

## Obama plan leaves 23 million uninsured

### Sooner, rather than later, our nation must adopt a single-payer, Medicare-for-all health reform

The recently passed reform will expand Medicaid and provide partial subsidies to low-income Americans for the purchase of bare-bones private coverage starting in 2014. But like several states that have passed similar reforms, the Obama health plan will predictably fail to control costs, jeopardizing any long-term gains in coverage. Indeed, there are already concerns that employers will react to the bill by dropping coverage for their workers, choosing instead to pay lower-cost fines. For PNHP's statement on the bill, comparison to states that have tried similar plans in the past, and more, see the special section on the Obama Health Plan, pages 3-28, this issue.

#### Dr. Margaret Flowers on Bill Moyers, Frontline

Dr. Margaret Flowers, PNHP's congressional fellow, appeared on Bill Moyers Journal and in a PBS Frontline special that aired in April. PBS' ombudsman concluded that the latter show had been unfairly biased against single payer after he received nearly a thousand complaints about its failure to mention the single-payer reform option (despite a lengthy advance interview with Dr. Flowers and the airing of a video depicting her arrest protesting the Senate Finance Committee's exclusion of single-payer testimony). Dr. Paul Song appeared on "Larry King Live," and Dr. Steffie Woolhandler and Dr. Claudia Fegan appeared on Fox News. These were just a few of the many media appearances by PNHPers during the reform debate. Print, radio, and blog coverage also featured PNHPers. See [www.pnhp.org](http://www.pnhp.org) for video of more PNHPers in the news.



#### Campaigns for state single-payer plans, divestment from private insurers

In addition to PNHP's ongoing work in support of national single-payer reform, PNHPers in over a dozen states are active in campaigns for state single-payer legislation, including in California, where single payer has twice passed both houses of the Legislature and a major push is planned for 2010-2012. In addition, Indiana PNHPer Dr. Rob Stone "sees the day when socially responsible investors will divest themselves from health insurers' stocks." He's initiating a national campaign to divest from private insurers, starting with Indiana's WellPoint. See "WellPoint shareholders revolt!" page 30.

## Insurers add no value to U.S. health system

The chief of the Washington Bureau of Financial Times, Edward Luce, endorsed single payer in an April 30 appearance on C-SPAN, noting its ability to control costs and improve global competitiveness. Single payer "would help begin to solve America's fiscal problem," he said. Health economists who study the private health insurance industry have concluded that the industry is not adding any value to the U.S. health system and that mergers have raised premiums, according to Northwestern University's Leomore Dafny. For details on these and other developments, see Data Update, page 7.

#### PNHP Annual Meeting Nov. 5-6, 2010, Denver, CO

PNHP's 2010 Meeting will be held on Saturday, Nov. 6, in Denver at the Sheraton Denver Downtown Hotel. It will be preceded by PNHP's popular leadership training institute, a one-day course in health policy and politics, on Friday, Nov. 5. Reserve your room (\$149 single/double) before Oct. 5 at 800-325-3535.

Nearly 300 PNHPers, including over 50 medical students, participated in our 2009 Annual Meeting last October in Cambridge, Mass. In addition to PNHP leaders, speakers included Dr. Marcia Angell, economist Dr. William Hsiao, journalist T.R. Reid, Sen. Bernie Sanders, Rep. Anthony Weiner and Cigna whistleblower Wendell Potter.

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## Welcome new PNHP members, chapters

Welcome to 1,971 new members who have joined PNHP in the last year! PNHP now has over 17,500 members. We invite new (and long-time) PNHP members to participate in our activities and take the lead on behalf of PNHP in their community.

PNHPers in Alabama, Colorado (northern), New Jersey, Tennessee (middle and northeast), Texas, West Virginia (upper Potomac) and Wisconsin are starting or reinvigorating PNHP chapters in their areas. To get involved in a PNHP chapter near you, see the chapter reports, page 66, or contact our national chapter organizer Ali Thebert at ali@pnhp.org.

PNHP is hosting exhibits at several medical specialty meetings this year, including the American College of Physicians, American Psychiatric Association, American College of Emergency Physicians, American Academy of Family Practice, and the American Academy of Pediatrics. PNHPers attending these meetings are encouraged to contact Matthew Petty at matt@pnhp.org to volunteer to help with recruiting at the booth.

## Single-payer supporter to head ACP

Vermont PNHPer Dr. Virginia Hood is the president-elect of the American College of Physicians, the second largest medical association in the U.S. Congratulations, Dr. Hood!

### What PNHP members can do

1. Give a grand rounds presentation on the grave problems in health care that will persist despite the recently enacted reform and the need for single-payer national health insurance. Updated slides covering the new health law ([www.pnhp.org/slideshows](http://www.pnhp.org/slideshows), password = fein) are now available. To invite another speaker, call the PNHP national office at (312) 782-6006.
2. Write an op-ed or letter to the editor for your local newspaper, medical association or specialty society publication. Dr. John Day's article appeared in the American Journal of Respiratory and Critical Care Medicine (see page 32).
3. Introduce a resolution supporting single payer to your medical specialty society. Sample resolutions are available online at [www.pnhp.org/resolution](http://www.pnhp.org/resolution).
4. Join or renew your membership in PNHP online today at [www.pnhp.org/join](http://www.pnhp.org/join).
5. Encourage your colleagues to join PNHP.

## NOW, unions endorse single payer

The 500,000 member National Organization for Women reaffirmed its support for single payer in March. NOW's national president, Terry O'Neill, criticized the Obama plan for its reliance on the "failing, profit-driven private insurance system," its abortion restrictions, and its gender- and age-rating provisions. Labor support for single payer continues to grow. Single-payer legislation has been endorsed by 581 union organizations in 49 states, including 39 state chapters of the AFL-CIO.

OBSERVATIONS: U.S. HEALTH REFORM

# Obama's reform: no cure for what ails us

By David U. Himmelstein and Steffie Woolhandler

*As the applause fades for President Obama's health reform, David Himmelstein and Steffie Woolhandler fear that the new law will simply pump funds into a dysfunctional, market-driven system*

It was a stirring scene: President Obama signing the new health reform law before a cheering crowd,



and a beaming vice president whispering in his ear, "This is a big fucking deal." As doctors who have labored for universal health care, we'd like to join the celebration, but we can't. Morphine has been dispensed for the treatment of cancer – the reform may offer a bit of temporary relief, but it is certainly no cure.

The new law will pump additional funds into the currently dysfunctional, market-driven system, pushing up health costs that are already twice those in most other wealthy nations. The Medicaid public insurance program for poor people will expand to cover an additional 16 million poor Americans, while a similar number of uninsured people with higher incomes will be forced to buy private policies. For the "near poor" the government will pay part of these private premiums, channeling \$447 billion in taxpayer funds to private insurers over the next decade.

Unfortunately, private insurers win in the marketplace not through efficiency or quality but by maximizing revenues from premiums while minimizing outlays. They pursue this goal by avoiding the sick and forcing doctors and patients to navigate a byzantine payment bureaucracy that currently consumes 31 percent of total health spending. The health reform bill's requirement that uninsured people buy insurers'

defective products will fortify these firms financially and politically.

Meanwhile insurers will exploit loopholes to dodge the law's restrictions on their misbehaviors. For instance, the limit on administrative overheads will predictably elicit accounting gimmickry, for example by relabeling some insurance personnel as "clinical care managers." While insurers are prohibited from

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"cherry picking" – selectively enrolling healthy, profitable patients – they've circumvented similar prohibitions in the Medicare health maintenance organizations (HMOs). The ban on revoking policies after an individual falls ill similarly replicates existing but ineffective state bans.

Sadly, even if the reform works as planned, 23 million people will remain uninsured in 2019. Meanwhile public and other safety net hospitals that uninsured people rely on will have to endure a \$36 billion cut in federal government funding.

Moreover, many Americans will be left with coverage so skimpy that a serious illness could lead to financial ruin. At present, illness and medical bills contribute to 62 percent of all bankruptcies, with three-quarters of the medically bankrupt being insured. The reform does little to upgrade this inadequate coverage; it man-



BMJ 2010;340:c1778

dates that private policies need cover only 70 percent of expected medical costs. The president has often promised that "if you like your current coverage you can keep it." Yet Americans who now get job based insurance will be required to keep it – whether they like it or not. And many who receive full coverage from an employer will face a steep tax on their health benefits starting in 2018.

Soaring costs and rising financial strains seem inevitable, despite claims that the reform will "bend the cost curve." Computer vendors have trumpeted imminent cost savings for half a century (see, for instance, a video made by IBM in the 1960s, available at <http://bit.ly/cckdtB>). Prevention, though laudable, does not generally reduce costs. Windfalls from prosecuting fraud and abuse have been promised before. The new Medicare advisory board merely tweaks an existing panel. Without an enforcement mechanism,

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stepping up comparative effectiveness research cannot overcome drug and equipment makers' promotion of profligate care. Existing insurance exchanges where patients can compare and shop among private plans haven't slowed growth in costs for public workers nationally or in California. And the mandated experiments with capitated payment systems are warmed-over versions of President Nixon's pro-HMO policies and subsequent failed initiatives to fix America's health cost crisis through managed care.

Experience with reforms in Massachusetts in 2006 – the template for the national bill – is instructive. Our state's costs, already the highest of any state,

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grew by 15 percent in the first two years after reform, twice the national rate. Moreover, capitated physician groups had costs at least as high as those who were paid on a fee-for-service basis. Meanwhile, after initial improvements in the state, access to care has begun to deteriorate, and the state has begun to cut back coverage.

Overall, President Obama's is a conservative bill, drafted in close consultation with the drug and insurance industries. Its modest salutary provisions – such as an extra \$1 billion a year for community health centers and the expansion of Medicaid – mirror measures that have been passed even under Republican regimes. Its central tenet, that the government should force citizens to buy coverage from a for-profit firm, was first proposed by Richard Nixon when faced with the seeming inevitability of national health insurance in 1972. Similarly, Mitt Romney, a favorite of conservatives, embraced the Nixon approach as Massachusetts governor in 2006, a stance he has now abandoned. Democrats, having retreated from their traditional push for national health insurance, freed Republicans to move still further to the right.

Throughout the reform debate we, and the 17,000 others who've joined Physicians for a National Health Program, advocated for a far more thoroughgoing reform: a non-profit, single payer national health insurance program. We will continue to do so. Our health care system has not been cured or even stabilized. For now, we will continue to practice under a financing system that obstructs good patient care and squanders vast resources on profit and bureaucracy.

Passage of the health reform law was a major political event. But for most doctors and patients it's no "big fucking deal."

*David U. Himmelstein, M.D., is associate professor of medicine at Harvard Medical School and Steffie Woolhandler, M.D., M.P.H., is professor of medicine at Harvard Medical School. They are also co-founders of Physicians for a National Health Program.*

# No Time to 'Wait and See' on Health Law

BUILDING THE SINGLE-PAYER MOVEMENT

By Dr. Quentin Young

Having just gone through a grueling, frequently raucous debate on health reform, capped by the narrowest of votes to pass the Obama administration's bill, many activists are now tempted to adopt a "wait-and-see" attitude on how the new law plays out.

A few others are putting their emphasis on helping the administration implement the law, in some cases enthusiastically trumpeting their strange-bedfellow partnership with the profit-hungry health insurers and Big Pharma. Still others – the hostile, noisy Know-Nothings associated with the Republicans and Tea Party crowd – continue to rail against President Obama's "socialized medicine" plan (a misnomer if there ever was one) and pledge to obstruct or overturn it. Conservatives vow to make political hay out of the law in the run-up to the midterm elections.



**Supporters of single-payer national health insurance face several challenges, the chief of which is how to transform the various efforts of single-payer Medicare-for-All activists into a movement for political and legislative success.**

Wall Street, on the other hand, is very comfortable with the new legislation. Mutual fund analysts now say it's increasingly clear that the law is beneficial for health industry stocks, particularly for pharmaceutical and medical equipment companies, because there are no "onerous cost controls" in the law. And health insurance company stocks continue a yearlong trend upward, and the industry's CEO salaries continue to be astronomical.

After all, the health insurers wrote the bill. Sen. Max

Baucus was recently caught on tape heaping effusive praise on his aide Elizabeth Fowler for her pivotal role in crafting the legislation. Fowler is a former vice president of WellPoint, the giant health insurer.

Baucus himself, a key actor in this bad movie, was surrounded by health industry lobbyists from the very beginning, and he has received more than \$2.8 million in campaign contributions from these toxic sources over the past few years. That he earned his payoff was demonstrated when Karen Ignagni, the president of America's Health Insurance Plans, congratulated him (during the April 13 episode of "Frontline") on his handling of the single-payer nonviolent disruption of his Senate Finance Committee hearing after single-payer advocates like Dr. Margaret Flowers were excluded from giving testimony.

Supporters of single-payer national health insurance face several challenges, the chief of which is how to transform the various efforts of single-payer Medicare-for-All activists into a movement for political and legislative success.

## Key tasks for single-payer activists now:

- Educating candidates for political office (and current officeholders) from all political parties about the merits of the single-payer proposal, and offering to advise them on health policy matters.
- Ensuring the reintroduction and largest possible legislative sponsorship for national single-payer bills like Rep. John Conyers' H.R. 676 and Sen. Bernie Sanders' S. 703.
- Supporting efforts (including a change in the new law) to permit states to experiment with their own, independent single-payer models of reform right away.
- Defending Medicare from harmful budget cuts and educating Medicare beneficiaries about their self-interest in improving and expanding the program to cover everyone, i.e., embracing the slogan, "Everybody in, nobody out."
- Continuing our educational work about the merits – nay, the necessity – of adopting a single-payer system. The sooner we initiate a truly universal, egalitarian, humane and efficient system, the sooner the American people will enjoy the high-quality health care our nation and our health professionals are capable of providing.

A major burden the enactment of the new law imposes on single-payer advocates is its timeline. Specifically, major elements in the legislation do not kick in for two, four or even eight years' time.

But "wait and see" is not an option for us. The legislation that just passed is completely inadequate to the task at hand.

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Under the new law, the suffering and financial hardship imposed on Americans by our private-insurance-based system will largely continue unabated for four more years, and then only be subject to very modest regulation. (Loopholes in the law abound.) More than 50 million people will remain uninsured until 2014, which translates into 50,000 preventable deaths annually. A comparable number will remain underinsured, with many vulnerable to medical bankruptcy when serious illness strikes, even after 2014.

Even if the new law works as planned, at least 23 million people will remain uninsured at 2019. So "universal health care" remains a dream deferred.

That spells human misery. This week a new Harvard-based study showed that people with migraines who lack health insurance, or who are on Medicaid, disproportionately suffer from their condition because they can't get access to the standard medications they need to reduce their pain and other symptoms. And that's just one example of the unnecessary suffering that lies in wait.

Meanwhile costs, including for health insurance premiums, will continue to escalate.

The unrelenting advocacy of single payer by Physicians for a National Health Program also stems from a careful study of repeatedly unsuccessful experiments with state-based reforms based on private insurance, including the Massachusetts plan (upon which the new law is modeled). The evidence is clear: incremental reforms of this type – based on the private-insurance model – will not work. They invariably succumb to skyrocketing costs.

Single-payer Medicare for All is the reform that's required. Just like almost all other major areas of progress in American life, fundamental health reform requires a movement based on equity, justice, prudence and science that is free of market greed. That movement today is single payer.



Jack Ohman / The Oregonian

# Data Update

## UNINSURED AND UNDERINSURED

▶ 46.3 million Americans, including 7.4 million children, were uninsured in 2008, the most recent year for which complete data are available, up from 45.7 million in 2007 primarily due to a continuing decline in employer-sponsored coverage. 58.5 percent of the population was covered by employer-sponsored coverage in 2008, down from 64.2 percent in 2000. The Children's Health Insurance Program has reduced the number of uninsured children 23 percent, from 9.0 million, since 1999. The health reform bill recently signed by President Obama will leave at least 23 million Americans without coverage, including millions of children (Bureau of the Census, 9/09).

Lack of health insurance increases the risk of a child dying during hospitalization by 60 percent, according to researchers at Johns Hopkins School of Medicine. They estimate that an excess of 16,787 hospitalized children have died over the past 18 years due to a lack of health insurance (Abdullah, et al, "Analysis of 23 million U.S. hospitalizations: Uninsured children have higher all-cause in-hospital mortality," *Journal of Public Health* 10/19/09).

▶ Medicaid rolls grew by 7.5 percent, 3.3 million people, between June 2008 and July 2009 – the largest one-year increase on record. Enrollment increased in all 50 states. About 46.9 million Americans, including those eligible for both Medicare and Medicaid, were covered by Medicaid last year. An estimated 16 million people will gain Medicaid coverage under the new health law, but the coverage won't start until 2014 (USA Today, 2/13/10).

▶ Interruptions in Medicaid coverage, a common occurrence, are associated with a higher rate of hospitalization for ambulatory care-sensitive conditions like heart failure, diabetes, and chronic obstructive pulmonary disease. A study of 4.7 million non-elderly Medicaid beneficiaries in California showed more than 60 percent had some interruption in their coverage between 1998 and 2002; the average interruption was 25 months. Beneficiaries whose benefits were interrupted had a substantially higher risk of hospitalization for ambulatory care-sensitive conditions than did those with continuous coverage (Bindman, A.B., et al. Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions. *Annals of Internal Medicine*, 2008).

▶ Often-touted as a model for the "exchange" in the health reform legislation, the Federal Employees Health Benefits Program (FEHBP) has failed to control costs or cover all fed-

eral workers. Jacqueline Simon, policy director for the American Federation of Government Employees, estimates "there are about 250,000 federal employees who are uninsured. They're eligible, but they can't afford the premiums" (AP, "How health care bills compare to lawmakers' plan," 12/6/09).

Insurance with a deductible exceeding \$1,000 is increasingly prevalent. 22 percent of workers were enrolled in high-deductible plans in 2009, up from 10 percent in 2006. Among smaller firms, high deductible plans now account for 40 percent of coverage, up from 16 percent in 2006 (Kaiser, *Employer Health Benefits: 2009 Annual*, 9/09).

▶ 60 percent of Americans say they or a member of their household "delayed or skipped health care in the past year" due to cost. 36 percent reported skipping dental care or checkups, and 29 percent skipped filling a prescription due to cost (Kaiser Health Tracking Poll, April 2009).

▶ Miami's public hospital system stopped providing outpatient kidney dialysis for the indigent in January. At least 175 patients have been left at the mercy of emergency-room dialysis visits. Medicaid finances such visits, but those ineligible for Medicaid – such as immigrants – are now left with no options. (Kevin Sack, "Hospital Cuts Dialysis Care for the Poor in Miami," *The New York Times*, 1/8/10).

▶ Lack of health insurance significantly increases the risk of mortality. An estimated 44,789 excess deaths occurred in 2008 due to the lack of health insurance, including 2,266 excess deaths among veterans (A. Wilper, S. Woolhandler, et al, "Health Insurance and Mortality in US Adults," *American Journal of Public Health* 99:12 Dec 2009, and S. Woolhandler and D. Himmelstein, "Over 2,200 veterans died in 2008 due to a lack of health insurance," [www.pnhp.org/news](http://www.pnhp.org/news) 11/10/09).

▶ The uninsured are far more likely to have undiagnosed serious illnesses and to forgo needed care than the insured. 46 percent of uninsured patients with diabetes are unaware of their condition, compared to 23.2 percent of the insured. Similarly, 52.1 percent of uninsured patients with high cholesterol are unaware of their condition, compared to 29.9 percent of the insured. In addition, uninsured patients with a known serious illness are more likely to forgo treatment. Although data on under-insured patients is not available, it is likely that the human cost of under-insurance is also high. (A. Wilper, S. Woolhandler, et al, "Hypertension, Diabetes, and Elevated Cholesterol Among Insured and Uninsured US Adults," *Health Affairs Web Exclusive*, October 2009).

## COSTS

► U.S. health spending in 2009 was an estimated \$2.5 trillion, \$8,047 per capita, 17.3 percent of GDP. Expenditures are projected to reach \$4.48 trillion by 2019, 19.3 percent of GDP (GAO, February 4, 2010).

► Health insurance premiums for employer-sponsored coverage averaged \$4,824 for individual and \$13,375 for family policies in 2009, with employees bearing 16.1 percent and 26.3 percent of the cost, respectively (Kaiser Foundation Employer Health Benefits: 2009 Annual Survey Sept, 2009).

Total healthcare costs for a typical family of four increased to \$18,074 in 2010, up \$1,303 or 7.8% from 2009, according to the actuarial firm Milliman. The firm tracks average yearly costs for a family covered by an employer-sponsored PPO (Milliman Medical Index, Modern Healthcare, 5/11/10).

► 62.1 percent of bankruptcies in 2007 were medically related, up from 46.2 percent in 2001, according to a study by PNHP co-founders Drs. Steffie Woolhandler and David Himmelstein with Deborah Thorne of Ohio University and Elizabeth Warren of Harvard Law School. More than three-quarters of those bankrupted (77.9 percent) were insured at the start of the bankrupting illness, and most

were solidly middle class. Medically bankrupt families with private insurance reported medical bills that averaged \$17,749 vs. \$26,971 for the uninsured (D. Himmelstein et al, "Medical Bankruptcy in the United States, 2007: Results of a national Study," The American Journal of Medicine June, 2009).

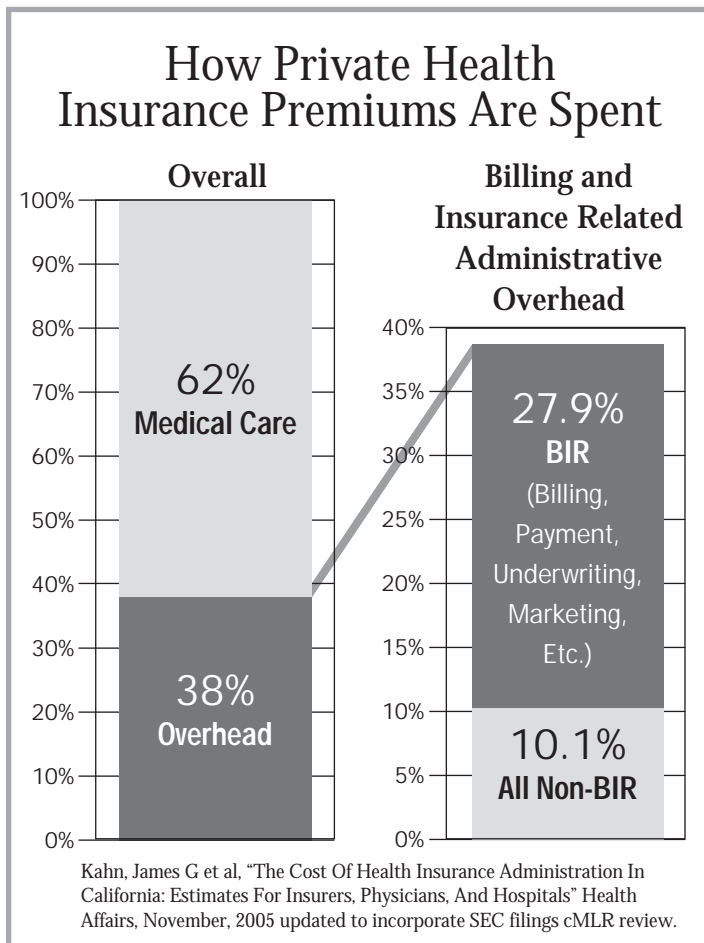
► Medicare spending is significantly higher for previously uninsured seniors with cardiovascular disease, diabetes or severe arthritis (\$5,796) than for previously insured (\$4,773) seniors with the same conditions. Previously uninsured adults had higher adjusted annual hospitalization rates, accounting for 65.7 percent of the \$644 difference in annual Medicare inpatient spending between all previously uninsured and insured adults (McWilliams, et al. "Medicare Spending for Previously Uninsured Adults," Annals of Internal Medicine, October 5, 2009).

► Worldwide, there's a strong correlation between national income (GDP) and national health expenditure. According to the Organization for Economic Cooperation and Development (OECD), the US is the only statistical outlier. Based on the average correlation, the U.S. is spending about \$2,500 more per capita than it should, or an excess of about \$750 billion annually (OECD Health Data 2009).

## SOCIOECONOMIC INEQUALITY

► American adults report worse health than residents of 10 nations in Europe and England. Americans are less healthy than Europeans at all wealth levels, but the poorest Americans experience the greatest disadvantage relative to Europeans. Eighteen percent of Americans report heart disease, compared with 11 percent of Europeans and 12 percent of the English. Health disparities by wealth are significantly smaller in Europe than in the United States and England. The odds ratio of heart disease in a comparison of the top and bottom wealth tertiles were 1.94 in the U.S., 2.13 in England, and 1.38 in Europe (Avendano, M, Glymour, M, Banks, J, and Mackenbach, J. Health Disadvantage in US Adults Aged 50 to 74 Years: A comparison of the health of rich and poor Americans with that of Europeans, AJPH, March 2009).

► The life expectancy of all Americans is lower than that of all Canadians. Until the 1970s, this disparity was attributable to a low life expectancy among African Americans. Since then, however, the life expectancy of white Americans has not improved as much as that of all Canadians. Canada's system of national health insurance has contributed to these differences (Kunitz, S.J., and Pesis-Katz, I. Mortality of White Americans, African Americans, and Canadians: The Causes and Consequences for Health of Welfare State Institutions and Policies. Milbank Q. 83, 2005).





► Economic inequality has increased substantially in the U.S. since the early 1970s. Inequality in mortality by socioeconomic status increased from 1960 to 1986, a trend that accelerated from 1986 to 2000. A comparison of age-adjusted mortality rates by educational attainment for 1960, 1986, and 2000 revealed that improvements in mortality accrued disproportionately to those with the most education (Hadden, W.C., and Rockwold, P.D. Increasing Differential Mortality by Educational Attainment in Adults in the United States. *International Journal of Health Services*, Vol 38, 2008).

## MONEY AND POLITICS

### Health Industry Spent \$3.1 billion on lobbying Congress 2008-2009

Pharmaceutical companies, medical device firms, and health insurers spent over \$2.3 billion lobbying Congress in 2008 and 2009. Hospitals and nursing homes spent \$397 million on lobbying during that period, while health professional associations spent \$289 million. The top spenders by firm were PhARMA (\$63.7 million), Pfizer (\$45.1 million) and Blue Cross and Blue Shield (\$45.3 million), closely followed by the AMA (\$43.1 million) and the American Hospital Association (\$41.6 million). America's Health Insurance Plans spent \$18.5 million, while insurance giant UnitedHealth Group spent \$13.5 million. Altogether, the health care industry spent \$3.1 billion on lobbying in the two years leading up to the passage of health reform. The American Association of Retired Persons, which receives a third of its revenues from the sale of private insurance to its members, also topped the lobbying charts in 2008-2009, spending \$49.1 million (See chart, reprinted on page 24 from [www.OpenSecrets.org](http://www.OpenSecrets.org)).

In addition the health industry made \$243 million in contributions to political campaigns in the 2008 and 2010 election cycles. As of late March, drug and medical device firms had invested \$46.3 million in campaign contributions for the 2008 and 2010 elections; they split their contributions about equally between Democrats and Republicans, as did insurers and health professional associations. Insurers donated \$29.1 million to campaigns over the same period. Health professional associations were by far the largest campaign donors, making \$133.1 million in contributions. Hospitals and nursing homes gave \$34.4 million to candidates, with about 60 percent going to Democrats (Open Secrets.org, based on data from the Federal Elections Commission available on March 21, 2010).

► Barack Obama received over \$7 million in campaign contributions from the health industry for his 2008 presidential campaign. Although he endorsed single payer as an

Illinois state senator in 2003, during his campaign he maintained that single payer was not feasible due to the entrenched employer-based system of U.S. health insurance (OpenSecrets.org accessed on April 21, 2010).

► Senator Max Baucus of Montana, Chairman of the Senate Finance Committee and a key player in this year's health reform debate, raised \$4.4 million from the health care industry for his campaign committee and leadership PAC during the 2008 and 2010 election cycles (as of March 21, 2010). Baucus was instrumental in keeping single payer "off the table" as an option for reform and enlisted a former WellPoint executive, Liz Fowler, to draft the Senate's Bill. He received over \$1.1 million from the pharmaceutical industry and \$697,000 from insurers. The largest single contributor to his 2008 re-election campaign was drug giant Schering-Plough, which donated \$72,200. Aetna and Blue Cross/Blue Shield gave \$45,250 and \$42,600 respectively (Open Secrets.org).

## CORPORATE MONEY AND CARE

► Profits increased 56 percent, to \$12.2 billion, at the nation's five largest health insurers in 2009. The big five – WellPoint, UnitedHealth, Cigna, Aetna and Humana – cover 101.3 million Americans, including 14.1 million with taxpayer-funded coverage through Medicaid managed care or Medicare Advantage plans. ("Health Insurers Break Profit Records as 2.7 Million Americans Lose Coverage," *HealthCare for America Now*, 2/10).

Insurance giant WellPoint has already reclassified more than half a billion dollars of administrative expenses as "clinical" to meet the minimum medical loss ratios specified by the new health reform law. Minimum medical loss ratios (80 percent for individual and small group policies, and 85 percent for large group plans) won't go into effect in 2011, but Wellpoint, Aetna (see below) and other insurers are already skilled and highly motivated to reclassify administrative expenses as medical expenses, according to an investigation by the Senate Commerce Committee. "Every basis point [.01 percent] these companies can shift from the "administrative" to the "medical" expense column is money these companies can retain as potential profit, rather than refund to their policyholders." ("Implementing Health Insurance Reform: New Medical Loss Ratio Information for Policymakers and Consumers," Senate Committee on Commerce, Science, and Transportation, 4/15/10).

► Aetna overstated the amount it spent on patient care in the small group market by \$4.9 billion in 2008, according to an investigation by the Senate Commerce Committee. Investigators found that Aetna's reported medical-loss ratio

- that is, the proportion of its total expenditures that are actually spent on care - was off by at least 3 percentage points. Aetna reported spending of revenue on care, while the real figure was 79 percent. (Avery Johnson, "Aetna Overstated Spending on Patient-Care Category," Wall Street Journal, 12/8/09).

### **Private health insurance does "not add value" to the U.S. health system**

Physicians probably won't be surprised to learn this, but others might be: Health economists who study the private health insurance industry have concluded that "private health insurance does not add value" to the U.S. health system. Indeed, such a conclusion is so firm that it has been "taken for granted" among U.S. health economists for the past five years.

