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# PNHP Newsletter Fall 2014

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## Seeking Health Equity: PNHP Meeting, Nov. 15, New Orleans

Register now for PNHP's Annual Meeting in New Orleans on Nov. 15! Plenary speakers will include campaign finance reform activist Lawrence Lessig of Harvard, U. of Pennsylvania professor Dorothy Roberts, PNHP co-founders Drs. Steffie Woolhandler and David Himmelstein, physician-author Dr. Adam Gaffney (on updating PNHP's proposal), Dr. Diljeet Singh (on the ACA and women's health), and more. The meeting will be preceded by PNHP's Leadership Training Institute on Nov. 14. For details, visit [www.pnhp.org/meeting](http://www.pnhp.org/meeting). The venue is the Hampton Inn Convention Center New Orleans, (504) 566-9990.

## Single payer in the news

Dr. Steven Nissen, chair of cardiology at the Cleveland Clinic and past president of the American College of Cardiology, endorsed single payer in an Aug. 15 radio interview (see [www.pnhp.org/nissen](http://www.pnhp.org/nissen)). About a dozen newspapers published single-payer op-eds by PNHPers marking Medicare's 49th anniversary in late July, including the Albany Times Union, The Sacramento Bee, and the St. Louis Post-Dispatch. Dr. Adam Gaffney's commentary opposing a "private option" for Medicaid appeared in USA Today, and Dr. Ida Hellander's letter on "how cost deters care" was published by The New York Times (see p. 53). Both Drs. David Himmelstein and David Scheiner got in plugs for single payer in recent interviews on MSNBC.

## On the Hill: 'Special orders' and Lobby Day

On July 30, Rep. John Conyers Jr., D-Mich., chief sponsor H.R. 676, the single-payer bill, marked Medicare's anniversary with a "special order," a statement from the House floor in support of single payer. It was broadcast by C-SPAN. Activists are encouraged to ask their representatives to co-sponsor H.R. 676; 60 lawmakers have already done so. Conyers' speech coincided with a national call-in effort by single-payer groups in support of his bill.

On May 22, PNHP joined forces with Public Citizen, National Nurses United, the American Medical Student Association, the National Organization for Women, Healthcare-NOW! and a host of other groups for a National Single-Payer Lobby Day in Washington. The day before, PNHP President Dr. Andy Coates and Public Citizen President Rob Weissman were among those on a panel convened by Sen. Bernie Sanders, I-Vt. Dr. Margaret Flowers' testimony at the panel appears on p. 10.

## Dr. Robert Zarr is PNHP's president-elect

PNHP is proud to announce that Dr. Robert Zarr, a pediatrician dedicated to the care of underserved children, was elected by the Board of Directors to be PNHP's new president beginning in January 2015. Dr. Zarr is the longtime chair of PNHP's Washington, D.C., chapter and is past president of the D.C. chapter of the American Academy of Pediatrics. He received his medical degree from the Baylor College of Medicine, completed



a residency at Texas Children's Hospital in Houston, and obtained his M.P.H. from the University of Texas. He practices at Unity Health Care, a federally qualified community health center, where he cares for a low-income and immigrant population, and teaches at two area medical schools. He is fluent in Spanish and is a leader in both single-payer advocacy and in the effort to get kids out into nature through the "Park Prescription Project," recently featured on NPR. Congratulations, Dr. Zarr!

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**National Office Staff:** PNHP's headquarters in Chicago is staffed by Matt Petty, executive director; Dr. Ida Hellander, director of health policy and programs; Mark Almberg, communications director; Dustin Calliari, technology and social media associate; Angela Fegan, membership associate; and Emily Henkels, national organizer.

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## Membership drive update

Welcome to over 520 physicians and medical students who have joined PNHP in the past year! PNHP's membership stands at 19,265. We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community. Need help getting started? Drop a note to PNHP National Organizer Emily Henkels at e.henkels@pnhp.org.

## Single-payer debate rekindled at AMA

Boston University medical student Brad Zehr and 60 other students from 18 institutions backed a single-payer resolution presented to the Medical Student Section of the AMA at that group's annual meeting in Chicago in June. While the resolution failed in a procedural vote, it sparked a vigorous and useful debate, as did a single-payer resolution introduced into the AMA House of Delegates by Public Health delegate Dr. Kevin Sherin. State AMA affiliates may do better (Hawaii passed one!); a sample single-payer resolution is available at [www.pnhp.org/sampleresolution.pdf](http://www.pnhp.org/sampleresolution.pdf).

## Single payer at the upcoming AAFP

PNHP will host an exhibit at the American Academy of Family Physicians in Washington, D.C., Oct. 23-25, 2014. A resolution by the AAFP's Minnesota chapter requests that "the AAFP Congress of Delegates promote AAFP participation in national deliberations and discussions pertaining to single payer financing systems for health care reform," and the Oregon chapter submitted a resolution calling on the AAFP to endorse single-payer national health insurance. PNHPers are encouraged to ask their local AAFP chapters to support these resolutions. Longer term, Dr. Alap Shah is interested in forming a caucus to promote single payer at the 2015 AAFP meeting; to join, drop him a note at [slap.ahah@gmail.com](mailto:slap.ahah@gmail.com).

## Advantages of single payer over the ACA

Truly universal coverage • Dramatic reduction in administrative waste • Removal of financial barriers to care • Coverage of all essential health care services • Free choice of hospitals and health care professionals • Removal of the interventions and excesses of the private insurers • Taxpayer financing based on ability to pay • Infrastructure reform that would slow spending to sustainable levels.

*Excerpted from the July 25 "Quote of the Day" by Dr. Don McCanne, PNHP's senior health policy fellow. To subscribe to Dr. McCanne's succinct commentaries, drop a note to [don@mccanne.org](mailto:don@mccanne.org).*

# Health care crisis by the numbers:

## Data update from the PNHP newsletter editors

### UNINSURED AND UNDERINSURED

#### Early reports on the ACA

- The proportion of non-elderly adults who are uninsured fell from 20 percent in August 2013 to 15 percent in May 2014 (at the end of the first open enrollment period of the health exchanges), a drop of 9.5 million people.

The decline affected almost every demographic group except for blacks, among whom the uninsured rate barely budged, from 21 percent in 2013 to 20 percent in 2014, according to a telephone survey of 4,425 people by The Commonwealth Fund. A disproportionate share of black respondents (62 percent) live in states that are not expanding their Medicaid programs, but researchers don't think that's the whole explanation. Two of the three states with the highest population of Latinos, Texas and Florida, did not expand their Medicaid programs, yet the proportion of uninsured Latinos reportedly fell from 36 percent to 23 percent. Among whites, the uninsurance rate fell from 16 percent to 12 percent.

In states that expanded Medicaid, the proportion of uninsured adults fell to 10.1 percent, while it dropped only slightly, to 18.3 percent, in those states not expanding Medicaid. 47.2 million people were uninsured in 2012, according to the Census Bureau (Flavelle, "Obamacare is working. Unless you're black," Bloomberg News, 7/10/14).

The Congressional Budget Office estimates that 36 million people will be uninsured in 2015, 30 million in 2016, and 31 million in 2024. Of those who remain uninsured in a decade, about 30 percent will be undocumented immigrants ineligible for subsidies or Medicaid benefits; about one-quarter will be people legally eligible for public benefits but uninsured, either because they live in a state that has not expanded Medicaid (5 percent), or because they don't know about the program or choose not to enroll (20 percent); the remaining 45 percent "will not purchase insurance to which they have access" (CBO, "Updated estimates of the impact of the insurance coverage provision of the ACA," April 2014).

- Among people who shopped for insurance during the Affordable Care Act's first enrollment period but didn't enroll, the main reasons given for remaining uninsured were "the costs aren't worth it" (39 percent), website problems (27 percent) and "too confusing" (26 percent). 48 percent of the uninsured who didn't shop on the exchanges cited cost as their reason for remaining uninsured, according to a survey funded by the Robert Wood Johnson Foundation ("Why did some people enroll, and not others," PerryUndem Research, 5/21/14).

- The proportion of uninsured Minnesotans (the first state to

release data) fell by 40 percent, from 8.2 percent of the population, 445,000 people, to 4.9 percent, 264,500 people, between September 2013 and April 2014, the first open enrollment period for the ACA. Of the 180,500 people who gained coverage, 155,000, 86 percent, enrolled in one of the state's two government-sponsored health programs for the poor, Medicaid, for people with incomes up to 138 percent of poverty, and MinnesotaCare, for people with incomes up to 200 percent of poverty. Although 42,265 people signed up for private coverage on the state's exchange, MNSure, many of them had prior coverage. The impact of the ACA in Minnesota is similar to the experience in Massachusetts under Romneycare, where the expansion of Medicaid and availability of subsidized coverage reduced the number of uninsured by about half ("Early impacts of the Affordable Care Act on health insurance coverage in Minnesota," University of Minnesota State Health Access Data Assistance Center, June 2014).

- According to early reports, the proportion of Californians who were uninsured dropped from 22 percent in September 2013 to 11 percent in April 2014 as 3.4 million residents gained coverage. Of those remaining uninsured, 62 percent were Hispanic, and of these, half were undocumented and ineligible for coverage. Many of the rest were in families with mixed documentation status. In a survey, 54 percent of uninsured Hispanics in California, including 37 percent of those who are documented and eligible for ACA coverage, said they were worried that they would draw attention to their relatives' immigration status if they sought coverage (DiJulio et al., "Where are California's Uninsured Now?" Kaiser Family Foundation, 7/30/14).

- Surgery patients with Medicaid coverage in Michigan went into surgery in worse health, experienced a higher rate of complications, and were more than twice as likely to die within the first 30 days after their operation compared with their privately insured counterparts, according to a study of 14,000 surgical patients aged 18 to 64 by researchers at the University of Michigan Medical School. Medicaid patients also needed an average of one more night in the hospital, and were more likely to be readmitted than privately insured patients, increasing their costs by 50 percent. Not all hospitals accepted Medicaid patients; 61 percent of all operations on patients covered by Medicaid were done at 20 of the 52 hospitals studied ("Surgery study shows worse health, more problems, and higher costs among Medicaid patients," University of Michigan Health System, 5/12/14; Waits et al., "Anticipating the Effects of Medicaid Expansion on Surgical Care," JAMA Surgery, July 2014).

- Two new studies indicate that uninsured patients and Medicaid enrollees face disparities in cancer care. Among 473,722 patients aged 18 to 64 years diagnosed with one of the 10



deadliest cancers, patients with non-Medicaid (i.e. Medicare or private) insurance were much less likely to present with distant disease (16.9 percent) than those with Medicaid coverage (29.1 percent) or without insurance coverage (34.7 percent). Patients with non-Medicaid insurance were more likely to receive definitive therapy (79.6 percent) compared with those with Medicaid (67.9 percent) or without insurance (62.1 percent). After controlling for demographic and other factors, Medicaid patients were 44 percent more likely to die of their disease, and the uninsured were 47 percent more likely to die, compared with patients with non-Medicaid insurance. In the second study, young adults with cancer who lacked insurance were 16 percent more likely to present with metastatic disease, 95 percent less likely to receive definitive therapy, and 23 percent more likely to die than their insured counterparts, according to a study of nearly 40,000 cancer patients aged 20 to 40 years (Walker et al., "Disparities at stage at diagnosis, treatment and survival in nonelderly patients with cancer according to insurance status," *Journal of Clinical Oncology*, 8/4/14; Aizer et al., "Cancer-Specific Outcomes Among Young Adults Without Health Insurance," *Journal of Clinical Oncology*, 6/2/14).

## SOCIOECONOMIC INEQUALITY

- Patients living in high-poverty neighborhoods were 24 percent more likely than others to be readmitted to a hospital within 30 days, after adjusting for demographic characteristics and clinical conditions, according to a study of 6,832 admissions at Henry Ford Hospital in Detroit. Patients who were married had a lower rate of readmission. CMS assumes that readmissions are a result of poor quality care, and has started penalizing hospitals whose 30-day readmission rate exceeds a target, effectively taking resources away from hospitals that serve the poor. Henry Ford Hospital received a 1 percent penalty in Medicare reimbursement in 2013, and will be penalized again in 2014 (Jianhui Hu, "Socioeconomic status and readmissions: Evidence from an urban teaching hospital," *Health Affairs*, May 2014).

- Food insecurity contributes to health inequities. In California, hospital admissions for hypoglycemia are more common in diabetics with low incomes than high incomes (270 versus 210 admissions per 1,000,000 admissions). In addition, the risk of a hypoglycemic admission among low income patients increases by 27 percent in the last week of the month – when food budgets may be exhausted. High-income diabetics show no such end-of-month increase. Reductions in the Supplemental Nutrition Assistance Program budget promise more such problems in the future (Seligman et al., "Exhaustion of food budgets at month's end and hospital admissions for hypoglycemia," *Health Affairs*, January 2014).

## COSTS

- U.S. health spending is expected to rise 6.7 percent in 2014 to \$3.05 trillion, 17.7 percent of GDP. Prescription drug spending is

expected to rise faster, 9.3 percent, to \$293 billion ("Health Sector Economic Indicators, Spending Brief," Altarum Institute, 4/8/14).

- The cost of health care for a family of four covered by an employer-sponsored health plan in 2014 is \$23,215, up 5.4 percent from 2013, according to the Milliman Medical Index (MMI). This includes an employer contribution of \$13,520, and employee spending of \$9,695 on out-of-pocket costs and premiums ("Cost of Employer-Sponsored Health Care Increases 5.4 percent in 2014," *Zane Benefits*, 5/22/14).

- Health care inflation slowed to 3.3 percent annually between 2008 and 2011, down from 6.6 percent between 2000 and 2007. Why? Two studies, one based on historical trends in inflation and the other on health spending in geographic areas differentially affected by the recession, found that 70-75 percent of the moderation in health spending was due to the economic slowdown. Health care inflation was lowest in areas hardest hit by the recession, where the unemployment rate in 2011 was still 65 percent above the pre-recession level. These results suggest health care inflation may again increase as the economy improves, as in the past ("Assessing the effects of the economy on the recent slowdown in health spending," Kaiser Family Foundation, 4/22/13; Dranove, "Health spending slowdown is mostly due to economic factors, not structural change in the health care sector," *Health Affairs*, August 2014).

After four years of slow cost growth, Medicare will spend an estimated \$12,243 per beneficiary in 2014, nearly \$1,000 less than the Congressional Budget Office predicted in 2010. This cost slowdown will extend the "life" of the Medicare Trust Fund by 13 years, to 2030. What happens then? At that point the fund will still be able to cover 85 percent of projected Medicare hospital costs, declining gradually to 75 percent by 2047 and remaining flat after that (assuming no change in Medicare's base payroll tax, which has not been increased since 1986). ("Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund," 7/28/14.)

## HOSPITALS, INC.

- CEOs of the five largest for-profit hospital chains received lavish pay in 2013. The highest paid was Tenet's CEO, Trevor Fetter, who received \$22.7 million in total compensation. Dallas-based Tenet, which owns 77 community hospitals, has a long history of corporate malfeasance. The firm paid \$900 million in fines and penalties for Medicare overbilling in 2006, and nearly \$1 billion in the 1990s (when they operated under the name National Medical Enterprises) to settle civil and criminal charges of fraud, overbilling, kickbacks and forcing juvenile patients to stay in their psychiatric facilities until their insurance ran out.

Richard Bracken, CEO of HCA, a Nashville-based chain of 165 hospitals, received the second highest compensation, \$16.5 million. By comparison, the chief of the U.S. Department of Veterans Affairs, responsible for running 153 hospitals and 1,400 other sites of care such as clinics and nursing homes,

makes \$199,700 per year (Evans, “Bonuses still tied to better financials,” *Modern Healthcare*, 4/28/14).

- Louisiana Governor Bobby Jindal, a Republican who helped craft the 2003 federal legislation authorizing private Medicare Part D drug plans during a stint at HHS, is seeking to privatize six public hospitals, including those in New Orleans, Lafayette, and Houma. Although Jindal has turned down federal funds available to expand Medicaid under the Affordable Care Act, he is seeking \$440 million from CMS to prop up the deals by claiming that \$260.8 million in proposed “advance lease payments” should count as state Medicaid spending. CMS said the payments violate regulations prohibiting donations from providers (“Adviser says hospital decision may wreck budget,” *Capital News Bureau*, 5/5/14).

## **GALLOPING TOWARDS OLIGOPOLY**

- There were \$328.8 billion in mergers and acquisitions in the health care sector during the first six months of 2014, up 207 percent from all of 2013. The total does not include several mergers and so-called inversions of pharmaceutical companies that are in the works so the total could rise dramatically before the end of the year (“U.S. Drug Firms Seek Inversion Deals to Evade Taxes,” [stockmarketbloggers.com/dealbook](http://stockmarketbloggers.com/dealbook), 7/15/14).

A national study of small and medium-size primary care practices found that practices with 1-2 physicians had ambulatory care-sensitive admission rates (admissions that could be prevented with good primary care) 33 percent lower than the rate in practices with 10-19 physicians. Practices with 3-9 physicians had rates of admission just above practices with 1-2 physicians. The findings surprised the researchers, who noted that the smallest practices cared for more dual-eligible patients and more patients with co-morbidities, while the larger practices had higher patient-centered medical home scores and more resources for support staff. The study also found that physician-owned practices had 13 percent lower ambulatory care-sensitive admission rates than hospital-owned practices, despite higher use of patient-centered medical home processes by hospital-owned practices. “It is possible that small practices have characteristics that are not easily measured but result in important outcomes,” the authors write (Casalino et al., “Small primary care physician practices have low rates of preventable hospital admissions,” *Health Affairs*, 8/13/14).

- Small physician specialty groups in anesthesia and pediatric subspecialties like neonatology and cardiology are being rapidly consolidated by an investor-owned holding company, MEDNAX. The firm’s Pediatrix unit, through affiliated professional corporations, employs 2,200 physicians in 34 states and contracts with 340 NICUs. The company’s American Anesthesiology unit employs 875 physicians and 1,175 non-physician anesthesiologists in 10 states. In early 2014, Mednax acquired Sum-

mit Anesthesia Associates in New Jersey, Physicians Anesthesia Associates in Maryland, and Great Lakes Anesthesia Associates in Michigan, along with two other anesthesia providers and a pediatrics group. MEDNEX CEO Dr. Roger Medel received compensation of \$8.8 million in 2013. The firm’s web site says that to allow future growth the company will not restrict itself to any specialty or subspecialty (“Top paid execs by health sector,” *Modern Healthcare*, 4/28/14; [www.MEDNAX.com](http://www.MEDNAX.com)).

- Some university hospitals are going into business with large, investor-owned chains, belying their mission of public service. Duke Lifepoint, a joint venture formed between for-profit Lifepoint and not-for-profit Duke University, recently acquired nonprofit Rutherford Regional Health System in North Carolina. It is the new firm’s sixth acquisition since it was formed in 2011. Rutherford will convert to for-profit status, while Duke Lifepoint will invest \$60 million in the hospital over the next 10 years and pay off their debt. Duke Lifepoint now has four hospitals in North Carolina, one in Virginia, and one in Michigan; their next acquisition target is Conemaugh Health System, a three-hospital network based in Johnstown, Pennsylvania (*Modern Healthcare*, 6/9/14).

Yale New Haven Health System is partnering with investor-owned Tenet to buy four not-for-profit hospitals in Connecticut: Waterbury Hospital, Bristol Hospital, Rockville General Hospital, and Manchester Memorial Hospital. Connecticut lawmakers are concerned about the push to profit from the health care needs of Connecticut residents; legislation to prohibit not-for-profit hospitals from converting to for-profit status has passed the state’s Joint Committee on Public Health (Landen, “Hospital conversion bill advances in Connecticut,” *Modern Healthcare*, 3/26/14).

### **Catholic hospital system moving into insurance market**

Catholic Health Initiatives (CHI), with 89 hospitals, bought Soundpath, a Medicare Advantage plan in Washington with 17,000 enrollees, for \$24 million, and is in the process of developing Medicare Advantage plans for other states with the Arkansas insurer it recently acquired, QualChoice. The chief operating officer of CHI, Michael Rowan, described the Medicare Advantage market as “a low-risk means of getting into the insurance business.” (Evans, “CHI eyes Medicare Advantage Growth,” *Modern Healthcare*, 4/5/14).

- The dialysis industry is shifting into the delivery of medical care. The giant German dialysis firm, Fresenius, with 2,150 dialysis clinics and 53 vascular-care centers, is paying \$600 million to acquire a majority stake in a large inpatient physicians’ group based in Tacoma, Wash. Sound Physicians has over 1,000 hospitalists and other physicians practicing around the country. Fresenius’ main rival, DaVita, paid \$4.4 billion for the medical group HealthCare Partners in 2012 (Blesch, “Fresenius takes majority stake in Sound Physicians,” *Modern Healthcare*, 6/28/14).

## PHARMA

- Another wave of drug company mergers and acquisitions is in the works. Mergers with European firms are particularly attractive as they allow U.S. companies to boost profits (at the expense of the U.S. Treasury) by reincorporating overseas in nations with lower tax rates, a process known as “inversion.” They will continue to pay taxes in the U.S. only on domestic sales, but not on their international earnings.

AbbVie, a spin-off from Chicago-based Abbott Laboratories, is buying Ireland’s Shire for \$53 billion, and will reincorporate on the British island of Jersey. Pittsburgh-based Mylan, a giant generic manufacturer, is acquiring the international generic operations of Abbott Laboratories for \$5.3 billion, and then reincorporating in the Netherlands, a maneuver being called a “spinversion.” The maneuver is expected to lower the firm’s effective tax rate from 25 percent to the high teens. Generic manufacturer Actavis is already reincorporated in Ireland after a tax-driven acquisition by Warner Chilcott in 2013. Pfizer failed in its hostile takeover bid of \$118 billion for Britain’s AstraZeneca, but may make a second attempt later this year. Walgreens, which is merging with the Swiss firm Alliance Boots, considered reincorporating in Switzerland and doing an inversion, but ultimately decided against it. Walgreens reaps almost a quarter (\$16.7 billion) of its annual revenues from Medicare and Medicaid.

Device makers are also looking into the tax-inversion strategy. Minnesota-based Medtronic recently bid \$43 billion for the Irish lab equipment maker Covidien (Solomon, “In Deal to Cut Corporate Taxes, Shareholders Pay the Price,” *New York Times*, 7/8/14).

Valeant Pharmaceuticals International is pioneering a new growth strategy. It buys rivals, slashes their research and development budgets, and arbitrages tax domiciles (rather than pursuing clinical innovation). Valeant spends just 3 percent of its revenue on research and development while their current takeover target, Allergan, spends 17 percent of revenues on R&D. Valeant intends to cut around 28,000 jobs if the deal goes through. Valeant CEO Mike Pearson defends his firm’s “new model” of growth bluntly: “R&D on average is no longer productive. I think most people accept that.” Which raises the question asked by Bill George, a Harvard business school professor and former CEO of the medical device firm Medtronic: “Is the role of leading large pharmaceutical companies to discover lifesaving drugs or to make money for shareholders through financial engineering?” (Sorkin, “Do drug companies make drugs, or money?” *New York Times*, 6/2/14).

- CareFusion, the manufacturer of the skin antiseptic Chloraprep, is paying \$40.1 million to settle allegations by the U.S. Department of Justice that the company violated the False Claims Act by paying kickbacks to boost sales. The firm paid \$11.6 million to Dr. Charles Denham while Denham served as the co-chair of the Safe Practices Committee at the National Quality Forum, an influential organization that promotes

standardized quality measures and practices. Many hospitals abruptly switched from iodine-based preparations to the more costly (and more flammable) chlorhexidine-isopropyl alcohol, Chloraprep, after a *New England Journal of Medicine* study found that it was superior for surgical site antiseptics, despite an increased risk of operating room fires. The study’s authors were subsequently found to have financial ties to CareFusion, and follow-up research by other investigators found no difference among antiseptics. This is the first major scandal to rock the quality movement, undermining the credibility of recommendations put out by the National Quality Forum (Sibert, “Why the quality measures used in health care are deeply flawed,” *KevinMD.com*, 5/12/14).

The exorbitant price of Sovaldi (sofosbuvir), the hepatitis C drug which costs \$84,000 for a 12-week course, threatens to drain Medicaid and Medicare funds. The high price even prompted Karen Ignagni, CEO of America’s Health Insurance Plans, to take a public swipe at pharmaceutical companies. “Manufacturers are charging whatever they can get away with,” she said. “We can’t have a system that operates that way” (Demko, “Excessive drug costs could invite price caps: AHIP’s Ignagni,” *Modern Healthcare*, 5/26/14).

While Sovaldi is priced at \$1,000 per pill, it costs less than \$1 to manufacture. Moreover, taxpayers have already paid for Sovaldi once, in the form of multiple NIH research grants to Dr. Raymond Schinazi’s laboratory at the Atlanta VA Medical Center from 1983 to 2013, where the molecule was discovered. Dr. Schinazi subsequently founded the firm Pharmasset, which purchased sofosbuvir from Emory, and went public in 2007. Gilead bought Pharmasset for \$11 billion in 2011, and cites this high price tag as the main reason for the drug’s high cost. The phase III trials required for FDA approval were probably relatively inexpensive since manufacturing the drug is simple, the treatment regimen is short, and the results are immediate (Berkrot, “Gilead could have had Pharmasset cheap: founder,” *Reuters*, 11/22/11; Hill et al., “Minimum costs for producing Hepatitis C direct-acting antivirals for use in large-scale treatment access programs in developing countries,” *Clin Infect Dis.*, 2/13/14).

Gilead’s sales of Sovaldi totaled \$3.5 billion in the second quarter of 2014 and almost \$6 billion for the first six months of the year. The firm’s CEO, John Martin, credited Medicaid, which is covering the drug in all but three states, for part of the drug’s success. In Massachusetts, Medicaid managed care plans are blaming Sovaldi for driving \$140 million in losses so far this year. Hepatitis C kills an estimated 350,000 people a year worldwide and 85 percent of the 185 million people infected with Hepatitis C live in low- and middle- income countries (Dickson, “Gilead reports massive Q2 earnings jump thanks to Sovaldi,” *Modern Healthcare*, 7/23/14).

- Prices for 73 brand-name medicines have surged over 75 percent since 2007, six times higher than the increase in the consumer price index over that period, 12 percent. Ironically, price increases are especially common when a higher-priced rival is released, and in the final years of a product’s patent life.



“Everyone is engaging in extreme prices because they can get away with it,” said former industry executive Bernard Munos. In 2013, increases in the prices of existing brand name drugs raised costs by \$20 billion, offsetting \$19.3 billion in revenue declines due to patent expirations.

- Pfizer has raised the price on nine of its products by over 75 percent since 2007, including on Lipitor, which lost patent protection in 2011. Prices for some insulin products, like Lilly’s Humulin and Sanofi’s Lantus, have increased over 150 percent over the same period. Sanofi justified the increase by saying it helped “align” Lantus with competing drugs. With sales declining due to competition, Biogen raised the price of its multiple sclerosis drug Avonex by 147 percent, from \$552 per injection in 2007, to \$1,363 per injection in 2014. “It makes business sense for brand companies to match one another’s higher prices and price increases rather than to try and compete on cost,” according to economist Robert Kemp. Manufacturers are even raising prices on costly cancer drugs. Novartis increased the price of Gleevec for chronic myeloid leukemia from \$119 per pill to \$306 per pill, while Roche raised the price of lung cancer drug Tarceva 90 percent. Novartis also settled a patent litigation lawsuit with generic drugmaker Sun Pharmaceuticals that will delay entry of a generic version of Gleevec for seven months, at a cost to the health system of half a billion dollars (Langreth, “First million-dollar drug near after prices double on dozens of treatments,” Bloomberg News, 4/30/14; Falconi, “Novartis manages to push back competition to leukemia drug in the U.S.,” Wall Street Journal, 5/15/14).

- Ian Smith, CFO of Vertex Pharmaceuticals, is the highest paid executive in Big Pharma, with compensation of \$36.6 million in 2013. Vertex sells Kalydeco, a drug approved in 2012 for cystic fibrosis patients with a specific genetic mutation, costs \$311,000 for a year of treatment. (“Top paid execs by health-care sector,” Modern Healthcare, 4/28/14).

- Medtronic will pay a fine of \$9.9 million to the U.S. Department of Justice to settle allegations that the giant device maker violated the False Claims Act by paying speaking fees and giving gifts to doctors who used its defibrillators and pacemakers on Medicare and Medicaid patients (AP, “Medtronic settles whistleblower lawsuit for \$9.9 million,” 5/29/14).

## ACA UPDATE

- The giant insurer Anthem is facing lawsuits and an investigation in California over allegations that the firm misrepresented the size of its physician networks and benefits in its exchange plans. A group of 33 Anthem customers are suing the company in Los Angeles, claiming the insurer cancelled their PPO, herded them into EPOs (exclusive provider organizations, with no out-of-network benefits) and inaccurately claimed that their doctors were in-network, exposing them to large medical bills at their usual source of care (Terhune, “Anthem Blue Cross sued again over narrow-network health plans,” Los Angeles Times, 8/19/14).

- Big insurers are raising premiums on their ACA-compliant plans by 8.5 percent to 22.8 percent next year, with most increases hovering around 10 percent, based on rate filings in 10 states. Aetna CEO Mark Bertolini reported that premiums for its 450,000 enrollees would increase by “less than 20 percent.” (Bertolini received compensation of \$30.7 million in 2013). For some patients, these rate increases may have an unexpected side effect. Consumers who automatically re-enroll in their current plan may find their share of the premiums has increased because their subsidy has fallen. The ACA’s subsidies are tethered to the price of the second-lowest cost silver plan (the “benchmark” plan). As a result, if insurers market new plans that cost less than the benchmark, then the 2015 subsidies will fall from those available in 2014. There’s also no guarantee that a plan offered in 2014 will continue to be available in 2015. (Radnofsky, “Premiums Rise at Big Insurers,” Wall Street Journal, 6/18/14).

### Another tool to shift costs to workers: Reference pricing

The Obama administration’s rule-making on ACA implementation to date has tilted the law towards corporations and away from patient protection. Their latest announcement, in May, continues this trend. The administration will allow large or self-insured employers to use so-called reference pricing in designing health plan benefits and to use generic drug prices to set reference prices for drug benefits. If an employee sees a provider who charges more than the reference price for a particular service, or prescribes a brand-name drug instead of a generic drug, the employee is responsible for the difference. Moreover, the additional costs do not apply to the caps on annual out-of-pocket spending of \$6,350 for an individual and \$12,700 for a family, as if the employee went “out of network.” Currently about 10 percent of large employers, including CalPERS and Safeway, use reference pricing for at least one service, such as hip replacement, and 22 percent are considering it. Plans sold on the health exchanges don’t currently use reference pricing (Appleby, “7 things you should know about the next big benefit change,” Kaiser Health News, 5/28/14).

- A key part of the ACA, subsidies for insurance purchased on the federal exchange (rather than state exchanges), is the latest target of GOP attacks. To date, two U.S. appeals courts have weighed in with conflicting rulings. An IRS regulation implementing the law gave the agency the authority to allow subsidies to be provided in exchanges run by the states and the federal government, even though the legislation itself only refers to state exchanges. In *Halbig v. Burwell*, the U.S. Court of Appeals for the District of Columbia Circuit ruled 2-1 that the IRS does not have the authority to allow subsidies to be dispersed on the federal exchange. Within hours, a Richmond, Va.-based appeals court unanimously reached the opposite conclusion. The *Halbig* ruling, if upheld, could affect 5 million people in 36 states who are already enrolled in private plans, raising their premiums by an average of 76 percent (Hansard, “ACA supporters predict ruling against subsidies won’t go into effect,” Bloomberg News, 7/23/14; Carpenter, “Upcoming fed-

eral court decision could mean premium increases for nearly 5 million Americans,” Avalere Health, 7/17/14).

- Health benefits consulting firms like Aon Hewitt, Towers Watson, and Mercer are aggressively marketing “private exchanges” modeled after the ACA’s exchanges to large employers. Consultants tout their exchanges’ ability to allow employers to shift to a “defined contribution” model in which employees are responsible for premiums above a predetermined amount. Mercer says its data show that the average actuarial value of plans selected by employees who used their exchange dropped to 71.9 percent from their prior coverage of 80.4 percent (Modern Healthcare, 6/9/14).

## ACO UPDATE

- ACOs have grown rapidly, fueled by incentives included in the Affordable Care Act. There are currently 626 ACOs operating in the U.S., covering an estimated 20.5 million people. Over half of them (329) have Medicare or Medicaid contracts. Medicare Pioneer ACOs cover 669,000 Medicare enrollees, while 5.3 million people are covered by the Medicare Shared Savings Program. 210 ACOs have contracts with commercial payers. Commercial ACO contracts now cover 12.4 million people. Cigna has the largest market share (19 percent), followed by Aetna (9.1 percent) and United Healthcare (4 percent). (Peterson, “Growth and Dispersion of ACOs,” Leavitt Partners, June 2014)

- A survey of 173 ACOs found that 51 percent were physician led, and another 33 percent were jointly led by physicians and hospitals. However, in only 40 percent of ACOs do physicians own the equipment and employ the physicians (“First national survey of ACOs finds that physicians are playing strong leadership and ownership roles,” The Commonwealth Fund, 6/3/14).

- New research suggests that ACOs may not control costs. Over one-third of Medicare beneficiaries attributed to an ACO in 2010 and 2011 were not in the same ACO in both years, and these “unstably” assigned beneficiaries were more likely to be in high-cost groups, according to a study of 145 organizations participating in Medicare ACO programs. Moreover, two-thirds of office visits to specialists by patients attributed to a Medicare ACO are provided outside their assigned ACO, and less than 40 percent of outpatient Medicare spending billed by

ACO physicians was for care for ACO beneficiaries. PNHP senior health policy fellow Dr. Don McCanne commented that “some [experts] suggest that tighter relationships need to be established between Medicare patients and ACOs, but that already exists in the Medicare Advantage plans – a model proven to increase costs” (McWilliams et al., “Outpatient Care Patterns and Organizational Accountability in Medicare,” JAMA Internal Medicine, 4/21/14).

