



PHYSICIANS FOR
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PROGRAM



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Renewed debate over single payer

Sen. Bernie Sanders' vigorous advocacy of Medicare for All in the Democratic presidential primary has reopened the national debate over single payer and built a base of millions of new supporters. Hits to PNHP's website have tripled since December, spiking at 95,760 in February. In response to attacks on single payer by Hillary Clinton and others, PNHPers have published numerous op-eds and articles; a selection is reprinted on pages 11-23. Some attacks have claimed that implementing single payer would be financially disruptive to patients and providers; PNHP's plan for a smooth transition to single payer published in JAMA in 1991 (reprinted on p. 45, with updated tables) rebuts those claims. PNHP has also issued a report card grading the presidential candidates' health plans, which is available at www.pnhp.org/reportcard.



Students pack auditorium at Summit's opening. Photo: Mark Chee

Successful Student Summit in Nashville

In March, PNHP's student wing, Students for a National Health Program (SNaHP), held its fifth annual Summit at Vanderbilt University School of Medicine. Nearly 170 medical and health professional students from 48 schools in 22 states participated in the inspiring event, "New Frontiers for the Civil Rights Movement." Dr. Stephen Raffanti, an internationally-known AIDS expert and faculty member at Vanderbilt, gave the keynote. The Summit's student-led workshops, focused on building political advocacy skills, were a highlight. For details, see p. 35.

Save the date – Annual Meeting Nov. 19

PNHP's Annual Meeting will be held on Saturday, Nov. 19, in Washington, D.C., at the Westin City Center (1400 M St. NW). It will be preceded by PNHP's popular Leadership Training on Friday, Nov. 18. The theme of the meeting will be "Post-election opportunities and challenges for single payer."

New Physicians' Proposal unveiled

Kicking off the release of a newly updated Physicians' Proposal for health reform with an editorial in the American Journal of Public Health, Drs. Adam Gaffney, Marcia Angell, Steffie Woolhandler and David Himmelstein write that a single-payer program "would at long last take the right to health care from the realm of political rhetoric to that of reality" (p. 9). The full proposal, "Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care," has been posted online by the American Journal of Public Health and is reprinted in this newsletter starting on p. 39. PNHP members are encouraged to distribute the articles widely and invite colleagues to join PNHP at www.pnhp.org.

Two-thirds of health care funded by taxes

We already pay for national health insurance, but don't get it. Taxes funded 64.3 percent of total U.S. health spending in 2013, a figure that is expected to rise to 67.3 percent by 2024, according to a new study in the American Journal of Public Health. Americans pay the highest taxes for health care in the world (11.2 percent of GDP in 2013), exceeding the total of public and private health spending as a share of GDP in every other nation. See study, p. 24.

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Membership drive update

Welcome to 690 physicians and medical students who have joined PNHP in the past year, bringing our total membership to 20,378. We invite new (and longtime) PNHP members to participate in our activities and take the lead of behalf of PNHP in their communities. Need help getting started? Drop a note to PNHP National Organizer Emily Henkels at e.henkels@pnhp.org. Membership is half-price for medical residents who join or renew their membership in June – just \$20!

Help staff PNHP's booth at AAFP

PNHP is hosting exhibits at the meetings of the American College of Physicians (Washington, D.C., May 5-7) the American Psychiatric Association (Atlanta, May 15-17), and the American Academy of Family Physicians (Orlando, Sept. 21-23). Several PNHPers have formed a single-payer interest group within the AAFP. To join the group and its monthly organizing calls, contact Dr. Parker Duncan at pduncs@gmail.com.

Upcoming PNHP webinars

PNHP has a webinar program for ongoing education and inspiration for members, especially graduates of our Leadership Training. PNHP's 2016 webinar series was kicked off on March 10 by Dr. Steve Kemble, who delivered a presentation on "**Responding to recent attacks on single payer.**" Dr. Kemble's engaging talk was recorded and is posted online on PNHP's YouTube channel at bit.ly/1VOgNDx.

The next webinar, "**Recent developments in single payer research**" will be presented by Dr. Danny McCormick on Thursday, June 9, at noon. Dr. McCormick is a health services researcher, an associate professor at Harvard Medical School and a primary care physician at the Cambridge Health Alliance.

The final two webinars of the year will be "**Elements of an effective PNHP chapter,**" presented by Drs. Ann Sett gast and Jessica Schorr Saxe on Thursday, September 8, and "**A post-election grand rounds for single payer,**" with Dr. Dave Dvorak on Thursday, December 8. Dr. Sett gast is an assistant professor of internal medicine at the University of Minnesota and a primary care physician at HealthPartners Center for International Health. She co-chaired the Minnesota chapter of PNHP for many years, building it into one of PNHP's most robust chapters. Dr. Jessica Schorr Saxe is a family physician in Charlotte, N.C., and the chair of the Health Care Justice chapter of PNHP. Dr. Dave Dvorak practices emergency medicine in Minnesota and frequently writes and lectures in support of single payer.

To register for a webinar, drop a note to PNHP Policy Director Dr. Ida Hellander at ida@pnhp.org.

In memoriam

We are deeply saddened to announce the death of PNHP's longtime national coordinator, Dr. Quentin Young, at age 92. He made working on single payer a lot of fun. See page 30.

Health care crisis by the numbers:

Data update from the PNHP newsletter editors

UNINSURED AND UNDERINSURED

- 32.3 million non-elderly people lacked health coverage in the U.S. at the beginning of 2015. Of these, 51 percent (16.4 million) are not eligible for assistance under the Affordable Care Act or their state has not expanded Medicaid, while 49 percent (15.9 million) of the uninsured are eligible for Medicaid or subsidized private coverage but haven't enrolled.

About 10 percent (2.9 million) of the uninsured are poor individuals who lack coverage because they live in one of 19 states that failed to expand Medicaid. About 15 percent (4.9 million) are undocumented immigrants who are excluded from ACA coverage. Another 15 percent of the uninsured are ineligible for assistance because they have turned down an offer of employer-sponsored coverage, while 12 percent have incomes too high for subsidized coverage (Garfield et al., "New estimates of eligibility for ACA coverage among the uninsured," Kaiser Family Foundation, 1/22/16).

- Eighty-five percent of the uninsured were unaware that the deadline for signing up for coverage for 2016 was Jan. 31, according to a Kaiser poll conducted in mid-January. The minimum penalty for being uninsured in 2016 is 2.5 percent of income, or \$695 per adult and \$347.50 per child, up to a maximum of \$2,085. Starting in 2017, the penalty will be 2.5 percent of income or the flat fee, which will be adjusted annually for inflation (Kodjak, "Still uninsured? Buy a health plan this week to avoid a tax penalty," NPR, 1/28/16).

- About 12.7 million people enrolled in private health insurance through the federal and 13 state marketplaces for 2016, up from 11.7 million in 2015. Of those who enrolled in 2015, 9.3 million paid their premiums and were still enrolled in September. The Obama administration estimates that 10.1 million people will have exchange coverage throughout 2016 (Galewitz, "2016 Obamacare Enrollment Tops Expectations at 12.7 million," Kaiser Health News, 2/4/16).

- About 36 percent of privately insured Americans were covered by high-deductible health plans in 2015, up from 25 percent in 2010, according to the CDC (National Center for Health Statistics, February 2016).

COSTS

- Prescription drug spending accounts for about 10 percent of national health expenditures. But drugs represent a larger share, 19 percent, of employer spending on health benefits, and a similar share of Medicare spending when drugs administered mainly by physicians are included (Altman, "Prescription drugs' sizable share of health spending," Wall Street Journal, 12/13/15).

- Health care costs are projected to rise 5.8 percent to \$3.4 trillion, \$10,527 per capita, 18.1 percent of GDP in 2016. Last year they were an estimated \$3.2 trillion, \$10,125 per capita, 18.0 percent of GDP. At this rate, by 2024, health care costs will top \$5.4 trillion, consuming 19.6 percent of GDP, according to CMS (Keehan, "National Health Expenditure Projections 2014-2024," Health Affairs, July 2015).

Twenty percent of insured Americans reported having trouble paying their medical bills last year in a Kaiser poll. Among those who reported having problems paying medical bills despite having insurance, 75 percent said the amount they had to pay for co-pays, deductibles, or coinsurance was more than they could afford, 63 percent said they used up all or most of their savings, and 43 percent said they skipped medical care they needed in the past year due to the cost. Two-thirds of those with a medical bill problem said it stemmed from a one-time event like a hospitalization or accident rather than treatment for a chronic illness. A separate survey by the Harvard School of Public Health found that 26 percent of all adults reported a "somewhat" or "very" serious financial problem as a result of health care costs (NPR/RWJ/Harvard School of Public Health poll, Sept. 8-Nov. 9, 2015, "Patients Perspectives on Health Care in the U.S.," Robert Wood Johnson Foundation, February 2016; New York Times/Kaiser poll, 1/5/16).

- The average employer-based family policy cost \$17,545 in 2015, of which employees paid \$4,955. The average deductible for a family HMO policy was \$2,758 ("2015 Kaiser Employer Health Benefits Survey," Kaiser Family Foundation, 9/25/15).

A recent study examined the persistence of high health spending over time. Among enrollees who incurred health care costs in the top 10 percent (> \$30,000) in any given year, 43 percent were also in the top 10 percent the following year, and 34 percent were in the top 10 percent five years later. Conversely, over the six-year period of the study, 69.8 percent of enrollees never had annual spending in the top 10 percent, and the bottom 50 percent of enrollees accounted for less than 10 percent of spending. The authors concluded that "the persistence at both ends of the spending distribution indicates the potential for adverse selection and cream skimming" (Hirth et al., "New evidence on the persistence of health spending," Medical Care Research and Review, June 2015).

ACA UPDATE

- The cost of marketplace plans increased an average of 12.6 percent in 2016, according to the Robert Wood Johnson Foundation, but in some states the hike was threefold higher. Prices

for the second-cheapest silver plan (the benchmark plan) for a 27-year-old ranged from a low of \$189 in Arizona to a high of \$590 in Alaska, where premiums jumped 35.6 percent (Modern Healthcare, 11/9/15).

ACA plans limit access to specialists, particularly oncologists. A study of silver plans on the market in 2014 found that 36 percent of plans had “ultra-narrow” networks of specialists (less than 25 percent of area specialists were in the plan) while only 21 percent were “broad” (with more than 60 percent of area specialists). Access to oncologists was especially limited. For cancer care, 59 percent of plans limited access to an ultra-narrow network, while only 4 percent allowed broad access to oncologists in the region (Weiner, “The skinny on narrow networks in health insurance marketplace plans,” LDI/Robert Wood Johnson, 6/23/15).

- The federal and state health care marketplaces are costly to run. The state exchanges received \$4.3 billion in federal funds to get started, but as of Jan. 1, 2015, are supposed to be self-supporting. The federal marketplace tacks a 3.5 percent fee on premiums to cover its costs. At the state level, the assessments vary, from 2 percent of premiums in Idaho, to 3.5 percent in Minnesota, to \$13.95 per member per month in California. Several states – Colorado, Connecticut, Kentucky, Maryland, New York, and the District of Columbia – assess a 1 to 2 percent fee on all plans sold in the state, not just on the exchanges. Hawaii, Nevada, New Mexico, and Oregon have shifted costs to the federal government by becoming “federally-supported state-based marketplaces” (Miskell, “State-based marketplaces look for financing stability in shifting landscape,” Commonwealth Fund, 5/14/15; “State Health Insurance Marketplace Types 2016,” Kaiser Family Foundation).

The ACA requires health insurers to cover 10 essential health benefits, including prescription drugs and substance abuse treatment. But private insurance plans sold in the marketplaces are not required to cover the medication-assisted treatment (MAT, most commonly with methadone or buprenorphine) that many opioid addicts need. In addition, providers and patient advocates report that high co-pays and other barriers limit access to treatment. Despite the highly lethal opioid epidemic, the nation’s largest health insurers and pharmacy benefit managers are lobbying CMS against adding MAT to essential health benefits (Herman, “Opioid addiction treatment argued as essential insurance benefit,” Modern Healthcare, 1/4/16).

- The nation’s largest health insurer, UnitedHealthcare, may pull out of the ACA marketplaces after this year, disrupting care for 800,000 policyholders. UnitedHealthcare estimates it will lose about \$720 million in 2015 and 2016 on the plans. But overall, it reported 2015 profits of \$6.8 billion, on revenues of \$131.3 billion, mostly from government payers. Blue Cross and Blue Shield of North Carolina reported a loss of more than \$400 million on its first two years on the exchanges. In response, it raised

its rates an average of 32.5 percent (Herman, “UnitedHealth’s ACA exchange losses reach \$720 million,” Modern Healthcare, 1/19/16; Conover, “Obamacare pummels Blue Cross Blue Shield of NC,” Forbes, 1/30/16).

- The so-called Cadillac tax, a 40 percent excise tax originally scheduled to go into effect in 2018 on private health plans with premiums above a certain threshold (> \$10,200 for individual coverage and \$27,500 for family coverage) has been delayed by two years. The cost of paying the tax was also made tax deductible. But employers are unlikely to reverse the trend of shifting more of the cost of health care onto workers in anticipation of the tax, which is projected to raise over \$70 billion between 2020 and 2025 (Alonso-Zaldivar, “Workers unlikely to see relief from delay of health plan tax,” Washington Post, 12/16/15).

Health plans sold in the ACA’s marketplaces offer less protection against high prescription drug costs than employer-based plans, according to an analysis supported by the Commonwealth Fund. Only 11 percent of employer-based plans require an enrollee to meet a deductible before receiving coverage for prescription drugs, compared with 91 percent of bronze plans, 52 percent of silver plans, and 37 percent of gold plans. Co-pays for drugs on the marketplace are also higher than for employer based coverage e.g. the average co-pay for a preferred (low-tier) brand in a bronze plan is \$60 compared to \$31 under employer-sponsored coverage and the average co-pay for a non-preferred (high tier) brand is \$102 versus \$53 for employer-sponsored coverage. Marketplace plans also have higher general deductibles. The average general deductible for bronze plan was \$5,187, compared with \$2,951 for a silver plan and \$1,217 for employer-based coverage (Gabel et al., “Consumer Cost-Sharing in Marketplace vs. Employer Health Insurance Plans, 2015,” The Commonwealth Fund, December 2015).

- Spending on health care premiums and out-of-pocket expenses by people insured through the ACA’s marketplaces consumes a significant share of household income, especially if health care needs are high, according to a simulation by the Urban Institute. Among families with modest incomes (between 200 percent and 500 percent of the federal poverty level) and median health expenses, health care consumes 11 to 15 percent of income, but that rises to 21 to 23 percent of income if health care spending is in the highest decile. People ineligible for Medicaid with median health care expenses and incomes below 200 percent of FPL spend 6.6 percent of their household incomes on health care. But their costs rise to 18.5 percent of income if they are in the highest decile for health spending (Blumberg, “How much do marketplace and other non-group enrollees spend on health care relative to their incomes?” Urban Institute, December 2015).

MEDICARE

- A recent analysis by the Kaiser Family Foundation found that a Medicare Part D beneficiary taking one of 12 specialty drugs used to treat four health conditions – hepatitis C, multiple scler-

rosis, rheumatoid arthritis, and cancer – would incur \$4,000 to \$12,000 in out-of-pocket costs a year for that drug alone. Among plans that cover the hepatitis C medication Sovaldi, the median out-of-pocket cost in 2016 is \$6,608. In 2014, 2 percent of seniors were prescribed a specialty-tier drug, defined by Medicare as a drug that costs more \$600 per month (Hoadley, “It pays to shop,” Kaiser Family Foundation, 12/2/15).

- Government Accountability Office auditors estimated that CMS overpaid private Medicare Advantage plans by \$3.2 billion to \$5.1 billion between 2010 and 2012 because of the inaccuracy of their risk-adjustment model. CMS has also failed to establish a timeline to correct the problem, according to the chief of the GAO, Gene Dodaro (Rein, “All that advice on how to save money? Lots of it goes down the drain, watchdogs tell Congress,” Washington Post, 12/11/16).

- CMS has proposed a net 3.55 percent increase in payments for private Medicare Advantage (MA) plans in 2017, despite the plans already being overpaid. MA plans garner excess payments through a variety of means, including by performing health risk assessments on new enrollees to log extra diagnoses (that may never require treatment). This “upcoding” allows the plans to game the risk-adjustment scheme in their favor. MedPAC voted 15 to 1 against using data from health risk assessments in determining payment, but CMS ignored their recommendation, citing the need to increase payments for coverage of dually eligible beneficiaries. (Dually eligible beneficiaries are covered both by Medicare and Medicaid.) Although a recent study by the consulting group Avalere Health found that MA plans were underpaid by an estimated \$401.8 million for dually eligible patients with three or more chronic conditions, the same study found that MA plans were overpaid threefold more, by \$1.2 billion, for dually eligible members with few or no chronic conditions. This year, more than 360 members of Congress, led by Sen. Chuck Schumer, D-N.Y., signed a letter urging CMS to maintain MA payment levels. Schumer has received hundreds of thousands of dollars in campaign donations from health insurers (“2017 Medicare Advantage and Part D Advance Notice and Draft Call Letter,” CMS.gov, 2/19/16; opensecrets.org).

- CMS suspended enrollment in Cigna’s Medicare Advantage and Medicare Part D drug plans after “widespread and systemic failures” were discovered by a federal audit, but that won’t stop Cigna from getting up to \$350 million in bonus money for meeting quality goals under Medicare’s “star rating” program. The plans, which enroll about 1.5 million people, inappropriately denied care and mishandled appeals and grievances, threatening beneficiaries’ health, according to a Jan. 21 letter from CMS. CMS rescinded its policy of reducing the star ratings of MA plans facing sanctions just weeks before the deadline. “It’s enough to make someone cynical about health insurance,” wrote Bloomberg reporter Max Nisen. “Cigna allegedly spent years making it tougher for seniors to get care. ... Hopefully sanctions will prompt the company to clean up its act. But the long-term impact on the industry is likely to be pretty much zilch” (Nisen, “Cigna Medicare sanctions are just a wrist slap,”

BloombergGadfly, 1/25/16; and Herman, “Anthem, Cigna enjoy stock boost after Medicare Advantage change,” Modern Healthcare, 3/10/16).

- Humana was fined \$3.1 million by CMS for mishandling prescription drug coverage for seniors. “Humana’s failures in these areas were systemic and resulted in enrollees experiencing inappropriate delays or denials in receiving covered benefits or increased out-of-pocket costs,” CMS wrote. Aetna was also fined \$1 million. The firm listed nearly 7,000 non-network pharmacies as being “in-network,” misleading seniors who had to change pharmacies or pay out-of-pocket for medications (Ladwig, “Feds fine Humana \$3.1 million for Medicare violations,” Insider Louisville, 3/9/16).

MEDICAID

- Since 2014, 31 states and the District of Columbia have adopted the Medicaid expansion legislated under the Affordable Care Act. 19 states have not adopted the expansion. Medicaid enrollment is up 26 percent, to 72 million, since 2013 (“Current Status of State Medicaid Expansion Decisions,” Kaiser Family Foundation, 3/14/16).

Medicaid provides better financial protection than private insurance. Low-income households with Medicaid spend less on health care annually than their counterparts without Medicaid. On average, health spending was \$235 by households with Medicaid (1 percent of income) compared with \$1,739 (6 percent of income) by low-income households without Medicaid in 2014. Non-Medicaid households spent less on food and housing than households with Medicaid, suggesting that their higher health spending is crowding out spending on other necessities. Low-income families in which every family member is privately insured spent tenfold more on health care than families with Medicaid, \$2,401 vs. \$235, respectively. The privately insured also had higher out-of-pocket costs (\$391) than families with Medicaid (\$147) (Majerol, “Health care spending among low-income households with and without Medicaid,” Kaiser Family Foundation, 2/4/16).

- Iowa privatized its Medicaid program, which enrolls 560,000 people, in January. Three private firms – UnitedHealthcare, Amerigroup, and Amerihealth – will receive as much as \$504 million in the first year to run the state’s \$4.2 billion Medicaid program. Iowans opposed to the move cited the negative experience of Kansas, which moved 95 percent of its Medicaid beneficiaries to managed care in 2013. A hospital administrator at Kansas’s Lawrence Memorial Hospital testified before that state’s legislature that she has had to double the number of staffers dealing with claims and appeals since private insurers took over Kansas’s Medicaid program. Although the hospital has a 90 percent success rate in appealing Medicare denials, it only succeeds in appealing Medicaid managed care denials one-third of the time (Hancock, “LMH accuses KanCare contractors of systematically denying legitimate claims,” LJWorld.com, 12/29/15).

- Arkansas is the latest state to seek to charge premiums for beneficiaries of the ACA's Medicaid expansion with incomes of as little as 50 percent of the federal poverty limit. The state is also seeking to make a referral to job training mandatory for enrollees. Arkansas enrolled about 250,000 people into private insurance plans instead of traditional Medicaid (Kauffman, "Arkansas governor asks feds to explore Medicaid expansion changes," KUAR Public Radio, 1/4/16).

GALLOPING TOWARD OLIGOPOLY

- Hospitals in the Atlanta area are consolidating. Wellstar Health System, which operates five hospitals in Marietta, Ga., is purchasing five hospitals in Atlanta from Tenet Healthcare Corp. for \$661 million. It is also finalizing a partnership with West Georgia Health, a hospital and health system 60 miles from Atlanta. Piedmont Healthcare, a six-hospital nonprofit in Atlanta with \$1.9 billion in revenue in 2015, merged with Newton Medical Center in Covington, Ga., and is exploring a merger with Athens Regional Health System. Athens is eager to find a partner after a disastrous rollout of a new electronic health record last year. Emory's proposed merger with Wellstar fell through; it has brought in a new CEO to help it expand (Barkholz, "Hospital consolidation speeds up in Atlanta," Modern Healthcare, 1/4/16).

- The U.S. Justice Department's antitrust division is reviewing three large insurance mergers: Anthem's \$54 billion purchase of Cigna, Aetna's \$37 billion purchase of Humana, and Centene's \$7 billion deal to buy Medicaid insurer Health Net. Decisions are expected this summer (Herman, "Insurer mergers, ACA exchanges' sustainability will be issues to watch in 2016," Modern Healthcare, 1/1/16).

- Nonprofit health firms are merging too. Kaiser Permanente is acquiring Seattle's Group Health, part of a wave of hospital system and health insurance mergers nationwide. Kaiser has 10.3 million members in eight states and Washington, D.C., and \$60 billion in annual revenues. Group Health has 590,000 members and \$3.5 billion in annual revenues. Kaiser Permanente will put \$1.8 billion into a new Group Health Community Foundation as a part of the plan. Group Health told their members they were pursuing the merger for several reasons, starting with "our members need and deserve better billing systems" (Aleccia, "Group Health to be acquired by Kaiser Permanente," Seattle Times, 12/4/15; and Group Health news release, "Q and A: Group Health Joining Kaiser Permanente," 1/15/16).

CORPORATE MONEY AND CARE

- Cigna CEO David Cordani's compensation nearly doubled to \$49.0 million in 2015, placing him among the most highly paid insurance executives last year, according to SEC filings. He also received \$13 million in stock awards and option awards that will provide value in future years. Medicaid managed care insurer Centene paid CEO Michael Neidorff \$44.0 million, an increase of 56 percent over his 2014 compensation. Neidorff also received \$12.3 million in stock and option awards. Anthem CEO Joseph Swedish made \$15.7 million last year, not including stock and option awards of \$10.4

million (Analysis of SEC filings for 2015 by PNHP).

- Insurance giants UnitedHealth Group, Aetna, and Anthem have shifted their business model to taxpayer-funded coverage. Between 2009 and 2014, Medicare and Medicaid-funded coverage increased from 49 percent of United Healthcare's revenues to 59 percent, while Aetna increased its Medicare and Medicaid-funded coverage from 24 percent of revenues to 42 percent. Thirty-one percent of Medicare beneficiaries, 17.9 million people, were in private Medicare plans last year, while 70 percent of all Medicaid beneficiaries, 51.3 million people, were in private Medicaid plans. Both insurers have ditched America's Health Insurance Plans, the trade organization for health insurers, and joined a Medicare Advantage lobbying group, the Better Medicare Alliance. Anthem's revenues from Uncle Sam (\$40.1 billion) exceeded its revenues from commercial insurance (\$37.6 billion) for the first time in 2015. Wall Street is happy about the shift: Since 2009, stock prices for Anthem, Aetna, and UnitedHealth Group are up 469 percent, 628 percent, and 814 percent, respectively (Herman, "Seismic changes in health insurance bring opportunities and friction," Modern Healthcare, 1/1/16; Potter, "No, Obamacare isn't killing the insurance industry," healthinsurance.org, 3/1/16).

- Companies that help hospitals with billing and collections ("revenue cycle management") are growing. The market for revenue cycle software and services is expected to grow to \$52 billion by 2020, up from \$43 billion this year, according to the consulting firm McKinsey. Pamplona Capital Management, a private equity firm, recently acquired MedAssets for \$2.7 billion, after acquiring Precyse, a firm that documents medical treatment for insurers, last year. In 2015, MedAssets collected \$450 billion in gross revenues. The equity firm is also buying a stake in Patientco Holdings and planning other acquisitions. Accretive and Tenet's Conifer are the other major revenue cycle firms (Evans, "Behind Pamplona's bid to build a revenue-cycle giant," Modern Healthcare, 1/25/16).

- Olympus will pay \$646 million for violating federal kickback statutes in connection with payments and equipment given to doctors and hospitals to purchase its endoscopes and other medical devices. The settlement includes \$312.4 million to resolve the criminal charges and \$310.8 million for causing providers to submit false billing claims to Medicare and Medicaid. The firm made cash payments of as much as \$100,000 annually to key physicians (Silverman, "Olympus to pay record \$646 million to settle charges of kickbacks," STAT, 3/1/16).

PHARMA

- Pfizer called off its \$160 billion merger with the Irish firm Allergan after new U.S. regulations were adopted to make "tax inversion" deals more difficult. The deal would have allowed Pfizer to move its headquarters to Ireland and dodge \$35 billion in U.S. taxes on profits from international sales that it is currently holding in offshore tax shelters. U.S. firms are taxed when they bring profits they've earned abroad into the U.S., but as an Irish firm, Pfizer would have been off the hook (Clemente, "Pfizer: Price Gouger, Tax Dodger," Americans for Tax Fairness, February 2016).

The high cost of Gilead's greed

Former Gilead CEO John Martin garnered \$232 million in total compensation in 2015, on top of \$193 million in pay in 2014 and \$169 million in 2013. Gilead's costly hepatitis C drug Sovaldi was approved by the FDA in December 2013 (Analysis of SEC filings for 2015 by PNHP).

The Senate Finance Committee investigating Gilead's pricing strategy of Sovaldi found that it was entirely driven by the goal of "maximizing revenue." A review of 20,000 pages of internal company documents found no evidence that R&D costs, the multibillion-dollar purchase of the firm holding the patent, Pharmasset, or human consequences factored into how Gilead set the price at \$1,000 per pill, \$84,000 for a single course of treatment. "Fostering broad, affordable access was not a key consideration," the committee found. Instead, the firm set the price high in order to garner greater revenues than existing treatments, and to create a baseline for its combination drug Harvoni, which it priced at \$94,500. Gilead offered state Medicaid programs rebates of up to 10 percent, but only if states dropped their restrictions, such as limiting the drug to patients with advanced disease. In the 18 months following Sovaldi's approval, Medicare spent nearly \$8.2 billion before rebates on Sovaldi and Harvoni. The vice-chair of the Finance Committee, Sen. Ron Wyden, D-Ore., said, "If Gilead's approach to pricing is the future of how blockbuster drugs are launched, future cures for cancer, Alzheimer's, diabetes and HIV will be "unaffordable and out of reach to millions who need them." (News release, "Wyden-Grassley Sovaldi investigation finds revenue-driven pricing strategy behind \$84,000 hepatitis drug," U.S. Senate Finance Committee, 12/1/15).

Meanwhile, class action lawsuits have been filed in four states – Indiana, Massachusetts, Minnesota, and Pennsylvania – charging that state Medicaid programs and prisons are denying hepatitis C patients effective but costly treatment with medications like Sovaldi and Harvoni. Medicaid recipients have a slightly higher rate of hepatitis C infection than people with private insurance, while prisoners have a rate thirtyfold higher. Due to their high cost, and few discounts from the manufacturers, state Medicaid programs and prisons have restricted the new treatments to patients in advanced stages of the disease. But under federal law, a state can only exclude a drug from Medicaid if its prescribed use is "not for a medically accepted indication." The standard for prisoner's health care is lower: Prisons must not demonstrate "a deliberate indifference to serious medical need." In 2014, Medicaid programs spent \$1.3 billion on Sovaldi to treat just 2.4 percent of the estimated 700,000 Medicaid enrollees with hepatitis C. The medical director of Oregon's state prison system estimated that it would cost over \$200 million to treat all Oregon prisoners with the disease, fourfold more than the system's entire annual health care budget (Ollove, "Are states obligated to provide expensive Hepatitis C drugs?" Texas Herald Democrat, 2/9/16).

- Drug prices are continuing to climb after skyrocketing 12.2 percent in 2014. Pfizer raised its list prices on over 60 brand name drugs by 10.6 percent at the beginning of year. At least three other big drug firms – Amgen, Allergan, and Horizon – have also raised prices for a broad spectrum of products. Several very costly drugs are among those receiving price hikes. Vanda has raised the price of Hetlioz, which treats a sleep disorder in blind people, by 76 percent since it was introduced in 2014, to \$148,000 per year. Acorda raised the price of Ampyra, for multiple sclerosis, by 11 percent to \$23,650 per year. Amgen has raised the price of anti-inflammatory drug Embrel by 26 percent since mid-2015, to more than \$36,600 a year. The price of Alcantin A, a combination of steroid and antibiotic gel to treat eczema and skin infections, is up almost twentyfold in the past year. The average annual retail price among 622 medications commonly used by seniors doubled from \$5,571 in 2006 to \$11,341 in 2013, according to an analysis by the AARP (Loftus, "Drugmakers raise prices despite criticism," Wall Street Journal, 1/10/16; "AARP: Price hikes doubled average drug price over 7 years," Associated Press, 2/29/16).

