




Health Care Reform Round Table

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Outline

- Brief history of health care legislation in the United States
- Why should we change anything?
- The current proposal
- How might changes affect doctors and patients?
- Your input and discussion




History

- 1920's:
 - Physicians and hospitals begin to charge more for services than the average person can afford.
 - The Great Depression makes the gap between medical need and the ability to pay even wider.
 - 1929: Baylor University Hospital in Dallas starts pre-paid hospitalization plan to offset lack of payment for individual care given.




History

- 1930's:
 - 1930: Herbert Hoover creates VA by executive order. (Some form of vet support since 1636 Pilgrim law.)
 - Baylor plan becomes prototype for Blue Cross.
 - "The Blues" are groups of nonprofit health insurers who keep premiums low in exchange for tax break.
 - Cover 3 million Americans within 10yrs (2%)
 - Charge every person the same premium regardless of age, sex, pre-existing conditions.




History

- 1940's:
 - Unemployment drops to 1.2%, with strict government control of wages during WWII years.
 - Employers compete for workers by offering health insurance coverage.
 - Government supports this trend by tax exempting company expenses on employee health care.
 - 1945: Henry Kaiser and Dr. Sidney Garfield start Kaiser Permanente for Kaiser shipyard workers in Richmond, CA.




History

- 1950's:
 - President Truman proposes national health insurance.
 - Opponents defeat it by noting that nonprofits have the issue under control.
 - Private insurers begin entering the health care market, which they previously considered too risky.
 - Private insurers calculate premiums according to risk, and refuse people considered too risky.
 - 1955: 70% of Americans are covered.
 - 1959: Federal Employees Health Benefits Act




History

- 1960's:
 - Blues change to for-profit and also begin to calculate premiums based on risk.
 - Large companies with many employees begin to self insure.
 - Uninsured population becomes largely:
 - Unemployed (retired)
 - Unemployed (poor)
 - Uninsurable (high-risk preconditions)
 - 1965: President Johnson signs Medicare and Medicaid into law (debates coverage for all).
 - 1965: CHAMPUS enacted (TRICARE)




History

- 1970's:
 - Health care cost rising: now 8% of GDP.
 - Uninsured above 10%; unemployment 10%.
 - 1973: Health Maintenance Organization Act -- federal grants and loans to help non-profit HMO's start.
 - Comprehensive Health Insurance Program, "Nixon Plan"
 - Ted Kennedy, Wilbur Mills, and Joseph Califano
 - Basic coverage to be standardized for all citizens
 - Maximum co-pays defined
 - Option to continue coverage through employer
 - Option to select state-run coverage paid for by "high-risk pools," funded by insurers licensed in each state.
 - "Cadillac plans" not tax deductible.




History

- 1980's:
 - HMO's transition to for-profit, from 12% in 1981 to a majority late in the decade.
 - 1986: COBRA passed by Congress -- continues employer insurance coverage 18-36 months after job loss when ex-employee pays full premium.
 - President Reagan is consistently against all forms of public health insurance.




History

- 1990's:
 - 1993: Clinton Plan
 - "Managed competition" model.
 - State-based alliances serve as group purchaser for any citizen not on Medicare.
 - Companies with ≥5000 employees can act as own alliance.
 - Guaranteed package of basic coverage for everyone.
 - Hospital, office, prevention, hospice, home health, LTC.
 - Consumers may select more expensive plan.
 - Mental health and substance abuse to be added by 2001.
 - May opt out only if Medicare, VA, or Indian Health covered.
 - 1999: House Speaker Hastert proposes tax deductible Medical Savings Accounts, attempting to return coverage choice to individuals.




History

- 2000's:
 - 2003: Medicare Prescription Drug Improvement and Modernization Act, signed by President Bush.
 - Priced at \$400 billion to garner conservative support
 - After passage, cost re-estimate \$1.2 trillion
 - Subsidizes employers for retiree prescription coverage
 - Federal gov't may not negotiate drug costs
 - Federal gov't may not have a formulary
 - Pays high premiums to private insurers (≥\$800/month) to enroll Medicare patients
 - 2008: All candidate platforms contain health care reform.
 - 2009: Health care cost rising: >16% GDP.
 - 2009: Uninsured above 16%; unemployment 9.5%.



Why Change?

