PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter Spring 2017

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White coats and marching shoes

PNHP members have been active on many fronts in opposing threatened cuts to health programs and organizing for single payer. Nationally, PNHP is collaborating in building a coalition for "guaranteed health care" (improved Medicare for All) with the 185,000-member union National Nurses United, the Labor Campaign for Single Payer, Healthcare-Now, Progressive Democrats of America, and other single-payer allies. PNHP chapters and activists have participated in numerous demonstrations, town hall meetings, and other actions (see the chapter reports, starting on p. 48, for details). As we go to press, Students for a National Health Program, PNHP's medical student section, is getting ready to host its sixth annual Student Summit in Philadelphia. Nearly 300 physicians and medical students convened in Washington, D.C., on Nov. 19, at PNHP's Annual Meeting. PNHP co-founders Drs. David Himmelstein and Steffie Woolhandler's updated slides, suitable for grand rounds, are available online to PNHP members at **www.pnhp.org/slideshows** (password = paris).

Drs. Woolhandler and Himmelstein discuss annual deaths linked to lack of insurance on "CNN Tonight with Don Lemon," Jan. 24.

Single-payer bill, H.R. 676, reintroduced

Rep. John Conyers Jr. reintroduced his single-payer legislation, the Expanded and Improved Medicare for All Act, H.R. 676, in Congress on Jan. 24 with 51 original cosponsors. Subsequently, new cosponsors from California, Illinois, Kentucky, Maryland, New York, and Pennsylvania have brought the total to 61 (at this writing). The bill is based on PNHP's proposal for single-payer reform. PNHP members are encouraged to urge their representatives to cosponsor H.R. 676. Sen. Bernie Sanders is reportedly working on an update of his single-payer legislation for the Senate.

PNHP in the news

PNHP President Dr. Carol Paris was featured in an article on H.R. 676 in the Los Angeles Times, "Looking for a really good Obamacare replacement? Here it is" (reprinted on page 32). Drs. Steffie Woolhandler and David Himmelstein appeared on CNN in conjunction with their Washington Post op-ed titled "Repealing the ACA will kill more than 43,000 people annually" (p. 15). Drs. Woolhandler and Himmelstein also published "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs," in the Annals of Internal Medicine (p.12). Their commentary is believed to be the first full-length call for single payer in the journal's 90-year history. Dr. Marcia Angell's op-ed on single payer appeared in USA Today (p. 16), while PNHP National Coordinator Dr. Claudia Fegan's piece appeared in STAT, a Boston Globe-related outlet (p. 10). New research publicized by PNHP detailing how many people with chronic illness still go without needed care despite the ACA was covered by CNN, ABC News, and HealthDay (see news release, p. 34), and the stark racial and insurance segregation at academic medical centers in New York City received coverage from Politico and Reuters (p. 19), among other outlets.

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PNHP Board of Directors, 2017

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Save the date – Sat., Nov. 4

PNHP's 2017 Annual Meeting will be held in Atlanta on Sat. Nov 4. It will be preceded by PNHP's popular leadership training course on Friday, Nov. 3. Details will be posted online as they become available at **www.pnhp.org/meeting**.

Message from PNHP President Dr. Carol Paris


Dr. Carol Paris

I am honored to be serving you as PNHP's president. When I returned to the U.S. in 2014 after working for a year in New Zealand (which has a national health program), I decided to retire from clinical psychiatric practice. It was a difficult decision at the time, but I see now that it freed me up to focus on working for our common goal: a comprehensive, high-quality, nonprofit, publicly funded health care program, equitably accessible to all residents of the United States.

As you know, many issues at the national level impact PNHP's work. In early February, as I write this, these issues include the president's nominations of Rep. Tom Price as secretary of health and human services and Seema Verma to head CMS, and the partisan momentum to dismantle the Affordable Care Act and replace it (or "repair" it) with a more "business friendly" alternative. These steps, if taken, would move our nation's health backward, not forward.

PNHP's leadership has chosen to join strategically (and temporarily) national coalitions whose primary focus is either (1) to block the Price nomination, or (2) to defend the ACA from repeal without a replacement that at least maintains the protections that millions of our patients currently rely on. As physicians, medical students and health care providers, we cannot allow our patients to become "collateral damage" of partisan politics.

But let me be very clear: In these temporary coalitions our message is unchanged. The only viable way to fix our troubled health care system going forward is to improve Medicare and expand it to everyone residing in the U.S. The best time to do that is now.

I was joined at the history-making Women's March on Washington, D.C., by our immediate past president, Dr. Robert Zarr, and many other PNHP members. As we stood together, wearing white coats and chanting slogans, we were joined by other white-coated physicians and medical students.

For three hours we interacted with hundreds of people who came forward to tell us, "Of course, I want Medicare for All," even if the signs they were carrying said "Save the ACA," "Black Lives Matter," "Protect Planned Parenthood," "Climate Change is Real," "Protect LGBTQ Rights," and "We Stand With Immigrants," among others.

As we pondered this later, it became clear to us that the work of PNHP and all single-payer organizations is to use every tool available to create a political environment in which all people know that they have the power to influence Congress and make Improved Medicare for All the only "politically feasible" solution. Only then will Congress do the work of the people.

Health care crisis by the numbers:

Data update by Dr. Ida Hellander, with Drs. David Himmelstein and Steffie Woolhandler

UNINSURED AND UNDERINSURED

• An estimated 30 million to 32 million people will lose health coverage if the ACA is repealed without being replaced, according to estimates by the Urban Institute and the Congressional Budget Office. The newly uninsured would include 12.9 million who are currently covered by Medicaid or CHIP and 9.3 million with tax-subsidized private coverage. An additional 7.3 million with unsubsidized private coverage would lose it due to a near collapse of the non-group insurance market, according to the Urban Institute. The total number of uninsured could exceed 60 million, significantly more than were uninsured before the ACA passed, and uncompensated care would rise by $1.1 trillion between 2019 and 2028 (Blumberg et al., "Implications of partial repeal of the ACA through reconciliation," Urban Institute, 12/6/16; "How repealing portions of the Affordable Care Act would affect health insurance coverage and premiums," Congressional Budget Office, 1/17/17).

• Twenty-nine million Americans (9.1 percent), including 3.7 million children, were uninsured during all of 2015, down from 33 million (10.4 percent) in 2014. The number of uninsured has fallen by 41 percent since the passage of the Affordable Care Act (ACA) in 2010. Hispanics continued to have the highest uninsured rate in 2015 (16.2 percent) compared to Blacks (11.1 percent), Asians (7.5 percent) and non-Hispanic whites (6.7 percent) ("Health insurance coverage in the United States: 2015," Census Bureau, 9/13/16).

Forty percent of privately insured Americans under age 65 were in high-deductible health plans (HDHPs) in 2016, up from 25.3 percent in 2010. HDHPs have minimum deductibles of $1,300 for an individual and $2,600 for a family that must be met before enrollees are eligible for benefits (Cohen et al., "Health insurance coverage: Early release of estimates from the National Health Interview Survey," National Center for Health Statistics, September 2016).

• An estimated 43.8 million people under age 65 (16.2 percent) were in families having problems paying medical bills in the first six months of 2016, down from 56.5 million in 2011. The slight drop in the number of people reporting problems between 2015 and 2016 was not statistically significant, indicating a leveling off of gains due to the ACA. Those still reporting hardship six years after the health reform law passed included 23.0 percent of the poor, 24.9 percent of the near poor (earning between 100-200 percent of poverty), and 12.6 percent of non-poor persons. Blacks and Hispanics were more likely than others to report problems with medical bills; 17.4 percent of Hispanics, and 23.0 percent of non-Hispanic Blacks were in families with medical bill problems (Cohen et al., "Problems paying medical bills among persons under age 65: Early release of estimates from the National Health Interview Survey, 2011–June 2016," Division of Health Interview Statistics, National Center for Health Statistics, November 2016).

Nearly 25 percent of all low-income adults (those earning less than 138 percent of poverty) experience "churning" – changes in their insurance coverage – each year, according to a survey by Harvard-affiliated researchers. The ACA's Medicaid expansion didn't significantly affect the rate of churning, which remained stable between 2013 and 2015. More than half of respondents who had coverage changes experienced a gap in coverage, but even those who were continuously insured were more likely to report receiving fair- or poor-quality medical care, to have trouble getting appointments, or to need to change doctors, and were more likely to use an emergency department than their counterparts who didn't experience churning (Sommers et al., "Insurance churning rates for low-income adults under health reform: Lower than expected but still harmful to many," Health Affairs, October 2016).

COSTS

In 2017, health care spending is expected to rise 5.4 percent to $3.5 trillion, $10,832 per capita, 18.3 percent of GDP, according to the latest projections from the Center for Medicare and Medicaid Services (CMS). Prescription drug spending is expected to rise to $360.1 billion, a nearly 35 percent increase in drug spending over the past five years. In 2025, health spending is projected to top $5.5 trillion, 19.9 percent of GDP. Private employers fund one-fifth of total health expenditures (Keehan et al., "National Health Expenditure Projections, 2016–25: Price increases, aging push sector to 20 percent of economy," Health Affairs published online 2/15/17).

• In 2016, average annual premiums for employer-sponsored health insurance increased to $18,142 for family coverage, and $6,435 for single coverage. Employees paid an average of $5,277 of the premiums for family coverage, and $1,129 for individual plans. Employee contributions to premiums and deductibles as a share of median household income have increased dramatically over the past decade, from 6.6 percent in 2006 to 10.1 percent in 2015. The average deductible for individual coverage increased to $1,478, a 63 percent increase since 2011. During that period workers' earnings have increased 11 percent. Eighty-three percent of covered workers were in plans with an annual deductible in 2016, up from 74 percent in 2011. In addition to premiums and deductibles, 64 percent of covered workers faced coinsurance for hospital care, with the average coinsurance rate for hospital care an astronomical 19 percent of charges (Collins, "Slowdown in employer cost growth: Why many workers still feel the pinch," Commonwealth Fund, 10/26/16; "2016 Employer Health Benefits Survey," Kaiser Family Foundation, 9/14/16).

• An estimated 11.2 million people were pushed into poverty in 2015 by out-of-pocket medical expenses, according to the U.S. Census Bureau. A total of 45.7 million people were poor using the Supplemental Poverty Measure, which takes into account non-discretionary expenses like medical bills, compared to 43.5 million using the official definition of poverty (Herman, "Uninsured rate drops, but medical expenses still drag millions into poverty," Modern Healthcare, 9/13/16).

Single payer would reduce insurer overhead by $600 million in Oregon

Single payer would cut insurer overhead by $600 million in Oregon. A single-payer system could cover comprehensive benefits for everyone in Oregon, including undocumented immigrants, without increasing health spending, according to a study of four health care options by the RAND Corporation. Of the four options (single payer, managed competition, public option, and status quo) single payer achieved the greatest administrative savings ($600 million) and was the only reform that would "significantly" reduce out-of-pocket costs for middle-income individuals as well as the poor. The study estimated that single payer could be financed with a 6.3 percent payroll tax on employers with more than 20 workers and an increase in the income tax, which would make the financing of health care more progressive. While generally favorable to single payer, the study greatly underestimated administrative savings under single payer because it failed to take into account hundreds of millions of dollars in savings on the administrative overhead in doctors' offices and hospitals, and used an incorrect estimate of Medicare's overhead – 6.5 percent (a figure that includes the overhead of Medicare Advantage plans) rather than 2.2 percent (overhead in the traditional Medicare plan) (White et al., "A comprehensive assessment of four options for financing health care delivery in Oregon," January 2017).

• Americans had $7.4 billion in health savings accounts (HSAs) at the end of 2015. HSAs are promoted as a way to reduce health costs. In a recent study, health spending per HDHP enrollee was $659 lower than in conventional plans in 2014. But HDHP enrollees paid nearly one-fourth of their medical costs out of pocket ($1,030), compared to 14 percent in other plans. In addition, HSAs' tax benefit disproportionately rewards higher-income households. Fifty-eight percent of tax returns claiming HSA-deductible contributions in 2013 were from households with incomes over $100,000, and 70 percent of all contributions to HSA came from households at that income level. In 2015, there were about 4 million HSA accounts with an average balance of $1,844 (Andrews, "HSA balances climb but benefits reward healthier consumers most," Kaiser Health News, 12/2/16; and Hancock, "Studies: Employer costs slow as consumers use less care, deductibles soar," Kaiser Health News, 9/14/16).

Single payer would reduce U.S. health spending

A single-payer health plan with comprehensive benefits could cover nearly everyone and reduce national health expenditures by $121 billion in 2017, according to a fiscal study by RAND graduate student Jodi Liu. Liu estimated that a single-payer plan with a 98 percent actuarial value would increase national health spending by $435 billion, but the additional costs would be more than offset by $556 billion in savings on administrative overhead and pharmaceutical costs. Single payer would make household spending on health care more equitable, with significant savings for everyone except those making over 1,000 percent of the federal poverty level, $253,000 for a family of four. If employers passed back savings on health benefits to workers, wages and salaries would also increase by $187 billion, or $1,420 per worker (Liu, "Dissertation: Exploring single-payer alternatives to health care reform," Pardee RAND Graduate School, May 2016).

SOCIOECONOMIC INEQUALITY

• In the U.S., higher income is associated with greater longevity, and inequality in life expectancy is increasing. Between 2001 and 2014, life expectancy increased by 2.3 years for men and 2.9 years for women in the top 5 percent of income distribution, while it rose by only 0.3 years for men and did not change for women in the bottom 5 percent. The life expectancy gap between the richest 1 percent and poorest 1 percent of Americans at age 40 was 15 years for men and 10 years for women in 2014 (Chetty et al., "Effects of local health interventions on inequality in life expectancy," American Journal of Public Health, December 2016).

• CEO pay is much higher than previously thought. When "actual realized gains" (ARGs) on stock are included (rather than stock and option "awards," which provide value in future years), senior executives made 949 times as much money as the average worker in 2014, not "merely" 373 times more, as usually reported. When companies file their annual DEF 14A report with the Securities and Exchange Commission, ARGs are reported in a separate table than CEO "total compensation"; but including the ARG data is necessary to determine senior executives' actual take-home pay (what they report in their personal income-tax filings with the IRS). Measuring executive pay based on stock and option awards, as opposed to ARGs, underestimates CEO pay, especially when stock prices are rising. For example, from 1996 through 2015, Gilead CEO John Martin's pay was $209 million, including stock awards. But his total ARG pay was just over $1 billion, with 95 percent coming from gains on stock that vested and options he exercised (Lazonick and Hopkins, "Corporate executives are making way more money than anybody reports," The Atlantic, September 2016).

• Global wealth is highly concentrated. Eight men own as much wealth as the 3.6 billion poorest people, half of all people on the planet, according to Oxfam. The eight individuals are Bill Gates,

Spain's Inditex founder Amancio Ortega, Warren Buffett, Mexico's Carlos Slim, Jeff Bezos, Mark Zuckerberg, Larry Ellison, and Michael Bloomberg. New and better data on the distribution of wealth around the world, particularly in India and China, where people are worse off than previously thought, was used to create the comparison ("The world's 8 richest men are now as wealthy as half the world's population," Reuters, 1/16/17).

• Under the Temporary Assistance to Needy Families (TANF) program, which replaced the Aid to Families with Dependent Children (AFDC), or the "welfare" program, in 1996, recipients face a five-year lifetime limit on receiving benefits. Only 23 percent of families with children living in poverty receive cash assistance today, down from 68 percent in 1996. The assistance is inadequate and hasn't kept up with inflation, leaving families below 50 percent of the federal poverty line in every state, and below 30 percent of FPL in most states. In two states, Mississippi and Tennessee, assistance is less than $2 per person per day, $240 per month for a family of four. Making matters worse, fewer than 16 percent of poor working mothers receive any assistance with childcare. The Supplemental Nutrition Assistance Program, or food stamps, reaches about three-quarters of the working poor (and 85 percent of TANF recipients), but in most states it doesn't nearly cover the cost of a healthy diet (Potts, "The American social safety net does not exist," The Nation, 10/13/16).

ACA UPDATE

The nation's five largest health insurance firms have garnered profits of $65.5 billion since the ACA's passage, according to their SEC filings. Between 2011 and 2015, UnitedHealth made the highest profits, $27.8 billion. Anthem was second at $12.9 billion, followed by Aetna ($10.0 billion), Cigna ($8.6 billion), and Humana ($6.3 billion). The firms' profits remained roughly consistent in 2015 after the implementation of the ACA in 2014. UnitedHealth, Aetna and Humana have all cited losses as their reason for major withdrawals from the marketplace, forcing 1.5 million enrollees to switch plans in 2017 and leaving 10 states with only one or two insurers on their exchanges (Public Citizen news release, 10/26/16; Norris, "Your carrier's leaving the exchange. Now what?" Healthinsurance.org, 8/24/16).

• Premiums for benchmark plans sold at Healthcare.gov (the federal exchange) jumped an average of 25 percent in 2017, on top of a 7 percent increase in 2016. The benchmark plan, used to calculate premium subsidies, is the second-lowest-cost silver plan. The average monthly premium for the benchmark plan rose from $242 in 2016 to $302 in 2017. The average monthly premium for all silver plans increased from $496 per month to $554 per month in 2017. At the same time, benefits are shrinking: Average deductibles for silver plans rose by 20 percent in 2017 to $3,703. In addition, the percentage of silver plans that were HMOs or EPOs (exclusive provider organizations) rose from 61 percent in 2015 to 69 percent in 2016. The premium and cost-sharing increases occurred despite the suspension of a $13.9 billion tax on insurers, set to go into effect in 2017, a suspension that Marilyn Tavenner, president of America's Health Insurance Plans (and former CMS administrator), claimed would reduce premiums (Reuters, "Obamacare premiums for 2017 jumped 25 percent on Healthcare.gov," 10/25/16; Herman, "Feds forgoing $13.9 billion from ACA insurance tax," Modern Healthcare, 3/1/16).

• The federal government spent $32.8 billion on premium subsidies for private health insurance purchased in the ACA marketplaces for an estimated 9.4 million Americans (85 percent of enrollees) in 2016. New York residents received the lowest average subsidy, $178 per month, while subsidies to Alaska residents were the highest at $750 per month ("Estimated total premium tax credits received by marketplace enrollees," Kaiser Family Foundation, 12/5/16).

Anthem switched hundreds of thousands of PPO customers on the California health exchange to EPOs with narrower networks without their consent. The firm sent customers a notice saying they would be automatically enrolled in "similar coverage" for 2017, but the EPO has different providers and doesn't cover any out-of-network costs. Premiums also increased by 17 percent. A consumer group has filed a class-action lawsuit against the firm, alleging the insurer violated the law by failing to provide "guaranteed renewal" of their existing coverage (Seipel, "Consumer group sues Anthem Blue Cross for allegedly misleading consumers on 2017 health plans," Mercury News, 11/1/16).

• In Minnesota, premiums in the individual market increased by 50 percent to 67 percent in 2017. One insurer, HealthPartners, pulled out of 57 of the 67 counties where it offered plans in 2016. Regulators had to allow the remaining three insurers to cap their enrollment to keep them from leaving the market too. The average premium subsidy for an ACA plan increased to $637 per month, but 75 percent of Minnesotans who buy coverage in the individual market do so outside the exchange and are ineligible for subsidies (Snowbeck, "Ask Minnesota if the individual insurance market is stable," Star Tribune, 10/3/16).

• About 5.9 million Americans, or 56 percent of all ACA enrollees, were receiving cost-sharing reductions (CSRs, an additional set of subsidies offered to those with incomes below 250 percent of poverty to help them pay their copayments and deductibles) as of mid-2016, at a cost of $130 billion over the next 10 years. House Republicans filed a lawsuit challenging the legality of CSRs in 2014, on the grounds that Congress never explicitly appropriated the funds to pay for them. A U.S. District Court Judge in Washington, D.C., ruled in favor of the House in May of 2016, but the ruling was stayed pending the resolution of an appeal from the Obama administration. With Trump's election, many experts expect the Department of Justice to drop the appeal, effectively ending the subsidies. The alternative is for Congress to approve $9 billion to fund the subsidies in 2017, which now seems unlikely (Jost, "Two recipients of ACA cost-sharing subsidies seek voice in litigation," Health Affairs Blog, 12/20/16).

MEDICARE, INC.

• Medicare Part D plans' benefits are shrinking, even as premiums and cost sharing rise. The average monthly premium in a stand-alone plan in 2017 is $42.17, up 9 percent from $38.57 in 2016. Deductibles increased by 7 percent, to $195 per year. Instead of copayments, most plans now charge coinsurance, typically 40 percent, for non-preferred brand name and specialty drugs ("Medicare Part D: A first look at prescription drug plans in 2017," Kaiser Family Foundation, October 2016).

"Seamless conversion" is one more way in which CMS is providing private insurers with an unfair advantage over traditional Medicare. Private insurers are allowed to automatically enroll their current commercially insured customers into their MA plan when they turn 65 without the client's explicit consent. Private insurers need only send the beneficiary a letter explaining the new coverage, which goes into effect within 60 days unless the senior opts out. Twenty-nine insurers selling plans in 16 states – including UnitedHealthcare, Aetna and some Blue Cross Blue Shield affiliates – are allowed to do seamless conversion, according to CMS data (Jaffe, "Some seniors surprised to be automatically enrolled in Medicare Advantage plans," Kaiser Health News, 7/27/16).

• WellCare Health Plans is buying Universal American Corp., a Medicare Advantage (MA) insurer with 114,000 members, for $800 million. Universal American also manages 24 Medicare accountable care organizations (ACOs) covering more than 280,000 Medicare beneficiaries. WellCare's MA plans now cover 3.8 million seniors. No WellCare MA plan has achieved a four-star quality rating. WellCare also owns Medicaid managed care plans in 11 states. WellCare was kicked out of Iowa's new Medicaid privatization program for "disclosure and ethics lapses" (Herman, "With WellCare deal, future looks bright for Medicare Advantage plans," 11/21/16; "WellCare completes purchase of Care1st Arizona health plan," Modern Healthcare, 1/4/17).

ACOs raised Medicare spending by $216 million

CMS Administrator Andy Slavitt claimed that ACOs had saved the Medicare program over $1 billion in 2015. A closer look at the data shows that the ACO program actually raised Medicare's spending by $216 million. Of the 392 ACOs in Medicare's Shared Savings Program (MSSP), 203 (51.2 percent) reported savings, but 189 (48.2 percent) reported losses. When those losses, and the amount ($645 million) that Medicare had to pay or "share" with ACOs are taken into consideration, the net impact of ACOs on Medicare was to raise Medicare spending by $216 million. Adding the cost of administering the ACO program, which Medicare has not disclosed, would further raise costs (Jha, "ACO winners and losers: A quick take," The Health Care Blog, 8/31/16).

• In 2016, 17.6 million seniors, 31 percent, were enrolled in Medicare Advantage plans, up from 5.3 million in 2004 ("Medicare Advantage," Kaiser Family Foundation, 5/11/16).

MEDICAID

Disruption and churning in Minnesota's Medicaid program

The largest insurer in Minnesota's managed Medicaid program, Medica, has notified the state that it is terminating coverage for nearly all of its 312,000 enrollees in May 2017. About 800,000 Minnesotans are in the state's Medicaid program. This is the second year in a row in which hundreds of thousands of poor Minnesotans have had to switch plans. The state started a bidding program for Medicaid contracts in 2015, which resulted in over 300,000 UCare enrollees having to switch to one of the lower-bidding insurers last year. Medica estimates it lost $150 million on revenues of about $1.5 billion in 2016, largely driven by "changes in the population" (i.e. former UCare patients joining their plan) (Snowbeck, "Minnesota Medicaid shake-up to affect 311,000," Star Tribune, 1/27/17).

• On average, Medicaid only covers about 93 percent of hospitals' costs. However, when disproportionate share (DSH) payments from Medicare that are linked to Medicaid admissions are taken into account, hospitals do make money on their Medicaid patients, according to a study of 2,774 hospitals that qualify for the DSH program. Medicaid days, along with Medicare days for low-income patients on Supplemental Security Income (SSI), serve as a proxy for uncompensated care and trigger additional payments from Medicare's DSH program if they account for at least 15 percent of patients. On average, a single Medicaid day will increase a hospital's Medicare payments by over $300 in 2017, bringing government payment for Medicaid admissions to 107 percent of costs, researchers estimate (Stensland et al., "Contrary to popular belief, Medicaid hospital admissions are often profitable because of additional Medicare payments," Health Affairs, December 2016).

• Medicaid will forgo $75 million in rebates on higher-priced "abuse deterrent formulations" of opioids (ADFs) over the next decade. Pharma lobbyists argued that waiving the rebates made sense because ADFs make it more difficult for an individual to crush, break, or dissolve a drug, hence making it harder to abuse. Oxycontin, the opioid painkiller that launched the current epidemic, was similarly marketed as being less prone to cause addiction when it first came out because it was "longer acting" (Whyte and Perrone, "Drugmakers set to gain as taxpayers foot new opioid costs," Associated Press, 12/15/16 and Ryan et al.,"You want a description of hell? Oxycontin's 12-hour problem," Los Angeles Times, 5/5/16).

• Health Link, Iowa's newly privatized Medicaid managed care program for 600,000 residents, has increased bureaucracy and created financial problems for hospitals and doctors, according to news reports. Trump's nominee to head CMS, Seema Verma, helped design the flawed program (along with Medicaid reforms in Indiana and Kentucky that impose premiums on Medicaid recipients, with penalties for non-payment). Iowa outsourced the $4.2 billion program in 2015, hoping to save $110 million by the end of the first fiscal year in June 2016. Insurers complain that the program is "drastically underfunded" even after the state increased funding by $127.7 million and hiked capitation rates. Sixty-one percent of 423 Medicaid providers surveyed said privatization had reduced the quality of the services they could provide and 90 percent said it had increased administrative costs (Castellucci, "UnitedHealthcare among insurers blasting Iowa's managed-care program," Modern Healthcare, 1/2/17; Martin, "In Iowa, financial pain follows Trump-style Medicaid reforms," 1/24/17).

• CMS denied Ohio's application for a Medicaid waiver that would allow the program to charge premiums and to exclude individuals unless they paid all outstanding premiums. Ohio's own analysis showed the provisions would cause over 125,000 people to lose coverage. If approved, Ohio would have been the first state allowed to drop people with incomes below 100 percent of poverty for failing to pay a premium or contribute to a health savings account (Candisky, "Feds block Ohio's attempt to charge new Medicaid fees," The Columbus Dispatch, 9/9/16).

