PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter Summer 2015

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PNHP in the news

PNHP President Dr. Robert Zarr was featured in several radio interviews after the Supreme Court's ruling in King v. Burwell. Dr. Adam Gaffney writes in Salon that while the court decision averted adding an estimated 8.2 million people to the ranks of the uninsured, "America's health care system is still broken" (reprinted on page 28).

CNBC, the Wall Street Journal and other media reported on research by Drs. David Himmelstein and Steffie Woolhandler at the Health Affairs Blog that the Affordable Care Act will add $273.6 billion in extra insurance overhead to the U.S. health system between 2014 and 2022 (see p. 12). The Washington Post and Marketwatch reported on PNHP board member Dr. Danny McCormick's research showing that Massachusetts' health reform, the model for the ACA, failed to reduce preventable hospitalizations, or ethnic or racial health disparities (p. 19). California Healthline and other media covered research led by Dr. Leah Zallman showing that undocumented immigrants help keep Medicare solvent, contributing $35.1 billion in surplus contributions from 2000 to 2011 (see pages 30-31).

As we go to press, PNHP is making plans to publicize Medicare's 50th anniversary on July 30 in coalition with National Nurses United and others. Stay tuned!

Medical students send a message at Feb. 14 summit in Chicago.

Residents for a National Health Program

PNHP is excited to announce a new section for medical residents and fellows called Residents for a National Health Program. RNHP is led by PGY1 residents Nahiris Bahamon, Arielle Hirschfeld, and Daniel Ash in Chicago, and PGY2 resident Meghan Geary at Brown, with assistance from PNHP National Organizer Emily Henkels. RNHP members around the country launched their section with a "Match Day Pledge" to continue to advocate for single payer throughout their training. For a list of where PNHP students have matched, see p. 41.

Bills boost single payer's profile in New York, California

Assemblyman Richard Gottfried's single-payer New York Health Act passed the Assembly in May by a vote of 92-52 after a campaign by single-payer activists. The California Senate passed Sen. Ricardo Lara's bill extending coverage to undocumented immigrants under the ACA. Weeks before, PNHPers, including Dr. Paul Song and a large contingent of medical students, had rallied in Sacramento for the measure. In a partial victory, Gov. Jerry Brown signed a budget that includes public coverage for undocumented children. For details, see the chapter reports, page 53.

Annual Meeting – Sat., Oct. 31, Chicago

PNHP's 2015 Annual Meeting will take place at the Chicago Sheraton Hotel and Towers on Saturday, Oct. 31. Our keynote speaker will be Tsung-Mei Cheng, an expert on Taiwan's single-payer system (see p. 44). It will be preceded by our popular Leadership Training on Friday, Oct. 30. RSVP at www.pnhp.org or 312-782-6006. Make hotel reservations by Wed., Sept. 30, for PNHP rate ($225 single/double) by calling 888-627-7106.

In This Issue

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2015

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Membership drive update

Welcome to 768 physicians and medical students who have joined PNHP in the past year. PNHP's membership stands at 19,911. We invite new (and longtime) PNHP members to participate in our activities and to 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.

Organized medicine update

Dr. Ray Drasga hosted a PNHP exhibit at the **American Society of Clinical Oncology**. This year's conference featured a plenary talk by a prominent oncologist at Memorial Sloan Kettering Cancer Center, Dr. Leonard Saltz, who criticized the pharmaceutical industry's outrageous prices for new medications that are often little better than older therapies. Dr. Drasga hopes to organize a panel on single payer for next year's meeting.

The Annual Leadership Forum of the **American Academy of Pediatrics** overwhelmingly passed a resolution on March 15 recommending that AAP's Committee on Child Health Financing "examine and report on financing universal health care by means of a single, not-for-profit public fund." The full text of the resolution, which was spearheaded by PNHP member Dr. Robert Vinetz, appears on p. 40.

The **Latino Medical Student Association (LMSA)** passed a pro-single payer resolution on March 27 at its Annual Policy Summit in Washington. The resolution, calling on LMSA to "support and advocate for legislation to implement a single-payer health insurance system," was introduced by Camilo Acuña, a medical student at New York University who is active in PNHP's student section, Students for a National Health Program (SNaHP). You can read the full resolution on p. 39.

PNHP is hosting an exhibit at the annual meeting of the **American Academy of Family Physicians** in Denver Oct. 1-3. Fifty family practitioners in PNHP have formed an interest group within the AAFP to promote single payer. If you would like to learn more or volunteer to help out at the booth, please drop a note to PNHP National Organizer Emily Henkels at e.henkels@pnhp.org.

Thanks and congratulations to PNHPer Dr. Leslie Gise, clinical professor of psychiatry at the University of Hawaii, who for the past 10 years has organized a popular session on single payer at the **American Psychiatric Association's** Annual Meeting. This year's session, "It's a wonderful life: Psychiatry in Canada," featured a panel of U.S. and Canadian psychiatrists, including former APA President Dr. Steve Sharfstein (a longtime PNHP member), along with Dr. Randall White from British Columbia and Dr. Jon Davine from Ontario.

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

UNINSURED AND UNDERINSURED

Special note: Definitive data on the impact of the Affordable Care Act (ACA) on the number of uninsured in 2014, the year the coverage expansions went into effect, is not yet available. Phone surveys to determine insurance status are known to underestimate the number of uninsured, but more accurate studies that use in-person interviews, like the Census Bureau's and the National Health Interview Survey, are costly and take more time. Until more definitive data is available this fall, estimates of the number of newly insured persons by RAND, the Urban Institute, Gallup and others, should be considered preliminary. (For details, see Berk, "Counting the uninsured: Are we getting it right?" Health Affairs Blog, 5/12/15.) Confounding matters further, the Census Bureau changed its methodology for determining uninsurance in 2013, leading to a significant artifactual drop in the estimate of uninsured that year, by 6 million people. Attempts to assess the impact of the ACA on the uninsured since the law's passage in 2010 need to take this into account.

• Recent phone surveys by RAND, the Urban Institute, and the Commonwealth Fund estimate that 25 million to 27 million Americans remain uninsured in mid-2015 after the second round of open enrollment under the ACA.

A net of 16.9 million Americans aged 18-64 gained insurance coverage between September 2013 and February 2015, according to RAND. Although 22.8 million Americans acquired insurance, 5.9 million people lost their insurance over that period. Among those newly gaining coverage, the largest share, 9.6 million people, enrolled in employer-sponsored health plans, followed by Medicaid (6.5 million), individual coverage purchased through exchanges (4.1 million), non-exchange individual plans (1.2 million) and other insurance sources (1.5 million). The study also found that 24.6 million people who were already insured changed their coverage, including 7.1 million who enrolled in plans sold on the exchanges, and 6.1 million who enrolled in Medicaid.

The Urban Institute estimates that the number of uninsured adults fell by 15 million between September 2013 and March 2015, a decline of 42.5 percent (Carman et al., "Trends in Health Insurance Enrollment, 2013-15," Health Affairs, 5/4/15, and Long et al., "Taking Stock: Gains in Health Insurance Coverage under the ACA as of March 2015," Urban Institute, 4/16/15; "Americans experiences with marketplace and Medicaid coverage," Commonwealth Fund, May 2015).

• According to a poll of 43,575 adults by Gallup-Healthways, the rate of uninsurance among adults dropped to 11.9 percent in early 2015. Despite gains in coverage, the uninsurance rate among low-income adults and Hispanics is still about two- to threefold higher than the national average: The uninsured rate among all adults in households earning less than $36,000 annually dropped to 22.0 percent, while the proportion of uninsured Hispanics fell to 30.4 percent.

The proportion of working-age adults 18-64 lacking coverage in early 2015 declined to 14.5 percent, down from 20.8 percent at the end of 2013, according to Gallup-Healthways (Levy, "In U.S., Uninsured Rate Dips to 11.9 percent in First Quarter," Gallup.com).

31 million Americans, 23 percent of adults age 19-64 who were insured for all of last year, are underinsured, nearly double the rate in 2003, according to a new survey by the Commonwealth Fund. Underinsurance was defined as having out-of-pocket costs (not including premiums) over 10 percent of household income (or over 5 percent if low-income), or having a deductible over 5 percent of household income. Forty-four percent of the underinsured went without a doctor's visit, medical test, or prescription due to cost, while 51 percent had problems paying medical bills or were paying off medical debt over time. The proportion of people with employer-sponsored coverage who are underinsured has doubled since 2003, to 20 percent. The underinsurance rate in 2014 was higher among adults with individual coverage (37 percent) and permanently disabled non-elderly adults (42 percent) (Collins et al., "The problem of underinsurance and how rising deductibles will make it worse," Commonwealth Fund, 5/20/15).

• In states like Texas that haven't expanded Medicaid, the number of uninsured adults has only dropped about 31 percent, compared to a 53 percent drop in states that have expanded Medicaid. The number of uninsured adults 18-64 earning less than 138 percent of the poverty level fell by just 19.7 percent in Texas, compared to a 44.5 percent drop among Texans with incomes between 138 percent and 400 percent of poverty. As a result, lower-income Texans are now almost four times more likely to be uninsured than higher-income individuals (Walters, "Study: Texas' Rate of Uninsured Falls," Texas Tribune, 4/30/15; Ho and Marks, "Health Reform Monitoring Survey – Texas," Rice University, April 2015).

One-quarter (25.2 percent) of adults who bought private health insurance in the non-group market in 2014 (e.g. on the health exchanges) went without needed medical care last year because they could not afford it. Adults with low to middle incomes and those with high deductibles were the most likely to forgo needed care. Half (50.6 percent) of adults in the non-group market were in plans with deductibles of $1,500 or more, and 30 percent had deductibles of $3,000 or more ("Non-group health insurance," Families USA, May 2015).

SOCIOECONOMIC INEQUALITY

• In 2014, the 80 richest people in the world owned collective wealth of $1.9 trillion, up $600 billion since 2010. In 2010, the richest 388 billionaires had combined wealth equal to the wealth of the bottom half of the world's population, 3.5 billion people; last year it took just the top 80 to reach that level. A disproportionate share (20 percent) of the world's 1,645 billionaires are from the financial and insurance sectors; that industry spent $400 million on lobbying in the U.S. alone in 2013. About 90 billionaires (5 percent) profited from health care and pharmaceutical interests, another sector that invests heavily in lobbying, spending more than $487 million in 2013 in the U.S., or about 13 percent of all lobbying that year ("Wealth: Having it all and wanting more," OXFAM issue briefing, January 2015).

COSTS

• In 2014, the average premium for employer-sponsored health insurance was $6,025 for single coverage and $16,834 for family coverage. But many plans cost much more, due to geography, enrollees' preexisting conditions, a lack of network discounts, age of the workforce, and other factors. About 20 percent of covered workers are in plans with premiums for family coverage of over $20,201. Average premiums for high-deductible health plans with a "savings option" were not much cheaper; they cost $5,299 for single coverage and $15,401 for family coverage (2014 Employer Health Benefits Survey, Kaiser Family Foundation, 9/10/14).

A study by the actuarial firm Milliman estimated the cost of health care for a family of four in a PPO in 2015 at $24,671, up 6.3 percent from the previous year. Employers fund, on average, $14,198 of that amount in premiums, while workers pay $6,408 in premiums and $4,065 out-of-pocket. Rising prescription drug costs are a factor. According to Express Scripts, a pharmacy benefits manager, nearly 140,000 people had drug costs exceeding $100,000 in 2014, nearly triple the number in 2013, and 576,000 Americans spent more than the median household income on prescription medications in 2014, up 63 percent from 2013 (Munro, "Annual Healthcare Cost For Family Of Four Now At $24,671," Forbes, 5/19/15).

• Premiums for plans purchased on the ACA's health exchanges are spiking upward after two years of relative stability. Last year's average rate increases were about 5 percent, $300 to $400 annually. This year many insurers are seeking double-digit increases and in some cases as much as 50 percent, although rates won't be finalized until Nov. 1. A variety of factors, including the elimination of some low-cost plans that weren't ACA-compliant, along with claims data on enrollees for 2014 that was higher than projected, are driving the increase. Although costly new drugs for hepatitis C and cancer have raised health spending nationally, a recent study in Health Affairs found that average monthly prescription drug spending by ACA exchange enrollees in 2014 was only $72, slightly less than the $93 spent for individuals with employer-sponsored plans (A searchable list of plans proposing rate increases of 10 percent of more is at www.ratereview.healthcare.gov; Japsen, "Obamacare's double-digit rate hikes for 2016 disclosed," Forbes, 6/1/15).

• Health spending grew an estimated 5.6 percent in 2014. Higher health spending was driven by increased costs in three sectors: prescription drugs (up 13.1 percent), health insurance industry overhead (up 10.6 percent), and durable medical equipment (up 6.3 percent). Spending on physician and clinical services rose by just 2.9 percent (Goozner, "Drug firms and insurers move to center stage in the cost debate," Modern Healthcare, 2/23/15).

'Cadillac tax' to accelerate employer cuts to health benefits

The Affordable Care Act's so-called Cadillac tax, a whopping 40 percent excise tax on health benefits that exceed a certain limit, goes into effect in 2018. The tax applies to health benefit costs over $10,200 for an individual and $27,500 for a family, a threshold many employer-sponsored plans will soon exceed, particularly in industries with older, unionized workforces and geographic regions with high medical costs.

Benefits consulting firm Mercer says that because health costs are growing faster than inflation (5.6 percent vs. 2 percent), about one-third of employers will be affected by the tax in 2018, and almost 60 percent by 2022, far more than the "small portion of the very highest-cost health plans" that the Obama administration claimed in 2009. Some unions, like the United Auto Workers, negotiating multi-year contracts must factor the tax into negotiations this year. The Big Three automakers spend over $2 billion annually on health benefits, about $14,800 per active worker, and will be among the first industries hit by the tax.

The tax is supposed to fund $87 billion of the ACA's costs over a decade. A recent survey found that just 2.5 percent of 562 companies surveyed say they will pay the tax; most are looking to cut benefits, e.g. by shifting employees to a high-deductible health plan. The tax will eventually all but eliminate the tax break companies get for providing health insurance, according to former Obamacare adviser Jonathan Gruber (Faler, "'Cadillac tax' the next big Obamacare battle," Politico, 4/6/15; Rogers, "Auto workers medical benefits at risk under new tax," Wall Street Journal, 3/24/15).

• Among H&R Block clients, the average fine for being uninsured in 2014 was $178, double the flat $95 fee that most people expected. In 2015 the penalty increases to $325 or 2 percent of income, whichever is more. The Treasury Department estimates that up to 6 million people will pay the penalty this year. Almost two-thirds of the estimated 7.5 million people who bought insurance on the health exchanges with the help of federal tax subsidies had to repay the government at tax time, H&R Block reported, with repayments averaging $729. Only one in four

purchasers of subsidized insurance was due a credit, averaging $425 ("Final ACA Stats," H&R Block press release, 4/27/15).

> The average annual deductible for single coverage in an employer-based plan was $1,217 in 2014. Yet a study from the Federal Reserve Board found that two-thirds of non-elderly, non-poor, low-income households (less than 250 percent of poverty) and over one-third (37 percent) of moderate-income households (less than 400 percent of poverty) do not have sufficient liquid financial assets to cover a deductible of $1,200 for an individual or $2,500 for a family. In plans offered through the federal exchange, HealthCare.gov, the average combined medical and drug deductible for single coverage in a silver plan was $2,556. Eighty percent of low-income households and 54 percent of moderate-income households do not have enough assets to cover the deductible. Although lower-income households may be eligible for cost-sharing subsidies in addition to their premium subsidies, moderate-income families are not ("Many families would struggle to pay a typical health insurance deductible, new analysis finds," Kaiser Family Foundation, 3/11/15).

• Total Medicare Part D spending totaled $103.7 billion in 2013, according to data released recently by CMS, with 26 percent of spending going to pay for the costliest 1 percent of claims (more than $3,000 per prescription). The bill for Nexium, prescribed to 1.5 million beneficiaries, was $2.5 billion, the most spent on any drug. The generic version of an alternative drug, omeprazole, costs less than $20 per claim, while Nexium costs $308 per claim. Over $2.2 billion was spent on Abilify, an antipsychotic prescribed for schizophrenia, making it the fourth costliest drug. Abilify is frequently prescribed off-label to seniors with agitation, despite warnings that it can increase their risk of death (Walker and Mathews, "Small number of drugs drives big Medicare bill, spending data show," Wall Street Journal, 4/30/15).

MEDICAID

Twenty-one states have opted not to expand their Medicaid programs under the ACA, despite the potential benefits. The Kaiser Family Foundation estimates that if the remaining 21 states expanded Medicaid, non-elderly Medicaid enrollment would increase by about 7 million, reducing the number of uninsured by 4.3 million (Kaiser Family Foundation, 5/5/15).

• Medicaid and CHIP enrollment was 70,515,716 in February 2015, making it the nation's largest health insurance program. Enrollment is up by 20 percent, 13 million people, since the ACA expansion began in 2014. Nearly three-quarters (74 percent) of all Medicaid beneficiaries are in private managed care plans (Paradise and Musumeci, "Awaiting New Medicaid Managed Care Rules: Key Issues to Watch," Kaiser Family Foundation, March 2015).

• The for-profit insurers that run most Medicaid managed care plans got a big boost in enrollment in 2014, driving their stock prices up 75 percent. Between the third quarter of 2013 and the third quarter of 2014, Anthem, the largest Medicaid insurer, saw its Medicaid enrollment grow 17.4 percent to 5.1 million enrollees, while UnitedHealth Group's Medicaid business grew 24.4 percent to 4.9 million enrollees. Four other for-profit insurers have over 2 million Medicaid enrollees – Centene Corp., Molina Healthcare, WellCare Health Plans, and Aetna ("Top Medicaid managed-care insurers," Modern Healthcare, 3/23/15).

• Medicaid managed care (MMC) doesn't reduce health expenditures and may worsen access to care for non-disabled adults, according to a study from the Urban Institute using data from the 2006-2009 Medical Expenditure Panel Survey and other sources. As MMC penetration increased (by county) from 10 percent or less, to 80 percent or more, the probability of an ED visit by non-disabled adult MMC enrollees increased by 4.9 percentage points to 24.2 percent; the proportion of enrollees saying they had difficulty seeing a specialist among those who reported the need to see one increased 9.5 percentage points, to 41.8 percent; and the probability of an unmet need for prescription drugs doubled, to 3.4 percent. The authors of the study conclude that the main advantage of MCC for the states is "administrative simplification" and "budget predictability" (despite the well-known higher costs and higher administrative costs associated with Medicaid managed care) (Caswell and Long, "The expanding role of managed care in the Medicaid program: Implications for health care access, use, and expenditures for nonelderly adults," Urban Institute, May 2015).

• The comprehensiveness of Medicaid coverage is shrinking: Indiana is the latest state to receive federal approval to impose cost sharing on Medicaid beneficiaries below the poverty level, joining Arkansas and Iowa. Poor enrollees in Indiana who don't pay a premium of $3 to $15 a month will face copayments for care and will lose vision and dental benefits. Indiana also has a stringent lockout provision: enrollees above poverty are required to pay premiums of 2 percent of their incomes, up to $25 a month, into a health savings account. If they miss two consecutive payments Indiana will lock them out of coverage for six months (Dickson, "Indiana Medicaid expansion may spur other state cost-sharing proposals," 2/2/15).

• CMS has so far rejected attempts by Indiana, Florida, Utah and several other GOP-dominated states to tie work requirements to Medicaid, saying it would undermine the program. Most (57 percent) potential Medicaid recipients already work (compared to 63 percent of adults overall). Of those who are not working, about a third are taking care of a family member, 20 percent are looking for work, and 17 percent are mentally ill or disabled (Wheaton, "GOP warms to Obamacare – if Americans work for it," Politico, 4/30/15).

• Medicaid officials in at least 10 states say they will attempt to recover the cost of care for newly eligible enrollees over age 55 from their estates after they die, a practice known as "estate

recovery." A 1993 federal law authorizes estate recovery from patients whose medical bills were paid by Medicaid after they exhausted, or "spent down" their non-housing assets. In 2011, the latest year for which data is available, states recovered $498 million from deceased beneficiaries' estates. Unless states waive their right to recover assets from older enrollees in the ACA's expanded Medicaid program (as Washington state did recently), the estates of older enrollees may be liable for the total cost of their medical care (or managed care premiums) while in the program. State officials from California, Colorado, Iowa, Massachusetts, Nevada, New Jersey, New York, North Dakota, Ohio and Rhode Island told Consumers Union that they plan to go after deceased beneficiaries' assets, even though Medicaid beneficiaries under age 55 and people who received subsidies to purchase coverage on the exchanges (or "marketplaces") face no such threat. The California Legislature passed a bill to eliminate estate recovery at the end of 2014, but it was vetoed by Gov. Brown, citing the $15 million in estimated lost revenues to the state (Metcalf, "Will Medicaid take my house?" Consumer Reports, January 2014; Armour, "New Wrinkle for Health Law," Wall Street Journal, 4/12/15; Aliferis, "On Medi-Cal now, lose your house later?" KQED News, 3/24/15).

MEDICARE

• Medicare Advantage (MA) plans will get an average 3.25 percent rate increase from CMS in 2016, not the 0.95 percent cut to the benchmark rate proposed in February. Medicare Advantage enrollment grew by 8.5 percent last year, to 17.3 million beneficiaries in early 2015, about one-third of total Medicare enrollment. Enrollment in MA plans is up by 40 percent since 2010, contradicting projections that enrollment would dip due to payment reductions mandated by the ACA. Meanwhile, MA benefits are decreasing; 41 percent of enrollees had an out-of-pocket maximum over $5,000 in 2014, up from 25 percent in 2013 (Herman, "Despite complaints, Advantage plans continue to grow," Modern Healthcare, 4/11/15, and Herman, "Medicare Advantage rates show insurers' lobbying muscle," Modern Healthcare, 5/7/15).

• Researchers at the National Bureau of Economic Research also recently published a study indicating that MA plans are receiving large overpayments. Without an adjustment for upcoding, MA plans would be overpaid by about $10.5 billion annually, $604 per MA enrollee per year, according to the NBER study. It estimated that enrollees in MA plans receive average diagnosis-based risk scores 6.4 percent higher than they would in FFS Medicare, inflating payments to MA plans for their care. Vertically integrated HMOs, where doctors work for the hospital or HMO, increased their risk score even more, by 16 percent.

Overpaying MA plans due to upcoding distorted beneficiaries' choices "by implicitly creating a voucher that is larger when consumers choose a plan with higher coding intensity," the researchers said. In other words, the playing field for beneficiaries is tilted towards enrollment in restrictive and inefficient MA plans over FFS Medicare.

An actual 7 percent increase in risk scores among MA plan enrollees is implausible, the NBER study noted, because it would be equivalent to "all consumers in the market becoming paraplegic, 12 percent developing Parkinson's disease, or 43 percent becoming diabetics."

Importantly, these results likely apply to any program that depends upon risk-adjustment to determine payment. A main conclusion of the study was that "increasing the competitiveness of the market can … reduce net efficiency" (Geruso and Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," NBER, May 2015).

The Medicare Payment Advisory Commission (MedPAC) reports that MA plans will cost Medicare 5 percent more per enrollee than their care would have cost in traditional Medicare in 2015, even after applying a 5.16 percent discount (the minimum mandated by law) to MA payments to offset upcoding. Medicare calculates its payments to MA plans for each beneficiary by multiplying the plan's payment rate by the enrollee's risk score. The risk score for each patient is derived from diagnoses that fee-for-service (FFS) providers coded during the year before the payment year, or that MA plans reported to Medicare for their enrollees. Overall, MedPAC estimates that risk scores in MA plans have grown 8 percent faster than scores in the fee-for-service population, or 3 percent more than the mandatory adjustment. In addition to the 3 percent excess payment related to upcoding, MedPAC found that MA plans were being paid an additional 2 percent over the cost of traditional Medicare, for a total overpayment of 5 percent, according to MedPAC calculations (MedPAC Report to the Congress, March 2015, and March report highlight: "MedPAC quantifies plan coding practices," 3/27/15).

UPDATE ON WAITS FOR CARE AT THE VA

• Less than 3 percent of the 5,063,122 visits at Veterans Administration facilities in April (excluding surgeries and procedures) had wait time exceeding 30 days, according to data posted online by the VA. Average wait times were short for primary care (4.15 days), specialty care (4.87 days) and mental health care (2.82 days). Nonetheless, the VA is under fire because these figures represent a slight uptick since August 2014, when Congress authorized additional funds for the program. Average waits for mental health care are a particular concern; they increased from 2.4 days to 2.8 days. Meanwhile, only about 7,500 patients per month have made appointments for private-sector care though the Choice program – just 0.2 percent of the appointments per month at the VA. The VA is scrambling to ramp up its in-house capacity, having added a net of 8,000 employees, including 800 physicians and nearly 2,000 nurses between April and December of last year, but is behind in planning, building, and staffing new facilities in the warmer, southern states that retirees favor. In addition, as access improves, more vets are coming for care. The number of completed visits in April 2015 is up 8 percent over the tally for August 2014 (VA data at http://1.usa.gov/1KauqIX; Caruso, "VA makes little headway in fight to

shorten waits for care," 5/9/15; and Caruso, "Few vets getting care through $10 billion VA program," Baltimore Sun, 4/23/15).

CORPORATE MONEY AND CARE

• Blue Shield of California's tax-exempt status was revoked last fall, making it liable for tens of millions of dollars in state taxes annually. Although the reason was not publicly disclosed, the firm has behaved like its for-profit rivals in most respects. Blue Shield amassed reserves of $4.2 billion, four times as much as the Blue Cross and Blue Shield Association requires its member insurers to hold, and paid the firm's former CEO $4.6 million annually. Blue Cross of California converted to for-profit status in 1996 (Gold, "Blue Shield of California loses its state tax exemption," Kaiser Health News, 3/18/15).

Six health insurance CEOs were paid a combined total of $157.6 million in direct compensation in 2014. In addition, they received a combined $63.3 million in stock and option awards, which will yield value in future years, bringing their total take last year to $220.9 million. That's an average of $36.8 million per CEO, $141,538 each workday. In comparison, the average annual earnings of full-time wage and salary workers was $41,148. The head of CMS, responsible for administering coverage for 115 million people, earns $200,000 a year. UnitedHealth's CEO Stephen Hemsley was paid the most, $66.1 million, plus $9.5 million in stock and option awards, followed by Medicaid-HMO operator Centene's Michael Neidorff ($28.1 million, with $13.9 million in awards), Cigna's CEO David Cordani ($27.2 million with $11.1 million in awards), Aetna's CEO Mark Bertolini ($15.0 million with $12 million in awards), Humana's Bruce Broussard ($13.1 million with $6.8 million awards) and Anthem's Joseph Swedish ($8.1 million with $10 million in awards) (Sources: SEC 14A Schedules, Bureau of Labor Statistics, Current Population Survey. Annual CEO direct compensation includes salary, bonus, non-equity incentive plan, other compensation and actual realized stock option gains and stock award gains).

