PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Newsletter

Winter 2015/2016

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

PNHP in the news

PNHPers had over 150 op-eds, letters, and articles on single payer published in 2015, a record high. PNHP President Dr. Robert Zarr was featured in the Houston Chronicle (p. 18) and on Houston public radio during a speaking tour, while PNHP co-founder Dr. Steffie Woolhandler appeared on Democracy Now to talk about the collapse of insurance co-ops under the Affordable Care Act. New research by PNHP members on Medicaid's positive impact on health (see Abstract, p. 27) was covered by Reuters, while Bloomberg Business and several other media outlets covered a study of cheating on Medicare's hospital readmissions measures (see study, p. 26). Sen. Bernie Sanders' response to the Wall Street Journal's attack on his single-payer health plan is reprinted on p. 11.

A feeder march joins the PNHP-led protest rally outside Blue Cross in Chicago, Oct. 30. Photo by Annette Gaudino.

Rally with USW kicks off Annual Meeting

Thomas Conway, international vice president of the United Steelworkers (USW), was a featured speaker at a protest rally at Blue Cross' Chicago headquarters on Oct. 30. The rally, which capped PNHP's daylong Leadership Training session, ended with a spontaneous march through downtown Chicago. Conway talked about the failure of the ACA to protect workers' health benefits, and the need to work together for improved Medicare for All. Over 360 physicians and medical students attended PNHP's Annual Meeting held the next day, making it one of the largest ever. New slides from Drs. David Himmelstein and Steffie Woolhandler are now available at www.pnhp.org/slideshows (password = zarr).

Family physicians, psychiatrists organize for single payer

Drs. Andrea DeSantis, Parker Duncan, Michael Kaplan and Alap Shah sponsored several single-payer events at the American Academy of Family Physicians meeting in Denver, including a talk by PNHP Board member Dr. Ed Weisbart, an evening reception, and a booth that recruited 28 new PNHP members. To join the AAFP single-payer member interest group and its monthly organizing calls, contact Dr. Parker Duncan at pduncs@gmail.com. Dr. Leslie Gise has organized a panel titled "The case for single payer post-ACA" for the 2016 American Psychiatric Association meeting in Atlanta in May. PNHPers Drs. Steve Sharfstein, Steve Kemble, and Wes Boyd will be speaking.

Student Summit set for March 5 in Nashville

Medical students and other health professional students are heading to Nashville, Tenn., for the fifth annual Students for a National Health Program (SNaHP) summit on March 5, 2016. With five medical schools in the area (Vanderbilt, Meharry, University of Tennessee, Quillen, and LMU), student organizers are expecting a large and diverse turnout.

In This Issue

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

PNHP Board of Directors, 2016

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Membership drive update

Welcome to 741 physicians and medical students who have joined PNHP in the past year, bringing our total membership to 20,224. We invite new (and longtime) PNHP members to participate in our activities and to take the lead on behalf of PNHP in their communities. Need help getting starting? Drop a note to PNHP National Organizer Emily Henkels at e.henkels@pnhp.org.

Film 'Fix It' makes the business case for single payer

Richard Master's documentary "Fix It" received a standing ovation at the PNHP Annual Meeting (fixithealthcare.org). The film shows his manufacturing firm's experience with rising health care costs and features numerous PNHP members and economists explaining how a single payer would reduce health care costs for business. PNHPers are encouraged to show the film especially to business and conservative audiences. A review of the film by consumer advocate Ralph Nader is reprinted on page 47. Drop a note to info@pnhp.org to obtain a copy of the DVD.

Medical students hold vigils for the uninsured

Hundreds of medical students from more than 30 institutions participated in rallies, marches, and candlelight vigils on Oct. 1 to mourn lives lost due to lack of health coverage and call for Improved Medicare for All. The national day of action, nicknamed "TenOne," was organized by the SNaHP, the student section of PNHP, and co-sponsored by several other groups including the Latino Medical Student Association and White Coats for Black Lives. The actions garnered media attention from dozens of local outlets and were featured on the front page of Medscape. See related articles, pages 33-36.

Medicare's 50th anniversary

PNHP members participated in over 40 Medicare anniversary celebrations in July. Many of the events were held in conjunction with National Nurses United (NNU) and received extensive media coverage. Sen. Bernie Sanders, NNU Executive Director RoseAnn DeMoro, PNHP President Dr. Robert Zarr, and others spoke out in support of single payer at a "Medicare turns 50" rally in Washington on July 30. The rally was covered by The Hill, the Washington Post, and the Los Angeles Times, among others.

PNHPers published at least 29 op-eds and 20 letters to the editor across the country celebrating Medicare's anniversary and calling for single payer (including in prominent outlets such as The New York Times), and 10 different PNHP spokespeople appeared on two dozen radio shows. Our social media efforts reached more than 275,000 Facebook and Twitter users over the course of just a few days.

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

UNINSURED AND UNDERINSURED

• 33.0 million Americans (10.4 percent) were uninsured during all of 2014, the first year the main coverage expansion provisions of the ACA were in effect, a drop of 8.8 million from 2013. Changes in survey methodology caused an additional artifactual drop of 5 million in 2013. The number of uninsured children fell by 1 million to 4.8 million (6.2 percent). States that expanded their Medicaid programs under the ACA have, on average, a lower proportion uninsured (9.8 percent) than states that did not implement the Medicaid expansion (13.5 percent). The poor continue to experience a high rate of uninsurance (19.3 percent), along with Hispanics (19.9 percent) and blacks (11.8 percent). Non-citizens are over three times more likely to be uninsured (31.2 percent) as citizens (8.7 percent). At the state level, Texas has the highest uninsurance rate (19.1 percent) followed by Florida (16.6 percent) ("Health Insurance Coverage in the United States: 2014," U.S. Bureau of the Census, September 2015).

• Medicaid expansion alone would not cover all of the uninsured. The 33.0 million uninsured Americans are almost evenly divided between states that have expanded their Medicaid programs and those that have not, according to the Kaiser Family Foundation (Altman, "Covering the uninsured: not just a red state issue," Wall Street Journal, 10/14/15).

• 28.5 million people (9.0 percent) were uninsured in the first six months of 2015, the second full year of ACA coverage expansions, a drop of 7.5 million from 2014, according to a preliminary analysis of data from the National Health Interview Survey (Martinez and Cohen, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-June 2015," National Center for Health Statistics).

• About 170,000 undocumented children will become eligible for Medicaid in California starting in May 2016, due to new legislation signed by the governor. Unfortunately, accessing care will still be challenging because of a shortage of providers accepting Medicaid due to low payment rates, and some parents may still delay seeking care for their children because they fear being billed or deported (Dickson, "California to expand coverage for undocumented immigrants," Modern Healthcare, 6/22/15).

1.8 million households, 40 percent of the 4.5 million households that received tax subsidies to purchase private health insurance in 2014, had not filed the tax forms required under the ACA by Oct. 1, according to the IRS. Unless these households follow through with their delayed filings, they will lose their subsidies in 2016. In most cases the households failed to file Form 8962, a new form to account for federal subsidies, or hadn't filed a 2014 tax return at all (Alonso-Zaldivar, "Tax filing problems could jeopardize health law aid for 1.8 million," New York Times, 8/7/15).

• Enrollment in individual private insurance plans purchased through the exchanges is expected to climb by only a net of about 900,000 people in 2016, for a total enrollment of 10 million, according to the Obama administration (Muchmore, "Obama administration lowers bar for 2016 open enrollment," Modern Healthcare, 10/19/15).

Over 423,000 immigrants lost health insurance in the first nine months of 2015 because of missing or incomplete paperwork related to their immigration status. This figure, which only accounts for people who lost coverage from the federal exchange, not the state exchanges, is up almost fourfold from all of last year, when 109,000 people lost coverage due to citizenship and immigration issues. A new 95-day time limit for resolving documentation questions contributed to the increase. The overwhelming majority of those losing coverage are legal immigrants, according to the National Immigration Law Center ("More than 400,000 immigrants losing health care after change in coverage procedure," Fox News Latino/AP, 9/13/15).

• A new study by the Department of Health and Human Services (HHS) found that 80 percent of the uninsured have less than $1,000 in savings, half have less than $100 in savings, and half report difficulty affording basic necessities such as food and housing in the past year. In addition, many have other financial priorities, such as car or home repairs, or paying down debt, which takes precedence over buying health insurance (Finegold et al., "Uninsured populations eligible to enroll for 2016," HHS, 10/15/15).

• The penalty for not having health insurance in 2016 is rising to $695 per adult, $347.50 per child, or 2.5 percent of household income, whichever is higher, up from $325 per adult, $162.50 per child, and 2 percent of income in 2015 (https://www.healthcare.gov/fees/fee-for-not-being-covered/).

Cancer patients with Medi-Cal (i.e. Medicaid) coverage or no health insurance were likely to be diagnosed at a later stage, receive lower quality of care, and have worse health outcomes than patients with private health insurance, according to a study of 743,000 cases of breast, colon, rectum, lung, and prostate cancer in California from 2004 to 2012. Breast cancer patients with Medi-Cal were more likely to be diagnosed at a late stage of disease (26.9 percent diagnosed at stages III or IV compared with 11.9 percent for the privately insured). Patients with Medi-Cal were less likely to be diagnosed with early stage lung cancer and, even if they were diagnosed at stage 0 or 1, had a lower five-year survival rate (64.8 percent for privately insured vs. 46.1 percent for patients with Medi-Cal) (Parikh-Patel et al., "Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance," Institute for Population Health Improvement, University of California, Davis, November 2015).

COSTS

• National health expenditures are projected to rise from $3.1 trillion in 2014 (17.4 percent of GDP) to $5.4 trillion (19.6 percent of GDP) in 2024, an average increase of 5.6 percent annually, according to projections by CMS (Keehan et al., "National Health Expenditure Projections, 2014–24: Spending Growth Faster than Recent Trends," Health Affairs, August 2015).

Average employer-based family health insurance premiums rose 4 percent in 2015, to $17,545. Workers paid an average of $4,955 towards the cost of family coverage. Average premiums for single coverage rose to $6,251, with workers paying $1,071. The average deductible in 2015 is $1,318 for single coverage and $2,758 for HMO family coverage. Over the past five years, deductibles have risen three times faster than premiums and about seven times faster than wages ("2015 Employer Health Benefits Survey," Kaiser Family Foundation/HRET, 9/22/15).

• Over half of adults (52 percent) who visited the marketplaces did not sign up for coverage, according to a survey of adults under age 65 in mid-2015. Among those who didn't enroll, 57 percent said they could not find an affordable plan and 43 percent said they were not eligible to enroll in Medicaid or financial assistance. Twenty-six percent had incomes below 100 percent of poverty but were not eligible for Medicaid in their states (Collins et al., "To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not," Commonwealth Fund, 9/25/2015).

• The cost of health plans sold on HealthCare.gov is rising faster than the cost of medical goods and services. Premiums are going up an average of 7.5 percent in 2016 for the benchmark plan in the 37 states using the HealthCare.gov marketplace, 5 percent faster than last year's Consumer Price Index for medical care services (up 2.4 percent). The benchmark plan is the second-lowest-cost silver plan in a state; premium subsidies are pegged to the cost of the benchmark plan ("2016 Affordability Snapshot," Centers for Medicare and Medicaid Services, 10/26/15).

• Federal employees' share of premiums in the Federal Employees Health Benefits Program (FEHBP) is rising by an average of 6.4 percent for individual coverage and 10.7 percent for family coverage in 2016, far faster than the 1.3 percent pay raise they are in line to receive. Another public employees' plan, CalPERS, is facing premium increases of 7 percent to 11 percent (Yoder, "Federal health-care plan costs to rise by most in five years," Washington Post, 9/29/15).

• One-quarter of privately insured working-age adults who were continuously insured all year had unaffordable health care costs in 2015, according to a survey by the Commonwealth Fund. Among the privately insured with low-incomes (below 200 percent of poverty), 53 percent reported unaffordable health care costs. The Commonwealth Fund's new Health Care Affordability Index defines "unaffordable" as being "underinsured" (out-of-pocket costs over 10 percent of income, or over 5 percent of income if low-income; or the deductible is 5 percent or more of income) or having unaffordable premiums. Premiums are considered unaffordable if they are 10 percent or more of income, or are 7 percent or more of income if low-income. According to the Index, 13 percent of people with private insurance had premiums that were unaffordable, 10 percent had unaffordable deductibles, and 11 percent had unaffordable out-of-pocket costs. Nearly all of the 1,687 adults in the survey were in employer-based plans.

Respondents were also asked their views on the affordability of health care, and many more perceived their premiums or deductibles as "unaffordable" than predicted by the Affordability Index. For example, 43 percent of adults who had private insurance all year said their deductible was difficult or impossible to afford compared with only 10 percent who had unaffordable deductibles as measured by the Index. One quarter of adults said their premiums were difficult or impossible to afford (Collins et al., "How High is America's Health Care Cost Burden?" Commonwealth Fund, 11/20/15).

High deductibles don't foster price-shopping by patients, but they do lead patients to forgo care. That's the conclusion of a recent study of 150,000 employees and dependents whose employer switched them from coverage with no cost sharing to a high ($3,750) deductible health plan (HDHP) and a $6,250 out-of-pocket maximum. Overall health spending fell by 19 percent, but there was no move to lower-cost providers. The entire drop was due to a decrease in utilization in services, particularly by the sickest quartile, who reduced their health spending by 25 percent, most of it early in the year, when they were under the deductible. Utilization fell across the board, including imaging (down 22 percent), preventive care (16 percent), mental health care (8 percent), inpatient hospital care (14 percent), emergency care (27 percent) and medications (20 percent) (Handel, "Health care cost-sharing prompts consumers to make big cuts in medical spending," The Conversation, 6/15/15).

• A study of nearly 3,000 nonprofit hospitals found that the value of tax breaks for tax-exempt hospitals doubled from $12.6 billion to $24.6 billion between 2002 and 2011. Forgone state and local taxes accounted for $11.6 billion in 2011, while forgone federal income taxes accounted for $13 billion (Rosenbaum et al., "The value of the nonprofit hospital tax exemption was $24.6 billion in 2011," Health Affairs, 11/12/15).

• Only 42 percent of nonprofit hospitals notify patients about their charity care policies before trying to collect unpaid bills, according to a new study. Under the ACA, hospitals are required to have a written policy on charity care, make those policies known to patients, and are prohibited from charging the uninsured more than they charge privately insured or Medicare patients. But most hospitals aren't following the rules. Only 29 percent say they charge the uninsured the same rates as other patients. Twenty percent report patients to credit agencies, garnish wages, and put liens on property, practices that shouldn't be needed if hospitals followed the rules (Sun, "How nonprofit hospitals overcharge the (under and) uninsured," Washington Post, 11/13/15).

SOCIOECONOMIC INEQUALITY

The mortality rate for white men and women in the U.S. ages 45-54 increased between 1999 and 2013, reversing decades of progress, according to a study by Anne Case and Nobel laureate Angus Deaton. The increase was largely due to deaths from drug and alcohol poisonings, suicide, and chronic liver diseases. Those with less education had the sharpest increases. There was a parallel increase in midlife morbidity, with self-reported increases in chronic pain, along with declines in health, mental health, and ability to work. If midlife mortality among whites had continued to decline at its previous (1979-1998) rate of 2 percent a year, instead of rising by half a percent per year since 1999, half a million deaths would have been averted. Death rates for U.S. blacks and Hispanics, as well as for other rich countries, continued to decline. The authors speculated that the rise in economic insecurity among whites with low educational levels may play a role ("Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century," Proceedings of the National Academy of Sciences, 11/2/15).

ACA PLANS

• ACA plans discourage patients with HIV from enrolling by limiting access to needed medicines, a covert method of risk selection. An analysis of nearly 1,500 different silver plans sold on the federal health exchange in 31 states and D.C. found that only 16 percent of plans covered all 10 of the top HIV/AIDS drug regimens and charged less than $100 a month in co-payments for them. A majority (57 percent) of plans covered fewer than seven of the most common medications or charged more than $200 a month in co-payments (Andrews, "Study finds marketplace silver plans offer poor access to HIV drugs," Kaiser Health News, 11/13/15).

• Nearly 15 percent of plans sold on the federal exchange completely lack in-network physicians for at least one specialty, according to a recent study in the JAMA. The problem is widespread across multiple insurers and states, and not only impairs access to care but also serves as covert risk-selection strategy (Dorner et al., "Adequacy of outpatient specialty care access in marketplace plans under the Affordable Care Act," JAMA, 314(16):1749-1750).

• Twelve out of 23 health insurance co-operatives formed under the ACA have folded in the past year, disrupting coverage for over 500,000 enrollees in Arizona, Michigan, Oregon, New York, Nevada, Colorado, Kentucky, Tennessee, South Carolina, Utah, Iowa/Nebraska, and Louisiana. Only one of the 23 co-ops (Maine) was in the black in 2014. The rest lost money, including Kentucky, which lost $50.4 million, and New York, which lost $35 million. The co-operatives, which were added to the ACA after the public option was defeated, were at risk from the beginning. Although the New York co-op had over 200,000 enrollees, most of the co-ops were small and attracted less healthy enrollees who incurred high health care costs. Some leaders of the failed co-ops blamed the federal "risk corridor" program which was supposed to compensate insurance plans with excessive claims but paid out only 12.6 percent of what insurers expected after Congress blocked additional funding. The Kentucky co-op expected $77 million in assistance but received less than $10 million (Norris, "Co-op health plans: patients' interests first," Healthinsurance.org, 11/7/15).

UnitedHealth Group, the nation's largest health insurer, announced that it may exit the health insurance marketplaces in 2017 after projecting that it will lose $425 million on individual marketplace plans in 2015 and 2016. The firm cited lowered growth projections for the marketplaces overall, the failure of half of the co-operatives participating in the marketplaces, and higher than expected medical costs among its 550,000 exchange enrollees as reasons for pulling back. Health Care Services Corp., which operates Blue Cross plans in five states, lost $282 million in 2014, mostly on marketplace plans. Aetna and Anthem, which each have over 800,000 enrollees in marketplace plans, have also voiced concerns about the viability of their exchange plans (Herman, "UnitedHealth considers ditching ACA's exchanges due to giant losses," Modern Healthcare, 11/19/15; UnitedHealth Group news release, 11/19/15).

GALLOPING TOWARD OLIGOPOLY

• In 2014, there were 1,299 merger and acquisition deals in health care, valued at a total of $387 billion, both record highs. Drug company deals were dominant, along with companies providing long-term care. There were 79 hospital mergers and 58 physician group deals (Vaida, "Health care consolidation," Alliance for Health Reform, November 2015).

The nation's five largest health insurers, which account for 83 percent of the market, are merging into three giants. Aetna is acquiring Humana for $37 billion, creating a firm with 53 million beneficiaries and revenues of about $115 billion, much of it from the federal government for Medicare Advantage enrollees. Meanwhile, Anthem is buying rival Cigna for $54.2 billion. Anthem said the merger would result in lower premiums, despite evidence that insurance industry mergers in the past have raised prices. The deals are expected to be finalized in 2016 (Lazare, "Healthcare oligopoly wave continues as Anthem gobbles Cigna," Common Dreams, 7/24/15; Bray, "Anthem to buy Cigna amid wave of insurance mergers," New York Times, 7/24/15).

• Political action committees run by Aetna and Anthem have donated to the campaigns of all five Republicans on the Senate Subcommittee on Antitrust, Competition Policy and Consumer Rights that heard testimony against the merger, including the chair of the subcommittee, Mike Lee, and one of the four Democrats. The former top lawyer for of the subcommittee, Seth Bloom, is now a lobbyist for Aetna. An AMA spokesperson testified that the mergers would exceed antitrust guidelines in 97 metropolitan areas in 17 states (Potter, "Firms pulling Washington's power levels on Capitol Hill," Center for Public Integrity, 9/21/15).

• Medium-sized insurers are also merging. St. Louis-based Centene Corp. is buying rival Health Net for $6.8 billion. The deal will create a firm with more than 10 million medical members and $37 billion in revenues. Health Net operates health plans in Oregon, Washington, California and Arizona while Centene operates in 23 states. Centene is also buying Trillium Community Health Plan, an Oregon Coordinated Care Organization (CCO) that provides care to Medicaid beneficiaries, for $130 million. Oregon's Medicaid enrollees were assigned to CCOs under Gov. John Kitzhaber in an attempt to control costs (Hayes, "Oregon insurer to be sold in blockbuster $6.8 billion health care deal," Portland Business Journal, 7/2/15; "Proposed sale of Oregon CCO to Fortune 500 firm generates controversy," Portland Business Journal, 6/5/15).

• California's Blue Shield is purchasing Care1st Health Plan, a small Medicaid insurer in the state, for $1.2 billion (Terhune, "Blue Shield's proposed acquisition of Care1st faces tough scrutiny," Los Angeles Times, 6/9/15).

• Two giant pharmacy benefit managers (PBMs) are merging. UnitedHealth Group's OptumRx, currently the industry's third-largest PBM, is buying Catamaran for $12.8 billion. The three largest PBMs, Express Scripts, CVS, and the combined OptumRX-Catamaran, will process about 75 percent of all pharmacy claims annually (Mathews, "UnitedHealth to buy Catamaran for $12.8 billion in cash," Wall Street Journal, 3/30/15).

• In the face of insurer consolidation, hospitals are launching their own insurance plans. In 2013, 19.1 million Americans were covered by provider-run health insurance plans. A recent survey of 45 large health care systems found that one-third already offered an insurance plan, and three-quarters of those without plans were planning to start one or considering it (Kelly, "As U.S. insurers aim to get bigger, hospitals eye health plan entry," Reuters, 10/13/15; Modern Healthcare, p. 21, 6/29/15).

• For-profit behavioral health care, particularly substance abuse treatment, is attracting investors and consolidating rapidly. "There are thousands of [addiction treatment] operations we can buy up over the next five to ten years," according to Michael Cartwright, CEO of American Addiction Centers (AAC). AAC, an investor-owned inpatient substance abuse firm, had its IPO in October 2014. Since then it has made six acquisitions. Acadia Healthcare, a fast-growing operator of psychiatric hospitals, bought CRC Health, a substance-abuse treatment provider, for $1.2 billion, and Quality Addiction Management for $53 million. Not-for-profits are consolidating too. Centerstone, which operates more than 120 behavioral health and substance abuse treatment facilities in four states, most recently acquired WellSpring Resources, which provides Medicaid managed mental health care services in Illinois (Kutscher, "Coverage parity draws investors to behavioral health," Modern Healthcare, 7/20/15).

• A giant for-profit rehabilitation firm is getting bigger. Birmingham, Ala.-based HealthSouth Corp. is buying Reliant Hospital Partners, a chain of 11 inpatient rehabilitation hospitals in Massachusetts, Ohio, and Texas, for $730 million (Briefs, Modern Healthcare, 6/15/15, and chart, p. 23, 6/22/15 issue).

MEDICARE

• Marilyn Tavenner went from being the head of Medicare to being the CEO of the lobbying group for the health insurance industry, America's Health Insurance Plans (AHIP), in just six months. When asked about her priorities, she told the New York Times that "she wanted to protect Medicare Advantage, the program under which private insurers manage care for more than 30 percent of the 55 million beneficiaries of Medicare" (Pear, "Head of Obama's health care rollout to lobby for insurers," New York Times, 7/15/15).

• In 2011, Medicare projected saving between $10 million and $320 million on ACOs in 2014. Instead, after paying out $422 million in bonuses to 97 ACOs, the latest government data shows that the ACO program has resulted in a net loss of $3 million to the Medicare Trust Fund. In 2014, 353 ACOs contracted with Medicare to care for some 6 million Medicare beneficiaries. 196 ACOs cost Medicare less than expected, while 157 ACOs cost more. The number of ACOs opting to share risk with Medicare ("Pioneer ACOs") has shrunk from 32 at the start of the program to 19. The rest are in the "Shared Savings" program where they are eligible for bonuses but face no penalties for losses (Rau and Gold, "Medicare yet to save money through heralded medical payment model," Kaiser Health News, 9/14/15).

• Dartmouth-Hitchcock Medical Center, where the ACO movement began is the latest ACO to pull out of the Medicare Pioneer ACO program. The New Hampshire-based health system had to pay Medicare $3.6 million in its third year for failing to meet performance targets (Evans, "Dartmouth-Hitchcock ends pioneer participation," Modern Healthcare, 10/25/15).

