PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter Spring 2015

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

Single-payer bill introduced in Congress

Rep. John Conyers Jr., D-Mich., reintroduced the "Expanded and Improved Medicare for All Act," H.R. 676, along with 44 other House members, on Feb 3. Conyers' bill would replace our fragmented payment system with an expanded and improved version of traditional Medicare. H.R. 676 would fundamentally reform the U.S. health system, replacing today's market-orientation that treats illness as a "profit center" with a service-oriented system that delivers care based on medical need. The bill largely mirrors PNHP's proposal for single-payer national health insurance. The text and current list of co-sponsors can be found at pnhp.org/HR676-sponsors. Please thank your representative for becoming a co-sponsor or urge them to do so, as the case may be. Call the Capitol switchboard at (202) 224-3121.

Single payer in the states

Vermont's "pathway to single payer" hit a roadblock in late December when Gov. Peter Shumlin balked at the high tax rates and the lack of any administrative savings his aides projected under his Green Mountain Care plan. Although Shumlin's plan was far from single payer, there are plenty of lessons for PNHPers in other states (see p. 28). Subsequently in Vermont, in February, legislation to publicly finance primary care for all using a capitation payment scheme (H. 207) was introduced.

Meanwhile, PNHP chapters and activists in Massachusetts, New York, Maine, New Hampshire, Rhode Island, South Carolina, Illinois and Oregon report that single-payer bills have been introduced into their legislatures for consideration in 2015. Hundreds of people turned out across New York state for a series of hearings on its single-payer legislation (see p. 31). Dr. Donald Berwick, formerly the top administrator of Medicare, recently spoke at a rally in support of the Massachusetts bill. He also spoke at PNHP's Annual Meeting in New Orleans on single payer and the Triple Aim (see p. 19).

Annual Meeting on October 31, Chicago

PNHP's 2015 Annual Meeting will be held in Chicago on Saturday, Oct. 31, 2015. It will be preceded by our popular Leadership Training course, which is being expanded to a full day. Our meeting in New Orleans last November drew 250 participants, including over 80 medical students. Highlights from the meeting and a new PNHP slide set for use in grand rounds may be found at pnhp.org/2014-annual-meeting-materials.

Student Summit: 'Healing the Heart of Medicine'

Over 170 medical and other health professional students from more than 50 institutions gathered at the University of Illinois, Chicago, for the fourth annual Students for a National Health Program (SNaHP) Summit on Feb. 14. Speakers included Drs. Robert Zarr, Claudia Fegan and Linda Rae Murray. The program included more than a dozen workshops with titles such as "Single Payer 101," "Building a Social Media Presence," "Intersections of Race, Health and Social Justice," and "Myth Busters: Answering Difficult Questions about Single Payer."

The SNaHP Summit is PNHP's largest student gathering and is organized and led by medical students. This year SNaHP worked with local chapters of the Student National Medical Association and the Latino Medical Student Association. In December, students at 91 medical schools held "White Coat Die-Ins" (pnhp.org/die-ins) in support of the Black Lives Matter movement.

In This Issue

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2015

Editors: Dr. David Himmelstein, Dr. Steffie Woolhandler, Dr. Ida Hellander, and Mark Almberg.

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

Local chapter staff include Katie Robbins and Annette Gaudino (New York Metro); Dr. Bill Skeen, Perla Flores, and Angelica Ramirez (California); and Taina Maki (Minnesota).

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

Membership drive update

Welcome to 648 physicians and medical students who have joined PNHP in the past year! PNHP's membership stands at 19,619. We invite new (and longtime) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community. Need help getting started? Drop a note to PNHP National Organizer Emily Henkels at e.henkels@pnhp.org.

Research/Media Update

PNHP President Dr. Robert Zarr appeared on Thom Hartmann's "The Big Picture" TV program in February. CNBC and the New Republic reported that single payer would free up $375 billion a year now spent on billing and insurance-related tasks, citing research led by Aliya Jawani, with PNHPers Dr. Jim Kahn, Steffie Woolhandler and David Himmelstein. Their study was published in the journal BMC Health Services Research in January (see p. 40). HealthDay's Physician's Briefing, Medscape and others reported on findings by Woolhandler and Himmelstein that doctors spend an average of 8.7 hours per week, or 16.6 percent of their time, on administrative tasks, and doctors who spend more time on bureaucracy report lower professional satisfaction. In 2014, an estimated $102 billion in physician time was spent on administration. A new study co-authored by PNHPer Dr. Wes Boyd found that psychiatric care is difficult to get, even for the well-insured. Researchers posing as patients were able to get appointments with only 26 percent of doctors listed as in-network for Blue Cross and Blue Shield in three cities. The study received coverage in Psychiatric News and Reuters, among other outlets (see p. 41).

The International Journal of Health Services recently published "The Affordable Care Act and Medical Loss Ratios: No Impact in First Three Years" by Benjamin Day, Dr. David U. Himmelstein, Michael Broder, and Dr. Steffie Woolhandler. See p. 25.

Several media outlets, including The New Yorker and The New York Times, cited studies by PNHP's Andrew Wilper, Steffie Woolhandler, David Himmelstein and Danny McCormick in their coverage of King v. Burwell, the most recent challenge to the Affordable Care Act. The studies documented both the deaths and under-treatment of chronic illness among the uninsured, and was also cited in at least one amicus brief.

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

PNHP is hosting exhibits at the meetings of the American College of Physicians (Boston, April 30-May 2), the American Psychiatric Association (Toronto, May 4-6), the American Society of Clinical Oncology (Chicago, May 30-June 1), the American Academy of Family Practice (Denver, Oct. 1-3), and the American Public Health Association (Chicago, Nov. 1-4). Drs. Parker Duncan, Michael Kaplan, and Alap Shah, among others, have formed a single-payer interest group within the AAFP. If you would like to join the group and help promote single payer at the AAFP 2015 meeting, please drop a note to Dr. Alap Shah at alap.pradip.shah@gmail.com.

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

UNINSURED AND UNDERINSURED

• As of Feb. 15, enrollment in the Affordable Care Act's exchange health plans for 2015 was 11.4 million, up 4.7 million over enrollment at the end of 2014, but less than the 13 million originally projected by the Congressional Budget Office. An estimated 5.4 million of the enrollees were previously uninsured and will stay on their exchange plans until the end of the year. Medicaid and CHIP enrollment is up by 13.7 million since 2013, including both people who were already eligible and people newly eligible under the Medicaid expansion. The deadline for enrolling on the exchanges has been extended to April 15 in most states; Medicaid enrollment is open year-round ("Total monthly Medicaid and CHIP enrollment," Kaiser Family Foundation, Timeframe: November 2014 and Roy, Forbes, 2/18/15).

• The CBO projects that the ACA will eventually reduce the number of uninsured by 25 million people, but 27 million will remain uninsured in 2025. Of those, less than one-third will be undocumented immigrants; 10 percent will be people in poverty who live in states that have not expanded Medicaid; and the rest will be those who "opt not to enroll" (Pear, "Budget office slashes estimated cost of health coverage," New York Times, 1/26/15; CBO, March 2015).

• 42.0 million Americans (13.4 percent of the population), including 5.9 million children (7.6 percent of all children) were uninsured during all of 2013, according to the U.S. Census Bureau. Minorities were more likely to be uninsured: 15.9 percent of Blacks and 24.3 percent of Hispanics were uninsured, compared with 9.8 percent of non-Hispanic Whites.

53.9 percent of the population had employment-based private coverage in 2013, down dramatically from 69.2 percent in 2000. Over one-third of the population was covered by government health insurance in 2013, not counting civilian government employees such as teachers, whose coverage is also government-funded. The largest public program was Medicaid (54.1 million people), followed by Medicare (49.0 million) and military health care (14.1 million in VA, Tricare, and other programs). The Census Bureau adopted new definitions of health insurance coverage in 2013, so this year's figures are not directly comparable to previous years'. Additionally, they predate the launch of the ACA's main coverage expansion provisions, which started in 2014 ("Health Insurance Coverage in the United States: 2013," U.S. Census Bureau).

• Preliminary data from the second half of 2014 indicate that major problems with access to care for adults age 19-64 remain, despite some improvements. According to a survey conducted by the Commonwealth Fund, 66 million people reported delaying or forgoing needed medical care in the past year due to cost, down from 75 million in 2010. A similar number of people reported problems with medical debt in 2014, 64 million, down from 73 million in 2014. The Commonwealth Fund estimated that 29 million working age adults were uninsured in late 2014, down from 37 million in 2010 (Collins et al., "The rise in health care coverage and affordability since health reform took effect," Commonwealth Fund, 1/15/15).

• The number of people who are underinsured has continued to rise since the passage of the ACA in 2010, with the poor and sick being most likely to be underinsured, according to the Commonwealth Fund. In 2014, 39 million adults age 19-64 were underinsured (21 percent), up from 16 percent in 2010 and 10 percent in 2003. Underinsurance was defined as being insured all year but having out-of-pocket medical costs (excluding premiums) in excess of 10 percent of income (5 percent when income is less than 200 percent of the federal poverty line) or having an insurance deductible of 5 percent of income or more.

41 percent of insured people with incomes below the poverty line were underinsured in 2014, as were 27 percent of people in fair or poor health or who reported more than one chronic condition. One-quarter of the poor have deductibles exceeding 5 percent of their incomes, double the national average, and 58 percent of the poor report having trouble paying their deductible, compared to 43 percent of all privately insured adults. High deductibles limit access to care: 40 percent of people with deductibles over 5 percent of their income reported that they delayed or went without medical care. Similarly, nearly half (46 percent) of insured adults with incomes under 200 percent of poverty said they did not fill a prescription or see a doctor when needed due to copayments or coinsurance, compared to 21 percent of adults with higher incomes (Collins et al., "Too high a price: Out-of-pocket healthcare costs in the United States," Commonwealth Fund, November 2014).

> Private insurance doesn't offer adequate financial protection, according to a poll of non-elderly adults with private coverage. Half of the privately insured reported not going to the doctor when sick, going without preventive or recommended care, and other access problems. About 1 out of 8 privately insured adults, more than 16 million people, reported that medical bills have caused major financial hardships like going without basic needs or using up all their savings. 1 in 4 people with high deductible health plans reported that they used up all their savings paying for health care. ("Privately insured in America: Opinions on Health Care Costs and Coverage," AP-NORC Center for Public Affairs Research, November 2014).

• Privately insured ACA enrollees are flooding community health centers. About 20 percent of enrollees are in bronze plans, with deductibles that average $5,331 for an individual. Some plans even require that the full deductible be paid before any drug coverage kicks in. The out-of-pocket cap for bronze plans

in 2015 is a whopping $6,600 for an individual and $13,200 for a family. The Department of Health and Human Services (HHS) ruled in September that community health centers are allowed to offer sliding-scale fees to privately insured patients under 200 percent of poverty and write off the discounts as uncompensated care. "Some people with these plans are reluctant to get health care at all," reported Deb Polun at the Community Health Center Association of Connecticut (Dickson, "Uninsured ACA enrollees strain health centers," Modern Healthcare, 9/29/14).

• On Jan. 1, Walmart stopped providing health coverage to about 30,000 part-time employees who worked less than 30 hours per week. Walmart's employee health plan covers only 60 percent of health care costs, equivalent to a bronze plan under the ACA. The firm said it would help employees find other forms of coverage. It's low-wage, part-time workers are likely to be eligible for Medicaid or subsidized private insurance on the health exchanges, effectively making taxpayers underwrite Walmart's profits. In 2013, 62 percent of large retail chains didn't offer health benefits to any part-time workers, up from 56 percent in 2009 (AP, "Walmart scraps health benefits for some part-timers," 10/7/14).

• Although coverage for "pediatric services" is mandated under the ACA as an essential benefit, there is no uniform definition of what is included. Other than covering oral health and vision care, state benchmark plans vary in their coverage for pediatric conditions, and many specifically exclude services for children with special health care needs (e.g. autism) (Grace et al., "The ACA's Pediatric Essential Health Benefit," Health Affairs, December 2014).

• A glitch over hospital benefits in the online calculator developed by HHS to check if coverage met "minimum value" standards for 2015 under the ACA has left a "significant" number of low-wage employees of large firms underinsured. Large employers may be fined up to $3,120 per worker next year if they don't provide "minimum value insurance." But the HHS calculator gave insurance plans without any coverage for hospitalization the green light. With premiums about half of what plans with hospital benefits cost, a significant number of low-wage employers that hadn't offered coverage before, like retailers, restaurants and hotel chains, signed up for the hospital-free insurance. It's not clear what will happen to employers – or their employees – who have already bought the skimpy policies (Hancock, "Administration signals doubts about calculator permitting plans without hospital benefits," Kaiser Health News, 10/16/14).

NETWORK BLUES

• Half of all doctors listed by insurers as accepting Medicaid patients don't offer appointments to enrollees, according to the Office of the Inspector General in HHS. Investigators called 1,800 providers listed by more than 200 health plans under contract with Medicaid in 32 states. 35 percent of providers were not at the location listed, 8 percent did not participate in the Medicaid plan listed, and another 8 percent were not accepting new patients (Pear, "Half of doctors listed as serving Medicaid are unavailable, investigation finds," New York Times, 12/8/14).

There are no in-network E.D. doctors for Humana or UnitedHealthcare at about half of Texas hospitals (56 and 45 percent, respectively), and no in-network E.D. doctors for Blue Cross at one-fourth (24 percent) of Texas hospitals, according to a recent study. Increasingly, E.D. physicians, anesthesiologists, and radiologists are employed by firms that contract to provide care in hospitals, not for the hospitals themselves. As a result, patients with medical emergencies are getting stuck with uncovered doctors' bills, even when they seek care at an in-network hospital ("Network blues: Big bills surprise some E.R. patients," Center for Public Policy Priorities, Houston Public Media, 11/11/14).

• More than 25 percent of the physicians listed by Blue Shield and Anthem Blue Cross as in-network for the plans they sold on the Covered California health exchange were not at the stated location or were not accepting exchange plans, according to an investigation by the state's Department of Managed Health Care. The two insurers accounted for about 60 percent of ACA enrollment in California for 2014. A number of lawsuits have been filed in the state by patients who inadvertently saw out-of-network providers and received large bills (Terhune, "Top insurers overstated doctor networks, California regulators charge," Los Angeles Times, 2/5/15).

DRUG BENEFITS DESIGNED TO EXCLUDE OR PENALIZE THE SICK

• Insurers are designing their drug benefits to discourage HIV-infected and other expensively ill patients from choosing their plans on the health exchanges. A study of the cost sharing required for nucleoside reverse-transcriptase inhibitors (NRTIs), a common class of drug prescribed for HIV, found that 12 of 48 "silver" plans from 12 states were "adverse tiering plans" (ATPs), that is, they place all NRTI drugs in a tier level with a copayment or coinsurance of at least 30 percent. In ATP plans, the average annual cost per drug ($4,892) was more than triple that for enrollees in non-ATP plans ($1,615). Half of the ATP plans also had a drug-specific deductible (i.e. a payment that must be made towards the cost before insurance kicks in), compared to 19 percent of other plans. An earlier study in the American Journal of Managed Care found that Massachusetts' health plans used drug tiering to penalize employees who need the drugs of choice for a wide range of chronic conditions, including diabetes, HIV, psychosis, and multiple sclerosis (Jacobs, "Using drugs to discriminate – adverse selection in the insurance marketplace," NEJM, 1/29/15)

• Medicare Part D plans are shifting more costs to seniors. Two-thirds of Medicare Part D plans now have at least two tiers that charge coinsurance (i.e. a percentage of cost rather than a fixed payment), "specialty" and "non-preferred brand" tiers. While there are rules limiting what drugs insurers may put on the spe-

cialty tier, and the amount of cost sharing that may be imposed, there are no limits on the second coinsurance tier. Insurers may put drugs taken by a large proportion of the population, and even expensive generics, on the second coinsurance tier, with seniors required to pay 35 percent to 50 percent of a drug's actual cost. The added tier means that formularies with five tiers with varying amounts of cost sharing are now the norm, used by 89 percent of plans ("Avalere Analysis: Medicare beneficiaries will pay higher out-of-pocket costs as PDP's increase use of coinsurance in 2015," 11/13/14).

COSTS

• The ACA will cost nearly $1.707 trillion over the next 10 years, according to the latest projections from the CBO. About $849 billion will be for subsidies for private insurance ($599 billion in tax credits for premiums and $136 billion for a second set of subsidies that offset cost sharing for low-income people). $847 billion of the ACA's costs will go to fund Medicaid and CHIP. The private insurance subsidies are substantial, on average $3,960 per newly covered household in 2015, rising to $6,600 per household in 2025. Starting in 2018 the ACA imposes a 40 percent excise tax (the so-called Cadillac tax) on insurance plans with premiums over $10,200 for individual coverage and $27,500 for family coverage. Such plans often cover union members at firms with older, sicker workers that have hung on to decent benefits through wage concessions over the years. The CBO projects the excise tax will raise $87 billion over eight years ("Insurance Coverage Provisions of the Affordable Care Act – CBO's March 2015 Baseline").

It's a myth that the U.S. has a privately financed health care system. In 2015, U.S. health spending is projected to rise to $3.2 trillion, $9,982 per capita, 17.6 percent of GDP, according to the Centers for Medicare and Medicare Services. Government's share of spending is 46 percent (excluding tax subsidies for the purchase of private insurance and public workers' coverage), compared to 26 percent by households and 20 percent by business (Sisko et al., "National Health Expenditure Projections, 2013-23: Faster Growth Expected With Expanded Coverage And Improving Economy," Health Affairs, 9/3/14).

• The average annual premium for employer-sponsored family health coverage was $16,834 in 2014. Workers paid $4,823 of the premium. Individual coverage averaged $6,025, with workers contributing $1,081. In 2014 the average deductible for employer-sponsored health insurance was $1,217, nearly double the average deductible of $584 in 2006. In 2014, 41 percent of covered workers had deductibles over $1,000, and 18 percent had deductibles over $2,000. Workers in firms with fewer than 200 workers are hardest hit, with an average deductible of $1,797, and 34 percent of employees facing deductibles of $2,000 or more ("Employer-Sponsored Family Health Premiums Rise 3 Percent in 2014," Kaiser Family Foundation, 9/10/14).

The Consumer Financial Protection Bureau estimates that 43 million patients have medical debt in collection, and that medical collections make up 52 percent of collection accounts on credit reports, far more than other types of debt (Hillebrand, "7 ways to keep medical debt in check," Consumer Financial Protection Bureau, 12/11/14).

• As health care costs continue to outstrip wage growth, they are consuming a larger share of family income. The cost of employer-sponsored family coverage has climbed by 73 percent since 2003, while median family income has risen by only 16 percent. As a result, average annual premiums were 23 percent of median family income in 2013, up from 15 percent in 2003. Strikingly, average deductibles for an individual plan were 5 percent of median income in 2013, up from 2 percent in 2003. Having a deductible that meets or exceeds 5 percent of income is one definition of underinsurance. In 2013, the combination of premium contributions and deductibles for individual coverage averaged 9 percent of median income (Collins et al., "National Trends in the Cost of Employer Health Insurance Coverage, 2003-2013," Commonwealth Fund, 12/9/14).

Enrollment in high-deductible health plans with a health savings account (HSA) option rose to 20 percent of all covered employees in 2013, up from 8 percent in 2009. In 2013, the average deductible for these plans was $2,098 for single coverage and $4,037 for family coverage. While the average employer contribution to companion HSAs was $950 for individual plans and $1,680 for family plans, about half of employers didn't contribute towards the accounts at all. In 2015, nearly a third of large employers will offer only high-deductible plans (Bernard, "High health plan deductibles weigh down more employees," New York Times, 9/1/14).

• In 2013, states paid $25.1 billion towards the coverage of 2.7 million public workers, while workers contributed $5.6 billion. The coverage varied from state to state, but had an average actuarial value of 92 percent (indicative of reasonably good coverage); 80 percent of state employees had an annual deductible less than $500. Local government employees were excluded from the analysis ("State Employee Health Spending," Pew Charitable Trusts, 8/12/14).

MEDICARE, INC.

• Since 1985, private Medicare Advantage plans have cost Medicare nearly $300 billion more than care would have cost in traditional Medicare. Medicare Advantage plans now enroll about 30 percent of all Medicare beneficiaries (15.7 million), up from 13 percent in 2005. A rising share of people (22 percent) newly eligible for Medicare elect Medicare Advantage plans, up from 15 percent in 2006. Among current enrollees, the same proportion (less than 5 percent) switch from traditional Medicare to Medicare Advantage each year as switch from private plans to the traditional program. However, high-needs patients, such as those dually eligible for Medicare and Medicaid, and disabled

persons under age 65, disenroll from private Medicare Advantage plans at higher than average rates (10.1 percent and 7.0 percent, respectively) ("At least half of new Medicare Advantage enrollees had switched from traditional Medicare during 2006-2011," Kaiser Family Foundation, January 2015).

• The Centers for Medicare and Medicaid Services (CMS) took 35 enforcement actions against Medicare Advantage plans and Medicare Part D drug plans in 2014, the most since it started scrutinizing plans more closely in 2010. Agency audits showed insurers don't comply with basic standards despite repeated instructions. The most commonly found problems included inappropriate denials of care, and requiring unnecessary preauthorization of services and medications, resulting in cost shifting to beneficiaries. However, the fines imposed by CMS have been paltry. Thirty firms paid civil penalties totaling $4.9 million, and only five firms were barred from enrolling new beneficiaries until the problems are resolved. UnitedHealthcare paid the largest fine CMS has ever levied against a Medicare Advantage plan, a mere $2.2 million, in 2012; the insurer has Medicare revenues of $44 billion annually (Herman, "Medicare is doing more to police Advantage and Part D lapses, but does it matter?" Modern Healthcare, 12/4/14).

• Several whistleblower lawsuits have been filed under the False Claims Act alleging that providers and Medicare Advantage plans defrauded the Medicare program by manipulating their members' medical data to make them appear sicker (so-called upcoding) in order to inflate payments. A new industry has sprung up around sending physicians to enrollees' homes to document diagnoses (without offering to treat them) that boost the risk scores used to calculate Medicare's capitated payments. In one of the lawsuits, an employee of Santa Ana-based MedXM alleges that the firm made diagnoses without proper examinations or tests for Medicare Advantage plans in six states. According to a 2013 Government Accountability Office report, Medicare Advantage risk scores were 4.2 percent higher in 2010 than they would have been if the same beneficiaries had been enrolled in traditional Medicare. CMS estimates it made $70 billion in "improper" payments to insurers between 2009 and 2013, mostly overbillings due to inflated risk scores. The OIG plans to investigate the matter this year (Schencker, "Were patients really sicker?" Modern Healthcare, 11/24/14, and Schulte, "Another whistleblower suit alleges Medicare Advantage fraud," Center for Public Integrity, 10/29/14).

• A literature review of 40 studies since 2000 on health care access and quality in Medicare Advantage plans versus traditional Medicare by the Kaiser Family Foundation found that beneficiaries rated traditional Medicare more favorably than Medicare Advantage plans in terms of quality and access, and this difference was particularly large among beneficiaries who are sick. Older, more established Medicare HMOs tended to perform better than traditional Medicare in delivering preventive service. However, the research dates from before 2010, when the ACA added first-dollar coverage for preventive care. HMOs' resource use was somewhat lower, but it's not clear how that affected sicker patients. Few studies focused on sicker beneficiaries who need more care (Gold and Casillas, "What do we know about health care access and quality in the Medicare Advantage versus the traditional Medicare program?" Kaiser Family Foundation, 11/6/14).

MEDICAID: ADDING NEW FINANCIAL BARRIERS TO CARE

• The median monthly income of adults who would be eligible for Medicaid, but live in one of the 23 states that didn't expand Medicaid in 2014, is $792. About 4.5 million low-income, uninsured adults in those states would qualify for expanded Medicaid, including 42 percent of all uninsured black adults in the U.S. (Modern Healthcare, 10/20/14).

• In Arkansas, spending to buy private plans (its alternative to expanding Medicaid) exceeded estimates by $9.3 million in 2014. Now, Arkansas legislators are seeking to charge premiums of $5 monthly for Medicaid enrollees with incomes from 50 percent to 99 percent of the federal poverty line, and to impose cost sharing on those who don't pay. Since the Arkansas Legislature must reauthorize the expansion every year with a 75 percent majority, the state's GOP can threaten to shut down the expansion if the federal government will not accept their harsh conditions (Dickson, "CMS gives Arkansas, Iowa more leeway in Medicaid expansion waivers," Modern Healthcare, 1/5/15).

• Since Arkansas received a CMS waiver to go ahead with its "private" Medicaid option, Medicaid programs in several other GOP-controlled states have received permission from the Obama administration to make changes that penalize Medicaid enrollees. Some states, like Alabama and Wyoming, are seeking a work requirement for eligibility, although none have received a waiver to do so yet. Pennsylvania's newly elected Democratic governor recently announced that the state would drop its request for a waiver and instead expand traditional Medicaid (Giammarise, "Federal regulators approve Gov. Corbett's 'Healthy PA' Medicaid overhaul," Pittsburgh Post-Gazette, 8/29/14).

• Under Indiana's recently approved program, enrollees will be required to pay premiums of 2 percent of their incomes for coverage. People earning less than poverty are not required to pay premiums, but if they don't, they will be forced to pay copays for care, such as $4 for a doctor's visit and $75 for hospitalization, and will lose their dental and vision benefits. Cost sharing for the poor may reach as high as 5 percent of family income. People above the poverty line will lose their coverage entirely for 6 months (unless they are deemed "medically frail") if they miss a payment – a penalty never before applied to Medicaid patients (Goodnough, "Indiana will allow entry to Medicaid for a price," New York Times, 1/27/15).

• A handful of other states have also received federal permission to impose premiums for Medicaid expansion coverage. In Michigan, enrollees over the poverty line must pay 2 percent of their income in premiums, while in Iowa, they must pay $10

a month. Iowa, which also has a "private" Medicaid option for people with incomes of 101 percent to 133 percent of poverty, will impose monthly premiums of $5 on people earning just 50 percent to 100 percent of poverty. Michigan and Iowa also require beneficiaries to participate in wellness initiatives to avoid penalties like higher copays, a trend that is spreading in employer-sponsored private health insurance (Dickson, "Medicaid cost-sharing seen as deterring enrollment," Modern Healthcare, 9/22/14).

• Multiple studies show that charging Medicaid beneficiaries premiums reduces access to care. Virginia eliminated a $15 per child monthly premium on families with incomes between 150 percent and 200 percent of poverty because families struggled to pay them and the state determined it spent $1.39 on the collection bureaucracy for every dollar it collected. A decade ago, Oregon's Medicaid enrollment plummeted 77 percent in less than three years after the state imposed premiums and copays. A national study found that a $10 increase in monthly premiums led to a 6.7 percent enrollment decline for children in CHIP among families earning between 100 percent and 150 percent of poverty. In Wisconsin, a premium of $10 per month reduced the probability of beneficiaries remaining enrolled for a full year by 12 percent to 15 percent (Abdus, "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," Health Affairs, August 2014; Dickson, "Medicaid cost-sharing could reduce enrollment, experts warn," Modern Healthcare, 9/16/14; Dague, "The effect of Medicaid premiums on enrollment: A regression discontinuity approach," Journal of Health Economics, September 2014).

UPDATE ON THE VA

• In the wake of the national uproar over long wait times at some VA facilities (but little evidence that wait times are longer than elsewhere), Congress passed legislation allowing veterans to seek care at private facilities if they are unable to get an appointment within 30 days or live more than 40 miles from a VA. Congress allocated $10 billion to the VA to reimburse private providers over the next three years, but only $5 billion for the VA to hire more doctors and nurses. In 2013, the VA paid $4.8 billion, 10 percent of its budget, for private care. In the first two months after the policy was adopted in mid-2014, the VA made more than 830,000 referrals to private physicians, a 25 percent increase over the same period in 2013 (Reno, "In just two months 800K vets were referred to private doctors," AP, 8/15/14).

