PNHP Summer 2019 Newsletter

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM | 29 E. MADISON STREET, SUITE 1412, CHICAGO, IL 60602 | WWW.PNHP.ORG

SNaHP members protest pharma price gouging at a rally in New York on March 3.

SNaHP Summit builds next generation of physician leaders

Nearly 200 students from across the U.S. convened at Columbia University Medical Center in New York City for the eighth annual Students for a National Health Program (SNaHP) Summit on March 2.

SNaHP board members opened the summit with a single-payer update, and then introduced PNHP president Dr. Adam Gaffney by playing a clip from his now-viral appearance on *Fox Business News*.

Following Dr. Gaffney's keynote, students participated in a variety of workshops, including "Long-term Care: A Vital Piece of Single-Payer Legislation," "Segregation in Health Care," "Activism for Harm Reduction and the Opioid Crisis," and "Advocating for Single Payer: Policy, Public Opinion, and Messaging." After lunch, they learned about state single-payer initiatives, such as those in Washington, California, and New York.

The final panel focused on intersectionality in the single-payer movement, led by PNHP board adviser Dr. Roona Ray, PNHP NY Metro board member Winn Periyasamy, M.P.H., and SNaHP student Wendy Coard. Students ended the day with regional planning sessions, followed by a set of "fireside chats" on concrete ways to make SNaHP and PNHP more inclusive.

On Sunday morning following the summit, students joined members of the PNHP NY Metro chapter, the Campaign for New York Health, ACT UP New York, and other allied organizations to rally against price gouging and in favor of single-payer reform at the headquarters of Pfizer pharmaceuticals.

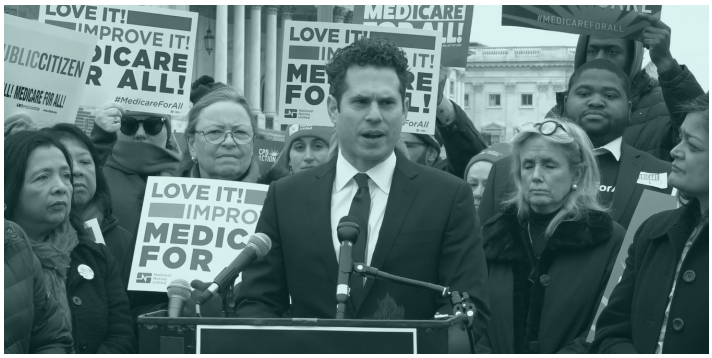
PNHP Annual Meeting, Nov. 1-2 in Philadelphia

Our 2019 Annual Meeting and Leadership Training will take place Nov. 1-2 at the Sonesta Philadelphia Rittenhouse Square. Our theme for the meeting is "*Single Payer is for Every Body*." For more information, visit **pnhp.org/meeting**.

Reps. Jayapal and Dingell introduce single-payer bill in the House

Reps. Pramila Jayapal and Debbie Dingell introduced the Medicare for All Act of 2019 (H.R. 1384) on Feb. 27. Amid the noise of incremental "faux" Medicare for All plans, H.R. 1384 stands out for achieving universal comprehensive coverage and long-term cost control. The bill covers all medically necessary care, including dental, vision, and hearing; mental health services; reproductive care, including abortion; long-term care; and prescription drugs, and requires no patient cost-sharing. It also bans institutional providers from diverting payments to profits, although it stops short of phasing out for-profit ownership of medical providers, as PNHP advocates.

By eliminating the waste of private insurance, negotiating drug costs, and paying hospitals through global budgets, H.R. 1384 would provide the cost savings necessary to cover everyone living in the U.S. and provide much-needed support for health facilities in rural and other underserved areas.



PNHP president Dr. Adam Gaffney helps introduce the Medicare for All Act of 2019 in Washington, D.C. on February 27.

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PNHP Board of Directors 2019

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Message from PNHP President Dr. Adam Gaffney


Dr. Adam Gaffney

As the result of many years of activism, single payer is now in the headlines on an almost daily basis. On the airwaves, in newsprint, in congressional hearings, in medical journals, on social media, on the campaign trail, and in our hospitals and clinics and offices, the debate over Medicare for All is white hot.

PNHP has long played a critical role in this debate, but with the 2020 elections looming, the voice of our membership is needed more than ever.

We urgently need to educate our colleagues and the general public about what Medicare for All means. Many Americans, including many physicians, are confused by the slew of "public option" bills — Medicare X, Medicare for America, Medicare at 50 — that sound like Medicare for All, but fall well short.

Unlike single payer, none of these "faux" plans could cover all the uninsured, upgrade coverage for the underinsured, end patients' disruptive annual insurance "churn," slash administrative waste, reduce useless billing, coding, and documentation activities, and roll back the corporatization of health care.

Single-payer opponents thrive on this confusion, and PNHP members are uniquely situated to dispel that confusion with facts, evidence, and experience.

Adding to the confusion are new myths — including recent commentary in the *Journal of the American Medical Association* — suggesting that Medicare for All would all but bankrupt hospitals.

The reality is that hospitals would be *more stable* under single payer. Today, hospitals spend a quarter of their revenue on administration and billing, double that of Canadian hospitals. In the U.S., we spend more than $80,000 per physician dealing with insurance companies — four-fold higher than what is spent in Canada. By reducing this gargantuan waste of dollars and physician time, we could easily provide more care to the previously uninsured and underinsured. Single payer would also give us unique and powerful tools to control costs, like ensuring that new hospital facilities are built where they are needed, not merely where they are profitable.

It's no surprise that a majority of physicians now support Medicare for All: We see the harm that our fragmented, privatized system does to our patients, while also experiencing the ways it prevents us from being the best doctors we can be. As PNHP member Dr. Farzon Nahvi powerfully testified at the recent Medicare for All hearings in the House, "I feel like I'm practicing medicine with one hand tied behind my back."

When it comes to health care reform, PNHP is the moral voice of the American medical profession — a voice that can turn the tides of the Medicare-for-All movement in the days ahead.

Health care crisis by the numbers

Data update from the PNHP newsletter editors

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

Costs and access to care

Americans borrowed $88 billion in 2018 to pay for needed health care, according to a recent Gallup survey. The survey also found that 26% of Americans deferred treatment, 15 million went without medications for serious health conditions, 23% cut back household spending, and 41% avoided emergency care; 45% say they are concerned or extremely concerned that a major health event in their household could lead to bankruptcy. When asked about the reason for rising health care costs, 47% cited insurance company profits as the chief culprit, with 21% blaming better care, and 16% higher prices. *("The U.S. health care cost crisis," Westhealth - Gallup, 1/14 - 2/20/2019)*

The burden of premiums and deductibles on workers has increased sharply in recent years. In 2017, employees' share of premiums averaged 6.9% of median income, up from 5.1% in 2008. During that same period, the average single-person deductible for employer-sponsored coverage increased to 4.8% of employees' median income, up from 2.7%. Disturbingly, the biggest increases occurred in the most recent year. *(Collins and Radley, "The cost of employer insurance is a growing burden for middle-income families," Commonwealth Fund, December 2018)*

Many patients forego needed medications due to soaring drug costs and inadequate drug coverage. Nearly 20% of Medicare patients failed to fill a new prescription within 30 days to treat a chronic disease. Among patients who faced out-of-pocket medication costs of more than $50 who were not previously taking any medication, more than half failed to fill a new prescription within 30 days. *(Franklin et al., "Time to filling of new prescriptions for chronic disease medications among a cohort of elderly patients in the USA," Journal of General Internal Medicine, November 2018)*

In states that accepted the ACA Medicaid expansion, many more patients starting dialysis were enrolled in Medicaid, fewer were uninsured, more had an AV fistula rather than a venous catheter for dialysis access (an AV fistula is the preferred access method, but the fistula graft takes time to mature, requiring planning months before the start of dialysis), and the one-year mortality rate for new dialysis patients fell faster (to 6.1% from 6.9%) than in non-expansion states (to 6.8% from 7.0%). Mortality reductions were largest for black patients and those age 19-44 years. *(Swaminathan et al., "Association of Medicaid expansion with one-year mortality among patients with end-stage renal disease," JAMA, December 2018)*

Medicaid expansion in Michigan was associated with large improvements in financial health among Medicaid enrollees, including reductions in all unpaid bills, medical bills, over-limit credit card spending, delinquencies, and adverse public records such as evictions, court judgments, and bankruptcies. Medical bills in collection fell by an average of $515, bankruptcies declined 10%, and individuals were 16% less likely to overdraw credit cards. Those with greater medical needs experienced the largest improvements. *(Mills et al., "The ACA Medicaid expansion in Michigan and financial health," NBER Working Paper No. 25053, September 2018)*

Health insurance deductibles have increased sharply in recent years. A new study finds that diabetics whose employer forced them into health plans with a high deductible (more than $1,000) delayed getting care for macrovascular complications of diabetes like angina, transient ischemic attacks, and lower-limb ulcers. Compared to persons whose deductibles didn't increase, the high-deductible group delayed seeking care for an extra 1.5 months for the first major symptom of their macrovascular disease, 1.9 months for the first diagnostic test, and 3.1 months for the first procedure. *(Wharam et al., "High-deductible insurance and delay in care for macrovascular complications of diabetes," Annals of Internal Medicine, 12/18/2018)*

Even small copays discourage some patients from getting needed medications. Among people who received approval from their insurer for a prescription for a PCSK9 inhibitor to lower cholesterol, more than one-third abandoned the prescription at the pharmacy. Almost none of those with a $0 copay failed to fill the prescription, but the abandonment rate was about 27% for those with a copay between $10 and $19, and much higher for those facing copays of $20 or more. *(Navar et al., "Association of prior authorization and out-of-pocket costs with a patient access to PCSK9 inhibitor therapy," JAMA Cardiology, November 2017)*

Soaring copayments and deductibles, as well as employees' increasing share of premiums, exact a heavy toll on low-income adults (income less than 250% of the federal poverty line) with employer-sponsored private insurance. Health care costs (premiums plus out-of-pocket payments) consumed more than 20% of disposable income for 46.9% of persons with two or more chronic conditions covered by a high-deductible plan, and for 36.9% of those covered by a low-deductible plan. Even among those with no chronic conditions, health care costs consumed more than 20% of disposable income for 20.6% of persons with high-deductible coverage and 17.5% covered by a low-deductible plan. The findings under-

line the importance of upgrading the coverage of the millions of Americans who currently have private insurance. *(Abdus and Keenan, "Financial burden of employer-sponsored high-deductible health plans for low-income adults with chronic health conditions," JAMA Internal Medicine, December 2018)*

More than one quarter (26.5%) of people with diagnoses of cerebrovascular or coronary disease say medical bills caused financial hardship, although they were able to pay the medical bills. An additional 18.9% say they were completely unable to pay their medical bills. Even among those with insurance, 27.0% reported financial hardship from paying medical bills, and 16.4% were unable to pay at all. After adjustment for family income and insurance, individuals unable to pay medical bills had three-fold higher odds of cost-related medication non-adherence (odds ratio 3.39) and food insecurity (odds ratio 2.89) compared to those without financial hardship from medical bills. *(Valero-Elizondo et al., "Financial hardship from medical bills among nonelderly U.S. adults with atherosclerotic cardiovascular disease," Journal of the American College of Cardiology, 2/19/2019)*

High-deductible coverage causes delays in care for women with breast cancer. Compared to a matched group with low (less than $500) deductibles, low-income women with breast cancer facing deductibles of more than $1,000 experienced delays averaging 1.6 months to breast imaging, 2.7 months to first biopsy, 6.6 months to early-stage cancer diagnosis, and 8.7 months to the start of chemotherapy. Delays for higher-income women were only slightly shorter. *(Wharam et al., "Vulnerable and less vulnerable women in high-deductible health plans experienced delayed breast cancer care," Health Affairs, March 2019)*

Each year, more than 250,000 appeals for donations to pay medical bills appear on GoFundMe.com, accounting for about one-third of all funds donated through GoFundMe. *(Bluth, "GoFundMe CEO: 'Gigantic gaps' in health system showing up in crowdfunding," Kaiser Health News, 1/16/2019)*

Pay-for-performance, ACOs, and 'paying for value, not volume': More evidence of failure

Medicare's Hospital Readmission Reduction program that penalizes hospitals with high readmission rates appears to have backfired. Thirty-day death rates for patients with heart failure and pneumonia (although not myocardial infarction) increased significantly after the penalties were announced, and increased further after they were implemented. The mortality increases were mainly among patients who were not readmitted, suggesting that hospitals' worries about incurring penalties were causing them to deny needed admissions. *(Wadhera et al., "Association of the Hospital Readmission Reduction Program with mortality among Medicare beneficiaries hospitalized for heart failure, acute myocardial infarction, and pneumonia," JAMA, 12/25/2018)*

Another study of Medicare's Readmission Reduction Program indicates that the claimed reductions in readmission rates have been overstated, and may be entirely illusory. That's because as the program was being rolled out, a change in electronic billing transaction standards allowed hospitals to document a larger number of diagnoses. This made patients look sicker (and hence, higher risk) in the period after the start of the readmission penalties, artifactually lowering the risk-adjusted readmission rates. A risk adjustment that excluded the extra diagnoses from the readmission penalty era wiped out virtually all of the supposed reduction in readmissions. *(Ody et al., "Decreases in readmission credited to Medicare's program to reduce hospital readmissions may have been overstated," Health Affairs, January 2019)*

Disease management programs for patients with chronic illness have been widely touted, but randomized trials of such programs often yield disappointing results. In a major new trial involving 2,924 heart failure patients being discharged from the hospital, those randomized to an intensive case management program fared no better than the control patients. *(Van Spall et al., "Effect of patient-centered transitional care services on clinical outcomes in patients hospitalized for heart failure: The PACT-HF randomized clinical trial," JAMA, 2/26/2019)*

Many employers have implemented workplace wellness programs on the promise that they will reduce health care costs, and sometimes coerce their workers into participating. But a new randomized trial suggests that the programs neither improve health nor cut medical spending. Researchers randomly assigned 32,974 employees of BJ's Wholesale Club to either usual care or to an intensive eight-module wellness program, with each module lasting four to eight weeks. The program slightly increased the proportion of workers who said they were considering or trying to lose weight, and the proportion who said they were exercising. But it had no effect on the other 27 self-reported health outcomes, the 10 clinical health markers (including BMI, blood pressure, lipids, and mental health status), the 38 measures of utilization, or the three employment outcomes assessed in the study. *(Song and Baicker, "Effect of a workplace wellness program on employee health and economic outcomes: A randomized clinical trial," JAMA, 4/16/2019)*

Complex financial incentives for physicians often backfire, causing unintended consequences — in Canada as well as the U.S. Ontario's single-payer program has increased the use of capitation payments for primary care doctors. Because patients in Ontario remain free to seek care from other physicians, provincial authorities have sought to minimize the "leakage" from capitated physicians by offering the doctors substantial "access bonuses" tied to minimizing the amount of primary care (but not ED or specialist care) their patients receive from other providers. But a new study finds that the access bonuses went disproportionately to physicians whose patients made fewer primary care visits (probably due to "cherry picking"

of healthier patients), yet received less after-hours care and more ED visits, while generating higher ambulatory care costs overall — exactly the reverse of what was intended. *(Glazier, "Do incentive payments reward the wrong providers? A study of primary care reform in Ontario, Canada," Health Affairs, April 2019)*

Medicare's payments to Accountable Care Organizations (ACOs) are adjusted for enrollees' diagnoses at the time of enrollment, but rise little if enrollees subsequently accumulate expensive new diagnoses. This payment strategy gives ACO incentives to get rid of enrollees who develop expensive new illnesses. A recent national study found that the sickest 5% of ACO patients were more likely than average-risk patients to exit the ACO each year (21.6% vs. 16.5%), and patients whose severity of illness increased after ACO enrollment were also more likely to leave than others. Moreover, doctors who cared for very sick patients were also more likely to leave the ACO than other doctors. The findings suggest that as Medicare has constrained some of ACO's "cherry picking," the ACOs are doing more "lemon dropping," i.e., finding ways to get rid of unprofitable patients and clinicians. *(Markovitz, "Risk adjustment in Medicare ACO program deters coding increases but may lead ACOs to drop high-risk beneficiaries," Health Affairs, February 2019)*

Insurers, billing, and paying

Medicare Advantage (MA) plans can also profit from "lemon dropping" and a new study confirms that the practice is common. Among 1.3 million high-needs Medicare enrollees, 14.8% of dual eligibles (persons covered by both Medicare and Medicaid) switched out of MA plans to traditional Medicare, while only 3.3% of non-high needs patients switched into MA plans. The switch-out rate was highest (42.8%) among low-quality plans (as indicated by a low Medicare star rating). But even in high-rated plans, the switch-out rate for high-needs enrollees was higher compared to less needy (and more profitable) enrollees (4.9% vs. 1.8%). In contrast, high-needs persons enrolled in traditional Medicare were slightly less likely than less-needy persons to switch to an MA plan. The findings confirm several previous studies showing that MA plans have profited — at the taxpayers' expense — by avoiding expensively ill patients and shunting them to traditional Medicare. *(Meyers et al., "Analysis of drivers of disenrollment and plan switching among Medicare Advantage beneficiaries," JAMA Internal Medicine, 2/25/2019)*

Insurers denied coverage of newer, highly effective hepatitis C medications to 35.5% of 9,025 patients prescribed such medications. Denials were more frequent among persons covered by commercial insurers (52.4%) than among those covered by Medicaid (34.5%) or Medicare (14.7%). The denial rate increased during the period covered by the study, to 43.8% in April 2017 from 27.7% in January 2016. *(Gowda et al., "Absolute insurer denial of direct-acting antiviral therapy for hepatitis C: A national specialty pharmacy cohort study," Open Forum Infectious Disease, June 2018)*

Commercial insurers and private Medicare Advantage (MA) plans pay 13% to 14% less for in-network mental health services than fee-for-service Medicare pays for the identical services. In contrast, private insurers' fees are 12% more than Medicare's for other services. In addition, commercial and MA patients more frequently go out-of-network for mental health than for other services, increasing their out-of-pocket costs. *(Pelech and Hayford, "Medicare Advantage and commercial prices for mental health services," Health Affairs, February 2019)*

Patients with private insurance or managed Medicaid coverage are increasingly restricted to narrow provider networks, saddling some patients hospitalized at an in-network hospital with surprise bills for out-of-network care. A recent study of 620,000 in-network admissions found that 14.5% of people hospitalized at an in-network hospital received a surprise bill for out-of-network services from a physician or other health care provider involved in their care. Anesthesiology professionals were responsible for the largest share of surprise bills (16.5%), followed by primary care (12.6%), and emergency medicine (11.0%). Surprise bills from independent labs were also common. *(Kennedy et al., "Surprise out-of-network medical bills during in-network hospital admissions varied by state and medical specialty, 2016," Health Care Cost Institute, 3/28/2019)*

When nonprofit Blue Cross and Blue Shield plans in markets where they have substantial market share convert to for-profit status, not only do their premiums increase (by 13%) but the premiums of their competitors increase as well, according to a study from Harvard Business School. Moreover, Medicaid enrollment rises, suggesting that families are "crowded out" of the private insurance market by the rising prices. Additionally, the rise in medical spending by rival plans following the Blues' conversion suggests that the post-conversion for-profit Blue plans intensify risk-selection efforts, shifting high-risk patients to other plans. *(Dafny, "Does it matter if your health insurer is for-profit? Effects of ownership on premiums, insurance coverage, and medical spending," American Economic Journal: Economic Policy, February 2019)*

Corporate medicine

Hospitals and health systems are buying physician practices at a rapid clip. The proportion of vertically integrated (i.e., hospital or health-system-owned) multispecialty adult primary care practices grew to 44% in 2017 from 21% in 2007, while vertical integration of surgical practices increased to 44% from 10%. The largest increases were among cardiology and oncology practices. *(Nikpay, "Hospital-physician consolidation accelerated in the past decade in cardiology, oncology," Health Affairs, July 2018)*

Past studies have found — and a new study confirms — that prices rise when hospitals buy physician practices. In California, the percentage of physician practices owned by hospitals increased to 40% in 2016 from 25% in 2010. The increase in hospital ownership was associated with a 9% increase in outpatient specialist prices, a 5% increase in primary care prices, and a 12% increase in ACA marketplace premiums. *(Sheffler et al., "Consolidation trends in California's health care system: Impacts on ACA premiums and outpatient visit prices," Health Affairs, June 2018)*

Vertical integration was supposed to make care easier for patients to access. But the shift to hospital ownership of physician practices has coincided with a steep decline in primary care office visits for acute problems, and an increase in ED use. Primary care visits for acute care fell to 637 per 1,000 in 2015 from 938 per 1,000 in 2002, a 32% drop. At the same time, ED visits increased 12%, to 430 per 1,000 in 2015 from 385 in 2002. *(Chou et al., "Primary care office visits for acute care dropped sharply in 2002-2015, while ED visits increased modestly," Health Affairs, February 2019)*

Hospital profits (labeled "surpluses" in nonprofit hospitals) are on the rise. According to the American Hospital Association, U.S. hospital profits totaled $88 billion in 2017, a 12.5% increase from 2016, and a 27% increase since 2013. Total hospital revenues reached $1 trillion in 2017, with operating revenues rising 4.6% from the previous year. The increase in hospital revenues and profits comes as more care has shifted to outpatient settings, a shift that was supposed to hold down costs. In 2017, almost half of hospital revenues came from outpatient care. Inpatient days were flat, while surgeries and births declined slightly. Meanwhile, outpatient revenues rose 5.7%, although outpatient visits (including urgent care and surgery center visits) rose only 1.2%, and ED visits fell slightly. *(Bannow, "Outpatient revenue catching up to inpatient," Modern Healthcare, 1/07/2019)*

Expenditures for advertising of prescription drugs, health services, and lab tests, along with so-called disease awareness campaigns, totaled $29.9 billion in 2016. Pharmaceutical firms spent $20.3 billion marketing to health professionals (including $5.6 billion for drug detailing, $13.5 billion for free samples, and $979 million for direct payments to physicians), $6 billion on 4.6 million direct-to-consumer (DTC) ads for prescription drugs, and $430 million on "disease awareness" campaigns for diseases treated by their drugs. Health care providers spent $2.9 billion on DTC ads for health services. Since 1997, drug firms have paid more than $11 billion in fines for off-label and deceptive marketing. All of these costs are folded into the prices paid by patients. *(Schwartz and Woloshin, "Medical marketing in the United States, 1997-2016," JAMA, January 2019)*

Caremark, CVS' pharmacy benefits management subsidiary, which managed the prescription drug benefit for Ohio's Medicaid program, paid CVS stores higher rates than competitors' stores. According to an analysis commissioned by the Ohio Department of Medicaid, CVS stores received 25% higher rates for generics than Kroger stores, and 29% higher rates than Riesback's. The analysis also found that Caremark charged taxpayers $197 million more for drugs than it paid pharmacies; OptumRx, another pharmacy benefit management firm, billed taxpayers $224 million more than it paid pharmacies. The firms have been locked in a court battle with the state over release of the report. *(Schladen and Candisky, "CVS paid itself far more than some major competitors, report says," Columbus Dispatch, 1/20/2019)*

Graduates of for-profit nursing schools often fail the nursing licensing exam, according to a George Washington University study. Between 2011 and 2015, 68% of for-profit graduates passed the licensing exam on their first try, vs. 84% of graduates of nonprofit schools, and 88% of public school graduates. The pass rates of for-profit graduates have declined over time. The findings are particularly disturbing in light of the Trump administration's loosening oversight of for-profit schools, and the recent growth of for-profit medical schools. *(Johnson, "Study: For-profit nursing grads more likely to fail licensing exams," Modern Healthcare, 1/15/2019)*

Burnout is more common among primary care practitioners in small, health-system-owned practices or Federally Qualified Health Centers (FQHCs) than those working in physician- or physician assistant-owned practices (adjusted odds ratios 1.42 and 1.36, respectively). Burnout was also more common among those working in small groups than among solo practitioners (odds ratio 1.71). The study did not include physicians in larger groups. *(Edwards et al., "Burnout among physicians, advanced practice clinicians, and staff in smaller primary care practices," Journal of General Internal Medicine, December 2018)*

