The Human Face of ObamaCare

Promises vs. Reality and What Comes Next

"This book is a must read for any American who has been or will be exposed to the American healthcare system. That would be all of us."

—Philip Caper, M.D., internist with long experience in health policy since the 1970s, and past chairman of the National Council on Health Planning and Development

John Geyman, M.D.

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John Geyman, M.D.

Copernicus Healthcare
Friday Harbor, Washington

Reviews

"Dr. Geyman advocates for single-payer health care with his usual wit, reason, and immaculate documentation. This time he fortifies his points with personal stories from across the country, describing the wreckage left by the Affordable Care Act. Putting human faces on ObamaCare brings the argument home poignantly. The people telling their stories of our failed health care system could be our friends, our families, and us. The unhappy consequences of ObamaCare touch us all."

—Samuel Metz, M.D., adjunct associate professor of anesthesiology, Oregon Health and Science University, Portland, OR

"This book has heartbreaking stories of U. S. citizens who face medical and financial catastrophes due to our dysfunctional healthcare system which now includes the ACA.

We need to listen to these stories to feel the true impact of how the profit-based medical industry is harming our society. A major paradigm change to single-payer is discussed as an equitable and viable solution.

—Ray Drasga, M.D., long-time community-based oncologist and leader toward universal health care in his own specialty organization, the American Society of Clinical Oncology.

"Many liberal Democrats supported ObamaCare as a step toward a universal single-payer public health insurance system. As Dr. John Geyman's book makes clear, ObamaCare was instead a leap into the arms of a rapacious private insurance industry that hiked premiums, denied care, cancelled policies, narrowed networks, jacked deductibles, drove doctors to burnout, fueled the rise in medical costs, raided the public treasury, bloated the bureaucracy and corporate profits, privatized Medicare and Medicaid, decreased the quality of care, and left 30 million Americans uninsured. Next time, can we learn from this debacle? Read this book. Then just say no to the private health insurance industry and those who would play their deadly game."

—Russell Mokhiber, Single Payer Action

"Although many had high hopes for ObamaCare, as John Geyman shows us the human faces, we realize that reform fell too short for too many. He shows us not only those human faces but also the pained face of health care justice. He provides us with an understanding of what is wrong with our system, and then describes options for the future. He encourages us all to participate in the reform dialogue so that we can finally get this right. The Human Face of ObamaCare is a great place to start."

—Don McCanne, M.D., family physician, senior health policy fellow and past president of Physicians for a National Health Program (PNHP).

"In his latest book John Geyman takes stock, honestly and objectively, of the state of American health care five years into the implementation of ObamaCare. He examines the law's effects on our healthcare system, on the healing professions, and on individual Americans and makes a persuasive case that ObamaCare is unsustainable. He presents three possible scenarios for future reforms.

After reading this comprehensive and persuasive critique, I am more convinced than ever that an improved and expanded "Medicare for All" system is not only the best for the vast majority of Americans but is the only reasonable option for those of us who believe health care should be focused on the prevention and treatment of illness rather than wealth-extraction from patients.

The only question now is how much longer the public will tolerate the accelerating corruption of our healthcare system Geyman documents and the charade that masquerades in Washington as a real debate about health care policy.

This book is a must read for any American who has been or will be exposed to the American healthcare system. That would be all of us."

—Philip Caper, M.D., internist with long experience in health policy since the 1970s, and past chairman of the National Council on Health Planning and Development

"Dr. Geyman has done it again: another up-to-the-minute report on the current state of our ailing health care system. This time, he includes a report card on the first five years of the Affordable Care Act, where it has succeeded and failed, and his forecast of what may come next. Like everything else he has written, his research is thorough and remarkably current. Where others rehash yesterday's statistics and arguments, Geyman's books are like breaking news. In this book he makes the facts personal: faces and cases of recurring failures in our privately-insured and profit-driven system to meet the medical costs of our people when they're sick. The system is still broken in 2015, Geyman explains, and it is breaking us. Finally, unlike so many critics of ObamaCare, Geyman shows us a rational and practical way out."

—Rick Flinders, M.D., family physician and inpatient program director, Santa Rosa Family Medicine Residency, Sutter Santa Rosa Regional Hospital, Santa Rosa, CA

"Dr. John Geyman gives us a clear summary of failed incremental reform attempts over many decades. The Affordable Care Act, AKA ObamaCare, is the latest example, and Geyman highlights its many shortcomings, including perverse incentives, rising costs, narrow choices, and still-incomplete coverage. He concludes with a cogent, compelling argument for a single-payer national healthcare system: the approach that's worked everywhere else in the world."

—Richard Deyo, M.D., Kaiser Permanente Professor of Evidence-Based Family Medicine, Oregon Health and Science University, Portland, and author of Watch Your Back!

"An insightful critique of ObamaCare and an impassioned plea for a single-payer system, enlivened by stories of real people poorly served by the Affordable Care Act. An invaluable contribution to the discussion of how to make health care in America better and more affordable for everyone."

—Kenneth Ludmerer, M.D., professor of medicine and the history of medicine at Washington University in St. Louis, and past president of the American Association for the History of Medicine

"The Affordable Care Act (ACA) was passed with great fanfare in 2010 with the promise to increase the number of Americans who have affordable health insurance, reduce unfair insurance restrictions, and reduce the costs of health care. In *The Human Face of ObamaCare*, Dr. Geyman holds the ACA up to the microscope and contrasts its promises and outcomes. Combining stories of patients with sound economic analysis, Dr. Geyman illuminates where the ACA has fallen short of its goals and points the way to an improved health care system that would be more affordable for both patients and for our country."

—Jeffrey Cain, M.D., past president American Academy of Family Physicians

"I have enthusiastically supported the Affordable Care Act, but have always regarded it as Health Reform 1.0. Health Reform 2.0 or 3.0 would inevitably be universal health care. The Human Face of ObamaCare does an excellent job of updating us on the successes and failures of the ACA and showing why universal health care is currently the best option for America's future."

—Howard Brody, M.D., Ph.D., Director of the Institute for Medical Humanities, University of Texas Medical Branch, Galveston

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Political insiders don't see that the biggest political phenomenon in America today is a revolt against the 'ruling class.'. . . but the revolt against the ruling class won't end with the 2016 election, which means the ruling class will have to change the way it rules America. Or it won't rule too much longer.

—Robert Reich, professor of public policy at the University of California Berkeley and chairman of Common Cause[1]

CHAPTER 18

CONTINUANCE OF THE ACA, WITH IMPROVEMENTS AS NEEDED

Introduction

After more than six years of discussion and debate over the ACA, one might wonder if the political war over U.S. health care is over. We are told by supporters of the ACA that the law is here to stay, and that too many people are being helped to repeal or dismember it at this point. But many conservatives and Republicans in leadership in Congress and state houses are still bent on taking the law apart by whatever means possible. Partisan differences along ideological lines have not changed, and are being amplified by disinformation campaigns in the 2016 election cycle. The war is not over, just entering a new stage in the ongoing conflict.

