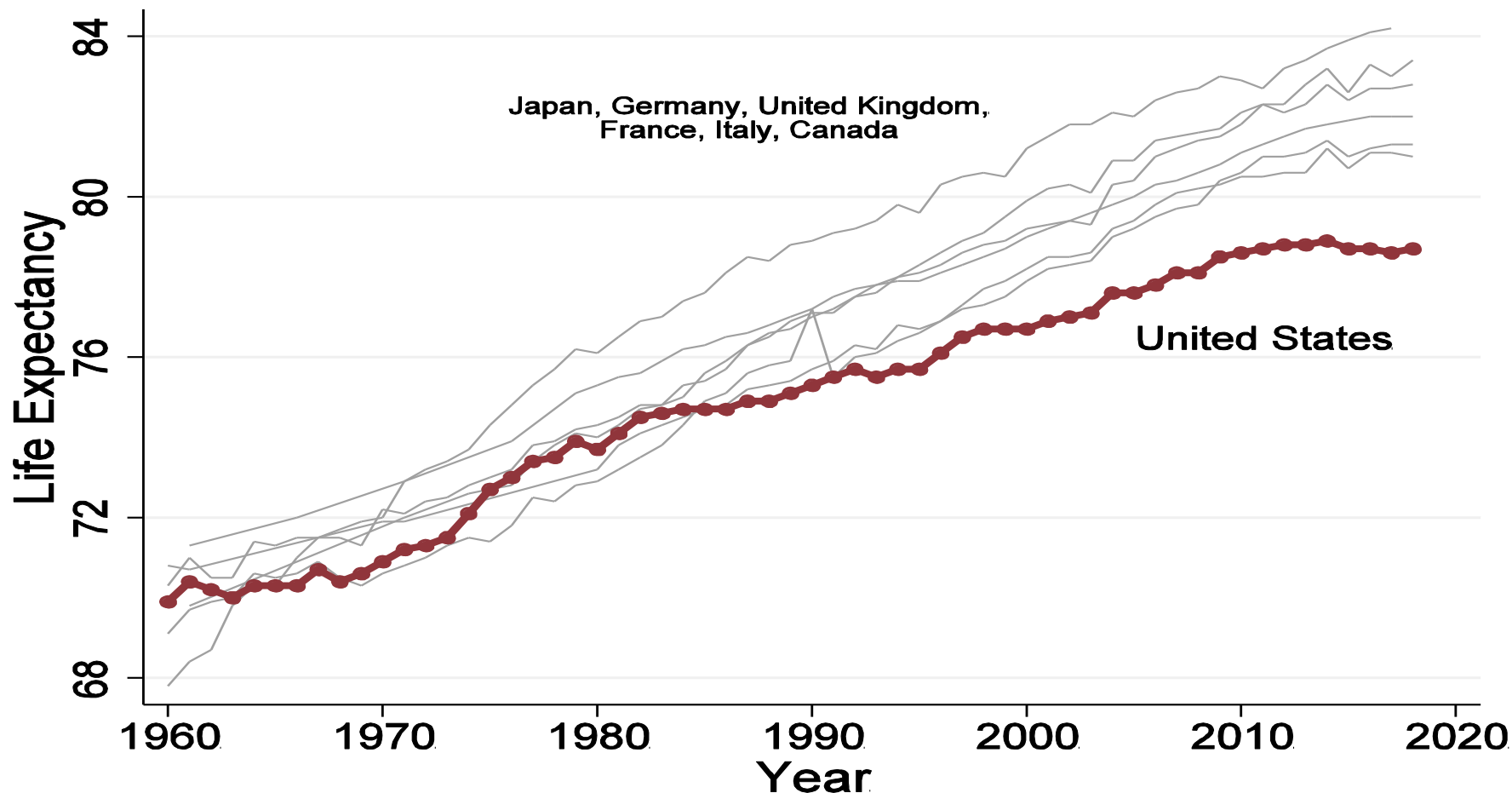


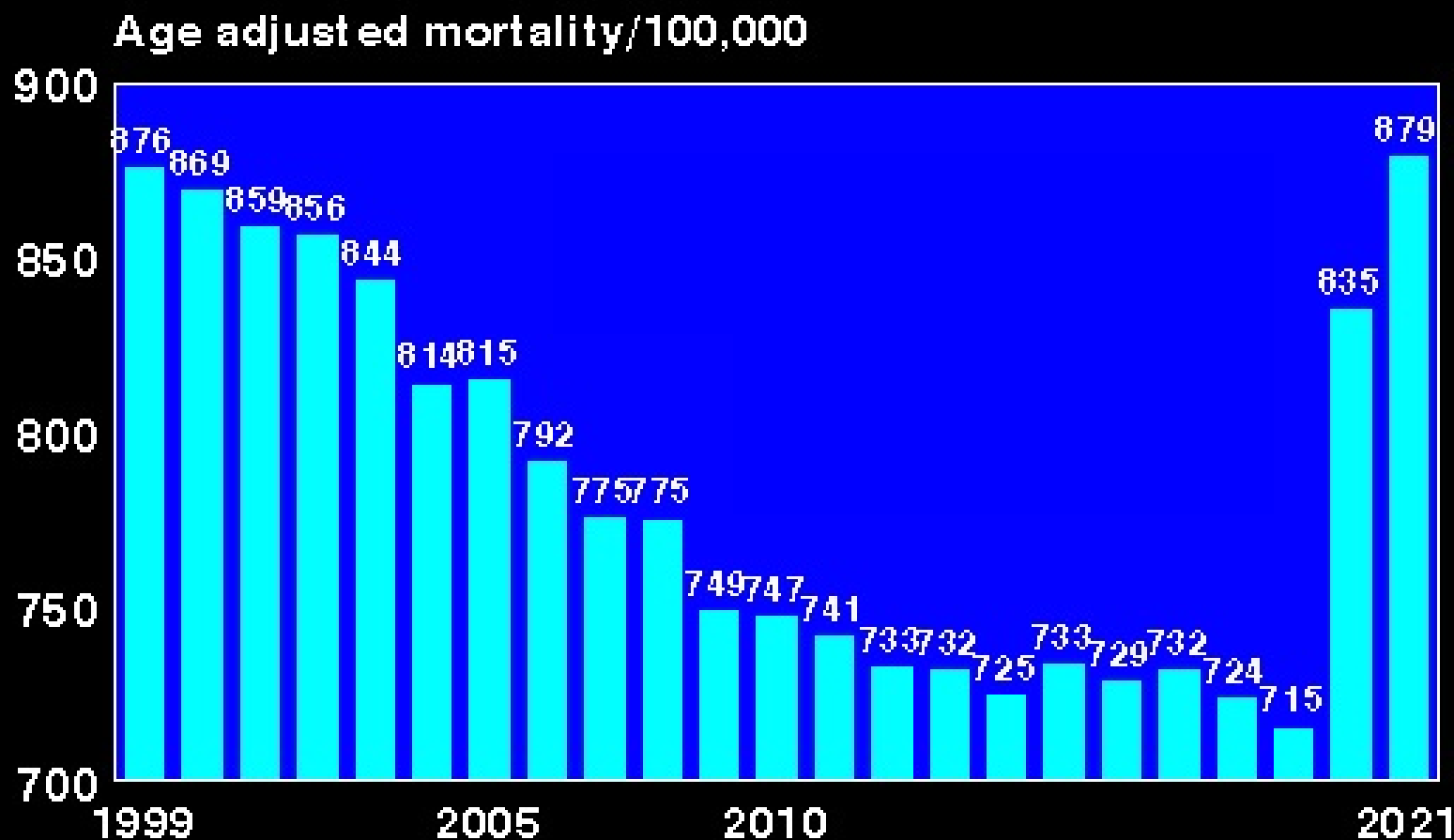


**Slides prepared by Drs. Steffie Woolhandler & David Himmelstein, Faculty at the City University of New York at Hunter College and Harvard Medical School, and Research Associates, Public Citizen Health Research Group**

# Life expectancy in the US and other G7 countries, 1960–2018

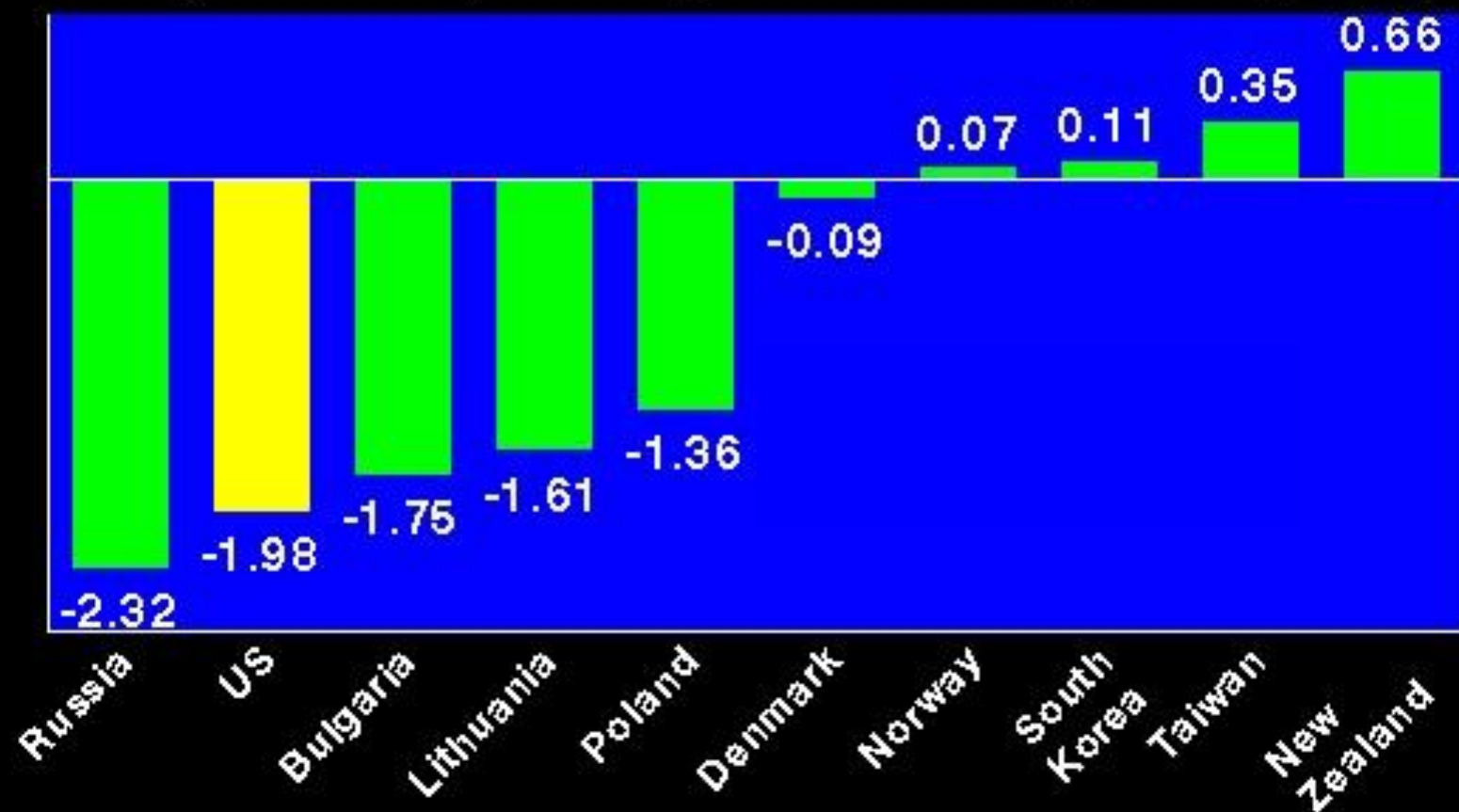


# Progress on Mortality Slowed, Even Before COVID-19



# Life Expectancy Fall from COVID-19: Greater in the US Than Anyplace but Russia

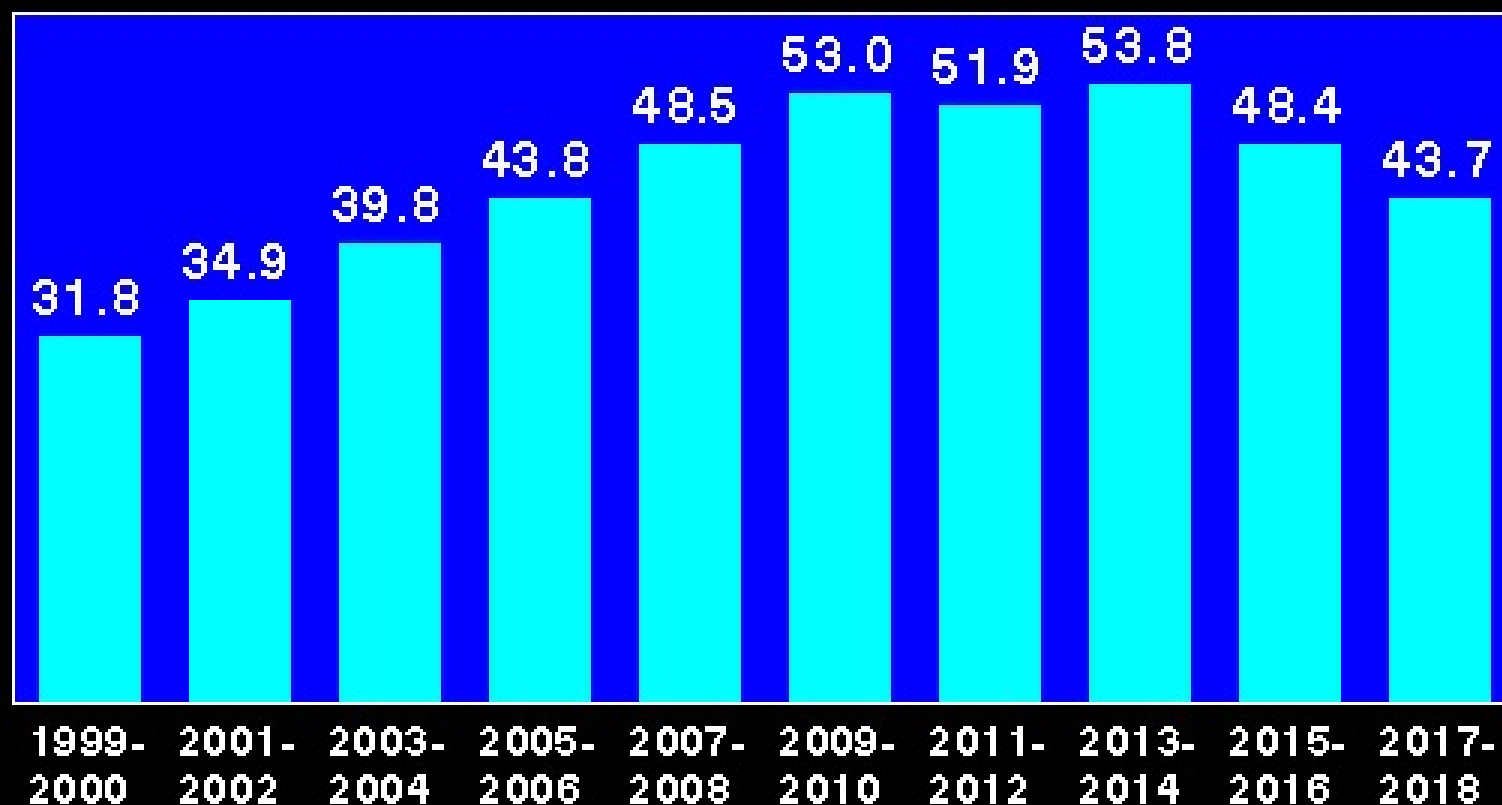
Change in life expectancy in 2020 vs. expected (years)



# Worsening Blood Pressure Control

A Rising Share of US Adults Have Uncontrolled Hypertension

Percent of adults with hypertension whose BP was controlled



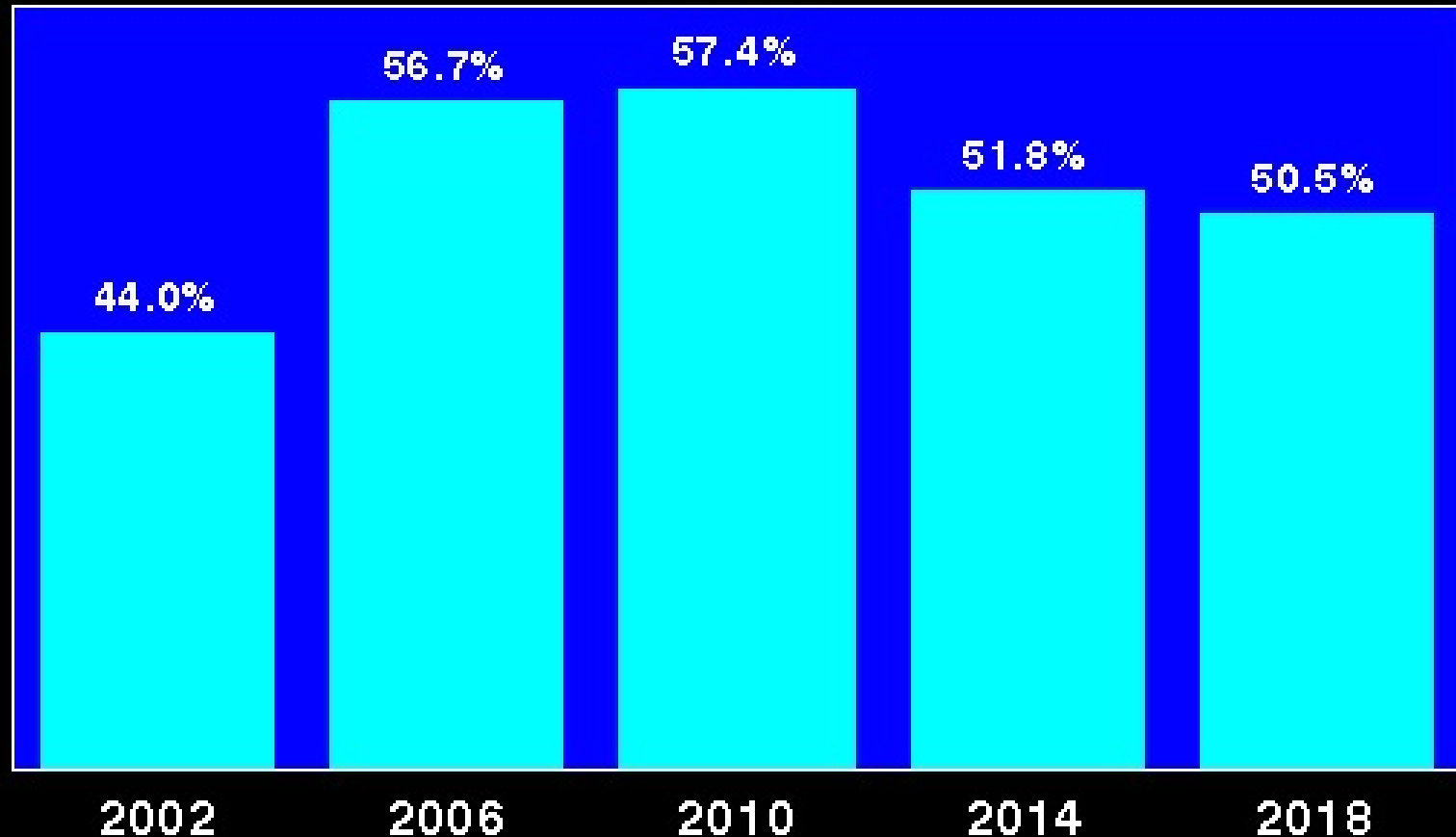
Source: JAMA 2020;324:1190 - Worsening control was seen in virtually every demographic group

Note: On average, 35.3% of US Adults had hypertension during the study period

# Diabetes Care is Deteriorating

---

% of diabetic Americans with Hgb A1C <7.0%



Source: NEJM 2021;384:2219

Note: Data are 4 year averages ending in year shown

# Growing Gap in Life Expectancy by Income

Dramatic Gains for the Wealthy, Losses for Lower Income

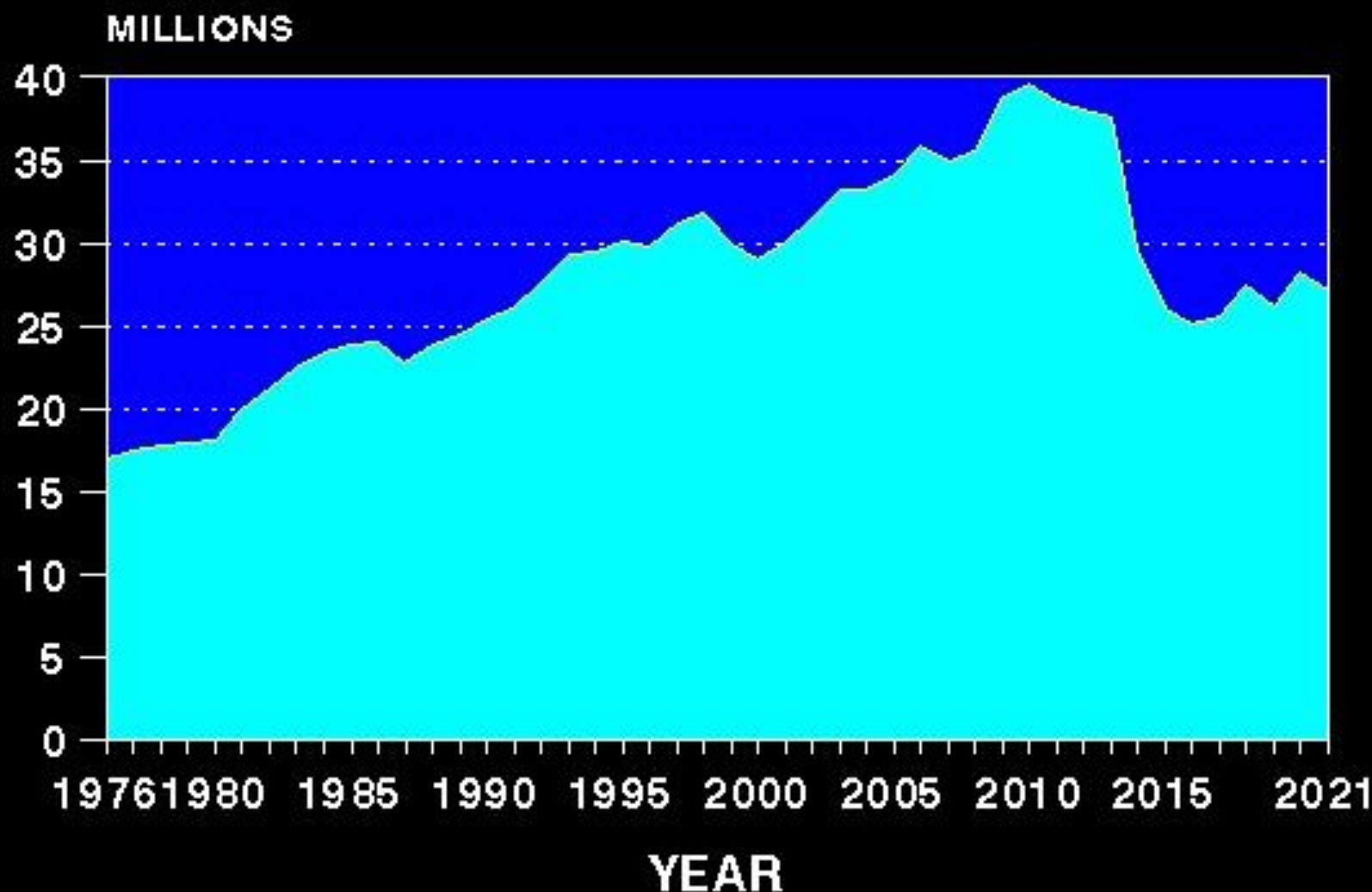
## Remaining life expectancy at age 50



# The Uninsured



# Americans Uninsured All Year, 1976-2021



Source: Himmelstein & Woolhandler - Tabulation from CPS, ACS & NHIS Data

Note - At time of survey, an additional 2 to 3 million are uninsured

# 36,355 Deaths During 2021 Due to Uninsurance

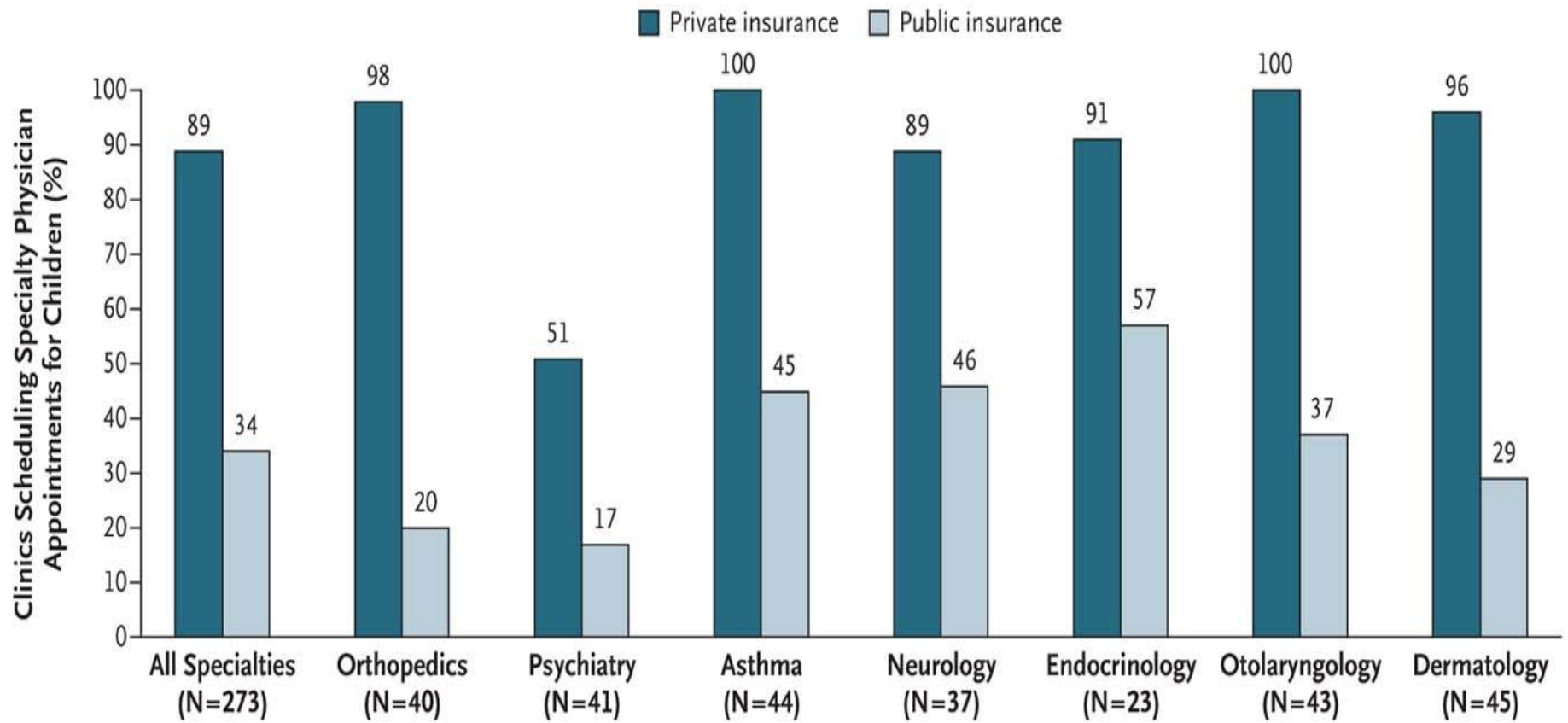
State	% Uninsured	Excess Deaths
Texas	18.0	6,793
California	7.0	3,528
Florida	12.1	3,378
Georgia	12.6	1,741
North Carolina	10.4	1,402
New York	5.2	1,325
<b>U.S.</b>	<b>8.6%</b>	<b>36,771</b>

Source: Woolhandler & Himmelstein, Ann Int Med 2017;167:424

Based on best estimate from multiple studies of 1 death per 769 uninsured/year, and # uninsured at time of survey

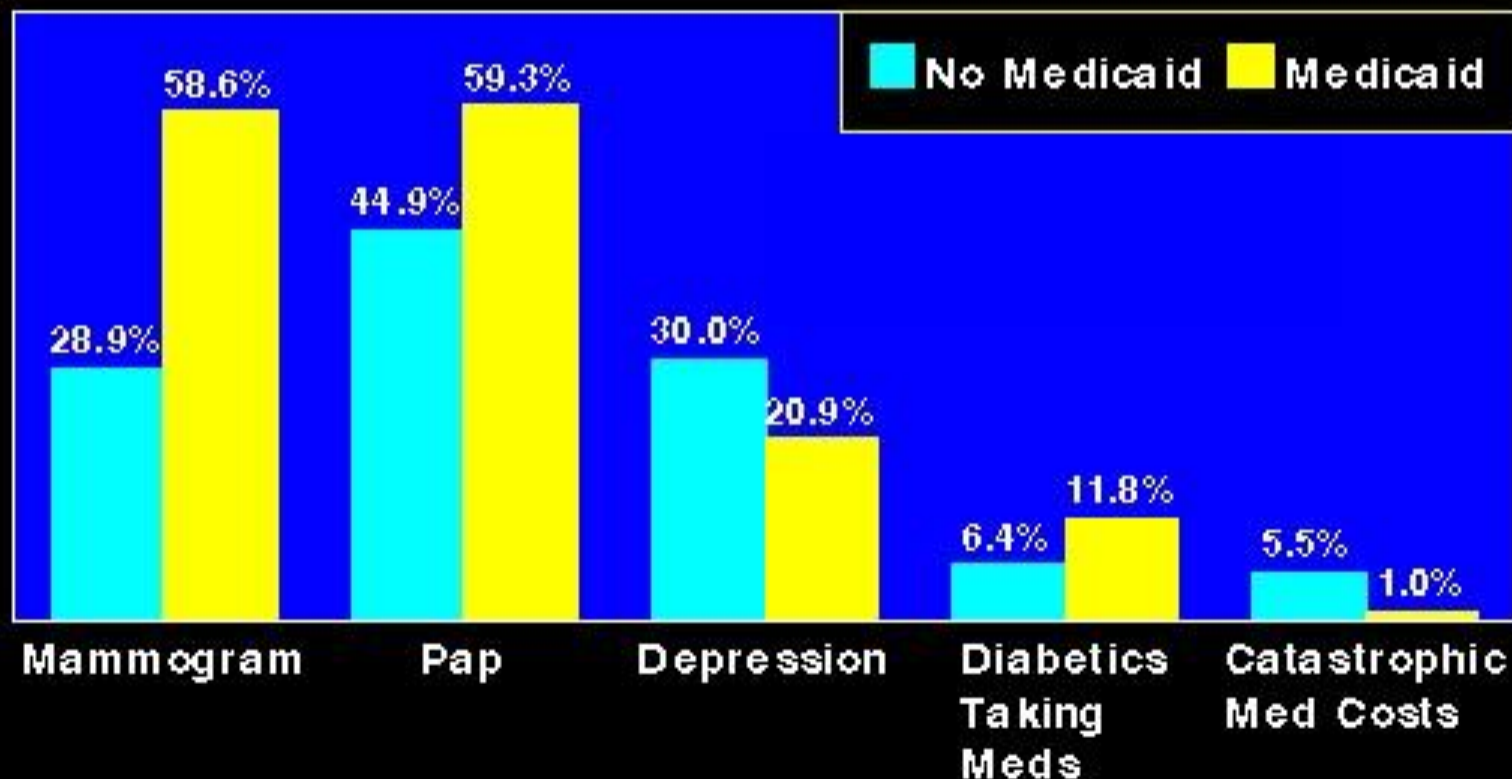
**Medicaid:  
Poor Access, But  
Better Than Nothing**