Famous hospitals have increasingly shared their "brands" with affiliated hospitals, hoping that the flagship's reputation for excellence will attract patients to the affiliate. Yet merely sharing a name does not mean that care is comparable. Among 29,228 Medicare beneficiaries over 65 undergoing complex cancer surgery, the 90-day mortality rate at 343 affiliates was significantly higher (odds ratio 1.40) than at 59 top-ranked cancer hospitals. Mortality was lower at the top-ranked hospital than at the affiliate in 41 of the 49 networks. *(Hoag et al., "Differential safety between top-ranked cancer hospitals and their affiliates for complex cancer surgery," JAMA Network Open, 4/12/2019)*

Regions of the U.S. with more hospital beds and hospital-based specialists per capita have more overuse of 20 types of low-value care. In contrast, regions with more primary care physicians have less overuse. These findings confirm the 1959

observation by Milton Roemer — now known as "Roemer's Law" — that "in an insured population, a hospital bed built is a filled bed." The findings carry important implications for health care reform: Appropriate control of the supply of hospital beds and specialists can decrease unnecessary care and hold down costs, without compromising quality. *(Zhou et al., "Regional supply of medical resources and systemic overuse of health care among Medicare beneficiaries," Journal of General Internal Medicine, December 2018)*

Markets can't work in health care for many reasons, including that many regions don't have enough population to support multiple competing hospitals or specialists — a town's only hospital or neurosurgeon can't compete with itself. Not surprisingly, a new study finds that premiums in the ACA marketplaces are 5% (or $424 per year) higher in regions in the top third for concentration of hospital care, i.e., where one or a very few hospitals dominate the market, compared to the third of regions with the least concentrated hospital markets. The study also found that a paucity of insurers drove up premiums: For each additional insurer offering coverage in a region, yearly premiums declined by $276. *(Boozary et al., "The association between hospital concentration and insurance premiums in ACA marketplaces," Health Affairs, April 2019)*

Health care inequality

People living in poor neighborhoods get less of most types of prescription drugs than those in more affluent areas. For instance, people in high-income neighborhoods filled twice as many prescriptions for drugs to treat mental health problems, and 2.5 times more prescriptions for migraines than persons residing in the lowest-income areas. The same pattern was present for drugs to treat anaphylaxis, birth control medications, and "lifestyle" medications for conditions like acne, erectile dysfunction, and hair loss. In contrast, patients in poorer neighborhoods had higher prescription fill rates for HIV and hepatitis C medications, and treatments for nutritional deficiencies. *(Marsh et al., "Disparities between rich & poor: The effect of income on prescription fill patterns," GoodRx Research, 2/07/2019)*

Denying dialysis to undocumented persons with end-stage renal disease (ESRD) is not only cruel, but costly. In most areas of the U.S., undocumented immigrants only receive dialysis when they become acutely and dangerously ill. A recent study found that among undocumented immigrants with ESRD, those who received emergency-only dialysis had death rates 4.6-fold higher than those who were dialyzed regularly. Moreover, overall costs were actually $5,768 per month higher for the emergency-only group, reflecting their much higher use of emergency department care (6.2 visits more per month) and hospitalization (9 hospital days more per month). *(Nguyen et al., "Association of scheduled vs. emergency-only dialysis with health outcomes and costs in undocumented immigrants with end-stage renal disease," JAMA Internal Medicine, 12/21/2018)*

Pharma

"We have to hammer on [drug] abusers in every way possible. They are the culprits and the problem. They are reckless criminals." — Email from Richard Sackler when he was CEO of Purdue Pharma, maker of OxyContin. *(Meier, "Sacklers directed efforts to mislead public about OxyContin, court filing claims," New York Times, 1/16/2019)*

The VA obtains deep discounts on drugs through negotiations with pharmaceutical manufacturers and use of a formulary. For the top 50 oral drugs covered by Part D Medicare plans, paying VA prices would have saved $14.4 billion in 2016, 44% of what insurers and beneficiaries actually paid. Potential savings from adopting VA prices totaled $71.1 billion between 2011 and 2016. Even these figures underestimate potential savings since they exclude all injectable drugs, as well as all but the top 50 oral drugs. *(Venker et al., "Assessment of spending in Medicare Part D if medication prices from the Department of Veterans Affairs were used," JAMA Internal Medicine, 1/14/2019)*

The health care workforce

The median income of women internists is $50,000 lower than their male counterparts, according to a survey by the American College of Physicians Research Center. Gender differences in income were evident across virtually every internal medicine specialty, demographic, and employment characteristic. The gender-based income gap was larger among older physicians, those in solo practice, and those in administration. *(Read et al., "Compensation disparities by gender in internal medicine," Annals of Internal Medicine, 11/06/2018)*

A study of gender-based pay differences across multiple specialties found even larger disparities: an average income difference of $90,890. Some of the difference was attributable to the number of hours worked (2,470 hours per year for men vs. 2,074 for women), specialty mix (49.1% of men in primary care vs. 70.5% of women), and likelihood of performing procedures, but a large gap persisted even after adjustment for such differences. *(Apaydin et al., "Differences in physician income by gender in a multiregion survey," Journal of General Internal Medicine, September 2018)*

More Americans are employed in health care than in any other industry, including 18% of all employed women and 23% of employed black women. According to a new study, many of them live in poverty and are themselves uninsured. More than one third (34%) of female health care workers, and nearly half of the black and Latina women working in the health sector, earn less than $15 per hour; 5% of all women health care workers — including 10.6% of black and 8.6% of

Latina women health care workers — live in poverty. Overall, the 1.7 million women health care workers and their children who lived below the poverty line in 2017 accounted for nearly 5% of all people living in poverty in the U.S. Seven percent of female health workers — more than 1 million — were uninsured. Raising the minimum wage to $15 per hour would cut the poverty rate among female health care workers by half, while increasing U.S. health care costs by less than 1.5%. *(K. Himmelstein and A.Venkataramani, "Economic vulnerability among U.S. female health care workers: Potential impacts of a $15-per-hour minimum wage," American Journal of Public Health, 1/16/2019)*

About 15 years ago, Barbara Starfield published several studies showing that, both in the U.S. and internationally, an increased supply of primary care practitioners reduced population mortality and prevented illness. A new study, which examines detailed data on mortality, physician supply, and other indicators of medical resources in 3,142 U.S. counties, updates and confirms Starfield's observations, and indicates that the U.S. is moving backward on primary care. The mean primary care physician-to-population ratio fell to 41.4 physicians per 100,000 in 2015 from 46.6 per 100,000 in 2005. Adjusted for multiple demographic, medical resource, and environmental variables, an increase of 10 primary care physicians per 100,000 population was associated with a 51.5-day increase in life expectancy, and 0.9% to 1.5% reduction in death rates from cardiovascular, cancer, and respiratory diseases. A comparable increase in the number of specialists had smaller effects, including a 19.2-day increase in life expectancy. The findings reemphasize the importance of reversing U.S. health financing policies that advantage specialty care and discourage primary care. *(Basu et al., "Association of primary care physician supply with population mortality in the United States, 2005-2015," JAMA Internal Medicine, 2/18/2019)*

Veterans Administration

Several studies have found that VA care nationwide is at least as good, on average, as care in the private sector. However, none have directly compared VA care to private care in the same community. In a new analysis of 15 hospital quality measures across all 121 regions that have both a VA hospital and a private facility, VA care was significantly better for 14 of the 15 measures, with one measure showing no difference. A VA hospital scored highest on quality measures in at least half of the regions, worst in fewer than 15% of regions, and above average in at least two-thirds of regions. The findings underscore the folly of the Trump Administration move to take billions of dollars out of the VA budget to pay for private sector care. *(Weeks and West, "Veterans Health Administration hospitals outperform non-Veterans Health Administration hospitals in most health care markets," Annals of Internal Medicine, 3/19/2019)*

Polls & public support for Medicare for All

A March 2019 Kaiser survey found continuing strong support for single-payer health reform. Overall, 35% of respondents strongly favor such reform and 21% somewhat favor it, while 38% oppose it (the rest have no opinion). Among Democrats, 79% favor Medicare for All and 16% oppose it; Among independents, 55% support it and 39% oppose. And even among Republicans, 24% favor Medicare for All (72% oppose it). The terminology used to describe health reform affects views somewhat, but even a program described as "socialized medicine" gains support from 44% overall (including 67% of Democrats and 14% of Republicans), with 44% opposed. *("Public opinion on single-payer, national health plans, and expanding access to Medicare coverage," Kaiser Family Foundation, 4/24/2019)*

The Democratic Party's base has been mounting increasing pressure on party leaders to pursue a single-payer, Medicare for All strategy, and most Democratic politicians now say that Medicare for All is their goal, at least in the long term. However, party leadership has been dragging its feet on the issue, or worse. In December, House Speaker Nancy Pelosi's top health policy aide privately assured Blue Cross Blue Shield executives that the party leadership had strong reservations about single-payer reform and was more focused on lowering drug prices and protecting the ACA than moving forward to Medicare for All. *(Grim, "Top Nancy Pelosi aide privately tells insurance executives not to worry about Democrats pushing 'Medicare for All,' The Intercept, 2/05/2019)*

[Editor's note: Despite Democratic leadership reluctance to move forward on single payer, pressure from single-payer advocates has resulted in substantial progress on Capitol Hill. A recent hearing on Medicare for All in the House Rules Committee featured compelling testimony from single-payer advocate Ady Barkan and emergency physician Dr. Farzon Nahvi, a NYC-Metro PNHP board member. Barkan, who is wheelchair-bound due to neurologic illness, was added to the witness list after an outcry from single-payer supporters, and was escorted into the hearing room by Speaker Pelosi. On the day of the hearing, the Chair of the House Ways and Means Committee (which has jurisdiction over health care) announced that his committee would likely hold its own hearing. The Chair of the House Budget Committee had previously announced plans for a hearing on Medicare for All.]

Voters in Idaho and Utah approved ballot initiatives expanding Medicaid in 2018, but politicians in those states scaled back the voter-passed measures, limiting the expansions. The Utah rollback is expected to cut the number who will be newly covered by about 70,000, while the Idaho measure would impose a work requirement for Medicaid eligibility. *(Minemyer, "Idaho becomes second state to support scaled-back Medicaid expansion," Fierce Healthcare, 4/11/2019)*

The Cost of National Health Insurance: An Economist's View

By Professor Rashi Fein

Editors' note: We reproduce below the text of a talk by Rashi Fein, Ph.D. at a conference in Washington on April 15, 1975 on the cost of national health insurance, and particularly the the single-payer plan introduced by Sen. Edward Kennedy that was then under debate. Rashi was among the most distinguished health economists of his generation. In 1952 he served on the staff of the Truman Commission on the Health Needs of the Nation. From 1961-1963 he served as senior staff on John Kennedy's Council of Economic Advisors, and played a key role in developing the initial Medicare legislation which adopted a social insurance model rather than the public option or subsidized private coverage models then favored by Republicans. He went on to serve as Professor of the Economics of Medicine at Harvard Medical School and the Kennedy School of Government, was a charter member of the Institute of Medicine of the National Academy of Science, and served on the Board of the Committee for National Health Insurance. He died in 2014.

I have been asked to speak today on the costs of national health insurance. I intend to do that, but it is only fair to warn you that I will not try to restrain myself and will say a few words on other matters concerning national health insurance that I consider important. I suppose that you may ask why I will not stick entirely to the topic and surely that is a fair question. Let me answer it with a question: Can one, should one, devote an entire talk to a topic that really should not be a topic at all, to an issue that should not be an issue, to a concern that should not be a concern, to a matter that is raised by those who oppose national health insurance not because they want to elevate the level of debate but because, like the witches in Macbeth, they throw everything they can think of into the pot to make the caldron bubble.You know the question that is asked of us, of you and me and all the others who believe in national health insurance because it is comprehensive, universal, fair, and equitable. We are asked, "But what will it cost; can we afford it?" Some may ask that, really wondering, and we owe them an answer and that answer is what I am here to talk about. But let us be clear about one thing: many of the people who ask — and they are located disproportionately in this city — are not asking because they really wonder and are honestly concerned but because they want to muddy the waters, because they want to cast doubt, because they think that every day is Halloween and want to raise hobgoblins. They are not interested in an answer for they know the answer: yes, we can afford it; we cannot afford to be without it. Their problem is that they know the answer — they just don't like it.

You may think that I am being harsh when I suggest that there is an element of dishonesty in some of the language used, questions asked and issues raised by some of those who opposed national health insurance in the past, oppose it today and will not be voting aye in the future. Maybe I am harsh, maybe it is not dishonest but only misleading, a slip of the tongue. If so, the American people await their apology.

Now I would ask you to note that I have not said that honest men and women cannot disagree about a number of issues involving national health insurance. Indeed they can, and that is as it should be. We can and should debate matters relating to financing, to private and public mix of funds, to ways of paying for services. There is a lot legitimately to argue about. Nor am I saying that honest men and women all understand the issues of cost perfectly. They do not. But I am saying that there are some who do understand the issues correctly but use scare tactics about cost to confuse the public. They do not believe their own testimony before the Congress, but they hope the public will believe it. We ought to recognize that for what it is so that we turn our attention to the real task before us — explaining the issues to the American people.

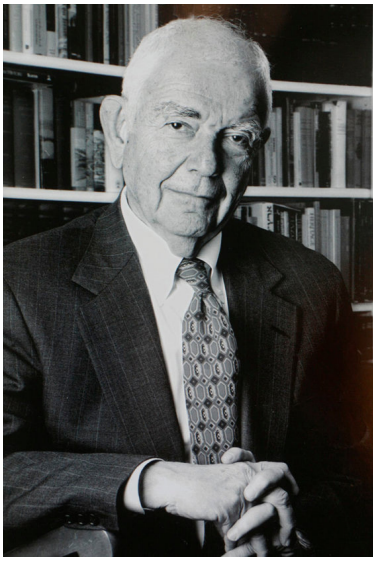
What is the story of costs; what can we afford; what is national health insurance all about in dollars and cents? I am not going to reveal any mysteries to you, but it may be useful to remind ourselves of the situation as it is today and to consider the situation as it will be when national health insurance is enacted and implemented.

We are spending over $100 billion a year in the health sector today. This is not a projection or prediction. It is a reality. In fiscal 1974 — last year — the total was $104 billion, and $98 billion of that was for health care and supplies. (The remainder was for research and construction.) That was money spent — dollars transferred from individuals, insurance companies, government to the health sector, to providers of goods and services. There is an ongoing health activity. It employs over 4 million persons, provides over a billion physician visits and about 250 million hospital inpatient days per annum. The health sector is alive and thriving (at least as measured by the dollars — 7.7 percent of the Gross National Product — flowing into it). It is inefficient. It wastes resources. It fails to deliver care to large numbers of people who cannot afford to pay for services or who do not find services available when and where they need them. But it is there; it exists; it is financed; it utilizes resources.

You and I feel that we should be getting more than we are for the $100 billion. We should, but that is not my point at this time. What is important for the moment is that there is a $100 billion industry out there, we are not talking of creating a new enterprise — a new health industry — when we speak of national health insurance. It is not as if we have nothing today and want to create 350,000 doctors, l .5 million hospital beds, and all the rest and pay for it. We are not an underdeveloped country without a health care system engaged in a great

debate over whether to invest scarce resources in developing personnel and facilities. We already have a system — a $l00 billion enterprise.

All that is important because it is that that lies at the heart of one of the significant differences between national health insurance and other proposed government expenditures and programs. It is at the heart of the discussion about costs and what we can and cannot afford.



Rashi Fein

When government spends money for new desks and chairs, for parks or dams, even for the CIA, this represents a change in the way resources are allocated in the economy. Those are cases in which government pays for things that were not going to be paid for by the private sector. When government builds or pays for a dam, it does not ask whether it, government, should pay for a dam or whether individuals should buy it on their own. It asks, instead, whether we should have a dam at all. And it adds a constraint: if we say "yes," it means we will have to do without something else. To ask "should we have a dam" is to ask a meaningful question — for, if government authorizes a dam, it is a new dam that is created. If government puts new money into new programs that deliver services previously not available or delivered, we are talking about new services: parks, roads, inspection, regulation, and so forth. New services require new resources — resources that could have been used for other things in the public or private sector.

If, on the other hand, government talks of assuming the costs of services already being delivered and paid for by the citizenry — as in fact is the case with health services — there are no new total dollars or total resources involved. Every dollar that government spends on health relieves us, the public, of dollars that we would have spent on health. There is, of course, a new and different financing mechanism, a new way of spending old dollars, but that is not the same as new dollars. New parks, roads, bombers, or White House tape recorders represent money for things that we, the people, would otherwise not have and were not already spending our own money for. These represent new expenditures, and whether we can afford them depends on our priorities — how much are we willing to give up to have these new things. But medical care is different: we are already spending $104 billion, and private expenditures account for $63 billion of that total. That is money that is already coming out of our income.

So the issue is a non-issue. Can we, as a people, afford national health insurance really means can we afford to spend what we are already spending, and surely the answer is "yes." The issue is not whether we are spending more than we can. The issues are whether we are getting what we should for our money and whether the present arrangements which make health expenditures depend on a family's income are fair, just and humane.

Ah, say the critics, but what about those people who today cannot afford to purchase medical care. Won't national health insurance cost more than we are now spending when it attempts to provide care to those who today find price a barrier? They ask whether we can really afford a universal national health insurance program that brings health care to the forgotten and the rejected Americans? What does that really mean?

He who asks those questions apparently believes that we do not have enough and cannot produce enough medical care services (and that's untrue) and that rather than alter, modify and improve the health care system, he prefers to continue rationing health care on the basis of ability to pay (and that is unjust). Perhaps price is the way to ration Cadillacs, yachts and fur capes. Perhaps that is the way to ration dinners at the Ritz, skiing vacations in Aspen, and opening nights at the Met. But that is not the way we choose to ration education and that is not the way we ought to ration health care.

In part, of course, the critics say that they agree, and that is why they contribute to charity and "support" Medicaid. But, of course to the extent that charity and Medicaid do purchase health care we are back at square one, talking about dollars that are already being spent. In our view, national health insurance is fiscally a substitute for, not an addition to Medicaid, but it is also different from and better than Medicaid. It is a better way of spending the dollars that are already being spent. No, the reason some of our critics may prefer even Medicaid to national health insurance does not relate to the total dollars going for care. The real reason is that there are some who like the Medicaid system — not because it is efficient, just, humane, and decent — but because they feel it is an appropriate system for those whom they consider undeserving. Their chief complaint about it is not that it is a demeaning system in which people are required to trade their dignity for some health care. Their chief complaint is that we are spending too much on it. And when they say, "We are spending too much," they do not mean America cannot afford it. They really mean, "why spend that much on people who aren't making it on their own?"

The fact is that even with Medicaid and other programs, there are persons, too many persons, who receive inadequate care. National health insurance will permit them to enter the medical care system and will require resources for their care. That is good. That's what we want. That is one of the important reasons that we favor the Health Security Act. I am not ashamed of being in favor of decency, humaneness and justice. I am willing to spend dollars, new dollars, to achieve it. In fact, however, I am convinced that we can have a well-run system of health care that, by eliminating present waste and inefficiency

can provide care for all the people with fewer resources than are now providing care for only some of the people. For $l00 billion we can provide for all 213 million Americans. We can — but even if our critics disagree, even if they argue it will cost more than we are now spending what would they have us do — continue to deny care to those who need it but cannot pay? Come now, do they really mean we cannot afford it, or do they mean that they prefer not to concern themselves with the problems of those less fortunate than they?

Unemployment is costing our economy billions upon billions of dollars — aside from the human suffering. And yet we are told the nation cannot provide health care for its people. If we did not have public education, they would tell us we could not afford that either. If we did not have unemployment compensation, they would tell us we could not afford that — or Social Security or higher education or Workmen's Compensation. Their economic policies cost the nation countless tens of billions of dollars in lost wages and products and untold human suffering, and they dare to ask us whether the nation can afford national health insurance!

And so we find yet another argument used: If government pays for medical care, you and I (it is said) will attempt to get more care than we need. We will flood the hospitals and the doctor's offices, we will inundate the system, we will bankrupt the economy. Where, I ask, is the evidence that we are all so in love with medical care that, facing waiting time and travel costs, absence from work, fear and concern we will behave that way? Is the evidence found in prepaid group practices where monetary barriers to care have been eliminated or reduced? No. Is it found in outpatient departments that have to mount outreach and follow-up programs to get people to use the services that are needed and available? No. Is it found in the experience of other nations? No. How is it that Canada can manage to meet its commitments but we presumably would be unable to meet ours. Yet this is the rationale offered for coinsurance and deductibles — for that which is so pleasantly called "cost sharing."

Cost sharing is supposed to make you and me behave responsibly, but the real issue is how to induce the system to behave responsibly. You and I do not decide to order unnecessary lab tests. You and I don't really make the decision that we would like to enter or stay in hospital an extra few days. You and I are not out there balancing prices and satisfaction and deciding whether we prefer another $10 worth of care or something else. The bulk of those decisions are made for us. High cost sharing is not consistent with the goals and aims of a comprehensive, universal and equitable national health program. Low cost sharing — and that which is low for some is high for others — is not worth the administrative costs. Those who are so concerned about costs might want to join us in eliminating the unnecessary costs involved in administering a system of deductibles and coinsurance. Moving billions of pieces of paper around is expensive — that is waste and, therefore, is something we cannot afford.

At the margin, and for the poor the margin is narrow indeed, price does make a difference. But will the system go bankrupt without price barriers? If the critics won't look at the evidence we might present, perhaps they will look at the estimates provided by the Department of Health, Education and Welfare, a Department not known for its support of the Health Security Act. HEW has estimated that the difference in total expenditures — total dollars spent on health, whatever the source of the expenditure — between the Health Security Act and the Administration's bill as introduced in the last Congress was $6.5 billion on a total estimated expenditure of about $123 billion. We believe that that is a substantial overestimate of the costs of the Health Security Act. Among other things, it fails to take account of the very real savings that will come about because of system changes that are part and parcel of the Health Security Act. The HEW estimates assume that the Health Security Act will only finance care and not change the delivery system one iota, and you know and I know that that is not what Health Security is all about. Nevertheless, even HEW admits that the Health Security Act — even without system savings — would add only 10 percent to what we, the nation, will spend if no legislation were enacted and only 5 percent to what the inadequate Administration bill with cost sharing would cost. Small wonder, then, why we are prepared to argue we can afford a Health Security Act and to argue further that with system change the Health Security Act will save, not cost, the nation money. There is surely more than 10 percent waste and inefficiency in the present system.

Is the argument really about going bankrupt because of an additional expenditure of some $6 billion? Is that what our critics mean when they say that we cannot afford — in a trillion-dollar economy — the Health Security Act?

Hardly. The critics know that is only a smoke screen. The argument is not really about total dollars and total costs but about where the dollars come from and where they will go. That is the real explanation for the cost sharing and also for the mandating proposals that have been offered by the previous administration. Requiring that patients pay out of pocket or that employers make health insurance available to their employees is not really cheaper — it only looks that way in terms of federal funds. The dollars all stay in the private sector with mandating, and government does not enter the picture. The dollars are not greener, prettier, cleaner, nicer. Nor are they fewer. But they are private; not public. That is the real issue, and that issue is real for there is a social-insurance approach in the Health Security Act and it is there for a reason. The fact of the matter is that in health care private financing operating with private-insurance principles has not met the problems of the people — nor can it. W needed Social Security. We needed Medicare. We got them because those who fought for those programs understood that there were basic issues involved. The same issues lie at the heart of the fight for national health insurance.

Keeping things substantially as they are or building upon a

foundation that is weak to start with will not lead to universality or equity. The Administration's bill, after all, would transfer only about 5 percent of total costs from the private to the public sector. This is what they call national health insurance — the Federal Trade Commission ought to look into that kind of mislabeling. Is it equitable that low-income employees spend a higher proportion of their income on health care than do others — via coinsurance, deductibles and premiums that are fixed amounts and do not vary with income or with payroll? Is it universal to have a multiplicity of plans into which people must be sorted? And in dollar-cost terms doesn't all this increase administrative costs? Whatever they may say about the Health Security Act, at least they must admit that the dollars that it would spend would go for health care and to the health system — not on paperwork and to accountants.

On March 5, 1975, the Washington Post published an editorial entitled, "It Is Time for Economic Impact Statements." It suggested that the Congress should examine the true costs of government programs — not just the costs to government, but the real costs. The Post said:

"The argument over health care provides a classic example of the way the present system works. Health insurance plans before Congress are usually discussed in terms of how much they will cost federal or state governments in tax money. while these figures are of obvious importance, the true cost of any such plan must include the additional expenses the plan will impose on employers and employees. If those additional expenses are paid by the employers, they will be reflected, sooner or later, in prices. If they are paid by employees, they will be reflected in a loss of buying power. In either case, they are real costs, just as tax increases are real costs.