CORPORATE MONEY AND CARE

Insurers and their CEOs big winners from ACA

• Insurers' profits got a boost from a flood of new customers from the ACA, and lower spending on medical care, in 2014. The nation's largest health insurer, UnitedHealth Group, made a near-record $5.6 billion in profit in 2014 and its share price jumped 30 percent over 2013. The company cut its medical loss ratio (the proportion of revenue it spends on medical care) from 81.5 percent in 2013 to 80.9 percent in 2014. The firm added about a million Medicaid enrollees to its ranks in 2014 from the ACA's Medicaid expansion, and is expanding its offerings on the exchanges for 2015 (Herman, "UnitedHealth ends 2014 with sizable profits," Modern Healthcare, 1/21/15).

Anthem, the nation's second largest insurer, which operates Blue Cross health plans in 14 states, reported profit of $2.6 billion. Anthem cut its medical loss ratio in the fourth quarter of 2014 to 84.5 percent, compared with 87.8 percent in the fourth quarter of 2013. Aetna's profits topped $2.0 billion in 2014, up from $1.9 billion in 2013. Aetna's medical loss ratio fell from 82.3 percent in 2013 to 81.7 percent in 2014. Humana's profits topped $2.2 billion in 2014, a modest increase over 2013, but its stock price soared on the news that the firm is projecting a 13 percent rise in enrollment in its lucrative Medicare Advantage plans for 2015. Cigna's profits jumped 42 percent in 2014, to $2.1 billion ("Aetna's 2014 profits grow despite 4Q setback," Reuters, 2/4/15; "Insurer Anthem's profit beats expectations as enrollments rise," Reuters, 1/28/15; Herman, "Cigna closes 2014 with profitable quarter," Modern Healthcare, 2/5/15; "Humana profit misses but shares rise on 2015 outlook," Reuters, 2/4/15).

The ACA was supposed to increase competition in the insurance market. But according to the General Accountability Office (GAO), the nation's three largest health insurers, UnitedHealth, Anthem, and Humana, covered an average of 86 percent of policyholders in the individual market last year, up from 83 percent in 2010. In 2013, these three firms sold over 95 percent of individual plans in nearly a dozen states (Ferris, "GAO: Biggest insurers flourishing under ACA," The Hill, 12/1/14).

Insurers paid an extra $72 million in taxes in 2013 to protect their CEOs' outsize compensation packages. A provision of the ACA reduced the amount of pay corporations could deduct on their taxes to $500,000 per employee (including stock options and other payments), down from $1 million (excluding stock options) before the law passed. Even with the disincentive, pay for 57 executives at the 10 largest publicly traded health plans jumped from an average of $5.1 million in 2012 to $5.4 million in 2013, for a total of payout of $300 million. The nation's largest insurer, UnitedHealth Group, paid $19 million in taxes, of which $6 million was for CEO Stephen Hemsley, whose pay totaled $28 million (Appleby, "Health law ups taxes on insurers with big pay packages," Kaiser Health News, 8/27/14).

• Account information for up to 80 million people was hacked from Anthem, the nation's second largest insurer, in January, making it the largest security breach in the health care industry and among the top three nationally. Although no patient medical information was stolen, hackers gained access to Social Security numbers, dates of birth, names, street addresses, email addresses and employment information (including income data) – all the information needed for identity theft. Anthem skimped on security precautions and didn't encrypt the data, making it an easy target, and raising the question of whether

a bevy of private insurers should be entrusted with such important data (Parker, "Anthem hack exposes data on 80 million; experts warn of identity theft," Los Angeles Times, 2/5/15).

• Another large nursing home chain will pay a multimillion-dollar settlement to the federal government for inappropriate billing and poor care. Extendicare, which owns 150 homes in 11 states, will pay $38 million to settle charges that it inappropriately billed for physical therapy and did not hire enough nurses to care for patients in 33 of its homes, leading to "pervasive" problems with substandard care (Thomas, "Chain to pay $38 million over claims of poor care," New York Times, 10/10/14).

• Weapons manufacturers and defense contractors like General Dynamics, Lockheed, Booz Allen Hamilton, and Northrup Grumman are getting into the health business and becoming some of the Department of Health and Human Services' largest contractors. While defense spending is falling, HHS' business purchases have doubled to $21 billion in the past decade, on everything from cybersecurity to electronic medical records. General Dynamics got the contract to run call-centers for the rollout of the ACA. Lockheed's business with HHS for computer services is up to $300 million annually, and the firm is one of several bidders on an $11 billion contract to modernize the Pentagon's electronic medical records. Northrup Grumman manages data sharing for the NIH, is helping launch ACOs for Medicare, and has created software to help detect Medicare fraud. Booz Allen Hamilton acquired the health division of Geneva Technologies to help quadruple its sales of technology and consulting services to HHS to $170 million annually (Hancock, "Federal contractors now find opportunities for growth in healing, not war," Washington Post, 12/6/14).

Dialysis giant DaVita HealthCare Partners will pay $389 million to settle allegations that it paid kickbacks to doctors for patient referrals to its dialysis clinics. DaVita allegedly targeted physicians who were "young and in debt" in geographic areas with large populations of patients with kidney disease and offered them joint venture deals if they referred patients to their facilities (Schencker, "DaVita pays $389 million in anti-kickback case," Modern Healthcare, 10/27/14).

• Average compensation for 147 not-for-profit health system CEOs jumped 24.2 percent to $2.2 million between 2011 and 2012, the most recent year for which data are available. Twenty-one of the CEOs got raises of more than 50 percent. Top compensation went to two New Jersey executives, Ronald Del Mauro of Barnabas Health, who received $24.6 million in base pay and deferred retirement compensation, and Joseph Trunfio of Atlantic Health System in Morristown, N.J., who received $10.7 million in 2012, largely due to payouts for a retention bonus and other deferred compensation. Other top earners included George Halvorson at Kaiser Permanente ($9.9 million), William Petasnick at Froedtert Health ($6.6 million) and Patrick Fry at Sutter Health ($6.4 million) (Landen, "Another year of big pay hikes for not-for-profit hospital CEOs," Modern Healthcare, 7/11/14).

• Companies save money with wellness programs by collecting penalties from workers who don't participate or meet targets, not in reduced medical costs. Under the ACA, employers are allowed to offer workers who participate in wellness programs incentives of up to 30 percent of premiums and out-of-pocket costs, and up to 50 percent for programs that target smoking. Nearly all (95 percent) large employers offer workplace wellness programs, which cost $100 to $300 per worker per year, yet save almost nothing on medical costs. Among the two-thirds of large employers that use incentives, almost a quarter impose penalties on employees who opt out, usually $500 or more, according to a 2014 survey by the Kaiser Family Foundation. Honeywell reaped over $2.5 million in penalties in 2014 from 5,000 of its employees who did not participate in its programs (Reuters, "Coming soon to a workplace near you: Wellness or Else," New York Times, 1/13/15).

GALLOPING TOWARD OLIGOPOLY

• WellPoint's (now Anthem's) California subsidiary, Anthem Blue Cross, and seven hospital systems in the Los Angeles area have entered into a joint venture to launch Vivity, a new network. Anthem's new hospital partners will share in any profits and losses from the new HMO, giving them a financial incentive to aggressively manage care. Anthem currently has a 23 percent share of the market for employer-sponsored care in California, compared to Kaiser's 40 percent. The partners include UCLA, Cedars-Sinai, Good Samaritan, Huntington Memorial, MemorialCare Health, PIH Health, and Torrance Memorial Health. Altogether, the system includes over 6,000 physicians and 14 hospitals. If it is profitable, Anthem hopes to expand the model to the 13 other states where it owns Blue Cross plans (Abelson, "Hospitals and Insurer Join Forces in California," New York Times, 9/17/14; Terhune, "New Anthem Blue Cross plan take on Kaiser," 9/16/14).

The consolidation of physician practices raises costs, according to a study of 4.5 million commercial California HMO patients between 2009 and 2012 published in JAMA. In 2012, mean health expenditures per patient at physician-owned practices totaled $3,066, compared to $4,312 at practices owned by local hospitals, and $4,776 for practices owned by multi-hospital systems. After adjusting for severity of illness and other factors, expenditures were 10.3 percent higher at practices owned by local hospitals, and 19.8 percent higher at practices owned by multi-hospital systems, than at practices owned by physicians. Previous research found that small physician-owned practices hospitalized their patients less often than large physician-owned practices and hospital-owned practices (Robinson JC, Miller K, "Total expenditures per patient in hospital-owned and physician-owned organizations in California," JAMA, 10/22/14).

• Six health systems in Wisconsin, comprising over 5,600 physicians and 44 hospitals, and offering care to about 90 percent of Wisconsin's population, have formed a partnership with their state's Anthem Blue Cross subsidiary to offer a commercial

health plan through the federal and private employer health exchanges. The ultimate goal of the collaboration is to become an ACO and share profits. The six systems are Aspirus, Aurora Health Care, Bellen Health Systems, Gundersen Health System, ThedaCare, and UW Health (Herman, "Six Wisconsin systems create pact, aim for ACO," Modern Healthcare, 8/6/14).

• The for-profit hospital chain Prime Healthcare Services continues to expand. The firm bought 11 hospitals in the fourth quarter of 2014, bringing their total to 40. Recent purchases include Dallas Regional Medical Center and Riverview Regional Medical Center (from Community Health Systems); North Vista Hospital, a Las Vegas medical center (from Iasis Healthcare); two Missouri hospitals, St. Joseph Medical Center and St. Mary's Medical Center (from Ascension Health); and, for $843 million, the six-hospital California-based Daughters of Charity Health System ("Prime buying continues as it adds CHS hospital in Texas," Modern Healthcare, 11/24/14; and "Details emerge on structure of Prime Daughters deal," Modern Healthcare, 11/3/14).

• A wave of consolidation is hitting the Chicago area. Chicago's largest health system, Advocate Health Care, with 11 hospitals and 6,300 physicians, is merging with NorthShore University HealthSystem, with four hospitals and 2,100 physicians, to create a mega-system with $7 billion in annual revenues. The combined firm will be called Advocate NorthShore Health Partners. About 2,000 of the physicians are employed by the new system, while the rest are affiliated. The merging groups' CEOs cite health care reform and the need to be able to manage population health as the reason for the deal; together they already have about 660,000 people in ACOs. Meanwhile, Northwestern Memorial HealthCare is merging with Cadence Health to expand into the affluent suburbs around Chicago. The combined system will have $3 billion in annual revenues and include three suburban hospitals in addition to Northwestern's 885-bed academic health center in downtown Chicago (Herman, "Northwestern, Cadence complete merger," Modern Healthcare 9/1/14; and Herman, "Advocate-NorthShore merger continues trend toward regional supersystems," 9/15/14).

• In the Detroit area, Botsford Health Care and Oakwood Healthcare are merging with Beaumont Health System to create a $3.8 billion not-for-profit system, Beaumont Health. Beaumont Health System's attempt to merge with the Henry Ford Health System fell through (Jaimy Lee, "Beaumont Health completes three-system merger," Modern Healthcare, 7/8/14).

• Hospitals are consolidating in Arizona. Banner Health, a not-for-profit chain of 23 hospitals, recently purchased the University of Arizona Health Network's two hospitals and its physician group for over $1 billion. Tenet, a for-profit chain of 80 hospitals, took over five Phoenix-area hospitals a few years ago as part of its acquisition of Vanguard Health System. Now Tenet is taking the lead in a complex joint venture to buy partial ownership of Carondelet Health Network, a small system with three hospitals and two medical groups. The deal will split ownership of the health system among three firms. Tenet will operate the system and hold 60 percent ownership, while California-based Dignity Health will invest $30 million and take a 20 percent stake. Ascension, Carondelet's current owner, will retain a 20 percent share ("Details emerge on planned deal by Dignity, Tenet, Ascension," Modern Healthcare, 10/20/14; and Kutscher, "Tenet, Ascension and Dignity partner up in Tucson," Modern Healthcare, 7/28/14).

• Health care IT is a big, profitable business due to the complexity of billing. Optum, the nation's largest health care IT firm, owned by UnitedHealth Group, has contracts with 80 percent of U.S. hospitals for billing software and consulting services. Optum is acquiring Texas-based MedSynergies, which provides IT services and billing software to physicians, for an undisclosed amount. Optum's operating margin was 6.9 percent on revenues of $47.7 billion last year (Gregg, "UnitedHealth's IT division to acquire MedSynergies," Becker's Hospital Review, 10/1/14; News Release, UnitedHealth Group, 1/21/15).

• Aetna is buying the Chicago-based private health exchange, Bswift, for $400 million. Private exchanges allow employers to easily switch to "defined-contribution" health insurance, which limits their contribution towards coverage to a fixed amount. Employees theoretically have greater choice of health plans on private exchanges, but are responsible for premiums above what the employer pays, in addition to cost sharing. Unless the employer contribution keeps pace with rising health care costs, benefits will shrink over time ("Aetna spends $400 million on exchange technology provider," Charlotte Observer, 11/3/14).

• The highest profits in the long-term care industry accrue not to providers but to real estate investment trusts (REITs) that own and lease out the facilities (and are immune to lawsuits for poor quality care). Now, the sixth-largest trust, Ventas, with more than 1,500 senior-living facilities, skilled-nursing facilities, medical office buildings and hospitals, is buying American Realty Capital Healthcare Trust for $2.6 billion. American Realty owns 141 medical office buildings and senior housing facilities in 31 states. Ventas aspires to be the largest owner of health care and senior living facilities globally, with a "focus on private-pay assets." In a separate transaction, Ventas is buying 29 senior housing communities in Canada from Holiday Retirement for $900 million (McGrath, Forbes, 6/2/14; and Modern Healthcare, 9/29/14).

PHARMA: PAY THE TICKET AND KEEP ON SPEEDING

Another string of drug companies paid settlements over violations of the False Claims Act last year, signaling that the industry sees such payments as merely part of the cost of doing business.

• Teva Pharmaceuticals paid $28 million to settle charges including allegedly paying kickbacks to a Chicago psychiatrist to prescribe the powerful antipsychotic clozapine to thousands of Medicare and Medicaid patients between 2003 and 2009. The

psychiatrist became the largest prescriber of generic clozapine in the nation. Payments included $50,000 in annual "consulting fees" along with free travel, meals, and tickets to sporting events. Israel-based Teva is one of the largest generic drugmakers worldwide, with $20.3 billion in sales in 2013 (Schorsch, "Drug giant Teva settles false billing claims for nearly $28 million," Crain's Chicago Business, 3/11/14).

• Ohio-based Omnicare, a supplier of pharmaceuticals to nursing homes, will pay $124 million to settle Justice Department charges that it paid kickbacks to skilled nursing facilities to gain their business, and submitted false claims to federal programs (McCarty, "Omnicare agrees to pay $124 million settlement," The Plain Dealer, 6/25/14).

• The U.S. arm of Japan's Daiichi Sankyo Pharmaceuticals will pay $39 million to settle allegations that it paid kickbacks to doctors to prescribe its products, including Welchol (a bile acid sequestrant), and its anti-hypertensives Azor and Benicar. The firm allegedly paid speaking fees to doctors, even to talk to their own staff, and hosted lavish dinners (Schencker, "Pharma company settles claims it paid doctors to talk to their own staffs," Modern Healthcare, 1/9/15).

• AstraZeneca is being investigated by the Texas attorney general for illegal marketing of its anti-psychotic Seroquel. The drug maker allegedly paid $465,000 in kickbacks to state mental health officials with influence over the state's Medicaid formulary, in addition to marketing the drug for unapproved uses. AstraZeneca paid $520 million to settle federal charges of off-label marketing five years ago. The Texas attorney general also took on Janssen Pharmaceuticals for illegal marketing of their antipsychotic Risperidal in the state, winning a settlement of $181 million against the firm (Silverman, "Texas AG Lawsuit Claims AstraZeneca Improperly Marketed Seroquel," Wall Street Journal, 10/10/14).

The U.S. subsidiary of Ireland's Shire pharmaceuticals will pay $56.5 million to resolve charges that it illegally marketed several of its products, overstating efficacy and promoting off-label use. The products involved were Adderall XR, Vyvanse, and Daytrana for ADHD, and Pentasa and Lialda for ulcerative colitis. Shire allegedly claimed Adderall XR would prevent poor academic performance and violent behavior and promoted it for conduct disorder without FDA approval. Shire also promoted Lialda off-label for the prevention of colorectal cancer (Dulany, "Shire to Pay $56.5 Million to Settle False Marketing Claims," Wall Street Journal, 9/24/14).

• Despite a new Treasury Department rule intended to put a brake on inversions – a strategy corporations use to lower their taxes by merging with a foreign company and reincorporating overseas – two more deals by medical device makers, and several by drugmakers, are in the works. Steris is acquiring Britain's Synergy Health for $1.9 billion and will reincorporate in the U.K. Tennessee-based Wright Medical is merging with Tornier in a $3.3 billion deal; the combined firm will be headquartered in the Netherlands. Dublin-based Actavis is buying Chicago-based Durata Therapeutics for $616.4 million. But at least one drugmaker scrapped their inversion plans: AbbVie will pay a $1.6 billion fee to pull out of its merger with Ireland's Shire. The new rule makes it harder for inverted firms to gain access to their overseas earnings (Gelles, "A brake on reincorporating abroad via mergers," New York Times, 12/8/14; "Chicago-drug company Durata getting Irish owner," AP, 10/6/14).

• Gilead had revenue of $10.3 billion on sales of its Hepatitis C drug sofosbuvir (Solvadi) in 2014. Gilead sells the drug in the U.S. for a whopping $1,000 per pill, $84,000 for a 12-week course of treatment. A Philadelphia transit agency launched a class action lawsuit against the firm for price gouging after spending $2.4 million on Solvadi last year. India rejected Gilead's attempt to patent sofosbuvir, clearing the way for Indian drugmakers to sell generic versions to developing countries for much less (Loftus, "Gilead faces suit over hepatitis drug's price," Wall Street Journal, 12/10/14; Einhorn, "How India's patent office destroyed Gilead's global game plan," Bloomberg, 1/15/15).

• Pharma and medical device makers paid $3.5 billion to doctors and hospitals in the last five months of 2013. Individual firms, physicians, and hospitals who received about $825 million in payments were identified in data released so far under the ACA's Sunshine Act. Payments were categorized as either "general" or "research." Genentech topped the list of manufacturers in "general payments," paying a total of $130 million, mostly to City of Hope National Medical Center in California. Dr. Stephen Burkhart, an orthopedic surgeon in San Antonio, was the most highly rewarded physician, with $7.4 million in royalties/general payments from Arthrex, a maker of orthopedic surgical supplies. Bristol-Meyers Squibb made $18 million in research grants, topping other manufacturers. Boston's Dana Farber Cancer Institute received $14.5 million in research grants, more than any other hospital (Yaraghi, "Pharma pays $825 million to doctors and hospitals," Brookings Institution, 10/23/14).

ACA UPDATE

• The Supreme Court heard oral arguments on March 4 in King v. Burwell regarding whether people who buy policies on the federal exchange, HealthCare.gov, are eligible for tax subsidies, or whether subsidies are only available to people who buy plans on the state-run exchanges. Currently, 13 states and the District of Columbia run their own exchanges. It's unclear what will happen to people with tax-subsidized coverage, and the ACA itself, if the subsidies are ended. (For more details, see p. 55.)

• Despite over $4 billion in federal grants, many of the state-run health exchanges are running deficits and it's not clear how they will survive. The ACA mandates that they be self-sustaining this year, but most are still operating on leftover federal funds.

The states tack fees for operating their exchanges on top of premiums (e.g. California charges $13.95 per month, $167.40 per year) but they aren't enough. Minnesota charges a 3.5 percent tax on premiums, but that will only generate $5.3 million of the $85.8 million budget of MNsure this fiscal year. Colorado, Oregon and Rhode Island may abandon their exchanges due to financial difficulties. In Washington state, the exchange is seeking $59.2 million from the Legislature for operations (Demko and Tahir, "Funding woes imperil future of state-run insurance exchanges," Modern Healthcare, 1/2/15).

• An estimated 3 million to 6 million tax filers will face penalties for not being insured in 2014. The penalty for not having health insurance in 2014 is $95 per adult and $47.50 per child, or 1 percent of taxable income, whichever is greater. For 2015 the penalty is $325 or 2 percent of taxable income, whichever is greater. In 2016 the penalty rises to $695 or 2.5 percent of taxable income (Pugh, "Millions may face tax penalties," McClatchy News Service, 1/28/15).

• People who bought subsidized private insurance in 2014, but ended the year with higher than expected incomes, may be surprised to find they have to pay some or all of those subsidies back. The amount is capped at $2,500 for people earning less than 400 percent of poverty, but people whose incomes rose above 400 percent of poverty are on the hook for the full amount (Andrews, "IRS eases repayment rules for excess health premium subsidies," Kaiser Health News, 1/30/15).

• The employer mandate in the ACA has been postponed twice. The Obama administration delayed penalties for midsize firms with between 50 and 99 workers for two years, from Jan. 1, 2014, to Jan. 1, 2016, and gave a one-year delay and an extra year for phasing-in coverage to large employers (100 or more workers). Starting Jan. 1, 2015, large employers are required to offer coverage to 70 percent of employees who work more than 30 hours per week. In 2016, they are required to offer coverage to 95 percent. The mandate imposes a "no offer" fee of $2,089 and a "free rider" penalty of $3,126 per employee on businesses that have employees who buy subsidized insurance on the health exchange. The GOP-controlled Congress is aiming to raise the threshold so that businesses only have to cover employees working 40 or more hours per week (Kaiser Family Foundation, "Employer responsibility under the Affordable Care Act," Dec. 17, 2014).

POLLS

• A New York Times/CBS poll of 1,006 adults in early December found that 43 percent would favor "a single-payer health care system, in which all Americans get their health insurance from one government plan that is financed by taxes" (Rosenthal, "How the high cost of medical care is affecting Americans," New York Times, 12/18/14).

• A majority of Americans, 51 percent, support enacting "a national health plan in which all Americans would get their insurance through an expanded, universal form of Medicare," according to a recent poll of 1,500 likely voters by GBA Strategies for the Progressive Change Institute. Another 12 percent of those surveyed were neutral on universal Medicare; only 35 percent were opposed. Supporters included 79 percent of Democrats and 23 percent of Republicans. (http://bit.ly/1FXMgMC accessed on 1/21/15).

• Public opinion on the ACA continues to be negative, with nearly one-third of Americans favoring repeal and 14 percent favoring scaling it back, according to a recent Kaiser poll. But 19 percent want to see the law move forward as is, and, strikingly, about one-fourth (23 percent) would like to see the law expanded. The poll also asked Americans what Congress should do if the Supreme Court (in King v. Burwell, with a decision expected this summer) restricts tax subsidies to residents of states operating their own exchanges. Two-thirds (64 percent) of respondents said Congress should pass a law making subsidies available to people in all states (Kaiser Family Foundation, 1/28/15).

INTERNATIONAL: U.S. SENIORS HAVE WORSE COVERAGE AND WORSE HEALTH

• Older adults in the U.S. are sicker and have more problems paying their medical bills and accessing care than people age 65 or older in 10 other nations, according to a phone survey of 15,617 seniors in Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the U.K. and the U.S. Two-thirds (68 percent) of seniors in the U.S. report two or more chronic diseases like diabetes and heart disease, compared with 37 percent of seniors in New Zealand and 33 percent of seniors in the U.K. Eleven percent of U.S. survey respondents said they had trouble paying their medical bills, compared to 1 percent in Norway and Sweden. Nineteen percent of U.S. seniors reported they had not seen a doctor, skipped a recommended test or treatment, or not filled a prescription due to cost, compared with 3 percent of older adults in France. Twenty-one percent of U.S. seniors spent more than $2,000 out-of-pocket on medical bills annually, compared with 0 percent in France and 2 percent in the U.K. In addition, one-fifth of U.S. seniors provide care at least once a week to another aged, ill or disabled person, in comparison to 3 percent of French seniors. Medicare does not protect older adults from financial burdens as well as other nations' health financing systems, primarily due to cost sharing, especially for medications, and a lack of coverage for long-term care under Medicare (Osborn et al., "International survey of older adults finds shortcomings in access, coordination, and patient-centered care," Health Affairs, December 2014).

EXHIBIT 1

National Health Expenditures (NHE), Amounts And Annual Growth From Previous Year Shown, By Spending Category, Selected Calendar Years 2008–23

Spending category	2008[a]	2012	2013	2014	2015	2019	2023
EXPENDITURE, BILLIONS							
NHE	$2,411.7	$2,793.4	$2,894.7	$3,056.6	$3,207.3	$4,042.5	$5,158.8
Health consumption expenditures	2,257.3	2,633.4	2,735.1	2,893.3	3,040.8	3,834.0	4,891.3
Personal health care	2,017.1	2,360.4	2,448.3	2,579.3	2,706.0	3,413.1	4,359.7
Hospital care	729.0	882.3	918.8	959.9	1,008.5	1,276.1	1,637.7
Professional services	652.8	752.3	776.7	822.7	856.8	1,077.4	1,369.1
Physician and clinical services	486.5	565.0	583.9	618.5	641.9	805.2	1,023.8
Other professional services	64.0	76.4	79.8	87.6	92.3	119.3	153.4
Dental services	102.4	110.9	113.0	116.6	122.7	153.0	191.8
Other health, residential, and personal care	113.5	138.2	145.6	153.1	161.5	206.9	267.1
Home health care	62.3	77.8	81.5	86.2	91.7	121.5	162.3
Nursing care facilities and continuing care retirement communities	132.6	151.5	156.4	162.3	170.2	215.6	271.4
Retail outlet sales of medical products	326.9	358.3	369.2	395.2	417.3	515.6	652.3
Prescription drugs	242.6	263.3	272.1	290.7	309.3	381.8	482.8
Durable medical equipment	34.9	41.3	42.3	44.0	45.8	56.0	71.3
Other nondurable medical products	49.5	53.7	54.8	60.5	62.2	77.8	98.2
Government administration	29.4	33.6	35.1	36.3	37.8	50.1	66.7
Net cost of health insurance	139.2	164.3	174.5	196.7	212.5	268.7	341.0
Government public health activities	71.5	75.0	77.2	81.1	84.5	102.1	123.9
Investment	154.4	160.0	159.7	163.3	166.5	208.5	267.4
Noncommercial research	44.0	48.1	47.1	47.2	46.4	55.8	69.5
Structures and equipment	110.4	111.9	112.6	116.2	120.1	152.7	197.9
ANNUAL GROWTH							
NHE	7.1%	3.7%	3.6%	5.6%	4.9%	6.0%	6.3%
Health consumption expenditures	7.0	3.9	3.9	5.8	5.1	6.0	6.3
Personal health care	6.9	4.0	3.7	5.3	4.9	6.0	6.3
Hospital care	7.2	4.9	4.1	4.5	5.1	6.1	6.4
Professional services	6.4	3.6	3.2	5.9	4.2	5.9	6.2
Physician and clinical services	6.4	3.8	3.3	5.9	3.8	5.8	6.2
Other professional services	6.7	4.5	4.5	9.8	5.3	6.6	6.5
Dental services	6.1	2.0	1.9	3.1	5.3	5.7	5.8
Other health, residential, and personal care	7.0	5.0	5.3	5.1	5.5	6.4	6.6
Home health care	8.8	5.7	4.8	5.7	6.4	7.3	7.5
Nursing care facilities and continuing care retirement communities	5.6	3.4	3.2	3.7	4.9	6.1	5.9
Retail outlet sales of medical products	7.6	2.3	3.1	7.0	5.6	5.4	6.1
Prescription drugs	8.3	2.1	3.3	6.8	6.4	5.4	6.0
Durable medical equipment	4.8	4.3	2.5	4.0	4.1	5.2	6.2
Other nondurable medical products	6.3	2.1	2.1	10.4	2.7	5.8	6.0
Government administration	6.4	3.4	4.3	3.4	4.3	7.3	7.4
Net cost of health insurance	10.1	4.2	6.2	12.7	8.1	6.0	6.1
Government public health activities	6.2	1.2	2.9	5.1	4.2	4.8	5.0
Investment	7.8	0.9	–0.2	2.3	1.9	5.8	6.4
Noncommercial research	6.4	2.2	–2.1	0.1	–1.7	4.7	5.7
Structures and equipment	8.4	0.3	0.6	3.2	3.4	6.2	6.7

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found at CMS.gov. National Health Expenditures Accounts: methodology paper, 2012: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 [cited 2014 Jan 6]. Available from: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-12.pdf. Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2002–08.