# Many Specialists Won't See Kids With Medicaid



# Medicaid Helps

## An RCT in Oregon



Source: NEJM May 2, 2013

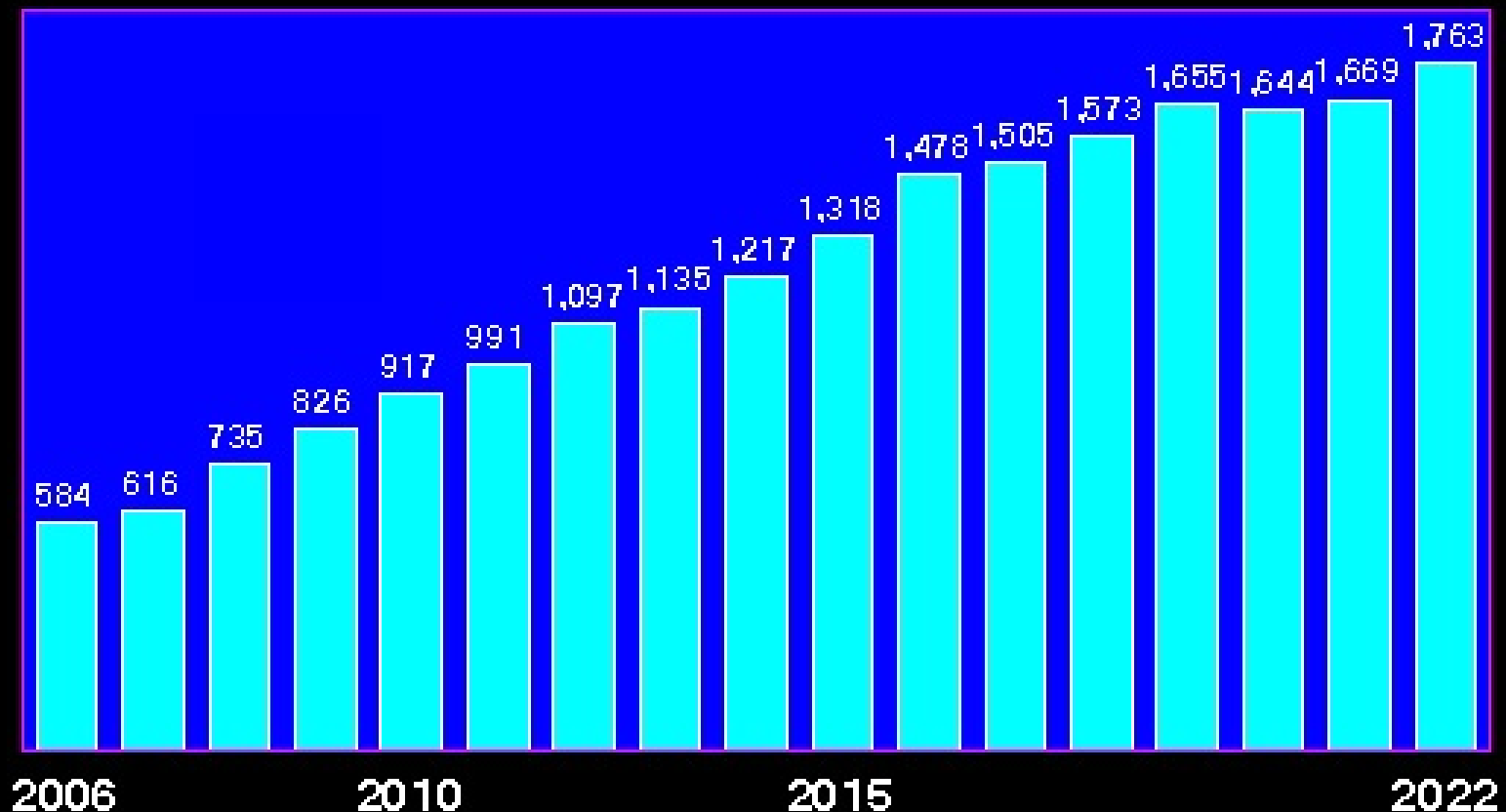
Note: Catastrophic medical costs = out-of-pocket spending >30% of income

Depression = screened positive for depression using PHQ8

# Under-Insurance

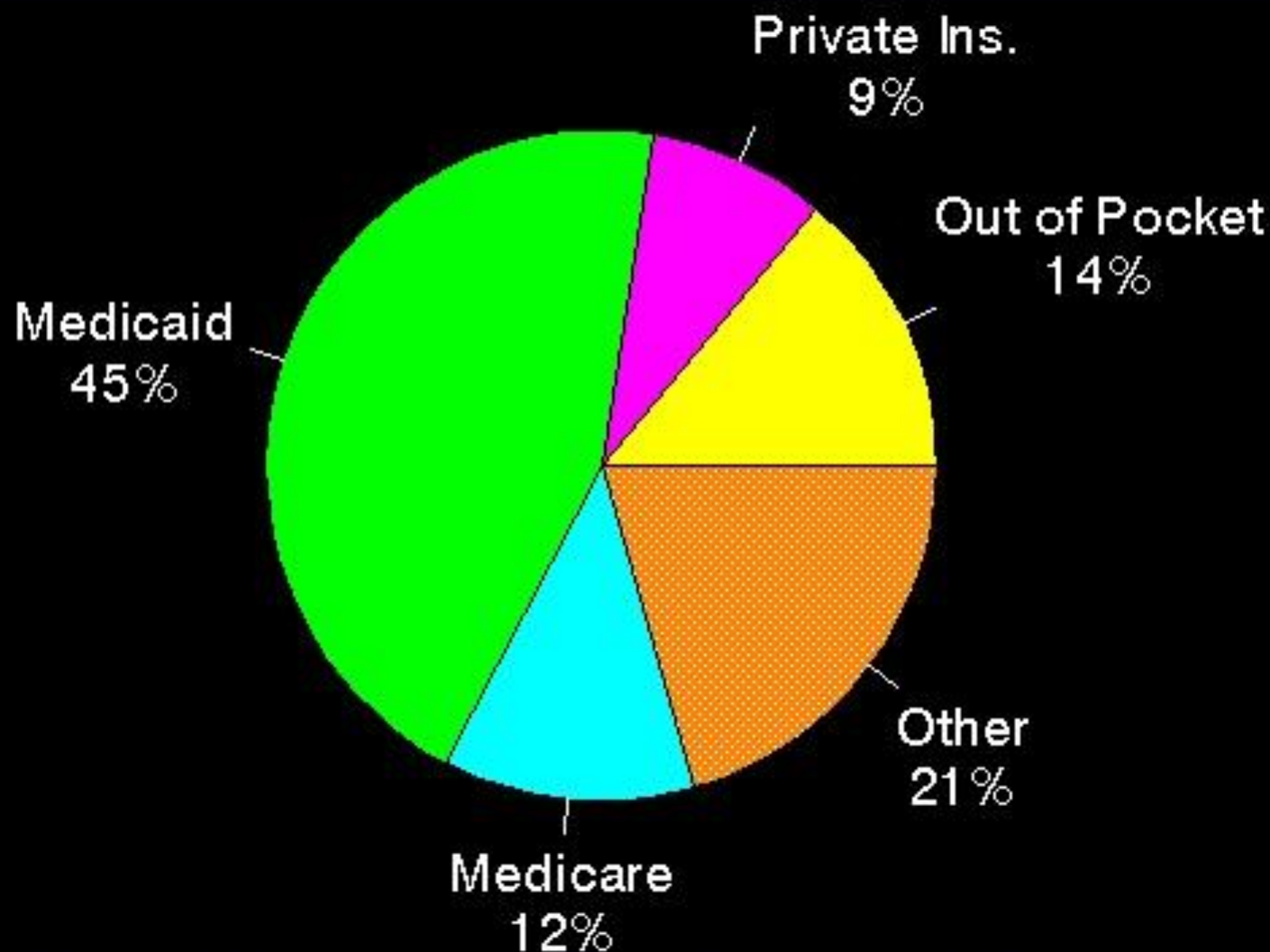
# Average Deductible Rising

**Average Deductible for Covered Workers,  
Single Coverage (\$)**



Source: Kaiser/HRET Survey of Employer-Sponsored Benefits

# Who Pays for Long Term Care?



Source: NCHS - National Health Expenditure Accounts - Data are for 2021

Note - Includes spending for NHs + Home care + "other residential and personal care"



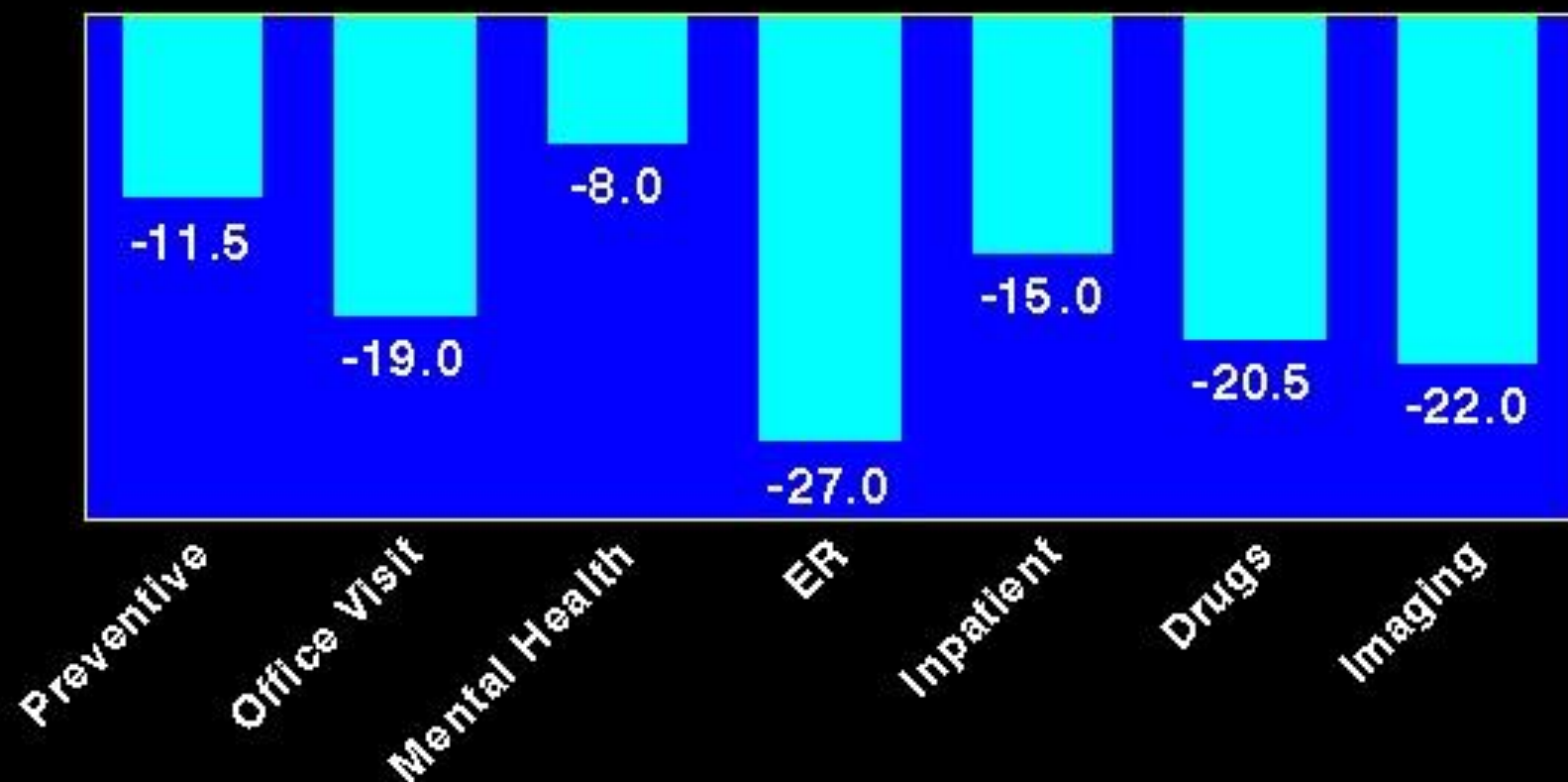
Under-Insurance  
Impedes Care,  
Worsens Health

# High Deductibles Cut All Kinds of Care

150,000 Employees Lost "Cadillac" Coverage

No Evidence that Patients Shifted to "Higher Value" Care

Percent utilization reduction



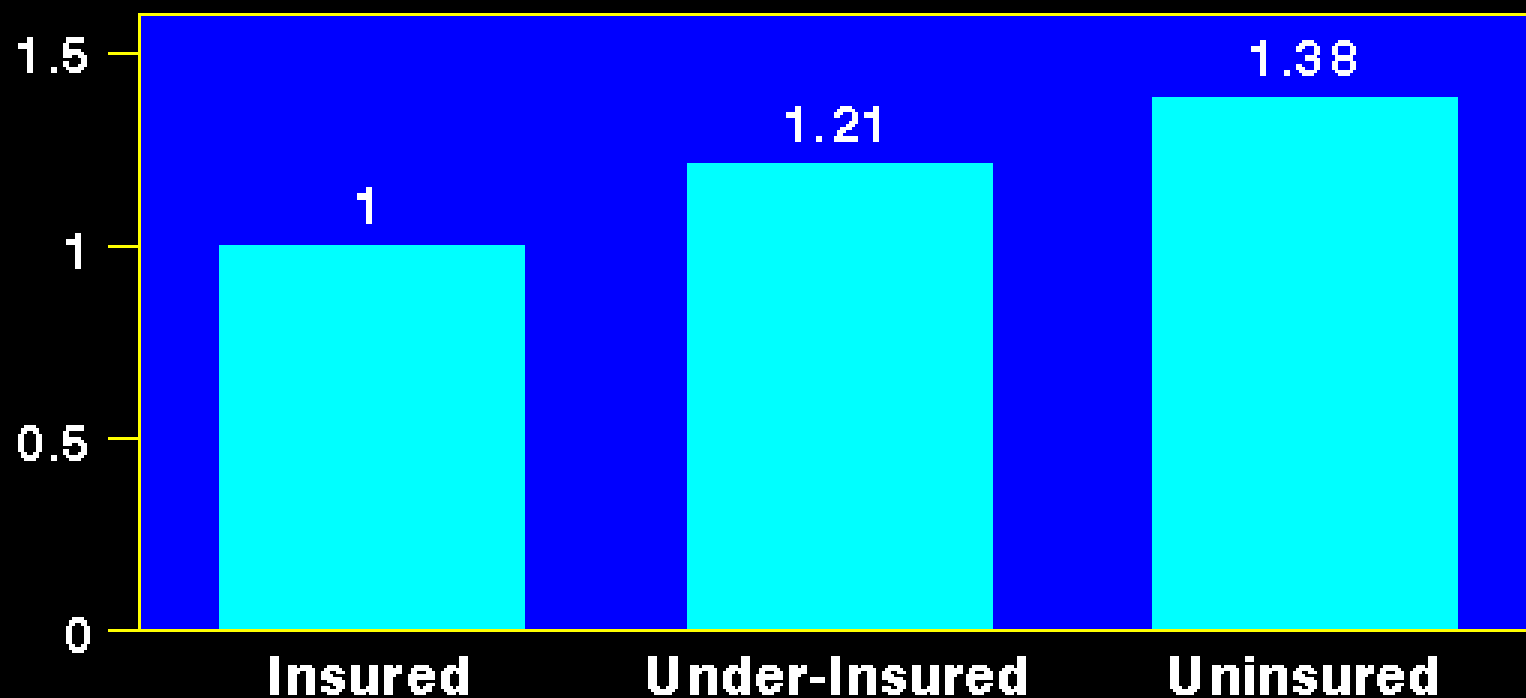
Source: Brot-Goldberg et al, 6/2015 - <http://eml.berkeley.edu/~bhandel/wp/BCHK.pdf>

Note: Findings closely resemble those of Rand Health Insurance Experiment

Note: Study found no evidence that patients shopped for lower prices

# Uninsured and Under-Insured Delay Seeking Care for Heart Attacks

Odds ratio for delayed care\*



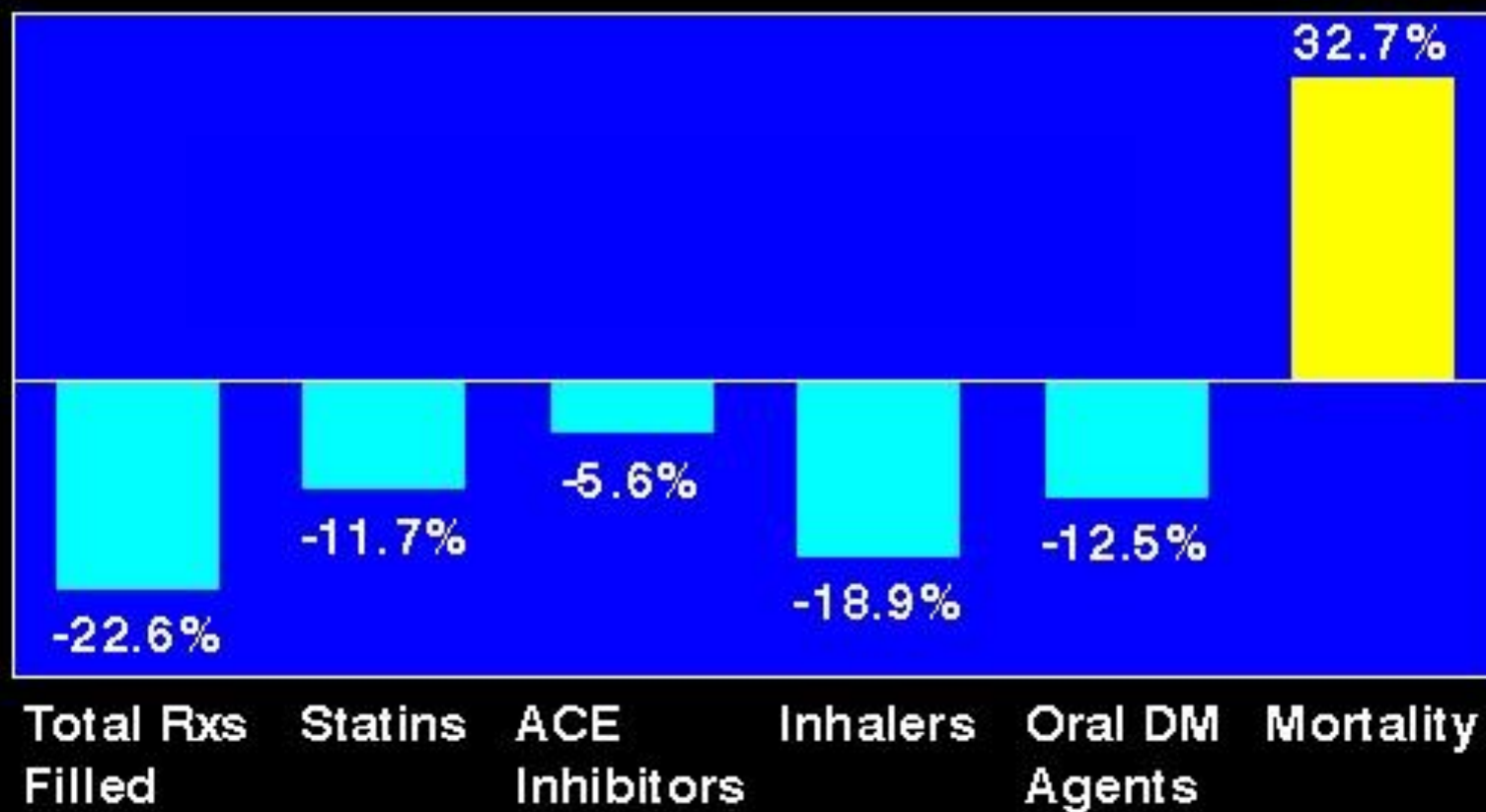
Source: JAMA April 15, 2010;303:1392

\*Adjusted for age, sex, race, clin. characteristics, hlth status, social/psych factors, urban/rural  
Under-insured = Had coverage but patient concerned about cost

# Drug Copayments Kill

## Quasi-Experimental Analysis of Medicare Part D Copays

% change with \$10.40 (34%) increase in copay/drug



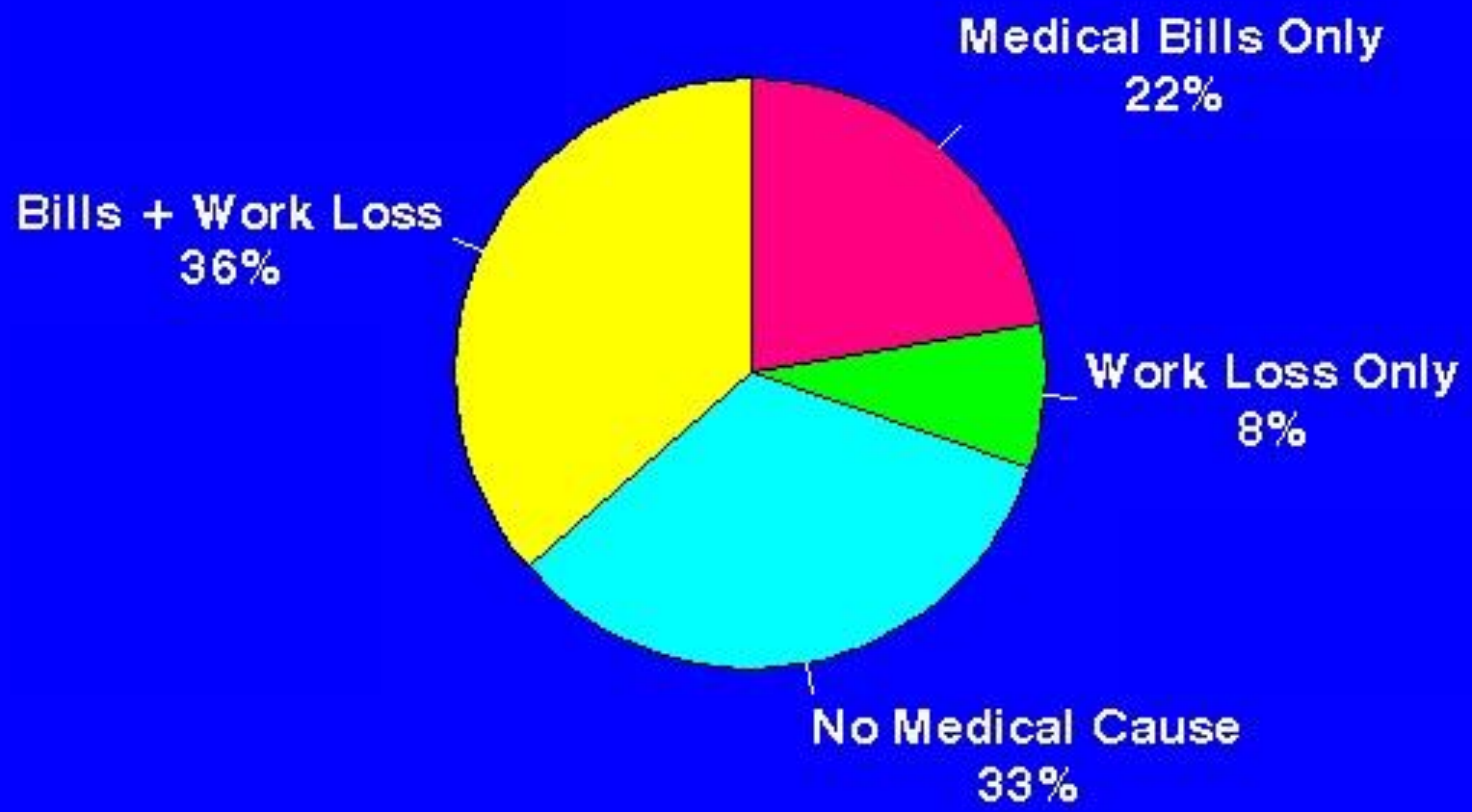
Source: "The Health Costs of Cost Sharing) NBER #28439, February, 2021

Many patients stopped all drugs; Reductions in use largest in patients on many drugs

**Under-Insurance:  
A Leading Cause of  
Financial Distress and  
Ruin**

# 2/3 of Bankruptcy Filers Cite Medical Bills or Illness-Related Work Loss as a Cause

National Survey of Debtors, 2013-2016

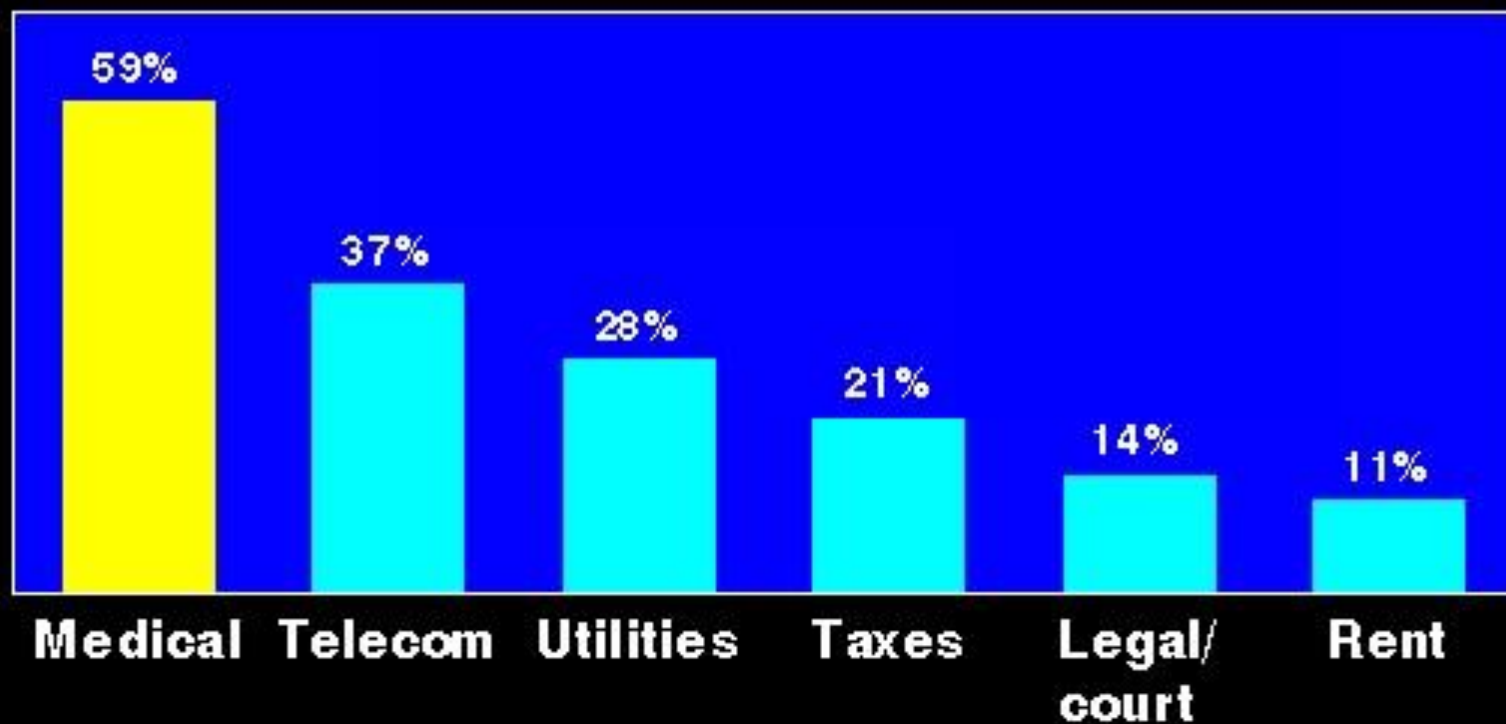


Source: Himmelstein, Thorne, Lawless, Foohey, Woolhandler - AJPH 2019;109:431

Work loss = "work loss due to illness"

# Medical Bills are Most Common Reason for Collection Calls

Percent of consumers receiving collection calls with specific type of debt



Source: Consumer Financial Protection Bureau, January, 2017

Note: Medical collection calls were the only category which did not differ by income