Newly released audits of Medicare Advantage plans offered by UnitedHealth Group, Aetna, Humana, Blue Cross, and Lovelace provide evidence of overcharges by the plans. The audits were obtained by the nonprofit Center for Public Integrity through a court order in a Freedom of Information Act lawsuit. Auditors had inspected medical records for a sample of 201 patients at each plan in 2007. The auditors concluded that risk scores, used to calculate reimbursement, were too high for more than 800 of the 1,005 patients, leading to annual overpayments of at least $5,000 for at least 200 of the patients. Auditors could not confirm one-third of the medical conditions the plans attributed to patients, and Medicare paid the wrong amount for more than half of the 1,005 patients in the sample. The payment amount was almost always too high, and the total error topped $3.3 million for this sample of 1,005 patients (Schulte, "More Medicare advantage audits reveal overcharges," Center for Public Integrity, 7/10/15).

• Medicare Part B premiums in 2016 will remain $104.90 for 70 percent of beneficiaries, but rise to $121.80 for beneficiaries who are not on Social Security. For higher income beneficiaries, premiums will range from $170.50 to $389.90. The deductible for Part B is increasing to $166. (Cubanski, "What's in store for Medicare's Part B premiums and deductible in 2016, and why?" Kaiser Family Foundation, 11/11/15).

Medicare overpays nursing homes for so-called "intensive therapy," according to a report by the Office of the Inspector General. Patients who receive at least 720 minutes of therapy a week receive the highest daily payments from Medicare, $560 in 2013. An analysis by the Wall Street Journal found that the proportion of inpatient days billed at the highest rate increased to 54 percent in 2013, up from 7 percent in 2002. One of the largest nursing home chains, Genesis HealthCare Corp., billed Medicare for the highest rate for therapy for 58 percent of patient days, versus 8.1 percent in 2002. HCR billed for ultrahigh services 68 percent of the time in 2013, up from 8.8 percent in 2002. Other operators showed similar trends (Weaver, "How Medicare Rewards Copious Nursing-Home Therapy," Wall Street Journal, 8/15/15).

MEDICAID

• A 2012 Supreme Court decision gave states the option of refusing the ACA's Medicaid expansion. Many states have used the ruling as leverage in negotiations with CMS to impose premiums and co-pays on Medicaid recipients, which had previously been prohibited. CMS has allowed at least six states (Arkansas, Iowa, Indiana, Michigan, Montana and New Hampshire) to mandate that Medicaid recipients pay premiums or make contributions to an HSA, even for beneficiaries under 100 percent of the federal poverty level. Now, Ohio is seeking a waiver from CMS to allow the state to drop adult Medicaid beneficiaries who don't pay into a health savings account, regardless of their income. Some 2.9 million Ohio residents have Medicaid coverage, about a quarter of the state's population. Two states, Indiana and Montana, already may "lock out" certain beneficiaries for failure to pay (Rubenfire, "Ohio wants all Medicaid beneficiaries to make HSA contributions," Modern Healthcare, 7/20/15; Rudowith and Musumeci, "The ACA and Medicaid Expansion Waivers," Kaiser Family Foundation, 11/20/15).

• The 4.3 million adults who gained Medicaid coverage in 2014 as a result of the Affordable Care Act incurred average medical costs of $5,517, about $1,000 higher than expected, according to CMS. The new enrollees had pent-up demand for services, according to the CMS actuary (Radnofsky, "Cost of covering new people under ACA significantly higher than expected," Wall Street Journal, 7/10/2015).

• A recent study claiming that Medicaid coverage was not cost-effective was biased. The study, using data from the Oregon Health Insurance Experiment, purported to show that each dollar in Medicaid coverage provided only 20 cents to 40 cents of value to beneficiaries. But it arrived at those results by discounting the value of the care beneficiaries received in two ways: (1) it assumed that Medicaid enrollees would have received most care free without coverage anyway, and (2) it assumed that an extra year of life for Medicaid beneficiaries was worth only about $25,000, far lower than the value of a life that has been used in other cost-effectiveness studies. One commentary noted that "if you start out by assuming that Medicaid beneficiaries' lives are worth very little, you will find that it is not worth spending much money to prolong them" (Finkelstein et al., "Interpreting results from the Oregon Health Insurance Experiment, Working Paper 21308," National Bureau of Economic Research, June 2015).

CORPORATE MONEY AND CARE

• In 2014 the average compensation for CEOs of health care companies in the S&P 500 was $13.5 million, the highest pay of all eight sectors studied. The CEOs of Aetna, Anthem, Centene, Cigna, Health Net, and UnitedHealth Group took home combined pay of $100 million in 2014, an average of $16.6 million per executive. Average compensation for CEOs at 270 hospital systems rose 8.2 percent in 2014, to $1.2 million ("Data points," Modern Healthcare, 8/17/15).

Blue Cross and Blue Shield of Alabama no longer has to disclose what they pay their executives, according to a bill that passed near-unanimously in March. CEO Terry Kellogg took home $4.84 million in 2013. The chief of staff for the Alabama Department of Insurance, Mark Fowler, said that the industry asked to keep salaries confidential, and his office agreed because "it had to do with personal information" that "didn't contribute to regulating those companies." (Yurkanin, "Want to see what Alabama insurance executives make? New law says that's now secret," Birmingham News, 9/28/2015).

• During the five years prior to the implementation of Obamacare in late 2013, the health care industry was the fourth-best performing sector among the 10 sectors in the Russel 3000. In the nearly two years since, health care has become the top performer. The 458 firms in the Russel 3000 Health Care Index have delivered a 35.9 percent return over the past two years, almost twice the 18.5 percent total return for the rest of the stock market (Winkler, "Ask investors whether Obamacare is working," Bloomberg View, 10/16/15).

• A high proportion of investor-owned health care firms have directors with academic medical affiliations. Of 446 publicly traded health care companies on the New York Stock Exchange, 180 (41 percent) have one or more directors affiliated with an academic medical institution, according to a study in the BMJ. Directors are affiliated with 85 different nonprofit medical education institutions. Of 279 academically affiliated directors, 15 are university presidents and eight are medical school deans or presidents. Average annual compensation for board participation ($193,000) rivaled an academic medical faculty salary, and academically affiliated directors also owned an average of 50,699 shares of stock. In addition, this same research team found that the 47 largest drug firms often have academic medical center leaders on their boards. Annual cash compensation to those directors averaged $300,000 (Anderson et al., "Prevalence and compensation of academic leaders, professors, and trustees on publicly traded US healthcare company boards of directors: cross sectional study," BMJ, 9/29/15).

PHARMA

• Pfizer, the world's largest drug company, is buying Ireland-based Allergan in a $155 billion "tax inversion" deal. Pfizer can avoid billions in U.S. taxes per year by shifting its headquarters to Dublin, where corporate taxes are lower, even though the majority of Allergan's operations are based in New Jersey. Reincorporating as a "foreign company" will also allow Pfizer to use its supposedly offshore profits in the U.S. tax-free. According to a report from Citizens for Tax Justice, Pfizer operates 151 subsidiaries in tax havens, holding $74 billion in profits offshore, the fourth-highest amount among the Fortune 500. Under current rules, Pfizer would have to pay American corporate taxes on earnings from international operations if it brings the money into the U.S. In order to sidestep U.S. rules about tax inversions, the deal is being structured as if Allergan is buying Pfizer (Merced, "Pfizer, Allergan reported close to buyout deal," New York Times, 11/23/15).

• One-third of 185 meta-analyses of randomized controlled trials on the effectiveness of antidepressants were written by pharmaceutical industry employees, according to a study in the Journal of Clinical Epidemiology. Almost 80 percent of the analyses had some sort of industry tie or conflict of interest, and 7 percent of studies were by researchers with undisclosed conflicts of interest. Co-author John Ioannidis, an epidemiologist at Stanford, was amazed that "there is such a massive influx of [industry] influence in this field" noting that meta-analyses "have traditionally been a bulwark of evidence-based medicine." Meta-analyses by industry employees were 22 times less likely to have negative statements about a drug than those done by unaffiliated researchers (Jacobson, "Many antidepressant studies found tainted by Pharma company influence," Scientific American, 10/21/15).

• Turing Pharmaceuticals, a start-up run by a former hedge-fund manager, made headlines for raising the price of a 62-year-old drug for toxoplasmosis, Daraprim, 5,000 percent, from $13.50 a pill to $750. (That medicine is sold in England for 66 cents.) Prices are skyrocketing on many other older medications as well, including Doxycycline, an antibiotic made by Major Pharmaceuticals, which jumped in price from $20 a bottle to $1,849 in one year; and Cycloserine, a drug to treat multi-drug resistant tuberculosis, which rose from $500 for a month of treatment to $10,800 after its purchase by Rodelis Therapeutics. Valeant raised the price of Cuprimine (penicillamine), a drug sold by some foreign pharmacies for $1 a tablet, to $260 per tablet, or $31,200 for a month's supply, and the price of a monthly supply of Glumetza (a branded formulation of metformin) from $519 to $4,643 (Pollack, "Drug goes from $13.50 a tablet to $750, overnight," New York Times, 9/20/15; Pollack and Tavernise, "Valeant's drug price strategy enriches it, but infuriates patients and lawmakers," New York Times, 10/4/15).

> Medicare Part D could save between $15.2 billion and $16 billion annually – of the $36 billion it pays for brand-name drugs – if Medicare were allowed to negotiate prices with pharmaceutical companies and obtain the same price as Medicaid and the VA, according to researchers at Public Citizen and Carleton University. Medicare pays about 73 percent more for brand-name medications than Medicaid and 80 percent more than the VA. Congress prohibited Medicare from negotiating drug prices directly with manufacturers in the 2003 Medicare Modernization Act (Silverman, "U.S. could save up to $16 billion if Medicare Part D prices are negotiated," Wall Street Journal, 7/23/15).

• Mylan has raised the price of the lifesaving EpiPen, which delivers about $1 worth of epinephrine, by 400 percent since it acquired the medicine from Merck in 2007. A package of two EpiPens costs about $415 in the U.S., compared to $85 for similar pens in France (Koons, "How marketing turned the EpiPen into a billion-dollar business," Bloomberg Businessweek, 9/23/15).

> Gilead, which sells hepatitis C drugs Sovaldi and Harvoni (both of which contain sofosbuvir), along with several HIV treatments, raised its full-year sales forecast for 2015 at least three times, saying it now expects revenues of $30 billion to $31 billion. The firm sold $4.8 billion of Sovaldi and Harvoni in the third quarter alone; the drugs are priced at $84,000 and $95,000 for a course of treatment, respectively. CEO Martin John Martin all but admitted that the drugs are not affordable when he told investors that revenues for its hepatitis C medications are constrained by "country-specific budgets rather than the number of patients." Despite raking in windfall profits, Gilead is limiting enrollment in its patient-assistance program to pressure private insurers and Medicaid to pick up the tab. But Medicaid programs say they can't afford to treat all of their enrollees who might benefit. A study of 2,342 patients in four states found that Medicaid programs denied coverage for hepatitis C medications 46 percent of the time, compared with 5 percent for Medicare and 10 percent for private insurance. A lawsuit filed in federal court in Boston alleges that the state prison system is not providing the medications to prisoners, some of whom are already seriously ill from their infections (Barber, "Gilead posts surge in Q3 profit," FirstWord Pharma, 10/27/15; Loftus, "Prisoners Sue Massachusetts for Withholding Hepatitis C Drugs," Wall Street Journal, 6/11/15; Sapatkin, "Medicaid denies half of prescriptions for new hepatitis C drugs," Inquirer, 11/14/15).

• The average annual price of 115 widely used specialty drugs (drugs that require special handling, administration, or monitoring) rose to $53,384 in 2014, higher than the U.S. median income. The number of specialty drugs is growing rapidly: 19 of the 28 drugs approved by the FDA in 2013 are specialty drugs (Johnson, "Specialty drugs now cost more than the median household income," Washington Post, 11/20/15).

• The Trans-Pacific Partnership Trade Agreement (TPP) "represents nothing less than a disaster for global health," according to public health professor Dr. Deborah Gleeson. The agreement allows patents for new uses of using existing products, and a minimum of five years' market exclusivity for biologics, among other provisions impairing patient access to medicines. The pharma-

(continued on next page)

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Despite health law's bow to prevention, U.S. public health funding is declining: American Journal of Public Health study

Researchers say per capita public health spending has dropped 9.3 percent since 2008, reflecting a $40.2 billion loss to disease prevention and related programs from 2009 through 2014

FOR IMMEDIATE RELEASE, November 12, 2015

Although the language of the Affordable Care Act places considerable emphasis on disease prevention – for example, mandating insurance coverage of clinical preventive services such as mammograms – funding for public health programs to prevent disease have actually been declining in recent years, researchers say.

"Per capita public health spending (inflation-adjusted) rose from $39 in 1960 to $281 in 2008, and has fallen by 9.3 percent since then," write Drs. David Himmelstein and Steffie Woolhandler in the American Journal of Public Health. "Public health's share of total health expenditures rose from 1.36 percent in 1960 to 3.18 percent in 2002, then fell to 2.65 percent in 2014; it is projected to fall to 2.40 percent in 2023."

Their article, titled "Public Health's Falling Share of U.S. Health Spending," draws on five decades of data from the National Health Expenditure Accounts compiled by the U.S. Department of Health and Human Services and from the U.S. Census Bureau.

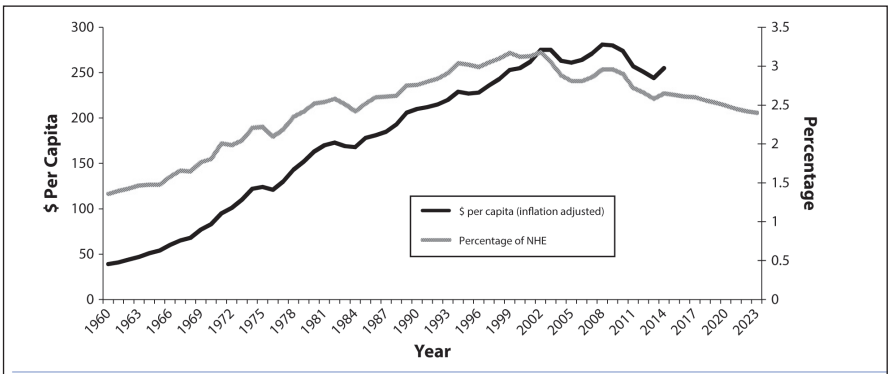

FIGURE 1—US public health expenditures in dollars per capita and as percentage of National Health Expenditure (NHE): 1960–2023.

Himmelstein, a professor at the City University of New York (CUNY) School of Public Health at Hunter College and lecturer in medicine at Harvard Medical School commented: "Obamacare was supposed to add $15 billion to public health funding. But in 2012 Congress cut that by $6.25 billion, and sequestration imposed further cuts in 2013. This year, public health will get less than half of the $2 billion promised by the ACA. And state and local government public health spending has also fallen, even while their other health expenditures have continued to rise."

Woolhandler, a primary care doctor in New York City, professor at CUNY's public health school at Hunter College and lecturer at Harvard Medical School, said: "Our health care system is dangerously out of balance. We're spending more and more treating disease, but less and less to prevent it."

She continued: "We're breaking the bank paying for hepatitis C and cancer drugs, while drug abuse prevention, needle exchange programs and anti-smoking campaigns are starved for funds."

The authors note that if the nation's inflation-adjusted public health funding had remained at the 2008 level ($281 per capita), an additional $40.2 billion would have been devoted to public health between 2009 and 2014.

In addition to their academic posts and clinical work, Himmelstein and Woolhandler are co-founders and leaders of Physicians for a National Health Program, a nonprofit organization that advocates for a single-payer health system. PNHP had no role in funding their study.

"Public Health's Falling Share of U.S. Health Spending." David U. Himmelstein, M.D., and Steffie Woolhandler, M.D., M.P.H. American Journal of Public Health, Nov. 12, 2015.

(***Data update,*** *continued from previous page)*

ceutical industry was the most active industry working to influence the drafting of the TPP early on (between 2009 and 2013), as measured by the number of lobbying reports filed by the industry, 251, over twice as many as filed by the next most active industry, automakers (Drutman, "How Big Pharma (and others) began lobbying on the Trans-Pacific Partnership before you ever heard of it," Sunlight Foundation, 3/13/14).

Health Affairs

August 2015

National Health Expenditure Projections, 2014–24: Spending Growth Faster Than Recent Trends

By Sean P. Keehan, Gigi A. Cuckler, Andrea M. Sisko, Andrew J. Madison, Sheila D. Smith, Devin A. Stone, John A. Poisal, Christian J. Wolfe, and Joseph M. Lizonitz

EXHIBIT 1

National Health Expenditures (NHE), Amounts And Annual Growth From Previous Year Shown, By Spending Category, Calendar Years 2007–24

Spending category	2007[a]	2012	2013	2014	2015	2018	2024
EXPENDITURE, BILLIONS							
NHE	$2,303.9	$2,817.3	$2,919.1	$3,080.1	$3,243.5	$3,785.5	$5,425.1
Health consumption expenditures	2,158.8	2,653.6	2,754.5	2,915.3	3,075.9	3,593.8	5,154.2
Personal health care	1,921.0	2,379.3	2,468.6	2,596.3	2,728.6	3,184.3	4,550.1
Hospital care	692.5	898.5	936.9	978.3	1,031.1	1,213.6	1,755.1
Professional services	618.6	752.0	777.9	815.1	849.9	978.6	1,373.6
Physician and clinical services	461.8	565.3	586.7	615.0	640.3	735.5	1,034.8
Other professional services	59.5	76.8	80.2	85.5	90.5	108.5	155.4
Dental services	97.3	110.0	111.0	114.5	119.1	134.6	183.4
Other health, residential, and personal care	107.7	140.1	148.2	153.0	159.3	184.8	251.1
Home health care	57.8	77.1	79.8	81.9	86.5	103.6	156.0
Nursing care facilities and continuing care retirement communities	126.4	152.2	155.8	160.2	167.1	195.9	274.4
Retail outlet sales of medical products	318.1	359.4	370.0	407.8	434.7	507.7	739.8
Prescription drugs	236.0	264.4	271.1	305.1	328.4	385.1	564.3
Durable medical equipment	34.3	41.3	43.0	44.2	46.5	53.2	76.9
Other nondurable medical products	47.8	53.7	55.9	58.4	59.8	69.4	98.7
Government administration	29.3	34.2	37.0	39.9	42.5	52.3	82.2
Net cost of health insurance	142.6	165.3	173.6	200.4	222.8	261.0	384.3
Government public health activities	65.9	74.8	75.4	78.7	82.0	96.2	137.7
Investment	145.1	163.7	164.6	164.8	167.6	191.7	270.8
Noncommercial research	42.5	48.0	46.7	45.9	46.7	53.3	72.0
Structures and equipment	102.7	115.7	117.9	118.9	120.9	138.3	198.9
ANNUAL GROWTH							
NHE	7.3%	4.1%	3.6%	5.5%	5.3%	5.3%	6.2%
Health consumption expenditures	7.3	4.2	3.8	5.8	5.5	5.3	6.2
Personal health care	7.2	4.4	3.8	5.2	5.1	5.3	6.1
Hospital care	6.4	5.3	4.3	4.4	5.4	5.6	6.3
Professional services	6.9	4.0	3.4	4.8	4.3	4.8	5.8
Physician and clinical services	6.7	4.1	3.8	4.8	4.1	4.7	5.9
Other professional services	8.1	5.2	4.5	6.6	5.8	6.2	6.2
Dental services	6.9	2.5	0.9	3.2	4.1	4.1	5.3
Other health, residential, and personal care	9.3	5.4	5.8	3.2	4.1	5.1	5.2
Home health care	10.1	5.9	3.4	2.6	5.6	6.2	7.0
Nursing care facilities and continuing care retirement communities	6.8	3.8	2.4	2.8	4.3	5.5	5.8
Retail outlet sales of medical products	9.0	2.5	2.9	10.2	6.6	5.3	6.5
Prescription drugs	11.2	2.3	2.5	12.6	7.6	5.5	6.6
Durable medical equipment	6.1	3.7	4.2	2.9	5.1	4.6	6.3
Other nondurable medical products	4.7	2.4	4.0	4.6	2.3	5.1	6.0
Government administration	8.7	3.1	8.2	8.0	6.4	7.2	7.8
Net cost of health insurance	9.6	3.0	5.0	15.5	11.2	5.4	6.7
Government public health activities	7.6	2.6	0.8	4.3	4.3	5.4	6.2
Investment	6.9	2.4	0.5	0.1	1.7	4.6	5.9
Noncommercial research	7.4	2.5	–2.6	–1.8	1.9	4.5	5.1
Structures and equipment	6.6	2.4	1.9	0.9	1.7	4.6	6.2

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** Definitions, sources, and methods for NHE categories can be found at CMS.gov. National Health Expenditure Accounts: methodology paper, 2013: definitions, sources, and methods [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2014 [cited 2015 Jul 2]. Available from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/dsm-13.pdf. Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007.

EXHIBIT 4

National Health Expenditures (NHE) Amounts, Average Annual Growth From Previous Year Shown, And Percent Distribution, By Type Of Sponsor, Selected Calendar Years 2007–24

Type of sponsor	2007[a]	2012	2013	2014	2015	2018	2024
EXPENDITURE, BILLIONS							
NHE	$2,303.9	$2,817.3	$2,919.1	$3,080.1	$3,243.5	$3,785.5	$5,425.1
Businesses, households, and other private revenues	1,372.5	1,592.7	1,652.8	1,711.1	1,786.3	2,052.8	2,880.1
Private businesses	522.6	587.3	610.9	642.5	673.8	753.0	1,034.0
Households	678.0	801.5	823.8	845.1	882.5	1,029.4	1,465.1
Other private revenues	171.9	203.9	218.1	223.5	230.0	270.4	381.0
Government	931.4	1,224.6	1,266.3	1,369.0	1,457.3	1,732.7	2,545.0
Federal government	530.7	731.5	757.5	833.8	897.6	1,070.5	1,579.1
State and local governments	400.8	493.1	508.8	535.3	559.6	662.2	965.9
ANNUAL GROWTH							
NHE	7.3%	4.1%	3.6%	5.5%	5.3%	5.3%	6.2%
Businesses, households, and other private revenues	6.5	3.0	3.8	3.5	4.4	4.7	5.8
Private businesses	6.8	2.4	4.0	5.2	4.9	3.8	5.4
Households	6.1	3.4	2.8	2.6	4.4	5.3	6.1
Other private revenues	6.8	3.5	7.0	2.5	2.9	5.5	5.9
Government	8.8	5.6	3.4	8.1	6.4	5.9	6.6
Federal government	9.4	6.6	3.5	10.1	7.7	6.0	6.7
State and local governments	8.2	4.2	3.2	5.2	4.5	5.8	6.5
DISTRIBUTION							
NHE	100%	100%	100%	100%	100%	100%	100%
Businesses, households, and other private revenues	60	57	57	56	55	54	53
Private businesses	23	21	21	21	21	20	19
Households	29	28	28	27	27	27	27
Other private revenues	7	7	7	7	7	7	7
Government	40	43	43	44	45	46	47
Federal government	23	26	26	27	28	28	29
State and local governments	17	18	17	17	17	17	18

SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. **NOTES** For definitions, sources, and methods for NHE categories, see CMS.gov. National Health Expenditure Accounts: methodology paper, 2013: definitions, sources, and methods (see Exhibit 1 notes). Numbers may not sum to totals because of rounding. Percent changes are calculated from unrounded data. [a]Annual growth, 1990–2007.

THE WALL STREET JOURNAL.

SEPTEMBER 17, 2015

Sen. Sanders: I'll create jobs, provide better care for less

By Sen. Bernie Sanders

Your article "Price Tag of Sanders Proposals: $18 Trillion" (page one, Sept. 15) is misleading.

It is true that I would invest $1 trillion into rebuilding our crumbling infrastructure. Not only would this long-overdue investment make our country more productive and efficient, it would put 13 million Americans to work in good-paying jobs. It is true that I would invest in making all public colleges and universities tuition free and substantially reduce student debt. This higher-education proposal, estimated to cost about $75 billion a year, would be more than paid for by a tax on Wall Street speculation. It is true that I proposed to extend the solvency of Social Security until the year 2065 and to expand benefits.

This proposal would be offset by lifting the cap on taxable income above $250,000 a year.

