

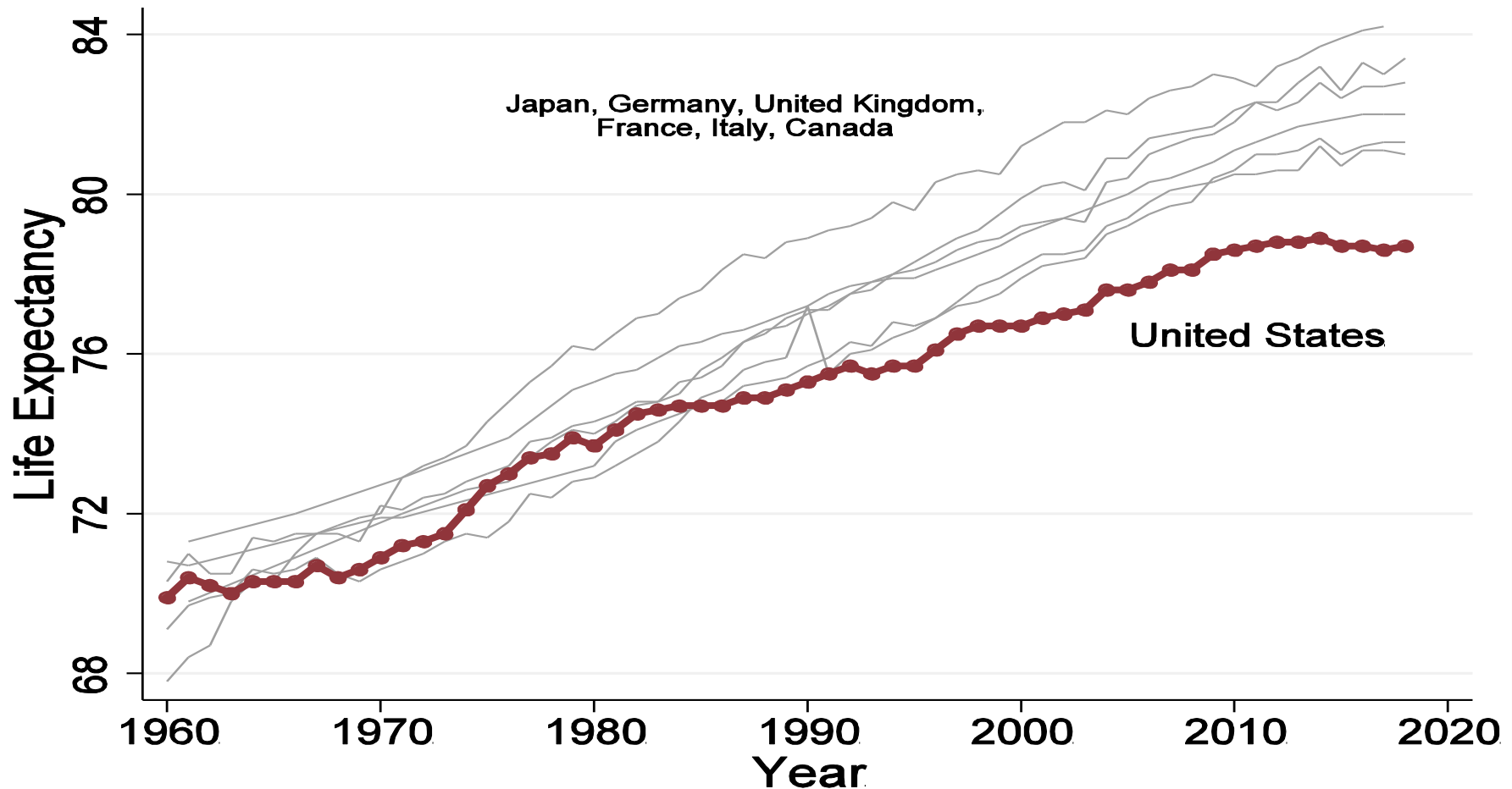


**Slides prepared by Drs. Steffie Woolhandler & David Himmelstein, Faculty at the City University of New York at Hunter College and Harvard Medical School, and Research Associates, Public Citizen Health Research Group**

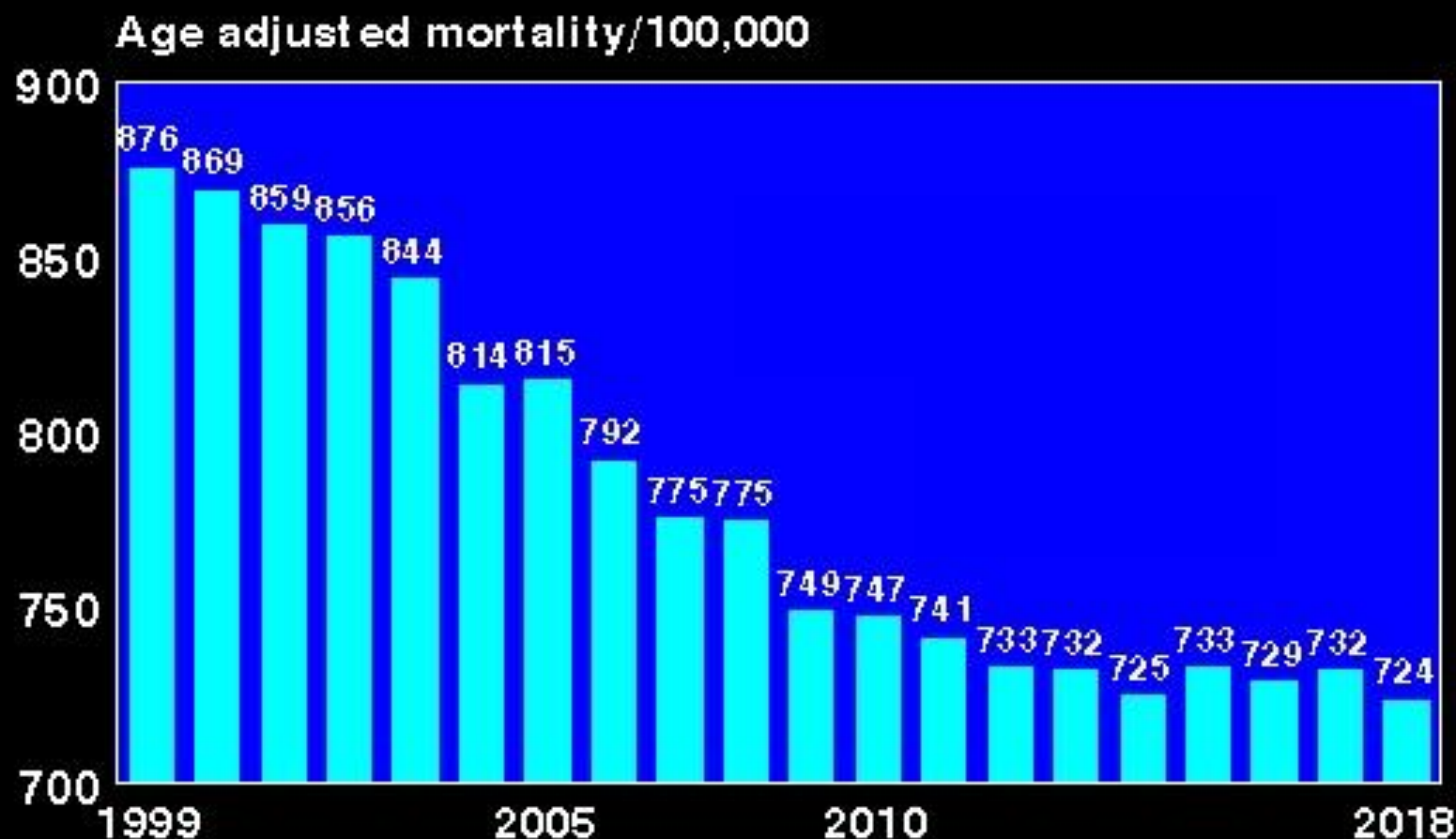
# Why was the U.S. so Vulnerable to COVID-19?

- 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.