A recent conference of health economists (March 22 and 23, 2010) at the Federal Reserve Bank of Chicago highlighted numerous findings along these lines, including that increasing consolidation in the insurance industry has led to higher premiums, fewer jobs for health care workers and reduced physician earnings. The 1999 merger of Aetna and Prudential resulted in a 2.8 percent increase in premiums for employer-sponsored plans, a 2.4 percent decrease in health worker employment, and a 2 percent reduction in physician pay. Nearly all Americans now live in markets dominated by a tiny number of health insurers; between 1998 and 2006 the proportion of "highly concentrated" local insurance markets increased from 68 percent to 99 percent. (Dafny, L.S., et al. "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," National Bureau of Economic Research Working Paper w15434, October 2009).

► Despite his firm's admission to federal investigators that it improperly kept \$40 million in payments from Florida's Medicare and Healthy Kids programs, Heath Schiesser, former CEO of the managed care firm WellCare Health Plans, will receive an \$800,000 bonus and \$1.2 million separation fee in addition to his \$400,000 salary for 2009. WellCare agreed to pay an \$80 million penalty to avoid criminal prosecution. It also paid a \$10 million penalty to settle a lawsuit brought against the company by the Securities and Exchange Commission (St. Petersburg Times, 12/21/09).

► UnitedHealth Group paid \$50 million in 2009 to settle allegations of balance-billing fraud stemming from an investigation by the Office of the Attorney General of New York State. Aetna paid \$5.1 million to students and physicians as part of the same investigation, which centered on the improper [UnitedHealth Group's Ingenix research division] manipulation of data on physician fees which resulted in lower reimbursements for care. An AMA lawsuit against

Wellpoint over the same issue is pending (Kaiser Daily Health Policy Report 2/3/09 and 3/26/09, and "Health insurer accused of overcharging millions," NBC Today, 1/13/09).

### **Insurance CEO's top \$100 million in Pay**

Stephen J. Hemsley, CEO of UnitedHealth Group, reaped a windfall \$98.6 million from exercising stock options in 2009. When combined with his salary, cash bonuses and other stock-related awards, his income for 2009 exceeded \$107.5 million. Total enrollment at UnitedHealth Group was 29.3 million in 2009.

H. Edward Hanway, CEO and chairman of the board of insurance giant Cigna, garnered a total of \$104 million in pay in 2008 and 2009, including a \$73 million retirement bonus (awarded December 31, 2009) and \$31 million in salary and other compensation. Total enrollment at Cigna is about 11 million.

Before Hanway's \$73 million retirement bonus and Hemsley's \$99 million in stock options, Ronald Williams of Aetna was the top-paid CEO in the health insurance industry, garnering \$38.1 million in total compensation in 2009, including costs associated with his personal use of corporate aircraft, and \$24.3 million in 2008, for a total of \$62.4 million over the past two years. Aetna has 18.9 million enrollees.

Other top paid CEO's include Michael B. McCallister of Humana, who garnered \$43.3 million in compensation in 2008 and 2009 with 8.3 million enrollees; Angela Braly, president and CEO of WellPoint (\$18.5 million, 30.7 million enrollees), Michael Neidorff of Centene (\$14.9 million, 1.4 million enrollees) and Health Net CEO Jay Gellert (\$5.8 million, 2.9 million enrollees). These figures may underestimate CEO compensation due to underreporting and undervaluing of stock options.

Nonprofit private insurers also awarded seven-figure payouts to CEOs, including a \$7.25 million lump-sum payout to the retiring CEO of Blue Cross Blue Shield of Vermont, William Milnes Jr.

In comparison, the head of the Centers for Medicare and Medicaid Services (CMS), which has over 90 million beneficiaries, earns a salary of no more than \$200,000 a year.

(Washington Post, 4/16/10; Kaiser Health News, 3/30/10; "Cigna CEO Retires with \$73 million Bonus," Healthcare Journal of Northern California, 1/6/10; Executive PayWatch Database 2010, AFL-CIO; and "Health Care Blues," Seven Days, 1/8/09).

► The state of Minnesota ordered Allina Hospitals & Clinics to pay out \$1.1 million to patients charged illegally high interest rates. Although the state cap on medical debt-related interest rate is 8 percent, Allina had been charging as much as 18 percent ("Allina Hospitals Settles

Minnesota Interest Rate Charges, Will Reimburse Payments \$1.1M," Kaiser Daily Health Report 4/16/09).

▶ Nearly 21 percent of all medical insurance claims submitted to California's six largest insurers were rejected between 2002 and June 30, 2009. Both the state's largest for-profit health plan (Anthem Blue Cross) and its largest nonprofit plan (Kaiser) rejected approximately 28 percent of claims. (L. Girion, "HMO claims - rejection rate triggers state investigation," Los Angeles Times 9/4/09).

▶ Between her stints as Obama's national health policy czar and head of Medicare in the Clinton administration, Nancy-Ann DeParle garnered more than \$6.6 million from her service on the boards of several health care firms that were the subject of federal investigations, whistle-blower lawsuits and other regulatory actions. She received over \$2 million from DaVita Inc., an Atlanta-based chain of kidney dialysis centers that was Senator Max Baucus' (D-Mont.) fifth-largest contributor in 2008. She joined the board of Guidant Corp. in 2001, only days after the company admitted that it had covered up 12 deaths and 2,000 injuries caused by a faulty surgical device (Fred Schulte, "DeParle profited from health care companies under scrutiny," Investigative Reporting Workshop of the American University School of Communications 7/2/09).

## MEDICARE

Premiums for Medicare Advantage (MA) plans jumped 14.2 percent in 2009, on top of a 5.2 percent increase in 2008. The average monthly MA premium for 2010 is \$39.61. Payments to MA plans in 2009 were estimated to be 13 percent greater than the corresponding costs in traditional Medicare – an average of \$1,138 per MA plan enrollee, for total excess costs to taxpayers of \$11.4 billion (Associated Press, 2/19/10 and Commonwealth Fund, 5/4/09).

▶ Disease management doesn't save money or control costs. An analysis of 18,209 Medicare beneficiaries in 15 separate care coordination programs from 2002-2006 found that none of the 15 programs generated net savings and that 13 showed no significant differences in hospitalization rates (Peikes, et al., Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures among Medicare Beneficiaries, JAMA, 2/11/2009).

## BIG PHARMA

▶ 29 percent of researchers who performed drug trial work published in the Journal of Clinical Oncology between January 2006 and June 2007 had financial ties with the pharmaceutical industry. This connection was particularly

acute amongst lead study authors, who were 4.3 times more likely to have financial ties with the pharmaceutical industry than supporting authors (Johnson and Horn, "Authorship and Industry Financial Relationships: the Tie that Binds," Journal of Clinical Oncology, 1/11/10).

### Drugs companies spend \$500.7 million lobbying Congress 2008-2009

The pharmaceutical industry spent an astronomical \$263.4 million on lobbying Congress in 2009, up from its previous record high of \$237.3 million in 2008. Its lobbying expenditures have grown by 365 percent over the past eleven years, rising from roughly \$72.2 million in 1998. (These figures, from federal lobbying reports compiled by OpenSecrets.org, do not include lobbying or campaign contributions at the state level, which are also substantial).

▶ 2009 was a banner year for health industry consolidation, led by mergers of four of the world's largest pharmaceutical firms. Pfizer acquired Wyeth in October for about \$68 billion and Merck bought Schering-Plough in November for \$ 49.6 billion. Health industry mergers accounted for about 30 percent of all US mergers in 2009 (McCracken, "Mergers thrive in health industry," The Wall Street Journal 10/20/09).

▶ A Credit Suisse report on the eight largest U.S. drug makers found that wholesale prices of brand-name prescription drugs grew by 8.7 percent in 2009, the fastest rate since 1992. The rate of brand-name prescription drug cost inflation has been growing steadily since 2004, when drug prices grew an average of approximately 5 percent (Wilson, "Drug Makers Raise Prices in Face of Health Care Reform," The New York Times 11/15/09).

A Government Accountability Office inquiry requested by Sen. Charles Schumer (D-N.Y.) found that 416 brand-name medications had "extraordinary price increases" between 2000 and 2008 – mostly ranging between 100 and 499. The G.A.O. cites pharmaceutical firm consolidation, a lack of competition due to patent exclusivity and drug repackaging as the leading causes for these drugs' extraordinary price increases. (Government Accountability Office, "Brand-Name Prescription Drug Pricing: Lack of Therapeutically Equivalent Drugs and Limited Competition May Contribute to Extraordinary Price Increases," GAO-10-201 12/22/09).

▶ Eli Lilly pleaded guilty to charges that it illegally promoted its schizophrenia drug Zyprexa for unapproved uses. It agreed to pay out at total of \$1.4 billion in settlement fees, including a criminal fine of \$515 million, the largest crimi-

nal fine for an individual corporation ever imposed in any United States criminal prosecution. Amongst the unapproved uses Eli Lilly promoted for Zyprexa were sedation of nursing home patients and treatment of ADHD in children (Department of Justice, "Eli Lilly and Company Agrees to Pay \$1.415 Billion to Resolve Allegations of Off-label Promotion of Zyprexa," 1/15/09).

## PUBLIC and PHYSICIAN OPINION

▶ Although 90 percent of Americans favored "allowing the federal government to use its buying power to negotiate lower prescription prices with drug companies" in a January, 2009 poll, the Obama health reform contains no such provisions (Kaiser Family Foundation/Harvard School of Public Health Survey, Jan. 2009).

▶ A Kaiser poll in July, 2009 found 58 percent of Americans support "a national health plan in which all Americans would get their insurance through an expanded, universal form of Medicare for all." An April, 2009 Kaiser poll with slightly different wording found 49 percent of Americans support "having all Americans get their insurance from a single government plan." Most polls find about two-thirds of all Americans favor single payer, such as the 2007 AP/Yahoo poll that found that 65 percent of Americans favor "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." For a full discussion of public opinion on single payer, see the six-part series by Kip Sullivan on PNHP's blog at [www.pnhp.org/blog/2009/12/06/two-thirds-support-1/](http://www.pnhp.org/blog/2009/12/06/two-thirds-support-1/) (Kaiser Health Tracking Polls, April 2 to 8, 2009 and July, 2009).

▶ A survey of American physicians published in the Journal of General Medicine found rapidly growing physician support for a "government-run, taxpayer-financed single-payer national health insurance program." 42 percent of surveyed physicians expressed support for this statement in 2009, compared with only 26 percent support in 2004 for a "single government payer that covers everyone." Only 9.1 percent of physicians "would preserve the status quo." (Danny McCormick, Steffie Woolhandler, Anjali Bose-Kolanu, Antonio Germann, David Bor, and David Himmelsstein, "U.S. Physicians' Views on Financing Options to Expand Health Insurance Coverage: A National Survey," Journal of General Internal Medicine April, 2009).

Similarly, a 2008 survey of physicians found a 10 percentage point increase in support for national health insurance over the past five years. 59% of surveyed doctors agreed either "strongly" or "generally" with the statement "In principle, do you support or oppose government legislation to establish national health insurance," up from 49 percent five years earlier (A. Carrol and R. Ackerman, "Support for

National Health Insurance among US Physicians: 5 years later" Annals of Internal Medicine April, 2008).

### British Conservatives support NHS

British Conservative leader David Cameron recently acknowledged the value of Britain's National Health Service on his party's Web site. "Millions of people are grateful for the care they have received from the NHS – including my own family," he said.

"One of the wonderful things about living in this country is that the moment you're injured or fall ill – no matter who you are, where you are from, or how much money you've got – you know that the NHS will look after you."

Cameron's words were reinforced by the party's election manifesto, in which it calls itself "the party of the NHS" and pledges "never to change the idea at its heart that healthcare in this country is free at the point of use and available to everyone based on need and not ability to pay." (Armstrong, Paul "Socialized healthcare: The 'untouchable' of UK politics" CNN, 5/5/10)

In Canada, 70% of Canadians believe their health care system is working "very" or "fairly well," and 82% believe "that Canada's health care system is superior to the US health system," according to a recent Harris/Decima poll. Only 8% feel that the US' system is superior. Among conservative party-supporting Canadians, 76% believed in the superiority of the Canadian health system, with only 12% affirming the contrary (Harris/Decima Poll, 7/5/09, [www.harrisdecima.com](http://www.harrisdecima.com)).

▶ It's old but worth remembering: A national Harris Poll released in October 2008 on the trustworthiness of dozens of different industries found that only 7% of Americans believed that the health insurance industry or HMOs "are generally honest and trustworthy - so that you normally believe a statement by a company in that industry." Only the oil and tobacco industries fared worse (Harris Poll, October 2008).

## INTERNATIONAL COMPARISONS

▶ Despite spending 17.3 percent of GDP on health care, nearly double the OECD average of 8.9 percent, Americans get less physician and hospital care than residents of most other developed nations. Of 30 OECD member countries (most EU nations, Australia, New Zealand, Japan, South Korea, Canada, the United States, Mexico, and Turkey), the United States ranks 27th in the rate of doctor visits (3.8 per capita, nearly half the OECD average of 6.8 per capita), 23rd in the number of physicians per person (2.4 per 1,000 population vs. OECD average of 3.1 per 1,000 population), 23rd in the number of acute care hospital beds per person, 22nd

in the number of hospital discharges per capita, and 23rd in average length of stay in acute care. All OECD member states with the exception of Turkey and Mexico provide nearly universal health coverage. This includes emerging market nations such as Poland, Slovakia, and the Czech Republic.

► Despite leaving 46 million Americans uninsured, U.S. public spending on health care exceeded public spending in all OECD countries in 2007 except Norway and Luxembourg. Including the cost of U.S. tax subsidies for employer-sponsored coverage as “public spending,” American public health expenditures exceeded total (private + public) health expenditures of all but the three top spending nations, Norway, Luxembourg, and Switzerland. Note that per capita incomes are higher in these nations than in the U.S. (\$94,837 in Norway, \$113,044 in Luxembourg, and \$68,433 in Switzerland versus \$47,440 in the U.S.), a factor correlated worldwide with higher health spending. Yet health care expenditures in next-highest spending Norway per capita (\$4,763) were 35 percent lower than American expenditure per capita (\$7,290) (OECD Health Data 2009).

► China is seeking to boost government funding of public hospitals and reduce hospitals' dependence upon user fees in an effort to control costs and reduce inequities in care. Out-of-pocket expenditures for Chinese patients accelerated in the 1990s, peaking at 60 percent of total health care expenditures. In 2008, China declared that the for-profit health reforms it adopted in the 1980's were counter-productive to national health objectives. Low-income Chinese were hard-hit, particularly in rural areas. Through a program of major funding increases and other health reforms China now aims to achieve 90 percent coverage by 2010 and universal health coverage by 2020. Harvard economist and the architect of Taiwan's successful single payer program, William Hsiao, is doing research in China on expanding health coverage in rural areas (Mei Fong and Jason Leow, "Beijing Plans Health Care for Everyone," Wall Street Journal, 20th October 2008 and Tsung-Mei Cheng, July/August 2008).

► Canada has a good primary health care system, although some problems remain, according to the largest survey of Canadians on primary care ever conducted. Some 95 percent of Canadians with chronic conditions have a regular source of care, and 85 percent of adults requiring immediate care for a minor problem are seen within a day, according to the Canadian Institute for Health Information. Eighty-five percent of people aged 12 and older have a regular doctor, and two-thirds have been seeing the same doctor for more than five years (Globe and Mail, 7/23/09).

### Long-term care programs in Germany, Japan, cost less, cover more seniors

Although the Obama health plan will establish a new long-term care insurance program for purchasing "community living assisted services and support" (CLASS), the U.S. still will not have nearly as comprehensive a system as Germany, or Japan, which established single payer long-term care insurance systems in 1994 and 1997, respectively.

The CLASS program, a voluntary program financed through optional payroll deductions starting in 2011 (with benefits to start in 2016 after a five year vesting period), is supposed to provide beneficiaries with functional limitations who need help living in the community a cash benefit of "not less than" an average of \$50 a day.

In Germany and Japan, in contrast, social insurance programs are universal, support family caregivers, and provide flexible ways of obtaining necessary services. A recent review by John Campbell, Naoki Ikegama, and Mary Jo Gibson described the lessons from public long-term care insurance in Germany and Japan:

"Germany and Japan introduced comprehensive long-term care insurance because their frail older populations were growing; their traditional resources for care were declining; and their existing fragmented long-term care programs were increasingly seen as costly, inefficient, and unfair. The situation in the United States today is similar, if not worse.

Germany passed its long-term care insurance legislation in 1994, when 15.8 percent of its population was age sixty-five and older. In Japan, the legislation passed in 1997, when the elderlies share of the population was 15.7 percent. Population aging is about to pick up in the United States, and it should cross the same line toward the end of this decade.

Although the lives of frail old people and their family caregivers in Germany and Japan remain difficult – arguably the human condition – comprehensive long-term care insurance has undoubtedly brought major improvements for them. It has also been popular with the general public and has been accepted as a normal component of social policy in both countries.

These two models of comprehensive long-term care insurance differ sharply. Japan offers a high level of services in the community and provides benefits to 13.5 percent of its population age sixty-five and older, yet its per capita public expenditure is only 9 percent more than what the U.S. government spends. Germany mostly offers cash to support family caregiving, providing benefits to 10.5 percent of its population age sixty-five and older, and spends 26 percent less than the United States spends. Only 4.5 percent of Americans age sixty-five and older receive publicly supported long-term care, but spending is quite high." (Campbell, et al., Lessons from Public Long-Term Care Insurance in Germany and Japan, Health Affairs, January 2010.)

## ARTICLES OF INTEREST

### On the Obama health plan and the debate over the "public option":

1. Navarro, Vicente. "Obama's mistakes in health care reform: Why Obama needs single payer on the table" [www.pnhp.org/news/2009/september/why-obama-needed-single-payer-on-the-table](http://www.pnhp.org/news/2009/september/why-obama-needed-single-payer-on-the-table)
2. Redmond, Helen. "A rejoinder to Atul Gawande: How to get things wrong." 4/21/10, [www.seminal.firedoglake.com/diary/42425](http://www.seminal.firedoglake.com/diary/42425)
3. Skala, Nicholas. "Hold out for single payer." Remarks presented to the Congressional Progressive Caucus 6/4/10, [www.pnhp.org/news/2009/june/hold-out-for-single-payer](http://www.pnhp.org/news/2009/june/hold-out-for-single-payer)
4. Sullivan, Kip. "The rise and fall of the public option." Remarks presented in a conference call hosted by Healthcare-Now 2/16/10, online at [www.healthcare-now.org/notes-from-medicare-for-all-still-the-one/](http://www.healthcare-now.org/notes-from-medicare-for-all-still-the-one/)
5. Sullivan, Kip. "Comment on Deborah Stone's 'Single Payer-Good Metaphor, Bad Politics.'" *Journal of Health Politics, Policy and Law*, April 2010.

### On rising income inequality in the U.S., an important determinant of health outcomes:

1. Alperovitz, Gar; Daly, Lew. "The Undeserving Rich: Collectively produced and inherited knowledge and the (re)distribution of income and wealth." *Dollars and Sense*, March-April 2010.

### On the VA as a successful model of a single-payer, national health service, in the US with exemplary use of health information technology:

1. Oliver, Adam. "The Veterans Health Administration: An American Success Story?" *The Milbank Quarterly*, 2007.
2. Byrne, C.M., et al. "The Value from Investments in Health Information Technology at the U.S. Department of Veterans Affairs." *Health Affairs*, April 2010.

### On one physician's journey from an impoverished childhood to taking care of the poor and the need for fundamental health reform:

1. Reynolds, Teri. "Dispatches from the Emergency Room." *New Left Review*, Jan.-Feb. 2010.

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## Journal clubs: opportunities for dialogue

By Ana Malinow, M.D.

Since the early days of modern medicine in 19th-century London, surgeons and other physicians have joined journal clubs, keeping up-to-date on the best medical practices by swapping articles from scholarly journals to read and discuss with their colleagues.

Journal clubs in the 21st century offer us an excellent opportunity to share evidence-based research that points to why a single-payer system is the most rational, cost-effective and equitable way to finance health care. They are yet another way to educate the profession about findings that reinforce our message.

I have used the opportunities in my own journal club to present articles published by PNHP co-founders David Himmelstein and Steffie Woolhandler to medical students, residents, fellows and faculty whom might otherwise not have been exposed to evidence-based

health policy research published in peer-reviewed journals.

Five years ago, I shared an article published in *Health Affairs* on illness and injury as contributors to bankruptcy. In 2008, I used Aaron Carroll's article from *Annals of Internal Medicine* to show how a growing majority of physicians support national health insurance.

Most recently, I presented "Health Insurance and Mortality in U.S. Adults," an article in the *American Journal of Public Health*. Because journal clubs tend to rely heavily on biostatistics, I focused on the paper's use of the Third National Health and Nutrition Examination Survey. Once I had established the validity of using survey analyses to study diverse topics, we turned to the article and its conclusion that about 45,000 deaths annually are linked to lack of health insurance.

All of these readings led to educa-

tional discussions about health care. I found that shining a light on the failings of our health care system gave me the opportunity to bring up the strengths of the single-payer alternative.

In their evaluations over the years, participants have indicated they found the content appropriate and useful and appreciated the fact that I had defined and discussed the research design and methodology. Consistently, participants mentioned the timeliness of the topic and how this was new information for them.

I highly recommend those with the opportunity to present at journal clubs to use articles recently published by the PNHP community. The articles have all been published in peer-reviewed journals, are highly educational, are evidence-based and allow for the discussion of single payer, a topic not discussed enough among our colleagues.



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## A false promise of reform

*The following statement was released today by leaders of Physicians for a National Health Program, [www.pnhp.org](http://www.pnhp.org). Their signatures appear below.*

As much as we would like to join the celebration of the House's passage of the health bill last night, in good conscience we cannot. We take no comfort in seeing aspirin dispensed for the treatment of cancer.

Instead of eliminating the root of the problem – the profit-driven, private health insurance industry – this costly new legislation will enrich and further entrench these firms. The bill would require millions of Americans to buy private insurers' defective products, and turn over to them vast amounts of public money.

The hype surrounding the new health bill is belied by the facts:

- About 23 million people will remain uninsured nine years out. That figure translates into an estimated 23,000 unnecessary deaths annually and an incalculable toll of suffering.
- Millions of middle-income people will be pressured to buy commercial health insurance policies costing up to 9.5 percent of their income but covering an average of only 70 percent of their medical expenses, potentially leaving them vulnerable to financial ruin if they become seriously ill. Many will find such policies too expensive to afford or, if they do buy them, too expensive to use because of the high co-pays and deductibles.
- Insurance firms will be handed at least \$447 billion in taxpayer money to subsidize the purchase of their shoddy products. This money will enhance their financial and political power, and with it their ability to block future reform.
- The bill will drain about \$40 billion from Medicare payments to safety-net hospitals, threatening the care of the tens of millions who will remain uninsured.
- People with employer-based coverage will be locked into their plan's limited network of providers, face ever-rising costs and erosion of their health benefits. Many, even most, will eventually face steep taxes on their benefits as the cost of insurance grows.
- Health care costs will continue to skyrocket, as the experience with the Massachusetts plan (after which this bill is patterned) amply demonstrates.
- The much-vaunted insurance regulations – e.g. ending denials on the basis of pre-existing conditions – are riddled with loopholes, thanks to the central role that insurers played in crafting the legislation. Older people can be charged up to three times more than their younger counterparts, and large companies with a predominantly female workforce can be charged higher gender-based rates at least until 2017.
- Women's reproductive rights will be further eroded, thanks to the burdensome segregation of insurance funds for abortion and for all other medical services.

It didn't have to be like this. Whatever salutary measures are contained in this bill, e.g. additional funding for community health centers, could have been enacted on a stand-alone basis.

Similarly, the expansion of Medicaid - a woefully underfunded program that provides substandard care for the poor - could have been done separately, along with an increase in federal appropriations to upgrade its quality.

But instead Congress and the Obama administration have saddled Americans with an expensive package of onerous individual mandates, new taxes on workers' health plans, countless sweetheart deals with the insurers and Big Pharma, and a perpetuation of the fragmented, dysfunctional and unsustainable system that is taking such a heavy toll on our health and economy today.

This bill's passage reflects political considerations, not sound health policy. As physicians, we cannot accept this inversion of priorities. We seek evidence-based remedies that will truly help our patients, not placebos. A genuine remedy is in plain sight. Sooner rather than later, our nation will have to adopt a single-payer national health insurance program, an improved Medicare for all. Only a single-payer plan can assure truly universal, comprehensive and affordable care to all.

By replacing the private insurers with a streamlined system of public financing, our nation could save \$400 billion annually in unnecessary, wasteful administrative costs. That's enough to cover all the uninsured and to upgrade everyone else's coverage without having to increase overall U.S. health spending by one penny.

Moreover, only a single-payer system offers effective tools for cost control like bulk purchasing, negotiated fees, global hospital budgeting and capital planning.

Polls show nearly two-thirds of the public supports such an approach, and a recent survey shows 59 percent of U.S. physicians support government action to establish national health insurance. All that is required to achieve it is the political will.

The major provisions of the present bill do not go into effect until 2014. Although we will be counseled to "wait and see" how this reform plays out, we cannot wait, nor can our patients. The stakes are too high.

We pledge to continue our work for the only equitable, financially responsible and humane remedy for our health care mess: single-payer national health insurance, an expanded and improved Medicare for All.

**Oliver Fein, M.D.**  
President

**Garrett Adams, M.D.**  
President-elect

**Claudia Fegan, M.D.**  
Past President

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## After the Reform: Aiming High for Health Justice

By Margaret Flowers, M.D.

**A**s we sit here on the other side of the recent health reform process, we have an opportunity for reflection. There were many times during the past year and a half when passage of a health bill seemed unlikely. However, in the end, the White House and Democratic leadership joined forces and converted the last holdouts with scare tactics of electoral turnovers and even a trip on Air Force One in order to muscle a bill over the final hurdles. The mere fact that any bill was passed at all was hailed as the great accomplishment because no honest proponent of health reform could call the final product a solution to our nation's serious health care crisis.

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This entire health reform process occurred under the shadow of the previous attempt to pass significant health legislation. President Obama made this his signature issue, and so for his administration failure was not an option. He surrounded himself with many of those who were traumatized by their participation in the last go-round. Thus, the resulting strategy was based more on fear of the opposition than on sound health policy. An opportunity for an honest debate about the needs of our people was squandered for backroom deals with industry giants and the photo ops so reminiscent of the previous administration. And for the most part, the resulting legislation benefits the very industries that profit most from our current situation more than it benefits the people of America.

### Pros and Cons of the Legislation

There are some provisions within the bill that are positive steps: comparative effectiveness research; funding for demonstration projects to improve care; a new emphasis on prevention, wellness and public health; increased funding for community health centers; and incentives for primary care providers. These are all necessary provisions, but they do not offset the harm done by other provisions in the bill, such as the individual mandate to purchase private insurance with

penalties for noncompliance and the \$447 billion in public dollars being used to subsidize such purchases. The bill will omit at least 23 million people from having any coverage. And the requirement to accept people with pre-existing conditions will most certainly increase premiums such that they become unaffordable, or people will purchase policies with skimpier coverage. This will likely result in a larger population of underinsured people—those who risk bankruptcy from medical debt should they develop health problems.

And none of the positive steps turn us in the direction of creating a national health system such as there is in every other advanced nation. Rather, on the whole, this legislation, which was written with heavy input from private health insurance and pharmaceutical lobbyists, further privatizes the financing of our health care and further enriches and empowers the very industries that are the problem. We know from experience both in the United States and abroad that market-based financing of health care is both the most expensive model and the most unjust, providing only as much health care as the patient can afford.

### The Public Option Was Ruled Out at the Start

From the beginning of this process, it was clear that the administration and leadership had developed a strategy based on an outcome they believed they could achieve. The path was predetermined. All of the steps along the way, from the house parties that started during the winter of 2008 to the hearings, to the media spin, were planned so that the resulting "debate" was a drawn-out performance of political theater. In order to disarm the corporate interests, the health industries that had opposed previous reforms were included on the inside. In order to disarm the Right, bipartisanship was at the forefront. In order to disarm the supporters of a single-payer plan, who are the majority, a campaign was developed around a promised "compromise," the public option, and given tens of millions of dollars for organizing and advertising. The public option succeeded in splitting the single-payer movement and confusing and distracting it with endless discussion about

**Despite all of the attention, the public option was never meant to be part of the final legislation. As early as March 2009, Senator Baucus admitted that the public option existed as a bargaining chip to convince private insurers to accept increased regulation.**

what type of public option would be effective.

Despite all of the attention, the public option was never meant to be part of the final legislation. As early as March 2009, Senator Baucus admitted that the public option existed as a bargaining chip to convince private insurers to accept increased regulation. And a year later, Glenn Greenwald and others confirmed that the public option had been privately negotiated away, although members of Congress continued the charade and "fought" for it.

Toward the final vote, supporters of the public option were hearing the same excuses that single-payer advocates have heard for decades. We are always told that single-payer is not politically feasible. However, we know that political feasibility can change. We are told to be pragmatic, yet we know that the reform being passed was not practical, in that it failed to guarantee health care to everyone and to be financially sustainable. We are told we are asking for too much and should accept incremental change. However, we know that the smallest effective step we can take in health reform is the creation of a publicly funded health system. Beyond that, there is much more to do in order to create a health system that raises us into the top ten in the world.

### **Profit-Driven Insurers Cannot Prioritize Care**

While politicians claim that we have finally achieved comprehensive health reform and that now all Americans will have guaranteed affordable health care, we in the single-payer movement experience a sense of déjà vu. We have seen the same scenario occur at the state level from Oregon to Maine to Tennessee, and most recently in Massachusetts. Every state that has passed a health reform package has made these claims, only to find that within a few years they were unable to cover the number of people they had hoped to cover and that their health care costs exceeded their budget. The reason for this is that every state, and now our federal government, ignored the data showing that we cannot achieve universal and affordable health care as long as we retain private insurers as an integral part of health care financing. This truth has been documented both in practice and in numerous economic studies.

We cannot control health care costs, without severe rationing, as long as we retain multiple private insurers, because this model wastes at least a third of our health care dollars on areas that have nothing to do with direct health care: marketing, high CEO salaries, profits, and administration. We cannot guarantee that patients will be able to afford needed care using private insurers because the private insurance model is profit driven. These corporations profit by avoiding the sick and denying and restricting payment for care. Their bottom line is profit, not improved health. And no amount of industry regulation to date has been successful in changing that bottom line. Likewise, the new federal legislation is full of loopholes that will allow private insurers to continue to skirt the regulations.