• The health care industry spent $489 million on lobbying in 2014, just 12 percent less than the $555 million they spent in 2009 at the peak of the health reform debate. About half of that, $231 million, was spent by the pharmaceutical industry, which is eager to thwart attempts to control drug prices, and to gain more rapid approval for drugs and devices based on weaker evidence. Gilead, which markets Sovaldi and Harvoni, spent $2.2 million in 2013 to work on "hepatitis C policy"; they hired 26 lobbyists, many of whom had held influential government positions, to assure that the drug received FDA approval, that the USPSTF would reverse itself and recommend screening for hepatitis C, and that CMS would pay for that screening. In 2014 the firm spent $2.9 million on lobbying to dampen congressional pushback on their drugs' exorbitant prices. Half of all health care lobbyists are former government officials. Altogether, corporations outspend unions and public interest groups on lobbying 34 to 1 (Demko, "Healthcare's hired hands," Modern Healthcare, 10/6/14, and www.opensecrets.org).

Insurance companies overcharge firms that self-insure

Blue Cross Blue Shield of Michigan (BCBSM) was ordered to repay $6.1 million after it was found guilty of overcharging Hi-Lex Controls, an automotive technology business with 800 workers, while processing claims for the self-insured company. The overcharges consisted of bogus fees that the insurer tacked on to Hi-Lex workers' medical bills ("provider network fees," "other-than-group-subsidy fees," etc.), and failing to pass on discounted rates with providers, in effect marking up hospital bills by as much as 22 percent. A dozen other firms have been awarded summary judgements against BCBSM for the same offense and are awaiting settlements. An expert from the consulting firm Milliman, Inc., testified under oath that other insurers engage in the same practices (Wendell Potter, "Court case shows how health insurers rip off you and your employer," Center for Public Integrity, 5/11/15; Faucher and Vanic "Undisclosed fees in the health plan setting, and the potential danger to health plan sponsors," DrinkerBiddle, ERISA litigation, November 2012).
About 60 percent of U.S. companies self-insure. Self-insurance is especially common among large firms with 5,000 or more workers: 91 percent of employees at large firms were in self-insured plans in 2014, up from 62 percent of employees 15 years ago (Herman, "Self-service insurance: Insurers forced to compete harder for self-insured customers," Modern Healthcare, 1/3/15).

• Extendicare, which operates 146 skilled nursing facilities in 11 states, and owns Progressive Step Corp., a rehabilitation provider, will pay $38 million to settle allegations that it provided such substandard care at 33 of its facilities that the care was "worthless." This is the largest penalty the Justice Department has ever levied against a nursing home operator for poor-quality care. In addition, the firm provided unnecessary rehabilitation services to Medicare Part A patients in order to increase Medicare reimbursement. The firm has entered into a five-year corporate integrity agreement that requires independent monitoring of all its facilities (Thomas, "Chain to Pay $38 Million Over Claims of Poor Care," New York Times, 10/10/14).

• Dialysis giant DaVita will pay $450 million to settle a lawsuit brought by whistleblowers that the firm engaged in Medicare fraud. The settlement is the largest for a case under the False Claims Act in which the government did not join the suit. A doctor and a nurse who worked for the firm alleged that DaVita boosted its Medicare payments by billing for costly medication that was discarded, in particular Zemplar (a man-made form of vitamin D), and Venofer, an iron supplement. This is the third whistle-blower lawsuit against the firm since 2012, with payouts totaling nearly $1 billion (Stempel, "DaVita to pay $450 million in Medicare fraud lawsuit over wasted drugs," Reuters, 5/4/15).

GALLOPING TOWARD OLIGOPOLY

• UnitedHealth Group's Optum subsidiary is buying MedExpress, a national chain of retail clinics with 140 locations across 11 states. Optum's Convenient Care division already owns nine clinics in Texas, Nevada, and Kansas. UnitedHealth Group is the owner of United Healthcare, the nation's largest health insurer (Brino, "UnitedHealth's Optum digs in to retail health market," Healthcare News, 4/10/15).

• Kindred Healthcare, an operator of 2,300 transitional care hospitals, and nursing, rehabilitation, and assisted-living centers, is buying Gentiva Health Services in a $720 million deal. Gentiva is a home health and hospice provider (Modern Healthcare, 10/20/14).

Health insurance giants to merge

The nation's five largest health insurance companies are consolidating. Anthem is seeking to acquire Cigna for $53.8 billion. The deal is being held up for now by Cigna CEO David Cordani, who has demanded to be named CEO of the new company. The combined firm would have 53 million covered members and revenues of $115 billion, and overtake UnitedHealth Group, currently the nation's largest insurer, in membership. For its part, UnitedHealth Group is seeking to acquire Aetna in a $40 billion deal that would create a firm with $200 billion in projected annual revenues. Meanwhile, Aetna is buying Humana, one of the largest Medicare Advantage insurers, for $37 billion. The mergers will likely attract scrutiny from the U.S. Justice Department, as well as drive another round of consolidation among providers (Herman, "Anthem offers to buy Cigna in $54 billion deal," Modern Healthcare, 6/20/15; "Anthem Raises Offer for Cigna; Similuca, Aetna Bids for Humana," Wall Street Journal, 6/21/15).

• Consolidation among Part D drug plans is also increasing. In 2007, the nine largest insurers accounted for 60 percent of enrollment. In 2014, they accounted for 80 percent (MedPAC Report to the Congress, March 2015).

• Meanwhile, the market for long-term care insurance is collapsing. The number of insurers selling a significant number of long-term care policies has fallen from 102 firms in 2002, to 15 companies in 2012, while the number of new policies sold annually has fallen by more than half, to 322,000. Large insurers like Aetna and Humana, as well as many small companies, have stopped selling LTC policies, and premiums for those plans still on the market are rising (Johnson, "Questions loom as LTC insurers falter," Modern Healthcare, 1/19/15).

PHARMA

• Amgen, Sanofi, Pfizer, and other drug companies are racing to see who can be the first to bring a profitable PCSK9 cholesterol-reducing drug to market. At an estimated price of $10,000 per patient per year, the cost to treat patients with familial hyperlipidemia alone could exceed $16 billion, with another $20 billion potential market among patients who are statin-intolerant. Eager to speed its drug to market, Sanofi/Regeneron paid $67.5 million to buy a "FDA priority review voucher" that allowed it to skip to the front of the FDA's review line; the review panel recommended approval last month. The FDA originally gave the voucher to BioMarin to develop a treatment for a rare pediatric disease, but FDA rules allow firms to resell them (Wolinsky, "Cholesterol cost shock: Insurers brace as FDA considers pricey lipid-lowing injectables," Modern Healthcare, 4/13/15).

• Six pharmaceutical company CEOs received combined total direct compensation of $260.2 million in 2014. In addition they received stock and option awards worth $76.4 million, bringing their total pay last year to $336.6 million, an average of $56.1 million each. Gilead's CEO John C. Martin topped the list with direct compensation of $192.8 million ($741,403 per day) and stock and option awards worth $13.6 million; followed by Pfizer's Ian C. Read ($22.8 million plus $12.8 million in awards); Merck's Kenneth Frazier ($13.9 million plus $16.3 million); Amgen's Robert Bradway ($10.9 million plus $9 million); and Johnson & Johnson's Alex Gorsky ($7.9 million plus $13.6 million) (Source: SEC 14A Schedules. Annual CEO direct compensation includes salary, bonus, non-equity incentive plan, other compensation and actual realized stock option gains and stock award gains.)

• The price of Amphastar Pharmaceutical's version of naloxone, a life-saving antidote for opiate overdoses, has doubled in the past year, to $105 per kit, hampering efforts to get it into the hands of police, community members, families and users. Amphastar went public in mid-2014, and its stock is up 70 percent. In some countries naloxone sells for less than $1 per dose ("Heroin overdose antidote's rising price prompts worries," Associated Press, 3/10/15).

• The high price of Gilead's two drugs to treat hepatitis C, Sovaldi and Harvoni (a combination of Sovaldi and another drug) which are manufactured for less than $1 per pill, but cost up to $1,000 per pill, $84,000 for a 12-week course of treatment, is drawing protest and focusing attention on the role of Wall Street in skyrocketing drug prices and wealth inequality. Global sales of the two drugs topped $4.5 billion in the first three months of 2015, mostly in the U.S., yielding huge profits for Gilead, and making it one of the world's most profitable pharmaceutical firms. About 3.5 million Americans and 175 million people globally are living with the virus. U.S. private and public insurers say they can't afford to treat everyone with hepatitis C who could benefit. Private insurers require pre-authorization, while 27 state Medicaid plans will pay for treatment only for people with severe liver damage. Some Medicaid plans withhold treatment from recent drug abusers.

Gilead didn't discover Sovaldi; it acquired the company that brought the drug to market, Pharmasset, for $11 billion (a windfall for Pharmasset's investors), then set the price high enough to recoup their costs plus profits. Hedge funds and other inves-

tors flocked to Gilead stock, betting that the firm's price-gouging scheme would be profitable. Six hedge funds increased their shares in Gilead twelvefold in 2014. Julia Robertson of Tiger Management said "I love Gilead right now. I think it's fabulous. … They're going to get inundated with cash from the profits on the Hepatitis C drug" (Langreth, "More medicine goes off limits in drug-price showdown," 11/25/14; Pollack, "Gilead hepatitis drugs brought in $4.55 billion in first quarter," New York Times, 4/30/15).

Pharma fraud: Pay the ticket and keep on speeding

• The New York attorney general won a lawsuit against the Ireland-based drug company Actavis that will save Medicare an estimated $6 billion on a single dementia medication between 2015 and 2024. The firm sought to limit access to its Alzheimer's medication, Namenda, which will soon come off patent, so that physicians would have to prescribe a pricier new version of the drug, Namenda XR. Namenda XR is patented until 2029. Actavis limited distribution of the old drug to a single mail-order pharmacy and required physicians to submit a note that the old version was "medically necessary" for patients. Actavis internally estimated that only 3 percent of patients would get such a note (Appleby, "Battle over dementia drug swap has big stakes for drugmakers, consumers," Kaiser Health News, 3/19/15).

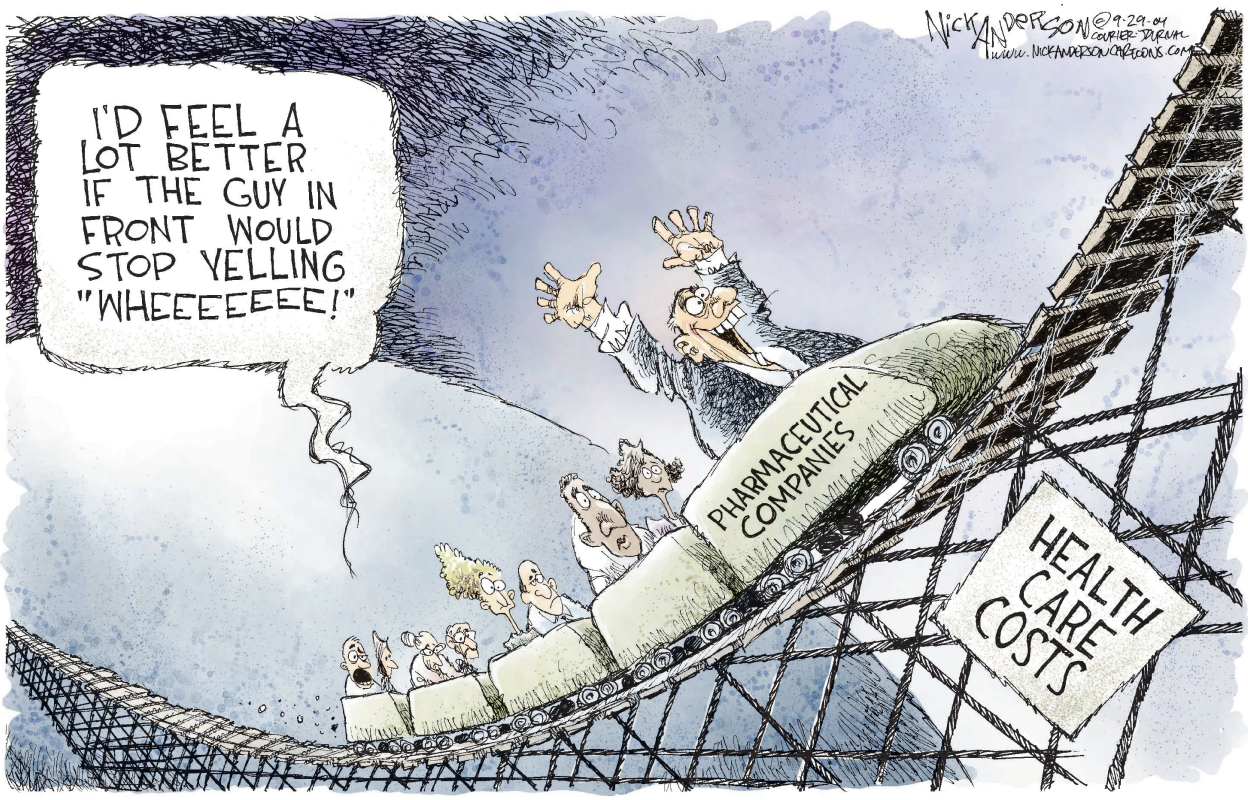
• Netherlands-based Organon, now owned by Merck, will pay $31 million to settle allegations that it underpaid Medicaid rebates in nearly every state, paid illegal kickbacks to nursing home pharmacy companies to prescribe two anti-depressants, Remeron and Remeron SolTab, and promoted its medications for unapproved uses (OIG, 10/30/14).

• Cardinal Health will pay $26.8 million to settle Federal Trade Commission allegations that the firm illegally monopolized the sale of radiopharmaceuticals in 25 markets. The settlement is the second largest in FTC anti-trust history and is intended to offset the money Cardinal made via illegal means (Schenker, "Cardinal to pay $26.8 million for alleged monopolization of radiopharmaceuticals," Modern Healthcare, 4/20/15).

• AstraZeneca will pay $7.9 million to settle allegations by the Department of Justice that it paid kickbacks to Medco, a pharmacy benefits manager, to maintain Nexium's "sole and exclusive" status on certain formularies, and other marketing activities. The kickbacks were in the form of discounts on other AstraZeneca products (Morse, "AstraZeneca to pay $7.9 million in kickback settlement over Nexium drug," Healthcare Finance, 2/13/15).

• In the first settlement of its kind, Teva will pay $1.2 billion in refunds to buyers who overpaid for Provigil because of a lack of generic competition due to a "pay to delay" deal. The drug's maker, Cephalon, bought by Teva in 2012, paid generic drugmakers not to challenge its monopoly on the drug. The FTC has fought pay for delay deals for 10 years; it received a boost from a 2013 Supreme Court ruling that such deals are potentially illegal (Bartz, "U.S. settles 'pay for delay' fight with drugmaker Teva over Provigil," Reuters, 5/28/15).

• Prescription drug spending was $373.9 billion in 2014, up 13.1 percent, the fastest annual growth since 2001. Higher drug spending is being driven by the pharmaceutical industry's aggressive new tactics in acquisitions and pricing, not research and development. Firms are: (1) raising prices on their older



medications, sometimes every few months; (2) buying the rights to brand-name drugs (or the companies that make them) and then raising their prices (e.g. Valeant's purchase of the rights to Isuprel and Nitropress, two heart drugs, and raising their prices 525 percent and 212 percent, respectively); (3) acquiring companies working on treatments for rare diseases or their products and then marketing them at astronomical prices; and (4) snapping up generic drugmakers to gain a monopoly on a commonly used drug or ingredient and then raising the price.

Generic pharmaceutical companies engaged in more than $100 billion in deals in 2014, five times more than in any year since 2005. Half of all generic drugs rose in price between July 2013 and June 2014, and 10 percent more than doubled in price. Prices on branded-drugs are up by 127 percent since 2008 (Harrison, "Myland board unanimously rejects takeover bid as too low," 4/27/15; Rockoff and Silverman, "Pharmaceutical firms contribute to wealth inequality," Wall Street Journal, 4/26/15).

Pharma's race to consolidate ownership of rare or generic drugs

• Alexion Pharmaceuticals Inc. is buying Synageva BioPharma Corp. for $8.4 billion, more than twice its market value, in a bet that medicines for rare diseases will continue to command exceptionally high prices. Alexion's sole product, Soliris (eculizumab), a treatment for two rare, life-threatening illnesses, paroxysmal nocturnal hemoglobinuria and atypical hemolytic uremic syndrome, costs over $500,000 a year and had sales of $2.3 billion last year. Synageva's Kanuma, a drug for a rare condition that causes a build-up of fat in the blood and liver, is awaiting approval by the FDA. Alexion's CEO says Kanuma's sales will exceed $1 billion (Nathan, Grover and Berkrot, "Alexion to bolster rare disease offering with $8.4 billion deal," Reuters, 5/6/15).

• AbbVie is buying Pharmacyclics, and the domestic rights to market its sole product, Imbruvica, for $21 billion. Imbruvica, a drug to treat mantle cell lymphoma, currently sells for $130,000 for a year of treatment, even though it has not been shown to extend patients' lives. It has recently been approved for two other cancers, another rare lymphoma and the relatively common illness, chronic lymphocytic leukemia. Imbruvica was developed in conjunction with Johnson & Johnson, which will market the drug overseas (Sachdev, "AbbVie closes $21 billion deal for Pharmacyclics," Chicago Tribune, 5/26/15).

• Ireland's Shire is buying New Jersey-based NPS Pharmaceuticals for $5.2 billion. NPS developed two drugs for rare diseases, Gattex, a treatment for short-bowel syndrome that NPS put out in 2013 at a cost of $295,000 per year, and Natpara, for hypoparathyroidism. A month's supply of Natpara, approved in 2015, costs over $8,000. Shire received a windfall of $1.6 billion when AbbVie abandoned its $52 billion bid to buy the firm last year. Shire's CEO and other top executives are based in Lexington, Mass., while the firm is based in Dublin for the explicit purpose of avoiding taxes. This is the seventh company the firm has purchased in the last three years (Baigorri, "Shire to Buy NPS for $5.2 Billion for Rare-Disease Drugs," Bloomberg Business, 1/12/15).

• Merck is buying Cubist, a Lexington, Mass.-based firm, for $8.4 billion. More than 80 percent of Cubist's sales are generated by the antibiotic Cubicin, with sales of $977 million in 2014. Cubicin faces generic competition starting in 2016, but the firm has four more antibiotics under development, and, if approved, they could receive an extra five years of market exclusivity under an incentive program to drugmakers to develop more treatments for infectious diseases (Chen et al., "Merck to Buy Cubist for $8.4 Billion to Add Antibiotics," Bloomberg Business, 12/8/14; Merck Investor Relations FAQ, 2/4/15).

• Israel-based generic drugmaker Teva is buying Auspex Pharmaceuticals, a company developing drugs to treat Huntington's disease and other movement disorders, for $3.5 billion. Teva's top-selling drug for multiple sclerosis, Copaxone, which costs over $12,000 a month and accounted for $4.3 billion in revenues and half its profits in 2010, is facing competition from generics and oral treatments. Teva is using the contact list from its 24-hour support hotline in the U.S. to contact MS patients and persuade them to switch to a longer-acting version of Copaxone which remains under patent until 2030, rather than to a generic version (Wainer, "Teva Braces for Tussle With Insurers Over Copaxone's Heir," Bloomberg, 3/3/14; Cohen, "Teva to buy U.S. drug developer Auspex Pharma for $3.5 billion," Reuters, 3/30/15).

• Ireland's Endo is acquiring New Jersey-based generic drugmaker Par Pharmaceuticals in an $8 billion deal, on top of acquiring three other firms manufacturing generics (Qualitest, Boca, and Dava) in the past five years. Par makes "hard-to-manufacture" generics that attract less competition and bring in higher profit margins. The acquisition will make Endo the fifth largest seller of generic drugs in the U.S. Endo attempted to purchase Salix Pharmaceutical, but was outbid by Valeant Pharmaceuticals, another "serial acquirer" (Johnson, "Endo buying Par for $8B in push for generics, higher profit," Washington Post, 5/18/15).

• Pfizer is buying Hospira, a maker of injectable drugs and biosimilars, for $15.2 billion. Hospira was spun off from Abbott in 2004. The global market for generic sterile injectables is projected to be $70 billion by 2020 (Gelles, "Pfizer to Buy Hospira for $15 billion as drugs lose patent protection," New York Times, 2/5/15).

• Generic drugmaker Mylan's $34 billion bid to purchase Perrigo (also Ireland-based), a maker of over-the-counter pharmaceuticals, was rejected. The combined firm would have had $15.3 billion in sales. Mylan is itself the target of a hostile takeover by rival Teva. It rejected Teva's most recent bid for $43 billion, but Teva is expected to keep pushing for a deal (Merced, "Mylan Raises Offer for Perrigo Again and Is Rejected Again," New York Times, 4/29/15; "Mylan proposes to acquire Perrigo for $205 per share," Mylan press release, 4/18/25).

POLLS

• A poll by Nielsen for the Texas Medical Association found that 42 percent of Texans favor a tax-supported, single-payer, Medicare-for-all plan ("citizens who pay taxes get insurance like

Medicare or Medicaid"), a higher level of support than for the other two options (employer-paid group coverage or employer-paid exchange coverage) combined. In addition, 81 percent of respondents were willing to pay more to guarantee universal coverage (Deam, "Health care survey yields surprises for the medical community," Houston Chronicle, 4/27/15).

• A survey of 3,000 low-income residents in three states (Arkansas, Kentucky and Texas) found that low-income Americans view Medicaid as better than being uninsured, and better than private coverage in terms of quality and affordability of care. Private coverage was considered better for access to and respect from providers. Overall, nearly 80 percent of respondents in all three states supported Medicaid expansion (Epstein et al., "Low-income residents in three states view Medicaid as equal to or better than private coverage, support expansion," Health Affairs, November 2014).

ACA EXCHANGE UPDATE

• HHS' Inspector General is investigating state exchanges to see if they are misusing federal grant funding to pay for ongoing operations. A total of 37 states received grants from the federal government to establish exchanges, costing $4.8 billion since the law began. The exchanges add a fee to the cost of each plan sold, but that's usually not enough to cover operations, and state legislatures are reluctant to cover deficits (Ferris, "Auditor: States might be using ObamaCare grant money illegally," The Hill, 4/29/15).

• The Oregon Senate voted in March to close the Cover Oregon health insurance exchange. The site, which cost $305 million to build, never worked properly and Oregon and software giant Oracle are suing each other over the botched rollout. Oregon used the federal exchange, HealthCare.gov, to sign up individuals for the second open-enrollment period (Dickson, "Oregon's exchange closing after a history of tech woes," Modern Healthcare, 3/16/15).

GOP HEALTH PROPOSALS

• The GOP-dominated House's budget proposal didn't pass, but it did provide a glimpse of GOP health policy. The proposal called for (1) turning Medicaid into a block-grant program and slashing its budget in 2017 to $306 billion from the $386 billion currently projected by the CBO; (2) repealing the ACA, eliminating both the Medicaid expansion and subsidies for private coverage; and (3) transforming Medicare into a voucher program (Goozner, "The economic and political consequences of King v. Burwell," Modern Healthcare, 3/2/15).

INTERNATIONAL

• The U.S. spent $1,010 per capita on medications in 2012, more than in Australia ($588) and Germany ($668), two nations that, along with the U.K., use their government's purchasing power to obtain lower drug prices from pharmaceutical firms. Spending on specialty drugs accounted for a disproportionate share of U.S. drug costs – even before the introduction of costly new hepatitis C treatments – and is expected to balloon from $87 billion in 2012 to $400 billion by 2020. Although the VA and Medicaid receive statutory discounts, Medicare is legally barred from any price negotiation. In Australia, the Pharmaceutical Benefits Scheme, in operation since the late 1940s, negotiates prices with drug companies. In Germany, prices for drugs that are determined to have some added benefit over current therapy are negotiated between drug companies and the federal association of 131 "sickness funds" (nonprofit insurers that vary by the industries they cover, but all pay the same negotiated prices to providers). Those with no added benefit are priced the same as older therapies ("reference pricing"). Some drug companies won't sell their products in Germany to avoid clinical scrutiny. In the U.K., the NHS is required to pay for drugs approved by the National Institute for Health and Clinical Excellence (NICE), which analyzes the cost-effectiveness and safety of treatment. The U.K.'s Pharmaceutical Price Regulation Scheme negotiates prices with drug firms, with a cap on profit margins, and, since 2014, a limit on the annual growth in drug prices. Alternatively, drug companies can give the NHS a mandatory discount of 15 percent off the list price (a proposal would increase the discount to 25 percent); about 10 percent of branded medicines used by the NHS are priced this way ("Pharmaceutical Pricing: Lessons from Abroad," Kaiser Permanente Institute for Health Policy, May 2015).

• Rachel Notley was elected premier of Alberta, Canada, in May on a platform of restoring $1 billion in funding cuts and ending privatization of the health system. Her victory for the left-leaning New Democratic Party marks the end of 44 years of Conservative government. Notley opposed the growth of a two-tier health system and said she would eliminate regressive "personal levies," i.e. out-of-pocket payments by the sick ("Alberta health system needs new prescription," Calgary Sun, 4/29/15).

• Dutch family physicians recently staged a protest at the headquarters of Health Insurers Netherlands in Zeist to protest how much control health insurance companies have over contracts and payment arrangements. In March, they delivered a manifesto titled "Everything must change" to Health Minister Edith Schippers that was endorsed by 7,418 (65 percent) of the nation's family doctors. According to the manifesto, competition and an explosion in bureaucratic tasks dictated by the insurers is making it impossible to practice good primary care. They demand that doctors be removed from the nation's Competition Act and that the principle of cooperation, not competition, guide future health policy and insurance contracts. Stay tuned (Van Jaarsveldt, "Over 65 pct. of family doctors protest health insurers," NL Times, 4/17/15; http://www.hetroermoetom.nu/ accessed on 6/26/15).

HealthAffairs Blog

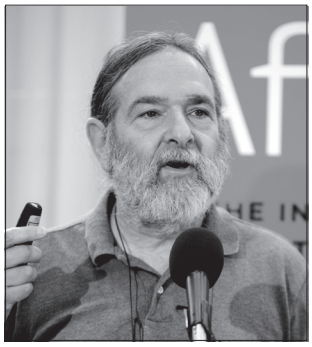
May 27, 2015

The Post-Launch Problem: The Affordable Care Act's Persistently High Administrative Costs

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

Last year we, and many others, drew attention to the chaotic and costly roll out of the Affordable Care Act's (ACA) exchanges. The chaos is mostly over (unless King prevails over Burwell), but the costs will linger on. The roughly $6 billion in exchange start-up costs pale in comparison to the ongoing insurance overhead that the ACA has added to our health care system – more than a quarter of a trillion dollars through 2022.