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



# Progress on Mortality Halted



Source: NCHS

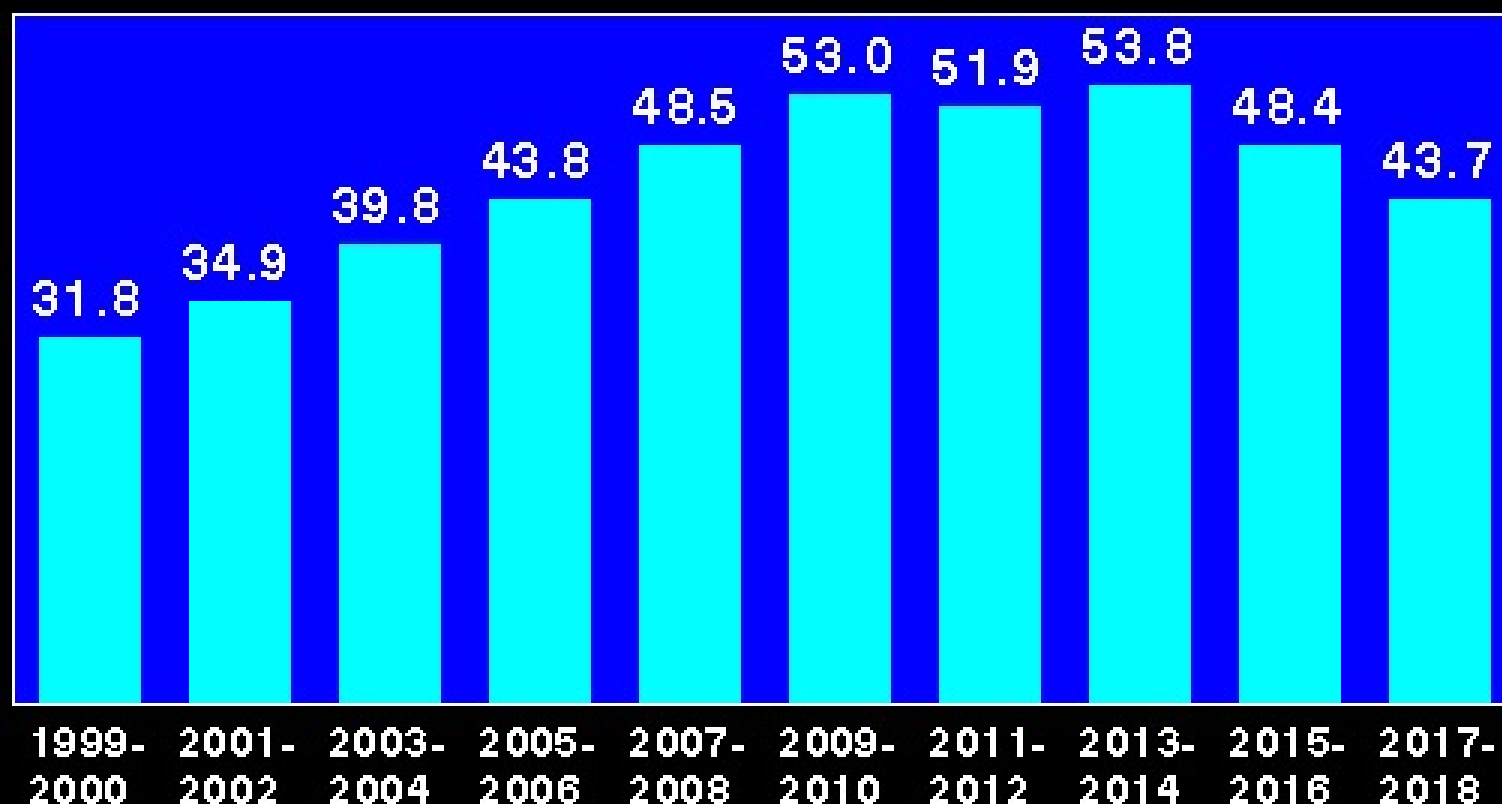
Note: Data for 2017 is preliminary



# Worsening Blood Pressure Control

A Rising Share of US Adults Have Uncontrolled Hypertension

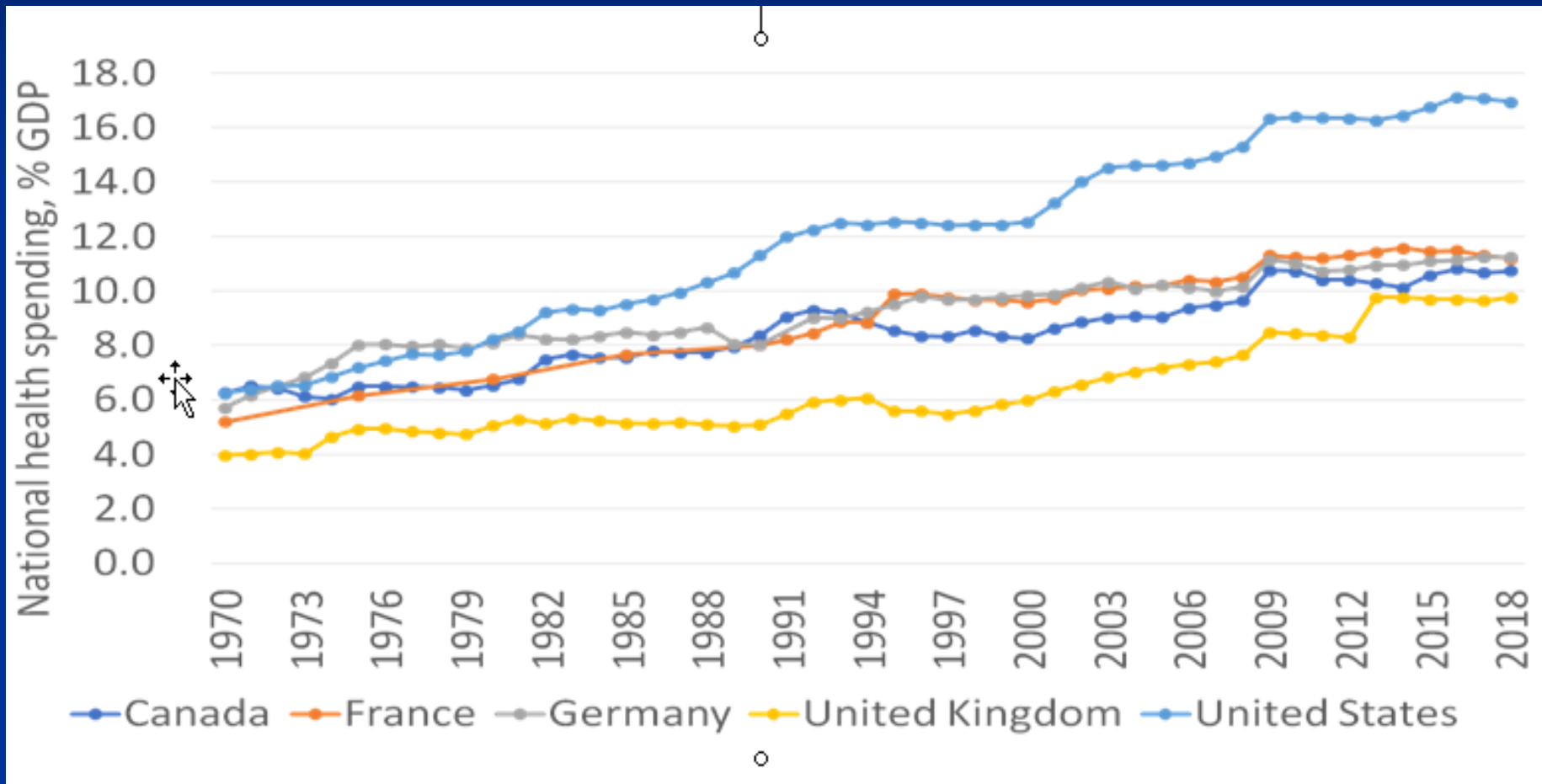
Percent of adults with hypertension whose BP was controlled



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

# 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.

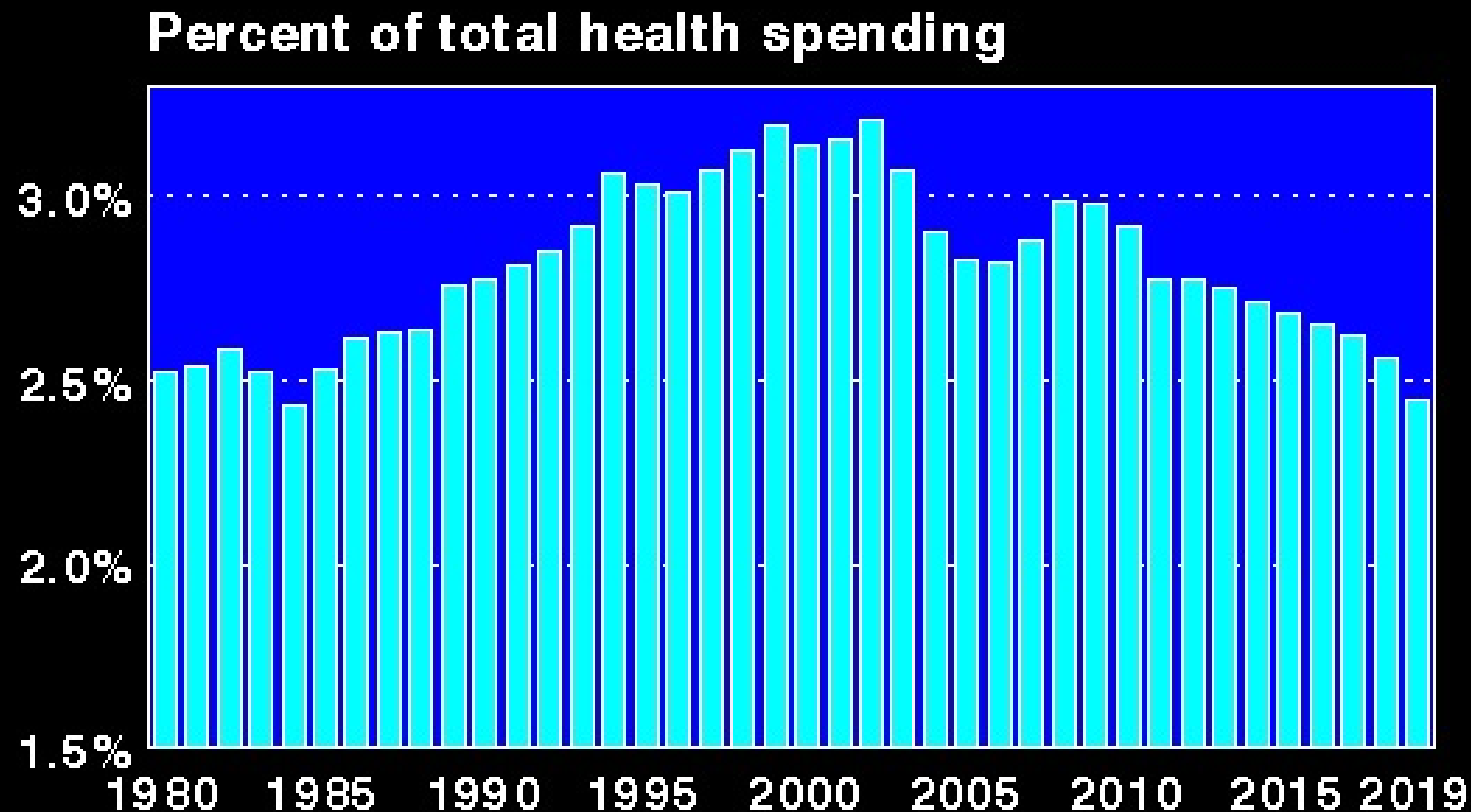
# Many Democrats Joined the Neoliberal Bandwagon

