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It helps to look at where we have been to know where we are going & health care is no exception. One of the first courses I took in PA school was history of physician assistants in 2002. I remember learning how in some places doctors were paid regularly while patients were healthy—and paid nothing when they were sick. It made sense in a way—why expect sick people who wouldn't be at their best & perhaps couldn't be working to cover the costs of their medical care? It incentivized the providers to keep their patients healthy. Yet in our country, this is not at all how the system is set up.

I remember working in lipidology research and seeing multiple lawyers in clinical studies. They were volunteering because they frequently did not have good health insurance through their work, and the only way they could afford medicine was via clinical trials. Of course they weren't the only patients who were there because they couldn't afford meds in our system. It was just telling that it had nothing to do with their employability or intelligence; the system simply did not work for them. For many of them with heterogenous familial hypercholesterolemia, they could expect to have heart attacks or strokes typically in their 30's or 40's if left untreated. Statins were already available, but the system was failing them.

I remember being stunned in clinical endocrinology as I met with a patient for her type 1 diabetes—because she didn't have a med listed for her multiple sclerosis. MS is one of the top causes of disability in adults. It wasn't a typo; it wasn't just missing from her list of meds. I asked and was told she could not afford the cost of the medication.

In 2009 someone I know started taking Copaxone for MS. At the time it was about $24,000/year. By the end of the year there was a rate increase to $30,000. The next year $36,000. Soon thereafter $42,000. About 2 years ago that person was switched to the first-available branded generic, Glatopa. I think it's cost was around $60,000-$70,000. We were told this was a cost-savings (Copaxone's price had gone up to around $90,000). What sense does it make for a medication to more than triple in price in 9 years? Especially when a generic becomes available—and why should the generic, provided by a company that didn't do the original research, be allowed to cost so much? We are told that next year, there will be another generic available that the health insurance will require patients to be switched to, because it will cost less. The last time meds were switched, multiple doses were missed because the mail-order pharmacy didn't have things right in their system. There is not a choice to pick up this med at local pharmacies, because patients are locked into using the mail-order, specialty pharmacy system designated by the health insurance company. This price tag is more than the average person even earns per year. How is this a just system?

I remember being told in PA school that Americans change health insurance companies on average every 2 years. This could be because they change employers; or it could be because their employer changes the health insurance company instead. I am fortunate to be a dependent of someone working for Procter & Gamble, and they are considered a, "self-insured,' entity. This means that although they contract with a health insurance company to provide this service for their employees, they actually

have an incentive to try to keep their employees healthy, since many have long-term careers with the company, often lasting decades. The difference is noteworthy. We get mailings encouraging us to see our providers for annual physicals or to get second opinions, and can earn money for achieving certain health goals. This is because the financial incentives are aligned to keep us healthy in order to keep premiums lower, rather than delaying treatment until someone else is covering the tab.

My oldest son was born with something called hydronephrosis, which in simplified terms means his one kidney was retaining fluid instead of it draining properly. He had surgeries at ages 5 months & 6 years and was released from follow-up at age 8. Does this mean that he is now considered to have a pre-existing condition, and if not for the affordable care act, he could be denied future health care insurance if he ever has a lapse in coverage?

It is my understanding that the point of health insurance, is to spread the cost out over a group of people, so that the burden is shared, and not that a small number of people would be left with extremely high costs. Yet this is not how our system has been working. Health insurance companies do their best to cherry-pick patients by excluding those with higher risk, which is the opposite of what a functioning system ought to do if the intent were to maximize better health outcomes.

It seems to me that big money, perhaps even dark money, has flooded our system. We are projected to spend 19% of our GDP on healthcare sometime soon—I think this is I the next decade. In or around 2024 we can expect social security to no longer have enough funds to cover expected expenditures. How can we make both systems sustainable? How is it that countries like Australia only spend about 8% of their GDP on their health care, and have good outcomes, but our system's costs seem unsustainable?

If you look at what big money is doing to our system—the lobbyists for big pharma, health insurance companies, marketing & the list goes on—I think you will find that what might be considered a public good has been confused for an opportunity to maximize profits. Why else do leaders at big pharma make the news when they do things such as increase the cost of Epipens that contain a generic drug, used to prevent life-threatening allergic reactions, by hundreds of dollars per dose, despite no new technology being used in its continued production? Why do some upper managers say there is a moral obligation to maximize profits?

In Dodge Brothers v. Ford Motor Company, the ruling gave people the understanding that it is a top if not primary goal of for-profit companies to maximize profits for their shareholders. Is this now what the government is becoming—a vehicle mainly used to enable companies to profit? Is it ethically correct to prioritize increasing the wealth of the few over preserving the health of the many? Why does the health of our very citizens no longer seem like it is the top priority compared to the wealth of corporations? I understand that we no longer require corporations to create a public good in order to be chartered like at the start of our nation, but is it fair for them to create economic hardships such as bankruptcies due to health care costs in search of excessive profits for such goods? Why don't we even have the choice of single-payer health care as an alternative?

Respectfully Submitted, Debra Schroeck, MS, PA-C