## MEDICAID MANAGED CARE

- Nearly all of the 6 million new Medicaid beneficiaries added under the ACA are enrolled in managed care plans. In 2013, 70 percent of Medicaid’s beneficiaries were in some form of managed care organization (MCO), up from 10 percent in 1991. Medicaid managed care currently accounts for 18 percent of insurance industry revenues, \$75 billion annually, and is a rapidly growing line of business. While some MCOs are not-for-profit, provider or government-owned, most are investor-owned. Despite accounting for over 27 percent of federal Medicaid expenditures, oversight has been lax, according to the General Accountability Office (GAO).

CMS leaves responsibility for oversight of MCOs to the states, but a recent GAO review of fraud control operations in seven states found they focused almost exclusively on Medicaid fee-for-service because “MCO plan and provider audits and investigations are more complex.” States rely on the MCOs themselves to provide claims data, and obtaining that data from each MCO requires significant time and effort, particularly in states with multiple MCO plans. GAO noted that 4 of the 7 states where it conducted reviews had 20 or more MCOs in operation. The GAO is calling on CMS to require states to start auditing Medicaid payments to and by managed care organizations (“Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures,” GAO, May 2014).

- In the meantime, at least two states have stopped using private Medicaid plans. Oklahoma dropped their plan in 2003 after insurers sought a major rate hike during a budget crunch. Connecticut ended its 15-year history with MCOs in 2011, and used the money it had been spending on insurers’ overhead to boost pay for primary care doctors (Dickson, “Benefits unclear as states rush into Medicaid managed care,” Modern Healthcare, 7/5/14).



## It's time for single-payer, universal health care

By Pat Barcas

CHICAGO – Discussion about single-payer, universal health care has been ongoing for the last 100 years. Now, Dr. Andrew Coates says the fight is about to come to an impasse – this country needs universal health care to move forward.

“This is something that every first-world, civilized country has,” said Coates at a special Chicago conference entitled “Beyond Obamacare” May 8.

Dr. Coates is president of Physicians for a National Health Program. He is chief of hospital medicine at Samaritan Hospital in Troy, N.Y., and an assistant professor of medicine and psychiatry at Albany Medical College. He previously served on the statewide executive board of the Public Employees Federation, AFL-CIO, and founded Single Payer New York, a statewide grassroots coalition of single-payer organizations and activists.

He criticized the Affordable Care Act, saying it will leave 30 million uninsured once fully implemented. It's also wasteful, costing \$368 million just to set up the New York state marketplace.

Under the current system, Coates said, 60 percent of those filing for bankruptcy due to health care bills have health insurance. Deductibles eat up savings. Households have to pick which bills to pay, or permanently forgo necessary surgeries.

There are fewer people going to the emergency room now, said Coates, but admissions into the hospital are on the rise.

“There are fewer ER visits because it's so expensive, but people are becoming much sicker,” he said.

Coates said there are no legitimate downsides to single payer: It's cheaper in the long run, it levels racial and wealth disparities, it makes for a healthier populace, and there's a reliable model right next door in Canada.

“Imagine the liberation of working people. It's very profound,” he said. “We're up against the whole establishment. They don't want it. This is a basic economic right.”

He called on unions to lead the charge in changing public opinion, and turn the political tide toward voting for single payer.

“Unions have the expertise – how to organize, how to lead the fight,” he said.

A major argument against the single-payer system in Canada, Coates said, is that there can be a waiting list for non-life-threatening surgery, such as knee surgery.

“In Canada, sure, you may wait weeks to get elective surgery, but it's free at the point of service. Here in America, the wait time is infinity if you can't afford it,” he said. “Imagine if you don't have to worry about paying for you or your child's care – we have the expectation that we're free, but we aren't until we all have health care. We just don't have the political will.”

The event was co-sponsored by Physicians for a National Health Program and the Illinois Single Payer Coalition.

## PNHP booth sparks dialogue at ASCO

For the first time, PNHP had a booth at the annual meeting of the American Society of Clinical Oncology (ASCO), held this year at the McCormick Place Convention Center in Chicago from May 29 through June 2.

The team staffing the booth – oncologist and ASCO member Dr. Ray Drasga of Indiana and PNHP's national organizer, Emily Henkels, aided by Drs. Ida Hellander and Anne Scheetz of Illinois – signed up 24 new members of PNHP on the spot, in addition to engaging in animated dialogue with scores of others.

“In the sea of slick, commercial exhibits, particularly from Big Pharma, PNHP's booth really stood out,” Henkels said. “And Dr. Drasga was an excellent conversationalist.”

PNHP's presence at the meeting follows the January publication of “Why oncologists should support single-payer national health insurance” in the *Journal of Oncology Practice*, co-authored by Dr. Drasga and Dr. Lawrence Einhorn, past president of ASCO. Copies of the paper were distributed from the booth.

ASCO has since listed the Drasga-Einhorn article as among its top downloaded articles in 2014. Dr. Ida Hellander, PNHP's director of health policy, notes that it's an excellent model for those in other specialties.



Dr. Drasga converses with Dr. Craig Nichols at the PNHP booth.

Dr. Ann Settgest, a leader of PNHP Minnesota, reports that her chapter has identified oncologists who are members of the Minnesota Medical Society and mailed them a copy of the Drasga-Einhorn paper. She encourages other chapters to consider doing something along the same lines.

# Single Payer: Where do we go from here?

By Margaret Flowers, M.D.

*The following testimony was presented by Dr. Margaret Flowers to a "Single-Payer Summit" panel convened by Sen. Bernie Sanders, I-Vt., at the Dirksen Senate Office Building in Washington on May 21, 2014.*

Thank you for inviting me to participate in this important discussion today.

The first step in the work to move to a single-payer plan must be to take stock of where we are and where we are headed. We must do what we can to prevent further damage while we organize for the real solution to our health care crisis: a national single-payer health system.

We are continuing a trend that began in the 1980s of privatization of every facet of our health care system. This is the opposite direction from where we need to go. If we viewed the U.S. health care system as an experiment, which it largely is – one that defies sound health policy – we would see that it has failed. If we treated our system as an experiment, we would be required to stop it because of the high number of preventable deaths, wide health disparities and financial ruin caused by illness and medical costs. These are our outcomes despite the fact that the U.S. spends the most per capita each year on health care, two and a half times more than the average OECD nation.

There is no affordable market solution to the health care crisis even though the public is being steeped in market rhetoric as we speak. The private health insurance industry has proven for decades that it defies regulation. Our market-based system will continue to increase health care spending, leave people out and result in poor health outcomes because the bottom line is profit, not health. Until we change this fundamental dynamic, we will continue to fail to significantly improve the health of our population.

It is time for an honest national conversation about our health care system. We must ask ourselves whether we want to continue to treat health care as a commodity so that people receive only what they can afford or whether we want to join the rest of the industrialized world and create a health care system that treats health care as a public good so that people receive the health care they need.

The primary obstacle to a national single-payer health system is political will. But we know from past experience that political will can change through public pressure. To effectively create this pressure we must recognize that the U.S. is not a legitimate democracy. It is an oligarchy, or more accurately a plutocracy. Health spending is almost one-fifth of U.S. GDP. The medical industrial complex wields tremendous political influence. Therefore, single payer will only be on the table when the public puts it there. There is no easy way to do this, no secret back door. A national single-payer health system will come from

steadfast determination and strategic organizing and action.

As we are educating, organizing and mobilizing the public to demand a single-payer health system, we need to take steps to challenge further privatization of our health system. I have three major areas of concern: the privatization of our public insurances, the trend towards more people being required to purchase inadequate insurance through the exchanges, and increasing subsidies to private insurers that will be used as justification to cut social programs.

One harmful trend that should be addressed immediately is the privatization of our public insurances, Medicaid and Medicare. Currently at least 75 percent of Medicaid enrollees are in Managed Care Organizations, private administrators that act

like private insurers by keeping a high percentage of their payment for administration, profits and salaries and cherry-picking the healthiest patients. This percentage is expected to grow. It is no coincidence that WellPoint moved to buy AmeriGroup after the ACA was passed. They saw a huge profit opportunity in the Medicaid expansion.

We should examine the impact of private industry involvement in Medicaid.

Two states have already moved to make their Medicaid completely public – Oklahoma in 2005 and Connecticut in 2012. They cited lower costs and better quality by doing so. They were able to shift more funding to direct patient care. In Maryland, our Medicaid program for children with chronic conditions has an overhead of less than 2 percent and is easier for patients and health professionals to use. We are currently looking into the overhead of our MCOs which we suspect is significantly higher than the public plan. This committee should investigate how much of our public dollars for Medicaid are going to private insurance administration.

Likewise, Medicare Advantage is a private insurance for Medicare patients. Although the Affordable Care Act (ACA) was supposed to curb the wasteful Medicare Advantage plans, reimbursement to them has risen and enrollment has grown at least 30 percent since the ACA was passed in 2010. A study in 2013 found that private insurers in Medicare Advantage were overpaid \$34.1 billion in 2012 alone, money that could have gone to expanding Medicare services instead of padding private insurer's pockets. This committee should be examining why this wasteful spending is occurring especially when Medicare is facing pressure to make cuts.



**Dr. Margaret Flowers**

A very concerning trend is the movement of people eligible for public insurance into purchasing private health insurance on exchanges. The White House signaled early in 2010 through a Fact Sheet that it was OK with this approach for Medicaid. Arkansas was granted a waiver by HHS to subsidize its Medicaid population's purchase of private insurance on the state exchange. And top White House health care experts, David Cutler and Jonathan Gruber, have indicated support for moving seniors onto the exchanges to purchase private insurance using a defined contribution (read waiver) approach.

Movement in this direction must be adamantly opposed because it would ultimately destroy our public insurances and place our most vulnerable populations at the hands of private industry rather than protecting them through the social safety net.

And finally, we must be wary of further increases in public subsidies for private insurance. The ACA has taken on tremendous financial responsibility for the cost of health care through subsidies to purchase private insurance and to offset out of pocket costs. Hundreds of billions of public dollars are being given directly to the private insurance industry without guarantees that people will be able to afford the health care they need. We must examine whether this transfer is the best use of our public dollars and question any demand for more from the industry. We must not allow what is essentially corporate welfare to be used to justify cuts to necessary social programs.

I want to close with a comment on the approach to single payer. There are currently many efforts towards single payer at the state level including in my own state of Maryland where I am on the steering committee of the Maryland Health Care is a Human Right campaign. Of course, the most advanced state

is your home state, Sen. Sanders, Vermont. I believe that these state efforts are important for pushing state health legislation to be the best that it can be and are a way to educate and organize movement towards national single payer. I do not believe that we should allow these efforts to take our focus off of the ultimate goal of a national single-payer health care system.

There are significant barriers to single-payer systems at the state level as you are learning in Vermont. Without a national movement, there is no guarantee that state reform will translate to the national level. And there is no need to experiment. We know what works. We have three health systems in the United States and the ones that have the greatest savings and best outcomes are the Veterans Health Administration and traditional Medicare. These are two types of single-payer health systems and both are more effective than the market-based system.

We must continue to communicate that a national single-payer health system is possible and that improved Medicare-For-All is the best solution to guarantee that all people living in the U.S. have access to the health care that they need, that people are covered no matter where they are and that will allow the leverage necessary to control health care spending in a way that doesn't reduce coverage. We must move forward without delay because every day our current market-based health system is resulting in preventable suffering, financial ruin and death. This is unacceptable in the wealthiest country in the world. Thank you.

*Dr. Margaret Flowers is a pediatrician and an editor of Popular-Resistance.org. She is co-chair of the Maryland chapter of Physicians for a National Health Program and serves on the board of the Maryland Health Care is a Human Right campaign.*

***We must move forward without delay because every day our current market-based health system is resulting in preventable suffering, financial ruin and death.***

## **New fact sheet on TPP agreement and health care**

The U.S. is seeking to export market-driven health care through the Trans-Pacific Partnership Agreement (TPP) governing commercial relations between the U.S., Japan, Australia, Chile, Canada, Malaysia, Mexico, Peru, Singapore, New Zealand, Brunei and Vietnam.

The agreement, which is being negotiated in secret (although portions of it have been leaked), has been supported by Big Pharma and the for-profit health care industry, and opposed by health professional, union, and social justice groups worldwide.

Dr. Margaret Flowers has written a very useful, annotated "Backgrounder on the Trans-Pacific Partnership and health care," the full text of which is available at [bit.ly/VNCs3o](http://bit.ly/VNCs3o).

The six section headings of the backgrounder are these:

- The TPP is part of a global effort to circumvent the failed World Trade Organization talks and dramatically shift power to multinational corporations.
- The TPP will raise the cost of health care, particularly of medications, by extending the length of patents, placing barriers to generics and giving the pharmaceutical and medical device industries greater legal standing to challenge reimbursements.
- The TPP will lower access to health care.
- The TPP threatens public health.
- The TPP is a significant barrier to single-payer health systems.
- The TPP undermines democracy.

Again, to obtain the full text of Dr. Flowers' backgrounder, please visit [bit.ly/VNCs3o](http://bit.ly/VNCs3o).



## Vermont Is 'Single-Payer' Trailblazer

By Michael Ollove

BERLIN, Vt. – Dr. Marvin Malek has been yearning and advocating for a publicly financed, single-payer health care system for at least two decades. Now, as Vermont stands on the threshold of being the first state to launch such a plan, he's confessing to trepidation.

"I am pretty damn nervous," he confided before bounding off for rounds at the Vermont Central Medical Center, still clutching the bicycle helmet he wore on his ride to work.

It's not that Malek has reservations about the desirability of a single-payer system. He and other supporters in Vermont point out that it is already in place in many developed countries that produce better health outcomes at lower cost than the U.S.

It's that getting there seems so fraught with complexity. "The problem is that the tentacles of our completely dysfunctional U.S. health system reach so deeply into every state," he said. "How do you disentangle from that abysmal structure to create single-payer?"

That explains why Malek and many others here believe the Vermont legislature's landmark vote in 2011 to move the state to a single-payer system by 2017 was the easy part of the process. Devising how to actually do it, a process the state is enmeshed in now, will be much more grueling.

The outcome couldn't be more consequential, not only for Democratic Gov. Peter Shumlin, who put single-payer health care at the center of his first gubernatorial campaign in 2010, but for many others who have long cherished the idea of universal health care built on the foundation of a single-payer system.

Some believe that if the Vermont experiment is successful, other states could follow. In Canada, they note, single payer started in one province and then spread across the country.

"We could be the Saskatchewan of America," said Bram Kleppner, CEO of Danforth, a pewter manufacturer in Middlebury with roots tracing back to colonial America. He is among a group of business executives in Vermont Businesses for Social Responsibility, which actively promotes single payer. He also sits on a board advising the governor on the financing of the plan.

### Maverick State

A single-payer system is one in which the government, rather than private insurance companies, pays all health care costs. Some on the left have long harbored hopes for a national single-

payer system, but the odds that Congress would ever extinguish the private insurance industry have never been anything but long.

Vermont is different. Vermonters proudly bring up the state's maverick, progressive past: first state to mandate public financing for universal education in its constitution, first to partially outlaw slavery in its constitution, first to introduce civil unions for same-sex couples, and first to allow gay marriages by legislation, rather than through a court order. Many Vermonters hope a single-payer health system will be the latest addition to that list.

But it's way too early to predict that other states will fall like dominoes for single payer. Vermont's unusual characteristics helped make that legislative vote possible. It is tiny and it has Democratic super-majorities in both legislative chambers. Its seven hospitals (eight if you count Dartmouth-Hitchcock Medical Center just across the border in New Hampshire), are spread out and tend not to think of themselves as competitors.

Nevertheless, other states will be watching closely to see if Vermont can successfully build the elements of its single-payer plan, including a unified data and claims system, a method for measuring the delivery of quality health care and a pay-for-performance scheme to replace the traditional "fee-for-service" model.

"Even for states that are keeping it 'old school,' watching a state create a unified health budget and seeing how it benefits them and the process they use, that will be enlightening to everybody," said Hilary Heishman, a program analyst at the Robert Wood Johnson Foundation.

Medicare, Medicaid, and health benefit plans for both veterans and active duty military personnel will continue to operate in Vermont after 2017. Other plans would also continue, including those serving employees and retirees of out-of-state companies, and tourists and other visitors. Plus, there are major businesses in the state that could continue to self-insure if they are exempted from the new taxes. (Some countries with single-payer systems also have separate health plans for some constituencies, such as veterans.)

Despite those caveats, Act 48, as it is called, represents the first time a state has guaranteed all its citizens health care simply on the basis of their residency. Instead of premiums, Vermonters and businesses would pay for health care through yet-to-be determined taxes. Benefits and formularies (the prescription medicines that are covered in a plan) would be uniform, excluding Medicare and Medicaid, although both programs, through

***"We could be the Saskatchewan of America," said Bram Kleppner, CEO of Danforth, a pewter manufacturer in Middlebury with roots tracing back to colonial America.***



Healthcare-NOW

## Single-payer advocates rallied on the steps of the Vermont Statehouse in Montpelier, Vt., on March 26, 2011.

waivers, would be folded into a unified claims administration and payment system run under a new, independent agency called Green Mountain Care.

### Billions in Savings?

The Vermont plan largely derives from Harvard economist William Hsiao, who described it in a 2011 Health Affairs paper. He estimated that single payer would save 25.3 percent over current state health spending, cut employer and household health care spending by \$200 million, create 3,800 jobs and raise the state's economic output by \$100 million.

The savings, according to Hsiao, would come from the consolidation of insurance functions, reduced administrative costs for providers, better mechanisms for detecting fraud and abuse and shifting to a no-fault medical malpractice model.

Hsiao said the savings, an estimated \$4.3 billion over five years, could be used to pay for coverage of the uninsured and improved benefits, reducing the overall savings to a still healthy \$2.3 billion.

Those numbers quickly proved overly optimistic. The legislature didn't adopt the malpractice reforms Hsiao recommended, and the multiple payers still active in the state could reduce the expected administrative savings. Meanwhile, a University of Massachusetts study commissioned by the state estimated Vermont would have to raise \$1.6 billion in new revenues each year to support the plan. A later report by Avalere Health, a consulting firm, estimated the annual cost to be \$1.9 billion to \$2.2 billion.

Robin Lunge, director of Health Care Reform for the Shumlin

administration, said last week the state is assuming it will need between \$1.7 billion and \$2.2 billion in additional annual revenue. Right now, Vermont collects about \$2.85 billion in annual revenue from state sources, mainly through taxes, so raising that amount would be a huge lift for the state. But Lunge thinks a fairer comparison is the amount of new revenue that would have to be raised versus the \$1.9 billion in private health insurance premiums that Vermonters pay now.

### Mixed Feelings

Shumlin missed a 2013 deadline for revealing exactly how he planned to finance the reforms. Now he is promising to do so in January, in time for the next legislative session. Some critics say he purposely withheld the details to not imperil his re-election in November.

Lunge said the state will raise most of the revenue through some combination of income and payroll taxes on both employers and employees. People will not be asked to pay premiums, although Lunge said she expects there will be some kind of cost-sharing (as in co-pays or co-insurance) to discourage overuse of medical services.

"You can say it will be the biggest tax increase in Vermont's history," Lunge said, "but you could also say it'll be the biggest premium decrease in our history, too." She also pointed out that the tax increase will be based on household income, while under the current system people pay the same premiums no matter how much they earn.

The Vermont public seems to have mixed feelings about single-payer. A VT Digger/Castleton Polling Institute survey in April

found Vermonters equally divided. Another poll by Vermont Leads, a pro-single-payer organization, found 55 percent of Vermonters in favor of single payer once the upcoming changes had been explained to them.

### Too Radical?

Detractors, though, aren't hard to find. Cynthia Browning, a House Democrat from Bennington who voted against Act 48, said that while she supported universal coverage, she can't fathom why the state would risk so radical an approach. "I thought we should see where we were after the Affordable Care Act had been in effect."

She has filed suit against the Shumlin administration to force it to be more transparent in its decision-making.

Another critic is Dan McCauliffe, a 59-year old dermatologist in Rutland, who said he fears that creating a finite state budget for health care will inevitably lead to long waiting times for patients and the rationing of medical care. "If I was younger, I would probably leave the state," he said.

Ted Adler, owner of Union Street Media, a Burlington web design firm, predicted that for him and his employees, the new taxes will exceed any premium savings by more than \$150,000 a year. The cost of the company's current insurance plan reflects the relative youth and health of its 40-person workforce.

Adler believes single payer will accelerate the departure of young people from Vermont, which already has the country's second-oldest population. "If we already have a lot of problems keeping young people, do we want to penalize a business that employs a lot of young people?" he asked.

Darcie Johnston, a Republican political consultant, created Vermonters for Health Care Freedom to rally opposition to the plan. She was handed her best weapon when the Vermont health exchange website, like the federal website and sites in many other states, performed disastrously after its launch last year. "If they can't even build a website, how are they going to build government-run health care for 600,000 people?" she asked last week in her Montpelier office.

Still, many others are excited about the plan. When Shumlin proclaimed during his first gubernatorial run that the Affordable Care Act didn't go far enough, he energized Deb Richter, a doctor practicing addiction medicine in Berlin and a leader in Vermont Health Care for All.

Many of Richter's patients experience abrupt changes in their

incomes, frequently forcing them to switch from one insurance plan to another, or to none at all. With single payer, that will never happen. Richter also expects single payer to vastly reduce the time she has to spend dealing with insurance matters.

"All my patients will have the same insurance and the same benefits," said Richter. "There will be one set of rules, one set of regulations, one set rate of reimbursement and one formulary."

### 'The Price of My Life'

Walt Carpenter, a 59-year-old with a sandy-colored walrus mustache who is a jack-of-all-trades at a ski resort, is covered by Medicaid now, but he has often been uninsured or underinsured. In the 2000s, he suffered from a liver disease that turned his skin yellow. During a bad spell in 2006, he said could hardly sleep at all, lost 90 pounds in a matter of weeks and was tortured by merciless itchiness. His doctors said he needed endoscopic surgeries, but his insurance plan resisted. "I'd wake up in the morning everyday wondering, 'Okay, which plan denial do I fight today?'"

Three procedures were eventually covered. By the time he needed a fourth, however, the company he had joined six months earlier because of its health insurance, decided it could

no longer afford an employee health plan. The hospital told him the cost of his procedure would be \$20,000. When he replied that he was without insurance, a hospital employee told him the "uninsured rate" was \$14,000.

"We went back and forth negotiating what the price of my life was worth to save," Carpenter said. They eventually arrived at \$8,000.

Not surprisingly, Carpenter is an ardent backer of single payer. "Health care is a human right. It shouldn't be treated like a commodity that's based on your income or employment," he said.

Don Mayer, the 65-year old owner of Small Dog Electronics, an Apple retailer and service supplier, serves on Shumlin's health care advisory board. True to its name, six or seven little dogs wander around the firm's Waitsfield offices. Mayer said providing health insurance to his 60 employees is 22 percent of his overall personnel costs, and he finds it difficult to compete against companies that don't cover their workers.

"If you were designing the system now and put 20 people in a room and said, 'How are you going to pay for health care?' not one of them would pick the ludicrous, Rube Goldberg system we have now," he said.

***"If you were designing the system now and put 20 people in a room and said, 'How are you going to pay for health care?' not one of them would pick the ludicrous, Rube Goldberg system we have now."***



# Massachusetts Single Payer Fact Sheet

## By PNHP-Massachusetts and Mass-Care

272,000 Massachusetts residents lacked health insurance in 2012, 4.1 percent of the population. (Source: U.S. Census Bureau)

About 300 adults die from lack of health insurance coverage annually in the state. (Ann Intern Med 2014;160:585 & AJP 2009;99:2289)

At least 530,000 Massachusetts residents under age 65 are under-insured, meaning they have coverage, but still devote a large share of income to cover costs including copayments and deductibles. Many more lack adequate coverage for long-term care or mental health services. For 618,000 with private coverage, their premiums are so high that they're unaffordable, according to federal guidelines. (Commonwealth Fund 2014)

Massachusetts' per capita health costs are about 30 percent above the national average and continue to rise. Between 2009 and 2011 private insurance premiums in Massachusetts increased 9.7 percent despite a 5.1 percent fall in benefit levels – effectively a 14.8 percent cost increase. (CMS Office of the Actuary & Mass. Center for Health Info. and Analysis)

Federal, state and local governments already pay about 64 percent of all health costs in Massachusetts, which totals about \$8,500 per resident in 2014. This figure includes health benefits for public employees and tax subsidies for private insurance, as well as government programs such as Medicare and Medicaid. That's more than total (public + private) health spending in any other nation. (Health Affairs, 2002;21(4):88 – updated by the authors)

Surveys show strong support for single payer. Nationally, 56 percent of adults favor a “universal program like Medicare” (ABC/USA Today/Kaiser survey, 2006) and one-third of those opposed to Obamacare say it's “not liberal enough” (CNN/ORC survey, May 2013). Among Massachusetts doctors, 60 percent favor single payer or public option, a policy that many conflate with single payer (Mass Medical Society Survey, October 2012).

Single-payer health insurance in Massachusetts could save about \$12.3 billion annually on paperwork and administration (NEJM 2003;349:768-75 – updated by authors). Separate studies commissioned by the Massachusetts Medical Society and the state legislature found that the administrative savings under single payer would be large enough to cover all of the uninsured, eliminate all co-pays and deductibles, and upgrade coverage for Medicare enrollees – without any increase in health spending.

- Massachusetts' three largest private insurers (Blue Cross, Harvard Pilgrim and Tufts) employ about 6,600 workers to administer coverage for 5 million people (Companies' annual reports, Boston.com and Patriot Ledger). That's more people than work for the Center for Medicare and Medicaid Services, which administers coverage for 54 million Medicare enrollees and 61 million Medicaid and CHIP enrollees. Nationally, private insurance overhead

averages 12 percent vs. traditional Medicare's 2.1 percent.

- At present, Massachusetts hospitals devote on average 24.0 percent of total expenditures to administration, about double the percentage for hospitals in nations with single-payer systems which greatly simplify billing and the documentation that private insurers require. (Himmelstein and Woolhandler analysis of 2012 Medicare cost reports, and NEJM 2003;349:768-75)
- Reducing hospital administration spending to the levels in Canada would save about \$3.4 billion annually.
- The complexity of the current payment system forces doctors and clinics to spend less time on patient care and to waste money and time on billing-related documentation and paperwork.

Whatever their other merits, the Affordable Care Act and the 2006 Massachusetts reform have increased administrative costs.

- In Massachusetts, the costs of running the Connector have added an additional 2 percent overhead (on top of the private insurers' overhead) to the policies it sells.
- Nationally, the cost of setting up exchanges exceeded \$6 billion in 2013. That's about \$750 for each of the 8 million people who enrolled through exchanges by March 31, 2014.
- In contrast, the cost of getting Medicare up and running in 1966 was \$867 million (in current dollars). But that figure includes the cost of administering payment for the 18.9 million Medicare enrollees, and also doesn't subtract the \$376 million in overhead that was saved on the programs Medicare displaced. In other words, the net startup costs for Medicare were \$491 million, or \$26 per enrollee. The original Medicare sign-up form is reproduced in its entirety below.

If you would like more information, please email [pnhp@bu.edu](mailto:pnhp@bu.edu) or [director@masscare.org](mailto:director@masscare.org)

Published on July 2, 2014.

488-40-6969-A  
APPLICATION FOR ENROLLMENT  
in the  
Supplementary Medical Insurance Program  
Under the Social Security Act  
PLEASE READ THE ENCLOSED LEAFLET  
Harry S Truman  
Independence, Missouri

TO GET MEDICAL INSURANCE  YES  
CHECK

The Federal Government will pay half the cost of this insurance. Your share of the cost (\$3) will be deducted from your monthly social security benefits.

IF YOU DO NOT WANT THIS MEDICAL INSURANCE  NO  
CHECK

SIGN HERE *Harry S Truman*  
Signature by mark (X) must be witnessed below.

SIGNATURE OF WITNESS *[Signature]*

ADDRESS OF WITNESS

Do not write in the space above

## PNHP backgrounder on the VA

### 1. Waits for care in the Veterans Health Administration are probably similar to (or shorter than) waits elsewhere, but are more carefully scrutinized in the VA.

Notwithstanding recent reports of long waits for non-urgent care at some sites for new patients, a recent audit of VA wait times system-wide found that 96 percent of the 6,004,350 appointments currently scheduled have wait times of 30 days or less. Only 4 percent of appointments have wait times of more than 30 days.

At the Phoenix VA, where the investigation started, 89 percent of appointments have wait times under 30 days. The average wait for established patients to see a primary care doctor was 3 days, and to see a specialist was 14 days.

Overall, the audit found 57,436 veterans (<1 percent of appointments) can't be seen in the next 90 days and are waiting for appointments, and another 63,869 veterans (1 percent) have enrolled in the VHA in the past 10 years but have never sought an appointment, most likely because they have other coverage. (Some veterans sign up for the VA in case eligibility standards tighten in the future.) The VA plans to contact the last two groups (VA Audit Wait Times Fact Sheet, 6/9/2014).

According to a recent Massachusetts Medical Society survey, the average wait time for a new patient appointment for an internist in that state (which has the most doctors per capita) is 50 days and for a family physician is 39 days (MMS Patient Access to Care Study, Massachusetts Medical Society, 7/2013).

According to a recent Merritt Hawkins survey of wait times, the cumulative average wait time to see a physician in five specialties (family medicine, OB/GYN, dermatology, cardiology and orthopedic surgery) in 15 major metropolitan markets in 2013 was 18.5 days, and in some cases much longer (2014 Physician Appointment Wait Times, Merritt Hawkins).

Even the longest waits for care in the private sector don't reflect the true extent of unmet need because over one-third (37 percent) of adults forgo care due to financial concerns (Schoen et al., "Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries," Health Affairs, 11/2013).

In many locales, Medicaid patients face long waits because many private physicians and hospitals do not accept Medicaid. A recent study found that children with Medicaid waited 22 days longer for an appointment than the privately insured (Bisgaier et al., "Auditing Access to Specialty Care for Children with Public Insurance," NEJM, 6/16/2011).

### 2. Long waits in the VA result largely from inadequate resources, especially a shortage of clinicians, not inefficiency.

There are over 400 positions for primary care physicians that are currently unfilled in the VA, reflecting both a national shortage of primary care doctors and the VA's relatively low pay scale (Oppel and Goodnough, "Doctor Shortage Is Cited in Delays at V.A. Hospitals," New York Times, 5/29/14).

The VA has faced a surge in demand by aging Vietnam-era vets with a rapidly growing burden of chronic illness and the 6.2 million veterans of the wars in Iraq and Afghanistan, many of whom have severe injuries that will require lifelong care and/or mental health problems such as PTSD. Another factor contributing to increased demand is a greater willingness to seek mental health care among younger veterans.

The loosening of VA eligibility standards by the Obama Administration in 2010 contributed to a large influx of new patients. Veterans with certain illnesses that have been linked to Agent Orange exposure (including Parkinson's disease, prostate cancer, diabetes and ischemic heart disease) are now presumed to have a service-related condition and to be eligible for

VA care. The VA simultaneously reduced demands for documentation supporting claims of post-traumatic stress disorder (Longman, "VA Care: Still the Best Care Anywhere?" Washington Monthly, 6/3/2014).

While the VA budget kept up with overall medical inflation between 2003 and 2012, rising from \$25.5 billion to \$45.5 billion, the increase did not take into account the increased demand for services (Merrill Goozner, "Beyond the theatrics of the VA wait-list scandal," Modern Healthcare, 5/24/2014).

The inadequate supply of VA resources is particularly acute in the South (e.g. Phoenix and Miami), where the population of older vets has increased rapidly, but VA resources have not.

### 3. Studies indicate that quality of care at the VA is, on average, as good as or better than in the private sector.

A Rand study found that:

VA patients received much more of the care recommended by national standards, 66 percent as opposed to 50 percent in a representative national sample of non-veterans.

Among chronic care patients, VA patients received about 70 percent of recommended care, compared with about 60 percent in the national sample.

For preventive care, the difference was greater: VA patients re-

ceived about 65 percent of recommended care, while patients in the national sample received 45 percent.

VA patients received consistently better care across the board, including screening, diagnosis, treatment, and follow-up (Asch et al., “Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample,” *Annals of Internal Medicine*, 12/21/2004).

A recent systematic review concluded: “Studies that assessed recommended processes of care almost always demonstrated that the VA performed better than non-VA comparison groups. Studies that assessed risk-adjusted mortality generally found similar rates for patients in VA and non-VA settings” (Trivedi et al., “Systematic review: comparison of the quality of medical care in Veterans Affairs and non-Veterans Affairs settings,” *Medical Care*, 1/2011).

A direct comparison of quality in the VA and Medicare Advantage (MA) plans concluded that: “Among persons aged 65 years or older, the VA health-care system significantly outperformed private-sector MA plans and delivered care that was less variable by site, geographic region, and socioeconomic status” (Trivedi et al., “Quality and equity of care in the VA and Medicare Advantage health plans,” *Medical Care*, 6/2011).

Patients cared for in the VA have lower risk-adjusted mortality compared with those in private Medicare Advantage plans. (AJ Selim et al., “Risk-adjusted mortality as an indicator of outcomes: comparison of Medicare Advantage Program with the Veterans Health Administration” *Medical Care*, 4/2006).

Patient satisfaction scores at the VA are consistently higher than the private sector. For patients recently discharged from a VA hospital, average overall satisfaction is 4 points higher (84 out of 100 points) than for patients discharged from non-VA hospitals. When asked if they would use a VA medical center the next time they need inpatient or outpatient care, veterans overwhelmingly indicate that they would (96 percent and 95 percent, respectively). (Final report: 2013 Customer Satisfaction Inpatient Survey, CFI Group, 3/2014).