EXHIBIT 3

National Health Expenditures (NHE), Amounts, Share Of Gross Domestic Product (GDP), And Average Annual Growth From Previous Year Shown, By Source Of Funds, Selected Calendar Years 2008–23

Source of funds	2008[a]	2012	2013	2014	2015	2019	2023
EXPENDITURE, BILLIONS							
NHE	$2,411.7	$2,793.4	$2,894.7	$3,056.6	$3,207.3	$4,042.5	$5,158.8
Health consumption expenditures	2,257.3	2,633.4	2,735.1	2,893.3	3,040.8	3,834.0	4,891.3
Out of pocket	300.7	328.2	338.6	338.1	345.7	413.5	512.2
Health insurance	1,703.2	2,014.4	2,094.1	2,246.1	2,372.5	3,015.2	3,875.9
Private health insurance	807.8	917.0	947.5	1,012.2	1,082.4	1,330.4	1,653.2
Medicare	467.9	572.5	591.2	615.9	632.7	825.3	1,111.3
Medicaid	344.9	421.2	449.5	507.2	541.1	711.3	918.8
Federal	203.5	237.9	254.1	302.4	323.0	423.2	542.6
State and local	141.4	183.3	195.4	204.8	218.1	288.2	376.2
Other health insurance programs[b]	82.6	103.8	105.9	110.8	116.2	148.2	192.6
Other third-party payers and programs and public health activity	253.4	290.8	302.3	309.2	322.7	405.3	503.2
Investment	154.4	160.0	159.7	163.3	166.5	208.5	267.4
Population (millions)	303.9	313.3	315.9	318.5	321.3	333.2	345.2
GDP, billions	$14,720.3	$16,244.6	$16,799.7	$17,354.1	$18,204.4	$22,275.5	$26,691.1
NHE per capita	7,935.7	8,914.8	9,164.3	9,595.7	9,982.5	12,131.1	14,943.8
GDP per capita	48,437.1	51,842.7	53,185.6	54,479.7	56,660.1	66,847.0	77,318.0
NHE as percent of GDP	16.4%	17.2%	17.2%	17.6%	17.6%	18.1%	19.3%
ANNUAL GROWTH							
NHE	7.1%	3.7%	3.6%	5.6%	4.9%	6.0%	6.3%
Health consumption expenditures	7.0	3.9	3.9	5.8	5.1	6.0	6.3
Out of pocket	5.3	2.2	3.2	–0.2	2.3	4.6	5.5
Health insurance	7.7	4.3	4.0	7.3	5.6	6.2	6.5
Private health insurance	7.0	3.2	3.3	6.8	6.9	5.3	5.6
Medicare	9.5	5.2	3.3	4.2	2.7	6.9	7.7
Medicaid	6.3	5.1	6.7	12.8	6.7	7.1	6.6
Federal	6.3	4.0	6.8	19.0	6.8	7.0	6.4
State and local	6.3	6.7	6.6	4.8	6.5	7.2	6.9
Other health insurance programs[b]	10.6	5.9	2.1	4.7	4.9	6.3	6.8
Other third-party payers and programs and public health activity	5.2	3.5	4.0	2.3	4.4	5.9	5.6
Investment	7.8	0.9	–0.2	2.3	1.9	5.8	6.4
Population[c]	0.9	0.8	0.8	0.8	0.9	0.9	0.9
GDP	4.8	2.5	3.4	3.3	4.9	5.2	4.6
NHE per capita	6.1	3.0	2.8	4.7	4.0	5.0	5.4
GDP per capita	3.8	1.7	2.6	2.4	4.0	4.2	3.7

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditures Accounts: methodology paper, 2012: definitions, sources, and methods (see Exhibit 1 Notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 2002–08. [b]Includes health-related spending for Children's Health Insurance Program, Titles XIX and XXI; Department of Defense; and Department of Veterans Affairs. [c]Estimates reflect the Bureau of the Census's definition for *resident-based population*, which includes all people who usually reside in one of the fifty states or the District of Columbia but excludes residents living in Puerto Rico and areas under US sovereignty, and US Armed Forces overseas and US citizens whose usual place of residence is outside of the United States. Estimates also include a small (typically less than 0.2 percent of the population) adjustment to reflect census undercounts. Projected estimates reflect the area population growth assumptions found in the 2014 *Medicare Trustees Report* (see Note 9 in text).

Table 2.

Effects of the Affordable Care Act on Health Insurance Coverage

Millions of Nonelderly People, by Calendar Year

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Insurance Coverage Without the ACA[a]											
Medicaid and CHIP	38	38	38	38	38	38	39	39	39	40	40
Employment-based coverage	154	156	157	158	159	160	160	161	161	161	162
Nongroup and other coverage[b]	26	26	26	27	27	27	27	28	28	28	28
Uninsured[c]	52	52	51	51	51	51	51	51	51	52	52
Total	270	271	272	274	275	276	277	278	280	281	282
Change in Insurance Coverage Under the ACA											
Insurance exchanges	11	21	24	24	23	23	23	23	23	22	22
Medicaid and CHIP	10	12	12	12	13	14	14	14	14	14	14
Employment-based coverage[d]	-1	-6	-7	-8	-8	-7	-8	-8	-8	-7	-7
Nongroup and other coverage[b]	-3	-4	-4	-4	-4	-4	-5	-5	-5	-4	-4
Uninsured[c]	-17	-23	-24	-24	-24	-25	-25	-25	-25	-25	-25
Uninsured Under Current Law											
Number of uninsured nonelderly people[c]	35	29	27	27	26	26	26	26	27	27	27
Insured as a percentage of the nonelderly population											
Including all U.S. residents	87	89	90	90	90	91	91	91	90	90	90
Excluding unauthorized immigrants	89	92	92	93	93	93	93	93	93	93	93
Memorandum:											
Exchange Enrollees and Subsidies											
Number with access to unaffordable employment-based insurance[e]	*	*	*	*	*	*	*	*	*	*	*
Number of unsubsidized exchange enrollees[f]	3	6	6	6	6	6	6	6	6	6	6
Average exchange subsidy per subsidized enrollee (Dollars)	3,960	4,040	4,250	4,650	4,850	5,070	5,340	5,630	5,900	6,300	6,600

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: Figures for the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; * = between zero and 500,000.

a. Figures reflect average enrollment over the course of a year and include spouses and dependents covered under family policies; people reporting multiple sources of coverage are assigned a primary source.

b. "Other coverage" includes Medicare; the changes under the ACA are almost entirely for nongroup coverage.

c. The uninsured population includes people who will be unauthorized immigrants and thus ineligible either for exchange subsidies or for most Medicaid benefits; people who will be ineligible for Medicaid because they live in a state that has chosen not to expand coverage; people who will be eligible for Medicaid but will choose not to enroll; and people who will not purchase insurance to which they have access through an employer, through an exchange, or directly from an insurer.

d. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.

e. Under the ACA, health insurance coverage is considered affordable for a worker and related individuals if the worker would be required to pay no more than a specified share of his or her income (9.56 percent in 2015) for self-only coverage. If coverage is considered unaffordable, the worker and related individuals may receive subsidies through an exchange if other eligibility requirements are met.

f. Excludes coverage purchased directly from insurers outside of an exchange.

The New York Times

December 1, 2014

Underinsurance remains big problem under Obama health law

By Aaron E. Carroll, M.D.

The Affordable Care Act, like most health care reform efforts, focuses on people without insurance. That's fine, because those people do face significant problems obtaining health care in the United States.

But underinsurance is a real concern, too, and it's often ignored.

Before the A.C.A. was passed, underinsurance was prevalent. Of adults age 19-64 in 2010, 16 percent, or 29 million, met the Commonwealth Fund's definition of being underinsured: one's out-of-pocket health care costs exceeding 10 percent of income (5 percent when income is less than 200 percent of the federal poverty line), or one's insurance deductible being more than 5 percent of income. The number of underinsured Americans had grown by 80 percent from 2003 to 2010.

Some of the A.C.A.'s regulations, such as removing annual or lifetime limits on reimbursements, were aimed at reducing the out-of-pocket spending that people might have to make. When the act went into effect and some people found their policies had been canceled (despite President Obama's now-infamous assurance that "if you like your health care plan, you can keep it"), it was often because those policies left them underinsured, even if they didn't realize it.

But the A.C.A. has not done as much as many had hoped it would to reduce underinsurance. In fact, it may be helping to spread it. And proposed modifications to the law, like those that would introduce a new tier of "copper" plans in addition to bronze, silver, gold and platinum, might make underinsurance worse.

This is important, because research shows that those who are underinsured are more likely to go without needed care.

In the most recent update of the Commonwealth Fund survey, conducted in September and October of this year, investigators found that 13 percent of all adults 19-64 spent more than 10 percent of their income on out-of-pocket health care costs. Poor adults were the most likely to spend this amount. More than 30 percent of nonelderly adults earning less than the poverty line spent more than 10 percent of their income on out-of-pocket costs, and 18 percent of those making between 100 percent and 200 percent of the poverty line did so. All of these people were insured.

Deductibles remain high for Americans as well. Over all, 13 percent of people age 19-64 had a deductible that was 5 percent of their income or more. Since Medicaid traditionally doesn't have deductibles, pretty much all of these people had private insurance. Still, those at the lowest end of the socio-economic spectrum were hit the hardest. A full quarter of nonelderly adults below the poverty line had deductibles this large, and 20 percent of those making between 100 percent and 200 percent of the poverty line did.

Dr. Aaron Carroll

This is too much for many to spend. More than 40 percent of people who were surveyed said their deductibles were unaffordable. Almost two-thirds of people making between 100 percent and 200 percent of the poverty line said they were unaffordable.

The point of having insurance is to be able to get care when you need it, without too large a financial burden. Underinsured Americans are not receiving this benefit, though. They can't get the care they need. Twenty-seven percent of adults with a deductible large enough to render them underinsured didn't see the doctor when they were sick; 23 percent didn't get a preventive care test; 29 percent skipped a test, treatment or follow-up appointment; and 22 percent didn't see a specialist to whom they were referred. Forty percent of them had at least one of these cost-related access problems.

The point of having insurance is to be able to get care when you need it, without too large a financial burden. Underinsured Americans are not receiving this benefit, though.

These are people who had private health insurance for the full year. They are not the uninsured.

Last year, the average deductible for a silver-level plan offered in the exchanges was more than $2,500. Some plans had deductibles as high as $5,000. These figures are most likely at least 5 percent of income for many, if not most, Americans (half of American households earn less than $53,046 per year), even for those who qualify for cost-sharing subsidies. If people choose bronze plans, things are even worse. The average deductible for such plans was more than $5,000, with some plans hitting the out-of-pocket maximum of $6,350. Almost anyone purchasing such plans would be, by definition, underinsured.

(continued on next page)

BMJ

December 5, 2014

One year into Obamacare: where is it now?

By Jeanne Lenzer

About one year since the launch of the Patient Protection and Affordable Care Act's insurance exchange program, the overwhelming majority of the 48 million people who were uninsured in 2012, remain uninsured — a problem that will persist for the next 10 years, according to government projections. The Congressional Budget Office estimates that 37 million people will not have health insurance in 2015 and 31 million will be uninsured in 2024.

About 6.7 million (corrected from an earlier estimate of 7.3 million) were newly insured under the act known as Obamacare during 2014.

Access to insurance has been liberalized in several ways: insurers may no longer deny coverage to individuals with pre-existing illnesses; young adults under age 26 may remain on their parents' policy; and Medicaid has been extended to include some poor single adults and adults without children. …

According to a study by the Kaiser Family Foundation, "The ACA [Affordable Care Act] establishes an affordability standard for health insurance premiums, but not for out-of-pocket medical expenses. Even with limits on cost-sharing established under the ACA, deductibles and other cost-sharing will continue at a level above what many people could afford if a significant illness or injury strikes."

Even with limits on cost-sharing established under the ACA, deductibles and other cost-sharing will continue at a level above what many people could afford if a significant illness or injury strikes.

It was hoped that reducing the number of uninsured people would also reduce the number of people putting off medical care because of costs. However, according to a Gallup poll conducted in early November 2014, the proportion of families who put off medical treatment rose from 30 percent in 2013 to 33 percent in 2014. The proportion of people with serious medical problems who put off treatment increased from 19 percent to 22 percent. ...

Progressive challenges to Obamacare include a bill introduced in Congress (HR 676) to establish a universal single payer healthcare system. Physicians for a National Health Program supports the bill, which it says could slash administrative costs by more than $400bn annually and solve many of the problems of the act — including providing care for the estimated 31 million people who will still be uninsured in 2024 under Obamacare.

For the full text, including comments on how the public views Obamacare, the status of the "contraceptive mandate," health spending, and legal threats to the law, visit bmj.co/1E2Xlu8.

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

Moreover, efforts are underway to go even further. The Expanded Consumer Choice Act, co-sponsored by six Democratic senators and one independent, seeks to add a new level of insurance coverage. "Copper" plans would have 50 percent actuarial value. Such plans would have significantly lower premium costs than bronze plans, which might increase the number of people who will buy insurance.

But this would be accomplished at the expense of higher out-of-pocket costs. Deductibles for these plans might have to be as high as $9,000, which would mean increasing the out-of-pocket maximum allowable by law. This would lead to even more people being underinsured.

As I've highlighted in previous Upshot articles, people who have chronic illnesses fare worse when they have more cost-sharing. They are also more likely to be underinsured. The Commonwealth Fund found that 17 percent of people who were in fair or poor health, or who had a chronic condition, spent at least 10 percent of their income on out-of-pocket costs. This was on top of the cost of their insurance premiums, because all of them were insured.

Just a month ago, Gallup asked Americans to identify the "most urgent health problem facing this country at the present time." Eighteen percent replied that it was access to health care, or universal health coverage; but 19 percent replied that it was affordable health care or costs.

In the quest for universal coverage, it's important that we not lose sight of "coverage" in order to achieve "universal." The point of improving access is, after all, to make sure that people can get, and afford, care when they need it.

Aaron E. Carroll is a professor of pediatrics at Indiana University School of Medicine. He blogs on health research and policy at The Incidental Economist, and you can follow him on Twitter at @aaronecarroll.

Robert Zarr to lead Physicians for a National Health Program

Robert Zarr, M.D., M.P.H., an alumnus of The University of Texas School of Public Health, was recently appointed president-elect of the organization Physicians for a National Program (PNHP). Zarr earned an M.P.H. at the School of Public Health, which is part of The University of Texas Health Science Center at Houston (UTHealth), and an M.D. at Baylor College of Medicine.

Zarr is a board-certified pediatrician at Unity Health Care in Washington, where he cares for a low-income and immigrant population. The clinic is a federally qualified health center. Zarr will be presiding over sessions of PNHP's Annual Meeting in New Orleans on Nov. 15 and will fully assume the office of president on Jan. 1, 2015.

In addition to his work with Unity Health Care and PNHP, Zarr is a strong supporter of physical activity as a prescription for health problems. He works with the Parks Rx program coordinated with the National Park Service and George Washington University. "From my angle, as a physician, I'm literally prescribing parks, prescribing nature now," says Zarr. He says the research on that should be published soon.

Physicians for a National Health Program is a nonprofit research and educational organization of more than 19,000 members (physicians, retired physicians and medical students) who support single-payer national health insurance. Surveys show that among U.S. physicians, pediatricians tend to be among the most supportive of national health insurance.

"It seemed fitting for me to volunteer my time with PNHP because I personally see so much of the unnecessary lack of access to health care and all its consequences," says Zarr.

Zarr will be working with PNHP's founders, Dr. David Himmelstein and Dr. Steffie Woolhandler; as well as other supporters such as Dr. Quentin Young who was a personal physician for Martin Luther King Jr. "These are people who have really wonderful hearts, who have done so much work to improve all of our lives," says Zarr. "I'm just so honored that they would even think of me as a peer and a leader in their organization."

"We're really about a single issue – which is, in my opinion and the opinions of thousands of other physicians around the country the most important first step – we've got to eliminate this financial barrier to seeking care," says Zarr about PNHP.

Zarr mentioned the Dallas Morning News article written by the nephew of Ebola patient Thomas Eric Duncan, which mentions that Duncan was uninsured. "Whether we want to face that fact or not, we know that it plays a very important part in delaying care and in receiving care. Once a person takes the initiative to receive care, it's undoubtedly a factor that millions – right now we're still at 42 million – Americans are still uninsured, which is nearly one in six. That's a lot of people and is a crisis."

Zarr spoke more about epidemic-sized infectious diseases, specifically Ebola in 2014, and also severe acute respiratory syndrome (S.A.R.S) and the situation that occurred in Asia in 2002-2004.

Dr. Robert Zarr

"When you have a looming disaster like this [Ebola], a public-health disaster, people need to know that they can receive care without the stigma of not being able to pay or in the worst case without being deported," says Zarr. "If you look at S.A.R.S. in China, the government was having a hard time getting ahold of the outbreak and was trying to prevent pandemic. What they found was that people weren't going to the hospital because they couldn't pay the bill – they were scared. One of the first things the government did was say, 'Listen, we'll pay all the bills: anybody who comes in with S.A.R.S.-related symptoms – it's all paid for.' And it worked. It was a very important measure."

Zarr says not having health insurance delayed Duncan's decision to go to the emergency room when he was having Ebola symptoms. "We've already had one person who didn't have health insurance and we don't know all the reasons why he went in when he did, but we know that care is definitely delayed when one does not have health insurance." Duncan died two days after returning to the hospital for the second time.

When a country has a national health insurance program, Zarr says, it is important for the citizens to remember that it is not "free." Zarr described the National Health Service's formation in the United Kingdom of Great Britain and Northern Ireland in 1948, a few years after the end of World War II. He said the government helped people understand that it would be paid for through taxes in the same way that roads, police, fire departments and schools are paid for.

"I think it was a really important move on their part," Zarr said. "People tend to understand it shouldn't be free – we do pay for it. And we're paying for it now; it's just that it's not equitable now. Not everybody has equal access and that is the issue that we've been grappling with for so long."

As a physician, Zarr said that the additional M.P.H. degree has given him a good foundation in public health to be an advocate for his patients and people without access to health insurance. "An M.P.H. is really a fantastic supplement to any physician's career really. I think when you graduate with your M.P.H., you leave there understanding that big picture, which you really need to have in order to effect change on a big scale."

(continued on next page)

The Progressive

October 17, 2015

Top Doc Says Ebola Shows Skewed Priorities

By Amitabh Pal

The Ebola crisis has revealed severe deficiencies in how the American health care system works, experts say.

Dr. Walter Tsou, past president of the American Public Health Association and the former health commissioner for Philadelphia, says that the Ebola crisis shows the skewed priorities of the U.S. health care system.

"Our chronic disease-oriented health care system is ill-equipped to address an acute infectious disease outbreak," Dr. Tsou, a board adviser to Physicians for a National Health Program, tells The Progressive. "We don't have enough biocontainment units, sufficiently trained experts on how to control for highly infectious disease agents, trained sanitation crews who can clean up and properly handle waste disposal."

Tsou says that the Ebola epidemic has uncovered big flaws in the global health system, too.

"We have known about Ebola since 1976 and yet we still have no vaccine or treatment," he points out. "The fact that we are now scrambling to find some type of vaccine and treatment only speaks to the paucity of research that we have invested in the developing world. In the cruel economics of the pharmaceutical industry, unless the drugs promise a significant return on investment, they are unwilling to invest in it essentially condemning most of the developing world."

The Ebola crisis has also made apparent the impact of drastic health budget cuts. Bloomberg News reports that there's been a nearly one-fifth reduction in public health employees at the state and local levels in just the last six years, with 60,000 fewer people employed than in 2008. This manifests itself in many ways.

"There are fewer people to deploy to take care of education, training, public service messages, and other information," Johns Hopkins Professor Albert Wu tells Bloomberg. "Ebola is not the first and is not the last challenge to our public health system."

Dr. Tsou says that the lack of sufficient resources is not confined to the United States.

"The World Health Organization is a shadow of what it should be and is unable to mount a 'boots on the ground surveillance, mitigation and quarantine program," he says. "The United Nations has called for the world to donate $1 billion to confront the Ebola crisis, but we only have $100,000 in the bank so far."

National Nurses United Executive Director RoseAnn DeMoro has commended the recent appointment of an Ebola czar, but has asked the Obama administration to go further.

"What we need is a real czar to assure public safety, not a communicator, and the power to cut the hospitals' Medicare and Medicaid funding if they still refuse to adhere to those standards and leave their patients, nurses and other caregivers at extreme risk," she states in a press release.

For Dr. Tsou, one key public policy measure is necessary to combat such public health emergencies.

"All residents, including immigrants regardless of legal or financial status, should be able to access the health care system to be diagnosed and treated," he says. "Our health care system already excludes over 42 million who are uninsured and erroneously denies insurance to millions of immigrants, many who are the most likely to bring Ebola into the country. A single payer system, open to all, offers the best mechanism to ensure early detection of illnesses."

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

PNHP supports two congressional bills: House bill H.R. 676 and the Senate companion bill S. 1782. "It's an important step we need to take so that we can reach the level of outcomes and equity that we haven't seen ever in this country," said Zarr about the bills.

"We've had a lot of discussion about Affordable Care Act within PNHP and there are a lot of things about ACA that are very good: the expansion of Medicaid, the extension of benefits up to age 26 for a young adult to be on his or her parents' plan, the elimination of preexisting conditions – but at the end of the day, even by 2016 when it's supposed to be fully implemented, there's still going to be around 30 million uninsured and many millions more underinsured. Even though people have an insurance card, they're still going not to have access to the care they need primarily because they won't be able to afford the copays and the deductibles. They're very high, even with the silver plan."

Zarr is a past president of the Washington, D.C., chapter of the American Academy of Pediatrics and served as a CATCH facilitator in D.C. for five years. He holds adjunct professorships at Children's National Medical Center and George Washington University.

In addition to his work with PNHP and Parks Rx, he is active in a variety of quality improvement initiatives including asthma management, injury prevention, literacy promotion, breastfeeding awareness, youth advocacy, tuberculosis prevention and compliance with early and periodic screening, diagnostic and treatment standards.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

November 15, 2015

Single payer: a powerful tool for better care, better health and reduced costs

By Donald M. Berwick, M.D.

The following is an unofficial transcript of the remarks delivered by Dr. Donald Berwick to the Annual Meeting of Physicians for a National Health Program on Nov. 15, 2014, in New Orleans. Dr. Berwick spoke to the assembly via live video.

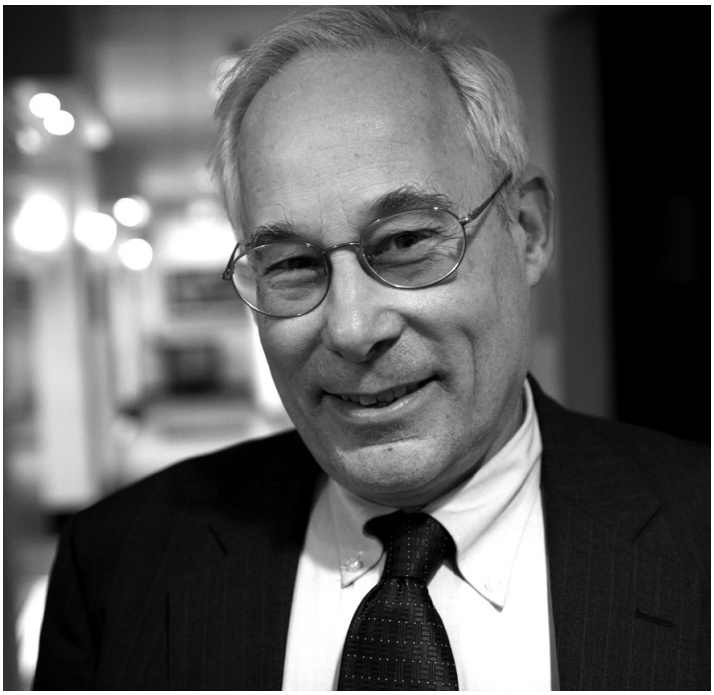
Greetings, everyone.

I wish I were there in person, but I'm very grateful you're letting me join you in this way. Obviously I'm talking to people who have had the vision and leadership and energy on this crucial issue for longer than I have, and I feel flattered you've asked me to share my thoughts.

As Gordy [Dr. Gordon Schiff] said, I just ran for the Democratic nomination for governor in Massachusetts. Unfortunately, I did not win the primary election. But in that experience I got much closer, face-to-face, with public policy and social justice issues – not just health care, but more than a dozen other issues – housing, homelessness, education, transportation, environment, energy, support for the arts, criminal justice, and frankly everywhere, poverty and immense debt, disparity, and inequality in our society, including in the state of Massachusetts.

And in the course of that campaign, and partly as a result of speaking to that very wide range of issues, I did take a clear stand – for the first time in my career – in favor of single-payer health care, Medicare for All, in Massachusetts.

I did it openly, I did it as forcefully as I possibly could, and I said it to no matter who I was talking to. And I want to explain in a few minutes why I did that, what I've learned from that campaign, and then a few thoughts about what I think is next, although I have to defer to you and your colleagues gathered at your meeting today on the latter.



Dr. Donald Berwick

Single payer is smart policy

First: Why did I do this?

I want to frame something first: single-payer health care is important in terms of policy, but it is not, in and of itself, a moral commitment. Social justice and equality, ending poverty and hunger: those would be moral aims. But how we pay for the care we want, and how we get that care, isn't a matter of morality; it's just a mechanism.

The test of the value of single payer as a policy isn't whether or not it is self-evidently or ethically right, but only whether it's a smart way to achieve quality of care, and I think it is. And I want to tell you why that is.

Drawing on my experience at the Institute for Healthcare Improvement, I've seen how powerful the concept of the Triple Aim is: an attempt to designate or help advance health care as an enterprise by starting with what specifically needs to be accomplished on behalf of the communities and the people that we serve. There's a constellation of such aims in each and every system, and you cannot take them apart.

The Triple Aim includes, first, the aim of better care if you need care, from a check-up to treatment for a heart attack. There is a social need for better care for individuals; that means care that is safe, effective, patient-centered, timely, efficient, and equitable. That's the first aim: better care for individuals.

The second aim is to help people not get sick in the first place, i.e. better health for populations.

And the third aim is to reduce the per capita cost of health care, so that resources are freed up for worthy alternative public and private endeavors.

(continued on next page)

(*Berwick, continued from previous page*)

Achieving the Triple Aim

So what I began to believe, more and more fully, is that if we consolidate payment into a single pool, a single stream, under public accountability, we'll be better able to attain the Triple Aim. And that is the key argument for single-payer care.

That would help us achieve the first aim, better care. We have problems in our care. We have care that doesn't match need, and care that is not safe. The progress toward patient safety is nowhere near where it really needs to be in this country, and not, very frankly, in other countries as well. Our care could be far, far more effective. People too often get care they don't need, and care that is not aligned with science. Nor is care truly patient-centered. There has been some progress, but it's limited.

I think single-payer care is a strong lever on better care. With it, we could decide to make care safer as a nation, and we could decide to align it with science. We have a lot of trouble doing this with a multi-payer system.

In my Medicaid work at the CMS, I got a report from the Inspector General about overuse of anti-psychotic drugs on Medicaid patients in nursing homes. The report came to my desk, and it showed 300,000 patients in nursing homes getting over-sedated.

The test of the value of single payer as a policy isn't whether or not it is self-evidently or ethically right, but only whether it's a smart way to achieve quality of care, and I think it is.

So I picked up the phone and called in the head of the nursing home associations, the for-profits, the nonprofits, a dozen people, asking that they meet with me. And they all showed up. I said overmedication in our nursing homes was not OK. "Either you fix it," I said, "or we will." Within a few weeks I had reports on my desk, replies from those associations, none perfect, but all showing strong plans to decrease the use of such medications, and those projects are still underway today with good success.

With a single-payer system you have leverage, a voice for improvement. The leverage that you have in the form of payment is powerful.

Shifting resources toward need

A single-payer system would also help us achieve more meaningful transparency about the quality of care. Uncoordinated and multiple metrics are driving people in health care crazy right now. We need transparency, we need consolidated metrics that really work.

It would be much easier to achieve meaningful and parsimonious measurement under a single-payer system. It allows us to see how we're doing. Where did the money go? How is our quality? It's very hard to get that information, across time and space, in a fragmented, multi-payer system. A single-payer system provides much clearer eyes on the care, to the advantage of patients and the community, like it should be.