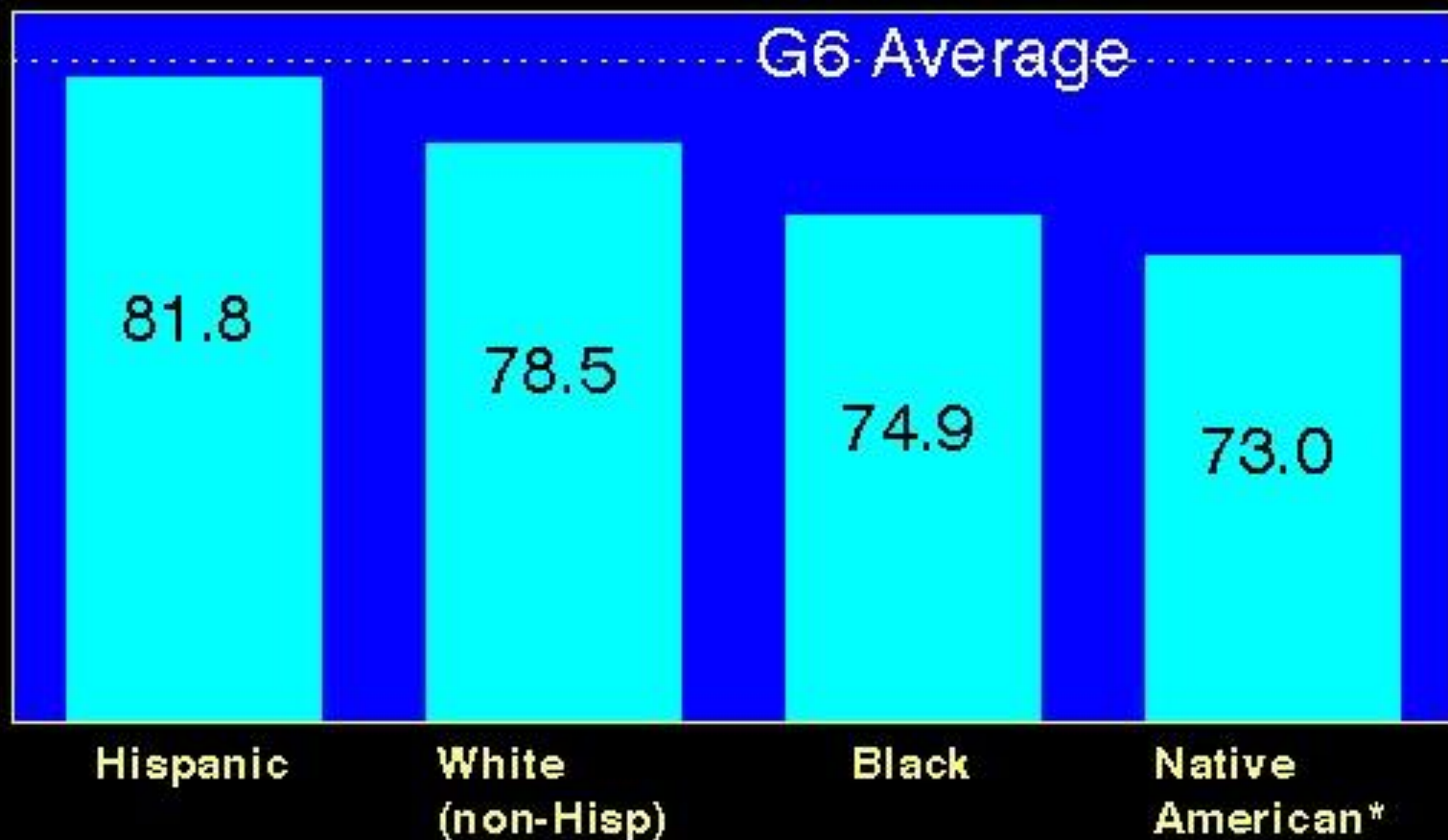
# Racism Harms Health



# Black and Native Americans Die Younger

But Life Expectancy for Every Group is Shorter Than Other G7 Nations

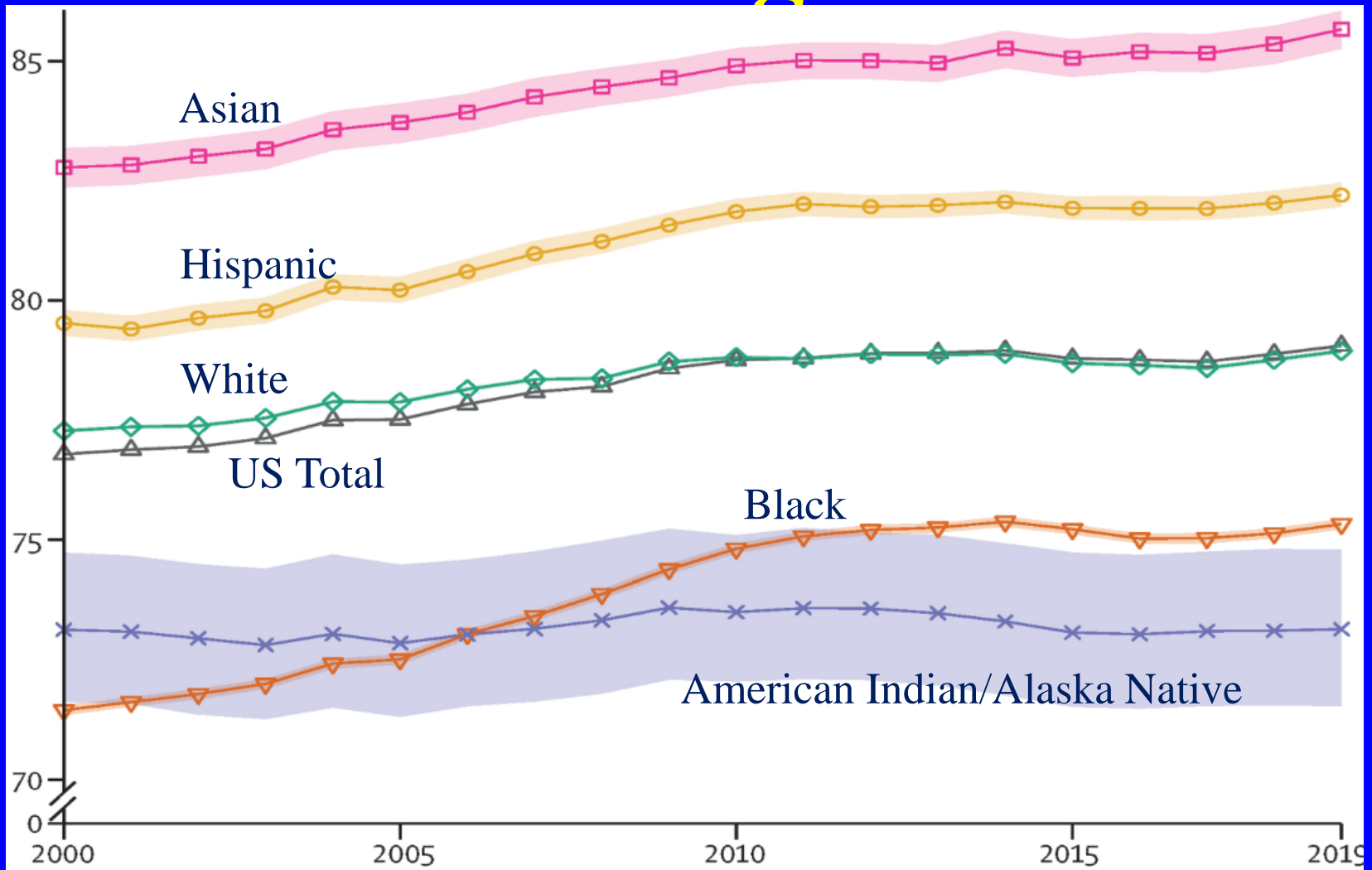
Life expectancy, years



Source: NCHS, IHS, OECD

Other G7 nations = Canada, France, Germany, Italy, Japan, UK

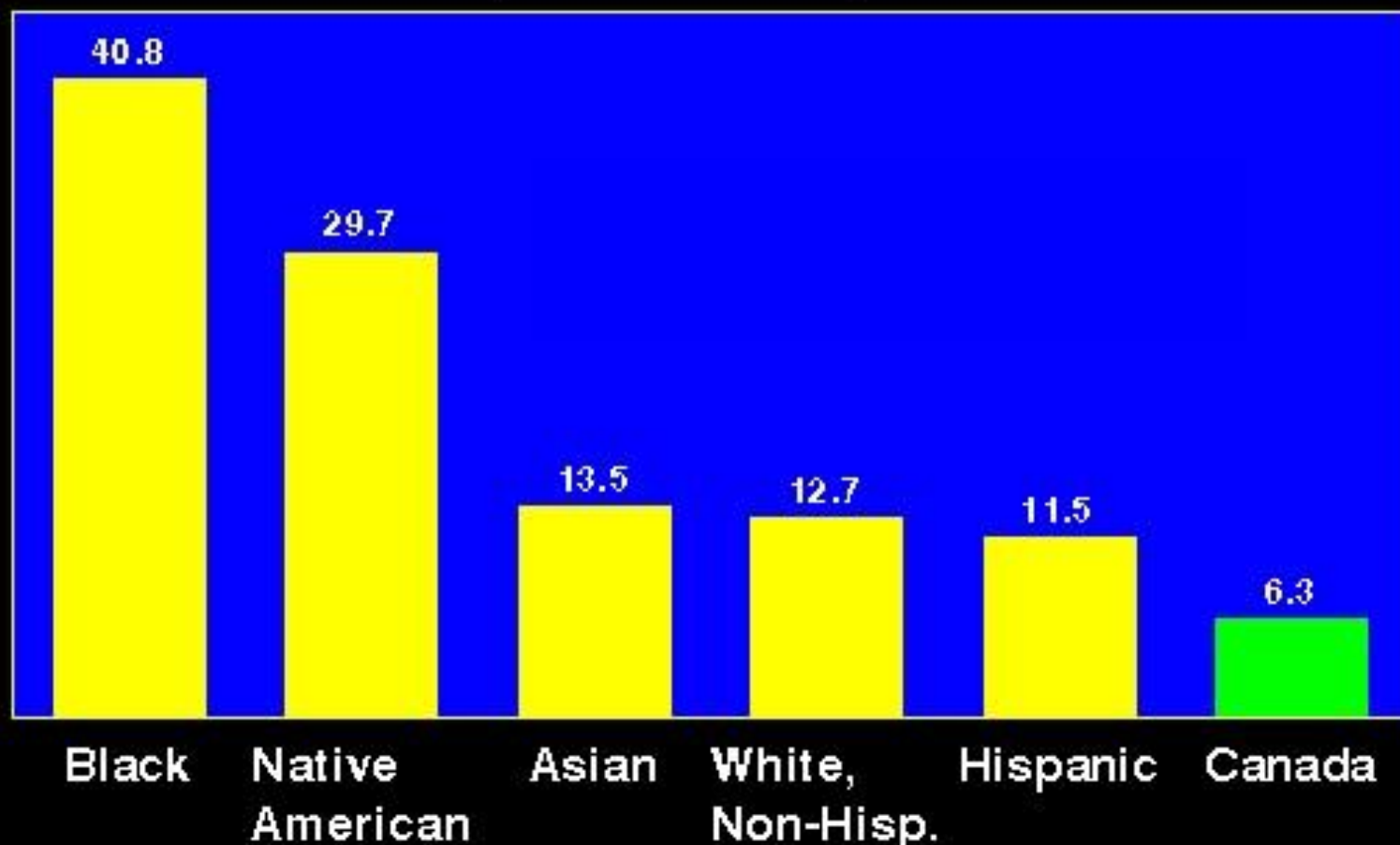
# Native Americans Die Youngest



# Race/Ethnicity and Maternal Mortality

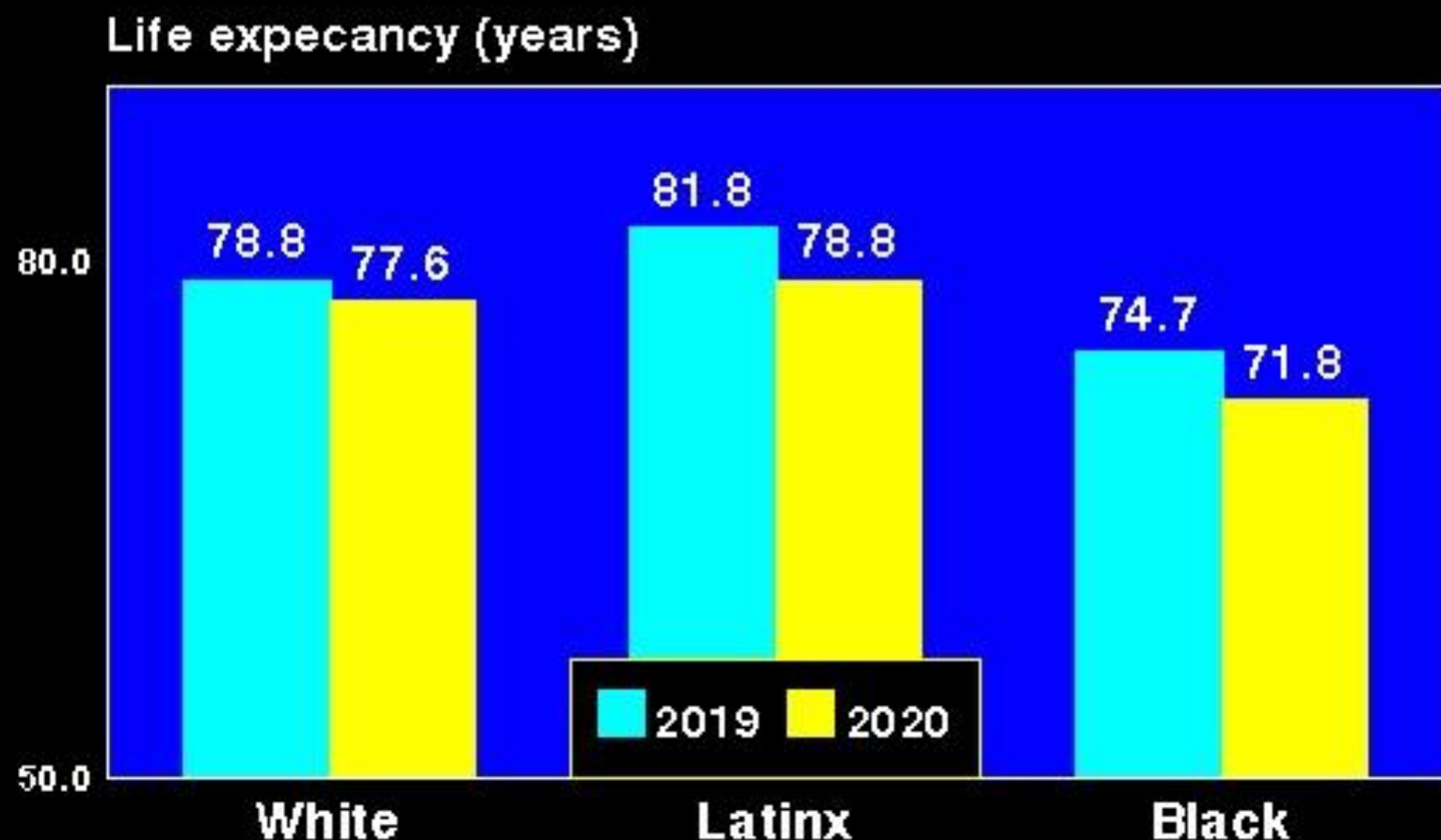
Every Group in the US Does Worse than Canadians

Maternal deaths/100,000 live births, 2016



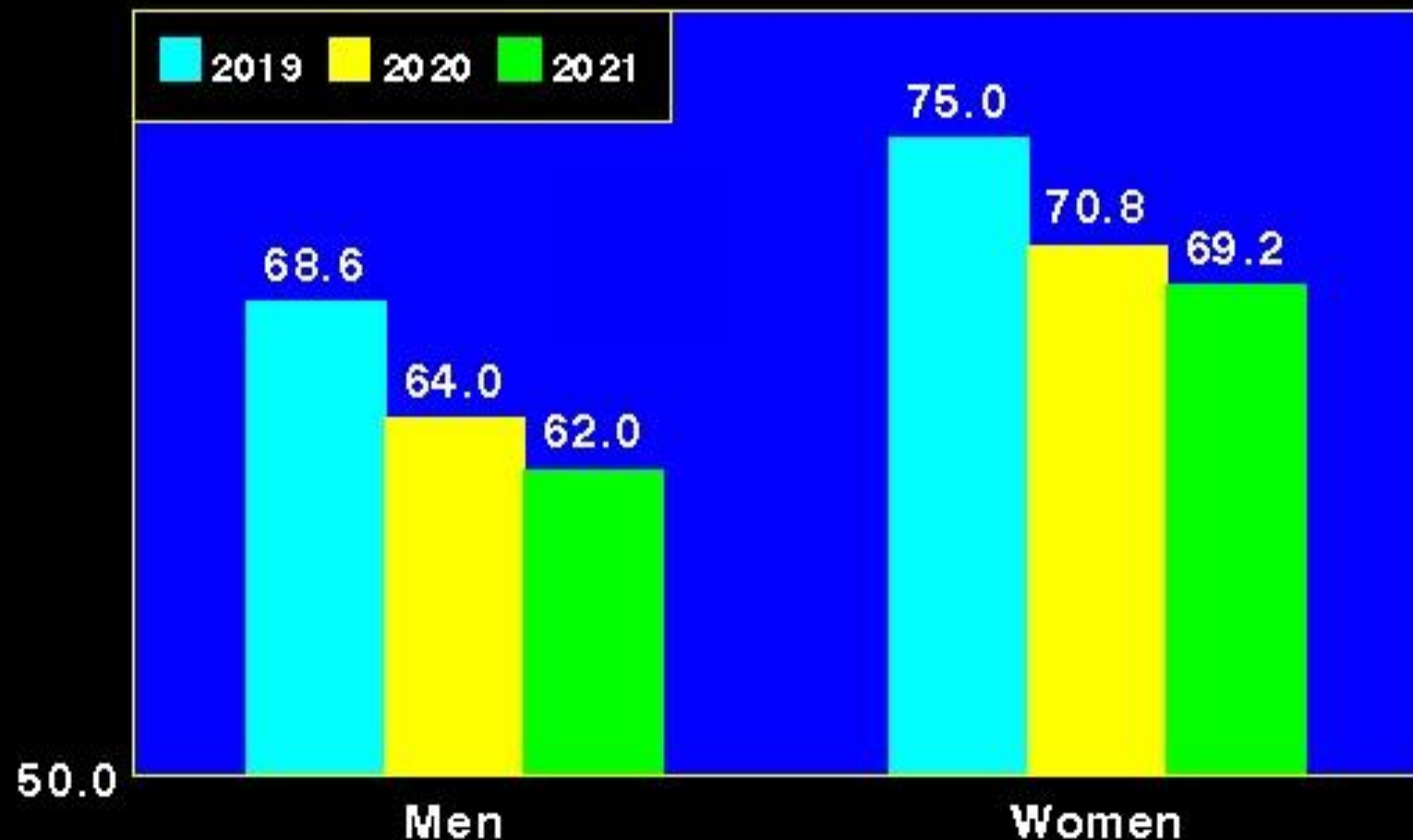
Source: MMWR September, 2019 and OECD

# COVID-19 Has Sharply Reduced Black and Latinx Life Expectancy



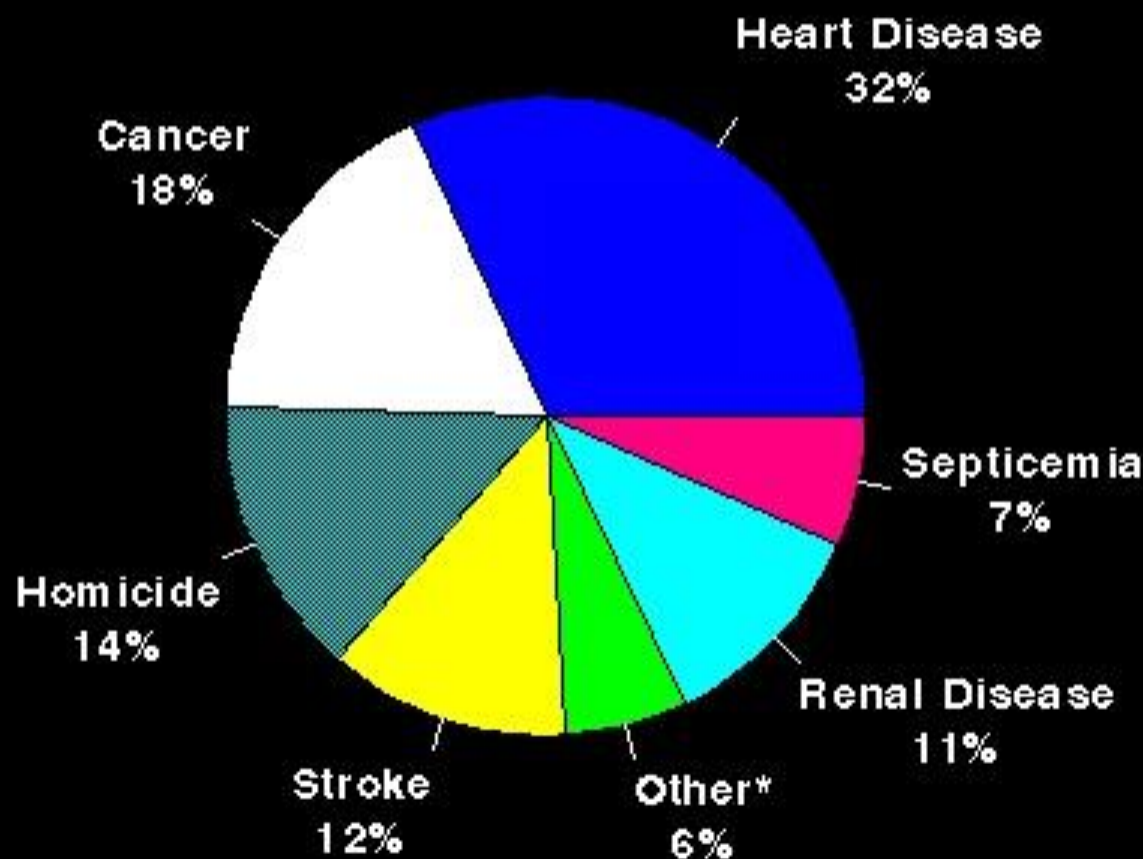
# Native Americans' Life Expectancy Plummeted During COVID-19 Pandemic

Life expectancy at birth



Source: Goldman and Andrasfay, Demographic Research July 27, 2022

# Causes of Black/White Disparity in Adult Mortality

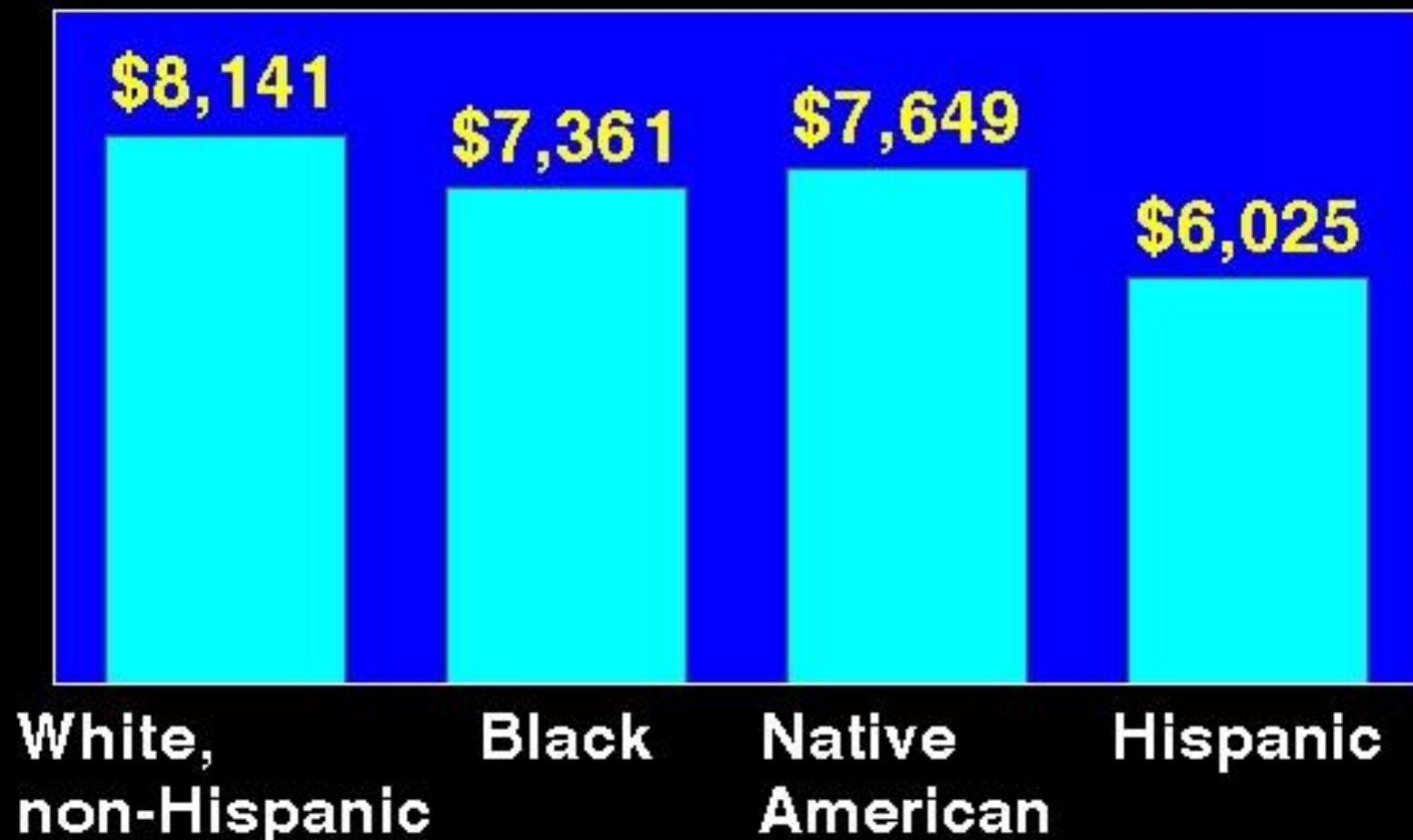


Source: MMWR May 2, 2017

\* Includes conditions (e.g. diabetes) for which Black death rates are higher and some (e.g. COPD, cirrhosis) for which Black death rates are lower

# People of Color Get Less Care

Total health care received (\$s per capita, age adjusted)



# Black Serving Hospitals Get Paid Less

## Structural Racism in Hospital Financing



Source: Gracie & Kayty Himmelstein and Joniqua Ceasar - submitted for publication

Note: "Black Serving" = 10% of hospitals with largest proportion of Black patients (i.e. >25.8%)

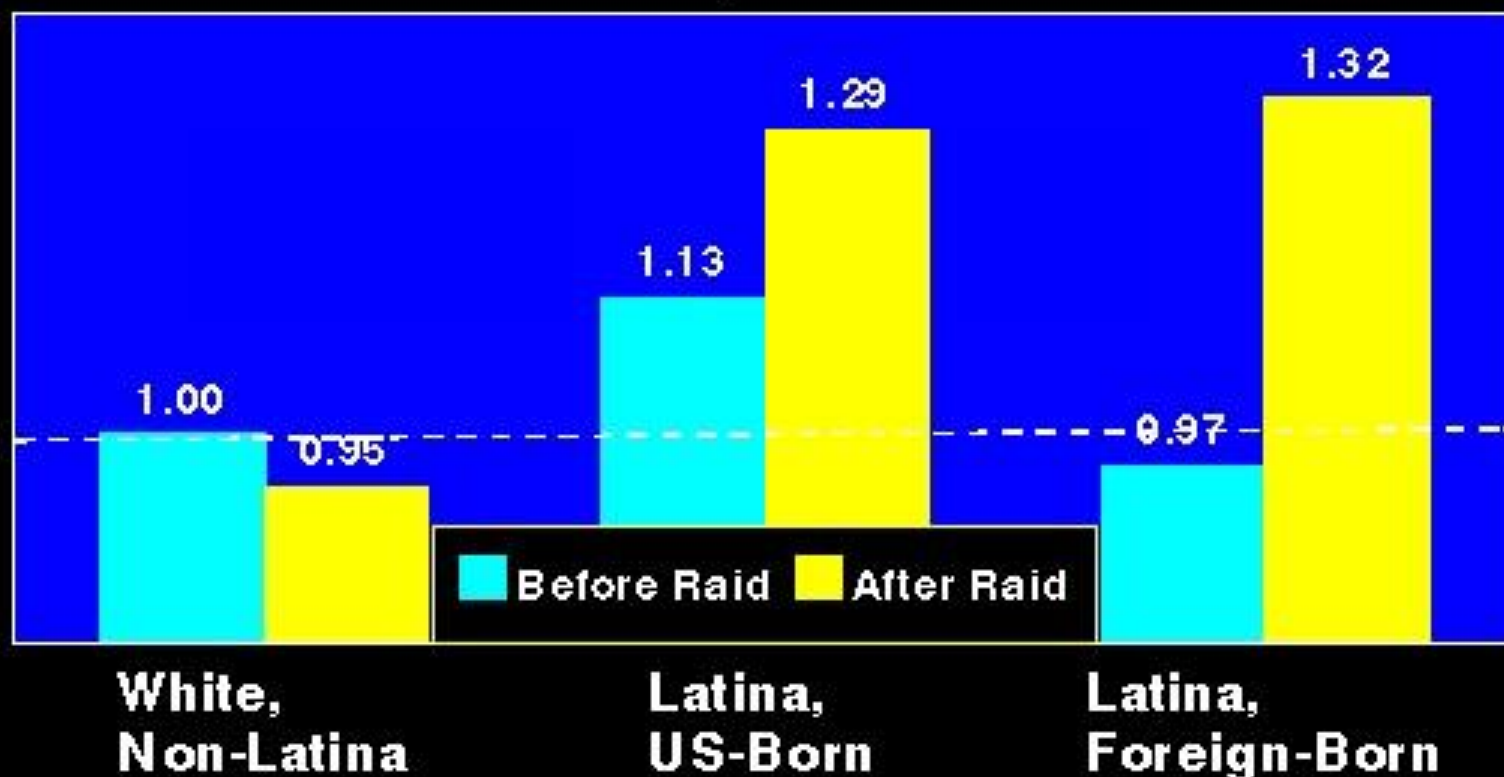
Note: Data are means, 2016-2018



# Protecting Immigrants' Right to Health Care

# Low Birth Weight Increased In Iowa After A Massive Immigration Raid

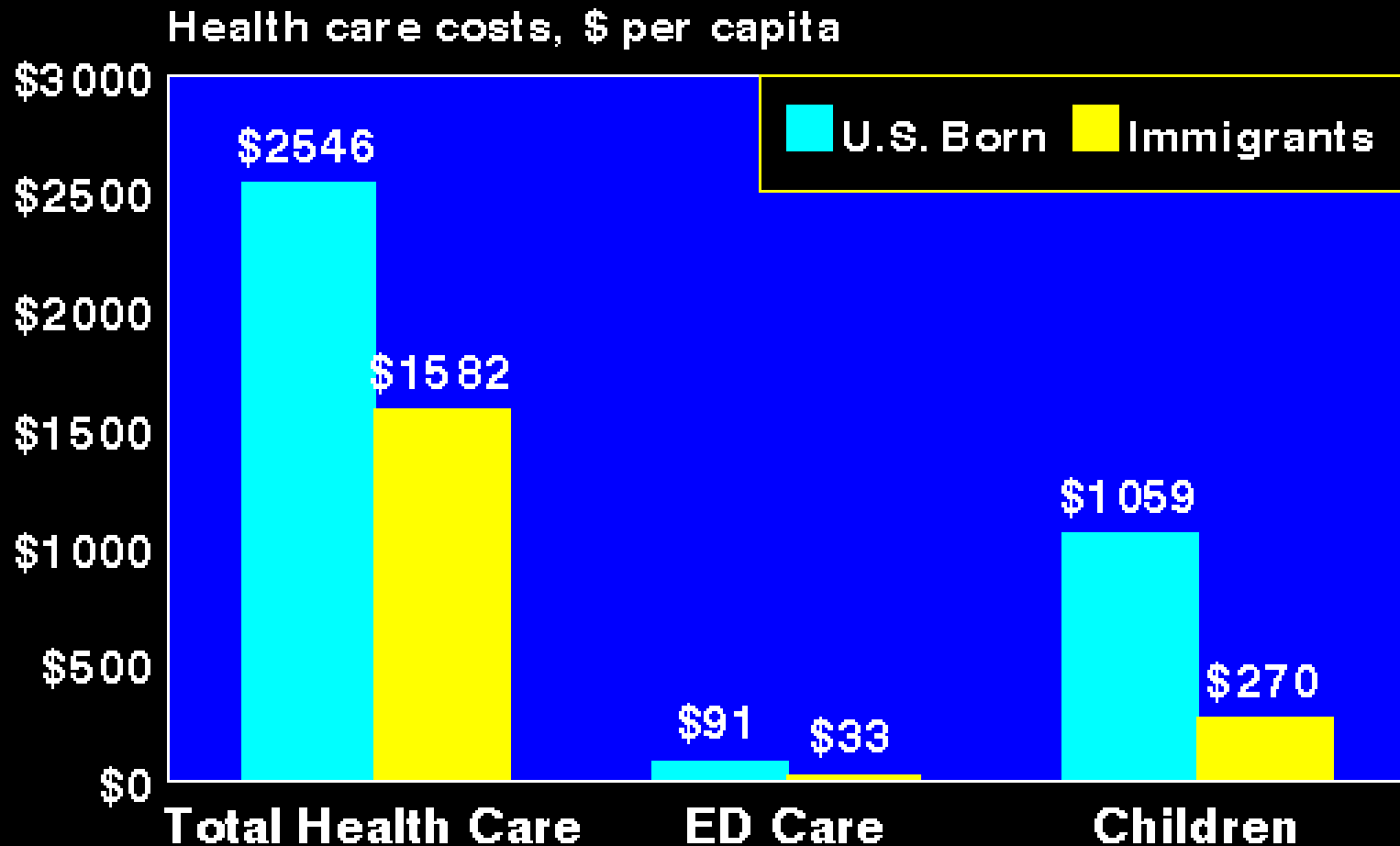
Relative risk of Low Birth Weight



Source: Int J Epidemiol 2017;839

Note: 2008 Postville, Iowa raid was largest single-site immigration raid in history. 900 agents handcuffed and chained all Latinos at meatpacking plant

# Immigrants Get Little Care

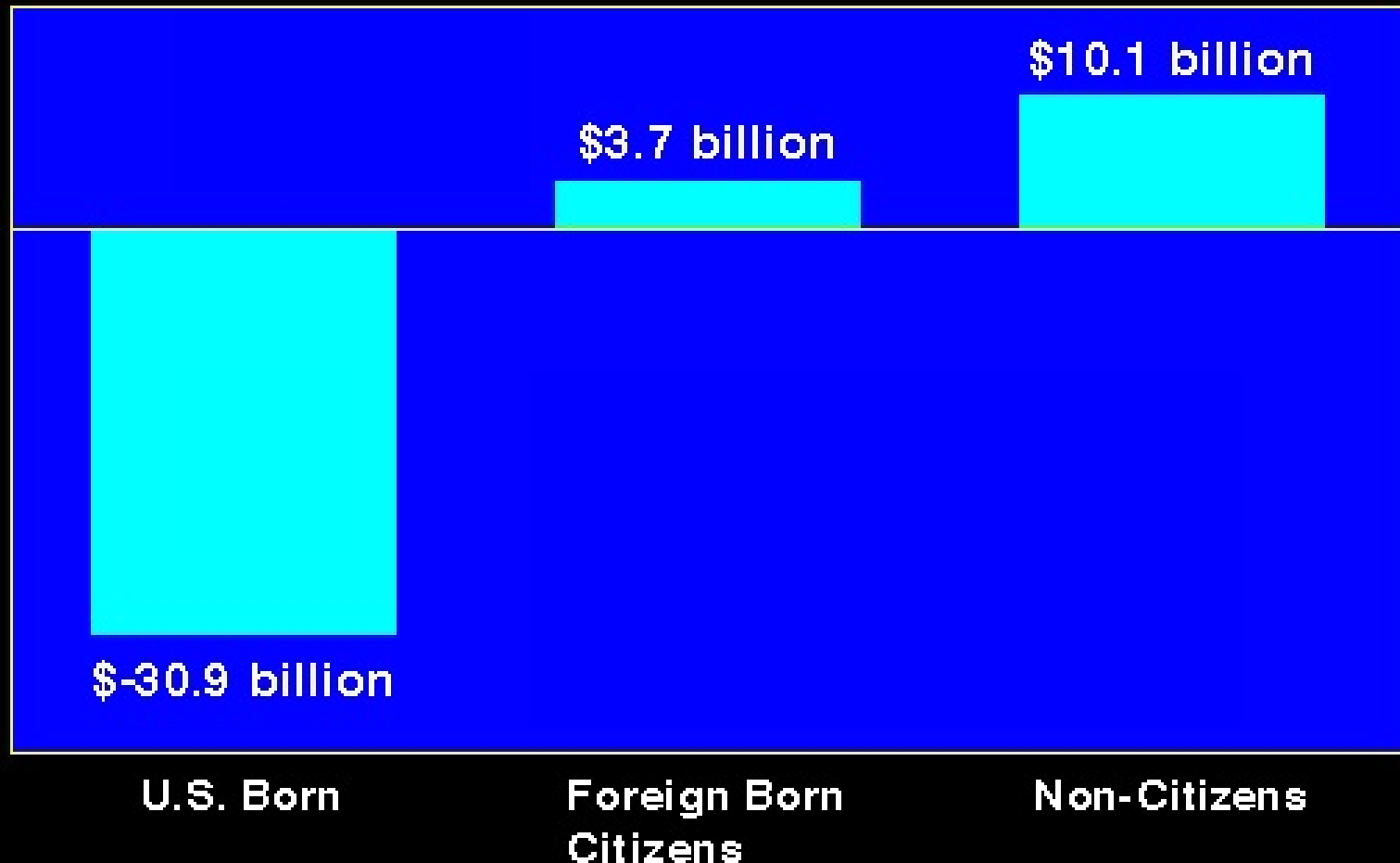


Source: Mohanty et al Am J Public Health 2005;95:1431

\* Adjusted for ethnicity, poverty, age, insurance status, patient/parent-reported health status