- Biosimilars have been viewed as a promising way to reduce drug costs by increasing competition among pharmaceutical companies. But the savings may be far less than expected. The first biosimilar to come to market, Sandoz's biosimilar version of Amgen's bone marrow stimulant Neupogen, was priced only 15 percent less than the original (Johnson, "Pfizer-Allergan deal could reduce biosimilar cost savings," Modern Healthcare, 12/7/16).

- It's not an accident that an estimated 1.9 million people are addicted to prescription painkillers. In 2007 Purdue Pharma and three of its top executives pleaded guilty to illegally promoting OxyContin, a time-release version of the generic oxycodone, as having a lower potential for abuse and addiction, and fewer narcotic side effects, than existing painkillers. A \$600 million fine was levied on the firm, a record at the time. The highly addictive painkiller became a blockbuster with annual sales exceeding \$1 billion within a few years of its 1995 introduction and total sales to date amount to \$35 billion. The three brothers who founded Purdue Pharma, Arthur, Mortimer and Raymond Sackler, have amassed a personal fortune exceeding \$14 billion, mostly off OxyContin, according to Forbes. Two-thirds of opioid deaths each year are due to prescription drugs, not heroin (Helfand, "OxyContin sales put Purdue's Sackler family on Forbes rich list," FiercePharma.com, 7/6/15; Goozner, "The iatrogenic roots of the opioid epidemic," Modern Healthcare, 2/15/16).

INTERNATIONAL

- Health care costs as a share of GDP are rising more rapidly in the Netherlands than in 21 other OECD nations. Between 2000 and 2013, health care costs in the Netherlands rose by 58.6 percent, compared with a 31.2 percent jump in the U.S. over the same period. The Netherlands is now tied with Switzerland as the second most costly health system in the world, spending 11.1 percent of its GDP on health care. The U.S. system is the most costly (16.4 percent of GDP in 2013). The reason costs are rising so quickly

in the Netherlands? They introduced for-profit insurance plans and managed care in 2006 (“Healthcare’s share of GDP,” *Modern Healthcare*, 2/8/16).

- In January, the People’s Health Movement, a global network of grassroots and academic health activists and organizations, endorsed “single payer financing and publicly managed health care delivery” as the best model for universal health coverage (UHC) and expressed their concern that “the marketization of UHC ... undermines the implementation of comprehensive primary health care.” It specifically rejected “market-based insurance, mixed delivery systems and a safety-net approach to UHC.” For details, see the position paper, “Priority Setting for Universal Health Care,” by Dr. David Legge, La Trobe University, Australia, at www.phmovement.org/en/node/10225.

POLLS

A Kaiser poll in December found that 58 percent of Americans support Medicare for All, including 34 percent who say they strongly favor it. By party affiliation, 81 percent of Democrats, 60 percent of Independents and 30 percent of Republicans supported Medicare for All (DiJulio, “Kaiser Health Tracking Poll,” December 2015).

- A Kaiser poll in February found that 50 percent of Americans support “guaranteed health insurance coverage in which all Americans would get their insurance through a single government health plan.” 43 percent were opposed. The poll also tested reactions to different phrases, such as “Medicare-for-all” (64 percent positive), “guaranteed universal health coverage (57 percent positive), “single payer health insurance system” (44 percent positive) and “socialized medicine” (38 percent positive). Frank Newport, Gallop’s editor, summarized single-payer polling this way: “reactions to the specific idea of a single-payer system tilt more positive than negative among Americans, across a number of different ways of asking about it, with the possible exception of a question that calls it socialized medicine.” (“Kaiser Health Tracking Poll,” February 2016; Newport, “American Public Opinion and Sanders’ Proposal for Single-Payer Healthcare System,” 3/11/16).

- Primary care physicians in the U.S. are less likely than their counterparts in 10 other nations to feel “the health care system works well, needing only minor changes.” Only 16 percent of U.S. primary care physicians agreed with that statement, compared to 67 percent in Norway and 57 percent in New Zealand. On the op-

posite end of the spectrum, 14 percent of U.S. primary care physicians feel the system needs to be “completely rebuilt,” compared to 1 percent to 3 percent of physicians in Norway, New Zealand, Switzerland, Netherlands, Australia, and Canada (Osborn, “Primary care physicians in ten countries report challenges in caring for patients with complex health needs,” *Health Affairs*, December 2015).

STATE-LEVEL REFORM JUST GOT HARDER

- On March 1, the Supreme Court overturned a Vermont health care law that required all health insurers to provide de-identified health data to the Vermont Green Mountain Care Board. The Board is charged with helping to manage the state’s health system. Liberty Mutual successfully argued that because it managed health plans for companies that self-insure under the federal Employee Retirement Income Security Act (ERISA), state law did not apply. About 135,000 people in Vermont are covered by self-insured firms, a significant share of the state’s total population of about 625,000 (Sterrett, “U.S. Supreme Court Overturns Vermont Health Care Law,” *vtlawyer.biz*, 3/15/16).

WORTH QUOTING

- Fareed Zakaria: “There’s absolutely no question that when we look at the ability to provide good health care at an affordable price, lower levels of massive inequality in health care outcomes or provision, a single government payer and multiple private providers is the answer. It’s absolutely clear that is the only way you can achieve that goal. The revolution that’s needed here is not an information revolution, it’s a political revolution” (Monegain, “Fareed Zakaria: Health IT is no magic bullet,” *Health IT News*, 10/21/15).

- Thomas Friedman: “A single-payer universal health care system. If it can work for Canada, Australia and Sweden and provide generally better health outcomes at lower prices, it can work for us, and get U.S. [insurance] companies out of the health care business” (Friedman, “Up with extremism,” *New York Times*, 1/6/16).

- Kenneth Arrow: “I wouldn’t say I’m strongly in favor of a single-payer system. I can find objections to it. But I still think it’s better than any other system” (“There Is Regulatory Capture, But It Is By No Means Complete,” interview with Kenneth J. Arrow in *Pro-Market: The blog of the Stigler Center at the University of Chicago Booth School of Business*, 3/16/16).

Moving Forward From the Affordable Care Act to a Single-Payer System

For almost a century, efforts to achieve universal health care in the United States raised hopes, fears, and prodigious lobbying, but yielded little beyond Medicare and Medicaid. In 2010, the Affordable Care Act (ACA; Pub L No. 111-148) ushered in a new era of reform. Last year, the Supreme Court upheld the legality of the ACA subsidies, rejecting the last serious legal challenge to President Obama's signature health care legislation. "[W]e finally declared," Obama said after the *King v. Burwell* decision, "that in America, health care is not a privilege for a few, but a right for all."

But was that the message? There's reason for skepticism. A decade from now, according to the Congressional Budget Office, 27 million Americans will remain uninsured despite full implementation of the law. Many more are underinsured or constrained by "narrow networks" of providers that limit choice and rupture longstanding therapeutic relationships. Doctors and nurses contend with growing requirements for mind-numbing electronic documentation¹ in a health care marketplace increasingly tilted toward giant insurers and hospital conglomerates that amass power through consolidation. Finally, the system's administrative complexity, which robs patients and providers of time, money, and morale, was further fueled by the ACA.

There is an alternative. Over a decade ago, three of us, together with many colleagues, published a detailed proposal for a single-payer national health program (NHP).² Recently, single-payer reform has reemerged in the context of the presidential primaries. While the need for such reform has not diminished, the ACA has shifted the health care landscape. For that reason, we have developed an updated proposal (available as a supplement to the online version of this editorial at <http://www.ajph.org>) that has thus far attracted the endorsement of more than 2200 colleagues. (Other health professionals are invited to add their endorsement at: www.pnhp.org/nhi.)

Here, we summarize the proposal, with an emphasis on how it would remedy the persistent shortcomings of the current health care system.

COVERAGE

Unfortunately, the ACA falls short in terms of both universality and comprehensiveness. Fewer than half of America's uninsured residents have gained coverage, and underinsurance remains ubiquitous. Employers seeking to restrain their health benefit costs have tripled deductibles since 2006,³ and the ACA's excise tax on expensive "Cadillac" plans—recently postponed until 2020—is poised to accelerate this trend. Many of the estimated 11 million

Americans who have purchased plans on the ACA's exchanges face punishingly high copayments and deductibles, which average more than \$5300 in Bronze plans. Such underinsurance often compromises access to care and financial well-being. In 2014, 36% of non-elderly adults skipped needed care because of cost (down from 41% in 2010),⁴ and more than half of all overdue debts on credit reports were medical.⁵

A single-payer NHP, in contrast, would provide comprehensive coverage without copayments or deductibles to everyone in the country, replacing our current complex and wasteful patchwork of coverage.

All medically necessary services would be covered, including inpatient, outpatient, and dental care, as well as prescription drugs. The NHP would also cover long-term care, a benefit that few Americans currently enjoy.

COSTS

The ACA's very name reflects the hope that it would, at long

last, bring health costs under control. The experience of recent years seemed to provide cause for optimism: five years of relatively low spending growth coincided with the law's passage and implementation. However, the slowdown began before the ACA's enactment, suggesting that the deep recession was at least partly responsible, and that full economic recovery would rekindle medical inflation. Recent figures suggest that this is, indeed, happening.

The resumption of health care inflation should not be surprising, since many of the ACA's cost-control provisions rest on scant evidence. For instance, many hoped that replacing fee-for-service with capitation-like reimbursement—the Accountable Care Organization (ACO) strategy encouraged by the ACA—would spur providers to improve coordination and efficiency, thereby lowering costs. Yet, Medicare has, to date, realized little⁶ or no savings⁷ from ACOs. Moreover, the ACO strategy has encouraged the consolidation of hospitals and physicians' practices into giant systems with the market leverage to demand higher prices, driving up costs for the privately insured.⁸ Meanwhile, tying payment to quality metrics—thought necessary to

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prevent the denial of care in capitation-like systems such as ACOs and Health Maintenance Organizations—has elicited ubiquitous gaming of risk adjustment and quality measures,⁹ which distort the data needed for fair payment and real quality improvement.

An NHP, in contrast, would shrink administrative costs, and have fewer incentives for corruption. Overall, cutting administrative spending to Canadian levels would save about 15% of national health expenditures,¹⁰ freeing up nearly \$500 billion annually for expanded and improved coverage. Significant sums would also be saved by allowing the NHP to negotiate with drug companies over prices, as do universal health programs in other advanced nations. The greater efficiency and simplicity of the NHP would curb inflation in health costs, so that cost savings would grow with time.

PAYMENT

There has been much hope (in truth, hype) that by simply changing how providers are paid, we can simultaneously lower health spending and improve quality. In reality, any method of payment can create perverse incentives in a market-based system when an ethos of professionalism and commitment is lacking. Therefore, under an NHP, we envision flexibility regarding modes of payment: physicians and other practitioners could be paid either through a streamlined, binding fee-for-service schedule or through salaries at not-for-profit hospitals, group practices or other facilities.

The NHP would pay institutional providers like hospitals and nursing homes for their operating expenses through global

(“lump-sum”) budgets, akin to how cities fund fire departments. By eliminating per-patient billing, the administrative savings from such a change would be enormous. Operating funds could not be diverted to profits, advertising or capital investments. Instead, the NHP would fund modernization and expansion projects through separate, explicit capital grants targeted to community needs, rather than profitability.

CHOICE AND CONTINUITY

Free choice of providers and the preservation of doctor-patient relationships are threatened by our current system. With each enrollment cycle, patients seeking affordable premiums or changing jobs must often switch insurers and risk breaking existing relationships with providers.

An NHP, in contrast, would do away with narrow networks, replacing them with one large network that allows free choice of hospital and clinician, thereby eliminating involuntary turnover and preserving therapeutic relationships.

CONCLUSIONS

Despite the ACA, many serious problems remain in American health care. Uninsurance and underinsurance endure, bureaucracy is growing, costs are likely to rise, and caring relationships take second place to the financial prerogatives of health insurers and providers. A single-payer NHP offers a salutary alternative, one that would at long last take the right to health care from the

realm of political rhetoric to that of reality. **AJPH**

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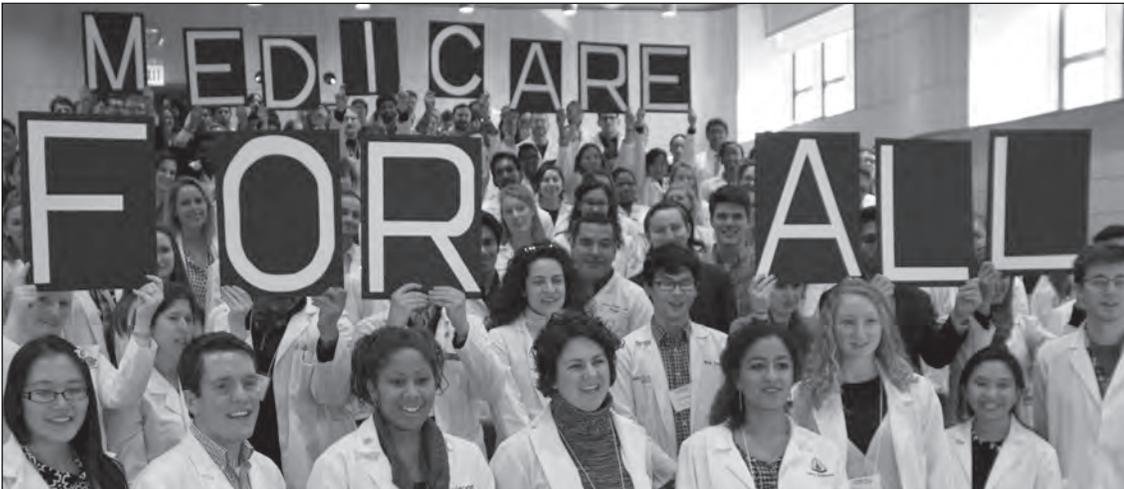
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PNHP note: To read the full text of the Physicians' Proposal, please turn to p. 39.

Setting the record straight on Medicare for All

An open letter from physicians and medical students



Physicians-in-training voice their support for single-payer national health insurance. Photo: Al Nowakowski.

The renewed debate over the merits of single-payer health reform has been marred by misleading claims that such reform is unnecessary and unaffordable. We write to set the record straight.

Despite the advances of the Affordable Care Act (ACA), the health care financing system continues to inflict needless suffering on our patients. Nearly 30 million Americans remain uninsured, and co-payments, deductibles and insurers' narrow networks obstruct care for many more. Insurers skim billions from premiums, and impose expensive and time-consuming paperwork on doctors, nurses and hospitals.

Studies in the most trusted journals have quantified the bureaucratic savings achievable through single payer reform. We devote 31 percent of medical spending to administration, vs. 16.7 percent in Canada – a difference of \$350 billion annually. And single-payer systems in Canada, the UK and Australia all use their bargaining clout to get discounts of 50 percent from the prices drug companies charge our patients.

The potential savings on bureaucracy and drugs are enough to cover the uninsured, and to upgrade coverage for all Americans – a conclusion affirmed over decades by multiple analysts, including the Congressional Budget Office and the Government Accountability Office.

Recent critics of Medicare for All warn of large increases in government spending, but fail to note that these would

be fully offset by savings on private insurance premiums and out-of-pocket costs. Their forecasts of massive surges in doctor visits and hospital care conflicts with past experience of coverage expansions. When 15 million Americans gained insurance under the ACA in 2014, hospital admissions didn't budge. No surge in hospital use or doctor visits occurred when Medicare and Medicaid were rolled out, or when Canada's single-payer system started up; doctors saw sick and poor patients more often, but their healthy, wealthy patients a bit less often.

Experience in many nations over many decades provides convincing evidence that single-payer reform is both medically necessary and economically advisable.

This statement has been signed by more than 1,000 physicians and medical students. It was crafted by Andrea Christopher, M.D., fellow in general internal medicine at Harvard Medical School, Adam Gaffney, M.D., fellow in pulmonary and critical care medicine at Massachusetts General Hospital and Harvard Medical School, and Steffie Woolhandler, M.D., and David U. Himmelstein, M.D., professors at the City University of New York School of Public Health at Hunter College, lecturers in medicine at Harvard Medical School, and co-founders of Physicians for a National Health Program. Other physicians and medical students are invited to read and sign the statement at medicare-for-all.us

Medicare's history belies claim that Medicare-for-All would disrupt care It disrupted Jim Crow, but otherwise the transition was smooth

By Steffie Woolhandler and David Himmelstein

Hillary Clinton and others charge that Bernie Sanders' Medicare-for-All plan would disrupt and threaten Americans' health care. But the smooth rollout of Medicare-for-Seniors in 1965 – which many had also predicted would bring chaos – belies that charge.

Medicare, signed into law on July 30, 1965, went live just 11 months later. By then, 18.9 million seniors had signed up, 99 percent of those eligible.

To accomplish this feat (largely without computers) the Social Security Administration mailed an information leaflet and sign-up cards preprinted with each individual's name and Social Security number (see example below) to seniors on the Social Security and railroad retirement rolls, as well as Civil Service annuitants and a million other seniors identified through IRS records.

President Truman's application for Medicare, courtesy of the Social Security Administration History Archives.

To contact hard-to-reach seniors, the federal government reached out to nursing and retirement homes, employers, unions and civic organizations offering to help people apply; organized hundreds of local information meetings; and enlisted postal workers, forest rangers and agricultural representatives to help locate residents of remote areas. The Office for Economic Opportunity hired 5,000 low-income seniors who went door-to-door in their neighborhoods.

All told, Medicare's overhead costs for the first year totaled only \$120 million (equivalent to \$882 million in 2015). By comparison, setting up the insurance exchanges for private coverage under Obamacare cost more than \$6 billion – about seven times as much. But even the modest figure for Medicare's start-up costs is an overstatement since it includes the cost of processing six months' worth of medical bills, not just the enrollment costs. Moreover, Medicare and Medicaid (which was passed at the same time) displaced several smaller federal health assistance programs, saving about \$383 million (in 2015 dollars) on

their overhead costs.

Even as it became clear that Medicare enrollment was proceeding smoothly, many saw disruption ahead. The Association of American Physicians and Surgeons (AAPS), a group to the right of the American Medical Association (AMA), threatened that 50,000 doctors would boycott Medicare. (Today, the AAPS is sounding the alarm that Medicare-for-All would take away “what remains of your doctor's liberty.”) Wall Street Journal headlines warned that “Most MDs Won't Cooperate,” and foresaw a “Patient Pileup,” as “flocks of Medicare beneficiaries ... suddenly clog the nation's 7,200 hospitals.”



Dr. Steffie Woolhandler

None of this came to pass. Doctors continued to care for elderly patients, mostly accepted Medicare payment, and soon came to rely on Medicare as an economic pillar of their practices. Even the AMA, which had spent millions fighting Medicare's passage (including an infamous ad campaign featuring then-actor Ronald Reagan) cooperated in the program's implementation. Hospitals ran smoothly, with only a handful reporting more than minor problems.

But Medicare did cause a major disruption, it disrupted Jim Crow hospital care.

The 1964 Civil Rights Act banned racial discrimination in facilities receiving federal funds (which included most hospitals), but enforcement was lax until Medicare. Many hospitals, particularly in the South, still refused to care for black patients at all, while others relegated them to separate entrances and shabby basement wards. Black physicians were often barred from hospital staffs, and in many locales ambulance services were separate, and distinctly unequal.

With Medicare on the horizon, federal officials made it clear to hospitals that segregated hospitals would be excluded from the program. In the spring of 1966, three months before Medicare took effect, 51 percent of American hospitals were still segregated. By August of that year, 99.5 percent had desegregated.

While Medicare ended overt racial segregation in hospitals, segregation by insurance remains legal and common – and often perpetrates de facto racial segregation. Most of New York City's prestigious academic medical centers – and many hospitals elsewhere – maintain separate clinic systems, and even separate wards, for Medicaid patients (the 33 million uninsured need not apply).

(continued on next page)

Is 'Medicare for All' really unrealistic?

By Ken Brummel-Smith, M.D.

There has been much in the news lately about the "single payer" health insurance reform idea, or so-called "Medicare for All," and whether it is realistic or politically unfeasible. I have been a member of the Physicians for a National Health Program, the original proponents of this idea, for more than 20 years. I've also been practicing medicine since 1978 so I have some idea of how things work in medicine.

Here are the facts:

1. The single-payer system is the only health reform that will pay for itself. By replacing the thousands of private insurers – each with its own marketing, billing and corporate profits – estimates of savings range from \$400 billion to \$600 billion. This alone would cover the 30 million people who don't have health insurance now.
2. Studies have shown that 95 percent of Americans would come out ahead financially. They would not have to pay as much in taxes for this program (it would be funded through a progressive tax) as they pay now for their health insurance.
3. Doctors and hospitals would be freed from the huge burden they deal with in having to bill hundreds of different insurers. That would add more savings to the cost of health care, and more time they have to see patients.
4. Surveys show a majority of both patients and doctors favor a single-payer system.
5. It would fix some of the problems of the Affordable Care



Dr. Ken Brummel-Smith

Act – such as rapidly rising premiums and copays. It would also cover things not in the ACA – like dental and long-term care.

So who fights Medicare for All? It is the insurance companies (they won't be needed), the pharmaceutical companies (they don't want to negotiate to have fair pricing) and the for-profit medical-industrial complex (they want to keep the money flowing in, from your pockets).

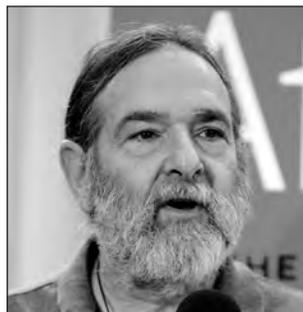
So the question Americans need to answer is: Do you want to keep the "reality" of our current system, which doesn't work and empties your wallet, or do you want a system that saves money, is easier to use and is fairer. Which one is realistic?

What can you do to help make "Medicare for All" a reality? Ask your representatives to support and co-sponsor H.R. 676. (It has 60 co-sponsors, but Rep. Gwen Graham, D-2nd District, has not signed on.) Physicians can join the Physicians for a National Health Program (www.pnhp.org). Citizens can join HealthCare-Now! (www.healthcare-now.org). Finally, people can speak up at Democratic and Republican forums to call for the truth.

Ken Brummel-Smith, M.D., is the Charlotte Edwards Maguire Professor and chair of the Department of Geriatrics, Florida State University College of Medicine.

(Woolhandler and Himmelstein, continued from previous page)

Medicare-for-All would give all Americans complete and equal coverage, completing the disruption of hospital segregation that Medicare began a half century ago.



Dr. David Himmelstein

Aside from that welcome disruption, Medicare-for-All would greatly simplify life for hospitals and doctors. Instead of the laborious and expensive task of billing patients and their insurers for each Band-Aid and aspirin tablet, hospitals would receive a lump-sum budget, much as we pay for a fire station. Doctors would bill one plan, using one billing form instead of the dozens of complex billing schemes – each with its own rules and redundant documentation requirements – that

we face today.

Most important, Medicare-for-All would end many of the disruptions that our patchwork coverage system currently inflicts on patients. All Americans would, for the first time, enjoy a free choice of doctor and hospital, and would never again be forced to change doctors merely because their insurance changed, or their doctor was dumped from their insurer's network. And patients' lives would no longer be disrupted by financial ruin from medical bills.

Drs. Steffie Woolhandler and David U. Himmelstein, professors of health policy and management at the City University of New York School of Public Health at Hunter College and Lecturers in Medicine at Harvard Medical School, co-founded Physicians for a National Health Program, a nonpartisan organization. The opinions expressed do not necessarily reflect those organizations'.

How liberals tried to kill the dream of single payer

Prominent progressives have undercut a cherished policy goal of the left. They're wrong on both the politics and the economics.

By Adam Gaffney, M.D.

Around the time that the insurgent campaign of Bernie Sanders hit its stride, a chorus of liberal pundits and economists began to coalesce around a decidedly grim message for the 60 million people in America who remain either uninsured or underinsured: Give up on your pipe dream.

Single payer, Paul Krugman wrote in one of a series of posts in January, “isn’t a political possibility,” and is in fact “just a distraction from the real issues.” Last week in the *American Prospect*, sociologist Paul Starr went further in describing single payer as a “hopeless crusade for a proposal that will go down to defeat again, as it has every time it has come up before.” And in an earlier article, he argued that even if single payer was possible, other priorities should take precedence. Hillary Clinton is on the record agreeing with such sentiments: As she put it, single payer “will never, ever come to pass.”

Single-payer universal health care, in other words, is dead on arrival. Time to move on.

Their essential arguments are twofold: Single-payer reform is politically impossible on the one hand, and economically infeasible on the other. However, they are very wrong on both counts. The first argument rests on a severely impoverished political vision, the second on inexcusably flawed economic and policy assumptions. Though the Sanders campaign is facing increasingly daunting obstacles to the Democratic nomination, the American health care question is not going anywhere. These criticisms therefore require greater dissection and contestation – before they congeal as the conventional wisdom.

Yes, the political terrain is tough

Let’s first admit the obvious: The political terrain for transformational health care reform is currently quite adverse. A single-payer bill would encounter colossal resistance from, for instance, the health insurance lobby, which is understandably in no great rush to be legislated off the face of the planet (nor does the pharmaceutical industry look forward to long-avoided price negotiations with the government). It’s also true that a Democratic sweep of both houses of Congress is unlikely in the coming election. And Democrats are, in any event, divided on the issue, as this primary election demonstrates.

To proceed, however, from an admission of these facts to an ac-

ceptance that the cause should be abandoned is to concede the contest before the first shot has been fired. This is something the Democratic Party has excelled at – with disastrous consequences – for decades. Conservatives, in contrast, have been far more willing to adopt ambitious, long-range political goals, even when contemporaneous political forces are arrayed against them.

As Daniel Stedman Jones describes in his “Masters of the Universe: Hayek, Friedman, and the Birth of Neoliberal Politics,” the



Dr. Adam Gaffney

articulation of an initially unpopular, highly ambitious, anti-New Deal “neoliberal” program – outlined and promoted in the decades following World War II by economists like Friedrich Hayek and Milton Friedman and associated think tanks – took decades to “bear fruit.” But when political and economic circumstances changed in the 1970s, conservatives had an ambitious program ready to launch, and the right-wing revolutions of Ronald Reagan and Margaret Thatcher could begin in earnest. From the 1980s onward, Jones writes, Hayek’s early “ideological vision” became reality with a vengeance:

“The free market became the organizing principle for microeconomic reform ... Trade unions were vanquished and the power of labor was diluted ... Market mechanisms became the models for the operation of health care ... The purity that Hayek advocated was meant as an optimistic and ideological and intellectual tactic rather than a blueprint. The results have been extraordinary.”

In the years since Reagan and Thatcher, conservatives have had continued success in pushing the political center – on economic, if not social, issues – further and further rightward. Yet just as the right marched forward to the drum of Hayek, liberals have far too often been content to passively follow behind, albeit while maintaining something of a respectable distance. Nowhere is this clearer than in health care.

Enter the Affordable Care Act

Enter the Affordable Care Act

This story is well known and often told: Many – perhaps most – of the key provisions of the Affordable Care Act are derived from (formerly) conservative health policy proposals. As the sociologist Jill Quadagno describes in a 2014 article in the *Journal of Health Politics, Policy and Law*, the ACA’s “employer mandate” was drawn from Nixon’s 1974 “Comprehensive Health Insurance Plan” (itself a

counterproposal to Ted Kennedy's single-payer plan). Meanwhile, the individual mandate was first articulated by Stuart Butler at the Heritage Foundation, a conservative think tank. And by 1993, Republicans in Congress were proposing a bill (the Health Equity and Access Reform Today Act, or HEART Act) that, as she puts it, had "nearly identical" provisions to the ACA, including "an individual mandate, an employer mandate, a standard benefit package, state-based purchasing exchanges, subsidies for low-income people, [and] efforts to improve efficiency" (She also does note a few differences, most prominently the ACA's Medicaid expansion, which is by far the law's most beneficial provision.)

Yet like Nixon's 1974 bill, the 1993 Republican embrace of this individual mandate-based plan was provoked, in part, less by an earnest desire to expand health coverage than by a legitimate fear of single-payer reform. The economist Mark Pauly – one of the authors of a slightly earlier version of an individual mandate-based plan prepared with the hope of enticing the first Bush administration – acknowledged this in a 2011 interview with Ezra Klein at *The Washington Post*: The idea was to deflect "the specter of single-payer insurance," as he told Klein.

Baucus: Anything but single payer

Today, of course, Republicans are no longer afraid of the menace of single-payer, for a perfectly good reason: The mainstream of the Democratic Party has largely abandoned it. As Steven Brill noted in "America's Bitter Pill: Money, Politics, Backroom Deals, and the Fight to Fix Our Broken Healthcare System," when the Democratic Senate Finance Committee Chairman Max Baucus began formulating a health care agenda after the election of President Obama, he was clear about "one thing" above all else: His proposal would not look like single payer. Instead, Baucus's plan would, as Brill writes, be a "moderate plan ... that could attract bipartisan support." Yet despite this massive concession to (or embrace of) conservative health care principles, the ACA failed miserably in attracting bipartisan support: It didn't even earn a single Republican vote in the House or the Senate. So much for the much-vaunted politics of compromise.

Today, Republicans have by and large abandoned earlier "moderate" positions on health care, and instead tried to lamely recycle various tired nostrums – Health savings accounts! Insurance across states lines! Medicare vouchers! – to a weary nation. Yet the net effect of this push and pull has meant that the health care center has veered rightward to a striking degree, such that today, liberals like Starr and Krugman contend that a law that is largely the same as the Republican HEART Act from the early 1990s should – with perhaps a few tweaks down the road – form the core of our health care system.