- Decreasing access to health care
- Large inequities in system
 - Limits choices in medical care
 - Limits choices in career
- Higher cost without higher value
- Healthier citizens = healthier country




Is health care for everyone?

- USA only wealthy, industrialized nation that does not ensure all citizens are covered (IOM)
- 47 million uninsured Americans (1 in 6)
 - 75 million if counting underinsured (1 in 4)
- Why is this tolerated?
 - Our government?
 - Our insurers?
 - Our citizens?
 - Our health care providers (us)?




Who are the uninsured?

- Working Poor
 - 2/3 of the uninsured, ~ 30 million
 - Employer does not offer coverage or work part-time
 - Cannot afford private coverage
 - Premiums 3x what they were in 2000
 - Do not qualify for state coverage
 - Earnings > 3x poverty line (3 x \$10,830)




Who are the uninsured?

- Better Off
 - 9 million in households, \geq \$75,000
 - Up to half are large or extended families
 - Other half choose not to buy
 - Risk that accident or illness will require charity care or cause bankruptcy




Who are the uninsured?

- Young Adults
 - 13 million between age 19-29
 - 10% are college graduates
 - 5% make \geq \$60,000
 - 50% make \leq \$16,000




Who are the uninsured?

- Eligible for public insurance
 - 11 million, mostly children
 - Unaware or intimidated
 - Enroll during ER visit or hospitalization, but after they've missed out on much preventive care




Who are the uninsured?

- Underinsured
 - 25 million
 - Inadequate policies
 - High deductions
 - Many restrictions
 - Large \$ uncovered expenses lead to postponed care, debt
 - 75% of bankruptcies declared for health reasons are among insured




Is this your patient?

N.S. is a 55 yo woman who left her job with a major university to contract privately to teach her subject at several different schools. She bought COBRA. During the COBRA period, she was diagnosed with stage II breast cancer. Surgery and initial chemo were covered. At the end of the COBRA period, she could not buy health insurance due to her pre-existing condition, and she has been informed that she is uninsurable for 10 years.




Is this your patient?

P.B. is a 54 yo male informed last fall he would be laid off from his tech industry job. COBRA would cost \$1000 per month. He and his wife had full physicals, and when no major problems were discovered, declined COBRA in order to afford their mortgage and other expenses. A month later, R-sided pain and sepsis lead to discovery of an impacted gallstone with complex abscesses. I.R. placed two external drains. Cholecystectomy, now elective, was denied due to lack of coverage. P.B. was attempting to find a new job while carrying around 2 external biliary drains, until he was finally approved for surgery through Scripps benevolence funding.




Inequities: Career Choice

- L.I. has worked for a large corporate law firm since 1991 and pays \$50/month pre-tax for her health coverage.
- J.L. has worked since 1982 for a small law practice that does not offer a health care benefit. He had private health insurance until the late 1990's and now drives to Tijuana to buy the medications prescribed at his last MD visit years ago.




Inequities: Self-Employment

- N.L. is an employee at a large medical/research institute and pays \$58 pretax per paycheck for full health and dental coverage for himself and his spouse. Additional expenses include some office co-pays and a \$50 deductible for any non-prevention dental work.
- His sister runs a B&B and small organic farm. She pays \$301 monthly for one "well visit" per year for her and her husband, not including any testing ordered. They must spend an annual deductible of \$5000 before any additional coverage kicks in, thereafter having 30-80% co-insurance depending on the service required. They have no dental coverage.




Inequities: US versus Canada

- Kim was our whitewater guide on the Green River in CO and UT. While moving a boat, her foot wedged between 2 boulders, and she had a crush injury and loss of a nail on her L great toe. I bandaged and padded it and advised an orthopedic visit and tetanus shot. She said she had no coverage and that her mother had long been nagging her to get "a real job with benefits."
- Drew was our whitewater guide on the white mile in BC. While attempting to secure a boat in fast water, he dislocated his R shoulder. I lamented his lack of coverage and his need for orthopedic attention, when he reminded me of his Canadian citizenship and free access to care.




Inequities: Coverage Choices

- For most people, insurance plan options (provider and hospital options) are decided upon and changed at will by employer.
- Completely free choices from amongst all doctors and hospitals are available only to the wealthy and healthy.