GALLOPING TOWARDS OLIGOPOLY

Physician practices are consolidating rapidly. Between 2013 and 2015 the proportion of physicians in large groups (those with 100 or more physicians) increased from 29.6 percent to 35.1 percent. Meanwhile the proportion of physicians in small groups (those with nine or fewer physicians) fell from 40.1 percent in 2013 to 35.3 percent in 2015 (Muhlestein and Smith, "Physician consolidation: Rapid movement from small to large group practices, 2013-2015," Health Affairs, September 2016).

• Northwell Health Physician Partners, the seventh-largest physician group practice in the nation, with over 2,500 employed physicians, is buying University Physicians Group in New York City, with 60 physicians, and Westchester Health Associates, with over 100 physicians. Northwell Health (formerly North Shore-Long Island Jewish Health System) is the state's largest health care system, with 21 hospitals and 450 outpatient practices. University Hospitals Health System in Cleveland added 278 physicians in 2015, bringing its total to 1,356.

• The share of physicians employed by hospitals or in practices at least partially owned by a hospital rose from 29 percent in 2012 to 33 percent in 2014, according to the Medical Group Management Association (Barkholz, "Physicians seek employed status to weather payment risks," Modern Healthcare, 7/11/16).

The Department of Justice (DOJ) won its lawsuits to block the $37 billion merger of Aetna and Humana and a similar $49 billion merger between Anthem and Cigna. The combined firm of Aetna and Humana would have controlled one-fourth of the Medicare Advantage (MA) market, created MA monopolies in 70 counties, and increased market concentration (and premiums) in hundreds more, according to the DOJ. The merger of Anthem and Cigna would have reduced competition in the sale of insurance services to large national employers who self-insure in 35 markets. Aetna will pay Humana a $1 billion fee for the breakup of their merger, while Anthem could end up paying Cigna $1.85 billion in "reverse termination fees" (Coombs, "Aetna-Humana antitrust trial to hinge on Medicare market," CNBC, 12/5/16; Coombs, "U.S. court blocks Anthem Cigna deal," CNBC, 2/9/17).

PHARMA

• The pharmaceutical industry spent $109 million to defeat California Prop. 61, an initiative that would have allowed state agencies to pay the same discounted prices for drugs as the Veterans Health Administration. The AIDS Healthcare Foundation donated the majority of the funding to promote the initiative, $18.7 million. Despite being outspent 5:1 and facing a tsunami of misleading advertising, including claims that the measure would hurt veterans and patients with HIV, the measure was only narrowly defeated ("Contributions to healthcare campaigns across the country," Modern Healthcare, 11/21/16).

The pharmaceutical industry spends nearly $20 million per month on lobbying Congress, far more than any other industry. Since the passage of the ACA in 2010, drug companies have spent over $1.6 billion on lobbying. The industry has over 1,400 federal lobbyists, and spent $468,108 per member of Congress in the 18 months leading up to the November election alone, according to the Center for Responsive Politics (Silverstein, "Lobbyists, campaign cash help drug industry stymie bid to restrain Medicare prescription costs," opensecrets.org, 10/19/2016).

• Valeant Pharmaceuticals raised the price of a decades-old treatment for life-threatening cases of lead poisoning, Calcium EDTA, from $950 when it acquired the drug in 2013 to nearly $27,000 in 2016 (Silverman, "Huge Valeant price hike on lead poisoning drug sparks anger," STAT, 10/11/16).

• The CEO of Mylan, Heather Bresch, daughter of W.Va. Sen. Joe Manchin, made $43.6 million when her actual realized stock gains are included in her 2015 compensation, twice as much as admitted to when she testified before Congress. Over the past five years, the firm has paid its top five managers a total of nearly $300 million, according to The Wall Street Journal. In comparison, the median earnings of a full-time wage and salary worker in 2015 were $42,068 (Sources: DEF 14A schedules, Securities and Exchange Commission; annual compensation includes salary, non-

equity incentive pay, other compensation, and value of stock options exercised and stock awards that vested; Maremont, "EpiPen maker dispenses outsize pay," Wall Street Journal, 9/13/16).

Mylan will pay $465 million to settle charges by the Justice Department that it improperly classified the EpiPen as a generic drug, leading Medicaid to overpay for it. Drugmakers pay rebates of 13 percent of the average price of a generic drug to the government, but pay a higher rebate, 23 percent of the average price, for a brand-name drug. Brand-name drugs also pay higher rebates if their prices rise faster than inflation. Mylan raised the price of the EpiPen from about $100 for a pack of two when it bought the product in 2007, to more than $608 in 2015. The EpiPen brings in more than $1 billion a year in revenue for the firm, which relocated to the Netherlands last year to avoid paying U.S. taxes (Thomas, "Mylan to settle EpiPen overpricing case for $465 million," New York Times, 10/8/16).

• Retail prices for 268 brand-name prescription drugs frequently used by seniors increased by an average of 15.5 percent between 2014 and 2015, compared with a general inflation rate of 0.1 percent. But the cost of many popular drugs rose much more. The price of Glumetza, for diabetes, increased 381 percent, while the cost of the anxiolytic Ativan increased by 1,264 percent. The average annual cost of a brand-name medication for a chronic illness increased by $1,000, to $5,800 in 2015 ("Brand name prescription drug prices increase by double-digit percentage for fourth straight year," AARP, December 2016).

• Generic drug prices are skyrocketing too. Nine of the 20 drugs with the largest price increases to Medicaid between 2014 and 2015 were generics. Since 2010, 48 generic drugs have had price increases of 500 percent or more and 15 have had price increases of 1,000 percent or more. Three-fourths of the increase in Medicaid drug spending in 2015 is due to rising drug prices, not utilization, according to CMS. Early indications are that generic versions of biologics won't produce many savings, as drugmakers are pricing them only 15 percent or 20 percent off the price of the branded drug. For example, Johnson & Johnson's blockbuster arthritis drug Remicade is $1,113 for a vial. Pfizer's version, Inflectra, is $946 (Harris, "Small savings for drugs made to mimic biotech," NPR, 10/19/16; Mangan, "Drug price shock: Feds reveal how medication costs hit Medicare and Medicaid," CNBC, 11/14/16; "315 generics more than doubled in price since 2010," General Accountability Office Report, September 2016).

• In 2016, profits at major drug firms averaged 21.4 percent, far higher than the 7.5 percent average profit margin in all other industries. Unlike other industries, the pharmaceutical industry's profits are entirely dependent on government-granted monopolies in the form of patents and FDA-conferred exclusive marketing rights (Yahoo Finance database, accessed on 11/4/16).

The Justice Department is starting to bring charges in its sweeping, two-year investigation into price manipulation by generic drugmakers. Generic drugs are a $75 billion market in the U.S., accounting for 88 percent of drugs sold in the U.S., and their prices have been rising sharply (see above). Two former executives of Heritage Pharmaceuticals pleaded guilty in January to charges of conspiring to manipulate the prices of the antibiotic doxycycline and diabetes medication glyburide. The average price of doxycline rose from $20 for 500 pills in 2013 to $1,849 six months later. Pennsylvania and 19 other states are also suing six leading generic drugmakers, including Heritage, alleging collusion and price-fixing (Roebuck, "Ex-N.J. pharma execs admit to fixing generic drug prices," Philadelphia Inquirer, 1/10/17).

INTERNATIONAL

Financial barriers to care greater in U.S. than 11 other nations

Americans are more likely to report financial barriers to health care than the citizens of 11 other nations surveyed, including Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the U.K., all of which provide universal coverage. Thirty-three percent of U.S. respondents, including 43 percent of low-income respondents, reported financial barriers to care. The U.K. stood out for providing the most financial protection, with only 7 percent of all respondents, and 9 percent of low-income respondents, reporting any cost-related access problems. Other countries provide better cost protection than the U.S. in a variety of ways. The U.K. has no copays or deductibles for care or medications; low-income adults and those with chronic illnesses are exempt from cost sharing in France; and out-of-pocket spending is capped at 1 percent of income for the chronically ill in Germany and at US$123 in Sweden. The Swiss, who are subject to high copayments, reported the second highest overall rate of financial barriers to care (22 percent), while Canadians (whose universal coverage does not include coverage for prescription drugs) were about half as likely as Americans to report problems. The U.S. performed well, relative to other nations, on access to after-hours care and waiting times for specialty care, but ranked last or nearly last on financial barriers to dental care, use of the emergency department, not being able to get care the same day or next day, and on hearing back from regular doctor on the same day (Osborn et al., "In new survey of eleven countries, U.S. adults still struggle with access to and affordability of health care," Health Affairs, November 2016).

• Since 1999, the number of opioid overdose deaths in the U.S. has nearly quadrupled to 78 per day, yet only about 10 percent of addicts receive any form of specialized treatment, according to the U.S. surgeon general. In contrast, the Swiss have had a successful opioid addiction program since 1994 that combines a daily dose of methadone (or in < 1 percent of cases, heroin)

with outpatient therapy and help with finding a job or housing. The average length of treatment is three years. The program has been so successful that it has been adopted in Germany, Belgium and Denmark, and is being tested in four other countries: Holland, England, Spain and Canada (Seelye, "Fraction of Americans with drug addiction receive treatment, surgeon general says," New York Times, 11/17/16; "Summary: Swiss heroin assisted treatment 1994 – 2017," citizensopposingprohibition.org, accessed on 1/20/17).

• Maternal mortality is rising in the U.S., while global maternal death rates have fallen by more than a third from 2000 to 2015. There were an estimated 25 maternal deaths – defined as deaths due to complications from pregnancy and childbirth – per 100,000 births in the United States in 2015, triple Canada's rate that year, and up from 23 in 2005. About a quarter of the deaths were due to cardiovascular diseases and heart failure, a rare cause of maternal death in the past. Texas saw a particularly large upswing in maternal deaths (Tavernise, "Maternal mortality rate in U.S. rises, defying global trend, study finds," New York Times, 9/21/16).

POLLS

• Forty-nine percent of Americans now favor keeping the ACA in place, including 19 percent who want to move forward with implementing the law and 30 percent (the largest fraction) who want to expand it. Just 43 percent want to repeal the law (26 percent) or scale it back (17 percent), according to a Kaiser Family Foundation poll. A clear majority of Trump voters favor all of the ACA's main features (e.g. allowing people to stay on their parents insurance until age 26, eliminating pre-existing condition exclusions, Medicaid expansion, premium assistance to help people afford coverage), with the exception of the individual and employer mandates (Kaiser Health Tracking Poll, 12/1/16).

Most Americans believe government responsible for health care

Sixty percent of Americans say the government should be responsible for ensuring health care coverage for all Americans, up from 51 percent last year. Supporters include majorities of Democrats (80 percent), Democratic-leaning Independents (85 percent), respondents with family incomes below $30,000 per year (74 percent) and respondents with incomes of $75,000 or higher (53 percent). About one-third (32 percent) of Republicans and Republican-leaning Independents say the federal government should be responsible for health care coverage. There were large increases since last year in the share of Republicans with modest incomes that say the government should be responsible for health care. The proportion of Republicans earning less than $30,000 who say health care is a government responsibility rose to 52 percent, up from 31 percent last year, while it rose to 34 percent from 14 percent last year among Republicans with incomes $30,000 to $74,999 (Bialik, "More Americans say government should ensure health care coverage," Pew Research, 1/13/17).

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Board nominations

The following candidates have been nominated for Board seats up for election:

- West region (2 seats): Paul Hochfeld, MD; Paul Song, MD
- North Central region (1 seat): Ann Settgast, MD
- South region (1 seat): Olveen Carrasquillo, MD
- At-large (1 seat): Philip Verhoef, MD, PhD

Additional nominations should be sent to Matthew Petty at **matt@pnhp.org** or 29 E. Madison, Suite1412, Chicago, IL 60602, by Monday, April 24, 2017.

Membership drive update

Welcome to 791 physicians and medical students who have joined PNHP in the past year, bringing our total membership to 21,108. We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their communities. Need help getting started? Drop a note to PNHP National Organizer Emily Henkels at **e.henkels@pnhp.org**.

Help staff PNHP booths

PNHP is hosting exhibits at three large specialty society meetings in 2017: ACP, AAFP, and AAP.

- American College of Physicians (ACP), San Diego, March 30-April 1
- American Academy of Family Physicians (AAFP), San Antonio, Sept. 12-16
- American Academy of Pediatrics (AAP), Chicago, Sept. 16-18

If you know you'll be attending any of these meetings, please drop PNHP organizer Emily Henkels a note at **e.henkels@pnhp.org**. PNHPers are encouraged to help staff the booths and organize support for single payer at the meeting (e.g. via a social event, workshop, or resolution). To join the AAFP single-payer interest group, drop a note to Dr. Parker Duncan at **pduncs@gmail.com**.

Although PNHP can't fund exhibits at other meetings, we can provide speakers, slides, and other materials, as well as connect you with other PNHP members in your specialty. To get started, drop a note to **info@pnhp.org** or call the PNHP office at 312-782-6006.

STAT

JANUARY 20, 2017

Replace Obamacare with single-payer national health insurance

By Claudia Fegan, M.D.

During the bruising 2016 presidential campaign, Donald Trump vowed to repeal Obamacare "on day one of the Trump administration." Today is that day. If soon-to-be President Trump makes good on that promise, I urge him to replace it with single-payer national health insurance.

If it, or some other equitable form of insurance, isn't quickly put in place, I worry about the patients who will die when they lose access to timely health care.

Dr. Claudia Fegan

The Affordable Care Act expanded coverage to 20 million people and improved their access to care. Every day I see its beneficial impact on the patients I serve as the chief medical officer at Chicago's largest public hospital. Tens of thousands of our patients were covered for the first time, many under the law's Medicaid expansion, and we were able to provide them care that was previously out of their reach.

While the ACA represents an important step forward in other respects, such as eliminating penalties for preexisting conditions and covering children until age 26 on their parents' plan, our health care system is still the worst of any wealthy nation.

Millions remain uninsured, and most Americans' coverage comes with gaping holes, like a hospital gown that looks pretty good in front but leaves a lot hanging out in back. Patients often find they can't afford care, given the high deductibles and copays, and their choice of doctors and hospitals is often restricted. Costs continue to soar, and greedy corporations have gained an even tighter stranglehold on health care.

Defending that status quo, as many Democratic politicians have been trying to do, is a losing battle. The ACA continues to allow insurance companies to limit access to health care, and the pharmaceutical industry to limit access to lifesaving treatment with predatory pricing.

Soon-to-be President Trump and the Republicans want the law repealed. Most people in favor of that happening want something better, not a return to the past. Replacement has to move forward to universal and upgraded coverage and move away from shifting costs to the patients least able to bear the financial burden of illness rather than going backward to the bad old pre-ACA days.

Here's one inspiring vision of health care reform that would lift the vast majority of Americans: single-payer national health insurance. Enactment of a single-payer plan would demonstrate that we are a caring nation. People shouldn't die in the richest country in the world due to lack of access to care.

According to a Gallup poll last year (and a similar Kaiser survey), more than half of Americans wanted to repeal the ACA, and most Americans still have a dim view of the law. They know it is not working. They know the deductibles are too high and they can't afford the copayments. (Curiously, on the eve of its repeal, a growing number of Americans say they support the law.)

But the Gallup poll also showed that 58 percent of Americans – including 41 percent of Republicans and 53 percent of those who favored repeal – wanted the ACA replaced with "a federally funded health care program providing insurance for all Americans," in other words, single-payer reform. They want a plan that covers the care they need and lets them see the providers they choose with no out-of-pocket costs.

Now is the time for a single-payer health system – improved Medicare for all. It would take the hundreds of billions now wasted on insurance bureaucracy and billing paperwork and use that money to expand and upgrade coverage. It would cover all of the uninsured. And it would abolish copayments and deductibles for the 91 percent of Americans who are currently covered by health insurance.

After Trump's election, my newly insured patients began to ask if they were going to lose their health insurance. Trump has said he has a plan to cover everyone, cut costs, and cut painful deductibles and copayments that limit access to care. But so far there is no firm plan, he is notoriously unpredictable, and his cabinet nominees indicate that his administration will take a different course.

Single-payer health systems have a proven track record on cost control. When Canada passed its single-payer medical insurance plan in the 1960s, its health spending was commensurate with ours and growing at the same rate. Today, Canada spends about half of what the US does. Much of the savings have come from slashing insurance overhead and paperwork. Where insurance giant Aetna keeps about 20 cents of every premium dollar for itself, the comparable figure for overhead in Canada's system is 2 cents, and for Medicare it's 3 cents. And Canada has saved vast amounts by simplifying hospitals' and

(continued on next page)

Enactment of a single-payer plan would demonstrate that we are a caring nation. People shouldn't die in the richest country in the world due to lack of access to care.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

JANUARY 25, 2017

Doctors hail reintroduction of Medicare-for-all bill

Saying status quo is 'unacceptable' and GOP plans even worse, physicians group says it's time to move forward to single-payer plan

A national physicians group today hailed the reintroduction of a federal bill that would upgrade the Medicare program and swiftly expand it to cover the entire population, saying it's the only workable and equitable way to move forward in U.S. health care.

The Expanded and Improved Medicare for All Act, H.R. 676, introduced last night by Rep. John Conyers Jr., D-Mich., ranking member of the Judiciary Committee, with 51 other House members, would replace today's welter of private health insurance companies with a single, streamlined public agency that would pay all medical claims, much like traditional Medicare works for seniors today.

The full text of H.R. 676 will be available at Congress.gov in the next few days, but is expected to be unchanged from the version introduced in the last Congress.

The doctors group says that an improved-Medicare-for-all system, also known as "single payer," would vastly simplify how the nation pays for care, saving hundreds of billions of dollars on administrative overhead that could be used to improve patient health, restore free choice of physician, and eliminate copays and deductibles.

"International experience shows that single-payer financing systems, like the one described in Rep. Conyers' bill, are the fairest and most cost-effective way to assure that everyone gets high-quality care," said Dr. Carol Paris, president of Physicians for a National Health Program, a nonprofit research and educational group of 20,000 doctors nationwide.

Paris continued: "The Affordable Care Act, despite its modest achievements, has shown itself incapable of providing universal health care. With nearly 30 million Americans still uninsured, and tens of millions who are underinsured, the doors to health care remain shut to many in need.

"The status quo is unacceptable," she said, "and the ideas pushed by the Republican majority in Congress, which are based on even more privatization and patient cost-sharing, would only exacerbate our problems and lead to an additional tens of thousands of unnecessary, preventable deaths."

Paris, a Nashville, Tenn.-based psychiatrist, continued: "In contrast, an expanded and improved-Medicare-for-All program would assure truly universal coverage, cover all medically necessary services, including dental, vision and long-term care, and would remove the growing financial barriers to care – high premiums, copays, deductibles and coinsurance – that our patients and their families are increasingly facing, often with tragic results.

"In addition to the enormous administrative savings from a single payer, such a program would also have the financial clout to negotiate with drug and medical equipment suppliers for lower prices. And doctors would have more time to spend with their patients, instead of dealing with mountains of paperwork and haggling with insurers. The key step is removing the private health insurers from the picture.

"Recent Kaiser and Gallup surveys have shown that nearly 6 in 10 Americans, 58 percent, support a Medicare-for-all approach, with the Gallup poll finding that 41 percent of Republicans favor replacing the ACA with 'a federally funded health care program providing insurance for all Americans,'" she said. "And surveys show physician support is also strong and growing. Hundreds of labor, civic and faith-based organizations have endorsed this model of deep-going reform.

"The time for fundamental health care reform is now," Paris said. "No more tweaking. No more incrementalism. No more 'political feasibility' arguments. It's time for Congress to stop putting the interests of private insurance and Big Pharma over constituent needs. It's time to make H.R. 676, Improved Medicare for All, the law of the land."

Physicians for a National Health Program (www.pnhp.org) is a nonprofit research and education organization of more than 20,000 doctors who support single-payer national health insurance. It was founded in 1986.

(***Replace with single payer,*** *continued from previous page)*

doctors' billing paperwork.

Republican plans for the ACA threaten the health of my patients and millions of other Americans, and the status quo is unacceptable. That's why I, and the 20,000 colleagues who have joined me in Physicians for a National Health Program, are fighting for single payer – a health reform that would cure America's health care ills, not just provide some pain relief.

Now is the time to take that step.

Claudia Fegan, MD, is an internist who serves as the national coordinator of Physicians for a National Health Program. She is a coauthor of "Universal Health Care: What the United States Can Learn from Canada" and is a contributor to "10 Excellent Reasons for National Health Care."

Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs

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

President Donald Trump and congressional Republicans have vowed to repeal and replace the Patient Protection and Affordable Care Act (ACA). Repealing it is relatively easy. Replacing it with "something great" is much trickier. The president has promised universal coverage and reduced deductibles and copayments, all within tight budgetary constraints. That is a tall order and unlikely to be filled by proposals that Republicans have offered thus far.

Speaker of the House Paul Ryan's blueprint (1) would rebrand the ACA's premium subsidies as "tax credits" (technically, the subsidies are already tax credits) and offer them to anyone lacking job-based coverage—even the wealthy—reducing the funds available to subsidize premiums for lower-income persons in the United States. He would allow "mini-med" plans offering miniscule coverage and interstate sales of insurance, circumventing state-based consumer protections. And he would augment tax breaks for health savings accounts, a boon for persons in high tax brackets.

Speaker Ryan would also end the long-standing federal commitment to match states' Medicaid spending, substituting block grants that state governments could divert to nonmedical purposes. Moreover, decoupling federal contributions from actual medical expenditures amounts to a sotto voce cut. For Medicare, he would trim federal spending by delaying eligibility until age 67 years; replace seniors' guaranteed benefits with vouchers to purchase coverage; and tie the vouchers' value to overall inflation, which lags behind health care inflation.

In sum, Speaker Ryan's proposal, and a similar one from Secretary of Health and Human Services Tom Price, would shrink the coverage of poor and low-income persons in the United States while maintaining (or expanding) outlays for some higher-income groups. That approach might save federal dollars by shifting costs onto patients and state budgets. But containing overall health care costs requires denting the revenues (and profits) of corporate giants that increasingly dominate care—an unlikely outcome of policies that expand the role of private insurers and weaken public oversight.

Although Republicans' proposals seem unlikely to achieve President Trump's triple aim (more coverage, better benefits, and lower costs), single-payer reform could. Such reform would replace the current welter of insurance plans with a single, public plan covering everyone for all medically necessary care—in essence, an expanded and upgraded version of the traditional Medicare program (that is, not Medicare Advantage).

The economic case for single-payer reform is compelling. Private insurers' overhead currently averages 12.4% versus 2.2% in traditional Medicare (2). Reducing overhead to Medicare's level would save approximately $220 billion this year (Table) (3). Single-payer reform could also sharply reduce billing and paperwork costs for physicians, hospitals, and other providers. For example, by paying hospitals lump-sum operating budgets rather than forcing them to bill per patient, Scotland and Canada have held hospital administrative costs to approximately 12% of their revenue versus 25.3% in the United States (4). Simplified, uniform billing procedures could reduce the money and time that physicians spend on billing-related documentation.

All told, we estimate that single-payer reform could save approximately $504 billion annually on bureaucracy (Table). Any such estimate is imprecise; however, this figure is in line with Pozen and Cutler's estimate ($383 billion, updated to reflect health care inflation) (5), which excludes potential savings for providers other than physicians and hospitals. Additional savings could come from adopting the negotiating strategies that most nations with national health insurance use, which pay approximately one half what we do for prescription drugs.

Of course, single-payer reform would bring added costs as well as savings. Full coverage would (and should) boost use for the 26 million persons in the United States who remain uninsured despite the ACA. And plugging the gaps in existing coverage (abolishing copayments and deductibles, covering such services as dental and long-term care that many policies exclude, and bringing Medicaid fees up to par) would further increase clinical expenditures.

Studies provide imperfect guidance on the probable magnitude of changes in use under single-payer reform. Microlevel experiments indicate that when a few persons in a community gain full coverage, their use surges (6). But when many persons gain coverage, the fixed supply of physicians and hospitals constrains community-wide increases in use. For example, when Canada rolled out its single-payer program, the total number of physician visits changed little; increased visits for poorer, sicker patients were offset by small declines in visits for healthier, more affluent persons (7). Despite dire predictions of patient pileups, Medicare and Medicaid's start-up in 1966 similarly shifted care toward the poor but caused no net increase in use (8).

Despite some uncertainties, analysts from government agencies and prominent consulting firms have concluded that administrative and drug savings would fully offset increased use, allowing universal, comprehensive coverage within the current health care budgetary envelope (9). International experience with

Table. Estimated Administrative and Prescription Drug Savings Under Single-Payer Reform, 2017

Sector	2017 Spending Without Reform, *$ (billion)*	Savings With Single-Payer Reform, *%*	Savings Available to Expand and Improve Coverage Under Single-Payer Reform, 2017, *$ (billion)*
Insurance overhead and administration of public programs	323.3*	68.0	220.0†
Hospital administration and billing‡	283.9	52.6	149.3
Physicians' office administration and billing§	187.6	40.1	75.3
Total administration§	1091.7	46.1	503.6
Outpatient prescription drugs	362.7*	31.2‖	113.2
Total administration plus outpatient prescription drugs	–	–	616.8

* From National Health Expenditure Amounts by Type of Expenditure and Source of Funds: Calendar Years 1960–2025 in projections format (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE60-25.zip).
† Based on the assumption that insurance overhead would decrease to 2.2% (overhead in traditional Medicare program according to the 2016 Medicare Trustees' report) and that the share of expenditures covered by insurance would increase from the current value of 74% to 80%.
‡ Based on data from reference 4 applied to the national health expenditure accounts estimate of 2017 hospital spending.
§ Based on data from reference 3 applied to 2017 national health expenditure estimates. Total administration estimates include additional administrative savings for nursing homes, home care agencies, nonphysician practitioners, and employers.
‖ Assumes no savings for Medicaid, U.S. Department of Veterans Affairs, and other federal government programs that already receive discounts; 50% savings on brand-name drugs; and no savings on generics, which account for approximately 28% of prescription drug spending.

single-payer reform provides further reassurance. It has been thoroughly vetted in Canada and other nations where access is better, costs are lower, and quality is similar to that in the United States.

The potential health benefits from single-payer reform are more important than the economic ones. Being uninsured has mortal consequences. Covering the 26 million persons in the United States who are currently uninsured would probably save tens of thousands of lives annually. And underinsurance now endangers many more by, for example, delaying persons from seeking care for myocardial infarction or causing patients to skimp on cardiac or asthma medications. Single-payer reform would also free patients from the confines of narrow provider networks and lift the financial threat of illness, a frequent contributor to bankruptcy and the most common cause of serious credit problems.

