward, we can expect to see wild battles across the health care landscape, including these examples:

- Continued mergers among the major players, including insurance companies, hospital systems, medical groups and others, which will end up increasing costs and prices while limiting patients' choices of physician and hospital.
- Continued lobbying by the insurance industry to mold accountable care organizations and insurance exchanges in their interests (i.e. cherry-pick enrollees and pass along sicker patients to public programs).
- Further privatization and exploitation of Medicare and Medicaid.
- Efforts by insurers to limit definitions of minimal essential benefits.
- Further fragmentation and increasing bureaucracy of our market-based health care system with worse health outcomes.

Under this onslaught, the ACA will not hold up. Health care reform needs to be more progressive than how it ended up with the ACA. The only real fix for our problems is single-payer, improved Medicare for All, a proposal introduced by Rep. John Conyers (D-Mich.), H.R. 676, coupled with a private delivery system.

Health care is just one more example of the 99/1 percent challenge facing the country. These are some of the directions that we, the citizens of this great country, can take in restoring hope that all Americans can gain their rightful access to the health care that they deserve:

- Speaking out, individually and collectively, at community, state and federal levels to expose the abuses and cruelty of what passes for health care in its under-regulated state.
- Fighting for a defined benefit program that covers all Americans in a single risk pool with full choice of physicians, other health professionals and institutions, as H.R. 676 would provide.
- Supporting efforts at the state level for single-payer financing in the event that reform may first need to be demonstrated at the state level before a national program can be passed by Congress.
- Pushing for a more responsible government oversight of health care at state and federal levels to oversee health care, including an independent, well-funded national institute to deal with coverage and cost-effectiveness issues on the basis of scientific evidence, not upon which profit-based interest group can scream the loudest.
- Supporting and participating in divestiture efforts against abusive insurers and other stakeholders in the health care marketplace.

Despite what we are being told by politicians on both sides of the aisle, our deregulated health care marketplace is not sustainable, and there is no real fix short of single-payer financing reform coupled with a more accountable private delivery system.

Other advanced nations around the world learned many years ago that one or another form of public financing is fundamental to a good health care system. The U.S. remains an outlier among these nations in having the most expensive system that still does not provide universal access to essential health care -- even at that we have variable quality and worse outcomes. It is long overdue to learn from the experience of other countries that have coped more successfully with the same health policy issues that we face in this country.

John Geyman, M.D., is professor emeritus of family medicine at the University of Washington, author of "Health Care Wars: How Market Ideology and Corporate Power Are Killing Americans," past president of Physicians for a National Health Program (PNHP), and a member of the Institute of Medicine.

POLITICO

February 1, 2013

Secret donors back new Obamacare push

By Kenneth P. Vogel and Jennifer Haberkorn

Several former White House staffers have found a new way to promote Obamacare: They're spending millions of dollars in secret corporate and union cash, and they're harnessing grass-roots tactics to some of the biggest names in the health care industry.

Organizing for Action, the successor to President Barack Obama's presidential campaign, and Enroll America, a group led by two former Obama staffers that features several insurance company bigwigs on its board, are planning to unleash the same grass-roots mobilization and sophisticated micro-targeting tactics seen in the 2012 campaign.

Instead of getting people to vote, they're trying to get people to buy insurance.

If the coalition is successful, 30 million uninsured Americans will get health coverage and the now-unpopular law that Obama's team pushed through Congress and defended at the Supreme Court could go down in history alongside lauded national institutions such as Medicare and Social Security.

But if large numbers of younger and healthier Americans don't sign up for coverage this fall alongside the older and sicker ones, the whole thing won't work.

The challenge is real: The White House has not been able to penetrate the confusion and skepticism about the law in the nearly three years since its passage. Numerous polls have shown that people still don't know what's in the law, or how it could benefit them.

The president's allies are completely setting aside their qualms about the unlimited cash they once railed against.

So it is both fitting and ironic that — for perhaps the most significant battle in the war over Obamacare — the president's allies are completely setting aside their qualms about the unlimited cash they once railed against. They plan to use it to unleash the 20 million-address strong email list of Organizing for Action, to hire up to 100 people at Enroll America and to flood television, radio and social media with ads this fall. They even hope to go door to door, walking people through the sign-up process.

"This is going to be run like a political campaign," said Families USA Executive Director Ron Pollack, who helped conceive and fund Enroll America in 2010 and is chairman of the board.

It's clear Enroll America is a priority for Team Obama. The group received a blessing from Organizing for Action at a private gathering of Democratic donors during Inauguration weekend. Its new president, Anne Filipic, just resigned as the deputy director of the White House Office of Public Engagement, where she had worked under Organizing for Action's director Jon Carson. Its new managing director, Chris Wyant, led the ground game in Ohio for Obama's reelection campaign.

The private effort is relying on many of the tools, donors and operatives that were pivotal to Obama's reelection, but also streams of cash — including secret and corporate money — that Obama once eschewed.

"There is a long list of organizations that want to see this effort be successful, including a whole set of organizations on the progressive side, and also so many entities on the private sector side and local and community-based organizations," said Filipic.

That long list includes many of the corporate groups who would benefit from millions of people signing up for insurance. Enroll America's board includes senior officials from Blue Shield of California, Kaiser Permanente and Teva Pharmaceuticals.

Business Forward, which is run by Democratic operatives and leveraged industry support to help pass the fiscal cliff deal, is planning something similar on Obamacare, including February meetings on the West Coast between business leaders and Obama Health and Human Services officials. It also sponsored the Newseum conference where Filipic pitched Enroll to donors, and at which leaders from CAP and the Democracy Alliance appeared, along with Obama campaign manager Jim Messina and former President Bill Clinton.

But leaders of Enroll, Families USA and Business Forward say their groups will be entirely non-partisan and that they're only interested in good policy, with Filipic and Families stressing that their goal is simply to get insurance coverage to as many people as possible.

Enroll America's advisory council is a cross-section of the most influential health-related organizations, companies and unions in the country, including: AARP, Aetna, CVS Caremark, the NAACP and the Service Employees International Union.

The money push began Inauguration weekend when hundreds of Obama donors, Democratic operatives and corporate representatives gathered at Washington's Newseum for a meeting of Obama's National Finance Committee.

"There is a whole long list of fights we won in the first term that we have to implement now," Carson, OFA's director, said. "First among those is the challenge and opportunity to get 40 million Americans on health care insurance through the implementation of the Affordable Care Act."

Carson called Enroll America the "group that's going to be leading the charge on health care implementation."

Filipic, who worked on Obama's 2008 campaign and then at the Democratic National Committee, praised the assembled donors.

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It was "due to the incredible work you and many people did" that the Affordable Care Act passed, she said, adding, "Enroll America is going to be a major ACA enrollment campaign."

Filipic's appearance at the Newseum meeting seemed to be partly intended to make Obama donors comfortable giving to Enroll America, some attendees told POLITICO. The group saw its budget soar from $1 million when it was founded in 2010 to $3.9 million in 2011, according to tax filings. It would not say how much it raised last year, nor whether it planned to disclose its donors.

But it got nearly $350,000 in seed funding from the California Healthcare Foundation and United Health Foundation, according to tax filings identified by the Capital Research Center.

Families USA, which worked closely with the White House to get the health law passed, also saw its revenue increased dramatically — from $4.3 million in 2010 to $11 million in 2011, according to its tax filings — as it became clear that the fight over Obamacare wasn't dying down, but continuing in Congress and the courts, and then to the states and the regulators.

Other big money White House allies expected to play major roles in the Obamacare fight include the corporate-funded trade group Business Forward, the think tank Center for American Progress and the liberal donor network Democracy Alliance.

White House spokesman Bradley Carroll declined to comment on whether the White House was directly involved in Enroll, which has been active for a while but with a much lower profile.

"The administration is committed to helping Americans get access to affordable health care, and appreciates the experience, energy and commitment of groups like Enroll America working toward the same goal," he said.

Organizing for Action did not respond to questions about its list or relationship with Enroll America. But generally, Filipic said her group will lean on "the strength of the Obama organization" and conceded "absolutely there are comparisons there and frankly, we learned a lot of lessons about how to do it well."

Asked whether the group would be able to access Organizing for Action's vaunted email list, which POLITICO has learned includes as many as 20 million addresses, Filipic said "that would be a question for OFA more than for us."

The right isn't just ceding the battle, either. Despite spending significant resources unsuccessfully trying to kill Obamacare in Congress and then in the Supreme Court, deep-pocketed conservative groups, like the Koch brothers-backed Cato Institute, have been urging states not to implement Obamacare's health insurance exchanges and Medicaid expansions.

Adversaries have also focused on niche pieces of the legislation, notably through the dozens of suits filed against the contraception coverage requirements. Conservative think tanks and analysts pump out studies and forecasts that insurance premiums will skyrocket, making it more of an "Unaffordable Care Act." America's Health Insurance Plans, the trade group, has waged a viral campaign arguing that any increases in premiums in 2014 are the fault of the law, not the insurance industry.

But advocates say covering the uninsured will help control rising health care costs. Insured people are more likely to take care of small health problems in a doctor's office before they become big expensive ones in an emergency room. There won't be as much inefficient cost shifting to pay for the uninsured.

And once people have a "benefit," it's hard for politicians to take it away — or for Republicans to renew efforts to repeal it if they win control of the Senate or the White House.

But to get the benefit, people have to sign up.

Enroll America's strategy is to advise state leaders and target the uninsured themselves to help them navigate the new system, which includes expanded Medicaid, tax credits to subsidize insurance, and new online marketplaces called health insurance exchanges.

It plans to use micro-targeting, just like the Obama campaign did, to identify where the uninsured live, neighborhood by neighborhood. So far, its demographics data shows that the uninsured are typically young adults, male, from communities of color or low-income areas. Some have had bad experiences with insurance companies in the past, finding that the policies were too expensive or hard to understand.

Enroll has also found that the uninsured are more likely to take action if they can talk with a real person. Similar to the Obama campaign, the group hopes to work with volunteers to knock on doors and walk people through the process.

"We certainly know from recent successful electoral campaigns — but also from different successes in the private sector — that we have to really develop a granular list, in this case of the uninsured, and study what motivates them," Filipic said. "That will be an important part of the work we do."

They're dealing with a public that just doesn't really know what's in the law. Enroll America focus groups found that 78 percent of the uninsured have no idea that they could be eligible for help obtaining coverage as soon as Oct. 1 of this year.

Business Forward — which is funded by corporate members that have a major stake in implementation, including AT&T, Comcast, Dow, Ford, Google, McDonalds, Microsoft, Verizon and Walmart — intends to bring to bear the cache of the opposite end of the socio-economic spectrum.

"During the health care debate, we brought officials around the country to meet with business leaders," said Business Forward president Jim Doyle, who worked in the Clinton administration. "We're interested in doing more on implementation because a lot of the business leaders we work with are interested in it," he said, but he stressed, "We haven't spoken to Organizing for Action or Enroll America about joint programming yet. We wouldn't rule it out."

Sister Carol Keehan, president and CEO of the Catholic Health Association and a member of Enroll's board of directors, said having coverage expansion in law won't do any good if people don't sign up for it.

"We knew that enrollment was critical if we were going to help the people the act was explicitly targeted to help," said Keehan, whose organization contributed $100,000 to Enroll.

And she thinks the public will respond. "At heart, the people of this nation are kind and caring and they sympathize with people who have three children and have no insurance for them," she said.

Byron Tau contributed to this report.

Common Dreams.org
Building Progressive Community

February 28, 2013

Winning Medicare for All? 'I Like Our Chances'

By James Kahn, M.D., M.P.H.

In his recent Time magazine article, Steven Brill paints a vivid and rather depressing picture of the perverse malfunctioning of our health care system – overpriced and technology-addicted – and he acknowledges some of the advantages of Medicare.

Sadly, however, he shies away from an endorsement of the obvious solution: an improved Medicare for all, i.e. single-payer national health insurance.

I'll come back to that a little later. However, let me first say that Brill masterfully illuminates much of what's wrong with U.S. health care.

Take, for example, the "chargemaster" list: an archival, bizarrely hyper-inflated price list in each hospital based on some long-lost secret formulas and automatically inflated over time.

As a physician and health policy researcher, I've long known about the massive charges offered to non-contract payers (read: individuals not covered by a public or private insurer), charges that are completely meaningless for costing studies because they're almost never paid in full and don't represent the real resources used to provide care. However, what Brill lays out brilliantly (pun intended) is the following:

- Some very poor (lower-middle income) people actually do pay the sky-high chargemaster rates.
- There is a cottage industry (growing, I'm sure, if nothing else due to this article) to help those hapless souls negotiate steep discounts on these ridiculous bills.
- Hospital administrators either refuse to discuss the chargemaster list or offer up the most heinous, transparently nonsensical justifications for using it.
- Perhaps worst of all, the CEOs of large not-for-profit providers are paid literally millions of dollars (OK, not tens of millions like big for-profit companies, but still …), thereby introducing into a supposedly public-good-oriented setting the compensation (and marketing) tone of for-profit industry.
- When these not-for-profits list their "charity" care they value it at the price levels in the chargemaster, even though the cost to produce those services is less than 10 percent of the chargemaster price.

In these and other instances, Brill performs an outstanding public service. However, he regrettably stops short (or his editors stopped him short) of explaining why a single-payer health care system is the only effective remedy for the mess we find ourselves in today. This despite the fact that much of what he says would lead you directly to that conclusion.

He goes so far as to quote others, including John Gunn, Sloan-Kettering's chief operating officer, who says, "If you could figure out a way to pay doctors better and separately fund research … adequately, I could see where a single-payer approach would be the most logical solution. … It would certainly be a lot more efficient than hospitals like ours having hundreds of people sitting around filling out dozens of different kinds of bills for dozens of insurance companies."

Dr. James Kahn

Yet Brill characterizes single payer, the most logical solution, as "unrealistic" and fraught with the danger of government overreach and intrusion, summarily dismissing it. Need we mention insurance-company overreach and intrusion in the doctor-patient relationship? Need we note the freedom of Medicare beneficiaries to choose their own doctor and hospital, something that would also characterize a single-payer system?

Incidentally, Brill sharply undervalues the government role in paying for health care. He says that the federal government pays $800 billion per year out of our $2.8 trillion health bill, with the remainder mainly picked up by private insurers and individuals.

The $800 billion federal spending on Medicare and the federal portion of Medicaid is right. However, when you add in other federal programs, the state portion of Medicaid, other state and local programs, health insurance for government employees, and tax subsidies, the total government contribution is over 60 percent of total health spending, and rising. Our government already spends enough to pay for universal single payer!

Single-payer health reform is clearly the answer. We need to create the meme and the momentum and the aura of inevitability to do the right thing — despite the opposition of individuals and organizations with massive vested financial interests in the private health industry. They can be overcome.

Think Lincoln and the 13th amendment. As he said (or at least Daniel Day-Lewis said in the movie), regarding prospects of passing the amendment out of Congress, despite doom-saying by his advisers — "I like our chances" (slight smile).

I like our chances on single payer because it's now so obvious how irremediably broken our system is, and the house of cards will eventually fall. It's all about perseverance and timing.

James G. Kahn, M.D., M.P.H., is a professor at the Philip R. Lee Institute for Health Policy Studies, Global Health Services, and the Department of Epidemiology and Biostatistics, all at the University of California, San Francisco.

The Lund Report (Portland, Ore.) February 5, 2013

Oregon rally shows growing support for single payer

By Christopher David Gray

SALEM, Ore. – Nearly a thousand people swarmed the front of the Oregon Capitol Building for the opening session Monday, demanding that Oregon become the second state to enact single-payer health care legislation, which would set up a government financing system to pay for and provide health care coverage and access for all Oregon residents.

Protesters at the Health Care for All Oregon rally hoisted signs, listened to speeches, heard woeful tales of the current health care system, and sang along to bluesman Norman Sylvester: "I don't care what party you're in, Democrat or Republican, we don't need to fight, health care is a human right."

"The brother said we don't need a fight, but they're going to fight us," said Rep. Michael Dembrow, D-Portland, leading the crowd. Dembrow is the chief sponsor of the single-payer legislation, House Bill 1914. "We don't necessarily need to fight back, we need to organize. Let's go forward and organize this state, everybody in, nobody out."

Dembrow said HB 1914 and companion legislation in the Senate already had 19 co-sponsors, all Democrats — eight more sponsors than its predecessor from the last session, HB 3510.

One of those new sponsors, Rep. Jennifer Williamson, D-Portland, said she supported the legislation because her sister was one of the thousands of Oregonians who each year file for bankruptcy under the weight of medical bills.

"I've been a legislator for three weeks now," Williamson said. "The first bill I signed onto as chief legislator was a bill for universal health care."

Dr. Paul Gorman, a member of Physicians for a National Health Program, said he ran a free clinic where a man came in complaining of pain in his abdomen. The man had no insurance and he put off seeing a doctor for a long time, allowing his pain to get worse and worse. "By the time he came to see us, his liver cancer was advanced, and he died." Gorman said 500 Oregonians die each year because they don't have insurance.

Health Care for All Oregon argued that while the Affordable Care Act signed into law by President Obama in 2010 does improve access for some people — expanding Medicaid and offering private health insurance subsidies to others — the single-payer advocates said the reforms were inadequate and would do little to rein in skyrocketing costs.

Single-payer health care would work similar to Medicare, with a single government fund paid for through taxes rather than paying premiums to several private companies.

HB 1914 isn't expected to pass the Legislature or even come to the floor for a vote this session. But Dembrow expected to double the number of legislative sponsors and asked everyone in the crowd to lobby their representatives to support single-payer, hoping to find three more legislators by the end of the day.

The number of sponsors didn't immediately grow to the goal of 22 legislators, but Marissa Johnson, an aide for Dembrow said they hoped to exceed that goal by the end of the week.

"We have interest from more than a handful of representatives and [Dembrow] will be following up with them today," Johnson said.

Dembrow said at the rally he expected a million votes would be needed to pass a statewide measure while withstanding millions of dollars of negative advertising from groups like the for-profit private health insurance industry, which would be cut out of health care under the proposed system.

"The real work is not going to be done inside this building," he said. "It's going to be solved by a million people in Oregon, organized."

"I think it's going to take a lot of people stepping outside their comfort zones," said Rio Davidson of Newport, who volunteered at the end of the rally handing out lists of legislators and asking people to contact their representatives. "Unfortunately, a lot of people who want single-payer are working low-wage jobs."

Longtime advocate Betty Johnson said afterward that 60 organizations had been involved in the Health Care for All Oregon rally, and the group had recently hired a full-time field organizer. "Absolutely we are growing. We are organizing a number of chapters throughout the state," she said.

Gov. John Kitzhaber has not shown support for single-payer, putting his energies instead into implementing a private health insurance exchange and transforming the health care delivery system through coordinated care organizations. Despite his position, Johnson said she hoped he would meet with single-payer advocates to discuss how it could work in tandem with the CCO model.

"He's strengthening the delivery system," Johnson said. "We really want to change the financing system. When we pass single-payer, the CCO system will work alongside it."

Dembrow said there are restrictions in the federal Affordable Care Act that prevent states from passing single-payer laws without special permission before 2017. He lamented the added restriction, but said it also gave single-payer supporters three years to build support, get better organized, and develop a plan that would work for Oregon.

The state of Vermont enacted single-payer legislation in 2011 to cover all of its residents, but funding mechanisms are still being worked out and the state will also have to wait until 2017 to receive federal waivers.

Dembrow is introducing a second bill this session that would call on the Legislature to support a formal study of how single-payer would work in Oregon. Activists on Monday called on supporters to ask their legislators for public money, but Johnson said Dembrow believes the study could be paid for with private money.

The St. Louis American

December 20, 2012

Our ever-evolving health care system

By Nathaniel H. Murdock, M.D.

The great American healthcare experiment is continuing to develop. The next stage is starting, so this is a good time to look back before we look ahead.

How did our healthcare get so tied up with our employment? In World War II, to preserve funds for the war effort, the government froze wages. To compete for workers, employers began to pay for health insurance, supported with business tax deductions. This quickly became an unfettered marketplace, with virtually no regulation on price or quality.

Premiums began rising and problems emerged. Employers could no longer afford to fully cover their employees. The elderly became increasingly unable to afford medical care. Many of our parents and grandparents fell into medical poverty, and even more were simply unable to afford any care. Diseases went untreated, often with disastrous consequences.

The next experiment was proposed in the 1960s: the government would provide health care coverage, called Medicare, to all Americans beginning at age 65. No longer would our elderly need to sell their homes to scrape together the resources for life-saving medical care, living in poverty for their final years. It was a humane and compassionate solution to an unacceptable social injustice, and has saved countless millions of lives.

While the senior population immediately embraced Medicare, many medical organizations lobbied extensively against it, perceiving a threat to their autonomy.

One of the few groups that immediately took a strong leadership position in favor of Medicare was the National Medical Association (NMA). I should disclose to you that I am a past president of the NMA. We supported Medicare when it began, and continue to proudly support it today.

Although Medicare did not pay physicians well, costs continued to escalate. In response, insurance companies developed the "managed care" experiment. They promised physicians that if we discounted our fees, they would direct more of their patients toward us.

The insurance companies could not possibly deliver on this promise. Discounted fees became the new normal. As reimbursement fell, physicians began to spend less time with each patient. Patients found it increasingly difficult to find care. Medical care was arbitrarily cut to reduce costs. Managed care became rationed care, and America didn't like it.

The next major step is the Affordable Care Act, an important step forward, but much remains to be done.

When picking a doctor, we will still need to look to our insurance company to determine if that doctor is "in network." Prevention may soon be free, but treatment will continue to bankrupt many. Despite Massachusetts' health care reform, they have more citizens than ever declaring bankruptcy due to illness.

Dr. Nathaniel Murdock

Most Americans, including most doctors, now feel that a plausible strategy to achieve universal health coverage is to improve Medicare and provide it to all Americans. This is often called a "single-payer" model as the only payer of health care services would be our government, not our employers or insurance companies. Coverage would be for everyone, young and old, in sickness and in health.

Most economists tell us that this solution would actually cost less than we spend today. We'd spend more to cover today's uninsured, but we'd save even more through simplification and coordination. People could afford to go to their physician for regular maintenance and preventive care. We should be able to decrease many causes of preventable sickness and death. We would save lives.

Those who argue against a single-payer plan claim it would bankrupt the country. They're wrong; almost every industrialized country provides universal health coverage from birth to death, at a fraction of what we spend.

Insurance companies claim that single-payer will not work. I wonder if their skepticism is related to the fact that this plan would marginalize their role. We need to keep this in mind when we hear their fears. We need to remind them that most other modern countries already do this. Of course it would work; it already does.

I would like to see us have a single-payer with universal comprehensive health coverage for all Americans. This is an idea whose time has come.

Dr. Murdock is a founding member of Physicians for a National Health Program – St. Louis and past president of the National Medical Association.

Recent noteworthy letters to the editor

Los Angeles Times

How to rein in Medicare costs

By Carl Berdahl, M.D., Dec. 13, 2012

Aside from partial measures like allowing Medicare to negotiate with drug companies for lower prices, the best way to assure Medicare's fiscal stability is to improve and expand the program to cover all Americans. The resulting single-payer system would slash wasteful paperwork and bureaucracy, yielding savings of up to $400 billion annually. Furthermore, young and old alike would have a clearer stake in sustaining a single, equitable system.