#### **4. VA costs are lower than private sector costs and rising more slowly.**

If the VA were paid at Medicare rates, the payments would be 20 percent higher than actual VA costs, a difference of more than \$5 billion in 2003 (Nugent et al., “Value for Taxpayers’ Dollars: What VA Care Would Cost at Medicare Prices,” *Medical Care Research and Review*, 2004: 61, 495-508).

According to the Congressional Budget Office, between 1999 and 2005, per enrollee costs grew by 1.7 percent in the VA compared to 29.4 percent in Medicare and 70 percent for private family coverage (CBO, “The Healthcare System for Veterans: An Interim Report,” 12/2007).

In 2009, the VA provided \$3.2 billion worth of care to Medicare HMO enrollees, but collected only \$9.4 million for that care – providing a large subsidy to the private plans (Trivedi, A., et al., “Duplicate federal payments for dual enrollees in Medicare Advantage Plans and the Veterans Affairs health care system.” *JAMA*, 7/4/2012).

Privatizing the VA would increase costs and reduce quality. Allowing private HMOs into Medicare has raised Medicare’s costs by over \$283 billion since 1985. In addition, the VA “significantly outperforms” Medicare Advantage plans on quality measures. (Hellander et al., “Medicare Overpayments to Private Plans, 1985-2012,” *International Journal of Health Services*, Volume 43, Number 2, 2013 and Trivedi et al., “Quality and equity of care in the VA and Medicare Advantage health plans,” *Medical Care*, 6/2011).

#### **5. The alleged fraudulent reporting of wait times by VA officials was apparently stimulated by pay-for-performance (P4P) incentives. Similar fraudulent reporting occurs in the private sector. P4P incentives are the problem, not the VA.**

95 percent of Medicare HMOs falsely inflate their quality statistics (Cooper et al., “Underreporting high-risk prescribing among Medicare Advantage Plans: A cross-sectional analysis,” *Annals of Internal Medicine*, 10/2013).

Behavioral economics research indicates that such financial incentives generally result in widespread cheating (Ariely, “The Honest Truth About Dishonesty,” 2013).

#### **6. The VA is not a single-payer system. It coexists with many other payers, and not all veterans are eligible for care at the VA.**

Of 21.6 million veterans, only 9.1 million are enrolled in the VHA system.

2.3 million veterans and their family members were uninsured in 2010. Nationally, 41.2 percent of uninsured veterans report unmet medical needs and 33.7 percent report delaying care due to cost (Haley and Kenney, “Uninsured Veterans and Family Members,” *Urban Institute*, 5/2012).

VA care is not an entitlement. Iraq and Afghanistan veterans are automatically eligible for VA care for five years after discharge. After that, they are subject to means testing or must show that they have a service-related condition as Vietnam-era veterans do determine if they are eligible. Eligibility determinations can take 6-9 months or longer, and veterans and the media often confuse these delays with waiting times for appointments, which are completely separate. The need to determine eligibility would be unnecessary in a single-payer system.

*Published in June 2014.*



## Privatizing VA health care would be the greatest tragedy of all

By Jon Perr

With its shameful backlog and secret waiting lists at some of its facilities, the Veterans Health Administration is facing an urgent crisis. But the only reform certain to make things worse would be to privatize the system of 1,700 VA facilities that serve 8.76 million American vets. Despite its troubles, studies consistently show that VA health care is very popular, delivers quality service and costs less than private sector alternatives. Nevertheless, the usual suspects on the right like John Fund and Charles Krauthammer are predictably calling for its replacement by a voucher program.

Appearing on Fox News on Monday, Krauthammer declared, “Well, if you would suggest that we go to a voucher system, where everybody will get a voucher for treatment in any hospital he or she chooses, and I were a vet, I would choose that,” adding, “I would rather go to Georgetown University Hospital than to a VA.” If that formulation sounds familiar, it should. During the 2012 presidential campaign, GOP nominee Mitt Romney floated the same trial balloon, which just about every veterans’ group in the nation quickly shot down:

“Sometimes you wonder if there would be some way to introduce some private-sector competition, somebody else that could come in and say, you know, that each soldier gets X thousand dollars attributed to them, and then they can choose whether they want to go in the government system or in a private system with the money that follows them,” said Romney. “Like what happens with schools in Florida, where people have a voucher that goes with them. Who knows?”

Actually, many people know exactly what would happen, among them (as ThinkProgress noted) AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and the Veterans of Foreign Wars. Sending millions of older, sicker Americans—many of them requiring specialized care for rare and complex health problems—into the waiting arms of private insurers, private doctors and private pharmaceutical firms is a recipe for chaos and de facto rationing on a grand scale. As the nonpartisan Congressional Budget Office (CBO) concluded its assessment of Paul Ryan’s premium support proposals for Medicare, the result would be a dramatic shift of health care

***Sending millions of older, sicker Americans—many of them requiring specialized care for rare and complex health problems—into the waiting arms of private insurers, private doctors and private pharmaceutical firms is a recipe for chaos and de facto rationing on a grand scale.***



**The Veterans Health Administration has 153 hospitals, 900 clinics, 300 mental health centers, and other facilities — many located in rural areas that the private sector ignores — that care for more than 230,000 people a day.**

costs onto patients.

As the RAND Corporation explained in 2012 (“Socialized’ or Not, We Can Learn from the VA”), the VA system delivers care as good or better than its private sector counterparts, all while doing a much better job of controlling costs for American taxpayers.

RAND’s study, led by Dr. Steven Asch, found that the VA system delivered higher-quality care than the national sample of private hospitals on all measures except acute care (on which the two samples performed comparably). In nearly every other respect, VA patients received consistently better care across the board, including screening, diagnosis, treatment, and access to follow-up...

Among chronic care patients, VA patients received about 70 percent of recommended care, compared with about 60 percent in the national sample. For preventive care, the difference was greater: VA patients received 65 percent of recommended care, while patients in the national sample received recommended preventive care

roughly 45 percent of the time...

After adjusting for a changing case mix as younger veter-

ans return from Iraq and Afghanistan, the CBO calculated that the VA's average health care cost per enrollee grew by roughly 1.7% from 1999 to 2005, an annual growth rate of 0.3%. During the same time period, Medicare's per capita costs grew by 29.4 %, an annual growth rate of 4.4%. In the private insurance market, premiums for family coverage jumped by more than 70% (PDF), according to the Kaiser Family Foundation.

Sadly, it wasn't always this way. The turnaround at the VA isn't merely, as Paul Krugman explained, "one of the great policy success stories of the past two decades." Writing in the *Washington Monthly*, Steve Benen highlighted the 2005 findings of Phillip Longman in "The Best Care Anywhere":

As Longman explained at the time, "Who do you think receives higher-quality health care? Medicare patients who are free to pick their own doctors and specialists? Or aging veterans stuck in those presumably filthy VA hospitals with their antiquated equipment, uncaring administrators, and incompetent staff? An answer came in 2003, when the prestigious *New England Journal of Medicine* published a study that compared veterans health facilities on 11 measures of quality with fee-for-service Medicare. On all 11 measures, the quality of care in veterans facilities proved to be 'significantly better.' ... The *Annals of Internal Medicine* recently published a study that compared veterans health facilities with commercial managed-care systems in their treatment of diabetes patients. In seven out of seven measures of quality, the VA provided better care."

In June 2010, Elizabeth McGlynn, associate director of Rand Health, a division of the Rand Corp., concurred with the assessment that "it's hard to top veterans' health care."

"You're much better off in the VA than in a lot of the rest of the U.S. health-care system," she said. "You've got a fighting chance there's going to be some organized, thoughtful, evidence-based response to dealing effectively with the health problem that somebody brings to them."

The combination of its information system and support tools, routine performance reporting and financial incentives for managers who hit quality targets gives it an edge, said McGlynn, who co-authored a comparative study published in the *Annals of Internal Medicine* in 2004 that found the VA outperformed its community health-care counterparts by 20 percentage points in preventive care. It also performed significantly better on chronic disease care and in overall quality.

Just as telling, a June 2011 study by Amal Trivedi and Regina Grebla published in the journal *Medical Care* found that the VA delivered much better results for elderly patients than private sector Medicare Advantage (MA) plans:

Among persons aged 65 years or older, the VA health-care system significantly outperformed private-sector MA plans and delivered care that was less variable by site, geographic region, and socioeconomic status.

Back in 2006, the Defense Department reported that "VA Out-ranks Private Sector in Health Care Patient Satisfaction." President Bush's VA Secretary R. James Nicholson called the findings of the annual American Customer Satisfaction Index, "the greatest story never told."

Veterans who recently used VA services and were interviewed for the 2005 ACSI survey gave the VA's inpatient care a rating of 83 on a 100-point scale -- compared to a 73 rating for the private-sector health care industry. Veterans gave the VA a rating of 80 for outpatient care, five percentage points higher than the 75 rating for private-sector outpatient care and 9 percent higher than the average satisfaction rating for all federal services.

"Although VA has received many wonderful endorsements recently, the support of our veterans -- the people who know us best -- is the highest praise," Nicholson said.

As the *Washington Post* noted last month, "The American Customer Satisfaction Index for 2013 shows that the VA health network, which serves more than 8 million veterans, achieved marks equal to or better than those in the private sector."

At the end of the day, the fiasco at VA could not come at a worse time. While Congress is wrangling over the size of the defense budget, the total costs of the wars in Iraq and Afghanistan could reach up to \$6 trillion once veterans' pensions and health care are factored in. Over the next 10 years, the Veterans Administration will need more money, not less. And redirecting those resources to the private sector as Mitt Romney, Charles Krauthammer and the conservative commentariat urge can have only one outcome. As Krugman summed it up in 2011:

You know what voucherization would mean in practice: the vouchers would be inadequate, and become more so over time, so that veterans who don't make enough money to top them up would fail to receive essential care. Patriotism!

It's no wonder the Veterans of Foreign Wars tersely responded to Mitt Romney's proposal by simply declaring, "The VFW doesn't support privatization of veterans' health care."

## Myth vs. Fact: Comparing US and Canadian Healthcare Systems

By Trudy Lieberman

One thing Americans and Canadians can agree on is that we don't want each other's healthcare systems. In truth, most Americans don't know how Canada's system works and Canadians don't know much about the U.S. system.

What Americans know has come mainly from the negative talking points of politicians and others who have argued for years against national health insurance. Two decades ago, *The New York Times* reported that Canadian women had to wait for Pap smears, a point vigorously refuted by the Canadian ambassador who shot back in a letter to the *Times* editor: "You, and Americans generally, are free to decide whatever healthcare system to choose, avoid or adapt, but the choice is not assisted by opinions unrelated to fact."

Yes, there are waiting lists for some services – but, no, Canadians are not coming across the border in droves to get American care.

There's misinformation among Canadians, too. Wherever I went in Canada, Canadians told me they thought, mostly based on what they said they heard on CNN and Fox, that Obamacare meant America was getting universal health coverage like their country has.

When I explained the law was simply another patch on a patchwork quilt of coverage, and the Congressional Budget Office had estimated last year there would still be some 30 million people without insurance, the reaction was "the news media didn't tell us that." A former deputy health minister in New Brunswick said to me, "After all that, you will still have 30 million people without coverage!"

Separating fact from opinion as the Canadian ambassador long ago urged was something I tried to do as I made my way across Canada while visiting there recently. In some ways, the Canadian system is very different from U.S. healthcare. In other ways, it's very much the same and faces similar challenges in the years ahead.

### What We Don't Share

Although the Affordable Care Act in the U.S. calls for more people to have health insurance by offering subsidies and mandating all Americans have it or face penalties, the concept of universality is still a far distant goal.

The Canada Health Act, on the other hand, calls for universality – all residents must be covered by the public insurance plan run by their province on uniform terms and conditions. They have coverage wherever they are treated in their home province, and there's none of this stuff about limiting the doctors and hospitals that patients can use as a condition of getting full benefits. In Canada, there are no financial barriers to care at the point of service as there are and will continue to be in the U.S.

Canadians don't pay coinsurance of 30 percent or 50 percent if they have an outpatient procedure or go to an urgent care

clinic, charges that are becoming increasingly common in the U.S. They don't worry about paying a gigantic bill if they happen to use an out-of-network doctor or hospital.

The publicly-funded system north of the border bases patients' access to medical services on need, not on the ability to pay. To use the word "ration," Canadians ration by need; Americans ration by price and will continue to do so as the ACA is implemented.

Because it's publicly funded, Canadian healthcare is more equitable. There's no such thing as buying a platinum plan and getting first-rate coverage or a cheapo bronze policy and paying 60 percent of the bill yourself.

The tiered policies available in the state exchanges further bake inequality into the U.S. system. People have wildly varying benefits depending on where they live, how old they are, where they work, and how much they can afford to spend on health insurance.

That's not the case in Canada, except when it comes to prescription drug coverage. Drug benefits are quite unequal in Canada, and the lack of them is a pretty big hole for about 10 percent of the population.

There is no universal drug benefit, although two provinces have mandatory drug insurance – you can get it from an employer or buy it from a public plan. About 40 percent of the population gets coverage from their employers. If you can't afford the premium, there are subsidies. In that sense, Canadian drug coverage in those provinces resembles Obamacare.

Still, having drug benefits does not necessarily mean adequate coverage, says *Globe and Mail* health columnist, André Picard: "The big difference from the rest of Canada's system is there is very little first-dollar coverage of prescription drugs."

On a recent trip to Canada I heard much more about the social determinants of health than I hear in the U.S. Almost everyone I interviewed mentioned the dismal health stats for aboriginal populations and the need to improve access and quality of care. I tried to remember the last time I heard anyone discuss the medical problems of Native Americans or quality of care provided by the Indian Health Service.

I asked Michael Decter, a health policy expert and a former deputy health minister in Ontario, what his wish list for Canadian healthcare was. Topping his list was not more money for the health system; it was more for education aimed at improving the lives of aboriginal peoples. Better education correlates with better health. The second was drug coverage. Canada's infamous waiting times were not high on his list of priorities. In fact, he didn't even mention them as a problem.

*Trudy Lieberman, a former president of the Association of Health Care Journalists, is a contributing editor to the Columbia Journalism Review.*



## Legal challenge threatens Canada's medicare

### No evidence that for-profit health care results in better outcomes

By **Monika Dutt** and **Rachel Tutte**

We are just four short months away from an unprecedented legal challenge to Canadian public health care that will put the fundamental Canadian principle of care based on need, not ability to pay, on trial.

The legal case is being driven by Dr. Brian Day, owner of the Vancouver-based for-profit Cambie Surgery Centre, infamous for unlawfully billing patients for health care services.

Dr. Day hopes to strike down the rules that prevent a U.S.-style system in Canada, where some people get to pay privately to jump the queue. His claim is that B.C.'s Medicare rules violate the Canadian Charter of Rights and Freedoms.

It is hard to overstate the significance of this challenge. If Dr. Day wins, the public system that Canadians rely on – and overwhelmingly support – will be dismantled across the country. We will be left with a system that looks very much like that of the United States – physicians will be permitted to charge patients any amount they like for services, and the rich elite will get care faster than the rest of us.

Evidence shows that the kind of system Dr. Day is seeking via the courts would result in longer wait times and poorer health outcomes for Canadians.

An abundance of evidence shows that for-profit hospitals reduce access to care for everyone but the wealthy elite. Studies in Canada, Europe, and the UK show that patients who can't pay, and whose doctors work in both public and private systems, have the longest waits. Australian research shows that private for-profit clinics drain the limited supply of doctors and other health professionals from the rest of the health care system, lengthening waiting times for all but those who can afford expensive private insurance.

This bears emphasizing: A second, for-profit tier does not relieve pressure on the public system; instead, evidence shows wait times actually increase.

Similarly, there is no evidence that private for-profit care results in better outcomes – not anywhere in the world.

There is no doubt we are in need of improvements to our system. Those improvements need to reflect the Canadian values of equity and cost-effectiveness. We need to scale up evidence-based innovations that have been proven to reduce wait times and improve health outcomes. Across Canada, there are dozens of innovative projects improving access, quality, and cost-effectiveness while protecting equitable access to care. For example, the Alberta Bone and Joint Institute reduced wait times from 11 months to nine weeks for hip and knee surgery.

Dr. Day's true motives are clear. A provincial audit of Day's



**Dr. Monika Dutt**



**Dr. Rachel Tutte**

Cambie Surgery Centre and the associated Specialist Referral Clinic found that patients were unlawfully extra-billed \$491,654 in just 30 days. In one case, a Cambie patient was billed \$7,215.00 for services that would only have cost \$1,288.04 in the B.C. health care system. Auditors also found over \$66,000 in overlapping claims – evidence that suggests double dipping for the same services.

Charging patients nearly six times the actual cost of a procedure is not about human rights, and it's not about system improvement. It's about profit.

For the good of all Canadians, let's hope this dangerous legal challenge is struck down and we can get on with the work of improving a system that cares for all of us.

*Dr. Monika Dutt, chair of Canadian Doctors for Medicare, is a Medical Officer of Health, Cape Breton District, and a family physician. Rachel Tutte is co-chair of the BC Health Coalition and a physiotherapist.*

### **Update: Cambie trial delayed**

As this issue of the PNHP Newsletter goes to press, Dr. Brian Day, who is spearheading the constitutional challenge to British Columbia's health system (and, by extension, Canada's single-payer system), has requested a delay in the trial, and the court has granted a six-month delay from the originally scheduled Sept. 8 start date. Day said he wants to negotiate a resolution to some of the issues out of court, and single-payer supporters are hopeful of reaching a settlement that preserves Canada's public system.

## U.S. doctors migrating north

By Wendy Glauser

TORONTO – With the prospect of greater pay, fewer bureaucratic headaches and the opportunity to provide better care for patients, the number of American doctors migrating north is rising, according to Canadian recruiters and Canadian Medical Association data.

Susan Craig, president of the Toronto-based physician recruiter, Susan Craig Associates, said that Canada is becoming “increasingly attractive,” while John Philpott, the Halifax-based chief executive director of Can-Am Recruiting, noted “interest is doubling each year for American doctors” seeking to move north.

Increased pay is the main driver of this interest. Philpott said family physicians, pediatricians and psychiatrists can make \$100,000 more in Canada, on average, compared to the U.S.

According to data from the Canadian Medical Association, the number of U.S.-trained physicians grew less than 3 percent from 1996 to 2005 (up from 493 to 506), but jumped 42 percent from 2006 to 2014 (508 to 721).

The increase would be much higher, however, if estimates distinguished between specialists and family doctors, as the majority of U.S. physicians crossing the border are in family medicine, said Philpott.

In the U.S., thanks to insurance company loopholes and technicalities, American family physicians aren't paid up to 30 percent of the time, whereas under a single-payer system, only about 2 percent of his billings don't get covered, explained Dr. Sajad Zalzal, a U.S.-trained family physician who moved to Windsor, Ont., in 2012.

Communicating with insurance companies and filing claims is so bewilderingly bureaucratic, in fact, that while “a family physician in Canada can manage with one or two secretaries, in the U.S., one doctor could need 10 secretaries,” said the recruiter Susan Craig.

Even referrals are a headache as insurance companies often only pay for specific hospitals and specialists, added Zalzal.

The introduction of Obamacare isn't stemming the tide of U.S. physicians heading North. Quite the opposite, in fact.

“For every problem that Obamacare solves, it creates two to three other problems,” said Zalzal. For example, the Blue Cross plan under the Affordable Care Act is different from the Blue Cross employer-paid plan, so doctors will have double the paperwork.

### Canadian registration constraints

Depending on the regulations of the provincial Colleges of

Physicians and Surgeons, U.S. doctors have to undergo a period of supervision (usually several months to a year) or must complete the Medical Council of Canada exams, or both, to obtain a full license to practice in Canada.

There are numerous procedural delays and doctors often have to show they have a job before they can start the process, which can lead to a period of unemployment, said Dr. Bridget Reidy, who moved north two years ago and has worked as a locum doctor in Prince Edward Island, as a full time physician in Ontario, and is about to start a job in BC.

“I think a lot more doctors would want to work in Canada if [the licensing process] was easier,” she said, adding that the barriers are a shame as most provinces “desperately need doctors.”

Since the credentials of U.S.-trained doctors are recognized by the Canadian College of Family Physicians (CCFP), Philpott doesn't understand why the provincial colleges put barriers up.

“The provincial colleges are slapping the CCFP in the face,” said Philpott. “I guess they feel they have a greater understanding of certification than our own national bodies.”

But Craig thinks the supervision is a “wise thing.” There are billing practices and different drug names to be learned, and

American doctors often feel the need to order more tests — a practice known as defensive medicine — to avoid lawsuits, she said. “In the U.S., they practice fairly intensive defensive medicine and in Canada we don't encourage that.”

Another attraction for family doctors is that their work is more valued in Canada, said Reidy, who explained that U.S. patients tend to go to walk-ins or straight to specialists. “There's just not that understanding of the need for someone to be the captain of the outpatient care. Doing proper care becomes more difficult as a result,” she said.

Dr. Jack Lucas, who works in forensic psychiatry in New York City and commutes to Owen Sound, Ont., to practice psychiatry two weeks every month, said he appreciates that his Canadian patients can access psychiatric services much more easily than in the U.S., and are supported through social programs rather than being “criminalized” like they are south of the border.

And Zalzal appreciates that the lack of a “defensive medicine” culture. “If I'm worried about missing something, it's because I'll feel terrible for the patient, not because the patient will come back and sue me,” he said.

***The number of U.S.-trained physicians migrating to Canada jumped 42 percent from 2006 to 2014. Increased pay is the main driver.***

## After Hobby Lobby: A Single-Payer Health Care Solution?

By Fred Rotondaro and Christopher J. Hale

Now that the initial shouting and – at times – vitriol from both sides has subsided after Monday’s Supreme Court ruling in the Hobby Lobby case, it’s time to take a sober look at what the ruling says about the future of health care reform in the United States. The majority’s ruling was an imperfect solution to a complicated case involving the reach of religious liberty to exempt organizations from providing certain medical benefits that they find morally objectionable to their employees. The fact that these medical benefits were almost exclusively offered to women makes this decision all the more difficult to accept for some.

But at its core, the case reveals something else as well. It brings to the forefront something we’ve all known for sometime: that Obamacare – for all the good it’s done in increasing access to quality and affordable healthcare – is a messy law. It asks employees to be at the whim of its employers’ objectives and mission for what health care benefits they receive. It also asks employers to at times reject its deepest convictions in order to provide certain benefits to its employees.

This isn’t sustainable. A person’s access to quality healthcare shouldn’t depend on who their boss is. And an employer shouldn’t be heavily fined if they don’t compromise their religious convictions in providing healthcare for their staff.

President Obama’s Affordable Care Act is a monumental first step in achieving a just and equitable American health care system that seeks first to serve those on the margins of society. But as we look towards the future, it’s necessary to consider major alterations or even alternatives to Obamacare to continue to advance healthcare reform.

For those of us who value both universal access to quality healthcare and the strong American tradition of protecting religious liberty, there might be a solution in a single-payer system.

A single-payer system overturns an unsound principle of Obamacare: relying too heavily on private organizations to deliver the public good of healthcare. When you require private organizations to enforce what the government believes ought to be public policy, you open yourself to a myriad of legal and ethical qualms. How can you expect organizations as diverse as Hobby Lobby, the Little Sisters of the Poor and the American Atheists to agree on what health care benefits are appropriate for their employees?

Amidst all the fuss this week over the Supreme Court ruling, both sides actually agreed on one thing: they disliked the accommodation provided by the Obama Administration for religious organizations. Religious groups argue the exemption is too narrow and doesn’t protect the autonomy of some organizations to practice their convictions. Women’s groups argue that the current accommodation unfairly denies women working for religious groups access to birth control, which is a basic benefit in any healthcare plan.

A single-payer public health care option eliminates such complications. No matter who your boss is or what business you work for, you get access to the healthcare you need. And employers will not be forced to compromise their religious beliefs while providing the public good of healthcare.

And let’s be clear, if you have something that is both supported by the United States Conference of Catholic Bishops and Planned Parenthood, you might be onto a plan that proves the angel Gabriel right: nothing is impossible with God.

*Fred Rotondaro is the chair of Catholics in Alliance for the Common Good and a senior fellow at the Center for American Progress. Christopher Hale is a senior fellow at Catholics in Alliance for the Common Good. He helped lead national Catholic outreach for President Obama’s re-election campaign.*

### PNHP note on the Hobby Lobby case

The recent Supreme Court ruling in *Burwell v. Hobby Lobby* illustrates why keeping health insurance tied to employment is one of the biggest flaws in the ACA.

The law’s intent was to require insurance to cover the full cost of “preventive” health care services for women, defined by the Institute of Medicine as including all 20 contraceptive products approved by the Food and Drug Administration.

Religious institutions were exempt from the mandate from the beginning, and nonprofit organizations with religious affiliations received an accommodation. Now, some private, for-profit corporations can opt out as well.

Owners of the retail chain Hobby Lobby objected to covering four of the contraceptive products, which they believe to be abortifacients. In *Burwell v. Hobby Lobby*, the Court ruled 5-4 that the mandate, as applied to closely held firms, violated the Religious Freedom and Restoration Act.

The Court found that there was a “compelling government interest” to provide no-cost contraception to women, but that the mandate was not “the least restrictive means” to pursue that interest. Instead, for-profit firms should use the same accommodation the administration and insurers devised for nonprofit firms – that is, submit their objection in writing to the insurer, who will then provide their employees with coverage directly.

The only problem with this workaround is that now the religious groups are back in court, objecting to the deal. Until insurance is a universal entitlement, essential health benefits for women will remain hostage to corporate dictates. (See Carlson, “Supreme Court backs Hobby Lobby; employers can deny contraceptive coverage,” *Modern Healthcare*, 6/30/14).



# The Argument Against Reimbursing Physicians for Value

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Since the time of Hippocrates, it has been assumed that a physician's first obligation is to provide the best possible care to individual patients, without distortion by competing societal interests.<sup>1</sup> This once near-sacrosanct principle is being tested by the high costs of the health care in the United States, which increasingly threaten the economy. Because physicians control much of the delivery of health care, they have a natural role in helping to control health care costs. But historically, our society has been uneasy about assigning this role to physicians. When people are sick and helpless, do they really want their physicians to be influenced by costs, or do they need to believe that their physicians want only to serve them according to their medical needs?

Physician organizations—under pressure to respond to growing costs—have increasingly asserted the profession's responsibility to take a role in allocating resources, for example, by developing efficient practice guidelines and participating in the development of health policy.<sup>2</sup> However, their policy statements have also consistently reaffirmed the primacy of physicians' responsibilities to individual patients. When these statements gingerly approach the topic of cost control at the bedside, they are careful to sidestep any conflict between physicians' general advocacy for cost-effective care and their specific advocacy on behalf of individual patients. Under mounting pressure, the seal between these 2 different roles for physicians has largely held.

Recently however, the concept of reimbursing physicians for "value" in health care has breached the wall. Value is defined as the health outcomes achieved per dollar spent—essentially, the ratio of quality to cost. Value has taken center stage in health policy deliberations and has become the basis for major changes in physician reimbursement, led by the Centers for Medicare and Medicaid Services (CMS). In 2015, CMS pay-for-performance programs for hospitals and for physicians will include measures of both quality and cost, and proposed legislation would incorporate value into the Medicare physician fee schedule. Private insurers are following the lead of the federal government, and health care organizations are posing the risk to their physicians with internal pay-for-performance programs that reward both quality performance and lower costs.

The concept of value has become popular precisely because it seems to offer a way that physicians can both take care of their patients and control costs for society without conflict of interest. The premise of value is harmony, or at least a peaceful resolution when there is tension between the 2 goals (the word *value* even carries virtuous overtones). As Leo has observed, "value is emerging as a concept—perhaps the only concept—that all stakeholders in health care embrace."<sup>3</sup> The term

value is often used loosely, blurring the components of quality and costs—almost as though value were a third entity, different from the ratio of its components. But in practice, the components may be separated, so that efforts to control costs remain but there is little attention to safeguarding of quality.

Consider CMS's new pay-for-performance program for physicians. Beginning in 2015, as part of the Affordable Care Act, Medicare payments to physicians will include an adjustment called the Value-Based Payment Modifier, which is based on 2 separate composite scores: 1 for quality, and 1 for costs. Although the formula links the 2 scores when the adjustment is determined, quality and costs may be considered quite separately at the point of care. For example, a physician could increase his or her reimbursement by concentrating on improving performance on several reported quality measures, while reducing spending broadly in other areas of care.

It might be hoped that ensuring quality care would serve as an anchor to prevent excessive or integrated decreases in expenditures. But this is possible only if quality is accurately and comprehensively measured—a goal that remains elusive, despite impressive academic and efforts by CMS and its collaborators over the past decade. The relative weakness of the quality part of the determination of value is evident in the Value-Based Payment Modifier program. As Brennan and Kizer<sup>4</sup> have pointed out, the performance measures capture a narrow, misleading picture of overall performance for any given physician and do not correlate with broader efforts to improve quality.<sup>5</sup> Worse, reimbursing physicians based on performance measures can cause detrimental distortions in care, such as inordinate attention to the measures, the neglect of other important aspects of care, or the avoidance of sicker, poorer patients. In effect, then, Medicare will be paying physicians to decrease costs, without a reasonable guarantee that they will maintain quality.

It is true that the goal of increasing the quality of care and decreasing costs often dovetail. For well-insured patients, overtesting, overtreatment, and iatrogenic illness may be the biggest threats to the quality of health care—and in many geographic areas, higher spending is associated with worse health outcomes.<sup>6</sup> Conversely, the low health organizations that achieve the best clinical outcomes do so at lower cost, by providing care that is standardized, integrated, and based on evidence. But it does not follow that rewarding institutions and physicians for decreasing spending will always encourage high quality. Although health care costs may be lowered by tighter, parsimonious care—or by systems that create intelligent, coordinated processes—they may also and increasingly be lowered by indiscriminately altering care. In fact, substantial data suggest

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that lower spending at the patient or hospital level is associated with poorer outcomes for patients.<sup>6</sup>

If physicians' pay depends on considering costs as well as quality, each time a physician approaches a patient's bedside, he or she may consider whether it is possible to provide lower-cost care—whether, for example, a large decrease in cost is worth a small reduction in chance for diagnosis or cure. These choices will end up being based on the belief system (or susceptibility to financial incentives) of individual physicians. In aggregate, I believe, they undermine the single-minded commitment of doctors to their patients that has always been the hallmark of the profession.

It may be that reimbursing physicians for value is better than the existing reimbursement system, in which ordinary fee-for-service payments encourage overtesting and overtreatment. But it should be noted that many of the proposals to incorporate value (including the Value-Based Payment Modifier program) do not replace the fee-for-service structure; they merely layer on additional incentives—adding to an increasingly complex array of financial considerations. Which incentives will prevail in influencing physicians' behavior is not clear. One thing is certain, however: the influence of patients' medical needs becomes ever more obscured. In my view, salary without bonuses or withhold is a better means to pay physicians because it sweeps away these layers of complexity. Reducing the financial incentives that lead to overtesting and overtreatment would in and of itself improve value. But if our society chooses to use pay-for-performance programs to reimburse physicians, then as physicians we should insist that these programs are based on quality measures that are unambiguously in our individual patients' best interests. These quality measures could and should include those for avoiding unnecessary testing and treatment—but on the basis of quality alone.

Conceivably, the United States could reach a point of economic distress at which the public interest in cost control outweighs its interest in protecting physicians' advocacy for their patients, but we are not there yet. We have not yet seriously addressed the waste in our profit-oriented system or sufficiently studied the successes in other countries that demonstrate better outcomes at considerably less cost—in other words, higher value.<sup>7</sup> In contrast to the evidence provided by international models, there is not a little evidence that pay-for-performance can improve outcomes.<sup>8</sup> Measuring and rewarding value is expensive, adding a large layer of bureaucracy and complexity to our already top-heavy system. Reimbursing for value fails by its own standard.

It is unrealistic to expect that physicians should or could entirely avoid considering the costs of care. External budget constraints are common. But when we put on our white coats and approach the bedside, we should put aside considerations of costs—and financial incentives to do more or less—and remember our professional commitment to our patients. Many parties stand to gain from changing patients' care, and financial incentives are constantly shifting. The cost of a treatment or test in any given year is as capricious as whether an insurer covers it, or the duration of a patient—and as senseless as what the market will bear. In this unstable and economically driven environment, it is critical that the patient retains one—just one—financially disinterested advocate. And in serving this role, we as physicians indirectly serve as a touchstone for wider public health and policy decisions.

Value is not a parable, or even more. It is simply a mathematical manipulation of two very old players—costs and quality. It does not absolve us of the need to consider the conflict inherent in asking physicians to be medical doctors, party contractors, however packaged.

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## Dr. Arnold Relman, 91, Journal Editor and Health System Critic, Dies

By Douglas Martin

Dr. Arnold S. Relman, who abandoned the study of philosophy to rise to the top of the medical profession as a researcher, administrator and longtime editor of *The New England Journal of Medicine*, which became a platform for his early and influential attacks on the profit-driven health care system, died at his home in Cambridge, Mass., on Tuesday, his 91st birthday.

His wife, Dr. Marcia Angell, said the cause was melanoma.

Dr. Relman and Dr. Angell filled top editorial posts at the journal for almost a quarter-century, becoming “American medicine’s royal couple,” as the physician and journalist Abigail Zuger wrote in *The New York Times* in 2012.

The couple shared a George Polk Award, one of journalism’s highest prizes, for an article in 2002 in *The New Republic* that documented how drug companies invest far more in advertising and lobbying than in research and development.

His extended critique of the medical system was just one facet of a long and accomplished career. Dr. Relman was president of the American Federation for Clinical Research, the American Society of Clinical Investigation and the Association of American Physicians – the only person to hold all three positions. He taught and did research at Boston University, the University of Pennsylvania, Oxford and Harvard, where he was professor emeritus of medicine and social medicine.