# Immigrants Keep Medicare Afloat

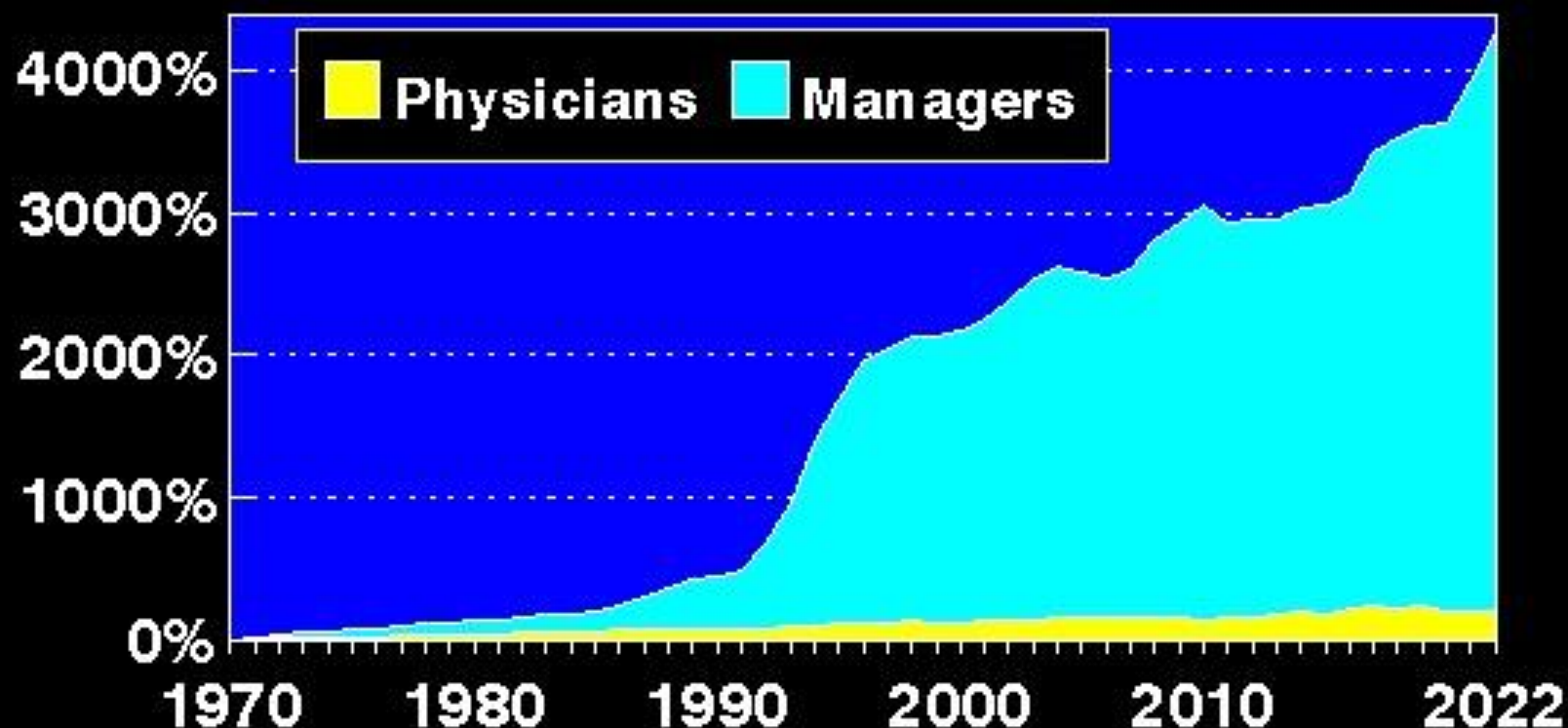
Net Contribution to Medicare Trust Fund, 2009



# Administrative Overhead Rising

# Growth of Physicians and Administrators 1970-2022

## Growth Since 1970



Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS  
Note - Managers are shown as 3 year moving average

Investor-Owned Care:  
Inflated Costs, Inferior  
Quality

# Health Industry Profits, 2020

Pharmaceuticals	\$52.4 bil
Insurers	\$26.2 bil
Pharmacy/Lab/Benefit Mgr.	\$19.7 bil
Equipment/Supplies	\$11.5 bil
Providers	\$6.7 bil
Distributors/Wholesalers	\$6.4 bil

Source: Fortune 500, 2021

Note: Excludes firms not in Fortune 500 which account for substantial pharma profits



# Health Industry Profits, 2021

Pharmaceuticals	\$117.1 bil
Insurers	\$28.3 bil
Equipment/Supplies	\$20.3 bil
Pharmacy/Lab/Benefit Mgr.	\$18.6 bil
Providers	\$10.1 bil

Source: Fortune 500, 2022

Note: Excludes firms not in Fortune 500 which account for substantial pharma profits

# For-Profit Hospitals Cost 19% More

Source: CMAJ 2004;170:1817

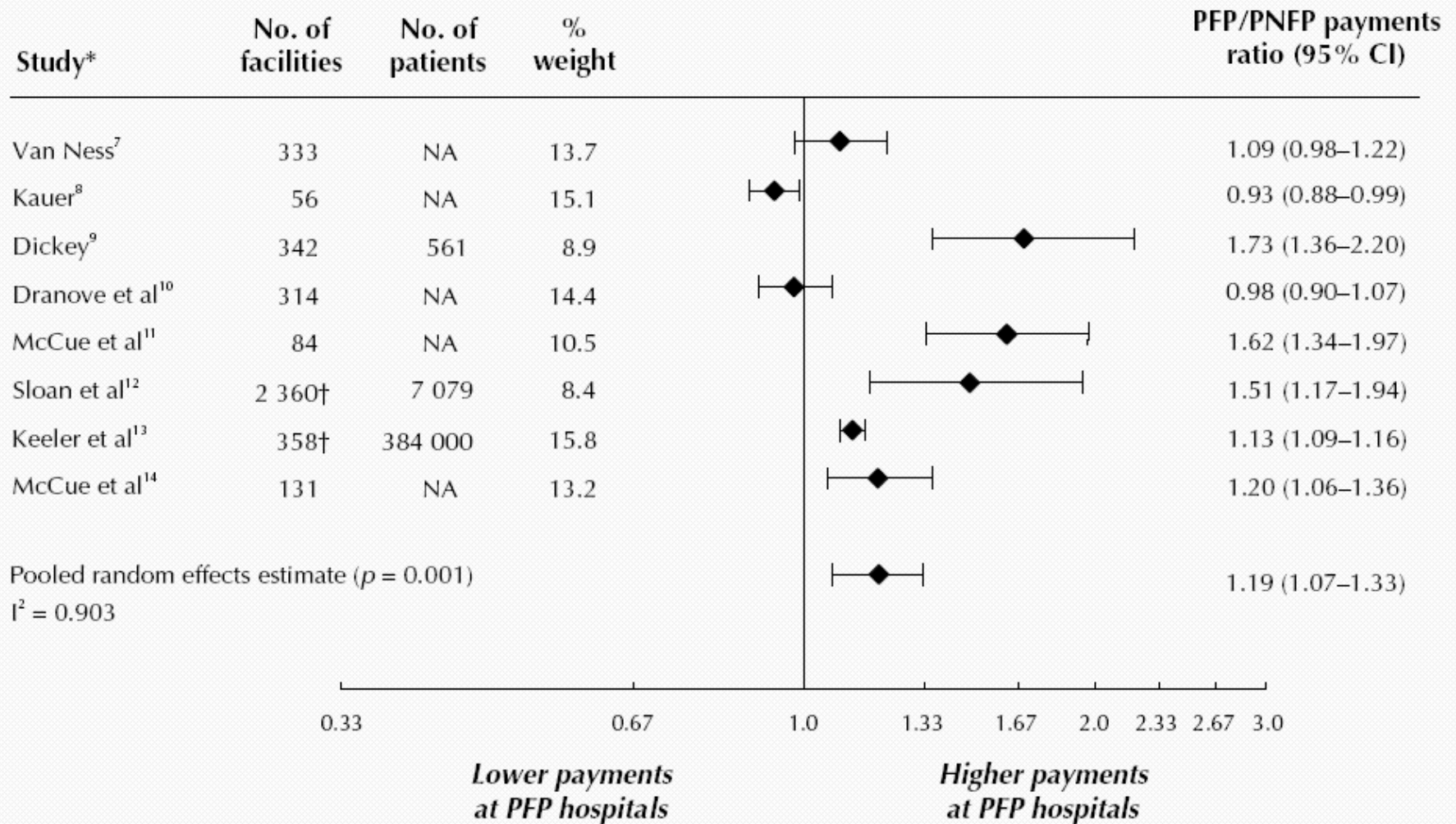
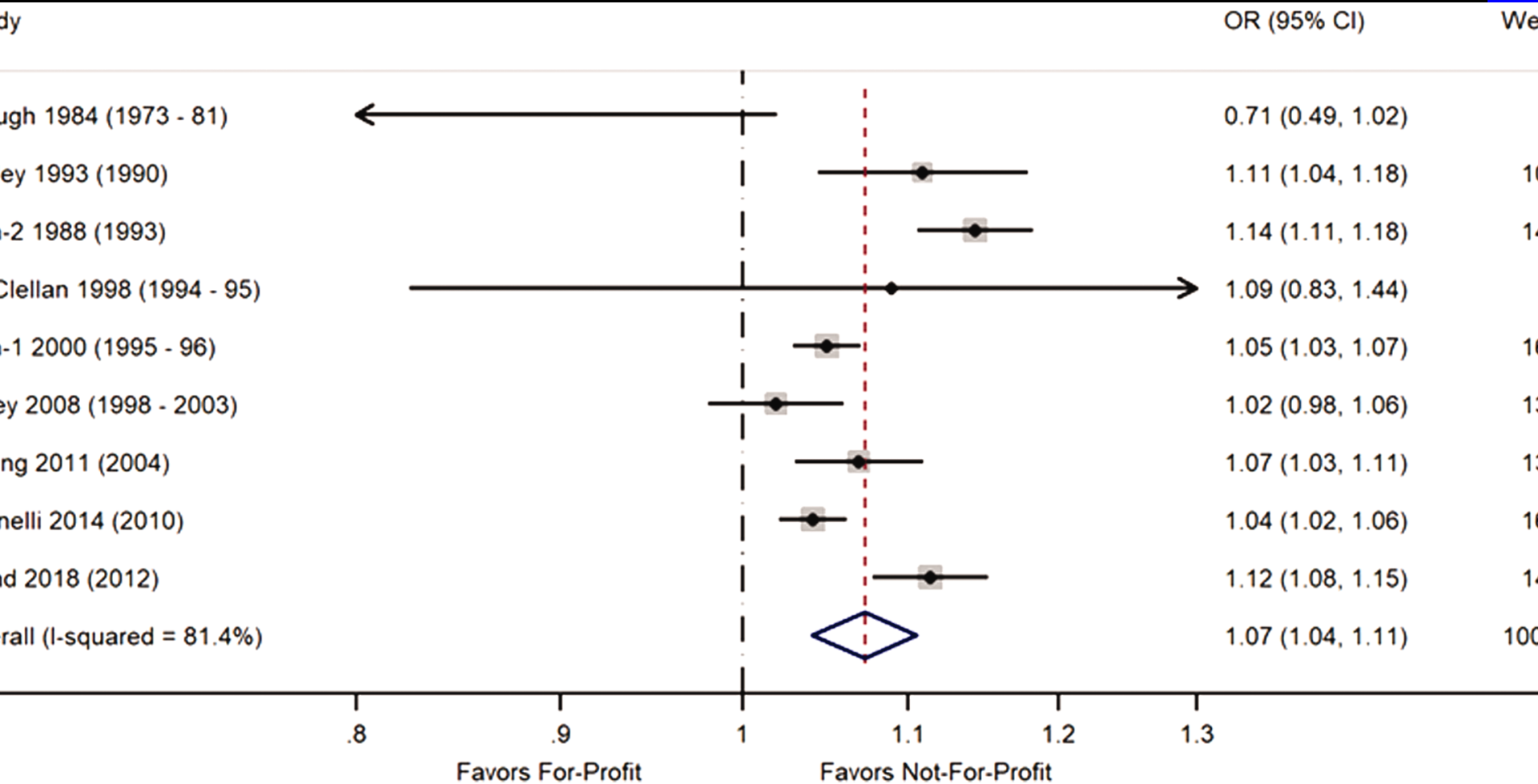


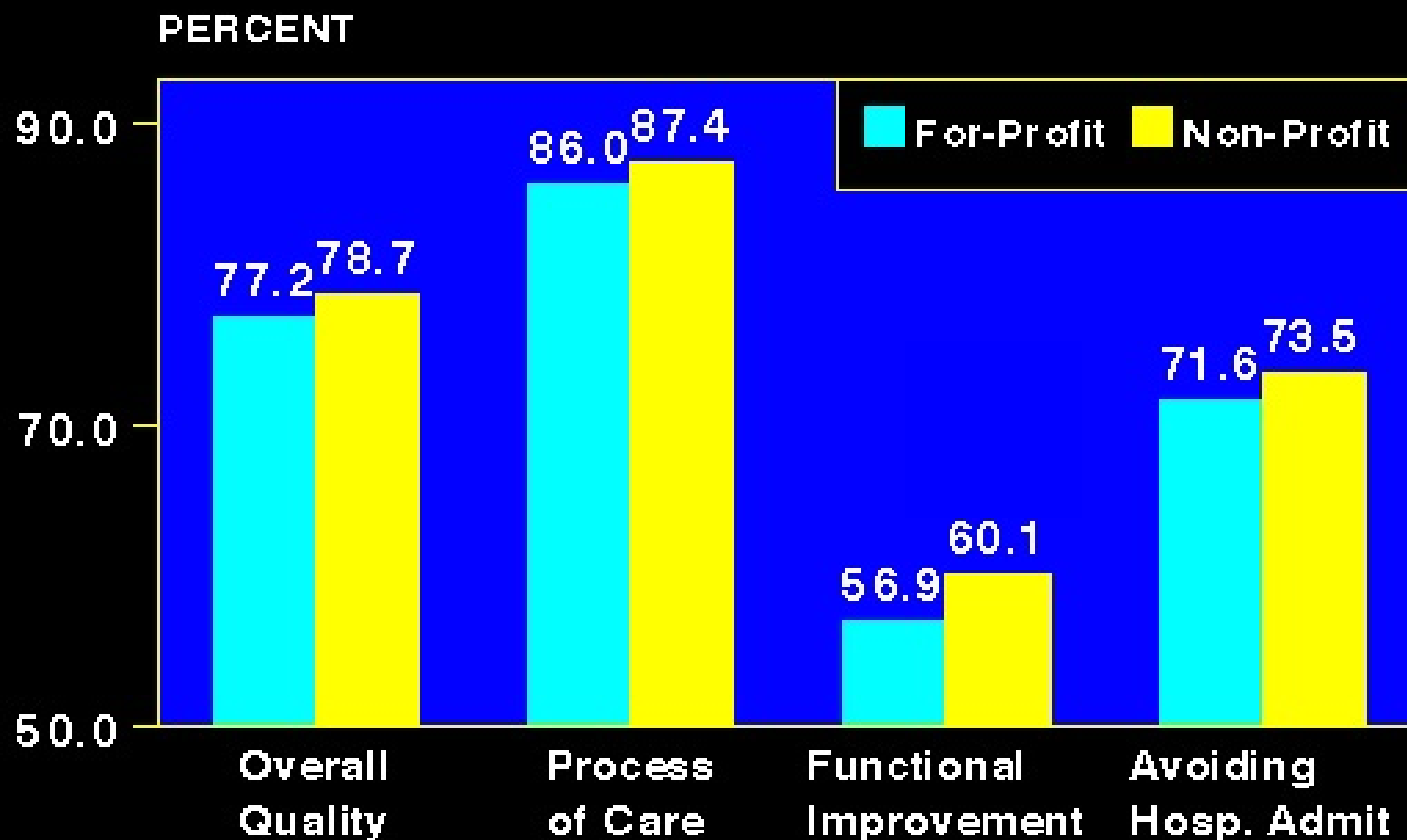
Fig. 2: Relative payments for care at private for-profit (PFPP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.

\*The studies are in chronological order by midpoint of the data collection period. †Approximation from investigator.

# For-Profit Dialysis Clinics' Death Rates are 7% Higher 3800 Excess Death Annually

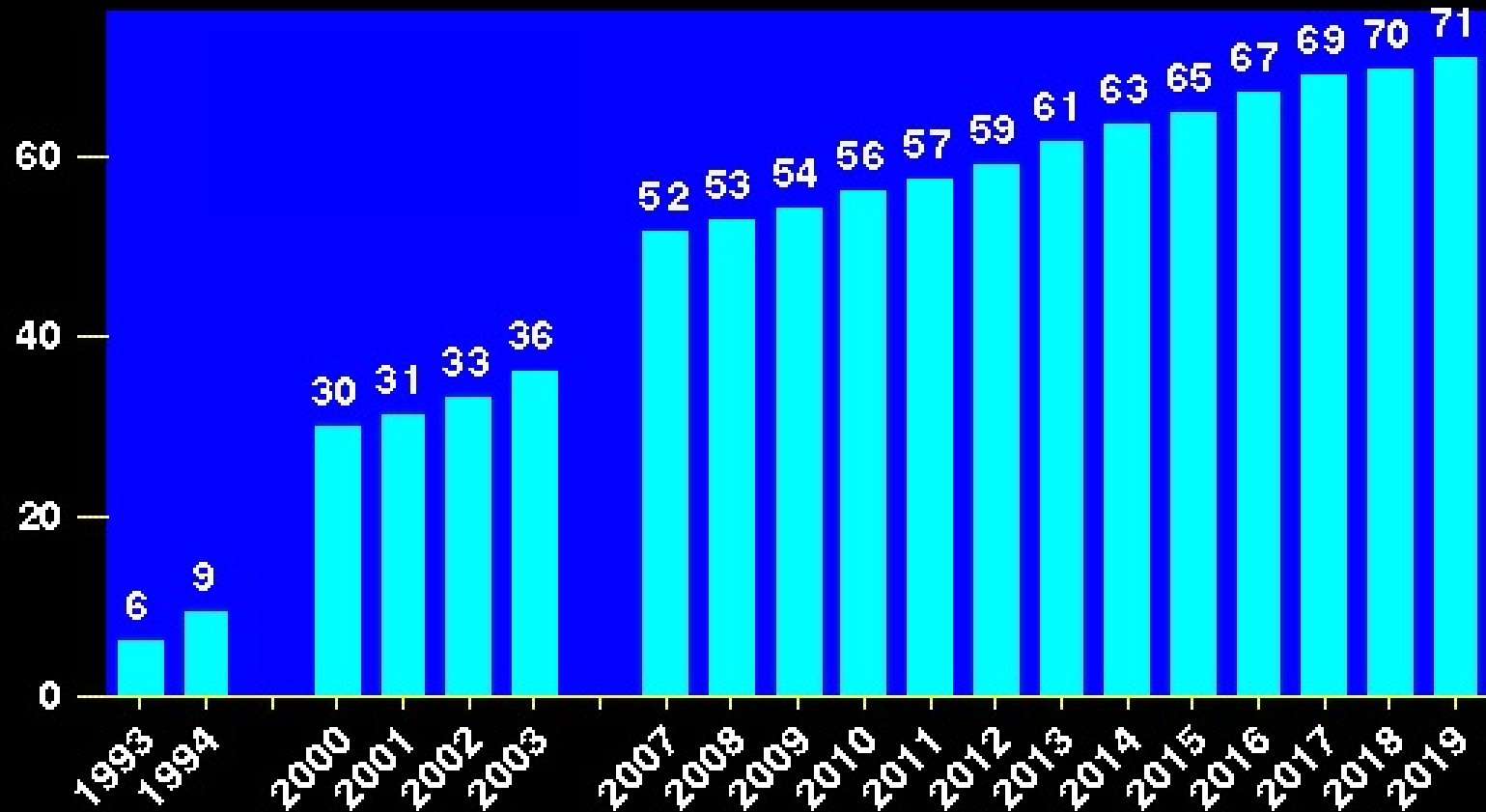


# For Profit Home Care: Lower Quality



# Hospice Goes For-Profit

Percent of hospices under for-profit ownership



Source: MedPac Annual Report, 2021 and previous

Note: Profit rate: for-profits = 19.0%; non-profits = 3.8%

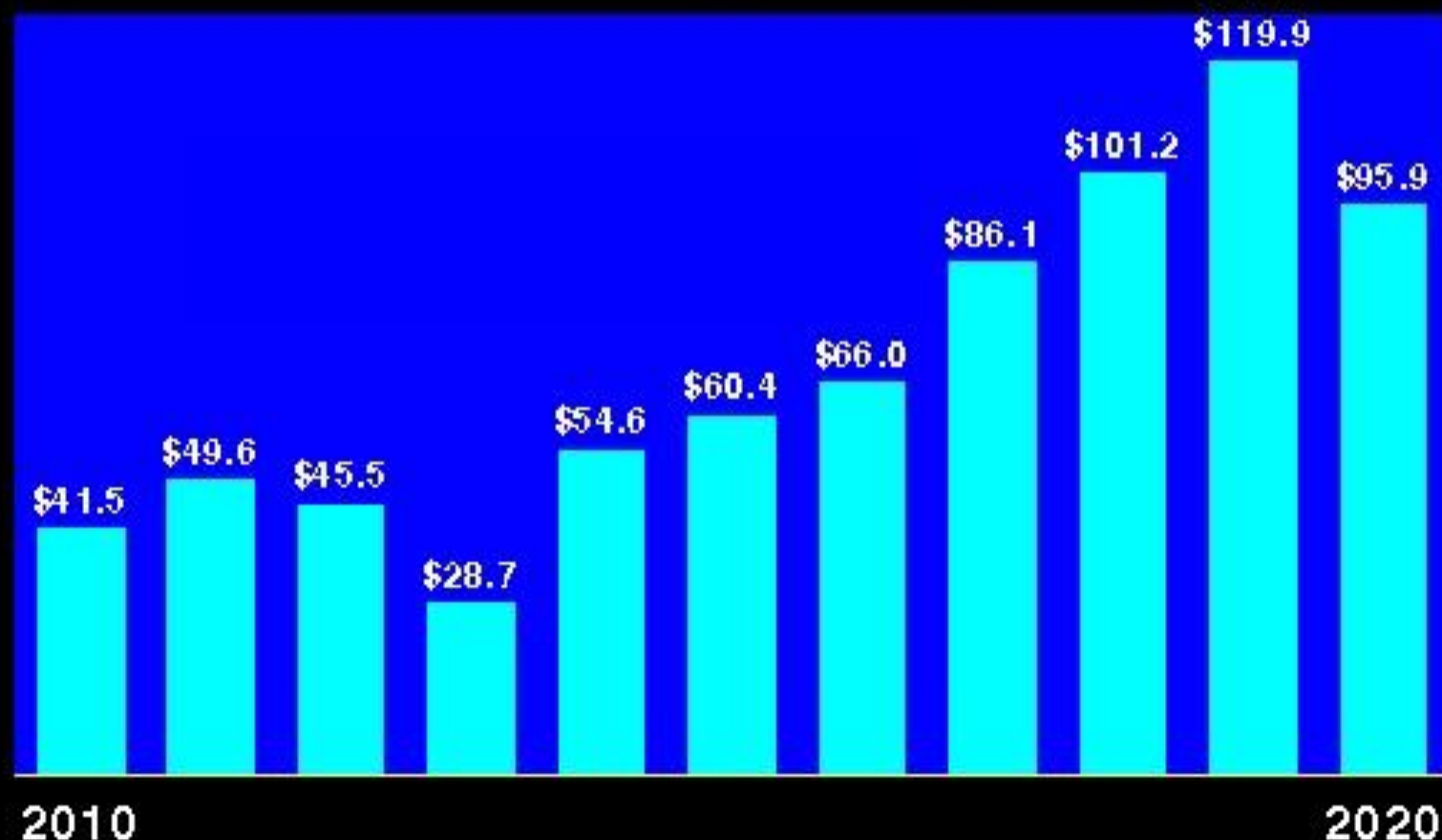
Mean LOS: for-profits = 112 days; non-profits = 71 days

# Private Equity Health Care Takeovers

## \$749 Billion, 2010-2020

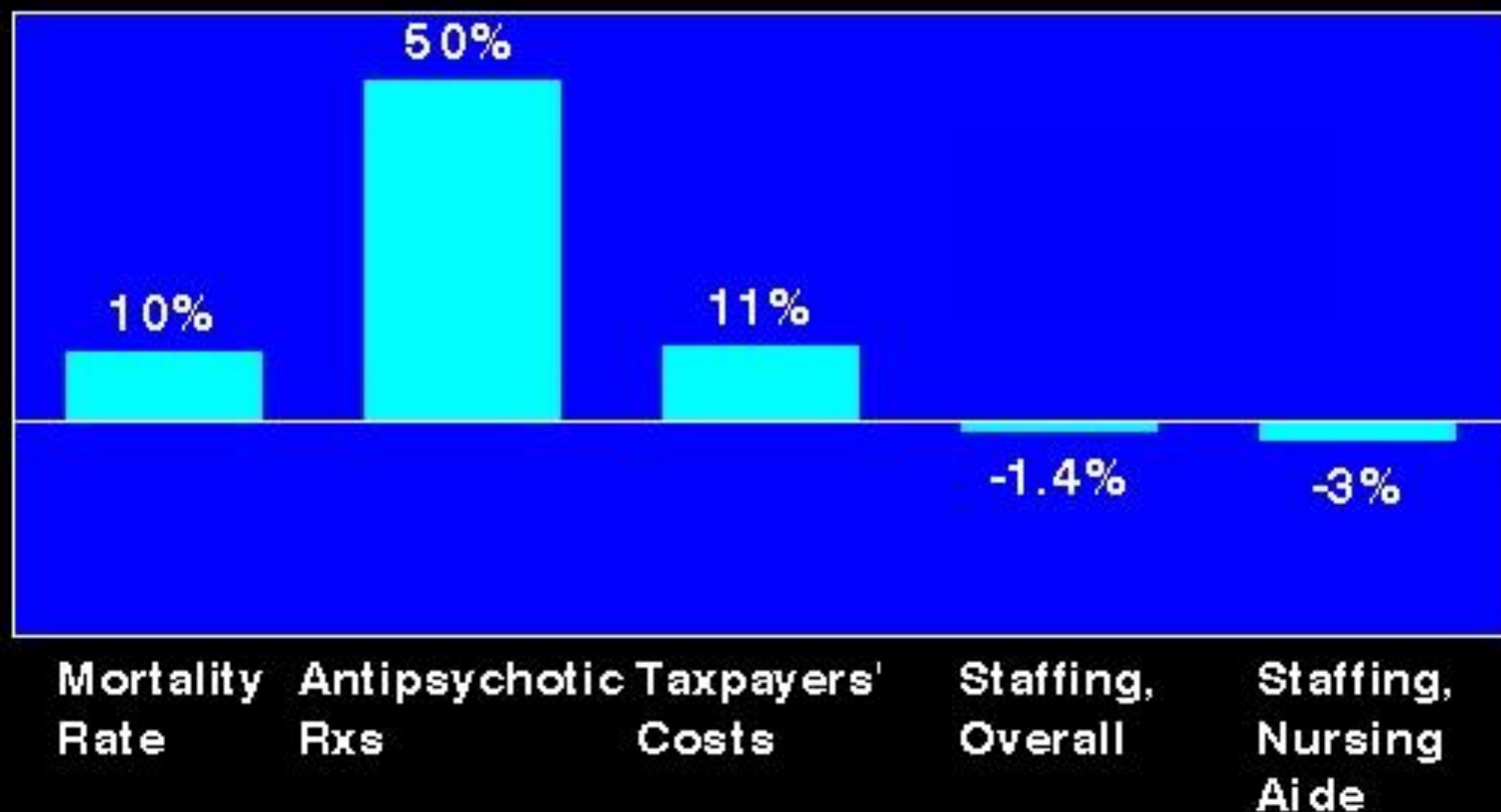
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Estimated value of deals (\$ billions)



# Private Equity Nursing Home Takeovers Harm Patients, Raise Costs

% change with private equity acquisition

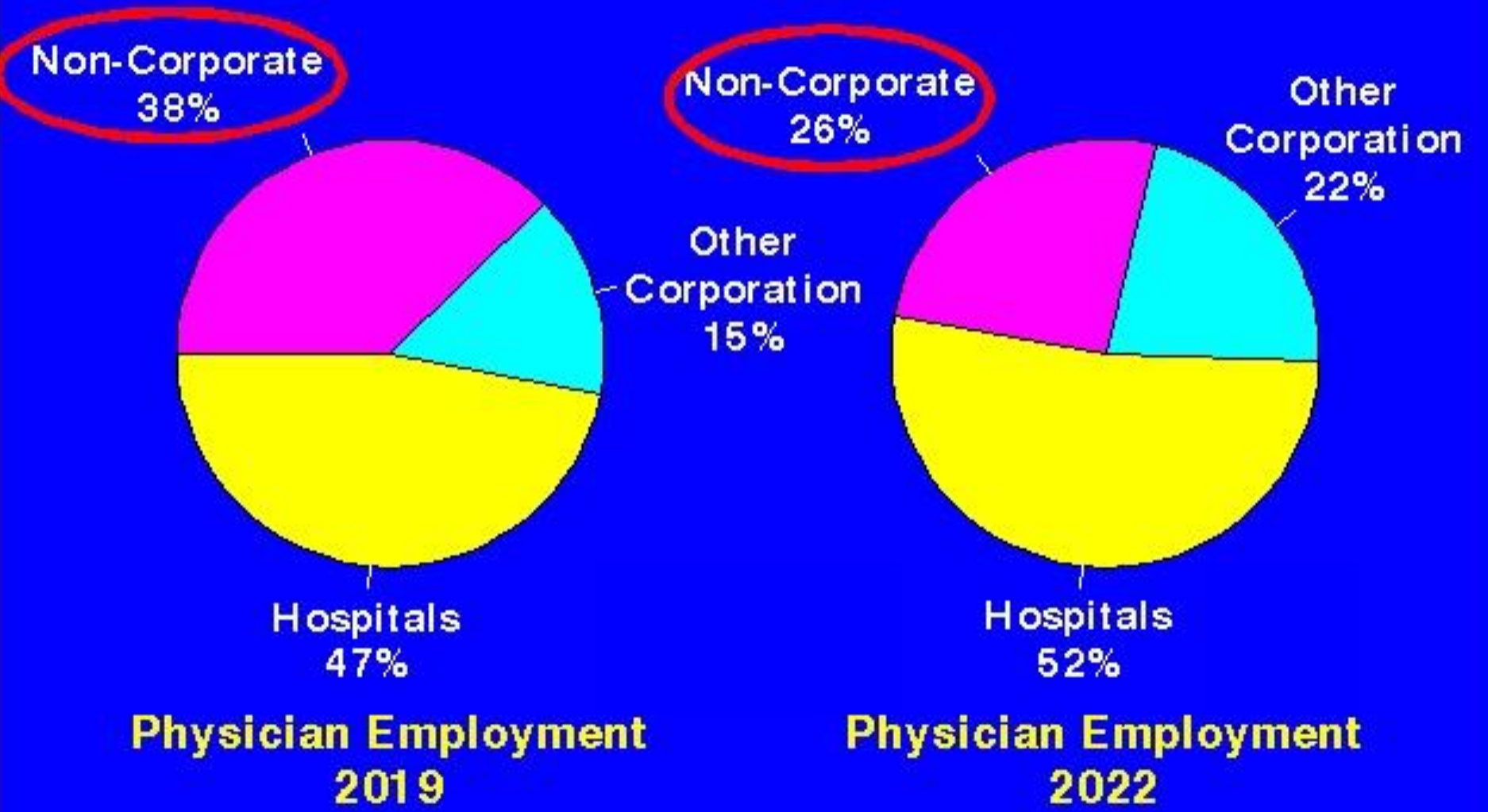


Source: "Does Private Equity Investment in Healthcare Benefit Patients" NBER #28474, February, 2021

Note: Study used a within-facility DiD analysis + instrumental variable control for pt. factors

# Most Physicians Are Corporate Employees

## Rapid Growth During Pandemic



Source: Avalere Health April, 2022  
Note: Data are for Medicare-participating physicians

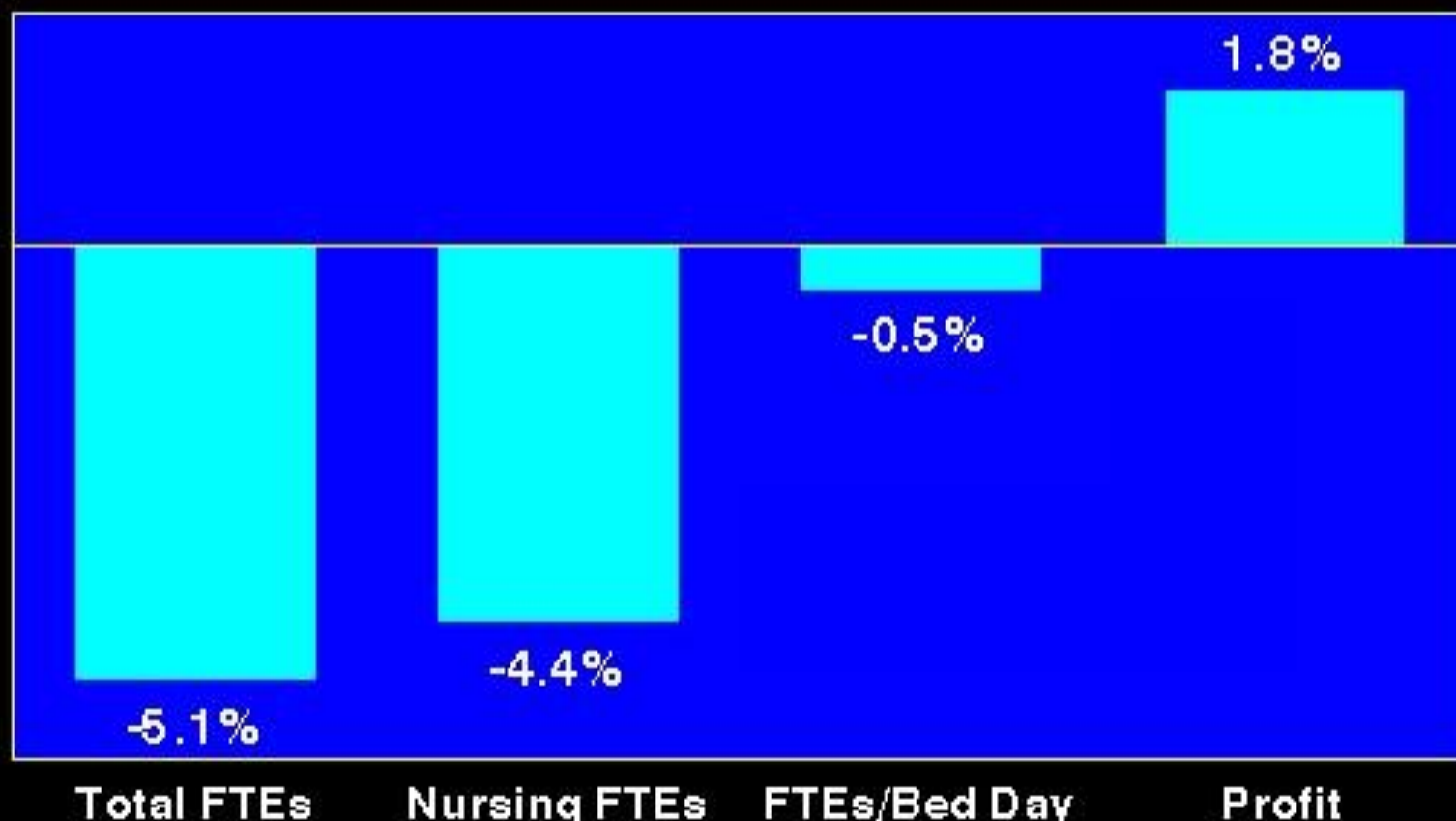


# What Happens When PE Buys a Dermatology Practice?

- Push sales of cosmeceuticals.
- Offer bonuses for increasing elective procedures (and continued elective procedures throughout pandemic).
- Pushed MDs to increase (e.g. double) visit #s.
- Mobile clinicians do frequent skin check and biopsies on demented nursing homes patients.
- Bring dermatopathology services “in house”, increasing biopsy rates and likely false positive melanoma Dx's.
- Extensive use of poorly-supervised PAs and NPs for skin checks and procedures.
- Skimp on supplies.
- Increase Medicare billings/taxpayer costs.