“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



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

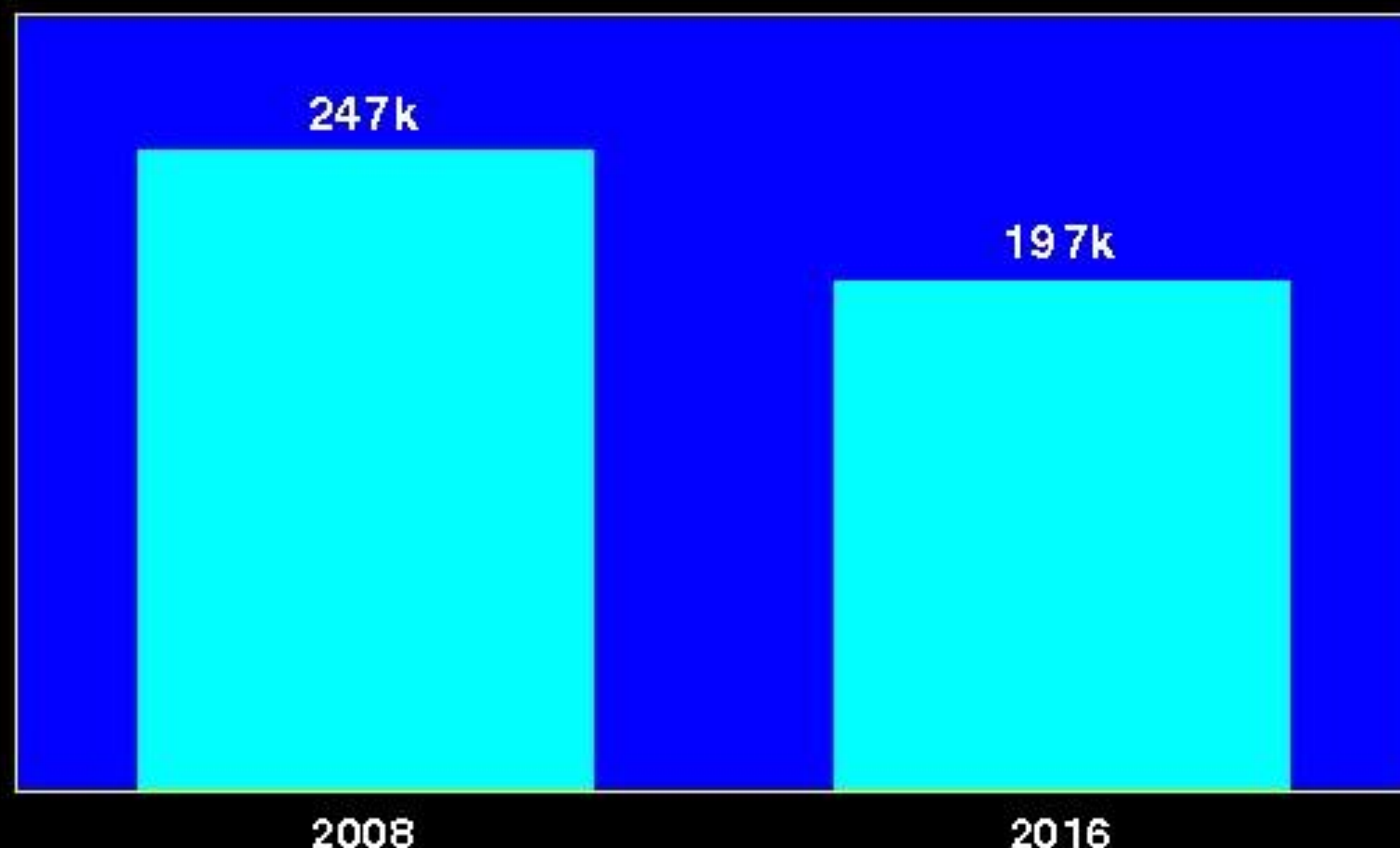


# Public Health Workforce Declined 20%

## Frontline Personnel to Fight Epidemics

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Number of personnel employed by state/local health departments

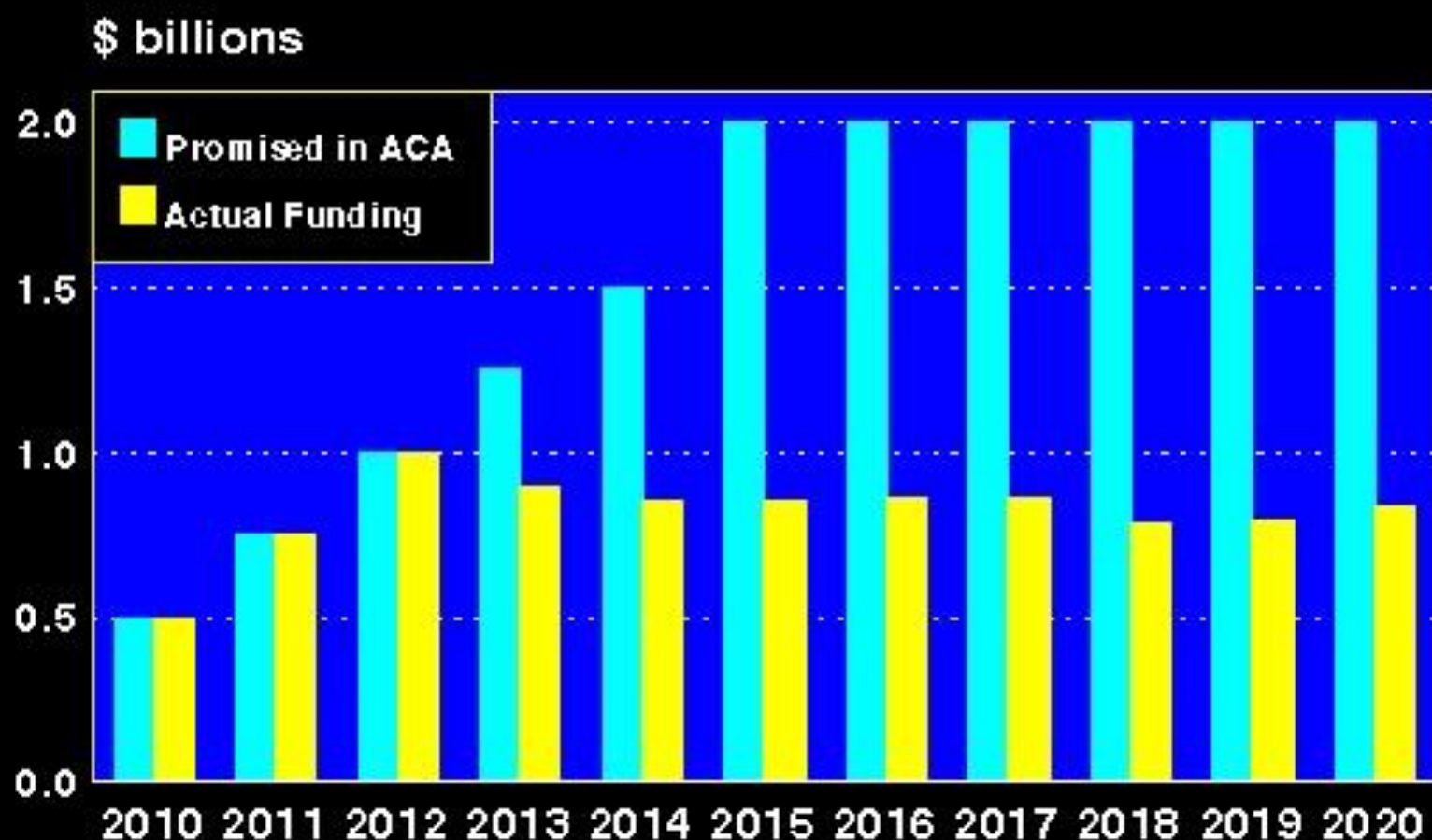


# How the ACA's \$15 bil. Public Health and Prevention Fund shrank to \$8.6 billion

- ACA promised \$15 billion over 10 years.
- 2012 - \$6 billion cut to pay for Medicare “doc fix”
- 2013 - HHS used \$450 million to build ACA's federal exchange, \$67 million for ACA navigators
- 2016 - \$3.5 billion cut as part of the 21st Century Cures Act.
- 2017 - \$750 million cut by continuing resolution.
- 2018 - \$1.35 billion cut over 10 years.