The White House and Congress claimed throughout the process that we must retain private insurance because

**The White House and Congress claimed throughout the process that we must retain private insurance because Americans desire choice, and this has been framed as choice of insurance. However, this is a false concept. No person can anticipate what their health care needs will be or which insurance will be best. Health care needs change the day a patient has a serious accident or is diagnosed with a serious illness. We all need the same health insurance: one that covers all medically necessary care when and where we need it.**

Americans desire choice, and this has been framed as choice of insurance. However, this is a false concept. No person can anticipate what their health care needs will be or which insurance will be best. Health care needs change the day a patient has a serious accident or is diagnosed with a serious illness. We all need the same health insurance: one that covers all medically necessary care when and where we need it. Those of us who travel and listen find that people in America desire choice of health care provider and choice of treatment: the two choices that private health insurers restrict.

So what are the White House and Congress really saying when they claim that we must retain a private insurance model? That they are unwilling to take on these powerful industries, and so we, the people, must be willing to compromise and work within their framework. Mohandas Gandhi said:

"All compromise is based on give and take, but there can be no give and take on fundamentals. Any compromise on mere fundamentals is a surrender. For it is all give and no take."

When it comes to health reform, compromise on the fundamentals is unacceptable because the human costs are continued preventable deaths, continued suffering as patients fight for needed care, and continued bankruptcy from medical debt as families struggle to pay for deductibles and uncovered services. In a study published in *Health Affairs* in January 2008 that looked at the top 19 industrialized nations, the United States ranked the worst—we have the highest number of preventable deaths (101,000 each year) because we lack a health system. All of the other industrialized nations have health systems based on the principles of health care as a human right: universality, equity, and accountability.

### **Why Obama Failed**

Why have the American people been denied this same right? As I look back at the health reform process, I see three

serious errors: a willingness to compromise, a lack of clarity about what we require and a fear that failure to pass reform will have electoral consequences. These are the areas we must address as a people if we want to see real change in this nation, not just in health care but also in many areas that affect our ability to survive on this planet.

The willingness to compromise has occurred repeatedly at the state level. As a result, fewer people have access to care, and health care costs continue to rise; the fundamental problems are not corrected. This willingness to compromise is based on a real sense of desperation. We see real suffering. We want to do something. We are told that this reform, whatever it is, is the best we can get this time. We accept that and tell ourselves that it is something; it is a step.

As the congressional fellow of Physicians for a National Health Program, I saw this desperate attempt to pass something, anything, rise to the surface in the final weeks of the reform process. Patients and their families were brought into Congress to tell their stories of abuse at the hands of private insurers. Well-meaning legislators looked them in the eye and told them that this reform would change that. When I challenged the truth of that response, I was told, often in heated tones, that they (the legislators) had to do something and that at least this reform would help some people. I could only think of those who would not be helped. What about them?

The lack of clarity was grounded in the belief that if we simply advocated based on principles such as access and affordability, then the legislation would meet those principles. Legislators and pro-reform groups were content to speak based on principles as long as they were not challenged about whether those principles were being met. We must go beneath the surface of simple principles, educate ourselves, and define what is acceptable and what isn't. If we don't know exactly what we are asking for, we won't get it. And we mustn't be afraid to ask for what we require. As a people, we have become willing to accept crumbs when we require so much more than crumbs.

The final mistake was to pin the results of the upcoming elections to the success or failure of passing reform. Those who were reluctant to support the legislation were forced to support it in the end or risk being blamed for possible electoral consequences. As has often happened in past campaigns, people were forced to vote for the lesser of two evils instead of for what they truly wanted.

### **We Can Still Create a National Health Program!**

So what do we do now that a health bill has been signed? Now that the clamor has quieted, it is time for a civilized discussion of what our health needs are and how best to meet them. This discussion is unlikely to occur in mainstream media dominated by advertising dollars from health insurance and pharmaceutical corporations. We will need to have this discussion at a more personal level and through independent sources of media. We must educate ourselves and those around us about what is possible to achieve in

this nation.

It is possible to create a national health program in which every person living in this country is able to receive the same high standard of medical care whenever and wherever needed, without fear of financial consequences. We call this health security. Other advanced nations have achieved this goal. The United States has not, and is currently ranked 37th in the world for health outcomes. We spend more per

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capita on health care than every advanced nation, yet leave a third of our population either completely on the outside or vulnerable to financial ruin should they have a serious health problem.

Physicians for a National Health Program, founded in 1987, educates and advocates for a health system that will improve our health outcomes and provide health security based on the evidence of what has worked in our nation and what is effective in other advanced nations. We envision a lifelong universal health system—much like traditional Medicare—that is nationwide. We envision a system that allows patients to choose where they receive their care, permits caregivers and patients to determine the best course of treatment with assistance from evidence-based data, controls costs in a rational way through simplified administration and negotiation of fair prices, and is progressively financed. Its publicly funded nature would make it transparent and accountable. Because it would be privately delivered, it would allow caregivers to compete based on quality of care provided. Private health insurers would be relegated to a position of offering supplemental plans or possibly providing administrative support.

The Rev. Dr. Martin Luther King Jr. taught us that to witness an injustice and not work to correct it is in itself an act of violence. As a physician and an advocate for nonviolence, I cannot ignore the injustice of the great health inequality that exists in our nation or ignore those in need who cannot afford medical treatment. We have delayed this struggle for too long. Alice Walker said, "We are the ones we have been waiting for." So, let's do it. We have the resources. Now we must create the political will. Together, we can create a health justice movement, educate ourselves, speak with clarity and organize independently of any political party. Please join us. You can learn more at [www.pnhp.org](http://www.pnhp.org) or join the grassroots movement at [www.healthcare-now.org](http://www.healthcare-now.org).

# The Rise and Fall of the “Public Option”

Remarks by Kip Sullivan

Conference call hosted by Healthcare-NOW!

[www.healthcare-now.org](http://www.healthcare-now.org)

February 16, 2010

## INTRODUCTION

It's easy enough to explain why the “public option” was defeated. It's a lot harder to explain why it rose to prominence in the first place. Even in the watered-down form in which it was adopted by Democrats, the public option was probably no more politically feasible than single-payer was, but it was a lot harder to explain. And the watered down form wouldn't work, and it probably wouldn't even have survived.

The public option was so tiny when Democrats introduced it in June 2009 that it is fair to say it was moribund upon arrival if not dead on arrival. It was placed on life support when Senator Reid struck it from the Senate bill in November, and it was finally put out of its misery by the election of Scott Brown in Massachusetts in January of this year.

The public option wasn't politically feasible in 2009 for the obvious reason that it was opposed by the same people who would have opposed a single-payer system. Perhaps as importantly, the public option wasn't politically feasible because the people who promoted it weren't serious enough about it to make it a condition of their support for the Democrats' bill.

So it's pretty easy to explain why the public option fell. What's not so easy to explain is why a lot of smart people thought the public option was such a good idea to begin with and why, if they thought it was such a good idea, they didn't make it their bottom line. When the campaign for the public option began in 2005, it wasn't at all clear that the leaders of the campaign intended to throw the public option overboard if that's what it took to get Congress to pass an insurance industry bailout (by which I mean the individual mandate and the subsidies to make the mandate affordable). But by June 2009, it was clear the leaders of the public option campaign had NO intention of making a big, powerful public option a condition that Democrats had to meet. And by Christmas Eve 2009, it was clear the public option campaign had no intention of even making a TINY, ineffective public option a precondition for its support.

It appears, in short, that the leaders of the public option campaign saw an insurance industry bailout as more important than the public option. Many leaders of the public option campaign may even have seen the public option as

merely a fig leaf to induce progressives (both inside and outside of Congress) to think it was OK to support a bailout.

The modern version of the public option was brought to us by Jacob Hacker. And it was promoted by Health Care for America Now and the Herndon Alliance. The Herndon Alliance has received much less publicity than HCAN, but it played a seminal role in the development of the public option campaign. So, to understand why the proponents of the public option supported it, but not enough to make it a non-negotiable demand, it helps to review the thinking of Hacker and of the founders of HCAN and the Herndon Alliance.

I doubt I'll have enough time to describe both Hacker's thinking and that of the Herndon Alliance and HCAN leaders. I think what I'll do is describe Hacker's original version of the public option, his rationale for it, what happened to the public option after it arrived in Congress in 2009, and how Hacker accommodated himself to the degradation of the public option. And then, if I have any time left over, I'll talk briefly about the Herndon Alliance and HCAN. If I don't have time

to talk about HCAN and the Herndon Alliance, that's ok. Their thinking pretty much mirrored Hacker's. Like Hacker, they saw single-payer as politically infeasible; they started out supporting a big public option as a more politically feasible substitute for single-payer; and they didn't object when congressional Democrats unveiled a microscopic form

of the public option in June.

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## THE ORIGINAL HACKER PROPOSAL

Hacker first proposed what he called Medicare-Plus in a paper he wrote in 2001. He published another version of his idea in 2007. In that second paper, he called his idea “Health Care for America.” The label “public option” didn't appear till early 2009.

Hacker's idea, basically, was to have the federal government create a health insurance company that would sell health insurance to the nonelderly. Hacker assumed this company would enjoy all the efficiencies of Medicare and would therefore be able to undersell the insurance industry. Hacker never used the word “company” or “business” to describe the federal program he had in mind. Instead, he repeatedly described his proposed public entity as a program that would be “like Medicare.” Hacker's refusal to use appropriate terminology contributed greatly to the confusion that became rampant among public option advocates by 2009.

There is, of course, a huge difference between what Hacker was proposing and Medicare. Medicare is a single-payer program – it's the only insurer of basic medical services for

Americans over 65 and the disabled. Because it is a single-payer insuring such a large population, and moreover a population with above-average medical needs, Medicare enjoys advantages that the insurance industry will never enjoy, including huge size, low overhead and an ability to induce docs and hospitals to accept below-industry reimbursement rates.

The public company Hacker was proposing would have to compete with 1,500 other insurance companies within the multiple-payer jungle. The public company he was proposing would *not* be a single payer – it would be just one insurance company among hundreds. It's therefore far more accurate to refer to what Hacker was proposing as a company, a corporation, or a business that would be set up by the government. It was *always* misleading for Hacker to refer to his proposed entity as a government program like Medicare, and it was *extremely* misleading for him and his acolytes to continue doing so after the Democrats adopted a microscopic version of the public option.

However, the early version of the public option that Hacker proposed *did* have the potential to become a Medicare-for-all program for nonelderly Americans. In his 2001 and 2007 papers, Hacker said he wanted to give his public insurance company several very important advantages that would have allowed the company to start out with enormous size and to grow even larger early in its life. Hacker proposed five advantages or criteria for his original public option:

(1) It had to be prepopulated (he would have shifted Medicaid and SCHIP enrollees and all or some of the uninsured into the public option);

(2) Subsidies would go only to the public option;

(3) It would be open to all non elderly Americans;

(4) It would have the authority to use Medicare rates (this was not as important as the first three criteria); and

(5) The insurance industry had to offer the same coverage.

According to an analysis of Hacker's 2007 paper by the Lewin Group, Hacker's original public option would have enjoyed premiums 23% below those of the insurance indus-

cent below the industry's would have quickly destroyed the insurance industry. Twenty-three percent is an enormous differential. To put 23 percent in perspective, consider that HMOs in the 1980s had premiums only 5 to 10 percent lower than the traditional non-managed-care insurance companies they eventually displaced. Even though most Americans didn't want to be in HMOs, employers all over the country

**Now it was crystal clear to anyone who understood what Hacker had originally proposed that the public option the Democrats had adopted was so small it wouldn't affect the insurance industry. The Congressional Budget Office said the Senate version of the public option would insure no one; it said the House version would insure 10 million, and then later scaled that back to 6 million.**

pushed their employees into HMOs in order to take advantage of that 5 to 10 percent premium differential. And that was two decades ago when premiums took less of a bite out of everyone's pocket. Can you imagine how fast employers would dump their existing insurance company today for a 23 percent cut in their premium, especially if the public option were as kind and gentle as public option advocates say it would be?

It's hard to believe that someone as informed about health policy as Hacker didn't know his original public option had the potential to become a single payer for the non elderly. Let me read to you a portion of a transcript of a phone conference call sponsored by EPI on January 11, 2007 in which two participants, Ezra Klein (a blogger for the Washington Post) and Bob Kuttner (co-editor of the American Prospect), asked Hacker why he thought his proposal would succeed any better than Clinton's 1993 Health Security Act. Klein says, "What you've proposed here is much more fundamentally dangerous to the actors who killed it [i.e., the Clinton bill] the last time around." Kuttner, who must have seen an early draft

of the Lewin report, says, "[Y]ou're setting in train a gradual process whereby the whole system gradually shifts from 50/50 [meaning, 50 percent are in the public program and 50 percent are insured by the insurance industry] to 60/40 to 70/30. So after a couple of generations, almost everybody is in the quasi-Medicare program. Is that the intent?"

Hacker denied that was his intent. He agreed that the public option would start out at 50 percent, but then it would basically just get stuck there despite its enormous cost advantages over the private insurance industry. Here's what Hacker said: "[Lewin] did not forecast a huge shift over just a 10-year period. I think it was a shift of two percentage points over that period. So, at that rate, we'd have everyone within Medicare in about 250 years."

But Hacker was wrong. As I've already told you, when the Lewin Group released its analysis of Hacker's proposed program a year after this conversation took place, they project-

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try and would have enrolled 129 million people, or about half the non-elderly population. According to the Lewin Group, Hacker's original version of the public company would grow rapidly, from insuring half the non elderly in 2008 to two-thirds of the non elderly within a decade. Conversely, the insurance industry's share of the non elderly market would shrink from half to 35 percent within ten years.

In my view, the Lewin Group grossly underestimated how much damage Hacker's original version of the public option would do to the insurance industry. I think a public insurer with half the non-elderly population and premiums at 23 per-

ed a 34 percent increase in the public option's enrollment over a decade, not 2 percent. And as I said, I think Lewin was being way too conservative.

Hacker's answer to Klein and Kuttner illustrates the strange state of denial Hacker and other public option advocates induced in themselves as they tried to sell the public option as a politically feasible alternative to single-payer even though it would, in its original form, do a lot of damage to the insurance industry and would probably have led to a single payer for the non elderly.

But Hacker's confusion (and the confusion of other public option leaders) over whether the public option would be more feasible than a single payer was *minor* compared to the confusion that set in when congressional Democrats adopted a microscopic version of Hacker's original public option. When the Democrats released their draft legislation in June 2009, it was clear they had stripped out four of the five criteria for the public company that Hacker had specified in his original papers.

The only criterion the Democrats kept was the one requiring insurance companies to offer the same coverage as the public option. Now it was crystal clear to anyone who understood what Hacker had originally proposed that the public option the Democrats had adopted was so small it wouldn't affect the insurance industry. The Congressional Budget Office said the Senate version of the public option would insure no one; it said the House version would insure 10 million, and then later scaled that back to 6 million.

Now that the public option had been shriveled down from 129 million people to zero to 6 million, public option advocates faced not only the same old political feasibility problem (the insurance industry and the Republicans continued to scream about the tiny public option as if it were a big public option or a single-payer), but they also faced a huge logistical problem. A public option that represented no one on the day it opened for business wouldn't be able to crack most insurance markets in the U.S., and might not even be able to survive.

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This is where Hacker's habit of always comparing the public option to Medicare became extremely misleading. When Medicare commenced operations on July 1, 1966, it represented nearly all seniors. With the exception of a few hospitals in the South that temporarily resisted integrating their facilities, all clinics and hospitals in America immediately began accepting Medicare enrollees even though there was no law requiring them to do so. The reason all clinics and hospitals did that is that Medicare represented an enormous constituency on day one and providers didn't want to walk away

**It would have to do what NO insurance company has done in the last three or four decades, which is to create a new, successful insurance company in every state in the US. ... For the last three decades, insurance companies that wanted to expand their empires have done so by *buying* their way into new markets. That is, they bought an existing insurance company.**

from so many patients and so much money.

The tiny public option the Democrats incorporated into their bills was no Medicare. It would represent no one on the day it opened for business. It would have to do what *no* insurance company has done in the last three or four decades, which is to create a new, successful insurance company in every state in the U.S. In fact, I'm pretty sure no insurance company has expanded into even *one* new market in the last three decades by building a new insurance company from scratch. For the last three decades, insurance companies that wanted to expand their empires have done so by *buying* their way into new markets. That is, they bought an existing insurance company.

But Hacker and other public option advocates blithely ignored this issue. They ignored it because they continued to talk about the Democrats' public option as if it were the same huge public option Hacker had originally proposed. I might add that the CBO totally ignored this issue as well. The CBO never examined the issue of whether the public option would be able to crack even one U.S. market, much less all of them. I think the CBO was being extremely generous to the House version of the public option when they said it would insure 6 million people.

Nevertheless, as inexplicably rosy as it was, the CBO's reports on the public option sealed its fate. The poor public option was already hated by the right wing and the insurance industry. It was being promoted by people who cared more about an insurance industry bailout than the public option. And now the CBO was revealing the truth about the Democrats' version of the public option – that it was laughably small and for that reason was going to save little or no money.

When Democrats throughout Congress, especially those in swing districts, asked themselves why they should vote for something as controversial as a public option when the darn thing wouldn't save any money, public option advocates had no answers.

To sum up: The public option rose to prominence because powerful Democratic constituency groups thought single payer was not feasible but the public option was. They were wrong. The public option failed politically, and it failed as a policy idea. Politically, it turned out to be no more feasible than single-payer. As a policy, it was a disaster. The tiny public option adopted by Democrats would have accomplished nothing other than to embarrass all of us who believe government must play a prominent role in insuring the uninsured.



## Summary of Coverage Provisions in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act passed by the Senate on December 24, 2009 and by the House of Representatives on March 21, 2010. The following summary explains key health coverage provisions in the new law and incorporates modifications to the law included in the Health Care and Education Reconciliation Act of 2010, signed by President Obama on March 30, 2010.

The legislation will do the following:

- Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health Insurance Exchange with premium and cost-sharing credits available to some people to make coverage more affordable. Small businesses will be able to purchase coverage through a separate Exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid will be expanded to 133% of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four in 2009) for all individuals under age 65.

The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of \$938 billion over ten years, while reducing the deficit by \$124 billion during this time period.

### Individual Mandate

All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of \$695 per person (up to a maximum of \$2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; those for whom the lowest cost health plan exceeds 8% of income; and if the individual has income below the tax filing threshold (\$9,350 for an individual and \$18,700 for a married couple in 2009).

### Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four in 2009) based on modified adjusted gross income. This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid). Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level who do not have access to employer-sponsored insurance will obtain coverage through the newly created state health insurance Exchanges.

- The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for years 2014 through 2016, 95% federal funding for 2017, 94% federal funding for 2018, 93% federal funding for 2019, and 90% federal funding for 2020 and subsequent years. States that have already expanded adult eligibility to 100% of the poverty level will receive a phased-in increase in the FMAP for non-pregnant childless adults.
- Medicaid payments to primary care doctors for primary care services will be increased to 100% of Medicare payment rates in 2013 and 2014 with 100% federal financing.

**American Health Benefit Exchanges**

States will create American Health Benefit Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

- Access to Exchanges will be limited to U.S. citizens and legal immigrants. Small businesses with up to 100 employees can purchase coverage through the Exchange.
- Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity. In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.
- Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.
- Premium subsidies will be provided to families with incomes between 133-400% of the poverty level (\$29,327 to \$88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level.
- Cost-sharing subsidies will also be available to people with incomes between 133-400% of the poverty level to limit out-of-pocket spending.

**Changes to Private Insurance**

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage.

- Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.
- Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.
- Increases in health plan premiums will be subject to review.
- Young adults will be allowed to remain on their parent's health insurance up to age 26.
- States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact.
- Waiting periods for coverage will be limited to 90 days.
- Existing individual and employer-sponsored insurance plans will be allowed to remain essentially the same, except that they will be required to extend dependent coverage to age 26, eliminate annual and lifetime limits on coverage, prohibit rescissions of coverage, and eliminate waiting periods for coverage of greater than 90 days.

**Employer Requirements**

There is no employer mandate but employers with more than 50 employees will be assessed a fee of \$2,000 per full-time employee (in excess of 30 employees) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers that do offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of \$3,000 for each employee who receives a premium credit or \$2,000 for each full-time employee.

- Employers that offer coverage will be required to provide a voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income to enable them to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.
- Large employers that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.



**Coverage and Cost Estimates**

The Congressional Budget Office (CBO) estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of \$938 billion over ten years. According to CBO, by 2019, the legislation will result in 24 million people obtaining coverage in the newly created state health insurance Exchanges, including some who previously purchased coverage on their own in the individual market. In addition, 16 million more people would enroll in Medicaid and the Children's Health Insurance Program. The cost of the legislation will be financed through a combination of savings from Medicaid and Medicare and new taxes and fees, including an excise tax on high-cost insurance. The Congressional Budget Office estimates the health care components of the legislation will reduce the deficit by \$124 billion over ten years (the total reduction in the deficit including the health care and education components is estimated to be \$143 billion over ten years).

For more information about the **Summary of Coverage Provisions in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010** see the side-by-side comparison of the health reform proposals at <http://www.kff.org/healthreform/sidebyside.cfm>.

## Health Industry Lobbying and PAC Contributions

Category/Big Players	Lobbying 2008 and 2009	Contributions 2008 and 2010 election cycles
<b>PHARMACEUTICAL/HEALTH PRODUCTS</b>	<b>\$1,045,055,939</b>	<b>\$46,293,202</b>
PhARMA	\$63,743,020	\$371,230
Biotechnology Industry Association	\$20,917,500	\$365,979
Pfizer	\$45,091,836	\$3,361,071
Eli Lilly & Co.	\$28,275,750	\$1,493,977
<b>INSURANCE</b>	<b>\$1,329,458,083</b>	<b>\$29,185,787</b>
Blue Cross/Blue Shield	\$45,346,604	\$4,047,269
America's Health Insurance Plans	\$18,495,000	\$669,220
UnitedHealth Group	\$13,515,000	\$1,853,868
<b>HEALTH PROFESSIONALS</b>	<b>\$289,486,297</b>	<b>\$133,098,143</b>
American Medical Association	\$43,135,000	\$2,094,651
<b>HOSPITALS/NURSING HOMES</b>	<b>\$397,289,373</b>	<b>\$34,457,465</b>
American Hospital Association	\$41,608,380	\$3,097,406
Federation of American Hospitals	\$8,911,000	\$734,271
<b>TOTAL</b>	<b>\$3,061,289,692</b>	<b>\$243,034,597</b>

Note: All the numbers on this page are based on Federal Election Commission data available electronically on Sunday, March 21 2010 and includes contributions to federal candidates, PACs, and parties.

Source: [www.OpenSecrets.org](http://www.OpenSecrets.org)

# Meet the New Health Care Reform, Same as the Old Health Care Reform

By Aaron E. Carroll

*Associate Professor of Pediatrics, Indiana University School of Medicine*

We're so close to health care reform! Even Paul Krugman is starting to talk about what comes next. Me? I've been thinking about what comes next for a long time. I think this bill will pass. We will get the incremental reforms we were promised. Things will likely get better in the short term. Then, since we didn't contain costs, we'll need to enact real reform. Or, things will go right back to the status quo.

How do I know that? We've been here before.

President Obama said, in his address to Congress, that he was determined to be the last president to deal with health care reform. That's not going to happen. He should have read his history. At least, he should have read the *New York Times*.

Governor Mitt Romney thought the same thing in Massachusetts in 2006. I saw it – right there in the *New York Times*:

The bill does what health experts say no other state has been able to do: provide a mechanism for all of its citizens to obtain health insurance.

"This is really a landmark for our state because this proves at this stage that we can get health insurance for all our citizens without raising taxes and without a government takeover. The old single-payer canard is gone." (4/5/2006)

But wait. I'd heard that before. In the *New York Times*. In 1988:

Massachusetts last week ventured where no state had gone before: It guaranteed health insurance for every resident.

The plan requires that by 1992 every employer of six or more pay \$1,680 per worker per year for insurance. The employer may buy the insurance directly for his workers and their dependents, thereby earning a tax credit...The Massachusetts plan recognizes the value of an employer-based approach, which it would expand by forcing more businesses either to insure or pay. (4/26/1988)

That time was under Governor Michael Dukakis. He was going to be the last one to deal with health care reform, too. Just so you know, the rate of uninsurance in Massachusetts was 8.4% in 1998 around the time of the first "unique" reform and 5.5% in 2008, after two times they said they were going to achieve universal coverage. I don't think they understood the concept of "fixed."

And that's just Massachusetts. Look at Tennessee. They went all out with incremental reform in 1994. There's that *New York Times* again:

The Tennessee program, which went into effect last Jan. 1, covers 803,800 people who were formerly on Medicaid and 335,300 who had no health insurance. Gov. Ned McWherter, a Democrat, said that 94 percent of the state's residents were now insured. He predicted, "Tennessee will cover at least 95 percent of its citizens with health insurance by the end of 1994, seven years faster than the most aggressive goal set for the nation under legislation being debated in Congress." (9/16/1994)

Tennessee's rate of uninsurance was 10.2% in 1994 and 15.1% in 2008.

Governor Howard Dean, no stranger to the cause of health care reform, "fixed" the problem of health care reform way back in 1992. Per the *New York Times*:

Gov. Howard Dean, the only Governor who is a doctor, signed a law here today that sets in motion a plan to give Vermont universal health care by 1995.

The Vermont law creates a state agency, the Health Care Authority, that will have the power to bargain for health insurance for the state's residents, using what Governor Dean called "enormous leverage" to gain better coverage at lower rates. (5/12/1992)

Wow. That sounds like—a public option! Let's go to the scoreboard: Vermont's rate of uninsurance was 9.5% in 1992 and 9.3% in 2008.

Minnesota tried this, too, in 1992. Of course, how would anyone know about that? It was only in the *New York Times*:

Minnesota is enacting a program that will be the most sweeping effort yet to provide health insurance to people who lack it.

The legislation, called HealthRight, provides state-subsidized insurance coverage for people of modest income, a provision that is expected to cost Minnesota \$250 million a year, along with steps to control the health-care industry's steeply rising charges. (4/19/1992)

Subsidies to buy insurance. That must have worked, right? Minnesota's rate of uninsurance was 8.1% in 1992 and 8.7% in 2008.

Washington State? 1993. *New York Times*:

Washington will have one of the most aggressive health-care experiments in the nation, a program that would extend medical benefits to all 5.1 million residents of the state and try to control costs through a cap on insurance premiums.

The plan would require all employers to pay at least half the cost of health insurance premiums for their employees...

“We weren’t going to create some huge new government bureaucracy, so we took that away from the critics.”  
(5/2/1993)

God forbid! A government system might actually—I don’t know—do something. Anyway, Washington’s rate of uninsurance was 12.6% in 1993 and 12.4% in 2008.

Since the administration has put Senator Olympia Snowe somewhat in charge of health care reform, you would think they would at least know about efforts in Maine. Right? To the New York Times, please!

The Maine Legislature today passed a comprehensive health insurance plan that will make low-cost coverage available to all state residents by 2009.

The legislation will create a semiprivate agency that provides private coverage to the state’s 180,000 uninsured residents, businesses and municipalities with fewer than 50 employees and the self-employed. Employers would pay up to 60 percent of an employee’s premium. (6/14/2003)

That looks like it could have come right out of H.R. 3200. You’d never know if was from 2003. How did that pledge to achieve universal coverage by 2009 go? Maine’s rate of uninsurance was 10.4% in 2003 and 10.4% in 2008.

We pretend these problems are new; we pretend that these solutions are new. Subsidies have been done. Community ratings are old news. “Public plans” have been around for a while. Mandates, both individual and employer, weren’t invented this year.

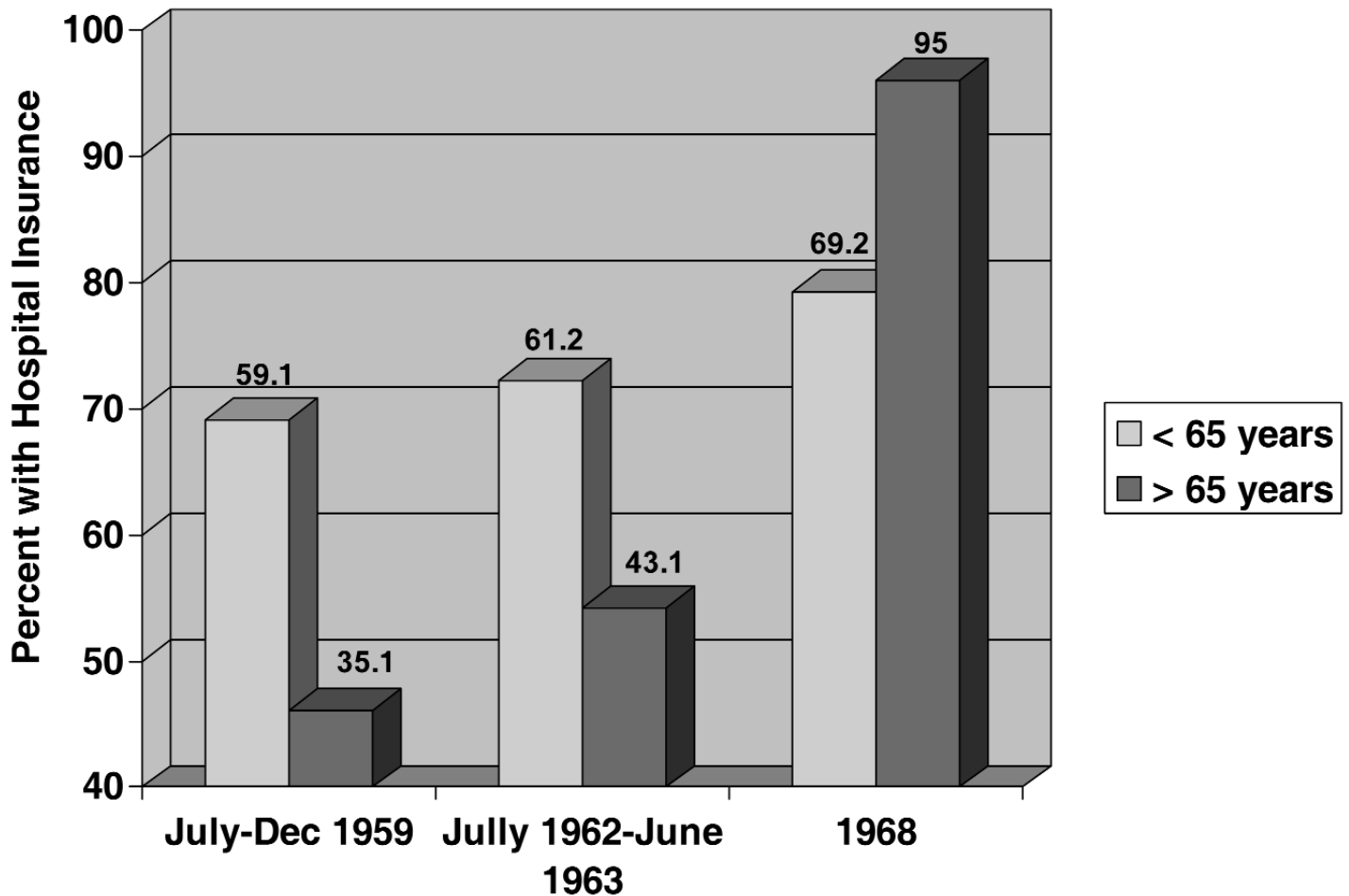
In 1988, before the first of these plans went into effect, 13.4% of Americans were uninsured. In 2008, it was 15.4% of Americans. They don’t work. Not in the long run.