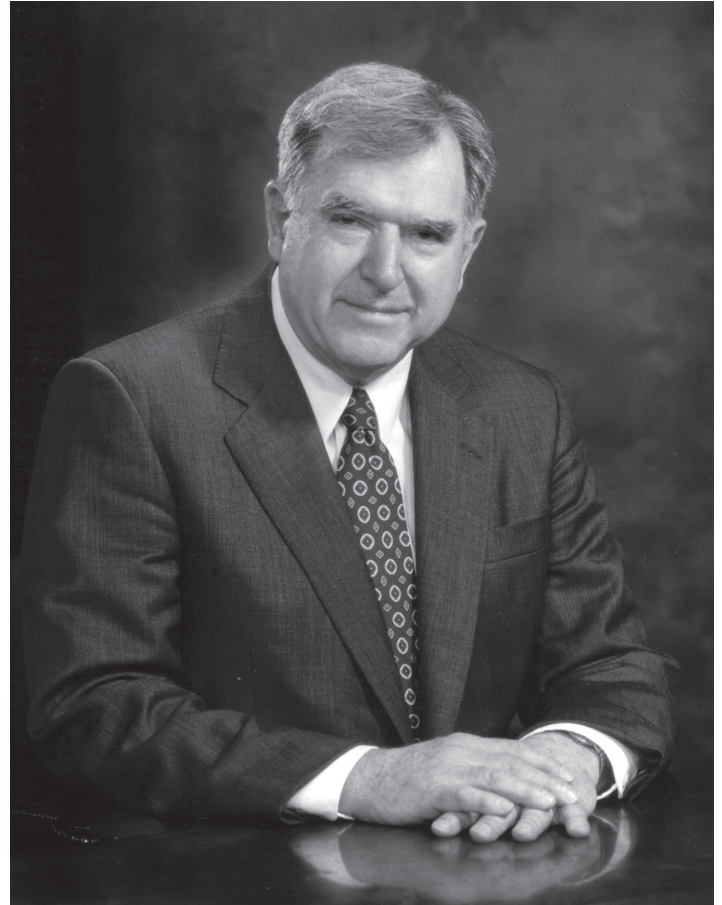
Early in his career, he did pioneering research on kidney function.

He was also editor of *The Journal of Clinical Investigation*, a bible in its field, and he wrote hundreds of articles, for both professional journals and general-interest publications. Days before he died, Dr. Relman received the galleys of his final article, a review of a book on health care spending for *The New York Review of Books*, to which he was a frequent contributor.

In a provocative essay in the *New England journal* on Oct. 23, 1980, Dr. Relman, the editor in chief, issued the clarion call that would resound through his career, assailing the American health care system as caring more about making money than curing the sick. He called it a “new medical-industrial complex” – a deliberate analogy to President Dwight D. Eisenhower’s warning about a “military-industrial complex.”

His targets were not the old-line drug companies and medical-equipment suppliers, but rather a new generation of health care and medical services – profit-driven hospitals and nursing homes, diagnostic laboratories, home-care services, kidney dialysis centers and other businesses that made up a multibillion-dollar industry.

“The private health care industry is primarily interested in selling services that are profitable, but patients are interested only in services that they need,” he wrote. In an editorial, *The Times* said he had “raised a timely warning.”



**Dr. Arnold Relman**

In 2012, asked how his prediction had turned out, Dr. Relman said medical profiteering had become even worse than he could have imagined.

His prescription was a single taxpayer-supported insurance system, like Medicare, to replace hundreds of private, high-overhead insurance companies, which he called “parasites.” To control costs, he advocated that doctors be paid a salary rather than a fee for each service performed.

Dr. Relman recognized that his recommendations for repairing the health care system might be politically impossible, but he insisted that it was imperative to keep trying. Though he said he was glad that the health care law signed by President Obama in 2010 enabled more people to get insurance, he saw the legislation as a partial reform at best.

The health care system, he said, was in need of a more aggressive solution to fundamental problems, which he had discussed, somewhat philosophically, in an interview with *Technology Review* in 1989.



“Many people think that doctors make their recommendations from a basis of scientific certainty, that the facts are very clear and there’s only one way to diagnose or treat an illness,” he told the review. “In reality, that’s not always the case. Many things are a matter of conjecture, tradition, convenience, habit. In this gray area, where the facts are not clear and one has to make certain assumptions, it is unfortunately very easy to do things primarily because they are economically attractive.”

Dr. Relman edited *The New England Journal of Medicine* from 1977 to 1991. Founded in 1812, it is the oldest continuously published medical journal in the world, reaching more than 600,000 readers a week. Dr. Angell was the editor in 1999 and 2000.

When he took the journal’s helm, interest in health news was booming, and newspapers and magazines competed to be first in reporting new developments. One policy he instituted was to ask general-interest publications not to disclose a forthcoming article in advance, a request almost always honored, albeit sometimes grudgingly.

He also began requiring authors to disclose any financial arrangements that could affect their judgment in writing about the medical field, including consultancies and stock ownership.

Dr. Relman and Dr. Angell met when she was a third-year student and he was a professor at Boston University School of Medicine. They published a paper on kidney disease together in *The New England Journal of Medicine*, then did not see each other for years.

After he became the journal’s editor, he asked her to come on board as an editor, which she did, abandoning her career as a pathologist. They began living together in 1994 – both were divorced by then – and married in 2009.

They became the ultimate medical power couple, not least because they were gatekeepers for one of the world’s most prestigious medical journals. Their outspoken views further distinguished them.

“Some have dismissed the pair as medical Don Quixotes, comically deluded figures tilting at benign features of the landscape,” Dr. Zuger wrote in *The Times*. “Others consider them first responders in what has become a battle for the soul of American medicine.”

Arnold Seymour Relman was born on June 17, 1923, in Queens (in an elevator, according to Dr. Angell) and grew up in the Far Rockaway neighborhood. His father was a businessman and avid reader who inspired his son’s love of philosophy. His mother nicknamed him Buddy, and friends called him Bud the rest of his life.

He skipped grades in school and graduated at 19 from Cornell with a degree in philosophy, but he chose not to pursue the field because it “seemed sort of too arcane,” his wife said. He earned a medical degree from the Columbia University College of Physicians and Surgeons at 22. His first marriage was to Harriet M. Vitkin.

In addition to Dr. Angell, he is survived by his sons, David and John, and a daughter, Margaret R. Batten, all from his first marriage; his stepdaughters, Dr. Lara Goitein and Elizabeth Goitein; six granddaughters; and four stepgrandsons.

Last June, Dr. Relman fell down a flight of stairs and cracked his

skull, broke three vertebrae in his neck and broke more bones in his face. When he reached the emergency room, surgeons cut his neck to connect a breathing tube. His heart stopped three times.

“Technically, I died,” he told *The Boston Globe*.

He went on to write an article about his experience for *The New York Review of Books*, offering the unusual perspective of both a patient and a doctor.

“It’s both good and bad to be a doctor and to be old and sick,” he told *The Globe*.

“You learn to make the most of it,” he added. “Schopenhauer, the German philosopher, said life is slow death. Doctors learn to accept that as part of life. Although we consider death to be our enemy, it’s something we know very well, and that we deal with all the time, and we know that we are no different. My body is just another body.”

## The responsibility of physicians

*The following is an excerpt from Dr. Arnold Relman’s article titled “Physicians and Politics” in the June 2, 2014, issue of JAMA Internal Medicine.*

“A new health care system that provides universal access and is affordable and efficient will be difficult to achieve. The private insurers and all the other businesses that profit from the current commercial system will resist it. Major reform will need wide public support, which in turn will rely on advocacy by the medical profession. But I believe that reform will nevertheless be eventually enacted because it meets a widely shared and growing public desire for more fairness in an American society pervaded by inequality in access to good health care and many other social benefits.

“Physicians have a unique power to reshape the medical care system. They are what makes it work and are best qualified to use and evaluate its resources. But if they never unite to press for major reform, the future of health care in the United States will indeed be bleak. We will end up either with a system controlled by blind market forces or with a system entangled in complicated and intrusive government regulations. In either case it would be impossible to practice good patient-centered medicine, and the quality and effectiveness of our health care system would sink even lower among the ranks of developed countries. It is up to the medical profession to see that this does not happen.”

*PNHP note:* Shortly before his death, Dr. Relman asked that in lieu of flowers, donations in his memory be directed to Physicians for a National Health Program. PNHP is honoring Dr. Relman’s legacy by establishing The Arnold Relman Memorial Fund, dedicated to expanding PNHP’s special outreach programs to the medical profession, including to medical residents and fellows, to advance the understanding and realization of Dr. Relman’s vision. To contribute online to the fund, visit [pnhp.org/relman](http://pnhp.org/relman).

## Why Obamacare can't lower costs

By Kip Sullivan, J.D.

President Obama and the Democratic Party dug themselves into a deep hole by claiming the Affordable Care Act would cut the nation's health care costs when in fact it will raise them. It's the gift that will keep on giving to opponents of the law.

The ACA cannot cut costs because its proponents subscribed to the wrong diagnosis of the U.S. health care crisis. They accepted the conventional wisdom that overuse of health care services is the most important reason why per capita health care costs are double those of the rest of the industrialized world, and that overuse is caused by two chronic failings among American doctors: (1) they routinely order services patients do not need and (2) they fail to provide them with obviously beneficial preventive ones that would keep them healthy and minimize later need for medical interventions.

This diagnosis is wrong. First, underuse is far more common than overuse, even among the insured. To cite one example, 80 percent of insured Americans showing telltale symptoms, such as shortness of breath, do not see a doctor. Second, preventive services usually raise spending because they cost more to supply than they save.

Predictably enough, the mistaken "overuse" diagnosis led ACA proponents to the wrong solution, namely, that doctors can be forced or induced to stop ordering unnecessary services and provide more preventive services if they are subjected to more control by insurance companies. But the premises upon which this solution is based are also false. It is not true that the methods that the insurance industry uses to control doctors are so precise that they reduce overuse without aggravating underuse. It is also not true that the insurance industry's methods are so inexpensive compared with the savings due to reduced overuse that, on balance, costs go down.

Health care spending now eats up 17 percent of our income. Since the 1970s, observers across the political spectrum have agreed that America will never achieve and maintain a substantial reduction in our uninsured rate, never mind universal coverage, unless we reduce the cost of our health care system. As a candidate and as president, Barack Obama made it clear he understood that.

He made that clear, for example, in response to a question put to him by a woman at a town hall meeting in New Mexico in May 2009. The woman asked why "single payer has been taken off the plate." Obama prefaced his response by emphasizing the importance of cost containment. "If we simply insured everyone under the current system we couldn't afford it," he said. "We'd go broke. We've gotta drive down costs."

But in the rest of his reply, Obama made it clear he had no idea how to reduce health care spending. He said he didn't support a single-payer system because it was "too disruptive," and then

went on to say there were other ways to cut costs. He characterized these as "simple things we can do that will save money," such as "prevention and wellness programs," "reimbursing doctors not just for treating people after they get sick but for helping people stay well," and information technology to reduce "error rates" in physician decision making.

The advisers that Obama selected also revealed his belief in the overuse diagnosis and the mantra that keeping people healthy is the solution to overuse. Tom Daschle (Obama's first choice for Health and Human Services secretary), Peter Orszag (Obama's budget director), and Ezekiel Emanuel and Nancy-Ann DeParle (his choices for health policy advisers within the White House) were all proponents of the overuse diagnosis and the prevention mantra.

Similarly, Obama's enthusiastic endorsement of an article in the June 1, 2009, *New Yorker* by Atul Gawande revealed his firm belief in the overuse diagnosis. The article, entitled "The Cost Conundrum," alleged that "across-the-board overuse of medicine" explains America's high health care costs. The *New York Times* reported that Obama brought Gawande's article into a meeting with senators and said, "This is what we've got to fix."

Overuse does exist. The overuse of antibiotics is a good example. But underuse is rampant, and not merely among the uninsured, but among the insured as well, and not just with respect to inexpensive preventive services, but to expensive procedures like heart surgery. Here are some examples of underuse taken from papers published in the peer-reviewed literature. Note that the subjects of these studies all had insurance.

Eight in 10 insured Americans who suffer serious symptoms such as unexplained loss of consciousness, unexplained bleeding, or shortness of breath from climbing a flight of stairs do not see a doctor. Six in 10 seniors insured by Medicare who have been told they need gall bladder surgery don't get it done. Half of all insured Americans who should have an angiogram to detect blocked coronary arteries don't get one, and one-fourth of those who do have an angiogram that indicates they have dangerously blocked arteries do not undergo surgery to treat the blockages. Half of all insured people with high blood pressure are not being treated for it.

According to the best study of the rates of both under- and overuse (a 2003 paper in *The New England Journal of Medicine*), underuse occurs at about four times the rate of overuse – 46 percent versus 11 percent. Here is how the authors summarized their findings: "Underuse of care was a greater problem than overuse. [P]atients failed to receive recommended care about 46 percent of the time, compared with 11 percent of the time when they received care that was not recommended and potentially harmful."

Once you realize underuse is far more serious than overuse, the claim that reducing overuse can cut costs loses its seductiveness. The question naturally arises, if our goal is to lower costs through better health, how do we improve the overall health of the populace while leaving all that underuse untouched? The logical answer is we can't (and the moral answer is we shouldn't). And if we decide we must eliminate or reduce underuse to improve health, how do we do that without spending a lot more money to provide the underused services? The answer is we can't eliminate or even reduce underuse without spending a lot more money.

The inaccuracy of the overuse diagnosis is compounded by the inaccuracy of their claim that prevention, such as smoking cessation treatment and mammograms, must inevitably lead to lower costs. It just isn't true. A review of the literature on this issue published in *The New England Journal of Medicine* by Joshua T. Cohen et al. concluded, "Although some preventive services do save money, the vast majority reviewed in the health economics literature do not."

The reason preventive services generally don't save money is threefold: (1) such services cost money and have to be administered to millions of patients in order to prevent disease in a few of them, (2) like all medical services, preventive services are not 100 percent effective (think flu shots, for example, that are effective in about half the people who receive them) and (3) some preventive services, such as colonoscopies and mammograms, turn up incipient diseases that require treatment, sometimes extensive treatment.

Scholars have reached the same conclusion about a close cousin of prevention known as "disease management."

Of course there are exceptions to this rule that prevention and disease management cannot save money. The insurance industry and its allies in business and academia love to talk about these exceptions. Do not be fooled. They are exceptions to the rule.

Contrary to the conventional wisdom that seduced Obama and proponents of the ACA, the insurance industry's methods are too crude to reduce overuse without aggravating underuse, and the industry has no secret formula for making patients healthier without spending more money. The industry's methods for reducing overuse and making patients healthier fall into two categories: financial incentives, and direct interference in doctor-patient decision making.

The most commonly used financial incentive is known as "pay for performance" (P4P). Doctors are paid bonuses if they score well on report cards that purport to measure a tiny proportion of all the activities doctors engage in during the course of a day's work. For example: the percent of diabetics who receive an eye exam once a year.

The most commonly used method of interfering in doctor-patient decision making is "utilization review," which means someone at the insurance company has to approve a physician's

decision, such as whether to hospitalize a patient.

But P4P and utilization review are far too crude to reduce overuse without increasing underuse. P4P, for example, cannot accurately measure which patients "belong" to which doctors, and how much of a bad "grade" is attributable to the patient's health or income and how much is due to the doctor. Moreover, P4P induces "teaching to the test," that is, it encourages overworked doctors and nurses to shift resources away from patients whose care is not being measured to those whose care is being measured, thereby aggravating underuse for the unmeasured patients.

Perhaps the single best evidence of the insurance industry's inability to cut costs is its performance within Medicare, the nation's program for the elderly and the disabled enacted in 1965. Beginning in 1972, lawmakers allowed the insurance industry to stick its nose further into the Medicare program by accepting the industry's claim that its role in the program would somehow lead to less overuse and lower costs. Today 30 percent of all Medicare beneficiaries are insured through the privatized Medicare Advantage program.

But Medicare Advantage is raising, not lowering, Medicare's total costs. According to the latest report from the Medicare Payment Advisory Commission, Medicare Advantage increases costs per enrollee by at least 4 percent compared with costs

***According to the best study of the rates of both under- and overuse (a 2003 paper in The New England Journal of Medicine), underuse occurs at about four times the rate of overuse – 46 percent versus 11 percent.***

under the traditional program, and probably more (other estimates indicate the Medicare Advantage program raises costs much more than 4 percent). The reason for the uncertainty is that Medicare Advantage insurers "upcode" far more aggressively than do doctors treating patients under the traditional

Medicare program. "Upcoding" means the insurance industry tells Medicare its enrollees are sicker than they really are in order to induce Medicare to pay them more.

Medicare's experience with private insurance is a harbinger of what the country can expect from the ACA – more insurance industry control over doctors and hospitals, higher administrative costs, an aggravation of the underuse problem, and higher expenditures on health care.

The Medicare Advantage experience should long ago have caused Congress to terminate the privatized program. But Congress has continued wasting taxpayer dollars on it.

Why is that? The short answer is the insurance industry has the power to propagate the myths discussed in this article – overuse is the main problem, prevention will save money, and it has a secret sauce for reducing spending without aggravating underuse – and our political leaders, in the face of that power, are willfully gullible, gutless or both.

*Kip Sullivan is an attorney, activist and writer whose work has appeared in The New York Times, The Nation, Health Affairs, The New England Journal of Medicine and the Los Angeles Times. This is a slightly abridged version of his original article at Truthdig, which can be found at [bit.ly/VCQq7E](http://bit.ly/VCQq7E).*



RESEARCH LETTER

**Academic Medical Center Leadership on Pharmaceutical Company Boards of Directors**

Financial relationships between the pharmaceutical industry and physicians have come under increased scrutiny. Less attention has been paid to relationships between industry and the leadership of academic medical centers (AMCs), who wield considerable influence over research, clinical, and educational missions.

When AMC leaders serve on pharmaceutical company boards, they hold a fiduciary responsibility to shareholders to promote the financial success of the company, which may conflict or compete with institutional oversight responsibilities and individual clinical and research practices.<sup>1</sup> The potential conflict between responsibilities of individuals who hold leadership roles in both industry and academia deserves exploration.

**Methods** | We studied the prevalence of AMC leaders on pharmaceutical company boards of directors. Data on board composition and academic positions were collected in January 2013 from the websites of the 50 largest pharmaceutical companies based on 2012 global prescription drug sales.<sup>2</sup> Financial compensation for individuals who served the entirety of 2012 was collected from 2013 company proxy statements from the US Securities and Exchange Commission's public database<sup>3</sup> and from 2012 shareholder reports.

Compensation figures reflect annual compensation for services on boards including cash, stock awards, dividends, and charitable contribution matching. We defined AMCs as US medical schools, health professional schools, teaching hospitals, and health care systems.<sup>4</sup> Leadership positions included CEOs, clinical department chiefs, division directors, medical school deans, and hospital boards of directors. Given their oversight over medical schools, we also included university presidents and boards of directors.

**Results** | Of the 50 companies examined, 3 private companies lacked public data on governance. Nineteen of 47 (40%) companies had at least 1 board member who concurrently held a leadership position at an AMC, including 15 of 17 (88%) US companies (Table). Forty-one board members held AMC leadership positions in 2012, receiving a mean financial compensation for board membership of \$312 564 (excluding the 6 industry executives).

Eighteen industry board members (5% of all board members) held at clinical or administrative leadership positions including 2 university presidents, 6 deans, 6 hospital or health system executive officers, and 7 clinical department chiefs or center directors. Twenty-five industry board members (5%), including 6 industry executives and 2 who also held clinical

Table. Academic Medical Center Leaders on Pharmaceutical Company Boards of Directors

Pharmaceutical Company	Academic Medical Center Affiliations of Company Board Members in January 2013 <sup>a</sup>	Annual Compensation for Board Membership <sup>b</sup>
Abbott Laboratories	Yale School of Medicine	\$250 825- \$257 324
	Yale-New Haven Hospital	
	Northwestern University (n = 2)	
Actavis	Montefiore Medical Center	\$307 472
Allergan	Johns Hopkins University School of Medicine	\$106 854- \$557 172
	University of Southern California Keck School of Medicine	
	Children's Hospital and Research Center Oakland	
Amgen	University of Southern California	\$281 194
	Northwestern Memorial HealthCare	
Baxter International	Emory University	\$266 069
Bristol-Myers Squibb	Welli Cornell Medical College	\$267 833
Celgene	City of Hope National Medical Center	\$442 484
	Atlantic Health System	
Eli Lilly	New York Presbyterian Hospital	\$309 500
Endo Health Solutions	Jefferson School of Population Health	\$308 002
Forest Laboratories	Massachusetts General Hospital	\$314 179
	Catholic Health Initiatives <sup>c</sup>	
Gilead Sciences	University of Alabama-Birmingham School of Medicine	\$417 467- 432 467
	Rush University Medical Center	
	Morehouse School of Medicine	
	Northwestern University	
	University of Southern California	
GlaxoSmithKline	University of Texas Southwestern Medical Center	\$165 000- \$212 000
	New York University Langone Medical Center	
	Texas Medical Center	
Hospira	Lurie Children's Hospital of Chicago	\$252 000
Johnson & Johnson	David Geffen School of Medicine at University of California Los Angeles	\$274 913- \$309 913
	University of Michigan	
	UCLA Health System	
	Morehouse School of Medicine	
	Eisenhower Medical Center	
Merck	Northwestern Memorial Hospital	\$260 000- \$325 000
	Memorial Sloan-Kettering Cancer Center (n = 2)	
	New York Presbyterian Hospital	
Mylan	Welli Cornell Medical College	\$276 869
	University of Southern California School of Pharmacy	

(continued)

Table. Academic Medical Center Leaders on Pharmaceutical Company Boards of Directors (continued)

Pharmaceutical Company	Academic Medical Center Affiliations of Company Board Members in January 2013 <sup>a</sup>	Annual Compensation for Board Membership <sup>b</sup>
Novartis International	University of Illinois College of Medicine	\$350 025-450 038
	Harvard University	
	Rockefeller University	
	Partners HealthCare	
Pfizer	Massachusetts General Hospital	\$275 550-320 000
	University of Texas Southwestern Medical Center	
	Weill Cornell Medical College	
	University of Chicago	
Valiant Pharmaceuticals	Harvard Medical School	\$472 770

<sup>a</sup>Academic medical centers include health professional schools, post-graduate, teaching hospitals, and health systems. Doctor affiliations were collected in January 2013. Some individuals held leadership roles at multiple academic institutions (eg, at a medical school and a hospital) in which case each separate academic institution is listed.

<sup>b</sup>Compensation figures are for academic medical center leaders only. Compensation figures exclude CEOs of companies who also serve as hospital or academic leaders as well as individuals who served only a portion of the year. All compensation figures are from 2013 annual proxy statements (DEF-14A forms) filed by companies to the US Securities and Exchange Commission, except for Novartis and GlaxoSmithKline, for which compensation data were obtained from 2012 annual reports to shareholders.

<sup>c</sup>Details: Health Institutes is a health system that includes major affiliate hospitals of Tufts, Dartmouth, and Baylor medical schools.

positions, held all positions as trustees or board members of 15 hospitals, medical schools, or universities.

**Discussion** | Oversight of potentially intersecting institutional missions, fiduciary responsibility to shareholders, and the magnitude of compensation make board membership by AMC leaders potentially more problematic than other financial relationships between medicine and industry. Our study builds on the few prior studies of institutional conflicts of interest.<sup>4-6</sup>

Association of American Medical College guidelines<sup>7</sup> and most institutional policies require internal disclosure of board membership for institutional review. The Physician Payment Sunshine Act will make all financial relationships with industry public in 2014. Further management strategies, such as capping industry payment to a \$5,000 daily limit, have been implemented.<sup>8</sup> Others have suggested limiting compensation to a percentage of academic salary,<sup>9</sup> which bears similarity to conflict of commitment policies and thus provides a mechanism to ensure that board membership remains secondary to the academic appointment.

Severing ties between companies and AMC leaders might eliminate the potential benefits of academic-industry collaboration; however, the extent to which individuals who hold coexisting leadership positions have fostered beneficial partnerships and at what potential cost remains unclear. Severing the fiduciary ties by banning voting board membership would still allow academic leaders to serve as consultants.

Our study is limited to a single industry and a single year; thus we cannot comment on temporal trends. We relied on company disclosures of compensation that cannot be independently verified. We do not make any conclusions about whether specifically identified relationships led to actual, rather than potential, conflicts of interest.

However, given the magnitude of competing priorities between academic institutions and pharmaceutical companies, dual leadership roles cannot simply be managed by internal disclosure. These relationships present potentially far-reaching consequences beyond those created when individual physicians consult with industry or receive gifts.

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# Godzilla has risen: The insurance industry under the ACA

By Emily Dalton, M.D.

When inquired if Godzilla was “good or bad,” producer Shogo Tomiyama likened it to a Shinto “God of Destruction” which lacks moral agency and cannot be held to human standards of good and evil. “He totally destroys everything and then there is a rebirth; something new and fresh can begin,” he said.

Despite all the hopes many of us had for the Affordable Care Act (ACA), the current system of medical insurance is a dysfunctional nightmare. I should know, because I am in the unique position of experiencing it from three perspectives simultaneously: that of a patient who uses an insurance plan, that of a small business owner who purchases insurance for a group of employees, and that of a physician who contracts with and gets paid by insurance companies.

## The ‘deny’ mantra

As a patient, I am tricked by the expensive insurance plan I bought. Even though the card says “HSA 2000,” the deductible for my family is actually \$4,000. After that the insurance only pays for 70 percent of covered charges when initially we were told 80 percent.

When I call my insurance company to address problems, I must make sure that I have several hours of free time, so that I can stay on hold long enough to get through to the low level representative who has little power to do anything. The disclaimer “Description of covered benefits is not a guarantee of payment” makes me fearful and insecure. I am at the mercy of large, for-profit corporation that is beholden to shareholders and run by greedy CEOs who do not care about me.

Having insurance means little anymore. Deductibles are high, share of costs are high, and many benefits are simply not covered. Deny, deny, deny! The company has so many devious ways of denying payment that even a sophisticated health care “consumer” can be taken by surprise. The reason for denial could be the type of treatment (no counseling for you!), or lack of a contract with a specific provider, or that your medication is non generic, or not on formulary.

Deductibles can vary depending on the type of service: medical, pharmacy, durable medical, or mental health (don’t even mention dental or vision). After my insurance denied the fourth claim submitted, I realize what is going on. In the past insurances could kick you off for getting sick or refuse to accept you for having a pre-existing condition, but now they are legally obliged to accept all comers. However, they have found a new way to shed their undesirable patients: balk, deny, hassle and ignore you until you willingly transfer your diseases to another company. Ah, insurance is wonderful – just don’t get sick!

## Alphabet soup

As a small business owner, I have over 25 employees, most of whom rely on me to provide insurance. Over the past decade,

we dread the arrival of each new year, because the insurance plans offered previously are cancelled and replaced by more expensive plans with fewer benefits. Typically we see the price of premiums increase by 25-40 percent. The plans are so complicated we can’t even understand them, and we have three full time medical billing specialists on staff. The alphabet soup of HMOs, EPOs, PPOs, HSAs is overwhelming, the rules that regulate the deductibles, copays, share of cost, prior authorizations and formularies can be mind-boggling, and even if you understand them, remember: Descriptions of benefits are not a guarantee of payment.

As a physician, I have had no end of problems dealing with the nine different insurance companies with which we have contracts. Our office has three full-time employees whose job it is to make sure the claims we send in get paid correctly, each according to its own set of terms. It seems that any reason is good enough for an insurer to underpay or deny payment. If we don’t catch the mistakes, we lose out.

I pay my staff their hourly wage as they beg, bicker and bargain so we can get reimbursed. Sometimes we call the California Medical Association to get help, and sometimes we yell at our insurance broker, but we don’t often reach out to the understaffed, overburdened Department of Insurance or the Department of Managed Health Care. I also pay my staff to overcome other hurdles and barriers the insurance industry has created like “prior authorizations” that are required before patients can get their medications, consults or procedures.

## A broken system

When the ACA was rolled out, our office was also offered a very low reimbursement rate to see a certain insurer’s Covered California patients, so we declined the contract. However, that insurer gave patients deceptive insurance cards that looked identical to those of our contracted patients, and we were also falsely promoted as contracted providers on their website.

Our office and our patients did not find out who had Covered California status and who had regular status until bills were denied, and it fell upon my staff to inform parents that their insurance had not covered their costs and that they owed us money. Dumbfounded and dismayed, families wept and raged at our medical billers.

My newest employee quit because she felt she could not con-



**Dr. Emily Dalton**



tinue in a job that was so hurtful to young families. After sending out patient after patient in tears, she decided the bad karma invoked by performing her duties could not be justified, and she decided to move on to a happier job. When things reach a point where your employees feel like they will face eternal damnation just for doing their job then the system is broken.

Every time the company refuses to pay for a procedure, consult or a medication, the company gets to keep the money! Every time the company suckers some poor clinic into accepting low rates, the company gets to keep the money! Every time the company “forgets” to pay a claim, the company gets to keep the money! Each time the company raises premiums, the company gets to keep the money! The worse they behave, the more money they get. Are we crazy to tolerate such a system?

The Affordable Care Act, despite the best of intentions, has fortified a monster. By mandating that everyone purchase insurance, the industry is stronger and feels emboldened to take even

more advantage of patients and health care providers. Exponentially larger and more powerful than the agencies assigned to oversee it, the industry finds ways to circumvent and resist restrictions.

This leech has gotten firmly latched on to the lifeblood of American medicine, and is sucking money and energy out of medical care from all angles. Like a cancer, it has created harmful malfunctioning growths that waste our precious health care dollars. How long are we going to stand for this?

I wish “Obamacare” was what the conservatives imagine it to be and hate - a comprehensive, Medicare-like, government-run system - and I wish I could sign up for it.

*Emily Dalton is a pediatrician in Eureka, Calif. A shorter version of this article appeared in the North Coast Journal in Humboldt County, Calif., under the title “The Insurance Leech” (June 19).*

## Health Insurance Company CEOs' Total Compensation in 2013

 <p><b>Joseph Swedish, WellPoint</b>  <b>\$17.0 million</b>            (\$49,853 per day)</p> 	 <p><b>Michael Neidorff, Centene</b>  <b>\$14.5 million</b>            (\$42,560 per day)</p> 
 <p><b>Stephen Hemsley, UnitedHealth</b>  <b>\$12.1 million</b>            (\$35,484 per day)</p> 	 <p><b>Mark Bertolini, Aetna</b>  <b>\$30.7 million</b>            (\$90,029 per day)</p> 
 <p><b>David Cordani, Cigna</b>  <b>\$13.5 million</b>            (\$39,589 per day)</p> 	 <p><b>Bruce Broussard, Humana</b>  <b>\$8.8 million</b>            (\$25,807 per day)</p> 

**Average income of all occupations in 2013: \$35,239**

Sources: AFL-CIO Executive Pay Watch and 2013 SEC 14A schedules

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM / [WWW.PNHP.ORG](http://WWW.PNHP.ORG) 

### PNHP Facebook post reaches more than 2.7 million users

The graphic above, depicting the outlandish compensation given to the health insurance industry’s top six executives, reached the news feed of more than 2.7 million Facebook users this May. If you haven’t visited PNHP’s Facebook page or Twitter feed recently, please do so. Dustin Calliari, PNHP’s technology associate and social media maven, regularly updates our presence in both venues with new, provocative stories, links and infographics, and the number of our followers is growing.

## Through a Glass Darkly – How Can So Many Health Care Executives Be Visionaries?

By Roy M. Poses, M.D.

**Visionary** (noun): (1) *one whose ideas or projects are impractical; dreamer*; (2) *one who sees visions; seer*; (3) *one having unusual foresight and imagination*.

In 1997, Sherif Abdelhak, the CEO of the then unusually large vertically integrated health care system based in Pennsylvania, the Allegheny Health Education and Research Foundation (AHERF), was described in an American College of Physicians publication as a “visionary.” Abdelhak had previously been called a “visionary” or a “genius” in the Philadelphia Inquirer. In 1998, AHERF was bankrupt, and Abdelhak eventually pleaded guilty to misusing charitable funds and went to jail.

Mr. Abdelhak was one of the earlier examples I found of the hospital leader regarded as fearless leader, visionary, even messianic, and the possible bad effects of putting so much money, power, and faith in one person.

Modern health care, the U.S. economy, and many developed countries have seen increasing domination by administrators, managers and executives. In particular, U.S. hospitals were once small nonprofit institutions based in communities or universities, often threadbare, and run by dedicated if harried health care professionals. They now have morphed into huge organizations run by professional managers who may become multimillionaires in the process.

Meanwhile, U.S. health care has become increasingly expensive, but without any obvious advantages to patients’ or the public’s health.

As we have noted, justification for the domination by professional managers and their lavish remuneration often includes paeans to their brilliance. Most recently we discussed how the rise of the professional manager has been explained by a not very clear analogy between such managers and the “great men” of history.

### Can They All be Visionaries?

The notion of every hospital CEO as a Napoleonic figure seems ridiculous, but there seems to be little public skepticism of the notion of executives, including hospital leaders as fearless leaders.

One reason may be that the exposure most people have to these notions is limited. One may see the local hospital CEO extravagantly praised, but it is always possible the local CEO is brilliant. Most people probably do not see the praises sung for the CEO of the hospital 100 miles away.

So inspired by our most recent discussion of the public relations talking points used to justify health care CEOs often million-dollar-plus compensation, I set out to see if brilliant hospital leaders are really a dime a dozen. My methods were simple. I used Google News to search back about one month, and looked simply

for hospital CEOs or other top leaders described as “visionaries.” Here are the results, in chronological order.