# The Incredible Shrinking Public Health and Prevention Fund

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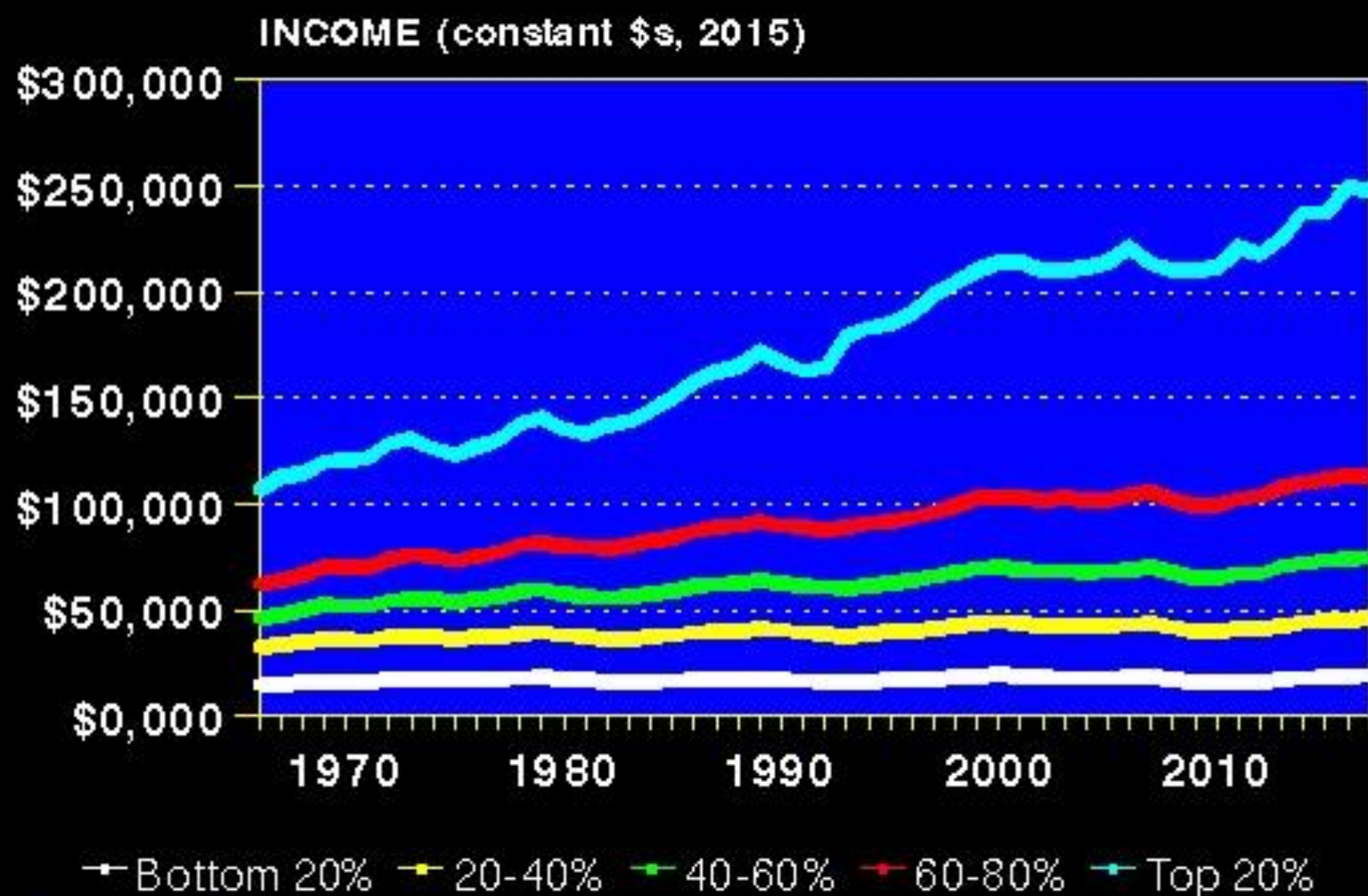
# Trump Further Weakened Pandemic Response Capacity

- 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.



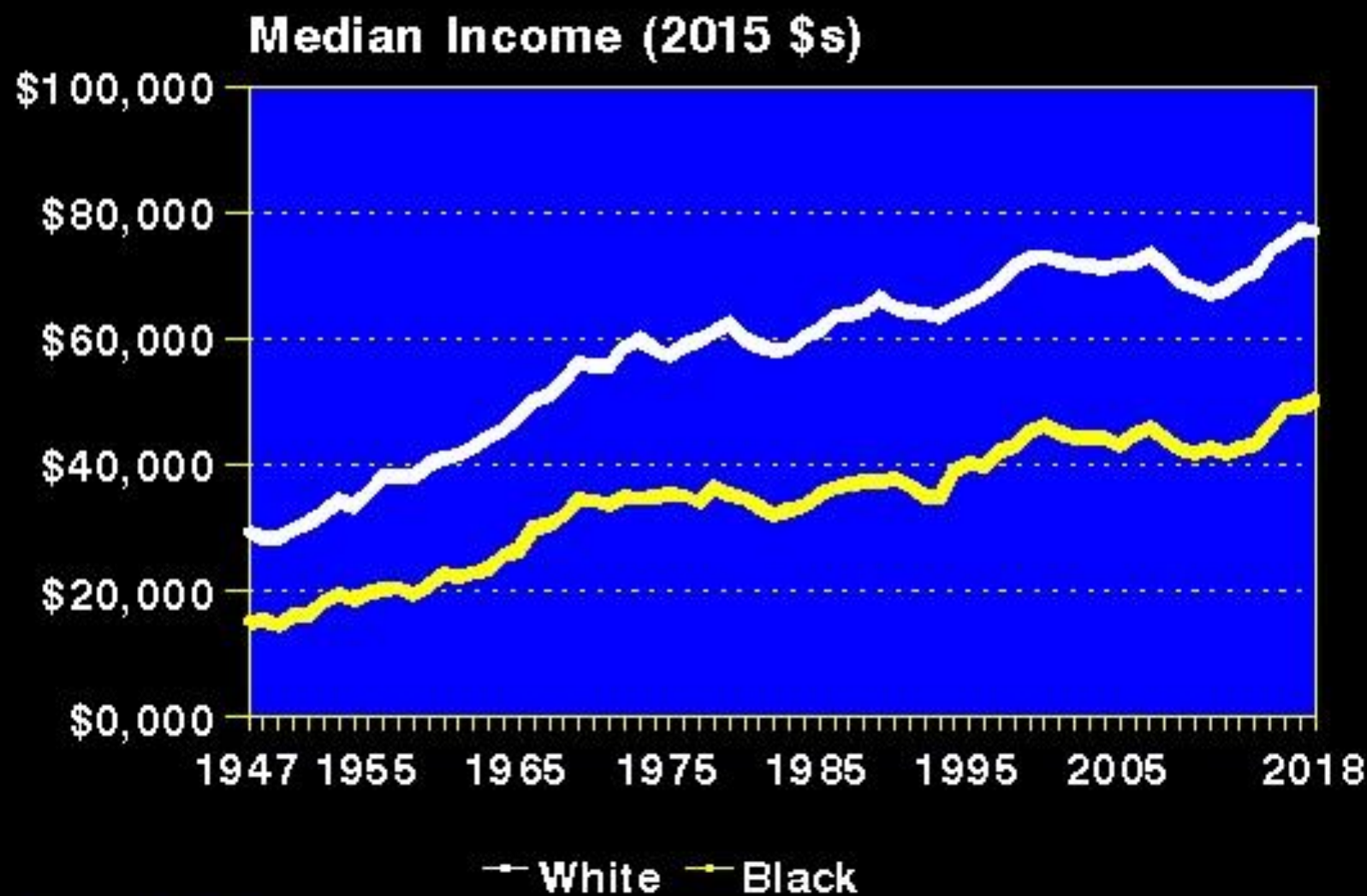
# Increasing Economic Inequality

# Mean Family Income for Each Fifth: 1966-2018 (Inflation Adjusted)



Source: Bureau of the Census

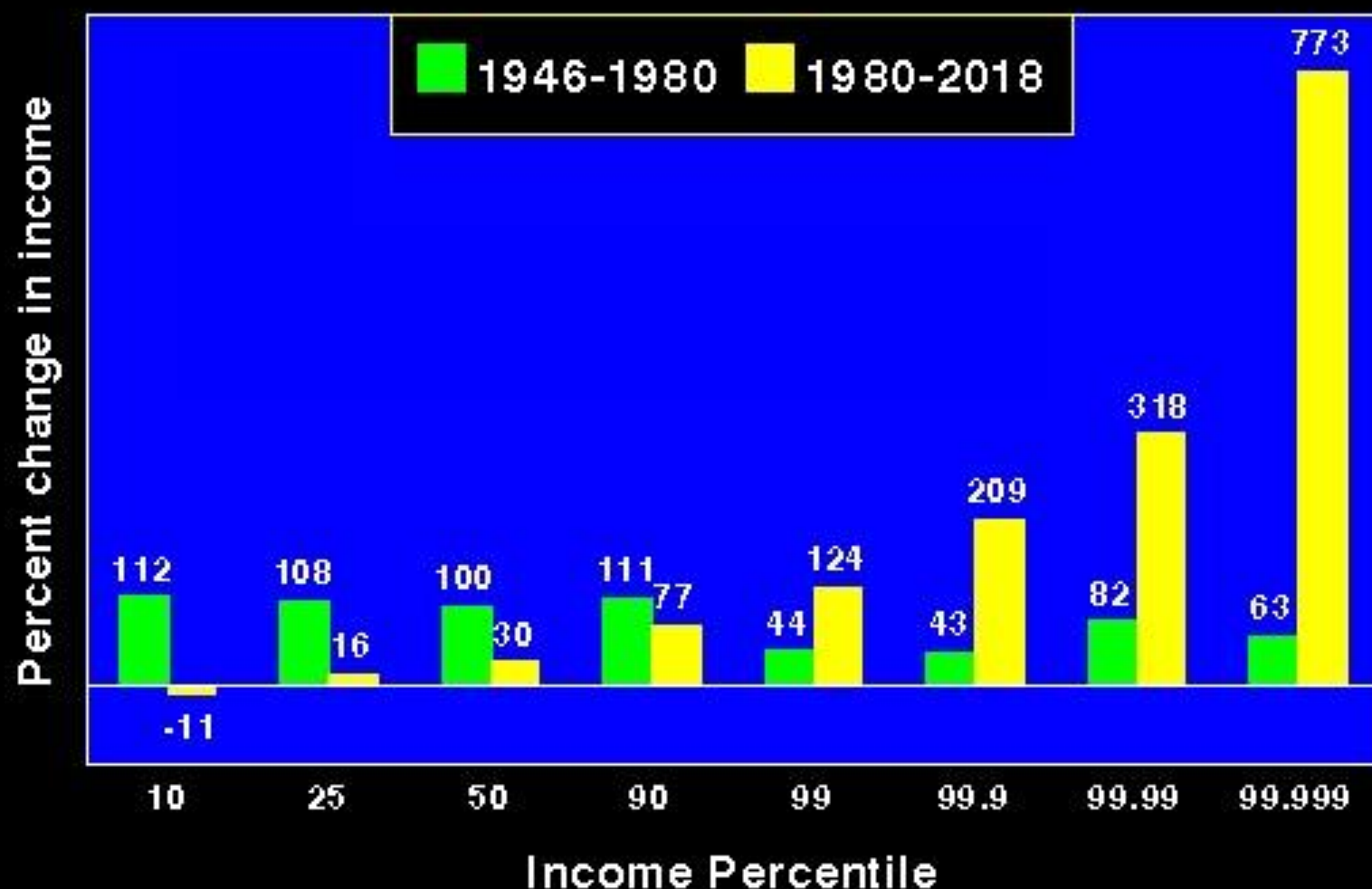
# Median Family Income for Blacks and Whites: 1947-2018 (Inflation Adjusted)