The ACA has helped millions. However, our health care system remains deeply flawed. Nine percent of persons in the United States are uninsured, deductibles are rising and networks narrowing, costs are again on the upswing, the pursuit of profit too often displaces medical goals, and physicians are increasingly demoralized. Reforms that move forward from the ACA are urgently needed and widely supported. Even two fifths of Republicans (and 53% of those favoring repeal of the ACA) would opt for single-payer reform (10). Yet, the current Washington regime seems intent on moving backward, threatening to replace the ACA with something far worse.

From The City University of New York at Hunter College, New York, New York.

Disclaimer: Drs. Woolhandler and Himmelstein served as unpaid advisors to Senator Bernie Sanders' presidential campaign. They cofounded and remain active in Physicians for a National Health Program, an organization that advocates for single-payer national health insurance. They have received no financial compensation from that organization and have no financial conflicts of interest regarding this commentary.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M17-0302.

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References

1. **A Better Way.** A better way: our vision for a confident America. 22 June 2016. Accessed at https://abetterway.speaker.gov/_assets/pdf/ABetterWay-HealthCare-PolicyPaper.pdf on 1 February 2017.
2. **The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.** 2016 annual report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 22 June 2016. Accessed at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf on 2 February 2017.
3. **Woolhandler S, Campbell T, Himmelstein DU.** Costs of health care administration in the United States and Canada. N Engl J Med. 2003; 349:768-75. [PMID: 12930930]
4. **Himmelstein DU, Jun M, Busse R, Chevreul K, Geissler A, Jeurissen P, et al.** A comparison of hospital administrative costs in eight nations: US costs exceed all others by far. Health Aff (Millwood). 2014;33:1586-94. [PMID: 25201663] doi:10.1377/hlthaff.2013.1327
5. **Pozen A, Cutler DM.** Medical spending differences in the United States and Canada: the role of prices, procedures, and administrative expenses. Inquiry. 2010;47:124-34. [PMID: 20812461]
6. **Baicker K, Taubman SL, Allen HL, Bernstein M, Gruber JH, Newhouse JP, et al; Oregon Health Study Group.** The Oregon experiment–effects of Medicaid on clinical outcomes. N Engl J Med. 2013;368:1713-22. [PMID: 23635051] doi:10.1056/NEJMsa1212321
7. **Enterline PE, Salter V, McDonald AD, McDonald JC.** The distribution of medical services before and after "free" medical care–the Quebec experience. N Engl J Med. 1973;289:1174-8. [PMID: 4754965]
8. **Wilder CS.** Volume of physician visits. United States–July 1966-June 1967. Vital Health Stat 10. 1968;10:1-60. [PMID: 5303847]
9. **Physicians for a National Health Program.** How much would a single payer cost? A summary of studies compiled by Ida Hellander, MD. 2016. Accessed at www.pnhp.org/facts/single-payer-system-cost on 2 February 2017.
10. **Newport F.** Majority in U.S. support idea of fed-funded healthcare system. Gallup. 16 May 2016. Accessed at www.gallup.com/poll/191504/majority-support-idea-fed-funded-healthcare-system.aspx on 2 February 2017.

THE DENVER POST

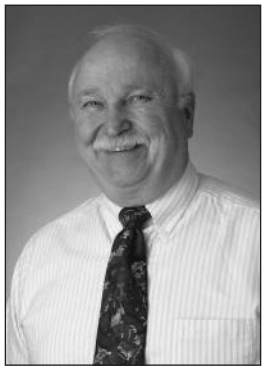
DECEMBER 17, 2016

U.S. is on fast track to health care train wreck

By Richard D. Lamm and Vince Markovchick, M.D.

With the impending repeal of Obamacare, America is headed toward a public policy train wreck.

Three seemingly unstoppable trends in America are on collision course: 1) the inventiveness of the promoters of medical technology; 2) health care insurers and providers' excessive costs; and (3) the health care expectations of the American public.



Dr. Vince Markovchick

America is sleeping as this collision draws nearer. As Winston Churchill warned us 70 years ago, democracies always seem to wake up 20 years too late. We believe that even if America awoke tomorrow, it would be too late to avoid many aspects of the coming collision.

But what an opportunity! If we spent what other developed nations spend on health care, we could balance the budget and fund a myriad of other important public needs.

In 2015 we spent $3.2 trillion on health care, which was $10,000 per person in the U.S., ($25,000 for a typical American family). This is 17.5 percent of the U.S. gross domestic product (GDP). To put this in perspective, this is more than twice what most other developed nations spend on health care while insuring all of their residents. This year we are on track to exceed that amount with it being 18 percent of GDP.

Even with the implementation of the Affordable Care Act, we still have 28 million people with no health insurance, and many more are under-insured due to rising co-pays and deductibles. Most families are unaware of the magnitude of spending since their employer pays most of their $17,000 family annual health insurance premiums. Because most do not need to be hospitalized, they are unaware of the extremely high cost of medical care.

Even with the implementation of the Affordable Care Act, we still have 28 million people with no health insurance, and many more are under-insured due to rising co-pays and deductibles.

Of the $3.2 trillion health spending, 70 percent goes directly to fund the cost of our healthcare. The remaining 30 percent is spent on administration and profit, which is more than twice that of any other nation. In 2014, studies published by the Institute of Medicine, Rand Corporation, and the Center for Medicare/Medicaid Services estimated that out of total health care spending, as much as $900 billion, or about one-third of our total spending, can be attributed to waste, fraud and abuse.

Over the past 25 years, health care inflation has been three to four times the rate of overall inflation. This has forced employers to pay more and more for health insurance, which is one of the major causes of wage stagnation during this period. During this same period employees have had to pay a higher share of their health insurance premiums as well as higher co-pays and deductibles.

This current system is unsustainable, but who will tell the American public? We suggest that the solutions to the real problems of health care are hardly being talked or written about.

The ideal health insurance system is one that: provides free choice of hospitals and doctors; provides insurance coverage to all at all times (i.e., not tied to an employer); is affordable and will remove all risk of medical bankruptcy. This system should have an administrative cost of less than 5 percent and have everyone in the risk pool, thus making premiums affordable. We have such a system now: Medicare covers all persons over 65, those on total disability, and all renal dialysis patients.

Currently 20 percent of the population accounts for 80 percent of our total health care spending, most of this coming from Medicare and Medicaid. Medicare should be improved by allowing the government to negotiate for prescription drug prices, and to pay directly for prescription drugs, thus eliminating the private health insurance prescription drug coverage. This improved Medicare will eliminate the need for costly Medicare supplemental insurance and the large subsides to Medicare Advantage private insurers. It will also dramatically reduce waste, fraud and abuse. It would be funded by an increase in the Medicare tax and by cost savings.

Medicare, with all the fraud and other issues, still operates with about 3 percent to 4 percent overhead. That is much less than the profit and overhead added by U.S. health insurers, which is instead 15 percent to 20 percent. In addition, Obamacare, Veterans Affairs and Medicaid each add another entire layer of expensive bureaucracies. All these, along with the government being unable to bid for drugs purchased under Medicare, add up to unnecessary cost and waste in our system.

These costs would be dramatically reduced if the VA and Medicaid coverage could be put under Medicare instead, and if drugs could be bid for on a competitive basis. Similarly, there would be tremendous cost savings if under Medicare as a single payer, it is authorized to negotiate for hospital care on a more cost-efficient and more comparable basis across the nation.

This is where we need to go to avoid the looming disaster that we face in the future.

Dr. Vince Markovchick is president of the Healthcare for All Colorado Foundation. Richard D. Lamm is former governor of Colorado.

The Washington Post

JANUARY 23, 2017

Repealing the Affordable Care Act will kill more than 43,000 people annually

The impact of Republicans' war on Obamacare is likely to be worse than anyone expects

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

Now that President Trump is in the Oval Office, thousands of American lives that were previously protected by provisions of the Affordable Care Act are in danger. For more than 30 years, we have studied how death rates are affected by changes in health-care coverage, and we're convinced that an ACA repeal could cause tens of thousands of deaths annually.

The story is in the data: The biggest and most definitive study of what happens to death rates when Medicaid coverage is expanded, published in the New England Journal of Medicine, found that for every 455 people who gained coverage across several states, one life was saved per year. Applying that figure to even a conservative estimate of 20 million losing coverage in the event of an ACA repeal yields an estimate of 43,956 deaths annually.

With Republicans' efforts to destroy the ACA now underway, several commentators have expressed something akin to cautious optimism about the effect of a potential repeal. The Washington Post's Glenn Kessler awarded Sen. Bernie Sanders (I-Vt.) four Pinocchios for claiming that 36,000 people a year will die if the ACA is repealed; Brookings Institution fellow Henry Aaron, meanwhile, predicted that Republicans probably will salvage much of the ACA's gains, and conservative writer Grover Norquist argued that the tax cuts associated with repeal would be a massive boon for the middle class.

But such optimism is overblown.

The first problem is that Republicans don't have a clear replacement plan. Kessler, for instance, chides Sanders for assuming that repeal would leave many millions uninsured, because Kessler presumes that the Republicans would replace the ACA with reforms that preserve coverage. But while repeal seems highly likely (indeed, it's already underway using a legislative vehicle that requires only 50 Senate votes), replacement (which would require 60 votes) is much less certain.

Moreover, even if a Republican replacement plan comes together, it's likely to take a big backward step from the gains made by the ACA, covering fewer people with much skimpier plans.

Although Aaron has a rosy view of a likely Republican plan, much of what they – notably House Speaker Paul D. Ryan (R-Wis.) and Rep. Tom Price (R-Ga.), who is Trump's nominee to head the Department of Heath and Human Services, which will be in charge of dismantling the ACA – have advocated in place of the ACA would hollow out the coverage of many who were unaffected by the law, harming them and probably raising their death rates. Abolishing minimum coverage standards for insurance policies would leave insurers and employers free to cut coverage for preventive and reproduction-related care. Allowing interstate insurance sales probably would cause a race to the bottom, with skimpy plans that emanate from lightly regulated states becoming the norm. Block granting Medicaid would leave poor patients at the mercy of state officials, many of whom have shown little concern for the health of the poor. A Medicare voucher program (with the value of the voucher tied to overall inflation rather than more rapid medical inflation) would worsen the coverage of millions of seniors, a problem that would be exacerbated by the proposed ban on full coverage under Medicare supplement policies. In other words, even if Republicans replace the ACA, the plans they've put on the table would have devastating consequences.

The frightening fact is that Sanders's estimate that about 36,000 people will die if the ACA is repealed is consistent with well-respected studies. The Urban Institute's estimate, for instance, predicts that 29.8 million (not just 20 million) will lose coverage if Republicans repeal the law using the budget reconciliation process. And that's exactly what they've already begun to do, with no replacement plan in sight.

Even if Republicans replace the ACA, the plans they've put on the table would have devastating consequences.

No one knows with any certainty what the Republicans will do, or how many will die as a result. But Sanders's suggestion that 36,000 would die is certainly well within the ballpark of scientific consensus on the likely impact of repeal of the ACA, and the notion of certain replacement – and the hope that a GOP replacement would be a serviceable remedy – are each far from certain, and looking worse every day.

David Himmelstein is a professor of public health at the City University of New York at Hunter College, a Lecturer in Medicine at Harvard Medical School, and a founder of Physicians for a National Health Program.

Steffie Woolhandler is a professor of public health at the City University of New York at Hunter College, a Lecturer in Medicine at Harvard Medical School, and a founder of Physicians for a National Health Program.

USA TODAY

JANUARY 6, 2017

Medicare for all should replace Obamacare

Republicans have no realistic alternative to the ACA. It's time for single-payer.

By Marcia Angell, M.D.

Even before the election of Donald Trump, Obamacare was in trouble. Premiums on the government exchanges for individual policies are projected to increase an average of 11 percent next year, nearly four times the increase for employer-based family policies. And some large insurers are pulling out of that market altogether in parts of the country.

Those who buy insurance on the exchanges often find that even with subsidies, they can't afford to use the insurance because of mounting deductibles (about $6,000 for individual Bronze plans). It's become clear that health insurance is not the same as health care.

Dr. Marcia Angell

In 2010 when Obamacare was enacted, about 50 million Americans (16 percent) were without health insurance. The U.S. was then spending some $2.6 trillion per year on health care. Last year, about 29 million (9 percent) remained uninsured, and we spent $3.2 trillion on health care in 2015 – $600 billion more than in 2010, while insuring only an additional 7 percent of Americans. This comes to nearly $30,000 for each person newly insured. That doesn't seem like much of a bargain. Costs matter. Expanding access to health care, as Obamacare does, is only half the job. The other half requires controlling costs, so the system can be sustained.

The problem is that the underlying causes of the cost inflation were left largely untouched by Obamacare. The system remains in the hands of investor-owned insurance companies, drug companies, and profit-oriented providers that can charge whatever the market will bear – and in health care, the market will bear much more than in most sectors of the economy. Like all markets, this one is driven to expand, and does. Moreover, these industries are consolidating, so that they behave more like oligopolies than competitive businesses. President Obama was so eager for the political support of the health industries that he naively assumed they would modulate their drive for profits in the public interest.

What will the Trump administration do? While Trump calls for "repealing and replacing" Obamacare, he has never said what he would replace it with. But isolated proposals have been offered by other Republicans: They would permit insurance to be sold across state lines, which means that companies in states with lax regulations would be able to sell substandard plans elsewhere; they would abolish the mandate that requires people to buy insurance, but keep the provision that requires insurers to cover people with pre-existing conditions (an idea that would cause premiums to skyrocket); and they would promote health savings accounts, which are essentially tax-free savings plans that favor the wealthy. What is absolutely certain, given the Republican rhetoric and Trump's nomination of Rep. Tom Price for secretary of Health and Human Services, is that we will move very sharply toward an even more expensive, inadequate and unequal health system.

Bernie Sanders had it right. The best way to provide universal health care at a sustainable cost is to extend Medicare to everyone, while implementing some needed reforms. Medicare is essentially a single-payer system for those over age 65 – government financed, but privately delivered. Because it uses the same profit-oriented providers as the rest of the system, it would need some reforms. That would include shifting hospitals and other providers to a non-profit delivery system, admittedly a huge challenge that could prove as controversial as Obamacare itself. We could ease the transition by switching to universal Medicare one decade at a time, starting by dropping the eligibility age from 65 to 55.

Paying for Medicare for All would require an increase in taxes – perhaps an earmarked progressive income tax for the purpose – but that increase would be offset by the elimination of premiums and out-of-pocket costs, and the slowing of inflation that stems from our market-based system. As it now stands, some 65 percent of health costs are already paid by the federal government in one way or another. Health policy experts estimate this would increase to 80 percent with Medicare for All. Since employers would no longer have the expense of providing health insurance, they would be more competitive in global markets and would likely hire more workers.

We are now between a rock and a hard place. Obamacare is faltering and the incoming Trump administration has no realistic alternative. Paradoxically, this might be exactly the right time to push for a national health program. Yes, repeal Obamacare, but not without replacing it, and the best replacement is Medicare for All. Some polls suggest most Americans favor such a system; we should pick up our metaphorical pitchforks and torches and make that preference known.

Marcia Angell is a corresponding member of the Faculty of Global Health and Social Medicine at Harvard Medical School and Faculty Associate in the Center for Bioethics. She stepped down as editor-in-chief of the New England Journal of Medicine in 2000.

The New York Times

DECEMBER 16, 2016

Want to get rid of Obamacare? Be careful what you wish for

By Robert H. Frank

With Donald J. Trump's choice of Tom Price to head the Department of Health and Human Services, it's clear that Republicans have a good chance of fulfilling their pledge to repeal Obamacare. In January, Republican majorities passed a measure similar to the one now proposed, which President Obama promptly vetoed. But with control of the presidency, they can prevail.

The prospect portends one of the biggest political backlashes in recent history. On Monday, a search of The New York Times archives since 1981 turned up 344 articles containing the phrase "Be careful what you wish for." As the repeal effort gathers steam, expect that number to grow sharply.

Opponents of the Affordable Care Act have denounced it bitterly for more than six years, so it is not surprising that, despite the program's successes, public opinion about it would be divided. Even so, a repeal would unleash the awesome power of loss aversion, among the more deeply rooted human tendencies known to behavioral scientists. Their consistent finding: The amount of effort people will expend to resist being stripped of something they already possess is significantly larger than the effort they will devote to acquiring something they don't already have.

When the possession in question is an insignificant material object, such as a coffee mug, people must be offered roughly twice as much to part with it as they would have been willing to pay to acquire it initially. If the possession relates to health or safety, that ratio becomes drastically larger.

In one experiment, subjects who were asked to imagine having been exposed to a rare fatal disease – there was a 1 in 1,000 chance they had caught it – were willing to pay only $2,000 for the only available dose of the antidote. The same subjects said that, under the same conditions, they would pay roughly 250 times as much to avoid any exposure to the disease if there was no available antidote.

The asymmetry is striking, since in both cases, people would be buying a one-in-a-thousand chance at reducing their likelihood of death. The findings suggest that people would fight hundreds of times harder to retain the health benefits they currently possess than they would to acquire those same benefits if they lacked them.

The scale of the losses at stake for Obamacare is staggering. A study by the Urban Institute estimates that a repeal would result in almost 30 million Americans losing their health coverage. Research on loss aversion thus suggests that the repeal would precipitate a political firestorm of epic proportions.

Republicans have promised to replace Obamacare with something better. Everyone, Mr. Trump included, insists that any plan must require insurers to offer affordable coverage to people with pre-existing health conditions. But that's not possible financially unless the insured pool includes predominantly healthy people. And because many healthy people won't buy insurance unless they are required to do so, no developed country relegates its health coverage entirely to unregulated private insurance markets.

The same logic explains why private/government hybrid programs – like Obamacare, and its predecessor in Massachusetts, Romneycare – include an individual mandate. Opponents of the mandate argue that it limits individual freedom, which of course it does. But traffic lights and homicide laws also limit individual freedom; everyone celebrates liberty, but sometimes we must choose among competing freedoms. Failure to include a mandate would eliminate the freedom of citizens to purchase affordable health insurance. In such cases, we must decide which of the competing freedoms is more important.

The third feature of Obamacare (and Romneycare) is that both provide subsidies for low-income people. You simply cannot require people to buy something they cannot afford.

In short, it's logically impossible to cobble together a private-insurer-based replacement for Obamacare that offers affordable coverage to people with pre-existing conditions without also including an individual mandate and subsidies. That's why, despite scores of House votes to repeal it, no one has come forward with a coherent proposal to replace it. Hence the dilemma currently facing Republicans.

Some hope they can sidestep it by enacting a "repeal and delay" bill – one that repeals the Affordable Care Act immediately while promising to replace it with an unspecified alternative several years hence. That won't solve the problem. As numerous health economists have explained, repeal without immediate replacement would result in a speedy collapse of the Obamacare insurance exchanges.

Bad times are looming for health insurance. If Mr. Trump wants to avoid a political buzz saw, what might he do? Unlike Republican congressional leaders, he seems to have no ideological commitment to a largely unregulated, and hence untenable, private health insurance system. And he has already demonstrated that Republican base voters will side with him rather than their congressional leaders.

The upshot is that, unlike President Obama, he may actually have the political power to enact the most sensible system for providing basic universal health coverage: the single-payer approach taken by most other developed countries. Older Americans have been covered under a single-payer system since the 1965 enactment of Medicare, which delivers basic health coverage more cost effectively than private insurance plans can, and which they are of course free to supplement with private insurance.

But having just announced plans to phase out Medicare, Republicans are extremely unlikely to voluntarily embrace a single-payer insurance option for all Americans, and Mr. Trump's true intentions are, to say the least, unclear.

So buckle up. Whatever happens, there's a rough ride ahead.

Robert H. Frank is an economics professor at the Johnson Graduate School of Management at Cornell University.

AL.COM HUNTSVILLE, ALA. SEPTEMBER 23, 2016

Single payer: Because black lives matter ... and so does black health care

By Jack Bernard

Black Lives Matter has its supporters (43 percent of Americans, per Pew Research Center), as well as its detractors (22 percent), but one thing is unmistakable: it has brought visibility to a very real problem. For too long, the general public has ignored the increasingly frequent violence against African Americans, especially men.

Homicide mortality rates are much higher for blacks (21 per 100,000 population) than whites (3/100,000). Sometimes, this violence is perpetuated by law enforcement officers. All too often, it is done by other black men.

But, homicide is not the only area in which black mortality exceeds that of whites. Unfortunately, the national black health crisis is also being ignored by an unknowing and oblivious public.

The overall death rate per 100,000 African Americans vs. whites is 867 versus 734. In fact, rates are much higher in every mortality area:

- Heart Disease: 239 white versus 308 black
- Cancer: 196 versus 239
- Stroke: 55 versus 76
- Diabetes: 22 versus 50
- AIDS: 2 versus 23

The causes of higher African American mortality rates are complex. There are many factors to consider, including: income, education, gun policies, the ingrained racism that stubbornly persists in our theoretically egalitarian society and health insurance being tied to employment (which is also related to historical racism).

In this short narrative, it is impossible to fully cover all of these topics in detail, but let's look at the situation from the 20,000 feet view.

Income and employment are directly tied to health status in our society. Americans who have insurance and can afford health care utilize these services at a much greater rate than those who are without assets and insurance. This is not only a fact, it is intuitive.

Education, unemployment and income are inter-related. People who are better educated are able to find and keep their jobs, and get new ones if their jobs are lost. Likewise, higher education and employment leads to higher income.

Undeniably, our nation has a shameful history of prejudice against African Americans, going back centuries. Although we have made tremendous progress in the last few decades, the legacy of slavery still exists.

Simplistically, let's look at this as in terms of a foot race. If one contestant has his feet tied together for the first portion of the race, how hard will it be for him to catch up after he is untied? Who can say how long it will take? Our racial history is the cause of these inequities.

Black income levels continue to be much lower than whites ($35,398 vs. $60,256 – 2014 Census). Likewise, 2016 2nd quarter black unemployment rates are higher (8.3 percent vs. 4.2 percent – BLS). Partly because health insurance in America is closely tied to employment and employers, the uninsured rate for African Americans in 2016 is also higher (11.4 percent vs. 6.4 percent-Gallup, 4-16).

Jack Bernard

There are a multitude of actions that can be taken by America to correct the situation with regard to education, employment and income. Once again, our space is too limited to address these issues. However, I would like to return to the question of health insurance.

When we examine the other developed nations of the world, we find that every one of them provide for universal health insurance for all of their citizens. In America, even after the Affordable Care Act (ACA, Obamacare), we are still left with 30 million uninsured, many of them minorities.

Unfortunately, neither political party has put forth a realistic way of addressing this problem. Democrats want to tinker with the ACA, which will make only minor improvements to the uninsured percentage. The GOP wants to privatize and incentivize, ignoring the basic problem (the private insurance system) and almost certainly worsening the situation for many citizens. And, neither party has advocated for the obvious solution as part of their platform: Medicare for All.

In America, even after the Affordable Care Act, we are still left with 30 million uninsured, many of them minorities.

The American public sees a national plan as preferable to the ACA. According to a recent Gallup poll, 58 percent of those surveyed were for it and no wonder.

Premiums are constantly going up for employees as employers cost shift their increasing benefit expenses, driven by insurance companies which are in turn battered by rapidly rising drug prices by price-gouging international pharmaceutical corporations. Bloomberg (6-16) surveyed a sampling of 39 common drugs and found prices for 30 had doubled from 2009 to 2015.

Single payer provides for leverage and cost control. It is the only way to get the rapidly rising cost of health care (currently paid for primarily out of government funds, just not effectively) under control.

The adoption of single payer provides for health insurance for

(continued on next page)

REUTERS

FEBRUARY 9, 2017

Few poor or minority patients in New York City's academic hospitals

By Lisa Rapaport

Black patients are half as likely as white patients to get care at academic medical centers in New York City even after accounting for differences in health insurance, a recent study suggests.

Compared to privately insured patients, people with coverage through Medicaid, the government health program for the poor, are three times less likely to receive treatment at these elite New York hospitals, the study also found. Uninsured patients are five times less likely to get care at academic hospitals.

"Academic medical centers are generally better able to provide highly specialized care for patients with complex or rare illnesses," said lead study author Roosa Sofia Tikkanen, a researcher at the University of Massachusetts Medical School in Worcester who completed the work while at City University of New York School of Public Health at Hunter College.

"Most experts believe unequal access to high-quality health care contributes to disparities in health outcomes," Tikkanen added by email. "In New York City, life expectancy can differ by up to 10 years between two neighborhoods that are located just six subway stops apart."

About 18 percent of patients at academic medical centers are black, compared with almost one-third at other hospitals in the city, the analysis of discharge data from 2009 and 2014 found.

At the same time, 22 percent of patients were insured by Medicaid at academic hospitals, compared with 42 percent at other hospitals in the city. And only 1 percent of academic hospital patients were uninsured, compared with 4 percent elsewhere.

While Medicaid and uninsured patients accounted for nearly half of all patients at non-academic hospitals in the city, they made up less than one-quarter of inpatients at academic medical centers. At one-third of academic hospitals, less than 10 percent of patients had Medicaid or were uninsured.

To see how race, ethnicity and payer status affect the likelihood of being treated at an academic medical center, researchers analyzed data on adults discharged from hospitals in New York City in 2009 and 2014, and they also looked at similar data for Boston hospitals in 2009.

In Boston, uninsured and Medicaid patients were just as likely to be treated at academic medical centers as at other hospitals. And racial and ethnic minorities were slightly overrepresented at academic hospitals.

It's possible some of the differences between the two cities might be explained by the extensive public hospital network in New York, the authors note in the International Journal of Health Services.

All of the academic medical centers in Boston and New York are nonprofit hospitals, however, and enjoy tax exemptions worth tens of millions of dollars, the researchers point out. In exchange, they are expected to provide community benefits, including caring for Medicaid and uninsured patients.

One limitation of the study is that researchers didn't account for patients' diagnoses or severity of illnesses, which could influence which hospital they went to for care, the authors add. The analysis of two cities also might not reflect what happens in other communities.

The study also didn't examine the role of residential segregation or neighborhood poverty on use of academic medical centers, noted Asal Mohamadi Johnson, a public health researcher at Stetson University in Florida who wasn't involved in the study.

"In New York City, life expectancy can differ by up to 10 years between two neighborhoods that are located just six subway stops apart."

"The issue of equity and fairness is at stake here," Johnson said by email. "Academic medical centers should be held to higher levels of ethical standards in providing care for low income and minority patients."

When there are disparities in patients' access to care, academic medical centers may not offer the best possible education to new doctors, Johnson added.

"Active participation of academic medical centers in caring for non-whites and the poor prepares a more qualified and culturally competent generation of physicians and health care providers who will have more familiarity with the unique circumstances and barriers confronting these patients," Johnson said.