With the amount our nation spends each year on healthcare, we can afford to provide universal coverage. However, we choose not to. Instead, we waste money on private health insurance companies. While Medicare allocates just a few percentage points of its revenue to overhead, private companies spend about 15% on overhead and profits.

We should expand Medicare, the nation's most efficient health insurance system, rather than cutting it.

Carl Berdahl, M.D., resides in Los Angeles.

The Washington Post

Create Medicare for all

By Harvey Fernbach, M.D., Jan. 21, 2013

Harold Meyerson ["America flunks its checkup," op-ed, Jan. 16], citing the recent report of the Institute of Medicine, provides an excellent commentary on the failings of our health-care system — failings that will, in too many cases, persist under the Affordable Care Act. While Mr. Meyerson's diagnosis of the problem hits a home run, however, his prescription for a remedy unfortunately stops at third base.

Until we establish an "improved Medicare for all" — a single-payer system that ends the flagrant waste, inefficiency and injustice associated with the private insurance industry — we won't get to home plate. As the institute's report makes plain, such systems are more equitable, economical and user-friendly for patients, practitioners and businesses than are our current arrangements, even as they deliver better medical outcomes.

In 2009, a majority of Americans told pollsters that they wanted the simplicity, portability, increased choice of doctors and peace of mind that an improved Medicare for all would bring. Why should we settle for less?

Harvey Fernbach, M.D., M.P.H., is co-director of the District of Columbia chapter of Physicians for a National Health Program. He resides in College Park, Md.

The New York Times

Profit-Driven Health Care

By Leonard Rodberg, Jan. 21, 2013

Re "Health Care and Profits, a Poor Mix," by Eduardo Porter (Economic Scene, Jan. 9):

The way we Americans provide health care is actually far worse than Mr. Porter suggests. It is not just that for-profit health insurance is more costly and less efficient than the nonprofit or government alternatives; it is inherently contradictory. The more health care the insurance companies provide — the more they respond to the needs of patients — the less profit they make. That's why they cherry-pick the healthy and avoid the sick. That's why we patients face denials and delays when we try to receive care.

The results are predictable; we have some of the worst health statistics of any advanced country. Other countries make health care a government responsibility, with the result that their people are healthier and they spend far less.

When will we learn, as your headline suggested, that health care and profits don't mix?

Leonard Rodberg is a professor and chairman of the urban studies department, Queens College, CUNY. He resides in Flushing, Queens.

Lessons from Canada's program

By Steffie Woolhandler, M.D., and David U. Himmelstein, M.D., Feb. 20, 2013

Re "Fix Medicare to save it," by Thomas M. Cassidy:

Canada's Medicare program — phased in at the same time as the American version — shows how we can make Medicare simpler and thriftier, while simultaneously upgrading its coverage. Canada's program covers all Canadians (not just the elderly) under a single public program in each province, and bans co-payments and deductibles.

Patients can choose any doctor and hospital. Cutting out private insurers and the complexity and fragmentation they impose has simplified paperwork for patients, doctors and hospitals. Administrative costs are roughly half United States levels, saving more than $1,000 per capita.

Over all, Medicare spending on the elderly has grown three times faster in the United States than in Canada since 1980, while life expectancy (for the elderly, as for all age groups) has grown faster in Canada. If American Medicare costs had risen at Canadian rates, we'd have saved more than $2 trillion by now, and Medicare's trust fund would show a healthy surplus.

The writers, internists and professors at the CUNY School of Public Health at Hunter College, co-founded Physicians for a National Health Program.

The New York Times

Free-market fantasy on health care

By Caroline Poplin, M.D., Feb. 21, 2013

Re "The Health Benefits That Cut Your Pay" (Sunday Review, Feb. 17):

With the best intentions, David Goldhill has described a free-market fantasy of health care. Market prices are based on power. In the United States today, hospitals and large doctor groups wield enormous market power, and they exercise it ruthlessly; consumers have none. Hospitals charge whatever the market will bear; uninsured patients pay the highest prices.

Large insurers bargain for "discounts" from prices set high enough so that hospitals still profit, and pass some of the "savings" on to large employers, who also have market power, but not to small businesses or individuals.

Whatever their faults, single-payer systems using government leverage, like the Canadians' — or Medicare — deliver decent quality care to more people at lower cost. Mr. Goldhill makes the best the enemy of the good.

Dr. Caroline Poplin is a primary care physician. She resides in Bethesda, Md.

The Boston Globe

Profits should not be put above patients' well-being

By J. Wesley Boyd, M.D., Feb. 10, 2013

Re "Steward is already a force for change" (Page A1, Feb. 3): Although the for-profit Steward Health Care System might be investing in repaved parking lots, nicer waiting areas in their facilities, or other renovations, nobody should discount the significant negative impact on patient well-being of cuts in nurse staffing, stifling demands on physicians to see ever-increasing numbers of patients, or disgruntled employees in general.

The fact that Cerberus, owner of Steward Health Care, has been a major owner of weapons manufacturers blatantly illustrates that it does not care about health per se but instead about generating revenue. The final sentence of the article nicely sums this up when an observer states that the goal of Steward executives "in the end … is to make money for their investors."

Practically speaking, this means whenever there is a choice that Steward needs to make between turning a profit or improving health, one can expect profit to win out every time. Most Americans believe that health care is a right, and subjecting anything that is a right to the whims of the marketplace places our humanity in jeopardy.

Dr. J. Wesley Boyd is a psychiatrist at Cambridge Health Alliance and an assistant clinical professor of psychiatry at Harvard Medical School. He resides in Needham.

CHICAGO SUN-TIMES

Why not good health care for all?

By Philip A. Verhoef, M.D., Jan. 7, 2013

I am glad that Sen. Mark Kirk has made such a successful recovery from the devastating stroke he suffered a year ago, and even more thrilled that he will be "much more focused on Medicaid and what [his] fellow citizens face." However, his experience highlights some of the flaws in our current health-care system, many of which are exacerbated by ObamaCare. First, there are multiple tiers of care in our health-care system, which may partly explain the observation that impoverished males have a life expectancy 14 years less than those of the upper socioeconomic strata; clearly, it's hard to rise out of the lower class when one is constantly having to choose between putting food on the table or paying for health care. The ObamaCare solution is to require insurers to offer various levels of insurance that may only cover 60 percent of health care costs and carry ever-higher deductibles, thus shifting the costs of health care to the people who can least afford it and perpetuating our multitiered system.

Second, as noted by the Sun-Times on Jan. 2, Sen. Kirk "incurred major out-of-pocket expenses" even though he has, arguably, the best health care insurance in the country. This means that his Cadillac insurance still provides insufficient coverage. As he alludes to, Medicaid provides vastly inadequate support for stroke rehabilitation. Further, very few medical providers accept Medicaid patients for outpatient care. Part of the ObamaCare solution is to expand Medicaid eligibility to more people, while allowing states to opt out of administration of the Medicaid expansion. The end result is that more people will have Medicaid, and they will have to shoulder more out-of-pocket expenses, like Kirk.

Why not expand and improve the Medicare system and extend it to everyone? It could be paid for by redirecting the money that we already pay for private health insurance (which costs 10-fold more to administer than Medicare).

I hope that Sen. Kirk will consider this common-sense approach to health-care reform. I know that my patients and I would really appreciate it.

Dr. Philip A. Verhoef is a physician in the adult and pediatric intensive care units at the University of Chicago.

Tips for writing letters, op-eds

You can find a list of tips on how to write an opinion piece or a letter to the editor on PNHP's website. Here's one direct pathway to the tips: http://bit.ly/UIa7ZM

The New York Times

January 8, 2013

Health Care and Profits, a Poor Mix

By Eduardo Porter

Thirty years ago, Bonnie Svarstad and Chester Bond of the School of Pharmacy at the University of Wisconsin-Madison discovered an interesting pattern in the use of sedatives at nursing homes in the south of the state.

Patients entering church-affiliated nonprofit homes were prescribed drugs roughly as often as those entering profit-making "proprietary" institutions. But patients in proprietary homes received, on average, more than four times the dose of patients at nonprofits.

Writing about his colleagues' research in his 1988 book "The Nonprofit Economy," the economist Burton Weisbrod provided a straightforward explanation: "differences in the pursuit of profit." Sedatives are cheap, Mr. Weisbrod noted. "Less expensive than, say, giving special attention to more active patients who need to be kept busy."

This behavior was hardly surprising. Hospitals run for profit are also less likely than nonprofit and government-run institutions to offer services like home health care and psychiatric emergency care, which are not as profitable as open-heart surgery.

A shareholder might even applaud the creativity with which profit-seeking institutions go about seeking profit. But the consequences of this pursuit might not be so great for other stakeholders in the system — patients, for instance. One study found that patients' mortality rates spiked when nonprofit hospitals switched to become profit-making, and their staff levels declined.

These profit-maximizing tactics point to a troubling conflict of interest that goes beyond the private delivery of health care. They raise a broader, more important question: How much should we rely on the private sector to satisfy broad social needs?

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From health to pensions to education, the United States relies on private enterprise more than pretty much every other advanced, industrial nation to provide essential social services. The government pays Medicare Advantage plans to deliver health care to aging Americans. It provides a tax break to encourage employers to cover workers under 65.

Businesses devote almost 6 percent of the nation's economic output to pay for health insurance for their employees. This amounts to nine times similar private spending on health benefits across the Organization for Economic Cooperation and Development, on average. Private plans cover more than a third of pension benefits. The average for 30 countries in the O.E.C.D. is just over one-fifth.

We let the private sector handle tasks other countries would never dream of moving outside the government's purview. Consider bail bondsmen and their rugged sidekicks, the bounty hunters.

American TV audiences may reminisce fondly about Lee Majors in "The Fall Guy" chasing bad guys in a souped-up GMC truck — a cheap way to get felons to court. People in most other nations see them as an undue commercial intrusion into the criminal justice system that discriminates against the poor.

Our reliance on private enterprise to provide the most essential services stems, in part, from a more narrow understanding of our collective responsibility to provide social goods. Private American health care has stood out for decades among industrial nations, where public universal coverage has long been considered a right of citizenship. But our faith in private solutions also draws on an ingrained belief that big government serves too many disparate objectives and must cater to too many conflicting interests to deliver services fairly and effectively.

Our trust appears undeserved, however. Our track record suggests that handing over responsibility for social goals to private enterprise is providing us with social goods of lower quality, distributed more inequitably and at a higher cost than if government delivered or paid for them directly.

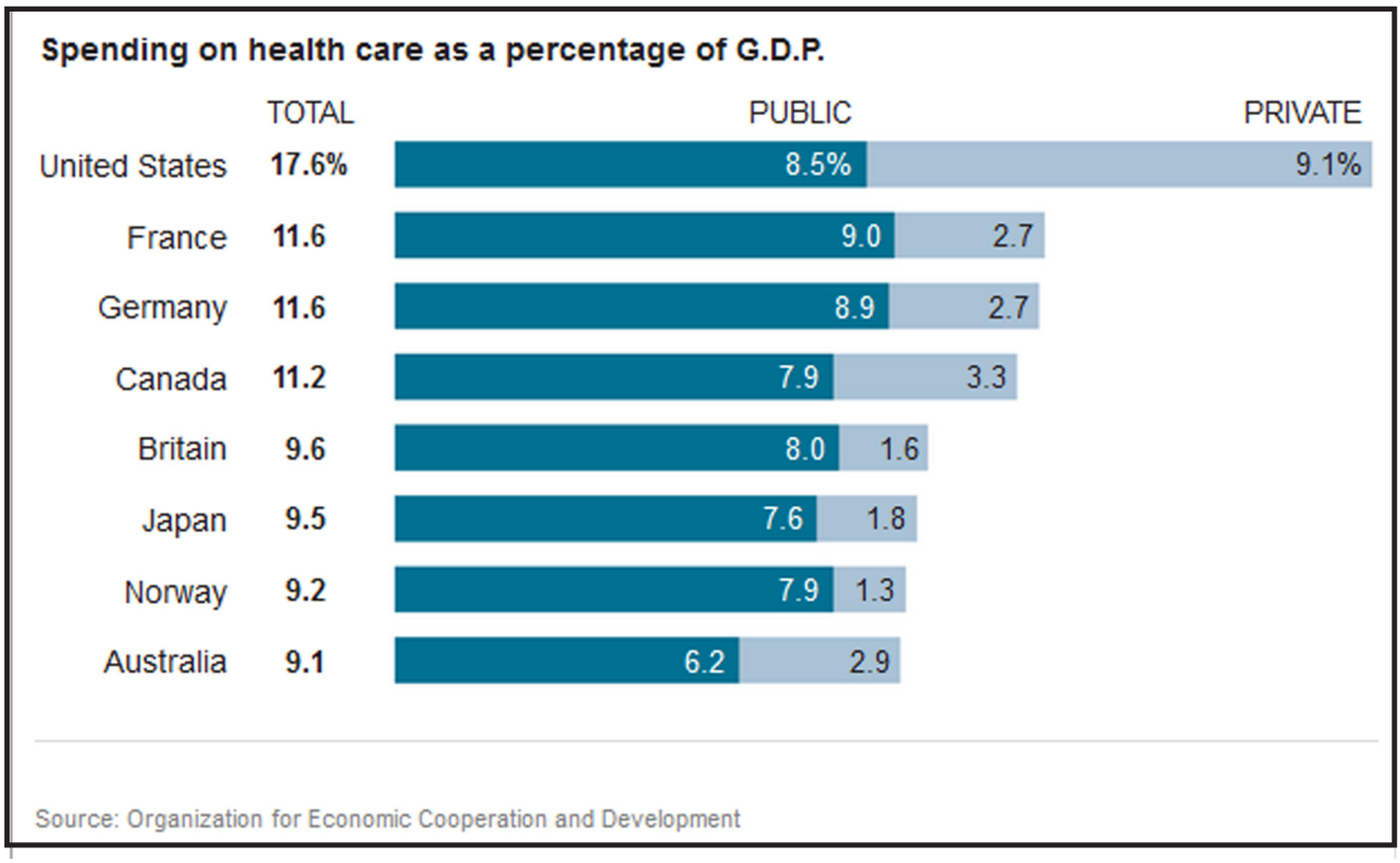
The government's most expensive housing support program — it will cost about $140 billion this year — is a tax break for individuals to buy homes on the private market.

According to the Tax Policy Center, this break will benefit only 20 percent of mostly well-to-do taxpayers, and most economists agree that it does nothing to further its purported goal of increasing homeownership. Tax breaks for private pensions also mostly benefit the wealthy. And 401(k) plans are riskier and costlier to administer than Social Security.

From the high administrative costs incurred by health insurers to screen out sick patients to the array of expensive treatments prescribed by doctors who earn more money for every treatment they provide, our private health care industry provides perhaps the clearest illustration of how the profit motive can send incentives astray.

By many objective measures, the mostly private American system delivers worse value for money than every other in the developed world. We spend nearly 18 percent of the nation's economic output on health care and still manage to leave tens of millions of Americans without adequate access to care.

Britain gets universal coverage for 10 percent of gross domestic product. Germany and France for 12 percent. What's more, our free market for health services produces no better health than



the public health care systems in other advanced nations. On some measures — infant mortality, for instance — it does much worse.

In a way, private delivery of health care misleads Americans about the financial burdens they must bear to lead an adequate existence. If they were to consider the additional private spending on health care as a form of tax — an indispensable cost to live a healthy life — the nation's tax bill would rise to about 31 percent from 25 percent of the nation's G.D.P. — much closer to the 34 percent average across the O.E.C.D.

A quarter of a century ago, a belief swept across America that we could reduce the ballooning costs of the government's health care entitlements just by handing over their management to the private sector. Private companies would have a strong incentive to identify and wipe out wasteful treatment. They could encourage healthy lifestyles among beneficiaries, lowering use of costly care. Competition for government contracts would keep the overall price down.

We now know this didn't work as advertised. Competition wasn't as robust as hoped. Health maintenance organizations didn't keep costs in check, and they spent heavily on administration and screening to enroll only the healthiest, most profitable beneficiaries.

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One study of Medicare spending found that the program saved no money by relying on H.M.O.'s. Another found that moving Medicaid recipients into H.M.O.'s increased the average cost per beneficiary by 12 percent with no improvement in the quality of care for the poor. Two years ago, President Obama's health care law cut almost $150 billion from Medicare simply by reducing payments to private plans that provide similar care to plain vanilla Medicare at a higher cost.

Today, again, entitlements are at the center of the national debate. Our elected officials are consumed by slashing a budget deficit that is expected to balloon over coming decades. With both Democrats and Republicans unwilling to raise taxes on the middle class, the discussion is quickly boiling down to how deeply entitlements must be cut.

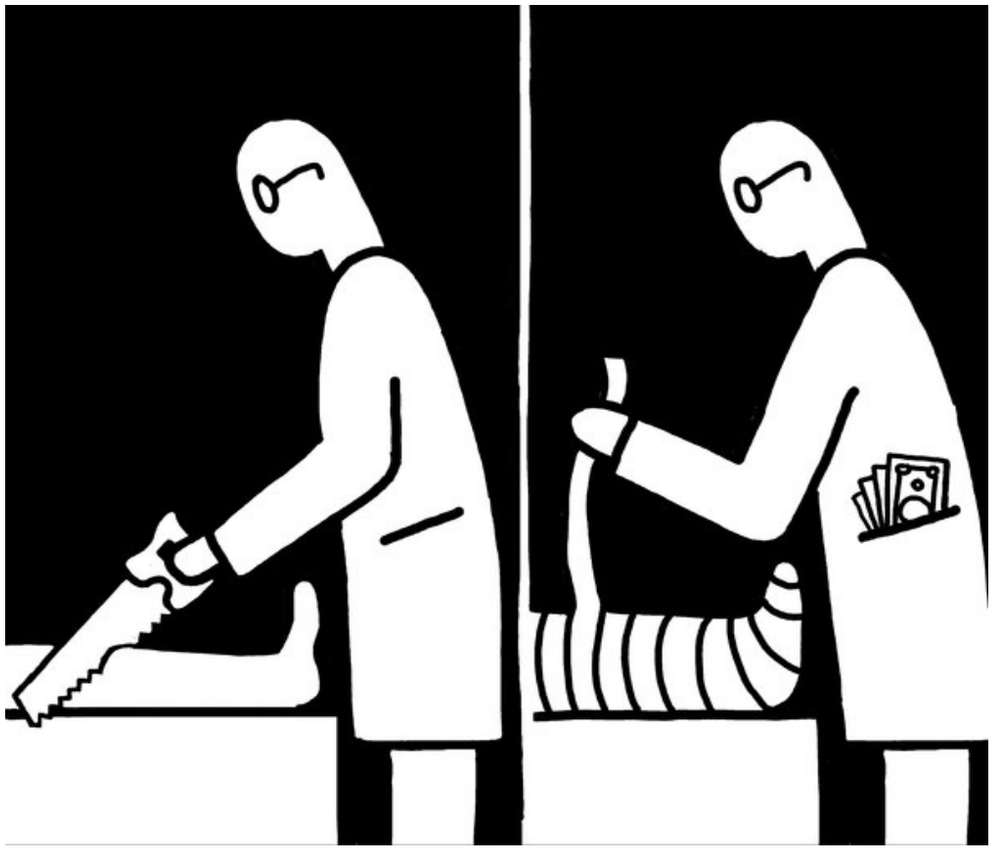
We may want to broaden the debate. The relevant question is how best we can serve our social needs at the lowest possible cost. One answer is that we have a lot of room to do better. Improving the delivery of social services like health care and pensions may be possible without increasing the burden on American families, simply by removing the profit motive from the equation.

The New York Times

January 27, 2013

Carrots for Doctors

By Bill Keller



Nicholas Blechman

With its ambitious proposal to pay doctors in public hospitals based on the quality of their work — not the number of tests they order, pills they prescribe or procedures they perform — New York City has hopped aboard the biggest bandwagon in health care. Pay for performance, or P4P in the jargon, is embraced by right and left. It has long been the favorite egghead prescription for our absurdly overpriced, underperforming health care system. The logic seems unassailable: Reward quality, and you will get quality. Stop rewarding waste, and you will get less waste. QED! P4P!

If only it worked.

For if you spend a little time with the P4P skeptics — a data-bearing minority among physicians and health economists — you will come away full of doubts. In practice, pay for performance does little to improve outcomes or to control costs. But if you look hard enough at why this common-sense approach doesn't deliver, you find some clues to what might.

The New York plan would give hospitals bonuses to distribute to their doctors based on such indicators as patient satisfaction, speeding the flow of cases through the system and administering specific therapies. It is an attempt to get ahead of the federal law we all know as Obamacare, which includes rewards for hospitals that peg pay to a list of quality metrics. I've said before that I consider Obamacare an important leap forward, mainly for extending the basic safety net to millions of Americans. And there are aspects of the law, notably the Medicare Independent Payment Advisory Board, that may help bring down costs, if Congress can resist the temptation to interfere. But the pay-for-performance provisions are a triumph of theory over experience.

The first problem with P4P is that it does not address the biggest problem. Americans spend more than twice as much per capita as other developed countries on health care — a crippling 18 percent of the country's economic output, and growing. Before studying the statistics, I assumed the root of the problem was doctors who, paid piecemeal for the services they provide, load up patients with marginal tests and treatments. In fact, America's health care system is not much different from other developed countries in the volume of service. Our doctors prescribe more or less the same number of pills and X-rays, perform similar numbers of blood tests and surgeries, as doctors in the best European countries. While there are undoubtedly savings to be had by cutting unnecessary services (shortening hospital stays, for example), the main problem is that our system charges far more for each service — each office visit, each hip replacement, each day in a hospital bed, each dose of antibiotic. "The facile explanation is that doctors do too much," said Peter Bach, a doctor at Memorial Sloan-Kettering who studies quality of cancer care. "But if you compare us to

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other countries on volume, we're not leading in any category. The flip side is, we pay double for a lot of stuff." (Actually, we lead in tonsillectomies and knee replacements, but his point is generally right.)

Doctors cite a number of reasons our medical treatments cost more — the high price of malpractice insurance being a favorite, and genuine, culprit. But the main reason everything costs less in other countries is that other countries tend to have one big payer — usually the government — with the clout to bargain down prices. A single-payer system has, so far, proven politically unpalatable in this country. And even Medicare, which has the power of scale and uses it to drive down prices, wields its power sparingly, because doctors threaten to stop serving Medicare patients if the reimbursements fall too low. As hospitals merge into mightier megachains, they may be able to bargain down the payments to doctors and drug companies and device-makers, and create economies of scale by standardizing treatments. (The physician and New Yorker writer Atul Gawande proposed in a provocative August article that hospitals could drastically improve productivity by studying the example of restaurant chains like the Cheesecake Factory.) But that's not what P4P is about.

Instead of leverage, P4P employs incentives. Reduce the length of stay for acute-care patients, cut the rate of readmission for pneumonia cases, make sure heart-attack victims get a talk about diet before they are discharged, and you stand to find a little windfall in your paycheck.