"In order to get a true picture of the full costs of a health plan or noise reduction regulation or any other federal program, Congress needs an 'economic impact' statement not unlike the environmental impact statements now required of many construction programs. Then it could know how much a particular program or set of regulations really costs."

It surely would be advisable if the Administration prepared economic impact statements such as the Post calls for. We who support the Health Security Act would welcome honest analyses — we have nothing to fear and much to gain from public information and understanding. Social legislation — Medicare, national health insurance — is never harmed by public understanding. It is misinformation that is harmful.

Actually, since OMB has not been doing that which the Post calls for, you have done it for them. That is why we know that, in largest measure, the Health Security Act is fiscally responsible. Its economic impact is in terms of equity not total expenditures. It calls, not for an increase in real costs but, for a shift, a transfer, in expenditures — a shift that is needed and a transfer we can afford. It calls for a social-insurance approach.

Thus it follows that the argument that the economy cannot accommodate itself to national health insurance, that it represents an increase in total expenditures and that we have to put national health insurance on the back burner because it is inflationary is false and deceptive. It is an argument without merit, and it does not become any more persuasive when we are told that, after all, there is no such thing as a free lunch. There isn't, and we know it. But this is a lunch that is already being paid for. In fact, if the Health Security Act were passed and signed into law and if the people who administer it believe in it, the changes in the health care system and in its financing would enable us — for the same money — to have a fine dinner instead of a blue plate lunch.

Recently we were told that the President would veto a national health insurance bill even if spending were delayed a year because enactment of a spending program would encourage an inflationary psychology. If we do our job, if the facts are placed before the public and the issues are recognized for what they are — if the public is not misled — no inflationary psychology need result. There are no witches out there, and it is less than honest first to keep frightening us with the imaginary demon of inflation and then to tell us we cannot have national health insurance because some people believe the stories of demons and witches.

Government expenditures on health will go up under the Health Security Act — that is a design feature, not an unfavorable side-effect. But private expenditures on health will go down. That is also a design feature. The Health Security Act will be financed out of new revenues which can be obtained in an equitable manner and which all of us will find ourselves better able to pay, in part because we will be saving what we are now already spending on medical care and health insurance and in part because of the growth in tax revenues resulting from the turnaround and expansion in the economy. We do not argue that Health Security should come at the expense of other social programs in education, manpower training, income maintenance; we can finance Health Security because we are already financing health care.

Indeed, if people want to talk about inflation we can respond positively. It is the existing organization and financing of health care that — in the absence of legislation — would continue to contribute to inflationary pressures in the future. The real issue is whether we can continue to afford the waste and inflation inherent in the present system of care and finance. Inflationary pressures, conversely, can be contained and moderated by the kind of responsible intervention that is embodied in the Health Security Act. When it is said, as it sometimes is, that it is automatically inflationary for dollars to be transferred through government back to the private sector for health care, we can respond: "Whose administrative costs are less, the Social Security System which handles Medicare efficiently or the private health insurance sector whose administrative costs are often an order of magnitude higher than that of government?"

And so national health insurance is within our means. We may not be as wealthy a nation as some of the Arab oil states, but neither are we less wealthy than a host of industrial na-

tions that have had national health insurance. We are not so poor that we cannot afford one of the hallmarks of a civilized society — the right to health care regardless of income. Yes, a hallmark of a civilized society — for that is the crux of the matter. When all the myths are dispelled, when all the rhetoric and testimony and analyses are over with, that is what we are left with — the argument about justice for all. Make no mistake about it — the guts of the issue is not about dollars. Those who opposed the Social Security Act, Disability Insurance, Medicare were not really arguing about money but about how the pie is shared. And the same is the case with national health insurance. The real question is whether resources shall be allocated so that everyone receives his fair share in a system in which the use of medical care is related to medical need or whether we shall continue, as in the past, to ration care on the basis of income. The answer can, should, must, and will be in favor of justice and decency, in favor of civilized behavior, in favor of national health insurance. A bill will be enacted and will be signed into law.

We must recognize, however, that enactment of a law is only the beginning of a process and not the end of it. The law must be administered. Because we are concerned about cost — about saving money in the health field so that we can devote resources to other social uses, for medical care is not the only unsolved problem on the American agenda — and because we are concerned about equity, all of us will be required to make certain that those who are called upon to administer the legislation work at making it effective. I know of only one force that can assure that that occurs. That force is public vigilance, concern and understanding.

Public understanding. That is the missing ingredient. No one will "give" us national health insurance — not the professionals or the experts or the Congress or the Office of Management and Budget — except as we, the people, organize to press for it. The battle for national health insurance is first a battle of public understanding. Social legislation is not enacted because of the good will of special interest groups — but over their opposition. It is not enacted because a few legislators are concerned but because many legislators who would rather sit on the fence find — because of the pressure of concerned citizens — that that position becomes increasingly uncomfortable. We will not convince OMB or the AMA, but we can convince the public.

Thus far, at least on issues of cost, the people (your neighbors and mine) have been confused. Honesty compels us to admit that we have not won the battle of public understanding against those who have sown the seeds of public confusion. That is a battle that we must win. I believe, I strongly believe, that it can be won for the facts are on our side. However difficult it is for facts to prevail in a struggle against deception, if enough people work hard enough at it, the public will recognize truth from error. Then, having won the battle of understanding and organization, we will have national health insurance. And we will not go bankrupt!

CNN

March 1, 2019

The Medicare for All bill is a winner

By Jeffrey D. Sachs

Jeffrey Sachs

Rep. Pramila Jayapal introduced a sweeping Medicare for All (MFA) bill on Wednesday (H.R. 1384), and the national debate on health care is bound to intensify through the 2020 election. Voters rank health care costs as their second most important priority, just after the economy. The political fate of MFA will likely depend on one key question: Will it reduce health care costs while preserving the freedom to choose health providers?

If properly structured, MFA can do that: cut costs while improving choice.

Medicare for All has come a long way since Sen. Bernie Sanders launched his 2016 presidential campaign on that theme, while fellow Democrats ran from the label. Sanders also faced the wrath of mainstream pundits like Paul Krugman, who described Sanders' health care plan as "smoke and mirrors." Now, every major Democratic Party candidate endorses the label, (though they will certainly differ on the details) and Sanders could well become president in 2021 on the basis of his clear and persistent MFA advocacy.

No doubt the debate will become heated, even shrill. We are talking about serious money, and the largest single sector of the American economy. Health care outlays in the U.S. account for nearly 18% of the country's GDP. Profits are soaring in the private health care and pharmaceutical industries, both of which will fight fiercely against MFA. Pres. Donald Trump has weighed in, declaring that Democrats are "radical socialists who want to model America's economy after Venezuela."

While former Pres. Barack Obama spoke out in favor of a single-payer plan, he avoided the battle back in 2009 with the Affordable Care Act. And by making health insurance available to millions more Americans, the ACA allowed private industry to raise prices given the increase in demand. The result is that Obamacare expanded overall coverage, and provided hugely popular guaranteed coverage for pre-existing conditions, while avoiding any decisive steps on cost containment.

MFA picks up at that point. Real cost containment will be the critical issue that either makes or breaks each MFA proposal.

Americans currently pay around $10,000 per person per year in health outlays, compared with roughly half that amount in other high-income countries such as Canada, Japan, the Netherlands, or Sweden. The reasons have been debated and studied in detail. Do Americans use more and better health care and therefore also pay more? Alas, no. Americans use roughly the same or less health care, but pay far more for health services including drugs, hospital stays, and medical procedures such as an MRI.

The Canada comparison

A comparison of health costs between the U.S. and 10 other high-income countries allows a detailed comparison of the U.S. and Canada, the most relevant peer country. According to the comparative data, the U.S. spends 17.8% of GDP compared with Canada's 10.3%, amounting to $9,403 per person in the U.S. compared with Canada's $4,641.

All Canadians are covered by the health care system, while 10% of Americans lack public or private insurance coverage. Total pharmaceutical spending per person per year averages a whopping $1,443 in the U.S., compared with $613 in Canada.

For example, the cholesterol drug Crestor is $86 per month in the U.S., and $32 in Canada; the arthritis drug Humira is $2,505 in the U.S., compared with $1,164 in Canada. Yet despite the much higher health spending per person, life expectancy in the U.S. is 78.8 years, while in Canada it is 81.7 years.

The article reaches the following conclusion: "The U.S. spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the U.S. were largely similar to those in other nations. Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the U.S. and other high-income countries."

Huge private costs in the U.S.

U.S. private health insurance costs are out of sight. A typical U.S. family of four covered by employer-based health insurance pays, in total, around $28,000 per year,

taking into account the insurance premium paid for by the employer out of the worker's total compensation, the premium paid directly by the household, and all of the extra costs, including deductibles, copayments, and out-of-network payments. The cost of health care is crippling working-class families, which may explain why it is at the top of the political agenda.

What is the reason for these extraordinary costs in the U.S.? Astronomical administrative costs, for one, are the result of countless and conflicting payments systems facing almost any patient who visits the doctor's office or hospital. One study in 2014 suggested that America's extraordinarily complicated multi-payer system leads to administrative costs for billing and insurance that are five times the costs of a simplified payment system such as Canada's.

The second is the soaring monopoly profits and sky-high salaries along the entire private supply chain, from drug manufacturers to hospitals. The drug companies use their extraordinary monopoly power, whether due to patents or FDA approvals on out-of-patent drugs, to overcharge Americans with markups that are sometimes hundreds of times the production cost of the medicines. And private providers are a highly concentrated industry in most metropolitan areas.

With the mergers and closures of hospitals during the past 20 years, driven by for-profit medicine, this market power has soared, and so too have monopoly profits and health care costs facing consumers.

Check out the CEO compensation of the big systems providers — $59 million for Aetna, and $44 million for Cigna in 2017 — or the salaries of the executives of the "not-for-profit" hospitals in your area, often running several million dollars per year.

For these reasons, health care costs in the U.S. could be brought down by cutting three main areas: administrative costs, drug prices, and monopoly profits of private insurers, which in turn could be achieved by much lower reimbursement rates for medical services and more effective contracting. Recent studies have shown prospective savings on national health expenditures resulting from Medicare for All would save trillions of dollars over 10 years.

Smart cost control

The Jayapal bill is smart on cost control. It would have Medicare negotiate with pharmaceutical companies to drive drug prices down, with the threat of removing the monopoly rights of patents if the drug company doesn't reach a reasonable agreement on prices. (Technically, the government would issue a compulsory license to competitors). It would have Medicare set an annual budget with hospital providers. This annual budget would focus on health care provision rather than wasted time and expenses on billing. It would not permit astronomical management salaries and super-profits.

By wringing massive administrative costs, monopoly profits, and sky-high salaries out of the health care system, costs would be slashed, with the savings passed on to households. Remember, if the U.S. paid the same share of income as our peer countries like Canada, the total saving would be on the order of 6% of GDP (from 18% today to around 10-12% as in the peer countries). With a GDP of around $62,000 per person in the U.S., 6% of GDP saving comes to a cost saving of around $3,700 per person, or around $14,800 for a family of four.

Such savings wouldn't be achieved in full, or even in the early years. The pushback from industry against cost-cutting will be fierce. Moreover, the sheer inertia of existing costs, prices, budgets, and administrative systems cannot be doubted. But what can be said with confidence is that a well-designed MFA system would put the U.S. on a path toward the reasonably priced health care systems of other comparable countries.

Moreover, MFA would allow us to rethink health care delivery to take into account perhaps the biggest feasible benefit in health outcomes. America's current disease burdens often reflect unhealthy life circumstances — great stress, obesity-inducing diets, lack of exercise, drug dependence, and others. These are social ills turning into medical ills.

A fairer, more balanced, health system based on good health rather than maximum profits would turn its attention to helping Americans live healthier lives.

Getting MFA through the political process won't be easy. The drug industry is one of America's top lobbies and campaign contributors, befitting a massive economic sector rolling in profits. Lobbying outlays in 2018 across the health sector are estimated at around $549 million and campaign funding in the 2018 election cycle at $255 million. The industry will be ready to fight an MFA plan with guns blazing, and trot out the usual arguments: stop socialized medicine, save personal choice, don't put yourself into the hands of government bureaucrats, don't let American become Venezuela — you name it.

Yet Sanders and Jayapal and their many colleagues who have come on board now have the best chance to prevail in our modern history. Americans know that the health care system is rigged, and they will support a new system that convincingly shows the way to fair and reasonable health care costs.

Jeffrey Sachs, Ph.D. is a professor of economics and director of the Center for Sustainable Development at Columbia University. He will be speaking at PNHP's Annual Meeting on Nov. 2 in Philadelphia.

Medical Bankruptcy: Still Common Despite the Affordable Care Act

Myriad anecdotes—of a Nobel laureate who sold his medal to pay medical bills,[1] or the more than 250 000 GoFundMe medical campaigns last year[2]—attest to the financial toll of illness on American families. National surveys confirm that medical bills frequently cause financial hardship,[3] and the US Consumer Financial Protection Bureau reported that they were by far the most common cause of unpaid bills sent to collection agencies in 2014, accounting for more than half of all such debts.[4]

Less evidence is available on the medical causes of bankruptcy, a public and stigmatizing confession of impoverishment. In surveys conducted by researchers with the Consumer Bankruptcy Project in 2001[5] and 2007,[6] a majority of recently bankrupt debtors implicated medical bills or illness-related work loss as causes of their bankruptcy, findings that President Obama used to argue for passage of the Affordable Care Act (ACA). The ACA both expanded and upgraded health insurance coverage, banning preexisting illness exclusions, imposing a cap on out-of-pocket spending, and mandating coverage for essential benefits. Although these reforms might attenuate the risk of medical bankruptcy, increasing medical costs and stagnant incomes could have the opposite effect.

We sought to assess the incidence of medical bankruptcy in the current era using methods similar to those employed by the Consumer Bankruptcy Project in its 2001 and 2007 surveys. From court records of all US bankruptcy filers from 2013 to 2016, we randomly sampled 200 each quarter, abstracted their court record data, and (with institutional review board approval) mailed them a questionnaire closely modeled on the questionnaires used in those earlier studies.[5,6]

Of the 3200 surveys we mailed, the postal service returned 108 as undeliverable and 910 debtors responded, for a response rate of 29.4%. Court records indicated that nonrespondents' financial characteristics mostly resembled those of respondents; their median net worth was similar (–$32 947 vs –$30 409; $P = .17$), as were their assets, debts, and ongoing medical expenses ($P > .05$ for all comparisons), although nonrespondents had slightly higher monthly incomes ($2750 vs $2489; $P < .001$).

Table 1 displays debtors' responses regarding the (often multiple) contributors to their bankruptcy. The majority (58.5%) "very much" or "somewhat" agreed that medical expenses contributed, and 44.3% cited illness-related work loss; 66.5% cited at least one of these two medical contributors—equivalent to about 530 000 medical bankruptcies annually.

The share of debtors reporting a medical contributor before the ACA's January 1, 2014 implementation (65.5%) and after implementation (67.5%) was similar ($P = .37$). Both of these figures are close to the 62.1% estimate from the 2007 survey, and in a difference-in-differences analysis we found no evidence that trends differed between states that did versus did not accept the ACA's Medicaid expansion ($P = .76$). The responses regarding individual items in the current survey are also similar to those in 2007, when 57.1% of debtors cited medical bills as contributors to their bankruptcy and 40.3% cited income loss due to illness.[6]

Among those we surveyed from 2013 to 2016, medical debtors were more likely than other respondents to live with a spouse or partner but were similar in age, gender, and likelihood of being uninsured. Medical debtors more frequently self-reported fair or poor health (odds ratio [OR] = 2.88; $P < .001$), major disability (OR = 2.52; $P < .001$), foregoing needed medical attention in the two years prior to the bankruptcy filing (OR = 1.77; $P < .001$), and foregoing needed medications (OR = 2.65; $P < .001$).

Like all surveys, ours relies on respondents' candor. Moreover, the modest response rate—17.1% lower than the response rate in the 2007 study—mandates cautious interpretation of our current findings. However, the similarities between respondents and nonrespondents is reassuring. Even if the medical bankruptcy rate among nonrespondents were half that of respondents, the overall rate would exceed 40%.

Our findings contrast with those of a recent study analyzing the financial sequelae of hospitalization in California from 2003 to 2007.[7] That study found that hospitalization increased medical debts and decreased employment and income, but it suggested that medical bankruptcies were uncommon. However, its econometric approach rests on four assumptions likely to underestimate the medical bankruptcy rate. First, its cohort excluded most persons with frequent hospitalizations, a group at high risk of medical bankruptcy. Second, it assumed that only hospitalized patients can suffer a medical bankruptcy, although patients hospitalized in the course of a year account for only 18.2% of out-of-pocket costs paid by

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This editorial was accepted November 27, 2018.

doi: 10.2105/AJPH.2018.304901

TABLE 1—Share of Debtors Citing Specific Contributors to Their Bankruptcy: United States, 2013–2016

Reasons Cited as Contributors to Bankruptcy	(A) Very Much Agree, %	(B) Somewhat Agree, %	(A) + (B) Very Much or Somewhat Agree, %
Medical-related reasons			
Medical expenses	37.0	21.5	58.5
Medical problems causing work loss	27.9	16.5	44.3
Either of above	44.2	22.3	66.5
Change in family size such as birth or death	13.7	7.9	21.6
Any of above	50.1	21.4	71.5
Other reasons			
Income loss (including persons with medically related work loss)	61.5	16.3	77.8
Unaffordable mortgage or foreclosure	29.2	15.8	45.0
Spending/living beyond means	17.2	27.2	44.4
Student loans	14.3	11.1	25.4
Divorce/separation	18.5	5.9	24.4
Tried to help friends/relatives	12.7	15.7	28.4

Note. The sample size of the survey was n = 910.

US households (Himmelstein and Woolhandler, unpublished analysis of data from the 2015 Medical Expenditure Panel Survey). Third, it assumed that a child's, elderly parent's, or other relative's illness never causes a bankruptcy. Finally, the study's assumption that every bankrupting illness starts at the moment of an initial hospitalization is contradicted by its cohort's upsloping rate of bankruptcy filings in the baseline period prior to hospitalization. Because bankruptcy rates do not rise with age, this suggests that financial distress from illness frequently predated hospitalization. Because the study estimated medical bankruptcies from changes in filing trends before versus after hospitalization, failure to account for the upsloping baseline probably introduced a substantial downward bias.

The California study's authors argued that survey-based ascertainment of the causes of bankruptcy is unreliable, because debtors cannot know the true cause of their financial predicament—just as heart attack patients cannot know what caused their illness.[7] Yet in our (D. U. H. and S. W.) clinical experience, most such patients can accurately identify the smoking, dietary habits, and family history that put them at risk. Moreover, debtors are peculiarly well positioned to identify the contributors to the bankruptcy. As part of their bankruptcy proceedings, all of our respondents had recently prepared detailed documentation of their assets, debts, and current finances, and had sworn to its accuracy.

Medical bankruptcy has garnered public attention because it resonates with the abuse that Americans—including many middle-class Americans—suffer at the hands of our health care finance system. Despite gains in coverage and access to care from the ACA, our findings suggest that it did not change the proportion of bankruptcies with medical causes. That's not surprising because the chronically poor—the group most affected by the ACA's coverage expansion—have reduced access to credit, have few assets (such as a home) to protect, and face particular difficulty in securing the legal help needed to navigate formal bankruptcy proceedings.

Moreover, medical costs continue to outpace incomes, 29 million remain uninsured, and many of those with health insurance face unpredictable and unaffordable out-of-pocket costs as copayments and deductibles ratchet up. And few Americans have adequate disability coverage, leaving them vulnerable to illness-related income loss that amplifies the financial distress caused by medical bills.

Rather than acting to make health care more affordable, the current administration seems intent on further hollowing out coverage: encouraging a migration to bare-bones, short-term insurance policies that leave enrollees largely unprotected; allowing states to impose Medicaid work requirements that threaten to swell the ranks of the uninsured; and joining a suit that would end enforcement of the ACA's preexisting condition coverage mandate.

The results of the midterm election—in which health care was the most prominent issue—stand as a rebuke to these retrograde steps. Instead, policymakers should move forward from the ACA and implement programs that guarantee coverage that is not just universal but also comprehensive, as well as sick leave and disability coverage that replaces income during illness.

Although death is inevitable, good public policy can ensure that financial suffering from illness is not. AJPH

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D. U. Himmelstein, R. M. Lawless, and S. Woolhandler performed data analyses. D. U. Himmelstein and S. Woolhandler drafted the initial version of the manuscript. R. M. Lawless, D. Thorne, and P. Foohey were responsible for data collection. All authors reviewed and revised the final version of the manuscript.

CONFLICTS OF INTEREST
The authors had no conflicts of interest.

April 4, 2019

People lose their employer-sponsored insurance constantly

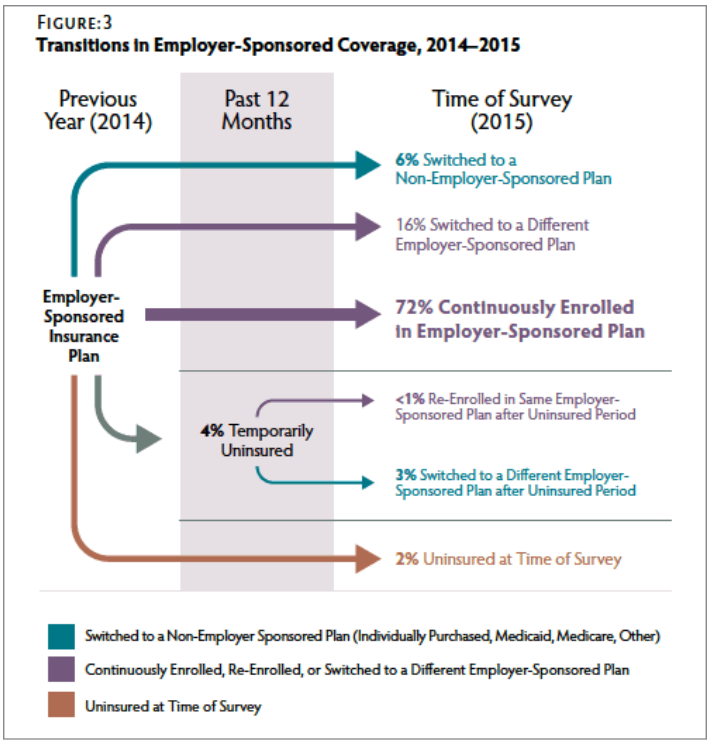
By Matt Bruenig

Nancy Pelosi said this about Medicare for All yesterday:

"When most people say they're for Medicare-for-all, I think they mean health care for all. Let's see what that means. *A lot of people love having their employer-based insurance* and the Affordable Care Act gave them better benefits."

The bolded part is probably the most dishonest argument in the entire Medicare for All debate. It implies that, under our current health insurance system, people who like their employer-based insurance can hold on to it. This then is contrasted with a Medicare for All transition where people will lose their employer-based insurance as part of being shifted over to an excellent government plan. But the truth is that people who love their employer-based insurance do not get to hold on to it in our current system. Instead, they lose that insurance constantly, all the time, over and over again. It is a complete nightmare.

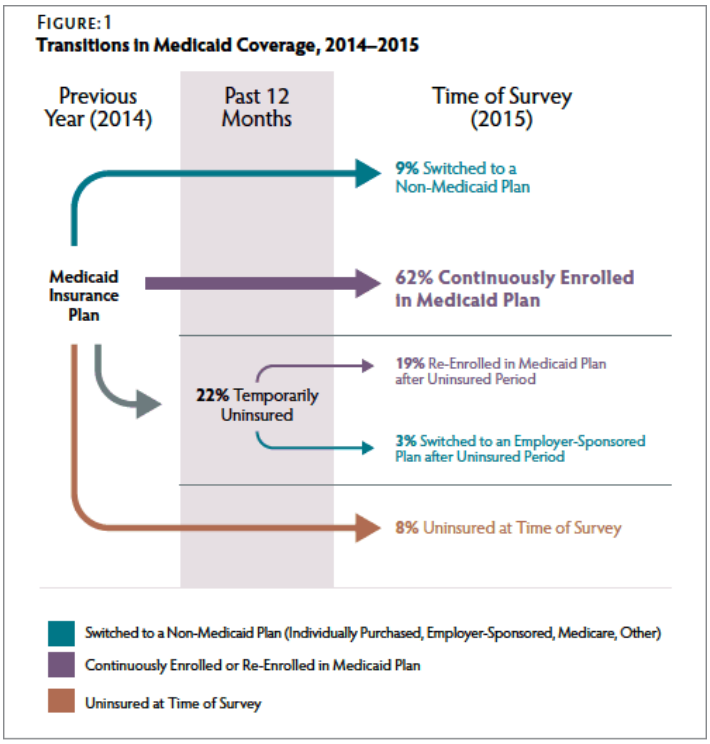
I have illustrated this point previously by showing just how often people switch jobs. The latest JOLTS data shows that, in 2018, 66.1 million workers separated from their job at some point. And longitudinal data from BLS shows that the average worker has 11.9 different jobs by the time they are 50. This labor turnover data leaves little doubt that people with employer-sponsored insurance are losing that insurance constantly, as are their spouses and kids.