Under a single-payer system we can shift resources toward need. A single payer can get a better handle on fee-for-service. We can invest in behavioral health care, as some of you are talking about today, I know. And we would have the kind of community risk pool that we need in order to achieve justice and equality in health care.

And finally, a single payer would be even more effective than Medicare is today. We could do much more under the aegis of a consolidated payment system. It would be a powerful lever for better care.

Prevention and investing upstream

As for Aim Two, better health, a single-payer system would let us invest upstream, for population health, to address population-based causes of poor health, over space and over time. It would be a powerful force for cross-sectional justice.

I have an illustrative story from New Zealand: I was talking with their Chief Medical Officer several years ago who was proudly telling me that they have an annual budget for health care, and that one year he asked that some of the money originally intended for the Ministry of Health be turned over to the Ministry of Housing. He understood that a lot of the burden of illnesses among children, particularly Maori children, is the result of poor housing conditions. So he actually proposed that money be taken from the health care pot and moved to the housing pot. You can't do that under a multi-payer system. That won't work.

So a single-payer system can offer new and powerful levers for prevention.

A single-payer system allows us to track a patient, which is very difficult under a multi-payer system.

Better cost control

Finally, the third leg of the Triple Aim triangle, beyond better care and better health, is lower cost. And here is where single payer stands out.

You know from the studies of David [Himmelstein] and Steffie [Woohandler] about administrative costs. I don't know the total, I don't know exactly what it is – something like 12 percent or 15 percent of health care spending is spent on supporting the complexity of our system, not better care. As I pointed out as a candidate for governor, some of that money should be used for building housing, schools, roads. It's not right for health care to take more than it needs.

A single payer would also give us stronger bargaining power in payment for hospital supplies and more. I oversaw several procurements for durable medical equipment under Medicare, which we put out to bid, and which achieved a 42 percent decline in costs, with higher quality and service, over a several-year period.

Consolidated payment means better metrics and better quality on behalf of the people we serve.

An overarching consideration in this picture is justice. Until

health care is less costly per capita, we will be unable to properly address the problems of our schools, poverty, and hunger.

Lessons from my election campaign

So what I learned, very briefly, is that our current approach – a complex multi-payer system – makes it harder for us to get where we should get: to the Triple Aim.

With respect to health care, I think I discovered a sense of helplessness, a latent anger in the public that was sobering. As I campaigned in working-class communities, many of which may have voted Republican, people are weary. They're worn down by forces they do not understand.

With a single-payer system you have leverage, a voice for improvement. The leverage that you have in the form of payment is powerful.

I remember meeting a carpenter, a soft-spoken guy. He told me about his health insurance problems and debts that have been weighing on him for more than a year and that were driving him over the edge.

That said, I want to stress, people don't really understand the term single payer. They often lack a clear idea of what the term means or intends.

I would say that maybe a majority of the people I spoke with thought that single payer, Medicare for All, means both a government payer and a government provider or governmentally run delivery system. They thought I was speaking of the English or Scottish health systems or the VA.

That is not actually correct. You can have a single payer as a form of payment, and you can have a unified health care delivery system, but they're not the same idea. Both can be discussed, but they're not the same idea. It is quite possible to have a single payer and the same time have a pluralistic, partly public and partly private health care delivery system such as we have today in the U.S.

I believe that I saw that much of the business community, which actually may stand to gain the most, doesn't understand the benefits of single payer. They don't understand what improvements and cost reductions they could get under a system of consolidated payment.

That said, the number of people was large who pulled me aside at a town meeting, a coffee, or a forum, and said quietly, "I'm almost embarrassed to say it, but I think you're right."

Some of the largest resistance, it seems to me, comes from some of the largest corporations. The key pushback from the public was job loss, concern about the loss of jobs at insurance companies. Of course, such losses would be largely offset by the number of jobs created in public sector, but we should not be glib or unfeeling about the dislocation that a single-payer system would cause in the existing funding organizations.

My basic takeaway

Overall, I'll tell you this: My takeaway is that given my experience in living rooms, libraries, and town meetings, this [single payer] is possible. This can be done.

What is next? You're in the best position, perhaps, to judge. I have only a couple of ideas.

First, I like the idea of action at the state level.

Second, I like the idea of trying to forge an alliance of groups, including business, in support of this proposal.

Third, a very big obstacle to progressing this policy is the widespread perception that government is unable to solve problems – that government cannot manage itself well. Indeed, some of the problems we have seen at the federal and state level contribute to this belief. I think there's a natural need here for single-payer advocates to talk about government and responsible management, to make the case that government can solve problems and manage its business well.

Finally, I think we need to continue making the economic analysis for our case. It can be strong, but it has to be disciplined and intellectually honest.

I think I'll stop there and be happy to take a few questions. Thank you.

Dr. Donald Berwick, an internationally recognized leader in the field of quality, is president emeritus and senior fellow at the Institute for Healthcare Improvement and former chief administrator of the Centers for Medicare and Medicaid Services.

Berwick: When you do the math, you see the problem

(Excerpt) Donald Berwick, M.D., former administrator of the Centers for Medicare and Medicaid Services (CMS) in the Obama administration, said that after he left the agency and decided to run for governor of Massachusetts, "I did not enter the race as single-payer advocate, but my mind got changed very early" as he looked at the state's budget and saw the increasing amounts of money going to health care.

During his tenure at CMS, Berwick was criticized by Republicans for stating his admiration of the British health care system, which they said indicated support of rationing health care.

When he was campaigning, Berwick said he encountered a lot of confusion about the issue. "The first was confusion between the consolidation of payment in single-payer, and socialized medicine, where the government takes over delivery of care. People thought single-payer meant that the government becomes the provider of health care."

In addition, the rising cost of health care was kind of buried, Berwick said. "People sort of know their own contributions to health care are going up, but when they actually do the subjective math, they can see the problem."

From "Barriers to More Healthcare Reform Are Numerous" by Joyce Frieden in MedPage Today, Jan. 28. The story is about a panel that day at annual meeting of the National Academy of Social Insurance in Washington, D.C.

Common Dreams.org
Join the movement. For the greater good.

February 4, 2015

Universal health care advocates renew push toward Medicare-for-All

U.S. Rep. John Conyers: 'I believe that a single-payer, universal health care system is the only way we can truly reshape our broken system'

By Deirdre Fulton

Single-payer advocates are celebrating the reintroduction of the so-called 'Medicare-for-All' bill that would replace the nation's byzantine health care system, dominated by private health insurance companies, with a single, streamlined public agency that would pay all medical claims for the entire population, much like Medicare does for seniors today.

Lead sponsor Rep. John Conyers Jr. (D-Mich.) put forth the "Expanded and Improved Medicare for All Act" (H.R. 676) on Tuesday evening, along with 44 other House members. The legislation would create a publicly financed, privately delivered health care system that expands the already existing Medicare program to all U.S. residents and all residents living in U.S. territories. The bill has been defeated in three previous House sessions.

Proponents say the approach would vastly simplify how the nation pays for care, improve patient health, restore free choice of physician, eliminate co-pays and deductibles, and yield substantial savings for individuals, families, and the national economy.

At his website, Conyers says: "I believe that a single-payer, universal health care system is the only way we can truly reshape our broken health care system."

Dr. Robert Zarr, president of Physicians for a National Health Program, a nonprofit research and educational group of 19,000 doctors nationwide that supports Conyers's bill, echoed that claim.

"The global evidence is very clear: single-payer financing systems are the most equitable and cost-effective way to assure that everyone, without exception, gets high-quality care," Zarr said. "Medicare is a good model to build on, and what better way to observe Medicare's 50th anniversary year than to improve and extend the program and its benefits to people of all ages?"

The Medicare-for-All bill would be an improvement on the Affordable Care Act, Zarr said. He continued: "[T]he enactment of Rep. Conyers' bill would take us much further down the road to a humane, just and sustainable health care system than the 2010 health law, which, despite its modest benefits, will not be able to control costs and will still leave 31 million people uninsured in 2024, according to the Congressional Budget Office. Millions more will be inadequately insured, with skimpy coverage.

Rep. John Conyers Jr.

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

Last month, Common Dreams reported that just over 50 percent of Americans – and more than 80 percent of Democrats – say they still support the idea of single-payer health care, according to a poll by the Progressive Change Institute.

Last month, Common Dreams reported that just over 50 percent of Americans – and more than 80 percent of Democrats – say they still support the idea of single-payer health care, according to a poll by the Progressive Change Institute.

Meanwhile, the Republican-controlled House voted Tuesday largely along party lines to repeal and replace Obamacare. The legislation is likely to fail in the U.S. Senate and would certainly be vetoed by President Obama should it reach his desk.

Dierdre Fulton is a staff writer at Common Dreams.

MINNESOTA / ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

December 19, 2014

What is single payer and why should emergency physicians care?

By Dave Dvorak, M.D., M.P.H.

As emergency physicians, we have chosen to work in a setting that treats all patients, regardless of their ability to pay. We deliver more uncompensated care than any other specialty. Whether you see this as honorable or unfair, it is emblematic of a long broken system.

Yes, the Affordable Care Act has gotten more Americans insurance coverage – but what kind of coverage? Increasingly, ultra-high deductibles and copays are making patients reluctant to seek care when they need it – and vulnerable to financial ruin when they do.

America spends plenty on health care – twice per-capita as other industrialized nations – but with staggering inefficiency. Administrative overhead devours 31 percent of our health spending. It's our health insurance premiums that pay for those catchy HMO commercials and billboards, marketing departments, underwriters, lobbyists, eight-figure insurance executive salaries, and handsome investor profits. Has any of this ever helped you care for a patient?

What if we redirected those wasted health care dollars into actual health care, while ensuring that all citizens have access to quality care? This is the case for single-payer health reform.

The power of single payer is its efficiency. It replaces the dizzying labyrinth of private insurance plans with a single, unified public financing stream. Yet it maintains the private practice of medicine, encouraging market-based competition where it matters – among providers. Single payer streamlines payment for health services and products by establishing uniform, transparent pricing. It replaces the costly, cumbersome practice of itemized hospital billing with global annual budgeting, removing layers of hospital administrators and bloated billing departments.

Most importantly, single payer guarantees quality coverage to all, removing crippling out-of-pocket liabilities. The win-win result is that emergency physicians are compensated fairly for every patient we treat, while our patients no longer fear crushing medical bills and visits by debt collectors.

The ACA's State Innovation Waiver will allow individual states, beginning in 2017, to apply for federal waivers to implement their own innovative health systems, provided they can cover at least as many residents without costing more. This is a huge opportunity for Minnesota to lead.

The Lewin Group recently studied the economic feasibility of a Minnesota single-payer system. It found that such a system could provide comprehensive health and dental coverage to every Minnesotan while saving the state an extraordinary $65 billion in health spending over 10 years. The median-income Minnesota family would save an average of $3,512 per year on health care. Importantly, the savings came primarily from reduction of administrative waste; provider compensation remained unchanged.

Dr. Dave Dvorak

The Lewin Group recently studied the economic feasibility of a Minnesota single payer system. It found that such a system could provide comprehensive health and dental coverage to every Minnesotan while saving the state an extraordinary $65 billion in health spending over 10 years.

Because I believe single payer is the most sensible, equitable and sustainable way forward, I'm a member of the Minnesota chapter of Physicians for a National Health Program, which advocates for universal coverage through single-payer reform. I'm in good company – currently, over 1,000 fellow Minnesota physicians and health professionals have signed the resolution in support of single payer. I encourage all Minnesota emergency physicians to learn more about single payer and consider supporting the movement at PNHPminnesota.org.

Dr. Dvorak is an emergency physician who has practiced with EPPA for 20 years. This article appeared in the "Member Point of View" section of the newsletter of the Minnesota chapter of the American College of Emergency Physicians.

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

January 28, 2015

What are the barriers to real health reform?

By Marcia Angell, M.D.

PNHP note: The following are the prepared remarks of Dr. Angell at a panel titled "Persistent Barriers to Reform of the American Health Care System" at the 27th Annual Policy Research Conference of the National Academy of Social Insurance in Washington, D.C., on Jan. 28, 2015.

This country has long subscribed to the ideology that the best and most efficient way to distribute anything is through a private market, and we've applied that ideology to health care. We distribute it like a market commodity, according to the ability to pay, and not like a social service, according to medical need.

But there's a great mismatch between the ability to pay and medical need. The people who most need health care are precisely those least able to pay. So while the private sector concentrates on those who can pay, as businesses are supposed to do, those who can't pay go without adequate care or depend on the government to step in.

At the same time, well-insured people often get far more medical care than they need or is even good for their health.

This reliance on a private market to distribute health care is what leads to the grotesque inadequacies, maldistribution, and inefficiencies in our system, and what distinguishes us from every other advanced country. Even in countries that permit the sale of private health insurance, the prices and benefits are tightly regulated, and care is delivered in a predominantly nonprofit system.

A welter of financial incentives

There are different financial incentives at work in our profit-driven system, depending on who you are. Employers and insurers, including government insurers, have every incentive to stint on care. The best way to do that is to refuse to insure high-risk people at all, if possible; to shift costs to patients at the point of service by increasing deductibles and co-payments; and to limit the benefit package.

In contrast, hospitals and other facilities have every interest in expanding, so that they're in a better position to bargain with insurers for higher prices. In Boston, for example, we've witnessed a colossal struggle over the years between insurers and Partners Health Care – the giant entity created by the merger of the Massachusetts General Hospital and the Brigham and Women's Hospital. Partners now controls large panels of physicians, and facilities throughout the region. Since no insurer can afford to leave Partners out of its network, it can command much higher prices than other hospitals in the state.

For their part, physicians just want to keep their income up, while the wars between insurers and hospital conglomerates rage around them. Like society at large, however, the inequality among physicians is huge.

Dr. Marcia Angell

While primary care doctors struggle, specialists are thriving – particularly procedure-oriented specialists. They are mainly paid fee-for-service, and those fees are greatly skewed to reward tests and procedures. Specialists thus have every incentive to do as many of them as possible, particularly when prices are controlled.

There's much talk now about aligning these disparate incentives. But in our current system, none of these incentives is good for patients, and perhaps the last thing we should want is to align them.

The main problem: costs

We need to remember that the main problem with our health system is costs, because everything else depends on that. After all, if money were no object, everyone could have all the health care they could possibly use or want.

But money is an object. And sadly, the Affordable Care Act is a misnomer, because it's not really affordable. Yes, it has expanded access, but the costs will not be sustainable – unless deductibles and co-payments are greatly increased and benefits cut.

The problem is that the ACA attempted to reform the system while retaining the private insurance industry and the profit-driven delivery system, with all its distortions and waste. It even made the private insurance companies the linchpin of the reform, providing them with millions more publicly subsidized customers.

The thought was that anything else was politically unrealistic. Given our politics, that may have been so, but that does not mean that the ACA can work. It's unrealistic for different reasons.

A lesson in point. In 2006, Massachusetts implemented Romneycare, the prototype of Obamacare, in a state that had everything going for it – an already high rate of insurance, a large fund to provide for the uninsured, and a Medicaid waiver. But the state now spends more per capita on health care than any other state in the union (in 2009, about $9,278 per person, compared with a national average of $6,815). Health spending now consumes over half the state budget, at the expense of nearly every other state function – including education, public safety, human services, and infrastructure.

We need Medicare for all, but …

I believe the only way to provide universal and affordable health care is to extend Medicare to everyone – perhaps gradually, by lowering the qualifying age one decade at a time. The public, I'm sure, is much friendlier to this idea than Congress, despite the latter's protestations to the contrary.

I believe the only way to provide universal and affordable health care is to extend Medicare to everyone – perhaps gradually, by lowering the qualifying age one decade at a time. The public, I'm sure, is much friendlier to this idea than Congress, despite the latter's protestations to the contrary.

Max Baucus, the chairman of the Senate Finance Committee who pushed Obamacare through Congress, received more money from the health industry that year than any other member of Congress, so it's no wonder that he dismissed the idea of Medicare for all as politically unrealistic.

But Medicare for all is not enough. We also need a less profit-driven delivery system in which physicians are paid by salary, and hospitals are not permitted to divert operating income to expansion.

So what are the barriers to achieving such a reform? Much of the public now opposes the new health reform law, and it's often claimed that their opposition reflects the American public's antipathy toward big government.

I see no reason to believe that. While it may be true for some people, I believe it's largely a canard promulgated by the health industries and many public officials (such as Max Baucus) and the media.

The issue for the public, I suspect, is not the size of government, but the feeling that it often doesn't work for their benefit, and instead serves special interests. I have no doubt that if instead of Obamacare, the plan had been to extend Medicare to everyone, most of the public would have been delighted.

In fact, polls have consistently shown that a majority of Americans favor such a system; the percentages vary according to the framing of the question, but they are almost always well above 50 percent. Americans have no problem with government programs that serve their interests, such as Medicare, Social Security, or, say, the National Institutes of Health.

But they are very suspicious of the private health industry, which now has the largest lobby in Washington — even larger than the defense industry. The major barrier to real reform, then, is money — the wealth of the medical-industrial complex.

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

The Affordable Care Act and Medical Loss Ratios: No Impact in First Three Years

By Benjamin Day, David U. Himmelstein, Michael Broder, and Steffie Woolhandler

International Journal of Health Services
Vol. 45, No. 1, January 2015

Abstract

The Patient Protection and Affordable Care Act (ACA) set limits on insurers' overhead, mandating a medical loss ratio (MLR) of at least 80 percent in the individual and small-group markets and 85 percent in the large-group market starting in 2011. In implementing the law, the Obama administration introduced new rules that changed (and inflated) how insurers calculate MLRs, distorting time trends. We used insurers' filings with the U.S. Securities and Exchange Commission to calculate the largest insurers' MLRs before and after the ACA regulations took effect, using a constant definition of MLR. MLRs averaged 83.04 percent in the three years before reform and 83.05 percent in the three years after reform. We conclude that the ACA had no impact on insurance industry overhead spending.

doi: http://dx.doi.org/10.2190/HS.45.1.i

The New York Times

January 30, 2015

Don't trade away our health

By Joseph E. Stiglitz

A secretive group met behind closed doors in New York this week. What they decided may lead to higher drug prices for you and hundreds of millions around the world.

Representatives from the United States and 11 other Pacific Rim countries convened to decide the future of their trade relations in the so-called Trans-Pacific Partnership (T.P.P.). Powerful companies appear to have been given influence over the proceedings, even as full access is withheld from many government officials from the partnership countries.

Among the topics negotiators have considered are some of the most contentious T.P.P. provisions – those relating to intellectual property rights. And we're not talking just about music downloads and pirated DVDs. These rules could help big pharmaceutical companies maintain or increase their monopoly profits on brand-name drugs.

The secrecy of the T.P.P. negotiations makes them maddeningly opaque and hard to discuss. But we can get a pretty good idea of what's happening, based on documents obtained by WikiLeaks from past meetings (they began in 2010), what we know of American influence in other trade agreements, and what others and myself have gleaned from talking to negotiators.

Trade agreements are negotiated by the office of the United States Trade Representative, supposedly on behalf of the American people. Historically, though, the trade representative's office has aligned itself with corporate interests. If big pharmaceutical companies hold sway – as the leaked documents indicate they do – the T.P.P. could block cheaper generic drugs from the market. Big Pharma's profits would rise, at the expense of the health of patients and the budgets of consumers and governments.

There are two ways the office of the trade representative can use the T.P.P. to maintain or raise drug prices and profits.

The first is to restrict competition from generics. It's axiomatic that more competition means lower prices. When companies have to fight for customers, they end up cutting their prices. When a patent expires, any company can enter the market with a generic version of a drug. The differences in prices between brand-name and generic drugs are mind- and budget-blowing. Just the availability of generics drives prices down: In generics-friendly India, for example, Gilead Sciences, which makes an effective hepatitis-C drug, recently announced that it would sell the drug for a little more than 1 percent of the $84,000 it charges here.

That's why, since the United States opened up its domestic market to generics in 1984, they have grown from 19 percent of prescriptions to 86 percent, by some accounts saving the United States government, consumers and employers more than $100 billion a year. Drug companies stand to gain handsomely if the T.P.P. limits the sale of generics.

The second strategy is to undermine government regulation of drug prices. More competition is not the only way to keep down the prices of essential goods and services. Governments can also directly restrain prices through law, or effectively restrain them by denying reimbursement to patients for "overpriced" drugs – thus encouraging companies to bring down their prices to approved levels. These regulatory approaches are especially important in markets where competition is limited, as it is in the drug market. If the United States Trade Representative gets its way, the T.P.P. will limit the ability of partner countries to restrict prices. And the pharmaceutical companies surely hope the "standard" they help set in this agreement will become global – for example, by becoming the starting point for United States negotiations with the European Union over the same issues.

Americans might shrug at the prospect of soaring drug prices around the world. After all, the United States already allows drug companies to charge what they want. But that doesn't mean we might not want to change things someday. Here again, the T.P.P. has us cornered: Trade agreements, and in particular individual provisions within them, are typically far more difficult to alter or repeal than domestic laws.

We can't be sure which of these features have made it through this week's negotiations. What's clear is that the overall thrust of the intellectual property section of the T.P.P. is for less competition and higher drug prices. The effects will go beyond the 12 T.P.P. countries. Barriers to generics in the Pacific will put pressure on producers of such drugs in other countries, like India, as well.

Of course, pharmaceutical companies claim they need to charge high prices to fund their research and development. This just isn't so. For one thing, drug companies spend more on marketing and advertising than on new ideas. Overly restrictive intellectual property rights actually slow new discoveries, by making it more difficult for scientists to build on the research of others and by choking off the exchange of ideas that is critical to innovation. As it is, most of the important innovations come out of our universities and research centers, like the National Institutes of Health, funded by government and foundations.

The efforts to raise drug prices in the T.P.P. take us in the wrong direction. The whole world may come to pay a price in the form of worse health and unnecessary deaths.

Joseph E. Stiglitz, a Nobel laureate in economics, a professor at Columbia and a former chairman of the Council of Economic Advisers, is the author of "The Price of Inequality."

Bangor Daily News

November 20, 2014

How ACA fuels corporatization of American health care

By Philip Caper, M.D.

A new Harvard study has found that Americans' trust in the medical profession has dropped dramatically in recent years and lags behind that in many other wealthy countries. At the same time, doctors are becoming increasingly unhappy with our profession. In his new memoir, "Doctored," Dr. Sandeep Jauhar eloquently explains why: More and more doctors are coming to view our profession as just another job.

We now have a situation where patients are losing confidence in their doctors, while doctors are losing confidence in our ability to do the right thing for our patients. We have a health care system becoming more hostile to doctors and patients and more friendly to health care corporations.

These trends are collateral damage caused by another trend: our increasingly corporatized, commodified and commercialized U.S. health care "industry" that is being put into hyper drive by the Affordable Care Act. The ACA is accelerating an ongoing wave of hospital consolidations and acquisition of doctors' practices by large corporations, such as Eastern Maine Healthcare Systems and MaineHealth.

As we continue down this road, doctors see our clinical autonomy disappearing as more and more of us become corporate employees subject to pressure to meet corporate financial goals that often differ from what is best for our patients. Patients sense that pressure as they are rushed through exams and are subject to more tests and procedures, some of them of questionable clinical value. They can almost hear the cash registers ringing as they move through their doctors' offices, as more wealth is transferred from patients to those selling health care goods and services.

Why is American medicine, once the crown jewel of American professionalism and a proud and respected calling, becoming just another commercial enterprise? In his 2010 book "Hijacked," Dr. John Geyman, chairman emeritus of the department of family medicine at the University of Washington, explains how during the year-long congressional debate leading up to enactment of the ACA, the interests of the public, including doctors and patients, were subverted to those of large health care corporations.

The hijacking of health care reform is paying off handsomely. Robert Pear of The New York Times recently described how the federal government and the commercial health insurance industry have morphed into one big fan club for the ACA. He quotes the libertarian Cato Institute's Michael Cannon explaining that since the ACA's enactment, "Insurers and the government have developed a symbiotic relationship, nurtured by tens of billions of dollars that flow from the federal Treasury to insurers each year."

Pear goes on to report that "Since Mr. Obama signed the law, share prices for four of the major insurance companies – Aetna, Cigna, Humana and UnitedHealth – have more than doubled, while the Standard & Poor's 500-stock index has increased about 70 percent."

Pharmaceutical companies also have done very well. The ACA contains no authority for the government to negotiate pharmaceutical prices but continues the federal prohibition on the importation by U.S. residents of lower priced prescription drugs from many foreign countries.

This situation won't change anytime soon. Congress is gridlocked. What is widely recognized as a drafting error in the ACA – which, in saner times, could have been fixed quickly without attracting much attention – is now headed to the Supreme Court.

Of course, health care is just one of many examples in which the welfare of corporations has been put ahead of the interests of the public, but it may be the poster child. Health care is now more than a sixth of our economy, and human lives and dollars are at stake.

Corporate stranglehold of our public policy traces back to the increasingly corrupt way our political campaigns are financed. The recent midterm elections were a stark reminder of that, setting record levels for corporate spending, even on local races, and saturating voters with negative, intrusive and often obnoxious messages.

What's at stake is the future of health care and many other issues that will determine what kind of a country our children will live in. That future depends on how active and informed the public is willing to become in electing public officials who place the welfare of their constituents ahead of the wishes of their corporate contributors.

The results of the recent elections are not encouraging. But what's becoming clearer is that our struggle is not between Democrats and Republicans, liberals and conservatives, or occupiers and tea partiers. It is between real American people and corporations.

I, for one, intend to continue pointing that out. That's where our attention should be focused.

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

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

January 10, 2015

What happened in Vermont: Implications of the pullback from single payer

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

Gov. Peter Shumlin's Dec. 17, 2014, announcement that he would not press forward with Vermont's Green Mountain Care (GMC) reform arose from political calculus rather than fiscal necessity. GMC had veered away from a true single payer design over the past three years, forfeiting some potential cost savings. Yet even the diluted plan on the table before Shumlin's announcement would probably have cost no more than the current system in Vermont, while covering all of the state's uninsured.

Background

Decades of exemplary grassroots organizing (and strong labor union support) in Vermont put single payer on the agenda. During Shumlin's 2010 gubernatorial campaign, he promised to implement a single-payer reform, which was a factor in the Progressive Party's decision not to field a candidate. But the details of Shumlin's plan weren't fleshed out during the campaign.

After his victory, Shumlin and the legislature commissioned economist William Hsiao to study options for health reform in Vermont, including single payer. Rejecting a fully public single-payer plan, Hsiao instead proposed a "public-private hybrid" model and projected $580 million in savings, including large administrative cost savings, in the program's first year.

Spurred by Hsiao's positive projections, in 2011 the legislature passed a health reform law that laid out plans for implementing the Affordable Care Act in the short term, and called for a later transition to a single payer GMC plan. But while the law gave a detailed prescription for implementing the ACA (including construction of an exchange whose final cost was about $250 million), the sections on single payer were vague, and punted decisions on critical issues to the governor and a GMC Board (appointed by the governor). They would determine whether critical services like long-term care would be covered; the amount of copayments; how hospitals and doctors would be paid; and whether capital funds would be folded into operating budgets or allocated through separate capital grant (the sine qua non of effective health planning). Critically, the bill included no plan for funding the single-payer program.

An early signal of trouble was Shumlin's appointment of Anya Rader Wallack to chair the new GMC board. Wallack had deep ties to the private insurance industry, having held key positions (including the presidency) at the Blue Cross Blue Shield of Massachusetts Foundation. That foundation played a central role in designing and pushing for Massachusetts' 2006 Romneycare reform, and subsequently issued a series of glowing evaluations of Romneycare that helped buttress the case for replicating its structure in the ACA.

From the outset, Shumlin's team embraced an Accountable Care Organization payment strategy that would enroll most Vermonters in large hospital-based, HMO-like organizations that would be overseen by a "designated entity" – presumably Blue Cross. To-date, ACOs have shown little or no overall cost savings, have increased administrative costs, and have driven hospitals to merge and gobble up physician practices. The consolidation of ownership triggered by ACO incentives has raised concern that regionally dominant ACOs will use their market power to drive up costs. In Vermont, Dartmouth Hitchcock and the University of Vermont's Fletcher Allen system dominate the market, and have initiated a for-profit, joint venture ACO.