**Re the CEOs of Frederick Regional Health System, Meritus Health, and Western Maryland Health System (Cumberland Times News, June 9, 2014):**

The context: “Frederick Regional Health System, Meritus Health and Western Maryland Health System announced Trivergent Health Alliance as the name of their regional health care alliance. ... After a national executive search, Raymond Grahe, senior vice president and chief financial officer of Meritus Health based in Hagerstown, has been named chief executive officer of Trivergent Health Alliance MSO, the management services organization that is a subsidiary of the alliance.”

This is what Grahe said about the CEOs of the three hospitals: “It is thanks to the dedication of these three visionary CEOs that Trivergent Health Alliance exists today.”

**Re Baystate Health’s CEO (Masslive.com, June 18, 2014):**

In the course of a tribute to retiring CEO Mark R. Tolosky, an attorney by training, Mary Jo Stafford, a nurse, said, “He has been incredibly accessible and is a visionary.”

**Re Anna Jacques Hospital’s CEO (Newburypost News, Mass., June 18, 2014):**

On the announcement of the retirement of Delia O’Connor, David LaFlamme, chairman of the hospital board, said, “Her legacy is that of a visionary, decisive leader whose extraordinary contributions to the hospital and local area have earned her the trust and respect of the entire community.”

**Re CoxHealth’s Vice President for Marketing and Public Affairs (KY3 News, Springfield, Mo., June 23, 2014):**

On the announcement of the appointment of Jim Anderson as the new Vice President for Marketing and Public Affairs, CoxHealth CEO Steve Edwards said, “We welcome Jim Anderson, a great visionary with a passion for our community.”

**Re Good Shepherd Medical Center’s Chief Medical Officer (KYTX News, Tyler, Texas, June 25, 2014):**

Per a news report on the announcement of the appointment of Dr. Lawrence T. Verfurth as new Chief Medical Officer: “Dr. Verfurth, who joined the Good Shepherd staff earlier this month, is a visionary physician executive with a broad base of operation and clinical leadership spanning the spectrum of healthcare.”

**Re Bassett Healthcare Network’s President and CEO (HANNYS news release, Rensselaer, N.Y., June 27, 2014):**

On the occasion of awarding the Distinguished Service

## Single-payer advocate makes pitch to doctor executives

By Andis Robeznieks

The American College of Physician Executives annual meeting drew a record 830 attendees, including one doctor whose presentation on the merits of a national single-payer system may have been something of a surprise.

Dr. Ed Weisbart described himself as a long-time ACPE member who is also a member of Physicians for a National Health Program and now serves as chairman of the single-payer advocacy group's Missouri chapter.

Weisbart, a family physician, had a table full of PNHP literature and a poster indicating that salaries for Canadian physicians are comparable or better than those earned by U.S. doctors. The poster also said that Canadian physicians pay lower

malpractice insurance premiums.

His intent, Weisbart said, was to build bridges between the two organizations, and he left with "several pages" of new names to add to the PNHP mailing list. "I think it was time well-spent."

One visitor to his table questioned whether the government could be trusted to run the nation's healthcare system. Weisbart replied that he agrees. PNHP's goal, he said, is to have a publicly funded, privately operated system.

"I think many people wouldn't want to see a government-delivered healthcare system with physicians employed by the federal government," he said.

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Award by the Healthcare Association of New York State (HANYS) to Dr. William F. Streck as Bassett Healthcare Network President and CEO, HANYS President Dennis Whalen said, "Under Dr. Streck's visionary leadership, a single hospital in Cooperstown, with 70 physicians, has grown into a network of six affiliated hospitals, with 45 community- and school-based health centers, and more than 400 providers serving eight counties."

**Re Milford Hospital's CEO (Milford Medical Laboratory, Conn., news release via BusinessWire, June 26, 2014):**

On the occasion of an article published by Milford Hospital researchers, Dr. Sin Hang Lee, one of the authors and director of Milford Medical Laboratory, a Milford Hospital affiliated laboratory said, "The four employees of Milford Hospital's Department of Pathology are carrying out the commitment of the hospital's visionary president and CEO Joseph Palaccia."

**Re St. Jude Children's Research Hospital's CEO (Memphis Daily News, June 26, 2014):**

On the announcement of the appointment of Dr. James R. Downing as the new CEO of St. Jude Children's Research Hospital, Terry Burman, chairman of the St. Jude Board of Governors, said, "Dr. Downing is an exceptional scientist whose visionary approach to the next era of growth and discovery at St. Jude will mirror the legacy established by Danny Thomas more than 50 years ago."

### Summary

So with a very cursory search covering less than one month I was able to find eight CEOs, one vice president for marketing, and one CMO, from 10 hospitals in seven states who were called visionary or visionaries. It is hard to believe that

all these people were truly visionaries using the definition above.

None of the news articles or press releases that used the "V word" provided any detailed justification. In most cases, the visionary designation was made either by someone who worked directly for the leader in question, or was a member of the organization's board of trustees and hence responsible for that individual holding a leadership position. This is more evidence that there are cults of leadership surrounding most health care leaders these days.

Actually, labeling a health care manager a visionary should evoke more suspicion than admiration. As in the unfortunate case of Mr. Abdelhak and AHERE, we have seen many health care leaders praised for their brilliance and paid royally despite leadership resulting in financial distress, threats to the organizations' health care missions, poor patient care, unethical behavior, or even crime.

Yet health care CEOs are just people, sometimes smart, but almost never brilliant. Promoting them as messianic or "great men" (or more rarely women) to bewitch key constituencies, justify the remuneration of other top managers, and the hiring of more public relations flacks is likely to lead to the sort of organizational disasters and system-wide dysfunction we discuss on Health Care Renewal. The rise of the falsely messianic leader may allow the entry of the most dangerous false messiahs, the psychopathic ones.

In the secular occupation of health care, we ought not to yearn for messiahs, or even "great men" or women, but instead hope for reasonable leadership that draws on the collective knowledge and values of health care professionals rather than dubious "visions." True health care reform would promote leaders who show accountability, integrity, transparency, honesty, and ethics.



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Mary E. Wheat MD  
Madeline J. White MD  
Robert B. White MD  
Tessa Whitley MD  
Arnold L. Widen MD MACP  
Bruce Wilder MD MPH JD  
John L. Williams MD  
Kathryn A. Williams MD  
Stephen Williamson MD  
Lecke Wilson MD  
Clyde Winter  
James F. Wittmer MD MPH FACP  
FACPM  
Oliver Wolcott MD  
Sidney Wolfe MD  
Philip E. Wolfson MD  
Curtiss B. Wright DO  
Kenneth C. Wright MD  
Brian Yablom MD  
Mary Ann Zetes MD &  
Peter Mazonson MD  
Therese M. Zink MD

## Surprise In MA Primary: 21 Percent For Single-Payer Candidate Berwick

By Carey Goldberg

Note to politicians: Backing “Medicare for all” is looking less and less like electoral poison. If, deep in your heart, you believe American health care would be better off with a Canadian-style, single-payer system, you might now consider coming out of the closet. (In Democratic primaries in blue states, at least.)

That’s my suggested takeaway from the striking Massachusetts Democratic primary showing of Dr. Donald Berwick, who rocketed from near-zero name recognition among general voters to 21 percent at the polls. Catch him saying forcefully in the video above: “Let’s take the step in health care that the rest of the country hasn’t had the guts to take: single payer. Medicare for all.”

Now, Vermont not only has a mainstream politician who backed a single-payer system — Gov. Peter Shumlin — it’s actually translating the idea into practice as we speak. But let’s put it this way: This seems to be the first time that a candidate in a mainstream political party in a state that is not a verdant utopian duchy has run on a single-payer platform. And though he did not defeat the longtime familiar faces, he did surprisingly well.

Of course, we knew that Massachusetts voters tend to like the idea of single payer. As recently as 2010, 14 fairly middle-of-the-road districts voted in favor of a non-binding ballot measure calling for “creating a single payer health insurance system like Medicare that is comprehensive, cost effective, and publicly provided to all residents of Massachusetts.”

Analysts projected that the results meant a statewide majority in support of a single-payer system. The single-payer idea had polled well in non-binding ballot measures before, as well. But now we’ve seen that sentiment translated into support for a candidate.

Other politicians, including President Obama, have backed the general idea of a single-payer system, but they always add a “but,” said Dr. Steffie Woolhandler, who helped found Physicians for a National Health Program.

“And the ‘but’ usually has to do with the political situation,” she said. “But it’s actually important to say what’s the right thing to do and to really work toward the right solution, and that’s what Don [Berwick] has been willing to do, to say, ‘We need single payer and skip the ‘but,’ let’s just say we need single payer and that we need to start working toward it.’”

Will Dr. Berwick’s strong showing change the playing field for other candidates? Dr. Woolhandler says yes: “Politicians understand votes. Unfortunately, they also understand money. But they do understand votes, and I think other politicians will see that voters are behind the idea of single payer.”

I asked Dr. Berwick about the reaction to his single-payer position in his many campaign-season travels, and he said the

biggest surprise was how positive the response had been from voters who would likely not call themselves progressives. They either already agreed with the idea, he said, or responded instantly after one sentence of explanation with, “That sounds right to me. Let me tell you my story.”

“I remember a carpenter in Hingham,” he said. “I don’t think he would have said he was a progressive — he was a somewhat older carpenter struggling to make ends meet, sitting on a sofa at a gathering, a meet-and-greet, and I started talking about this, and I guess — embarrassingly, to me — I was expecting some pushback. But he immediately said, ‘I’ve got to tell you a story.’ And he told me about his struggle to get health insurance.

“He very carefully went through the policy options, he had picked one that had a maximum deductible that was pretty stiff, and he was ready to swallow it. And he did, he signed up for that plan. And then, the problem was that he had three major illnesses the following year. And he discovered — to his dismay — that the deductible did not apply to the year, it applied to each separate episode. So this guy, who’s working with his hands and trying to just get through and have his family’s ends meet, suddenly found himself tens of thousands of dollars in debt, because of the complexity [of health insurance.] And he said, ‘Enough of this!’ He immediately understood and was fully on board, and that kind of experience has been pretty constant for me.”

Overall, Dr. Berwick said, “The response has been extremely positive beyond anything I would have anticipated. When I took the position, I had no polling information. I did it because I was looking at the state budget and seeing the erosive impact of rising health care costs on everything else we need to do.

“People do have questions, like, ‘Is this a government takeover of health care?’ And you explain, ‘No, no, no. It’s the same delivery system, your doctors and hospitals, this is not nationalization or the state taking over care, but it is a single payment system. So I would say, the reaction to this has been stunningly positive. Could this be catalytic? I certainly hope so. I’d hate to see Vermont lap Massachusetts on being the first to show what a rational payment system looks like.’”

Neither of the Massachusetts primary winners — Democrat Martha Coakley and Republican Charlie Baker — backs a single-payer system, so it’s actually pretty well guaranteed that Vermont is going to lap Massachusetts in the single-payer realm.

But perhaps the question is whether Vermont and Massachusetts will follow the pattern of gay marriage: The Vermont Supreme Court broke the ice in late 1999 with its decision on “civil unions,” but it was — arguably — the 2003 decision by the highest court of Massachusetts that set gay marriage on the road to the big-time.



## How a St. Louis-based health care system became one of the nation's biggest

By Jim Doyle

Anthony Rocco Tersigni is one of the most powerful business leaders in the St. Louis area, but his is not a household name.

A thoughtful, low-key executive, Tersigni often leads business meetings with a prayer. The multibillion-dollar organization that he has headed for 10 years also enjoys a low profile in its hometown.

But under Tersigni's leadership, Ascension has emerged in the past decade as the nation's third-largest health care system – acquiring dozens of nonprofit hospitals and immersing itself in numerous for-profit ventures.

That dramatic growth culminates Tuesday with the grand opening in the Cayman Islands of the first phase of a \$2 billion “health city” complex – a project that seems far removed from the nonprofit health system's humble origins and its Catholic mission to serve the poor and vulnerable.

Ascension executives say they hope through this joint venture with a for-profit, India hospital chain to learn ways to reduce medical costs.

But the Caribbean investment also illustrates how dramatically U.S. health care is changing. In its rapid-fire evolution, Ascension has become a leading example of a nonprofit health system that often acts like a for-profit, blurring the line between businesses and charities. Its health ministry has drawn criticism for risk-taking and its ties to Wall Street. And some critics have raised questions about its tax-exempt status.

### Daughters of Charity

Not so long ago, Ascension was a little-known entity with ties to a religious order called the Daughters of Charity of St. Vincent de Paul – which created schools for orphans and hospitals for the poor, including the first hospital in St. Louis, in 1828.

Ascension was formed in 1999 with the merger of the St. Louis-based Daughters of Charity National Health System and the Michigan-based Sisters of St. Joseph Health System. A wave of hospital mergers in the past 15 years catapulted its journey from a regional hospital operator to the nation's largest Catholic and nonprofit health system.

Its parental sponsor, Ascension Health Ministries, is a corporation within the Roman Catholic Church that reports to the Vatican on its key transactions and must adhere to church di-

rectives such as the prohibition on abortions.

Ascension's headquarters, which houses several hundred employees, is located in a nondescript office building in Edmondson, not far from Lambert-St. Louis International Airport. Tersigni and his deputies travel first class and on charter jets to conduct business across the country and overseas, espousing health care's Holy Grail to deliver high-end medical care at lower prices.

In fiscal year 2013, Ascension's network of for-profit and nonprofit subsidiaries reported \$17 billion in revenue, yet paid no corporate income taxes on its nonprofit operations and few property taxes, capital gains taxes and sales taxes. Like other nonprofit health systems, it has access to tax-exempt bond financing.

According to its financial statements, Ascension's \$30 billion in assets include cash and investment portfolios worth about \$15 billion. Its \$2.7 billion in nonoperating earnings – such as gains from investments – in 2013 dwarfed its nearly \$400 million in earnings from its hospitals.

Ascension is not the only nonprofit health system to have spawned for-profit ventures. Chesterfield-based Mercy Health has for-profit subsidiaries that distribute medical supplies and provide emergency medical services. But industry experts say Ascension's scope of investment in for-profits is unrivaled in nonprofit health care.

Tersigni, through a spokesman, declined to comment for this story.

John D. Doyle, an Ascension executive vice president, said in an interview that the health ministry needs “new sources of revenue to sustain our enterprise. ...

***“They provide health services for the poor, but it's not their primary mission anymore. Ascension has transformed itself over time to a major big business enterprise.”***

Our job as a generation of managers is to make sure our platform is strong for the next couple of hundred years.”

That goal, he said, is complicated by the enormous cost and uncertainties of health reform, including lower government reimbursement

rates.

Ascension's critics say the health ministry has strayed from its mission.

“Why is this organization charitable? In my view, it's not,” said John Colombo, a professor at the University of Illinois College of Law and expert on tax-exempt organizations.

“They provide health services for the poor, but it's not their

primary mission anymore,” Colombo said. “Ascension has transformed itself over time to a major big business enterprise. I’m not denying that they do some charitable things, but so does Microsoft – and they pay taxes.”

Doyle stressed that Ascension provides charity care to the poor and also \$775 million in community benefits to the general public. Last year, it provided traditional charity care to the poor that cost \$525 million, or about 3 percent of its operating revenue. That rate is comparable to other local nonprofit health systems.

“As a tax-exempt organization, Ascension acts for the public good,” Doyle said. “We are a faith-based ministry that’s trying hard every day to make sure we have the resources to take care of people.”

### Venture capital funds

Ascension’s holdings include about 220 tax-exempt subsidiaries, from hospitals and nursing homes to outpatient clinics. Its largest nonprofit subsidiary, Ascension Health, operates 114 acute care hospitals in 23 states and the District of Columbia and has about 155,000 employees. The closest Ascension hospitals are in Kansas City.

Its subsidiaries also include more than 125 for-profit companies that specialize in radiology services, medical equipment sales and rental, outpatient surgeries, endoscopic centers and cardiac care services as well as investment firms, condominium associations, a laundry in Michigan and a local travel agency.

Ascension Ventures LLC, an Ascension for-profit subsidiary, has created venture capital funds on Wall Street to pool \$550

million in investments in startup companies. Ascension and its limited partners, which include Mercy Health, have spawned startups that create medical devices and provide health technology services. In fiscal year 2012, Ascension Ventures reported income of \$240,000, according to its parent’s tax filing.

Olivette-based ISTO Technologies, which is developing products for sports medicine and spinal therapy, was among the startups that Ascension Ventures backed in its first venture capital fund. ISTO uses the cartilage and bone of dead children – made available through organ donations – to develop products for use in the surgery and repair of adult knees and spines.

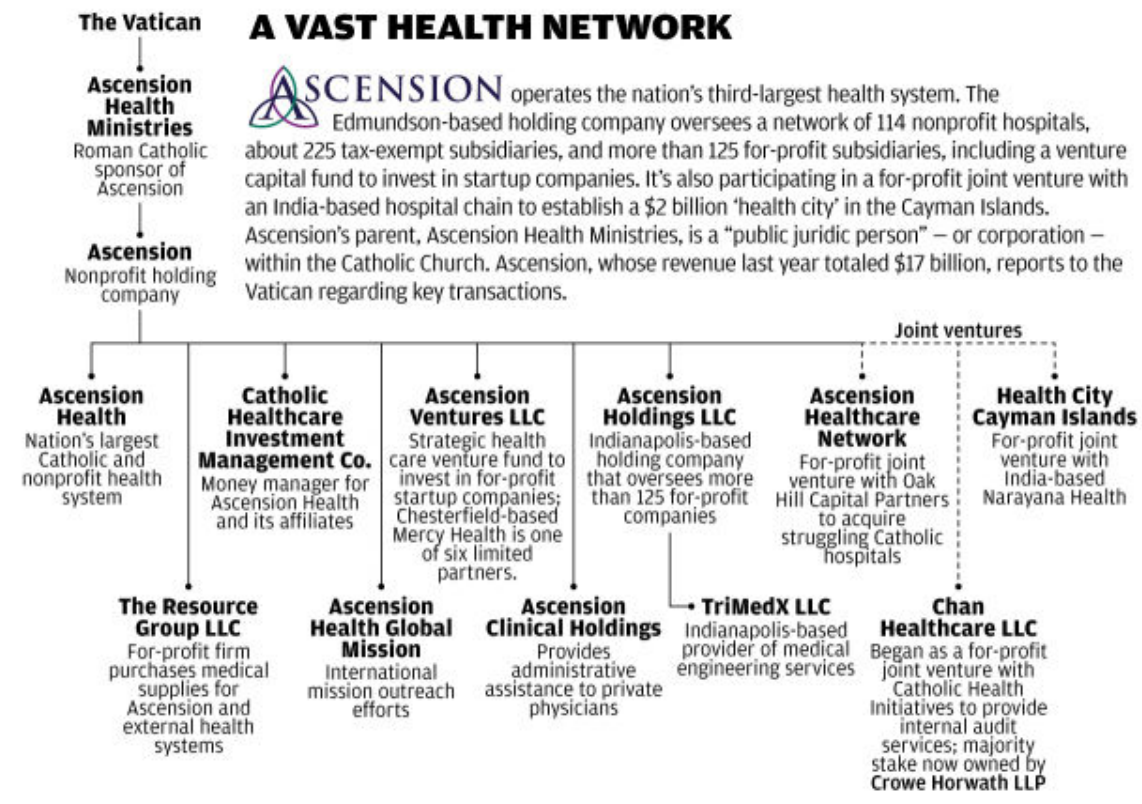
Ascension Ventures has backed at least two other local startups: Clayton-based Neuroolutions, which makes a headset to aid stroke victims; and St. Louis-based Stereotaxis, which makes robotic cardiology instruments.

Susan Feigenbaum, a professor of economics at University of Missouri-St. Louis with research focus in health economics, called Ascension’s investment in startups “an incredible gamble. ... You’re in effect playing roulette. What does a hospital know about being a venture capitalist? Hospitals are risk-averse institutions.”

The goal of the venture funds, Ascension’s Doyle said, is “to find and encourage innovation that will make a difference in health care. ... Because of our vetting process, we have a pretty good track record of selecting companies that will succeed.”

Ascension also provides medical supplies and services to other health systems.

Indianapolis-based TriMedx LLC, an Ascension for-profit subsidiary, provides medical engineering services to about 1,000 hospitals and reported nearly \$117 million in income in fiscal



SOURCE: Ascension, its Form 990 tax filings, consolidated financial statements, and tax-exempt bond financing reports and disclosures Post-Dispatch

year 2012. Another subsidiary, the Resource Group LLC, which purchases medical supplies for Ascension hospitals and outside clients, reported nearly \$23 million in profits that year.

In 2011, Ascension founded the Ascension Health Care Network, a for-profit joint venture with private equity firm Oak Hill Capital Partners to acquire struggling Catholic hospitals. “They don’t have the capital to do it themselves, so this spreads the risk,” Feigenbaum said. “Venture partners from Wall Street don’t want to be partnering with a nonprofit. They want a pay-out. ... To get capital, you have to do business with the devil.”

## Transforming health care

Tersigni, 64, is president and CEO of Ascension. He has been a health care executive for more than 25 years. In fiscal year 2012, he received total compensation of \$4 million.

He and his wife, Flora, own two houses in Frontenac and also own a 7,000-square-foot house in Carefree, Ariz., that overlooks the seventh fairway of the Desert Forest Golf Club.

He’s known to St. Louis-area business leaders as a generous executive who has given back to the community by volunteering his time to help run local civic organizations such as the Regional Business Council.

“He’s a visionary,” said Kathy Osborn, the council’s executive director. “He’s the kind of person who really challenges you, but in a way that you want to meet that challenge.”

Tersigni also serves on the board of directors of a publicly traded company, ProAssurance Corp., an Alabama-based property and casualty company that sells professional liability insurance to doctors. In the last fiscal year, he received \$88,585 in stock awards and board member fees from ProAssurance.

Since Jan. 1, 2011, ProAssurance has had an agreement with Ascension in which some physicians affiliated with its hospitals are provided liability insurance, according to papers filed at the Securities and Exchange Commission.

Tersigni has spoken publicly of Ascension’s goal to provide “person-centered care,” but not all of its affiliates may share that goal.

Chicago-based Accretive Health Inc. won early support from Ascension Ventures. Accretive collects debts for Ascension and other hospital systems. In 2012 Accretive was accused of illegal practices at two Minnesota nonprofit hospitals not affiliated with Ascension.

An investigation by the Minnesota attorney general found Accretive stationed bill collectors in emergency rooms, awarded prizes to hospital staffers who collected the most money and fired those who failed to meet quotas. Ascension, which owns a 7 percent stake in Accretive, said it “has policies regarding patient accounts that reflect our commitment to recognize the human dignity of our patients.”

This was not a new issue. In 2004, Tersigni testified at a con-

gressional hearing that collection agencies hired by Ascension had at times been overzealous.

“There have been instances, and I believe they are rare, when collection agencies have been more aggressive in their practices than our values would support,” he testified. “That there may only be a few instances does not excuse us.”

Ascension hospitals have earned high marks in recent years by significantly reducing its number of preventable injuries and deaths, but it does not operate any of the nation’s highest-ranked centers for cardiology and heart surgery, cancer, or neurology or neurosurgery.

## Caribbean venture

In 2012, Ascension announced its plan to build and operate a 2,000-bed medical center on Grand Cayman Island in partnership with India-based Narayana Health, a for-profit hospital chain that is known for its low-cost surgeries. Narayana’s chairman, Dr. Devi Shetty, is a pediatric cardiologist who has long sought to create a medical tourism center in the Caribbean.

Progress is made on Ascension’s construction site for its Health City Cayman Islands project. On Jan. 15, 2014. Photo courtesy of Ascension.

Health City Cayman Islands plans to accept its first patients in March. The initial, 140-bed hospital will offer cardiac surgery, cardiology, orthopedics and joint replacement. Plans call for the for-profit medical center to expand in the next decade and to include specialties such as neurology and oncology.

The new hospital, Doyle said, marks the first time Grand Cayman residents will have access to certain specialized care on the tropical island and also offers an opportunity to help transform U.S. health care.

“What we think we can learn from Dr. Shetty is how we can do (cardiac surgeries and procedures) with more efficiency,” Doyle said.

He said there’s no plan to refer U.S. patients to the Cayman facility, but “those who seek out higher quality, lower cost options would be welcome.”

Leigh Turner, an assistant professor at McGill University Health Centre, has questioned Ascension’s choice of the Cayman Islands, which is best known as an offshore tax haven and tourist destination with a high standard of living.

“My guess is that they thought this will be a wealthy enough island with a built-in domestic market, and if you attract other patients from other islands and other countries they think it’s a plausible model,” he said.

Dr. Tarun Khanna, a Harvard Business School professor, said medical costs in Narayana hospitals are “a tiny fraction” of U.S. hospitals and that low-cost surgeries at the Cayman center should attract uninsured and underinsured patients from the United States. “I’m very optimistic about this experiment.”



By David U. Himmelstein, Miraya Jun, Reinhard Busse, Karine Chevreul, Alexander Geissler, Patrick Jeurissen, Sarah Thomson, Marie-Amelie Vinet, and Steffie Woolhandler

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# A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far

## David U. Himmelstein

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**ABSTRACT** A few studies have noted the outsize administrative costs of US hospitals, but no research has compared these costs across multiple nations with various types of health care systems. We assembled a team of international health policy experts to conduct just such a challenging analysis of hospital administrative costs across eight nations: Canada, England, Scotland, Wales, France, Germany, the Netherlands, and the United States. We found that administrative costs accounted for 25.3 percent of total US hospital expenditures—a percentage that is increasing. Next highest were the Netherlands (19.8 percent) and England (15.5 percent), both of which are transitioning to market-oriented payment systems. Scotland and Canada, whose single-payer systems pay hospitals global operating budgets, with separate grants for capital, had the lowest administrative costs. Costs were intermediate in France and Germany (which bill per patient but pay separately for capital projects) and in Wales. Reducing US per capita spending for hospital administration to Scottish or Canadian levels would have saved more than \$150 billion in 2011. This study suggests that the reduction of US administrative costs would best be accomplished through the use of a simpler and less market-oriented payment scheme.

All nations struggle with rising health care costs, but the United States remains a cost outlier. In 2010 it spent 17.6 percent of its gross domestic product on health care—far more than the next-highest spenders, the Netherlands (12.0 percent) and France and Germany (both 11.6 percent).<sup>1</sup> Several factors help explain the US excess spending: greater use of high-tech interventions;<sup>2</sup> more emphasis on specialty care and the underprovision of primary care;<sup>3</sup> higher drug prices;<sup>4</sup> and higher physician fees.<sup>5</sup>

A few studies have noted US health insurers' and providers' outsize administrative costs, mostly in relation to Canadian costs.<sup>6-13</sup> How-

ever, no research has compared the administrative costs of hospitals across nations representing a broad spectrum of health care systems. Cross-national differences in accounting standards make such international comparisons challenging. To address this challenge, we assembled an international team of health policy experts to analyze hospital administrative costs for eight nations: Canada, England, Scotland, Wales, France, Germany, the Netherlands, and the United States. This article summarizes the findings of this research team and offers some lessons for policy makers who are searching for payment strategies that minimize administrative overhead.

## Study Data And Methods

**DATA SOURCES AND ANALYSIS** To assess the impact of a range of payment strategies, we analyzed data from nations with widely varying health care systems. Three of the nations—England, Scotland, and Wales—are within the United Kingdom. Each has a public National Health Service (NHS) funded by taxes, but the three systems vary in their hospital funding.

Canada has a single-payer public insurance system in each province. France has a system akin to a single-payer social insurance model. However, payments are funneled through several nominally separate insurance funds. Germany and the Netherlands have compulsory, multi-payer social insurance systems, but the Netherlands is transitioning to a market-based payment system. The United States has a largely private, multipayer health care system.

For each nation we obtained official hospital cost accounting data that covered most or all hospitals. The data were for 2010 or 2011.

Starting with the comprehensive Medicare Cost Reports submitted by US hospitals, we developed a classification scheme that apportioned costs between clinical and administrative functions, including information technology (IT). We distributed a few costs, such as employee benefits, between the clinical and administrative categories. We allocated capital costs to administrative and clinical cost centers based on each center's share of total operating expenses. We excluded research and teaching costs. These methods emulate those employed in previous analyses of US and Canadian hospitals.<sup>9</sup>

The level of detail in the Medicare data allowed us to identify administrative costs incurred at any US hospital location—for example, costs for a ward secretary or a clinic receptionist. Some administrative arms of clinical functions, such as nursing administration, were categorized separately. In other cases, Medicare required hospitals to allocate administrative costs incurred in clinical units to administrative categories.

Data for Canada, the Netherlands, England, Scotland, and Wales were sufficiently detailed to allow full replication of this analysis. However, in the German and French data, clerical work performed at clinic or ward locations was sometimes charged to a clinical cost center, as were some IT costs. Hence, for these two nations we could not fully apply the US-based classification scheme. Instead, we constructed an alternative, narrower measure for the German and French data, which we called central administration costs. This category excluded IT costs and administrative or clerical work on wards and at other clinical locations. Data to calculate this narrower measure were available for all but

the UK nations.

For each of the eight nations we reviewed detailed documentation describing hospital expense categories, and we mapped those categories to the US ones. In most cases, this mapping was straightforward, because the available documentation provided sufficiently detailed descriptions or lists of items subsumed under each category to resolve ambiguities. When uncertainties remained, we obtained additional specific descriptions of the items included in the category from national experts and officials. In some cases, we also consulted Medicare auditors to ascertain where such items would be classified in the US cost reporting scheme.

The online Appendix summarizes the data sources and classification schemes employed for each nation.<sup>14</sup> However, the voluminous documentation of the cost reporting schemes for several nations precluded listing all of the available details even in the Appendix. For instance, the instruction manual for Medicare Cost Reports is over 500 pages long.

To generate per capita cost estimates, we assumed that the administration share of costs at hospitals for which we lacked data (for example, those in Quebec and private hospitals in England) was the same as the administration share at other hospitals in that nation. All figures were adjusted to US dollars using purchasing power parities for the appropriate year.

Time trend data on administrative costs were available only for the United States and Canada. However, time trend data on administrative full-time equivalents (FTEs) as a share of total FTEs (which likely tracks trends in the administration share of costs) in the hospital and community health sectors were available for the United Kingdom. This allowed us to assess precise time trends for administrative costs in the United States and Canada and approximate time trends in the United Kingdom.

**LIMITATIONS** Several caveats apply to our findings. First, nations differ in many ways besides health care financing. The mix of services provided by hospitals, especially their role in ambulatory care, varies across nations. Many US hospitals operate outpatient clinics that provide both specialty and primary care. In contrast, hospitals in most other nations provide only specialty outpatient services.

Similarly, our figures for US, Canadian, and Dutch hospitals excluded most physician compensation. In contrast, the hospital spending figures in the other nations included substantial physician compensation for care delivered on the premises. For instance, German hospitals employ large numbers of physicians whose average pay is relatively low.

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**Marie-Amelie Vinet** is a health economist at the Paris Health Services and Health Economics Research Unit at the Assistance Publique-Hôpitaux de Paris and also a member of the ECEVE team (UMR 1123) of the French National Institute of Medical Research.

**Steffie Woolhandler** is an internist; a professor at the School of Public Health and Hunter College, CUNY; and a lecturer at Harvard Medical School.

Even the definition of *hospital* may vary somewhat both within and across nations. For instance, in some nations, hospital accounts include the costs of ambulance services. Some US hospitals' Medicare Cost Reports include some services that are provided by affiliated home care agencies, while others' reports cover only those activities carried out within the hospital's walls—as is generally the case with financial figures for hospitals in some other nations.

However, these differences across nations should not have greatly distorted our estimates. In all nations, the core inpatient services account for the bulk of budgets.

Moreover, previous studies have found that at least for the United States and Canada, administrative costs associated with physician compensation (equivalent to 26.9 percent of physicians' gross incomes in the United States versus 16.1 percent in Canada) were similar, in percentage terms, to hospital administrative costs.<sup>9</sup> In contrast, Dutch hospital expenditures include some costs of administering reimbursements for physicians not employed by the hospitals, which would have led us to slightly overstate hospital administrative costs.

A further limitation is that our data sources excluded some hospitals in most of the nations we studied (notably, eight university centers in the Netherlands) and a larger number of institutions (NHS Foundation Trust and private hospitals) in England. However, limited data from NHS Foundation Trusts' audited year-end accounts for 2010–11 indicate that their administrative staffing levels are similar to those of the NHS hospitals in England that we studied. UK private hospitals' administrative costs may be higher than those of NHS hospitals, but they account for a small proportion of expenditures. Furthermore, the omission of a few large Dutch university hospitals is unlikely to distort our estimates, since size was not related to administrative costs among the hospitals in the Netherlands for which we had data.

For the United States, we lacked data on military hospitals and those in the Department of Veterans Affairs, which do not file Medicare Cost Reports. The exclusion of these federal hospitals with global budgets, which probably have low administrative costs, might have caused us to slightly overestimate US administrative costs. However, Medicare Cost Reports omit profits and most advertising, which cannot be billed to Medicare. This would have caused us to underestimate US overhead costs.

Other limitations are that there is no international standard for hospital cost accounting, and that our alignment of categories was imperfect. Our analysis allocated some capital costs to ad-

## The proportion of hospital costs devoted to administration was highest in the United States, at 25.3 percent.

ministration, based on the administration share of operating expenses. Our analysis handled capital costs uniformly across the eight nations. However, it should be noted that Dutch hospitals' capital costs are higher than those in the United States, and about double those of the other European nations.

Our data do not address the question of which components of administrative spending drive international differences. However, fragmentary data from other sources suggest that a larger number of managers and clerical workers—not differences in wage levels, benefit costs, or non-wage costs—explains much or all of the higher administrative costs in US hospitals compared to hospitals in the other nations we studied.<sup>8,11,15,16</sup>

Finally, our study did not include the administrative costs of insurers and regulators who deal with hospital payments.