Critics, who have evidence from a host of pilot programs, say that the bonuses are typically too small to change behavior; New York's would be a maximum of 2.5 percent of a doctor's salary, and most P4P programs pay less than that. Often the performance indicators measure things that are not within the doctor's control. Luis Marcos, a former president of the agency that runs New York's public hospitals, plucked several examples from the list of 13 metrics proposed for New York. Reducing waits in the emergency room (No. 4) is a worthy goal, he said, but it depends on a whole cast of people, from the clerk who greets the patient to the orderly who makes the bed ready. Shortening hospital stays (No. 13) requires having someone in the community — family, a social worker — to receive the patient; that's an especially hard requirement for hospitals that treat a lot of low-income or homeless people.

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Another problem with P4P is that providers learn how to manipulate the results. "Once you define performance, people manage toward those metrics and neglect other things that don't get counted," said the Princeton health economist Uwe Reinhardt, who writes for The Times's Economix blog. New York doctors have a favorite, possibly apocryphal, story of medical providers gaming the system: Miami hospitals that use patient feedback as a performance measure wait until spring to do their surveys, because that's when the cranky, hard-to-please New Yorkers go home from their winter refuge.

Ashish Jha, a doctor at the Harvard School of Public Health, argues that P4P might get results if the incentive payments to hospitals were substantially bigger, the formulas were simplified and the performance indicators were kept to a few, clear measures that doctors and patients agree matter: mortality rates, infection rates, recurrence of heart attacks. "If hospitals achieve great outcomes, it matters little how they did so," Jha wrote in the latest Journal of the American Medical Association. And death rates are harder to game than administrative procedures.

Jha also proposes a little experiment in behavioral psychology: give hospitals 100 percent of the bonus at the beginning of the year, but require them to send a refund at the end of the year to pay for any shortcomings. Givebacks really focus the mind.

Peter Pronovost, a physician and professor at Johns Hopkins, says that rather than bribe doctors to adopt better practices, we should play to doctors' professionalism. Pronovost is famous for a scheme that drastically reduced infections associated with catheters by disseminating to doctors and nurses a simple, five-point operating-room checklist of reminders: Wash your hands, wear a sterile mask, etc. No pay incentives were involved, just an appeal to professional pride — and, later, public reporting of the results. "I wouldn't rule out economic incentives," Pronovost told me. "But you can do a lot just working with professional norms."

Pronovost has a more radical piece of common sense to offer. He proposes that the United States create an agency that would do for medicine what the Securities and Exchange Commission does for securities markets: compile and audit information about the performance of hospitals, and make it public. Rankings of hospitals now come either from news organizations or consumer groups working with untested and inconsistent data, or they are propaganda produced by medical providers themselves. "There are stronger regulations about what a company can say about toothpaste than what a hospital can claim about quality," Pronovost said.

For image-conscious doctors and hospitals, pride and shame might be the most effective kind of carrots and sticks.

Bill Keller is an op-ed columnist for The New York Times and writes for The New York Times Magazine.

Managed cost, mismanaged care

By Meade Klingensmith

Dr. Molly Droge is the chair of the subcommittee on access to care at the American Academy of Pediatrics. Growing up in West Texas, she lived next door to an old general practice doctor. She didn't know him well, but, as she told Remapping Debate, "I did know his reputation in the town, and I knew what his patients thought of him." He was known for doing everything he could to help his patients, and would often do it without any payment at all. "He got a bowl of tomatoes in the summer, or he got two chickens for whatever care that he had provided someone," Dr. Droge said. "There was a trust there. And that's the way I thought doctors acted."

When Dr. Droge entered pediatric practice in the early 1980s, she joined a managed care organization in Dallas run by Cigna HealthCare and was surprised at how different it was from what she had imagined medicine to be. She found the managed care organization was "all about maximizing profit." She had difficulty getting necessary referrals for patients. She was forced to try several different medications on patients before she would be allowed to administer the one she knew to be best from the outset, because the best medication wasn't part of Cigna HealthCare's list of approved drugs. "Physicians really had to work to make sure that our patients got the care that they needed. It was not a given," she said.

Dr. Droge's story is hardly unique. On the contrary, from interviews with health care experts and doctors, as well as in Remapping Debate's own research into the history of managed care, it appears that the defining feature of the managed care era is a profound rhetorical and practical shift — politically and among health care advocates, observers, providers, and insurers — away from a focus on quality of care and towards an obsession with cost control.

How did this happen? Health care experts suggested the existence of two powerful forces working in tandem. First was the birth and development of the market-based, for-profit health insurance industry, built on the back of what was once a progressive model for how to maximize quality of care: the prepaid group practice, which was later adapted into "managed care." Second was the spread of an ideology that subordinated quality concerns to cost control while asserting that both could be achieved — an ideology that held particular sway among the New Democrats of the 1990s.

Tracing these two forces requires starting at the origins of managed care: the prepaid group practices that appeared on the West Coast of the United States as early as 1929.

Origins of managed care

The prepaid group practice originated as an attempt to meet comprehensively the health care needs of specific defined communities. The first such practice, the Ross-Loos Medical Group, was created in 1929 by two doctors to care for employees of the Los Angeles Department of Water and Power. Kaiser Permanente, the most famous of the early prepaid group practices and the one most responsible for bringing the model to national attention, was founded by Henry Kaiser during World War II as a medical program for employees of his shipyards and steel mills. Kaiser opened the plan to the public after the war.

Members of these practices would pay an upfront monthly subscription fee, and in return would have all of their health

Cost control uber alles

This is the first in a series of articles (PNHP Note: The second appears on page 34) examining the phenomenon by which health care policy has come to be dominated by a single-minded desire for cost control, while concerns about maximizing the quality of care have been downgraded or ignored entirely.

Our research and reporting identifies three ideological underpinnings for this shift: (1) the selling of the idea that a competitive "free market" environment could work in the context of the provision of health care and health insurance; (2) the promise that the interests of a for-profit industry were aligned with the interests of citizens who needed health care; and (3) the assumption that rising costs had to be constrained by reducing health care usage — an assumption made without asking the questions, "What is the highest standard of care that we can achieve?" "How far below that standard are we, and for how many?" "What would such a system cost?" or "How can we minimize the extent of deviation from the highest standard of care if we as a society decide that we prefer to have some of our fellow citizens go without that highest standard of care?"

This article describes the origins of the Health Maintenance Organization (HMO) model, the modern incarnation of that model, and the evolution of HMOs to the vehicles through which a for-profit health insurance industry came to dominate the market by the 1990s.

The next article (pg. 34) in the series will examine the crucial role that Clinton-era "New Democrats" played in promoting the view that the principal problem to be addressed was cost control, and that the best and only solution to providing health care was through a for-profit, market-based system of insurance (albeit a regulated one), not a single-payer or not-for-profit HMO model.

— Editor

care needs met. The practices were generally physician-led and multispecialty, with the intent of fostering collaboration among doctors and providing all health services under one roof — a plausible prospect for a relatively small practice in an era before the growth of advanced medical technology and countless specialties and sub-specialties. Physicians in such practices were often paid on salary rather than for services rendered.

According to a paper published by the Tufts Managed Care Institute in 1998, the premiums for prepaid group practices "were as expensive or more expensive than other insurance, but their coverage and benefits were superior, including a major emphasis on preventive care, outpatient care, well-child care services, immunizations, and other services not covered by [others]."

Dr. David Himmelstein, a professor of public health at the City University of New York School of Public Health at Hunter College, a visiting professor at Harvard Medical School, and a co-founder of Physicians for a National Health Program (PNHP), sees these early plans as motivated by the desire to find a new model for providing better care: "The prepaid-group-practice era was characterized by a great deal of altruism and [the] conviction[s] that organized prepaid group practice was a better way to care for people and that you could do more for them."

"Shouldn't we as a society embrace useful technologies, even if they increase medical costs? "Yeah, that's called health care," David Himmelstein replied. "Almost everything we do, it's cheaper to just not bother doing it, but we do it because we think there's a point in trying to help keep people alive and make them feel better."

Dr. Ida Hellander, the director of policy and programs at PNHP, agrees. Cost control "was not the primary motivation," she said. "The primary motivation was to find a better way of practicing medicine."

Dr. Georges Benjamin, executive director of the American Public Health Association, added, "It was very much about care over cost." And Dr. Marc Bard, co-director and physician leader at the Tufts Health Care Institute, said prepaid group practices were "deeply committed to an egalitarian model…The whole idea was that the care provided should be based on the care needed, not on anything else."

Dr. Jim Scott, president-elect and vice president of internal affairs at the National Physicians Alliance, a multi-specialty medical trade association, noted the practices were seen as radically progressive, but they proved a remarkable success. "They were vilified as socialist or communist organizations, but in fact they delivered demonstrably superior care at a higher value. In other words, good care at a reasonable cost."

Despite their reputation as radical outfits and their consequent demonization by the American Medical Association and others, the success of the prepaid group practices ultimately caught the eye of some who felt that, with a little tweaking, they could become the key to a revolution in American medicine. Chief among them was Paul Ellwood, a pediatric neurologist who was discontented with the American medical system.

Managed care as public policy: the theoretical origins

In 1971, Ellwood published an article titled "Health Maintenance Strategy" in the journal Medical Care. The article coined the phrase "Health Maintenance Organization," or HMO, to describe the types of organizations pioneered by Henry Kaiser and his contemporaries. It proposed a national strategy of incentivizing the creation and growth of HMOs with federal funds and eliminating any legal barriers to their proliferation.

Ellwood positioned his strategy as a response to the lack of regulation in the American health care system. "Since payment is based upon the number of physician contacts and hospital days used," he wrote in the article, "the greater the number of contacts and days, the greater the reward to the provider. The consumer, unable to judge his own treatment needs, pays for whatever he is told he needs." To Ellwood, this lack of regulation meant health care provision "works against the consumer's interest" and that though care is generally good, "no matter how hard each provider works, services are not available to everyone who needs them."

Ellwood believed effective government regulation of the health care system was not an option: "Regulation of such scope and complexity would be difficult even in industries which produce easily identifiable goods. It is virtually impossible to do so in a service industry in which professional judgment is required on the level of individual nurses or doctors dealing with individual patients." The only choice, as he saw it, was to force the industry to self-regulate, and the only way to achieve that was to create a system of competitive market mechanisms in which HMOs, which he felt were "capable of producing services more economically and effectively than conventional providers by integrating and coordinating the many elements of health care," would compete with one another over cost and quality.

David Himmelstein said the HMO strategy was from the outset intended to create a for-profit health insurance industry dominated by large conglomerates. "The strategy can only be participated in by an organization that includes a large number of primary care doctors, a large number of specialists, and a hospital offering a full range of services," he said. He estimated that such an organization requires a population base of at least 300,000 to 400,000 people. "Half of the country lives in regions without the population density to support more than one such organization. So what [Ellwood] was really saying was, we're going to have health care delivered by very large-scale organizations and managed like a business."

Indeed, Ellwood hoped his strategy would create a free market health care economy which "could stimulate a course of change in the health industry that would have some of the classical aspects of the Industrial Revolution — conversion to larger units of production, technological innovation, division of labor, substitution of capital for labor, vigorous competition, and profitability as the mandatory condition of survival."

(continued on next page)

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Himmelstein believes the Ellwood article was a major turning point in transforming the American health care field from a not-for-profit system into a for-profit industry. Ellwood, he said, was the first person to make the argument that the provision of health insurance, and hence the provision of health care could have the characteristics of industrial production. "Before that there were really professional incentives — 'we can do better, organizing ourselves in a better way.'" Ellwood's argument laid the theoretical groundwork for corporate interests to begin a relentless scramble for profit, but it took an act of public policy to fully open the door.

Managed care as public policy: the political origins

According to Theodore Marmor, a professor emeritus of both political science and public policy and management at the Yale School of Management and the co-author of "Politics, Health, and Health Care," Ellwood's ideas caught the eye of a group of what Marmor called "liberal Republicans from California" in the Nixon Administration. They included Robert Finch, the secretary of Health, Education and Welfare (HEW) and later a private counselor to the president, and Lewis Butler, an assistant secretary at HEW. They encouraged President Nixon to use Ellwood's ideas as the model for a reform proposal, and on February 18, 1971, Nixon announced a new national health strategy centered on HMOs.

Nixon's motives for embracing Ellwood's strategy are not entirely clear. Marmor believes he was looking for "a model of cost containment" in response to the increased rate of health care inflation, which at that point was just beginning to outpace the overall rate of inflation. Himmelstein suspects it was in part a defensive measure designed to neutralize the threat to business interests posed by Senator Ted Kennedy's single-payer national health insurance bill. (See box titled, "Democrats fight for single payer.")

John Ehrlichman: for-profit HMOs can thrive because "all the incentives are toward less medical care, because the less care they give them, the more money they make." Richard Nixon: "Well, that appeals to me…Not bad."

"They had to respond with something," Himmelstein said, "and there was a rising tide of calls for something that would negatively affect the corporate interest in health care," by which Himmelstein meant a national health program. As evidence, Himmelstein pointed to President Nixon's announcement of his adoption of the HMO strategy. In that statement, Nixon said, "The purpose of this program is simply this: I want America to have the finest health care in the world — and I want every American to be able to have that care when he needs it." This adoption of the language of universal coverage, Himmelstein said, was "a direct response to Kennedy. And that's pretty clearly what was the motivation for Nixon, at that moment, to jump in with that initiative."

Nixon's true motives, however, might best be revealed by his infamous White House tapes. A recording from February 17, 1971 captured a conversation between President Nixon and John Ehrlichman, the president's chief domestic advisor. On the tape, which has been transcribed by the Presidential Recordings Program at the University of Virginia, Ehrlichman brought up the idea of incentivizing the creation of HMOs as a model for reform. Nixon was initially hesitant ("You know I'm not too keen on any of these damn medical programs"), but Ehrlichman argued, "This is a private enterprise one…Edgar Kaiser is running his Permanente deal for profit, and the reason that he can do it… All the incentives are toward less medical care, because the less care they give them, the more money they make." Nixon's response: "Well, that appeals to me…Not bad." He announced his HMO plan the next day.

Over the next two years, congress developed a bill based on Ellwood's model of reform. The final legislation, the HMO Act of 1973, was a compromise between the bill that emerged from the House of Representatives, which was sponsored by Congressman Paul Rogers and aligned fairly closely with President Nixon's proposal, and the Senate version of the bill, sponsored by Senator Ted Kennedy. Both men were Democrats.

Democrats fight for single payer

The traditional Democratic stance on health care reform was to create a national single-payer health system. The closest that effort came to success, and the measure that some believe Nixon attempted to neutralize by adopting Ellwood's HMO strategy, was the Kennedy-Griffiths Health Security Act, proposed in 1970 by Senator Ted Kennedy and Congresswoman Martha Griffiths, both Democrats. The act would have insured all Americans under a federal single-payer health plan, to be financed through payroll taxes.

Kennedy described the goal of the program as follows: "The program calls on the federal government to make sure that every American can pay for health care, that every American has good health care offered to him in ways suited to his needs, and that enough providers, facilities, and equipment are available to do the job."

Congressman John Sieberling, a freshman member of the House of Representatives at the time and another Democrat, co-sponsored the bill. He later described its failure: "The bill had a formidable set of opponents, including not only the insurance industry, but also the health care provider 'industry' — doctors, hospitals, pharmaceutical manufacturers, and their respective trade associations. Some labor organizations and a few employers favored it, but the voting public was largely apathetic. Faced with powerful opposition and lacking any strong public pressure or presidential leadership, Congress, as might be expected, took no action."

After the bill's defeat, Senator Kennedy largely gave up on a complete overhaul of the U.S. health care system. Instead, he attempted to find ways to modify the existing system in order to provide higher quality health care to more Americans. His first effort was to try to incorporate patient-protective provisions into the HMO Act of 1973.

The Health Maintenance Organization Act of 1973

The HMO Act of 1973 appropriated $375 million (more than $1.9 billion in today's dollars) in grants and contracts to federally qualified HMOs for a five-year period, established guidelines for what constituted a federally qualified HMO, superseded "restrictive" state laws that "impede[d] the development of HMOs," required employers of 25 or more workers who received health insurance benefits to give their employees an HMO option if there was an HMO in the area (the "dual choice" requirement), and empowered the secretary of HEW to regulate HMOs receiving financial assistance under the act. In other words, it offered federal money (and the prospect of new enrollees) to HMOs that were willing to abide by a relatively strict set of rules (HMOs not getting federal funding could ignore the rules).

In addition, the bill included provisions added by Senator Kennedy that were intended to ensure that HMOs would be a vehicle for maximizing the quality of health care and providing it to those who were currently uninsured.

These provisions included an open-enrollment rule that required federally qualified HMOs to accept any person who applied, regardless of medical history, and a community-rating rule that required HMOs to charge all subscribers the same premium, regardless of their history of using services.

According to Theodore Marmor, "The HMO Act of 1973 set in motion the developments that emerged in the '90s" — referring to the for-profit, conglomerate model that came to dominate U.S. health care in that period.

Dr. Philip Caper, a member of Senator Kennedy's staff, told The New York Times in 1975 that the motivation behind Kennedy's additions was to "get away from the antisocial practices in health insurance…The private sector has not assumed their social responsibility. They are in it to make money. The government should get involved to do what private industry has not done." That is, provide the highest possible quality care at an affordable price.

According to Theodore Marmor, "The HMO Act of 1973 set in motion the developments that emerged in the '90s" — referring to the for-profit, conglomerate model that came to dominate U.S. health care in that period.

Loosened restrictions

In attempting to balance the ideology of cost-control and market competition (promoted by President Nixon and other Republicans), with that of maximizing health care quality and access (promoted by Sen. Kennedy and his allies), the final bill that emerged was unable to fully realize either set of goals. Both parties were unsatisfied, but the GOP's initial view came to have more and more sway. Over the next two decades, a series of amendments loosened the restrictions of the bill, effectively gutting the Kennedy provisions. These amendments were signed into law by President Ford in 1976 and by President Reagan in 1988. (They stripped, among other things, the requirement that federally qualified HMOs cover "supplemental benefits," including long-term care facilities, vision, dental, drugs, and rehabilitative services.) In addition, President Carter signed a bill in 1978 extending grant funding for HMOs, as the original five-year allotment was set to expire.

The burgeoning for-profit health insurance industry was, unsurprisingly, the loudest voice in favor of amending the HMO Act. A large group of health insurers created a lobbying outfit called the Consensus Group, which argued the law was too stringent to allow federally qualified HMOs to compete with those who chose to simply bypass the federal seal of approval (and the grants that went with it). To them, the HMO Act "require[d] HMOs to be better, more humane and more generous than the entire health and delivery system of which they are a part" (criticizing, in other words, the precise point of Senator Kennedy's additions to the bill).

Himmelstein contends that corporate interests — and their allies in government — were not merely responding to cost pressure, but exploited the trend toward cost concerns as an opportunity for an "offensive measure." They used the rising cost pressures of health care as a "crowbar," he said, in order to advance their own agenda: the transformation of health insurance into a for-profit industry.

Over the course of the 1970s and 1980s, the federal government continued to actively promote HMOs as a cost-saving mechanism. The most notable example of this effort came from the Carter Administration. Secretary Joseph A. Califano Jr., President Carter's secretary of HEW, held a marketing blitz to encourage the private sector to invest in HMOs. He held a conference on May 10, 1978, in which HEW staff, health insurance insiders, and pro-HMO business leaders addressed representatives of more than 600 corporations on why they should move toward HMOs as the primary mode of providing health care to their employees. An article in The Washington Post described Califano's goal as being "to help reduce health care costs by supporting potentially money-saving health maintenance organizations." According to the article, Paul Parker, the executive vice president of General Mills at the time, told the conference how the HMO his company sponsored "reduced health care costs by drastically cutting hospitalization."

Due in part to the efforts of the federal government, HMO enrollment steadily climbed throughout this period, though HMO enrollees remained overall a small portion of the American population. In 1970, 3 million Americans were enrolled in HMOs; that number climbed to 10 million in 1980 and to 32 million in 1990. The business model of HMOs was changing, too. According to data from the Kaiser Family Foundation, 88 percent of HMOs were not-for-profits in 1981. By 1993, only 48 percent of HMOs were not-for-profits.

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The overall health insurance industry, however, was still predominated by traditional fee-for-service insurers. In 1988, the earliest year that such data is available, 73 percent of American workers with health insurance had a traditional fee-for-service plan, with the remaining 27 percent in some form of managed care.

Those figures were soon to reverse at an astonishing speed — a process that was driven by the proliferation of other forms of managed care, most notably Preferred Provider Organizations (PPOs) and Point of Service (POS) plans.

These were variations on the basic principles of HMOs: capitation (in which physicians are paid a set amount for each patient per period of time, regardless of the services rendered), gatekeeper physicians (a primary care physician assigned to a patient who must approve all referrals to specialists for those services to be covered by insurance), and networked doctors (doctors who contract with the same insurance plan; depending on the type of managed care plan, doctors outside that network might be more expensive for patients, or might not be covered by insurance at all). They offered some greater flexibility than the "pure" HMOs that had sprouted in the 1970s and 1980s, but retained the underlying principle: to control cost and make a profit.

The managed care explosion of the 1990s

By 1993, managed care had become the primary form of health coverage in America. 46 percent of workers had a fee-for-service plan, with 54 percent in managed care. In 1996, only 27 percent were left in fee-for-service; in 1999, only 10 percent.

What caused the enrollment explosion? According to Dr. Himmelstein, one major factor in this was the concern among corporations that health care costs were growing too quickly. "There was a perception and a reality that costs were an issue," he said. "They were an issue for the first time for corporate purchasers of care. It wasn't just out-of-pocket costs that were going up, but you had the auto industry for instance beginning to say, 'We can't afford these [rising health insurance costs].' In the '90s that was certainly a major push."

Dr. Jim Scott agreed: "If you're an employer, it wasn't such a big deal when it was a fairly small increase [as it was throughout the 1970s], but then it compounded over the years. That's why by the late '80s and early '90s, [employers] were going 'whoa, we can't afford this continued rate of inflation.'" (See box titled, "The root of rising health care costs.")

While noting the reality of rising health care costs, Himmelstein said the important question is "how you respond to those cost pressures." Many employers saw managed care as the solution, and were undoubtedly helped to this belief by the efforts of the federal government over the previous two decades.

According to data from the Kaiser Family Foundation, 88 percent of HMOs were not-for-profits in 1981. By 1993, only 48 percent of HMOs were not-for-profits.

Himmelstein contends that corporate interests — and their allies in government — were not merely responding to cost pressure, but exploited the trend toward cost concerns as an opportunity for an "offensive measure." They used the rising cost pressures of health care as a "crowbar," he said, in order to advance their own agenda: the transformation of health insurance into a for-profit industry, with the spread of managed care plans as the primary instrument. In the 1990s, they found a partner in the New Democrats.

Coming next week: the New Democrats, proselytizing in favor of market solutions, subordinate concerns about quality of care to an all-consuming desire to control costs and ignore what some say was a patently obvious conflict between the interests of for-profit insurers and those of the patients that the insurers were being relied on to serve.