SOURCE: ***bit.ly/2kvPClc*** *International Journal of Health Services, online February 2, 2017.*

(*Black lives matter,* *continued from previous page)*

all Americans, removing one of the major barriers to improvement in health care for African Americans and other minorities, while helping white Americans as well. Rep. John Conyers of Michigan has repeatedly introduced Medicare for All bills in the House. It is long past time for members of both parties to unite in backing this legislation.

Jack Bernard is a retired healthcare exec and the former director of health planning for the state of Georgia. He was also on the Jasper County Board of Health and County Commission.

We condemn the AMA and AAMC endorsements of Tom Price for HHS secretary

As students and future health care professionals, we are deeply troubled by the AMA and AAMC endorsements of Rep. Price

By Janine Petito, Andrew Hyatt and Michael Zingman

Early Tuesday morning, President-elect Donald Trump announced his selection of Representative Tom Price (R-Ga.) for secretary of health and human services (HHS), to succeed Secretary Sylvia Mathews Burwell. Almost immediately, the American Medical Association (AMA) and Association of American Medical Colleges (AAMC) expressed strong support for this nomination.

As students and future health care professionals, we are deeply troubled by the AMA and AAMC endorsements of Rep. Price. The policies he has endorsed not only stand in stark contrast to our ideals, but also threaten the well-being of our patients. We question why these organizations–established to protect the interests of all physicians, students, patients, and communities–would ignore the priorities of those they represent. As HHS secretary, Dr. Price will endanger medical institutions and policies, as well as jeopardize our medical education and the very practice of evidence-based medicine.

Though Price, an orthopedic surgeon, claims to prioritize patient, family, and physician needs, his track record suggests decidedly otherwise. In 2015, as leader of the House Budget Committee, he proposed repealing the Affordable Care Act (ACA) in its entirety, privatizing Medicare, making enormous cuts to federal Medicaid funding, and abolishing the mandate that states use Medicaid dollars for patient care. These proposals would guarantee an immediate loss of health insurance for 22 million Americans; increase health care costs for the aged and disabled; and reverse recently-gained protections for vulnerable members of our society, abolishing protections of women's health, addiction, LGBTQ+, and other necessary medical services.

Despite evidence of the substantial harm his policies would inflict upon patients, Rep. Price continues to advocate for them in his fiscal plan for 2017, promising to destroy the systems already in place to protect the neediest among us and placing the health of millions of Americans at risk.

The AMA's support of Price lies in direct conflict with the organization's purported values and its mission "to promote the art and science of medicine and the betterment of public health." If the AMA is truly committed to promoting the science of medicine, it must recognize that this country cannot afford to place power in the hands of a man who opposes promising scientific breakthroughs like embryonic stem cell research. Similarly, it must ensure that the nation's HHS secretary values the truth. On the contrary, Rep. Price has demonstrated a severe lack of respect for facts, exemplified by his false claims that women have always been able to afford birth control, and that "not one" has benefited from the ACA's contraceptive mandate.

Janine Petito, Andrew Hyatt and Michael Zingman

If the AMA is truly concerned about the betterment of public health, it is frankly irresponsible to endorse a nominee who wants to decimate Medicaid–which serves more than 70 million Americans who cannot otherwise afford care–and privatize Medicare, creating narrow networks for enrollees, making seniors increasingly responsible for their health expenses, and decreasing access to needed care.

We find the AMA's paradoxical endorsement objectionable, but unsurprising. This would not be the first time the organization has acted in the interest of profits over patients; it supported the ACA only begrudgingly, and has historically blocked every effort for universal health care reform, despite evidence of the innumerable benefits that a Medicare-for-All system would afford patients and providers alike. While the AMA has failed to represent the priorities and values of its member physicians for decades, the situation at hand poses too great a danger to our nation's health for the medical community to remain silent.

The AAMC's endorsement of Price is equally, if not more disturbing, given its role in molding future physicians and its mission to "serve and lead the academic medicine community to improve the health of all." In its endorsement, the AAMC claims that Price "has long been a proponent of academic medicine." This blatantly ignores the fact that the financial solvency of most academic medical centers depends directly on Medicare and Medicaid payments, given that individuals covered by these programs comprise a large percentage of those receiving care at

(continued on next page)

these institutions. Without these programs, academic medicine as we know it would cease to exist.

If the AAMC truly wishes to "improve the health of all," it cannot reasonably justify endorsing the nomination of a man who would strip 22 million people of health insurance, who has vocally opposed expanding health benefits for children, who believes our government has no responsibility to provide coverage to transgender individuals, and who ignores substantial evidence that access to preventative screenings, contraception, and abortion services have overwhelmingly positive impacts on women's health.

We find the AMA's paradoxical endorsement objectionable, but unsurprising. This would not be the first time the organization has acted in the interest of profits over patients.

As medical students and physicians, we condemn the AMA and AAMC endorsements of Price for HHS secretary, and are disheartened by professional organizations like the American Academy of Family Physicians (AAFP) and others choosing to follow suit. Price's stances are incompatible with the values of the medical profession and with the stated missions of the above organizations. Their support reveals a warped set of priorities, with the short-term professional and financial interests of hospitals and physicians superseding the health and wellbeing of patients. We staunchly reject these endorsements and urge their immediate withdrawal.

In endorsing Price's nomination and contravening their founding principles, the AMA and AAMC have failed to represent us, the future health care providers of this country. As members and supporters of Students for a National Health Program (SNaHP), we will combat every attempt to deny Americans the health care they deserve, and will fight to create a single-payer health care system that covers every person living in this country without discrimination. If the AMA and AAMC truly believe in their own missions, we urge them to join us in this fight.

Please consider adding your name to our statement to show your support in our condemnation of the AMA, AAMC, and others who endorse the nomination of Rep. Price for secretary of health and human services.

Janine Petito is a fourth-year medical student at Boston University School of Medicine, who plans to complete residency in internal medicine and pursue a career in adult primary care. She is co-chair of the Students for a National Health Program (SNaHP) Political Advocacy Team and a Physicians for a National Health Program (PNHP) student board member.

Andrew Hyatt is a third-year medical student at Boston University School of Medicine, an active member of Students for a National Health Program (SNaHP), and co-chair of the SNaHP Political Advocacy Team.

Michael Zingman is a first-year student at Columbia College of Physicians & Surgeons and active member of Students for a National Health Program (SNaHP).

PNHP issued the following statement on Feb. 10, 2017, after Tom Price was confirmed as secretary of health and human services by a vote of 52 to 47:

The Senate's confirmation of Tom Price as health secretary is a **body blow to the health and welfare** of all Americans.

Price's vision for reforming U.S. health care would result in **millions of Americans losing their existing health insurance coverage**, and millions more having to make do with bare-bones policies that offer little to no meaningful protection.

If Price's policies come to pass, the **free-market ideologues** who supported them will no longer be able to hide behind false promises like "universal access." The results will be laid bare for everyone to see, and elected officials will have to answer to the poor, working-class, elderly, and chronically ill Americans who will suffer needlessly as a result.

Congress urgently needs to reverse course and embrace the obvious solution: **improved Medicare for all**.

- Dr. Carol Paris, PNHP President

pnhp.org

#SINGLEPAYER #CANTAFFORDPRICE

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

The Obama Years: Tepid Palliation for America's Health Scourges

President Obama inherited an economy in crisis, burgeoning inequality in wealth and health, and a legion of medically uninsured Americans whose ranks had grown by 11 million under the previous administration. He staunched the bleeding but provided no cures.

The Affordable Care Act (ACA; Pub L No. 111–148), Obama's signature achievement, covered millions, but leaves 9% uncovered. It minimally regulated insurers and imposed a modest new tax on the wealthy but accelerated the corporate takeover of health care and endorsed high-deductible insurance plans that offer illusory protection. It provided $11 billion in new funds for community health centers and public health agencies but drained money from safety-net hospitals and failed to reverse the downward trend in funding for public health.

Aside from the ACA, Obama's health record is mixed at best. He made some progress on environmental regulation, and the terrible threat of climate change has at least been acknowledged. But the yawning gap between rich and poor—in both wealth and health[1]—has widened.

THE AFFORDABLE CARE ACT

The ACA reduced the number of uninsured by 42% to 29 million, about as many as were uninsured in the early 1980s (Figure 1); even if all states expanded Medicaid, about 24 million would remain uninsured. The poor, near-poor, and minorities saw the largest gains, yet 25.8% of poor, nonelderly adults remained uninsured in 2015.

The Medicaid expansion that accounted for much of the new coverage was compromised by some states opting out entirely and by federal waivers allowing others to impose onerous out-of-pocket costs on impoverished enrollees. The ACA also expanded private coverage, but the skimpy plans endorsed by the law and sold on the exchanges (Bronze policies cover just 60% of medical costs) have encouraged the hollowing out of insurance across the board. By 2015, 51% of employer-based individual plans carried deductibles of $1000 or more, up from 27% in 2010.[2] In addition, Americans are increasingly constrained by insurers' narrow provider networks that often exclude leading referral centers, and by restrictive formularies that can make vital medications (e.g., antiretrovirals for HIV) unaffordable. On a more positive note, the ACA mandated first-dollar coverage for contraception and other preventive services and (nominal) parity for mental health and addiction treatment in exchange plans.

Access to care has improved, but remains abysmal, in part because many who gained coverage cannot afford to use it. In 2014, 66 million working-age adults skipped doctor visits, tests, or prescriptions because of costs—down from 80 million in 2012—while collection agencies dunned 37 million for medical debts, a reduction of 4 million.[3] Post-ACA, the Consumer Financial Protection Bureau reported that medical debts still account for 52% of all bills sent to collection agencies.

It is disturbing that the ACA has abetted corporate dominance in health care. The law funneled most of its trillion dollars in new federal spending through private insurers as payments for exchange coverage and Medicaid managed care plans, fortifying insurers' bottom line and political clout. Meanwhile, insurers have skirted the law's caps on overhead; Aetna's overhead actually rose from an average of 17.0% in 2008 to 2010, to 19.5% in early 2016. Taken together, insurers' added overhead and that of the new exchanges will consume 22.5% of the new federal spending.[4]

The ACA's promise to cut overpayments to Medicare Advantage plans (estimated at $1000 or more per enrollee) was also undermined, as the Centers for Medicare and Medicaid Services handed out "quality bonuses" to almost all of these private plans. In both the Medicare Advantage program and the exchanges, insurers are abandoning unprofitable local markets while continuing to reap large profits from federal payments in others, essentially cherry-picking by county. The insurance giants, awash in cash, have gone on a shopping and merger spree that will shrink the number of major insurers from five to three, unless two pending mergers are blocked on antitrust grounds.

The ACA's mandate that Medicare pay for "value not volume" through health maintenance organization–like entities called accountable care organizations has driven a wave of corporate takeovers. The move from fee-for-service to quasi-capitation has not garnered the promised savings[5] (and its health impacts remain unknown) but is driving small-scale providers from the market. They lack the financial reserves to bear risk

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REFERENCES

1. Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001–2014. *JAMA*. 2016;315(16):1750–1766.

2. The Kaiser Family Foundation and Health Research and Educational Trust. Employer health benefits 2016: summary of findings. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2016/09/employer-health-benefits-2016-summary-of-findings.pdf. Accessed September 15, 2016.

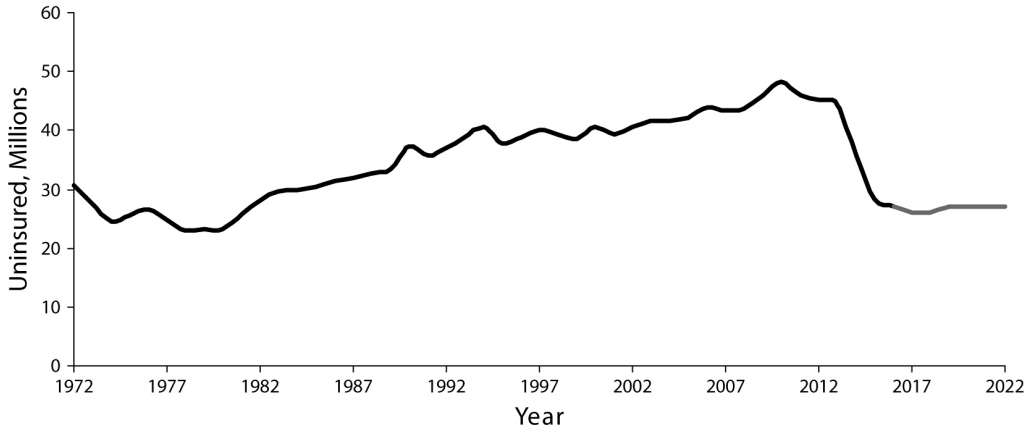
3. Collins SR, Rasmussen PW, Doty MM, Beutel S. The rise in health care coverage and affordability since health reform took effect: findings from the Commonwealth Fund Biennial Health Insurance Survey, 2014. Available at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1800_collins_biennial_survey_brief.pdf. Accessed September 15, 2016.

4. Himmelstein DU, Woolhandler S. The post-launch problem: the Affordable Care Act's persistently high administrative costs. 2015. Available at: http://healthaffairs.org/blog/2015/05/27/the-post-launch-problem-the-affordable-care-acts-persistently-high-administrative-costs. Accessed September 29, 2016.

5. Jha A. ACO winners and losers: a quick take. 2016. Available at: https://blogs.sph.harvard.edu/ashish-jha/2016/08/30/aco-winners-and-losers-a-quick-take. Accessed September 29, 2016.

6. Dickman SL, Woolhandler S, Bor J, McCormick D, Bor D, Himmelstein D. Health spending for low-, middle-, and high-income Americans, 1963–2012. *Health Aff (Millwood)*. 2016;35(7):1189–1196.

7. Newport F. Majority in US support idea of fed-funded healthcare system. Available at: http://www.gallup.com/poll/191504/majority-support-idea-fed-funded-healthcare-system.aspx. Accessed September 17, 2016.



Note. Figures for 1972–2016 are from the National Health Interview Survey, with authors' interpolations for missing years. Projections for 2017–2022 (shown in red) are from the Congressional Budget Office.

FIGURE 1—Number of Persons Younger Than 65 Years in the United States Who Were Uninsured, 1972–2016, and Projected Through 2022

for high-cost patients or to invest in the information technology and administrative systems needed to manage that risk or game the complex new payment incentives, as well as the market clout to bargain with suppliers and private payers. Giant systems have been snapping up practices and hospitals, despite compelling evidence that such takeovers raise costs (particularly when they create regionally dominant systems) and scant evidence that they improve care. The Medicare Access and CHIP Reauthorization Act of 2015 physician payment reform, which disproportionately penalizes small practices, promises to accelerate this trend.

Although some credit the ACA with slowing health care cost growth, the slowdown began in 2005, well before the law was passed, and ended in 2014 when it was fully implemented. It is disturbing that the slowdown was only seen among low- and middle-income Americans; health spending for the wealthiest 20% soared.[6]

WORSENING HEALTH INEQUALITY

In 2015, there was an almost unprecedented increase in overall US death rates, while the poorest 20% of Americans and middle-aged, non-Hispanic Whites have suffered rising mortality over the longer term. Some of this deterioration represents increasing rates of self-harm and fatal substance use, complex problems that cannot be blamed entirely on politicians. But politicians bear responsibility for the underfunding of mental health and addictions care, and for shrinking public health resources.

Congress and the president have also failed to pull policy levers—regulation, taxation, and social spending—that could ameliorate the market forces deepening the income divide and working-class despair. Between 2009 and 2015, the wealthiest 1% of Americans captured 52% of total income growth—continuing a decades-long trend—pushing the Gini index of income inequality up by 2.4%. Although median family income rose sharply in 2015 (with the poor enjoying the largest percentage gains), it remains 1.6% below the 2007 level.

In sum, inequalities in income and longevity are growing with no apparent inflection during the Obama years.

CONCLUSIONS

Could Obama have done better? Not by waging policy battles largely inside the Washington, DC, Beltway. Even during Obama's first two years in office, when the Democrats controlled Congress, the lobbying clout of insurers and pharma (generous donors to Democrats as well as Republicans) made fundamental reform unwinnable in an inside game. The compromised ACA legislation, crafted to appease these corporate interests, offered nothing to the majority of Americans dissatisfied with the health care status quo, precluding grass roots mobilization and allowing Republicans to rally opposition. It is striking that, in a 2016 Gallup poll, 51% of Americans wanted to repeal the ACA, but 58% (including 41% of Republicans) would replace it with single-payer reform[7] (findings that accord with a recent Kaiser survey).

The Sanders and Trump campaigns (and, indeed, Obama's historic 2008 victory) demonstrated the electorate's hunger for new directions. America has taken bold and difficult steps in the past: the abolition of slavery, women's suffrage, Social Security, civil rights, and marriage equality, to name a few. All were gained through powerful, persistent social movements that eventually got their message through to Washington.

Our health and health care deficits are man-made scourges, not products of nature. Curing them will require broad popular mobilizations, not just a well-intentioned president. AJPH

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Simulated ACOs vs Real-World ACOs

By Kip Sullivan, J.D.

CMS began two Medicare ACO experiments in 2012 – the Pioneer program and the Medicare Shared Savings Program (MSSP). Data on these programs available at CMS's website paints a discouraging picture of their ability to cut costs.

Here are the net savings for Medicare for each of the first four years of the Pioneer program.

- 2012: 0.2 percent
- 2013: 0.5 percent
- 2014: 0.7 percent
- 2015: 0.1 percent

Here are the net losses for the MSSP program for its first four years, presented as three "performance years"

- 2012-2013: -0.2 percent
- 2014: -0.1 percent
- 2015: -0.3 percent

But two papers published in the last two years in the Journal of the American Medical Association paint a much rosier picture. David Nyweide et al. claimed to find the Pioneer ACO program generated gross savings two times more in 2012, and slightly more in 2013, than CMS reported. Similarly, J. Michael McWilliams claimed to find the MSSP program saved money in 2014 while CMS's data says it lost money.

What explains the discrepancy?

The JAMA papers examined simulated ACO programs, not the actual Pioneer and MSSP ACO programs.

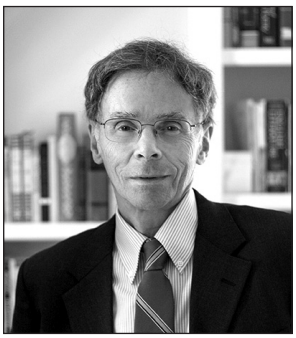
Moreover, Nyweide et al. neglected to report that shared savings payments would have greatly reduced the gross savings, and both Nyweide et al. and McWilliams ignored the start-up and maintenance costs the ACOs incurred. (JAMA's editors redeemed themselves somewhat by publishing a comment by former CMS administrator Mark McClellan which warned readers that Nyweide et al. failed to measure the "shared savings payments to the ACOs" and "the investments of time and money" made by the ACOs.)

In this essay I will describe how the simulations reported in the JAMA papers differed from the actual ACO programs, and I'll question the propriety of conflating simulated with actual results.

Results from the real world

CMS does not make it easy to determine whether its ACO programs save money. In fact, it is fair to say CMS is routinely deceptive. When CMS releases ACO data, it announces only the total savings achieved by a minority of ACOs and ignores the costs CMS incurs. But CMS does post spread sheets on its website that permit the more dogged among us to calculate net figures, that is, the savings CMS celebrates minus the losses CMS doesn't talk about.

To sum up, after four years of trying, the Pioneer ACOs cut Medicare's costs by somewhere between one- and seven-tenths of a percent annually, while the MSSP ACOs raised Medicare's costs by somewhere between one- and three-tenths of a percent annually. Note that these underwhelming results do not include the start-up and maintenance costs incurred by the ACOs nor the costs CMS incurred to administer these complex programs. Note also that these results are consistent with four decades of research on managed care experiments, including HMOs, "medical homes," "coordinated care," and the Physician Group Practice Demonstration. As Robert Laszweski put it in 2012 commenting on a CBO report on managed-care tactics, "(Almost) nothing works."



Kip Sullivan

But according to Nyweide et al., the Pioneer ACOs achieved gross savings of 4.0 percent in 2011 and 1.5 percent in 2012, above the 1.2 and 1.3 percent gross savings figures for those years according to CMS data. Similarly, McWilliams' JAMA paper found both gross and net savings for MSSP ACOs in 2014 (McWilliams found net savings of 0.7 percent) while CMS's data indicated a net loss of a tenth of a percent that year and net losses in all other years.

If at first you don't succeed, simulate

The design of the simulated versions of the Pioneer and MSSP ACO programs that Nyweide et al. and McWilliams examined varied substantially from the design of the real programs. The single most fundamental difference is the comparison group used to determine ACO spending. The real-world programs determine the performance of the ACOs by comparing the Medicare expenditures on patients "attributed" to ACO doctors in "performance years" with expenditures on patients attributed prior to the performance year. Nyweide et al. and McWilliams chose a different set of providers and patients to serve as the comparison groups: They chose providers (and their attributed patients) who had not signed up with an ACO.

Other important differences between the simulated and real ACO programs include: differences in methods used to attribute patients to doctors (for example, whether to count visits to specialists and primary care doctors or only primary care doctors, and whether to look back two years versus three years to attribute patients); and in calculating savings and losses generated by ACOs (how many years to look back to create the baseline expenditure, whether to trend the baseline forward using national or local inflation rates; and what risk-adjustment method to use to adjust the baseline and the performance year expenditures to reflect changes in patient health).

These design changes are significant. The change in attribution methods means, obviously, the experimental group of patients (those in

(continued on next page)

The News-Gazette CHAMPAIGN, ILL. OCTOBER 25, 2016

Insurance firms the true culprits

By Mark Neahring, M.D.

The News-Gazette editorial board accurately expressed the frustration of many when it critiqued President Obama's signature legislation, the Affordable Care Act.

But it got a very important point wrong. The ACA is not an "all-encompassing government-run health care program."

After insurance company lobbyists spent hundreds of millions of dollars to influence the legislation, they were able to craft a health care law that protected their own bottom line over the common good.

The premiums and deductibles of my patients are skyrocketing while these profiteers write – and change at will – the rules of the game.

According to Physicians for a National Health Program, Aetna CEO Mark Bertolini made $27.9 million in 2015 in compensation. This at the same time the insurance company is backing out of many states' health care exchanges because they not profitable enough.

Let's not scapegoat President Obama when the real villains are so sinister. Corporate greed has no place in our nation's health care system.

The best solution would be an improved "Medicare-for-all" plan, where patients have free choice of provider, complete coverage and controlled costs.

Dr. Mark Neahring resides in Dewey, Ill.

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

ACOs) was not the same experimental group tested by the real-world ACO programs. The difference in the algorithms used to calculate savings and losses means the simulated ACOs experienced different rewards and penalties from the real-world ACOs, and that, in turn should have caused doctors and hospitals in the simulated programs to behave differently from the providers in the real programs.

In short, the authors of the JAMA papers changed every important parameter. They changed the control group, the experimental group, the method for calculating how the ACOs affected costs and, with that, the size of and distribution of rewards and penalties.

Why simulate when you have real ACO programs right in front of you?

Simulations (as the word is used in science) can serve very useful purposes. Modeling or simulating an existing system under conditions that differ from real-world conditions can improve our knowledge of how the system works and suggest ways to improve it. As one expert on simulations puts it, "Another broad class of purposes to which computer simulations can be put is in telling us about how we should expect some system in the real world to behave under a particular set of circumstances."

But what justification is there for studying a simulated version of existing ACO programs – a version in which the programs are subjected to "a particular set of circumstances" that have never been applied in the real world – and declaring the results of the simulation to be the results of the real-world program? I can't think of any.

Can we learn anything from the JAMA papers?

The JAMA papers might be helpful if we could conclude that they demonstrate techniques for improving the accuracy with which CMS measure's ACO savings and losses. Well-designed simulations should help us understand how to improve existing systems. Unfortunately the papers don't do that. In fact, it's quite possible that accuracy of measurement achieved by Nyweide et al's simulation was worse than it is in the real programs.

The most important confounder in any comparison of patients is differences in patient health and income. Adjusting for these differences is commonly called "risk adjustment." The new comparison group that Nyweide et al. inserted into their simulated version made accurate risk adjustment even more essential and slightly more difficult.

That's because the method Nyweide et al. used to create their control group guaranteed that the control and experimental (ACO) patient pools would vary on at least one crucial dimension – continuity of care or, if you prefer, patient loyalty.

Nyweide et al.'s method of assigning patients to the control group was to first select out from all Medicare patients in a given region those who "belong" to doctors in ACOs. They determined "belongingness" by assessing where patients generated a plurality of their primary care visits. All patients who didn't make the cut – who didn't get assigned to an ACO doctor by the plurality method – got thrown back into the pool of "control" patients.

By definition, then, the comparison group in Nyweide et al's simulation consisted of less loyal patients – patients who have less continuity of care than ACO patients. We don't need to know which way the causality runs – healthier patients lead to greater continuity, or continuity leads to healthier patients – to know that this method of creating a control group only makes accurate risk adjustment more important.

Yet despite decades of trying, neither CMS nor anyone else has come up with a risk adjuster that is remotely accurate. The fact that Nyweide et al. reported declines in utilization in every single category of medical service, including primary care, for the ACOs is circumstantial evidence that the ACOs got healthier patients and that Nyweide et al. were unable to adjust their expenditure data accurately.

We cannot conclude, therefore, that the simulations taught CMS or the rest of us anything useful about how to improve the measurement of ACO performance. All we can say with certainty is (a) Nyweide et al. and McWilliams presented no evidence for claiming their method of measuring ACO performance is superior to the method CMS has been using, and (b) they badly misled their readers by claiming the positive results their simulated ACOs achieved should be viewed as results of the real-world ACOs.

Kip Sullivan, J.D., is a member of PNHP Minnesota's legislative committee. Full article and references may be found at ***thehealthcareblog.com****.*

JACOBIN

FEBRUARY 15, 2017

Obamacare's original sin

We can resist Republican efforts to repeal Obamacare without providing cover for the law's deep ideological flaws

By Adam Gaffney, M.D.

Republicans are struggling to find the proper pitch for their attack on the Affordable Care Act (ACA). "Repeal and replace" – the tried and true formulation – may be mutating into something mellower, albeit more vacuous. "Americans want the ACA repealed and repaired," Republican strategist Frank Luntz recently told the Associated Press, using the new nomenclature.

Should this right-wing retreat – or rather, recalibration – be construed as a victory, however minor? Probably not, for two reasons. First, whatever the tweak in marketing, the crux of the matter hasn't changed: Republicans seem poised to engineer an enormous increase in uninsurance in the coming years (at the cost of countless lives). And second, "repeal and repair" will double down on the worst elements of the status quo. Whatever term they use, Republicans never intended to remove the central pillar of the US health care system (and the ACA): private health insurance.