The liberal retreat on single payer is in line with a long history of centrist Democratic thinking that haplessly confuses rearguard action with political vision. Passing a federal single-payer bill would, no doubt, necessitate key electoral victories, a powerful campaign at the governmental level, and a formidable grassroots struggle. Useful initial steps in this direction might include the election of a president determined to pass single payer, the restoration of single payer to the platform of the Democratic Party, and vigorous sup-

port for such reform by pundits and scholars in high places. That none of these things may wind up happening is a cause of the alleged political "impossibility" of single payer – not its result.

Too costly?

This brings me to the second of the two core arguments of the single-payer naysayers: "Medicare-for-all" would come at a price we simply cannot afford. The most recent iteration of this argument traces back to Kenneth Thorpe, an economist at Emory University, who published an analysis asserting that the Sanders plan (itself based on calculations of the economist Gerald Friedman, who has also taken a lot of criticism from Krugman and others for his optimistic economic projections under a President Sanders) would be about twice as expensive as his campaign has argued. Thorpe's numbers spread like wildfire: After being initially reported and evaluated by Dylan Matthews at *Vox*, they've been cited by Starr, Krugman, the editorial board of *The Washington Post*, and basically everybody else. "[H]is health-care plan rests on unbelievable assumptions," noted the *Post*, "about how much he could slash health-care costs without affecting the care ordinary Americans receive."

But there are many ways to look at the issue of single-payer financing. David Himmelstein and Steffie Woolhandler, health policy professors at the City University of New York School of Public Health and lecturers in medicine at Harvard Medical School, efficiently took apart Thorpe's numbers in two point-by-point by critiques. To get into the nitty gritty of the major errors in Thorpe's economic assumptions, I'd direct readers to their article at the *Huffington Post* [*reprinted in this issue, p. 18*]. And notably, as they describe in *The Hill*, Thorpe had himself previously found single-payer to be entirely affordable – indeed, he once asserted that it would reduce costs even as it expanded coverage.

Passing a federal single-payer bill would, no doubt, necessitate key electoral victories, a powerful campaign at the governmental level, and a formidable grassroots struggle.

Friedman, Thorpe, and Starr have also engaged in an exchange at the *Prospect* about these issues. In truth, it seems that more economic analysis may be needed with respect to the precise mix of taxes that are necessary. But the reality is that the specific taxes laid out in Sanders's slim single-payer proposal are relatively unimportant at the current time; they would have to undergo significant re-examination and revision as the proposal was transformed into an actual bill. At this stage, it's more useful to take a step back and look at the debate over the affordability of single payer in more general terms, by asking three larger questions. First, what new costs would a single-payer system generate? Second, what savings would single payer deliver? And third, could the new costs roughly balance the savings?

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A closer look at affordability

First, when speaking about new costs, I mean actual new expenses, not existing private expenditures that become public expenditures. The difference is crucial: with the proper mix of progressive taxes, the transition from private to public spending can be achieved without imposing any economic burden on the non-affluent (and indeed, lightening it for many). But actual new expenses, in contrast, can be seen as a legitimate source of real “new spending.”

For instance, according to the latest estimates from the National Center for Health Statistics, some 29 million people were uninsured in 2015. Covering these individuals requires cash. It's worth pointing out, however, that many of these individuals are already using health care, with some of the costs either coming out of their own pockets or being passed on to other public or private payers. Replacing those existing expenditures will have zero effect on overall national health spending. At the same time, many of these individuals are, sadly, currently forgoing health care, and to the extent that universal health care allows them to go to the doctor or get tests or medicines they've so far been avoiding, some new money will indeed need to be spent.

We can, in other words, afford to provide comprehensive health care to everyone in the nation, free at the point of use, with “one large network” of physicians and hospitals available to all.

Second, proposals for “Medicare-for-all” usually call for the elimination of cost sharing, which is to say no copayments, deductibles, and co-insurance. I'd argue that this is an essential aspect of real universal health care (with some notable exceptions, such as payments are absent from the systems of Canada and the United Kingdom). The harms of such payments are all too real: As a result of out-of-pocket exposure, an analysis of survey findings published by the Commonwealth Fund last year put the number of underinsured Americans – the insured who lack sufficient coverage against the cost of medical care – at 31 million in 2014. Though discarding such out-of-pocket payments might sound like a pricey proposition, to the extent that these monies are already being spent, their elimination would be a wash, with no net effect on overall national health expenditures. But again, as is the case with the uninsured, insofar as some individuals and families are avoiding health care because of out-of-pocket payments, the elimination of these financial barriers would result in some real increases in health care utilization.

There are some other points to be made (like the additional costs of providing universal long term care and dental care), but in reality these two items – covering the uninsured and improving coverage for the underinsured – are the main new costs that a single-payer national health program would have to cover. Taking that into consideration, is single payer indeed “unaffordable”?

To answer, we have to look at the opposite side of the equation, at the potential for efficiency savings in such a transition. And clearly, the biggest source of savings is the reduction of the vast bureaucratic apparatus that undergirds the entirety of the health care system, as Himmelstein and Woolhandler emphasize (and have studied in depth). This “apparatus” is devoted to such critical tasks as the compilation of lengthy itemized hospital bills, the pursuit of medical debtors, the design of needlessly complex yet shoddy insurance products, the issuance of bills to innumerable payers, the endless clinical documentation necessary to generate proper payment from insurers, and so forth. Overall, this represents a massive, parasitic drain on the American economy. And so, too, does our unnecessarily high pharmaceutical expenditures. But it is, in particular, the issue of administrative savings that has received insufficient attention in discussions on health care reform.

Physicians challenge single payer's detractors

Frustration with the lack of accurate discussion around such savings (and around single payer more generally) led several physicians – including myself, Andrea Christopher (a fellow in general medicine at Harvard Medical School), Himmelstein, and Woolhandler – to organize an open letter contesting this crystallizing critique of single payer. The letter was published in February in the Huffington Post, and has been signed by more than 1,000 physicians and medical students [see p. 9 of this newsletter]. It makes this bottom-line point about the balance of savings and costs:

“We devote 31 percent of medical spending to administration, vs. 16.7 percent in Canada – a difference of \$350 billion annually. And single-payer systems in Canada, the U.K., and Australia all use their bargaining clout to get discounts of 50 percent from the prices drug companies charge our patients. The potential savings on bureaucracy and drugs are enough to cover the uninsured, and to upgrade coverage for all Americans – a conclusion affirmed over decades by multiple analysts, including the Congressional Budget Office and the Government Accountability Office.”

Moreover, our letter notes that expansions of health coverage have historically been accomplished without massive increases in health care utilization: Essentially, doctors devote more attention to those who are sick and somewhat less to those who are well, resulting in relatively modest increases in health care use. “Experience in many nations over many decades,” we conclude, “provides convincing evidence that single-payer reform is both medically necessary and economically advisable.”

We can, in other words, afford to provide comprehensive health care to everyone in the nation, free at the point of use, with “one large network” of physicians and hospitals available to all. Currently existing private spending will be largely replaced by public spending, which would require a mix of new taxes. Overall health spending would stay roughly say the same, though future cost increases could be much better controlled. The number of the uninsured would fall from some 29 million to near zero. At the same time, the rest of us who are already insured would be able to stop worrying about which providers are in- or out-of-network, whether or not a doctor's visit or a medication is worthwhile in light of a

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Medicare for All can solve America's financial crisis

By Mark S. Krasnoff, M.D.

I've practiced general internal medicine for over 20 years, and I've personally witnessed the average American's health care burdens descend into a national financial crisis. Yes, crisis.

On Jan. 5, the Kaiser Family Foundation and the New York Times revealed their joint survey indicating 20 percent of insured Americans have serious problems paying their medical bills. Of those, 63 percent must sacrifice most or all of their savings; 75 percent are forced to cut back on food, clothing or other essentials. Medical bills financially cripple 44 percent to 45 percent of those who have a significant illness, whether they got sick while insured or not.

Today, health care insurance for many merely slows the fall to bankruptcy, and the rest of us are financially hammered at every turn with co-pays, deductibles, coinsurance and soaring drug costs. Employer-provided "coverage" substitutes for the wage increases Americans used to be able to expect.

There is no chance for affordability while insurance companies are calling the shots. There is no chance to rein in drug prices without being able to negotiate with suppliers en masse as other countries do. Our entire health care system is out of control.

The answer? Traditional Medicare (A & B) has a phenomenally efficient 3 percent to 4 percent overhead and a proven, 50-year



Dr. Mark Krasnoff

track record. We need Medicare for everyone, Medicare For All. It's simple, efficient, fair and logical, and that's why politicians who are beholden to special interests will fight against it every step of the way. Don't let them win. Medicare For All is the answer.

Dr. Mark S. Krasnoff resides in Ladue, Mo.

THE WALL STREET JOURNAL. MARCH 29, 2016

Better care for the poor, more return on cost

By Jack Bernard

Re: Dr. Scott Atlas's "How to Fix the Scandal of Medicaid and the Poor" (op-ed, March 16): Dr. Atlas is correct about many of the problems faced by Medicaid, but his cure is worse than the disease. The fact is the poor can't afford to go the high-deductible or health-savings-account route. Yes, they will ask for less care, as Dr. Atlas states, but he seems to forget that people don't go to doctors for the joy of the experience. They go because they are ill.

A more effective direction would be to expand the Medicare program by moving these individuals into it. In fact, if you examine per capita health expenditures of the U.S. versus other developed nations, our costs are much higher because we do not have national universal health insurance – Medicare for all. *Jack Bernard is a former head of health planning for Georgia.*

(Gaffney, continued from previous page)

steep copayment, how to decipher a daunting medical bill, or the loss of coverage that might accompany dismissal from a job, loss of a partner, or the descent into poverty. This, to me, seems like a very good bargain.

Paul Starr, who (as noted) has penned several recent articles dismissing single-payer (as well as blasting Sanders's candidacy more broadly), is perhaps most famous for his Pulitzer Prize-winning 1982 book "The Social Transformation of American Medicine." It's a book that I read as a first-year medical student, and that has shaped my understanding of the American health care system greatly. In it, he traces the emergence of the American medical profession, and follows how our failure to publicly organize the health system gave way to the rise of a "corporate medical enterprise," a sector – as he notes in the final chapter – that is "likely to aggravate inequalities in access to health care." Clearly, this has come to pass.

But I wish to conclude by turning to the very first words of the book. "The dream of reason did not take power into account," the

book begins. "The dream was that reason, in the form of the arts and sciences, would liberate humanity from scarcity and the caprices of nature, ignorance and superstition, tyranny, and not least of all, the diseases of the body and the spirit." Power – whether of the medical profession or of the corporatized organizations that have since superseded it – complicated the fulfillment of the dream.

The dream, however, is not yet dead. With respect to health, the idea that all lives should be as long and as healthy as is possible – a vision that can only be fulfilled by the universal and equal provision of the very best that modern medical science has to offer – still burns bright. But now, in twenty-first century America, it is not just conservatives, but many liberals, who are among the powerful standing in opposition to its fulfillment.

Adam Gaffney is a physician and writer whose articles have appeared in the Los Angeles Review of Books, Salon, CNN.com, USA Today, In These Times, Jacobin, and elsewhere.

On Kenneth Thorpe's analysis of Senator Sanders' single-payer reform plan

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

Professor Kenneth Thorpe recently issued an analysis of Senator Bernie Sanders' single-payer national health insurance proposal. Thorpe, an Emory University professor who served in the Clinton administration, claims the single-payer plan would break the bank.

Thorpe's analysis rests on several incorrect, and occasionally outlandish, assumptions. Moreover, it is at odds with analyses of the costs of single-payer programs that he produced in the past, which projected large savings from such reform.

We outline below the incorrect assumptions behind Thorpe's current analysis:

1. He incorrectly assumes administrative savings of only 4.7 percent of expenditures, based on projections of administrative savings under Vermont's proposed reform.

However, the Vermont reform did not contemplate a fully single-payer system. It would have allowed large employers to continue offering private coverage, and the continuation of the FEHBP and Medicare programs. Hence, hospitals, physicians' offices, and nursing homes would still have had to contend with multiple payers, forcing them to maintain the complex cost-tracking and billing apparatus that drives up providers' administrative costs. Vermont's plan proposed continuing to pay hospitals and other institutional providers on a per-patient basis, rather than through global budgets, perpetuating the expensive hospital billing apparatus that siphons funds from care.

The correct way to estimate administrative savings is to use actual data from real world experience with single-payer systems such as that in Canada or Scotland, rather than using projections of costs in Vermont's non-single-payer plan. In our study published in the *New England Journal of Medicine* we found that the administrative costs of insurers and providers accounted for 16.7 percent of total health care expenditures in Canada, versus 31.0 percent in the U.S. – a difference of 14.3 percent. In subsequent studies, we have found that U.S. hospital administrative costs have continued to rise, while Canada's have not. Moreover, hospital administrative costs in Scotland's single-payer system were virtually identical those in Canada.

In sum, Thorpe's assumptions understate the administrative savings of single-payer by 9.6 percent of total health spending. Hence he overestimates the program's cost by 9.6 percent of health spending – \$327 billion in 2016, and \$3.742 trillion between 2016 and 2024. Notably, Thorpe's earlier analyses projected much larger administrative savings from single-payer reform – closely in line with our estimates.

2. Thorpe assumes huge increases in the utilization of care, increases far beyond those that were seen when national health insurance was implemented in Canada, and much

larger than is possible given the supply of doctors and hospital beds.

When Canada implemented universal coverage and abolished copayments and deductibles there was no change in the total number of doctor visits; doctors worked the same number of hours after the reform as before, and saw the same number of patients. However, they saw their healthy and wealthier patients slightly less often, and sicker and poorer patients somewhat more frequently. Moreover, the limited supply of hospital beds precluded the kind of big surge in hospitalizations that Thorpe predicts. In health policy parlance, "capacity constraints" precluded a big increase in system-wide utilization.

Thorpe bases his estimates on what has happened when a small percentage of people in a community have had copayments eliminated or added. But in those cases there are no capacity constraints, so it tells us little about what would happen under a system-wide reform like single-payer.

Thorpe does not give actual figures for how many additional doctor visits and hospital stays he predicts. However, his estimates that persons with private insurance would increase their utilization of care by 10 percent and that those with Medicare-only coverage would increase utilization by 10 to 25 percent suggest that he projects about 100 million additional doctor visits and several million more hospitalizations each year – something that's impossible given real-world capacity constraints. There just aren't enough doctors and hospital beds to deliver that much care.

Instead of a huge surge in utilization, more realistic projections would assume that doctors and hospitals would reduce the amount of unnecessary care they're now delivering in order to deliver needed care to those who are currently not getting what they need. That's what happened in Canada.

3. Thorpe assumes that the program would be a huge bonanza for state governments, projecting that the federal government would relieve them of 10 percent of their current spending for Medicaid and CHIP – equivalent to about \$20 billion annually.

No one has suggested that a single-payer reform would or should do this.

4. Thorpe's analysis also ignores the large savings that would accrue to state and local governments – and hence taxpayers – because they would be relieved of the costs of private coverage for public employees.

State and local government spent \$177 billion last year on employee health benefits – about \$120 billion more than state and local government would pay under the 6.2 percent payroll

(continued on next page)

The flip-flop behind the flawed attacks on Sanders's single-payer plan

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

Dear Editor:

The Jan. 29 editorial “The real problem with Mr. Sanders” alleged that Sen. Bernie Sanders’s (I-Vt.) health care plan “rests on unbelievable assumptions about how much he could slash health care costs.” That dismissive claim was based on a deeply flawed analysis by Kenneth Thorpe, an Emory University professor and former Clinton administration official who, like Democratic presidential candidate Hillary Clinton, has done a recent flip-flop on the facts about single payer.

So what has changed? In 2003, Thorpe calculated that single payer would achieve huge administrative savings – more than 10 percent of total health spending, equivalent to \$350 billion this year alone. Now he has cut that estimate by more than half, even though the costs of bureaucracy in the United States have continually climbed, while they’ve remained low in single-payer nations.

Thorpe previously predicted that single payer would cause a modest uptick in the utilization of care. Now – despite the fact that fewer are uninsured – he has decided there would be a huge increase.

Finally, Thorpe says nothing about savings on drug prices, despite the fact that every nation with a national health-insurance program gets discounts of about 50 percent.

The old Kenneth Thorpe – like the old Hillary Clinton – acknowledged the facts about single payer. The new one ignores them. The editorial board should know better.

Himmelstein and Woolhandler are professors of health policy and management at the City University of New York School of Public Health and lecturers in medicine at Harvard Medical School. They reside in New York.

(Thorpe rebuttal, continued from previous page)

tax that Senator Sanders has proposed. The federal government could simply allow state and local governments to keep this windfall, but it seems far more likely that it would reduce other funding streams to compensate.

5. Thorpe’s analysis also apparently ignores the huge tax subsidies that currently support private insurance, which are listed as “Tax Expenditures” in the federal government’s official budget documents.

These subsidies totaled \$326.2 billion last year, and are expected to increase to \$538.9 billion in 2024. Shifting these current tax expenditures from subsidizing private coverage to funding for a single-payer program would greatly lessen the amount of new revenues that would be required. Thorpe’s analysis makes no mention of these current subsidies.

6. Thorpe assumes zero cost savings under single-payer on prescription drugs and devices.

Nations with single-payer systems have in every case used their clout as a huge purchaser to lower drug prices by about 50 percent. In fact, the U.S. Defense Department and VA system have also been able to realize such savings.

In summary, professor Thorpe grossly underestimates the ad-

ministrative savings under single-payer; posits increases in the number of doctor visits and hospitalizations that exceed the capacity of doctors and hospitals to provide this added care; as-

sumes that the federal government would provide state and local governments with huge windfalls rather than requiring full maintenance of effort; makes no mention of the vast current tax subsidies for private coverage whose elimination would provide hundreds of billions annually to fund a single-payer program; and ignores savings on drugs and medical equipment that every other single-payer program has reaped.

In the past, Thorpe estimated that single-payer reform would lower health spending while covering all of the uninsured

and upgrading coverage for the tens of millions who are currently underinsured. The facts on which those conclusions were based have not changed.

PNHP note: Physicians for a National Health Program (PNHP) is a nonprofit, nonpartisan, educational and policy research organization that neither supports nor opposes any candidate for public office nor any political party.



Kenneth Thorpe of Emory University at Washington Post Live’s forum on noncommunicable diseases in October 2012. Photo: Jeff Martin/Washington Post

Is a single-payer health insurance program feasible?

Two letters: Alan Meyers, M.D., and Jim Recht, M.D.

To the Editor:

Re: "Health Reform Realities" (column, Jan. 18):

I'm glad to see that Paul Krugman acknowledges that "if we could start from scratch, many, perhaps most, health economists would recommend single-payer, a Medicare-type program covering everyone." His argument that we should not work for it now is unconvincing.

Just because private insurers are powerful doesn't mean a concerted national campaign can't overcome their well-funded opposition. Already a majority of the general public (58 percent in a recent Kaiser poll) supports single-payer. Cost will never be controlled until we do away with the bloated administrative expenses of our hopelessly complex financing arrangements and for-profit medicine.

And while the Affordable Care Act has indeed been a great help for many seeking health insurance, it has left over one-fourth of Americans ages 18 to 64 with problems paying their medical bills. As you have reported, that can be the case even for those with insurance ("Medical Debt Often Crushing Even for Insured," The Upshot, Jan. 5).

We can do better, as every other developed nation has demonstrated.

Dr. Alan Meyers resides in Boston. He is a professor of pediatrics at Boston University School of Medicine and a founding member of Physicians for a National Health Program.

Paul Krugman argues that perhaps the "most important" reason not to pursue single-payer health care financing is that it "would impose a lot of disruption on tens of millions of families who currently have good coverage through their employers."

As a physician who happens also to be an employee of a large Boston-area human services agency, I can tell you from personal experience, as well as from the (frequently desperate) experiences of my patients, that "good" is not how any of us would describe our coverage.

Premiums are jaw-droppingly high (and projected to increase anywhere from 6.8 to 16.5 percent this year); high-deductible and other "Swiss cheese" insurance policies have become the norm, resulting in increasing out-of-pocket co-pays and deductibles; and obstacles to care, from arbitrary "prior authorization" requirements to restricted panels, regularly prevent people from receiving the care they need.

Along with so many of my patients and colleagues, I am convinced that single-payer is right for us, right now.

Dr. Jim Recht resides in Cambridge, Mass. He is an assistant professor of psychiatry at Harvard Medical School.

The Washington Post

Why Medicare for all is the best plan

By Robert Zarr, M.D.

Regarding the Jan. 29 editorial "The real problem with Mr. Sanders":

Single-payer expanded and improved Medicare for all would provide universality, affordability and cost containment. Single-payer would allow doctors to focus on their patients' health needs, rather than on patients' ability to pay. What Americans want is choice of doctor, not choice of health insurance. Americans want comprehensive, lifelong insurance that assures them they will get the care they deserve.

Although it may seem fantastical to provide more care to more people for less money, there is a preponderance of scientific data

to support this claim. In the United States, we waste \$375 billion a year on billing and insurance-related bureaucracy, and not a dime of it goes toward a doctor's visit, vaccination, procedure or medication. In contrast with private insurance with double-digit administrative overhead, Medicare runs at less than 3 percent. The vast majority of Americans and physicians favor expanding and improving Medicare.

So what's stopping us? Certainly not the facts, because the facts are on our side.

The writer is president of Physicians for a National Health Program. He resides in Washington.

PBS NewsHour’s erroneous claim that most Americans don’t want single payer

By Garrett Adams, M.D., and Kip Sullivan, J.D.

PNHP note: During a PBS NewsHour discussion of Hillary Clinton’s and Bernie Sanders’ health care proposals on Jan. 22, news anchor Judy Woodruff posed this question: “Essentially the argument is whether you just wipe away what we have done and you go to a single-payer health care system, which most Americans say they don’t want, right, I mean ...?” [Our emphasis.] Neither of her guests directly responded to her remark. Shortly thereafter, Dr. Garrett Adams, past president of PNHP, wrote letters to Woodruff and the PBS ombudsman, Michael Getler, challenging them on this claim. The response he received from them was that a Pew poll in 2014 showed only 21 percent of the U.S. population supports single payer. What follows is a lightly edited version of the reply Dr. Garrett Adams and Kip Sullivan, J.D., made to the PBS ombudsman’s response. To save space, this version omits many links to original source materials.

February 3, 2016

Michael Getler
PBS Ombudsman

Dear Mr. Getler,

Thank you for your response to our concern about Judy Woodruff’s mistaken remark that “most Americans say they **don’t** want [single-payer health care].”

In your reply, you justified Ms. Woodruff’s statement by citing a single poll – a 2014 Pew Research poll which claimed to find only 21 percent of American adults support a “single national health insurance system run by the government.”

In this letter we want to make two points: (1) The Pew poll is an outlier, by a wide margin, among polls that sought to determine American support for a single-payer or Medicare-for-all system; (2) the Pew poll is an outlier because half of the respondents were never asked a question about single payer, thus guaranteeing a result very different from those reached by other polls.

One of us, Kip Sullivan, J.D., has done considerable research on this matter over a period of many years.

The Pew poll is an outlier

Since the late 1980s, when polls began to ask Americans about their support for single-payer systems, polls have generally shown support **in the 60 percent to 70 percent range when the poll offered some information about what a single payer is (usually by comparing it to Medicare or the Canadian health**

system), and in the 50 to 60 percent range when little information is provided to respondents.

Obviously, the Pew poll is a distant outlier among these polls. Here are some representative examples of polls taken over the last quarter century:

Table 1. Examples of polls taken over the last 28 years

Polls of the general public in which support was 58% or higher	Supporting single payer	Opposing single payer
Harvard University/Harris (1988)(a)	61%	not asked
LA Times (1990)(b)	66%	not asked
Wall Street Journal-NBC (1991)(c)	69%	20%
Wash Post-ABC News (2003)(d)	62%	not asked
Civil Society Institute (2004)(e)	67%	27%
AP-Yahoo (2007)(f)	65%	not asked
Kaiser Family Foundation (2009)(g)	58%	38%
Kaiser Family Foundation (2015)(h)	58%	34%
Kaiser Family Foundation (2016)(i)	64%	29%
Polls of the general public in which support was below 58%	Supporting single payer	Opposing single payer
AP-Yahoo (2007)(f)	54%	44%
Kaiser Family Foundation (2009)(g)	50%	44%
Kaiser Family Foundation (2016)(i)	50%	43%

Notes to Table 1: Examples of polls taken over the last quarter century

(a) The question asked by this poll was described in the Health Affairs article reporting the results as follows: “The majority of Americans (61 percent) state they would prefer the **Canadian** system of national health insurance where ‘the government pays most of the cost of health care for everyone out of taxes and the government sets all fees charged by hospitals and doctors,’ to the one they now have.” An analogous question posed to Canadians found that only 3 percent of Canadians said they would prefer the American system.

(b) The question asked was: “In the **Canadian** system of national health insurance, the government pays most of the cost of health care out of taxes and the government sets all fees charged by doctors and hospitals. Under the **Canadian** system – which costs the taxpayers less than the American system – people can choose their own doctors and hospitals. On balance, would you prefer the **Canadian** system or the system we have here in the United States?” Sixty-six percent chose the Canadian system and 25 percent chose the U.S. system.

(c) The question was: “Do you favor or oppose the U.S. having a universal government-paid health care system like they have in **Canada**?”

(d) The poll asked: “Which would you prefer – (the current health insurance system in the United States, in which most people get their health



Judy Woodruff discusses health care with her guests on the PBS NewsHour, Jan. 22, 2016.

insurance from private employers, but some people have no insurance); or (a universal health insurance program, in which everyone is covered under a program like **Medicare** that’s run by the government and financed by taxpayers?)” Thirty-three percent preferred the current system while 62 percent preferred the “universal system.”

(e) The poll asked: “Other major nations, such as **Canada and England**, guarantee their citizens health insurance on the job, through government programs, or via a nonprofit source. Would it be a good or bad idea for the United States to adopt the same approach to providing health care to everyone?”

(f) The poll asked two questions. One asked respondents which of these two proposals they agreed with: (1) “The United States should adopt a universal health insurance program in which everyone is covered under a program like **Medicare** that is run by the government and financed by taxpayers” (65 percent chose this option); (2) “The United States should continue the current health insurance system in which most people get their health insurance from private employers, but some people have no insurance” (34 percent chose this option). The second question was: “Do you consider yourself a supporter of a single-payer health care system, that is a national health plan financed by taxpayers in which all Americans would get their insurance from a single government plan, or not?” (54 percent said they were supporters of single-payer and 44 percent said they were opposed).

(g) The poll asked: “Now I’m going to read you some different ways to increase the number of Americans covered by health insurance. As I read each one, please tell me whether you would favor it or oppose it.” This was followed by eight proposals which, with the exception of the question about the “public option,” were asked in a random order (the “option” question was always asked at the end). Two of these questions asked about single payer. The first read: “Having a national health plan in which all Americans would get their insurance through an expanded, universal form of **Medicare-for-all**.” Fifty-eight percent said they favored this proposal while 38 percent said they opposed. The second read: “Having a national health plan – or single-payer plan – in which all Americans would get their insurance from a single government plan.” Only 50 percent favored this proposal while 44 percent opposed.

(h) The poll asked: “Now, please tell me if you favor or oppose having a national health plan in which all Americans would get their insurance through an expanded, universal form of **Medicare-for-all**?”

(i) This poll initially asked about support for “guaranteed health insur-

ance in which all Americans would get their coverage through a single government health plan.” Fifty percent favored the plan, while 43 percent opposed. The poll also tested reactions to different phrases, such as “**Medicare-for-all**” (64 percent positive), “guaranteed universal health coverage (57 percent positive), “single payer health insurance system” (44 percent positive) and “socialized medicine” (38 percent positive). Support fell by 20 percentage points if supporters were told that the plan would “increase taxes” or “give government too much control” and by 14 points if supporters were told that the plan would “eliminate or replace the current health law.” Support rose by 14 points if opponents were told that the plan would make health insurance a “basic right” and by 11 points if opponents were told the plan would “reduce health insurance administrative costs,” or “eliminate all private premiums, co-pays, and deductibles by employers and individuals.”

Note that none of these polls informed respondents that universal coverage under multiple-payer systems would be more expensive than a single-payer system. It is reasonable to predict that if pollsters did that, the results would show even higher single-payer support than the two-thirds level seen in the polls listed in Table 1. To illustrate the role that more or less information plays, and to illustrate what a typical poll asks, consider these questions posed by the 2007 AP-Yahoo poll (quoted in Table 1).

Table 2. Two questions for the AP-Yahoo 2007 poll

ISS14. Which comes closest to your view?	
<i>The United States should continue the current health insurance system in which most people get their health insurance from private employers, but some people have no insurance.</i>	<i>The United States should adopt a universal health care program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers.</i>
34%	65%
ISS15. Do you consider yourself a supporter of a single-payer healthcare system, that is a national health plan financed by taxpayers in which all Americans would get their insurance from a single government plan, or not?	
Yes	54%
No	44%

Table 2 indicates that **when respondents are told that a national single-payer system would resemble Medicare, a program that Americans are quite familiar with, 65 percent support a single-payer system** (even though they are not told that universal coverage under the current system would be more expensive). Table 2 also indicates that when the question fails to mention Medicare, and instead asks “are you a single-payer supporter,” support drops by 11 points to 54 percent. Fifty-four

percent is, obviously, still far higher than 21 percent.

Why, among all of the well-known polls that consistently show a majority of Americans support single payer, did the NewsHour decide to rely on the Pew poll?