The root of rising health care costs

The advancement of medical technology is often cited as one root cause of health care inflation. Theodore Marmor, from the Yale School of Management, however, believes that argument is "just nonsense. Of course [technology] has played some role," he said, but "what explains the distinctive American failure to keep expenditures under reasonable control is that we pay more for most of the things that everybody else pays less for." And what is behind that phenomenon? "We have no countervailing organized power to deal with the understandable and predictable pressures on medical expenditures." In other words, no national health care system.

As for the role technological advancement does play in the rising cost of health care, according to Dr. David Himmelstein, a professor of public health and a co-founder of Physicians for a National Health Program, "The incentives in the current system are very strongly to introduce new technologies whether they improve care or not, and particularly expensive new technologies." He cited the constant introduction into the marketplace of new artificial hips and knees, "many of which it turns out are terrible."

There are, of course, technologies that genuinely improve the quality of medical care. Shouldn't we as a society embrace such technologies, even if they increase medical costs? "Yeah, that's called health care," Himmelstein replied. "Almost everything we do, it's cheaper to just not bother doing it, but we do it because we think there's a point in trying to help keep people alive and make them feel better."

The role of the New Democrats in the explosion of managed care

By Meade Klingensmith

The "New Democrats" of the 1990s — those who thought the Democratic Party should move further to the right and position itself as a "centrist" alternative to the GOP — promoted a model of health care reform called "managed competition." Fundamental premises behind the strategy — such as the idea that the interests of insurers would be aligned with the interests of those needing a doctor and that Americans, if anything, were getting too much medical care — were much more faith-based than evidence-based. And some of the negative consequences of the greater reliance on "managed care" created a short-term backlash. Nevertheless, the assumptions and rhetoric of the New Democrats live on, embedded in the architecture of the Affordable Care Act (ACA) and in the rhetoric of a wide range of politicians and journalists, as well as many of the experts who study the health care industry.

Will Marshall was a co-founder of the Democratic Leadership Committee (DLC), for more than two decades the heart of the New Democrats (the DLC shut its doors in 2011). He was also the founder and is still the president of the Progressive Policy Institute (PPI), the organization that provided the blueprints for many of the policies advocated by the DLC.

In an interview with Remapping Debate, Marshall described managed competition as "a system of private provision, competing health care providers who are under the supervision of public law and regulation that protects patients." The idea, he said, was to create marketplaces in which health insurers sold their products, either to companies or directly to enrollees. (In the 1990s, these marketplaces were called "purchasing alliances"; in 2010, they were later incorporated into the ACA as "exchanges.")

The marketplaces would be the only way to purchase health insurance in the United States, and all products sold within them would be required to meet certain standards of coverage. Under the Clinton plan, every employer in the U.S. would have been required to provide health insurance to its employees. And, crucially, managed competition models in general assumed that for-profit managed care organizations would become the dominant actors in the system, as their lower cost would naturally attract purchasers.

Theoretically, adoption of the model would achieve three things: (1) it would control health care costs by guiding patients into managed care organizations, forcing insurers to directly compete over customers, and enabling mass-scale group purchasing; (2) it would ensure universal coverage; and (3) it would do these things through regulated market mechanisms rather than a national health program, thereby appealing to what Marshall views as "the American economic and cultural outlook."

Aligning incentives?

A central claim of managed care is that it aligns the incentives of health care providers with those of their patients. In the original formulation by Paul Ellwood (the "father" of managed care), found in his 1971 article for the journal Medical Care, the argument went as follows: "Since the economic incentives of the contracting parties [provider and patient] are identical [to keep the patient healthy], both would have an interest in maintaining health."

"The incentive … is to recruit the healthiest patients you can, to make them look on paper as sick as you can, and to avoid giving them care as much as you can." Or, more simply, "If you deliver less care, you profit. If you deliver more care, you lose."

- Dr. David Himmelstein

Remapping Debate asked Marshall whether, even if managed competition and managed care could control costs and provide some form of universal coverage, it would do so by denying medical services to patients who need them. Marshall insisted managed care would theoretically not deny useful procedures. Its goal, he said, was to "eliminate unnecessary procedures, root out waste, and, when it's done right, try to bring together specialists and general practitioners to take a holistic approach to the health care of the patient, rather than parceling them out by body part or disease and never communicating with each other."

When asked whether PPI ever worried about the potential for managed care to deny necessary services, Marshall said it did. "If you can get away with dropping coverage and denying services," he said, "some actors will do that, and did." Then why would a for-profit managed care organization ever prioritize quality of care over making a profit? "The customers leave," Marshall responded. "We have exit … I remember being in several HMOs that I didn't like, and I left them and got into something that I thought was better care for me. Choice and exit are powerful forces."

According to Dr. David Himmelstein, a professor of public health at the City University of New York School of Public Health at Hunter College and a co-founder of Physicians for a National Health Program (PNHP), however, the argument does not stand up. Because managed care is a profit-driven enterprise, he said, "The incentive … is to recruit the healthiest patients you can, to make them look on paper as sick as you can,

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and to avoid giving them care as much as you can." Or, more simply, "If you deliver less care, you profit. If you deliver more care, you lose."

Dr. Jim Scott, president-elect and vice president of internal affairs at the National Physicians Alliance, a physician advocacy organization, agreed. He told Remapping Debate that from the perspective of a for-profit managed care organization (as opposed to the doctors who work there), "what you want to do is manage the population. You want to have the healthiest population you can, deny the most care you can, and get away with it. That's about managing cost. That has nothing to do with managing care." Calling such organizations "managed care," he said, is "a lie."

Remapping Debate pointed out to Marshall that most people in the United States receive health insurance through their employers, whose incentive is to control their own costs. How were those employees supposed to "exit"? "That constrains choice," he said. "We're not dealing with a perfect marketplace here. It's got all kinds of peculiarities. And most people can't afford to forgo the group purchasing functions of their employers."

Where then, were they supposed to go? At that point in the interview, Marshall acknowledged that choice and exit alone were not powerful enough to prevent managed care from denying necessary services to patients. "That's why you have to have legal protections. Aligning the incentives of health care providers with the interest[s] of patients cannot be left to the market alone." For that reason, he said, having regulated "purchasing alliances" that would increase the negotiating leverage of health insurance "consumers" was an important part of the managed competition theory — but one that was not realized in the 1990s.

Cost, cost, cost

Managed competition was at the heart of President Clinton's health care reform proposal, the Health Security Act (HSA), which was formulated by a group of health insurance insiders known as the Jackson Hole Group. The HSA died in 1994 of what Ida Hellander, the director of policy and programs at PNHP, called "political asphyxiation." Neoconservative political commentator William Kristol, through his organization called Project for the Republican Future, spearheaded the opposition.

But records of the public debate around the HSA provide a window into how health care was discussed in the New Democrat era. Upon examining a range of speeches and testimony given during this period by politicians, health insurance lobbyists, and think tank representatives, and comparing those with the rhetoric of the last major health care debate in the 1970s, it is clear quality concerns took a back seat to a focus on controlling cost in the 1990s. As Will Marshall acknowledged, "The assumption [in the 1990s] was that quality wasn't a huge problem…The assumption was that cost inflation was the problem."

The text of President Clinton's 1993 speech on health care encapsulates the general trend of the 1990s. Its underlying assumption was that the quality of American health care was already excellent and needed little improvement: public policy should focus on quality health care only insofar as it does not harm quality; the priority was controlling cost, not improving quality. "We're blessed with the best health care professionals on earth, the finest health care institutions, the best medical research, the most sophisticated technology," Clinton said. However, "medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on earth, and the gap is growing, causing many of our companies in global competition severe disadvantage."

President Clinton's speech was just the vanguard of what became a stampede of calls for controlling the cost of health care, with quality as an afterthought. For example, on November 8, 1993, Kenneth Thorpe, deputy assistant secretary for health policy at the Department of Health and Human Services, in testimony at a hearing on health care reform held by the Housing Energy and Commerce Committee, said, "Why must we remain committed to a strong cost containment strategy? Because the total costs of health care are high and rising…The rising costs of the current system harm businesses, government, and households." The only mention of quality was as a factor for health insurance plans to compete over as part of a market-oriented bid at controlling cost.

And on March 10, 1994, Joan Simmons, the vice president of the Healthcare Leadership Council, an association of CEOs from several health insurers, pharmaceutical companies, hospitals, and other corporations in the health care field, testified to the House Education and Labor Committee, "People from across the globe come to the United States to receive the highest quality care. In this respect, our health care system is the envy of the world. It is proof that our system does more for its patients…Our delivery is undoubtedly the best in the world…Yet the financing system does require swift legislative reform…Congress must pass and the President must sign a bill that contains health care costs and makes coverage affordable and accessible to all."

There were a number of key reasons that might have caused lawmakers and policy advocates to appreciate some cost increases as appropriate. These included the increased availability of demonstrably improved and necessary medical technology, the population growth, and the beginning of the aging of the population. But, in general, this view was not expressed or explored, with the rising cost of health care seen as exclusively a negative that needed to be thwarted.

And quality?

There were, of course, some voices calling for quality as well, but even those often explicitly acknowledged they were swimming against the tide. For example, in testimony to the House Education and Labor Committee on November 8, 1993, Samuel Havens, board chairman of the Group Health Association of America, said, "We want to emphasize that while much of the impetus for reform comes from the need to reduce the inordinately high rate of increase in the overall health care costs, an even greater emphasis on assuring appropriate care

and on maintaining and continuously improving the quality of care will be necessary if reform efforts are to succeed." A call for "continuously improving the quality of care" was rare indeed, the record shows.

In testimony that pointed directly to the risk posed to quality of care by a strategy that focused entirely on cost control, given before the House Committee on Ways and Means on March 21, 1995, Robert Brook, a professor of medicine and health services at the UCLA Center for the Health Sciences, said, "If we are going to contain the growth of health care costs in the United States, as most people insist we must, mechanisms that rely solely on economic and administrative principles will result in the indiscriminate elimination of care that is both beneficial and not beneficial to the patient…We must work toward ensuring that quality, not just cost and access, is considered when the structure of the health system is altered by forces such as managed care and competition."

"If we are going to contain the growth of health care costs in the United States…mechanisms that rely solely on economic and administrative principles will result in the indiscriminate elimination of care that is both beneficial and not beneficial to the patient."

— Prof. Robert Brook

Consequences of cost control fever

Near-relentless focus on cost and access, said Theodore Marmor, a professor emeritus of both political science and public policy and management at the Yale School of Management, will generally "put pressure on quality." Marmor believes a basic health care policy dictum: "If you push for any two of the following three aspirations, you put pressure on the third. That is, if you put pressure on access and on cost, you're going to do something to quality. If you put pressure to expand quality and to increase access, you're going to put pressure on cost. If you put pressure to get cost under control and to maintain quality, you're going to have real pressure on access." This rule, he said, generally holds true "for anything other than vaccinations." According to Marmor's rule, then, by focusing the debate of the 1990s so strongly on cost and access, the New Democrats guided the way toward pressure on quality.

The health care debate in the 1970s was different. There, Marmor said, "the scope of reform was much broader." Democrats, led by Senator Ted Kennedy, pushed for a national health program as a means of improving cost and quality, with both factors seen as equally in need of improvement. In a speech on health care at the 1978 Democratic National Convention, Kennedy said, "One of the most shameful things about modern America is that in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high."

According to Marmor's rule, wouldn't a focus on quality and cost put pressure on access? "Allocating care has got to happen," Marmor said, "and allocating it by ability to benefit and the seriousness of the medical need is a just, in my view, way of talking about this, as distinct from allocating it by ability and willingness to pay. That's the central philosophical issue in medical care."

Marmor insisted that it was not possible to provide "unlimited" highest-quality care for everyone: "You cannot do all the things that are possible and live within a reasonable budget," he said, adding in a follow-up interview that doing so was also logistically impossible.

But what about trying to identify the highest standard of care currently available, estimating the cost of delivering that care universally, and only then deciding what compromises were necessary (rather than simply starting with the judgment that current expenditure levels are the appropriate place from which to start cutting)?

Marmor acknowledged the possibility that one could "imagine extending to everybody suffering [from an] illness the quality of care that is [provided] at very good places," and derive, at least in broad terms, the cost of doing so. He was skeptical, however, because of what he described as practical impediments to the delivery of such care on a universal basis (including the difficulty of replicating universally best-practice care now being delivered by a self-selected population of doctors to a self-selected population of patients), and did not weigh in on the question of whether cutting should precede or follow the identification of, and cost associated with, universal best practices.

Fallout and backlash

Despite the failure of the HSA as a piece of legislation, the principles behind it had an enormous impact on American health care. Its ideas — and the bipartisan acceptance of those ideas — sent a signal to the for-profit health insurance industry that no one would stop a scramble for profit, and scramble they did.

Hellander, noting that previous Democratic administrations had consistently aimed at creating a national health program, said, "That's what capital and business and everyone thought was eventually going to happen, so they weren't going to invest too much money in the health sector as a for-profit industry. Health insurance at that point was still mostly not-for-profit," despite the steady growth of the for-profit sector over the previous two decades.

According to Theodore Marmor, some New Democrats had "a faith in market instruments, if not markets, that was practically theological in their fundamental orientation."

"Once it became clear that they [the New Democrats] were on the side of big business," she said, "there was an all-out rush of insurance companies to merge…There were a lot of billionaires made during that period. Before that we'd seen people get rich in medicine, they'd have a few million dollars, but we'd never seen the creation of these billionaires."

During this same period, the percentage of American workers

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in some form of managed care plan exploded — from 27 percent in 1988 to 90 percent in 1999 — primarily because employers favored them as a means of cost control. Managed care transformed from a niche market that catered largely to self-selecting enrollees into the primary way that Americans received medical care. "We got the market reorganization without the superstructure of public law and regulation," PPI's Marshall said, referring to the fallout from the New Democrats' support of a market-based system, combined with the failure to pass the HSA.

This was most Americans' first taste of managed care, and many found it bitter. The result was what is often called "the managed care backlash," a period in which newspapers filled with horror stories about patients being denied care by their HMOs, or made to jump through so many hoops that when care finally came, it was at a grave cost. A 1996 op-ed column by Bob Herbert in The New York Times that excoriated a North Carolina HMO for forcing a three-month-old girl with leukemia to receive treatment in a different state for several months, away from her family, is a typical example.

Of course, not every managed care enrollee had to deal with denials of service. Enough did, however, and enough newspapers reported about such cases that in a 1997-1998 survey of consumer satisfaction, only tobacco companies were seen as providing worse service than managed care companies and health insurance companies. Banks and oil companies both received higher satisfaction ratings.

Though demands for more access remained a resonant political theme, and ultimately resulted in the increases in access promised by the ACA, demands for improving the "gold standard" of care have not been heard in force for 20 years. Indeed, rather than engaging in a process of first determining what the gold standard is, then making that standard of care available to all (in other words, the provision of care that would be "the envy of the world"), the ACA adopted a very different concept: it speaks in the language of "minimum essential benefits," with each state being able to define that standard by matching it to the level of coverage currently provided by one of the largest health insurers or managed care organizations in the state (as long as certain broad categories of coverage are met).

What motivated the New Democrats on health care?

Will Marshall said the PPI's approach to health care policy was based on "the failure to achieve universal coverage after eight decades of agitation around that on the progressive end…We were trying to figure out how to get the goal of universal coverage in a new way, since the old ways didn't seem to be yielding any progress."

Chris Jennings, one of President Clinton's primary health care advisors and a congressional liaison for Hillary Clinton, told Remapping Debate, "The motivator was [that] they wanted to have a successful effort to pass and enact legislation, and they felt that single payer was never going to pass."

And Theodore Marmor, the Yale professor emeritus, said that some New Democrats "were advancing these [ideas] not because they thought this was the best way to go, but because they thought the institutions of American government made it so easy to block things that the only way you could do anything would be to provide a conception of health reform…that could draw Republican votes."

But Dr. Ida Hellander rejected the idea that New Democrats were just seeking a practical way to achieve greater access to and affordability in health care: "The New Democrats were all about an alliance between Democrats and business…They were looking for a way to regain power, and they figured that moving to the right a whole lot was the way to do it."

Were the New Democrats "all about" such an alliance? Marshall denied it, but in language remarkably similar to that used by those who are pro-business: the New Democrats, he said, had a "pro-growth agenda," were "pro-market," and tried to create policy solutions "that went with the grain of market logic."

According to Marmor, some New Democrats did indeed have "a faith in market instruments, if not markets, that was practically theological in their fundamental orientation." Marmor said Alain Enthoven, an economist formerly associated with the RAND Corporation (not himself a New Democrat), was the "quintessential example" of the beliefs of this faction.

When asked where the PPI got its ideas for health care reform, Will Marshall cited the work of Alain Enthoven.

StarTribune

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Managed care needs a better watchdog

The Star Tribune failed that role in a story about UnitedHealth

By Kip Sullivan

So UnitedHealth Group has figured out a way to cut Medicare's costs "without cutting services"? That is how the Star Tribune characterized the organization's self-serving claims in a recent story ("UnitedHealth says Medicare can save big without big cuts," Jan. 20).

The Star Tribune has long had a policy of clearly distinguishing advertisements from news reporting. That policy was violated by the story on United, which characterized the firm's claims as a fresh perspective in the debate about how to cut Medicare's costs. In fact, United and every other large health insurance company has been peddling similar hype for decades.

The reader had to wade through 15 paragraphs to find a dissenting view, expressed by the Congressional Budget Office. The Star Tribune relegated the CBO's views to this single sentence: "The Congressional Budget Office ... tends to downplay or even ignore numbers like the ones UnitedHealth now offers, experts said." It would have been helpful if the article had gone on to explain why.

The reason is that CBO requires supporting evidence before it will report back to Congress that a health care reform proposal will save money. The evidence the CBO looks for is not news releases and "studies" from health insurance companies but papers based on the principles of science and published in peer-reviewed journals. To date, the scientific literature does not support the cost-containment claims made by United and the rest of the managed-care insurance industry.

Neither the CBO nor professional journals are infallible. But they have no financial stake in the debate.

United thinks "private success stories need to drive public reforms." In other words, that self-serving anecdotes from the health insurance industry should mean more to lawmakers than the scientific literature does. How does the state's largest newspaper let such nonsense go unexamined?

Minnesota badly needs the equivalent of a CBO. I urge the Star Tribune to consider playing the role. That would require regular reporting on the evidence for the cost-containment claims made for "payment reform," "pay for performance," "report cards," "bundled payments," "disease management," and the other health care reform fads collectively known as "managed care."

First, how can United Health Group claim to have discovered methods that will lower Medicare costs when the health insurance industry, including United, has a long track record of raising, not lowering, Medicare's costs?

Here are two questions to investigate:

First, how can United claim to have discovered methods that will lower Medicare costs when the health insurance industry, including United, has a long track record of raising, not lowering, Medicare's costs? A steady stream of research has shown that it costs more to insure seniors through health insurance companies than it does through the traditional fee-for-service (FFS) Medicare program.

A steady stream of research has shown that it costs more to insure seniors through health insurance companies than it does through the traditional fee-for-service (FFS) Medicare program.

The current name for the private-sector branch of Medicare is Medicare Advantage (MA). The Medicare Payment Advisory Commission, which is very sympathetic to managed care, had this to say in a recent report to Congress: "Currently, Medicare spends more under the MA program for similar beneficiaries than it does under FFS."

The second question to investigate is United's claim that "health improvement programs such as diabetes prevention and weight control could save $53 billion" for Medicare and Medicaid. The peer-reviewed literature on this claim currently supports the opposite conclusion -- that the cost of administering "disease management" programs in general, and diabetes and obesity prevention programs in particular, exceeds the savings in medical costs achieved by these programs.

There are a few exceptions to this rule, but diabetes and obesity are not among them. It remains possible that such programs targeted at a very small number of diabetics and overweight people (for example, those who are highly motivated to get well) will someday prove to save more than they cost the health care system, but in that event the total savings will be small compared with total health care spending.

The Star Tribune is capable of good reporting on managed-care hype. It has done so infrequently in the past. But it needs to do so regularly.

Kip Sullivan, J.D., is a member of the steering committee of Physicians for a National Health Program, Minnesota chapter.

HEALTH AFFAIRS

The Redistribution Of Graduate Medical Education Positions In 2005 Failed To Boost Primary Care Or Rural Training

By Candice Chen, Imam Xierali, Katie Piwnica-Worms and Robert Phillips

January 2013

ABSTRACT Graduate medical education (GME), the system to train graduates of medical schools in their chosen specialties, costs the government nearly $13 billion annually, yet there is little accountability in the system for addressing critical physician shortages in specific specialties and geographic areas. Medicare provides the bulk of GME funds, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 redistributed nearly 3,000 residency positions among the nation's hospitals, largely in an effort to train more residents in primary care and in rural areas. However, when we analyzed the outcomes of this recent effort, we found that out of 304 hospitals receiving additional positions, only 12 were rural, and they received fewer than 3 percent of all positions redistributed. Although primary care training had net positive growth after redistribution, the relative growth of nonprimary care training was twice as large and diverted would-be primary care physicians to subspecialty training. Thus, the two legislative and regulatory priorities for the redistribution were not met. Future legislation should reevaluate the formulas that determine GME payments and potentially delink them from the hospital prospective payment system. Furthermore, better health care workforce data and analysis are needed to link GME payments to health care workforce needs.

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Health Aff, vol. 32, no. 1, 102-110

Medicare Beneficiaries' Costs Of Care In The Last Year Of Life

By Christopher Hogan, June Lunney, Jon Gabel and Joanne Lynn

July 2001

ABSTRACT This paper profiles Medicare beneficiaries' costs for care in the last year of life. About one-quarter of Medicare outlays are for the last year of life, unchanged from twenty years ago. Costs reflect care for multiple severe illnesses typically present near death. Thirty-eight percent of beneficiaries have some nursing home stay in the year of their death; hospice is now used by half of Medicare cancer decedents and 19 percent of Medicare decedents overall. African Americans have much higher end-of-life costs than others have, an unexpected finding in light of their generally lower health care spending.

doi: 10.1377/hlthaff.20.4.188
Health Aff, vol. 20, no. 4, 188-195

P4P Concerns, Medicare vs. Private Insurance Lead Health Affairs Blog's 2012 Most-Read List

By Chris Fleming

Jan. 10, 2013

Will pay for performance in health care backfire? That was the question addressed through the lens of behavioral economics by Steffie Woolhandler, Dan Ariely, and David Himmelstein in the most-read Health Affairs Blog post for 2012. Next on the most-read list are two posts, one by Diane Archer and the other by Archer and Theodore Marmor, contrasting Medicare and private insurance.

[PNHP note: For the top 15 Health Affairs Blog posts of 2012, please visit bit.ly/U8nyj0. The P4P article by Woolhandler, Ariely and Himmelstein also appeared in PNHP's Winter 2012 newsletter.]

The Pulse (Oregon Health & Science University student newspaper)

December 17, 2012

Health care reform: the issue is equity

By Gabriel Edwards, MS1

The process of getting through medical school is fraught with uncertainty. What kind of residency will I apply to? Which lunch talks this week are offering free food? What innervates the palatoglossus muscle?

There's another question I've considered as I get through the first year. I wonder what our country's health care system (the system in which I will practice medicine) will look like in the next few years. Embedded in this question is one thing I'm certain of: our health care system is broken.