Unfortunately, this war has been fought over many years with little acknowledgement or guidance from evidence and experience derived from the health policy community. The power, money, and political influence of corporate stakeholders in a largely deregulated marketplace have long dominated election results at both federal and state levels.

As the 2016 election campaigns heat up, with the future of health care in the balance, it is likely that only two alternatives will be discussed by most candidates—what to do with the ACA or replacing it with whatever plans the Republicans can come up with. This would be a mistake. We need to include the third major option—single-payer national health insurance (NHI), expanded and improved Medicare for all, as supported by Bernie Sanders, and assess the advantages and disadvantages of all three alternatives on the basis of evidence and experience.

At this stage of the campaigns, the political spectrum on health care ranges from single-payer NHI with Bernie Sanders on the left, to Hillary Clinton in the center calling for incremental changes to the ACA, to candidates on the right eager to repeal and replace the ACA, rein in Medicaid, reduce spending, and give more power to the states over health care.[1]

As we assess these three basic alternatives, we need to consider two sets of related principles that should be helpful in bringing rational discourse and even consensus about where to go next in our efforts to assure access to affordable, necessary health care for all Americans with the best possible quality and outcomes. Based on these principles, we can then compare the three major alternatives toward still urgently needed health care reform.

Some Guiding Non-Partisan Principles

Most conservatives in other advanced countries around the world have long accepted the concept of health care as a human right. Donald Light, Ph.D., professor of comparative health care at the University of Medicine and Dentistry of New Jersey and co-author of the 1996 book, *Benchmarks for Fairness for Health Care Reform*, has found that conservatives and business interests in every other industrialized country have supported universal access to necessary health care on the basis of these four conservative moral principles—*anti-free-riding, personal integrity, equal opportunity, and just sharing*. He has proposed these 10 guidelines for conservatives to stay true to these principles:

- *Every one is covered, and everyone contributes in proportion to his or her income.*
- *Decisions about all matters are open and publicly debated. Accountability for costs, quality and value of providers, suppliers, and administrators is public.*
- *Contributions do not discriminate by type of illness or ability to pay.*

- *Coverage does not discriminate by type of illness or ability to pay.*
- *Coverage responds first to medical need and suffering.*
- *Nonfinancial barriers by class, language, education and geography are to be minimized.*
- *Providers are paid fairly and equitably, taking into account their local circumstances.*
- *Clinical waste is minimized through public health, self-care, strong primary care, and identification of unnecessary procedures.*
- *Financial waste is minimized through simplified administrative arrangements and strong bargaining for good value.*
- *Choice is maximized in a common playing field where 90-95 percent of payments go toward necessary and efficient health services and only 5-10 percent to administration*.[2]

In its 2004 report, *Insuring America's Health: Principles and Recommendations*, the Institute of Medicine, called for Congress to "adopt universal health coverage by 2010 to avoid needless deaths and substantial monetary costs to society, based on these guiding principles":

- *Health care coverage should be universal*
- *Health care coverage should be continuous*
- *Health care coverage should be affordable to individuals and families*
- *The health insurance strategy should be affordable and sustainable to society, and*
- *Health care coverage should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.*[3]

Based on these principles, which hopefully can be endorsed across party lines if the political debate is held to responsible and civilized standards, we can now consider the first option—continuation, with revisions as needed, of the ACA. The following two chapters will discuss the other two alternatives.

Continuation of the Affordable Care Act

There is no question that the ACA has accomplished some good things for many Americans, including bringing coverage to some 16 million people through the exchanges and expanded Medicaid, dropping the uninsured rate from about 18 percent to 10.4 percent (33 million people), and establishing some limited insurance reforms.

But as supporters of the ACA take a victory lap over the 2015 decision by SCOTUS, they overlook major problems of the law more than five years after its enactment. Far from achieving any of the two sets of non-partisan principles previously outlined, these are some of the inconvenient facts on the ground:

- According to the National Health Interview Survey of the National Center for Health Statistics, there are 29 million uninsured in 2015, down from 36 million in 2014[4]; the CBO projects that we will still have 26 million uninsured in 2020[5], but that projection was based on an estimated 20 million enrollees in 2016, and HHS has just acknowledged that achieving one-half of that number is probably the best that can be done by the end of 2016.[6]
- It will be very difficult to reduce the number uninsured much further under the ACA; the remaining uninsured are a hard core group, many of whom can't afford health insurance even with subsidies; almost 80 percent of the uninsured have less than $1,000 in savings[7]; and there are 3.1 million people in the "coverage gap" in the 20 red states opting out of Medicaid expansion.[8]
- Whatever the number of uninsured over the next few years, we will still have tens of millions underinsured, and will never achieve universal coverage under the ACA.
- A 2014 report from the Commonwealth Fund found that one in three Americans cannot afford necessary care and that the ACA does not address these underlying causes of medical

debt: high cost-sharing under many plans, limited protections for out-of-network care, limits on essential health benefit standards, and lack of resources for consumer assistance.[9]

- Despite some new requirements in the ACA, private insurers still have a number of ways to discriminate against the sick, including benefit designs that limit access, restrictive drug formularies, inadequate provider networks, high cost-sharing, and deceptive marketing practices.[10]
- A recent national study shows that 40 percent of physician networks for plans sold on the exchanges include less than 25 percent of physicians in their region; HMO plans typically don't cover any out-of-network providers.[11]
- The administrative overhead of private Medicare Advantage is about five times higher than traditional Medicare.[12]
- There are inadequate price controls in the ACA, which has given insurers, hospitals, and drug companies, and others in the medical-industrial complex new markets with minimal oversight.
- Insurance co-ops were funded under the ACA with the hope that they would increase competition in state insurance markets and give consumers more options; But they have been plagued by lack of support by the Centers for Medicare and Medicaid Services (CMS), low enrollments and net losses, forcing some to close down due to adverse claims experience[13]; co-ops have already failed in 11 states—Arizona, Colorado, Iowa, Kentucky, Louisiana, Nevada, New York, Oregon, South Carolina, Tennessee, and Utah—leaving some 500,000 people scrambling to find health insurance for 2016.[14]
- A recent projection by the Centers for Medicare and Medicaid Services (CMS) estimates that an expanding bureaucracy under the ACA will take up one quarter of federal health care spending and add almost $274 billion in new administrative costs heading into 2022.[15]

Can the ACA Be Improved?