As two of my colleagues, David Himmelstein and Steffie Woolhandler, put it shortly after Trump's election:

> *We suspect that the [Republican's] likeliest replacement [for the ACA] is a meaner (and rebranded) facsimile of the ACA that retains its main structural element – using tax dollars to subsidize private insurance – while imposing new burdens on the poor and sick.*

The 2016 health care reform framework of Paul Ryan and the House Republicans, for instance, would provide tax credits to help individuals and families purchase private plans "through multiple portals, including private exchanges." Ryan's tax credit scheme amounts to a more regressive version of the ACA's subsidies for plans bought on the "marketplace" (also known as "exchange" or "Obamacare" plans).

In other words, we should expect the looming GOP health care overhaul to be more right-wing regression than reactionary revolution. This relative continuity highlights an important point: one of the ACA's key mechanisms for moving us toward universal health care – publicly subsidized, privately sold "marketplace" plans – was never going to achieve its goal.

Millions now rely on these plans, and we should defend them until we can win something better. But we also shouldn't entertain any illusions: the ACA marketplaces rest on a flawed health care ideology that tellingly attracts many adherents on the Right, including Ryan. What are the roots of this ideology – sometimes known as "managed competition" – and how can we move beyond it?

The origins of managed competition

In 1971, a physician named Paul Ellwood coauthored a hugely influential proposal called the "health maintenance strategy." Formulated at a time when a national health insurance program seemed just around the corner, Ellwood and his colleagues framed their program as a pro-market alternative.

Under the plan – unlike the bold 1971 national health insurance proposal of liberal senator Ted Kennedy or the even more radical program of democratic socialist congressman Ron Dellums – "the consumer would be able to purchase health maintenance services from a variety of competing organizations." Nixon latched on to the proposal, while the momentum behind national health care reform dissipated, at least until the Carter administration.

Yet Carter – and after him, Bill Clinton and Barack Obama – never returned to the national health insurance proposals of the early 1970s. Instead, Democrats increasingly turned to remedies rooted in managed competition.

In 1978, Alain Enthoven published a reworked vision of this approach (which he initially drafted for the Carter administration) in two papers in the "New England Journal of Medicine." Calling his new iteration the "consumer-choice health plan," Enthoven explained that the proposal "seeks to give the consumer a choice from among alternative systems for organizing and financing care, and to allow him to benefit from his economizing choice." He saw the private health industry as the critical player: the consumer-choice health plan, Enthoven wrote in the final words of the paper, "offers private health insurers continued existence and a meaningful role."

Over time, Enthoven's model of health care reform (along with other often conservative ideas like the individual mandate) found a central place in prominent Democratic Party health policy proposals. (Sociologist Howard Waitzkin has argued that Enthoven's managed care approach gained purchase not only in the US, but throughout the world.)

By the time Barack Obama took up the charge for health care reform, most Democrats had given up on the idea of public national health insurance. The final bill Obama signed reflected the shift in policy remedies – particularly the ACA marketplaces. As Enthoven himself noted in 2014, the ACA "exchanges drew on the MC [managed competition] idea, with cost-conscious individual choice of plan" (though, as he added, this was only "for a small part of the population").

Although the marketplaces differ in important ways from what

Enthoven and others had in mind, they share a common assumption: that the best system is one in which consumers shop for the private health insurance plan that best suits their individual needs. The resulting competition among plans, Enthoven and others argue, will keep down costs and improve access.

Despite Republicans' bluster about the horrors of the ACA, they share the same basic philosophy. They too want insurance exchanges – just more meager and more privatized ones.

Marketplace dreams

It's easy today to forget what grandiose hopes the ACA's architects had for the law's marketplaces. Ezekiel Emanuel – President Obama's special adviser on health care reform during the years the ACA was written – was among those who thought the marketplaces could refashion the whole of American health care.

In his 2014 book Reinventing American Healthcare (lauded by Lawrence Summers as the "definitive primer on health care in America"), Emanuel predicted:

> *[O]nce the websites are fixed and working smoothly – certainly by 2016 – the exchanges will generate positive branding . . . That means the websites need to provide an engaging, "Amazon-like" shopping experience . . . By 2016 the insurance exchanges will provide an attractive, informative, and engaging insurance shopping experience with an adequate variety of choices.*

But Emanuel foresaw (and hoped for) much more. Gradually, employers would stop providing insurance, and workers would increasingly gravitate toward (or, more precisely, get dumped onto) the marketplaces. It would start with millenials:

> *Younger workers who have little experience and expectation of getting health insurance from their employer and are used to shopping for books, music, shoes, clothes, smartphones, and cars on the web will probably be most amenable to now getting their health insurance on the web as well.*

As for older, perhaps less web-savvy, workers, Emanuel acknowledged that they might resist the new zeitgeist. In that case, they'd have to be "socialize[d]...on how exchanges work" through the use of "private exchanges."

A broader "cultural" reorientation would also have to occur: "Companies will have to be convinced that they can still be viewed as good employers even if they do not offer health insurance," Emanuel wrote. He predicted that big private companies would be the first to see the light and stop offering insurance, while the public sector would stubbornly fight the marketplace road since "unions are very conservative on health coverage." (Emanuel, to be fair, also envisioned workers receiving wage increases in exchange for the lost health benefits.)

Finally, over time, employer-provided health insurance would morph into "a voucher system" in which "[i]ndividuals rather than employers will be choosing from a variety of health insurance options in a marketplace...[W]ith the voucher, the consumers will have a strong incentive to be frugal in their purchase of insurance."

Emanuel's consumer-friendly future hasn't come to pass. Far from overtaking the employer market, marketplace enrollment has consistently fallen below expectations. And dysfunctions in the marketplaces, while exaggerated by the Right, have been by no means imaginary.

Last year, for instance, two big insurers, Aetna and UnitedHealth, announced they would withdraw from the majority of marketplaces where they sold plans. And in October, just before the 2017 open enrollment period began, the White House admitted that premiums for many Obamacare plans would see significant increases – 22 percent, on average.

Obamacare's foibles

The most obvious problem with the marketplace plans is that they fail too many individuals – even if they offer more protections (and are more affordable, with subsidies) than the individual plans they succeeded.

Consider the cost-sharing burden (i.e. out-of-pocket costs after premiums) that marketplace plans place on enrollees. Here are the 2017 estimates from the firm Health Pocket for average deductibles and out-of-pocket maximums (the most an enrollee forks over annually for health services after they pay their premium):

Metallic Tier	Annual Deductible (family plan)	Annual Out-of-pocket maximum (family plan)
Bronze	$12,393	$13,810
Silver	$7,474	$12,952
Gold	$2,745	$10,168
Platinum	$809	$4,318

Although subsidies reduce the financial burden for those earning less than 250 percent of the federal poverty level, cost-sharing still remains onerous for many individuals and families. This allows Republicans to cynically score points, criticizing sky-high deductibles while simultaneously embracing "consumer-driven" high-deductible health plans that will almost certainly make the problem worse.

But the shortcomings of the marketplace model go beyond issues of cost.

For proponents, the beauty of managed competition is that it allows consumers to avoid premium increases by simply shopping for a new plan. In some cases, it works out this way: companies compete, and consumers avert skyrocketing premiums. But even in the best-case scenario, it is a preposterous way to manage health care costs. Take, for instance, the individuals and families who need several doctors or require care from particular hospitals. Changing plans annually can mean having to abruptly sever all provider relationships and make appointments with an entirely new panel of doctors every year. Such discontinuity of care is not just massively inconvenient – it can also be positively dangerous.

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THE HUFFINGTON POST NOVEMBER 16, 2016

Health reform in the Trump era

A big step back, but possibilities for bigger steps forward

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

The 2016 election turned on racism, xenophobia and anger at the status quo, including the Affordable Care Act (ACA). The law covered about 20 million, and modestly improved access to care. But it didn't address the health care problems facing most working families, feeding the perception that the Democratic Party had neglected them. Trump seized on the ACA as a symbol of the establishment's false promises, and has placed repeal at the top of his to do list.

There are many indicators of what Trump has in mind to replace the ACA, but they're pointing in different directions. We suspect that the likeliest replacement is a meaner (and rebranded) facsimile of the ACA that retains its main structural element – using tax dollars to subsidize private insurance – while imposing new burdens on the poor and sick.

For Republicans, the ACA poses a difficult dilemma. Its model was conceived by Richard Nixon's henchmen in 1971, celebrated and elaborated by the Heritage Foundation in 1989, and first implemented by Mitt Romney in 2006. Obama's version, like these earlier ones, called for sliding-scale public subsidies to help low-income individuals purchase private coverage through insurance exchanges, along with a mandate that individuals (and sometimes employers) buy coverage. For the poor, Obama (like

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(*Obamacare's original sin,* *continued from previous page)*

The point is not that the ACA has made things worse. On the contrary – it's expanded health insurance to an estimated 20 million people, and improved coverage for many more. One recent survey found that the number of non-elderly adults who had problems getting health care because of financial reasons fell from a whopping 80 million in 2012 to (a still whopping) 63 million in 2016. (The number of people paying off medical debt, however, has not really budged.)

But if the gains of the ACA are real, its failures are also considerable. And those failures are due in large part to the managed competition model baked into the law.

The egalitarian alternative

Some might argue that this is an inopportune time to criticize the ACA. The law – it is no doubt true – is under existential threat, and its repeal would wrest health coverage away from millions. And with Donald Trump in the White House and the GOP in control of Congress, single-payer is quite unlikely to pass in the near future.

Still, if we hitch our wagon to the managed competition vision – even out of expediency – we may doom our chances of achieving an egalitarian health system in the future. We must oppose the repeal of the ACA at the same time we reject the fundamentally conservative model of health reform at its foundation.

Doing otherwise could give ammunition to the conservatives and neoliberals who seek to buttress the private insurance system, and who long to privatize Medicare.

Ryan's plan, for instance, endorses an expanded "space for innovative purchasing platforms, like private exchanges." It also proposes setting up a new public exchange where seniors could shop for private plans that would compete against traditional Medicare. Ryan's Medicare Exchange closely resembles the ACA marketplaces – managed competition with public subsidization (and in the case of the former, a public option).

And it's entirely in line with Enthoven's health reform vision. In 2014, Enthoven expressed optimism that the "entrepreneurial private sector" could burnish the reputation of managed competition through private exchanges, like those promoted by Ryan and company. He held out hope that what he called the "last holdout" – Medicare – might "follow the lead of the private sector," and embrace managed competition. This is anathema to any egalitarian health agenda.

Medicare – despite its real and likely growing flaws (in part due to ongoing privatization) – operates according to a principle altogether different from managed competition. Whereas Ryan and Enthoven preach the alchemical power of the market, traditional Medicare rejects market prerogatives altogether and guarantees health insurance as a universal social right.

Going forward, the Left will have to do battle on two fronts to advance the latter principle: first, defend current (albeit flawed) forms of health care coverage from right-wing attacks; and second, march forward with our own vision of real universal health care, not conceding an inch to the tired nostrums of managed competition.

A kinder, more beneficent health care system lies on the horizon. Single-payer or bust.

Adam Gaffney is an instructor in medicine at Harvard Medical School, a pulmonary and critical care doctor at the Cambridge Health Alliance, and a national board member of Physicians for a National Health Program. He blogs at ***theprogressivephysician.org****.*

Nixon) relied on expanding Medicaid, but almost all of the ACA's new Medicaid coverage was channeled through private Medicaid-managed-care insurers. And Obama added progressive elements to the Republican formula, e.g. requiring insurers to cover essential benefits (notably contraception and preventive care) and a new "Medicare" tax on some investment income.

Drs. Steffie Woolhandler and David Himmelstein

Will Republicans reclaim their health care heritage after years spent rabidly attacking its Obamacare variant? Paul Ryan's recent pronouncements (and the abiding interests of powerful insurance, drug and hospital firms) suggest that they will. Ryan would rebrand the Obamacare premium "subsidies" as "tax credits," but make them available to anyone who lacks employer-paid coverage, including the wealthy. In essence, he'd shift some of the subsidy money up the income scale and undermine employer-based coverage. He'd maintain (at least for the time being) Obamacare's boost to Medicaid funding, but let states cut Medicaid coverage and divert the funds to other uses. And he'd hasten the privatization of Medicare, which has already been proceeding apace.

If there's a brighter side to this dark picture, it's that Trump and his allies will reclaim ownership of the Nixon/Heritage/Romney/ACA model. This shift seems likely to unmuzzle single-payer supporters who closeted themselves during the ACA era, fearful that calls for more radical reform would fan right-wing attacks. Already Elizabeth Warren, previously reluctant to criticize the ACA, has been liberated: "Let's be honest: [The ACA's] not bold. It's not transformative. … I'm OK taking half a loaf if our message was 'Here's half, now let's go get the rest.'"

If there's a brighter side to this dark picture, it's that Trump and his allies will reclaim ownership of the Nixon/Heritage/Romney/ACA model. This shift seems likely to unmuzzle single-payer supporters who closeted themselves during the ACA era.

A similar strategic perspective motivated PNHP's founding at a conference of clinicians caring for the poor. After years spent parrying Reagan's assaults on Medicaid and community clinics, we concluded that a defensive stance was untenable. The U.S. health care system, even with Medicaid intact, prioritized corporate greed over patients' needs, and was politically indefensible. It wasn't possible to fix health care for the poor without fixing it for everyone.

That conclusion holds today. For the working class, incomes have stagnated and out-of-pocket costs have soared. For whites without a college education, death rates are rising, driven by diseases of despair like suicide and substance use. Trump spoke (disingenuously) to that despair; Clinton failed to. The resonance of Bernie Sanders' single-payer message is backed up by polls that show three-fifths of Americans – including a majority of those who want the ACA repealed, and 41 percent of Republicans – favor a "federally funded healthcare program providing insurance for all Americans."

In health care, reform must address the pressing problems of the majority who have private coverage and Medicare, as well as those who are uninsured or on Medicaid. Only single payer can do that.

A few suggestions for work in the months ahead:

1. Colleagues are, more than ever, receptive to the single-payer message. Let's talk about it in corridors, conferences, lecture halls and national meetings; use Facebook, Twitter, email and snail mail to recruit new PNHP members; and push journal editors to end their virtual blackout on single payer.

2. With Medicaid under attack, in many states we'll need to join in its defense. But we must simultaneously declare that this halfway measure is no substitute for real reform. Let's not repeat the error of ACA backers who tried to convince people that their health care problems had been solved. Similarly, defense of Medicare should not paper over that program's flaws.

3. We need to help focus the anger at elites onto the real health care elites: insurance and drug firms, and corporate health care providers.

4. In the past PNHP has focused narrowly on single-payer reform, avoiding participation in most broad-based coalitions. We should reconsider that stance in the context of the broad opposition to the Trump regime, and the urgency of threats to our communities. Effective action will require coalitions that span many issues. We should participate in those that include a demand for single payer.

5. It's time to ramp up organizing for H.R. 676. Politicians can no longer seek refuge in the fiction that health reform is a "done deal" and is working. While work for state-based reforms can provide a useful organizing tool, it cannot address the nation's most acute health care problems, which are concentrated in states with little hope of local legislation.

Drs. Woolhandler and Himmelstein are professors of health policy and management at the City University of New York School of Public Health at Hunter College and lecturers in medicine at Harvard Medical School. They co-founded Physicians for a National Health Program.

Vox

JANUARY 25, 2017

Paying doctors bonuses for better health outcomes makes sense in theory. But it doesn't work.

It can even lead doctors to shun treating the sickest patients

By Stephen B. Soumerai and Ross Koppel

For decades, the costs of health care in America have escalated without comparable improvements in quality. This is the central paradox of the American system, in which costs outstrip those everywhere else in the developed world, even though health outcomes are rarely better, and often worse.

In an effort to introduce more powerful incentives for improving care, recent federal and private policies have turned to a "pay-for-performance" model: Physicians get bonuses for meeting certain "quality of care standards." These can range from demonstrating that they have done procedures that ought to be part of a thorough physical (taking blood pressure) to producing a positive health outcome (a performance target like lower cholesterol, for instance).

Economists argue that such financial incentives motivate physicians to improve their performance and increase their incomes. In theory, that should improve patient outcomes. But in practice, pay-for-performance simply doesn't work. Even worse, the best evidence reveals that giving doctors extra cash to do what they are trained to do can backfire in ways that harm patients' health.

The stakes are high. Britain, with a much different health system – single payer – has embraced pay-for-performance in a big way, spending well over $12 billion on such programs in 12 years. And pay for performance is a feature of virtually every major health program in the US.

While cost estimates are scarce, regulations intended to incentivize doctors for quality and efficiency cost physicians more than $15 billion just for documenting their actions. In yet another assault on common sense, Congress passed an enhanced pay-for-performance law ("MACRA") that went live January 1.

Blame for the wasteful embrace of pay-for-performance measures can be directed to at least two sources: First, an overreliance on economic theory in the absence of empirical testing. (*Of course*, performance will get better if you pay people for outcomes, an Econ 101 student might say.) Second, numerous studies have purported to show that health outcomes improve when doctors' pay is pegged to performance outcome – yet these studies have fatal flaws.

Many such studies suffer from what's known as "history bias." That is, they tend to treat any positive health trend after the introduction of performance pay as the result of that payment system. But it's often the case that the positive trend predates the introduction of the treatment.

The failure of pay for performance has been demonstrated repeatedly in scientific studies. In a recent article in the CDC's "Preventing Chronic Disease," we showed that much of the early research on the supposed success of pay for performance was conducted with serious research design flaws. For example, in the UK, effective treatment of high blood pressure has been increasing for years – well before pay-for-performance measures designed to improve blood-pressure treatment had begun. Doctors had both been getting better at identifying patients with high blood pressure and drug treatment regimens had been improving. But the early research inappropriately credited pay for performance with all the improvements that followed its introduction.

Consider the following graph, from a major study evaluating the United Kingdom's pay-for-performance policy where diabetes is concerned. It purported to find a major positive effect. The red dashed line shows where the rewards program began:

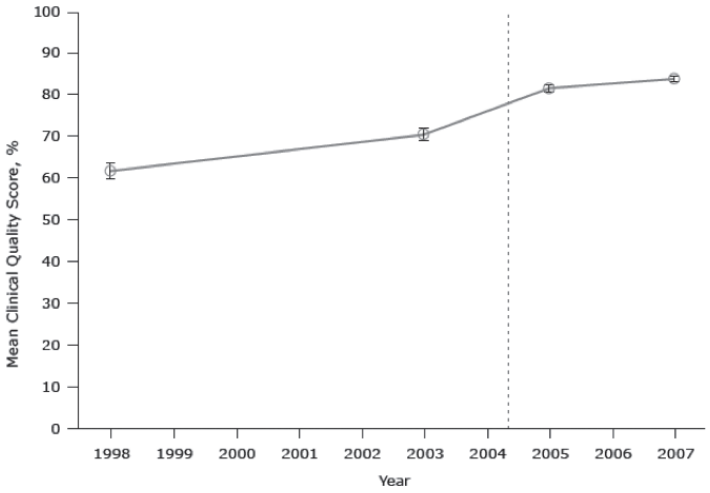


Figure 1. Mean clinical quality scores for diabetes treatment at 42 practices participating in a study evaluating pay-for-performance in the UK. The scale for scores ranges from 0 percent (no quality indicator was met) to 100 percent (all quality indicators were met for all patients). Campbell SM, Reeves D, Kontopantelis E, Sibbald B, Roland M. Effects of pay for performance on the quality of primary care in England. N Engl J Med 2009;361(4):368–78.

The key problem here is that the researchers use only two data points during the long period before the program was implemented, and two data points afterward. If anything, it

appears that the improvements – to the extent any are detectable by examining only two data points – may have grown less quickly after implementation of pay-for-performance. We also don't know if any small improvements resulted from pay-for-performance or from some other changes in physicians' practice.

The next figure illustrates a result of one of the most convincingly negative studies of the UK's pay-for-performance policy. In this case, the treatment question involved patients with hypertension. Using a strong long-term research design and seven years of monthly data for 400,000 patients before and after the program's implementation (84 time points), the study showed that the pay-for-performance program was introduced in the middle of a slight rise in the percentage of patients who began blood pressure treatment.

It seems clear from the trend line that pay for performance did not cause the rise:

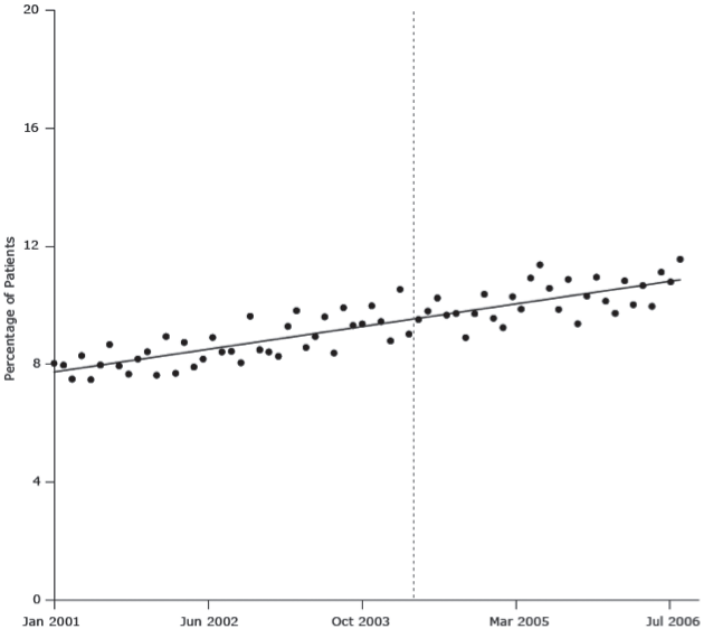


Figure 2. Percentage of study patients who began antihypertensive drug treatment from January 2001 through July 2006. The dashed line indicates when the UK's pay-for-performance policy was implemented (April 2004). Serumaga, Ross-Degnan, Avery, Elliott, Majumdar, Zhang, et al. Effect of pay for performance on the management and outcomes of hypertension in the United Kingdom. BMJ 2011.

This is a big deal: a $12 billion program that links doctors' incomes to measures of health-care quality had no effect.

The strongest design for evaluating policies is a randomized controlled trial (RCT). In such study designs, random allocation of participants into intervention and control groups increases the likelihood that the only difference between the groups is the pay-for-performance intervention. In a recent RCT, physicians in the pay-for-performance condition were eligible to receive up to $1,024 whenever a patient met target cholesterol levels. Physicians in the control groups received no economic incentives to hit those targets.

There was no real difference in improvements between the two groups:

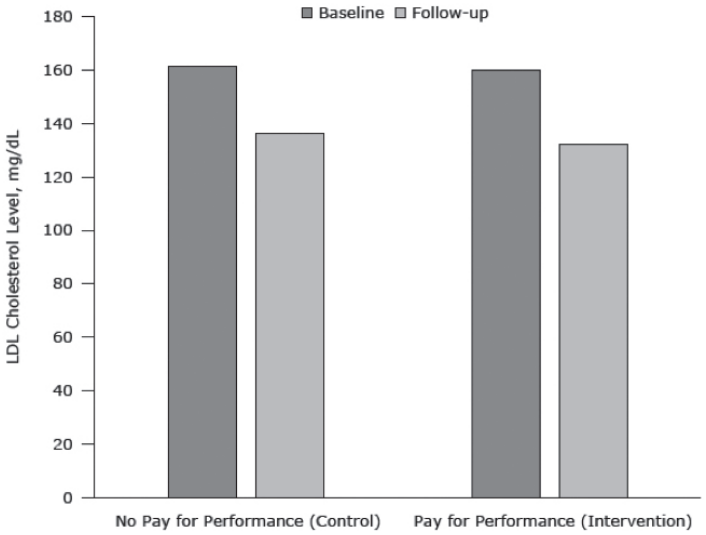


Figure 3. Mean LDL cholesterol levels at baseline and 12-month follow-up in an intervention (pay-for-performance) group and a control group (no pay-for-performance). The difference between the 2 groups was neither statistically significant nor clinically meaningful. Figure is based on data from Asch, Troxel, Stewart, Sequist, Jones, Hirsch, et al. Effect of financial incentives to physicians, patients, or both on lipid levels. JAMA 2015.

No study is perfect, and it's unlikely that a single study can determine the truth. But when you single out the most rigorous systematic reviews, empirical support for pay for performance evaporates.

Why doesn't pay for performance work?

There are a few reasons why performance incentives fail. They reward doctors for things they already do, like prescribing antihypertensive drugs. What's more, the programs often use lousy, unreliable quality measures: For example, they might penalize doctors for not prescribing antibiotics to patients who are allergic to them.

More troubling, there is evidence that such policies may even harm patients by encouraging unethical practice. One international systematic review found – in addition to no positive effects – that pay-for-performance programs had the unintended consequence of discouraging doctors from treating the sickest and most costly patients; there's an incentive to cherry-pick the healthiest, active, and wealthy patients.

Health professionals do not respond to economic carrots and sticks like rats in mazes. As the leading health care economist Uwe Reinhardt said, "The idea that everyone's professionalism and everyone's good will has to be bought with tips is bizarre."

Some health policy experts, like Harvard public health professor Ashish Jha, have argued that the awards in pay-for-performance programs simply ought to be increased: "Make the incentives big enough, and you'll see change," he has said. But there's no evidence that the program has failed because doctors aren't being paid enough. A pay-for-performance program in the UK paid an extra $40,000 per year on average to family doctors, but it still failed to improve care.

The pattern goes deeper than flawed study design and quality measures. Policymakers too often show unbridled confidence in economic theories and models that are unsupported by evi-

(continued on next page)

Los Angeles Times

FEBRUARY 3, 2017

Looking for a really good Obamacare replacement? Here it is

By David Lazarus

Supporters of healthcare reform may feel disheartened as President Trump and Republican lawmakers prepare to repeal the Affordable Care Act and replace it with … well, something. They can't even agree among themselves on what the U.S. healthcare system should look like.

But there's reason for hope, albeit a long shot.

OK, a very long shot.

Rep. John Conyers Jr. (D-Mich.) has introduced a bill that would expand Medicare to "provide for comprehensive health insurance coverage for all United States residents."

In other words, it would build on the successful single-payer insurance program that already covers more than 55 million people and bring the United States in line with almost all other developed nations in providing taxpayer-funded health coverage for everyone.

Needless to say, the legislation – HR 676 – has no chance of passage by the Republican-controlled Congress.