Dr. Steffie Woolhandler



Dr. David Himmelstein

Bloated Administrative Costs

We calculated these new overhead costs from the official National Health Expenditure Projections for 2012-2022 released by the Centers for Medicare and Medicaid Services (CMS)' Office of the Actuary in July 2014. The projections included separate tables projecting costs with, and without, the effects of the ACA, allowing calculation of the incremental insurance overhead costs directly attributable to the reform.

We use the July 2014 release of projected figures because the projections released subsequently no longer included any "without ACA" figures. Although the latest projections forecast slightly lower health care cost growth in the coming decade – 5.7 percent annually vs. 5.8 percent in the earlier release – this change would only minimally affect our estimates.

In health care, public insurance gives much more bang for each buck.

The table below shows the CMS actuaries' estimates for private insurance overhead and government program administration with and without the ACA. It also shows our estimates of the administrative cost increases attributable to the ACA, and the administrative cost per newly-insured person and as percent of federal government expenditures under the ACA (calculated using the CBO's estimates of coverage and cost).

Between 2014 and 2022, CMS projects $2.757 trillion in spending for private insurance overhead and administering government health programs (mostly Medicare and Medicaid), including $273.6 billion in new administrative costs attributable to the ACA. Nearly two-thirds of this new overhead – $172.2 billion – will go for increased private insurance overhead (data not shown in table).

Most of this soaring private insurance overhead is attributable to rising enrollment in private plans which carry high costs for administration and profits. The rest reflects the costs of running the exchanges, which serve as brokers for the new private coverage and will be funded (after initial startup costs) by surcharges on exchange plans' premiums.

Government programs – primarily Medicaid – account for the remaining $101.4 billion increase in overhead. But even the added dollars to administer Medicaid will flow mostly to private Medicaid HMOs, which will account for 59 percent of total Medicaid administrative costs in 2022. (The subcontracting of Medicaid coverage to private HMOs has nearly doubled Medicaid's administrative overhead, which has risen from 5.1 percent of total Medicaid expenditures in 1980 to 9.2 percent this year).

The $273.6 billion in added insurance overhead under the ACA averages out to $1,375 per newly insured person per year, or 22.5 percent of the total federal government expenditures for the program.

Better Options

Insuring 25 million additional Americans, as the CBO projects the ACA will do, is surely worthwhile. But the administrative cost of doing so seems awfully steep, particularly when much cheaper alternatives are available.

Traditional Medicare runs for 2 percent overhead, somewhat higher than insurance overhead in universal single payer systems like Taiwan's or Canada's. Yet traditional Medicare is a bargain compared to the ACA strategy of filtering most of the new dollars through private insurers and private HMOs that subcontract for much of the new Medicaid coverage. Indeed, dropping the overhead figure from 22.5 percent to traditional Medicare's 2 percent would save $249.3 billion by 2022.

The ACA isn't the first time we've seen bloated administrative costs from a federal program that subcontracts for coverage through private insurers. Medicare Advantage plans' overhead averaged 13.7 percent in 2011, about $1,355 per enrollee. But rather than learn from that mistake, both Democrats and Republicans seem intent on tossing more federal dollars to private insurers. Indeed, the House Republican's initial budget proposal would have voucherized Medicare, eventually diverting almost the entire Medicare budget to private insurers (the measure passed by the House on April 30 dropped the "premium support" voucher scheme).

In contrast, a universal single payer system would pare down both insurers' and providers' overhead, yielding huge administrative savings – $375 billion in 2012 according to one recent estimate.

In health care, public insurance gives much more bang for each buck.

Dr. David Himmelstein is a professor of public health at the City University of New York, a lecturer in medicine at Harvard Medical School, and a cofounder of Physicians for a National Health Program with Woolhandler. He received a medical degree from Columbia University; completed a medical residency at Highland Hospital in Oakland, California, and a fellowship in general internal medicine at Harvard University; and has practiced primary care internal medicine for three decades in Cambridge and the South Bronx.

Dr. Steffie Woolhandler has earned degrees from Stanford University (BA Economics), LSU Medical Center (MD), and U.C. Berkeley (MPH) as well as an honorary degree from Harvard (MA). She has worked as a primary care internist for decades, has authored over a hundred scientific articles on health and health care policy, and is a well-known advocate for nonprofit, single-payer national health insurance. She is currently a professor of public health at CUNY School of Public Health at Hunter College and a lecturer in medicine at Harvard Medical School.

Table 1

Year	Private Insurance Overhead + Government AdministrationWith ACA[a] ($ billions)	Private Insurance Overhead + Government Admininstration Without ACA[a] ($ billions)	Change in Private + Government Overhead Due to ACA[b] ($ billions)	Annual Overhead Per Newly Insured Person With ACA[c] ($s/person)	New Overhead as % of Federal Costs Under ACA[c]
2014	241.3	224.2	17.1	1,427	45.1
2015	259.7	233.9	25.8	1,519	32.7
2016	271.4	234.7	36.7	1,594	31.6
2017	284.1	255.6	28.5	1,873	20.4
2018	297.6	268.9	28.7	1,196	18.9
2019	318.7	286.2	32.5	1,353	20.2
2020	339.2	305.9	33.3	1,330	19.8
2021	361.8	326.3	35.5	1,419	20.2
2022	383.6	348.1	35.5	1,420	19.1
Total, 2014-2022	2,757.4	2,483.8	273.6	1,375	22.5

Notes

a. Source: National Health Expenditure Projections 2012-2022 Tables 2A and 2B (version archived on July 23, 2014).

b. Authors calculation from previous 2 columns.

c. Calculation of costs per newly insured person and new overhead as percent of new federal costs are based on estimates of coverage and costs under the ACA from: Congressional Budget Office. Insurance coverage provisions of the Affordable Care Act – CBOs March 2015 baseline. Data for 2014 are from the CBO's April 2014 Baseline.

TORONTO STAR

April 28, 2015

Why this U.S. doctor is moving to Canada

After five years of constant fighting with multiple private insurance companies to get paid, Dr. Emily Queenan decided to try her luck up north

By Emily S. Queenan, M.D.

I'm a U.S. family physician who has decided to relocate to Canada. The hassles of working in the dysfunctional health care "system" in the U.S. have simply become too intense.

I'm not alone. According to a physician recruiter in Windsor, Ont., over the past decade more than 100 U.S. doctors have relocated to her city alone. More generally, the Canadian Institute for Health Information reports that Canada has been gaining more physicians from international migration than it's been losing.

Like many of my U.S. counterparts, I'm moving to Canada because I'm tired of doing daily battle with the same adversary that my patients face – the private health insurance industry, with its frequent errors in processing claims (the American Medical Association reports that one of every 14 claims submitted to commercial insurers are paid incorrectly); outright denials of payment (about one to five per cent); and costly paperwork that consumes about 16 percent of physicians' working time, according to a recent journal study.

I've also witnessed the painful and continual shifting of medical costs onto my patients' shoulders through rising co-payments, deductibles and other out-of-pocket expenses. According to a survey conducted by the Commonwealth Fund, 66 million – 36 percent of Americans – reported delaying or forgoing needed medical care in 2014 due to cost.

My story is relatively brief. Six years ago, shortly after completing my residency in Rochester, New York, I opened a solo family medicine practice in what had become my adopted hometown.

I had a vision of cultivating a practice where patients felt heard and cared for, and where I could provide full-spectrum family medicine care, including obstetrical care. My practice embraced the principles of patient-centered collaborative care. It employed the latest in 21st-century technology.

I loved my work and my patients. But after five years of constant fighting with multiple private insurance companies in order to get paid, I ultimately made the heart-wrenching decision to close my practice down. The emotional stress was too great.

It broke my heart to have to pressure my patients to pay the bills their insurance companies said they owed. Private insurance never covers the whole bill and doesn't kick in until patients have first paid down the deductible. For some this means paying thousands of dollars out-of-pocket before insurance ever pays a penny. But because I had my own business to keep solvent, I was forced to pursue the balance owed.

I spoke with other physicians, both inside and outside my specialty, about alternatives. We invariably ended up talking about the tumultuous time that the U.S. health care system is in – and the challenges physicians face in trying to achieve the twin goals of improved medical outcomes and reduced cost.

Dr. Emily Queenan

The rub, of course, is that we're working in a fragmented, broken system where powerful, moneyed corporate interests thrive on this fragmentation, finding it easy to drive up costs and outmaneuver patients and doctors alike. And having multiple payers, each with their own rules, also drives up unnecessary administrative costs – about $375 billion in waste annually, according to another recent journal study.

I knew that Canada had largely resolved the problem of delivering affordable, universal care by establishing a publicly financed single-payer system. I also knew that Canada's system operates much more efficiently than the U.S. system, as outlined in a landmark paper in The New England Journal of Medicine on administrative costs. So I decided to look at Canadian health care more closely.

I liked what I saw. I realized that I did not have to sacrifice my family medicine career because of the dysfunctional system on our side of the border.

In conversations with my husband, we decided we'd be willing to relocate our family so I could pursue the career in medicine that I love. I'll be starting and growing my own practice in Penetanguishene on the tip of Georgian Bay this autumn.

I'm excited about resuming my practice, this time in a context that is not subject to the vagaries of backroom deals between moneyed, vested interests. I'm looking forward to being part of a larger system that values caring for the health of individuals, families and communities as a common good – where health care is valued as a human right.

I hope the U.S. will get there some day. I believe it will. Perhaps our neighbor to the north will help us find our way.

Emily S. Queenan, M.D., currently resides in Rochester, New York, where she had, for five years, a solo full-spectrum family medicine practice.

The Charlotte Observer

April 9, 2015

Taming high healthcare bills

By Jessica Schorr Saxe, M.D.

"Skin in the game." The phrase pops up frequently in health insurance discussions, as it did twice in the recent Charlotte Observer article about high deductible policies ("A Growing Risk: High Deductible Health Plans Can Ruin Finances," April 9).

In finance, the phrase refers to high-level executives investing their own money in stock in their company, so that they have a stake in its performance.

In health care, it refers to "consumers" having financial responsibility – in the form of high deductibles and co-pays in their insurance plans – for their health care so that they will be "smarter shoppers." This raises a number of questions.

What problem is it solving?

The call for skin in the game implies that Americans are profligate over-users of health care. In fact, we have fewer doctors, see them less frequently, and spend less time in the hospital than residents of most other developed countries.

According to the Commonwealth Fund, more than one-third of Americans missed medical care because of cost in 2014. And more than one-third of non-elderly adults have a problem with paying their medical bills or debt. It seems we already have plenty of skin in the game.

Does it promote smarter choices?

Cost-sharing does decrease medical expenditures in the short term. But, according to the Robert Wood Johnson Foundation, "patients do not accurately discriminate between essential and nonessential services when responding to changes in cost-sharing."

Avoiding a doctor visit to check your high blood pressure or skimping on a recommended medication because you have a high deductible might not turn out to be such a smart decision.

Does it save money? And, if so, for whom?

It certainly saves money for private health insurance companies: if patients don't get care, insurers don't have to pay for it. Healthy families who manage to avoid seeking medical care might see savings. But most people who have the misfortune to get sick are likely to find deductibles of thousands of dollars hard to pay. Such families have other losses in income, such as missed days of work for the patient and the caretaker, exacerbating their financial hardship.

With regard to national health care expenses, almost half are incurred by the 5 percent of people who are seriously ill. These people will not save money by putting skin in the game – they are likely already down to the bone. Robert Wood Johnson notes that increased cost-sharing will likely have no impact on national health spending.

Are patients the major drivers of excessive procedures?

Almost everyone knows someone who had an unnecessary MRI. But does that impetus come strictly from the patient? Medical device makers and pharmaceutical companies invest a lot of money in making us think we need more procedures and drugs. As a practicing physician, I noted that it was faster to order a test or lab than to do a meticulous exam. Our fee-for-service system has provided many people (other than patients) incentives for excessive spending.

Dr. Jessica Schorr Saxe

Is this how we want medical decisions made?

A recent Medical Economics article about dealing with high-deductible plans tells doctors that they need to adjust their care by discussing costs and options as defined by the patient's insurance plan. As a patient, I would like my doctor to let me know what recommendations are optional. Even if fully covered by insurance, I might prefer to spend my afternoon somewhere other than in a radiology waiting room or in a lab. Shouldn't doctors be advising everyone on what is medically indicated – and not spending precious, limited time with patients discussing cost?

Whom is insurance supposed to protect, anyway?

Do we evaluate the value of fire insurance by whether people who don't have fires feel secure in having it? Or by whether it protects those who actually have house fires?

Maybe health insurance is the wrong model after all. It differs from other insurance programs. Everyone needs health care, whereas not everyone needs fire care. Insuring against only catastrophic events (which high deductibles do) will ensure more catastrophic events, because of the resulting avoidance of primary and preventive care.

Americans need health care, but not private health insurance. We need accessible, affordable care without high deductibles or other barriers. Let's drop the "skin in the game" cliché like a hot potato and use constructive language and thought to move toward a single-payer health care system – with real savings in administrative and drug costs – that would provide care for all.

The writer is a Charlotte physician and chair of Health Care Justice-NC, a group of health professionals and non-medical providers pursuing a single-payer, universal healthcare system.

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March 6, 2015

Health care law did not end discrimination against those with pre-existing conditions

By Kay Tillow

In 2010 the giant health insurance company WellPoint created an algorithm that searched its database, located breast cancer patients, and targeted them for cancellation of their policies.

A few years earlier Michael Moore's stunning documentary, "Sicko," showed an unending list of illnesses that had been used by insurers to refuse to sell people policies, to charge them much more, or to deny payment for "pre-existing conditions."

The public became acutely aware of these harmful, widespread practices and sharply condemned them. So it was not by chance that this insistent popular support resulted in inclusion of a ban on these practices in the Affordable Care Act (ACA) that was passed in 2010.

The government website explains: "Your insurance company can't turn you down or charge you more because of your pre-existing health or medical condition like asthma, back pain, diabetes, or cancer. Once you have insurance, they can't refuse to cover treatment for your pre-existing condition."

Even some Republicans who are trying to repeal the ACA insist that they stand for keeping a provision against such discrimination. "We would protect people with existing conditions," say Reps. Paul Ryan, John Kline, and Fred Upton.

Regardless of opinions on mandates or the health reform law in general, the entire nation embraced the part of the legislation that outlawed discrimination on the basis of illness.

So we've won, right, at least this much reform? Sadly, no.

A letter to Burwell

Last July, over 300 patient advocacy groups wrote to Sylvia Burwell, secretary of health and human services, to express their concerns. "(W)e are increasingly aware of evidence that new enrollees, especially those with chronic health conditions, are still facing barriers to care," the letter said.

The groups that signed the letter are well known. They include the American Lung Association, Epilepsy Foundation, The Leukemia and Lymphoma Society, National Alliance on Mental Illness, The Parkinson's Association, Easter Seals, and the AIDS Institute. They praised the ACA for helping many of their members to finally get coverage. All of these groups supported the ACA prior to its passage and still do.

The letter urges action against discriminatory benefit designs that limit access for patients that were subjected to pre-existing conditions restrictions prior to the ACA. They spell it out. Some plans do not include all the drugs prescribed for enrollees. Some plans don't cover critical medications including combination therapies. Plans can remove medications during the plan year. Some plans are restricting access to drugs by requiring prior authorization, step therapy, and quantity limits. The network of physicians and hospitals in some plans is so narrow as to deny patients the specialty care needed. Much of the information needed for patients to choose the most appropriate plan is not available.

Kay Tillow

The letter details the damage. High cost sharing means patients don't get the drugs they need. Some plans sold on the exchanges require patients to pay 30, 40 or 50 percent for drugs that go for several thousand dollars a month. HIV drugs, certain cancer medications, and multiple sclerosis drugs are among them.

The Leukemia & Lymphoma Society found exchange plans in several states that charged patients with blood cancer as much as 50 percent co-insurance rates.

Charis Hill, a biking enthusiast from Sacramento, California, counted on the medication Enbrel to keep her moving despite her diagnosis of ankylosing spondylitis. But then the cost went up to $2,000, far more than she could afford. "Insurance companies are basically singling out certain conditions by placing some medications on high-cost tiers," Ms. Hill said. She called it "pretty blatant discrimination."

Julie Davis, a young wife and mother of two from Louisville, Kentucky, is struggling with the consequences of this failure to end the discrimination. Her epilepsy medication, Keppra, that had kept her stable and seizure free suddenly skyrocketed from $60 per month co-pay to $1,200. The high price forced her to change medications in spite of the professional judgment of her physician. The seizures returned. With the problem not yet solved, Ms. Davis has written an op-ed and testified before the Kentucky Senate Health and Welfare Committee. She and her organization, the Epilepsy Foundation of Kentuckiana, are publicizing the injustice and working to pass state legislation to cap drug co-pays in Kentucky.

HIV/AIDS patients have had to struggle to obtain the drugs crucial to their survival. Carl Schmid, deputy executive director of the AIDS Institute, asserted that "limited benefit coverage,

(continued on next page)

Science
AAAS

June 19, 2015

Health care reform unethical by research standards

By James G. Kahn, M.D., and Paul Hofmann, Dr.P.H.

A. Finkelstein and S. Taubman report on the underuse of randomized controlled trials for U.S. health care reform ("Randomize evaluations to improve health care delivery," Policy Forum, 13 February, p. 720). This reliance on suboptimal research compromises information needed for policy. However, a second problem about health reform decision-making is more serious, constituting a major ethical breach.

The principles of research with humans require that deviations from the standard of care are allowable only if there is real uncertainty regarding which intervention is better. This is called the "principle of equipoise"; only when we don't know which strategy yields the best results is it acceptable to compare them .[1]

Yet for health care reform writ large—i.e., the basic payment system—there is no equipoise. Research from dozens of developed countries demonstrates convincingly that single-payer financing reduces costs, assures access, and improves outcomes. [2-3]

To ignore this compelling evidence risks lives in the United States as we experiment with partial fixes to the multi-payer system. This experimentation would be rejected by any responsible university institutional review board as violating the principle of equipoise and causing unacceptable patient harm.

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

cost-sharing for medications that can reach as high as 50 percent, and lack of transparency … mean many patients … are not receiving the care and medications they need."

Even the insurance commissioner of the state of Washington, Mike Kreidler, said "there is no question" that "discrimination is creeping back."

After spelling out the many ways in which patients with chronic conditions are denied access to medications and specialists, the letter concludes: "We believe these practices are highly discriminatory against patients with chronic health conditions and may, in fact, violate the ACA non-discrimination provisions."

Burwell's response

On October 27, 2014, Secretary Burwell responded to the letter. She said they would take a look at all of the issues and work to make it better for the future.

The dialog between Burwell and the patient advocacy groups continues. The advocacy groups urge a crackdown on the companies that continue to discriminate.

As of February 2015, a study by Avalere Health found that some exchange plans place all drugs used to treat complex diseases – such as HIV, cancer, and multiple sclerosis – on the highest cost-sharing tier. In 2015 an even higher number of the plans in the exchanges have placed drugs necessary for special conditions on tiers out of reach for patients. "In spite of the pushback, it's getting worse, not better," said Don McCanne, M.D., Physicians for a National Health Program policy expert.

When patients can see that their medication is not covered or is far too expensive, they will avoid those plans. That will allow those insurers to "lemon drop," to keep those who have expensive chronic conditions out of their plans. The impact is the same as underwriting and rescission. Good for profits, bad for patients.

Insurance companies have more tricks than wily coyote. Their power at the center of our profit-based health care system leaves them in position to defy the law and call the shots. With most of the enforcement left to understaffed state regulators and violations ubiquitous, we can expect the insurance companies to continue to avoid the sick, to price care beyond their reach, and to find ways to refuse payment.

No other nation in the industrialized world allows insurance companies to run their health care system. Discrimination is inherent in for-profit health care. The United States has tried every solution that the insurance companies and their paid experts can devise. It's now time to admit that to end the discrimination we must move to single-payer public financing that frees our health care from the control of the insurance and drug industries.

Kay Tillow is a leader of Kentuckians for Single Payer Health Care and the All Unions Committee for Single Payer Health Care–HR 676. She resides in Louisville, Ky.

The Des Moines Register
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March 10, 2015

The 'Un'-Affordable Care Act is a weak start

By David E. Drake, D.O.

Potential 2016 presidential candidate Sen. Bernie Sanders has stated: "There is one major country on Earth that does not guarantee health care as a right for all. There is one major country on Earth that spends twice as much per capita on health care as almost any other. There is one major country on Earth where private insurance companies and drug companies earn huge profits. Guess which country."

As a physician in private practice I abhor each coming new year. This is the time when health care practices have to deal with patients with new insurance policies and former policies with stringent regulations. This year, more than any previous time, I'm noticing more and more folks who have high deductibles – allowed up to $6,600 with the Affordable Care Act (Obamacare). And for some folks that means they can't see me or they have to greatly limit the number of times they can receive services from me.

In some cases I have to refer middle-class folks with these high deductibles to places with sliding scales, places I used to refer indigent folks with no insurance. Not seeking or delaying care can lead to delayed diagnoses and possible tragic consequences. And as Michael Moore has pointed out, now it's the middle class who are hit with being under- or poorly-insured, while more indigent folks now have an expansion of Medicaid. The confusing mix of deductibles, co-pays, co-insurance and limitations on what services can be provided are now daily frustrations with our lack of guaranteed health care for all.

A single-payer system of reimbursement for health care services has never seemed more in need, with 38 percent of Americans citing health care costs they pay out of pocket as a somewhat or significant level of stress, according to the physician website Doximity.

Health care bills could go to one payer – an expansion and enhancement of Medicare – with a great reduction in administrative costs for paying the bills and for providers of health care and their offices. Single payer does not imply a system like the Veterans Administration, where all the providers are employees, but one that allows for private as well as employed practices.

Other Iowans join me in their support for moving the ACA past the private insurance companies as the regulating and paying source.

Dr. Maureen McCue, adjunct clinical professor at the University of Iowa, medical director of the Women's Clinic, and coordinator of the Iowa chapter of Physicians for Social Responsibility, wrote me:

Dr. David Drake

"Tinkering at the edges doing little to rein in the excesses of the profit-driven insurance system, pharmaceutical and biotech industries, and others. While allowing more citizens access to health insurance, the complexity of the new insurance mechanisms means accessing the health system itself has become ever more confusing and obtuse."

Dr. McCue offers hope for a change: "It doesn't have to be this way. There are tried and true solutions. The world's healthiest populations pay far less for medical services."

Douglas Steenblock is a physician from Marshalltown with extensive experience working in both the private and public sectors in his field of psychiatry. "It is unfortunate that Americans are so polarized when it comes to our medical system. Many people seem to think that any departure from our current profit-driven system represents 'socialized medicine' and that there is nothing in between the two extremes. I find it interesting that the ACA has been described as 'government-run healthcare,' when it is actually appears to be private healthcare run amok. The healthcare industry stands to profit handsomely from Obamacare, which explains why it was allowed to pass in the first place."

Former state Rep. Ed Fallon wrote me: "While some aspects of the ACA move us forward toward a more fair and just health care system, the insurance industry remains the entrenched powerhouse that pulls the purse strings and calls the shots."

Middle-class Iowans and Americans in general have much to gain from moving beyond the ACA. We will get to equitable health care for all in the U.S. It is simply the right thing to do.

Dr. David E. Drake is an adjunct clinical professor at Des Moines University and a relationship psychiatrist in private practice.

BMJ

April 1, 2015

Effect of Massachusetts healthcare reform on racial and ethnic disparities in admissions to hospital for ambulatory care sensitive conditions: retrospective analysis of hospital episode statistics

By Danny McCormick, M.D., M.P.H., Amresh D. Hanchate, Ph.D., Karen E. Lasser, M.D., M.P.H., Meredith G. Manze, Ph.D., M.P.H., Mengyun Lin, M.P.H., Chieh Chu, M.A., Nancy R. Kressin, Ph.D.

Abstract

Objectives. To examine the impact of Massachusetts healthcare reform on changes in rates of admission to hospital for ambulatory care sensitive conditions (ACSCs), which are potentially preventable with good access to outpatient medical care, and racial and ethnic disparities in such rates, using complete inpatient discharge data (hospital episode statistics) from Massachusetts and three control states.

Design. Difference in differences analysis to identify the change, overall and according to race/ethnicity, adjusted for secular changes unrelated to reform.

Setting. Hospitals in Massachusetts, New York, New Jersey, and Pennsylvania, United States.

Participants. Adults aged 18-64 (those most likely to have been affected by the reform) admitted for any of 12 ACSCs in the 21 months before and after the period during which reform was implemented (July 2006 to December 2007).

Main outcome measures. Admission rates for a composite of all 12 ACSCs, and subgroup composites of acute and chronic ACSCs.

Results. After adjustment for potential confounders, including age, race and ethnicity, sex, and county income, unemployment rate and physician supply, we found no evidence of a change in the admission rate for overall composite ACSC (1.2%, 95% confidence interval −1.6% to 4.1%) or for subgroup composites of acute and chronic ACSCs. Nor did we find a change in disparities in admission rates between black and white people (−1.9%, −8.5% to 5.1%) or white and Hispanic people (2.0%, −7.5% to 12.4%) for overall composite ACSC that existed in Massachusetts before reform. In analyses limited to Massachusetts only, we found no evidence of a change in admission rate for overall composite ACSC between counties with higher and lower rates of uninsurance at baseline (1.4%, −2.3% to 5.3%).

Conclusions. Massachusetts reform was not associated with significantly lower overall or racial and ethnic disparities in rates of admission to hospital for ACSCs. In the US, and Massachusetts in particular, additional efforts might be needed to improve access to outpatient care and reduce preventable admissions.

BMJ 2015;350:h1480

Comments on the study at PNHP's blog

By Don McCanne, M.D.

Goals of Massachusetts health care reform included extending coverage to low-income individuals (disproportionately comprising racial and ethnic minorities) and to reduce disparities in care. … So how has Massachusetts done? This study looked specifically at the rates of admission to hospitals for conditions that are sensitive to ambulatory care. With better access to outpatient care hospitalization rates should be lower, with racial and ethnic disparities diminishing. These did not happen. …

Although many factors contribute to the disparities, insurance should reduce financial barriers and thus improve access. Why didn't that happen here? Some blame should lie with the model of reform selected. In spite of mandates for coverage, many people still remain uninsured. Also the cost sharing associated with health plans erect financial barriers to care. Further, both narrow networks of the plans and the lack of willing providers reduce access. These factors can be enough to explain why there was no improvement in spite of the full implementation of the Massachusetts reform. We can anticipate the same disappointing results nationally in the years following full implementation of ACA since it incorporates the same policy deficiencies. …

Instead of an individual mandate, everyone should be covered automatically. Instead of erecting financial barriers to care, the health care system should be fully prepaid with first dollar coverage. Instead of perpetuating the administrative complexity of a multi-payer system of public and private insurers, one single simplified system should be put in place. Instead of separate restricted networks of providers, all professionals and institutions should be covered by one single program … such as an improved Medicare that covers everyone. That's what we need.