At the political center of the health care debate, Hillary Clinton would make some changes to the ACA, including capping patients' share of the costs of doctor visits and prescription drugs, repealing the tax on high-cost employer-sponsored insurance (the "Cadillac tax"), requiring insurers to cover three "sick visits" a year without charging a deductible, and allowing Medicare to negotiate prices for high-cost drugs and biotech medicines.[16] While she has expressed "serious concern" over the Aetna-Humana and Cigna-Anthem mergers, and feels that the "balance of power is moving too far away from consumers," she gives no indication of giving up on the ACA. [17]

The Urban Institute, a non-partisan organization that studies health care costs, access, quality and coverage, has recently tried to assess how the ACA could be improved. Its basic conclusions are that premium and cost-sharing subsidies are inadequate, that 21 states have not expanded Medicaid, that education, outreach and enrollment assistance still fall short of the need, and that regulatory oversight and enforcement resources are insufficient. It makes various recommendations, all of which require spending more money on the ACA, without acknowledging its basic flaws. As Dr. Don McCanne observes:

> *[These recommendations] are merely proposing patches to the patches. We will still be left with millions without insurance, millions who are underinsured, profound administrative waste, and little means to control our high health care costs.*[18]

We might wonder whether revival of the public option for health insurance could make a difference today. It was conceived as a way to bring needed competition into financing of our health care, and received initial strong verbal support from President Obama. It was part of the original ACA bill as it went through

Congressional committees and debate, where it was killed under fierce opposition by the private health insurance industry and its lobbyists.

With the demise of the public option, co-ops were included under the ACA to address that need, but many soon ran out of money. With the recent closure of the co-op in Utah, the *Salt Lake Tribune* posted this editorial:

> *The original ACA had funds to back the co-ops if—when—they ran out of money. But the Republican-controlled Congress, frustrated by many attempts to repeal Obamacare outright, cut back on the guarantees. . . . Meanwhile, premiums continue to rise and the private insurance sector is consolidating as big firms are bought by bigger ones. There is less and less of the competition that reformers of all ideological stripes were hoping, some with more faith than others, would keep costs down. What Obamacare opponents do not seem to grasp is that, if it doesn't work, if the co-ops fail and the exchanges don't meet the needs of working families, going back to a pre-ACA jungle will not be a workable or ethical option. . . . It'll be single-payer, or at least a robust public option. As it should have been from the beginning.*[19]

But the public option would not have worked then or now. The lack of success of insurance co-ops gives us one example of what would have happened to it had it gone forward with the ACA. Drs. Himmelstein and Woolhandler give us two reasons why the public option, in competition with the large private insurance industry, will never work in this country:

1. *It forgoes at least 84 percent of the administrative savings available through single-payer. The public plan option would do nothing to streamline the administrative tasks (and costs) of hospitals, physicians' offices, and nursing homes, which would still contend with multiple payers, and hence still need the complex cost tracking and bill-*

ing apparatus that drives administrative costs. These unnecessary provider administrative costs account for the vast majority of bureaucratic waste. Hence, even if 95 percent of Americans who are currently privately insured were to join the public plan (and it had overhead costs at current Medicare levels), the savings on insurance overhead would amount to only 16 percent of the roughly $400 billion annually achievable through single-payer—not enough to make reform affordable.

2. *A quarter century of experience with public/private competition in the Medicare program demonstrates that the private plans will not allow a level playing field. Despite strict regulation, private insurers have successfully cherry picked healthier seniors, and have exploited regional health spending differences to their advantage. They have progressively undermined the public plan—which started as the single-payer for seniors and has now become a funding mechanism for HMOs—and a place to dump the unprofitably ill. A public plan option does not lead toward single-payer, but toward the segregation of patients, with profitable ones in private plans and unprofitable ones in the public plan.*[20]

Dr. Samuel Metz, single-payer advocate and anesthesiologist at the Oregon Health and Science University, adds these compelling reasons why the public option is no panacea:

1. *There are few reasons why co-ops and public options should have significantly lower administrative costs than private health insurance companies. . . they still must spend money on marketing and lobbying. Moreover, their per-patient expenditures for care will be higher because private health insurance companies have already taken the healthier clientele.*
2. *No American health insurance plan can survive by selling comprehensive policies at affordable prices to people who will get sick.*[21]

The Future with the ACA

The future of the ACA in the immediate future is unpredictable, depending on the results of the 2016 elections and how the highly polarized political forces play out. But what we do know for sure is that the ACA will not achieve its goals of full access (never to be universal), cost containment, affordable care, and improved quality of care for all Americans. After almost six years with the ACA, earlier chapters have shown how far short of these goals the ACA is. And to boot, we are expending huge amounts of money, at taxpayers' expense, to prop up insurance companies in what has become further private exploitation of the public purse.

The ACA has given the private health insurance industry new life. Table 18.1 shows how the CEOs of six of our largest insurance companies have fared. They and CEOs of other corporate stakeholders in the medical-industrial complex, together with their shareholders, have been racking up big profits while more and more Americans lose out on getting a health care system they need and deserve.

We have only to look at the three insurance giants (Table 13.1 on following page) to know what the future holds. These giants are already worried that they are not making enough money and are starting to withdraw from less profitable markets in 2016. Wayne Deveydt, chief financial officer for Anthem Inc, sees the need to increase premiums over the next two or three years to realize the profits the insurer (and its shareholders) require. Anthem has decided to sacrifice market share to keep its plans profitable, acknowledging that:

> *When you have fewer national enrollees and you have price points that we don't believe are sustainable, we've just made a conscious decision we're not going to chase it [market share].*[22]

TABLE 18.1

HEALTH INSURANCE COMPANY CEOs' TOTAL COMPENSATION IN 2014

CEO	COMPANY	TOTAL COMPENSATION
Stephen Hemsley	UnitedHealthcare	$66.1 million ($254,328 per day)
Michael Neidorff	Centene	$28.1 million ($107,796 per day)
David Cordani	Cigna	$27.2 million ($104,479 per day)
Mark Bertolini	Aetna	$15.0 million ($57,745 per day)
Bruce Broussard	Humana	$13.1 million ($50,319 per day)
Joseph Swedish	Anthem	$8.1 million ($31,016 per day)

Median annual earnings of full-time wage and salary workers in 2014: $41,148

Note: Annual CEO direct compensation includes salary, bonus, non-equity incentive plan, other compensation and actual realized stock option gains and stock award gains.
Sources: SEC 14A Schedules, Bureau of Labor Statistics, Current Population Survey.

This prescient 2010 observation by Robert Reich, professor of public policy at the University of California Berkeley and author of *Beyond Outrage: What Has Gone Wrong with Our Economy and Our Democracy*, *and How to Fix Them*, is where we now find ourselves:

> *From the start, opponents of the public option have wanted to portray it as a big government preying upon the market, and private insurers as the embodiment of the market. But it's just the reverse. Private insurers are*

exempt from competition. As a result, they are becoming ever more powerful. And it's not just their economic power that's worrying. It's also their political power, as we've learned over the last ten months. Economic and political power is a potent combination. Without some mechanism forcing private insurers to compete, we're going to end up with a national healthcare system that's controlled by a handful of very large corporations accountable neither to American voters nor to the market.[23]

As in other parts of our economy bigness is not necessarily best. Neither big banks nor big insurance companies are too big to fail, and why should taxpayers bail them out when they are not serving the public good?