We need comprehensive reform. This plan will pass; it won’t be enough. President Obama will not be the last president to deal with this problem.

We keep doing the same thing and expecting a different outcome. What does that signify?

[http://www.huffingtonpost.com/aaron-e-carroll/meet-the-new-health-care\\_b\\_334847.html](http://www.huffingtonpost.com/aaron-e-carroll/meet-the-new-health-care_b_334847.html)

## Percent Elderly Insured Before and After Medicare



National Health Statistics Reports (17) Jul 1 2009

# Whistleblower reveals how insurers can game healthcare bill

**Though bill cuts 'pre-existing conditions,' it still allows insurance companies to create 'pre-existing' categories to raise rates**

By Brad Jacobson

The Democrats' healthcare overhaul, billed as a monumental game-changer for Americans' health insurance coverage, provides numerous loopholes for health insurance companies which will allow them to raise rates to protect profit margins, a health insurance whistleblower says.

Wendell Potter, a 20-year veteran of the insurance industry and former vice president of communications for Cigna, warns that current healthcare legislation does nothing to prevent the insurance industry from continuing its ongoing practice of increasingly shifting healthcare costs to consumers.

A form of bait-and-switch, such practices often set up individuals, families and small businesses for inadequate or unaffordable access and a continued looming threat of financial ruin. The overlooked element, Potter says, is that insurance companies will be able to claim they are reducing premiums by forcing more Americans to pay higher deductibles and offering less coverage.

"We talk a lot about affordability, and we talk about affordability of insurance premiums," Potter told Raw Story in a nearly hour-long interview. "But when you talk about affordability, you need to talk about affordability of premiums plus out-of-pocket expenses."

He said that there's been a lot of discussion on how the Congressional Budget Office scored this legislation and what it says this legislation will cost the country in the long run, but little to no focus on how the legislation will directly impact individual Americans.

Potter pointed out, for example, that many plans – even after consumers received proposed government subsidies to help pay for them – would come with high deductibles that prohibit people from using their insurance or cause them the kind of financial hardships that healthcare reform was purported to prevent.

"What worries me," he said, "is people who are forced to buy coverage and all they can afford to buy is a high deductible. And if they get really sick, then they have to pay so much out of their own pockets that they're going to be filing for bankruptcy and losing their homes."

In the Senate bill, in particular, Potter noted, some people will be buying insurance that will only cover roughly 60 percent of their medical costs if they get sick.

"There are a lot of people who don't have insurance now because they can't afford premiums," he said. "They certainly couldn't afford premiums plus the out-of-pocket expenses in today's market."

Potter asserted that the current legislation will, in large part, simply move millions of people from being uninsured to underinsured,

or from insured to underinsured. Citing a 2007 study by the Commonwealth Fund, he said there are already over 25 million Americans who fall into the category of the underinsured.

Potter also noted the deleterious effect of cost shifting on small businesses. Many small business owners will earn just enough to be denied subsidies.

"After a certain income level, there are no subsidies," Potter explained. "But you still have to buy coverage. And I'm concerned that after you get above the median level of

income, you'll find that a lot of people who don't get subsidies will probably be forced to buy coverage. But the only coverage they'll be able to buy will make them underinsured."

There's also no prohibition in the legislation against insurance companies moving more and more people into high-deductible plans. Such plans, Potter argued, will help insurers' bottom lines because fewer policyholders will actually avail themselves of their insurance.

"When you have a benefit plan that requires people to pay a lot out of their own pocket, a lot of these people will never get to the point of using their insurance because they won't go to the doctor or pick up their medicines to satisfy the deductible," Potter told Raw Story.

"I see nothing in this legislation that essentially would protect people from losing their homes or filing for bankruptcy," he added.

## HOW INSURANCE COMPANIES CAN STILL GAME THE SYSTEM

While prohibitions on such practices as denying healthcare to people with pre-existing conditions remain in the legislation, Potter noted that the Senate bill, in particular, provides the insurance companies with "all the flexibility they need" to more than make up for any profits lost due to new reform measures and to prevent people from accessing coverage.

He pointed out, for example, that "health factors" such as chronic diseases and age would continue to play into how much individuals can be charged in premiums and how many of them may be forced into high deductible plans.

"What they will be doing, what they can in the Senate bill, is



Wendell Potter

charge people significantly more if they have certain health factors,” Potter said. “And it would be pretty much up to the industry to decide what those health factors are. You could have high blood pressure, high cholesterol, diabetes. You could be overweight, have a history of tobacco use. There definitely would be a wide range of things that the insurance industry would be able to look at and determine whether or not to charge you more.”

He also noted that the Senate bill would allow insurance companies to charge people who are older up to three times as much as those who are younger and, in the House bill, two times more than a younger person.

“And of course when people get older they develop more health factors,” Potter said. “So that is another way to get around the loss of revenue. Plus, of course, they would be able to get new revenue coming in from people who are younger and don’t have health factors that they charge more for.”

Moreover, he said, “They still would be getting a new revenue stream from people who are younger. So they’ll be getting significantly more in revenue. And those people are quite profitable too because they don’t file many claims.”

To justify this practice, Potter explained, insurers would claim that they’re providing lowered or discounted premiums to healthier people. But, in reality, premiums across the board are set so high that healthier people wouldn’t actually be receiving anything that could be considered a discount.

“Healthier people would be paying pretty much a standard rate at the end of the day,” said Potter, while the chronically ill and the aged would be paying exceptionally more on top of the already pricey standard rate.

## MEDICAL-LOSS RATIO

The former insurance executive also says another element of the healthcare overhaul is receiving too little attention: the medical-loss ratio, which determines what percentage of health insurance premiums are spent on actual medical costs. The difference of just a few percentage points can mean billions of dollars to the insurance industry.

“We’re talking about big-time money here,” said Potter. “The insurance industry doesn’t want to have any restrictions on the medical-loss ratio. So they’ll be doing all they can to keep it from being enacted if possible.”

Some members of Congress, led by Sen. Al Franken (D-MN), proposed an amendment to require that 90 percent of consumer premiums go to medical costs, but Potter doesn’t think that’s likely to happen and said insurers will fight tooth-and-nail to set any minimum as low as possible. The Congressional Budget Office said that the 90 percent figure was too high and would basically drive insurers out of business, recommending 80 to 85 percent instead. Democrats are expected to embrace the lower figures in their final bill.

**“When you have a benefit plan that requires people to pay a lot out of their own pocket, a lot of these people will never get to the point of using their insurance because they won’t go to the doctor or pick up their medicines to satisfy the deductible. I see nothing in this legislation that essentially would protect people from losing their homes or filing for bankruptcy.”**

– WENDELL POTTER

Potter cautioned that legislators need to keep an eye on how insurance companies define medical and administrative expenses. And he said that legislation should require companies to explain what they’re spending money on and what percentage in dollar amounts they’re spending.

“You can set the medical-loss ratio, but you need to make sure that it’s clearly understood what the components of the administrative expenses are,” Potter explained. “Because they can shift

stuff around from one bucket to another and claim that what they’re actually spending is beneficial to the patient when it may not be.”

For example, he said they can easily meet an 85 percent standard if the definition enables them to categorize such items as disease management programs as paying for medical care. Currently, money spent on disease management programs is counted toward administrative costs.

Potter also noted that insurance companies have kept the issue of the medical-loss ratio – something little understood by the American public – “pretty much just a conversation between them, their shareholders and the analysts who cover them. They don’t talk about it anywhere else.”

Potter raised this complex but critical issue during his Senate testimony in June.

“Every decimal point makes a big difference,” he added. “We’re talking in the billions.”



**Lobbyists were a lot of help on the new health care bill.**

# WellPoint Shareholders Revolt!

By Rob Stone  
Monday, May 3, 2010

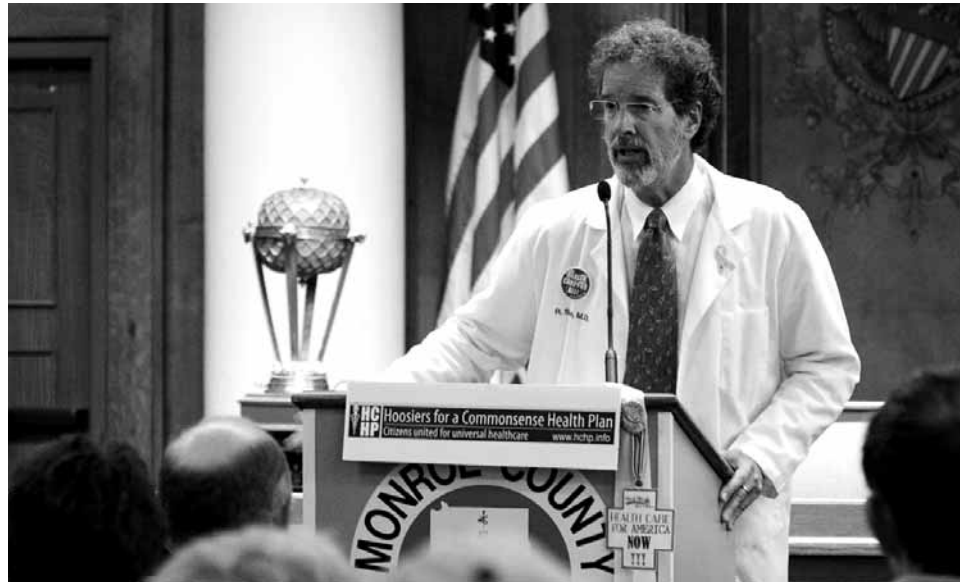
Wasichu is the Lakota (Sioux) word for “those who take the fat,” the greedy ones. WellPoint/Anthem, the health insurance behemoth born of Blue Cross, is a wasichu corporation.

As the Blue Cross movement grew in the 30’s, one of the foundational standards established in 1937 was “No private investors should provide money as stockholders or owners.” There was no concept of pre-existing condition. Excluding someone from health insurance because they might be likely to become ill (and need to actually use the policy) was felt to be immoral. Their mission was essentially charitable.

Over the following 50 years the Blues grew dominant, but in late 80’s the marketplace began to change, and many state Blue plans found themselves in trouble. Blue Cross of California established a for-profit subsidiary in 1994 and that summer the national Blue Cross Blue Shield Association changed its policies so that its licensees could convert to for-profit status and distribute their earnings to those who controlled the company. Enter WellPoint, under the guidance of Leonard Schaeffer.

A similar story played out in Indiana where the local Blue Cross began by merging with surrounding state plans

**Mr. Hubbard, an Indianapolis businessman, served in the GW Bush administration and is a former Director on WellPoint’s Board. He made no bones about being a Republican and shared a Republican view on where health care reform should go from here. At the end of his talk he concluded with this prediction, “My guess is that in 15 years we will have a single payer health plan, Medicare for All.”**



Dr. Rob Stone of PNHP’s Indiana chapter Hoosiers for Common Sense Health Plan.

and then “de-mutualized” to become a publicly traded company. Their initial stock offering in late 2001 raised \$1.7 billion, which only fed the acquisition and for-profit conversion rampage, culminating with the mother of all insurance mergers when WellPoint of California and Anthem of Indiana came together in 2004 to create the largest health insurance company in the country, with 34 million lives covered. Today, one American in 10 carries their card, and WellPoint is number 32 on the Fortune 500.

Corporate headquarters moved to Indianapolis, under Anthem’s Larry Glasscock, whose bonus was \$42.5 million for closing the deal. WellPoint’s Leonard Schaeffer retired with a package valued at \$337 million. Wasichu.

In 2005, my wife Karen and I bought five shares of WellPoint stock so we could make the hour’s drive up to Indianapolis for the company’s annual meeting and “speak truth to power.” Last year, I warned the WellPoint board that I would be coming back in 2010 with a shareholder resolution to change the direction of the company back toward its Blue Cross, charitable, non-profit roots.

We beat the odds and were successful in placing our resolution on the proxy ballot. The proxy was sent to all shareholders last week, to be voted on at the annual meeting May 18.

People ask me, why should WellPoint shareholders vote for a proposal to radically change the course of the company?

The reasons are being published every day. Going back just 12 weeks:

– The Indianapolis Star on January 16 revealed WellPoint to be covertly funding U.S. Chamber of Commerce attack ads against health care reform. WellPoint spent tens of millions on other non-covert lobbying. Keep in mind that the bill recently passed was largely written by former WellPoint Vice President Liz Fowler in her role as Max Baucus' chief health-care legislative aide.

– McClatchy Newspapers on February 24: "While Anthem Blue Cross proposed a 39 percent rate increase on thousands of its California customers, its parent company gave 39 of its executives more than \$1 million each and spent more than \$27 million on 103 lavish executive retreats, congressional investigators said."

– The Los Angeles Times on March 10 updated its readers on the rescission scandal dogging WellPoint in California. "Only a small fraction of eligible Californians have benefited from agreements that Anthem Blue Cross made to settle accusations that they systematically and illegally dropped sick policyholders to avoid paying for their care." These were people whose insurance coverage was cancelled after they were diagnosed with cancer and other serious conditions.

– Consumer Watchdog reported March 31 that WellPoint sent a message to investors describing how it would simply re-label administrative costs as "medical care" in response to the new health reform law. The message follows revelations that WellPoint, also intentionally padded already huge premium increases in California, in case regulators demanded reductions.

I could cite hundreds more, and now this week the news of CEO Angela Braly's 51 percent compensation increase, up to \$13.1 million. Their arrogance is overwhelming. Why wouldn't shareholders be concerned about where the company is heading? It's not like WellPoint even pays any dividends, while it has plenty to spend on its executives and lobbying.

Last Tuesday I heard Allan Hubbard speak on health care reform at Indiana University. Mr. Hubbard, an Indianapolis businessman, served in the G.W. Bush administration and is a former director on WellPoint's Board.

He made no bones about being a Republican and shared a Republican view on where health care reform should go from here. At the end of his talk he concluded with this prediction, "My guess is that in 15 years we will have a single-payer health plan, Medicare for All." He wasn't saying this gleefully.

He explained that all health insurance companies do is serve as middlemen between patients on one hand and doctors and hospitals on the other. He fears that as health care

**I see the day when socially responsible investors will divest themselves from health insurers' stocks. My recommendation is that WellPoint investors support a drastic change in direction for the company, and not wait for the stock price to plummet, for the health insurance bubble to burst.**

reform moves forward, Congress and the people will turn on them as a way to cut spending.

They (we) should.

The health insurance industry adds huge administrative costs to our system, not to mention the profits they siphon off. WellPoint is a parasitic middleman that adds no value, but actually increases the cost of healthcare for all of us.

I see the day when socially responsible investors will divest themselves from health insurers' stocks.

My recommendation is that WellPoint investors support a drastic change in direction for the company, and not wait for the stock price to plummet, for the health insurance bubble to burst.

Check your pension plan and mutual funds. If you own any WellPoint (WLP) stock, vote for Proposal No. 3, shareholder proposal concerning a feasibility study for converting to non-profit status. TIAA-CREF is the 12th largest holder of WellPoint stock. If you're invested with them, tell them what you think. If you have any affiliation with a university, ask them about their endowment holdings. Does your faith tradition have a policy for socially responsible investing?

Polls in 2008 and 2009 consistently showed more than 60 percent of the public favored a single payer plan. The public option polled over 70 percent approval well into the fall. Have those people gone away? No, but they (we) are disappointed, discouraged and weary. They (we) look back and say, "I wrote letters, made calls, went to rallies, and some of us were even arrested. And what did we get? Tens of millions of Americans forced to buy private insurance with our tax dollars subsidizing the premiums, a huge transfer of wealth from taxpayers to shareholders."

People ask me what I think about the new healthcare bill. My reply: "Healthcare reform: We're STILL FOR IT... and we're not done yet."

Money talks, like Arianna Huffington's Move Your Money campaign. Let's speak to the insurance behemoths in language they understand.

*Rob Stone M.D. practices emergency medicine in a community hospital in the Hoosier Heartland. He is the Director of Hoosiers for a Commonsense Health Plan and on the board of Physicians for a National Health Program.*



PRO: SINGLE-PAYER HEALTH CARE

# Simple, Fair, and Affordable

By John A. Day, Jr., M.D.

With the election of Barack Obama as our 44th President and the installation of a new United States Congress has come renewed attention to health care reform. Appropriately, there is a sense of urgency regarding the 47 million Americans without health insurance and the millions more underinsured, and to make matters worse, it is inevitable that both numbers will increase due to rising unemployment. In response to this crisis, most health care reform proposals attempt to guarantee at least some health coverage for all Americans. Yet nearly all proposals achieve this aim in large part through the current private insurance system. It is well worth asking: Exactly what value does the insurance industry bring to health care in this country? And if it contributes little of consequence, is there another way?

Using the private insurance industry to achieve universal coverage would require that all financially able U.S. residents or their employers purchase health insurance. Americans unable to afford health insurance, the poorest and potentially the sickest among us, would be covered by the government--most likely by incorporating them into a public insurance system, although a government subsidy (in all or in part) could be used instead to purchase private insurance coverage. If, as seems likely, a current or future public insurance program is used for this purpose, then this construct amounts to a massive preemptive bailout of health insurers. These private entities would profit by adding relatively healthy young people to their rolls, while potentially bankrupting the public systems that are charged with paying for the care of these unprofitable

patients.

Health insurance as a commodity is particularly unsuited to the so-called "wisdom of the market." Private insurers are dutybound to maximize profits for their shareholders, and profits are best achieved by minimizing risk through cherry-picking the healthiest enrollees and denying payment for services whenever possible (1). These goals are clearly not in the best interest of individuals seeking reliable health insurance coverage, enrollees who require ongoing or complicated care, or the taxpayers subsidizing care for those denied coverage.

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**Private insurers are dutybound to maximize profits for their shareholders, and profits are best achieved by minimizing risk through cherry-picking the healthiest enrollees and denying payment for services whenever possible. These goals are clearly not in the best interest of individuals seeking reliable health insurance coverage, enrollees who require ongoing or complicated care, or the taxpayers subsidizing care for those denied coverage.**

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Furthermore, health care reimbursement funneled through a private insurance industry does not necessarily lead to improved health. Thirty-one percent of United States health spending goes toward bureaucracy (2). Such remarkable inefficiency is directly attributable to the overhead and profit of the health insurance industry (3) and wasted clerical time, as providers must deal with a multitude of different insurers and health plans.

In contrast, Canada only spends about 17 percent on total system administration (2). Nor does having private insurance necessarily mean access to affordable,

quality health care. Large premium hikes have made it increasingly difficult for businesses to offer, and individuals to buy, comprehensive insurance. Instead, a profusion of high-deductible, high co-pay plans, along with plans offering extremely limited coverage, have put even insured patients at risk. This issue was nicely demonstrated in a 2005 study, which showed that three-quarters of the 750,000 American families entering into bankruptcy proceedings each year due to illness or medical bills actually had health insurance coverage at the time (4).

In the opinion of many, ending our reliance on the private insurance industry and adopting a single-payer health care system in the United States has long been the clear solution to these problems. Why is a single-payer health care system the best and only realistic solution to the crisis of the uninsured and underinsured?

The answer is simplicity, inclusiveness (everyone is in, no one is left out), breadth of service, equality, preservation of the current private delivery system, and, perhaps most of all, affordability. Multiple state and federal studies show that by eliminating the overhead associated with private insurance and negotiating prices with drug companies, it is possible to offer lifetime coverage to everyone in the country for an amount similar to that which we currently pay for coverage of only part of our population (5). Health insurance would be uncoupled from employment, so that individuals who lost or changed jobs would keep the same coverage, regardless of age, pre-existing conditions, or state of residence. No one would be without health insurance, accomplishing in the simplest way possible the overall goal of health reform--improving access to health care for all Americans.



Funding for a single-payer health care system would come from a combination of payroll tax for employers (about 7 percent of payroll, or less than the amount typically paid for employee health care coverage) and an increase in the federal tax on income (an increment of about 2 percent, or less than most people currently pay for out-of-pocket health care expenses). Patients would be free to choose any physician or hospital in the country, as opposed to the current system, in which patient choice is frequently limited to providers within the various health plan networks. Because, under the current system, most employers offer only one or two health plans, it is frequently the case that employers, not patients, in effect determine our choice of doctors, hospitals, and other health care providers. Providers of patient care would see significant reductions in paperwork, having to interact with only one health plan instead of the seemingly endless number of plans and subplans with which we now deal. A single-payer system would also facilitate comprehensive health planning, which could include regional disease management programs, strategies aimed at solving physician shortage issues, collective adoption of a unified electronic medical record, and a cohesive approach to the distribution of innovative health care

technologies (6).

Given the social, clinical, and economic benefits of single-payer health care, the only barrier would seem to be that of political feasibility. Indeed, adoption of a single-payer health care system will be challenging in today's economic climate and in a country seemingly dedicated to a free-market ideology. Yet many current social programs faced similar political obstacles at the time of adoption, including Social Security and Medicare.

Ironically, today it is the disbanding of these programs that would be considered not politically feasible. Although some major stakeholders (mainly the insurance and pharmaceutical industries) may be unalterably opposed to single-payer health care, the most important and relevant stakeholders are the American people and their health care providers. It is becoming evident that these factions increasingly support a single-payer system: 65 percent of the United States population and 59 percent of American physicians voiced this opinion in recent polls (7, 8). Finally, while there are major cost concerns regarding the proposed increased role for the private insurance industry in covering just some of the uninsured, a single-payer system would cover all comprehensively (something no other proposed system can claim) at a cost no higher than we are currently

spending, and potentially significantly less, if the experience of other industrialized nations is any guide. The time for true universal health coverage is now, and the best path to universal coverage is through single-payer health insurance.

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'I know, let's compromise and build it out of twigs.'

# Study finds nearly 45,000 excess deaths annually linked to lack of health coverage

## Lack of health insurance now more lethal

FOR IMMEDIATE RELEASE  
Sept. 17, 2009

**Contacts:**

Steffie Woolhandler, M.D., M.P.H.  
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A study published online today estimates nearly 45,000 annual deaths are associated with lack of health insurance. That figure is about two and a half times higher than an estimate from the Institute of Medicine (IOM) in 2002.

The new study, "Health Insurance and Mortality in U.S. Adults," appears in today's online edition of the American Journal of Public Health.

The Harvard-based researchers found that uninsured, working-age Americans have a 40 percent higher risk of death than their privately insured counterparts, up from a 25 percent excess death rate found in 1993.

Lead author Dr. Andrew Wilper, who worked at Harvard Medical School when the study was done and who now teaches at the University of Washington Medical School, said, "The uninsured have a higher risk of death when compared to the privately insured, even after taking into account socioeconomic, health behaviors and baseline health. We doctors have many new ways to prevent deaths from hypertension, diabetes and heart disease – but only if patients can get into our offices and afford their medications."

The study, which analyzed data from national surveys carried out by the Centers for Disease Control and Prevention (CDC), assessed death rates after taking education, income and many other factors including smoking, drinking and obesity into account. It estimated that lack of health insurance causes 44,789 excess deaths annually.

Previous estimates from the IOM and others had put that figure near 18,000. The methods used in the current study were similar to those employed by the IOM in 2002.

Deaths associated with lack of health insurance now exceed those caused by many common killers such as kidney disease.

An increase in the number of uninsured and an eroding medical safety net for the disadvantaged likely explain the substantial increase in the number of deaths associated with lack of insurance. The uninsured are more likely to go without needed care.

Another factor contributing to the widening gap in the risk of

death between those who have insurance and those who don't is the improved quality of care for those who can get it.

The research, carried out at the Cambridge Health Alliance and Harvard Medical School, analyzed U.S. adults under age 65 who participated in the annual National Health and Nutrition Examination Surveys between 1986 and 1994. Respondents first answered detailed questions about their socioeconomic status and health and were then examined by physicians. The CDC tracked study participants to see who died by 2000.

The study found a 40 percent increased risk of death among the uninsured. As expected, death rates were also higher for males (37 percent increase), current or former smokers (102 percent and 42 percent increases), people who said that their health was fair or poor (126 percent increase), and those that examining physicians said were in fair or poor health (222 percent increase).

Dr. Steffie Woolhandler, study co-author, professor of medicine at Harvard and a primary care physician in Cambridge, Mass., noted: "Historically, every other developed nation has achieved universal health care through some form of nonprofit national health insurance. Our failure to do so means that all Americans pay higher health care costs, and 45,000 pay with their lives."

She added: "Even the most liberal version of the House bill would have left 17 million uninsured, according to the Congressional Budget Office. The whittled down Senate bill will be worse – leaving tens of millions uninsured, and tens of thousands dying because of lack of care. Without the administrative savings only attainable through a Medicare-for-all, single-payer reform – real universal coverage will remain unaffordable. Politicians are protecting insurance industry profits by sacrificing American lives."

\*\*\*\*\*

"Health Insurance and Mortality in U.S. Adults," Andrew P. Wilper, M.D., M.P.H., Steffie Woolhandler, M.D., M.P.H., Karen E. Lasser, M.D., M.P.H., Danny McCormick, M.D., M.P.H., David H. Bor, M.D., and David U. Himmelstein, M.D. American Journal of Public Health, Sept. 17, 2009 (online); print edition Vol. 99, Issue 12, December 2009.

A copy of the study, along with a state-by-state breakout of excess deaths from lack of insurance, is available at <http://www.pnhp.org/excessdeaths>



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# Illness, medical bills linked to nearly two-thirds of bankruptcies

## Study finds 50 percent increase from 2001

### Most of those bankrupted by illness were middle class and had insurance

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June 4, 2009, 12:01 a.m. EDT

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Medical problems contributed to nearly two-thirds (62.1 percent) of all bankruptcies in 2007, according to a study in the August issue of the American Journal of Medicine that will be published online Thursday. The data were collected prior to the current economic downturn and hence likely understate the current burden of financial suffering. Between 2001 and 2007, the proportion of all bankruptcies attributable to medical problems rose by 49.6 percent. The authors' previous 2001 findings have been widely cited by policy leaders, including President Obama.

Surprisingly, most of those bankrupted by medical problems had health insurance. More than three-quarters (77.9 percent) were insured at the start of the bankrupting illness, including 60.3 percent who had private coverage. Most of the medically bankrupt were solidly middle class before financial disaster hit. Two-thirds were homeowners and three-fifths had gone to college. In many cases, high medical bills coincided with a loss of income as illness forced breadwinners to lose time from work. Often illness led to job loss, and with it the loss of health insurance.

Even apparently well-insured families often faced high out-of-pocket medical costs for co-payments, deductibles and uncovered services. Medically bankrupt families with private insurance reported medical bills that averaged \$17,749 vs. \$26,971 for the uninsured. High costs - averaging \$22,568 - were incurred by those who initially had private coverage but lost it in the course of their illness.

Individuals with diabetes and those with neurological disorders such as multiple sclerosis had the highest costs, an average of \$26,971 and \$34,167 respectively. Hospital bills were the largest single expense for about half of all medically bankrupt families; prescription drugs were the largest expense for 18.6 percent.

The research, carried out jointly by researchers at Harvard Law School, Harvard Medical School and Ohio University, is the first nationwide study on medical causes of bankruptcy. The

researchers surveyed a random sample of 2,314 bankruptcy filers during early 2007 and examined their bankruptcy court records. In addition, they conducted extensive telephone interviews with 1,032 of these bankruptcy filers.

Their 2001 study, which was published in 2005, surveyed debtors in only five states. In the current study, findings for those five states closely mirrored the national trends.

Subsequent to the 2001 study, Congress made it harder to file for bankruptcy, causing a sharp drop in filings. However, personal bankruptcy filings have soared as the economy has soured and are now back to the 2001 level of about 1.5 million annually.

Dr. David Himmelstein, the lead author of the study and an associate professor of medicine at Harvard, commented: "Our findings are frightening. Unless you're Warren Buffett, your family is just one serious illness away from bankruptcy. For middle-class Americans, health insurance offers little protection. Most of us have policies with so many loopholes, co-payments and deductibles that illness can put you in the poorhouse. And even the best job-based health insurance often vanishes when prolonged illness causes job loss - precisely when families need it most. Private health insurance is a defective product, akin to an umbrella that melts in the rain."

According to study co-author Dr. Steffie Woolhandler, associate professor of medicine at Harvard: "Only single-payer national health insurance can make universal, comprehensive coverage affordable by saving the hundreds of billions we now waste on insurance overhead and bureaucracy. Reforms that expand phony insurance - stripped-down plans riddled with co-payments, deductibles and exclusions - won't stem the rising tide of medical bankruptcy."

\*\*\*\*\*

A copy of the study is available at [www.pnhp.org/new\\_bankruptcy\\_study](http://www.pnhp.org/new_bankruptcy_study) or through the American Journal of Medicine, [ajmmedia@elsevier.com](mailto:ajmmedia@elsevier.com), (212) 633-3944. The authors have also prepared a supplementary "Fact Sheet" and a "Q&A" on medical bankruptcy, both of which detail the study's methods and findings. See same link above.

"Medical bankruptcy in the United States, 2007: Results of a national study," David U. Himmelstein, M.D.; Deborah Thorne, Ph.D.; Elizabeth Warren, J.D.; Steffie Woolhandler, M.D., M.P.H. American Journal of Medicine, June 4, 2009 (online).

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Thanks to anyone we may have missed as we go to press.

