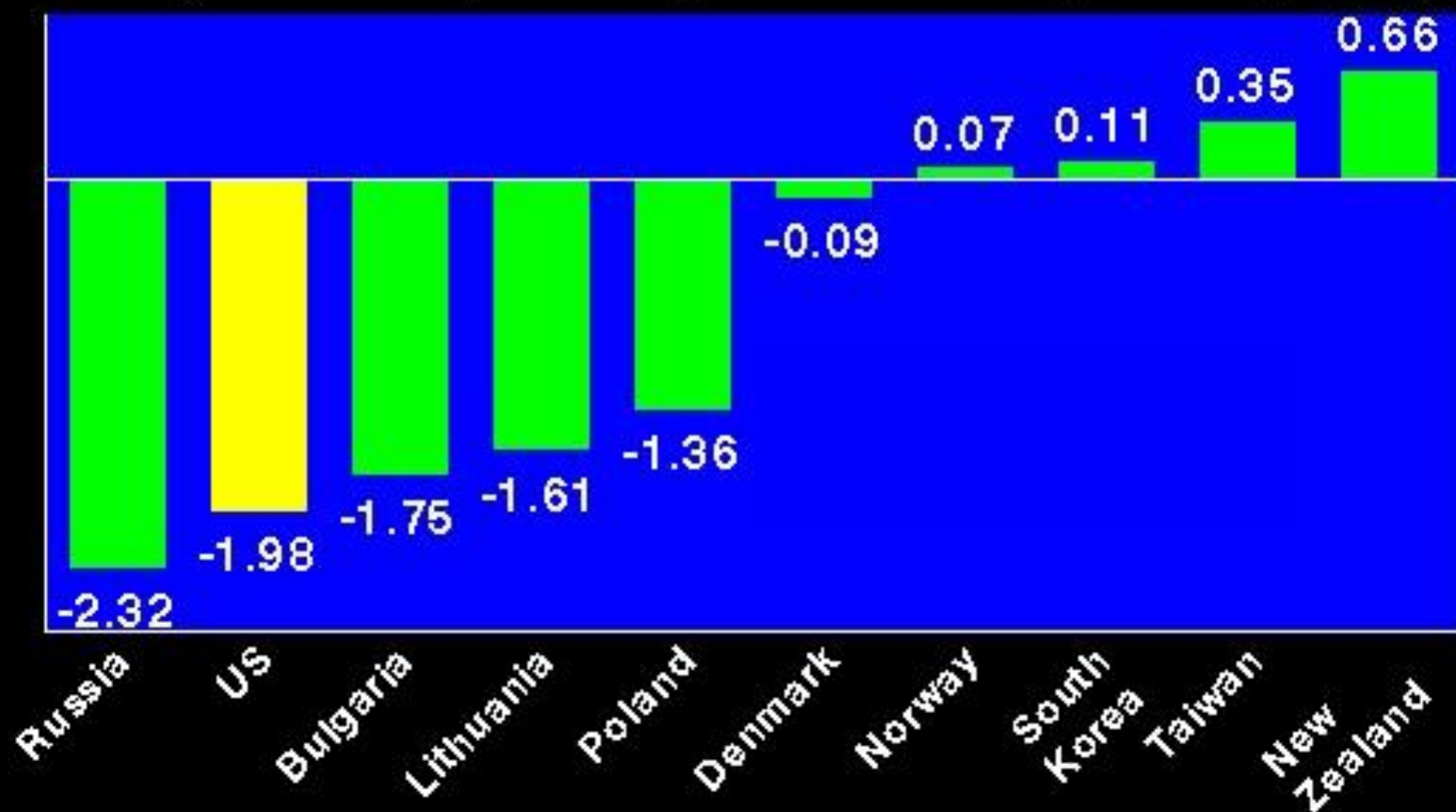




Slides prepared by Drs. Steffie Woolhandler & David Himmelstein, Faculty at the City University of New York at Hunter College and Harvard Medical School, and Research Associates, Public Citizen Health Research Group

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

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

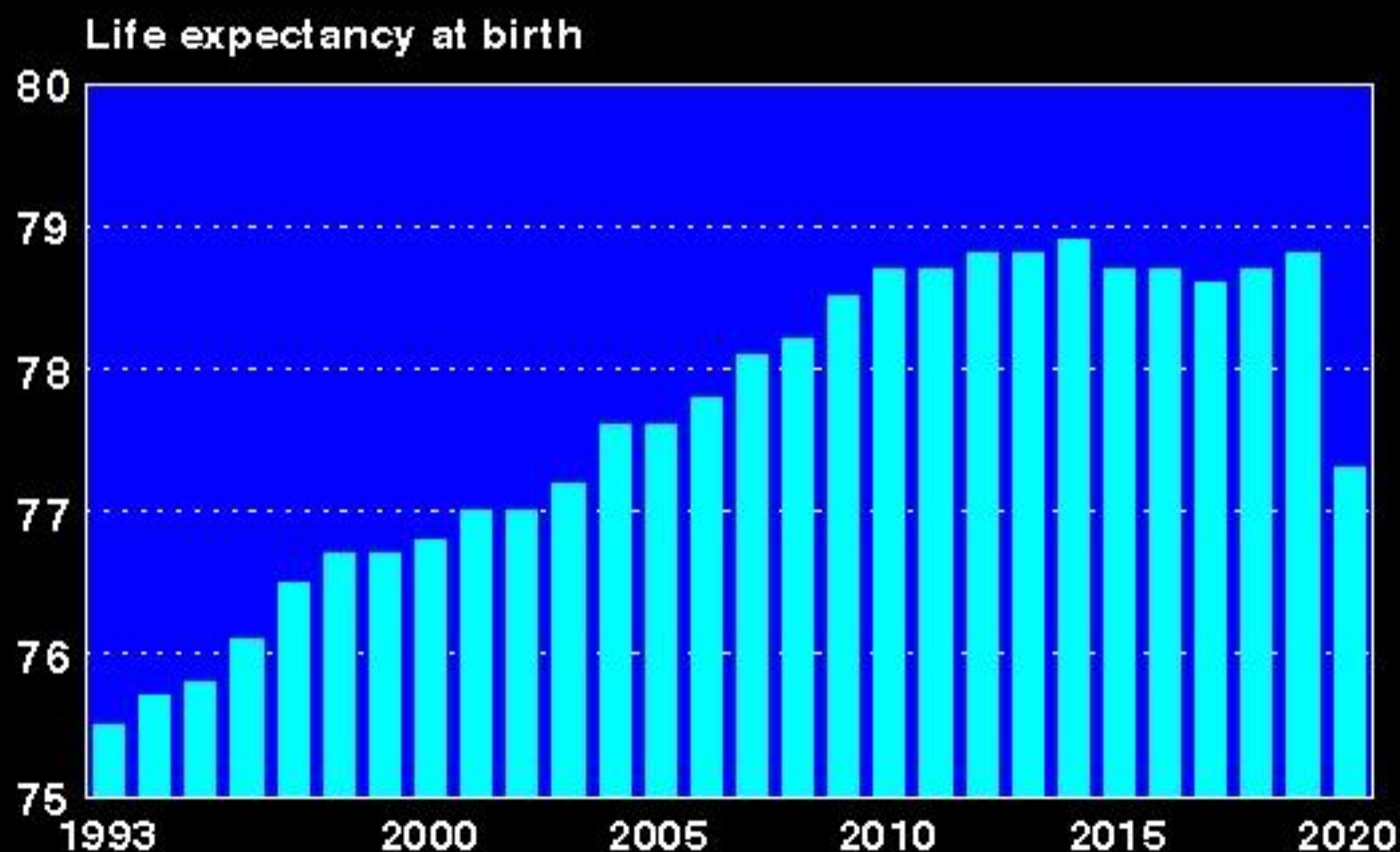


Why was the U.S. so Vulnerable to COVID-19?

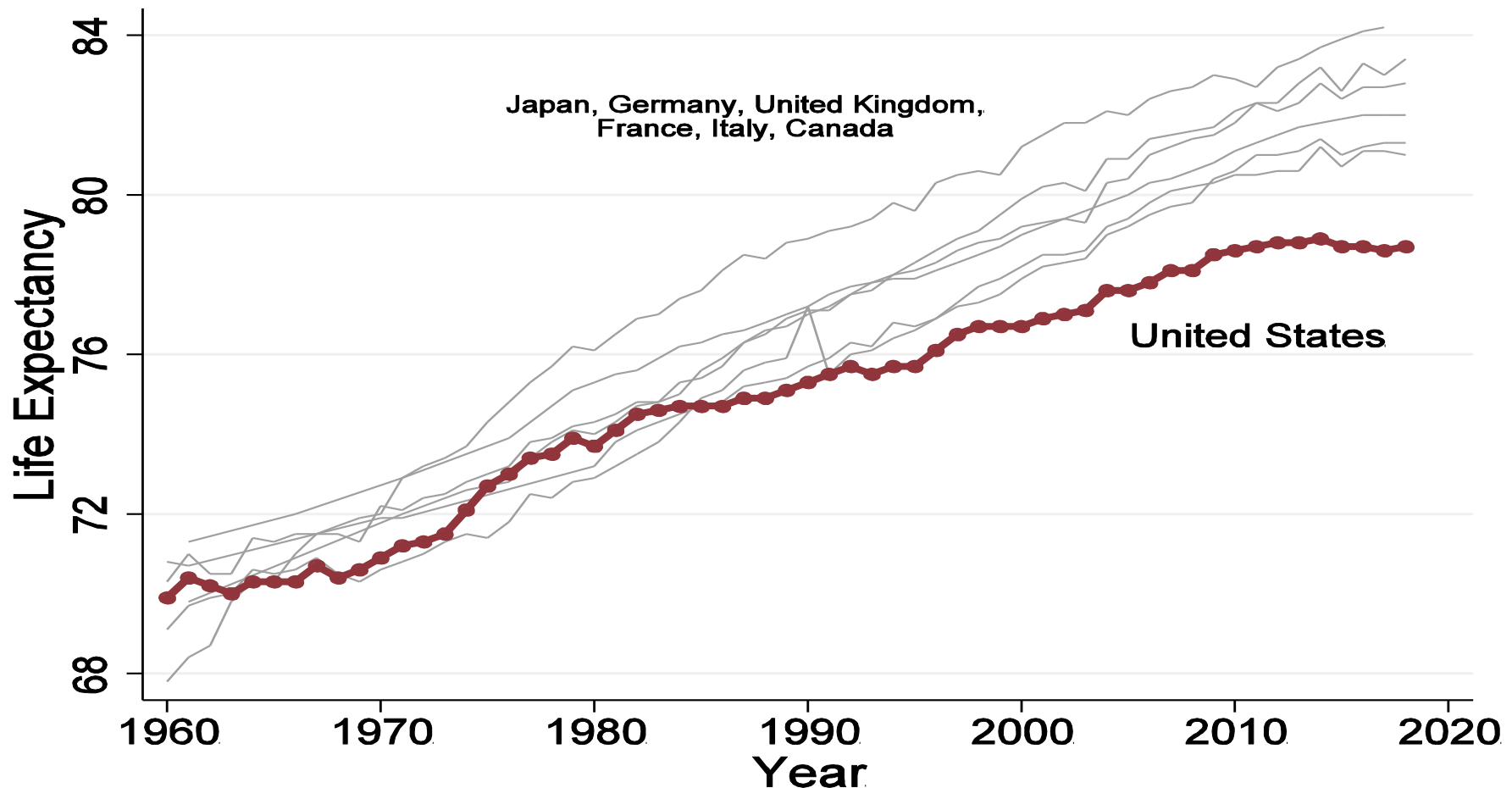
- Deteriorating health status.
- Weakened public health capacity.
- Increasing economic inequality.
- Racism that harms people of color and erodes support for safety-net programs.
- Wasteful health care system that prioritizes profitability over needs.

Progress on Longevity Halted

Even Before COVID-19 Pandemic



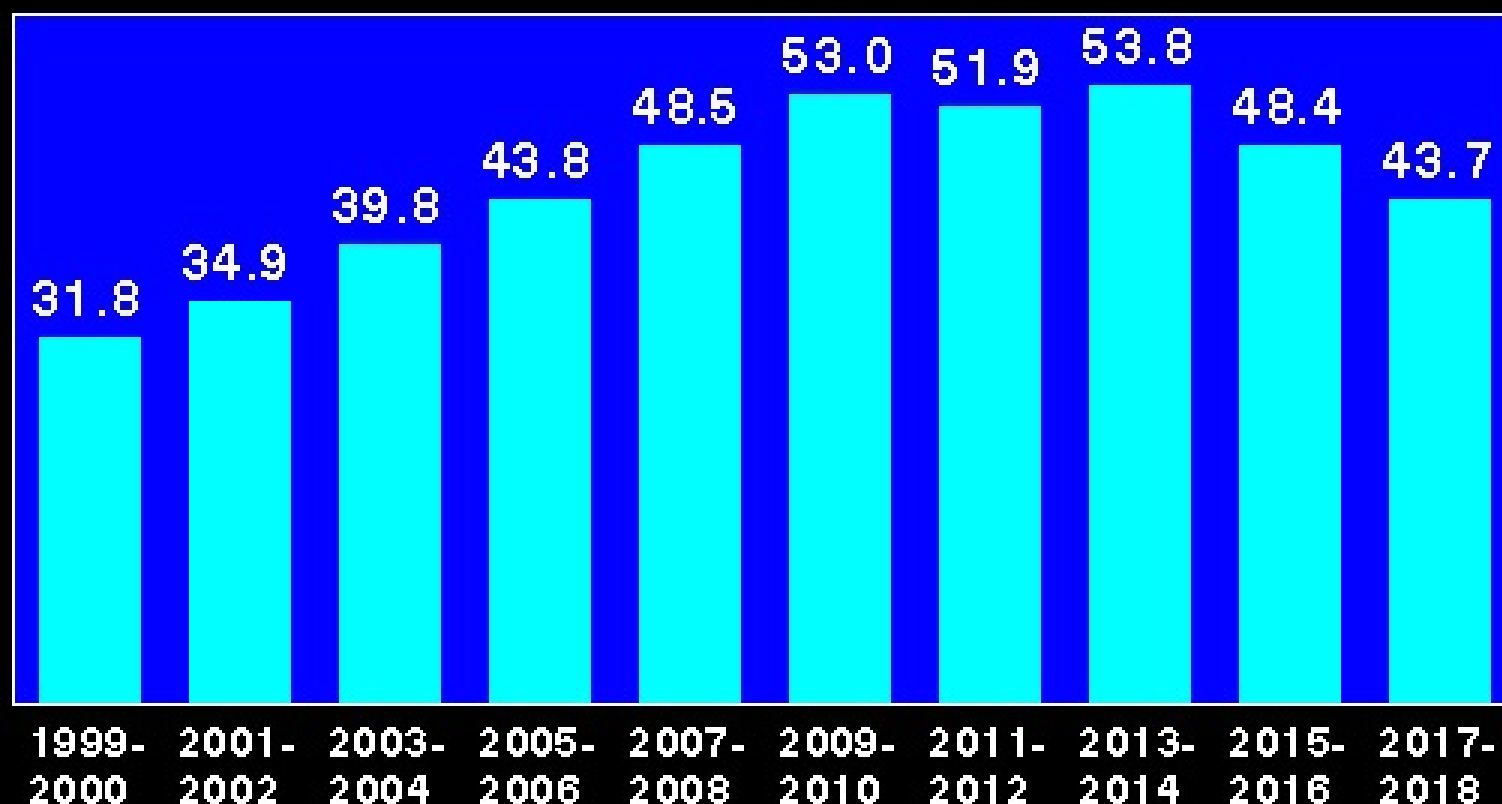
Life expectancy in the US and other G7 countries, 1960–2018



Worsening Blood Pressure Control

A Rising Share of US Adults Have Uncontrolled Hypertension

Percent of adults with hypertension whose BP was controlled

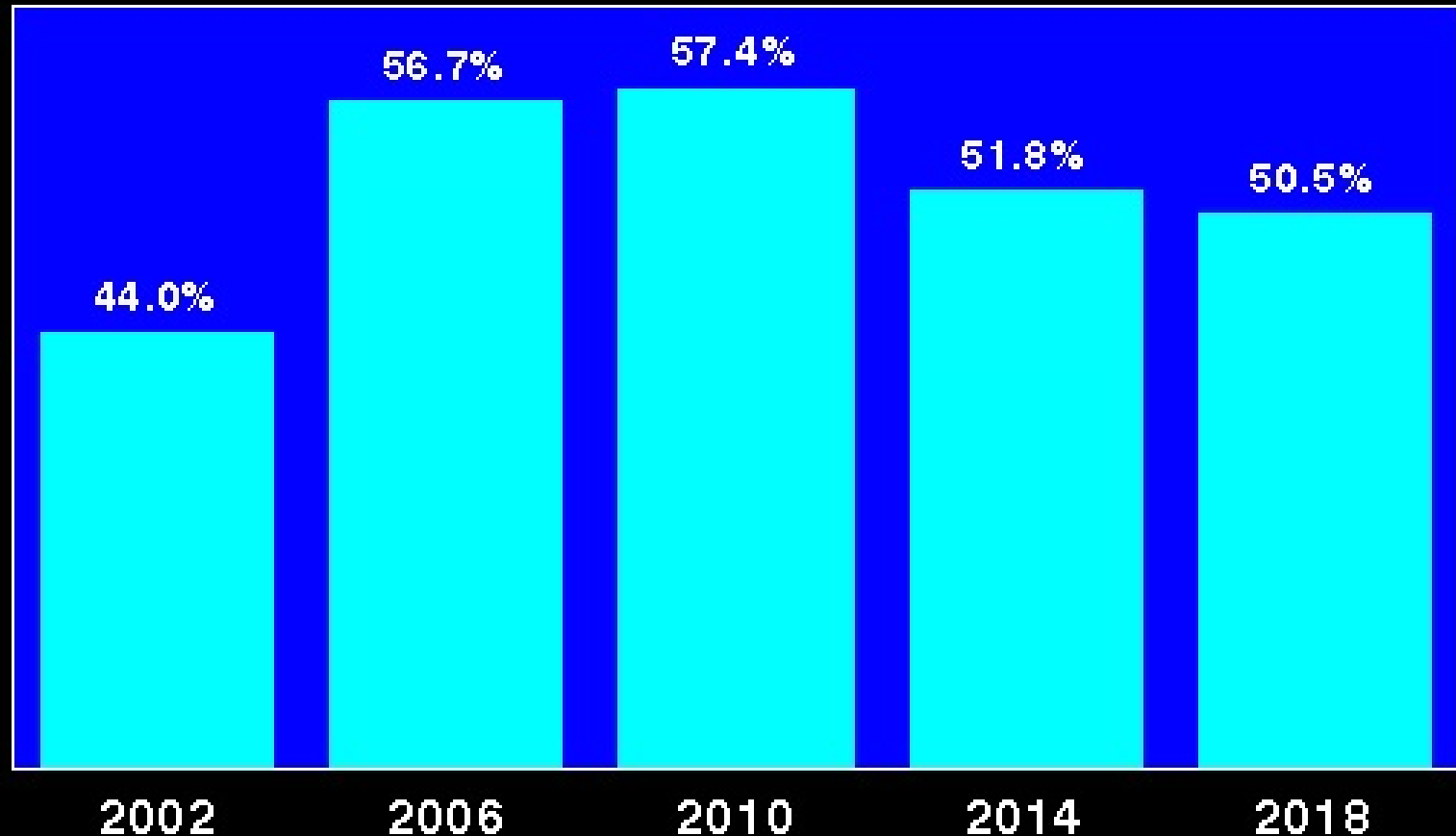


Source: JAMA 2020;324:1190 - Worsening control was seen in virtually every demographic group

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

Diabetes Care is Deteriorating

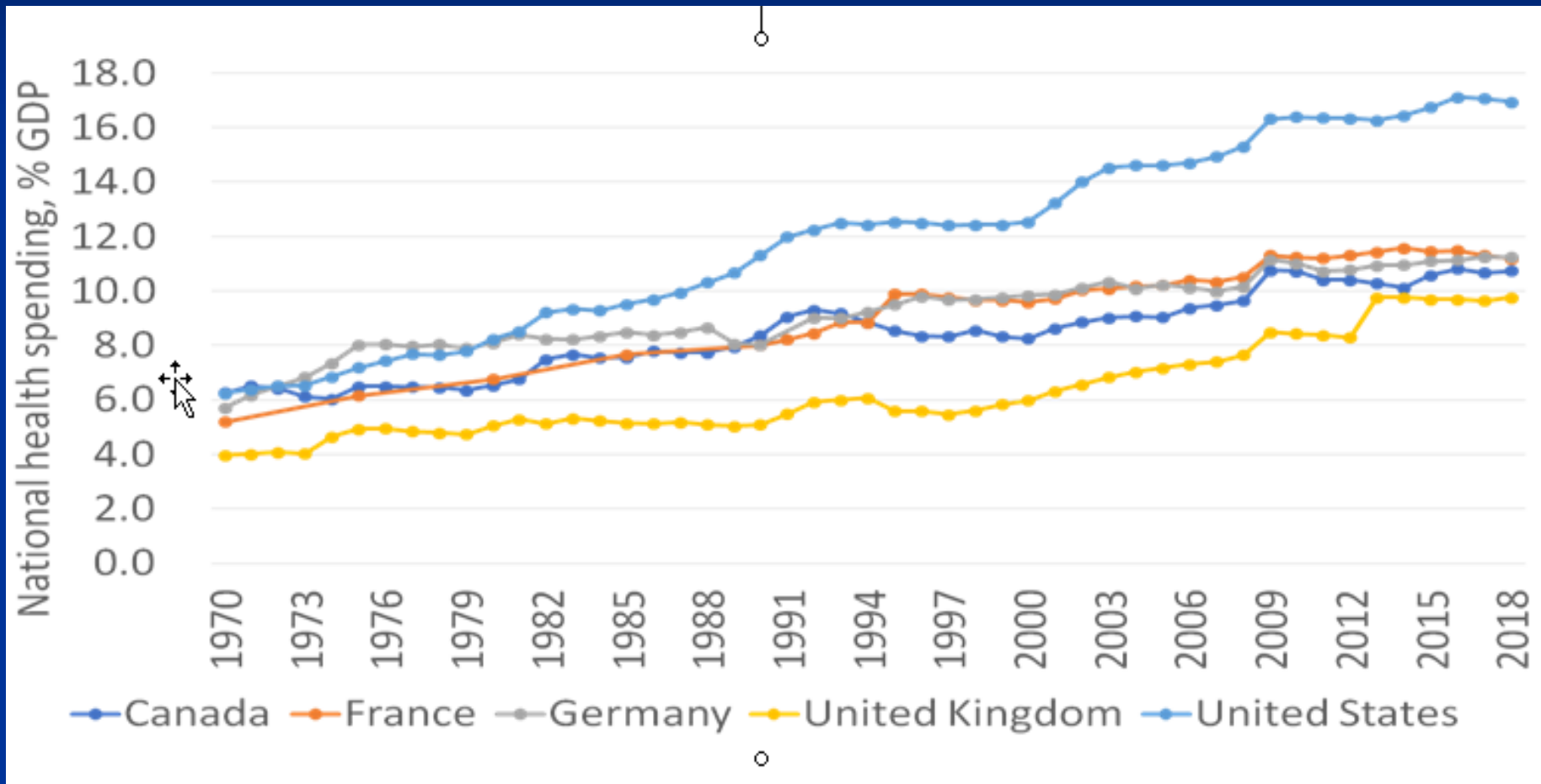
% of diabetic Americans with Hgb A1C <7.0%



Source: NEJM 2021;384:2219

Note: Data are 4 year averages ending in year shown

US Health Expenditures Started Diverging from Other Nations' ~1980



Source: A. Gaffney based on OECD data, 2020

**Why Did US Longevity
Stall and Health Costs
Soar Starting in ~ 1980?**

Neoliberalism

(AKA Market Fundamentalism)

- Markets regulate themselves
 - ❖ They give everyone what they deserve
 - ❖ Unions distort markets, impede formation of merit-based hierarchy
- Government is incompetent
 - ❖ Taxes and regulation should be cut
 - ❖ Public services should be privatized
- Seeking equality is counterproductive and morally corrosive



Background photo from The American Prospect

Corporate Social Responsibility?

"Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their shareholders as possible."

Source: Milton Friedman - Capitalism & Freedom, 1962.

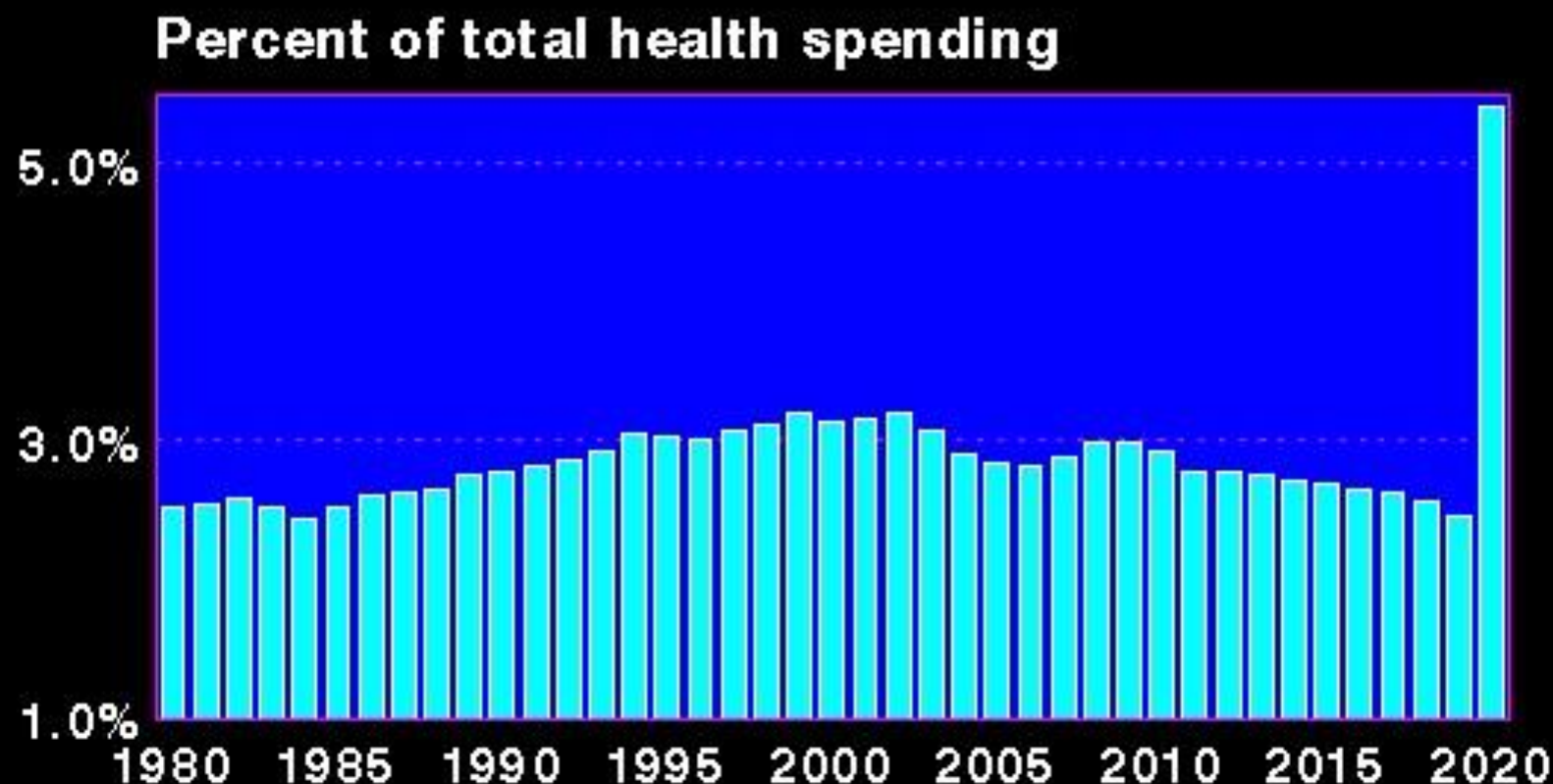
Many Democrats Joined the Neoliberal Bandwagon

“The most terrifying words in the
English language are: ‘I’m from
the government and I’m here to
help’ ” Ronald Reagan

“The era of big government is over”
Bill Clinton

Weakened Public Health Capacity

Public Health's Falling Share of Total Health Spending Left the US Vulnerable to COVID-19

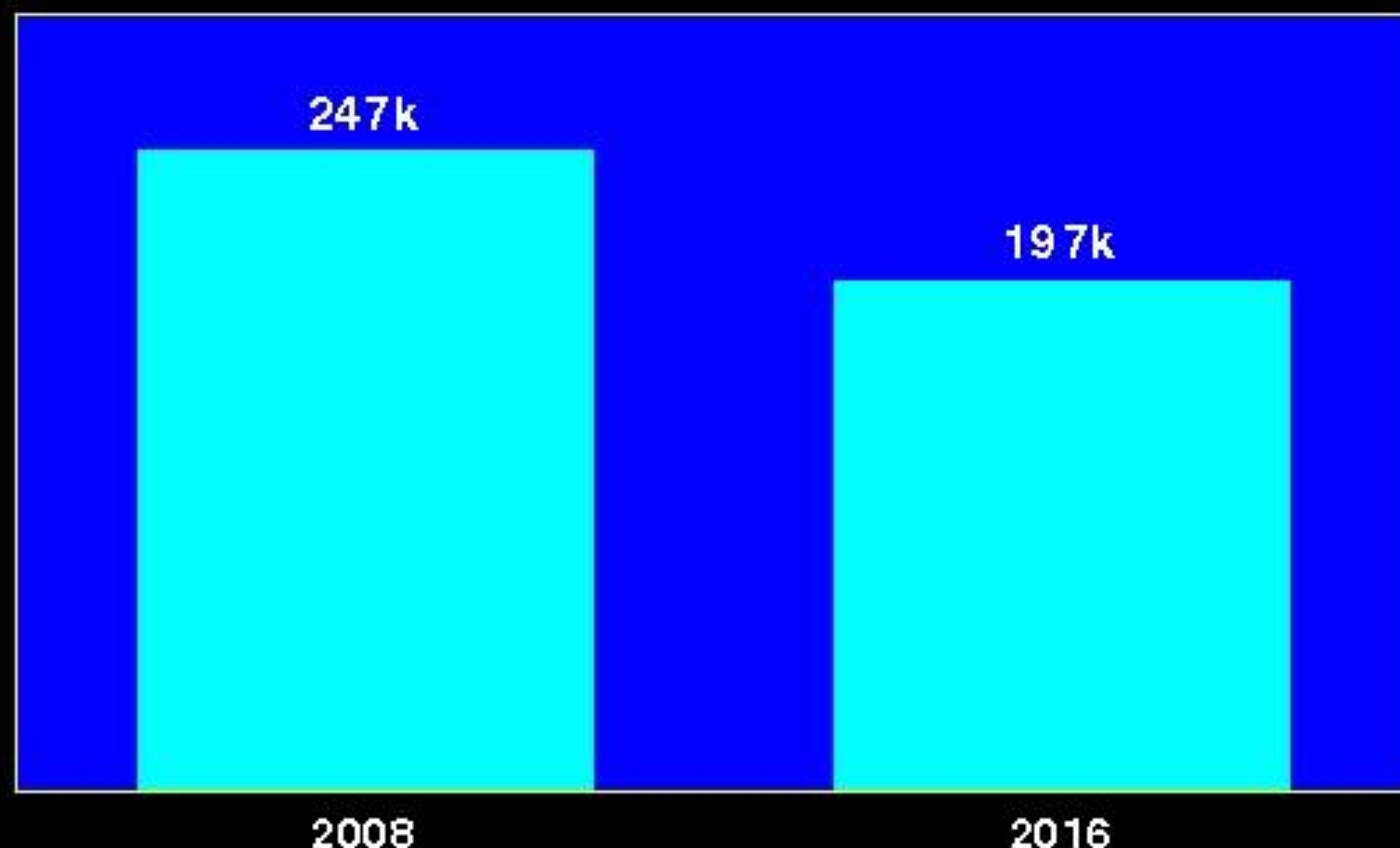


Source: Woolhandler/Himmelstein - Am J Public Health 2016;106:56 (updated)
Note public health's share in Canada = 6.2%

Public Health Workforce Declined 20%

Frontline Personnel to Fight Epidemics

Number of personnel employed by state/local health departments

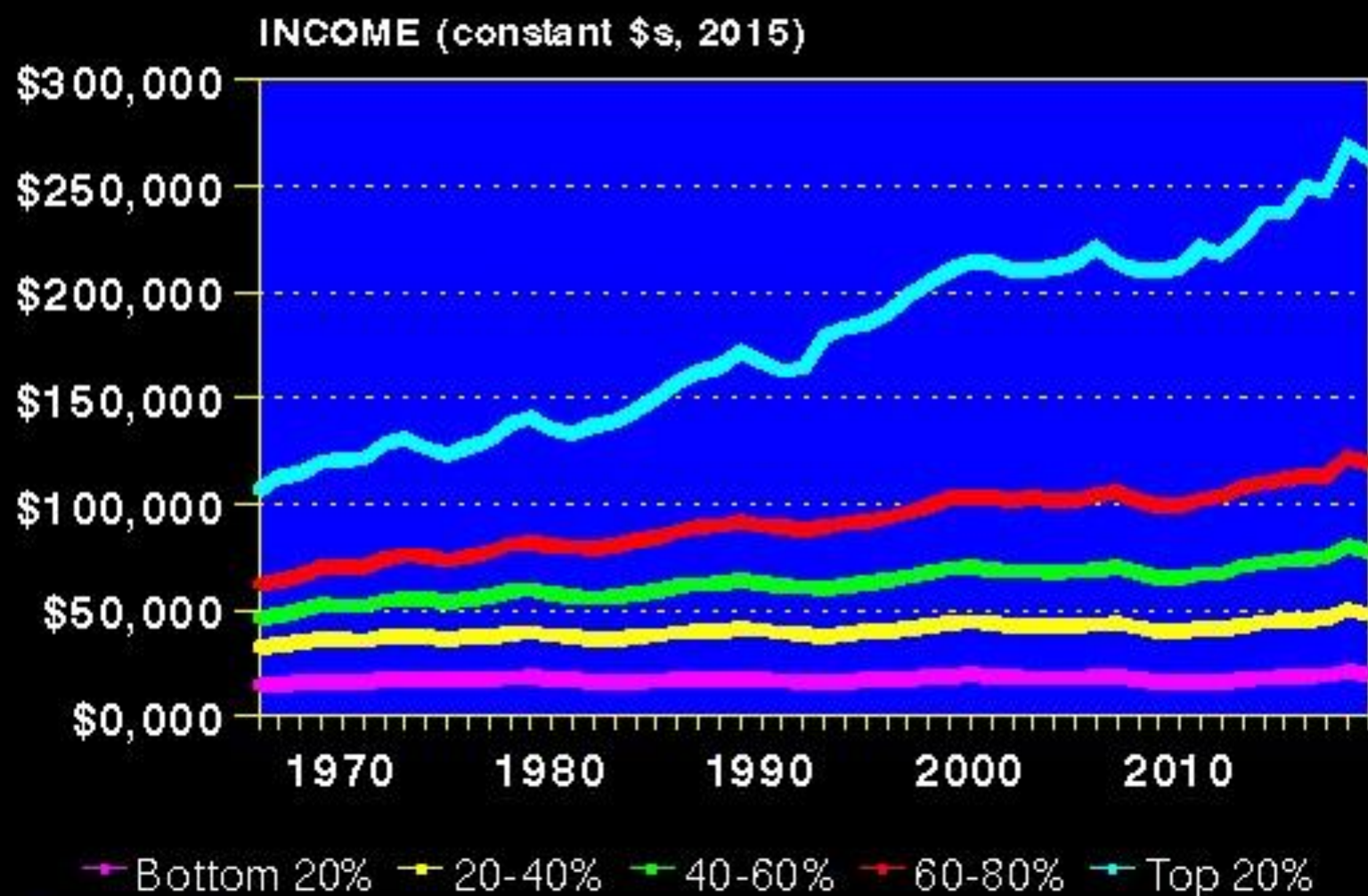


Trump Further Weakened Pandemic Response Capacity

- 2017 Hiring freeze at CDC left 700 vacant positions.
- 2018 - Abolished Global Health Security team of the National Security Council
- 1600 government scientists have left positions since January 2017.
- Many key science policy positions (e.g. OSHA Administrator) remain vacant.
- Defunding WHO in 2020 – A crime against humanity.

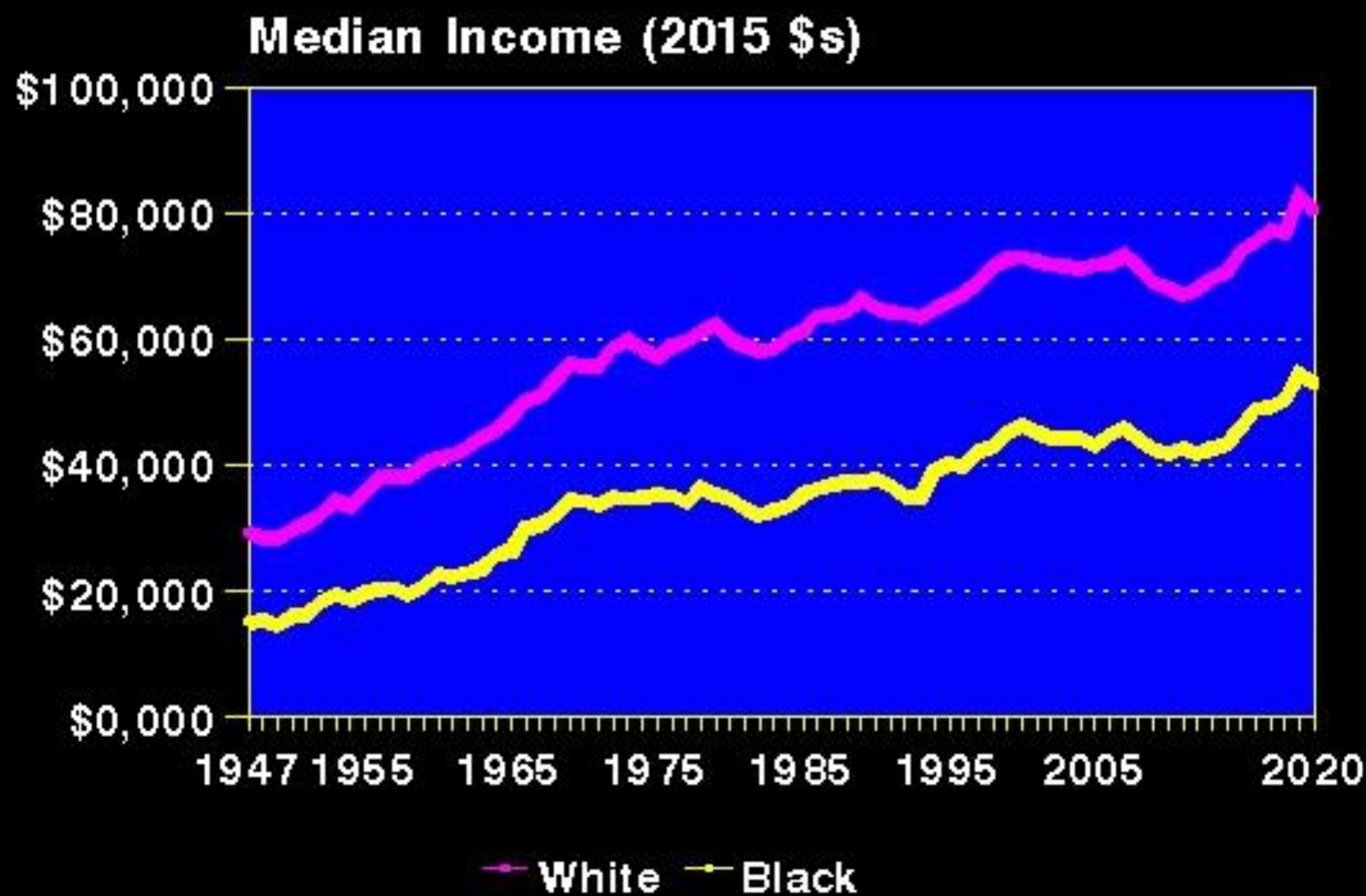
Increasing Economic Inequality

Mean Family Income for Each Fifth: 1966-2020 (Inflation Adjusted)



Source: Bureau of the Census

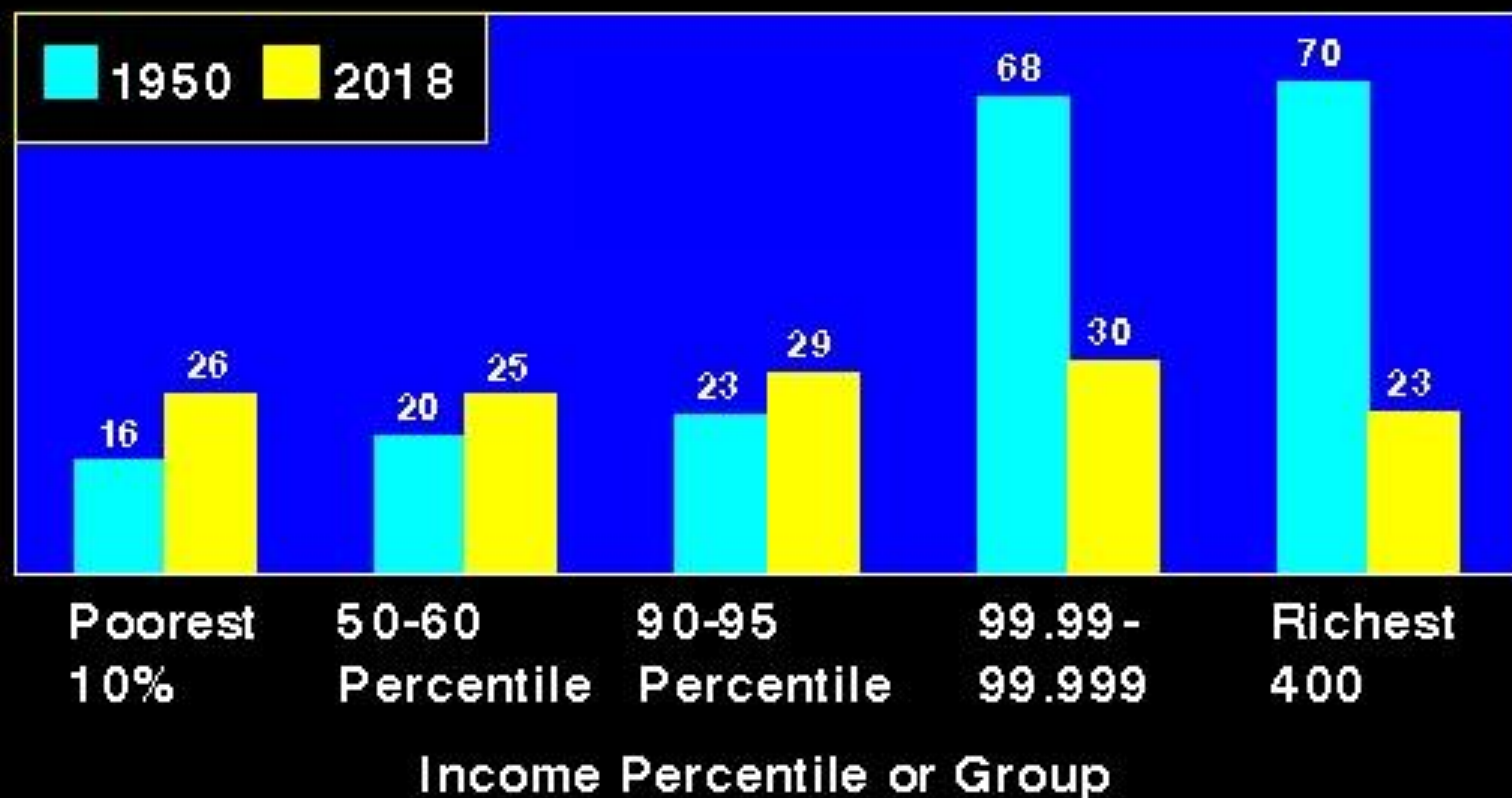
Median Family Income for Blacks and Whites: 1947-2020 (Inflation Adjusted)



Source: Bureau of the Census

Tax Rate Has Fallen for the Super-Rich, Risen for Others

Taxes as share of income



Source: Saez and Zucman (Saez's website, 2020)

Trump's \$1.9 Trillion Tax Cut: A Windfall for the Wealthy

Tax cut per taxpayer, 2020

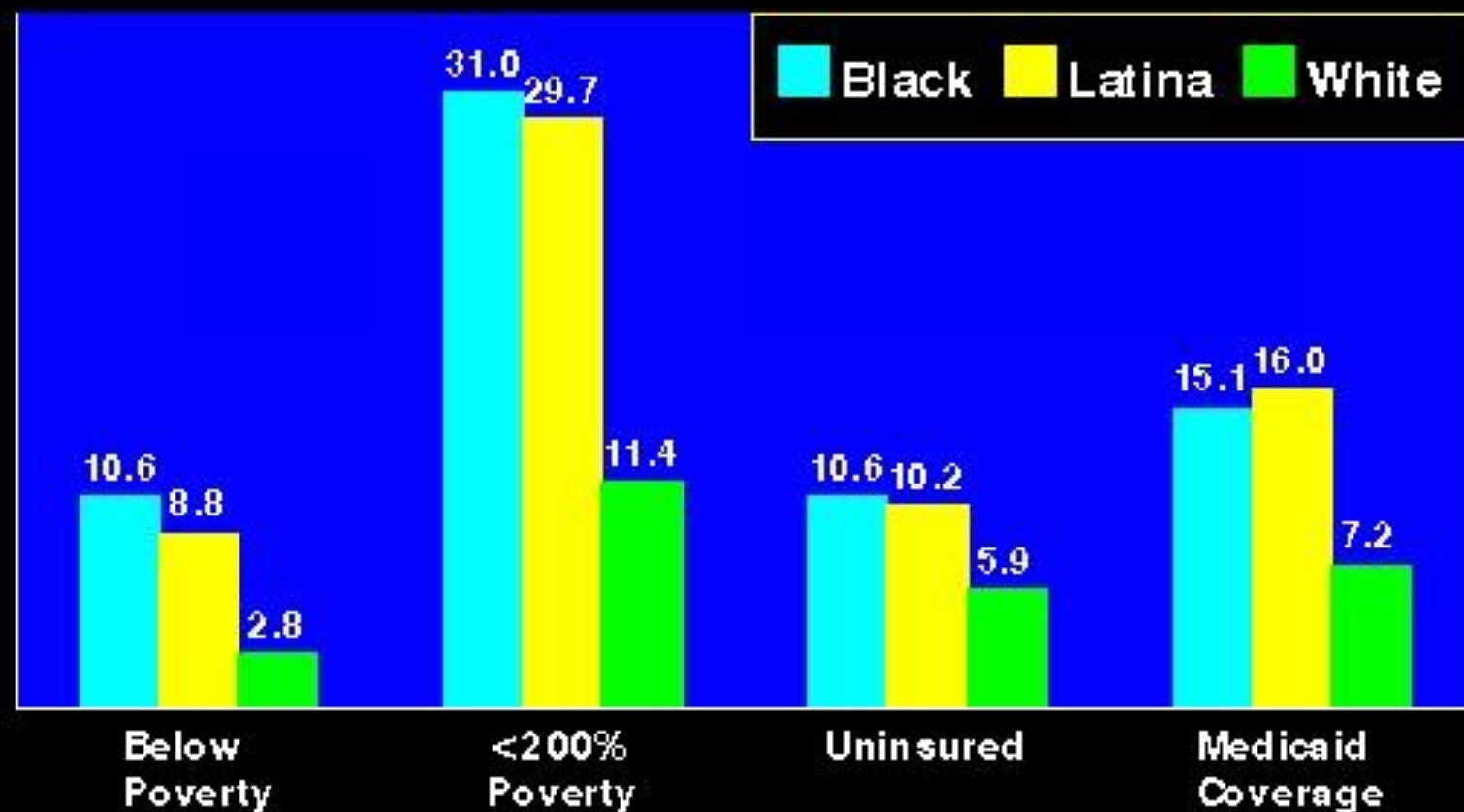


Source: Institute for Taxation and Economic Policy, 9/2020

Women Health Workers' Low Pay

1.7 Million of Them and Their Children Live in Poverty

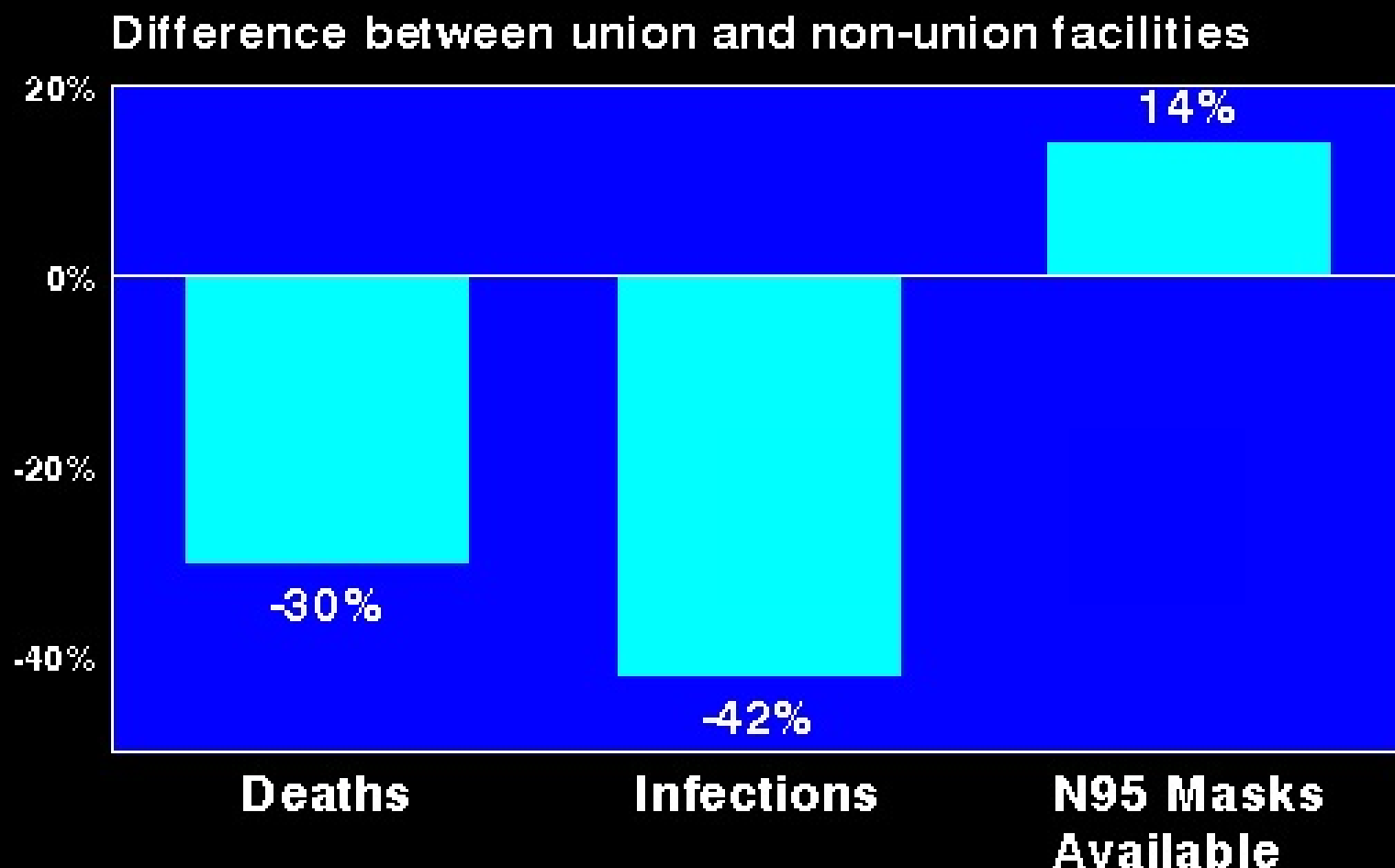
Percent



Source: Himmelstein K, Am J Public Health 2019;109:198

Note: 34.9% of the 14.1 million women health care workers earn < \$15/hour.

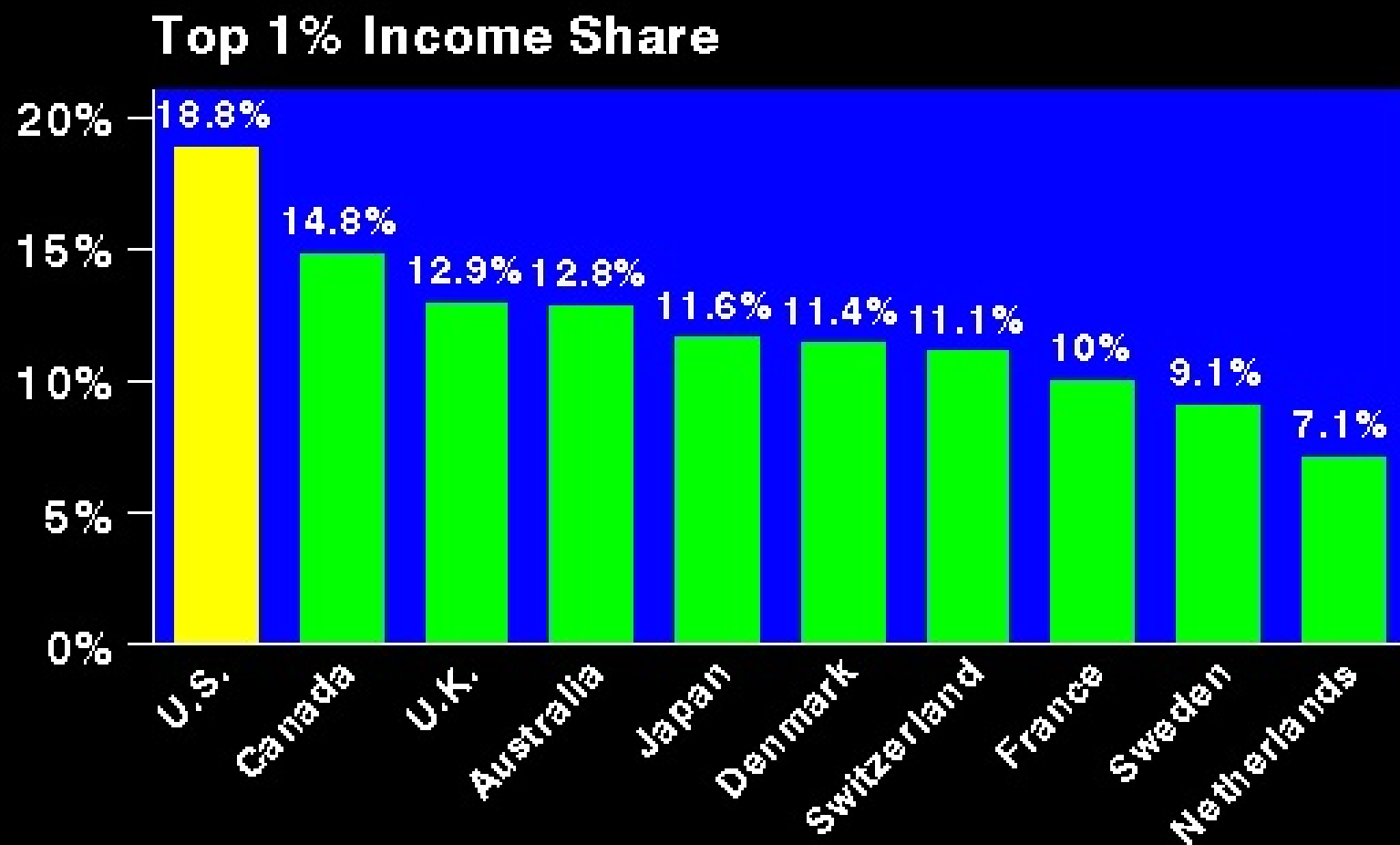
Unionized Nursing Homes: Fewer COVID-19 Deaths, Infections, PPE Shortages



Source: Dean, Venkataramani, Kimmel. Health Aff 2020;39:11:1

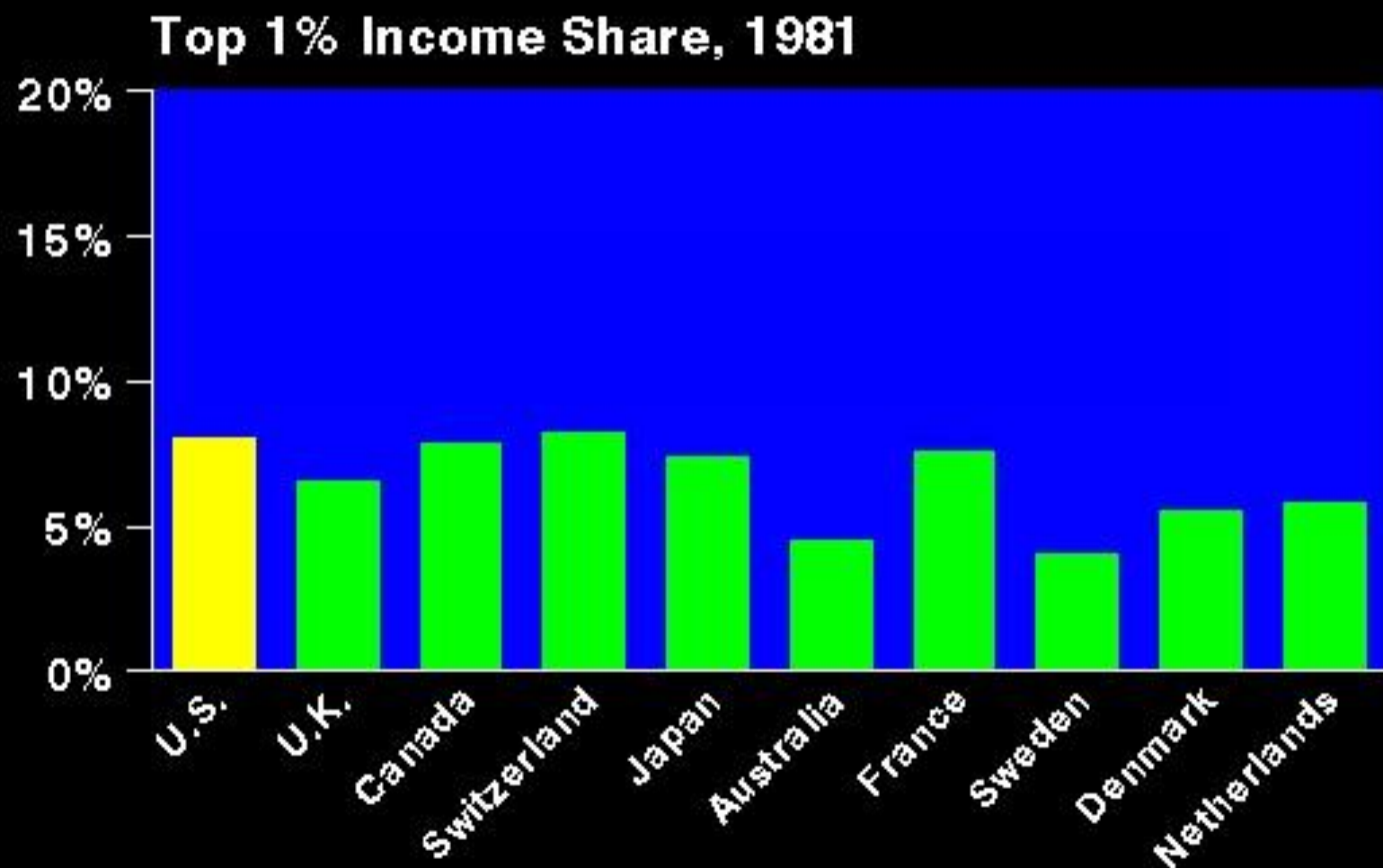
Note: Data are from nursing homes in NY State - adjusted for resident, NH & county characteristics,

Income Inequality Worst in U.S.



Source: World Inequality database - Data are for 2019 or most recent available

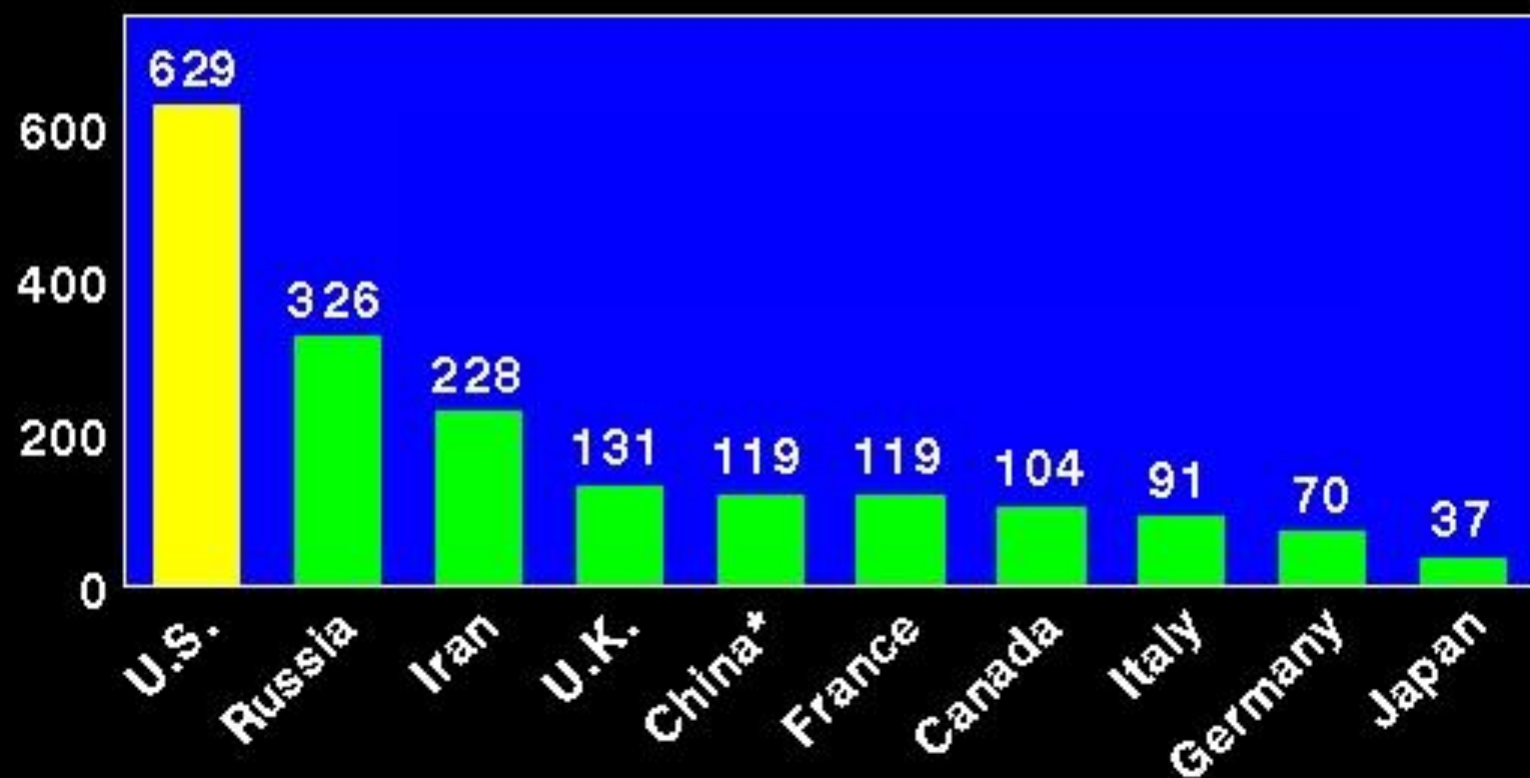
U.S. Income Inequality Was Less in 1981



Source: World Top Incomes database

Incarceration Rates

Prisoners per 100,000 population



Source: Walmsley - World Prison Population List, 13th Ed.

* Figure for China includes only sentenced prisoners

Prisoners Face Copays for Care

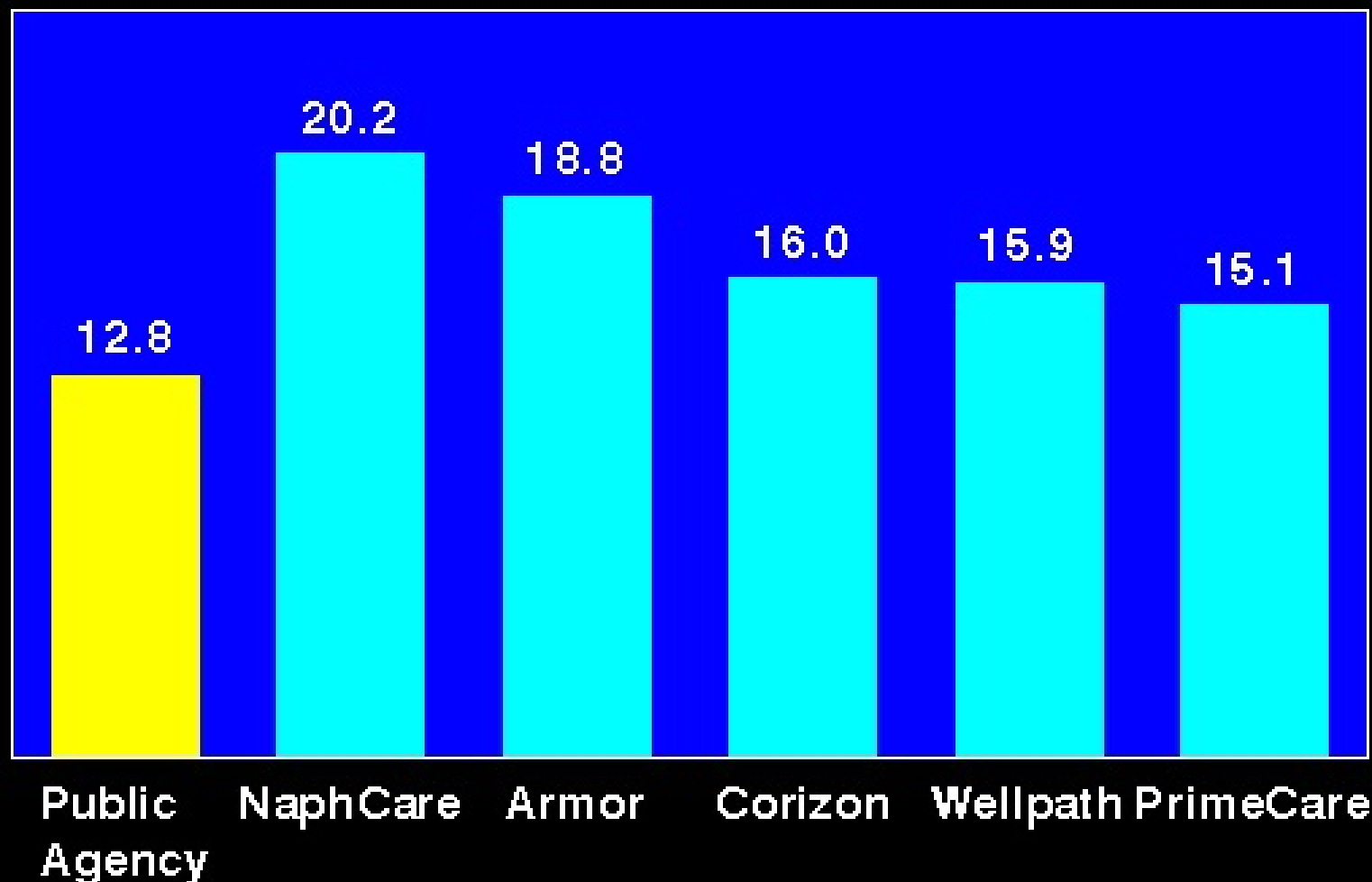
- 42 states + federal prison system charge copays for a visit.
- Average copay = \$3.47/visit.
- In Oklahoma, prisoners earning 5 cents/hr. face a \$4 copay (80 hours of work income, equivalent to \$580 for a minimum wage workers.)



Source: The Marshall Project, May 30, 2018

Outsourcing Jail Medical Care = More Deaths

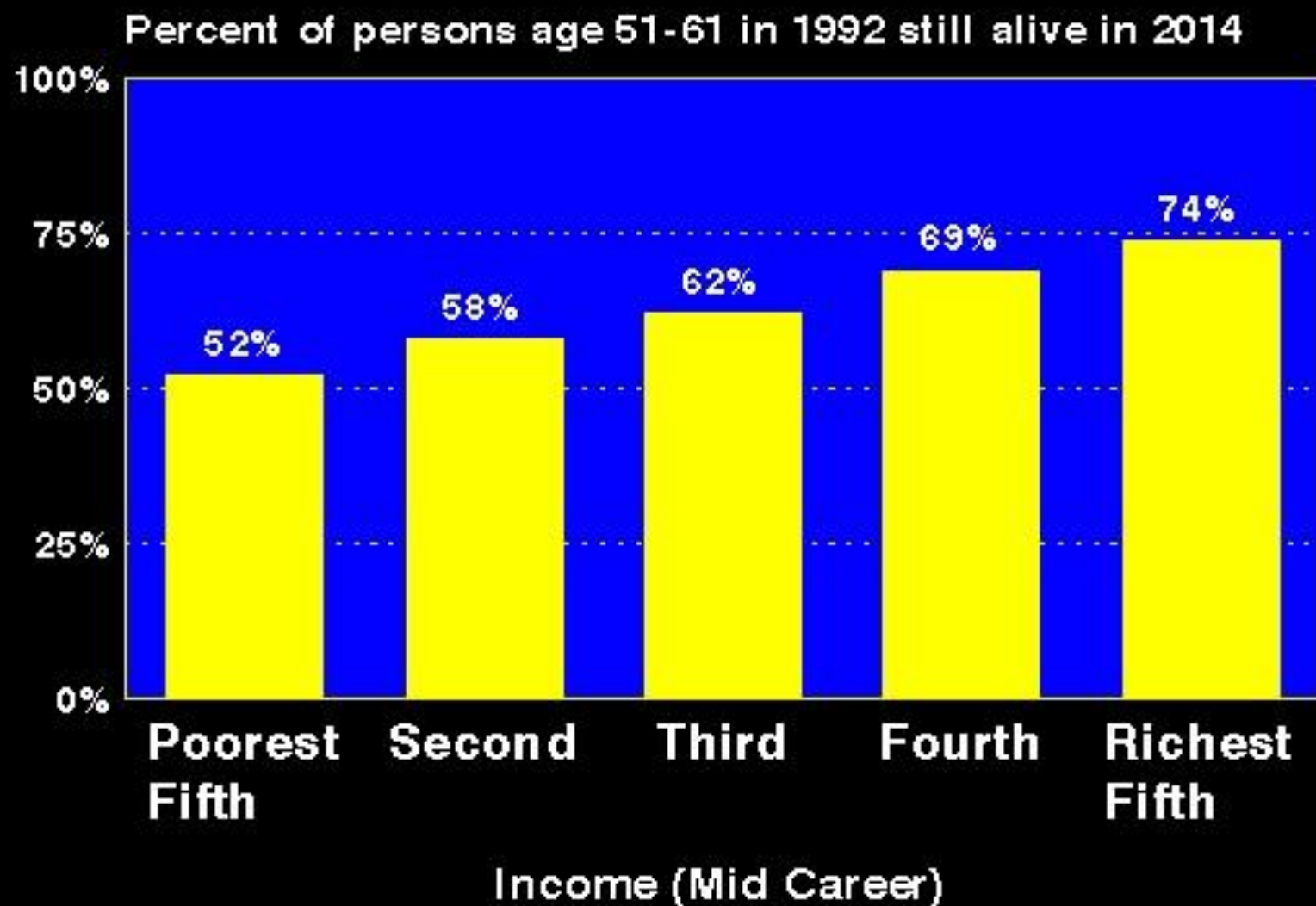
Deaths per 10,000 inmates annually



Source: Szep J. Reuters, October 26, 2020

Increasing Economic Inequality Harms Health

Lower Income, Shorter Lives



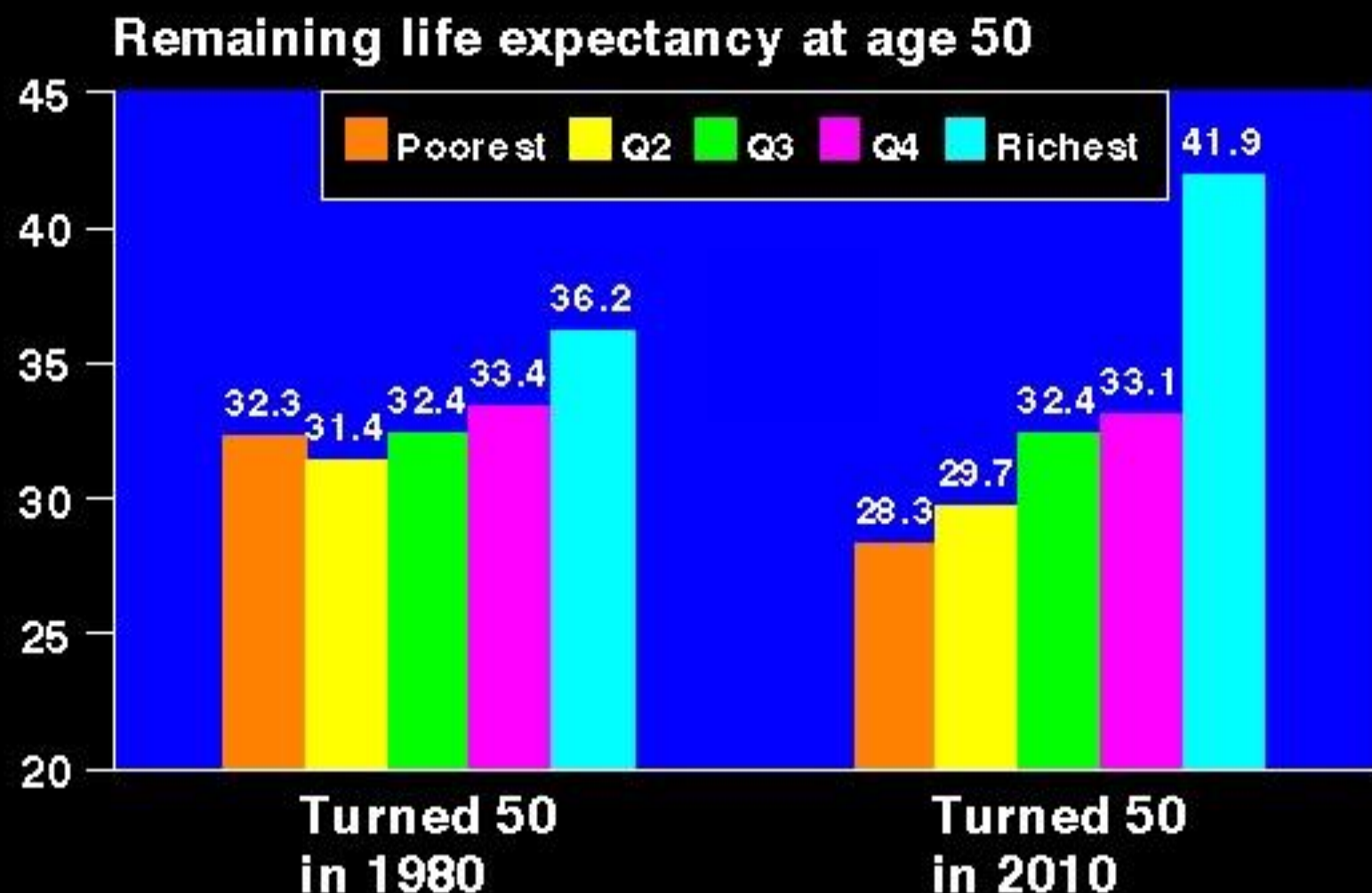
Widening Gap In Life Expectancy Between High and Low Earners

Remaining Life Expectancy for Men Turning 60



Growing Gap in Life Expectancy by Income

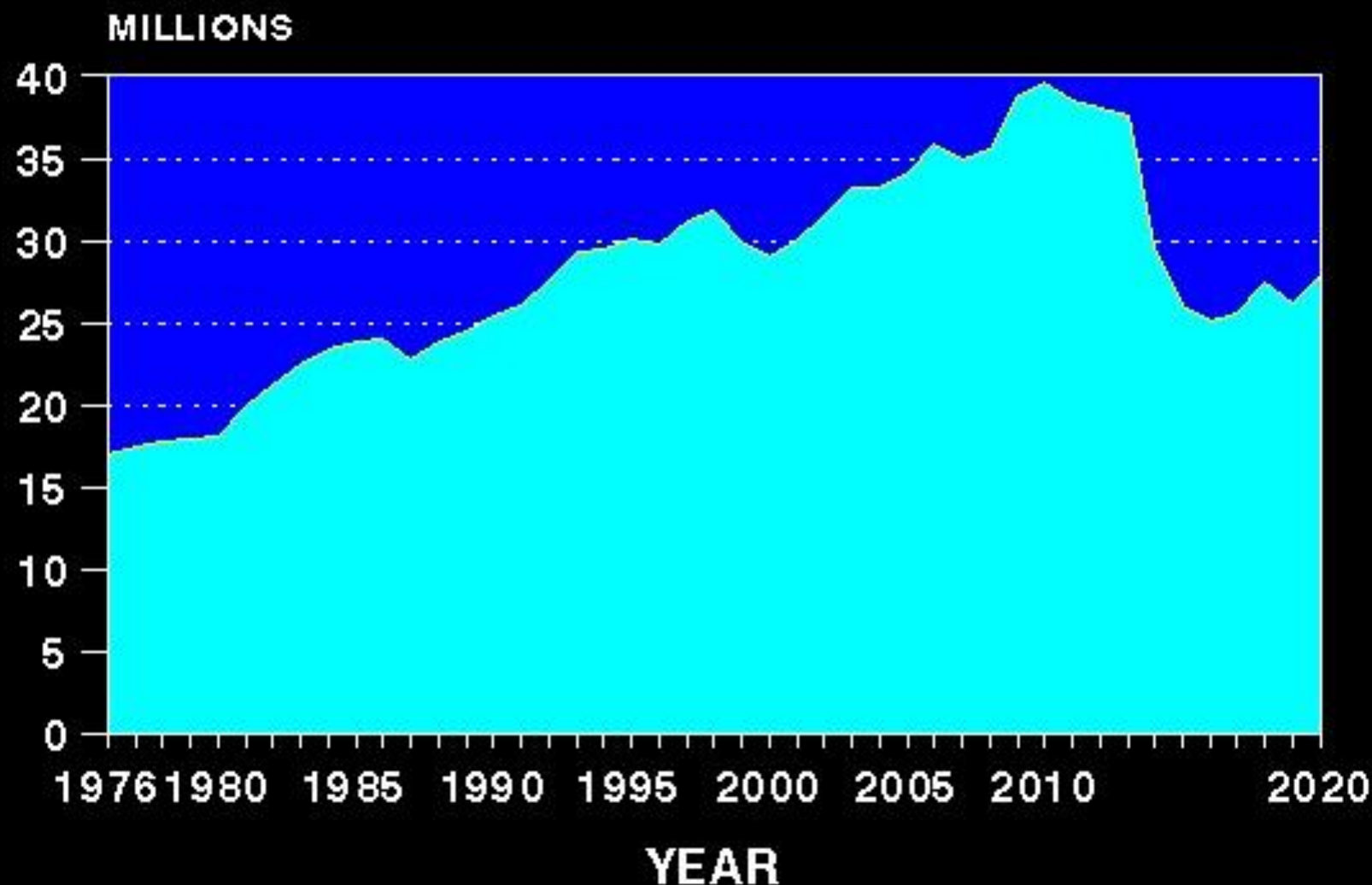
Dramatic Gains for the Wealthy, Losses for Lower Income



Source: Growing Gap in Life Expectancy by Income, National Academy of Sciences, 2015

The Uninsured

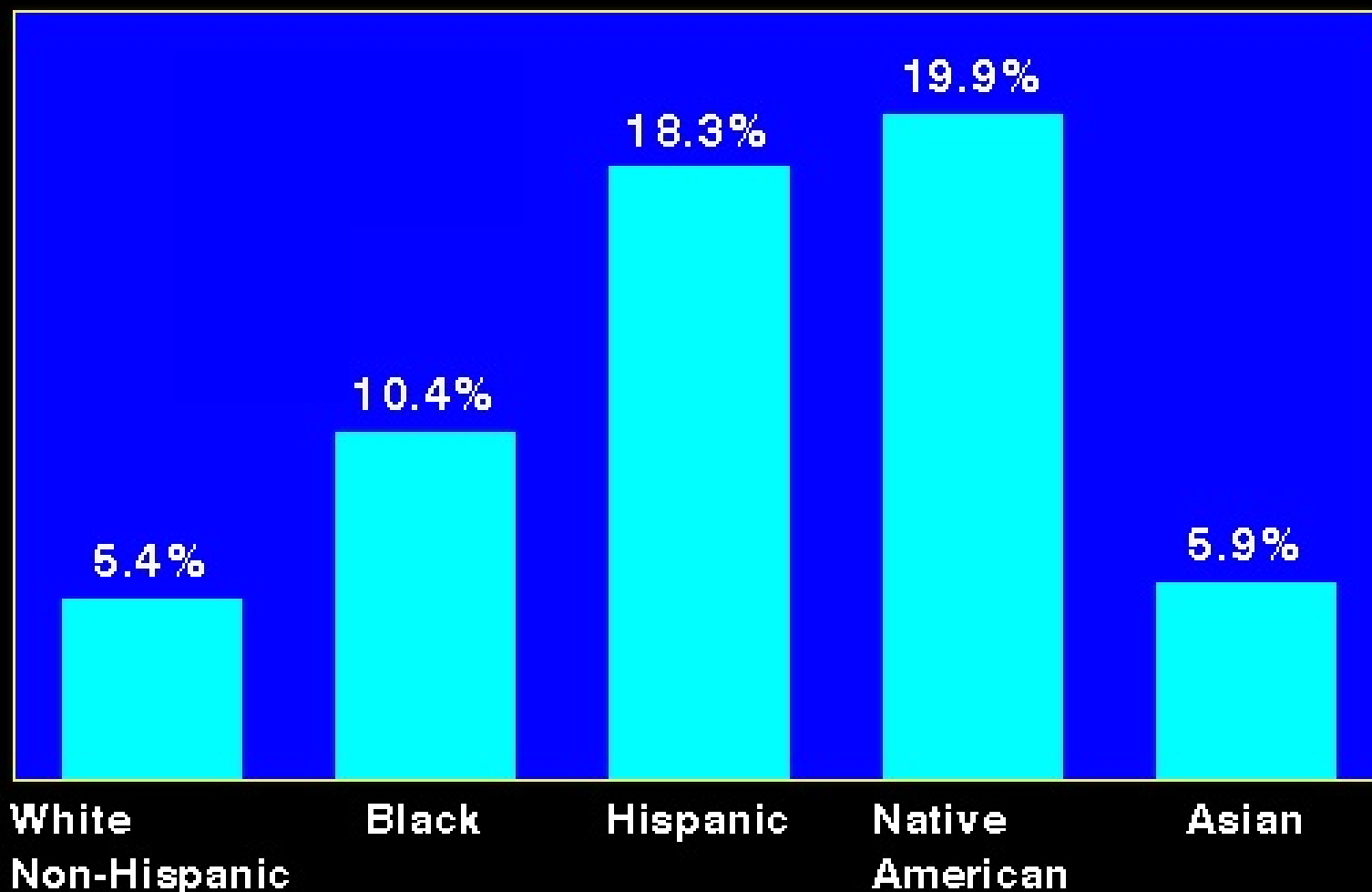
Americans Uninsured All Year, 1976-2020



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

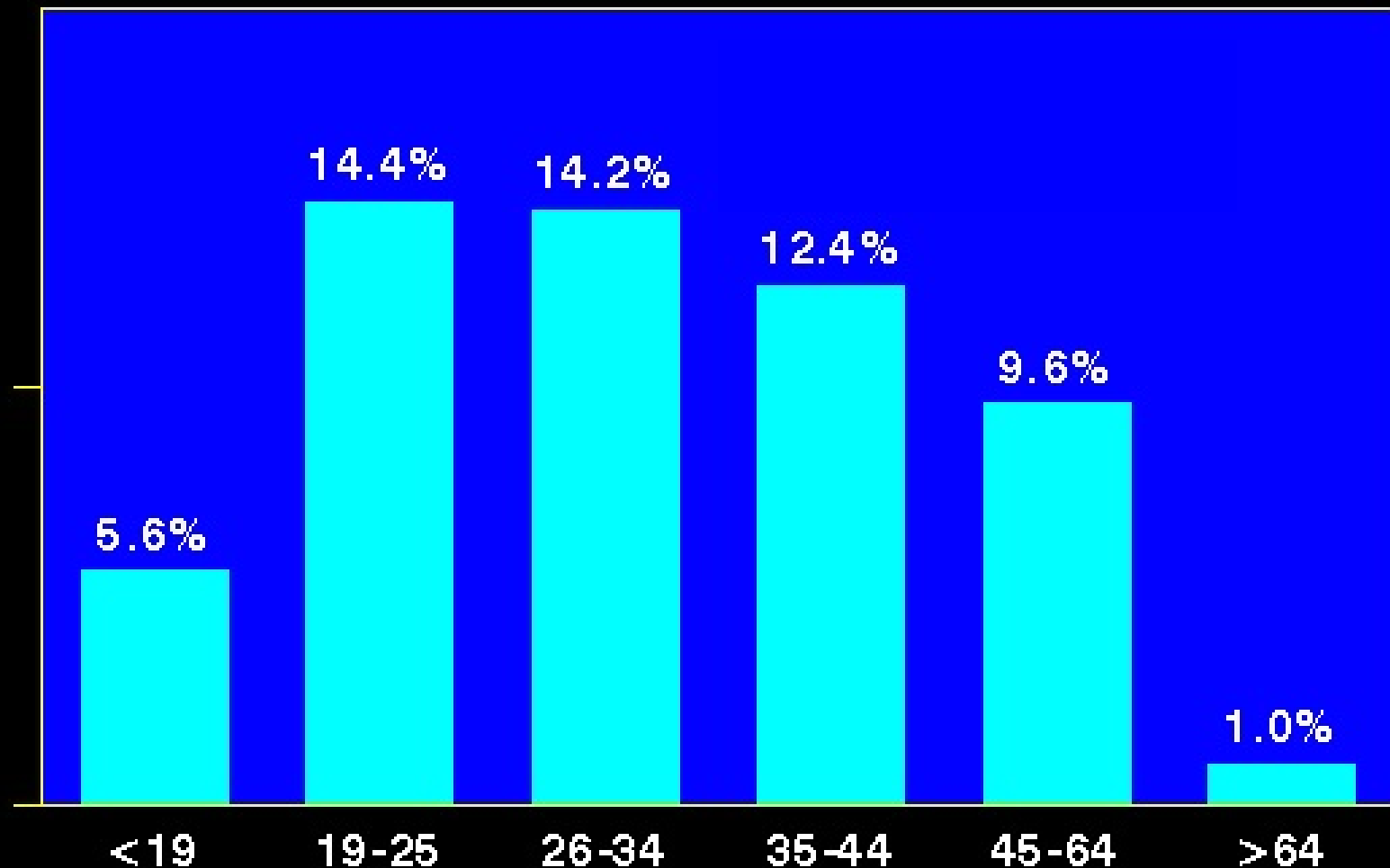
Note - At time of survey, an additional 2 to 3 million are uninsured

Percent Uninsured by Race/Ethnicity, 2020



Source: CPS (figure for Native Americans is for 2019 from ACS)

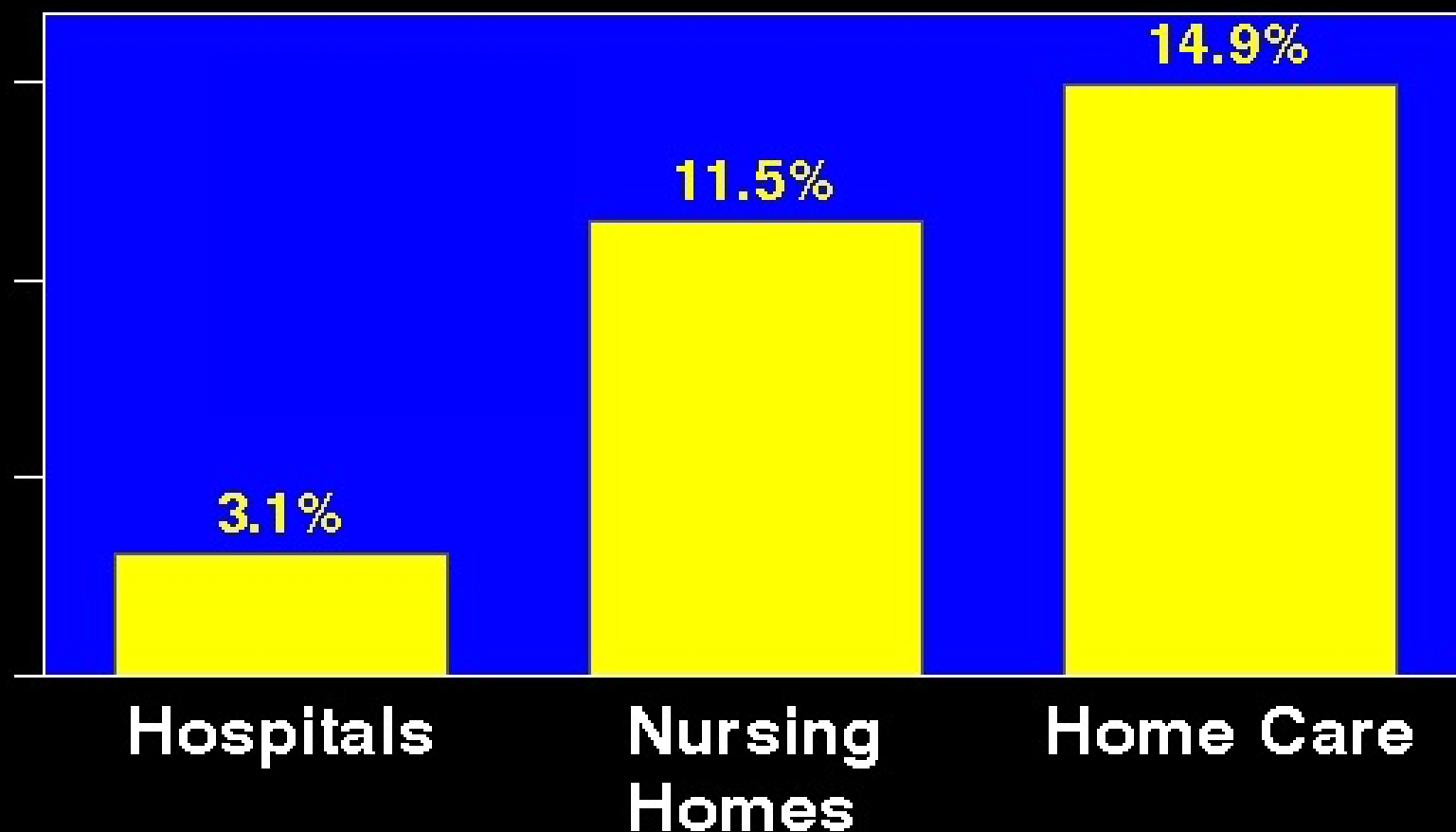
Percent Uninsured by Age Groups, 2020



Source: CPS

Many Frontline Health Workers Are Uninsured

Percent uninsured, 2019



Source: Himmelstein & Woolhandler, Analysis of data from 2019 Current Population Survey

Note: 663,000 hospital, nursing home and home care workers were uninsured

70% of New York home care agencies do not provide PPE to employees

38,531 Deaths During 2019 Due to Uninsurance

State	% Uninsured	Excess Deaths
Texas	18.4	6,804
California	7.7	3,903
Florida	13.2	3,619
Georgia	13.4	1,817
Noth Carolina	13.4	1,504
New York	5.2	1,309
U.S.	9.2%	38,531

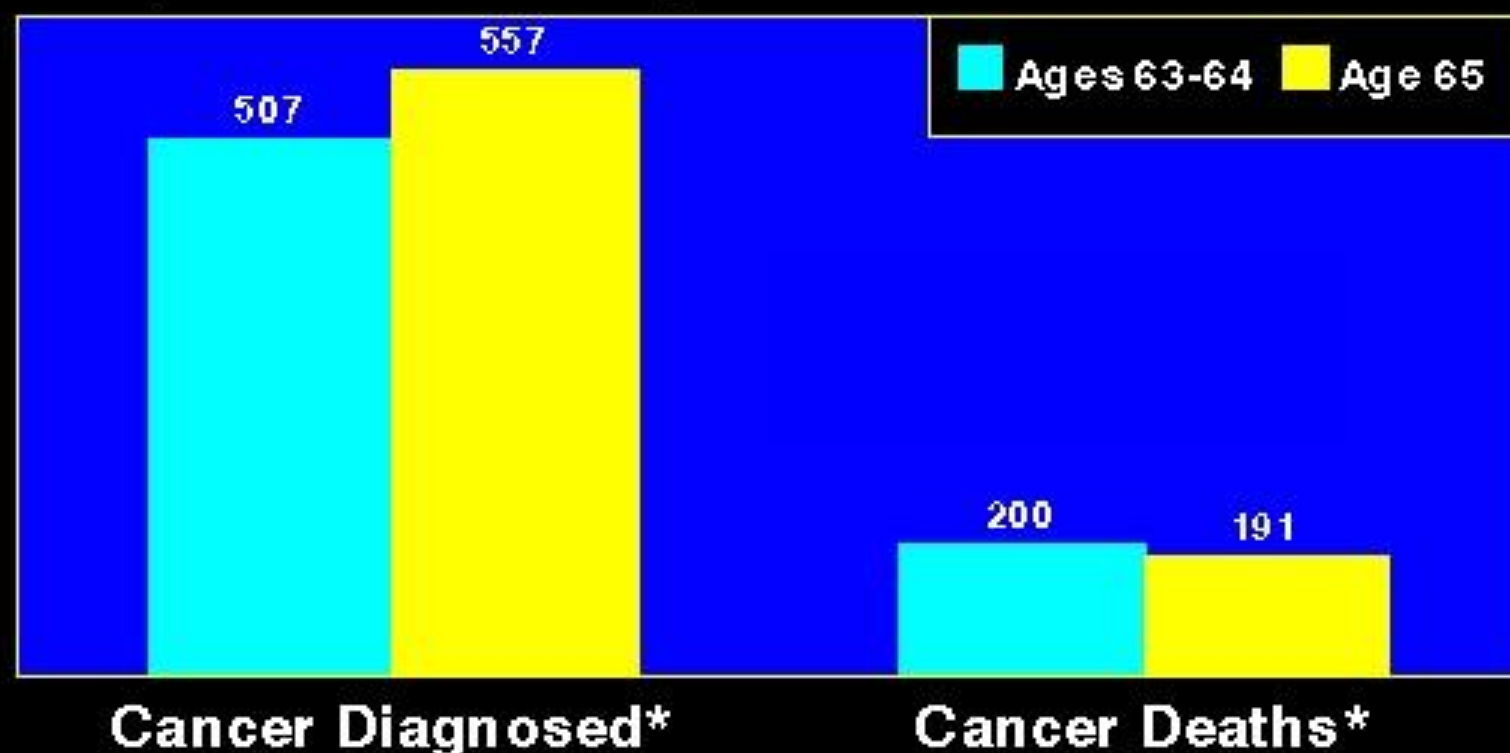
Source: Woolhandler & Himmelstein, Ann Int Med 2017;167:424 - Based on 2019 ACS

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

Medicare Coverage Improves Cancer Detection and Outcomes

Diagnoses Rise, Deaths Fall at Age 65

Rate per 100,000 women/year

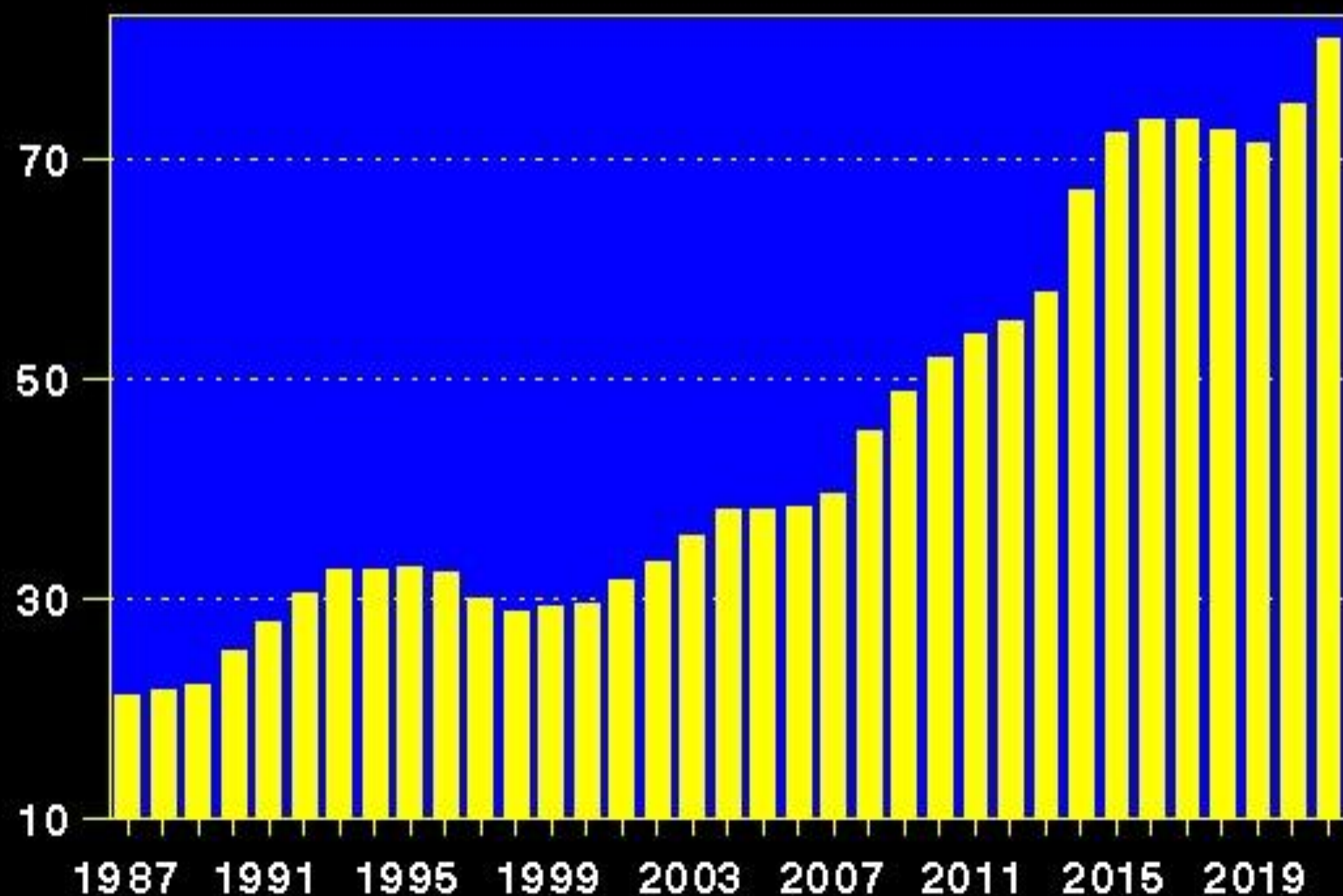


Source: NBER Working Paper 26292, September, 2019

* Breast, colorectal or lung cancer

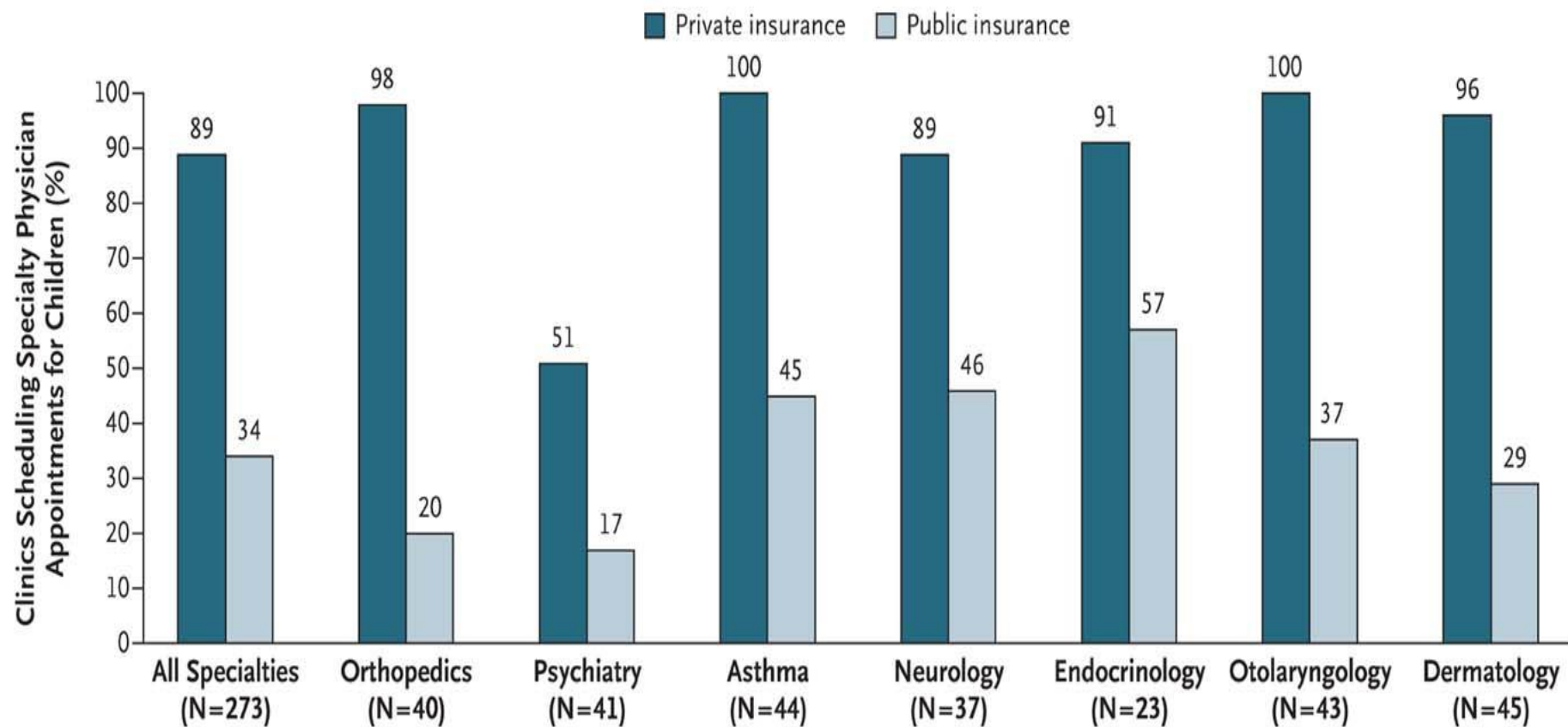
**Medicaid:
Poor Access, But
Better Than Nothing**

Medicaid Enrollment, 1987-2021



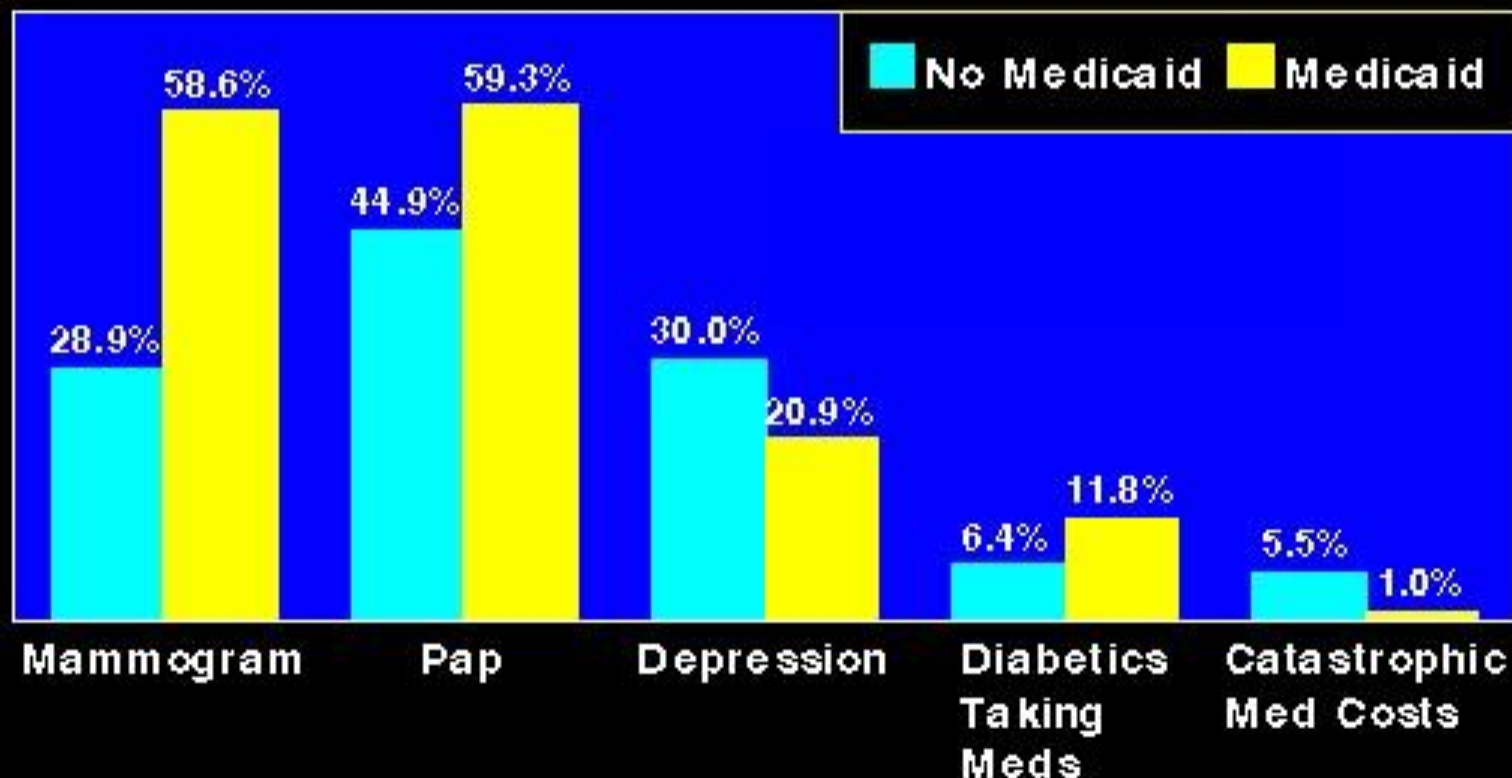
Source: Kaiser Foundation - Figures are for mid year

Many Specialists Won't See Kids With Medicaid



Medicaid Helps

An RCT in Oregon

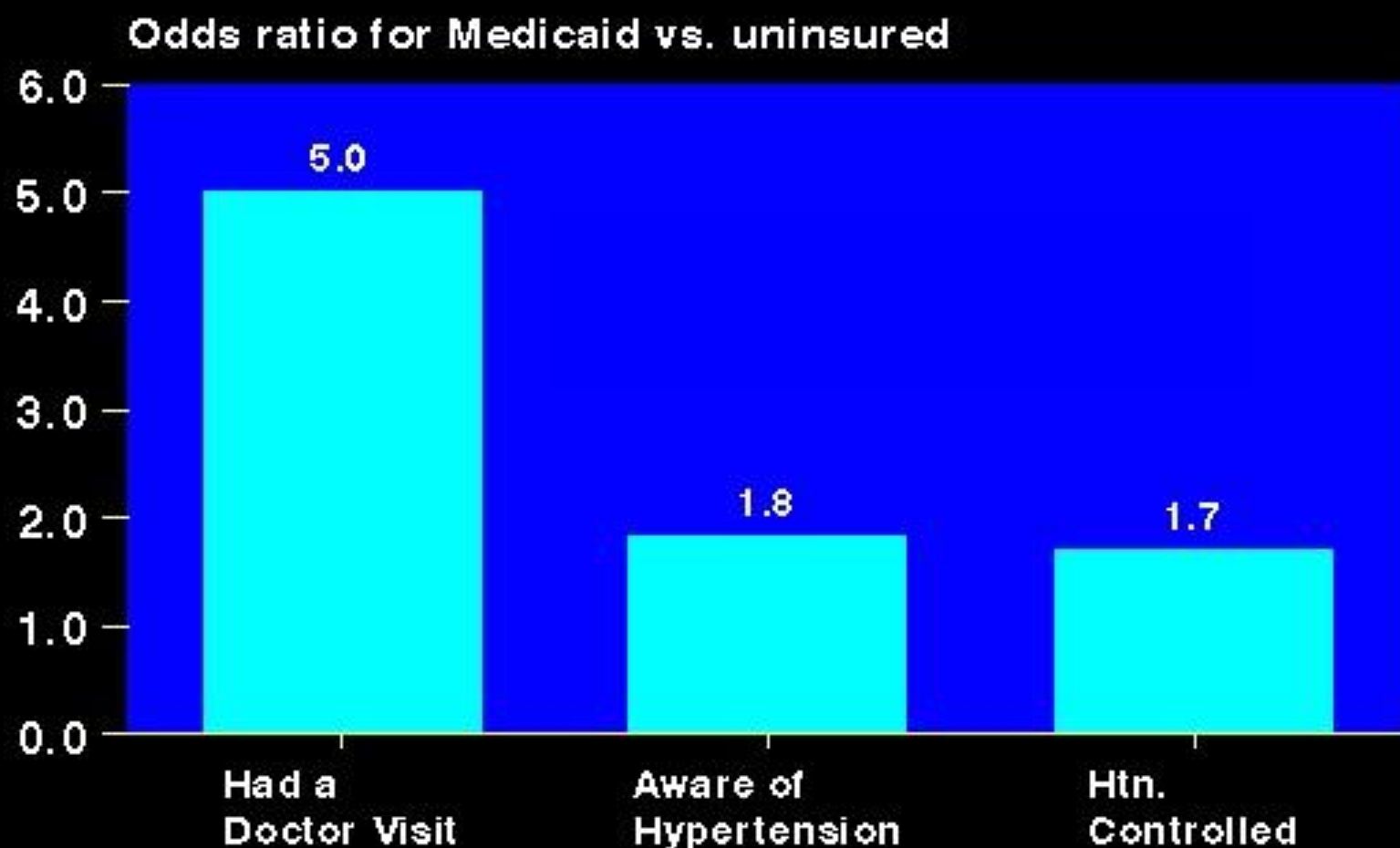


Source: NEJM May 2, 2013

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

Depression = screened positive for depression using PHQ8

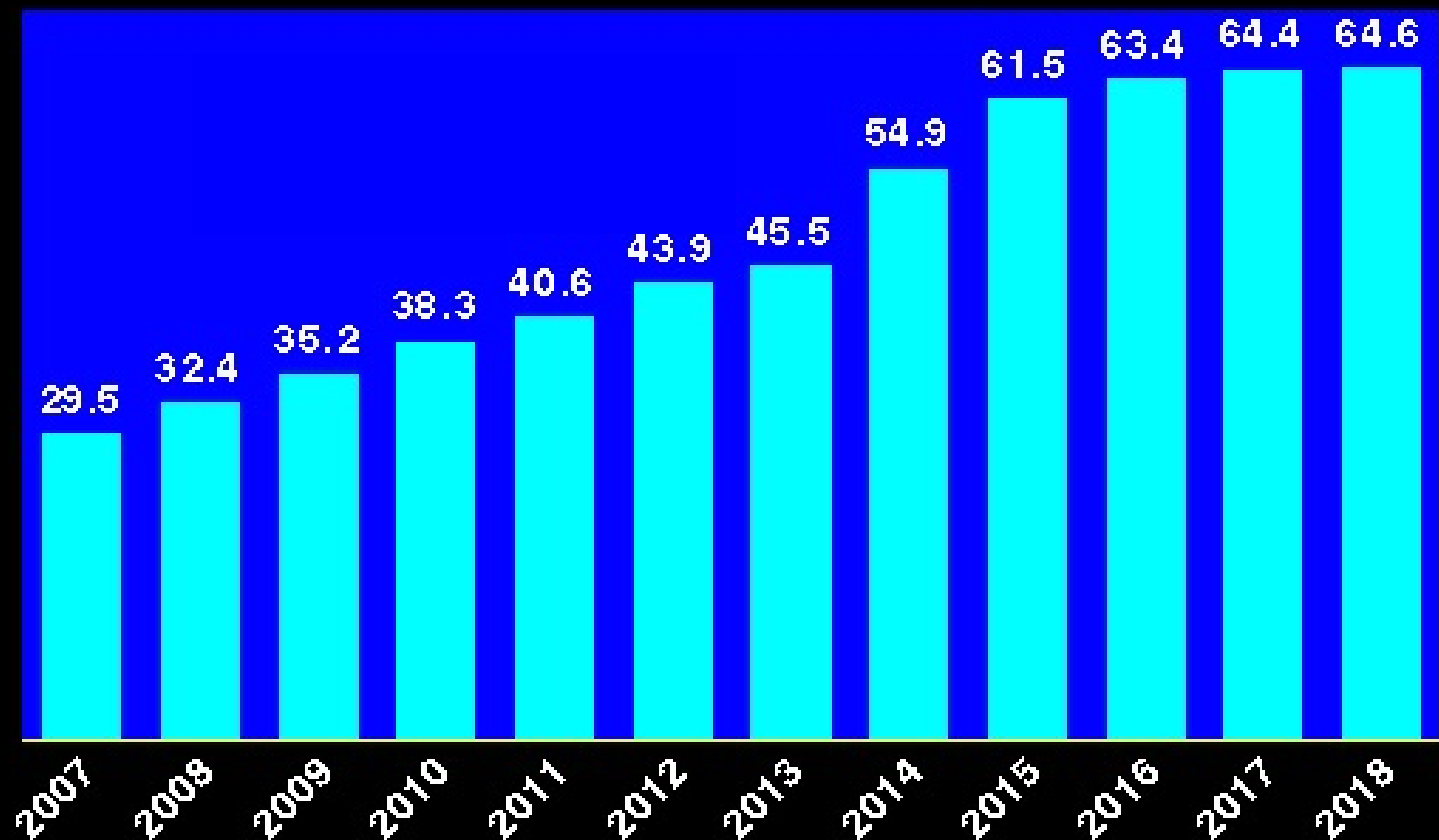
Medicaid Improved Access & Hypertension Control for the Poor



Source: Christopher, Wilper, Himmelstein, Woolhandler, McCormick - AJPH 2015
Odds ratios are adjusted for sex, age, race/ethnicity, presence of chronic condition, disability

Medicaid Managed Care Enrollment Soaring

Millions of Enrollees

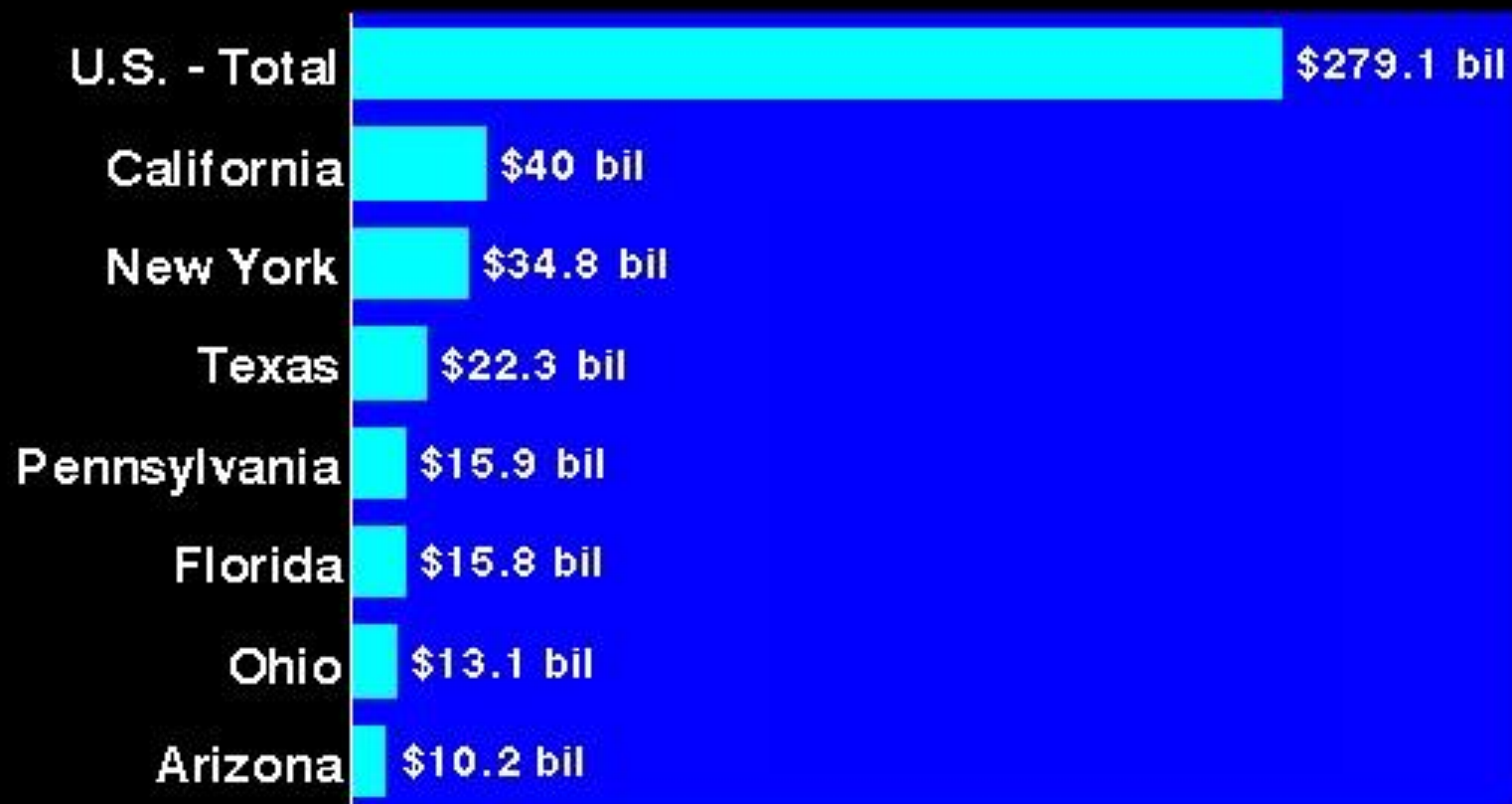


Source: **Sanofi Public Payer Digest, 2016 and 2020**

Note: Medicaid payments to mgt. care firms, 2019 = \$279.1 bil., MLR = 88.6 (overhead = \$9 bil.)