Source: CHRT Cover Michigan Survey 2015.

But we don't need to indirectly surmise this fact from labor turnover data. A study from the University of Michigan tracked insurance churn directly by surveying Michiganders in 2014 about their health insurance situation and then following up with survey participants 12 months later. The amount of insurance churn they picked up was even higher than I would have imagined.

Among those who had employer-sponsored insurance in 2014, only 72 percent were continuously enrolled in that insurance for the next 12 months. This means that 28 percent of people on an employer plan were not on that same plan one year later. You like your employer health plan? You better cross your fingers because 1 in 4 people on employer plans will come off their plan in the next 12 months.

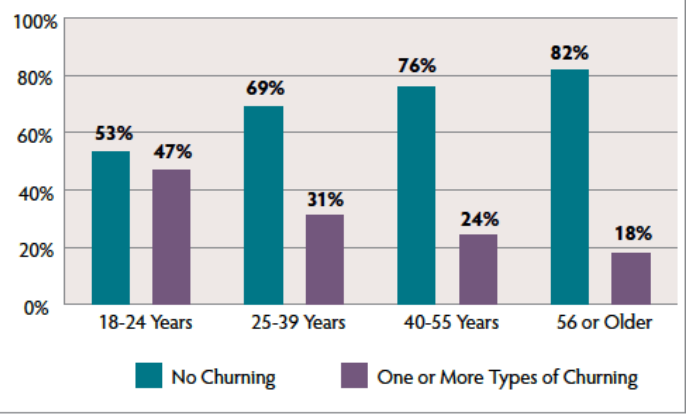


Source: CHRT Cover Michigan Survey 2015.
Percentages do not add up to 100% due to rounding.

The situation is even worse for other kinds of insurance. One thing opponents of Medicare for All frequently say is that poor people in the U.S. are already covered by free insurance in the form of Medicaid and that Medicare for All therefore offers them relatively little net benefit while potentially raising their taxes some. But what this argument misses, among other things, is that people on Medicaid churn off it frequently, with many churning into uninsurance.

According to the Michigan researchers, a whopping 30 percent of Michiganders on Medicaid in 2014 faced a spell of uninsurance in the 12 months after they were initially interviewed. Medicaid is a godsend for many, but it's wildly unstable coverage, and that's even in a state where the GOP is not doing everything it can to kick people off the Medicaid rolls.

FIGURE:4
Age Differences in Insurance Churning, 2014–2015*



Source: CHRT Cover Michigan Survey 2015.
*Sample included Michigan adults whose primary source of insurance in 2014 was Medicaid, an individually purchased plan, or an employer-sponsored plan. See Methodology for details.

As with many things in current U.S. politics, the divide of opinion on whether Medicare for All is a good idea is heavily generational. Young people are for it. Old people are more skeptical. This age gap is probably mostly driven by ideological differences between the generations: The current crop of young people is much more left wing than the current crop of old people. But there may also be an objective material basis for this divide. In this Michigan survey, 47 percent of adults aged 18 to 24 churned off their insurance plan during the 12-month survey span. Only 18 percent of adults 56 or older did.

It is easy therefore to see why young people are not as spooked by the idea of losing their current insurance as part of the transition to a Medicare for All system: half of them already lose their insurance every single year. Although older people have it somewhat better, it is worth emphasizing that their churn is still unacceptably high with nearly 1 in 5 of them churning off their insurance every year.

Critics of Medicare for All are right to point out that losing your insurance sucks. But the only way to stop that from happening to people is to create a seamless system where people do not constantly churn on and off of insurance. Medicare for All offers that. Our current system offers the exact opposite. If you like losing your insurance all the time, then our current health care system is the right one for you. If you like having permanent coverage no matter your life situation, then you should want Medicare for All.

Matt Bruenig is currently the president of People's Policy Project. He previously worked as a lawyer at the National Labor Relations Board and as a policy analyst at the Demos Think Tank. His prior work primarily focused on inequality, poverty, and welfare systems.

The Washington Post

April 12, 2019

'We've done a lot more than you would think': How the health insurance industry is working to pull Democrats away from Medicare for All

By Jeff Stein

At a company town hall meeting in late February, a UnitedHealthcare executive assured employees that the private health insurance giant was indeed working to undercut support for Democratic lawmakers' push for Medicare for All. But the company, he said, is trying to tread lightly.

"One of the things you said: 'We're really quiet' or 'It seems like we're quiet.' Um, we've done a lot more than you would think," chief executive Steve Nelson said in response to an employee's question about the company's role in the Medicare-for-all debate, according to a video of his remarks obtained by *The Washington Post*. "You want to be kind of thoughtful about how you show up and have these kind of conversations, because the last thing you want to do is become the poster child during the presidential campaign."

The remarks come amid a broader push from the health insurance industry to prevent legislation to enact Medicare for All from getting off the ground, including by trying to direct Democrats toward more centrist efforts and reject plans that would effectively legislate many of the companies out of existence.

Wary of bringing unwanted political controversy to their companies, some private health-care firms have in part relied on advocacy groups and lobbyists in their fight against Medicare for All — joining the push without leaving too many company-specific fingerprints.

Congressional Democrats, including some of the party's leading 2020 presidential contenders, are pushing proposals that would establish a single-payer health care system in which all Americans would receive government insurance. Legislation in both the House and the Senate would outlaw coverage that is duplicative with generous government plans, reducing the multibillion-dollar health insurance industry to a small, supplemental role.

The bills are still longshot proposals that are near-universally opposed by Republicans, and their passage into law would require Democrats to take the White House in 2020 and win sizable majorities in both chambers of Congress. But they have moved from a fringe position among Democratic lawmakers to a goal that is broadly embraced by much of the party.

Facing this threat, some private health companies are mounting a lobbying offensive, sending literature to staff members on Capitol Hill, starting advertising campaigns, and regularly warning politicians, reporters and the public about the dangers of a single-payer system.

These private insurers have pushed for Democrats to instead focus on repairing the Affordable Care Act passed under President Barack Obama, arguing a more incremental approach could include extending health insurance to all Americans without requiring a radical transformation of existing markets.

"These companies completely understand that the federal government can discipline prices, and that doing so could have a fundamental impact on every single thing in their business," said Harold Pollack, a health care expert at the University of Chicago, referring to proposals that could set prices or create government programs to compete with private insurers.

In an email, UnitedHealth spokesman Tyler Mason said Nelson's comments came during an internal company meeting and were made in response to a question from an employee who may not have known about the company's existing policy positions, which have been publicly available for many years. Mason pointed to a company report that calls for, among other policies, expanding Medicaid and protecting the health insurance that tens of millions of Americans receive through their employers.

"We have publicly supported universal coverage for over 20 years and have been engaging in thoughtful conversations with policymakers, employers, care providers and our own employees on solutions that build upon the success of existing public-private partnerships," Mason said in an email.

In the February meeting with employees, Nelson said the company opposes Medicare for All because it excludes the private sector, which he said does a better job of delivering health care than the government, and said he doubted how a single-payer system could be funded or effectively administered.

"We are advocating heavily and very involved in the conversation," Nelson said. "Part of it is trying to be thoughtful about how we enter in the conversation, because there's a risk of seeming like it's self-serving."

The UnitedHealth Group, which recorded about $17 billion in earnings in 2018, spent about $8 million on lobbying efforts last year on a broad range of health care issues, according to the Center for Responsive Politics, which tracks money in politics. The company, the parent of UnitedHealthcare, declined to comment on whether it had met with Democratic presidential candidates.

Other industry groups also are fighting back against a single-payer system. America's Health Insurance Plans, a trade association representing private health insurers, has lobbied

Congress on a single-payer bill by Sen. Bernie Sanders (I-Vt.), as has the Healthcare Leadership Council, an industry group whose members include private health insurance giants such as Anthem, according to the Center for Responsive Politics.

AHIP last summer also joined with insurers such as Blue Cross Blue Shield, as well as hospital associations and pharmaceutical companies, in forming a group called the Partnership for America's Health Care. In February, the partnership — whose members spent $143 million on lobbying in 2018 — said it would begin a six-figure digital advertising campaign to oppose both Medicare for All and a public option that would allow Americans to buy into Medicare. The group also is running an ad attacking Rep. Lori Trahan (D-Mass.) for backing Medicare for All legislation, according to Politico.

A report in *Splinter*, a left-leaning publication, revealed last month that several people quoted in the partnership's news releases had ties to lobbying firms or private health insurance companies not mentioned in the statements. A spokesman for the group declined to comment on the *Splinter* story, but Lauren Crawford Shaver, executive director of the partnership, said the organization is committed to "fixing what is broken so that it works better for every American," such as by improving the number of Americans with insurance and reducing health care costs for consumers.

On Capitol Hill, meanwhile, about half a dozen representatives of lobbying firms said they had pushed for meetings with Democrats over single payer and other proposed government expansions of health care. Lobbyists with the National Association of Health Underwriters, which represents health insurance agents and brokers, recently delivered a list of talking points critical of Medicare for All to Sen. Jacky Rosen (D-Nev.). It included the argument that single payer "would be prohibitively expensive" and "reduce the standards of quality and access Americans currently enjoy in their health care."

"You have a new majority with a lot of new members, so it's a whole new pool of folks to get in and talk to," said Robert G. Siggins, a senior policy adviser at the lobbying firm Alston & Bird who previously served as the chief of staff to a House Democrat. Siggins has lobbied on behalf of several private health care companies. "You're really trying to get a sense of where they're coming from, and provide information."

Democratic staff members also are receiving mailers warning against health plans that fall short of single-payer health care. One report sent last month to Senate Democratic offices, written by the KNG Health Consulting group but prepared on behalf of the American Hospital Association and Federation of American Hospitals, warned against "Medicare X," a plan from moderate Democratic Sens. Michael F. Bennet (Colo.) and Tim Kaine (Va.) that would allow all Americans to buy into a public health insurance plan, according to a copy of the report.

To some political insiders, this lobbying push from private health care companies underscores the enormous obstacles facing Medicare for All legislation and other large government interventions in health care. When Obama pushed the Affordable Care Act, Democrats tried working with private insurers and hospitals to minimize industry opposition to the legislation. Health insurance companies at the time helped defeat a proposed "public option" that would have competed with private plans.

"The insurance industry is still a very powerful force within the political process," said Jim Manley, who served as an aide to former Senate majority leader Harry M. Reid (D-Nev.). "Having them on the opposite side of single-payer will be a very difficult obstacle to overcome."

But single-payer advocates have argued for the necessity of their more radical proposal to transform the American health system, noting that the United States spends about twice as much per person as peer nations on health care despite lagging behind significantly on several key health indexes. To supporters of single payer, the frenzy of federal lobbying against Medicare for All highlights the need to upend the health-care status quo.

"When the people begin organizing against private insurance, the lonely insurance executives turn to their only friends: the elected officials beholden to their cash," said Tim Faust, an activist for single-payer health care.

Things PNHP members can do:

1. Call or meet with your congressional representatives and urge them to support single-payer Medicare for All.
2. Follow PNHP on Facebook and Twitter (@PNHP), share PNHP posts, and use **#MedicareForAll** when posting to social media.
3. Form a chapter of PNHP, or get involved in a chapter near you. To get started, contact **organizer@pnhp.org**.
4. Speak at a grand rounds or other forum at your hospital, or invite another PNHP member to do so. Contact organizer@pnhp.org for assistance putting together your presentation or finding a speaker.
5. Introduce a single-payer resolution at the next meeting of your local medical society or specialty society. Sample resolutions are available at **pnhp.org/SampleResolution**.

The Intercept_

February 27, 2019

The special interests behind Rep. Pramila Jayapal's Medicare for All bill are not the usual suspects

By Ryan Grim

Ryan Grim

The Medicare for All legislation unveiled Wednesday by Rep. Pramila Jayapal, a Democrat from Washington state, was written with the help of a broad swath of lobbyists and special interest groups, if perhaps not the kind associated with typical health policy legislation on Capitol Hill.

The key outside groups involved in the drafting included nurses, doctors, disability rights activists, and advocates for the elderly, as well as public interest organizations such as Public Citizen and the Center for Popular Democracy.

The result is legislation that, within one year of its passage, would provide improved Medicare coverage for everyone 19 and under, as well as everyone 55 and over. Within two years, it would cover everyone between the ages of 19 and 55, as well.

The legislation, which is being introduced with more than 100 co-sponsors, is the most far-reaching since a Senate version sponsored by Sen. Bernie Sanders, I-Vt., and includes benefits that are more generous. It also moves to full implementation in two years — as compared to four years under Sanders's plan — a recognition by Democrats that the opposition party will push to repeal it if they come into power, but doing so will be more difficult once the benefits have gone into effect.

The effort includes related legislation that would change the way long-term care is covered. Under the current system, Medicaid is the last resort, which effectively means that the sick and dying must impoverish themselves in order to qualify. The new bill would end that practice and allow people to die with dignity at home.

That measure was written with the help of disability rights activists, led by the Consortium for Citizens with Disabilities. "She wrote it with our community holding the pen. Over months, disability rights activists went back and forth on the language. We are included. Not just as a sidebar or footnote," said Ady Barkan, an activist dying of ALS, who collaborated with the Consortium for Citizens with Disabilities and others on the bill.

"It will allow me to live at home for the rest of my life. With my wife. And my son. My friends. My family. Surrounded by the things and people I love. That make me whole and settled. That connect me to humanity. That give me dignity," Barkan wrote on Twitter. He has mostly lost the ability to speak and to type with his hands, but can communicate on social media using a program that tracks his eye movements to type. "My living at home will make life easier for my family. My wife won't have to choose between spending time with me or spending time with our son. She won't have to drive hours to my facility to see me. She won't have to worry about how I'm treated when she leaves."

The new law, among its swath of new benefits, would provide dental coverage, a major boost to the health and quality of life of millions who suffer constant toothaches, or worse, for lack of access to dental care.

Along with Consortium for Citizens with Disabilities, the main groups involved in drafting the legislation were National Nurses United, a major nurses union that has long been on the forefront of the fight for single payer; Physicians for a National Health Program; the Center for Popular Democracy, where Barkan works and which organizes poor and marginalized communities; Public Citizen; and Social Security Works, which represents more than a million progressive seniors who support expanding the Medicare coverage they have to the rest of the population.

Meanwhile, the insurance and pharmaceutical industries played little to no role in the drafting process — an anomaly on Capitol Hill. Their marginalization in the process represents a major departure from the approach taken with the Affordable Care Act and reflects the type of bill being drafted: one less concerned about the profits, or even survival, of interest groups like insurers and more concerned with delivering care to the largest amount of people in the most cost-effective way.

Noticeably absent from the central drafting room was the Center for American Progress, the leading center-left think tank, which reflects a reticence by many in the progressive policy community to embrace something as sweeping as Medicare for All. The Center for American Progress, instead, has pushed what it calls "Medicare Extra for All," an expanded version of a public option that people could buy into. "The American people and Congress are further out

ahead and more visionary than a lot of advocates," said Jennifer Flynn, director of mobilization and advocacy for the Center for Popular Democracy, who was closely involved in the drafting of the Jayapal legislation.

The liberal think tank's reticence in the new health care conversation comes with a historical irony, in that the bill itself might not exist if not for the Center for American Progress. In March 2008, the think tank hosted a presidential candidate forum on health care in Las Vegas, at which Hillary Clinton, Barack Obama, and John Edwards all appeared. Edwards, then running on his theme of "two Americas," stole the show with a sophisticated plan, the centerpiece of which was a public insurance option that would be similar to Medicare and would compete with private plans. Obama left the forum embarrassed, having shown up empty-handed, and instructed his staff to put together a robust plan. Obama's health care plan eventually, if reluctantly, included a public option for health insurance, though it was traded away during negotiations with industry stakeholders.

It was the battle over the public option — and Sanders's 2016 campaign for president — that reinvigorated Democratic interest in public health care as the solution to the crisis. Once it became clear that Republicans were determined to repeal the compromise version of health care reform that Democrats had implemented, the focus shifted to Medicare for All. If Republicans were going to call the Affordable Care Act socialized medicine, progressive Democrats reasoned, they might as well go for the real thing.

In the fall of 2008, before Obama was elected president, Sen. Ted Kennedy, D-Mass., convened a large group of stakeholders to find consensus on a path forward for reform. Dubbed the "Workhorse Group," the gang included some activists, such as Ron Pollack of Families USA; representatives of labor groups like the Service Employees International Union; as well as every major industry group: Big Insurance, Big Pharma, for-profit hospitals, and medical device-makers.

John McDonough, Kennedy's top health policy staffer, led the meeting in the Dirksen Senate Office Building and laid out three avenues that Congress could go down if and when Democrats took control in January.

"We aren't trying to cram things into a system that has never worked. We are creating a functional health care industry."

The first was called Constitution Avenue, a full break with employee-based coverage, either to single payer or to a kludgy and since-discarded scheme cooked up by Sens. Ron Wyden and Bob Bennett. The second was Independence Avenue, a small-ball approach that involved state-based high-risk pools and other fiddling at the edges. Then came Massachusetts Avenue, which would take the model developed by the conservative Heritage Foundation and implemented by Republican Gov. Mitt Romney in Massachusetts, and take it national. The result was the Affordable Care Act.

After an hour and a half of debate, a vote was called. Zero hands went up for Constitution; zero went up for Independence. Of the roughly 20 participants, 15 hands went up for Massachusetts.

The consensus among those who mattered — the people in that room — was that single payer wasn't viable, and that's been the attitude of the majority of lawmakers toward universal coverage since then. Wednesday's press conference and unveiling — coming with the co-sponsorship of nearly half of the Democratic caucus — is a signal that the consensus has been broken. Whether a new one emerges remains to be seen.

Flynn said the authors of the new bill learned from and built on what came before it. Obama "tried to cram too many health care delivery systems into his proposal. We learned from those lessons. I honestly believe that Medicare for All is the smartest, simplest way to get health care for all. It's more strategic. We are giving people the health care that they want. We aren't trying to cram things into a system that has never worked. We are creating a functional health care industry," she said. "Jayapal's is also a very thought-out policy proposal, written by women and mostly women of color. It's certainly smart strategy to stake out the policy you want before compromising."

The goal for advocates is to convince a skeptical public that quality health care for all can become a reality. If it's seen as a real option on the table, Flynn said, it will be unstoppable. "Look, if we are able to get out that we can have health care for all — and all means all. And it's free. No copays, no out-of-pocket deductibles, no bills — here isn't a human who won't want it," Flynn said. "But we have an uphill battle to convince people that's a real thing."

Ryan Grim is the D.C. Bureau Chief at The Intercept and author of the forthcoming book "We've Got People: The End of Big Money and the Rise of a Movement."

Activist Ady Barkan testifies before Congress, April 30, 2019

KHN
KAISER HEALTH NEWS

February 27, 2019

There's a new Medicare-for-All bill in the House. Why does it matter?

By Shefali Luthra

Members of the House on Wednesday offered their version of a Medicare-for-All bill that is broader than what's been put forth by Sen. Bernie Sanders (I-Vt.), whose 2016 presidential run pushed the issue into the political mainstream.

Rep. Pramila Jayapal (D-Wash.) and Rep. Debbie Dingell (D-Mich.) unveiled the "Medicare for All Act of 2019," which redefines what the change in health care coverage might mean. The specifics included in the bill could play a role in the upcoming Democratic presidential primary campaign because candidates seeking support from the party's progressive wing leverage the phrase. But often, they use it to mean various things.

Is this bill so different from Medicare-for-All proposals that have come before? And why would those differences matter? Here are the essential takeaways:

In terms of the policy 411, the Jayapal-Dingell bill includes provisions not in other proposals.

In many ways, the proposal sounds familiar: The government would establish a health plan that pays for basically all forms of medical care for all citizens. That's how it gets the moniker "Medicare for All."

Under this plan, patients would not be responsible for any cost sharing of medical expenses, and the government coverage would include hospitals, doctors, preventive care, prescription meds and dental and vision care. Private insurers would not be allowed to sell plans that compete with the government program.

Senior citizens would be folded into the new Medicare plan, which would be more generous than their current coverage, and the government would make sure any medical care they are getting is not disrupted. The bill leaves two other government health care payers intact: the Veterans Health Administration and the Indian Health Service. Beneficiaries enrolled in these programs would have a choice of enrolling in the new Medicare-for-All plan or sticking with their current coverage.

Just like the Sanders bill, the House legislation covers what it calls "comprehensive reproductive health." Backers say it is meant to cover abortion — a controversial provision. Right now, government-funded health plans are legally prohibited from providing funds for abortions.

There are differences, too. For one, the transition to the new Medicare-for-All system would take place over two years, which would be a fast turnaround for a substantial task. Sanders' bill suggested a four-year transition.

The biggest difference: This House vision of Medicare-for-All would also cover long-term care. That isn't part of the Sanders bill, and it is not covered by Medicare. But for people with disabilities and the elderly, it's a significant benefit — and one that can get very expensive to pay for out-of-pocket. (The Affordable Care Act included a long-term care provision that was eventually scrapped because of its high cost.)

The House bill also would take a swipe at high prices for prescription drugs by empowering the government to negotiate prices directly with manufacturers and to take away and reissue drug patents if such efforts faltered. This idea, known as "compulsory licensing," has appeared in drug-pricing bills, but not in other Medicare-for-All legislation.

And the bill wades into one of the hottest Medicare-for-All controversies: the role of private health care. Notably, it permits it. Private plans can cover services not included in the single government health plan. Doctors can also refuse to participate in the program and charge patients cash for medical treatment instead.

"Whether there's someone out in Beverly Hills who sees the stars and doesn't partake — that would be possible," said Dr. Adam Gaffney, a doctor and president of Physicians for a National Health Program, a single-payer advocacy group that supports the legislation. "The way the whole program is structured is to really make it such that that's a very insignificant overall phenomenon."

And the legislation takes on wonkier questions, like health care costs — proposing so-called global budgets that set a firm amount the federal government would pay for hospitals, for instance, as a strategy to bring down spending.

Still, the legislation leaves a lot of meaningful details open to interpretation.

Three big ones: what precisely would be covered, what doctors would be paid and how the program would be financed.

Generally, Medicare for All would provide "comprehensive benefits," accounting for health care needs as "medically necessary or appropriate." That means covering hospital and doctor visits, but also, for instance, mental health, maternity services, addiction treatment, pediatrics and medications.

Where it gets tricky is determining which specific services qualify as "necessary." Sometimes that's obvious —

insulin for diabetics or a cast for a broken leg.

In other cases, it's not as clear. Examples include politically controversial treatments, like gender confirmation surgery. Many experts do say the procedure is an important option for people with gender dysphoria. But specific components of it are sometimes deemed cosmetic or unneeded — often by those skeptical of the treatment to begin with.

There are also reconstructive surgeries that provide medical value, but may be deemed cosmetic.

The Department of Health and Human Services would have significant discretion in interpreting what specific services are "medically necessary." That means political leanings or scientific debates could sway what's covered, even from administration to administration.

"Reasonable people could disagree on certain things," Gaffney acknowledged.

The legislation also spells out steps for determining how to pay doctors — a tricky issue, since doctors often complain that traditional Medicare pays them less than does private insurance. But the bill doesn't set up a reimbursement system.

Of course, there's the question of how the U.S. pays for the new program. Studies suggest Medicare for All would bring down national health care costs. Currently, though, much of that health spending is borne by the private sector. Under the Jayapal-Dingell bill, the money would have to come out of taxpayer dollars.

That would mean new taxes, and that's a subject that does not appear anywhere in the Jayapal-Dingell bill. (Jayapal has said she will put out a separate list of potential taxes that could finance her single-payer proposal. Sanders also used this strategy — a separate list of "pay-fors" — to make a case for his bill.)