We spend double the money of every other developed nation in the world, and our health is worse for it. We are fairly unique among developed countries in the degree to which our quality of health care depends on income or employment.

Wealthy Americans receive some of the best health care ever devised by humans. Less wealthy Americans are denied care because of lack of resources, succumbing to preventable illnesses at rates higher than our industrialized counterparts.

Both major political parties say that the health care system needs to be reformed, that costs need to be contained lest they eventually bankrupt the country.

During the latest battle of reforming health care there was talk about what would happen to various stakeholders in our current systems. What would reform mean for doctors? For private insurers? For patients? For President Obama's political prospects? For the opposition's political prospects?

Another question is asked far less frequently: What does it say about us as a society that, compared to other countries, so many more people are dying from preventable diseases or going bankrupt due to health care costs?

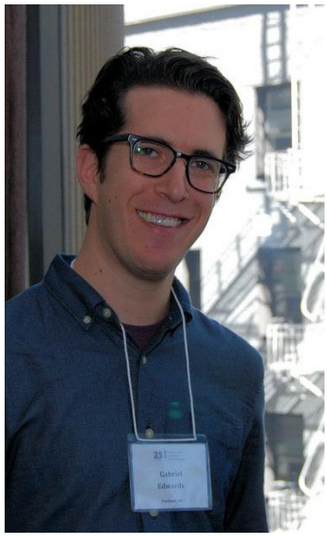
Our country has already decided that every American is entitled to education, police protection, and fire protection. Prisoners have a guaranteed right to health care. Right now there are tens of millions of Americans who don't have the right to adequate health care.

What does it say about us as a society that, compared to other countries, so many more people are dying from preventable diseases or going bankrupt due to health care costs?

Obamacare, fully implemented, would cut the number of uninsured only by half, leaving 23 million Americans without health insurance – 23 million who can't afford all the health care necessary to ensure a high quality of life. And the problem doesn't stop there. Insured individuals declare the majority of medically related bankruptcies. This is not a problem of insurance versus noninsurance. This is a problem of equity.

The solution to this problem, I believe, is to create a health care system that covers everyone, without exception. Obamacare will not do this, but a single-payer system could. I believe that this is the most moral solution.

Who is healthy and who becomes ill in life is not solely determined based upon personal merit; health care shouldn't be awarded based on what one's salary and job happen to be.



Gabriel Edwards, MS1

Everyone has a right to medically necessary care. I want to care for patients in a society that maintains that right. I strongly believe that we will get there together. Not because it's easy, but because it's the right thing to do.

Gabriel Edwards is a first-year medical student at Oregon Science & Health University in Portland, Ore. This article was originally published under the title, "Opinion: Health Care Reform."

Single-payer student summit set for May 11 in Chicago

Members of Students for a National Health Plan (SNaHP) are organizing a single-payer summit of medical and other health professional students on Saturday, May 11, in the City of Big Shoulders.

The summit will build on the success of last year's conference, which drew 40 students from 10 states. That gathering featured firsthand reports of student single-payer activism and breakout sessions on topics such as how to frame arguments for single payer and how to organize on campus. It also included talks by national PNHP leaders.

If you're interested, or if you know of a health professional student who might be, please contact PNHP at info@pnhp.org for more information. But in the meantime, hold the date and spread the word: May 11 in Chicago!

Penny-Wise and Pound-Foolish

Written testimony to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Care and Aging, January 29, 2013

By Claudia M. Fegan, M.D.

PNHP past president Dr. Claudia Fegan

Thank you Senator Sanders, Senator Enzi and other distinguished Senators for affording me this opportunity to address the issue of inadequate access to primary care in the United States.

The lack of adequate access to primary care speaks to the much larger issue of inadequate access to health care in this country as a whole. As the chief medical officer of John H. Stroger Jr. Hospital in Chicago, known to most people outside of Chicago as Cook County Hospital, I confront on a daily basis the reality of our country's failure to provide universal access to health care as a right to which I believe everyone is entitled.

Every single day, people without a physician line up across the street from our hospital to be seen in our walk-in clinic. Hundreds of people a week – tens of thousands a year – stand in line in the wee hours of the morning, hoping to be one of the 120-200 people who will be seen that day and even better, hoping to be one of the 12 patients who will be assigned to a primary care physician and given an appointment so they won't have to come back.

They hope to be one of the lucky ones who will be given a physician of their very own, who will get to know them and take care of them and be available when they have a problem or question, someone to help them meet their medical needs, someone to help them navigate our complicated health care system to get what they need. I have to admit I hesitate to refer to health care delivery in this country as a system, because so little is connected to anything else.

Every day I look at the charts of patients admitted to our public, safety-net hospital who were told by another hospital to come to us because they are uninsured. They come from distances great and small. I see patients who come from other cities, other counties, other states, other countries and patients who come from just a few blocks away.

Sometimes they come with their films or slides and have been told they need surgery or chemotherapy or a diagnostic study and they would be better off at "the County." These patients come to us in a state of desperation with great expectations. We take care of them and do the best we can with the limited resources we have. This is as we prepare to absorb the beginning of the phase out of Disproportionate Share Funds for Safety Net Hospitals on Oct. 1 of this year. The elimination of DSH funds with the presumption that everyone will be insured is just another challenge as we continuously struggle to meet the needs of all who come to our doors.

I know the Affordable Care Act promises to provide insurance coverage to more Americans, but I know there will still be 30 million people who will remain uninsured even after the Affordable Care Act is fully implemented. So I know the need for the safety net and places like Cook County will remain. I also know there are not enough primary care providers to care for all the patients who will need them.

Primary care shortage takes a toll

Whereas in 1930 the ratio of generalists or primary care physicians was about 80:20, today that ratio is reversed. It's not an exaggeration to say we are facing a crisis in this vital area.

Research show that primary care is the foundation of any high functioning health system. A well-developed primary care infrastructure makes access to care easier and more efficient; it contains costs, such as identifying and treating problems before they become more severe or advanced. It improves the coordination of resources and care; and most important, it yields better medical outcomes than when such an infrastructure is missing. It saves lives. I might add, studies have noted more expensive for-profit hospitals do not have better outcomes than our public safety-net hospitals. There is no correlation between the amount of money we spend on care and the quality of the outcomes.

Our current influenza epidemic highlights the vulnerabilities of our current patchwork for health care delivery. Too few people

in this country have access to a primary care provider. Their primary care provider could have educated them about influenza and the need for influenza vaccine, especially in vulnerable populations and those in contact with those populations. Then their primary care provider could have provided them with that vaccine.

Instead we are witnessing tens of thousands of people presenting to our emergency rooms sick and looking for help. At the peak, our emergency room at Stroger was seeing 450 patients a day while hospitals around the city closed their doors and went on bypass. At Cook County, we never go on bypass, we never close our doors.

People don't understand that influenza vaccination is not just about you and whether you get sick, but about everyone you encounter and the risk you will infect them. After we had a patient in our hospital infected by a visitor and a pregnant patient who wound up on a ventilator, we were forced to limit access to the hospitals in our System for visitors who might be sick. People are dying, dying from influenza, a preventable disease. This is an example of our tendency in this country to be penny-wise and pound-foolish in our funding of health care.

Primary care is undervalued

There is no doubt that for many years we have undervalued primary care. It shows up in a variety of ways.

As a nation we provide little incentive for young physicians to become primary care providers. By contrast, there are strong incentives for young clinicians to pursue higher-compensated specialties.

A medical education is expensive and most young physicians leave medical school with hundreds of thousands of dollars in debt. Because primary care physicians are the lowest compensated of physicians, and because the prospect of a heavy, long-term debt is so unappealing, medical students find themselves gravitating away from primary care toward higher paid specialties.

We say we value primary care physicians and yet we pay them half as much as we pay specialists. We say we appreciate the cognitive skills of primary care physicians so necessary to see patients as a whole and make decisions in the best interests of each individual, but we make it financially difficult for young clinicians to take this path.

Another example: We created the RBVS system to compensate physicians for their cognitive effort in the care of patients. It was hoped this would begin to level the playing field between primary care physicians and procedure based specialists. Yet the RVS Update Committee, which is tasked with annually reviewing how Medicare compensates physicians for care provided, has only a paltry few seats allocated for primary care when setting reimbursement rates.

If we would enact a single-payer national health care program, where everyone was entitled to health care as a right, we could focus on delivering to our patients the best care in the world and relieve our physicians of the administrative hassles required to ensure proper billing for services provided.

Expand funding for training in primary care

We want to increase the number of primary care physicians, but when Medicare funds graduate medical education in hospitals, we disburse the same amount for a plastic surgeon as a primary care physician. If we increase hospital reimbursement for primary care physicians in training over specialists in training, we will have more primary care physicians. You could do that.

I have to say that I have the privilege of being a primary care physician myself – previously in private practice and now at a large public hospital – and I love taking care of patients. It is one of the most fun things I do. My patients invite me into their lives as I teach them how to take care of themselves and get what they need. These experiences are often deeply moving and rewarding and they remind me why I chose medicine as a profession.

The daughter of a labor union organizer and a social worker, I would have never been able to afford medical school. I was fortunate enough to be a member of the National Health Service Corps, which paid for my medical education, so I was free to make the decision to follow my passion and become a primary care physician without having to worry how I would pay off my loans.

While the National Health Service Corps still exists, it is a shadow of its former self; more students receive funding in the form of loan repayment.

I would say to you: if medical students know before they begin school that they will have no debt upon completion of their studies, they are more likely to make the decision to pursue a career in primary care rather than a more highly compensated specialty.

There are other ways to make primary care more attractive to the next generation of physicians too.

Lift the administrative burden on doctors

The administrative burden we have placed on physicians is the product of our nation's fragmented, dysfunctional system of financing care through multiple private and public payers, including hundreds of private insurance plans, each with its own rules. The costly paperwork and headaches inflicted on our physicians, including primary care physicians is enough to drive many to distraction or exit from our profession.

If we would enact a single-payer national health care program, where everyone was entitled to health care as a right, we could focus on delivering to our patients the best care in the world and relieve our physicians of the administrative hassles required to ensure proper billing for services provided.

As a primary care provider myself, I feel the external control in the exam room with me and my patient as I struggle to make sure I have completed all the required elements on the computer screen, sometimes at the cost of neglecting to ask what the patient's concerns are today.

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Because of this onerous administrative burden, primary care physicians have lost something of their precious connection with their patients. Lifting that burden would help strengthen the doctor-patient relationship.

The stresses on primary care physicians are tremendous with the implementation of the electronic health record (EHR) that force them to spend more time looking at a computer screen than looking at the patient. Most EHR systems today were designed to enhance more efficient billing, not patient care. As a result, EHRs create a hideous documentation burden that robs precious time from physicians that they would rather spend engaging with their patients and understanding their needs.

There is no question that if we had designed the electronic health record to further clinical care we would have developed a very different tool. While it is true there are elements of the EHR that will improve patient safety, they are far overshadowed by the demands for administrative documentation. We lose the narrative of the individual patients to improve the point-and-click documentation and make billing more efficient.

It's just one more example of where we expect primary care doctors to address more and more issues, even as we expect them to see more and more patients.

I would say to the members of this committee, as members of Congress you have the opportunity to increase the number of primary care providers in this country.

1. Adjust the funding for graduate medical education to reimburse hospitals more for the primary care physicians than specialists.
2. Insist the American Medical Association increase primary care representation on RVS Update Committee.
3. Increase National Health Service Corps scholarship program.

I urge you to work to make a difference, not for me or you, but for the patients I have the privilege of serving, who desperately need their elected officials to care about what happens to them.

Claudia M. Fegan, M.D., C.H.C.Q.M., F.A.C.P., is chief medical officer, John H. Stroger Jr. Hospital of Cook County, and past president, Physicians for a National Health Program.

Ask your congressperson to show support for single payer via a special order

Sample letter from Dr. Henry Kahn, Atlanta

The Honorable John Lewis
United States House of Representatives
Washington, DC 20515

Dear Mr. Lewis,

I was happy to see your name added this month to the list of co-sponsors for the "Expanded & Improved Medicare For All Act" (H.R. 676). Your endorsement over the years has helped keep the single-payer message alive: Our country needs a simplified, efficient, and thoroughly universal system of health care insurance.

Shortly after your endorsement *Time* magazine printed a long article, titled "Bitter Pill," that illustrated how far we still have to go. It's not enough to have passed the Affordable Care Act. Medical costs are still much too high, and they will continue to rise so long as the commercial insurers and large pharmaceutical companies dominate the scene. People all over the U.S., and certainly here in Georgia, are painfully aware of this fact.

As a respected, senior member of our congressional delegation, perhaps you would ask the privilege to address the House on the importance of this issue. If it suits your purpose, I would be happy to send you a letter of concern signed by members of Physicians for a National Health Program (Georgia Chapter). I'm sure that other groups from our District would send similar letters. You could then take the opportunity to read these letters to the House, discuss the basis of your concern, and enter these proceedings into the Congressional Record.

Please let me know in what other ways we could help you speak out on this moral issue so important to us all.

Sincerely,

Henry S. Kahn, MD, FACP

Needed: more coverage, more primary care

Written testimony to the U.S. Senate Committee on Health, Education, Labor and Pensions, Subcommittee on Primary Care and Aging, January 29, 2013

By Andrew P. Wilper, M.D.

My name is Andrew Wilper. I am a practicing primary care physician (PCP) and researcher. In addition, I have substantial experience in medical education and care for the underserved. I am grateful to have been asked by Senator Sanders about my insights into the lack of health insurance in the United States and its effect on access to health care and health outcomes. I have also been asked to share my thinking on practical solutions to the primary medical care workforce shortage. I have divided my testimony into two parts. First I will address the evidence that lack of health insurance impedes access to health care and degrades health outcomes. Second, I will discuss the primary care physician shortage in the U.S. and strategies to increase the number of primary care physicians.

Dr. Andrew Wilper

I. The Effect of Lack of Health Insurance on Access to Care and Health Outcomes in the U.S.

For decades, researchers have demonstrated the ill effects of the lack of health insurance on access to medical care. This body of literature is enormous, and the signal is clear; lack of insurance is definitively associated with decreased access to medical care and poorer health for those without such access. The Institute of Medicine (IOM) summarized these findings and their implications in a six-volume series in the early part of this century, identifying three mechanisms by which insurance improves health: 1) Getting care when needed, 2) Having a regular source of care, and 3) Continuity of coverage.[1-6]

Research by myself and others has built on this work. The evidence continues to paint a clear and unambiguous picture. Lack of health insurance is associated with worse health status, decreased likelihood of having a usual source of medical care, and death.[7-,10]

In a 2009 article, we updated an older estimate produced by the IOM, linking 44,789 deaths in 2005 with lack of insurance, more than were estimated to die that year as a result of renal failure. Contrary to the popular notion that most uninsured are young and healthy, we found that roughly one-third of the uninsured had a chronic medical condition that would require medical care, and that the uninsured are more likely to suffer undiagnosed, and therefore untreated, chronic illness.[8,11]

The uninsured are more likely to go without needed care than the insured, and to be admitted to hospital for illness that could be prevented.[12,13] The data also supports the notion that when previously uninsured individuals gain coverage through Medicare, their decline in health reverses.[14,15] The research is consistent: health insurance leads to significant benefits and is good for your health.

These findings are borne out in my clinical practice. I have cared for many patients who delayed care as a result of lack of insurance.

Perhaps the most poignant case was Mr. A, who worked as a delivery man. He was also a diabetic. I cared for this gentleman while I was in my residency training in Portland, Oregon. He was admitted to the hospital for a hypertensive crisis, which is usually the result of longstanding hypertension that has not been adequately treated. His blood pressure was so high that he bled into his eyes. The damage extended to his kidneys. We were able to stabilize and send him home with new medications.

It turned out that his employer had dropped his coverage prior to our meeting in the hospital. As a result, he could no longer afford to go to his primary care doctor. He had been ordering his insulin from Canada, which would arrive by mail. He was using this without proper supplies or monitoring, and was without his blood pressure medications. This led to our meeting. Ultimately, his kidney function became so compromised that he needed permanent dialysis. As you know, this is an extremely expensive treatment, costing approximately $80K per year.

What I find so shocking about this story, is that as a society we were willing to pay for his dialysis treatments through the Medicare End Stage Renal Disease program, but were not able

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to treat his chronic conditions that likely would have allowed us to avoid dialysis in the first place. This case drove home the fact that even routine treatments are out of reach for people who are uninsured. Mr. A. was not simply the victim of bad luck, nor was he an outlier. His situation was a result of policies that have left millions of Americans without insurance and access to medical care.

II. Primary Care in the United States

Background

Good evidence supports the myriad benefits of a robust primary care workforce. Within the U.S., states with larger proportions of specialists actually have lower quality care.[16] Others have demonstrated that increased proportions of PCPs are associated with significant decreases in health care costs.[17] Primary care is also linked to lower all-cause mortality, infant mortality, fewer low birth weight babies, improved self-reported health, decreased costs, and decreased racial disparities.[18]

Studies suggest an association between the availability of primary care and decreased emergency department (ED) use. Many patients using the ED report that they would be willing to use another source of care were one available.

Nevertheless, we have not seen systematic changes to alleviate the shortage of PCPs in the U.S. This is in spite of widespread calls for reform. Indeed, in 2006 the American College of Physicians predicted that without comprehensive reform by Congress and Centers for Medicare and Medicaid Services (CMS), primary care, the backbone of the U.S. Health care system, may collapse.[19]

The proportion of U.S. physicians practicing in primary care is low compared to other industrialized nations. The Kaiser Family Foundation estimates a total of 834,000 practicing physicians in the U.S. in 2012.20 The proportion of physicians practicing in primary care in the U.S. is approximately 40 percent, with the remaining 60 percent practicing in sub-specialties. This specialist-dominated distribution has been linked to the high costs and poor health outcomes in the U.S.

This misdistribution occurs in the context of what many describe as a physician shortage. The Association of American Medical Colleges (AAMC), American College of Physicians, and the Council on Graduate Medical Education all estimate current shortages in the tens of thousands, and predict that these will continue to grow.[21-23]

Medical School

Numerous strategies exist to increase the number of medical students entering primary care. These include educational debt reduction, changes in federal funding streams to emphasize primary care, and increased funding to the National Health Services Corps. In addition, direct support for Community Health Centers participating in teaching medical students would support our nation's most vulnerable populations while training future PCPs.

Graduate Medical Education

Graduate medical education (GME) has been the focus of many federally supported programs to increase the primary care work force. Funding for Title VII programs, which support training for PCPs, is continuously threatened by congressional cuts. Only the Title VII programs provide money directly to primary care training programs. Remarkably, for every Title VII dollar there are about $1,000 Medicare GME dollars, and these Medicare GME dollars push training efforts toward inpatient and subspecialty care.

Medicare spending for GME is directed toward hospitals, which is heavily tilted toward hospital-based specialty care.[24] Medicare should direct funding to residency programs for education instead of directing it through hospitals. Medicare should also require assessments of community and regional physician work force for hospitals to qualify for GME funding. In effect, Medicare should begin requiring accountability in its subsidization of teaching hospitals.

Remarkably, the federal government spends nearly $10 billion dollars annually to produces a physician workforce without a workforce plan. As part of his testimony before the House Energy and Commerce Subcommittee on Health, Dr. Fitzhugh Mullan called for "requir(ing) teaching hospitals to undertake community or regionally oriented analyses of physician workforce needs and make application for training positions based on a fiduciary responsibility to train a complement of residents that corresponds to agreed upon regional needs."[25]

In its current form, GME is run by teaching hospitals to meet their own staffing needs, and graduates select their field of practice based on their personal interests. I have been personally told by a residency program director that his concern is the professional desires of his trainees, rather than population health needs. Given the annual income of certain physician types, Medicare could consider limiting or defunding training programs that do not meet population needs, or that could be reasonably funded via trainee loans given future income expectations.

Practice and Payment Reform

Payment reform is the most critical element of change needed to re-invigorate primary care. Remarkably, it is explicit federal government policy to direct oversized payment towards specialists and thereby skew workforce statistics. Efforts to reform the payment system in an effort to address the maldistribution of physicians by specialty have failed.

The resource-based relative values scale has grossly distorted relative physician reimbursement since 1992. Now PCP compensation is 30 percent to 60 percent less than subspecialists.24 Without payment reform, it is unlikely that efforts targeting medical students and residents will succeed in bolstering the primary care workforce. Indeed, the AAMC has declared that "education and training cannot overcome the intense market incentives that influence physician choices."[25] The income disparity could be addressed by increasing PCP

reimbursement or by decreasing that of subspecialists.

A focal point for payment reform is a committee of the American Medical Association called the Relative Value Scale Update Committee, known as the RUC. This group of 31 doctors wields tremendous influence over physician pay in the U.S., with CMS following nearly all of its recommendations. One estimate has the RUC directing $54 billion in federal spending annually. Yet the group has no government oversight. This opaque group benchmarks reimbursement rates for physician services in the U.S. and does so in a way that favors surgeons and specialists. Only three seats on the committee are designated for primary care specialties.[26]

Critics argue that RUC decisions are based on suspect data leading to systematic overstatement of time and work that favors surgery and subspecialty physicians.[27,28] The playwright George Bernard Shaw commented that "any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting of your leg, is enough to make one despair of political humanity."[29] We have gone a step beyond what Shaw feared by allowing physicians to set their own rates. At a minimum, the public deserves transparency in decision making from the RUC. Better yet, we should establish a process for rate setting that is not encumbered by conflicts of interest and does not favor narrow specialties.

Expanded patient access to PCP services could be achieved through strategies that reform current practice models. Expanded insurance via the Affordable Care Act will stress primary care supply. In the two years following health reform in Massachusetts, waits to see PCPs increased by 82 percent.[30] This has been linked to a mismatch between the supply and demand for primary care services. Policy efforts to implement the Patient Centered Medical Home will focus on risk-adjusted capitated payments, non-traditional visits such as telephone and email care, in addition to delegating physician decision making to non-physician team members. This will require changes in our reimbursement system, workforce and the culture of medicine.

In summary, it is eminently clear that health insurance affords better patient outcomes, and that it been associated with decreased risk of mortality. Despite this, our current reform efforts in the Affordable Care Act will leave as many as 30 million uninsured. The physician pipeline recommendations above have been made for years by health policy and workforce experts. Nonetheless, efforts to increase the number of PCPs have been frustrated by the funding mechanisms for medical education in the U.S.

This current system of funding is at best inefficient, meeting the needs of a narrow group of teaching hospitals and subspecialists. At its worst, the current GME funding stream acts as a principal driver for a workforce that meets the interests of physicians and hospitals rather than the health needs of the population. In addition, Medicare's grossly unequal fee payments to specialists and PCPs continues to discourage trainees from primary care careers.

I have worked for over a decade in medical education as a student, resident, fellow, faculty member and residency program and hospital leader. My conviction is that publically sponsored training should be planned to meet the health care needs of our population rather than the staffing needs of hospitals or the lifestyle preferences of young doctors. Thank you.