But, here's where the article is mistaken. While a Medicare-for-all program may cost $15 trillion over 10 years, this proposal would eliminate all payments made by Americans and businesses to health-insurance companies. At a time when the U.S. spends substantially more per capita on health care than does any other country on earth, a single-payer health-care program would substantially lower our total health-care costs and would guarantee health care to all Americans. This approach would end the international embarrassment of the U.S. being the only major country on earth that doesn't already do this. For The Wall Street Journal to ignore the enormous savings that Medicare-for-all would bring to our wildly inefficient and dysfunctional health-care system is irresponsible.

Sen. Bernie Sanders (I., Vt.) writes from Washington. He is a candidate for the Democratic Party's presidential nomination.

PNHP note: PNHP is a 501(c)(3) nonpartisan educational and research organization that neither supports nor opposes any candidate for public office.

AP Associated Press

October 2, 2015

Again? Broader health care debate for 2016

By Ricardo Alonso-Zaldivar

WASHINGTON – After seven years of the political drama known as "Obamacare," you might think voters would be tired of big ideas for revamping health care. If so, the presidential candidates seem to have missed the memo.

The 2016 hopefuls in both parties are offering a full spectrum of options, from a system wholly run by the federal government to dialing back Washington's lead role. Much is promised by the candidates, but each approach has pitfalls.

On the left, part of the appeal of Vermont independent Sen. Bernie Sanders is his years-long advocacy of "single payer," a tax-supported, Medicare-like plan for all. The idea is in the political DNA of liberals, and Sanders as president would lead a movement to make it happen, his campaign says.

On the right are the Republicans, united on repealing President Barack Obama's health care law, but unable to agree on what they would replace it with. They wouldn't stop with the Affordable Care Act, either. Republicans also want curbs on Medicaid, to reduce spending and let states, not Washington, set the tone. Medicaid covers low-income and disabled people.

In the middle – if one still exists on such a polarized issue – is Democrat Hillary Rodham Clinton. She would keep the basic structure of Medicare, Medicaid and the Obama health law while making incremental changes. This week she proposed repealing an insurance tax in the health law that's opposed by unions and big business but seen by experts as a needed brake on costs. She also wants to curb prescription drug prices and limit insurance cost-shifting to consumers.

If Sanders keeps gaining traction, the wonkish term for a government-run health care system could become a household word.

"The only person not in favor of 'repeal and replace' is Hillary Clinton," quips Republican economist Douglas Holtz-Eakin. "There is a debate being presented to the American people: Do you want to go further left, or do you want to go in the direction conservatives are advocating? The person who is basically arguing for the status quo is Hillary Clinton."

A look at the three approaches, and their potential drawbacks:

Single Payer

If Sanders keeps gaining traction, the wonkish term for a government-run health care system could become a household word. His supporters say Obama's hard-fought health overhaul hasn't done nearly enough.

"People are still one illness away from becoming bankrupt," said Dr. Deb Richter, who practices near Montpelier, Vermont, and focuses on addiction treatment. "Obamacare was hyped as this savior, and it has not been that."

Supporters say having the government take charge of health care finances would slow the growth of spending, keep things affordable for patients, and improve overall quality.

A major pitfall is the switch from employer-based and private coverage to the single-payer plan. Money that employers and individuals now pay for premiums would have to be diverted to government coffers – a massive tax increase.

[PNHP note: For a reply to this assertion, see Dr. John Geyman's "Misinformation about the cost of single-payer national health insurance" at bit.ly/1VXldKl].

"It's a dead end," said Princeton sociologist Paul Starr, a historian of the U.S. health care system. Supporters "don't face up to the significant tax changes that would be necessary."

Repeal and Replace

The Supreme Court upheld Obama's law, and the president won re-election in 2012. That didn't settle the debate, but 2016 may.

"For Republicans it's their last chance to litigate the Affordable Care Act," said Jim Capretta, an expert on entitlement programs at the conservative Ethics & Public Policy Center in Washington. "If they lose the election, the ACA is likely to become even more entrenched."

'Repeal' is a winning issue with the GOP's political base, but the 'replace' part gets tricky because Republicans don't agree on an alternative. In the general election, the GOP counterproposal will be measured against the health care law's progress in reducing the number of uninsured. A plan that repeals federal mandates and reduces insurance subsidies would probably leave more people uncovered.

Republican front-runner Donald Trump says his replacement plan would be different.

He'd make sure everybody in the country is covered, something not even Obama accomplishes. Trump says he'd make a deal with hospitals, and most people would still have private coverage.

"There is not nearly enough to go on from Trump's statements to assess what he actually has in mind," said Capretta.

But the biggest pitfall for Republicans could be Medicare, not

(continued on next page)

The New York Times

October 20, 2015

U.S. health care could be more like Denmark's

By Steffie Woolhandler, M.D.

The United States isn't Denmark, but it can, like Scandinavia, implement changes to its health care system that save money, cover everyone and help us live longer.

In the 1950s, U.S. health statistics were world class: infant mortality rate among the lowest, life expectancy among the highest, and health costs about average. One by one, other nations – not just Denmark and Sweden, but Australia, Britain, Canada and Taiwan, to name a few – adopted national health programs. By the end of the 20th century, the U.S. was the lone hold out for private, for-profit health insurance, and its health statistics lagged behind dozens of countries. Meanwhile, costs soared to twice the average in other wealthy nations.

Dr. Steffie Woolhandler

For Americans, national health insurance would mean comprehensive coverage, a free choice from a smorgasbord of any doctor or hospital and lower costs. Other countries have seen huge savings by evicting private insurers and the reams of expensive paperwork they inflict on doctors and hospitals. Aetna keeps 19 cents of every premium dollar for overhead and profit, leaving only 81 cents for care. And U.S. hospitals devote 25.3 percent of total revenue to administration, reflecting the high cost of collecting patient copayments and deductibles, and fighting with insurers.

Obamacare will direct an additional $850 billion in public funds to private insurers, and boost insurance overhead by $273.6 billion. Yet it will leave 26 million uninsured and similar numbers with such skimpy coverage that a major illness would bankrupt them. Most Americans have coverage that limits their choice of doctors and hospitals, and inflicts steep financial penalties when they stray "out-of-network" by accident or necessity.

For Americans, national health insurance would mean comprehensive coverage, a free choice from a smorgasbord of any doctor or hospital and lower costs.

In contrast, insurance overhead in single-payer programs (and fee-for-service Medicare) takes only 1 percent to 2 percent. In these programs, hospitals don't need to bill each patient; they're paid a lump sum budget, the way we fund fire departments, sharply cutting hospital administrative costs. Moving to a single-payer system would save about $400 billion annually on paperwork and administration – enough to ensure every American top coverage.

Messages like "We are not Denmark" insist we put blinders on and refuse to learn from others. That reasoning would have us ignore innovations like vaccination or CT scanners (British inventions), echocardiograms (a Swedish one) or cardiac stents (first used in France). A single-payer reform – like the one advocated by the 20,000 members of Physicians for a National Health Program – could save thousands of American lives each year. That's as American as apple pie.

Steffie Woolhandler is a co-founder of Physicians for a National Health Program.

(***Alonso-Zaldivar,*** *continued from previous page)*

"Obamacare." The party has previously advocated privatizing the insurance program for older Americans. In 2016, that would be asking for trouble.

"Seniors have been tilting Republican in the last elections," said Robert Blendon, a public opinion expert at the Harvard T.H. Chan School of Public Health. "The only thing that could get them to tilt the other way is a Medicare proposal."

Continuity, mostly

Hillary Clinton established her credentials on health care in the 1990s, although she and her husband, then-President Bill Clinton, failed to pass the overhaul legislation they proposed. She lost the 2008 Democratic nomination to Obama, but he adopted key parts of her health plan.

This time, Clinton is promising to build on Obama's coverage expansion and smooth its rough edges, while keeping Democrats' traditional commitment to Medicare and Medicaid.

The drawback is that Clinton's middle way may be seen as uninspiring. "I think there is a hunger among Democrats to see something more happen," Blendon said.

Ricardo Alonso-Zaldivar covers health care for The Associated Press.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

More Americans gain health coverage, but many can't afford to use it

Census Bureau says number of uninsured has dropped to 33 million in wake of Affordable Care Act, but is silent on problems of rising deductibles, copays, coinsurance and narrow networks

FOR IMMEDIATE RELEASE, September 16, 2015

"The Census Bureau's official estimate that 33 million Americans lacked health insurance in 2014 reflects a significant and welcome drop from the 42 million it reported as uninsured in 2013," said Dr. Robert Zarr, president of Physicians for a National Health Program, today. "But the number of people who remain without coverage is still intolerably high. And the Census Bureau report leaves entirely unmentioned the millions of people who have health insurance but who can't afford to use it because of high deductibles and copays."

"Having health insurance is better than not having coverage, as several research studies have shown," Zarr, a Washington, D.C.-based pediatrician, continued. "For example, the 33 million people the Census Bureau says were uninsured in 2014 means that approximately 33,000 people died needlessly last year because they couldn't get access to timely and appropriate care." He cited a landmark study in the American Journal of Public Health showing that for every 1 million persons who are uninsured in a given year, there are about 1,000 deaths linked chiefly to that factor.

A recent study by the Commonwealth Fund shows that about 31 million people who have health insurance – nearly a quarter of all non-elderly adults – are underinsured, nearly double the rate in 2003.

"That's an unnecessary death every 16 minutes," Zarr said. "That's completely unacceptable. Moreover, the Congressional Budget Office predicts at least 27 million people will be uninsured every year for the next 10 years – so that's tens of thousands of preventable deaths, year in and year out.

"And keep in mind that even if all the states had accepted the Medicaid expansion, about 24 million people would still be uninsured under the Affordable Care Act," he said. "We simply can't go on like this."

Zarr pointed out that the problem of underinsurance – i.e. of people having skimpy policies with high deductibles, copays, and other forms of cost sharing that deter them from seeking care and that leave them vulnerable to financial distress and medical bankruptcy in the event of serious illness – is not something the Census Bureau addresses in its annual reports. But it should take this question up, he said, especially in view of how rapidly the problem is worsening.

"A recent study by the Commonwealth Fund shows that about 31 million people who have health insurance – nearly a quarter of all non-elderly adults – are underinsured, nearly double the rate in 2003," Zarr said. "Of these, 44 percent went without a doctor's visit, medical test, or prescription due to cost, while 51 percent had problems paying off medical bills or were paying off medical debt over time.

"The average deductible – i.e. before insurance kicks in -- for families with popular silver plans in 2015 is estimated to be $6,010, and out-of-pocket costs for copayments and deductibles, after premium payments, for a family of four with an income of about $60,000 per year can be as high as $13,200," he said. "And of course this applies to 'in network' services only. Out-of-network costs can go much, much higher. Such financial barriers are untenable, economically and morally."

"In short, under the new health law we're witnessing a dramatic acceleration of the trend of shifting more and more medical costs onto the shoulders of patients and their families, even as medical costs and premiums rise and as private health insurance companies reap record profits.

"How is it possible that in 2015 one of the richest countries in the world still does not guarantee every resident the right to health care?" Zarr continued. "This question would not be necessary if we had a health care system worthy of the name – single-payer national health insurance, or an improved and expanded Medicare for All.

"A single-payer system would achieve truly universal care, affordability, and effective cost control. It would put the interests of our patients – and our nation's health – first."

Zarr continued: "Our patients, our people and our national economy cannot wait any longer for an effective remedy to our health care woes. The stakes are too high. We need to move beyond the administratively wasteful, complex and inadequate ACA to a more fundamental, comprehensive single-payer national health program for all."

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

The New York Times

November 14, 2015

Many say high deductibles make their health law insurance all but useless

By Robert Pear

WASHINGTON – Obama administration officials, urging people to sign up for health insurance under the Affordable Care Act, have trumpeted the low premiums available on the law's new marketplaces.

But for many consumers, the sticker shock is coming not on the front end, when they purchase the plans, but on the back end when they get sick: sky-high deductibles that are leaving some newly insured feeling nearly as vulnerable as they were before they had coverage.

"The deductible, $3,000 a year, makes it impossible to actually go to the doctor," said David R. Reines, 60, of Jefferson Township, N.J., a former hardware salesman with chronic knee pain. "We have insurance, but can't afford to use it."

In many states, more than half the plans offered for sale through HealthCare.gov, the federal online marketplace, have a deductible of $3,000 or more, a New York Times review has found. Those deductibles are causing concern among Democrats – and some Republican detractors of the health law, who once pushed high-deductible health plans in the belief that consumers would be more cost-conscious if they had more of a financial stake or skin in the game.

"We could not afford the deductible," said Kevin Fanning, 59, who lives in North Texas, near Wichita Falls. "Basically I was paying for insurance I could not afford to use."

He dropped his policy.

As the health care law enters its third annual open enrollment period, premiums and subsidies have been one of the administration's main selling points.

"Most Americans will find an option that costs less than $75 a month," President Obama said.

Sylvia Mathews Burwell, the secretary of health and human services, issued a report analyzing premiums in the 38 states that use HealthCare.gov. "Eight out of 10 returning consumers will be able to buy a plan with premiums less than $100 a month after tax credits," she said.

But in interviews, a number of consumers made it clear that premiums were only one side of the affordability equation.

"Our deductible is so high, we practically pay for all of our medical expenses out of pocket," said Wendy Kaplan, 50, of Evanston, Ill. "So our policy is really there for emergencies only, and basic wellness appointments."

Her family of four pays premiums of $1,200 a month for coverage with an annual deductible of $12,700.

In Miami, the median deductible, according to HealthCare.gov, is $5,000. (Half of the plans are above the median, and half below it.) In Jackson, Miss., the comparable figure is $5,500. In Chicago, the median deductible is $3,400. In Phoenix, it is $4,000; in Houston and Des Moines, $3,000.

Ms. Burwell said the administration had "seen high levels of satisfaction with the marketplace."

And the marketplaces do vary. In Newark, some plans have no deductible, although the median deductible is $2,000, according to HealthCare.gov.

"The deductible, $3,000 a year, makes it impossible to actually go to the doctor," said David R. Reines, 60, of Jefferson Township, N.J., a former hardware salesman with chronic knee pain. "We have insurance, but can't afford to use it."

Health officials and insurance counselors cite several mitigating factors. All plans must cover preventive services like mammograms and colonoscopies without a deductible or copayment. Some plans may help pay for some items, like generic drugs or visits to a primary care doctor, before patients have met the deductible. Under the Affordable Care Act, health plans must have an overall limit on out-of-pocket costs, to protect people with serious illness against financial ruin.

In addition, people with particularly low incomes can obtain discounts known as cost-sharing reductions, which lower their deductibles and other out-of-pocket costs if they choose mid-level silver plans. Consumer advocates say this assistance makes insurance a good bargain for people with annual incomes from 100 percent to 250 percent of the poverty level ($11,770 to $29,425 for an individual).

To those worried about high out-of-pocket costs, Dave Chandra, a policy analyst at the liberal-leaning Center on Budget and Policy Priorities, has some advice: "Everyone should come back to the marketplace and shop. You may get a better deal."

But for many consumers, the frustration is real, as is the financial strain. In employer-sponsored health plans, deductibles have also been rising as companies shift costs to workers. Still, the average annual deductible in employer plans, $1,320 for individual coverage according to the Kaiser Family Foundation, is considerably less than the deductibles in many marketplace plans.

The Internal Revenue Service defines a high-deductible health

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plan as one with an annual deductible of at least $1,300 for individual coverage or $2,600 for family coverage.

Sara Rosenbaum, a professor of health law and policy at George Washington University who supports the health law, said the rising deductibles were part of a trend that she described as the "degradation of health insurance."

Insurers, she said, "designed plans with a hefty use of deductibles and cost-sharing in order to hold down premiums" for low- and moderate-income consumers shopping in the public marketplaces.

Rising deductibles are part of a trend that she described as the "degradation of health insurance."

But the deductibles are so high they may be scaring away some consumers. Alexis C. Phillips, 29, of Houston, is the kind of consumer federal officials would like to enroll this fall. But after reviewing the available plans, she said, she concluded: "The deductibles are ridiculously high. I will never be able to go over the deductible unless something catastrophic happened to me. I'm better off not purchasing that insurance and saving the money in case something bad happens."

People who go without insurance next year may be subject to a penalty of $695 or about 2.5 percent of their household income, whichever is greater.

Karin Rosner, a 45-year-old commercial freelance writer who lives in the Bronx, pays about $300 a month, after a subsidy, for a silver insurance plan with a $1,750 deductible and a limit of $4,000 a year on out-of-pocket expenses.

She is extremely nearsighted and has an eye condition that puts her at risk for a detached retina, but has put off visits to a retina specialist because, she said, she would have to pay the entire cost out of pocket.

"While my premiums are affordable, the out-of-pocket expenses required to meet the deductible are not," said Ms. Rosner, who makes about $30,000 a year.

Mr. Fanning, the North Texan, said he and his wife had a policy with a monthly premium of about $500 and an annual deductible of about $10,000 after taking account of financial assistance. Their income is about $32,000 a year.

The Fannings dropped the policy in July after he had a one-night hospital stay and she had tests for kidney problems, and the bills started to roll in.

Josie Gibb of Albuquerque pays about $400 a month in premiums, after subsidies, for a silver-level insurance plan with a deductible of $6,000. "The deductible," she said, "is so high that I have to pay for everything all year – visits with a gynecologist, a dermatologist, all blood work, all tests. It's really just a catastrophic policy."

Another consumer, Anne Cornwell of Chattanooga, Tenn., said she was excited when Congress passed the Affordable Care Act because she had been uninsured for several years. She is glad that she and her husband now have insurance, because he has had tonsil cancer, heart problems and kidney stones this year.

But with a $10,000 deductible, it has still not been easy.

"When they said affordable, I thought they really meant affordable," she said.

Dr. Don McCanne's Quote of the Day blog September 18, 2015

Community health centers seeing more underinsured patients

At community clinics, underinsured replace uninsured

By Mark Zdechlik, MPR News

A few years ago, community health clinics routinely offered care to people with no health insurance. Today, offering care to people who have insurance – but still can't afford care – is becoming more common.

At the Sawtooth Mountain Clinic in Grand Marais, Minn., more people coming through the doors have a health plan, as required under the Affordable Care Act. But the plans with the lowest monthly premiums tend to have high deductibles.

Clinic CEO Rita Plourde said that for many clients, the problem now is being underinsured. They have health insurance but cannot afford the out-of-pocket costs.

In Coon Rapids, Nucleus Clinic gets some referrals from conventional clinics when patients are having difficulty with out-of-pocket expenses. Becky Fink, who runs the community reproductive health clinic, said that many patients with a high deductible health plan find it less expensive to bypass the insurance and pay cash.

Fink expects the growing demand for subsidized clinic services from people enrolled in health plans will continue despite the signature promise of Obamacare.

Dr. Don McCanne comments:

As we celebrate the successes of the Affordable Care Act, it is sobering to realize that the increasing prevalence of underinsurance is leaving many patients dependent on community health centers, much as they were before, when they were uninsured.

It is fortunate that our legislators, led by Sen. Bernie Sanders, recognized that there would still be a great need for community health centers and insisted on authorizing funding for these centers.

But wouldn't it be even better if everyone had comprehensive first dollar coverage? The clinics would no longer be geared to take care of mostly low-income patients but rather would be transformed into centers that could appeal to all of us, including specialists who would then welcome referrals from these centers.

All we need to do is to enact a well-designed single payer national health program, and the improvements would automatically follow.

This slightly abridged post is from Dr. McCanne's Quote of the Day, a daily health policy update from PNHP's senior health policy fellow. Readers can sign up to receive the QOTD via email at www.pnhp.org/qotd.

Brief comments on ColoradoCare

October 27, 2015

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

Organizers for the ColoradoCare ballot initiative have contacted some activists in Physicians for a National Health Program, seeking their endorsement and financial support. We summarize, below, our understanding of the initiative.

Description of the program

ColoradoCare is a ballot initiative for a publicly financed, universal health plan for the state of Colorado that would be operated by a private cooperative under a 21-person elected Board. While the ballot measure spells out the program's governance and Board structure in considerable detail, key aspects of the program are not specified, and/or left to the discretion of the Board. In the past the drafters made clear in public statements that ColoradoCare is NOT a single-payer plan.

The initiative would cover all Colorado residents under a publicly funded, cooperative insurance plan. While the new program would replace most private insurance, Medicaid and CHIP coverage, it would serve only as supplemental coverage for those covered by Medicare, the VA and TriCare. The initiative would not prohibit the purchase or sale of private coverage duplicating the public plan. However, proponents expect that little private insurance would persist, since most businesses and individuals would not want to pay twice for coverage.

The proposal would cover a broad range of benefits, but would not cover dental care for adults, or long-term care for most individuals.

ColoradoCare would be funded via a payroll tax of 6.67 percent on employers and 3.33 on employees, or 10 percent of non-payroll income (excluding pensions and annuities), along with federal funds that would have come to the state via subsidies for private coverage under the Affordable Care Act, for Medicaid, and for other programs.

The drafting of ColoradoCare was spearheaded by Colorado Sen. Irene Aguilar and psychologist Ivan Miller. Volunteers and paid staff gathered the signatures necessary to put it on the ballot. Journalist T.R. Reid has become a champion and spokesperson for the plan both inside and outside of Colorado.

Strengths of ColoradoCare

1. The proposal if implemented would cover all, or nearly all of Colorado's uninsured – apparently (and laudably) including the undocumented.
2. The proposal includes some useful cost-control features, notably the creation of an annual budget, and the ability to negotiate lower prices with pharmaceutical companies.
3. The plan allows for a free choice of primary care doctor.
4. The financing plan is more progressive than the current system.
5. ColoradoCare's organizers have mounted an impressive capaign with considerable mobilization.

Weaknesses of ColoradoCare

1. Multiple payers would persist – probably including private insurers. As a result, it sacrifices much of the administrative savings that could be realized through a true single- payer reform because providers would have to maintain much of their current cost-tracking and billing apparatus in order to apportion costs among the multiple payers. Published cost estimates for ColoradoCare overstate the savings that could be achieved through single payer, and do not take into account the additional costs entailed by ColoradoCare's failure to adopt a full single-payer structure.
2. The initiative makes no mention of how hospitals or other institutions would be paid – apart from a rhetorical nod favoring ACOs. It makes no mention of global budgeting, separating operating and capital payments, or other constraints on hospital capital spending. Global budgeting is critical to achieving administrative savings; separating operating and capital payments is a bedrock of effective health planning, which is essential for long-term cost containment.
3. The initiative would not ban for-profit hospitals or other providers, despite clear evidence that they inflate costs and compromise quality. For-profit ACOs (indistinguishable from HMOs in most respects) might also flourish.
4. The initiative specifies that patients would have a free choice of primary care physicians, but makes no mention of whether the choice of specialist or hospital could be restricted.
5. While the plan would outlaw deductibles, the Board could impose copayments.
6. While the 10 percent tax rate would apply to both the rich and poor (including those with incomes below the poverty line), income over $350,000 would not be taxed.
7. The campaign's anti-government rhetoric is problematic.
8. Rather than specifying critical aspects of the plan, the initiative leaves many of these to be decided later by the Board. Delaying such decisions has often favored corporate interests, who can intervene after the popular mobilization required to pass a reform has subsided. In the case of the ACA, corporate lobbying during the rule-making process attenuated cuts in Medicare HMO overpayments; reduced promised funding for public health and community clinics; effectively neutered limits on insurance overhead; and watered down the mandated benefit package. In Vermont, the broad-brush program initially passed by the legislature was whittled down in the detailed design stage, leading to rising cost estimates and ultimate rejection by the governor.

Dr. Ida Hellander is director of health policy and programs at Physicians for a National Health Program. Drs. David Himmelstein and Steffie Woolhandler are internists, professors at the City University of New York School of Public Health, lecturers in medicine at Harvard Medical School, and co-founders of PNHP.

HOUSTON CHRONICLE September 25, 2015

Head of physician group makes case for single-payer system

He points to 'tremendous gaps' years after passage of health act

By Jenny Deam

Dr. Robert Zarr, president of the Physicians for a National Health Program organization in Washington, D.C., was in Houston this week speaking to physicians and medical students at Baylor College of Medicine, promoting the idea of a single-payer system of health care in this country.

He sat down with the Chronicle to share his views. Edited excerpts follow.

Q: We are 5½ years into the Affordable Care Act. Has it been a success?