Why the Pew poll is an outlier

The Pew poll reported unusual results because it refused to let half of the respondents answer a question about single payer. Instead, the Pew poll asked an abstract question about “the responsibility of the federal government” and then, on the basis of the answer to that question, decided which respondents would be allowed to comment specifically on single-payer.

Table 3 contains the questions Pew used. We have bolded a question that added more bias to the poll.

Table 3. Pew Research poll questions

Government Role In Health Care	
Q121/a/b: Do you think it is the responsibility of the federal government to make sure all Americans have health care coverage, or is that not the responsibility of the federal government?	
ASK IF GOV'T RESPONSIBILITY: Should health insurance (Be provided through a single national health insurance system run by the government) OR (Continue to be provided through a mix of private insurance companies and government programs) [RANDOMIZE]?	
47%	Yes, government responsibility
21%	Be provided through a single national health insurance system run by the government
23%	Continue to be provided through a mix of private insurance companies and government programs
2%	Don't know/Refused
ASK IF NOT GOV'T RESPONSIBILITY: <i>Should the government (Not be involved in providing health insurance at all) OR (Continue programs like Medicare and Medicaid for seniors and the very poor) [RANDOMIZE]?</i>	
50%	No, not government responsibility
6%	Not be involved in providing health insurance at all
43%	Continue programs like Medicare and Medicaid for seniors and the very poor
1%	Don't know/Refused

As if refusing to give half of the respondents the opportunity to comment on single payer were not serious enough, Pew then committed one more error: The single-payer question that was posed to just half of respondents was paired with an

optional system that was so vaguely described (“a mix of private insurance companies and government programs”) it could have caused many respondents to think it meant a single-payer system. Every single-payer system in the world allows private insurance companies to play some role, albeit a much more limited role than they play in the U.S. system today. That vague response option helped drain off support for single payer. Now the 47 percent who said yes to the vague and esoteric question about “responsibility” was further reduced to 21 percent.

We question the rationale for posing such a series of convoluted questions when the most obvious and the least confusing approach is to pose the question at hand: Do you support single-payer health care (or Medicare for all)?

Conclusion

The evidence shows that a significant majority of Americans support single-payer, Medicare-for-all health care.

Sincerely,

Garrett Adams, M.D., M.P.H.

Past-president, Physicians for a National Health Program

Kip Sullivan, J.D.

On March 3, Dr. Adams' objection to the NewsHour's claim was substantially supported by the past president of the Association of Health Care Journalists, Trudy Lieberman, who, writing at Health Review News, implicitly criticized the NewsHour for relying on a single poll and for not taking account of how that poll was designed. You can read her critique at bit.ly/1ZKJLV3.

PNHP note: The phrase “single payer” entered the American vocabulary in 1989 following the publication in the New England Journal of Medicine of “A National Health Program for the United States: A Physicians Proposal.” The proposal called for a “national health program, as the single payer for services.” That paper was written by doctors affiliated with PNHP.

The Current and Projected Taxpayer Shares of US Health Costs

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

Objectives. We estimated taxpayers' current and projected share of US health expenditures, including government payments for public employees' health benefits as well as tax subsidies to private health spending.

Methods. We tabulated official Centers for Medicare and Medicaid Services figures on direct government spending for health programs and public employees' health benefits for 2013, and projected figures through 2024. We calculated the value of tax subsidies for private spending from official federal budget documents and figures for state and local tax collections.

Results. Tax-funded health expenditures totaled \$1.877 trillion in 2013 and are projected to increase to \$3.642 trillion in 2024. Government's share of overall health spending was 64.3% of national health expenditures in 2013 and will rise to 67.1% in 2024. Government health expenditures in the United States account for a larger share of gross domestic product (11.2% in 2013) than do total health expenditures in any other nation.

Conclusions. Contrary to public perceptions and official Centers for Medicare and Medicaid Services estimates, government funds most health care in the United States. Appreciation of government's predominant role in health funding might encourage more appropriate and equitable targeting of health expenditures. (*Am J Public Health*. Published online ahead of print January 21, 2016; e1–e4. doi:10.2105/AJPH.2015.302997)

The United States has the world's highest per capita health care costs—about double those of other wealthy nations.¹ According to both official figures and public perception, most health care funding in the United States comes from private payers. For instance, the Centers for Medicare and Medicaid Services (CMS) estimates that federal, state, and local governments accounted for 43% of health expenditures in 2013.²

These official figures reflect an accounting framework based on who wrote the final check as money flowed from households or employers to health care providers, and exclude many indirect government health expenditures. Thus, when government pays for veterans' care, CMS classifies it as a public expenditure because government writes the checks that fund the Veterans Health Administration. But CMS classifies government-paid health benefits for senators

or Federal Bureau of Investigation agents as "private" expenditures because a private insurer pays the claims. Moreover, the tax subsidies that fund a significant share of private health expenditures (e.g., private-employer spending) are not counted by CMS as government health spending, although the Office of Management and Budget (OMB) tabulates these subsidies as "tax expenditures" in official budget documents.³

In a previous study, we estimated that the public share of US health spending—after inclusion of these tax subsidies and government payments for public employees' health benefits—amounted to 59.8% of the total in 1999, nearly double the 1965 figure.⁴ The

current study provides detailed estimates of direct and indirect government health spending in 2013, as well as projected figures through 2024.

METHODS

We estimated total taxpayer expenditures for health care by summing 3 types of expenditures: (1) direct government payments for Medicare, Medicaid, and other public programs such as the Veterans Health Administration, the National Institutes of Health, and public health departments; (2) government agencies' expenditures for public employees' health insurance coverage; and (3) federal, state, and local tax subsidies to health care.

To estimate direct government payments for health care, as well as government agencies' expenditures for public employees' health benefits, we used figures from the national health expenditure projections prepared by CMS's Office of the Actuary.^{5,6}

To calculate the value of health care–related tax subsidies, we first obtained the OMB's official estimates of the value of the federal income tax and payroll tax subsidies to health care and health insurance each year.³

Like the federal government, state (and local) governments do not include the value of employer-paid health benefits when calculating income and income tax liability. Hence, we estimated state and local income tax subsidies in 2013 by multiplying the value of the federal income tax subsidy by the ratio of (local + state) income tax receipts to federal income tax receipts. We calculated this ratio with data from the Census Bureau's quarterly surveys of state and local tax receipts⁷ and

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Internal Revenue Service data on federal income tax receipts.⁸ For future years, we assumed that the ratio would remain at the 2013 level.

The OMB's estimates of health-related tax subsidies include tax subsidies to government employees, and we had already included the entire government contribution to its employees' health benefits as a tax-financed expenditure. Hence, to avoid double-counting, we adjusted the tax subsidy estimates downward to exclude government employees based on government employers' share of total employer-paid premiums as detailed in the CMS actuaries' projections.⁴

These methods emulate those we used to estimate public spending in 1999,⁴ with 1 modification. In the past, we used multiple data sources and complex methods to estimate payroll tax subsidies because no official figures for these subsidies were available. In 2008, OMB began providing such figures, which serve as the basis for our current estimates. Compared with our older method, use of the more accurate OMB figure increases our estimate of government's share by about 0.7%.

Finally, to offer perspective on the US taxpayer-funded health expenditures, we compared them to figures for several other developed nations by using data from the Organization for Economic Cooperation and Development (OECD).¹

We carried out data management and analyses with Microsoft Excel 2003 (Microsoft, Redmond, WA).

RESULTS

Tax-funded expenditures for health care totaled \$1.877 trillion in 2013 (\$5960 per capita) (Table 1). Tax-funded expenditures' share of overall health spending was 64.3% of total health expenditures in 2013. Projections suggest that government's share will rise to 67.1% in 2024.

Medicare will remain the largest category of tax-funded expenditures, rising from 20.1% of overall expenditures in 2013 to 22.5% in 2024 (Table 2). Medicaid's share rose more than 1% between 2013 and 2015, coincident with the rollout of the Affordable Care Act's (ACA's) Medicaid expansion, and is projected to stabilize at about 17% of national health spending.

TABLE 1—Tax-Financed Health Expenditures (Billions of Dollars): United States, 2013–2024

Expenditure	2013	2014	2015	2020	2024
Total national health expenditures	2919	3080	3244	4274	5425
Direct government health expenditures ^a					
Medicare	585.7	616.8	646.0	905.7	1221.3
Medicaid or Children's Health Insurance Program	462.9	517.0	559.6	728.6	914.6
Other health programs	345.9	353.5	366.0	485.1	611.3
Government expenditures for public employees' health benefits					
Federal government	32	33	34	40	49
State or local governments	156	169	177	239	307
Tax subsidies for private employer-paid health insurance and other privately paid care					
Federal government	249.2	262.7	276.4	345.9	453.2
State or local governments	45.7	47.4	49.8	63.5	85.7
Total tax-financed expenditures	1877.4	1999.4	2108.8	2807.8	3642.1
Tax-financed expenditures as a percentage of total national health expenditures, %	64.3	64.9	65.0	65.7	67.1

Note. Figures for 2013 are based on actual expenditures; 2014–2024 are based on Centers for Medicare and Medicaid Services and Office of Management and Budget projections.

^aEquivalent to traditional Centers for Medicare and Medicaid Services tabulation of government's share of expenditures.

Tax subsidies to private health spending totaled \$294.9 billion in 2013, and are expected to remain about 10% of total health expenditures through 2024. Federal income and payroll tax subsidies account for more than 80% of these tax expenditures, with state and local income tax subsidies accounting for the rest. The vast majority of tax expenditures subsidize employer-sponsored coverage; subsidies to out-of-pocket expenditures account for only 4.1% of the total.

Government employers currently account for 28% of all employer payments for private health insurance, a figure that is projected to rise to 31% in 2024. Most of these expenditures (more than four fifths) are made by state and local governments.

Private employers' spending for health insurance premiums as a share of national health expenditures reached a high of 18.5% in 2000 to 2001, falling to 16.7% in 2013, and are expected to decline to 14.5% in 2024. (These figures do not take account of tax subsidies, which would reduce these estimates by more than one third.)

As is well known, US health care costs are far higher than those in any other nation (Table 3). However, the high level of tax-funded spending in the United States receives less attention. Indeed, tax-funded health

expenditures in the United States account for a larger share of gross domestic product (11.2% in 2013) than do total health expenditures in any other nation.

DISCUSSION

Americans pay the world's highest health-related taxes. Yet many perceive that US health care financing system is predominantly private, in contrast to the universal tax-funded health care systems in nations such as Canada, France, or the United Kingdom. By 2024, government expenditures in the United States are expected to account for more than two thirds of national health spending. This is nearly the same proportion as in Canada, where official figures put government's share at 70.7% (although this figure excludes modest tax subsidies for supplemental private coverage).

Even as overall US health expenditures soared over the past half century, taxpayers' share grew substantially. After correction for differences in the methods used to estimate tax subsidies, the public share increased from about 31% in 1965 (before Medicare and Medicaid) to about 56% in 1980, 60% in 1999,⁴ and 64.3% in 2013.

(continued on next page)

TABLE 2—Tax-Financed Health Expenditures as a Percentage of Total Health Expenditures and of Gross Domestic Product: United States, 2013–2024

Category of Expenditure	2013, %	2014, %	2015, %	2020, %	2024, %
Medicare	20.1	20.0	19.9	21.2	22.5
Medicaid	15.9	16.8	17.3	17.0	16.9
Other government health program ^a	11.8	11.5	11.3	11.4	11.3
Public employee benefits	6.4	6.6	6.5	6.5	6.6
Tax subsidies	10.1	10.1	10.1	9.6	9.9
Total tax-financed expenditures as a percentage of total national health expenditures	64.3	64.9	65.0	65.7	67.1
Total tax-financed health expenditures as a percentage of gross domestic product	11.2	11.5	11.7	12.2	13.2

Note. Figures for 2013 are based on actual expenditures; 2014–2024 are based on Centers for Medicare and Medicaid Services and Office of Management and Budget projections.

^aIncludes health spending by the Department of Defense, Department of Veterans Affairs, Indian Health Services, the National Institutes of Health, maternal and child health programs, school health, public health activities, and other smaller categories of federal, state, and local health spending.

This trend seems likely to continue. The expected uptick in government’s share is attributable both to the effects of the ACA and to population aging, which will push Medicare enrollment up by 37% (19.0 million persons) between 2013 and 2024. Medicaid enrollment, which rose rapidly between 2013 and 2015 because of the ACA’s Medicaid expansion, is expected to increase by a further 10.8% (7.6 million) between 2015 and 2024.

Overall, the share of the population covered by Medicare and Medicaid is expected to rise from 36.9% in 2013 to 44.6% in 2024. Meanwhile, the ACA is expected to provide \$99 billion in government subsidies for private coverage in 2024.⁹

Several caveats apply to our findings. As in any forecast, our projections could prove inaccurate because of economic fluctuations or unforeseen changes in health or tax policy.

Official health and tax expenditure figures provided the raw data for our estimates; however, in several instances we made adjustments to avoid double-counting, and to estimate the magnitude of state and local tax subsidies for health care. Our analysis adopts the perspective that health care–related tax subsidies are tantamount to tax expenditures—an assumption that is widely shared within the policy community and by the OMB. Our analysis may slightly understate public expenditures as we did not include tax subsidies for nonprofit hospitals, which were estimated at \$24.6 billion in 2011,¹⁰ about 1% of health spending. Our international comparisons rely on data from the Organization for Economic Cooperation and Development. Despite that organization’s attempts to harmonize expenditure categories and definitions across nations, some differences may cloud comparisons. Finally, our figures for the public share of expenditures in other Organization for Economic Cooperation and Development nations exclude tax subsidies for their relatively small private insurance sectors (Switzerland does not offer tax subsidies for employer-paid insurance).

Public funds help the vast majority of Americans pay for care, but these funds flow through many different spigots. The funding streams for the poor, the elderly, veterans, family planning, and public sector workers are visible and hotly debated. Meanwhile, the hundreds of billions in tax subsidies that disproportionately benefit wealthier Americans have drawn far less public attention.

Although taxpayers fund the vast majority of health spending, overall priorities for this funding are rarely discussed. Appreciation of the magnitude of government funding might encourage more explicit, appropriate, and equitable targeting of these expenditures as components of a total health budget. **AJPH**

CONTRIBUTORS

Both authors contributed equally to all aspects of this work.

HUMAN PARTICIPANT PROTECTION

This research did not involve human participants. No institutional review board approval was sought for this research.

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TABLE 3—Total and Tax-Funded Health Expenditures: United States and Other Developed Nations, 2013

Country	Total Spending Per Capita, PPP \$	Total Spending as Share of GDP, %	Tax-Funded Spending Per Capita, PPP \$	Tax-Funded Spending as Share of GDP, %
Canada	4351	10.2	3074	7.2
France	4124	10.9	3247	8.6
Germany	4819	11.0	3677	8.4
Italy	3077	8.8	2381	6.8
Japan	3713	10.2	3090	8.5
Netherlands	5131	11.1	4495	9.7
Sweden	4904	11.0	4126	9.2
Switzerland	6325	11.1	4178	7.3
United Kingdom	3235	8.5	2802	7.3
OECD average (excluding United States)	3226	8.8	2443	6.5
United States	9267	17.4	5960	11.2

Note. GDP = gross domestic product; OECD = Organization for Economic Cooperation and Development; PPP = purchasing power parity. US figures are from national health expenditure accounts; figures for other nations are from OECD data. Figures for tax-funded spending in nations other than the United States exclude tax subsidies to private spending; Switzerland does not offer tax subsidies for employer payments for coverage.

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Chicago Medical Society calls for study of single payer

The Chicago Medical Society has voted to create a “research committee to analyze the benefits and difficulties with instituting and maintaining a single-payer health care system in Illinois ... and the United States, with consideration of both economic and health outcome and health disparity improvements.”

The action came at the society’s quarterly council meeting on Feb. 9, which drew about 80 participants, including a larger-than-usual group of medical students and residents.

The amended resolution passed unanimously, and it included a provision to forward the resolution to the Illinois State Medical Society and the AMA.

The measure that was ultimately adopted by the councilors, or delegates, was based in large part on the contents of an evidence-laden resolution titled “Single-payer health care: the logical solution that will not go away” introduced by Dr. Peter Orris, long-time CMS councilor and one of PNHP’s founding members.

Orris’ original resolution concluded by calling upon the CMS to formally endorse single payer. An active debate ensued. With the permission of the body, many students and some Chicago physicians who were not members of the council testified in favor of the proposal.

Speakers in support of the resolution pointed to the continuing financial hardships patients and their families are experiencing under the current multi-payer system, growing physician frustration with that system, and the moral imperative of achieving truly universal health care.

Strong opposition to the resolution was heard from a number of council members, with several confusing single payer with the underfunded socialized medical systems of the 1970s in Eastern Europe.

On a public “standing” vote, the “resolved” clause calling for CMS endorsement drew support from over one-third of the council members.

Orris notes that while this was more public support for single

payer among the councilors than in the past, many members newly sympathetic to the single-payer alternative signaled a preference for a more deliberative approach.

Student Section member James Curry then offered an amendment changing the “resolved” language to a call for a CMS study of single payer’s economic and health impacts.

The amended resolution passed unanimously, including a provision to forward it to the Illinois State Medical Society and the AMA.

After the meeting, Curry said he was pleased that students from every medical school in the area were in attendance. “Single-payer health care means many things, but to its supporters, including medical students, it means one very fundamental thing: the right to health care.”

He said the society’s leadership has pledged to involve students in the organization of the society’s discussion of single payer, and has expressed a willingness to conduct a membership survey on the issue as well.

-- PNHP staff



Medical students took an active part in the Chicago Medical Society debate on single payer in February.

(Taxpayer share, continued from previous page)

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Federal employees' union endorses H.R. 676

The National Executive Council of the American Federation of Government Employees (AFGE) unanimously endorsed H.R. 676, national single-payer legislation, in November

Whereas, America's health care system is in deep trouble. In spite of efforts to regulate the insurance industry for-profit health insurance companies are finding ways to skirt the law. The Affordable Care Act, passed in 2010, made it possible for some of the uninsured to find coverage, but did not resolve the problem that health insurance companies are pricing care beyond our means, and

Whereas, unions have battled to achieve the highest standards of health care for members and their families, and those gains have lifted up health benefits for all workers, even those who have no union. All of these achievements are now under constant attack as costs rise and employers seek to shift those costs to workers. Union multiemployer health plans are struggling under the unfair advantages allowed to non-union companies. Rising copays and deductibles make it more difficult for those who have insurance to get the care they need. The excise tax of 2018 will make things worse, and

Whereas, employers seek to drop health benefits for early retirees, for spouses, for part-timers. Some corporations use bankruptcy laws to shirk their contractual health care obligations. The rising cost of health insurance is blocking progress in wages and other areas, and

Whereas, insurance companies rather than patients are deciding what doctors we can see and what hospitals we can use. Drug company profits soar as, so far, congress has not used the power

With 1,100 local unions, AFGE is the largest federal employee union and has 670,000 members across the country.

of bulk purchasing to bring down the prices. The US spends double per capita what other industrialized nations spend, yet ranks far below in life expectancy and infant mortality, and

Whereas, we deserve better. It doesn't have to be this way. Firefighters don't ask us to pay before they save our families from burning houses. They just proceed to do the right thing. Health care is just as important as fire protection. Lives are at stake and all of us should have the best care that this wealthy nation has the ability to provide. Our tax dollars subsidize the research, the medical schools, and the hospitals. Unions led the way in other industrialized countries to assure universal coverage with good care through a form of single payer, and Congressman John Conyers Jr. (D-MI) has introduced H.R. 676, Expanded and Im-

proved Medicare for All. H.R. 676 will establish a single-payer health care system by expanding a greatly improved Medicare to cover everyone. It will restore our right to choose our physicians and free us from insurance company interference in medical decisions. It will free our health care from corporate control, and

Whereas, H.R. 676 will cover everyone for all necessary medical care including dental, prescription drugs, hospital, surgical, outpatient services, primary and preventive care, emergency services, mental health, home health, physical therapy, rehabilitation (including for substance abuse), vision care, chiropractic, eyeglasses, hearing aids, other medical devices and long term care. H.R. 676 will end deductibles and copayments, and

Whereas, H.R. 676 will save hundreds of billions annually by eliminating the high overhead and profits of the private health insurance industry and by using our purchasing power to rein in the drug companies. The transition to national health insurance would apply the savings from administration and profits to expanded and improved coverage for all, and

Whereas, standing up for all working people and leading the effort to win health care for all we will affirm labor's rightful role as a leader in the fight for social justice. Bold action by our unions can rally the nation to pass H.R. 676.

Therefore be it resolved, that AFGE wholeheartedly endorses Congressman Conyers' bill H.R. 676, "Expanded and Improved Medicare for ALL," a single-payer health care program.

Be it further resolved, that AFGE will work with other unions and community groups to build a groundswell of popular support and action for single payer universal health care and H.R. 676 until we make what is morally right for our nation into what is politically possible.

And that AFGE will send a copy of this resolution to Congressman Conyers, to all members of the U.S. House and Senate, to the AFL-CIO Executive Council, and to the news media.

And further, that AFGE will take other actions to mobilize our members and our community at the grassroots to encourage other members of the House to sign on as co-sponsors of H.R. 676 and to encourage senators to introduce a companion bill in the Senate.

For more information, contact Kay Tillow at Unions for Single Payer Health Care, nursenpo@aol.com, or visit unionsforsinglepayer.org.



More in Congress sign on as cosponsors of single-payer bill

In December six representatives, Danny Davis (IL), Grace Napolitano (CA), Emanuel Cleaver (MO), Jerry McNerney (CA), Robin Kelly (IL), and Alan Lowenthal (CA) added their names as cosponsors on H.R. 676, Congressman John Conyers' Expanded and Improved Medicare for All Act, the national single-payer legislation.

The total number of cosponsors is now 59, not including chief sponsor Conyers. [PNHP note: as of mid-March, the number of cosponsors is 62.]

The more cosponsors that are added, the more quickly this real solution becomes politically viable. The more representatives who speak boldly for H.R. 676, the higher single payer advances on the nation's agenda.

Call your representative and ask her or him to sign on to H.R. 676. The Capitol switchboard number is (202) 224-3121. Ask to speak to your representative by name.

When talking with representatives who have already signed on, encourage them to speak up for H.R. 676 on the House floor, to the press, in town hall meetings, and to put their support for H.R. 676 on their website. If they need further information, spend the time to bring the facts about H.R. 676 to their attention.

This clear and simple statement that Dr. Marcia Angell, former editor-in-chief, New England Journal of Medicine, which she made on June 10, 2009, may help:

"According to myth ... a single-payer system is a good idea, but unrealistic. ... What is truly unrealistic is anything else."

The list of representatives who were cosponsors of H.R. 676 in earlier Congresses but have not yet signed on in the 114th is below. This is a good place to start.

Rep. Xavier Becerra, California 34th
Rep. Sanford D. Bishop, Jr., Georgia 2nd
Rep. Corrine Brown, Florida 5th
Rep. G. K. Butterfield, North Carolina 1st
Rep. Andre Carson, Indiana 7th
Rep. Marcia Fudge, Ohio 11th
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Rep. Gregory W. Meeks, New York 5th
Rep. Donald M. Payne, Jr., New Jersey 10th
Rep. Jared Polis, Colorado 2nd
Rep. David Scott, Georgia 13th
Rep. Bennie G. Thompson, Mississippi 2nd
Rep. Nydia M. Velázquez, New York 7th
Rep. Peter J. Visclosky, Indiana 1st
Rep. Maxine Waters, California 43rd

H.R. 676 would institute a single-payer health care system by expanding a greatly improved Medicare to everyone residing in the U.S. Patients will choose their own physicians and hospitals.



Members of the International Brotherhood of Electrical Workers teamed up with Kentuckians for Single Payer Health Care at a 50th anniversary civil rights march in Frankfort, Ky. Photo: Kay Tillow

H.R. 676 would cover every person for all necessary medical care including prescription drugs, hospital, surgical, outpatient services, primary and preventive care, emergency services, dental (including oral surgery, periodontics, endodontics), mental health, home health, physical therapy, rehabilitation (including for substance abuse), vision care and correction, hearing services including hearing aids, chiropractic, durable medical equipment, palliative care, podiatric care, and long-term care.

H.R. 676 ends deductibles and co-payments. H.R. 676 would save hundreds of billions annually by eliminating the high overhead and profits of the private health insurance industry and HMOs.

In the current Congress, H.R. 676 has 59 [now 62] cosponsors in addition to Congressman Conyers.

H.R. 676 has been endorsed by 624 union organizations including 151 Central Labor Councils/Area Labor Federations and 44 state AFL-CIOs (KY, PA, CT, OH, DE, ND, WA, SC, WY, VT, FL, WI, WV, SD, NC, MO, MN, ME, AR, MD-DC, TX, IA, AZ, TN, OR, GA, OK, KS, CO, IN, AL, CA, AK, MI, MT, NE, NJ, NY, NV, MA, RI, NH, ID).

For a list of union endorsers, or a sample endorsement resolution, contact Kay Tillow, All Unions Committee for Single Payer Health Care--H.R. 676, c/o Nurses Professional Organization (NPO), 1169 Eastern Parkway, Suite 2218, Louisville, KY 40217; phone: (502) 636-1551; email nursespo@aol.com.

Medicare for all really is ‘the only answer’

By the Editorial Board

Dr. Quentin Young, one of the greatest economic and social justice campaigners of the modern era, has died at age 92. Young served as a personal physician for the Rev. Martin Luther King Jr. and organized the Medical Committee for Human Rights, which provided medical support for activists during the 1964 Freedom Summer in Mississippi. He helped to shape and advance the call for an understanding of health care not as a commodity but as a human right.

Young was a friend and ally of this newspaper, a source of insight and inspiration for many years, and an ally in our campaigning for universal health care, which dates back to the days when Capital Times founder William T. Evjue was cheering on the efforts of Franklin Delano Roosevelt and Harry Truman to establish a national health care program. Over the years, we celebrated Young’s work and joined him and his dear friends, the late Madison area physicians Gene and Linda Farley, in championing efforts to establish a single-payer “Medicare for all” health care system in the United States.

More than three decades ago, as he was working to forge the Physicians for a National Health Program movement, Young warned of “the corporate takeover of medicine.” As PNHP notes, “he sounded the alarm about the growing encroachment of corporate conglomerates on U.S. health care, noting that giant investor-owned firms were rapidly subordinating the best interests of patients and the medical profession to the maximization of corporate profit.”

To counter the crisis, PNHP said in its statement on the doctor’s death, Young became “the nation’s most eloquent and high-profile spokesperson for single-payer national health insurance, or improved Medicare for all.” He worked closely with an old ally from civil rights movement days, Congressman John Conyers Jr., D-Mich., on behalf of H.R. 676, “The Expanded and Improved Medicare for All Act,” the single-payer health care proposal backed by dozens of House and Senate members. Young gave credit to the efforts of President Obama — a friend and a patient of the physician’s Chicago clinic — to develop and implement the Affordable Care Act. But while he could identify positive elements of the ACA, Young argued it was an inadequate reform that left too many Americans with no coverage or insufficient coverage and that failed to control costs because it maintained an arrangement where “the insurance companies are still going to make their profits.”

Young, who served as PNHP’s national coordinator for more than two decades, remained an outspoken advocate for single-payer to the end. Making his case for “single-payer national health insurance, government-run, based on the tax system,” Young said in a 2004 interview posted on the organization’s

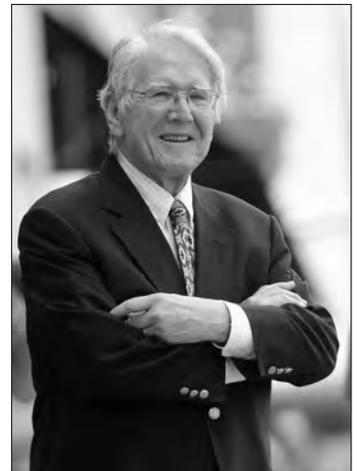
website that “universal health care is no longer the best answer; it’s the only answer. There was a time when there were alternatives that might have worked, but that day is passed. We’ve had too much of a transfer of power from patients and physicians, for that matter, to giant corporate interests that are dedicated to the goal of maximizing profits, which accounts for much of the distress in the American health system.”

During the course of the 2016 presidential race, proposals for single-payer reform have taken hits from the campaigns of Hillary Clinton and a number of the Republicans who are seeking the presidency. Clinton has argued that the plan for single-payer offered by Vermont Sen. Bernie Sanders, her opponent for the Democratic presidential nomination, is “an idea that will never, ever come to pass.”

In the Democratic debate on March 10 in Miami, the former secretary of state complained about “Senator Sanders wanting to throw us into a contentious debate over single-payer.” Sanders, who has hailed Young as “a national hero,” replied: “I think if the rest of the world can do it, we can. And by the way, not only are we being ripped off by the drug companies, we are spending far, far more per capita on health care than any other major country on earth. You may not think the American people are prepared to stand up to the insurance companies or the drug companies. I think they are.”

That was the view that Young advanced in his last years, including in his brilliant 2013 autobiography, “Everybody In, Nobody Out: Memoirs of a Rebel Without a Pause.” The doctor wrote: “I’ve never wavered in my belief in humanity’s ability — and our collective responsibility — to bring about a more just and equitable social order. I’ve always believed in humanity’s potential to create a more caring society.”

The Capital Times has embraced that faith since its founding in 1917, but there is no question that our faith was enhanced and extended by our association with Young. We will honor his memory by continuing to be absolute and unequivocal in our championship of the essential understanding that health care must never be undermined by profiteering. It must always be understood as a human right that should be guaranteed for all.



Dr. Quentin Young

Dr. Quentin Young was the best of doctors

By the Editorial Board

What always struck us as remarkable about Dr. Quentin Young is that he managed to hold down big, important, establishment jobs.