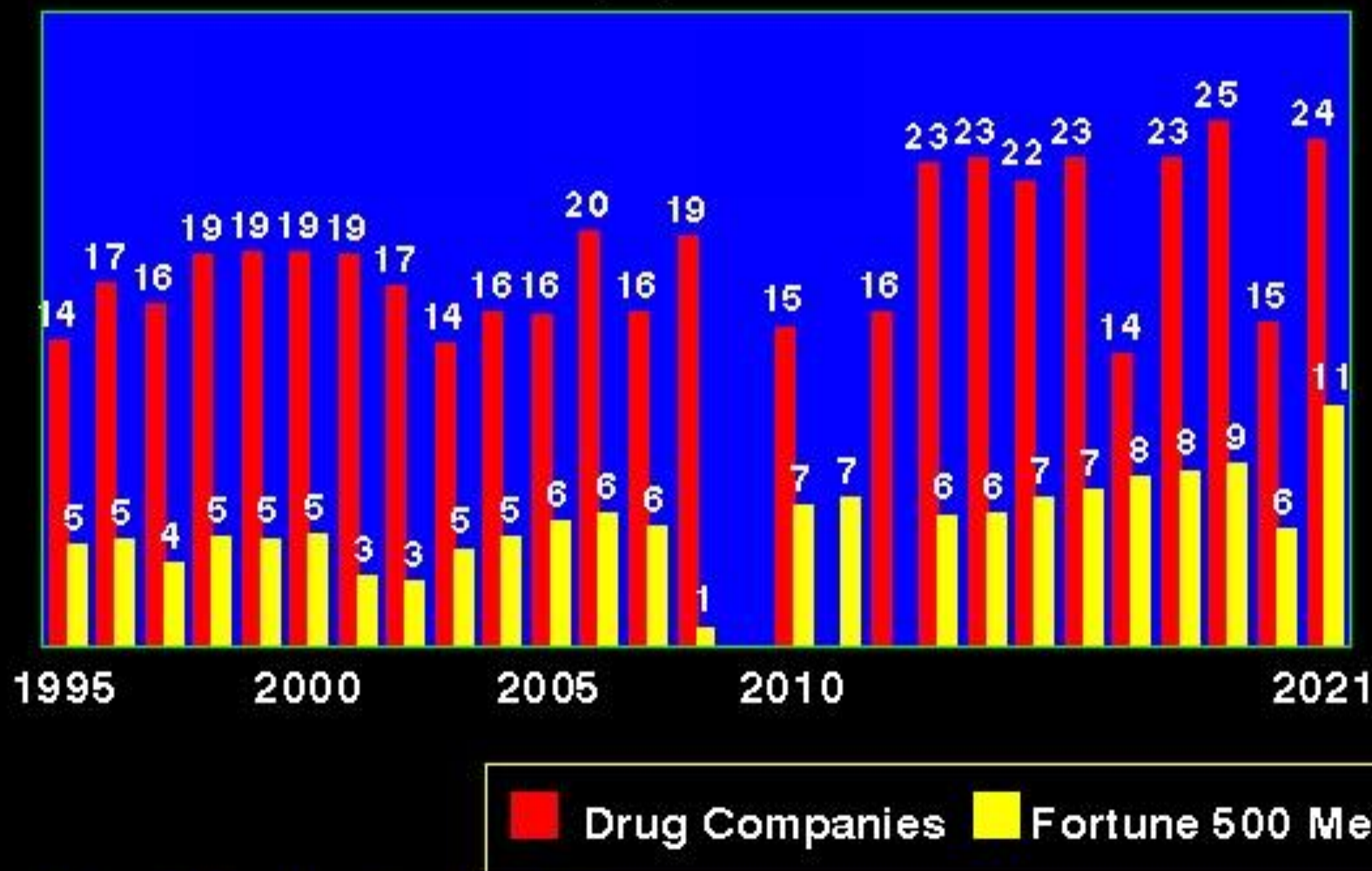
# Private Equity Hospital Takeovers: Falling Care, Rising Profits

Percent change after PE acquisition, compared to controls



# Drug Company Profits, 1995-2021

## Return on Revenues (%)



Source: Fortune 500 rankings for 1995-2022

# COVID-19 Vaccine Makers Jack Up the Price

\$s per vaccine dose

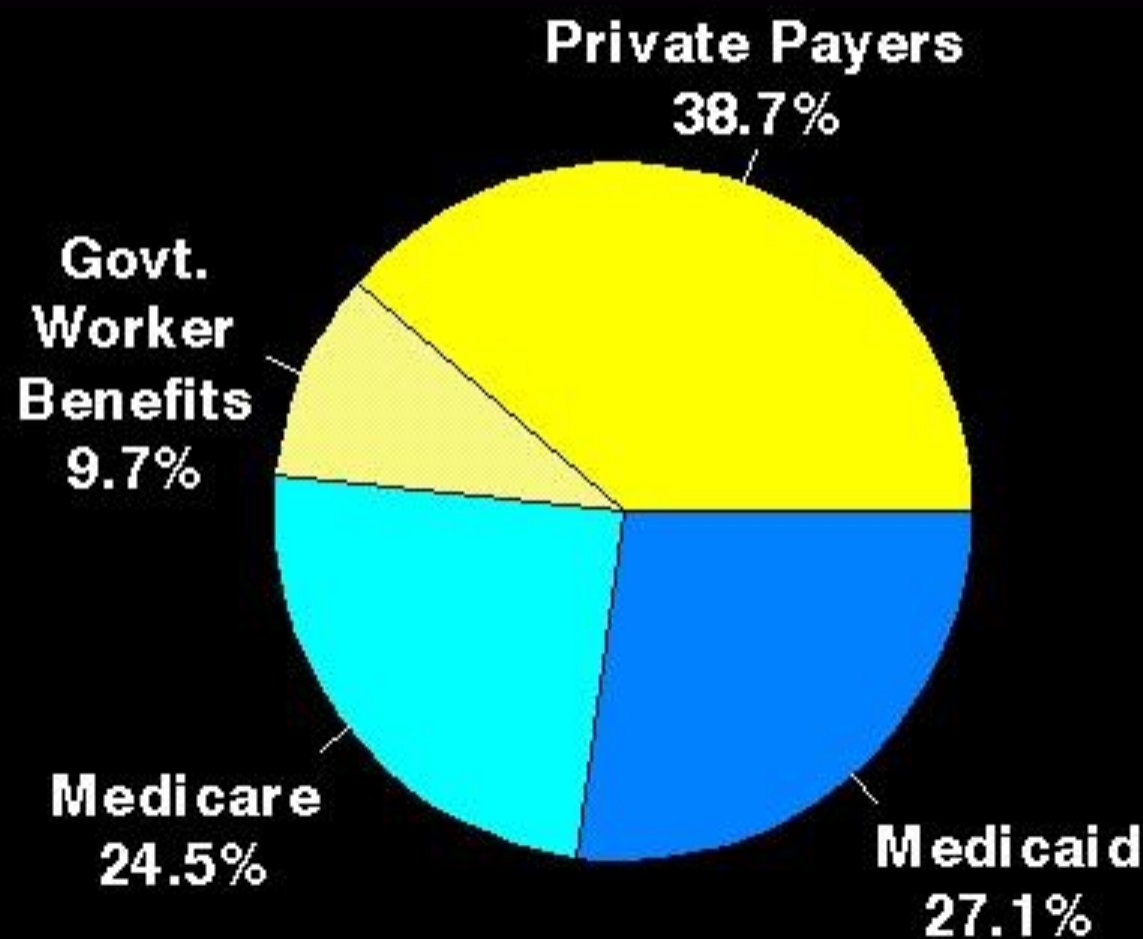


Source: Light & Lexchin. J Royal Soc Med 2021;114:502

\*Cost figure includes estimated cost of materials + capital + personnel

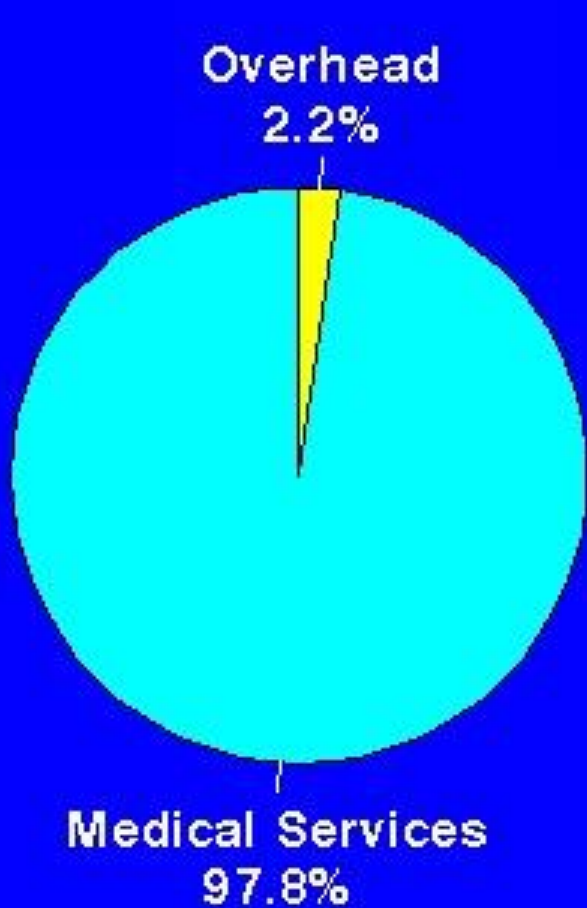
**Private Insurers:  
Middlemen Who Add  
Costs But Not Value**

# 61% of Private Insurers' Revenues Come From Government Payers

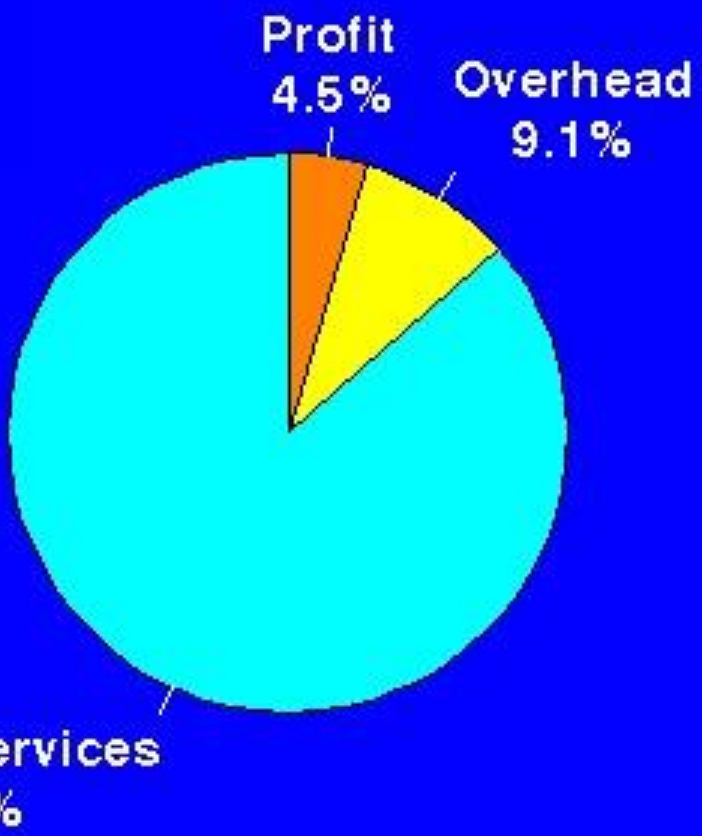


**Medicare Advantage:  
Privatizing Medicare,  
Raising Taxpayers' Costs  
and a Public Option  
Preview**

# Medicare Advantage Plans' High Overhead



**Traditional Medicare**

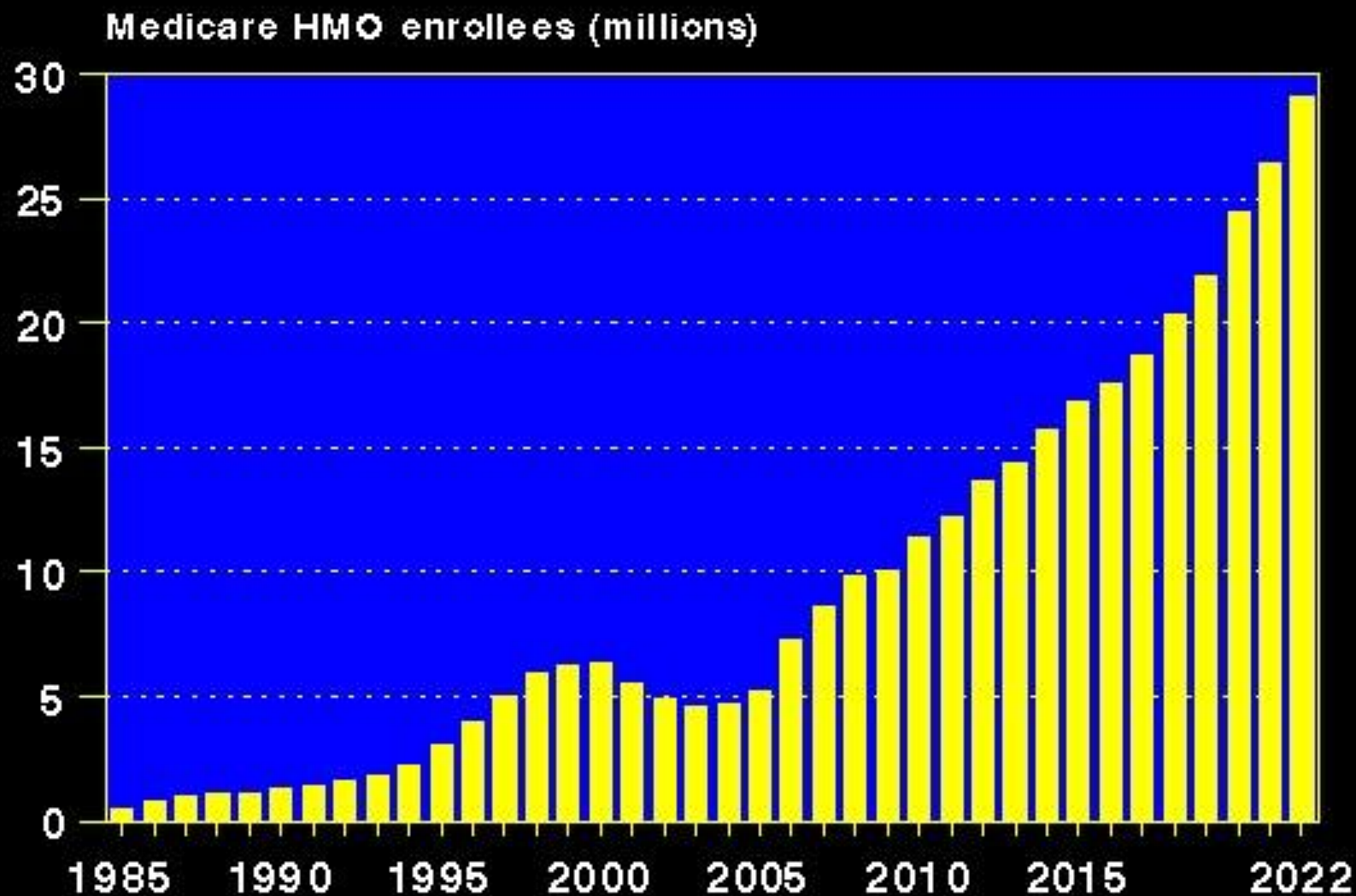


**Medicare Advantage Plans**

Source: GAO 12/2013 and Medicare Trustees report 2012 - Figures are for 2011  
Note: MA overhead = \$905/enrollee; profit = \$447/enrollee; total profit = \$3.3 billion



# Medicare HMO Enrollment, 1985-2022

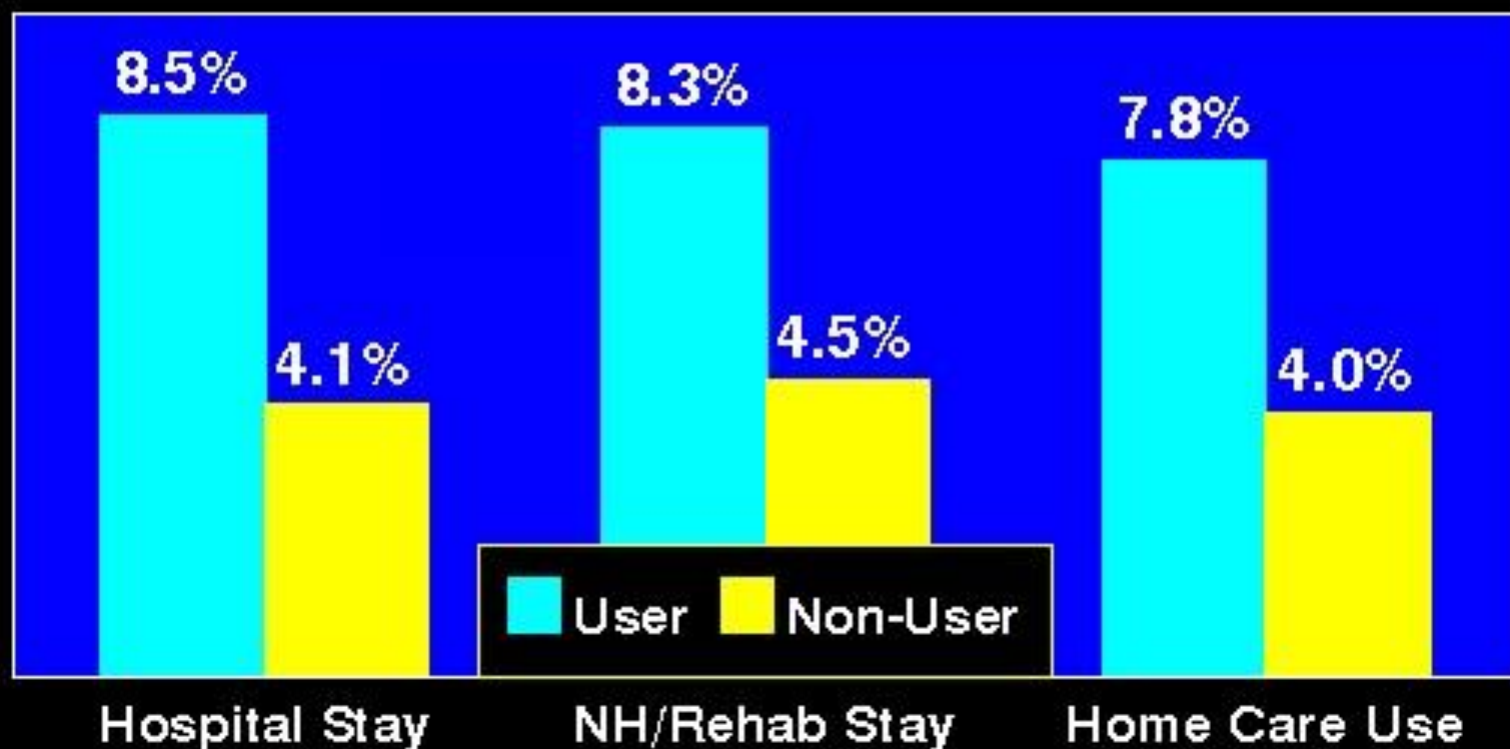


# How do Medicare Advantage Plans With High Overhead Outcompete Traditional Medicare?

- **Cherry-picking + Lemon-dropping**
  - Exclude hospitals/doctors attractive to high-cost patients
  - Benefit/formulary design
  - Hassle factor
- **Upcode + over-diagnose** to game risk adjustment
- **Outright cheating**

# MA Plans Eject Patients Using Expensive Care

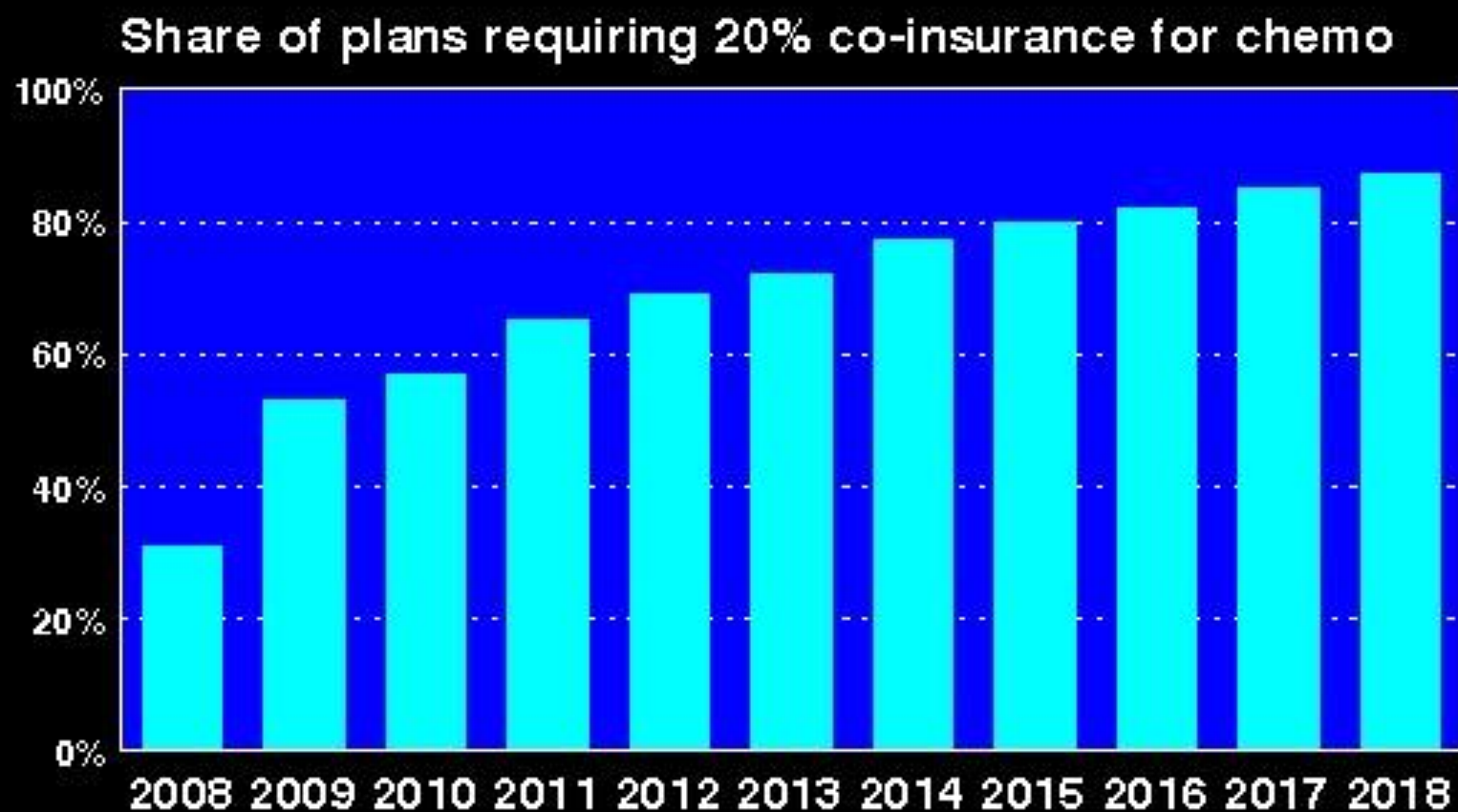
% switching from MA to Traditional Medicare



Source: Health Affairs 2021;40:469

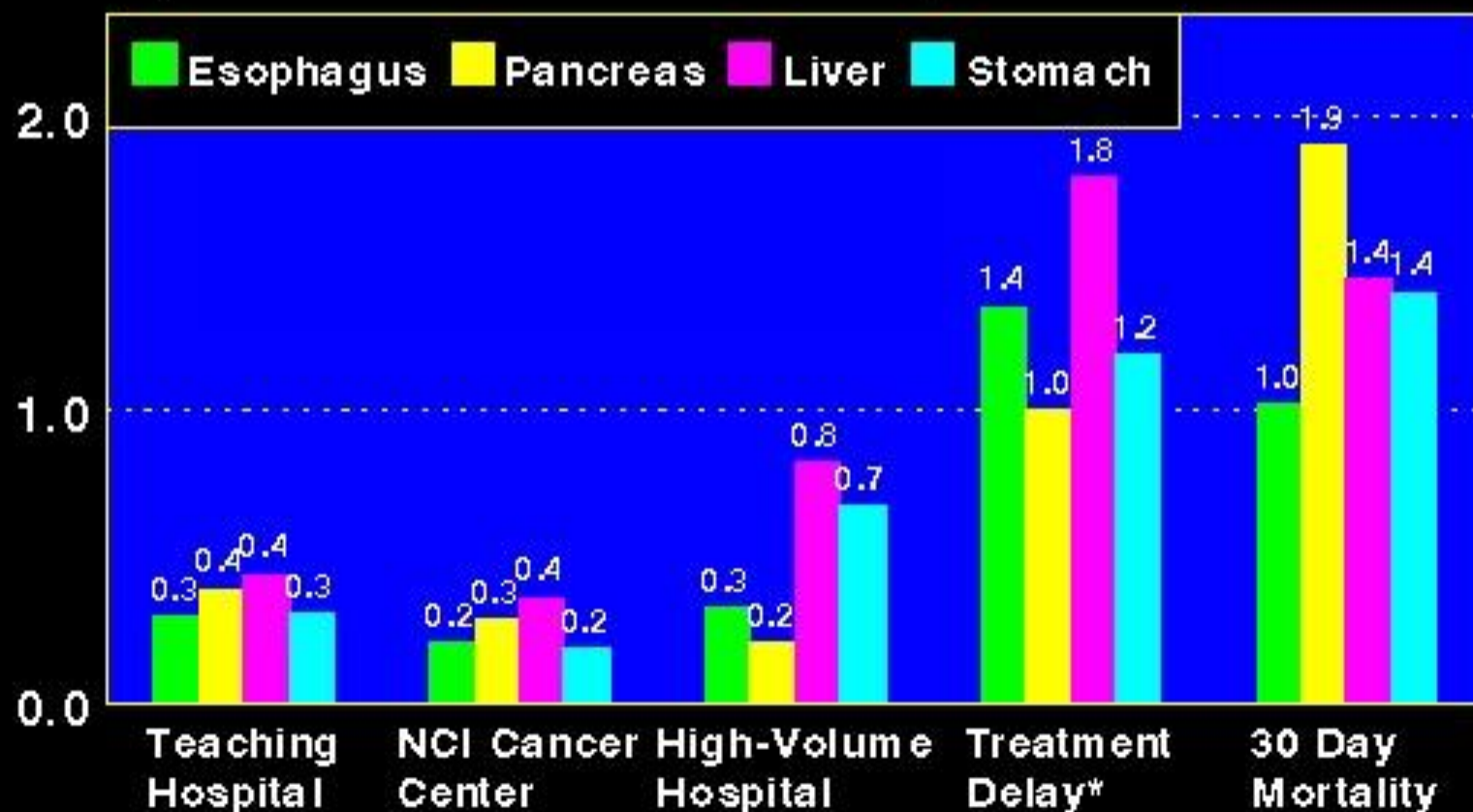
Note: Data shown are for non-rural enrollees. Differences were similar for rural enrollees

# Medicare Advantage Plans Push Cancer Patients Out by Imposing 20% Co-Insurance for Chemotherapy



# Medicare Advantage Cancer Patients: Inferior Surgical Care

Adjusted risk ratio - Medicare Advantage:traditional Medicare



Source: J Clin Oncol - Published online 11/2/2022

\* >2 weeks between Dx and Rx

Dr. Smith sees Ms. Jones, a 76 year-old Medicare beneficiary as a FFS patient and simply submits the one or two diagnoses treated during any visit.