A: It depends a lot on who you are. It depends a lot on where you live. It depends a lot on what life was like before the passage of ACA. But in terms of hard numbers we know now, the U.S. Census Bureau has come out with another report, and we're down to 33 million uninsured in 2014, and that's down from 42 million the year prior. So from that sort of bird's-eye view, yes, more people have an insurance card in their back pocket. So that's great.

Dr. Robert Zarr

Q: It feels like there's a "but" coming.

A: There are tremendous gaps. There are approximately 31 million Americans underinsured, and that's not something we talk a lot about. We're all happy that we have this increase in insured, but what does it fully mean to have insurance? Does it mean you're going to get the care you need? Does it mean you're not going to be medically bankrupt? Does it mean you're going to stop worrying about whether you can afford to buy that medicine your doctor prescribed? And in large part, the answer is no.

Under-insurance is better understood by looking at medical bankruptcies. I love to point this out because it is a shocker: If you have about a million bankruptcies claimed every year, about 60 percent of them, 600,000, are medical bankruptcies. They couldn't pay their bills. What's even more interesting is that of those 600,000 every year, what percentage had insurance when they got sick? Seventy-five percent.

Q: That's an amazing statistic. What does that mean for people in this country?

A: What the ACA has done is made under-insurance the new norm. At the end of the day, you and I would like to be assured when we need care, we get it and we don't spend enormous amounts of our money out of pocket to get it. I think one of the biggest flaws of the ACA is it has relied more on private insurance. The reality is that ACA has bolstered the private insurance industry.

Q: What is the solution?

A: I sometimes say that what needs to happen is we're going to have to hate the insurance companies more than we fear the government to get to a sensible system. Even if you hate ACA, you very likely believe in entrepreneurship, you believe in free choice, you believe autonomy, and the only way to get to those things is through single payer.

Q: How would single payer work in this country?

A: Single payer is very simple, and that's why I love it. It's simply a progressive tax system. You generate the funds through a progressive tax, and you take that money and put it into a fund and you allow the private delivery of health care. So if you have a solo practice, or you have a family-owned pharmacy, or whatever you are, you keep doing what you are doing - except all of the bureaucracy of these hundreds of insurance companies disappears and you are left with one.

Q: What if you have a catastrophic illness versus someone who has the flu?

A: A runny nose, or a heart attack, a stroke, a dismemberment, it all gets paid for by this national health insurance fund. As a taxpayer you pay into that. It is the reality for most industrialized countries.

Q: The argument has often been the United States has the best standard of care in the world. Would such wholesale change jeopardize that?

A: The truth is we don't have the best health outcomes, in part because for every 1 million uninsured, we have 1,000 excess deaths every year. The World Health Organization has ranked us 37th in the world in a number of categories.

Q: But what if you are poor and don't pay taxes?

A: It's a progressive tax, so if you make zero income, you put in zero but you still get services.

Q: Isn't that where it all falls apart?

A: One day there is a good likelihood you will find yourself in a situation like the person you are talking about. We live in a civilized society. We care for each other. We know that people go through ups and downs in their lives.

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The Charlotte Observer

July 21, 2015

Charlotte doctors host advocate of Medicare for all

Despite ACA, doctor says need for reform remains

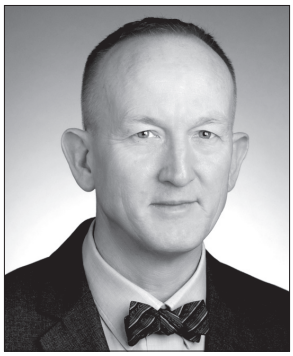
By Karen Garloch

Dr. Andrew Coates agrees with some critics of the Affordable Care Act. In many ways, he says the federal law "reinforced or worsened some of the most egregious inequalities and injustices in the health system."

Coates, a New York physician and immediate past president of Physicians for a National Health Program, suggests that the United States, like other developed nations of the world, should adopt a single-payer plan, such as Medicare. The federal program could be expanded to all citizens, not just those 65 and over or disabled.

He'll be in Charlotte on Thursday, at the invitation of Health Care Justice-North Carolina, to make his case for expanding Medicare. His free talk is 6-7:30 p.m. at Myers Park Baptist Church, Heaton Hall, 1900 Queens Road.

As Medicare marks its 50th anniversary this year, Coates said it's interesting to note the contrast between that popular "model of publicly financed comprehensive" health insurance compared with the "current mess" in the private health insurance market, "including the exacerbation of that mess by the Affordable Care Act."



Dr. Andy Coates

Like many others, Coates praises the ACA for expanding insurance coverage to many who previously had none or who were excluded because of pre-existing medical conditions. But he added that it "entrenched the interests of the private insurance companies." He said that the mandate for electronic medical records was a good idea but has not produced the projected cost savings.

"In terms of sweeping health reform, we did not get that with the Affordable Care Act," said Coates, chief of hospital medicine at Samaritan Hospital in Troy, N.Y., and assistant professor of medicine and psychiatry at Albany Medical College.

Coates acknowledges that a single-payer plan is not popular with leaders of either major political party. But he said there is agreement in the country that everyone should have comprehensive health insurance. "In Main Street America, that is absolutely a consensus. I've talked to big groups and small groups. Republican town councilmen and liberal Catholic clergy. The idea that everyone should have access to health care is not a real debate."

Despite arguments to the contrary, Coates said a single-payer plan would not be "a government takeover." Services would still be provided by private hospitals and doctors. The payment system would be administered by the federal government, and that would save millions of dollars in administrative costs that could then be spent on services, Coates said.

As Americans face higher deductibles and copays for insurance, the need for reform remains great, he says. "A health care crisis is still very likely to cause personal bankruptcy," Coates said. And when that happens, it's seen as a personal failure rather than a societal one.

"It's kind of a private shame. You see the collection jars at the fire company or the church. It's not seen as a collective shame and a scandal."

Karen Garloch is The Charlotte Observer's medical writer.

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

Q: As a nation, can we afford this?

A: There have been all kinds of cost analyses on single payer, and at the end of the day, 95 percent of the population is going to pay what they pay now or less to get a ton more, and 5 percent will pay a little bit more.

Q: Still, how do we get from where we are now to there, especially in such a politically divided climate?

A: We've been polling Americans for more than 15 years on this issue, and every poll I've seen says the vast majority of Americans want the establishment of national health insurance. We have polled physicians. People think physicians don't support this. They do. The public is onboard, the physicians are onboard, the unions are onboard. We have a lot of our country that wants this. Part of the problem is we're used to life as it is. We're willing on some level to accept it, and we hope it will get better. It's hard to find the extra energy to see what the future holds for us.

Jenny Deam writes on health care for the Houston Chronicle.

Journal of Urban Health
Bulletin of the New York Academy of Medicine
September 17, 2015

White Coats for Black Lives: Medical students responding to racism and police brutality

By Dorothy Charles, Kathryn Himmelstein, Walker Keenan, and Nicolas Barcelo, for the White Coats for Black Lives National Working Group

Last fall, Black people and their allies took to social media and the streets to assert that, despite the non-indictment of officers responsible for the deaths of Michael Brown and Eric Garner, Black lives matter. While these protests sparked national dialogue about racism and violence against communities of color, our medical school campuses remained silent and detached. As medical trainees invested in the lives and well-being of people of color, we felt called to action by the #BlackLivesMatter movement. Medicine is not immune to the racism that pervades our education, housing, employment, and criminal justice systems. Moreover, racism and police brutality damage the health and lives of people of color, particularly Black people, and must be addressed as a public health crisis.

Initially, students at different medical schools initiated conversations and planned separate actions to engage with larger, national struggles for racial justice. For example, students at the University of California San Francisco, School of Medicine and the Icahn School of Medicine at Mount Sinai independently planned die-in demonstrations regionally and locally, respectively, in solidarity with national die-ins in public spaces. Students at the Perelman School of Medicine at the University of Pennsylvania, who at the time were writing an open letter calling for a public response to racism from medical professionals, heard about the actions being planned at UCSF and Mount Sinai and created a line of communication among the three schools. Students at these schools coordinated a single, national die-in demonstration on December 10, International Human Rights Day.

Through social media, interpersonal connections, and a press release sent out by Physicians for a National Health Program, who endorsed the action, news of the die-in quickly spread nationwide. Ultimately, over 3000 students at more than 80 medical schools across the country participated in the action, demonstrating solidarity with communities protesting against racism and police brutality and publicly stating that health professionals must confront police violence and institutionalized racism. This message was not confined to individual campuses. Under the hashtag #whitecoats4blacklives, these actions trended on social media and were covered by traditional media, including print, radio, and TV, amplifying our message of solidarity and the call for racial justice in medicine.

Having created a national network of justice-minded medical students, we wanted to build on our classmates' energy around the protests and ensure that #whitecoats4blacklives was not simply a one-time action but an ongoing movement. Moreover, we wanted to continue to emphasize that the influence granted to physicians should be directed toward social progress for all, particularly to those most affected by racism and burdened by poor health outcomes. We therefore sought to reinvigorate efforts within the medical establishment to promote health equity and support communities of color in their struggles for justice. The national medical student organization, White Coats for Black Lives (WC4BL), was therefore created on Martin Luther King, Jr. Day, 2015, to further these goals.

In founding WC4BL, we identified three key levels on which medical students could promote racial justice. First, we must fight to eliminate racism in housing, criminal justice, education, and other areas as a threat to the lives and well-being of people of color. Second, we must end racial discrimination in the distribution and provision of medical care. Finally, we must demand that our medical schools create a physician workforce that reflects our nation's diversity and is prepared to fight for racial justice.

We recognize that discrimination based on insurance status is a mechanism of "color-blind" racial discrimination … and therefore support the creation of a single payer health insurance system.

To accompany these broad areas of work, we have outlined specific goals and action steps. We recognize that discrimination based on insurance status is a mechanism of "color-blind" racial discrimination: while patients cannot legally be denied care because of their race, patients of color are frequently turned away from hospitals because they do not have private health insurance. We therefore support the creation of a single payer health insurance system to ensure that all patients have access to the care they need. To address the underrepresentation of Black, Latino, and Native American people in medicine, we have pushed our schools to create recruitment, retention, and promotion policies that would ensure that people of color are represented among physicians at least at the same rate as they are among the general population. We believe that expanding the use of holistic admissions practices, for example, might increase access to medicine for people of color and enhance the learning environment for all trainees. We have further urged our medical schools to end their overwhelming curricular and research silence on the history of racism in medicine, the role of racism in creating disparate health outcomes, and strategies

for physicians to promote racial justice. Finally, we have called on individual physicians, physician organizations, and medical institutions to publicly acknowledge the role of structural racism in damaging the health of their patients of color and to join communities fighting for racial justice.

In the past 4 months, students at medical schools across the country have begun to take action on these goals. Students at dozens of schools, including Case Western, Baylor, and UC San Diego, have facilitated focus groups, 'town hall' meetings, and discussions among health professions students and administrators about health and racial justice. These discussions have led to curricular changes and the development of new structures to support the needs of faculty and students of color. Discussions at UCSF, for example, led the administrators to change the theme of the annual Dean's retreat to "Race Matters," which highlighted the relevance of race in student and faculty experiences, patient outcomes, and in scientific research. WC4BL also facilitated a photography project featuring portraits of students from Penn, NYU, UCSF, Yale, and Boston University describing what racial justice or equity in medicine meant to them and posted these photographs to social media. Finally, in support of our colleagues at SUNY Downstate, Columbia, and Einstein, the WC4BL National Working Group recently backed and circulated a letter to Surgeon General, Vivek Murthy that brought specific attention to the role of structural violence and racism to the health and wellbeing of communities of color.

WC4BL students have also added their voices to public protests against racism, brutality, neglect, and exclusion. Medical students in Baltimore, San Francisco, New York, and Philadelphia joined demonstrations over the police killing of Freddie Gray and other victims of police brutality. In addition to direct actions, students from Brown, Mount Sinai, Creighton, UCSF, and other medical schools have expressed their solidarity and concern through published articles and op-eds responding to incidents of police brutality and the injustices currently plaguing healthcare. Medical student participation in these efforts reflects a variety of motivations. For some, it is a reminder of life before medical school and a motivator to continue training in demanding circumstances. For others, it is an act of humility, an acknowledgement that privilege blinds us to the lives and needs of many of our neighbors and patients.

These organized actions and written pieces have generated discussion on medical campuses about the impact of racism on public health and the presence of racism within our healthcare system. Promoting awareness of these topics is, however, only the first step in eliminating racism. Our call to reflection must be followed by concrete action. Moving forward, we hope to continue working with our student peers nationwide to identify targets for sustainable institutional change. Opportunities for further action include organizing support within the healthcare community for the End of Racial Profiling Act in the Senate, creating medical student curricula and professional practice guidelines that address interpersonal and systemic manifestations of racism that affect the health of people of color, and joining national efforts to enact a single payer health insurance system.

Although we are trainees entering a hierarchical system, it is imperative that we advocate for change in medicine and other systems that affect the health of our patients and their communities. We are encouraged to see the movement of medical students fighting for racial equity in health care grow and intend to continue this work by building on students' activism and ideas. We look forward to collaborating with allies in other healthcare fields, including public health, nursing, and medical anthropology, to build a more equitable healthcare system and to support community-based efforts to promote racial justice. We hope that, as we expand our biomedical knowledge, we will also develop our humanity and solidarity, and that we will ultimately serve in a healthcare system and in a country that promotes the health and wellbeing of all of our patients.

Students at Boston University School of Medicine were among those participating in the White Coats for Black Lives photography project. Clockwise, from top left, are Victoria Gore, Deandre King, Olindi Wijesekera, and Stephon Martin. Photos by Ann Wang; PNHP illustration.

Acknowledgments

The White Coats for Black Lives National Working Group is further comprised of: Charlotte Austin, Elorm Avakame, Joniqua Ceasar, Georgia Himmelstein, Julia Jeffries, Giselle Lynch, Ezekiel Richardson, and Jennifer Tsai. This working group would like to further acknowledge all student participants and supporters of the White Coats for Black Lives student movement.

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HARVARD PUBLIC HEALTH REVIEW

July 20, 2015

Single-payer health reform: A step toward reducing structural racism in health care

By Dominic F. Caruso, M.D./M.P.H. candidate, David U. Himmelstein, M.D., and Steffie Woolhandler, M.D.

Racial and income equality are too often absent from conversations about health care financing. Research continually exposes alarming health disparities in the United States, particularly impacting African Americans and Native Americans. These groups have lower life expectancies than non-Hispanic white Americans, and experience higher rates of most major causes of death including infant mortality, trauma, heart disease, and diabetes. Yet despite their greater need, access to care is worse for minority populations by most measures.

Unequal medical care is often viewed as a consequence of broader social inequalities, but the current health financing system also reinforces and institutionalizes inequality; unequal care may be viewed as a form of structural racism.

While most Americans rely on private insurance, rates of private coverage are much lower for minorities and the poor.

The Patient Protection and Affordable Care Act (ACA) offered subsidies to expand private coverage, making insurance more affordable for many families. However, many of these new private plans carry high deductibles and co-payments. Deductibles for the ACA's bronze and silver plans average over $5000 and $2900, respectively, for single coverage, and over $10,000 and $6,000, for family coverage.

Deductibles have also soared in employer-sponsored plans; in 2014, more than 40% of such plans carried a deductible of more than $999, up from just 10% in 2006. Moreover, while Medicaid traditionally imposed virtually no cost-sharing, several conservative state governors have extracted waivers from the Centers for Medicare and Medicaid Services allowing the imposition of cost-sharing on recipients as a condition for implementing the ACA's Medicaid expansion.

High cost-sharing particularly impacts minority families, whose average incomes are far lower than those of non-Hispanic whites. Yet even figures on income disparities understate minorities' disadvantage when confronted with high out-of-pocket costs. With medical bills often reaching into the thousands for even routine care such as childbirth and appendectomy, many families must tap savings or other assets like housing equity, and racial/ethnic disparities in assets dwarf the differences in income. African American and Hispanic median household income was 58 percent and 70 percent, respectively, that of non-Hispanic whites in 2011. In contrast, the median net worth of black and Hispanic householders was $6,314 and $7,683, respectively, vs. $110,500 for non-Hispanic whites, a 15-fold difference. Hence, the average family deductibles for bronze and silver plans would bring financial ruin to most African American and Hispanic households. Even the lower cost-sharing now increasingly common under Medicaid may be prohibitive for poor families, many of whom have zero or negative net worth.

The ACA's drafters erred in relying on private, for-profit insurers to fund health care. Health insurance's social purpose is to pay for care in order to promote access to health services and prevent financial hardship. For-profit insurers' purpose is to maximize shareholders' profits, a goal that provides strong incentives to maximize premiums and minimize the health care they pay for. Historically, this incentive led to such practices as denying coverage for pre-existing conditions and canceling policies for expensive enrollees. Although the ACA prohibits these tactics, recent evidence indicates that insurers are finding ways to subvert these regulations, e.g. through tiered pharmacy benefits that discriminate against enrollees with potentially expensive illnesses such as HIV, Parkinson's, seizures, psychosis and diabetes.

Unequal medical care is often viewed as a consequence of broader social inequalities, but the current health financing system also reinforces and institutionalizes inequality.

The persistence of our corrupt and irrational insurance system may stem in part from the way Americans (and particularly health professional students) are taught to think about health care. In a recent conversation with a Canadian student at Harvard's school of public health, he expressed surprise that many of his U.S. classmates perceive health care interactions as business transactions, and reflected that Canadians, who have a publicly-funded universal coverage system, view health care as a fundamental right to be provided for all.

Should we in the U.S. continue to treat health care as a commodity distributed according to financial ability, or shift to a financing system that assures it as a right equally available to all without regard to income, health status, race or ethnicity? While market theorists might claim that a commodity-based approach to care breeds efficiency, facts on the ground argue otherwise. At present, we have the world's highest per-capita health care expenditures, yet tens of millions remain un- and under-insured, and our health outcomes trail most other wealthy nations.

This isn't just an indication of failed policy, it's a national em-

(continued on next page)

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

barrassment. We have the resources to provide everyone in the U.S. with access to health care. And Canada provides a working model for how to put those resources to good use: a public, single-payer, national health insurance program, similar to an expanded and improved Medicare for all.

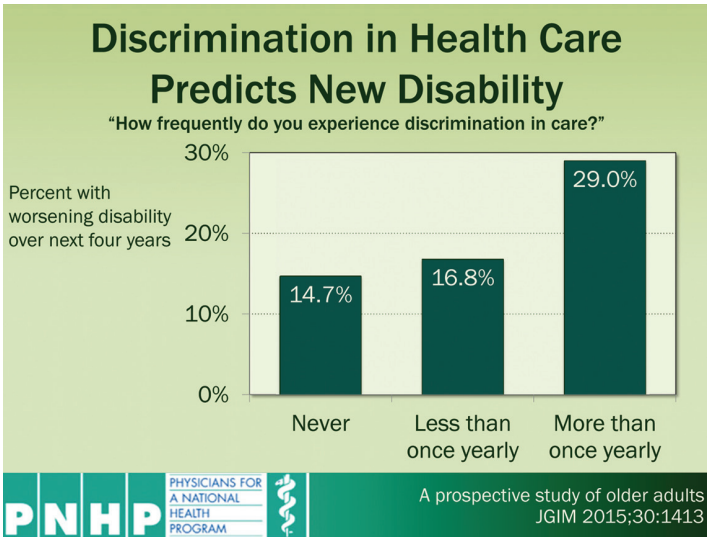
In our view a national single-payer health insurance program offers the best possibility for equitable financing of U.S. health care. It would eliminate the motive to deny needed care or discriminate against the expensively ill for the sake of profit. A national public insurance system would provide coverage based on residence in the U.S., not employment status, income level or ability to pay, as in the current regime. A program that abolished co-payments and deductibles would level the playing field for minorities and the poor who generally lack the assets to surmount these barriers.

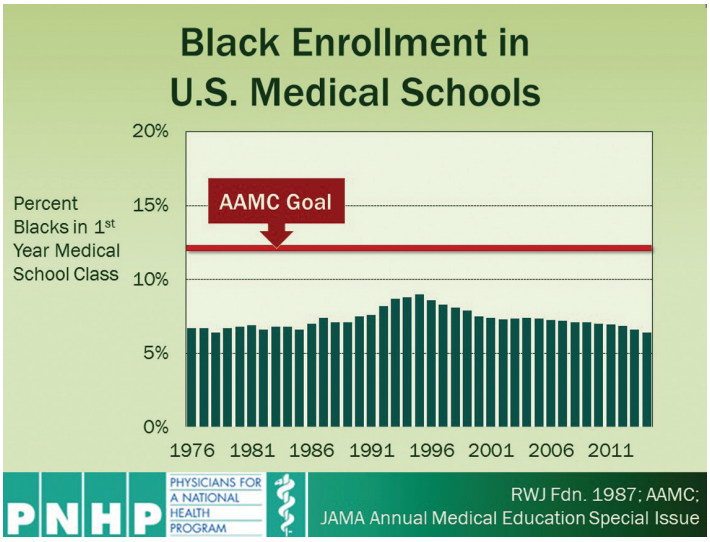
A single-payer system would also offer economic benefits. A federally-run financing system would have far lower administrative costs than private insurance, as the Medicare program consistently demonstrates. A universal public model would lift a significant financial burden from businesses that currently fund health insurance for their employees. Finally, a single-payer program would largely eliminate the financial burden of illness, a leading cause of bankruptcy and debts sent to collection.

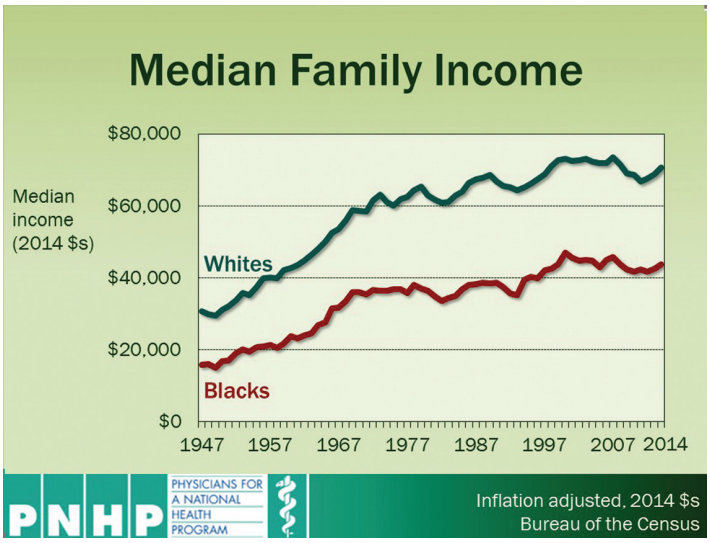
Perhaps most importantly, a single-payer system would make a clear statement that health care is a human right. This framework recognizes health care as a universal necessity, not a commodity reserved for those lucky enough to have won the economic lottery, and most definitely not a scheme for denial and discrimination. While implementing a single-payer insurance program will not solve all of our nation's health, racial or social inequities, it is clearly a step in that direction.

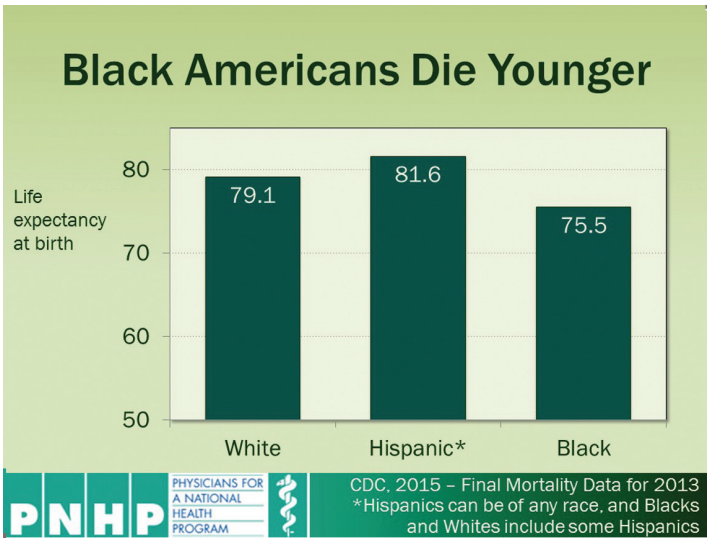
References for this article are available at bit.ly/1Nex6Yi.