No evidence of cost savings, some evidence of worse quality

Medicaid Managed Care: A Major Revenue Source for Insurers



Medicaid Managed Care Spending, 2019

Source: Kaiser Family Foundation, 2020

Note: Per Milliman, average overhead + profit = 11.4% of revenues (~ \$32 billion)

Medicaid Managed Care Patients Can't Get Appointments

HHS OIG Survey of 1800 MDs Listed on Managed Care Rosters Finds Majority are Unavailable

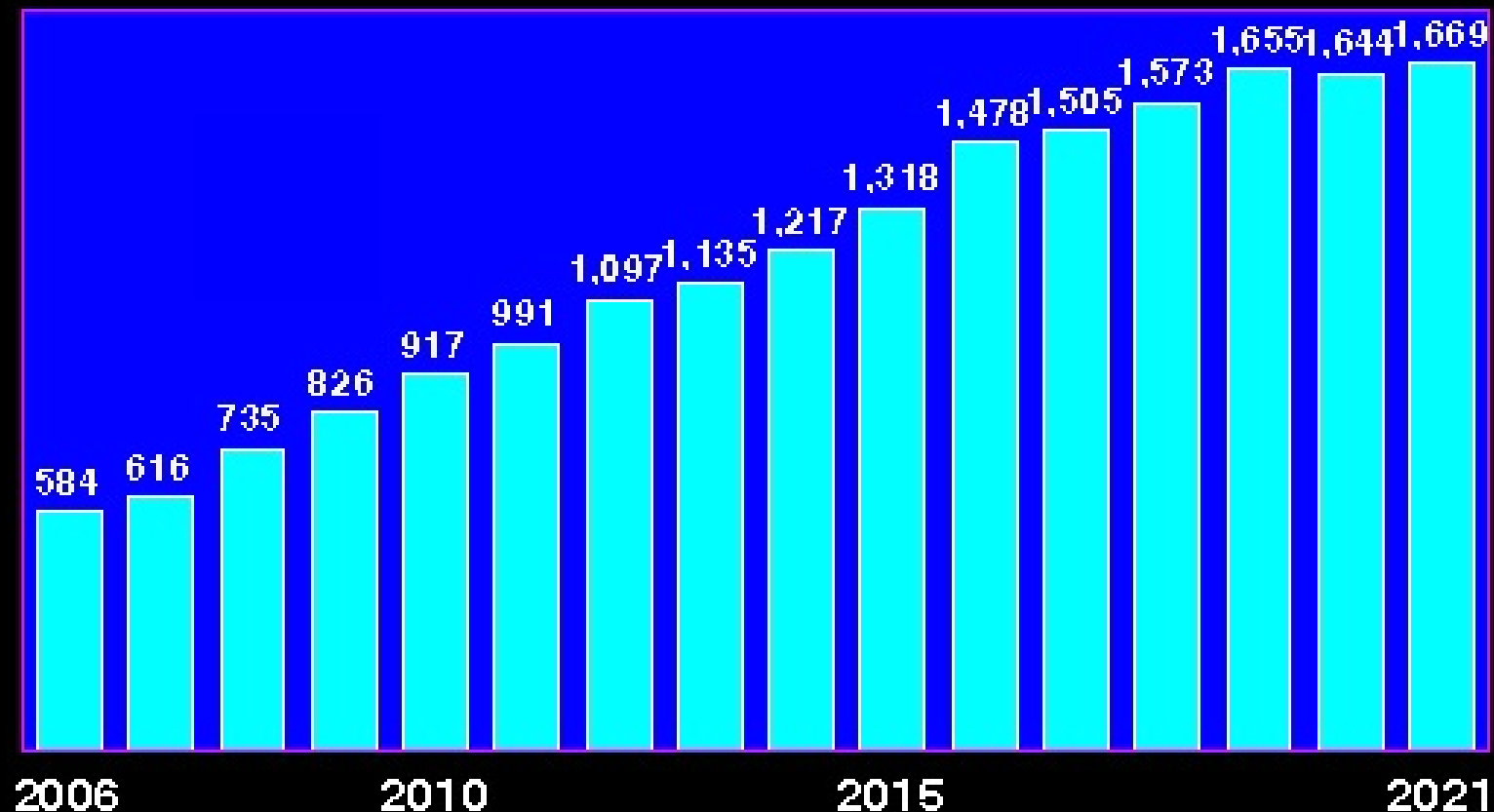


Appointment Availability

Under-Insurance

Average Deductible Rising

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

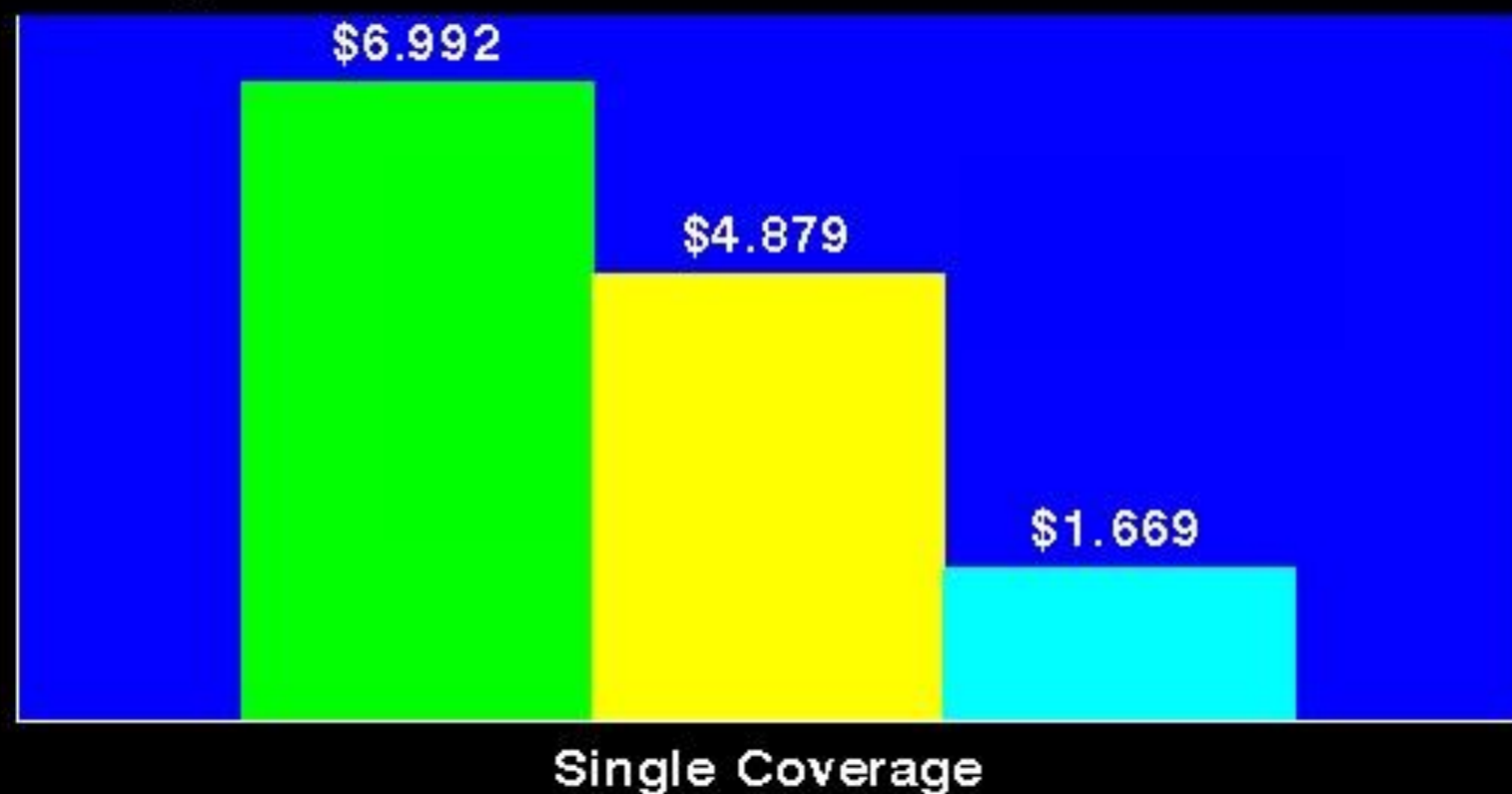


Source: Kaiser/HRET Survey of Employer-Sponsored Benefits

ACA Exchange Plans' Deductibles

Higher Than Average Job-Based Plan

Average deductible

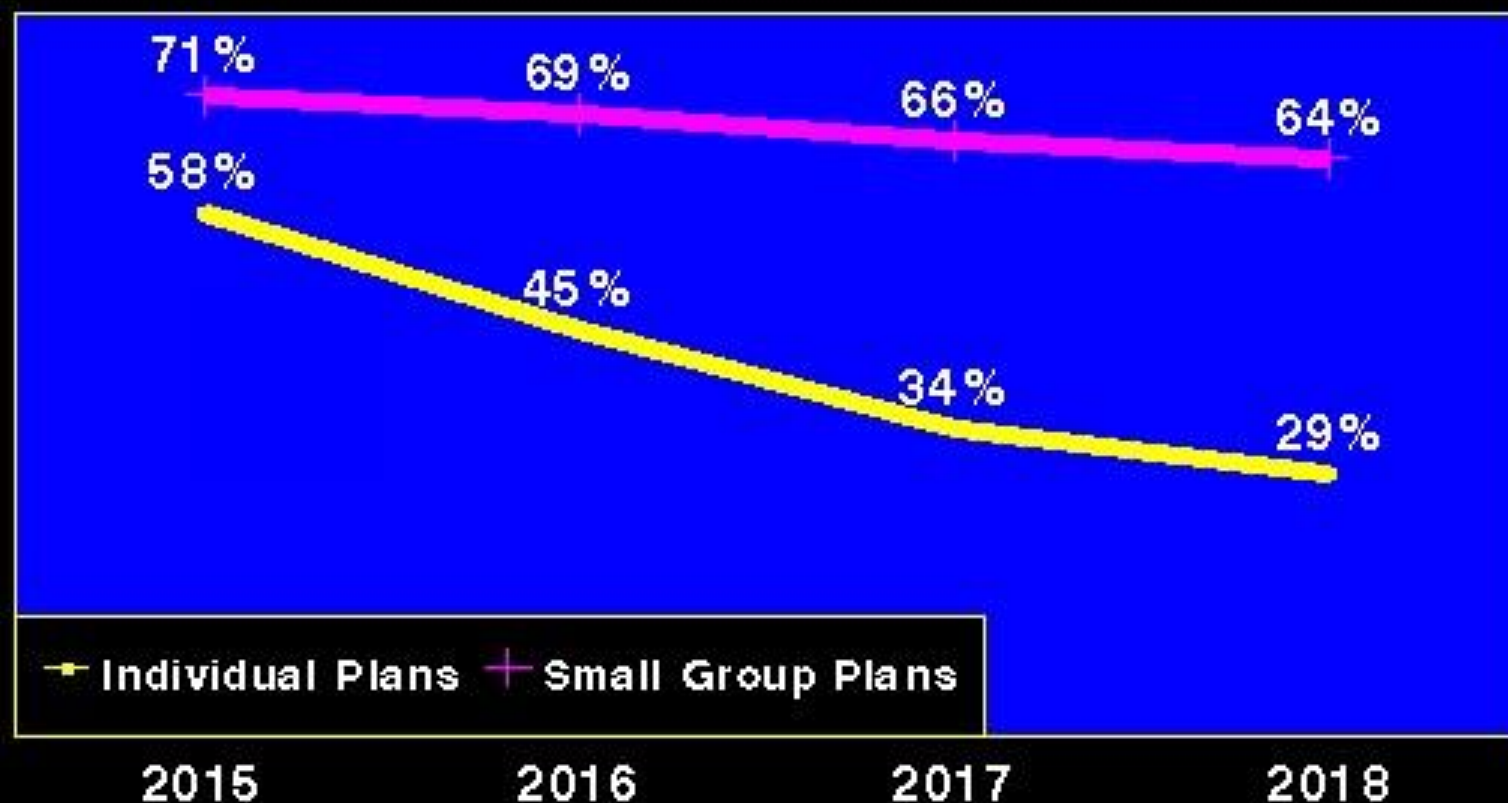


Exchange Bronze Exchange Silver Average Employer Plan

Source: KFF and Kaiser Foundation 2021 Employer Health Benefits Survey

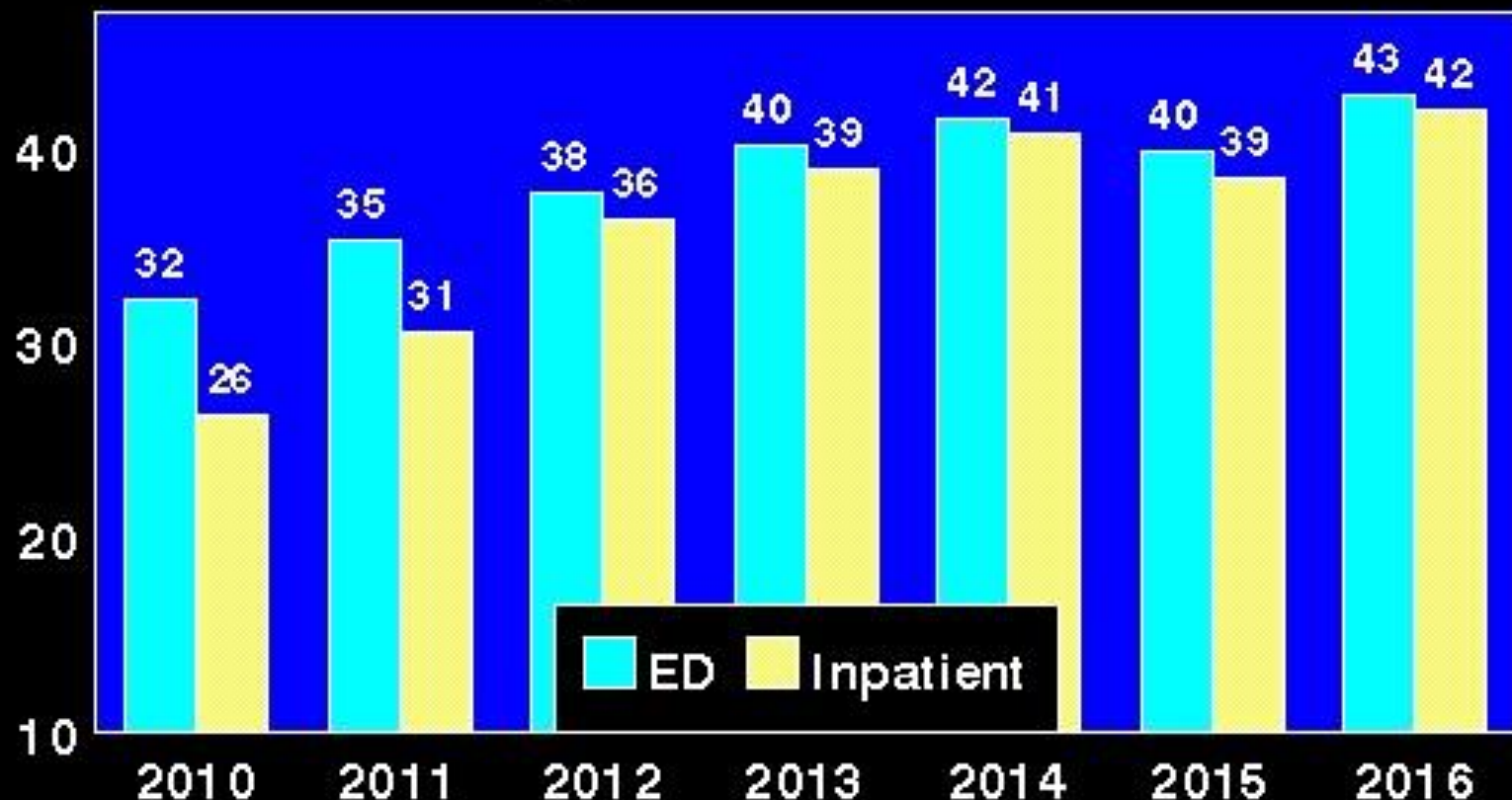
Many Plans Now Pay NOTHING for Out Of Network Care

Percent with ANY out of network benefit



Out of Network Bills Rising

Percent receiving out of network bill



Source: JAMA IM 2019;179:1543

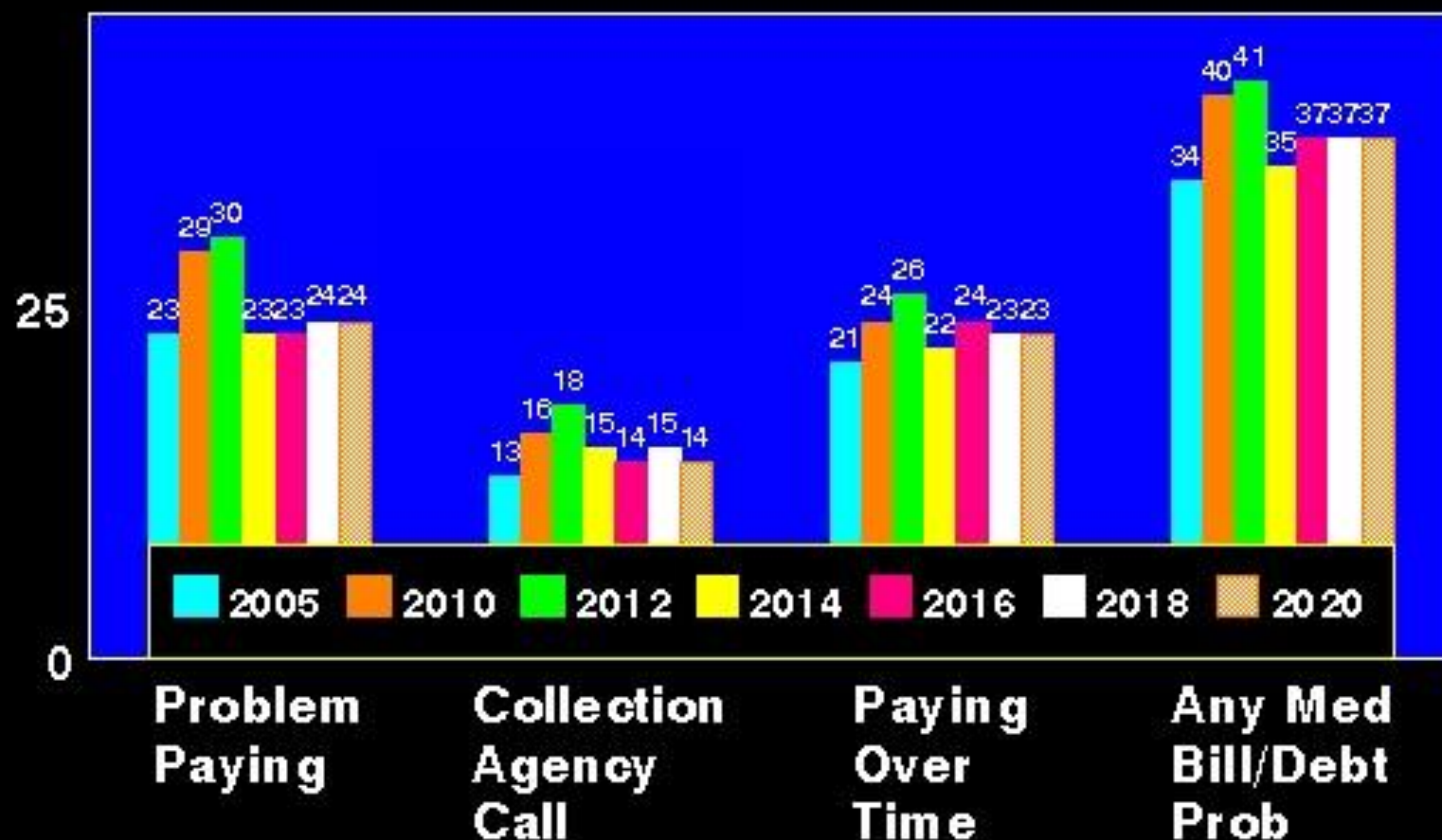
Mean out of network bill for ED care rose from \$220 to \$628

Mean out of network bill for inpatient stay rose from \$804 to \$2040

Medical Bill and Debt Problems, 2005-2020

No Better than in 2005

Percent of adults 19-64 reporting medical bill/debt problems

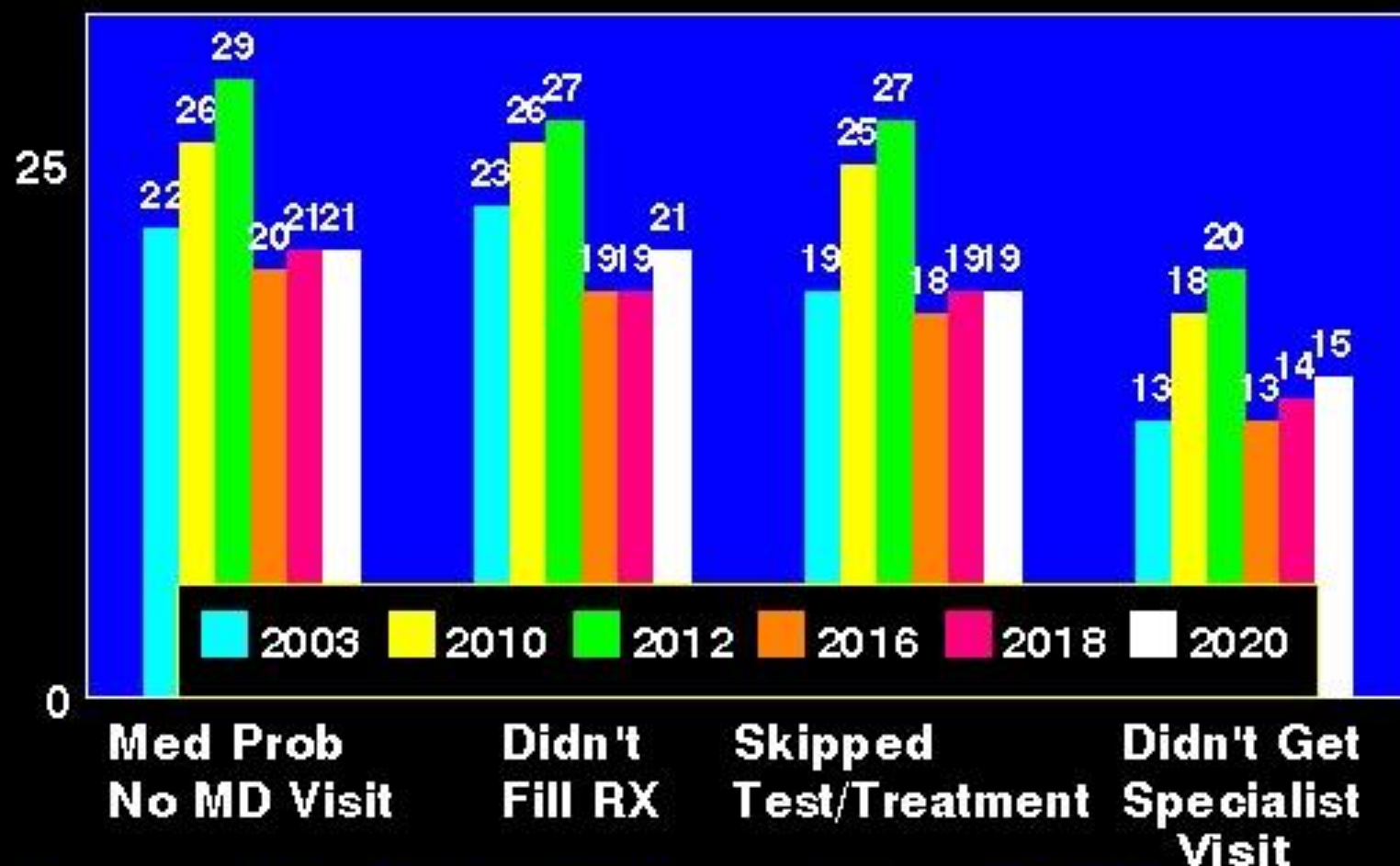


Source: Commonwealth Fund Biennial Health Insurance Surveys 2005, 2010, 2012, 2014, 2016, 2018

Access to Care Problems, 2003-2020

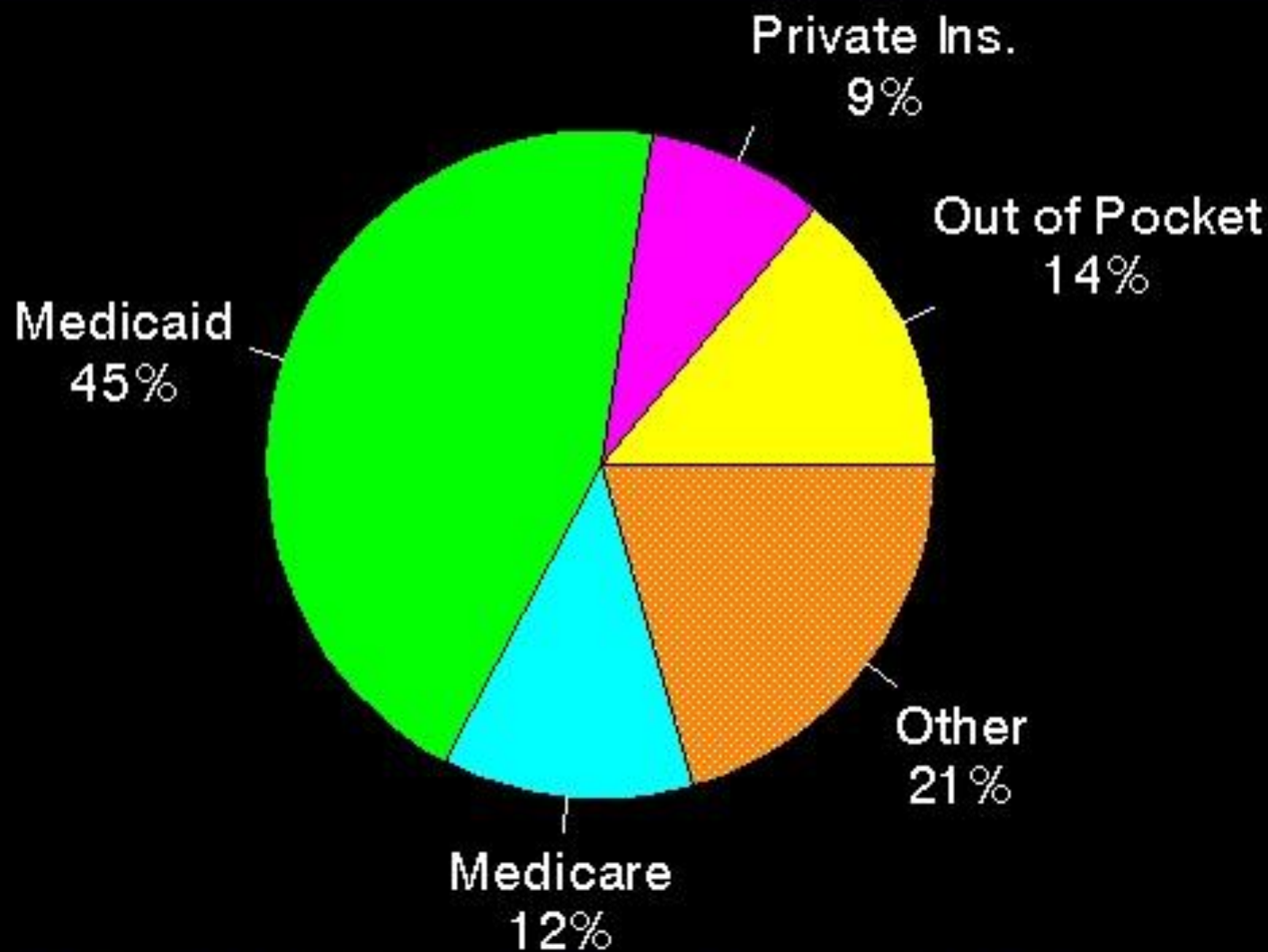
Little Progress Since 2003

Percent of adults 19-64 reporting access problems



Source: Commonwealth Fund Biennial Health Insurance Surveys 2003-2020

Who Pays for Long Term Care?



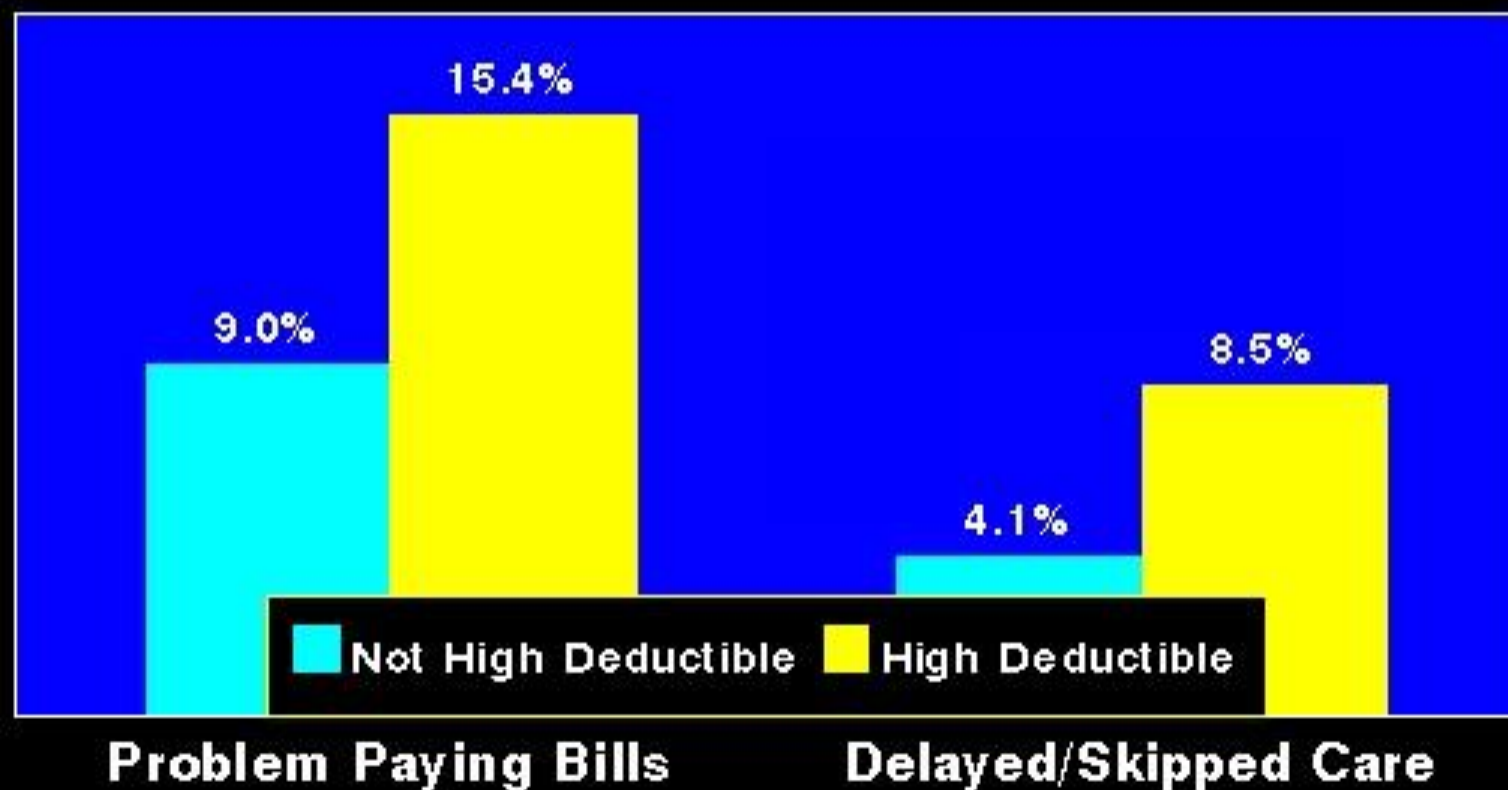
Source: NCHS - National Health Expenditure Accounts - Data are for 2021

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

Under-Insurance
Impedes Care,
Worsens Health

High Deductible Coverage (HDHP) Compromises Finances and Access

Percent of adults 18-64



Source: Cohen & Zammiti, NCHS, June, 2017 - Based on 2016 NHIS data

Note: Of people with job-based coverage, 26.9% had HDHP in 2011, rising to 39.6% in 2016

Note: HDHP = >\$1200/\$2400 single/family deductible in 2011, \$1300/\$2600 in 2016

Many Families Lack Assets to Pay High Deductibles

Median Financial Assets (Thousands)



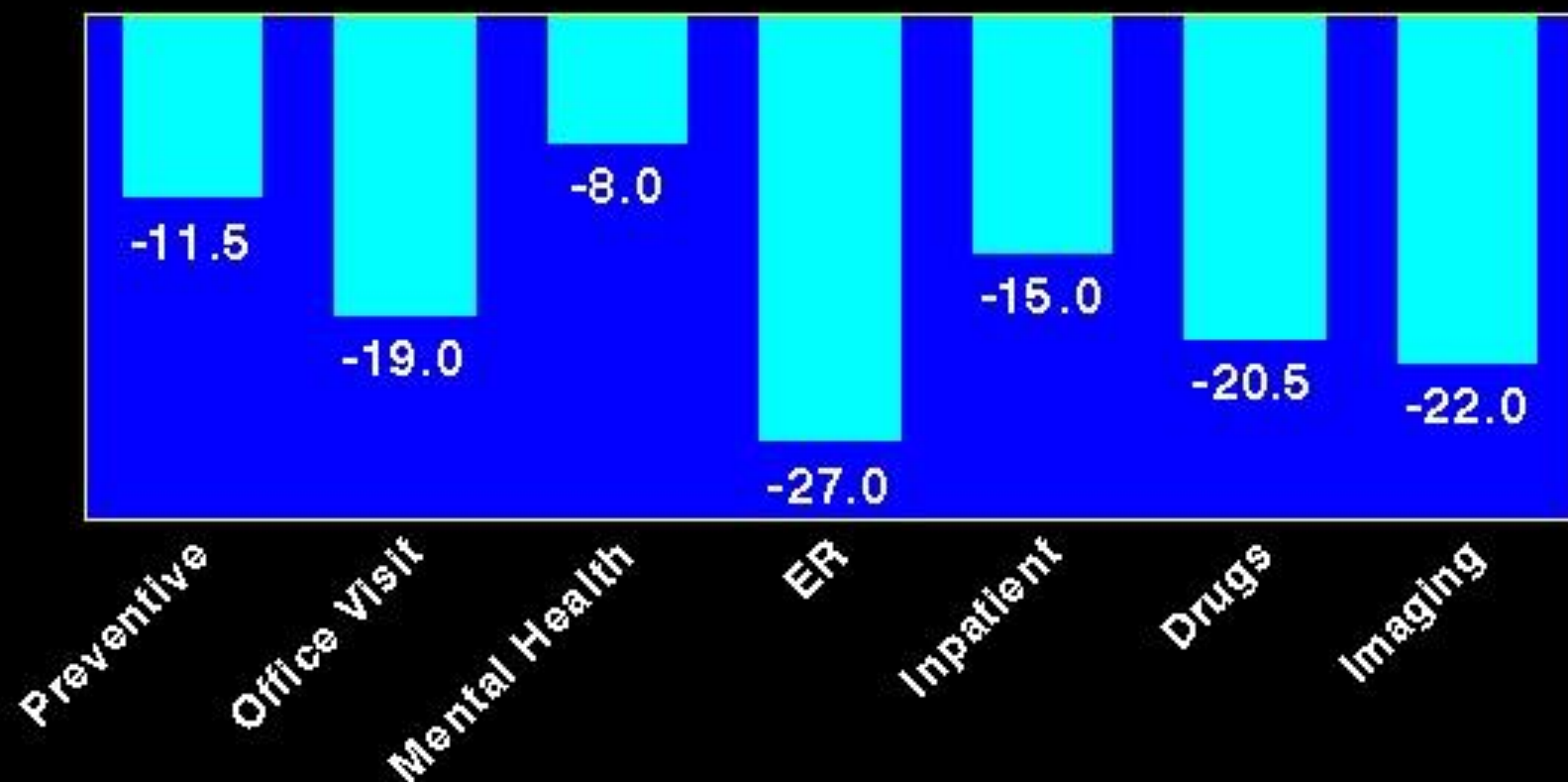
Source: Federal Reserve Survey of Consumer Finance 2019

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>

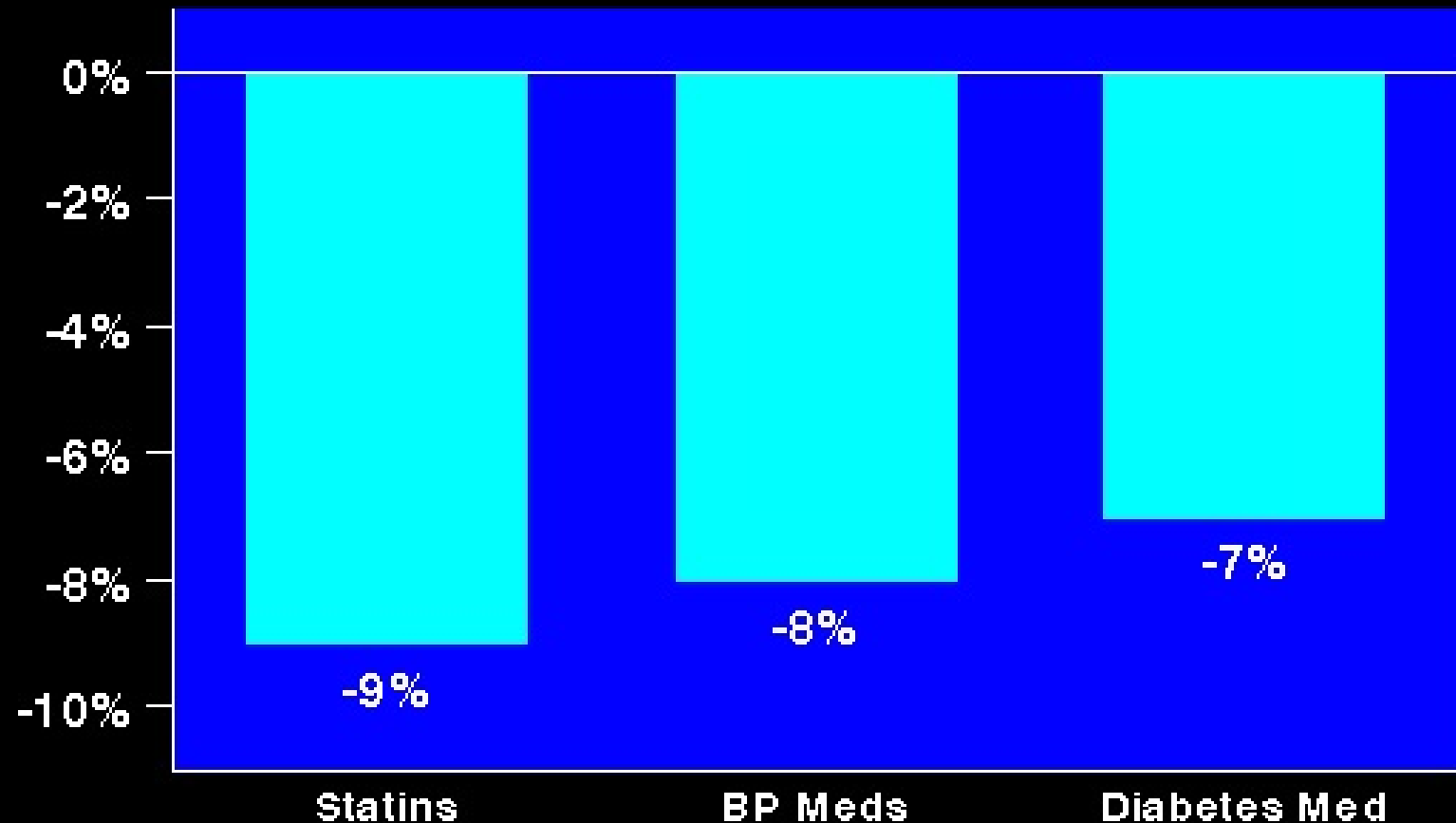
Note: Findings closely resemble those of Rand Health Insurance Experiment

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

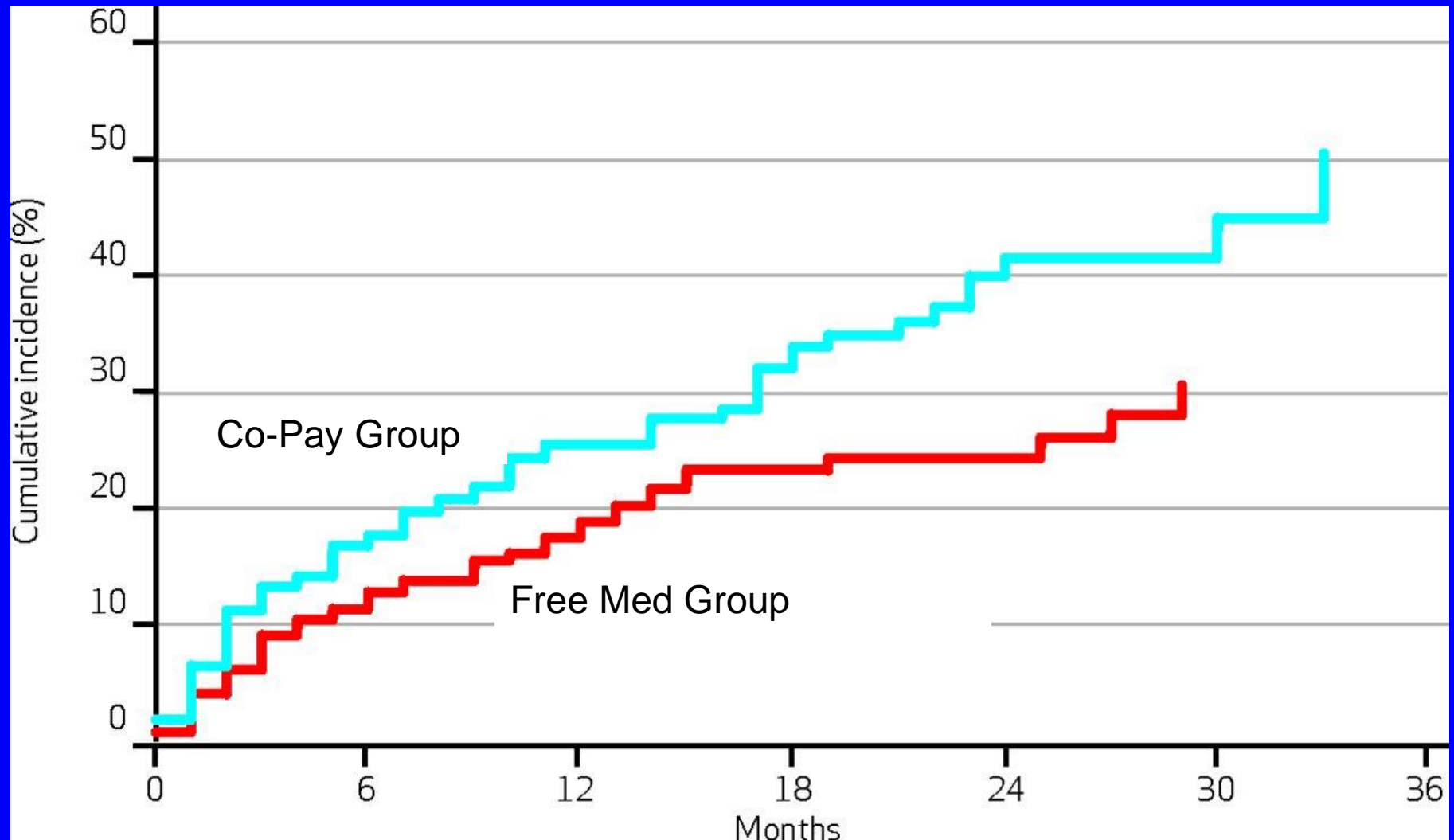
Drug Deductible Reduced Needed Medication Use

Comparison at Firms That Added vs. Didn't Add Drug Deductible

Percent Change in Days of Medication Use After Drug Deductible Implemented



Medication Co-pays Increased Post-MI Vascular Events in Minorities – An RCT

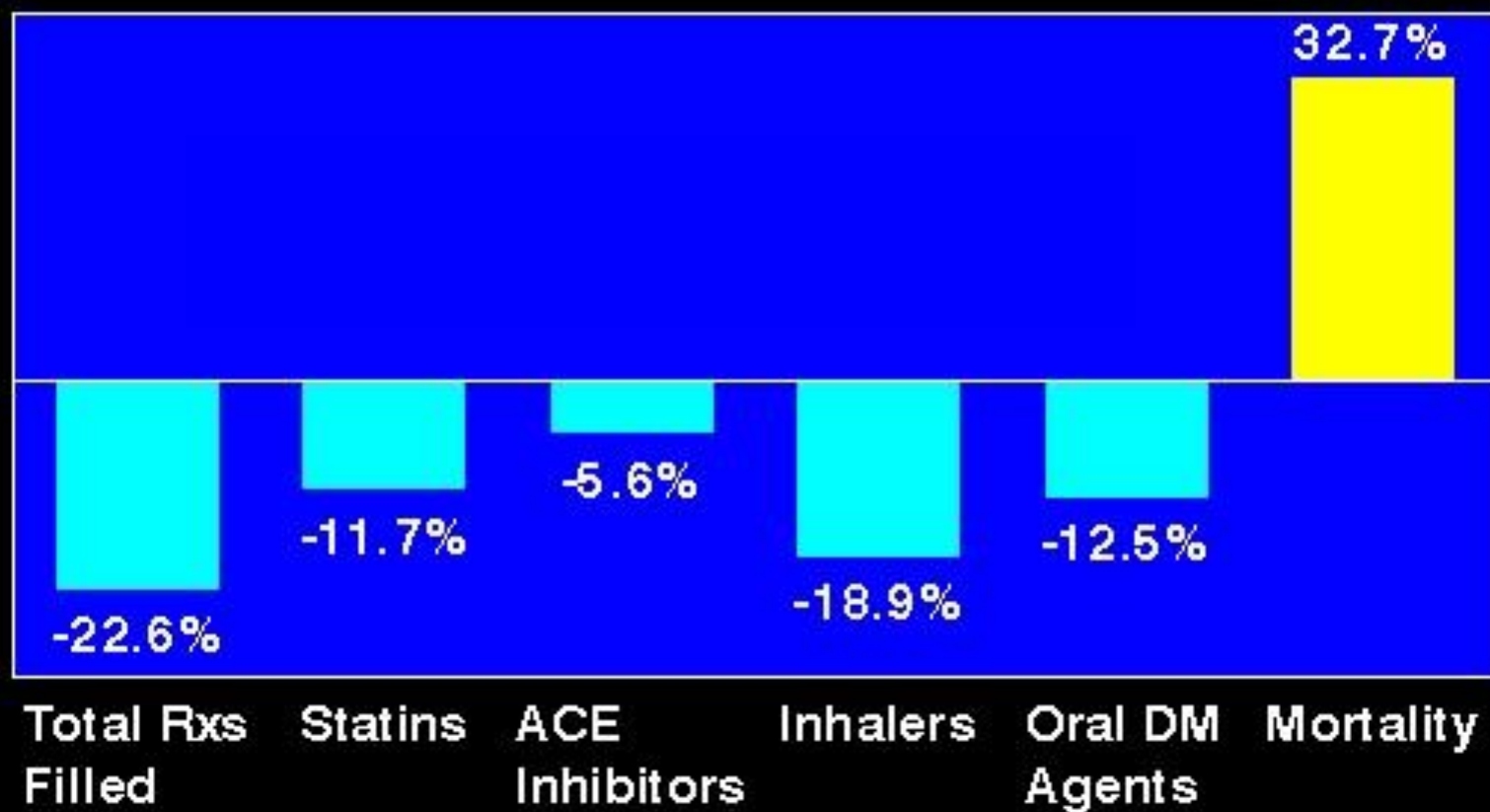


Source: Health Aff 2014;33:863

Drug Copayments Kill

Quasi-Experimental Analysis of Medicare Part D Copays

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

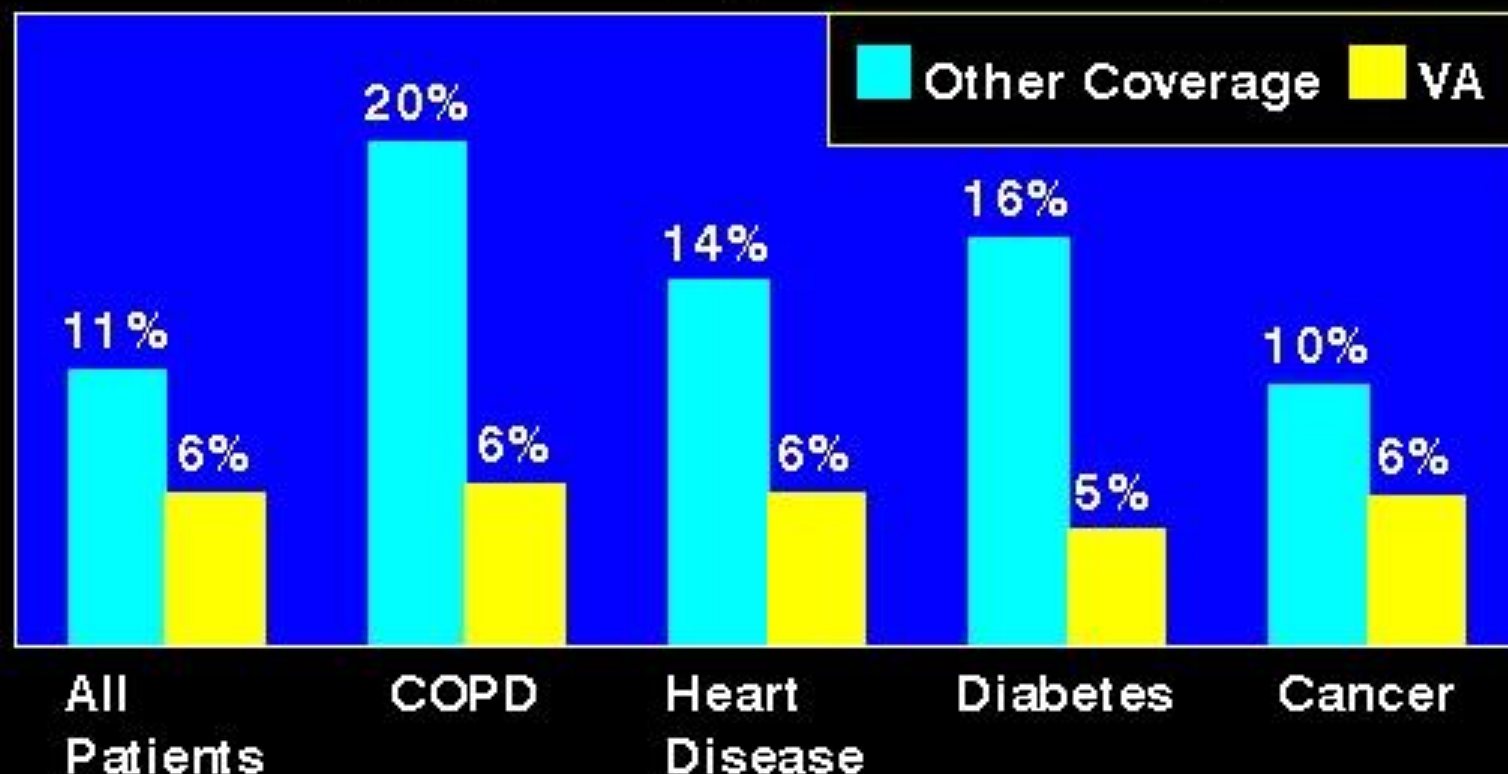


Source: "The Health Costs of Cost Sharing) NBER #28439, February, 2021

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

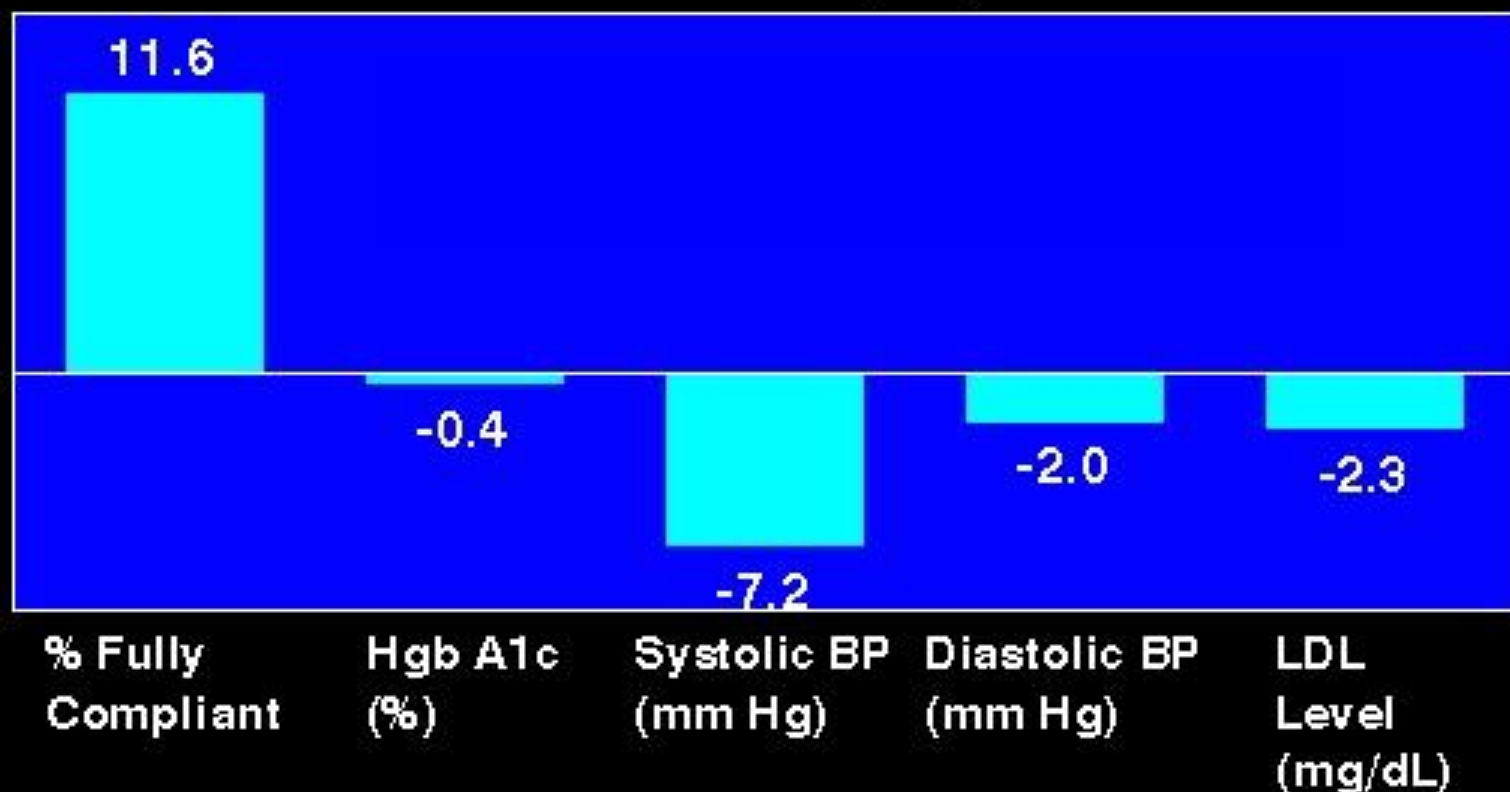
VA Drug Coverage Cuts Cost-related Non-Adherence

Percent skipping/delaying meds to save \$s



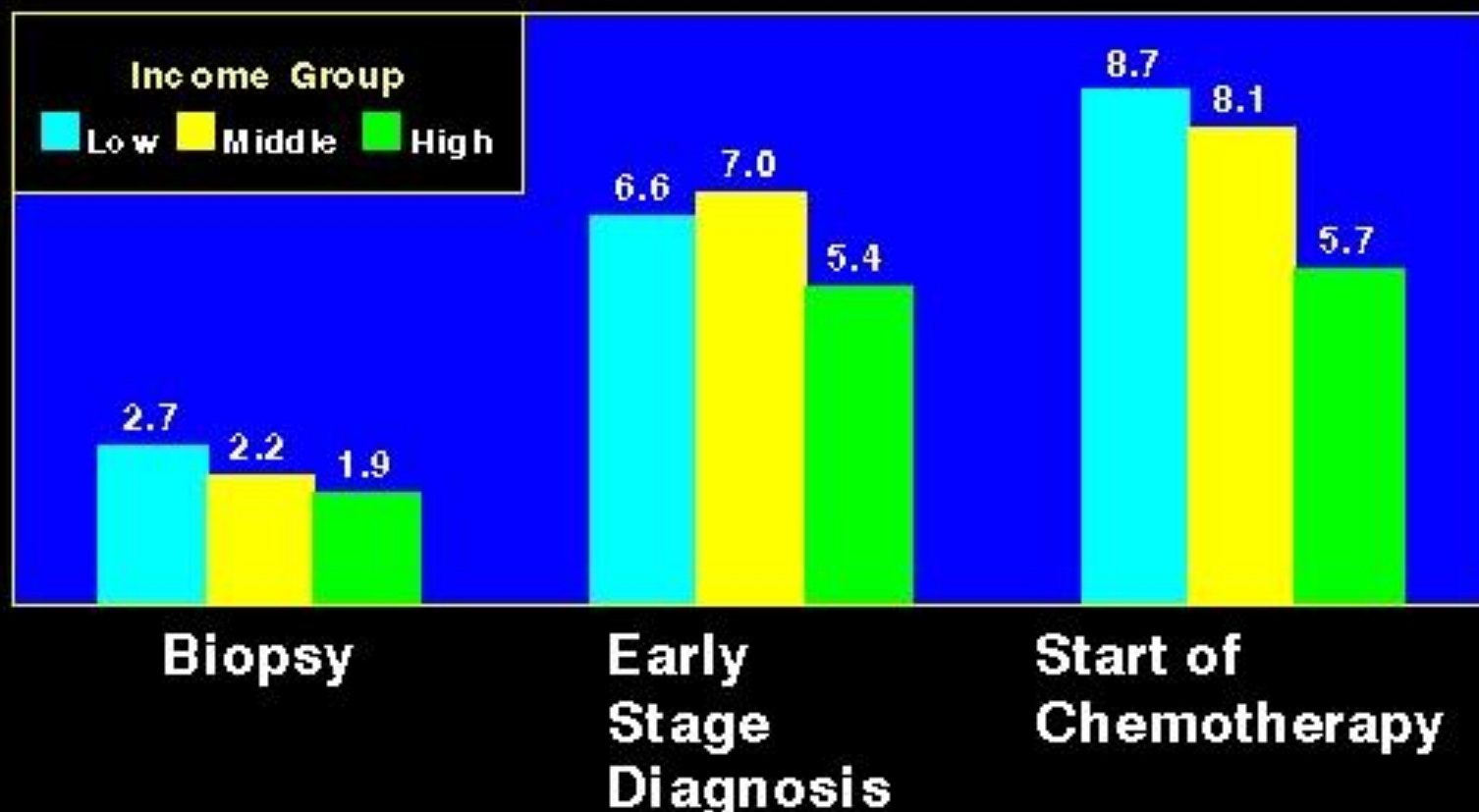
RCT: Free Meds Improved Compliance and Outcomes

Difference: free meds vs. control group



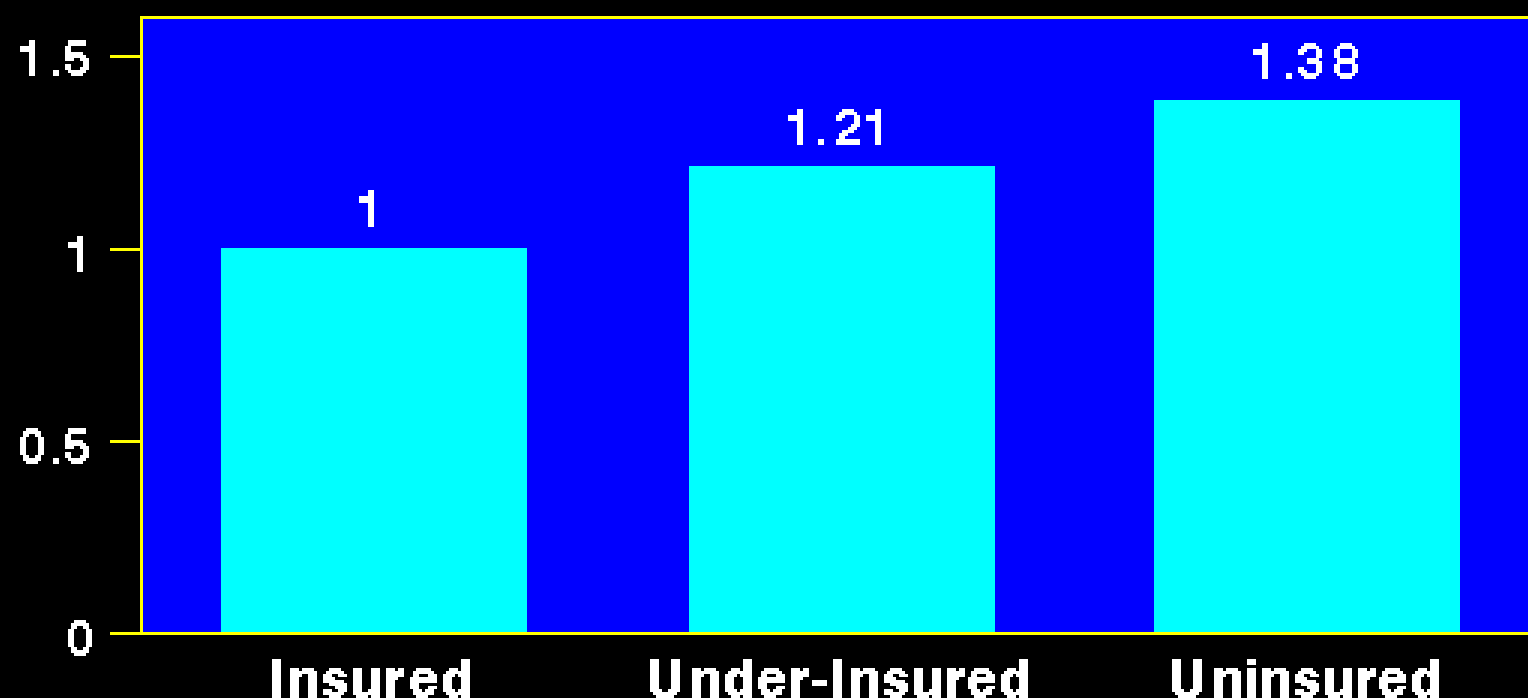
High Deductible Plans Delayed Breast Cancer Care

Extra delay (months) high vs. low deductible



Uninsured and Under-Insured Delay Seeking Care for Heart Attacks

Odds ratio for delayed care*



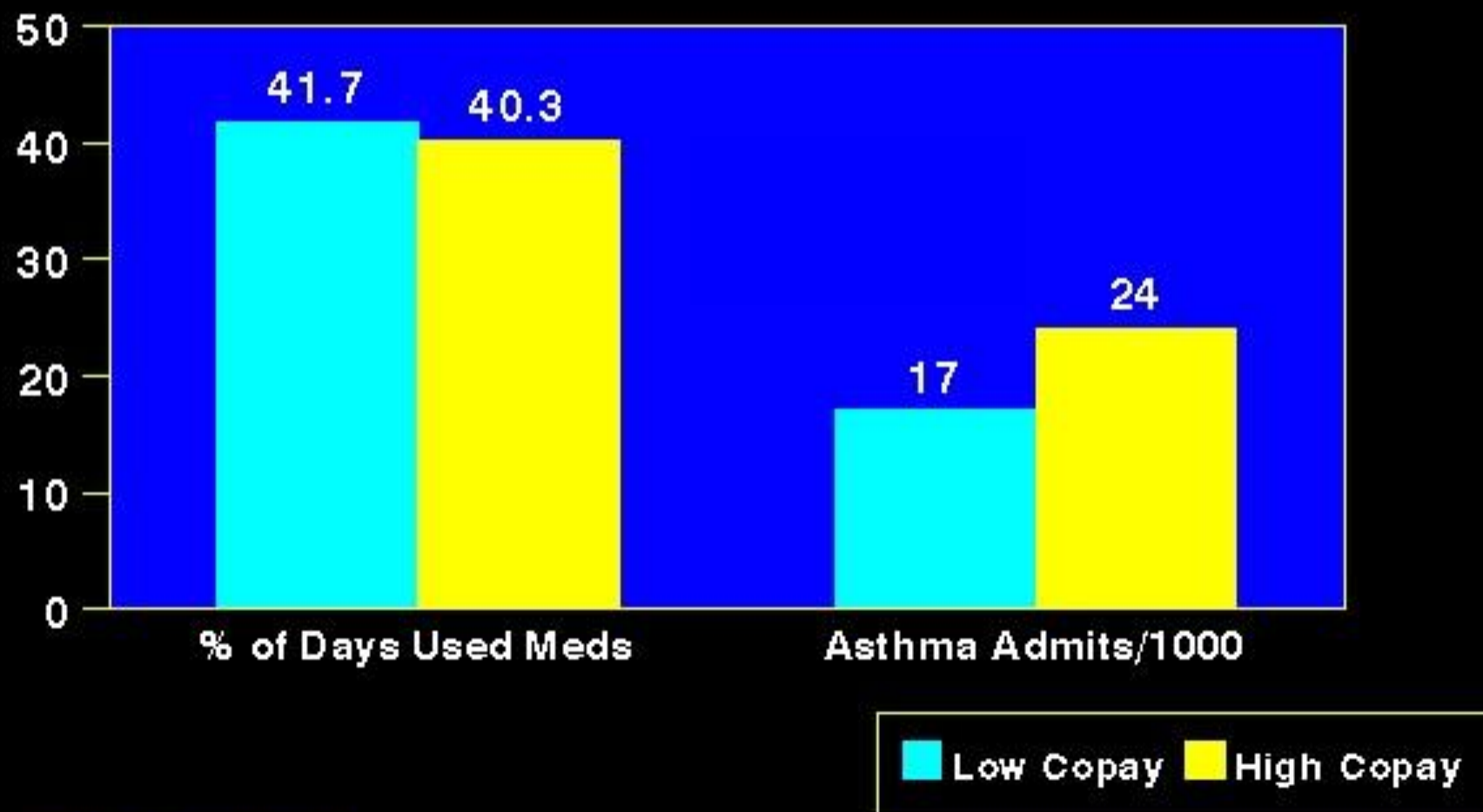
Source: JAMA April 15, 2010;303:1392

*Adjusted for age, sex, race, clin. characteristics, hlth status, social/psych factors, urban/rural

Under-insured = Had coverage but patient concerned about cost

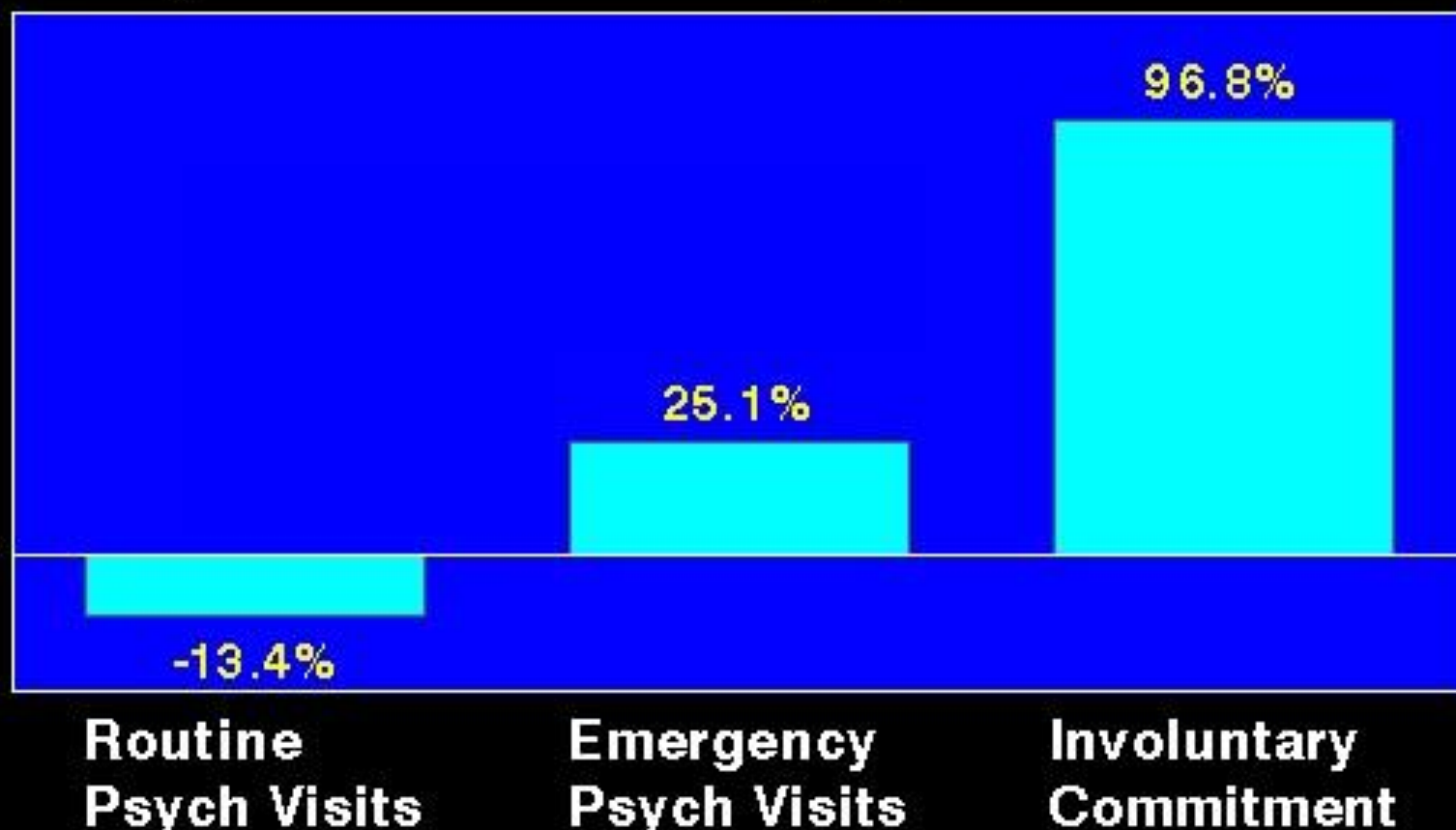
Higher Medication Co-Pays = Worse Asthma Outcomes

Children Age 5-18



200 Euro Copayment Cut Routine Psych Visits, Increased Crisis Care in Holland

Change in visit rates after copay added



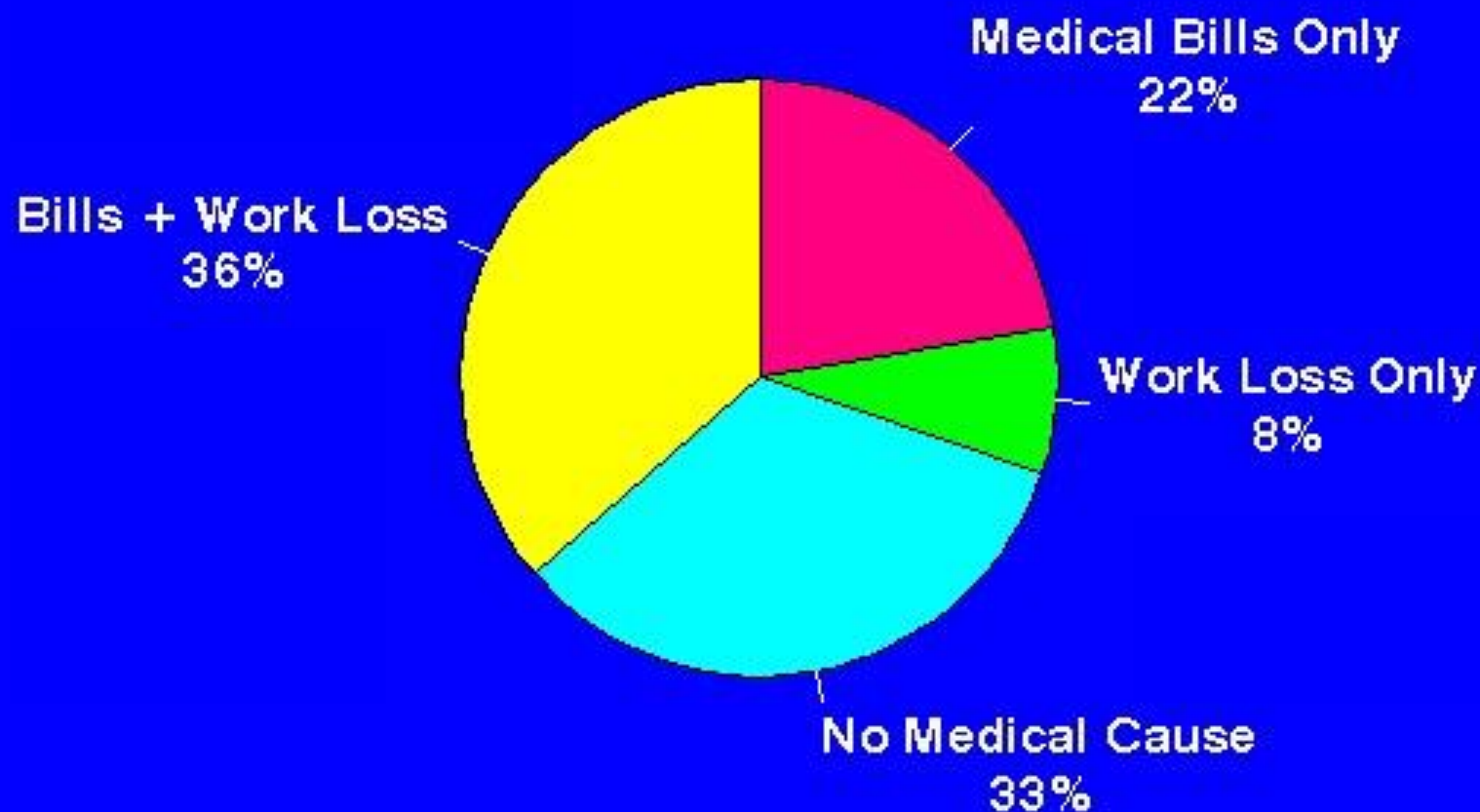
Source: JAMA Psychiatry 2017;74:932

Note: Copay was not applied to children, whose use rates remained stable

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

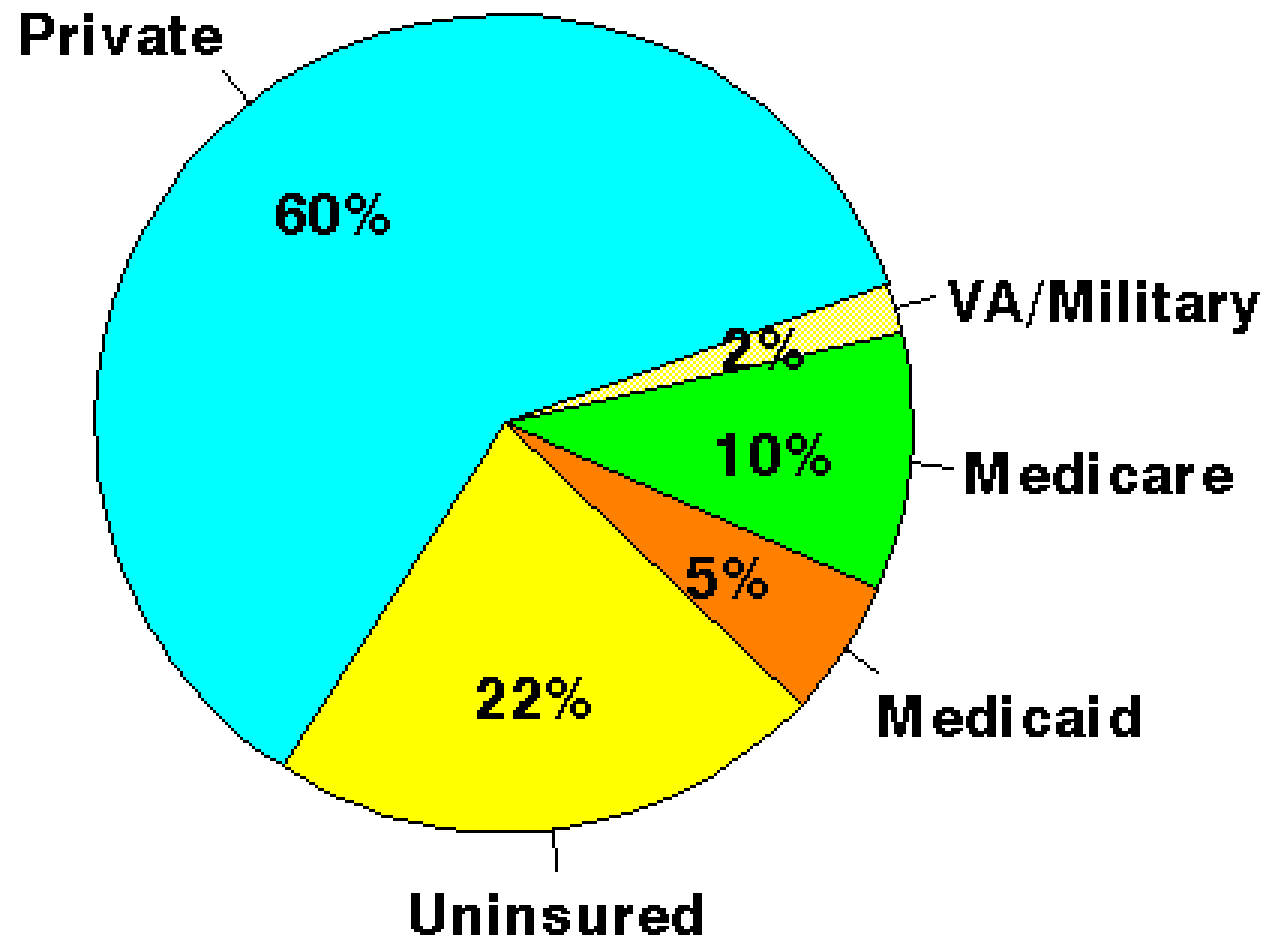
National Survey of Debtors, 2013-2016



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

Work loss = "work loss due to illness"

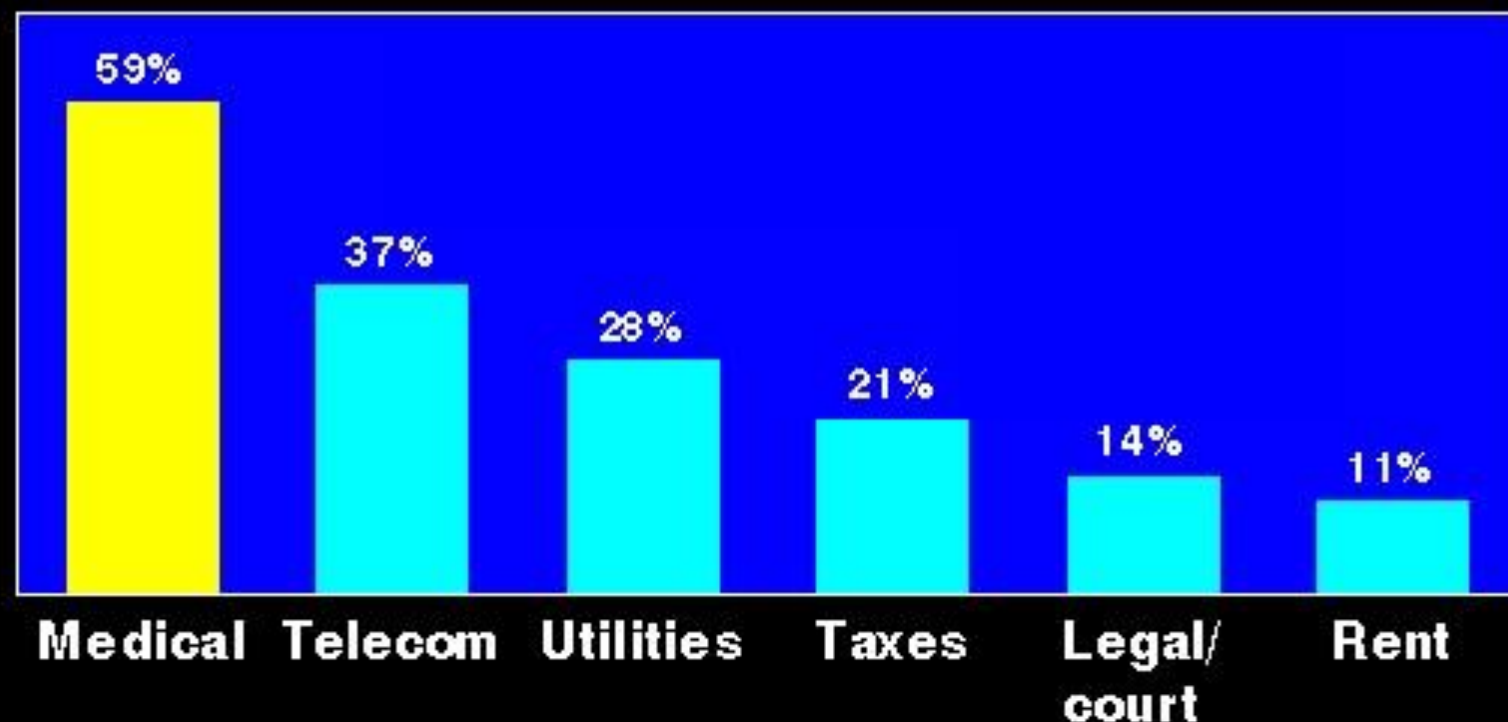
Most of the Medically Bankrupt Had Coverage



Insurance at Illness Onset

Medical Bills are Most Common Reason for Collection Calls

Percent of consumers receiving collection calls with specific type of debt

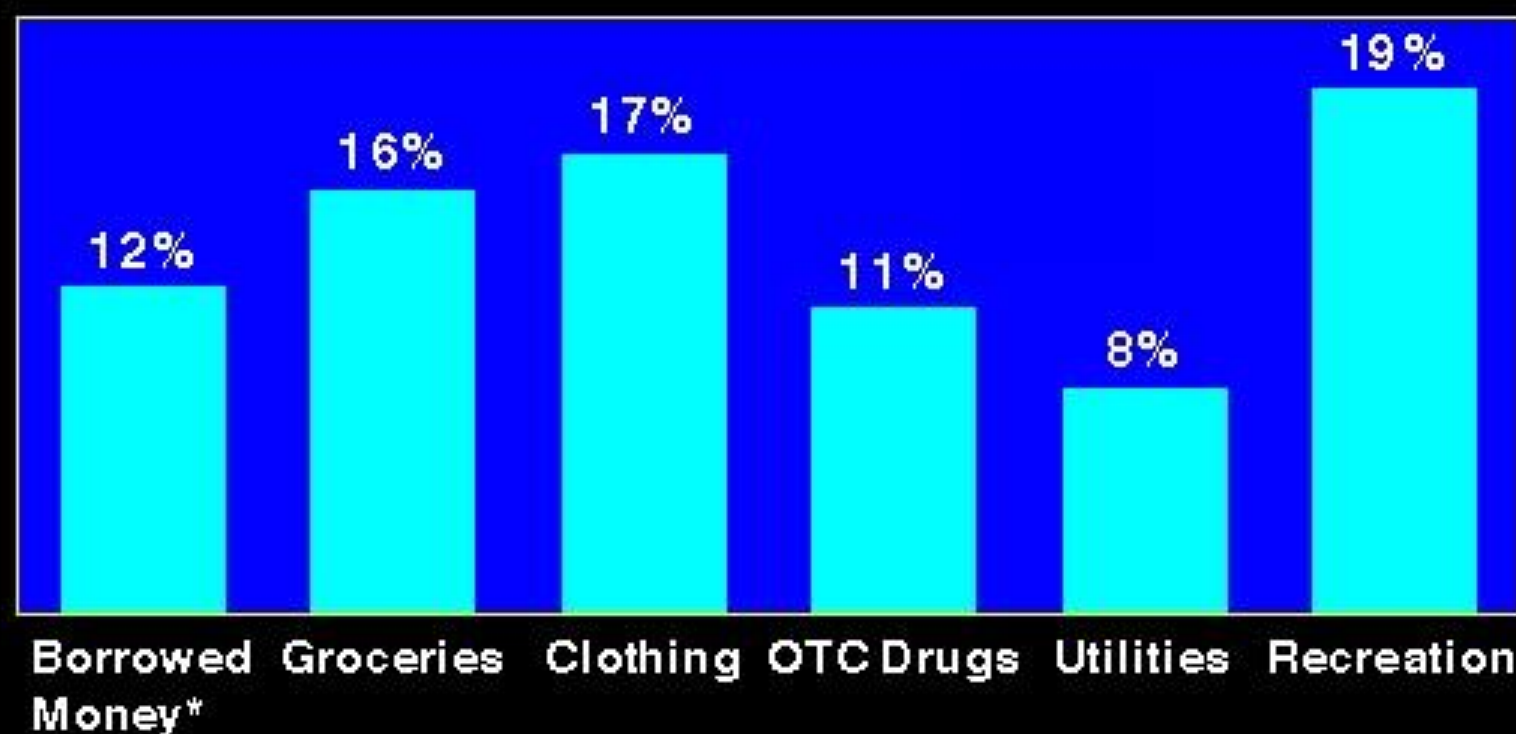


Source: Consumer Financial Protection Bureau, January, 2017

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

Health Costs Force Millions into Debt and to Forego Other Essentials

Percent of adults who have borrowed money or reduced spending due to health care costs



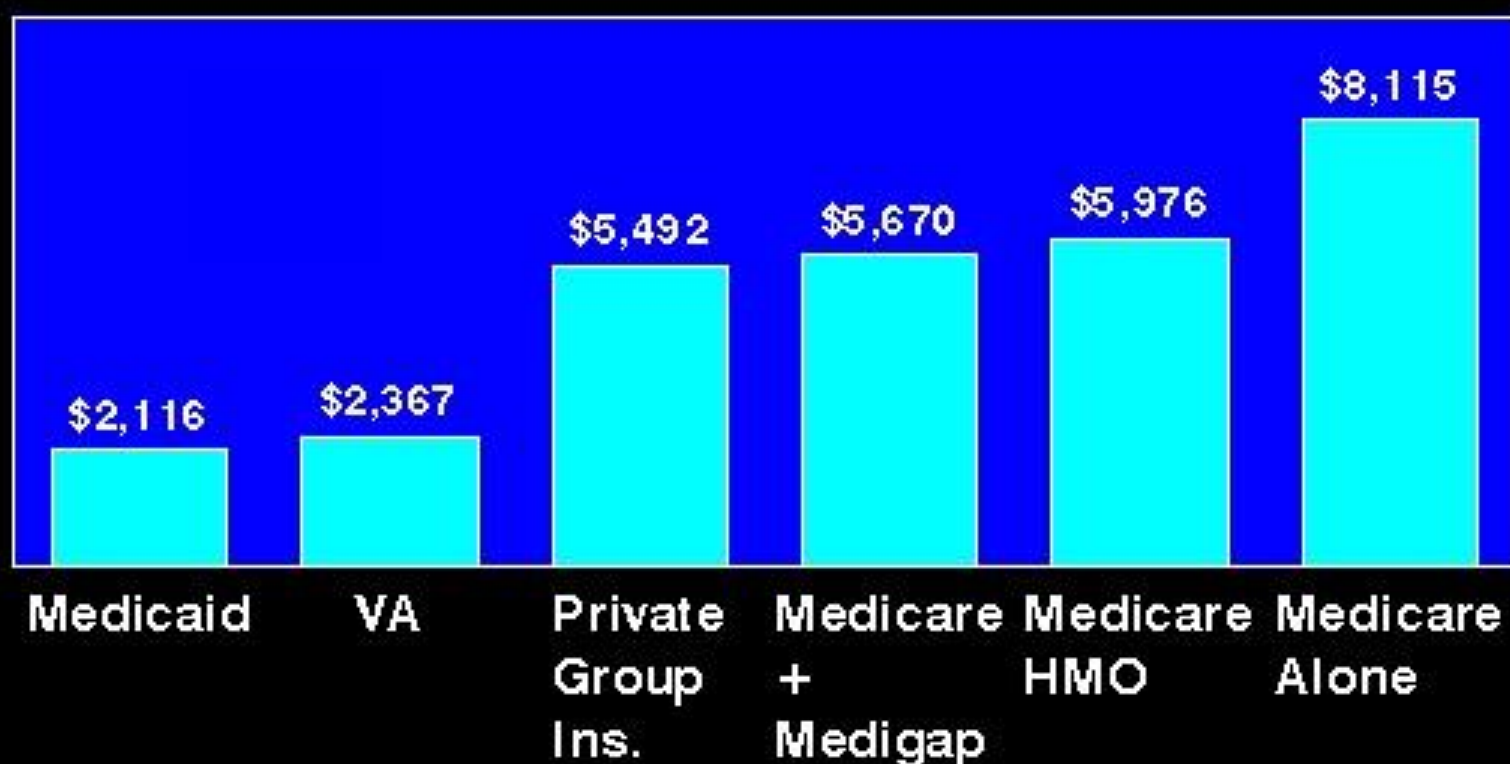
Source: Westhealth/Gallup - Public Perceptions of the U.S. Healthcare System - 2019