Summary

After almost six years with the ACA, we still have increasing health care costs, less affordable for many millions, increasing pain and worse outcomes for patients, and long-term bankruptcy staring us in the face, whether for many patients and their families, state or federal budgets. We have learned what we should have learned years ago—in the current political and regulatory environment, the private health insurance industry cannot be sufficiently regulated to serve the public interest—it just serves its own self-interest based on its business "ethic."

This is a key nodal point for U.S. health care. Let's see in the next chapter what the Republicans plan to do, if they maintain or increase their political power after the 2016 elections.

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The ACA's greatest legacy may finally be the fulfillment of a conservative vision laid out three decades ago, which sought to transform American health care into a market-driven system. The idea was to turn patients into shoppers, who would naturally look for the best deal on care—while shifting much of the cost onto those very consumers.

—Trudy Lieberman, past president of the Association of Health Care Journalists[1]

CHAPTER 19

THE REPUBLICAN 'PLAN' FOR HEALTH CARE: "EMPOWER THE PATIENT, LET COMPETITION WORK"

With her insightful observation above, Trudy Lieberman reminds us that what we now have in health care is the product of the last 30-plus years of conservative thought in this country. Although enacted during a Democratic administration, the ACA is essentially a conservative bill, originally brought forward by the Heritage Foundation years ago as a way to keep private health insurers alive and ward off national health insurance. The 2006 Romney plan in Massachusetts, after which the ACA is modeled, was also a conservative plan. As Paul Krugman, *New York Times* Op-Ed columnist and Nobel laureate in economics, has noted:

> *ObamaRomneyCare is a three-legged stool that needs all three legs. If you want to cover preexisting conditions, you must have the mandate; if you want the mandate, you must have subsidies. If you think there's some magic market-based solution that obviates the stuff conservatives don't like while preserving the stuff they like, you're deluding yourself. . . What this means in practice is that any notion the Republicans will go beyond trying to sabotage the law and come up with an alternative is fantasy.*[2]

This chapter has three goals: (1) to summarize some of the competing GOP proposals being offered during this election season; (2) to provide reasons why none of them will work; and (3) to briefly discuss the political dilemma Republicans now find themselves in concerning health care.

Competing Republican Proposals for Health Care

The main reaction of Republicans in Congress since passage of the ACA in 2010, has been "repeal and replace" it. Since then, the GOP-led House has voted 56 times to repeal or undermine the ACA, but has not yet come up with any proposals to replace it.[3]

In the spring of 2015, the GOP-dominated House budget proposal did not pass, but its contents suggest where the Republicans would like to go on health care: (1) turning Medicaid into a block-grant program with a 2017 budget cut; (2) repealing the ACA, with elimination of both the Medicaid expansion and subsidies for private coverage; and (3) transforming Medicare into a voucher program.[4]

Following discussions with health care experts and lobbyists, Jonathan Cohn of the *New Republic* distilled these specifics of what Republicans will try to do:

- Repeal the individual mandate.
- Repeal or modify the employer mandate (e.g. change the threshold to a 40-hour week).
- Eliminate "risk corridors."
- Repeal the medical device tax.
- Abolish the Independent Payment Advisory Board (IPAB).
- Introduce a "copper plan" with a 50 percent actuarial value.[5]

GOP presidential candidates have offered a variety of competing ideas, with little substance and no guidance by health policy experience or research. These are examples:

- Jeb Bush would repeal the ACA, eliminate the individual mandate, loosen federal requirements on insurance companies, and shift more authority to the states to regulate insurers; block grants would be provided to the states for health programs for lower-income people, together with tax credits to help people purchase low-cost catastrophic insurance plans.[6]
- Donald Trump would repeal and replace the ACA with "something much better for everybody . . . much better and less expensive for people and the government."; he would put emphasis on insurers selling health plans across state lines; although he was a single-payer advocate in 2000, he seems to have backed away from that now, but his current plan is sketchy at best.[7,8]
- Marco Rubio would deregulate the health insurance market, eliminate the requirement that insurers cover essential benefits, create separate high-risk pools for people with pre-existing conditions, and let insurers charge higher prices for sicker enrollees.[9]

All these are just ideas. The Republicans still have not come up with a replacement plan if they are ever able to repeal the ACA. These ideas just perpetuate their long-held philosophies that free markets can fix health care, that individuals need to be empowered to make their own choices in their health care, that they should have more "skin in the game" to make more prudent decisions, that competition will keep prices and costs at bay, and health savings accounts will allow people to save for the costs of their own care.

There's nothing new in any of this. If the ACA goes away, libertarian theorist Michael Strain, resident scholar at the American Enterprise Institute, defends these ideas in this way:

> *In a world of scarce resources, a slightly higher mortality rate is an acceptable price to pay for certain goals—including more cash for other programs, such as those*

that help the poor; less government coercion and more individual liberty; more health-care choice for consumers, allowing them to find plans that better fit their needs; more money for taxpayers to spend themselves; and less federal health spending. This opinion is not immoral. Such choices are inevitable. They are made all the time.[9]

Figure 19.1 illustrates what this means to a growing part of our population.

FIGURE 19.1

'CARE-FREE'?

"Hmmm ... no health insurance. Take him to the Intensive I Don't Care Unit."

Source: Reprinted with permission from Len Chapman

Why None of These Republican "Plans" Will Work

These are some of the reasons that the so-called plans being put forward by Republicans are nothing more than failed policies of the last three decades:

- Continued inflation of health care costs over the last 25 years has demonstrated that consumer-directed health care has been ineffective in containing costs, even as cost-sharing with patients increases.
- As the hospital and insurance industries continue to consolidate after enactment of the ACA, prices tend to *increase* as market shares grow.
- If the Republicans have their way, individuals and families might pay less for skimpy insurance products, but would pay much more for necessary health care if they could afford it at all.
- As a result, more people will forgo needed care because they are underinsured and can't afford it, leading to worse outcomes and declining quality of care.[11]
- High-risk pools, tried in many states for years, have been plagued by many problems, including limited benefits, high premiums, extended waiting lists, and inadequate funding.[12]
- Health savings accounts (HSAs) were introduced in 2004, typically tied to high-deductible health plans, with the idea that people could set aside that money tax-free and invest it for future medical expenses; however, very few HSA-holders actually invest this money, and this is unlikely to protect them from the costs of a serious accident or illness.[13,14]
- Selling insurance across state lines is based on the idea that choice could be improved and costs cut by reducing state insurance regulation; if adopted nationally, it would likely lead to insurers shopping among states with the most lax regulations and the least consumer protections.[15]
- Republican policies for health care, if ever adopted, would continue down the track of unsustainability and bankruptcy.