The bill could resonate throughout the 2020 campaign.

The House bill keeps a spotlight on the Medicare-for-All issue — requiring Democratic presidential primary candidates to answer more questions and spell out stances on this particular policy.

That could create some land mines. Medicare for All is controversial, and already major health industry groups have ramped up opposition to the broad idea. This bill's specific provisions, such as its coverage of abortion, would add more adversaries. Its long-term care coverage would further drive up its multitrillion-dollar price tag.

But Robert Blendon, a health care pollster at the Harvard T.H. Chan School of Public Health, pointed out that addressing concerns such as the long-term care benefit could add to the measure's political muscle. It could make the idea more attractive to older voters, who otherwise might be hesitant to change their coverage but who do turn out disproportionately to vote in primaries.

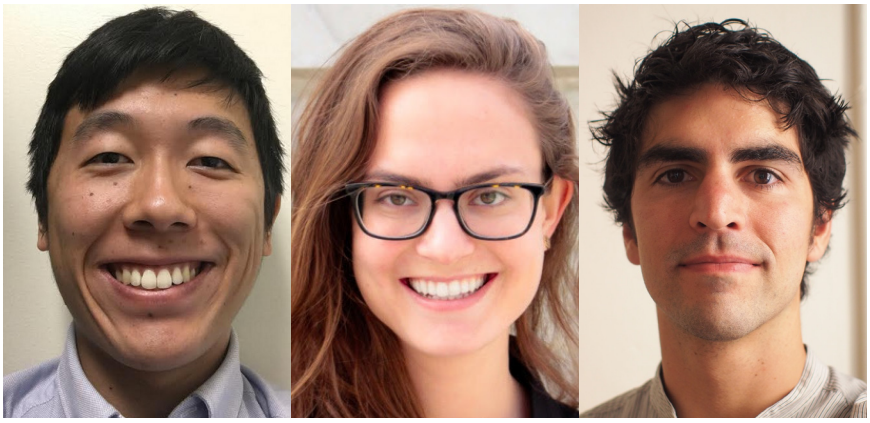
That dynamic, he said, could skew primary results to favor candidates who endorse Medicare for All, as opposed to more moderate Democrats who have distanced themselves from the issue. (In a general election, he noted, costs could certainly diminish that support.)

"The long-term care piece is unbelievably significant," he said. "It surely will help [progressives] with older voters."

Single-payer health care is the only solution

By Chris Cai, Isabel Ostrer, and Jackson Runte

We are a group of UCSF medical students who firmly believe that a single-payer system is the only sustainable solution to our nation's out-of-control health care spending and growing disparities in health care access. California and Bay Area physicians have the opportunity to lead the way on developing truly equitable and affordable health care reform. We define single-payer as a unified, government-financed health care system, with streamlined administration, minimal cost-sharing and universal coverage. Evidence shows that a single-payer system will benefit physicians, generate substantial cost savings, and vastly improve healthcare equity.



Chris Cai Isabel Ostrer Jackson Runte

Single payer benefits physicians

Physicians stand to gain from a single-payer system due to administrative simplification and decreased malpractice rates. Over half of all practicing physicians in the U.S. experience burnout, which is often linked to excessive administrative burden and inefficiency. Currently, half of physicians' time is consumed by these responsibilities. As the government becomes the sole payer, providers are relieved of the burdens of multiple payers and made less vulnerable to uncompensated care.

In addition, malpractice rates are likely to go down under a single-payer system. Roughly half of malpractice fees are designated for future medical payments so patients can pay for care to manage complications from improper treatment. In a single-payer system with minimal cost sharing, the need for these fees will be eliminated, reducing the financial incentive to initiate malpractice suits. While more research needs to be conducted on this subject, evidence from other countries is promising. For example, the proportion of health care spending dedicated to malpractice in the U.S. is nearly double that in Canada. Finally, a single-payer system has the potential to create a unified health record and vastly streamline information distribution and access, thereby improving provider communication and quality of patient care. A unified payer system is the first step toward a unified EHR.

A common concern among providers is that physician compensation will decrease under a single-payer system. However, with expanded coverage and minimal cost sharing, total utilization of provider services increases. At the same time, providers' billable hours increase due to decreased administrative load.

Single payer is cost effective

The United States has the most expensive health care system in the world. Compared to other developed countries, the U.S. spends nearly twice as much on medical care while performing worse on health outcomes, including life expectancy. The U.S. spent 17.8% of its gross domestic product on health care, while spending in other developed countries ranges from 9.6 to 12.4%. Furthermore, health care spending is projected to grow at an average annual rate of 5.6% through 2025, expanding to nearly 20% of GDP.

Moving to a single-payer system would save the U.S. money. Even as more people gain health insurance coverage and more services become covered, health spending is projected to decrease under a single-payer system.

The largest contributor to these cost savings is administrative simplification. The most cited study on U.S. health care administrative expenditures, published in the *New England Journal of Medicine*, estimated that administrative costs accounted for 31% of health care spending in the U.S. compared to 16.7% in Canada. Across the board, single-payer analyses show that savings would be realized from lower administrative costs. Many single-payer projections also show that bulk purchasing of medications and durable medical equipment would lead to significant savings. A recent study published in *JAMA* comparing U.S.

health care spending to that of 10 other high-income countries showed that pharmaceutical spending was vastly higher in the U.S. Per capita spending for pharmaceuticals in the U.S. was $1,443 compared to between $466 and $939 in other countries. Single-payer cost analyses consistently project savings on pharmaceuticals and medical equipment in the range of 1.8% to 4% of total health care spending.

A streamlined, single-payer system would allow the U.S. to realize savings while covering more Americans and increasing the amount of money actually going towards care.

Single payer improves health care equity

As we prepare to enter the health care workforce, we are deeply concerned by barriers to health care that disproportionately harm the patients most in need. The most glaring of these is insurance coverage: While the ACA reduced uninsurance rates nationwide from 16.7% to 10.3% between 2013 and 2016, many remain uninsured. Nearly half of this population cite the high cost of insurance as the main reason they remain uninsured. But when it comes to health care access, the challenges are far more complex than insurance coverage alone.

Rapidly expanding cost-sharing requirements are affecting all types of health insurance policies in the U.S., which means that being insured does not guarantee affordable access to care. Among individuals insured by large employers, deductibles have increased nearly 170% over the past 10 years with cost sharing by patients increasing at a faster rate than insurer payments. Underinsurance is also a growing problem, with 24% of those with employer plans and 44% with individual or marketplace plans underinsured in 2016. This is primarily due to high deductibles and out-of-pocket costs, according to the Commonwealth Fund. Underinsurance is problematic because individuals with high levels of cost sharing have been shown to reduce use of care for both minor and serious symptoms. In addition, large and concerning increases in high-severity emergency department visit expenditures and hospitalization days have been documented among underinsured low-income groups. When underinsured patients are forced to use health care services, financial losses can be astronomical. A single-payer system would completely eliminate uninsurance and underinsurance in the U.S.

Even more troubling are the amplified effects of increased cost sharing on specific patient populations. People of color have incomes and savings that are just fractions of their white counterparts, which severely impacts affordability of health care in our for-profit insurance system. According to the most recent U.S. Census data, average net worth and income for black households are 8% and 65% of white households, respectively.

Consider an average black family with a net worth of $9,211 insured by an ACA bronze plan: With a family deductible of over $12,000, this family could be bankrupted by a single high-cost health system encounter — an encounter a higher-earning family would be able to withstand far more easily. The disproportionate effects of cost sharing on minorities should be considered a form of structural racism; that is, our health system is itself a structural force that perpetuates racial group inequity on the societal level.

Other distinct patient groups are being victimized by unequal health care distribution and costs. For example, while the ACA outlawed denial of coverage due to pre-existing conditions, insurers are finding new ways to deny coverage to high-cost patients. "Adverse tiering," or the structuring of drug formularies to place entire drug classes in a high cost-sharing tier, has been documented across insurance plans for several high-cost chronic diseases such as mental illness, cancer, diabetes, rheumatoid arthritis, and HIV. This effectively deters these patients from enrolling in their plans. Simplifying our insurance system to a single, public payer would vastly reduce the capacity of health care financing to systematically oppress specific patient groups in the U.S.

The principle of distributive justice, an ideal we acknowledge under oath in our earliest days of medical school, tells that all patients should be valued equally. If we truly care about justice in our health care system, it is essential that clinicians examine how for-profit insurance systems incentivize discriminatory behavior in our own clinical and business practices. If access to our services continues to be determined by reimbursement size, we allow for the persistence of a health care system that preferentially serves wealthier, healthier individuals. The value of our work is not dependent on any aspect of the individual patient sitting in front of us in the exam room. Just imagine a health care system that empowers providers to treat any and all individuals with equal care regardless of income, health status, disability, race, or citizenship!

Actions San Francisco Marin Medical Society can take

As the organized voice of physicians, medical societies play a major role in advocating for and advancing health reform. The current political and social climates present an opportunity for organized medicine to take a leadership role in transforming health care. We urge SFMMS to advance single-payer through formal advocacy at the state and national levels. Single-payer health care is the only viable model for improving physician work quality and generating significant cost savings while also creating a more just health care system.

Chris Cai, Isabel Ostrer, and Jackson Runte are all second-year medical students at the University of California-San Francisco. They are active members of Students for a National Health Program and PNHP.

The New York Times

February 24, 2019

Fixing our health care system

By Claudia Fegan, M.D.

To the Editor:

Re "What's Good Health Care Worth?" (editorial, Feb. 17):

Thirty-six thousand Americans die prematurely each year because they are uninsured. And more than half a million households declare bankruptcy each year because of illness or medical bills. Who could possibly benefit from such an inhumane system?

Dr. Claudia Fegan

Private insurers.

High deductibles and copays, narrow networks of doctors, and prior authorization paperwork keep patients from getting the care they need, while funneling more money into the pockets of insurance companies. Private insurers add nothing of value to our health care system and drain billions of dollars that should be spent on patient care.

A single-payer "Medicare for All" system would end this needless loss of life and life savings.

Dr. Claudia Fegan is the chief medical officer of Cook County Health and the national coordinator of Physicians for a National Health Program.

Is single-payer health care a pipe dream?

By Elizabeth R. Rosenthal, M.D.

March 5, 2019

To the Editor:

In the near future Medicare for all will join the heap of other impossible dreams that came true: women's suffrage, Social Security, Medicare, integration and gay marriage.

All we need are bold leaders with imagination and a strong grassroots movement to support them.

Dr. Elizabeth Rosenthal

They are on their way!

Dr. Elizabeth Rosenthal, a retired dermatologist, is on the board of Physicians for a National Health Program-NY Metro Chapter.

How to write a letter to the editor:

Writing a letter to the editor is an effective way to influence the debate on health care reform. Local newspapers, national magazines, and even medical journals publish letters from readers. Most letters are written in response to a published article or an issue that is regularly covered in that outlet, like health care.

Tips for submitting an effective letter:

- Keep it short — fewer than 150 words, or one paragraph.
- Choose one point and stick to it.
- Speak from your experience as a health care professional.
- Mention the name and date of the article you are responding to.
- Send your letter in the body of an email (no attachments) and include your full name and title, address, and phone number for verification.

Questions? Email PNHP communications specialist Clare Fauke at **clare@pnhp.org**.

Times Standard

March 16, 2019

Single-payer health care is the only solution

By Corinne Frugoni, M.D.


Dr. Corinne Frugoni

"How on earth am I going to pay for this?" That was my first thought when diagnosed with cancer as a medical student. I would need two surgeries, and only had a limited student health plan. It turned out I was lucky. My surgeon friend got me discounted rates for services and I was cancer free within a year. I recognize that my experience is not the norm.

For years I've heard patients talk about this same paralyzing fear of cost. But after Rep. Pramila Jayapal (D-Wash.) introduced a Medicare-For-All bill in the U.S. House of Representatives on Feb. 27, I have renewed hope that all Americans will never have to face such fear again.

The Medicare for All Act of 2019 would replace costly insurance premiums, copays and deductibles with less costly taxes that would cover essential care for everyone: doctor visits and hospitalizations, mental health, long-term care, prescription drugs. Even dental, vision and hearing would be covered. Everyone will have coverage regardless of health, wealth or employment status. Health insurance will be replaced by health assurance.

Eliminating for-profit insurance companies is the key to saving billions in administrative and operational costs, along with the government's ability to negotiate lower pharmaceutical and medical device prices. With everyone in one risk pool, costs are distributed more evenly. Recent research shows that the U.S. could save trillions and simultaneously offer high quality health care that's equally accessible to all residents. The U.S. president, Congress members, factory workers and single mothers will all have the same coverage. With a one-tier system, you bet government officials will make sure the system will work to benefit all.

Rather than shareholders competing for high-yield stock options, all Americans would gain financial peace of mind.

Funded by combining the substantial sources we already have, including for Medicare, Medicaid and other federal health insurance systems, only modest new taxes would be needed.

The vast majority of people will save money.

Rural counties like ours that have difficulty recruiting and retaining doctors would benefit. That's partly because Jayapal's bill would provide regional funding for medically underserved areas.

Additionally, providing universal coverage would create a more uniform, fair-market value reimbursement rate, allowing private practice physicians, community clinics, and rural hospitals to remain open. The current bureaucratic quagmire of multiple insurance regulations, a major cause of burnout for physicians, would also be eliminated. Regions could identify physician shortages and offer incentives to doctors to practice where they're needed the most.

A Medicare-for-All system could lift the burden from local governments saddled with paying for employee health benefits. Health policies for Humboldt County's 2,300-plus employees cost $18 million in 2017. Under a single-payer system, our local government could put those savings toward higher wages, infrastructure, or programs to improve quality of life.

Two concerns of organizations opposing single payer are choice and loss of private insurance. Let's be clear about choice: Under our current fragmented system, we choose among an array of complicated insurance plans.

Under a Medicare-for-All plan, we will have a choice of health care providers and hospitals because networks will be eliminated. Single payer means one network. It means giving up private insurance plans that target profit for hassle-free improved benefits. Your benefits card would entitle you to a doctor of your choice who is free to provide the best care for you!

This system is already in place — and working — in a number of countries.

There are so many compelling reasons to upgrade our health care system. But as a physician, my thoughts return to a former patient without health insurance. I discovered a suspicious growth in her colon, but she delayed surgery for three years, waiting to qualify for Medicare. By that time, the cancer had spread throughout her body and it was too late.

How many more will die in our country because they're not getting the essential medical care they need? That choice is in the hands of our legislators. We will hold them accountable for their decisions.

Write or call your federal lawmakers at 202-224-3121 to express your support for Jayapal's new bill. We must act before it's too late for ourselves and our loved ones.

Dr. Corinne Frugoni is a family physician in Humboldt and an Arcata resident. She's a member of Physicians for a National Health Program and Health Care for All-California.

THE Nation.

February 18, 2019

We don't need private health insurance

New single-payer plans don't need to worry about carving out roles for health-care profiteers.

By Adam Gaffney, M.D., M.P.H.

Dr. Adam Gaffney

Does achieving "Medicare for All" mean mostly eliminating private health insurance? Single-payer proponents say yes: After all, if a public plan provides comprehensive, no-deductible coverage for everyone, nobody would want — much less be willing pay for — duplicative private coverage.

Yet candidates who previously embraced single payer sometimes seem a bit unsure. For instance, Sen. Cory Booker, who co-sponsored Sen. Bernie Sanders's single-payer plan back in 2017, was asked whether he would "do away with private health care" recently, and he responded, "Even countries that have vast access to publicly offered health care still have private health care, so no."

There are actually two distinct questions wrapped into one here. First is whether we want a universal public plan for everyone, or a hodgepodge of public and private plans that cover different parts of the population according to age, income, workplace, disability, and so forth, but that together cover everyone. Last year in *Dissent*, I made the case that a nation like ours — with enormous unmet medical needs, an inadequate safety net, and galling inequality — is a poor fit with a multi-payer system that divides the population into a hierarchy of public and private plans with inequitable levels of access, varied copays and deductibles, and unequal benefits and provider networks. This would never achieve the equity, universality, or efficiency of a public plan that provides complete coverage to everyone.

But there's another question. Let's assume we agree on the need for a universal public-insurance plan that covers everyone, as in Canada, Great Britain, or France. Would there still be a role for private insurance? If so, what would it be?

In nations that have universal public-insurance programs, private health plans fall into three categories: "duplicative" plans, "supplementary" plans, and "complementary" plans. "The debate over eliminating [private] health insurance is actually offering a false choice," says Sarah Kliff of *Vox*.

Let's start with "duplicative" coverage, which refers to private plans that "duplicate" benefits of the public plan, like covering doctor visits or procedures that are also covered by the single-payer plan.

At first glance, it might seem odd that insurers would offer such plans, much less that anyone would pay for them. You wouldn't, for instance, buy a private plan hawked by a company that promises you "access" to Central Park. You already have that. Obviously, such plans must offer some advantage to be viable.

And they do: In the single-payer context, they let individuals jump to the front of the line, gaining wider or quicker access to physicians' services or other care covered by the public plan. Consider a case from the intensive-care unit where I work. Assume it's a busy day, and the ICU is crowded. Should a scarce bed go to a less sick person over a sicker one who needs it more, just because the former has better-paying insurance? Most, I believe, would find that appalling.

But essentially, that's what duplicative plans promise, albeit usually for non-emergency care. Now, some might argue that allowing people to have preferential access to office appointments or elective surgery is less problematic than when it involves an ICU bed. But such distinctions are arbitrary. Various types of care can be lifesaving, or limb-saving. Whether you're talking about access to a primary-care doctor or a specialist, a psychiatrist or a hospital bed, health — not wealth — should be the factor determining access.

It is true, as Kliff describes, that countries with universal coverage handle this differently. Great Britain has retained a small private-insurance market that gives some people a leg up in seeing the doctor. But Canada prohibits duplicative coverage, and, in fact, so does the U.S. It has long been illegal to sell duplicative individual coverage to Medicare beneficiaries. I've never heard any older adults complain about this fact and pine for a private, marketplace plan; in fact, I'm guessing few are even aware of the exclusion.

Duplicative plans, in other words, are not desirable, but they are also unnecessary. We should not embrace them.

But how about "supplementary" coverage, the private plans that provide benefits for services not covered by the public system? As Kliff notes, in Canada, the public system doesn't offer universal drug benefits or dental care, so people need supplementary private plans to cover their medicines and their teeth. Similarly, in the U.S., Medicare doesn't cover dental-care benefits, and until 2003 didn't cover prescription drugs.

The single-payer bills in Congress do not ban supplementary

private coverage. However, because both the forthcoming bill in the House and (with the exception of long-term care) the bill in the Senate have comprehensive benefits — including dental care, prescription drugs, and vision care — there is not much left for supplementary plans to cover. Perhaps cosmetic surgery, or trips to Swiss medicinal spas?

The only way these bills could make way for supplemental insurance would be to strip coverage benefits for the sole purpose of creating business opportunities for the private insurance industry. Surely, we could do that: We could remove coverage for dental benefits or kidney care, for colonoscopies or elbow surgeries, and perhaps a private insurance market would emerge to cover such services. But why would we possibly want to?

Consider that Canada's exclusion of drug coverage from its public system is a major problem — it's the reason why Canada has higher rates of people not taking their medication because of cost relative to other high-income nations, apart from the U.S.

When fashioning any new health program, we should pick and choose the best policies. For instance, the U.K. does have universal drug coverage (mostly without copays) and, consequently, basically everyone gets the medicine they need. That should be our model. The underlying question is simple: Do we offer comprehensive benefits in the universal public system, or do we drop benefits at random so as to give Aetna and Cigna something to do? The answer, to my mind, seems clear.

Finally, many nations have "complementary" private plans, which cover the copays and deductibles imposed by some (but not all) public systems.

For instance, many Medicare beneficiaries take out so-called "Medigap" plans today, which cover that program's often substantial out-of-pocket expenses. In France, almost everyone has a complementary plan that covers the cost-sharing (e.g., copays) imposed by the single-payer program. The U.K. and Canada, in contrast, have no copays for physician care, diagnostic testing, emergency-room care, surgical procedures, or hospital care.

In order to preserve a role for private insurers under any new single-payer scheme, legislators would have to add copays for the purpose of accommodating a publicly subsidized private insurance bureaucracy. And even if the single-payer bills were rewritten along those lines, insurers would still fight them tooth-and-nail, and the program would still be branded as a Soviet death-panel scheme by the right.

But far more importantly, let's not forget how bad copays and deductibles are. It's not just that they are unnecessary for cost control: Canada and the U.K. provide no-deductible universal coverage and have lower overall health-care costs. And it's not just that they squeeze family budgets, effectively worsening inequality: By deterring the use of needed care, they are also harmful to health itself, including for those with heart disease, lung disease, diabetes, and multiple sclerosis.

The presence of complementary private plans requires the erection of unnecessary financial barriers to care. Without the latter, we won't need the former.

In other words, the only way to make room for a significant role for private insurance in the American context is to make the public system paltrier or skimpier, to impose onerous copays and deductibles, or to let the rich preferentially displace working-class people from hospital beds and doctors' offices. But it doesn't seem to make sense to punch holes in your own floor just to create work for a carpenter. That is particularly true if your floor is your health care — and your carpenter is an extractive insurance giant.

Dr. Adam Gaffney is a pulmonary and critical care specialist at the Cambridge Health Alliance and Harvard Medical School, and president of Physicians for a National Health Program.

Americans borrowed $88 billion in 2018 to pay for health care.

We need improved #MedicareForAll so patients can focus on their health, not their medical bills.

PNHP

Source: The U.S. Healthcare Cost Crisis, Gallup, March 26, 2019

What is single-payer health care?

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

Excerpt from third edition of "Social Injustice and Public Health," edited by Barry Levy, M.D., M.P.H.

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

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

In some single-payer systems, such as in Scotland and Spain, the government not only pays for care, but also owns most hospitals and employs most medical workers — a model known as a national health service.

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

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

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

In contrast, the governments in Scotland and Canada pay each hospital a global budget that covers all of the care that hospital delivers — similar to the way local governments in the U.S. pay their fire departments or the U.S. federal government funds VHA hospitals. Hospitals in Canada do not bill for individual patients or need to get an approval from an insurer for each diagnostic procedure or treatment. As a result, Canadian hospitals spend about 12% of their revenues on administration — compared to about 25% spent by U.S. hospitals. And billing by Canadian physicians is also far simpler: Canadian physicians have billing costs that are two-thirds lower than those of U.S. physicians.

A single-payer system also saves on insurance overhead, which consumes about 14% of premiums in the U.S., compared to 1% in Canada. Overall, a properly structured single-payer system in the U.S. could decrease insurance overhead, hospital bureaucracy, and physicians' paperwork costs by about $500 billion annually.

A single-payer system in the U.S. could realize additional savings through improved health planning to assure that hospitals and other "high-tech" facilities are available where they are needed and not duplicated where they are wasteful — or even harmful. An excessive number of hospital beds and medical technology induce overtreatment — a phenomenon now known as Roemer's Law: "A built (hospital) bed is a filled bed."

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

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

Polls show substantial support for such reform, both among the general public and among health professionals. Pharmaceutical and insurance firms, which would lose huge amounts of money, continue to spend enormous sums to influence politicians to keep a single-payer system off the political agenda. In the U.S., groups such as PNHP, HealthCare Now, National Nurses United, and Public Citizen are working to educate the public about single-payer health care and to build a popular movement that can lead to the establishment of a single-payer health care system in the U.S.

ThinkProgress

April 1, 2019

House Democrats on key committees receive funding from anti-single payer groups

By Amanda Michelle Gomez

Medicare for All has attracted widespread support in the Democratic Party, but faces a major threat: big spending by health care and insurance interests determined to preserve the status quo.

An analysis found that those industries donated nearly $1.2 million in the 2017-18 election cycle to Democratic members of four key House committees that could determine the fate of Medicare for All.