* Total borrowing to pay health costs = **\$88 Billion**

Insured Cancer Survivors' High OOP Costs

A study of 1,409 Cancer Survivors Over 50

Mean annual out-of-pocket medical costs



Source: JAMA Oncology 2017;3:753 - Based on analysis of data from Health and Retirement Study

Note - Median household income was \$51,371

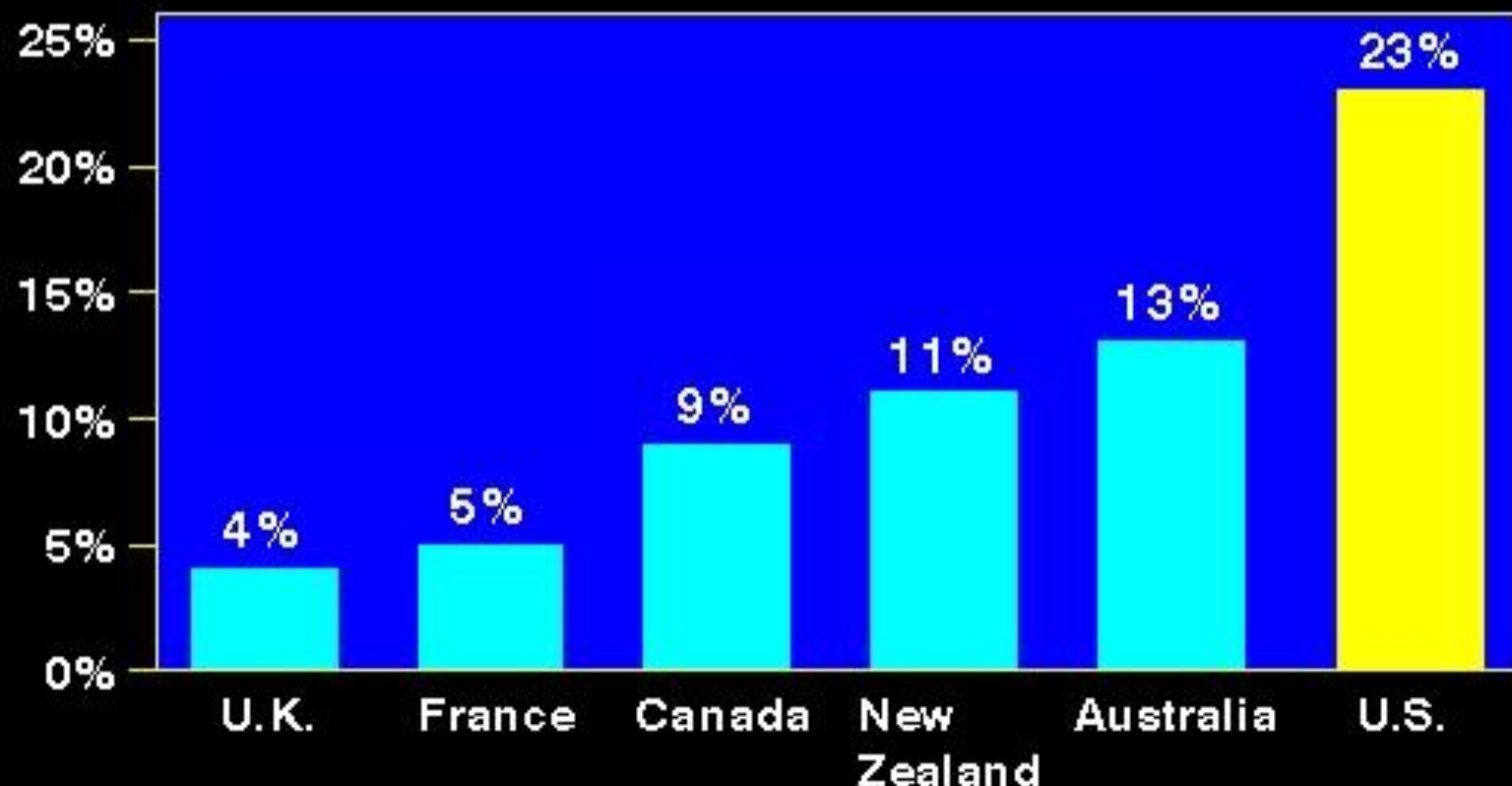
Dementia in US = High Out-of-Pocket Costs

Average annual out-of pocket spending by persons with dementia



Despite Medicare, U.S. Seniors Have More Cost-Related Access Problems

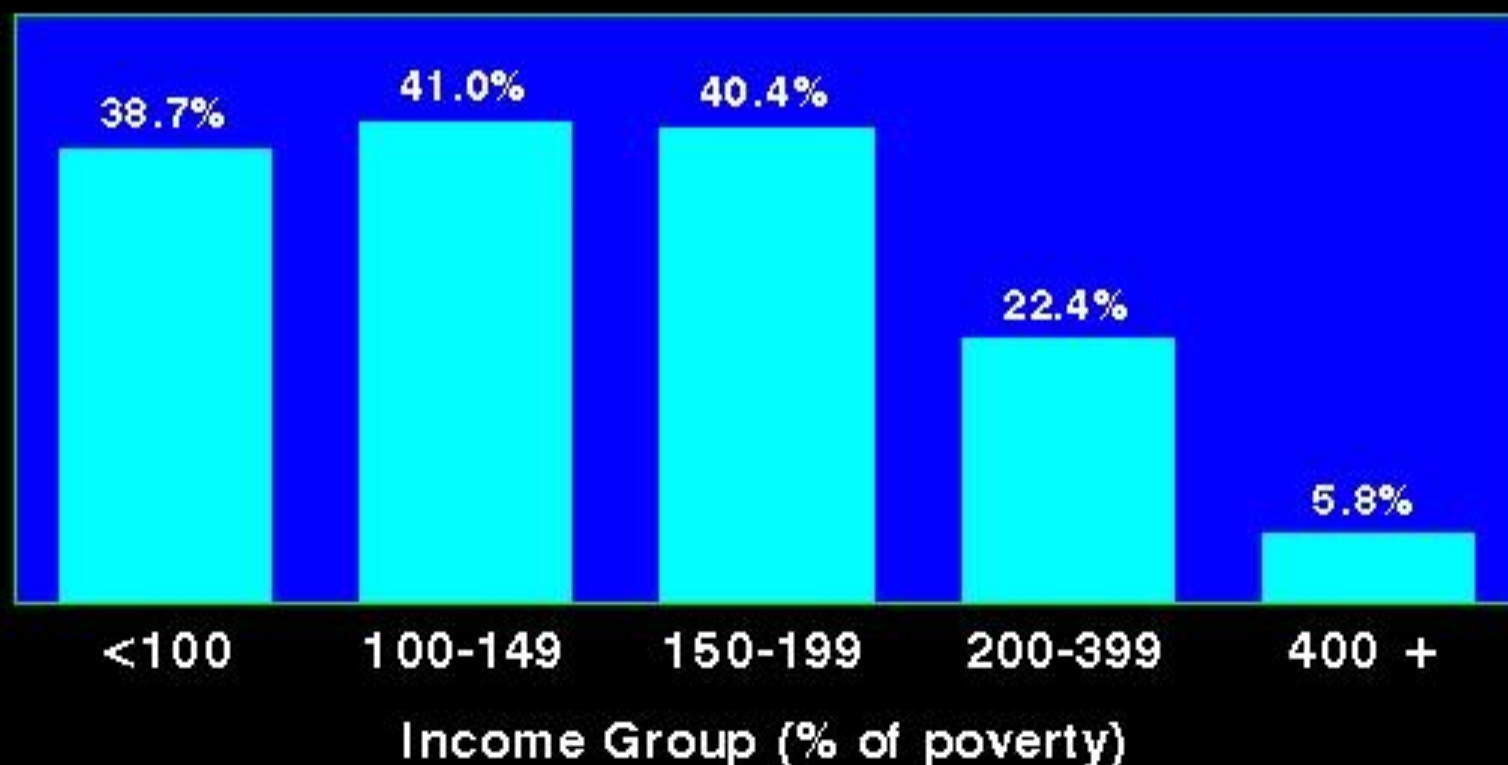
Percent of Persons >65 Reporting Cost-Related Access Problem in Past Year



Medicare Needs Improvement

For Many Seniors, Medical Costs
Consume More Than 1/5th of Income

% of seniors spending at least 20% of income on
premiums + OOP medical costs

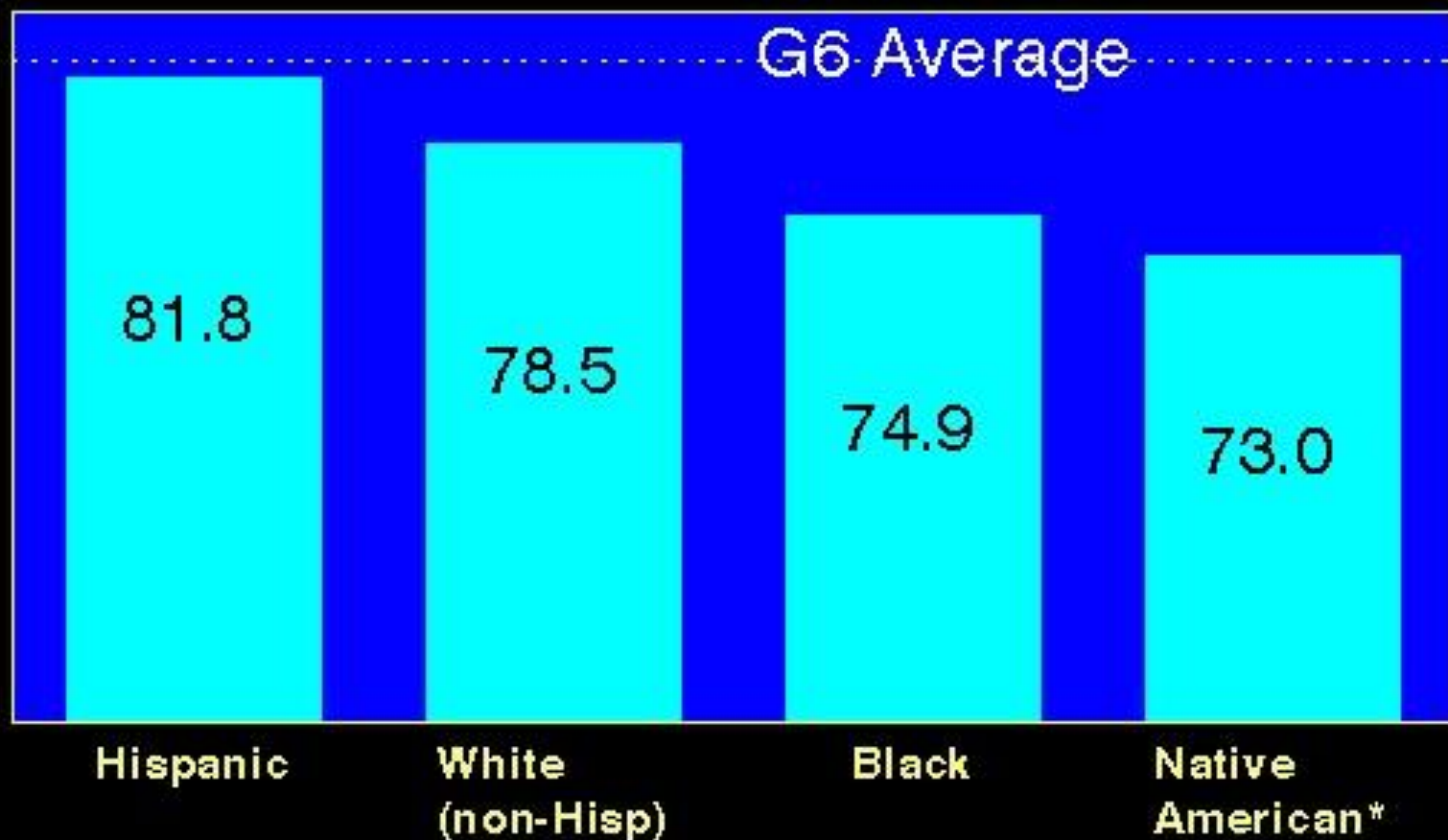


Racism Harms Health

Black and Native Americans Die Younger

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

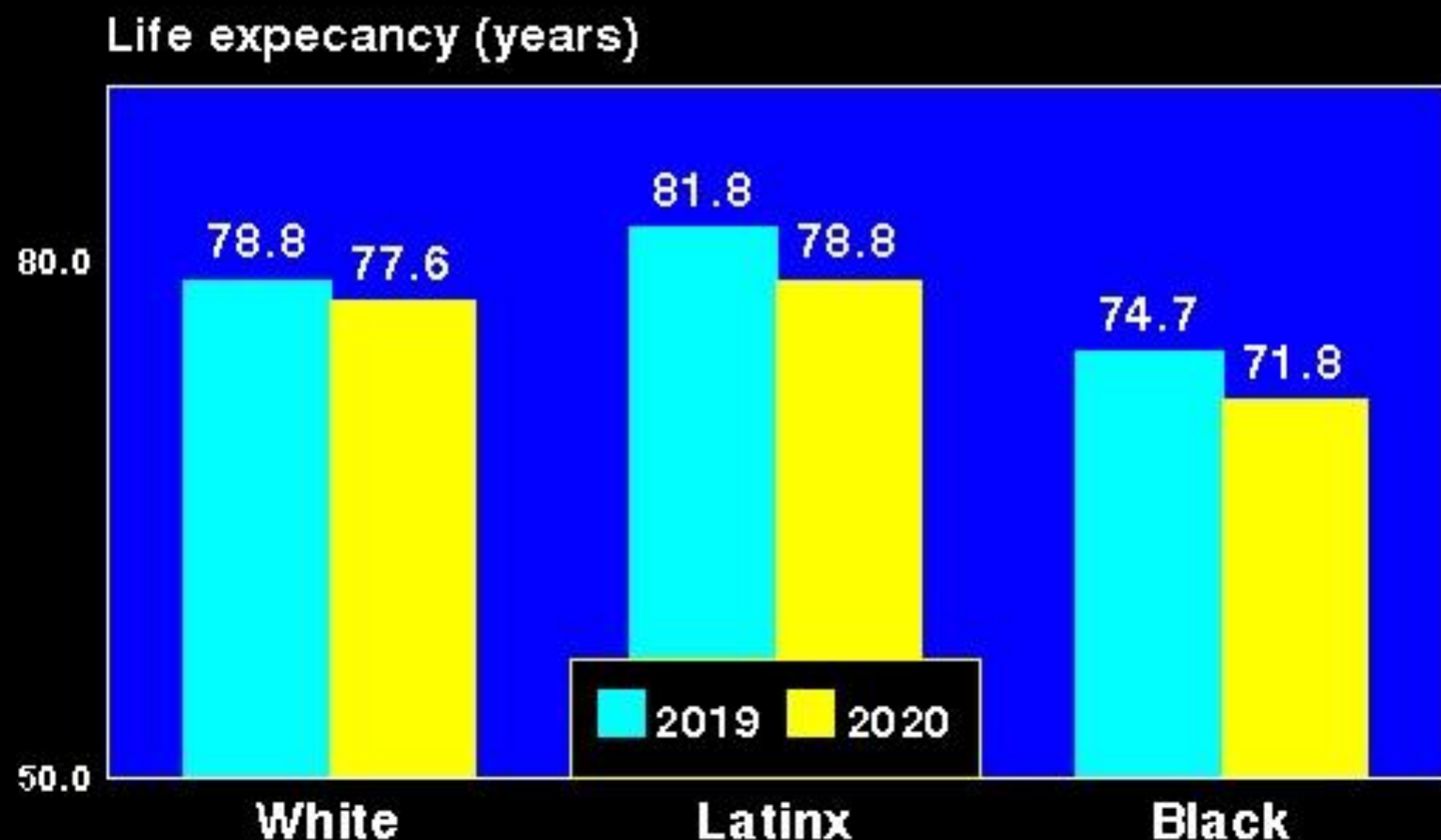
Life expectancy, years



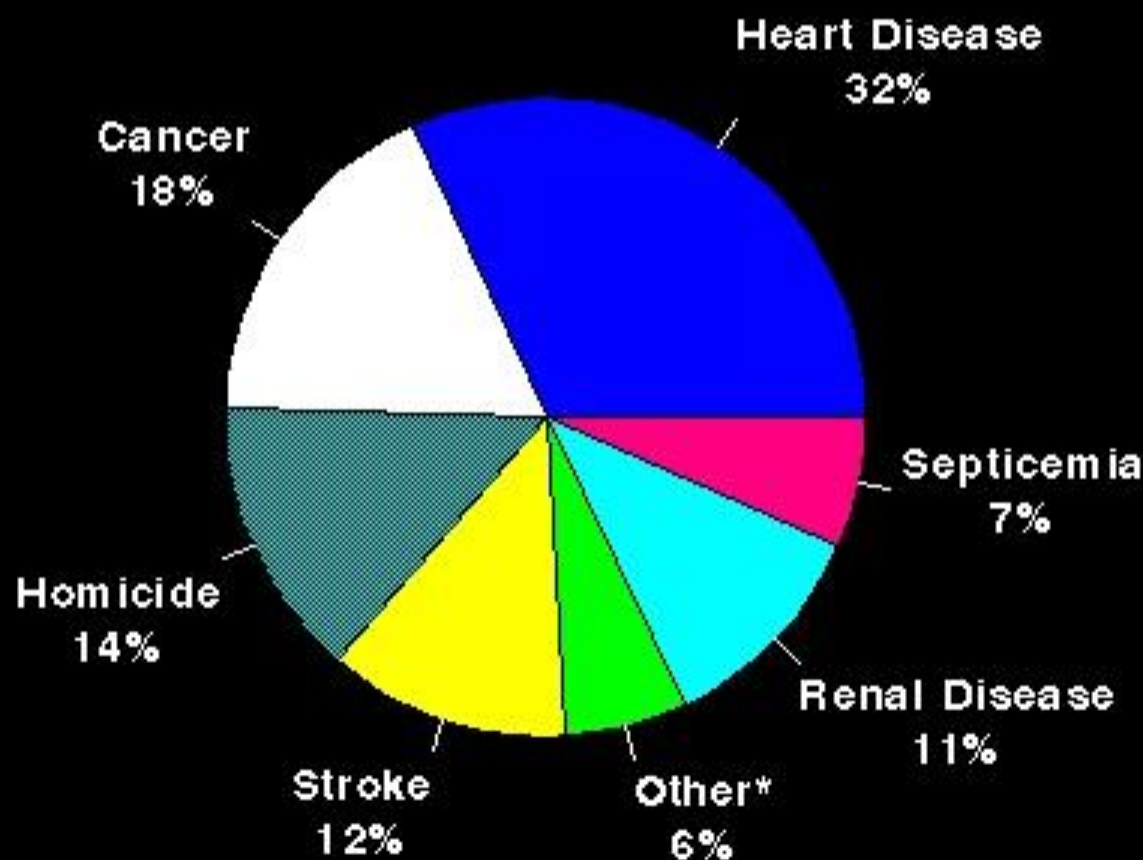
Source: NCHS, IHS, OECD

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

COVID-19 Has Sharply Reduced Black and Latinx Life Expectancy



Causes of Black/White Disparity in Adult Mortality

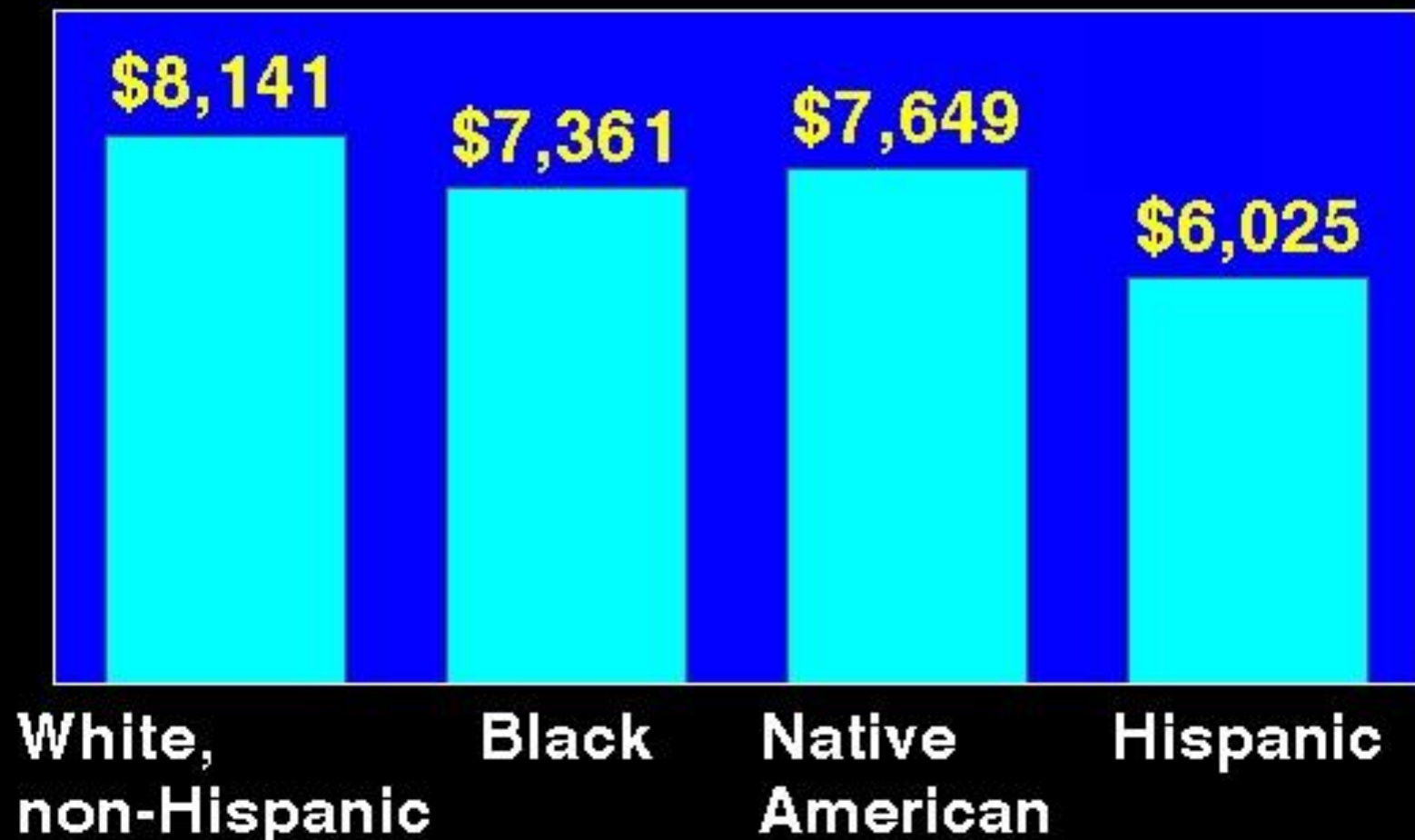


Source: MMWR May 2, 2017

* 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

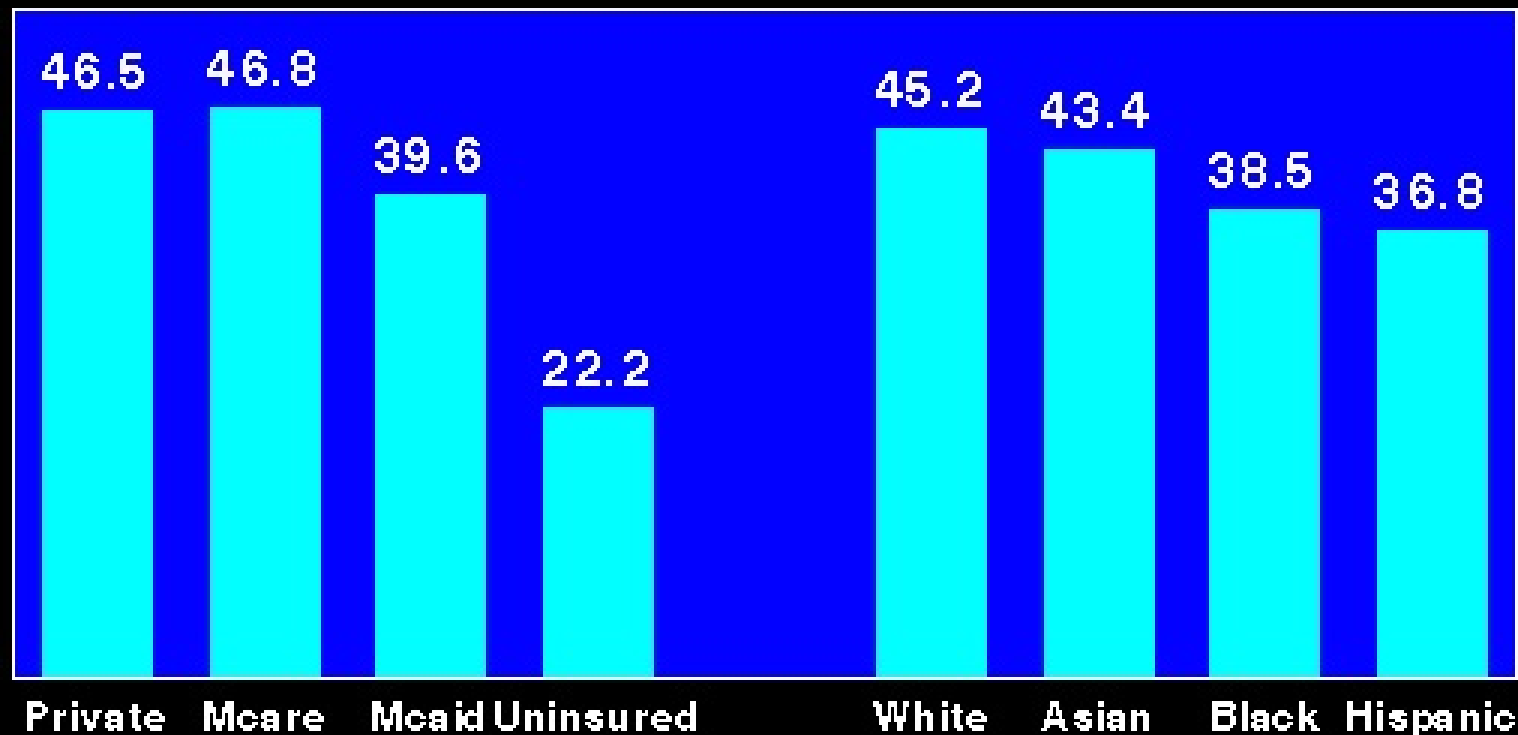
People of Color Get Less Care

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



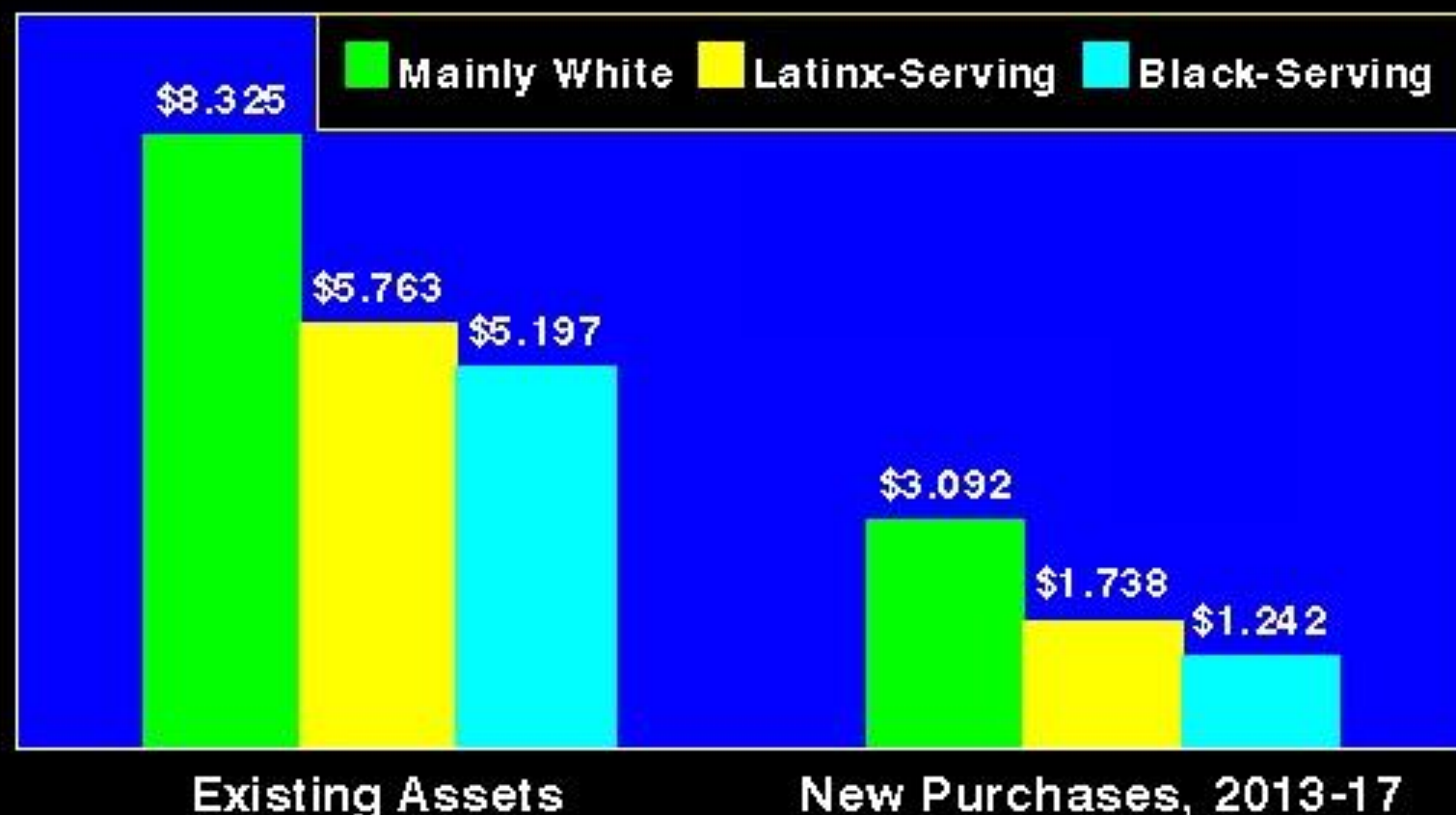
Uninsured and People of Color Have Worse Blood Pressure Control

Percent of adults with hypertension whose BP was controlled, 2016-2017



Black- and Latinx-Serving Hospitals Have Less Funding for Buildings and Equipment

Value of buildings and equipment, \$s per bed day

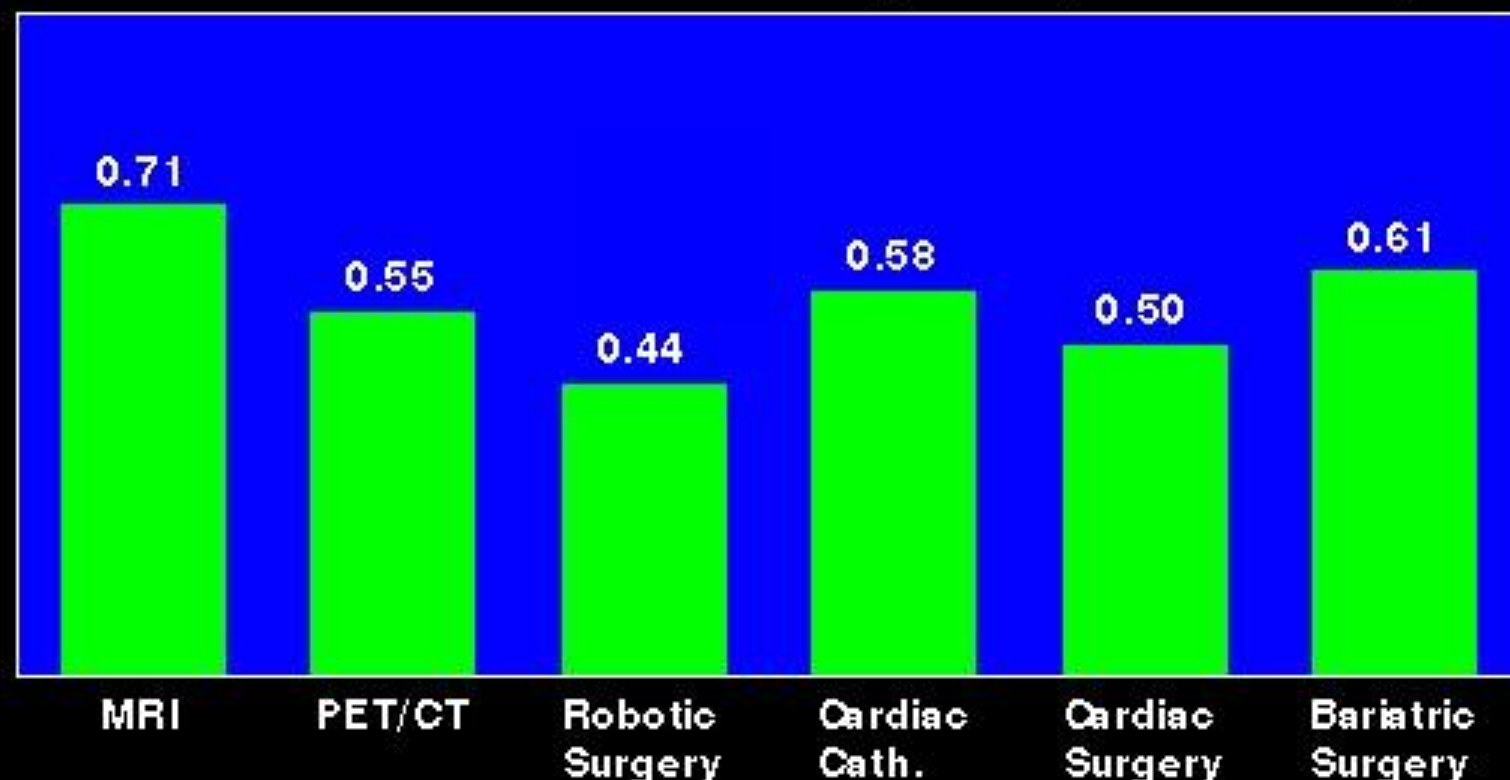


Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020

Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts.

Black- and Latinx-Serving Hospitals Offer Fewer High Tech Services

Odds that service is available, minority-serving vs. other hospitals



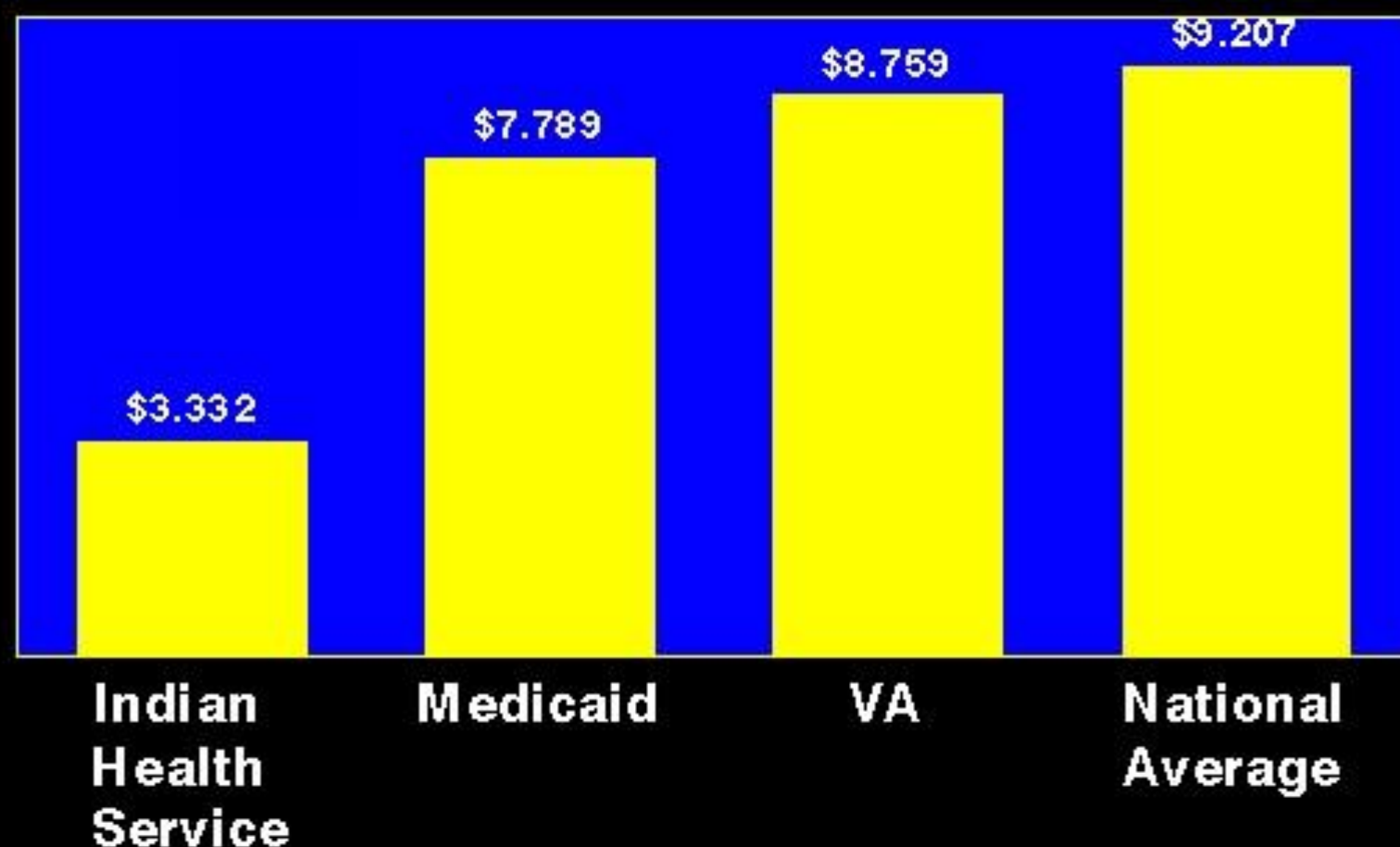
Source: Gracie and Kathryn Himmelstein, *Int J Health Services* 2020

Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts.

Odds ratios are adjusted for size, location, teaching status and ownership

Indian Health Service, Grossly Underfunded

Medical spending, 2017 per **user**

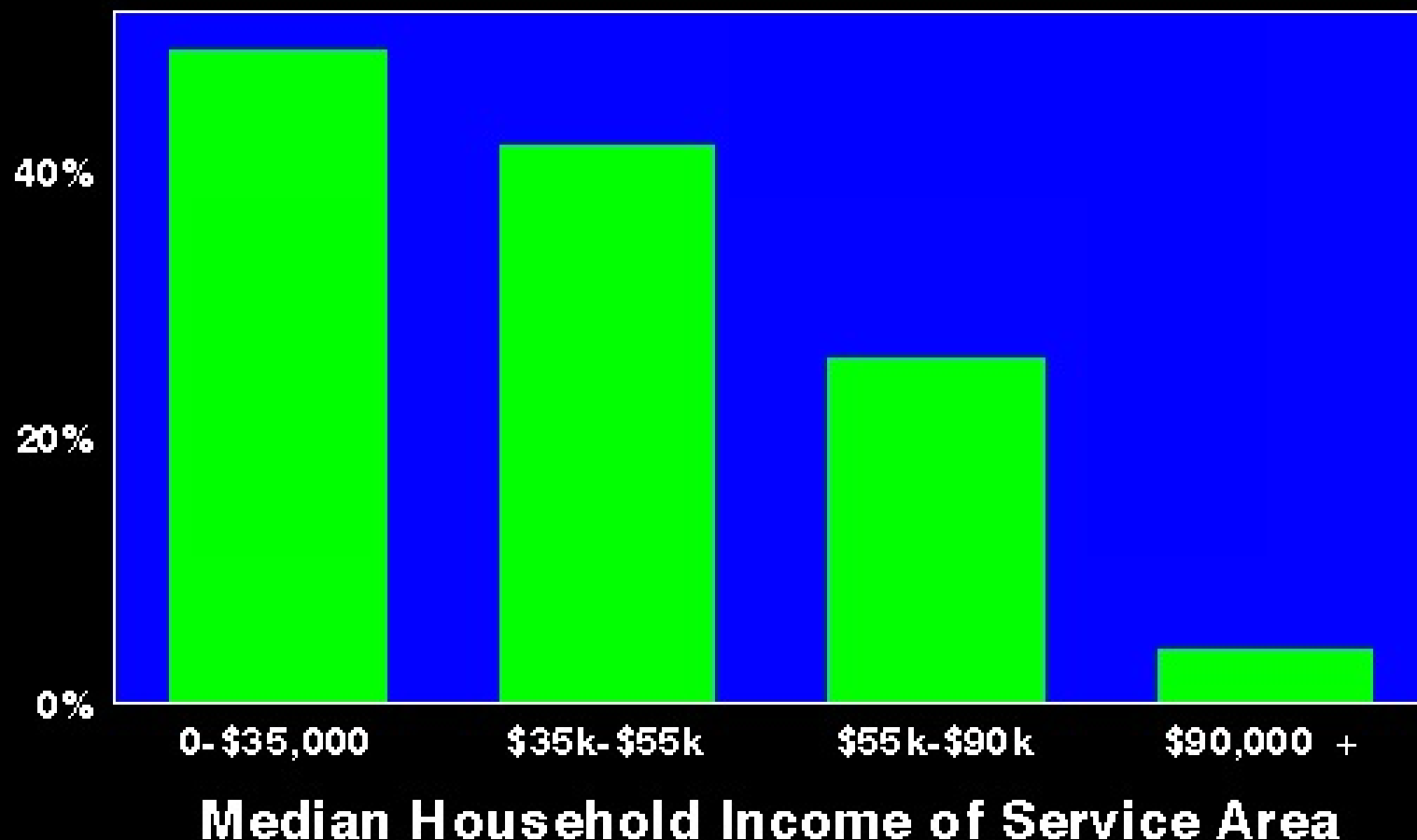


Source: National Tribal Budget Formulation Workgroup, April, 2018

Note: Estimated spending shortfall, including facility upgrades = \$36.83 billion

Poorer Regions, Fewer ICU Beds

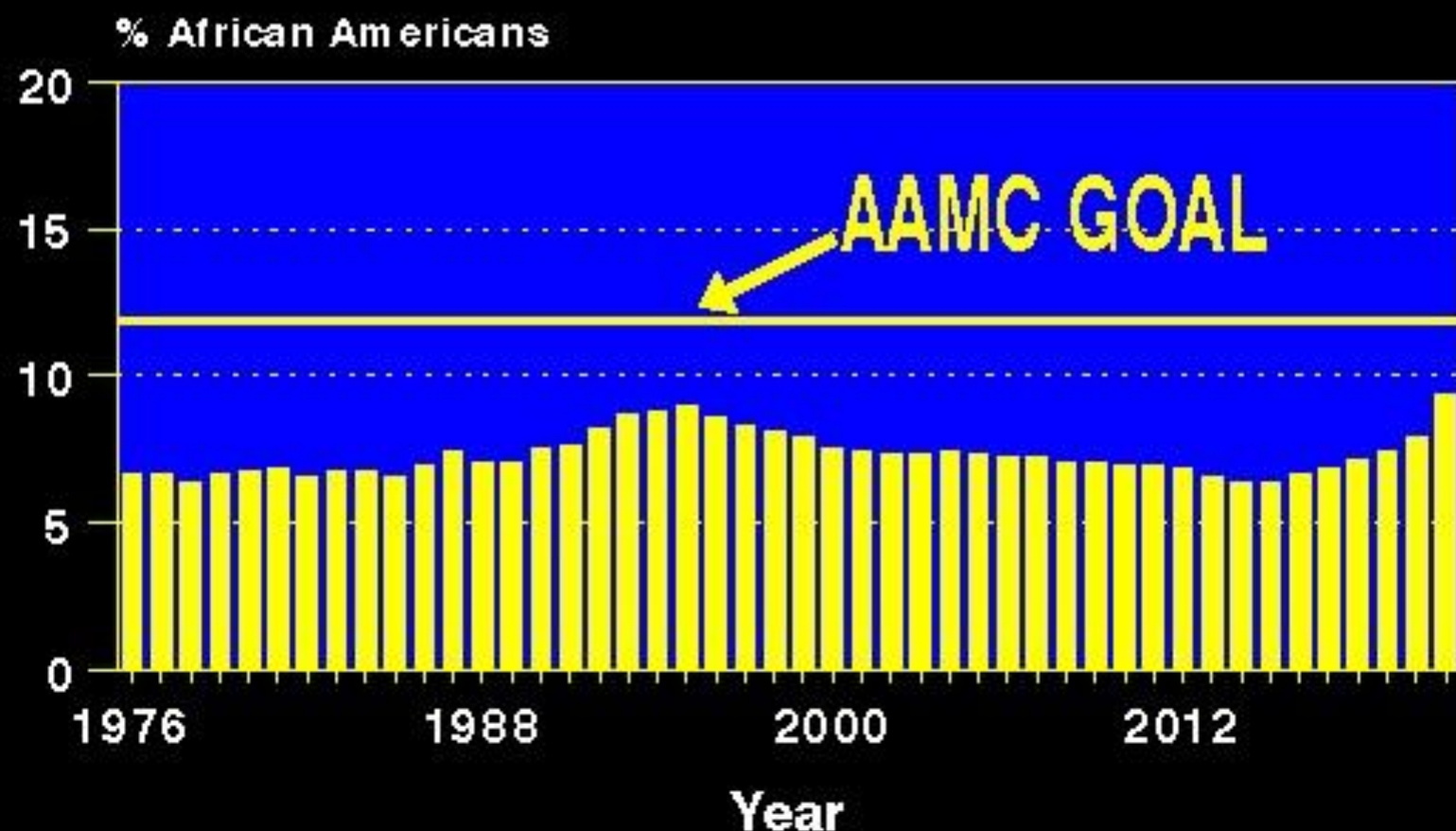
Share of hospital service areas with NO ICU



Source: Health Aff 2020;39:1362

Note: A \$10,000 increase in median income was associated with a 11.8% increase in ICU beds

Black Enrollment in U.S. Medical Schools, 1976-2021/22

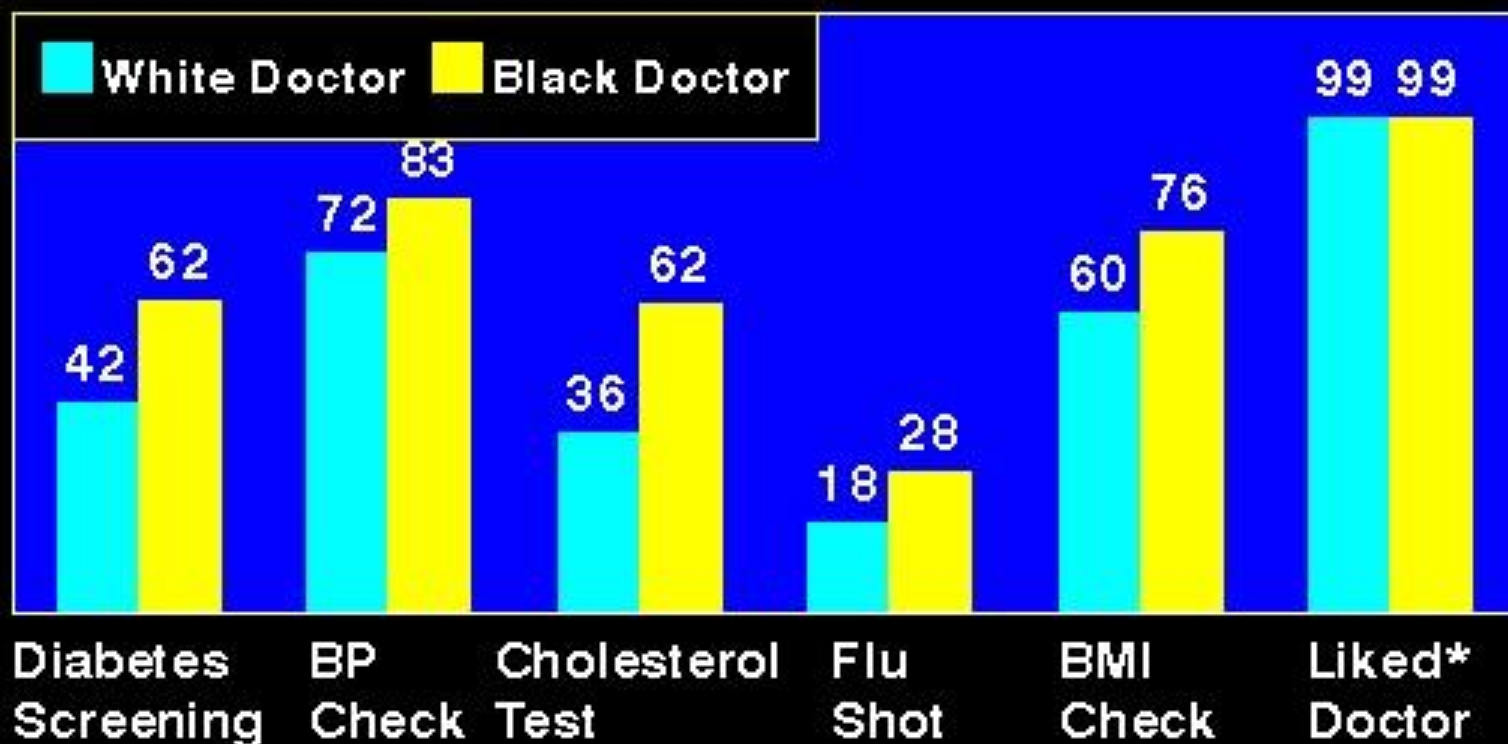


Source: RWJ Fdn. 1987; AAMC; & JAMA Annual Medical Education Special Issue

Black Men More Often Followed a Black Doctor's Advice: An RCT

Even Though They Gave Black and White Doctors Same Ratings

Percent following prevention advise (or recommending the doctor)



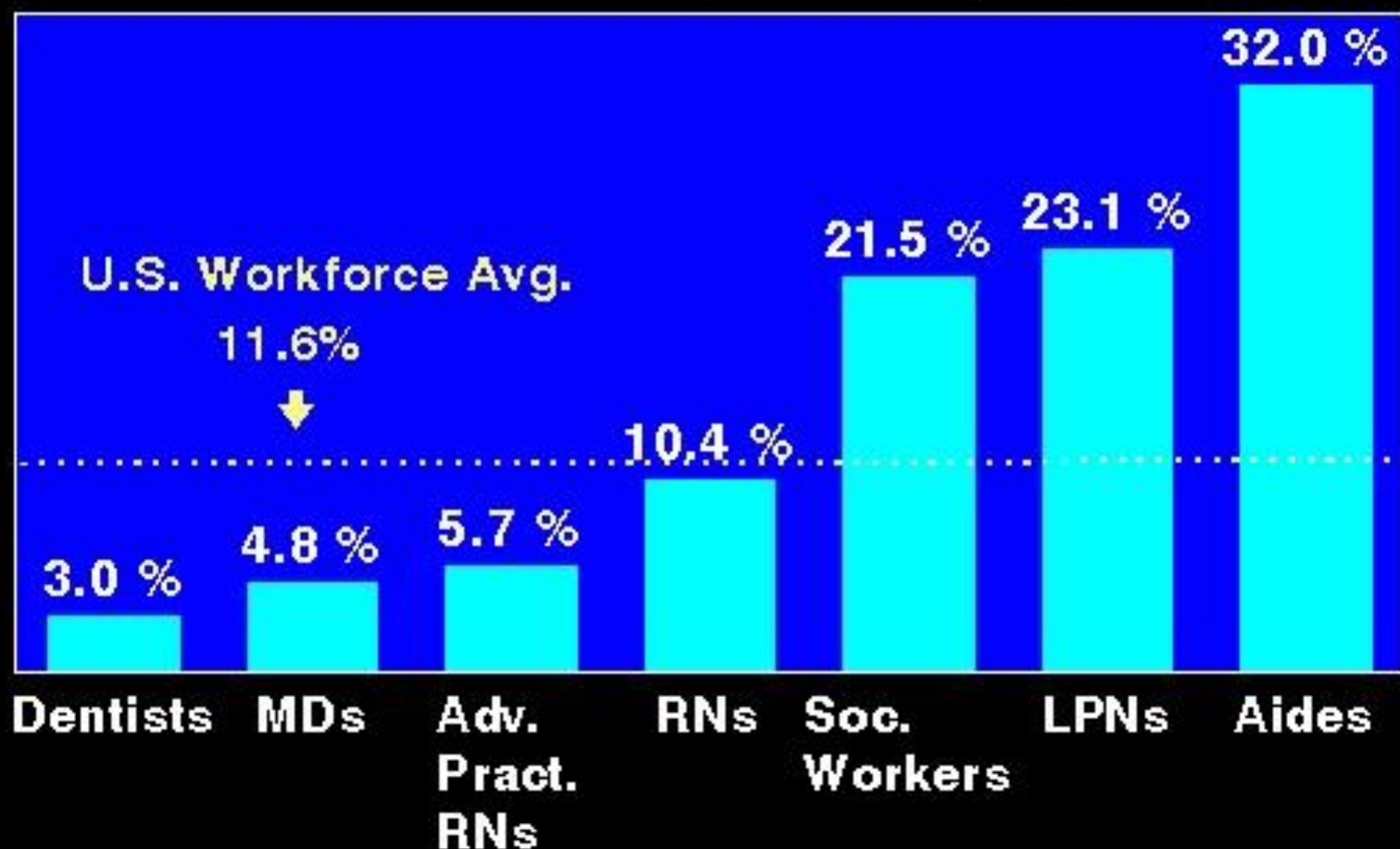
Source: American Economic Rev 2019;109:4071

Authors estimate that universal availability of Black doctors could cut B:W CV mortality gap by 19%

* Liked = would recommend doctor to others

Blacks in Health Occupations

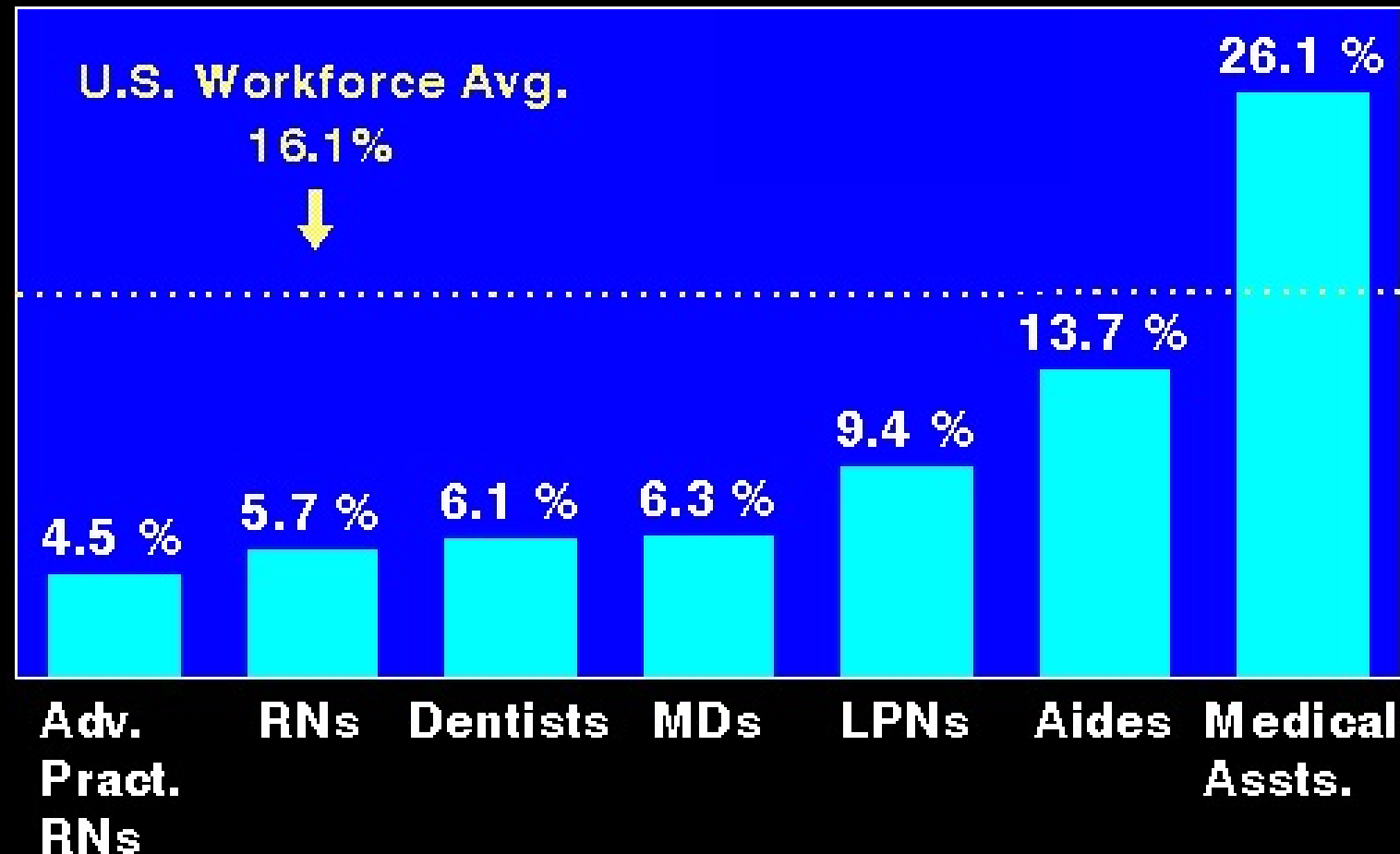
Blacks as percent of occupational group



Source: HRSA based on data from American Community Survey 2011-2015

Hispanics in Health Occupations

Hispanics as percent of occupational group



Source: HRSA based on data from American Community Survey 2011-2015

Black and Female Physicians Earn Less

Annual Income

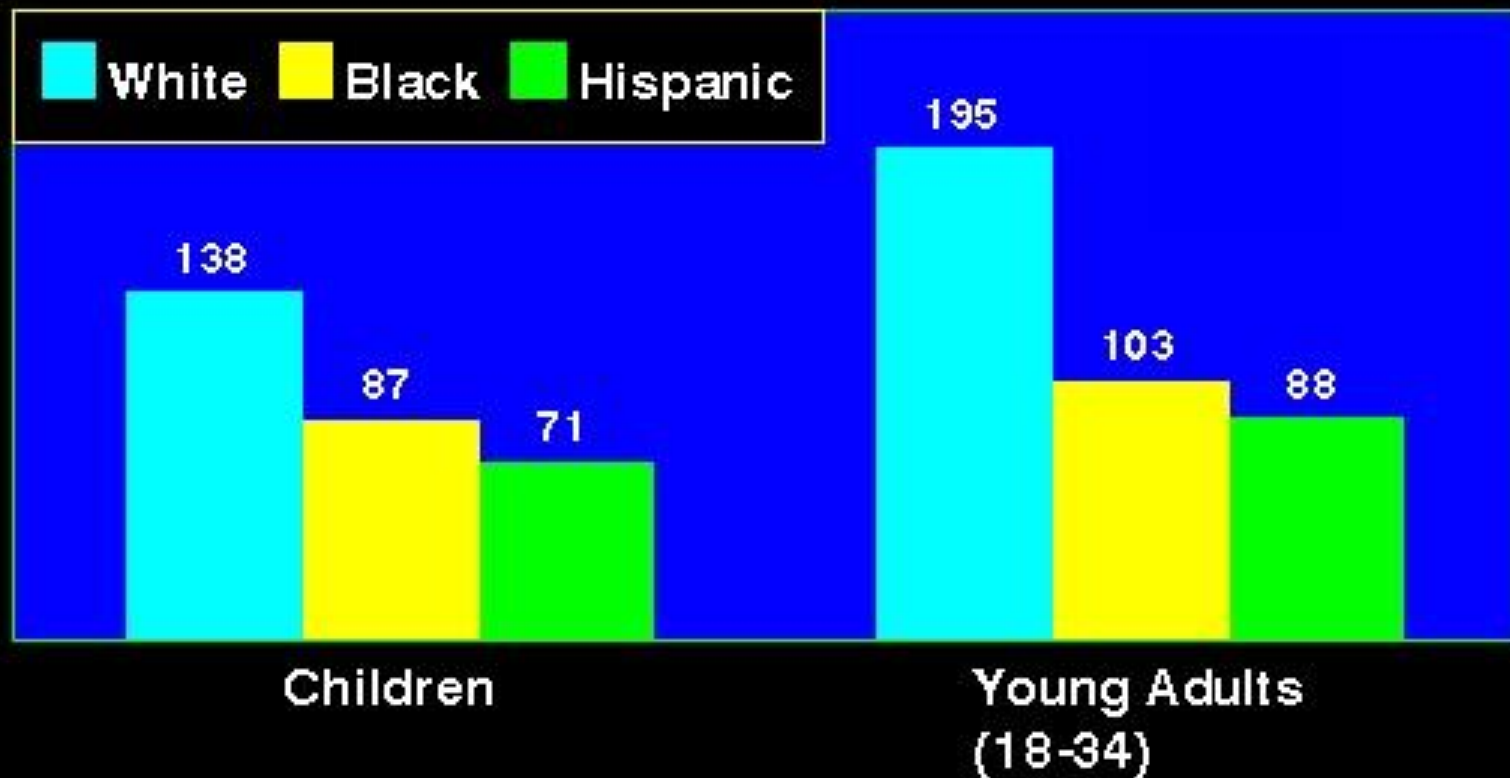


Source: Ly et al. BMJ 2016;353:2923

Note: Figures are adjusted for hours worked, specialty, age, years in practice, practice type, % of revenue from Medicare/Medicaid

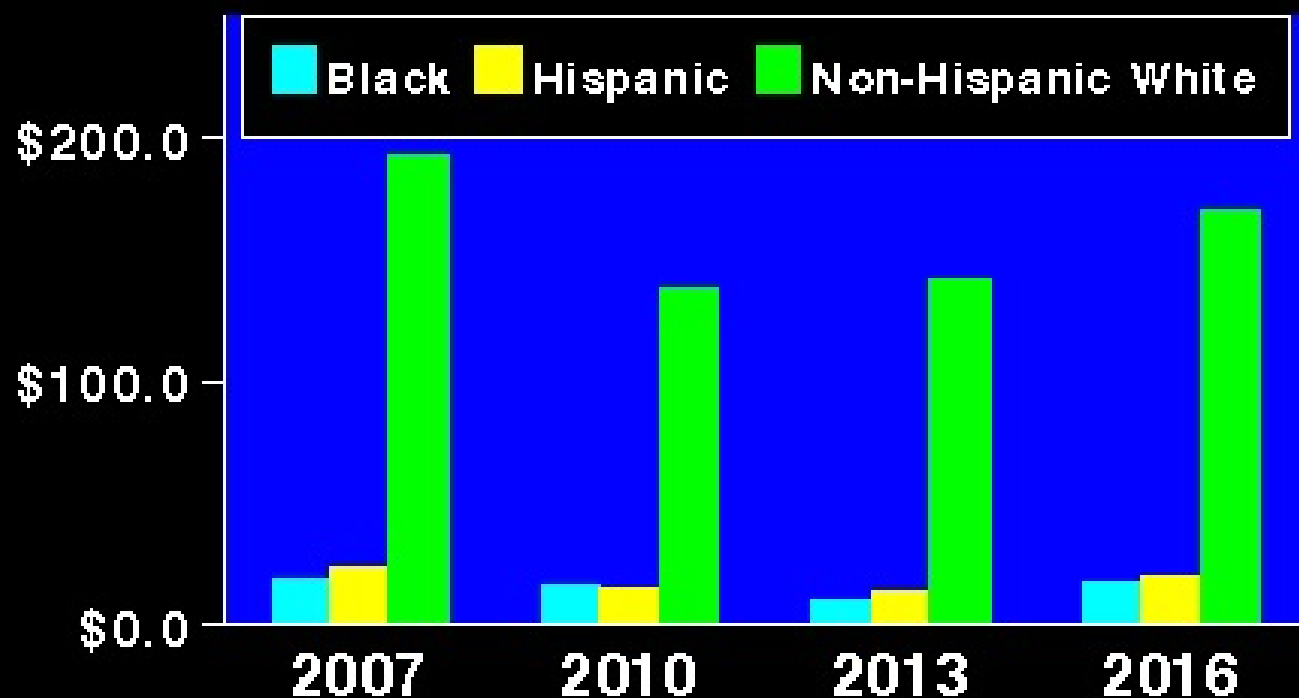
Minority Children & Youth Get Few Psychiatrist Visits

Psychiatrist visits/year/1000 population



Growing Wealth Gap for Minorities

Median household net worth (2013 \$1000s)

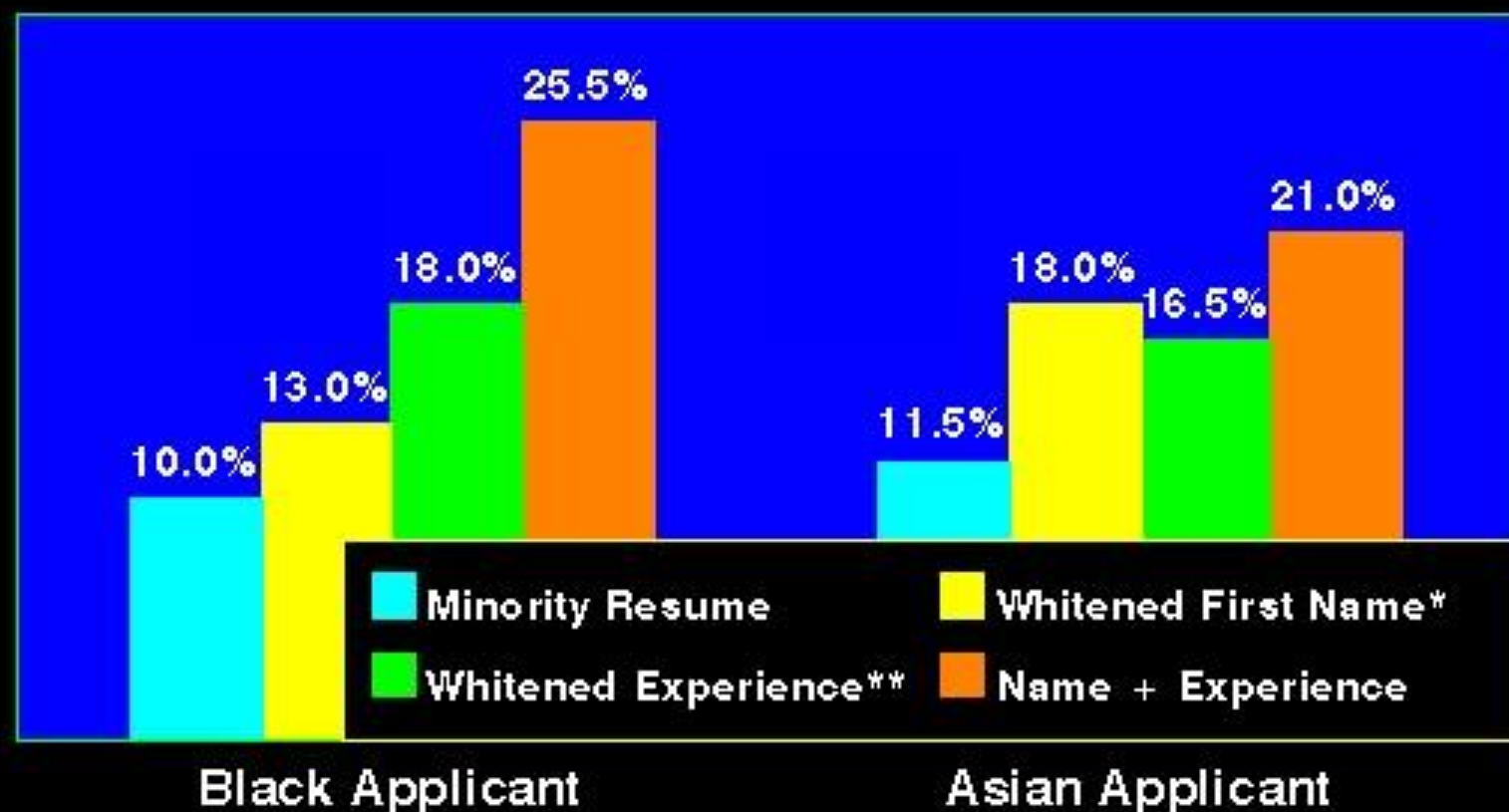


Black	2007	2010	2013	2016
Hispanic	\$19.2	\$16.6	\$11.0	\$17.6
Non-Hispanic White	\$23.6	\$16.0	\$13.7	\$20.7
	\$192.5	\$138.6	\$141.9	\$171.0

Job Discrimination Persists

Experimental Study of the Impact of "Whitening" Resumes

Calback rate after resume submitted



Source: Kang SK, et al. Admin Sci Q, 2016 - Job ads with pro-diversity language yielded same result

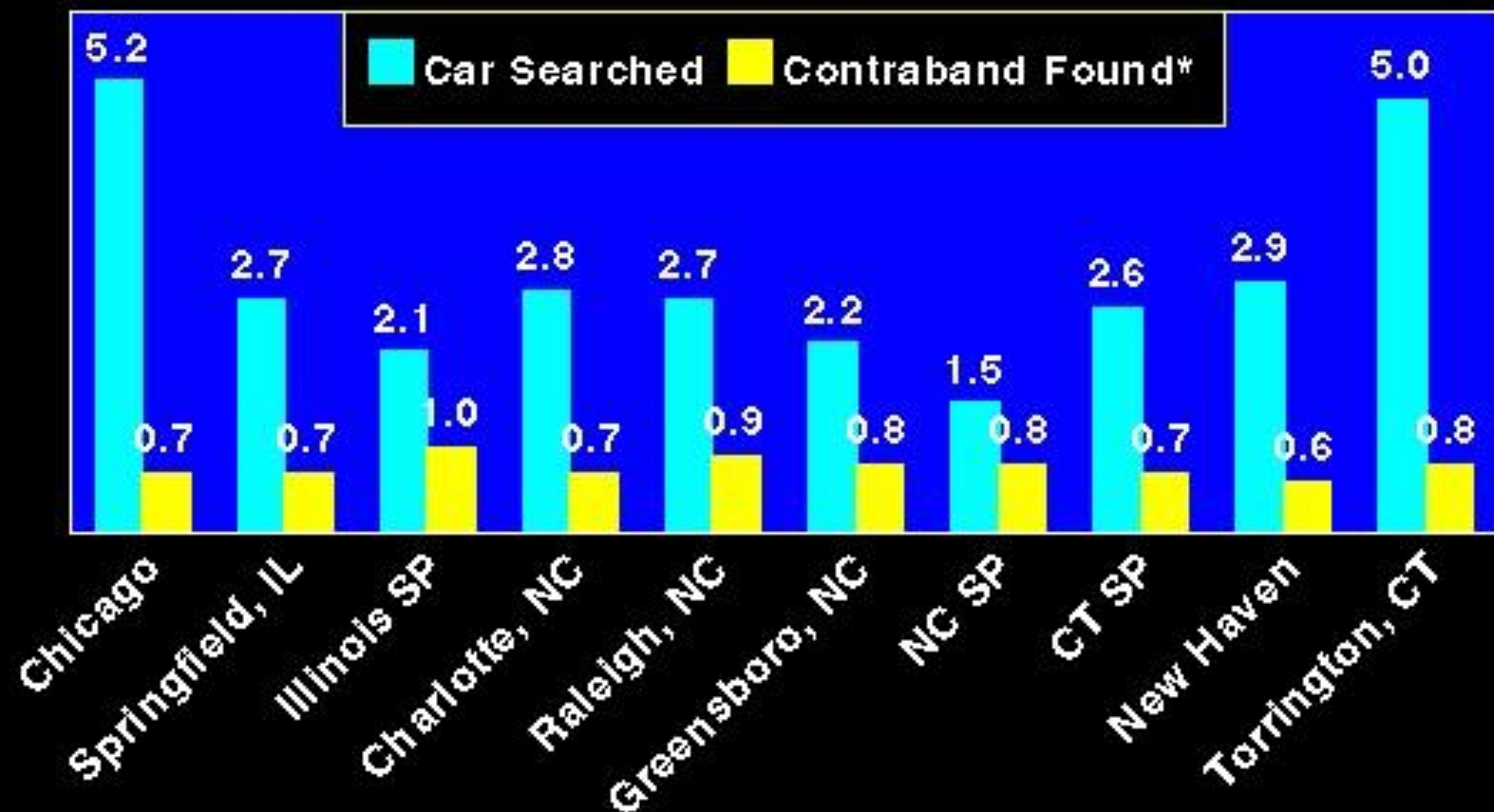
* e.g. change "Lamar J. Smith" to "L. James Smith" or "Lei Zhang" to "Luke Zhang"

** e.g. change "Aspiring Asian Business Leaders" to "Aspring Business Leaders"

Driving While Black

More Likely to Be Searched, Less Likely to be Found With Contraband

Black Rate/White Rate (1.0 = Equally Likely)

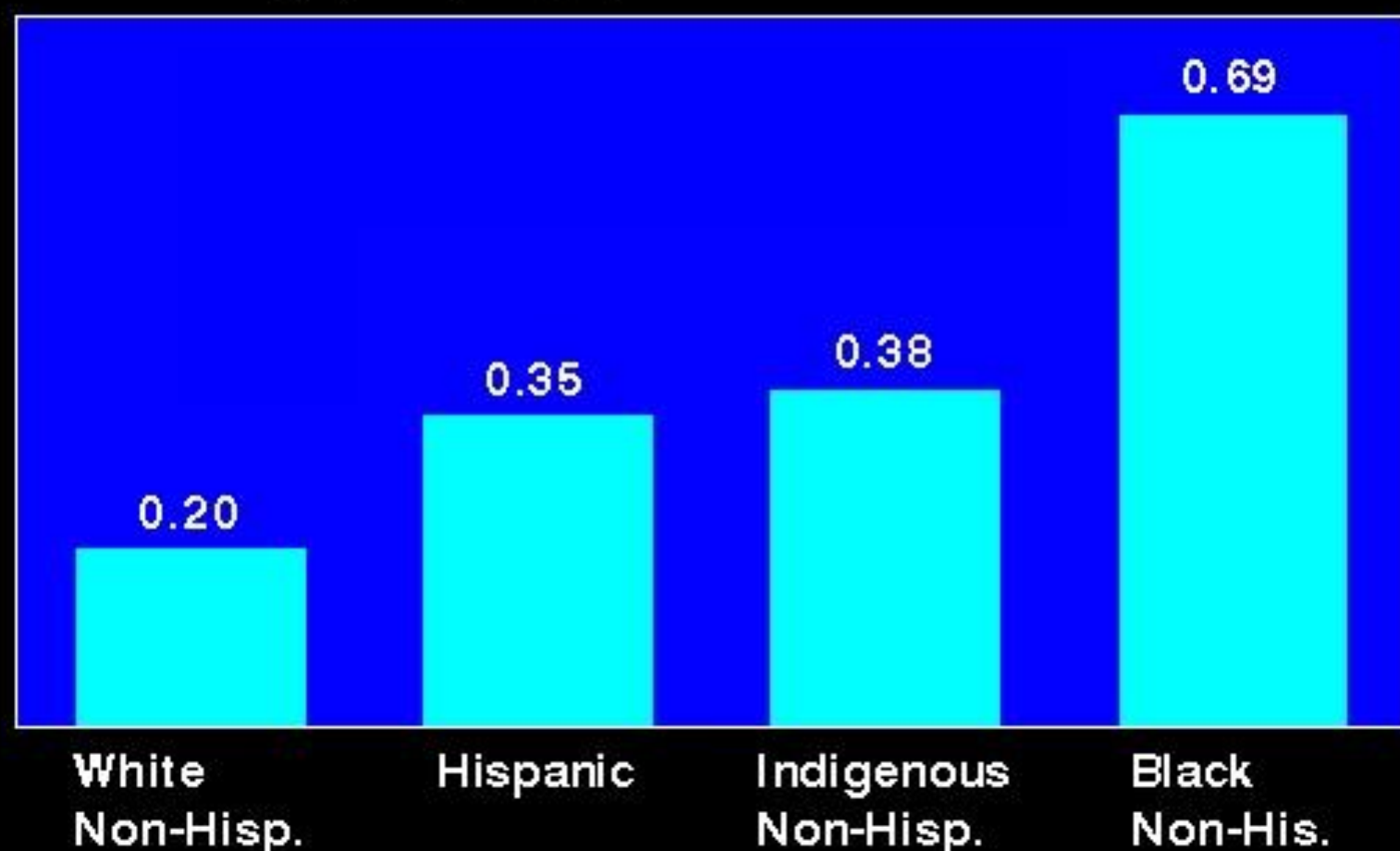


Source: NY Times 10/25/15

* Contraband found among those searched

Police Killings Target People of Color

Police killings/100,000 population



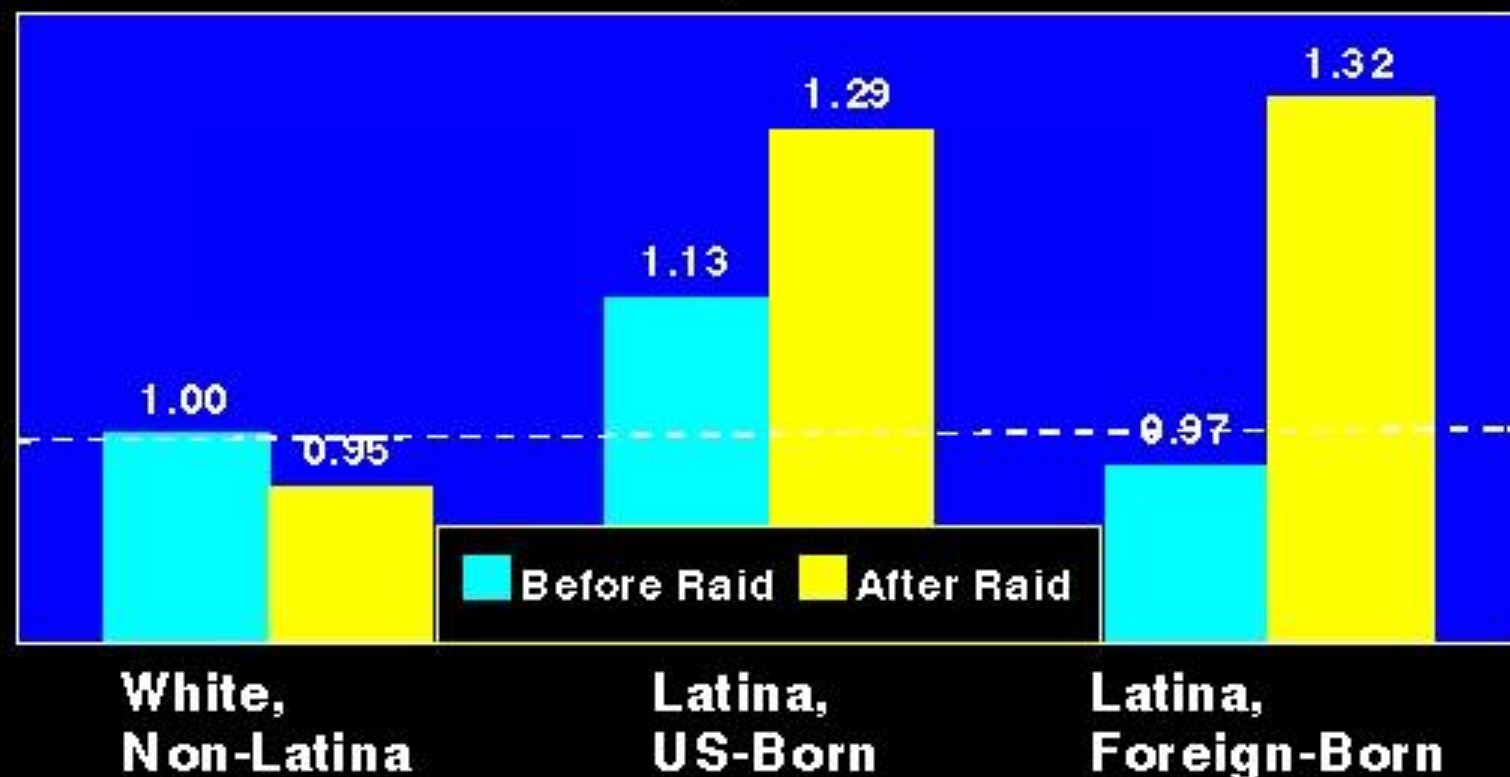
Source: Lancet 2021;398:1239

Note: The rate of police killings rose 38.4% between the 1980s and 2010s

Protecting Immigrants' Right to Health Care

Low Birth Weight Increased In Iowa After A Massive Immigration Raid

Relative risk of Low Birth Weight

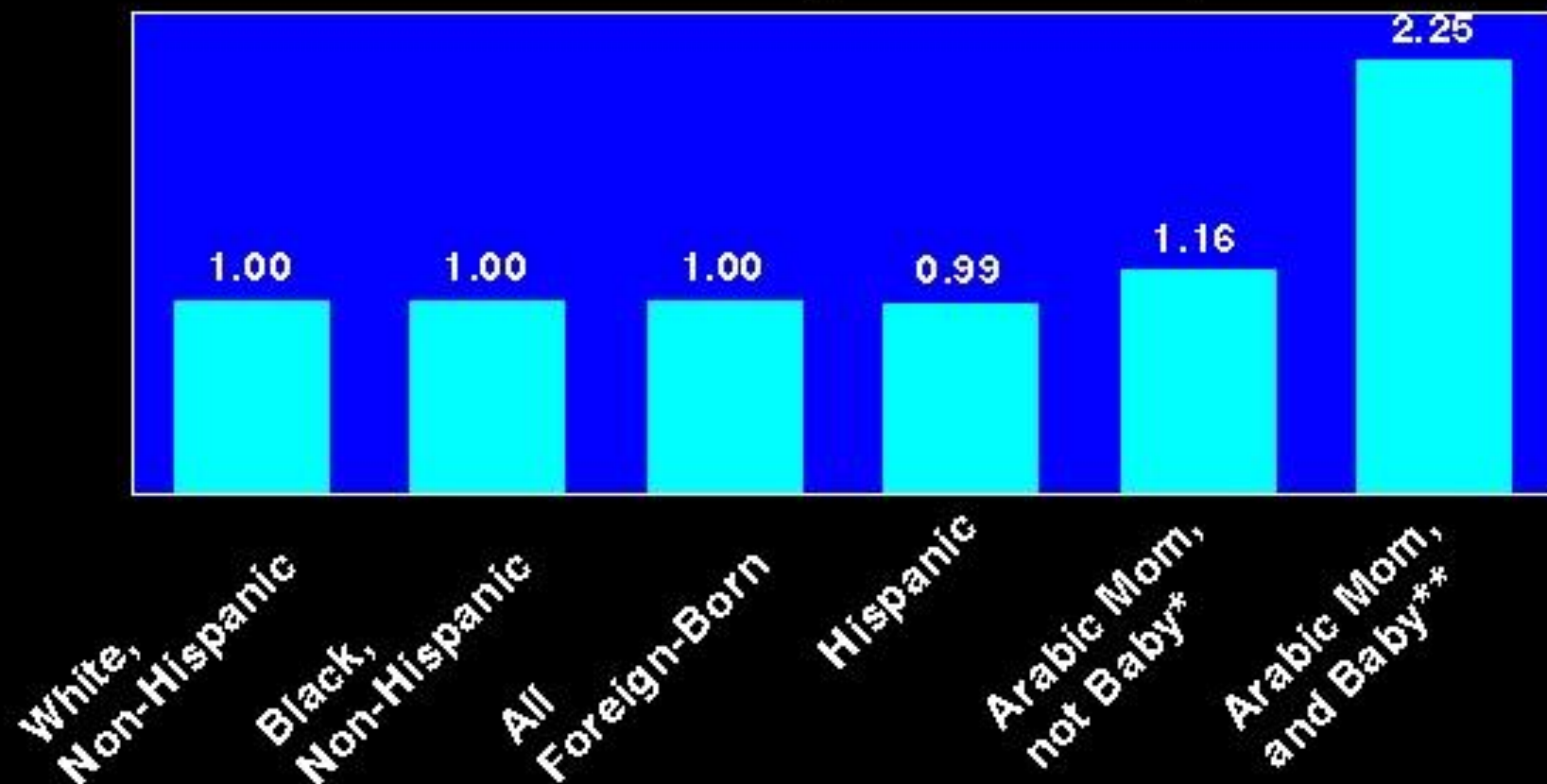


Source: Int J Epidemiol 2017;839

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

Low Birth Weight Rose Among Arabic-Named Women in California After 9/11

Relative risk of Low Birth Weight Post vs. Pre-9/11



Source: Demography 2006;43:185

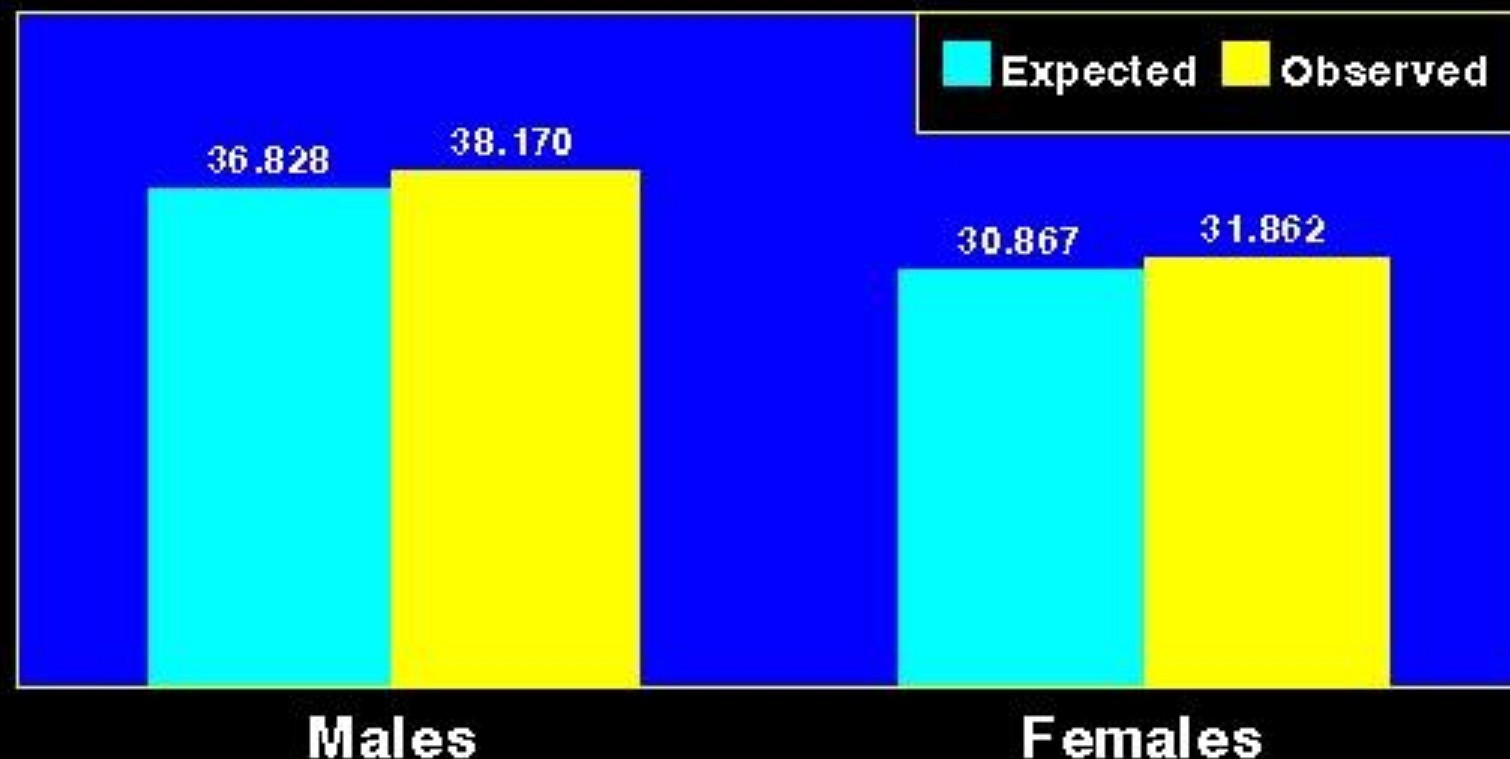
* Mother's name Arabic, infant's name not ethnically distinctive

** Mother's name Arabic, infant's name ethnically distinctive

Preterm Latinx Births Increased After Trump's Election

2337 Excess Preterm Births During 9 Months Post-Election

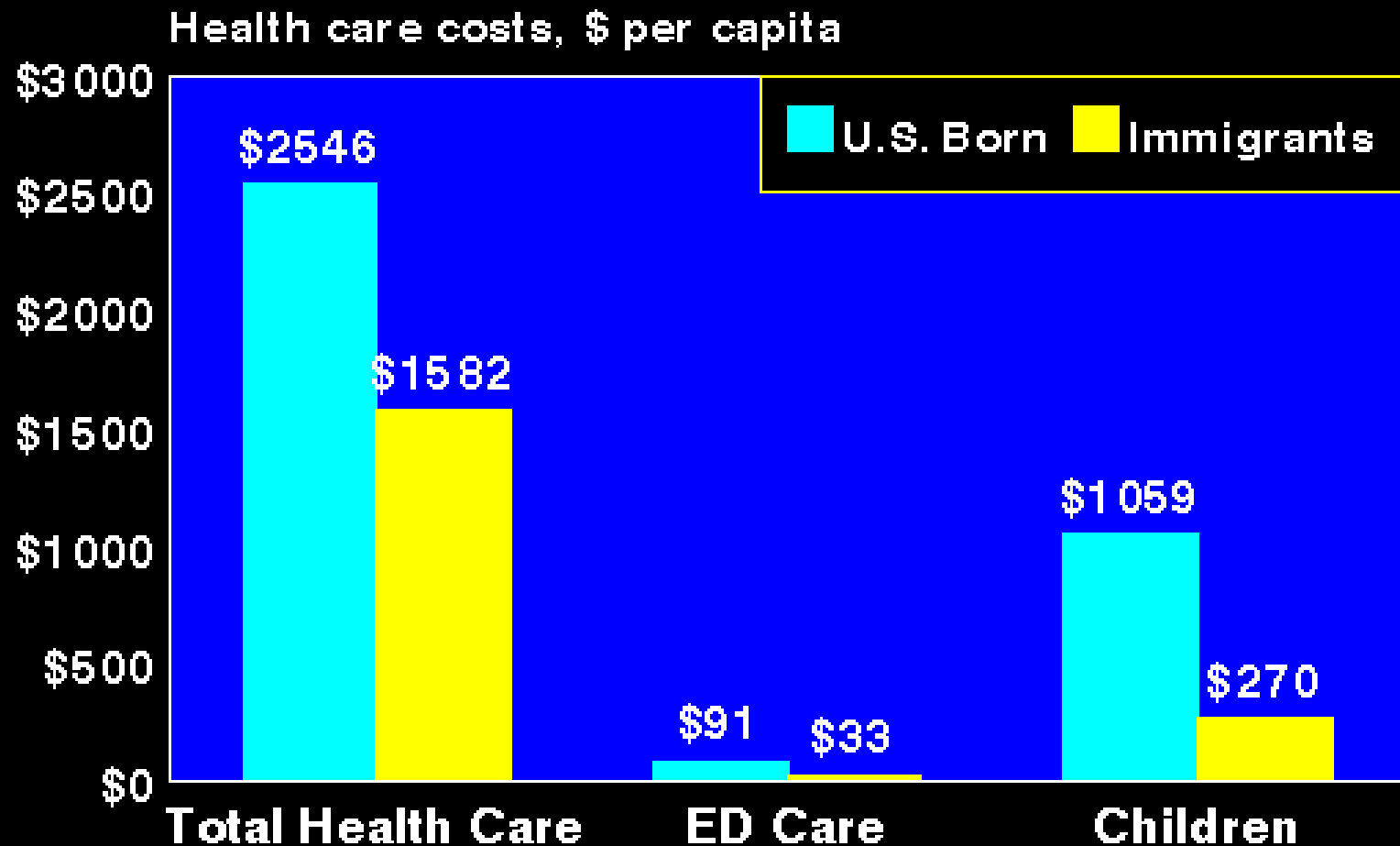
of preterm births to Latina women, 11/2016-7/2017



Source: Gemmill et al, JAMA Network Open July 19, 2019

Note: Expected number calculated based on trends, 2009-October, 2016

Immigrants Get Little Care

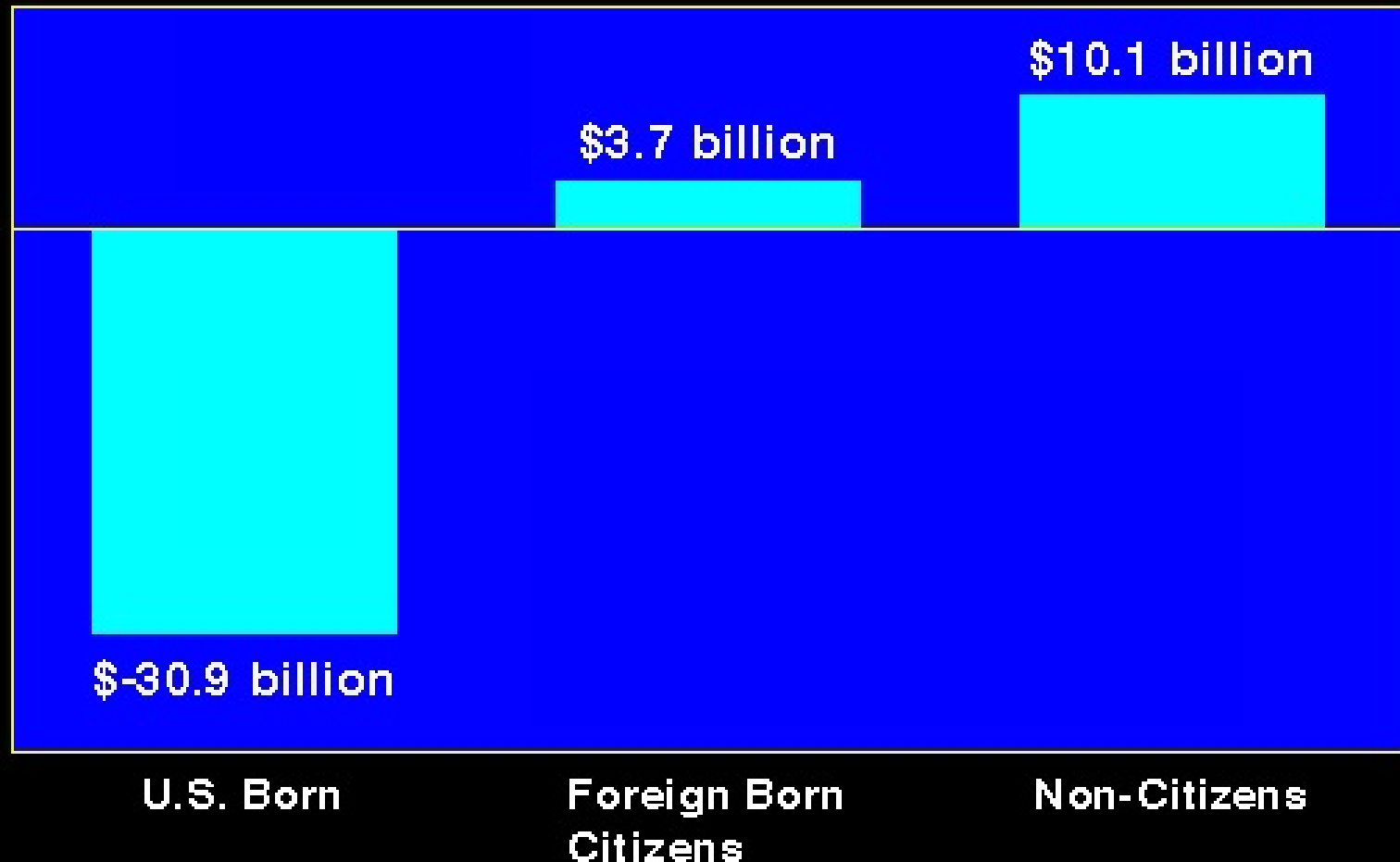


Source: Mohanty et al Am J Public Health 2005;95:1431

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

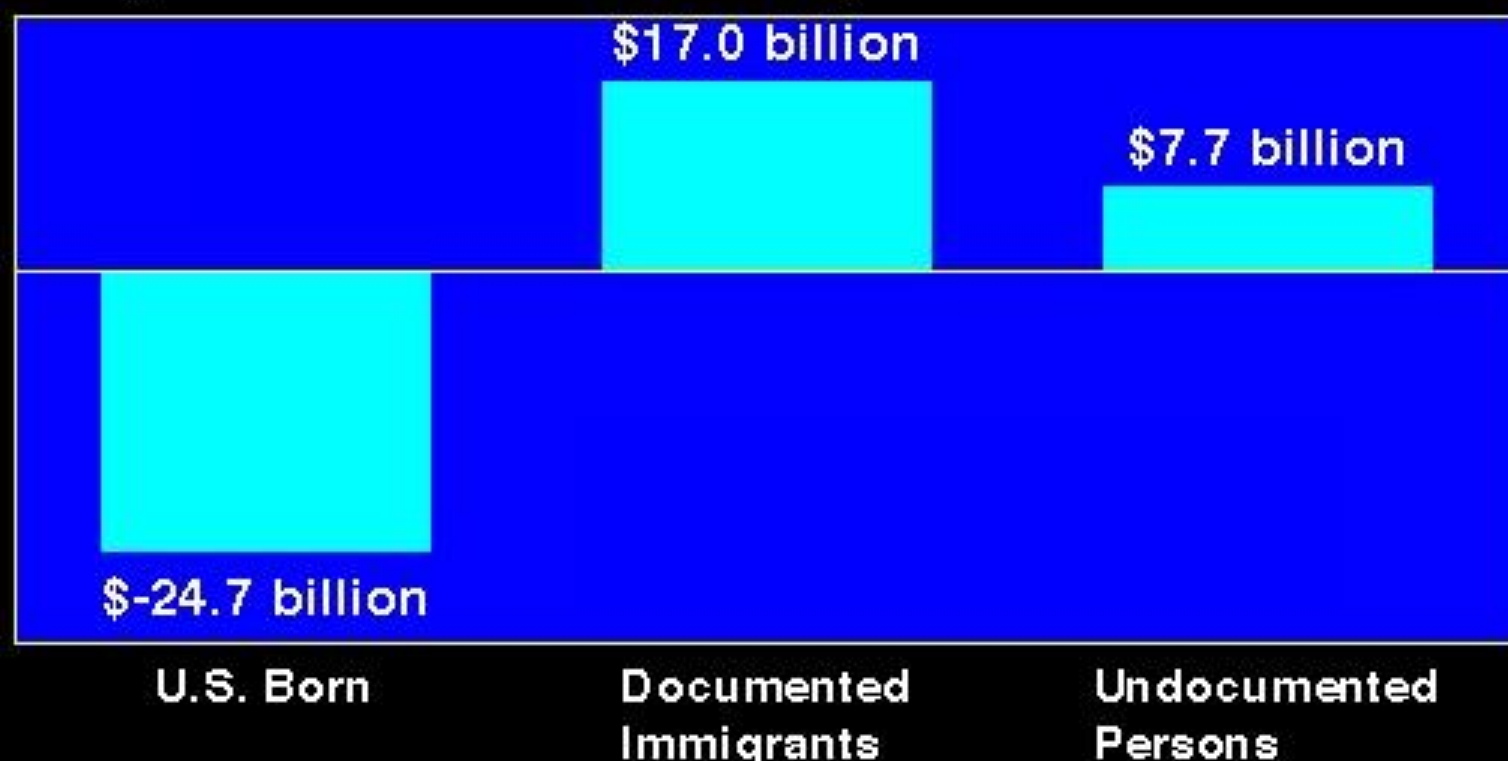
Immigrants Keep Medicare Afloat

Net Contribution to Medicare Trust Fund, 2009



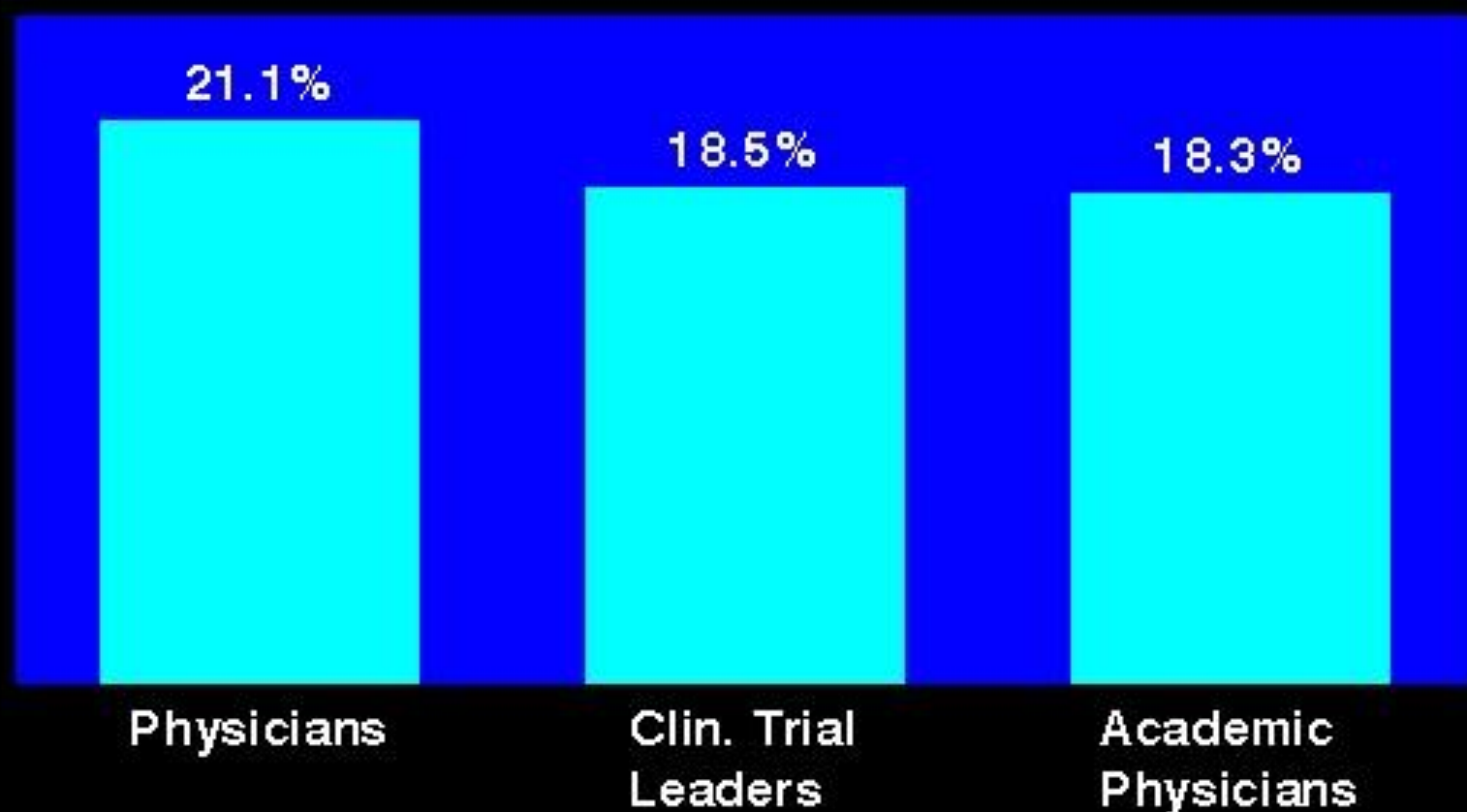
Immigrants Subsidize Native-Born in Private Insurance