Dr. Young was a fighter for social justice every day of his life, which can be a terrific way to end up in an unemployment line. He scolded public officials, locally and nationally, who would short-change health care for the poor and powerless. He led the fight, sure to make him enemies, to desegregate Chicago hospitals. Yet he was chairman of Cook County Hospital for many years and once ran the Chicago Board of Health.

Our theory is this: Dr. Young was just too good a doctor and

administrator to be exiled for too long. He might get fired – and he was, in fact, dismissed as head of the county hospital three times – but mayors and county board presidents would pick up the phone and bring him back.

The rightness of Dr. Young's cause was impossible to deny. Anybody could see it. That, too, explained his success. He understood the interplay of social factors, such as poverty and racism, in health care, and he advocated all his life for this larger approach to delivering care.

Dr. Young, who died Monday at age 92, was a rebel because he was the best of doctors.



A patient thanks Dr. Quentin Young

PNHP note: The following letter from one of Dr. Quentin Young's patients, "Joanne," is but one expression of the high regard many of his patients held him in. Her surname has been redacted in the interest of privacy.

November 2009

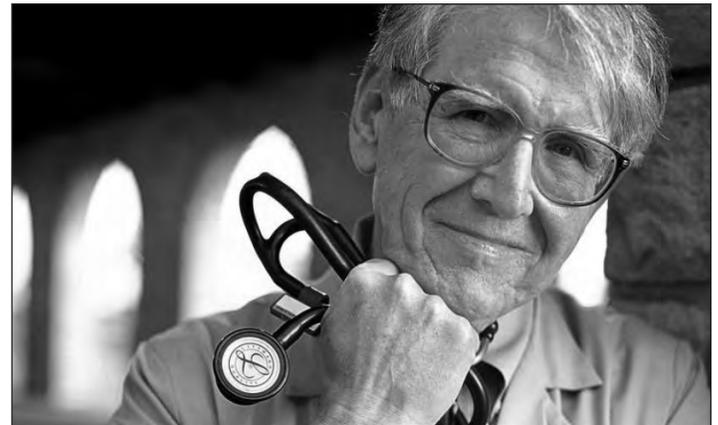
Dear Dr. Young,

I am a patient you treated over 50 years ago in 1955 at Winfield Sanitarium. I was just 21 years old and have never forgotten the care and hope you instilled in me when I had none. Your cheerful personality as well as medical care made me realize I could and did defeat the then-dreaded disease tuberculosis. I'm happy to report that I have never had a recurrence of this disease.

I was thrilled to read the article "Doc Quixote" in the Chicago Tribune magazine of Dec. 9, 2001. I have read and re-read the article, and I am so pleased learning at last you have received some of the recognition you so well deserve.

You performed pneumoperitoneum on me at Winfield as well as at Michael Reese, and follow-up care in your Hyde Park office. Pneumo was a painful and traumatic treatment, however you made it bearable by singing "Yellow Rose of Texas" to relax me during the injection. I'm sure no other doctor would ever think of such a thing while doing a medical procedure.

Thank you so much for the exceptional care you gave me and the other TB patients at Winfield. I know I wasn't the only one



"We cannot rest until everyone, without exception, has unimpeded access to high-quality care," Dr. Quentin Young writes in his memoirs. Photo: Milbert Brown, Chicago Tribune.

who appreciated you during this time. Many patients felt as I did, only probably none of us thought to express our heartfelt gratitude.

Sorry I didn't write sooner but unfortunately the young are often thoughtless as I was.

You have left a lasting impression on me, not only for the medical care I received but for all the years and hard work you have done to help promote National Health Care. You are a true humanitarian.

Better late than never.

Sincerely,
Joanne

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You can help sustain PNHP's work throughout the year with a monthly gift. Use the enclosed card or go to www.pnhp.org/donate to show your continuing support for single payer. Monthly contributions of any amount also include ongoing membership in PNHP.

Other ways to further PNHP's mission

There are many ways to support PNHP other than direct contributions. Gifts of stock or IRA disbursements, as well as remembering PNHP in your will or trust, will help further our mission in support of single payer.

Gifts of Stock

PNHP accepts gifts of stock and other securities. Shares of stock can be donated to PNHP without paying capital gains tax and are eligible as a tax-deductible charitable donation. Please consult with your investment adviser regarding donating stock to PNHP.

IRAs and Retirement Plans

If you have reached the age of 70½, you may make a qualified charitable distribution from your IRA (excluding inherited IRAs) or individual retirement annuity to PNHP of up to \$100,000. These types of donations meet the minimum distribution requirement for the tax year in which the distribution is made.

Bequests

We encourage you to include PNHP in your will using the sample language below. It is always best to review any changes in your will with an attorney to make sure they are consistent with your entire estate plan.

- A fixed amount of money or a designated property: "I give to Physicians for a National Health Program (FEIN 04-2937697), located in Chicago, Illinois, \$_____ (or describe the real or personal property, including exact location)."
- A percentage of the estate: "I give to Physicians for a National Health Program (FEIN 04-2937697), located in Chicago, Illinois, _____% of my estate."
- A residual bequest: "I give all the residue of my estate, including real and personal property, to Physicians for a National Health Program (FEIN 04-2937697), located in Chicago, Illinois."

If you would like more information about any of these giving options, please contact Matthew Petty at matt@pnhp.org or (312) 782-6006, or send a letter to 29 E. Madison, Suite 1412, Chicago, IL 60602.

By Mitchell Hayes, M2, and Monisha Bhatia, M2

The fifth annual summit of Students for a National Health Program was held at Vanderbilt University in Nashville, Tenn., on March 5. Nearly 170 students from 48 schools in 22 states gathered in Music City to discuss the advancing single payer movement, and the role medical students and future residents will continue to play in making single payer a reality.

Many sessions of the daylong event highlighted this year's summit theme: "New Frontiers of the Civil Rights Movement."

Our keynote speaker, Vanderbilt's Dr. Stephen Raffanti, began with reflections on the HIV epidemic and its relationship to achieving universal health care for all. He took us on a historical tour of the civil rights movement, and described some of the activists who carried that movement's legacy into the 1980s and 1990s in response to the HIV epidemic.

More generally, he underscored the importance of having passionate, persistent advocates in the struggle for a life-and-death cause – citing the role of physicians who vigorously advocate for their patients' best interests (including the need for single payer) as an example.

After the keynote, we dispersed into breakout sessions on topics ranging from "Single Payer 101" to "Mental health disparities among marginalized populations" to "Legislative power mapping." Students had the opportunity to reflect, debate, and postulate with peers in an intimate setting.

At lunch, students met with local PNHP physician mentors who spoke firsthand about their lives of advocacy in medicine. This new addition to the conference schedule was well received by students. The informal dialogue over barbecue was one of the highlights of the day.

The afternoon breakout sessions shifted the focus to strategy. SNaHP veterans took the stage to identify concrete steps students can take in medical school to influence politics and policy makers. Key sessions addressed Bird-Dogging and Lobbying, with students laying out plans for how to approach candidates running for office, record their support for single payer, and revisit them once elected in order to keep them accountable for promises made on the campaign trail.

First-time summit-goers like us were electrified to hear all of the work that seasoned students had already accomplished. The group then split up by region to discuss how we could imple-

ment similar strategies. We ended by setting specific regional goals to achieve by next year's summit.

The wrap-up of the meeting included the traditional goodbyes and thank-yous to everyone who had contributed to its success. But then Scott Goldberg, M4 at the University of Chicago, unexpectedly took the podium to show a YouTube clip from the movie "Braveheart" – the famous segment in which William Wallace urged on his troops before the final battle with the English Army.

Laughter and cheers were heard up and down the halls as Scott narrated the scene, point-

ing out the metaphorical insurance and pharmaceutical companies and their lobbyist knights. After the conference, many of the students gathered at a local pub. Having the summit in Nashville (all previous ones were held in Chicago) allowed students from new SNaHP chapters across the South – from Alabama, Louisiana, Georgia, Texas, Virginia, the Carolinas, and Tennessee – to show up in record numbers. As students at the host school, we could not help but feel a swell of pride at the large southern turnout.

As medical students in the South, we constantly see the need for a single-payer system during our work in hospitals and clinic. Every day we see how many people health care reform has left behind. But we also face a steep slope when it comes to changing local opinions about Medicare for All, often among those same patients and their families.

The summit was a much-needed opportunity for us to learn from more experienced chapters how we can make progress toward that goal, and to gain strength from our peers. We hope that the SNaHP Summit will return to Nashville for some more southern hospitality soon!



Medical students from across the U.S. gather in Nashville for the SNaHP Summit. Photos: Mark Chee



Dr. Stephen Raffanti

Congratulations on Match Day!

PNHP congratulates its student members who matched into residency programs on March 18. Contact Emily Henkels at e.henkels@pnhp.org for information on how to connect with these incoming residents at your institution. The following is a partial list of our student members who matched, organized by state.

CALIFORNIA: **Leon Clark**, Dermatology, UCSF • **Michelle Crespo**, Family Medicine, California Hospital Medical Center/USC • **Sam Dickman**, Internal Medicine-Primary Care, USCF • **Nina Duh**, Family Medicine, Kaiser Permanente/Fontana • **Jessamine Faustino**, Pediatrics, Children's Hospital, Oakland • **Scott Goldberg**, Internal Medicine-Primary Care, UCSF • **Aubrey Jordan**, Family Medicine, Ventura County • **Tim Muldoon**, Internal Medicine, Santa Clara Valley Medical Center • **Christy Tabit**, OB/GYN, Kaiser Permanente/Los Angeles • **Evan Tamura**, Family Medicine, Harbor UCLA • **Sayaka Weis**, Family Medicine, Harbor UCLA

COLORADO: **Ajay Major**, Internal Medicine, UC Denver

CONNECTICUT: **Queenie Ann Delacruz Abad**, Yale Primary Care Residency • **Zachary Solomon**, General Surgery, UC SOM Farmington

D.C.: **Anna Zelivianskaia**, OB/GYN, Georgetown MedStar Washington Hospital

ILLINOIS: **Eric Jackson**, Pediatrics, Northwestern University Lurie Children's Hospital • **Leslie Mataya**, Pediatrics, University of Chicago Comer Children's Hospital
• **Margaret Russell**, Family Medicine, McGaw Northwestern Residency, Norwegian American Hospital • **Talia Shear**, Child Neurology, Northwestern University • **Megan Silas**, Ophthalmology, University of Chicago Hospital • **Daniel Silva**, Med/Peds, University of Chicago Hospital • **Apar Singh Ghuman**, Physical Medicine and Rehabilitation, Northwestern University - Marianjoy Rehabilitation Hospital

IOWA: **Pierre Gingerich-Boberg**, Family Medicine, Northeast Iowa Family Medicine Residency

MARYLAND: **Russell Becker**, Urology, Johns Hopkins Medical Center • **Nicky Mehtani**, Internal Medicine, Johns Hopkins Osler Medical Residency

MASSACHUSETTS: **Kathryn Berndtson**, Pediatrics, Massachusetts General Hospital • **Hila Calev**, Internal Medicine, Beth Israel Deaconess • **Katrina Ciraldo**, Family Medicine, Boston University/Boston Medical Center • **Swathi Damodaran**, Psychiatry, Cambridge Health Alliance • **Madeline Haas**, Family Medicine, Boston University/Boston Medical Center •

Jo Henderson-Frost, Internal Medicine/Primary Care, Massachusetts General Hospital • **Shira Lerner**, Family Medicine, Greater Lawrence Family Health Center • **Adi Rattner**, Family Medicine, Boston University/Boston Medical Center • **Noah Schwartz**, Internal Medicine, Beth Israel Deaconess

MICHIGAN: **Ashley Cobb**, Med/Peds, University of Michigan • **Jared Goldberg**, Internal Medicine, Detroit Medical Center

NEW JERSEY: **Vimal Bodiwala**, Internal Medicine, Rutgers Robert Wood Johnson



Graduating medical students pledge their support for single payer.

NEW YORK: **Elle Fisch**, OB/GYN, University at Buffalo • **Xin Guan**, OB/GYN, New York University Lutheran/Langone • **Elizabeth Kolod**, Primary care/Social internal medicine, Montefiore • **Kerim Odekon**, Internal Medicine, SUNY Stony Brook • **Alex Simao**, Family Medicine, Ellis Medicine Schenectady

NORTH CAROLINA: **Audrey Bowes**, OB/GYN, Carolinas Medical Center • **Mansi Shah**, Family Medicine, Duke University

OHIO: **Joshua Faucher**, Emergency Medicine, Ohio State University

OREGON: **Dominic Caruso**, Family Medicine, Oregon Health & Science University

PENNSYLVANIA: **Adys Mendizabal**, Neurology, Hospital of the University of Pennsylvania • **Martina Risech**, Pathology, Drexel University/Hahneman

TENNESSEE: **Ndang Azang-Njaah**, Med/Peds, Vanderbilt University Medical Center

TEXAS: **Allison Louis**, Family Medicine, John Peter Smith Residency Program, Fort Worth

WASHINGTON: **Laura Krinsky**, Family Medicine, Swedish Cherry Hill • **Antonia Nemanich**, Emergency Medicine, University of Washington Hospital

WISCONSIN: **Fred Ketchum**, Neurology, University of Wisconsin • **Marina Sharifi**, Internal Medicine, University of Wisconsin

Medical students call for single-payer health insurance

By Mark Chee, Rebecca Gieseke and Rachel Stones

As medical students, we have chosen a profession dedicated to treating illness and helping people live healthy lives.

Yet, early on during our training, we learn about the unequal access to care, unaffordable treatments, and medical debt that patients face because of our current private, for-profit health insurance system. We hear about physicians who are increasingly burdened with paperwork and frustrated by a system that does not serve their patients. We discover that despite spending more per capita on health care than other developed countries, the U.S. population has a shorter life expectancy, higher infant mortality, and worse overall health.

While the implementation of the Affordable Care Act (ACA) has expanded coverage, it fails to sufficiently address the problems our health care system faces. Around 33 million Americans remain uninsured, some indefinitely. These individuals are immigrants, who still cannot afford health insurance or live in states that have blocked Medicaid expansion.

In addition to this remaining lack of coverage, increasing deductibles and cost sharing are also being used to shift the financial burden from insurers to patients. Over 50 percent of bankruptcy filings in the U.S. are due to illness and medical debt, even though the majority of individuals in this group has some form of coverage when they file for bankruptcy. Expanding insurance coverage that leaves patients vulnerable to the financial burden of illness is not the answer.

Furthermore, narrow network health plans prevent patients from having continuity of care with their physicians and expose them to exorbitant (and often unexpected) out-of-network costs.

Medical students often ask what can be done about this. The clear solution is a single-payer health care reform. In a single-payer system, Medicare would be expanded to cover all U.S. residents, but care would continue to be delivered by private institutions.

This would guarantee access to health care for the 33 million Americans who remain uninsured under the ACA, cover necessary services without co-pays, coinsurance, or deductibles, and contain health care costs by reducing the high administrative costs of for-profit insurers.

While a single-payer wouldn't solve all the problems that our health care system faces, it would be an important first step to make our health system more equitable, affordable, and efficient.

Implementing single-payer, or Improved Medicare for All, is far from revolutionary, and it can work in the U.S. We already spend more money than other countries that have implemented universal coverage.

Furthermore, public opinion favors this approach. Recent polls have found that 58 percent of the U.S. population sup-

ports the idea of Medicare-for-all. Here at the Pritzker School of Medicine, a fall 2015 survey distributed by the school's chapter of Physicians for a National Health Program (PNHP) identified 108 medical students and 119 physicians/faculty (including at least seven deans and six third-year clerkship directors) who publically supported single-payer.

While many argue that single-payer would be too expensive for patients and the government, an economic analysis of the single-payer bill HR 676 in the U.S. House of Representatives showed that 95 percent of Americans would actually save money.

As a key hospital on the South Side of Chicago, single-payer could benefit rather than harm the bottom line for the University of Chicago Medicine. During the discussions around the Level I trauma center, a main argument brought forth against the expansion of the University's emergency department involved the need to have a financially viable patient mix.

As the next generation of physicians, if we stand together and make our voices heard, single-payer will be achieved in our lifetime.

Since Medicare and Medicaid reimbursement often do not cover the full cost of treating a patient, privately insured patients are needed to subsidize this uncompensated care. A trauma center would likely be used by patients in the surrounding communities who are insured by Medicare or Medicaid or are otherwise uninsured.

Under a single-payer health care system, varying rates of reimbursements would not be an issue, and there would no longer be a financial incentive to serve the wealthy over the underinsured and vulnerable.

As doctors-in-training, we are excited to devote our futures to serving others, but we have already seen the struggles and burnout faced by providers and patients under our fragmented, expensive, and inefficient system.

We want to practice medicine in a system that serves all Americans and guarantees health care as a basic human right for all.

Those who stand to lose from single-payer in the U.S. have significant voices in the political sphere and include the for-profit insurance companies and their stakeholders, Big Pharma, and political leaders who benefit from the current status quo. However, as the next generation of physicians, if we stand together and make our voices heard, single-payer will be achieved in our lifetime.

Mark Chee, Rebecca Gieseke, and Rachel Stones are medical students at the Pritzker School of Medicine at the University of Chicago.

Single-payer health system would cost less, provide more

By Katie Johnson

The presidential primaries have catapulted “Medicare for All” or a single-payer health program, back into the national debate about how to fix our chronically ailing health care system. There’s no shortage of claims and counterclaims.

Here’s a question that cuts through the chatter: If you were offered a health plan that guaranteed all the care that you need – including prescription drugs, dental, vision and long-term care – for no more money, and likely less, than what you’re paying now, would you sign up for it?

What if such a plan also included free choice of doctor and hospital and also had no copays or deductibles?

Is this an unaffordable pipe dream? No. It’s the reality of a single-payer national health insurance program, as outlined in H.R. 676, the Expanded and Improved Medicare for All Act. The bill currently has 61 congressional sponsors.

Studies have shown such a program, if enacted, would reap huge savings – about \$400 billion annually – by eliminating all the wasteful paperwork associated with our current (and very complex) multipayer system of paying for care.

The money we’d save by setting up such a streamlined, nonprofit system would be plowed back into covering everyone, improving benefits and retraining insurance company workers into more socially beneficial tasks such as providing actual care.

It’s not difficult to see why surveys have repeatedly found that two-thirds of Americans support this kind of “Medicare for All” approach when it’s been explained to them. It’s simple, efficient and equitable.

In the U.S., we spend \$9,086 per person – that’s 17.1 percent of Gross Domestic Product – on health care, more than any other developed country in the world. Despite this, we have mediocre health outcomes. Compared to 34 other democratic nations, we rank 27th in life expectancy, 24th in cancer mortality and 31st in infant mortality.

The situation is dire. About 45,000 Americans die annually due to their lack of insurance. Medical bills contribute to two-thirds of personal bankruptcies. These problems are unheard of in other developed nations.

We spend 31 cents of every dollar on administrative tasks, most of it waste. This includes insurance company paperwork,

overhead, CEO salaries and profits, not to mention all the paperwork inflicted on doctors, hospitals and patients.

Private insurers’ overhead ranges from 12 percent to 20 percent. In contrast, Medicare’s overhead is about 2 percent, and Canada’s single-payer system operates with about 1 percent overhead. So there would be big administrative savings right off the top.

Single payer is a national health insurance system in which a single public or quasi-public agency organizes health care financing, but delivery of care remains largely private. Single payer is an “everybody in, nobody out” system. Everyone is covered.

Single payer is not socialized medicine. Socialized medicine is publicly funded and publicly delivered, as in the British National Health Service or in our VA system. Single payer is publicly funded and privately delivered, much like Medicare works today for seniors.

The combination of public funding and private delivery ensures decisions about health care are made by you and your doctor – not by bureaucratic lobbyists, corporate influence or for-profit insurance companies.

If you were offered a health plan that guaranteed all the care that you need – including prescription drugs, dental, vision and long-term care – for no more money, and likely less, than what you’re paying now, would you sign up for it?

Single payer is not Obamacare. Obamacare leaves profit-oriented private insurance companies at the heart of our system, with all the problems – denials of care, high overhead, siphoning of dollars away from care to corporate coffers – that entails. And Obamacare will leave an estimated 27 million Americans still without insurance coverage in 2025.

Single payer is not more expensive for families. A “Medicare for All” program would eliminate health premiums, deductibles, copays, co-insurance, replacing them with taxes based on ability to pay. One recent study shows 95 percent of U.S. households would end up saving money under H.R. 676 – and all would have ready access to care.

Educate your friends about single payer, and urge your lawmaker to co-sponsor H.R. 676. We’ll save lives and money, and we have no time to lose.

Katie Johnson, a fourth-year medical student at Mayo Medical School in Rochester, is pursuing a career in pediatrics.



Katie Johnson

Beyond the Affordable Care Act: A Physicians' Proposal for Single-Payer Health Care Reform

This proposal was drafted by the 39 member Working Group on Single-Payer Program Design and has been endorsed by 2,231 other physicians and 149 medical students, who are listed at the end of this article. [See www.pnhp.org/nhi for full list.]

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Abstract

Even after full implementation of the Affordable Care Act (ACA), tens of millions of Americans will remain uninsured or only partially insured, and costs will continue to rise faster than the background inflation rate. We propose to replace the ACA with a publicly financed National Health Program (NHP) that would fully cover medical care for all Americans, while lowering costs by eliminating the profit-driven private insurance industry with its massive overhead. Hospitals, nursing homes, and other provider facilities would be non-profit, and paid global operating budgets rather than fees for each service. Physicians could opt to be paid on a fee-for-service basis, but with fees adjusted to better reward primary care providers, or by salaries in facilities paid by global budgets. The initial increase in government costs would be offset by savings in premiums and out-of-pocket costs, and the rate of medical inflation would slow, freeing up resources for unmet medical and public health needs.

Introduction

In the United States the right to medical care remains a dream deferred, despite passage of the Affordable Care Act (ACA). The U.S continues to spend strikingly more on health care than other industrialized nations,¹ while our health outcomes lag behind. Even with the ACA fully implemented, an estimated twenty-seven million will remain uninsured,² while many more face rising copayments and deductibles that compromise access to care and leave them vulnerable to ruinous medical bills.³⁻⁹ We propose a single-payer National Health Program (NHP) covering all Americans for all needed medical care. The design of such a program has been previously described,^{10,11} but intervening developments – notably the proliferation of large integrated delivery systems – require revisions.

The NHP can be conceptualized as an expansion of Medicare to the entire population, with correction of that system's deficiencies – most glaringly, high cost sharing, limitations on coverage, and subcontracting to wasteful private plans. By dramatically reducing administrative costs and other inefficiencies, the NHP could eliminate both uninsurance and underinsurance without any increase in overall health care expenditures. It would sever the problematic link between employment and insurance, and minimize patients' and physicians' paperwork burden. Although the system we envision would be publicly financed, it would rely largely on existing private hospitals, clinics and practitioners to provide care. However, because investor ownership of health care providers is known to compromise quality and divert funds from clinical care to overhead and profits,¹²⁻¹⁴ the NHP would not include such providers. Following are the essential features of the proposed system.

A single-payer NHP would cover every American for all medically necessary services, including mental health, rehabilitation and dental care, without copayments or deductibles. Covered services would be determined by boards of experts and patient advocates; ineffective services would be excluded from coverage.

Patient cost sharing blocks access to vital care (e.g. by delaying care for patients with myocardial infarction); reduces adherence to medications; and selectively burdens the sick and the poor.^{5,15-19} Moreover, cost sharing has proven ineffective at containing system-wide costs, in part because collecting and tracking co-payments and deductibles entails substantial administrative effort and cost.

The NHP would, like Medicare, ban private insurance that duplicates the public coverage to forestall the emergence of a two-tiered health care system, in which insurers would compete by lobbying to underfund the public part of the system. Moreover, in the NHP, as in Medicare, inclusion of the affluent would serve as an important guarantor of adequate coverage.

Hospital Payment

The NHP would fund each hospital with a "global budget," a lump sum covering all operating expenses, eliminating per-patient billing. Global budgets would be negotiated annually between hospitals and the NHP based on previous years' operating expenses, changes in demand and input prices, and proposed service enhancements. Global budgets would cover operating expenses, but could not be used for expansion or modernization, which the NHP would fund separately through explicit capital allocations. Nor could operating funds be used for advertising, profit, or bonuses. For-profit hospitals would be converted to nonprofit governance and their owners compensated for past investments. In some instances, the NHP might fold hospital budgets into global operating budgets paid to non-profit or public integrated systems that provide primary through tertiary care.

At present, hospital CEOs anticipate their institution's budget for the upcoming year, but garner funds from thousands, even millions of individual transactions. Hospital billing offices tabulate lengthy itemized bills and charge a multitude of payers using inefficient, complex and separately negotiated rate schedules. Current payment systems have also encouraged rampant gaming through "upcoding" (exaggerating the severity of patients' illnesses), "cherry picking" (concentrating on lucrative services for well-insured patients), and other financial maneuvering.²⁰ Global budgeting with separate, explicit capital allocation would provide a "cost-neutral" payment framework, minimizing hospitals' incentives to avoid (or seek out) particular patients or services, inflate volumes, or upcode. Global budgets would also eliminate hospital billing and relieve clinicians of billing-related documentation, freeing up resources to enhance clinical services. In Scotland and Canada, which fund hospitals through global budgets, administration consumes about 12% of

hospital spending vs. 25% in the U.S. – suggesting that an NHP could shift about \$150 billion annually from hospital administration to patient care.²¹

Payment for Physicians and Outpatient Care

The NHP would accommodate two different modes of payment for physicians and other outpatient practitioners: fee-for-service using a simple binding fee schedule, or salaries for those working in nonprofit hospitals, clinics, capitated group practices, HMOs, and integrated health care systems.

While conventional wisdom blames the failings of our health care system (especially cost)²² on fee-for-service incentives, every mode of payment has pitfalls. Yet other countries have found fee-for-service – as well as capitation and salaried practice – compatible with quality and cost containment, as long as the fees do not unduly reward procedure-oriented specialists compared with primary care providers. Regardless of the payment mode, the NHP would prohibit the diversion of operating revenues to profits or capital investments, and the payment of bonuses tied (either positively or negatively) to utilization or to institutional profitability. The NHP would shrink physicians' overhead expenses by simplifying (under fee-for-service) or virtually eliminating (under salaried practice) billing-related tasks.

For fee-for-service practitioners, the NHP and organizations representing the practitioners would negotiate a simple, binding fee schedule. The NHP could draw on a number of tools that other countries have found effective in countering the inflationary tendency of fee-for-service, including: monitoring for extreme practice patterns; adjusting fee schedules to attenuate discrepancies between cognitive and procedural care; enforcing regional caps on fee-for-service payments; and facilitating education on low-value medical interventions.

Practitioners could also choose salaried practice in non-profit globally budgeted providers such as hospitals, clinics, group practices, etc. Where appropriate, the global budget could include funding for community programming (e.g. needle exchange programs or school-based services) not attributable (or billable) to individual patients.

Integrated health care systems would also employ salaried practitioners. In such systems, hospitals might be paid through a separate global budget, or through a unified global budget for the entire organization. Integrated provider networks and accountable care organizations (ACOs) offer potential benefits, but also the threat that they will exploit oligopoly market power to drive up costs and profits, and pressure physicians to help achieve these goals. Hence, the NHP would allow, even encourage integrated systems, but would mandate that regionally dominant systems be publicly controlled.

Long-Term Care (LTC)

The NHP would fund the full spectrum of LTC for the disabled of all ages. Local public agencies employing expert panels of social workers, nurses, therapists, and physicians would assess eligibility and coordinate care. These agencies would receive a

global budget from the NHP to LTC for all individuals within their catchment area. They would contract with individual caregivers, as well as nonprofit and public agencies and facilities. Alternatively, integrated provider organizations could receive an augmented capitation fee or global budget to provide LTC as well as acute care services.

Countries such as Japan and Germany with universal LTC coverage provide more and better care, yet spend no more than the U.S.²³ The NHP would emphasize LTC provided in patients' homes and communities rather than institutions.

Health Planning and Explicit Capital Funding

The NHP would fund all major capital investments through explicit appropriations. Regional health planning boards would allocate capital funds for new facilities and expensive new equipment based on medical need, project quality and efficiency. Private donations for projects that would entail increases in NHP operating expenses would be proscribed.

When capital funding and operating payments are combined in a single revenue stream, as is now the case, profitable health care institutions are able to expand and modernize, regardless of medical need, while those with less favorable bottom lines fall further behind. Too often, profitability reflects not efficiency or quality, but the avoidance of unprofitable patients and services, a willingness to game payment systems, and the exercise of market clout. As a result, the implicit capital allocation process has created both medical deserts – areas of great need and few resources – and lavish, often redundant medical palaces that compete for lucrative patients and are tempted to provide unneeded care.

Planning should also assure that training programs produce an appropriate mix of health professionals. Residency programs (already publicly funded) must train generalists and specialists in proportions that reflect societal needs. Currently, debts incurred by medical students are, over the long run, paid off from medical salaries and fees, and skew students' career choices toward high-income specialties. Instead, we advocate that the NHP fully subsidize the education of physicians, as well as that of nurses, public health professionals and other health care personnel.

Medications, Devices, and Supplies

The NHP would cover all medically necessary prescription medications, devices and supplies. It would directly negotiate prices with manufacturers, producing substantial savings. An expert panel would establish and update a national formulary, which would specify the use of the lowest cost medications among therapeutically equivalent drugs (with exceptions where clinically required).

Full drug coverage is an essential component of an NHP. Co-payments reduce adherence to medications and worsen clinical outcomes. The NHP would, like other large purchasers, use its market clout and formularies to negotiate lower drug prices

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with manufacturers. For instance, the Veterans Administration pays only 56-63% as much as Medicare does for drugs,²⁴ because Medicare is prohibited from negotiating for lower prices.