However, the fact that such a bill exists serves as a reminder that there are some in positions of power who understand the pitfalls of the U.S.'s private-sector-dominated health insurance system, and who are willing to place national interest ahead of corporate profits.

Also, some backers of the legislation think there's at least one prominent Republican who might come around to their way of thinking.

(continued on next page)

(*Pay for performance,* *continued from previous page)*

dence. Health economists aim to predict how doctors will respond to incentives, but without understanding the complex pressures they face that shape behavior – including high patient loads, incomprehensible insurance rules, increasing time demands for more and more regulatory requirements, duplicative or conflicting regulations, and documentation of often unnecessary clinical data in different and noncommunicating electronic medical records systems.

Health professionals do not respond to economic carrots and sticks like rats in mazes. As the leading health care economist Uwe Reinhardt said, "The idea that everyone's professionalism and everyone's good will has to be bought with tips is bizarre."

In April 2015, ignorant of decades of research, a bipartisan Congress passed a huge new law ("MACRA") that will tie even more funding to these questionable "quality scores" beginning this month – even amid the tumult of the Obamacare debate. The government's MACRA rules took up almost 2,400 pages of text, and physicians are already balking at the additional paperwork and screen time.

Under MACRA, doctors who opt into pay for performance are allowed to themselves choose, out of many possibilities, the six criteria on which their performance will be judged by the Centers for Medicare and Medicaid Services (CMS). Letting doctors choose their own criteria clearly lets doctors game the system for extra income, and it seems unlikely to provide any useful data – especially with almost every doctor choosing a different mix of standards.

We can do better. Researchers, policymakers, and journalists have a responsibility to understand the crucial role of robust research design. Academic journals should adopt the same research design standards used by Cochrane, the leading international medical research organization that conducts reviews of medical evidence. Cochrane weeds out the weakest studies.

Instead of a punitive incentive-and-penalty approach, policymakers should try to identify the reasons for poor performance. In contrast to numbers that can be gamed, doctors and nurses want concrete information they can use to improve care and save money. One of the most celebrated successes in American medicine involved the use of doctors, nurses, and pharmacists to counsel frail elderly people being discharged from hospitals and follow them at home to help them take their drugs and stay healthy. This program avoided costly and painful readmissions to the hospital.

We also must rethink the role of abstract economic theory and dubious economic models in policymaking. While much of human activity can be attributed to simple financial incentives, not all can nor should be. This is not just an academic argument. America spends more on medical care than any other nation but gets second-rate results. We need better research and more realistic theory to guide our massive investments in health care.

Stephen Soumerai is professor of population medicine and research methods at Harvard Medical School and the Harvard Pilgrim Health Care Institute. Ross Koppel teaches research methods and statistics in the sociology department at the University of Pennsylvania, conducts research on health care IT, and is a senior fellow at the Wharton School's Leonard Davis Institute of Health Economics.

Taking 20 million people out of Obamacare is going to help our cause. We've got all the arguments on our side. – Rep. John Conyers Jr. (D-Mich.)

"Donald Trump is a businessman, not a lifetime politician," said Dr. Carol Paris, head of Physicians for a National Health Program, which represents 20,000 doctors who support creation of a U.S. single-payer insurance system. "HR 676 is a formula for good business. It makes good business sense."

She'll get no argument from me. A 2014 study by the Commonwealth Fund compared the U.S. healthcare system to those of 10 other developed countries, including Canada, Germany, France and Britain.

It found that the United States had by far the most expensive system in the world but trailed its peers in delivering bang for its healthcare bucks.

Administrative costs – paperwork, incompatible computer systems, interactions between doctors, hospitals and hundreds of insurers – eat up about 25 percent of U.S. healthcare spending.

Meanwhile, at an average of more than $10,000 per person, the United States pays more for healthcare annually than any other developed country without any significant improvement in outcome, such as longer life expectancy. The typical American can expect to live to 79, whereas citizens of other developed nations will live past 80, according to the Organization for Economic Cooperation and Development.

"International experience shows that single-payer financing systems, like the one described in Rep. Conyers' bill, are the fairest and most cost-effective way to assure that everyone gets high-quality care," Paris said.

Conyers, however, isn't holding his breath.

He told me he doesn't think Trump – whom he described as "erratic" – will suddenly embrace the common-sense advantages of Medicare for all. Nor does he think House Republicans will be flexible in their thinking.

"This is not something that they're going to buy into," Conyers said, "even though countries with universal healthcare find that it costs less and is healthier for people. We're just too polarized right now."

"International experience shows that single-payer financing systems, like the one described in Rep. Conyers' bill, are the fairest and most cost-effective way to assure that everyone gets high-quality care."

Nevertheless, he said he's optimistic about the future. Conyers expects the Republicans' replacement of Obamacare to be so troublesome that the public will grow increasingly receptive to new ideas. This will allow a case to be made for Medicare expansion.

"Taking 20 million people out of Obamacare is going to help our cause," he said. "We've got all the arguments on our side."

His bill already has 51 co-sponsors, including California's Judy Chu, Mark DeSaulnier, John Garamendi, Jared Huffman, Barbara Lee, Ted Lieu, Zoe Lofgren, Grace Napolitano, Lucille Roybal-Allard and Mark Takano. No Republicans have signed on.

David Lazarus

Under HR 676, "all individuals residing in the United States (including any territory of the United States) are covered under the Medicare For All Program, entitling them to a universal, best quality standard of care."

The bill would cover primary care, emergency care, prescription drugs, medical equipment, long-term care, mental health services, dental services, chiropractic services, basic vision care and other healthcare needs.

And try this on for size: "No deductibles, copayments, coinsurance or other cost-sharing shall be imposed with respect to covered benefits." Instead, funding would be made primarily through payroll taxes, as is already the case with Medicare and Social Security.

A 2013 analysis of an earlier version of Conyers' legislation by Gerald Friedman, a healthcare economist at the University of Massachusetts Amherst, found that progressive federal tax payments "would cost less for 95 percent of households" than the current system of deductibles, premiums and copayments.

He also concluded that because of huge administrative savings and greater negotiating strength with hospitals, doctors and drug companies, a Medicare-for-all system "would make it possible to provide universal coverage and comprehensive benefits to future generations."

This isn't "socialism" and it isn't "government-run healthcare." Doctors would still be free to practice medicine as they see fit.

It's simply a more effective and efficient way of managing healthcare risk for the entire population.

Private health insurers would battle ferociously to prevent such a change, but they wouldn't be put out of business. Rather than providing total coverage, they'd simply shift to offering supplemental plans, as they already do. A more competitive market for added coverage would only benefit Americans.

It's widely believed that Republican replacements for the Affordable Care Act will include health savings accounts coupled with high-deductible plans from private insurers, as well as high-risk pools for people with pre-existing conditions that all but guarantee limited coverage and sky-high premiums.

Think about that. Now think about the broad coverage featured in Conyers' bill being available for less than what you pay now.

Think about having the same coverage regardless of your job (or lack thereof). Think about the number of people without insurance dropping to zero.

Think about Americans finally enjoying the same healthcare benefits as the rest of the developed world.

What's not to like?

David Lazarus is an award-winning business columnist for the Los Angeles Times, focusing on consumer affairs.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

JANUARY 23, 2017

The Affordable Care Act helped chronically ill Americans, but many still can't get the care they need

5 percent of Americans with heart disease, cancer and other conditions gained coverage, but twice as many still lacked insurance after the ACA's implementation: new Harvard study

The Affordable Care Act (ACA) provided insurance coverage and improved access to medical care for Americans with chronic diseases, but a year after the law took full effect, many remained without coverage and faced significant barriers to getting regular medical care, according to a new study published today [Monday] in the Annals of Internal Medicine by researchers at Harvard Medical School.

The study is the first to document the effect of the law on Americans with chronic illnesses, who have higher health care needs and face significant health consequences when they lack coverage. The researchers estimated that 4.9 percent of those with chronic diseases such as cancer, heart disease and asthma gained insurance coverage in the first year of the ACA's major reforms. Gains were greater in states that opted to implement the ACA's expansion of Medicaid coverage to low-income residents. The study also found that racial and ethnic disparities in coverage were narrowed under the ACA.

However, despite the gains nearly 1 in 7 of those with a chronic disease still lacked coverage after the ACA, including nearly 1 in 5 chronically ill Blacks and 1 in 3 chronically ill Hispanics.

"Patients with chronic diseases need to get regular medical care and take medications daily to prevent serious complications," said study author Dr. Elisabeth Poorman, a primary care physician at the Cambridge Health Alliance (CHA). "For the millions with a chronic disease that got coverage under the ACA, it is a big deal. But it is really unfortunate that so many chronically ill Americans remain uncovered despite the ACA."

The new study analyzed nationally representative data on 606,277 adults aged 18 to 64 years with diseases such as asthma, chronic obstructive pulmonary disease (COPD), or a history of heart attack, stroke, chronic kidney disease, cancer, or arthritis in 2013, the year before the ACA's major reforms were implemented, and in 2014, the first year after the reforms. The study found that coverage for this group increased the most in states that expanded Medicaid, from 83 percent to 89 percent. In states that declined to expand Medicaid under the ACA, coverage increased more modestly, from 77 percent to 81 percent. After the ACA's full implementation in 2014, the percentage of chronically ill people with insurance ranged from a high of 95 percent in Massachusetts to a low of 74 percent in Texas. West Virginia saw the biggest coverage gain, a 12 percent increase.

"Our finding that insurance coverage increased more in states that opted to expand Medicaid, and the fact that coverage rates were already lowest in non-expansion states before the ACA, highlights the importance of the Medicaid expansion for the chronically ill," said the study's lead author, Dr. Hugo Torres, also a physician at CHA.

In addition to increases in coverage, the study found that Americans with chronic diseases were less likely after the ACA to forgo a doctor visit due to cost, and were more likely to have a check-up in the last year. The study found no increase in how many of the chronically ill had a primary care physician.

The study examined only the first year after implementation of the ACA, 2014, and the authors point out that additional small improvements in coverage and access to care examined in the study may have occurred in 2015 and 2016.

The study comes at a time when the new administration and Republican leaders in Congress are poised to repeal the ACA, but have not announced plans for its replacement.

"Repealing the ACA without an equivalent replacement would strip coverage from millions of chronically ill Americans, spelling disaster for many of them," said the study's senior author, Dr. Danny McCormick, a physician at CHA and an associate professor at Harvard Medical School.

McCormick continued: "A comprehensive Medicare-for-All plan is the replacement for the ACA that's most likely to provide coverage and good access to care for everyone with a chronic illness. Polls show that such reform is popular with the Americans people – even among those favoring repeal of the ACA – but unfortunately, the politicians that control the White House and Congress are unlikely to embrace it."

"Coverage and Access for Americans With Chronic Disease Under the Affordable Care Act: A Quasi-Experimental Study," Hugo Torres, M.D., M.P.H.; Elisabeth Poorman, M.D., M.P.H.; Uma Tadepalli, M.D.; Cynthia Schoettler, M.D., M.P.H.; Chin Ho Fung, M.D.; Nicole Mushero, M.D., Ph.D.; Lauren Campbell, M.D., M.P.H.; Gaurab Basu, M.D., M.P.H.; and Danny McCormick, M.D., M.P.H. Annals of Internal Medicine, published online first, Jan. 23, 2017, at 5 p.m. EST.

*Physicians for a National Health Program (**www.pnhp.org**) is a nonprofit research and educational organization of more than 20,000 doctors who support single-payer national health insurance. PNHP had no role in funding or otherwise supporting the study described above.*

PhRMA rally for single payer

NOVEMBER 18, 2016

Postal workers union president calls for single-payer system

The following is an unofficial transcript of the remarks delivered by Mark Dimondstein, president of the American Postal Workers Union (APWU), AFL-CIO, to a protest rally outside the national offices of the Pharmaceutical Research and Manufacturers of America (PhRMA) in Washington, D.C., on Nov. 18.

The protest, which drew more than 150 people – physicians, medical students, unionists and health reform activists – denounced the greed of the pharmaceutical drug industry and called for a single-payer national health system. It featured several rally speakers, one of whom was President Dimondstein, whose union represents more than 200,000 USPS employees and retirees, and nearly 2,000 private-sector mail workers. He was introduced by Dr. Robert Zarr, president of Physicians for a National Health Program, which organized the protest.

President Mark Dimondstein's remarks

It's nice for me personally to be seeing doctors and medical students when I'm not sick. [*Audience laughter, applause.*] But we are sick of a system based on profit, a criminal system based on profit, that that leaves the people of this country and humanity hanging without the kind of health care that we all deserve.

Sisters and brothers, the people that I represent, for the most part, do have health insurance right now. But every day it's going up, every day we have to pay more, every day the benefits go down, every day we're in a fight with the insurance companies.

And for those who don't know, the price of future health insurance is being used to choke the public Postal Service that is being demanded to put $5 billion a year into a fund for future health benefits for workers that aren't even born yet.

So it's hurting all of us, it's hurting all of us, sisters and brothers.

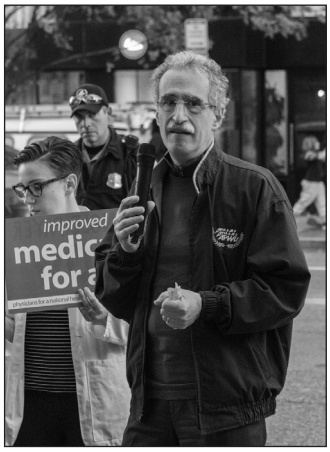
And when we go to the bargaining table, guess what: Management always wants, and it's not just arguing, they want our health benefits, if we can even keep them, to be less and less, and more and more coming out of the wages and benefits of the workers.

So we would all benefit – all of us – from a system of single payer and Medicare for All.

Now, we're in front of PhRMA. I did a little thinking last night. Big Pharma wants to convince all the people of this country that you have to have this obscene system of profit-making, and CEOs that make $43 million, and lobbyists and enriching – you mention obscene profits – because that's what's going to drive the innovation of life-saving drugs.

You're all in the medical field, so you know who Dr. Jonas Salk was, don't you? [*Shouts of "Yes," applause.*] When he was working on a polio vaccine, which was an epidemic in this country and the world, he purposely decided that his work was not going to be based on personal gain. And when he was asked, "Who has the patent?" You know what he said? He said, "There is no patent. You can't patent the sun." You can't patent the sun.

That patent, by figures today, that figure would have been worth $7 billion to the pharmaceutical industry, and he said no. And you're here in the tradition of Dr. Salk, practicing medicine and fighting to have a system of practicing medicine that is good for the patients and good for the people of this country.



APWU President Mark Dimondstein addresses the crowd outside PhRMA.

And we all have stories. We all have family and friends. My wife and I were good friends with the real Norma Rae, Crystal Lee Sutton, an American heroine. And when she got sick, and was fighting brain tumors, the insurance company of her husband cut off the benefits. And she could not afford the life-saving drugs that she needed, and she died at a fairly young age.

When my wife was sick, fighting a life-threatening thing, the medicine she needed, the shot, was $5,000 a pop. We had health insurance. What about all the people that don't?

And when we say that Big Pharma is criminal, that's what we mean, because people die on the altar of profits, sisters and brothers. And you know that better than anybody.

We're very friendly with the Canadian Union of Postal Workers. And when we meet with the Canadian Union of Postal Workers they brag about their health care system. They pull out their medical card – and it's different by each province – they say, "Here it is. We go anywhere we want to. We have full choice of physicians. We have cradle to grave benefits. And we never see a bill because it's part of the public good."

Sisters and brothers, you're out here fighting for the public good in your way, we feel we're fighting for the public good in our way, in terms of defense of the public Postal Service. Together, we can fight for the kind of country we need.

It's not an accident, to me anyway, in my thinking, that the Bernie Sanders campaign electrified this country. And what was one of the main demands of that that campaign? [*Shouts of "single-payer health care."*] Single-payer health care. And in a way we should look at that primary season in this election as a referendum on those kind of issues, because the people of this country are ready for a Medicare-for-all single-payer system.

And with advocates and fighters like you, sisters and brothers, working hand in hand with unions like ours and the communities of ours, guess what? We can win, can't we? [*Cheers.*]

Sisters and brothers, it's great to be here with you. Solidarity forever, as we say in the union movement. And carry on your great fight with the great spirit you have here today. Thank you all. [*Cheers, applause.*]

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

NOVEMBER 19, 2016

Reining in the drug companies

By Marcia Angell, M.D.

The following text served as the basis of Dr. Angell's keynote address to the Annual Meeting of Physicians for a National Health Program, which took place on Nov. 19, 2016, in Washington, D.C.

The top multinational drug companies – like the Swiss giant, Novartis, or the British giant, GlaxoSmithKline, or the American giant, Pfizer – have annual sales of tens of billions of dollars, exceeding the GDPs of many whole countries. And an astonishing percentage of these revenues are pure profit.

The pharmaceutical industry is consistently among the most profitable in the U.S. And no surprise, it has the largest lobby in Washington. It uses its wealth to co-opt the institutions that might in any way curb its drive for profits – including Congress, the Food and Drug Administration, and the medical profession. I'd like to begin by giving you a brief overview of its modus operandi by way of background, before I suggest specific ways to rein it in.

Three keys to Big Pharma's 'success'

The astonishing commercial success of the pharmaceutical industry depends on three conditions.

First, the government grants drug companies very long and easily stretched monopoly rights for their new drugs, during which they can price them as high as they want.

Second, their drugs don't have to be new at all, but can be slight variations of drugs already on the market – called "me-too" drugs. Me-too drugs are now their main product, and the companies don't have to show that they're any better than the drugs already on the market.

And third, since 1980, drug companies no longer have to do their own innovative research, but can feed off research done by investigators funded by the National Institutes of Health, NIH, at academic medical centers and small biotech companies.

The last circumstance is the result of legislation called the Bayh-Dole Act. The small companies are often start-ups founded by academic investigators and their institutions. The big companies then either license the drugs or buy the small companies outright. Even the European giants set up gleaming research centers near American institutions like Harvard Medical School or MIT, to be near the real source of innovation – NIH-funded researchers. Then the big fish swallow the little fish.

Since the big drug companies no longer do innovative research, what do they do? What they do is turn out me-too drugs and fund the late-stage development of drugs they acquire from universities and small biotech companies. But with their vast public relations apparatus, they try to convince us that their astounding prices are necessary to fuel innovation and cover their R&D costs. That's clearly not true.

An important – and insufficiently appreciated – point is that drug companies almost never compete on price, because high prices benefit all of them. So while a company's ads extol the virtues of a particular drug, they don't say its price is lower than that of competitors. Think about that; I can't think of any other industry that doesn't compete on price.

In short, drug companies behave like an oligopoly, not a competitive market. Even after generic drugs enter the market, the price of the original brand-name drug isn't reduced. In fact, it tends to rise particularly rapidly just before the generic is launched, because the company anticipates less resistance from insurers and can set a new floor for the industry.

Drug prices are now rising at an annual rate of 16 percent.

A few examples

All of this is by way of background before I suggest a few ways of reining in the industry. But first, just a few specific examples of what I've described generally.

First, Sovaldi. This is a drug that in just three months can cure hepatitis C – a chronic, life-threatening disease that affects more than 3 million Americans. Sovaldi is owned and sold by a large company called Gilead Sciences, but the company had nothing to do with the research that created it. Instead, it was patented and developed by a small company called Pharmasset, which in turn was a start-up of researchers at Emory University.

Gilead bought Pharmasset for $11 billion five years ago, and priced Sovaldi at $84,000 for a three-month course – a price that clearly had nothing to do with its costs. Because of the expense, Solvadi is now restricted by Medicaid and private insurers to only the sickest patients, even though other patients could also be cured. In the UK, the National Health Service has decided not to make it available at all. This is the rationing of life-saving treatment simply through price-gouging.

But look at the benefits to Gilead. Last year, the company had sales of $32.5 billion, of which 55 percent was pure profit. Eleven percent went for marketing and administration, and only 9 percent for R&D. This picture is fairly typical of the big drug companies that have essentially won the lottery by acquiring a winning drug.

When Novartis brought Gleevec to market – a drug that stops a form of leukemia in its tracks – the company priced it at $27,000 per year, even though the research and most of the development was done by an NIH-funded investigator at the Oregon Health and Science University. It cost Novartis very little. This was in 2001; Gleevec is now priced at $120,000 for a year's supply.

Last year, Novartis had sales of $49.5 billion; profits were 36 percent of sales, 29 percent was spent on marketing and administration, and only 18 percent on R&D.

Six steps we could take now

Clearly, this industry needs to be reined in. There are multiple ways to do that. I'll mention the six most important.

First is something the medical profession could do entirely on its own, with no help from Congress or the FDA. We could end all involvement of drug companies in medical education. Doctors should pay for their own continuing education, just as other professions do. Period.

And the profession could see that drug companies' involvement in clinical research is limited to arm's-length grants given to investigators with no other ties to the company whose product they're studying. As it now stands, the industry funds much continuing medical education, CME, and is intimately involved in all aspects of clinical research, with the predictable bias that introduces.

Dr. Marcia Angell speaks at the PNHP Annual Meeting.

Second, and more complicated since it would involve Congress, we need to get access to critical information that drug companies withhold or obscure. There's now no way to know what they spend to bring any given drug to market, nor even to know the price, since prices are varied across payers and purposely hidden by various rebates and discounts.

These companies should be treated like public utilities, since they have much in common with them. Despite their PR about being a triumph of the free market, they are really heavily subsidized by the public, and their books should be opened. A bill has just been introduced in Congress by Sen. John McCain and Rep. Jan Schakowsky, called the Fair Drug Pricing Act, that would go a long way toward doing that.

Third, Congress should repeal the provision of the 2003 Medicare Prescription Drug Benefit that expressly prohibits Medicare from bargaining with drug companies for lower prices. Bargaining means having a formulary; there's no other way to do it. This provision was written into the legislation by the pharmaceutical industry, and is absurd on the face of it, since other government agencies bargain for lower drug prices, including the Veterans Administration, which gets much lower prices, as do the major health insurers.

The congressman most instrumental in putting this bizarre prohibition in Medicare Part D was Billy Tauzin, then chair of the House Energy and Commerce Committee, which had jurisdiction over the legislation. Shortly after the legislation passed, he was rewarded by being named president of PhRMA, the industry's trade group, reportedly for a salary of $2 million. That's how these things work.

Fourth, the FDA should not approve me-too drugs unless they're compared in clinical trials with older drugs to treat the same condition. The FDA has the authority to require that, but doesn't. All the companies have to do is show their drug is better than a placebo. So there's no way to know whether a new me-too drug is better, worse, or the same as older ones.

For example, Prozac, which came on the market in 1987, was the first of the SSRI antidepressants. Since then, five more have been approved. For all we know, Prozac was the best, and the others are getting successively worse. One FDA official defended placebo controls by saying we might not know whether any in the class was any good, so why bother comparing a new drug with an old one? The answer to that is to require a trial with three arms – new drug, old drug, and placebo.

Eliminate conflicts of interest

And that brings me to the fifth reform. We need to eliminate financial conflicts of interest at the FDA.

As it now stands, drug companies pay "user fees" to the FDA for each drug the agency reviews for approval. User fees were first established by Congress in 1992, when it passed the Prescription Drug User Fee Act, otherwise known as PDUFA. They now account for more than half the support of the part of the FDA that approves new drugs, and they're contingent on a speedy decision. They cannot generally be used for other essential functions of the agency, such as review of generic drugs, advertising, and manufacturing standards.

PDUFA sunsets every five years, unless renewed. It's up for renewal next year, and it should be allowed to die. The public is the "user" of the FDA, not the industry it supposedly regulates, and the public should provide adequate support to this vital agency.

In addition, the FDA advisory committees, consisting of experts from all over the country, should not include members with financial ties to drug companies. There are some limitations now, but they are extremely lax. The prohibition of conflicts of interest should be absolute.

Sixth and finally, we should enforce all provisions of the law that permit drug companies to feed off NIH-funded discoveries – again, the Bayh-Dole Act. This legislation had two restrictions that have never been enforced. One requires companies to make the fruits of the research they acquire available to the public on "reasonable terms." The second permits the government to "march in" if it deems it of public health importance to override the company's monopoly rights.

If these two restrictions were enforced, it would do much to counter the current widespread price-gouging.

Even better would be a return to the pre-1980 policy of keeping all publicly funded research in the public domain. It is simply wrong to charge the public twice for prescription drugs – first for the research, and then at the pharmacy.

So these are six reforms I would suggest. They would permit the industry to remain private, encourage it to conduct its own innovative research, and allow for reasonable profits.

An alternative proposal would be simply to nationalize the industry altogether. I think we could reform it piecemeal short of nationalization, and have a better chance of getting at least some of the reforms accomplished.

I'm well aware, sadly, that there is currently very little chance of any salutary reforms. But it's still useful to know what we need to do, so that we're ready when it becomes possible again. For an infinitude of reasons, I hope we won't have to wait too long.

Dr. Marcia Angell is a member of the faculty of Global Health and Social Medicine at Harvard Medical School and former editor-in-chief of The New England Journal of Medicine.

THE HILL

NOVEMBER 16, 2016

Which way for Trump and progressives on pharmaceutical reform?

By Adam Gaffney, M.D.

Last January, to the astonishment of many, Donald Trump asserted that he favored allowing Medicare to negotiate with pharmaceutical companies over drug prices, a longstanding progressive policy that was also supported by the Democratic candidates. "We don't do it. Why? Because of the drug companies," Trump said.

Will he pursue such a populist course on drug prices once in office? It seemed unlikely then. But now, it seems pretty clear that the promise was a bait-and-switch: his new website does not include a word about Medicare drug negotiations.

Dr. Adam Gaffney

Instead it calls for "[r]eform[ing] the Food and Drug Administration [FDA], to put greater focus on the need of patients for new and innovative medical products," code words for a pro-Pharma agenda that would weaken the FDA standards for drug approval.

A similar pro-industry agenda was embodied in the 21st Century Cure Act that was passed by the House last year. As an article in the "New England Journal of Medicine" described, that act would "lead to the approval of drugs and devices that are less safe or effective than existing criteria would permit," producing a windfall for the drug industry but greatly increasing the likelihood that unsafe medications would gain approval.

Drug company stock prices rocketed the day after Trump's election, reflecting investors newfound confidence in the industry's prospects under his presidency.

While the President-elect's plans for the drug industry remain clouded, it will be difficult for him to dodge the issue, as a broad majority wants the government to take action on drug prices.

A Kaiser poll published last month found that 74 percent of Americans, including 68 percent of Republicans, believe that addressing the affordability of pricey drugs for chronic ailments must be a priority for the next government. And some 63 percent called for government action to bring down drug prices.