Net contribution to private insurance, 2014
(premiums minus benefits)



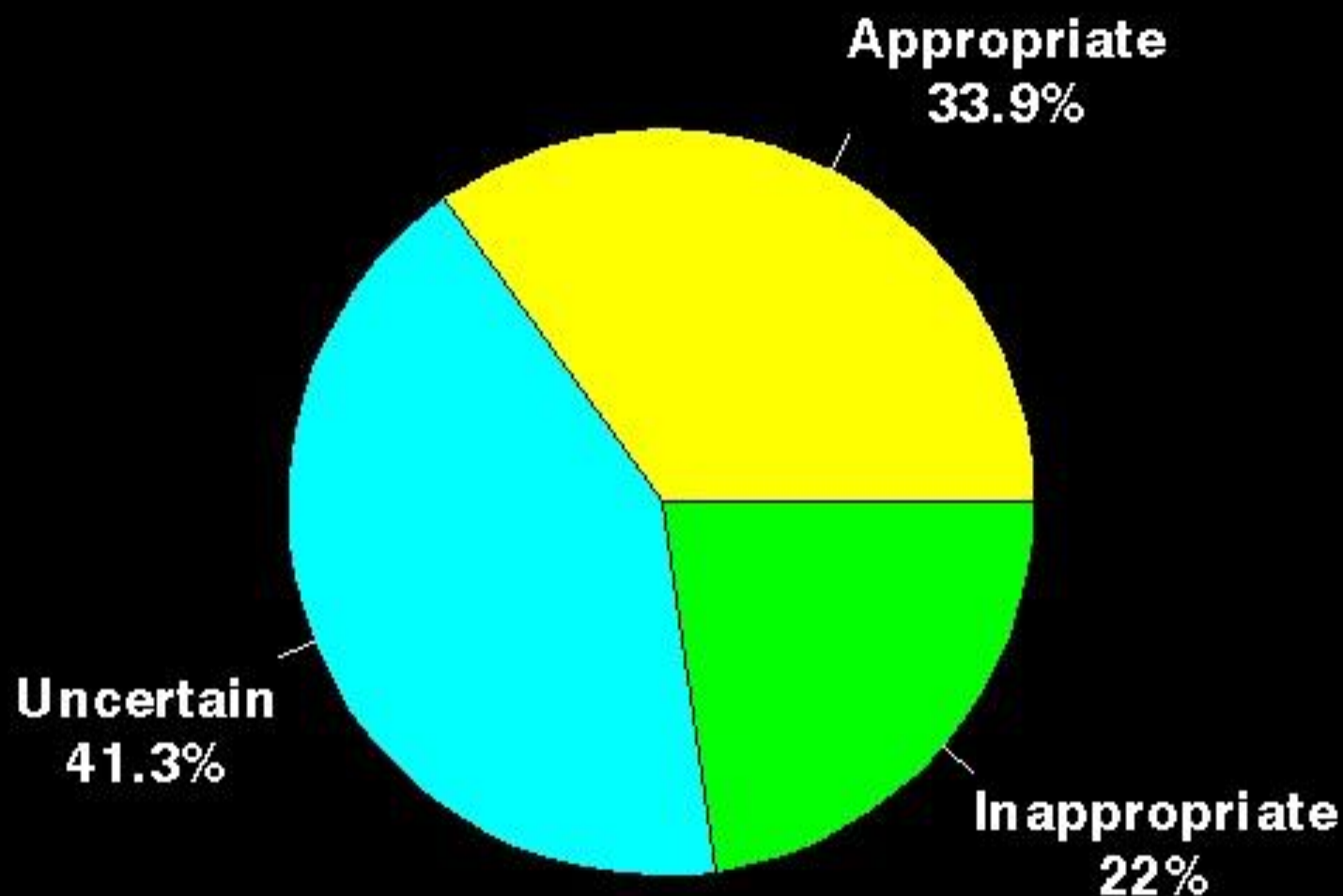
Immigrants Play Vital Roles in U.S. Care, Science and Education

Foreign medical graduates' share of total



While Many Go Without
Vital Services, Others
Get Low- or No-Value
Care

Many Elective PCIs Are Inappropriate

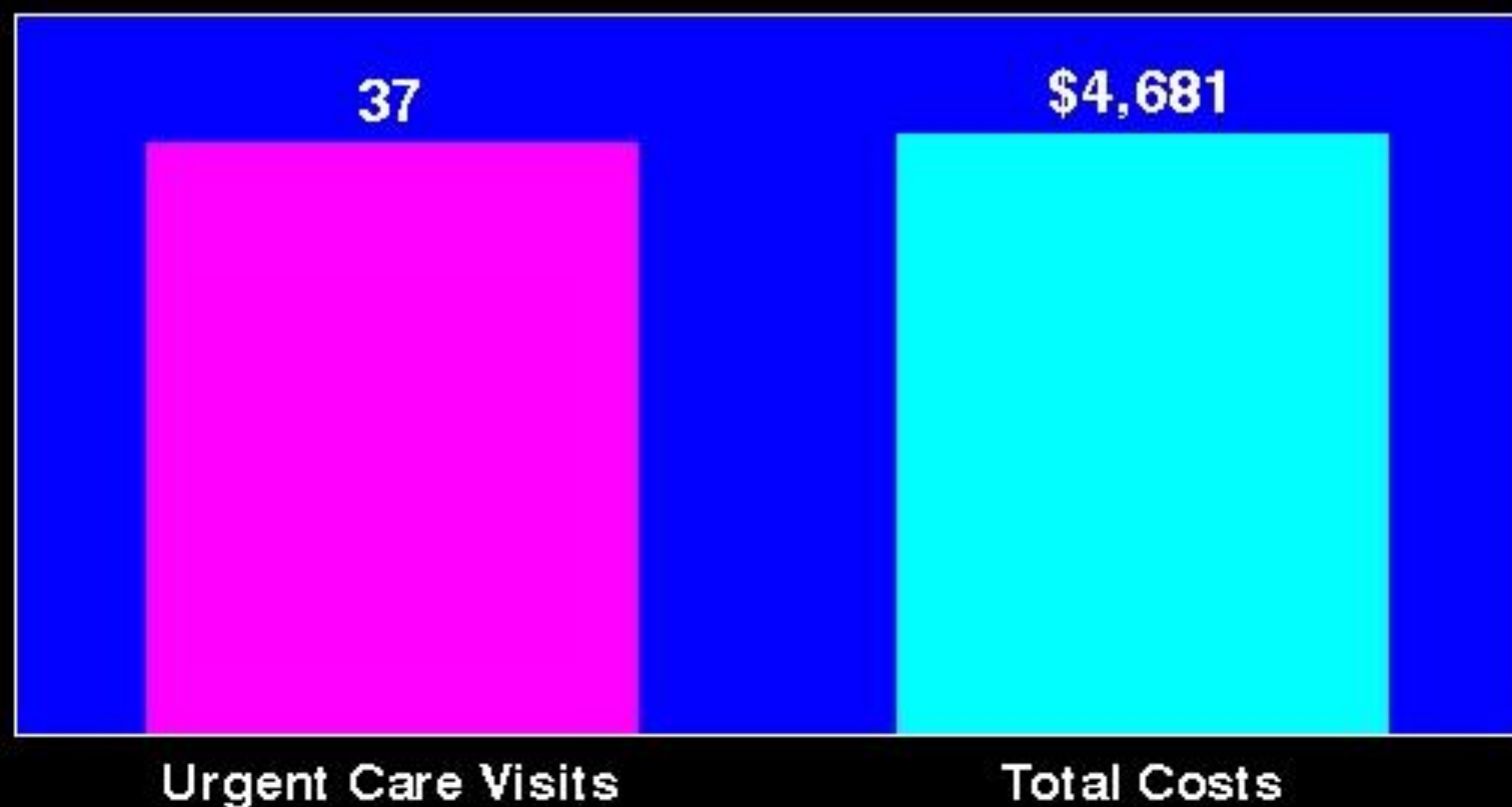


Source: JAMA IM 2014;174:1630 - Based on 1,225,562 patients in PCI Cath registry

Urgent Care Centers Raise Costs

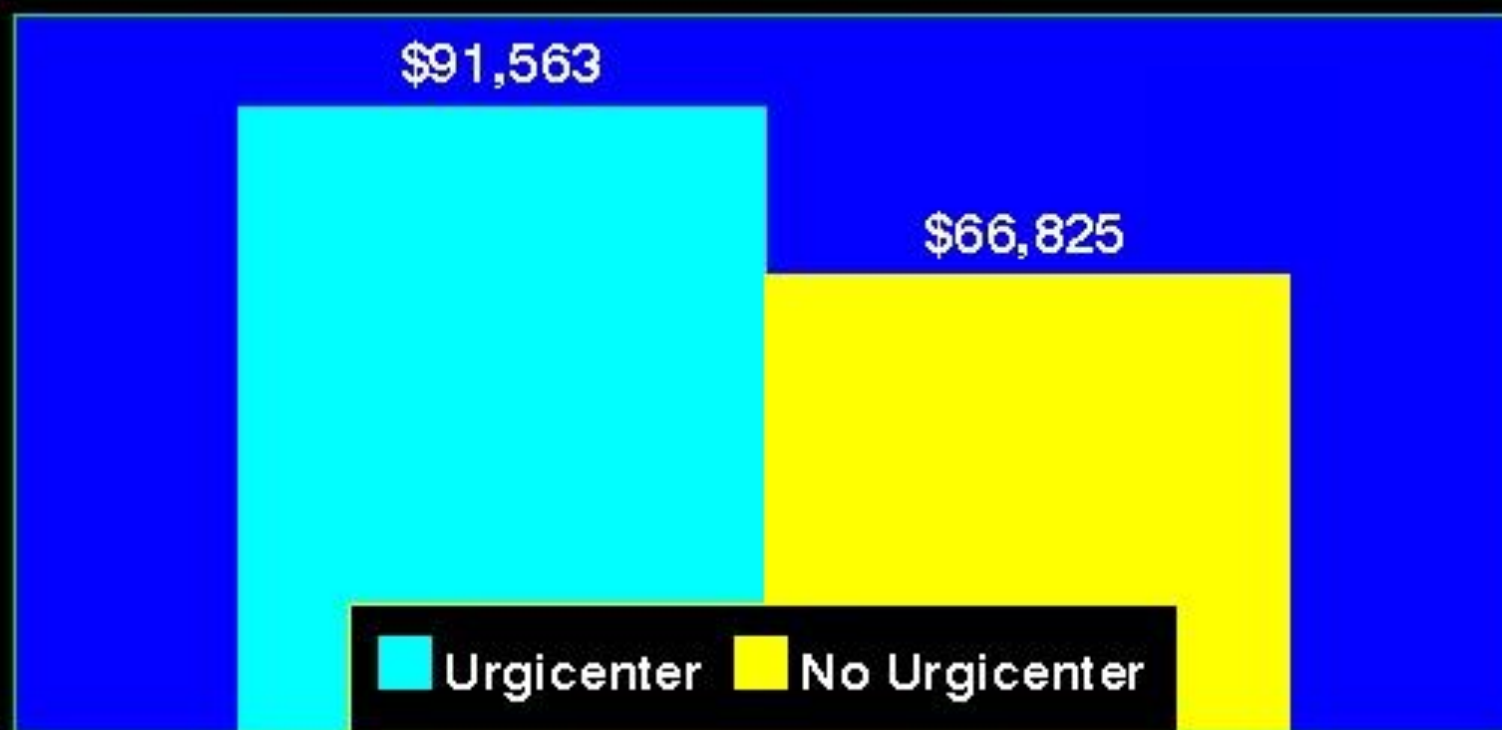
Extra Urgent Care Visits Outweigh Decreased ED Visits

Change per low acuity ED visit avoided when
urgent care enters market



Free Standing ERs in Texas Avoid Areas of Greatest Need

Mean family income in service area

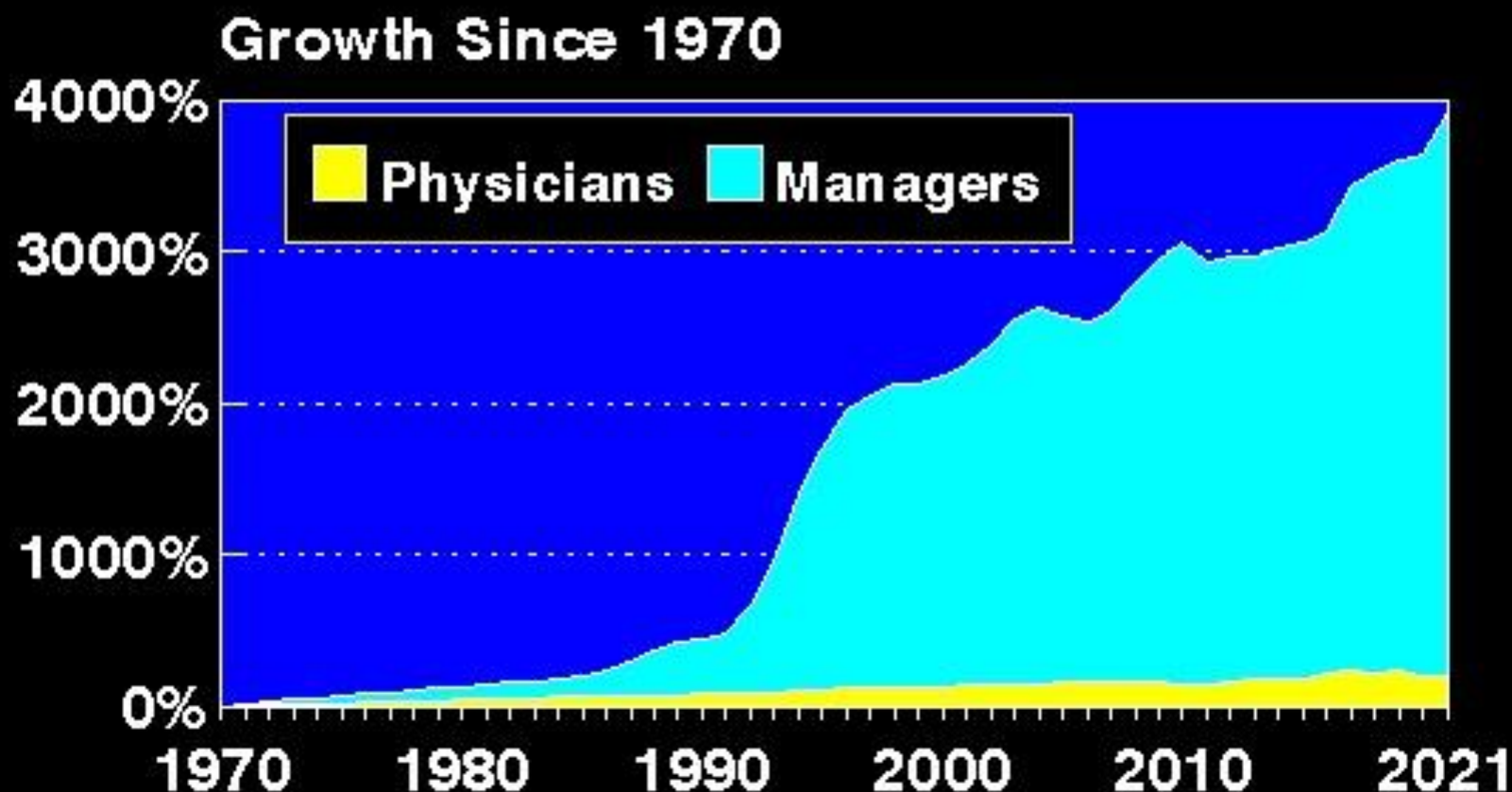


Source: Health Affairs 2017;36:1712 -

Note: Urgicenters were also more likely to locate in areas with more private insurance (70% vs. 57%) less Medicaid (14% vs. 21%) and uninsured (13% vs. 19%). Presence of hosp. ED not predictive

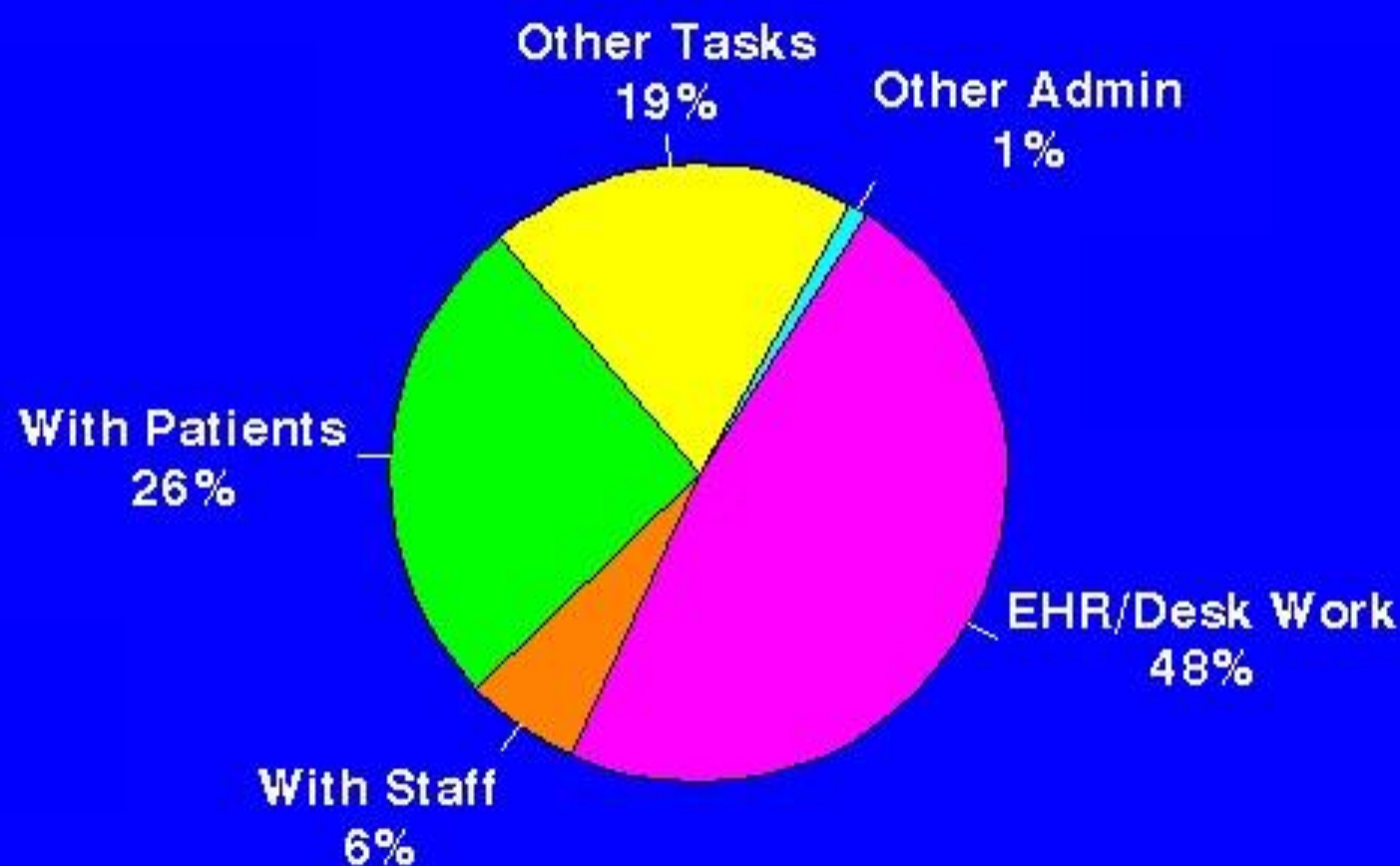
Administrative Overhead Rising

Growth of Physicians and Administrators 1970-2021



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

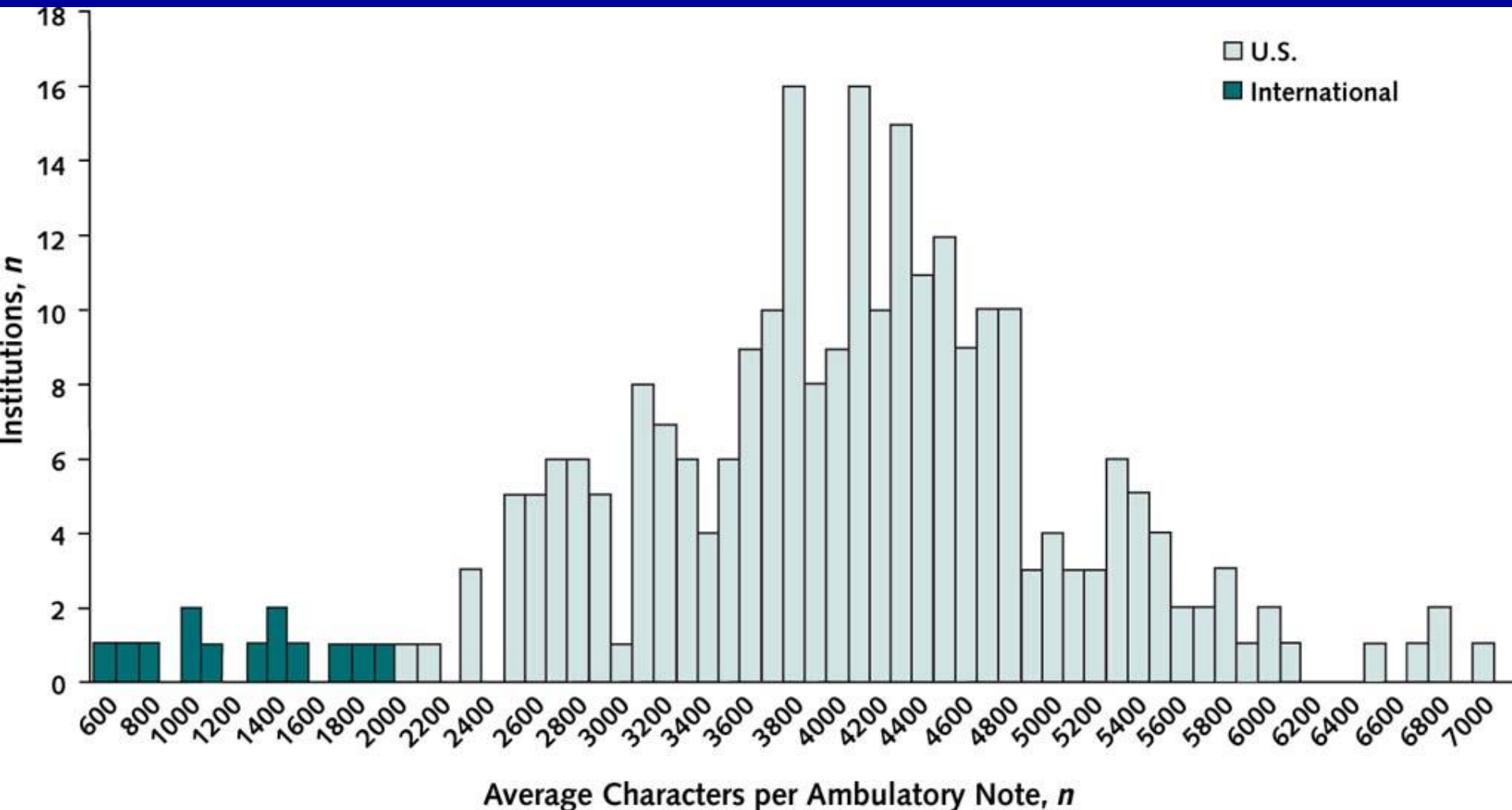
Doctors Spend Twice as Much Time on EHR/Desk Work as With Patients



Source: Sinsky et al. Ann Int Med 9/6/2016 - based on time/motion observation + home diary
Note: Figures are percent of office hours - exclude the 1-2 hrs/night of home EHR/desk work

EPIC EHR Notes 4x Longer in US

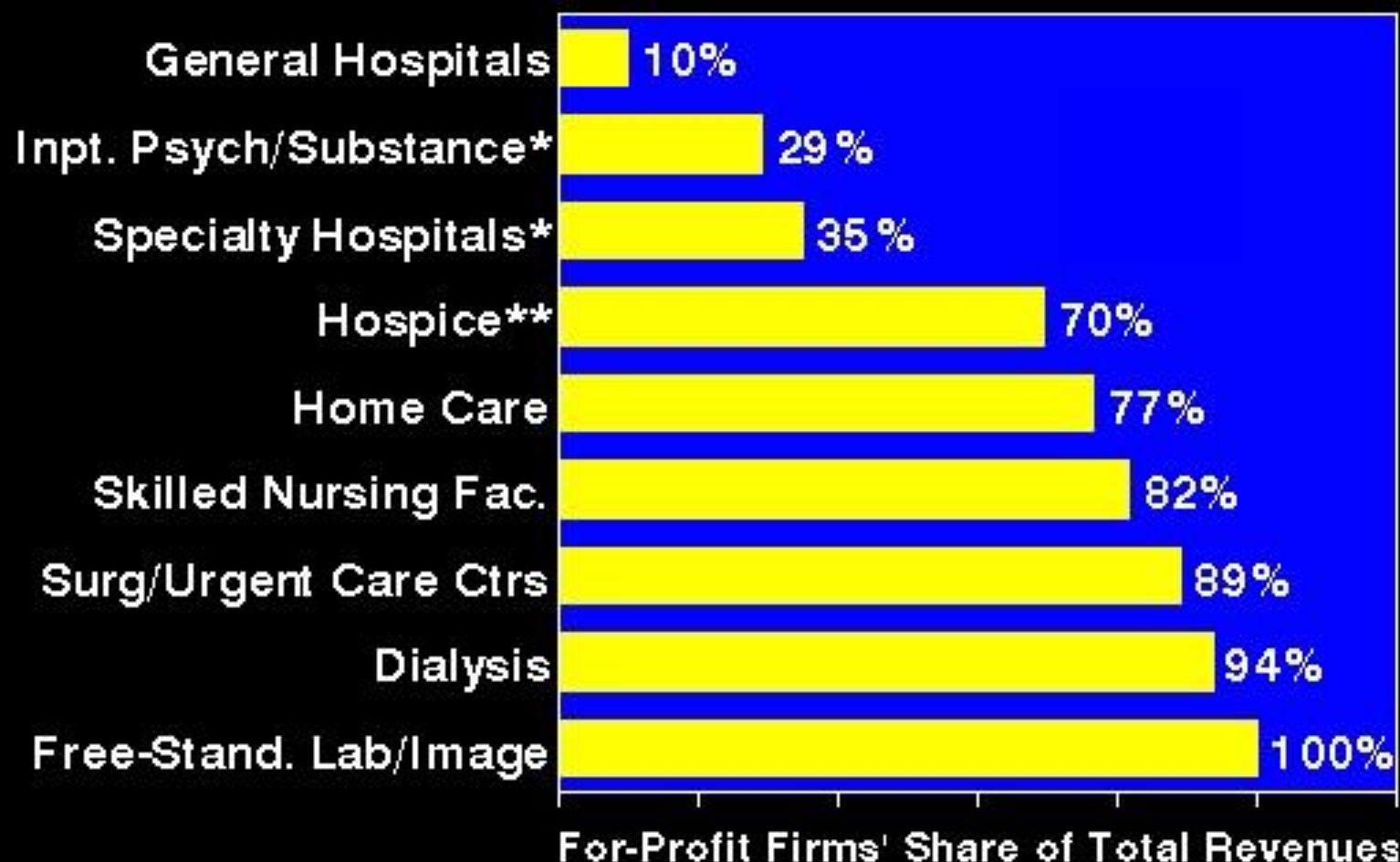
Documentation Driven by Payment Complexity



Source: Ann Intern Med 2018; 169:51

Investor-Owned Care: Inflated Costs, Inferior Quality

Extent of For-Profit Ownership



Source: Commerce Dept. Service Annual Surveys & MedPac. Data are Q1, 2019 or most recent available

* Data are for non-government-owned hospitals

** Data are for share of establishments

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 Care CEO's Pay, 2020

CEO	Firm	Total Pay
Amir Rubin	1Life (primary care)	\$199.0 mil.
Helmy Eltoukhi	Guardant (genetic profiling)	\$113.9 mil.
Mike Pycosz	Oak Street (primary care)	\$73.6 mil.
Javier Rodriguez	Davita	\$73.4 mil.
Ido Schoenberg	AmericanWell (telehealth)	\$69.3 mil.
Pablo Legorreta	Royalty Pharma	\$55.7 mil
Stanley Erck	Novavax	\$48.1 mil.
Michael Weiss	TG Therapeutics	\$32.5 mil.
Clinton Jones	GoHealth (insurance marketplace)	\$31.7 mil.
Samuel Hazen	HCA	\$30.4 mil
David Ricks	Eli Lilly	\$23.7 mil.
Larry Merlo	CVS/Aetna	\$23.0 mil.
Kenneth Frazier	Merck	\$22.1 mil.
Albert Bourla	Pfizer	\$21.0 mil.
Robert Ford	Abbott	\$20.5 mil
Ronald Rittenmeyer	Tenet	\$16.7 mil

Source: AFL-CIO

The Profits of "Non-Profit" Health Systems

Health System	2020 Profit	2019 Profit
Kaiser	\$2,217 mil.	\$2,732 mil.
UPMC	\$836 mil.	\$27 mil.
Intermountain	\$743 mil.	\$506 mil.
Mayo	\$728 mil.	\$1,063 mil.
AdventHealth	\$694 mil.	\$829 mil.
Indiana U. Health	\$656 mil.	\$679 mil.
Baylor Scott & White	\$558 mil.	\$725 mil.
Houston Methodist	\$402 mil.	\$651 mil.

"Non-Profit" Health Systems Becoming Speculative Investors

Organization	Hedge Fund Investments	Private Equity	Total Investments
Kaiser	2.820 bil.	10.180 bil.	35.486 bil.
Ascension	1.357 bil.	3.424 bil.	22.002 bil.
Mayo	3.421 bil.	3.869 bil.	14.320 bil.
MGH/Brigham	NA	1.140 bil.	12.914 bil.
Cleveland Clinic	3.335 bil.	2.061 bil.	12.880 bil.
Advocate Aurora	2.115 bil.	1.959 bil.	12.192 bil.
Indiana U. Health	1.218 bil.	0.802 bil.	7.839 bil.
Sutter	1.132 bil.	0.414 bil.	7.812 bil.

Source: Modern Healthcare 5/3/2021

Non-Profit Leaders Collecting Big Paydays From Pharma

Name	Position	Company	Board Pay 2017	Share Value
Robert Alpern	Dean, Yale	AbbVie	\$335,929	\$4.3 mil
Peter McDonnell	Dir, Hopkins/Wilmer Eye	Allergan	\$449,941	\$0.7 mil
Tyler Jacks	Dir, MIT Koch Inst.	Amgen	\$343,998	\$1.1 mil
Julia Haller	Chief, Wills Eye Hosp.	Celgene	\$525,470	\$86.5 mil
Marshall Rung	Dean, U Mich.	Lilly	\$279,000	\$1.1 mil
Kevin Lofton	CEO, Catholic Hlth Init.	Gilead	\$415,803	\$1.8 mil
Laurie Glimcher	CEO, Dana Farber	Glaxo	\$101,000	\$0.1 mil
Mary Beckerle	CEO, Huntsman Cancer	J & J	\$324,893	\$0.7 mil
Mark McClellan	Dir, Duke Hlth Pol	J & J	\$284,893	\$1.2 mil
A E Washington	CEO, Duke	J & J	\$284,893	\$2.3 mil
John Noseworthy	CEO, Mayo	Merck	\$234,167	\$0.3 mil
Charles Sawyers	Chair, MSKCC	Novartis	\$367,000	\$0.7 mil
Dennis Ausiello	Dir, MGH Ctr.	Pfizer	\$375,000	\$1.9 mil
Joseph Goldstein	Chair, U Tx Southwest	Regeneron	\$1,307,211	\$4.2 mil

Source: BioPharma Dive - "Directors who hold board seats and lead non-profits"

For-Profit Hospitals Cost 19% More

Source: CMAJ 2004;170:1817

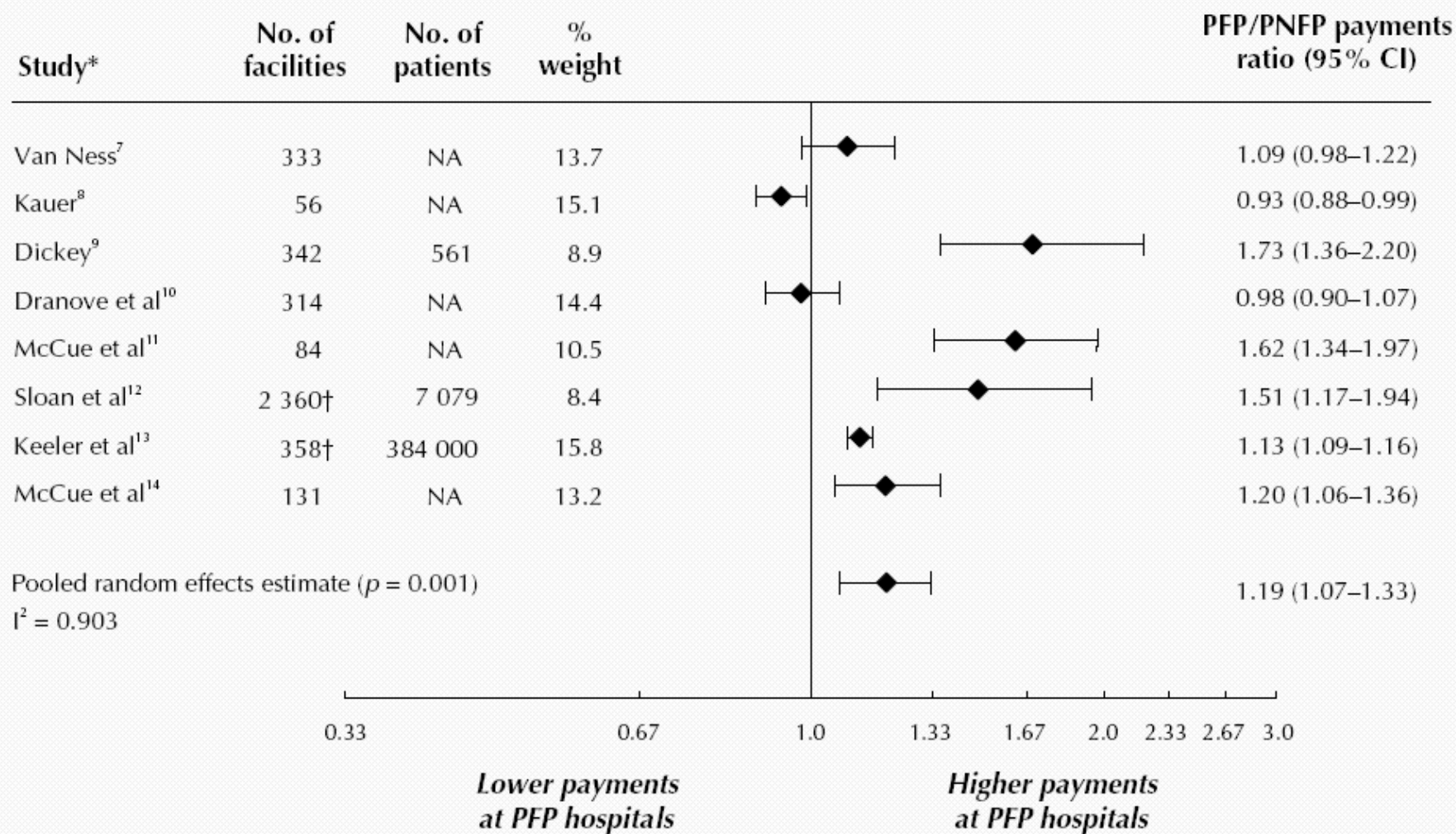
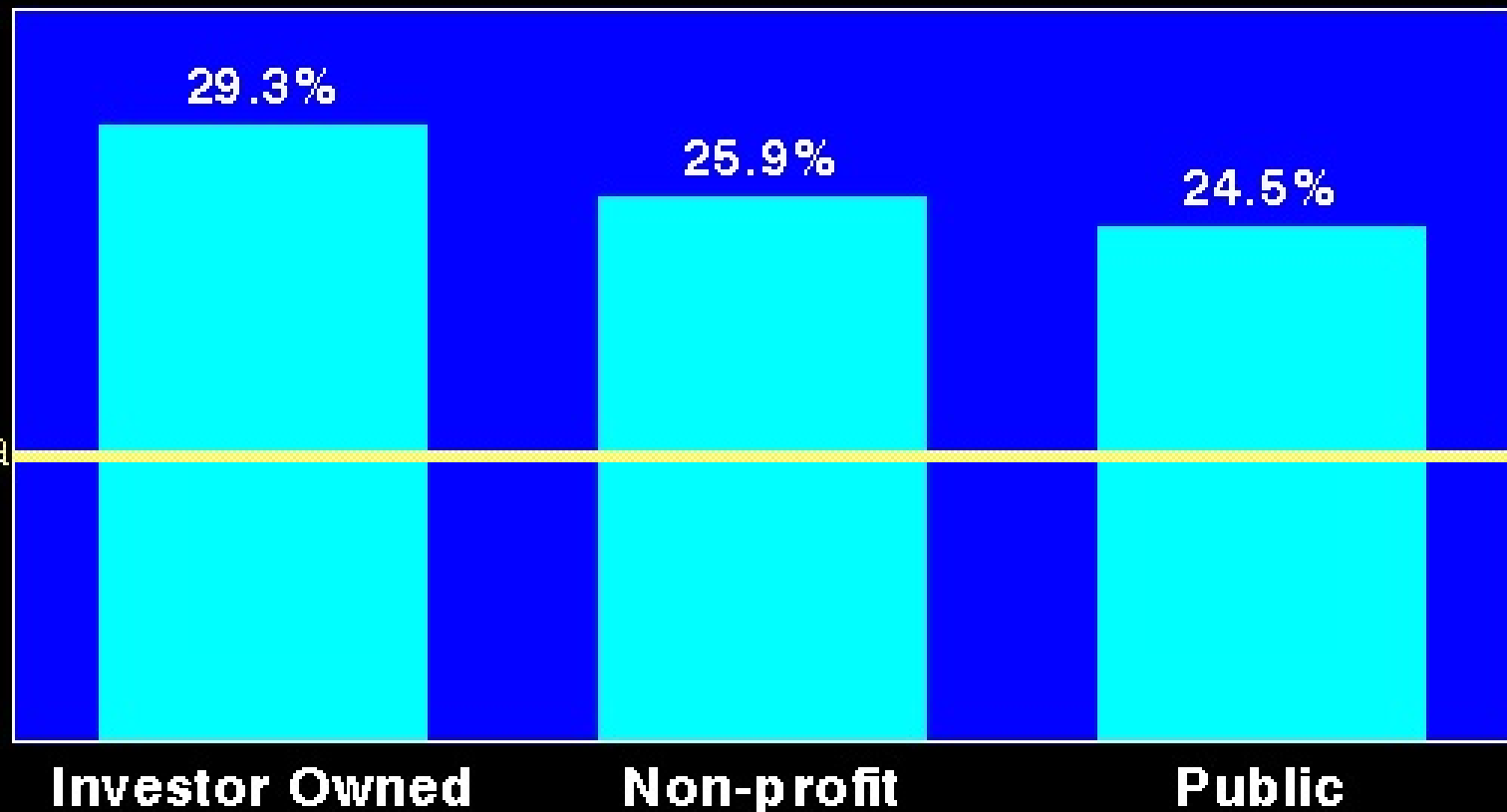


Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.

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

For-Profit Hospitals' Administrative Costs are Higher

% spent on administration

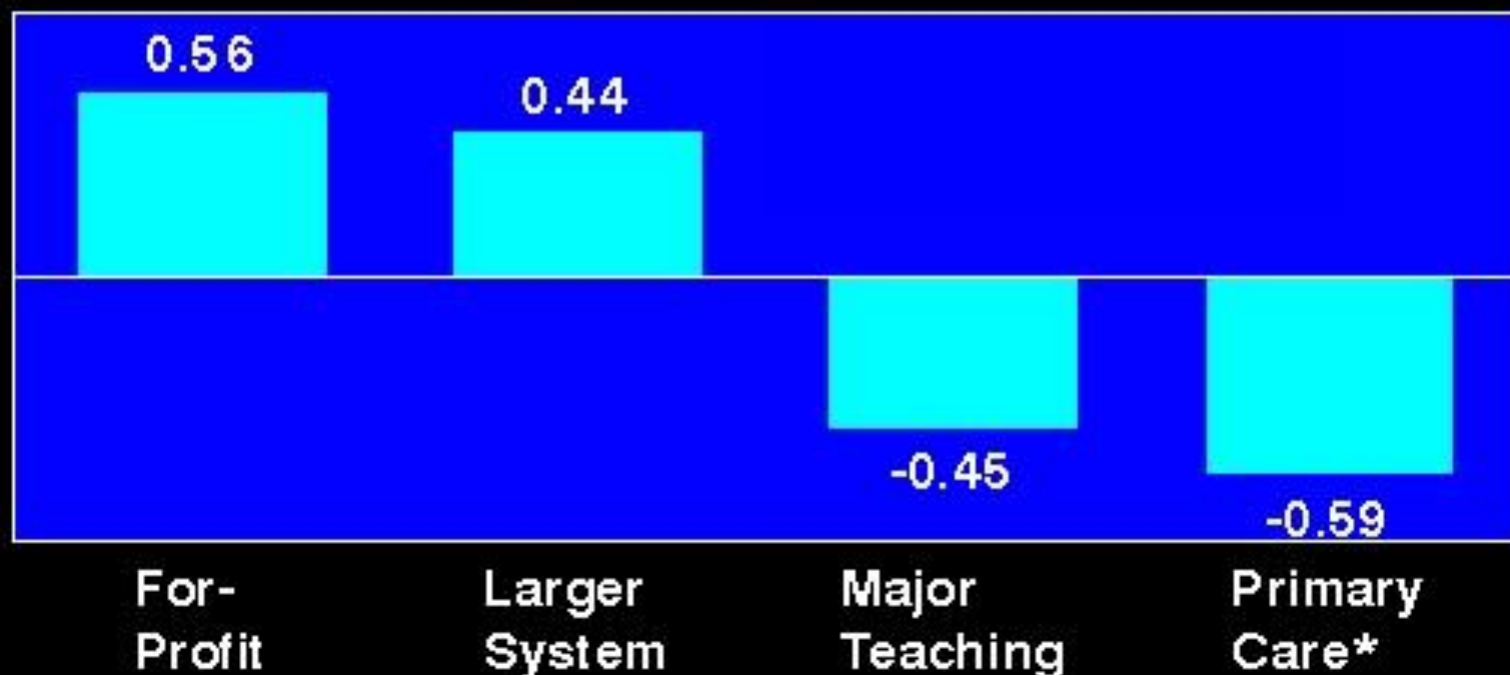


Source: Woolhandler & Himmelstein analysis of Medicare Cost Reports + Ann Int Med 2020

For-Profit Hospitals, Larger Systems Deliver More Low/No-Value Care

Teaching Hospitals and Those With More Primary Care Deliver Less

Overuse index
(expressed as standard deviations from mean)



Source: JAMA Health Forum 2022;3:e214543

Note: Overuse index is summary measure based on volume of 17 low/no value services

* Highest tertile of primary care physician supply

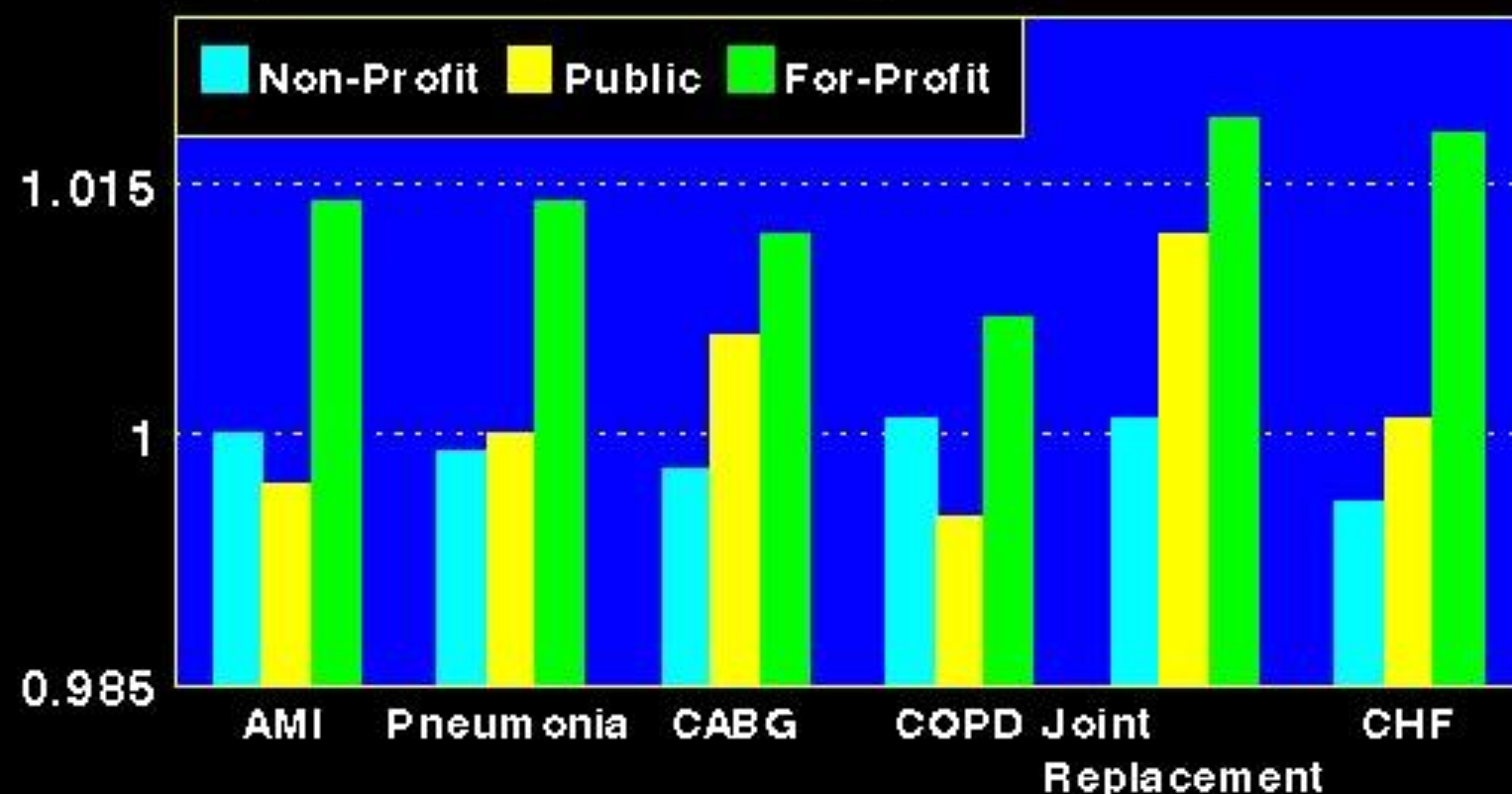
Doctors at For-Profits Take More Pharma Money

Proportion of doctors receiving drug company payments

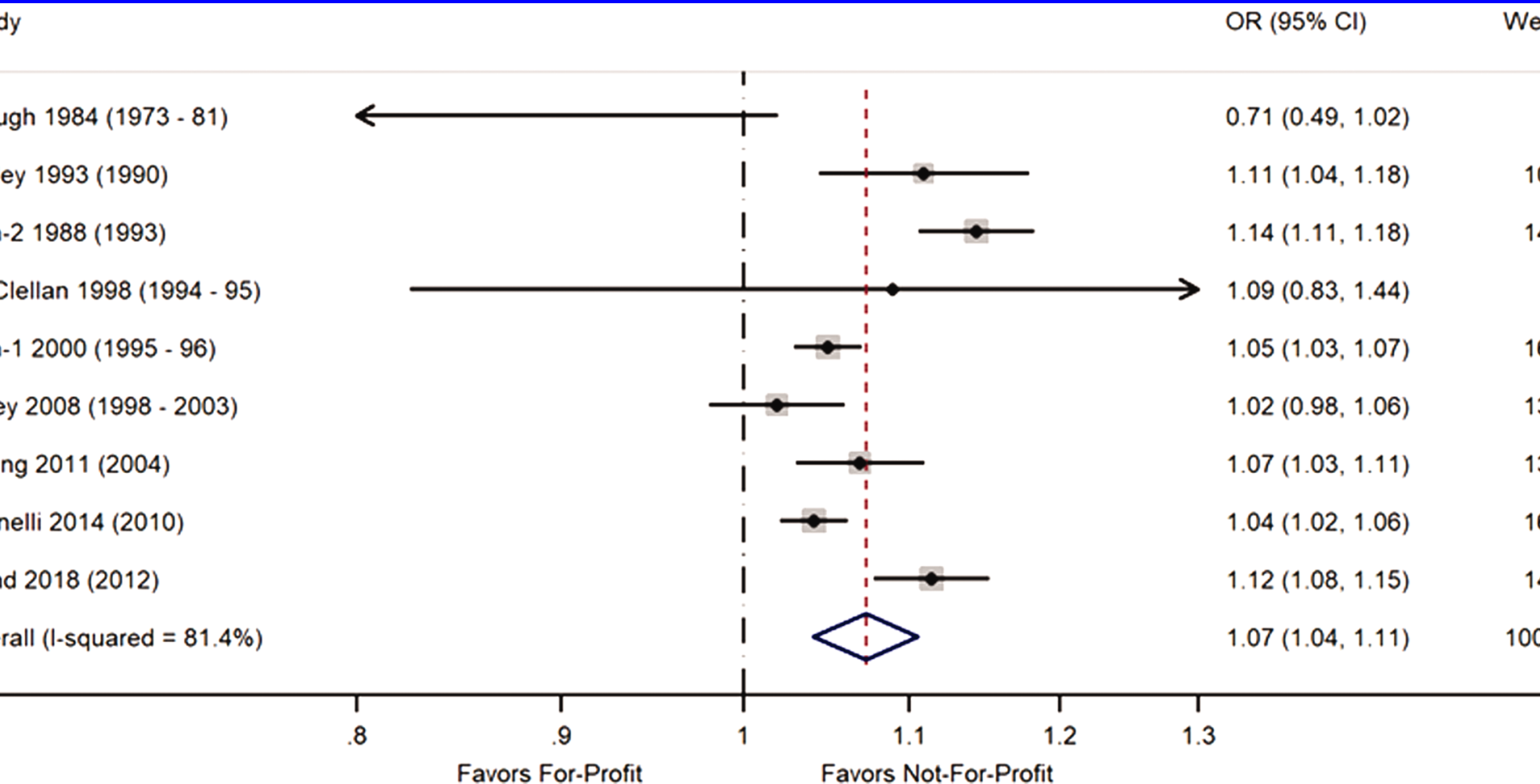


For Profit Hospitals Have Highest Readmission Rates for EVERY Condition

Readmission rate adjusted for severity
(1.00 = expected rate)



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



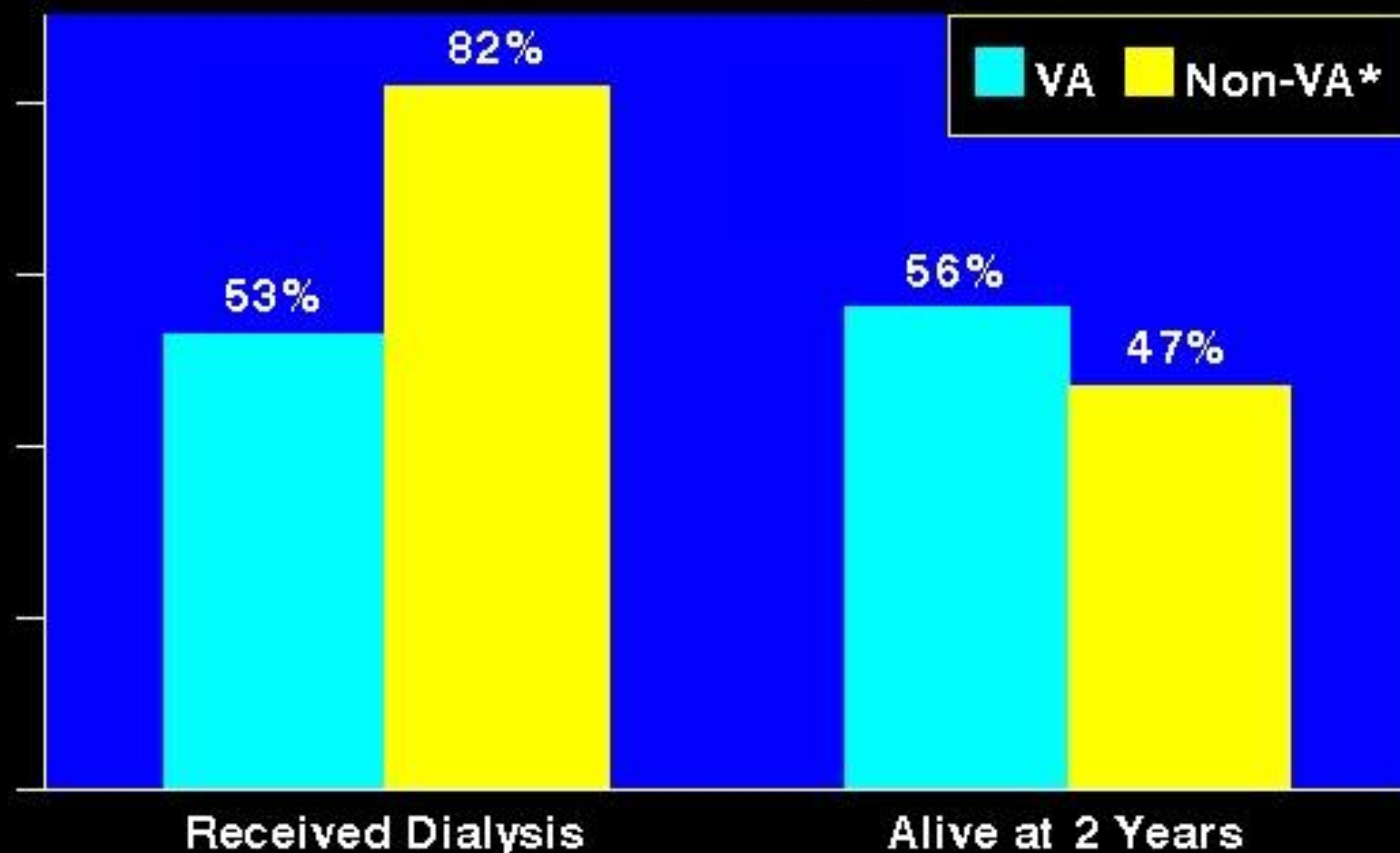
Investor-Owned Dialysis Clinics Discourage Transplants

Percent of dialysis patients placed on transplant list



VA Kidney Care: Less Dialysis, Better Survival

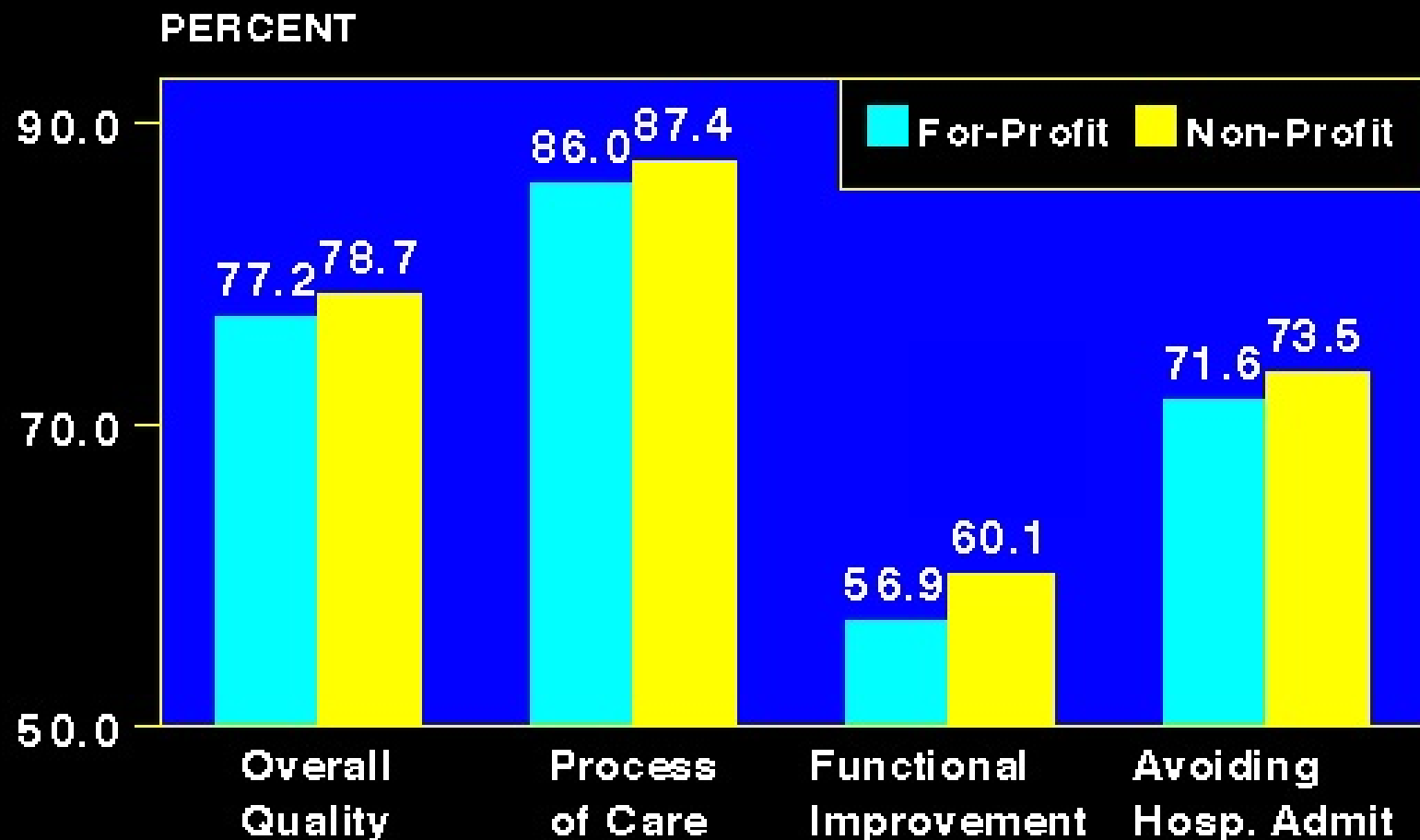
Percent of patients with new kidney failure (eGFR < 15)



Source: JAMA IM 2018;178:657

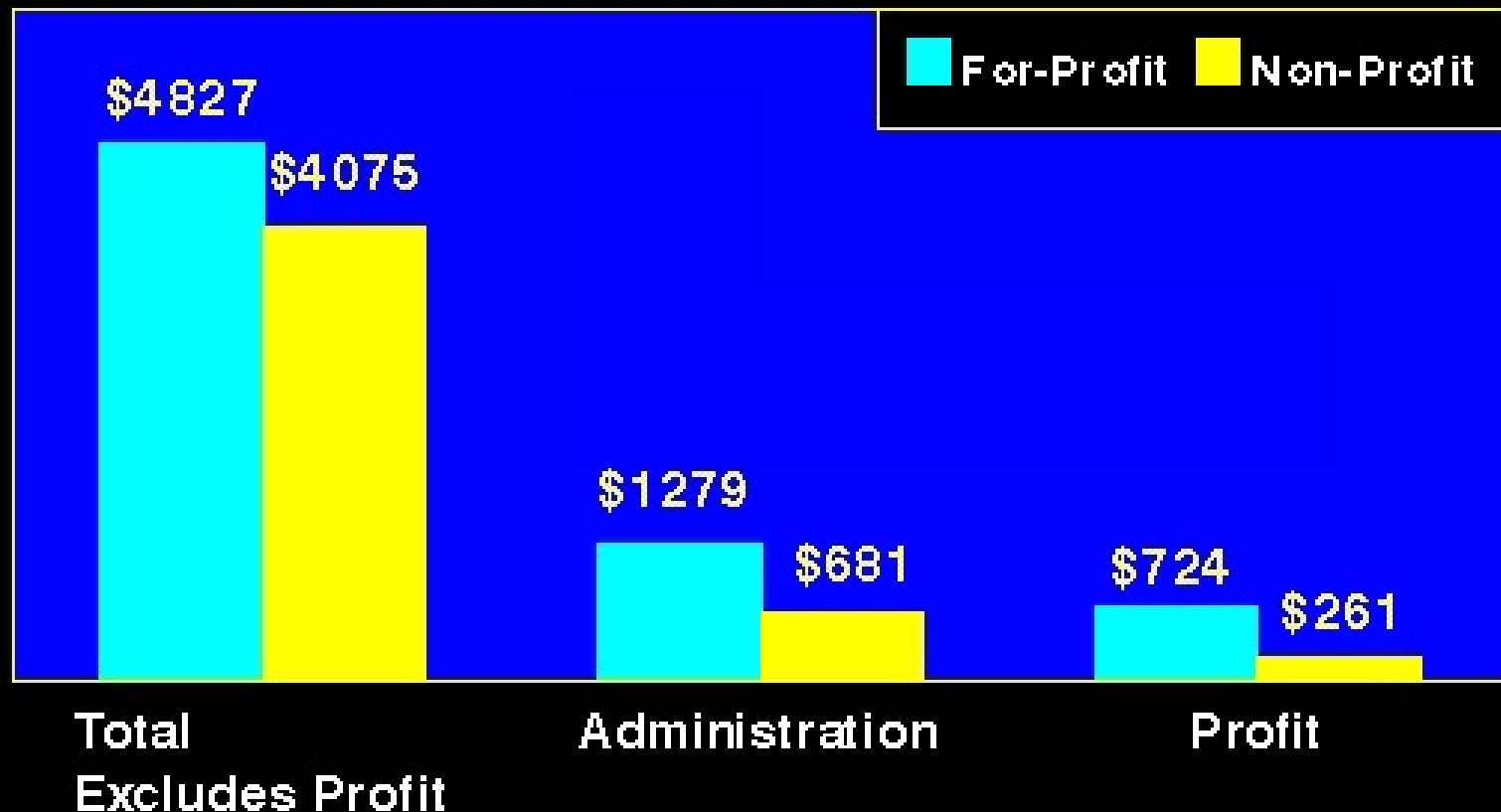
*Non-VA = Medicare-paid, mostly delivered by investor-owned facilities

For Profit Home Care: Lower Quality



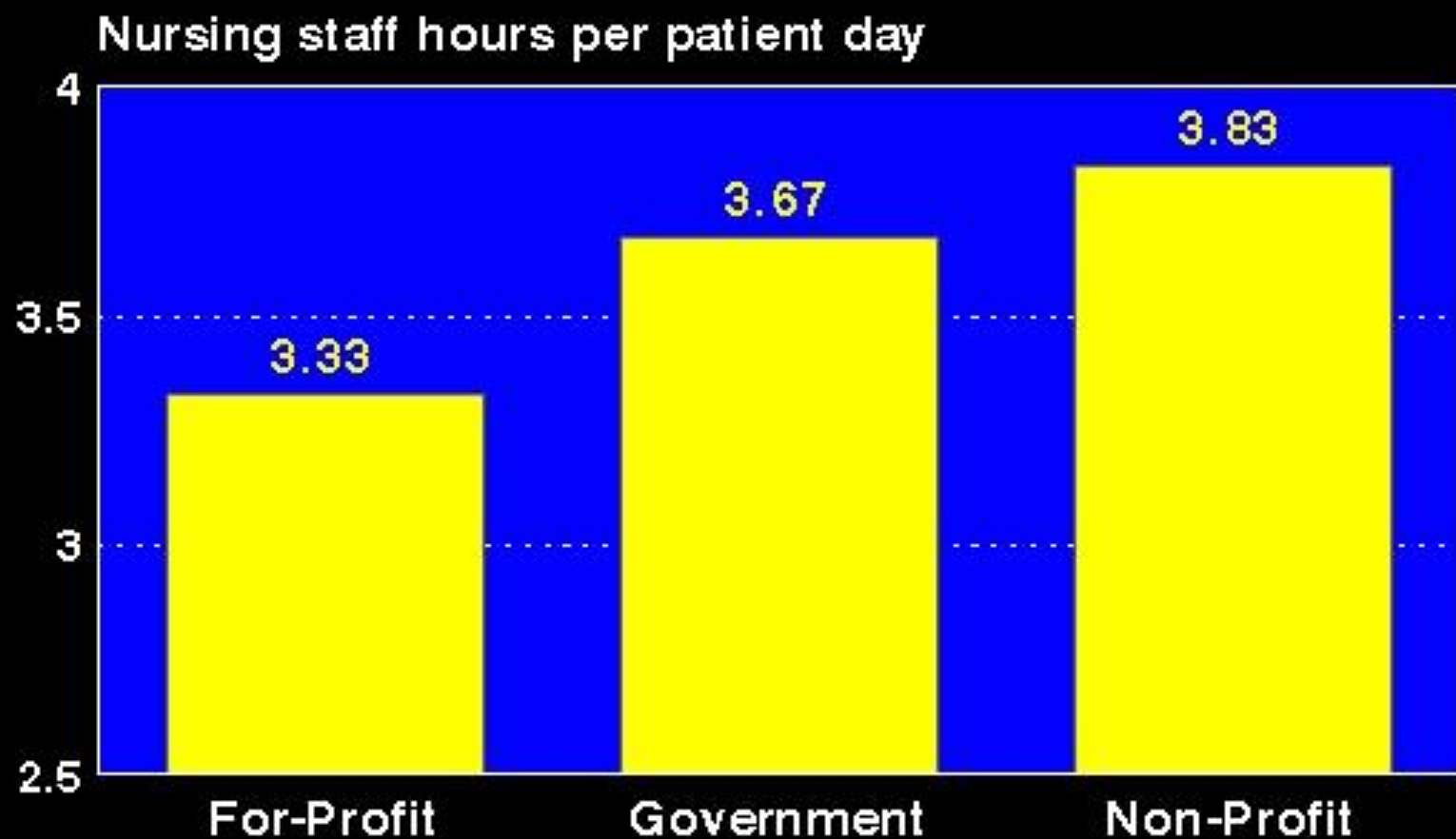
For Profit Home Care: Higher Cost

Annual Cost Per Patient



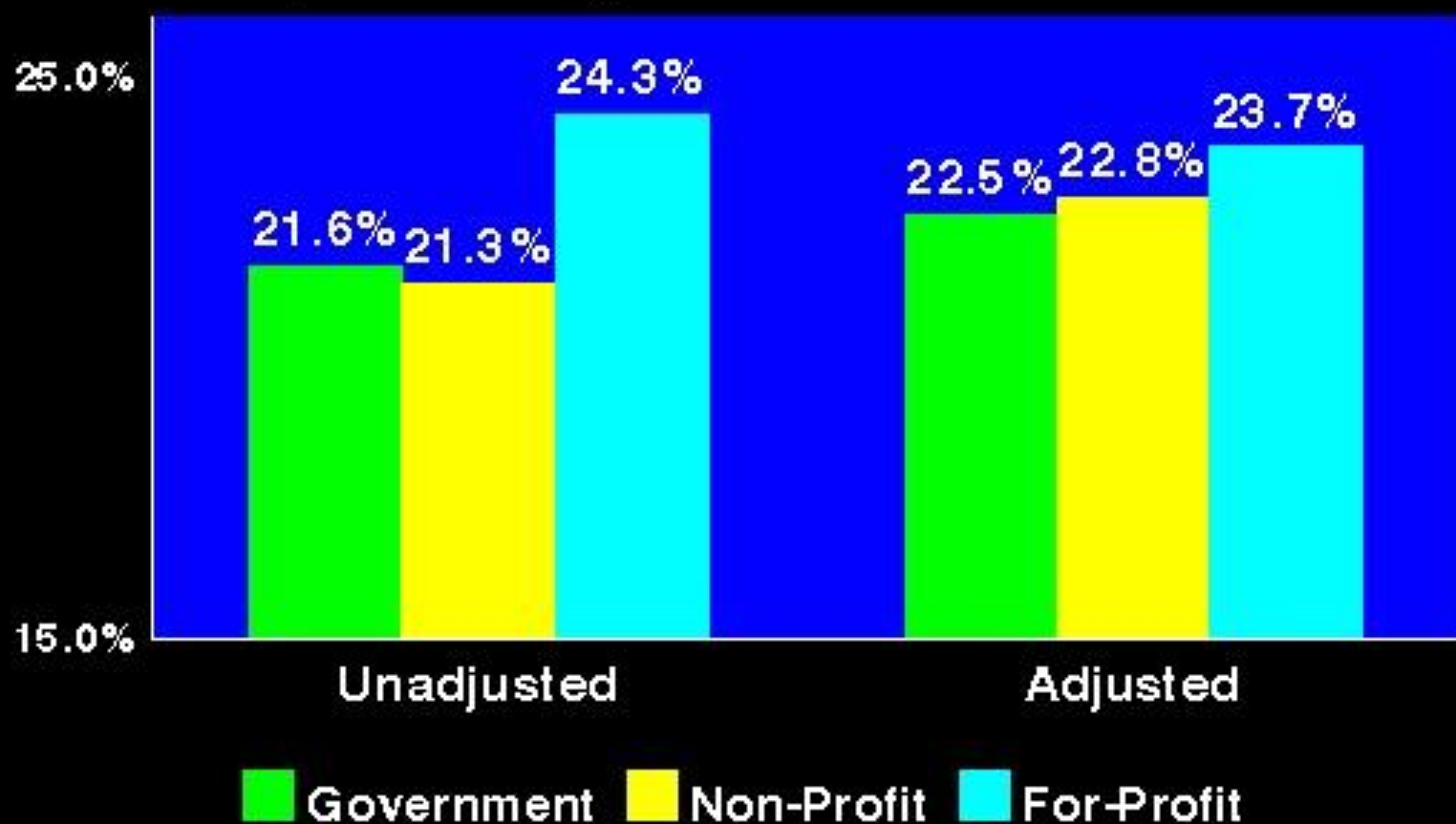
For-Profit Nursing Homes: Less Nursing Care

A National Study



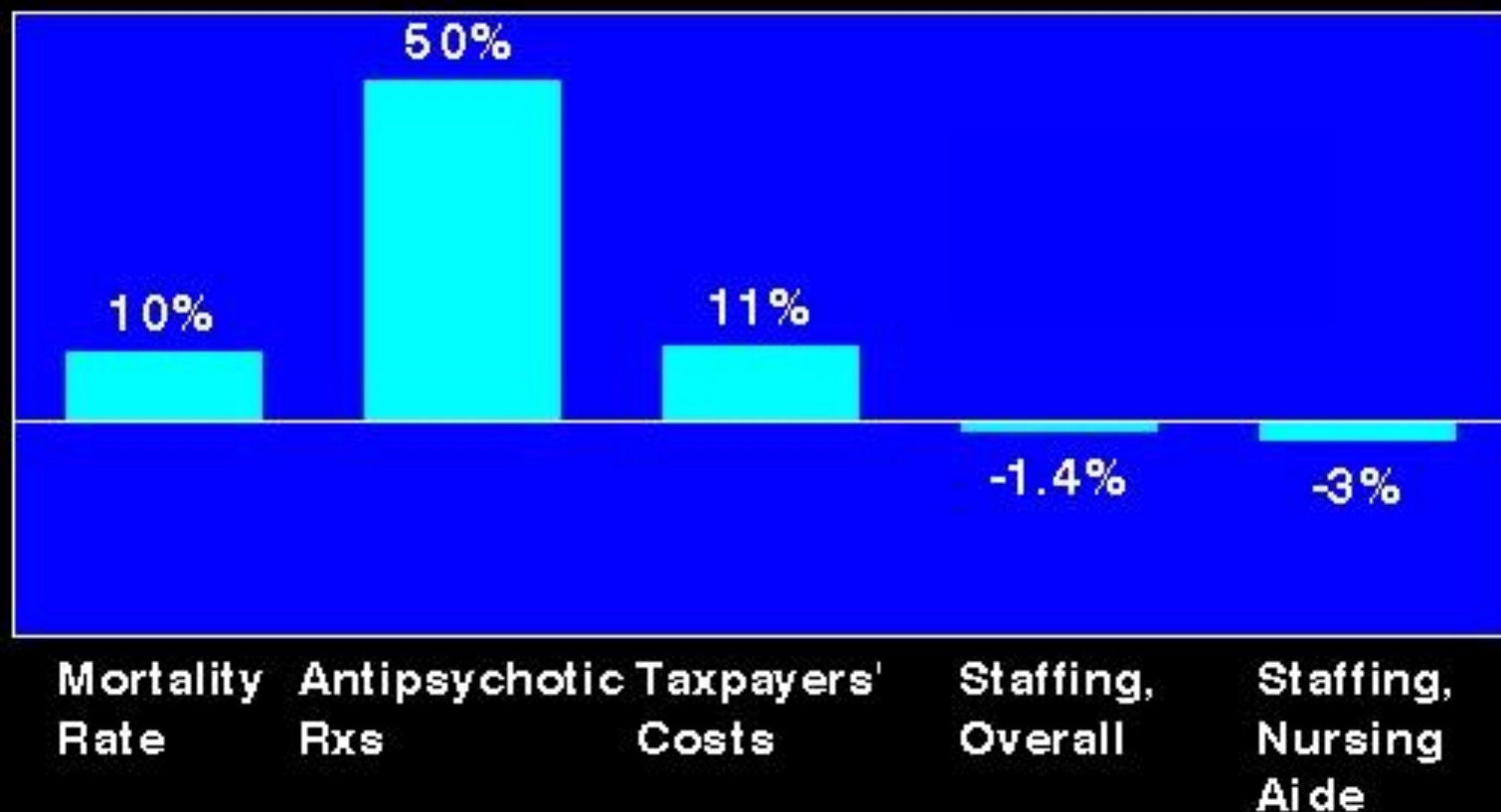
For-Profit Nursing Homes (SNFs): More Deaths and Hospital Readmissions

Percent of patients dying or readmitted within 30 days
of hospital discharge



Private Equity Nursing Home Takeovers Harm Patients, Raise Costs

% change with private equity acquisition

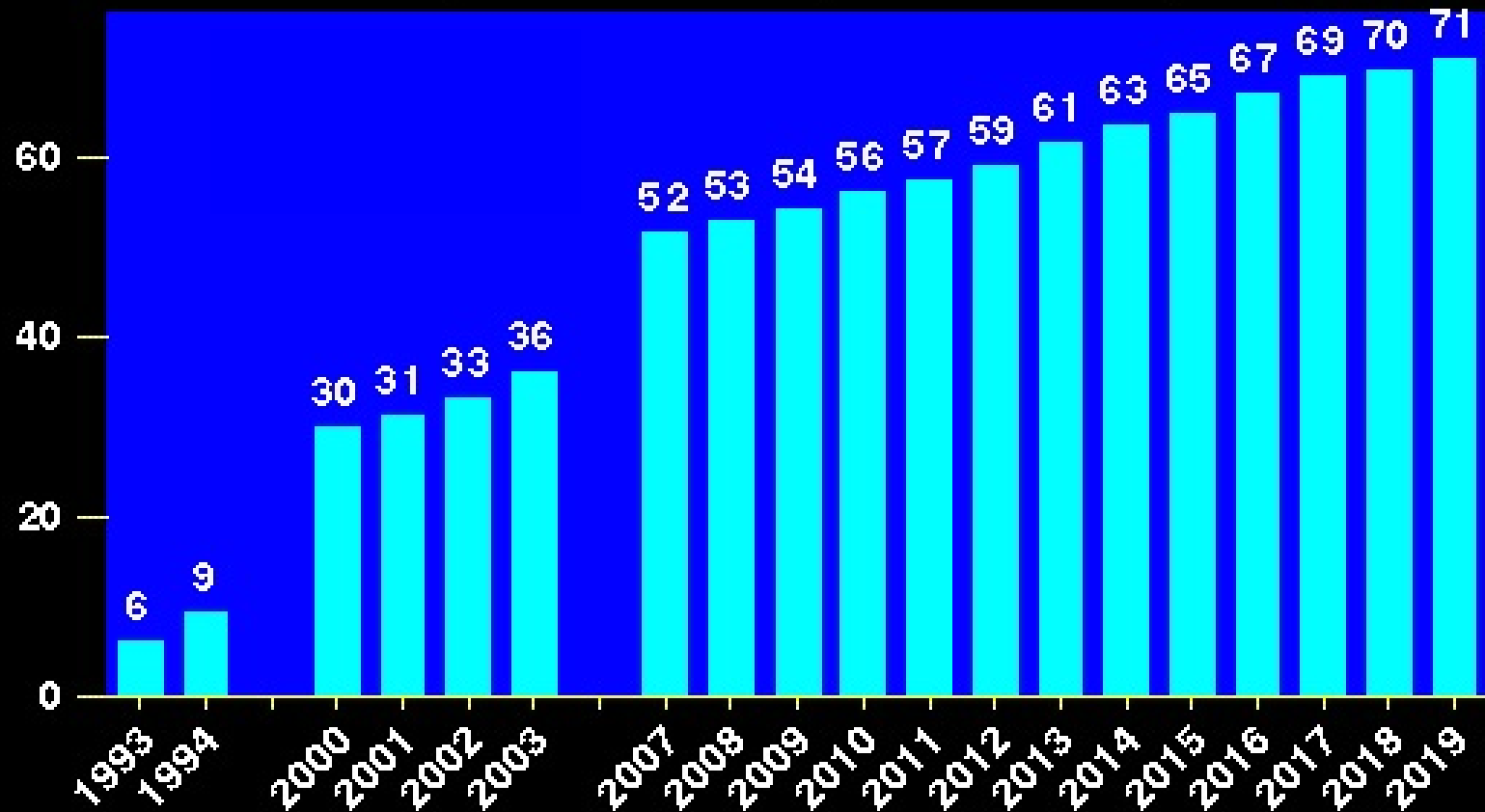


Source: "Does Private Equity Investment in Healthcare Benefit Patients" NBER #28474, February, 2021

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

Hospice Goes For-Profit

Percent of hospices under for-profit ownership



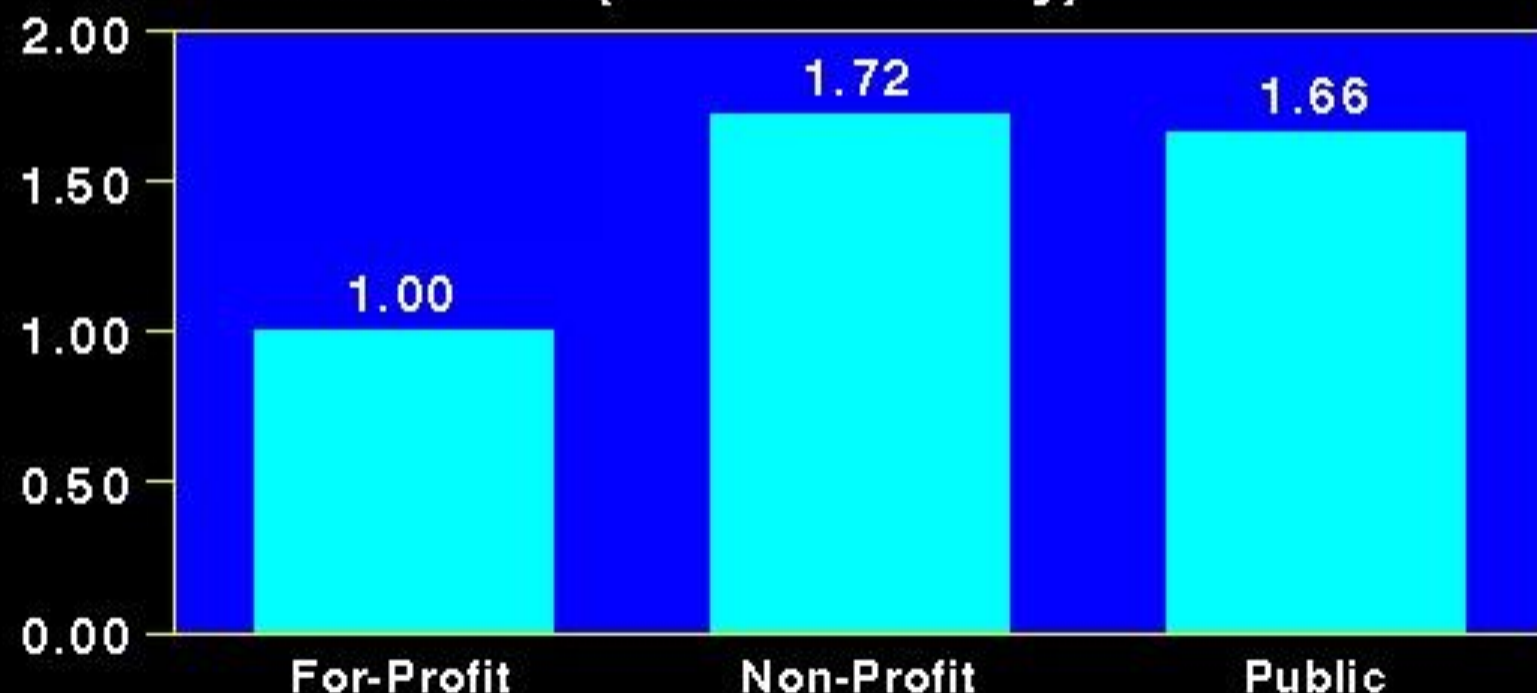
Source: MedPac Annual Report, 2021 and previous

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

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

For-Profit Hospices Avoid Unprofitable Patients

Likelihood of Accepting All Patients, Regardless of Care Needs (and Profitability)



Source: Health Affairs 2012;31:2690

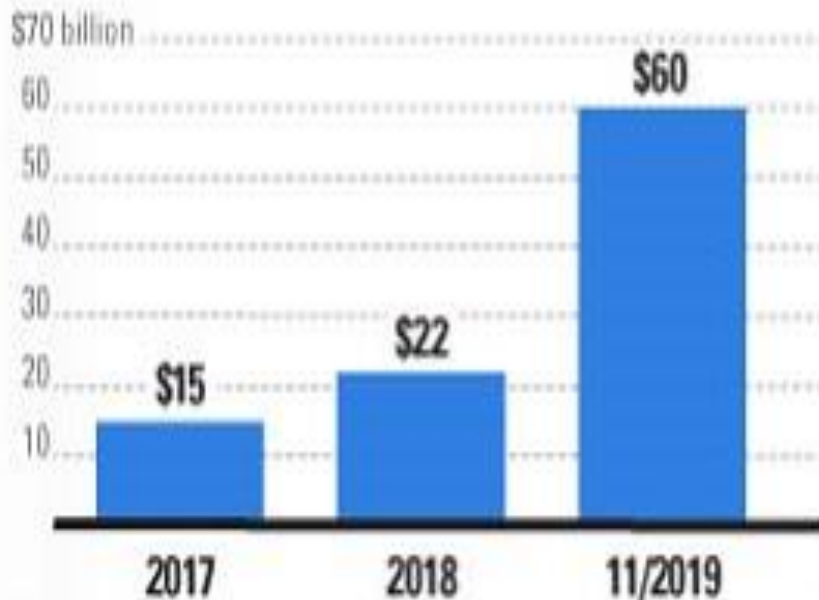
Note: Based on accepting pts. on chemo, TPN, transfusions, tube feeds, intrathecal cath, palliative radiation, or living alone

For-Profit Hospices Minimize Care, Maximize Payment

- **Offer narrower range of services**
- **Employ less skilled staff**
- **Choose patients needing less care + longer life expectancy**
- **More complaints and deficiencies**
- **Less charity care, research, training**
- **More ED and hospital use**
- **More D/C's of demented patients**
- **Account for 90% of hospices with lowest spending on care**



Private equity and venture investment in physician practices

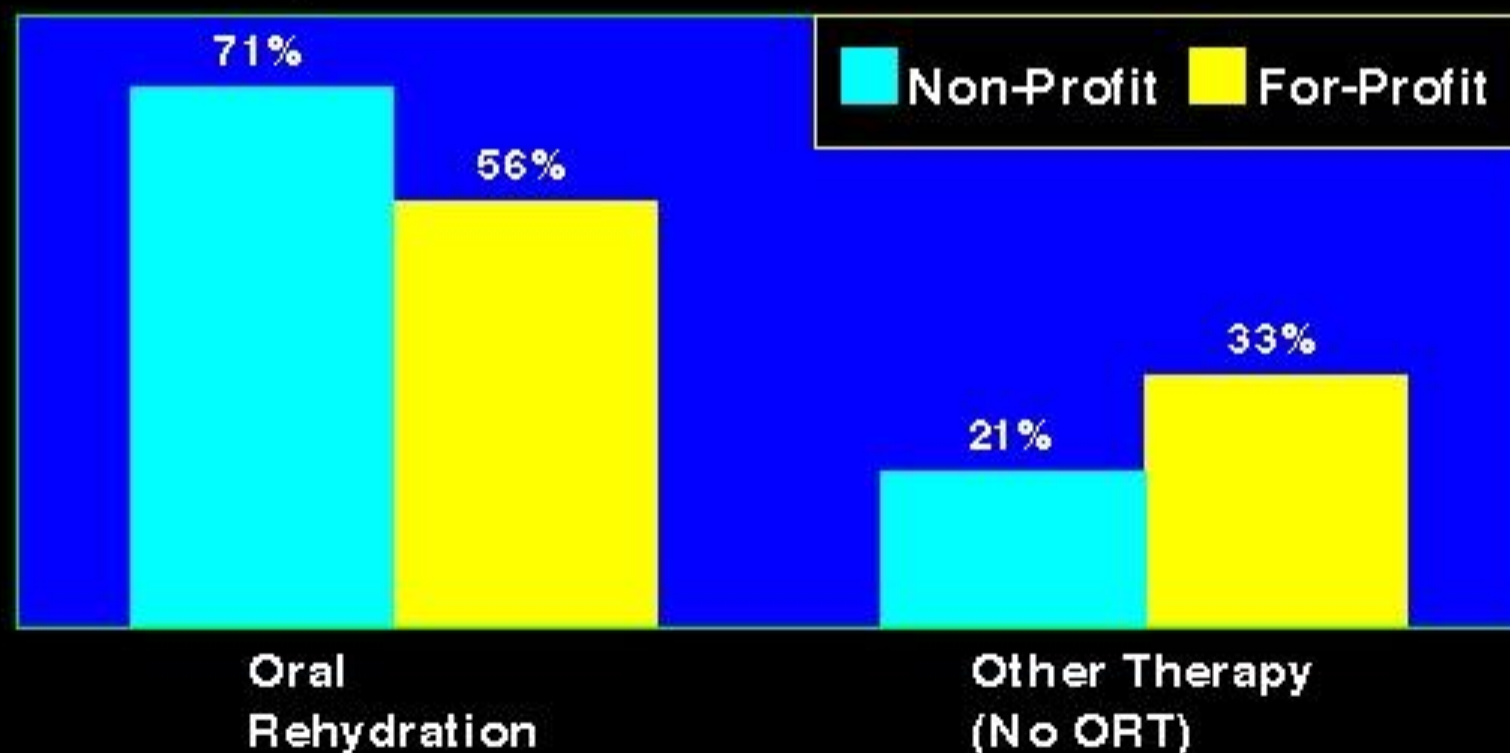


Source: "Private equity in healthcare," Medical Economics, Nov. 12, 2019

For-Profits in Africa Less Likely to Give Children Appropriate Dehydration Treatment

More Likely to Give Ineffective Treatments

Probability of Treatment



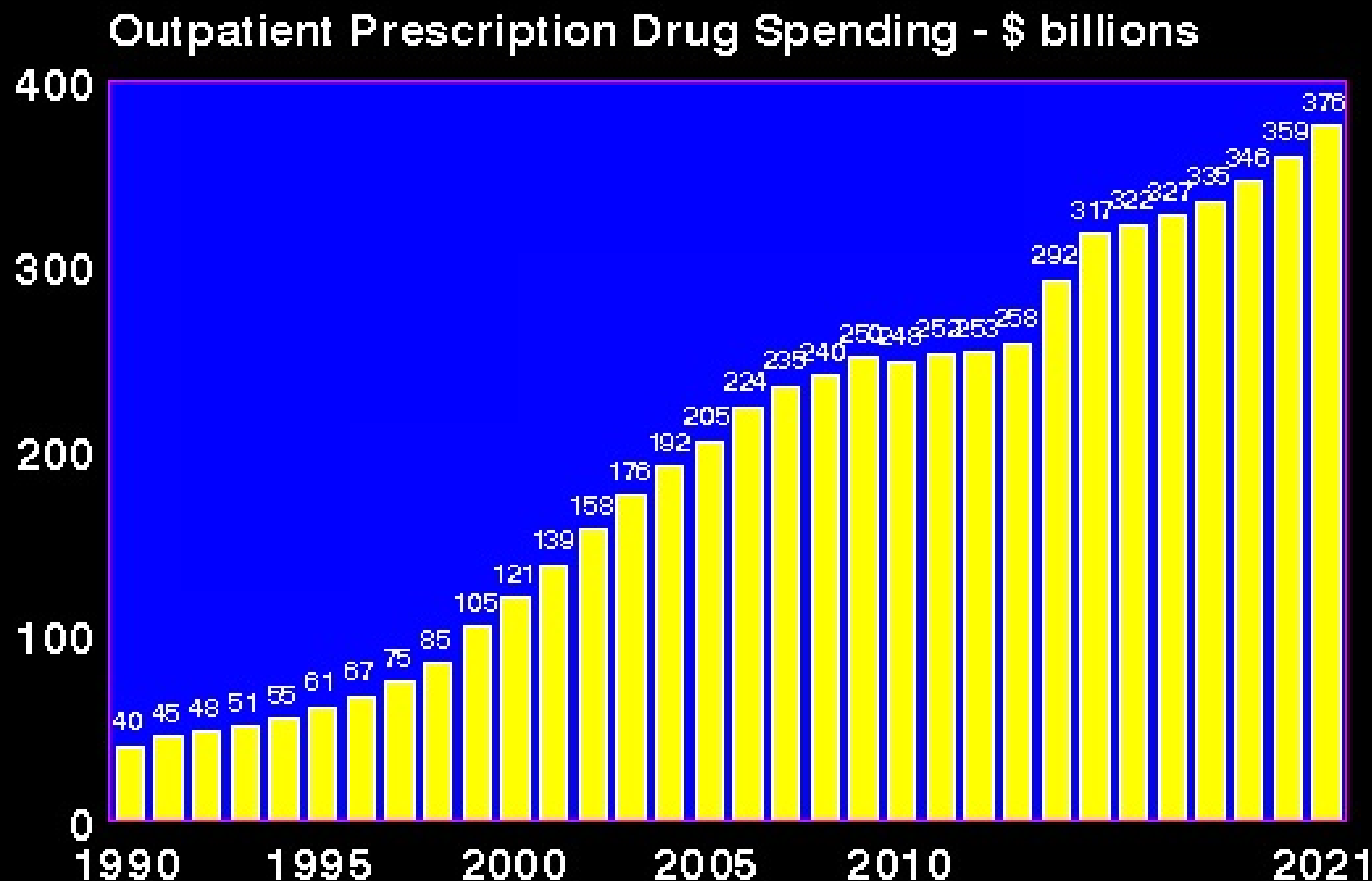
Source: Am J Trop Med Hyg 2014;90:939

Note: Study included treatment at any health/pharmacy facility

Note: Over 700,000 children die from diarrhea annually, ORT is life-saving

Drug and Device Firms
Inflate Prices,
Distort Priorities

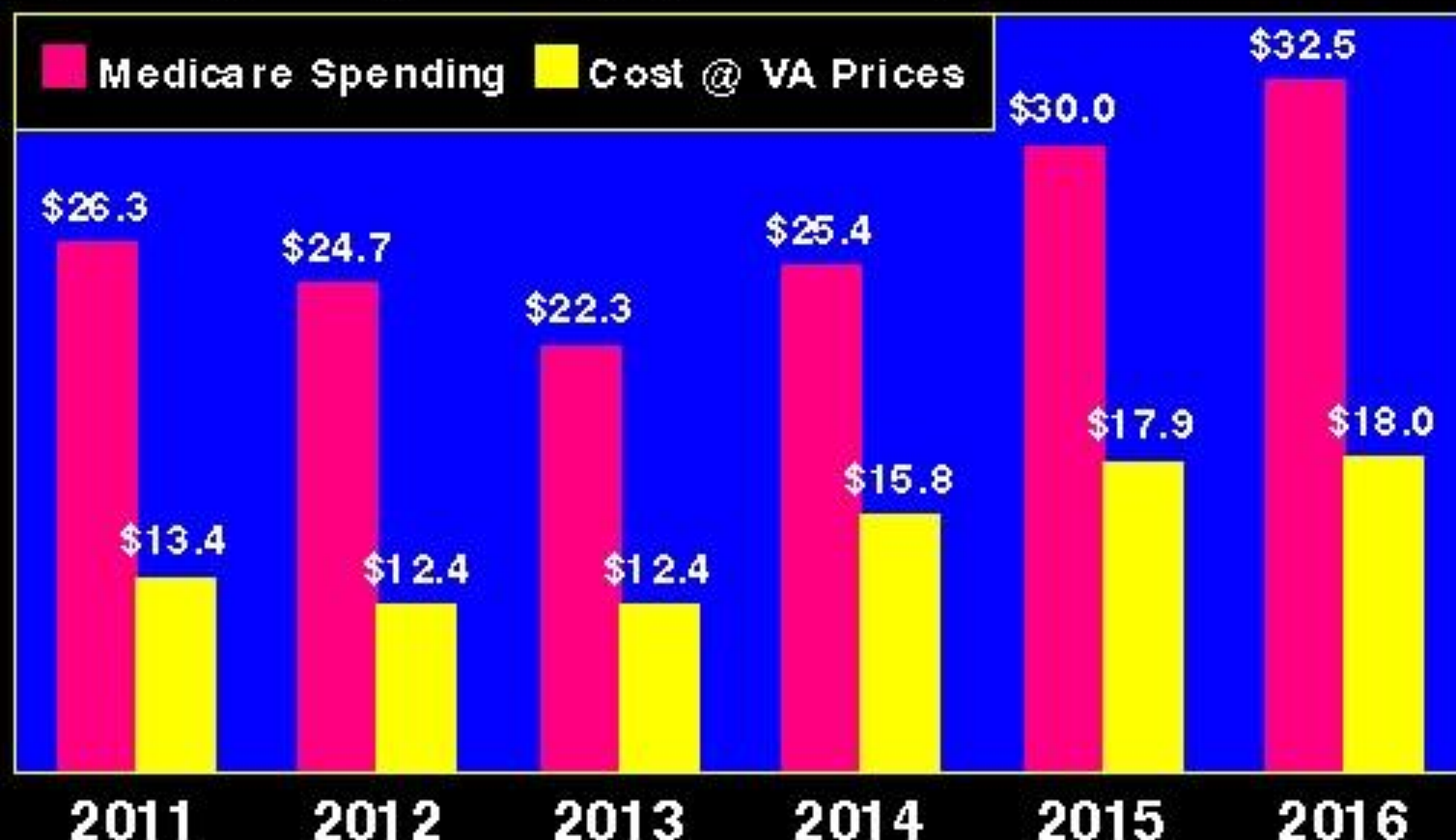
U.S. Drug Spending, 1990-2021



Source: CMS, Office of the Actuary - Note: 2020 - 2021 estimated

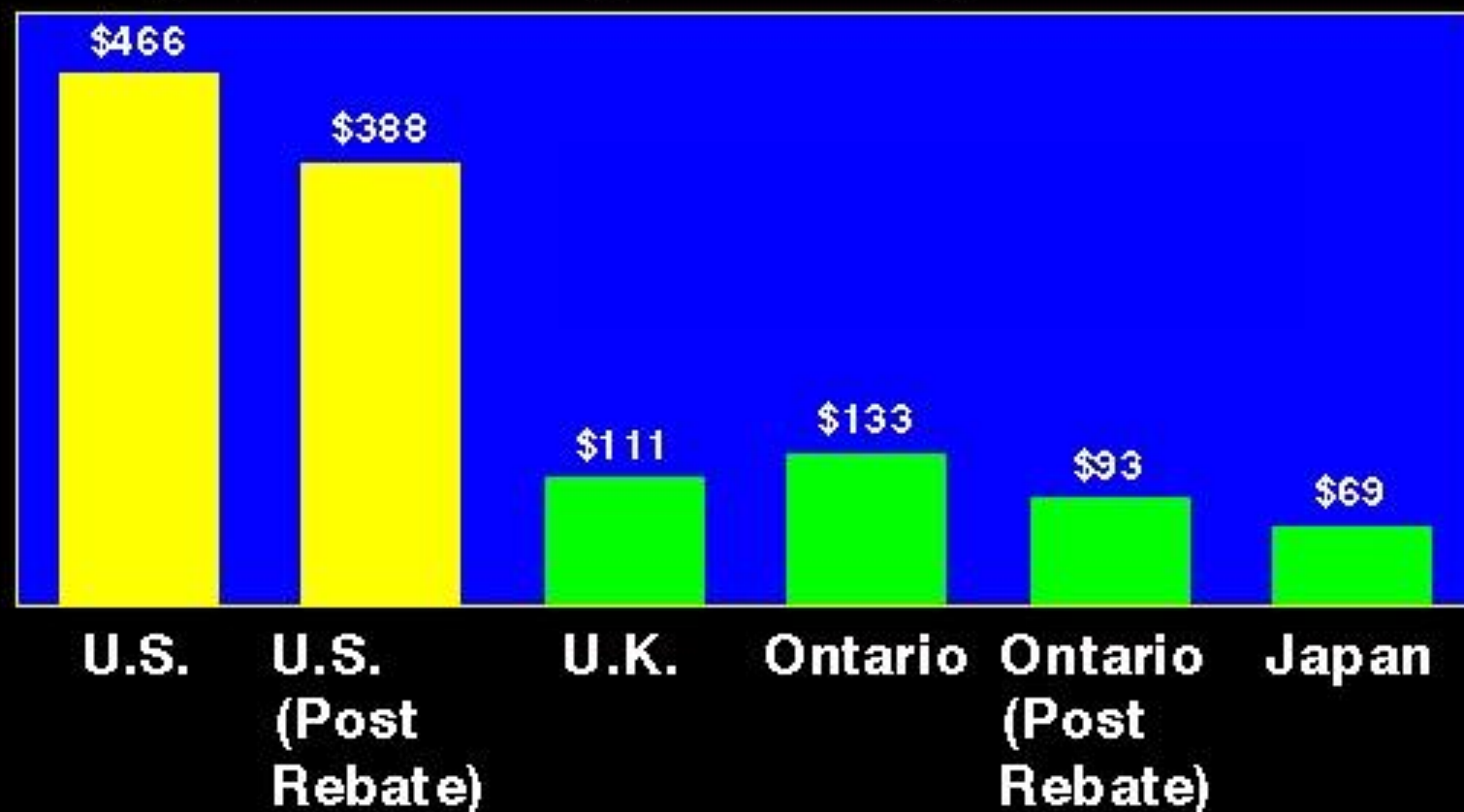
Medicare Would Have Saved \$71 Billion Over 6 Years if it Paid VA Prices

Spending for top 50 drugs (\$s billions)



Medicare Part D Drug Prices are Several-Fold Higher than in Other Nations

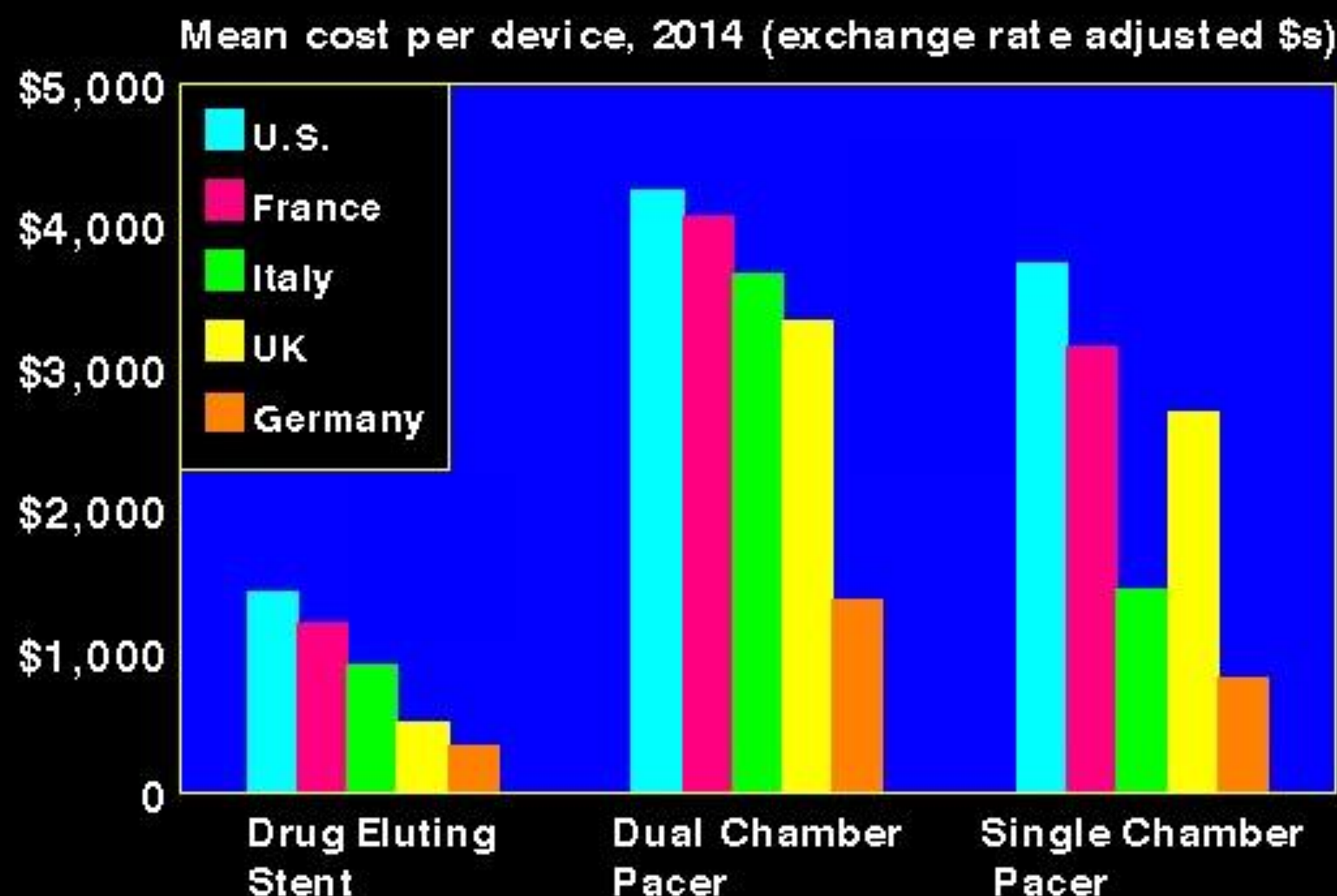
Average price of 79 single source drugs



Source: Health Affairs 2019;38:804

Note: Purchasing these 79 drugs at the UK price would have saved Medicare \$41 bil. in 2018

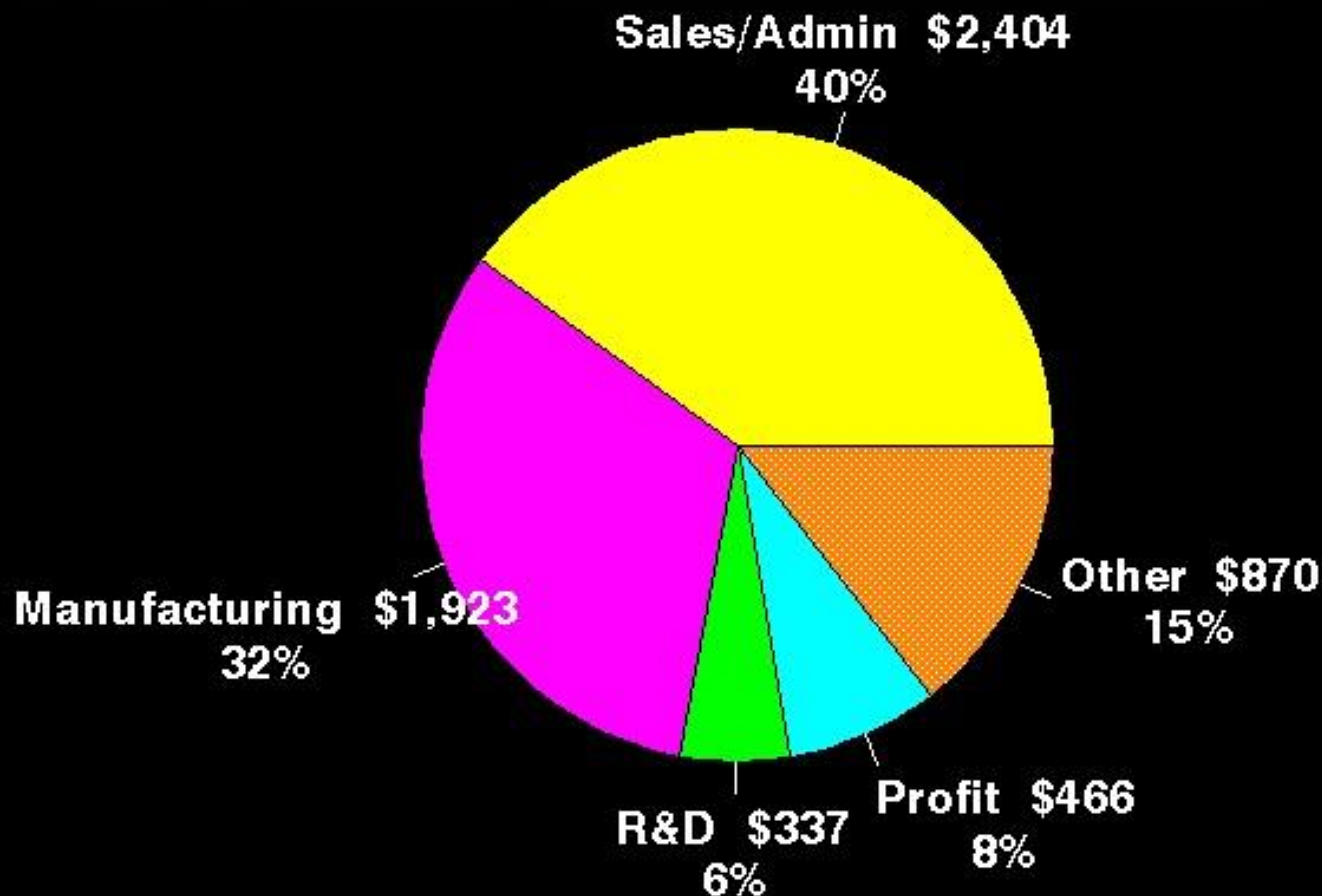
As With Drugs, Devices Price are Highest in U.S.