Source: Bureau of the Census

# Income Growth Fastest for Poor and Middle Class After WWII; for Rich Since 1980

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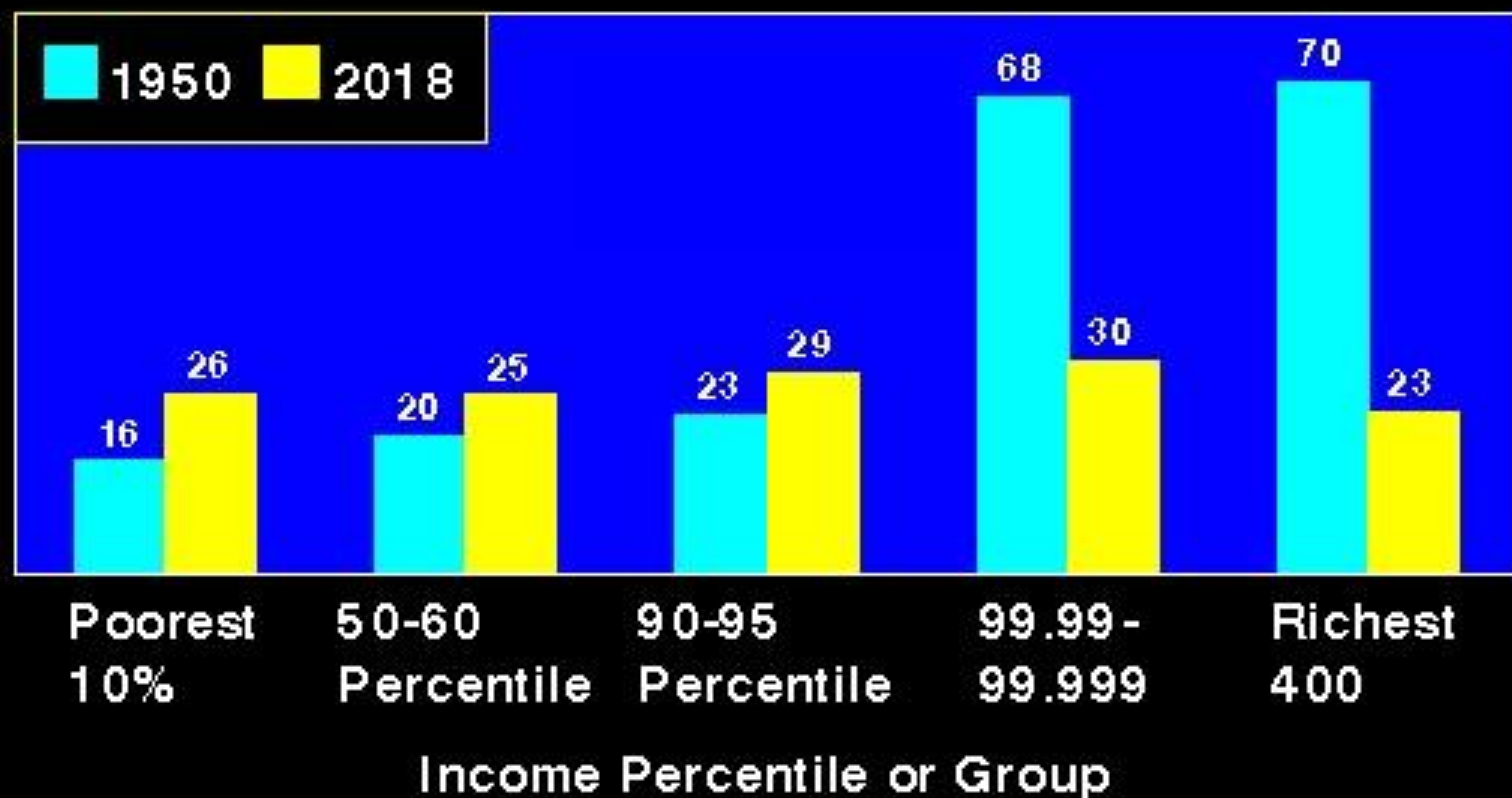


Source: Saez and Zucman (Saez's website, 2020)



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

Taxes as share of income



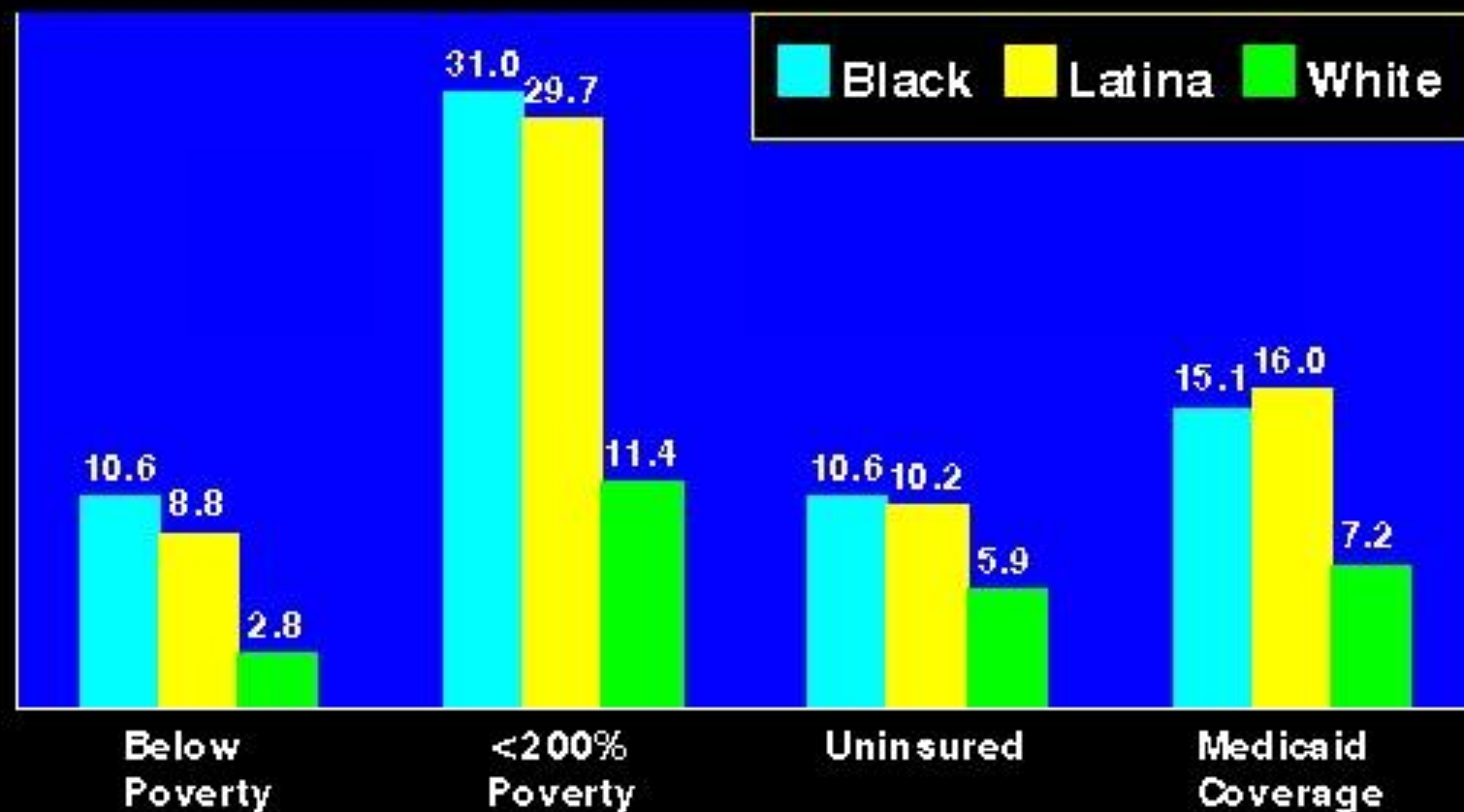
Source: Saez and Zucman (Saez's website, 2020)

# Women Health Workers' Low Pay

## 1.7 Million of Them and Their Children Live in Poverty

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Percent



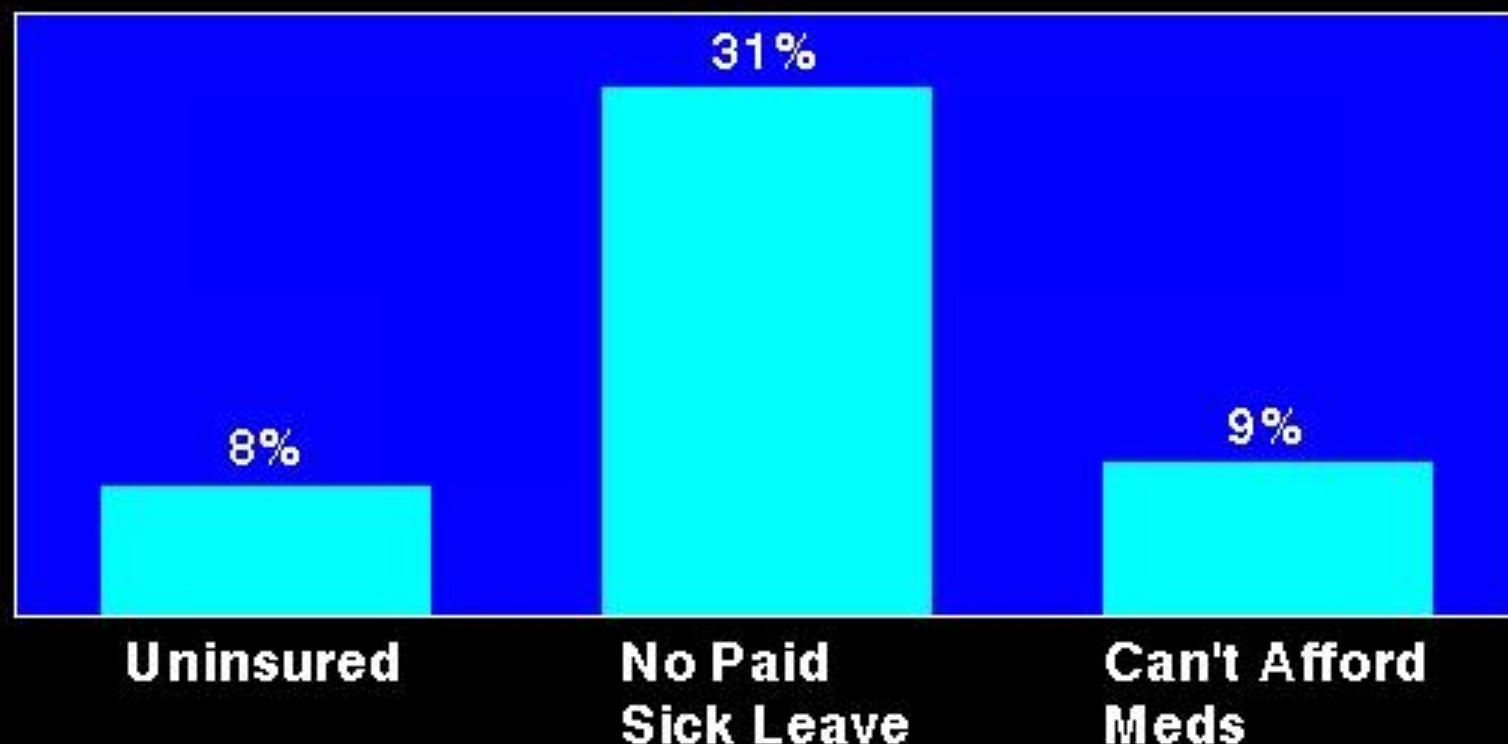
Source: Himmelstein K, Am J Public Health 2019;109:198