# Illness often undiscovered and undertreated among the uninsured

## Study indicates gaps in care for diabetes, cholesterol, hypertension

**EMBARGOED UNTIL:**  
Oct. 20, 2009, 12:01 a.m. EDT

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A new study shows uninsured American adults with chronic illnesses like diabetes or high cholesterol often go undiagnosed and undertreated, leading to an increased risk of costly, disabling and even lethal complications of their disease.

The study, published online today [Tuesday] in Health Affairs, analyzed data from a recent national survey conducted by the Centers for Disease Control and Prevention (CDC). The researchers, based at Harvard Medical School and the affiliated Cambridge Health Alliance, analyzed data on 15,976 U.S. non elderly adults from the National Health and Nutrition Examination Survey (NHANES), a CDC program, between 1999 and 2006.

Respondents answered detailed questions about their health and economic circumstances. Then doctors examined them and ordered laboratory tests.

The study found that about half of all uninsured people with diabetes (46 percent) or high cholesterol (52 percent) did not know they had these diseases. In contrast, about one-quarter of those with insurance were unaware of their illnesses (23 percent for diabetes, 29.9 percent for high cholesterol).

Undertreatment of disease followed similar patterns, with the uninsured being more likely to be undertreated than their insured counterparts: 58.3 percent vs. 51.4 percent had their high blood pressure poorly controlled, and 77.5 percent vs. 60.4 percent had their high cholesterol inadequately treated.

Surprisingly, being insured was not associated with a widely used measure of diabetes control (a hemoglobin A1c level below 7), a finding the authors attribute to the stringent definition of good diabetes control used in the NHANES survey. Even with excellent medical care, many diabetics fail to achieve such low hemoglobin A1c levels. Using less stringent hemoglobin A1c thresholds of 8 and 9, uninsured adults had significantly worse blood sugar control than their insured counterparts, the researchers found.

Lead author Dr. Andrew Wilper, who worked at Harvard when the study was done and who now teaches at the University of Washington Medical School, said: "Our study should lay to rest the myth that the uninsured can get the care they need. Millions have serious chronic conditions and don't even know it. And they're not getting care that would prevent strokes, heart attacks, amputations and kidney failure."

Referring to a study released in the American Journal of Public Health last month, which has been widely quoted by Sen. Max Baucus and others, he added: "Our previous work demonstrated 45,000 deaths annually are linked to lack of health insurance. Our new findings suggest a mechanism for this increased risk of death among the uninsured. They're not getting life-saving care."

Dr. Steffie Woolhandler, professor of medicine at Harvard and study co-author, said: "The uninsured suffer the most, but even Americans with insurance have shocking rates of undertreatment, in part because high co-payments and deductibles often make care and medications unaffordable. We need to upgrade coverage for the insured, as well as covering the uninsured. Only single-payer national health insurance would make care affordable for the tens of millions of Americans with chronic illnesses."

Dr. David Himmelstein, associate professor of medicine at Harvard and study co-author, said: "The Senate Finance Committee's bill would leave 25 million Americans uninsured and unable to get the ongoing, routine care that could save their lives and prevent disability. No other wealthy nation tolerates this, yet Congress is turning its back on tens of millions of Americans."

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"Hypertension, diabetes and elevated cholesterol among insured and uninsured adults," Andrew P. Wilper, M.D., M.P.H.; Steffie Woolhandler, M.D., M.P.H.; Karen Lasser, M.D., M.P.H.; Danny McCormick, M.D., M.P.H.; David H. Bor, M.D.; David U. Himmelstein, M.D. Health Affairs, Oct. 20, 2009.

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# Over 2,200 veterans died in 2008 due to lack of health insurance

## 1.46 million working-age vets lacked health coverage last year, increasing their death rate

FOR IMMEDIATE RELEASE  
Nov. 10, 2009

**Contacts:**

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A research team at Harvard Medical School estimates 2,266 U.S. military veterans under the age of 65 died last year because they lacked health insurance and thus had reduced access to care. That figure is more than 14 times the number of deaths (155) suffered by U.S. troops in Afghanistan in 2008, and more than twice as many as have died (911 as of Oct. 31) since the war began in 2001.

The researchers, who released their analysis today [Tuesday], pointedly say the health reform legislation pending in the House and Senate will not significantly affect this grim picture.

The Harvard group analyzed data from the U.S. Census Bureau's March 2009 Current Population Survey, which surveyed Americans about their insurance coverage and veteran status, and found that 1,461,615 veterans between the ages of 18 and 64 were uninsured in 2008. Veterans were only classified as uninsured if they neither had health insurance nor received ongoing care at Veterans Health Administration (VA) hospitals or clinics.

Using their recently published findings in the American Journal of Public Health that show being uninsured raises an individual's odds of dying by 40 percent (causing 44,798 deaths in the United States annually among those aged 17 to 64), they arrived at their estimate of 2,266 preventable deaths of non-elderly veterans in 2008.

"Like other uninsured Americans, most uninsured vets are working people - too poor to afford private coverage but not poor enough to qualify for Medicaid or means-tested VA care," said Dr. Steffie Woolhandler, a professor at Harvard Medical School who testified before Congress about uninsured veterans in 2007 and carried out the analysis released today [Tuesday]. "As a result, veterans go without the care

they need every day in the U.S., and thousands die each year. It's a disgrace."

Dr. David Himmelstein, the co-author of the analysis and associate professor of medicine at Harvard, commented, "On this Veterans Day we should not only honor the nearly 500 soldiers who have died this year in Iraq and Afghanistan, but also the more than 2,200 veterans who were killed by our broken health insurance system. That's six preventable deaths a day."

He continued: "These unnecessary deaths will continue under the legislation now before the House and Senate. Those bills would do virtually nothing for the uninsured until 2013, and leave at least 17 million uninsured over the long run. We need a solution that works for all veterans – and for all Americans – single-payer national health insurance."

While many Americans believe that all veterans can get care from the VA, even combat veterans may not be able to obtain VA care, Woolhandler said. As a rule, VA facilities provide care for any veteran who is disabled by a condition connected to his or her military service and care for specific medical conditions acquired during military service.

Woolhandler said veterans who pass a means test are eligible for care in VA facilities, but have lower priority status (Priority 5 or 7, depending upon income level). Veterans with higher incomes are classified in the lowest priority group and are not eligible for VA enrollment.

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Some sources for possible patient stories are available upon request. Please contact Mark Almberg at (312) 782-6006 or mark@pnhp.org.

Physicians for a National Health Program (www.pnhp.org) is an organization of 17,000 doctors who support single-payer national health insurance, often called an improved Medicare for All. To speak with a physician/spokesperson in your area, visit www.pnhp.org/stateactions or call (312) 782-6006.

# Projections of savings from health IT are baseless

## National survey of U.S. hospitals shows information technology has yielded neither administrative efficiencies nor cost savings

**EMBARGOED UNTIL:**  
Nov. 20, 2009, 12:01 a.m. EST

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The increased computerization in U.S. hospitals hasn't made them cheaper or more efficient, Harvard researchers say, although it may have modestly improved the quality of care for heart attacks.

The findings, published in today's online edition of *The American Journal of Medicine*, contradict claims by President Obama and many lawmakers that health information technology (health IT), including electronic medical records, will save billions and help make reform affordable.

"Our study finds that hospital computerization hasn't saved a dime, nor has it improved administrative efficiency," said lead author Dr. David Himmelstein, associate professor at Harvard Medical School and former director of clinical computing at Cambridge Hospital in Massachusetts. "Claims that health IT will slash costs and help pay for the reforms being debated in Congress are wishful thinking."

The study uses data from the most extensive survey ever undertaken of hospital computerization. Data from approximately 4,000 hospitals for the years 2003 to 2007, including those on a list of the "100 Most Wired," were analyzed for evidence of increased quality, cost savings or improvements in administrative efficiency.

The data came from the authoritative Healthcare Information and Management Systems Society (HIMSS) Analytics annual survey of hospital computerization; Medicare Cost Reports that virtually all hospitals submit annually to the Centers for Medicare and Medicaid Services (CMS); and the 2008 Dartmouth Health Atlas, which compiles CMS data on costs and quality of care.

Although the researchers found that U.S. hospitals increased their computerization between 2003 and 2007, they found no indication that health IT lowered costs or streamlined administration, even in the "most wired" insti-

tutions. While U.S. hospital administrative costs increased slightly, from 24.4 percent in 2003 to 24.9 percent in 2007, hospitals that computerized most rapidly actually had the largest increases in administrative costs. (By way of comparison, older studies have estimated administrative costs in Canadian hospitals at 12.9 percent).

The study found no evidence of lagged effects, e.g. lower costs in 2007 resulting from information technology introduced in 2003.

Modest quality gains were noted in the treatment of heart attacks (acute myocardial infarction) in more-computerized hospitals, but even these small improvements may merely represent better documentation rather than actual gains to patients.

Dr. Steffie Woolhandler, professor of medicine at Harvard and study co-author, said several factors may explain why health IT has failed to reduce administrative costs.

"Any savings may have been offset by the costs of purchasing and running new computer systems," she said. "In addition, most software is designed around the accounting and billing needs of hospitals, not the clinical side."

She noted that a computer success story in recent years has been at the Veterans Administration, where global budgets eliminate most billing and internal cost accounting, allowing physicians to focus instead on delivering care.

"The VA system now has our nation's highest quality and patient approval ratings," Woolhandler said. "Congress should take note: to get the most benefit from our health care dollars and from health IT, we should adopt a single-payer, Medicare-for-all program. Nothing short of that will allow us to reap the full potential of computerization or to provide comprehensive, quality and affordable care to all."

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"Hospital computing and the costs and quality of care: a national study," David U. Himmelstein, M.D., Adam Wright, Ph.D., and Steffie Woolhandler, M.D., M.P.H., *The American Journal of Medicine*, Nov. 20, 2009 (online).



# Health, life insurers hold \$1.88 billion in fast-food stocks: AJPH article

## Harvard researchers say insurers put profits over health

**EMBARGOED until:**  
April 15, 2010, 5 p.m. Eastern time

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Just weeks after the passage of a health bill that will dramatically increase the number of Americans covered by private health insurers, Harvard researchers have detailed the extent to which life and health insurance companies are major investors in the fast-food industry.

Although fast food can be consumed responsibly, research has shown that fast-food consumption is linked to obesity and cardiovascular disease – two leading causes of death – and contributes to the poor health of children. The evidence is so compelling that as part of the new law more than 200,000 fast-food and other chain restaurants will be required to include calorie counts on their menus, including their drive-through menus.

A new article on insurance company holdings, published online in today's [Thursday, April 15] American Journal of Public Health, shows that U.S., Canadian and European-based insurance firms hold at least \$1.88 billion of investments in fast-food companies.

"These data raise questions about the opening of vast new markets for private insurers at public expense, as is poised to happen throughout the United States as a result of the recent health care overhaul," says lead author Dr. Arun Mohan.

Among the largest owners of fast-food stock are U.S.-based Prudential Financial, Northwestern Mutual and Massachusetts Mutual Life Insurance Company, and European-based ING.

U.S.-based Northwestern Mutual and Massachusetts Mutual Life Insurance Company both offer life insurance as well as disability and long-term care insurance. Northwestern Mutual owns \$422.2 million of fast-food stock, with \$318.1 million of McDonald's. Mass Mutual owns \$366.5 million of fast-food stock, including \$267.2 in McDonald's.

Holland-based ING, an investment firm that also offers life and disability insurance, has total fast-food holdings of \$406.1 million, including \$12.3 million in Jack in the Box, \$311 million in McDonald's, and \$82.1 million in Yum! Brands (owner of Pizza Hut, KFC and Taco Bell) stock.

New Jersey-based Prudential Financial Inc. sells life insur-

ance and long-term disability coverage. With total fast-food holdings of \$355.5 million, Prudential Financial owns \$197.2 of stock in McDonald's and also has significant stakes in Burger King, Jack-in-the-Box, and Yum! Brands.

The researchers also itemize the fast-food holdings of London-based Prudential Plc, U.K.-based Standard Life, U.S.-based New York Life, Scotland-based Guardian Life, Canada-based Manulife and Canada-based Sun Life. (All data current as of June 11, 2009.)

"Our data illustrate the extent to which the insurance industry seeks to turn a profit above all else," says Dr. Wesley Boyd, senior author of the study. "Safeguarding people's health and well-being take a back seat to making money."

Mohan, Boyd and their co-authors, Drs. Danny McCormick, Steffie Woolhandler and David Himmelstein, all at the Cambridge Health Alliance and Harvard Medical School, culled their data from Icarus, a proprietary database of industrial, banking and insurance companies. Icarus draws upon Securities and Exchange Commission filings and news reports from providers like Dow Jones and Reuters. In addition, the authors obtained market capitalization data from Yahoo! Finance.

The authors write, "The health bill just enacted in Washington will likely expand the reach of the insurance industry. Canada and Britain are also considering further privatization of health insurance. Our article highlights the tension between profit maximization and the public good these countries face in expanding the role of private health insurers. If insurers are to play a greater part in the health care delivery system they ought to be held to a higher standard of corporate responsibility."

Several of these same researchers, all of whom are affiliated with Physicians for a National Health Program, have previously published data about the extent to which the insurance industry is invested in tobacco. They say that because private, for-profit insurers have repeatedly put their own financial gain over the public's health, readers in the United States, Canada and Europe should be wary about insurance firms' participation in care.

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"Life and Health Insurance Industry Investments in Fast Food," Arun V. Mohan, M.D., M.B.A.; Steffie Woolhandler, M.D., M.P.H.; David U. Himmelstein, M.D.; and J. Wesley Boyd, M.D., Ph.D. American Journal of Public Health, April 15, 2010.

# Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States

Leighton Ku, PhD, MPH

There is substantial public policy disagreement in the United States about whether the nation should restrict or expand health care for immigrants. Polls show that roughly half of Americans believe that immigrants are a burden on the nation because they take jobs, housing, and health care from US-born citizens.<sup>1</sup> Some further believe that “high rates of immigration are straining the health care system to the breaking point”<sup>2</sup> or that “illegal aliens in this country are taking a large part of our health care dollars.”<sup>3</sup> But others believe that steps should be taken to bolster immigrants’ health care, such as restoring their eligibility for Medicaid or having insurers pay for interpreter services for patients who are not proficient in English.<sup>4–6</sup>

Researchers have found that immigrants’ unadjusted per capita medical utilization and expenditures are actually much lower than those of US-born citizens. Mohanty et al. analyzed the 1998 Medical Expenditure Panel Survey (MEPS) and found that immigrants’ average per capita medical costs were approximately half those of US-born citizens.<sup>7</sup> Goldman et al. examined data from a 2000 Los Angeles survey and concluded that immigrants incurred a disproportionately small share of medical expenses, both government-paid expenses and overall expenses.<sup>8</sup> These findings are consonant with studies showing that immigrants have less access to health insurance and use less health care than the native born.<sup>9–14</sup> However, previous research has not clearly examined the relationships among immigrants’ health care expenditures, immigration status, and insurance coverage. To learn more about these relationships, I analyzed data from a recent nationally representative survey of adult US residents.

## METHODS

I analyzed data on nonelderly adults (19–64 years old) from the full-year consolidated data file of the household component of the 2003 MEPS, which was released in November

*Objectives.* I examined insurance coverage and medical expenditures of both immigrant and US-born adults to determine the extent to which immigrants contribute to US medical expenditures.

*Methods.* I used data from the 2003 Medical Expenditure Panel Survey to perform 2-part multivariate analyses of medical expenditures, controlling for health status, insurance coverage, race/ethnicity, and other sociodemographic factors.

*Results.* Approximately 44% of recent immigrants and 63% of established immigrants were fully insured over the 12-month period analyzed. Immigrants’ per-person unadjusted medical expenditures were approximately one half to two thirds as high as expenditures for the US born, even when immigrants were fully insured. Recent immigrants were responsible for only about 1% of public medical expenditures even though they constituted 5% of the population. After controlling for other factors, I found that immigrants’ medical costs averaged about 14% to 20% less than those who were US born.

*Conclusions.* Insured immigrants had much lower medical expenses than insured US-born citizens, even after the effects of insurance coverage were controlled. This suggests that immigrants’ insurance premiums may be cross-subsidizing care for the US-born. If so, health care resources could be redirected back to immigrants to improve their care. (*Am J Public Health.* 2009;99:1322–1328. doi:10.2105/AJPH.2008.144733)

2005.<sup>15,16</sup> MEPS is a nationally representative survey of the US civilian noninstitutionalized population, with an oversampling of Hispanics and Blacks. It includes data on demographic characteristics, health status indicators, insurance coverage, health care utilization, and medical expenditures. MEPS uses a longitudinal, overlapping panel design in which new respondents are recruited each year and are interviewed 5 times over a 2.5-year period. The survey is administered by the Agency for Healthcare Research and Quality (AHRQ).

Although AHRQ has released subsequent years of MEPS data since the 2003 data were released, immigrant indicators are not available for those years because of technical difficulties that affected those data (but not the 2003 data). The 2003 MEPS sample is drawn from households that responded to the National Health Interview Survey in 2001 or 2002, so it may underrepresent those who had recently entered the United States or who had recently left the military or an institution. MEPS had an

overall response rate of 64.5% for the 2003 full-year file. Data collected from household respondents were supplemented by information drawn from a medical provider component that validated data on medical events reported in the household survey and added information about medical expenditures from hospitals and other health care providers.

## Immigration Status

Although MEPS does not indicate immigrants’ legal status, the MEPS data allowed us to define 3 immigration-status categories: recent immigrants, who had been in the United States for fewer than 10 years; established immigrants, who had been in the United States for 10 years or more; and US-born citizens. Based on census data, the Pew Hispanic Center has estimated that in 2003 46% of recent immigrants to the United States (those who had been in the United States for fewer than 10 years) were undocumented, 42% were legal noncitizens (lawful permanent residents or refugees),

6% were temporary legal immigrants (e.g., admitted with visas), and 5% were naturalized citizens. The center also estimated that among immigrants who had been in the United States for 10 or more years, the majority (52%) were naturalized citizens, 31% were legal noncitizens, and 17% were undocumented immigrants. About two thirds of those who were undocumented immigrants were recent immigrants (Jeffrey Passel, PhD, Pew Hispanic Center, written communication, March 2008). Thus, the length of time that an immigrant has been in the United States is a useful indicator of legal status. Recent immigrants are primarily undocumented or legal noncitizen immigrants, whereas established immigrants are primarily naturalized citizens or legal noncitizens.

Legal immigrants who have been in the United States for at least 5 years are eligible for Medicaid, so I also performed alternative analyses distinguishing immigrants who had been in the United States for fewer than 5 years from those who had been in the United States for 5 or more years. However, this subdivision reduced the sample size of recent immigrants by more than half and impaired statistical power. In addition, these analyses did not capture Medicaid coverage of undocumented immigrants or of refugees.

### Demographic and Medical Variables

Race, ethnicity, nativity, and other demographic and health status variables were self-reported. Activity limitations were assessed with a composite measure of whether the individual had any limitations in activities of daily living, limitations in instrumental activities of daily living, functional limitations, or sensory limitations (e.g., blindness) during the previous year. The presence of chronic conditions was assessed based on whether the person had been diagnosed as having arthritis, diabetes, coronary heart disease, hypertension, or emphysema. Insurance coverage was evaluated on a monthly basis and was divided into public insurance (Medicaid, Medicare, State Children's Health Insurance Program [CHIP], and other state or local programs) and private insurance (including employer-sponsored and individual insurance). For adults aged 19 to 64 years, public insurance coverage was primarily Medicaid, and private coverage was primarily employer-sponsored insurance.

I constructed 4 primary categories of annual medical expenditures: public, private, self-paid, and total. The public category comprised expenditures paid by Medicaid, Medicare, SCHIP, other public insurance programs, or other public direct-payment sources, including the estimated value of free care or unpaid monies for care provided by public providers. Private expenditures comprised private insurance payments and other private payments other than self-paid expenses. MEPS does not estimate the value of free care or bad debt for care provided by private health care providers. Self-paid expenses were out-of-pocket expenditures, such as deductibles or copayments, or for services or goods that were not covered by the person's insurance (this category does not include consumers' share of insurance premiums). The total category was the sum of all 3 subcategories of expenditures (public, private, and self-paid).

### Analyses

For multivariate analyses, I created 2-part models. The first used logistic regression models to identify whether a person had had any medical expenditure during the previous year, and the second used linear regression models for those who had a positive expenditure, with the natural logarithm of the medical expenditure as the dependent variable. Such models are widely used for highly skewed, heteroskedastic dependent variables, such as medical expenditures, which can range from zero to very high values. Results from the logistic and linear regression models (which used both the estimated probability of having had an expenditure and the estimated expenditure level, conditional on having had an expenditure) were used to retransform estimates into linear annual dollar estimates via the Duan smearing estimator method.<sup>17,18</sup>

To illustrate the independent effects of immigration status and use both components of the 2-part model, I used a simulation exercise known as the method of recycled predictions. For the sample of US-born adults, I applied model coefficients to estimate annual expenditures per person based on a variation in immigration status (with all other characteristics held constant), that is, on the basis of being a US-born adult (the baseline), an established immigrant, or a recent immigrant. Thus, all

characteristics except immigration status were constrained to be the same. Standard errors were computed by weighted jackknife methods replicated 11391 times.<sup>19</sup>

In general, all results I discussed are statistically significant with 95% or better confidence, unless stated otherwise. Because MEPS uses a clustered, stratified survey design, all analyses presented are weighted analyses, adjusting for complex survey design. I used SAS version 8.2 (SAS Institute Inc, Cary, NC) or Stata version 10 (StataCorp LP, College Station, TX) to conduct all analyses.

## RESULTS

Immigrant and US-born adults differed in many ways (Table 1). Compared with their US-born counterparts, recent immigrants (those who had been in the United States for fewer than 10 years) tended to be younger and established immigrants (those who had been in the United States for 10 years or more) were slightly older. Both recent and established immigrants were far more likely to be Hispanic or Asian and less likely to be Black, non-Hispanic; White, non-Hispanic; or other. Immigrants were likely to be poorer, to be less educated, and to live in the West compared with non-immigrants.

Immigrants were much less likely than US-born adults to report being in fair or poor health, to have 1 of the chronic health conditions examined (arthritis, diabetes, coronary heart disease, hypertension, or emphysema), or to have an activity limitation. Recent immigrants appeared to be healthier than established immigrants, who were in turn somewhat healthier than US-born citizens. This may be a result of immigrants having more undiagnosed ailments because they receive less medical care.

### Health Insurance Coverage and Medical Expenditures

Table 2 shows that immigrants were more likely to be uninsured and to spend longer periods being uninsured than were their US-born counterparts. However, contrary to stereotypes that immigrants are mostly uninsured and rarely have private insurance, almost half (44%) of recent immigrants and about two thirds (63%) of established immigrants were

**TABLE 1—Characteristics of Adults Aged 19 to 64 Years, by Immigration Status: Medicare Expenditure Panel Survey, 2003**

	US Born, No. or %	Established Immigrant <sup>a</sup>		Recent Immigrant <sup>b</sup>	
		No. or %	P	No. or %	P
Unweighted sample size	14 446	3 166		1 461	
Mean age, y	40.7	42.0	<.001	33.0	<.001
Race/ethnicity					
Hispanic	6.7	45.3	<.001	51.9	<.001
Non-Hispanic Black	12.5	7.4	<.001	7.4	<.001
White/Other	79.8	24.0	<.001	19.8	<.001
Asian	1.0	23.4	<.001	20.9	<.001
Women	51.3	49.9	NS	48.8	<.01
Married	55.8	65.2	<.001	59.6	<.01
Health measures					
Activity limitations <sup>c</sup>	23.1	15.3	<.001	6.4	<.001
Chronic conditions <sup>d</sup>	31.8	24.2	<.001	8.4	<.001
Fair or poor health	11.4	12.0	NS	5.6	<.001
Income					
Below 100% of poverty level	10.2	12.6	<.01	14.8	<.001
100%–199% of poverty level	13.7	20.7	<.001	31.4	<.001
200%–399% of poverty level	30.4	30.1	NS	30.6	NS
400% or more of poverty level	45.7	36.7	<.001	23.2	<.001
Employed	76.2	75.6	NS	73.6	<.05
Education					
Less than high school diploma	11.0	3.0	<.001	36.6	<.001
High school diploma	54.4	37.4	<.001	31.6	<.001
Any college	34.6	32.6	NS	31.8	NS
Region					
Northeast	18.1	22.6	<.001	19.7	NS
Midwest	24.9	11.5	<.001	11.3	<.001
South	37.2	24.8	<.001	36.5	NS
West	19.9	41.1	<.001	32.4	<.001

Note. NS = not statistically significant. Significance levels compare mean values for immigrants to mean values for US-born adults.

<sup>a</sup>Defined as having lived 10 or more years in the United States.

<sup>b</sup>Defined as having lived fewer than 10 years in the United States.

<sup>c</sup>Activity limitations include activities of daily living, instrumental activities of daily living, and other functional or sensory limitations.

<sup>d</sup>Chronic conditions include diagnosed arthritis, diabetes, coronary heart disease, hypertension, and emphysema.

insured for all 12 months of the analysis period. Although immigrants are less likely to be fully insured than are nonimmigrants ( $P < .001$ ), full-year coverage, primarily from private insurance, is nonetheless relatively common among immigrants. Recent immigrants were less likely to be publicly insured than were US-born residents ( $P < .001$ ). This is not surprising; undocumented immigrants and legal noncitizen immigrants who have been in the United States for fewer than 5 years are ineligible for

Medicaid (except for coverage of emergency care or for state-funded coverage).<sup>19,20</sup>

The bottom half of Table 2 provides data on respondents' average annual medical expenditures. The average total annual medical expenditure of recent immigrants (\$1308) was less than half that of US-born citizens, and the average total annual medical expenditure of established immigrants (\$1950) was about two thirds that of the US-born citizens (\$3156;  $P < .001$  for both comparisons). Immigrants had

lower public and private medical expenditures than did US-born citizens. Analyses also indicated that immigrants, and recent immigrants in particular, had lower medical utilization: they had fewer medical visits, inpatient admissions, outpatient hospital visits, and emergency medical visits (data not shown).

The results for very recent immigrants (those who had been in the United States for fewer than 5 years) were similar but somewhat more pronounced. Half of the very recent immigrants (50%) were uninsured for all 12 months of the analysis period, and their mean total medical expenditure was a scant \$768 per year, about one fourth that of native-born citizens (analyses not shown).

Table 2 also presents average expenditures for 3 fully insured subpopulations: those insured for all 12 months (whether by public insurance, private insurance, or a combination of the 2), those privately insured for all 12 months, and those publicly insured for all 12 months. Even when immigrants had full-year private health insurance coverage, medical expenditures for recent immigrants (fewer than 10 years of US residence) were roughly half the size, and for established immigrants about two thirds the size, of the medical expenditures of US-born citizens. Recent immigrants who had public insurance for a full year had expenditures about one sixth the size of the expenditures of US-born citizens.

Table 3 compares the aggregate distribution of the nonelderly adult population and their medical expenditures by immigration status. Although recent immigrants make up 5.1% of the national population of adults, they only incur 2.3% of the total medical expenditures for adults and just 1.4% of total public medical expenditures for adults. Established immigrants make up 11.6% of the national population of adults, but they incur only 7.8% of the total medical expenditures for adults and 8.9% of public medical expenditures. Immigrants as a group consume a disproportionately small share of medical care in the United States.

### Characteristics Affecting Medical Expenditures

I used 2-part multivariate models to analyze per-person annual medical expenditures for those who had any insurance coverage in the sample year. My findings regarding the effects of immigration status and several other key

**TABLE 2—Health Insurance Coverage and Medical Expenditures of Adults Aged 19 to 64 Years, by Immigration Status: Medicare Expenditure Panel Survey, 2003**

	US Born, Mean	Established Immigrant <sup>a</sup>		Recent Immigrant <sup>b</sup>	
		Mean	P	Mean	P
<b>Insurance coverage</b>					
No. average months uninsured	2.21	3.56	<.001	5.85	<.001
No. average months publicly insured	1.31	1.22	NS	0.80	<.001
No. average months privately insured	8.74	7.35	<.001	5.37	<.001
<b>Insurance for prior year</b>					
% uninsured all year	13.6	24.2	<.001	42.8	<.001
% insured all year	75.1	63.4	<.001	43.5	<.001
% publicly insured all year	8.9	8.2	NS	4.5	<.001
% privately insured all year	67.4	55.5	<.001	38.9	<.001
<b>Annual medical expenditures by type, \$</b>					
Total medical expenditures	3156	1950	<.01	1308	<.001
Public medical expenditures	533	376	<.001	135	<.001
Private medical expenditures	1991	1141	<.05	949	<.05
Self-paid medical expenditures	635	433	<.001	224	<.001
<b>Mean total expenditures, \$</b>					
For those insured all year	3499	2511	<.001	1401	<.001
For those privately insured all year	3211	2154	<.001	1405	<.001
For those publicly insured all year	8009	4927	<.001	1269	<.001

Note. NS = not statistically significant. Significance levels compare mean values for immigrants to mean values for US-born adults.

<sup>a</sup>Defined as having lived 10 or more years in the United States.

<sup>b</sup>Defined as having lived fewer than 10 years in the United States.

**TABLE 3—Distribution of Population and Medical Expenditures of Adults Aged 19 to 64 Years, by Immigration Status: Medicare Expenditure Panel Survey, 2003**

	US Born, %	Established Immigrant, <sup>a</sup> %	Recent Immigrant, <sup>b</sup> %
Proportion of total adult population	83.3	11.6	5.1
<b>Medical expenditures</b>			
Proportion of total medical expenditures	90.0	7.8	2.3
Proportion of public medical expenditures	89.8	8.9	1.4
Proportion of private medical expenditures	90.2	7.2	2.6
Proportion of self-paid medical expenditures	89.5	8.5	1.9

<sup>a</sup>Defined as having lived 10 or more years in the United States.

<sup>b</sup>Defined as having lived fewer than 10 years in the United States.

variables on medical expenditures are detailed in Table 4. Being a recent immigrant or an established immigrant was independently associated with both a reduced likelihood of using any medical care in the year and with lower total medical expenditure levels, compared with US-born adults. The models also showed that being Hispanic, non-Hispanic

Black, Asian, or less educated (including having less than a college degree) also reduced medical utilization and expenditures. By contrast, having private or public health insurance, being a woman, having fair or poor health, having activity limitations, and having chronic diseases increased both the likelihood of medical care and the level of expenditures.