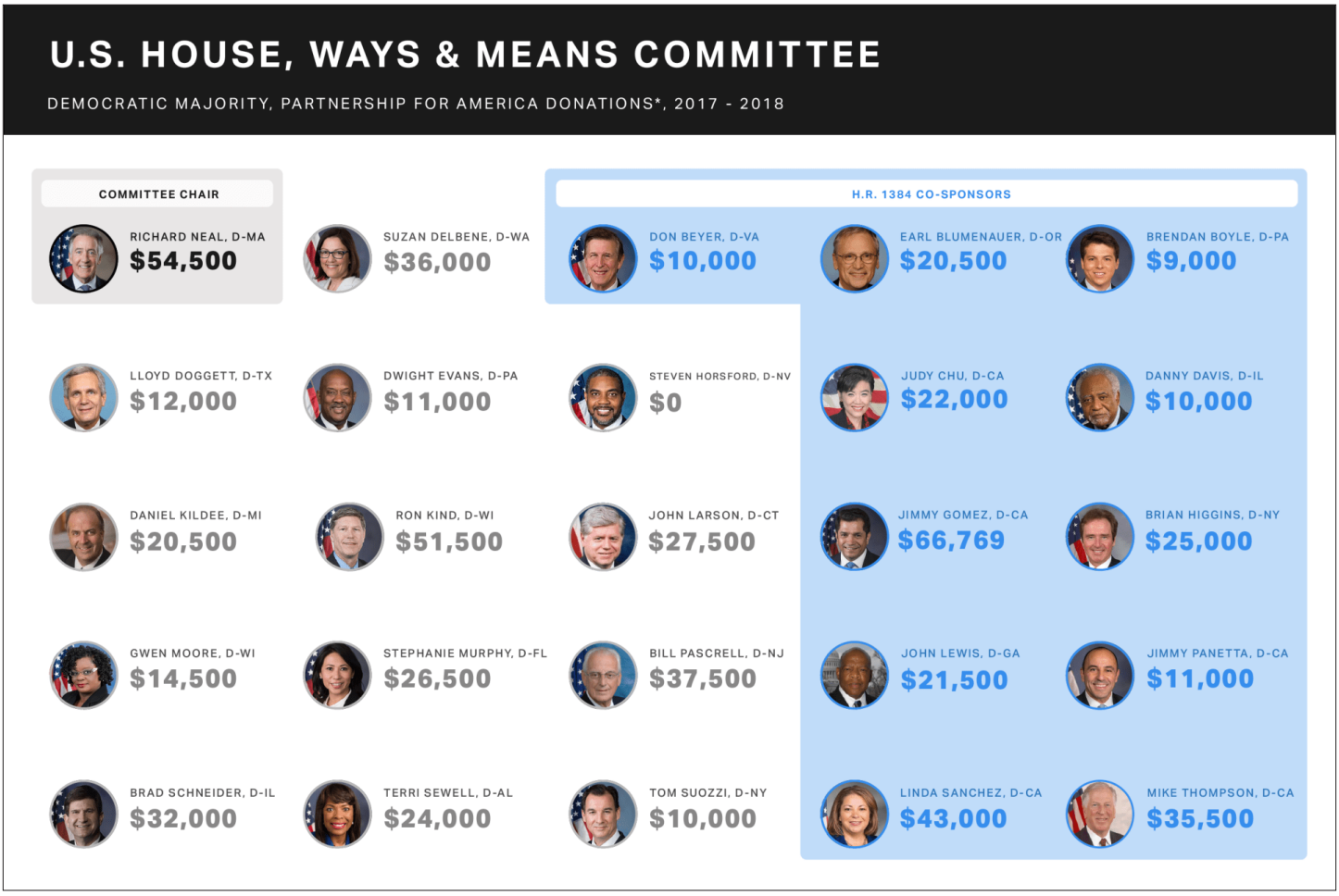
Last summer, leading pharmaceutical, insurance, and hospital interests [including the American Medical Association] formed the Partnership for America's Health Care Future to curb favor for Medicare for All. And they've been donating a lot to get their views across — more than $7.5 million to congressional candidates during the midterm elections.

Rep. Richard Neal (D-MA), the chairman of the House Ways and Means Committee, received $54,500. Chairmen of the Budget and Rules committees, Reps. John Yarmuth (D-KY) and James McGovern (D-MA), received $5,000 and $3,500 respectively.

House Energy and Commerce Committee Chairman Rep. Frank Pallone (D-NJ) received $56,000 from Partnership members — the most of any chairman of those committees, and thousands more than committee chairs who promised to hold Medicare for All hearings.

"We know that corporate opposition to Medicare for All has deep pockets and they wouldn't be giving this money to Congress if they didn't think it would have its desired effect," said Dr. Adam Gaffney, the president of Physicians for a National Health Program.

"It's like when pharmaceutical companies give money or gifts to physicians — they wouldn't be doing it if it didn't matter."



thebmj

Changes in midlife death rates across racial and ethnic groups in the United States: systematic analysis of vital statistics

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Additional material is published online only. To view please visit the journal online.

Cite this as: *BMJ* 2018;362:k3096 http://dx.doi.org/10.1136/bmj.k3096

Accepted: 11 July 2018

ABSTRACT

OBJECTIVE

To systematically compare midlife mortality patterns in the United States across racial and ethnic groups during 1999-2016, documenting causes of death and their relative contribution to excess deaths.

DESIGN

Trend analysis of US vital statistics among racial and ethnic groups.

SETTING

United States, 1999-2016.

POPULATION

US adults aged 25-64 years (midlife).

MAIN OUTCOME MEASURES

Absolute changes in mortality measured as average year-to-year change during 1999-2016 and 2012-16; excess deaths attributable to increasing mortality; and relative changes in mortality measured as relative difference between mortality in 1999 versus 2016 and the nadir year versus 2016, and the slope of modeled mortality trends for 1999-2016 and for intervals between joinpoints.

RESULTS

During 1999-2016, all cause mortality in midlife increased not only among non-Hispanic (NH) whites but also among NH American Indians and Alaskan Natives. Although all cause mortality initially decreased among NH blacks, Hispanics, and NH Asians and Pacific Islanders, this trend ended in 2009-11. Drug overdoses were the leading cause of increased mortality in midlife in each population, but mortality also increased for alcohol related conditions, suicides, and organ diseases involving multiple body systems. Although midlife mortality among NH whites increased across a multitude of conditions, a similar trend affected non-white populations. Absolute (year-to-year) increases in midlife mortality among non-white populationsoften matched or exceeded those of NH whites, especially in 2012-16, when the rate of increase intensified for many causes of death. During 1999-2016, NH American Indians and Alaskan Natives experienced large increases in midlife mortality from 12 causes, not only drug overdoses (411.4%) but also hypertensive diseases (269.3%), liver cancer (115.1%), viral hepatitis (112.1%), and diseases of the nervous system (99.8%). NH blacks experienced increased midlife mortality from 17 causes, including drug overdoses (149.6%), homicides (21.4%), hypertensive diseases (15.5%), obesity (120.7%), and liver cancer (49.5%). NH blacks also experienced retrogression: after a period of stable or declining midlife mortality early in 1999-2016, death rates increased for alcohol related liver disease, chronic lower respiratory tract disease, suicides, diabetes, and pancreatic cancer. Among Hispanics, midlife mortality increased across 12 causes, including drug overdoses (80.0%), hypertensive diseases (40.6%), liver cancer (41.8%), suicides (21.9%), obesity (106.6%), and metabolic disorders (60.0%). Retrogression also occurred in this population; after a period of declining mortality, death rates increased for alcohol related liver disease, mental and behavioral disorders involving psychoactive substances, and homicides. NH Asians and Pacific Islanders were least affected by this trend but also experienced increases in midlife mortality from drug overdoses (300.6%), alcohol related liver disease (62.9%), hypertensive diseases (28.3%), and brain cancer (56.6%). The suicide rate in this group increased by 29.7% after 2001. The relative increase in US midlife mortality differed by sex and geography. For example, the relative increase in fatal drug overdoses was greater among women than among men. Although the relative increase in midlife mortality was generally greater in non-metropolitan (ie, rural) areas, the relative increase in drug overdoses among NH whites and Hispanics was greatest in suburban fringe areas of large cities, and among NH blacks was greatest in small cities.

CONCLUSIONS

Mortality in midlife in the US has increased across racial-ethnic populations for a variety of conditions, especially in recent years, offsetting years of progress in lowering mortality rates. This reversal carries added consequences for racial groups with high baseline mortality rates, such as for NH blacks and NH American Indians and Alaskan Natives.

WHAT IS ALREADY KNOWN ON THIS TOPIC

Mortality rates among whites aged 25-64 years (midlife) have increased since the 1990s, a trend attributed primarily to drug overdoses, alcohol related liver disease, and suicides

Prior studies suggested that this trend was not occurring among non-Hispanic blacks and Hispanics, the largest minority populations in the US

WHAT THIS STUDY ADDS

Midlife mortality rates in the US are increasing not only among non-Hispanic whites but also among Hispanics and non-Hispanic American Indians and Alaskan Natives, blacks, and Asians and Pacific Islanders

Although drug overdoses, alcohol related liver disease, and suicides played a major role, mortality rates also increased across a broad spectrum of diseases involving multiple body systems

The wide range of affected conditions points to the need to examine systemic causes of declining health in the US

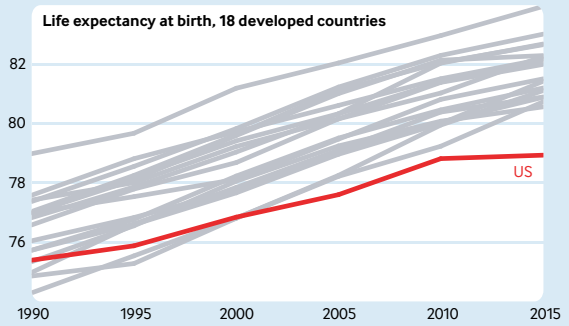
thebmj Visual summary

Why is US life expectancy falling behind?

Coming in last

The United States now ranks near the bottom of life expectancy rankings, when compared to other high income countries.

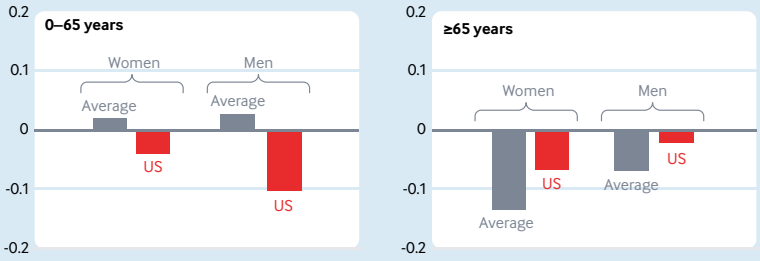
In a 2018 paper in *The BMJ*, authors Ho and Hendi compared life expectancy trends from 1990 to 2015 in 18 countries commonly used in cross national comparisons. These countries have all achieved high levels of development, and underwent changes in mortality associated with that development at roughly the same time. They also have large enough populations to produce reliable estimates of mortality.



2015 ranking		
1	Japan	84.0
2	Switzerland	83.0
3	Spain	82.7
4	Australia	82.7
5	Italy	82.3
6	Norway	82.3
7	Sweden	82.2
8	France	82.2
9	Canada	82.0
10	Netherlands	81.5
11	Finland	81.4
12	Austria	81.2
13	Portugal	81.1
14	United Kingdom	80.9
15	Belgium	80.9
16	Denmark	80.7
17	Germany	80.6
18	United States	78.9

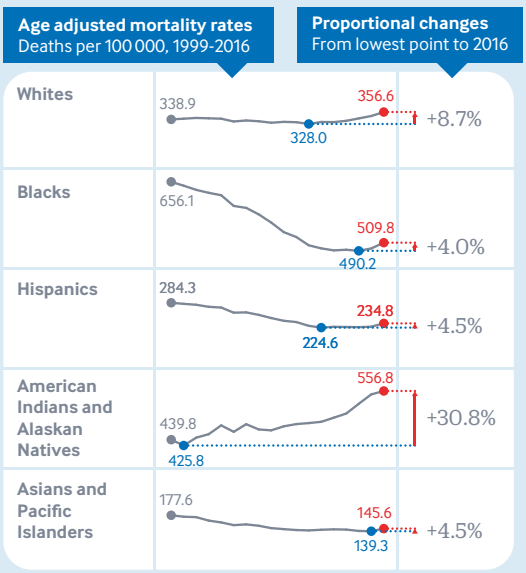
Before their time

Ho and Hendi observed recent widespread life expectancy declines across the 18 high income countries. The decline in most countries was concentrated at ages ≥65, and mostly attributable to diseases related to a severe influenza season. However, the US decline was largely concentrated at younger ages, particularly those in their 20s and 30s, and attributable to external causes like drug overdose.



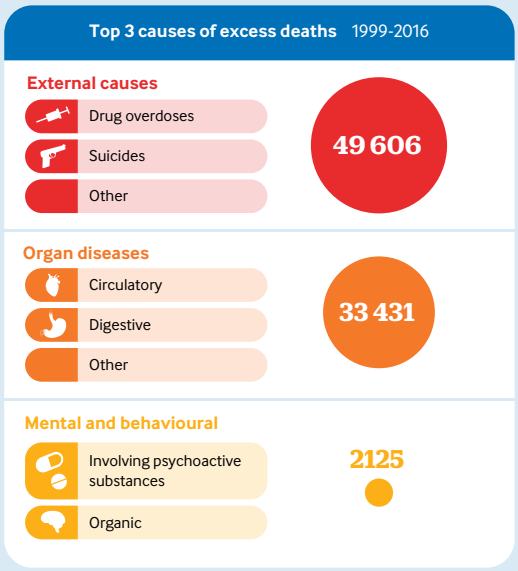
Who is affected?

Further detail is provided by Woolf et al, in their simultaneously published paper in *The BMJ*. They compared midlife mortality patterns in the US across racial and ethnic groups from 1999 to 2016. Among people aged 25-64 years, increases in mortality rates have been observed in all groups in recent years.



Cause for concern

Within these groups, there are a variety of different reasons for the observed changes in mortality. Changes were driven not only by external causes of death, but also by a variety of organ diseases and increases in mortality from mental and behavioral disorders.



SERVING ALL OF PICKAWAY COUNTY
Circleville Herald

March 13, 2019

Insurance churning: An instability for health care users

No one has ever kept insurance they like

By Brad Cotton, M.D.

Dr. Brad Cotton

It is true that President Obama misspoke during the crafting of the Affordable Care Act, promising that anyone who likes his or her health insurance can keep it. The truth is that, even before the ACA, no one (or almost no one) kept the same insurance year after year.

The fact is everyone loses insurance they like, constantly, and if you have employer purchased health insurance, there is very darn little of your so-called free market choice about it. You get the insurance your employer picks for you, or maybe you get to choose from two or three plans. You can bet that the choice of plans from year to year will have higher premiums, your employer will require a higher percentage of the premiums be deducted from your check, the deductibles will be higher, there will be narrower networks or restricted drug formularies forcing you to change your doctor, your hospital or your meds. I see patients daily who can't see their new doctor, can't afford their new medications, or were forced into physicians, hospitals or medications they don't like.

The insider term for this constant insurance instability is "churning," and it is an inevitable and undesirable event as profit-based health insurers plot to keep more of your premium dollars and avoid paying for your care. Insurance companies look for the least expensive doctors, hospitals or drugs while you get a new but worse deal each year. What a perverse system. We pay health insurers so that we may get health care when we need it; the insurer sees our hard-earned cash as theirs to keep and fights tooth and nail to avoid paying for your care.

Churning leaves you feeling as if you had been thoroughly churned in your washing machine, pockets inside out, wallet gone and feeling as if you have been taken to the cleaners.

If you have ever had to fight with an insurance company, you know they will fight you and your physician with denial after denial. Prior to the ACA, many health insurers spent as little as 50-60 percent of your premiums on actual paying for health care. The industry term is the "medical loss ratio" or MLR. The ACA requires health insurers to spend 90 percent of your premiums on actually caring for you, or refund the difference.

The constant churning of your coverage, the constant instability, that feeling that you and your family are on thin ice is real, and it is unsafe. The ACA was an immense regulatory attempt to force health insurers to behave responsibly by limiting an insurer's ability to avoid covering anyone with pre-existing conditions, limiting their abilities to sell junk policies, or to actually dump you once you get sick. The monster of profit in health care can never be safely tamed and the ACA was an ineffectual attempt to do so.

For more detailed reading on the deviousness of the health insurance industry read former Cigna insider Wendell Potter's book: "Deadly Spin: An Insurance Company Insider Speaks Out on How Corporate PR is Killing Health Care and Deceiving Americans." I further suggest "Trumpcare: Lies, Broken Promises, How it is Failing, and What should be Done," by physician John Geyman.

Safety lies in improved Medicare for All. Ask any senior how safe even currently unimproved and unexpanded traditional Medicare is. That 65th birthday is a lighthouse, guiding the way into the safe harbor of traditional Medicare. Traditional Medicare has never limited physician, hospital, medications and treatment choice. Improved and expanded means we eliminate deductibles and copays and offer first-dollar coverage; benefits also include vision, dental, and long-term care. Medicare for All would also eliminate the private Medicare Advantage plans that re-introduce all the downsides of private insurance, including churning.

Don't be afraid of Medicare. Be afraid of getting churned when the corporate health insurer can sell your employer a cheaper or skimpier plan. When you are sick, do you go to the doctor or do you go to the banker? There are an abundance of U.S. physicians who support improved Medicare for All. That fact ought to tell us something.

Dr. Brad Cotton is an emergency medicine physician in Westerville, Ohio. He is active in PNHP and the Ohio Single Payer Action Network.

Medicare for All and Its Rivals: New Offshoots of Old Health Policy Roots

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

The leading option for health reform in the United States would leave 36.2 million persons uninsured in 2027 while costs would balloon to nearly $6 trillion (1). That option is called the status quo. Other reasons why temporizing is a poor choice include the country's decreasing life expectancy, the widening mortality gap between the rich and the poor, and rising deductibles and drug prices. Even insured persons fear medical bills, commercial pressures permeate examination rooms, and physicians are burning out.

In response to these health policy failures, many Democrats now advocate single-payer, Medicare-for-All reform, which until recently was a political nonstarter. Others are wary of frontally assaulting insurers and the pharmaceutical industry and advocate public-option plans or defending the Patient Protection and Affordable Care Act (ACA). Meanwhile, the Trump administration seeks to turbocharge market forces through deregulation and funneling more government funds through private insurers. Here, we highlight the probable effect of these proposals on how many persons would be covered, the comprehensiveness of coverage, and national health expenditures (Table).

Medicare for All

Medicare-for-All proposals are descendents of the 1948 Wagner–Murray–Dingell national health insurance bill and Edward Kennedy and Martha Griffiths' 1971 single-payer plan (2). They would replace the current welter of public and private plans with a single, tax-funded insurer covering all U.S. residents. The benefit package would be comprehensive, providing first-dollar coverage for all medically necessary care and medications. The single-payer plan would use its purchasing power to negotiate for lower drug prices and pay hospitals lump-sum global operating budgets (similar to how fire departments are funded). Physicians would be paid according to a simplified fee schedule or receive salaries from hospitals or group practices.

Similar payment strategies in Canada and other nations have made universal coverage affordable even as physicians' incomes have risen. Those nations have realized savings in national health expenditures by dramatically reducing insurers' overhead and providers' billing-related documentation and transaction costs, which currently consume nearly one third of U.S. health care spending (3). The payment schemes in the House of Representatives' Medicare-for-All bill closely resemble those in Canada. The companion Senate bill incorporates some of Medicare's current value-based payment mechanisms, which would attenuate administrative savings. Most analysts, including some who are critical of Medicare for All, project that such a reform would garner hundreds of billions of dollars in administrative and drug savings (4) that would counterbalance the costs of utilization increases from expanded and upgraded coverage. Reductions in premiums and out-of-pocket costs would fully offset the expense of new taxes implemented to fund the reform.

"Medicare-for-More" Public Options

Public-option proposals, which would allow some persons to buy in to a public insurance plan, might be labeled "Medicare for More." Republican Senator Jacob Javits and Representative John Lindsay first advanced similar proposals in the early 1960s as rivals to a proposed fully public Medicare program for seniors. This approach resurfaced during the early 1970s as Javits' universal coverage alternative to Kennedy's single-payer plan and gained favor with some Democrats during the 2009 ACA debate.

Policymakers are floating several public-option variants, most of which would offer a public plan alongside private plans on the ACA's insurance exchanges. Although a few of these variants would allow persons to buy in to Medicaid, most envision a new plan that would pay Medicare rates and use providers who participate in Medicare. Positive features of these reforms include offering additional insurance choices and minimizing the need for new taxes because enrollees would pay premiums to cover the new costs. However, these plans would cover only a fraction of uninsured persons, few of whom could afford the premiums (5); do little to improve the comprehensiveness of existing coverage; and modestly increase national health expenditures. The Medicaid public-option variant, which many states might reject, would probably dilute these effects.

Medicare for America, the strongest version of a public-option plan, would automatically enroll anyone not covered by their employer (including current Medicare, Medicaid, and Children's Health Insurance Program enrollees) in a new Medicare Part E plan. It would upgrade Medicare's benefits, although copayments and deductibles (capped at $3500) would remain. The program would subsidize premiums for those whose income is up to 600% of the poverty level, and employers could enroll employees in the program by paying 8% of their annual payroll. The new plan would use Medicare's payment strategies and include private Medicare Advantage (MA) plans (which inflate Medicare's costs [6]) and accountable care organizations.

Medicare for America would greatly expand coverage and upgrade its comprehensiveness but at consid-

This article was published at Annals.org on 2 April 2019.

Table. Characteristics of Major Health Reform Proposals as of March 2019

Characteristic	Medicare for All (Single Payer)	Medicare for America	Medicare Public Option	Medicaid Public Option	Trump Administration White Paper and Budget Proposal
Chief sponsors	Jayapal (D-WA) and Sanders (I-VT)	DeLauro (D-CT) and Schakowsky (D-IL)	Merkley (D-OR) and Murphy (D-CT) Higgins (D-NY), Kaine (D-VA), and Bennet (D-CO) Schakowsky (D-IL) and Whitehouse (D-RI) Others	Schatz (D-HI) and Lujan (D-NM)	Executive branch actions and proposals; not yet in legislative form
Provenance	Wagner–Murray–Dingell Bill (1948) Kennedy–Griffiths Bill (1970)	Javits Bill (1970) Center for American Progress (2018)	Javits Bill (1962) Javits–Lindsay Bill (1964)	Lindsay proposal (1964)	Nixon proposals (1971) Long–Ribicoff Bill (1973) Medicare Modernization Act (2003)
Enrollment	Automatic for all U.S. residents	Automatic for all U.S. residents unless an employer opts to provide private coverage	Available as an option on ACA exchanges	States may choose to provide this strategy as an option on ACA exchanges	Little change
Extent of coverage expansion	Universal	Universal	Modest	Very modest; some states would probably decline to participate	Coverage would probably decrease
Comprehensiveness of coverage	Broad benefits; no copays or deductibles	Broad benefits; out-of-pocket costs capped at $3500	Somewhat broader than the current Medicare plan; out-of-pocket costs are similar to or somewhat lower than those under current ACA plans	Similar to ACA exchange plans; states set copays and deductibles	Weakens ACA mandates on coverage of "essential benefits" and preexisting conditions; relaxes network-adequacy standards; encourages higher deductibles
Role of private insurers	None	Large employers may opt to provide private insurance; MA continues with stricter regulations	Probably modestly reduced	Probably modestly reduced	Private MA plans expand at the expense of traditional Medicare
Payment structure	Global budgets for hospitals; physicians paid according to a fee-for-service system or receive a salary; negotiated drug prices	Similar to the current Medicare system with increased primary care fees; negotiated drug prices	Little change	Medicaid adopts Medicare payment rates	Accelerated shift from a fee-for-service system to value-based purchasing and ACOs
Funding mechanism	New taxes replace current out-of-pocket payments and premiums	New taxes; individual and employer premiums; out-of-pocket payments	Enrollee-paid premiums	Enrollee-paid premiums	Proposed cuts of $1.5 trillion to Medicaid and $818 billion to Medicare over 10 y
Effect on overall national health expenditures	Initially similar to the status quo but lower thereafter because of administrative and drug savings	Probably moderate to large increases	Small increases	Small increases	Uncertain
Other major provisions	Coverage of long-term care varies	Premiums capped at 9.69% of income	Some proposals increase ACA subsidies	Premiums capped at 9.5% of income	Lifts moratorium on new for-profit specialty hospitals; expands the scope of practice of nonphysician providers; relaxes standards for FMGs; overrides states' "any-willing-provider" and certificate-of-need regulations

ACA = Patient Protection and Affordable Care Act; ACO = accountable care organization; FMG = foreign medical graduate; MA = Medicare Advantage.

erable cost. As with other public-options reforms, it would retain multiple payers and therefore sacrifice much of the administrative savings available under single-payer plans. Physicians and hospitals would have to maintain the expensive bureaucracies needed to attribute costs and charges to individual patients, bill insurers, and collect copayments. Savings on insurers' overhead would also be less than those under single-payer plans. Overhead is only 2% in traditional Medicare (and 1.6% in Canada's single-payer program [7]) but averages 13.7% in MA plans (8) and would continue to do so under public-option proposals. Furthermore, as in the MA program, private insurers would inflate taxpayers' costs by upcoding as well as cherry-picking and enacting network restrictions that shunt unprofitable patients to the public-option plan. This strategy would turn the latter plan into a de facto high-risk pool.