It's a misnomer to label Vermont's Green Mountain Care plan "single payer."

The design for GMC incorporated several other features that increased the administrative complexity, and hence administrative costs of the proposed reform. The plan never envisioned including all Vermonters in a single plan, instead retaining multiple payers. Hence, hospitals, physicians' offices, and nursing homes would still have had to contend with multiple payers, forcing them to maintain the complex cost-tracking and billing apparatus that drives up providers' administrative costs. It proposed continuing to pay hospitals and other institutional providers on a per-patient basis, rather than through global budgets, similarly perpetuating the expensive billing apparatus that siphons funds from care. And hospitals would have continued to rely on surpluses from day-to-day operations as their main source of capital funds for modernization and expansion. This undermines health planning and raises bureaucratic costs by forcing hospital administrators to undertake the additional work needed to identify and pursue profit opportunities.

Some of this complexity was forced on Vermont by federal statutes that may preclude folding Medicare and the military's Tricare program into a state single-payer plan, and restrict states' ability to outlaw private employer-provided coverage that duplicates the public plan. But the decisions to abandon lump-sum hospital payment, and separate grants for capital came from the governor and his advisors.

The End Game of Vermont's Reform

Vermont's November 2014 gubernatorial election had very low voter turnout, a circumstance that generally favors the right. Gov. Shumlin – who had hedged on health reform during the campaign – eked out a narrow plurality, leaving the state Legislature to decide between him and the Republican candidate, and greatly weakening Shumlin's position. A month later, while awaiting the Legislature's decision (they elected him to a third term on Jan. 9), Shumlin announced his pullback from reform.

Shortly thereafter, he released the detailed cost projections which he said had convinced him not to go ahead. The report by his staff estimated zero administrative savings from its proposed plan. It also projected zero savings on drugs and medical devices, tacitly acknowledging that GMC wouldn't use bargaining clout to rein in prices, and ignoring the fact that Quebec, its neighbor to the North, has gotten big discounts.

The Shumlin administration's cost estimates also incorporated an old (too high) estimate of the number of uninsured Vermonters, inflating the projected increase in utilization and cost. Finally, it assumed that doctors would expand their work hours (and incomes) to care for the newly insured, rather than maintaining their current work hours by seeing their other patients a little less frequently – as happened with the implementation of single-payer coverage in Quebec.

But even the administration's inflated cost estimates indicate that universal coverage under its quasi-single payer plan would have cost no more than the current system. The voluminous report includes detailed tabulations of new costs to the state treasury under the proposed reform. But the report scrupulously avoids providing any clear statement of the impact of reform on the total cost of health care (public and private) in the state. However, as detailed below, it projects savings for the vast majority of Vermonters, and the figures indicate that total spending wouldn't increase.

So why did Gov. Shumlin declare the reform unaffordable? Many have noted that the $2.5 billion in new state expenditures required under the reform would nearly double the state's previous budget. But these numbers are meaningless absent an accounting of the savings Vermont households would realize by avoiding private insurance premiums and out-of-pocket costs. These savings would likely fully offset the new taxes.

But although the total costs of care wouldn't have changed even under the flawed GMC plan, some – mostly higher-income, healthy Vermonters whose taxes would go up the most – would have paid more. Although the GMC tax plan was far from progressive, it was far less regressive than the current pattern of health care funding in the state. The governor's staff report estimated that most of the 340,214 families earning less than $150,000 annually would have gained, while most of the 24,102 families above that income level would have lost. Overall, employers' costs would have risen by $109 million – with many small businesses experiencing cost increases, a political sore point.

Conclusion

It's a misnomer to label Vermont's Green Mountain Care plan "single payer." It was hemmed in by federal restrictions that precluded including 100 percent of Vermonters in one plan, and its designers further compromised on features needed to maximize administrative savings and bargaining clout with drug firms, and improve health planning.

But even the watered-down plan that emerged could have covered the uninsured, improved coverage for many who currently face high out-of-pocket costs, and actually reduced total health spending in the state – albeit far less than under a true single payer plan. A true single-payer plan would have made covering long-term care affordable, and allowed the elimination of all copayments and deductibles.

Vermont's experience holds important lessons for single payer advocates.

1. Effective grassroots organizing makes a difference. It got real health care reform on the political radar screen in Vermont, and can get it back on the radar there and elsewhere. Indeed, single-payer forces in Vermont are already rallying to reverse Shumlin's decision. The virtues, value, and simplicity of a single-payer approach have broad popular appeal.
2. Federal restrictions impose significant compromises on state-level single-payer plans. For this, as well as other reasons, organizing for single-payer state plans and organizing for national legislation are not competing strategies, but complementary ones. The ultimate goal for both is a single, inclusive program for the entire nation.
3. As single-payer work advances, we need to anticipate that corporate opposition will mobilize – often behind the scenes. The only effective antidote is continued grassroots mobilization. Delayed implementation and punting key decision to the future opens the door for corporate influence and smear campaigns.
4. Beware of "experts" with a track record unsympathetic to single payer. Economic projections are always based on assumptions, which are often highly political.
5. Even when we don't get the whole pie, demanding it often yields a significant piece. Although a major single-payer effort was stymied in Vermont, it achieved substantial progress. It's no accident that Vermont's uninsurance rate has come down to 3.7 percent; that virtually all children in that state are covered; that its Medicaid program is among the best; that its hospitals have come under tighter fiscal regulation; and that single payer remains in the limelight there. Even as he backed off from single payer for now, the governor promised to press for future health reform.

Dr. Steffie Woolhandler and Dr. David U. Himmelstein are internists, professors at the City University of New York's School of Public Health at Hunter College, and lecturers at Harvard Medical School. They co-founded Physicians for a National Health Program.

Common Dreams.org
Join the movement. For the greater good.

November 11, 2014

How to end health insurance 'churn'

By Anne Scheetz, M.D.

With the Affordable Care Act's new enrollment period starting on Nov. 15, and then, for many, the activation of new insurance coverage on Jan. 1, we'll be witnessing an intense period of "churn."

Churn is the term often used to describe people moving back and forth between health insurance plans, e.g., between eligibility for Medicaid and eligibility for federal subsidies for private insurance bought on the ACA's exchanges.

Such eligibility hinges on your income, which can change from year to year. Also, the subsidies themselves can fluctuate if your income changes by as little as one dollar. Suddenly you're in a new bracket.

There are other scenarios, too. People with employer-sponsored insurance may now be required to join a high-deductible plan. Still others may have their hours cut so that they lose eligibility for job-based coverage altogether, throwing them on to the individual market.

Yet others may decide to change plans in search of lower premiums, deductibles, or co-pays. Or perhaps they want to follow a doctor who has left their plan's network.

How many people are we talking about? Writing in Health Affairs in 2011, researchers estimated 28 million adults are subject to health insurance churn annually.

But churn can also be used more broadly to describe any disruption in coverage, doctors, hospitals, or access, whether initiated by enrollees or forced on them by employers or insurers.

Churn is an expensive, intricate process. It requires the work of thousands of people, the creation of new branches of specialized knowledge and new software, and the expenditure of millions of dollars every year to track and make adjustments for such changes.

Churn is frustrating for nurses and doctors, and it adds to our health system's outrageously high administrative costs. We're told we're entering a new era of coordination of care, yet churn makes coordination impossible.

Churn is harmful to patients, and it is most harmful to the sickest patients. Loss of continuity of any aspect of access or care means that appointments are canceled, test results are lost, critical procedures don't get done, prescriptions don't get filled, and difficult decisions have to be revisited. It can result in preventable complications and even premature death.

Our private-insurance-based system is extremely complex. A recent Kaiser Family Foundation report notes that in the first year of the ACA's exchanges, "assister programs" employed more than 28,000 full-time-equivalent staff and volunteers to help people navigate the health insurance maze. Even people with extensive experience of the health care system are bewildered by the complex trade-offs they face.

The Kaiser report also makes clear that the need for assisters continues long-term. It recommends funding for "different models for specialized assister expertise," in, for instance, tax, family, and immigration law. It proposes development of "norms of professional practice for Marketplace assisters," a national assistance information center, and "prototype information management systems."

Yet all of this added bureaucracy doesn't necessarily give people access to affordable, high-quality care. It only gets some of them - for some will still fall through the cracks - some kind of health insurance that may well turn out to have high deductibles and co-pays that deter them from seeking care they truly need. And those who do seek care may find themselves in severe financial distress as a result.

Shouldn't we be providing all necessary health care to everyone, with a minimum of time and money devoted to bureaucracy?

I believe the answer is clearly yes – and that we have an effective model in front of our noses.

By using the Medicare program as a foundation and improving upon its existing benefits, we could quickly cover everyone – of all ages – in the country.

Researchers have shown that by eliminating costly private-insurance-related overhead and redirecting those savings into clinical care, we could assure that everyone has coverage for all necessary care, free choice of doctor and hospital, and no more co-pays and deductibles – for no more than our nation is spending now. Ninety-five percent of households would end up spending less.

The "single-payer" program's buying clout would also rein in health spending.

And there would be no more churn: Once you're in the Medicare for All program (i.e. when you're born), you'd be covered for life. End of story.

We know the path to providing high-quality care while enhancing everyone's financial security. It's called an improved Medicare for All.

Let's get it done.

Anne Scheetz, M.D., is an internist in Chicago and a member of Physicians for a National Health Program.

CRAIN'S
NEW YORK BUSINESS

December 16, 2014

N.Y. single-payer health bill gets wide support

Council member Corey Johnson and Raging Grannies face off against insurance brokers at daylong hearing

By Deirdre Fulton

The Affordable Care Act has made an unwieldy system of health insurance even more complicated, and should be replaced with a centralized, tax-funded health care system.

That was the prevailing view at Tuesday's all-day hearing on the New York Health Act, Assemblyman Richard Gottfried's bill to create statewide single-payer health insurance that stands almost no chance of passing in the state Senate.

The handful of insurance representatives who testified for a wait-and-see approach followed their speeches with a swift exit, often to the tune of hisses and groans from patients, health care workers and unions in the audience who far outnumbered them.

"No one advancement is big enough to bend the cost curve in itself," said Lawrence Thaul, president of Millennium Financial, an insurance brokerage. "It took many years to improve Medicare. Let us not be shortsighted and impatient – and you've been anything but that, chair," he hastily added to Mr. Gottfried, who chaired the hearing.

Mr. Gottfried, who heads the Assembly's committee on health, has carried a version of his single-payer legislation since 1999.

Many doctors and health care workers bemoaned the amount of time spent billing and collecting payment for medical care.

"I employ 24 separate billing people," said Dr. Neil Calman, president of the Institute for Family Health, "each of whom develops a relationship with one or two paying companies." Dr. Donald Moore, who recently stopped accepting commercial health insurance, said he used to spend the equivalent of three to four weeks every year billing for his work.

But without this back-and-forth between providers and insurance companies to drive down providers' charges, health care would cost even more, argued insurance executives.

"Price controls would not work because there would be no one on whom to shift the excess costs," said Craig Hasday, the legislative chair of the New York State Association of Health Underwriters. "Over time, the issue of affordability will return, but as a tax issue."

Proponents of the bill included speakers from the nurses' union and other organized labor groups, Green Party activists and even eight elderly activists who called themselves the Raging Grannies. The grannies, decked in flowers, sang songs supporting the bill to the tune of "Rudolph the Red-Nosed Reindeer."

State Rep. Richard Gottfried takes questions following a hearing in Syracuse, one of six that occured across New York State.

Councilman Corey Johnson spoke about the inconvenience of getting his prescriptions even under the City Council's generous health plan. Even the mayor's office weighed in, writing in a letter that "a single-payer system merits serious consideration because of its financial benefits for the city."

This iteration of the New York Health Act comes at a time when providers and insurers increasingly are turning to population health management and ever-larger systems as a way of controlling costs. One of the state's largest Medicaid reform attempts to date, the $8 billion DSRIP waiver, asks hospitals, community providers and insurance companies to collaborate to reduce hospital admissions.

'A single-payer system merits serious consideration because of its financial benefits for the city,' wrote the mayor of Syracuse

For Dr. Hemant Sindhu, a resident at Brookdale Hospital, Medicaid reform is single-payer in miniature.

"There is no doubt," he said, "that having a unified payment system allowed to rapid transformation and improvement of health care."

Minneapolis St. Paul
THE MINNESOTA DAILY

February 11, 2015

A simpler approach to health care

By Aatif Mansoor, Channing James and Jenny Zhang

We are medical students who have devoted eight years of our lives to educating and training ourselves, along with three to seven more years of training left for our chosen specialty.

We don't put ourselves through all of that because we have a penchant for staying in school, purchasing expensive textbooks and accruing student loans – we do it so we will be able to properly take care of our future patients.

During the application process, we are all asked to write a personal statement about why we want to go medical school. I would wager that 100 percent of the responses from my classmates and from across the nation included some verbiage that referred to wanting to help people.

But as we have learned more and more about the system in place to take care of people in this country, we have become more concerned.

Yes, the Affordable Care Act has gotten more Americans insurance coverage – but what kind of coverage? Increasingly, ultra-high deductibles and copays are making patients reluctant to seek care when they need it – and vulnerable to financial ruin when they do.

America spends plenty on health care – twice per capita as other industrialized nations – but with staggering inefficiency. Administrative overhead devours 31 percent of our health spending.

It's our health insurance premiums that pay for those catchy health-maintenance organization commercials, ads that cover an entire light-rail car, marketing departments, underwriters, lobbyists, eight-figure insurance executive salaries and handsome investor profits. None of this has helped us take care of our patients.

What if we redirected those wasted health care dollars into actual health care, while ensuring that all citizens have access to quality care?

This is the case for single-payer health reform.

The power of single-payer health care is its efficiency.

It replaces the dizzying labyrinth of private insurance plans with a single, unified public-financing stream. Yet it maintains the private practice of medicine, encouraging market-based competition where it matters – among providers.

Single-payer care streamlines payment for health services and products by establishing uniform, transparent pricing.

It replaces the costly, cumbersome practice of itemized hospital billing with global annual budgeting, removing layers of hospital administrators and bloated billing departments.

Most importantly, single-payer care guarantees quality coverage to all, removing crippling out-of-pocket liabilities.

The win-win is that we as future physicians would be compensated fairly for every patient we treat, while our patients no longer fear crushing medical bills and visits by debt collectors.

Because we believe single-payer care is the most sensible, equitable and sustainable way forward, we are members of the Minnesota chapter of Physicians for a National Health Program, which advocates for universal coverage through single-payer reform.

We currently have support from over 1,000 fellow Minnesota physicians, medical students and other health professionals who have signed the resolution in support of single-payer.

We encourage all University of Minnesota students at our institution to learn more about the single-payer system and consider supporting the movement.

The authors are University of Minnesota Medical School students.

AAMC

February 2015

Medical students step into advocacy roles

By Kim Krisberg

(Excerpt) External action is central for medical students involved with Physicians for a National Health Program and its 35 student chapters.

At the national level, the organization's annual summit educates attendees on a single-payer health care system, offering workshops on topics such as advocacy, public speaking, and letter writing. According to James Besante, a fourth-year student at the University of New Mexico School of Medicine and a student representative on the board of PNHP, students want to know more about policy and how to influence the process.

"Students want to take an active role in the health justice movement," he said. "The medical profession has lost a lot of ground in protecting the physician-patient relationship. We are the future of medicine, and we want to make it work not only for our patients, but also for ourselves."

The full text of this article is available at bit.ly/1E41PwQ. The AAMC Reporter is a publication of the American Association of Medical Colleges.

CHICAGO SUN-TIMES

December 23, 2014

As aspiring doctors, we see the racial toll of poor health insurance

By Scott Goldberg

On December 10, medical students at more than 70 schools across the country held "white coat die-ins" in response to the lack of indictments in the police killings of Michael Brown in Ferguson, Mo., and Eric Garner in New York.

Here in Chicago, I and more than 100 students from Rosalind Franklin University, Northwestern, Rush, the University of Chicago, and University of Illinois at Chicago lay down together in protest on the campus of UIC. It was a moving experience.

A 'Black Lives Matter' protest at the University of Chicago. Photo: Victoria Thomas

Why did we do this? Like many Americans, we are angered by the repression and injustice that affects communities of color. Yet we are not outside observers to these systematic injustices.

Every day, we see the toll inequality has on the lives and health of our African American, Latino, and other nonwhite patients. If we do not speak out on behalf of our patients, then we are not living up to the standards set by our profession.

In an important journal article from 2005, former Surgeon General Dr. David Satcher and co-authors demonstrated that while overall survival for both African American and white populations has improved over the last 40 years, there has been little improvement in the mortality gap between blacks and whites. In fact, this "death gap" worsened for black infants and black men age 35 and older.

What this means is that in 2002, blacks suffered 40.5 percent more deaths – 83,570 excess deaths – than would be expected if they had experienced the mortality rate of whites. This is a shocking statistic for a country with the greatest wealth and resources ever seen in human history.

While there a number of reasons why this racial disparity exists, the lack of universal health insurance coverage is an obvious one. Importantly, it's a fixable problem.

Every other industrialized country in the world has some form of public health insurance. Many countries, like Canada, have a single-payer system whereby the government funds the private delivery of health care. In Canada, everyone is guaranteed care, medical outcomes are as good if not better than in the U.S., and yet per capita health spending is about two-thirds what we spend.

Our own extremely popular Medicare program, whose 50th anniversary will be observed in the new year, resembles a single-payer system in many ways. For those who qualify, Medicare provides ready and equitable access to care, free choice of doctor and hospital, and a minimum of wasteful paperwork.

As long as private health insurance companies remain in our health care system, there were will be steep financial barriers to people of color and all people with lower to middle incomes getting access to medically necessary, life-saving care. A Medicare-for-All system, without co-pays or deductibles, would eliminate these barriers, save money and improve health.

Regrettably, the Affordable Care Act does not come close to removing these barriers to care. Nearly 31 million people will remain uninsured even after full implementation of the law, and millions more will have skimpy health insurance policies that will leave them vulnerable to financial distress in the event of illness.

As a medical student and future physician, I believe access to high-quality health care is a right of all people and should be provided as a public service rather than bought and sold as a commodity. Until this becomes a reality, the death gap between blacks and whites will continue to afflict us.

This state of affairs is unacceptable. As Dr. Martin Luther King Jr. once remarked, "Of all the forms of inequality, injustice in health is the most shocking and inhuman." We shouldn't settle for it. We need an improved Medicare for All.

Scott Goldberg is a third-year medical student at the University of Chicago Pritzker School of Medicine.

Op-Ed News (www.opednews.com) November 18, 2014

AMA students back state laws to achieve universal care

By Joan Brunwasser

My guest today is second-year medical student Brad Zehr. Something very interesting happened at the American Medical Association recently. What can you tell us about it?

Brad Zehr: The Medical Student Section of the AMA adopted a resolution at the Interim AMA meeting in Dallas expressing support for innovative state legislation to achieve universal health care, including but not limited to single-payer health insurance. The reason this policy item was particularly high-profile and groundbreaking was because it is the first instance of any section of the AMA adopting policy in support of single-payer health insurance. Although the Medical Student Section (MSS) is only one of 10 sections of the AMA, and although this resolution pertains only to the MSS and not the full AMA, the resolution signals a generational shift in organized medicine's approach to health care reform.

Historically, the AMA has explicitly opposed any forms of single payer, including opposition to the creation of U.S. Medicare in 1965. The AMA House of Delegates (HOD), which is the highest policy-making body of the AMA and includes representation from all of the AMA sub-sections and from state medical societies and medical specialty societies, still has three policies stating express opposition to single-payer health insurance in the U.S. The MSS boldly voiced support for single payer despite the HOD's continued hypersensitivity to single payer.

Joan Brunwasser: How did this come about?

BZ: Several recent developments in U.S. health care contributed to this. First, the Affordable Care Act includes a lesser known component called "Sec. 1332: Waiver for State Innovation." The section allows states to apply for an exemption from the federal ACA law beginning on January 1, 2017, to implement their own alternative, state-based health care law, given that their state law would cover at least as many people as the ACA would have, that the coverage would be as affordable to individuals and families as the ACA coverage would be, and that the state law would not increase the federal deficit.

Upon receiving approval from the U.S. Department of Health and Human Services and the U.S. Department of the Treasury, such innovative states would receive federal funds equivalent to what they would have received under the ACA in order to implement their alternative health care reform plan.

Vermont is the first, and so far only, state to commit to applying for a Section 1332 State Innovation Waiver.

A second recent development that motivated our resolution was the Massachusetts gubernatorial candidacy of Dr. Don Berwick, an internationally recognized health policy scholar and former chief administrator of the U.S. Centers for Medicare and Medicaid Services. Berwick campaigned on a pledge to move Massachusetts toward a single-payer system. Although he lost the Democratic primary to Martha Coakley, he mobilized incredible stores of political energy in the state with his bold commitments.

Brad Zehr

Finally, we wrote the resolution because single-payer has been conspicuously absent from the health policy conversation at the AMA-MSS throughout this past 15 years of upheaval in U.S. health care. The last time medical students debated single payer at the AMA was at the interim meeting in 1999. That resolution asked the AMA to study the advantages and disadvantages of a single-payer system, but the MSS did not adopt it.

We submitted a single-payer resolution to the Annual 2014 meeting this past June in Chicago. That resolution was strong: asking the AMA HOD to advocate for national single-payer health insurance. Sixty-one medical students from 18 medical schools co-authored that resolution. However, the MSS Reference Committee recommended the resolution not be adopted based on the argument that asking the AMA HOD to advocate for national single payer in light of their continued opposition was politically futile and a waste of our limited MSS influence. Furthermore, many student delegates expressed support for single payer, but said that it should be tried on a state-by-state basis, and that we should keep this policy within the MSS.

With the feedback of dozens of medical students from around the country, we crafted a compromised resolution for re-submission at the Interim meeting in November. This second version of the resolution was internal to the MSS, and asked for support for state-based single payer. And rather than being co-authored by 61 individual students, it was co-authored by four delegations: Massachusetts, Wisconsin, University of Vermont College of Medicine, and SUNY-Downstate College of Medicine. During the MSS General Assembly, the Reference Committee recommended adoption after amending the resolution to be expanded to include other innovative state legislation to achieve universal health care, in order to garner broader support. The resolution was adopted by approximately a two-thirds

majority, although only 51 percent was required for adoption.

JB: This is definitely encouraging, but what does it all mean? You're clearly out of step with the AMA as a whole. How do you explain the gap?

BZ: From the highest levels of organized medicine, medical students hear that U.S. health care is not working and that we need to advocate for the system we want during our careers. This is exactly what we are trying to do with this resolution. We know that single payer is one of the best ways to guarantee universal health care while controlling costs. The evidence to support this assertion is extensive, some of which we included in the Whereas clauses of our resolution. We think it is time to treat the AMA's hypersensitivity to single payer in the U.S. and have an evidence-based debate about the merits of such a system, especially in light of the fact that one state has already committed to it.

JB: You're passionate about this. Have you always been?

BZ: Single-payer health care reform was not on my radar going into medical school. Throughout college and grad school, I had followed the national health reform debate, from the 2008 presidential elections through the tumultuous rollout of HealthCare.gov in October 2013. I learned about single payer a year ago by attending the annual meeting of Physicians for a National Health Program, which happened to take place in Boston. Drs. David Himmelstein and Steffie Woolhandler, the co-founders of PNHP, presented several hundred slides of data analyzing the poor performance of our current health care system – or "non-system" as they demonstrated. Medical students and physicians respond to evidence and data. The evidence presented at that meeting was so compelling that several classmates and I decided to start a PNHP chapter at our school and to study single payer in between studying anatomy, physiology, biochemistry, and histology. What we discovered was an energized community of physicians whose priority is to create a health care system where everyone is in, nobody is out, and the profit motive is removed from health financing. I've made single payer a major part of my medical education because I want to practice in a more sane, ethical, and sustainable system.

From the highest levels of organized medicine, medical students hear that U.S. health care is not working and that we need to advocate for the system we want during our careers. This is exactly what we are trying to do with this resolution.

JB: What's wrong with what we've got now? Aren't we a lot better off with the Affordable Care Act?

BZ: The ACA will leave about 30 million uninsured and tens of million more underinsured. It is inadequate. Half the states are opting out of the Medicaid expansion. The most popular plans on the exchanges are silver and bronze, which are low-cost up front but high-cost out of pocket, exposing patients to extreme financial toxicity. Patient choice of doctor and hospital are limited by private insurance networks. The administrative overhead in the private health insurance system is 15 to 20 percent, whereas the overhead of single-payer Medicare is less than 2 percent. Our country spends twice as much per capita on health care as the other advanced nations yet we consistently achieve poorer health outcomes across the board and leave millions out. Physicians are tired of fighting with private health insurance plans to cover the care their patients need.

We need a modern, 21st-century health care system that includes every citizen automatically and simply. The ACA exacerbated the flaws of the pre-ACA system and further entrenched the private health insurance industry. It is a patchwork fix and will not suffice. Millennials have a low tolerance for needless complexity and systemic inequality, and they demand simplicity and fairness. Millennial physicians will not tolerate a system that leaves out millions, outspends all other peer nations for poorer outcomes, and creates daily interferences with treating patients.

JB: Getting the insurance companies to surrender what has been a cash cow of gargantuan proportions will be another big fight. Any thoughts on that?

BZ: Polling shows a majority of Americans prefer national health insurance. A 2009 CBS News / New York Times poll showed 59 percent of Americans favor government-run national health insurance.

Ultimately, voters will need to force their representatives to write and pass legislation that creates a more equitable health care system. Things might have to get worse, sadly. Right now, our national political discourse is in disarray. Few are optimistic about major national reform in any area of policy, let alone one as sensitive as health care. We will likely need campaign finance reform to get to a place politically where the will of the majority of Americans is prioritized over the will of the wealthiest donors and private health insurance lobbyists.

In the meantime, there are a handful of states where there are popular movements advocating for the creation of state-based single-payer health insurance -- Vermont, New York, Massachusetts, Washington, Illinois, Pennsylvania, among others. We want to support those states that will move toward single payer in the coming decade. We will create a health care system for all Americans, eventually.

JB: This interview has been an eye-opener for me. I'm thrilled that our medical future will be guided by souls such as yourself so dedicated to the true spirit of the Hippocratic Oath. Good luck to you!

Joan Brunwasser is a co-founder of Citizens for Election Reform has written for OpEdNews since December 2005. This article has been shortened from the original, which is available at opednews.com.

The New York Times

November 17, 2014

Health care law recasts insurers as Obama allies

By Robert Pear

WASHINGTON – As Americans shop in the health insurance marketplace for a second year, President Obama is depending more than ever on the insurance companies that five years ago he accused of padding profits and canceling coverage for the sick.

Those same insurers have long viewed government as an unreliable business partner that imposed taxes, fees and countless regulations and had the power to cut payment rates and cap profit margins.

But since the Affordable Care Act was enacted in 2010, the relationship between the Obama administration and insurers has evolved into a powerful, mutually beneficial partnership that has been a boon to the nation's largest private health plans and led to a profitable surge in their Medicaid enrollment.

The insurers in turn have provided crucial support to Mr. Obama in court battles over the health care law, including a case now before the Supreme Court challenging the federal subsidies paid to insurance companies on behalf of low- and moderate-income consumers. Last fall, a unit of one of the nation's largest insurers, UnitedHealth Group, helped the administration repair the HealthCare.gov website after it crashed in the opening days of enrollment.

"Insurers and the government have developed a symbiotic relationship, nurtured by tens of billions of dollars that flow from the federal Treasury to insurers each year," said Michael F. Cannon, director of health policy studies at the libertarian Cato Institute.

So much so, in fact, that insurers may soon be on a collision course with the Republican majority in the new Congress. Insurers, often aligned with Republicans in the past, have built their business plans around the law and will strenuously resist Republican efforts to dismantle it. Since Mr. Obama signed the law, share prices for four of the major insurance companies – Aetna, Cigna, Humana and UnitedHealth – have more than doubled, while the Standard & Poor's 500-stock index has increased about 70 percent.

The relationship between the Obama administration and insurers has evolved into a powerful, mutually beneficial partnership that has been a boon to the nation's largest private health plans.