Four slides from PNHP's 2015 slideshow









The above four graphs are adapted from the "Persistent Racial Inequalities" section of the 2015 PNHP slideshow prepared by Drs. David Himmelstein and Steffie Woolhandler in connection with PNHP's Annual Meeting in Chicago in October. The full slideshow is available at www.pnhp.org/slideshows, password = zarr.

SJR
The State Journal-Register

September 27, 2015

U.S. policies hinder good health care for all

By Anne Scheetz, M.D.

During September we observe Sickle Cell Disease Awareness Month with the goal of bringing greater attention to this genetic disease that affects 4,000 to 5,000 Illinoisans.

A disease of red blood cells, SCD can affect many body organs, including brain, bones, heart and lungs. Some people have few symptoms; others suffer serious complications such as childhood strokes, pneumonia, episodes of severe pain (pain crises), leg ulcers and early death. Under the best conditions SCD causes great suffering to severely affected people. With inadequate care, suffering is much worse.

Dr. Anne Scheetz

Medical advances, including medications, blood transfusions and treatment of stroke risk, have improved symptoms, reduced organ damage and prolonged life for many people. All can have adverse effects. Stem cell transplants appear to cure select cases but carry a risk of death.

Known ancestry does not reliably indicate risk, so all infants should be screened. But most patients are black. Being black and being sick are risk factors for poverty; personal poverty and living in poor neighborhoods in turn adversely affect health.

People with severe forms of the disease require a lot of care. But current U.S. policy systematically erects barriers to care.

Doctors are supposed to keep patients healthy, and failure to do so is considered a sign of poor practice. Yet SCD is rarely curable, and many complications, including pain crises, are not preventable. Patients who suffer pain crises require frequent hospitalizations. Yet Medicare and Illinois Medicaid penalize hospitals for re-admissions.

People with Sickle Cell Disease suffer unnecessarily from policies that prevent good care, policies that stem from our private-insurance-based system. It doesn't have to be this way.

Despite increases in insurance coverage under the Affordable Care Act, people with SCD can find themselves uninsured. They can end up in high-deductible health plans. They may fail to get care or suffer financial hardship, and the stress of such pressures further worsens their health.

Pre-authorization requirements make it difficult for patients to get wound care products and medications on time. Network restrictions prevent people from getting care from their doctors and hospitals of choice. Restriction to a single pharmacy, required under some health plans, prevents people from going elsewhere for out-of-stock pain medicines. Some essential services, such as dental care, which is important for good nutrition, are not covered for most people with SCD as for most Americans.

U.S. health insurance plans are highly variable, and even the best do not cover all necessary care or provide first-dollar coverage. Insurance companies make their own determinations that certain treatments are experimental or not medically indicated, and drugs commonly used for chronic conditions may require high co-pays.

In summary, people with SCD, like people living with other chronic diseases, suffer unnecessarily from policies that prevent good care. It doesn't have to be this way. Lack of health insurance, unaffordable out-of-pocket costs, network restrictions, preauthorization requirements and penalties for readmissions all stem from our private-insurance-based system.

Under a Medicare-for-all system every U.S. resident would have first-dollar coverage for all necessary care. Patients and their clinicians would make medical decisions. Everyone would have complete choice of hospitals, pharmacies and other providers. Financing by a progressive tax would transfer wealth from the top down, with the greatest benefit going to those currently most disadvantaged, including poor people, people of color and all sick people.

Instead of creating barriers to care, we would greatly simplify administration, saving $400 billion per year – more than enough to cover the uninsured and eliminate deductibles and co-payments for all of us.

What better way to observe SCD Awareness Month than by pressing for a system that would allow us to provide the best care to people affected by this disease?

Dr. Anne Scheetz is a founding member of the Illinois Single-Payer Coalition and a leader of the Illinois chapter of Physicians for a National Health Program. She lives in Chicago.

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Medicare's pay-for-performance incentives unfairly penalizing safety-net hospitals: Annals of Internal Medicine editorial

Using unproven, 'value-based' penalties and bonuses, and ignoring socioeconomic disparities between patient populations, Medicare is diverting money from hospitals serving largely minority and low-income Americans to hospitals serving the more affluent

FOR IMMEDIATE RELEASE, September 8, 2015

Medicare's pay-for-performance incentives, which financially reward or punish hospitals depending on whether they hit specific numerical targets in matters such as curbing inpatient readmissions, are having the unintended side effect of taking dollars away from the nation's historically cash-strapped safety-net hospitals and boosting the revenue of wealthier hospitals that serve an economically better-off patient base.

That's one of the conclusions of an evidence-based editorial in today's [Tuesday, Sept. 8] Annals of Internal Medicine. The article, titled "Collateral Damage: Pay-for-Performance Initiatives and Safety-Net Hospitals," is written by two leading health-system researchers, Drs. Steffie Woolhandler and David U. Himmelstein, professors at the City University of New York School of Public Health and lecturers in medicine at Harvard Medical School.

"Medicare's P4P [pay-for-performance] program, which does not adjust for patients' socioeconomic status, assumes that bonuses and penalties will prod substandard providers to improve or see their patients migrate to higher-quality options," Woolhandler and Himmelstein write. "However, when quality problems are due to a hospital's financial distress and patients cannot go elsewhere, penalizing low scorers may well punish patients and exacerbate quality disparities. Prescribing a starvation diet for safety-net hospitals that are strapped for cash and are quality challenged makes no sense unless the goal is to close them."

The Woolhandler-Himmelstein commentary appears alongside a study led by Matlin Gilman at Rollins School of Public Health at Emory University in Atlanta of more than 3,000 acute care hospitals in 2014. That study examines the financial impact of Medicare's Value-based Purchasing program and Hospital Readmissions Reduction Program, two P4P initiatives inspired by the Affordable Care Act, and finds that, in fact, safety-net hospitals are suffering disproportionate penalties from the programs.

Woolhandler and Himmelstein say that the Gilman study's findings were "not unexpected," given the findings of related research. They also note, in view of the researchers' methods, the study very likely understates the extent of the disparity in penalties.

The evidence for the efficacy of P4P measures in medicine is "surprisingly slim," they write, and such programs can actually backfire by demoralizing physicians and crowding out the intrinsic motivation they have to do good work, for example.

The authors note that P4P schemes are easily "gamed" by hospital administrators who engage in such practices as encouraging physicians to upcode (that is, exaggerate) diagnoses to make the hospital's medical outcomes look better, or to place early returning Medicare patients in extended "observation stays" (which Medicare doesn't count as readmissions) rather than readmitting them as inpatients.

Even when it comes to gaming, the authors write, non-safety-net hospitals have a technological and economic advantage over safety-net hospitals – again, to the latter's detriment.

Woolhandler and Himmelstein warn that Medicare's P4P measures – particularly when combined with another provision of the ACA that mandates cuts to special federal payments (Disproportionate Share Hospital funds) to safety-net hospitals – will exacerbate existing inequalities and pose a threat to many large urban hospitals that have been mainstays of care for millions of people in low-income and minority communities.

"Paying for quality has strong intuitive appeal," the authors write. "However, as with other medical interventions, intuition may mislead, and adopting everywhere policies that have been proven nowhere puts millions at risk for unintended consequences."

In addition to their academic posts, Himmelstein and Woolhandler are primary care doctors in New York City. They are also co-founders of Physicians for a National Health Program (PNHP), an organization of 19,000 doctors who advocate for a single-payer national health insurance program. PNHP played no role in funding or otherwise supporting their article.

In a comment today, Woolhandler, who has worked as a primary care physician in safety-net hospitals for decades, said, "We need a single-payer system that treats all patients, and all hospitals, equitably."

Dr. Claudia Fegan, who is the Chicago-based national coordinator of PNHP and who also works in a safety-net hospital, added: "We take care of patients that no one else is prepared to take care of. As a result, we are victimized by the adverse selection created by a society that has yet to fully accept its obligation to take care of everyone."

"Collateral Damage: Pay-for-Performance Initiatives and Safety-Net Hospitals." Steffie Woolhandler, M.D., M.P.H., and David U. Himmelstein, M.D. Annals of Internal Medicine, online ahead of print, Sept. 8, 2015.

HealthAffairs Blog

August 27, 2015

Quality Improvement: 'Become good at cheating and you never need to become good at anything else'

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

The Centers for Medicare and Medicaid Services (CMS) has trumpeted the recent drop in hospital readmissions among Medicare patients as a major advance for patient safety. But lost amidst the celebration is the fact that hospitals are increasingly "observing" patients (or treating returning patients in the emergency department) rather than "readmitting" them. But while re-labeling helps hospitals meet CMS' quality standards (and avoid costly fines), it probably signals little real quality gain and often leaves patients worse off financially.

Observation Status

Debate over the seemingly arcane subject of "observation status" has blossomed in recent years because billions of Medicare payment dollars are at stake. What is "observation status?"

According to MedPac (page 57): "If a Medicare patient does not initially meet the criteria for inpatient admission but the attending physician concludes the patient should be observed in the hospital for a period of time before being sent home, the patient can remain in the hospital in observation status. Observation stays are billed as outpatient services rather than inpatient admissions."

In most cases, observation patients receive care in a regular inpatient unit, and get treated just like other inpatients. And in many cases, observation stays stretch out to several days: in 2012, 26 percent lasted two nights and 11 percent at least three. But from Medicare's point of view, this is outpatient care, which leaves patients responsible for more of the bill, and ineligible for Medicare-paid rehab or skilled nursing care.

Hospitals started designating more stays as "observation" after Medicare's auditors began disallowing the entire payment for some brief hospital "admissions." Even though "observation stays" pay less than inpatient admissions, hospitals took a better safe than sorry approach, classifying many brief stays as "observation." Between 2006 and 2013, observation stays increased by 96 percent, accounting for more than half of the apparent decline in total Medicare admissions during that seven-year period (see page 55).

Observation Classification

Medicare's recent adoption of penalties for readmissions offered hospitals a new incentive to shift some patients returning within 30 days of their discharge to observation status. A patient stay labeled "observation" doesn't count as a readmission, allowing hospitals that might otherwise be fined for having too many readmissions to skirt the penalty.

Recent data indicates that such gaming isn't just a theoretical possibility.

About 10 percent of all hospital stays occurring within 30 days of discharge are now classified as "observation"; a quarter of hospitals classified 14.3 percent or more of all repeat stays as "observation." Moreover, analysis of time trends in observation stays makes it clear that they account for a significant chunk of the reduction in readmissions. Between 2010 and 2013, 36 percent of the claimed decrease in readmissions was actually just a shift to observation stays.

Emergency Department Use

And it's not just observation stays that have been on the increase. More of the recently discharged patients are being treated in emergency departments (EDs) – without being admitted – as well.

Factoring in the 0.4 percent increase in ED visits within 30 days of discharge, the fall in the percent of discharged patients returning to hospitals for urgent problems is only 0.3 percent over the past three years – less than one-third of the improvement that CMS claims. And even this 0.3 percent overall fall may be partly an artifact of hospitals' "upcoding" (exaggerating the severity of patients' illnesses), which boosts diagnosis-related group (DRG) payments, and could also corrupt the formula used to risk-adjust expected readmission rates.

For patients discharged after heart attacks, the urgent return rate has actually risen slightly; the reported 1.8 percent fall in readmission is more than offset by a 0.7 percent increase in observation stays and a 1.2 percent increase in ED visits.

These aggregate figures surely hide vast differences among hospitals. Some hospitals have undoubtedly reduced readmissions by doing the hard work of fully stabilizing fragile patients prior to discharge, improving communications with outpatient providers, assuring diligent follow-up, etc.

But others appear to be hitting their readmission targets mostly by gaming the system – re-labeling rather than re-designing care. Medicare rewards both approaches equally, but for hospitals, re-labeling is probably far cheaper (and more profitable) than re-designing.

Medicare's readmission penalties are among the growing number of pay-for-performance (P4P) and value-based purchasing initiatives that offer bonuses to high performers and/or penalize the laggards. We previously pointed out that the evidence for

this carrot and stick approach is unconvincing. More recently, a long-term follow-up of the English hospital P4P program found that P4P generated no improvement in patient outcomes damping the enthusiasm generated by the rosy short-term findings, and reinforcing the need for skepticism.

Adopting unproven everywhere P4P strategies that have been proven nowhere risks quality failure on a monumental scale. It pressures hospitals to cheat, saps doctors' and nurses' intrinsic motivation to do good work even when no one is looking, and corrupts the data vital for quality improvement.

As the graffiti artist Banksy once said: "Become good at cheating and you never need to become good at anything else."

Drs. David U. Himmelstein and Steffie Woolhandler are internists, professors at the City University of New York School of Public Health, lecturers in medicine at Harvard Medical School, and co-founders of Physicians for a National Health Program.

Health Affairs

October 2015

High-cost patients had substantial rates of leaving Medicare Advantage and joining traditional Medicare

By Momotazur Rahman, Laura Keohane, Amal N. Trivedi, and Vincent Mor

Abstract

Medicare Advantage payment regulations include risk-adjusted capitated reimbursement, which was implemented to discourage favorable risk selection and encourage the retention of members who incur high costs. However, the extent to which risk-adjusted capitation has succeeded is not clear, especially for members using high-cost services not previously considered in assessments of risk selection. We examined the rates at which participants who used three high-cost services switched between Medicare Advantage and traditional Medicare. We found that the switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction for participants who used long-term nursing home care (17 percent versus 3 percent), short-term nursing home care (9 percent versus 4 percent), and home health care (8 percent versus 3 percent). These results were magnified among people who were enrolled in both Medicare and Medicaid. Our findings raise questions about the role of Medicare Advantage plans in serving high-cost patients with complex care needs, who account for a disproportionately high amount of total health care spending.

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doi: 10.1377/hlthaff.2015.0272

American Journal of PUBLIC HEALTH

November 12, 2015

Access to Care and Chronic Disease Outcomes Among Medicaid-Insured Persons Versus the Uninsured

By Andrea S. Christopher, MD, Danny McCormick, MD, MPH, Steffie Woolhandler, MD, MPH, David U. Himmelstein, MD, David H. Bor, MD, and Andrew P. Wilper, MD, MPH

Abstract *(excerpt)*

Objectives. We sought to determine the association between Medicaid coverage and the receipt of appropriate clinical care.

Results. Respondents with Medicaid were more likely than the uninsured to have at least 1 outpatient physician visit annually, after we controlled for patient characteristics (odds ratio [OR] = 5.0; 95% confidence interval [CI] = 3.8, 6.6). Among poor persons with evidence of hypertension, Medicaid coverage was associated with greater awareness (OR = 1.83; 95% CI = 1.26, 2.66) and control (OR = 1.69; 95% CI = 1.32, 2.27) of their condition. Medicaid coverage was also associated with awareness of being overweight (OR = 1.30; 95% CI = 1.02, 1.67), but not with awareness or control of diabetes or hypercholesterolemia.

Conclusions. Among poor adults nationally, Medicaid coverage appears to facilitate outpatient physician care and to improve blood pressure control.

doi: 10.2105/AJPH.2015.302925

INTERNATIONAL JOURNAL OF HEALTH SERVICES

November 6, 2015

Cost Sharing, Health Care Expenditures, and Utilization: An International Comparison

By Patryk Perkowski and Leonard Rodberg

Abstract

Health systems implement cost sharing to help reduce health care expenditure and utilization by discouraging the use of unnecessary health care services. We examine cost sharing in 28 countries [excluding the United States, an outlier lacking a true national system, and six other nations] in the Organisation for Economic Co-operation and Development from 1999 through 2009 in the areas of medical care, hospital care, and pharmaceuticals. We investigate associations between cost sharing, health care expenditures, and health care utilization and find no significant association between cost sharing and health care expenditures or utilization in these countries.

doi: 10.1177/0020731415615312

JACOBIN

September 22, 2015

Your wallet or your life

A lifesaving drug's overnight price hike shows why we must fight for a radically different health care system

By A.W. Gaffney, M.D.

Two individuals – both infected by the single-celled parasitic protozoa Toxoplasma gondii – "showed prompt, dramatic responses" after being started on a two-drug cocktail.

One of the drugs was pyrimethamine, also known by its brand name, daraprim. A recent dramatic medical advance? Not quite. This report – one of the earliest reported uses of the regimen for toxoplasmosis – appeared in the New England Journal of Medicine in 1957. Daraprim has been a first-line treatment for toxoplasmosis – a serious threat to the immunocompromised and to the newborns of infected women – ever since.

But when Turing Pharmaceuticals CEO Martin Shkreli saw daraprim, he didn't see an immutably inexpensive, age-old drug – he saw a gold mine.

As the New York Times reported on Sunday, the former hedge fund manager's pharmaceutical startup bought the drug last August. It then promptly raised the price fifty-five-fold, from $13.50 to $750 a tablet (in fact, it was a mere $1 a tab prior to an earlier acquisition).

Dr. Adam Gaffney

The circumstances of this money grab – an enormous increase in the price of a relatively ancient drug often relied upon by AIDS patients – might seem particularly pernicious. Yet this "gigantic overnight increase," as the Times called it, should not be viewed as an isolated incident. As a perspective in the New England Journal put it late last year:

"It is well known that new brand name drugs are often expensive, but US health care is also witnessing a lesser known but growing and seemingly paradoxical phenomenon: certain older drugs, many of which are generic and not protected by patents or market exclusivity, are now also extremely expensive.

An article in the Times last year, for instance, described exploding prices for a wide variety of generics, including the aged antibiotic doxycycline, which went from $20 to $1,849 a bottle.

The phenomenon of soaring pharmaceutical price tags is also not limited to the genus of the generics. On the contrary, the big headline-earners in recent years have been for new, extremely high-priced "specialty" drugs, whose patents effectively permit monopolistic pricing.

And this is why the story of galloping prices for decades-old medications is so revealing. Big Pharma apologists have long argued that high drug prices are a reflection of the cost of paying for drug research and development. Government interference will invariably inhibit innovation, the argument goes – and in the end we'll all suffer.

But $750-a-tablet daraprim disproves this well-honed PR defense: Turing Pharmaceutical didn't spend a dime on developing the drug or testing it in clinical trials. It is simply pricing the drug, as the saying goes, at "what the market will bear." The "market" of Toxoplasmosis-sufferers is, of course, a particularly vulnerable one. But this is the essential explanation for rising prices among both generic and patented drugs, drugs for asthma and hepatitis C and cystic fibrosis.

In other words, the massive spike in the cost of daraprim is a result of the political economy of American health care. The profiteering of Turing and like-minded companies aren't aberrations that can be dealt with by case-by-case shaming (and anyways, Shkreli seems unbothered by such castigation). The fundamental flaw is the system, not one admittedly repugnant CEO.

What, then, would a more just pharmaceutical framework look like?

A good first step would be to get rid of the statute, enshrined in the 2003 Medicare and Modernization Act, that prevents Medicare from bargaining with drug companies over prices, a reform that was left out of the Affordable Care Act to appease Big Pharma. According to a 2013 estimate by Dean Baker of the Center for Economic and Policy Research, allowing Medicare to negotiate drug prices down to what Canada or Denmark pays would save hundreds of billions of dollars over a decade.

When Turing Pharmaceuticals CEO Martin Shkreli saw daraprim, he didn't see an immutably inexpensive, age-old drug – he saw a gold mine.

Of course, we don't all have Medicare, so this would only go so far. A single-payer national health program – with universal coverage and comprehensive benefits including drugs – would directly negotiate prices with pharmaceutical companies for everyone in the country, thereby producing much larger savings. Such a program would also eliminate drug copayments, which function as a "tax on sickness" that, as study after study has shown, deters people from taking important medications.

(continued on next page)

HARVARD SCHOOL OF PUBLIC HEALTH / STAT | Reporting from the frontiers of health and medicine

November 2015

The controversy over rising drug prices: The public's views

Excerpts:

A new poll of adults in the United States by STAT and Harvard T.H. Chan School of Public Health finds that public concerns about the unreasonableness of brand-name prescription drug prices is fueling support for major governmental action to negotiate or set brand-name drug prices in the future.

About three-fourths (76 percent) of the public believes that brand-name prescription drug prices are unreasonably high today. This contrasts with the much lower 26 percent that believe generic prescription drug prices are unreasonable. A majority of both Democrats (80 percent) and Republicans (70 percent) believe brand-name prescription drug prices are unreasonable. This view was also found among both the 20 percent who reported that paying the costs of prescription drugs was a major problem for themselves and their families and the 80 percent who did not report that it was major problem.

Although much media attention has been focused on a small number of very high-priced medicines to treat serious diseases, a majority of the public (54 percent) report being more concerned about future rising prices for more routine brand-name drugs than about very high-cost drugs (30 percent).

In addition, the pressure for government intervention here is being spurred even further by the public's response to recent cases of pricing decisions by pharmaceutical companies that received substantial media attention. Two such cases were inquired about in this poll. [A pharmaceutical company raising the price of the standard drug used to treat a rare, life-threatening parasitic infection by more than 5,000 percent, from $13.50 to $750 per pill; and a pharmaceutical company launching an exclusive new drug to cure hepatitis C and set the price at $1,125 per pill, or about $100,000 for a full course of treatment.] In both cases, more than 90 percent of the public sees the companies' pricing decisions as being unreasonable, although they represent different types of medical situations. …

The controversy over high drug prices comes at a time when the pharmaceutical industry is seen less favorably than in the past by the public in general. Almost two decades ago, when the public was asked to assess how well pharmaceutical companies were serving their consumers, nearly eight in ten (79 percent) said they were doing a good job, 19 percent a bad job (Harris Poll, February 1997). The STAT /Harvard T.H. Chan School of Public Health poll finds that 49 percent now say pharmaceutical companies are doing a good job, 41 percent a bad job. When asked which of three factors contributes most to drug prices, a majority (53 percent) of Americans identified pharmaceutical company profits as the chief cause. That is more than double the 25 percent that believed pharmaceutically related medical research was the main reason. The proportion believing that profits are the most important contributor to drug prices rose from 42 percent in an April 2003 Harris Poll.

For the full report, visit bit.ly/1Suu0gZ.

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

These changes would go a long way towards rationalizing drug prices and unburdening the sick. However, deeper reform – aimed not only at lowering the cost of drugs, but also at improving their overall therapeutic potential – is needed.

Some notable exceptions notwithstanding, pharmaceutical development in recent years has been rather disappointing. In a 2012 article in the British Medical Journal, health policy scholars Donald Light and Joel Lexchin laid out this criticism well, arguing that the pharmaceutical industry's flawed approach towards drug development produces "mostly minor variations on existing drugs" that are usually "not superior on clinical measures." The pursuit of truly innovative new molecules, in other words, is discarded in favor of highly lucrative, derivative drugs – a consequence of a "hidden business model," as they describe it, that spends an estimated $19 on marketing for every $1 on basic research.

One potent fix would be direct public sponsorship of drug development, with therapeutic impact – not profitability – as the overall aim. Drugs would essentially become a public good. Without patent production, they could be cheaply produced throughout the world, increasing their accessibility in even the poorest countries.

The "conquest of disease," if clichéd, should be a fundamental goal for a just society – one that's far too important to be left to the likes of Turing Pharmaceuticals.

Above all, we should see the soaring price of daraprim as a symptom of a much deeper malady: a system based on the notion that health is not a social right, but instead a commodity that, in the very process of enriching some, impoverishes others.

A.W. Gaffney is a physician whose work has appeared in Salon, Dissent, and In These Times. He blogs at theprogressivephysician.org.

Outlook

July 2015

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New drug pricing: does it make any sense?

By Marc-André Gagnon

Why are drugs so expensive? A business model going adrift

Specialty drugs, also referred to as niche drugs because they usually target narrow markets, are generally very expensive. What is new, however, is the general trend for these specialty drugs to become the main driving factor for escalating costs in national health systems. A recent example is sofosbuvir (Sovaldi, or combined with ledipasvir in Harvoni), which would more than double the total cost of prescription drugs in the United States if every patient infected with hepatitis C virus were treated with these drugs.

Although only about 1% of prescriptions are for specialty drugs, they can account for more than one-quarter of total expenditure on prescription medications. And spending on specialty drugs is anticipated to quadruple by 2020. Unlike sofosbuvir, most new niche drugs often provide only marginal therapeutic benefits. In oncology for example, they sometimes prolong survival by only a few weeks, but provoke serious adverse effects and can cost more than US$100 000 per patient per year.

The significant and growing disparity between the therapeutic value of many new niche drugs and their price explains why these drugs are at the heart of the pharmaceutical industry's new business model.