Dr. Smith diagnoses sent to CMS	HCC Risk Score
Demographic Score	.448
Obesity	0
Type 2 diabetes, exudative retinopathy	.104
Major depress disorder, 1 episode, unspec	0
CHF	.323
Asthma	0
Pressure ulcer of right heel, unspecified	0
<b>HCC Score: 1.029</b>	
<b>FFS Expected Cost: \$9,000</b>	

Ms. Jones joins an MA Plan which sends a nurse to her home, reviews her charts, suggests Dr. Smith record other diagnoses: Cost to CMS increases 350%

Dr. Smith's Coding	HCC Risk Score
Demographic Score	.448
Obesity	0
Type 2 diabetes, exudative retinopathy	.104
Major depress disorder, 1 episode, unspec	0
CHF	.323
Asthma	0
Pressure ulcer of right heel, unspecified	0
<b>HCC Score: 1.029</b>	
<b>Expected CMS Annual Cost: \$9,000</b>	

Medicare Advantage Coding	HCC Risk Score
Demographic Score	.448
Type 2 diabetes w/ diabetic retinopathy	.318
Major depress. disorder, 1 episode, mild	.395
CHF, class 3	.323
COPD	.328
Pressure ulcer of right heel, stage 3	1.204
CHF*DM; CHF*COPD	.154,.19
<b>RAF Score: 3.633</b>	
<b>MA Plan Annual Payment: \$32,000</b>	

## Medicare for All Is Not Enough

*Communities, not corporations, should own our most vital health care assets.*

*By David U. Himmelstein, Steffie Woolhandler, Adam Gaffney, Don McCanne and John Geyman*

MARCH 31, 2022



Hospital workers, union members, and local politicians protested the imminent closure of Hahnemann University Hospital at a rally in Philadelphia on July 15, 2019. (Bastiaan Slabbers / NurPhoto via Getty Images)



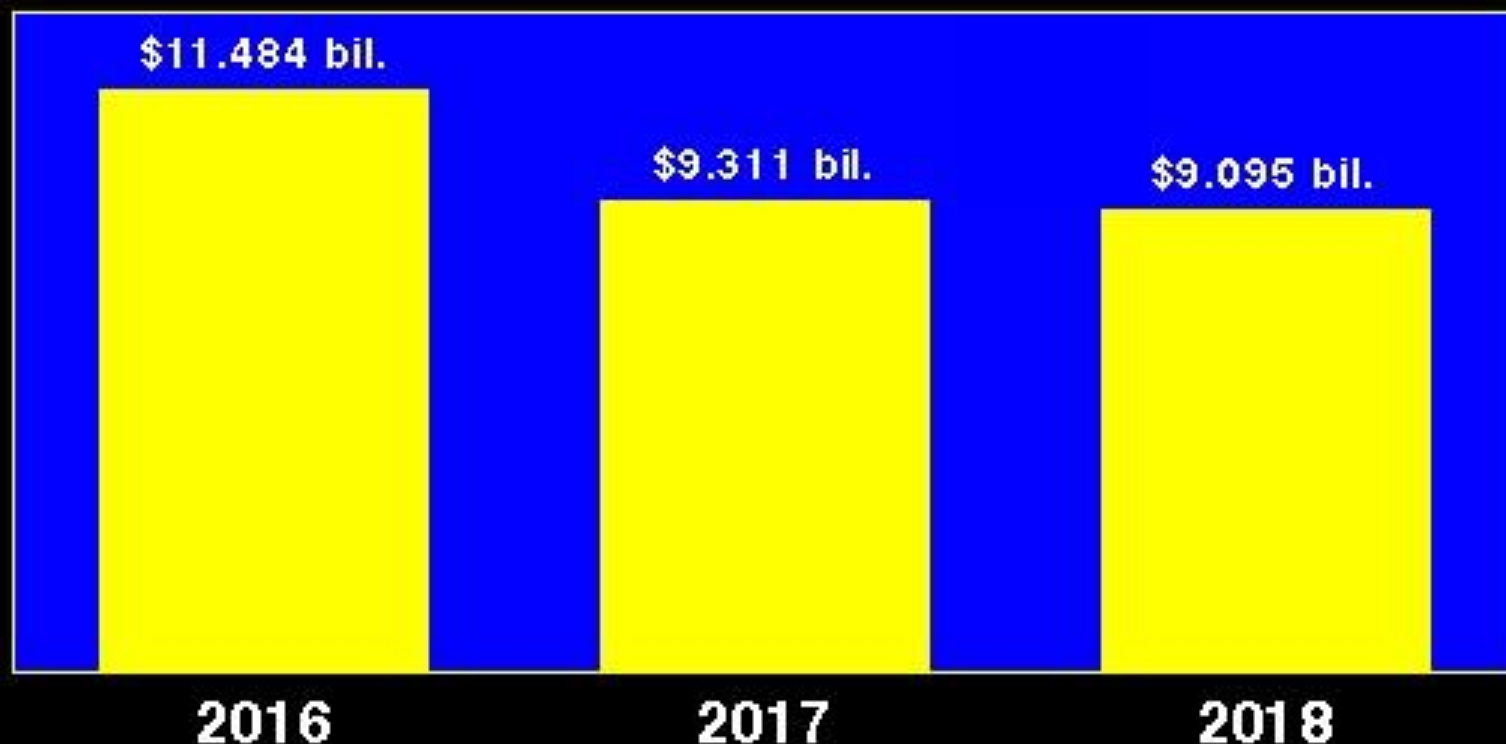


# Medicare Advantage Plans' Claims for Unsupported Diagnoses

CMS Chart Audit (But CMS Only Pursued Recovery for 0.2% of Projected Overcharges)

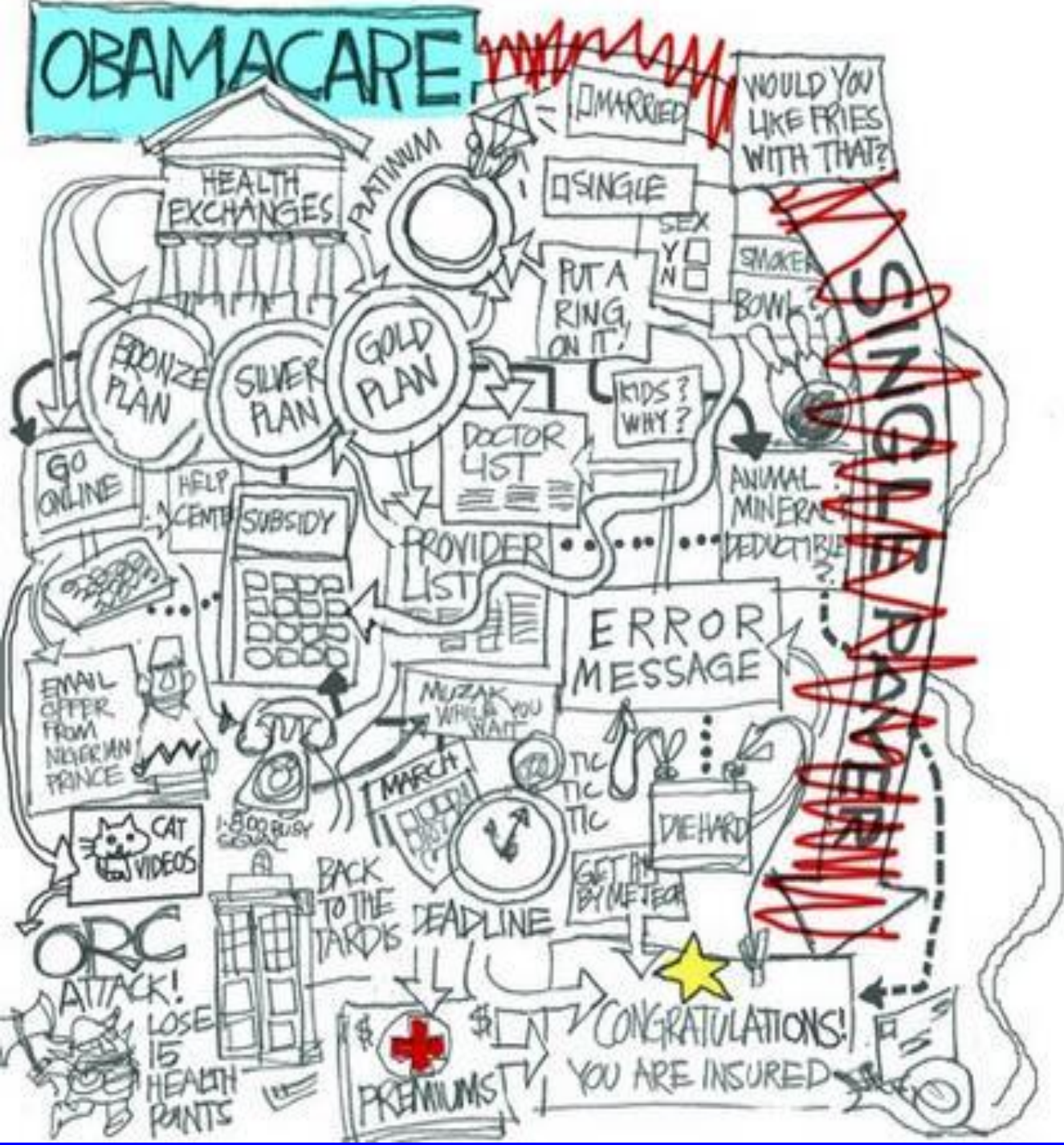
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CMS estimate of overcharges to Medicare for diagnoses not supported in chart



The ACA:  
A Complex and Expensive  
Way to Expand Coverage

# OBAMACARE



THE SIMPLE  
**GOP**  
 PLAN FOR THE  
 UNINSURED



# Medicare's "Software"

## 18.9 Million Seniors Enrolled Within 11 Months

488-40-6969-A

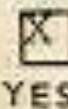
APPLICATION FOR ENROLLMENT  
in the

Supplementary Medical Insurance Program  
Under the Social Security Act

PLEASE READ THE ENCLOSED LEAFLET

Harry S Truman  
Independence, Missouri

TO GET MEDICAL INSURANCE



The Federal Government will pay half the cost of this insurance. Your share of the cost (\$3) will be deducted from your monthly social security benefits.

IF YOU DO NOT WANT  
THIS MEDICAL INSURANCE



SIGN  
HERE

  
Signature by mark (X) must be witnessed below.

SIGNATURE  
OF WITNESS

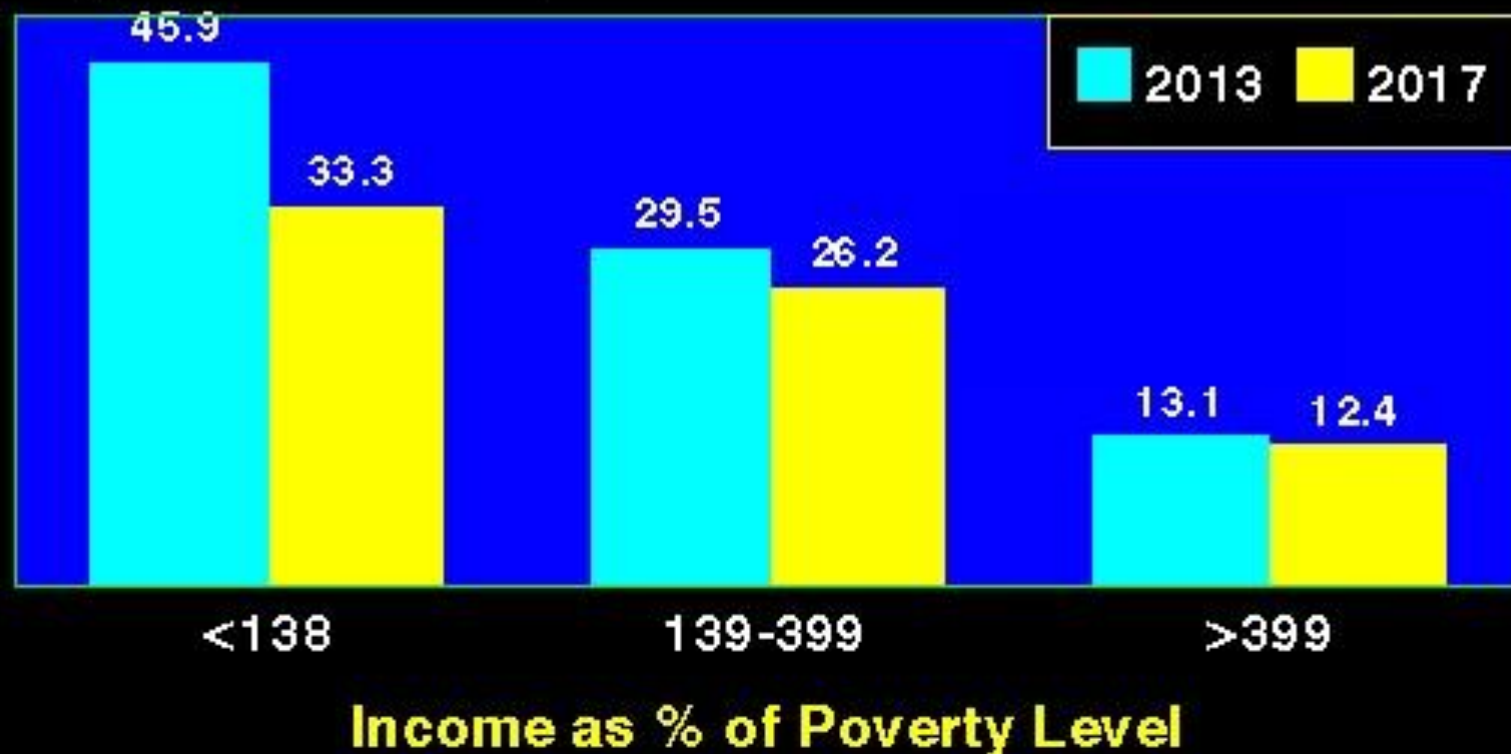
ADDRESS  
OF WITNESS

*Do not write in the space above*

# ACA Decreased Incidence of Unmet Medical Needs Due to Cost

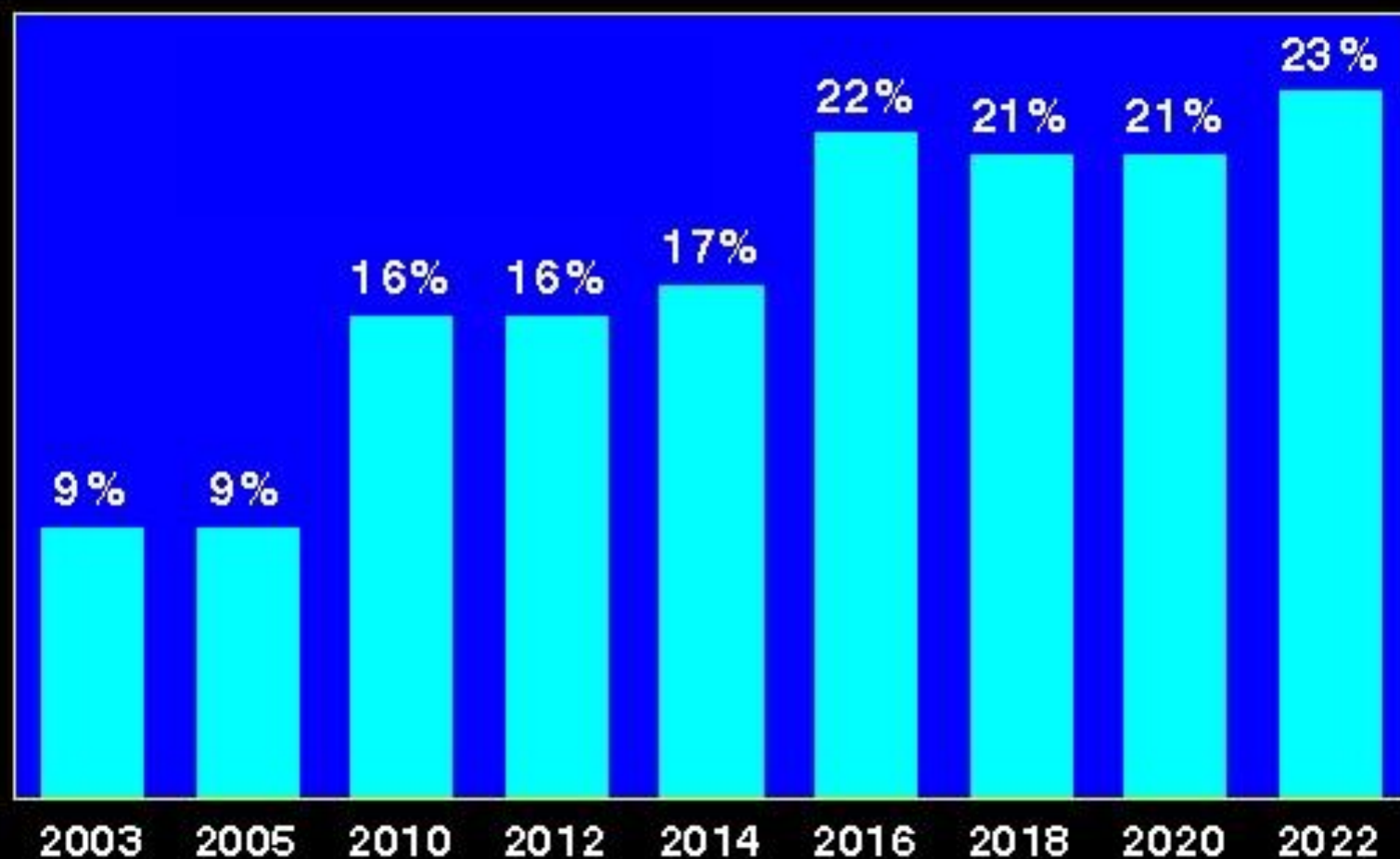
Better, But Still Not Good

% of adults 18-64 reporting an unmet need  
(past 12 months)



# Under-Insurance Increased After ACA

Percent of adults 19-64 under-insured\*



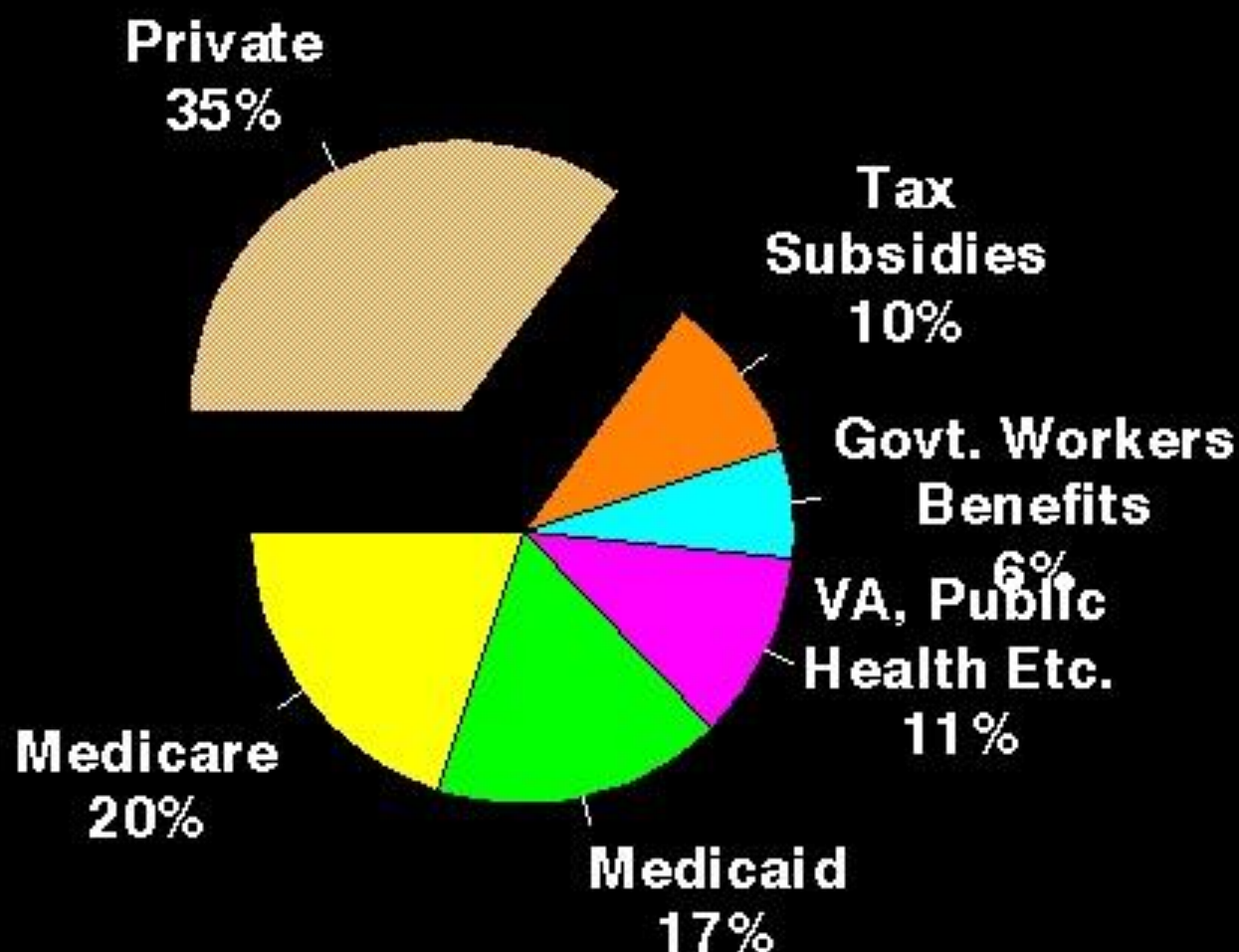
Source: Commonwealth Fund Health Insurance Surveys 2003-2022

\* Under-insurance: Insured all year but OOP > 10% of income (> 5% if low income) or deduct > 5% of income

American Taxpayers Already  
Pay More Than People in  
Nations With National Health  
Insurance

# Taxes Fund 2/3 of Health Spending

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**U.S. Health Care:  
Higher Costs, Worse  
Outcomes, Less Care**

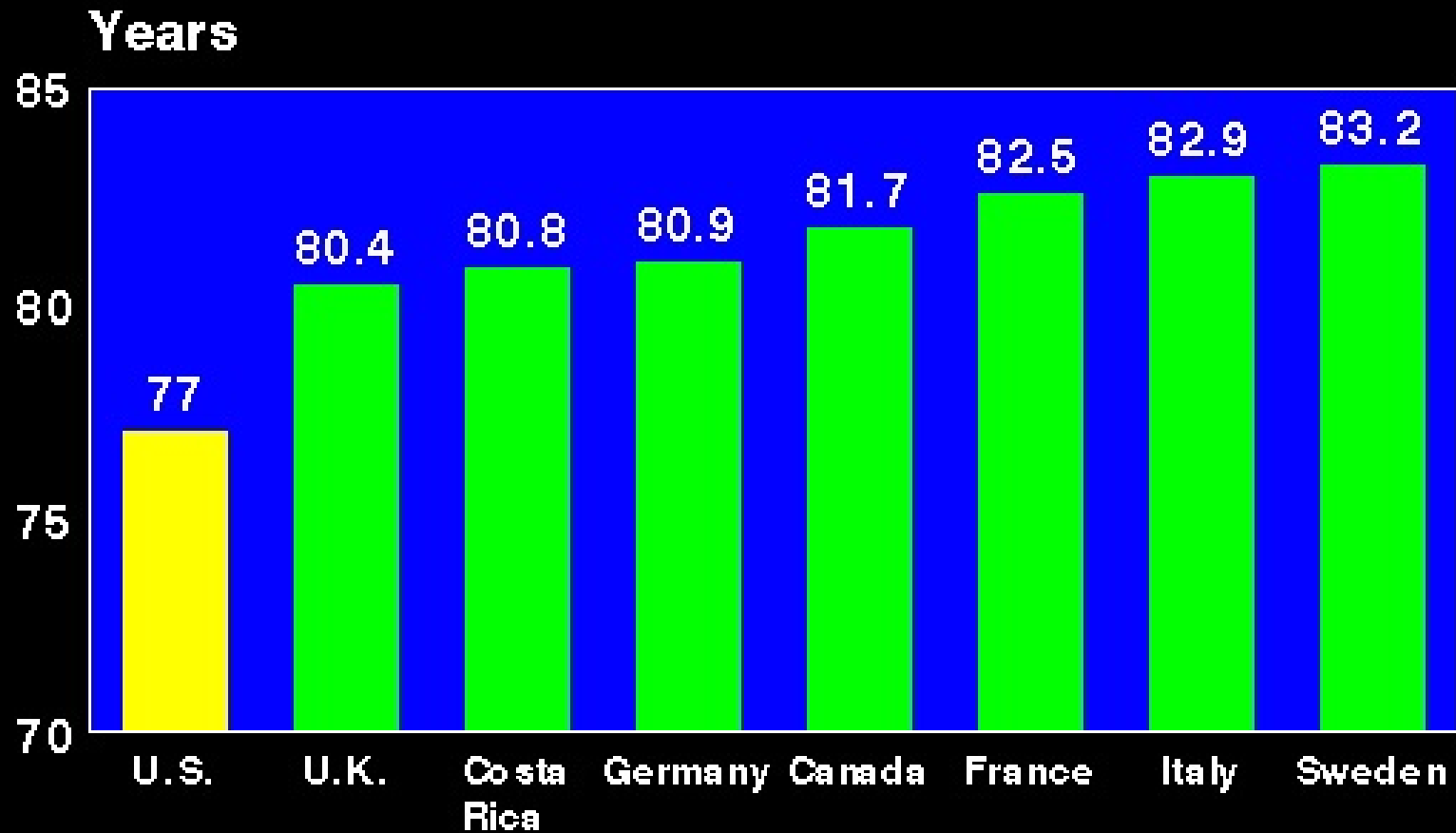
# U.S. PUBLIC Spending Per Capita for Health Exceeds TOTAL Spending in Other Nations



Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance

Source: OECD 2021; NCHS; AJPH 2016;106:449 (updated) - Data are for 2020

# Life Expectancy

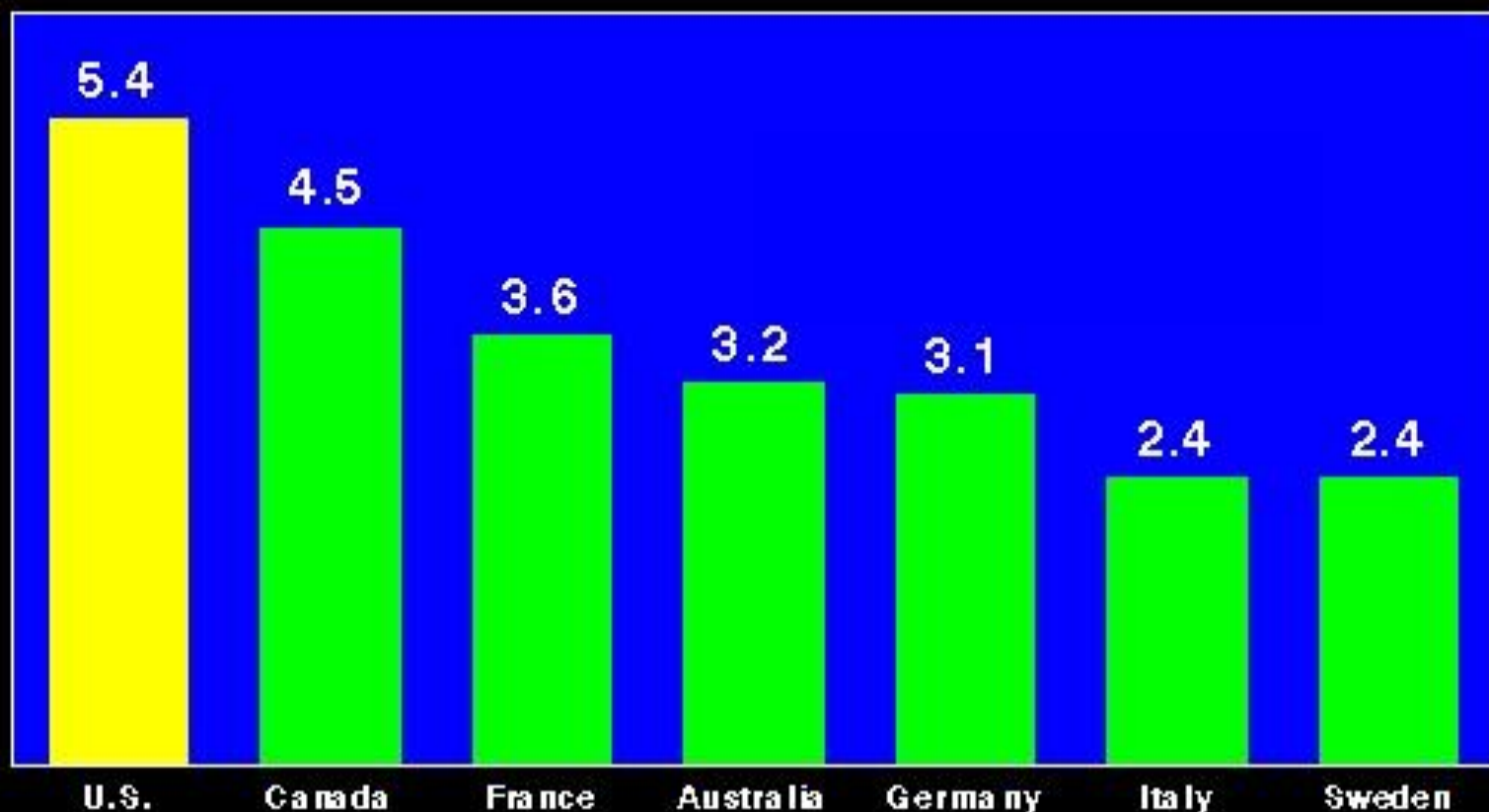


Source: OECD, 2022

Note: Data are for 2021

# Infant Mortality

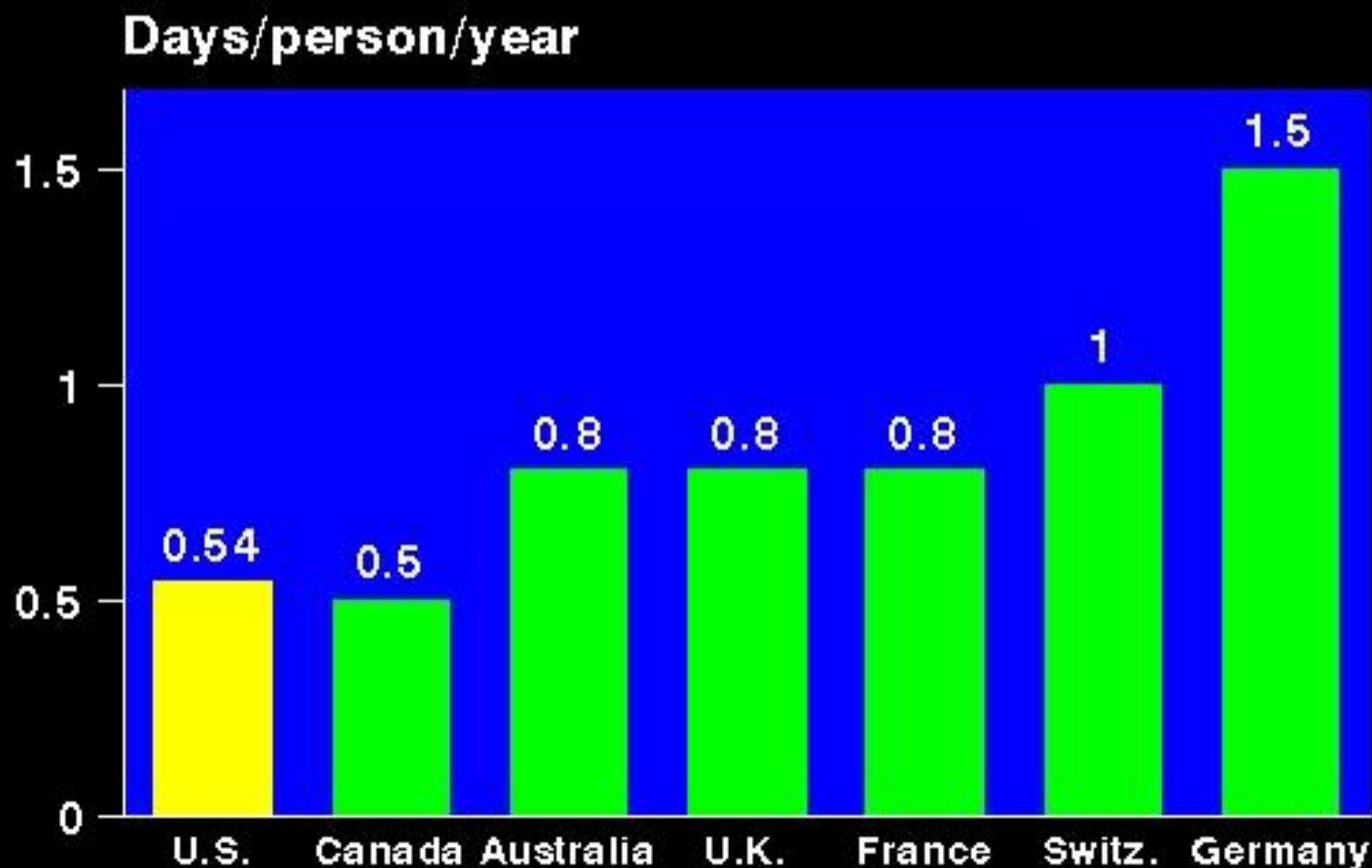
Deaths in First Year of Life/1000 Live Births