### Study Results

Exhibit 1 presents an overview of the health systems and hospital funding mechanisms of the eight nations. For additional details on coverage and hospital payment in the eight nations, see Appendix Exhibit A1.<sup>14</sup>

Canada, Scotland, and Wales pay hospitals global operating budgets (similar to the way in which a US firehouse is funded), with separate grants for capital needs such as new buildings and expensive new equipment. France and Germany use tightly regulated all-payer diagnosis-related group (DRG) payment systems, with separate public grants for most capital needs.

England also uses all-payer DRGs, but hospitals negotiate contracts for some services with local agencies. The Netherlands combines elements of DRG-like payment with market-based pricing (for example, pricing based on bargaining between individual hospitals and individual insurers). In both England and the Netherlands, hospitals increasingly depend on operating surpluses or profits to meet their capital needs.<sup>17,18</sup>

Health care spending in 2010 ranged from



**EXHIBIT 1**

**Principal Hospital Financing Characteristics Of Eight Nations, 2011**

Nation	Insurance coverage	Funding for hospital operating budgets	Primary source of capital funds
US	Multipayer; loosely regulated; substantial OOP; many people uninsured	Per patient payments; mechanisms (such as DRGs, per diem, and FFS), regulations, and rates differ by payer	Operating surpluses or profits
Canada	Single public payer in each province; universal coverage for hospital and physician care; minimal OOP; private coverage only for items not covered by public plan	Global, lump-sum budgets	Funds allocated directly by the provincial government
France	Universal social insurance; minimal OOP; optional private coverage reimburses patients' cost sharing	DRGs, uniform for all patients	Lump-sum payments for capital and other public missions
Germany	Tightly regulated, multipayer social insurance; minimal OOP; higher-income people may opt for private insurance with enhanced services and higher premiums	DRGs, uniform for all patients	Lump-sum payments from the states
Netherlands	Regulated, multipayer, private insurance; compulsory basic benefit package; optional supplementary coverage; minimal OOP	DBC (DRG-like system): about 30,000 DBCs; rates uniform for 2/3 of DBCs, negotiated between hospital and insurer for 1/3	Operating surpluses and capital add-ons included in the uniform DBC rates, but not in negotiated DBCs rates
England	Universal NHS coverage; prominent market features; most services purchased at local level by groups of GPs; minimal OOP; private coverage for care outside the NHS	60% from DRGs with uniform rates; 40% from lump-sum contracts negotiated with local agencies	Operating surpluses, with a central review of planned major investments
Scotland	Universal NHS coverage with few market features; virtually no OOP; private coverage for care outside the NHS	Global, lump-sum budgets	Funds allocated directly by the government
Wales	Universal NHS coverage with decreasing market features since 1999; virtually no OOP; private coverage for care outside the NHS	Global, lump-sum budgets	Funds allocated directly by the government

**SOURCE** Authors' analysis. **NOTES** OOP is out-of-pocket, or patients' spending. DRG is diagnosis-related group. FFS is fee-for-service. DBC is diagnostic-treatment-combination. NHS is National Health Service. GP is general or family practitioner.

9.6 percent of GDP in the United Kingdom to 17.6 percent in the United States (Exhibit 2). Germany had the largest supply of both hospital beds and physicians per 1,000 population, while the United States had the most specialists, measured as a percentage of all physicians.

The US population had smaller percentages of elderly people and smokers, compared to the populations of other countries, but its percentage of obese people was second only to Scotland's (Exhibit 2). Life expectancy was similar in the United States and Scotland, trailing that in the other nations by about two years.

**HOSPITALS' TOTAL ADMINISTRATIVE COSTS**  
The proportion of hospital costs devoted to administration was highest in the United States, at 25.3 percent (Exhibit 3). This was more than twice the percentages for Canada and Scotland, which spent the least on administration. Hospitals' administrative costs were notably higher in the Netherlands than in other European nations.

Differences were more marked when expressed as a percentage of GDP or in dollars per capita. For example, hospital administration

costs ranged from 1.43 percent of GDP in the United States (\$667 per capita) to 0.41 percent of GDP (\$158 per capita) in Canada (Exhibit 3).

Among the UK nations, Scotland's administrative costs were lowest, England's were highest, and Wales's were in between (Exhibit 3). This ranking correlates roughly with the role of market mechanisms in those nations' health care systems. The NHS internal market reforms introduced throughout the United Kingdom during the 1990s separated the commissioning and provision of care, with price-based competition among hospitals. Scotland reversed these market-based reforms soon after devolution in 1999; Wales did so somewhat later, in 2009.

In the United States, for-profit hospitals had higher administrative costs (27.2 percent) than did nonprofit (25.0 percent) or public (22.8 percent) institutions. Teaching hospitals, few of which are for-profit, had lower-than-average administrative costs (23.6 percent), as did rural facilities (24.7 percent, compared to 25.5 percent for urban hospitals).

Administrative costs for hospitals in Maryland

## HOSPITAL COSTS

### EXHIBIT 2

#### Demographic Characteristics And Health Expenditures, Resources, And Indicators For Eight Nations

	US	Canada	France	Germany	Netherlands	UK		
						England	Scotland	Wales
<b>DEMOGRAPHIC CHARACTERISTICS</b>								
Population older than 64 (%)	13.1	14.4	17.3	20.7	15.6	16.2	16.8	18.6
GDP per capita (PPP-adjusted US \$)	46,747	39,070	34,136	37,402	42,166	35,687	32,215 <sup>a</sup>	32,239 <sup>b</sup>
Smokers (percent of population older than 14) <sup>c</sup>	15.1	16.3	23.3	21.9 <sup>d</sup>	20.9	21.5 <sup>d</sup>	24.0	23.0
Obese people (percent of population older than 14) <sup>c</sup>	28.1	17.5	12.9	17.3 <sup>d</sup>	11.6	26.1	28.2	22.0
People with insurance (percent of population)	81.3 <sup>d</sup>	100.0 <sup>d</sup>	99.9 <sup>d</sup>	100.0 <sup>d</sup>	98.8 <sup>d</sup>	100.0 <sup>d</sup>	100.0 <sup>d</sup>	100.0 <sup>d</sup>
<b>EXPENDITURES</b>								
Health care spending								
Per capita (PPP-adjusted US \$)	8,233	4,445	3,974	4,338	5,056	3,433 <sup>e</sup>		
Percent of GDP	17.6	11.4	11.6	11.6	12.0	9.6 <sup>e</sup>		
Health insurance overhead and government health administration per capita (PPP-adjusted US \$)	587	147	274	233	183	— <sup>f</sup>	— <sup>f</sup>	— <sup>f</sup>
<b>RESOURCES</b>								
Physicians								
Number (per 1,000 population)	2.6	2.4	3.3	4.1	2.9 <sup>d</sup>	2.7	2.3 <sup>b</sup>	2.5
Percent specialists	87.7	53.0	51.3	58.0	57.7	70.9 <sup>e</sup>		
Hospital beds (per 1,000 population)	3.1 <sup>d</sup>	3.2 <sup>d</sup>	6.4	8.3	4.7 <sup>d</sup>	3.0	3.3	4.0
Average length of acute care hospital stay (days)	5.4	7.7	5.2	7.3	5.6	6.6	4.8	6.2
<b>HEALTH INDICATORS</b>								
Life expectancy (years)								
Females	81.1	83.1 <sup>g</sup>	84.7	83.0	82.7	82.6	80.6 <sup>d</sup>	81.8
Males	76.2	78.5 <sup>g</sup>	78.0	78.0	78.8	78.6	76.0 <sup>d</sup>	77.6
Infant mortality (per 1,000 live births)	6.1	5.1 <sup>g</sup>	3.6	3.4	3.8	4.2	3.7	4.0

**SOURCE** Authors' analysis of health data from the following sources: (1) Organization for Economic Cooperation and Development. OECD health statistics (see Note 1 in text). (2) Scottish Government. Health and community care [Internet]. Edinburgh: Scottish Government; [cited 2014 May 7]. Available from: <http://www.scotland.gov.uk/Topics/Statistics/Browse/Health>. (3) Welsh Government. Health statistics Wales [Internet]. Cardiff: Welsh Government; 2012 [cited 2014 May 20]. Available from: <http://wales.gov.uk/docs/statistics/2012/120927hsw12en.pdf>. **NOTES** Data are for 2010 except where otherwise indicated. PPP is purchasing power parity. <sup>a</sup>Excludes costs for care outside of Scotland. <sup>b</sup>Data are for 2011. <sup>c</sup>Older than fifteen for Scotland and Wales. <sup>d</sup>Data are for 2009. <sup>e</sup>Data are for England, Scotland, Wales, and Northern Ireland. <sup>f</sup>Not available. <sup>g</sup>Data are for 2008.

### EXHIBIT 3

#### Total Hospital Administrative Costs And Spending In Eight Nations, 2010

	US	Canada	France	Germany	Netherlands	UK		
						England	Scotland	Wales
<b>TOTAL HOSPITAL EXPENDITURES</b>								
Per capita, (PPP-adjusted US \$)	2,634	1,271	1,357	1,245	1,631	1,458 <sup>a</sup>	1,416	1,482
Share of GDP (%)	5.63	3.25	3.98	3.33	3.87	4.09 <sup>a</sup>	4.39	4.60
<b>CENTRAL ADMINISTRATION<sup>b</sup></b>								
Share of hospital costs (%)	15.51	7.40	8.77	9.00	10.85	— <sup>c</sup>	— <sup>c</sup>	— <sup>c</sup>
<b>HOSPITAL ADMINISTRATION</b>								
Share of hospital costs (%)	25.32	12.42	— <sup>c</sup>	— <sup>c</sup>	19.79	15.45	11.59	14.27
Share of GDP (%)	1.43	0.41	— <sup>c</sup>	— <sup>c</sup>	0.77	0.63 <sup>a</sup>	0.51	0.66
Expenditures per capita (PPP-adjusted US \$)	667	158	— <sup>c</sup>	— <sup>c</sup>	323	225 <sup>a</sup>	164	211

**SOURCE** Authors' analysis of data from the following sources: (1) Organization for Economic Cooperation and Development. OECD health statistics 2014 (see Note 1 in text). (2) Information Services Division, NHS National Services Scotland. Net expenditure, by board of treatment, by care type [Internet]. Edinburgh: NHS National Services Scotland; 2012 [cited 2014 Jul 23]. Available from: [http://www.isdscotland.org/Health-Topics/Finance/Publications/2011-11-29/Costs\\_R300s\\_2011.xls](http://www.isdscotland.org/Health-Topics/Finance/Publications/2011-11-29/Costs_R300s_2011.xls). (3) Welsh Government. Health statistics Wales. Cardiff: Welsh Government; 2012. (4) Form TFR3E, the Final Accounts NHS Trusts TFR (Treasury Financial Reports) for 2011. (5) Monitor—independent regulator of NHS foundation trusts. NHS foundation trusts: consolidated accounts 201/11 [Internet]. London: Stationery Office; 2011 Jul 14 [cited 2014 May 7]. Available from: <http://www.monitor-nhsft.gov.uk/sites/default/files/NHS%20Foundation%20Trusts%20Consolidated%20Accounts%201011%20website%20file.pdf>. **NOTES** Data for England, Scotland, and Wales are for April 1, 2010–March 31, 2011. Figures for Scotland and Wales are for National Health Service (NHS) hospitals only. PPP is purchasing power parity. GDP is gross domestic product. <sup>a</sup>Includes NHS Trusts and Acute NHS Foundation Trusts. <sup>b</sup>Central administration costs exclude costs of information technology and of administrative or clerical work on wards and at other clinical locations. <sup>c</sup>Not available.

(the only state with all-payer hospital rate setting, the type of reform that some policy experts suggest might reduce administrative costs)<sup>19</sup> were 25.2 percent of total hospital costs. This did not differ from the national average ( $p = 0.94$ ). Despite Maryland's all-payer rate-setting system, copayments, deductibles, documentation requirements, clinical guidelines, and so forth differ across payers.<sup>20</sup>

#### HOSPITALS' CENTRAL ADMINISTRATION COSTS

Hospitals' central administration costs followed a pattern similar to that for total administrative costs. Central administration costs were highest in the United States, followed by the Netherlands (Exhibit 3).

**TIME TRENDS** US hospital administrative costs rose from 23.5 percent of total hospital costs (\$97.816 billion) in 2000 to 25.3 percent (\$215.369 billion) in 2011. In the same period, the hospital administration share of GDP rose from 0.98 percent to 1.43 percent (Exhibit 4). The proportion spent on administration by Canadian hospitals fell slightly from 1999 (12.9 percent)<sup>9</sup> to 2011 (12.4 percent).

The administration share of hospital FTEs in the United Kingdom rose from 13.8 percent in 1980 to 23.9 percent in 2009.<sup>21</sup> This change reflects mostly trends in England, where 84 percent of the UK population lives, and coincided with market-oriented reforms. The UK time trends are shown in Appendix Exhibit A2.<sup>14</sup>

## Discussion

Hospitals' administrative overhead varied more than twofold across the nations we studied as a share of total hospital costs and more than fourfold in absolute terms. These costs were far

higher in the United States than elsewhere.

**WHAT LIES BEHIND THESE DIFFERENCES?** In all nations, hospital administrators must procure and coordinate the facilities, supplies, and personnel needed for good care. In nations where administrators have few responsibilities beyond these logistical matters, administration seems to require about 12 percent of hospital expenditures.

Modes of hospital payment can increase the complexity and costs associated with two additional management tasks: garnering operating funds and securing capital funds for modernization and expansion.

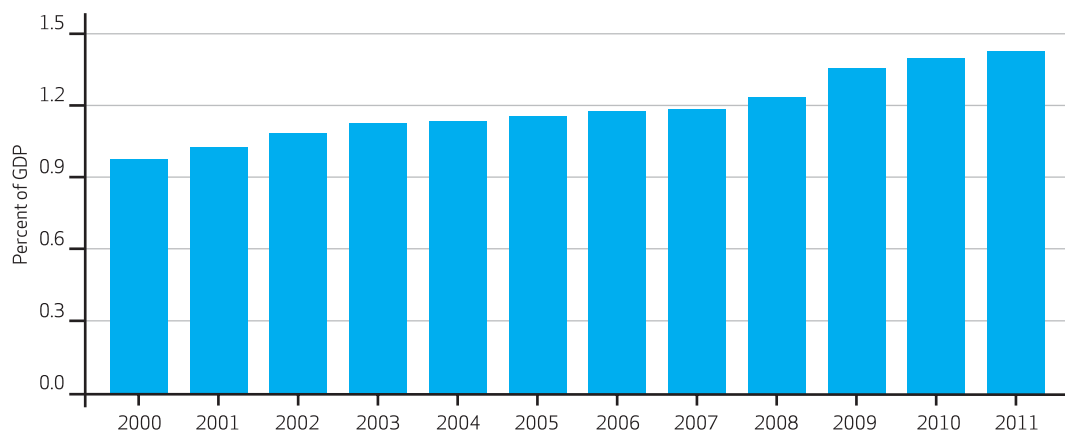
Garnering operating funds requires little administrative work in nations such as Canada, Scotland, and Wales, where hospitals receive global, lump-sum budgets. In contrast, per patient billing (for example, using DRGs) requires additional clerical and management personnel and special-purpose IT systems. This is true even in countries—such as France and Germany—where payment rates, documentation, and billing procedures are uniform.

Billing is even more complex in nations where each hospital must bargain over payment rates with multiple payers, whose documentation requirements and billing procedures often vary, as is the case in the United States and the Netherlands.

Differences in how hospitals obtain capital funds also appear to affect administrative costs. The combination of direct government grants for capital with separate global operating budgets—as in Scotland and Canada—was associated with the lowest administrative costs. (Wales has recently transitioned to such a system, reversing previous market reforms.) Hospitals in France

#### EXHIBIT 4

US Hospital Administration Costs As A Percentage Of Gross Domestic Product (GDP), 2000-11



SOURCE Authors' analysis of data from Medicare Hospital Cost Reports.



and Germany, where direct government grants account for a substantial share of hospital capital funding, have relatively low administrative costs despite per patient, DRG-based billing.

Administration is costliest in nations where surpluses from day-to-day operations are the main source of hospital capital funds: the United States and, increasingly, the Netherlands and England. In such health care systems, the need to accumulate capital funds for modernization and expansion stimulates administrators to undertake the additional work that is needed to identify and pursue profit opportunities.

This entrepreneurial incentive rewards hospitals that cut unnecessary operating costs and thereby improves efficiency. However, it can also reward hospitals for devoting resources to activities that decrease efficiency, such as advertising; upcoding bills—that is, exaggerating the severity of patients' illnesses in order to bill for higher DRGs;<sup>22</sup> and cherry-picking profitable patients, physicians and services while avoiding unprofitable ones.

The performance of US for-profit hospitals—whose explicit goal is profitability and whose administrative costs are high—helps clarify whether, on balance, entrepreneurial incentives improve efficiency. Compared to other US hospitals, for-profit institutions spend less on clinical personnel such as nurses<sup>23</sup> but provide costlier care.<sup>24,25</sup> Similarly, in Germany for-profit hospitals don't appear to be more efficient than other hospitals.<sup>26</sup>

The divergence between Scotland and England is also instructive. Administrative costs are low in Scotland, where hospitals don't bill for individual patients and capital projects are funded by direct government grants—which leaves administrators little leeway for financial entrepreneurship. In contrast, the administration share of costs is higher (and apparently rising) in England, where per patient billing has largely replaced global hospital budgets and recent market-based reforms encourage entrepreneurialism.

Hospital administrative costs appear to be driven by the complexity of the reimbursement system and the mode of capital funding. However, other factors could explain our findings. The greater intensity of care in US hospitals might explain why administrative costs are higher in that country than elsewhere. But the relatively low administrative costs of US teaching hospitals (which have high care intensity) argues against this explanation.

A heavier regulatory burden in the United States and the Netherlands than elsewhere might also impose administrative costs on hospitals. Some of this burden—for example, regu-

## Hospital administrative costs appear to be driven by the complexity of the reimbursement system and the mode of capital funding.

lations regarding privacy and translators in the United States—is unrelated to payment. Nonetheless, much of it reflects the tussle over reimbursement.

Our findings could also reflect a shift of responsibility (and costs) for some planning and budgeting tasks out of hospital offices and into the offices of government agencies and insurers in nations that have more centrally directed hospital systems. Perhaps the use of global budgets, regulated DRG pricing, and centralized capital allocation increases out-of-hospital costs to administer hospital payments and to monitor hospitals' activity and compliance. Our hospital-based analysis would not capture such costs, but they must be modest: Other nations spend far less than the United States on administration by government and insurers (Exhibit 2).

**DO HIGHER ADMINISTRATIVE COSTS YIELD BENEFITS?** If more administration eliminated clinical waste or enhanced patients' choices and market competition, administration's share might rise, but total costs would fall.<sup>27</sup> However, we found the opposite pattern: Total hospital costs were highest in the nations that had the highest hospital administrative costs. Moreover, Americans enjoy the widest choice of insurers, but patients in several nations with low administrative costs are free to choose to receive care at any hospital.

Nor do higher administrative costs appear to be associated with better care within the United States. A comprehensive meta-analysis of fifteen studies found that death rates at for-profit hospitals (adjusted for severity of illness, patients' socioeconomic status, and hospitals' teaching status) were 2 percent higher than those at non-profit hospitals.<sup>28</sup> For-profit hospitals also score lower on Medicare quality measures,<sup>29</sup> and their patients perceive their care less favorably,<sup>30</sup> compared to nonprofit institutions.

# Reforming the US health care system so that it operated on a single-payer basis could result in large savings on administration.

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Overall, there is no evidence that the high administrative costs in the United States translate into superior care.<sup>31</sup>

## Policy Implications

Our data hold lessons for policy makers. Hospital payment strategies can shift vast sums from care to administration, and vice versa. In the United States, administration consumes an increasing share of hospital budgets—a share that is far higher than in nations with simpler and less market-oriented payment schemes. To put the differences in perspective, in 2011 rolling back US spending for hospital administration

to the 2000 level (adjusted for inflation and population growth) would have saved \$74.4 billion. Reducing US spending to Canada's or Scotland's level on a per capita basis would have saved \$158 billion or \$156 billion, respectively—equivalent to 1 percent of the US GDP.

Reforming the US health care system so that it operated on a single-payer basis could result in large savings on administration. In contrast, current policy initiatives may boost administrative costs. Pay-for-performance schemes add new documentation requirements and incentives for data mining of patients' records to ferret out exceptions (for example, finding the phrase "patient refused test" in free-text entries). Similarly, DRGs have long given hospitals incentives to find and document clinically insignificant comorbidities among inpatients, and the transition to accountable care organizations (ACOs) adds incentives to extend upcoding to outpatients. The ACO strategy also stimulates hospitals to develop bureaucratic structures to carry out tasks that resemble components of managed care, such as referral management, underwriting, and utilization review.

In other nations, policy makers should take into account the added administrative costs of moving to activity-based funding (for example, DRGs) and market-based allocation of new capital investments for hospital modernization and expansion. The administrative burdens of pro-market reforms should be weighed against their putative benefits. ■

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# HealthAffairs

## Eliminating Medication Copayments Reduces Disparities In Cardiovascular Care

By Niteesh K. Choudhry, Katsiaryna Bykov, William H. Shrank, Michele Toscano, Wayne S. Rawlins, Lonny Reisman, Troyen A. Brennan, and Jessica M. Franklin

### ABSTRACT

Substantial racial and ethnic disparities in cardiovascular care persist in the United States. For example, African Americans and Hispanics with cardiovascular disease are 10 – 40 percent less likely than whites to receive secondary prevention therapies, such as aspirin and beta-blockers. Lowering copayments for these therapies improves outcomes among all patients who have had a myocardial infarction, but the impact of lower copayments on health disparities is unknown. Using self-reported race and ethnicity for participants in the Post-Myocardial Infarction Free Rx Event and Economic Evaluation (MI FREEE) trial, we found that rates of medication adherence were signifi-

cantly lower and rates of adverse clinical outcomes were significantly higher for nonwhite patients than for white patients. Providing full drug coverage increased medication adherence in both groups. Among nonwhite patients, it also reduced the rates of major vascular events or revascularization by 35 percent and reduced total health care spending by 70 percent. Providing full coverage had no effect on clinical outcomes and costs for white patients. We conclude that lowering copayments for medications after myocardial infarctions may reduce racial and ethnic disparities for cardiovascular disease.

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### The Financial and Economic Crises and Their Impact on Health and Social Well-Being

By Vicente Navarro and Carles Muntaner, eds.

Baywood Publishing Co., Inc., July 2014  
Softcover, 518 pp., \$74.95

A collection of 24 thought-provoking and topical articles that explore changes in national economies, welfare regimes, social inequalities, and population health, selected from the pages of the International Journal of Health Services.

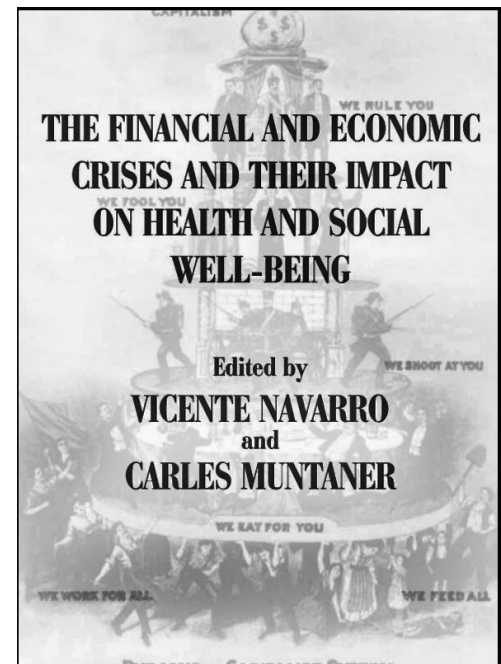
“Navarro and Muntaner have edited one of the best books on the financial crisis that I have read to date. The authors provide a much-needed critical perspective on the power and politics that underlie the ongoing economic crises in Europe and North America. Their political economy approach provides a deeper understanding of the root causes of the Great Recession, austerity measures, and their consequences for health inequalities. It is a clarion call to public health action.”

– David Stuckler, *professor of sociology, University of Oxford*

“The studies range widely over the human problems arising from the socioeconomic crises plaguing much of the world and suggest guidelines for addressing the underlying causes of circumstances that should not, and need not, be tolerated. An indispensable volume.”

– Noam Chomsky, *Institute Professor (retired), MIT*

Carles Muntaner, M.D., Ph.D., is professor on the faculty of medicine and nursing at the University of Toronto. Vicente Navarro, M.D., DrPH, is professor of health and social policy at the Johns Hopkins University, professor of economics at the University of Barcelona, and professor of political and social sciences at the Pompeu Fabra University.



## For-profit home care agencies cost Medicare billions extra, yet provide worse care: Health Affairs study

FOR IMMEDIATE RELEASE, AUGUST 4, 2014

For-profit home health agencies are far costlier for Medicare than nonprofit agencies, according to a nationwide study published today in the August issue of the journal *Health Affairs*. Overall cost per patient was \$1,215 higher at for-profits, with operating costs accounting for \$752 of the difference and excess profits for \$463. Yet the quality of care was actually worse at for-profit agencies, and more of their patients required repeat hospitalizations.

Researchers at the City University of New York School of Public Health analyzed detailed Cost Reports filed with Medicare by 7,165 home health agencies in 2010-2011, as well as data for 22 quality measures from Medicare's Home Health Compare database covering 9,128 agencies.

Compared to nonprofits, operating costs at for-profit agencies were 18 percent higher, with excess administration (at \$476 per patient) accounting for nearly two-thirds of the \$752 difference in operating costs. For-profits also did many more speech, physical and occupational therapy visits, which are often highly profitable under the complex Medicare payment formula. In addition, profits at for-profit agencies added 15 percent on top of operating costs vs. a 6.4 percent surplus at nonprofit agencies.

Despite their higher costs, for-profit agencies delivered slightly lower-quality care. On average, for-profits met each quality standard only 77.2 percent of the time, vs. 78.7 percent for nonprofits. Rehospitalizations, widely viewed as an important quality measure, were more frequent among for-profit agencies' patients: 28.4 percent vs. 26.5 percent at nonprofit agencies.

Quality of care was worst in the South, where for-profit firms provide the overwhelming majority of care, the authors said.

Medicare spent \$18 billion on home care in 2012, the most recent year for which figures are available. Until 1980 Medi-

care barred for-profit agencies from its home care program, which covers homebound seniors who need skilled nursing care, or occupational, physical or speech therapy. At present, 88 percent of agencies are for-profit and they care for 81 percent of Medicare home care patients.

"For-profit home care agencies are bleeding Medicare; they raise costs by \$3.3 billion each year and lower the quality of care for frail seniors," said Dr. Steffie Woolhandler, professor of public health at CUNY's Hunter College, lecturer at Harvard Medical School and senior author of the study. "Letting for-profit companies into Medicare was a huge mistake that Congress needs to correct."

Lead author William Cabin, assistant professor of social work at Temple University, said: "While our study is the first to show that profit-making has trumped patient care in

Medicare's home health program, that's no surprise. A large body of research on hospitals, nursing homes, dialysis facilities, and HMOs has shown that for-profits deliver inferior care at inflated prices."

Cabin continued: "Our findings show once again that the free-market, private-sector managed care model has failed."

Professor Cabin, who has decades of experience in the home care industry, undertook the research as part of his doctoral studies at the CUNY School of Public Health.

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"For-Profit Medicare Home Health Agencies' Costs Appear Higher And Quality Lower When Compared To Nonprofit Agencies," William Cabin, J.D., Ph.D., David U. Himmelstein, M.D., Michael L. Siman, Ph.D., Steffie Woolhandler, M.D., M.P.H. *Health Affairs*, August 2014.

A link to the abstract of the article is available here: [bit.ly/1sSz8T1](http://bit.ly/1sSz8T1).

## 'Private option' won't help poor: Traditional Medicaid will remain a crucial safety net

By Adam Gaffney, M.D.

Living in poverty is hard enough; having to face sickness without insurance while doing so is a fate no one should bear.

By expanding Medicaid to all earning less than 138 percent of the poverty level, the Affordable Care Act will help many avoid this outcome. Unfortunately, the Supreme Court ruled that states can opt out of the expansion, and 24 states have done that. Arkansas and Iowa, on the other hand, have won federal waivers to pursue a "private option" as a compromise, and other states may follow.

Private option Medicaid would give low-income families vouchers to purchase private insurance, instead of enrolling them in traditional Medicaid.

Why is that a problem?

First, private option plans impose new co-pays for doctor visits and medications on the dubious premise that patients need more "skin in the game." But co-pays often deter vital care: Heart attack victims delay coming to the ER, or children forgo asthma medications. And co-pays are especially hard on low-income families.

Second, the private option is inefficient. Insurers have much higher overhead than public programs such as Medicaid or Medicare. Privatized "Medicare Advantage" plans take more

than 13 percent for overhead (traditional Medicare is closer to 2 percent), gaining large profits at taxpayer expense.

The private option has also been used to make stealth benefit cuts: Iowa's plan eliminates the transportation benefit that helps patients get to treatments such as dialysis.

Medicaid is far from perfect, but the private option won't be an improvement. Medicaid patients, for instance, often have trouble finding doctors. But private option Medicaid plans, like many plans on the health exchanges, have very narrow doctor and hospital networks.

"Churning" is another problem: Families must often change providers as they move in and out of Medicaid eligibility. But churning will persist under the private option as people change jobs or plans change provider networks.

To truly address Medicaid's problems, we need a universal single-payer system. But until that is achieved, traditional Medicaid will remain a crucial safety net. We must fight to expand it, but also to protect it.

*Adam Gaffney is a physician and writer in Massachusetts who blogs at [theprogressivephysician.org](http://theprogressivephysician.org).*

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## The New York Times

MAY 9, 2014

### When Cost Deters Care

By Ida Hellander, M.D.

H. Gilbert Welch is right to be concerned that patients will forgo diagnostic mammograms, colonoscopies and other kinds of care for serious conditions if they aren't free, as "prevention" is under the Affordable Care Act ("The Problem With Free Health Care," Op-Ed, May 1).

Studies show that even patients who need emergency care for a potentially serious problem will go without it if they are in a high-deductible health plan (although this increases their risk of subsequent hospitalization). And therein lies the problem. While cost sharing discourages overuse of medical care, it wors-

ens a greater problem, that of underuse.

In an 11-nation survey by the Commonwealth Fund, more than a third (37 percent) of Americans reported not going to the doctor when sick or not filling a prescription because of cost, compared with a small percentage of people in Britain, Sweden and Norway. The difference: They have single-payer systems in which care is generally free at the point of service.

*The writer is director of health policy and programs for the Chicago-based Physicians for a National Health Program.*



## Recent noteworthy letters to the editor

THE  
COMMERCIAL  
APPEAL

MAY 31, 2014

Chicago Tribune

MAY 27, 2014

### Wake-up call for reform

By Arthur J. Sutherland III, M.D.

Your May 18 article “City health plan: Changes could cost retirees, employees” shows just how broken our health care delivery system has become.

Employer-based commercial health insurance is not working. This way of financing access to health care has persisted in spite of the evidence that the U.S. has the most complex, chaotic and costly health care system in the developed world.

We do not cover everyone in America and most people with insurance are underinsured. Your article gave dramatic examples of gaps in coverage for both active city employees and retirees.

The sad part of this story is that America spends twice as much per capita on health care as other countries, but gets inadequate results. We are the only developed country in the world not to provide universal coverage, and the World Health Organization ranks the U.S. 37th in overall health status compared to other nations.

The 2010 Patient Protection and Affordable Care Act was just “health insurance reform.” We are already seeing that this law will not cover everyone in America or control long-term costs. In essence, it is not sustainable because it added more cost and complexity, plus reduced the patients’ choice of providers and hospitals to narrow networks controlled by the insurance industry.

What we need is a public single-payer national health insurance system – a “Medicare for all” model. We were never able to get this debate on the table during the health care reform debate because of the excessive corporate influence that rendered our government incapable of making policy on the basis of evidence and the public good.

Your story should be our early warning, and a wake-up call to restructure our health care payment and delivery system.

*Dr. Arthur J. Sutherland III resides in Memphis, Tenn.*



**Dr. Art Sutherland**

### Make patients the priority, not profits

By Scott Goldberg, MS2

As a medical student, I appreciated Tribune reporter Peter Frost’s story, “Lawsuit accuses Blue Cross and Blue Shield parent of funneling profit to execs” (May 22).

Nominally nonprofit health insurers are reaping huge financial gains by employing the same practices as for-profit insurers (claim denials, restrictive networks) and paying for as little actual health care as possible. They then use these gains to pay multimillion-dollar executive salaries and bonuses and to construct lavish buildings like the BCBS Illinois Tower along East Randolph Street in downtown Chicago.

Frost’s article demonstrates that the problem with our health-care system is not whether insurers are for-profit or nonprofit, but that they exist at all.

That is why myself and 80 other medical students from across the country demonstrated outside that tower on May 12 to denounce our healthcare system for putting the interests of private insurance companies over patient needs. We were there as part of a national movement of medical students, physicians, nurses and other health professionals calling for a single-payer national health program.

The idea is straightforward – eliminate private insurers and have the government pay all medical claims directly, much like Medicare works for seniors today.

Every other industrialized country has a similar mechanism for providing universal, affordable and high-quality healthcare.

The problem with the Affordable Care Act (also known as Obamacare) is that it entrenches insurers like Blue Cross Blue Shield and even mandates that taxpayers purchase their broken product.

Single-payer health care is not “socialized medicine.” It is simply the best way to reform our deeply flawed healthcare system.

*Scott Goldberg is a medical student at the University of Chicago Pritzker School of Medicine.*



**Scott Goldberg**

## A plea for Medicaid coverage for our suffering citizens

By Jennifer Avegno, M.D., et al.

Louisiana has one of the highest rates of diabetes and cardiovascular diseases in the country. Recent state Medicaid changes are leaving our most vulnerable patients without access to physicians, health services and essential medications. The changes disrupt the relationships doctors have with patients and do not make economic sense.