"These companies all look at government programs as growth markets," said Michael J. Tuffin, a former executive vice president of America's Health Insurance Plans, the main lobby for the industry. "There will be nearly $2 trillion of subsidized coverage through insurance exchanges and Medicaid over the next 10 years. These are pragmatic companies. They will follow the customer."

The relationship is expected only to deepen as the two sides grow more intertwined.

Consumers are already hearing the same messages from insurance companies and the government urging them to sign up for health plans during the three-month enrollment period. Federal law requires most Americans to have coverage, insurers provide it, and the government subsidizes it.

"We are in this together," Kevin J. Counihan, the chief executive of the federal insurance marketplace, told insurers at a recent conference in Washington. "You have been our partners," and for that, he said, "we are very grateful."

Despite Mr. Obama's denunciations of insurers in 2009, it became inevitable that they would have a central role in expanding coverage under the Affordable Care Act later that year when Congress ruled out a government-run health plan – the "public option." But friction between insurers and the Obama administration continued into 2013 as the industry bristled at stringent rules imposed on carriers in the name of consumer protection.

A turning point came last fall, after the chaotic debut of HealthCare.gov, when insurers waived enrollment deadlines and helped the White House fix the dysfunctional website.

Now insurers say government business is growing much faster than the market for commercial employer-sponsored coverage. The Congressional Budget Office estimates that 170 million people will have coverage through Medicare, Medicaid and the insurance exchanges by 2023, an increase of about 50 percent from 2013. By contrast, the number of people with employer-based coverage is expected to rise just 2 percent, to 159 million.

In addition, the Affordable Care Act has engendered growth in the role of private insurers in Medicaid. The law expanded eligibility for Medicaid, and most of the new beneficiaries receive care from private health plans under contracts awarded by state Medicaid agencies. As a result, Medicaid enrollment is up more than eight million, or 15 percent, in the last year.

In a survey of 10 insurance companies, Joshua R. Raskin, an analyst at Barclays, reported that their revenues from the Medicare Advantage program were up about 10 percent this year. UnitedHealth Group's Medicaid enrollment surged by nearly one million people, or 24 percent, in the last year, said Stephen J. Hemsley, the chief executive. At another large insurer, WellPoint, the expansion of Medicaid "is proving highly profitable," Christine Arnold, a managing director of Cowen and Company, wrote in a recent report.

WellPoint is a case study in how companies have adapted to the law.

In 2010, as Democrats attacked the insurance industry for what they said were its high prices and discriminatory practices, no company was more of a target than WellPoint, which had sought rate increases of up to 39 percent in California. But WellPoint, which operates Blue Cross and Blue Shield plans in a number of states, is now prospering.

WellPoint announced recently that it had gained 751,000 subscribers through the health insurance exchanges and 699,000 new members through Medicaid. Since the end of 2013, WellPoint's Medicaid enrollment has increased by 16 percent, to a total of five million.

"Our government business is growing along multiple fronts" and accounted for about 45 percent of the company's consolidated operating revenues, said Joseph R. Swedish, the chief executive of WellPoint.

Aetna, in reporting its third-quarter results, said many people thought 2014 would "spell the death of our industry." But, the company said, it is having "a very good year," thanks in part to "excellent performance in our government business, which now represents more than 40 percent of our health premiums."

Insurers and the administration still have many disagreements, but open conflicts are rare.

"With all the politics of the Affordable Care Act, people don't realize how much the industry has benefited, and will continue to benefit, from the law," said Jay Angoff, the Obama administration's top insurance regulator from 2010 through 2012.

One insurer, Humana, derives about 65 percent of its revenue from its Medicare Advantage plans. Enrollment in these plans climbed 17.5 percent, to 2.9 million, in the year that ended Sept. 30, the company said.

At UnitedHealth Group, Medicaid and Medicare Advantage together are expected to provide more than $60 billion in revenue, or slightly less than half of the company's total, this year. United expects to participate in insurance exchanges in 23 states next year, up from four this year.

"The government, as a benefit sponsor, has been increasingly relying on private sector programs," United said in a document filed with the Securities and Exchange Commission. "We expect this trend to continue."

In another sign of the close relationship, the administration has recruited experts from the industry to provide operational expertise. Eight months after the unit of UnitedHealth Group, called Optum, helped repair HealthCare.gov, the administration hired a top Optum executive, Andrew M. Slavitt, as the No. 2 official at the Centers for Medicare and Medicaid Services. The administration waived conflict-of-interest rules so Mr. Slavitt could participate in decisions affecting UnitedHealth and Optum.

Now, as millions of Americans shop for insurance, federal officials are eager to collaborate with an industry they once demonized.

"The relationship between the marketplace and insurers is really critical to a successful program," said Ben Walker, director of open enrollment for the federal exchange. "Without that, we don't have any coverage."

The New York Times

The Health Law, in the Real World

By Nancy T. Block, M.D., February 16, 2015

As Elisabeth Rosenthal eloquently documents in "Insured, but Not Covered" (news analysis, Sunday Review, Feb. 8), our health insurance system is little better than the nonsystem we had before the Affordable Care Act.

President Obama's reform was doomed by the failure to exclude the major profit-driven industries (health insurance, drug manufacturers and for-profit, hospital-based medical-industrial corporations) from taking it over and milking it for profits.

Virtually all of the problems (excluding the initial enrollment difficulties) can be attributed to tactics intended to transfer more cost to the consumer (and the government, which is ultimately us), while delivering higher profits for less actual care, which we are discouraged from seeking.

Congressional Republicans propose to turn even more of the system over to private, for-profit entities; instead, we should be instituting "improved Medicare for all." Covering everyone equally, and eliminating time- and money-consuming confusion with a clearly defined, dependable system, relatively simple to understand and administer, would save billions of dollars while providing better care.

Dr. Nancy T. Block is a psychiatrist. She resides in Berkeley Heights, N.J.

Chicago Tribune

Out-of-pocket costs put care out of reach

By Anne Scheetz, M.D., December 6, 2014

Some of the newly insured have joined the ranks of those who can't afford to use their health coverage because their out-of-pocket costs are so high. This is an inevitable problem in a system in which people's total costs -- premiums plus deductibles, co-pays, co-insurance and non-covered expenses -- are related poorly if at all to what they have left after paying for food, housing, utilities, transportation and other necessities. It is an inevitable problem in a system in which those who have the greatest health care needs -- because they are women, or sick, or have disabilities -- have the highest health care costs.

Yet there is a simple solution that would save money for almost everyone -- for the country as a whole, for governments at all levels and for 95 percent of U.S. households. If we get rid of the enormous administrative waste created by our complex system of financing and implement instead single-payer Medicare for all, we can provide high-quality health care for everyone with no financial barriers or burdens. It's the common-sense solution, and it's the solution that would show us to be truly a nation united.

Dr. Anne Scheetz resides in Chicago.

Winnipeg Free Press

December 15, 2014

Canadian hospitals outperform America's

By Steffie Woolhandler and David Himmelstein

In many countries, bereaved families get condolence cards and flowers. In the U.S., the survivors are also deluged with hospital bills and insurance paperwork.

That paperwork isn't merely an insult. It costs U.S. society a fortune. Take hospitals, for instance. According to research we recently published in Health Affairs, U.S. hospitals spent $215 billion in 2011 on billing and administration, a striking 1.43 per cent of GDP.

Put another way, about $1 of every $4 of U.S. hospital spending goes to bureaucracy rather than patient care.

Other countries manage modern, first-rate hospital systems for far less. While administration devoured $667 per capita annually in the U.S., we found Canada spent only $158, Scotland $164, England $225 and the Netherlands $325.

If U.S. hospitals ran as efficiently as Canada's, the average U.S. family of four would save $2,000 annually on health care.

Moreover, U.S. hospital paperwork costs have risen sharply since 2000, even after adjusting for inflation. In contrast, administration's share of hospital budgets in Canada has actually fallen since 1999.

Economics textbooks hold that subjecting medicine to market forces will stimulate efficiency and root out waste. But reality stubbornly refuses to obey.

A generation ago, it took just one or two managers to run a U.S. hospital. Now, the CEO has been joined by "chief officers" for operations, finance, compliance, information, quality management and more.

Each chief commands his/her own legions – hundreds of billing and registration clerks, referral managers, upcoding specialists (to translate doctors' diagnoses into the most profitable billing codes) and massive IT departments whose first commandment is "get the bill right."

Why are U.S. hospitals so inefficient? Our multiple-payer insurance system forces every hospital to negotiate rates with dozens of insurance plans, each with its own coverage rules, billing procedures and documentation requirements. And each hospital must collect deductibles, copayments and co-insurance from tens of thousands of patients.

In contrast, Canada and Scotland – where bureaucratic costs are lowest – have single-payer systems that reject this kind of red tape and the need to bill for every Band-Aid. They pay hospitals simple lump-sum budgets the way we fund local fire stations. And like fire departments, their hospitals don't need to collect from each victim of misfortune.

But the complexity of hospital billing isn't the only thing driving bureaucracy. Hospitals have been forced to add layers of business expertise in order to survive in our market-driven system.

A hospital that doesn't show an operating profit can't fund essential new investments in new equipment and cutting-edge services or modern buildings. That means administrators have to devote resources to financial gaming such as marketing lucrative services (e.g. sports medicine); billing units to squeeze every penny from insurers and patients; and strategies to recruit profitable (well-insured) patients, and avoid unprofitable (e.g. uninsured) ones.

The dismal record of for-profit hospitals illustrates the problem with running hospitals as businesses. The for-profits have higher death rates and employ fewer clinical personnel such as nurses than their non-profit counterparts. But care at for-profits actually costs more, and they spend much more on the bureaucracy, a reflection of the high cost of implementing shrewd financial strategies.

Canadian and Scottish hospital administrators don't have to play financial games to assure their survival. Government grants – rather than operating profits – pay for new buildings and equipment. Even in France and Germany, where hospitals bill multiple payers, bureaucratic costs are modest because government directly funds most hospital investments.

England and the Netherlands provide unfortunate counterexamples. Pro-market reforms initiated during the Thatcher era have driven English hospital administrative costs sharply higher. And only U.S. hospitals have higher administrative costs than those in the Netherlands, where radical market-oriented reforms now pressure hospitals to show a profit.

Economics textbooks hold that subjecting medicine to market forces will stimulate efficiency and root out waste. But reality stubbornly refuses to obey. In health care, market-oriented policies encourage hospitals to shift resources to business strategies that boost the bottom line, but contribute nothing to care.

The authors are both professors of public health at the City University of New York and lecturers in medicine at Harvard Medical School. They are co-founders of Physicians for a National Health Program.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

October 23, 2014

Administrative work consumes one-sixth of U.S. physicians' time and erodes their morale, researchers say

Electronic health records increase doctors' bureaucratic burden

FOR IMMEDIATE RELEASE
Contact: Mark Almberg, communications director PNHP, mark@pnhp.org, (312) 782-6006

The average U.S. doctor spends 16.6 percent of his or her working hours on non-patient-related paperwork, time that might otherwise be spent caring for patients. And the more time doctors spend on such bureaucratic tasks, the unhappier they are about having chosen medicine as a career.

These are some of the findings of a nationwide study by Drs. Steffie Woolhandler and David Himmelstein, internists in the South Bronx who serve as professors of public health at the City University of New York and lecturers in medicine at Harvard Medical School. The study was published this week in the peer-reviewed International Journal of Health Services.

Woolhandler and Himmelstein analyzed confidential data from the 2008 Health Tracking Physician Survey (the most recent data available), which collected information from a nationally representative sample of 4,720 physicians who practiced at least 20 hours per week.

They found that the average doctor spent 8.7 hours per week, or 16.6 percent of their working time, on administration. This excludes patient-related tasks such as writing chart notes, communicating with other doctors and ordering lab tests. It includes tasks such as billing, obtaining insurance approvals, financial and personnel management, and negotiating contracts.

In total, patient-care physicians spent 168.4 million hours on such administrative tasks in 2008. The authors estimate that the total cost of physician time spent on administration in 2014 will amount to $102 billion.

Career satisfaction was lower for physicians who spent more time on administration. "Very satisfied" doctors spent, on average, 16.1 percent of their time on administration. "Very dissatisfied" doctors spent 20.6 percent of their time on such tasks.

Among various specialties, psychiatrists spent the most time on administration (20.3 percent), followed by internists (17.3 percent) and family/general practitioners (17.3 percent). Pediatricians spent the least amount of time (14.1 percent) on non-patient-related administrative tasks and also were the most satisfied group of doctors.

While solo practice was associated with more administrative work, small group practice was not. Doctors practicing in groups of 100 or more actually spent more time (19.7 percent) on such tasks than those in small groups (16.3 percent).

Interestingly, the authors note that physicians who used electronic health records spent more time (17.2 percent for those using entirely electronic records, 18 percent for those using a mix of paper and electronic) on administration than those who used only paper records (15.5 percent).

"Although proponents of electronic medical records have long promised a reduction in doctors' paperwork," they write, "we found the reverse is true."

The authors cite data showing that physicians in Canada spend far less time on administration than do U.S. doctors, and attribute the difference to Canada's single-payer system, which has greatly simplified billing and reduced bureaucracy.

They point out that the only previous nationally representative survey of this kind was carried out in 1995, and that study showed that administration and insurance-related matters accounted for 13.5 percent of physicians' total work time. Other, less representative studies, also suggest the bureaucratic burden on physicians has grown over the past two decades.

"American doctors are drowning in paperwork," said lead author Dr. Woolhandler. "Our study almost certainly understates physicians' current administrative burden. Since 2008, when the survey we analyzed was collected, tens of thousands of doctors have moved from small private practices with minimal bureaucracy into giant group practices where bureaucracy is rampant. And under the accountable care organizations favored by insurers, more doctors are facing HMO-type incentives to deny care to their patients, a move that our data shows drives up administrative work."

Dr. Himmelstein commented: "Our crazy health financing system is demoralizing doctors and wasting vast resources. Turning health care into a business means we spend more and more time on billing, insurance paperwork and the bottom line. We need to move to a simple, nonprofit national health insurance system that lets doctors and hospitals focus on patients, not finances."

"Administrative work consumes one-sixth of U.S. physicians' working hours and lowers their career satisfaction," Steffie Woolhandler, M.D., M.P.H., and David U. Himmelstein, M.D. International Journal of Health Services, Vol. 44, No. 4.

medpage TODAY'S KevinMD.com
Social media's leading physician voice

February 2, 2015

The financial sinkhole of health insurance complexity

By Jim Kahn, M.D.

We all know that the U.S. system of paying for health care is tremendously complex and inefficient: a multitude of insurers, thousands of insurance plans, innumerable medical bills, countless incorrect and denied claims.

But just how much do we waste on this administrative morass?

I led a research team that recently reviewed all the available evidence and published our findings. The resulting numbers are staggering.

Compared with countries that have a single health insurer (i.e., the government), we waste more than $375 billion per year in excess paperwork to pay medical bills.

That's $1 billion per day. That's more than $1 trillion every three years. That's 15 percent of all health spending – 1 in every 7 dollars spent on health care – on excess paperwork.

Let me put these big numbers into perspective. This waste equals $1,200 per year for each and every person in the United States. It represents 89 percent of total state and federal spending for Medicaid, our health insurance for the poor. It amounts to 2.3 percent of the U.S. economy.

And this striking toll doesn't even count the effort expended by employers for their employees' health insurance or time spent by patients and families dealing with insurance and bills.

What does this third of a trillion dollars each year pay for? It funds the endless detailed steps required in the "multi-payer" insurance system: designing health plans, contracting between insurers and providers, marketing health insurance, signing up subscribers, checking insurance status at each medical visit, collecting copayments, creating bills, sending out bills, processing incoming payments, disputing insurance claims, collecting unpaid bills.

We call this "billing and insurance-related" administrative waste, or BIR. In the dead of our current winter, I pronounce it "brrr" because it reflects a frightfully chilling reality.

Imagine what we could do, as a nation, with more than $375 billion.

We could pay for everyone to have high-quality health care. The massive savings from lower paperwork would be enough to cover all Americans with minimal or no deductibles or copays.

Are we speculating? No, we're summarizing solid empirical evidence, something sorely missing from most health care reform discussions.

What's the evidence? The U.S. is part of the OECD – Organization for Economic Cooperation and Development – the wealthy democracies. All of those countries have either a single-payer, or a single absolutely standard comprehensive health plan, with coverage of 98 percent of individuals or higher (compared to 87 percent in the U.S.).

All of them avoid BIR administrative waste. They also use the single payer to get lower prices on medications and durable medical goods like CT scanners, wheelchairs, and hearing aids.

So the $1 trillion over three years isn't an abstract number. It's a real savings we can achieve if we finally make the same decision that all of our counterpart countries have.

That should be our New Year's resolution.

Jim Kahn, M.D., M.P.H., is professor of health policy, epidemiology, and global health, University of California, San Francisco.

"**Billing and insurance-related administrative costs in United States' health care: synthesis of micro-costing evidence,**" by Aliya Jiwani, David U. Himmelstein, Steffie Woolhandler, and James G. Kahn. BMC Health Services Research, (2014)14:556.

Abstract (excerpts): The United States' multiple-payer health care system requires substantial effort and costs for administration, with billing and insurance-related (BIR) activities comprising a large but incompletely characterized proportion. … Using a consistent and comprehensive definition of BIR … we synthesized and updated available micro-costing evidence in order to estimate total and added BIR costs for the U.S. health care system in 2012.

Methods: We reviewed BIR micro-costing studies across healthcare sectors. For physician practices, hospitals, and insurers, we estimated the percent BIR using existing research and publicly reported data, re-calculated to a standard and comprehensive definition of BIR where necessary. ... We estimated "added" BIR costs by comparing total BIR costs in each sector to those observed in existing, simplified financing systems (Canada's single payer system for providers, and U.S. Medicare for insurers).

Results: BIR costs in the U.S. health care system totaled approximately $471 ($330 – $597) billion in 2012. This includes $70 ($54 – $76) billion in physician practices, $74 ($58 – $94) billion in hospitals, an estimated $94 ($47 – $141) billion in settings providing other health services and supplies, $198 ($154 – $233) billion in private insurers, and $35 ($17 – $52) billion in public insurers. Compared to simplified financing, $375 ($254 – $507) billion, or 80 percent, represents the added BIR costs of the current multi-payer system.

Conclusions: A simplified financing system in the U.S. could result in cost savings exceeding $350 billion annually, nearly 15 percent of health care spending.

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

October 15, 2014

Psychiatrist appointments hard to get, even for insured: study

Harvard researchers find poor access to outpatient psychiatric care in Boston, Chicago and Houston metro areas, with unreturned telephone calls, wrong numbers, and full practices

FOR IMMEDIATE RELEASE
Contact: Mark Almberg, communications director PNHP, mark@pnhp.org, (312) 782-6006

Obtaining access to private outpatient psychiatric care in the Boston, Chicago and Houston metropolitan areas is difficult, even for those with private insurance or those willing to pay out of pocket, a new study by Harvard researchers shows.

The researchers, who posed on the phone as patients seeking appointments with individual psychiatrists, encountered numerous obstacles, including unreturned calls, wrong numbers and providers who were no longer taking new patients. They met with success in only one-quarter of their attempts, even after two tries.

These and related findings were published online today by Psychiatric Services, a peer-reviewed journal of the American Psychiatric Association.

The researchers made telephone calls to 360 psychiatrists – 120 in each metro area – who were listed in the Blue Cross and Blue Shield (BCBS) online database of in-network providers. The callers posed as patients with BCBS PPO insurance or Medicare, or as willing to pay out of pocket.

They utilized the BCBS database because the BCBS system is the largest provider of health insurance in Massachusetts, Illinois and Texas. The psychiatrists were located within a 10-mile radius of suburban ZIP codes in Boston, Chicago and Houston.

Of 360 psychiatrists called, the "simulated patients" were able to obtain appointments with only 93 of them, or 26 percent. Although the callers were able to obtain appointments more frequently using BCBS or as self-pay compared to Medicare, this difference was not significant. There was a significant difference in success rate between cities, however, with psychiatrists in Boston least likely to offer an appointment and those in Houston most likely to do so.

In most cases, psychiatrists simply did not return calls (23 percent). There were also a large number of incorrect phone numbers (16 percent). The wrong numbers listed included a jewelry store, a boutique, and a McDonald's restaurant. Additionally, 15 percent of practices were full and not accepting new patients. Another 10 percent of the psychiatrists identified through the BCBS directory did not see general adult outpatients.

These findings add to the growing evidence that the mental health system is difficult for consumers to access. They are in line with national data demonstrating that two-thirds of primary care physicians cannot obtain outpatient mental health services for patients who need them.

The findings also show that having insurance is not enough to guarantee access to outpatient psychiatric care. The authors conclude that increasing the number of psychiatrists would increase access. As such, they call for measures to make psychiatry a more appealing field for medical students to enter, including through measures such as integrating psychiatric care with primary care, along with better reimbursements for psychiatric care by insurers and others.

Lead author Monica Malowney, M.P.H., formerly at the Harvard-affiliated Cambridge Health Alliance and now with the Department of Population Health at the Maimonides Medical Center in Brooklyn, N.Y., said: "This study poignantly illustrates how difficult it can be for patients to obtain needed mental health care. Insurance companies need to ensure that the lists of providers they offer patients contain accurate phone numbers as well as practices that are actually accepting new patients. How likely is it that a severely depressed person would persevere through so many obstacles?"

Senior author Dr. J. Wesley Boyd, an attending psychiatrist at Cambridge Health Alliance and Harvard Medical School faculty member, said: "Insurers provide lists of providers, but they are filled with names of individuals whose practices are full or who don't bother to return phone calls or with phone numbers that are simply wrong. Calling for a psychiatric appointment and reaching a McDonald's? That is totally unacceptable."

He continued: "Insurance companies care more about turning a profit than actually providing care. Everyone, even individuals with supposedly excellent insurance, has a hard time accessing psychiatric care, so what is needed is a comprehensive overhaul of psychiatric care in the context of a thoughtful single-payer system that allocates resources according to our nation's medical needs."

"Availability of Outpatient Care from Psychiatrists: A Simulated-Patient Study in Three Cities," by Monica Malowney, M.P.H., Sarah Keltz, Daniel Fischer, M.D., J. Wesley Boyd, M.D., Ph.D. Psychiatric Services, November 2014, Vol. 65, No. 11, published online in advance on Oct. 15, 2014.

HEALTHCARE FINANCE NEWS

January 8, 2015

More resources, not medical homes, for primary care

It is time to junk the "medical home" concept and to focus instead on expanding our primary care work force

By Kip Sullivan, J.D.

The "medical home" concept has become counterproductive. It is muddling the debate about how to improve medical care without raising costs, and it is punishing primary care clinics.

A recent paper in JAMA by Ricardo Mosquera et al. titled "Effect of an enhanced medical home on serious illness and cost of care among high-risk children with chronic illness: A randomized clinical trial" illustrates both problems. At the beginning of the paper, the authors assert there is no solid evidence for the claim that "patient-centered medical homes" (PCMHs) cut costs. That assertion is correct. A review of the research on PCMHs published in 2013 found "no evidence for overall cost savings."

A paper published in 2014 found that "one of the earliest and largest multi-payer medical home pilots conducted in the United States" achieved no savings after three years.

Mosquera et al. then go on to report on a program that appears to have cut costs substantially by spending more on outpatient care and thereby greatly reducing hospital utilization. But they note that the PCMH can only cut costs under the following conditions: The PCMH consists of a very expensive, highly specialized group of healthcare professionals; it is applied to a carefully selected group of very sick patients who represent far less than 1 percent of the population.

The authors seem to be uncomfortable using the PCMH label for the Texas clinic where the study was conducted. They invoke the label several times, but make no effort to explain why they equated the clinic with a PCMH. The paper lists only three of the accoutrements PCMH's are supposed to display (access to clinicians 24/7, electronic medical records, and the regular use of patient "satisfaction" surveys); and the doctors are all specialists (PCMHs are supposed to be primary care clinics).

In fact, the concept Mosquera et al. operationalized, and use repeatedly in the paper, is "comprehensive care," not "medical home." In the discussion section explaining why "comprehensive care" reduced total expenditures, the authors refer to the "high-risk population" and the extra staff.

Why the ostentatious name?

Why couldn't Mosquera et al. simply assert that the clinic was able to reduce hospital costs because it hired more staff? What is gained by claiming that a clinic that hires more staff deserves an ostentatious name like "medical home"?

I suspect the authors thought the paper would draw more attention if it could be associated with the "medical home" fad. But whatever the reason, the authors' effort to cram this experiment into the PCMH pigeonhole illustrates how the "home" fad confuses the debate about how to improve medical care without raising costs.

The fad has conflated two questions that must be kept separate: Whether a given problem needs more resources to solve it, and whether the problem should be addressed as well, or alternatively, with organizational change.

Organizational or structural change is implied by "medical home" and other language used by PCMH and managed care advocates such as "accountable care organization," "delivery system reform," "re-engineering," "restructuring," and "transformation." The implication of this language, especially when it is used repeatedly without reference to the new administrative and personnel costs these interventions generate, is that clinics and hospitals do not need more money, but instead need a change in structure that will cause them to work more efficiently.

It is clear from Mosquera et al.'s paper that the hiring of more staff explains the large reduction in hospital costs and the dramatic improvement in the health of the patients who received "comprehensive care." The clinic invested huge sums of money – $5,000 more per patient per year than it spent on "usual care" – to hire more specialists, nurses, and other staff. There is, conversely, no evidence in the paper indicating the clinic underwent any change in structure, much less a "transformation" into something so different it required a label like "medical home."

I understand the authors' reluctance to come right out and state the obvious: "We spent more money on clinic personnel and cut costs on hospital care." The idea that a problem can be solved by bringing more resources to bear is inconsistent with reigning managed care theology. That theology holds that whatever ails our healthcare system can be solved or ameliorated by structural change induced, or accompanied, by "payment reform" that shifts risk to doctors and hospitals.

But defects in structure or organization are not what ails the U.S. primary care sector. The problem is insufficient resources devoted to primary care professionals. This insufficiency is aggravated by unnecessary administrative costs inflicted on clinics by the multiple-payer system and by the endless stream of

managed care experiments hatched by the insurance industry, Congress and state legislatures.

High administrative costs

The overhead costs of PCMHs, to take one example of the managed care nostrums that are draining money out of clinics and hospitals, are substantial. How substantial? It's hard to say because the question is of no interest to PCMH advocates and has been the subject of little or no peer-reviewed research.

As was the case with other managed care fads, the policy entrepreneurs who launched the PCMH fad did so without an ounce of evidence on the intervention costs it would generate. The only relevant evidence I'm aware of is anecdotal evidence. It suggests that the costs clinics incur to become "homes" – additional medical staff plus new administrative costs – raise clinic costs by 15 to 25 percent.

Consider two bits of anecdotal evidence about PCMHs run by doctors who sincerely believe in the PCMH model.

In March of 2012, the Wall Street Journal published an article with the headline, "Why America's doctors are struggling to make ends meet." It was about Dr. Scott Hammond, one of three doctors who practice at the Westminster Medical Clinic in Denver, and the clinic's effort to participate in the Colorado Multipayer Patient-Centered Medical Home Pilot.

The article contained a photo of a small ledger showing a summary of the expenses and income for the clinic for 2011. The income side of that little ledger indicated the clinic received large upfront payments from several insurers participating in the pilot to offset the costs of becoming a "home" ($243,000) plus a grant to hire a social worker ($34,000).

These payments totaled $277,000 – 13 percent of the clinic's total income of $2.1 million in 2011.

Moreover, the expense side of the ledger indicated the clinic spent $6,000 on electronic medical records and the text of the article indicated the clinic's income fell $200,000 in forgone patient visits to free up staff time to devote to the PCMH pilot.

Anecdote 2: At a May 30, 2014, conference on PCMHs sponsored by WellPoint, Dr. Mark Frazier spoke about his experience running a PCMH for a program called the Comprehensive Primary Care Initiative (CPCI) run by WellPoint and the Centers for Medicare and Medicaid Services. Here is an excerpt from Dr. Frazier's remarks from the transcript:

What happened in our first year of the CPCI? Revenues actually dropped by 5 percent and office expenses increased by 19 percent. … [O]ur office overhead increased 52 percent. … I'm working 14 to 16 hours days every day and I can't figure out whether it's because of patient-centered medical home model, or the EMR, or a combination.