A Kaiser poll published last month found that 74 percent of Americans, including 68 percent of Republicans, believe that addressing the affordability of pricey drugs for chronic ailments must be a priority for the next government.

It's not surprising that people feel this way, for the U.S. is an outrageous outlier in terms of what we pay for drug spending, which was $1,026 per capita in 2013. This is compared to the Organization for Economic Cooperation and Development (OECD) average of $515.

Meanwhile, widely-publicized examples of price-gouging for decades-old generic drugs – like that pursued by Mylan pharmaceuticals or Martin Shkreli – have rightfully enraged the public, while also giving the lie to the proposition that drug prices are high only because of R&D costs.

Yet the problems with the drug industry go beyond the exorbitant prices they charge. In recent years the industry hasn't been producing many innovative new drugs. Too often they've focused on so-called "me too drugs"– newly patented drugs that cost more yet do nothing better than existing medicines.

Such drugs produce windfalls for the drug industry but do little to improve health, and too much of drug companies' R&D spending is wasted on developing these expensive, duplicative therapies.

What direction will Trump take? The dishonesty of his campaign rhetoric suggests that, once in office, he will ditch his populist promise to take on Big Pharma, and close ranks with his fellow billionaires.

In response, progressives need a clear and bold strategy on prescription drugs. A weakening of FDA standards for drug approval should be strongly opposed as a giveaway to Big Pharma, a position which seems to have majority support.

At the same time, Trump's feet should be held to the fire on his promise to support Medicare drug negotiations with Pharma, a policy that would save the federal government at least $230 billion and as much as half a trillion over 10 years, according to the Center of Economic and Policy Research, a liberal think tank.

However, it would be a major mistake to react to bad ideas on drugs coming from the Congress or president without offering a countervailing vision. Even though the current political climate is entirely adverse, a positive blueprint for Pharma reform could help to shift the terms of the debate.

For instance, we could get even bigger savings – at least $1.5 trillion over the next decade – if we brought all drug prices, not just Medicare's, in line with the prices paid by other high-income nations (excluding the portion of current drug spending that is already discounted.

The obvious route to achieving these savings would be to have a single payer directly negotiate with drug firms, as occurs in many European nations.

Apologists for Big Pharma will claim that high US drug prices are necessary to sustain spending on R&D. But their numbers

(continued on next page)

Portland Press Herald

DECEMBER 20, 2016

Remove profit motive from U.S. health care system

By Philip Caper, M.D., and Julie Pease, M.D.

Maine AllCare has received many responses to the Dec. 5 Maine Voices column "Trump's health care policy appears heavy on complexity, light on mercy." One respondent correctly observed that not every industrialized country has a "single-payer" system.

This observation misses the forest for the trees. Indeed, many countries employ private insurance companies. But they are overwhelmingly nonprofit, heavily regulated public utilities.

Insurance companies process Medicare claims, but most of the time Medicare, not the insurance companies, underwrites the costs of care. There is a reason for this. Having a for-profit health insurance system sets the tone for behavior throughout the system.

The United States is the only country in the world where profiteering and wealth extraction are not only tolerated and permitted, but also often celebrated.

The United States is the only country in the world where for-profit insurance and other products and service companies are central to its health care system. It is also the only society where profiteering and wealth extraction from sick, frightened and essentially powerless patients by insurance, pharmaceutical, medical device and other corporate providers of health care products and services (some of them nominally nonprofit) are not only tolerated and permitted, but also often celebrated.

Drs. Philip Caper and Julie Pease

In other countries, the mission of the health care system is facilitating the delivery of health care. Instead, our for-profit system often erects financial and other barriers to care (insurance companies), or prices their products out of reach of most Americans (pharmaceutical, medical device companies and corporate service providers), all in the cause of maximizing profitability.

We offer access to the most profitable services to those able to pay for them, often without regard to their clinical necessity or merit, leading to well-documented over-treatment, sometimes with disastrous results.

In other wealthy countries, health care is a right, not a privilege to be purchased by those with the means to do so, and is considered a public service, not a way to get rich quick. This was the column's central point, and one worth repeating over and over again.

Philip Caper, M.D., and Julie Pease, M.D., are members of the board of directors of Maine AllCare, ***www.maineallcare.org****.*

(***Pharma reform,*** *continued from previous page)*

simply do not add up. The "excess" $150 billion we spend on drugs in the US each year is more than double the industry's own estimate of total US private sector pharmaceutical R&D spending (in 2010, the lobbying group PhRMA put total private sector R&D at $67.4 billion annually).

If drug prices were lowered to OECD levels, some of the $150 billion in savings could be re-invested into public sector drug R&D, which could be directed at real health needs, not potential profits. Publicly developed and tested drugs could then be kept in the public domain and produced as generics from day one.

Some of the $150 billion in savings could also be used to expand drug coverage and eliminate the copayments that deter many from taking necessary, and even life-saving medications.

Americans today are suffering from high drug prices, whether they pay for them out-of-pocket or through high and rising premiums. Meanwhile, multimillionaire pharmaceutical CEOs, like Gilead's CEO – who raked in more than $1 billion while heading the firm – profit from our government's longstanding policy of generous corporate welfare for the pharmaceutical industry.

These are winning political points. In contrast, shilling for Big Pharma much less throwing the uninsured out of hospital beds and into the streets (figuratively speaking) – is unlikely to boost Republicans' popularity. Progressives absolutely need to relentlessly hammer – and defeat – their reactionary, immoral healthcare agenda. But we also need to present a vision of a better alternative that could take its place, knowing that inevitably, the political tide will turn, if not a day too soon.

Adam Gaffney is a physician and a writer who focuses on healthcare policy, politics, and history. He is also an Instructor in Medicine at Harvard Medical School, a practicing pulmonologist and critical care doctor, and a board advisor to the organization Physicians for a National Health Program.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

FEBRUARY 28, 2017

Physician views on single payer: A compilation of polling data 1992–2014

By Ida Hellander, M.D.

	Single-year polls	Support for single payer
1	Morning Sentinel, Me. (1992)	56%
2	J Fam Pract (1993)	25%
3	Burlington Free Press, Vt. (1993)	50%
4	Times Mirror Center (1993)	41%
5	Penn Phys Nat'l Health Prog (1996)	29%
6	New Eng J Med (1999)	57%
7	Arch Int Med (2004)	64%
8	Minn Med (2007)	64%
9	New Hamp Med Soc (2007)	67%
10	J General Int Med (2009)	42%

	Multiple-year polls	Support for single payer
11	AMA (1992)	18%
12	AMA (2004)	41%
13	Ann Int Med (2003)	49%
14	Ann Int Med (2008)	59%
15	Mass Med Soc (2010)	34%
16	Mass Med Soc (2011)	41%
17	Maine Med Soc (2008)	52%
18	Maine Med Soc (2014)	64%

Introduction

The term "single payer" entered the American health policy vocabulary in 1989, after the New England Journal of Medicine published PNHP's proposal for "a national health program, as the single payer for services" (1). Since then, polls of physicians' attitudes towards single payer – a form of national health insurance in which care is publicly financed, but largely privately delivered – have found substantial and growing support for single payer. Nearly all the surveys were conducted by independent researchers and published in peer reviewed journals, or were conducted by polling firms, usually for state branches of the American Medical Association. Three early polls (in 1992, 1993, and 1996) were done by chapters of PNHP, as noted in the text.

1. Survey of Maine physicians

Morning Sentinel, 1992

A survey of physicians in Maine found 57 percent in favor of "single payer," 26 percent opposed, and 17 percent neutral. The survey, by the Maine chapter of PNHP, was mailed to all 2,005 physicians in the state; 566 responded (2). In 2008 and 2014, the Maine Medical Association reported similar findings (described below) from its own surveys.

2. Survey of North Carolina physicians

Journal of Family Practice, 1993

A survey by researchers with the Cecil G. Sheps Center on Health Services Research focused on physician support for the two leading options for reform at the time, managed competition and single payer. Nearly one-third of surveyed physicians reported not having enough information to choose between the plans. Among physicians expressing a preference, 25 percent preferred a single-payer system, 37 percent favored managed competition, and 38 percent favored continuing the status quo. Pediatricians, rural physicians, and those dissatisfied with the current reimbursement system were mostly likely to support a single-payer system (3).

3. Survey of Vermont physicians

Burlington Free Press, 1993

A survey in Vermont asked physicians to choose between four options: the present system, a managed competition approach, "a single-payer health care system," and undecided. The survey, by the Vermont chapter of PNHP, was mailed to all 1,404 physicians in the state; 421 responded. The results showed that 50 percent of the state's physicians supported a single-payer health care system, including 71 percent of psychiatrists and 63 percent of pediatricians. Only 11 percent supported managed competition (4).

4. National survey of physicians

Times Mirror Center for the People and the Press, 1993

This national survey was designed to gauge physician attitudes towards the Clinton administration's health plan (managed competition) compared with single payer. Phone interviews were conducted with a sample of 408 physicians in March 1993. Here's how a single payer plan was described: "The government pays for all health care costs from taxes collected from workers,

employers, and from the general public. People could select any provider and pay for it with a national health care card. What is your reaction so far?" At this point 49 percent of physicians were "mostly positive" (49 percent) towards the plan. Support fell to 32 percent after being told "there would be a ceiling on health care costs. Medical societies would set fees based on annual government budgets for medical care. Hospitals would also be given annual budgets by the government. What is your reaction to this aspect of the plan?" Support rose to 41 percent after being asked "now taking everything into account, what's your overall reaction to such an approach." Fifty-eight percent of physicians were opposed to single payer, the same percentage that supported the managed competition approach (5).

5. Survey of Pennsylvania physicians

Pennsylvania Physician Survey by Walter Tsou, 1996

The Pennsylvania chapter of PNHP mailed surveys to 1,000 randomly selected physicians in the state; 288 replied (6). The survey asked physicians about their support for four different options for reform. Twenty-nine percent supported "a single-payer system in which everyone received coverage from a single, publicly accountable plan, paid by taxes." Thirty-three percent supported "medical savings accounts for individuals and high deductible insurance paid by employers/individuals for catastrophic expenses. Government pays for some of the uninsured," while 28 percent favored "a system based on managed competition between several private insurance plans with premiums paid by employers or individuals." A fourth option, "decrease the rate of increase of Medicare and Medicaid as passed by Congress. The remaining systems of public/private financing and access to care is acceptable," received 10 percent support.

6. Survey of students, residents, faculty and deans at medical schools in the United States

New England Journal of Medicine, 1999

A poll by researchers at Harvard Medical School published in the New England Journal of Medicine found that "all groups [deans, department chairs, residency training directors, physician faculty at medical schools, resident physicians, and medical students] expressed a preference for a single-payer health care system over both managed care and fee-for-service systems. Overall, 57.1 percent thought that a single-payer system with universal coverage was the best health care system for the most people with a fixed amount of money. A total of 21.7 percent favored managed care, and 18.7 percent preferred a fee-for-service system." The question asked "Which one of the following three structures would offer the best health care to the greatest number of people for a fixed amount of money? Fee-for-service system in a competitive marketplace, managed care system in a competitive marketplace, or single-payer system with universal coverage" (7).

7. Survey of Massachusetts physicians

Archives of Internal Medicine, 2004

A poll of Massachusetts' physicians by researchers at Cambridge Hospital/Harvard Medical School asked the same question as in No. 6 above. Overall, 63.5 percent preferred single payer, 25.8 percent fee-for-service care, and 10.7 percent managed care in a competitive market (8).

8. Survey of Minnesota physicians

Minnesota Medicine, 2007

A survey of Minnesota physicians found that 64 percent favored a single-payer system, 25 percent favored health savings accounts, and 12 percent favored managed care. The majority of physicians (86 percent) also agreed that it is the responsibility of society, through the government, to ensure that everyone has access to good medical care. The survey was similar to the questions used in surveys No. 6 and No. 7 (above) (9).

9. Survey of New Hampshire physicians

New Hampshire Medical Society, 2007

A 2007 survey of physicians in New Hampshire found that 67 percent of all physicians, and 81 percent of primary care physicians, support single payer ("favor a simplified payer system in which public funds, collected through taxes, are used to pay directly for services to meet the basic healthcare needs of all citizens") (10).

10. National physician survey

Journal of General Internal Medicine, 2009

A survey of American physicians published in the Journal of General Medicine found that 42 percent of physicians supported a "government-run, taxpayer-financed single-payer national health insurance program." Forty-nine percent favored either tax incentives or penalties to encourage the purchase of medical insurance. Only 9.1 percent "would preserve the status quo." The majority of respondents believed that all Americans should receive needed medical care regardless of ability to pay (89 percent); 33 percent believed that the uninsured currently have access to needed care. Nearly one-fifth of respondents (19.3 percent) believed that even the insured lack access to needed care. Views about access were independently associated with support for single-payer national health insurance (11).

11/12: National AMA member survey

American Medical Association, 1992 and 2004

In a 2004 poll of its members by the AMA, 41 percent of physicians supported a "national single-payer system," up from 18 percent support for "government-financed national health insurance" in 1992.

In 2004, the survey asked about support for single payer and five other options for reform, and allowed respondents to choose multiple options. A "national single-payer system" was favored by 41 percent, "expanding eligibility for public programs" by 38 percent, "individual mandates" to purchase coverage by 27 percent and "employer mandate" by 24 percent. Two options received more support than single payer, "use of tax credits" (53 percent support) and "government-sponsored catastrophic coverage (53 percent)." By specialty, psychiatrists were the most likely to support single payer (58 percent) while anesthesiologists were least likely to favor it (30 percent). Academic

(continued on next page)


Dr. Ida Hellander

medicine physicians were more likely to be supportive (57 percent) than office-based physicians (38 percent).

In 1992, the survey asked about three options for reform, and respondents could only choose one. The results were as follows: "government-financed national health insurance for everyone" (18 percent), an individual mandate with vouchers for the poor to buy insurance (46 percent), and an employer mandate with government-financed coverage for people without employer-based coverage (34 percent) (12).

13/14: National physician survey

Annals of Internal Medicine, 2003 and 2008

Ackermann and Carroll at Indiana University School of Medicine polled physicians twice, five years apart. For their 2003 survey, "physicians were asked whether they support or oppose 1) governmental legislation to establish national health insurance and 2) a national health insurance plan in which all health care is paid for by the federal government." Forty-nine percent supported governmental legislation to establish national health insurance, and 40 percent opposed it. Over one-quarter (26 percent) of all physicians supported a national health insurance plan in which all health care is paid for by the federal government.

In 2008 they asked physicians if they "support or oppose governmental legislation to establish national health insurance" (the same wording as question 1, above). They also asked physicians if they "support achieving universal coverage through more incremental reform?" Fifty-nine percent of physicians supported governmental legislation to establish national health insurance, up from 49 percent in 2003. Fifty-five percent of physicians supported incremental reform. Opposition to national health insurance fell to 32 percent while 9 percent of physicians were neutral in that survey of 2,193 physicians. Support for NHI was particularly strong among psychiatrists (83 percent) pediatric subspecialists (71 percent) emergency medicine physicians (69 percent) general internists (64 percent) and family physicians (60 percent). Fifty-five percent of general surgeons supported NHI, roughly doubling their support since 2003.

The authors subsequently analyzed the 2003 results by membership in the AMA (unpublished manuscript). Some 37.1 percent of AMA members were in support, versus 55.2 percent of members of other organizations, including 69 percent of members of the American Academy of Pediatrics (13).

15/16: Survey of Massachusetts physicians

Massachusetts Medical Society, 2010 and 2011

The Massachusetts Medical Society included questions about health care reform in its annual "Practicing Physician Surveys" in 2010 and 2011. Single payer was the most favored of five options for reform both years, with support for single payer rising to 41 percent in 2011 from 34 percent in 2010.

The full 2011 results were: "Single payer national health care system offering universal health care to all U.S. residents" (41 percent), a public option (23 percent), high-deductible plans (15 percent), the Massachusetts health reform (17 percent) and other (3 percent). Respondents were asked to pick only one of five options – although many respondents probably support more than one option.

The full 2010 results were: "Single-payer national health care system offering universal health care to all U.S. residents" (34 percent), public option (32 percent), high deductible plans (17 percent), the Massachusetts health reform (14 percent), and other (4 percent) (14).

Strikingly, few physicians favored the Massachusetts reform, the model for the ACA.

17/18: Survey of Maine physicians

Maine Medical Association 2008 and 2014

A 2008 survey of nearly 600 Maine physicians showed a majority in favor of a single payer or "Medicare for all" approach. The survey, conducted in November and December, showed 52 percent in favor and 48 percent against.

The survey was repeated in 2014 by the Maine Medical Association (MMA). It found that 64.3 percent of its members support a single-payer system. Both surveys asked, "When considering the topic of health care reform, would you prefer to make improvements to the current public/private system or a single-payer system such as a 'Medicare for all' approach?" Support for "improvements to the current public/private system" fell to 35.7 percent in 2014 from 47.4 percent in 2008. There was no significant difference in response to the question based upon age, geographic location, or MMA membership status. Primary care physicians and psychiatrists were more supportive of single payer than other physicians, as were physicians who did not own their own practices (15).

References

1. Himmelstein et al., "A National Health Program for the United States: A Physicians Proposal," NEJM, 1/12/89.
2. Harkavy, "Doctors: Health System Failing. Many favor single-payer national program, survey says," Morning Sentinel (Me.) 10/15/92.
3. Millard et al., "Primary care physicians views on access and health care reform: The situation in North Carolina," Journal of Family Practice, November 2003.
4. Sneyd, "Vt. doctors like system in Canada," Burlington Free Press (Vt.), 3/7/93.
5. "The public, their doctors, and health care reform," Times Mirror Center for People and the Press, 4/14/93.
6. Tsou, Walter, "Pennsylvania Physician Survey" 1996, unpublished manuscript.
7. Simon et al., "Views of Managed Care — A Survey of Students, Residents, Faculty, and Deans at Medical Schools in the United States," New England Journal of Medicine, 3/25/99.
8. McCormick et al., "Single-Payer National Health Insurance. Physicians' Views," Archives of Internal Medicine, 2/9/2004.
9. Albers et al., "Single-payer, health savings accounts, or man-

(continued on next page)

Help PNHP build support for single payer in the new Congress!

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Please call the U.S. Capitol switchboard at (202) 224-3121 and encourage your member of Congress to co-sponsor H.R. 676.

(***Physician polling,*** *continued from previous page)*

aged care? Minnesota physicians' perspectives," Minnesota Medicine, February 2007.

10. New Hampshire Medical Society press release, December 2007.

11. Danny McCormick et al., "U.S. Physicians' Views on Financing Options to Expand Health Insurance Coverage: A National Survey," JGIM, April 2009.

12. AMA Division of Market Research and Analysis, "Advocacy Agenda Setting Survey," Sept. 2004 online summary at http://www.pnhp.org/news/2004/november/ama-members-opinions-on-reform accessed on 2/17/17 and AMA Department of Issue and AMA Department of Issue and Communication Research, "Physician and Public Opinion on Health Care Issues," May 1992.

13. Ackermann and Carroll, "Support for National Health Insurance among U.S. Physicians: A National Survey," Annals of Internal Medicine, 11/18/03, and Carroll and Ackermann, "Support for National Health Insurance among U.S. physicians: Five years later," Annals of Internal Medicine, April 2008.

14. Physician Workforce Study, Massachusetts Medical Society, 9/28/11, online at http://pnhp.org/blog/2011/11/07/massachusetts-physicians-prefer-single-payer-over-the-affordable-care-act/ accessed on 2/21/17.

15. Associated Press, Sun Journal, 4/8/2009; Maine Medicine Weekly Update, 9/10/14; and Crescendo Consulting Group, "Payment Reform Survey – MMA Resolution Question," Maine Medical Association, 2014.

Dr. Ida Hellander is director of health policy and programs at Physicians for a National Health Program.

THE FOX VALLEY
LABOR NEWS

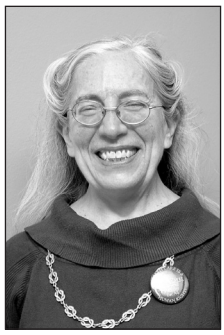
OCTOBER 7, 2016

Troubled workers' comp system shows need for single-payer health care

By Johanna Ryan and Anne Scheetz, M.D.

In Illinois and around the nation, big business has labeled workers' compensation a system in crisis. Illinois Gov. Bruce Rauner has depicted it as a millstone around the necks of Illinois employers, who he claims are shelling out too much money to treat injuries that might not even be work-related. Rauner and other Republican governors have made "reforming" workers' compensation a key part of their pro-business agenda.

However, any worker who has had to use the system lately knows the real "workers' comp crisis" is too little health care, not too much. In Illinois, as in most states, your employer is required to carry standard workers' comp insurance. But it's private companies like Liberty Mutual, Travelers and AIG/Chartis that provide the coverage – and they would much rather pay lawyers to fight your claim than pay doctors to help you get well.


Dr. Anne Scheetz

Under the system they've created, a worker hurt on the job is actually at higher risk of being denied medical care (or having their treatment cut short) than a worker who falls getting out of the bathtub at home.

We believe the best way to fight the growing attacks on workers' compensation is to take private insurance companies out of the picture. A public, single-payer health care system, financed by taxes rather than insurance premiums, would accomplish these goals:

- Eliminate delays and outright denial of care and the resulting long-term adverse effects on workers' health;
- Take medical decisions out of the hands of insurance companies and place them where they belong: in the hands of patients and their doctors; and
- Make prevention the preferred approach to work-related health problems by strengthening our public health infrastructure.

This is the type of health care system workers in almost every other wealthy industrialized nation take for granted. Here in the USA, it has been endorsed by the United Mine Workers, National Nurses United, the Machinists' Union, Amalgamated Transit Union and many others. Single-payer health care is a pro-active, rather than a reactive, approach to workers' health. It is an ambitious program, but workers deserve no less.

To get medical care in a workers' comp case, it's not enough to show it's necessary. You must also prove it's related to a workplace injury. This can be especially hard for "wear-and-tear" injuries like carpal tunnel syndrome or tendonitis, but it can also affect the worker who falls off a ladder or is struck by a forklift.

Private insurers love to litigate these cases – they know it has a chilling effect on the next worker who thinks about filing a claim. So they're happy to spend several thousand dollars to have you examined by an employer-friendly medical specialist who will declare your work injury was just a "minor strain," and your current symptoms are due to chronic arthritis, an old football injury or some other cause. No PT for you, pal, and definitely no surgery.

Rauner wants to make the standard for causation even higher, by requiring that an accident at work must be more than 50 percent responsible for an injury compared to all other causes. He also wants the records made by the treating physician – the one who actually knows the patient and who assessed the problem at the time of its occurrence – to count for less, and the opinions of those employer-friendly "independent medical examiners" to count for more.

Such changes taken together would gut workers' compensation. Employers who are reckless with workers' health will be even more confident they can get away with it. Workers' risk of injury will increase, and their access to care and compensation will decrease.

In theory, workers' comp expenses should give employers an incentive to make the workplace safer. It would be nice if that were the case. Unfortunately, it's hard to find anyone in the field who believes it. Workers' comp costs are much like the legal fines and penalties paid by drug companies – just a cost of doing business, which is never big enough to make them change their ways.

Employers are fond of moaning about the high cost of workers' comp, and make a public scandal out of any individual case of cheating, real or alleged. But the real root of rising costs is litigation, not featherbedding or fraud. Private workers' comp carriers have made Illinois a happy hunting ground for insurance defense lawyers, even as the number of workers' comp claims in the past decade has shrunk by more than a third. The changes Rauner proposes would make this much worse.

Take the example of one injured worker we know: A woman who's been waiting a year and a half for repair of her torn rotator cuff, precisely because of this type of dispute. She now has neck and back problems too, thanks to months of trying to use her trapezius muscles to compensate for her damaged shoulder. Ask any doctor: when she finally gets her surgery, the results will be worse than average on account of all that delay.

A single-payer health care system would cover the care she needed, with no questions asked. Her lawyers could concentrate on fighting to get her disability payments and an eventual cash settlement; we wouldn't have to fight over medical care. Our client could at least get her surgery and physical therapy, even if the workers' comp carrier denied her weekly benefit checks. She could recover and be working a new job while she waited for her shoulder claim to settle.

Relying on workers' comp claims filed by individuals (or their

(continued on next page)

The Boston Globe

DECEMBER 29, 2016

He'd take single-payer health care over Partners

By Samuel Shem, M.D.

Re "FIRST, do no harm" by David Torchiana, president and CEO of Partners HealthCare (Opinion, Dec. 19):

In understanding Partners, a touch of history may be relevant. There never was a need for a "Partners." It was created to make an alliance between Massachusetts General Hospital and Brigham and Women's Hospital – but also to make money.

American health care at first was a two-party system: doctor and patient. The next step was a third party: private insurance. Partners was born as a new third party, wedged between doctor-patient and private insurance (which became "a new 4th party"). Partners became a middleman and fee broker between doctor-patient-hospital and private insurance.

No wonder this added corporate giant added to health care costs, and has recently suffered record losses from ventures such as the installation of a new electronic medical records system and from running its own insurance company, Neighborhood Health Plan.

There's no need for a "Partners." The need, and solution, is for a national single-payer Medicare for all. Many, if not most, doctors want it. And ask any of us Medicare insurance patients: It's cheap, and it works.

The writer is the author of the novel "The House of God" and is professor of medicine in medical humanities and psychiatry at New York University Medical School.

(***Workers' comp,*** *continued from previous page)*

next of kin) to enforce respect for workplace safety just doesn't make sense. Would we depend on lawsuits alone to keep poisoned or spoiled foods off the market? Workplace safety, just like food safety, is a public health issue. We need public enforcement bodies, with real power, and with real penalties for violations.

According to an AFL-CIO report, in 2015, Illinois only had enough Occupational Safety and Health Administration (OSHA) inspectors to inspect all job sites only once every 143 years. The average penalty for a fatality investigation, of which there were 56, was $8,553. This clearly falls short of what's needed to enforce workplace safety standards and protect workers' lives. (A few states, such as Washington, have public workers' compensation insurance funds with some limited powers over workplace safety. Unions in Washington strongly support this system. When Liberty Mutual and other private insurers tried to enter the market a few years ago, labor fought the measure through a statewide referendum and won.)

Wouldn't we all be better off under a single-payer system that guaranteed treatment for any illness or injury, without a legal battle over the cause? Such a system would not only be cheaper, but it would provide better care. There was a time when most specialists welcomed workers' comp patients. However, given endless payment delays and litigation hassles, those days are fast becoming history.

Instead of seeing the best doctors, too many injured workers have to put up with pro-employer "occupational health" clinics, or third-rate providers who pad their bills with useless charges to compensate for long payment delays.