**Dr. Jennifer Avegno**

As physicians in the Interim LSU Hospital Emergency Department and a local community clinic, we have seen patients return time and again to the ER because they have been unable to fill their essential prescriptions or access their physicians.

The people most affected by these changes often live on the economic margins of our communities. Frequently, their chronic diseases get worse at the end of the month when they run out of food and cannot eat properly.

Few have jobs that have sick leave and a day in the ER is lost wages. The monthly costs for one of these patients' medication pales in comparison to the \$20,000 average cost for a four-day hospital stay.

Costs to the health system are multiples of what they would be if patients were being treated by routine outpatient visits and proper medications.

We believe the Legislature should prevail upon Gov. Bobby Jindal to reconsider his decision not to expand Medicaid and ask him to reverse the changes made to the program Jan. 1, 2014. We ask that everyone at or below the federal poverty level who has diabetes, hypertension and heart or respiratory disease receive medications to control these diseases.

This will improve the quality of their lives and minimize the costs of treating the future preventable complications.

The state and the city of New Orleans did a remarkable job of opening community health clinics in New Orleans after Katrina. What sense does it make for some of our patients to come to the clinics, receive high quality care, and leave without the means to treat their medical problems?

*Jennifer Avegno, M.D., is clinical assistant professor of emergency medicine Interim LSU Hospital New Orleans, and her co-authors of this letter were Joseph Kanter, M.D., chief resident, emergency department, Interim LSU Hospital; Elmore Rigamer, M.D., medical director of Catholic Charities Archdiocese of New Orleans.*

## Simpler, better

By George Dyck, M.D.

As we still hear about confusion surrounding the Affordable Care Act, I think about how different it is in Canada. I go there to work in the summer and see how much simpler things can be for the person who needs medical care. Residents of Canada can go to the Manitoba Health website and see the following:

“Medicare has become culturally and politically important to Canadians as a reflection of, and as a defining influence on, our national identity. Shared principles of equity, fairness and compassion are embodied in the health care system, and the services it provides are now regarded as a basic right.

“In order to receive medical attention, Canadians need only go to the physician or clinic of their choice and present the health insurance card issued to all eligible residents of a province or territory. There are no charges, deductibles or dollar limits for insured medical services (physician, hospital and surgical-dental), and there are no forms for patients to fill out.”

What is it that prevents Americans from embracing this kind of system? We hear voices saying we do not want to give up our freedoms. But what kind of freedom is this for those who cannot figure out how to get their medical care?

I do not hear people in Manitoba complaining about lost freedom. They shake their heads in disbelief about how complicated it is south of the border. And statistics show they have better health and greater longevity, as well as better overall satisfaction with their health care.

*Dr. George Dyck resides in North Newton, Kansas.*

## Why doctors run late

By David U. Himmelstein, M.D.

The best way to shorten waits to see a doctor (editorial, July 8) is to reduce physicians' crushing paperwork burden. The average American doctor spends almost nine hours each week on billing and bureaucratic tasks, twice the time spent by physicians in Canada.

The difference stems from the complex, business-oriented payment system in the United States, and Canada's simple, single-payer system.

*David U. Himmelstein, an internist, is a professor at the CUNY School of Public Health at Hunter College.*

# Why Medicare Advantage costs taxpayers billions more than it should

## Regulators have kept problems secret, and there's no fix in sight

By Fred Schulte, David Donald and Erin Durkin

In South Florida, one of the nation's top privately-run Medicare insurance plans faces a federal investigation into allegations that it overbilled the government by exaggerating how sick some of its patients were.

In the Las Vegas area, private health care plans for seniors ran up more than \$100 million in added Medicare charges after asserting patients they signed up also were much sicker than normal – a claim many experts have challenged.

In Rochester, New York, a Medicare plan was paid \$41 million to treat people with serious diseases – even though the plan couldn't prove the patients in fact had those diseases.

These health plans and hundreds of others are part of Medicare Advantage, a program created by Congress in 2003 to help stabilize health care spending on the elderly. But the plans have sharply driven up costs in many parts of the United States – larding on tens of billions of dollars in overcharges and other suspect billings based in part on inflated assessments of how sick patients are, an investigation by the Center for Public Integrity has found.

Dominated by private insurers, Medicare Advantage now covers nearly 16 million Americans at a cost expected to top \$150 billion this year. Many seniors choose the managed-care Medicare Advantage option instead of the traditional government-run Medicare program because it fills gaps in coverage, can cost less in out-of-pocket expenses and offers extra benefits, such as dental and eye care.

But billions of tax dollars are misspent every year through billing errors linked to a payment tool called a “risk score,” which is supposed to pay Medicare Advantage plans higher rates for sicker patients and less for those in good health.

Government officials have struggled for years to halt health plans from running up patient risk scores and, in many cases, wresting higher Medicare payments than they deserve, records show.

The Center's findings are based on an analysis of Medicare Advantage enrollment data from 2007 through 2011, as well as thousands of pages of government audits, research papers and other documents.

Federal officials who run the Medicare program repeatedly refused to be interviewed or answer written questions.

Among the findings:

- Risk score errors triggered nearly \$70 billion in “improper” payments to Medicare Advantage plans from 2008 through 2013 – mostly overbillings, according to govern-

ment estimates. Federal officials refused to identify health plans suspected of overcharging Medicare, citing agency policy that keeps many business records confidential. The Center is suing to make these records public.

- Risk scores of Medicare Advantage patients rose sharply in plans in at least 1,000 counties nationwide between 2007 and 2011, boosting taxpayer costs by more than \$36 billion over estimated costs for caring for patients in standard Medicare.
- In more than 200 of these counties, the cost of some Medicare Advantage plans was at least 25 percent higher than the cost of providing standard Medicare coverage. The wide swing in costs was most evident in five states: South Dakota, New Mexico, Colorado, Texas and Arkansas.

Some academic experts and researchers believe the increase in risk scores is more likely to reflect aggressive billing than a rapid deterioration in patients' health.

Industry executives don't dispute that billing errors occur. But they deny that they charge too much, arguing they only want to be paid fairly for their services.

Clare Krusing, director of communications for America's Health Insurance Plans, said that the industry trade group is “working together” with federal health officials to improve reporting of risk score data.

In the South Florida case, government lawyers have been investigating Humana, Inc. for several years as they try to determine if the company and some of its medical clinics manipulated the complex Medicare Advantage billing system. Humana says it is cooperating with the investigation.

In a separate civil case, a former Bush administration health official alleges in a whistleblower lawsuit unsealed earlier this year that two Puerto Rico health plans cheated Medicare out of as much as \$1 billion by inflating patient risk scores. The plans, which at the time were owned by a subsidiary of New-Jersey based Aveta, Inc., denied the allegations.

Government audits and research reports have warned for years that Medicare's risk scoring formula breeds overbilling, but efforts to hold the industry accountable have met with little success. Federal officials have yet to recoup hundreds of millions of dollars in suspected overpayments to health plans that date back as far as 2007.

Excellus Health Plan, the Rochester, New York, health plan that federal auditors said may have overbilled by as much as \$41 million in 2007 for treating patients with serious diseases,



paid but a fraction of that amount back years later. A company spokesman said the plan settled the matter by paying the government \$157,777 in December 2013.

Some critics expect little to change unless federal officials disclose Medicare Advantage plans' full service and billing histories – as they have recently done with Medicare fees paid to more than 880,000 individual doctors and others.

“The [Medicare Advantage] plans don't want the data out,” said Dr. Brian Biles, a professor in the Department of Health Policy at George Washington University, whose Freedom of Information Act lawsuits shook loose limited enrollment records used in this project. (Biles assisted Center for Public Integrity reporters with the analysis.)

Dr. David Wennberg, a Dartmouth Institute researcher who has studied the payment issue, said that with billions of tax dollars at stake federal officials need to hit the “reset button” on risk scoring.

Wennberg said Medicare Advantage “is a very large program with lots of money flowing through it. There are always vested interests in protecting the status quo.”

## Health care politics

The Affordable Care Act, or Obamacare, orders deep rate cuts in Medicare Advantage, partly to cover millions of uninsured people. That's consistent with an early Obama administration promise to reduce payments to the health insurers.

But support for Medicare Advantage in Congress has snowballed as it has attracted more and more seniors who are happy with their care and the price they pay for it. Earlier this year, the insurance industry mounted a fierce media campaign to block the rate cuts, enlisting support from more than 200 members of Congress and forcing the administration to partially back off.

The debate over how best to pay Medicare Advantage health plans – and how to curb overcharging – has been contentious for years.

As far back as the 1980s, Congress hoped that carving a bigger role for managed care plans like Medicare Advantage would help curtail overall Medicare spending and ward off waste and fraud that can pop up when doctors and hospitals are paid for each and every service they perform.

To that end, Medicare decided to pay health plans a set monthly rate for patients regardless of how much care they needed. But some health plans stacked the deck by signing up people who were healthier than average, a marketing ploy known in insurance circles as “cherry picking.”

That led to a “lot of game playing” and “dumping patients who were ill,” said Laurence Bishoff, a Boston health care consultant.

Congress thought it saw a remedy in the Medicare Modernization Act of 2003. The law created Medicare Advantage and phased in “risk adjusted” payments starting a year later.

Thomas Scully, who helped get the program running under

President George W. Bush, said rates were generous in hopes of enticing insurers to expand their Medicare business and not shy away from people in poor health.

“We very intentionally tried to overpay them a little bit,” said Scully, now a Washington lobbyist with numerous health care industry clients.

Health status was added to other factors such as sex, race and age in setting rates. Plans that took on the greatest risk by accepting the sickest patients were paid the most.

But turning to risk scores as the way to adjust payments ushered in a new form of Medicare billing abuse: Some health plans misstated how sick their patients were or failed to document they had treated illnesses Medicare paid them to treat, the Center's investigation found.

By 2009, government officials were estimating that just over 15 percent of total Medicare Advantage payments were inaccurate, about \$12 billion that year.

By the end of 2013, officials reported the error rate had dropped to nine percent, which still added up to \$11.8 billion for the year. Nearly 80 percent of that – \$9.3 billion – was overcharges, records show.

The Medicare Advantage billing error rate has averaged 12 percent over the past six years, at times outpacing that of standard government-run Medicare, which federal officials assert is highly vulnerable to billing fraud and abuse.

Medicare Advantage has faced much less scrutiny. The federal Centers for Medicare and Medicaid Services didn't try to recoup overpayments until 2012, eight years after phasing in risk scoring. And when it did, it won back only \$3.4 million – a tiny fraction of the estimated losses, according to government records.

Though the agency is beefing up collection efforts starting this year, most health plans won't see federal auditors for years.

Malcolm Sparrow, a professor at Harvard University's John F. Kennedy School of Government and health

fraud expert, said officials are “asking for trouble” by allowing health plans to generate the data on which risk scores and their revenues are based.

“You want to make sure this is audited rigorously,” Sparrow said. “It's much more expensive [to taxpayers] not to.”

## Federal probe

Four of the ten major Medicare Advantage plans with the highest average risk scores nationally are in Puerto Rico.

Medicare Advantage plans, which control 70 percent of the island market, argue their patients are poorer and sicker than average. They also say that cuts required under the Affordable Care Act have hit them hard, prompting cuts in benefits and higher premiums for patients who can ill afford to pay more.

Risk scores at the two Aveta-related health plans, MMM Healthcare and Preferred Medical Choice, shot up by an average of 11 percent from 2007 through 2011. Nationwide, the growth

rate averaged three percent over the same period. The company had no comment.

San Juan-based Medical Card System, known by the initials MCS, reported a 5 percent rise in the scores over the same time – nearly twice the national average.

The billing practices also have attracted legal scrutiny. The whistleblower lawsuit filed against Aveta by former executive Jose R. “Josh” Valdez alleges that the company overbilled Medicare by as much as \$1 billion by inflating risk scores.

Valdez alleges that Aveta paid its stockholders a \$100 million dividend during the time that it was overcharging Medicare.

MCS has faced its troubles over risk scores, too.

Federal agents searched the MCS tower headquarters on Oct. 13, 2011. MCS said in a 2012 financial statement that it had received four grand jury subpoenas as part of a U.S. Attorney’s Office investigation of its “risk adjustment data reporting.”

MCS said the company conducted an “internal review” that found no wrongdoing, but prompted it to return an “immaterial” amount of money to Medicare.

In an April interview inside the MCS tower in San Juan’s Hato Rey financial district, Chief Executive Officer Jim O’Drobinak said the federal probe has ended and MCS has been cleared.

“Nothing came of it,” he said, blaming the investigation on a “disgruntled former employee.” Law enforcement sources confirmed that the investigation has been closed.

Dr. Inés Hernández, MCS chief medical officer, said that the health plan has moved aggressively to treat patients in their homes and identify diseases so they can be treated in the early stages.

“We’re not just getting information for risk scores,” she said.

But CMS officials have been concerned that home visits and other health assessments by health plans can contribute to higher risk scores – and drive up costs without benefiting patients by providing them with more care.

## Over/under

Congressional auditors and some lawmakers have asserted for years that overpayments to Medicare Advantage plans may be much higher than federal officials have acknowledged.

Among the most steadfast critics is Rep. Henry Waxman, D-Calif. In a March 6, 2009, letter to an agency official, he argued that Medicare Advantage plans were a bad deal for taxpayers because each illness they discover, “whether it is treated or not can increase the payment the plan receives from CMS.”

Waxman, who then chaired the House Energy and Commerce Committee, criticized health plans for figuring out how to “manipulate” risk scores to wrest money they didn’t deserve from Medicare.

CMS officials have conceded that risk scores rose much faster for Medicare Advantage patients than for those in standard Medicare and that the rise couldn’t be explained away by saying that the health plan members were sicker.

Starting in 2010, they stepped in and cut payments to Medicare Advantage plans to offset rising risk scores.

Yet in January 2012 the Government Accountability Office, the watchdog arm of Congress, said that the cuts weren’t deep enough and opined that Medicare could have saved as much as \$3 billion a year by reducing risk scores further.

A year later, the GAO went a step further. A January 2013 report said CMS made “excess payments” to Medicare Advantage plans of between \$3.2 billion and \$5.1 billion between 2010 and the end of 2012 because risk scores were higher than justified.

The Center for Public Integrity data analysis found that Medicare Advantage can cost the government as much as 25 percent more than standard Medicare in some areas.

The data analysis also found that seemingly tiny variations in risk scores can boost taxpayer costs enormously – especially in health plans that are growing fast.

Industry officials have a different take.

They argue that their members tend to have lower incomes than the elderly population as a whole and have a higher risk of needing expensive medical care.

“They have looked healthier because of incompleteness of this data,” said John Gorman, a former federal health official who is now a prominent Medicare Advantage consultant.

Others blame the sheer complexity of risk-scoring for causing confusion about billing.

Jim Redmond, a vice president at Excellus Health Plan, which federal auditors in 2012 said couldn’t always document illnesses it was paid to treat, denied any impropriety. He said the billing system was “established with good intentions” but “didn’t fully recognize” how difficult it would be for health plans to oversee.

“We have more than 18,000 physicians submitting claims to us every day. We audit a portion of the claims and medical records for accuracy, completeness and consistency,” Redmond wrote in an email.

“However, the medical delivery system would grind to a halt if we made every provider submit all of the documentation for each and every claim they file on behalf of members.”

Court records show that the billing system’s complexity has stymied government investigators reviewing a whistleblower lawsuit filed in 2010 by physician Olivia Graves against Humana.

Graves, who has practiced in South Florida for more than three decades, alleges that a Humana-owned clinic diagnosed patients with conditions such as diabetes with complications, which boosted Medicare payments. She alleged that those diagnoses were “not supported by the medical records.” Her suit alleges that Humana knew about the alleged overcharging and did nothing to stop it.

The U.S. Attorney’s Office declined to join the South Florida case even though a federal judge granted it 11 requests for more time to investigate. They argued lawyers and other government personnel “had little or no experience in the applicable regu-

lations and operations of the [Medicare Advantage] program” However, government lawyers said their investigation is continuing.

The case was unsealed in May and is pending.

Humana also faces other investigations into allegations that it overbilled the government, including a criminal investigation by the Department of Justice in Washington and a criminal case involving the U.S. Attorney’s branch office in West Palm Beach, Florida, according to court records. Humana spokesman Tom Noland said “Humana to our knowledge is not the subject of a criminal investigation.”

### ‘Black box’

Many researchers are hoping that CMS will make public detailed Medicare Advantage billing and service data that might allow them to assess how well risk scoring is doing in predicting costs. They also want to study industry claims that they are treating lower income and sicker patients.

But that’s not yet possible because CMS has shown little interest in making Medicare Advantage data public.

That’s quite a different stance than the agency took in April,

when it released detailed information about how much individual doctors were paid by Medicare. The decision drew criticism from the American Medical Association, which has argued that it violated the privacy of doctors. CMS principal deputy administrator Jonathan Blum, who left the agency in May, previously announced on his blog that data “can shine a light on how care is delivered in the Medicare program.”

Sparrow, the fraud expert from Harvard, said that it should be easier for the government to cough up information about huge health care corporations than about individual physicians. The doctor billing data covers about \$77 billion in taxpayer spending for 2012, about half the Medicare Advantage

price tag.

“Anything that starts with a ‘b’ seems like a lot of money to me,” Sparrow said, adding that Medicare Advantage financial data and other records “ought to be a matter of ordinary public record.”

Medicare Advantage is a “black box,” added James Cosgrove, who heads health investigations for the GAO, the audit arm of Congress.

“We know what services they say they will provide ... but we never know exactly what services are being provided,” Cosgrove said.

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## Home is where the money is for Medicare Advantage plans

### Feds wanted to ban costly ‘house calls,’ but backed off due to lobbying blitz

By Fred Schulte

Electronic medical records, long touted by government officials as a critical tool for cutting health care costs, appear to be prompting some doctors and hospitals to bill higher fees to Medicare for treating seniors.

The federal government’s campaign to wire up medicine started under President George W. Bush. But the initiative hit warp drive with a February 2009 decision by Congress and the Obama administration to spend as much as \$30 billion in economic stimulus money to help doctors and hospitals buy the equipment needed to convert medical record-keeping from paper files.

In the rush to get the program off the ground, though, federal officials failed to impose strict controls over billing software, despite warnings from several prominent medical fraud authorities. Now that decision could come back to haunt policy makers and taxpayers alike, a Center for Public Integrity investigation has found.

Experts say digital medical records may prove – as promised – to be cost-effective, allowing smoother information sharing that helps cut down on wasteful spending and medical errors.

Yet Medicare regulators also acknowledge they are struggling to rein in a surge of aggressive – and potentially expensive – billing by doctors and hospitals that they have linked, at least anecdotally, to the rapid proliferation of the billing software and electronic medical records. A variety of federal reports and whistleblower suits reflect these concerns.

Regulators may lack the auditing tools to verify the legitimacy of millions of medical bills spit out by computerized records programs, which can create exquisitely detailed patient files with just a few mouse clicks.

“This is a new era for investigators,” said Jennifer Trussell, who directs the investigations unit of the U.S. Department of Health and Human Services Office of Inspector General.

“We are all excited about the many benefits of electronic health records, but we need to be on the lookout for unscrupulous providers who take advantage of this new technology,” she said.

The Center for Public Integrity has recently documented how some health professionals have seemingly manipulated Medicare billing codes to gain higher fees. The investigation unmasked thousands of doctors consistently billing higher-paying treatment codes than their peers, despite little evidence in many cases that they provided more care.

Some of the sharpest surges in more costly coding have occurred in hospital emergency rooms, according to the Center’s data analysis, where billing software has been widely used.

Interviews with hospital administrators, doctors and health

information technology professionals confirmed that digital billing gear often prompts higher coding, though many in the medical field argue that they are simply recouping money that they previously failed to collect.

For example, Holy Name Medical Center in Teaneck, N.J., saw a spike in billing codes after wiring up its emergency room in 2007, according to hospital CEO Joe Lemaire.

#### Coding ‘Slam Dunk’

Electronic medical records can influence pay scales known as “Evaluation and Management” codes. Medicare spent more than \$33.5 billion in 2010 using these numeric codes for services ranging from routine doctor office visits to outpatient hospital or nursing home care. More than half the doctors billing Medicare were using electronic records in 2011, and more are expected to follow.

For an office visit, a doctor must choose one of five escalating payment codes that best reflects the amount of time spent with a patient as well as the complexity of the care. The lowest-level code for a minor problem, 99211, pays about \$20. But the doctor can bill roughly \$100 more for the top level. Hospitals use similar codes for billing emergency room and outpatient services.

The subjective nature of the coding process has left the medical community and those who pay its bills in constant conflict. Many doctors and billing consultants argue that most practitioners habitually charge too little because they neglect to put down on paper all of the work they do, which if done more diligently would justify higher codes and fees.

The HHS Agency for Healthcare Research and Quality, an advocate for pressing ahead with electronic health records, accepted that view when it wrote in September 2009 that doctors may choose billing codes that are too low. The agency suggested that converting to digital systems would enable doctors to bill higher fees, “translating into enhanced revenue.”

By contrast, government auditors and many private insurance investigators see evidence that some doctors pick higher codes to inflate their bills – a practice known in medical circles as “up-coding.”

The rapid expansion of electronic health records is adding a whole new dimension to that quarrel. Government officials, however, have yet to step in and settle whether the hundreds of software products on the market consistently prompt doctors and hospitals to bill at higher levels than they did prior to going electronic – and if the higher fees are merited.



## Doctor Backlash

Warnings that digital billing equipment could unleash a torrent of inflated charges date back to the administration of President George W. Bush.

In July 2005, the American Health Information Management Association identified an “unintended incentive for fraud because healthcare organizations and software developers need to prove a return on investment for the coding products,” reads the report, which was commissioned by HHS officials.

Two months later, a second American Health Information Management Association panel stated that “without a deliberative effort to build fraud management” into networks of digital medical records “health care payers and consumers will be exposed to new and potentially increased vulnerability to electronically-enabled healthcare fraud.”

Dr. Donald W. Simborg, a California physician who co-chaired that panel, said its findings were dismissed out of fear that doctors would shun the digital devices if they thought buying one might lead the government to second-guess their fees, and perhaps even accuse them of impropriety.

Simborg also headed up an executive team HHS turned to in 2007 to recommend fraud controls in digital gear certified for sale to doctors and hospitals.

In a May 2007 report, the 23-member group, which included representatives from medical groups, health insurers and government, warned against approving software that assisted doctors in selecting billing codes. It is “not appropriate to suggest to the provider that certain additional data, if entered, would increase the level” of the billing code, according to the report.

“Our report was totally ignored for fear of a physician backlash,” said Simborg. The report saw print under the bland title “Recommended Requirements for Enhancing Data Quality in Electronic Health Records” that gave little hint it dealt with the sensitive fraud issue, he said.

The billing tools that the study panel panned have been trumpeted in recent years by electronic health record manufacturers hoping to persuade doctors and hospitals to shell out thousands of dollars – millions in the case of a hospital – to computerize.

“This is the big elephant right now and we aren’t touching it,” said Simborg.

Dr. Robert Kolodner, a physician who headed the federal push for electronic medical records in 2007, acknowledged that billing abuse took a backseat to steps likely to entice the medical community to embrace the new technology.

Kolodner said officials were certain the savings achieved by computerizing medicine would be so great that billing abuse, “while needing to be monitored, was not something that should be put as the primary issue at that time.”

That view didn’t change much with the 2009 arrival of the Obama team, which was sympathetic to some of the tech companies that stood to benefit handsomely from the conversion.

For instance, giant tech vendor McKesson submitted to the Obama-Biden Transition Team its vision for the rollout, which recommended “significant start-up funds” to get the ball rolling.

Since 2009, the Obama administration has held dozens of public meetings on electronic health record policies and standards, but

none that focused primarily on fraud control and billing integrity.

The administration’s Office of National Coordinator for Health Information Technology, which is spearheading the drive, declined to discuss the billing controversy.

But on April 27 of this year that office asked the HHS Office of Inspector General to study the issue. Spokesman Peter Ashkenaz said that ONC “will review any recommendations that are made in the report and will address those at that time.”

Donald White, a spokesman for the inspector general’s office, said that the issue “is on the radar” and the office will be “looking into these codes and how electronic health records may be affecting them.”

But government officials admit they lack a system to monitor the hundreds of billing and medical software packages in use across the country. That shortcoming caught the eye of the American Medical Association, which helped develop the billing codes and favors stricter government standards. In May, the doctors’ group urged officials to require testing that assures digital devices bill accurately and “do not facilitate upcoding.”

## ‘Improper Payments’

Connecticut doctor Stephen R. Levinson, who authored a major textbook on medical coding published by the AMA, strongly believes that many electronic medical records systems improperly raise coding levels.

He said the units are programmed to easily allow doctors to cut and paste records from prior encounters with a patient so that “records of every visit read almost word for word the same except for minor variations confined almost exclusively to the chief complaint.”

That extra documentation often triggers the software to raise the billing level and the size of the patient’s bill. But Levinson said information from previous visits is often not “medically necessary” to treat a current problem – and thus not a legitimate factor in charges.

Levinson said “cloned documentation” in a patient’s file often “doesn’t make sense clinically,” but it steps up billing and rewards the doctors with a “slam dunk” higher billing level, even though it takes 30 seconds to copy and paste.

“This is done in the wrong way and doesn’t satisfy the patient’s needs,” he said.

These “cut and paste” features produce voluminous files that are difficult for auditors to challenge, even when they suspect that the doctor did very little to warrant the higher fees.

That’s starting to change, however, greatly raising the stakes for doctors and hospitals that could face a demand for repayment from the government on behalf of patients.

Insurance auditors criticized “over documentation” as a billing ploy as far back as 2006. That year Medicare contractor First Coast Service Options chided Connecticut doctors who “frequently over-documented” to justify higher billing codes.

The Department of Health and Human Services Office of Inspector General late last year announced it would ratchet up audits of “potentially improper payments” linked to electronic medical records. The office also advised doctors they could be held accountable if the codes they used didn’t “accurately reflect

the services they provide.”

Electronic health records figured prominently in a critical Medicare audit of Texas and Oklahoma hospital emergency rooms in March. The audit concluded that \$45.14 of every \$100 billed for emergency room care “was paid in error.”

Auditors said that billing codes were “higher than was reasonable and necessary to adequately care for the patient’s needs or treat the presenting problem.”

One unidentified hospital billed Medicare for the highest level code, 99285, for treating a woman who arrived at the emergency room complaining of mild to moderate abdominal pain. The code is generally reserved for conditions of “high severity” that “pose an immediate significant threat to life and limb,” auditors wrote.

After a battery of tests, including a CT scan, and intravenous antibiotics and morphine, the doctor diagnosed a urinary tract infection, sent the woman home and told her to follow up with her regular doctor.

Auditors said the woman’s case should have been coded two rungs lower based on the degree of medical decision-making required.

They also criticized the electronic record system for generating “testis and penile assessment findings” for a female, noting “coding at a higher level based on clinically unnecessary (or anatomically incorrect) systems examined is not acceptable.”

Hospitals have faced scrutiny over their use of electronic billing in emergency rooms from other quarters as well.

Dr. Alan Gravett, an Illinois emergency physician, argues in a federal “whistleblower” lawsuit that hospitals have jacked up emergency room bills with the help of aggressive billing software.

The doctor filed suit under seal in the U.S. District Court for Northern Illinois in January 2007. He alleges Methodist Medical Center in Peoria, Ill., where he worked for six years, installed a McKesson Corporation digital records system in March 2006 “specifically to increase its billings and recovery from government funded health insurance programs.”

Gravett alleges that the billing system had a “tendency to inflate nearly every” emergency room code. This happened “despite the physicians’ belief that lower ... codes were warranted based on the degree of care they provided,” according to the suit.

The lawsuit alleged that patients who were treated in the emergency room for many seemingly simple conditions were “as a matter of course” coded at high levels. The diagnoses included toe injury, sprained ankle and toothache.

The software, according to Gravett, prompted charges for conditions such as “alcoholic intoxication” or “psychiatric cases” to a code four or five, “even when such patients are treated and released, or released with no treatment.”

The screen also prompts doctors to add documentation to reach a higher coding level, according to Gravett’s court filings.

To pressure doctors to go along, the hospital distributed a monthly report called a “lost charge analysis,” which ranked doctors by how much revenue they produced, according to the suit.

“This was done to pressure the physicians to out-bill one another, and weed out physicians that were not generating as much income as those willing to upcode,” according to the

court filing.

Methodist hospital spokesman Duane Funk said the hospital has yet to be served with the suit and would have no comment. McKesson did not respond to requests for comment.

A second “whistleblower” lawsuit filed in the state of Washington in 2006 alleged that Health Management Associates, a Florida-based hospital chain, used software called Pro-Med Clinical Systems that prompted questionable billing.

The suit was brought by two emergency room physicians at one of the company’s hospitals, Yakima Regional Medical and Heart Center. The doctors alleged that using Pro-Med led to “misleading medical charts,” including “examinations which had not occurred and physical observations which had not been noted by the physician.”

The software “automatically ordered a series of expensive and unnecessary tests,” according to the suit, which was dismissed in February 2009.

Pro-Med, based in Coral Springs, Fla., was not named as a defendant. Pro-Med CEO Thomas Grossjung said the hospital, not the software company, set the treatment protocols.

Maryann Hodge, vice president of marketing for Health Management Associates, said the hospital chain was never served with a copy of the suit, though it had cooperated with federal officials investigating the matter.

The hospital chain’s use of Pro-Med has come under review in a more recent federal investigation of emergency room billing, records show.

Health Management Associates, which owns or leases more than 60 hospitals in 15 states, disclosed in a May Securities and Exchange Commission filing that the HHS inspector general’s office was investigating its business operations, including whether “Pro-Med software has led to any medically unnecessary tests or admissions.” Hodge said the company could not comment further on the investigation.

A second hospital chain that has used Pro-Med also has been served with a subpoena from federal investigators.

Community Health Systems, Inc., which owns and operates some 130 hospitals in more than two-dozen states, told investors in April 2011 that HHS was investigating “possible improper claims.” The subpoena requested documents concerning use of the Pro-Med software in emergency rooms, according to the SEC filing. Tomi Galin, Community Health Systems’ vice-president for corporate communications, said at the chain’s hospitals the software does not order tests or “make any recommendation to physicians about whether to admit patients, place patients in observation or discharge patients.”

Both hospital chains said in SEC filings that they are cooperating with investigators. Pro-Med CEO Grossjung said his firm also had met with federal investigators, but the probe had “nothing to do with the software itself.”

Doctors’ groups also are reporting higher fees associated with electronic records, though they argue that the systems merely allow them to catch up with billing practices that for years did not pay them enough.

Robert Tennant, a Washington lobbyist with the Medical Group Management Association, which represents large medical practices, said the software simply helps doctors pick the

correct code. “With a paper based system there’s a little bit of concern from providers that they don’t have sufficient documentation to support a particular” coding level, he said. Electronic systems, however, can quickly retrieve a patient’s documented history.

“I don’t use the term ‘upcode.’ I use ‘correct code.’ I see it more as physicians being reimbursed more appropriately for the work that they’re doing,” he said.

## After the Gold Rush

Judging from their marketing strategies, there’s little doubt among the makers of electronic health records that their products will pay for themselves – and then some – through higher coding of patient bills.

Sales literature touts features such as “charge capture,” highlighting the computer’s skill at never missing a billable item that a human might overlook.

Many companies stress that the software can pay for itself through more lucrative codes, a benefit called “ROI,” short for return on investment. That pitch suggests a doctor who collects stimulus payments over time will cover the purchase costs and eventually turn a nice profit as a result of higher fees from higher coding.

For instance, one manufacturer predicts a rise of one coding level for each patient visit, which it said could add up to \$225,000 over the course of a year. Another cites a medical journal report that a medical practice in Utah “produced an average billable gain of \$26 per patient visit.”

Ross Koppel, a sociology professor at the University of Pennsylvania who has studied design weaknesses in the software, said that sales agents stress how the machines help doctors document the work they do.

“That presumably is fair and good, but everybody knows there is a ‘wink, wink’ behind that indicating it will help ... make the patient’s visit look more involved than it is.” That “generates additional revenue” for doctors, Koppel said.

The industry’s trade association, the Healthcare Information and Management Systems Society, has published a guide for doctors to use in estimating how much new revenue they can expect by going electronic. It cites as one key benefit, “increased coding due to elimination of lost charges and using appropriate coding levels based on services delivered.”

But some others note that doctors may initially lose money from wiring up their practices, mainly due to the time it takes them and their staffs to learn how to use the equipment and its high upfront cost.

## ‘Unintended Consequences’

The emphasis on improving the bottom line, rather than the quality of medical care, has disappointed some longtime health policy hands.

The Obama administration’s foray into digital medicine “has backfired at this point,” said Dr. Robert Berenson, a former vice chairman of MedPac, a commission that advises Congress on Medicare payment issues.

Berenson said that the current crop of electronic medical records encourage too much medical documentation “for the purposes of billing” and not better patient care.

The software helps doctors submit bills for “a higher level code than was performed,” said Berenson, who served as a member of the 2008 Obama transition team on health policy. “It’s a lot of money and the money goes right to the bottom line,” he said.

The criticisms are not just about money. The American College of Physicians, which represents more than 100,000 internists, considered the threat to patient safety serious enough that in May it announced a class for doctors in “potential problems associated with the use” of electronic medical records and “strategies to overcome these problems.”

Some doctors grumble about slogging through pages of redundant information that appears to be in a patient’s file simply to satisfy requirements for stepped up billing codes.

Just like in the days of poor physician handwriting, the voluminous computer generated files can prove tough for doctors to quickly decipher and decide how to treat a patient’s illness.

“We’re getting a whole generation of records that are not illegible, they are largely un-interpretable. It’s a horrific problem,” said Dr. Bob Elson, a former health information technology specialist, now a physician at the Cleveland Clinic.