Commentary by doctors involved in PCMHs confirms these anecdotes. A report published in the newsletter of the American Academy of Family Physicians on the academy's 2012 Congress of Delegates indicates the AAFP leadership got an earful from its members about the AAFP's support for PCMHs.

The article quoted three delegates who spoke about the high cost of PCMHs. One of them, Dr. Kim Yu, said she had to close her practice because she couldn't afford all the trappings associated with becoming a PCMH. The comments that other doctors posted at the end of this report were harshly critical of the AAFP's support for "homes."

Readers interested in reading the views of some other exasperated primary care doctors should read the comments that follow this report on the conference that Dr. Frazier spoke at.

Signs of stress are mounting

News of the financial and psychological stress that the PCMH experiment is imposing on primary care clinics seems to be filtering up to some of the august bodies that launched the "home" fad back in 2007 and 2008. At its March 6, 2014, meeting, several members of the Medicare Payment Advisory Commission (MedPAC), which endorsed "homes" in 2008 on no basis other than some unnamed "experts" thought it was a good idea, expressed concern about the high cost of meeting the requirements stipulated by the National Committee for Quality Assurance.

Commission chair Glenn Hackbarth called the requirements "gold-plated" and said he was worried NCQA's "bells and whistles" had put the "medical home model [at] a real cost disadvantage." (pp. 251-253, transcript)

But despite the growing awareness that PCMHs are stressing clinics and cannot save money when applied to the general population, neither MedPAC nor the AAFP nor any other of the major proponents of the "home" fad have withdrawn their support. They should. The concept has become counterproductive. It promotes the mistaken belief that our primary care sector needs to be "re-engineered" when what it really needs is more resources.

It justifies expenditures on paraphernalia that have never been shown to cut costs. It promotes the mistaken belief that the NCQA's one-size-fits-all model can save money when in fact it appears it can save money only for a tiny, very sick fraction of the population, and then only if we pretend a clinic that hires more staff isn't just a clinic with more staff but a "medical home."

It is time to junk the "medical home" concept and to focus instead on expanding our primary care work force.

Where might those resources come from? We could of course simply funnel more money into the healthcare system, either in the form of more premium payments to the insurance industry or higher taxes. But more money for the system would not be necessary under a single-payer system.

We could easily finance the training and hiring of more primary care doctors, nurses, social workers, and community health workers with the immense savings generated by a single-payer system.

Kip Sullivan, J.D., is a member of the board of Minnesota Physicians for a National Health Program. His articles have appeared in The New York Times, The Nation, The New England Journal of Medicine, Health Affairs, the Journal of Health Politics, Policy and Law, and the Los Angeles Times.

International Journal of Health Services

January 2015

A Five-Year Assessment of the Affordable Care Act: Market Forces Still Trump the Common Good in U.S. Health Care

By John P. Geyman, M.D.

Abstract

The Affordable Care Act (ACA) was enacted in 2010 as the signature domestic achievement of the Obama presidency. It was intended to contain costs and achieve near-universal access to affordable health care of improved quality. Now, five years later, it is time to assess its track record. This article compares the goals and claims of the ACA with its actual experience in the areas of access, costs, affordability, and quality of care. Based on the evidence, one has to conclude that containment of health care costs is nowhere in sight, that more than 37 million Americans will still be uninsured when the ACA is fully implemented in 2019, that many more millions will be underinsured, and that profiteering will still dominate the culture of U.S. health care. More fundamental reform will be needed. The country still needs to confront the challenge that our for-profit health insurance industry, together with enormous bureaucratic waste and widespread investor ownership throughout our market-based system, are themselves barriers to health care reform. Here we consider the lessons we can take away from the ACA's first five years and lay out the economic, social/political, and moral arguments for replacing it with single-payer national health insurance.

After a long and contentious political battle, the Affordable Care Act (ACA) was passed by the U.S. Congress and signed into law by President Obama in March 2010. Now dubbed Obamacare, it has been hailed by its supporters as the signature domestic achievement of his presidency. Halfway through its 10-year legislative life, it is time to assess its impact on the dysfunctional health care system in the United States.

Americans have waged a century-old debate over whether health insurance should be a public or private responsibility. As part of his campaign for the presidency as a progressive in 1912, Theodore Roosevelt first called for a system of national health insurance. It was later brought forward, again unsuccessfully, in the platform of Harry S. Truman in 1948. The nation finally achieved solid public programs for limited populations with the passage of Medicare and Medicaid in 1965, but the idea of national health insurance (NHI) invariably has been shut down by conservative interests, including the American Medical Association, and other private stakeholders in our market-based system.

Will the ACA be different, and if so, in what ways? And if it won't work, what next? These are the questions we will deal with in this article, drawing from my just-published book, How Obamacare Is Unsustainable: Why We Need a Single Payer Solution for All Americans[1]. The goals of this article are three-fold: (a) to compare the goals and claims for the ACA with its actual experience in the areas of access, costs, affordability, and quality of U.S. health care; (b) to summarize lessons we can already take away from its first five years; and (c) to briefly consider economic, social/political, and moral arguments for replacing the ACA with NHI.

Goals and Promises of the Affordable Care Act Versus Actual Experience

Access to Care

The initial goal of the ACA, when we had about 50 million uninsured Americans, was to extend health insurance to 32 million more people by 2019, one-half of that number through expansion of Medicaid. Online health insurance exchanges were to be set up by the federal government as well as by those states that chose to participate. These exchanges would provide the uninsured with a way to comparison shop for coverage, with those with annual incomes between 138 and 400 percent of the federal poverty level becoming eligible for federal subsidies to better afford coverage. Other provisions of the ACA favoring expansion of coverage included limited insurance reforms (such as banning private insurers from denying coverage because of pre-existing conditions and allowing parents to keep their children on their policies until age 26) and setting up high-risk pools to help sicker patients get insurance.

After the conclusion of the first open-enrollment period ending in April 2014 and before the second enrollment period starting in November 2014, some progress was made – 9.5 million fewer uninsured, with the uninsured rate dropping from 20 to 15 percent for adults, from 28 to 18 percent for young adults age 19 to 34, and from 28 to 17 percent for people in poverty in states that chose to expand Medicaid[2].

Despite this progress, however, there were some major problems. For starters, the U.S. Supreme Court ruled in 2012 that states may choose not to expand Medicaid. The federal government would pay 100 percent of the expansion costs for the first three years, phasing down to 90 percent by 2020. It was therefore surprising that 24 of the 50 states opted not to expand Medicaid, leaving 4.8 million people still uninsured in what became known as the Medicaid "coverage gap"[3]. This was a double hit for this group, since they already had incomes too low to

qualify for federal subsidies. Other access problems included: confusion and dysfunction of the federal website and exchanges, both federal and by states; inadequate coverage under both private and public plans (e.g., the most common selection by new enrollees for private coverage was for "silver" plans, which cover at best only 70 percent of health care costs); some states privatized their Medicaid programs, offering fewer benefits while requiring additional cost sharing by enrollees; and inadequate accountability of private insurers, who could still offer such skimpy policies as "fixed indemnity" plans that pay almost nothing toward the cost of a major illness or accident.

Cost Containment

Architects of the ACA counted on "competition" in the market-based system, including among insurers on the new health insurance exchanges, to contain costs for patients. That approach was naive for a number of reasons. For starters, it has long been documented that competition in health care does not work the same as in other industries. The health care industry is largely for-profit, relatively deregulated, with little transparency of prices and with perverse incentives among providers to maximize revenue. Experience with "consumer-directed health care" over the past 30 years, based on the concept that patients with "skin in the game" through cost sharing, has proven that it is ineffective in containing costs. Based on its studies of 12 randomly selected, nationally represented metropolitan communities, the nonprofit Center for Studying Health System Change has concluded that providers have enough market power to set their own prices and dictate the terms of their arrangements with insurers, and that there is insufficient competition among local health care systems[4]. The ACA has led to accelerating consolidation of hospital systems, which now employ an increasing majority of U.S. physicians, who have thereby lost clinical autonomy and clout in their ability to contain prices and rein in unnecessary and inappropriate care.

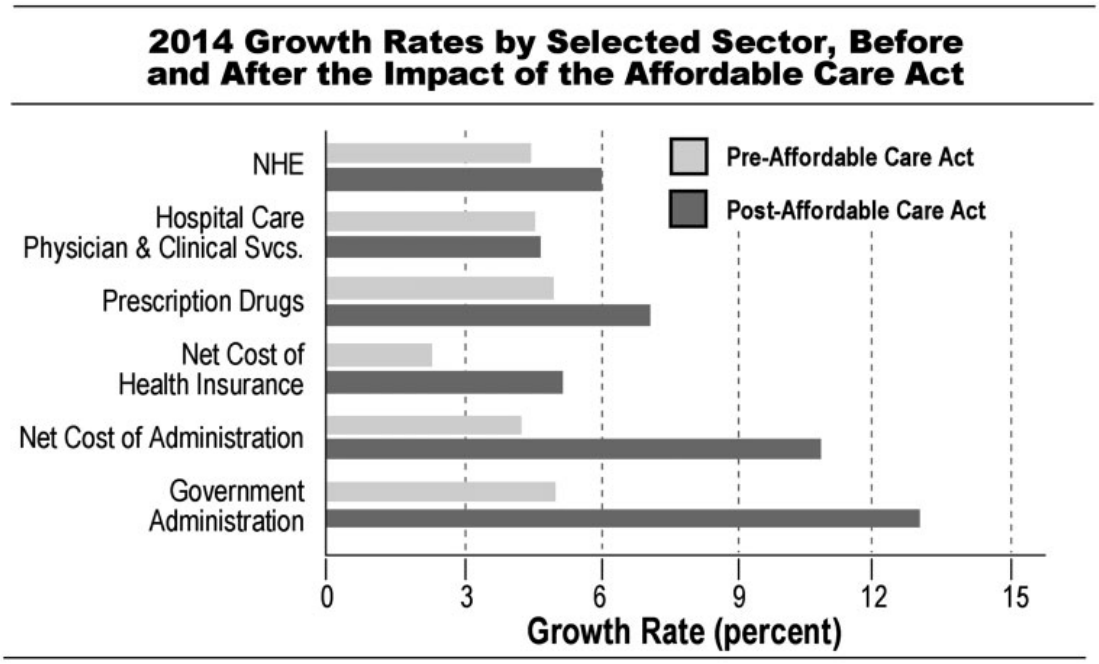
Will the ACA contain health care spending and taxpayer costs? The trends are not promising for that to happen. Health care as a proportion of the gross national product is expected to increase from 17.9 percent in 2012 ($9,216 per capita) (all dollar amounts in U.S. dollars) to 19.9 percent in 2022 ($14,664 per capita). Figure 1 breaks down these increases before and after enactment of the ACA, showing enormous growth in the net costs of health insurance and government administrative costs[5].

In the last quarter of 2013, health care spending grew at the fastest pace in 10 years, driven by an $8 billion rise in hospital revenue, even when the number of hospital days dropped by 1 percent in that quarter[6]. This was partly due to the increasing profit margin of hospital-based and affiliated emergency rooms since the advent of the ACA[7]. The large growth in the net cost of health insurance is mostly due to administrative costs, waste, and profits in handling new enrollees through the exchanges. Federal subsidies to private insurers are projected to total $1.03 trillion between 2015 and 2024, including $167 billion in subsidized cost sharing[8].

Affordability

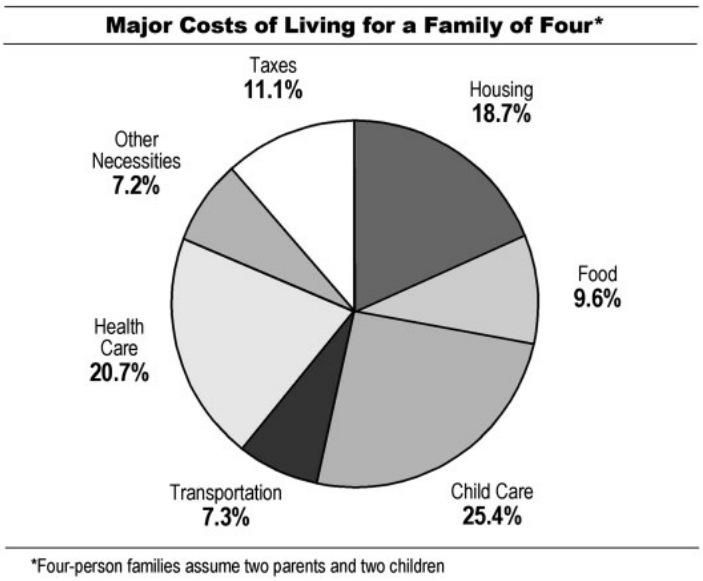
The emphasis of the ACA has been to expand the number of Americans with some kind of health insurance. But whether this helps to make health care more affordable depends on other important factors, including prices and costs of health care, the value of insurance coverage (usually 60 percent to 70 percent actuarial value), household incomes of patients and their families, and other essential costs of living. As the prices and costs of health care continue to go up without any cost containment in sight, many with insurance find themselves paying more for insurance through high-deductible plans that cover less of the cost of actual health care. An Associated Press poll in October 2014 found that one-quarter of insured Americans feel insecure about their ability to pay for necessary health care, whether insured by employer-sponsored insurance or coverage through the ACA's insurance exchanges[9]. Figure 2 shows that health care consumed 20.7 percent of the costs of living for a typical family of four in 2013[10]. When we factor in the median income for Americans in that year of $51,404[11] and total health care costs (including payroll deductions and out-of-pocket costs) of $23,215 for that family of

Figure 1



Source: Centers of Medicaid Services, Office of the Actuary, National Health Statistics Group, Health Affairs, October 2013.

Figure 2



Source: Gould, E, Wething, H, Sabadish, N et al. What families need to get by: the 2013 update of EPI's Family Budget Calculator. Economic Policy Institute, Washington, D.C.

four with employer-sponsored insurance in 2014[12], it is obvious how common it is that Americans feel anxious and insecure about health care costs. Health insurance gives very little protection these days, both before and after the ACA, as the insured increasingly face burdensome debt, even bankruptcy, as a result of coverage with low actuarial value (most commonly just 70 percent), health plan limits or exclusions, limited protections for out-of-network care, and high cost-sharing requirements[13].

Quality

The ACA was intended to improve quality of care in several ways – first, of course, by expanding access to care – but also by providing preventive services without cost sharing, payment changes attempting to encourage quality care, accountable care organizations (ACOs), expanded use of electronic health records, and establishing the Patient-Centered Outcomes Research Institute (PCORI). Each of these, in turn, has fallen way short of the mark.

A randomized controlled trial in Oregon has documented that people on Medicaid do better than the uninsured[14]. But there are still access problems for many Medicaid patients, including difficulties in finding a primary care physician and, especially, specialists to see them[15]. It has been estimated that 7,115 to 17,104 unnecessary deaths will be attributable to the lack of Medicaid expansion in the more than 20 states that have chosen not to expand Medicaid under the ACA[16].

While preventive services without cost sharing sounds like a good idea, we have seen a proliferation of profiteering in screening of asymptomatic people, including use of screening procedures lacking in evidence of efficacy or cost-effectiveness. One example is Life Line Screenings, a for-profit company that advertises its services as "harmless," "safe," and "may save your life." Free screenings are offered in community centers, churches, shopping malls, and other locations to anyone regardless of age and without counseling. The company partners with hospitals and surgery centers for follow-up. By 2014 the company had screened some 8 million people, with about 10 percent having "positive" or "abnormal" findings. As a result, follow-up procedures, especially for cardiovascular findings, have often been unnecessary, expensive, and potentially harmful to patients while being lucrative for participating hospitals[17]. Carotid ultrasonography is one example of an ineffective and inappropriate screening procedure that is widely offered[18].

Various pay-for-performance initiatives have been launched under the ACA that were intended to improve the quality, efficiency, and value of health care. These have been controversial among physicians, often use process measures of unproven value, are not adjusted for socioeconomic factors, and invite up-coding of diagnoses to generate higher revenue. A 2012 report by the Office of the Inspector General of the Department of Health and Human Services found that nearly one-half of chart audits at the PacifiCare unit of UnitedHealth Care were "invalid because the diagnoses were not supported"[19]. The Cochrane Collaboration has also found no evidence that financial incentives can improve patient outcomes[20].

ACOs have been established by the ACA in an effort to contain health care costs as well as to improve coordination and quality of care in and out of the hospital. As loosely designed managed care organizations involving hospital systems, physicians, and insurers caring for a population of at least 5,000 people, they are still very much a work in progress. Enhanced quality of care in ACOs is yet to be demonstrated[21].

While the use of electronic health records has expanded under the ACA, this too has been disappointing in terms of positive impacts on quality of care. Many such systems do not talk to each other, and a 2012 study found that almost one-half of physicians surveyed felt that patient care was worse after going to that system[22]. Another national study showed that physicians' access to electronic test results does not reduce the ordering of unnecessary tests[23].

PCORI was established under the ACA to oversee and set guidelines for urgently needed comparative effectiveness research as a way to address the problem that up to one-third of health care services provided in the United States are inappropriate or unnecessary. Important as this approach is, PCORI is hobbled by two major factors: (a) it lacks the authority to dictate coverage and reimbursement policies for federal health programs and (b) many stakeholders on the supply side of the delivery system profit from marketing and providing tests, procedures, and services of doubtful cost-effectiveness[24].

Some Lessons from the Affordable Care Act's First Five Years

The ACA's track record at age five is decidedly mixed. On the one hand, it has accomplished these positive changes:

- Government-sponsored exchanges have been established in every state, whereby the uninsured can shop for coverage.
- About 8 million have done so, 57 percent of whom gained insurance for the first time.

- About 7 million have gained new Medicaid coverage.
- Parents can now keep their children on their policies until age 26.
- Some new funding has been provided for community health centers, together with some increased reimbursement for primary care physicians on a temporary basis.

Notwithstanding these gains, ongoing problems remain, some exacerbated by the ACA:

- Many employers are shifting from a defined benefit to a defined contribution system, while others are shifting employees to the exchanges or dropping coverage altogether.
- Insurers are offering policies of decreasing value and raising premiums with little restraint.
- Narrow networks are limiting choice of physicians and hospitals across the country as expanding hospital systems gain near-monopoly market shares.
- The shortage of primary care physicians limits access for millions of the newly insured, especially for those on Medicaid with its low reimbursement rates.
- There is no evidence yet that the ACA has improved quality of care.
- Administrative bureaucracy, especially on the private side, has increased exponentially.
- New profitable markets have arisen that have increased prices and costs throughout the market-based system.
- By 2019, when the ACA is fully implemented, there will still be about 36 million uninsured (including nearly 5 million in the Medicaid "coverage gap" in opt-out states), plus an unknown number who choose not to participate in the exchanges, often because of costs[25].

What can we learn from the ACA's experience to date? The following lessons already stand out[26].

1. Health care "reform" through the ACA was framed and hijacked by corporate stakeholders.

As described in my earlier book, "Hijacked: The Road to Single Payer in the Aftermath of Stolen Health Care Reform," the interests of private insurers, the drug and medical device industries, hospitals, organized medicine, and other stakeholders in our medical-industrial complex took precedence over the needs of patients for broad access to affordable, quality health care. Based on ideology and political forces, the architects of the ACA never questioned whether the deregulated private marketplace could bring needed reforms. More fundamental questions were not asked, such as whether health care is a right or privilege based on ability to pay, whether universal access to care is the overriding goal, or whether health care is just a commodity for sale on an open market.

The political process was commandeered by corporate money and conflicts of interest among the drafters of the legislation. Lobbyists also played a major role in guiding the more than 2,000-page bill to its final passage. By the time of its enactment, about 4,525 lobbyists, eight for every member of Congress, had been hired at a cost of $1.2 billion[27]. A 2013 report from McKinsey & Company put the "business value at stake from government and regulatory intervention" at about 30 percent of earnings for companies in most sectors – in other words, what is spent on lobbying brings far more revenue than the cost of lobbying[28].

2. You can't contain health care costs by permitting for-profit health care industries to pursue their business "ethic" in a deregulated marketplace.

With new markets through health care exchanges and expansion of Medicaid, together with friendly federal subsidies and no effective price controls, corporate stakeholders have thrived under the ACA. Prices and costs continue to escalate for hospitals, physicians, and drug and medical device manufacturers as increasing consolidation and market power go forward among hospital systems and providers. One venture capitalist promoting investment opportunities for private exchanges under the ACA sees the likelihood to "turn chaos into gold"[29]. In fact, health care stocks soared by almost 40 percent in 2013, the highest of any sector in the S&P 500[30].

3. You can't reform the delivery system without reforming the financing system.

It was a naïve and ill-informed approach to think that we could cover more people at more affordable costs while retaining, even subsidizing, a largely for-profit, multi-payer financing system. Insurers are gaming the new system in new ways, still trying to avoid sicker enrollees, maximize their profits, and keep their shareholders happy. UnitedHealth Group, the nation's largest insurer, has recently reported a drop in its medical-loss ratio to 79.9 percent and higher earning projections based on the increasing prevalence of high-deductible health plans and provider contracts linking reimbursement to performance[31].

4. The private health insurance industry does not offer enough value to be bailed out by government.

The government has been more than friendly to the insurance industry through a number of perks, including longstanding tax exemptions for employer-sponsored insurance, overpayments to Medicare Advantage plans, and, with the ACA, permissive provisions including subsidized premiums through the exchanges, expansion of private and public markets, and a new "risk corridor system" protecting insurers from losses in the new marketplace. But these are some of the many reasons that the industry does not warrant a bailout by government at taxpayer expense:

- The overhead of private Medicare Advantage plans averages 19 percent versus 1.5 to 2 percent for traditional Medicare[32]. The administrative overhead of the 1,300 private insurers in the United States is more than five times higher than that of the single-payer program in two Canadian provinces[33].
- We are seeing an epidemic of underinsurance and high

levels of cost sharing, with some deductibles ranging as high as $8,000 to $10,000 per year. The actuarial value of plans through the ACA's exchanges range from 60 percent to 90 percent (with silver plans at 70 percent the most common), while the insurance industry is pushing for copper plans with an actuarial value of only 50 percent[34].

- Private insurers game the system for more profits instead of service to patients. As examples: Medicare Advantage plans have commonly claimed that enrollees are sicker than they are, thereby receiving $122.5 billion in overpayments since 2004[35]; some insurers are marketing short-term plans that last less than 12 months, evading any of the ACA's requirements[36].
- In the last three years, 32 executives of the country's largest for-profit health insurers have received a total of $548.4 million in cash and stock options[37].
- Accountability and regulation of insurance premiums remain lax and vary widely from state to state.

5. In order to achieve the most efficient health insurance coverage, we need the largest possible risk pool to spread risk and avoid adverse selection.

The larger and more diverse the risk pool is, the more efficient insurance can be in having healthier people share the costs of sicker people at affordable costs for everyone. But the ACA has perpetuated and further exacerbated fragmentation of risk pools in the United States. We cannot ignore the 20-80 Rule, which states that 20 percent of the population accounts for almost 80 percent of all health care spending. Despite assurances of the ACA's supporters, there appears to be no way that it can develop a big enough risk pool to avoid adverse selection, given the motivations of private insurers and the predictable behavior of markets. This is especially true since many younger, healthier people are not signing up on the exchanges, one-third of men between the ages of 50 to 64 have chosen to remain uninsured[38], and at least 12 million people are expected to file for one or another kind of exemption from the individual mandate[39].

Why the Affordable Care Act Should Be Replaced By National Health Insurance

The ACA, based as it is on subsidized continuation of a large private insurance industry, brings us restricted choices of physicians and hospitals, and in some cases of insurers, such as in rural areas. We still fall short of universal access, are growing the ranks of the underinsured, have little cost containment, and still restrict some essential services based on ability to pay. Consumer protection from high costs of care remains elusive. A recent study by the Kaiser Family Foundation found that one in three Americans with health insurance still have difficulty paying their medical bills. The study identified many ways that insured people still face burdensome medical debt, including through in-network cost sharing, out-of-network costs, "inadvertent" out-of-network care, health plan coverage limits or exclusions, and unaffordable premiums[40].

Table 1 compares and contrasts the difference between the multi-payer ACA and single-payer financing through NHI[41].

Although just halfway through its original legislative life (2010–2019), the ACA has already set in place trends that we can assume will fail to meet its original goals – provide near-universal access, contain costs, make health care affordable, and improve its quality. It is clear that more fundamental reform is needed, especially in financing of U.S. health care. The need to establish a single-payer financing system for NHI can be made

Table 1. The ACA VS. Single-Payer National Health Insurance.

ACA	NHI
36–45 million uninsured in 2019	Universal coverage when enacted
Employment and Medicaid based, with subsidies for many millions	Covers all ages regardless of work status, gender, etc.
Variable coverage and benefits	Comprehensive benefits
Multi-tiered system, based on ability to pay	Single standard for all, based on medical need
Limited choice of doctor and hospital	Free choice of doctor and hospital
Fragmented, inefficient risk pools	One big, efficient risk pool
Large Intrusive bureaucracy	Administrative simplicity
For-profit business ethic	Service ethic
No cost containment	Cost containment through negotiated fees, budgets and prices
Unsustainable	Sustainable through progressive taxes; employers and individuals pay less than they do now

on these three compelling arguments.

Economic Imperative

Given the enormous amount of money already going to inefficiency, administrative waste, and profits in today's health care system, there is plenty of money available to fund NHI and still achieve other savings. NHI will both save money and contain costs. It will provide universal coverage for all Americans, remove financial barriers to care, cover all essential health care services, provide free choice of physicians and hospitals anywhere in the country, cut costs by bulk purchasing as already takes place in the Veterans Administration system, and dramatically reduce administrative waste. It will initiate a transition process away from the business "ethic" toward a service-oriented ethic.

A classic 2013 study by Gerald Friedman, professor of economics at the University of Massachusetts, shows how this can be accomplished. He concludes that enactment of H.R. 676: The Expanded and Improved Medicare for All Act now in the U.S. Congress would save an estimated $592 billion annually by cutting administrative waste of the private health insurance industry ($476 billion) and reducing pharmaceutical prices to European levels ($116 billion). These savings would be enough to cover all 44 million uninsured and upgrade benefits for all other Americans, including dental and long-term care. Savings would also cover $51 billion in transition costs, such as retraining displaced workers and phasing out investor-owned, for-profit delivery systems over a 15-year period. About $154 billion of the savings could be applied to deficit reduction. Regressive funding sources that totaled more than $1.72 billion in 2014 would be replaced by a progressive taxation system as outlined in Table 2[42].

The payroll tax would be the main tax for all Americans with annual incomes below $225,000, amounting to $900 for those with incomes below $60,000, $6,000 for those making $100,000, and $12,000 for those with incomes of $200,000. Most Americans would pay less for health care than they do under the ACA, and only 5 percent of Americans would pay more for insurance under NHI[43].

NHI would bring us public financing, with one big risk pool, coupled with a private delivery system. We could expect improvement in quality of care as investor ownership is phased out, since investor ownership has long been associated with higher costs and lower quality, whether for hospitals, health maintenance organizations, dialysis centers, nursing homes, or mental health centers[44].

As physicians and hospitals transition to a not-for-profit system, the profit motive disappears from the equation, allowing physicians to practice evidence-based medicine without today's perverse business incentives and administrative hassle in dealing with many payers. Business would likewise do well with NHI, being relieved of the burden of providing employer-sponsored insurance, paying less than it does now, gaining a healthier workforce, and being able to compete better in global markets with other countries that have one or another form of universal health insurance.

Social/Political Argument

Growing income inequality among Americans has reached such proportions that necessary health care is not accessible or affordable for the uninsured or the growing ranks of the underinsured. The magnitude of this gap is striking, reminiscent of the Gilded Age more than a century ago. A recent report found that the richest 400 took in a total of $300 billion in 2013, an

Table 2. A Progressive Financing Plan For H.R. 676.