PNHP note: To subscribe to Dr. McCanne's "Quote of the Day" on health policy, visit www.pnhp.org/qotd.

FEATURE

ESSAY

Justifying conflicts of interest in medical journals: a very bad idea

A series of articles in the *New England Journal of Medicine* has questioned whether the conflict of interest movement has gone too far in its campaign to stop the drug industry influencing the medical profession. Here, three former senior *NEJM* editors respond with dismay

Robert Steinbrook *professor adjunct of internal medicine*[1], Jerome P Kassirer *distinguished professor*[2], Marcia Angell *senior lecturer on social medicine*[3]

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A seriously flawed and inflammatory attack on conflict of interest policies and regulations appeared recently in a most unexpected location: the venerable and trusted *New England Journal of Medicine (NEJM)*. In a series of rambling articles, one of the journal's national correspondents, Lisa Rosenbaum, supported by the editor in chief, Jeffrey Drazen, tried to rationalise financial conflicts of interest in the medical profession.[1-4] As former senior editors of the *NEJM*, we find it sad that the medical journal that first called attention to the problem of financial conflicts of interest among physicians would now backtrack so dramatically and indulge in personal attacks on those who disagree.

Physicians and the public rely on journals as unbiased and independent sources of information and to provide leadership to improve trust in medicine and the medical literature. Yet financial conflicts of interest have repeatedly eroded the credibility of both the medical profession and journals.[5 6] As the Institute of Medicine explained in its 2009 report, a conflict of interest is "a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest." The key issue is that "a conflict of interest exists whether or not a particular individual or institution is actually influenced by the secondary interest."[7] The report drew heavily on a 1993 *NEJM* article by Dennis Thompson, not cited by Rosenbaum, which made clear that the rules "do not assume that most physicians or researchers let financial gain influence their judgment. They assume only that it is often difficult if not impossible to distinguish cases in which financial gain does have improper influence from those in which it does not."[8]

The *NEJM* has now sought to reinterpret and downplay the importance of conflicts of interest in medicine by publishing articles that show little understanding of the meaning of the term. The concern is not whether physicians and researchers who receive industry money have been bought by the drug companies, as Drazen writes,[4] or whether members of guideline panels or advisory committees to the US Food and Drug Administration with ties to industry make recommendations that are motivated by a desire for financial gain, as Rosenbaum writes.[1 3] The essential issue is that it is impossible for editors and readers to know one way or the other.[6 7]

Judges are expected to recuse themselves from hearing a case in which there are concerns that they could benefit financially from the outcome. Journalists are expected not to write stories on topics in which they have a financial conflict of interest. The problem, obviously, is that their objectivity might be compromised, either consciously or unconsciously, and there would be no easy way to know whether it had been. Yet Rosenbaum and Drazen seem to think it is insulting to physicians and medical researchers to suggest that their judgment can be affected in the same way. Doctors might wish it were otherwise, but none of us is immune to human nature.

Straw men

Rosenbaum's language is colorful, but her arguments for the purported harms of conflict of interest policies and regulations are fanciful and data-free. No one is proposing that "we prevent the dissemination of expertise, thwart productive collaborations, or dissuade patients from taking effective drugs," or allow "true experts to be replaced—on advisory panels, as authors of reviews and commentaries, in other capacities of authority—by people whose key asset is being conflict-free."[3] Where is the evidence of "a loud chorus of shaming,"[2] or "a stifling of honest discourse,"[2] or that "the license to trample the credibility of

physicians with industry ties has silenced debate?"[3] Silliness and fear mongering about straw men are masquerading as scholarly analysis.

In 2014, under the Open Payments program (the Physician Payment Sunshine Act which is part of the Affordable Care Act), the Centers for Medicare and Medicaid Services in the United States published 4.45 million financial transactions from healthcare industries to physicians and teaching hospitals over just the last five months of 2013; the total value was nearly $3.7bn (£2.4bn; €3.4bn).[9] When full data for 2014 are reported later in 2015, the amounts may well exceed $9bn. Drug and device companies are investor owned businesses that are required to maximize profits by any legal means. These companies are not charities, so they expect to get something in return for all the largesse; the evidence is that they do, and it is naive to explain the situation otherwise.

Put simply, financial conflicts of interest in medicine are not beneficial, despite strained attempts to justify them and to make a virtue of self interest. Unmistakably, collaborations between academia and industry can speed medical progress and benefit patients. Such partnerships, however, can flourish with far less money in aggregate flowing from drug and device manufacturers to physicians and their institutions, and without the web of other lucrative ties between industry and physicians that lack a clear scientific or medical purpose. There are few reasons for physicians and other investigators to have financial associations with industry other than research support and bona fide consulting related to specific research programs and projects. Physicians who develop products and hold patents or receive royalties should not evaluate the product. Other types of payments, such as speakers' and other personal fees, payments to be ghost authors of review articles, and ill defined consulting arrangements, distort physicians' work and undermine our independence, as has been repeatedly documented. And there are no excuses for outright gifts, such as meals, travel, lodging expenses, and entertainment.

Editorial responsibility

In 1984, the late Arnold S Relman, then the *NEJM*'s editor in chief, instituted the first conflict of interest policy at any major medical journal.[10] The policy required authors of research papers to disclose all financial ties they had to health industries, and if the ties were deemed significant they were published. In 1990, Relman extended the policy to prohibit authors of editorials and review articles from having any financial interest in a company (or its competitor) that was discussed in the article, since these types of manuscripts do not contain primary data but rely exclusively on the authors' judgment in citing and interpreting the literature.[11] As Relman's successors, two of us (JPK and MA) continued these policies. We found that it was sometimes difficult, but nearly always possible, to find outstanding authors with the needed expertise and without a conflict of interest to write editorials and review articles.[12] In 2002, however, after Drazen succeeded Angell, the policy was weakened, so that it only applied to authors with "any significant financial interest in a company (or its competitor) that makes a product discussed in the article."[13] To its credit, *The BMJ* has taken the opposite approach and implemented a zero tolerance policy on educational articles by authors with industry ties.[14]

The privilege to serve as an editor of a major medical journal is accompanied by the responsibility to provide leadership on the critical issues that define the profession. How medicine responds to conflicts of interest and earns the trust of the larger society in which we exist is one such issue. In 1990, it was a bad idea for authors of editorials, review articles, and other opinion articles in medical journals to have financial conflicts of interest. A quarter of a century later, it is a very bad idea. The articles by Rosenbaum and the supportive editorial by Drazen could presage a further weakening of the conflict of interest policy at the *NEJM*, or they could serve as a wake-up call for all medical journals and the profession. It is time to move forward, not backward.

Competing interests: We have read and understood BMJ policy on declaration of interests and declare RS was deputy editor and national correspondent at *NEJM* and is now editor at large and viewpoints editor at *JAMA Internal Medicine*. JPK and MA were both editors in chief of *NEJM.*

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THE HUFFINGTON POST
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June 9, 2015

Where is Hillary on health care?

By John Geyman, M.D.

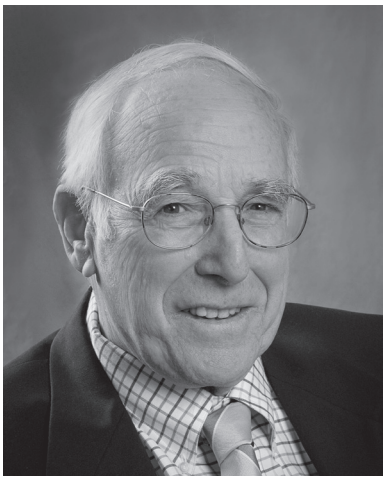
Twenty-one years ago, Hillary Clinton, then leading the presidential committee proposing a health care reform plan, made these statements in speaking to a group at Lehman Brothers Health Corporation on June 15, 1994, as revealed by a transcript made public through the Clinton Presidential Library:

> If there is not health care reform this year, and if, for whatever reason, the Congress doesn't pass health care reform … I believe that by the year 2000 we will have a single-payer system. … I don't even think it's a close call politically.
>
> I think that the momentum for a single-payer system will sweep the country … it will be such a huge popular issue … that even if it's not successful the first time, it will eventually be. …
>
> There are only three ways [to get to universal coverage]. You either have a general tax – the single-payer approach that replaces existing private investment – or you have an employer mandate, or you have an individual mandate.[1]

Now, two decades later, it is helpful to recall what happened to the Clinton Health Plan (CHP). After heated battles among competing stakeholders and their lobbyists, the CHP became more complex, expensive and confusing (1,342 pages), and died in committee without getting to a floor vote in the House. Colin Gordon, historian at the University of Iowa, described what happened to the bill this way:

The CHP's fatal flaw, at least in these terms, lay in its attempt to combine employer mandates (which attracted health interests and repelled many employers) and cost control (which attracted employers and repelled health interests). This pairing made for a slow dance to the right, as reaction set in from all quarters against employer mandates, against spending controls, against any increased federal presence in health care.[2]

The unfortunate end of the CHP could have been predicted by how the Clinton Health Care Task Force was selected – it brought together the key stakeholders in the medical-industrial complex, including the insurance and pharmaceutical industries, that themselves were responsible for health care system problems of access, costs, and quality. Though they might agree to a concept of "managed competition", there were deep divisions and separate agendas within and among stakeholders – as examples, big insurers were at odds with small insurers, while big business could support employer mandates as small business opposed them.[3]



Dr. John Geyman

The status of the Affordable Care Act (ACA), or Obamacare, enacted in 2010, is more familiar to us, but has striking similarities to the CHP. President Obama again chose to primarily involve corporate stakeholders in the medical-industrial complex in the planning and development of Obamacare, with its (watered-down) employer and individual mandates. The interests of insurers, the drug and medical device industries, hospitals and organized medicine took precedence over the needs of patients for broad access to affordable quality health care.

In fact, five years later, it is clear that these stakeholders have received a bonanza of expanded markets without real cost controls and still with many millions of Americans uninsured and tens of millions underinsured. Wall Street tells that story, as illustrated by health care stocks increasing by 40 percent in 2013, the highest of any sector in the S&P 500[4] and venture capital funding for health technology firms soaring by 176 percent in the first eight months of 2014 compared to the previous year.[5]

It is still completely unclear where Hillary stands on health care reform. Her recent comments suggest she supports the ACA as the best that can be done. Much of the public is concerned about her close ties to Wall Street and questions her trustworthiness on today's issues. Can she learn from the failure of the CHP and the problems of the ACA? She claims to want to champion the interests of the middle class, but will that include taking on corporate interests in our deregulated marketplace? How can we trust her punditry as a health care "expert" based on her apparent resistance to even bringing up single payer after her predictions 20-plus years ago?

The time has come for real leadership on health care, not continuing misguided and ill-informed rhetoric.

The upcoming debates among Democratic presidential candidates, followed by those between the two parties' candidates, will be a test of Hillary Clinton's credibility on health care re-

(continued on next page)

THE BLADE
One of America's Great Newspapers

March 8, 2015

Expanding Medicare for all would be wise

By Johnathon Ross, M.D.

The U.S. Supreme Court is hearing another case attacking Obamacare ("Bad case against Obamacare," editorial, March 4). This will not be the last.

The complexity of the Affordable Care Act makes it easy to attack. The 19,000 members of Physicians for a National Health Program, of which I am past president, agree it would be tragic, possibly fatal, for those with Obamacare subsidies to lose coverage.

But these attacks confirm that more durable and effective reform is needed. We would prescribe a constitutional remedy that is known to work – improved and expanded Medicare for all.

That would have many advantages over private insurance marketplaces. Medicare's financing is fair – all contribute and all benefit, versus a marketplace of private insurance that will ration care by ability to pay. Medicare's benefits are inclusive and generous, versus private insurance, which seems to be exclusionary, greedy, mean-spirited, and arbitrary.

Medicare for all would allow complete choice of providers, with access to services we prefer, versus private insurance with restricted provider networks and other barriers to care.

Medicare for all would focus on long-term improvements in the health of the nation with public accountability based on professional values, versus private insurance, which must focus on short-term profits, trade secrets, and commercial – and sometimes near-criminal – values. Multiple studies confirm that the simplicity of Medicare for all would save $400 billion a year – enough to cover all the uninsured and improve benefits for the rest of us.

We need to move on quickly from Obamacare. Improved and expanded Medicare for all will save money and save lives. It is the right thing to do.

Dr. Johnathon Ross resides in Ottawa Hills, Ohio.

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

form as well as the integrity of the "mainstream" media covering them. Let's hope that substance prevails over misleading and disingenuous rhetoric.

What if Hillary took a bold position in support of single-payer health care financing reform? If she did, she would follow in the steps of Teddy Roosevelt as a presidential candidate in 1910 and Harry Truman in 1948. She would have broad support of a majority of the American people, as shown by national polls over many years, and dating back to the 1940s, when 74 percent of the public supported a proposal for national health insurance.[6]

She would also have the support of a majority of physicians and other health care professionals, who would find a single-payer system far less bureaucratic than what we now have, with more time for more satisfying direct patient care. As one example of that support, 59 percent of U.S. physicians in 13 specialties support national health insurance, according to a large national study in 2008.[7]

The time has come for real leadership on health care, not continuing misguided and ill-informed rhetoric. We have 35 years' experience with marketplace-based "attempts" to make health care accessible and affordable – all have failed as the business "ethic" prevails over a service ethic in the public interest. Will Hillary step up to the challenge? If so, she can take charge of the health care debate, expose the lack of effective Republican plans for health care, win in 2016, and govern for two terms while setting a landmark legacy in this country.

Dr. John Geyman is professor emeritus of family medicine at the University of Washington School of Medicine in Seattle, a member of the Institute of Medicine, and past president of Physicians for a National Health Program. He is the author of more than 160 scholarly articles and more than a dozen books, the most recent of which is "How Obamacare is Unsustainable: Why We Need a Single-Payer Solution for All Americans" (Copernicus Healthcare, 2015).

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PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

April 12, 2015

SGR fix's new merit-based payment system for doctors will generate scores that are worse than useless

By Kip Sullivan, J.D.

The Medicare Access and CHIP Reauthorization Act of 2015, H.R. 2, the bill passed by the House of Representatives late in March to repeal the Sustainable Growth Rate formula [*and signed into law in April*], instructs the Secretary of Health and Human Services to measure the "total performance" of hundreds of thousands of doctors every year. "Total performance" is to be measured by a "composite performance score." This score will be some number between zero and 100.

According to the authors of H.R. 2, "total performance" refers to both the cost and quality of care. It is extremely difficult and costly to measure accurately either "total cost" or "total quality" alone, especially at the level of the individual doctor (as opposed to large groups of doctors).

Combining an inaccurate score for quality with an inaccurate score for cost to derive a "composite performance" is not a good idea. But even if each score were accurate, it would still not be a good idea because the decision about how much weight to give to each score is arbitrary.

In the Infinite Wisdom of Representatives John Boehner and Nancy Pelosi, who negotiated the final version of H.R. 2, the cost score will account for 30 percent of the composite score.

If Boehner and Pelosi had proposed that CMS share the grossly inaccurate and arbitrary composite score with physicians privately, the worst we could say about it is that it will be a waste of money. No human being, including doctors, can make use of feedback that is inaccurate.

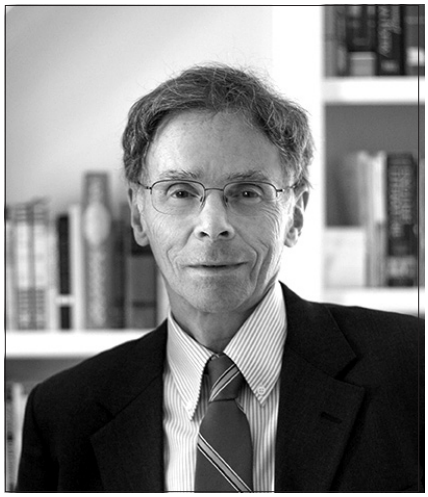
But Boehner and Pelosi are proposing to use the score to publish report cards listing "good" and "bad" doctors, and to punish "bad" doctors by withholding 9 percent of their reimbursement and using the savings to reward "good" doctors with a 9 percent increase. This pay-for-performance scheme is the heart of H.R. 2's so-called Merit-based Incentive Payment System (MIPS).

The negative consequences will vastly outweigh any positive consequences. Costs will rise, physician morale will be further damaged, sicker and poorer patients of all ages will be harmed, and concentration within the health care system will increase as rising administrative costs force small clinics to close and join large hospital-clinic fiefdoms.

Mind-boggling complexity

To construct a "composite score" on each doctor for cost or quality, the HHS Secretary will have to solve several difficult issues. Of these, the most important are (1) determining which patients "belong" to which doctors (the "attribution" problem), and (2) adjusting grades for factors outside physician control (the "risk adjustment" problem).

I'll focus the rest of this comment on the attribution problem. A brief explanation of its mind-boggling complexity should be enough to cause reasonable people to oppose MIPS.



Kip Sullivan

Here are H.R. 2's instructions to the Secretary on how to attribute patients to doctors who bill Medicare:

In order to facilitate the attribution of patients … to … physicians or applicable practitioners…. [t]he Secretary shall develop patient relationship categories and codes that define and distinguish the relationship and responsibility of a physician or applicable practitioner with a patient…. Such patient relationship categories shall include different relationships of the physician or applicable practitioner to the patient (and the codes may reflect combinations of such categories), such as a physician or applicable practitioner who—

1. considers themself to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
2. considers themself to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
3. furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
4. furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
5. furnishes items and services only as ordered by another physician or practitioner. [emphasis added]

Note first of all how different H.R. 2's attribution method is

from the methods used to attribute patients to "accountable care organizations" and "medical homes." The standard method used by Medicare and Medicaid to attribute patients to ACOs and "homes" is to attribute patients to the primary care doctor who provides the plurality of primary care services, measured either by visits or expenditures, to the patient during a one-year period. (In the case of ACOs, the patient is further attributed to an ACO if the doctor belongs to one.)

MIPS will make the Sustainable Growth Rate formula look like a stroke of genius.

But H.R. 2 uses the phrase "patient relationship." The Secretary is to develop "patient relationship" codes based on at least two criteria: whether the doctor's role is a "lead" role or a "supportive" role; and whether the patient's condition is acute or chronic. "Supportive" doctors are further divided into those who order services on their own versus those who order or provide services on the orders of another physician.

As if this weren't vague enough, the Secretary is authorized to create codes that combine these categories. Thus, a "lead doctor," say a primary care doctor caring for a patient with coronary artery disease over a long period of time, might bill as a hybrid "lead-supportive" doctor during a heart attack (an "acute episode"), at which time much of the "primary responsibility" for the patient shifts to a cardiologist. How will the division between "lead" and "supportive" be determined? The mind bridles and balks. But let us push on.

Despite the odd language in H.R. 2 about what a doctor "considers themself," it's a safe bet that doctors won't be allowed to "consider" any relationship they like and enter the code for that relationship on the claim form (doctors will have to enter a relationship code on every claim).

Because doctors will have every reason to think the Secretary's risk-adjustment scheme will not protect their composite score from being dragged down by sicker patients, they will have an incentive to "consider" that they were not the "lead" doctor for difficult, sicker patients and, conversely, that they were the "lead" doctor for easier, healthier patients.

So, if doctors are not going to be allowed to select any relationship that appeals to them, the Secretary will have to develop "percent of services" attribution algorithms that resemble those in use now in the Medicare and Medicaid ACO and "medical home" pilots.

Problematic algorithms, 'leakage' and 'churn'

These algorithms are already causing problems for ACOs, which consist of dozens and even hundreds of doctors, and which stand to lose only a percent or two of their incomes. The problems these algorithms will cause doctors under MIPS are much more severe. Under MIPS, individual doctors will eat all losses, and these losses could amount to 9 percent of their Medicare income.

ACOs are complaining about attribution algorithms because the use of a plurality threshold means many patients are assigned to doctors who really are not the patient's primary doctor (you can find the request for an "attestation" requirement in a Feb. 6, 2015, letter from the National Association of ACOs to CMS Administrator Marilyn Tavenner). Consequently, many patients assigned to an ACO visit doctors outside of the ACO. Analysts and business consultants refer to this problem as "leakage."

The small body of research on this "leakage" problem indicates it is serious. One study that simulated leakage under Medicare's ACO algorithm estimates it amounts to 30 percent. In other words, of the visits CMS assigned to ACOs, only 70 percent actually occurred to providers within the ACO. The other 30 percent "leaked" – they saw providers outside the ACO. For specialists, the leakage rate is 67 percent according to a study published last year.

A close cousin of the ACO "leakage" rate is the ACO "churn" rate – the rate at which patients are assigned to a different ACO each year. The estimated annual churn rate for the 10 large hospital-clinic chains that participated in the Physician Group Practice Demonstration (regarded widely as a test of the ACO concept) was 25 percent. (See Section II.E of CMS's final rule for the Medicare Shared Savings Program, p. 67861.)

It is possible to reduce "leakage" and "churn" by using a formula that attributes patients to doctors who provide a high percent of all services to a patient rather than the under-50-percent threshold used now. (Minnesota uses a 20-percent threshold for its Medicaid "home" program.)

Such a method would attribute only the most "loyal" patients to doctors. But this would create another problem: Relatively few patients could be attributed. Which would mean Boehner and Pelosi's pay-for-performance scheme would apply to only a small minority of patients and would, therefore, affect only a small portion of the average doctor's Medicare income.

MIPS, ACO, and "home" advocates must choose their poison: They can choose an attribution formula that cannot determine accurately which patients belong to which doctor but which will maximize the financial pressure on doctors; or they can choose a formula that will attribute far fewer "phantom" patients to doctors but which will greatly reduce the number of patients assigned to doctors and, consequently, the financial pressure doctors will be under to "perform."

Crude risk-adjustment schemes

Let me close with a brief description of the two remaining calculations that will determine the "composite score" required by H.R. 2: Adjusting physician scores for factors outside their control, and merging the quality and cost scores into a "composite score." The risk-adjustment calculation will be crude; the weighting of the composite score by cost and quality will be arbitrary.

As I mentioned at the outset, the MIPS pay-for-performance scheme depends not only on an accurate attribution method, but on an accurate method of risk-adjustment – adjustment of physician cost and quality scores for factors outside physician control such as patient health, income, and breadth of insurance coverage.

(continued on next page)

Modern Healthcare June 6, 2015

Simplify doc payment system

By Stephen Kemble, M.D.

Regarding the recent feature "Physician quality pay not paying off" (ModernHealthcare.com, June 1, p. 20), several reviews have shown no improvement in population health measures or cost savings from pay-for-performance or pay-for-quality. It is time to face the fact that this is not a case of performance measurement of individual physicians being in a "fledgling state." The reality is that healthcare, by its nature, is too complex and requires too much individualization to be amenable to management through standardized quality metrics for individual physicians. The metrics that anyone can come up with generally lack validity or are too narrow to have much meaning or value.

Instead of ever greater and more expensive efforts to measure individual physicians' performance, let's move to physician payment that is commensurate with the training and expertise necessary to do what physicians do, but is as simplified and incentive-neutral as possible. Then rely on professionalism and intrinsic motivation for quality improvement, which worked well for years without any financial incentives at all. The road to achieving the triple aim goals is not through pay-for-performance targeting individual physicians, but through administrative simplification leading to reduced healthcare prices and improved access to care for everyone who needs it in the most cost-effective (usually outpatient) settings.

Dr. Stephen Kemble is assistant clinical professor of medicine at John A. Burns School of Medicine University of Hawaii, Honolulu.

Health Affairs June 2015

The Single-Payer System In Taiwan

By Ida Hellander, M.D.

Evidence-based health policy could transform the US health system. The evidence for single-payer systems is well summarized by Tsung-Mei Cheng in her article (Mar 2015) on Taiwan's single-payer National Health Insurance (NHI). *[See page 44 of this newsletter for Tsung-Mei Cheng's article.]*

Taiwan's NHI was approved in 1994 and was implemented in less than a year. About 41 percent of Taiwan's population was uninsured before reform, compared with 16.3 percent of the US population before the passage of the Affordable Care Act. Today, 99.9 percent of Taiwanese are insured and enjoy free choice of physician. In contrast, twenty-seven million Americans will remain uninsured in 2025, tens of millions more are underinsured, and physician choice is restricted, except in traditional Medicare.

Taiwan's single-payer system is efficient, devoting only 1.07 percent of expenditures to overhead. In comparison, the largest private insurer in the United States, UnitedHealthcare, diverted 19.1 percent of premiums to administration, marketing, and profits last year. The United States could save $375 billion annually on administrative costs with a single-payer system, enough to cover all of the uninsured.

After two decades, Taiwan's NHI enjoys high public satisfaction and is evidence that affordable universal health care is possible, but only with a single-payer system.

Author affiliations: Physicians for a National Health Program, Chicago, Illinois

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

Even the best risk-adjustment schemes are deplorably inaccurate. Medicare's risk-adjustment scheme for the Medicare Advantage program, the most studied scheme in America and probably the world, can predict no more than 11 percent of the variation in expenditures among Medicare enrollees, according to a March 2011 report by RTI International.

But as is the case with the attribution problem, there is no feasible solution to the risk-adjustment problem. Improved risk-adjustment will require the collection of much more medical and demographic data on all patients, which will be very expensive.

Finally, let us ask by what logic or moral principle the House of Representatives decided to give the cost score 30 percent of the weight of the composite score. The question is rhetorical. There is no rational explanation for that choice.

In sum, the MIPS composite score will be a meaningless number for three reasons: The attribution method will be grossly inaccurate, the risk-adjustment method will be grossly inaccurate, and the useless cost and quality scores these methods will produce will be mashed together by an arbitrary 70-30 weighting ratio.

We will pay a heavy price for this latest experiment in the never ending experiment with managed care. MIPS will make the Sustainable Growth Rate formula look like a stroke of genius.

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.

Modern Healthcare

March 7, 2015

Integrated delivery networks: Is the whole less than sum of the parts?

By Jeff Goldsmith and Lawton R. Burns

For the past four decades, there has been one dominant theme in healthcare delivery-system reform: Hospitals and physicians must transform themselves into comprehensive-care enterprises to be paid a population-based global budget.

In the vision of pioneering health policy researchers Paul Ellwood Jr. and Alain Enthoven, consumers should choose among multiple Kaiser-like entities competing based on premium (e.g. total cost of care).

When the National Academy of Social Insurance sought to examine whether market concentration in hospital or health insurance markets was driving up costs, we noted that a significant fraction of the major actors in most hospital markets were actually vertically linked integrated delivery networks (IDNs), not horizontal chains. We proposed studying IDN performance to determine whether we could find evidence that IDNs were achieving their hoped-for promise – better care at lower total cost.

What we found was, frankly, disappointing. We reviewed more than 30 years of academic literature on vertical integration and diversification in healthcare, and found virtually no measurable benefits – either to society or to the sponsoring healthcare enterprises themselves – of putting health insurance, hospitals and physician services under the same structure.