Cost Containment

A single-payer system would trim administration, reduce incentives to over-treat, lower drug prices, minimize wasteful investments in redundant facilities, and eliminate almost all marketing and investor profits. These measures would yield the substantial savings needed to fund universal care and new investments in currently under-funded services and public health activities – without any net increase in national health spending.

Private insurers' overhead currently averages 12.0%,²⁶ as compared with only 2.1% for fee-for-service Medicare.²⁷ The complexity of reimbursement systems also forces physicians and hospitals to waste substantial resources on documentation, billing and collections. As a result, U.S. health care administration costs are about double those in Canada, where the single-payer system pays hospitals global budgets and physicians via simplified fee schedules. Reducing U.S. administrative costs to Canadian levels would save over \$400 billion annually.²⁵

Funding

Total expenditures under the NHP would be limited to approximately the same proportion of GDP as the year prior to its establishment. While the needed funds could be garnered in a variety of ways, we favor the use of progressive taxes in order to reduce income inequality – itself an important social determinant of poor health.

During a transition period, all public funds currently spent on health care – including Medicare, Medicaid, and state and local health care programs – would be redirected to the unified NHP budget. Such public spending – together with tax subsidies for employer-paid insurance and government expenditures for public workers' health benefits – already accounts for 60% of total U.S. health expenditures.²⁸ Additional funds would be raised through taxes, though importantly these would be fully offset by a decrease in out-of-pocket spending and premiums.

During the transition period, these additional public funds could be raised through a variety of measures, e.g. redirecting employers' health benefit spending to the NHP through payroll taxes. In the longer term, however, direct funding through progressive taxes would be fairer. By unburdening employers, the NHP would facilitate entrepreneurship while increasing the global competitiveness of American business.

Alternatives to NHP

The failings of our health care system have called forth a welter of other proposals for reform. All except an NHP would maintain a central role for private insurers and profit-oriented providers.

The ACA embodies the hopes of many for a more just health care system. Yet it will, according to the Congressional Budget Office (CBO), leave approximately 27 million Americans uninsured,² in part reflecting some states' refusal to expand Medicaid. Nor will it eliminate underinsurance. Disturbingly, the ACA has facilitated the imposition of new out-of-pocket costs on Medicaid recipients, and the skimpy coverage provided by many of the plans sold through the exchanges codifies the trend towards higher cost sharing for the privately insured.

While the law laudably reduces copayments and deductibles for some families with incomes 100-250% of poverty, the financial burden on the middle class will remain high despite the recent (and likely temporary) deceleration in health care inflation. Bronze plans purchased through the exchanges cover, on average, only 60% of enrollees' expenses, with families expected to bear out-of-pocket costs (on top of premiums) of up to \$13,200 annually for covered services. Moreover, care obtained outside of the narrow provider networks provided by many exchange plans is neither covered nor applied to the out-of-pocket cap.

Unlike an NHP, expanded coverage under the ACA will increase bureaucracy. In the decade ahead, the law will funnel an estimated \$895 billion in new federal subsidies² (and billions more in premiums paid by families) to private insurers, reinforcing their grip on care, and wasting billions on their overhead. Much of the \$700 billion in new Medicaid spending will also flow through private managed care firms. Overall, government actuaries predict that the reform will boost insurance overhead by \$265.8 billion between 2013 and 2022.²⁹

Accountable Care Organizations (ACOs)

ACOs are now widely promoted as a solution to our health care problems. These organizations combine groups of medical providers and hospitals that, in the words of the Center for Medicare and Medicaid Services (CMS), "come together to give coordinated high quality care ... while avoiding unnecessary duplication of services."³⁰ Proponents argue that aligning the financial incentives of insurers and providers will upgrade quality and motivate providers to be thrifty. Under ACO arrangements, insurers offer bonuses to hospitals and medical groups if they reduce health care costs, and (under some arrangements) penalize them when costs exceed targets. Like the HMOs of a previous era, ACOs invert fee-for-service incentives to provide excess care, instead offering rewards for reducing care. To counter the obvious risk that these inverted incentives may lead to the denial of needed care, ACO payment schemes invariably mandate extensive reporting of quality indicators, and withhold some payments unless quality targets are met.

Unfortunately, experience warns that quality monitoring may not protect patients in a profit-driven medical environment. Such monitoring figured prominently in the seminal HMO proposal³¹ that preceded the well-documented abuses of the 1990s. Even today, quality measurement remains rudimentary, with quality indicators assessing only a small slice of care, and

providers routinely “game” (and sometimes even falsify) quality metrics.³²

Claims of cost savings are also suspect. Initial results from Medicare’s Physician Group Practice Demonstration (PGP) suggested savings of 1.4% below expenditure targets.³³ But even these modest savings were called into question by the CBO’s finding that PGP practices’ aggressive upcoding boosted their expenditure targets, resulting in “apparent savings . . . but not actually fewer dollars spent.”³⁴ Moreover, the PGP figures, and more recent studies reporting savings in Medicare and private sector ACO programs have ignored bonus payments to providers;³⁵ savings evaporate once bonuses are factored in.

Value-Based Payment and Pay for Performance (P4P)

In recent years, “value” – essentially the ratio of desired outcomes to cost – has become the preeminent health policy buzzword. Many argue that rewarding providers on the basis of the value they create for patients, rather than the volume of care they deliver, will improve outcomes, contain costs, and foster innovation.³⁶⁻³⁸

Unfortunately, empiric support for this approach is lacking, and it rests on dubious assumptions about measurement and motivation. In assessing outcomes, isolating the “signal” of medical quality amidst the “noise” of genetic, social and behavioral factors that influence health is almost impossible. No current or foreseeable risk-adjustment algorithm reliably accounts for the many patient factors that are beyond clinicians’ control. Despite decades of effort to develop inpatient risk adjustment, four widely used algorithms yield strikingly divergent rankings of hospital mortality performance.³⁹ Hospitals that appear first-rate according to one algorithm can appear hazardous according to another. Similarly, even excellent doctors who care for disadvantaged patients often score poorly on quality metrics.⁴⁰ The largest hospital P4P demonstrations found initial gains, but no lasting improvement in outcomes.⁴¹⁻⁴³ Systematic reviews on P4P have concluded that high-quality evidence of benefit is lacking.⁴⁴

Conclusion

We face a historic crossroads in health care. One way would take us further down the path laid out by the ACA: down this road, millions of Americans remain uninsured, underinsurance grows, costs rise, and inefficiency and the search for profits are abetted. An alternative, market-based route, favored by conservative political leaders but not, according to surveys, by the public, would roll back the ACA’s expansion of coverage, degrade Medicare and Medicaid, and reward entrepreneurs at the expense of patients.

The single-payer NHP that we advocate is a third path. It is the best way – indeed, the only practical way – to provide comprehensive care to all Americans that would be affordable over the long term.

Implementation will require a detailed transition process and pose novel problems; for instance, significant resources will be

needed for job retraining and placement for displaced health insurance and billing workers. But those dislocations would be offset in part by increased employment in care delivery and in other sectors of the economy, since employers would be relieved of the burden of providing ever more expensive health insurance. Overall, the NHP would entail far less disruption for clinicians and patients than alternative reforms. Free choice of doctor and hospital would become the norm, not a privilege for the few. Clinicians would continue treating patients in their practices, albeit with substantially reduced paperwork and administrative expenses.

The reforms we propose would improve the fairness and efficiency of medical care, but additional measures would be needed to address other critically important determinants of health. Global warming would remain a looming threat. Policies that attenuate glaring income inequalities and assure an adequate standard of living for all Americans are essential if we are to reverse widening income-based health disparities⁴⁵. Similarly, the stain of racial inequality and racism must be addressed if we are to achieve health for all.

While the NHP would achieve savings on administration and profiteering, the benefits of these savings can only be realized if funds are redirected to currently underfunded health priorities, particularly public health⁴⁶. Moreover, many problems within medical care would remain. Regional health planning and capital allocation would make possible, but not assure, fair and efficient resource allocation; quality problems would persist; and areas such as long term and mental health care, and substance abuse will require new and creative solutions. Although an NHP would not solve these problems, it would establish a framework for addressing them.

Over the past century, myriad health care reforms – most well-intentioned – have been proposed and attempted. Yet continued reliance on private insurers and profit-driven providers has doomed them to fail. It is time to chart a new course, to change the system itself. By doing so, we can realize, at last, the right to health care in America.

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PNHP note: You can read the above proposal (and share it with others) at www.pnhp.org/nhi

PNHP note: In the current presidential debate, some have questioned whether a single-payer reform could be implemented without an unacceptable disruption of patients' care and the work lives of physicians and other health care workers. The article below, which appeared 25 years ago in the JAMA, outlines how a smooth transition could be implemented. Although health expenditures have soared since then, this transition plan remains viable today. We include, at the end of the article, tables that present figures updated to 2016.

Liberal Benefits, Conservative Spending

The Physicians for a National Health Program Proposal

Kevin Grumbach, MD; Thomas Bodenheimer, MD, MPH; David U. Himmelstein, MD; Steffie Woolhandler, MD, MPH

The Physicians for a National Health Program proposes to cover all Americans under a single, comprehensive public insurance program without copayments or deductibles and with free choice of provider. Such a national health program could reap tens of billions of dollars in administrative savings in the initial years, enough to fund generous increases in health care services not only for the uninsured, but for the underinsured as well. We delineate a transitional national health program budget that would hold overall health spending at current levels while accommodating increases in hospital and physician utilization. Future national health program spending would be indexed to the growth in gross national product adjusted for demographic, epidemiologic, and technologic shifts. Financing for the national health program would transfer funds into the public program without disrupting the general pattern of current revenue sources. We suggest a funding package that would augment existing government health spending with earmarked health care taxes. Because these new taxes would replace employer-employee insurance premiums and substantial portions of current out-of-pocket expenditures, they would not increase health costs for the average American.

(*JAMA*. 1991;265:2549-2554)

THE AMERICAN approach to financing health care has gone awry. From physicians to patients, from The Heritage Foundation to the AFL-CIO, there is agreement that the system needs reform. But what kind of reform? Although all concur that the system is ailing, proposals diverge in their therapeutic approach. Many advocate adjust-

ments of familiar regimens: larger doses of employment-based insurance and greater infusions of public funds to expand Medicaid or to subsidize risk pools for the uninsured.¹⁻⁴ Because such measures do not confront the interdependent problems of rising costs and declining access, they cannot ensure health services to all at a cost the nation can afford. A lasting remedy requires basic restructuring of the way we pay for care.^{5,6}

The Physicians for a National Health Program plan would cover all Americans under a publicly administered, tax-financed national health program (NHP). A single public payer would replace the present array of more than 1500 private insurers, Medicaid, and Medicare. A unitary program could initially pay for expanded care out of ad-

ministrative savings without adding new costs to the overall health care budget and would establish effective mechanisms for long-term cost control. Although consolidation of purchasing power in a public agency may cause apprehension among some physicians, the program could free them from the myriad administrative intrusions that currently plague the practice of medicine.

STRUCTURE OF THE NHP

We have previously described the design of the NHP in some detail.^{7,8} It would create a single insurer in each state, locally controlled but subject to stringent national standards. States could experiment with the precise structure of the single insurer. Some may place it within a government agency, while others may choose a commission elected by the citizens or appointed by provider and consumer interests.

Everyone would be fully insured for all medically necessary services including prescription drugs and long-term care. Private insurance duplicating NHP coverage would be proscribed, as would patient copayments and deductibles. Physicians and hospitals would not bill patients directly for covered services. Hospitals, nursing homes, and clinics would receive a global budget to cover operating expenses, annually negotiated with the state health plan—based on past expenditures, previous financial and clinical performance, projected changes in cost and use, and proposed new and innovative programs. Itemized patient-specific hospital bills would become an extinct species. No part of the operating budget could be

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diverted for hospital expansion, profit, marketing, or major capital acquisitions. Capital expenditures approved by a local planning process would be funded through appropriations distinct from operating budgets.

Fee-for-service practitioners would submit all claims to the state health plan. Physician representatives (probably state medical societies) and state plans would negotiate a fee schedule for physician services. The effort and expense of billing would be trivial: stamp the patient's NHP card on a billing form, check a diagnosis and procedure code, send in all bills once a week, and receive full payment for virtually all services—with an extra payment for any bill not paid within 30 days. Gone would be the massive accounts receivables and the elaborate billing apparatus that now beleaguer private physicians. Alternatively, physicians could elect to work on a salaried basis for globally budgeted hospitals or clinics, or in health maintenance organizations capitated for all nonhospital services.

COSTS OF THE NHP

To estimate total costs, we start by using the Health Care Financing Administration's projection of 1991 costs under current policies as our "baseline" figure. The Health Care Financing Administration estimates that \$567 billion will be spent on personal health care services and products in 1991, excluding nursing home costs and insurance overhead and profits (Table 1).⁹ (Although long-term care is covered by the NHP, we have omitted these costs to permit comparison with other acute care proposals.)

Universal coverage should increase the use of health services by the uninsured. According to the Lewin/ICF Health Benefits Simulation Model, approximately \$36 billion of the \$567 billion in 1991 spending projected under current policies will be accounted for by care for the uninsured, including free care at public hospitals, uncompensated care at private facilities cross-subsidized by insurance revenues, and services purchased out-of-pocket. The Lewin/ICF model estimates that an additional \$12.2 billion would be required to increase the utilization by the uninsured to levels commensurate with those of the insured (Needleman et al¹⁰ and J. Sheils, oral communication, October 1990).

The NHP will not only assist the uninsured, but will also cover services (eg, preventive) and payments (eg, deductibles) that many insurers currently exclude. Would this more extensive coverage "induce" a surge of utilization

among those currently insured? The RAND Health Insurance Experiment found that costs for persons assigned to a plan with no cost sharing were approximately 15% higher than the age-adjusted, per capita health care expenditures for the United States as a whole.¹¹ However, a more natural experiment, a study before and after the implementation of an NHP in Quebec, failed to detect the overall utilization surge predicted by the RAND experiment.^{12,13} Although the use of physician services in Quebec rose among those with lower incomes, the increase was counterbalanced by a decrease in utilization among the affluent. The net effect was convergence of utilization rates (adjusted for health status) among income groups, with no change in the overall rate.

Would an across-the-board increase in utilization be desirable? In the RAND experiment, lower-income patients with medical problems who received free care had better outcomes than those in cost-sharing plans.¹⁴ At the same time, many medical services currently provided are of no or of extremely marginal benefit,¹⁵⁻¹⁷ and it is not the intent of the NHP to inject an additional bolus of such unnecessary care into the health care system.

All these factors make it difficult to predict the level of overall utilization that would result from the NHP. For this analysis, we have added on the full \$12.2 billion cost of bringing utilization rates of the uninsured up to those of the insured. We will discuss in the "Budgeting Under the NHP" section below how the NHP budget could also accommodate increases in utilization among the currently insured.

Savings of the NHP

The administrative efficiencies of a single-payer NHP offer the opportunity for large savings during the implementation of the program.¹⁸ Providers would be relieved of much of the expense of screening for eligibility, preparing detailed bills for multiple payers, responding to cumbersome utilization review procedures, and marketing their services. In 1987, California hospitals devoted 20.2% of revenues to administrative functions,¹⁹ in contrast to 9.0% spent by Canadian hospitals (L. Raymer, Health and Welfare Canada, written communication, April 1990). (These figures exclude malpractice premium costs and administrative personnel in clinical departments such as nursing.) The 11.2% difference is attributable to Canada's simplified hospital payment method, a method we propose for the United States.

Determining the potential adminis-

Table 1.—Personal Health Care Costs for 1991, Excluding Nursing Home Care, With and Without a National Health Program (NHP), in Billions of Dollars*

	NHP	Current Policies
"Baseline" conditions	567	567
New costs for previously uninsured	12	...
Discount for 11.2% hospital administrative savings	(31)	...
Discount for 6.25% physician administrative savings	(9)	...
Subtotal: Personal Health Care	539	567
Insurance administration and profits	8†	35‡
Total Personal Health Care Plus Insurance Overhead	547	602

*This assumes Canadian-level administrative efficiency and changes in utilization only among the previously uninsured.

†1.4% of personal health care expenditures.

‡This is the amount estimated by the Health Care Financing Administration.⁹

trative savings in physician expenditures is more difficult. Although practice expenses are 49% of physician gross income in the United States and only 36% in Canada,^{20,21} it is uncertain how much of this difference is due to billing costs. Malpractice costs for US physicians, for example, are higher than those in Canada. We therefore extrapolated billing cost data from a recent American Medical Association survey to project minimum expected administrative savings in physician expenditures.²² The average physician spent approximately \$14 500 in 1988 billing Medicare and Blue Shield alone, representing 5.5% of gross physician income. In addition, physicians spent approximately 2.75% of their own professional time on billing-related activities for these claims. (The survey did not measure the costs of billing other third parties or patients and therefore yields a low estimate of physician billing costs.) We liberally estimate that physician billing expenses in Canada are 1% of physician costs and that Canadian physicians spend at the most 1% of their time on billing (D. Peachey, MD, Ontario Medical Association, written communication, June 1990). In sum, US billing costs for physician time and practice expenses are at least 8.25% of total physician expenditures in contrast to at most 2% of Canadian physician costs. An NHP functioning at Canadian-level administrative efficiency could save at least 6.25% of physician costs. Most of these savings can be realized rapidly. In the private practice of one of the authors (T. B.), for example, the change to a single payer would allow an immediate reduction in office payroll of 18%.

Administrative savings to hospitals and physicians function as price discounts when calculating costs. For example, if physicians could lower their

overhead by 6.25% of gross income by trimming billing expenses, fees could be lowered by 6.25% and physicians would still earn the same net income for the same volume of services. We therefore estimated the minimum potential administrative savings in hospital and physician expenditures to be \$40 billion by discounting projected hospital and physician costs by 11.2% and 6.25%, respectively (Table 1).

Additional savings accrue from the reduced administrative "load factor" of a public plan. In 1987, the cost of public and private insurance overhead and profits expressed as a percent of personal health care expenditures was 5.9% in the United States and only 1.4% in Canada.^{9,28} If our NHP operated with the efficiency of Canada's, the administration of health insurance would cost \$8 billion, less than one quarter the \$35 billion projected by the Health Care Financing Administration in 1991.

As indicated in Table 1, the net cost of personal health care and insurance overhead for universal coverage under the NHP, including expanded services for the previously uninsured, would be at most \$547 billion if the system operated with the administrative efficiency of the Canadian system. This is \$55 billion less than the \$602 billion that will be spent in 1991 under current policies that exclude approximately 35 million Americans.

Budgeting Under the NHP

We do not propose reducing the health care budget by \$55 billion under the NHP. As noted above, we are uncertain how utilization patterns might respond to universal, first-dollar insurance coverage. Nor can we be completely confident that hospitals and physicians will immediately shed their excess administrative poundage and assume the leaner proportions possible under a simplified payment system. We therefore propose the following budgetary strategy for the NHP: We would set the overall health care budget for the NHP's initial year at the amount projected under current policies (\$602 billion if implemented in 1991). To keep expenditures within this target, we would rely on the ability of a single payer to allocate and enforce prospective budgets for physician and hospital services. These budgets would challenge providers to extract administrative savings and redirect resources into patient care for the underserved. The budget would allow a range of utilization responses among patients and physicians.

For example, the NHP could set total hospital operating budgets at the Health Care Financing Administration

projected "baseline" 1991 level of \$273 billion (Table 2), though some individual hospitals' budgets might be adjusted to reflect past underfunding or large operating surpluses. On average, a hospital able to achieve full administrative savings would have 11.2% of its budget to devote to more or better clinical services. Billing personnel could be transferred to clinical departments to perform clerical duties, freeing up nurses for bedside care. Hospitals unable to realize immediate administrative savings would not be penalized in the short run. However, in the longer run, the single payer within each state would evaluate hospitals' clinical performance and efficiency and modify budgets, taking account of these hospital quality measures as well as community needs. The Canadian experience demonstrates that such a budgeting process need not be cumbersome or expensive, consuming less than \$2 per capita in British Columbia (D. Cunningham, British Columbia Ministry of Health, written communication, July 1990).

Prospective budgeting of physician services under fee-for-service methods would require expenditure targets or caps. On average, fees would be set at 6.25% below current levels, reflecting expected administrative savings to physicians. The expenditure target, however, could be set at \$154 billion, 6% above the "baseline" projected level for 1991 (Table 2). This would allow physician payments to accommodate a net utilization increase of up to 12.25%, sufficient to satisfy increased demand by the uninsured and underinsured, while allowing a net increase in physician income of 6%. A utilization increase above 12.25% would trigger a compensatory decrease in fees to keep expenditures within the budget target. Such a plan allows for control of costs with a minimum of the administrative waste or encumbrances of our current utilization review mechanisms.²⁴

Summing the aggregate hospital operating budget of \$273 billion, the physician budget of \$154 billion, and the other categories of personal health care spending and administration would still leave total expenditures \$18 billion below our proposed \$602 billion budget (Table 2). The \$18 billion balance could be used for start-up costs for the NHP, job training and placement programs for displaced administrative personnel, improved long-term care, and revitalized public health programs.

FINANCING THE NHP

Health insurance proposals are frequently shipwrecked on the shoals of their financing; any serious proposal

Table 2.—National Health Program (NHP) Budget, by Category of Expenditure, in Billions of Dollars

Category	Current Policies*	
	NHP	
Hospital	273	273
Physician	154	145
Other†	149	149
Insurance administration and profits	8	35
Subtotal	584	602
New health initiatives and transition costs	18	0
Total Budget	602	602

*These are Health Care Financing Administration projections.

†"Other" includes drugs, dental and other professional services, and so forth.

must specify a revenue package. Although the NHP would not result in a net increase in total health care expenditures, it would produce a major shift in payment sources toward government and away from private insurance and out-of-pocket payments. We emphasize that the average individual and business would not pay more for health care under the NHP but would pay taxes that take the place of, but do not exceed, current premium payments and out-of-pocket costs. Moreover, with the single payer's capacity to control inflation, individuals and businesses should soon enjoy reductions in the rate of increase of their health care costs.

What principle should underlie the choice of revenue sources? Health care is only one factor—sometimes a minor one—in the promotion and preservation of health. Poverty, racial oppression, substance abuse, lack of education, lack of exercise, overnutrition and undernutrition, and occupational and environmental hazards all damage health. Some of these factors can be influenced by society's revenue-generating mechanisms. For example, raising excise taxes on cigarettes and alcohol reduces their consumption and thereby improves health, particularly among teenagers and the poor.²⁵ On the other hand, burdening low-income families with high payments (whether taxes, premiums, or out-of-pocket dollars) reduces their disposable income and amplifies the ill effects of poverty. In contrast, a system of taxes and other payments that reduces the burden on low-income families without impeding job formation may ameliorate poverty's health consequences. Thus, funding mechanisms can be "healthy" or "unhealthy."

Health care financing in the United States is markedly regressive and hence unhealthy. The bottom income decile receives 1.3% of total income but pays 3.9% of health costs, while the top income decile receives 33.8% of income and pays only 21.7% of health costs. By comparison, in Britain the bottom decile

Table 3.—Public Plan's Share of 1991 Personal Health Care Expenditures Under National Health Program (NHP), in Billions of Dollars

Service	Total Cost	% Covered by NHP	NHP Cost
Hospital	273	96*	262
Physician	154	91*	140
Other	149	55†	82
New health initiatives and transition costs	18	100	18
Administration	8	85†	7
Total	602	85	509†

*These figures are based on the public share of spending for these services in Canada. The shares are less than 100% because certain services, such as cosmetic surgery, life insurance examinations, and private room surcharges, are not covered benefits.²⁴

†These figures are based on our "best guess" estimate, since the NHP will provide more extensive coverage of nonhospital and nonphysician services than do the Canadian provincial plans. Nonprescription drugs are an example of a product in the "other" category that will not be covered.

‡A total of \$93 billion of personal health care expenditures uncovered by the NHP remain as out-of-pocket and individual private insurance premium costs.

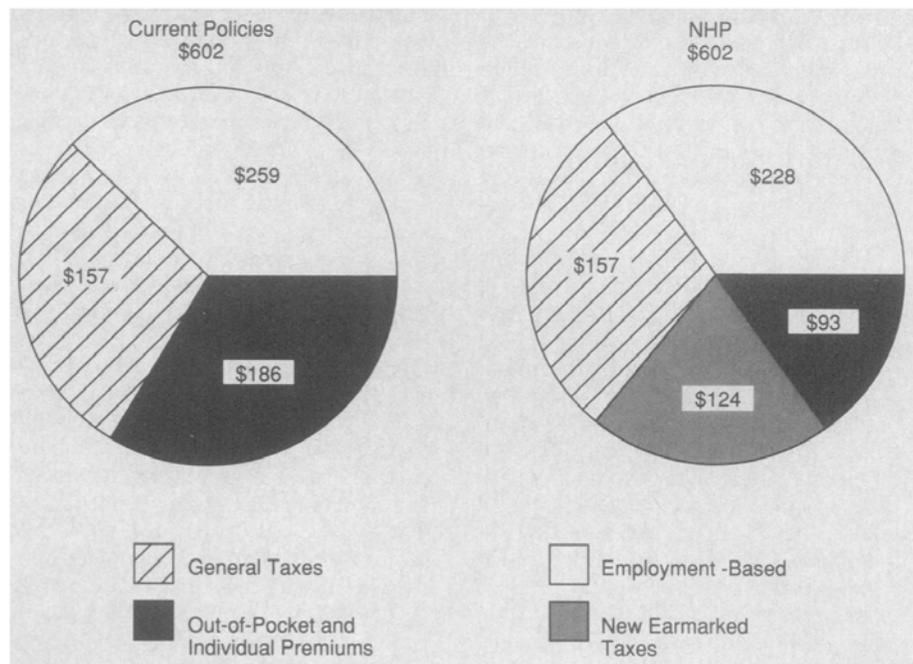
receives 2.3% of income and pays 1.7% of health costs, while the top decile receives 24.9% of income and pays 25.6% of costs.²⁶ Any departure from the existing configuration of US health care funding should reverse the current unhealthy pattern.

We estimate that public expenditures will account for 85% of health spending under the NHP, requiring \$509 billion in revenues for 1991 (Table 3). We will discuss these revenues in three categories: (1) payroll taxes, (2) general government revenues, and (3) payments by individuals (Figure).

Payroll Taxes

Employer-employee payments for group health insurance (31% of personal health expenditures [excluding nursing-home care]²⁷) are, in essence, a payroll tax,²⁸ with the money going to an insurance company or a self-insured fund rather than to the government. Social Security payments for Medicare (12% of health expenditures^{27,29}) are also a payroll tax. It is logical to combine these two sources of financing, which together account for 43% of health expenditures. To minimize economic disruption, we propose that a similar proportion of the NHP be funded by payroll tax.

The regressive nature of a payroll tax makes it a less-than-healthy revenue source; the employer share is often shifted to employees as lower wages or to consumers as higher prices.³⁰ It should be made more progressive by reducing the employee share for lower-wage employees, by raising the employee share for high-income employees (eg, eliminating the current Social Security cap), and by reducing the employer share for small business. Employers



Revenue sources. Figures are in billions of 1991 dollars. NHP indicates national health program.

and employees currently pay almost 2% of total payroll for Medicare-related Social Security taxes and approximately 10% for private health insurance—a combined health-related payroll tax of 13%.^{29,31,32} Using Department of Commerce figures, we project that under the NHP, an average tax rate of 9% for medium and large employers, with an average 2% rate for employees, and half these rates for businesses with fewer than 20 employees, would raise \$228 billion in revenues.³³ These precise tax rates are only initial suggestions and must be negotiated with the affected parties.

General Government Revenues

Twenty-six percent of personal health expenditures (excluding nursing-home care) comes from non-Social Security governmental revenues at the federal, state, and local levels.^{27,29} Of this total, 51% comes from individual income taxes, 12% from property taxes, 12% from sales taxes, 12% from corporation income taxes, 5% from gasoline, tobacco, and alcohol taxes, and 8% from other sources.³⁴ Although some of these revenue sources are unhealthy, we propose leaving them intact, adhering to the principle that implementing the NHP should not demand radical economic restructuring. These revenues would generate \$157 billion for the NHP in 1991.^{9,29}

Payments by Individuals

The third major source of health financing consists of payments by individuals; these payments currently account for 31% of health expenditures (5% in individual insurance premiums, 24% in out-of-pocket payments, 1% in Medicare premiums, and 1% in other private funds).^{27,29} They are the least healthy revenues because they burden lower-income families far more than they do the affluent. To the extent that they pay for services covered under the NHP, they will disappear.

We propose replacing the majority of individual payments with "healthier" revenues—taxes that reduce income disparities and discourage the use of harmful and polluting substances. The following measures, according to a Congressional Budget Office study,³⁵ would generate \$124 billion per year and could be considered as NHP tax revenue sources: (1) a new federal income tax bracket of 38% for families with income higher than \$170 000, (2) a cap on mortgage interest deductions for luxury homes, (3) a 0.5% tax on transfer of securities, (4) an increase in energy taxes to encourage energy conservation and reduce pollution, (5) an increase in excise taxes on cigarettes to 32 cents per pack and on alcohol to 25 cents per ounce, (6) an excise tax on sources of air and water pollutants, and (7) a tax on

fossil fuels to reduce carbon dioxide emissions. Although some of these taxes are regressive, their overall effects are health promoting.

To summarize, the NHP would fund approximately 38% of health expenditures from a payroll tax similar to current payroll expenses for Medicare and health insurance premiums; 26% from existing federal, state, and local revenues; and 21% from new, healthy federal tax revenues that would largely supplant current out-of-pocket expenditures. Fifteen percent of expenditures would remain out-of-pocket (Figure).

A majority of Americans would accept this type of tax package if it were earmarked for health care and placed in a health care trust fund. A 1990 poll found that 72% would support an NHP even if it required a tax increase; however, only 22% would pay more than \$200 extra per year.³⁶ Our proposal would not increase the sums paid for health care by low- and middle-income groups. It is designed to minimize winners and losers, aside from the private health insurance industry.