The models showed that immigrant status both reduced the likelihood of using any health services and reduced expenditures for those who used such services; therefore, the combined effect of immigrant status on medical expenditures was larger than either effect separately. As described earlier, I used the models to estimate the differences in medical expenditures for the US-born sample if they had had the same characteristics (such as health status, insurance, and race/ethnicity) as the immigrant population, differing only in terms of being US born, an established immigrant, or a recent immigrant. The models showed that the estimated annual total medical expenditure of an average recent immigrant was \$3066 (95% confidence interval [CI]=\$2995, \$3136), or about 20% less than the baseline average for a US-born adult with the same characteristics (\$3814; 95% CI=\$3728, \$3899). The average established immigrant's estimated total expenditures were \$3297 (95% CI=\$3222, \$3372; *P*<.001), or 14% less than the average for a US-born adult with the same characteristics. Similarly, the estimated average private and public medical expenditures associated with being a recent or established immigrant were less than those of being a US-born adult (analyses not shown).

These results differ somewhat from those reported by Mohanty et al., who used 1998 MEPS data.<sup>8</sup> One reason for this difference is that the relative expenditures for US-born adults and immigrants changed between 1998 and 2003. Average, unadjusted expenditures for nonelderly US-born adults grew 68% from 1998 to 2003, whereas average, unadjusted expenditures for nonelderly immigrants grew 39% during the same period, slightly more than half as much. Thus, on an unadjusted basis, the native-immigrant expenditure gap grew. Mohanty et al. reported that, after adjustment, immigrants' medical expenditures were 55% lower than those who were US born, a gap wider than the one I found. The reason for this discrepancy is that, although Mohanty et al. made adjustments to retransform the logit and linear regression estimates, they did not hold other characteristics of their population constant to isolate the effects of immigration status. By contrast, I used the method of recycled predictions to control for other differences in characteristics of the US-born and immigrant populations.

**TABLE 4—Two-Part Multivariate Models of Factors Associated With Annual Medical Expenditures Among Adults Respondents Aged 19 to 64 Years With Any Health Insurance Coverage: Medicare Expenditure Panel Survey, 2003**

Factor	Model 1: Likelihood of Having Any Medical Expenditures in Year, OR (95% CI)	Model 2: Log of Medical Expenditures, Among Those Above Zero, Coefficient (95% CI)
<b>Immigration status</b>		
US born (Ref)	1.00	
Recent immigrant <sup>a</sup>	0.61 (0.45, 0.81)	-0.19 (-0.37, -0.01)
Established immigrant <sup>b</sup>	0.74 (0.58, 0.94)	-0.13 (-0.25, -0.02)
<b>Race/ethnicity</b>		
Non-Hispanic White (Ref)	1.00	
Hispanic	0.68 (0.55, 0.85)	-0.19 (-0.28, -0.10)
Non-Hispanic Black	0.50 (0.41, 0.60)	-0.22 (-0.32, -0.12)
Asian	0.61 (0.45, 0.82)	-0.36 (-0.51, -0.22)
<b>Gender</b>		
Men (Ref)	1.00	
Women	3.35 (2.92, 3.85)	0.46 (0.40, 0.52)
<b>Education</b>		
Any college (Ref)	1.00	
Less than high school diploma	0.46 (0.36, 0.58)	-0.31 (-0.41, -0.20)
High school diploma	0.62 (0.52, 0.74)	-0.16 (-0.22, -0.10)
<b>Self-reported health status</b>		
Good/very good/excellent (Ref)	1.00	
Fair/poor health	1.83 (1.34, 2.50)	0.68 (0.60, 0.76)
<b>Functional limitations</b>		
No limitations (Ref)	1.00	
Any limitations	2.35 (1.81, 3.05)	0.57 (0.49, 0.64)
<b>Chronic disease</b>		
None (Ref)	1.00	
Has chronic disease	3.86 (3.10, 4.82)	0.59 (0.52, 0.65)
<b>Income</b>		
≥400% of poverty level (Ref)	1.00	
Income below poverty level	0.64 (0.49, 0.84)	0.06 (-0.05, 0.18)
100%–199% of poverty level	0.59 (0.48, 0.74)	-0.10 (-0.19, -0.01)
200%–399% of poverty level	0.78 (0.67, 0.91)	-0.07 (-0.13, -0.01)
<b>Months of insurance</b>		
Public	1.08 (1.04, 1.12)	0.06 (0.04, 0.07)
Private	1.08 (1.05, 1.10)	0.05 (0.04, 0.06)

Note. OR = odds ratio; CI = confidence interval. The models also were controlled for age, employment, marital status, and region of country, but the coefficients were generally not significant.

<sup>a</sup>Defined as having lived 10 or more years in the United States.

<sup>b</sup>Defined as having lived fewer than 10 years in the United States.

Table 2 shows that, on an unadjusted basis, recent immigrants' medical expenses were approximately half those of US-born adults, and established immigrants' medical expenses were about two thirds those of

US-born adults. These results suggest that slightly less than half of the overall (unadjusted) gaps in medical expenditures between immigrants and US-born citizens are attributable solely to immigrant status and that

slightly more than half of the overall gaps are attributable to other characteristics, including insurance coverage, health status, and race/ethnicity.

## DISCUSSION

My analysis of a nationally representative survey found that immigrants had significantly lower medical expenses than their US-born counterparts, even after controlling for level of health insurance coverage and other confounding factors. These findings suggest that, contrary to stereotypes, insurance premiums paid for immigrants may actually be cross-subsidizing the medical expenses of those who are born in the United States.

### Immigrants' Lower Medical Expenditures

As noted by Mohanty et al. and Goldman et al., the low per-person medical expenditures for immigrants indicate that immigrants consume a disproportionately small share of the nation's health care costs and do not create a major financial burden for the nation's health care system.<sup>7,8</sup> Recent immigrants are responsible for a little more than 1% of the amount spent by federal, state, and local governments for health care, although they constitute 5% of the adult population. Recent administrative data also reinforce these findings. In 2006 and 2007, US hospitals, emergency physicians, and ambulance companies documented providing an average of \$221 million per year of uncompensated emergency care for undocumented aliens under a special federal reimbursement program called Section 1011, which equals about 0.03% of total American hospital expenditures.<sup>22,23</sup> (These estimates adjust values upward when payments were subject to a pro rata cap on payment, so they reflect the actual value of uncompensated care). The Section 1011 data are conservative because some providers probably did not seek reimbursement under the program. However, because any public or private emergency care provider was eligible for federal reimbursement, those who provided any substantial amount of uncompensated care for the undocumented had a strong incentive to seek payment.

I found that even when immigrants were fully insured over the course of a year, their medical expenditures were approximately one half to two thirds as much as those of US-born

adults. Even after adjusting for health status, race/ethnicity, gender, health insurance coverage, and other factors, I found that immigrants' medical costs averaged about 14% to 20% less than those of US-born citizens.

### Potential Cross-Subsidies

I also found that a substantial portion of immigrants was insured but still incurred very low levels of medical expenditure. This finding raises the intriguing possibility that insurance payments made on behalf of immigrants are actually cross-subsidizing care for US-born citizens. It is not possible to say with certainty whether this cross-subsidization is actually taking place, because the MEPS household data do not include total health insurance premiums. On the one hand, insurers do not appear to use factors like race, ethnicity, or national origin in setting or risk-adjusting health insurance premiums, and most states explicitly prohibit insurers and managed care plans from discriminating on the basis of race, ethnicity, or national origin.<sup>24</sup> On the other hand, it is possible that immigrants or their employers are selecting less costly insurance plans, such as plans with higher cost-sharing, which could lead to lower total immigrant medical expenditures. However, immigrants' out-of-pocket payments for care are much lower than those of native citizens, which is not what one would expect if immigrants were subject to higher cost-sharing.

Cross-subsidies are not inherently problematic; an important function of health insurance is to pool risks and use premiums collected from the healthy to pay for the medical care of those who need it. But a cross-subsidy from immigrants to US-born citizens is more problematic in light of evidence of immigrants' limited access to care,<sup>9–13</sup> and such a situation would certainly contradict the assumption that those born in the United States are underwriting the medical care of immigrants. There is little doubt that immigrants' access to health care needs to be improved; thus, the possibility that immigrants are cross-subsidizing care for their US-born counterparts suggests that immigrant health care could be improved if resources were diverted away from immigrant cross-subsidies for US-born citizens and rechanneled into immigrants' care.

To effect such a rechanneling, insurers—both public and private—could take steps to reduce language barriers by paying for interpretation or other language services for patients with limited English proficiency. Language barriers contribute to poor access to care, increased risks of medical errors, unnecessary medical testing, avoidable hospitalizations, and patient dissatisfaction with the medical care they receive.<sup>12,25–28</sup> Providing interpreters also has been shown to stimulate patients' use of primary care services.<sup>29</sup> Although federal civil rights policy already requires health care providers to offer free interpretation or language assistance to patients with limited English proficiency,<sup>30</sup> a primary stumbling block is that insurance usually does not pay for language services, giving providers a disincentive to actually provide these services. Private insurers and Medicare do not pay for interpretation, and only a handful of state Medicaid programs pay for them.<sup>31</sup>

In addition, insurers—particularly public payers—could make efforts to increase the supply of providers, particularly primary care clinicians, who practice in areas with higher concentrations of immigrants. Even though immigrants are responsible for a disproportionately small share of medical expenditures across the nation, they may create more of a burden in areas with high or rapidly growing immigrant populations. Areas with rapid growth in Hispanic populations, predominantly in the South and Midwest, often have an insufficient number of safety-net providers, such as community health centers or public or charitable hospitals, causing the capacity of these providers to be sorely challenged.<sup>32</sup> Insurers could provide incentives for clinicians and safety-net facilities to practice in medically underserved areas, such as those whose immigrant populations have grown.

Finally, the government could improve the equity of access to health insurance by reinstating legal immigrants' eligibility for Medicaid and SCHIP, undoing the restrictions imposed under 1996 federal legislation.<sup>5,9</sup> This would help increase the number of low-income immigrants who have health insurance coverage, reducing the number of uninsured US residents and lessening the strain on safety-net care providers.

### Limitations

A limitation of this study is that MEPS, like other national data sets, does not include data on legal or citizenship status of immigrants. However, census data do indicate that recent immigrants are primarily undocumented or legal noncitizens and that established immigrants are primarily naturalized citizens or legal noncitizens. Recent or undocumented immigrants may be under-sampled in MEPS, although the distributions of recent and established immigrants and US-born adults are similar to those found in census data. Data on medical expenditures are subject to measurement error, and aggregate national medical expenditures in the 2002 MEPS were about 13.8% below those reported in the National Health Expenditure Accounts.<sup>21</sup>

### Conclusions

There is little reason to believe that the United States is spending “too much” on health care for immigrants. The medical care used by immigrants—both recent and established—is small compared with the amounts used by their US-born counterparts. But we might be able to spend more wisely and fairly. Resources could be rechanneled to support additional care for immigrants, such as language services and additional primary care and coverage; to reduce health care disparities; and to improve the quality of care provided to Hispanics, Asians, and other foreign-born people. ■

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## In Memoriam

PNHP is greatly saddened by the deaths this past year of staffer Nicholas Skala and activists Dr. Linda Farley, Dr. David Prensky, and Dr. John Shearer. They were tireless, generous, and committed leaders, and are greatly missed.



## Worlds of difference

Julian Tudor Hart

In 1992, I published a paper in *The Lancet* called *Two paths for medical practice*.<sup>1</sup> This paper suggested that Health Minister Kenneth Clarke had, by imposing his Conservative government's new contract on general practitioners, set our profession on a backward path, from public service back towards the marketplace. The path forward was still there, but we had been pushed off it.

It was a shameful retreat from Nye Bevan's original trumpet call in the House of Commons in 1948, against British Medical Association (BMA) last-ditch resistance:

"I think it is a sad reflection that this great Act, to which every party has made its contribution, in which every section of the community is vitally interested, should have so stormy a birth. I should have thought, and we all hoped, that the possibilities contained in this Act would have excited the medical profession, that they would have realised that we are setting their feet on a new path entirely, that we ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world - put the welfare of the sick in front of every other consideration."<sup>2</sup>

His new path initiated a metamorphosis of medical care from trade in human desperation, toward science-led and evidence-based public service. It was only a first step, bound at best to take several generations to complete, but it was immediately popular with an overwhelming majority of voters. An equal majority of clinicians took slightly longer to be convinced that medical science could reach all who needed it better through tax-funded public service than through fee-paid trade.

From 1948 to 1989, no politician dared openly to challenge this gift economy that evidently worked, as judged by contemporary expert opinion.<sup>3</sup> A socialising UK National Health Service (NHS) then seemed irreversible, but nowadays every major UK political party endorses some sort of return to the marketplace. Voters are no longer offered the option of a public-service system operating as a gift economy, based on social solidarity and funded from progressive taxation. To understand this problem, we must look to its origins.

Adam Smith, founder of economics as an academic discipline, recognised greed as the necessary fuel for commodity production through exponentially rising productivity, which was made possible by capital investment in collective, organised production. However, as a professor of moral philosophy, he also anticipated Marx's theory of alienation.<sup>4</sup> This dangerous fuel needed constraint by a robust social framework composed of its opposite—public service, which is driven by social duty, not profit.

This frame was initially provided intellectually by religion, and materially by the Poor Law and *noblesse oblige*, which together formed a gift economy that

complemented the commodity economy. Women at home produced, reared, and socialised new workers. Craftsmen at work, and teachers in schools and universities, apprenticed and educated them. Priests, police, and prisons enforced their acceptance of priority for property rights over human needs. And a few people, at work, in universities, and in occasional crevices of the social machine, were allowed to create the new knowledge and ideas required for exponential expansion of its markets, without which capitalism could not survive. The economy of greed needed a parallel but subordinated economy of altruism, duty, and creativity.

Adam Smith warned that without investment in this parallel economy, capitalism would at best reduce men and women to machines, able to produce and consume, but no longer able to live the intelligent, creative lives of which all children are potentially capable. At worst, it would produce a demoralised population of wreckers.<sup>5</sup>

The most important part of this parallel gift economy was in the home. The results of sucking even this part into commodity production have been appalling, but this is not my subject. I want to look at the institutional gift economy, particularly institutional care of ill health. Until 1948, the institutional gift economy was still organised around the principle of less eligibility, which was originally adopted by Edwin Chadwick to make life in workhouses meaner, uglier, and more uncomfortable than the worst life outside<sup>6</sup>—a principle endorsed by Sydney and Beatrice Webb,<sup>7</sup> and by most other eminent social reformers of the early 1900s, when Lloyd George nationalised the local mutual aid societies developed by industrial communities out of their own material and intellectual resources, to create the foundations for liberal state welfare. There were reformers with warm hearts, like Dr Thomas John Barnardo, but generally the public service and charitable gift economy could afford neither generous feelings nor imagination. There seemed to be too many poor people for it to be safe to open the floodgates.

Better than any other leading contemporary politicians, Bevan knew those who lived outside these gates. Poor people value medical care higher than they did any other consumer good,<sup>8,9</sup> but he was confident that if it was transformed from a traded commodity into a human right, public demands would still relate to public needs. Despite many largely unsubstantiated assertions to the contrary, studies of specific problems confirmed that he was right.<sup>10,11</sup> Even nowadays, with most influences on opinion geared to consumerism, people go to doctors because of real fears or needs, not because they enjoy shopping. Until the NHS was thrust back into the marketplace, rising costs reflected expanding scope and effectiveness of medical science, not growing consumer

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avidity. Bevan's NHS transformed health care from a commodity sold by doctors as shopkeepers, to a service given by clinical teams as applied science.

The results of this change are even nowadays still in their infancy. The old gift economy provided social supports that were necessary for stable commodity production, but it was not and could not be profitable. Its gifts were never provided without some reminder that they originated not from those who work the economic machine, but from those who own and direct it. Its central concern was social control: any suggestion that free public services might impair private trade instantly incurred the wrath of commercial and supposed professional interests. State pensioners too sick, too old, or too poor to look after themselves fell into workhouse infirmaries, whose culture still operated well into the 1960s, long after their legal basis had gone.<sup>12</sup>

Like anyone else who lived in the south Wales valleys between the two World Wars, Bevan knew how the old public service economy actually worked. It crushed minds and bodies to save souls, and to preserve the social order within which business might flourish to create the wealth on which everyone had to depend. Into this stagnant substrate, Bevan introduced a vital seed—medical science released from dependence on fees, funded from progressive taxation. He made the development and application of medical science into a national enterprise, through what was—in effect if not in appearance—a shift of wealth and power from the few who owned the commodity production machine, to the many who worked it.

He conceded the demand of honorary physicians and surgeons (or Royal Colleges acting on their behalf) to carry their trading interests with them into NHS hospitals, and of general practitioners (or the BMA acting on their behalf) to stay unresourced in their primitive cottage industry. The English Royal Colleges and the BMA still gave priority to the interests of medical trade, over the interests of NHS full-time staff.<sup>13</sup> Bevan rightly anticipated that once the principal means of medical production were in public ownership, and services were freely available according to need, this seed would flourish in the fresh air and sunlight of international medical science. The professional opportunities opened by the transformation of health care from a petty, often irrational commodity in an always suspect trading relationship, to an effective, evidence-based gift economy in which both staff and patients could share in production of health gain, swept the ground from under the feet of the old leaders.

The marketplace to which UK political leaders and senior civil servants now compel the NHS in England to return<sup>14</sup> is profoundly different from the one that Bevan took over in 1948. In those days, medical trade was in the hands of established doctors, hospital consultants, or principals in general practice. Their claims to produce health gain were still too erratic, too

doubtful, and too closely bound to their personal judgments to provide much opportunity for profitable corporate investment. Those days are gone. Even doctors attracted to boutique medicine can no longer operate on the shopkeeping scale of the past. To make their millions they require serious capital, to fund staff and equipment resembling that which NHS hospitals still need to salvage their failures. The UK Government is seeking neither better shopkeepers, nor better public servants: it aims to hand the entire responsibility for planning and providing health care so far as possible to competing business.

As yet, the NHS has been turned back to the marketplace by stealth, and often by lying. The biggest lie, most essential to people trying to justify their so-called reforms, is that they transfer risks from taxpayers to private investors. Spurred by knowledge that if they fail they will be first to suffer the consequences, for-profit contractors are expected to work harder and more conscientiously than any public service to meet the requirements of their NHS contracts. Actual experience now provides many examples of health care for profit which have failed to deliver what they promised, even on the generous terms offered by governments determined to pursue this course irrespective of advice from the workplace. Private finance initiative (PFI) hospitals with a capital value totalling £8 billion will end by costing £53 billion, yet so far not one PFI value-for-money assessment has been released, because all the details of contracts and values are ruled commercially sensitive.<sup>15</sup> Runaway PFI disasters like the new Edinburgh Royal Infirmary,<sup>16</sup> the Norfolk and Norwich Hospital,<sup>17</sup> the NHS England information technology project *Connecting for Health*,<sup>18</sup> and ruinous dependence on outside business consultants, have all pointed to huge profits even where eventual salvage of essential public services has ended with taxpayers, as inevitably happens.

However, there are more fundamental reasons to anticipate global failure for marketised health care. First, its measured and rewarded product is always process, never health outcome. We might agree that this notion has been all too true throughout the history of clinical medicine, but as a public service we had at least the first promising shoots of health gain as our product, targeting human needs rather than consumer demand. The market tramples this aim underfoot, with a cocksure ignorance reinforced by virtually all lay media, until its failure becomes so obvious that this reality becomes the better story, with blame attributed to medical science or professional incompetence, never to the market process.

Second, by casting patients as consumers who are concerned only with their own gain, marketised health care fails to recognise the role of patients as responsible citizens, most of whom have welcomed social solidarity and collectively pooled risks ever since 1948.<sup>19</sup> For health care (as for any other commodity), the market promotes individual demand irrespective of collective needs.

Finally, it makes rational allocation of resources virtually impossible, marginalises public-health skills, corrupts public service by opening it to insider trading and promise of lucrative future corporate directorships, and impairs trust at every level between staff and patients.

Of course there is a way out. Though it operated outside the marketplace, the NHS never failed for that reason. Like other public services, everything possible had already been done to ensure failure by systematic underfunding, but this strategy was limited by what voters would tolerate. Even while the NHS tottered on the edge of bankruptcy, it was still more popular than any visible alternative. The last place anyone wanted to go was the health-care marketplace seen in USA, but that is our intended destination. Wales and Scotland are doing their best to get back on course, but with 84% of the UK population residing in England that will be difficult.

Even to return whence we came might seem better than where NHS England is heading now, but would solve nothing. In the 1980s, the portal of entry for business was the undemocratic nature of the NHS. Unless people we serve get a voice, they will eventually be hooked by choice. The old NHS was indeed a service for the people, not for shareholders, so it was a huge social advance; but it was neither by the people, nor of the people. When we renationalise the NHS, this must change: progress in this direction has become a precondition for the huge social movement that is essential before real reform can even begin. We need to rebuild the NHS from its foundations, in primary care<sup>20</sup> and in what is left of local hospitals. The only way that these changes can resist the fragmentation of care caused by market competition will be by restoration of personal continuity, and doing so far more comprehensively than we did in the old NHS, so that patients' life stories become central to information systems, rather than disjointed episodes of repair.<sup>21</sup>

The NHS in 1948 was the product of a social upheaval that was preceded by at least 20 years' development. Renationalisation of the NHS, and its rebirth as a public service on the basis of participative democracy, will require an even broader social base, with even higher expectations. Among politicians, only Bevan foresaw the Labour landslide of 1945 which led to the NHS, though his view was shared by most servicemen and women.<sup>22</sup>

From the birth of our public services in the late 19th century until 1979, the world of public service was separate from the world of business. Each had its own traditions, culture, career structures, and ambitions. Public service disdained participative democracy, but its ethics were real enough to eliminate most outright corruption, and it always contained seeds of a future society of cooperation rather than competition. Business

ethics were and are something else altogether—an oxymoron as self-contradictory as military intelligence. Only a massive swing of public opinion can retrieve public service from the marketplace, but when this change occurs, it will itself set public service onto a new course toward participative democracy, and the higher, more stable and sustainable society that we need to survive this terrifying century. Millions voted in what they thought was this direction in 1997. They were cheated, but enough of them know this, to make another and better 1945 not only possible, but as probable as Bevan foresaw in 1944.

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## Health Care Abroad: Taiwan

By Anne Underwood

William Hsiao is a professor of economics at the Harvard School of Public Health and co-author of the 2004 book "Getting Health Reform Right." He served as a health care adviser to the Taiwan government in the 1990s, when officials decided to reform that country's health care system and to introduce universal coverage. He spoke with Anne Underwood, a freelance writer.

**Q. Taiwan instituted universal insurance in 1995. What was the health care system like before?**

A. Only a portion of the people were insured, including civil servants, employees of large firms and farmers. The military had its own system of coverage. But 45 percent of the population did not have insurance, and they faced financial barriers to access to health care. President Lee Teng-hui felt strongly that he wanted to do something concrete and visible for all the citizens. He thought of introducing national health insurance to touch the lives of all the people. There was a sense in Taiwan that health care is needed by everyone and a country has to assure everyone equal access.

**Q. How did you become involved in the health care reform process?**

A. The government initially appointed four Taiwanese professors to lead a task force of technical experts. But the four professors all had different ideas. It was like a wagon drawn by four horses, with each going in a different direction and nobody driving. After a year of this, government officials realized there was a problem. In addition, they wanted someone who understood health systems and health care abroad and what lessons other countries could offer to Taiwan. The domestic experts did not have much international experience.

I was invited to a three-day workshop, where they tested me. At the end, I was put in charge of the task force of four professors and 16 other technical experts. It turned out to be a big advantage that I'm not Taiwanese and had no aspirations of getting a job in Taiwan. At the end of the day, our recommendations and findings were perceived as more objective and free of self-interest.

**Q. What was your assignment as head of this task force?**

A. We had to design a national health insurance plan for Taiwan, based on international experience. Government officials wanted to understand how other advanced countries fund and organize health care and learn from their successes and failures, so I made a study of the systems in six high-income countries — the United States, the U.K., Germany, France, Canada, Singapore and Japan.

**Q. And what was your conclusion at the end of this study?**

A. We adopted a single-payer system along the Canadian lines. I did not invent it. I'm just in the transfer-of-knowledge business.

**Q. Why did you choose the Canadian model?**

A. Canada has a single-payer system with universal insurance coverage. It offers people free choice of doctors and hospitals, and it has competition on the delivery side between public and private hospitals. The quality of health services is very high, and people were very satisfied with the system from the 1980s through the mid-1990s.

Unfortunately, in the early-to-mid 1990s, Canada went through a severe recession for four or five years. The budget became very tight. The government underfunded national health insurance, which led to long waiting lines for elective surgery, MRIs and so forth. But when Canada adequately financed its N.H.I., it was a very good system.

**Q. In Taiwan, can people choose any doctor or hospital they want?**

A. Yes, any provider. Americans talk about choice. But in fact, insurance plans in this country restrict what providers you can go to. Canada gives its citizens more choice of providers. So does Germany. So does England. So does Taiwan.

**Q. How comprehensive is the coverage?**

A. It covers prevention, primary care and hospitalization, among other things.

**Q. I've read that it also covers Chinese massage, acupuncture, traditional herbal medicine, mental health care, dental, vision and long-term care.**

A. Yes, these services are covered. We tried to design a benefit package that would give people what they value. For many Taiwanese, that includes traditional Chinese medicine. Though Chinese medicine is not 100 percent proven to be medically effective, people believe in it. And some therapies have been proven effective. For example, when acupuncture is given in certain spots, it stimulates the brain to release opiates.

**Q. The Taiwanese system also covers home care.**

A. You need home care by visiting nurses for people who are chronically ill or bedridden. It's not rocket science to recognize this. Some people argue that the patients should pay for home care themselves. But if people have to pay out of pocket, they might not ask for visiting nurse services and their illnesses may get much worse. Then they will need to be hospitalized.

**Q. Is the system very expensive?**

A. Expensive is a relative term. Taiwan spends 6 percent of

G.D.P. on health care, compared to 16 percent in the United States.

**Q. How much do people have to pay?**

A. If you're employed, your employer pays 60 percent of your premium. The employee pays 30 percent, and the government subsidizes 10 percent. The government fully subsidizes the premiums for the poor and gives partial subsidies to veterans, the self-employed and farmers.

**Q. How much is the typical premium?**

A. The total insurance premium for employed workers is 4.6 percent of wages. That's much lower than in the United States, where the average is between 12 and 20 percent of wages for those who are covered by their employers.

**Q. Are there co-pays, too?**

A. Yes. The task force felt that service should not be totally free or else people might waste services. For example, we studied what happened in Taiwan when some insurance policies gave prescription drugs free to everyone. One-third of the drugs dispensed were never taken but thrown away. You can imagine, if you have free office visits, some people will say, "I have this little ache. I'll go see the doctor because it's free." We wanted to moderate this waste.

**Q. How high are co-pays?**

A. The charge is \$2 for a visit to a clinic and about \$4 to a hospital outpatient department. The co-pay for hospitalization is now 10 percent for the first 30 days and 20 percent for the days beyond 30 days. For prescriptions, it's 20 percent of the cost of the drug, but capped at \$6 for each prescription. Taiwan also sets a ceiling on the total co-pays, so patients won't face bankruptcy.

**Q. How long did it take to implement this program?**

A. Less than a year. Mr. Lee pushed through the legislation in four to five months, because an election was coming. Then he asked for the new system to be implemented six months after that — and they did it.

**Q. What percent of the population is now insured?**

A. Within the first year, Taiwan managed to insure 95 percent of the population. That increased that by another percent or so each year, until they reached 98 percent. They had trouble with that last 2 percent, because some were living overseas and others were homeless. The government literally sent people to find the homeless under bridges and enroll them. Now they have close to 99 percent enrollment.

**Q. Has this translated into better life expectancy or lower complication rates from major diseases?**

A. There is evidence of positive health results for select dis-

eases, like cardiovascular disease and kidney failure. But overall, it's really difficult to say that national health insurance has improved the aggregate health status, because mortality and life expectancy are crude measurements, not precise enough to pick up the impact of more health care. That said, life expectancy is improving, and mortality is dropping. And everyone now has access to good health care.

**Q. What does the system do particularly well?**

A. In addition to covering everyone, it has a uniform system of electronic health records. Every patient has a Smart Card. When you go in for services, the physician puts the card into his computer. You give him the code to access your records, which are all stored on the card — what medications you've taken, what tests, along with the results, the last time you saw another physician. With a single, unified electronic system, it improves treatment and it also vastly reduces claims processing. Hospitals and doctors get paid in a week or two. It's a paperless system. That's why it keeps administrative costs down to 2.3 percent of the total premium. In the United States, it's more than 10 percent.

Taiwan was also able to control health-expenditure increases very well in the early years. Unfortunately, now that the government budget is tight, it is overdoing it.

**Q. What are the system's weaknesses?**

A. In the legislative process, compromises had to be made. First, the president yielded on payment reform, so Taiwan kept its fee-for-service payment system. Unfortunately, that encourages doctors and hospitals to

give more treatment in order to boost their income.

Second, the Taiwanese system doesn't have a systematic way to monitor and improve quality of care.

Third, in the legislative process, they rejected a provision to adjust the premium automatically when the national health system depletes its reserves. In every country, health care costs are increasing faster than wages. When that happens, the premium has to go up. But that provision wasn't incorporated into the law. As a result, the system is running a deficit. National health insurance tries to cut the fees for hospital and physician services. But eventually these fee reductions will adversely affect the quality of health care.

**Q. What's the most important lesson that Americans can learn from the Taiwanese example?**

A. You can have universal coverage and good quality health care while still managing to control costs. But you have to have a single-payer system to do it.

For more details about Taiwan's system, see "Lessons from Taiwan's Universal National Health Insurance: A Conversation with Taiwan's Health Minister Ching-Chuan Yeh" by Tsung-Mei Cheng, Health Affairs, July/August 2009



## Perspective

### Patient-Centered Medical Homes in Ontario

Walter W. Rosser, M.D., Jack M. Colwill, M.D., Jan Kasperski, R.N., M.H.Sc., and Lynn Wilson, M.D.

As the United States debates health care reform, the concept of “patient-centered medical homes” is receiving increasing attention.<sup>1</sup> Many experts believe that medical homes with multidisciplinary

teams and financial incentives for providing comprehensive care will lead to improvements in health, increase efficiency, and reduce costs of care while making practice more attractive for primary care physicians. Lessons regarding the implementation of medical homes and their ability to accomplish these goals can be gleaned from Ontario’s experience with Family Health Teams (FHTs).