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

# 3.7 Million Medical Workers Have Risks for Severe COVID-19

Many Lack Coverage or Sick Leave, and Can't Afford Medications

Percent



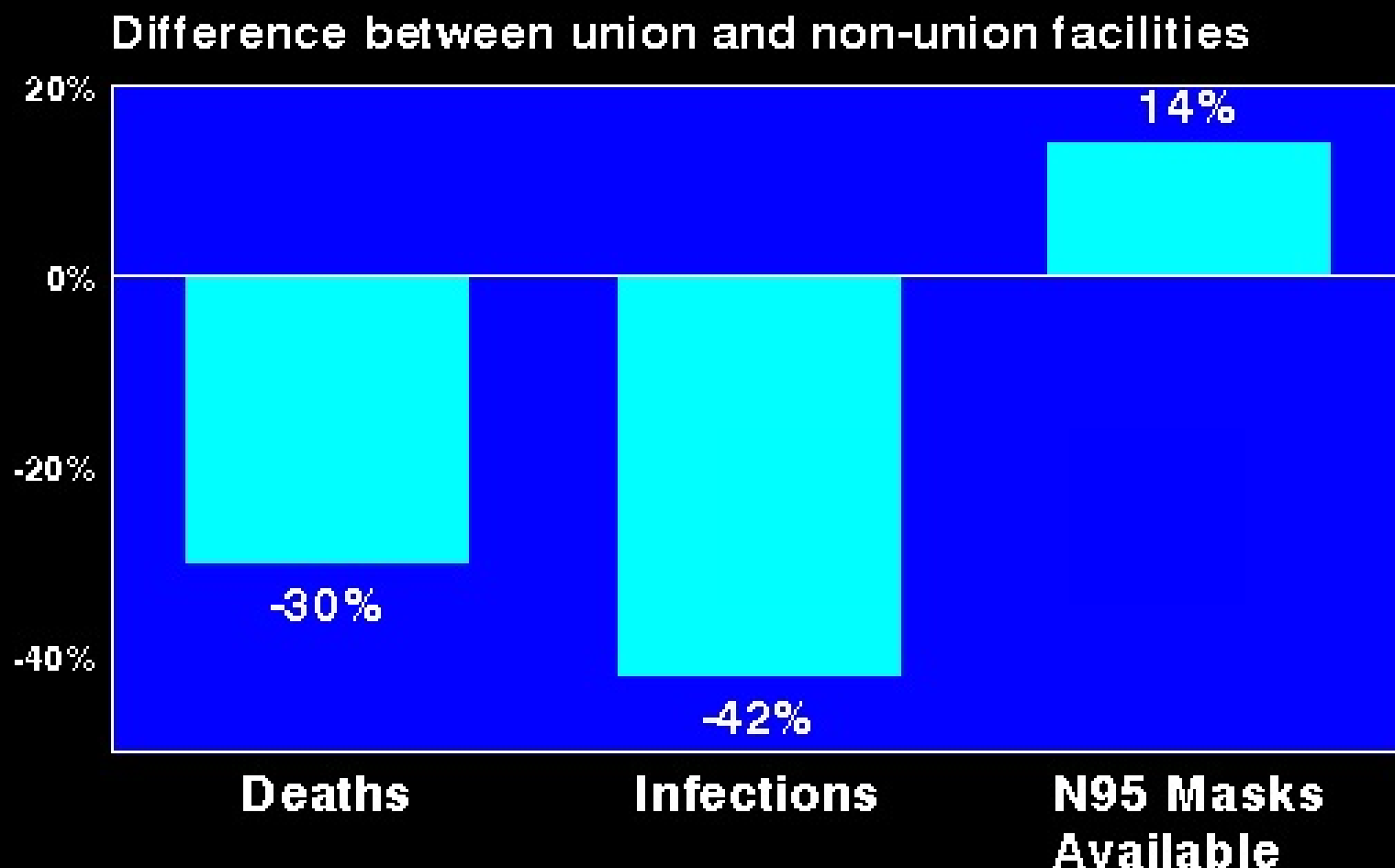
Source: Himmelstein & Woolhandler, Ann Intern Med 4/28/2020

Medical workers = persons with direct patient contact at work

Risk for severe COVID-19 based on CDC guidelines;

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

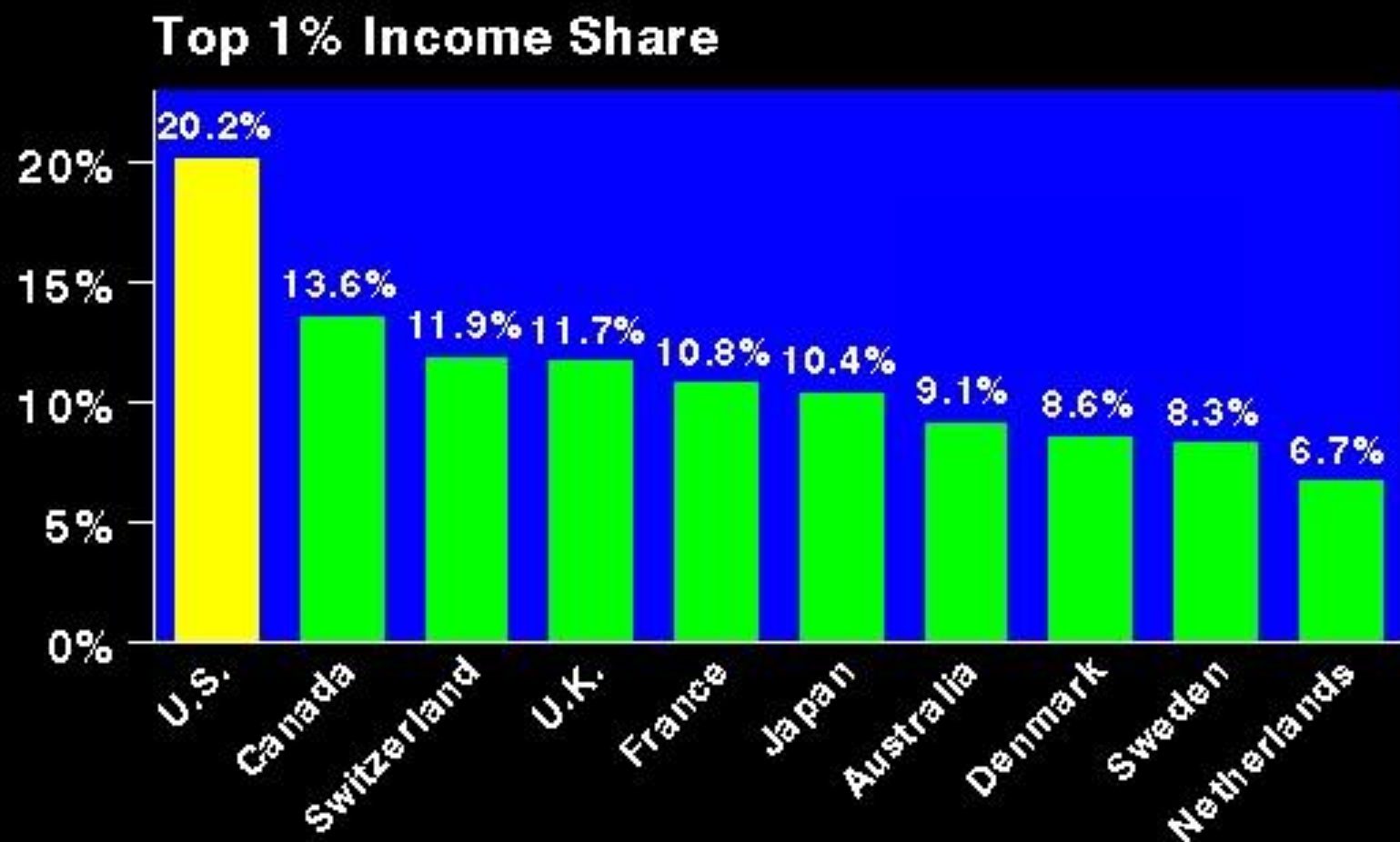
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Source: Dean, Venkataramani, Kimmel. Health Aff 2020;39:11:1