Source: Health Affairs 2018;37:1570

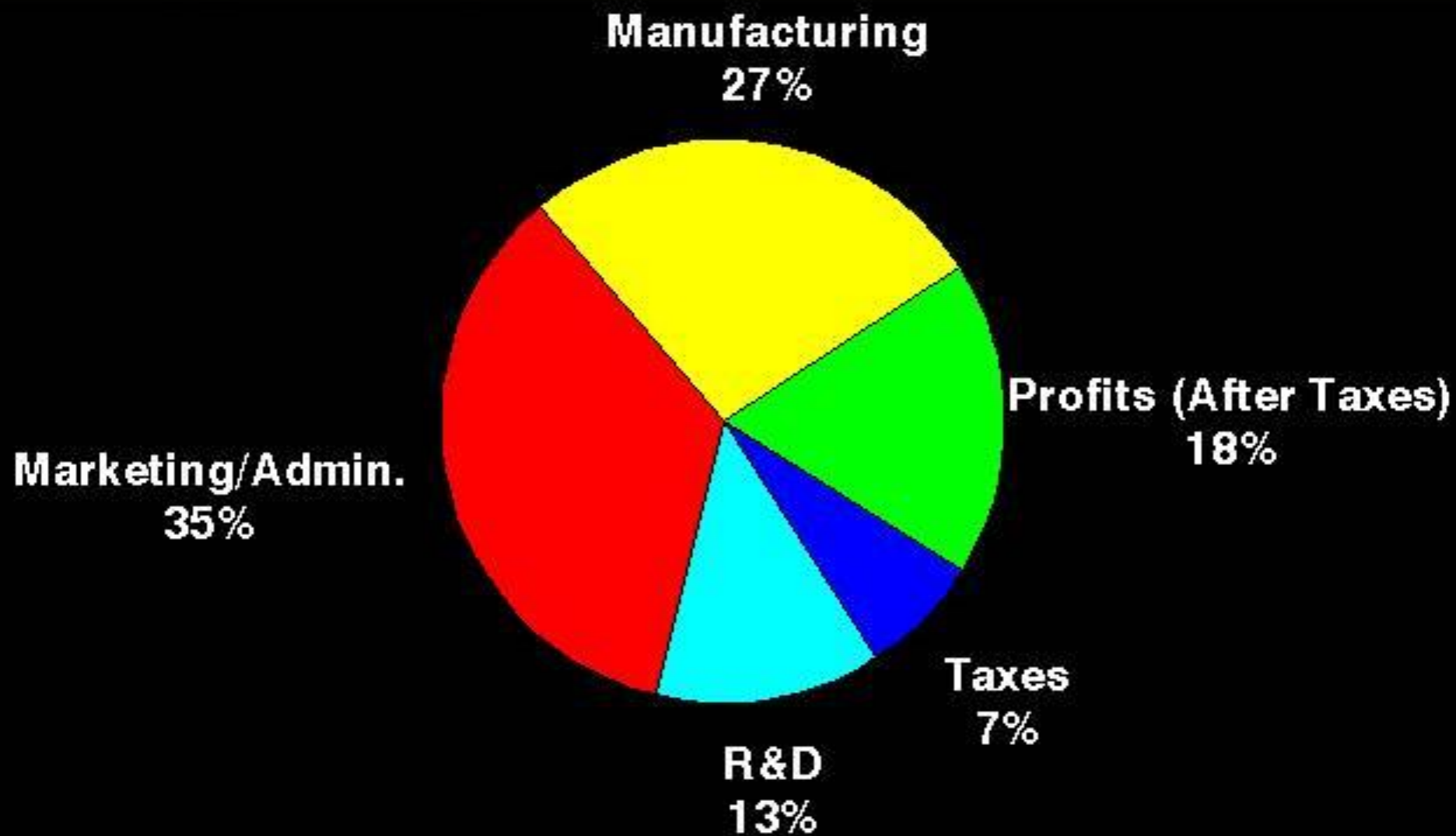
Note: Devices account for 6% of U.S. health expenditures

What Goes Into a \$6000 Orthopedic Implant



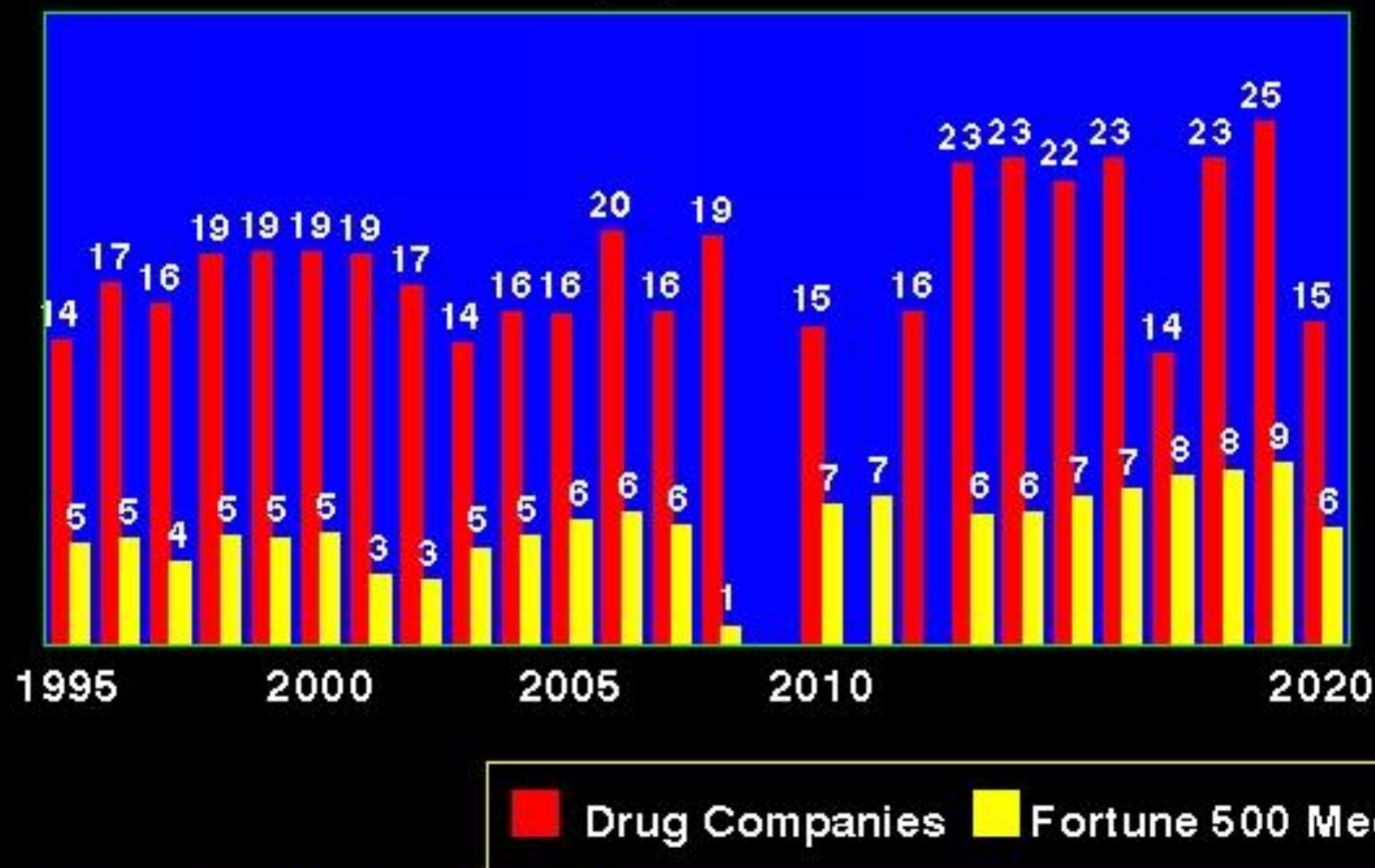
Source: Modern Healthcare 2/5/2018

Drug Companies' Cost Structure



Drug Company Profits, 1995-2020

Return on Revenues (%)



Source: Fortune 500 rankings for 1995-2021

Pharma Firms Have Paid \$43.33 billion in Penalties Since 2000

Despite Fines, Profits Totaled ~ \$2 Trillion



\$ billions in penalties since 2000

Goldman Sachs asks in biotech research report: 'Is curing patients a sustainable business model?'

Tae Kim | @firstadopter

Published 3:15 PM ET Wed, 11 April 2018 | Updated 7:20 PM ET Wed, 11 April 2018

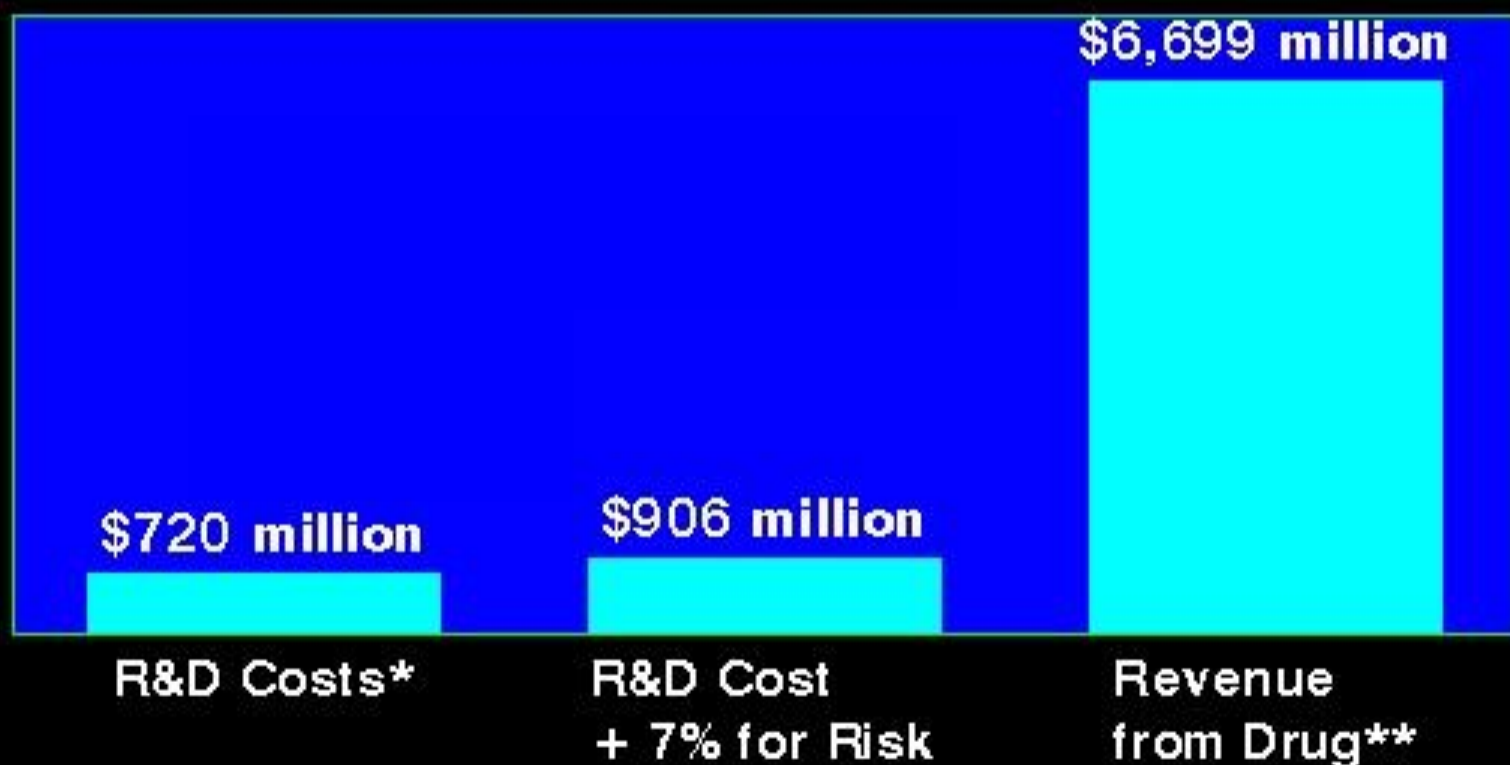


“The success of its [Gilead’s] hepatitis C franchise has gradually exhausted the available pool of treatable patients. . .In the case of infectious diseases such as hepatitis C, curing existing patients also decreases the number of carriers able to transmit the virus to new patients.”

Profits Dwarf Cancer Drug R&D Costs

Analysis of All Drugs Approved 2006-2015
From Firms With Only 1 Approved Drug

Mean cost or revenue per drug



Source: Prasad et al. JAMA IM, online 9/11/2017

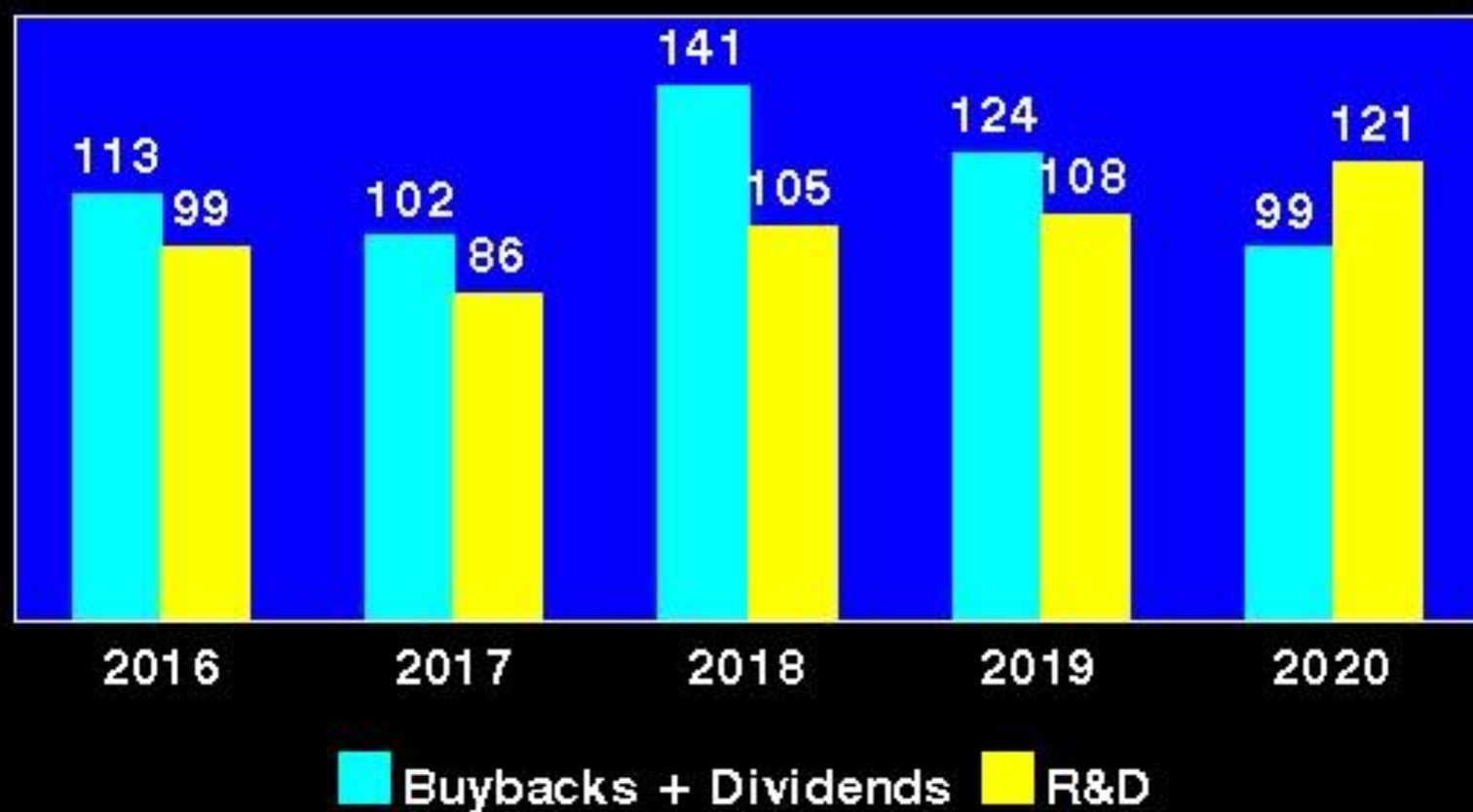
* Costs of all company R&D, including their non-approved agents

** Total revenue from sales since approval - mean of 3.8 years

Drug Firms Spent More on Stock Buybacks and Dividends Than on R&D

\$578 bil. for shareholders, \$522 bil. for R&D

\$ billions



Source: Congressional Committee on Oversight and Reform - July, 2021

Government Paid Twice for Vaccines

- Funded most of the basic science research underlying mRNA vaccines and that characterized the spike protein.
- Spent at least \$18 billion subsidizing vaccine makers' research and production, purchased all doses used in US.
- Firms refused to share vaccine recipe, limiting global production capacity and leaving billions unprotected.
- Cost to manufacture mRNA vaccine: ~\$2/dose for Moderna, ~\$1/dose for Pfizer. Sale price ~\$25/dose. (J Royal Soc Med 2021;114:502)
- “Pfizer, BioNTech and Moderna will make pre-tax profits of \$34 billion this year between them, which works out as over a thousand dollars a second.” (Peoples Vaccine Alliance)

COVID-19 Vaccine Makers Jack Up the Price

\$s per vaccine dose



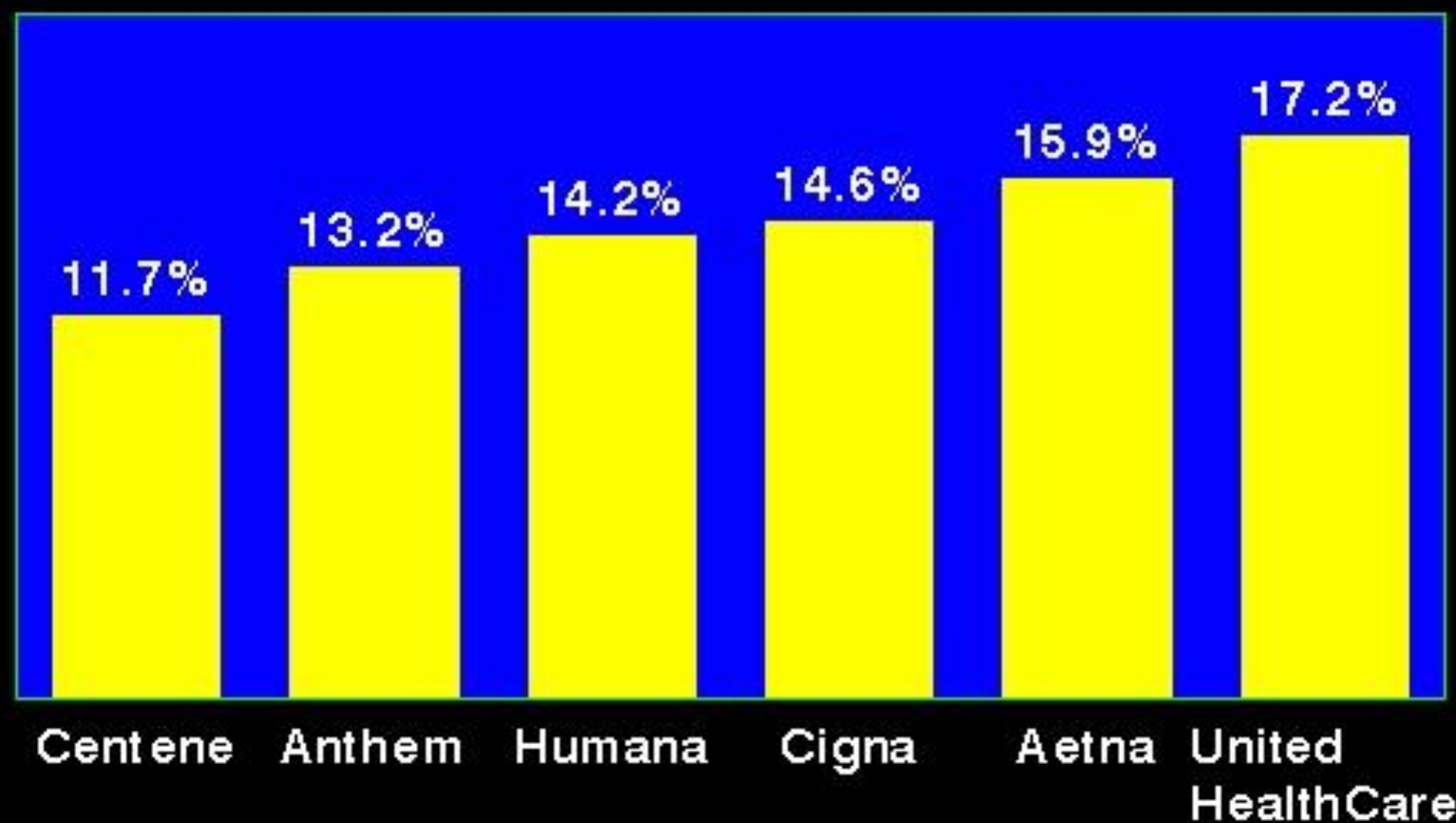
Source: Light & Lexchin. J Royal Soc Med 2021;114:502

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

Private Insurers:
Middlemen Who Add
Costs But Not Value

Insurance Overhead, 2021

Medical loss ratio

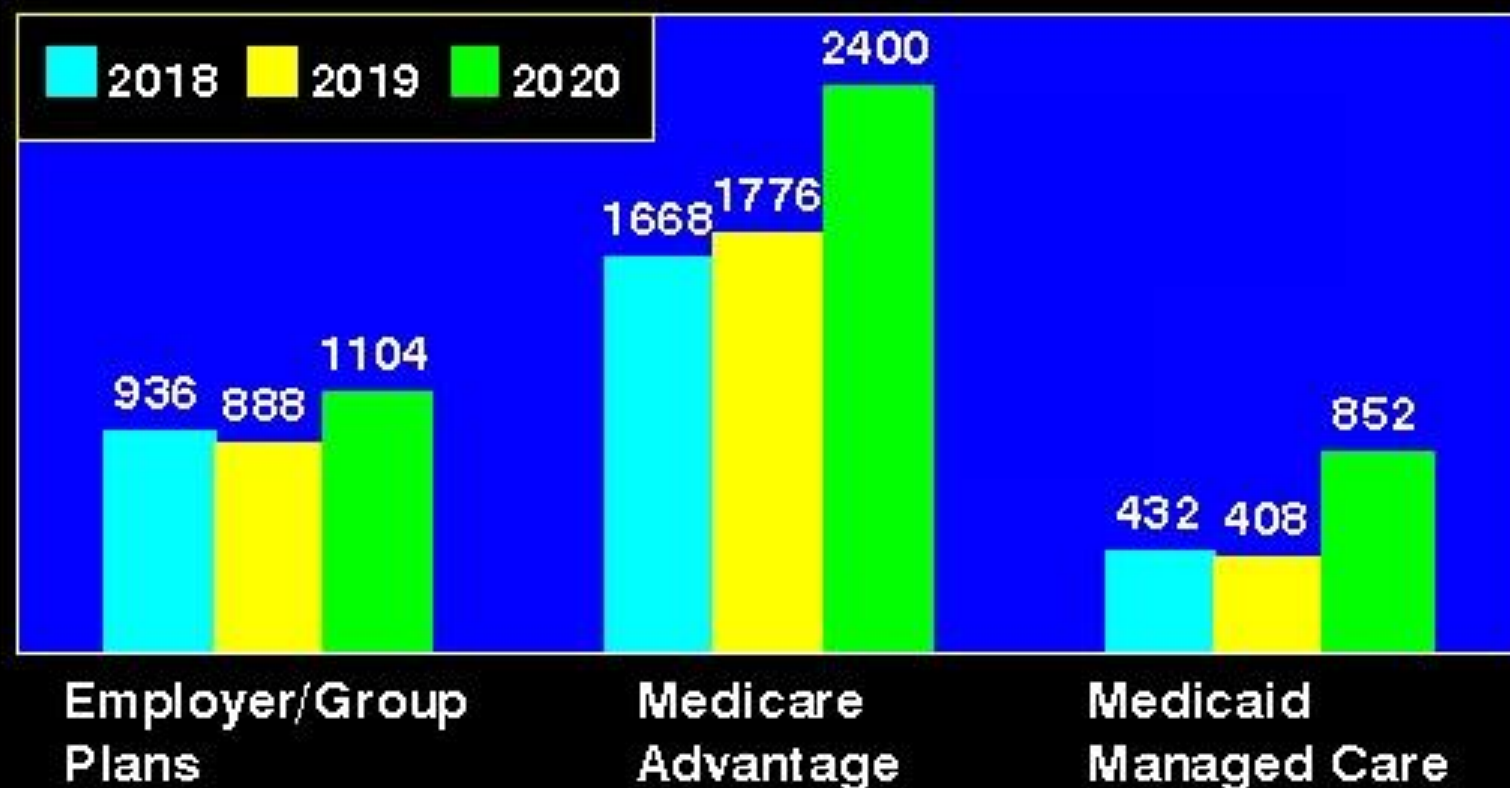


Source: SEC filings for second quarter, 2021

Note: Medical loss ratio = $1 - (\text{medical benefits}/\text{premiums})$

Private Insurers' Overhead/Profit Per Enrollee, 2018-2020

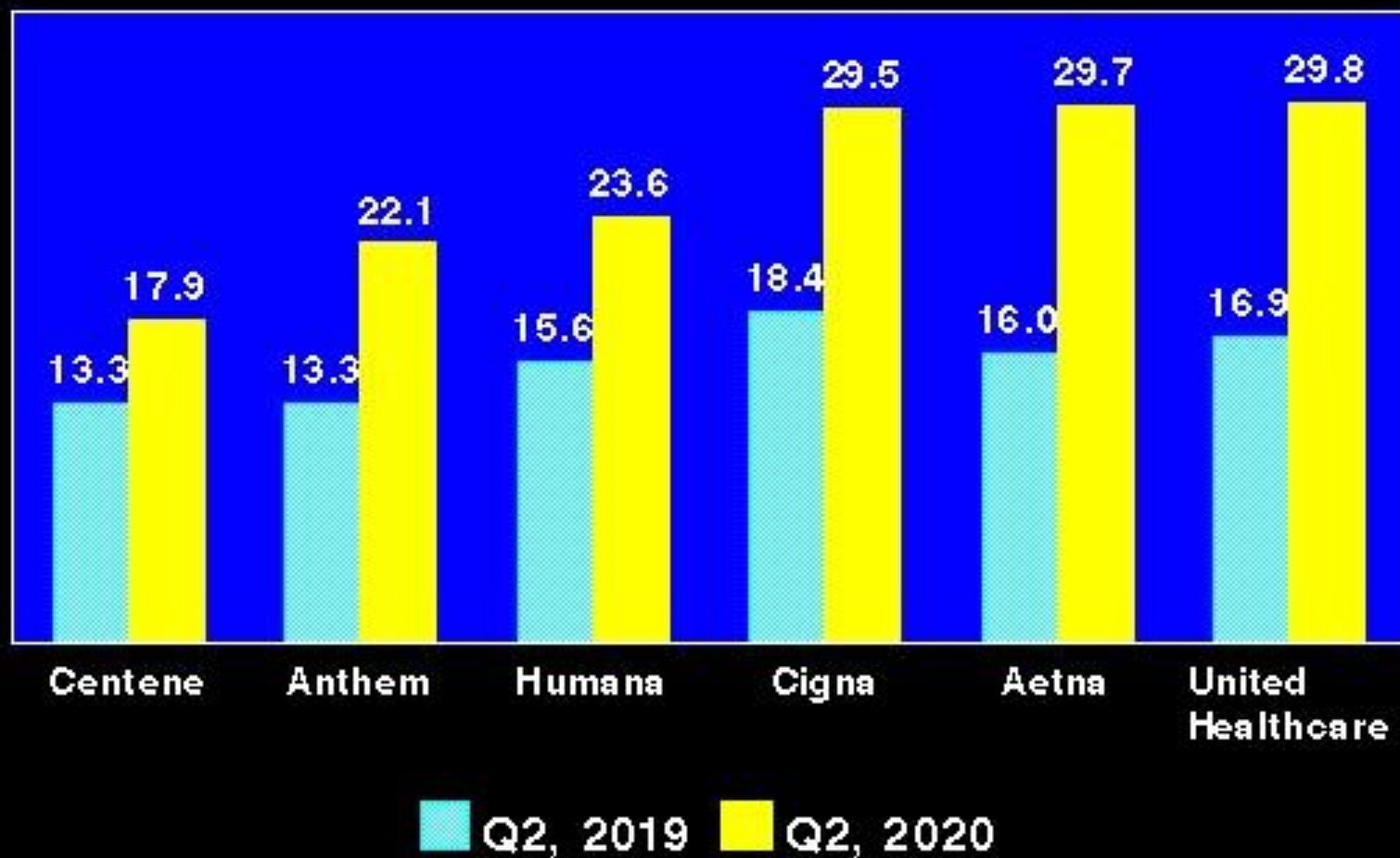
\$ per enrollee/year



Source: Kaiser Family Foundation analysis of National Assoc. of Insurance Commissioners' data
Note: Data are for January 1 - September 30, annualized

COVID-19 Boosted Insurers' Profits

Overhead + Profits (% of Premiums)

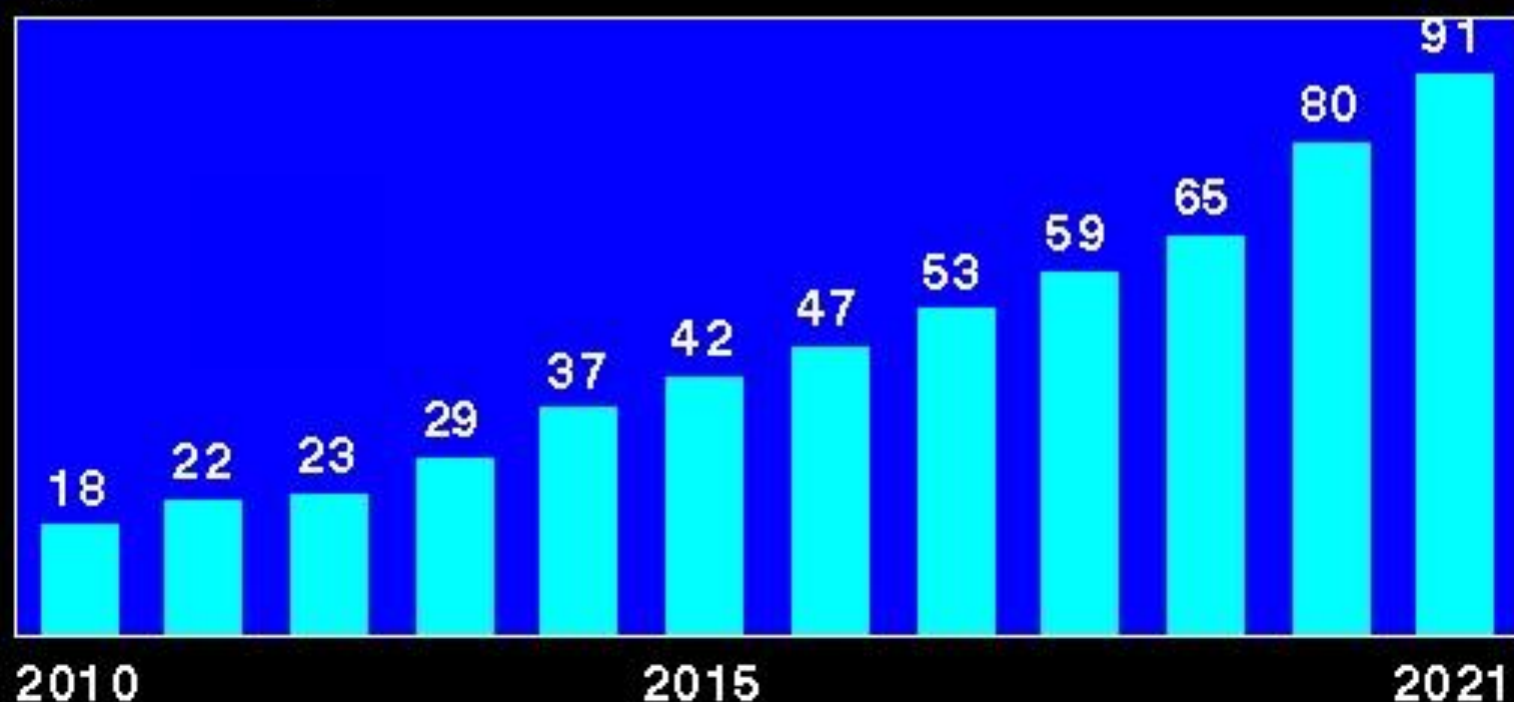


Source: SEC Filings

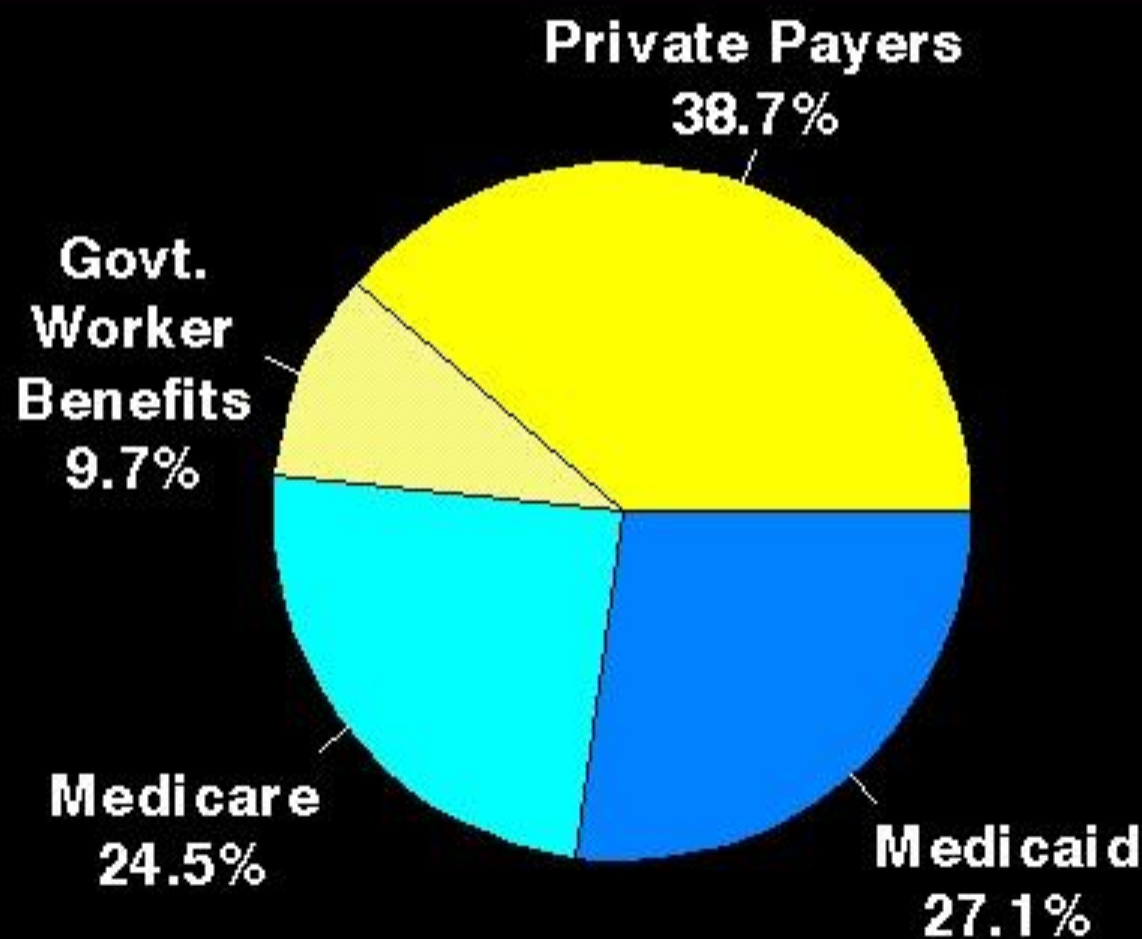
Insurers "Double Dip" to Skirt Medical Loss Ratio Limits

"Profits swell when insurers are also your doctors"

UnitedHealth payments to providers it owns
(\$ billions)



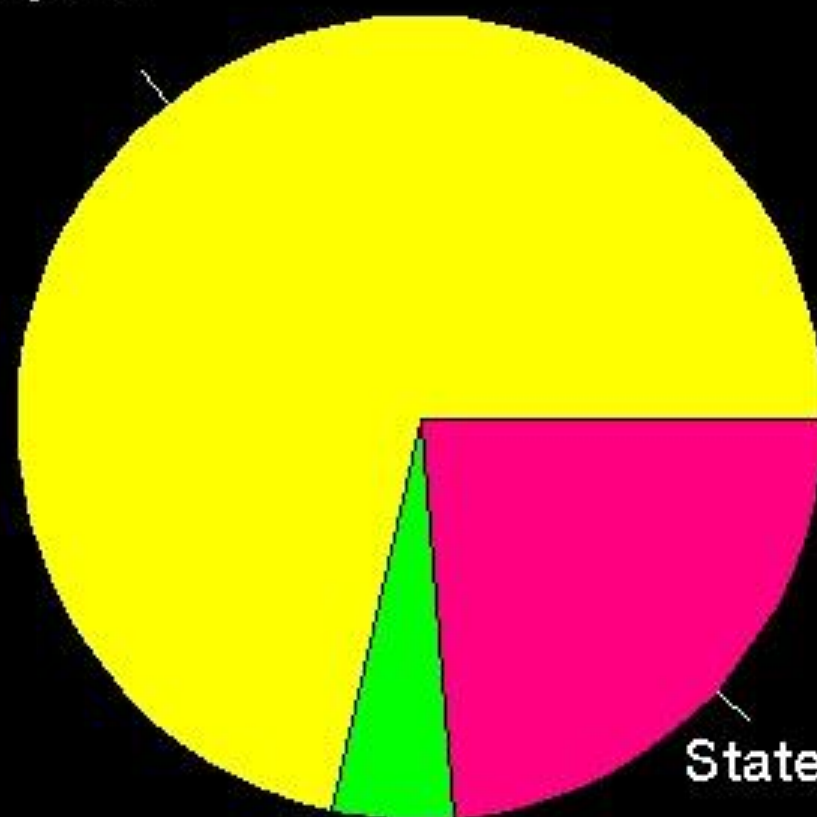
61% of Private Insurers' Revenues Come From Government Payers



Source: AM Best 8/13/2018 - Government workers' benefit costs estimated from CMS data

Employer Payments for Private Insurance, 2020

Private Employers
72%



State/Local Government
24%

Federal Government
5%

Insurers Risk Select Via Formulary Design

Put Generics Needed by Sicker Patients in High Co-Pay Tier

Drugs of Choice	Illness	Plan 1	Plan 2	Plan 3*
Anti-Retrovirals	HIV	No	No	No
Triptans	Migraine	No	No	No
Anti-Psychotics	Schizophrenia	No	No	No
Macrolides	Pneumonia	Yes	No	No
L-Dopa	Parkinson's	Yes	No	No
Anti-Convulsants	Seizure	Yes	No	No
ACE Inhibitors	Hypertension	Yes	Yes	No
Metformin	Diabetes	Yes	Yes	No

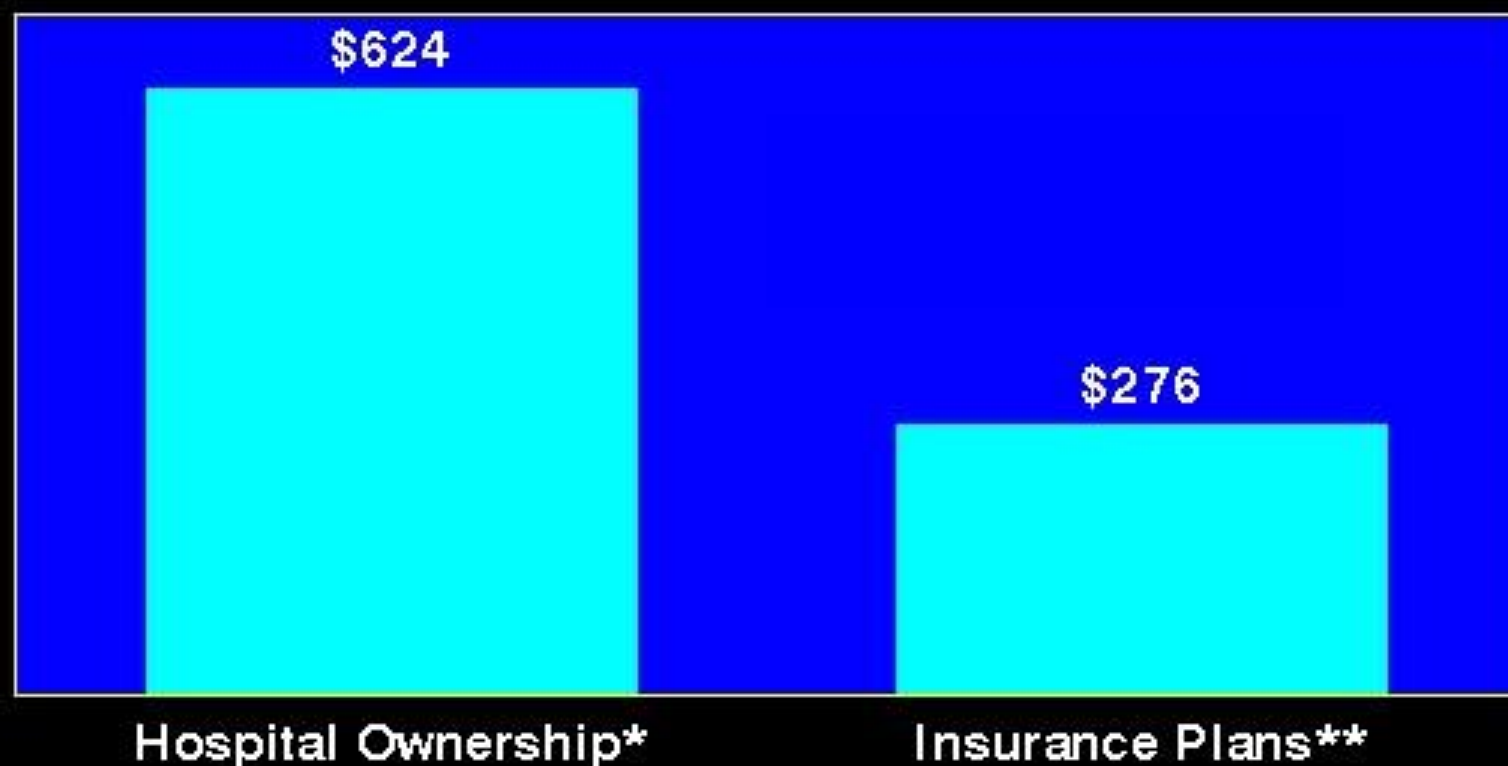
Source: Oster & Fendrick, Am J Managed Care 2014; 9:693-4

* Harvard Pilgrim

"No" = No drug of choice available in Tier 1 (lowest co-pay)

Both Hospital and Insurer Consolidation Raise Premiums

Annual premium boost



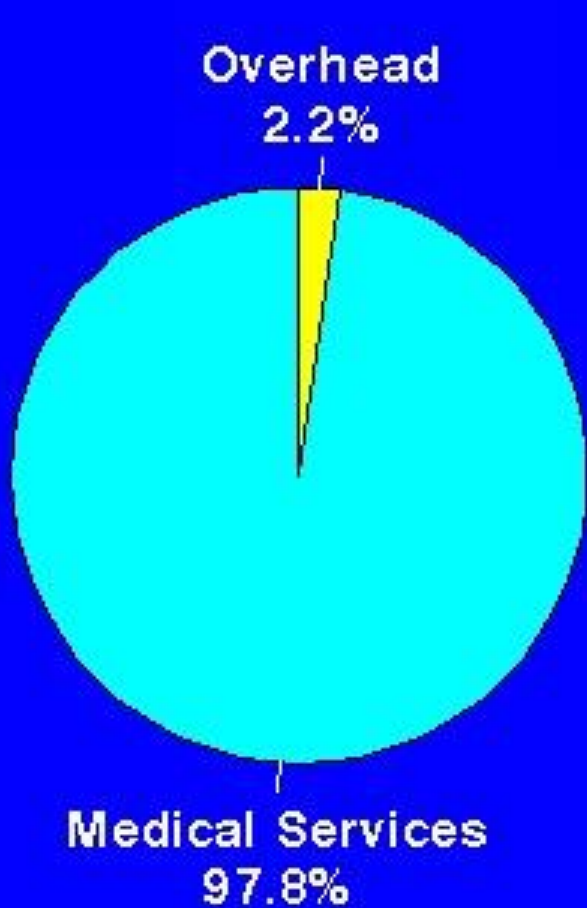
Source: Health Affairs 2019;34:668

* Difference between regions with most and least concentrated tertiles of ownership

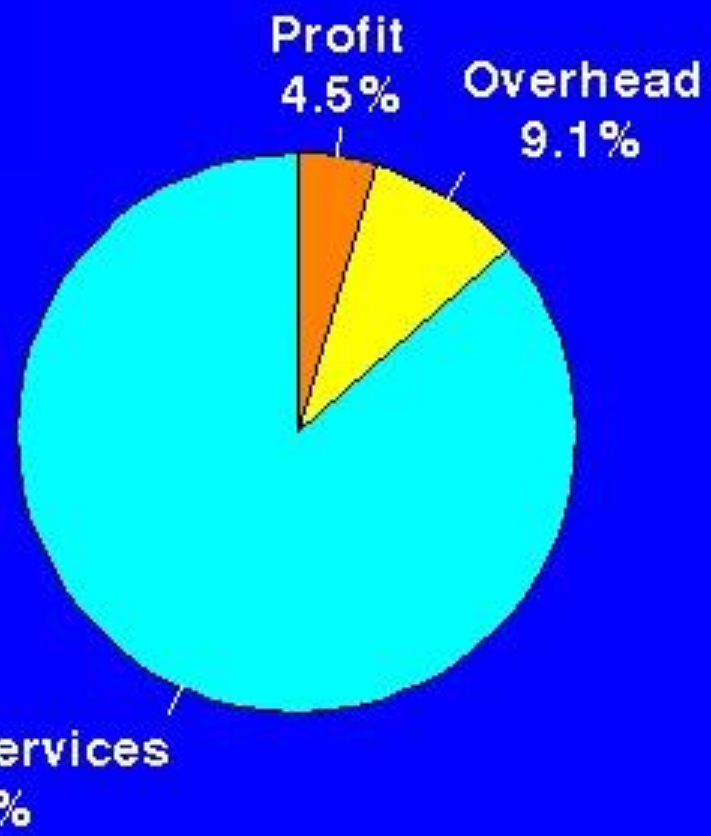
** Difference associated with the presence of one fewer insurer in region

Medicare Advantage:
The Only Working Model of
Competing Private Plans
and a Public Option
(Traditional, FFS Medicare)

Medicare Advantage Plans' High Overhead



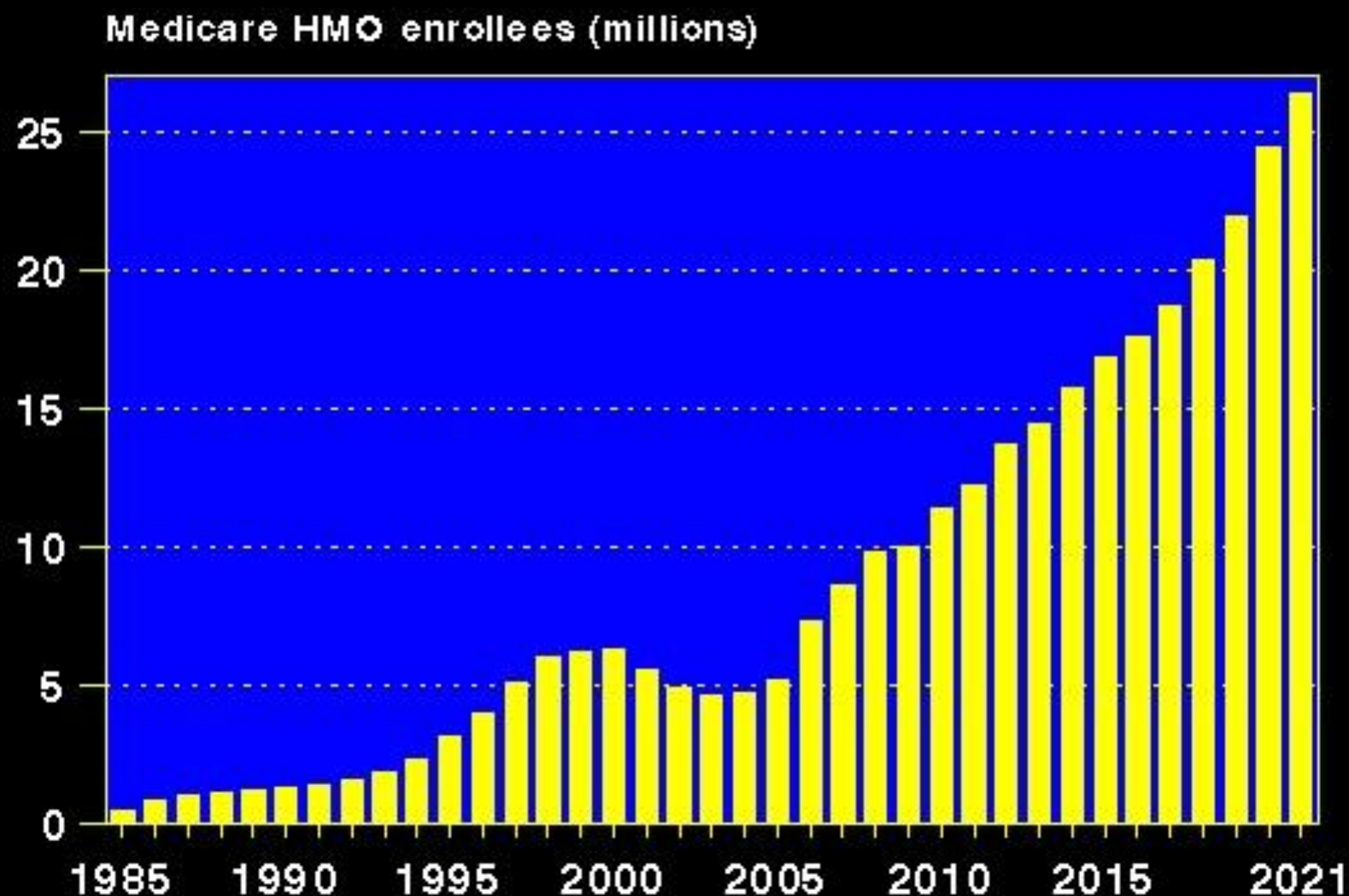
Traditional Medicare



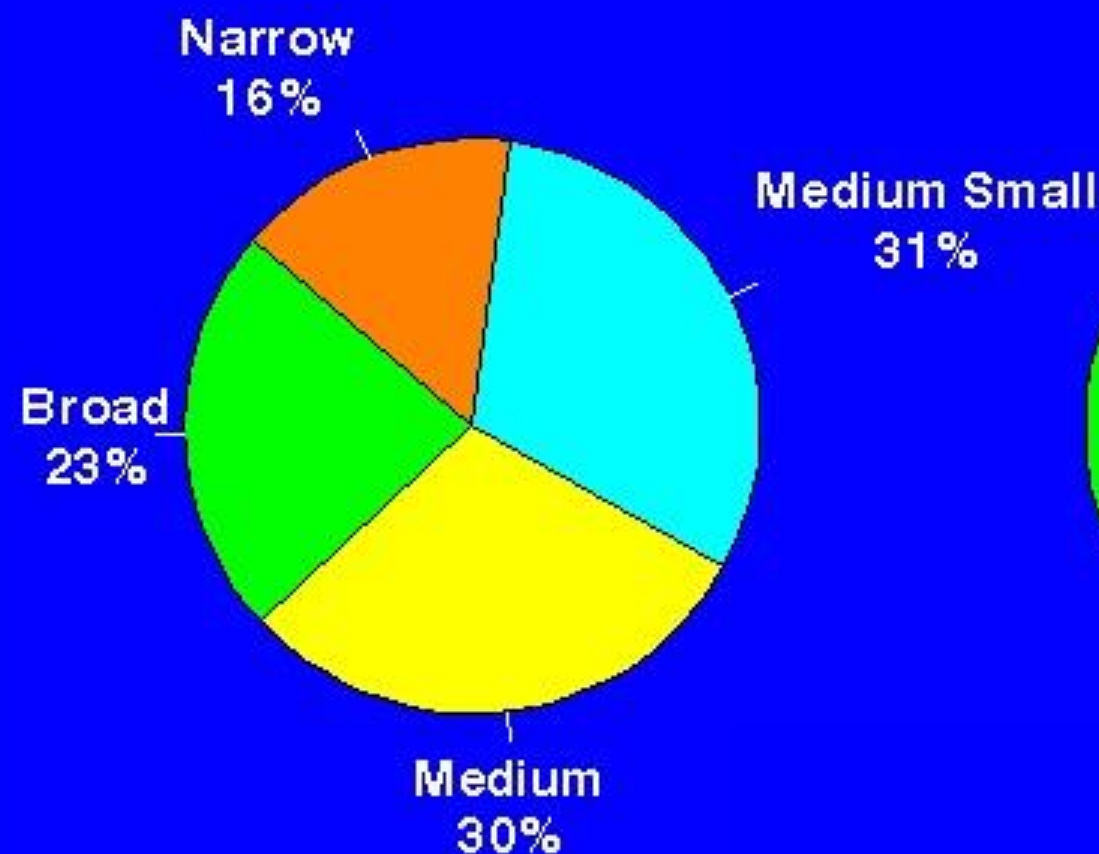
Medicare Advantage Plans

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

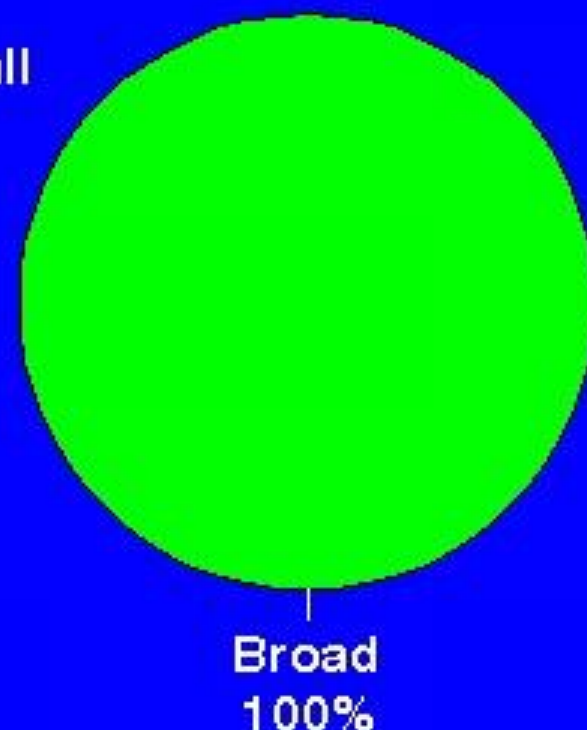
Medicare HMO Enrollment, 1985-2021



Medicare Advantage Plans' Narrow Networks



Medicare Advantage



Medicare

Source: Kaiser Family Foundation June, 2016

Note: Narrow = <30% of hospitals; Medium small = 20-49%; Medium = 50-69%; Broad = >69%

Note: >1/3 of all plans lack an NCI cancer ctr.; 49% of narrow networks exclude academic med centers

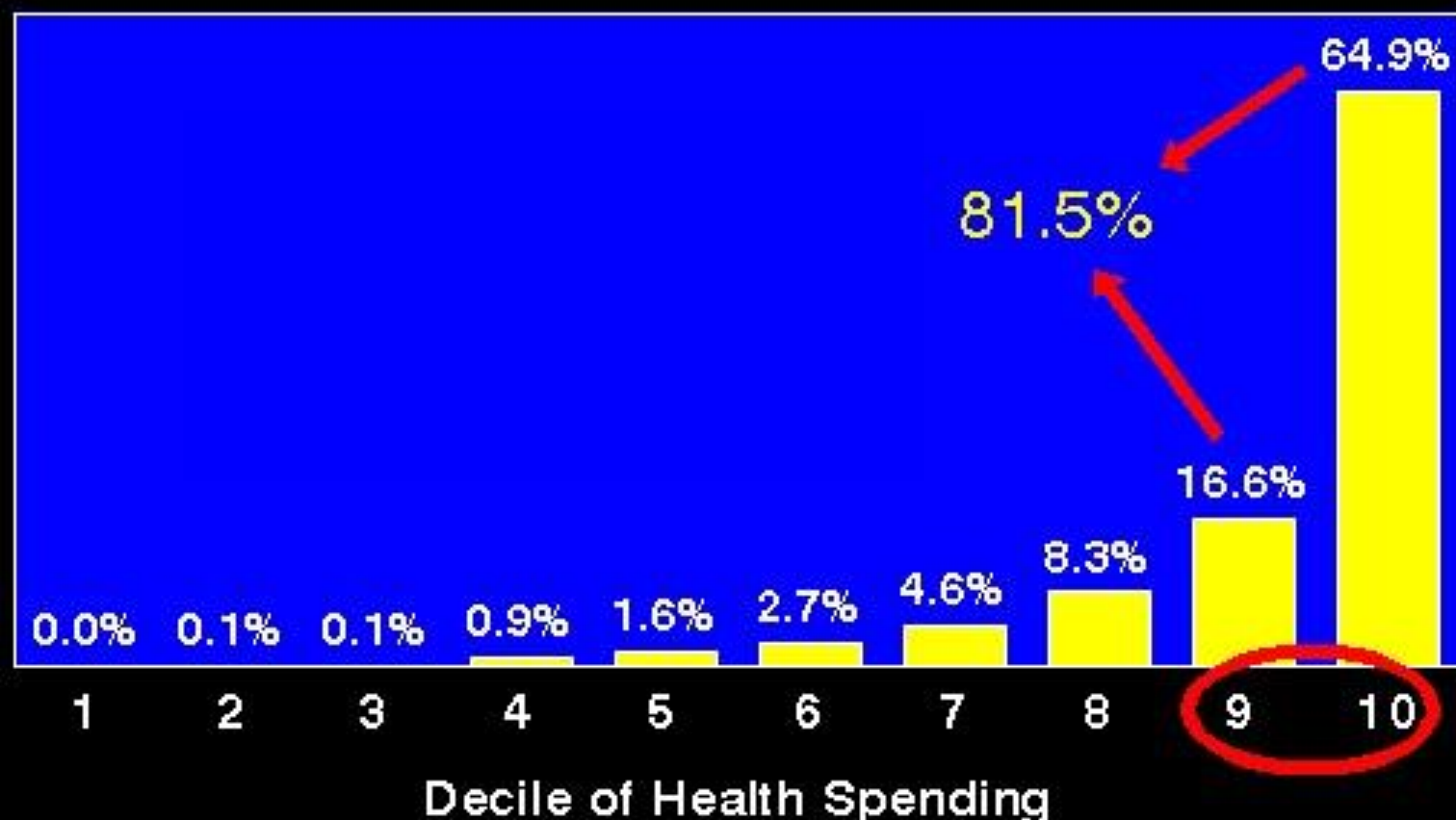
How do Medicare Advantage Plans Outcompete Traditional Medicare?

- 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

A Few Sick People Account for Most Health \$s

Percent of Total Spending for Each Decile Among Non-Institutionalized Americans

% of total health spending accounted for by decile



Medicare Advantage Plans' Strategies:

1- Cherry Picking



Marketing, network manipulation, benefit design

Medicare Advantage Enrollees Cost \$1,253/year Less Before Enrolling

MA plans selectively recruit low-cost enrollees within each diagnosis

Medicare expenditures in prior year, risk-score adjusted



Source: Kaiser Foundation May, 2019

Note: For example, difference for pts. with asthma = \$1410; depression = \$1198; arthritis = \$1371

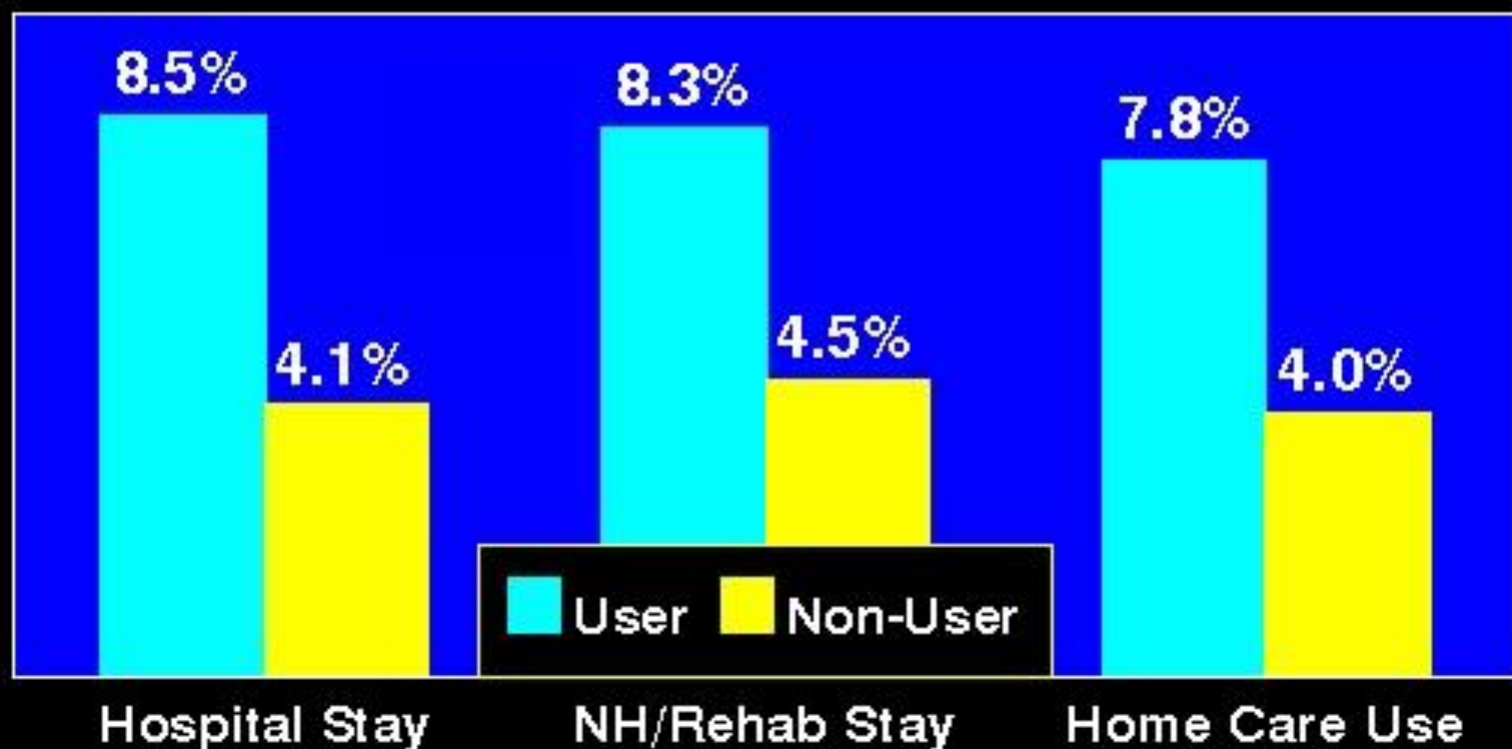
Medicare Advantage Plans' Strategies: 2 - Lemon Dropping



Network manipulation, benefit design, hassle factor

MA Plans Eject Patients Using Expensive Care

% switching from MA to Traditional Medicare

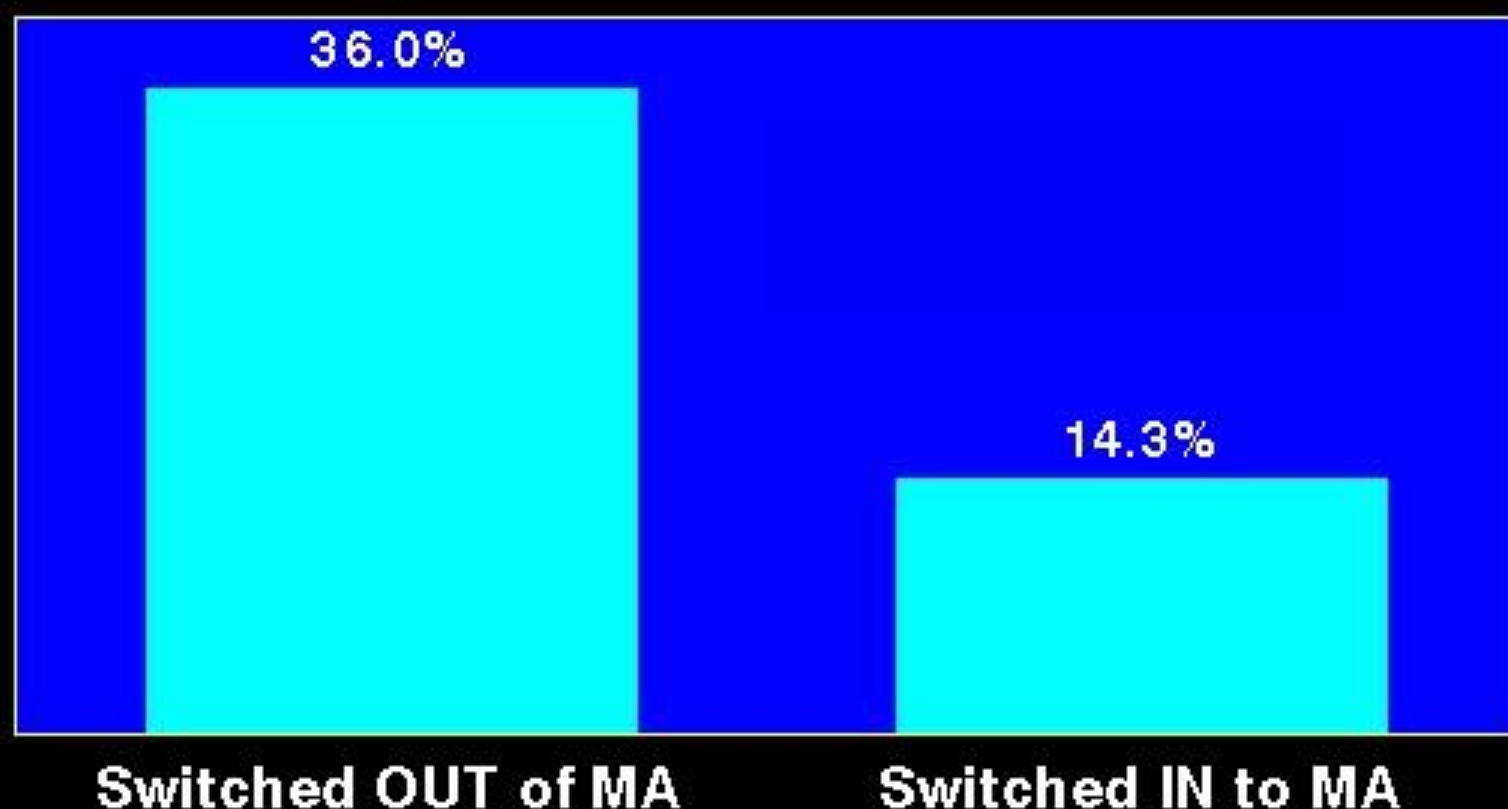


Source: Health Affairs 2021;40:469

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

Patients Acquiring New Disabilities Switch Out of Medicare Advantage

Percent of newly disabled who switched



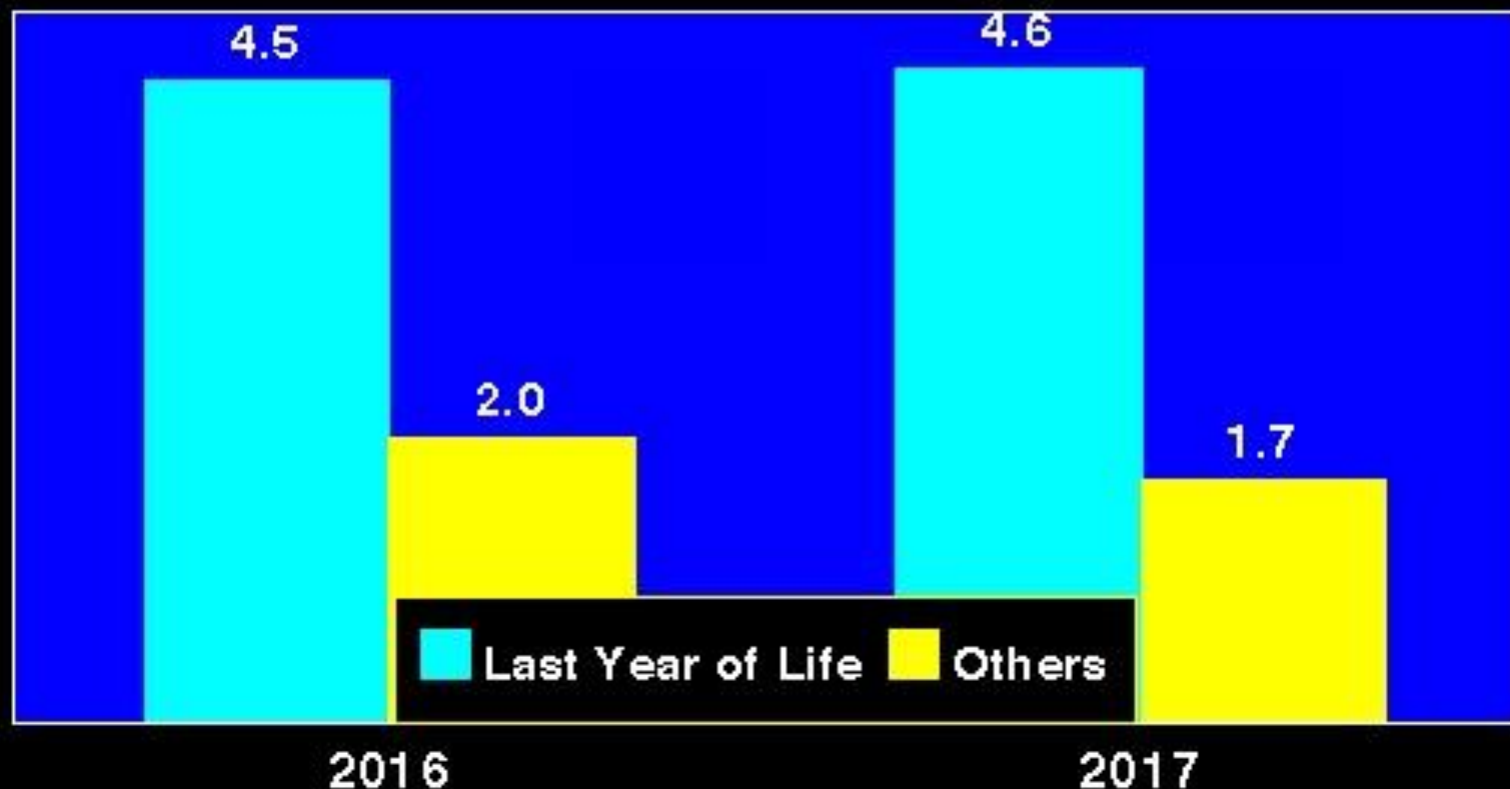
Source: Health Aff 2020;39:809

Note: New functional disability = needs assistance with >1 ADL

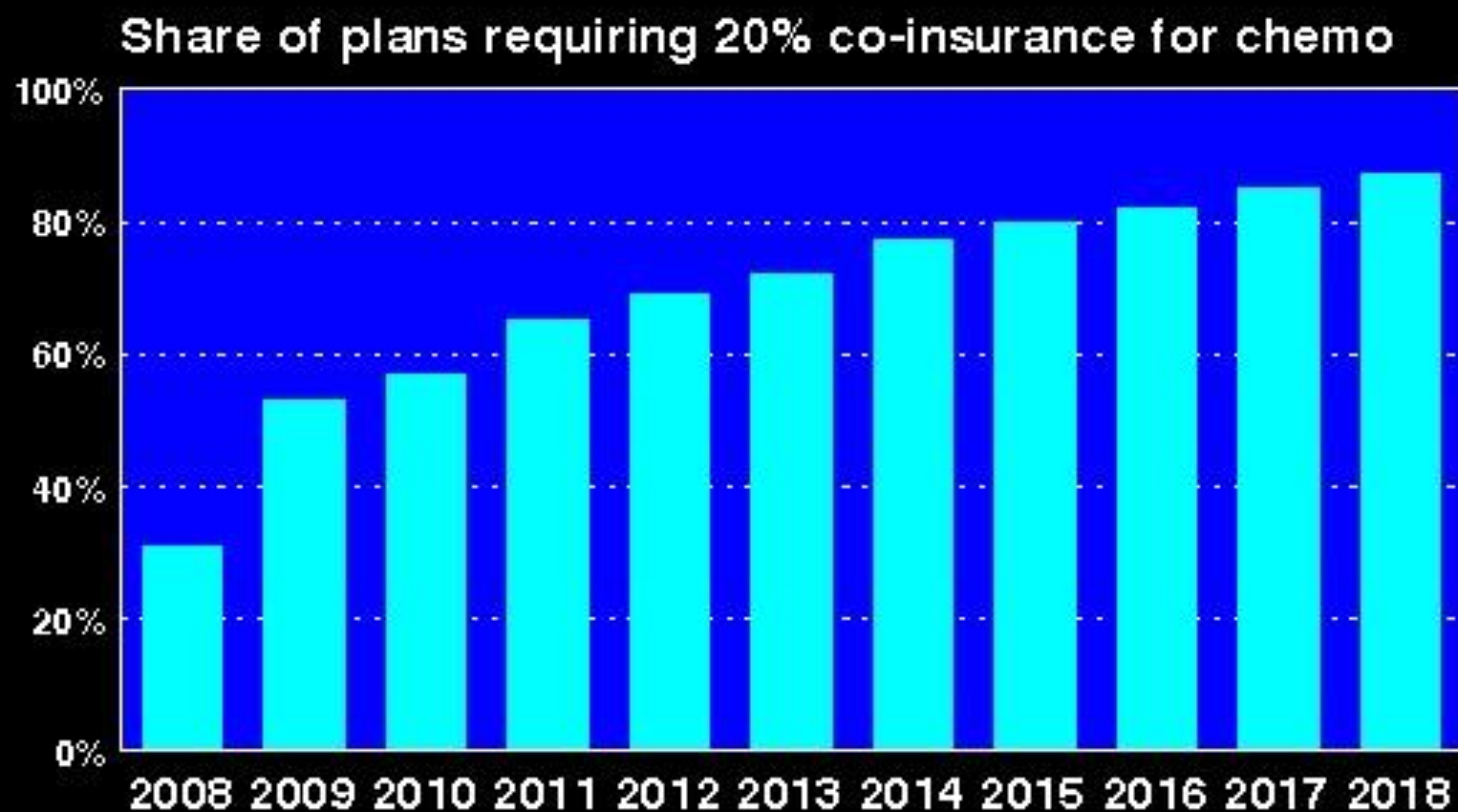
Medicare Advantage Plans Disenroll Dying (Expensive) Enrollees

Last-Year-of-Life Switches Raised Taxpayers' Costs by \$912 Million

% of MA enrollees who switched to FFS Medicare

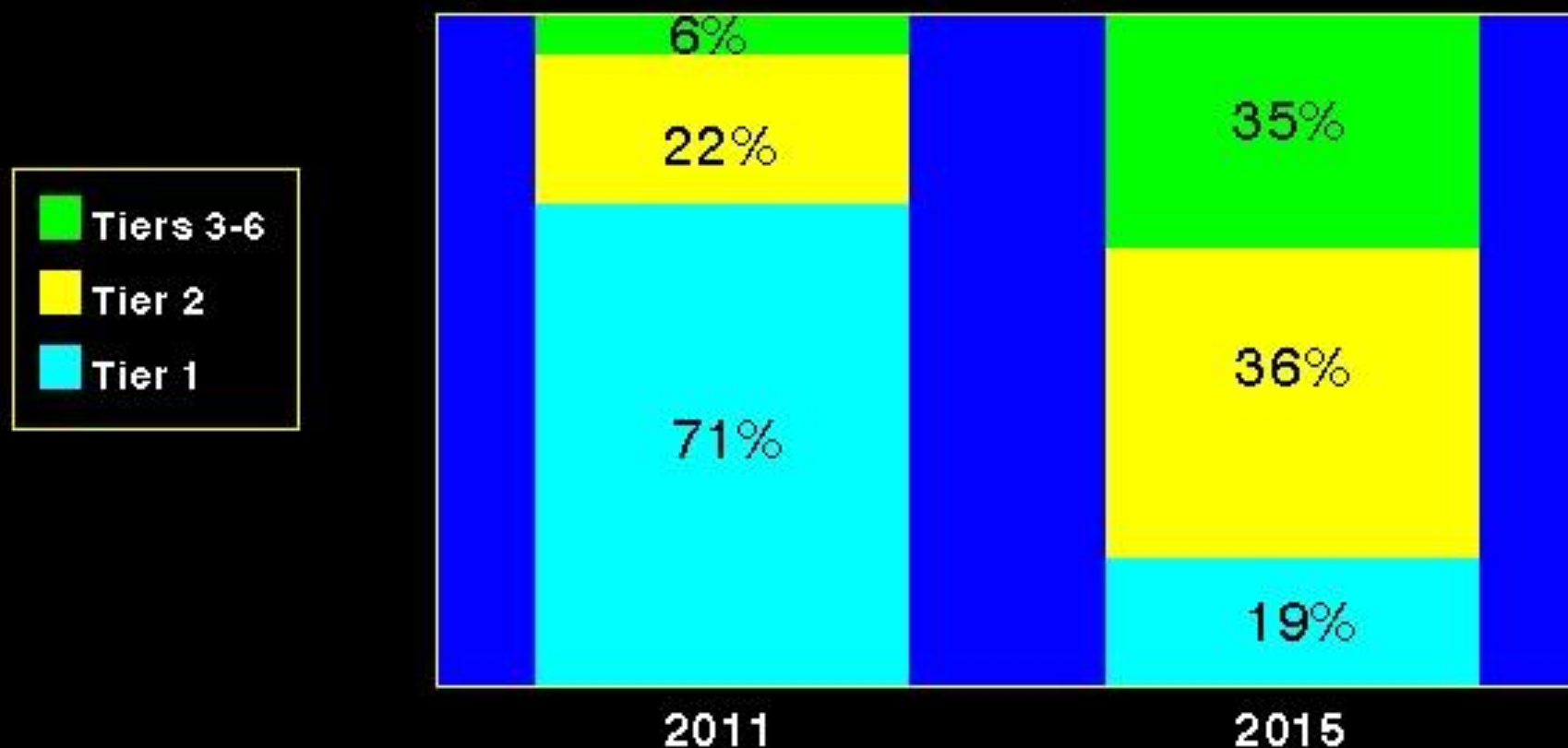


Medicare Advantage Plans Push Cancer Patients Out by Imposing 20% Co-Insurance for Chemotherapy



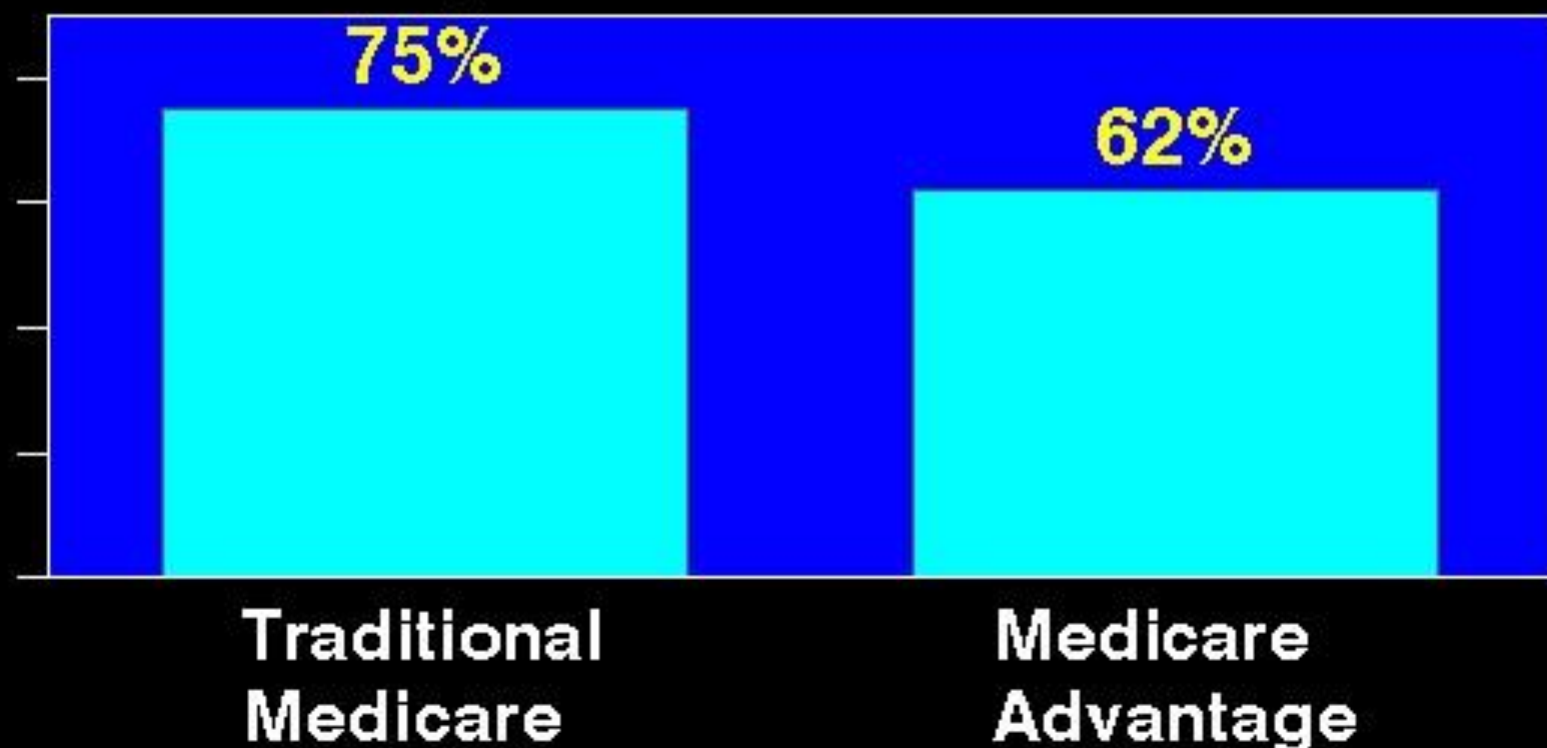
Medicare Plans Put Generics Into Higher "Tiers", Boosting Copays by \$6.2 bil.

Percent of generic drugs in each tier,
private Medicare Part D plans



Medicare Advantage Plans Deny Needed Home Care Pushing Out Unprofitably Ill Patients

Percent receiving home care



Source: JGIM 2021;36(8):2323-31

Receipt of home care among those whose hospital record indicated "discharged with home care"

Medicare Advantage Plans Skimp on Rehabilitation and Home Care

Decreased use relative to traditional Medicare*

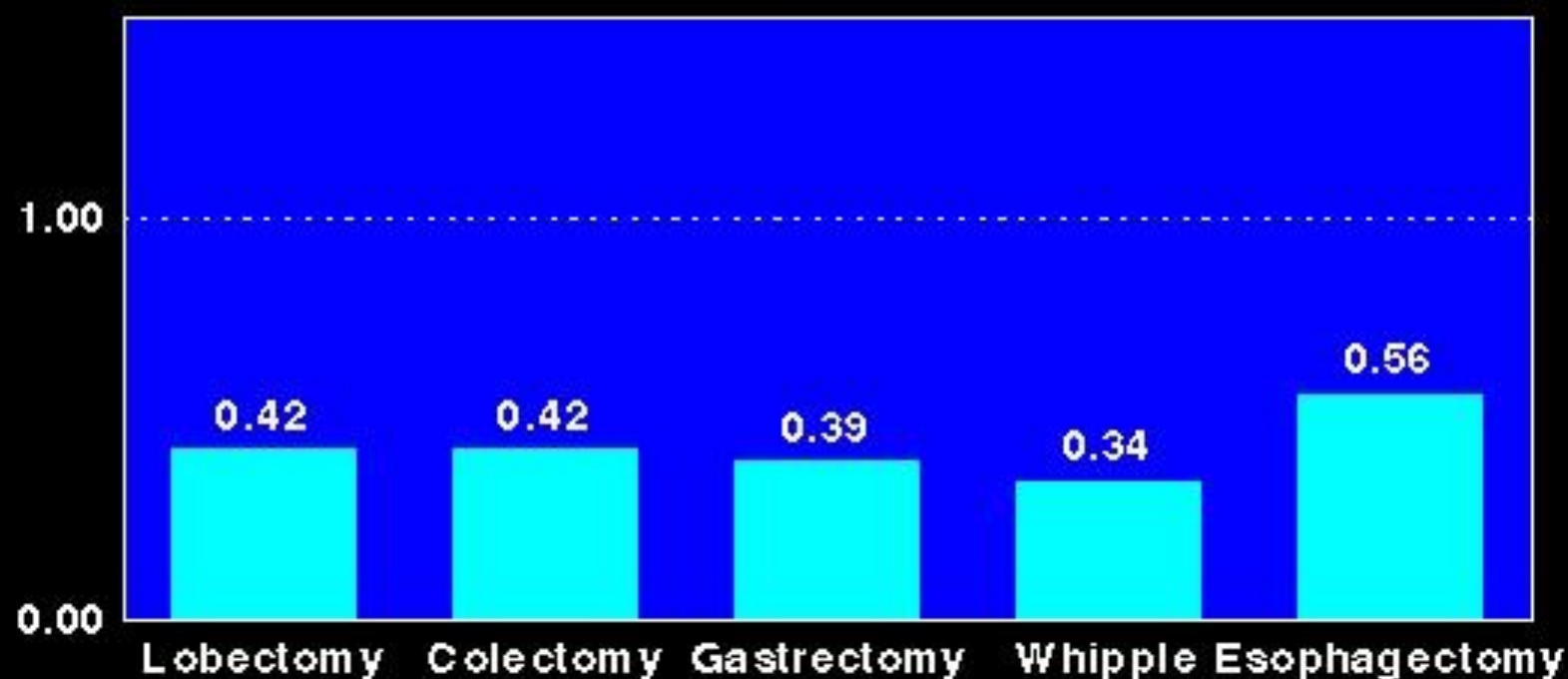


Source: Health Aff 2020;39:837

* Difference in share of patients receiving service in 90 days after discharge, adjusted for demographic, clinical and hospital characteristics

Medicare Advantage Cancer Patients Less Likely to Get Complex Surgery at Top-Ranked Cancer Center

Odds ratio that surgery occurred at top-ranked center, MA vs. FFS Medicare*



Source: Am J Managed Care 2021;27:(10):e355-e360

* Adjusted for multiple clinical factors and patients' distance from a top-ranked center

Medicare Advantage Plans' Strategies:

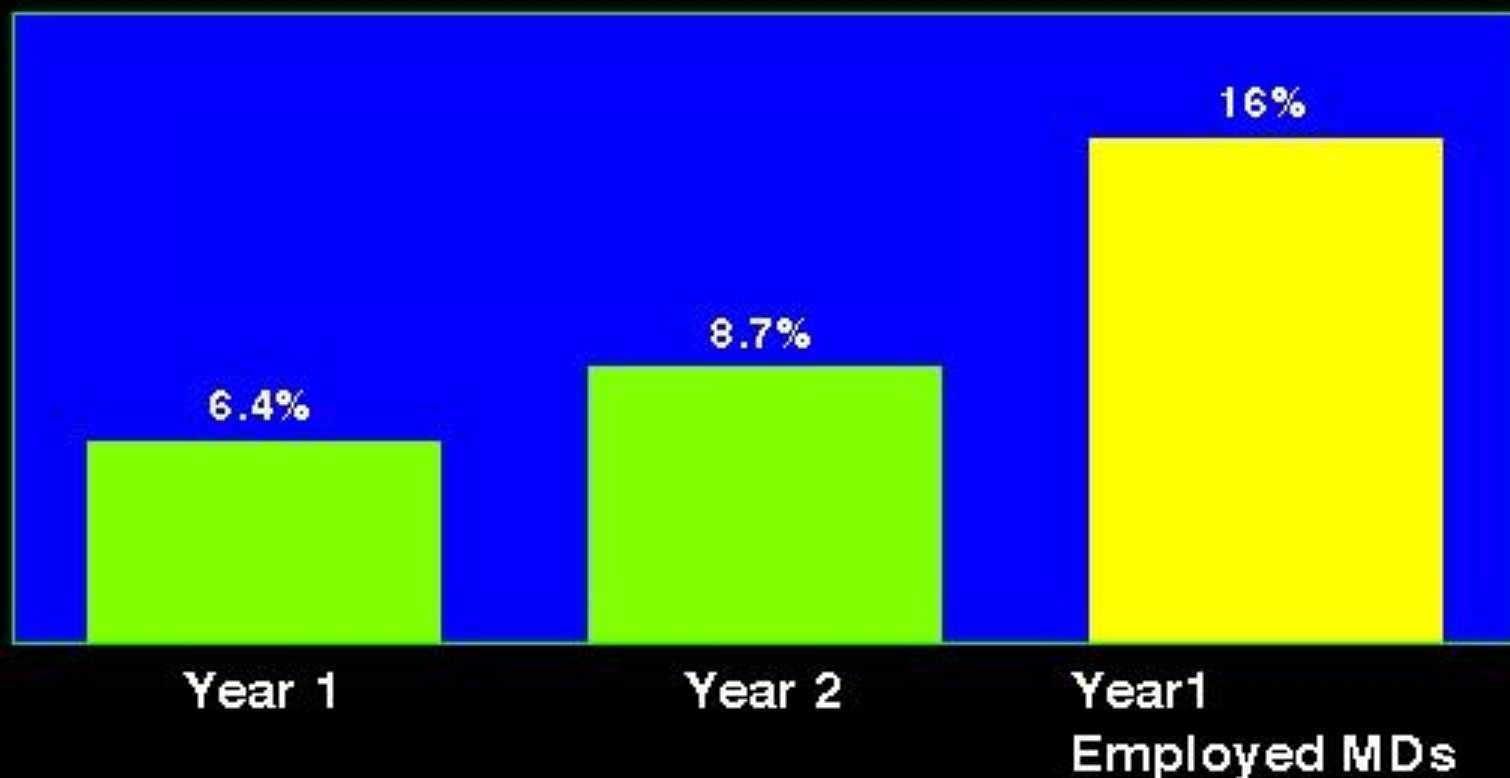
3 - Cheating



Medicare Advantage Plans "Upcode"

**Risk Scores Spike Immediately After Patients Enroll;
Biggest Jump in HMOs that Employ Doctors**

% increase in risk score vs. patients staying in FFS Medicare



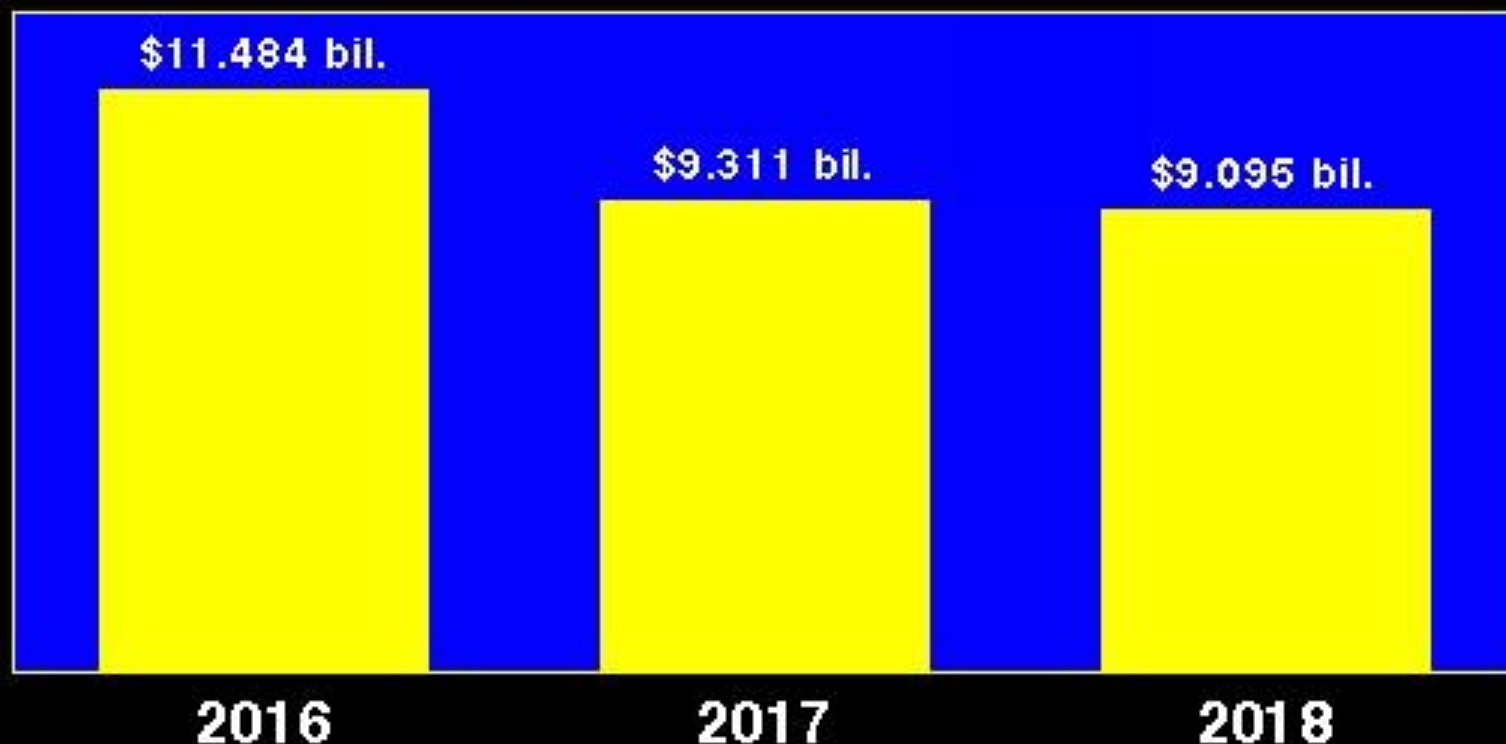
Source: NBER Working Paper # 21222

The 6.4% coding increase ups MA plans' payments from Medicare by \$10 billion/yr, ~\$650/enrollee. It is equivalent to 6% of all enrollees becoming paraplegic or 39% becoming diabetic.