These criticisms aside, many in the medical community regard the switchover not only as inevitable, but also as an opportunity to revolutionize medicine. For starters, researchers hope to be able to mine data from millions of patients to discover better ways to treat disease and improve the nation’s overall health.

The initiative continues to pick up speed behind a broad coalition of political players, from an elite corps of technology experts to organized labor groups that support moving medicine into the 21st century with dispatch.

Tennant, whose group represents medical practices, noted that Congress and the Obama administration have sent a “clear message” that they want physicians to adopt electronic health records.

He said “a slight uptick” in codes would be more than offset by savings on duplicative tests and other waste associated with paper records systems, and by higher quality care.

So far, the government has shelled out about \$5 billion in incentive payments to doctors and hospitals that have adopted the technology, according to the Government Accounting Office.

How much Medicare has paid out in higher codes related to digital billing is trickier to assess. In 2011, 57% of Medicare doctors were using an electronic health record, most for three years or less, according to an HHS survey. Officials expect those numbers to climb as doctors scramble to avoid Medicare payment cuts to those who fail to adopt the technology starting in 2015.

But Elson, the Cleveland clinic doctor, said that government officials may have oversold the benefits to Congress by failing to account for health care costs to rise from higher coding, at least in the short term.

“That’s a huge oversight if that whole issue wasn’t factored into the strategy,” Elson said.

*PNHP note:* This article and the one preceding it are part of a series. For the complete series, visit [bit.ly/114hmTg](http://bit.ly/114hmTg).



## Beyond Obamacare: Universalism and Health Care in the Twenty-first Century

By A.W. Gaffney, M.D.

The Affordable Care Act commentariat – including those confidently awaiting the day when all its promises are vindicated, those rooting for its ignominious demise, and those of us in a separate camp – have been kept occupied in recent months. Between autumn's website drama and winter's enrollment saga, the news cycle has been full of stories of IT dysfunctions tackled, right-wing challenges thwarted, enrollment goals met, electoral prospects threatened, and individuals newly insured (or variously dissatisfied).

Yet however important such details, stories, and analyses may sometimes be, we lose sight of the larger meaning of the ACA if we narrow our vision to its technological travails or to the latest enumeration of the insured. For those of us who are seeking a more fundamental and egalitarian change within the U.S. health care system, it seems particularly important at the current juncture to instead take a step back and appreciate the larger political, historical, and health policy significance of the ACA, to appreciate how we've come to have it, what it achieves, and what it leaves entirely undone. Understanding where we are and where we came from is, however, only the beginning of the story.

Moving forward, a focus on alternatives to the ACA, and of ways to achieve them, must increasingly be at the forefront of our discussions. A crucial question in this regard relates to how the struggle for true universal health care could fit within – and potentially propel – a larger popular mobilization against inequality. But to ask these questions, we should begin by looking back, to understand the road already travelled, as we seek to break off on a new, and bolder, path.

### The Politics of Passage

The ACA fell well short of what many of us had hoped for at the end of the hundred-year war for health care reform, which had begun with the Progressive-era campaign of the 1910s. It eliminates neither uninsurance nor underinsurance, as we shall soon examine in greater depth. It also leaves intact a grossly inefficient (if profitable) system of funding and organization.

But why did the ACA fail to achieve what most construe as “universal health care”? I would argue that there are two ways to interpret the outcome. The first is to emphasize the particular proximate political conditions at the time it was passed, namely the role of corporate interests, the machinations of partisan politics, and so forth. The second interpretation – and one that has received less attention – would be to understand the ACA in the context of the dynamics of a much larger and lengthier neoliberal turn within the United States – and, arguably, global – political economy of health care.

Now with respect to the first approach, it seems fair to conclude that disappointment could have been predicted before the health care reform brawl even broke out. The boundaries of health care reform had been largely drawn by the time that the 2008 election delivered the presidency and both houses of Congress to the Democratic Party (including, by July 2009, 60 votes in the Senate). As sociologist Paul Starr put it, Democrats had committed to only “minimally disruptive” reforms going into the election.<sup>1</sup> Obama's health care proposal during the primaries, for instance, was less expansive than that of Hillary Clinton, and in some respects narrower than the ACA itself.

But why? The role of the so-called “stake-holders” is one crucial factor here. In the years leading up to the election, a “rapprochement on health reform,” as Starr calls it, had formed between mainstream liberal groups and key industries. The corporate interests within this rapprochement seem to have perceived that the status quo of rising costs and uninsurance was politically – and economically – unsustainable. In 2008 the Board of Directors of America's Health Insurance Plans (AHIP) – the national lobbying group for the health insurance industry – released a statement that actually endorsed “universal coverage,” which it defined as a combination of “guarantee-issue coverage with no pre-existing condition exclusions with an enforceable individual mandate.”<sup>2</sup> In other words, if the government required everyone to buy private insurance, the industry would be happy to provide it, and would even stop discriminating against the sick. The document additionally endorsed government subsidies for those making less than 400 percent of the federal poverty level to enable them to buy private health insurance. These proposals, (“guaranteed issue,” an individual mandate, and subsidies for the purchase of private insurance) were core elements of the ACA, together with a limited employer mandate and a large expansion of Medicaid.

Other ideas that were not contained in the AHIP statement – for instance the proposal for a “robust” public option – had a less successful career. AHIP was, not surprisingly, rather lukewarm about the prospect of a competing public insurance plan, however “robust” or puny it might be. Though AHIP's president Karen Ignagni had earlier pledged support for Obama's health care reform, AHIP actually surreptitiously funneled some \$86.2 million to the U.S. Chamber of Commerce for lobbying against the law in 2009 alone – just as debates about the “public option” got underway.<sup>3</sup> AHIP thereby succeeded in keeping its place at the bargaining table, while simultaneously working against the bill, which had the effect of making the final product more amenable to its interests.

The pharmaceutical industry similarly perceived it could both



win and lose through health care reform. Most importantly, the industry needed to protect the great and treasured prize it had won in 2003, namely the clause in George W. Bush's Medicare Modernization Act (MMA) that explicitly prohibited Medicare from bargaining with insurance companies over drug prices. By some estimates, the elimination of that clause could have saved the public purse – and cost the industry – upwards of \$500 billion over a decade.<sup>4</sup> The other option would have been to re-import drugs – allowing them to be purchased much more cheaply abroad where such negotiations do take place – which would be a more roundabout way to achieve a portion of these savings. However, after some tense negotiations between the drug industry lobby group (the Pharmaceutical Research and Manufacturers of America, known as PhRMA) and the administration, neither Medicare-drug negotiation nor re-importation was included in the ACA.<sup>5</sup> This was, one supposes, the “politics of the possible,” though this merely speaks to the sadly impoverished range of possibilities in a political system permeated by corporate dollars.

### Neoliberalism and the Political Economy of American Health Care

While these machinations (and many others) are important to appreciate, it's also worth evaluating the Affordable Care Act in the context of the much longer neoliberal turn in American health care policy and thought. Though this is a separate and much larger story than can be told here, we can capture a glimpse of this multi-decade transformation simply by looking at the shift of the health care political center. In 1969, Edward Kennedy proposed legislation that would have created a program of national health insurance, with no copays, means testing, or cost sharing of any type. Nixon's counterproposal in 1971, on the contrary, looked very much like the ACA, with an employer mandate and an expanded Medicaid-like program for the poor. Like the ACA, it also involved copayments and cost sharing, not just to save money, but as a “matter of principle.” To paraphrase the historian Beatrix Hoffman, health care couldn't be made a right; it had to remain something you paid for.<sup>6</sup>

But as corporate and business interests began their powerful push for renewed preeminence in the late 1970s, the Democratic health care proposal – which in 1969 was basically a social-democratic universal system in line with those enacted by left and labor governments in Europe – quickly transmogrified into Nixon's plan. Jimmy Carter, though he argued in an interview in late March 2014 that “Medicare-for-all” would have been preferable to the ACA, during his presidency actually made no substantial effort to pursue health care reform. Health care reform didn't return to the national agenda until the administration of Bill Clinton, who again didn't seriously consider a national health insurance system. Even his less ambitious plan for uni-

versal coverage via way of “managed competition” sunk. Mitt Romney's health care reform in Massachusetts, which drew heavily from Nixon's “mandate model” plan, was, conversely, successful.

However, evaluating the rise and fall of the health care reform agenda only tells part of the story. These same decades, as the work of Thomas Piketty has so clearly laid out, were also characterized by soaring inequalities in income and wealth; this was the result, in part, of amplified corporate dominance of the political system and the interrelated decline of the power of labor. It would almost be surprising if alongside these dynamics there had not been a corresponding shift within health care thought, policy, and organization that favored these ascendant interests. Such a shift is indeed visible, and the manifestations of it are multifold: the corporate takeover of the Health Management Organization (HMO) during the 1980s and 1990s; a move by health policy experts and economists away from support for universal national health insurance to an obsession with the “moral hazard” of free health care; the growth of for-profit health care companies (hospices, hospitals, dialysis-centers, nursing homes); and soaring profits for pharmaceutical companies, which was mediated by key legislative victories (for instance, the Bayh-Dole Act of 1980 and the MMA of 2003).<sup>7</sup>

As the result of these changes, by the twenty-first century, the corporate health care sector had both unprecedented capital to spend and imperative interests to defend: there shouldn't be any surprise that lobbying money would flood – and not merely season – the health care reform debate of 2009. According to the Center for Responsive Politics, lobbying from the health industry reached an all-time high of \$554 million in 2009 alone. Physicians' organizations – which once were the central lobby

that could single-handedly make or break a health care reform initiative – were relegated to a bit part. Yet though it placated powerful interests, the ACA still contained some redistributionist elements, particularly with respect to the Medicaid expansion. In yet another sign of the shift of the political center, it thereby managed to deeply offend the Republican Party, even though (as Obama pointed out) its roots were to be found on their side of the aisle. To summarize, after all was said and done, a social-democratic alternative was barely considered, a Nixonian health care plan was barely passed, and more stayed the same than changed.

### The ACA: Accomplishments and Shortfalls

Among those working towards more fundamental health care change (for instance, as I'll discuss below, a single-payer system), an assessment of the overall impact of the ACA is a frequent cause for disagreement. Is the law a (possibly wobbly) step in the right direction to be embraced and expanded, a harmful compromise to be denounced and discarded, or some-

thing in between? My own sense here is that global assessments are problematic and not that helpful: the massive law does many different things for many different people, and so is better dissected (and criticized) with respect to its specific effects and shortcomings rather than rejected or championed en toto.

For instance, whatever the failures of the law may be and whatever injustices will persist, moving individuals out of the vulnerable ranks of the uninsured is clearly a good thing, and no amount of political analysis should belittle the benefit to – and relief felt by – these individuals. The ACA reduces uninsurance mainly via two mechanisms. First, as mentioned, it expands Medicaid to everyone below 138 percent of the federal poverty level. Unfortunately, as a result of the June 2012 Supreme Court ruling that made state participation optional, only 26 states (and the District of Columbia) are participating in the expansion, excluding millions from the benefits of Medicaid. Second, the ACA requires the establishment of an insurance “exchange” where private insurance can be sold to those without Medicare, Medicaid, or employer-based insurance; those with incomes below 400 percent of the federal poverty level will receive government subsidies to purchase insurance on these exchanges. However, between these programs and the employer and individual mandate, the ACA will still leave an estimated 31 million uninsured (compared with an estimated 57 million without it).<sup>8</sup> In other words, triumphant proclamations notwithstanding, the ACA does not create universal health care in the United States.

Now if eliminating the problem of uninsurance was our only goal, it seems that the ACA would be at least be a clear step in the right direction. Unfortunately, however, there is another phenomenon that has been evolving for some time, that the ACA neither created nor fixed but to some extent codifies, and which confers a highly inegalitarian element to our health care system: underinsurance. Underinsurance is often defined as having insurance but still having substantial out-of-pocket costs for medical care (i.e. greater than 10 percent of family income after premiums); it's clearly a growing problem, and it is by no means eliminated by the ACA.<sup>9</sup> The plans on the exchanges, for instance, incorporate high levels of cost sharing, or copays, deductibles, and coinsurance. They are graded into four metallic tiers based on their actuarial value (i.e. the percent of your health care expenses that insurance covers), beginning at a paltry 60 percent for the “bronze plans.” Putting aside the deeply inegalitarian concept of dividing a population into different grades of metal (the allusion to Plato's Republic has somehow not yet been made), such plans fulfill the long-held concern of health policy “experts” that patients need more “skin in the game” (i.e. cost exposure), such that they don't whimsically procure medically unnecessary procedures and diagnostic studies. Families will be subject to as much as \$12,700 annually in additional out-of-pocket costs for health care (after premiums are paid) to keep the dreaded “moral hazard” of “free

care” at bay.<sup>10</sup>

Putting aside what happens to the level of strictly defined “underinsurance,” I would argue that there is a larger problem on the rise, which one might call “malinsurance,” namely insurance that compromises the physical and economic health of the bearer. Malinsurance encompasses an even broader scope of problematic insurance plans: insurance where the price of the premiums impinges on a reasonable standard of living; insurance with unequal and inferior coverage of services, drugs, or procedures; insurance with “cost sharing” that forces individuals to decide between health care and other necessities; insurance with inadequate and inequitable access to providers or facilities; and insurance that insufficiently protects against financial strain in the case of illness.

Today, many (if not most) of us could in some ways be considered underinsured, while most (or maybe all) of us might be considered malinsured. This will, unfortunately, remain the case in coming years, even with the full and unimpeded enforcement of the ACA.

But what are the alternatives, and are they viable?

### **Moving Forward: A Single-Payer Solution?**

A “single-payer system” is probably the best-studied alternative for the United States. Conceptually, it is quite simple: national health insurance, with a single entity (the government) providing health insurance for the country. Its core principles (as generally agreed upon within the single-payer movement) can be briefly summarized. First, everyone in the country would be covered by national health insurance. Second, the system wouldn't impose “cost

sharing,” so health care would be free at the point of care, with underinsurance thereby eliminated (assuming an adequate level of funding). Third, it would drastically reduce spending on health care administration and bureaucracy through elimination of the fragmented multi-payer system, and also through the global budgeting of hospitals. It would also contain costs through health care capital planning, and through other measures like direct negotiations with pharmaceutical companies over drug prices. Putting this together, a single-payer system would constitute a markedly egalitarian turn in American health care. Access to health care would be made not only universal but also equal, with free choice of provider and hospital to everyone in the country, provided as a right.

Now, in light of the formidable resistance that could be expected from a wide-spectrum of powerful and well-funded “stake-holders” (for instance, AHIP and PhRMA), the actual realization of such a system is, to put it mildly, daunting. We can predict that the impressive resources that have been deployed in opposition to the ACA might be multiplied many times to counter even the specter of true universal health care. However, while our political prospects must always be judged soberly,

***Today, many (if not most) of us could in some ways be considered underinsured, while most (or maybe all) of us might be considered malinsured. This will, unfortunately, remain the case in coming years, even with the full and unimpeded enforcement of the ACA.***

there are also reasons for guarded optimism. The confluence of several of the following dynamics (and many others) may, for instance, create a political opening for such a project in the coming years.

First, dissatisfaction with our health care system will almost certainly rise, which I think will occur as we become more and more a “copay country,” with high-deductible, high-premium, and narrow-network health plans becoming the new normal. One could imagine considerable public outrage and mobilization against this new commodified status quo, just as there was against corporatized HMOs in the 1990s.

Second, though politics at the federal level may remain inhospitable to the cause for some time, single-payer campaigns at the state government level may provide an opening for the construction of more limited single-payer state systems, while also providing an opportunity for grassroots organizing and movement building that would, in turn, strengthen the larger national campaign.<sup>11</sup>

Third, support for a single-payer system among physicians (which already has majority support in some polls) might be translated into more vocal outrage in coming years. In particular, as patients pay more and more out-of-pocket at the time of care, physicians will increasingly be forced into the role of “merchants of health,” basing medical decisions not only on clinical evidence, but on their patients’ income and wealth. I believe – and deeply hope – that such class-based medicine will be rejected by the profession.

Fourth, and perhaps most important, a broader mobilization against the politics of inequality now seems to be in the making. As it is perceived that the excessive costs of American health care are actually contributing to the problem of inequality – for instance, insofar as high premiums indirectly reduce income or as cost sharing directly consumes a greater portion of already stagnant wages – one can imagine that the drive for a single-payer system might become closely linked with a much larger, and more powerful, political mobilization.

Of course, the precise road by which fundamental change in the health care system could be achieved remains obscure. Currently, the ACA remains at center stage, drowning out discussions of alternatives. With time, however, the changes instituted by the ACA will become subsumed within the fabric of the health care system: we’ll no longer be debating the benefits or shortcomings of Obama’s signature legislation; we’ll be declaiming the persistent injustices of our overall health care system. However powerful the opposition, if allied with a larger popular movement against ever-rising inequality, true universal health care may yet have its day in the sun.

At the same time, I believe that the struggle for health care justice – the fight for universal and equal health care for all – could, in turn, powerfully inform, and bolster, this larger movement. In polls, universal health care (and single-payer) garners support from a surprisingly large proportion of the country, generally a majority. In addition, Medicare has long remained a highly popular program, even (to some extent) across class and political lines. Perhaps, one might conjecture, this is because the need for health care speaks to our intuitive commonalities as human beings.

We may have soaring inequality and a political system more and more indebted to corporate sponsors. But I believe that we’ll ultimately reject the notion of class-based health care. The ideal of universalism still has great potential power; in time, we’ll learn to harness it.

*A. W. Gaffney is a physician and writer whose work has appeared in Salon, Dissent, Jacobin, and In These Times. He blogs at [www.theprogressivephysician.org](http://www.theprogressivephysician.org).*

## Footnotes

1. Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven: Yale University Press, 2011), 195.

2. “Board of Directors’ Statement: Now Is the Time for Health Care Reform: A Proposal to Achieve Universal Coverage, Affordability, Quality Improvement and Market Reform.,” (America’s Health Insurance Plans, 2008).

3. Drew Armstrong, “Insurers Gave U.S. Chamber \$86 Million Used to Oppose Obama’s Health Law,” Bloomberg.

4. Dean Baker, “Reducing Waste with an Efficient Medicare Prescription Drug Benefit” (Center for Economic and Policy Research, 2013).

5. Peter Baker, “Obama Was Pushed by Drug Industry, E-Mails Suggest,” *New York Times*, June 9, 2012.

6. Beatrix Rebecca Hoffman, *Health Care for Some: Rights and Rationing in the United States since 1930* (University of Chicago Press, 2012).

7. On the Bayh-Dole Act, see H. Markel, “Patents, Profits, and the American People – the Bayh-Dole Act of 1980,” *New England Journal of Medicine* 369, no. 9 (2013). On moral hazard, a good review can be found in J. A. Nyman, “American Health Policy: Cracks in the Foundation,” *Journal of Health Politics, Policy and Law*, vol. 32, no. 5 (2007).

8. “Effects of the Affordable Care Act on Health Insurance Coverage – Baseline Projections,” ed. Congressional Budget Office (2014).

9. The devil is very much in the definition here (i.e. what arbitrary cutoff defines sufficient versus insufficient coverage); using a conservative threshold, a recent study found that 12 percent of the U.S. population was insured but underinsured (in addition to the 18 percent uninsured). C. Schoen et al., “America’s Underinsured: A State-by-State Look at Health Insurance Affordability Prior to the New Coverage Expansions,” (The Commonwealth Fund, 2014).

10. In all fairness, however, we were already becoming a “copay country” even before the ACA. Those of us with employer-provided health insurance have, for instance, seen growing copay and deductibles in recent years. G. Claxton et al., “Health Benefits in 2013: Moderate Premium Increases in Employer-Sponsored Plans,” *Health Affairs*, vol. 32, no. 9 (2013). I discuss the issue of “copay country” in greater depth in “Your doctor copays are too high!” *Salon*, August 5, 2013.

11. That being said, state single-payer requires federal waiver to allow for the incorporation of Medicare into the system, and so requires federal cooperation.



## Chapter Reports

In **California**, PNHP leadership have been building the AllCare Alliance, supporting a West Coast tour of “The Healthcare Movie,” distributing the “Evidence-based Case for Single Payer” article from the Journal of Oncology Practice, and participating in a Black Health and Healing Summit. Dr. Jeff Gee and others are working to build the San Francisco chapter of PNHP. The state organization also ran a successful Indiegogo campaign in the summer to support its stellar team of CaHPSA student fellows. Finally, PNHP California welcomes new CaHPSA Coordinator Angelica Ramirez, who will coordinate programming for the many student chapters around the state. To get involved in PNHP California, contact Bill Skeen at [bill@pnhpcalifornia.org](mailto:bill@pnhpcalifornia.org).

In the **District of Columbia**, over 100 activists from PNHP, the American Medical Student Association, National Nurses United, Public Citizen, Healthcare-NOW!, the Labor Campaign for Single Payer, the All Unions Committee for Single Payer Healthcare, and several other allied groups participated in the first-ever single-payer Lobby Day on May 22. Activists made dozens of visits to lawmakers in both the House and Senate. Sen. Bernie Sanders held a panel on single payer prior to the event including Prof. Gerald Friedman of the University of Massachusetts at Amherst, Robert Weissman of Public Citizen and Michael Lighty of National Nurses United. Capping the two days of action, Public Citizen held a reception for participants in its Dupont Circle office. Contact Dr. Robert Zarr



**Dr. Robert Zarr and medical students at lobby day.**



**Illinois Single Payer Coalition Members with banner at Disability Pride Parade.**

at [rlzarr@yahoo.com](mailto:rlzarr@yahoo.com) to get involved in PNHP’s D.C. chapter.

In **Illinois**, Anna Zelivianskaia, a third-year medical student at the University of Illinois, Chicago, was a guest on America’s Work Force Radio where she discussed student advocacy and the need for single payer. Fellow UIC student Christiana Shoushtari was selected to participate in AMSA’s Seacouver Study Tour in July. Seacouver is a five-day program in Seattle and Vancouver, B.C., during which medical students visit clinics and hospitals, hear lectures from physician experts, and interview pedestrians in Canada and in the United States about their health systems. The Illinois Single Payer Coalition, of which PNHP Illinois is a part, was active all summer tabling at events like the American Postal Workers Union convention, Disability Pride, and Chicago street festivals. In southern Illinois, PNHP members have also tabled at farmer’s markets every month in Edwardsville, and chapter leader Dr. Pamella Gronemeyer took part in a panel after a performance of the one-man play “Mercy Killers” in St. Louis. PNHP member Alap Shah, M.D. is working to develop a single-payer interest group within the Illinois Academy of Family Practice. To learn more or get involved, contact Dr. Anne Scheetz at [annescheetz@gmail.com](mailto:annescheetz@gmail.com). Finally, Chicago Jobs with Justice passed a resolution in support of H.R. 676 after a meeting with PNHP President Dr. Andy Coates and Executive Director Matt Petty this spring. Susan Hurley, executive director of Chicago Jobs with Justice, commented on the resolution: “Single-payer health care has to be our ultimate goal in the United States. It is the only humane and civilized choice.”

In **Indiana**, Hoosiers for a Commonsense Health Plan (HCHP) joined a coalition of around 40 groups includ-



ing the AARP, the United Way, the Methodist Church and the League of Women Voters to build grassroots support to encourage Gov. Mike Pence, a Tea Party conservative, and the Legislature to support a Medicaid expansion. The chapter also worked with the Indiana Hospital Association and contacts in the Indiana Health and Human Services Department to develop an “inside-outside” strategy, with PNHP tackling grassroots organizing, and others focused on traditional lobbying. The culmination of the campaign was the presentation to the governor of over 10,000 petition signatures, a letter signed by bishops and other religious leaders, and a number of city and county council resolutions supporting Medicaid expansion. The event was covered by local print and television media, and the presentation was timed to be on the eve of the governor’s trip to D.C. to meet with Kathleen Sebelius, then head of HHS. In May, Gov. Pence announced that Indiana would move to expand Medicaid, albeit under an alternate method, and the state is moving forward aiming for a January 2015 implementation date. Next up for HCHP: Beginning with a new coalition aimed at bringing “Moral Mondays” to the Hoosier State. Contact Hoosiers for a Commonsense Health Plan at [grostone@gmail.com](mailto:grostone@gmail.com) with any questions or to get active with the chapter.

In **Kentucky**, former PNHP President Dr. Garrett Adams reports that in response to requests from their chapter, including during the recent Lobby Day activities, Rep. John Yarmuth of Kentucky has posted a plug for single payer and H.R. 676 on his official website. Dr. Adams was among 20 or so activists who held a lighted sign reading, “Happy 49th Medicare: Expand it, improve it, H.R. 676,” on Louisville’s Big Four Bridge overlooking a huge evening riverside concert. In other news, PNHP Kentucky member Dr. Ewell Scott has been meeting with prominent state officials and likely future candidates for office and educating them about single payer. To learn more about single-payer efforts in Kentucky, contact Dr. Adams at [kyhealthcare@aol.com](mailto:kyhealthcare@aol.com).

In **Massachusetts**, single payer has been a prominent topic in the gubernatorial primary, and Dr. Donald Berwick, the former chief of CMS, has been particularly outspoken in advocating for a single-payer system in the state. (As a reminder, PNHP is strictly nonpartisan and it neither supports nor opposes any candidate for public office.) Dr. Gordy Schiff and other PNHP mem-

bers have been very helpful in finding ways to educate all the candidates on the single-payer issue; e.g. a new fact sheet on “Massachusetts and single payer” has been circulating and is also available on the PNHP website. To get involved in Massachusetts, contact Dr. Rachel Nardin at [rnardin40@gmail.com](mailto:rnardin40@gmail.com).

In **New Orleans**, Louisiana, the new PNHP chapter under the leadership of Dr. Rade Pejic has grown to 15 members. The group is working to organize a medical student counterpart at Louisiana State University and Tulane after Dr. Pejic presented a lecture at Tulane titled “The Logic and Economic Necessity for a One-Payer Health Care System for the United States.” Dr. Pejic noted that after the lecture, he took a poll of the medical students in attendance and found an 89 percent positive response to the concept of single-payer health care. At the end of May, Drs. Marge Cohen, Gordy Schiff and Elizabeth Frost presented a lecture at the Health Care for the Homeless Annual Meeting in New Orleans on the impact of the Affordable Care Act on the homeless population. For more information, contact Dr. Pejic at [rpejicmd@gmail.com](mailto:rpejicmd@gmail.com).



**Dr. Mary Bassett accepting award at PNHP NY-Metro gala.**

The **New York Metro** chapter held a successful gala event in June to honor chapter board member Dr. Mary Bassett, the new commissioner of health for New York City. At the gala, Dr. Bassett gave a strong endorsement of single payer, a position echoed by several prominent community leaders. On May 31, the chapter brought together a physicians’ advocacy coalition with representatives from CIR, the Doctors’ Council, the National Medical Association, the National Physicians Alliance, Doctors for America, Doctors for the 99 percent, and others. In the spring, the chapter organized its annual Lobby Day for the New York Health bill, which brought the participation of about 250

people from around the state to Albany, and resulted in 84 lobby meetings and two additional cosponsors for the single payer bill. Finally, the chapter is pleased to announce the addition of several new staff members, including Annette Guadino as organizing consultant, Chelsea McGuire as medical student fellow, and Katie Robbins as executive director. Robbins recently completed a masters in public health at Columbia University, and was previously the executive director of Healthcare-NOW! To get involved in activities in New York, contact Katie Robbins at [katie@pnhpnymetro.org](mailto:katie@pnhpnymetro.org).

In **South Carolina**, repeated appeals to Rep. James Clyburn by PNHP chapter leaders resulted in Clyburn once again becoming a co-sponsor of H.R. 676. Dr. Ed Weisbart of St. Louis visited South Carolina during “Medicare’s birthday week” to give a talk at a South Carolina Medical Society breakfast, speak at a resident’s conference at the Medical Center of South Carolina, and hold a meeting with physicians and businesspeople at Roper Hospital in Charleston followed by a showing of “The Healthcare Movie” that evening. Dr. Weisbart also made a trip to the Healthcare Justice chapter in Charlotte, N.C., as a part of this visit, where he spoke and was interviewed by The Charlotte Observer. Finally, the South Carolina chapter is trying to get a single-payer bill introduced into the state Legislature, and the current bill has gone through a legislative council. For more information about PNHP South Carolina, contact Dr. David Keely at [dfkeely3@gmail.com](mailto:dfkeely3@gmail.com).



Dr. Ed Weisbart met with members of Healthcare for All South Carolina in Charleston during his visit in July.

In **Tennessee**, organizer Dr. Arthur Sutherland reports local PNHP chapters now exist in Western, Middle, and upper East Tennessee, in addition to a new student

chapter at the Quillen Medical School in Johnson City. The Middle Tennessee chapter, under the leadership of Dr. Jim Powers and Dr. Carol Paris, is working with medical students at Vanderbilt and Meharry to start additional student chapters at their schools. Members are also working to organize local chapters in Chattanooga and in the Knoxville-Oak Ridge area. PNHP Tennessee sponsored a student intern during the summer, Anand Saha, who is one of the co-founders of the Quillen Medical School chapter. Mr. Saha raised medical student awareness of PNHP across the state during his internship. To get involved with the organizing initiatives in Tennessee, contact Dr. Sutherland at [asutherland523@gmail.com](mailto:asutherland523@gmail.com).

In **Texas**, PNHP-affiliated Health Care for All Texas co-hosted an “Everybody INstitute” with Healthcare-NOW! in Houston on May 17. The event brought together 40 participants representing a wide range of organizations, including the Fe y Justicia Worker Center, RESULTS, the Living Hope Wheelchair Association, Harris County AFL-CIO, the Houston Women’s Group, the Green Party of Texas, Texas Together, and National Nurses United. After the event, HCFAT members persuaded Rep. Sheila Jackson Lee to again become a co-sponsor of H.R. 676. For more information, contact Ken Kenegos at [kkenegos@earthlink.net](mailto:kkenegos@earthlink.net).

In **Vermont**, PNHP members have spoken at several Rotary clubs over the spring and summer, and the chapter is planning outreach to medical students in the upcoming academic year. PNHP Vermont also joined a revamped coalition, Vermont Leads, to organize around the implementation of Green Mountain Care. Coalition partners, including Vermont Health Care for All, the Vermont Federation of Nurses & Health Professionals and the Vermont Workers Center are circulating a petition to urge lawmakers to recommit to Act 48. Go to <http://vermontforsinglepayer.org/> to sign the petition, or contact Dr. Marvin Malek at [mmalek66@gmail.com](mailto:mmalek66@gmail.com).

In **Washington** state, Dr. David McLanahan reports that Western Washington PNHP’s annual public meeting was held on July 19 at University of Washington. Dr. Phil Caper from Maine AllCare was a keynote, as were Seattle City Councilwoman Kshama Sawant and Dr. Randall White from Vancouver, B.C. Ms. Sawant, who has been turning the progressive landscape upside-down in Seattle through her work on the “Fight



From left to right: Dr. Randall White, Seattle city council member Kshama Sawant, Dr. Phil Caper, Martha Schmidt, and Rep. Jim McDermott, MD (D-WA) participated in a panel discussion at the Western Washington chapter's annual meeting on July 19th at the University of Washington.

for 15" minimum wage campaign, made a powerful keynote speech about single payer at the meeting. Additional efforts this past quarter have centered on getting the Health Care is a Human Right alliance, which the chapter helped to found, moving forward with the goal of obtaining an ACA waiver for a state single-payer system in 2017. The 45,000-member Washington Community Action Network just joined the coalition and has put single payer advocacy materials on its website. The chapter has also been involved in a number of rallies, demonstrations, events, and presentations, including a Martin Luther King Day workshop on single payer and a related march; a May Day rally and march for worker and immigrant rights; leading two workshops at an SEIU 1199 Nurses weekend conference; a panel discussion of the ACA at the Political Union Club of Seattle Pacific University; a meeting with housing activists on "health care is a human right" principles; a presentation on the ACA vs. single payer to family medicine residents at a Swedish hospital, along with a showing of "The Healthcare Movie" and support for a related tour. The chapter's board is working on a new strategic plan. For more information, contact Dr. McLanahan at pnhp.westernwashington@comcast.net.

In **West Virginia**, the Eastern Panhandle Single-Payer Action Network (EPSPAN) organized performances in five towns of Michael Milligan's one-man play, "Mercy Killers." Each performance was followed by a moderated discussion with the actor/playwright. An estimated 340 people, mostly "outside the choir," attended the performances. EPSPAN-recruited partners included the local NAACP, the area labor council, a state university (including its lifelong learning program), Single Payer Action, two places of worship, the League of Women Voters, and two art theaters. There was a

packed house at Shepherd University, with 65 nursing students in the audience, where a nursing professor, Dr. Bonnie Parker said: "[The play] left an indelible impression on my students, some of [whom] came up to my office to thank me for making them attend. ... I believe that it should be viewed by every member of our legislative body. It is time that we recognize the current crisis of our healthcare system and work toward development of a system that provides equity for health of all our citizens. Amazing job! Truly a life changing experience!" EPSPAN's current efforts include gathering signatures in support of single payer at selected community events. The chapter has delivered more than 800 signed forms to their members of Congress. For more information about efforts in West Virginia, contact Lynn Yellott at lynnnyellott@gmail.com.

In **Wisconsin**, the Gene and Linda Farley Chapter of PNHP hosted several educational film screenings, including "The Waiting Room" at The Farley Center in Verona, the student union at UW-Madison, and a Unitarian church in Hartland. The group has also tabled at local Madison festivals and the Dane County Farmers Market. The student group at University of Wisconsin-Madison has added a number of new members and is working to expand in the new academic year. For more information, contact Brooke Weber at brookenw@gmail.com.

**In memoriam: William Roy, M.D.**

We note with sadness the death of Dr. William Roy, former congressman from Kansas from 1971 to 1975. Dr. Roy, who practiced internal medicine in Topeka until 1989 and then served as a columnist for the Topeka Capital-Journal, was an early and vigorous supporter of single payer and PNHP.



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