In short, the Republican "plans" for health care defy all logic and disregard experience and evidence of what has happened to their conservative policies over these many years. They are a total disconnect from reality. The Republican mantra remains based on ability to pay, not medical need, and completely disregards the

fact that up to one-third of health care services being provided in our market-based system are inappropriate or unnecessary, with some actually harmful.[16]

Concerning the differences between health care and other markets, Republicans still haven't learned from what Nobel Prize-winning economist Kenneth Arrow knew more than 50 years ago—that uncertainty is the root cause of market failure in health care. He was aware that patients have no way of knowing what care they will need, that health professionals deal with uncertainty every day in clinical practice, and that insurers have to confront uncertainty in their rating policies. As Arrow concluded, [a] "laissez-faire solution for medicine is intolerable."[17]

The GOP's Political Dilemma

It may be that Republicans are becoming increasingly gun-shy of their "repeal and replace" strategy for the ACA. On the one hand, their base is enamoured of the prospect of killing Obama'a signature domestic achievement, resents the individual mandate and the intrusive role of government. But the Congressional Budget Office (CBO) estimates that the number of uninsured will increase by 19 million if the ACA is repealed.[18]

That would result in a huge backlash from the electorate, and the Republicans still have no concrete alternative plan of their own. As Larry Levitt, senior vice president of the Kaiser Family Foundation, recently noted about the ACA:

> *It's almost motherhood and apple pie now, that any plan should protect people with preexisting conditions and help people without health insurance to buy it. It's hard for any candidate to walk away from those ideas.*[19]

The latest projections by the non-partisan CBO also estimate repeal of the ACA would add $137 billion to the deficit over the

next decade, as well as more in the years to follow.[20]

If one looks at the claims and rationale for these latest GOP proposals, as well as how these ideas have fared over the years, they are obviously false. Beyond that is the plain hypocrisy of wanting to do away with government programs, especially Medicare and Medicaid, from which the private sector reaps huge profits.

Moreover, conflicts of interest through a revolving door between government, industry, and lobbying agencies, do not look good in the light of day. As examples, Marilyn Tavenner, the former Obama administrator in charge of the rollout of the ACA's HealthCare.gov, now heads America's Health Insurance Plans (AHIP), the industry's main lobbying organization; her highest priority is preservation of Medicare Advantage, where private insurers now cover more than 30 percent of the 55 million beneficiaries of Medicare.[21] And as we have seen, private insurers have taken in large overpayments from the government for many years compared to the costs of traditional Medicare. Meanwhile, Andy Slavitt, a former executive at UnitedHealth Group (the nation's largest private health insurer) and the now acting administrator of CMS after Tavenner's departure, sets the rules for his old boss at UnitedHealth Group, which draws 40 percent of its operating revenue from administering Medicare and Medicaid.[22]

Summary

It appears that present directions of the GOP in health care are a bridge to nowhere. Confusion and uncertainty within Republican ranks are also apparent. However, *if* the Grand Old Party could take a broader view of history, re-assess today's needs, and return to the kinds of conservative principles described in the last chapter, they could lead America toward a health care system that

our citizens need and deserve. If they do so, they will be embracing traditional American values—efficiency, choice, affordability, value, fiscal responsibility, equity, accountability, integrity, and sustainability.

In the next chapter, we will see how they could do that.

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CHAPTER 20

SINGLE-PAYER NATIONAL HEALTH INSURANCE

Promise: A universal health care plan. And that's what I'd like to see. But as you all know, we may not get there immediately. Because first we have to take back the White House. We have to take back the Senate, and we have to take back the House.

—Barack Obama, in a speech to the Illinois AFL-CIO on June 30, 2003

Single-payer has been missing from our national conversation on health care for many years, since it is so threatening to the insurance industry and other corporate stakeholders in our market-based system. The mainstream media, largely owned by corporate giants, want to continue the status quo, which benefits Wall Street so well. As a second-term state senator in Illinois, Obama gave the above verbal support for single-payer national health insurance as far back as 2003. But that support evaporated as early as 2006, when he responded to a question by David Sirota of *The Nation* magazine that he "would not shy away from a debate about single-payer, but is not convinced that it is the best way to achieve universal health care."[1] Both Republicans and Democrats kept single-payer off the table during negotiations over the ACA, with debate over the public option finally dying in 2009 as a small remnant of the idea.

The power of money in politics is a chronic problem. As the ACA was being drafted in 2009, more than 1,750 companies and organizations hired some 4,525 lobbyists—eight for every member of Congress—to influence the legislation. According to the non-partisan Center for Responsive Politics, 2009 was a record

year for influence peddling overall with business and advocacy groups spending more than $3.4 billion on lobbyists.[2]

Today, given the failure of incremental reform attempts over many decades, it is long overdue to have a full national debate over the single-payer alternative.

In this last chapter, we have four goals: (1) to describe what single-payer national health insurance (NHI) would look like; (2) to summarize what NHI *is not*; (3) to consider the many arguments for NHI, and compare it with the ACA and Republican plans; and (4) to briefly consider the political feasibility of enacting NHI as an improved and expanded form of Medicare for all.

What Would NHI Look Like?

Single-payer NHI, as soon as enacted, will provide universal access for all Americans to affordable, comprehensive health care wherever they live and regardless of income and health status. Health care costs will be shared across one large risk pool—all 330 million of us. This will be public financing coupled with a private delivery system, wherein care will be based on medical need, not ability to pay. Patients would just present their NHI cards at the point of service, good for anywhere in the country, with no cost sharing or out-of-pocket costs. Today's confusion over changing coverage and eligibility requirements would be a thing of the past. No longer would the first question asked when seeking care be—"Do you have insurance, and what is it?"

With NHI in place, patients would have free choice of physician, other health care professional, and hospital without restrictive and ever-changing networks as prevail under the ACA. Continuity of care, with corresponding improvement in quality of care, would improve over today's increasingly fractionated care. Clinical decision-making would be between the physician and the patient, without the need for pre-authorization or other intrusions of today's changing restrictions in coverage by insurers.

A comprehensive set of benefits would be covered by NHI, including all physician and hospital care, outpatient care, dental services, vision services, rehabilitation, long-term care, home care, mental health care, and prescription drugs. Bureaucracy would be reduced sharply, with administrative simplification, as with traditional Medicare today.

Health care would transition towards a not-for-profit system based on service, replacing today's predominant business "ethic" aimed at maximal revenues for hospitals, other facilities, medical groups, drug companies and other services on the supply side. H. R. 676 (the Expanded and Improved Medicare for All Act), the long-standing bill in Congress for NHI, includes funding to absorb the cost of converting investor-owned health care facilities to non-profit status over a 15-year transition period.

Cost controls would include negotiated annual budgets with hospitals and other facilities, negotiated fees with physicians and other providers, and bulk purchasing for prescription drugs, as the Veterans Administration has done for years in getting 40 percent discounts.