We also examined publicly available performance information on 15 nationally prominent IDNs and found no evidence of either lower cost or higher quality in the hospital systems they operated. This was not an easy analytic task. IDN disclosures to bondholders and the Internal Revenue Service were so opaque that we could not tell where they earned their profits, or even how much revenue they generated from their hospitals.

However, we found that IDNs' flagship hospitals, where significant financial and quality information was available, were more expensive than their direct in-market competitors, in cost per case and in total cost of care in the last two years of life. There was no apparent relationship between how concentrated the local hospital market was and the IDN's operating earnings. Further, the size of the IDN (measured either by hospital bed count or total revenue) did not correlate with profitability, challenging a key argument propounded by the hospital merger industry to justify consolidation. Neither scale nor scope economies could be detected.

We reviewed more than 30 years of academic literature on vertical integration and diversification in healthcare, and found virtually no measurable benefits of putting health insurance, hospitals and physician services under the same structure.

On the role of "captive financing" in the IDN portfolio, we found that the flagship hospitals of IDNs with significant revenue at risk were 23% more expensive than their nearest in-market competitor, while the flagships of IDNs with no revenue at risk were 8% less expensive. This is the reverse of what we would have expected if having revenue at risk was supposed to lead to more efficient and lower-cost care.

Data limitations aside, we believe the reasons for this disappointing performance lie in the impossibility of straddling two worlds with diametrically opposed incentives: the fee-for-service world with its lucrative profits from imaging, outpatient surgery and high-end cancer treatment, and the global-budgeted world of "population health." These split incentives magnify organizational risks, not reduce them. For this reason, we believe the current IDN financial disclosures are inadequate to enable bondholders to evaluate enterprise risk.

We think the best approach to learning more is voluntary disclosure by IDNs of more operating detail. If there is non-public information that validates organizing care in this way, it's long past time to see it. It should be possible from those disclosures to identify the amount and nature both of cross subsidies between IDN businesses and the operating contribution (or loss) generated by each. Physician and hospital compensation policies by the IDN's health plan subsidiaries should also be detailed.

Some of the nation's finest hospitals and clinical staffs can be found in our sample IDNs. This analysis is not intended to denigrate these fine institutions or their managements. Rather, we question the merits of the organizational model they collectively represent. After decades of strenuous policy advocacy, it is still not clear that, in the case of the IDN, the whole is greater than the sum of its parts, or that policymakers should be encouraging further IDN formation.

Read our study at www.nasi.org/research/2015/integrated-delivery-networks-search-benefits-market-effects and draw your own conclusions.

Jeff Goldsmith is president of Health Futures and an associate professor of public health sciences at the University of Virginia. Lawton R. Burns is a professor of healthcare management at the Wharton School of the University of Pennsylvania.

SALON

June 26, 2015

America's health care system is still broken: Why single-payer is the only thing that will ever fix it

The final triumph of Obamacare was great news for Americans depending on it -- but it still isn't enough

By A.W. Gaffney, M.D.

On June 25 the Supreme Court splintered yet another spear heaved by conservatives trying to destroy, by whatever means necessary, the Affordable Care Act. Those living in the 34 states that rely on the federal "exchange," who purchase health insurance using subsidies provided by healthcare reform, are understandably relieved.

"Without the subsidy, I am not sure what I was going to do," said one man, a hairdresser who was diagnosed last year with kidney cancer, to Kaiser Health News. "I was thinking of moving out of my apartment and go live in my car to afford coverage." Another man, suffering from a form of blood cancer, told the New York Times: "I am nervous about the Supreme Court decision, very nervous," he said. "If I don't take that pill, the cancer will come back." The pill, the Times reported, would otherwise have cost him more than $10,000 a month.

This is what matters most about yesterday's Supreme Court decision on Obamacare: Many Americans – some 8.2 million, according to an estimate from the Urban Institute – no longer need to worry about being unceremoniously dumped into the ranks of the uninsured. It has been estimated that a ruling in favor of the plaintiffs could have cost between 8,000 and 9,800 lives a year. How the case plays out with respect to ongoing Democratic and Republican political gamesmanship seems, in comparison, a piddling matter.

Now, in other news yesterday, health care stocks were spiking on Wall Street: Insurers (UnitedHealth and Aetna) and corporate hospital networks (Hospital Corporation of America) were seeing strong gains. The link between these events is, of course, obvious: The Affordable Care Act's premium subsidies are funneled through private health insurance companies, who take a cut. Corporate hospital chains, meanwhile, prefer a well-paying customer.

Together, this might be a bit puzzling for those who've adopted that age-old mantra, "What's good for the health insurance industry is bad for America." Yet this corporate compromise was fundamental to the passage of Obamacare, as Stephen Brill documents in his book "America's Bitter Pill." As a result, Obamacare is, by and large, good for the health care business. A few years back, as described in a New York Times story headlined, "The President Wants You to Get Rich on Obamacare," Thomas Scully – who comfortably alternates between working as a government administrator and a government lobbyist – tried to alleviate the concerns of a room of investors about Obamacare at the "21" Club in New York.

Dr. Adam Gaffney

"It's not a government takeover of medicine," he was quoted by the Times as saying, "It's the privatization of health care." As the Times put it, "Billions could flow from Washington to Wall Street, indeed."

Next question: Why should we care, if the insured are being covered in the process? Well, we should care because our corporate health care compromise comes at a serious cost.

First, it's a waste of good money. Private insurers have notoriously high overhead: They spend perhaps 12 percent of your premium on administration and profits. Traditional Medicare, in contrast, spends about 2 percent on overhead. A recent analysis found that the insurance expansion under the ACA has been particularly costly from this perspective, with about $1,375 spent on overhead for each newly insured person.

Why should we care, if the insured are being covered in the process? Well, we should care because our corporate health care compromise comes at a serious cost.

Second, the mandate model of health care reform was never intended to result in universal coverage. "If you took George H. W. Bush's health plan," Scully told the investors at the "21" Club with some fairness (again as quoted in the Times), "and removed the label, you'd think it was Obamacare." The problem with a mandate model – which

used to be the conservative approach to health care reform – is that some people will invariably fall between the cracks: Indeed, some 27 million will remain uninsured in the long term under the ACA. Some of these people are undocumented immigrants, while others are working- or middle-class people, for whom the purchase of health insurance is simply too costly.

Third, the problem of underinsurance — which is, roughly speaking, having insurance, but not being able to afford to use it because of copayments or deductibles — is going nowhere quickly. The percentage of non-elderly Americans with private insurance who have a "high-deductible health plan" rose from 22.5 percent in 2009 to 36.9 percent in 2014. Underinsurance doubled between 2003 and 2014, such that by one measure, 31 million Americans are now "underinsured."

Fourth, the delivery of health care by for-profit corporate enterprises has become an entrenched component of the political economy of American health care. For a particularly unseemly example, consider the explosion of the corporate hospice industry. There was a time not long ago when the hospice was a charitable, religious or not-for-profit enterprise. In the neoliberal era, however, it was all but inevitable that venture capital would try to get in on the market for dying: by 2013, 66 percent of Medicare-certified hospices were for-profit businesses. Quality issues with such for-profit providers are a perennial concern: An investigation by the Washington Post last year, for instance, found that "on several key measures, for-profit hospices as a group fall short of those run by nonprofit organizations," like the amount spent on nursing each patient.

Which brings us to the final question: What's the alternative? Is real universal health care – e.g. a single-payer national health program – at this point feasible?

Based on national polling, the answer is yes, absolutely, of course. A majority or near majority generally voice support for a single-payer system, including in one recent survey.

Now, I know, "will of the populace," yada yada. But on the other hand, there does seem to be a groundswell of outrage at rising inequality in our society that may not be so easily swept away. Electoral politics, to some extent, seem to be reflecting that. Bernie Sanders, for instance – now in second place behind Hilary Clinton in the Democratic presidential primary – has made economic justice the center point of his campaign. He's also a strong single-payer supporter: "What the United States should do," he put it in a statement about King v. Burwell yesterday, "is join every other major nation and recognize that health care is a right of citizenship. A Medicare-for-all, single-payer system would provide better care at less cost for more Americans." Well said, Bernie.

For those who want to open a bottle – or even a case – of champagne to celebrate yesterday's ruling, I'd say: enjoy. But tomorrow, once the hangover has cleared, the work to transform our corporatized, fragmented, and inequitable health care system remains before us.

For those who want to open a bottle – or even a case – of champagne to celebrate yesterday's ruling, I'd say: enjoy. But tomorrow, once the hangover has cleared, the work to transform our corporatized, fragmented, and inequitable health care system remains before us.

A.W. Gaffney is a research fellow in pulmonary and critical care medicine at Harvard Medical School and Massachusetts General Hospital. He received his medical degree from the New York University School of Medicine and completed residency training at Columbia University Medical Center, where he served as chief resident. He is a frequent writer on health policy, blogging at theprogressivephysician.org.

Health, Medicine and Justice: Designing a fair and equitable health system

By Joshua Freeman, M.D.
Copernicus Healthcare, 2015
Softcover, 307 pp., $18.95

Dr. Joshua Freeman is a practicing family physician and the chairman of the Department of Family Medicine at the University of Kansas School of Medicine. He is a longtime member of Physicians for a National Health Program.

"*Health, Medicine and Justice* is not your typical health care book. It challenges the very goals underlying the U.S. health care system: 'We are getting what our system is designed to get – profit and wealth for those who control it, rather than health for the people of the nation.' If you think this idea is too controversial, this book is full of facts that make the case."
– Thomas Bodenheimer, M.D., University of California, San Francisco

CaliforniaHealthline
The Daily Digest of News, Policy & Opinion

June 29, 2015

Undocumented immigrants help keep Medicare solvent: study

By George Lauer

Undocumented immigrants pay billions more into Medicare every year than they use in health benefits, and in fact they subsidize care for other Americans, according to researchers.

A study published in the Journal of General Internal Medicine contends that undocumented immigrants generated surplus Medicare contributions of $35.1 billion from 2000 to 2011, extending Medicare's estimated life span by one full year. The study appeared earlier this month as an "online first" article in the Journal of General Internal Medicine and will appear in a forthcoming print edition of the journal.

Researchers from Harvard Medical School, the Institute for Community Health and City University of New York's School of Public Health at Hunter College found that in one year alone – 2011 – undocumented immigrants generated an average surplus of $316 apiece for Medicare. Other Americans generated an average deficit of $106 apiece. Undocumented immigrants contributed $3.5 billion more than they received in care in 2011, according to the study.

Researchers concluded that restricting immigration would be bad for Medicare's financial health. They estimated that contributions from undocumented immigrants during the first decade of the century prolonged Medicare's trust fund solvency by one year. The trust fund is predicted to be insolvent in 15 years.

Background and study methodology

Undocumented immigrants are not eligible to participate in government health programs, including Medicare and the Affordable Care Act, but they do contribute by paying taxes. Payroll taxes are the major revenue source for Medicare's trust fund, used primarily to pay hospital bills. Using an Individual Tax Identification Number or an unauthorized Social Security number, most undocumented immigrants – the estimate in California is 90% – pay payroll taxes.

Researchers examined Medicare trust fund contributions and expenditures from 2000 through 2011, comparing data from the Census Bureau's Current Population Survey to calculate tax contributions. They used the HHS Medical Expenditure Panel Survey to determine medical expenses paid by Medicare.

"For years I have seen my unauthorized immigrant patients be blamed for driving up health care costs," lead author Leah Zallman, a faculty member at Harvard Medical School and researcher at the Institute for Community Health said in a prepared statement. "Yet few acknowledge their contributions. Our study demonstrates that in one large sector of the U.S. health care economy, unauthorized immigrants actually subsidize the care of other Americans."

CMS officials declined to comment on the research, citing a standing policy against commenting on "outside studies."

Dr. Leah Zallman

Implications for Medi-Cal

Although the research dealt exclusively with Medicare – the federal health coverage program for seniors and those with disabilities – the findings have implications for Medicaid – the state-federal partnership providing health care for those with low incomes – according to California Insurance Commissioner Dave Jones (D).

"While these are two different programs with different funding sources, I think there's no question that this study lends support to the efforts to extend Medi-Cal coverage to undocumented immigrants. I think many of the same points in this research – that undocumented immigrants contribute tax money to support government programs – applies to Medicaid and California's Medicaid program, Medi-Cal," Jones said.

Zallman said the study's underlying message – that undocumented immigrants' contributions should be recognized and appreciated – applies to Medicaid, as well.

"I think our study should cause us to re-examine our assumptions about the impacts of unauthorized immigrants in other sectors such as Medicaid," Zallman said.

Daniel Zingale, senior vice president at the California Endowment, said the Medicare research showed similar results to the Endowment's own efforts to secure health coverage for undocumented Californians.

"These findings mirror what we found in California – that undocumented people contribute far more than they take out," Zingale said.

As part of its Health4All campaign, the California Endowment did similar research in California and found undocumented Californians paid $3.2 billion in state and local taxes in 2012.

The Endowment's statistics are included in a You Tube video, "California's Hidden Truth."

Research may affect immigration reform

Jones and Zingale predicted the Medicare research would help advance immigration reform efforts.

"I believe this may be the first study to analyze the impact of

(continued on next page)

JGIM
Journal of General Internal Medicine

June 23, 2015

Unauthorized Immigrants Prolong the Life of Medicare's Trust Fund

By Leah Zallman, M.D., M.P.H., Fernando A. Wilson, Ph.D., James P. Stimpson, Ph.D., Adriana Bearse, M.S., Lisa Arsenault, Ph.D., Blessing Dube, M.P.H., David Himmelstein, M.D., and Steffie Woolhandler, M.D., M.P.H.

ABSTRACT

Background and objective: Unauthorized immigrants seldom have access to public health insurance programs such as Medicare Part A, which pays hospitals and other health facilities and is funded through the Medicare Trust Fund.

Design and Main Measures: We tabulated annual and total Trust Fund contributions and withdrawals by unauthorized immigrants (i.e., outlays on their behalf) from 2000 to 2011 using the Current Population Survey and Medical Expenditure Panel Surveys. We estimated when the Trust Fund would be depleted if unauthorized immigrants had neither contributed to it nor withdrawn from it. We estimated Trust Fund surpluses by unauthorized immigrants if 10% were to become authorized annually over the subsequent 7 years.

Key results: From 2000 to 2011, unauthorized immigrants contributed $2.2 to $3.8 billion more than they withdrew annually (a total surplus of $35.1 billion). Had unauthorized immigrants neither contributed to nor withdrawn from the Trust Fund during those 11 years, it would become insolvent in 2029 – 1 year earlier than currently predicted. If 10% of unauthorized immigrants became authorized annually for the subsequent 7 years, Trust Fund surpluses contributed by unauthorized immigrants would total $45.7 billion.

Conclusions: Unauthorized immigrants have prolonged the life of the Medicare Trust Fund. Policies that curtail the influx of unauthorized immigrants may accelerate the Trust Fund's depletion.

DOI: 10.1007/s11606-015-3418-z

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

unauthorized immigrants on the national Medicare program," Jones said. "The information is well researched and well documented and clearly shows they have had a very positive impact."

Jones said the study goes one step further and predicts that immigrants will continue to bolster Medicare's trust fund under President Obama's immigration reforms.

"This study also analyzes the potential impact of the president's efforts if the courts allow him to move forward with immigration reform to enable some portion of the unauthorized population to stabilize their status and move forward on a path to citizenship. The net contributions persist even if there's a path to citizenship," Jones said.

Zingale said Medicare's national status will help broaden the immigration arguments his organization has been making in California.

"This is another installment in a mounting number of facts that show how undocumented people are good for the health of our country," Zingale said. "Because Medicare is a big deal, it will advance that progress toward a greater understanding."

Zingale and Jones both pointed to California's budget agreement last week that includes health coverage for undocumented children.

"Clearing the way for children of unauthorized immigrants to join Medi-Cal is a good first step," Jones said.

"We're calling that the first ever health for all kids budget," Zingale said. "That shows you how far we've come. That budget received Republican votes. Indeed, we are in a very different place than we were just a few years ago. Remember Proposition 187?"

In 1994, California voters approved Prop. 187, a controversial ballot measure denying public services – including health care and education – to undocumented immigrants. Courts declared much of the initiative unconstitutional and last year, Gov. Jerry Brown (D) signed legislation repealing unenforceable provisions of the proposition.

Ties to national physicians group

Physicians for a National Health Program, a national advocacy organization, is helping spread the word about the Medicare research.

Although the group "had no role in conducting, financing or otherwise supporting the research, it decided to help publicize the study and its findings because they are consistent with PNHP's mission statement," Zallman said.

The organization's mission statement, in part, says:

"PNHP believes that access to high-quality health care is a right of all people and should be provided equitably as a public service rather than bought and sold as a commodity."

Two of the Medicare study authors – Steffie Woolhandler and David Himmelstein, both professors of public health at City University of New York and lecturers in medicine at Harvard Medical School, are co-founders of PNHP.

George Lauer is California Healthline's features editor.

The New York Review of Books

April 23, 2015

Health: The Right Diagnosis and the Wrong Treatment

By Marcia Angell, M.D.

America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System
By Steven Brill
Random House, 512 pp., $28.00

Steven Brill has achieved the seemingly impossible – written an exciting book about the American health system. In his account of the passage of the Affordable Care Act (now known as Obamacare), he manages to transform a subject that usually befuddles and bores into a political thriller. There was reason to think he might pull it off; his lengthy 2013 Time magazine exposé of the impact of medical bills on ordinary people was engrossing. But his success also owes much to the Bob Woodward method of writing best sellers about government policy: interviews with hundreds of insiders, many anonymous, some evidently willing to talk to him to increase their chances of being shown in a favorable light.

For example, one of Brill's principal sources and a great favorite is Liz Fowler, chief health counsel to Senator Max Baucus, chairman of the Senate Finance Committee, which oversaw the legislation. Brill credits her with being "more personally responsible than anyone for the drafting of what became Obamacare." He is unbothered by the fact that she was vice-president for public policy at WellPoint, the country's second-largest private insurance company, before taking her job with Senator Baucus, or by the fact that shortly after passage of the law (and a brief stint with the administration), she became head of global health policy at the drug company Johnson & Johnson – even though both of these industries benefited greatly from Obamacare.

By contrast, Brill is appropriately critical of others who used the revolving door between industry and government, such as Billy Tauzin, the congressman who pushed through the industry-friendly Medicare drug benefit in 2003 and then became head of the pharmaceutical industry's trade association. The excuse he gives for Fowler is that she was not a lobbyist, but that is hardly the point.

In view of his method, it's not surprising that there is as much political gossip and score-settling in Brill's book as analysis. Nevertheless, his description of our dysfunctional health system is dead-on. He shows in all its horror how the way we distribute health care like a market commodity instead of a social good has produced the most expensive, inequitable, and wasteful health system in the world. (The U.S. now spends per capita two and a half times as much on health care as the average for the other OECD countries, while still leaving tens of millions of Americans uninsured.) Brill makes it clear that the problems are unlikely to be fixed by Obamacare. For that alone, his book deserves to be widely read.

Dr. Marcia Angell

Here are a few items in Brill's indictment. "Healthcare," he writes, "is America's largest industry by far." It employs "a sixth of the country's workforce. And it is the average American family's largest single expense, whether paid out of their pockets or through taxes and insurance premiums." He estimates that the health insurance companies employ about 1.5 million people, roughly twice the number of practicing physicians. Hospital executives preside over lucrative businesses, whether nominally nonprofit or not, and are paid huge salaries, even while they charge patients obscene prices (Brill cites $77 for a box of gauze pads) drawn from "what they called their 'chargemaster,' which was the menu of list prices they used to soak patients who did not have Medicare or private insurance." He tells us that the CEO of New York–Presbyterian Hospital, where he had major surgery shortly after his article appeared in Time, had an income of $3.58 million. And finally, he gives us the really bad news: "All that extra money produces no better, and in many cases worse, results."

Obama's deals with the health industry

When Barack Obama became president in 2009, reforming the American health system was at the top of his domestic agenda – ahead even of the banking crisis, housing foreclosures, and unemployment. And he was candid about the reason: soaring health costs were undermining nearly everything else. As examples: Medicare – the government program for Americans over age sixty-five – was a growing contributor to federal deficits; businesses that offered health benefits to their workers were at a competitive disadvantage, both domestically and globally; workers were afraid to leave jobs because they would lose health insurance if they did; and medical costs had become the chief cause of personal bankruptcy. In short, the American health system was no longer supportable.

When Obama was a state senator in Illinois, he was on record as favoring a single-payer health system – that is, one in which the government ensures health care for all residents of the country and regulates the distribution of resources in a predominantly nonprofit system. That's the sort of system every other advanced country has. Even after he became president,

Obama acknowledged in a press conference on July 22, 2009, that a single-payer system was the only way to achieve universal health care. Even so, except for that one admission, there was no further consideration of single-payer health care – by Obama or, crucially, by Senator Baucus – during the year Obamacare was crafted.

Instead, the launch of the reform effort was a White House media event in March 2009 that featured spokespersons for the for-profit health insurance and pharmaceutical industries, who pledged to work with the president to reform the system. But not for nothing. As a condition of its support, the insurance industry demanded that all Americans – except those in Medicare and other government programs – be required to purchase private insurance. The central role of the insurance industry would thus be not only preserved, but expanded and enshrined by law. As a condition of its support, the pharmaceutical industry demanded the continuation of two laws that Obama, as a candidate, had promised to try to overturn – one that forbids Medicare from using its purchasing power to control drug prices, and another that forbids Americans from importing cheaper drugs from other countries.

After these deals were struck, there followed a year of congressional wrangling, replete with further deals to mollify conservatives and the health industries. For example, the idea of a "public option," that is, government-sponsored insurance to compete with private insurers, was scuttled. The final product – the Patient Protection and Affordable Care Act – was signed into law on March 23, 2010, and scheduled to go into effect over ten years, with the major provisions in effect by 2014.

Health law's key elements

There were three essential elements of the new plan for expanding access to health care: first, the new law encouraged employers to provide health benefits to workers by fining large companies that don't offer insurance and subsidizing small companies that do. Second, Medicaid, the program for the poor, which is jointly supported by the federal and state governments, was to be expanded to cover an additional 16 million people. And third, everyone under age sixty-five without employer-sponsored insurance or Medicaid – estimated as another 16 million people – would be required to purchase their own private insurance policies or pay a fine. But there would be subsidies for those earning less than four times the poverty level (it was anticipated that most uninsured people would qualify for them), and states would create shopping exchanges for individuals and small businesses to pool risks and offer a menu of approved plans. Those were the main provisions to extend coverage, but of the roughly 50 million uninsured Americans at the time, the new law would still leave about 18 million, or 6 percent of the population, without any coverage at all.

In addition to extending coverage, the law called for regulations to curb the worst abuses of the insurance industry. Insurers would no longer be permitted to exclude people because of preexisting medical conditions or to drop policyholders if they developed expensive illnesses. (They would, however, be permitted to charge those nearing Medicare age up to three times as much as younger customers.) Insurance companies would also be required to spend at least 80 percent of their premiums on medical services, instead of diverting over 20 percent to profits and overhead.

Financing the increased coverage would come from four main sources. First, the payroll tax that supports Medicare was to be increased for individuals who earn more than $200,000 per year or families that earn over $250,000 per year. Second, these same high earners would pay a 3.8 percent tax on unearned income, such as dividends or capital gains. Third, payments to Medicare Advantage plans would be reduced; these are government-supported private plans chosen by about a quarter of Medicare beneficiaries because they usually offer a broader package of benefits. The government had paid Medicare Advantage plans about 14 percent more than it would cost to cover the same people in ordinary Medicare. Fourth, beginning in 2018, there would be an excise tax on high-cost policies. There were also to be unspecified reductions in Medicare payments to hospitals and other health facilities, as well as a variety of small fees levied on health industry companies.

According to the Congressional Budget Office, these new funding sources, taken together, would more than cover the cost of the legislation to the federal budget. But costs to the private sector – businesses and individuals – were not addressed in the Congressional Budget Office analysis, nor was there any consideration of the growth in costs. The analysis was based on extremely optimistic assumptions.

Five years later

During the five years since then, there have been a series of delays and setbacks. In 2012, the Supreme Court decided that while the mandate to purchase insurance was constitutional, the requirement that states expand their Medicaid rolls was not. As a result, even though the federal government would pay virtually all of the additional costs, twenty-two states have refused the offer, leaving millions of people uninsured who would otherwise be covered by Medicaid.

In addition, thirty-six states have refused to set up state shopping exchanges, so that their residents have to rely instead on the federal exchange, created as a backup, to buy subsidized insurance. But that, too, is now before the Supreme Court, because of the implausible claim that the wording in one part of the law means that only state exchanges may offer subsidies.1 (A decision on that will probably come at the end of the Court term.) Payments to Medicare Advantage plans are still higher than costs for comparable patients in traditional Medicare. And finally, there have been delays in implementation for both businesses and individuals, partly as a result of the disastrous 2013 rollout of the Obamacare websites – something Brill describes well. Over the past few years, the rate of cost inflation in health care has slowed somewhat; whether as a result of Obamacare or the recession is unclear, but it is still higher than the general inflation rate.

Assuming the recalcitrant states come around and all parts of the law eventually go into effect, what are we to make of it? Brill

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

is pessimistic, and so am I. He well describes the two principal causes of escalating costs in our current system: first, the overuse of exorbitantly priced tests and procedures by entrepreneurial providers responding to a fee-for-service payment system that rewards such overuse, and second, the existence of hundreds of private insurance companies that generate huge overhead costs throughout the system, much of which supports or counters bureaucratic efforts to avoid or minimize payments for patients' care. Obviously, any health system reform must do something about these two drivers of cost inflation.

But Obamacare does very little about either of them. First, it does not change the entrepreneurial delivery system. Care will still be provided in for-profit facilities or nonprofit facilities that behave the same way, and doctors will still be paid largely on a fee-for-service basis, and the fees will still be skewed to reward highly paid specialists for prescribing as many procedures as possible. There is some language in the legislation about determining cost-effective practice and setting up demonstration projects that would pay doctors differently, but nothing specific. Moreover, the law actually forbids tying fees to findings from comparative effectiveness research. There has been an increase in the establishment of accountable care organizations (ACOs) that are paid a yearly fee to cover all a patient's medical needs, but while encouraged, ACOs are not required by the law.

Second, private insurance companies will still be able to set their own premium prices, and since the legislation will pour more money and customers into the insurance industry, it amounts to a recipe for inflation. Some regulations to prohibit abuses can be circumvented, and as an official in the insurers' trade association once told me, any adverse effect on the companies' bottom line can always be offset by raising premiums. Right-wing critics have referred to the law as a "government takeover," but it's actually much closer to a "corporate takeover."