Drug prices are not related to their research and development costs

The pharmaceutical industry often tries to justify high drug prices by claiming that they are necessary to fund the research and development (R&D) of new products. This would mean that the industry sets its prices at a level where it would recover the cost of its investments. However, in practice, there is little or no correlation between the price of a particular drug and the company's R&D investment, no more than between a drug's price and the cost of its production.

Costs of research and development: putting the industry's own estimates into perspective. According to the estimates of the Tufts Center for the Study of Drug Development, an institute largely funded by the pharmaceutical industry, it costs US$2.56 billion on average to develop a new drug up to the point where marketing approval is obtained.

This estimate is strongly disputed however. It is based on confidential data supplied by pharmaceutical companies, concerns a selected sample from among the most costly drugs, and is marred by a lack of transparency over the data presented. According to GlaxoSmithKline's CEO himself, Andrew Witty, the idea that it costs on average over US$1 billion to bring a new drug to the market is a myth, and the pharmaceutical industry could certainly be more efficient. For example, Fortune magazine demonstrated the inefficiency of Pfizer's in-house R&D, which succeeded in bringing only nine new drugs to the market between 2000 and 2008 despite spending US$60 billion on R&D, making a record average cost of US$6.7 billion per drug. Should patients be willing to pay more for this company's drugs because of its higher R&D costs due to its inefficiency?

Finally, half of this US$2.56 billion figure corresponds to the estimated "lost earnings" due to the fact that the money invested in R&D was not invested elsewhere (the opportunity cost of the investment). The estimate does not however take into account the generous tax credits generally given to pharmaceutical companies, which can account for up to half of R&D costs.

In summary, even using these data as a basis, actual spending would amount on average to about one-quarter of the claimed US$2.56 billion for each approved drug.

Costs of research and development are closer to US $100 million. Other independent estimates of the cost of R&D per drug arrive at very different results from those of the Tufts Center. A North American group of researchers recalculated the Tufts Center figures using a more comprehensive methodology to include cheaper drugs in their calculation and drugs produced in part with public funds or tax credits. According to these authors, the mean cost is closer to US$90 million per new drug and the median cost US$60 million. Based on 10 years' experience with the non-profit research organisation Drugs for Neglected Diseases Initiative, the non-governmental organisation Médecins sans Frontières (Doctors without Borders) considers that the average cost is actually about US$50 million per new drug, or US$186 million if drug candidates that fail to make it to the market are taken into account. A systematic review of publications on R&D costs shows that in reality it is impossible to get a precise idea of what the R&D of a new drug costs.

The exact cost of R&D does not really matter; the goal is to maximise profits. According to Pfizer's CEO, Hank McKinnell, "It's a fallacy to suggest that our industry, or any industry, prices a product to recapture the R&D budget". The exact cost of R&D does not really matter: prices are set simply to maximise profits and correspond to the maximum amount health systems are willing to pay.

Some people nevertheless continue to believe that the pharmaceutical industry's profit margins must remain as high as possible, so that it can invest more in R&D. Doctors and pharmacists sometimes even prefer to use brand name drugs rather than generics, under the misapprehension that this helps increase investment in research. This attitude is rather naïve: there is no reason to think that the additional profits will be reinvested in research.

The main incentive for pharmaceutical companies to invest in developing new drugs is the competition created by the arrival of generics when their patents expire. The corollary to this is that, if generics cannot adequately penetrate the market once the originator goes off-patent, the need to invest in the development of new products declines accordingly.

Profits do not lead to investment in R&D. It is an illusion to believe that an increase in profits will lead to increased investment in research.

In the capitalist dynamics at work in the knowledge-based economy, profits are generally distributed to shareholders, through dividends and share buy-backs. They can also be used to buy competitors through mergers and acquisitions, often resulting in the closure of research laboratories.

An accounting study based on the annual reports of ten of the largest global pharmaceutical firms over the 10-year period 1996-2005 revealed net operating profits after tax of US$413 billion and a net return on shareholders' invested capital of 28.7%, a very high return compared with other industrial sectors. These firms distributed 77% of net earnings (US$317 billion) to their shareholders as dividends or share buy-backs, used 16% (US$66 billion) of their net earnings to build provisions for future mergers and acquisitions, and invested 10% of net earnings (US$43 billion) in tangible fixed assets.

In summary: prices are set at the maximum buyers are willing to pay. If drug prices are not linked to the cost of their development or production, and if profits do not correlate with companies' investment in R&D, how are these prices actually determined? The answer is simple: a drug's price depends on the balance of power between the seller and the buyer. The aim of a pharmaceutical company is not to make drugs but to make profits. The prices of patented drugs are therefore set at the maximum amount that patients and the healthcare system will accept to pay.

The pharmaceutical industry generated higher profit margins than any other industrial sector in 2013, and likely remained the most profitable sector in 2014 as well. 2014 was also a record year in the pharmaceutical sector in terms of share buybacks and mergers and acquisitions.

The shift from the "blockbuster" to the "nichebuster" business model

To understand why drug prices have risen so sharply in recent years, one has to look at how the new business model that is starting to sweep across the pharmaceutical sector works: the "nichebuster" model.

The blockbuster model dominated the 1990s to the mid-2000s. A blockbuster is a drug that generates annual revenues for the company that markets it of over US$1 billion. The blockbuster business model dominated the 1990s and 2000s. It relied on developing drugs to be sold to the largest population possible.

In the blockbuster model, purportedly new drugs were often structurally similar variants of existing drugs. These "me-too" drugs had no real additional therapeutic value, but were often priced 20% to 40% higher than the original drug.

The success of a new drug depended less on its therapeutic value than on the company's ability to conduct massive promotional campaigns aimed at convincing doctors to prescribe the drug for the largest number of people possible. The success of these campaigns determined whether the new product became the new blockbuster in its category.

Despite the lack of convincing evidence for their greater efficacy, buyers, in particular medical insurance systems, agreed to pay for these new drugs without too much difficulty.

The blockbuster model running out of steam for the last 10 years. Around the mid-2000s, this model became a victim of its own success and slowly saturated the "me-too" market.

With sales growing faster than gross national product, and with new drugs often offering no therapeutic advantages over older products, the model was unsustainable. During a period when governments were trying to contain health expenditure, the various medical insurance systems became more selective about which new drugs they were prepared to fund and began to demand more value for their money. Clinical superiority over placebo was no longer sufficient, and pharmaceutical companies had to demonstrate the pharmacoeconomic value of new drugs in order to secure reimbursement.

Similarly, a higher price could only be justified by greater therapeutic value. The increasing use of health technology assessments in various member states of the Organisation for Economic Cooperation and Development (OECD) was a fundamental factor behind the crisis that hit the blockbuster model.

The major pharmaceutical companies responded to this crisis in various ways, specifically with rationalisation (staff cuts, closing R&D departments) and a wave of merger and acquisition deals. Other firms sought instead to diversify by moving into the generics or vaccines sector.

After a transition period of 10 years or so, the new emerging business model seems to be based on niche drugs: the "nichebuster" model.

The new nichebuster model. New specialty drugs, often produced through biotechnology, are mainly intended for the treatment of rare diseases and various forms of cancer. Crucially, by targeting specialty markets where no established therapy exists, companies can demand higher prices than they can in already saturated markets.

Some purportedly niche drugs, such as imatinib (Glivec) and trastuzumab (Herceptin), have progressively gained approval in many therapeutic indications, yet their price has not been lowered. With sales of about US$5 billion and US$6 billion respectively in 2012, they have achieved blockbuster status. Hence the term "nichebusters", coined for niche drugs that generate

(continued on next page)

(**Gagnon,** *continued from previous page*)
annual revenues of over US$1 billion.

Nichebusters, or when everyone wants to become an orphan

At the heart of the nichebuster model lie policies introduced to encourage the production of "orphan" drugs. A drug obtains orphan regulatory status when it is indicated for the treatment of a rare disease, i.e. a condition with a prevalence of not more than 5 in 10 000, according to European standards.

Significant, mainly regulatory, advantages. In the European Union and North America, when a product is recognised as an orphan drug, the company that markets it enjoys significant advantages, such as an expedited approval process, additional tax credits, financial assistance for research, and longer periods of market exclusivity.

Choosing to market orphan drugs brings other advantages too. First, the clinical trials required to obtain approval are smaller and therefore tend to be cheaper, even though patient recruitment can take longer. Secondly, orphan drugs are aimed at markets where few or no alternative treatments exist, which limits the negotiating power of health insurers. In particular, society is often more willing to pay higher prices to treat rare diseases and cancer. For example, some countries, including the United Kingdom, have established cancer drugs funds to cover the cost of these treatments, even when their benefits do not justify their high price tag. Finally, because niche drugs are aimed at specialty markets, they are prescribed by a small number of specialist clinicians. This reduces the company's marketing costs, because small targeted promotional campaigns require less effort than mass campaigns.

A growth market. Policies aimed at encouraging orphan drugs onto the market are clearly working. For example, in the European Union, 66 products were granted orphan-drug designation between January 2006 and October 2014. These policies sometimes favour genuine innovations that benefit patients with rare diseases. However, advances in biotechnology and the development of genetic testing, supposedly enabling a more "personalised" approach to medicine, has meant that the boundary between rare and common diseases is becoming increasingly malleable.

Salami slicing. In order to obtain orphan-drug designation, it is in pharmaceutical companies' interests to initially request marketing approval for a narrow therapeutic indication, corresponding wherever possible to a condition with a prevalence of 5 in 10 000 or less. The drug can then be re-submitted, for a new narrow therapeutic indication, and thus accumulate multiple orphan-drug designations.

This practice of "salami slicing" a drug's indications has become the norm, constituting the main corporate strategy for increasing sales of orphan drugs. For example, imatinib (Glivec) has been granted seven marketing approvals for different indications, thus obtaining orphan-drug status seven times over in the United States, while interferon, marketed under nine different brand names, has obtained 33 orphan-drug designations. Salami slicing is also an effective means of obtaining an additional period of market exclusivity by prolonging the protection afforded to regulatory data concerning the drug, thus boosting the profitability of a drug that has gone off-patent.

Excessive off-label prescribing. Orphan-drug designation is granted for very specific therapeutic indications, making off-label prescribing even more common, a practice often encouraged by dubious promotional strategies. For example, in the United States, about 50% of oncology prescriptions are off-label.

Is the nichebuster market also reaching saturation point? The advantages and exorbitant prices granted for orphan drugs are completely changing the dynamics of research. For example, at the end of 2014, clinical trials were in progress in the United States for seven different drugs for the same indication, lung cancer caused by ALK gene rearrangements (a rare genetic abnormality affecting only a few thousand patients). This situation is worryingly similar to the inefficient concentration of R&D resources observed in the blockbuster model...

In summary: nichebusters, a new business model proving to be another dead-end

The nichebuster model is based on two complementary trends: the "personalisation" of treatment in profitable niches, which also allows companies to obtain marketing approval on the basis of a pared-down evaluation (small trials of short duration); and a pricing level that would have been inconceivable 10 years ago.

Accepting astronomical prices for often insufficiently evaluated drugs that have obtained the somewhat malleable status of "orphan" drug skews the economic incentives that are supposed to enable efficient medical research that meets patients' needs. And as research has shifted towards the development of orphan drugs, there has also been pressure to reduce the regulatory requirements for obtaining marketing approval, leading to the development of "adaptive licensing" or the "adaptive pathways approach".

In addition, with rare diseases as the focus of a new gold rush for the pharmaceutical industry, a pricing policy on niche drugs that amounts to a blank cheque is a threat to the sustainability of health systems.

The excesses of the nichebuster model surely demonstrate the limits of industrial research based purely on profit maximisation. The question now before us is what are we prepared to pay for and what types of clinical research do we want to encourage in order to best meet real public health needs. Indeed, in many respects, the financial incentives in place in the nichebuster model and the disproportionate prices of new treatments mean that we can no longer properly meet the population's health needs.

In the meantime, it is important to remember that, from the patient's perspective, an unaffordable treatment is no more effective than a non-existent treatment.

Marc-André Gagnon is assistant professor in public policy a Carleton University (Ottawa, Canada).

References for this article are available at bit.ly/1Q8DFdU.

THE TENNESSEAN

October 19, 2015

Medicare for all would solve many health problems

By Monisha Bhatia, Margaret Axelrod, Emily Holmes, Mitchell Hayes and Connor Beebout

Just over a year ago, Sharon, a fast food worker from Middle Tennessee, walked into the Vanderbilt emergency department in the worst pain of her life.

Stones had formed in her gallbladder. Fortunately, this common and excruciatingly painful condition can be easily treated with surgery. Sharon, however, did not have health insurance and could not afford the surgery.

A few weeks ago, Sharon reappeared in the emergency department with worsening pain and vomiting. This time, her doctors found cancer in her gallbladder that had spread to her stomach and liver. There is no cure for her cancer.

Untreated gallstones are a major risk factor for this type of cancer. If Sharon had insurance and could afford the surgery, removing her gallbladder would have saved her life.

Sadly, Sharon's story is in no way unique.

Sharon is one of 90,000 Americans who will die this year because she does not have access to affordable health care. That so many Americans die unnecessarily is a profound failure to our fellow citizens.

Despite the Affordable Care Act, 33 million Americans, including 750,000 Tennesseans, remain uninsured. Over 30 percent of the uninsured in Tennessee would be covered were it not for the senseless refusal to expand Medicaid.

Even people with health insurance often face crippling medical expenses. In December 2014, almost half of Americans reported that acquiring basic medical care was a significant financial hardship — a 10 percent increase over the previous year. Health care is the leading cause of personal bankruptcy in this country, and 70 percent of those with medical debt have health insurance.

These outrageous costs and preventable deaths are not a problem in other developed countries. Out of 16 industrialized nations, the U.S. ranks first in cost and last in medically preventable deaths — 68 percent higher than the best-performing countries.

As medical students, we understand that we cannot protect our patients from illness with the power of medical science alone. We strongly believe that the only sustainable way to save health care from itself would be to expand Medicare to all Americans.

In a Medicare-for-all system, every citizen would automatically receive health care coverage regardless of income. No American would ever need to forgo treatment because they could not afford the exorbitant costs of modern medicine.

More than half of physicians support Medicare-for-all. Economists and politicians understand that a Medicare-for-all system is the only way to control costs in the long run while providing quality medical care to every American.

Expanding Medicare would actually reduce health care spending. A Medicare-for-all insurance program would create a streamlined nonprofit system with reduced overhead, no marketing expenses and reduced drug costs through increased purchasing power. Together these effects would reduce health care spending by up to $500 billion per year. Under a Medicare-for-all system, 95 percent of Americans would pay less than they currently do for health care.

Students from six universities in Tennessee and Kentucky (UT-Memphis, Louisville, Vanderbilt, East Tennessee State, DeBusk, and Meharry) are reaching out to their communities to bring attention to the problems and the future of American healthcare.

As physicians-in-training we understand that it is not enough

From left, Monisha Bhatia, Margaret Axelrod, Emily Holmes, Mitchell Hayes and Connor Beebout. Photo by Joe Luchsinger.

to provide the best care possible to our patients. Our experiences with people like Sharon remind us that health reform is not behind us. It is a necessary part of our future.

Without significant policy changes, the fundamental problems of our health care system will never be solved. HR 676, the Expanded & Improved Medicare for All Act, would provide these changes. Despite 63 cosponsors and considerable public support, this bill remains stalled in Congress.

Expanding Medicare to every American would ensure that we never again have to witness anyone struggle like Sharon.

We are at a critical moment in the history of American health care. Costs continue to skyrocket, and Americans continue to suffer.

There is no better time to act.

Monisha Bhatia, Margaret Axelrod, Emily Holmes, Mitchell Hayes and Connor Beebout, Vanderbilt University School of Medicine Chapter of Students for a National Health Program and Meharry Medical College Chapter of Students for a National Health Program.

OpEd News

September 13, 2015

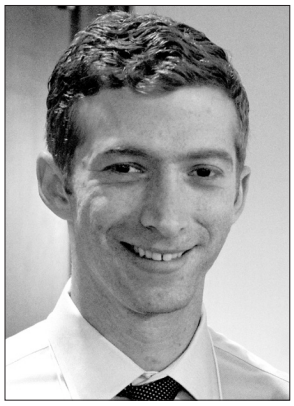
TenOne: Medicare-for-All National Student Day of Action on 10/1/15

By Joan Brunwasser

My guest today is Scott Goldberg, a fourth-year medical student at the University of Chicago's Pritzker School of Medicine and a board member of Physicians for a National Health Program. Welcome to OpEdNews, Scott.

JB: I understand you are helping to coordinate a national day of action, coming up soon. What can you tell us about it?

SG: Thank you for having me, Joan. Yes, I am one of the medical students from Students for a National Health Program (SNaHP) helping to plan the TenOne Medicare-for-All National Student Day of Action. SNaHP is the student section of the national organization, Physicians for a National Health Program, which has around 20,000 doctors and students who advocate for single payer health reform. The idea for TenOne came out of the SNaHP annual summit last February in Chicago. It was our 4th and largest summit thus far, with over 170 students in attendance. We had been inspired by the widespread involvement of students in the White Coats 4 Black Lives die-in that fall and we wanted to do something similar to energize and strengthen the student single payer movement. In short, TenOne is a nationwide action of medical students and allies to raise awareness about the failings of our private health insurance system and what we need to do to fix it – which is to expand and improve Medicare to all.



Scott Goldberg

JB: Before we get to the nitty gritty of the October action, can you tell us why single payer is so important to you and your fellow medical students?

SG: Well, for me, I became committed to single payer in 2009 after hearing a talk by Dr. David Himmelstein, one of the co-founders of PNHP. He presented so much evidence that national health insurance, as practiced particularly in Canada, is the most efficient, economical, and just way to provide high-quality, affordable, universal health care access. And that the United States is the only industrialized country in the world, despite our vast wealth, that doesn't have some form of universal health insurance. But it wasn't until I began medical school, and started working in the hospital, especially during my third-year clinical rotations, that I saw firsthand how devastating our system is on patients' lives. I remember one Spanish-speaking woman who was unable to receive a lung transplant at our hospital because we weren't "in-network." We had to send her to another hospital after developing a trusting relationship with her. I've seen patients die because they couldn't get the care they needed in time. This just does not happen in other first-world countries. So I'm sure my fellow medical students working on this issue feel the same way as I do – that no person, regardless of socioeconomic status, race, ethnicity, or whatever, should be denied something as fundamental to human life as medical care.

JB: Everything you say makes perfect sense to me, Scott. I covered the medical student die-in when it happened and it was an amazing statement. What kind of participation are you getting for this current action day?

SG: SNaHP now has 43 chapters at medical schools across the country. I think this is double the number just four years ago. For TenOne, we have 30 chapters participating as of now. Many of these chapters will be holding actions during the day including teach-ins and rallies. At night, all chapters will be holding a candlelight vigil remembering the approximately 25,000 people that die each year due to uninsurance and the millions more who suffer due to underinsurance. In cities like New York, Philadelphia, Chicago, Los Angeles, and Boston, a number of chapters from different schools will be working together to host one large nighttime action. Also, TenOne is sponsored by a number of other national medical student organizations including American Medical Student Association, Latino Medical Student Association, White Coats For Black Lives, Universities Allied for Essential Medicine, and Pre-health Dreamers. I can't think of another student-led nationwide action for single payer that has been done before.

JB: I'm curious if any of the medical schools push back against these single payer actions. Are any students fearful that their participation might affect their careers going forward?

SG: In my three years since starting a student chapter of PNHP, I've never had any push back from my medical school. In fact, I think our chapter is the most active on campus and has widespread support from the student body. Many of the faculty and administrators on campus support national health insurance (NHI) and are encouraged by our dedication to the cause. I've never heard of any other schools pushing back against single payer actions, but I can't say definitively if there have been.

I think some medical students may be anxious about throwing themselves into single payer advocacy for fear that it may affect their careers somehow. But I can say, from my own experience, that it has not affected my career thus far. And there are examples of outspoken faculty members on campus who don't face repercussions for their beliefs. This idea that speaking out for something as fundamental and urgent as universal health care is threatening to your career is something we need to dismiss.

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

Advocating for single payer is not a Democratic or Republican issue. It is at the core of what it means to be a doctor, which is doing everything in your power to help your patients.

JB: I'm glad you haven't experienced or witnessed any push back but I also understand that many students have taken out huge student loans. And that factor can affect everything, including decisions like participating or not in an action like this. What kind of press coverage have you arranged for TenOne? I ask because if you don't get enough coverage, isn't it like the proverbial tree falling in the forest with no one around to hear?

SG: It's true, student loan debt is a major problem. In fact, in countries like Canada, medical education is free. In H.R. 676, the house bill that would establish national health insurance, there is a provision making medical education free. But the idea that student loan debt affects one's decision to participate in actions is not something I've ever heard from my interactions with other students across the country. As medical students, we are paying a lot of money to schools and so they want to support us in whatever we do.

As for press coverage for TenOne, we're talking with national media outlets like OpEdNews! We also have upcoming interviews with other outlets like The Union Edge. We have national and local press coverage lined up for TenOne. And I think the power of this event is not just to generate media attention. No nationwide action like this has ever been done before. We are raising awareness, empowering students, and generating the basis for a broad-based movement for single payer.

This is not a one-off event just to attract media attention. This is the first in a series of actions to build a movement capable of achieving NHI. Ninety-nine percent of Americans suffer due to expensive, inadequate health care and we are bringing them into the movement. Single payer reform would be the greatest social and economic reform in this country's history, and so it will take time, energy, and a national movement to achieve. We often overlook that students have been at the forefront of social movements throughout history. The Civil Rights Movement in America was started by college students, specifically the Student Nonviolent Coordinating Committee.

JB: Again, quite true. Anything you'd like to add before we wrap this up?

SG: I hope those who read this go to student.pnhp.org to find a TenOne event in their area to attend. This day of action is led by students, but meant for everyone! Also, I'd like to encourage anyone who reads this to start having conversations with their friends, family, colleagues, whomever about the need for single payer health care. Canada passed national health insurance in the 1970s, but activists began having small, informal gatherings in their homes about reform as early as the 1910s. Although we face serious barriers to passing NHI including the enormous wealth of the health insurance and pharmaceutical industries, a majority of Americans currently support government-funded, privately delivered health care. We have the numbers, we just need to unify ourselves.

JB: Thanks so much for talking with me, Scott. Looking forward to TenOne and its aftermath!

Joan Brunwasser is senior editor at OpEd News.

Dr. Philip Verhoef, left, joins University of Chicago medical students outside of Humana at TenOne Day of Action. Photo courtesy of Mark Chee.

Medical students to hold National Day of Action for 'Medicare for All' on Oct. 1

FOR IMMEDIATE RELEASE, September 28, 2015

Media Advisory: Citing the persistence of thousands of preventable deaths each year due to lack of health insurance, students at more than 30 medical schools across the country will hold teach-ins, rallies and candlelight vigils on Thursday, Oct. 1, to bring national attention to 'our failing health care system' and the need for single-payer health reform.

What: Students for a National Health Program (SNaHP), the student arm of Physicians for a National Health Program – working in coalition with the American Medical Student Association, WhiteCoats4BlackLives, the Latino Medical Student Association, Universities Allied for Essential Medicine, California Health Professional Student Alliance, and Pre-Health Dreamers – will hold teach-ins, rallies, and candlelight vigils at more than 30 campuses to remember the millions of people in the U.S. who remain uninsured, underinsured and underserved by our current health care system. They will also underscore the need for a more fundamental health reform – a nonprofit, publicly financed, single-payer health system.

When: Thursday, Oct. 1, various times (see the #TenOne Facebook page for individual event details, or contact students at participating schools – see list below)

Who: Medical students other health professional students, along with allies on their campuses and from surrounding communities. The public is welcome to attend.

Where: Medical schools and a few public venues across the country, including but not limited to the list at the end of this advisory.

Why: The United States is the only industrialized nation in the world that does not guarantee universal health care. Unfortunately, the Affordable Care Act is neither universal nor affordable. It will leave 30 million Americans uninsured and a comparable number underinsured, vulnerable to financial distress in the event of illness. Sharply rising deductibles and copays are deterring the insured form seeking care, and skyrocketing drug prices are putting medications out of reach. Tens of thousands of people will continue to die every year just because they lack health insurance. Medical problems are the leading cause of bankruptcy in the U.S., and research shows nearly 80 percent of those declaring bankruptcy due to medical debt had insurance at the onset of their illness. Our patients need and deserve better.