How can we do all this without breaking the bank? NHI would be funded by an equitable system of progressive taxation in which 95 percent of taxpayers will pay less than they do now for health insurance, and get far more. In his classic 2013 study, Gerald Friedman, professor of economics at the University of Massachusetts, estimates that NHI would save $592 billion annually by cutting administrative waste of private insurers ($476 billion) and reducing pharmaceutical prices to European levels ($116 billion). Those savings would be enough to cover all 44 million uninsured, at the time of his calculations, and upgrade benefits for all other Americans, even including dental and long-term care. Co-payments and deductibles would be eliminated, while savings would also fund $51 billion in transition costs, such as retraining displaced workers and phasing out investor-owned for-profit delivery systems over a 15-year period.[3]

The payroll tax would become the main health care tax for all Americans with annual incomes below $225,000; that would amount to $1,500 for those with incomes of $50,000, $6,000 for those earning $100,000, and $12,000 for those with incomes of $200,000. Ninety-five percent of Americans would pay less than they do now for insurance premiums, deductibles, co-payments, actual care, and out-of-pocket payments; only 5 percent would pay more under NHI. Table 20.1 outlines a progressive financing plan for NHI under H. R. 676,[4] and Table 20.2 lists its main differences from the ACA. [5]

TABLE 20.1

A PROGRESSIVE FINANCING PLAN FOR H.R. 676

This plan replaces regressive funding sources and improves and expands comprehensive benefits to all (in billions of dollars).

New progressive revenue sources	
• Tobin tax of 0.5% on stock trades and 0.01% per year to maturity on transactions in bond, swaps, and trades.	442
• 6% surtax on household incomes over $225,000	279
• 6% tax on property income from capital gains, dividends, interest, or profits	310
• 6% payroll tax on top 60% with incomes over $53,000	346
• 3% payroll tax on bottom 40% with incomes under $53.000	27
Total new progressive sources	1,404
• Tax expenditure savings	260
• Federal Medicare, Medical, and other health spending, and 20% of current out-of-pocket spending (maintained from current system)	1.454
• Total Revenues	3,113
• Savings for deficit reduction	154

Source: Friedman, G. Funding H.R. 676 The Expanded and Improved Medicare For All Act. How We Can Afford a National Single Payer Health Plan. *Physicians for a National Health Plan*. Chicago, IL, July 31, 2013. Available at htpp://0HR%2067 6_Friedman_7.3.1.13.pdf

TABLE 20.2

THE ACA VS. SINGLE-PAYER NATIONAL HEALTH INSURANCE

ACA	NHI
At least 31 million uninsured in 2024	Universal coverage when enacted
Employment and Medicaid based, with subsidies for many millions	Covers all ages regardless of work status, gender, etc.
Variable coverage and benefits	Comprehensive & uniform benefits
Multi-tiered system, based on ability to pay	Single standard for all, based on medical need
Limited choice of doctor and hospital	Free choice of doctor and hospital
Fragmented, inefficient risk pools	One big, efficient risk pool
Large Intrusive bureaucracy	Administrative simplicity
For-profit business ethic	Service ethic
No cost containment	Cost containment through negotiated fees, budgets and prices
Unsustainable	Sustainable through progressive taxes; employers and individuals pay less than they do now

Source: Geyman, J.P., *How Obamacare is Unsustainable: Why We Need a Single-Payer Solution For All Americans*, Friday Harbor, WA. *Copernicus Healthcare*, 2015, p.193.

What NHI Is Not

There has been widespread confusion over the years about what NHI is and is not, much of it fanned and perpetuated by disinformation by opponents. Here are some of the frequent concerns that critics trot out:

1. *Single-payer would be socialism, and we're not that kind of a country.* This argument falls apart when we look at the definition of socialism, which means that hospitals and other facilities would be owned and operated by the government, with health professionals employed by the government. The National Health Service in England is such an example. Ironically, our Veterans Administration meets the definition of a socialized institution, but nobody is calling for it to go away.

Moreover, American seniors would revolt if Medicare or Social Security were threatened. NHI would not be socialized medicine. It would involve *not-for-profit financing* of health care, coupled with a *private delivery system*.

2. *NHI would be a government takeover of health care.* It would not be such a takeover, just changing to a more effective and fair financing system, with delivery of care left to the private sector. This would be in sharp contrast to the private takeover of health care that has already occurred among private insurers and other entrepreneurial interests, accelerated under the ACA, as described in earlier chapters.
3. *NHI will ration health care.* This common concern disregards two obvious things about health care—first, that we already ration care under our present system, in such ways as high financial barriers to care, restrictive choices, high prices, and denials of services by private insurers, and second, that *all* health care systems ration care in one way or another. Consider, for example, how the political decisions in 21 states that opted not to expand Medicaid under the ACA rationed health care in those states. Today's rationing is unnecessary, since we already have plenty of money in the system to afford NHI.
4. *Won't there be less competition in a NHI system?* We have already seen how competition in our present system is *decreasing* all the time as consolidation and oligopoly increases among hospital systems, giant insurers, drug companies and other corporate interests gaining controlling market shares in their respective areas. The environment would change under NHI, when physicians, other health professionals, hospitals and other facilities would compete for patients based on quality of care and service. Drug companies would have to compete based on the efficacy and cost-effectiveness of their drugs, not on the persuasiveness of their advertising and marketing.
5. *Universal health care through a single-payer system is a new and fringe idea.* Actually, the debate over whether health insurance should be a public or private responsibility goes

back more than 100 years. Teddy Roosevelt campaigned for national health insurance in 1912 when running as a progressive presidential candidate. It was part of Harry Truman's platform as a presidential candidate in 1948. Since then, although it has had broad public support, it has been shut down by private stakeholders in our market-based system, including the ever-reactionary American Medical Association.

Arguments for NHI

Given the continuing problems of inadequate access to affordable necessary health care in this country, and as costs go up without any containment in sight, the case for NHI becomes more compelling every day.

Economic imperative

The task at hand is to reallocate the enormous amount of money already going to inefficiency, administrative waste, and profits in today's health care system in a way that better meets the needs of our population. There is plenty of money available to fund NHI and still achieve other savings.

Both small and big business would do much better with NHI, paying less for health care than they do now and gaining a healthier work force. Business with international markets would be better able to compete in the global economy with other countries that have one or another from of universal health insurance.

NHI would require a more effective way to make coverage policies based on scientific evidence for efficacy and cost-effectiveness. The ACA postured in this direction by creating the Patient-Centered Outcomes Research Institute (PCORI). But it is banned by the law from making coverage or reimbursement policies, or setting clinical practice guidelines for federal health programs. We need an independent, non-partisan national scientific body, protected from political interference, with the authority to make coverage decisions in the public interest. The goal should

be to cover services that make a difference to both individuals and the population at large. These determinations should be based on solid evidence for the efficacy and cost-effectiveness of comparative approaches to preventive care as well as the diagnosis and treatment of disease. Inappropriate, unnecessary and harmful services would not be covered. Since they account for about one-third of all health services being provided today, that would be an additional way to save money and better allocate health care dollars.