THE TRUMP ADMINISTRATION WHITE PAPER AND BUDGET PROPOSAL

Unlike these proposals, reforms under the Trump administration have moved to shrink government's role in health care by relaxing ACA insurance regulations; green-lighting states' Medicaid cuts; redirecting U.S.

Department of Veterans Affairs funds to private care; and strengthening the hand of private MA plans by easing network-adequacy standards, upping Medicare's payments to these plans, and marketing to seniors on behalf of MA plans. A recent administration white paper (9) presents the administration's plan going forward: Spur the growth of high-deductible coverage, eliminate coverage mandates, open the border to foreign medical graduates, and override states' "any-willing-provider" regulations and certificate-of-need laws that constrain hospital expansion. The president's recently released budget proposal calls for cuts of $1.5 trillion in Medicaid funding and $818 billion in Medicare provider payments over the next 10 years.

Thus far, the effects of the president's actions—withdrawing coverage from some Medicaid enrollees and downgrading the comprehensiveness of some private insurance—have been modest. His plans would probably swell the ranks of uninsured persons and hollow out coverage for many who retain coverage, shifting costs from the government and employers to individual patients. The effect on overall national health expenditures is unclear: Cuts to Medicaid, Medicare, and the comprehensiveness of insurance might decrease expenditures; however, deregulating providers and insurers would probably increase them.

In 1971, a total of 5 years after the advent of Medicare and Medicaid, exploding costs and persistent problems with access and quality triggered a roiling debate over single-payer plans. As support for Kennedy's plan grew, moderate Republicans offered a public-option alternative, 1 of several proposals promising broadened coverage on terms friendlier to private insurers. Kennedy derided these proposals by stating, "It calms down the flame, but it really doesn't meet the need" (10). President Nixon's pro market HMO strategy—a close analogue of the modern-day accountable care strategy—ultimately won out, although his proposals for coverage mandates, insurance exchanges, and premium subsidies for low-income persons did not reach fruition until passage of the ACA.

Five years into the ACA era, there is consensus that the health care status quo spawned by Nixon's vision is unsustainable. President Trump would veer further down the market path. Public-option supporters hope to expand coverage while avoiding insurers' wrath. Medicare-for-All proponents aspire to decouple care from commerce.

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Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M19-0780.

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CQ ROLL CALL

March 26, 2019

How 'Medicare for All' went from pipe dream to mainstream

Universal health care debates could shape the 2020 election — and the future of the Democratic Party.

By Mary Ellen McIntire

Political candidates and activists in Maine, especially in rural areas, often got a sharp reaction five years ago when they knocked on doors to promote universal health care.

"The reaction was, 'Oh, you're a commie,'" said Phil Bailey, who back then advocated for various Democratic causes.

Now, voters in those same conservative areas have a different take.

"Of course" is a common response to calls for universal coverage, said Bailey, now executive director of Maine AllCare, part of a national coalition campaigning for single-payer health care. The organization saw enough growing momentum and received enough financial support to justify hiring Bailey and another full-time staffer last summer for the previously volunteer-led group.

What was once seen as a long-shot pitch from Vermont independent Sen. Bernie Sanders during his 2016 presidential campaign is now a proposal that at least four of his Senate colleagues also vying for the party's 2020 nomination supported during the last Congress. The issue is driving the national political health care debate.

But to succeed in enacting a single-payer system such as the "Medicare for All" plan that Sanders backs, liberals would need an unprecedented grassroots movement propelling the effort forward and would have to work out complicated policy details affecting nearly one-fifth of the nation's economy.

Democrats are already contending with industry groups hoping to shift the focus back to strengthening the current system. Most drug companies, hospitals and insurers oppose Medicare for All, which undoubtedly complicates progressives' efforts. The party's left wing is pushing a bold, pricey plan carrying political risks that make Democratic leaders shudder. Despite all the inevitable political hurdles, getting a single-payer law enacted may look easy compared to implementing it.

The most ardent advocates for a government-run, single-payer system are not content with incremental steps. They are seeking a wholesale reorganization of the nation's health care system.

The proposed two-year transition may be too fast for the entire industry to adapt to in an overhaul that experts warn would displace workers and jolt the economy.

"It is going to be a big administrative and logistical challenge. When you're talking about moving everyone in the country into a new health insurance program, that is not a small feat," said Linda Blumberg, an institute fellow at the Health Policy Center at the left-leaning Urban Institute.

Upending the industry

A single-payer health care plan would significantly change every sector of the health care industry. Hospitals and doctors would need to adjust to a new payment system, the insurance industry would shrink to a fraction of its size, and the government would bring drug companies to the negotiating table to determine prices.

The 2010 health care law left in place most of the existing health care infrastructure in the U.S. Still, experts warn that the lessons from that more incremental transition show how dramatic it would be to shift to a single-payer system.

Supporters aren't intimidated by the seismic nature of the change. The hope is not just to ensure that everyone has coverage, but also to take on health care companies seeking to maximize their profits, said Adam Green, a co-founder of the Progressive Change Campaign Committee, a political action committee that supports liberal candidates.

"Medicare for All boils down to two things," Green said. "One is universal coverage. The other is corporate accountability."

Setting up a single-payer system would most likely require creating a new government program to serve as the payer and oversee the system. A House bill by the co-leader of the Progressive Caucus, Pramila Jayapal, would also establish a national health care budget to cap costs.

The Washington Democrat's bill, like Sanders' plan, doesn't envision a large role for supplemental insurance.

It would be permitted, but aides say it would likely be unnecessary and used only to cover medically unnecessary treatments, such as cosmetic surgery. Unraveling the current insurance system is a Gordian knot-style task all its own.

Even public entitlement programs are often administered through private plans, with 68 percent of people in Medicaid and 34 percent of those in Medicare using comprehensive managed care plans.

Granddaddy of 2020 issues

The role of private insurance in a single-payer system has already

emerged in the fledgling Democratic presidential primary race.

California Sen. Kamala Harris sparked the debate over the survival of private insurance earlier this year, saying she favors a single-payer system that would eliminate it. Harris has also backed other proposals, but called the single-payer plan her top choice.

Minnesota Sen. Amy Klobuchar said such a move is not feasible and supports a bill by Hawaii Democratic Sen. Brian Schatz to let people buy into Medicaid. Similarly, former Texas Rep. Beto O'Rourke, who previously supported a single-payer system, now says another path to universal coverage may be more efficient.

The single-payer bills introduced so far would not be based on the current Medicare program, but instead would greatly expand the program's benefits.

Jayapal and Sanders both say the national health program would cover all medically necessary treatments. Those could be determined by a doctor or a newly formed national health program, said Jodi Liu, a RAND Corp. associate policy researcher.

Adam Gaffney, president of Physicians for a National Health Program, which supports a move to single payer, said those decisions could resemble the way Medicare determines what care is medically necessary. He supports a national list of covered drugs.

Advocates for a single-payer system say that enrolling people in the program may be the easiest part. After all, decades ago, the government signed up seniors in the newly created Medicare program the year after it was enacted. Unenrolled patients could be signed up at a doctor's office or hospital when they receive treatment, said Gaffney.

"Once you say you're going to enroll everyone, it actually takes a lot of the administration out of it," Gaffney said.

Compensation questions

One major challenge under a single-payer system would be how to pay medical providers. Advocates propose different types of plans, such as paying all providers at the same rate, possibly based on current Medicare rates, or global budgeting, through which institutions would regularly receive a lump sum of money as reimbursement for treatments.

Payment changes could benefit some doctors, such as those who currently treat many Medicaid enrollees and receive lower rates than Medicare. But providers who see mostly patients covered by commercial insurance could see payments fall.

The same goes for access to providers, said Liu. Since not all providers accept Medicaid, many patients would likely have an easier time finding doctors.

The government would face significant pressure to ensure that providers were compensated at the "right" rate, said Blumberg. Controlling health costs would be one goal, but the government would not want to skimp on quality or access to a sufficient number of providers.

In making decisions that affect the entire health care system, selecting the wrong payment rate could have serious ramifications, said Blumberg. "That process in and of itself is going to require a huge amount of attention and analysis and monitoring."

Under the Jayapal bill, hospitals and the government would negotiate a budget based on factors like the historic volume of services over three years, a hospital's normal expenditures and standard payment rates.

Hospitals would also get funding to cover their uncompensated care costs under an all-payer system.

Global lump-sum budgeting, which would give institutional providers an amount of money for health care services over a set amount of time, could contain costs, which advocates call a key benefit.

"If there was a national global budget, that's certainly a direct lever to address how much spending there is on health care, but of course, there's a lot of political issues that would come up," such as budgetary pressures, Liu said.

While hospitals and other institutions would be paid quarterly through a capped budget under Jayapal's proposal, individual doctors would be paid through a fee-for-service system for every procedure. The Health and Human Services secretary would have one year to set those providers' fees. Hospitals are already sounding the alarm about receiving lower payments under Democratic proposals.

Whether Jayapal's two-year transition is feasible is another question. A Jayapal aide said a fast transition provides less time for the industry to push back.

Still, Blumberg suggests a 10-year transition is more feasible. "The change for a lot of providers could be very substantial, and doing that in a very short period of time may have implications for disrupting the operation, the ability for these providers to continue to operate and the access for the patients," she said.

Although the challenges are great, Medicare for All advocates note that other large developed countries ensure all citizens can access health care.

"Across industrialized countries, the hallmark of the health care system is universal coverage," said Robin Osborn, a Commonwealth Fund vice president and director of international health policy and practice innovations.

Where's the funding?

For all the questions around a single-payer system, the biggest question may be how to pay for it. Neither Jayapal or Sanders included a financing plan in their bills, although Sanders released a list of possible ways to pay for his.

The price tag for Sanders' vision would be roughly $32 trillion over 10 years, according to two outside analyses of proposals Sanders put forward in 2016 and 2017, the first from the Urban Institute and the latter from the libertarian Mercatus Center.

That's an eye-popping balance, although Sanders emphasizes findings that the U.S. would actually save money on health care spending over a decade. Single-payer advocates argue that the U.S. health care system is already the most expensive in the world and would be more efficient under a new program.

"When you think about the fact that people are already paying, you have to recognize that this is just a scare tactic, primarily from

the right, saying you're going to end up paying much more," Jayapal said.

Still, asking taxpayers to pay the whole bill causes even some Democrats to balk.

Speaker Nancy Pelosi of California said in a recent *Rolling Stone* interview that a single-payer system may be easier administratively than other ways to reach universal coverage, but questioned how to pay for it.

Pelosi insists that Democrats should build on the 2010 health care law, which she helped shepherd through Congress a decade ago. Expanding the current Medicare program would not be as beneficial to Americans as that law, she argues.

"All I want is the goal of every American having access to health care," she told the magazine. "You don't get there by dismantling the Affordable Care Act."

Critics will likely highlight the lack of a financing plan — and the expected high tax increase — that would come with implementing a system that covers essentially all medical expenses.

Sanders' financing options include ending tax breaks that would become obsolete under a single-payer plan, adding a 4 percent income-based premium paid by households, imposing a wealth tax or a more progressive personal income tax, or leveraging fees on corporations, such as a one-time tax on offshore profits.

Other possibilities include sunsetting parts of the Republican 2017 tax overhaul or creating a tax on employers, which could mean that employers would not see much savings from not providing coverage to workers.

High-income earners are particularly at risk, said Larry Levitt, senior vice president for health reform at the Kaiser Family Foundation. "Depending on how it's financed, high-income people could end up paying much more in taxes than they now pay for health care," he said.

Because a transition to a single-payer plan would effectively eliminate most of the insurance industry, possibly 1 million to 2 million people who work in that industry would be displaced, according to Jayapal. Both Jayapal and Sanders proposed assistance for those workers with new job training, education or other programs.

Jayapal's bill introduction in February led health insurance stocks to slip, although analysts did not express much concern. Spencer Perlman, director of health care research at Veda Partners, wrote to clients that he did not believe the bill to be a risk to managed care.

"The only conceivable analogues for the approach envisioned by House Progressives are the Medicare Act of 1965 and the ACA, each of which were generational policies that nevertheless largely left intact the commercial insurance paradigm and private control of health care services," he wrote. That could be partially because a Medicare for All debate would draw in essentially every sector of the economy.

"It's hard to imagine a bigger and more all-encompassing debate than over Medicare for All," Levitt said. "Health care is such a big part of the economy, and you would just have every business and health care group weighing in."

Political calculus

Some Democrats doubt that a Democratic president and Congress would implement a single-payer system.

Bob Kocher, a partner at Venrock and former senior Obama administration health care official, said actions in office typically don't match the aspirations candidates invoke while campaigning.

"When you try to do it, the details matter and are hard and are often less disruptive and ambitious than what your poetry was," he said.

Liberals insist that a single-payer system is the only path forward. "This is not a messaging event. We are going to get health care for every American," Rep. Debbie Dingell, a Michigan Democrat, said at an event for the House bill.

If lawmakers were going to march toward a single-payer system, a massive shift in public opinion over a relatively short period of time would be needed.

Recent polls show that support for Medicare for All falls when people learn it would eliminate private insurance companies or raise taxes.

Whether Democrats decide to take up a single-payer plan would depend on how much a president campaigned on it, said Green.

A political boost could come if Medicare for All brought down "an old timer" who doesn't support the policy, such as Ways and Means Chairman Richard E. Neal of Massachusetts, Green suggested.

"Now what we're experiencing is there's a lot of candidates who campaigned and won on Medicare for All, including flipping red seats blue, but ironically, there's others who didn't campaign on Medicare for All, got attacked anyway and won, but were kind of spooked from the whole experience," Green said.

Still, Green added that if a "true progressive" wins the White House, he expects Medicare for All to be a priority.

Advocates hope that Medicare for All hearings in the coming months in the Rules and Budget committees will help the public understand the plan. Those hearings could also be a chance for single-payer opponents to raise concerns.

"Democrats are once again proposing fiscally irresponsible policies that will radically alter how hundreds of millions get their health care," Rep. Steve Womack of Arkansas, the Budget Committee ranking Republican, said when Jayapal's bill was released.

Mark Peterson, a political science professor at the University of California at Los Angeles, said historically, Americans have consistently said the health care system needs improvements, but they're also afraid of what they don't know.

"To the extent that what progressives are doing will stimulate that kind of action at the public level to really create that wave, a groundswell of support the way Social Security had, that can make an enormous political difference," he said.

JGIM Journal of General Internal Medicine

May 8, 2019

The Incidence of Diabetic Ketoacidosis During "Emerging Adulthood" in the USA and Canada: a Population-Based Study

By Adam Gaffney, M.D., M.P.H.; Andrea Christopher, M.D., M.P.H.; Alan Katz, M.B.Ch.B., M.Sc.; Dan Chateau, Ph.D.; Chelsey McDougall, M.Sc.; David Bor, M.D.; David Himmelstein, M.D.; Steffie Woolhandler, M.D., M.P.H.; and Danny McCormick, M.D., M.P.H.

Abstract

Background: As children with diabetes transition to adulthood, they may be especially vulnerable to diabetic ketoacidosis (DKA). Cross-national comparisons may inform efforts to avoid this complication.

Objective: To compare DKA hospitalization rates in the US and Manitoba, Canada, during the vulnerable years known as "emerging adulthood."

Design: Cross-sectional study using inpatient administrative databases in the US (years 1998-2014) and Manitoba, Canada (years 2003-2013).

Participants: Individuals age 12-30 years hospitalized with DKA, identified using ICD-9 (US) or ICD-10 codes (Manitoba).

Main Measures: DKA hospitalization rates per 10,000 population by age (with a focus on those aged 15-17 vs. 19-21). Admissions were characterized by gender, socioeconomic status, year of hospitalization, and mortality during hospitalization.

Key Results: The DKA rate was slightly higher in the US among those aged 15-17: 4.8 hospitalizations/10,000 population vs. 3.7/10,000 in Manitoba. Among those aged 19-21, the DKA hospitalization rate rose 90% in the US to 9.2/10,000, vs. 23% in Manitoba, to 4.5/10,000. In both the US and Manitoba, rates were higher among those from poorer areas, and among adolescent girls compared to adolescent boys. DKA admissions rose gradually during the period under study in the US, but not in Manitoba.

Conclusions: In years of "emerging adulthood," the Canadian healthcare system appears to perform better than the US in preventing hospitalizations for DKA. Although many factors likely contribute to this difference, universal and seamless coverage over the lifespan in Canada may contribute.

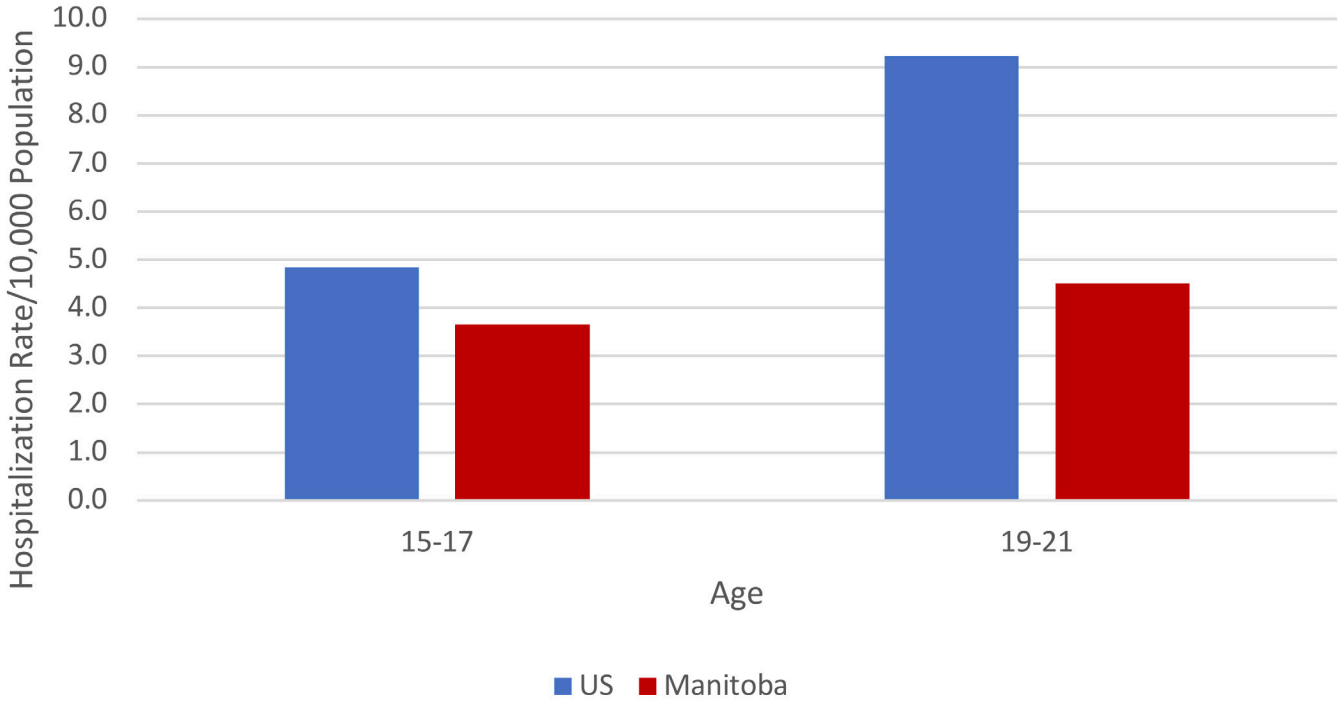

Figure 2: DKA hospitalization rates: age 15-17 and 19-21

PNHP Chapter Reports

In **CALIFORNIA**, PNHP members published op-eds in outlets across the state, including the *San Jose Mercury News*, *Orange County Register*, *Chico Enterprise-Record*, *Times of San Diego*, *Eureka Times-Standard*, and the *San Francisco Chronicle*. Dr. Paul Song spoke about Medicare for All with the SNaHP chapters at USC and UCLA medical schools, and gave a keynote address to the Hemophilia Foundation of America meeting in San Diego. In April, the Capitol Chapter organized a northern California speaking tour with Dr. Ed Weisbart, which included nine presentations and several appearances on local media. PNHP Napa County members met with their state assemblywoman, their state senator, and U.S. Rep. Mike Thompson to advocate for single payer. They also participated in a canvassing event in San Francisco to encourage House Speaker Nancy Pelosi to support Medicare for All and sponsored a community forum called "Single Payer/Medicare for All: What it Means for your Family, your Doctor, and your Community" on May 8, featuring former PNHP President Dr. Ana Malinow. Members of the UCSF SNaHP Chapter and Bay Area PNHP hosted canvassing and phone banking events in support of H.R. 1384, resulting in hundreds of phone calls to Speaker Pelosi's office. SNaHP students have been working with UCSF's administration to include single-payer education in the medical school curriculum. As a result, an op-ed written by SNaHP students and published in the *San Francisco-Marin Medical Society Journal* (see page 26) was included in course readings for all first-year medical students. To get involved in California, contact Dr. Paul Song at **paulysong@gmail.com**.

Members of PNHP's Bay Area chapter urge House Speaker Nancy Pelosi to support improved Medicare for All on June 1.

In early 2019, PNHP-**COLORADO** activists gave single-payer talks to several audiences, including Arvadans for Progressive Action, Denver Democratic Socialists of America (DSA), and medical students. Chapter leaders are building coalitions with other state-based health justice groups to advocate for Medicare for All at both the state and national levels. The University of Colorado SNaHP chapter submitted a proposal to host the SNaHP Summit in 2020, with assistance from PNHP-CO leaders. To get involved in PNHP-CO, contact Dr. Rick Bieser at **rgbieser@gmail.com**.

In **HAWAII**, more than 50 medical students, doctors, patients, and advocates attended a Medicare for All rally in Honolulu on Jan. 26. Speakers included Hawaii SNaHP chapter founder Arcelita Imasa, Hawaii chapter leader Dr. Leslie Gise, and PNHP board member Dr. Steve Kemble. The event was covered by the local newspaper and TV news stations. To get involved in Hawaii, contact Dr. Kemble at **stephenbkemble@gmail.com**.

Hawaii SNaHP members lead a Medicare for All rally in Honolulu on Jan. 26.

PNHP **ILLINOIS** members sponsored 21 students from five Illinois medical schools to attend the SNaHP Summit in New York. On March 2, PNHP board member Dr. Susan Rogers spoke about single payer at Amnesty International's meeting in Chicago. PNHP Illinois and Chicago Physicians for Social Responsibility hosted the ninth annual Soul of Medicine Dinner on March 8, honoring Dr. Rogers, who encouraged the next generation of physician leaders. That same weekend in southern Illinois, Dr. Pam Gronemeyer organized a Medicare for All town hall meeting at the Edwardsville Library. The Illinois Single Payer Coalition hosted an April 13 forum to discuss how H.R. 1384 would support health equity. PNHP National Coordinator Dr. Claudia Fegan spoke at a health care forum hosted by the Service Employees International Union. Dr. John Perryman spoke about single payer to several audiences, including the Elgin Medicare for All barnstorm, Wayne County Democrats, Sauk Valley Action for a Better Tomorrow, Winnebago County Democrats, Northern Illinois DSA, and the American Association of University Women. Drs. Susan Rogers and Phil Verhoef hosted a table at the 2019 Latino Medical

Student Association's Midwest Conference, where they signed up interested students. PNHP Illinois members also earned news coverage, including Dr. Gronemeyer's commentary in the *Illinois Business Journal* and Dr. Perryman's interview on Northern Public Radio and op-ed in the *Daily Herald*. In January, Midwestern University's SNaHP chapter hosted a lunch talk, "Professionalism within a Medicare for All Initiative." The University of Illinois-Chicago SNaHP chapter hosted a talk on the history of health care by Dr. Peter Orris, and the chapter led a workshop on passing single-payer resolutions in medical societies. To get involved in PNHP Illinois, contact Dr. Anne Scheetz at **anneschеetz@gmail.com**.