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End Notes

1. Insuring America's Health: Principles and Recommendations. Washington DC: The National Academies Press; 2004
2. Care without Coverage: Too Little, Too Late: Principles and Recommendations. Washington DC: The National Academies Press; 2002
3. Health Insurance is a Family Matter: Principles and Recommendations. Washington DC: The National Academies Press; 2002
4. Hidden Costs, Value Lost: Uninsurance in America: Principles and Recommendations. Washington DC: The National Academies Press; 2003
5. Coverage Matters: Insurance and Health Care: Principles and Recommendations. Washington DC: The National Academies Press; 2001
6. A Shared Destiny: Community Effects of Uninsurance: Principles and Recommendations. Washington DC: The National Academies Press; 2003
7. Finkelstein A., Taubman S., Write B et al. The Oregon Health Insurance Experiment: Evidence from the First Year. NBER Working Paper No. 17190. Issued July 2011
8. Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. A national study of chronic disease prevalence and access to care in uninsured U.S. adults. Ann Intern Med. 2008 Aug 5;149(3):170-6
9. Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. Health insurance and mortality in US adults. Am J Public Health. 2009 Dec;99(12):2289-95
10. Sommers BD, Baicker K, Epstein AM. Mortality and access to care among adults after state Medicaid expansions. N Engl J Med. 2012 Sep 13;367(11):1025-34
11. Wilper AP, Woolhandler S, Lasser KE, McCormick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured U.S. adults. Health Aff (Millwood). 2009 Nov-Dec;28(6):w1151-9
12. Lurie N, Ward NB, Shapiro MF, Brook RH. Termination from Medi-Cal-does it affect health? N Engl J Med. 1984;311:480-484
13. Weissman JS, Gatsonis C, Epstein AM. Rates of avoidable hospitalization by insurance status in Massachusetts and Maryland. JAMA. 1992;1992;268:2388-2394
14. McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. JAMA. 2007;298:2886-2894
15. McWilliams JM. Health consequences of uninsurance among adults in the United States: recent evidence and implications.. Milbank Q. 2009 Jun;87(2):443-94
16. Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. Health Aff (Millwood). 2004 Jan-Jun;Suppl Web Exclusives:W4-184-97
17. Kravet SJ, Shore AD, Miller R, Green GB, Kolodner K, Wright SM. Health care utilization and the proportion of primary care physicians. Am J Med. 2008 Feb;121(2):142-8
18. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502
19. American College of Physicians. The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care: a report from the American College of Physicians. January 2006.
20. United States: Physicians. The Kaiser Family Foundation. http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=100&rgn=1, accessed January 24, 2013
21.American Association of Medical Colleges. Physician Workforce Policy Recommendations. September 2012. https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendatio ns.pdf, accessed January 24, 2013
22. How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care? A comprehensive Evidence Review. American College of Physicians, 2008 http://www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf, accessed January 24, 2013
23. Physician Workforce Policy Guidelines for the United States, 2000-2020. Council on Graduate Medical Education. January 2005. http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/sixteenthreport.p df, accessed January 24, 2013
24. Thomas Bodenheimer, M.D., Kevin Grumbach, M.D., and Robert A. Berenson, M.D.A Lifeline for Primary Care. N Engl J Med 2009; 360:2693-2696
25. Mullan, Fitzhugh. Testimony before the House Energy and Commerce Subcommittee on Health. http://sphhs.gwu.edu/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublic ation_14EBB1B9-5056-9D20-3D27A281209EB378.pdf, accessed January 24, 2013
26. RUC Members Effective July 1, 2012. American Medical Association. http://www.ama-assn.org/resources/doc/rbrvs/ruc-members-current.pdf, accessed January 24, 2013
27. Wilde, A., McGinty, T. (2010, October 26) . Physician Panel Prescribes the Fees Paid by Medicare. Wall Street Journal. Retrieved from http://online.wsj.com/article/SB10001424052748704657304575540440173772102.html
28. Jerry Cromwell, Sonja Hoover, Nancy McCall and Peter Braun. Validating CPT Typical Times for Medicare Office Evaluation and Management (E/M) Services. Med Care Res Rev 2006 63: 236
29. George Bernard Shaw, The Doctors Dilemma, New York: Brentano's, 1911
30. Amireh Ghorob, A., Bodenheimer, T. Sharing the Care to Improve Access to Primary Care. N Engl J Med 2012; 366:1955-1957. May 24, 2012

New Internationalist

November 30, 2012

You are not a loan: 'Rolling Jubilee' takes aim at medical bankruptcy

By George Lavender

"Debt is the tie that binds the 99 per cent together," says Matthew McLoughlin. "Like most Americans I'm struggling … I've got $60,000 of student loan debt." McLoughlin was an organizer with Occupy in Chicago when he first heard about the Strike Debt campaign. "Right away it hit home as a way to further the conversation that the Occupy movement started last year."

"A bailout for the 99 percent" is how Strike Debt describes the "Rolling Jubilee," plan to abolish millions of dollars in personal debt. The idea is to buy up bundles of distressed debt on the secondary debt market, where it's sold for a knockdown price of about five per cent of its value and, instead of asking the people concerned to repay it, the debt would be abolished.

It's an idea that seems to be catching on. Since the campaign's launch in mid-November 2012, Strike Debt says it has raised enough money from supporters to buy, and then abolish, more than $8.5 million worth of debt. While that represents a tiny fraction of U.S. citizens' personal debt, the group has much bigger ambitions. "The idea behind the Jubilee is providing aid, but it's also raising awareness." explains McLoughlin. He hopes the Rolling Jubilee will highlight the size of the U.S. debt problem and its sources. "We don't feel that we owe these companies anything for the debts they're trying to collect from us, which are mostly for things that should be guaranteed: like housing, medicine, and higher education."

Rolling Jubilee will start by buying up medical debt, a problem that afflicts many Americans. As Steffie Woolhandler, a professor of public health at the City University of New York, and a member of Physicians for a National Health Program explains, "More than half of all personal bankruptcies in the United States are due, at least in part, to medical illness or medical debt."

"Bankruptcy is something I constantly think about," says Rebecca Randel, a 39-year-old graduate student. "It weighs on me all the time." Back in the winter of 2009 Randel had what she calls "a classic American health care experience." A week in hospital for emergency treatment left her with $24, 000 of medical costs. Without health insurance and the bills piling up she was forced to use her credit card to make the minimum payments required to keep it from going to collection agencies. "I would have nightmares about how to pay my bills," says Randel. "I couldn't sleep at night because I knew I had to make another credit card payment or I was about to max out a credit card."

Like many people, Randel says she was ashamed of her debt, until she found that she was far from alone. "People feel very guilty about unpaid debt," says Steffie Woolhandler. "They need to remember it's not their fault they got sick." By starting a public conversation about debt, Strike Debt activists say they hope to bring people together to challenge the system that creates it. "It's going to spread like wildfire," says Strike Debt organizer, Danielle Villarreal "in the same way that ideas about economic inequality did under Occupy, because that was also something that everyone felt and no one was talking about." Next, the group plans to organize people who can't or won't pay back money they owe, in a coordinated debt strike.

So far, Strike Debt has earned praise from some unlikely sources. Business Insider described the Rolling Jubilee as "brilliant," while Forbes ran a column entitled "Finally, an Occupy Wall Street Idea We Can All Get Behind." Meanwhile, Strike Debt groups have sprung up across the U.S., and further afield, including Britain.

For Nick Mirzoeff, a professor of media, culture and communication at New York University, tackling debt is just the beginning. "This is a way to begin a much wider conversation about what we value in our society," he says. "What we value in people and what we expect a life should be about. We think a life should be about more than just repaying loans, we think people are more than just a loan."

What is single payer?

The following appears in the forthcoming (2013) book "Social Justice and Public Health" by Barry Levy and Vic Sidel as a box in a chapter authored by H. Jack Geiger and Oliver Fein. The chapter is titled "What is single payer?"

By Steffie Woolhandler and David U. Himmelstein

In a single-payer health care system, virtually all health care funds flow through a single public (or quasi-public) agency that pays for care for an entire population.

Single-payer systems vary somewhat. In some countries, such as Canada or Taiwan, the government operates the single-payer insurance plan, but most physicians are in private practice and most hospitals and clinics are operated by private, nonprofit organizations. Such insurance-based, single-payer systems are generally called *national health insurance*—or sometimes *Medicare for all*. However, unlike U.S. Medicare, a true "single payer" is not one among many insurance plans, but one that covers the entire population—and, in a single-payer system, private insurance that duplicates public insurance is prohibited.

In some countries with single-payer systems, such as Great Britain and Spain, the government not only pays for care, but also owns most hospitals and employs most medical workers—a model known as a *national health service*. This model resembles the Veterans Health Administration in the United States, but it covers the entire population—not just veterans.

Both of the single-payer models described above facilitate greater equity in care because everyone is covered, and hospitals and physicians are paid the same amount to care for patients irrespective of their income or wealth. Therefore, in Canada, poor people get slightly more care than wealthy people—although, given their high rates of illness due to greater exposure to hazardous physical and social environments, poor people should probably get an even greater share of care. While class gradients in infant mortality (and other health outcomes) remain, even the poorest 20 percent of Canadians have a lower infant mortality rate than the overall infant mortality rate for the United States. Indeed, health outcomes in almost every nation with a single-payer system surpass those in the United States.

A single-payer system facilitates cost containment through several mechanisms. First, having virtually all funds flow through a single "spigot" enables setting and enforcing an overall health care budget. In contrast, in multi-payer systems like that in the United States, hospitals, clinics and physicians collect fees from hundreds of insurance plans and tens of millions of individual patients, making it almost impossible to track and control the flow of money.

A multiplicity of payers also generates mountains of needless paperwork. Providers must maintain elaborate internal cost-accounting systems to keep track of whom to bill for each bandage and aspirin tablet. And insurance firms—which profit when they avoid paying for care—demand extensive documentation to justify each bill. Therefore, both insurers and providers employ legions of workers to joust over payment and documentation.

In contrast, the government in Canada pays each hospital a global budget that covers all of the care that hospital delivers—similar to the way local governments in the United States pay their fire departments. Hospitals in Canada do not bill for individual patients or need to get an approval from an insurer for each diagnostic procedure or treatment. As a result, Canadian hospitals spend about 13 percent of their revenues on administration—compared to about 24 percent spent by U.S. hospitals. And billing by Canadian physicians is also far simpler; every patient has the same insurance plan, with the same simple set of rules. Canadian physicians have billing costs that are two-thirds lower than those of U.S. physicians.

A single-payer system also saves on insurance overhead, which consumes about 14 percent of premiums in the United States, compared to 1 percent in Canada. Overall, a properly structured single-payer system in the United States could decrease insurance overhead and physicians' paperwork costs by about $400 billion annually.

A single-payer system in the United States could realize additional savings through improved health planning to assure that hospitals and other "high-tech" facilities are available where they are needed and not duplicated where they are wasteful—or even harmful. An excessive number of hospital beds and excessive medical technology induce over-treatment—a phenomenon first noted by Milton Roemer, who articulated "Roemer's Law": "A built (hospital) bed is a filled bed."

In order to minimize incentives for gaming the payment system, and to match investment to need, control of new capital expenditures is essential, by forbidding hospitals and clinics from retaining any surplus funds (or profit) left over from their operating budgets. If hospitals and clinics could use these leftover funds to buy new buildings and high-tech equipment, they could avoid unprofitable patients and services and seek out profitable ones in order to expand. Conversely, in this scenario, hospitals and clinics that provide needed—but unprofitable—care could be starved for new investment. Therefore, effective health planning requires that funds for new capital be allocated through a transparent and democratic process.

In the United States, legislation to implement a single-payer system has been introduced in Congress and several state legislatures. Such a system would automatically enroll all residents and fully cover them for all medically necessary care. Patients would have free choice of physicians and hospitals. Hospitals and clinics would be freed of insurers' burdensome micro-management, but would have to adhere to their budgets.

Polls show substantial support for such reform, both among the general public and among health professionals. In contrast, pharmaceutical and insurance firms, which would lose huge amounts of money under a single-payer system, continue to spend enormous sums to influence politicians to keep a single-payer system off the political agenda. In the United States, groups such as Physicians for a National Health Program (www.pnhp.org), Healthcare Now (www.healthcare-now.org), the National Nurses Organizing Committee (www.NationalNursesUnited.org), and Public Citizen (www.citizen.org) are working to educate the public about single-payer health care and to build the popular movement that can lead to its being established.

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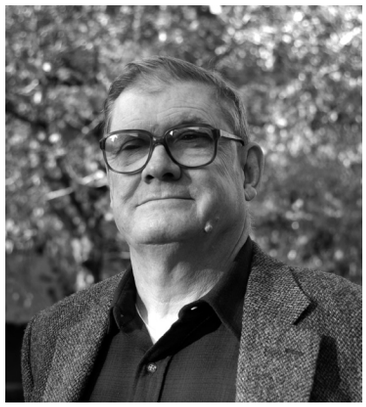
A Casualty in the Class War: Canada's Medicare

By Robert G. Evans

Abstract

"There's class warfare, all right, but it's my class, the rich class, that's making war, and we're winning." (Warren Buffett, five years ago.) Last year's Occupy Wall Street movement suggested that people are finally catching on. Note, *making* war: Buffett meant that there was deliberate intent and agency behind the huge transfer of wealth, since 1980, from the 99% to the 1%. Nor is the war metaphorical. There are real casualties, even if no body bags. Sadly, much Canadian commentary on inequality is pitiably naïve or deliberately obfuscatory. The 1% have captured national governments. The astronomical cost of American elections excludes the 99%. In Canada, parliamentary government permits one man to rule as a de facto dictator. The 1% don't like medicare.

"There's class warfare, all right," Mr. Buffett said, "but it's my class, the rich class, that's making war, and we're winning" (Stein 2006). Readers of The Undisciplined Economist may recall the same point being made slightly earlier that year (Evans 2006). There, we drew on the work of a number of quite disciplined economists – humble, useful people – who have demonstrated from taxation statistics in a number of countries the dramatic shift after 1980 from a relatively stable post-war income distribution to one that was becoming rapidly more unequal – and still is.



Robert Evans, Ph.D.

Buffett's methodology was somewhat less formal.

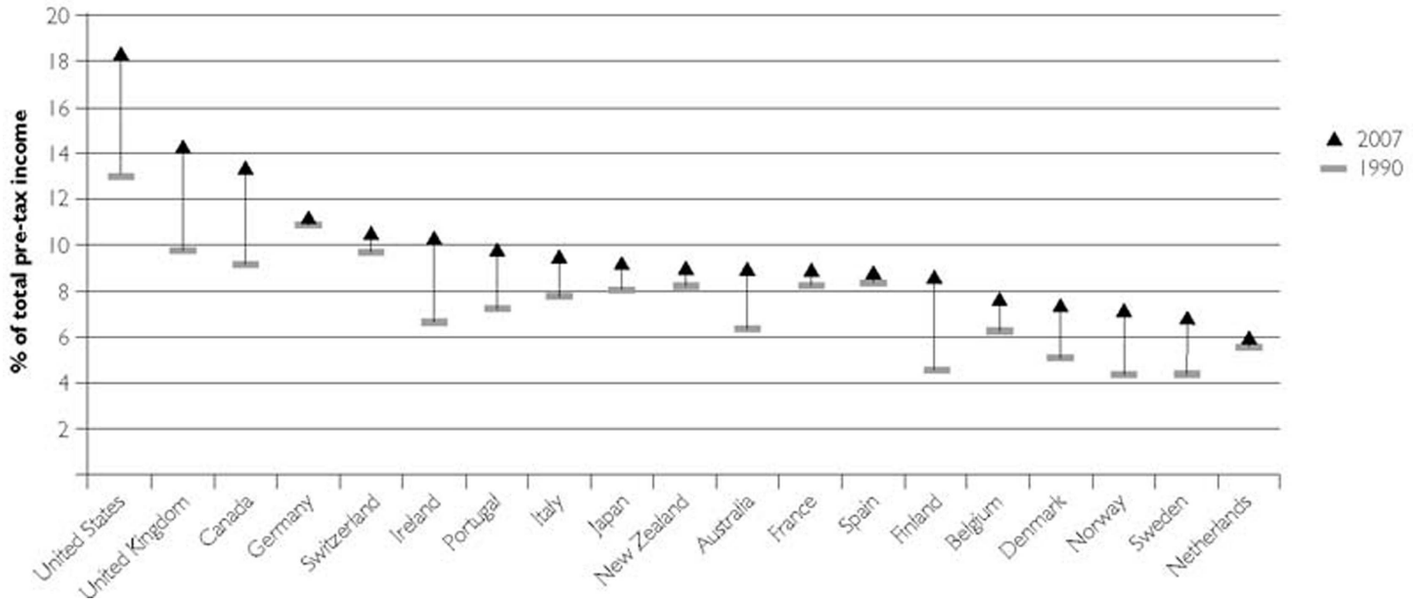
> [He] compiled a data sheet of the men and women who work in his office. He had each of them make a fraction; the numerator was how much they paid in federal income tax and in payroll taxes for Social Security and Medicare, and the denominator was their taxable income. … The people in his office were mostly secretaries and clerks, though not all.
>
> It turned out that Mr. Buffett, with immense income from dividends and capital gains, paid far, far less as a fraction of his income than … anyone else in his office. (Stein 2006)

And this without the aid of sophisticated "tax planning" (tax avoidance) advice. Mr. Buffett just filled out the IRS forms.

"How can this be fair?" he asked, "How can this be right?"

Healthcare Policy can actually claim publication precedence over Mr. Buffett on the subject of class war, though his remarks, reported in the *New York Times*, probably reached a somewhat wider audience.[1] But until the emergence of the "Occupy"

FIGURE 1. Income inequality in OECD member countries, shares of top 1% incomes in total per-tax income 1990-2007 (or closest year)



movement in 2011, the dramatic (and well-documented) growth of income inequality had received little mainstream press. Efforts in the United States to bring these trends to broad public attention and encourage discussion of their sources and implications were effectively shouted down by spokesmen for the now-famous "1%" – such as former President George W. Bush – as attempts to "foment class war."

Only in the last year does it seem to be sinking in that a one-sided class war has been going on for decades. Mr. Buffett was simply expressing an obvious and consequential truth. The rich, and especially the very, very rich, have gotten steadily much richer.[2] The rest have not. It remains to be seen whether this awareness will "have legs" or will fade as the media in the Excited States become fascinated with something else.

But does this have anything to do with Canada? Conveniently enough, the Organisation for Economic Co-operation and Development has just published a cross-national study of growing income inequality in OECD member countries (OECD 2011). As one would expect, the awful Americans top the inequality chart, with "the 1%" taking 17% of pre-tax income in 2005. But "kinder, gentler" Canada? Yep, the bronze.

The U.K. has been similar to the U.S., in both respects, over the past two decades. In 2005 the share of the top 1 per cent in pre-tax incomes varied from 5.6 per cent in the Netherlands and 6.3 per cent in Denmark and Sweden to 12.7 per cent in Canada, 14.3 per cent in the U.K. and 17.4 per cent in the U.S. Policies and social preferences – particularly the role of stock-driven rewards and of financial services at the top – make a very big difference. (Wolf 2011)

The inequality trends may be similar in both Canada and the United States, but there are a couple of important differences. In both countries, capture of the national government is a central feature of the redistribution strategy. But the process of capture has been quite different in the two countries – much quieter and less disruptive in Canada. The 1% in Canada are stealth fighters. And perhaps for that reason, very few Canadians have connected the dots to figure out that there is, in fact, a war on.[3]

Emphasis on the term "class war" underlines two very important points about the trends in income inequality. The first is that these trends are to a considerable extent a consequence of conscious, deliberate agency by more or less organized and coherent interest groups. They are not an inexorable result of the forces of nature, or the laws of motion of modern economies. When Warren Buffett says that his side is winning, he is not speaking metaphorically. The 99% may be only just beginning to realize what has been happening – after all, a great deal of effort and expense has been devoted to keeping them ignorant and confused on this score. But the 1% mostly know perfectly well what they are doing, and have a significant advantage in their influence over the instruments of propaganda.

The second point, grimly, is that there are real bodies. This war has casualties, in thousands and perhaps millions, though we never see them on the nightly news.

Let's start with the deaths. Professor Jeffrey Sachs is one of the world's leading students (and practitioners) of economic development. Writing in the *Huffington Post*, he almost scorches the (virtual) paper with his outrage as he predicts the consequences of a decision by the US government to renege on its pledge to the Global Fund to Fight AIDS, TB and Malaria (Sachs 2011a). That fund "has mobilized [scientific] knowledge over the past decade to save more than 7 million lives and to protect the health of hundreds of millions more." The elimination of the USD$4 billion contribution (over three years) would amount to a bit more than two days' spending on the American military, and is collateral damage from the ongoing ideological and financial "class struggle" over the US budget. "Millions of people are now at risk of death over the coming years" (Sachs 2011a). But of course, these people do not vote in American elections, much less make large political contributions. They are not PLUs (People Like Us).

Krugman and Wells (2006) bring the butcher's bill somewhat closer to home:

The United States is unique in being a place where the cost of illness and medical expense can bankrupt you, where the inability to pay for basic medical care can lead to a downward spiral in your health, and eventually death. Millions of Americans are unable to afford medical care and the results are dire. The best estimates suggest that something like 18,000 unnecessary deaths take place each year just because of inadequate health insurance. That's the equivalent of six 9/11s every year.

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The financing of medical care is a central battleground in the American class war. How could it be otherwise? Modern medicine is expensive and effective. While it is more expensive than it needs to be, and less effective than it could be, there is no denying its capacity to alleviate pain and suffering, maintain function and defer death. But need, or at least capacity to benefit, is extremely unequally distributed across all populations, bearing no relation to ability to pay. It follows that a modern health system is simply impossible without collective financing.

All this is well understood and has been for many years.[4] But the obvious implication is that a well-functioning modern health system requires the transfer, through taxation, of a very significant amount of money from the healthy and wealthy to the care of the unhealthy and unwealthy. This has always been much more politically contentious in the United States than in more civilized societies, which is why Americans remain saddled with a brutally inhumane and grotesquely inefficient and expensive health system.

As Stiglitz (2011) says about inequality in general, however, the American 1% actually like it that way. They get pretty much immediate access to some of the finest medical care in the world, without the necessity of supporting a similar standard for their fellow citizens. And indeed they are not, in any meaningful

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sense, fellow citizens. The 1% neither live with, nor die with, the 50-plus million Americans who have no health insurance coverage, public or private, and must get by with whatever care they can pay for out of thin pockets, or various forms of charity.

But the butcher's bill is by no means merely an account of inadequacies in the health system. The strong correlation between health and wealth has been known for years – centuries? – but over the last half-century a great deal of progress has been made in understanding the complex pathways through which social and economic inequality "get under the skin." In the face of rapid scientific advances, efforts to dismiss large social gradients in morbidity and mortality as simply a reflection of "bad behaviour and bad genes" have lost whatever credibility they might ever have had.

Social contexts – the environments in which people live and work – have mortal implications that unfold over long periods of time (see, e.g., Siddiqui and Hertzman 2007). And it is through degrading these environments that the class war being waged by the rich may generate the really big body counts – if anyone were counting.