Source: OECD, 2022

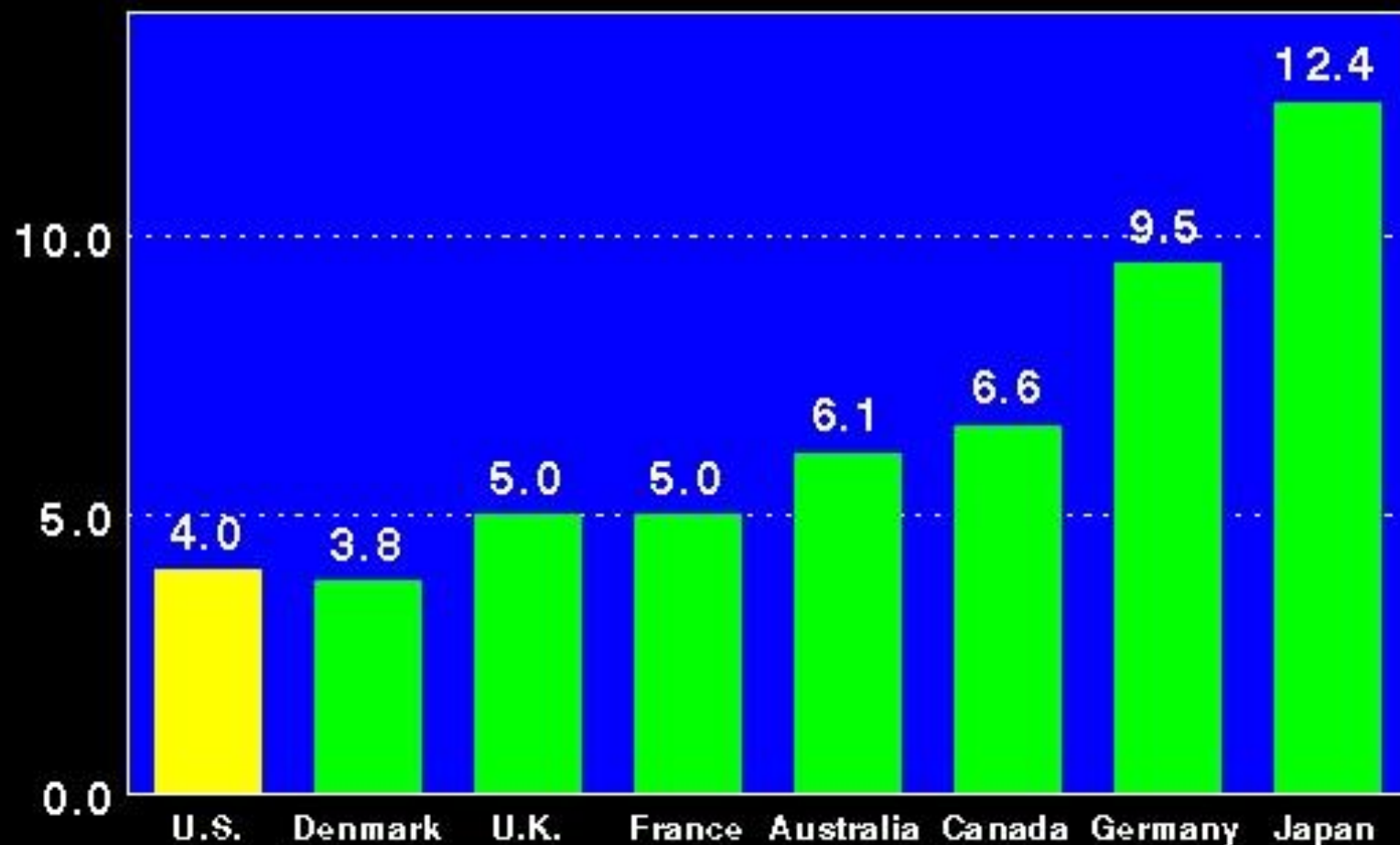
Note: Data are for 2021 or most recent year available

# Hospital Inpatient Days Per Capita



Source: OECD, 2022 & Kaiser Fdn. - Figures are for 2021 or most recent available

# Physician Visits Per Capita

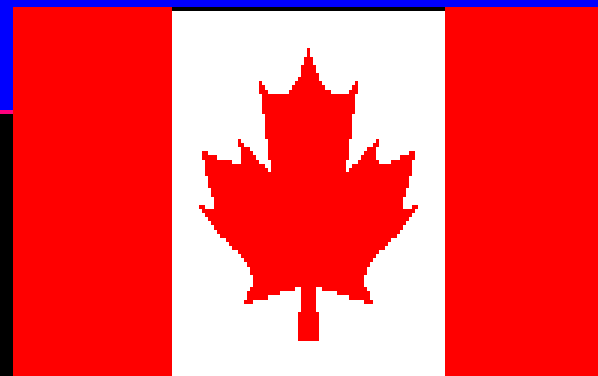
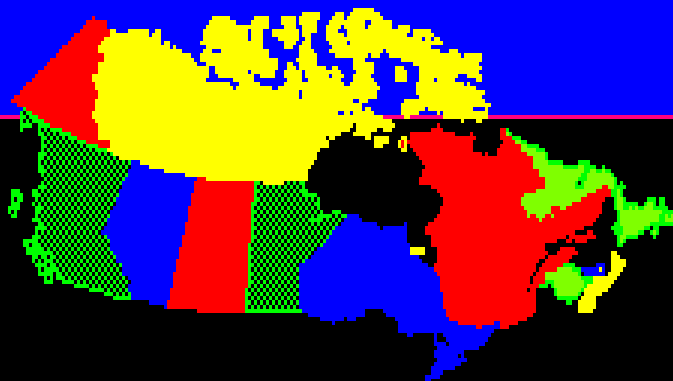


Source: OECD, 2022 - Data are for 2021 or most recent available year

Canada's Single Payer  
National Health  
Insurance Program

# MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

- 1. UNIVERSAL COVERAGE THAT DOES NOT IMPEDE, EITHER DIRECTLY OR INDIRECTLY, WHETHER BY CHARGES OR OTHERWISE, REASONABLE ACCESS.**
- 2. PORTABILITY OF BENEFITS FROM PROVINCE TO PROVINCE**
- 3. COVERAGE FOR ALL MEDICALLY NECESSARY SERVICES**
- 4. PUBLICLY ADMINISTERED, NON-PROFIT PROGRAM**

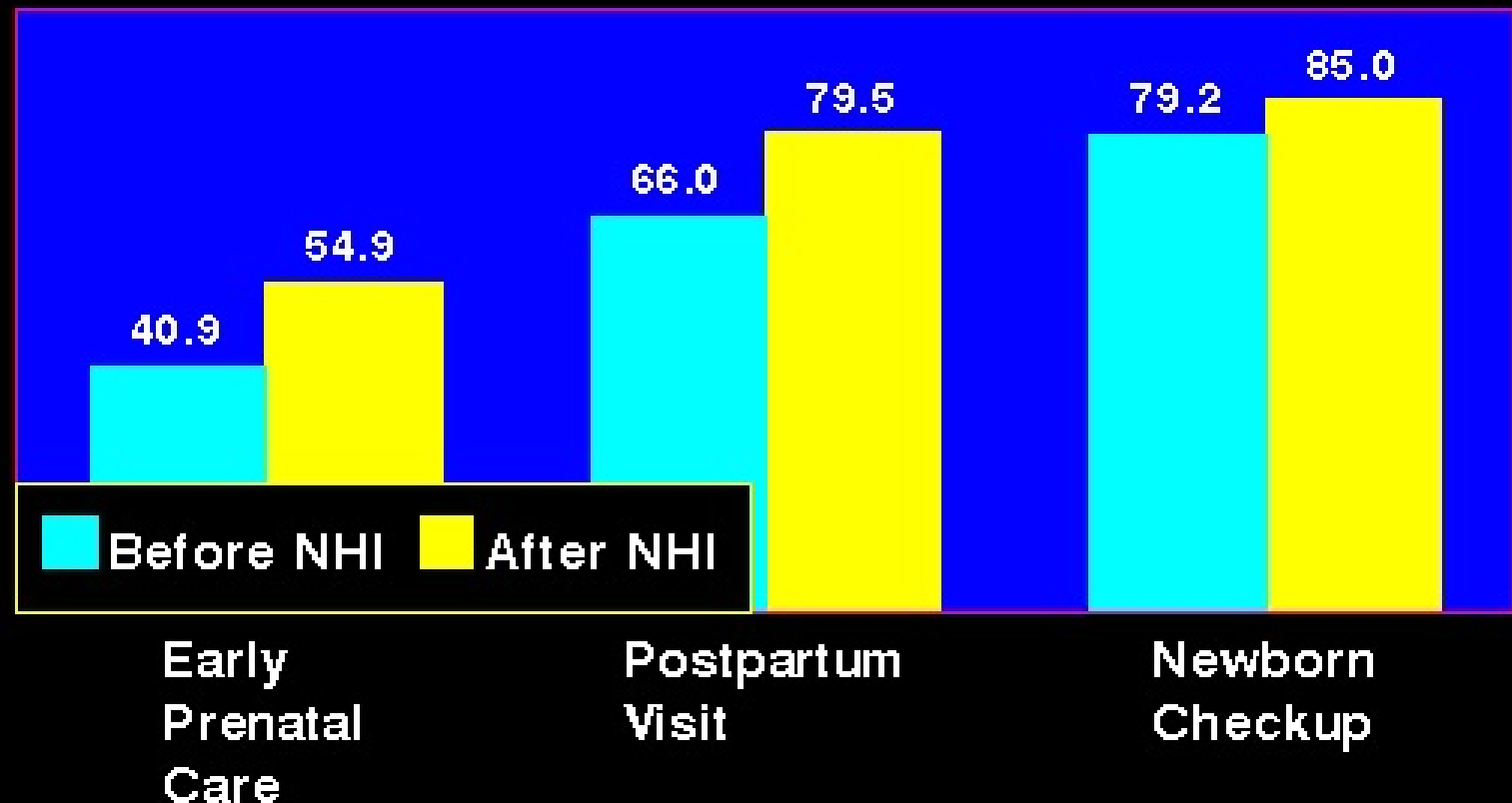




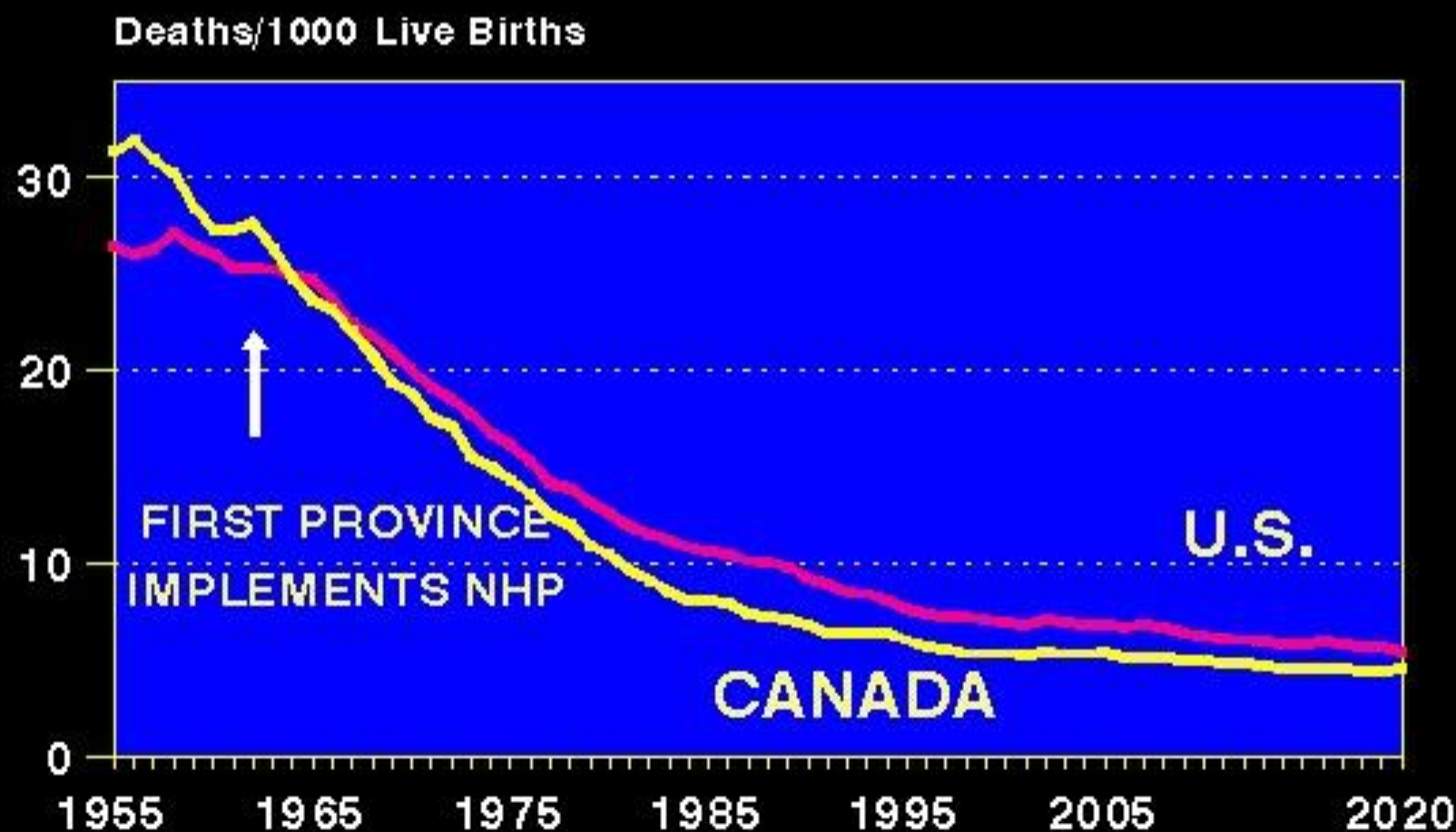
# Free Care in Quebec Improved Maternal/Infant Care

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Percent with visit



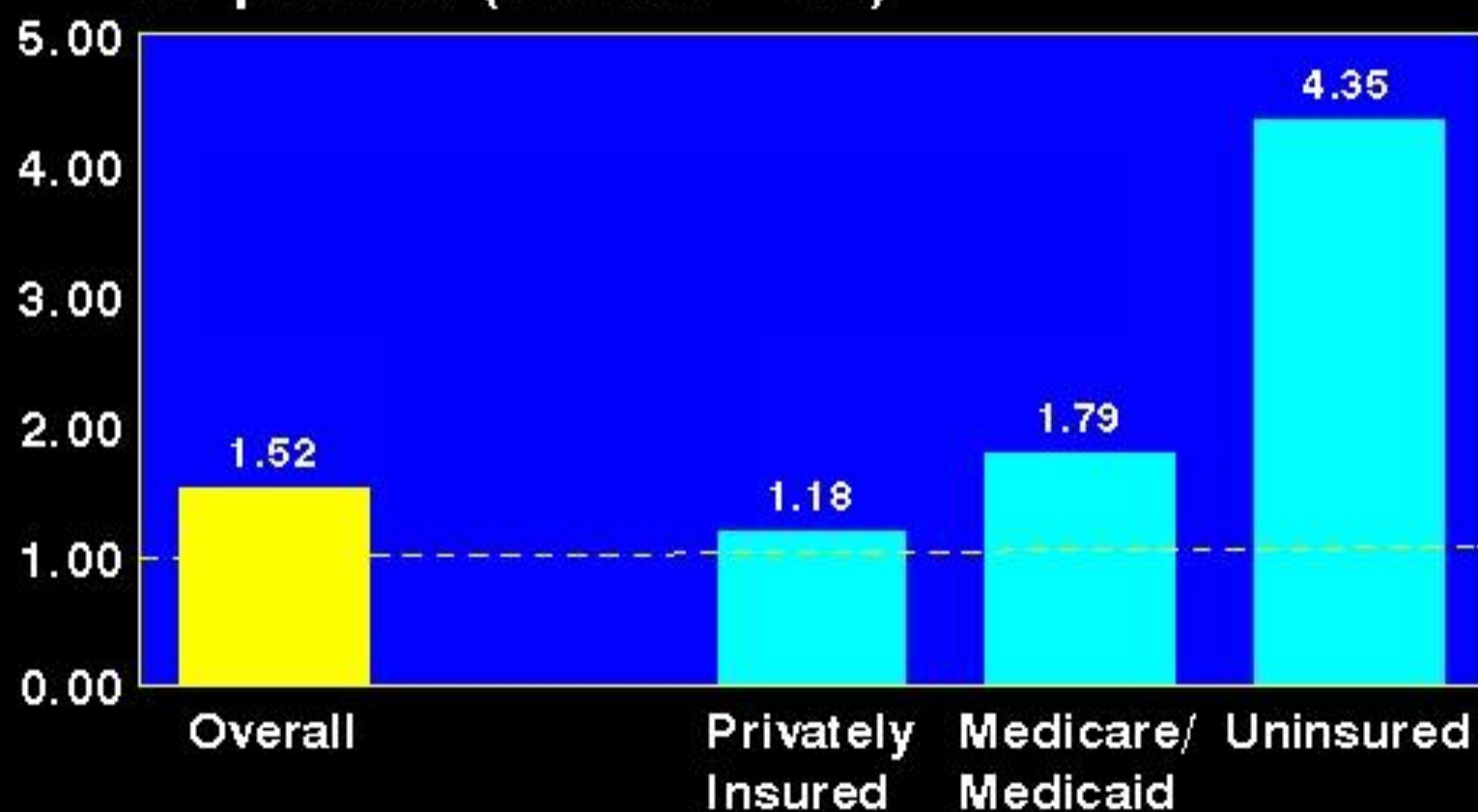
# Infant Mortality U.S. & Canada, 1955-2020



# Cystic Fibrosis Patients Live Longer in Canada

Uninsured in U.S. Have Highest Risk of Death

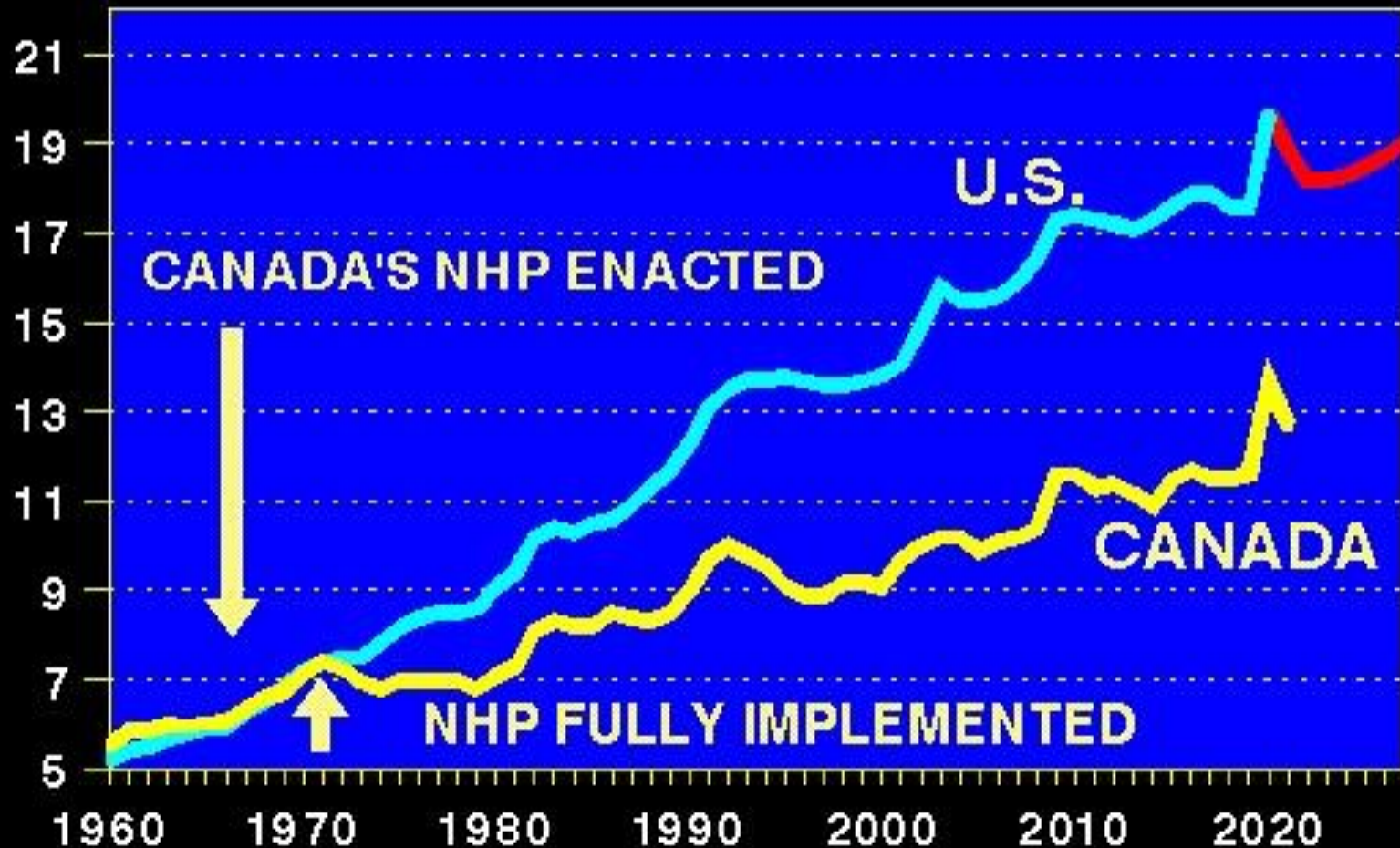
Hazard ratio for death, U.S. vs. Canadian  
CF patients (Canada = 1.0)



Source: *Ann Int Med* 2017;166:537

Note: Hazard ratios are adjusted for multiple genetic and clinical characteristics

# Health Costs as % of GDP: U.S. & Canada, 1960-2027

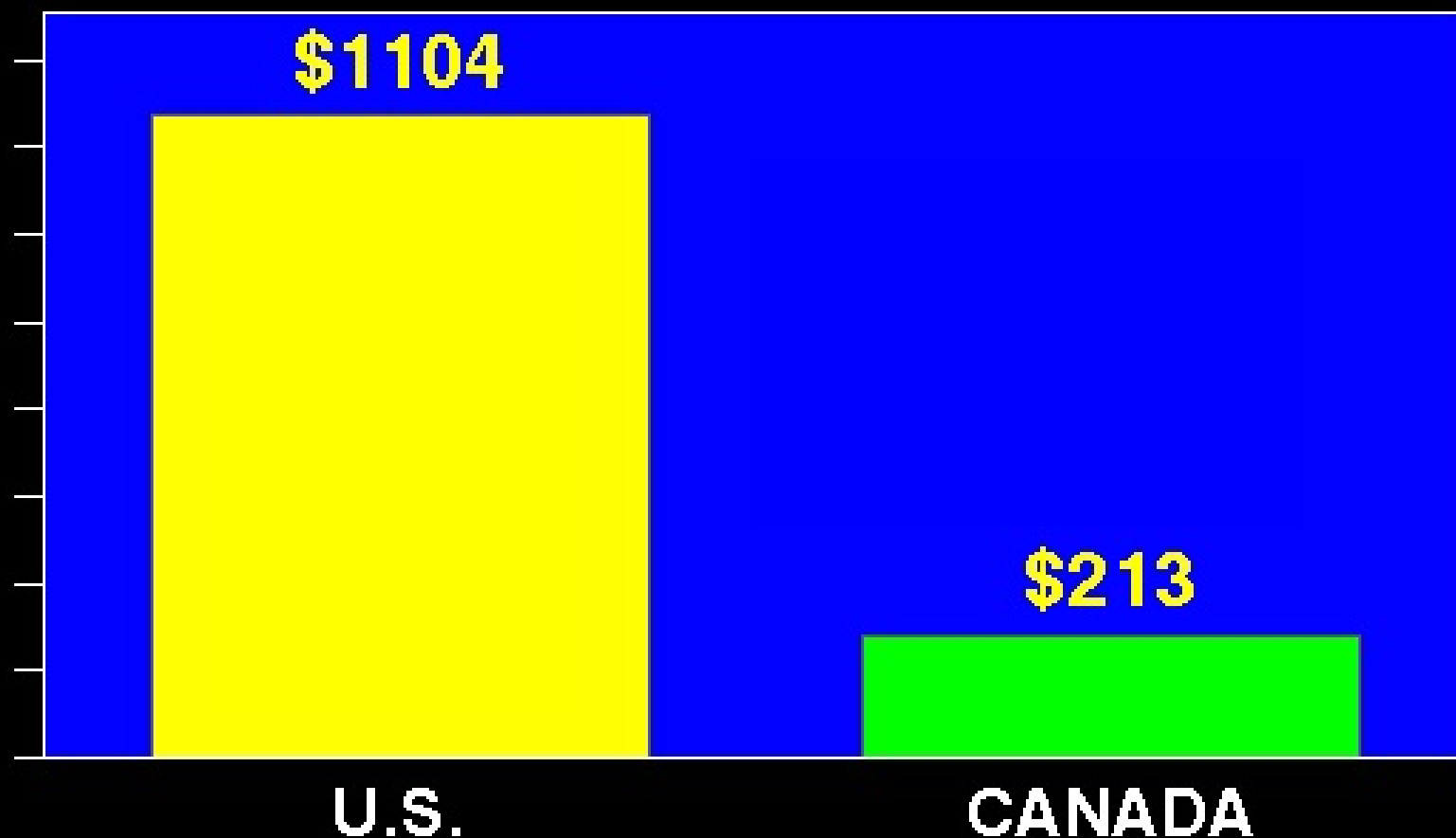


# How Canada Controls Costs

- Low administrative costs - 16.7% of health spending vs. 31.0% in U.S.
- Lump-sum, global budgets for hospitals
- Stringent controls on capital spending for new buildings and equipment
- Single buyer purchasing reins in drug/device prices
- Low litigation and malpractice costs
- Emphasis on primary care
- Exclusion of private insurers

# Insurance Overhead United States & Canada, 2022

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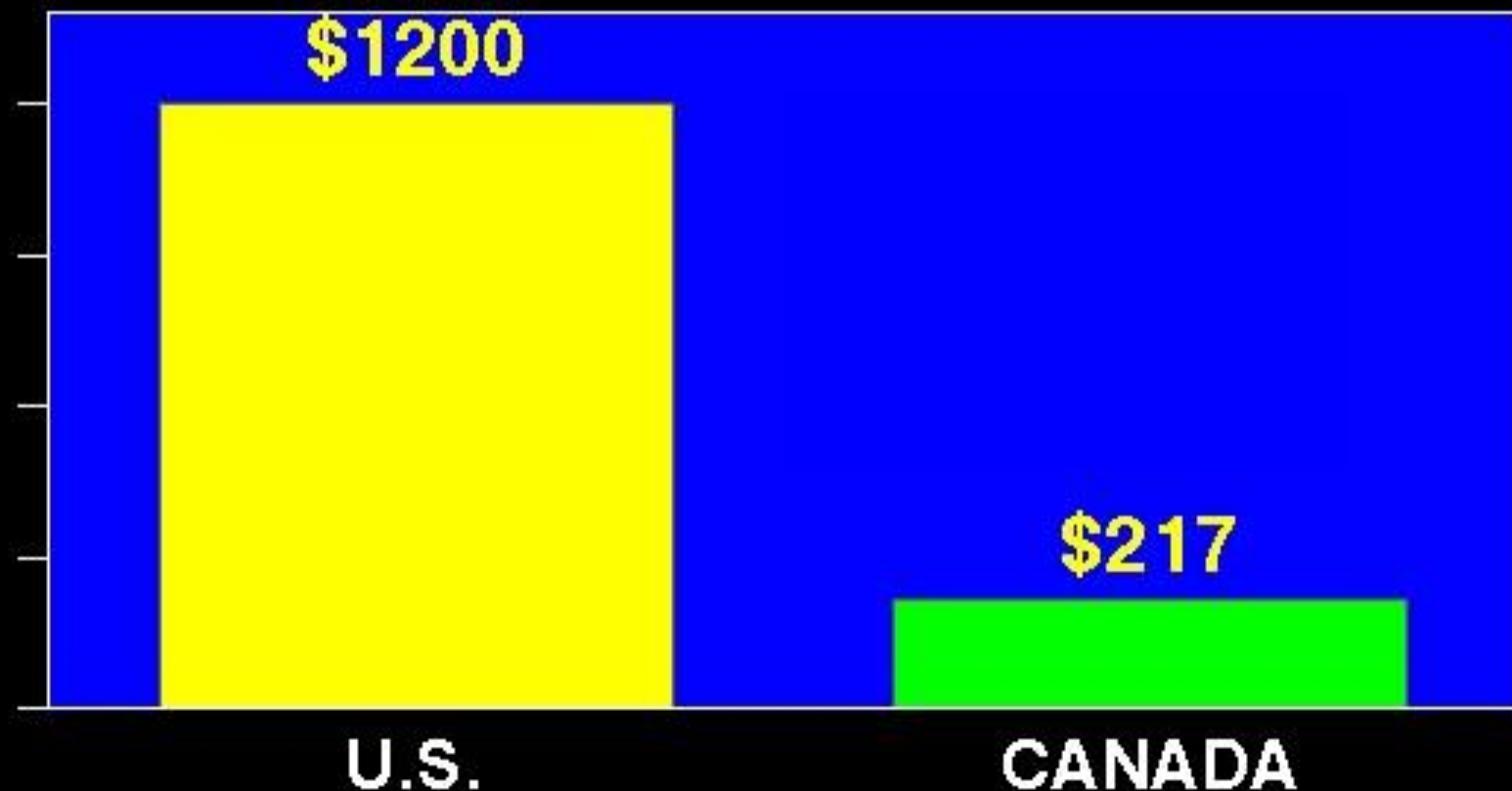