Back in 1969, Canada adopted a universal health insurance program. The federal government provided partial funding, and each province developed its own health care system under national guidelines. At first, the system was well

funded, and most Ontarians were satisfied. Family physicians practiced solo or in small groups and were paid on a fee-for-service basis. But by the mid-1980s, family doctors struggled to keep up with practice demands. Rising costs and either static or falling incomes pressured physicians to increase the number of patient visits, which, many observers believe, negatively affected both the quality of care and physicians’ personal lives. Interest in family medicine declined, and the proportion of Ontario medical graduates entering the field fell to 24% in 1998, though the health care system was based on the expectation that 50% of

physicians would be in family practice, Canada’s only primary care specialty.

In the early 1990s, the chairs of Ontario’s five university departments of family medicine became increasingly concerned that the payment system rewarded high-volume practices rather than broad, patient-centered care.<sup>2,3</sup> In response, a government-appointed committee identified a “basket” of services that family practices should provide. After physicians and politicians had been persuaded of its merits, the FHT was introduced in 2004. The FHT model is designed to expand the capacity of primary care through development of interdisciplinary teams and to improve the breadth and quality of care through incentives provided by a blended payment model. Today, about 720 physicians in 150 FHTs serve more than 1 million patients.

The model is flexible, and no two FHTs are the same. A typical practice includes at least seven family physicians and a multidisciplinary team that provides a broad range of services and 7-day-a-week access to care. Physicians sign a contract with the Ministry of Health to provide the basket of services and agree to the remuneration package. Patients wishing to receive care from an FHT must register with the Ministry and select a physician at a given practice. There is no certification process for FHTs, but electronic data, such as results of screening for colon cancer, document the services and provide information for reimbursement by the Ministry.

Primary care services focus on patient advocacy and coordination of care. Specifically included are episodic and acute care; mental health care; chronic disease care; evidence-based prevention; education for self-care; care in the hospital, at home, and in the community; support for the terminally ill; and arrangements for around-the-clock response for urgent problems. In essence, the FHT serves as the focus for all patient care, providing the majority of care and coordinating that provided by specialists and by other community resources. Not every physician delivers every service, but each group must be organized to do so. The patient's physician sees to it that appropriate services are provided.

Physicians have responsibility for a defined panel of patients and are assisted by other health professionals, such as nurses, nurse practitioners, psychologists, pharmacists, social workers, and health educators. A typical physician panel includes about 1400 patients, smaller than a typical U.S. prac-

tice. Inclusion of a nurse practitioner adds 800 patients to the expected practice size. The Ministry provides salaries for the other health professionals and funding for an electronic record system meeting Ministry requirements.

Physician payment is based on age- and sex-based capitation that is calculated from Ontario's fee-for-service experience. Additional fees are provided for services deemed to require added emphasis — visits for infants, for instance, or patients over 75 years of age. Physicians receive fees for procedures and for visits to hospitals, homes, and nursing homes. Graded bonuses are provided for achieving prevention goals for one's patient panel. Family doctors receive a bonus of \$100 to \$300 for every new patient, depending on the complexity of that patient's needs. The physician forfeits 1 month's capitation fee when a patient seeks care elsewhere. About 60% of physicians' incomes come from capitation and 40% from other fees and bonuses. Each FHT has a governing board with community representatives and is responsible for ensuring that standards are met, but standards of care are established by physicians.

Primary care reform in Ontario took more than a decade from conceptualization to implementation. Although many physicians were initially skeptical about its potential for success, as-yet-unpublished studies document high levels of patient and physician satisfaction. When the Ministry recently sought to delay expansion to 200 FHTs, protests by patient groups and physicians led to cancellation of the delay.

The use of interdisciplinary teams expands the range of services provided and reduces over-

load for individual physicians. Since income is not based primarily on physician visits, practices can explore broader roles for team members and may use telephone, e-mail, and group visits to enhance efficiency. The total number of visits per patient has not declined, but more visits appear to be occurring with team members other than the primary physician. One study has shown that control of hypertension is better among patients in FHTs than among those in fee-for-service practices.<sup>4</sup> The use of integrative electronic record systems appears to improve efficiency and communication, and we believe that quality incentives have made participating physicians more proactive in providing preventive services and providing care management for chronically ill patients. A full evaluation of this model's effects on health outcomes, quality measures, and costs will be completed in 3 to 5 years. One effect that is already obvious is an increase of approximately 40% in physicians' incomes: the average net income for a family physician has increased from \$180,000 (Canadian) in 2004 to \$250,000 within FHTs, but it has not risen substantially in the fee-for-service sector.

Most Ontario teaching practices are FHTs and emphasize the values of patient-centered care in both family medicine residency programs and undergraduate medical education. The percentage of Ontario medical school graduates entering family medicine has increased from 25% in 2004 to 39% in 2009 (as compared with an increase from 24% to 29% in other Canadian provinces). Anecdotal information suggests that the first choice of Ontario's family medicine residents is now to prac-

tice in FHTs. Family physicians who were initially skeptical are now seeking to participate.

Per capita, Canada has one third fewer active physicians than the United States, 15% more primary care physicians, and half as many specialists. Consequently, the heavy responsibilities of Canadian specialists promote shared care with family physicians, and specialists rarely see patients without referral. In the United States, only 30% of visits to specialists occur through referrals,<sup>5</sup> and patients are likely to see multiple specialists. Canada's physician mix has helped to contain costs, but the government recognizes that it faces shortages of both primary care and specialist physicians. Its goal is for every person to have a family physician. Ontario's large investment in FHTs signifies its commitment to enhancing the capacity and quality of primary care.

Could medical homes be implemented in the United States?

For many in primary care, Ontario's model represents the type of practice they always hoped to have. Already, many managed care organizations and some integrated delivery systems are headed in that direction. But multiple insurers in a region, rather than a single payer, would have to invest in the medical home for it to be viable for most primary care practices.

U.S. health care reform legislation anticipates a strong foundation of primary care — but that foundation is crumbling. Having faced similar problems, Ontario continues to convert fee-for-service practices to patient-centered medical homes, so far with positive results, including more graduates entering family medicine. Its experience can provide useful lessons for the United States as it addresses its primary care crisis.

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# Global Drug Discovery: Europe Is Ahead

A reanalysis of data from 1982–2003 contradicts the claim that U.S. drug firms overtook European firms in pharmaceutical innovation.

by Donald W. Light

**ABSTRACT:** It is widely believed that the United States has eclipsed Europe in pharmaceutical research productivity. Some leading analysts claim that although fewer drugs have been discovered worldwide over the past decade, most are therapeutically important. Yet a comprehensive data set of all new chemical entities approved between 1982 and 2003 shows that the United States never overtook Europe in research productivity, and that Europe in fact is pulling ahead of U.S. productivity. Other large studies show that most new drugs add few if any clinical benefits over previously discovered drugs. I discuss ways in which Congress, employers, and insurers can increase the value of drugs and revitalize the U.S. pharmaceutical industry. [*Health Affairs* 28, no. 5 (2009): w969–w977 (published online 25 August 2009; 10.1377/hlthaff.28.5.w969)]

FOR MORE THAN A DECADE, industry and official reports have concluded that the United States has overtaken Europe in the discovery of new drugs, commonly defined as new chemical entities (NCEs). “Europe risks to be relegated into the fringe of the industry,” concluded a seminal report that has shaped European policy.<sup>1</sup> “The United States has become the dominant player,” the European trade association reported in 2008, as U.S. research investments grew 5.2 times from 1990 to 2007 compared to 3.3 times in Europe.<sup>2</sup> Reinforcing this view, Henry Grabowski and Richard Wang examined all new chemical entities discovered between 1982–1992 and 1993–2003 and concluded that U.S. firms had overtaken their European counterparts.<sup>3</sup> They also concluded that although the number of new chemical entities declined, their quality is high and has increased. In other words, most new drugs that are discovered are better than existing drugs, and most come from the United States.

This paper offers a new perspective based on a reanalysis of Grabowski and Wang’s key findings and large studies of clinical quality over many years. It thus poses important challenges to widely held American beliefs about U.S. dominance in pharmaceutical research productivity and about the superior quality of those

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new drugs. The findings suggest that Congress and large purchasers are motivating companies to develop and market drugs that add little value, instead of rewarding true added value. This is not good for the long-term vitality of the industry or for those paying too much for too little.

### Research Productivity: The Basic Picture

Let us start with the findings of Grabowski and Wang based on their comprehensive data set from IMS Health of all 919 new chemical entities approved between 1982 and 2003.<sup>4</sup> They used various criteria to identify which were “global” (introduced into four or more of the Group of 7, or G7, countries), first-in-class, biotech, and orphan (those developed to treat rare, or orphan, diseases) NCEs. New chemical entities were assigned to the country in which the headquarters of the company that first launched them was located. This resulted in an exhibit showing how many of each type were discovered in Europe, the United States, or Japan for 1982–1992 and 1993–2003. The present reanalysis accepts their data and definitions in order to examine the percentages and ratios of innovation.<sup>5</sup>

If one simply calculates the percentage of NCEs credited to the United States, Europe, and Japan, one sees in Exhibit 1 that the U.S. share of all NCEs rose dramatically from the first period to the second, while the European and Japanese shares declined. The United States gained in global, first-in-class, biotech, and orphan NCEs as well.<sup>6</sup> One can see, however, that European research productivity scarcely declined, and Europe continued to dominate in discovering all NCEs as well as the highly profitable global NCEs.

Clearly, the United States did not overtake Europe in discovering new chemical entities, and European researchers lost less ground than either Europeans or Americans believe.<sup>7</sup> Despite the appeal of launching first in the big, highly profit-

**EXHIBIT 1**  
**Percentage Of New Chemical Entities (NCEs) Discovered In The United States, Europe, And Japan, During Two Time Periods (1982–1992 And 1993–2003)**

Type of NCE	United States		Europe		Japan	
	82–92	93–03	82–92	93–03	82–92	93–03
All	25.3	35.9	48.4	43.3	26.3	20.8
Global	37.3	39.5	55.9	54.6	6.6	5.8
First-in-class	46.2	50.0	44.2	45.0	9.6	4.5
Biotech	45.0	53.6	30.0	33.3	25.0	13.0
Orphan	50.0	57.4	45.0	42.6	5.0	0.0

**SOURCE:** Author’s calculations of data from H.G. Grabowski and Y.R. Wang, “The Quantity and Quality of Worldwide New Drug Introductions, 1982–2003,” *Health Affairs* 25, no. 2 (2006): 452–460, Exhibit 4, minus “rest of world.”

**NOTES:** Because the rest of the world is not shown here, percentages by period for each type of NCE represent percentages of 100, with the universe being the United States, Europe, and Japan. For example, for 1982–92, the percentages for all NCEs (25.3 U.S., 48.4 Europe, and 26.3 Japan) add up to 100 percent.

able U.S. market, where companies face the fewest delays to market and can charge the highest prices, overall NCE research productivity in Europe using Grabowski and Wang's criteria and data was greater, even in the later period.

### Research Productivity On A Level Playing Field

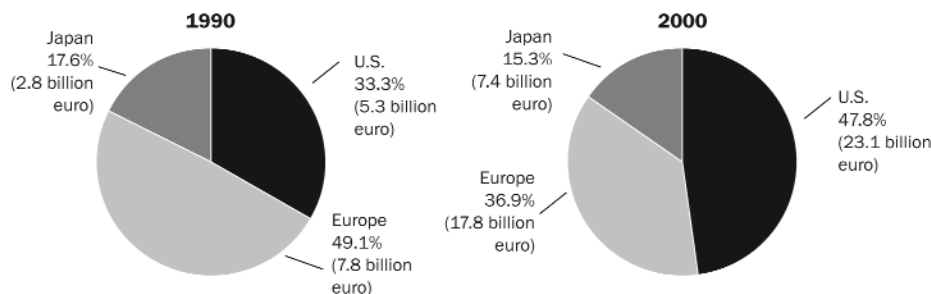
Research productivity and total funding are often confounded, as in the typical claim that “the U.S. has established itself firmly as the key innovator in pharmaceuticals since 2000.”<sup>8</sup> To what degree is this a self-fulfilling prophecy resulting from the industry's pouring more money into American research and development (R&D), and to what degree are American labs and teams becoming more innovative, dollar for dollar?

A simple but important measure of research productivity would compare the proportion of industry R&D funding for the United States, Europe, and Japan to the proportion of new chemical entities in each. The European Federation of Pharmaceutical Industries and Associations has culled investment figures for 1990 and 2000 reported by member companies to the U.S., Japanese, and European trade associations and corrected for exchange rates.<sup>9</sup> Because no annual figures are given, these can approximate funding distributions for the first and second decades analyzed by Grabowski and Wang; thus, they can be used to roughly calculate the relationship between research productivity and funding.<sup>10</sup>

As shown in Exhibit 2, pharmaceutical companies increased their R&D investments in the United States from about a third of the three-country total in 1990 to half in 2000. R&D investment in Europe dropped twelve percentage points during the decade, and investment in Japan declined around two percentage points. Absolute numbers increased everywhere because companies reported a rapid increase in total R&D investments, from 15.9 billion euro (US\$22.4 billion) in 1990 to 48.3 billion euro (US\$68.0 billion) in 2000.

#### EXHIBIT 2

#### Percentage Of Total Drug Research And Development (R&D) Funds Invested In The United States, Europe, And Japan, 1990 And 2000



**SOURCE:** European Federation of Pharmaceutical Industries and Associations, *The Pharmaceutical Industry in Figures*, 2008 ed. (Brussels: EFPIA, 2008). Company-reported figures were converted to euro.

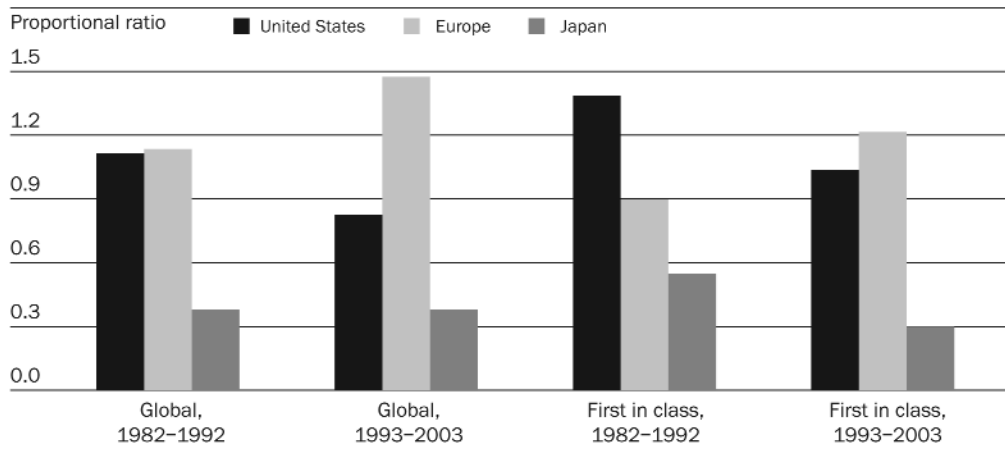
Overall research productivity can be measured by the proportion of new chemical entities to the proportion of R&D investment in the three countries. For example, if U.S. research teams received 33 percent of the budget, they should discover about 33 percent of all NCEs—a ratio of 1.0. By dividing the percentage of all NCEs in Exhibit 1 by the percentage invested, one can see that the United States discovered far fewer NCEs than its proportional share of funding: 0.76 (25.3/33.3) in the first period and 0.75 in the second. Europe’s ratio of all NCEs to investment went from 0.99 in the first period to 1.17 (43.3/36.9) in the second. Japan’s proportionate ratio was the highest: 1.49 in the first period and 1.36 in the second.

The big news in terms of innovation and international policy is the low and flat U.S. productivity and the high Japanese productivity. Of course, these ratios are constantly changing, and there is a lagged effect; however, Grabowski and Wang’s conclusions about U.S. dominance are not supported by their own data.

How did the United States, Europe, and Japan perform for global and first-in-class new chemical entities? In global NCEs, European research productivity was about the same as U.S. productivity in the first period but increased by 30 percent in the second period (1993–2003), while U.S. research productivity declined 26 percent (Exhibit 3). In first-in-class drugs, European relative innovativeness moved from well behind the United States in the first period to well ahead in the second. These are the most commercially and therapeutically important types of new chemical entities.

In biotech products, European researchers became much more innovative in the

**EXHIBIT 3**  
**Proportional Ratio Of Global And First-In-Class New Chemical Entities (NCEs) To Research And Development Industry Funding In The United States, Europe, And Japan, In Two Time Periods (1982–1992 And 1993–2003)**



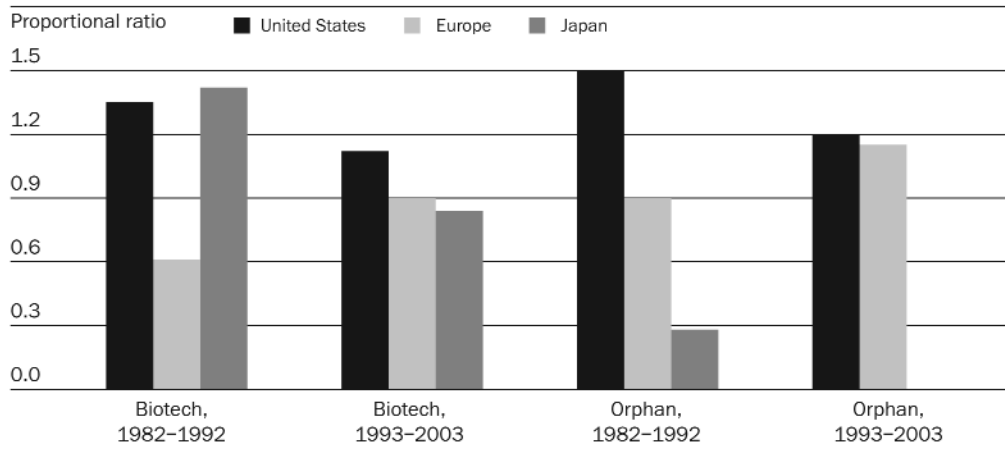
**SOURCE:** Author’s analysis based on data in Exhibits 1 and 2.  
**NOTES:** 1.00 equals innovation proportionate to investment, as shown in Exhibit 2. Percent change in productivity from first to second time period: Global, U.S. -26%; Europe, 30%, Japan, zero. First in class, U.S. -25%; Europe, 36%; Japan, -40%.

second period but did not catch up with their U.S. counterparts, even though U.S. productivity declined (Exhibit 4). In orphan drugs, proportional European research productivity gains and U.S. declines resulted in Europe’s moving from well behind the United States to about even in the second period. Overall, these results do not support the claim that “U.S. firms overtook their European counterparts in innovative performance of first-in-class, biotech, and orphan products.”<sup>11</sup>

Evidence of European research productivity would be stronger if one corrected for Grabowski and Wang’s ruling out first-in-class new chemical entities launched in Europe or Japan but not yet available in the United States, while ruling these drugs in if launched in the United States but not in Europe or Japan. They do not disclose how many of these there were. Likewise, they excluded orphan products not yet available in the United States but included orphan drugs available in the United States but not in Europe or Japan. A third source of possible bias favoring U.S. productivity comes from assigning new chemical entities to the country in which the launching company is headquartered. This tends to favor the United States because more companies have located there than in Europe or Japan since 1982 through mergers, acquisitions, and strategic business decisions. Twelve of the twenty largest companies are headquartered in the United States.

To summarize, this reanalysis provides strong, general evidence that U.S. firms have not overtaken their European counterparts in pharmaceutical innovation. European research productivity has actually increased in proportion to funds received and would prove stronger still if new first-in-class and orphan drugs

**EXHIBIT 4**  
**Proportional Ratio Of Biotech And Orphan New Chemical Entities (NCEs) To Research And Development Industry Funding In The United States, Europe, And Japan, In Two Time Periods (1982–1992 And 1993–2003)**



**SOURCE:** Author’s analysis based on data in Exhibits 1 and 2.

**NOTES:** 1.00 equals innovation proportionate to investment, as shown in Exhibit 2. Percent change in productivity from first to second time period: Biotech, U.S. –17%; Europe, 48%, Japan, –41. Orphan, U.S. –20%; Europe, 25%; Japan, –100%.

launched in Europe but not the United States had been included. Given the new institutes in European countries that bring together applied scientists from industry and academe to translate discoveries into drugs, such as Top Institute (TI) Pharma in the Netherlands; Karolinska Institutet Innovations in Stockholm, Sweden; and the broader European Innovative Medicines Initiative, returns on R&D investment in Europe may increase further during the next decade of 2004–2014.<sup>12</sup>

### **No Good Evidence Of Better Quality**

The claim that most new drugs are of high quality or “important” for patients is puzzling, because Grabowski and Wang never really define what they mean by “quality,” and my extensive correspondence with Grabowski produced no clear answer. From the perspective of patients, physicians, and health plans, “quality” means that new drugs are clinically more effective or have fewer side effects than existing treatments; however, Grabowski and Wang did not use data or studies of therapeutic outcomes. Instead, for example, they claim that global NCEs launched in four or more G7 industrialized countries are an “indicator of a drug’s commercial and therapeutic importance.” This confounds two quite different attributes.

Nexium and Lipitor, for example, are among the world’s top-selling drugs, but Nexium is widely regarded as a textbook case of a me-too drug, and Lipitor has little proven clinical advantage over other statins.<sup>13</sup> Most new cancer drugs generate large revenues at high prices but have not proved to be clinically superior to existing ones.<sup>14</sup> Only 7 percent of new biotech products were proven clinically superior to comparator drugs in randomized trials.<sup>15</sup> In short, commercial success is often distinct from therapeutic importance.

The best evidence of clinical quality comes from systematic efforts to assess therapeutic advantage and adverse effects compared with existing drugs. A detailed analysis of therapeutic quality in new drugs over the past twenty years found that 14 percent of all new chemical entities are either therapeutic breakthroughs or substantially superior to existing medications.<sup>16</sup> Likewise, a comprehensive review of all new drugs approved between 1989 and 2000 in the United States concluded that 14.8 percent were new chemical entities that provided significant clinical improvement, and a Canadian review board concluded that 10.7 percent of new chemical entities in 2000–2004 did so.<sup>17</sup> During an earlier period, an often-cited industry assessment of all global NCEs in the 1970s and 1980s found that only about 11 percent of all new “international” drugs brought substantial new benefits to patients—a ratio of one in nine.<sup>18</sup> These figures are lower than the proportion of drug candidates given a priority rating by the U.S. Food and Drug Administration (FDA), because this rating is based on several criteria of promising benefits that might not always materialize.

Thus, different organizations, using somewhat different criteria and procedures, have found that during the past forty years about 11–15 percent of new chemical entities have been therapeutically “important,” as Grabowski and Wang

*“Lower European prices seem to be no deterrent to strong research productivity.”*

put it, and 85–89 percent have not been—a contrast with their using nontherapeutic criteria to conclude that 88.8 percent of all new chemical entities have been therapeutically important.

### **Policy Reflections**

This study shows how data purporting to document how “U.S. firms overtook their European counterparts in innovative performance” actually document the greater and increasing research productivity of Europe. On the European side, a series of reports commissioned by the European Commission’s Directorate-General for Commerce between 1993 and 2003 pronounced that the United States had eclipsed Europe in research productivity, despite little solid evidence.<sup>19</sup>

Congressional leaders and others concerned about high prices of new patented drugs will be heartened by this analysis, because lower European prices seem to be no deterrent to strong research productivity.<sup>20</sup> A previous analysis using industry-based data showed that pharmaceutical companies recover all costs and make a good profit at European prices.<sup>21</sup> Europeans are not “free riders” on American patients—another myth promoted by industry that assumes that countries are separate R&D/market silos that should each pay for themselves.

The real innovation crisis for patients and society is not the recent decline in new molecular entities but the small percentage over many years of new molecular entities that provide clinical advantages to patients over existing medications. This longer pattern stems from defining “effective” as better than placebo and using soft surrogate endpoints, or substitute criteria, instead of hard clinical endpoints.<sup>22</sup> As a result, the vast majority of new drugs that constitute 80 percent of U.S. pharmaceutical costs offer few therapeutic advantages and greater risks than good drugs discovered in prior years.<sup>23</sup> High prices for these new drugs enable companies to spend two and a half times more on marketing than on R&D, to persuade physicians to prescribe them and patients to want them.<sup>24</sup> Thus, current incentives reward better marketing more than better value.

If we want new drugs to be clinically superior to existing ones, we need to reward companies for developing them and not for developing drugs that are merely superior to placebo. Arjun Jayadev and Joseph Stiglitz propose a key strategy: pay in terms of clinical value added, as some large purchasers already do and as *Consumer Reports Best Buy Drugs* does by comparing value with price.<sup>25</sup> Jayadev and Stiglitz also recommend having clinical trials independently run and paid for by a public body such as the National Institutes of Health so that they can be designed to measure comparative advantages and risks over existing treatments. Publicly funded trials would also reduce cost and risk for pharmaceutical companies and

increase competition from smaller firms by lowering the high cost barrier that company-funded trials pose. These are some ways in which incentives can be re-structured to foster greater competition for clinically superior drugs and to lower overall spending.

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*The author gratefully acknowledges funding for this study by a grant from the T1 Pharma Escher Project, University of Utrecht, the Netherlands, as part of a larger research project on European pharmaceutical policy. The author is indebted to Bert Leufkens, Wim Blockmans, and Geetha Kumar for their encouragement in pursuing this research. Comments and suggestions from several reviewers and editors also have been very helpful.*

#### NOTES

1. L. Gambardella, L. Orsenigo, and F. Pammolli, *Global Competitiveness in Pharmaceuticals: A European Perspective* (Brussels: Directorate General for Enterprise, European Commission, 2000); and High Level Group on Innovation and Provision of Medicines in the European Union, "Recommendations for Action" (Brussels: European Commission—Enterprise and Industry, 2002).
2. European Federation of Pharmaceutical Industries and Associations, *The Pharmaceutical Industry in Figures*, 2008 ed. (Brussels: EFPIA, 2008).
3. H.G. Grabowski and Y.R. Wang, "The Quantity and Quality of Worldwide New Drug Introductions, 1982–2003," *Health Affairs* 25, no. 2 (2006): 452–460.
4. IMS Health is the global leader in market intelligence and information on pharmaceuticals. See the IMS Health home page at <http://www.imshealth.com>.
5. Limitations of this analysis lie mainly in the original data. For example, assigning NCEs by where the launching company's headquarters was located is commonly used but is clearly less accurate than investigating where the real discovery and development took place. The first-in-class designation is the object of methodological debates discussed in the original article, but this reanalysis uses the count provided. Further limitations about research and development (R&D) investments also reside in the figures given. They cannot be verified and may include costs not reasonably considered R&D for new drugs. They may have been assembled by different trade associations in different ways. As in the original article, such limitations are accepted in order to focus on major trends using data presented by the industry.
6. Grabowski and Wang identified 659 global, first-in-class, biotech, and orphan NCEs out of their total 919 NCEs for both periods. Grabowski and Wang, "The Quantity and Quality."
7. Gambardella et al., *Global Competitiveness in Pharmaceuticals*; High Level Group, "Recommendations"; and U.S. Department of Commerce, *Pharmaceutical Price Controls in OECD Countries: Implications for U.S. Consumers, Pricing, Research and Development, and Innovation* (Washington: Department of Commerce, 2004).
8. S. Frantz, "Pharma Faces Major Challenges after a Year of Failures and Heated Battles," *Nature Reviews/Drug Discovery* 6, no. 1 (2007): 5–7.
9. EFPIA, *The Pharmaceutical Industry in Figures*, p. 4. I initially contacted Pharmaceutical Research and Manufacturers of America (PhRMA) in Washington to ask for the best information on changes in industry R&D investments. The senior manager of policy, Gretta Thorn, sent me the EFPIA report as the best source. Extensive and ultimately unresolvable debates could be held about the consistency and quality of R&D funding reported by different companies to their trade association.
10. More finely grained analyses will run into the problem of small numbers for first-in-class, biotech, and orphan drugs.
11. Grabowski and Wang, "The Quantity and Quality," 452.
12. Top Institute Pharma creates collaborative academic and industry research teams involving several larger and smaller biotech companies, universities, and the Dutch government to accelerate commercial use of discoveries. For an overview, see D.J.A. Crommelin, "Public-Private Partnerships and 'Le Defi Americain' Revisited," *EUFEPS Newsletter* 15, no. 2 (2006): 1–3. The T1 Pharma home page is <http://www.tipharma.com>. One of Europe's leading research institutes, Karolinska Institutet Innovations aims to develop commercial uses more fully before transferring technology through a licensing agreement to obtain more profitable terms. See its home page at <http://www.karolinskainnovations.ki.se>. Information on this large, complex European Innovative Medicines Initiative is available from Innovative Medicines Initiative, "Objec-



- tives," [http://imi.europa.eu/objectives\\_en.html](http://imi.europa.eu/objectives_en.html) (accessed 6 August 2009).
13. "Atorvastatin: Why Such a Commercial Success?" (editorial), *Prescrire International* 13, no. 74 (2004): 237; "Choix d'une Statine" (editorial), *La Revue Prescrire* 26, no. 276 (2006): 692–695; and P. Mansfield, D. Henry, and A. Tonkin, "Single-Enantiomer Drugs: Elegant Science, Disappointing Effects," *Clinical Pharmacokinetics* 43, no. 5 (2004): 287–290.
  14. S. Garattini and V. Bertele, "Efficacy, Safety, and Cost of New Anticancer Drugs," *BMJ* 325, no. 7358 (2002): 269–271; and G. Apolone et al., "Ten Years of Marketing Approvals of Anticancer Drugs in Europe," *British Journal of Cancer* 93, no. 5 (2005): 504–509.
  15. R. Joppi, V. Bertele, and S. Garattini, "Disappointing Biotech," *BMJ* 331, no. 7521 (2005): 895–897.
  16. "A Look Back at Pharmaceuticals in 2006: Aggressive Advertising Cannot Hide the Absence of Therapeutic Advances" (editorial), *Prescrire International* 16, no. 88 (2007): 80–86.
  17. M. Hunt, *Changing Patterns of Pharmaceutical Innovation* (Washington: National Institute for Health Care Management Research and Education Foundation, 2002); and Patented Medicine Prices Review Board, *Annual Report 2004* (Ottawa: PMPRB, 2005).
  18. P.E. Barral, *Twenty Years of Pharmaceutical Research Results throughout the World: 1975–94* (Paris: Rhone-Poulenc Rorer Foundation, 1996).
  19. P. Stolk and D.W. Light, "Did the U.S. Eclipse European Research Productivity? An Analysis of Major Reports as Searchlights in the Fog," Report to TI Pharma Escher Project (Utrecht: University of Utrecht, 2008).
  20. U.S. House Committee on Oversight and Government Reform, *Private Medicare Drug Plans: High Expenses and Low Rebates Increase the Costs of Medicare Drug Coverage*, <http://oversight.house.gov/documents/20071015093754.pdf> (accessed 6 August 2009); and U.S. Senate Committee on Finance, "Baucus Condemns Senate Failure on Medicare Drug Price Negotiation," Press Release, 18 April 2007, <http://www.senate.gov/finance/press/Bpress/2007press/prb041807a.pdf> (accessed 6 August 2009).
  21. D.W. Light and J. Lexchin, "Foreign Free Riders and the High Price of U.S. Medicines," *BMJ* 331, no. 7522 (2005): 958–960.
  22. F.R. Curtiss and K.A. Fairman, "Looking for the Outcomes We Love in All the Wrong Places: The Questionable Value of Biomarkers and Investments in Chronic Care Disease Management Interventions," *Journal of Managed Care Pharmacy* 14, no. 6 (2008): 563–570.
  23. M.K. Olson, "Are Novel Drugs More Risky for Patients than Less Novel Drugs?" *Journal of Health Economics* 23, no. 6 (2004): 1135–1158; D. Carpenter, E.J. Zucker, and J. Avorn, "Drug-Review Deadlines and Safety Problems," *New England Journal of Medicine* 358, no. 13 (2008): 1354–1361; and T.J. Giezen et al., "Safety-Related Regulatory Actions for Biologicals Approved in the United States and the European Union," *Journal of the American Medical Association* 300, no. 16 (2008): 1887–1896. Patented drugs make up 28.7 percent of sales volume but 80.6 percent of costs. P.M. Danzon and M.F. Furukawa, "International Prices and Availability of Pharmaceuticals in 2005," *Health Affairs* 27, no. 1 (2008): 227, Exhibit 5.
  24. A. Jayadev and J. Stiglitz, "Two Ideas to Increase Innovation and Reduce Pharmaceutical Costs and Prices," *Health Affairs* 28, no. 1 (2009): w165–w168 (published online 16 December 2008; 10.1377/hlthaff.28.1.w165). For *Consumer Reports Best Buy Drugs*, see <http://www.consumerreports.org/health/best-buy-drugs/index.htm>. Benefits, side effects, and costs are compared for thirty-five common conditions.