Imagine if everyone, from janitors to CEOs, carried the same health insurance card! You would choose your own doctors and other care providers. No specialist would turn you away because of the type of insurance you had. You and your doctor – not your employer's workers' comp carrier, or any other insurance company, would make decisions about tests, surgery, physical therapy, medical equipment, and other care.

All care would be paid for by progressive taxes, and free at the point of service. Hospitals would not shut down in low-income neighborhoods if the residents had the same high-quality insurance as everyone else. No one would lose their health insurance through leaving a job, going on strike, or for any other reason.

Also, injured workers could get immediate care without having to prove to anyone exactly where, when or how they got hurt.

Workers' comp lawyers (and we'd still need them) could concentrate on fighting for compensation – and we wouldn't see clients dropping their claims or settling for pennies because they were desperate for medical care.

A strong public health system, the foundation on which primary care and specialty care must rest in order to be effective, would make protection of workers' health a high priority.

That's what a single payer system could offer all of us, union or nonunion. It sounds like a better way to us.

Please sign up as a supporter, persuade your union to do the same, and make sure to get involved.

http://ilsinglepayer.org

References:

1. Number of Illinois workers' comp claims
2. Gov. Bruce Rauner's turn-around agenda
3. Illinois occupational illness and injury statistics

Johanna Ryan is a workers' comp paralegal and a member of the Illinois Single-Payer Coalition.

Anne Scheetz, M.D., a member of Physicians for a National Health Program and a founding member of the Illinois Single-Payer Coalition, cared for many patients with work-related health problems before her retirement from clinical practice.

DEMOCRACY
A JOURNAL OF IDEAS

OCTOBER 3, 2016

Canadian Medicare on trial

Could this be the beginning of the end for the Canadian single-payer system?

By Danielle Martin, M.D.

There's an old joke that Canadians like to tell: What's a Canadian? A gunless American with health care.

It's only funny because we half-believe it's true; despite the many things we have in common with our friends south of the 49th parallel, Canada's single-tier, publicly funded health care system has long been a point of differentiation–and pride–for most Canadians. A 2012 poll found that our health care system–known in Canada as "Medicare"–was almost universally loved, with 94 percent of those surveyed calling it an important source of collective pride. The notion that access to health care should be based only on need is a deeply ingrained Canadian value.

But we can't take our Medicare system for granted.

The challenges to Canadian Medicare have always been ideological and political. But, as of this month, they are also legal.

In the western province of British Columbia, a trial underway in that province's Supreme Court is challenging the very foundations of Medicare: providing care based solely on need, and not on ability to pay.

Cambie Surgeries Corporation and the Specialist Referral Clinic, represented by Dr. Brian Day, an orthopedic surgeon in Vancouver, are suing the government of B.C., trying to knock down the laws that protect our single-payer system. If successful, some Canadians will be able to pay out-of-pocket or through private insurance for hospital and physician services–and doctors will be able to charge them whatever the market will bear.

In British Columbia, as in all Canadian provinces, "Medicare" provides public funding for all medically necessary hospital and physician services to all legal residents. Core to the system are some key restrictions on physician behavior.

Let's say you come to see me in my office about a rash, or a possible pneumonia, or diabetes. I would talk to you, examine you, perhaps propose some laboratory tests, perhaps write you a prescription. The public insurance plan in my province would pay me for that 15-minute visit, let's say $50. As a Canadian physician choosing to be enrolled in Medicare, I bill the government that $50, but I am not permitted to then bill you an additional $20–meaning copayments, or "extra billing," is not allowed. In other words, Canadian doctors who bill the public insurance plan may not bill patients at all.

These restrictions on dual practice and extra-billing, coupled with B.C.'s ban on any private insurance that duplicates Medicare coverage, are the targets of the court challenge currently being brought forth by Dr. Day's private for-profit, investor-owned surgical clinic.

The essence of the claim is that, because wait times for some elective surgeries in that province are longer than we would like them to be, doctors should have a constitutionally protected right to provide them more quickly and at a higher price. This would be done by charging some patients privately, either out-of-pocket or through private insurance. They allege that existing limits on charging patients privately infringe on patients' rights to life, liberty, and security of the person under Section 7 of the Canadian Charter of Rights and Freedoms.

This legal challenge emerged in response to an audit of Cambie Surgeries Corporation, which was carried out after patients complained to the B.C. government that they were being charged out-of-pocket for care. From a sample of Cambie's billings, the auditors found that patients had been charged hundreds of thousands of dollars for health services already covered by Medicare. Championed by Dr. Day, Cambie Surgeries Corporation and the Specialist Referral Clinic then countered that the law preventing a doctor from charging patients more than the agreed upon fee schedule is unconstitutional–and a challenge to Canada's Charter of Rights and Freedoms was born.

The opening statements, which began on September 6, 2016, are behind us now, but Canadians are following the case–expected to last at least 24 weeks–in the popular press, as Cambie's lawyers try to paint a pretty dark picture of our health-care system. This, in spite of the fact that our outcomes are comparable to those in the United States and are achieved at a fraction of the price.

Meanwhile, the Attorneys General of B.C. and of the Government of Canada are countering that a multi-payer health care system would lure physicians from the public-pay sector to the private-pay sector, potentially reducing the availability, quality, and timeliness of care in the publicly funded system. Both governments will also argue that such a multi-payer health care system will drive up costs, forcing the public single payer to pay higher fees in order to "compete" with private insurers.

It is also worth noting recent efforts at tackling the main driver of this constitutional challenge: wait times for non-urgent surgery. These have come from within the public system, and include wait time targets, centralized intake for people with a common problem, and inter-professional health-care teams so that surgeons' time does not create a bottleneck. Such initiatives show tremendous promise for reducing waits deemed unreasonable, but governments need to implement them, and health-care organizations and doctors need to help accelerate this kind of reform.

Whatever the decision of the trial judge in B.C., it is likely to be appealed to the Supreme Court of Canada. The foundational pillar of Canadian Medicare–equitable access to health care for

(continued on next page)

the TIMBERJAY TOWER, MINN. OCTOBER 5, 2016

Minnesota Health Plan: New book outlines transition from the MNsure mess to a single-payer system

By the editors

A new book by Minnesota state Sen. John Marty offers something that few politicians have ever provided to the public before – a straightforward plan to transition to a single-payer health care system in the state.

If there's one thing, above all else, that passage of the Affordable Care Act has demonstrated, it is that any health care reform that maintains the existing private health insurance system is doomed to fail. While the ACA provided a brief respite in the spiraling cost of health care, premiums are now making up for lost time. Health officials here in Minnesota are already warning consumers that they are in for sticker shock when new MNsure rates are announced in a few weeks. Most plans are expected to see increases approaching 35-50 percent.

Despite skyrocketing premiums, Minnesotans are increasingly getting less in terms of coverage. To keep premium increases to a minimum, Minnesotans are opting for high deductible plans that require families to pay thousands of dollars before real insurance coverage kicks in. Even then, they still have co-pays and other charges. And many of the plans provide no dental coverage and only limited coverage for mental health care.

That leaves the obvious question. Where do we go from here?

Sen. Marty, in his new book, released at no charge in digital format this week, lays out a road map for the implementation of what he calls the Minnesota Health Plan, a comprehensive, single-payer health insurance proposal that he argues will provide significantly enhanced medical access for all Minnesotans, without spending any more than the $50 billion that Minnesotans and their employers currently pay for health care premiums and medical services every year.

The single-payer system would direct far more money towards actual care, however, since it would save the 15 cents on every health care dollar that goes to administering what is without a doubt the most inefficient health insurance system on the planet. That 15 percent amounts to seven billion dollars a year that Minnesotans and their employers spend on bureaucracy, whether it is administrative staff at hospitals, insurance companies, or in the government.

Complexity breeds inefficiency, as those who have struggled with the MNsure process are well aware. Yet it doesn't have to be that way. As Sen. Marty notes, the cost of signing up seniors for Medicare is just a tiny fraction of the cost of getting Minnesotans signed up for coverage through MNsure. It's not that government is inherently inefficient. Indeed, the Medicare system is far more efficient than any private insurance company. It's that when government systems are set up to benefit special interests– like the insurance industry in the case of the ACA–that common sense and efficiency regularly disappear out the window.

The transition to a statewide single-payer system may well be possible, since the ACA does allow for waivers, which would essentially allow states to utilize federal health care dollars to develop alternatives to the current system, as long as they meet certain standards, which the Minnesota Health Plan, as envisioned by Sen. Marty, certainly would. In addition to federal funding, the cost of care under the Minnesota Health Plan would be paid for primarily by a payroll tax and individual premiums, similar to the way that Medicare is funded today.

Those who say a single-payer system isn't viable are deploying mere rhetoric in place of reality. Many other developed countries manage to provide a successful single-payer system for their citizens, and so do we (Medicare). Would the Minnesota Health Plan face political opposition? Without a doubt. Many politicians maintain their office by defending powerful special interests, and few are more powerful than the insurance lobby.

But one thing is certain. You don't win if you don't try. We ended up with the Affordable Care Act, with all its flaws, because the Obama administration opted to avoid a battle with the insurance industry.

Perhaps it took the misfire of the Affordable Care Act to open the door to something better. If so, Sen. Marty's new book is pointing a way forward. It's definitely worth a read.

(***Canadian Medicare,*** *continued from previous page)*

all–could well be threatened from coast to coast to coast by the outcome of this decision.

It may be that the Cambie plaintiffs will be unsuccessful in their quest to dismantle the essence of Medicare, but clearly the stakes for ordinary Canadians are very high. Like all developed countries, Canada struggles to control growth in health-care costs, meet the needs of an aging population, and provide timely care of the highest standard. Whether we continue to work to do so for all Canadians, or only some, will, in part, be determined by the outcome of the Cambie case.

Danielle Martin is a family physician in Toronto and Vice President, Medical Affairs and Health System Solutions at Women's College Hospital. Her book, "Better Now: Six Big Ideas to Improve Health Care for All Canadians," will be released by Penguin Random House in January 2017 and is available for pre-order online.

PNHP chapter reports

In **California**, PNHP members are active in outreach, education, and coalition building. Activists in the Bay Area chapter of PNHP presented grand rounds at Highland Hospital in Oakland and hosted a screening of the film "Fix It" at the Ocean Park Health Center in San Francisco. In Southern California, Dr. David Carlisle gave an introductory talk on single payer to the UCLA chapter of Students for a National Health Program (SNaHP). SNaHP members met with their vice dean for education and the chief of medical education to encourage incorporating information about single-payer health systems into the curriculum. California PNHPers are also working with other single-payer and health justice organizations to defend Medicare and Medicaid and advocate for improved Medicare for all. In January, members participated in several events including a national day of action opposing the repeal of the ACA with Rep. Nancy Pelosi; Women's Marches in Oakland, San Francisco, Los Angeles and San Jose; a national call-in day to protect Medicare; and a direct action with the California Alliance for Retired Americans targeting California GOP House Majority Leader Rep. Kevin McCarthy at his Bakersfield office. PNHPers also hosted a public screening of the film "Now is the Time" at the Berkeley Public Library with Healthcare for All California. To get involved in California, contact Dr. Hank Abrons at **pnhpca@pnhp.org**.

SNaHP members participate in the "Protect our Patients" campaign at UCLA.

In **Washington, D.C.**, Dr. Diljeet Singh spoke on the need for Medicare for All at the "Rally to Save Healthcare" with Sen. John Warner in Alexandria, Va. The rally was one of hundreds of similar actions across the country in January organized in response to a call-to-action by Sen. Bernie Sanders. (Nationally, PNHP joined with Planned Parenthood, the National Physicians Alliance, Public Citizen, and other groups to collect and turn in more than 510,000 signatures opposing Rep. Tom Price's nomination for secretary of the Department of Health and Human Services.) Many PNHPers from across the country participated in the PNHP contingent in the Women's March on Washington, including PNHP President Dr. Carol Paris and our immediate past president, Dr. Robert Zarr. To get involved in D.C., contact Dr. Zarr at **rlzarr@yahoo.com**.

PNHP members at the Women's March on Washington, Jan. 21.

In **Illinois**, PNHPers have been active in speaking, and media and public outreach. PNHP national board member Dr. Susan Rogers gave a presentation on single payer to Rush University medical students, was featured on the local news program "Chicago Tonight," and delivered grand rounds at Florida State University College of Medicine. Dr. Alan Jackson led a workshop on single payer at the Student National Medical Association's regional meeting. PNHP also hosted a table at the SNMA meeting for the fifth consecutive year. Dr. Daniel Yohanna organized a grand rounds by Dr. Steffie Woolhander to the Department of Psychiatry and Behavioral Neuroscience at the University of Chicago. Drs. Claudia Fegan, Peter Orris, David Ansell and Phil Verhoef are frequent speakers to physicians, community groups and medical students about medical inequality and health disparities. Drs. Beth Dowell and David Ubogy hosted a chapter meeting in their home in Oak Park, raising $445 for the Nick Skala Scholarship Fund. Finally, PNHP and SNaHP members participated in the Women's March on Chicago, and distributed flyers at the American Medical Association's headquarters in Chicago opposing Rep. Tom Price's nomination as secretary for health and human services. To get involved in Illinois, contact Dr. Anne Scheetz at **anneschеetz@gmail.com**.

Chicago students distribute flyers against HHS nominee Tom Price.

In **Kentucky**, PNHPers participated in a rally in Louisville on Martin Luther King Day to defend Medicaid, Medicare, and the ACA from the Trump administration. The crowd applauded when Rep. John Yarmuth – a cosponsor of H.R. 676, the national single-payer bill – spoke in support of single payer. Members of the state's PNHP chapter, Kentuckians for Single Payer Health Care, also supported the Kentucky Alliance's "People's Inauguration" and participated in a "Rally to Move Forward" carrying large "Medicare for All" banners. To get involved in Kentucky, contact Dr. Garrett Adams at **kyhealthcare@aol.com**.

In **Louisiana**, Dr. Elmore Rigamer is active in speaking and helping medical students organize a SNaHP chapter at Louisiana State University (LSU) School of Medicine. Students at LSU, galvanized by the recent election, are planning to host a single-payer debate in the coming months. To get involved in New Orleans, contact Dr. Rigamer at **erigamer@ccano.org**.

In **Maine**, members of the state's PNHP chapter, Maine AllCare, hosted many talks, film screenings, and literature tables at art fairs and other events during the past year. Members signed up over 3,000 residents who support "healthcare for everyone" on Election Day, and a delegation of members traveled to Washington, D.C., to participate in the Women's March. Maine AllCare recently joined the steering committee of the Healthcare is a Human Right Campaign. To get involved in Maine AllCare, contact Dr. Phil Caper at **pcpcaper21@gmail.com**.

Maine PNHP members Dr. Phil Caper and Delene Perley at the Women's March on Washington.

In **Maryland**, PNHPers and other single-payer activists marched in the Martin Luther King Day parade in Baltimore under the banner of their statewide group, Healthcare is a Human Right (HCHR). HCHR Maryland hosted several screenings of a new documentary on single payer, "Now is the Time." The film is the sequel to "The Healthcare Movie" created by filmmakers Laurie Simmons and Terry Sterrenberg. The new movie features two local activists, Dr. Margaret Flowers and former HCHR staffer Sergio Espana. Finally, the campaign welcomed new statewide organizer, Brittany Shannahan, on February 1. To get involved in Maryland, contact Dr. Eric Naumburg at **HCHRMaryland@gmail.com**.

In **Minnesota**, the University of Minnesota-Duluth SNaHP chapter hosted a phone bank to call on Minnesota's members of Congress to oppose repealing the ACA without an equivalent or better replacement. The action was organized in conjunction with a national event supported by SNaHP and the #ProtectOurPatients student movement. To get involved in Minnesota, contact Dr. Chuck Sawyer at **csawyer@nwhealth.edu**.

In **New Hampshire**, Granite State PNHPers have been active in medical society outreach, lobbying, and medical student outreach. Activists established a single-payer interest group within the New Hampshire Medical Society (NHMS). The NHMS is including a four-page insert on single payer in its next quarterly newsletter promoting the Physicians' Proposal for Single Payer and the companion article in the American Journal of Public Health, "Moving forward from the Affordable Care Act to a single-payer system." PNHPers also drafted a bill for the state Legislature that calls for a study of the feasibility of universal coverage. The bill received support from the Committee on Health and Human Services, and PNHP members recently testified at a Commerce Committee hearing. The chapter is also supporting the development of a SNaHP chapter at the Geisel School of Medicine at Dartmouth in Hanover. Activists provided faculty for a Geisel School of Medicine elective called "The Equitable Distribution of Health Care in America." Finally, PNHP members are active in speaking on single payer to community groups and medical staff meetings. To get involved in New Hampshire, contact Dr. Don Kollisch at **donald.o.kollisch@dartmouth.edu**.

In **New York**, members of the New York Metro PNHP chapter participated in a press conference with New York City Health Commissioner Mary Bassett and other groups to denounce threats to repeal the ACA and to oppose the nomination of Tom Price as secretary of HHS. The event was covered by local news media, including several Spanish-language media outlets, and Dr. Oliver Fein appeared on Thom Hartmann's nationally syndicated television show. A large delegation of PNHPers participated in the New York Women's March. The chapter is organizing around the state single-payer bill, the New York Health Act, as well as single-payer legislation in the Congress. Four new activists have joined the board: Dr. Cheryl Kunis, Dr. Roona Ray, Henry Moss, Ph.D., and Michael Zingman, M.P.H. Members of the SNaHP chapter at Albany Medical College joined the national "Protect our Patients" day of action to oppose the repeal of Obamacare. Students carried signs declaring health care as a human right and marched from the Capitol Building to Congressman Paul Tonko's office. To get involved in New York, contact Katie Robbins at **katie@pnhpnymetro.org**.

New York Metro leaders spoke at a press conference, Jan. 5, joined by New York City Health Commissioner Dr. Mary Bassett (left).

In Chapel Hill, **North Carolina**, Health Care for All North Carolina delivered nearly 4,000 letters supporting Medicaid expansion to the governor's office in collaboration with the Coalition for Health Care of North Carolina. The chapter also cosponsored a legislative forum on Medicaid expansion that included six state legislators, and helped garner support from 20 churches and synagogues for Medicaid expansion. Chapter leader Dr. Jonathan Kotch reports plans for a board retreat with a professional facilitator to help the group focus on its core mission, single payer, and begin developing strategies for community organizing. To get involved in Chapel Hill, contact Dr. Jonathan Kotch at **jbkotch@yahoo.com**.

In **Charlotte, N.C.**, over 60 people attended the annual meeting of the Health Care Justice chapter of PNHP. Chapter Chair Dr. Jessica Schorr Saxe was the keynote speaker with a talk on "Health Care: Where We Are, What to Expect, and What to Aspire to." Dr. Andrea DeSantis is active in organizing a single-payer member interest group in the American Academy of Family Practice. She led a workshop at the PNHP meeting in Washington, D.C., on organizing medical societies for single payer. Dr. Denise Finck-Rothman organized the chapter's participation in several events, including the Pride Parade, the Martin Luther King Parade, and the Women's March on Charlotte. Margie Storch spoke at the "Save Our Health Care" rally and the Southern Piedmont Central Labor Council about single-payer health care. Finally, Dr. Saxe spoke to the interfaith group Mecklenburg Ministries, and helped chapter board member Marian Silverman screen "Fix It" to Havurat Tikvah, a Reconstructionist Jewish congregation. To get involved in Charlotte, contact Dr. Jessica Schorr Saxe at **jessica.schorr.saxe@gmail.com**.

PNHP members carry a PNHP banner in the Women's March on Charlotte, N.C.

In **Oregon**, the Portland and Corvallis chapters of PNHP host monthly meetings and are active in outreach to the state Legislature. A new, third Oregon PNHP chapter extends to teaching institutions across the state; its members include deans and senior faculty in public health, nursing, and allopathic and osteopathic schools, as well as faculty in public policy and political science programs. In January, PNHPers hosted seminars featuring former Gov. John Kitzhaber of Oregon and former Gov. Martin O'Malley of Maryland in conjunction with the City Clubs of Portland, Salem and Bend. The seminars drew a broad spectrum of participants, including CEOs, clinic and hospital leaders, legislators, health care providers, and community members. The Oregon Health and Sciences University SNaHP chapter hosted a viewing of "Now is the Time: Healthcare for Everybody." They also met with former Gov. Kitzhaber to talk about the future of health care reform in Oregon. To get involved, contact Dr. Peter Mahr at **peter.n.mahr@gmail.com** or Dr. Mike Huntington at 541-829-1182.

In **Pennsylvania,** the Villanova SNaHP chapter participated in a fall activity fair with the Center for Peace and Justice, and presented a workshop at the Villanova Freedom School titled "Healthcare Inequality in America." The Freedom School is a Villanova University celebration of the legacy of Martin Luther King Jr., featuring presentations by students and professors about inequality and oppression. PNHPers also participated in several recent actions and demonstrations, including the Philadelphia Women's March. To get involved in Pennsylvania, contact Dr. Walter Tsou at **macman@aol.com**.

In **Tennessee**, the West Tennessee Providers for a National Health Plan named Dr. Roger LaBonte chapter president for 2017. In association with the University of Tennessee SNaHP chapter, the group sponsored a public showing of "The Healthcare Movie" to 30 participants. Medical student Diana Alsbrook helped facilitate the discussion afterwards. The chapter also screened "Fix It – Healthcare at the Tipping Point" in Dr. Labonte's home in Memphis to about two dozen local businesspeople. Several members, including Drs. LaBonte and Art Sutherland, and medical student Anand Saha, published letters to the editor in local newspapers. The chapter is also working with the University of Tennessee SNaHP chapter in their efforts to recruit new student leaders. To get involved in Western Tennessee, contact Dr. LaBonte at **rlabonte02@gmail.com**.


PNHP members and business community leaders meet for a screening of "Fix It" in Memphis.

In Washington, the PNHP Western Washington chapter hosts popular monthly meetings. The chapter cosponsored successful resolutions before the Seattle City Council and the County Council asking Washington's congressional delegation to support the expansion of Social Security and Medicare. The chapter participated in demonstrations against ZoomCare, a chain of urgent care clinics, condemning the company and its financial backer, Endeavor Capital, for its for-profit business model and discriminatory denial of service to Medicaid and Medicare beneficiaries. The PNHP Western Washington chapter was instrumental in starting the Health Care is a Human Right–Washington coalition three years ago. At its latest meeting, more than 80 participants from 50 organizations agreed that HCHR-WA will lead the movement to resist attacks on exiting health programs and press forward for single payer. PNHPers are active in speaking to community groups and participated in several recent demonstrations, including the "Rally to Protect Healthcare" at Westlake Park, the rally at the Martin Luther King Jr. Day celebration, and the Women's March on Seattle. To get involved in Western Washington, contact Dr. David McLanahan at pnhpww@gmail.com.

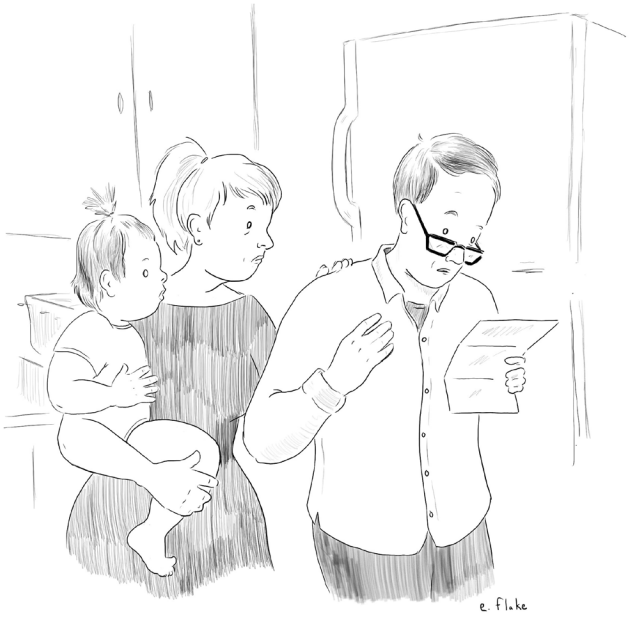
PNHP Western Washington marching in the MLK Jr. Day Parade in Seattle.

In **Wisconsin**, the Linda and Gene Farley Wisconsin Chapter of PNHP and the University of Wisconsin School of Medical and Public Health SNaHP chapters are active in organizing and outreach. Dr. Joseph Eichensaher recently spoke to three Rotary Clubs near Madison on single payer. Chapter members, including Dr. Melissa Stiles, participated in a press conference for "Healthcare as a Human Right" on Martin Luther King Day with the president of the Wisconsin chapter of the National Physicians Alliance, Dr. Jeff Huebner. SNaHP members helped organize a rally outside House Speaker's Paul Ryan's office in Janesville, Wis., where they delivered a petition signed by hundreds of medical students and physicians opposing the proposed Planned Parenthood cuts. Wisconsin PNHP and SNaHP also participated in call-in campaigns to oppose the ACA repeal without a viable alternative. To get involved in Wisconsin, contact Dr. Melissa Stiles at **melstiles1@gmail.com**.

Wisconsin PNHP member Dr. Melissa Stiles at a news conference at the State Capitol in Madison, Jan. 16.

SNaHP, PNHP's student section, organized a national Medicare-for-all day of action on Halloween called #TreatNotTrick. The tagline was, "Private health insurance is a trick, we just want to treat our patients." SNaHP chapters representing more than 30 schools around the country organized events ranging from vigils and marches to teach-ins and film screenings. SNaHP's leadership teams have also been active. The SNaHP Political Advocacy team published an op-ed in Common Dreams opposing Tom Price's nomination to head the Department of Health and Human Services. The team also organized a call-in day to defend the Affordable Care Act and push for an improved Medicare-for-all. The SNaHP Media team created a new website (**www.student.pnhp.org**) and blog to publish the written work of students on single-payer topics and serve as a hub for SNaHP information. The Health Justice Coalition team co-hosted a webinar with White Coats for Black Lives featuring Vernellia Randell, author of Dying While Black, on the topic of health care, racism, and single payer. The SNaHP Education and Base Building team is recruiting health professional students to serve as "regional chairs." Chairs will act as point people for communication among the over 50 SNaHP chapters around the country. Contact Emily Henkels at **organizer@pnhp.org** for more information.

Finally, SNaHP is currently wrapping up plans for the sixth annual SNaHP Summit at Lewis Katz School of Medicine at Temple University in Philadelphia in March. The theme of this year's summit is "From the Streets to the Hill" and will focus on organizing strategies for single payer; the keynote speaker is Nijmie Dzurinko of Put People First! Pennsylvania.



"It says our health insurance is being replaced by a series of tweets calling us losers."

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