Another important part of the economic imperative for NHI is the need to get rid of the huge bureaucracy, inefficiencies, and waste of the private health insurance industry. As Paul Krugman reminds us:

> *One classic example of government doing it better is health insurance. Yes, conservatives agitate for more privatization—in particular, they want to convert Medicare into nothing more than vouchers for the purchase of private insurance—but all the evidence says this would move us in precisely the wrong direction. Medicare and Medicaid are substantially cheaper and more efficient than private insurance; they even involve less bureaucracy.*[6]

Socio/Political Argument

As is described in earlier chapters, growing income inequality among Americans has reached such proportions that essential health care is neither accessible nor affordable for the uninsured or growing ranks of the underinsured. The gap between the 1 percent and the 99 percent of us is striking, reminiscent of the Gilded Age more than 100 years ago. In 2012, the top 10 percent of earners in the U.S. took in more than one-half of the nation's total income,[7] while the richest 400 took in a total of $300 billion in 2013.[8]

This stark income gap has serious consequences for much of the population. Two examples make the point. A recent study of

all-cause mortality of middle-aged white non-Hispanic men and women in the U. S. found a striking increase in morbidity and mortality between 1999 and 2013 from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis.[9] Another study of mortality by U.S. zip codes has found that people living in the poorest zip codes have death rates that are almost twice as high as those living in the most affluent zip codes.[10]

In their new book, *Social Insurance: America's Neglected Heritage and Contested Future,* Marmor, Mashaw, and Pakutka have this to say about the political implications of the widening income gap in the U.S.:

> *Social insurance programs engage most of the electorate precisely because they cover common risks and insure most of the population. And because practically everyone is both a contributor and potential beneficiary, the politics of social insurance tends to be "us-us" rather than "us-them" form. Each individual's sense of earned entitlement or deservingness makes reneging on promises in social insurance programs politically costly. Each individual's responsibility to contribute to the common pool makes extravagant promises of "something-for-nothing" future benefits less politically attractive. . . .*
>
> *Social insurance programs are economically sensible and socially legitimate and thus politically acceptable. . . . Social insurance is part of the essential social glue that holds an individualistic polity together and makes the economic risks of a market economy tolerable.*[11]

Moral Argument

In contrast to almost all other advanced countries around the world, health care as a human right is still controversial in the United States. The dominant culture in our market-based system still treats health care as a commodity, just products for sale on an open market, with access based on ability to pay. When any

of us is confronted by a serious illness or accident, with threat to life and/or bankruptcy, we are brought up short in realizing how inhumane, unfair, and cruel our system can be, too often without an adequate safety net.

These words by Dr. Bernard Lown, developer of the cardiac defibrillator and co-recipient of the Nobel Peace Prize in 1985 on behalf of International Physicians for the Prevention of Nuclear War, cut to the heart of the issue:

> *The United States subscribes to a business model that characterizes insurers as commercial entities. Like all businesses, their goal is to make money . . . Under the business model, casual inhumanity is built in and the common good ignored. Excluding the poor, the aged, the disabled, and the ill is sound policy since it maximizes profit. Under the social model, denying coverage to any member of society would refute the fundamental purpose of health insurance.*[12]

Comparison of our three alternatives

In summary, comparing single-payer NHI with the ACA and any of the Republican plans which may emerge, single-payer NHI is the only alternative of these three that can meet the nation's need for further health care reform, as shown in Table 20.3.

Is NHI politically feasible?

Beyond the many advantages of NHI, we always come around to the question of political feasibility. Arguably, if we had a true democracy, where votes counted without Citizens United and the overwhelming influence of money in politics, we might have had NHI by now. It is possible that universal coverage can be established on a state-by-state basis through the ACA's waiver provision starting in 2017, as illustrated by Colorado's ColoradoCare Campaign. Where are we now, in the midst of the 2016 elections with their outcomes still unpredictable on the feasibility question?

TABLE 20.3

COMPARISON OF THREE REFORM ALTERNATIVES

	ACA	*GOP*	*NHI*
Access	**Restricted**	**Restricted**	**Unrestricted**
Choice	**Restricted**	**Restricted**	**Unrestricted**
Cost containment	**No**	**No**	**Yes**
Quality of care	**Unimproved**	**Unimproved**	**Improved**
Bureaucracy	**Increased**	**Increased**	**Much reduced**
Universal coverage	**Never**	**Never**	**Immediately**
Accountability	**Limited**	**Limited**	**Yes**
Sustainability	**No**	**No**	**Yes**

On the support side.

There has been broad support for NHI for many years in this country, virtually ignored by the media, as shown by these measures:

- Americans have expressed high levels of support for NHI since the 1940s, when 74 percent of the public favored such a proposal;[13] by many national surveys, a majority of the public supported NHI between 1980 and 2000;[14] a 2009 CBS/*New York Times* poll found that 59 percent of respondents favored NHI, up from 40 percent in 1979.[15]
- A 2008 national survey of more than 2,200 U.S. physicians in 13 specialties found that 59 percent support NHI.[16]
- Activist positions for single-payer NHI have been taken by a growing number of health care organizations, including the American College of Physicians (the second largest physicians' organization in the country), Physicians for a National Health Program (PNHP), the American Society of Clinical Oncology, the American Psychiatric Association, the American Public Health Association, the American Women's Med-

ical Association, the American Medical Students' Association, and the American Nurses Association.

- Many other organizations across our society support NHI, including Healthcare NOW!, Labor Campaign for Single-Payer Health Care, One Payer States, National Nurses United, Progressive Democrats for America, and many others.
- To no surprise, support for NHI among legislators in Congress depends on the state, with those from states opting out of Medicaid under the ACA opposing NHI. (Figure 20.1)[17]
- A 2013 international survey by the Commonwealth Fund of overall views of health care systems in 11 countries found that 48 percent of respondents believe that our system needs "fundamental changes" and that an additional 27 percent thinks it should be "completely rebuilt."[18]
- According to a June 2015 survey by the Kaiser Family Foundation, 84 percent of respondents support Medicare negotiating discounted prices of prescription drugs.[19]
- After seven years' experience with health care reform in Massachusetts (the Romney plan), the model upon which the ACA was based, 72 percent of respondents prefer NHI to that plan.[20]