The Massachusetts experience

In 2006, my state of Massachusetts enacted legislation that closely resembles the new federal law and indeed served as its template. The Massachusetts law was originally promoted as a way to contain costs as well as expand coverage; the theory was that as people became insured, they would seek care from primary care physicians instead of in more expensive emergency rooms. But as costs continued to grow rapidly, the rationale changed. The new story is that the intention all along was just to get everyone insured and deal with costs later. Almost all Massachusetts residents now have health insurance, but premiums, deductibles, and copayments have increased, and some people have found they cannot afford to use their insurance. Massachusetts now spends more per capita on health care than any other state, and health spending consumes over half the current state budget, at the expense of nearly every other state function – including education, public safety, human services, and infrastructure. Clearly, while it's possible to expand access to health insurance by pouring money into a wasteful system, eventually the costs are shifted to patients in one way or another, and other important social goods are neglected.

Why was single payer off the table?

Practically every serious economic analysis of the American health system has concluded that the most efficient way to provide care to everyone is through some form of single-payer system, such as Medicare for all, and that any other approach will eventually be unsupportable. Why, then, was a single-payer system excluded from consideration and its proponents almost entirely barred from the discussion during the year Obamacare was written? That rejection can only reflect the enormous power of the health industry, which Brill reminds us has the largest lobby in Washington, D.C., and gave millions in campaign contributions to the key legislators. Indeed, Senator Baucus received more money from the health industry that year than anyone else in Congress.

Much of the public opposes Obamacare, and it is often claimed that their opposition reflects a philosophic antipathy toward big government. While that explanation may be partly true, I think it's largely a canard promulgated by the health industries and repeated by much of the media. The problem for most people, I suspect, is not the size of government, but the belief that government often does not work for their benefit, and instead serves special interests. I have no doubt that if instead of this reform, the plan had been to extend Medicare to everyone, most of the public would have been pleased. 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.

Medicare is a government-administered single-payer system similar to Canada's. It's the most popular part of the U.S. system, because it covers nearly everyone over the age of sixty-five for the same package of benefits, no matter what their medical condition; many sixty-four-year-olds can hardly wait to be sixty-five, so that they can get on Medicare. I've advocated gradually extending Medicare to the entire population by dropping the qualifying age one decade at a time – starting with age fifty-five. However, Medicare uses the same entrepreneurial providers as the private system, and its expenditures are rising almost as rapidly. Therefore, we would need to convert to a nonprofit delivery system, and we would need to stop preferentially rewarding specialists whose practice consists mainly of procedures. Paying doctors by salary makes the most sense.

Brill's proposal

Brill has a very different proposal. First, he documents the major responsibility of "brand-name" hospital conglomerates, such as New York–Presbyterian, for driving up health costs. They do so by their relentless expansion to push out competitors, their acquisition of large networks of physicians and outpatient facilities to feed them, the breathtaking prices they command from insurers that dare not refuse, their lush operating profits of on average about 12 percent (whether they are technically nonprofit or not), and their heartless pursuit of full payment from uninsured patients even while they pay their executives multimillion-dollar salaries.

Brill then comes up with this solution to our health care prob-

lems: "Let these guys [i.e., the hospitals] loose. Give the most ambitious, expansion-minded foxes responsible for the charge-master even more free rein to run the henhouse – but with lots of conditions."

His notion is that the hospitals would provide one-stop shopping for employers or individual customers, including acting as their own insurers. A customer would simply sign up at, say, New York–Presbyterian, which would provide everything for a set price; no more fee-for-service. Customers would buy the brand, and everything else would follow.

But, says Brill, there would have to be seven conditions to force these hospital conglomerates to behave better than they do now. First, "that any market have at least two of these big, fully integrated provider–insurance company players." If there were only one, its profits should be controlled like a public utility. Second, whether oligopoly or monopoly, operating profits would be capped "at, say, 8 percent a year."

Third, there would be "a cap on the total salary and bonus paid to any hospital employee who does not practice medicine full-time of sixty times the amount paid to the lowest salaried full-time doctor, typically a first-year resident." At the University of Pittsburgh Medical Center, where starting residents make $52,000, that would be $3.12 million.

Fourth, there would have to be a "streamlined appeals process" for patients who felt they had been denied adequate care.

Fifth, the CEOs of these hospitals would have to be physicians who had practiced medicine for a minimum number of years.

Sixth, the hospitals would have to insure a minimum percentage of "Medicaid patients at a stipulated discount." And seventh: "These regulated oligopolies would be required to charge any uninsured patients no more than they charge any competing insurance companies whose insurance they accept, or a price based on their regulated profit margin if they don't accept other insurance."

That's quite a list. Brill ends by pronouncing his dream of a system "certainly more realistic than pining for a public single-payer system that is never going to happen." I disagree. The foxes out there now would simply not accept such constraints. After all, their diet is hens.

A deficit of evidence

Shortly after the appearance of his Time article, Brill was diagnosed with an aortic aneurysm that required open-heart surgery, which was successfully performed at New York–Presbyterian Hospital (at a charge of over $190,000). As a result, he became enamored (there is no other word) with the hospital and its CEO, Steven Corwin, a heart surgeon. He also interviewed other physician-CEOs of large hospital conglomerates, including Delos "Toby" Cosgrove of Cleveland Clinic and Gary Gottlieb of Partners HealthCare in Boston. With very little reason other than their words, he decided that they were inherently less avaricious than other hospital CEOs.

At one point, he asks rhetorically whether CEOs should "have all that power" that his hypothetical system would give them, and answers: "That's where doctor-leaders like Corwin, Steele [Glenn Steele of Geisinger Health Sytem], Gottlieb, and Cosgrove come in. … Allow doctor-leaders to create great brands that both insure consumers for their medical costs and provide medical care."

His high regard for New York-Presbyterian, and by extension similar institutions, is at odds with his hardheaded finding that while the U.S. spends more on health than other developed countries, that does not buy it better health outcomes. He nevertheless seems to believe that the biggest, richest "brands" provide better care. Perhaps it helped that he got good care in one of them. But there is no reason to believe that his surgery would not have gone equally well with another surgeon at another hospital. Attempts to gauge quality, as, for example, by state tallies of surgical outcomes, which he reviewed to evaluate his surgeon, are necessarily crude and can be gamed, and Brill is too accepting of them.

Similarly, while I agree that hospital CEOs should be physicians, I don't see any evidence that they are less vulnerable to the drive to maximize profits. The doctor-leaders Brill interviewed claimed that their high prices were necessary to cover their efforts to improve quality, but their operating profits after those expenditures are still as high as hospitals without doctor-leaders, and they are evidently no more magnanimous to uninsured patients.

Brill's view that hospital conglomerates should serve as their own insurers also seems at odds with his earlier analysis. In the system he envisions, he wants insurers and providers to be on the same team, so that their interests are aligned. But elsewhere in the book, he points out that insurers are the only brake on providers' rising prices. He writes that in 2009 insurers' "tight profit margins were dwarfed by those of the drug companies, the device makers, and even the purportedly nonprofit hospitals." He argues that insurers "are the only industry players who, however unsympathetic, are on the customer and taxpayer side of the divide. Like us, they buy health care." It's not clear to me that insurers are on the customer side of the divide, but it's true that in our fragmented, uncoordinated system, there is some advantage to not having interests aligned. Let's look at how those interests line up now.

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 or to put a cap on their coverage (something that Obamacare is designed to prevent), to shift costs to patients at the point of service by increasing deductibles and copayments, and to limit the benefit package. In contrast, hospitals and other facilities have every incentive to expand, so that they're in a better position to bargain with insurers for higher prices. Brill tells us that New York–Presbyterian Hospital gave his insurer, UnitedHealthcare, a discount on prices of only 12 percent, but UnitedHealthcare could demand discounts of 30 to 60 percent from other hospitals.

For the most part, physicians just want to maintain their income, even as their influence wanes. Increasingly, as the struggle between insurers and hospital conglomerates grows, they are becoming absorbed by one or another of these two forces. But they are still paid mainly by fee-for-service, and those fees are skewed to reward tests and procedures. Procedure-oriented

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

specialists thus have every incentive to do as many of them as possible, particularly when unit prices are controlled. In his disturbing new book, "Doctored: The Disillusionment of an American Physician," Sandeep Jauhar describes cross-referrals among friendly colleagues simply to increase all their incomes.[2]

Note that none of these three disparate incentives I have described is designed to improve patients' health. Until they are aligned to do that, and not just to serve the interests of parts of the system, we should be wary of aligning them. Which of them, after all, would we choose to win out? To the extent that they now cancel one another out, eliminating one might make matters even worse.

Costs, sustainability, and health care as a social good

The fundamental issue in the U.S. health system is costs. After all, if money were no object, everyone could have all the health care he or she could possibly need or want. But money is an object, and sadly, the Affordable Care Act is a misnomer, because it's not really affordable except in the short run. Yes, it has expanded access, but the costs will not be sustainable – unless deductibles and copayments are greatly increased and benefits cut. That is happening now, particularly in the private sector, where employers are also capping their contributions to health insurance.

The problem is that Obamacare attempted to reform the system, while retaining the private insurance industry and the profit-driven delivery system with all its distortions and waste. Obamacare even made the private insurance companies the linchpin of the reform, providing them with millions more publicly subsidized customers. At the time Obamacare was enacted, its supporters argued that anything else was politically unrealistic. In view of our industry-friendly politics, that may have been so, but that does not mean that Obamacare can work. It's unrealistic for different reasons.

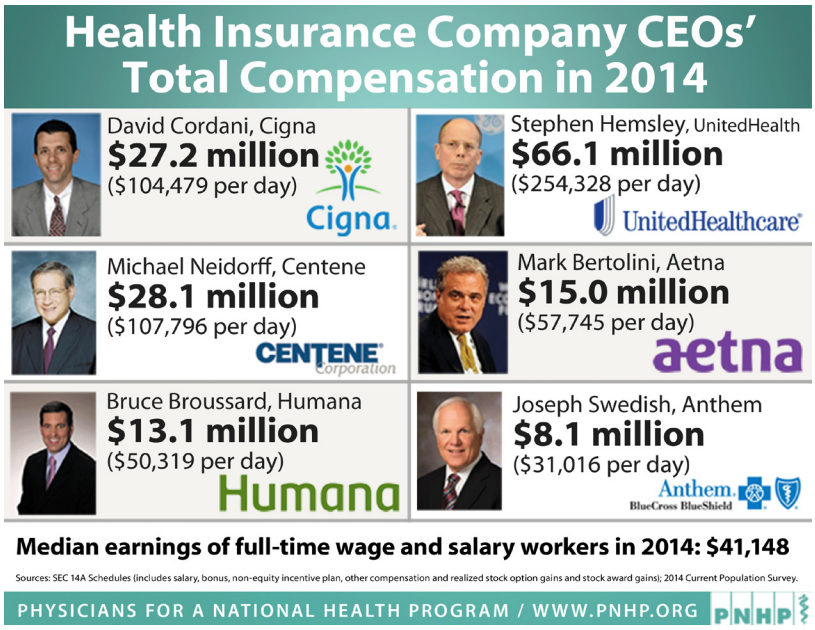
Until we begin to treat health care as a social good instead of a market commodity, there is simply no way to make health care universal, comprehensive, and affordable. Brill's book is a superb, even gripping, description of the American health system and the creation of Obamacare, but he is misguided in his recommendation for reform by turning over the administration of the health care system to hospitals. The last thing we need is more foxes guarding the henhouse.

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

Notes

1. See David Cole, "Can They Crush Obamacare?" The New York Review, March 19, 2015.
2. Farrar, Straus and Giroux, 2014.

Help get PNHP's message out!



Follow PNHP on Facebook (facebook.com/doctorsforsinglepayer) and Twitter (@pnhp) today and help us get the single-payer message in front of as many people as possible. We've gone viral multiple times, including the above graphic that reached approximately 3 million users this May, and need your help with sharing and retweeting our content!

THE HUFFINGTON POST
THE INTERNET NEWSPAPER: NEWS BLOGS VIDEO COMMUNITY

July 6, 2015

The Choice Ahead: A Private Health-Insurance Monopoly or a Single Payer

By Robert Reich

The Supreme Court's recent blessing of Obamacare has precipitated a rush among the nation's biggest health insurers to consolidate into two or three behemoths.

The result will be good for their shareholders and executives, but bad for the rest of us – who will pay through the nose for the health insurance we need.

We have another choice, but before I get to it let me give you some background.

Last week, Aetna announced it would spend $35 billion to buy rival Humana in a deal that will create the second-largest health insurer in the nation, with 33 million members.

The combination will claim a large share of the insurance market in many states – 88 percent in Kansas and 58 percent in Iowa, for example.

A week before Aetna's announcement, Anthem disclosed its $47 billion offer for giant insurer Cigna. If the deal goes through, the combined firm will become the largest health insurer in America.

Meanwhile, middle-sized and small insurers are being gobbled up. Centene just announced a $6.3 billion deal to acquire Health Net. Earlier this year Anthem bought Simply Healthcare Holdings for $800 million.

Executives say these combinations will make their companies more efficient, allowing them to gain economies of scale and squeeze waste out of the system.

This is what big companies always say when they acquire rivals.

Their real purpose is to give the giant health insurers more bargaining leverage over employees, consumers, state regulators, and healthcare providers (which have also been consolidating).

The big health insurers have money to make these acquisitions because their Medicare businesses have been growing and Obamacare is bringing in hundreds of thousands of new customers. They've also been cutting payrolls and squeezing more work out of their employees.

This is also why their stock values have skyrocketed. A few months ago the Standard & Poor's (S&P) 500 Managed Health Care Index hit its highest level in more than twenty years. Since 2010, the biggest for-profit insurers have outperformed the entire S&P 500.

Insurers are seeking rate hikes of 20 to 40 percent for next year because they think they already have enough economic and political clout to get them.

That's not what they're telling federal and state regulators, of course. They say rate increases are necessary because people enrolling in Obamacare are sicker than they expected, and they're losing money.

Remember, this an industry with rising share values and wads of cash for mergers and acquisitions.

It also has enough dough to bestow huge pay packages on its top executives. The CEOs of the five largest for-profit health insurance companies each raked in $10 to $15 million last year.

Robert Reich

After the mergers, the biggest insurers will have even larger profits, higher share values, and fatter pay packages for their top brass.

There's abundant evidence that when health insurers merge, premiums rise. For example, Leemore Dafny, a professor at the Kellogg School of Management at Northwestern University, and his two co-authors, found that after Aetna merged with Prudential HealthCare in 1999, premiums rose 7 percent higher than had the merger not occurred.

The problem isn't Obamacare. The real problem is the current patchwork of state insurance regulations, insurance commissioners, and federal regulators can't stop the tidal wave of mergers, or limit the economic and political power of the emerging giants.

Which is why, ultimately, American will have to make a choice.

If we continue in the direction we're headed we'll soon have a health insurance system dominated by two or three mammoth for-profit corporations capable of squeezing employees and consumers for all they're worth – and handing over the profits to their shareholders and executives.

The alternative is a government-run single payer system – such as is in place in almost every other advanced economy – dedicated to lower premiums and better care.

Which do you prefer?

Robert Reich is Chancellor's Professor of Public Policy at the University of California at Berkeley. He has served in three national administrations, most recently as secretary of labor under President Bill Clinton. He has written thirteen books, including "The Work of Nations," "Locked in the Cabinet," "Supercapitalism," and his most recent book, "Aftershock."

Journal of Health Politics, Policy and Law

April 2015

Overutilization, Overutilized

By Deborah Levine and Jessica Mulligan

ABSTRACT

Overutilization is commonly blamed for escalating costs, compromising quality, and limiting access to the US health care system. Recent estimates suggest that nearly one-third of health care spending in the United States is a result of unnecessary care. Despite the surge of exposés that purport to uncover this "new" problem, narratives about overutilization have been circulating in health policy debates since the beginnings of the health insurance industry. This article traces how the term overutilization has spread in popularity from a relatively small community of mid-twentieth-century insurance experts to economists, physicians, epidemiologists, and eventually the news media of the early twenty-first century. A quick glimpse at the history of the term reveals that there has been constant disagreement and debate over the meaning and impact of overutilization. Moreover, the term has been put to very different uses, from keeping socialism at bay to preserving the fiscal integrity of Medicare to protecting the health of patients. The overutilization narrative, seductive in its promise of cutting costs without sacrificing access to quality care, too often drowns out other difficult conversations about social welfare, health equity, prices, and universal coverage. …

Overutilization of certain services probably is one of the many problems in our health care system. But there are grave consequences to considering overutilization the central problem.

Conclusion: Overutilization Has Overreached

For sixty years, overutilization has been a key term in health policy debates. The term emerged in literature about the potential demise of voluntary insurance and then spread to new domains: first with inpatient hospital stays and then eventually with almost every other form of care. The audience for this narrative expanded as well: from industry insiders to economists, physicians, public health researchers, the media, and finally, patients.

Utilization review and other techniques for curbing overutilization like requiring prior authorization, capitated payments, and increasing patient cost sharing have now been employed by insurers and providers for decades. Yet the overall impact on health care costs appears negligible; costs continue to rise. Moreover, some analysts point out that the United States may be underutilizing a host of important services relative to other countries, especially primary care.

Overutilization of certain services probably is one of the many problems in our health care system. But there are grave consequences to considering overutilization the central problem. For one, the increased patient cost sharing that is supposed to rein in overutilization has contributed to a situation in which 31.7 million people with insurance are considered underinsured because they dedicate such a high proportion of their household income to medical bills. And as to the sizable uninsured population, the prospect of expanding coverage has too often been cast as a menace to the system rather than a laudable and socially responsible achievement.

There is a need for a more critical conversation about who wins and loses thanks to the present system setup. Some work is already happening in this regard, but it has yet to reach the wide popular audiences and become "common sense" in the way that overuse has. Academic researchers have called attention to how much we pay for services and pointed out that our high prices are largely to blame for runaway health care costs. Others have argued that risk-pooling techniques need to be resocialized by turning away from the highly segmented, experience-rated pools that currently dominate insurance marketplaces. But it is too difficult for these counternarratives to be heard above the seductive din about overutilization and the attendant need for individual consumer restraint that continues to dominate discussions of health care costs in the United States.

Overutilization is a management neologism that has become an economistic health policy fairy tale where costs can be cut, services denied, and hospital days reduced with no harm — financial, physical, or otherwise — to patients, providers, or payers. Curbing overutilization alone will not redeem our health care system. And real people stand to lose when reducing utilization and increasing efficiency is seen as the primary goal of health policies.

Deborah Levine and Jessica Mulligan are assistant professors of health policy and management at Providence College in Providence, R.I.

Latino Medical Student Association
Founded to represent, support, educate, and unify Latino(a) Medical Students

March 27, 2015

Latino Medical Student Association backs single-payer reform

PNHP note: The resolution below was adopted at the Annual Policy Summit of the Latino Medical Student Association (LMSA) in Washington, D.C., on March 27. It had been submitted to the assembly by 63 students at 19 medical schools. Among those advocating for its adoption at the meeting were co-author Camilo Doig Acuña, a student at the New York University School of Medicine, Kami Veltri, a student at the Georgetown University School of Medicine, and Dr. Robert Zarr, PNHP's president, who participated in the deliberations. In the interest of conserving space, we have removed the resolution's 27 footnotes.

Resolution on Advocacy for Single-Payer Health Insurance

Whereas, 48 million Americans lacked health insurance in 2012, and an estimated 31 million Americans will remain uninsured in 2024 despite advances made by the Patient Protection and Affordable Care Act (PPACA); and

Whereas, As of 2013, Latinos had the highest uninsured rate of any U.S. racial/ethnic group, with foreign-born Latinos having an uninsured rate of nearly 40%; and

Whereas, Latinos made the smallest gains in percent of uninsured receiving coverage under PPACA from 2012-2014; and

Whereas, Underinsurance is expanding as many patients are forced into private health insurance plans with high deductibles (> $1,000) and narrow provider networks; and

Whereas, 28 million low-income Americans will cross between Medicaid and the subsidized private health insurance exchanges annually, an effect called "churning," which erodes continuity of care; and

Whereas, The United States ranks last out of 19 high-income countries in preventing deaths amenable to medical care before age 75; and

Whereas, The United States ranks last out of 7 wealthy nations in health care access, patient safety, coordination, efficiency, and equity; and

Whereas, The United States spends twice as much per capita on health care compared to the average of wealthy nations that provide universal coverage; and

Whereas, Medicare overhead costs are less than 2%, and private health insurance overhead costs range from 7% to 30%, with an average of 12%; and

Whereas, Providers are forced to spend tens of billions more dollars dealing with insurers' billing and documentation requirements, bringing total administrative costs to 31% of U.S. health spending, compared to 16.7% in Canada; and

Whereas, The United States could save more than $380 billion annually on administrative costs with a single-payer system, enough to cover all of the uninsured and eliminate or dramatically reduce cost sharing (deductibles, co-payments, co-insurance) for everyone else; and

Whereas, A single-payer Medicare-for-All national health insurance system would fundamentally simplify the financing of health care in the United States; and

Whereas, A single-payer system would cover every American from birth for all necessary medical care and would virtually eliminate health uninsurance and underinsurance in the United States; and

Whereas, A single-payer system would increase patients' freedom to choose among health care providers and not be constrained by arbitrary private insurance networks; and

Whereas, A single-payer system would protect the physician-patient relationship from interference by for profit health insurance companies whose purpose is to maximize profit; and

Whereas, A single-payer system would facilitate regional health system planning, directing capital funds to build and expand health facilities based on evidence of need, rather than being driven by the dictates of the market, which increases geographical inequality; and

Whereas, Hospitals and clinics could remain private not-for-profit organizations under a government financed single-payer system, in contrast to the government-operated hospitals of the Veterans Administration; and

Whereas, A single-payer system would control costs through proven-effective mechanisms such as negotiated global budgets for hospitals and negotiated drug prices, thereby making health care financing sustainable; and

Whereas, Support among physicians for government legislation to establish national health insurance increased from 49% in 2002 to 59% in 2007; and

Whereas, Support among the general United States population for a single-payer health care system climbed from 28% in 1979 to 51% in 2015; and support for Medicaid expansion reached 67% in 2012, including a majority of independent voters; and

Whereas, There is single-payer legislation in Congress, H.R. 676, that outlines the transition to an expanded and improved Medicare for all, including re-training programs for private health insurance workers whose jobs would be lost; and

Whereas, many state legislatures are considering legislation to move toward single-payer, therefore be it

RESOLVED, That the Latino Medical Student Association shall support and advocate for legislation to implement a single-payer health insurance system.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN

Pediatrics group calls for study of single payer

The following resolution was approved by 73 percent of the 148 delegates at the voting session of the Annual Leadership Forum of the American Academy of Pediatrics in Schaumburg, Ill., on March 15. The chief sponsor of the resolution, Dr. Robert Vinetz of Los Angeles, worked closely with several like-minded pediatricians from across the country in making the case for its adoption and in the online discussion of its merits prior to the meeting.

Educating Pediatricians about Financing Universal Health Care

Whereas, the AAP's Principles of Access states "Quality health care is a right … for … all individuals," and the health and well-being of all children, including the 1 in 5 children living in poverty, is inevitably linked to and dependent upon the health and well-being of their parents, other caregivers, the community and the larger society; and

Whereas, even with the Affordable Care Act, some 30 million people will still be uninsured, tens of millions more left underinsured and, even those with insurance being at risk for its loss, restricted choice of providers and discontinuity of care including forced-change of their "medical home"; and

Whereas, overhead costs consume over 30 cents of every United States health care dollar, with commercial insurance overhead consuming 12 to 25 cents of every insurance dollar and imposing additional burdens on everyone; while in contrast, Medicare has an overhead of less than 3 cents per dollar, imposes much lower burdens and, when adequately funded, is a model for an efficient, single, public, not-for profit health care financing method; and

Whereas, if a single, public, not-for-profit method for financing universal health care existed in the United States, as it does in virtually every other developed nation, studies show the money now consumed by overhead could instead pay for care for everyone, fairly reimburse physicians and other providers, reduce waste and control costs for people, businesses and public agencies in our society, therefore be it

RESOLVED, that the Academy, through its Committee on Child Health Financing, examine and report on financing universal health care by means of a single, not-for-profit public fund.

Current cosponsors of H.R. 676

The following members of Congress are cosponsors of H.R. 676, the Expanded and Improved Medicare for All Act. This important legislation, which closely mirrors the Physicians' Proposal for Single-Payer National Health Insurance, was introduced by Rep. John Conyers Jr. (D-MI-13) in February. Rep. Conyers has consistently championed variations of the bill for more than a decade. If your congressperson is on this list, please thank him or her. If not, urge your representative to become a cosponsor. The Capitol Switchboard number is (202) 224-3121.

Bass, Karen (D-CA-37)
Beatty, Joyce (D-OH-3)
Brady, Robert A. (D-PA-1)
Cartwright, Matt (D-PA-17)
Chu, Judy (D-CA-27)
Clark, Katherine M. (D-MA-5)
Clarke, Yvette D. (D-NY-9)
Clyburn, James E. (D-SC-6)
Cohen, Steve (D-TN-9)
Cummings, Elijah E. (D-MD-7)
DeSaulnier, Mark (D-CA-11)
Doyle, Michael F. (D-PA-14)
Edwards, Donna F. (D-MD-4)
Ellison, Keith (D-MN-5)
Engel, Eliot L. (D-NY-16)
Farr, Sam (D-CA-20)
Fattah, Chaka (D-PA-2)
Green, Al (D-TX-9)
Grijalva, Raul M. (D-AZ-3)
Gutierrez, Luis V. (D-IL-4)
Hastings, Alcee L. (D-FL-20)
Honda, Michael M. (D-CA-17)
Huffman, Jared (D-CA-2)
Jackson Lee, Sheila (D-TX-18)
Jeffries, Hakeem S. (D-NY-8)
Johnson, Henry C. "Hank," Jr. (D-GA-4)
Kaptur, Marcy (D-OH-9)
Lee, Barbara (D-CA-13)
Lewis, John (D-GA-5)
Lieu, Ted (D-CA-33)
Lofgren, Zoe (D-CA-19)
McDermott, Jim (D-WA-7)
Moore, Gwen (D-WI-4)
Nadler, Jerrold (D-NY-10)
Nolan, Richard M. (D-MN-8)
Norton, Eleanor Holmes (D-DC-At Large)
Pingree, Chellie (D-ME-1)
Pocan, Mark (D-WI-2)
Rangel, Charles B. (D-NY-13)
Roybal-Allard, Lucille (D-CA-40)
Rush, Bobby L. (D-IL-1)
Schakowsky, Janice D. (D-IL-9)
Scott, Robert C. "Bobby" (D-VA-3)
Serrano, Jose E. (D-NY-15)
Takano, Mark (D-CA-41)
Tonko, Paul (D-NY-20)
Welch, Peter (D-VT-At Large)
Wilson, Frederica S. (D-FL-24)
Yarmuth, John A. (D-KY-3)

Congratulations on Match Day!