Medicare Advantage Plans' Claims for Unsupported Diagnoses

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

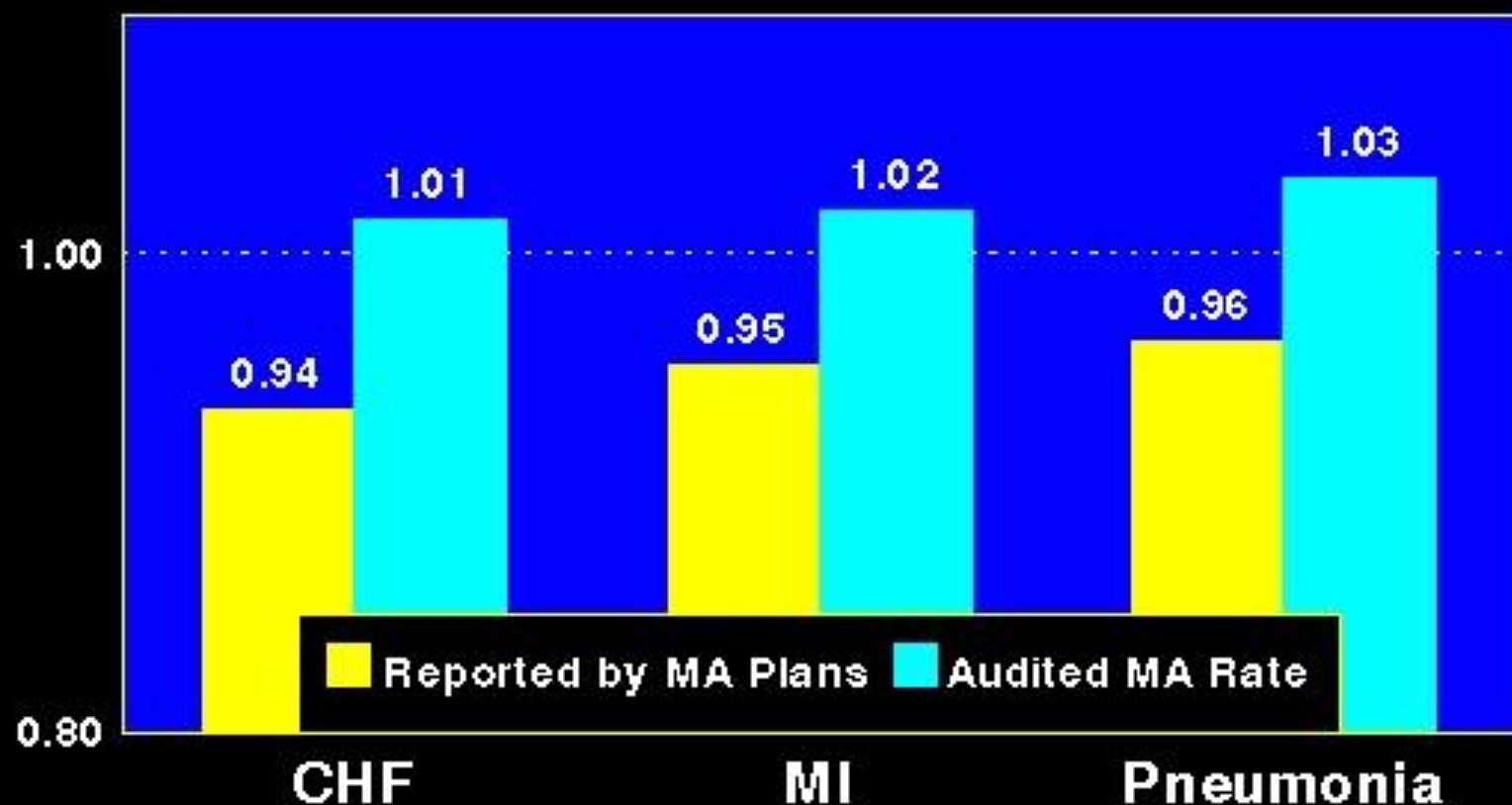
CMS estimate of overcharges to Medicare for diagnoses not supported in chart



M.A. Plans Lie About Quality

Advantage Plans Report few Readmits
But Audit Shows Rates Higher Than FFS Medicare

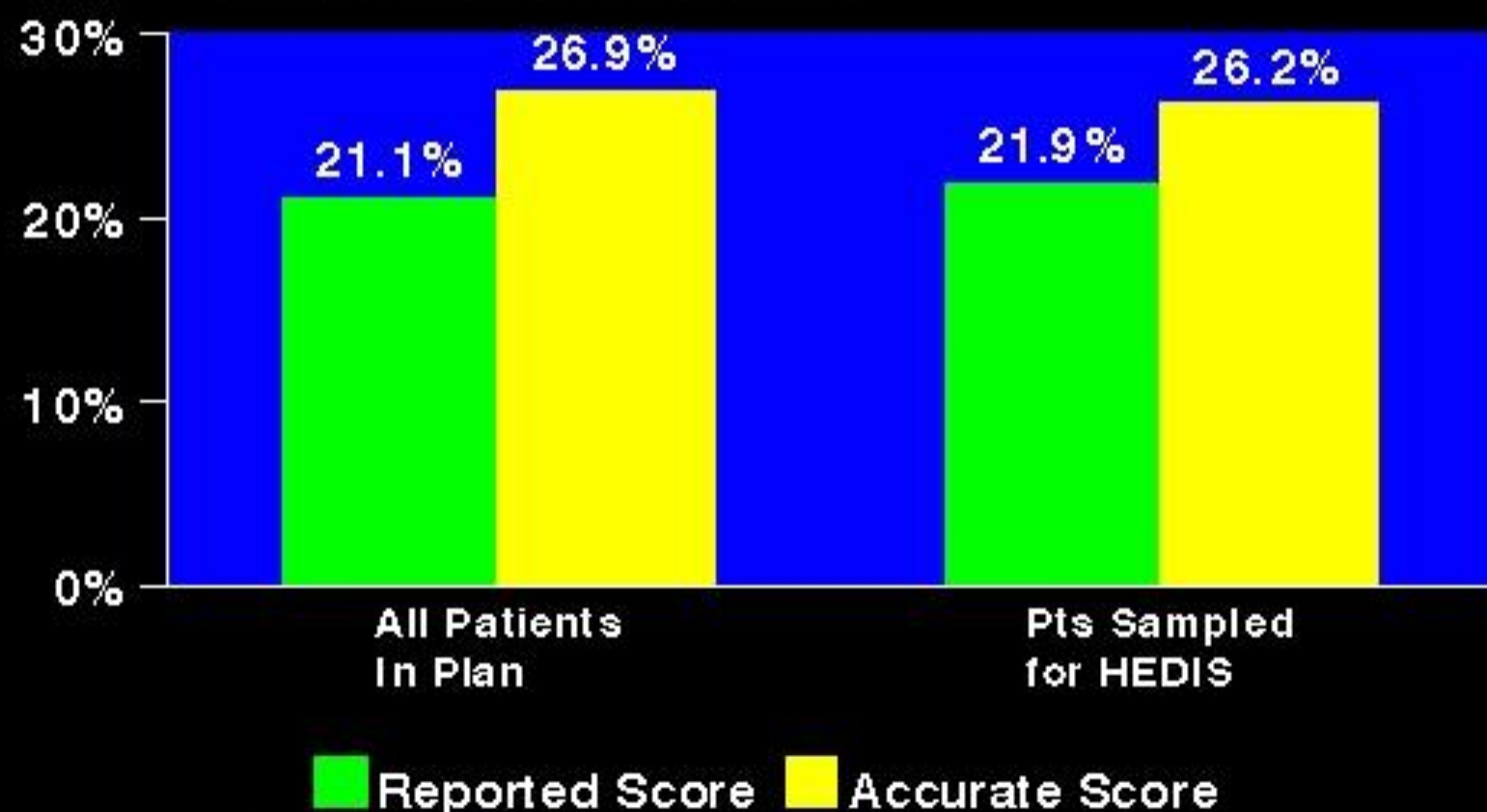
30 day readmission rate relative to Traditional Medicare



95% of Plans Cheat on HEDIS Quality Scores

Medicare Advantage Plans Failing to Cheat Fall in Rankings

Percent of elderly patients prescribed drugs that should be avoided



Source: *Annals of Internal Medicine* 2013;159:456

Researchers compared reported HEDIS scores for high risk prescribing to actual Medicare Part D payment records for all enrollees, and for enrollees sampled for the HEDIS scoring

HMO “Housecalls”

A New Upcoding Scam

- **HMOs send it “housecall” doctor – or one from Mobile Medical Examination Services Inc.**
- **Doctor seeks out unimportant diagnoses, e.g. mild arthritis**
- **No treatment offered**
- **Extra diagnoses allow HMOs to upcode - adding > \$3 billion/yr to Medicare Advantage payments**
- **Efforts to outlaw upcoding “housecalls” were scrapped after industry lobbying blitz**

Profit-Driven Upcoding Makes Accurate Risk Adjustment Impossible:

High Cost Providers Inflate Both
Reimbursement and Quality Scores by
Making Patients Look Sicker on Paper

Upcoding Boosts Advantage Plans' CMS-Paid Premiums

Same Patient, Different Coding

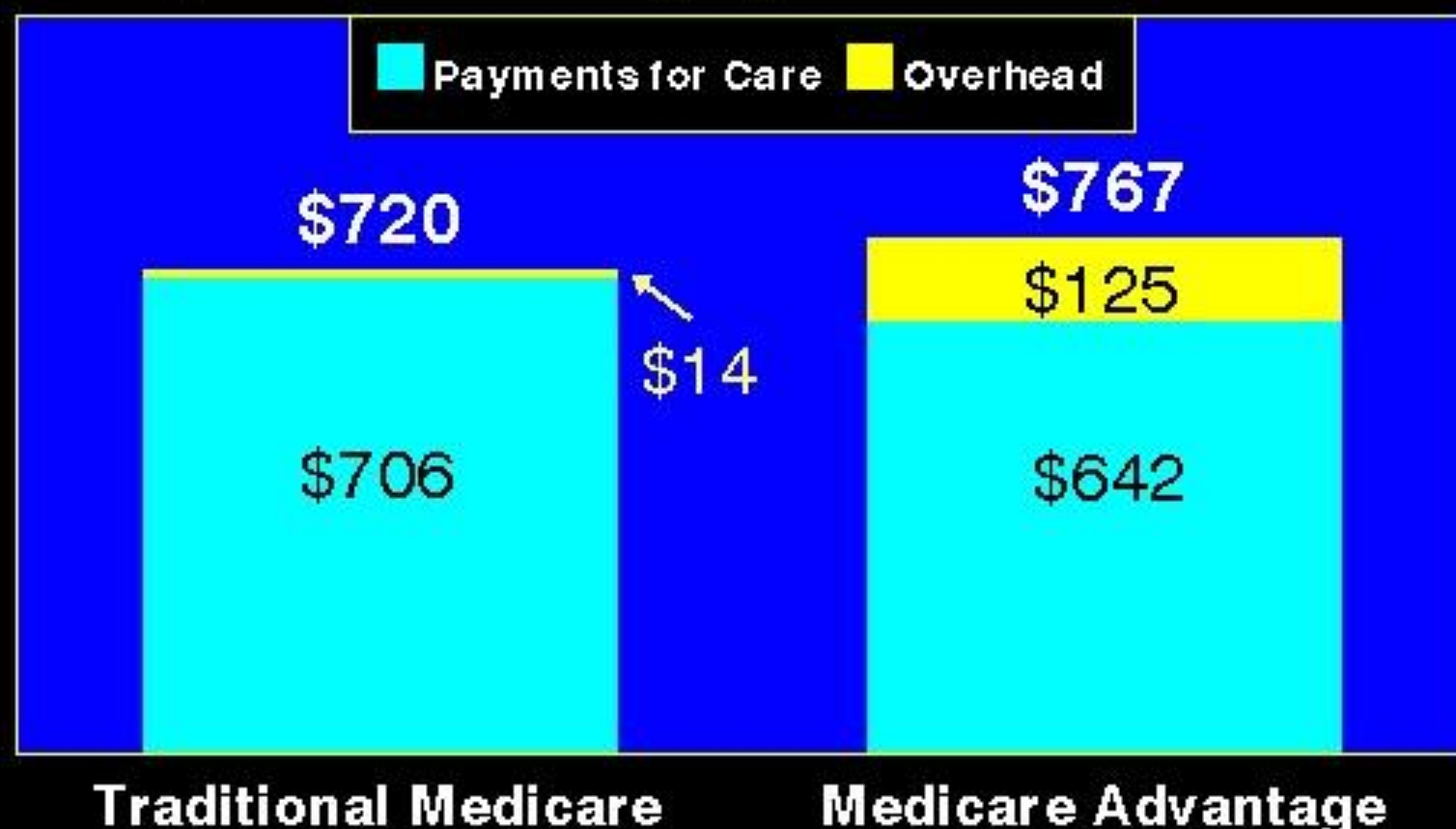
• Base rate	\$3950	• Base rate	\$3950
• Uncompl. DM	\$1040	• DM II with diab. CKD	\$3180
• CKD	\$0	• CKD stage 4	\$2370
• Obesity	\$0	• Morbid Obesity	\$2730
• Depression	\$0	• Major depression	\$3950
• Chronic CAD	\$0	• CAD with angina	\$1400
• Total	\$4990	• Total	\$17580

SOURCE: SGIM FORUM, 2017

Medicare Advantage Plans Raise Costs

Less Spending on Care, More on Overhead

Monthly cost per beneficiary, adjusted*

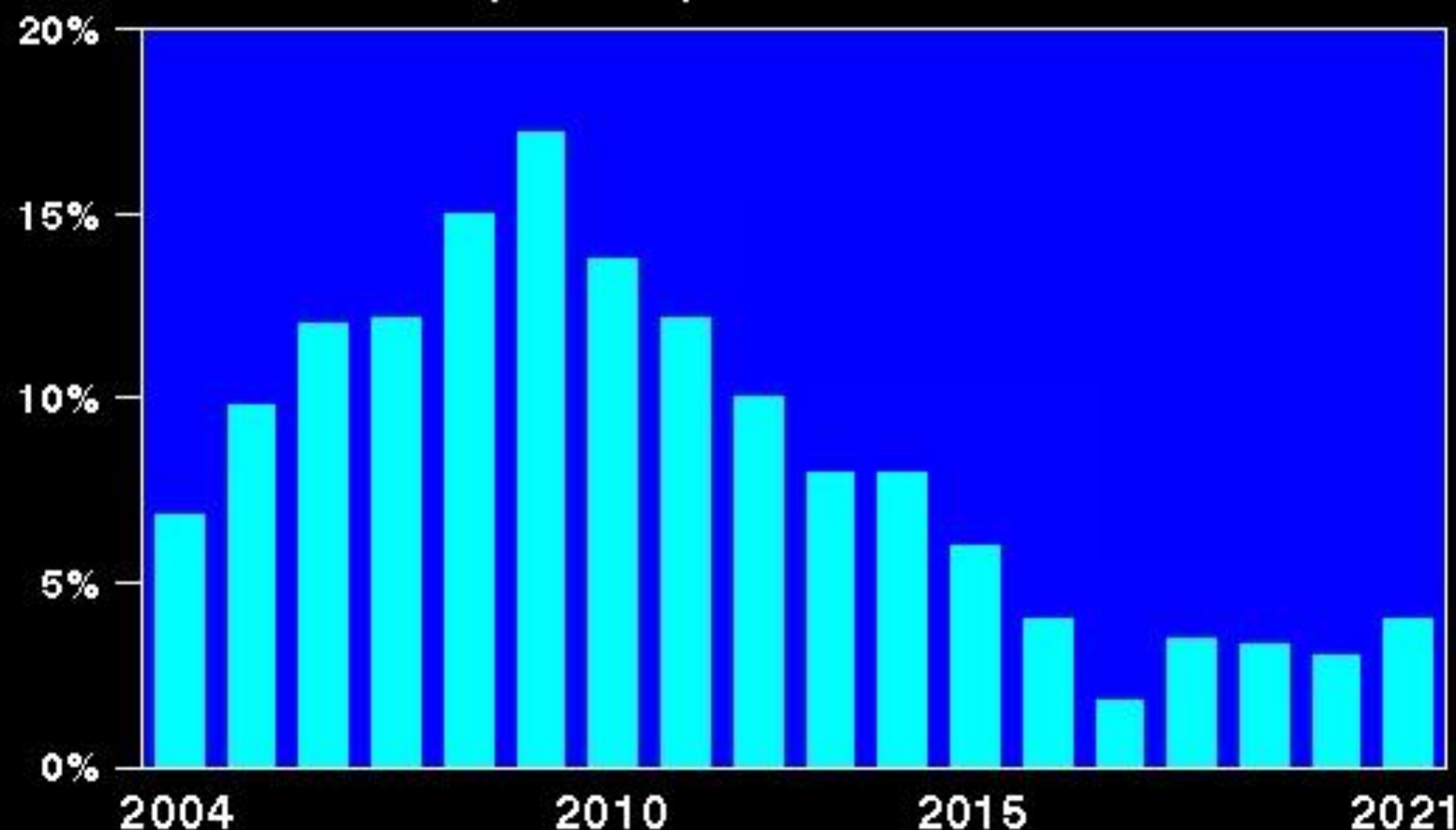


Source: Am. Econ. J. Applied Econ 2019;11:302 - Data are for 2010

* Health status adjustment based on diagnoses + mortality risk

Medicare Advantage Raises Taxpayers' Costs

Medicare overpayments to Medicare Advantage plans relative to comparable patients in FFS Medicare

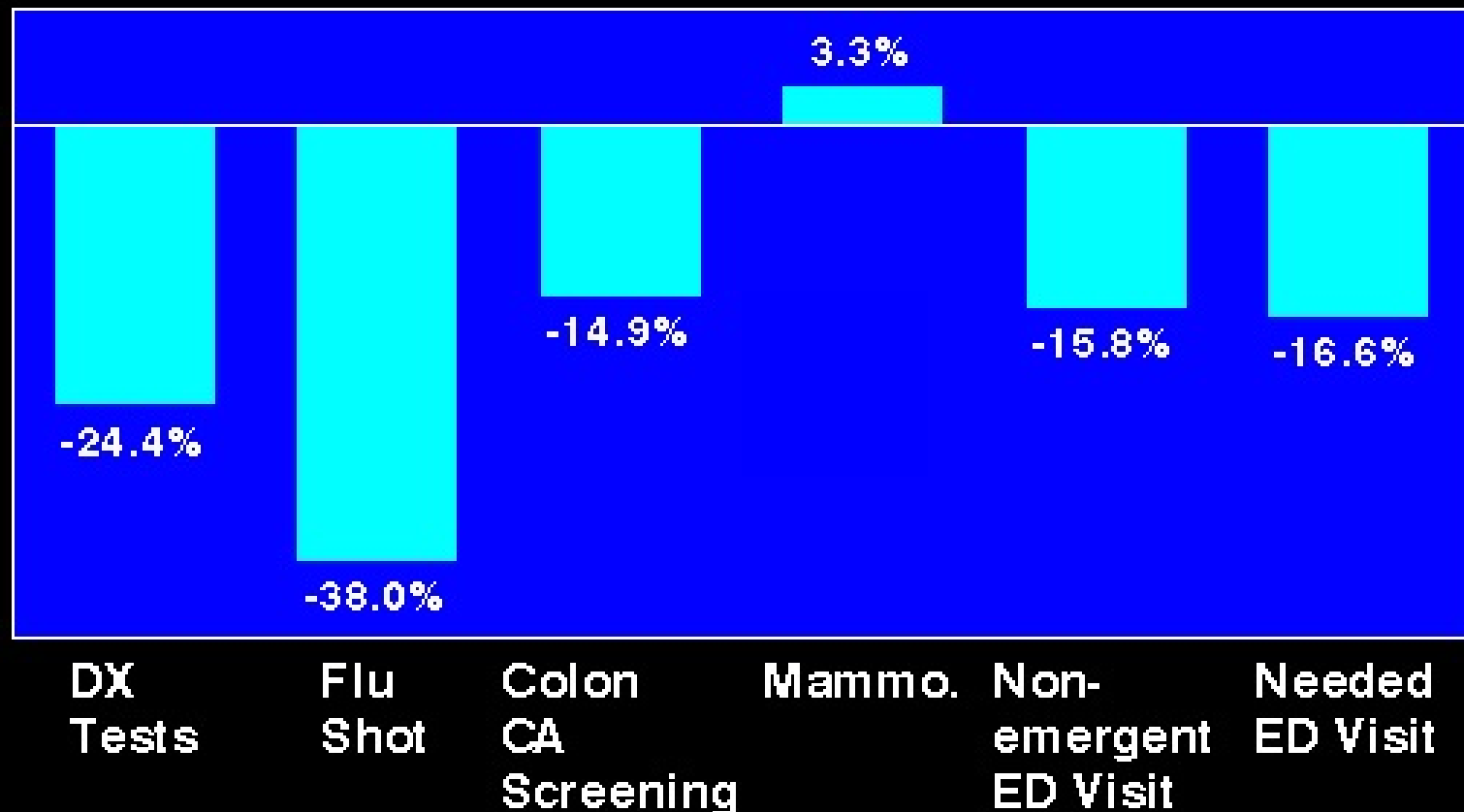


Source: MedPAC Blog March 3, 2021

Note: 2021 overpayment = \$13.9 billion.

Medicare Advantage Plans Cut Both Needed and Unneeded Care

Difference in rate: traditional Medicare - Medicare Advantage



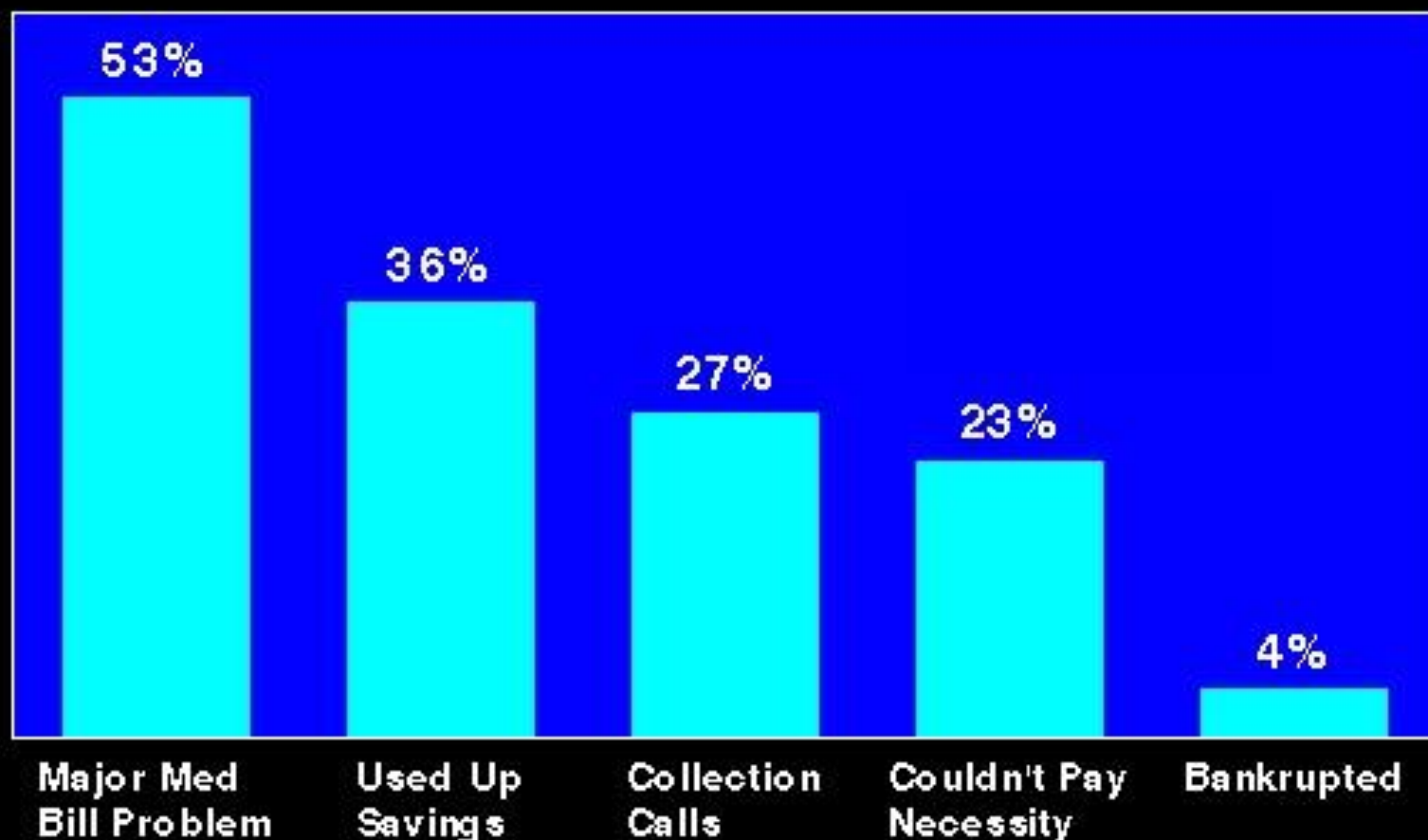
“Direct Contracting Entities” (DCEs)

The Latest Medicare Privatization Scheme

- Traditional Medicare enrollees assigned to a DCE – can’t opt out.
- DCEs paid capitation similar to Medicare Advantage (MA).
- Many owned by insurance giants or for-profit startups.
- As in MA, overdiagnosis/upcoding key to profitability, e.g.:
 - Routine screening carotid ultrasounds (contrary to USPSTF guidelines); + test raises capitation \$2800/patients.
 - “Clover Health” offers PCPs \$30/visit bonus to use its upcoding software.
- Wall Street valuing DCE startups at \$87,000 per patient enrolled, anticipating windfall profits from Medicare.

Medicare Needs Improvement

Financial Problems of Seriously Ill Enrollees



Source: Health Aff 2019;38:1801

Note: "Necessity" = Food, heat, housing

ACOs

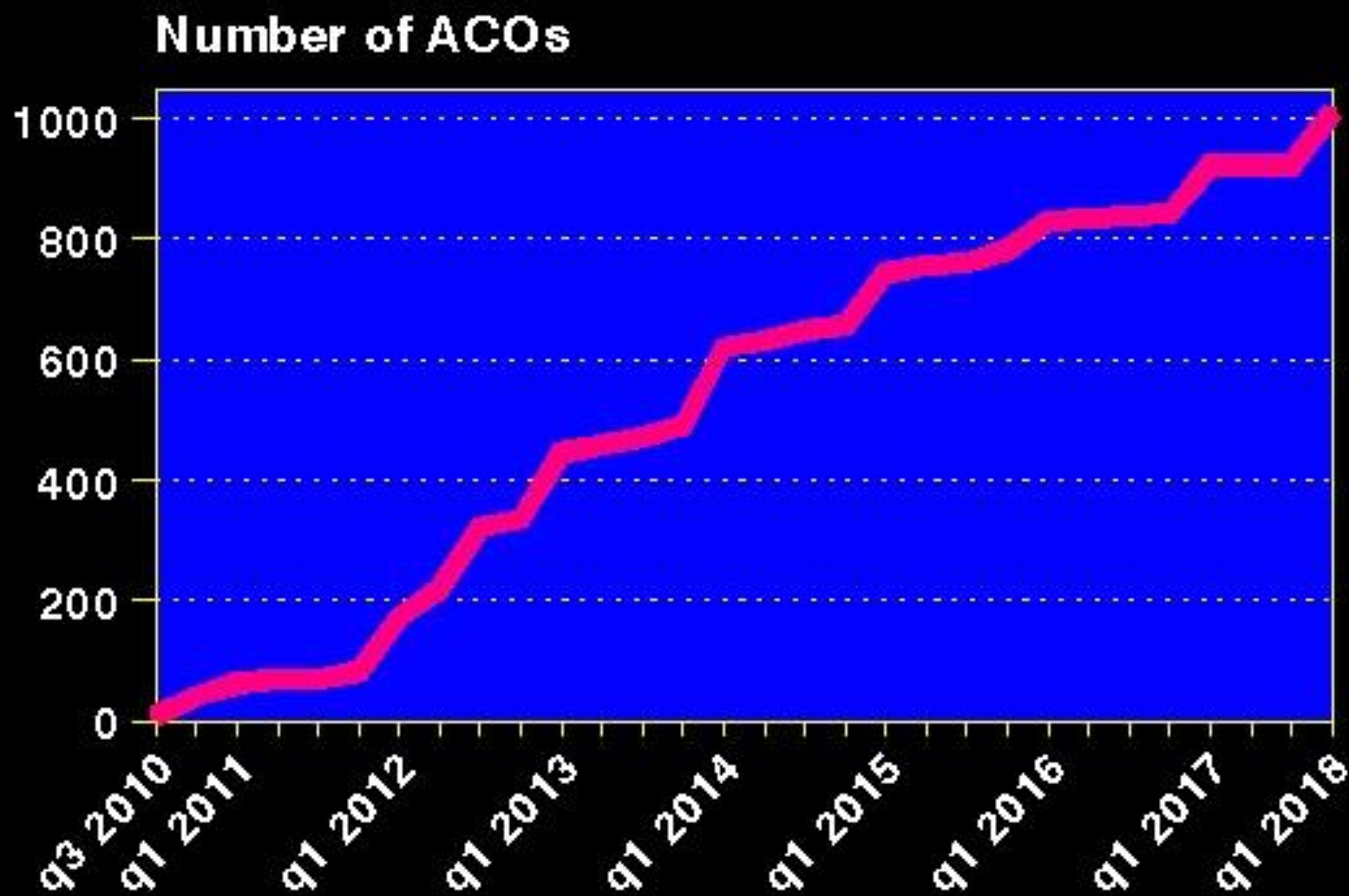
Warmed Over Managed Care



"IT'S LIKE
DEJA VU
ALL OVER
AGAIN."

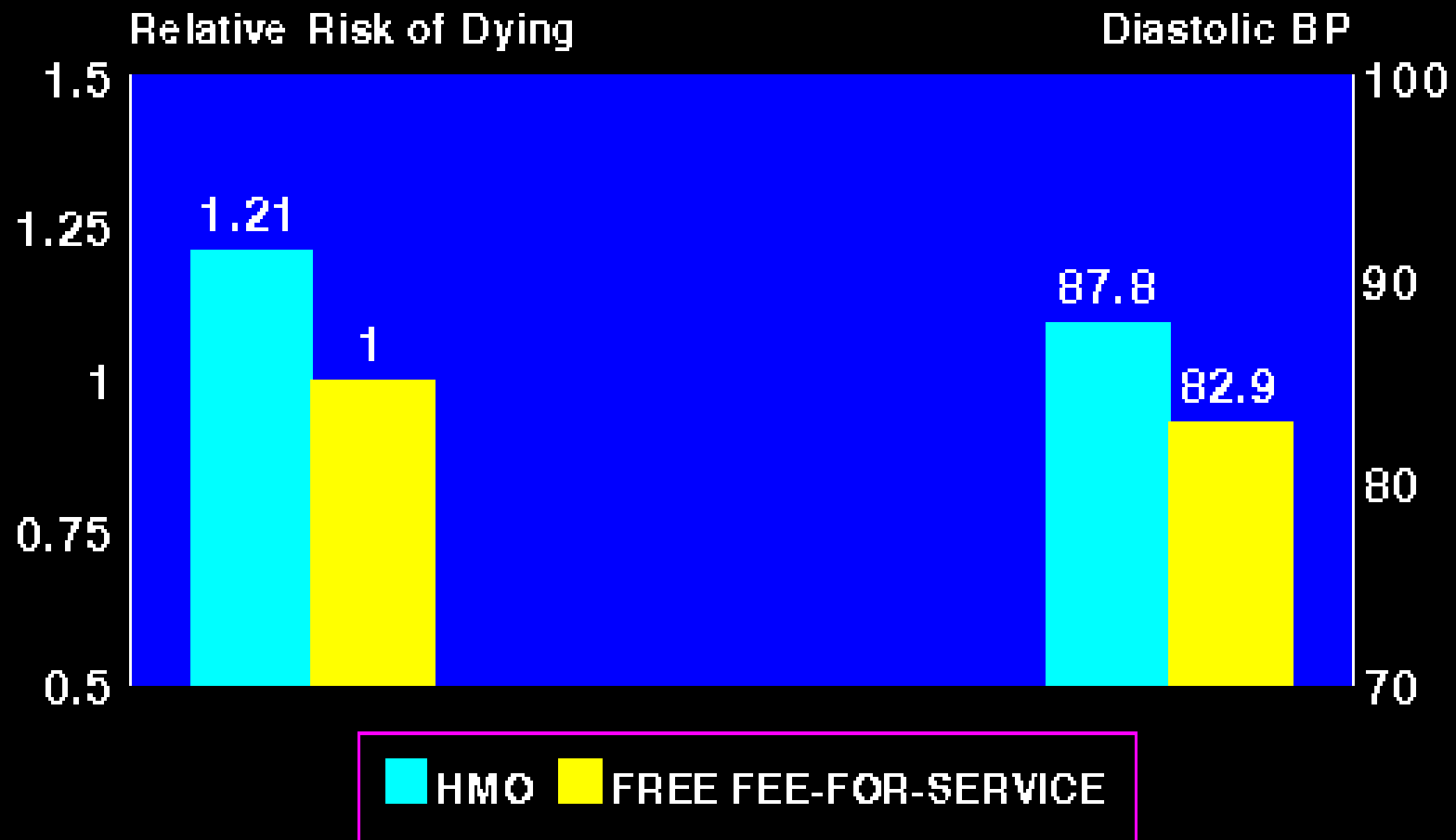
YOGI BERRA

ACOs' Explosive Growth Since 2010



Source: Health Affairs Blog 10/31/13 & 3/31/15, 8/14/19; Leavitt Partners 6/28/17

High Risk HMO Patients Fared Poorly in the Rand Experiment



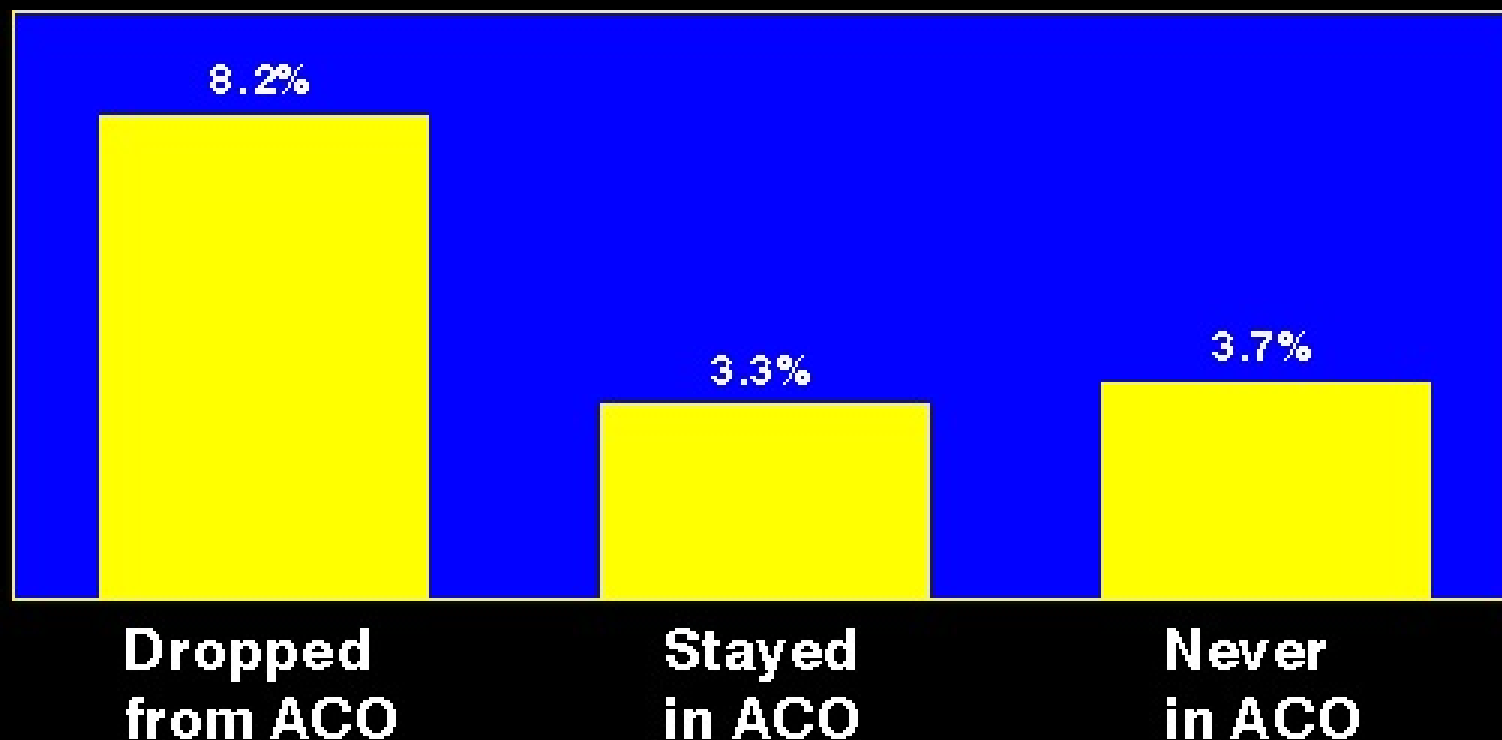
Source: Rand Health Insurance Experiment, Lancet 1988; i:1017

Note: High Risk = 20% of population with lowest income + highest medical risk

ACOs Got Rid of Patients in Deteriorating Health

For Patients Already Enrolled in ACO, Upcoding Doesn't Boost
Risk-Adjusted Payments So ACOs "Lemon-Drop" With Increasing Care Needs

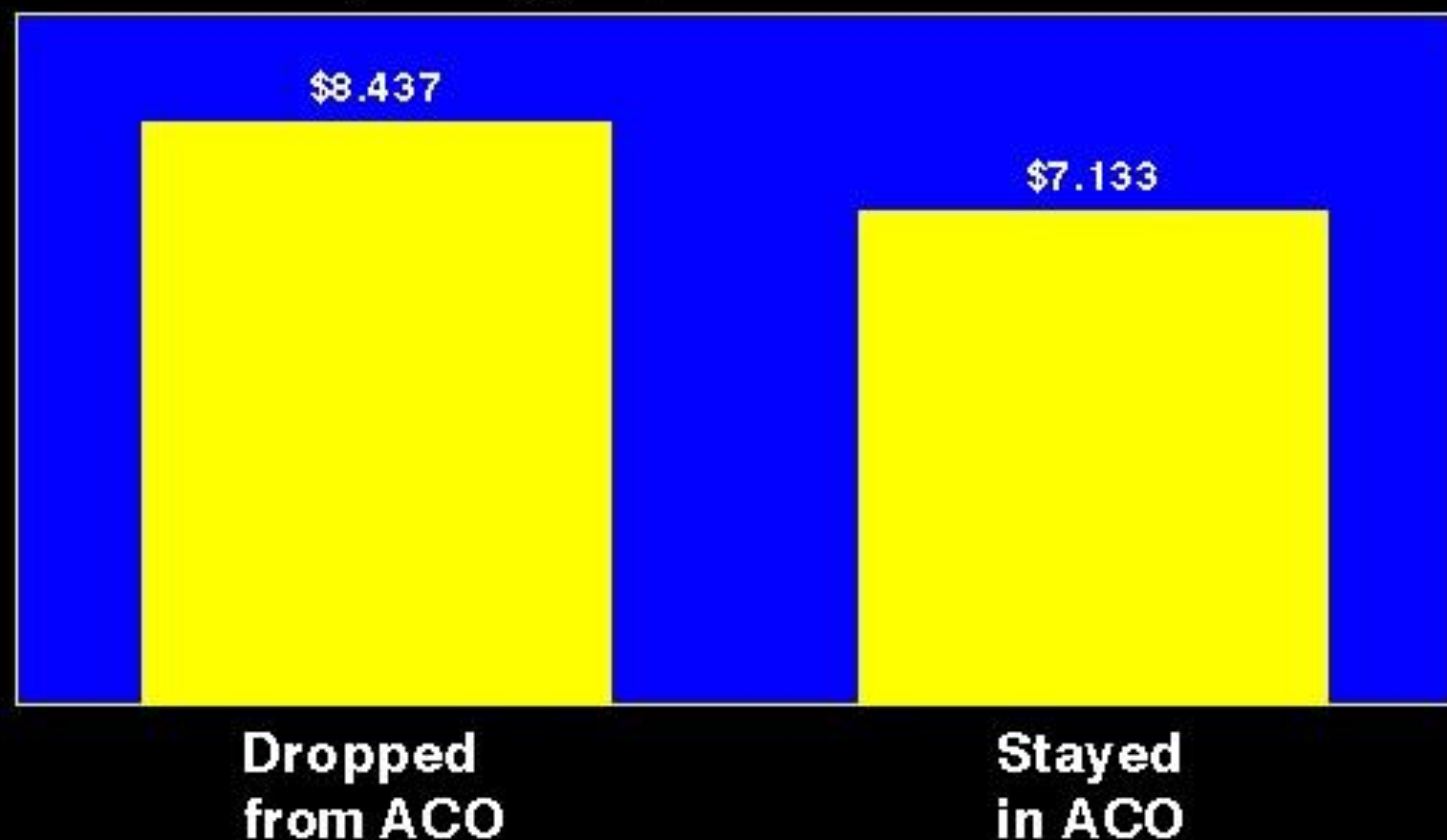
Change, 2012-2013 in risk score
("hierarchical condition codes")



ACOs Got Rid of High Cost Patients

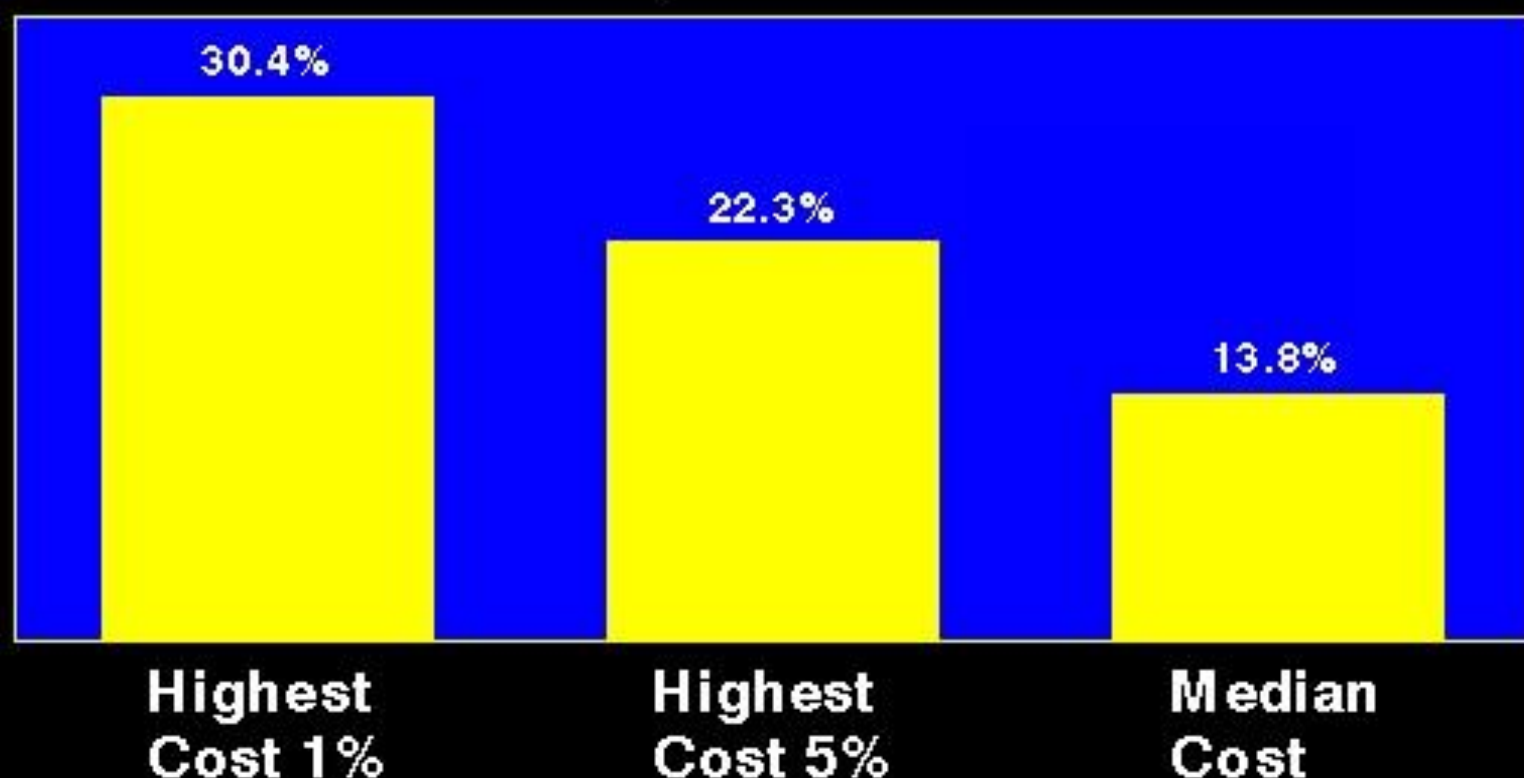
For Patients Already Enrolled in ACO, Upcoding Doesn't Boost Risk-Adjusted Payment
So ACOs "Lemon-Drop" High Cost Patients to Generate Bonuses from Fake Savings

Total annual spending per patient



ACOs Get Rid of High Cost Patients By Ejecting Their Doctors

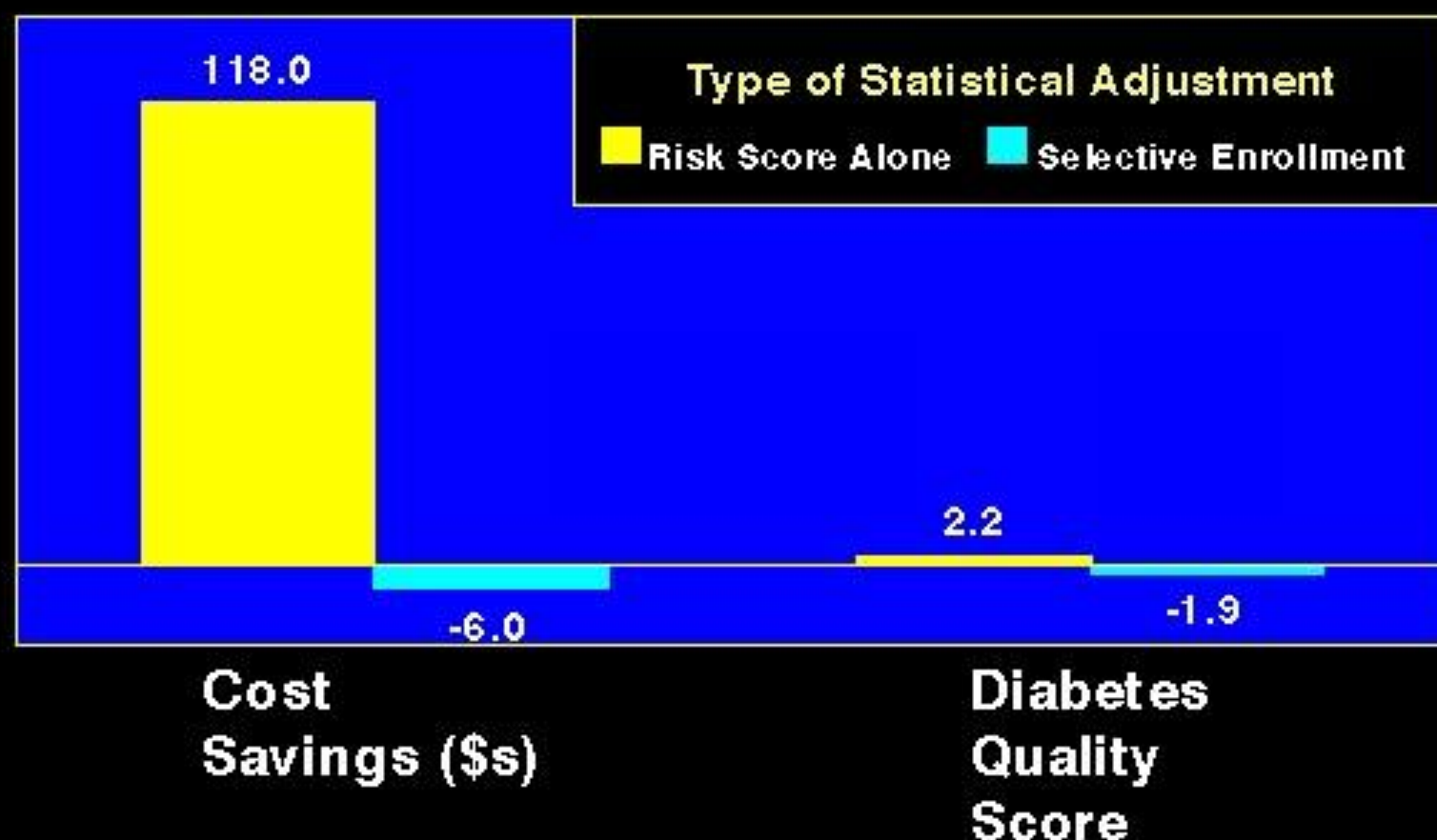
Percent of doctors leaving ACO



Doctors Rank According to Cost of Their Patients

ACOs: No Savings, No Quality Improvement After Control for Selective Enrollment

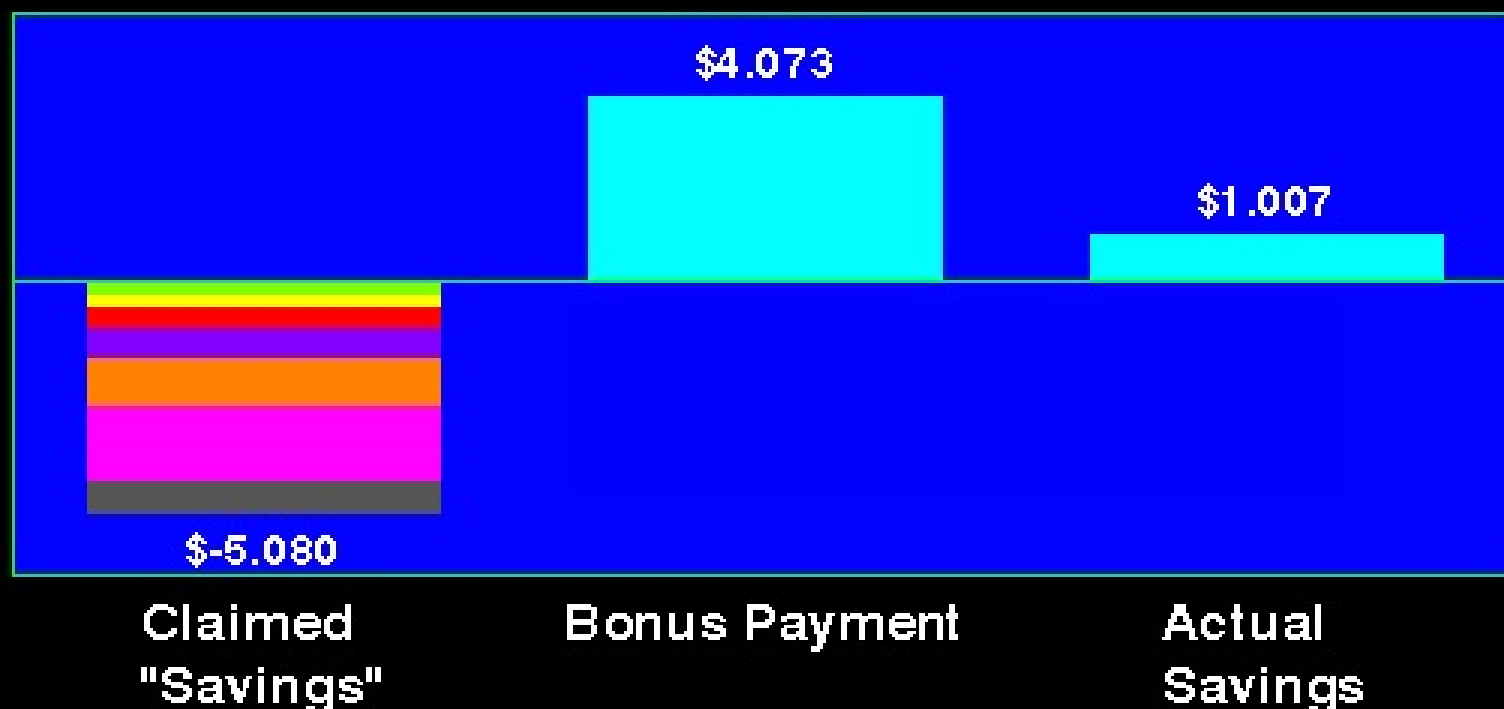
Estimated difference, ACO vs. non-ACO, per quarter



ACO Savings = \$1.007 bil. Over 7 Years = 0.21% of Spending

MEDPAC Estimate: ACOs Increased Administrative Costs by \$10.6 bil.

Medicare payments to ACOs, 2013-2019 (\$ billions)



2013 2014 2015 2016 2017 2018 2019

McKinsey:

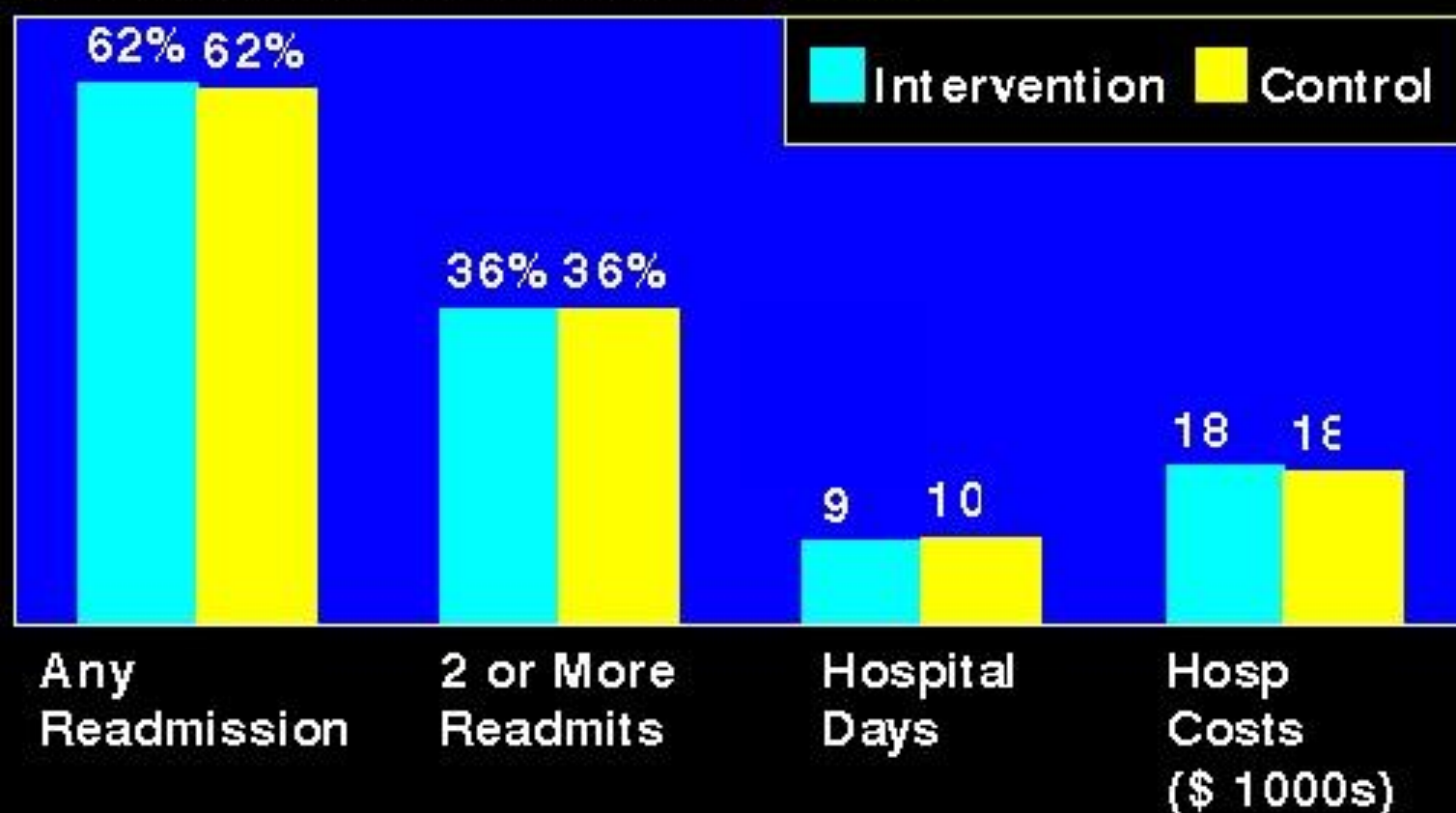
“The Math of ACOs”

- ~\$9 million/year/ACA spent on new data/analytics
- ~1.25% of total revenues for care management:
Success depends on curtailing patients' use of care and steering enrollees to lower-price providers, NOT managing chronic conditions.
- Additional costs for “executive director, head of real estate, head of care management, and lawyers and actuaries”

Hotspotting Didn't Work - RCT

Much Touted Camden Model Failed

180 day post-discharge outcomes



Failure of Medicare HMO Risk Adjustment: Implications for ACOs

- Despite decades-long effort, CMS has failed to stop cherry-picking
- Intensive coding makes patients appear sicker on paper, ups risk-adjusted capitation fee and factitiously raises quality scores
- ACOs that fail to cherry pick/upcode get low payments, and factitiously poor quality scores
- Implications:
 - No net savings, probable increased costs
 - Resources transferred from sick to healthy
 - Biggest cheaters are biggest winners
 - ACOs that embrace problem patients driven from the market

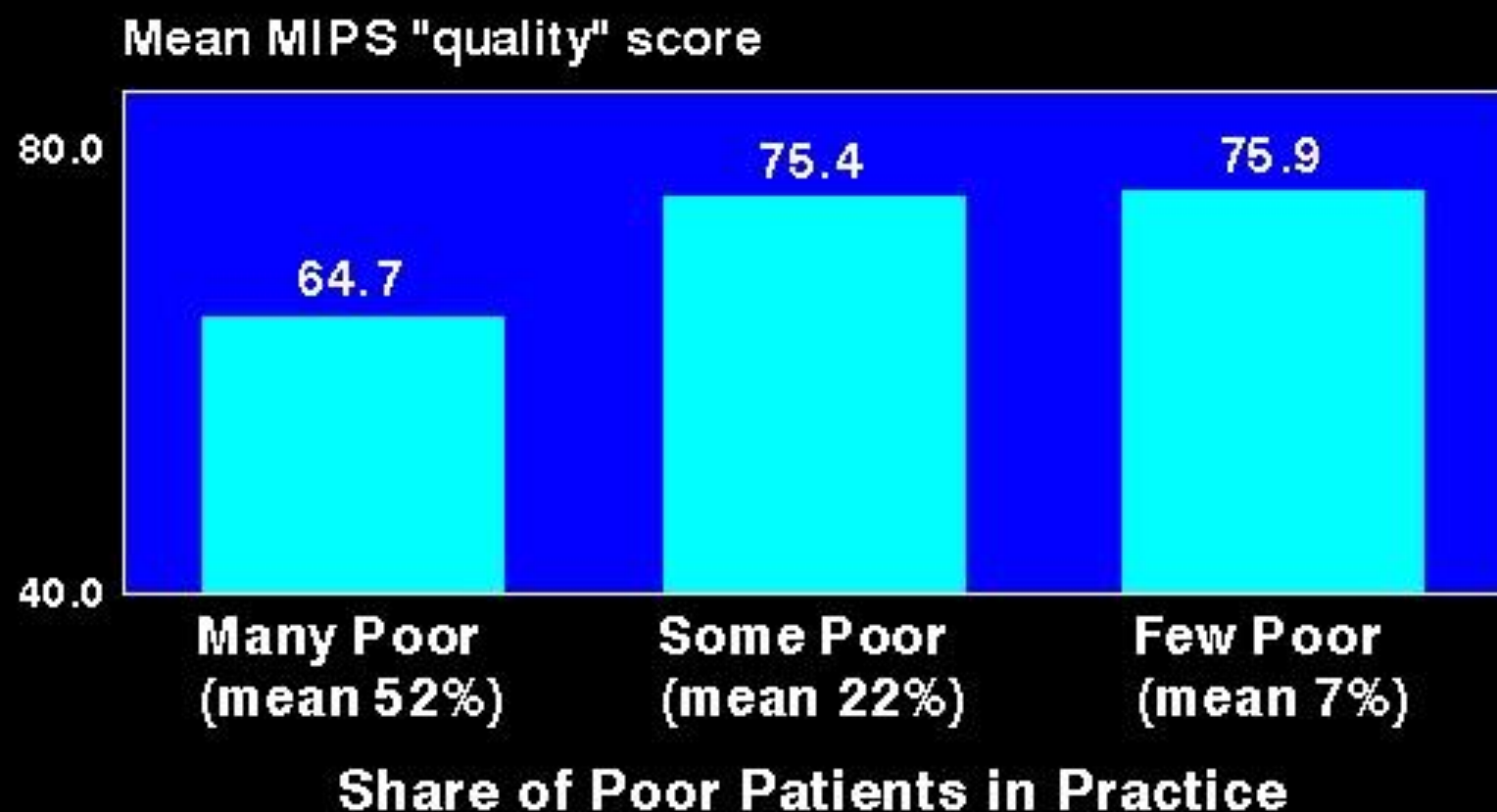
The Toxicity of Pay for Performance (P4P)

Assumptions Implicit in P-4-P

1. Performance can be accurately ascertained
2. Individual variation is caused by variation in motivation
3. Financial incentives will add to intrinsic motivation
4. Current payment system is too simple
5. Hospitals/MDs delivering poor quality care should get fewer resources

Medicare Quality Scores Penalize Doctors Caring for Poor Seniors

Score Difference = \$15,000 Lower Medicare Payments

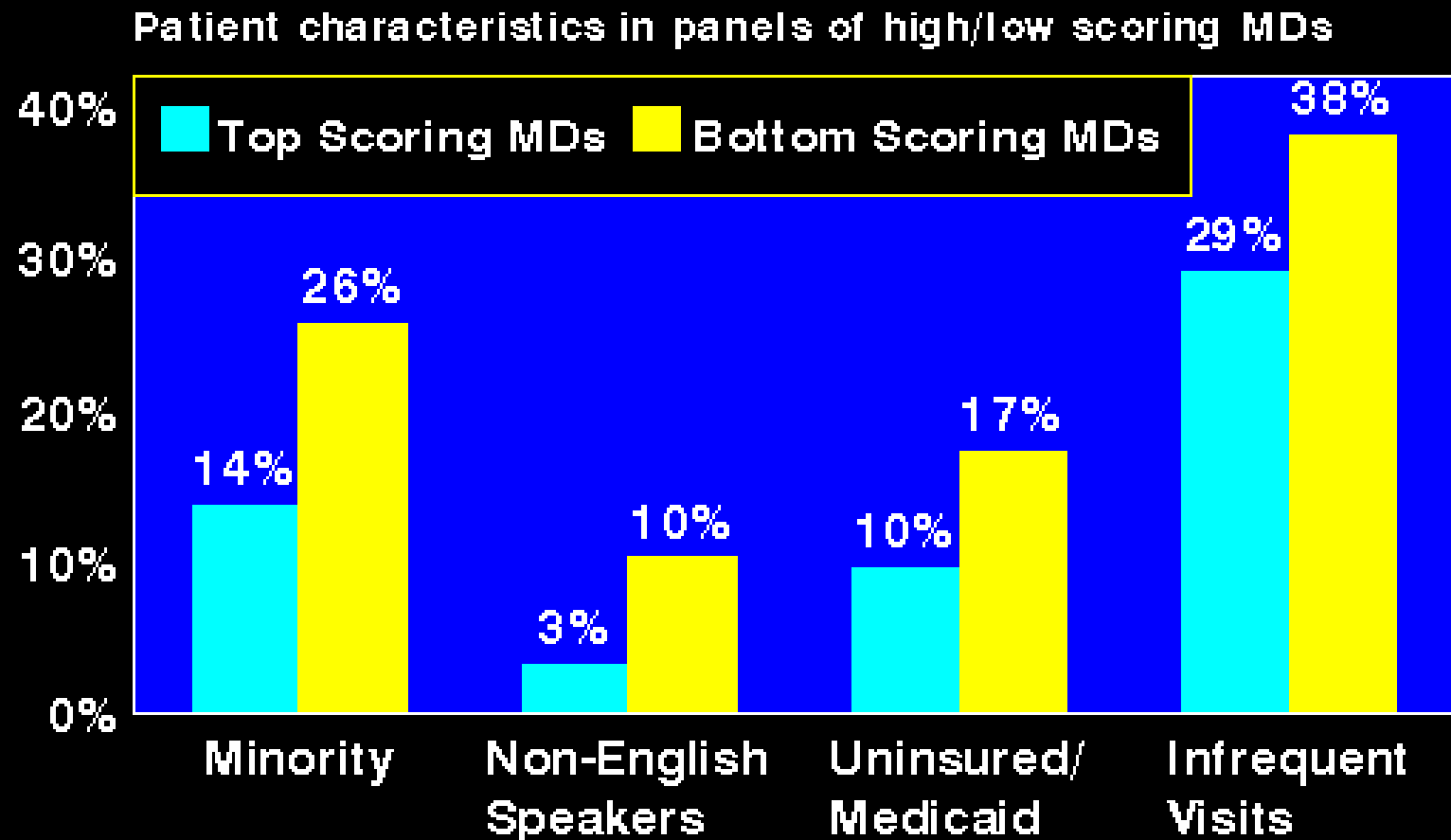


Source: JAMA 2020;324:975

Note: Poor is defined as dual (i.e. Medicaid) eligible

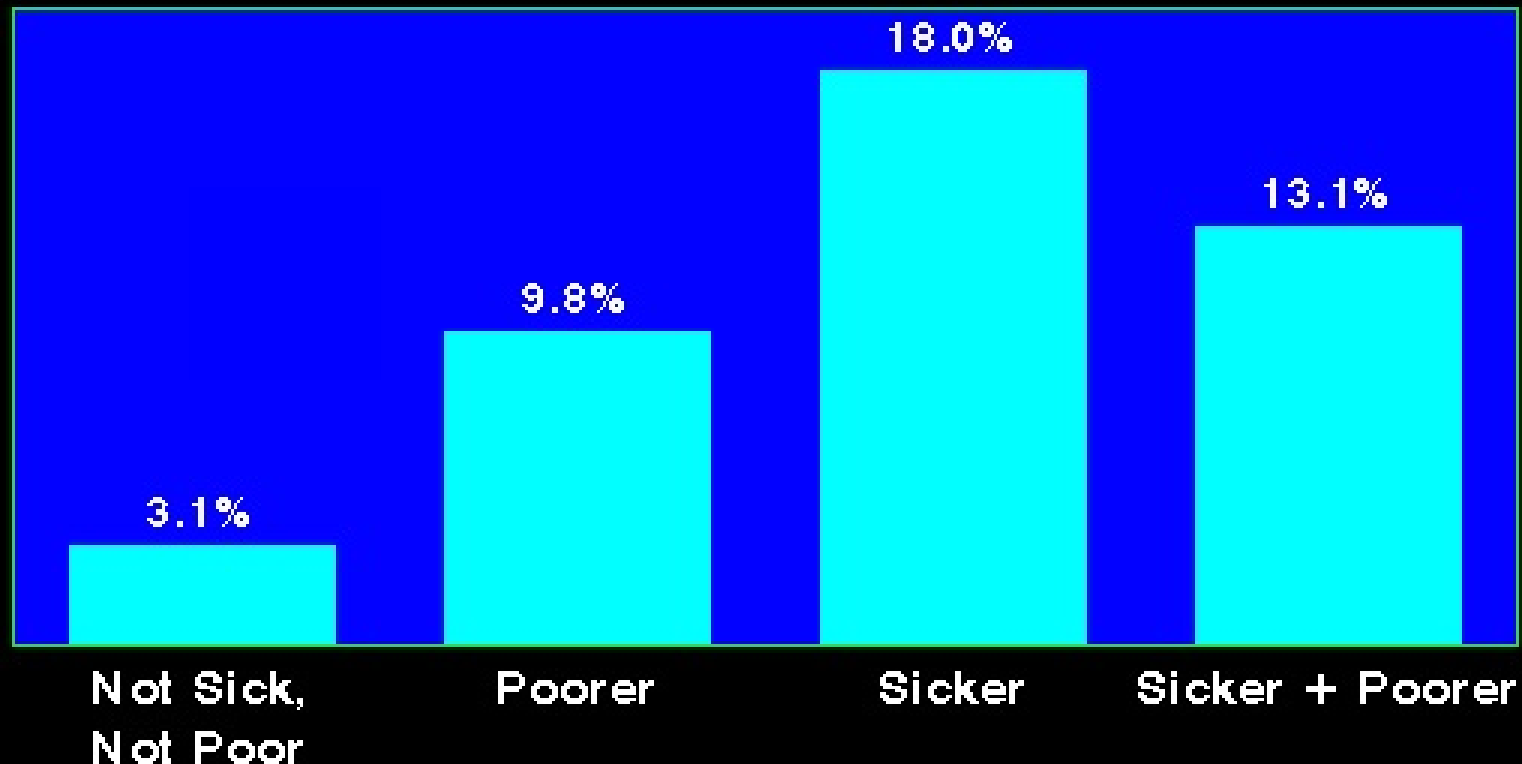
Quality Scores Tell More About Patients Than Doctors

Harvard Docs with Poorer/Minority Patients Score Low



Medicare's Value-Based Payment Program Penalizes Doctors Caring for High-Needs Patients

Percent of practices penalized*



Characteristics of Practices' Patients

Source: JAMA 2017;318:453

*Note: Estimate based on simulation of penalties under mandatory Physicians Value-Based Payment Modifier Program

Pay for Performance

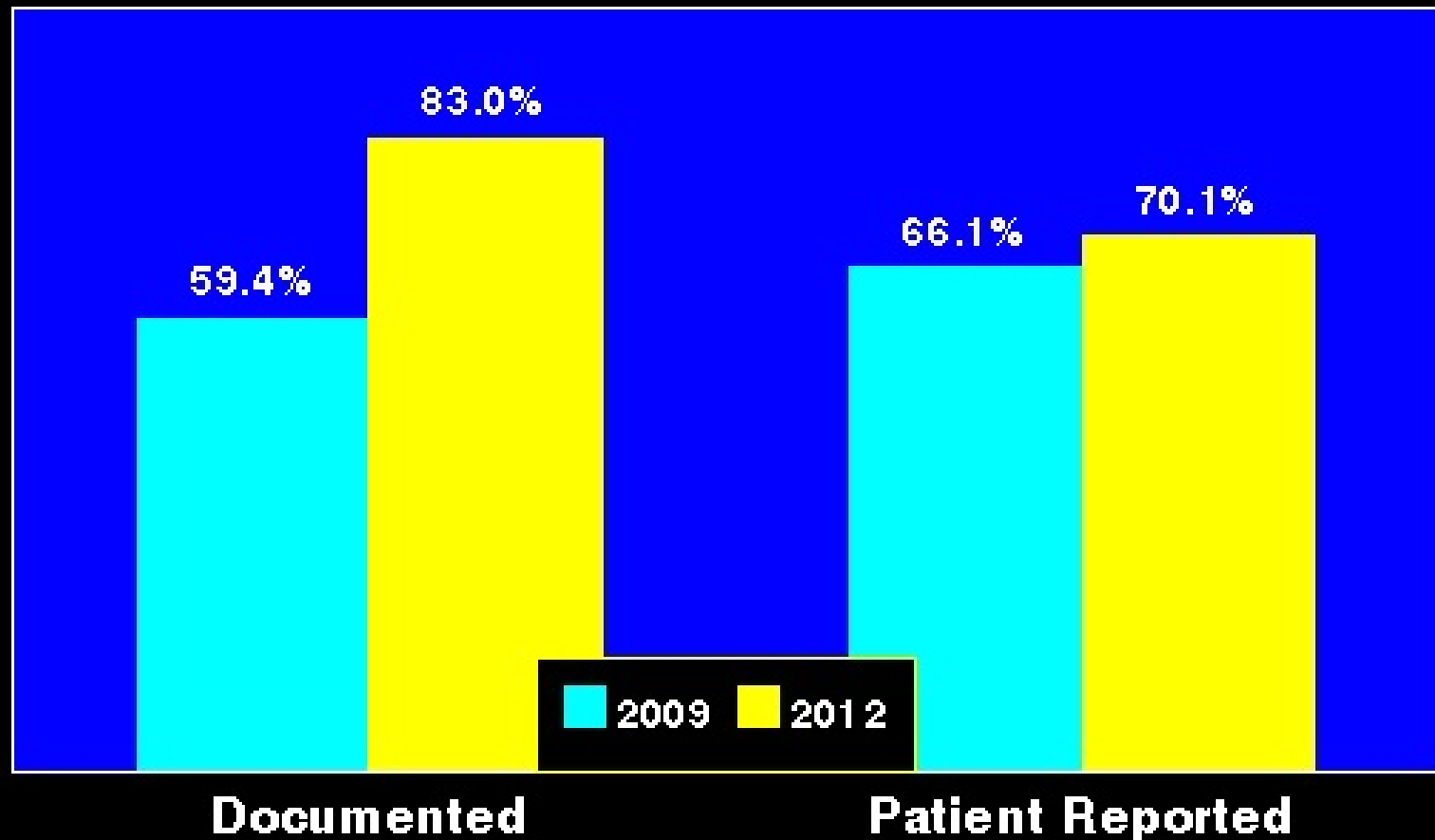
"I do not think its true that the way to get better doctoring and better nursing is to put money on the table in front of doctors and nurses. I think that's a fundamental misunderstanding of human motivation. I think people respond to joy and work and love and achievement and learning and appreciation and gratitude - and a sense of a job well done. I think that it feels good to be a doctor and better to be a better doctor. When we begin to attach dollar amounts to throughputs and to individual pay we are playing with fire. The first and most important effect of that may be to begin to dissociate people from their work."

Don Berwick, M.D,

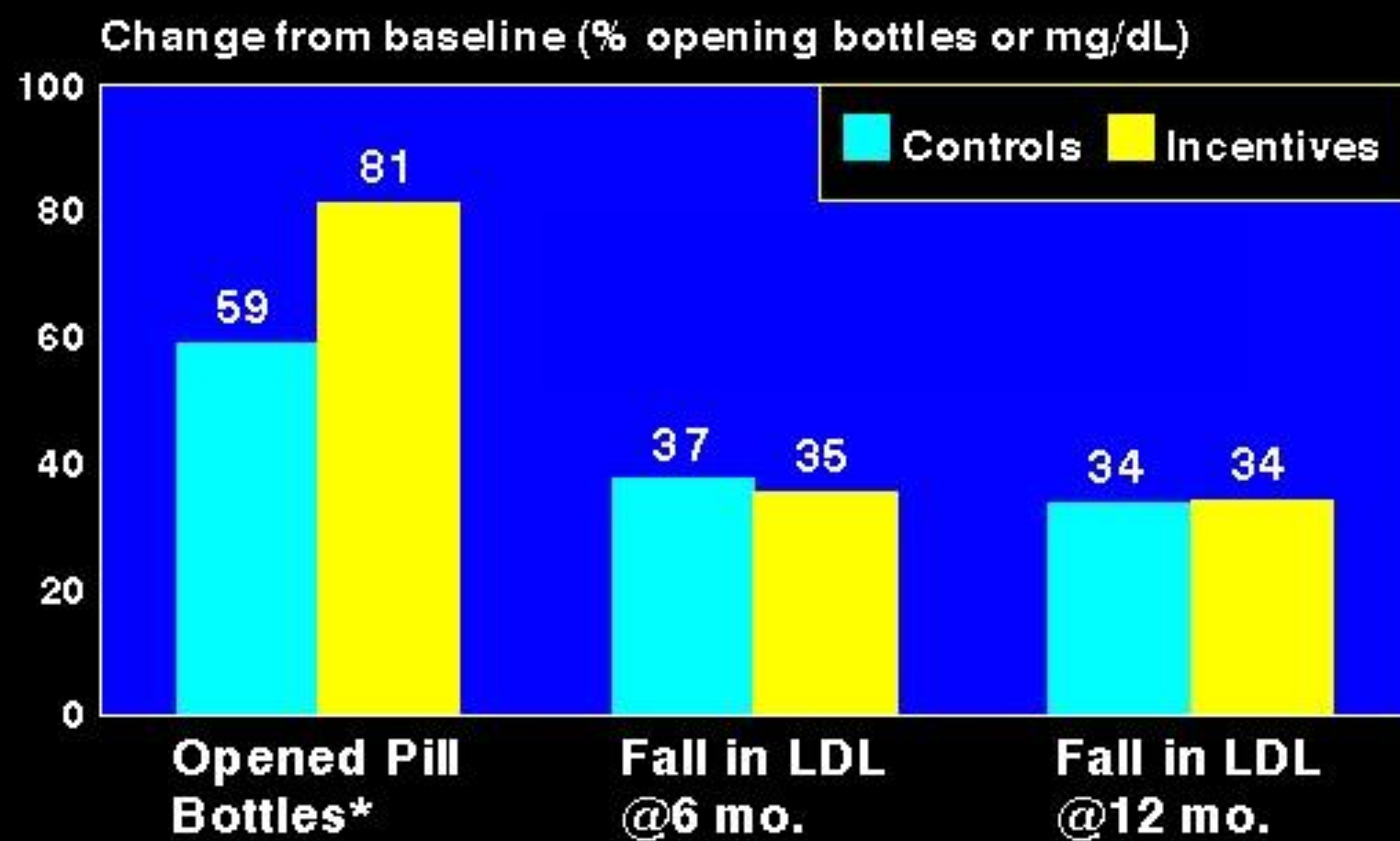
Source: Health Affairs 1/12/2005

Performance Monitoring Increased Documentation of Alcohol Counseling, But Not Real Counseling Rate

Alcohol counseling rate among patients screening positive for unhealthy ETOH use



\$450 Incentive to Take Statins Improved Pill Bottle Openings But Not LDL-C Levels



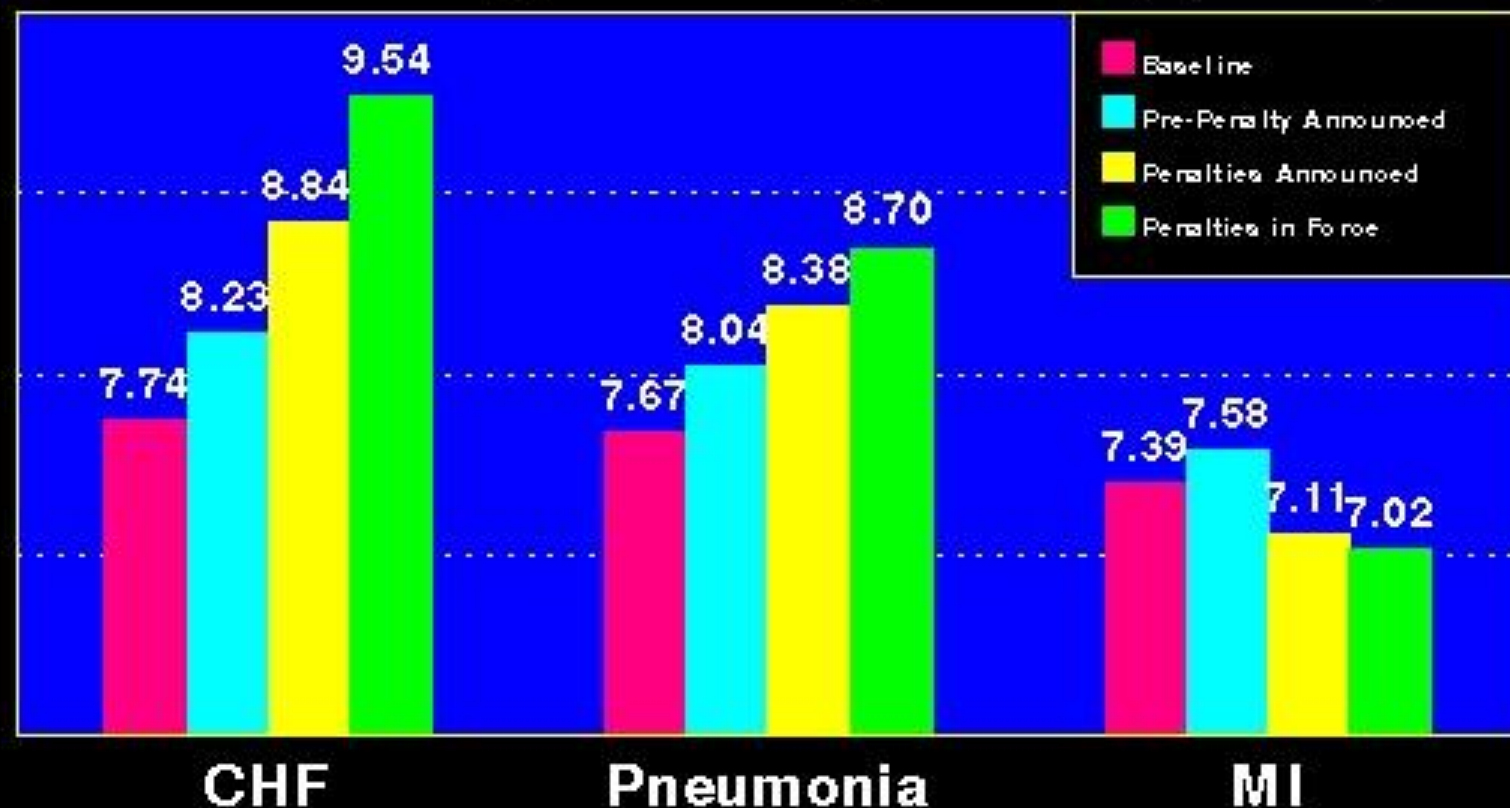
Source: JAMA Network Open 2020;3(10):e2019429 (RCT with 805 patients)

*Percent of first 180 days with pill bottle opening

CHF and Pneumonia Death Rates Rose With Readmission Penalties

Big Penalties for Readmission, Small Penalties for Mortality

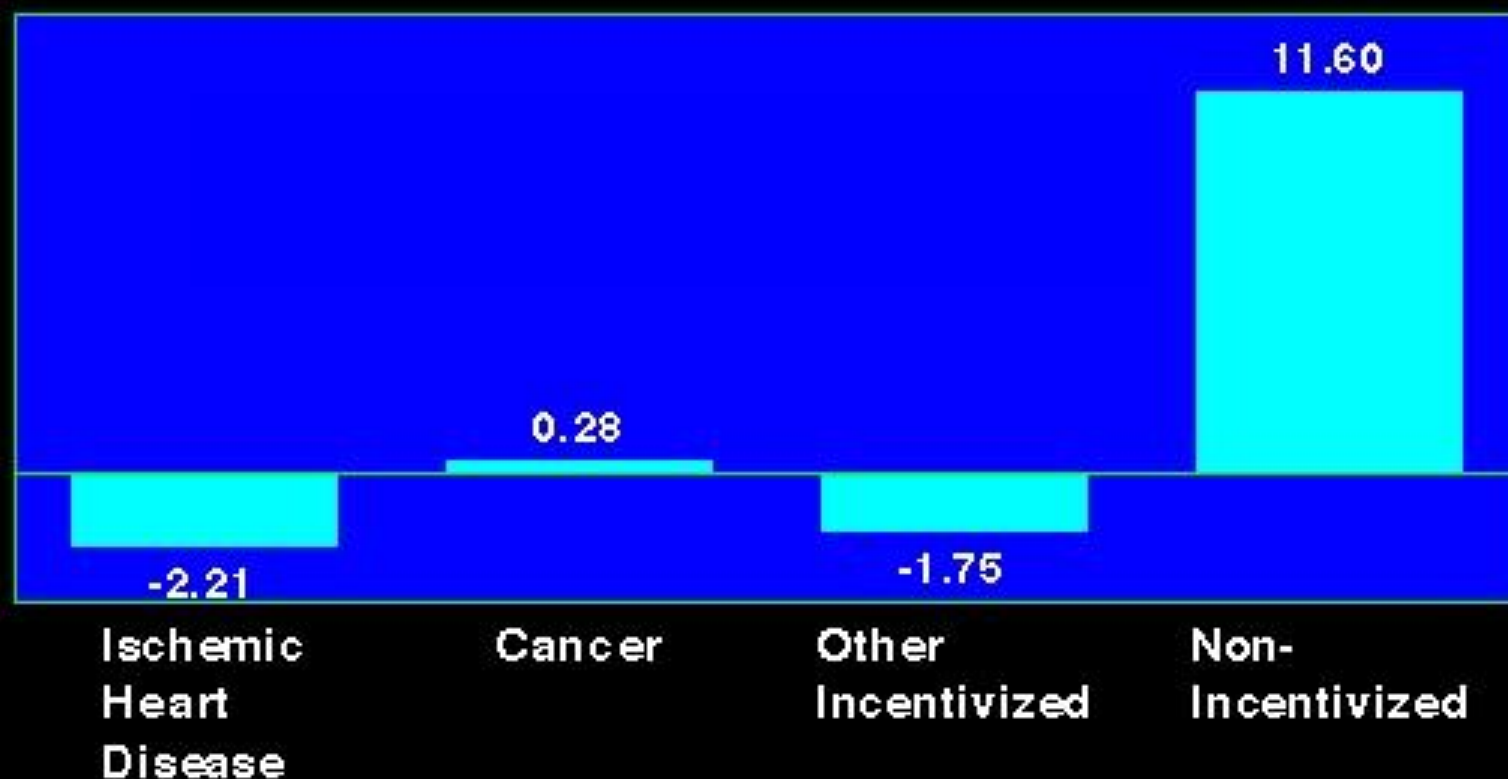
Time trend in 30 day post-discharge mortality (percent)



P4P Didn't Improve Mortality in England

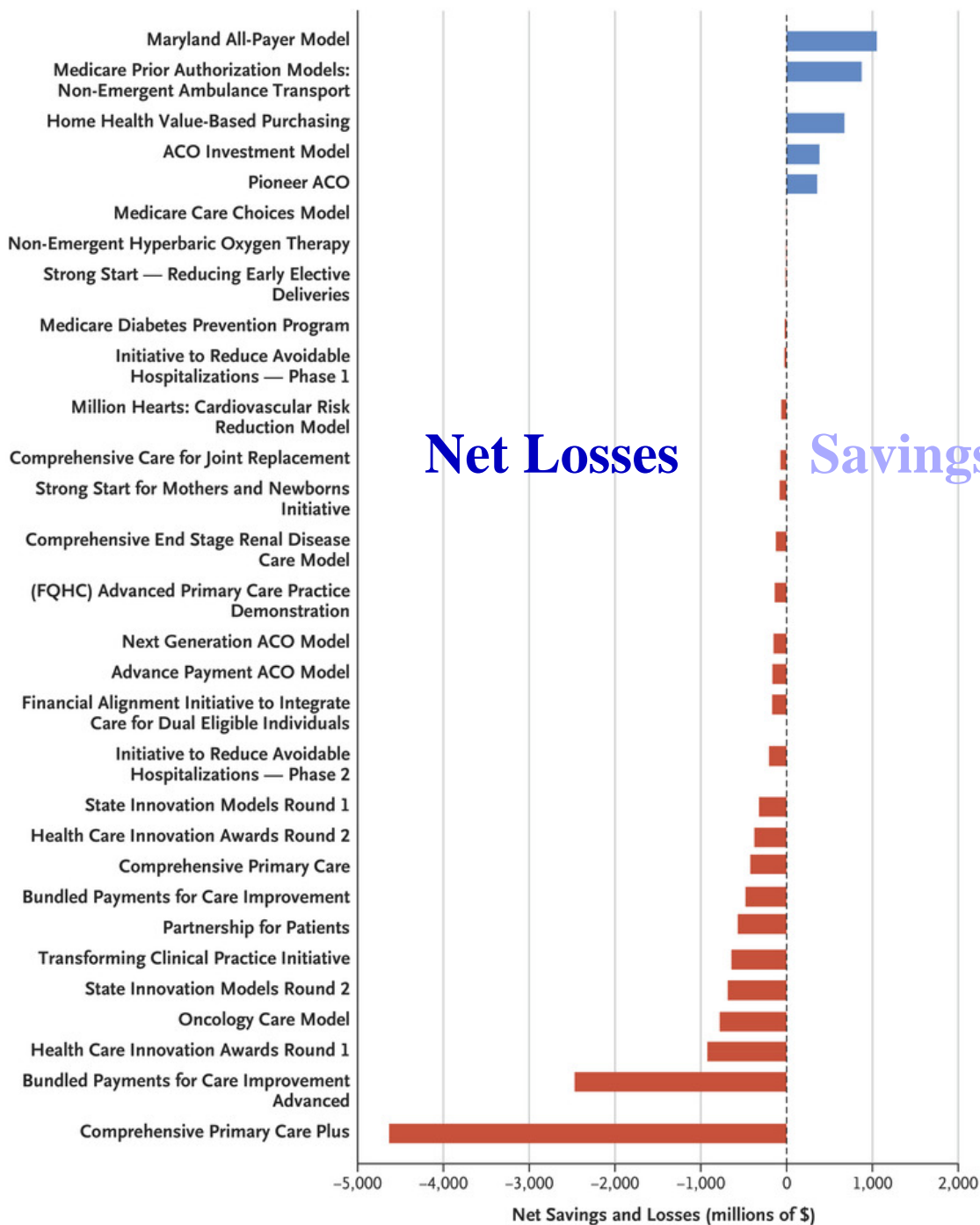
World's Largest P4P Program Tied 25% of GP Income to Quality Targets
>100 Quality Measures, >95% of Targets Were Met

Change in deaths/100,000 from pre to post
P4P implementation



Source: *Lancet* 2016;388:268

Note: Data show trends compared to developed nations without P4P

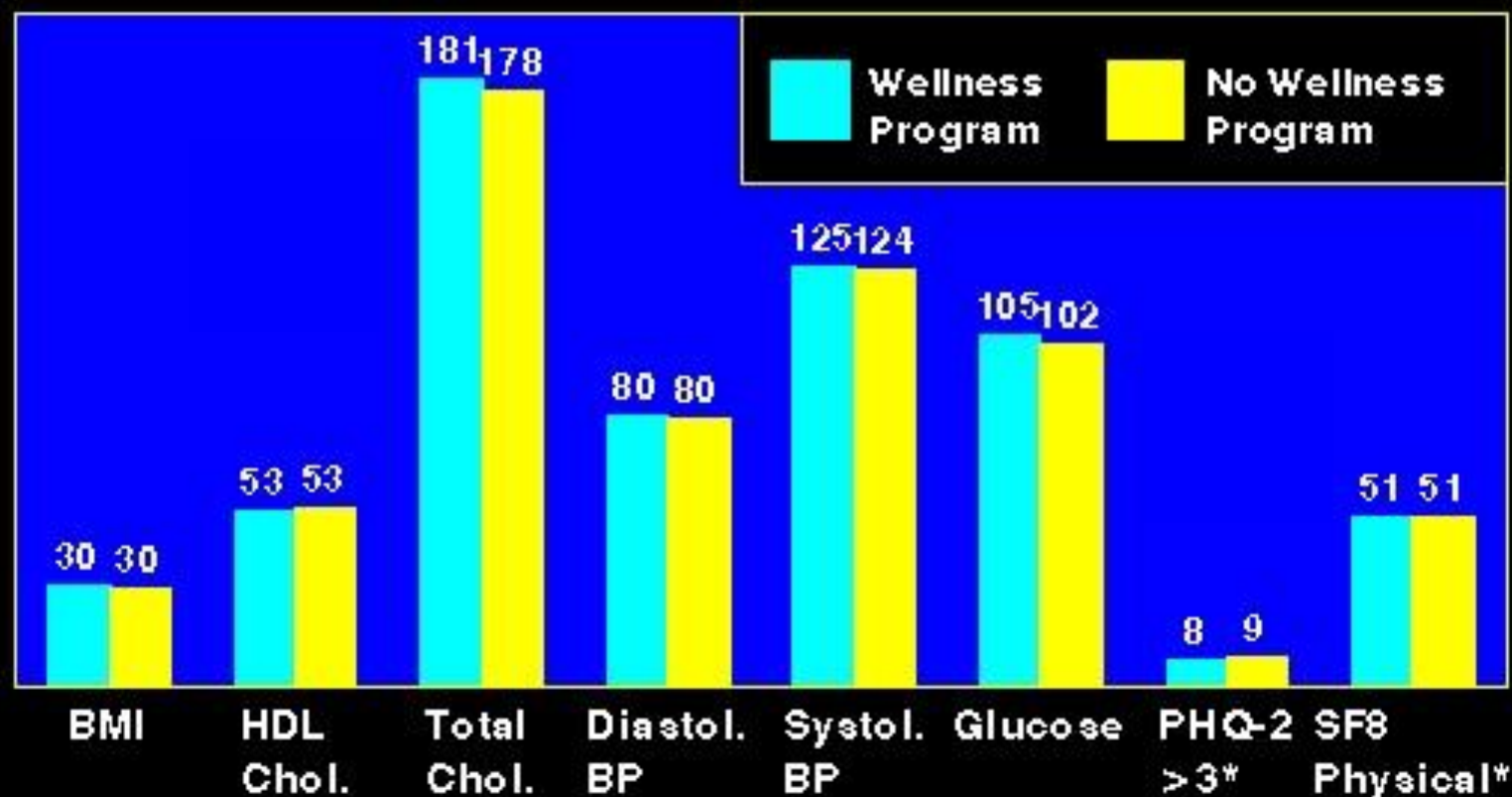


Most Value-Based Payment Programs Have Flopped: Costs Exceed Savings

Worksite Wellness Program - an RCT

No Benefit at 6 Months or 3 Years

Outcomes in wellness participants vs. non-participants



Source: JAMA 2019;32:1491; Health Aff 2021;40:951 - 6 month results show, 3 year almost identical

* PHQ-2>3 indicates likely depression; SF-8 Physical is a physical health score

Note: No significant differences in utilization of care or medical costs

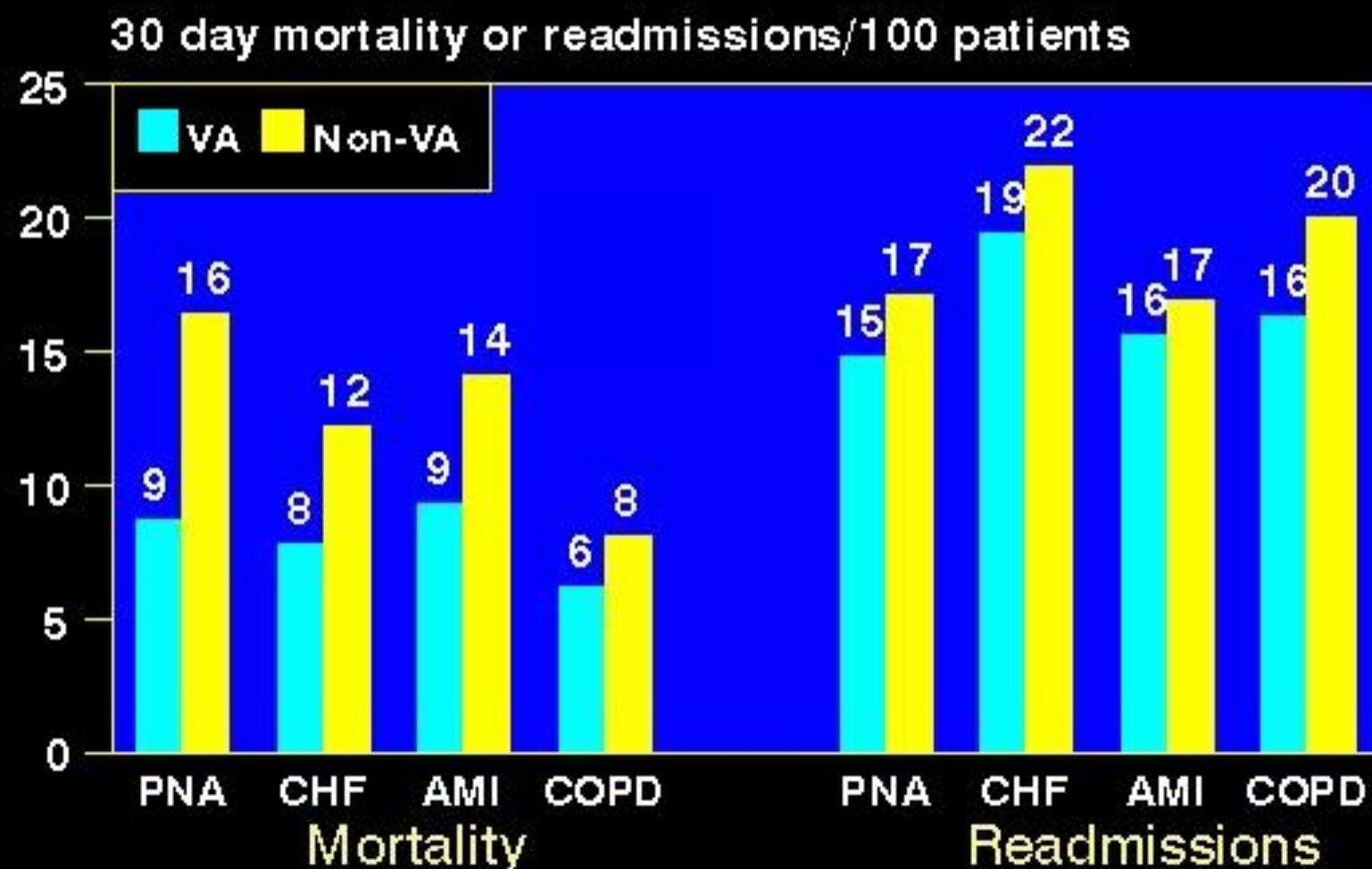
ACOs and P4P: Implementation Without Evidence

- P-4-P – Official Medicare policy, widely adopted by private payers
 - No RCTs showing improved outcomes.
 - No improvement in 3 largest programs.
 - Negative side effects likely, e.g. increased CHF deaths.
 - VA (no P4P) has better quality than hospitals paid P4P
- ACOs – Newest health policy panacea
 - No RCTs.
 - No savings once bonuses factored in.
 - Disturbing HMO experience.

Implementing everywhere interventions which have been
proven nowhere risks failure on a colossal scale

Veterans Health Administration: Better and Fairer Care

VA Hospitals Have Lower Mortality and Readmissions than Other Hospitals



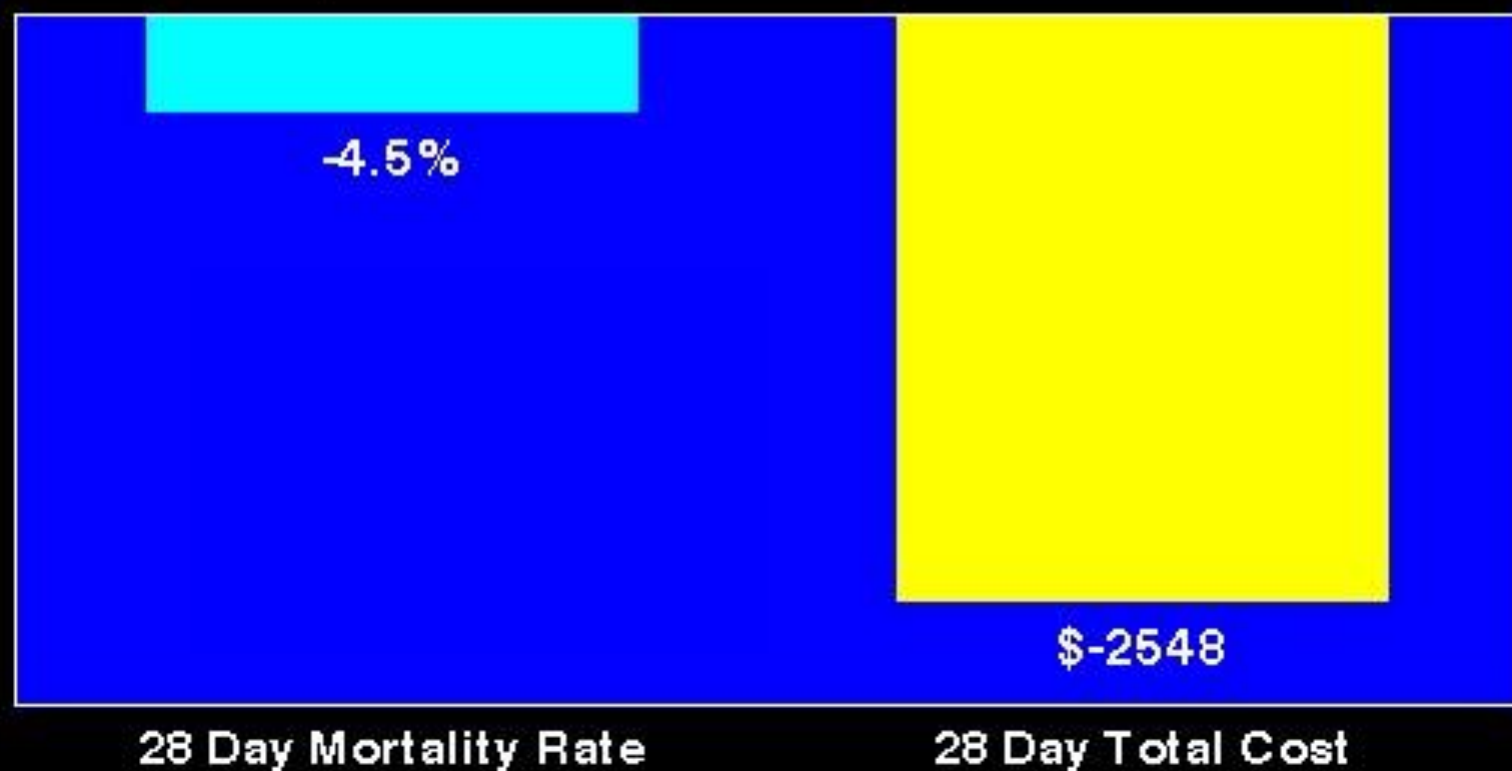
Source: JAMA IM 2017;177:882

Note: PNA=pneumonia; All rates are risk adjusted

VA vs. Non-VA Care for MI: Fewer Deaths, Lower Costs

A Quasi-Randomized Analysis

Difference, non-VA minus VA



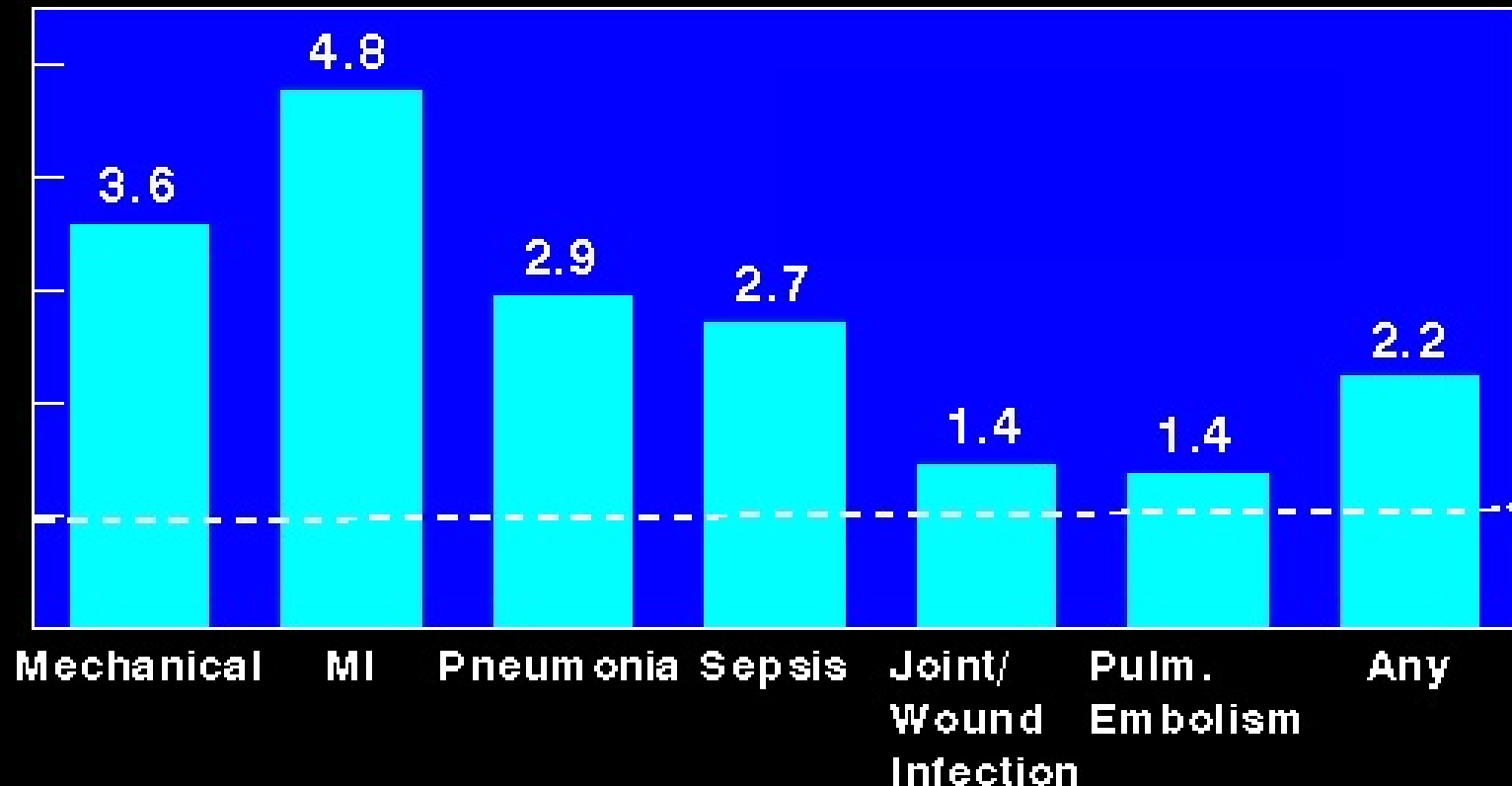
Source: "Is There a VA Advantage: Evidence From Dually Eligible Veterans." NBER November, 2020

Note: Quasi-randomized based on ambulance transport

VA-Paid Knee Replacement: Better at VA Hospital than Purchased Private Care

VA Privatization Worsens Care

Odds ratio for complication:
VA-Purchased vs. VA-Delivered Surgery

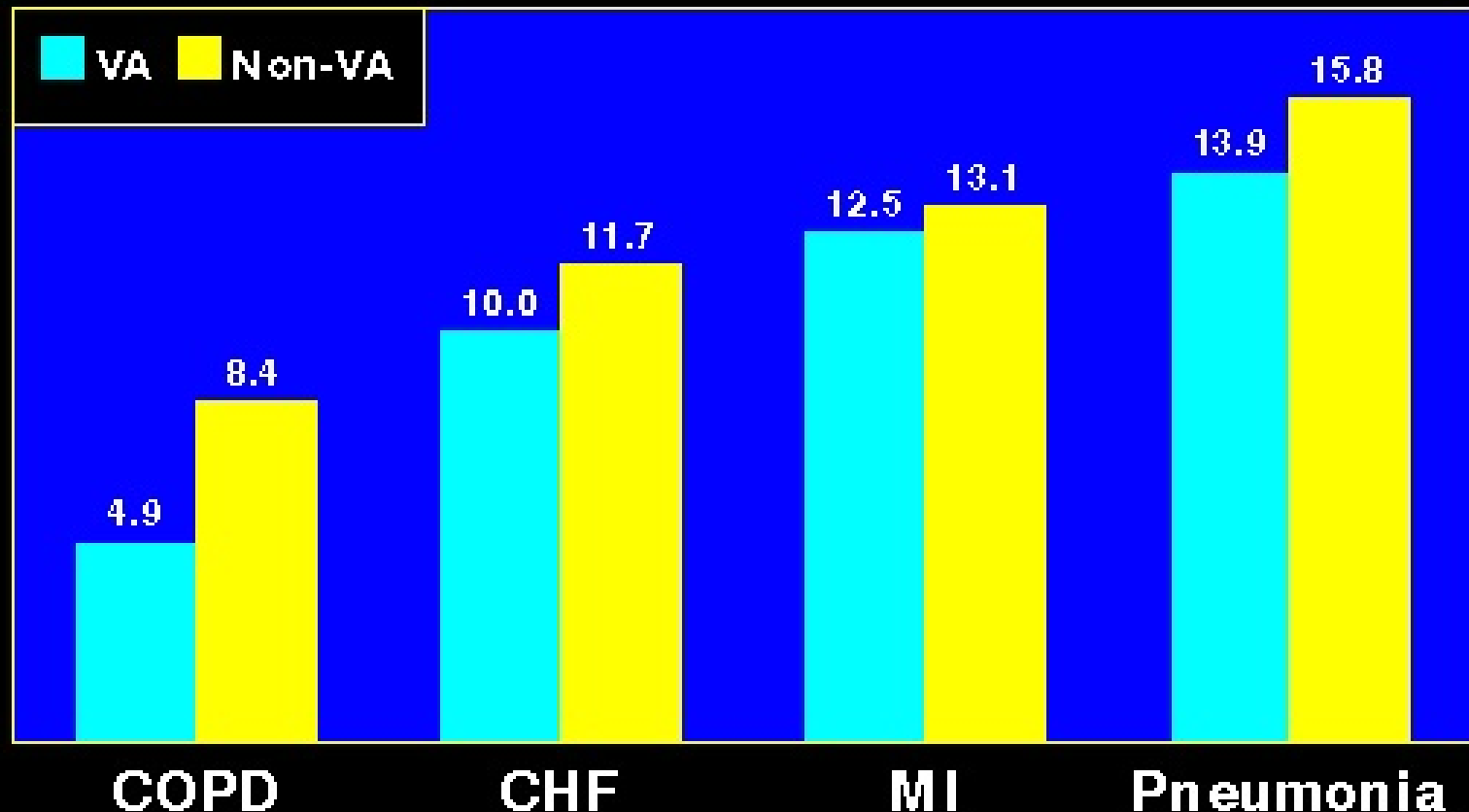


Source: Health Affairs 2021;40:1312v- Figures are adjusted for multiple patient characteristics

VA Hospitals Have Lower Mortality Than Nearby Hospitals

A comparison of VA and Non-VA hospitals in 121 Hospital Market Areas

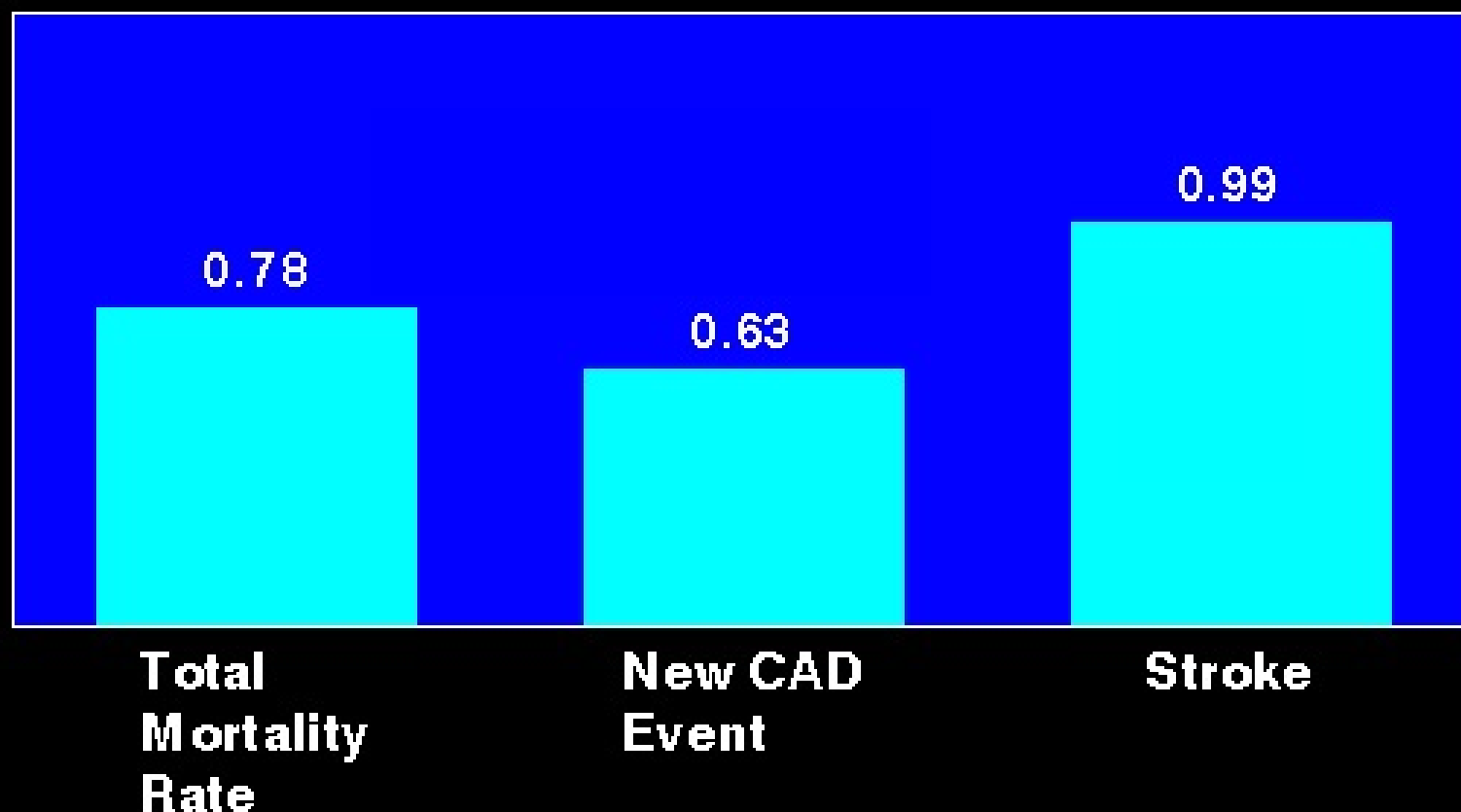
30 day mortality rate (%)



Blacks in VA: No Health Disadvantage

A Longitudinal Study of 3,072,966 Vets Cared for at VAs

Odds Ratio for Black vs. White Vets
(<1 indicates lower rate for Blacks)



Mandate Model Reform: Keeping Private Insurers In Charge

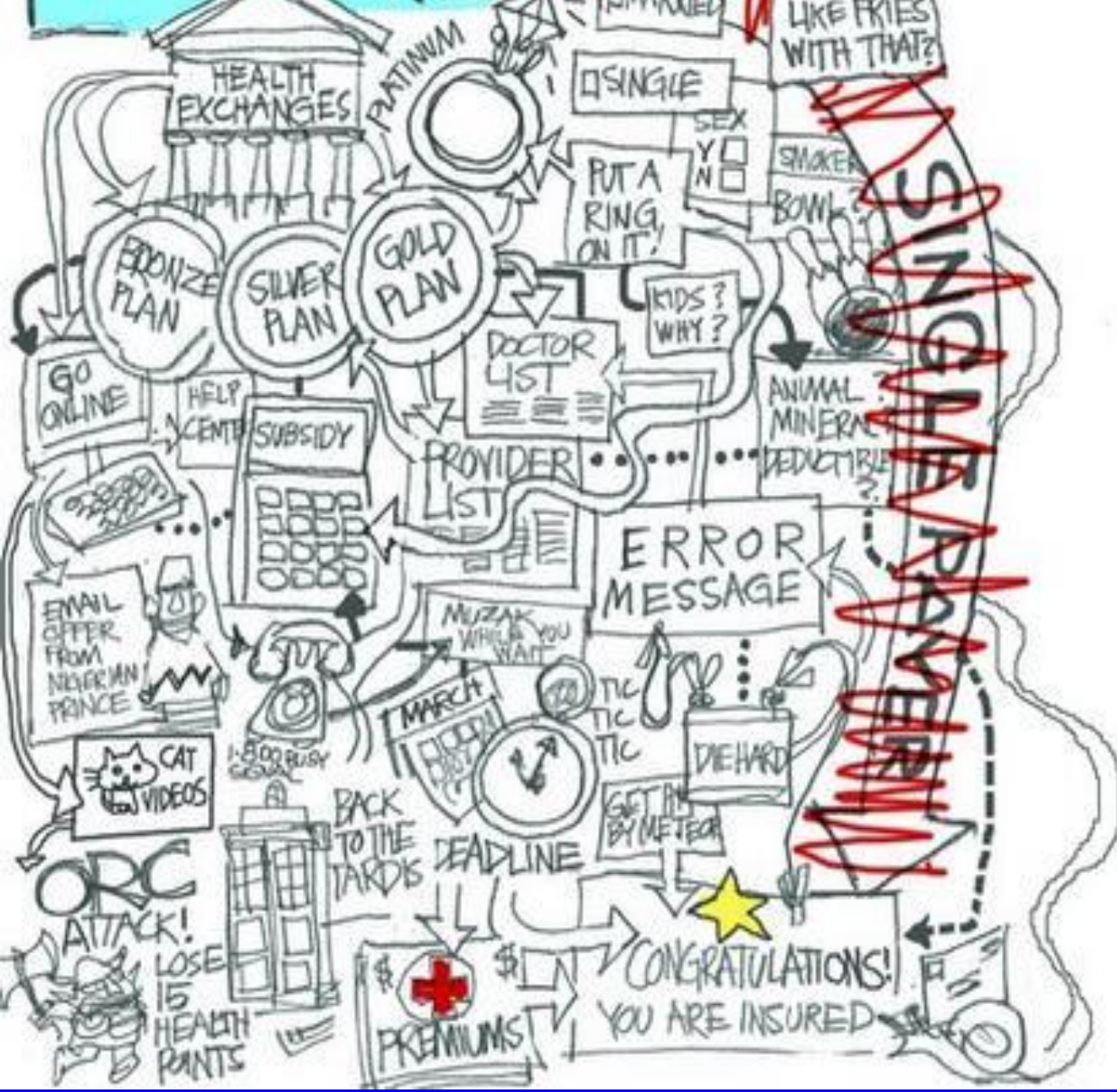
“Mandate” Model for Reform



1. Expanded Medicaid-like program
 - Free for poor
 - Subsidies for low income
 - Buy-in without subsidy for others
2. Employer Mandate +/- Individuals
3. Insurance Exchanges

THE STATE OF TEXAS - PAGE 13

OBAMACARE



THE SIMPLE
GOP
PLAN FOR THE
UNINSURED



Medicare's "Software"

18.9 Million Seniors Enrolled Within 11 Months

DHEW - SOCIAL SECURITY ADMINISTRATION

488-40-6969-A

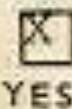
APPLICATION FOR ENROLLMENT
in the
Supplementary Medical Insurance Program
Under the Social Security Act

PLEASE READ THE ENCLOSED LEAFLET

Harry S Truman
Independence, Missouri

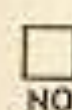
Do not write in the space above

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.