High Cost


- 2008: \$2.4 Trillion
- Almost 17% of our GDP
- About \$8,000 for every American
- Approximately double other developed nations



Higher Cost without Higher Value

EXHIBIT 2
 National Scorecard on U.S. Health System Performance, 2008:
 Scores on 37 Key Performance Indicators


Indicator	U.S. National Rate		Benchmark	Benchmark Rate	2008 Score: Ratio of U.S. to Benchmark
	2004 Scorecard	2008 Scorecard			
OVERALL SCORE					
HEALTHY LIVES					
1. Mortality amenable to health care, deaths per 100,000 population	115	110	Top 1 of 10 countries	98	85
2. Infant mortality, deaths per 1,000 live births	7.2	6.8	Top 10th states	6.7	68
3. Healthy life expectancy at age 65, years	Varies	*	Varies	Varies	87*
4. Adults under 65 limited in any activities because of physical, mental, or emotional problems, %	14.0	17.5	Top 10th states	11.5	64
5. Children scored 11 or more school days due to illness or injury, %	3.2	*	Top 10th states	1.8	77*



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OVERALL SCORE					
QUALITY					
6. Adults received recommended screening and preventive care, %	65	59	Target	60	62
7. Children received recommended immunizations and preventive care	Varies	Varies	Varies	Varies	86
8. Received mental health care and received treatment	Varies	Varies	Varies	Varies	78
9. Chronic disease under control	Varies	Varies	Varies	Varies	79
10. Hospitalized patients received recommended care for heart attack, heart failure, and pneumonia (composite), %	84	79	Top hospitals	100	79
11. Adults under 65 with accessible primary care provider, %	66	61	88th pct.	81	76
12. Children with a medical home, %	48	*	Top 10th states	60	77*
13. Care coordination at hospital discharge	Varies	Varies	Varies	Varies	74
14. Hearing, vision, hospital admissions and readmissions	Varies	Varies	Varies	Varies	63
15. Home health hospital admissions, %	28	29	Top 10th agencies	17	62
16. Patient reported medical, medication, or info not correct, %	14	12	7 countries	10	61
17. Single drug error	Varies	Varies	Varies	Varies	53
18. Hearing, vision residents with pressure sores	Varies	Varies	Varies	Varies	66
19. Hospital readmission (multiple visits, avoid to expected deaths)	100	82	Top 10th	74	59
20. Ability to see doctor consultant they asked for or second medical care, %	67	64	Best of 4 countries	81	67
21. Easy to get care after hours without waiting for a doctor, %	18	21	Best of 10 countries	72	58
22. Doctor-patient communication always, frequent, explained, showed respect, spent enough time, %	54	57	75th pct. health plans	71	75
23. Adults with chronic conditions given self-management plan, %	58	*	Best of 2 countries	45	89*
24. Patient centered hospital care	Varies	Varies	Varies	Varies	67



Higher Cost without Higher Value

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OVERALL SCORE					
ACCESS					
25. Adults under 65 scored at least 4 on understand, %	53	58	Target	100	55
26. Adults with no access problem due to costs, %	40	63	Best of 7 countries	95	66
27. Families spending 10% of income or 10% of income of low income, on out-of-pocket medical costs and premiums, %	91	77	Target	100	77
28. Population under 65 living in states where premiums for employer-sponsored coverage are 10% of median household income, %	18	23	Target	100	23
29. Adults under 65 with no mental health problems or mental illness, %	58	60	Target	100	59



Higher Cost without Higher Value

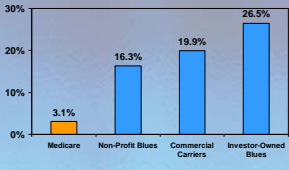
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OVERALL SCORE					
EFFICIENCY					
30. Want to emergency room for condition that could have been treated by regular doctor, %	30	27	Best of 7 countries	4	28
31. Hospital admissions for ambulatory care-sensitive conditions	Varies	Varies	Varies	Varies	54
32. Medicare hospital 30-day readmission rates, %	19	18	10th rule regions	14	76
34. Health care avoid costs of care and mortality for heart attack, hip fracture, or colon cancer (total health care charges, deaths per 100 hospitalized)	124,127	128,211	High rule regions	124,700	89
35. Health care avoid costs for chronic diseases (Diabetes, heart failure, COPD)	Varies	Varies	Varies	Varies	75
36. Health insurance administration as percent of national health expenditures	7.4	7.3	Top 1 of 10 countries	3.3	31
37. Physicians using electronic medical records, %	17	28	Best of 7 countries	66	38