The class warriors do not, of course, really want to kill anyone. Any disease, disability or death resulting from increased inequality is merely collateral damage from the collective pursuit by the 1% of ever greater economic advantage.[5] We turn, then, to consider the more bloodless matters of strategy and tactics in the American way of class war. Stiglitz (2011) matches Sachs in his outrage:

It's no use pretending that what has obviously happened has not in fact happened. The upper 1 percent of Americans are now taking in nearly a quarter of the nation's income every year. In terms of wealth rather than income, the top 1 percent control 40 percent. … Twenty-five years ago, the corresponding figures were 12 percent and 33 percent. … While the top 1 percent have seen their incomes rise 18 percent over the past decade, those in the middle have actually seen their incomes fall.

> It's no use pretending that what has obviously happened has not in fact happened. The upper 1 percent of Americans are now taking in nearly a quarter of the nation's income every year. In terms of wealth rather than income, the top 1 percent control 40 percent. … Twenty-five years ago, the corresponding figures were 12 percent and 33 percent. … While the top 1 percent have seen their incomes rise 18 percent over the past decade, those in the middle have actually seen their incomes fall. … All the growth in recent decades – and more – has gone to those at the top. (Stiglitz 2011)

Professor Stiglitz outlines briefly the broader social and economic costs of a lopsided income distribution – the decline of public infrastructure, institutions and services that the wealthy no longer need and so refuse to pay for. But his principal point is that one big part of the reason we have so much inequality is that the top 1 percent want it that way. … Lowering tax rates on capital gains, which is how the rich receive a large portion of their income, has given the wealthiest Americans close to a free ride. Monopolies and near monopolies have always been a source of economic power – from John D. Rockefeller … to Bill Gates. Lax enforcement of anti-trust laws, especially during Republican administrations, has been a godsend to the top 1 percent. Much of today's inequality is due to manipulation of the financial system, enabled by changes in the rules that have been bought and paid for by the financial industry itself. … Regulators turned a blind eye to a lack of transparency and to conflicts of interest. (Stiglitz 2011)

Stiglitz's summary: "Wealth begets power, which begets more wealth." But the process of begetting always takes place through intercourse between people.[6]

Virtually all U.S. senators, and most of the representatives in the House, are members of the top 1 percent when they arrive, are kept in office by money from the top 1 percent, and know that if they serve the top 1 percent well they will be rewarded by the top 1 percent when they leave office. By and large, the key executive-branch policymakers on trade and economic policy also come from the top 1 percent. When pharmaceutical companies receive a trillion-dollar gift – through legislation prohibiting the government, the largest buyer of drugs, from bargaining over price – it should not come as cause for wonder. It should not make jaws drop that a tax bill cannot emerge from Congress unless big tax cuts are put in place for the wealthy. Given the power of the top 1 percent, this is the way you would expect the system to work. (Stiglitz 2011)

And lest the money run short:

The Supreme Court, in its recent *Citizens United* case, has enshrined the right of corporations to buy government, by removing limitations on campaign spending. The personal and the political are today in perfect alignment. (Stiglitz 2011)

So the United States government is owned by the 1%, directly or through the corporations these people control. And the situation is likely to get worse before it gets better – if it ever gets better. But what has that to do with Canada, or with health policy? Well, let's take that issue in two bites.

First, consider a still more recent column by Stiglitz (2012), in which he argues that the present economic crisis in Europe and North America is not simply a consequence of the reckless greed of "the banksters" and the irresponsibility of regulators drunk on wacko economic theories. (Yes, you, Mr. Greenspan and Ms. Rand.) Ideology and the reckless greed that it permitted and justified have certainly led to great dislocation and suffering. But, Stiglitz argues, there is a more fundamental economic re-alignment taking place, akin to the massive shift during the 1930s. Then, great increases in agricultural productivity eliminated millions of jobs in that sector. Today, a combination of globalization and increased productivity is having the same effect on manufacturing in the high-income world. Millions of "good" jobs have gone, and they won't be back.[7] Now, as then, the result is long-term high levels of unemployment and the corresponding human misery and economic costs.

The crucial point, though, is that the necessary economic re-alignments of the 1930s did not take place through the

marketplace, even in the fabled "long run."[8] The Depression never really ended until the Second World War. (Go back and look at the historical data on unemployment and GDP per capita.) The many and justly celebrated achievements of Roosevelt's New Deal may have mitigated the effects of the Long Slump, but what ended it was massive government spending and taxation.

The war was also the historic break in the pattern of income inequality. It was followed by a generation of relatively more equal incomes, at least relative to what preceded and followed it (see Evans 2006 and the sources therein). If you really want to mitigate inequality, "tax and spend" works pretty well. That's why the 1% hate it like poison. It isn't a mystery.

Well, if Stiglitz is right, and the analogy with the 1930s holds, then we, all of the high-income world – even Canada, when commodity markets sag – are heading into another Long Slump. The only way out (that we know of) is a major government-led program of economic reconstruction. Is this anywhere on anyone's policy horizon? On the contrary, all the talk is of "austerity" and budget cuts, the same old fiscal orthodoxies that kept the Depression going.

The 1% were there during the Depression too, and battled Roosevelt's reforms all through the 1930s. The war simply overwhelmed them – for a time. But memories fade, and the pundits came back at the end of the 1970s with a repainted and refurbished collection of old economic fantasies. Depression-era restrictions on banking went first, with consequences we have seen. American Social Security is under continuing attack, as is the American watered-down version of medicare.

Yes, yes, the Americans are awful, we all know that. So what? Well, if Stiglitz is right, and the analogy with the 1930s holds, then we, all of the high-income world – even Canada, when commodity markets sag – are heading into another Long Slump. The only way out (that we know of) is a major government-led program of economic reconstruction. Is this anywhere on anyone's policy horizon? On the contrary, all the talk is of "austerity" and budget cuts, the same old fiscal orthodoxies that kept the Depression going.

> [I]n the face of high unemployment, growing inequality and looming budget deficits, most governments are paralysed, in thrall to powerful interests. Wall Street, the City of London, the Frankfurt banks and other corporate lobbies hold politics in their grip, and block effective change. (Sachs 2011b)

Build a big woodpile, folks, it could be a long winter.

The process of government capture, as noted above, has been completely different in Canada. Here is no political gridlock – quite the contrary. As students of political science are taught early on, any parliamentary government with a solid majority and no election in sight is essentially a dictatorship. The only constraints are customary – convention and precedent – and (in Canada) some constitutional restrictions. A majority government that chooses to ignore parliamentary conventions, even to be in contempt of Parliament, is to all intents and purposes a dictatorship. So while in the United States the 1% agenda is pursued through government gridlock and fiscal blackmail, here we have Stephen Harper's "strong, stable government."

Much could be said about the agenda of the Harper government, but not here. Readers will make their own assessments of the relationship between present federal policies and the agenda of the 1%. But there is the "curious incident of the dog in the night-time."

The Canadian right wing have tried for decades, first to prevent the emergence of universal public medicare[9] and then to undermine it by eliminating the federal cash transfer without which the federal standards cannot be enforced.[10] Medicare's enemies, like its architects, have always recognized the critical role of conditional federal cash transfers in maintaining the integrity of the system. If these cash transfers could be eliminated, the universal system would eventually crumble.

If there are no fiscal penalties for transferring health costs, directly or indirectly, from their own budgets to those of patients, the temptations for cash-strapped or ideologically unsympathetic provincial governments will become irresistible. An increasing share of the burden of payment will slowly (?) but steadily shift from taxpayers towards patients – from the 1% to the 99% – while access shifts in the other direction. At some point, the private insurance industry may return to impose a whole additional layer of "cost without benefit."

Until now, the broad privatization agenda has been (largely) frustrated by strong public support for Canada's most popular and effective social program. Yet, when Stephen Harper quietly slipped his knife into the heart of medicare – no more conditional cash transfers – few seem to have noticed. Where was the barking dog?[11] Very odd.

It may take some time for medicare to die – that's the point of the increased but "stringless" federal financing. Patch over the fatal wound – Stephen Harper is a patient man. When in due course medicare does crumble, he will be able to say to its ghost, as MacBeth says to Banquo's: "Thou can'st not say I did it. Never shake thy gory locks at me!"

It was the provinces.

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THE COMMONWEALTH FUND

DECEMBER 2012

Data Brief

Trends in Employer-Sponsored Health Insurance Premiums and Employee Contributions in Major Metropolitan Areas, 2003–2011

JACOB A. LIPPA AND CATHY SCHOEN
THE COMMONWEALTH FUND

ABSTRACT: Analysis of employer-sponsored health insurance costs in 41 U.S. metropolitan areas shows a 61 percent average increase in premiums for family coverage from 2003 to 2011, and a 21 percent increase over the past three years. Growth in family coverage premiums ranged from 35 percent in Sacramento, Calif., to 87 percent in Columbia, S.C. A similar trend was observed for individual insurance coverage: in 20 of the metro areas, single-person premiums increased at least 50 percent. If the average rate of growth seen over the past eight years continues to the year 2020, the cost of family coverage in 18 of these 41 metro areas will exceed $25,000.

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The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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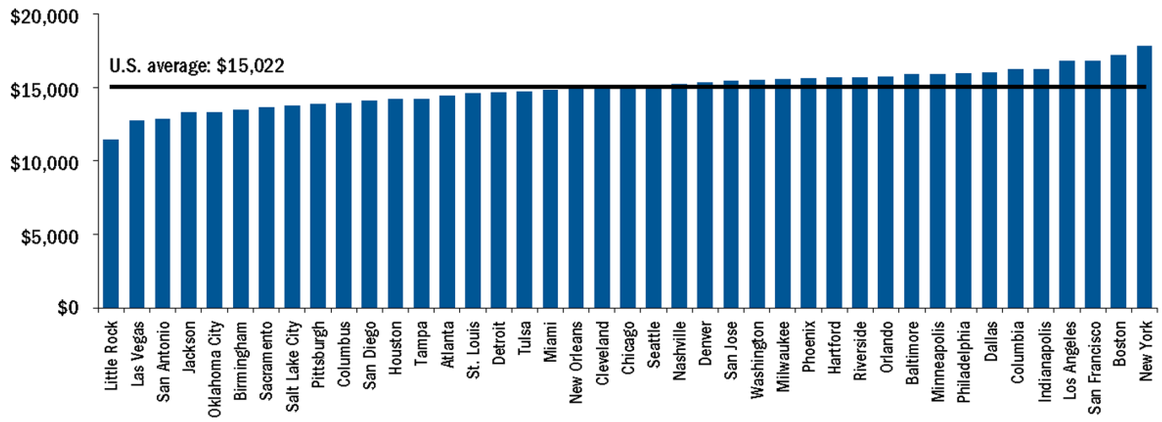
OVERVIEW

Across the United States, premiums for employer-sponsored health insurance reached an all-time high in 2011, rising far faster than incomes in all states. This data brief, a companion to The Commonwealth Fund report *State Trends in Premiums and Deductibles, 2003–2011: Eroding Protection and Rising Costs Underscore Need for Action*, examines trends in 41 major metropolitan statistical areas (MSAs), home to some 148 million people, over the period 2003 to 2011.

Based on our analysis of federal Medical Expenditure Panel Survey data, we find that employers and working families have seen the costs of health insurance increase by 61 percent over the past eight years and 21 percent over the past three years (2008 to 2011). All metro areas reported on here saw a marked increase in costs since 2003, ranging from 35 percent in Sacramento, Calif., to 87 percent in Columbia, S.C., for family coverage (Table 1). By 2011, average total premiums for employer-sponsored family coverage in the 41 MSAs ranged from

Exhibit 1. Average Total Premiums for Family Coverage, 2011



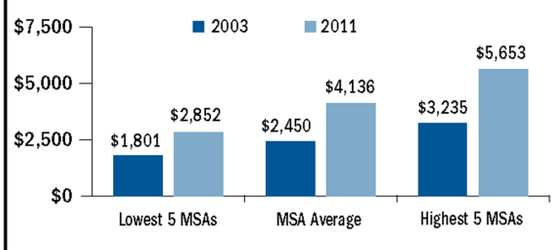
Source: Agency for Healthcare Research and Quality, 2011 Medical Expenditure Panel Survey–Insurance Component.

$11,398 in Little Rock, Ark., to $17,772 in New York, N.Y. (Exhibit 1), with relatively small variation in premiums for most MSAs.

Between 2003 and 2011, three-quarters (31) of the MSAs experienced an increase in insurance premiums of at least 50 percent. Differences in premiums, particularly for family coverage, widened over this period: in 2003, the difference between the lowest- and highest-cost areas was $3,068, but by 2011, it had more than doubled to $6,374.

The story for individual insurance coverage was similar. In half (20) of the metro areas, single-person premiums increased at least 50 percent. By 2011, average premiums for individual policies ranged from $4,190 in Las Vegas, Nev., to $6,072 in New York, N.Y. (with a median of $5,230).

Exhibit 2. Employee Share of Average Total Premiums for Family Coverage, 2003 and 2011



Source: Agency for Healthcare Research and Quality, 2003 and 2011 Medical Expenditure Panel Survey–Insurance Component.

A SHARP RISE IN EMPLOYEE AND FAMILY OUT-OF-POCKET PREMIUM COSTS

As employers seek to control their rising costs for health benefits, many have required their employees to pay a higher share of premiums. As a result, out-of-pocket premium costs for workers and their families have increased sharply in city after city (Tables 2 and 3). Between 2003 and 2011, the average annual employee share of premiums for family coverage increased by 69 percent, from $2,450 to $4,136 (Exhibit 2). In the five cities where the employee share was highest, average annual costs for family coverage paid by the employee reached $5,653, up 75 percent since 2003.

The share of premiums paid by workers for single coverage also rose markedly in many metro areas. Between 2003 and 2011, employee contributions for single coverage more than doubled in 12 of the 41 MSAs; the average increase was 78 percent. Workers' contributions toward single coverage in Riverside, Calif., climbed 165 percent between 2003 and 2011, to $1,126 per year, while the highest contribution was in Orlando, Fla. ($1,581).

RATES FOR METRO AREAS LARGELY REFLECT STATE RATES

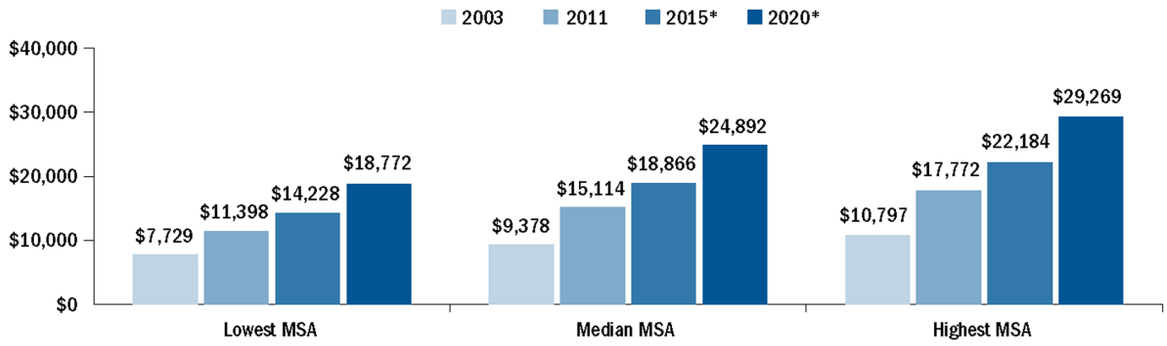
Given that the 41 metropolitan areas in this study are major population centers in their respective states, it is not surprising that their premium costs generally align with those observed at the state level. In fact, in 35 of these MSAs, average total premiums for family coverage were within 10 percent of the state rate, while in 15 MSAs they were below the state rate (Table 4). Similarly, in 39 of the 41 MSAs, single premiums were within 10 percent of the state rate, and in half (19) of these MSAs, the cost of single coverage was equal to or lower than the state rate.

Yet, the cost of employer-sponsored insurance also varies across cities within the same state, based on two large states for which data for multiple cities are available. Across six MSAs in California, family premiums varied by more than $3,000 per year in 2011, from a low of $13,614 in Sacramento to a high of $16,802 in nearby San Francisco. Similarly, in Texas, average total family premiums in Dallas were 25 percent higher than those in San Antonio in 2011 ($15,977 vs. $12,813).

NEED FOR ACTION TO CONTROL HEALTH CARE COSTS

The steady increase in the costs of employer-sponsored coverage has meant that less money is available for workers' wages or for investing in, and expanding, businesses. The trend speaks to the urgent need to address the underlying factors driving up health insurance costs. If the average rate of growth seen over the past eight years continues to the year 2020, the cost of family coverage in 18 of these urban areas will exceed $25,000, if the same rate of growth applied to all areas (Exhibit 3 and Table 5).

Exhibit 3. Average Total Premiums for Family Coverage, 2003–2020



* Based on 2003–2011 national average growth rate.
Source: Agency for Healthcare Research and Quality, 2003 and 2011 Medical Expenditure Panel Survey–Insurance Component.

Table 1. Average Total Premiums for Single and Family Coverage Across 41 Major Metropolitan Areas, 2003 and 2011

Sorted alphabetically by state and metropolitan statistical area

		Single			Family		
State	MSA	2003	2011	Percent change	2003	2011	Percent change
AL	Birmingham	$3,169	$4,895	54%	$7,729	$13,447	74%
AZ	Phoenix	3,159	4,961	57	9,047	15,615	73
AR	Little Rock	3,106	4,444	43	7,758	11,398	47
CA	Los Angeles	3,211	5,230	63	9,469	16,790	77
	Riverside	3,508	5,055	44	8,782	15,677	79
	Sacramento	2,914	5,397	85	10,099	13,614	35
	San Diego	3,384	4,774	41	8,476	14,052	66
	San Francisco	3,402	5,698	67	9,323	16,802	80
	San Jose	3,374	5,594	66	8,376	15,411	84
CO	Denver	3,710	5,159	39	9,752	15,296	57
CT	Hartford	3,504	5,446	55	9,705	15,666	61
DC	Washington	3,501	5,205	49	9,682	15,492	60
FL	Miami	3,572	5,168	45	10,390	14,793	42
	Orlando	3,564	5,409	52	9,872	15,695	59
	Tampa	3,821	5,006	31	8,823	14,162	61
GA	Atlanta	3,488	5,256	51	9,825	14,416	47
IL	Chicago	3,747	5,359	43	9,877	15,114	53
IN	Indianapolis	3,715	5,342	44	9,919	16,254	64
LA	New Orleans	3,360	5,478	63	8,890	15,077	70
MD	Baltimore	3,404	5,408	59	9,513	15,879	67
MA	Boston	3,524	5,809	65	9,955	17,188	73
MI	Detroit	3,755	5,215	39	9,790	14,639	50
MN	Minneapolis	3,547	5,426	53	10,105	15,888	57
MS	Jackson	3,145	5,140	63	8,743	13,253	52
MO	St. Louis	3,309	5,294	60	9,292	14,593	57
NV	Las Vegas	3,604	4,190	16	8,635	12,683	47
NY	New York	3,838	6,072	58	9,922	17,772	79
OH	Cleveland	3,211	5,273	64	9,097	15,103	66
	Columbus	3,321	4,692	41	8,862	13,892	57
OK	Oklahoma City	3,162	4,589	45	8,972	13,266	48
	Tulsa	3,603	4,894	36	8,965	14,673	64
PA	Philadelphia	3,719	5,557	49	9,378	15,930	70
	Pittsburgh	3,189	4,889	53	9,193	13,850	51
SC	Columbia	3,266	4,921	51	8,692	16,246	87
TN	Nashville	3,847	5,300	38	10,247	15,175	48
TX	Dallas	3,635	5,397	48	9,516	15,977	68
	Houston	3,339	5,034	51	10,204	14,158	39
	San Antonio	3,231	4,283	33	8,846	12,813	45
UT	Salt Lake City	3,463	4,576	32	8,120	13,729	69
WA	Seattle	3,530	5,273	49	9,451	15,147	60
WI	Milwaukee	4,043	5,405	34	10,797	15,563	44

Source: Agency for Healthcare Research and Quality, 2003 and 2011 Medical Expenditure Panel Survey–Insurance Component.

Table 2. Average Employee Contributions and Share of Total Premium for Single Coverage Across 41 Major Metropolitan Areas, 2003 and 2011

Sorted alphabetically by state and metropolitan statistical area

		2003		2011		
State	MSA	Average employee contribution	Share of total premium	Average employee contribution	Share of total premium	Percent change ($) 2003–2011
AL	Birmingham	$465	15%	$1,125	23%	142%
AZ	Phoenix	573	18	1,134	23	98
AR	Little Rock	663	21	798	18	20
CA	Los Angeles	449	14	929	18	107
	Riverside	425	12	1,126	22	165
	Sacramento	421	14	1,030	19	145
	San Diego	593	18	901	19	52
	San Francisco	429	13	1,009	18	135
	San Jose	729	22	1,147	21	57
CO	Denver	613	17	1,141	22	86
CT	Hartford	877	25	1,301	24	48
DC	Washington	750	21	1,278	25	70
FL	Miami	791	22	1,009	20	28
	Orlando	858	24	1,581	29	84
	Tampa	648	17	1,029	21	59
GA	Atlanta	650	19	1,314	25	102
IL	Chicago	620	17	1,201	22	94
IN	Indianapolis	791	21	1,175	22	49
LA	New Orleans	639	19	1,139	21	78
MD	Baltimore	749	22	1,229	23	64
MA	Boston	745	21	1,391	24	87
MI	Detroit	538	14	1,193	23	122
MN	Minneapolis	638	18	1,180	22	85
MS	Jackson	474	15	1,098	21	132
MO	St. Louis	561	17	1,340	25	139
NV	Las Vegas	433	12	1,093	26	152
NY	New York	632	16	1,159	19	83
OH	Cleveland	624	19	1,103	21	77
	Columbus	627	19	965	21	54
OK	Oklahoma City	661	21	1,028	22	56
	Tulsa	712	20	1,117	23	57
PA	Philadelphia	621	17	1,200	22	93
	Pittsburgh	646	20	1,011	21	57
SC	Columbia	691	21	1,059	22	53
TN	Nashville	885	23	1,301	25	47
TX	Dallas	536	15	1,106	20	106
	Houston	549	16	1,016	20	85
	San Antonio	527	16	1,036	24	97
UT	Salt Lake City	643	19	932	20	45
WA	Seattle	355	10	717	14	102
WI	Milwaukee	827	20	1,114	21	35

Source: Agency for Healthcare Research and Quality, 2003 and 2011 Medical Expenditure Panel Survey–Insurance Component.