Two additional principles should be incorporated in NHP funding. Per capita health spending should be equalized throughout the nation, with federal funds transferred to states under formulas adjusted for age, income levels, health status, wage, and other input costs. Finally, to protect the NHP from annual budgetary debacles in Washington, DC, it must be an entitlement program with a statutory expenditure floor as well as a ceiling. In contrast to entitlement programs restricted to poor families, the NHP would embrace the entire population and could thus command the level of support enjoyed by Social Security. Adequate increases in NHP funding (based on such factors as aging of the population, epidemics, advances in medical technology, and inflation) must be mandated by law. As suggested in our original NHP proposal,⁷ an expanded program of technology assessment would help guide budgetary allocations.

COMMENT

In health insurance, as in many things in life, simplicity is a virtue. The NHP's approach to universal access is simple: every American automatically qualifies for equal, comprehensive health insurance under a unitary public plan. The economic premises of the NHP are also simple: funnel all third-party payments through a single payer, thereby saving billions of dollars in administrative costs and achieving cost containment through global controls rather than minute bureaucratic scrutiny.

The administrative cost reductions during the NHP's initial phase are not, as some have argued, only a one-time saving.³⁷ Whether in Canada or New Zealand, Sweden or Britain, single-payer systems have stabilized costs in the past decade, while US health care inflation has been impervious to the most earnest attempts to control costs.³⁸⁻⁴⁰ Economist Robert Evans⁴¹ has concluded that "universality of coverage and sole-source funding are, as far as we know now, preconditions for cost control."

Global expenditure control can also enhance clinical freedom. Under the micromanagement model of cost containment, each of the multiple payers, lacking global budgetary levers, resorts to intrusive patient-by-patient utilization review.²⁴ Such day-to-day interference in medical practice is minimized in single-payer systems.⁴⁰ As John Wennberg¹⁶ recently observed:

The key to the preservation of fee-for-service markets, as the Canadians seem to recognize, is not the micromanagement of the doctor-patient relationship but the management of capacity and budget. The American problem is to find the will to set the supply thermostat somewhere within reason.

The NHP would benefit most Americans, though a few powerful interest groups would suffer. It would virtually eliminate financial barriers to care for those who are currently uninsured and underinsured, ensure patients a free choice of providers, ensure physicians a free choice of practice settings, diminish bureaucratic interference in clinical decision making, stabilize health spending, and reduce the growing burden of health care costs for many individuals and employers. Small-business owners who do not currently cover their employees would face modest cost increases, though far less than mandated by most alternative proposals. The health insurance industry would feel the greatest impact. Indeed, most of the extra funds needed to expand care would come from eliminating the overhead and profits of insurance companies and from abolishing the billing apparatus necessary to apportion costs among the various plans. Job retraining programs for displaced administrative and clerical personnel would be essential.

Although few dispute the ability of the NHP to provide universal coverage and control costs, critics have raised the specter of rationing, pointing to queues for some high technology services in Canada.⁴² We do not advocate cutting US health spending to Canadian levels. Even with a slower rate of growth under the NHP, US health expenditures will remain well above those of any

other nation. Deploying our greater resources with Canadian efficiency would permit increases in utilization and improvements in technology without skyrocketing costs. Compared with Americans, Canadians do, in fact, get more health care for their health care dollar. About half of the cost differential between the two nations is squandered on insurance overhead and paper pushing.^{18,43} Stanford economist Victor Fuchs⁴⁴ has concluded that "the quantity of [physician] services per capita is much higher in Canada than in the United States . . . the data firmly reject the view that Canadians save money by delivering fewer services."

Health financing reforms unable to extract administrative savings inevitably impose added costs for expanded services. Employer mandate proposals (eg, the Pepper Commission Plan,¹ the American Medical Association's Health Access America plan,³ the National Leadership Commission's proposal,² and Massachusetts' Universal Health Care Law [*New York Times*. April 11, 1991:A1]) would leave existing insurance in place while expanding public programs for the unemployed and requiring employers to insure their workers. None of these plans offer improved coverage for those currently insured, nor do they offer new cost control mechanisms. Hence high initial costs presage continuing inflation or far more stringent and intrusive micromanagement—probably both. Modifications of the employer mandate approach (eg, the UNYCare proposal in New York State)⁴⁵ that attempt to meld the cost containment features of a single-payer system with a continuing role for private insurance also eschew most administrative savings, compromising the ability of such measures to expand access without raising costs.

There is slim evidence that Enthoven and Kronick's⁴⁶ "managed competition" plan—featuring competing managed care insurers and higher patient copayments—can hold costs in check.⁴⁷ Does forcing consumers to bear premium costs for higher-priced plans hold down overall costs or simply segregate the market based on ability to pay? Do low-cost plans provide care more efficiently or simply market themselves more effectively to lower-risk subscribers? Is the rubric "Consumer Choice Health Plan" appropriate for a system likely to lock the vast majority of patients and physicians into closed panel health maintenance organizations run by insurance companies? The ultimate vision of managed competition—a landscape dominated by a limited number of huge health maintenance organizations man-

aging salaried physicians—is a more radical departure from the current health care scene than the NHP.

The objectives of the NHP are simple: (1) to minimize financial barriers to appropriate medical care, (2) to distribute costs fairly, and (3) to contain costs at a

reasonable level. Once a structure is in place for meeting these basic concerns, the medical profession and society as a whole can move on to the more complicated questions: Which health services truly improve the quality of life? What share of our human and material re-

sources should we devote to health care? How shall we reduce the toll now extracted by poverty, ignorance, and addictions? By implementing a national health program, we can turn and face the challenges ahead.

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Updated tables

Table 1. - Personal Health Care Costs for 2017, Excluding Nursing Home Care, With and Without a National Health Program (NHP), in Billions of Dollars*

	NHP	Current Policies
"Baseline" conditions	2,829.8	2,829.8
New costs for previously uninsured [1]	98.9	...
Discount for 12.9% hospital administrative savings [2]	(147.9)	...
Discount for 9.5% physician administrative savings [3]	(66.4)	...
Subtotal: Personal Health Care	2714.4	2829.8
Insurance administration and profits	68.3	298.2
Total Personal Health Care Plus Insurance Overhead	2,782.7	3,128.0

*This assumes Canadian-level administrative efficiency and changes in utilization only among the previously uninsured.

Table 2. - National Health Program (NHP) Budget, by Category of Expenditure, in Billions of Dollars

Category	NHP	Current Policies
Hospital	1147.1	1147.1
Physician	740.7	698.8
Other*	983.9	983.9
Insurance administration and profits	68.3	298.2
Subtotal	2,940.0	3,128.0
New health initiatives and transition costs	188.0	0
Total Budget	3,128.0	3,128.0

*Includes dental, medical equipment, home health, and other professional services, and so forth.

NOTES: 1. Based on the Urban Institute's estimate of these costs in 2008 (<https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7809.pdf>) adjusted upward for growth in per capita personal health expenditures and downward for the decrease in the number of uninsured persons. 2. Himmelstein DU, Jun M, Busse R, Chevreul K, Geissler A, Jeurissen P, Thomson S, Vinet M-A, Woolhandler S. A comparison of hospital administrative costs in eight nations: US costs exceed all others by far. *Health Aff* September 2014 33:1586-1594. 3. Jiwani A, Himmelstein D, Woolhandler S, Kahn JG. Billing and insurance-related administrative costs in United States' health: a synthesis of micro-costing evidence. *BMC Health Services Research* 2014;14:1472.

'Cadillac' tax on high-end health plans will hit middle class: study

By John W. Mitchell

The proposed Cadillac tax set to commence a few years from now under the Affordable Care Act will transform the current \$326 billion credit for employer-provided health insurance to an unfair financial burden for most taxpayers, according to researchers out of City University of New York School of Public Health.

"Economists and politicians have been justifying the ACA's Cadillac tax by describing it as a 'Robin Hood' maneuver that would take from the rich and give to the poor," Dr. Steffie Woolhandler, professor of health policy and management and co-author of a study just published in the peer-reviewed *International Journal of Health Services* told HCB News. "That view of the Cadillac tax is untrue."

Woolhandler said the tax is intended to eventually eliminate current subsidies to employer-sponsored health insurance plans. Critics claim that the current subsidies encourage over-insurance, which prompts policyholders to seek unneeded care. There is also a financial benefit to employees, especially higher paid employees.

"When an employer provides health benefits to an employee, the employee pays no income or FICA tax on the value of those benefits, although the benefits are obviously part of the employee's compensation," Woolhandler said. "In other words, the taxpayers are picking up part of the employee's health insurance costs."

But she and her co-author, fellow professor Dr. David Himmelstein, maintain the scheduled 2018 [now set for 2020] Cadillac tax will not make financing health insurance any fairer.

"The main beneficiaries of the current tax subsidies to employer-sponsored coverage are middle class families (defined by a family income between \$39,000 and \$100,000 in 2009 dollars) for whom the subsidies boost their effective incomes by about 5 percent," Woolhandler explained. "These are the people who would be most harmed when the Cadillac tax kicks in and curtails the current tax subsidies."

The Cadillac tax is controversial. While the tax is widely supported by economists, everyone from unions to the U.S. Chamber of Commerce (USCC) oppose it. The USCC maintains the ACA's Cadillac tax will increase costs and reduce benefits.

According to a study conducted by the nonprofit Kaiser Family Foundation (KFF) this past August, the tax's unpopularity is "reflective of an overall anti-tax sentiment among Americans." The Cadillac tax is intended to raise \$87 billion over the following decade to lower the cost of health insurance purchased through government-run insurance exchanges.

According to the KFF, employers are already making a number of changes to reduce the impact of the 40 percent Cadillac tax. This includes increasing deductibles, eliminating services and other measures.

Separate from her study results, Woolhandler advocates for a single-payer "Medicare-for-all" system – also controversial – to put health insurance on an equal footing.

"The U.S. needs a single-payer system to improve the fairness of health financing and the health of the American people," she said. "Until we get there, patchwork financing reforms like the Cadillac tax can make matters worse. Single payer is not socialized medicine, since doctors and hospitals could remain private. Rather it is socialized insurance."

In addition to their academic posts, Woolhandler and Himmelstein are co-founders of Physicians for National Health Program, a nonprofit organization with a membership of 20,000 physician, medical student, and health professional members. According to the authors, PNHP had no role in the funding or in otherwise supporting the study.

John W. Mitchell is senior correspondent at DOTmed Healthcare Business News Daily.

The "Cadillac Tax" on Health Benefits in the United States Will Hit the Middle Class Hardest: Refuting the Myth That Health Benefit Tax Subsidies Are Regressive. *Steffie Woolhandler, M.D., M.P.H., David U. Himmelstein, M.D. International Journal of Health Services, March 9, 2016.*

Abstract

U.S. employment-based health benefits are exempt from income and payroll taxes, an exemption that provided tax subsidies of \$326.2 billion in 2015. Both liberal and conservative economists have denounced these subsidies as "regressive" and lauded a provision of the Affordable Care Act – the Cadillac Tax – that would curtail them. The claim that the subsidies are regressive rests on estimates showing that the affluent receive the largest subsidies in absolute dollars. But this claim ignores the standard definition of regressivity, which is based on the share of income paid by the wealthy versus the poor, rather than on dollar amounts. In this study, we calculate the value of tax subsidies in 2009 as a share of income for each income quintile and for the wealthiest Americans. In absolute dollars, tax subsidies were highest for families between the 80th and 95th percentiles of family income and lowest for the poorest 20%. However, as shares of income, subsidies were largest for the middle and fourth income quintiles and smallest for the wealthiest 0.5% of Americans. We conclude that the tax subsidy to employment-based insurance is neither markedly regressive, nor progressive. The Cadillac Tax will disproportionately harm families with (2009) incomes between \$38,550 and \$100,000, while sparing the wealthy.

High costs of hepatitis medicine make a good case for universal Medicare

By the Editorial Board

Those who continue to argue that there is a “free market solution” to the unconscionable costs and gaps in the American health care system have to explain away the train wreck surrounding new cures for hepatitis C.

The good news is that there is a cure for hepatitis C, a blood disease that can lead to a slow and painful death as it destroys a victim’s liver. In fact, now there are a few. Gilead Sciences markets concoctions called Sovaldi and Harvoni. Janssen Research offers a drug called Olysio.

The bad news is that the cost of the full treatment regimen for a single patient can run from \$83,000 to \$189,000. That, obviously, is well beyond the reach of nearly every household and understandably enough to scare off both private insurance carriers and government-funded Medicaid.

The worse news is that, because the United States clings to the idea that wellness is a commodity subject to rational market forces, nobody is trying to limit these awful costs.

Pharmaceutical research is expensive, yes. But American drug companies remain by far the most profitable part of the health care sector.

The drug companies charge so much for these medications for one reason: Because they can.

Functioning free markets do not – and never will – exist in health care because the sellers so often hold all the cards. Unlike someone in the market for a car, a television or a cell phone, people who need a particular medication cannot just decide not

to buy a product until the price comes down, or just to do without it altogether. Unless they are interested in dying, or watching a family member die.

Civilized nations – a term that excludes the United States when discussing health care – either regulate the prices of drugs or use their concentrated purchasing power to negotiate a reasonable cost. In India, for example, a dose that is identical to what costs more than \$90,000 here costs \$900.

Drug makers argue that even the staggering cost of Sovaldi or related drugs is a bargain compared to avoided costs of more treatment, surgeries, disability, early death, etc.

But that doesn’t help the uninsured family that can’t afford either the drug or the alternative. And it isn’t always enough to push insurers to pay up, because Insurance Company A may bear the cost now, only to see the clients move on and endow Insurance Company B – or Medicaid or Medicare – with the avoided costs months or years later.

It is notable that single-payer systems, such as in the United Kingdom, have done the math and agreed to pay high – though less than in the U.S. – prices for these drugs. That’s because, in those nations, the single payer does, indeed, come out ahead by paying a lot now but saving many multiples of that later.

In other words, the case made by the drug companies for allowing them to charge such high prices is also an argument for Medicare for all.

PHYSICIANS FOR A NATIONAL HEALTH PROGRAM / WWW.PNHP.ORG

Gilead CEO John Martin
made \$232.0 million last year
That's \$888,827 per day
Single Payer Now

Separately, the pharma/biotech chief was given stock and option awards worth \$13.0 million this year, which will provide value in future years.
Source: SEC DEF 14A Schedule
Annual CEO pay includes salary, non-equity cash incentive pay, option awards exercised, stock awards that vested, and other compensation.

PNHP’s presence on Facebook, Twitter on the upswing

While PNHP has been engaging with its supporters and followers on Facebook and Twitter for many years, the extent of that engagement has grown significantly in the recent period. For example, the number of people who “like” PNHP’s Facebook page has grown from 11,000 in 2013 to more than 37,200 today. The followers of our Twitter account has nearly doubled over the same time frame, to 4,000 today.

PNHP’s provocative infographics (such as the one to the left) and links to timely, lively articles have contributed to this surge. If you’re on Facebook and haven’t already “liked” PNHP, please do so today. And when you see a new post by us, please comment on it and share our content with your friends and colleagues. And if you’re on Twitter, please follow and retweet us there, too!

Facebook.com/doctorsforsinglepayer
Twitter.com/PNHP (@PNHP)

Medicare for all: A solution for health care

By Sean Lehmann, D.P.M.

The Affordable Care Act (ACA or Obamacare) has most certainly had some successes. There are many who didn't have health coverage that do now and many others who can now get coverage that were previously denied due to pre-existing conditions.

With that said, still others have seen increases in their premiums, deductibles and co-pays. It has become more and more obvious the ACA is not a long term solution for our health care system. Unfortunately, neither party has championed a viable alternative. The majority of Democrats vow to protect the ACA, while the Republicans repeatedly attempt to "repeal Obamacare" which isn't a plan at all.

I began practice as a sole practitioner nearly 16 years ago. One of my first workplaces was the Fallon Tribal Clinic. The family practice doctor at that clinic told me it was a "grave mistake" when we decided as a country that health care would be treated as a for-profit commodity. During the years I have learned he was definitely right. I have had the unique perspective of being on the front lines of health care as both a provider and consumer.

In our current system, private for profit insurance companies are middlemen and as such, drive up the cost of health care. There are only two ways in which an insurance company can increase profits for its shareholders: raising premiums and denying care. This is a serious conflict of interest, yet we have allowed it to happen.

During 2014 alone, the CEO of United Health Care made \$66.1 million. Not to be outdone, the CEO of Gilead Pharmaceuticals made \$192.8 million in the same year. As a nation we spend 17 percent of our GDP on health care, while the next closest country, Norway, spends only 9.3 percent. The vast majority of nations spend less than 10 percent of their GDP on health care and still provide universal coverage for their citizens. We spend significantly more on health care than any other nation on earth, yet more than 50 percent of personal bankruptcies are due to medical bills or illness.

How do we fix this? The overhead for private for profit health insurance companies is nearly 20 percent, yet the overhead with Medicare is only 1.3 percent. Eliminating the middleman would account for an immediate 18 percent reduction in our healthcare costs. As Americans well know, we also pay infinitely more for prescription drugs than the rest of the world. In fact, we're the only country that allows pharmaceutical companies to charge whatever they want. By negotiating these prices, we could realize large savings.

Personally, I pay nearly \$6,000 a year to insure my family. We also have a \$10,400 deductible. This means I pay \$16,000 per year before my family and I get any health care coverage. I have heard horror stories from patients of mine who pay even more,

some significantly more.

What about Medicare? The program that covers seniors isn't perfect, but the costs to patients are infinitely lower. The monthly premium is \$104.90 and the deductible is \$166. This means seniors will pay just more than \$1,400 yearly before Medicare begins to cover them. My father was self-employed and paid enormous premiums to a private insurer before he turned age 65. He was relieved when he was finally able to enroll in Medicare, just like many others were when they became eligible. So why not extend Medicare to everyone? There's a bill to do just that, HR 676, "Expanded and Improved Medicare for All."

So how do we pay for it? There is already a payroll tax for Medicare. This payroll tax would be increased slightly, but the increase would pale in comparison to what we're already paying for health care. Remember, I'm already paying \$16,000 per year. Others are paying even more. Employers would see huge savings over what they are contributing to private for profit plans.

A recent study by the University of Massachusetts showed there would be an annual savings of \$592 billion. No other plan can achieve this magnitude of savings on health care.

It's clear Medicare for all could be positive for many patients, but what about physicians? Physicians for a National Health Program (PNHP) is a national organization of more than 20,000 physicians and other health care providers that endorse this plan.

In my own practice, it would be welcome change. Instead of dealing with hundreds of insurance companies and literally thousands of plans, I would only have to deal with one. Talk about making things easier! The countless hours spent credentialing, negotiating, and appealing with all these different plans would be reduced significantly.

The extra time I would have available could be spent where it should be: patient care. Moreover, with everyone on Medicare, there would be no networks and patient access would be increased substantially.

There's no perfect solution to our health care dilemma. However, I would propose Medicare for all is a viable and workable alternative. A recent poll by the Kaiser Family Foundation shows 58 percent of Americans agree. We have recently organized a Nevada chapter of PNHP and invite all those who support this initiative to join us. Please visit www.pnhp.org for more information.

Dr. Sean L. Lehmann is a practicing podiatrist in Carson City. He also has a master's degree in health care administration and is chair of the Nevada chapter of Physicians for a National Health Program.

What is single payer and why should obstetrician-gynecologists care?

By Carrie Ann Terrell, M.D.

Having a baby in Minnesota is a pretty good deal. Many pregnant women have health insurance. Most pregnant women who are not already insured are eligible for medical assistance (MA). The majority of visits and tests during pregnancy are covered by insurers in a package which precludes prenatal care, delivery, and post-partum care for up to six weeks.

Yet, insured women are becoming more concerned about potential charges, more commonly asking “will this be covered?” and finding themselves with large unpaid medical bills.

Given Minnesota is enrolled in the Affordable Care Act (ACA) and continues to support Medical Assistance why are women focusing more on coverage, medical bills, and policies than on their health and pregnancies. Additionally, why is the United States ranked 28th^[1] for maternal mortality and falling if we are insuring more women?

Women are still underinsured

Despite ACA and excellent medical assistance, women are still underinsured in Minnesota. Women seeking pregnancy and gynecological care with good insurance have high deductibles commonly in the thousands of dollars. For many women the understanding is employment equals benefits equals health insurance. The summation of the deductible along with co-pays for visits (clinic, Labor and Delivery, ER, OR, lab, and ultrasound) results in out-of-pocket costs which are insurmountable and lead to feelings of betrayal and mistrust of the insurance system or her employer.

Many women assume if they pay their monthly premium everything else should be covered. Even our more savvy patients do not understand which visits, tests, procedures will be covered or at least what percentage. Insurance companies compete by avoiding unprofitable patients and shifting costs to patients or providers. This system avoids caring for the sickest patients and creates huge administrative costs. Meanwhile, health insurance CEOs are financially rewarded for generating profits which do not increase the wellness of our communities.

How often have we heard a middle-aged patient, a friend, a coworker exclaim she is simply retaining a job until she qualifies for Medicare? How many of these patients put off visits, cancer screenings, wellness exams until Medicare “kicks in”?

The single-payer alternative

A single-payer program is essentially Medicare for all. The program would provide comprehensive coverage with free choice of providers and no direct charges to patients. A public agency

would manage the plan and budget.

Insurance company profits and multimillion-dollar company executive bonuses would be eradicated. Mandatory referrals and pre-authorization for medications would vanish. Improved access, the ability to obtain and monitor outcomes in a systematic way, and the ability to collect evidence-based care uniformly would improve the health of our populations.

There would be no confusion as to when or if a visit, lab, medicine, or surgery would be paid for. The funding would be accomplished by taxes. Note these taxes are in lieu of premiums, co-pays, and deductibles.

The Lewin Group recently studied the economic feasibility of a Minnesota single payer system. It found that such a system could provide comprehensive health and dental coverage to every Minnesotan while saving the state an extraordinary \$189.5 billion in health spending over 10 years. The median-income Minnesota family would save an average of \$3,512 per year on health care.^[2]

Today’s arrangements are unsustainable

Daily, I am saddened and frustrated with our current processes and systems. I envision a world wherein women can get the care they need when they need it without concern for cost. I desire a system in which the money invested in health care or insurance actually benefits patients.

The U.S. spends 25-31 percent of our health care dollars on administrative costs.^[3,6]

Administration of health care includes: running our practices/clinics/hospitals, paying executives to help us run our businesses, and dealing with various insurance companies.

According to a study published in 2010 by Dante Morra and Sean Nicholson, “We estimated physician practices in Ontario spent \$22,205 per year interacting with Canada’s single payer



Dr. Carrie Ann Terrell

agency – just 27 percent of the \$82,975 per physician per year spent in the United States.”^[4] The money spent on the administration of insurance includes: health insurers’ advertisements, lobbyists, eight-figure executive salaries and six-figure bonuses and profits for the investors in those companies.

As physicians we feel a lot of pressure to do our part to decrease the costs of medicine. We receive grades from our community (MN Community Measurement), the government (Meaningful Use), and insurance companies on how well we prescribe generic medications, integrate technology into patient care, the ordering of expensive tests, and our patients’ lab values.

While I do my best to limit excessive testing or prescribing I cannot have my practice do away with coders, billers, administrators who translate my clinical work into claims. I have no input on how many insurance companies exist or the rules for submitting claims.

Private insurers don’t put patients first

I am asked to focus on certain measures to elevate my practice’s tier within insurance companies. As an academician I fully appreciate and am eager to participate in programs which will improve the health of my patients or reduce unnecessary costs. Society and government do not and legally cannot put the same obligations onto insurance companies.

I envision a world wherein women can get the care they need when they need it without concern for cost. I desire a system in which the money invested in health care or insurance actually benefits patients.

We do not expect Medica, Blue Cross, HealthPartners to decrease their costs to patients or improve the health of their customers. And how can they? Citing Morra and Nicholson again, “U.S. senior administrators also spent more time per physician than those in Ontario, mostly on overseeing claims and billing tasks. Very little time was spent in Ontario or in the United States on submitting quality data to payers or reviewing data on quality.”^[4] So, we spend time and money dealing with insurance companies while trying to take care of patients and they spend time and money accepting, rejecting and negotiating our claims.

It’s not difficult to imagine how much more effective my care could be and how much safer, healthier, happier my patients would be if we spent a fraction of the money earned by insurance companies on actual health care.

I realize my view and expectations of a single payer universal health care system are probably oversimplified and even naive. I understand any proposed plan may increase taxes for some, even me, while lowering out-of-pocket costs for most Minnesota families. Currently, Governor Dayton has created the Minnesota Health Care Financing Task Force to evaluate and make recommendations for how Minnesota can increase access to care and the health of its citizens.

Lessons from Medicare

Our country started Medicare 50 years ago with the same objectives. It has been wildly successful for our population over age 65 and has increased coverage to younger individuals over time: In the 1970s we added long-term disability and end-stage renal disease. In the 1980s we added hospice care. In the 1990s and 2000s prescription drug coverage and those affected with ALS.^[5] These Medicare expansions demonstrate that we see value in universal health coverage for many U.S. citizens. I am confident Minnesota could create a system which is fiscally responsible and able to fulfill all Minnesotans’ health needs.

As a physician, I believe in good health and good health care for all our community members. As an OB/Gyn physician, I believe in good health and health care for our women. I believe providing women with attainable, equitable health results in healthier families and societies.

We’ve been told over and over our current system is not sustainable. We know our outcomes are not improving. We know our patients are dissatisfied with their current costs and coverage. We know insurance executives earn a salary much greater than ours. We know our hospitals barely stay afloat and cannot invest in basic infrastructure.

We know something has to change. Let’s do it in the right way. Let’s change it for the better.

Carrie Ann Terrell, M.D., FACOG, is assistant professor and division director of General OB-GYN at the University of Minnesota.

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Even insured can face crushing medical debt, study finds

By Margot Sanger-Katz

Here is the surest way to enjoy the peace of mind that comes with having health insurance: Don't get sick.

The number of uninsured Americans has fallen by an estimated 15 million since 2013, thanks largely to the Affordable Care Act. But a new survey, the first detailed study of Americans struggling with medical bills, shows that insurance often fails as a safety net. Health plans often require hundreds or thousands of dollars in out-of-pocket payments — sums that can create a cascade of financial troubles for the many households living paycheck to paycheck.

Carrie Cota learned the hard way that health insurance does not guarantee financial security. Ms. Cota, a 56-year-old travel agent from Rosamond, Calif., learned she had the autoimmune disease lupus in 2007. She ran up thousands of dollars in medical and dental bills and ended up losing her job, and eventually her house.

"I had to move in temporarily with my ex-husband," she said in a recent interview. "I'm staying with him until I can figure out what to do."

Selected NYT readers reply to the question, "How have medical bills changed your life?"

cold showers, can't fix plumbing. other needed repairs have been patched as best as possible but not fixed.

– man, 62, South

CANT TAKE THE KIDS ANYWHERE WISH I COULD DO MORE FOR MY KIDS!!!!!!

– man, 41, Midwest

Apt instead of house. Not getting groceries some weeks to get by.

– woman, 32, Midwest

In the new poll, conducted by The New York Times and the Kaiser Family Foundation, roughly 20 percent of people under age 65 with health insurance nonetheless reported having problems paying their medical bills over the last year. By comparison, 53 percent of people without insurance said the same.

These financial vulnerabilities reflect the high costs of health care in the United States, the most expensive place in the world to get sick. They also highlight a substantial shift in the nature of health insurance. Since the late 1990s, insurance plans have begun asking their customers to pay an increasingly greater share of their bills out of pocket though rising deductibles and co-payments. The Affordable Care Act, signed by President Obama in

2010, protected many Americans from very high health costs by requiring insurance plans to be more comprehensive, but at the same time it allowed or even encouraged increases in deductibles.

"We're at a point where there's been slow growth in health care costs and huge improvements in the numbers of people who have health insurance," said Sara Collins, a vice president at the Commonwealth Fund, a health research group. "But there is this underlying trend towards higher cost sharing that could put increasing numbers of people at risk for being underinsured."

became a recluse. dont do anything. my diet consists of frozen tv dinners.

– man, 59, Midwest

Letting people move in with us to help pay bills.

– woman, 25, South

Among those who reported having problems paying their bills despite having insurance, 63 percent said they used up all or most of their savings; 42 percent took on an extra job or more work hours; 14 percent moved or took in roommates; and 11 percent turned to charity.

Randy Farris, 58, a factory worker from Conger, Minn., needed a knee replacement three years ago. His insurance covered 80 percent of the bill, but he needed to cash in an I.R.A. to pay his \$4,000 share. "I haven't been to the doctor since because I don't want any more doctor bills," he said. His wife's retirement savings had been wiped out years before, he said, when he used them to pay her hospital bills after she died of cancer.

The health law has led to a decline in the number of Americans suffering financial stress from health problems, thanks to the new options for receiving coverage, especially for the poor. But the problem is still widespread, touching roughly a quarter of Americans under 65, when the insured and uninsured are looked at together. Americans older than 65 are covered by Medicare, which more frequently protects people from major financial trouble.

Unlike other polls, which have focused on the ways that insurance affects health care, the new Times-Kaiser survey explored the effects of medical bills on people's daily lives well beyond the medical system. We found that medical bills don't just keep people from filling prescriptions and scheduling doctors' visits. They can also prompt deep financial and personal sacrifices, affecting their housing, employment, credit and daily lives. Kaiser has released a report today, detailing the survey's main findings about this population.

"The major impact is actually a pocketbook or economic im-

Charges for my insulin exceeded \$1200 a month (3 X the amount of my house payment) I had to reduce the amount of insulin I took based on what I could afford, my health was negatively impacted as a result.