In 2019, **INDIANA**'s PNHP chapter changed its name from Hoosiers for a Commonsense Health Plan to Medicare for All Indiana. The state recently welcomed new chapters in Lafayette and Northwest Indiana, along with a revitalized chapter in Indianapolis, and SNaHP chapters in Bloomington and Indianapolis. PNHP members are working with partners such as DSA, Our Revolution, and Indivisible to roll back the state's Medicaid work requirement. They have also partnered with Faith in Healthcare to advocate for lower prescription drug prices, including an action at the gates of Indianapolis-based Eli Lilly. The SNaHP chapter at the Indiana University School of Medicine held an "Opioid Overdose Prevention, Recognition, and Response Training" with the Indiana Recovery Alliance, which included instruction on how to recognize an opioid overdose and administer naloxone safely. The chapter hosts a monthly "Policy and Pints" event at a local brewery to discuss health policy topics and chapter goals. To get involved in Indiana, contact Dr. Rob Stone at **medicareforallindiana@gmail.com**.

The University of Indiana School of Medicine SNaHP Chapter hosts a training on opioid overdose prevention and response on March 30.

In **KENTUCKY**, Kentuckians for Single Payer Health Care participated in a community celebration of Martin Luther King on Jan. 17. The following week, the University of Louisville SNaHP chapter hosted a panel discussion on single-payer health care, which included Dr. Wayne Tuckson, a colorectal surgeon and president of the Greater Louisville Medical Society; radiologist Dr. Karen Berg; Dr. Barbara Casper, internist and professor of medicine; family physician Dr. Charles Kodnar; and state Sen. Morgan McGarvey. In February, KSPH leaders, along with PNHP co-founder Dr. Steffie Woolhandler, met with House Budget Chair Rep. John Yarmuth to discuss Medicare for All hearings in his committee. Students at the University of Kentucky College of Medicine hosted a panel discussion about single payer that included state Sen. Reggie Thomas, Dr. Ewell Scott, and Dr. Glen Mays, who is a professor of health policy and administration. In April, Dr. Garrett Adams published an op-ed in the *Louisville Courier Journal*, where KSPH treasurer Charles Casper also published a letter to the editor. To get involved in Kentucky, contact Kay Tillow, R.N. at **nursenpo@aol.com**.

MAINE AllCare organized health care legislative forums in nine towns across the state, as well as several house parties, attracting both voters and legislators. Chapter leaders hosted a half-dozen screenings of *Fix It: Health Care at the Tipping Point*, followed by discussion forums. To get involved in Maine, contact Dr. Julie Pease at **jkpeasemd@gmail.com**.

In **MARYLAND**, 16 PNHP members braved freezing temperatures to join the Health Care is a Human Right Maryland contingent at the Martin Luther King Day parade in Baltimore. On January 10, activists visited U.S. Rep. Dutch Ruppersberger in Washington, D.C., to deliver 600 petition signatures urging him to support the Medicare for All Act. Maryland U.S. Reps. John Sarbanes and Jamie Raskin agreed to sponsor the bill after meeting with health care activists. Chapter leaders in Baltimore and Howard County organized barnstorming events in collaboration with NNU, Our Revolution, and DSA, followed by door-to-door canvassing throughout Maryland. Chapter leaders hosted two public showings of the movie *The Power to Heal*. To get involved in PNHP Maryland, contact Dr. Eric Naumburg at **HCHRMaryland@gmail.com**.

A delegation of PNHP Maryland members meet with Rep. Jamie Raskin to urge his support for Medicare for All.

Members of Health Care is a Human Right Maryland march in the MLK Parade in Baltimore.

In **MASSACHUSETTS**, PNHP's Boston chapter hosted a public forum on April 10 at Harvard Medical School called "Winning Improved Medicare for All: H.R. 1384 and the Battle Ahead," featuring former editor-in-chief of the *New England Journal of Medicine* Dr. Marcia Angell, PNHP President Dr. Adam Gaffney, and PNHP co-founder Dr. Steffie Woolhandler. Boston University's SNaHP chapter hosted a campus speaker series for the medical school community, including health policy professor Louise Parker, *New York Times* columnist Austin Frakt, and pharmaceutical expert Dr. Jing Luo. Each month the chapter hosts "SNaHP Chat,"a health policy book club. In January, chapter members participated in a single-payer lobby day at the Massachusetts State House, and in February organized a Week of Action featuring a talk by Dr. Gordie Schiff, a screening of the film *The Power to Heal*, and an afternoon of phone banking. The Tufts SNaHP chapter hosted an information session with PNHP President Dr. Adam Gaffney in February. Students have been meeting with sponsors of the Massachusetts state single-payer bill, and have voiced their support at the Medicare For All Caucus meetings at the state house. On campus, SNaHP members launched a campaign demanding that Tufts cut ties with the Sackler family, who profited from the illegal marketing of opioids and after whom the main medical school building is named. The campaign resulted in more than 200 medical student signatures, meetings with school administrators, and much local press coverage. To get involved in Massachusetts, contact Dr. Alan Meyers at **pnhp-ma@pnhp.org**.


Tufts SNaHP members meet with Rep. Lindsay Sabadosa (center) to discuss her state single-payer bill on Feb. 5.

PNHP **MICHIGAN** members have been working with NNU, DSA, and other single-payer allies on phone banking, postcard writing, and barnstorming events this spring. Dr. Susan Steigerwalt represented PNHP at a meeting of the Islamic Physicians Association. To get involved in Michigan, contact Dr. Steigerwalt at **spspnhp52@gmail.com**.

On Jan. 27, PNHP's **MISSOURI** chapter hosted a St. Louis screening of *Big Pharma: Market Failure*, followed by a discussion on single payer and pharmaceutical reform. At the end of March, PNHP-MO organized a lively public debate between single-payer advocates Drs. Ed Weisbart and Gillian Schivone, and Prof. Ken Schechtman and Dr. Dominic Reeds, who advocate for incremental reforms. The debate was moderated by Missouri state Rep. Cora Faith Walker. The Kansas City Metro Chapter, which was formed in October of 2018, has been busy organizing educational events and developing a speakers bureau. On Jan. 15, the chapter hosted a screening of *Fix It: Health Care at the Tipping Point* followed by a discussion. The University of Missouri-Columbia SNaHP chapter held its first event in January, followed by a screening of *Fix I*t in March. To get involved in Missouri, contact Dr. Weisbart at **pnhpMO@gmail.com**.

NEW JERSEY PNHP is an active member of the statewide New Jersey Universal Healthcare Coalition (NJUHC), which includes civic, labor, religious, and political organizations united for improved Medicare for All. In 2019, NJUHC met with several newly elected Democratic members of Congress to win their support for single payer. The coalition has partnered with NNU to participate in canvassing, phone banking, and legislative events. To get involved in New Jersey, contact Dr. Bill Thar at **wethar@gmail.com**.

This February in **NEW YORK**, PNHP NY Metro held a forum on "Addressing the Opioid Epidemic in a Profit-Driven Health Care System," which featured addiction expert Dr. Bruce Trigg along with NYU SNaHP leaders Ashley Lewis and Paul Frazel, who are also co-coordinators of the NYU student campaign against the Sackler family. In March, the chapter's forum explored the role of midwifery in women's reproductive health and the struggle to include it in comprehensive women's health care programs, including the New York Health Act. This spring, the chapter hosted a speaker training and a letters-to-the-editor training. On April 2, more than 70 health professionals and students met in Albany for New York Health Act Lobby Day. The group held a press conference and met with 20 lawmakers.

SNaHP and PNHP leaders participate in the "Health Justice at Upstate" conference on Jan. 21 in Syracuse.

Members of Health Care Justice North Carolina meet with U.S. Rep. Alma Adams (center, in hat) on Feb. 11.

The SUNY Upstate Medical University chapters of PNHP and SNaHP participated in several events this past winter and early spring. On Martin Luther King Day, SNaHP students co-hosted the second annual "Health Justice at Upstate" conference with Upstate's Student National Medical Association chapter, and Dr. Sunny Aslam gave a talk on "Achieving Universal Coverage with NY Health." In February, SNaHP conducted outreach at the Black Healing Expo, dedicated to improving maternal and child health outcomes for low-income patients and communities of color. Dr. Aslam and SNaHP students published an op-ed in April in the *Syracuse Post Standard*. Upstate SNaHP students testified in support of the New York Health Act at a meeting with state legislators hosted by the Onondaga County Medical Society. The Columbia University SNaHP chapter hosted 180 health professional students at the national SNaHP Summit on March 2, followed by a march and rally at Pfizer Pharmaceuticals' Manhattan headquarters. To get involved in New York, contact Executive Director Bob Lederer at **bob@pnhpnymetro.org**.

More than 70 health professionals rally at the state capitol for the New York Health Act on April 2.

Health Care Justice **NORTH CAROLINA** (HCJ-NC) in Charlotte welcomed new undergraduate SNaHP affiliates at UNC-Charlotte and Queens University. Both groups hosted screenings of *Fix It: Health Care at the Tipping Point* followed by physician panels. HCJ-NC co-hosted a showing of the documentary *The Power to Heal* with area churches. The Cornwell Center satellite group hosted a showing of *Fix It* to 60 local faith leaders. In February, a group of HCJ-NC members met with U.S. Rep. Alma Adams to encourage her support for single payer; she is now a co-sponsor of H.R. 1384. The chapter hosted former insurance executive (now single-payer advocate) Wendell Potter on April 12 for a full day of meetings with students, physicians, and business and political leaders, followed by a public forum. To get involved in the Health Care Justice Charlotte chapter, contact Dr. George Bohmfalk at **HCJusticeNC@gmail.com**.

The NC Cornwell Chapter convenes a Faith and Community Leaders Luncheon featuring a screening of "Fix It" and a panel of medical professionals on Feb. 27.

Health Care for All **WESTERN NORTH CAROLINA** helped organize a regional strategic planning meeting in Charlotte with all PNHP chapters and health justice organizations in North and South Carolina. Chapter leaders represented PNHP at the Buncombe County NAACP meeting as well as the MLK Association's Prayer Breakfast and Peace March in

Asheville. Throughout early 2019, the chapter hosted several screenings of *The Power to Heal* and *Big Pharma: Market Failure*, followed by panel discussions. On April 10, Wendell Potter spoke at two events. To get involved in Health Care for All NC, contact Mery Krause at **hcfawnc@gmail.com**.

In **OHIO**, the members of PNHP's Cincinnati chapter spoke about Medicare for All at several church groups, Democratic clubs, and community centers in early 2019. Chapter leaders met with the editorial board of the *Cincinnati Enquirer*, resulting in the paper's commitment to better coverage of Medicare for All. PNHP members have published letters and op-eds in most of the state's major daily newspapers, including the *Enquirer*, the *Toledo Blade*, the *Columbus Dispatch*, and the *Cleveland Plain Dealer*. The Cincinnati PNHP chapter remains active with SPAN, the state single-payer organization. The SNaHP chapter at the Case Western University School of Medicine hosted a webinar with UAEM and AMSA entitled, "Race, Justice, Poverty and Access to Medicines" in April. To get involved in Ohio, contact Dr. Jim Binder at **jamesbinder3@gmail.com**.

In **OREGON**, PNHP welcomed a new SNaHP chapter at Western University of Health Sciences College of Osteopathic Medicine of the Pacific-Northwest. The chapter's first goal is to integrate more health equity and single-payer policy into the official curriculum. In 2019, chapter leaders hosted events and speakers promoting Medicare for All on campus. To get involved in Oregon SNaHP, contact Luke Smith at **luke.smith@westernu.edu**.

PNHP Pennsylvania leaders host a screening and discussion of "Off the Table" on March 18 at the Westmoreland County Central Labor Council.

In **PENNSYLVANIA**, PNHP's Pittsburgh chapter worked with local union groups to co-host screenings of the short film *Off the Table*, which shows how Medicare for All could benefit union members, followed by panel discussions. Drs. Tony Fiorillo, Judy Albert, and Claire Cohen represented PNHP at the Pittsburgh Racial Justice Summit on January 26. The chapter also held two speaker training events in February. To get involved in Pennsylvania, contact Dr. Albert at **jalbertpgh@gmail.com**.

In **TENNESSEE**, PNHP's Chattanooga chapter participated in NNU's Medicare for All Barnstorm on February 9. The chapter is planning several canvassing and educational events for the spring and summer. To get involved in Tennessee, contact Dr. Laura Helfman at **riverdoc@outlook.com**.

The PNHP **WISCONSIN** Madison chapter participated in several public events this spring, including door-to-door canvassing with other single-payer advocacy groups. Dr. Joseph Eichenseher participated in a public debate about single payer at the Benjamin Rush Institute in Milwaukee. Dr. Eichenseher also gave a Medicare for All presentation at Midvale Lutheran Church in Madison. The new SNaHP chapter at the Medical College of Wisconsin-Milwaukee hosted a lunch talk by fourth-year medical student Enio Perez on the impact of the Trump Administration on the health of people of color. Students also organized a Safety Net Health Care Week in coalition with the Milwaukee Free & Community Clinic Collaborative, followed by a viewing of the documentary *The Waiting Room*. To get involved in Wisconsin, contact **wisconsin.pnhp@gmail.com**.

PNHP members discuss single-payer legislation with Rep. Pramila Jayapal (center) in her Seattle office.

In **WASHINGTON**, PNHP and SNaHP leaders met with Rep. Pramila Jayapal in early 2019 to discuss a single-payer agenda in Congress. The group subsequently met with Rep. Jayapal's district director; the meeting was live-streamed to SNaHP members across the U.S. The SNaHP Chapter at the University of Washington has maintained active medical school and undergraduate branches, and represented PNHP at several public events and health justice rallies in Seattle. In February, they hosted a discussion with Dr. Edwin Lindo on the impact of single payer on intersections of health, race, class, and gender. Student leaders are also working with their medical school administration and faculty to gather signatures in support of Medicare for All. To get involved in Washington, contact Dr. David McLanahan at **pnhpww@gmail.com**.

by the numbers

Most profitable not-for-profit healthcare systems

Ranked by operating income, fiscal 2017

Rank	System	Headquarters	Operating income ($ in millions) 2017	2016
1	Kaiser Foundation Health Plan and Hospitals	Oakland, Calif.	$2,152.0	$1,924.0
2	Adventist Health System	Altamonte Springs, Fla.	732.8	666.2
3	Mayo Clinic Health System	Rochester, Minn.	707.0	475.0
4	Indiana University Health	Indianapolis	600.6	565.5
5	Ascension Health	St. Louis	552.7	997.4
6	UCHealth	Aurora, Colo.	494.2	465.2
7	New York-Presbyterian	New York	404.5	324.6
8	Intermountain Healthcare	Salt Lake City	359.0	237.5
9	University of Pennsylvania Health System	Philadelphia	355.7	419.1
10	BayCare Health System	Clearwater, Fla.	342.7	318.8
11	Aurora Health Care	Milwaukee	339.1	373.3
12	Cleveland Clinic Health System	Cleveland	330.6	165.0
13	Sutter Health	Sacramento, Calif.	326.0	370.0
14	Texas Health Resources	Arlington	319.5	339.1
15	Northwestern Memorial Healthcare	Chicago	301.2	239.4
16	NYU Langone Health	New York	298.1	291.0
17	Baylor Scott & White Health	Dallas	291.9	494.1
18	Piedmont Healthcare	Atlanta	285.8	123.0
19	Duke University Health System	Durham, N.C.	275.3	303.2
20	OhioHealth	Columbus	272.0	240.4

Source: Modern Healthcare's Health Systems Financials database

Information in this chart may be subsequently revised at the discretion of the editor.
For more information on our research, contact **Megan Caruso** at **312-649-5471** or **mcaruso@modernhealthcare.com**.
FOR MORE charts, lists, rankings and surveys, please visit modernhealthcare.com/data.

by the numbers

Healthcare employment diversity

Based on 2018 household data

OCCUPATION	TOTAL EMPLOYED	Percentage of total employed				
		WOMEN	CAUCASIAN/ WHITE	AFRICAN-AMERICAN/ BLACK	ASIAN	HISPANIC/ LATINO
Clinical laboratory technologists and technicians	318,000	75.2%	70.0%	18.6%	8.5%	12.9%
Diagnostic related technologists and technicians	346,000	67.9	79.5	11.8	5.6	14.7
Emergency medical technicians and paramedics	214,000	33.9	84.3	11.9	2.2	13.9
Licensed practical and licensed vocational nurses	658,000	87.8	62.0	30.4	5.1	11.5
Medical and health services managers	639,000	72.0	80.9	11.5	5.0	9.0
Medical assistants	570,000	90.6	74.1	15.3	4.5	28.6
Medical records and health information technicians	171,000	93.6	72.3	15.5	9.2	9.2
Medical scientists	169,000	52.1	68.8	9.5	20.7	8.6
Nurse practitioners	212,000	87.2	79.1	11.2	8.8	2.6
Nursing, psychiatric and home health aides	2,035,000	89.3	55.8	35.8	5.4	16.3
Occupational therapists	116,000	86.8	91.1	2.5	6.4	4.2
Pharmacists	348,000	63.4	67.9	7.2	23.1	4.4
Phlebotomists	115,000	75.0	72.7	16.9	7.6	19.6
Physical therapists	286,000	69.5	76.4	7.4	14.3	4.3
Physician assistants	132,000	72.1	90.3	2.9	5.1	8.2
Physicians and surgeons	1,094,000	40.3	70.8	7.6	19.8	7.4
Registered nurses	3,213,000	88.6	75.5	13.1	9.0	7.2
TOTAL EMPLOYED/ ALL INDUSTRIES*	**155,761,000**	**46.9**	**78.0**	**12.3**	**6.3**	**17.3**

Note: Estimates for race groups do not add up to totals because data are not presented for all races. Persons whose ethnicity is identified as Hispanic or Latino may be of any race.
*Total includes employed persons age 16 and older.

Source: U.S. Bureau of Labor Statistics

Information in this chart may be subsequently revised at the discretion of the editor.

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Modern Healthcare

Corporate board compensation among health system CEOs

An examination of health care CEOs sitting on boards found a wide range of payment rates.

Health system	President/CEO	Company board	Latest annual director compensation
Adventist Health (Calif.)	Scott Reiner	Premier	$191,750
Banner Health	Peter Fine	Premier	$221,000
Brigham Health	Dr. Elizabeth Nabel	Medtronic	$378,892
Carilion Clinic	Nancy Howell Agee	RGC Resources	$31,767
Catholic Health Initiatives	Kevin Lofton	Gilead Sciences	$415,803
Catholic Health lnitiatives	Kevin Lofton	Rite Aid	$230,089
Dignity Health	Lloyd Dean	McDonald's Corp.	$280,800
Geisinger	Dr. David Feinberg	Douglas Emmett	$149,644
Hackensack Meridian Health	John Lloyd	OceanFirst Financial Corp.	*Not available*
Jefferson Health	Dr. Stephen Klasko	Teleflex	$205,085
Johns Hopkins Medicine	Dr. Paul Rothman	Merck & Co.	$311,833
Kaiser Permanente	Bernard Tyson	Salesforce	$151,165
Kaleida Health	Jody Lomeo	Evans Bancorp	$21,596
Mayo Clinic	Dr. John Noseworthy	Merck & Co.	$234,167
Medstar Health	Kenneth Samet	Evolent Health	$177,500
Mission Health	Dr. Ronald Paulus	Vocera Communications	*Not available*
Northwell Health	Michael Dowling	BankUnited	$134,410
Northwestern Memorial HealthCare	Dean Harrison	Northern Trust	$239,964
RWJBarnabas Health	Barry Ostrowsky	Public Service Enterprise Group	$135,043
Scripps Health	Chris Van Gorder	Abiomed	$269,956
Sharp HealthCare	Michael Murphy	Jack In The Box	$263,852
Spectrum Health	Richard Breon	WellCare Health Plans	$293,955
SSM Health	Laura Kaiser	Nuance Communications	*Not available*
Tenet Healthcare	Ronald Rittenmeyer	American International Group	$299,978
Tenet Healthcare	Ronald Rittenmeyer	IQVIA Holdings	$334,947
Texas Health Resources	Barclay Berdan	Premier	$169,750
UCSF Health	Mark Laret	Nuance Communications	$327,476
University Hospitals-Ohio	Thomas Zenty	Endologix	$151,558
UNC Health Care System	Dr. William Roper	DaVita	$339,857
UNC Health Care System	Dr. William Roper	Express Scripts Holding Co.	$315,000
Woman's Hospital (La.)	Teri Fontenot	Amerisafe	$109,972
Yale New Haven Health	Marna Borgstrom	Cryolife	*Not available*

Sources: Modern Healthcare research; latest Securities and Exchange Commission filings

Why are the leaders of health industry "nonprofits" taking home millions of dollars by serving on pharmaceutical boards?

Robert Alpern, Dean of the Yale School of Medicine received...	$335,929 in compensation from, and has a $4,294,612 stake in...	abbvie
Nesli Basgoz, Associate Chief and Clinical Director of Massachusetts General Hospital's infectious disease division received...	$473,941 in compensation from, and has a $906,701 stake in...	
Michael Greenberg, Co-leader of Harvard Medical School and Boston Children's Hospital's Allen Discovery Center for Human Brain Evolution...	recently joined the board of...	Allergan
Peter McDonnell, Director of the Wilmer Eye Institute at the Johns Hopkins University School of Medicine received...	$449,941 in compensation from, and has a $735,307 stake in...	
Brian Druker, Director of the Knight Cancer Institute at the Oregon Health & Science University...	recently joined the board of...	AMGEN
Tyler Jacks, Director of MIT's David H. Koch Institute for Integrative Cancer Research received...	$343,998 in compensation from, and has a $1,147,713 stake in...	
Julia Haller, Ophthalmologist-in-Chief at Wills Eye Hospital received...	$525,470 in compensation from, and has a $86,487.50 stake in...	Celgene
Marschall Runge, Dean of the University of Michigan medical school received...	$279,000 in compensation from, and has a $1,065,330 stake in...	Lilly
Kevin Lofton, CEO of Catholic Health Initiatives received...	$415,803 in compensation from, and has a $1,808,066 stake in...	
Richard Whitley, Associate Director for Drug Discovery and Development for the University of Alabama, Birmingham's Comprehensive Cancer Center's pediatric oncology program received...	$430,803 in compensation from, and has a $709,469 stake in...	GILEAD
Laurie Glimcher, President and CEO of the Dana-Farber Cancer Institute received...	$101,000 (prorated) in compensation from, and has a $75,707 stake in...	
Jesse Goodman, Director of Georgetown University's Center on Medical Product Access, Safety and Stewardship received...	$428,000 in compensation from, and has a $130,799 stake in...	gsk
Mary Beckerle, CEO of the Huntsman Cancer Institute at the University of Utah received...	$324,893 in compensation from, and has a $672,418 stake in...	
Mark McClellan, Director of the Margolis Center for Health Policy at Duke University received...	$284,893 in compensation from, and has a $1,183,284 stake in...	Johnson & Johnson
A. Eugene Washington, President and CEO of the Duke University Health System and the university's chancellor for health affairs received...	$284,893 in compensation from, and has a $2,334,629 stake in...	
Thomas Cech, Director of University of Colorado, Boulder's BioFrontiers Institute received...	$318,465 in compensation from, and has a $2,300,277 stake in...	
John Noseworthy, CEO of the Mayo Clinic received...	$234,167 (prorated) in compensation from, and has a $293,680 stake in...	MERCK
Charles Sawyers, Chair of Memorial Sloan Kettering's Human Oncology and Pathogenesis Program received...	$367,000 in compensation from, and has a $690,131 stake in...	NOVARTIS
Dennis Ausiello, Director for Massachusetts General Hospital's Center for Assessment Technology and Continuous Health received...	$375,000 in compensation from, and has a $1,858,001 stake in...	Pfizer
Michael Brown, Director of the Erik Jonsson Center for Molecular Genetics at the University of Texas Southwestern Medical Center at Dallas received...	$1,321,211 in compensation from, and has a $4,366,483 stake in...	
Joseph Goldstein, Chairman of University of Texas Southwestern Medical Center at Dallas' molecular genetics department received...	$1,307,211 in compensation from, and has a $4,243,080 stake in...	REGENERON science to medicine®
Huda Zoghbi, Director of Texas Children's Hospital's Jan and Dan Duncan Neurological Research Institute received...	$463,656 in compensation from...	

PNHP

Source: BioPharma Dive, Nov. 27, 2018

pnhp.org/pharma