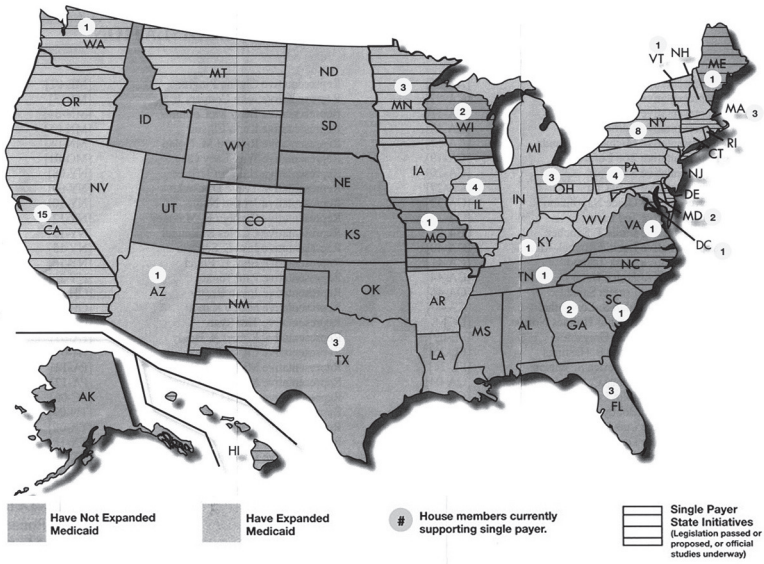
Forces opposing NHI

The forces against passage of NHI, of course, are very imposing, including private insurers, Big PhRMA, medical device makers, and other members of the medical-industrial complex. They have successfully warded NHI off over many decades. In the post-Citizens United world, they are even more imposing. The private health insurance industry, posturing in its past and present protests about some aspects of the ACA, is finding it a bonanza. The ACA's long-term trajectory, however, is unsustainable. The private health insurance industry would be on life support without the ACA bailout, and by any measure it does not deserve further bailout.

A 2014 Op-Ed by Dave Johnson of Campaign for America's Future, brings us this useful insight into long-term opposition to

FIGURE 20.1

HEALTHCARE - WHO'S IN AND WHO'S OUT



HEALTHCARE—Who's In and Who's Out. Public Citizen. Washington, D.C., 2015. Reprinted with permission.

NHI, as well as other more progressive policy changes:

> *The Koch brothers, other billionaires and corporate groups have been remarkably successful in pushing Congress to pass legislation that helps their interests while hurting the rest of us. . . .[They] put their money into think tanks, communication outlets, publishers, various media, etc. with a long-term plan to change the way people see things. This 'apparatus' has pounded out corporate/conservative propaganda 24/7 for decades.*[21]

There are more than 20 right-wing think tanks that employ full-time "scholars" to oppose NHI and advocate for privatization of health care, further deregulation, and other market-based initiatives. These include the American Enterprise Institute, the Cato Institute, the Galen Institute, the Heartland Institute, the Heritage Foundation, the Manhattan Institute, the National Center for Policy Analysis, the Pacific Research Institute, the National Center for Public Policy Research, and Freedom Works Foundation (founded by Charles Koch). Note the patriotic-sounding names of some that belie their intentions. At the state level, the American Legislative Exchange Council (ALEC), a spin-off of the Heritage Foundation, opposes any single-payer initiatives and lobbies strongly and effectively for private health insurance in state legislatures. Other right-wing organizations, such as the Fraser Institute, the Discovery Institute, and Americans for Prosperity, disseminate "information" that denigrates the Canadian single-payer system.[22]

As so many conservatives and corporate giants in the medical-industrial complex rail against the government, it is beyond irony that they depend so much for their revenues on government health care programs, at both the federal and state levels.

So What Comes Next?

The opening months of the campaigns for president seem to have caught political strategists, insiders, and pundits by surprise. Robert Reich notes that this is readily explained as a revolt against the 'ruling class', which has dominated Washington for more than three decades. Whether on the right or left, there is a level of dissatisfaction and anger not seen for many years. For as Reich observes:

> *What's new is the degree of anger now focused on those who have had power over our economic and political system since the start of the 1980s. Included are presidents*

and congressional leaders from both parties, along with their retinues of policy advisors, political strategists and spin doctors. Most have remained in Washington even when not in power, as lobbyists, campaign consultants, go-to lawyers, financial bundlers and power brokers. . . . The other half of the ruling class comprises the corporate executives, Wall Street chiefs and multimillionaires who have assisted and enabled these political leaders—and for whom the politicians have provided political favors in return.[23]

It is no accident that Donald Trump is blowing away the other Republican presidential candidates on the right with his bombastic calls for change, vague and unexplained as they are. And Bernie Sanders on the left is attracting the largest crowds of any candidate, right or left, with his wide-ranging progressive agenda, which is likely to resonate with a large part of the electorate as voters get to know him better.

We can hope for a major change in leadership toward a more progressive populism should this simmering anger come to a boil. These two data points illustrate this growing momentum that suggest that business as usual may soon be overturned in this country.

- According to American National Election Studies, 79 percent of voters in 2012 believed that "government is run by a few big interests looking after themselves", whereas 64 percent of voters in 1964 felt that "government was run for the benefit of all the people."[24]
- Gallup polls have shown big changes in the numbers of Americans satisfied or dissatisfied with "opportunities to get ahead by working hard"—in 2001, 76 percent were satisfied, but by 2014, only 54 percent were satisfied and 45 percent dissatisfied.[25]

As the late Howard Zinn, former political science professor at Boston University, social activist, and author of *The People's*

History of the United States, has reminded us, "Democracy is not what governments do. It's what people do."[26] We can also draw hope when we recognize that today's times are not what this country is about. As the second president of the U.S. and one of our founding fathers, John Adams gave us this wise guidance more than 200 years ago:

> *Government is instituted for the common good; for the protection, safety, prosperity and happiness of the people; and not for the profit, honor, or private interest of any one man, family, or class of men.*[27]

When we succeed in getting the democracy that we need, single-payer NHI will be a natural fit within a more progressive agenda serving the public good instead of the self-interest of the privileged few.

We can expect a continued and probably virulent debate over the future of our health care as this election season progresses toward November 2016. Most Democrats will fight to protect the ACA as a landmark achievement. Republicans will try to neutralize it, but realize that the President will veto any attempts to repeal it. Their goal will probably be to take the White House in 2016, maintain control of Congress, and dismember or replace the ACA in 2017. The insurance industry, Big PhRMA, and other business interests welcome ongoing expanded markets subsidized by the government. Meanwhile the public is sharply divided over the law, with the latest *Wall Street Journal*/NBC poll showing 50 percent of respondents saying it should have a major overhaul or be eliminated.[28]

Amidst the chaos of our present dysfunctional system, it is high time to seize this opportunity to seriously debate these three alternatives. We need to make a national policy decision based on evidence and experience informed by health policy research, not ideology. This should be a non-partisan process, based on the

principles outlined in Chapter 18. If we can assess past failed policies through an honest and rational debate of the issues, both political parties and the country will be winners.

Time will tell whether or not we are up to this challenge.

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