PNHP congratulates its student members who matched into residency programs on March 20. Contact Emily Henkels at e.henkels@pnhp.org for information on how to connect with these incoming residents at your institution. The following is a partial list of our students who matched, organized by state, student name, specialty, and residency institution.

California
Christian Cuevas, Family and Preventive Medicine, Loma Linda University
Jennifer Jones, Internal Medicine, University of California - Los Angeles
Teresa Kuo, Internal Medicine, Kaiser Permanente - San Francisco
Juliana Morris, Family Medicine, University of California - San Francisco
Caleb VanderVeen, Family Medicine, University of California – Los Angeles

Colorado
Kate Adkins, Obstetrics and Gynecology, University of Colorado
Matthew Nelson, Family Medicine, St. Mary's Medical Center – Grand Junction

Connecticut
Jessica Isom, Psychiatry, Yale New Haven Hospital
Ross Kristal, Internal Medicine/Primary Care, Yale New Haven Hospital
Hannah Rosenblum, Medicine and Pediatrics, Yale New Haven Hospital
Madhuri Tirumandas, Internal Medicine, Stamford Hospital

Florida
Neeka Akhavan, Internal Medicine, University of Florida Tallahassee
Morolake Amole, Internal Medicine, University of South Florida

Illinois
Daniel Ash, Internal Medicine, University of Illinois – Chicago
Nahiris Bahamon, Pediatrics, University of Chicago
Clare Crosh, Pediatrics, Advocate Christ Children's Hospital
Arielle Hirschfeld, Family Medicine, University of Illinois – Chicago
Alex Neuman, Family Medicine, West Suburban Medical Center

Indiana
Ina Clark, Emergency Medicine, Indiana University

Iowa
Wern Ong, Family Medicine, University of Iowa

Maryland
Chad Hochberg, Internal Medicine, Johns Hopkins University Hospital
Beth Pineles, Obstetrics and Gynecology, University of Maryland
Max Romano, Family and Preventive Medicine, MedStar Franklin Square Medical Center/Johns Hopkins Bloomberg School of Public Health

Massachusetts
Ed Bender, Psychiatry, University of Massachusetts
James Besante, Internal Medicine, Mount Auburn
Lina Brinker, Pathology, Massachusetts General Hospital
Steve Marsh, Family Medicine, Boston University
Chelsea McGuire, Family Medicine, Boston University
Melissa Palma, Family Medicine, Greater Lawrence Family Health Center

New York
Elijah Douglass, Internal Medicine, NYP/Weill Cornell
Sameen Farooq, Primary Care and Social Internal Medicine, Albert Einstein/Montefiore
Shanti Leon Guerrero, Family Medicine, Institute for Family Health – Mount Sinai-Harlem
Mariya Masyukova, Primary Care and Social Internal Medicine, Albert Einstein/Montefiore
Joseph Thomas, Internal Medicine, University at Buffalo

Oregon
Andrew Dilla, Anesthesiology, Oregon Health and Science University

Pennsylvania
Susanna O'Kula, Neurology, University of Pennsylvania

Virginia
Dan Moore, Family Medicine, Virginia Commonwealth University - Shenandoah

Washington
Erin Bulleit, Family Medicine, Swedish Medical Center- Cherry Hill
Janice Lee, Family Medicine, Southwest Washington/PeaceHealth Southwest

Wisconsin
Nan Sethakorn, Internal Medicine, University of Wisconsin – Madison
Sara Siddiqui, Internal Medicine, Medical College of Wisconsin

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June 18, 2015

The latest legal challenge to Canada's health care system

A primer on the legal dispute between Dr. Brian Day and British Columbia

By Karen S. Palmer, M.P.H., M.S.

In British Columbia, as in the rest of Canada, the health care system, "Medicare," provides public funding for all medically necessary hospital and physician services.

The Canada Health Act (federal legislation enacted in 1984) strongly discourages private payment, such as extra billing and user charges, for hospital and physician services covered under Medicare. If provinces (except Quebec) allow private payment for such services, the federal government is mandated to withhold an equivalent amount from federal cash transfers. With rare exceptions, this financial penalty for failing to comply with the legislation has been effective in restricting extra billing and other user fees.

The CHA is silent on care delivery, taking no position on whether health care should be delivered in private, not-for-profit or private, for-profit facilities.

When are doctors legally permitted to charge patients?

Under BC legislation, physicians enrolled in (and thus being paid by) the BC Medical Services Plan (MSP) must work entirely within the publicly-funded system when providing medically necessary care, whether that care is provided in hospitals or privately-owned facilities. As long as physicians are enrolled in MSP, they are prohibited from charging BC residents any fee for, or in relation to, the delivery of medically necessary hospital and physician services.

Physicians are, however, permitted to completely un-enroll from MSP. Non-enrolled physicians in BC may charge patients whatever amounts they want for providing medically necessary services, so long as those services are not provided in a "hospital" or a "community care facility" (as defined by the Hospital Act).

Patients are permitted to pay a non-enrolled physician out-of-pocket, but not with private "duplicative" insurance (such insurance — covering the same patients and services as the public insurance — does not currently exist in BC). Very few BC physicians are non-enrolled in MSP.

What's the court case about?

Dr. Brian Day, the president and CEO of two private for-profit investor-owned facilities (Cambie Surgery Centre and their partner, Specialist Referral Clinic, neither of which is designated as a "hospital") is challenging the prohibition on private billing by enrolled physicians.

Dr. Day alleges that the limits on charging patients privately, enshrined in the Canada Health Act (CHA, and its equivalent provincial legislation in BC), infringe patients' rights to life, liberty and security of the person under Section 7 of the Canadian Charter of Rights and Freedoms.

The essence of Dr. Day's claim is that, because the publicly-funded system compels some patients to wait for the delivery of some medically necessary services (in particular, elective surgery), patients should have the right to obtain such services more quickly by paying privately, either out-of-pocket or through private insurance.

Dr. Day supports a system of "dual practice" in which physicians can be paid from both public and private purses, including through private health insurance covering medically necessary hospital and physician care.

Beyond this, Dr. Day also argues that even physicians still enrolled in MSP should be allowed to "extra bill" patients — through out-of-pocket payment and private insurance — who do not wish to wait their turn for publicly-funded care. His rationale is that since BC physicians not enrolled in MSP are already permitted to collect out-of-pocket payments for care delivered outside of hospitals or community care facilities, then private duplicative insurance should also be for sale to BC patients who do not wish to wait for publicly-funded care, even when they are treated by physicians still enrolled in MSP.

Why is the province of BC opposing Day's position?

The Attorney General (AG) of BC will argue against these changes to Medicare, based on evidence affirming that allowing a parallel private payment system, and physician dual practice, in an otherwise publicly-funded health care system, negatively affects these systems.

The AG will argue that there is no causal connection between BC's limits on private payment and the alleged deprivation of life, liberty or security of the person.

Instead of care being delivered on the basis of need, as is the case now, overturning the limitations on private payment would result in care being provided first to those who can afford to pay. This means that if the law impeding extra-billing is over-turned,

(continued on next page)

CMAJ Medical knowlege that matters

March 16, 2015

Estimated cost of universal public coverage of prescription drugs in Canada

By Steven G. Morgan, PhD, Michael Law, PhD, Jamie R. Daw, BHSc, MSc, Liza Abraham, BSc, Danielle Martin, MD, MPubPol

ABSTRACT

Background: With the exception of Canada, all countries with universal health insurance systems provide universal coverage of prescription drugs. Progress toward universal public drug coverage in Canada has been slow, in part because of concerns about the potential costs. We sought to estimate the cost of implementing universal public coverage of prescription drugs in Canada.

Methods: We used published data on prescribing patterns and costs by drug type, as well as source of funding (i.e., private drug plans, public drug plans and out-of-pocket expenses), in each province to estimate the cost of universal public coverage of prescription drugs from the perspectives of government, private payers and society as a whole. We estimated the cost of universal public drug coverage based on its anticipated effects on the volume of prescriptions filled, products selected and prices paid. We selected these parameters based on current policies and practices seen either in a Canadian province or in an international comparator.

Results: Universal public drug coverage would reduce total spending on prescription drugs in Canada by $7.3 billion (worst-case scenario $4.2 billion, best-case scenario $9.4 billion). The private sector would save $8.2 billion (worst-case scenario $6.6 billion, best-case scenario $9.6 billion), whereas costs to government would increase by about $1.0 billion (worst-case scenario $5.4 billion net increase, best-case scenario $2.9 billion net savings). Most of the projected increase in government costs would arise from a small number of drug classes.

Interpretation: The long-term barrier to the implementation of universal pharmacare owing to its perceived costs appears to be unjustified. Universal public drug coverage would likely yield substantial savings to the private sector with comparatively little increase in costs to government.

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

then all physicians would be able to charge patients whatever fees they wished, on top of what physicians are already paid by the government.

The AG will argue that care should be delivered on the basis of need, not ability to pay. If the same physicians are delivering both publicly-funded and privately-funded care, evidence from other countries shows that patients who can afford to pay out-of-pocket or through private insurance are likely to get care faster, regardless of their need. When physicians preferentially treat private pay patients, the probable result of a parallel public-private pay system is increased wait times for those unable to pay.

The AG will also bring evidence to show that allowing a multi-payer health care system will lure physicians from the public-pay sector to the private-pay sector, potentially reducing the availability, quality and timeliness of care in the publicly-funded system. It will also argue that a multi-payer health care system that includes private health insurance will drive up costs, forcing public funders to pay higher prices to "compete" with private insurers.

The trial is expected to commence in the British Columbia Supreme Court in November 2015.

Karen Palmer is adjunct professor in the Faculty of Health Sciences at Simon Fraser University, British Columbia, where she taught comparative health care policy until 2013. She is currently an independent health policy analyst and health services researcher.

Dr. Brian Day defeated in bid to head BC doctors

Doctors of BC – the British Columbia medical association – announced on June 19 that Dr. Alan Ruddiman, a strong supporter of Canada's single-payer system, defeated Dr. Brian Day, a sharp critic of that system, in a run-off election for the presidency of the group. Of the 5,525 votes cast, Ruddiman received 3,065, or 55 percent.

By Tsung-Mei Cheng

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ANALYSIS & COMMENTARY

Reflections On The 20th Anniversary Of Taiwan's Single-Payer National Health Insurance System

Tsung-Mei Cheng (maycrein@princeton.edu) is a health policy research analyst at the Woodrow Wilson School of Public and International Affairs, Princeton University, in Princeton, New Jersey.

ABSTRACT On its twentieth anniversary, Taiwan's National Health Insurance (NHI) stands out as a high-performing single-payer national health insurance system that provides universal health coverage to Taiwan's 23.4 million residents based on egalitarian ethical principles. The system has encountered myriad challenges over the years, including serious financial deficits. Taiwan's government managed those crises through successive policy adjustments and reforms. Taiwan's NHI continues to enjoy high public satisfaction and delivers affordable modern health care to all Taiwanese without the waiting times in single-payer systems such as those in England and Canada. It faces challenges, including balancing the system's budget, improving the quality of health care, and achieving greater cost-effectiveness. However, Taiwan's experience with the NHI shows that a single-payer approach can work and control health care costs effectively. There are lessons for the United States in how to expand coverage rapidly, manage incremental adjustments to the health system, and achieve freedom of choice.

In 1986 Taiwan's government began planning to provide universal health insurance for its citizens. At the time, 41 percent of Taiwan's population (8.6 million people) was uninsured and either paid for care out of pocket or went without it. The objective was to provide every citizen with timely access to needed health care, on equal terms, without unduly burdening the budgets of households, but also with effective controls on the growth of overall health spending.

In the relatively short time from the late 1980s to 1994, Taiwan's health policy planners carefully studied alternative health care systems around the world. This global survey persuaded the planners to consolidate the more than ten insurance programs then in existence in Taiwan into a single-payer government-run health insurance system modeled after the Canadian provincial health plans, but coupled with a financing scheme inspired by Germany's payroll-based premium system.[1]

The legislation for implementing the reform was passed in July 1994, and the implementation began March 1, 1995. Uptake of the new insurance program was swift. By the end of 1995, 92 percent of Taiwan's population was enrolled in the National Health Insurance (NHI).[2]

This year marks the twentieth anniversary of Taiwan's major health reform. The rapid uptake of reform can be attributed to a "window of opportunity" presented by the confluence of several enabling factors: strong public demand, strong political leadership, competition between rival political parties, and the need to control double-digit growth in health care spending.[1(p73)] Other

facilitating factors were decades of high economic growth; a well-educated and highly motivated civil service; and a preexisting national health care service network, which provided the delivery capacity for the NHI.[3]

Overview Of The National Health Insurance System

BENEFITS Taiwan's NHI provides a comprehensive national benefit package, which includes inpatient, outpatient, and dental care; traditional Chinese medicine; renal dialysis; prescription drugs; prenatal care; physical rehabilitation; home nursing care; chronic mental illness care; and preventive services such as pediatric and adult health examinations and cancer screening. Patients have access to over 19,000 contracted providers (92.6 percent of all hospitals, clinics, and other health care facilities in Taiwan) and over 16,700 drugs.[4]

CHOICE, ACCESS, AND WAITING TIMES Patients in Taiwan have complete freedom of choice among providers when they seek care; they enjoy easy access to doctors, including specialists; and their access to care is protected by multiple measures. According to former health minister Ching-Chuan Yeh, "Anytime you wish to see a doctor, you can. For example, if you decide to see an ophthalmologist, within ten minutes you can find one to see, even in the evenings."[5(p1036)]

Patients in Taiwan rarely face long wait times for health care services and enjoy a high degree of timely access to care, which is a key measure of responsiveness for any health system. For example, wait times for joint replacement in Canada range from months to years and "often exceed the optimal time for many patients."[6] In Taiwan the average wait times for a total hip replacement and a knee replacement are twelve and eighteen days, respectively.[7]

Measures aimed at protecting access by removing financial barriers, especially for the sick and disadvantaged, include premium subsidies for the poor and relief loans and installment payment plans for premiums for the near-poor or people who are temporarily unemployed. There are also copayment exemptions for thirty catastrophic illnesses or conditions; prenatal care and delivery; preventive health services; medical services in remote, mountainous areas and on offshore islands; and low-income households, veterans, and children under age three. Copay ceilings further safeguard access to care.

Finally, an integrated delivery system, established in 1999, delivers health care—including twenty-four-hour emergency service and evening and overnight outpatient care—to over 400,000 residents of Taiwan's forty-eight mountainous areas and offshore islands via medical personnel from twenty NHI contract hospitals who rotate in and out of these areas.[4]

New drugs are often not introduced in Taiwan until two years after their introduction in the United States. For expensive drugs, the delay can be up to five years.[5]

ENROLLMENT AND ADMINISTRATION An enrollment mandate applies to all citizens and foreign nationals living in Taiwan for longer than four months. Enrollment is simple and straightforward, with the NHI serving as the single insurer and thus forming a single risk pool. One flat premium rate and a uniform enrollment process apply to everyone, regardless of sex, age, health, or employment status.

As of 2013 over 99.9 percent of Taiwan's 23.4 million residents were insured. Only 40,000 people were uninsured—mostly Taiwanese living overseas permanently, who are exempt from enrollment (Wen-Ta Chiu, minister of health, Taiwan, personal communication, February 26, 2013).

The NHI is administered by the government-run National Health Insurance Administration, under the Ministry of Health and Welfare. As the single purchaser, the National Health Insurance Administration wields considerable monopsonistic power over the providers of health care.

FINANCING A national health system may be financed by taxes, premiums, out-of-pocket payments, or some combination of the three. From the NHI's inception in 1995 to 2012, Taiwan used premium financing, with premiums derived from regular (primary) payroll income, which constitutes approximately 60 percent of Taiwan's total national income.[8] However, government premium subsidies based on general taxation for certain population groups play a role in the NHI's overall financing.

The NHI premium base proved insufficient to meet the program's expenditure growth. This led to periods of serious financial imbalances, which threatened the stability and sustainability of the system. In addition, purely payroll-based financing was deemed to be inequitable.

Thus, in January 2013 a supplemental premium scheme based on six sources of income not based on a regular payroll—bonuses, professional fees, pay for second jobs, interest, dividends, and rents—was introduced as an important part of a major reform known as the Second-Generation National Health Insurance reform. The new premium base draws on over 90 percent of Taiwan's total national income,[8] which is a significant improvement in the fairness of financial contribution based on people's ability to pay. In 2014 the insured, employers, and the government contributed 36.92 percent, 29.30 percent,

and 33.78 percent, respectively, of the premiums for the NHI.[9]

The current monthly premiums consist of a flat rate of 4.91 percent of the insured person's wages or salary and supplemental non-payroll-based premiums, at a flat rate of 2 percent. For both types of premiums, ceilings and floors apply. For example, any amount of a monthly salary in excess of US $6,067 and the first US $166 of monthly income from a second job are exempt.[4]

The NHI levies premiums per capita, up to a maximum of three dependents (children and elderly parents) per household. Families with dependents thus pay more in premiums.

People insured by the NHI are categorized into six population groups, based mainly on occupational status (Exhibit 1). Premiums are levied on members of the six groups that make up the program's insurance pool. There are government subsidies in varying amounts for members of each group.

DELIVERY SYSTEM Taiwan's health care delivery system is a mixture of private nonprofit and government-owned hospitals, private clinics, and other health care facilities. For-profit hospitals are not allowed in Taiwan. However, many nonprofits behave as if they were for profit: They compete fiercely to maximize their revenues and profits.

Compared to countries in the Organization for Economic Cooperation and Development (OECD), excluding Japan and South Korea, Taiwan has a much higher number of beds per 1,000 population, as a result of hospital capacity expansion in response to competition (Exhibit 2).

Taiwan also has much lower numbers of doctors and nurses per 1,000 population compared to other OECD countries (Exhibit 2): The doctor-population ratio in Taiwan is 58.6 percent that of the median in OECD countries (3.0 per 1,000 population in 2010).[8] Taiwan's government limits the number of graduates from medical schools to 1,300 a year, a policy decision Taiwan's physician associations agree with. Hospitals keep nurse staffing ratios low to save costs.

PAYING PROVIDERS Taiwan's providers derive revenues from three sources: NHI payments, copays by patients, and the sale of services and products not covered by the NHI. Fee-for-service is the predominant payment method for pro-

EXHIBIT 1

Taiwan's National Health Insurance Premium Contribution Percentages, By Population Group

Group (percent of population)		Contribution (%)		
		Insured	Employer	Government
GROUP 1 (53.76)				
Civil servants, volunteer servicemen, public office holders	Insured and dependents	30	70	0
Private school teachers	Insured and dependents	30	35	35
Employees of publicly or privately owned enterprises or institutions	Insured and dependents	30	60	10
Employers, self-employed professionals, technical specialists	Insured and dependents	100	0	0
GROUP 2 (17.08)				
Occupation union members, foreign crew members	Insured and dependents	60	0	40
GROUP 3 (11.85)				
Members of farmers', fishermen's, and irrigation associations	Insured and dependents	30	0	70
GROUP 4 (0.69)				
Military conscripts, alternative servicemen, military school students on scholarships	Insured	0	0	100
Institutionalized convicts	Insured	0	0	100
GROUP 5 (1.34)				
Low-income households	Household members	0	0	100
GROUP 6 (15.28)				
Veterans	Insured	0	0	100
Dependents of veterans	Dependents	30	0	70
Others	Insured and dependents	60	0	40

SOURCE Author's analysis of data from Bureau of National Health Insurance, National Health Insurance in Taiwan (Note 4 in text). **NOTE** "Insured" includes up to three dependents in the household.

viders under the NHI's global budget system. Under an umbrella global budget that covers total NHI expenditures, there are five separate global budgets for the following sectors: hospital care, primary ambulatory care (at independently owned and operated clinics), dental care, traditional Chinese medicine, and renal dialysis.

All providers expand their volume of services to maximize their share of the common budget, making it a classic zero-sum game. This sets off fierce competition for patients, who in a fee-for-service system always "are both objects of human compassion and cash-yielding biological structures."[10]

The National Health Insurance Administration is in the process of expanding diagnosis-related group (DRG) payments to hospitals. As of 2013, 164 DRGs had been introduced, which accounted for 17.36 percent of hospital inpatient payments.[8] As of 2014, 401 of 1,062 DRG items, accounting for 23 percent of total inpatient claims, have been implemented.[11]

The National Health Insurance Administration has pilot programs aimed at improving the quality of outcomes and reducing waste. Examples include pay-for-performance, capitation, family physician–based integrated care, hospital outpatient integrated care, and a plan to improve the quality of postacute care to reduce disability and avoid repeat admissions.[8]

SETTING FEES With input from the National Health Insurance Commission—a thirty-five-member multistakeholder body under the purview of the Ministry of Health and Welfare—the National Health Insurance Administration sets national uniform fees for the five sectoral global budgets, which are paid out quarterly. A basic relative-value schedule for the various services is expressed initially in points, with different point values assigned to different services (for example, the value for a normal vaginal delivery was 36,335 points—approximately US$1,200—in 2010). That schedule is then translated into a monetary fee schedule by valuing one point at NT$1 at the start of each quarter. To keep the lid on global budgets, the administration uses a "quarterly floating NT$–point-value mechanism," under which the value "floats," or is automatically adjusted. The adjustment is usually downward so that total payments to providers each quarter do not exceed the total budget for the quarter.

Quarterly NT$–point values may differ among the five sectors, depending on the total number of points—that is, the sum of all the services provided in the sector for the quarter—billed by the providers within the different sectors against their common budget. For example, from the first quarter of 2007 through the third quarter of 2014, quarterly NT$–point-values ranged from a high of NT$0.992 for the dental sector to lows of NT$0.919 for the hospital sector and NT$0.828 for the renal dialysis sector (Cheng-Hua Lee, deputy director-general of the National Health Insurance Administration, Taiwan, personal communication, November 14, 2014).

Different fee schedules apply to hospitals and clinics, according to which of four categories (levels) they belong to: large hospitals and medical centers, regional hospitals, district hospitals, and clinics. All providers in a single level are paid the same fees. Providers cannot bill patients for more than the fees in the fee schedule except for several devices (for example, special-function intraocular lens implants, drug-eluting stents, and artificial joints and limbs). In those cases, patients can pay extra for their preferred choices.

EXHIBIT 2

Numbers Of Physicians, Nurses, And Hospital Beds Per 1,000 Population In Taiwan And Selected Organization For Economic Cooperation And Development (OECD) Countries, 2012 Or Nearest Year

	Physicians	Nurses	Beds
Taiwan	1.7	5.06	6.9
OECD median	3.2	8.8	4.8
Australia	3.3	10.2	3.8
Canada	2.5	9.4	2.7
France	3.3	9.1	6.3
Germany	4.0	11.3	8.3
Japan	2.3	10.5	13.4
South Korea	2.1	4.8	10.3
Switzerland	3.9	16.6	4.8
United Kingdom	2.8	8.2	2.8
United States	2.5	11.1	3.1

SOURCE Author's analysis of data from the following sources: (1) Second-Generation National Health Insurance Evaluation Commission. [Second-generation National Health Insurance comprehensive evaluation report] (Note 8 in text). (2) OECD. Health policies and data: OECD health statistics 2014—frequently requested data (Note 13 in text).

System Performance

COST CONTAINMENT Before implementation of the NHI, annual growth of national health expenditures in Taiwan averaged in the double-digit range. During the period 1992–95, for example, average annual growth was 13.9 percent.[12] In the years immediately following the NHI's introduction, that growth decreased to 6.0–9.0 percent. Since full implementation of the global budget system in July 2002, annual growth in national health expenditures has slowed further, averaging 3.0–4.5 percent (Ex-

EXHIBIT 3

Growth In Taiwan's National Health Expenditures (NHE), 1992–2013

Year	Growth in NHE (%)	Growth in GDP (%)	NHE as % of GDP
1992	17.37	11.62	4.68
1993	13.55	10.40	4.81
1994	10.74	9.42	4.87
1995	17.33	8.86	5.25
1996	10.84	8.64	5.36
1997	8.29	8.46	5.35
1998	8.87	7.34	5.43
1999	8.14	4.83	5.60
2000	4.26	5.58	5.53
2001	3.67	–2.52	5.88
2002	6.32	4.85	5.96
2003	5.98	2.73	6.15
2004	7.23	6.25	6.21
2005	4.27	3.30	6.26
2006	4.34	4.29	6.27
2007	3.79	5.45	6.17
2008	2.87	–2.25	6.49
2009	5.26	–1.10	6.91
2010	2.61	8.58	6.53
2011	2.57	1.16	6.62
2012	2.75	2.68	6.63
2013	3.21	3.43	6.61

SOURCE Author's analysis of data from the following sources: (1) For 1994–2007: Health Statistical Trends 2010. National Health Expenditure 2010. Department of Health, Taiwan. 2011. Chinese. (2) For 2008–13: Taiwan Ministry of Health and Welfare. [Statistics and trends in health and welfare 2013] (Note 14 in text). **NOTE** GDP is gross domestic product.

hibit 3).[8] For 2015 the National Health Insurance Commission recommended a 3 percent annual growth rate.

Total national health expenditures in Taiwan were 6.63 percent of gross domestic product (GDP) in 2012 (Exhibit 3). This is low when compared to the average of 9.3 percent for OECD countries in the same year.[13]

Per capita health spending in purchasing power parity US dollars in 2012 was $2,668 in Taiwan.[14] In contrast, the average spending in 2012 was $3,484 for the OECD countries and $8,745 for the United States.[14]

In 2013 NHI expenditures accounted for 52.2 percent of Taiwan's national health expenditures. Out-of-pocket spending by the insured accounted for another 35.8 percent.[14] Government public health and general administration expenditures accounted for 6.0 percent, and health care investments (capital formation) accounted for 5.4 percent.[14]

Out-of-pocket spending in Taiwan may appear high at first glance. But according to Huang San-Gui, director-general of the National Health Insurance Administration (personal communications, August 8 and September 4, 2014), only 33.8 percent of reported out-of-pocket spending was for medical expenses associated with office visits and inpatient care in the form of copays and coinsurance. Therefore, out-of-pocket spending in Taiwan associated with necessary health care (such as medical and dental care and drugs) amounted to only 12.1 percent of the national health expenditures in 2012.

OVERCOMING FINANCIAL CRISES Except for the first three years of the NHI's operations, the program's expenditures have typically outstripped revenues. In the period 1996–2008, its revenues increased at an average annual rate of 4.34 percent, compared to a rate of 5.33 percent for its expenditures.[15]

To make the budget balance, NHI officials resorted to both supply- and demand-side measures. These included higher copays for certain types of health care visits, drugs, inpatient care, lab tests, and examinations; the sale of lottery tickets; higher tobacco taxes; and borrowing from banks.[1] Costs were reduced by cutting drug prices; introducing a sliding scale of payments for outpatient visits if providers exceeded the "reasonable" number of patients seen; stepping up claims reviews; eliminating subsidies for medical education; introducing DRGs for hospitals; and, ultimately, global budgeting, a measure proven to be effective for cost containment in OECD countries in the 1980s.[1]

These combined measures enabled the National Health Insurance Administration to keep the program in operation, even adding benefits annually. However, in 2009 the NHI's cumulative deficits reached 15.1 percent of its annual revenue.[16]

A long-overdue premium rate increase in 2010, only the second in the NHI's history, ultimately restored the program's financial balance. The increase eliminated all deficits by 2012 and enabled the NHI to begin accumulating healthy surpluses. As of October 31, 2014, cumulative surpluses amounted to 27 percent of the program's expenditures for the first ten months in 2014, or 2.7 times the monthly expenditure in 2014.[16] The NHI's sound financial status is expected to last through 2016 or 2017.