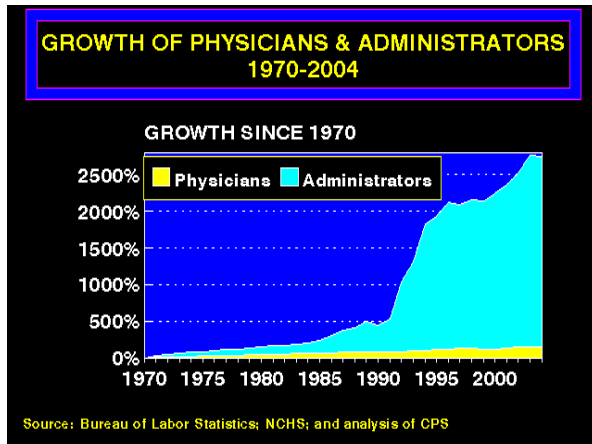
Why is U.S. cost higher?

- Administrative costs
 - Complex health insurance plans (>7000)
 - 7.5% of total health expense (c/w 2.3%)
 - Would save \$51 billion per year if decreased to level of countries with mixed private/public system (half of the estimate to cover all US uninsured)



International Journal of Health Services 2005; 35(1): 64-90





Why is U.S. cost higher?

- High ratio specialists:primary care
 - Canada 50:50
 - U.S.A. 70:30
- Do more of expensive tests/procedures
 - MRI tests per capita 3x higher than Canada
- More standby capacity
 - 4.5x as many MRI machines as Canada
 - Competing medical centers each pay for staffing and machines to offer all things all the time.

Why is our cost higher?

- Open-ended funding
 - Countries with public funding set budgets to stay within
- Less social support for poor
 - 12-15% Americans live below poverty level
 - Sicker on average
 - More ER and hospital care than outpt care
- Many more malpractice suits
 - Expensive defensive medicine
 - Expense of liability insurance

Why is our cost higher?

- Higher drug pricing
 - 50-100% higher pricing than same drug in other countries
- Higher incomes for health professionals

Country	Pay (U.S. \$1,000 PPP's)
United States	~150
UK	~100
Netherlands	~80
Switzerland	~70
Germany	~60
Canada	~50
France	~45
Australia	~40
Sweden	~35
Finland	~30
Spain	~25
Portugal	~20
Belgium	~15
Czech Republic	~10
Hungary	~5
Mexico	~2

Why is our cost higher?


- More uninsured
 - Cost passed on to everyone else
- American lifestyle
 - Sedentary; obese; tobacco; seat belts.
- Disease care rather than health care
 - Best at complex, advanced, expensive “rescue” care once ill
 - Poor at preventive service and chronic disease

Why is our cost higher?

- Duplicity of care in competing systems
- Avoidance of end-of-life realities
 - Extravagant care that will not improve quality
 - B.H. receives depot octreotide injections monthly (\$2500) for her carcinoid, despite few symptoms and no change on CT in prior 2 years
 - Expensive therapies with little survival benefit
 - Prophylactic brain radiation increases median survival for advanced small cell lung CA by 1.3 months
 - Sorafenib increases median survival for advanced HCC by 2.7 months (but not time to symptom progression)


"I'm better off if my neighbor is insured."

- "My taxes pay for ER visits by uninsured people." (UCSD Hillcrest ER, 20-25% of its visits.)
- "I just want to know that the child sitting next to my child in school is as healthy as he can be."
- "If we spend less on health care as a nation, we'll have more money to:"
 - Improve education
 - Fix bridges
 - Grow businesses/economy
 - Reduce taxes



Summary


- History – how we got here.
- Need for change:
 - Decreasing access to health care
 - Unfair/undesirable inequities in system
 - Medical care
 - Career choices
 - Higher cost without higher value
 - Healthier citizens = healthier society/economy
- How to change...