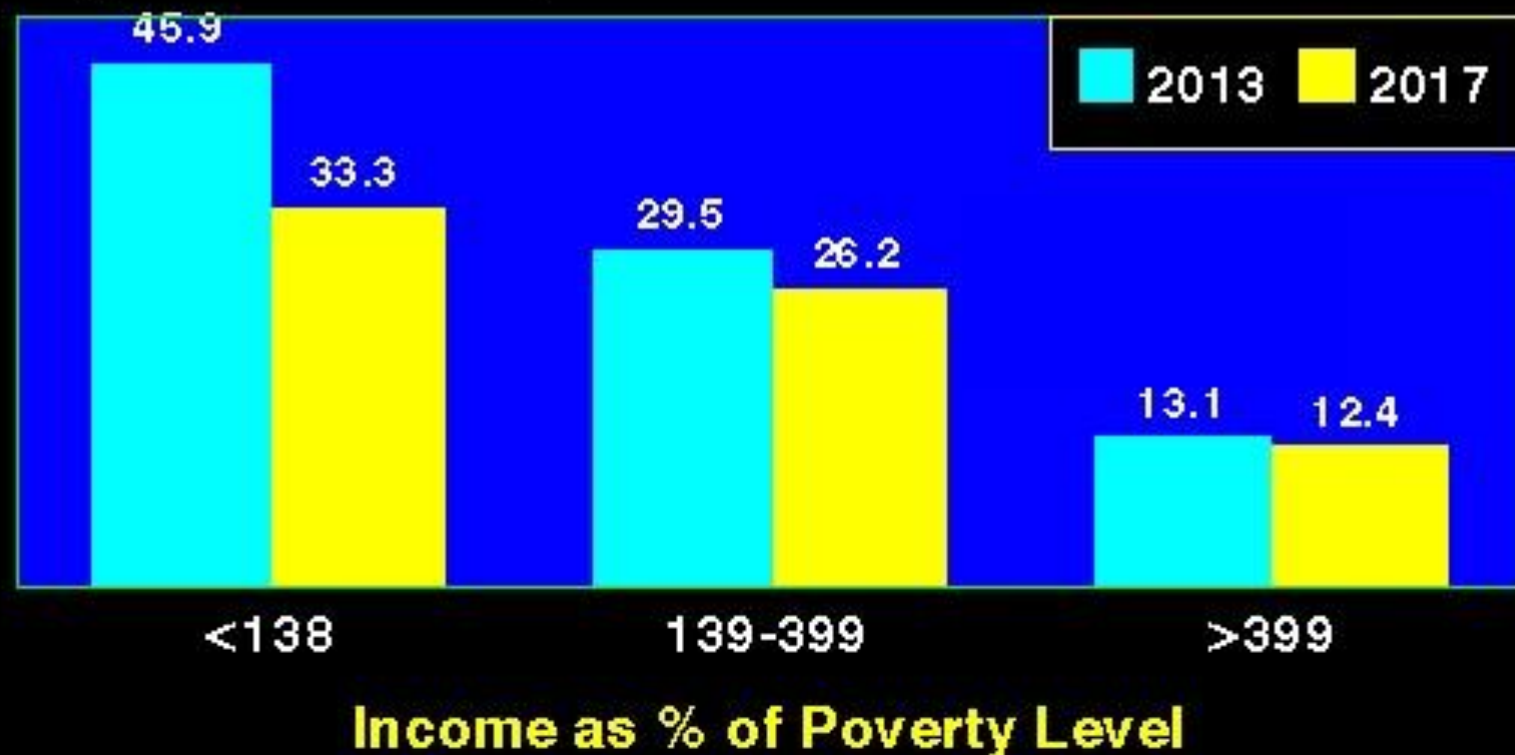
SIGNATURE
OF WITNESS

ADDRESS
OF WITNESS

ACA Decreased Incidence of Unmet Medical Needs Due to Cost

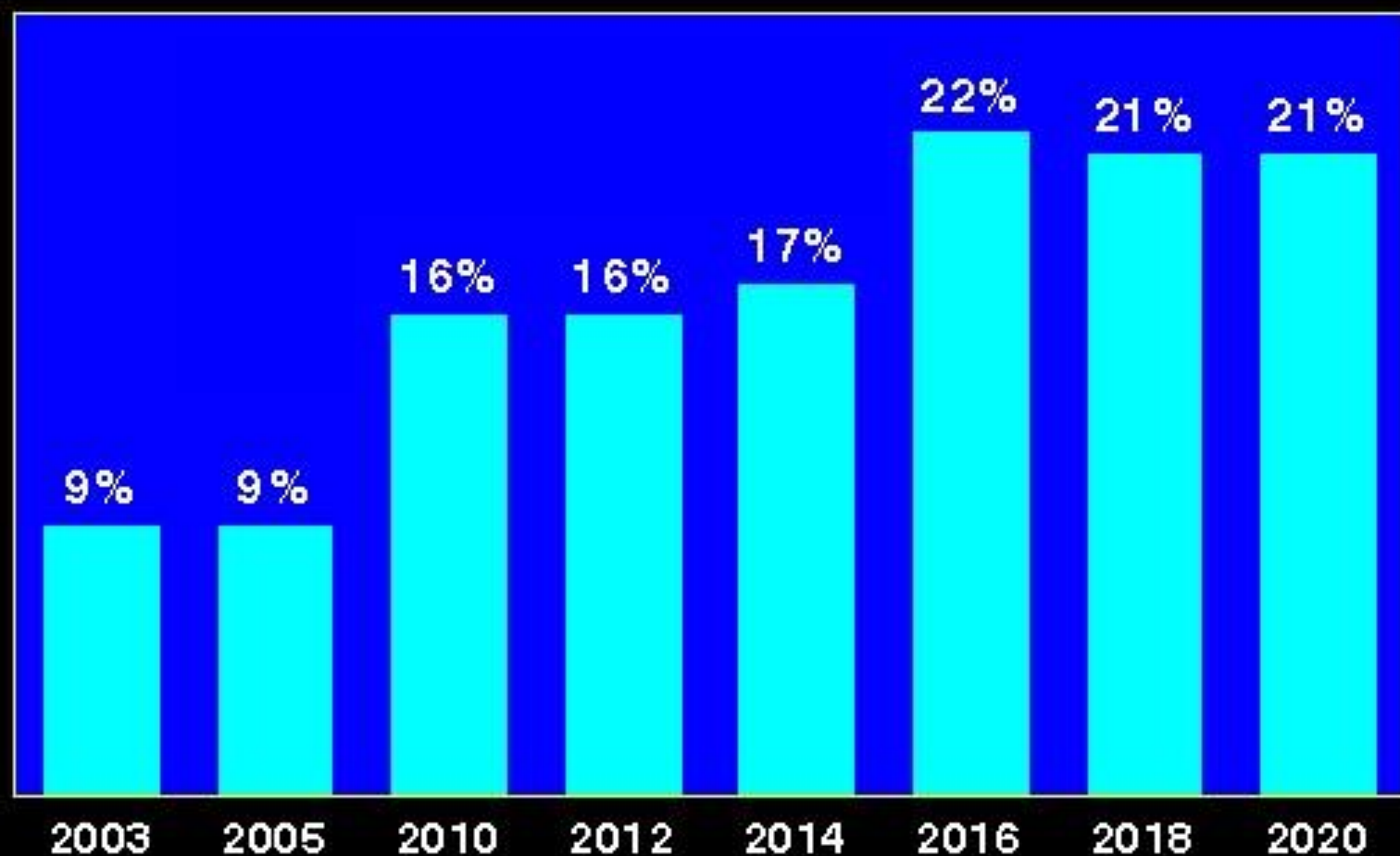
Better, But Still Not Good

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



Under-Insurance Increased After ACA

Percent of adults 19-64 under-insured*

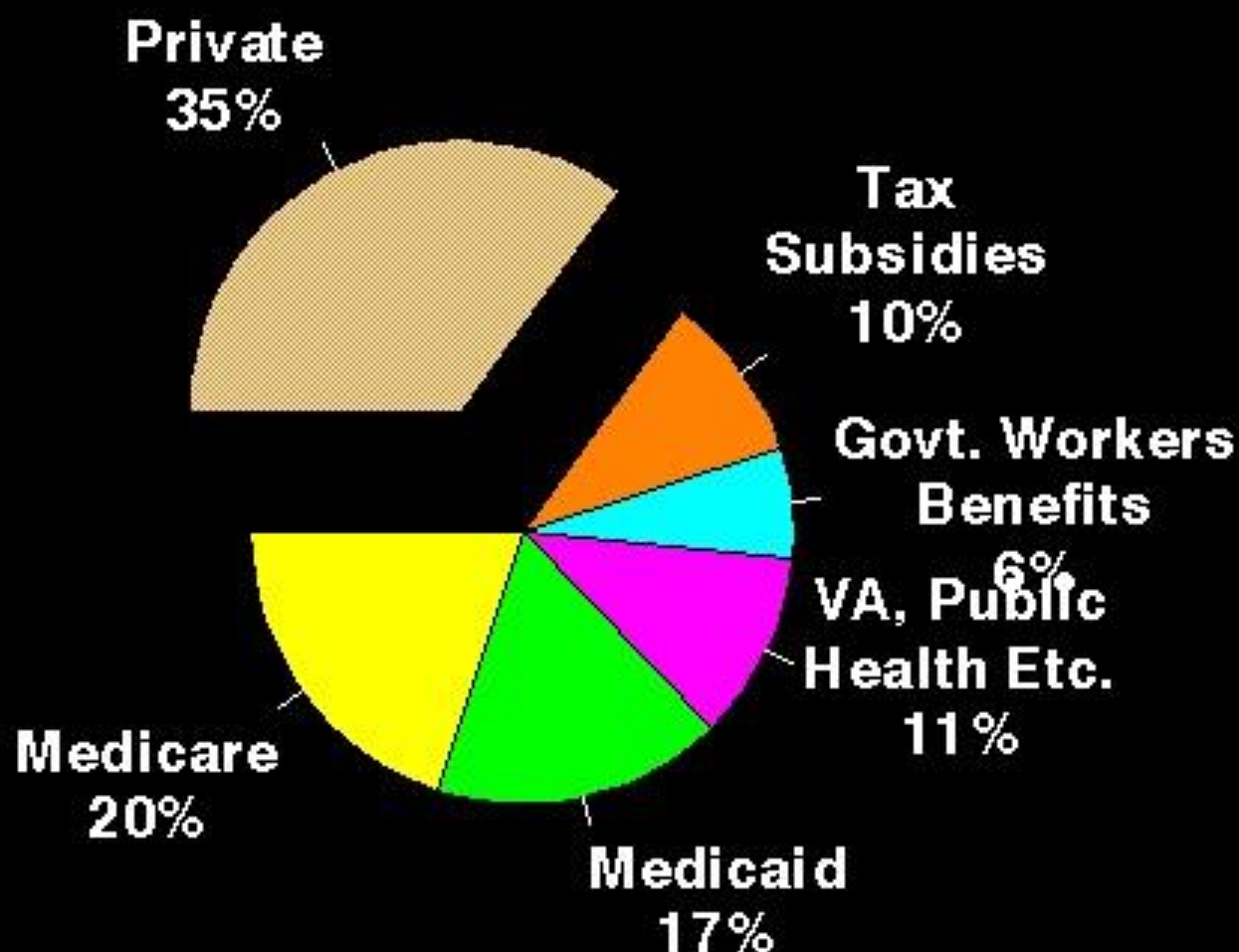


Source: Commonwealth Fund Health Insurance Surveys 2003-2020

* 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



Source: Himmelstein & Woolhandler - Analysis of NCHS data

Tax-Financed Share of Total Health Spending, 1965-2020

Tax-financed share as % of NHE



Source: Woolhandler & Himmelstein - Health Aff July/Aug. 2002 & AJPH March, 2016 - Updated
Tax-financed = govt. health programs + govt. employees' benefit costs + tax subsidy for private ins.

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



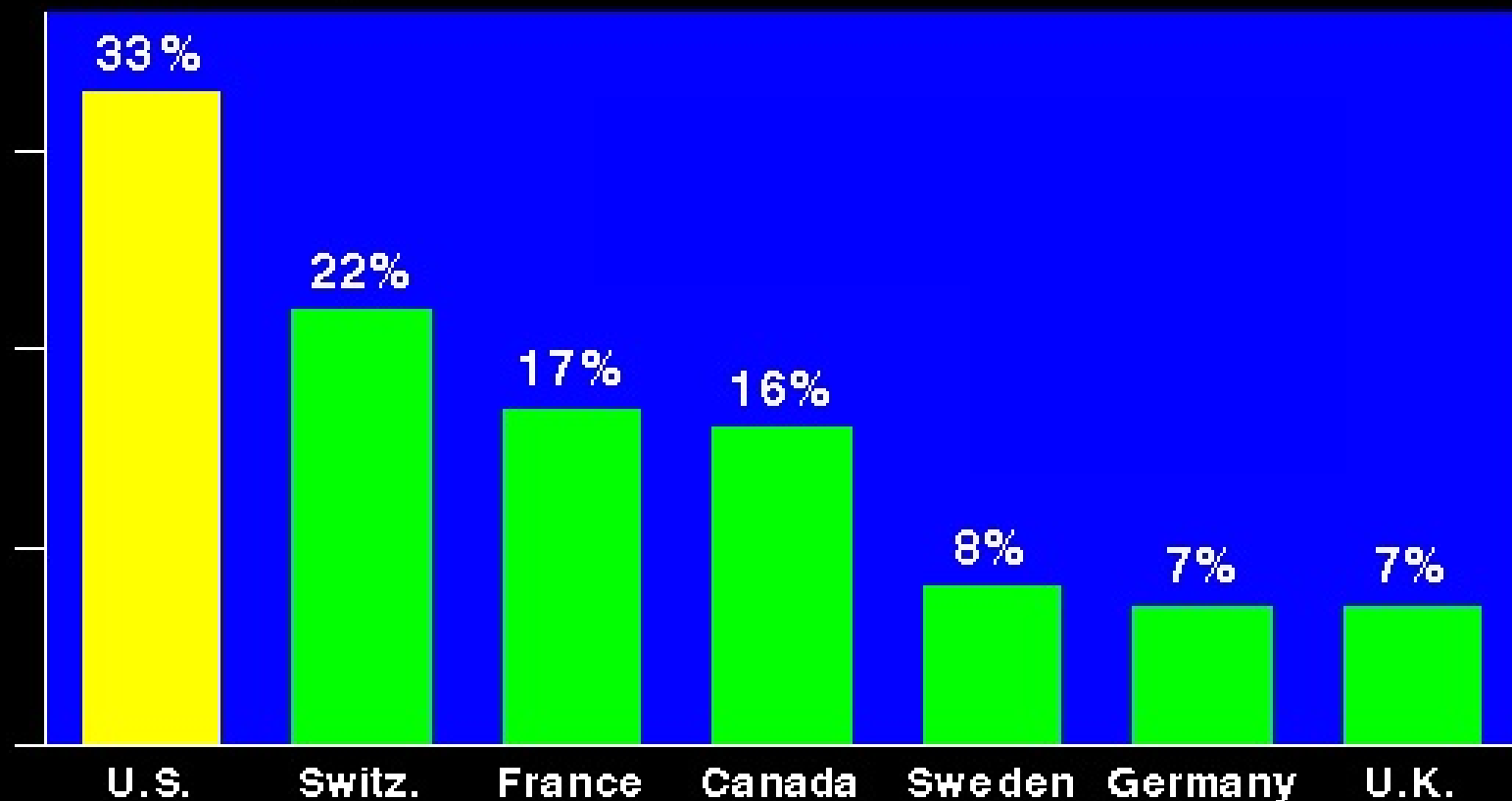
Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance

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

The U.S. Trails Other Nations on Health

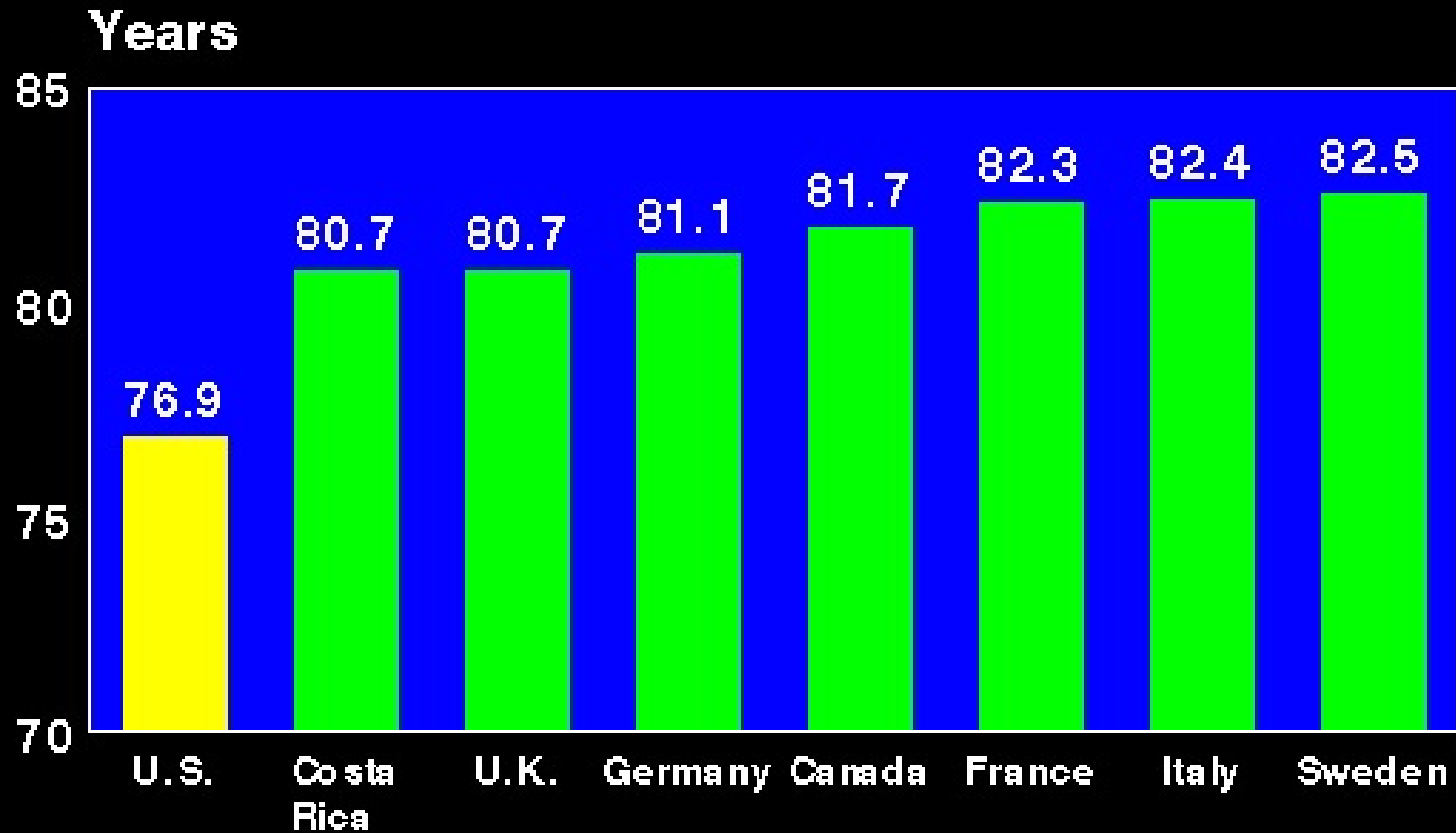
U.S. Patients Skip Care More Often

Percent skipping a consultation, test, treatment, Rx, or f/u due to cost past 12 months



Source: Commonwealth Fund Survey 2016

Life Expectancy

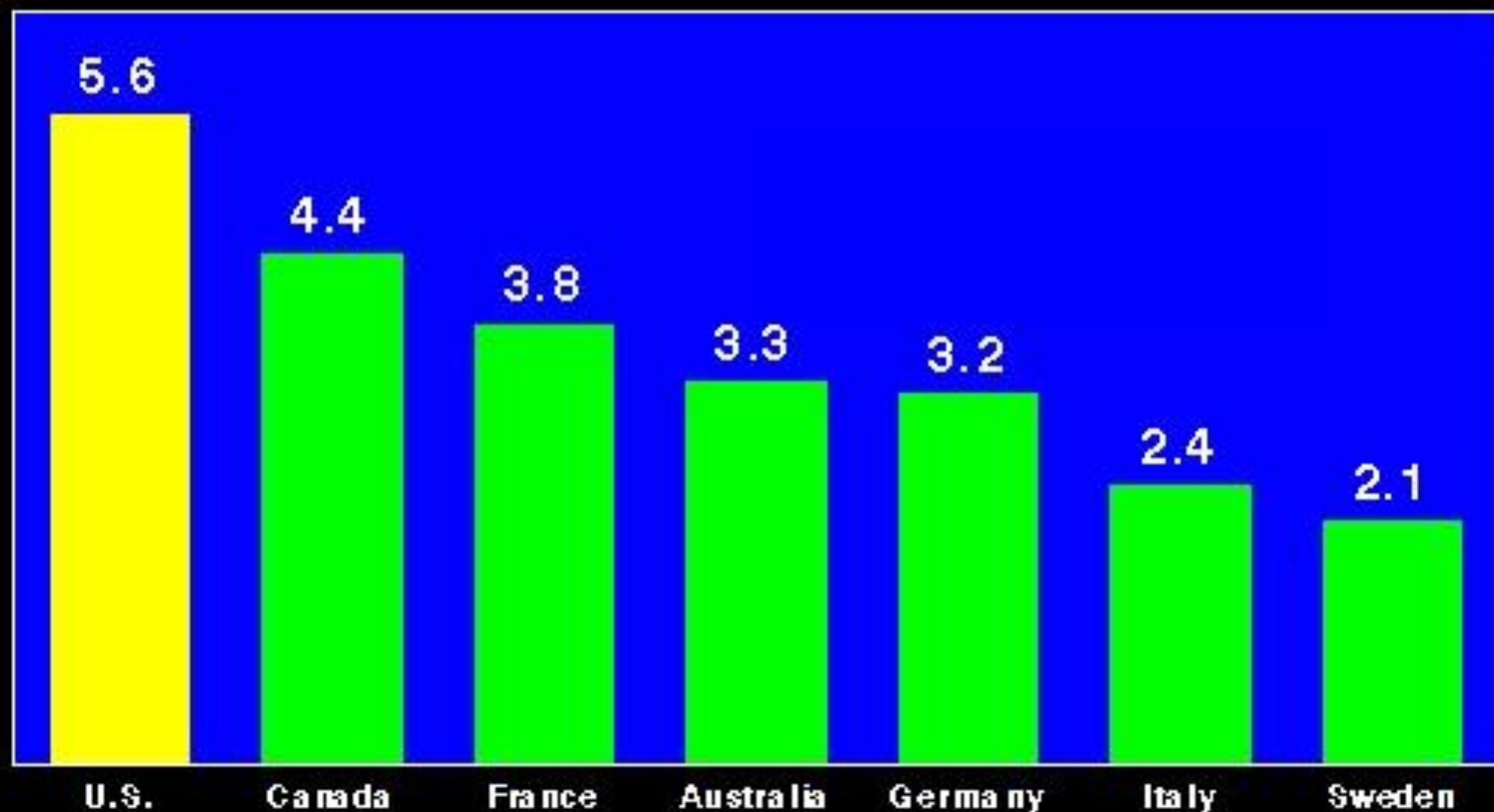


Source: OECD, 2021 and S. Woolf (BMJ 2021)

Note: Data are for 2020

Infant Mortality

Deaths in First Year of Life/1000 Live Births

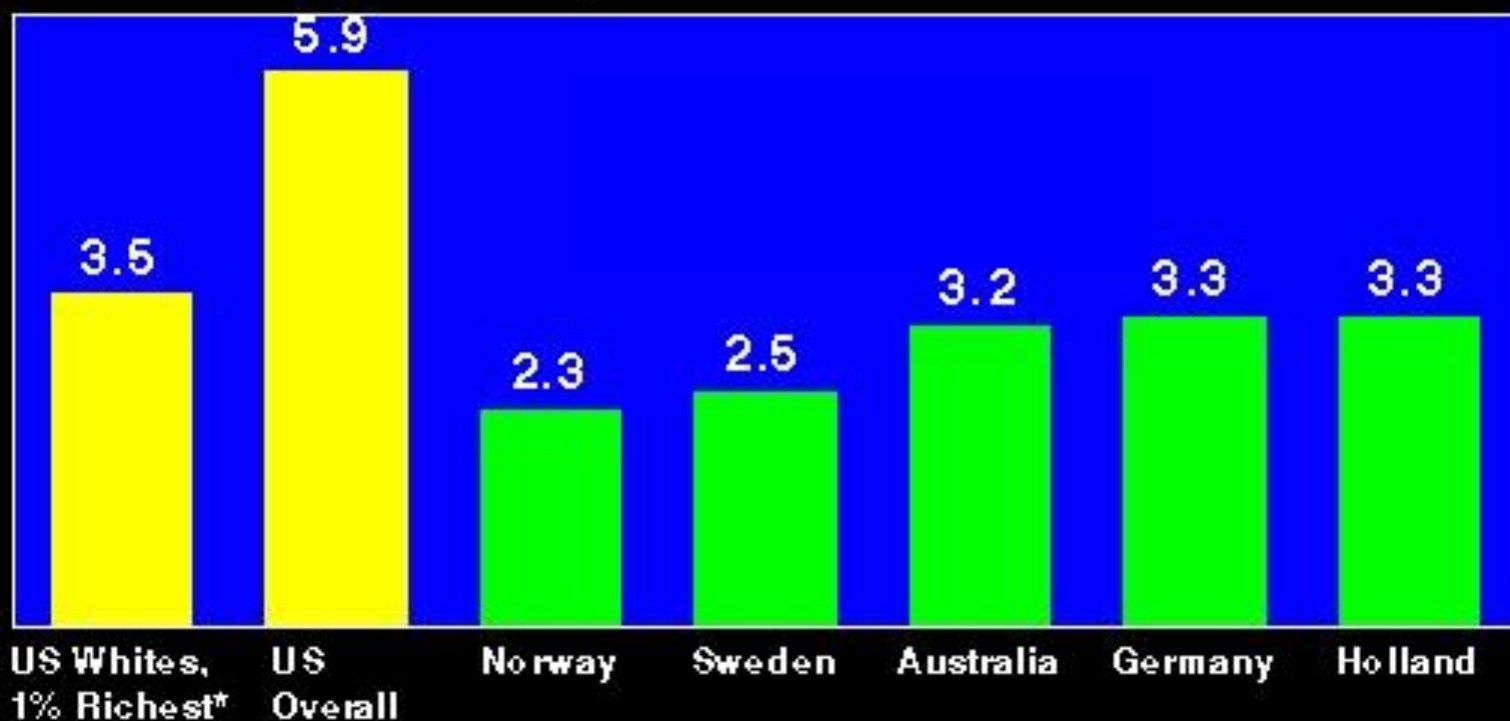


Source: OECD, 2021

Note: Data are for 2020 or most recent year available

Even Wealthy White Americans Have High Infant Mortality

Deaths in first year of life per 1000 live births



Source: JAMA IM 2021;181:339

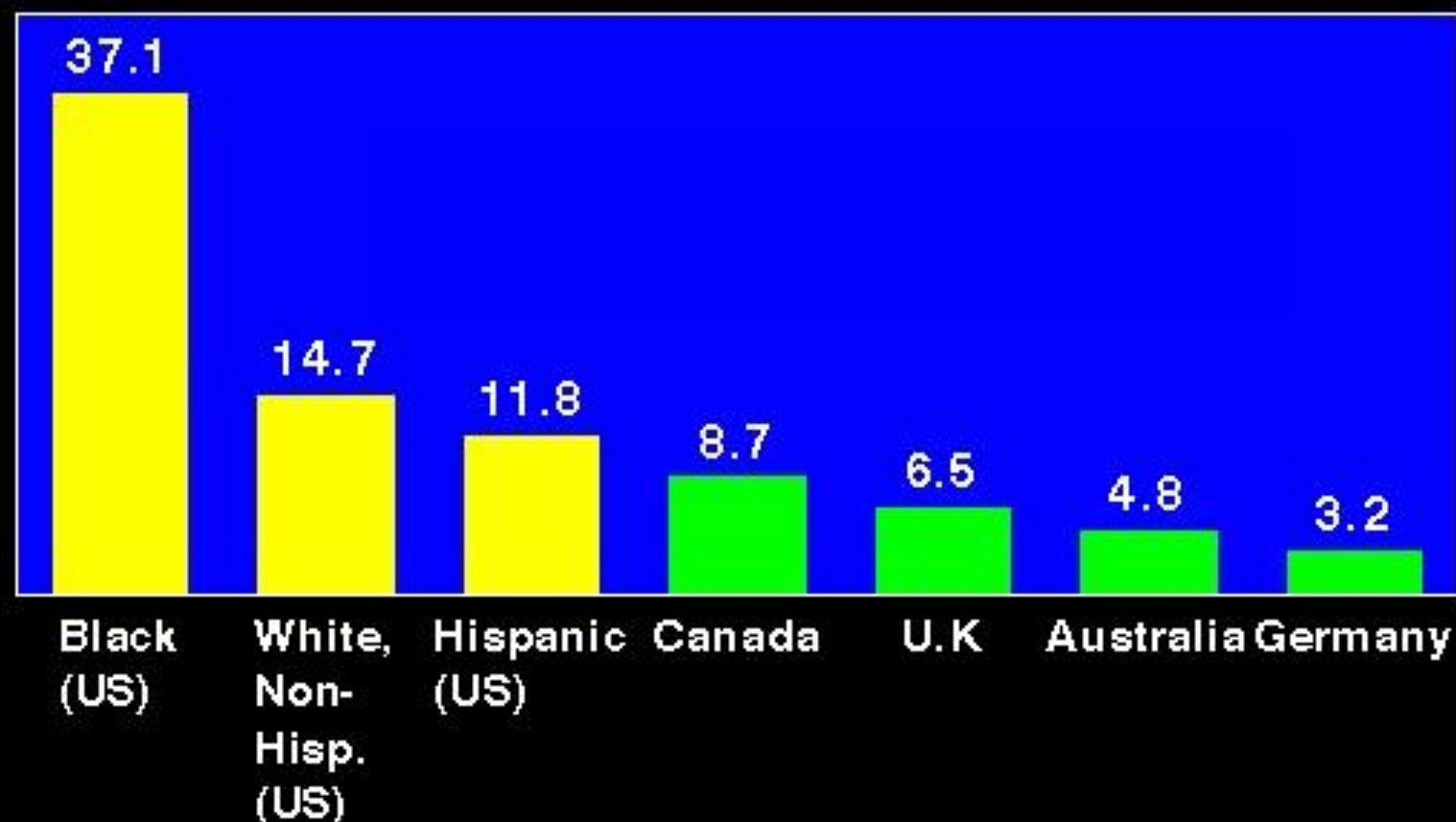
Note: Data are for 2015

* White people living in the wealthiest 1% of US counties

U.S. Mothers at Risk

Black Women at Highest Risk, But All Fare Poorly

Maternal deaths per 100,000 live births, 2018

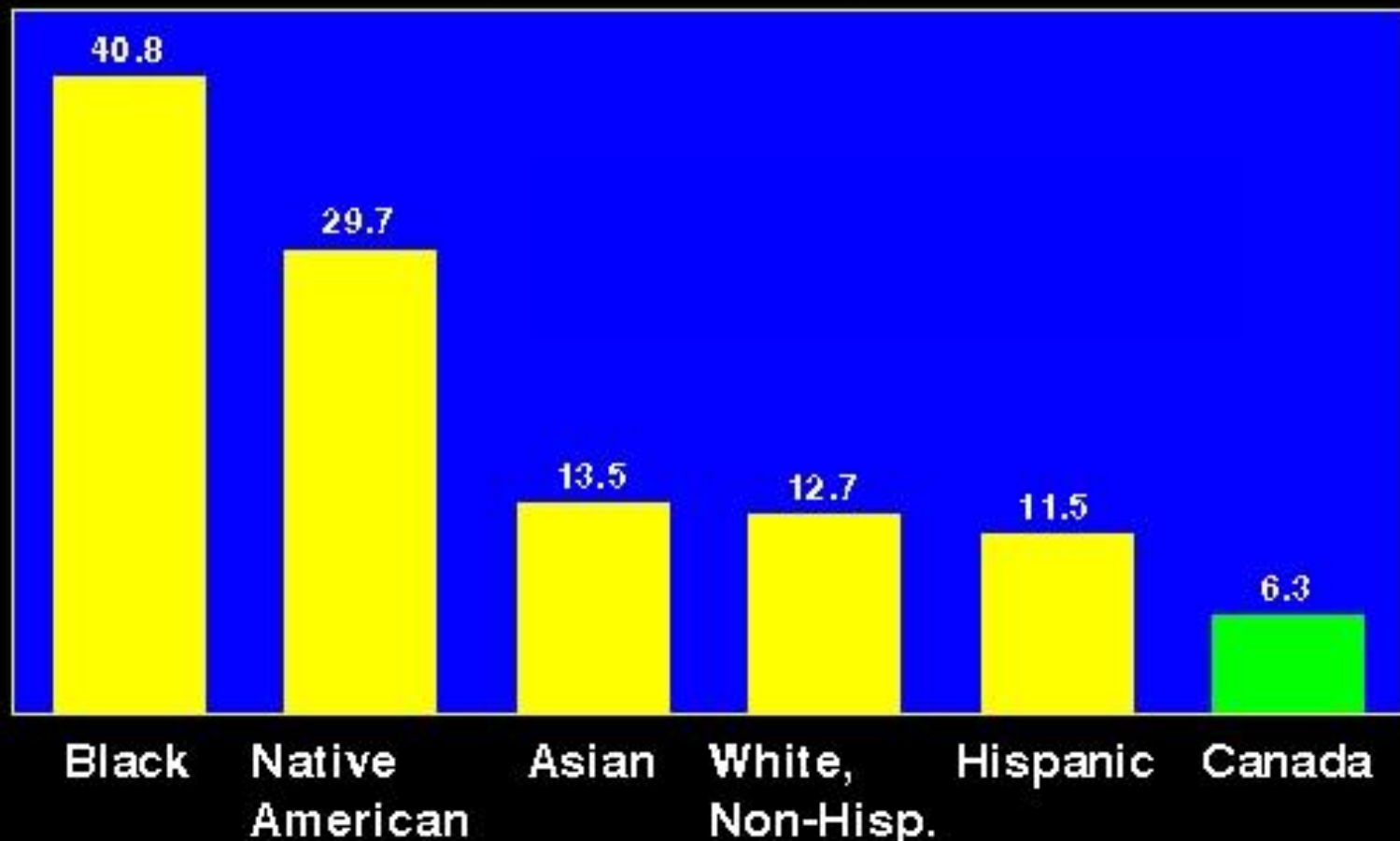


Source: CDC, January 30, 2020 and OECD 2020

Race/Ethnicity and Maternal Mortality

Every Group in the US Does Worse than Canadians

Maternal deaths/100,000 live births, 2016

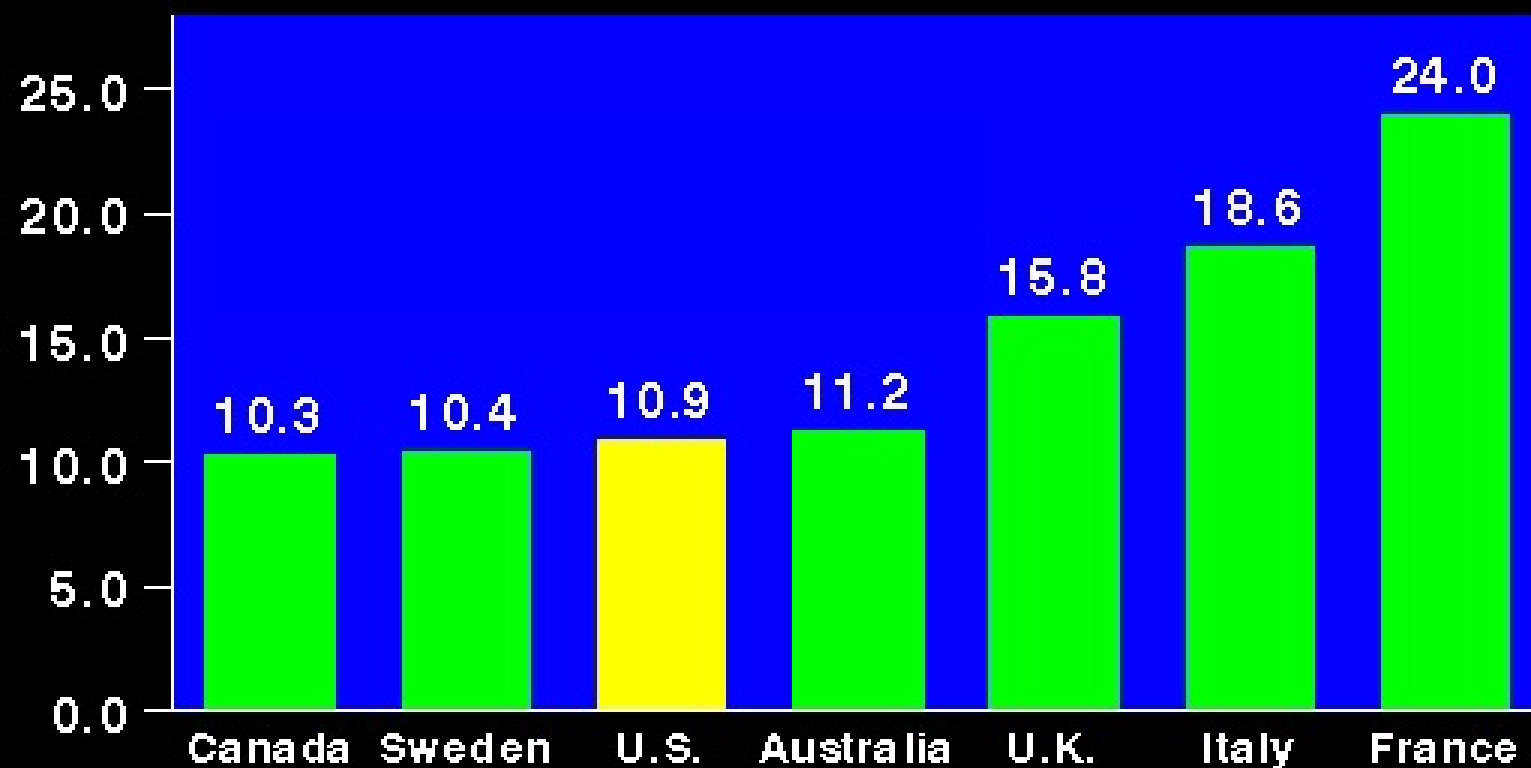


Source: MMWR September, 2019 and OECD

High U.S. Costs Don't
Result From Bad Health
Habits, Aging or Overuse
of Care

Smoking Prevalence

% of population >15 who smoke daily

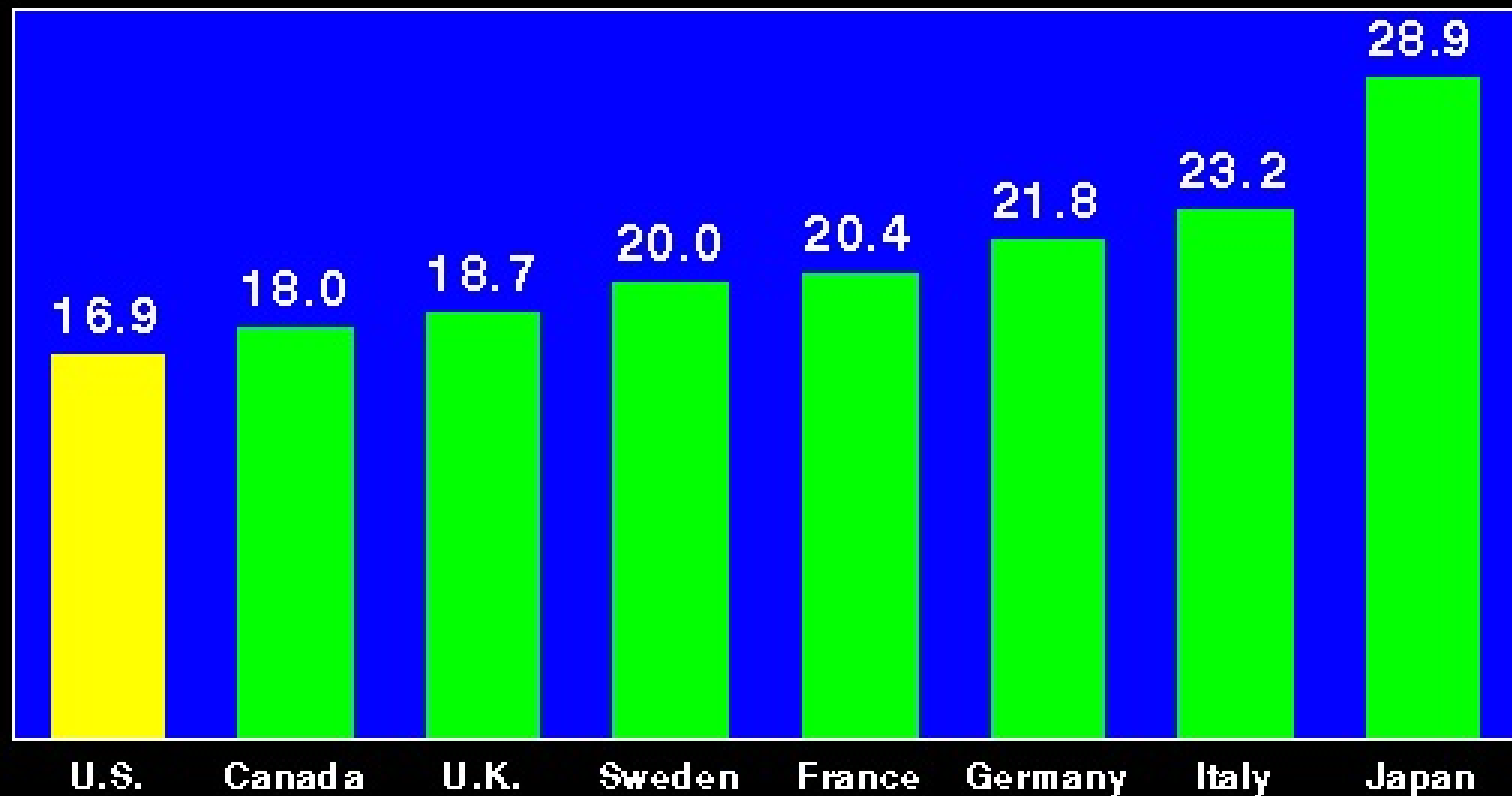


Source: OECD, 2021

Note: Data are for 2020, or most recent year available

Percent Elderly

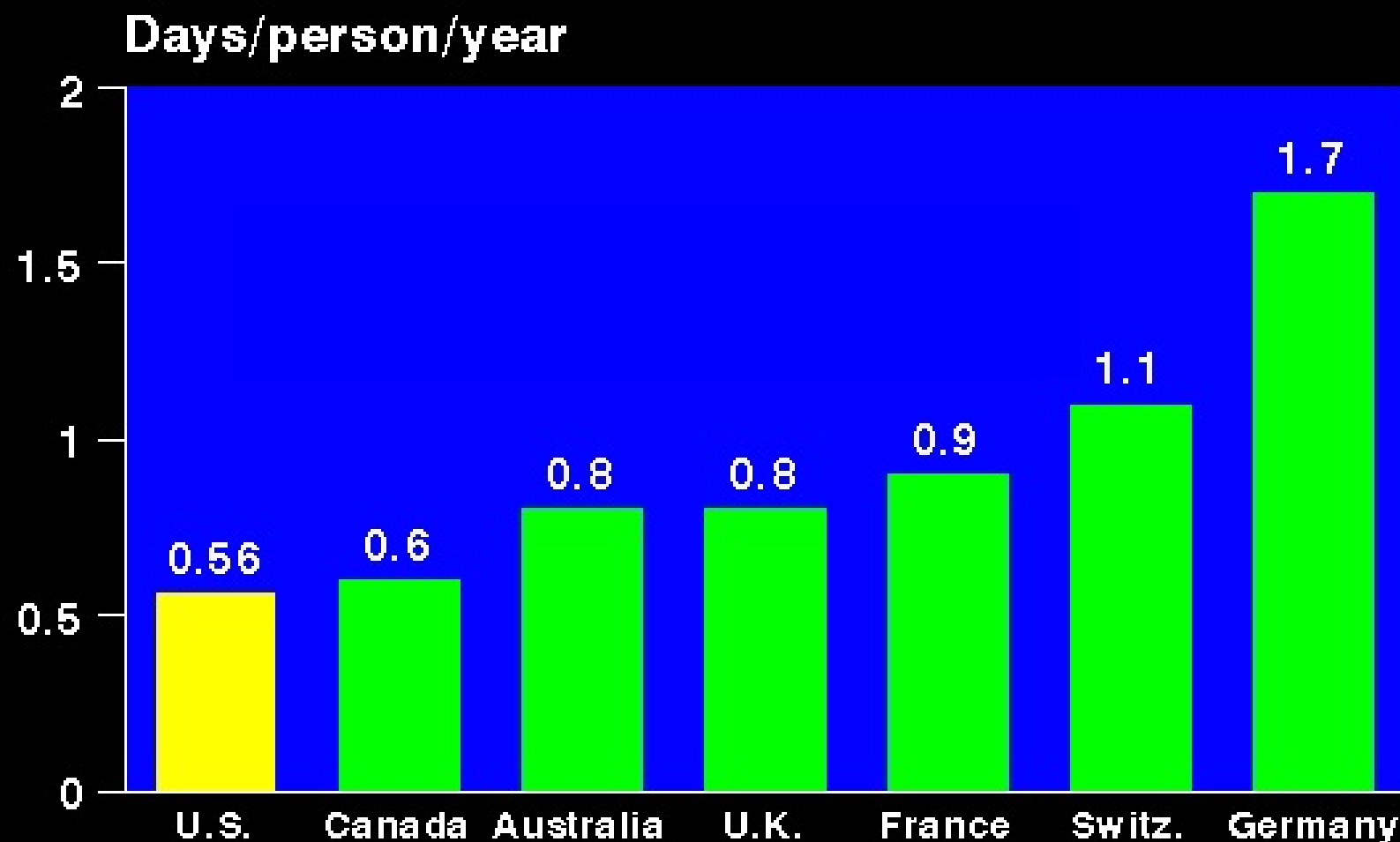
% of Population > 64



Source: OECD, 2021

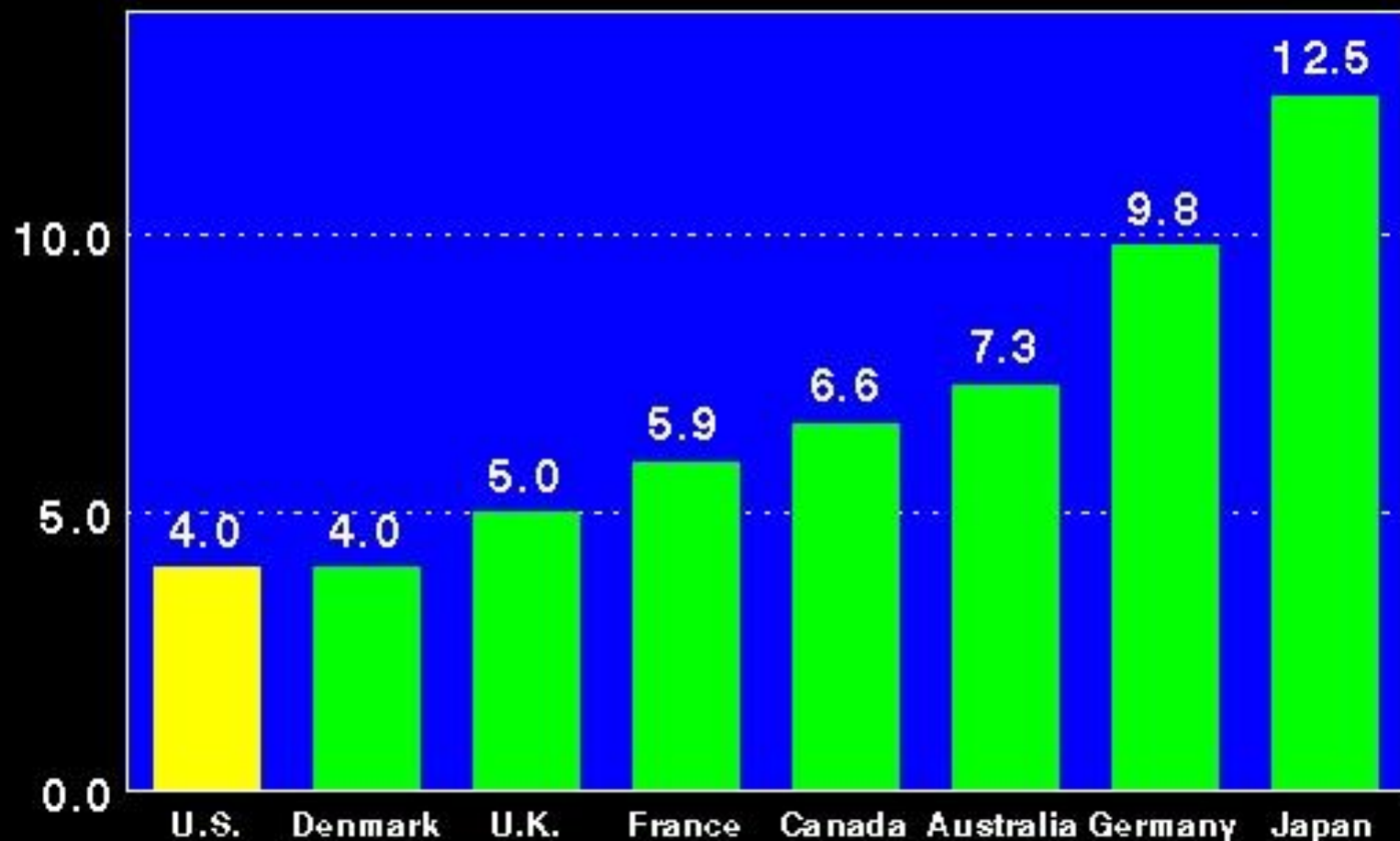
Note: Data are for 2020 or most recent year available

Hospital Inpatient Days Per Capita



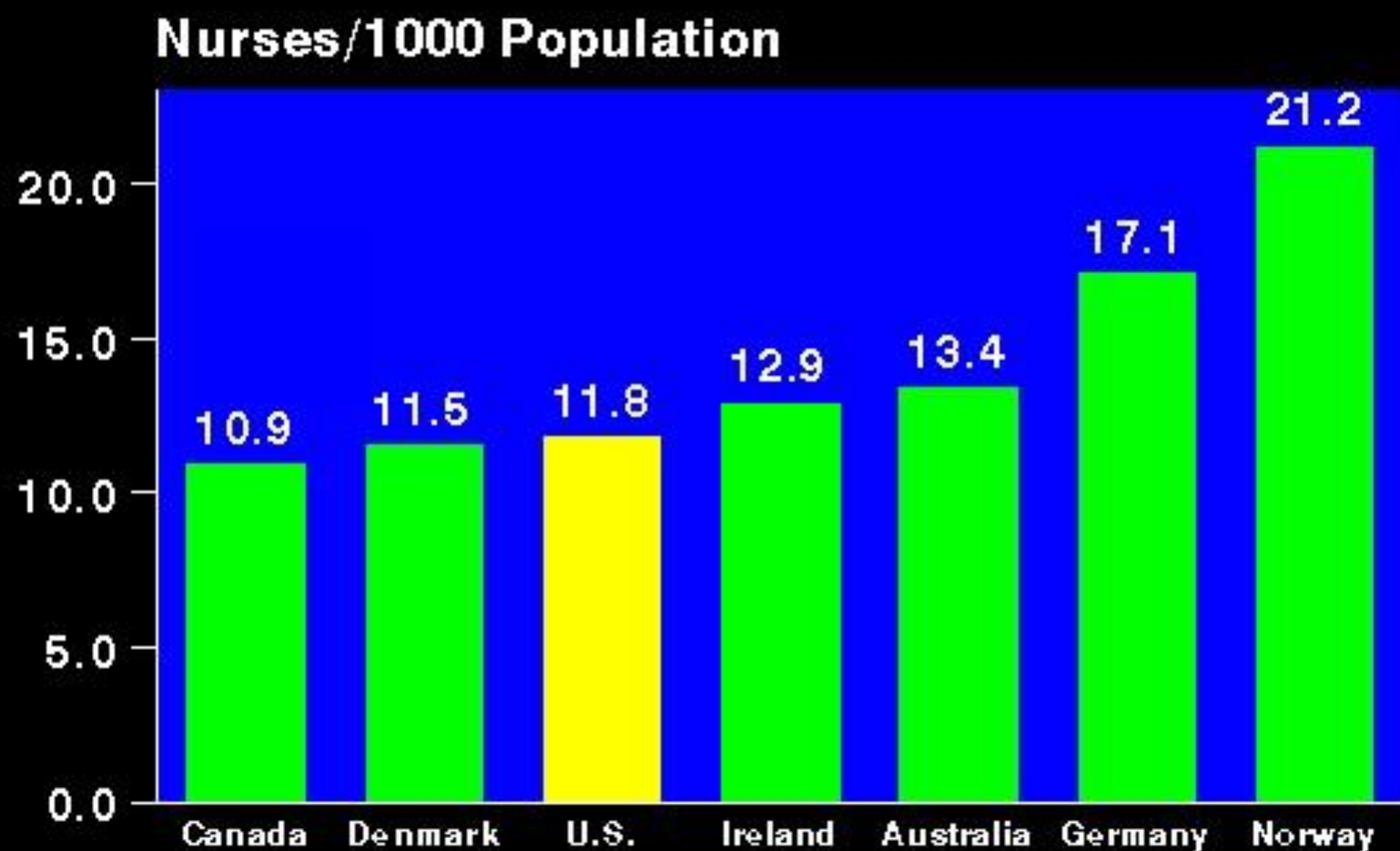
Source: OECD, 2021 & Kaiser Fdn. - Figures are for 2020 or most recent available

Physician Visits Per Capita



Source: OECD, 2021 - Data are for 2020 or most recent available year

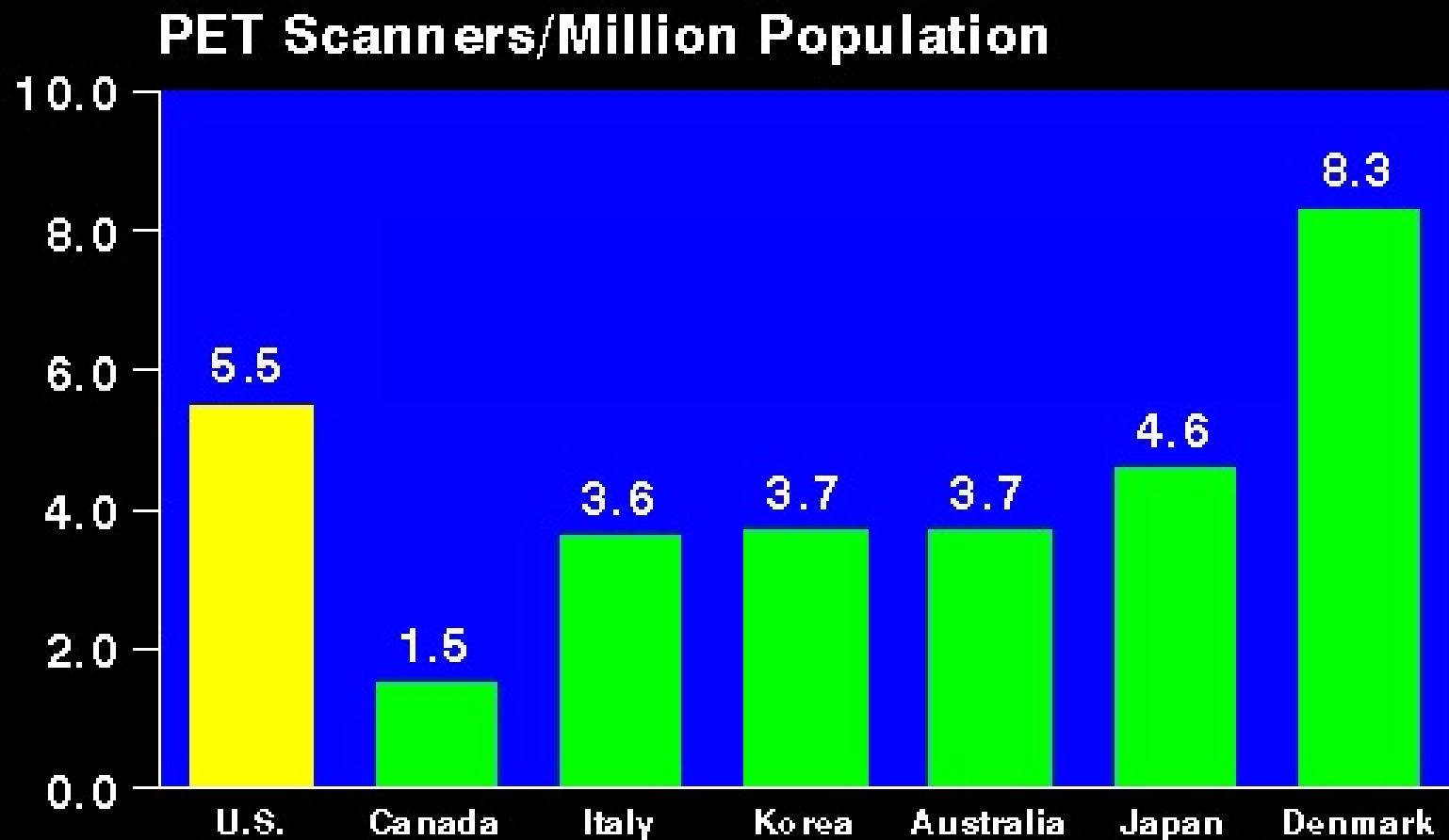
Number of Nurses Per 1000 Population



Source: OECD, 2021

Note: Data are for 2020 or most recent year available

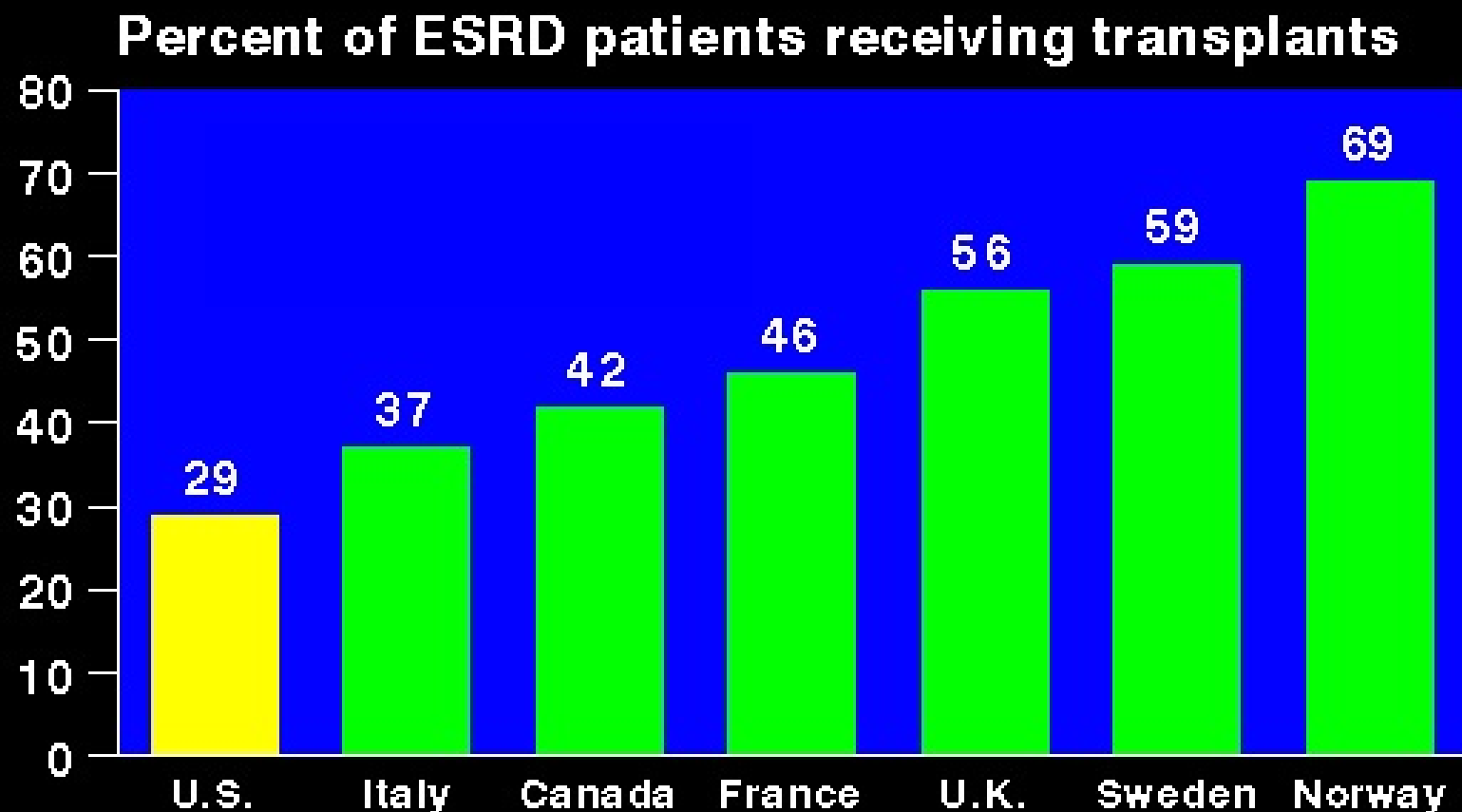
PET Scan Units/Million Population



Source: OECD, 2021

Note: Data are for 2020, or most recent year available

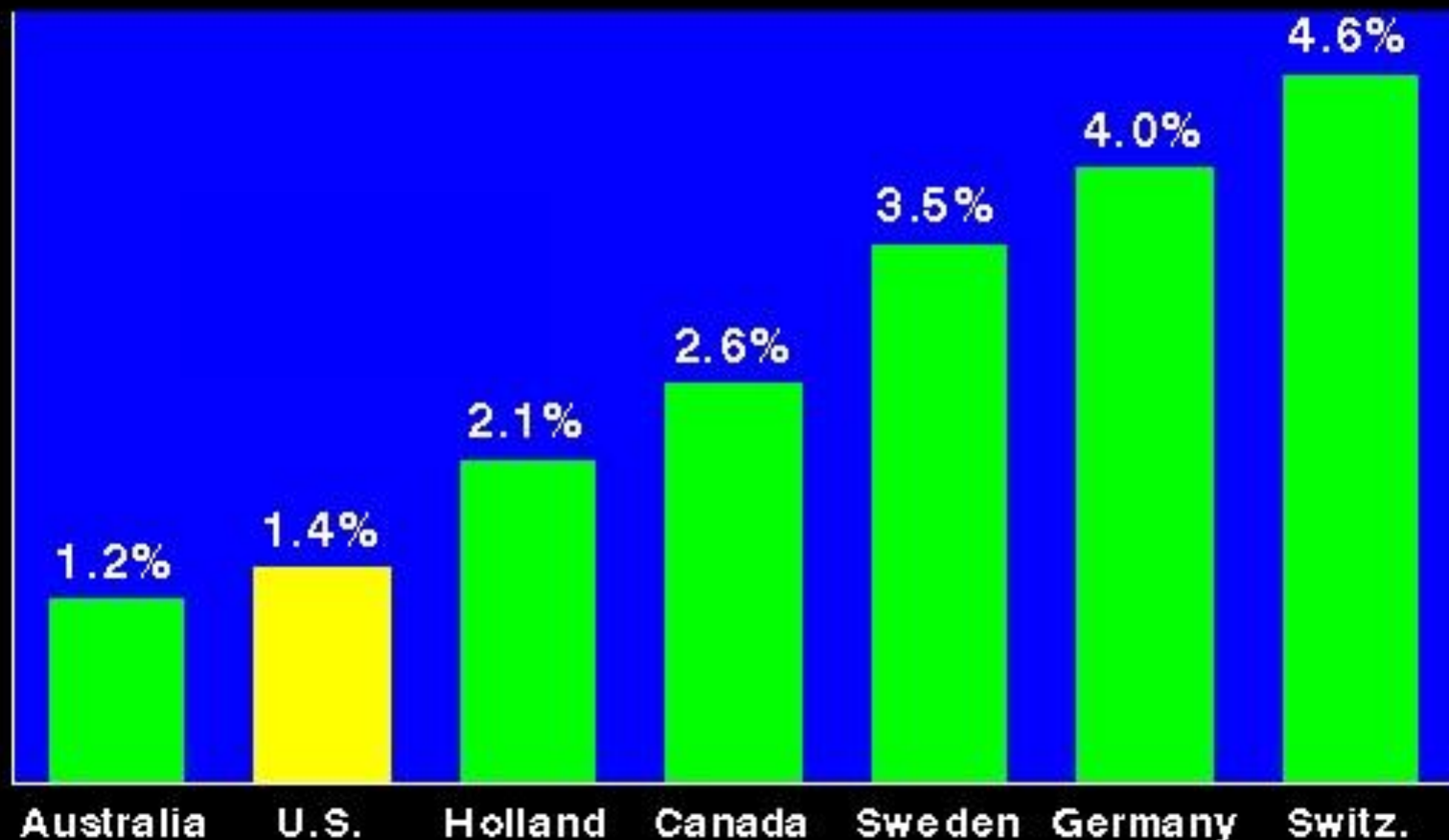
U.S. Renal Failure Patients: Fewer Receive Transplants



Source: U.S. Renal Data System Annual Report, 2020 - Data are for 2018

Other Countries Provide More Long Term Care at Home

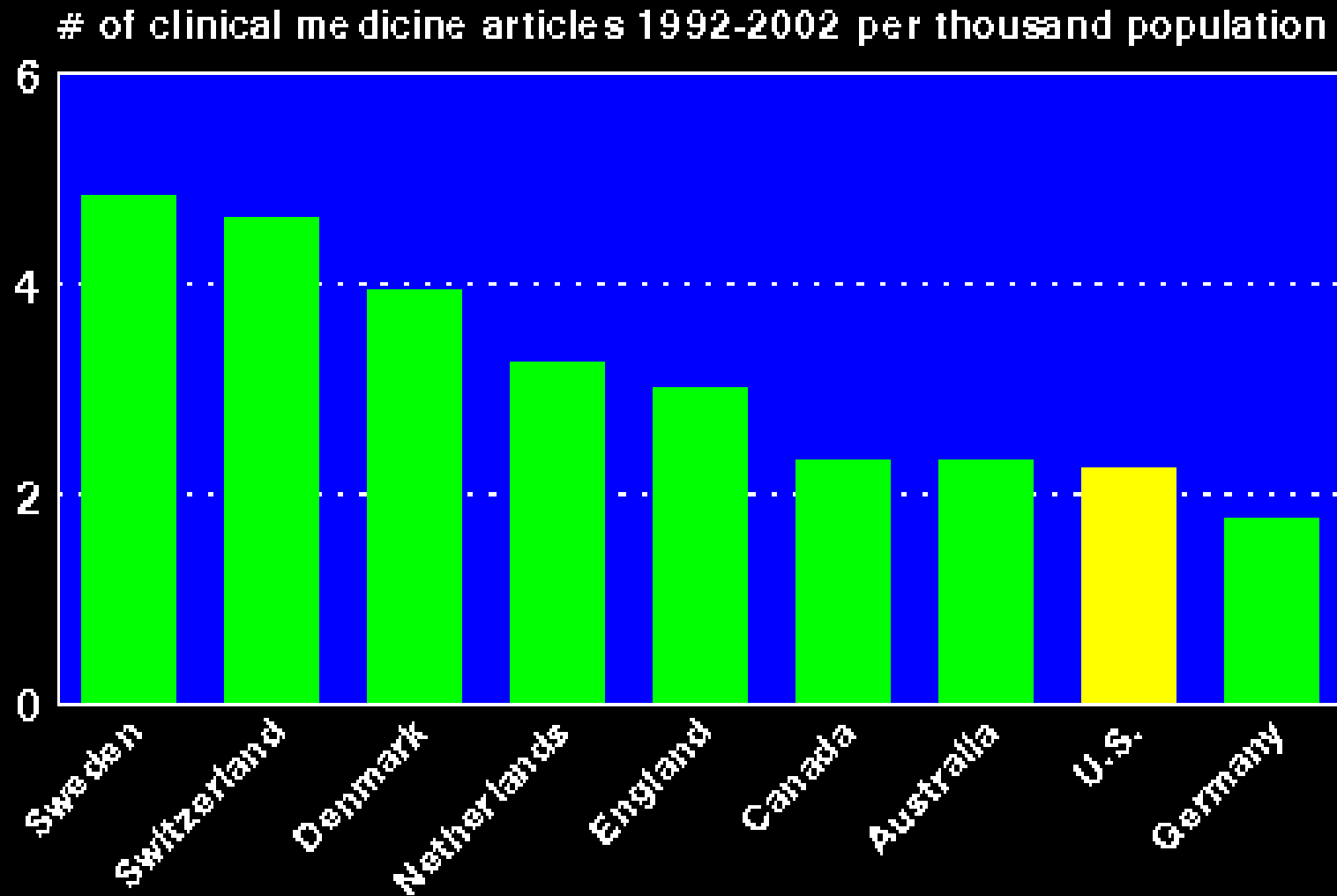
Percent of total population receiving home care



Source: OECD, 2021

Note: Data are for 2019 or most recent year available

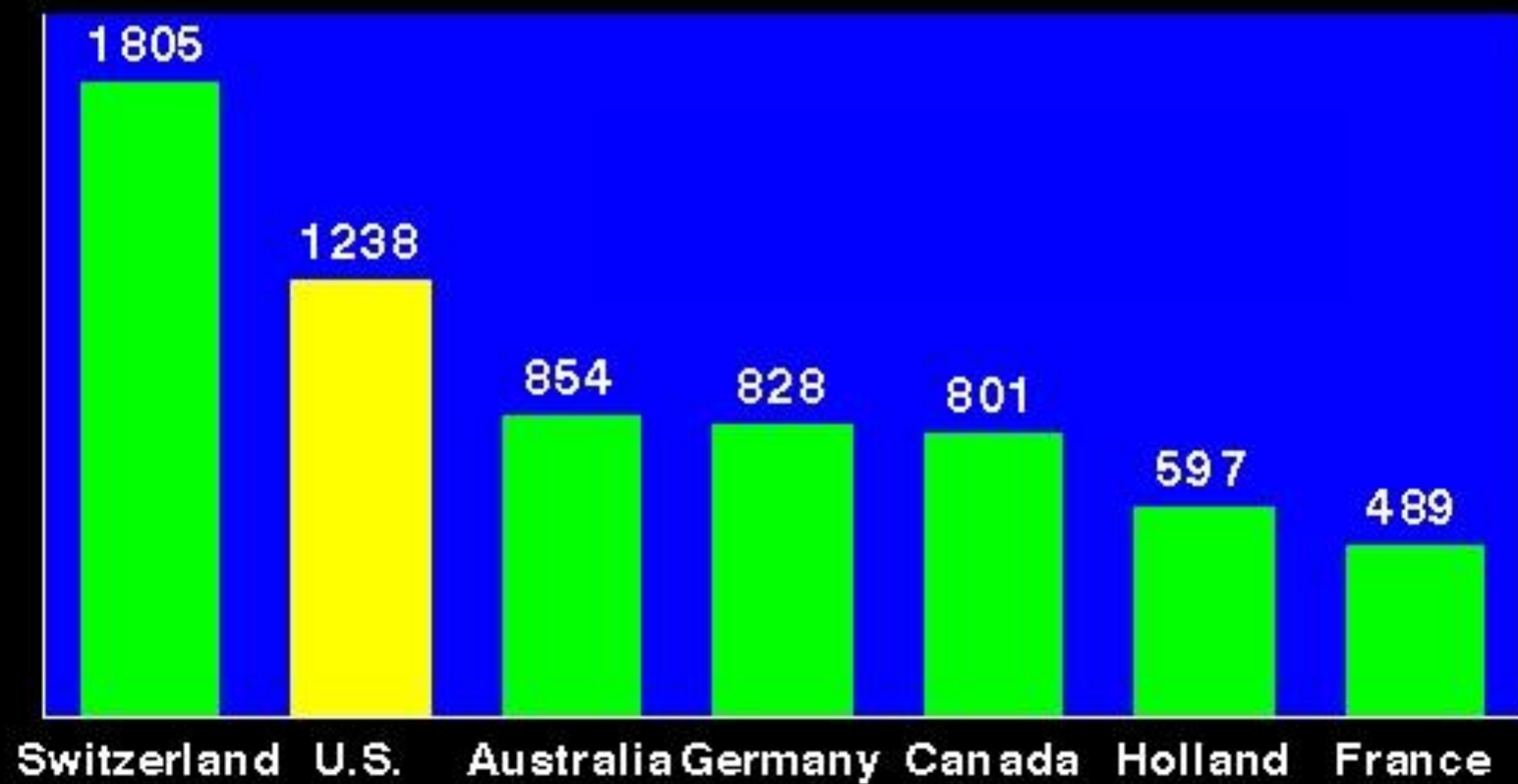
Medical Journals Articles Per Capita



Source: Lancet 2004; 363:250

Out-Of-Pocket Payments

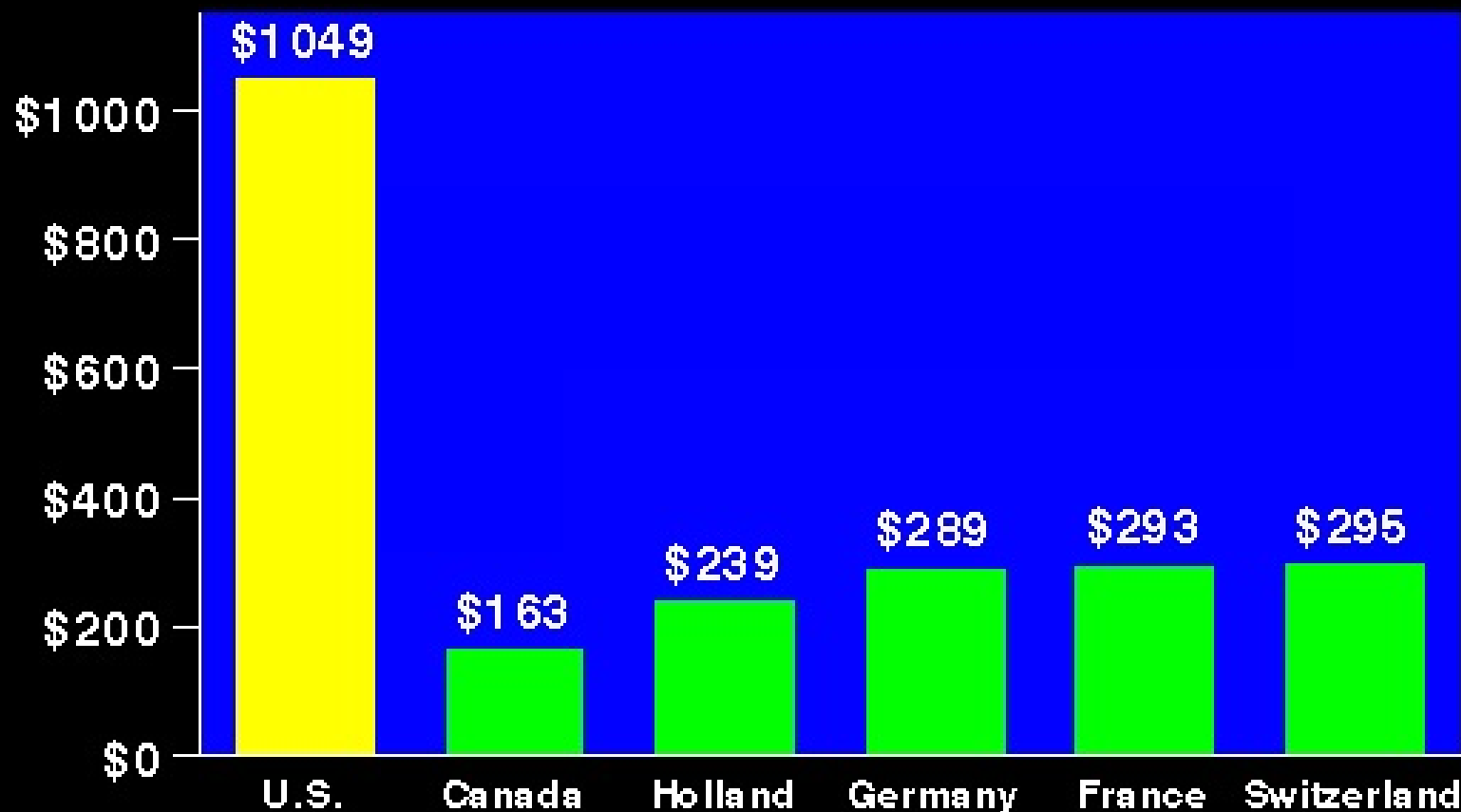
\$/Capita



Source: OECD, 2021 & NCHS

Note: Data are for 2020 or most recent year available; figures adjusted for Purchasing Power Parity

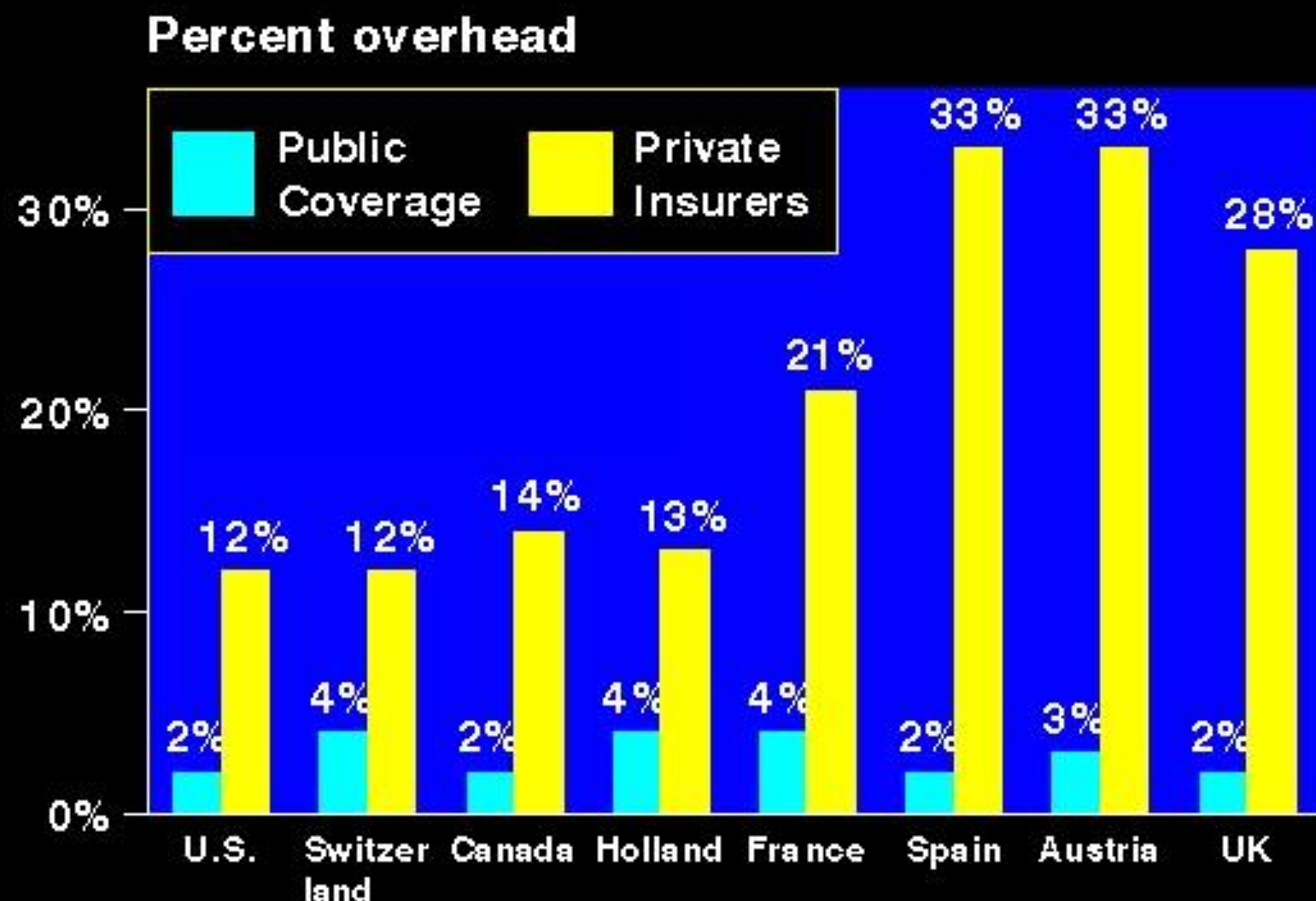
Insurance Overhead



Source: OECD, 2021; NCHS; CIHI

Note: Figures adjusted for Purchasing Power Parity; data are for 2020 or most recent available

Private Insurance: High Overhead Everywhere

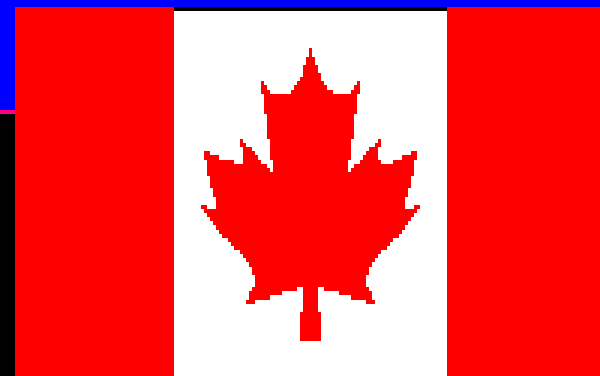
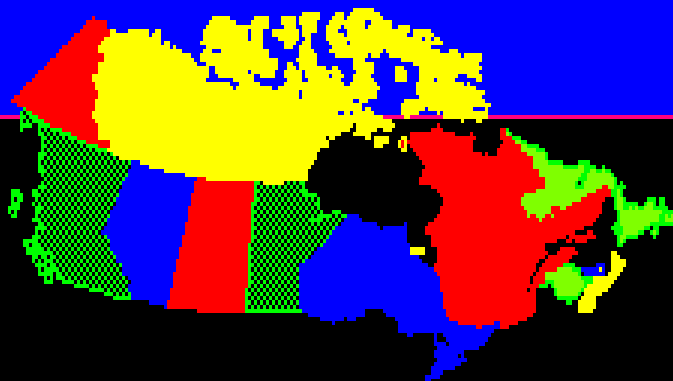


Source: Int J Health Planning and Management 2018;e:263 and NCHS

Canada's Single Payer National Health Insurance Program

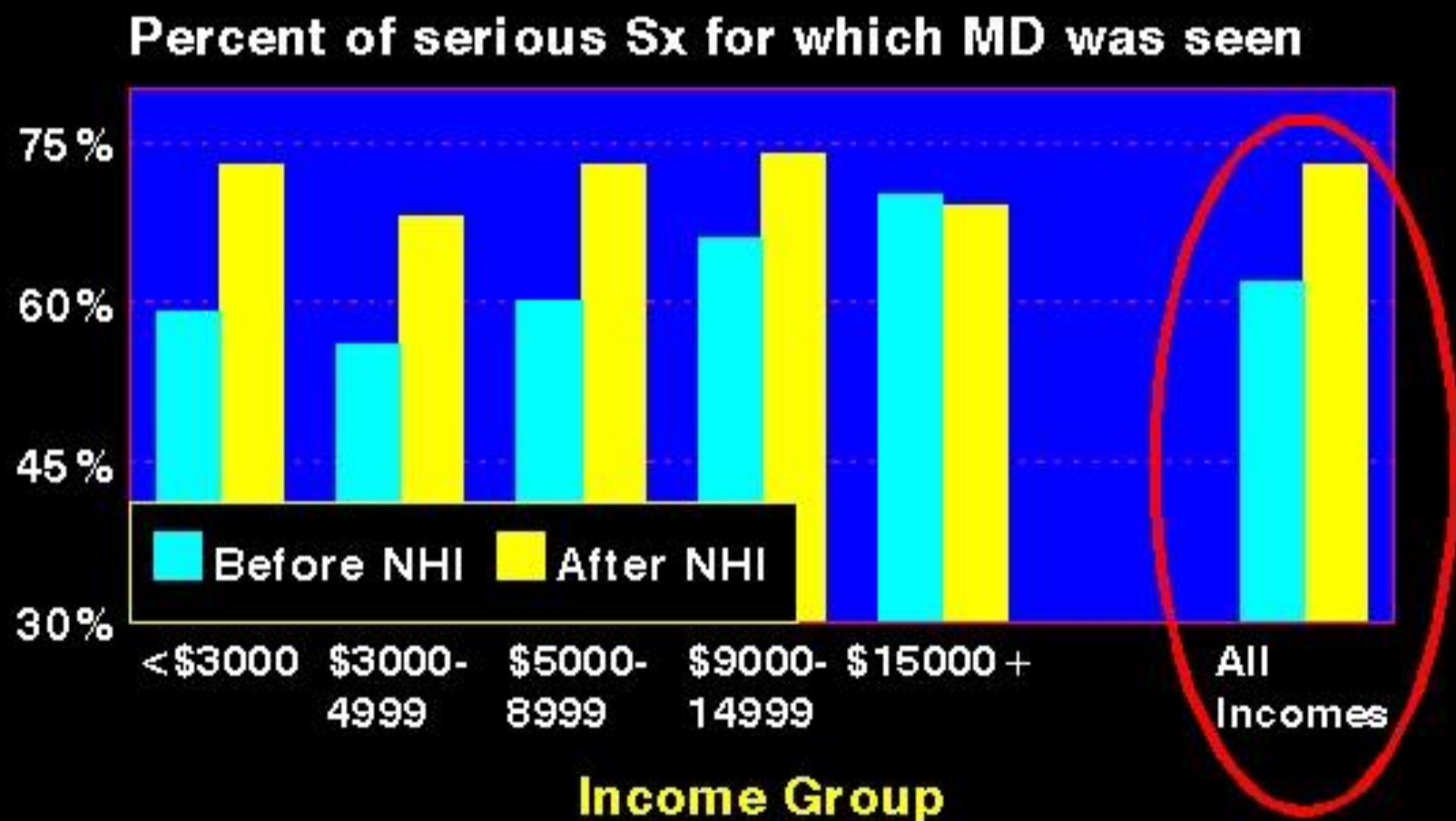
MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

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 Increased Physician Care for Serious Symptoms

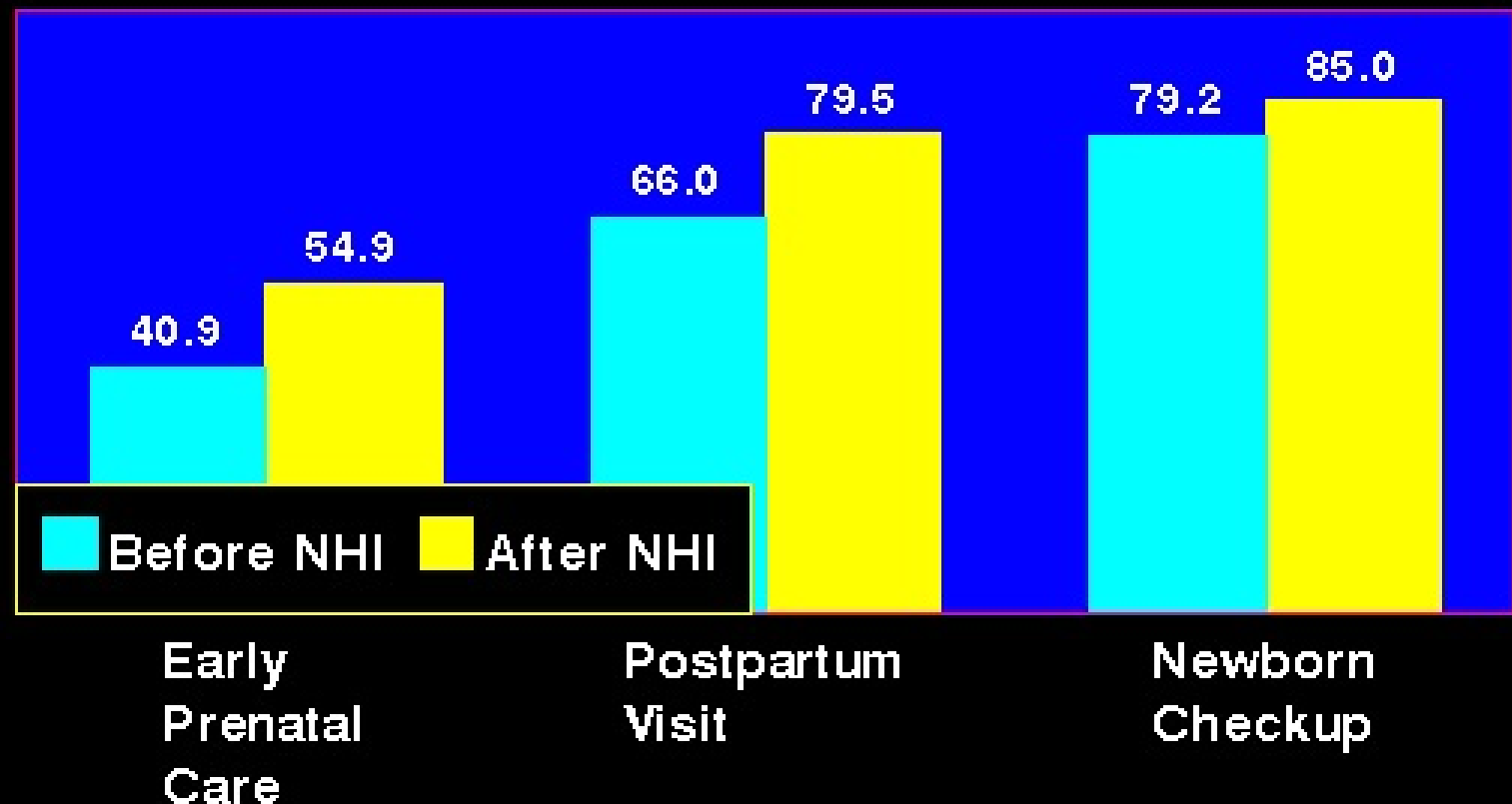
Biggest Impact on Poor and Middle Class



Free Care in Quebec

Improved Maternal/Infant Care

Percent with visit



Quality of Care Slightly Better in Canada Than U.S.