This year marks the 50th anniversary of Medicare. As medical students, part of our mission is to ensure that everyone who needs care gets it. One way to achieve this goal is by improving the Medicare program and expanding it to cover all Americans. There is a bill in Congress, H.R. 676, that would do precisely that.

We urge our fellow students and the public to join us for this #TenOne: Medicare-for-All National Day of Action on Thursday, Oct. 1, to bring national attention to our failing health care system and the need for single-payer health reform.

#TenOne Local Events

CALIFORNIA. Coordinator: Angelica Ramirez, California Health Professional Student Alliance; Touro University California, Matthew Musselman; UC Berkeley, Ana Ibarra; UC Davis School of Medicine, Umer Waris, Keyon Mitchell, Callum Rowe; UC Irvine, Michelle Crespo; UCLA, Jonathan Gomez; UC San Francisco, Nicolas Barcelo; UC San Diego, Firooz Kabir. ILLINOIS. Chicago Medical Schools Coalition: University of Chicago, Scott Goldberg; University of Illinois at Chicago, Kieran Holzhauer; Rush Medical College, Jordan Centers; Chicago College of Osteopathic Medicine, Jillian Caldwell. IOWA. University of Iowa Carver College of Medicine, Lisa Wehr. KENTUCKY. University of Louisville School of Medicine, Brandi Jones. MAINE. University of New England College of Osteopathic Medicine, Natasha Neal. MASSACHUSETTS. Boston University School of Medicine, Andy Hyatt. NEW MEXICO. University of New Mexico School of Medicine, Bryant Shuey. NEW YORK. PNHP N.Y. Metro (coordinators): Becca Mahn and Katie Robbins; Albany Medical College, Justin Pegueros; Albert Einstein College of Medicine, Tauhid Mahmud and Dahlia Kenway; Columbia University Mailman School of Public Health, Michael Zingman; Cornell University (Ithaca), Christine Liu; Icahn School of Medicine at Mt. Sinai, Alice Shen; New York University School of Medicine, David Wang and David Collins; SUNY Downstate, Keriann Shalvoy; Weill Cornell Medical School, Claire Kenney. OHIO. Case Western Reserve University School of Medicine, Vanessa Van Doren. PENNSYLVANIA. Philadelphia Medical Schools Coalition: Temple University, Emily Kirchner; University of Pennsylvania, Tony Spadaro and Dorothy Charles. TENNESSEE. Lincoln Memorial University-DeBusk College of Osteopathic Medicine, Aron Haire; University of Tennessee Health Science Center College of Medicine, Diana Alsbrook; Vanderbilt University School of Medicine, Mitchell Hayes. VERMONT. University of Vermont College of Medicine, Kelsey Sullivan. WASHINGTON. University of Washington School of Medicine, Darius Fullmer.

The Commercial Appeal

July 30, 2015

Grow Medicare to save lives, money

By Arthur J. Sutherland III, M.D.

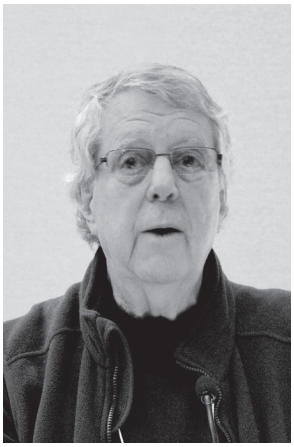
Medicare, one of our nation's most valuable and popular social programs, turns 50 on July 30, and we have the chance to make it even better.

Medicare is a federal health insurance program enacted and signed into law in 1965 by President Lyndon B. Johnson. The program currently covers 55 million Americans-people age 65 and older, and younger people with permanent disabilities. That's about 17 percent of the population.

Medicare was originally conceived as a first step toward covering everyone in U.S. society under a national health insurance program. The program has sharply reduced poverty among seniors and significantly improved the financial security of their families. It has reduced health disparities related to race, ethnicity, and socioeconomic status.

Traditional Medicare only spends about 2 percent on administration/overhead. It's very frugal versus private insurance, whose overhead and profits amount to closer to 12-14 percent or more.

Medicare has a slower rate of health cost growth than private insurance, and it pays providers quickly and with fewer hassles than private insurers. Patients in traditional Medicare can go to the health provider or hospital of their choice.



Dr. Art Sutherland

There are misguided political pressures to privatize Medicare because of skyrocketing health costs, but Medicare is one of the victims of our dysfunctional system of insurance dominated by the private insurers, and our supply-driven medical markets.

There are misguided political pressures to privatize Medicare because of skyrocketing health costs, but Medicare is one of the victims of our dysfunctional system of insurance dominated by the private insurers, and our supply-driven medical markets.

The United States has never had a well-thought-out and debated national health care program with national standards, regional planning, and local implementation.

Cutting Medicare would be a mistake because it would increase poverty, worsen health outcomes and increase costs.

We already see what is happening in the Medicare Advantage plans, which are operated by private insurers. They cost the Medicare program about 14 percent more than traditional Medicare.

Research done by Physicians for a National Health Program, pnhp.org, shows that in 2014, Medicare Advantage plans were overpaid $34.1 billion, or $2,526 per enrollee. This documents that having private MA plans competing with traditional Medicare does not save money, but costs taxpayers billions of dollars more each year.

The solution to our health care crisis and the economic suffering it contributes to everyone in this country is to establish a publicly financed, mainly privately delivered national improved and expanded Medicare for All – a single-payer system.

Private insurance companies have clearly failed us. To increase their bottom line, they strive to enroll the healthy, screen out the sick, and deny care. They afflict our health system with a mountain of unnecessary paperwork – about 31 cents of each health care goes to administration, most of it waste.

Meanwhile they pay their CEOs multimillion-dollar salaries and squander money on advertising, etc.

The Affordable Care Act unfortunately builds of the faulty foundation of private insurance companies, and adds more cost and complexity to health care access and delivery. Transitioning the ACA into the Medicare single-payer national health program would solve this problem. At the same time, rolling Medicaid into Medicare would complete the consolidation of our national programs.

A pipe dream? No. There is legislation in Congress, the Expanded and Improved Medicare for All Act, H.R. 676 that would put such a single-payer system in place.

Other nations have enacted systems like this with great success. Our neighbor to the north, Canada, implemented their single-payer Medicare Program in 1971. They spend half of what we do, and live longer. Their people will not allow their Medicare to be privatized.

Passing an improved Medicare for All will save lives and money, and put our nation on the path of becoming one of the best health systems in the world.

We have the talent, we have the resources: let's put them to work! That would show real "American Exceptionalism."

Dr. Arthur J. Sutherland, III, a retired cardiologist, is the Physicians for a National Health Program Tennessee chairman and national board adviser.

THE HUFFINGTON POST
THE INTERNET NEWSPAPER: NEWS BLOGS VIDEO COMMUNITY
July 30, 2015

Medicare at 50: Strengths to build on

By John Geyman, M.D.

Traditional, or Original, Medicare turns 50 on July 30, having had many challenges and achievements from the days of its passage to today. It is time to celebrate its many successes, note some of its current challenges and threats to its future, and briefly discuss how it gives us a strong foundation upon which to build still-needed health care reform.

When it was enacted in 1965, about one-half of seniors in the U.S. lacked health insurance, and many could not afford necessary health care. When it was passed with strong bipartisan support (313-116 in the House, and 70-24 in the Senate), 20 million Americans age 65 and older gained health insurance.

From the start, Medicare was a political football raising strong arguments for and against any kind of universal health insurance, quite similar to those we hear today, including from the American Medical Association, hospitals, and the health insurance industry. But a "corporate compromise" was struck in 1965 whereby private insurers were relieved of their worse health risks, hospitals could expect assured payments for their costs of serving a previously disadvantaged population, and physicians gained a permissive "usual, customary, and reasonable" reimbursement policy. Claims processing and bill auditing were contracted out by the government to private fiscal intermediaries, especially Blue Cross and Blue Shield plans.

From the beginning, Medicare has provided a broad set of benefits, defined by law, protecting all seniors, many of whom could not afford health insurance in the private market. Part A provides hospital insurance, while Part B provides supplementary medical insurance for 80 percent of physician services (initially with a $50 deductible and 20 percent coinsurance), X-ray and laboratory tests, and some home health and outpatient and mental health services. Some additional benefits were added in later years to this basic program, including coverage for the disabled and patients with end-stage renal disease in 1972 and partial coverage for prescription drugs in 2003 (Part D). Medicare's benefits have always been considered an earned right, not an entitlement, since all beneficiaries pay into the program through mandatory contributions from individuals and/or employers.

Today, Medicare is a very large program, covering more than 55 million Americans, including all seniors and 9 million people with permanent disabilities under age 65. It accounted for 14 percent of the federal budget in 2014 and about 20 percent of total personal health expenditures in 2013.5 Since the 1990s, we have seen an increasing trend toward privatized Medicare plans (Part C), starting with Medicare + Choice HMOs in the 1990s and their sequel, Medicare Advantage (MA) since 2003. These plans have been promoted by conservative policymakers and think tanks with a goal to replace Medicare as an "entitlement program" with private market plans, health savings accounts and vouchers. Almost one-third of seniors are now enrolled in MA plans.

The many strengths of traditional Medicare over 50 years

Traditional Medicare has performed much better over the years than any of these private plans, which operate with the goal of profits more than service. Table 1 summarizes the major differences between traditional Medicare and privatized plans.

Table 1

Comparison of Privatized and Traditional Medicare

Privatized Medicare	Traditional Medicare
Limited open enrollment	Universal coverage
Managed competition	Social insurance as earned right
Proposed defined contribution	Defined benefits
Segmented risk pool	Broad risk pool
Market pricing to risk	Administered prices
Volatile access and benefits	Reliable access and benefits
Increased cost-sharing	Less cost-sharing
Ineffective cost containment	More effective cost containment
Less accountability	More accountability
Less choice of provider & hospital	Full choice of both
Less efficient, higher overhead	More efficient, lower overhead

These comparisons are supported by many studies over the years. As just four examples:

A literature review by the Kaiser Family Foundation of 40 studies since 2000 found that beneficiaries rated access and quality of care better in traditional Medicare than in Medicare Advantage, especially by those who were sick.

An analysis by the Urban Institute over three decades found that private Medicare plans cost the government more than fee-for-service traditional Medicare, which contained costs better than private plans over those years.

Traditional Medicare operates with an administrative overhead of 2 percent, compared to overhead of Medicare Advantage about seven times higher.

The Centers for Medicare and Medicaid Services (CMS) took 35 enforcement actions against Medicare Advantage plans and Medicare Part D plans in 2014, particularly for inappropriate denials of care and requiring unnecessary preauthorization of services and medications that resulted in more cost shifting to beneficiaries.

Some major challenges facing Medicare today

As in 1965, Medicare remains a lightning rod for intense political debates over its future. Despite its proven track record for efficiency, reliability, and responsible service over these last 50 years and widespread public support, Republicans are united in their attempts to dismember it, convert it to a voucher program, and shift patients to the private marketplace, all under the guise of reining in federal spending and austerity. Some Democrats are amenable to raising the eligibility age for Medicare and increasing cost sharing. These ideas are a complete disconnect with the needs of our aging society in a time of increasing inequality of incomes. More than 25 million seniors and people with disabilities live on annual incomes of $23,500 or less, many of whom cannot afford premiums and cost-sharing in either traditional or privatized Medicare. And as our population ages, pensions that in the past assured defined benefits are shifting to defined benefit pensions, without such assurances. There are still many gaps in coverage, even within traditional Medicare, including for long-term care and dental care.

Future funding for Medicare is seriously threatened and murky at best. The Obama administration has told us that the Affordable Care Act (ACA) will be financed in part by $716 billion in Medicare cuts over 10 years, with the unbelievable claim that these cuts will not result in reduction of services. The recently passed H.R. 2, the "doc fix" bill, has provisions in it that will require new deductibles in first-dollar supplemental Medigap plans (held by 40 percent of Medicare beneficiaries) and expand means-testing for Medicare Part D, both of which will increase costs for seniors and further undermine traditional Medicare.

Just as the future of Medicare is unclear, so is that of our entire health care system. The U. S. Supreme Court is expected to rule in coming days on the legality of subsidies under the ACA. A negative ruling will be a serious blow to the ACA and call into question where we should go next. Republicans in Congress will push for repeal or defunding parts of the ACA. As the debate heats up, the leading alternatives will likely be: (1) continuation of the ACA as it unravels, (2) some GOP "plan" based on patients having "more skin in the game" that further threatens access and affordability of care; (3) revival of the "public option" idea, hardly an effective fix as merely adding one more payer to our dysfunctional multi-payer financing system; and (4) long-overdue consideration of single-payer national health insurance that would cover all Americans in a large risk pool with more benefits, less cost, more reliability and equity in a sustainable way, as described in my recent book, "How Obamacare Is Unsustainable: Why We Need a Single-Payer Solution for All Americans."

Traditional Medicare has proven its superiority over any private, market-based alternatives for the last 50 years. It is time to build on this social insurance model as the health care debate continues.

References for this article are available at bit.ly/1LoYMlS.

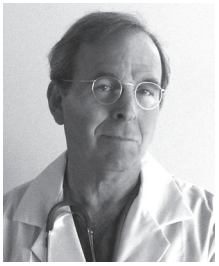
Dr. John Geyman is professor emeritus of family medicine at the University of Washington School of Medicine in Seattle, a member of the Institute of Medicine, and past president of Physicians for a National Health Program. Dr. Geyman's latest book is titled "The Human Face of ObamaCare: Promises vs. Reality and What Comes Next" (Copernicus Healthcare, January 2016).

The New York Times

July 11, 2015

Medicare: Successes and drawbacks

By Samuel Metz, M.D.



Medicare provides better care at lower cost than private health insurance can achieve. But it is woefully underfunded and may become insolvent. Many argue for privatization. However, every health care system in the world, especially our private insurance industry, faces increasing costs and a decreasing willingness of patients (and taxpayers) to pay for them.

Remarkably, Medicare costs are rising slower than those of private insurance — despite caring for older, sicker patients. Privately administered Medicare Advantage costs more than traditional Medicare; that's not because patients receive care they don't need, but because private insurance companies receive extra federal payments they don't earn. Clearly Medicare needs less private interference, not more.

Medicare delivers high value. Its critical features — prepayment during high earning periods, reduced cost-sharing at time of need, inclusion of the broadest possible population, comprehensive benefits — should be reinforced. Then these features should extend to the rest of us. Medicare for some is good. Medicare for all is better.

Dr. Samuel Metz resides in Portland, Ore. He is an anesthesiologist and a member of Physicians for a National Health Program.

PNHP note: The letter above was one of three in the July 11 edition of the New York Times advocating for an improved version of Medicare for All; the other two letters were by Dr. Marcia Angell of Massachusetts and Dr. Ann Troy of California.

the BILLFOLD

July 30, 2015

Thoughts on Medicare's 50th birthday

By Emily Kirchner, M3

"What the patient really needs is better insurance."

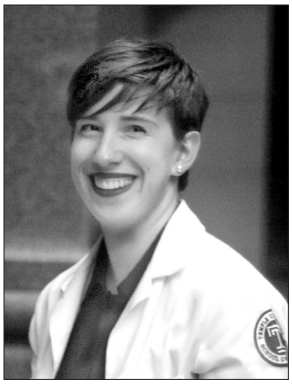
The physician said it abruptly, matter-of-factly. Her comment was not meant to evoke empathy in the rest of the medical team. She stated it like a diagnosis.

The recommended care was out of the question because of the patient's insurance. Two seconds later, the discussion had moved on – how to address our patient's other medical problems, or maybe when the patient could be discharged from the hospital.

I, the lowly third-year medical student, was still stuck on the doctor's words: "What the patient really needs is better insurance."

Today, Medicare turns 50.

Medicare, the federal health insurance program that insures adults age 65 and older as well as younger people with permanent disabilities, currently covers 55 million Americans – that's 17 percent of the population.



Emily Kirchner

Before Medicare, senior citizens delayed or forewent medical attention. In 1959, a retired Detroit autoworker named John Barclay described why for the Senate Subcommittee on Problems of the Aging or Aged:

"[The] retired person must pretty much exhaust any savings he has before he can get free hospitalization. This is a constant source of worry. Many of my acquaintances will not visit a doctor for minor illness because they have no money to pay for drugs. After they exhaust their savings they go on welfare to get medical aid, but then, in many cases, it is too late."

About half of our seniors did not have hospital insurance and one in four seniors went without medical care because of cost concerns. The cost burdens of health care and hospitalization meant that the elderly were the group most likely to be living in poverty. In 1965, 1 in 3 seniors was considered poor.

The 1963 Survey of the Aged concluded that "Many aged persons never recover from the economic effects of a single hospital episode. Unfortunately, the heaviest burden is likely to fall on those with the least resources. Those with insurance are better able to absorb the blow than those without such protection, but even for the insured there is no present guarantee against dependency in old age caused by catastrophic medical expenses."

Prior to Medicare, segregation policies in many hospitals legally and routinely denied African Americans and other marginalized racial minorities access to medical care. To receive Medicare reimbursements, institutions were required to see patients of all races. Government officials oversaw desegregation programs to ensure that hospitals could collect Medicare payments.

After it was signed into law by President Johnson in 1965, Medicare enrolled 19 million seniors and covered their 1966 medical expenses for a cool $867 million in today's dollars. (To put that in perspective, it took over $6 billion for enrollment costs alone in the first year of the Affordable Care Act.) Congress extended Medicare coverage to younger individuals with permanent disabilities in the early 1970s.

And yet a half-century after this landmark legislation became law – the first step, in the eyes of its proponents, toward universal coverage under a national health insurance program – I am treating many patients whose biggest problem is not their medical diagnosis, but their insurance status.

The statistics about health care costs in the U.S. are frightening. Sixty-two percent of all personal bankruptcies in the U.S. are linked to medical bills or illness, and three-quarters of those people had health insurance when they got sick.

Even after the expansion of coverage promised by the Affordable Care Act, about 31 million people will remain uninsured in 2023. High out-of-pocket expenses, including copays, deductibles, and coinsurance, still plague tens of millions of Americans who are technically "insured" but in reality underinsured.

The U.S. spends more on health care than any other country in the world, $3 trillion annually – about 17 percent of our GDP. For all of the money that we are spending on health insurance premiums, out-of-pocket expenses, and taxes to sustain our health care system, we aren't getting very good care. The U.S. was ranked 37th out of 191 countries in the 2000 World Health Report. We haven't done much better in any ranking that has emerged since then.

As Medicare turns the big 5-0, it is as good a time as any to consider what our country could look like with improved, expanded Medicare for everyone – i.e. a single-payer national health program.

A publicly financed, improved Medicare for All would allow patients to go to the doctor or hospital they prefer. Coverage would no longer be tied to employment. Financial barriers to care such as premiums, copays and deductibles would be removed.

A single-payer system would cut down on bureaucratic waste for hospitals and physicians and, with its strong bargaining power, cut the costs of drugs, equipment, and services. Universal coverage would encourage more preventive care, keeping

(continued on next page)

The Herald-Times Bloomington, Ind. November 6, 2015

Country must move to Medicare for all

By Rob Stone, M.D.

Do you look forward to calling your health insurance company with a problem?

Happy to call Anthem to have them explain a bill?

Do you think it will be even easier to get satisfaction when Anthem merges with Cigna?

The health insurance industry already consolidated from hundreds of companies in the 1970s to being dominated by just five huge companies by the time the Affordable Care Act passed in 2010.

Now, in the wake of the recent Supreme Court decision upholding the ACA, out of those Big 5, Humana and Aetna along with Anthem/Cigna are merging to create the Big 3.

We should be alarmed. When companies get this big, it's not good for us little people. The ACA didn't start this problem. Neither can it fix it.

Medicare, one of our nation's most popular social programs, turns 50 on July 30. As noted in a July 3 New York Times editorial, in 1965 when Medicare was enacted, advocates of Medicare, which today covers 46 million Americans over the age of 65 and 9 million younger disabled people, expected that it would expand to cover virtually all Americans.

Although polls between 1999 and 2009 showed consistent majorities in favor of expanding Medicare to people between the ages of 55 and 64 to cover more of the uninsured, it never happened.

Medicare already takes care of the most complex and expensive patients in our system, and does it well.

Medicare only spends about 2 percent on administration and overhead. In other words, it's very frugal versus private insurance, whose overhead and profits amount to 12 to 25 percent.

As the giant health insurers consolidate, they will not be looking for ways to pay for more beneficial services.

They will be introducing more "innovations" that prevent patients from getting the care that they need.

That's the way that the marketplace for health insurance works.

Medicare doesn't work that way.

In traditional Medicare, you have free choice of doctors and hospitals. At the same time, payments are based on legitimate costs and fair margins.

Medicare (and Medicaid) are the victims of skyrocketing health costs, not the cause. Despite the ACA's expansion of coverage, about 27 million people will remain uninsured in 2025 (Congressional Budget Office).

The complexity of this highly fragmented system of paying for health care is unique to the United States and results in high costs and inequities that leave tens of millions underinsured and tens of millions more with no insurance at all.

Based on international comparisons, our healthcare quality is mediocre and our healthcare costs are by far the highest of all nations. Politicians may say "we have the best healthcare in the world," but that doesn't make it true.

Five years ago, Congress could have and should have extended Medicare to cover all Americans. Instead, it passed the complex ACA, which keeps the wasteful and bureaucratic insurance industry in charge.

It's not too late to take the next step – Medicare for all.

Dr. Rob Stone of Bloomington, Indiana, is director of Hoosiers for a Commonsense Health Plan.

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

everyone healthier for longer. Not only do I want this system for me and my family, I want it for my patients.

Improved, expanded Medicare for all is not out of reach. The political climate and lobbying powers of insurance companies and pharmaceutical companies make it challenging but not impossible to attain.

The American Medical Association backed an extraordinary campaign against Medicare in the early years of the Kennedy administration. The AMA tried to tie Medicare to the bogeyman of "socialized medicine" and an imminent threat of communism. But the scare campaign failed, Medicare was enacted, and our nation has been bettered for it.

There's no doubt that well-financed scare campaigns by the health industry remain a threat to bringing about more fundamental health reform. But today a majority of physicians support universal coverage, and a majority of Americans do, too.

When we talk about the health care system, we often talk about money. But underlying these arguments are people: the waiter with the flu, your mother-in-law's shoulder pain, a coworker's shortness of breath. Whether these are minor events or serious health crises, everyone should have access to good health care.

There is an economic argument and a moral argument to be made for deeper reform, and both point to the same answer: We need to go beyond the Affordable Care Act to an improved Medicare for all.

Emily Kirchner is a third-year medical student in Philadelphia.

The Pueblo Chieftain

July 30, 2015

Medicare at 50: Successes, shortcomings

By Louis Balizet, M.D.

Fifty years ago – on July 30, 1965 – President Lyndon Johnson signed Medicare into law.

Medicare's 50th birthday seems a good time to reflect on the program's successes, shortcomings and future.

First, Medicare's successes:

- Medicare insures access to health care for more than 50 million Americans.
- Medicare has covered hundreds of millions since 1965.
- Medicare is popular – ranking with Social Security as the most valued government service.
- Medicare has shielded countless millions from financial ruin due to medical expenses – protection that, outside the Medicare population, 35 million Americans still lack.
- Medicare has sparked spectacular growth in hospitals, medical practices, pharmaceutical companies and medical device manufacturers.
- Medicare is efficient – it operates with an overhead of 2 percent, compared to 20 percent in private health insurance.

Incidentally, Medicare ended segregation in over a thousand hospitals in the South, since its substantial benefits were withheld from institutions that maintained separate wards based on race.

But Medicare has its shortcomings:

- Medicare has become intertwined with the private health insurance industry, making health care overall much more complicated and expensive for its beneficiaries.
- Medicare has failed to address adequately the cost of medical care.
- Medicare's benefits are too thin in many instances; people over 65 spend an average of 20 percent of their income on health care expenses.

What is Medicare's future?

Despite its shortcomings, Medicare is still the best template for delivering health care to all Americans in the future, much more so than the Affordable Care Act:

- Medicare's shortcomings are fixable (as opposed to the ACA's baked-in problems).
- Medicare's benefits can be broadened, eliminating the need for most, if not all, supplemental private insurance. The statutory prohibition against bargaining for drug prices with pharmaceutical companies can be repealed.
- Thus modified, Medicare could simply be expanded to cover all Americans, eliminating in the process the ACA, Medicaid, CHIP and private medical insurance. The age for eligibility for Medicare could be lowered from your 65th birthday to the day you are born.
- The idea of National Health Insurance is not a crazy or unattainable one. It is the norm in every developed country in the world but ours.