This plan replaces regressive funding sources and improves and expands comprehensive benefits to all (in billions of dollars).	
New progressive revenue sources	
• Tobin tax of 0.5% on stock trades and 0.01 % per year to maturity on transactions in bond, swaps, and trades.	442
• 6% surtax or household incomes over $225,000	279
• 6% tax on property income from capital gains, dividends, interest, or profits	310
• 6% payroll tax on top 60% with incomes over $53,000	346
• 3% payroll tax on bottom 40% with incomes under $53,000	27
Total new progressive sources	1,404
• Tax expenditure savings	260
• Federal Medicare, Medical, and other health spending, and 20% of current out-of-pocket spending (maintained from current system)	1.454
• Total Revenues	3,113
• Savings for deficit reduction	154

Source: Friedman, G. Funding H.R. 676 The Expanded and Improved Medicare For All Act. How We Can Afford a National Single Payer Health Plan. Physicians for a National Health Plan. Chicago, IL, July 31, 2013. Available at htpp://0HR%2067 6_Friedman_7.3.1.13.pdf.

average gain of $750 million for each member of the Forbes 400, and an amount larger than the entire safety-net budget for that year[45]. In 2012, the top 10 percent of earners in the United States took in more than one-half of the nation's total income, the highest level yet recorded[46].

This stark income gap has serious consequences for much of the population. As one example, a study of mortality by U.S. zip codes has found that people living in the poorest zip codes have death rates that are almost twice as high as those living in the most affluent zip codes[47].

There are political implications to this widening income gap in the United States. As Marmor, Mashaw, and Pakutka point out in their recent book, Social Insurance: America's Neglected Heritage and Contested Future:

> "Social insurance programs engage most of the electorate precisely because they cover common risks and insure most of the population. And because practically everyone is both a contributor and potential beneficiary, the politics of social insurance tends to be of the 'us-us' rather than the 'us-them' form. Each individual's sense of earned entitlement or deservingness makes reneging on promises in social insurance programs politically costly. Each individual's responsibility to contribute to the common pool makes extravagant promises of 'something-for-nothing' future benefits less politically attractive ... Social insurance programs are economically sensible and socially legitimate and thus politically acceptable. Social insurance is part of the essential social glue that holds an individualistic polity together and makes the economic risks of a market economy tolerable"[48].

The Moral Case for National Health Insurance

The dominant culture in the U.S. market-based health care system, unchanged by the ACA, still treats health care services as commodities, just products for sale on an open market. When one among us has a major accident or serious illness threatening life and/or bankruptcy, we are brought up short in realizing how unfair, inhumane, and cruel our system can be. Too often, there is no safety net to catch us.

In sharp contrast to almost all other advanced countries around the world, health care as a human right remains controversial in the United States, especially among conservatives. Within our system, it is still a privilege based on ability to pay.

Dr. Bernard Lown, developer of the cardiac defibrillator and co-recipient of the Nobel Peace Prize in 1985 on behalf of International Physicians for the Prevention of Nuclear War, cuts to the heart of the issue in this way: "The United States subscribes to a business model that characterizes insurers as commercial entities. Like all businesses, their goal is to make money ... Under the business model, casual inhumanity is built in and the common good ignored. Excluding the poor, the aged, the disabled, and the ill is sound policy since it maximizes profit. Under the social model, denying coverage to any member of society would refute the fundamental purpose of health insurance"[49].

Conservatives in many other advanced countries around the world have long favored the concept of health care as a human right. Donald Light, Ph.D., a Fellow at the University of Pennsylvania's Center for Bioethics and author of Benchmarks for Fairness for Health Care Reform, has found that conservatives and business interests in every other industrialized country have supported universal access to necessary health care on the basis of four conservative moral principles: anti-free riding, personal integrity, equal opportunity, and just sharing. He suggests these 10 guidelines for conservatives to hold to these principles:

1. Everyone is covered, and everyone contributes in proportion to his or her income.
2. Decisions about all matters are open and publicly debated. Accountability for costs, quality and value of providers, suppliers, and administrators is public.
3. Contributions do not discriminate by type of illness or ability to pay.
4. Coverage does not discriminate by type of illness or ability to pay.
5. Coverage responds first to medical need and suffering.
6. Nonfinancial barriers by class, language, education, and geography are to be minimized.
7. Providers are paid fairly and equitably, taking into account their local circumstances.
8. Clinical waste is minimized through public health, self-care, prevention, strong primary care, and identification of unnecessary procedures.
9. Financial waste is minimized through simplified administrative arrangements and strong bargaining for good value.
10. Choice is maximized in a common playing field where 90–95 percent of payments go toward necessary and efficient health services and only 5–10 percent to administration[50].

It is remarkable that these commonsense guidelines have not gained consensus within the business and corporate class in the United States as health care becomes ever more expensive, inefficient, unfair, wasteful, and beyond the reach of a growing part of the population. We seem to have a societal blind spot in failing to seriously address this problem.

Conclusion

The ACA built upon the flaws of our market-based system and, quite predictably, is failing to contain costs and provide broad access to affordable, quality health care. Corporate interests still trump the common good in U.S. health care. More fundamental reform is required based upon universal access to health care as a right. A broad-based social movement will be needed to support a larger role of responsible government in enacting NHI and protecting it from privatization. Until that happens, we can expect continued turmoil and increasing public backlash to a dysfunctional system that places profits over service. It is just a matter of time before the country will be forced to choose between discredited, deregulated markets and a more efficient single-payer system that ensures access to essential health care for all Americans.

References

1. Geyman, J.P. How Obamacare Is Unsustainable: Why We Need a Single Payer Solution for All Americans. Copernicus Healthcare, Friday Harbor, WA, 2015.
2. Collins, S.R., Rasmussen, P.W., and Doty, M.M. Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment. The Commonwealth Fund, July 10, 2014.
3. Radnovsky, L. A national policy on health care? Sort of. Wall Street Journal, June 9, 2014, A5.
4. Nichols, L.M., et al. Are market forces strong enough to deliver efficient health care systems? Confidence is waning. Health Aff 23(2):8–21, 2004.
5. Cuckler, G.A., et al. National health expenditure projections, slow growth until coverage expands and economy improves. 2012–2022. Health Aff 32(10):1820–1831, October 2013.
6. Davidson, D. Health spending growth hits 10-year high. USA Today, March 30, 2014. 7. Wilson, M., and Cutler, D. Emergency department profits are likely to continue as the Affordable Care Act expands coverage. Health Aff 33(5):792–799, May 2014.
8. Congressional Budget Office. Insurance Coverage Provisions of the Affordable Care Act. Washington, DC, April 2014.
9. Associated Press. Poll: Many insured struggle with medical bills. Leader Herald, October 13, 2014.
10. Gould, E., et al. What Families Need to Get By: The 2013 Update of EPI's Family Budget Calculator. Economic Policy Institute, Washington, DC.
11. Plumer, B. Chart: Median household incomes have collapsed since the recession. Workblog, March 29, 2013.
12. Girod, C.S., Mayne, L.W., and Weltz, S.A. Milliman Medical Index . May 20, 2014. 13. Pollitz, K., et al. Medical Debt Among People With Health Insurance. Kaiser Family Foundation, January 2014.
14. Baicker, K., et al. The Oregon Experiment – effects of Medicaid on clinical outcomes. N. Engl. J. Med 368(18):1713–1722, May 2, 2013.
15. Bisgaier, J., and Rhodes, K.V. Auditing access to specialty care for children with public insurance. N. Engl. J. Med 364:2324–2333, June 16, 2011.
16. Dickman, S., et al. Opting out of Medicaid expansion: The health and financial impacts. Health Affairs Blog, January 30, 2014.
17. Gold, J. Prevention for profit: questions raised about some health screenings. Kaiser Health News, October 28, 2013.
18. U.S. Preventive Services Task Force. (2007). Screening for carotid artery stenosis: U.S. Preventive Services Task Force recommendation statement. Ann. Intern. Med 147:854–859, 2007.
19. Report of the Office of the Inspector General, DHHS, November 2012.
20. Woolhandler, S. Should physician pay be tied to performance? No, the system is too easy to game – and too hard to set up. Wall Street Journal, June 16, 2013.
21. Rau, J. Medicare data show wide differences in patient care. Kaiser Health News, February 21, 2014.
22. Verdon, D.R. Physician outcry on HER functionality, cost will shake the health information technology sector. Medical Economics, February 10, 2014.
23. McCormick, D., et al. Giving office-based physicians electronic access to patients' prior imaging and lab results did not deter ordering of tests. Health Aff 31(3):488–495, March 2012.
24. Dayoub, E. Lessons from abroad and at home: How PCORI can improve quality of care (and prove it) by 2019. Health Affairs Blog, May 2, 2014.
25. Geyman, J.P. How Obamacare Is Unsustainable: Why We Need a Single Payer Solution for All Americans. Copernicus Healthcare, Friday Harbor, WA, 2015, pp. 154–156.
26. Geyman, J.P. How Obamacare Is Unsustainable: Why We Need a Single Payer Solution for All Americans. Copernicus Healthcare, Friday Harbor, WA, 2015, pp. 156–169.
27. Center for Public Integrity, as cited by Moyers, B., and Winship, M. The unbearable lightness of reform. Truthout, March 27, 2010.
28. Fang, L. The shadow lobbying complex. The Nation, March 10/17, 2014.
29. Suennen, L. Here come the exchanges ... And the opportunity to turn chaos into gold. Venture Valkyrie, October 6, 2013.
30. Soltas, E. Nobody should get rich off Obamacare. Bloomberg View, December 3, 2013.
31. Calia, M. UnitedHealth gets lift from lower medical costs. Wall Street Journal, October 17, 2014, B5.
32. Healthcare-Now! Single-Payer Activist Guide to the Affordable Care Act. Philadelphia, PA, 2013, p. 22. www.healthcare-now.org.
33. Woolhandler, S., Campbell, T., and Himmelstein, D.U. Costs of health care administration in the United States and Canada. N. Engl. J. Med 349:768–775, 2003.
34. Andrews, M. Proposal to add skimpier "copper" plans to marketplace raises concerns. Kaiser Health News, July 1, 2014.
35. Outrage of the Month: Medicare Advantage – Whose advantage? Health Letter. Public Citizen 29(6), June 2013.
36. Andrews, M. Short-term plans can skirt health law requirements. Kaiser Health News, October 28, 2013.
37. UNITE HERE. The irony of Obamacare, March 2014.
38. Flavelle,C. Obamacare's dropouts are middle-age men. Bloomberg News, March 17, 2014.
39. Jost, T. Implementing health reform: The state of the exchanges, income verification, and more. Health Affairs Blog, October 16, 2013.
40. Pollitz, K., et al. Medical debt among people with health insurance. Kaiser Family Foundation, January 2014.
41. Geyman, J.P. How Obamacare Is Unsustainable: Why We Need a Single Payer Solution for All Americans. Copernicus Healthcare, Friday Harbor, WA, 2015, p. 181. 42. Friedman, G. Funding H.R. 676: The Expanded and Improved Medicare for All Act. How We Can Afford a National Single-Payer Health Plan. Physicians for a National Health Program. Chicago, 2013. http://www.pnhp.org/sites/default/files/Fundingpercent20HRpercent20676_Friedman_final_7.31.13.pdf.
43. Geyman, J.P. How Obamacare Is Unsustainable: Why We Need a Single Payer Solution for All Americans. Copernicus Healthcare, Friday Harbor, WA, 2015, p. 42.
44. Geyman, J.P. The Corrosion of Medicine: Can the Profession Reclaim Its Moral Legacy? Common Courage Press, Monroe, ME, 2008, p. 37.
45. Buchheit, P. Another shocking wealth grab by the rich, in just one year. Nation of Change, January 20, 2014.
46. Lowrey, A. The rich get richer through the recovery. New York Times, September 10, 2013.
47. Wilkenson, R., and Pickett, K. The Spirit Level: Why Greater Equality Makes Societies Stronger. Bloomsbury Press, New York, 2010, p. 13.
48. Marmor, T.R., Mashaw, J.L., and Pakutka, J. Social Insurance: America's Neglected Heritage and Contested Future. Los Angeles, Sage Publications, 2014, p. 217.
49. Lown, B. Physicians need to fight the business model of medicine. Hippocrates 12(5):25–28, 1998.
50. Light, D. W. A conservative call for universal access to health care. Penn. Bioeth. J 9(4):4–6, 2002.

DOI: 10.1177/0020731414568505

Just published:

How Obamacare is Unsustainable

For a more detailed analysis of the Affordable Care Act and the need for single-payer national health insurance, read Dr. Geyman's newly published book, "How Obamacare is Unsustainable: Why We Need a Single-Payer Solution for All Americans." Each of the book's 15 chapters is replete with figures, tables, and footnotes. Includes glossary and index.

About the author

Dr. John Geyman served as chairman of the department of family medicine at the University of Washington School of Medicine in Seattle from 1976 to 1990. He was the founding editor of the Journal of Family Practice and subsequently edited the Journal of the American Board of Family Practice. He is the author of more than a dozen books. Dr. Geyman is a past president of Physicians for a National Health Program and a member of the Institute of Medicine.

How Obamacare is Unsustainable
By John Geyman, M.D.
Copernicus Healthcare, January 2015
ISBN paper: 978-0-9887996-9-1
Softcover, 328 pp., $18.95
Available from the PNHP Store (at a special price of $15) or your favorite bookseller.

Chapter Reports

In **California**, the AllCare Alliance has grown to over 120 organizational members. Both PNHP California and the California Health Professional Student Alliance are founding members. The AllCare Alliance will partner with the Health4All coalition on a lobby day in Sacramento on April 13 to advocate for S.B. 4, sponsored by state Sen. Ricardo Lara, which would assure health care for undocumented residents. The coalition will also use the lobby day to push for improved Medicare for All. PNHP California also welcomed new Education and Outreach Coordinator Perla Flores in October. To get involved in PNHP California, contact Dr. Bill Skeen at bill@pnhpcalifornia.org.

In **Illinois**, state Rep. Mary Flowers reintroduced her state single-payer bill, "The Illinois Universal Health Care Act," H.B. 108, in the General Assembly on Jan. 14. All of the co-sponsors of the bill in the previous General Assembly were re-elected, and two newly elected representatives are known supporters. The Illinois PNHP chapter has been very active over the past few months. In the fall, PNHP Illinois partnered with Chicago Physicians for Social Responsibility on an event hosted by oncologist Dr. Ray Drasga, where students reported on health care justice-related activities and plans for the year. Northwestern medical students attended a performance of the play "Mercy Strain" (alternative title of "Mercy Killers") and met with the playwright/actor Michael Milligan. In December, medical and nursing students from UIC, Rush, Northwestern, Rosalind Franklin, Loyola, and University of Chicago took part in the national White Coat Die-in as part of the #whitecoats4blacklives and #blacklivesmatter movement. Additionally, Dr. Claudia Fegan joined Mark Dudzic of the Labor Campaign for Single Payer in a presentation on single payer and ACA-related bargaining issues to the leadership of the Brotherhood of Maintenance of Way Employees Division of the Teamsters. Dr. Anne Scheetz interviewed single-payer and disability rights activist Susan Aarup for Chicago Community Access Network (CAN) TV on "Access to Health Care for People with Disabilities." Medical students from UIC worked with the national office staff to plan the Feb. 14 Students for a National Health Program (SNaHP) Summit, which was attended by more than 170 health professional students from around the country. Finally, Dr. William Reed is executive producer of a new music video, "Single Payer Shuffle," which is available through PNHP. To get active with PNHP Illinois, contact Dr. Anne Scheetz at anneschеetz@gmail.com.

White Coat Die-In at University of Illinois at Chicago.

Photo: Sonny Patel

In **Maine**, the fall of 2014 was highlighted by the re-election of Republican Gov. Paul LePage and a shift toward a more conservative Legislature in Maine. At Maine AllCare's annual board retreat in December, the board took the time to regroup and to re-evaluate their efforts and strategy. The chapter began 2015 with new energy, some fresh faces, and a renewed focus on their goal of single-payer universal health care. The Maine chapter's email list has almost 900 supporters, and their Facebook page has a weekly "reach" of between 500 and 1,500 people. Dr. Phil Caper continues to write his monthly column for the Bangor Daily News, and he gave a successful grand rounds presentation in Rockland in February. He and other PNHP members continue to give talks to community groups. The chapter has also launched a fundraising campaign, raising over $9,000 for the chapter. At least three Maine lawmakers have submitted health reform legislation, including a single-payer bill. Hearings on these bills are expected in early spring. To become involved in Maine, contact Dr. Julie Pease at jkpeasemd@gmail.com.

In **North Carolina**, the Health Care Justice chapter of PNHP in the Charlotte area has been very active, and hosted two national speakers in the past several months. Most recently, Dr. Oliver Fein from the PNHP New York Metro chapter visited Charlotte as part of a three-state, 24-hour tour of the South. Over 100 people attended his presentation, and Dr. Fein was interviewed by the medical reporter from the Charlotte Observer. During the summer, Dr. Ed Weisbart from PNHP St. Louis spoke to an audience of about 70, and was interviewed on TWC News. A chapter member spoke at a

Medicaid expansion rally in October, and the chapter is also circulating a petition for Medicaid expansion. Chapter member Dr. Andrea DeSantis has worked with others to create a national single-payer interest group within the American Academy of Family Physicians. In Chapel Hill, PNHP member Dr. Jonathan Kotch is participating in the PNHP Mentoring Program with University of North Carolina medical student Rita Kuwahara. Ms. Kuwahara also represented UNC at the SNaHP Summit in Chicago in February. Finally, the chapter has been working to circulate the physicians' proposal for single-payer among its members – who now number 258. To get involved in North Carolina, contact Dr. Jessica Shorr Saxe at jsaxe@earthlink.net or Dr. Kotch at jonathan_kotch@unc.edu.

In **New Hampshire**, Dr. Don Kollisch reports that a state single-payer bill, HB 686, was introduced in the Legislature by state Rep. Dick McNamara in early February. Although the bill received two committee hearings and a House floor debate, it was voted down in the House on Feb. 18. Nonetheless, Granite State PNHP members were successful using the bill as an educational and organizing tool, getting media and legislative attention for single payer. Chapter members are meeting in March to plan their next steps. To learn more about what is happening in New Hampshire, contact Dr. Kollisch at donald.o.kollisch@dartmouth.edu.

In **New Mexico**, PNHP's immediate past president, Dr. Andrew Coates, made a weeklong chapter visit to Albuquerque and the surrounding areas this past fall. The PNHP chapter hosted Dr. Coates at a series of well-attended events, including a presentation at the University of New Mexico and an encore presentation at the Albuquerque Peace and Justice Center. Dr. Coates also gave a grand rounds at the Northern Navajo Medical Center in Shiprock. A new student chapter of PNHP at UNM used Dr. Coates' visit to recruit new members and educate their peers on single payer. The group also sent a contingent to PNHP's Annual Meeting in November. To get involved in New Mexico, contact Dr. Bruce Trigg at trigabov@gmail.com.

PNHP NY Metro student members testifying at NY Health Hearing

In **New York**, the New York Metro chapter had an integral role in a series of six hearings held around the state for the New York Health Bill in December and January. The bill's author, Assemblyman Richard Gottfried (who chairs the Assembly's Health Committee), chaired the hearings. More than 50 supporters testified on the bill at the hearing in New York City, including nine PNHP board members. Labor leaders and medical students have also turned out in large numbers at the hearings. The campaign is planning additional statewide hearings and other activities. In December, medical schools all over New York City and in Albany participated in the national White Coat Die-In in support of the #blacklivesmatter movement. Albert Einstein College of Medicine student Hannah Keppler had a reflection of the die-in published in AMSA's "On Call" blog. Finally, the New York Metro chapter has added five new members to its advisory board, which now totals 40 members. To get involved in New York Metro PNHP, contact Katie Robbins at katie@pnhpnymetro.org.

In **Ohio**, there has been an upswing in student organizing for single payer. Dr. Johnathon Ross recently presented a grand rounds in Columbus, which was followed by meeting with over 40 Ohio State University medical students. Dr. Ross also gave a presentation to a brand new student chapter at Case Western Reserve University School of Medicine and Cleveland Clinic Lerner College of Medicine in January. First-year students Vanessa Van Doren and Joshua Nifratos were inspired by the talk, and with the help of Dr. Ross, published an excellent letter to the editor in Ohio's largest newspaper, The Plain Dealer. The student chapter will table for PNHP and SNaHP at the national Latino Medical Student Association conference in Cleveland on April 24-26. To get involved in Ohio, contact Dr. Ross at drjohnross@ameritech.net.

The **Oregon** chapter of PNHP held an event with the Health Care Professional Caucus for Southeast Portland, composed of physicians and nurses, in January. The chapter has also kept busy in the winter with events including a screening of "The Healthcare Movie," which was followed by a spirited dialogue on the need for sin-

gle payer. To get involved in Oregon, contact Dr. Peter Mahr at peter.n.mahr@gmail.com.

In **Pennsylvania**, there has been snowballing student interest in single payer at several of Philadelphia's five medical schools. Second-year students Danielle Baurer and Emily Kirchner started a new chapter at Temple University School of Medicine. First-year student Anthony Spadaro at the University of Pennsylvania Perelman School of Medicine is participating in the PNHP Mentoring Program with longtime PNHP member Dr. Gene Bishop. Second-year Archana Murali at Drexel University School of Medicine was appointed chair of the SNaHP Coalition Building Leadership Team within PNHP's national student leadership structure. All of these students, and many more from the Philadelphia area, were among the strong contingent at the SNaHP Summit in Chicago in February. To get involved in Pennsylvania, contact Dr. Walter Tsou at macman2@aol.com.

In **Rhode Island**, Dr. J. Mark Ryan reports that a state single-payer bill, "The Rhode Island Comprehensive Health Insurance Program," H. 5387, was introduced into the State Assembly by five lawmakers on Feb. 11. Dr. Oliver Fein from the New York Metro chapter gave a successful presentation on single payer to Brown University medical students and the public on Feb. 2. Professor Gerald Friedman of University of Massachusetts, Amherst, did an economic analysis of how implementing a single-payer system in Rhode Island would improve health care coverage and act as an economic stimulus for the state. They are using the study as an educational and organizing tool in conjunction with the state bill. To get involved in Rhode Island, contact Dr. Ryan at pnhp.ri@gmail.com.

South Carolina was one of three states that hosted Dr. Oliver Fein from the New York Metro chapter for a series of presentations in January. David Ball reports that 40 people turned out in Columbia, S.C., for an evening lecture. Also in January, Health Care for All-South Carolina submitted a state single-payer bill, inspired by the work of several other states. The chapter hopes to use the bill as an educational and organizing tool. To get involved in South Carolina, contact Dr. David Keely at dfkeely3@gmail.com.

In **Tennessee**, Dr. Art Sutherland has been working with medical students to establish new student chapters at Meharry Medical College in Nashville and University of Tennessee Health Sciences Center in Memphis. Additionally, new student leaders have taken the reins at the Eastern Tennessee State University Quillen School of Medicine chapter. In January, Dr. Laura Helfman gave a successful presentation to over 50 people at a Central Labor Council meeting in Chattanooga. As a result of the event, the UAW local in Chattanooga plans to consider a resolution in support of H.R. 676 at its next meeting. To get involved in Tennessee, contact Dr. Art Sutherland at asutherland523@gmail.com.

In **Washington**, Dr. David McLanahan reports that the state Legislature's House of Delegates considered a resolution in favor of single payer this past fall. The Western Washington PNHP chapter recruited physicians from Canada to testify at the House Reference Committee meeting. They also alerted U.S. Rep. Jim McDermott, who testified and promoted the idea of a waiver from the ACA to enact a single-payer plan. The Reference Committee referred the resolution to a work group for study. The Western Washington chapter has also kept busy participating in local events, such as marching in the Jan. 19 Martin Luther King Jr. Day parade under a PNHP banner. Finally, the chapter recently elected its new board for the 2015 year, and is assisting the development of a new student chapter at the University of Washington. To get involved in Western Washington, contact Sherry Weinberg at weinbergsk@msn.com.

In **Wisconsin**, the PNHP chapter has amped up its events over the past few months, using documentary screenings as an educational tool. Chapter staff person Brooke Weber reports that the chapter has purchased rights to the documentary "The Waiting Room" and has aimed for one screening each month. Though universal health care isn't explicitly mentioned in the documentary, nearly every scene lends itself to a discussion of single payer. Most recently, the chapter held a screening in the State Capitol for senators, assembly representatives, and legislative aides. PNHP Wisconsin has also focused on building coalitions with like-minded organizations, and keeping local medical students involved in PNHP. To get involved in Wisconsin, contact Brooke Weber at wisconsin.pnhp@gmail.com.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

March 2015

Talking points on King v. Burwell case at Supreme Court

The Supreme Court heard oral arguments March 4 on the case of King v. Burwell. The case is a legal challenge to a small piece of the Affordable Care Act that, if upheld, would have potentially big consequences. A ruling is expected in June.

At issue is whether the ACA's language allows the federal government to provide subsidies to people who buy health insurance in states that didn't set up their own "marketplaces," i.e. in states that rely on the federally run marketplace, HealthCare.gov, in whole or in part, to serve their populations.

Only 13 states (plus the District of Columbia) have clearly set up their own state-managed marketplaces. Thirty-seven states did not, three of them because their own IT systems failed.

King and his fellow plaintiffs argue that a subsection of the ACA that says subsidies should flow to people "through an exchange established by the state" should be interpreted to mean that only people who live in states with state-managed marketplaces should be entitled to subsidies. They say people who buy through the federally run marketplaces should not get subsidies.

The government argues that the expression "established by the state" is a "term of art," which, if read in the context of the entire law, clearly signifies that everyone, regardless of whether they buy insurance through a state-managed or federally run exchange, is entitled to subsidies. The government also argues that this was Congress' clear intent and that, in any event, the IRS has the authority to interpret the law in this way.

Were the Supreme Court to uphold King's challenge, the Urban Institute estimates 9.3 million people in 34 states would lose their subsidies within the year, which in turn would largely make their premiums unaffordable. An estimated 8.2 million of these would join the ranks of the uninsured.

There would be many other ramifications to the ruling, too, including the invalidation of the employer mandate in those 34 states, leading to workers losing employer-sponsored coverage. (The situation is not as clear in three other states that turned to the federal IT system because of technical problems.) Other parts of the ACA would largely remain in force. King v. Burwell is not a constitutional challenge, but a statutory challenge to this particular provision.

For more background on the case, Kaiser Health News has a number of helpful articles, including one here: bit.ly/1AOFTmV. More detailed analyses are available at the Scotus Blog where you can also obtain an overview of the 50 or so amici curiae ("friends of the court") briefs that have been filed.

PNHP's suggested talking points

1. The Affordable Care Act clearly lacks the simplicity and legal robustness that a single-payer plan would have. This latest legal challenge demonstrates, once again, how the ACA's administrative complexity and internal flaws make it vulnerable to attacks of this type. In contrast, a single-payer plan would offer few legal loopholes for opponents of universal care to exploit. Single payer would be simple: everyone in the U.S. would be covered for all medically necessary care in a single program financed by equitable taxes.
2. If the Supreme Court upholds this challenge, the health and financial harms of an additional 8 million people losing insurance coverage will only increase the intolerable suffering we see today. One consequence, based on a landmark study of insurance and mortality, would be an estimated 8,000 additional deaths annually due to lack of insurance. That figure is over and above the 30,000 annual excess deaths that are currently estimated under the ACA due to its continuing lack of coverage of 30 million people. (Even if all states had accepted Medicaid, an estimated 24 million people would still be uninsured.)
3. Regardless of how the court rules, the unfortunate reality is that the ACA won't be able to achieve universal coverage. It won't make care affordable or protect people from medical bankruptcy. Nor will it be able to control costs.
4. The ACA is fundamentally flawed in these respects because, by design, it perpetuates the central role of the private insurance industry and other corporate and for-profit interests (e.g. Big Pharma) in U.S. health care.
5. In contrast, a single-payer system – an improved Medicare for All – would achieve all three goals mentioned above: truly universal care, affordability, and effective cost control. It would be simple to administer, saving approximately $400 billion annually by slashing the administrative bloat in our private-insurance-based system. That money would be redirected to clinical care. Copays and deductibles would be eliminated.
6. A growing section of the insured population is already facing very high copays, deductibles and coinsurance, deterring them from seeking needed care. Physicians can't wait for an effective remedy any longer, nor can our patients. The stakes are too high. We urgently need to go far beyond the Affordable Care Act – we need to establish single-payer national health insurance, an improved Medicare for All. It's the only moral and fiscally responsible thing to do.

"Your insurance plan covers only the eighty percent of you that's healthy."

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

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

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

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

Address Service Requested