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## Suggested additional reading on the pharmaceutical industry and the need for reform:

"Extraordinary Claims Require Extraordinary Evidence." Light, D.W. & Warburton, R.N. (2005), *J Health Econ*, 24, 1030-1033  
 Online: <http://bit.ly/light-claims>

"Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet." Light, D.W. & Lexchin, J. (2004), *Am J Bioethics*, 4, W3-W6.  
 Online: <http://bit.ly/light-drug-prices>

"Foreign Free Riders and the High Price of U.S. Medicines." Light, D.W. & Lexchin, J. (2005), *Brit Med J*, 331, 958-60.  
 Online: <http://bit.ly/light-free-riders>

# PNHP Chapter Reports – Spring 2010

**Alabama** PNHP's new chapter, North Alabama Healthcare for All, was launched in 2009. Members are active in speaking to physician and public audiences, lobbying, and building a grass-roots coalition in support of an improved Medicare for All. Dr. Wally Retan has appeared on ABC News and in other media. The Huntsville Times ran an op-ed in support of single payer signed by seven local physicians. Dr. Oliver Fein, PNHP president, had a very successful visit to Birmingham and Huntsville in late February, with multiple speaking events. Contact Dr. Pippa Abston in Huntsville at [pabston@aol.com](mailto:pabston@aol.com).

PNHP's **Arizona** chapter, the Arizona Coalition for State and National Health Plans, is growing. Members are active in speaking at town hall meetings and other events. The state Democratic Party passed a resolution in favor of single payer. Drs. Jonathan Weisbuch, Mary Ellen Bradshaw and George Pauk were among the many physicians who attended a rally and lobby day in support of Medicare's 44th birthday in Washington, D.C. A news program in Prescott featured Nancy Martin, RN, on

the advantages of single payer. Activists are working to block passage of a referendum measure that would pre-empt a single-payer plan at the state level; a similar measure was narrowly defeated in 2008. Contact Dr. Pauk in Phoenix at [gpauk@earthlink.net](mailto:gpauk@earthlink.net) or Dr. Eve Shapiro in Tucson at [shapiro@u.arizona.edu](mailto:shapiro@u.arizona.edu).

PNHP's **California** affiliate, the California Physicians' Alliance (CaPA) is active in promoting single payer at the national (H.R. 676) and state level (S.B. 810). In recent months, chapter members have been active in speaking, participating in rallies, educating medical students, and lobbying Rep. Nancy Pelosi and other members of Congress. One of the founders of the new L.A. chapter of PNHP, Dr. Matt Hendrickson, was arrested for participating in civil disobedience in support of single payer at Cigna offices in October. J.B. Fenix, CaPA's medical student fellow, helped organize hundreds of medical students for a successful lobby day for single payer in Sacramento in early January. CaPA is deeply saddened by the death of former President Dr. John Shearer, who worked tirelessly to build CaPA and the movement for single payer in California and nationally. Contact CaPA at [capa@pnhp.org](mailto:capa@pnhp.org), or contact Dr. Hendrickson at [hendrickson1965@yahoo.com](mailto:hendrickson1965@yahoo.com).

**Colorado** PNHPers are active in speaking, writing, lobbying, and coalition-building with Health Care for All Colorado. Dr. Irene Aguilar gave a presentation on health care financing and reform at HCAC's legislative kickoff. Activists spoke at numerous town-hall meetings and other educational events and are supporting the development of a statewide single-payer plan for Colorado. HCAC hosted Dr. Margaret Flowers for a single-payer

rally in mid-February. Contact Dr. Elinor Christiansen at [echris7doc@gmail.com](mailto:echris7doc@gmail.com).

**Florida** PNHPers are continuing to speak across the state, present grand rounds and work with media. Dr. Ray Bellamy's op-eds on single payer often appear in the Tallahassee Democrat. The Leon County Democrats passed a resolution in support of H.R. 676 last spring. In May, Dr. Ken Brummel-Smith presented a single-payer resolution to the Leon County Board of County Commissioners. PNHPers have appeared on numerous radio programs. Drs. Olveen Carrasquillo and Ana Palacio had an article published in *El Diario-La Prensa* of New York on the need for health reform that would benefit non-English speakers. Contact Dr. Bellamy at [ray.bellamy@med.fsu.edu](mailto:ray.bellamy@med.fsu.edu).

In **Georgia**, the chapter is continuing to engage new physicians and medical students. Dr. Henry Kahn was interviewed on the local NBC affiliate and had an article published in the *Atlanta Journal-Constitution* on why he supports single-payer national health insurance. Dr. Daniel Blumenthal and others had several articles published on why they support an improved Medicare for all. Contact Dr. Kahn at [hkahn@emory.edu](mailto:hkahn@emory.edu).

**Hawaii** PNHPers are active in giving grand rounds, speaking to community groups and organizing single-payer events. Dr. Steve Kemble garnered the endorsement of the Hawaii Medical Association for single-payer health reform at both the state and national level. Dr. Leslie Gise spoke at the Asian and Pacific Islander American Health Forum in Washington, D.C., on "Quality Affordable Health Care for All." Dr. Gise also chaired a symposium on single payer at the American Psychiatric Association's Institute for Psychiatric Services in New York City. A rally in Hilo drew over 200 single-payer activists. Contact Dr. Gise at [leslieg@maui.net](mailto:leslieg@maui.net).



Dr. Ann Settgaast, left, and Dr. Elizabeth Frost helped lead a delegation to the State Capitol in St. Paul, Minn., in September to ask that state lawmakers speak out in support of Rep. Dennis Kucinich's proposed amendment to let states experiment with single-payer health programs.

**Idaho** PNHPers are active in speaking, research and media outreach. Dr. Andy Wilper's research on the 45,000 Americans who die annually due to lack of insurance has been frequently cited in the national debate over health reform. Dr. Lou Schlickman's op-eds have appeared in the Idaho Statesman. Dr. Robert Vestal was featured on Idaho Public Television discussing the economic necessity of single payer. The chapter hosted PNHP board member Dr. Joseph Jarvis from Utah who spoke on the conservative case for single-payer national health insurance. A rally for single payer in Boise at City Hall was covered by the media. To get involved, contact Dr. Schlickman at [schlicklou@msn.com](mailto:schlicklou@msn.com).

**Illinois** PNHP members are active in speaking, lobbying, media outreach, and state and national coalition building. Dr. David Scheiner, Obama's former physician, and Dr. Claudia Fegan were featured in the media as respondents to Obama's health policy. PNHP members participated in numerous town hall and other educational forums across the state. Dr. Diljeet Singh is the new co-president of Health Care for All Illinois, the local PNHP affiliate. Dr. Singh worked with Dr. Fegan and chapter co-president Dr. Anne Scheetz to host a successful speaker's training session in December. Drs. David Scheiner and Margaret Creedon hosted a well-attended chapter-building social in March. State Rep. Mary Flowers continues to support a single-payer bill for Illinois; she helped garner an endorsement from the Illinois House for single payer to commemorate the anniversary of Medicare. PNHP is greatly saddened by the death of former staffer Nick Skala, who argued the case for single payer over other reform options before the Congressional Progressive Caucus in D.C. in July. Contact the chapter at [info@healthcareil.org](mailto:info@healthcareil.org).

In **Indiana**, PNHPers are active in speaking, lobbying, hosting public events, and coalition building with their statewide group, Hoosiers for a Commonsense Health Plan. In June, Dr. Rob Stone made a presentation on single payer to members of the Blue Dog Congressional Coalition



Harvard economist William Hsiao, Ph.D. with Vermont PNHP chapter chair Deborah Richter, M.D. at the Vermont Statehouse.

in D.C. Dr. Aaron Carroll appeared on The Colbert Report on Obama's health policy. Activists hosted a chapter visit and speaker's training with PNHP President Dr. Oliver Fein and chapter organizer Ali Thebert. Dr. Rob Stone is working with other emergency medicine physicians to organize within his specialty. Contact Dr. Stone at [grostone@gmail.com](mailto:grostone@gmail.com).

In **Iowa**, PNHPers are active in media and grassroots outreach, lobbying, and building a local speakers bureau. Dr. Jess Fiedorowicz spoke eloquently at the White House health forum in Des Moines and has published op-eds in the Des Moines Register. Dr. Miles Weinberger was featured on a local radio show. Contact Dr. Fiedorowicz at [mkejess@yahoo.com](mailto:mkejess@yahoo.com).

In **Kentucky**, PNHPers are speaking and rallying in support of single payer. About 50 Kentuckians participated in a demonstration in Washington, D.C., to commemorate the anniversary of Medicare. Single-payer events are increasingly covered by the local media. A candlelight vigil in memory of the nearly 45,000 Americans who die annually due to uninsurance was featured on the front page of the Louisville Courier-Journal. Dr. Garrett Adams and other activists recently participated in a sit-in at Humana headquarters to support improved Medicare for All.

Dr. Fein visited Louisville and Lexington in March for a very successful speaking tour. Contact Dr. Adams at [kyhealthcare@aol.com](mailto:kyhealthcare@aol.com).

**Maryland** PNHP members are active in speaking, writing and lobbying at both the state and national level, and doing outreach to the media. Drs. Margaret Flowers, Pat Salomon and Carol Paris were among those arrested for disrupting a Senate Finance Committee hearing that excluded single-payer advocates in May. Drs. Flowers and Paris have published several op-ed pieces in addition to contributing to the PNHP blog. In late January, in response to President Obama's request to "let me know" if anyone has a better solution to our health care crisis, Drs. Flowers and Paris were arrested holding a sign in support of Medicare for All outside a hall where the president was speaking. Maryland activists hosted a speaker's training in later February with over 40 attendees and speakers from across the country. Dr. Flowers, PNHP's congressional fellow, has been featured in the media, including on Bill Moyers Journal and Frontline, and is a frequent speaker to civic, religious and academic groups. She received the Dr. Quentin Young Health Activist award at PNHP's Annual Meeting. Activists are also promoting Maryland's state single-payer bill. Contact Dr. Flowers at [mdpnhp@gmail.com](mailto:mdpnhp@gmail.com).



Dr. Garrett Adams of Louisville, Ky., pauses for a moment with Dr. Arthur Sutherland of Memphis, Tenn., during Dr. Oliver Fein's chapter visit to Louisville in March 2010. Dr. Adams is PNHP's president-elect.

**Massachusetts** PNHPers are active in speaking, research, media outreach and lobbying on the state and national level. Drs. David Himmelstein, Steffie Woolhandler and their colleagues published several groundbreaking studies in 2009, including a study showing that nearly 45,000 people die annually due to lack of insurance. Drs. Himmelstein and Woolhandler were featured widely in the press, including in the Boston Globe, The New York Times, and the CBS Evening News. Dr. Rachel Nardin spoke at a press conference in Washington, D.C. on the flaws of the Massachusetts health plan. Medical student Iyah Romm testified in support of single payer before the Massachusetts Legislature, and he and resident Sylvia Thompson had an op-ed published in The Huffington Post. Nearly 200 physicians signed an ad that appeared in the Boston Globe saying that Massachusetts' health care is not a model for the nation. Contact Dr. Nardin at [rnardin40@gmail.com](mailto:rnardin40@gmail.com).

In **Minnesota**, PNHP members are active in speaking, writing, lobbying and working in coalition with other organizations on both the state and national level. Chapter members are frequent speakers to community groups and have been featured in several radio interviews. Dr. Oliver Fein, PNHP's national president, gave grand rounds, attended a fundraiser, and met with two newspaper editorial boards and local activists during a recent

visit. Leaders hosted a very successful speaker's training this winter that was widely attended. Contact Dr. Ann Settgast at [settg001@umn.edu](mailto:settg001@umn.edu) or Dr. Elizabeth Frost at [libbess@gmail.com](mailto:libbess@gmail.com).

**Mississippi** PNHPers are active in speaking to community organizations and working in coalition with the Mississippi Health Advocacy Program. Dr. John Bower has presented on single payer many times, including once when he shared the platform with Dr. Steffie Woolhandler, co-founder of PNHP. Contact Dr. Bower at [jbower564@aol.com](mailto:jbower564@aol.com).

**Missouri** activists are active in delivering grand rounds, speaking to the public and reaching out to the media in support of single payer. Dr. William Parks presented the case for single payer to over 100 people at an event sponsored by a coalition of university groups. Dr. Joshua Freeman presented grand rounds at KU Medical Center. Drs. Robert Blake and David Mehr were featured in interviews on their support for a single-payer system. Contact Dr. Tom Lieb at [tfml@sbcglobal.net](mailto:tfml@sbcglobal.net).

In **Montana**, PNHPers are active in speaking, lobbying, media outreach, and coalition-building with Montanans for Single Payer. An eloquent op-ed in the Missoulian in support of health care as a human right was signed by Dr. Hal Braun

and over a dozen other physicians. Activists, union leaders, and community groups continue to make the case for single payer to Sen. Max Baucus whenever he holds a public meeting. Contact Dr. Robert Putsch at [poo@lincintel.net](mailto:poo@lincintel.net).

In **New Hampshire**, PNHPers are active in delivering grand rounds, speaking to community groups and meeting with legislators. PNHPers recently formed a speakers bureau to further their advocacy efforts. Drs. Thomas Clairmont and Marcosa Santiago have published several op-eds in area papers. Dr. Rob Kiefner's article on why his patients won't be helped by the recent federal health care legislation was recently published in the Concord Monitor. Contact Barbara Power, RN, at [bjpower2@gmail.com](mailto:bjpower2@gmail.com) or Dr. Clairmont at [tppc48@aol.com](mailto:tppc48@aol.com).

The **Capital District New York** PNHP chapter is active in supporting pro-single payer resolutions, hosting community events, coalition-building, lobbying and media outreach. Dr. Andy Coates' op-ed on the "death of the public option" and need for single payer appeared in over a dozen newspapers. Dr. Coates represented PNHP at the International Association of Health Policy meeting in Spain. Danielle Alexander and other medical students held a vigil in support of single payer. The New York State Senate endorsed H.R. 676 due to the efforts of PNHP members and labor activists. Contact the Capital District chapter at [pnhpcapitaldistrict@gmail.com](mailto:pnhpcapitaldistrict@gmail.com).

The PNHP **New York Metro** chapter hosted numerous speakers' trainings, forums, medical student talks, and other events this year. N.Y. Metro PNHPers participated in countless media interviews and meetings with state and federal lawmakers. Dr. Laura Boylan was arrested with seven others in December for sitting in for single payer at the office of Sen. Charles Schumer, D-N.Y. Drs. Oliver Fein, Alex Pruchnicki, Mary O'Brien, along with Dr. Boylan and Leonard Rodberg, the chapter's research director, have been keeping active speaking schedules, presenting the case for single payer to the public and the press. Contact PNHP New York Metro at [info@pnhpnymetro.org](mailto:info@pnhpnymetro.org).

In **Oregon**, PNHP activists have been speaking at community events and grand rounds, lobbying, and doing media interviews. Dr. Mahr's op-eds have appeared in *The Oregonian*. "Mad as Hell Doctors" Paul Hochfeld, Peter Mahr, Samuel Metz, Bob Seward, Gene Uphoff and Michael Huntington took to the road, appearing in 22 cities at town-hall meetings, rallies and vigils en route to Washington, D.C. They generated substantial media coverage for single payer. Oregon PNHPers hosted Dr. Oliver Fein for a chapter visit in January that included dozens of speaking events, a fundraiser, and numerous media appearances. Contact Dr. Mahr at [peter.n.mahr@gmail.com](mailto:peter.n.mahr@gmail.com).

**Pennsylvania** PNHPers are speaking, educating legislators at local and federal levels, and coalition building. PNHPers participated in a rally at the Capitol in Harrisburg. The chapter hosted former Cigna executive turned whistle-blower Wendell Potter to speak on the private health insurance industry. Dr. Dwight Michaels testified in support of a state single-payer plan before the Pennsylvania Legislature. Contact Dr. Walter Tsou in Philadelphia at [mcaman2@aol.com](mailto:mcaman2@aol.com) or Dr. Scott Tyson in Pittsburgh at [styson@pediacssouth.com](mailto:styson@pediacssouth.com).

**Tennessee** PNHPers are active in speaking, meeting with community leaders, and coalition-building on the need for single-payer reform. Dr. Art Sutherland is a frequent speaker on single payer to faith and civic groups and recently participated in a press conference stressing the need for real health care reform. In October, PNHPers joined a rally against the private health insurance industry. Recently members participated in a candlelight vigil for health reform. Contact Dr. Sutherland at [asutherland@sutherlandclinic.com](mailto:asutherland@sutherlandclinic.com).

The **Texas** PNHP chapter, Health Care for All Texas (HCFAT), is active in speaking, lobbying, giving media interviews, and participating in community events. HCFAT members worked with a coalition of nearly 100 members to advocate for single payer within communities of faith. Dr. Ana Malinow participated in

Houston PBS' town-hall meeting. During a recent visit to the chapter, PNHP President Dr. Oliver Fein spoke to medical students and residents, delivered grand rounds, met with the media and faith community leaders, and presented the case for single payer to a local public health advocacy organization. Contact [info@hcfat.org](mailto:info@hcfat.org).

In **Vermont**, PNHPers have been active in speaking, lobbying, coalition building, and participating in town-hall meetings and rallies. Dr. Deb Richter spoke at the White House regional summit on health reform and on Capitol Hill to congressional staff with Con Hogan, former head of Vermont's Human Services Agency. She has also spoken to dozens of community organizations, including Rotary clubs, and had an op-ed published on patients who have died because they lacked health insurance. PNHPers attended many of Sen. Bernie Sanders' town-hall meetings during the legislative recess and report that the vast majority of attendees were single-payer supporters. Contact Dr. Richter at [drdebvt@sover.net](mailto:drdebvt@sover.net).

**Western Washington** PNHPers have been active in speaking, lobbying, coalition-building and doing media outreach. Dr. Oliver Fein, PNHP president, delivered grand rounds, spoke to community groups, and gave media interviews in a

recent visit. PNHP members participated in a march and other demonstrations for single payer. The Washington State Democratic Party released a poll showing that Democrats support single payer 2 to 1. Dr. Jason MacLurg's op-ed was published in the *Seattle Post-Intelligencer*. Dr. John Geyman was interviewed many times on regional and national radio about the health insurance industry and single payer. Dr. Ken Fabert arranged for single-payer public service ads on the local NPR station and was interviewed by Fox Business News. In late February local activists hosted an annual meeting featuring speakers from across the country, including the Mad as Hell Doctors and Donna Smith of CNA/NNOC. Contact Dr. David McLanahan at [mcltan@comcast.net](mailto:mcltan@comcast.net).

Several **Wisconsin** PNHPers, including Drs. Rian Podein, Laurel Mark, and Melissa Stiles, have stepped up to become more active since the death of Dr. Linda Farley, the much-loved, tireless, and enthusiastic leader of the chapter for many years. Dr. Gene Farley continues to speak out and has been featured on local radio a number of times. Dr. Cindy Haq was interviewed on Wisconsin Public Radio. Several PNHPers, including Dr. Jeff Patterson, are active in distributing information on single payer to the public. Contact Dr. Rian Podein at [rpodein@gmail.com](mailto:rpodein@gmail.com).



Dr. Gustavo Montana of Chapel Hill, N.C., makes a point with PNHP past president Dr. Claudia Fegan of Chicago at the 2009 Annual Meeting in Cambridge, Mass.

# FAQ

## WHAT ARE THE TOP TEN SOURCES OF SAVINGS UNDER SINGLE-PAYER NATIONAL HEALTH INSURANCE?

1. Insurers' overhead.
2. Hospital administrative costs.
3. Physicians' offices/clinics' administrative costs.
4. Nursing home administrative costs.
5. Employers' costs to administer health benefits.
6. Monopsony drug and device purchasing.
7. Elimination of current incentives for overuse of technology and procedures by banning for-profit ownership of imaging facilities, specialty hospitals, etc.
8. Enhanced ability to identify fraud and abuse due to centralized payment system that can identify suspicious practice/billing patterns – e.g. billing for ultrasound on every gynecology visit.
9. Malpractice insurance and defensive medicine due to elimination of need for patients to sue to cover future medical expenses and the ability of patients to choose and keep their physicians, enhancing continuity, doctor-patient communication, and confidence in care.
10. Longer term savings attendant on improve health planning/capital allocation & shifting specialist/primary care balance toward an appropriate mix.

\* Patients' time spent on billing paperwork (priceless).

## WHAT WILL HAPPEN TO INSURANCE COMPANY AND CLERICAL EMPLOYEES DISPLACED BY SINGLE PAYER?

1. Many insurance industry workers already have clinical degrees (e.g. nurses). Instead of helping to administer a system that profits by denying care, they can return to the bedside. They'll be badly needed.
2. Many workers can be retrained to work in the new system, particularly in shortage areas like home care, long-term care, and mental health care.
3. Another area in which more workers are needed (and for which they'll be more investment under single payer) is in public health – e.g. in education and guidance in diet, exercise, chronic disease management, etc.
4. Some will find jobs vacated by people who are only working today because they need their employer-sponsored health coverage either for themselves or a family member, e.g. lots of people in their 50s or 60s who are not yet eligible for Medicare.
5. Congressional single-payer legislation includes several measures to help displaced clerical workers, including (1) first priority in retraining and job placement in the new system; and (2) eligibility for two years of unemployment benefits."

## RECOMMENDATION:

# HMO exemption in state single-payer legislation must be specific and narrow

By David Himmelstein, Kip Sullivan & Steffie Woolhandler

The single-payer model precludes private insurance that duplicates the public coverage – a measure required both to control costs and to avoid the emergence of two-class care. The question of how to treat nonprofit, staff- and group-model HMOs is complex because they combine a nonprofit provider of care (clearly acceptable in a single-payer model) with a private insurance plan (which is not acceptable). After much debate, PNHP decided to include such organizations in its proposals, but with tight restrictions to minimize the problems inherent in the insurance component of HMOs.

Because the term "HMO" has been used to cover a wide variety of insurers, it is important that legislation clearly define the parameters for HMOs that could participate in a single-payer system, and spell out the restrictions on participating HMOs. Failing this, private insurers would surely exploit any exemption for HMOs to maintain their stranglehold on the health care system.

Both PNHP's proposals and H.R. 676 (the single-payer legislation sponsored by Rep. John Conyers; you can find the legislation on the PNHP website at: <http://www.pnhp.org>) have spelled out the key features that distinguish HMOs allowed to continue under a single-payer system from those that would be proscribed. Specifically, participating plans must:

- (1) be nonprofit;
- (2) "actually deliver care in their own facilities" through salaried physicians who are employees (not contractors) of the HMO;
- (3) not use their capitation or budget payments to cover hospital services (hospital services would be paid for through a global budget paid directly to the hospital); and
- (4) not offer financial incentives based on utilization.

Very few HMOs will qualify under this definition.

When single-payer supporters in California drafted single-payer legislation (the current version is S.B. 810), they inserted language into the bill that was intended to exempt Kaiser Permanente. However, the language used in the bill leaves the door open to many private insurance firms who could label themselves "integrated health care delivery systems," "independent practice associations," or "integrated service networks" and hence qualify them to receive global budgets or capitation payments from the single payer.

The potential for confusion was illustrated in Minnesota where legislators introduced legislation (S.F. 2324 / H.F. 2522) modeled on SB 840 (the predecessor to S.B. 810) in May 2007. The drafters stated their intention to exclude private health plans, including HMOs. However, an analysis by the research office for the Democratic Farmer Labor Party caucus in the Minnesota House of Representatives stated that the bill did permit "health plans" to participate.

To avoid confusion, and the possibility that private insurers could slip through a loophole, we recommend that any single-payer legislation that proposes to exempt HMOs use either H.R. 676's definition of "HMO" or a similarly narrow and specific definition.

# Baucus thanks Wellpoint VP Liz Fowler for writing health care bill

By Jane Hamsher

Not a surprise really that upon passage of the health care bill, Max Baucus would openly thank Liz Fowler, the former Wellpoint VP, for writing it:

Mr. BAUCUS. Mr. President, there are a flood of emotions going through all of us today as we pass this reconciliation bill which improves upon the bill the President signed 2 days ago. I would like to focus only on one part – a very important part but only one part – and that is to thank the people who have worked so hard, especially in this body, to help accomplish this result.

[...]

We all want to thank so many people. Once we start mentioning a couple or three names, we run the danger of offending people whose names are not mentioned. We all know that. There will be an appropriate time for us to make all the thanks, and I will make mine so sincerely because I am so grateful for all the hard work my staff has put into this.

I wish to single out one person, and that one person is sitting next to me. Her name is Liz Fowler. Liz Fowler is my chief health counsel. Liz Fowler has put my health care team together. Liz Fowler worked for me many years ago, left for the private sector, and then came back when she realized she could be there at the creation of health care reform because she wanted that to be, in a certain sense, her profession lifetime goal. She put together the White Paper last November 2008 – the 87-page document which became the basis, the foundation, the blueprint from which almost all health care measures in all bills on both sides of the aisle came. She is an amazing person. She is a lawyer; she is a Ph.D. She is just so decent. She is always smiling, she is always working, always available to help any Senator, any staff. I thank Liz from the bottom of my heart. In many ways, she typifies, she represents all of the people who have worked so hard to make this bill such a great accomplishment.

I will have printed in the Record the names of all my professional staff. There are more than I realized, so I can't name them all. I ask unanimous consent to have that list printed in the Record and just regret that I cannot thank everybody personally.

It's right up there with Tom Carper's insistence that the Senate had to respect the White House deal with PhRMA

because after all they paid for it with \$150 million in political advertising as "most telling moments of the health care debate."

Nancy Pelosi says the foundations of the health care bill were written by the Heritage Foundation. Probably true, Heritage is awash in corporate money. And really, the plan is no different than the one that AHIP (then HIAA) wrote in 1992:

- Every American was required to buy 'an essential package' of benefits

- The government would help define the essential package and private insurers would provide the standard package "regardless of a person's medical history"

- Only the essential package would be protected from taxation. If employers bought more than the basic benefits, the premiums paid for the extra coverage "would be treated as income to the employees, and they would have to pay income tax on it."

- The government would work with private insurers to "stabilize health-care prices" and make sure private insurers and government programs pay similar amounts for the same services in the same geographic area.

All of the underpinnings of the insurance "reform" package were already there, waiting for someone to sweep in and make AHIP's champagne dreams come true. And now that the Chamber of Commerce is not funding the mandate repeal effort any more, those legislative efforts are stalling out across the country. Republicans in Alaska, Kansas, Georgia and Michigan have all voted down anti-mandate bills since the Chamber pulled the plug (failing by one vote in Kansas after Republican Dwayne Upmeyer "accidentally" voted against it. "Oops" was his response.) Sarah Palin didn't mention the mandate in her speech before cheering Tea Partiers at Searchlight, no doubt conscious of the \$2.5 million in donations the health care sector contributed to McCain/Palin in 2008.

The insurance industry has spent their money well, spreading it across both parties. They got what they paid for with this neoliberal health care bill. Ken Silverstein's prescient 2006 article in Harpers on Obama's early vetting by corporate interests still stands up. They sized up the situation accurately years ago.

Thanks indeed, Liz Fowler. The country really does owe you one.



## Thanks for the question, Mr. President

Letter to the Editor **The New York Times**

To the Editor:

President Obama's State of the Union address had a high point when he pledged that anyone with a "better approach that will bring down premiums, bring down the deficit, cover the uninsured, strengthen Medicare for seniors, and stop insurance company abuses, let me know."

Thank you, Mr. President. The answer is the reform supported by 65 percent of the public and even 59 percent of physicians. It's remarkably simple, and the nation has already had 44 years of successful experience with it in financing health care for our elderly and the totally disabled.

It is, of course, Medicare-for-all, single-payer, not-for-profit national health insurance. Its superiority lies in excluding profit-seeking insurance companies and Big Pharma from controlling and undermining our health system. This is your answer, Mr. President.

Quentin Young  
Chicago, Jan. 28, 2010

The writer, a doctor, is national coordinator of Physicians for a National Health Program.



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