Table 3. Average Employee Contributions and Share of Total Premium for Family Coverage Across 41 Major Metropolitan Areas, 2003 and 2011

Sorted alphabetically by state and metropolitan statistical area

		2003		2011		
State	MSA	Average employee contribution	Share of total premium	Average employee contribution	Share of total premium	Percent change ($) 2003–2011
AL	Birmingham	$2,112	27%	$3,328	25%	58%
AZ	Phoenix	2,942	33	5,216	33	77
AR	Little Rock	2,186	28	3,557	31	63
CA	Los Angeles	2,755	29	4,858	29	76
	Riverside	1,588	18	2,588	17	63
	Sacramento	2,345	23	4,605	34	96
	San Diego	1,917	23	2,743	20	43
	San Francisco	1,963	21	3,969	24	102
	San Jose	2,623	31	3,506	23	34
CO	Denver	2,611	27	4,681	31	79
CT	Hartford	2,790	29	3,885	25	39
DC	Washington	2,808	29	4,573	30	63
FL	Miami	3,395	33	4,486	30	32
	Orlando	2,998	30	5,846	37	95
	Tampa	2,582	29	4,264	30	65
GA	Atlanta	2,417	25	4,341	30	80
IL	Chicago	2,215	22	3,822	25	73
IN	Indianapolis	3,918	39	3,773	23	–4
LA	New Orleans	2,193	25	4,666	31	113
MD	Baltimore	2,592	27	4,287	27	65
MA	Boston	2,322	23	4,160	24	79
MI	Detroit	1,774	18	3,472	24	96
MN	Minneapolis	2,539	25	4,367	27	72
MS	Jackson	2,549	29	5,568	42	118
MO	St. Louis	2,058	22	4,335	30	111
NV	Las Vegas	2,050	24	4,431	35	116
NY	New York	1,761	18	3,887	22	121
OH	Cleveland	2,055	23	3,332	22	62
	Columbus	2,449	28	2,836	20	16
OK	Oklahoma City	2,924	33	4,146	31	42
	Tulsa	1,994	22	4,701	32	136
PA	Philadelphia	2,564	27	4,003	25	56
	Pittsburgh	2,029	22	3,433	25	69
SC	Columbia	2,908	33	4,665	29	60
TN	Nashville	2,772	27	6,778	45	145
TX	Dallas	2,527	27	4,435	28	76
	Houston	2,655	26	4,840	34	82
	San Antonio	2,691	30	3,695	29	37
UT	Salt Lake City	2,390	29	3,154	23	32
WA	Seattle	2,224	24	3,393	22	53
WI	Milwaukee	2,267	21	2,937	19	30

Source: Agency for Healthcare Research and Quality, 2003 and 2011 Medical Expenditure Panel Survey–Insurance Component.

Table 4. Average Total Premiums for Single and Family Coverage Across 40 Major Metropolitan Areas, State vs. MSA Rates, 2011

Sorted alphabetically by state and metropolitan statistical area

		Single		Family	
State	MSA	State	MSA	State	MSA
AL	Birmingham	$4,828	$4,895	$12,940	$13,447
AZ	Phoenix	4,880	4,961	14,854	15,615
AR	Little Rock	4,392	4,444	12,474	11,398
CA	Los Angeles	5,255	5,230	15,837	16,790
	Riverside		5,055		15,677
	Sacramento		5,397		13,614
	San Diego		4,774		14,052
	San Francisco		5,698		16,802
	San Jose		5,594		15,411
CO	Denver	5,212	5,159	14,850	15,296
CT	Hartford	5,592	5,446	16,265	15,666
FL	Miami	5,216	5,168	14,732	14,793
	Orlando		5,409		15,695
	Tampa		5,006		14,162
GA	Atlanta	5,109	5,256	13,963	14,416
IL	Chicago	5,375	5,359	15,167	15,114
IN	Indianapolis	5,132	5,342	14,713	16,254
LA	New Orleans	4,681	5,478	13,572	15,077
MD	Baltimore	5,225	5,408	15,315	15,879
MA	Boston	5,823	5,809	16,953	17,188
MI	Detroit	5,061	5,215	14,458	14,639
MN	Minneapolis	5,426	5,426	15,539	15,888
MS	Jackson	4,846	5,140	13,420	13,253
MO	St. Louis	5,019	5,294	13,888	14,593
NV	Las Vegas	4,528	4,190	13,633	12,683
NY	New York	5,717	6,072	16,572	17,772
OH	Cleveland	5,025	5,273	14,327	15,103
	Columbus		4,692		13,892
OK	Oklahoma City	4,807	4,589	13,906	13,266
	Tulsa		4,894		14,673
PA	Philadelphia	5,244	5,557	15,096	15,930
	Pittsburgh		4,889		13,850
SC	Columbia	5,281	4,921	15,252	16,246
TN	Nashville	4,799	5,300	13,189	15,175
TX	Dallas	5,198	5,397	14,903	15,977
	Houston		5,034		14,158
	San Antonio		4,283		12,813
UT	Salt Lake City	4,597	4,576	13,455	13,729
WA	Seattle	5,144	5,273	14,559	15,147
WI	Milwaukee	5,444	5,405	15,505	15,563

Source: Agency for Healthcare Research and Quality, 2011 Medical Expenditure Panel Survey–Insurance Component.

Table 5. Average Total Family Premiums Across 41 Major Metropolitan Areas: Actual and Projected Amounts Through 2020

Sorted alphabetically by state and metropolitan statistical area

		Actual		Projected	
State	MSA	2003	2011	2015	2020
AL	Birmingham	$7,729	$13,447	$16,785	$22,146
AZ	Phoenix	9,047	15,615	19,491	25,717
AR	Little Rock	7,758	11,398	14,228	18,772
CA	Los Angeles	9,469	16,790	20,958	27,652
	Riverside	8,782	15,677	19,569	25,819
	Sacramento	10,099	13,614	16,994	22,421
	San Diego	8,476	14,052	17,540	23,143
	San Francisco	9,323	16,802	20,973	27,672
	San Jose	8,376	15,411	19,237	25,381
CO	Denver	9,752	15,296	19,093	25,191
CT	Hartford	9,705	15,666	19,555	25,801
DC	Washington	9,682	15,492	19,338	25,514
FL	Miami	10,390	14,793	18,465	24,363
	Orlando	9,872	15,695	19,591	25,849
	Tampa	8,823	14,162	17,678	23,324
GA	Atlanta	9,825	14,416	17,995	23,742
IL	Chicago	9,877	15,114	18,866	24,892
IN	Indianapolis	9,919	16,254	20,289	26,769
LA	New Orleans	8,890	15,077	18,820	24,831
MD	Baltimore	9,513	15,879	19,821	26,152
MA	Boston	9,955	17,188	21,455	28,307
MI	Detroit	9,790	14,639	18,273	24,109
MN	Minneapolis	10,105	15,888	19,832	26,166
MS	Jackson	8,743	13,253	16,543	21,827
MO	St. Louis	9,292	14,593	18,216	24,034
NV	Las Vegas	8,635	12,683	15,831	20,888
NY	New York	9,922	17,772	22,184	29,269
OH	Cleveland	9,097	15,103	18,852	24,874
	Columbus	8,862	13,892	17,341	22,879
OK	Oklahoma City	8,972	13,266	16,559	21,848
	Tulsa	8,965	14,673	18,316	24,165
PA	Philadelphia	9,378	15,930	19,885	26,236
	Pittsburgh	9,193	13,850	17,288	22,810
SC	Columbia	8,692	16,246	20,279	26,756
TN	Nashville	10,247	15,175	18,942	24,992
TX	Dallas	9,516	15,977	19,943	26,313
	Houston	10,204	14,158	17,673	23,317
	San Antonio	8,846	12,813	15,994	21,102
UT	Salt Lake City	8,120	13,729	17,137	22,611
WA	Seattle	9,451	15,147	18,907	24,946
WI	Milwaukee	10,797	15,563	19,426	25,631

Source: Agency for Healthcare Research and Quality, 2003 and 2011 Medical Expenditure Panel Survey–Insurance Component.

Methodological Notes

Data for this analysis were taken from the insurance component of the 2003, 2008, and 2011 Medical Expenditure Panel Survey (MEPS–IC), an annual survey of employers conducted by the Agency for Healthcare Research and Quality (AHRQ), a division the U.S. Department of Health and Human Services. A subset of metropolitan statistical areas (MSAs) was selected based on population size and data availability. MEPS data are only available for cities with sufficient employer sample size to draw statistically valid inferences. We selected all available MSAs with 1 million or more people for which MEPS data are available, and also included several other MSAs with populations between 500,000 and 1 million to achieve geographic spread. Many of the MSAs are composed of multiple municipalities. For simplicity, we have abbreviated these MSA names to best represent the area of analysis. For example, we refer to the Washington–Arlington–Alexandria MSA as "Washington." The appendix tables display average annual total premiums and employee share of annual premiums for single and family policies. Data presented are limited to private-sector establishments. To illustrate future costs if the historical trend continues, we applied the historical average annual rate of growth to all cities and projected rates by 2015 and 2020.

Chicago Tribune

March 5, 2012

Teachers, colleges getting early lesson in Obamacare

By Eric Zorn

They jokingly refer to themselves as "road scholars," the part-time, often itinerate employees who teach the majority of the classroom hours at community colleges.

Without their willingness to work for modest pay, tuition at these colleges would be out of reach for many of those looking to put a foot on the first rung of secondary education.

And now some of these instructors are finding themselves among the first to be ensnared by a requirement of Obamacare — the Affordable Care Act — as their employers are planning to cut their teaching hours to make sure they don't qualify for health care benefits under the new law.

Friday morning, adjunct professors and their supporters are planning a protest rally during an Illinois Council of Community College Presidents meeting in Lombard to urge leaders of the state's community colleges to "Keep the 'care' in the Affordable Care Act," as their promotional flier puts it.

Here's the problem: Starting next year, Obamacare will require companies that employ more than 50 full-time workers to provide health insurance to employees who work 30 or more hours a week, or else pay a fine.

But what's an "hour" for a college teacher? Depending on the subject matter, level of interaction with students and other factors, one hour in the classroom can require two, three or more hours of preparation, grading, conferences and so on.

This is probably just the first example of the many similar issues that will arise as the big, clumsy law tries to blend the private, employer-provided insurance model with the idea of near-universal medical coverage. Yet another lesson in Single-payer 101.

"How do we account for all that time? How do we measure it?" asks David Baime, senior vice president for governmental relations for the American Association of Community Colleges, which represents 1,167 institutions nationwide. "With almost 70 percent of our (classroom) credits now taught by adjuncts, the colleges are extremely concerned about how the law will be interpreted and the extra costs they might get hit with."

The Internal Revenue Service will hold a public hearing April 23 in Washington on this issue to attempt to sort out the concerns of the colleges and give them better guidance. But many schools are already planning out the 2013-14 school year, and some are erring on the side of caution, pre-emptively altering schedules and throwing some teachers into a panic.

Oakton Community College, with campuses in Des Plaines and Skokie, last month announced it would be cutting the hours of certain particularly active adjunct teachers starting this summer in order to make sure they won't qualify as full-time employees under the Obamacare threshold when it kicks in.

Oakton's marketing manager Janet Spector Bishop estimates 50 or fewer of the roughly 400 adjunct faculty members will lose hours when the somewhat complicated formula is applied.

Oakton's Adjunct Faculty Association union President Barbara Dayton puts the number at 85.

Whichever number is correct, here's the problem these teachers face: They're already at the low end of the pay scale — a typical adjunct teaching two classes that meet four hours a week might make $8,000 for a semester, with no job benefits — and now they're being told they're going to make even less money right when the law will compel them to buy insurance.

"It's a double whammy," said Bill Silver, an Illinois Education Association union representative who's helping organize Friday's rally. "They'll be earning 30 to 70 percent less money, then being told to go buy their (health) insurance on the exchanges."

Students, he said, will see either fewer class offerings or classes being taught by less experienced part-timers.

Ideally, Silver said, all community colleges would offer health care benefits for their part-timers.

An administrative memo at Oakton said the additional costs associated with Obamacare stood to be "several million dollars" depending on how the law is ultimately applied. And this, of course, could result in higher tuitions, larger class sizes or both.

Either way, it looks like students lose.

And this is probably just the first example of the many similar issues that will arise as the big, clumsy law tries to blend the private, employer-provided insurance model with the idea of near-universal medical coverage.

Yet another lesson in Single-payer 101.

Eric Zorn is a Chicago Tribune columnist.

Chapter Reports – Spring 2013

In **California**, nearly 300 medical and health professional students traveled from across the state in February to rally for single payer in Sacramento, the state capital. Cindy De La Cruz, Shearer Student Fellow and California Health Professional Student Alliance (CaHPSA) statewide coordinator, organized PNHP's successful Lobby Day and advance training session this year. The students met with 57 Assembly members and 2 state senators. Although the legislators are focused on implementing the ACA, they heard from the students that only single payer will cover every California resident and control health care costs. California PNHPers are also active in building a diverse coalition for reform and meeting with potential backers to discuss strategy to win single payer through either legislation or a ballot initiative (or both). Dr. Paul Song has been speaking and networking with other progressive organizations, and was recently appointed the first fellow in the California Insurance Commissioner's office. A new PNHP chapter began meeting in San Francisco in December. For details, contact Executive Director Bill Skeen at bill@pnhpcalifornia.org.

Dr. Arthur Chen of California speaks during CaHPSA's student lobby day.

In **Hawaii**, Dr. Stephen Kemble, president of the Hawaii Medical Association, has been outspoken in exposing problems in the state's Medicaid managed care system and in supporting single-payer reform. He served on several committees of the Hawaii Health Transformation Initiative, and was successful in educating those members representing doctors and the medical school. Nonetheless, the insurance industry-backed leadership is going ahead with implementing the ACA with for-profit Medicaid managed care. Kemble and other Hawaii PNHPers plan to focus on public education, media outreach and grassroots organizing, and to publicize the failures in of the ACA over the next two years. They will also seek the Hawaii AFL-CIO's endorsement of H.R. 676 and continue to fight Medicaid managed care. For details, contact Dr. Kemble at sbkemble@hawaii.rr.com.

The **Illinois** chapter of PNHP has been active in hosting events and launching two new medical student chapters. Scott Goldberg is helping to organize a student group at the Pritzker School of Medicine at the University of Chicago. Ina Clark is helping organize a chapter at Northwestern University, where medical students will be using H.R. 676 as the basis for study and discussion. Illinois PNHPers are also active in outreach to minority medical students, most recently at the Midwest meeting of the Latino Medical Student Association. State Representative Mary Flowers of Chicago reintroduced the Illinois Universal Health Care Act in January. The bill has a new number, HB 942, and one chief co-sponsor, state Rep. Kelly Cassidy of Chicago. The chapter's annual co-sponsored "Soul of Medicine" dinner was attended by over 60 physicians, medical students and other health professionals. This year's honoree was Dr. Linda Murray, past president of the American Public Health Association and longtime progressive health activist. The chapter hosted Dr. David Wrigley, a visiting general practitioner from the U.K. and a leader of the anti-privatization group Keep Our NHS Public, for several events in Chicago – one with medical students, one with labor contacts, and a reception for physicians and other health professionals. Finally, the chapter is working on getting the Illinois AFL-CIO to endorse H.R. 676. For details, contact Dr. Anne Scheetz at anneschеetz@gmail.com.

In **Indiana** PNHPers are active in writing, speaking, and working with other groups to publicize the need for the state to expand its Medicaid program to the full extent allowed under the ACA. The current Medicaid eligibility rules are extremely restrictive and the Republican governor is opposed to the expansion. Dr. Rob Stone, Karen Green Stone, and Dr. Jonathan Walker also continue to be active in organizing Hoosiers for a Commonsense Health Plan and in the campaign to divest from health insurers. For details, contact Dr. Rob Stone at grostone@gmail.com.

In **Minnesota** the chapter held a successful "Day on the Hill" in February. Over 60 physicians, medical students, and others gathered to lobby state lawmakers to support Rep. John Marty's state single-payer plan. Chapter co-leader Dr. Elizabeth Frost was featured in a Feb. 27 video interview, "Fighting for health care that doesn't leave you broke and naked," on St. Paul's news site www.theUptake.com. The chapter has gathered endorsements from over 800 physicians who publicly support single payer. For details, contact Dr. Elizabeth Frost at libbess@gmail.com.

North Carolina (Charlotte) PNHPers led by Dr. Jessica Saxe have launched a new chapter, "Health Care Justice." They are working with Health Care for All North Carolina and other groups to push the state to expand its Medicaid program under the ACA. They also plan to circulate a resolution in support of single payer patterned after the one that's been used in Minnesota. For details, contact Dr. Jessica Saxe at jsaxe@earthlink.net.

The **New York Metro** chapter of PNHP is active in a coalition with 49 other groups to defend the Medicare program from cuts ("The No Grand Bargain Coalition"). They are also involved in the effort to address the serious medical needs of New Yorkers in the wake of Hurricane Sandy – everything from emergency medical support to demanding the re-opening, on

an improved basis, of several hospitals that have been closed by the storm (i.e. "build back better"). The chapter participated in a forum featuring Sandy survivors and medical professionals and recently sponsored a unique one-man play titled "Mercy Killers" featuring Michael Milligan. The chapter is also building support for Rep. Gottfried's single-payer bill; they are planning a statewide Lobby Day in Albany, a call-in day, and a day of meetings with legislators in their home districts. Activists continue to be involved with Occupy Wall Street. Dr. Steffie Woolhandler is working with an Occupy offshoot called Strike Debt/Rolling Jubilee. Strike Debt is planning a week of actions on medical debt and single payer that will culminate in a rally in New York City on March 23. For details, contact chapter Executive Director Laurie Wen at laurie@pnhpnymetro.org.

In **Buffalo, N.Y.,** Dr. Katie Grimm and other PNHPers organized a forum featuring PNHP's new President Dr. Andy Coates and several local advocates for health care justice. About 100 people attended the forum. Dr. Coates' talk, and his comparison of the Affordable Care Act to the single-payer model, were very well received. Activists also arranged for Dr. Coates to meet with the editorial board of the Buffalo News and several local physicians. His visit resulted in two stories in the local media. For details, contact Dr. Grimm at kategrimmmd@gmail.com.

In **Oregon,** PNHPers are building a statewide single-payer coalition, Health Care for All Oregon, with over 40 other organizations. The chapter and coalition recently held a lobby day and rally in Salem that drew over 800 people. The theme was "Health care is a human right" and participants wore red T-shirts featuring that slogan. Participants of the lobby day visited at least half of the state's lawmakers. Rep. Michael Dembrow has reintroduced single-payer legislation in the House. PNHP members plan to give testimony at upcoming hearings on that bill as well as on legislation that would authorize a study of the economic impact of single payer on Oregon's economy. PNHPers are also helping to plan the second annual "Healing the Health Care Blues Fest"; last year's event drew about 2,000 people and raised $10,000. For details contact Dr. Paul Gorman at gormanp@me.com.

In **Rhode Island**, Dr. J. Mark Ryan recently spoke to the Rhode Island federation of the AFL-CIO on single-payer health reform. The federation subsequently voted unanimously to endorse H.R. 676. The chapter's future plans include speaking to more labor, physician, and community groups. For details, contact Dr. Ryan at pnhp.ri@gmail.com.

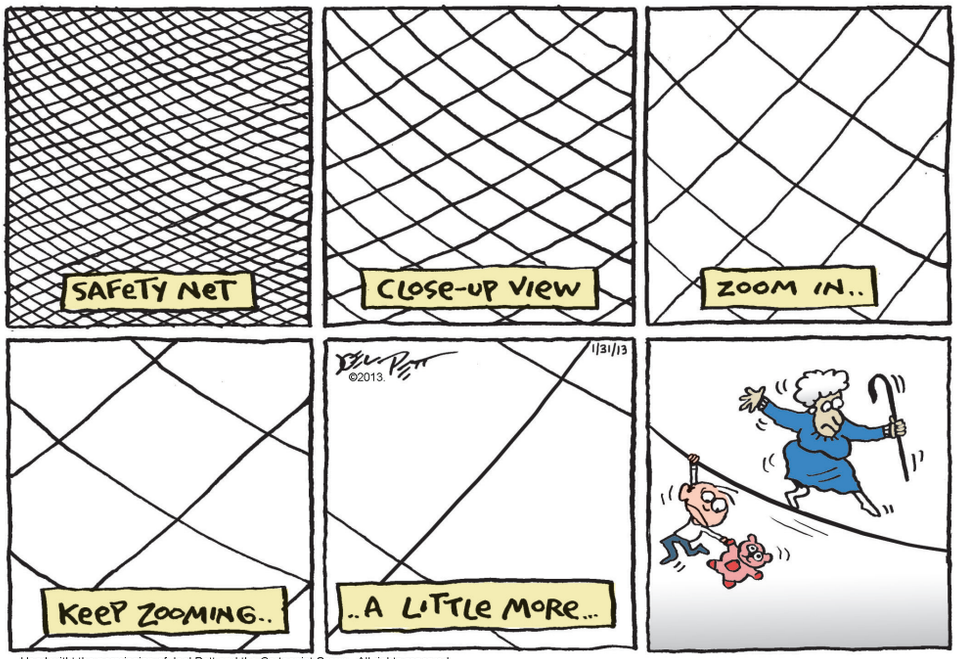
In **South Carolina**, a new chapter of PNHP led by David Ball and Dr. David Keely has started holding meetings and building relationships with other organizations, including the South Carolina Alliance of Retired Americans, labor groups, and others. The chapter has launched a web site (www.pnhpsc.org) with support from Dustin Calliari in the PNHP national office. Meetings are drawing about two dozen people. Two speakers from Health Care for All-NC laid out the business case for single payer at a recent gathering. The chapter has big plans for the future, including speaking, recruiting, and possibly promoting a state single-payer bill in South Carolina. For details, contact David Ball at david47@gmail.com.

David Ball of South Carolina with Rep. John Conyers Jr., D-Mich.

In **Tennessee**, PNHP board member Dr. Art Sutherland has been speaking and traveling across the region to build support for single payer. He and PNHP Past President Dr. Garrett Adams conducted a very successful multicity speaking tour through Tennessee and Kentucky, speaking to physicians, nurses, faith groups and the public. Dr. Sutherland is helping plan an upcoming conference on "Bias in health care" at Tougaloo College in Jackson, Mississippi. Dr. James Powers is working with Dr. Sutherland and others to form a **Middle Tennessee** chapter of PNHP. They are giving presentations and pushing the state to expand Medicaid under the ACA. For details, contact Dr. Sutherland at asutherland523@gmail.com.

In **Vermont** activists are building support for single payer through frequent speaking engagements, op-eds, letters to the editor, and ongoing monitoring of the implementation of health reform in the state. Activists have been especially vocal in their opposition to ACOs. PNHP Past President Dr. Deb Richter was recently featured in a lengthy article about single payer in Vermont Life. The chapter is hoping to mail a letter of invitation to join PNHP to every physician in the state. For details, contact Dr. Anna Carey at peggycareyster@gmail.com.

Western Washington state PNHPers are active in outreach to medical students and building support for single payer at the state and national levels. University of Washington medical students organized a well-attended debate between Dr. Hugh Foy of PNHP (supporting single payer) and Bob Crittendon, of the Herndon Alliance (supporting the ACA). The state's single payer bill, the Washington Health Security Trust, has been reintroduced and PNHPers will give testimony in the state House and Senate. The PNHP chapter is participating in the launch of a "Health care is a human right" campaign with the aim of building a grassroots movement for single payer in the state. One of its strategic partners in the campaign is the Washington State Labor Council. Chapter members led a workshop on "Health care as a human right and moving beyond the ACA" at the annual Martin Luther King Day celebration in Seattle. For details, contact Dr. Jim Squire at squirsky@earthlink.net.



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