Source: NCHS and CIHI

# Hospital Billing & Administration United States & Canada, 2022

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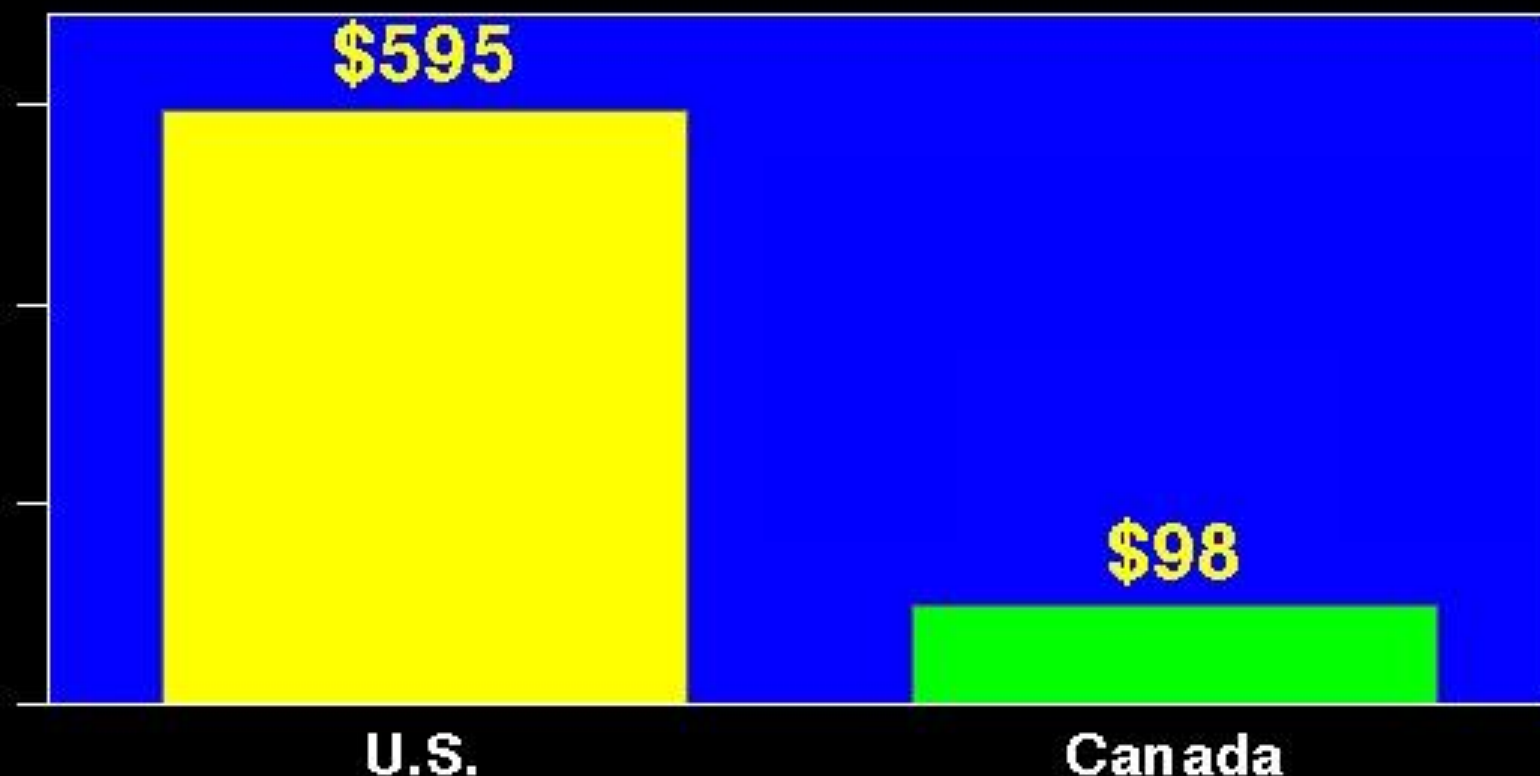
\$ per capita (PPP adjusted)



Source: Himmelstein, Campbell & Woolhandler - Ann Int Med 2020 (Updated)

# Physicians' Billing-Related Expenses United States & Canada, 2022

\$ per capita (PPP adjusted)



**Source: Woolhandler/Campbell/Himmelstein Ann Int Med 2020 (Updated)**

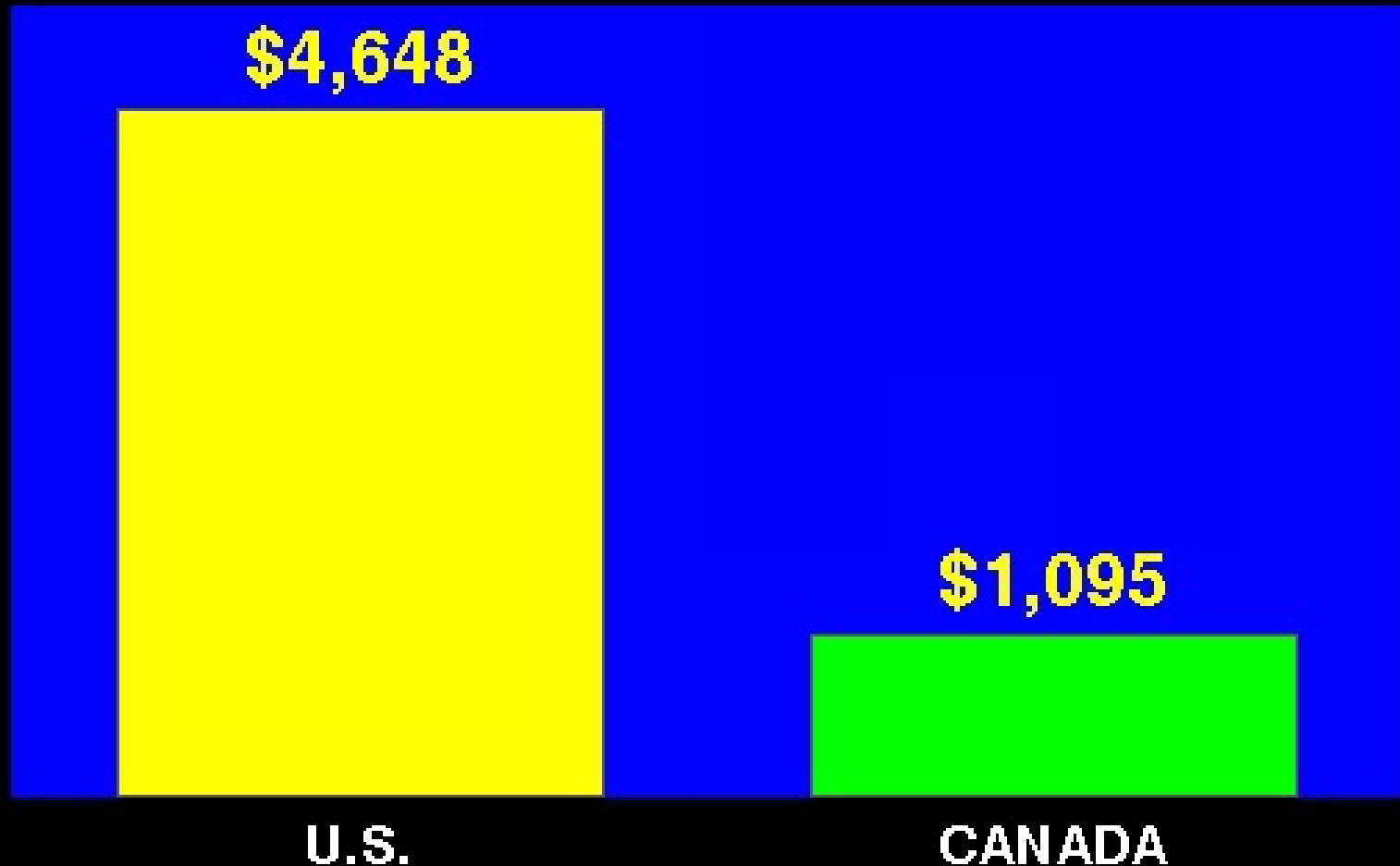
Note: Excludes dentists and other non-physician, office-based practitioners

Note: Excludes non-billing-related costs for documentation compliance etc.



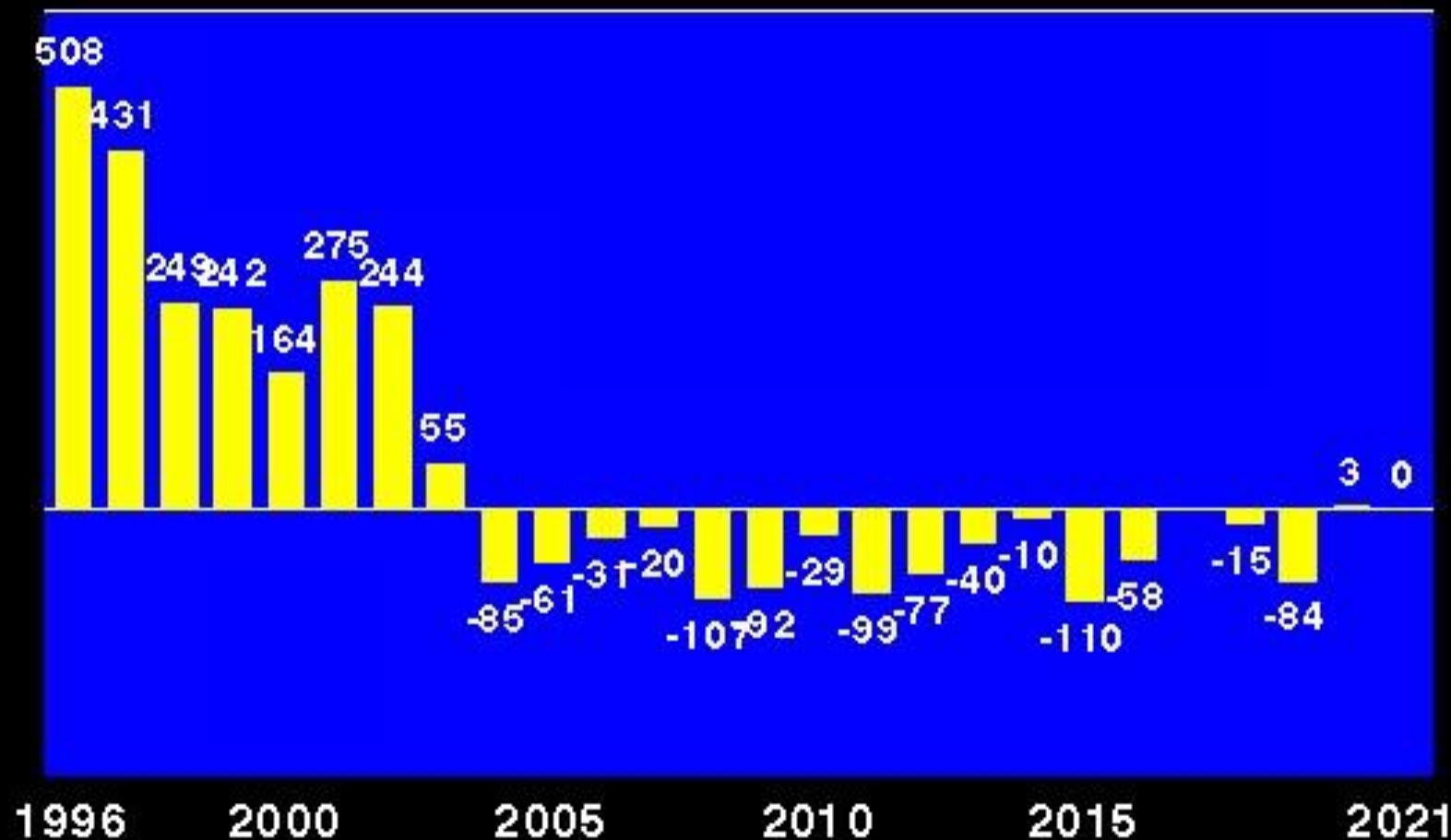
# Overall Administrative Costs Per Capita United States & Canada, 2022

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# Few Canadian Physicians Emigrate

Net Loss (# moving abroad minus # returning)



Source: Canadian Institute for Health Information

Note - A negative number indicates that more physicians returned from abroad than moved abroad

# Canadian Physicians' Incomes, 2019/2020

## Average Clinical Payments Per Physician

Family Medicine	\$287,326
Int. Medicine	\$414,126
Pediatrics	\$316,265
Psychiatry	\$280,078
Dermatology	\$398,522
Ob/GYN	\$394,684
General Surg.	\$472,415
Thoracic Surg.	\$594,141
Ophthalmology	\$804,945
All Physicians	\$354,487

Source: Canadian Institute for Health Information - figures are in Canadian \$s

# What's OK in Canada?

Compared to the U.S.

- **Life expectancy 2 years longer**
- **Infant deaths 25% lower**
- **Universal comprehensive coverage**
- **More MD visits, hospital care; less bureaucracy**
- **Quality of care equivalent to insured Americans'**
- **Free choice of doctor/hospital**
- **Health spending half U.S. level**

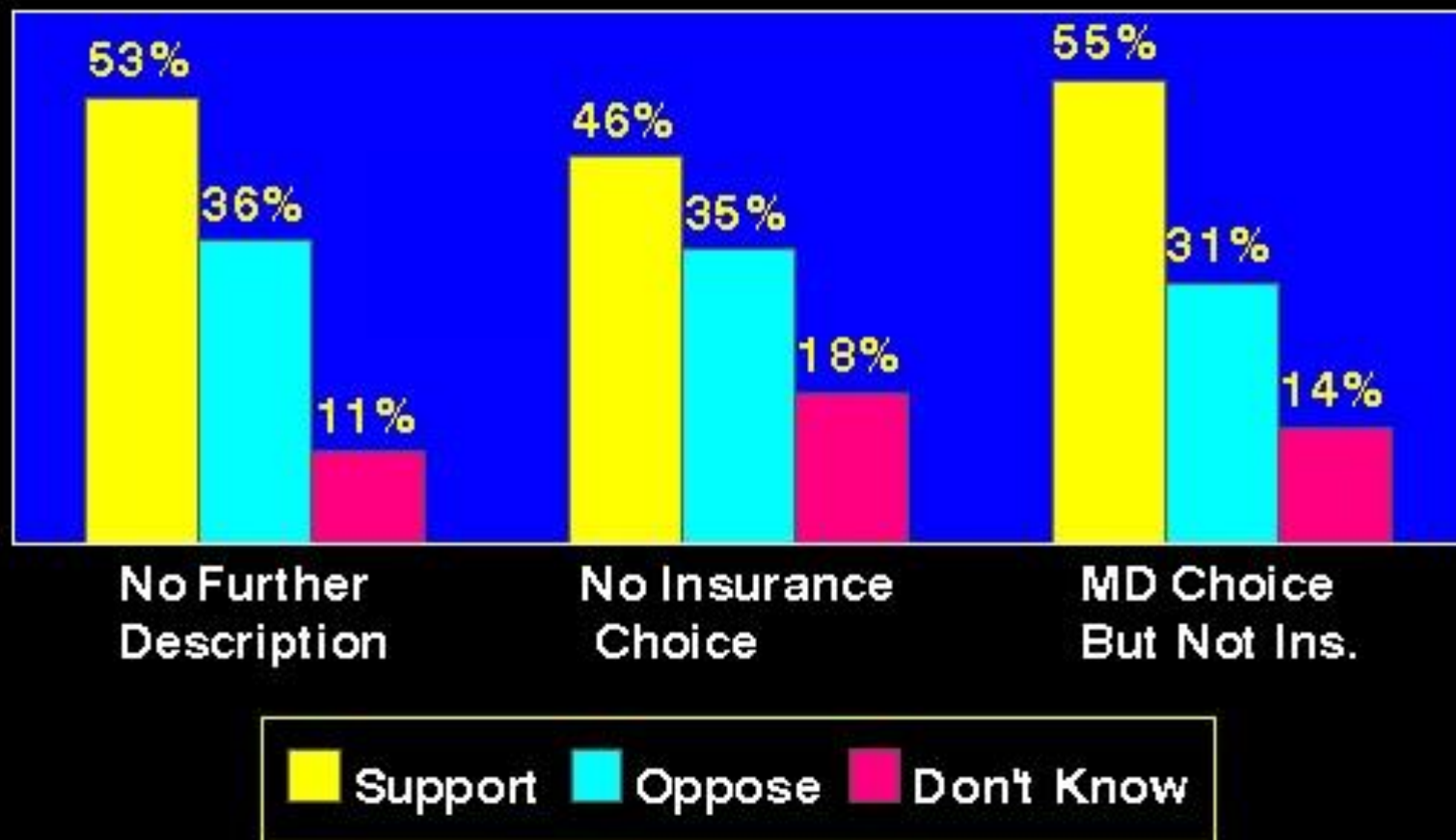
# What's the Matter in Canada?

- **The wealthy lobby for private funding and tax cuts; they resent subsidizing care for others**
- **Result: government funding cuts (e.g. 30% of hospital beds closed during 90s) causing dissatisfaction and waits for care**
- **U.S. and Canadian firms seek profit opportunities in health care privatization**
- **Conservative foes of public services own many Canadian newspapers**
- **Misleading waiting list surveys by right wing Fraser Institute**

Medicare for All Enjoys  
Wide Support

# Most Favor Phasing Out Private Plans if They Can Keep Their Doctor/Hospital

Percent supporting Medicare for All with . . .

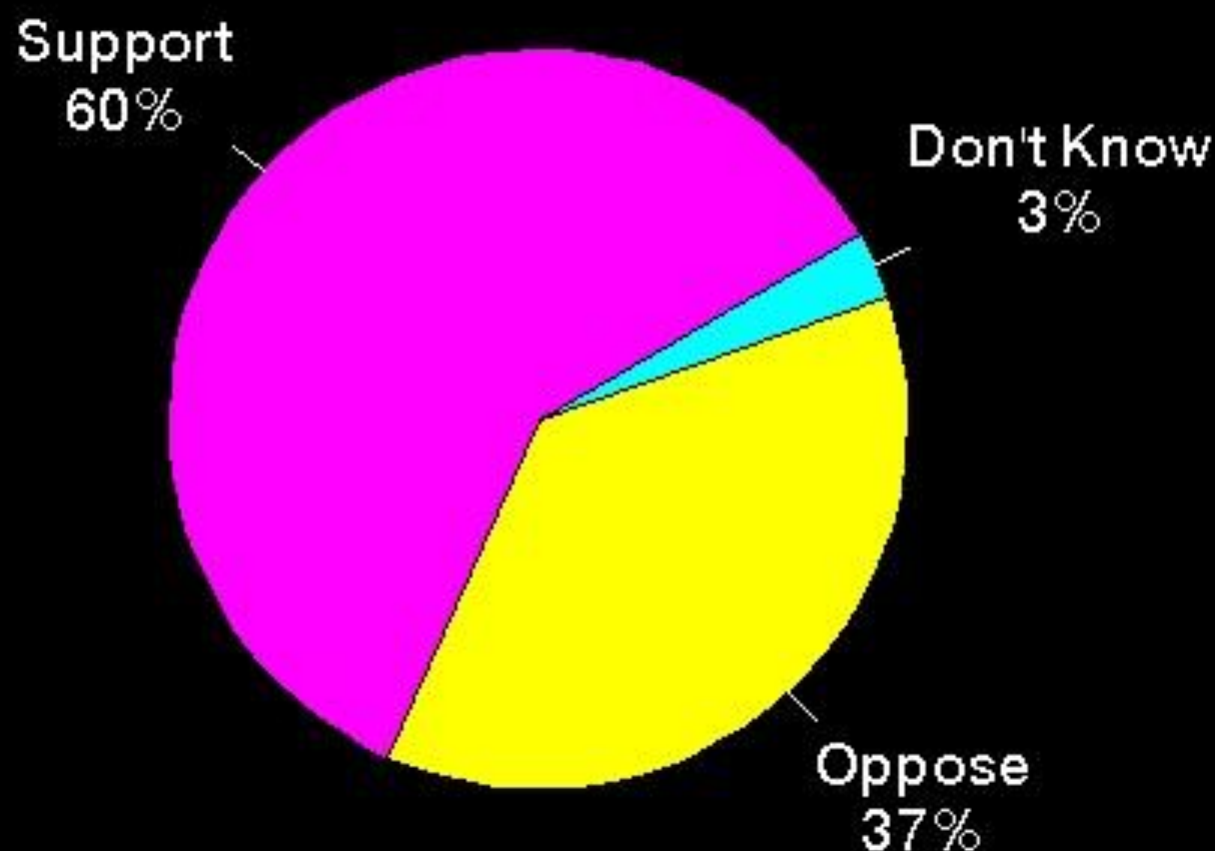


Source: Morning Consult July, 2019

Note: Question asked about choice of doctor AND hospital

# 2021 Poll: 60% Want Medicare for All

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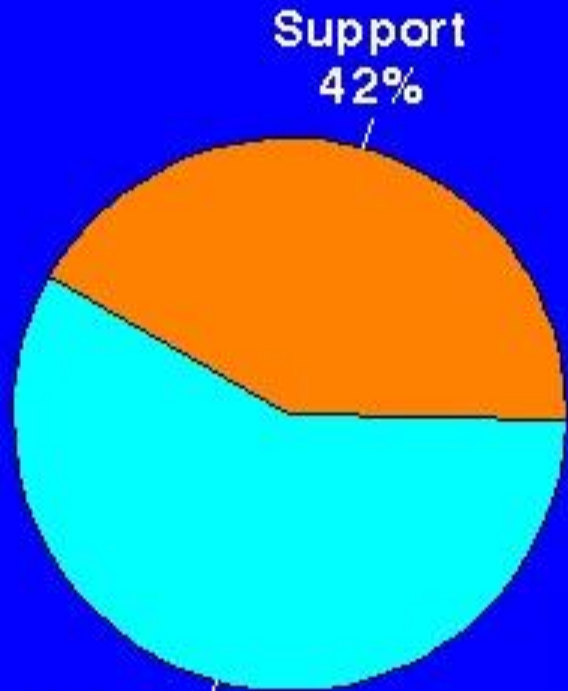
Source: Commonwealth Fund/Harvard Public Health School Survey January, 2021

**"Do you support/oppose changing our health care system so that all Americans would get health insurance from Medicare ... paid for by taxpayers ... often called Medicare for all"**



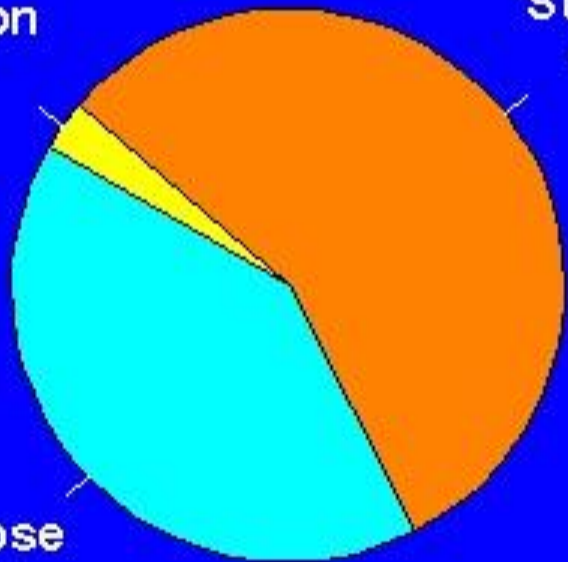
# Most Doctors Favor Single Payer

## Support Has Sharply Increased



2008

No Opinion  
3%



2017

Source: Merritt Hawkins surveys of physicians

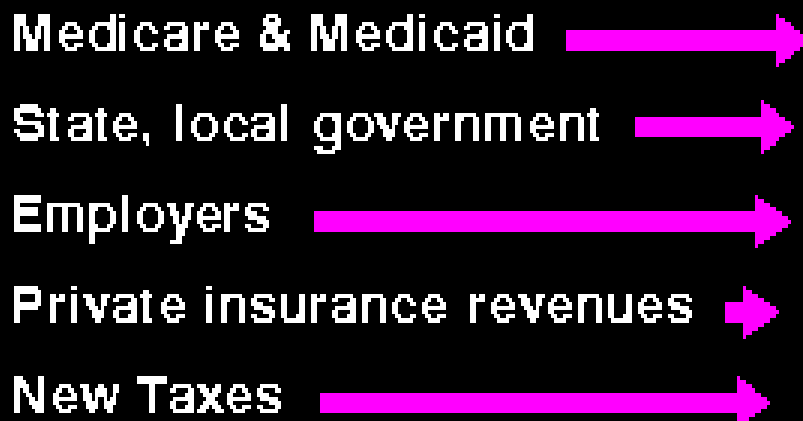
# A National Health Program for the U.S.

# National Health Insurance

- Universal - covers everyone
- Comprehensive - all needed care, no co-pays
- Single, public payer - simplified reimbursement
- No investor-owned HMOs, hospitals, etc.
- Improved health planning
- Public accountability for quality and cost, but minimal bureaucracy

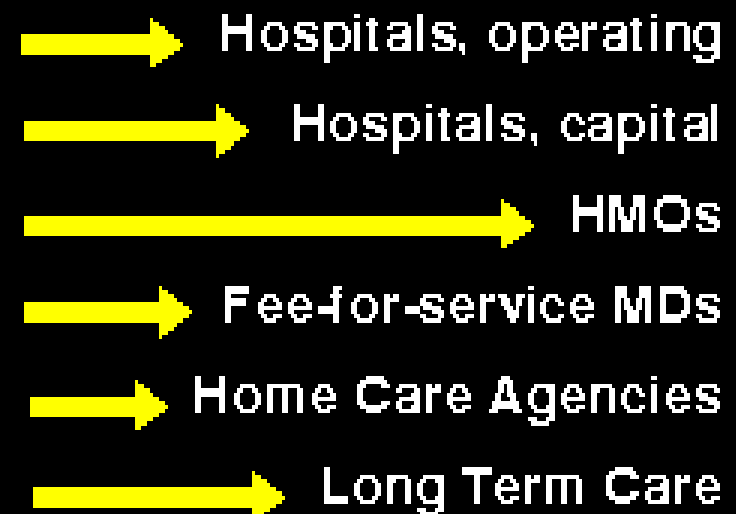
# FUNDING FOR THE NHP

## SOURCES OF REVENUE



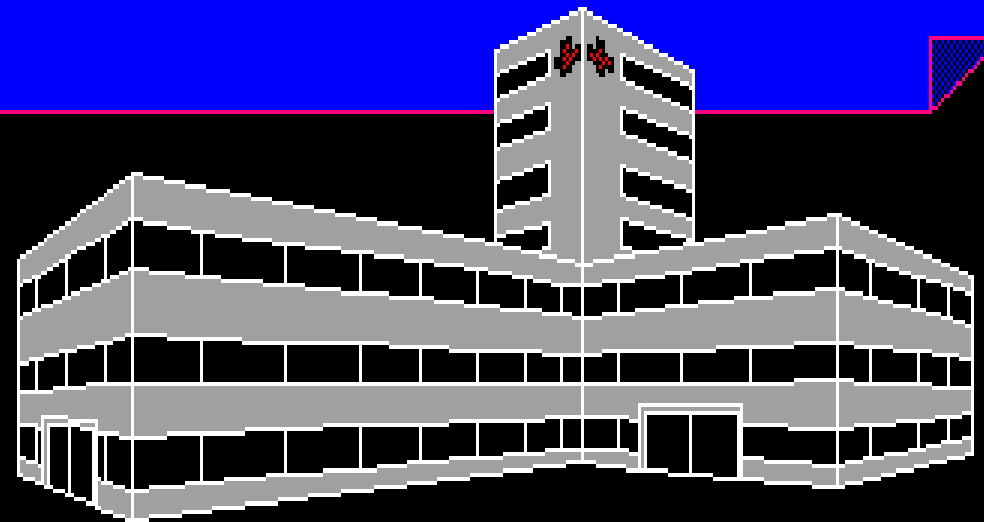
NET  
REVENUE

## RECIPIENTS OF MONEY



# HOSPITAL PAYMENT UNDER AN NHP

- Hospitals remain privately owned and run
- Negotiated global budget for all operating costs. Operating funds cannot be diverted to capital.
- Capital purchases/expansion budgeted separately based on health planning goals



# Global Operating Budgets: Key to Single Payer Savings

- Cuts hospital administrative costs.
- Eliminates disparities in profitability of patients.
- Banning hospitals from keeping surplus minimizes entrepreneurial incentives.
- Funding capital through explicit grants minimizes unneeded duplication of expensive services.

# Prescription Drugs and Single Payer

- Full coverage, no deductibles/copays.
- Prices reduced by negotiations, national formulary, threat of patent revocation.
- Funding for public drug development, testing, and (when necessary) manufacture.
- Raise standards and FDA funding for drug approval, marketing and post-approval surveillance.
- Eliminate tax deductions for advertising; prohibit pharma-funded CME and guideline development.

# Single Payer Transition:

## For Displaced Clerical and Administrative Workers

- All 400,000 health insurance workers and about ½ of the 2.6 mil. clerical/administrative employees in healthcare providers likely to be displaced – total 1.7 million.
- Many likely to be redeployed in expanded clinical workforce.
- Funding for income support and job retraining modeled on WWII GI Bill.



# Single Payer Transition: For Patients

- Every U.S. resident receives an insurance card.
- Full coverage for all medically necessary care, no copayments, deductibles or coinsurance.
- Prescription drug formulary, with alternatives covered when medically indicated
- Free choice of any participating provider or hospital.

**Medicare for All**

**vs.**

**Medicare for More  
(e.g. Public Option)**

# Single Payer and Private Coverage

- **Allowed:** Supplemental non-competing – but can only cover benefits NOT covered by the public plan.
- **Banned:** Private insurance (including Medicare Advantage) duplicating public plan benefits – Key to administrative savings.

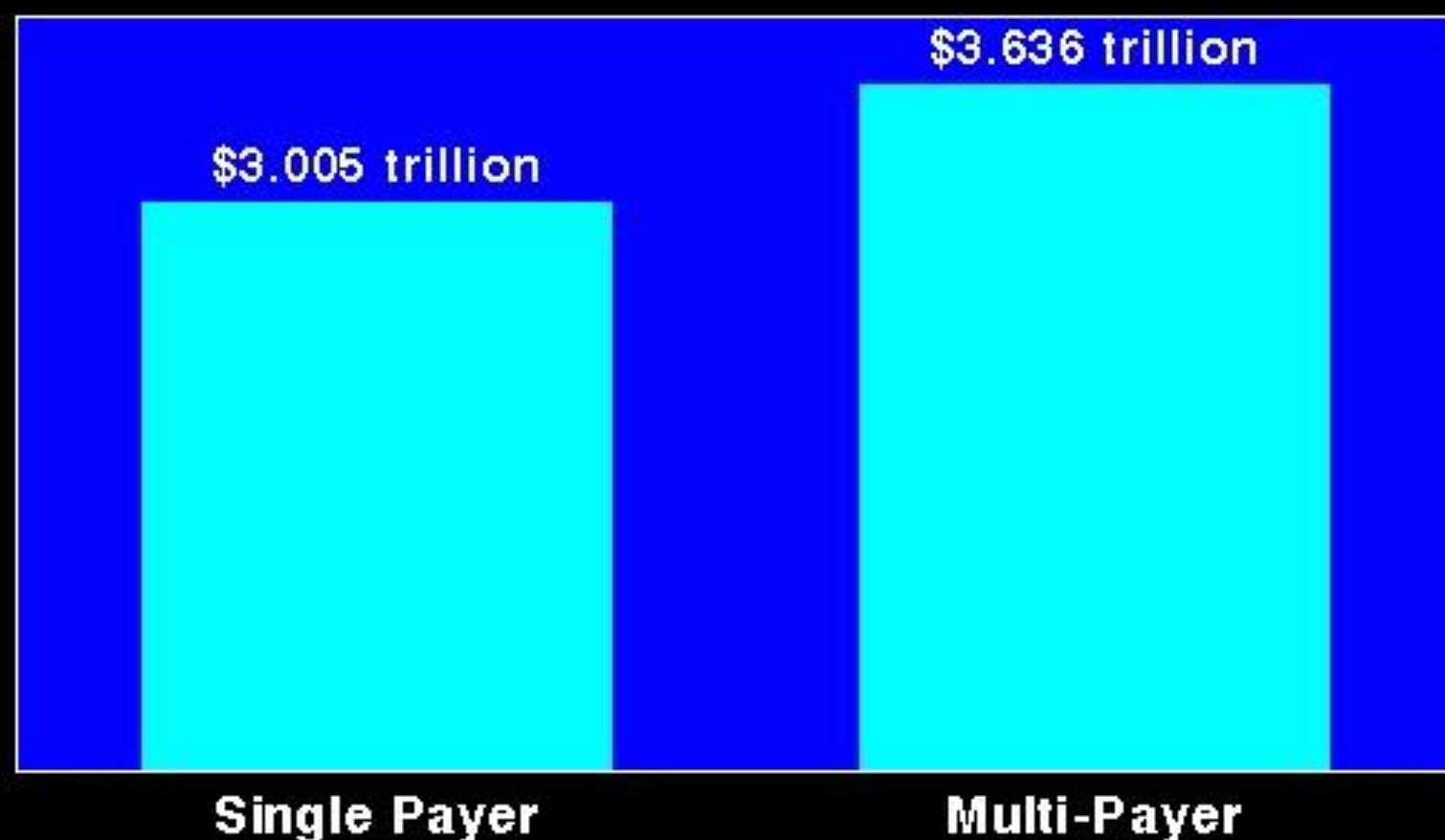
# Public Option = High Costs

- Less savings than single payer on insurers' overhead
- Multiple payers = no savings on doctor/hospital billing and administration.
- Private insurers will tilt the playing field (as under Medicare Advantage) raising system-wide costs and perpetuating network restrictions, cherry-picking, lemon dropping, upcoding, cheating.
- Higher system-wide costs (compared to single payer) assure political pressure for benefit cuts.

# Single Payer Would Cost \$631 Billion Less Than a Universal Multi-Payer Reform

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Total health expenditures/year



## Medicare for All Is Not Enough

*Communities, not corporations, should own our most vital health care assets.*

*By David U. Himmelstein, Steffie Woolhandler, Adam Gaffney, Don McCanne and John Geyman*

MARCH 31, 2022



Hospital workers, union members, and local politicians protested the imminent closure of Hahnemann University Hospital at a rally in Philadelphia on July 15, 2019. (Bastiaan Slabbers / NurPhoto via Getty Images)