Is health care for everyone? Citizens

Fw: SENIOR DEATH WARRANTS:

- The actress Natasha Richardson died after falling skiing in Canada. It took eight hours to drive her to a hospital. If Canada had our healthcare she might be alive today. In the United States, we have medical evacuation helicopters that would have gotten her to the hospital in 30 minutes...
- In England anyone over 59 cannot receive heart repairs or stents or bypass because it is not covered as being too expensive and not needed...
- Please use the power of the Internet to get this message out. Talk it up at the grassroots level. We have an election coming up in one year and nine months. And we have the ability to address and reverse the dangerous direction the Obama administration and its allies have begun and in the interim, we can make their lives miserable. Lets do this!




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= "We all deserve Medevac services and coronary revascularization."




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= "Stop reform. The current system is ok with us."



Inequities: Luck of the Draw

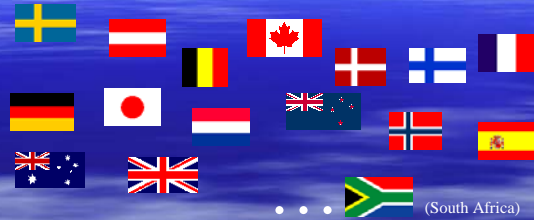
- D.W. works for a biotech start-up that initially did not offer insurance. The company became successful, hired more employees, and now D.W. pays \$28 pretax per paycheck for his health insurance. Last year his L4/5 disc herniation began to cause R foot numbness and difficulty with his swimming routine. He had disc surgery at no cost to him.
- T.S. worked for a small Silicon Valley start-up and was "drafted out of college" at age 21 to be a programmer amongst the first 15 employees. He was not offered health insurance and did not buy it on his own. Seven months later he presented with weakness, fatigue, hypotension, and profound dehydration. He was found to have adrenal insufficiency and DI, and was diagnosed with a pituitary tumor. He and his parents are trying to pay his bills.



Health Care Reform 2009

A Scripps Round Table
by
Laura Nicholson
& Santosh Rao

Countries with NHI



Industrialized countries without NHI?

only one ...



Why do we Need Reform?

- (1) We don't cover everyone
14,000 Americans/day losing insurance
46 million uninsured (6.7 mill in California)
- (2) We think we can do a better job
Payment structure values quantity over quality
Focus on Prevention and Wellness
Physician dissatisfaction – defensive medicine
- (3) We pay too much for health care
Avg cost of health care/family = \$16,771
Half of bankruptcies due to medical expenses
Slowing Economic growth

What are Some Advantages to Having Everyone Covered?

- Decreases per/person cost of health care.
- Uninsured show up disproportionately to ER, often in late stages of disease.
- Lost wages and free medical care estimated to cost \$100 billion/year.
- Public Health – i.e. Swine Flu
- Limits bankruptcies from illness
- Focus on Prevention

White House: Goals of Health Care Reform

- Reduce long-term growth of costs
- Protect families from bankruptcy or debt
- Affordable, quality coverage for all Americans
- Maintain coverage when you change/lose jobs
- End barriers to coverage for pre-existing conditions
- Guarantee choice of doctors and plans
- Invest in prevention and wellness
- Improve patient safety and quality of care

Health Care Reform - Politics

- Senate: 2 bills from HELP committee (Health, Education, Labor, Pension) and Finance Committee (bi-partisan bill, unlikely to include public option). Senate needs to merge bills and vote.
- House: 3 committees (Ways & Means, Education & Labor, Commerce) – **HR 3200** – must still vote on and pass bill (slated for September)
- After bills finalized, house and senate conference, merge bills, vote again before it gets to Obama.



Health Care Reform – HR 3200

- How does it increase coverage and access to care?
- How does it reform the insurance industry?
 - Health Insurance Exchange
 - Public Option
 - Medicare Reforms
- How do we pay for it?
- How does this affect health care providers?

Getting Everyone Covered

- Getting health insurance is mandatory
 - Individual and employer fines
- Medicaid is expanded to 133% poverty level
- Subsidized insurance for those who qualify
- Estimated 97% of non elderly would be covered vs. current 81%
- Half of those uninsured are illegal immigrants

How Does HR3200 Improve Access to Medical Care?