ADMINISTRATIVE SIMPLICITY In 2014 the National Health Insurance Administration's staff of 2,958 administered the program for Taiwan's population of 23.4 million.[8] Because the system uses a common nomenclature—that is, standard names for the various procedures performed by all providers of health care—it is easy to use modern health information technology (IT) to administer the NHI efficiently. In 2014 the Taiwan NHI administrative budget was only 1.07 percent of the program's expenditures.[8]

SATISFACTION OF THE PUBLIC AND PROVIDERS The NHI's public satisfaction ratings have been

Researchers in Taiwan have found a positive correlation between better access to health care and improved population health outcomes.

consistently high—around 80 percent in recent years.[8] Comprehensive benefits, low premiums, low copays, easy accessibility, free choice of providers, and virtually no waiting times explain the high ratings.[8] Public satisfaction with the NHI declined when the first premium rate increase took effect in 2002 and again in 2006, when a second premium rate increase was being considered. But both times public approval ratings recovered quickly.[4]

However, doctors in Taiwan, especially those based in hospitals, complain about being overworked and underpaid. These are common complaints from doctors in most countries. Nonetheless, doctors in Taiwan do work extremely hard, including seeing patients at night and on weekends. A 2013 study by researchers in Taiwan reported both high incidence of burnout ("emotional exhaustion") and high risk of malpractice among Taiwan's doctors.[17]

In recent years, serious doctor shortages have developed in four medical specialties[8]—internal medicine, surgery, pediatric medicine, and obstetrics and gynecology—as a result of discontent with the NHI's fee schedules, long hours, and prospects of malpractice suits. The program also faces serious nurse shortages.

INFORMATION TECHNOLOGY Taiwan's government invested in building a strong IT infrastructure at the NHI's inception. All claims are filed and processed electronically. The National Health Insurance Administration's automated IT-supported claims review checks for the overall appropriateness of claims. It also selects a small percentage of all claims for individual professional review by clinical experts.

Everyone in Taiwan carries an NHI card. The card has a memory chip that stores personal information, including the past six visits to health care providers, diagnoses, prescriptions, and allergies; and public health (vaccinations and organ donation and do-not-resuscitate instructions) and insurance data. The card makes seeing a doctor at a clinic or hospital as convenient as shopping in a mall with a credit card.

The patient presents the card at a clinic or hospital, and the provider swipes it through a card reader, along with the provider's own card. Data are transmitted to the National Health Insurance Administration instantly.

Providers are required to report to the administration all services delivered daily, by patient. This allows the administration to perform detailed profiling of both patients and providers.[5] The administration thus knows utilization and costs for the entire health care system in almost real time. Such rapid data transmission also makes it possible to efficiently detect and monitor public health emergencies—for example, cases of severe acute respiratory syndrome (SARS) in 2003 and of H1N1 flu in 2009.

In 2014 the National Health Insurance Administration implemented two IT initiatives aimed at improving quality and reducing the information asymmetry between patient and provider, so that patients could better manage their health care. The first initiative, which the administration dubbed the Pharma-Cloud program, aims to improve patient safety by enabling the prescribing physician to check for potential adverse reactions among multiple drugs prescribed by different doctors and to avoid duplication of prescriptions.

The second initiative is the "My-Health-Bank" book, a personal health record book that contains the patient's complete medical history for the past year and that can be downloaded from the Internet and updated at any time. As of November 2014 more than 443,000 Taiwanese had obtained a personal identification number—which is required to safeguard patient privacy—to access their records online and download the information into their "My-Health-Bank" book.[18]

HEALTH OUTCOMES As of 2013 life expectancy in Taiwan was 76.69 years for men and 83.25 years for women.[19] The figures for the United States in 2011 were 76.3 for men and 81.1 for women.[13]

Researchers in Taiwan have found a positive correlation between better access to health care and improved population health outcomes. One study showed that life expectancy increased 1.8 years in the ten years before the implementation of the NHI, and 2.9 years in the ten years after it. The increase was greater among people in less-than-perfect health.[8]

A 2010 study showed that the NHI has been associated with a reduction in deaths from amenable causes—that is, deaths avoidable through

access to timely and effective health care—in Taiwan.[20] Deaths from amenable causes had been declining between 1981 and 1993, but the decline slowed between 1993 and 1996. Following the NHI implementation in 1995, the decline in deaths from amenable causes accelerated significantly, reaching 5.83 percent per year between 1996 and 1999.

Challenges

Overall, Taiwan can be justly proud of what its National Health Insurance has achieved in terms of safeguarding and improving the health of the Taiwanese population, and of the peace of mind that citizens enjoy when comprehensive health insurance coverage protects them from financial shocks due to illness. However, certain tasks and some future challenges remain.

POPULATION AGING Taiwan's population is aging rapidly. The cost of health care for the elderly accounted for 34 percent of NHI spending in 2011, when only 11 percent of the population was ages sixty-five or older.[8] According to government statistics, in 2015, 12.5 percent of Taiwan's population will be in this age group. That percentage will increase to 24.1 percent by 2030 and to 36.9 percent by 2050.[18] The share of spending for health care for the elderly will increase apace.

LONGER-TERM FINANCIAL SUSTAINABILITY In addition to the aging population, other factors will continue to put financial pressure on the NHI: the increase in noncommunicable disease, the introduction of expensive new technology, and the population's rising expectations.

There is room to expand the NHI's premium base. In September 2014 a major government report that evaluated the performance of the second-generation NHI so far recommended that additional sources of income be added to the premium base to increase the NHI's revenue and fairness in financial contribution.[8]

Taiwan's health spending as a percentage of GDP is low by international standards, considering its relatively high GDP per capita (US purchasing power parity $41,539) in 2013.[21] Taiwan therefore appears to have enough economic elbow room to improve the economic and clinical performance of the NHI system.

PAYMENT-INDUCED DISTORTIONS As of 2014, people in Taiwan had 11.05–12.07 outpatient visits per year, excluding visits for dental care and traditional Chinese medicine.[8] These visits tend to be short, usually under five minutes. The number of annual visits is lower than in Japan (13.0 visits in 2011) and South Korea (14.3 visits in 2012),[12] but much higher than in most other OECD countries (OECD median: 6.6 visits in 2011).[13] The low fees paid by the National Health Insurance Administration to providers and fierce competition among providers contribute to the high numbers of visits in Taiwan.

Taiwan's case illustrates that health policy makers should not miss windows of opportunity for major health reform.

In addition, the manner in which hospitals pay staff physicians affects the number of visits. A significant part of staff physicians' salary is a percentage of the money they generate for the hospital in the form of payments from the National Health Insurance Administration, copays from patients for insured services, and out-of-pocket payments for services not covered by the NHI.

The easy access that patients have to physicians drives up visit rates from the demand side. It is the age-old "moral hazard" problem that is inherent in all health insurance contracts, especially if fee-for-service is the predominant payment method.

Reforming the payment system to eliminate or at least reduce these distortions remains a major challenge for the future. Taiwan and other nations can learn from current efforts at payment reform in the United States—for example, demonstration projects now under way for bundled payments that cover entire defined episodes of health care and the Alternative Quality Contract implemented by Blue Cross Blue Shield of Massachusetts.[22]

SUBSTANDARD ADMINISTRATIVE BUDGET The extremely low administrative budget for the National Health Insurance Administration—as noted above, a mere 1.07 percent of the NHI's expenditures in 2014[8]—has forced the administration to be highly efficient in managing Taiwan's NHI program. But that budget severely constrains funding for other tasks, including continuous recalibrations of the fee schedules in light of evolving medical technology, health services research by academics or researchers in think tanks, health care technology assessment, workforce planning, more general payment reform (for example, a move to bundled pay-

ments), and continuously upgrading the IT system. The administrative budget has been declining over the years (Exhibit 4). Taiwan's government has recognized this deficiency, concluding in its 2014 evaluation of the second-generation NHI that the program's administrative budget is "seriously low for the proper administration of the National Health Insurance."[8(p236)]

Lessons Learned

Taiwan offers lessons for other nations, especially emerging-market countries that aspire to equitable universal health care.

The most important lesson of Taiwan's experience is that the single-payer approach can offer all citizens timely and affordable access to needed health care on equal terms, regardless of the patient's social, economic, and health status; sex; age; place of residence; and employment status.

A second lesson is that a single-payer model such as Taiwan's can control costs effectively. It is administratively simple and inexpensive and is the ideal platform for a powerful health IT system. It also facilitates global budgeting, if that is the only way to keep health spending in line with the growth of GDP.

A third lesson is the importance of investing heavily, up front, in a modern IT infrastructure. A modern IT system such as Taiwan's allows the government to have information about health utilization and spending in almost real time.

Fourth, Taiwan's case illustrates that health policy makers should not miss windows of opportunity for major health reform. Enabling factors include rapid economic growth, which makes it easier to redistribute resources; strong popular demand for reform; strong political leadership; a broad social and political consensus on the ethical principles that guide the health system; and the availability of a cadre of competent civil servants motivated and able to implement reform.

Lessons For The United States

Taiwan's experience demonstrates that with competence and goodwill, the challenge of adding a large influx of newly insured citizens can be met. Health systems appear to be adaptive, and the case of Taiwan illustrates that incremental improvements on reform are possible.

Taiwan's experience also might induce Americans to think more deeply about the term *freedom of choice*. In health care, freedom of choice could mean choice among health insurance carriers and health insurance contracts, choice among health care providers, or both. For Taiwan's citizens, freedom of choice among providers of health care trumped freedom of choice among insurance carriers and contracts. These citizens' high satisfaction with their health system suggests that they still endorse that choice. By contrast, in the United States freedom of choice among insurance carriers and products ranks above freedom of choice among health care providers, which often is limited to narrow networks of providers.

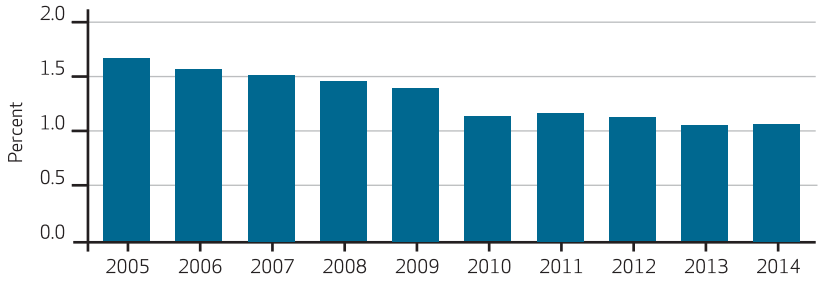
A growing body of literature has shown that by international standards, enormous human resources are used in the United States to facilitate choice among insurers and insurance products, process claims, and annually negotiate a payment system that results in rampant and bewildering price discrimination.[23] Relative to the less complex health systems elsewhere in the industrialized world, the US system is a poor platform for the effective use of modern health IT.

According to a recent report by the Institute of Medicine, the US system has excessive administrative costs that in 2009 amounted to $190 billion.[24] That is more than it would cost to attain true universal health care in the United States.[25]

It is not this author's role to prescribe what Americans should or should not do in regard to freedom of choice. But it is appropriate to invite readers to think more deeply about the relative benefits and costs of their choices. It is remarkable that in cross-national surveys, Americans have consistently given their health care delivery system relatively high marks, but their health system relatively poor ones.[26] ■

EXHIBIT 4

Administrative Expenses As Percentage Of Total National Health Insurance Expenditures, 2005–14



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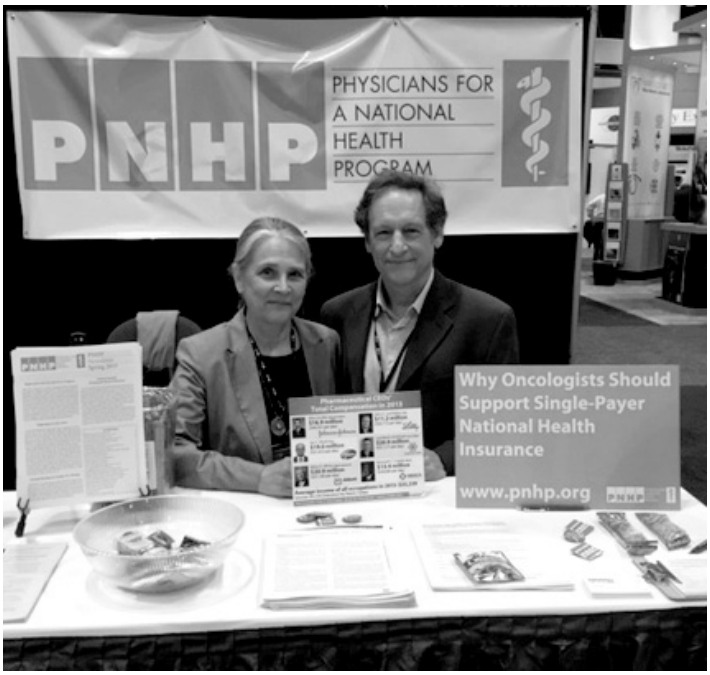
Chapter Reports

More than 400 people attended the Health4All Leadership and Training Conference and Lobby Day in Sacramento, **California**, on April 12-13. National PNHP board member Dr. Paul Song was a featured conference speaker and received a standing ovation with his call for an improved Medicare for All. The following day, participants visited the offices of 90 state lawmakers to advocate for S.B. 4, which would offer limited health coverage for the undocumented in California under the ACA. Thanks in part to the grassroots lobbying effort, an amended S.B. 4 was passed. Gov. Jerry Brown subsequently announced the state budget would include public coverage for children of the undocumented, a partial victory. Lobby Day 2015 was a partnership between the AllCare Alliance and the Health4All Coalition, bringing together hundreds of organizations representing advocates for health care reform, immigrant rights, Latino and Asian human rights, and labor rights. To get involved, contact Dr. Bill Skeen at bill@pnhpcalifornia.org.

PNHP medical student Keyon Mitchell speaks at the California Lobby Day rally in Sacramento, April 13.

The **Illinois** Single Payer Coalition and PNHP Illinois have been very active this spring. In central Illinois, the Champaign County AFL-CIO endorsed H.R. 676 and the Labor Campaign for Single Payer, the first Illinois central labor council to do so since the passage of the Affordable Care Act. PNHP Illinois sponsored a presentation by PNHP co-founder Dr. Steffie Woolhandler in Springfield titled "Health Care Reform 2.0: Beyond the Affordable Care Act" on May 1. In Chicago, the 2015 Soul of Medicine dinner honored Dr. Pam Gronemeyer and Marcia Rothenberg, R.N. Additionally, Dr. Susan Rogers hosted a Medicine in Action dinner sponsored by AMSA's Race, Ethnicity, and Culture in Health (REACH) Committee. Dr. Phil Verhoef represented PNHP in a debate on health care reform at the University of Chicago. Dr. David Ansell and members of the Students for a National Health Program (SNaHP) chapter at Rush Medical College gave a presentation on single payer to a campus audience. PNHP Illinois board member Dr. Ray Drasga generously supported a booth at the 2015 American Society of Clinical Oncologists (ASCO) convention in Chicago in May, where local PNHP volunteers engaged oncologists in a dialogue on the need for single payer. To get involved in Illinois, contact Dr. Anne Scheetz at anneschеetz@gmail.com.



Dr. Peter Gann and Wendy Pollock at the PNHP booth at ASCO 2015.

In **Iowa**, a new chapter of Students for a National Health Program was formed this spring at the University of Iowa Carver College of Medicine. Dr. Jess Fiedorowicz spoke to the students at a dinner meeting in April. Dr. Fiedorowicz also was invited to speak at the "Governing Under the Influence Symposium" in Iowa City, where he gave a presentation titled "Can we ever have truly universal health care?" To get involved in Iowa, contact Dr. Fiedorowicz at amkejess@yahoo.com.

In **Massachusetts**, Mass-Care organized a series of health care speak-outs in the spring to shed light on the broken health care system and call for single payer. Over 100 people attended the speak-out in Boston on March 26. The event was supported by Massachusetts PNHP and the Boston University Students for a National Health Program chapter. The SNaHP chapter has also been active in the movement for racial equity in medicine, and participated in a photojournalism project with the national student organization WhiteCoats4BlackLives. The project is designed to document what "racial justice in medicine" and "health care as a human right" mean to physicians in training. Medical student Dominic Caruso helped organize a session on "Health Financing as a Form of Structural Racism" at Harvard's annual student-led Health Equity and Leadership Conference. To get involved in Massachusetts, contact Ture Turnbull at director@masscare.org. WhiteCoats4BlackLives chapters can be contacted through whitecoats4blacklives.org.

Boston University students take part in "racial justice in medicine" photo project.

The SNaHP chapter at the University of **New Mexico** has been active in advocating for single payer throughout the spring semester. Medical students gave a "Single Payer 101" presentation to the pre-AMSA group this spring that was met with numerous questions and excitement from the students in attendance. In addition, students met with Rep. Michelle Lujan Grisham to discuss single-payer health reform and to ask for co-sponsorship of H.R. 676. Although Lujan Grisham deferred on co-sponsoring the bill, she has added SNaHP to her health advisory panel. To get involved in New Mexico, contact Dr. Bruce Trigg at trigabov@gmail.com.

In **New York**, PNHP members, including members of the PNHP N.Y. Metro chapter, celebrated the New York State Assembly's passage of the New York Health Act on May 27 by a nearly 2 to 1 margin. The New York Health Act would create a universal, single-payer-like health care system in the state. While the Republican-led state Senate is not expected to pass the bill, its passage in the Assembly has boosted activism and awareness around single payer. The surge in popular support for the legislation is due to a growing coalition called the Campaign for New York Health, which includes labor, community groups, physicians, nurses, and other health care workers. In addition to the state-level advocacy, the N.Y. Metro chapter looks forward to celebrating Medicare's 50th anniversary this summer with allies at the New York State Nurses Association on Aug. 2 in Poughkeepsie. The theme for this family-oriented birthday party is that "Medicare is as American as apple PIE": with PIE standing for "Protect, Improve, and Expand" Medicare. In other news, PNHP co-founder Dr. David Himmelstein spoke to a group of physicians, faculty, and health professionals at the SUNY School of Public Health in Albany this spring. Through an outreach effort in the Times Union, including an op-ed by Dr. David Ray and an advance interview with Dr. Himmelstein, and a public radio segment featuring the latter, the Capital District chapter of PNHP reached thousands with their message. To get involved in New York, contact Katie Robbins, M.P.H., at katie@pnhpnymetro.org.

In **North Carolina**, Dr. Jessica Schorr Saxe published a commentary in The Charlotte Observer debunking the idea of requiring "skin in the game" to control health care costs. (See page 15.) The Charlotte-based PNHP chapter, Healthcare Justice – North Carolina, is developing a closer relationship with the North Carolina Academy of Family Physicians, which has agreed to add both a single-payer meeting and a panel discussion on health financing to its annual meeting. The chapter will host Dr. Andy Coates for a series of presentations in late July. To get involved in the Healthcare Justice chapter, contact Dr. Schorr Saxe at jsaxe@earthlink.net.

In **Ohio**, the Single Payer Action Network Ohio hosted an Everybody INstitute with Healthcare-NOW's executive director, Benjamin Day, on May 22 in Columbus. Additionally, medical student chapters have recently formed at Case Western, Cleveland Clinic, and Ohio State University. The Cleveland-based students had a PNHP table at the Latino Medical Student Association national meeting at Case Western in April following the organization's endorsement of single payer. Dr. Johnathon Ross gave grand rounds in both Akron and Toledo this spring, and PNHP members have participated in several lobby days over the past four months to advocate for single-payer bills reintroduced in the Ohio House and Senate. To get involved in Ohio, contact Dr. Ross at drjohnross@ameritech.net.

In **Pennsylvania**, Dr. Walter Tsou reports that Health Care for All Philadelphia sponsored a lecture titled "U.S. Drugs: Why So Expensive?" by Temple University professor Albert Wertheimer at the Free Library of Philadelphia. The PNHP chapter is also working with the local nurses union to plan a celebration of Medicare and Medicaid's birthday at the end of July. To get involved with PNHP in Pennsylvania, contact Dr. Tsou at macman2@aol.com.

PNHP welcomes two new chapters in **Tennessee**: a student chapter at Vanderbilt University School of Medicine and a regu-

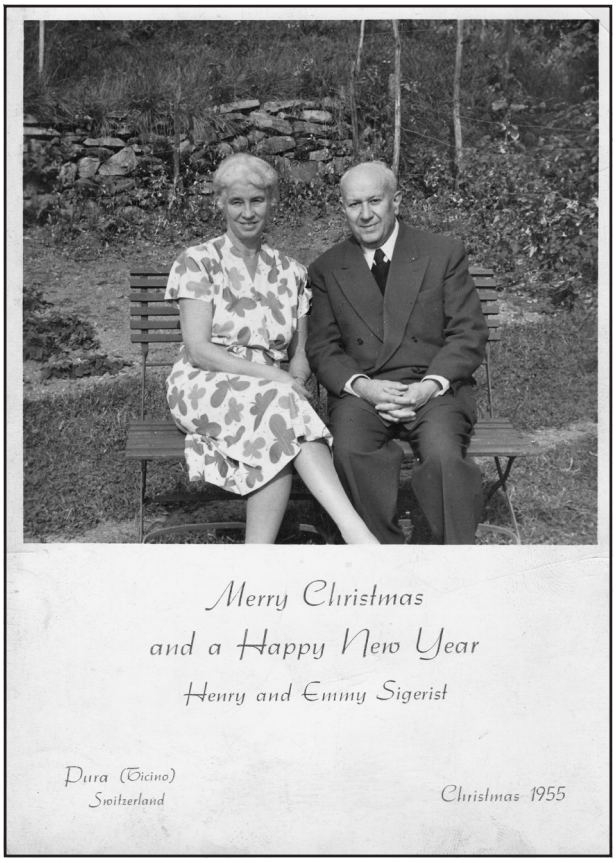
Founding members of the new student chapter at Vanderbilt with their advisers, Drs. Jim Powers and Carol Paris.

lar chapter in Chattanooga. At Vanderbilt, the student chapter met at the home of Dr. Jim Powers to view and discuss the PBS Frontline documentary, "Sick around the World." Anand Saha, a student at the Quillen College of Medicine, reports that 3 out of 5 of the state's medical and osteopathic schools now have a PNHP chapter, with two more in active development. One of Chattannoga's leading newspapers ran an announcement of the chapter's April 20 meeting that cited the recent endorsement of H.R. 676 by the area's Central Labor Council. To get involved in Tennessee, contact Dr. Art Sutherland at asutherland523@gmail.com.

In **Texas**, Health Care for All Texas organized a successful monthlong tour of the one-man play "Mercy Killers" written and performed by Michael Milligan. Many of the performances were followed by audience dialogues on the U.S. health care system. The performances were used to educated hundreds of Texans on the need for a Medicare-for-all health care system. To get involved in Texas, contact Ken Kenegos at kkenegos@earthlink.net.

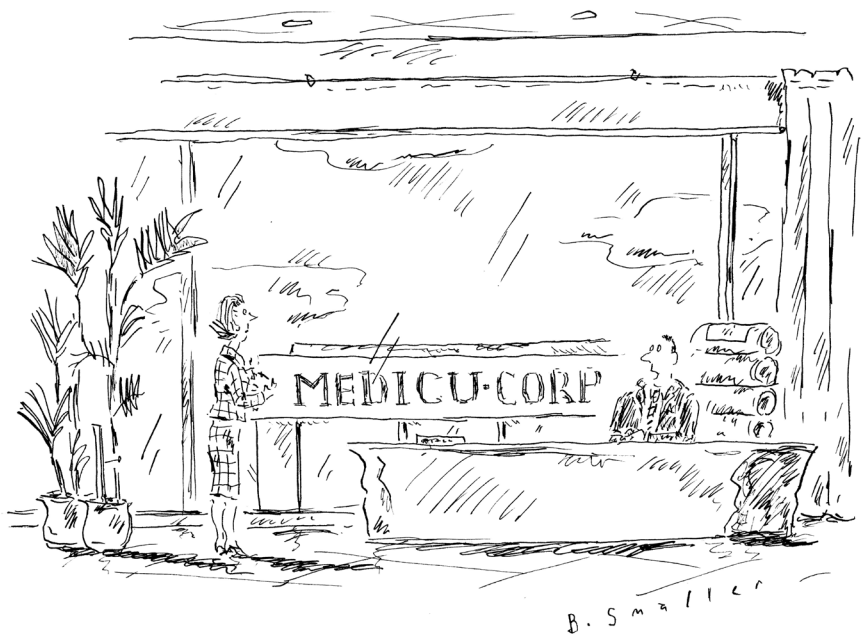
Student dialogue with keynote speakers before PNHP Western Washington's Annual Meeting.

The PNHP **Western Washington** chapter held its annual public meeting on March 28 in Seattle with featured speakers Dr. Margaret Flowers of PNHP and PopularResistance.org, James Haslam of the Vermont Workers' Center, and City Councilwoman Kshama Sawant. The John Geyman Health Justice Advocate Award was presented to the Vermont Workers' Center for its "Healthcare is a Human Right" campaign. The SNaPH chapter at the University of Washington held a successful "Healthcare 101" on campus, which provided students with an introduction to single-payer health care, and it organized a special student dialogue with the annual public meeting keynote panelists. The chapter subsequently organized a screening of "The Healthcare Movie," and co-sponsored a May 8 presentation by Dr. Randall White, a psychiatrist in British Columbia, who the good and bad of Canadian and U.S. health systems. The Western Washington chapter once again brought the single-payer message to in Seattle's annual May Day parade, where it got a warm reception. To get involved in Western Washington, contact Dr. Sherry Weinberg at weinbergsk@msn.com.



Henry Sigerist, medical historian, visionary

This holiday card from Henry and Emmy Sigerist was sent to the late Dr. George Silver, a longtime PNHP supporter. Dr. Sigerist, the leading medical historian of the 20th century, directed the Johns Hopkins Institute for the History of Medicine. A strong advocate for a government-funded, compulsory health program, he headed the Sigerist Commission, which surveyed the health needs of Saskatchewan in 1944, and played a key role in the design of the Saskatchewan Medical Care Insurance Plan, the first significant step in the creation of Canada's national health system. Thanks to Dr. Sidney Wolfe, the recipient of Dr. Silver's archives, for providing the card.



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