I practiced medical oncology in Pueblo between 1976 and 2013. Over that time, an ever-increasing number of my patients suffered as much from the financial burden of their cancer care as the cancer itself. In fact, 2 percent of all cancer patients file for bankruptcy.

Thanks to Medicare, people over 65 are largely shielded from the tragedy of financial ruin from illness. Should this protection not be afforded to all Americans, regardless of age?

Medicare should be improved, streamlined, then expanded to all Americans. By showing us the way out of our present complicated, unfair and exorbitantly expensive medical system, Medicare may yet enjoy its finest hour.

Dr. Louis Balizet practiced medical oncology in Pueblo between 1976 and his retirement in 2013, first at the Southern Colorado Clinic, then at Rocky Mountain Cancer Centers. He is active in Physicians for a National Health Program, a physician group that advocates for universal single-payer health care.

Proclamation: Medicare's 50th Anniversary

Whereas: President Lyndon B. Johnson signed Medicare into law on July 30, 1965, issuing the first Medicare card to former President Harry S. Truman; and

Whereas: Medicare has provided access to medical care for hundreds of millions of the elderly, the disabled, or those who suffer from chronic renal failure; and

Whereas: Medicare has protected hundreds of millions of Americans from financial ruin brought about by medical bills; and

Whereas: Medicare has always been regarded as one of America's most treasured governmental services;

Now, therefore, we, the City Council of the City of Pueblo, Colorado, and the Board of County Commissioners of the County of Pueblo, Colorado, by the authority vested in us, do hereby officially proclaim July 30, 2015, as "Medicare's 50th Anniversary Day" in the City and County of Pueblo, Colorado, as we recognize the millions of lives saved and appreciate the comfort and security brought to millions of our senior and disabled citizens.

In witness whereof, we have hereunto set our hands and caused the Seals of the City and County of Pueblo, Colorado, to be affixed this 1st day of July, 2015.

Stephen G. Nawrocki, President of the City Council
Liane "Buffie" McFadyen, Chair of the Board of County Commissioners

The Philadelphia Inquirer

July 30, 2015

Medicare and Medicaid have worked wonders, but we need true national health insurance for everyone

By Walter Tsou, M.D.

By the early '60s, America was in the throes of the civil rights movement led by its charismatic leader, Rev. Martin Luther King. Discrimination and Jim Crow laws applied not only to bus rides and dining rooms but also to hospital wings and doctors' waiting rooms, which often had separate curtains for blacks and whites. As it turned out, separate but equal was a failure not only in education, but in health care, too. Well before we started to measure health disparities, it was well known that minorities suffered far worse health outcomes.

Dr. Walter Tsou

But nothing shook the nation quite like the assassination of John F. Kennedy in 1963. With the overwhelming mandate of completing Kennedy's unfinished agenda, President Johnson signed the Civil Rights Act in 1964 and the laws creating Medicare and Medicaid in 1965. Led by Wilbur Cohen, who had been the Assistant Secretary of Legislation in the Department of Health, Education and Welfare (HEW) under Kennedy and later Secretary of that department under Johnson, the architects of these laws saw them as a first step toward true national health insurance. To those who created Medicare and Medicaid, national health insurance would not only be a way to end separate but equal in waiting rooms, but also to establish health care as a right of all Americans.

But there was strong opposition by Southern legislators as well as many physicians and private insurers. As a result, Congress settled for health insurance only for the elderly (Medicare) and for the very poor who were aged, blind, or disabled (Medicaid). Because Medicare was designed as a companion program to Social Security, 20 million seniors were auto-enrolled in 1965 in one year. (Compare that to the disastrous enrollment problems in October 2014 with the ACA with its complex eligibility rules.)

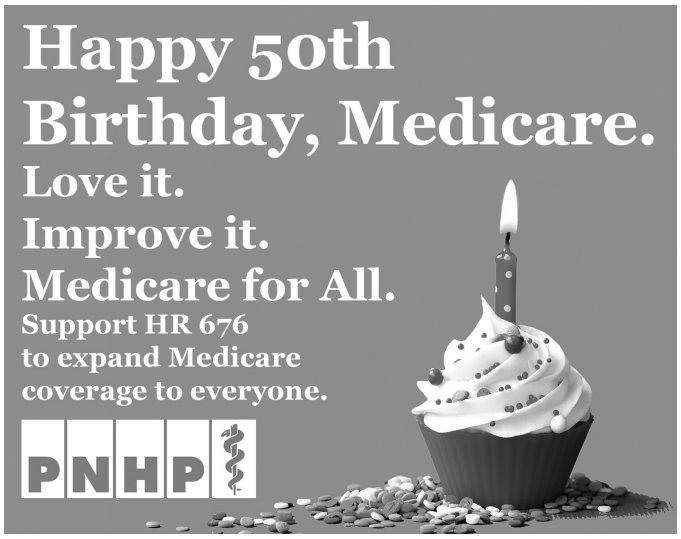
Fifty years later, Medicare and Medicaid have proven themselves as the most successful health programs in American history. They have given hundreds of millions of Americans access to care and have allowed tens of millions of them to avoid bankruptcy due to medical debt. Equally important, Medicare ended physical separation by race in doctors' waiting rooms in most of the South, although much provider racial discrimination still persists.

Unfortunately, the failure to enact true national health insurance for everyone has led to our current patchwork health care financing system that is unimaginably complex, bureaucratic, and inefficient. The system continues to base access to health care on employment, income, and disease category, which indirectly reflect race. Even today, the black infant mortality rate in the United States overall, as well as in Philadelphia, is more than twice the rate for whites.

Money wasted determining eligibility for coverage could be used to cover everyone. The amount of money wasted on administration in the United States is more than 40 percent higher per capita than in any other country in the world. It is more than enough to fully fund our schools, build bridges, and address other public priorities.

Wilbur Cohen, while defeated in his goal of achieving national health insurance for everyone, said that he believed in the "salami" approach – getting one slice at a time until there were enough of the pieces together to cover everyone. Fifty years later, it is time to make his dream a reality.

Dr. Walter Tsou is former commissioner of the Department of Public Health for the City of Philadelphia and past president of the American Public Health Association. He is currently adjunct professor of family and community health at the University of Pennsylvania.



PNHP chapter reports

UC Davis medical student Keyon Mitchell speaks at the "Medicare turns 50" rally in Oakland, Calif., July 30.

In **California**, PNHP members participated in numerous events celebrating Medicare's 50th anniversary in July. Medical student and former Shearer Student Fellow Keyon Mitchell spoke at a large rally in Oakland, while author and PNHP California Advisory Board member George Lakoff was a featured guest at a well-attended house party. Professor Gerald Kominski, also on the Calif. Advisory Board, spoke about the importance of Medicare at a garden party at the home of attorneys Jan Goodman and Jerry Manpearl, along with Santa Monica Mayor Kevin McKeown and U.S. Representative Ted Lieu. In October, the California Medical Association passed a resolution mandating a study of improvements to the Affordable Care Act that can be introduced under the Section 1332 Waiver. PNHPers are advocating that the study consider single payer as the best possible "improvement." In addition, the 4,300-member Union of American Physicians and Dentists voted on Oct. 24 to endorse single payer in response to a resolution submitted by longtime PNHP member William Tarran, D.P.M. To get involved in California, contact Bill Skeen, M.D., at bill@pnhpca.org.

Students from four Chicago-area medical schools rallied and marched in the city's Loop on Oct. 1.

In **Illinois**, PNHPers worked in conjunction with National Nurses United, the Illinois Single-Payer Coalition, and many other groups to hold a Medicare-for-All rally and protest outside Humana's Chicago headquarters on July 30. The event drew more than 200 health professionals and community members. In downstate Illinois, PNHP members and their allies in Southern Illinois People for Progress commemorated the day by arranging for a "Medicare's biggest birthday card" billboard on northbound Interstate 55. In the fall, the Illinois chapter hosted a PNHP table at the Student National Medical Association local conference. Medical students participated in a rally and candlelight vigil for victims of our health care system on Oct. 1. The vigil was part of a student day of action with events at over 30 medical schools nationwide. Finally, Illinois chapter members Dr. Susan Rogers, Dr. Claudia Fegan, and Dr. Anne Scheetz played prominent roles at the PNHP Annual Meeting and Leadership Training in October. Dr. Scheetz received the Dr. Quentin Young Health Activist Award, PNHP's highest honor, at the meeting. To get involved in PNHP Illinois, contact Dr. Anne Scheetz at anneschеetz@gmail.com.

Students at the Louisville School of Medicine designed T-shirts to publicize the #TenOne "Medicare for All" Day of Action.

In **Kentucky**, PNHP members helped to organize a new medical student chapter at the University of Louisville. The new student group, along with local PNHP members and community members, participated in the National Medicare-for-All Day of Action on Oct. 1, marching from the University of Louisville campus to a downtown square, where PNHP past President Dr. Garrett Adams spoke at a vigil for the uninsured. National PNHP board member Dr. Johnathon Ross also spoke in conjunction with Medicare's 50th anniversary, while chapter members served pieces of apple pie to community members at a public library to celebrate the successful Medicare program. To get involved in PNHP Kentucky, contact Dr. Garrett Adams at KYHealthCare@aol.com.

In **Maine**, the Maine AllCare chapter of PNHP celebrated Medicare's 50th anniversary at three events. Volunteers gathered hundreds of signatures on a petition to the Maine Congressional delegation urging support for H.R. 676 and for legislation to protect Medicare from privatization. The petitions were delivered in person to local congressional offices in October. Throughout the fall, PNHP members gave several talks to hospital and community organizations, and had multiple letters to

the editor published in local newspapers. The SNaHP chapter at the University of New England College of Osteopathic Medicine organized a teach-in with PNHP leaders as special guests. To get involved in Maine AllCare, contact Dr. Julie Pease at jkpeasemd@gmail.com.

In **Minnesota**, PNHPers are working with the Minnesota Nurses Association to build physician-nurse leadership teams throughout the state. This summer, chapter leaders mentored four medical student interns from the University of Minnesota. The interns completed research projects, set up speaking engagements for PNHP Minnesota members at residency programs, and distributed a health care survey at community events. In the fall, the chapter elected a new president, Dr. Charles Sawyer. The chapter also welcomes its new outreach coordinator, Amanda Shoberg. To get involved in PNHP Minnesota, contact Amanda Shoberg at amandapnhp@gmail.com.

Dr. Ed Weisbart, chair of PNHP Missouri, speaks from the floor at PNHP's Annual Meeting in Chicago on Oct. 31. Photo by Rob Zalas.

In **Missouri**, PNHP members gave more than 50 presentations in 2015. To facilitate speaking engagements, the chapter has crafted two new presentations – a talk tailored to a conservative audience, and a presentation geared towards helping single-payer supporters communicate with conservatives and independents. Chapter leader and PNHP board member Dr. Ed Weisbart reports that the conservative-oriented presentation is particularly well-received in rural Missouri. Additionally, chapter members have had several op-eds and letters to the editor published in recent months. To get involved in PNHP Missouri, contact Dr. Weisbart at edweisbart@gmail.com.

In **Nevada**, a group of eights physicians gathered to form the Nevada chapter of Physicians for National Health Program. Co-chairs Dr. Sean Lehmann and Dr. Joanne Leovy will lead the chapter, with help from board representatives in Las Vegas, Reno, and Carson City. The new chapters intends to spread awareness of single payer to friends and colleagues, as well as build support for H.R. 676 and develop a presence at two new medical schools which will open in Las Vegas in 2016. The chapter actively seeks new members and ideas moving forward. To get involved, contact Dr. Sean Lehmann at lehmann.dpm@gmail.com.

Dr. Mary O'Brien of the N.Y. Metro chapter is congratulated by Dr. Oliver Fein on receiving the Dr. Quentin Young Health Activist Award at PNHP's Annual Meeting. Photo by Rob Zalas.

The **New York Metro** chapter has continued to build on the momentum from the spring passage of the New York Health bill in the State Assembly. On Medicare's anniversary approximately 100 people gathered at the office of the Professional Staff Congress, the CUNY-faculty union, in Manhattan, where N.Y Metro PNHP Chair Dr. Oliver Fein spoke. Many of the attendees also traveled to the offices of their congressional representatives and asked them to halt the privatization of Medicare and support single payer. The chapter has developed eight SNaHP chapters at New York metro-area medical and public health schools with the help of their two student fellows, Becca Mahn from Albert Einstein School of Medicine and Alexander Edwards from Columbia University School of Public Health. The N.Y. Metro chapter also continues its successful monthly forum, featuring topics such as "Wrong Prescription? The Failed Promise of the Affordable Care Act," "Puerto Rico's Fight for Single-Payer Health Care," and a film about Remote Area Medical's large-scale free-clinics for the underserved. To get involved in the PNHP N.Y. Metro chapter, contact Katie Robbins at katie@pnhpnymetro.org.

The **New York Capital** District chapter organized a very successful Medicare anniversary event near Albany that drew 250 people and featured music by Peter Yarrow (formerly of Peter, Paul and Mary). The event was co-sponsored by the Capital District Alliance for Universal Healthcare, the Albany Confederation of Labor, the New York AFL-CIO, the Alliance of Retired Americans, and the United Auto Workers. To contact the Capital District chapter, email Dr. David Ray at doctorklez@yahoo.com.

In **North Carolina**, the Health Care Justice chapter in Charlotte and the Health Care for All North Carolina chapter in Chapel Hill partnered to organize a Medicare anniversary tour of the state with PNHP's immediate past president, Dr. Andy Coates. Dr. Coates gave presentations to medical and grassroots audiences in three cities. The chapters are working with the North Carolina Council of Churches to fight for Medicaid expansion in North Carolina. To get involved in North Carolina, contact Dr. Jonathan Kotch in Chapel Hill at jonathan_kotch@unc.edu or Dr. Jessica Schorr Saxe in Charlotte at jsaxe@earthlink.net.

Philadelphia medical students from Temple, UPenn and Rowan participated in the nationally coordinated actions and vigils on Oct. 1.

In **Pennsylvania**, Health Care for All Philadelphia has been working with Pennsylvania State Representative Pam DeLissio to create a state single-payer health care bill. PNHP chapter leaders anticipate that the bill will be introduced in the winter of 2015-2016. Pennsylvania businessman Richard Master produced a one-hour movie, "Fix It," which makes the business case for single payer. About half of the film was made in Pennsylvania and features many local PNHP leaders. Medical students at Temple University, the University of Pennsylvania, and the Drexel School of Medicine braved inclement weather to participate in the national Medicare-for-All Day of Action on Oct. 1. PNHP members also supported the event. Finally, PNHP Board Adviser Dr. Walter Tsou has given several grand rounds throughout the fall and winter. To get involved in Pennsylvania, contact Dr. Tsou at macman2@aol.com.

Tennessee medical students from Vanderbilt and other schools participated in celebrations of Medicare's 50th anniversary.

In **Tennessee**, the new Vanderbilt University SNaHP chapter organized a single-payer symposium to introduce their fellow students to the concept of Medicare for All. Dr. Art Sutherland spoke at the symposium, and students read PNHP's proposal for single payer as well as "Bitter Pill" by Steven Brill. A potluck celebration for Medicare's 50th anniversary was co-sponsored by Middle Tennessee PNHP. The Vanderbilt SNaHP chapter is looking forward to hosting the fifth annual national SNaHP Summit on March 5, 2016. To get involved in Tennessee, contact Dr. Art Sutherland at asutherland523@gmail.com.

In **Texas**, Health Care for All Texas hosted PNHP president Dr. Robert Zarr for a chapter visit in late September. Highlights of Dr. Zarr's visit included grand rounds at Texas Children's Hospital, an interview with the Houston Chronicle, two radio interviews, a reception with local PNHP members, and a Spanish-language presentation to the Living Hope Wheelchair Foundation, which is a community group of mostly Mexican immigrants with spinal injuries. After Dr. Zarr's visit, medical students at the University of Texas were inspired to form a new chapter of Students for a National Health Program in Houston. Recently, PNHP National Board member Dr. Ed Weisbart gave two presentations in Dallas, including to the SNaHP chapter at University of Texas – Southwestern. To get involved in Texas, contact Rosalia Guerrero-Luera at info@hcfat.org.

University of Washington School of Medicine students joined the nationwide #TenOne actions and vigils.

In **Western Washington**, the PNHP chapter is working with the Health Care is a Human Right Campaign and many other organizations to improve and amend their state universal health care bill, H.B.1321. The chapter is also finalizing its five-year strategic plan, including preparations for its Annual Public Meeting on Feb. 20, 2016. In August, PNHP member Dr. Hugh Foy spoke at Seattle's birthday celebration for Medicare, Medicaid, and Social Security. Dr. Sherry Weinberg and Dr. Hal Stockbridge succeeded in passing a resolution in the Washington State Medical Association's House of Delegates (HOD) to set up a workgroup to study and monitor efforts to achieve universal health coverage in the state, and report back to the HOD next year. Dr. Weinberg hopes to participate in that workgroup.

Finally, PNHP Western Washington continues to support the University of Washington SNaHP chapter, which now has over 70 members. To get involved in Western Washington, contact Dr. Sherry Weinberg at weinbergsk@msn.com.

PNHP members honored by peers for 'Excellence'

Congratulations to **Dr. James Mitchiner**, a tireless activist for single payer in Michigan. Dr. Mitchiner received the Excellence in Health Policy award from the American College of Emergency Medicine in October.

Congratulations to **Dr. Oliver Fein** of New York City for receiving the American Public Health Association's Award for Excellence in November. He was recognized for his lifetime achievements in health care advocacy and activism.

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November 6, 2015

'Fix It': CEO Richard Master masterminds full Medicare for All

By Ralph Nader

Just when the prospects for single-payer or full Medicare for everyone, with free choice of doctors and hospitals, appear to be going nowhere, from Pennsylvania's Lehigh Valley comes a stirring that could go national and make single-payer a reality.

Throwing down the gauntlet on the grounds of efficiency and humanness, businessman Richard Master, CEO of MCS Industries Inc., the nation's leading supplier of wall and poster frames, is bent on arousing the nation's business leaders to back single-payer – the efficient full Medicare for all – solution.

The woefully wasteful and profiteering health care industries have blocked majority opinion, and a majority of physicians and nurses, to keep the present sky-high costly system in place, that receives huge taxpayer subsidies without any reasonable, and meaningful, price restraints. Health care companies exploit the complexities of Obamacare, which is powerless to restrain price spirals (note the staggering rise in recent prices of certain drugs). But the health care industry cannot defeat an organized business community fed up with uncontrollable cost burdens and the further competitive disadvantages they experience with western European countries, Japan or Canada – countries that have single-payer systems at half the per capita costs or less.

Mr. Master's first step is now complete. He has produced a short movie called "Fix It: Healthcare at the Tipping Point" which makes a powerful business case for replacing the current wasteful multi-payer system with a single payer one. He traveled with his award-winning filmmakers to Canada, where he interviewed doctors, nurses and conservative business people. The latter were aghast over why their fellow conservatives in the U.S. are not seeing the light.

One industrialist, Dann Konkin, told the filmmakers that he embraces the Canadian healthcare system because it reduces his company's costs. The film quotes Michael Grimaldi, former president of General Motors of Canada, as declaring that the Canadian healthcare system "significantly reduces total labor costs for automobile manufacturing firms."

Master and his crew then traveled to Taiwan, which has free choice of physician and hospital, and spends just 1.6 percent of its total operating health care budget on administration. Compare that figure with what Master estimates to be over 30 percent in the United States, with every doctor on average paying $80,000 a year on such administration costs.

Master has his numbers down. This year, health care will exceed the $3 trillion level in the U.S. People are anxious and worried about whether they are covered, what their co-pays, deductibles and exclusions will be or what they qualify for under the health industry fine-print contract, or the Obamacare criteria. Master believes that lifting the burgeoning burden and paperwork by enacting a system with public insurance and private delivery of health care will make our economy more efficient and our business more expansive.

His own company just got a 35 percent initial premium increase this year. That amounts, he says, to be $1.50 to $2.00 an hour for a production or warehouse worker in his firm.

The fifty members of the House of Representatives who have signed on to H.R. 676 legislation for single-payer, full Medicare for all will probably be delighted to hear about Richard Master's film and his plans to spark a movement through our nation's small and big businesses.

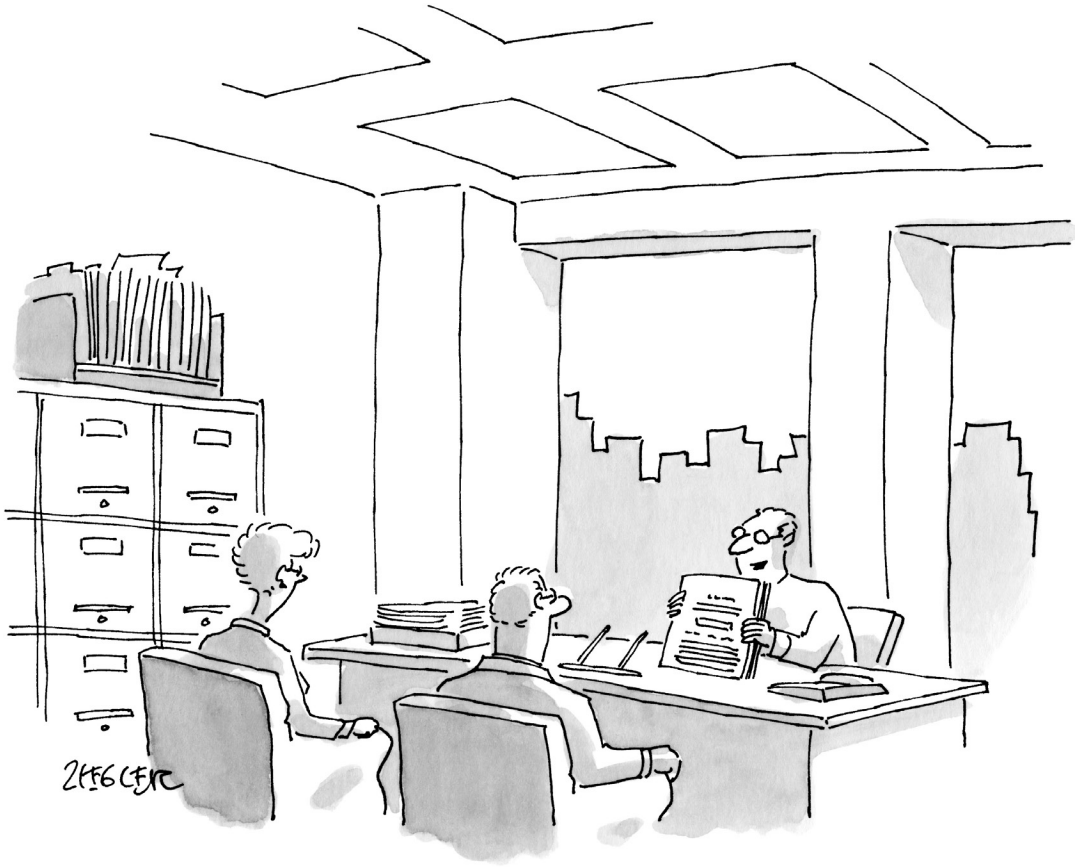
I asked Master why the business community, surely knowing what he knows about the costs, did not unfurl the single-payer flag long ago. He replied that they are misinformed by legions of insurance agents and others in the industry who populate chambers of commerce everywhere. He knows that single-payer actually strengthens the free, competitive market of delivering health care, far more than the insurance companies and restrictive networks do.

There is another reason businesses haven't championed this issue. Businesses do not like to take on other sectors of business or changes that present an existential peril to the latter. Single-payer, as Medicare for the elderly did in the mid-Sixties, replaces the health insurance companies. That is too much conflict for corporations. The next step for this historic advance is for Mr. Master to take his film to business audiences around the nation. I suggested that Mr. Master also organize a major conference of representatives of all business sectors in Washington, D.C. to make the definitive statement that rational health care through full Medicare for all is about to be put on the national policy agenda.

What issue could more enliven more a presidential election year?

Master's film can be found at www.fixithealthcare.com.

Ralph Nader is a consumer advocate, lawyer and author.



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