- Expands primary care workforce
 - Allied Health Provider's roles may expand
- Increases funding for National Health Service Corp
- Invests in Community Health Centers
- Invests in efforts to address racial/ethnic and regional health disparities

We Need More Primary Care Practitioners

- Increased training
 - Increase in ambulatory care training in community/non hospital settings
 - Unfilled GME residency spots preferentially to those interested in training in primary care
- Financial Incentives
 - Attempts to enhance primary care workforce by increasing payments through Medicare and Medicaid and by providing loan forgiveness to those working in underserved areas.
 - New Models to enhance primary care income

Insurance Reforms in HR 3200

- Limits out of pocket spending for health insurance and preventive services
- Health plans would be required to spend a certain amount of premiums on health related expenses rather than overhead and profits. (85%)
- No denial based on pre-existing conditions.
- Forbids insurance rating based on gender or health status
- No lifetime/annual cap on benefits.
- Guaranteed renewability

Health Insurance Exchange

- A government regulated market place for people to buy public or private coverage in a region that meets minimum criteria
- Regulated by Advisory Committee of experts and commissioner that recommend basic services that need to be included in both public and private plans in exchange.

Who Takes Part in the Exchange

- Initially limited to uninsured and small business employees who don't qualify for Medicaid, and people who can't afford their employer offered health plan
 - Likely 30 million participants
- Subsidies for individuals/families making up to 400 % of poverty
 - Annual caps on cost sharing
- Eventual inclusion of larger employers



The Public Option

- Available only within the Health Exchange
- Basic services – to be decided by panel
- Premiums based on local market
- Initially linked to Medicare rates
 - Primary providers paid 5% +
- Can see out of network providers

How Does the Public Plan Help with Insurance Affordability?

- Large pool of patients could help control premiums
- Give a choice to patients vs private insurance in locations previously lacking competition
- Lower administrative costs
- Public option could compete for lower prescription drug rates due to size

Will Public Plan lead to the elimination of private plans?

- Level playing field – same rules
- Limited to Health Exchange Participants
- Physicians need not participate
 - Reimbursements need to be competitive.
- Financially self-sustaining, repay start up costs.
- Protects competition and choice
 - Not single payer
- Experts conclude only 10 million participants

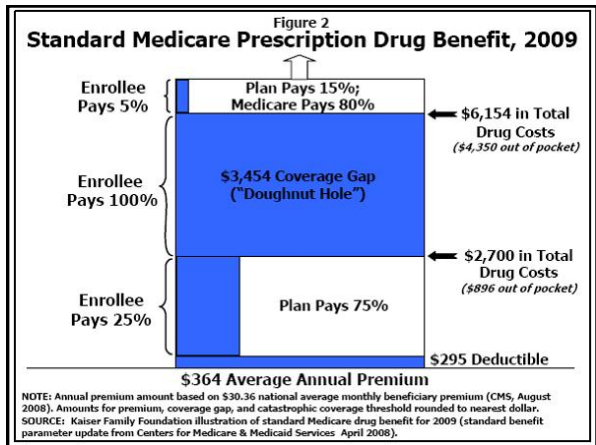
Massachusetts Experiment

How is it working?

- Mandated health insurance
 - Only 2% uninsured
- Commonwealth plans subsidized for low income people
- Cost dramatically increased with higher than expected consumption
 - limited cost savings and insurance reforms
- Access difficulties with primary care shortage

Medicare Reforms in HR3200

- Prohibits co-pays for preventive services
- Closing the doughnut hole for Medicare part D while increasing premiums
- Pilots for efficient and cost effective coordinated care programs
 - accountable care organizations
 - patient centered medical homes
 - bundling of acute and post-acute provider payments.
- End of life counseling stricken from bill now



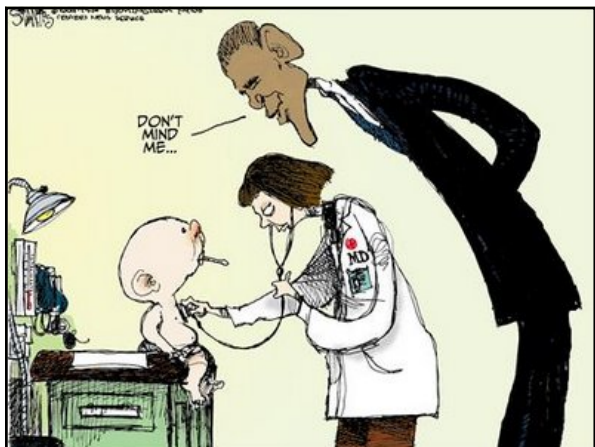
Fiscal Impact on Medicare

- Without reform, Medicare on course for bankruptcy in 8 yrs.
- Erases existing SGR (Sustainable Growth Rate) debt – \$229 billion
- Cuts in Medicare moving forward:
 - Decrease in updates for reimbursements
 - Payment incentives for “preventable” readmissions to hospital and decreased hospital reimbursements
 - Administrative simplification and efficiency
 - Levels Medicare Advantage payments