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

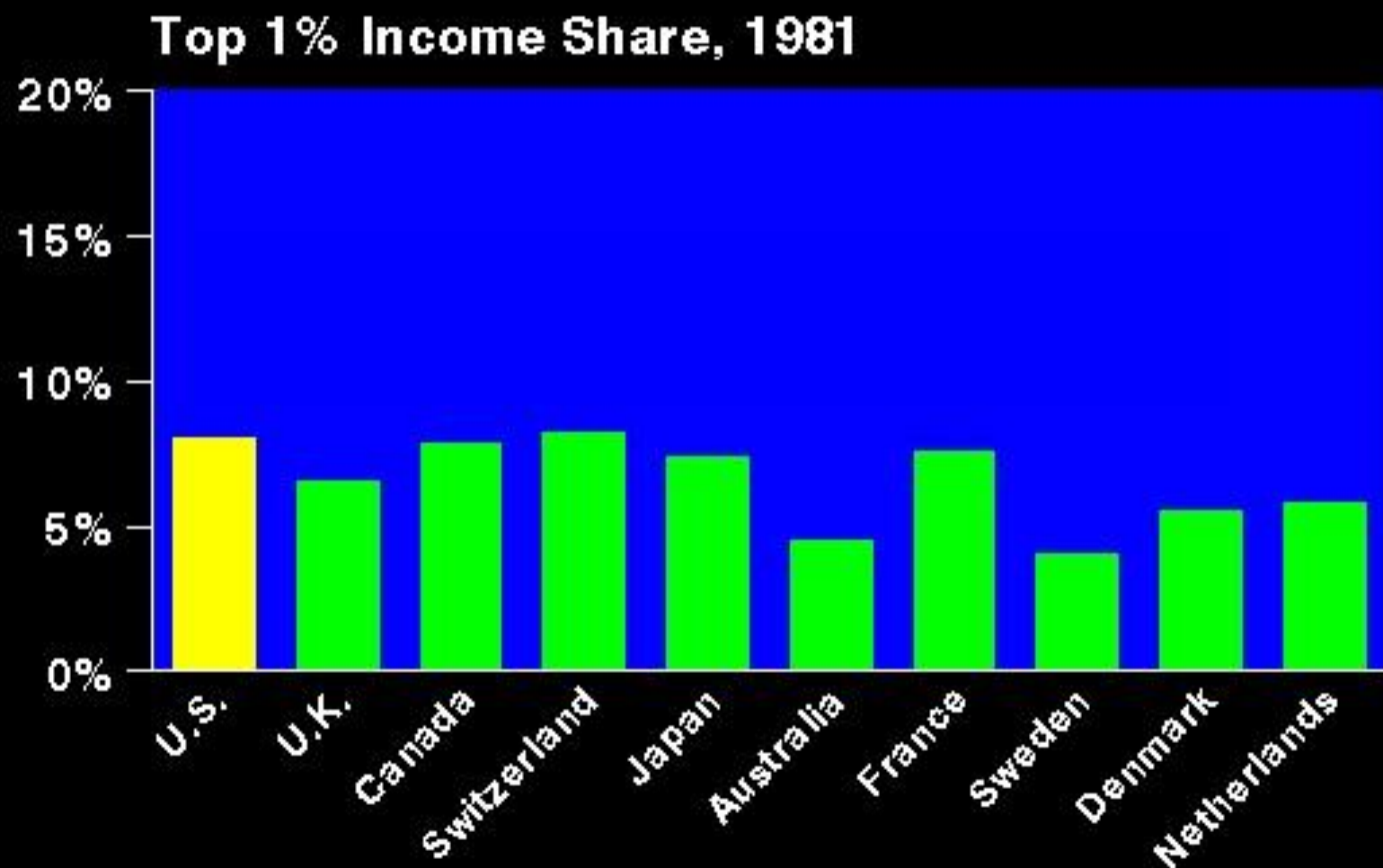
# Income Inequality Worst in U.S.



Source: World Top Incomes database - Data are for 2017 or most recent available



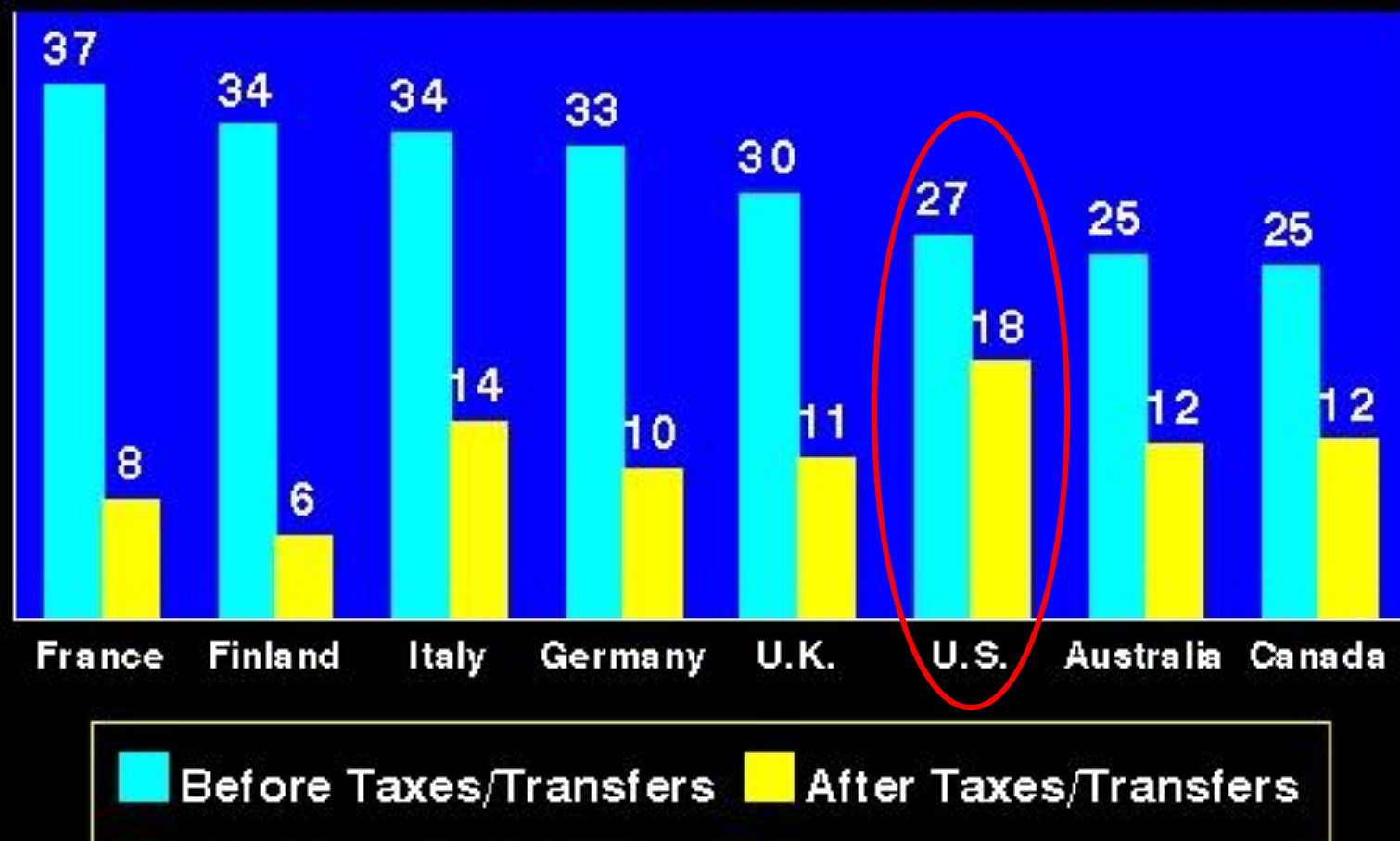
# U.S. Income Inequality Was Less in 1981