A Meta-Analysis of Patients Treated for Same Illnesses

(U.S. Studies Included Mostly Insured Patients)

Table 1: Summary of findings

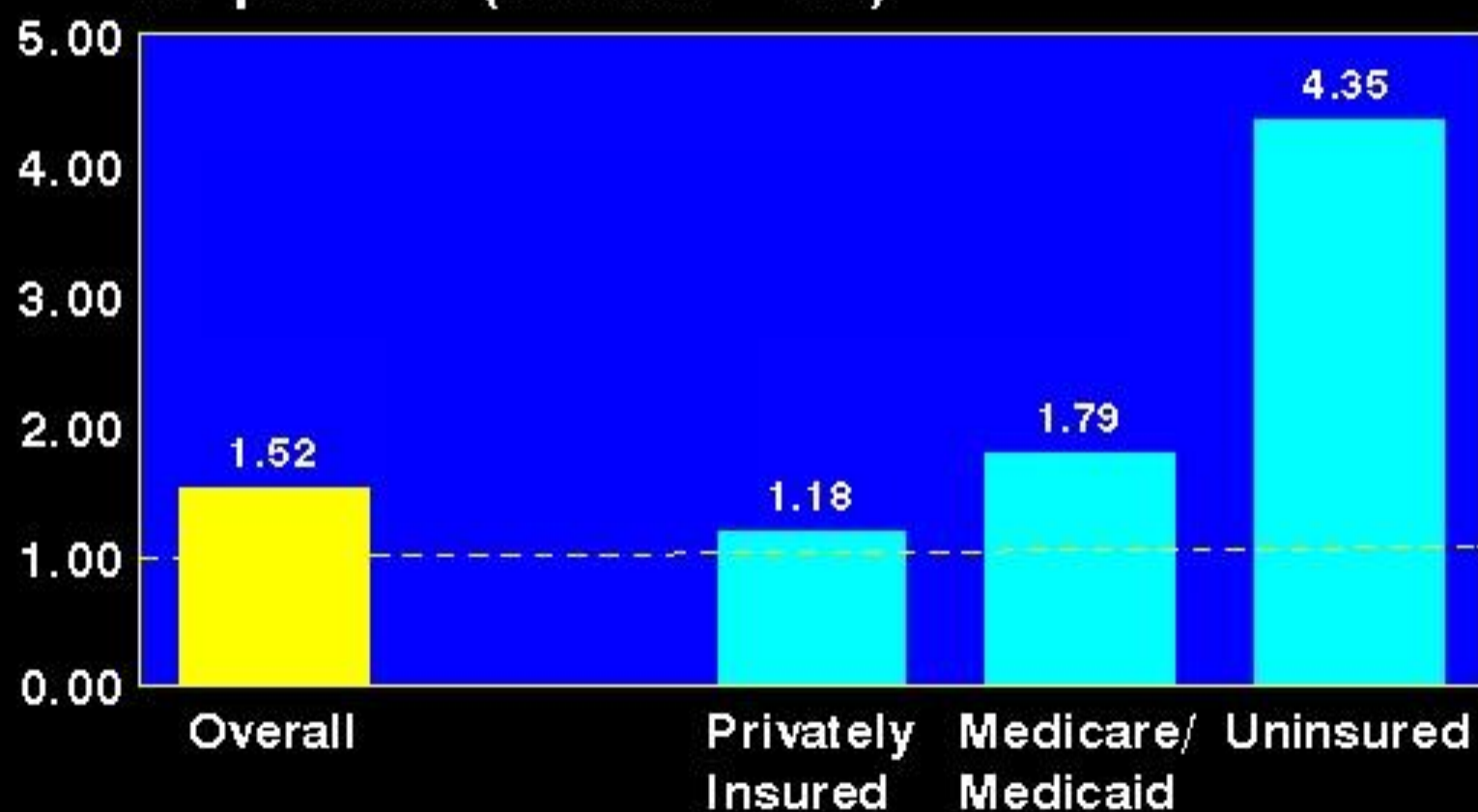
	High-quality studies	Low-quality studies
Results favoured United States	2	3
Results favoured Canada	5	9
Mixed or equivocal results	3	16

Source: Guyatt et al, Open Medicine, April 19, 2007

Cystic Fibrosis Patients Live Longer in Canada

Uninsured in U.S. Have Highest Risk of Death

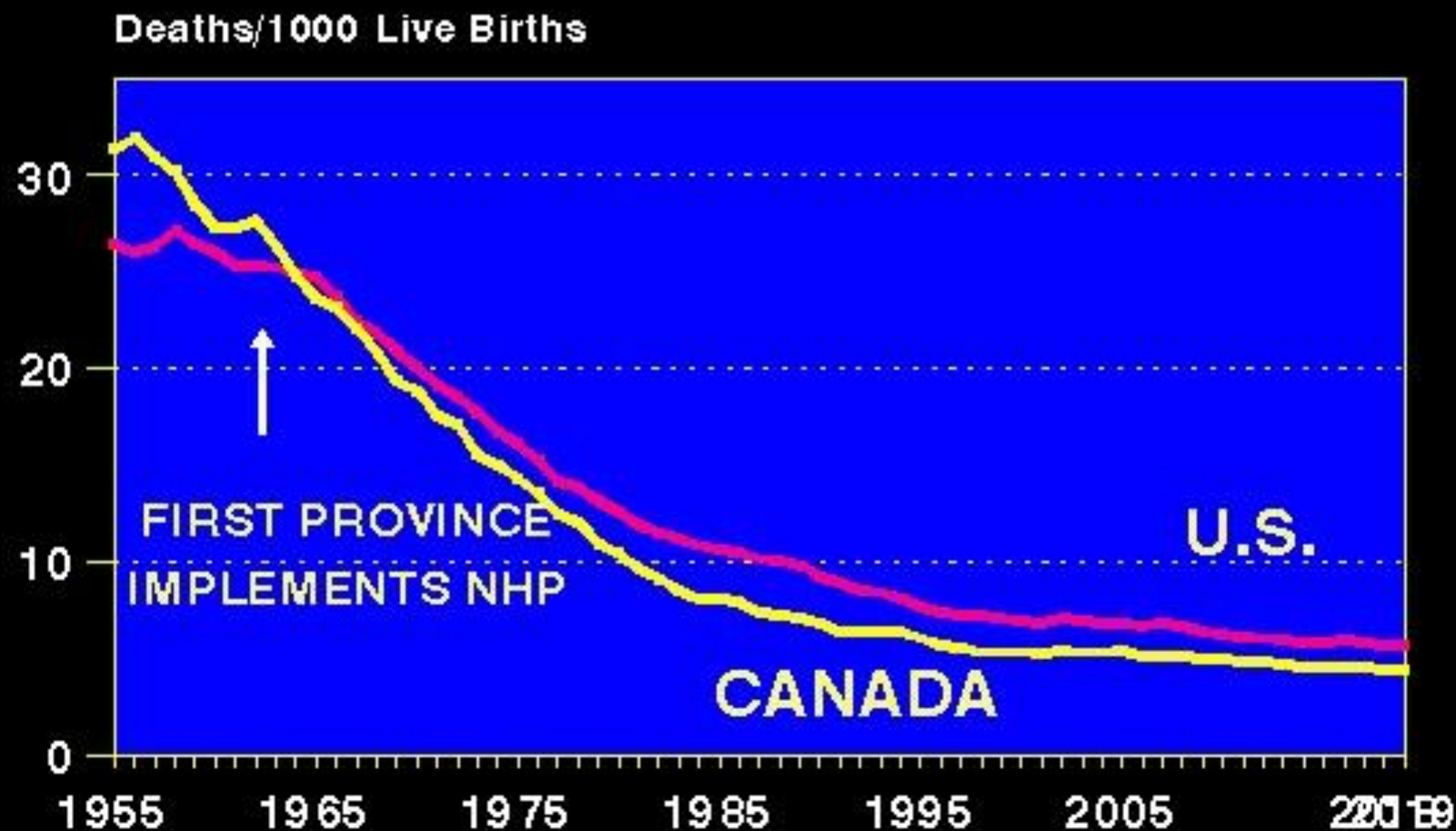
Hazard ratio for death, U.S. vs. Canadian
CF patients (Canada = 1.0)



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

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

Infant Mortality U.S. & Canada, 1955-2019

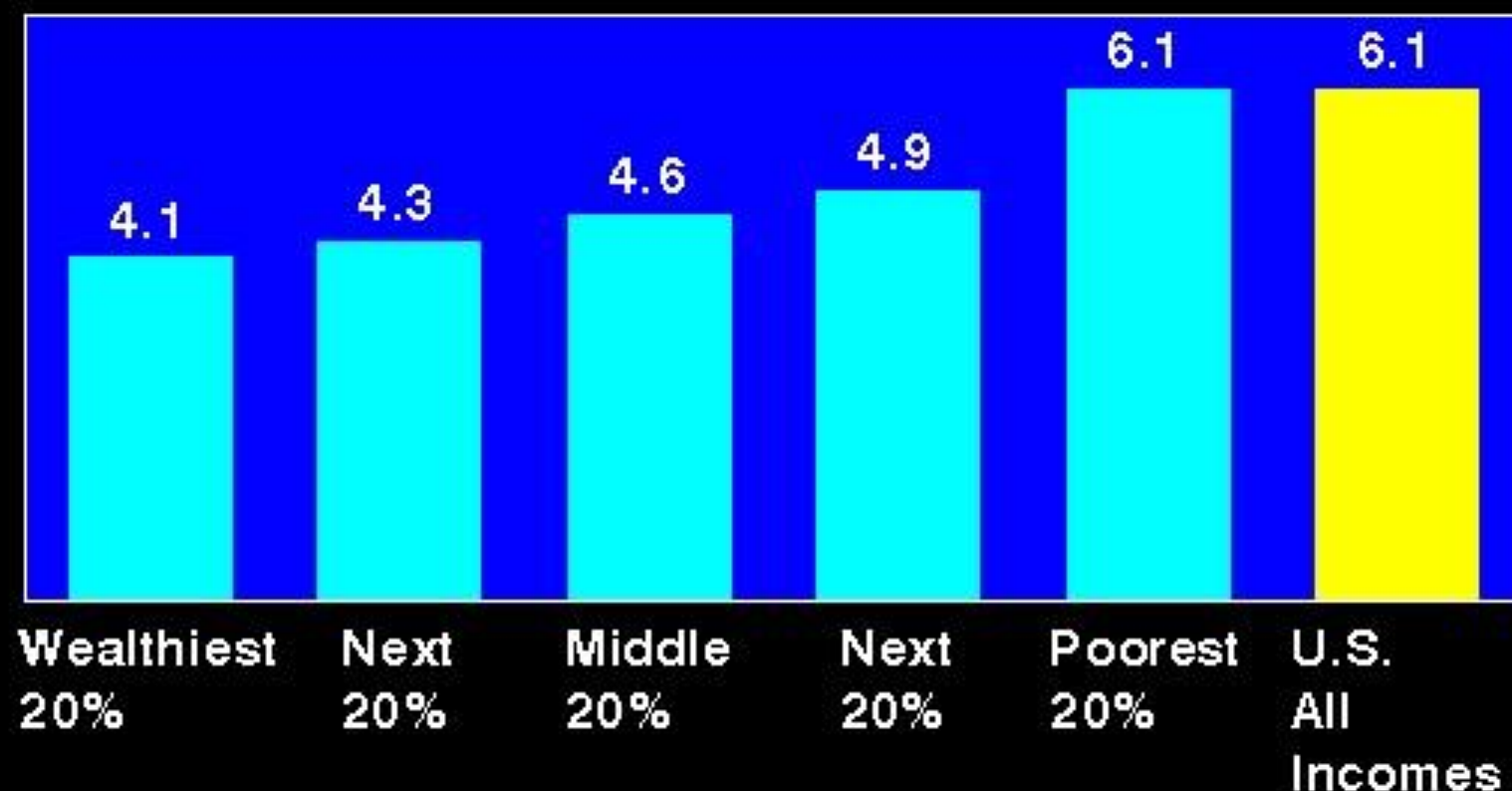


Source: Statistics Canada, Canadian Institute for Health Information, Natl Ctr for Health Statistics

Infant Deaths by Income, Canada 2011

Even the Poor Do as Well as the U.S. Average

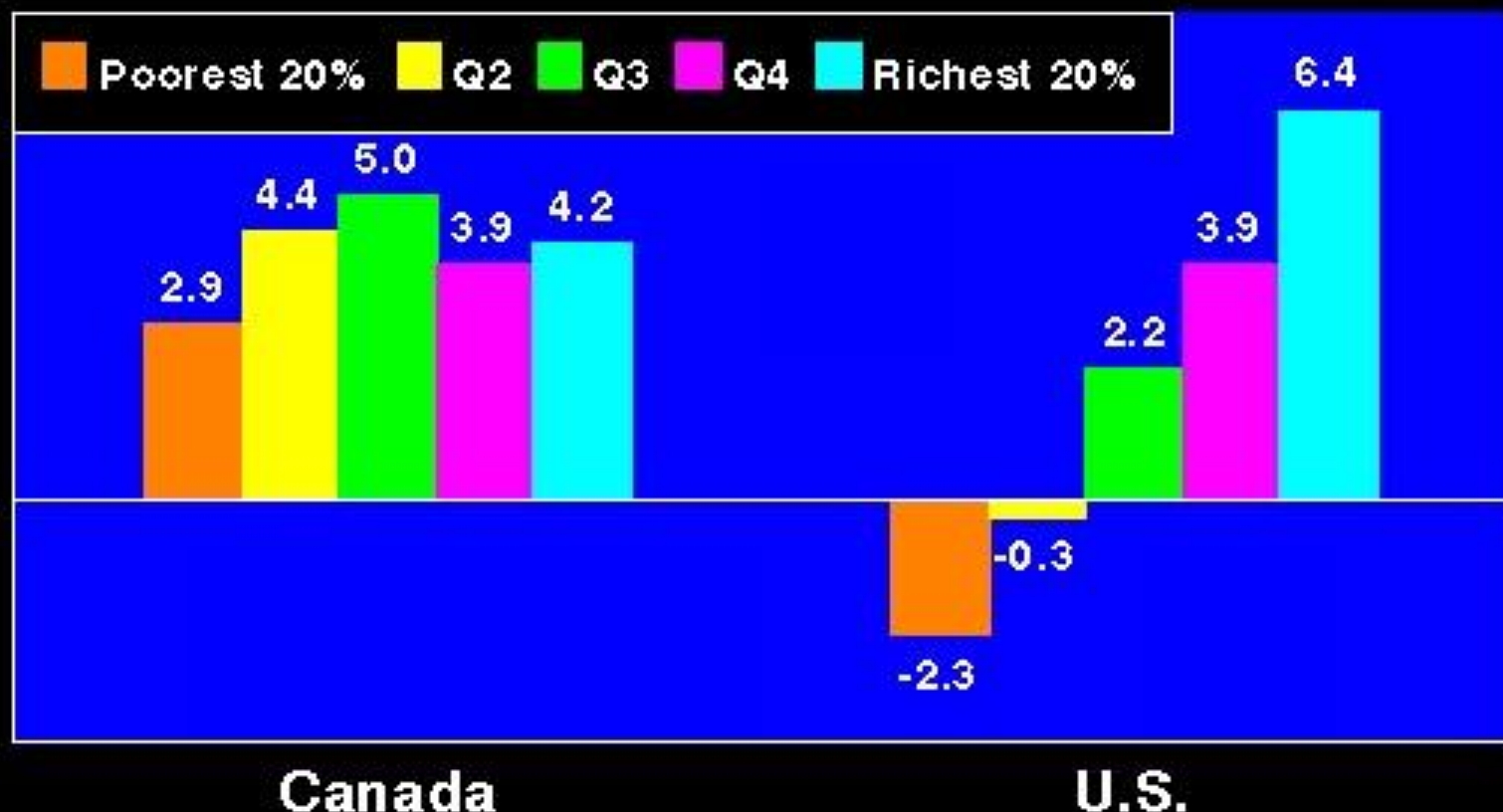
Infant mortality per thousand



Income Quintiles, Canada

Life Expectancy Falling for Lower-Income Americans, Rising for All Canadians

Change in life expectancy at age 50 over past 3 decades.

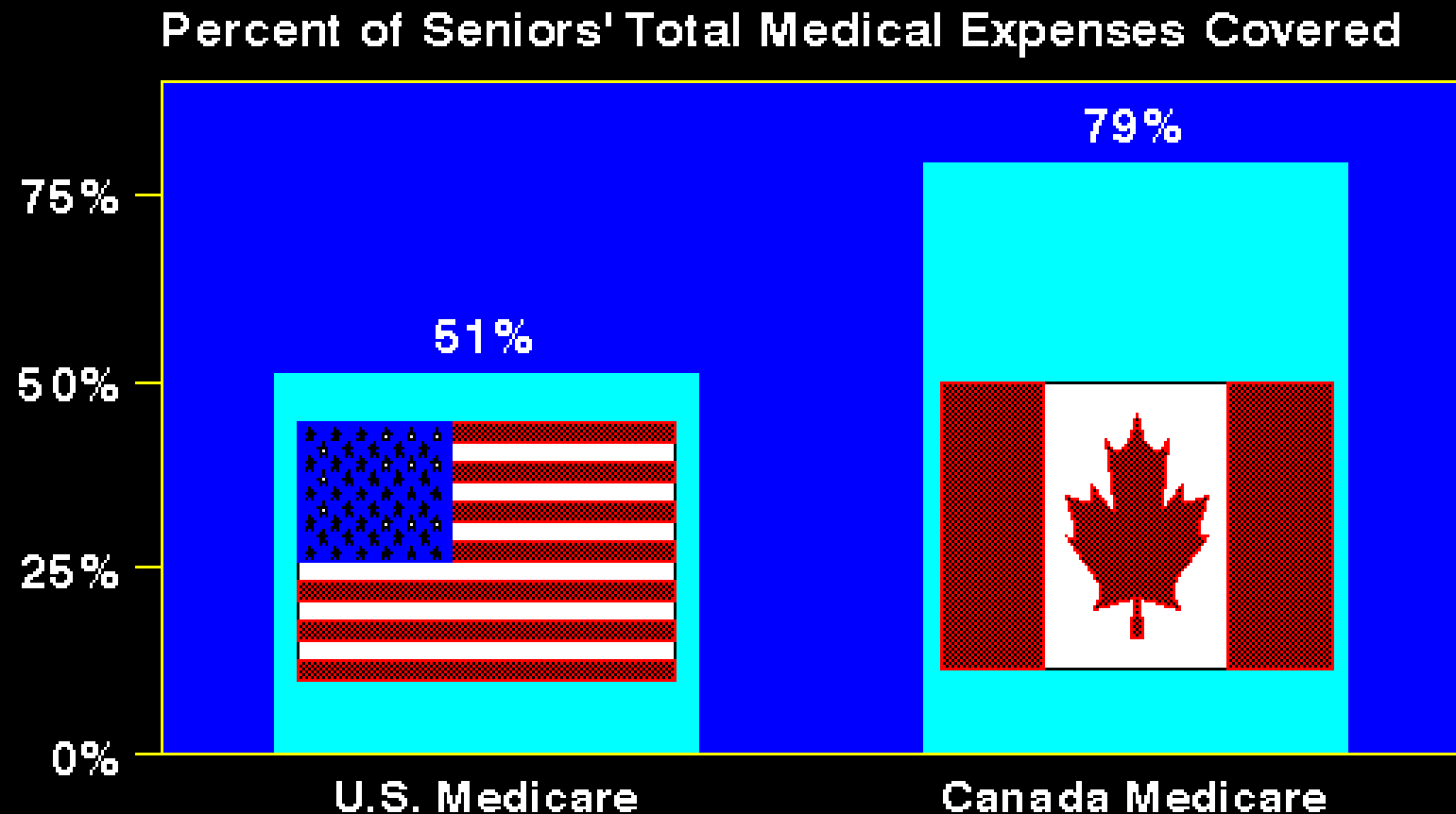


Source: Growing Gap in Life Expectancy by Income, NAS; Rich Man Poor Man, CD Howe Institute

Data is non-weighted average of male and female figures.

Data are for Canadians turning 50 in 2000 vs. 1970 and for Americans turning 50 in 2010 vs. 1980

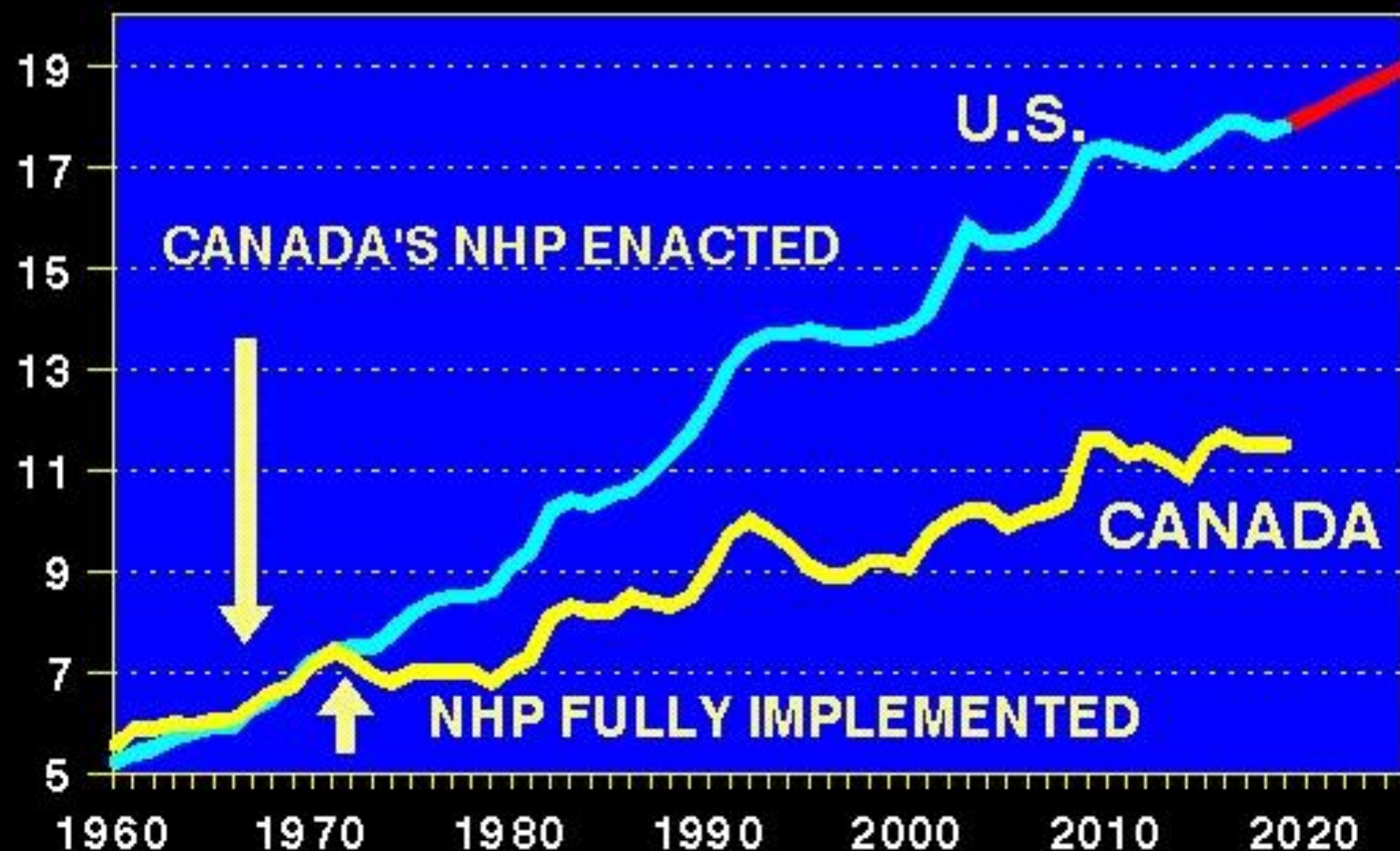
U.S. Medicare Coverage, Much Worse Than Canada's



Source: EBRI and Himmelstein/Woolhandler analysis of Health Canada data

Note - Not comparable to figures for employer coverage because of high LTC needs in elderly

Health Costs as % of GDP: U.S. & Canada, 1960-2025

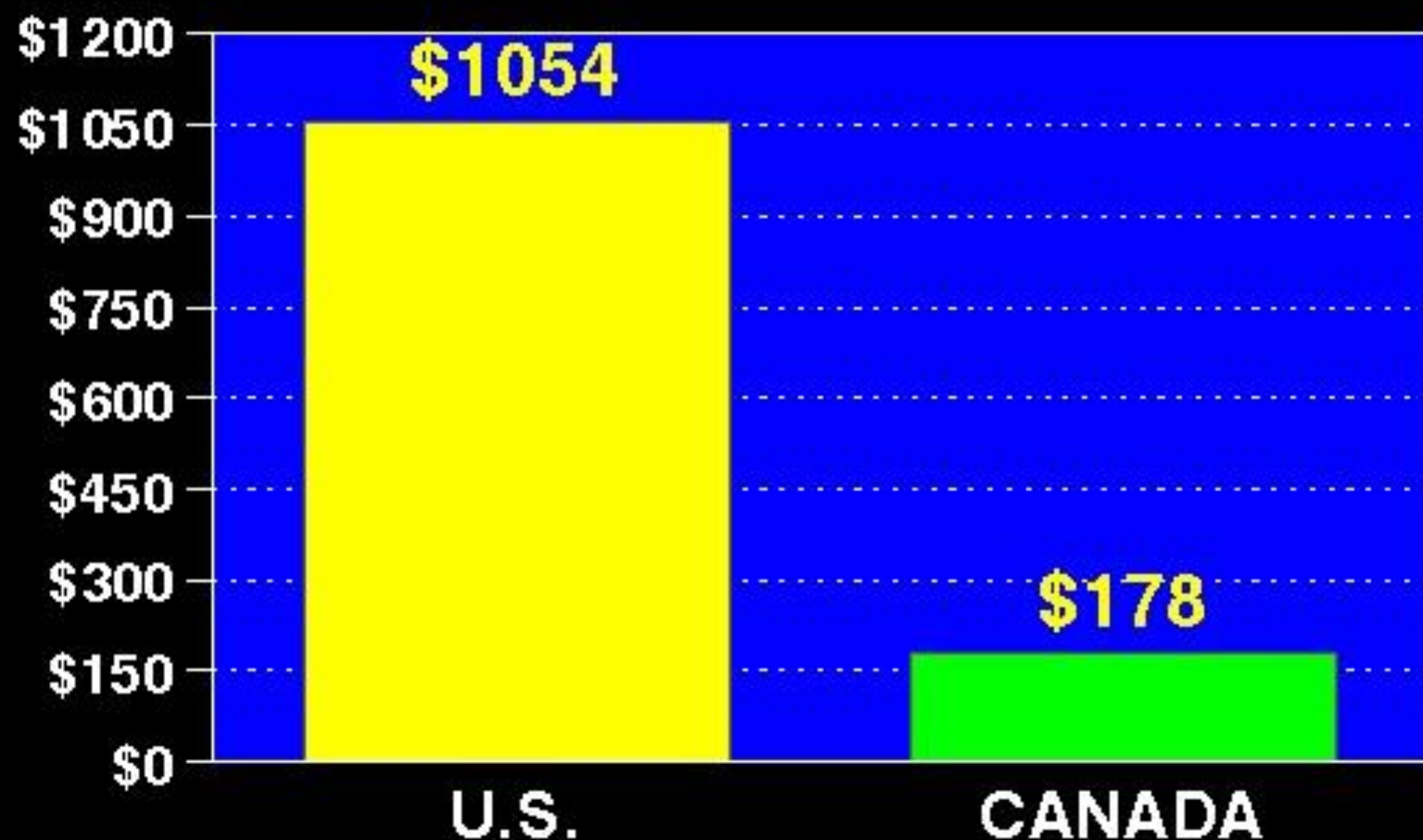


How Canada Controls Costs

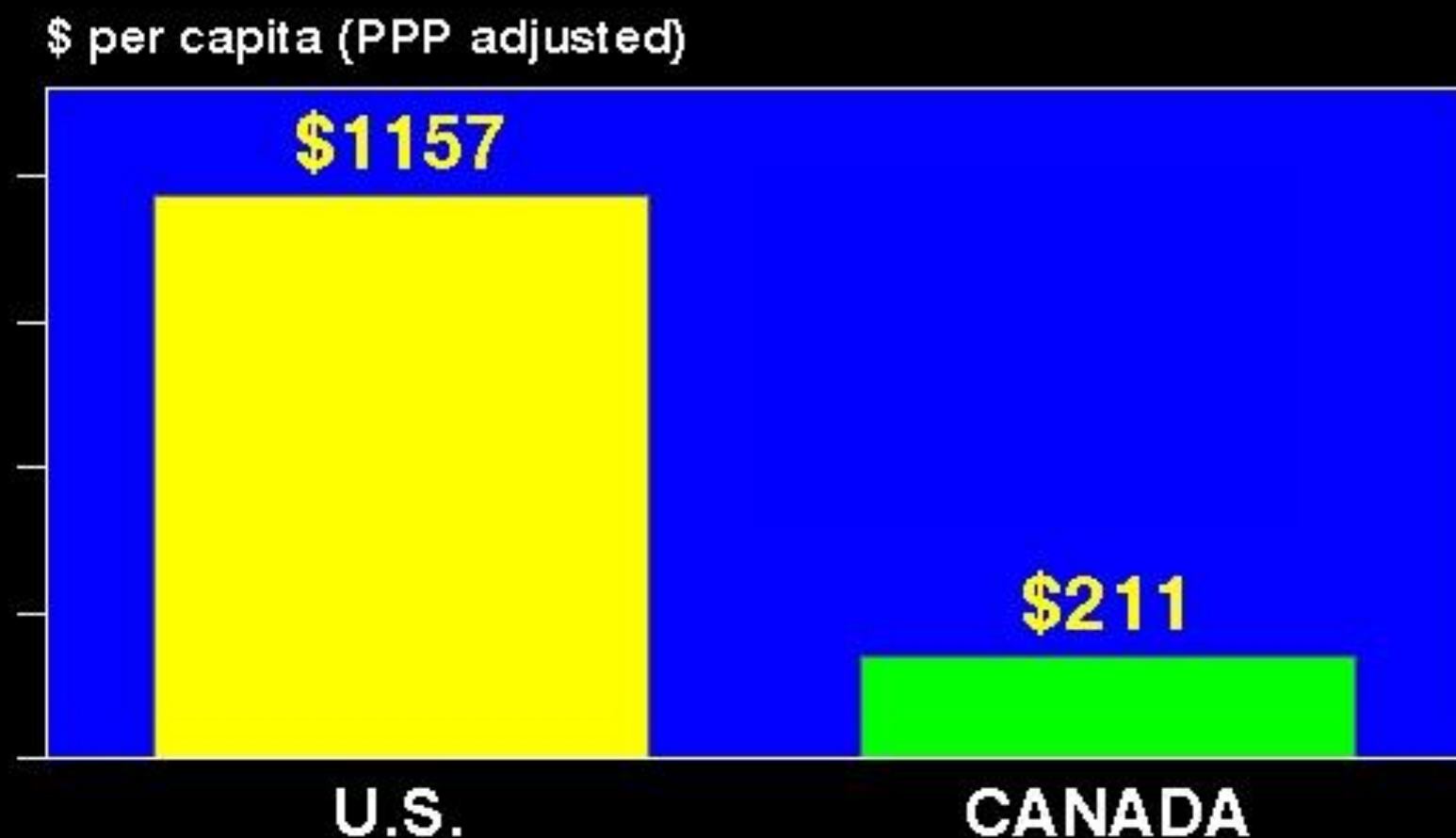
- Low administrative costs - 16.7% of health spending vs. 31.0% in U.S.
- Lump-sum, global budgets for hospitals
- Stringent controls on capital spending for new buildings and equipment
- Single buyer purchasing reins in drug/device prices
- Low litigation and malpractice costs
- Emphasis on primary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

Insurance Overhead

United States & Canada, 2021



Hospital Billing & Administration United States & Canada, 2021



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

Hospital Financing: Medicare vs. Medicare

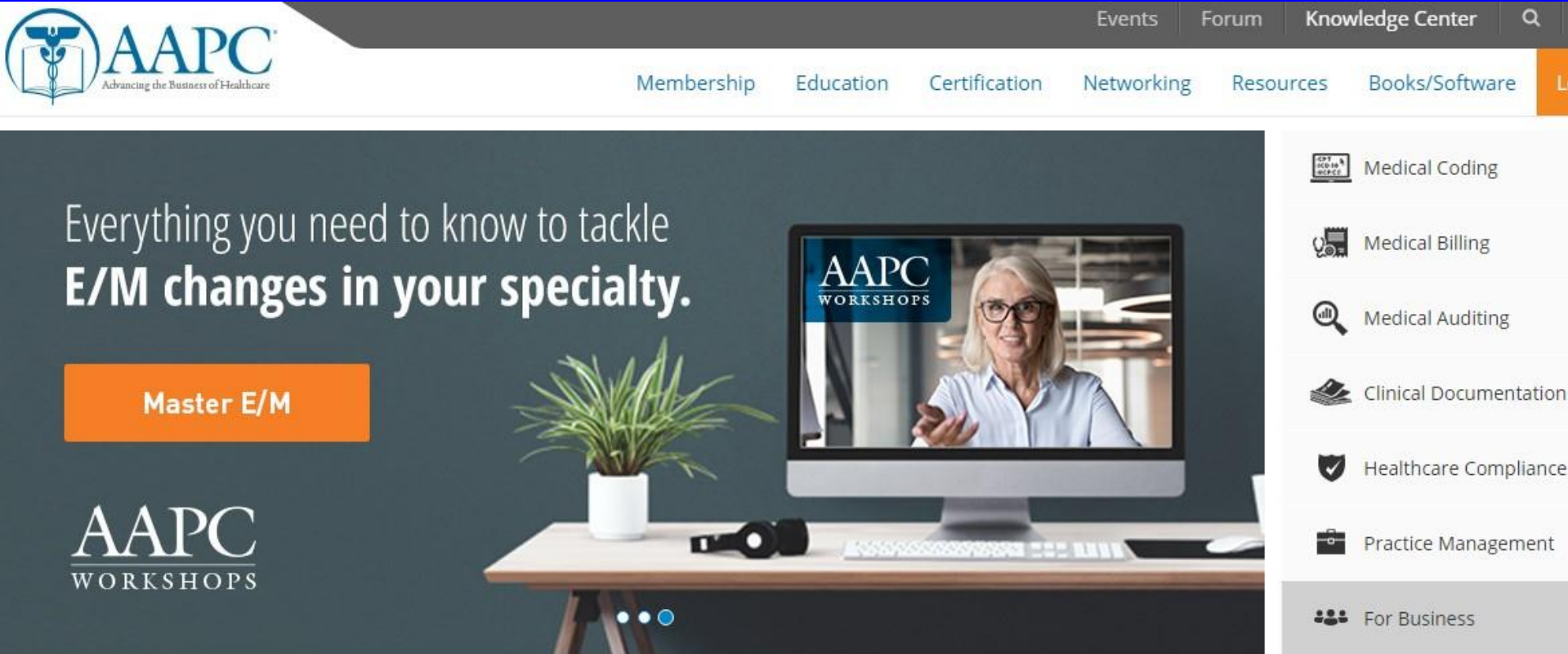


- Per-patient payments
- Capital and operating payments intermixed
- New investments funded from surplus/profit
- For-profits thrive



- Global budget
- Separate payment for capital
- New investments funded by government grants
- Eliminates opportunity for profitmaking

American Association of Professional Coders: 190,000 Members and Growing



The image shows the top portion of the AAPC website. At the top left is the AAPC logo with the tagline "Advancing the Business of Healthcare". To the right are navigation links: Events, Forum, Knowledge Center, and a search icon. Below these are more links: Membership, Education, Certification, Networking, Resources, and Books/Software. The main banner features the text "Everything you need to know to tackle E/M changes in your specialty." and a button labeled "Master E/M". Below this is the "AAPC WORKSHOPS" logo. To the right of the banner is a list of topics: Medical Coding, Medical Billing, Medical Auditing, Clinical Documentation, Healthcare Compliance, Practice Management, and For Business. Each topic has a small icon next to it.

AAPC
Advancing the Business of Healthcare

Events Forum Knowledge Center

Membership Education Certification Networking Resources Books/Software

Everything you need to know to tackle
E/M changes in your specialty.

Master E/M

AAPC
WORKSHOPS

- Medical Coding
- Medical Billing
- Medical Auditing
- Clinical Documentation
- Healthcare Compliance
- Practice Management
- For Business

190,000 Members
& Growing

AAPC is the world's largest training and credentialing organization for the business of healthcare, with more than 190,000 members worldwide who work in medical coding, medical billing, clinical documentation improvement, medical auditing, healthcare compliance, revenue cycle management, and practice management. Join this premier association to grow your network and advance your career.

[Join AAPC Today](#) ➔

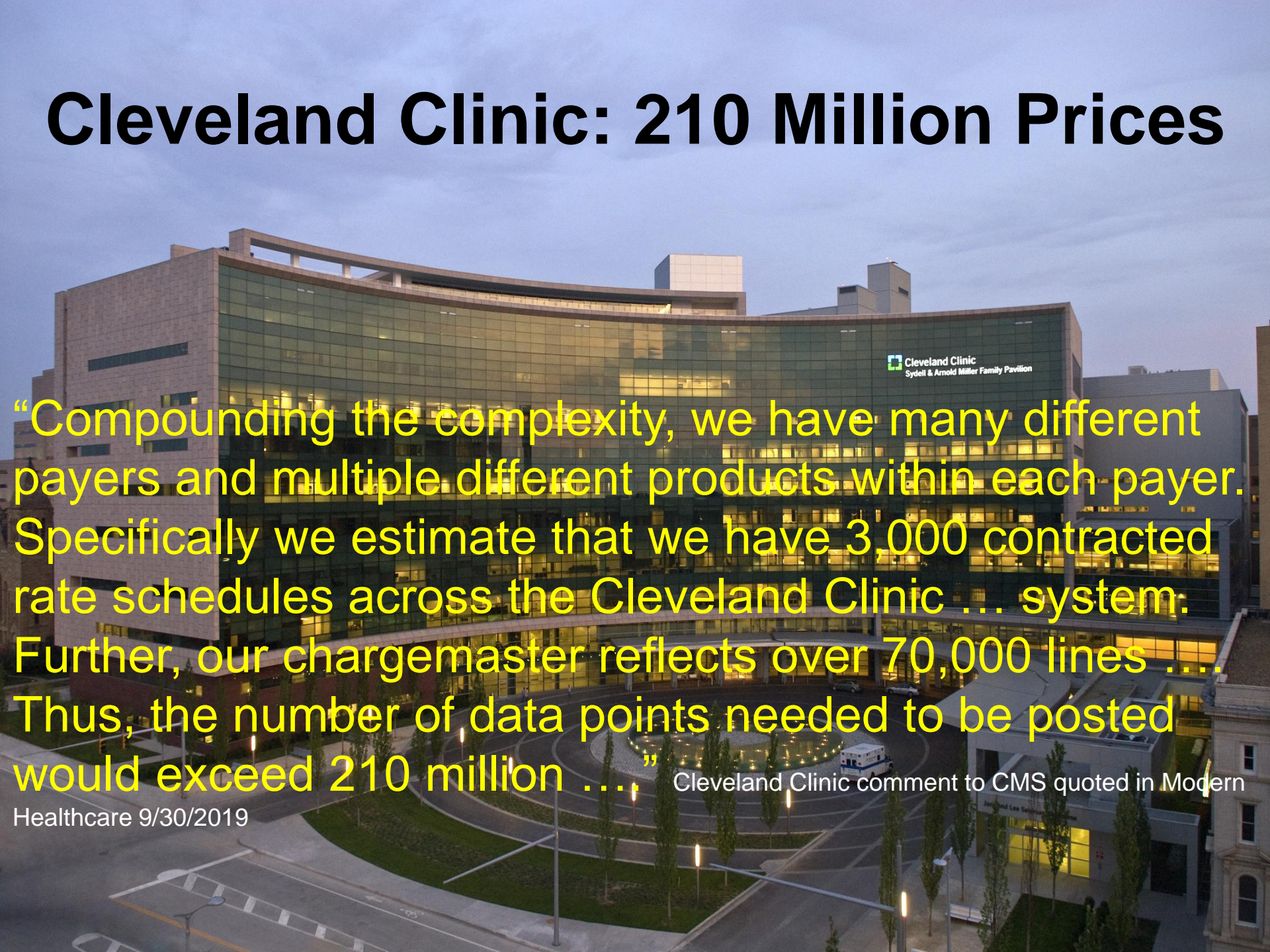


Medical Coding Training



Medical Coding Certification

Cleveland Clinic: 210 Million Prices

An aerial photograph of the Cleveland Clinic Sydell & Arnold Miller Family Pavilion at dusk. The building is a large, modern structure with a curved glass facade that reflects the sky. The interior lights are on, and the building is surrounded by a landscaped area with trees and a circular driveway. A sign on the building reads "Cleveland Clinic Sydell & Arnold Miller Family Pavilion".

“Compounding the complexity, we have many different payers and multiple different products within each payer. Specifically we estimate that we have 3,000 contracted rate schedules across the Cleveland Clinic ... system. Further, our chargemaster reflects over 70,000 lines Thus, the number of data points needed to be posted would exceed 210 million”

Cleveland Clinic comment to CMS quoted in Modern

Healthcare 9/30/2019

An aerial photograph of the Duke Medical Center, showing a large, multi-story beige building complex with a central courtyard and surrounding parking areas. The sky is blue with scattered white clouds. A large yellow text overlay is centered over the image.

.Duke Medical
Center: 957 beds,
1 600 billing clerks

Source: JAMA 2018;319:691

Physicians' Billing-Related Expenses United States & Canada, 2021



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

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

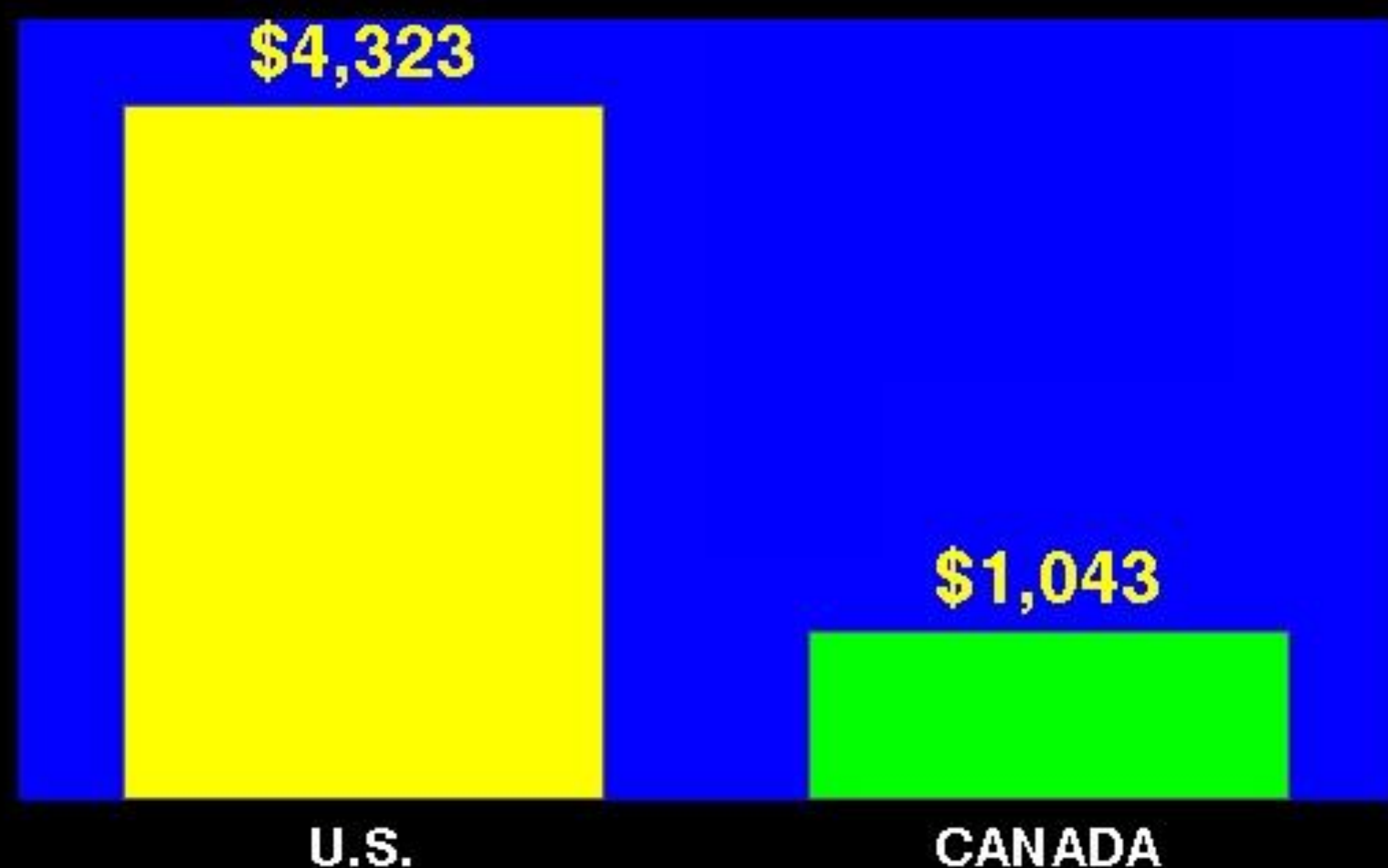
Note: Excludes non-billing-related costs for documentation compliance etc.



• Duke's costs to send
bills for one PCP:
\$99,000 annually

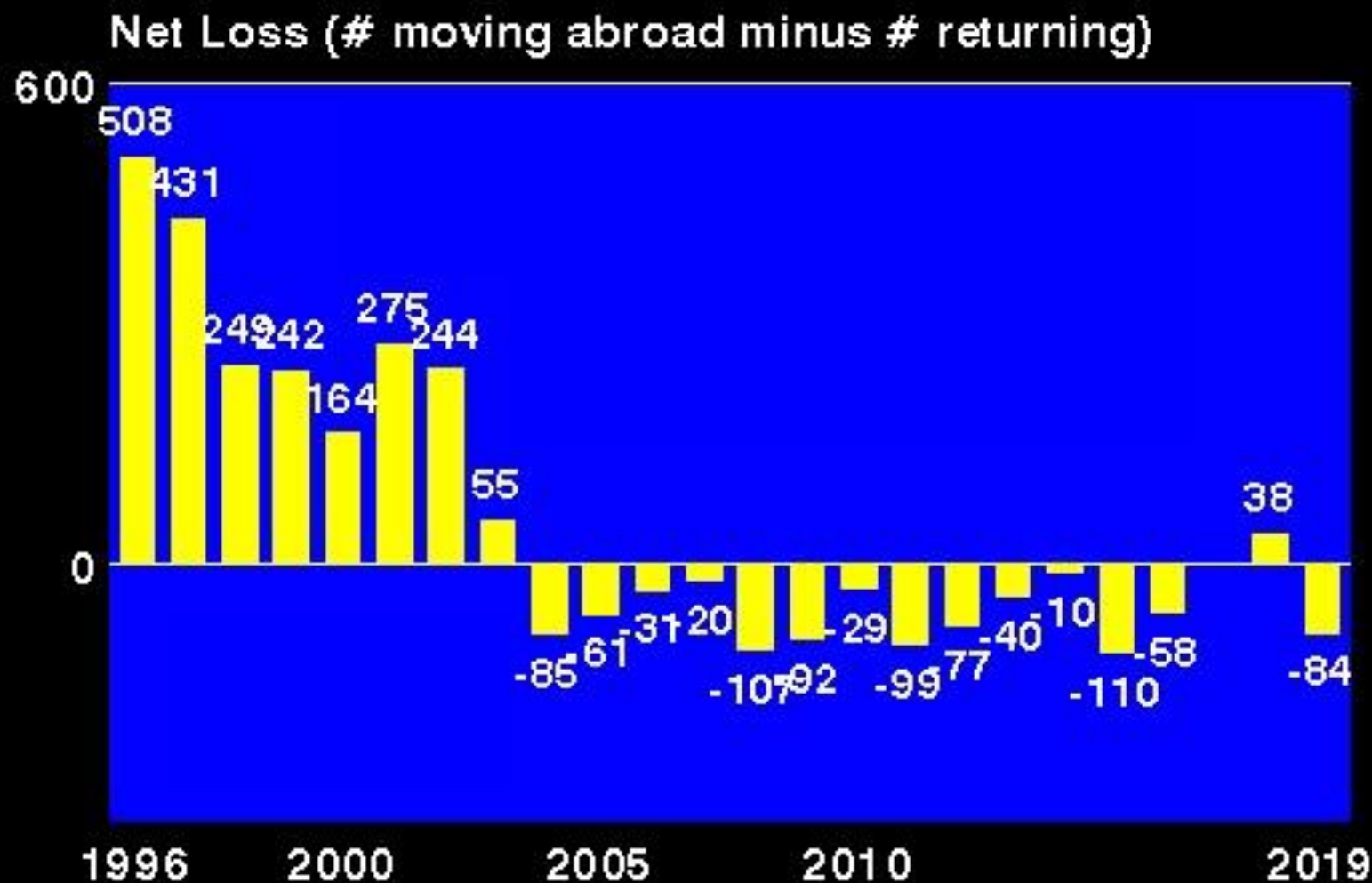
Source: JAMA 2018;319:691

Overall Administrative Costs Per Capita United States & Canada, 2021



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

Few Canadian Physicians Emigrate



Source: Canadian Institute for Health Information

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

Canadian Physicians' Incomes, 2018/2019

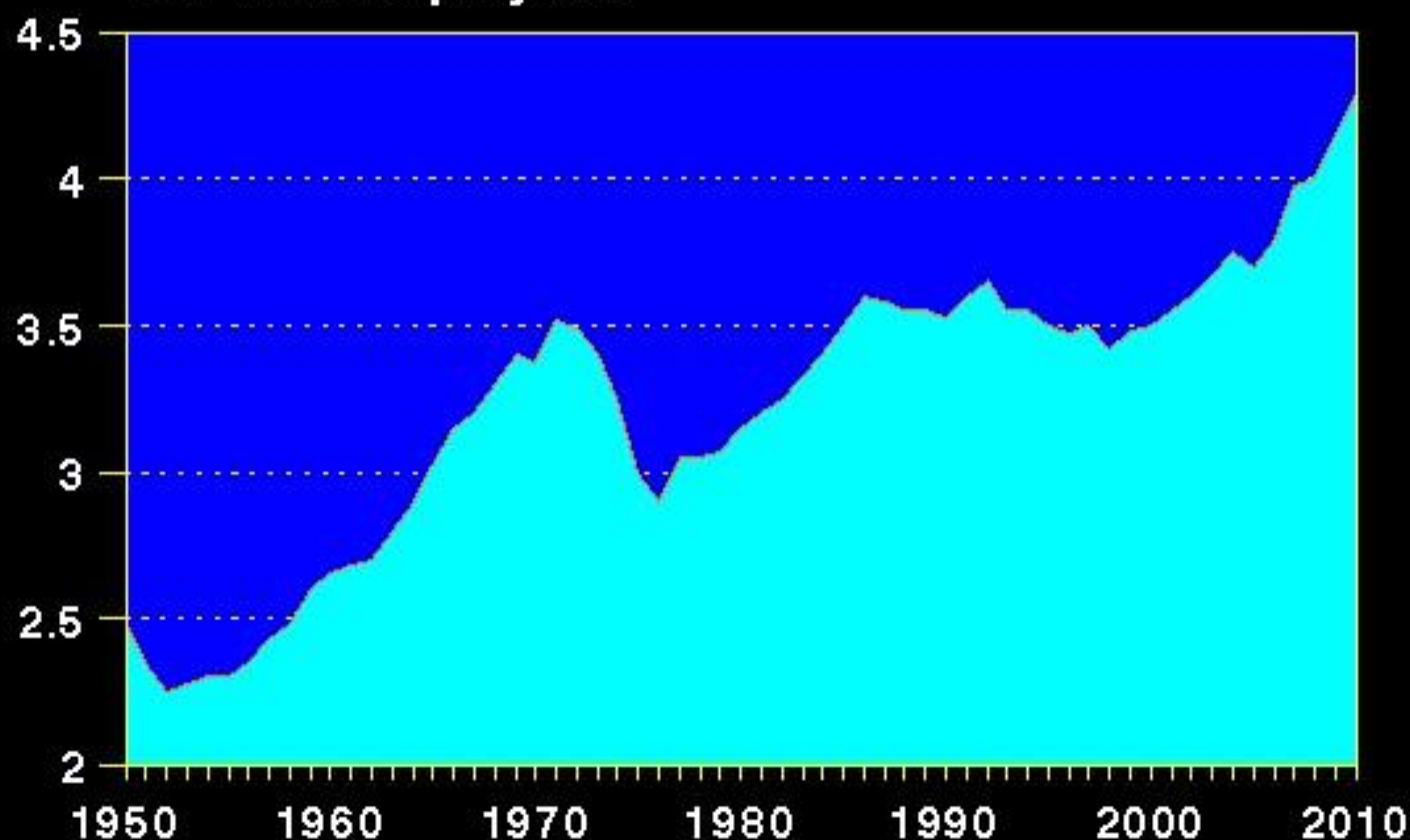
Average Clinical Payments Per Physician

Family Medicine	\$279,929
Int. Medicine	\$407,171
Pediatrics	\$296,010
Psychiatry	\$281,614
Dermatology	\$384,815
Ob/GYN	\$392,115
General Surg.	\$465,707
Thoracic Surg.	\$587,585
Cardiology	\$610,793
Ophthalmology	\$791,406
All Physicians	\$347,464

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

Trend In Canadian Physicians' Incomes, 1950-2010

Mean Physician Income As Multiple All Canadian Full Time Employees



Malpractice Insurance Costs in Canada, 2021

All Figures in Canadian \$s

Specialty	Ontario*	Quebec	BC & Alberta
Family Med	\$4,440	\$955	\$2,988
Psychiatry	\$4,440	\$955	\$2,988
Cardiology	\$7,500	\$1,007	\$4,272
Anesthesia	\$10,884	\$1,033	\$6,564
Neurosurgery	\$33,900	\$1,269	\$20,844
Obstetrics	\$63,552	\$3,178	\$38,640

Source: Canadian Medical Protective Association - www.cmpa-acpm.ca

* Government reimburses MDs for premiums above 1986 level

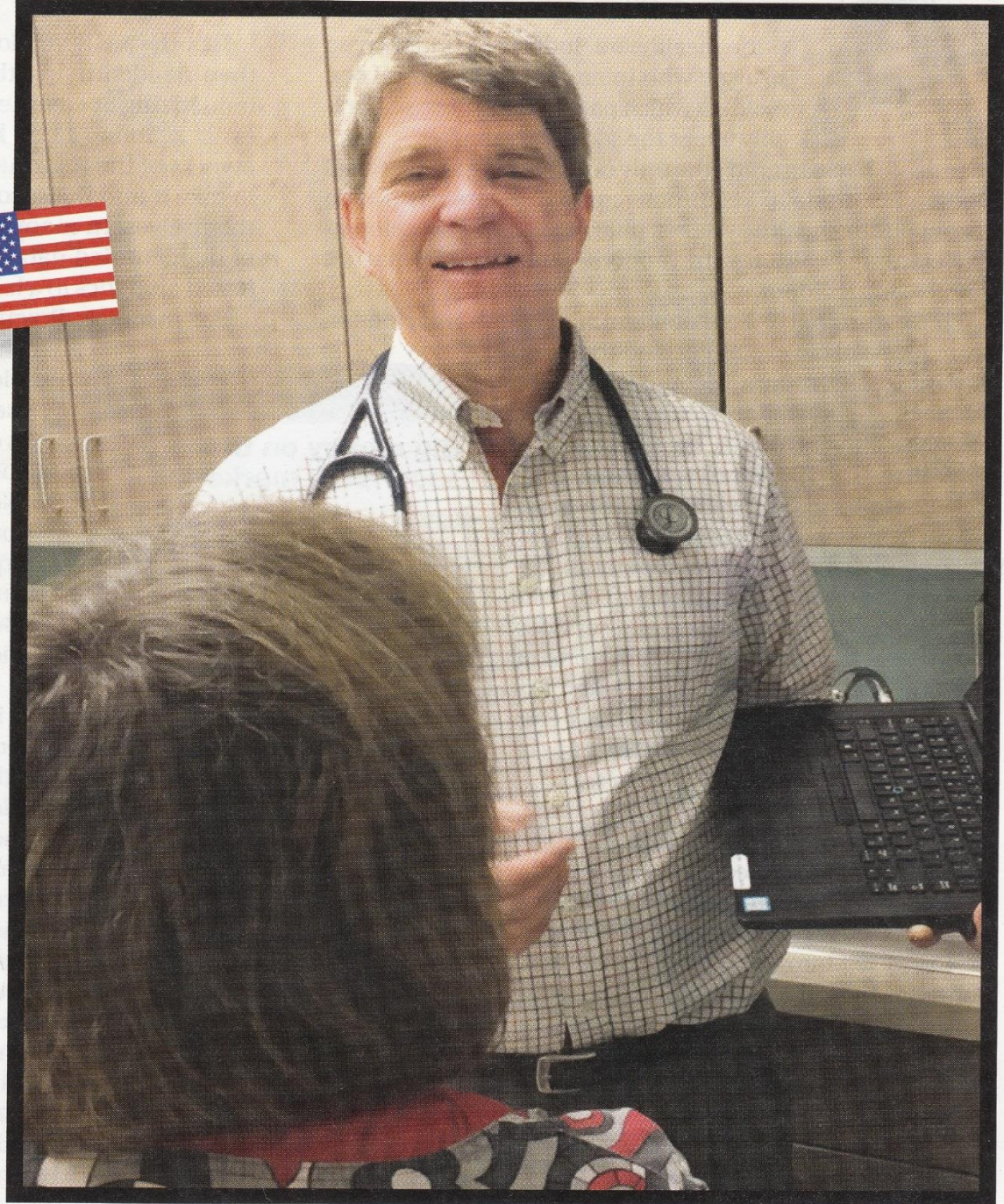


“It’s not a big hassle. I can focus on patient issues, not administrative issues.”

Dr. Trina Larsen Soles,
president of Doctors of
BC, which represents
physicians in British
Columbia

**"It's an
incredible
bureaucratic
mess to get
anything
done for
patients."**

Dr. John Cullen,
president-elect
of the American
Academy of Family
Physicians



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

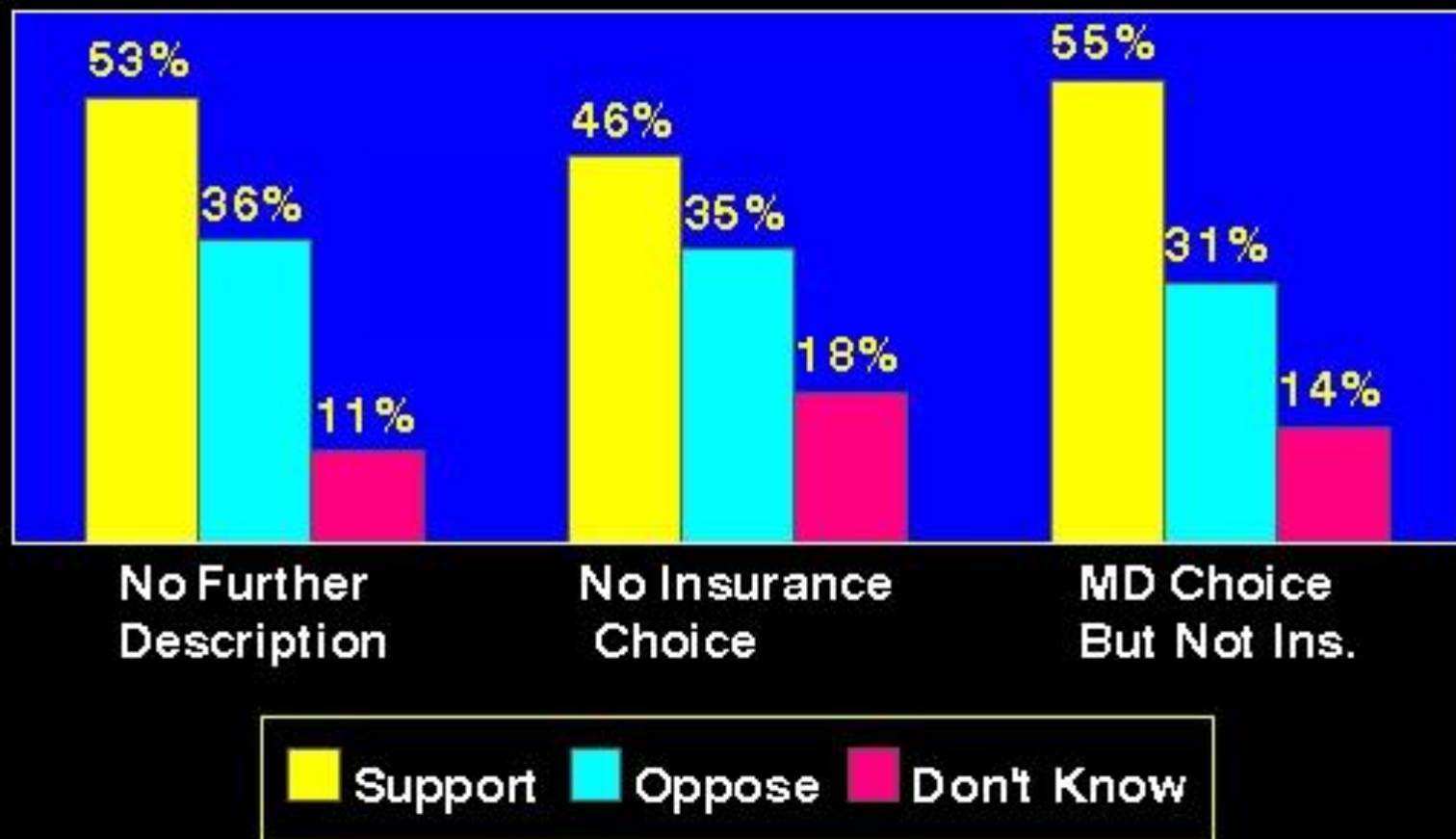
What's the Matter in Canada?

- 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 . . .

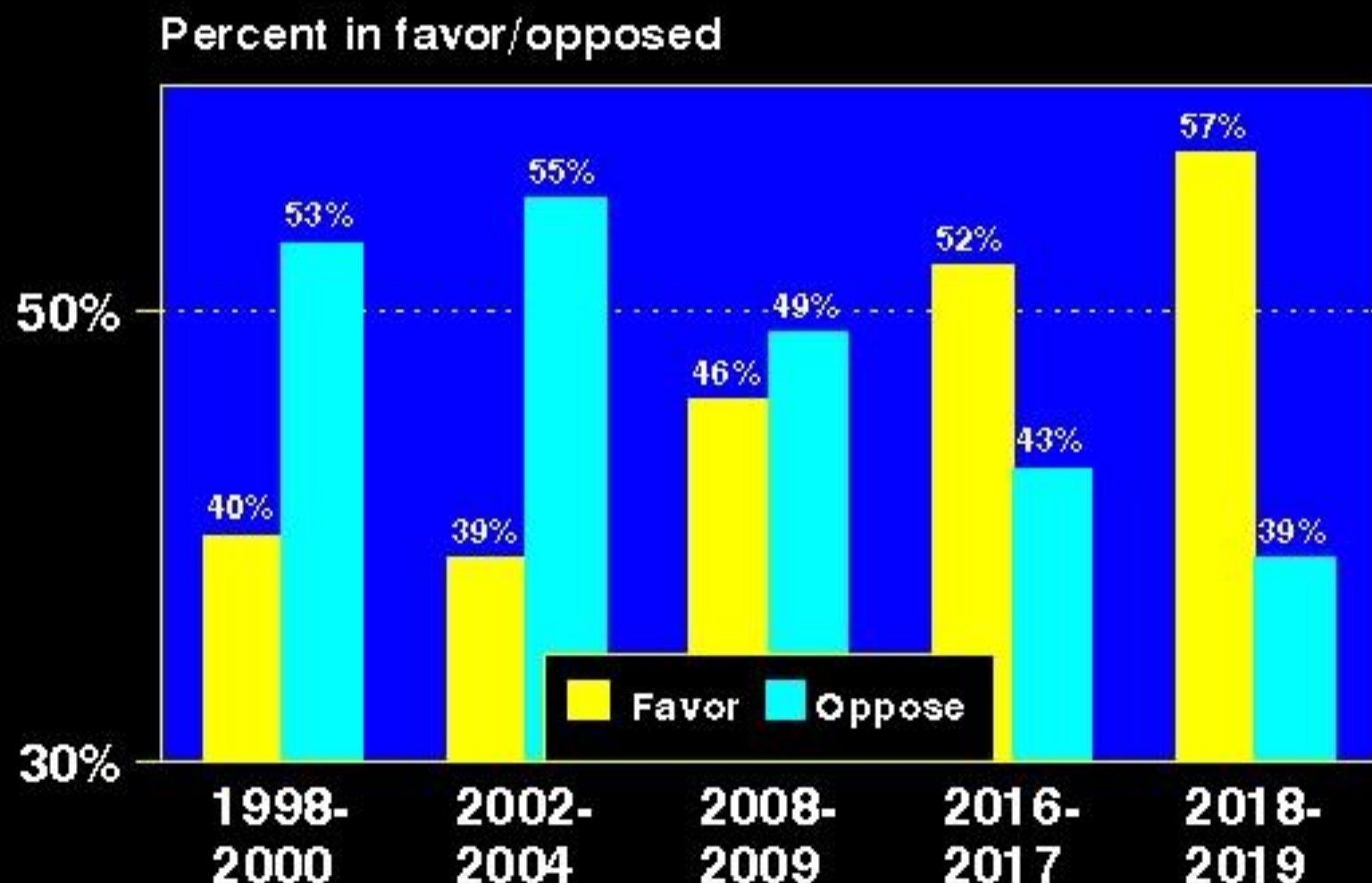


Source: Morning Consult July, 2019

Note: Question asked about choice of doctor AND hospital

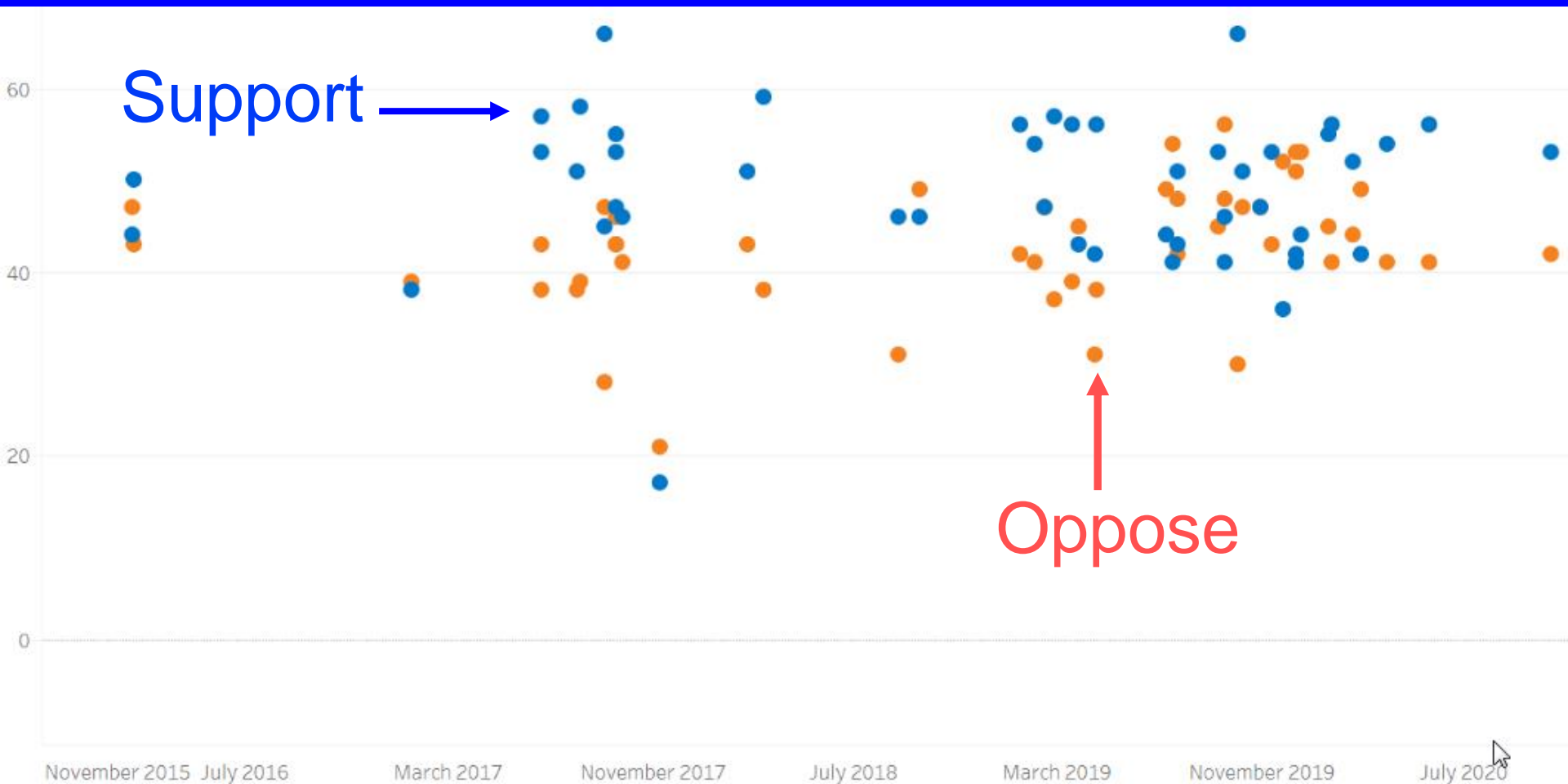
Increasing Support for Single Payer

"All Americans Would Get Their Insurance from a Single Government Plan"

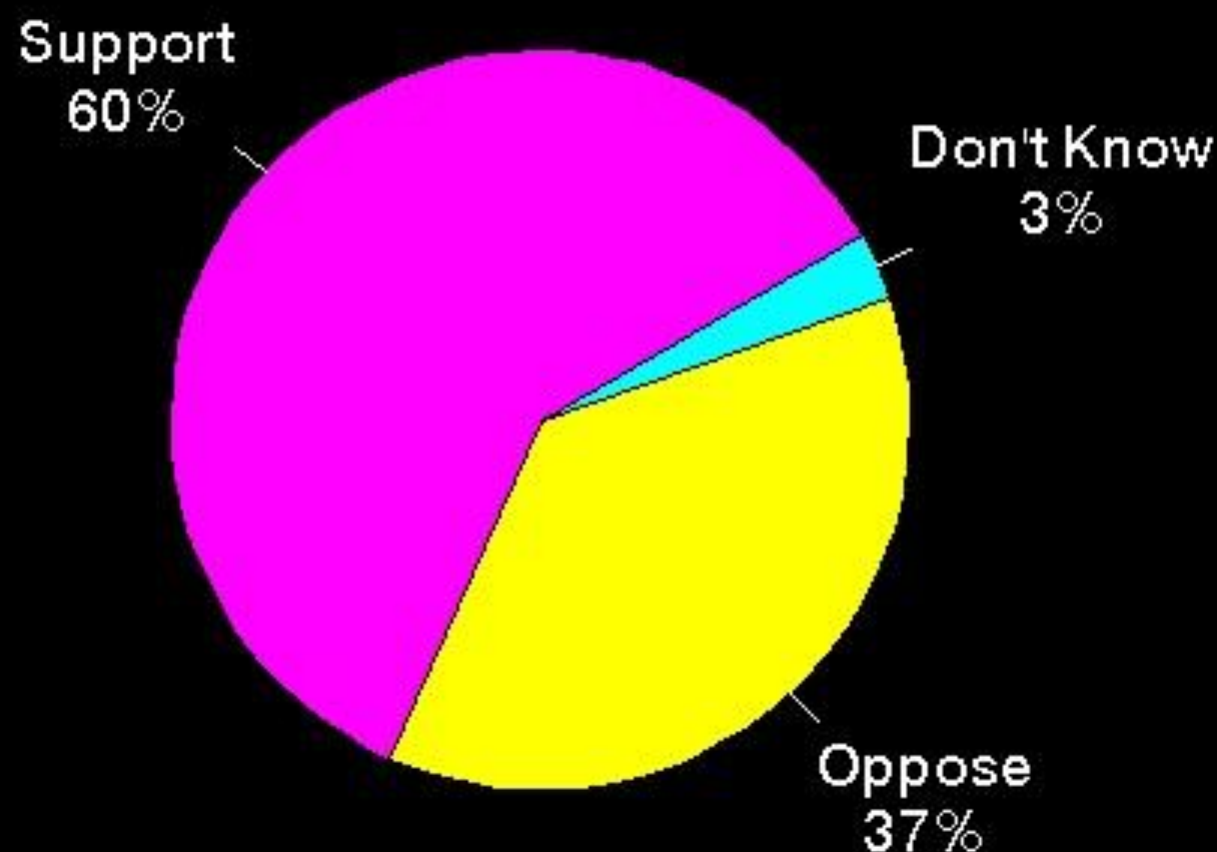


Source: Kaiser Family Foundation Polls

Polls: Consistent Support For M4A, Nov. 2015 – July 2020



2021 Poll: 60% Want Medicare for All

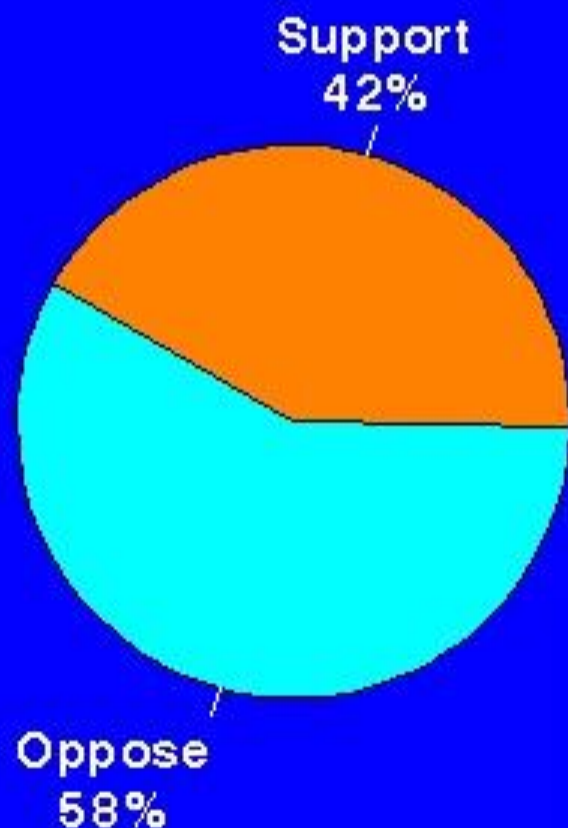


Source: Commonwealth Fund/Harvard Public Health School Survey January, 2021

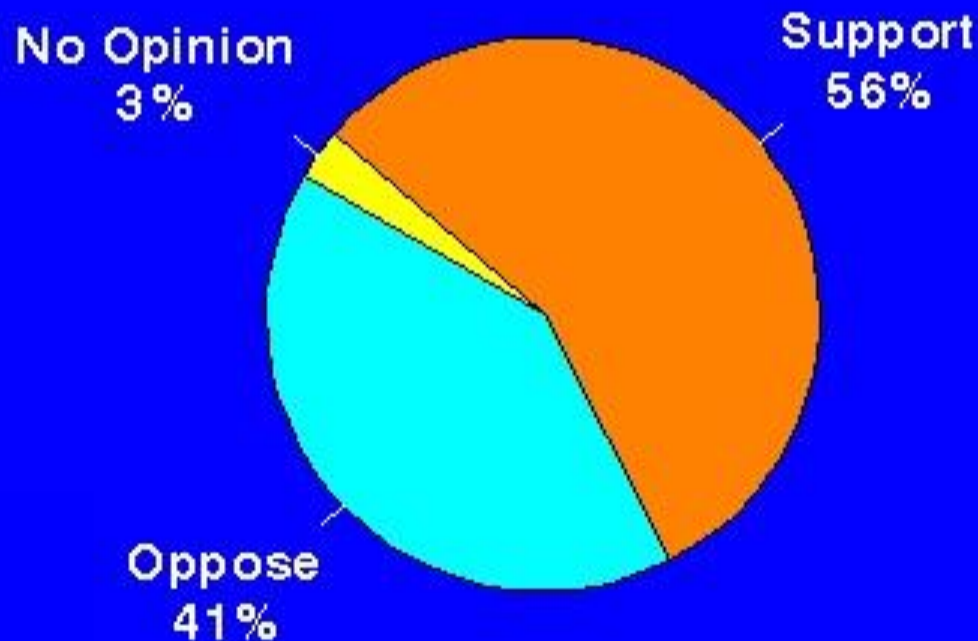
"Do you support/oppose changing our health care system so that all Americans would get health insurance from Medicare ... paid for by taxpayers ... often called Medicare for all"

Most Doctors Favor Single Payer

Support Has Sharply Increased



2008



2017

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

Medicare & Medicaid →
State, local government →
Employers →
Private insurance revenues →
New Taxes →

N
H
P

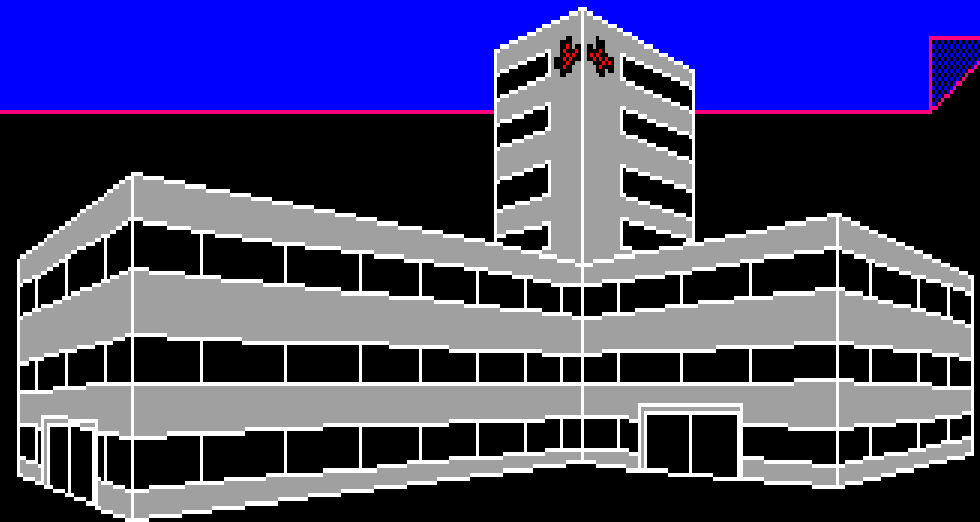
F
U
N
D

RECIPIENTS OF MONEY

→ Hospitals, operating
→ Hospitals, capital
→ HMOs
→ Fee-for-service MDs
→ Home Care Agencies
→ Long Term Care

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.

Current Senate and House Bills



Strengths



- Universal coverage, single public plan
- Comprehensive acute care benefits
- No copays for covered services
- Bans duplicative private coverage
- Exemption from Hyde Amendment
- Drug formulary and price negotiations

Current Senate and House Bills



Concerns



- Both allow for-profit providers, with constraints
- Senate bill: Adopts Medicare's needlessly complex payment strategies, raising administrative burdens/costs and perpetuating incentives for upcoding etc., focusing on profitable services, etc.

Single Payer Transition:

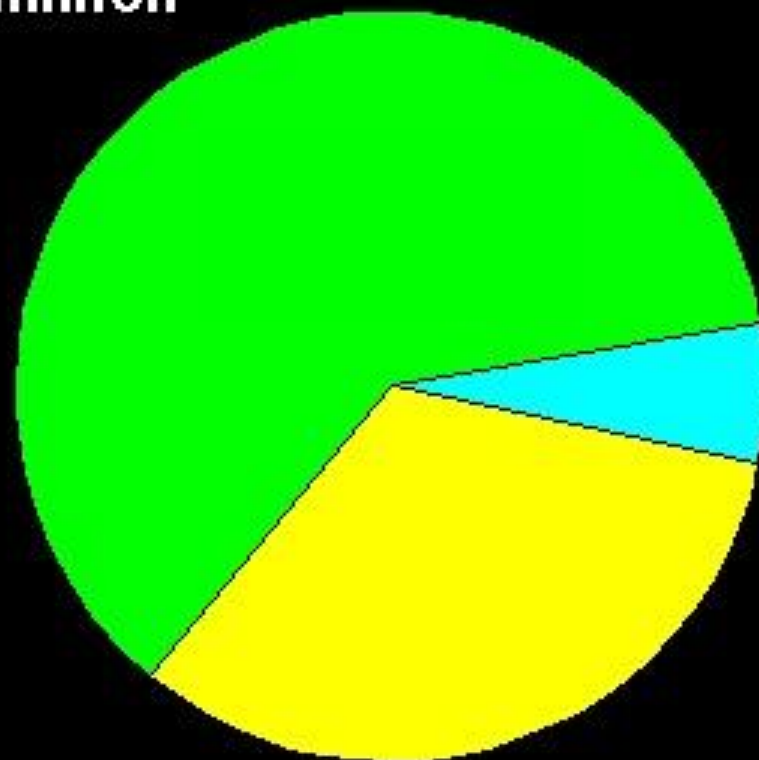
For Displaced Clerical and Administrative Workers

- 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.
- Job displacement is common in the US – 60 million/year, including 20 million who are fired: 1.7 million = number who are fired every 31 days. (source: People's Policy Report)

66.1 Million U.S. Workers Separated from Jobs in 2018

Putting Job Displacement Due to Single Payer Into Perspective

Quit - 41million



Other* - 4.1million

Laid off/fired - 21.9million

Source: Bureau of Labor Statistics - Job Opening and Labor Turnover Survey, January, 2019

* Other includes deaths, retirements, transfers, disability

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
or
Medicare for More?

Single Payer and Private Coverage

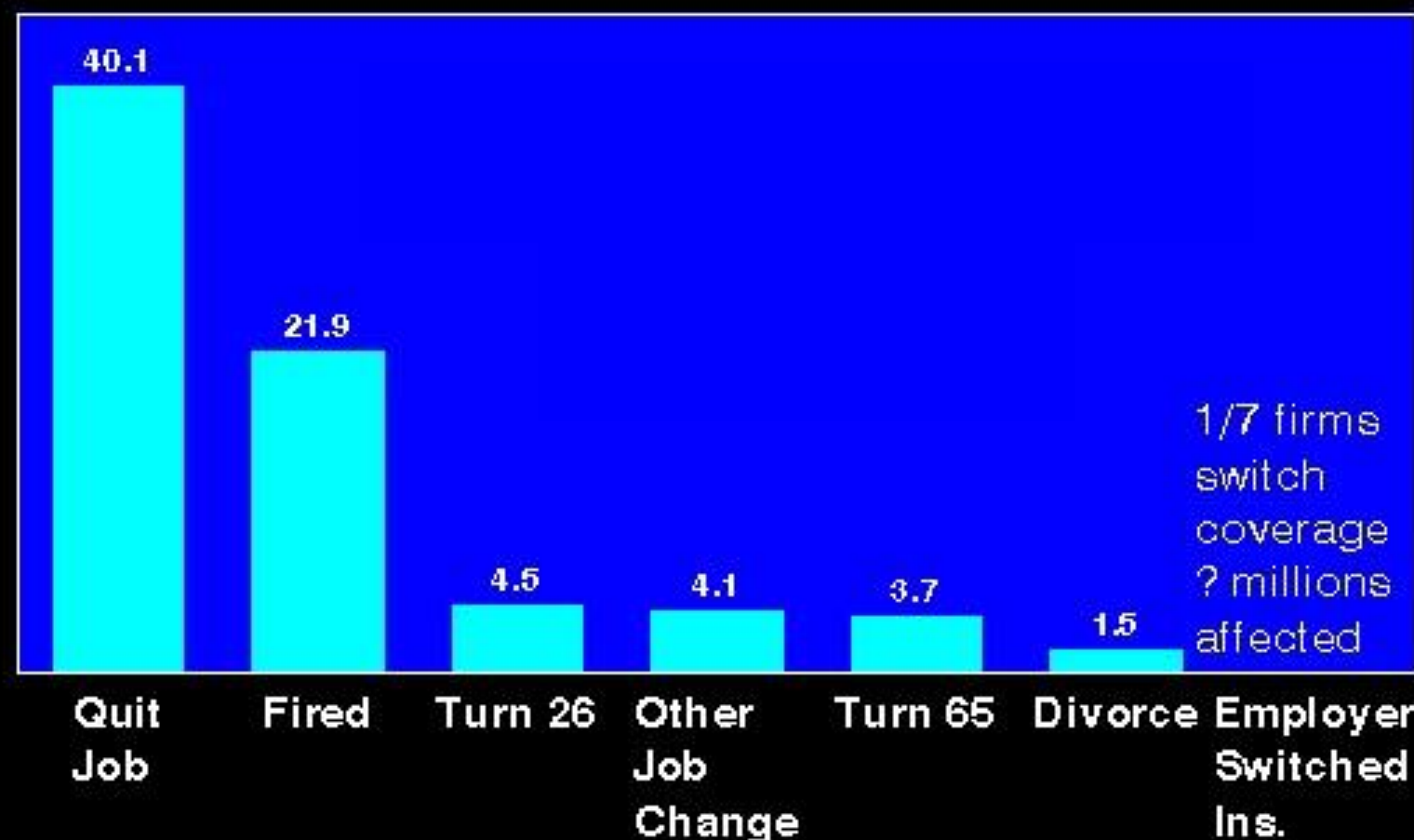
- **Allowed:** Supplemental non-competing – but can only cover benefits NOT covered by the public plan.
- **Banned:** Private insurance (including Medicare Advantage) duplicating public plan benefits – Key to administrative savings.

Public Option Rhetoric

- “Don’t strip 150 million Americans of their private insurance; let them choose”
- “M4A means a giant tax increase”
- “If public is better, it will outcompete private insurance”
- “There’s lots of ways to get to universal care”

Millions Lose Private Insurance Every Year

affected (millions)



Source: Bruenig - Jacobin Blog Post July, 2019

Other reasons for involuntary switch: Employer stopped offering coverage; coverage too expensive; policy holder died; hours dropped

Transitioning to Germany

- Non-profit sickness funds: boards $\frac{1}{2}$ union, $\frac{1}{2}$ employer.
- All insurers pay same rates and include every doctor, every hospital.
- States fund most hospital capital investment.
- Single payer for long term care.

Transitioning to Switzerland

- Mandatory coverage sold ONLY by non-profit insurers.
- All insurers pay same rates and include every doctor, every hospital.
- Cantons fund most hospital capital investment.
- Only US has higher health costs.

Transitioning to Netherlands

- Developed as German-style universal coverage.
- Private insurers introduced 2006.
- Doctors now complain of unbearable administrative burdens, and rupture of cooperation.
- Hospital administrative costs 2nd only to US.
- Single payer for long term care.

65% of Dutch GPs Sign Manifesto: “Everything Must Change”

- “Insurers have too much power”
- “Bureaucracy is growing”
- Remove doctors from Competition Act* and make “cohesion through cooperation” the guiding principle in primary care

*Act forces each GPs to negotiate individual contract with insurers

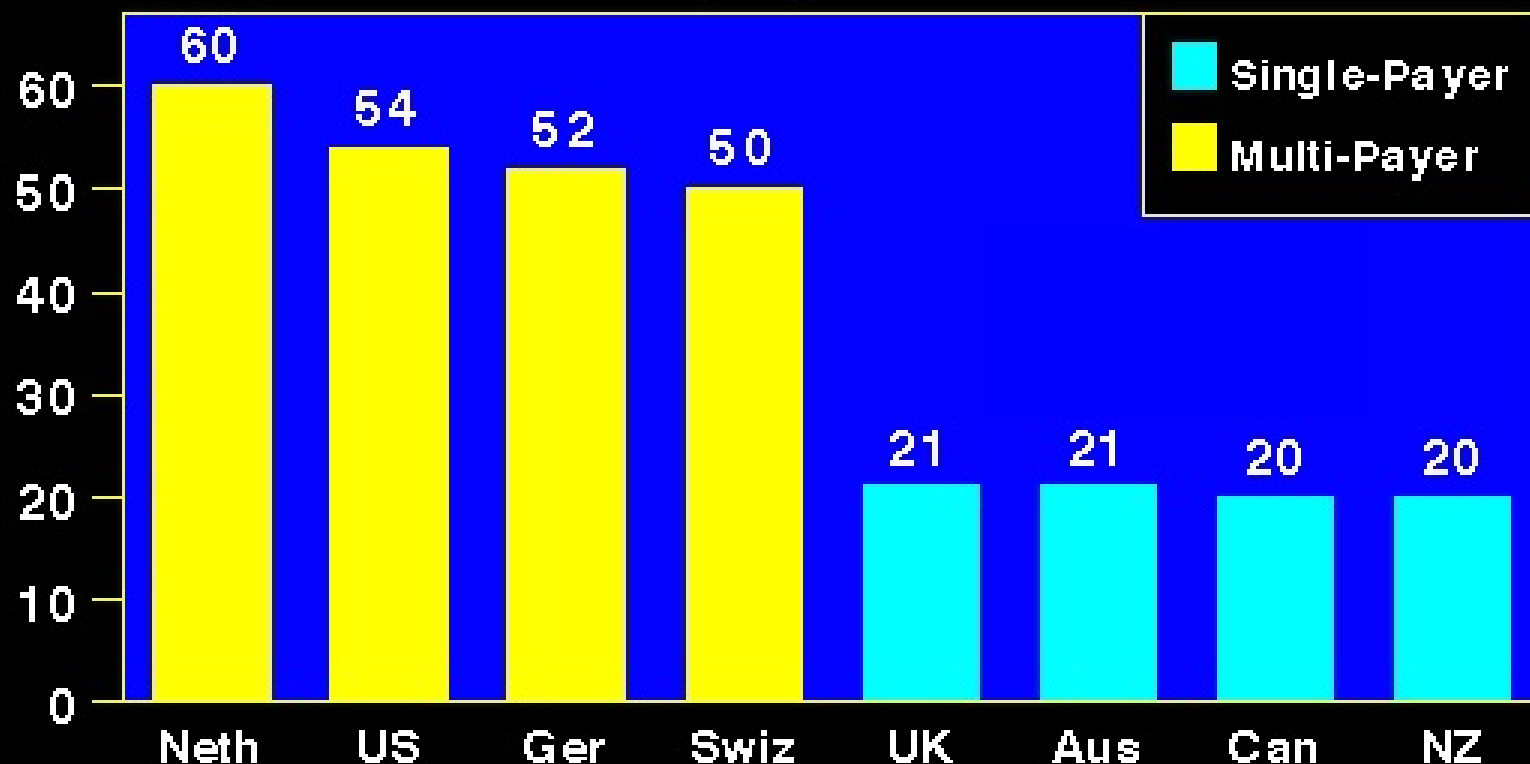
Source: “Competition Hurts Healthcare: Doctors” NL Times 4/17/15

“Insurers in the Netherlands and Switzerland are not as a matter of public policy conceived of as private businesses and in important respects they are not allowed to function as private businesses. The Dutch and Swiss models--built on a uniform mandated benefit package, a limited menu of cost sharing, and provider rate regulation-- are not the models that private insurers in the United States are in fact advocating, but rather represent a quite different tradition based on social solidarity and not on market competition.”

“They have not, moreover, been successful in holding down costs or expanding access to insurance. Finally, their experience demonstrates again the tendency of insurers—even nonprofit insurers--to compete based on risk selection rather than cost, and the difficulty posed by trying to control this tendency through legal regulation.”

Doctors in Multi-Payer Systems Have More Insurance Hassles

Percent of doctors reporting that time spent on insurance/claims is "major problem"



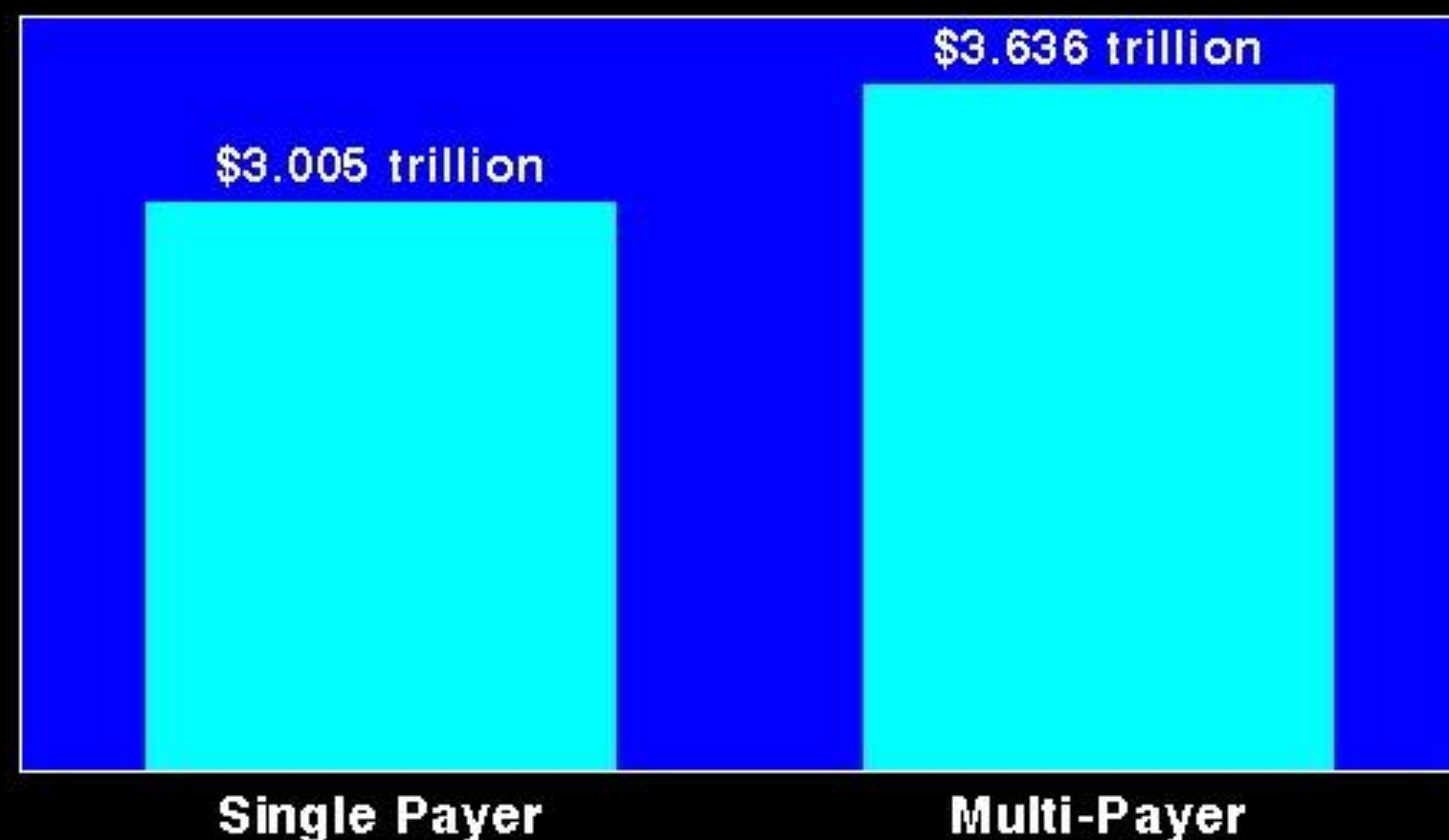
Public Option = High Costs

- 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 etc.
- Higher system-wide costs (compared to single payer) assure political pressure for benefit cuts.

For Any Level of Spending,
Single Payer Would
Purchase More Care and
Less Administration
Than Public Option

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

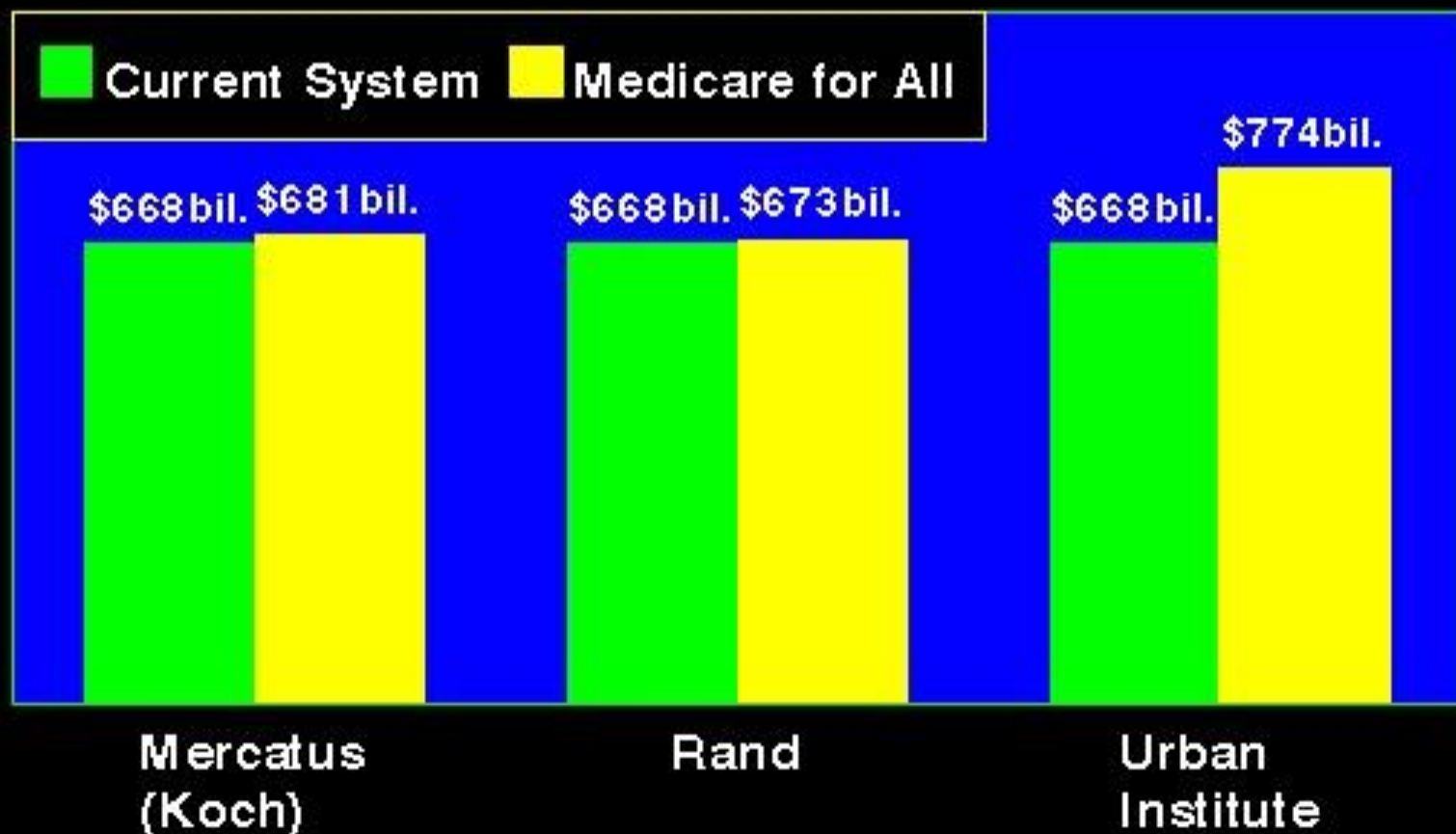
Total health expenditures/year



Source: Galvani & Fitzpatrick, Lancet 2020;395:1692

Total Payments to America's ~ 1 Million Physicians With and Without Medicare for All

Three Recent Estimates by Single Payer Skeptics



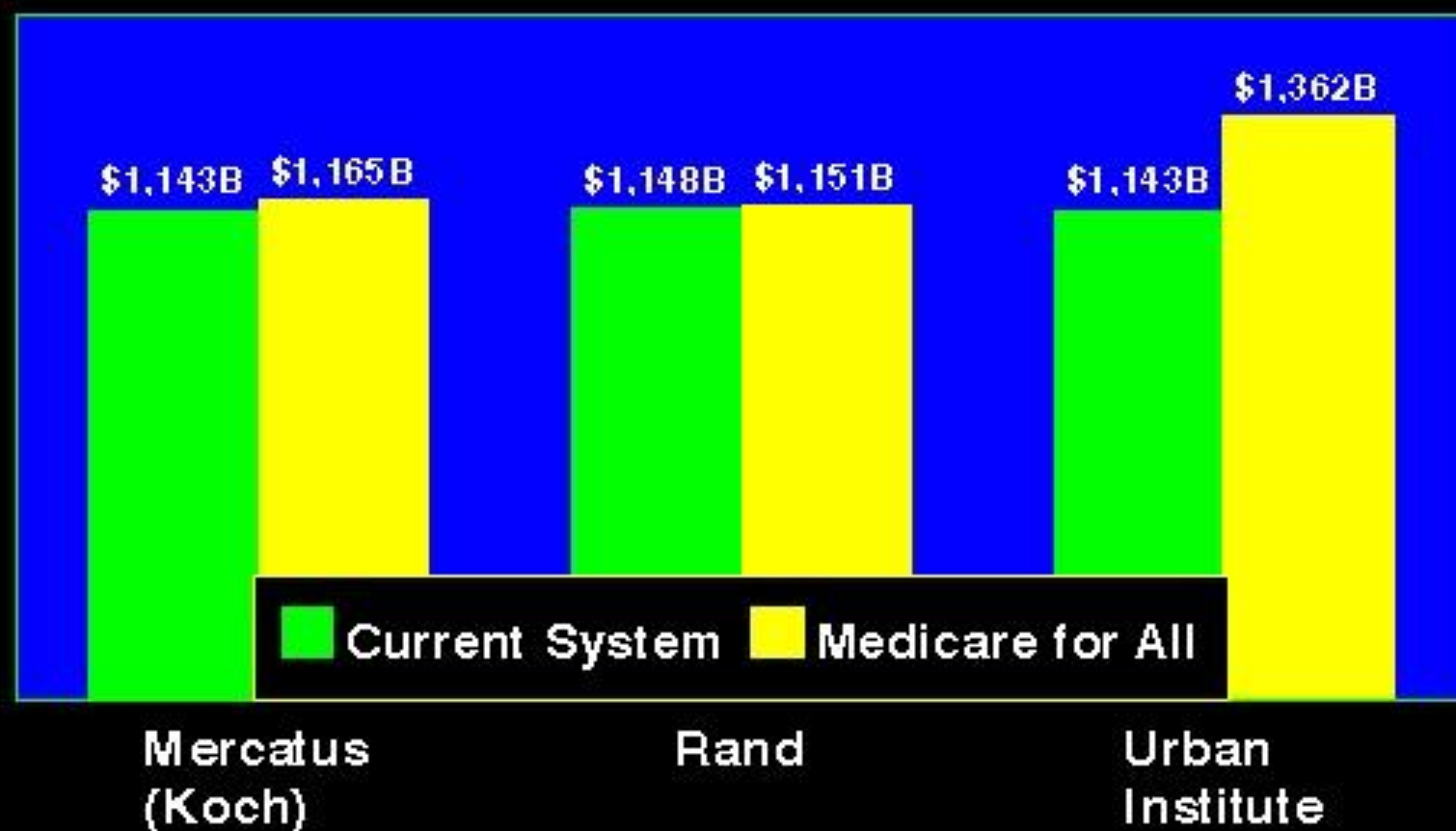
Sources: Rand Corporation (2019), Urban Institute (2016), Mercatus Center (2018)

Note: Percentage estimates from original studies, applied to 2019 total physician expenditures

Note: Urban argued that "physician incomes would be squeezed" even as payments rose by >\$100 bil.

Total Payments to America's ~ 5,500 Hospitals With and Without Medicare for All

Three Recent Estimates by Single Payer Skeptics

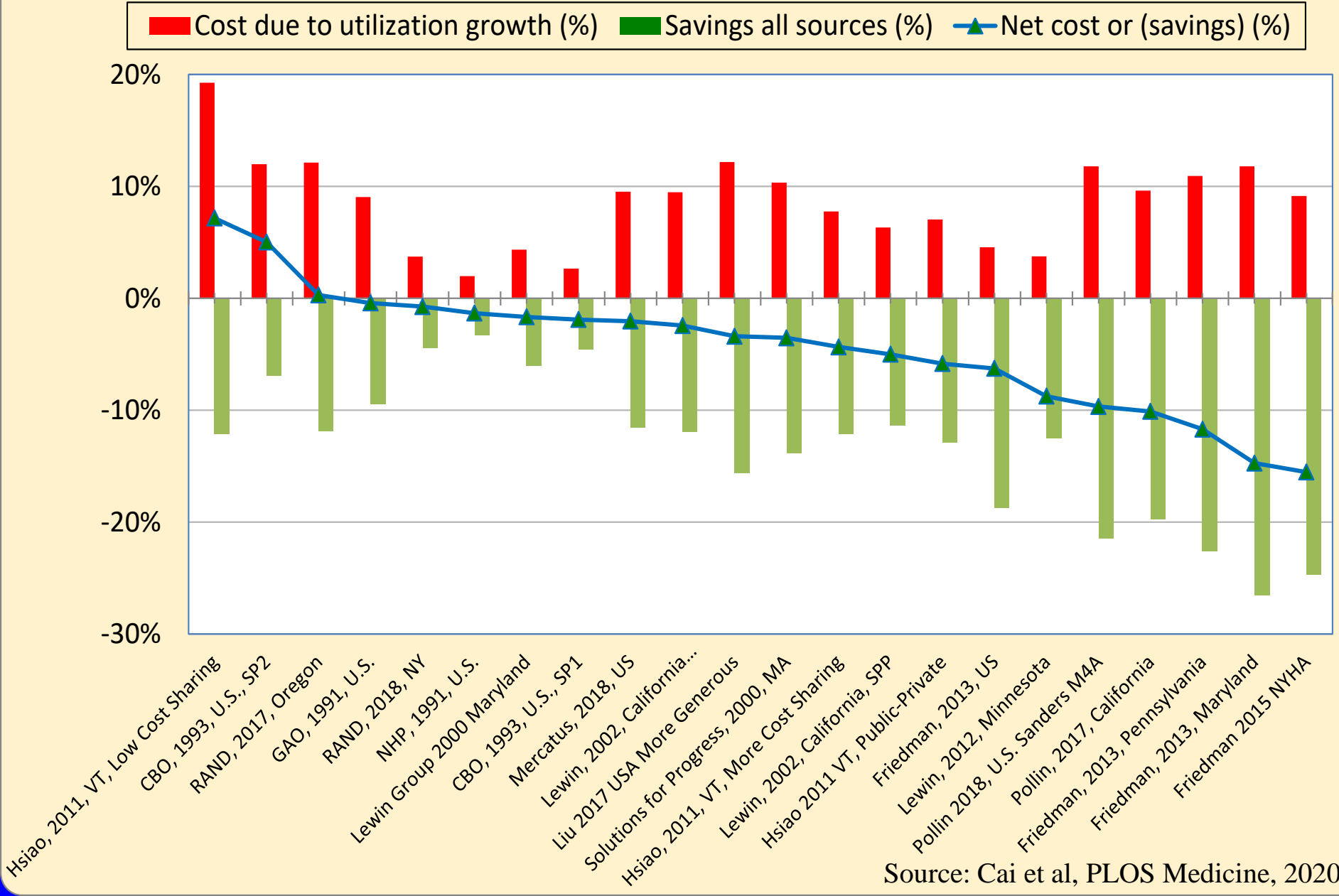


Sources: Rand Corporation (2019), Urban Institute (2016), Mercatus Center (2018)

Note: Percentage estimates from original studies, applied to 2017 total hospital payments

Note: Urban's 2019 estimate is similar to 2016 estimate overall, but lacks detail.

Single Payer Estimated Utilization, Savings, & Net, by Net Cost/Savings





THE NEW
**NATIONAL
HEALTH
SERVICE**

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a “charity”. You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

“...There are no charges, except for a few special items”

“...no insurance qualifications”

An equal right to healthcare