The Cost of Extending Coverage and Various Ways of Paying for It.*

Cost or Revenue Source	2019	2010-2019
	billions of dollars	
HR 3200		
Spending increases to boost coverage	+230	+1,182
Net from taxes on and transfers to businesses to encourage private coverage	-28	-140
Outlay reductions (roughly half from cuts in annual updates in Medicare payments to providers)	-50	-219
Tax increases (mostly income surtax on high-income filers)	-86	-583
Total net increase in the deficit	65	239
Administration proposals ("reserve for health care reform")		
Medicare and Medicaid savings	-88	-619
Capping value of itemized deductions	-39	-269
Other tax-increase options		
Capping exclusion of employer-financed health insurance premiums		
From income and payroll tax at 50th percentile, unindexed	-232	-1,142
From income tax only at 75th percentile, indexed according to the consumer price index	-101	-456
From income tax only at 75th percentile, indexed according to medical prices	-9	-62
Increasing alcohol taxes to \$16 per proof gallon	-6	-61
Taxing sweetened beverages 3 cents per 12-oz can	-5	-50
Collecting a 1% value-added tax†	-97	-1,001

* Positive values indicate increases in spending or reductions in taxes; negative values indicate reductions in spending or increases in taxes. Values may not sum to the stated totals because of rounding. Data are from the Urban Brookings Tax Policy Center, the Center on Budget and Policy Priorities, the Office of Management and Budget, and the Congressional Budget Office.
 † Value added is the difference between the value of a business's sales and its purchases from other companies. This estimate is based on



How will reform affect physicians' income?

- Increase in Insured Patients - Likely Influx of Patients
- Increases primary care providers' reimbursement.
 - Looking at new models of care.
- *May adversely affect specialists' salaries and reimbursements for procedures/imaging*
- Medicare cuts

Issues for us in California

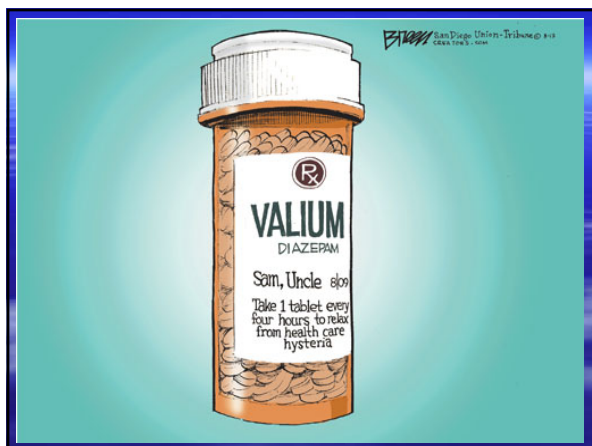
- Aging workforce
 - 48% physicians > 50 yo
- Difficult practice environment
- Severe primary care shortage
- California Medicare payment locality boundary to match Metropolitan Statistical Areas

Changing the Practice of Medicine?

- Quality vs Quantity
 - Funding for comparative effectiveness research and PQRI
- Coordination of Care
- Less Fee for Service, more Pay for Performance
- Focus on Prevention
- No Liability Reform in Bill.
 - Obama has stated he expects liability reform to be part of health care reform.
 - No caps on malpractice at present

Unanswered Questions Open for Discussion

- Can we cover everyone and control costs?
- Is Medicare an efficient model on which to base a national strategy of increased government influence?
- How much money can we save by changing our billing system?
- How do we approach end of life care?
- What are Americans' expectations from their health care system? Will we eventually "ration" health care?



Websites

- www.HealthReform.GOV
- CBO Health Reform
- NEJM Health Care Reform 2009
- www.dr sforamerica.org
- AMA and ACP websites

Thanks to Laura Nicholson, Dan Dworsky, Ken Serio and Steve Poceta