– woman, 41, Midwest

let home go in foreclosure.

– woman, 40, West

Gave up college and any other expenses such as using my car and had to give up my pets.

– man, 51, South

pact: their ability to pay the rent or the mortgage or buy food,” said Drew Altman, president of the Kaiser Family Foundation.

People without health insurance, of course, are more vulnerable to medical bills than those with health coverage. The study found that the people most likely to report bill problems were uninsured, poor or disabled. But the majority of people struggling with bills are insured. Of the people in the survey reporting difficulty with their medical bills, 34 percent lacked health insurance, 39 percent had insurance through work, 14 percent were covered through public programs and 7 percent had purchased their own health plans.

One reason, many experts said, is a gradual shift in the norms about the generosity of health insurance. In recent years, health plans have come with growing deductibles and narrowing networks of providers, provisions devised to lower the cost of premiums. Those features have made health insurance accessible to a larger share of the population, but may also be leaving more insured Americans vulnerable.

Ten years ago, David Dranove, a professor of health management at Northwestern’s Kellogg School of Management, conducted research on people experiencing medical bankruptcies. The study he co-authored found that bankruptcy was largely a problem of the uninsured. “But with more people buying less generous health insurance, I think the old evidence might no longer be relevant,” he said.

Insured people with financial problems often have plans with higher deductibles. But many said that the smaller co-payments piled up to make their care unaffordable. Many also received big bills that were not covered by their insurance. Among the 32 percent of insured patients stuck with an out-of-network bill, more than two-thirds of patients said they didn’t know the provider wasn’t covered. More than 25 percent of the insured

Sold car and have 3 jobs.

– man, 48, South

I’ve cut back on just about everything for my family & the way we live.

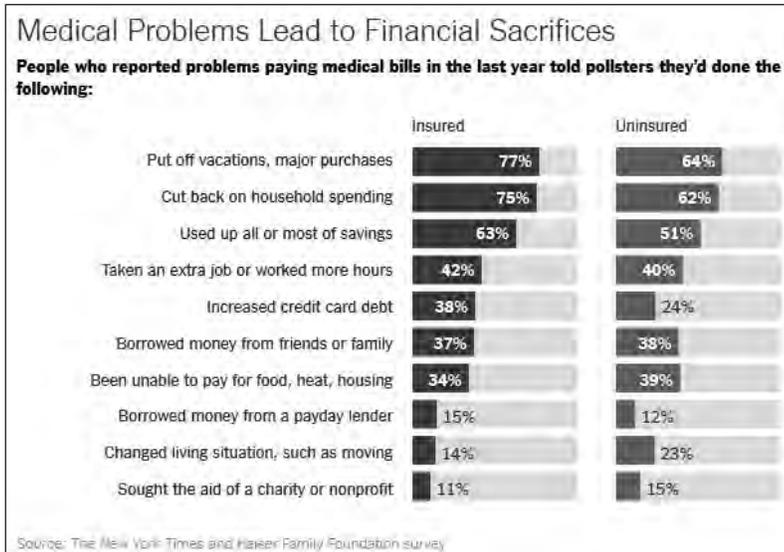
– woman, 50, Northeast

respondents said a medical claim had been denied.

Medical bill problems rarely occur in a vacuum, the survey found. Most of the people surveyed said their finances were tight even before there was an illness in their family. This pattern held true even for families higher on the income scale. The rates at which people with medical bill problems sought charity or borrowed money from friends was similar among people earning less than \$25,000 and those earning more than \$100,000.

Research on medical bankruptcies has been controversial because it can be hard to untangle how medical bills fit into a family’s overall pattern of financial troubles. Twenty-nine percent of the people with medical bill problems said a family member had been forced to stop working or cut back on hours. (On the other side, about 41 percent of people said they’d taken on extra work to help pay bills.)

“Is that a job problem or a medical bill problem?” said David Himmelstein, a professor of public health at the City University of New York’s Hunter College School of Public Health who has studied medical bankruptcies. “It’s both of those things.”



The survey included a random sample of 1,204 adults under 65 who reported problems paying household medical bills in the past 12 months. Interviews were conducted online and by telephone between Aug. 28 and Sept. 28, and some respondents gave follow-up interviews in December. The margin of sampling error is plus or minus 4 percentage points.

The survey asked people to describe the ways that bills had changed their lives. The chart above shows some of the most common answers. The quotations that are displayed throughout this article were entered by survey respondents when they were asked to describe “what other significant changes” they made in their lives. We’d like to hear how readers would answer a similar question. If you’re struggling with medical bills, please tell us about how your life has changed in the box at the top of this article. We may contact you about featuring your story in the future.

Marina Stefan contributed reporting.

Now is the time: Improving access to health care for people in Canada without insurance

By Rebecca Cheff

TORONTO – On February 9, the Wellesley Institute and the Health Network for Uninsured Clients held a full day symposium which brought together settlement workers, researchers, policy makers, politicians, funders, and a range of health care providers to discuss current research, practice and policy opportunities to improve access to health care for uninsured clients and to realize the universal right to health of all Ontario residents.

Public health care insurance provides important access to a spectrum of care that spans from preventative care to keep us healthy through to emergency care to help us when we're sick or injured. But despite our universal health care system, many people in Ontario do not have public health care coverage and are left without access to essential health care or face the possibility of having to pay out-of-pocket for care.

People become uninsured for a wide variety of reasons, including:

- People who have lost their identification are often eligible but denied OHIP coverage. This can be particularly difficult for people who are homeless and/or experiencing severe mental health challenges.
- New immigrants, returning Canadians and Canadians moving between provinces have to wait three months for OHIP coverage. In 2014, over 80 000 newcomers were denied health care in their first three months because of this policy.
- Cuts to the Interim Federal Health program (IFH) in 2012 reduced and/or eliminated refugee and refugee claimant's access to basic health care, medication and mental health support.
- Temporary visa holders such as visitors and students do not have public health care coverage.
- An estimated 200,000-500,000 people live, work and go to school in Canada without status due to expired visas, denied refugee claims and failed sponsorships. Without status, individuals and families are unable to access care through public health insurance programs.

People without access to public health insurance often face delayed and inconsistent care, worsened health conditions and large out-of-pocket expenses. Uninsured clients' experiences are further shaped by income, precarious and unsafe work conditions, and experiences of discrimination and oppression.

Many successes to celebrate

The symposium aimed to build on successes in policy, practice and research, and to identify emerging opportunities to improve access to care for people who are uninsured. Import-

tant progress has been made in recent months and years at the local, provincial and federal levels.

Of particular importance was recent progress on the Interim Federal Health Program. Arif Virani, MP for Parkdale-High Park and Parliamentary Secretary to the Minister of Immigration, Refugees and Citizenship, began the day by reiterating the new federal government's commitment to providing immediate health care access to Syrian refugees through the IFH program and to reinstating IFH for all refugees.

This is a major step forward as the IFH cuts had health impacts for refugee claimants in Canada. The restoration of IFH for all refugees and claimants provides the foundation for all refugees to receive the basic health care services that they need to get off to a healthy start in Canada.

There have also been significant steps forward in improving access to care in Toronto and Ontario.

In January 2015, midwives secured additional funding from the Ministry of Health and Long-Term Care to provide care to uninsured clients throughout their pregnancy including necessary lab tests, ultrasounds and physician referrals. This ensures that pregnant clients have access to the full range of services required for a healthy birth.

In 2013, City of Toronto declared itself a Sanctuary City and in doing so committed to providing access to city services for all Torontonians regardless of status. This policy is being rolled out across the city and has the potential to ensure that all Torontonians have access to services that support good health.

Also at the local level, the Toronto Central Local Health Integration Network (TCLHIN) continues to work with community health centres to provide care to uninsured clients and with hospitals to harmonize and reduce fees for uninsured clients. The TCLHIN is also building a health equity roadmap that holds promise in addressing the health care needs of uninsured and other vulnerable populations.

Now is the time

Strong coalitions of service providers, policy makers and researchers have led to these recent policy changes. We have made

(continued on next page)



Rebecca Cheff

Canadian doctors urge health minister to uphold law

By Ryan Meili, M.D.

Extra billing in Ontario, private MRIs in Saskatchewan and user fees in Quebec: violations of the Canada Health Act are on the rise across the country. Canadian doctors are concerned about the impact of this trend not only on their patients, but on our public health care system as well.

Health Canada is required to publish a report every year in order to detail how provincial and territorial health care insurance plans have (or have not) satisfied the conditions for payment under the Canada Health Act. Provinces that are not in compliance are to be penalized with a reduced Canada Health Transfer (CHT) payment.

This year's report showed that in 2014-15, the only province that received such a penalty was British Columbia. Their CHT payment was docked \$241,637, about half of the amount in extra billing a 2012 audit found to have been committed by Dr. Brian Day's Cambie clinic in just one month. It's notable that British Columbia, the only province docked funds, is also the only province currently seeking to enforce the act by cracking down on Cambie's activities.

Physicians and clinics have quietly been charging extra fees for health services for many years, yet calls for the federal government to enforce the Act have been ignored. Coming down hard on extra-billing may not sound as exciting as announcing new funding for specialized medical services, but it is the job of the provincial and federal health ministers to protect the Canada Health Act and guarantee equitable access to Canadian health care.

In Ontario alone, the frequency of such charges has grown at an alarming rate and escaped the notice of provincial and federal auditors and health ministers. The Ontario Health Coalition published a report in 2014 listing dozens of instances where in-

dependent health facilities (e.g. eye surgery, colonoscopy, diagnostic and executive health clinics) charged extra fees for medical consultations, examinations, diagnostic testing and other manners of "upgraded services." These fees are for services that are covered by the health system. This is otherwise known as extra billing, a practice that is against federal and provincial law.

Despite these contraventions, previous Canada Health Act reports show that Ontario has never been penalized.

This year's report has the potential to be more than a quiet committee discussion with no subsequent action. It can be the springboard for Health Minister Jane Philpott to assert her government's commitment to defending medicare, Canada's most treasured social program.

User fees, access charges, extra billing all come down to the same thing – inequitable access to Canadian health care.

Charging patients at the point of care for medically necessary services strikes at the heart of the principle that access to health care should be based on need rather than ability to pay. It undermines equity, increases system costs and reduces public commitment to universal coverage.

The Trudeau government promised real change. As an acclaimed physician, Minister Philpott has an opportunity to take a new approach to defending Canadian health care by sending a strong statement to the provinces that they must adhere to the Canada Health Act.

It is time for Minister Philpott to show there is a doctor in the House and take action to ensure medicare will be there for all Canadians in their time of need.

Dr. Ryan Meili is a family physician in Saskatchewan, vice-chair of Canadian Doctors for Medicare.

(Canada, continued from previous page)

good progress, but more needs to be done as considerable gaps persist in access to health care.

Symposium speakers and participants identified a number of local, provincial and federal opportunities to build on recent successes and take advantage of new windows of opportunity. Locally, Toronto hospitals should follow through on their commitment to harmonize fees for uninsured clients with OHIP rates so that vulnerable uninsured clients are not charged above standard rates.

Ending the three month wait period for OHIP would be an important first step to ensuring that provincial policy recognizes all residents' right to health and the expansion of OHIP-level coverage to all Ontarians.

Finally, federal immigration reform and regularization of status is needed to ensure that there are ways for individuals and

families to obtain status, settle and integrate into communities, schools and jobs without fear of status precarity and lack of public health care coverage.

The symposium was an opportunity to pause, to reconnect across organizations and sectors, to celebrate recent successes, to highlight persistent gaps, to reaffirm our commitment to the right to health for all Toronto and Ontario residents, and to plan for continued and collective action to improve access to care for some of the most vulnerable Torontonians.

Rebecca Cheff is a Wellesley Junior Fellow and Bob Gardner Equity Fellow at the Wellesley Institute, a Toronto-based nonprofit and nonpartisan research and policy centre that works to increase health equity by using evidence, ideas, and community mobilization.

This is the right thing to do

By Mark A. Krehbiel, M.D.

The divisiveness in the world today seems very troubling to me. Information technology gives us the ability to respond immediately to situations that arouse our emotions. The “oh my gosh!” or “can you believe that?” are common utterances that feed our senses to join the bandwagon, laugh it away, become upset or even angry.

Of course, there are exceptions to every rule, but I truly believe that as humans we have core values that most of us can agree upon. We believe in individuality, equality and the right to be comfortable and work hard to achieve goals. Most would agree that volunteerism and helping those in need are strong core values.

We are entering a new year with many questions and fewer answers about how to solve our differences. I find it interesting that our president’s low approval rating is very similar to President George W. Bush’s rating at the same point in his administration. Although both men had different styles and different agendas, I believe they both have similar core values and tried their best to do the right thing for our country and the world. Apparently, there are many Americans who think things could be better. We forget how blessed we are to live in this country of opportunity and freedom.

Many of us think our health care system needs improvement. The Affordable Care Act was an attempt to get more uninsured Americans better access to health care. I laud Barack Obama’s attempt, but disappointing facts remain. Many of us, insured, underinsured and uninsured, are not happy with the system.

The insurance companies and pharmaceutical companies need to be taken out of the driver’s seat. Let doctors and hospitals do their jobs without worrying about payment.

As it turns out, the insurance companies and pharmaceutical companies are the big winners. Insurance coverage costs are rising. Insured customers are not using their insurance because of high deductibles. There are still millions who cannot get the care they need. Our nation still ranks very low in infant mortality and other health care outcomes. If you live in Canada or Cuba, your life expectancy is longer than if you live in the U.S.

As one of only a few industrialized countries in the world that does not have universal coverage for all of its citizens, now is

the time to continue reaching for that goal. The insurance companies and pharmaceutical companies need to be taken out of the driver’s seat. Let doctors and hospitals do their jobs without worrying about payment.

There are now more employees working in billing and administration than there are the number of beds in U.S. hospitals. In contrast, there are three people working in billing at one large Toronto, Canada, hospital.

The solution is one insurance company. A single-payer system or Medicare for all would achieve truly universal care, affordability and effective cost controls. By taking private insurance companies and administrators out of the equation, it is estimated we would save \$400 billion (that is with a “B”) annually.

Many are concerned about another government-run system. The fact is that regulations now exist from the Centers for Medicare and Medicaid Services that basically tell hospitals and physicians what they need to provide, what they can charge and how much they get paid. The insurance companies just take a percentage off the top.

Some states are thinking of trying this system. Colorado, Oregon, Massachusetts and Vermont have all been discussing this. Although admirable, we need the whole country behind

such a change. More than 60 percent of physicians are in favor of such a system. Other polls have shown that two-thirds of Americans would favor this.

The system as described would cover all doctor visits, deductibles, medications, hospital charges, nursing home services and ancillary health care needs. It would be paid for by a tax that for most of us would be less than we now pay for insurance.

If you agree with any part of a single-payer system, would like to take the hassle out of deciding on your health insurance annually, or just need some health care and a way to afford it, just check out legislation already before Congress. H.R. 676, the Expanded and Improved Medicare for All Act, has more than 60 sponsors. It explains how this would work.

In this politically charged environment and election year, this might seem to be an insurmountable task. However, I truly believe that with enough groundswell of support, like many past, slow-moving social change events, this will become a reality. There are many reasons for covering the basic needs of health care for all of us Americans. Mostly, I believe, because it is the right thing to do.

Dr. Mark A. Krehbiel has practiced medicine in Salina, Kansas, for nearly 37 years.



Dr. Mark Krehbiel

PNHP chapter reports

In **California**, PNHPers are preparing for their annual student conference and lobby day in Sacramento May 15 and 16. Last year students lobbied for single payer and helped California become the sixth state to cover children under Medicaid, regardless of immigration status. This year the focus is on legislation that would allow the undocumented to purchase health plans in California's marketplace, or become eligible for Medi-Cal. The California Health Professional Student Alliance (CaHP-SA) is coordinating the logistics for Lobby Day, along with PNHP California and over 200 organizational partners in the Health4All Coalition and California's single-payer coalition, the AllCare Alliance. The PNHP California board of directors met in March for a daylong board retreat. Contact Dr. Bill Skeen at bill@pnhpca.org.



The PNHP California Board at their annual retreat.

In **Georgia**, Dr. Henry Kahn is working with medical students at Emory in Atlanta and the Medical College of Georgia in Augusta to form new student chapters of PNHP. Eight medical students from the area attended the SNaHP Summit on March 5 in Nashville, where they were inspired to plan single-payer events on their campuses. In May, PNHP's Atlanta chapter will host a special meeting on mental health care under a single-payer system with Dr. Leslie Gise, a longtime PNHPer from Hawaii who has been active in organizing psychiatrists. Chapter members will also assist at the PNHP booth at the national meeting of the American Psychiatric Association (APA) May 15-17. Contact Dr. Kahn at hkahn@emory.edu.

In **Kentucky**, Kentuckians for Single-Payer Health Care (KSPH) worked with the chair of the state's House Health and Welfare Committee to arrange a screening of "Fix It" before the full committee on Jan. 14. At the end of the film the chair expressed hope that the film could be shown to the full Legislature. On Feb. 22, KSPH sponsored a showing of the film at Louisville's public library. The event drew 100 people who, in addition to seeing the movie, heard panelists including a state lawmaker, the president of the University of Louisville SNaHP chapter, a leader of a Latino community center, and a professor of medicine at the University of Louisville. The event was led by KSPH leader Kay Tillow. A lively discussion with the audience ensued. Contact Dr. Garrett Adams at KYHealthCare@aol.com.

In **Illinois**, the PNHP chapter has been mentoring medical students to spread the single-payer message. The chapter sponsored four local Student National Medical Association students to give a presentation on "Single Payer Health Care" at the annual SNMA Medical Education Conference in Austin, Texas, in March. Dr. Susan Rogers and University of Illinois at Chicago medical student Nasya Mendoza-Elias organized a PNHP table at the regional Latino Medical Student Association meeting in Cincinnati where Dr. Rogers also presented a well-received talk. PNHP member Dr. Peter Orris and University of Illinois at Chicago medical student Jim Curry presented a resolution in support of single-payer health care at the Chicago Medical Society meeting this February. Curry organized the testimony of medical students and PNHP supporters at the meeting. Although the original resolution did not pass, a resolution calling for a study of single payer did. For more, see page 27. Contact Dr. Anne Scheetz at annescheetz@gmail.com.



Dr. Susan Rogers



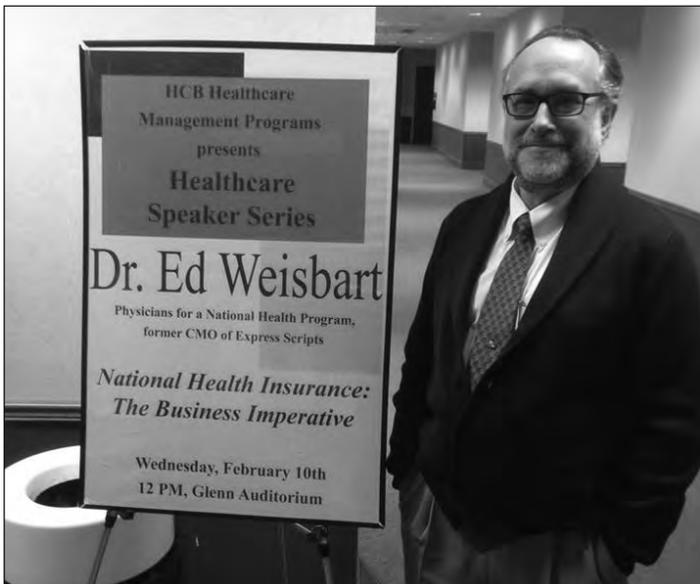
Illinois med student John Elue speaks at a single-payer workshop at SNMA's meeting in Austin, Texas.

In **Maryland**, PNHPers continue to support Healthcare is a Human Right Maryland, a grassroots organizing campaign, in conjunction with Healthcare-Now Maryland and United Workers. The campaign's five chapters have been showing "Fix It" around the state, including a showing for a local Chamber of Commerce. Maryland PNHP is also considering a campaign to de-privatize the state's Medicaid system, following the examples of Connecticut and Oklahoma. Drs. Eric Naumburg and Margaret Flowers' presentation to medical students at Johns Hopkins was well received. Contact Dr. Eric Naumburg at hchrmaryland@gmail.com.

In **Minnesota**, PNHP partnered with the Minnesota Nurses Association, Take Action Minnesota, The Land Stewardship Project, and other local organizations to organize a collaborative "Single Payer Day" at the state capitol on March 31. The chapter is planning an educational conference on May 7 titled "Univer-

sal Health Care: Studies and Solutions from Around the Globe” with Wendell Potter giving the keynote address, and the Theater of Public Policy performing during lunch. The program will feature two panels on international health systems, and breakout topics will include Environmental Racism, Healthcare and Black America; Healthcare and Refugees; Transitioning to Single Payer; and Why Women Need Health Care, among others. Minnesota Gov. Mark Dayton included a request for \$500,000 to study single payer in his supplemental budget proposal March 15. Contact Amanda Shoberg at amandapnhp@gmail.com.

In **Missouri**, the PNHP chapter has kept up a busy speaking schedule with nearly 50 single-payer presentations in the past year. The chapter is successfully using creative social media tools for outreach. Its regular Facebook posts are attracting a substantial number of views, and a longer editorial on its Facebook page this spring by PNHP Missouri board member Dr. Mark Krasnoff was viewed by 2,884 people. Building off this success, the chapter also circulated the piece as an email blast, generating the most supportive email traffic in the chapter’s history. Chapter leader Dr. Ed Weisbart credits the quality of the editorial for its success, but also believes that interest in single payer is on the rise in Missouri. Contact Dr. Ed Weisbart at edweisbart@gmail.com.



Dr. Ed Weisbart at a recent talk he gave in Missouri.

In **Nevada**, Dr. Sean Lehmann of Carson City is Chair of the new PNHP chapter while Dr. Joanne Leovy of Las Vegas is vice chair. Dr. Leovy had a letter to the editor published in the Las Vegas Sun and Dr. Lehmann had an op-ed published in the Nevada Appeal. Additionally, Dr. Lehmann addressed the Carson City Democratic Committee on the need for single-payer reform. His comments were well received and the party is considering support for single payer as part of its platform. Contact Dr. Joanne Leovy at nevadapnhp@gmail.com.

In **New Hampshire**, the Granite State Chapter of PNHP sponsored a single-payer-study bill in the New Hampshire Legisla-

ture, which the Commerce Committee voted down. However, the Committee on Health and Human Services has held two hearings on a bill to establish a commission to study single payer; the final outcome is pending. The chapter participated in an energetic Medicare-for-all rally at the New Hampshire State House. PBHP supporter Ed Helm arranged for both the documentary film “Fix It” and “The Healthcare Movie” to be streamed by Community Access Television across the state. Contact Dr. Donald Kollisch at donald.o.kollisch@dartmouth.edu.

In **New Orleans**, Dr. Elmore Rigamer is using the documentary film “Fix It” to educate his community about single payer. The documentary, which focuses specifically on the business case for single-payer reform, has been well received by more conservative, business, and non-traditional audiences. Dr. Rigamer is currently working with city official Nancy Marshall to show the film to wider audiences. Contact Dr. Rigamer at erigamer@ccano.org.

In **New York**, 35 medical students from eight local SNaHP chapters traveled to Albany on Feb. 2 to lobby in support of the state’s single-payer bill. Assemblyman Richard Gottfried and state Senator Bill Perkins convened a panel on health equity on Feb. 13. PNHP New York Metro Board member Dr. Donald Moore participated in the panel, which was also sponsored by the Black, Puerto Rican and Asian caucuses. The chapter also funded stipends for 19 medical students to attend the fifth annual SNaHP Summit in Nashville on March 5. Contact Katie Robbins at katie@pnhpnymetro.org.



Students join Assemblyman Gottfried, right, on Lobby Day.

In **Oregon**, the PNHP chapter sponsored a March 7-11 speaking tour by Dr. Josh Freeman, longtime PNHP member and chair of the Family Medicine Department at the University of Kansas Medical School. About 300 people heard his talks to medical and community audiences around the state. In 2015, the Oregon Legislature passed a bill allocating \$300,000 for a study to compare state single-payer health reform to two other options. The Oregon Health Authority contributed another \$100,000, but the state has yet to announce a contractor. To keep the Legislature on track, PNHP Oregon and Health-

care for All Oregon are sponsoring municipal advisory ballot measures urging the legislature to create a public process for creating a universal system. Contact Dr. Mike Huntington at mchuntington@comcast.net.

In **Tennessee**, the Nashville PNHP chapter provided assistance to the Vanderbilt Students for a National Health Program chapter, which hosted the fifth annual student summit on March 5. About 170 students attended the summit from 48 schools around the country. Nashville PNHP members Dr. Carol Paris and Dr. Reid Finlayson participated in a “Flash Mentoring” session during the program, and Vanderbilt SNaHP leader Mitchell Hayes co-presented a workshop titled “Single Payer 101.” Vanderbilt professor Dr. Stephen Raffanti gave the keynote presentation. Anand Saha, a PNHP student board representative and Eastern Tennessee State University medical student, reports that all five medical schools in the state now have SNaHP chapters. Contact Dr. Art Sutherland at asutherland523@gmail.com.



Vanderbilt SNaHP leader Mitchell Hayes advises a student colleague at the SNaHP Summit.

In **Western Washington**, the PNHP chapter hosted its annual public meeting on Feb. 20. The program featured Donna Smith, executive director of Healthcare for all Colorado and executive director of Progressive Democrats for America, and John Nichols, senior national affairs correspondent for *The Nation* magazine. Over 100 supporters attended the meeting, which was themed, “Fixing Health Care: Principles Versus Profits.” As part of the program, “The Healthcare Movie” filmmakers Laurie Simons and Terry Sterrenberg were awarded the John Geyman Health Justice Advocate Award.



Dr. John Geyman presents the John Geyman Health Justice Advocate Award to Laurie Simons and Terry Sterrenberg in Seattle.

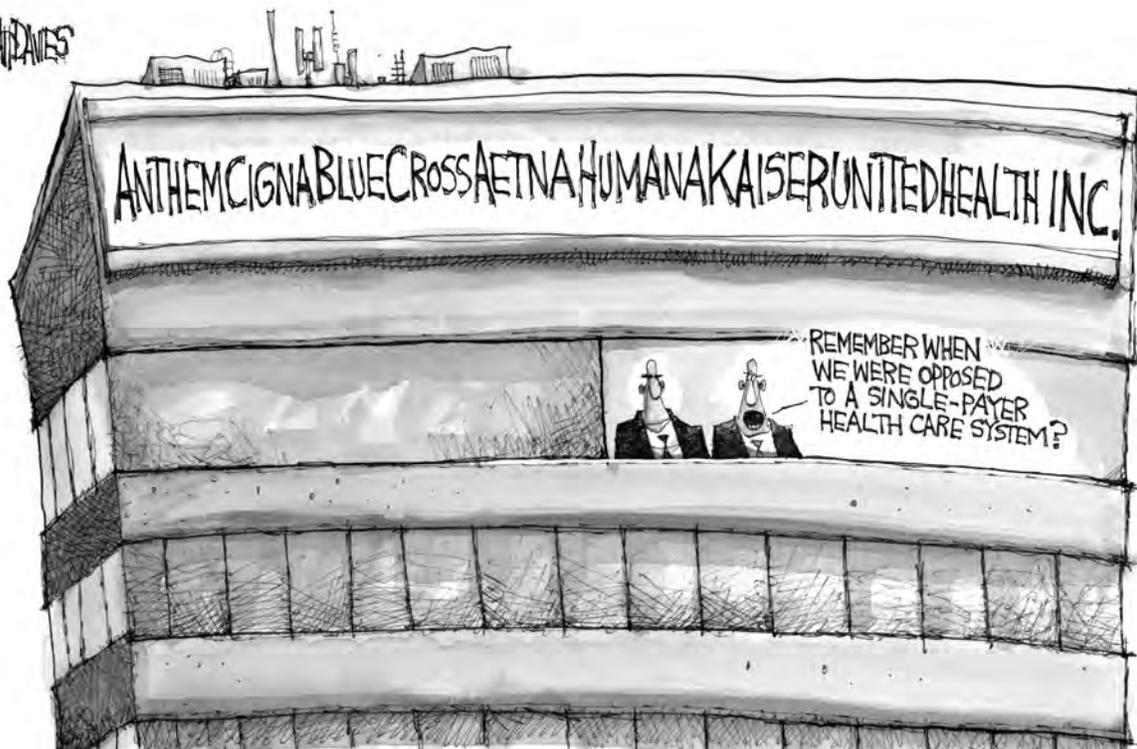
award. You can see all of the presentations from the annual meeting at www.pnhpwesternwashington.org. Prior to the annual meeting, SNaHP members at the University of Washington hosted a private meeting with Donna Smith attended by over 30 students. Smith also gave several media interviews during her visit. Contact Dr. David McLanahan at pnhp.westernwashington@comcast.net.

In **Wisconsin**, the Linda and Gene Farley Chapter of PNHP organized several screenings of the documentary film “Fix It” for chapter and community members at the Madison Public Library. Seven medical students from the PNHP student chapter at the University of Wisconsin attended the SNaHP Summit in Nashville on March 5, and put their newly honed skills to work during the SNaHP chapter’s lobby day for H.R. 676 on March 9. Prior to contacting elected officials, students gathered to discuss the “dos and don’ts” of lobbying and learn from the personal experiences of two University of Wisconsin faculty who are active members of PNHP. Students met with Jasmine Badreddine, an aide to U.S. Sen. Tammy Baldwin of Wisconsin, and with U.S. Rep. Mark Pocan, who is a co-sponsor of H.R. 676. Congressman Pocan encouraged students to talk about the benefits of single-payer health care whenever possible and to continue asking elected officials to pledge their support. Contact Dr. Melissa Stiles at melstiles1@gmail.com.



PNHP members and medical students at the Wisconsin Lobby Day in Madison.

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