Source: World Top Incomes database

# Other Nations Ameliorate Poverty Through Taxes and Social Spending

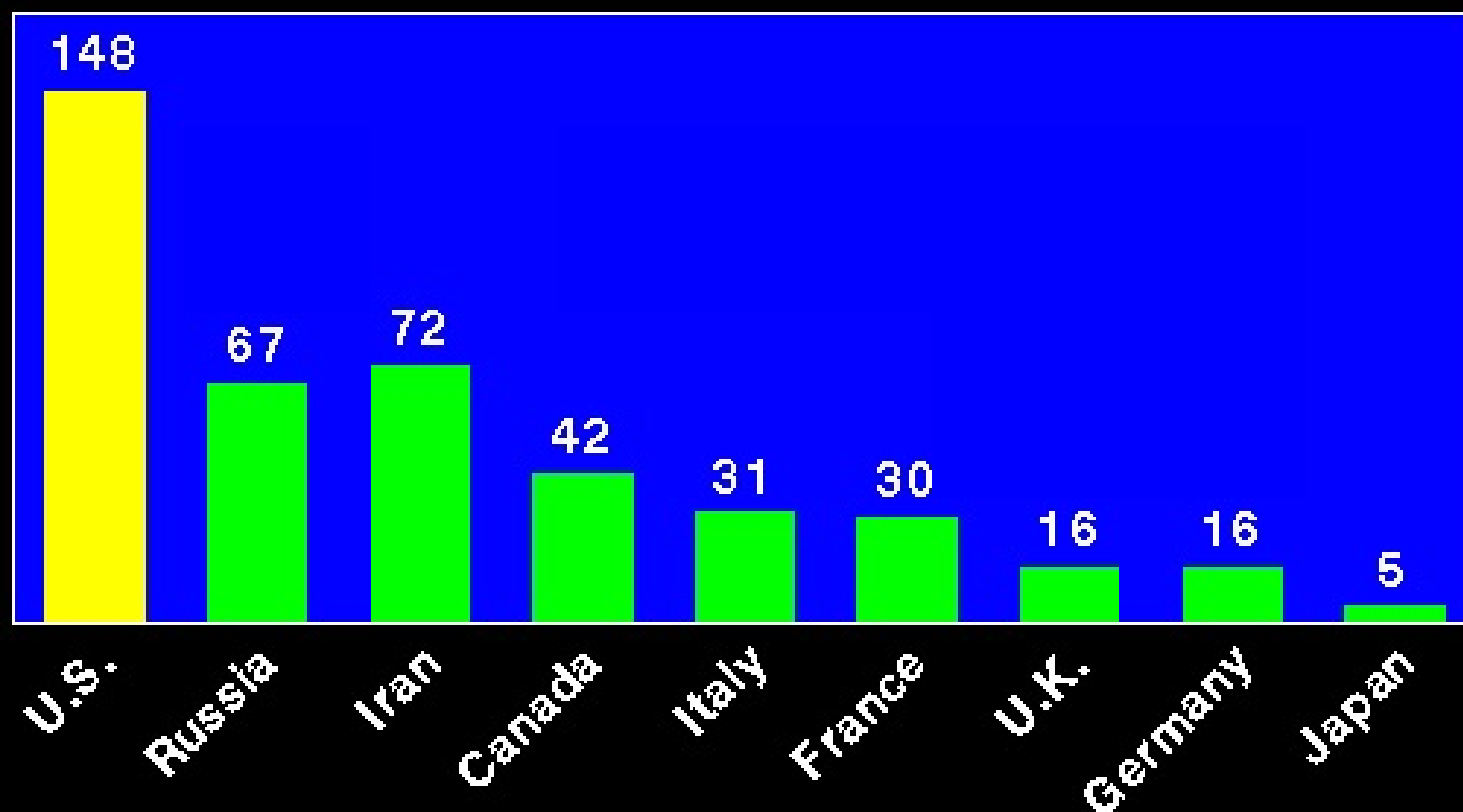
Percent with incomes <50% of median



Source: OECD Poverty Statistics, 2019

# Prisoners in Pre-Trial Detention

Pre-trial detainees per 100,000 population

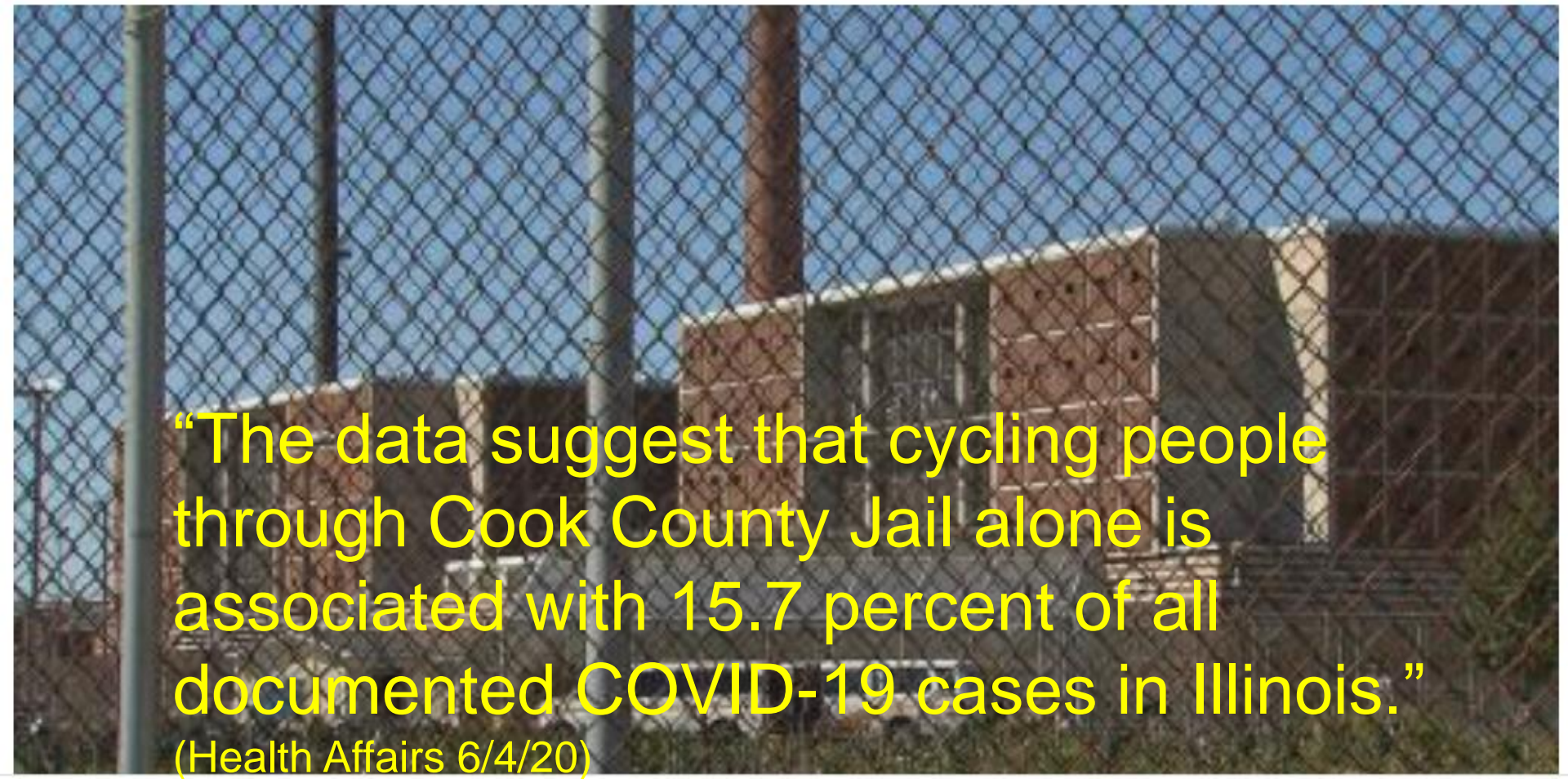


Source: Walmsley - World Pretrial Remand List, 4th Ed.



# Report: 1 in 6 Chicago COVID-19 Cases Can Be Tied to Cook County Jail

Matt Masterson | June 4, 2020 6:33 pm

A photograph of the Cook County Jail building, a large brick structure with multiple windows, viewed through a chain-link fence. The sky is blue and clear.

“The data suggest that cycling people through Cook County Jail alone is associated with 15.7 percent of all documented COVID-19 cases in Illinois.”

(Health Affairs 6/4/20)

# 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



# > 400,000 kids in NYC Live in Poverty



114,000 Students in N.Y.C.  
Are Homeless. These Two  
Let Us Into Their Lives.

NOV. 19, 2019

Written by **Eliza Shapiro**; Photographs by **Brittany Newman**

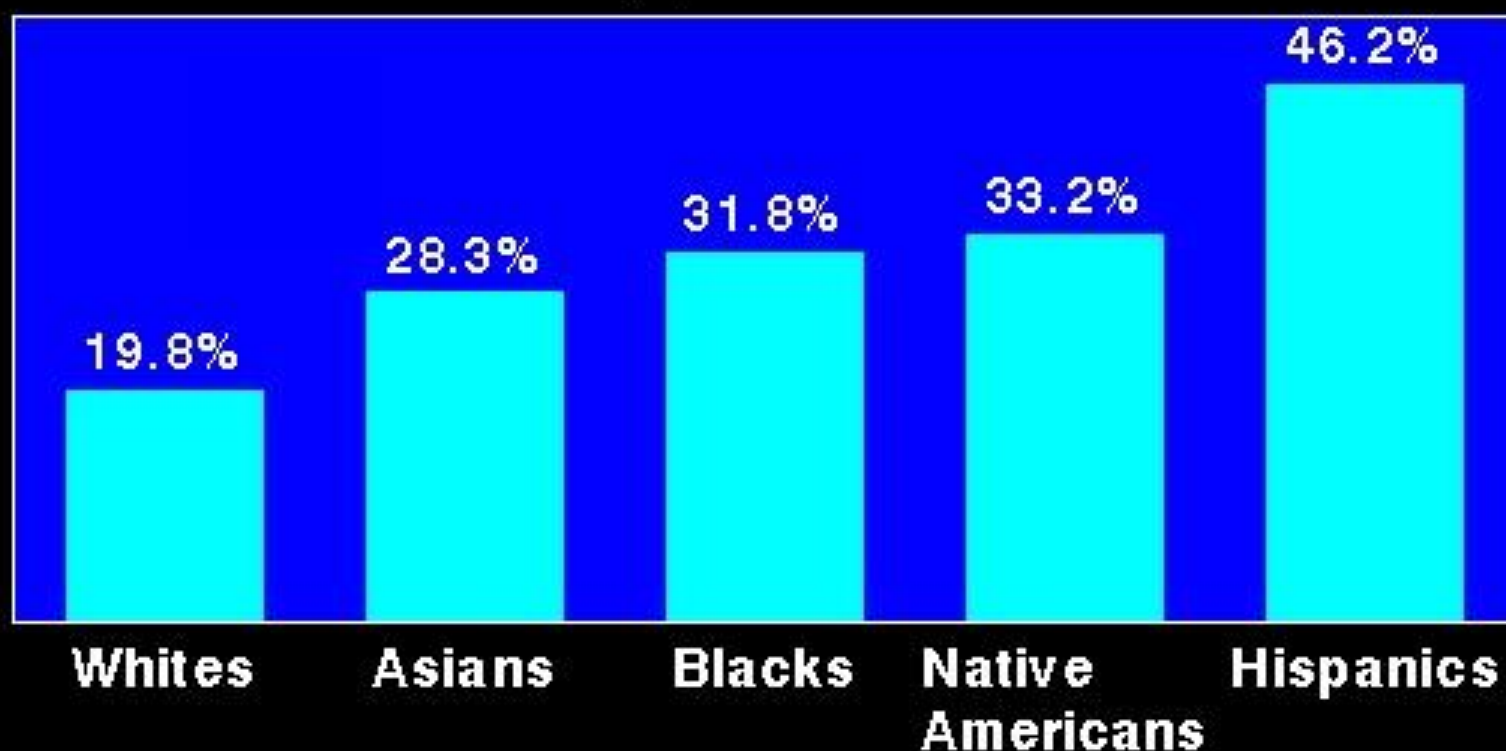
# Increasing Economic Inequality Harms Health

# Many Live in Homes Unsuitable for Quarantine/Isolation

## Too Many People, Too Few Bedrooms or Bathrooms

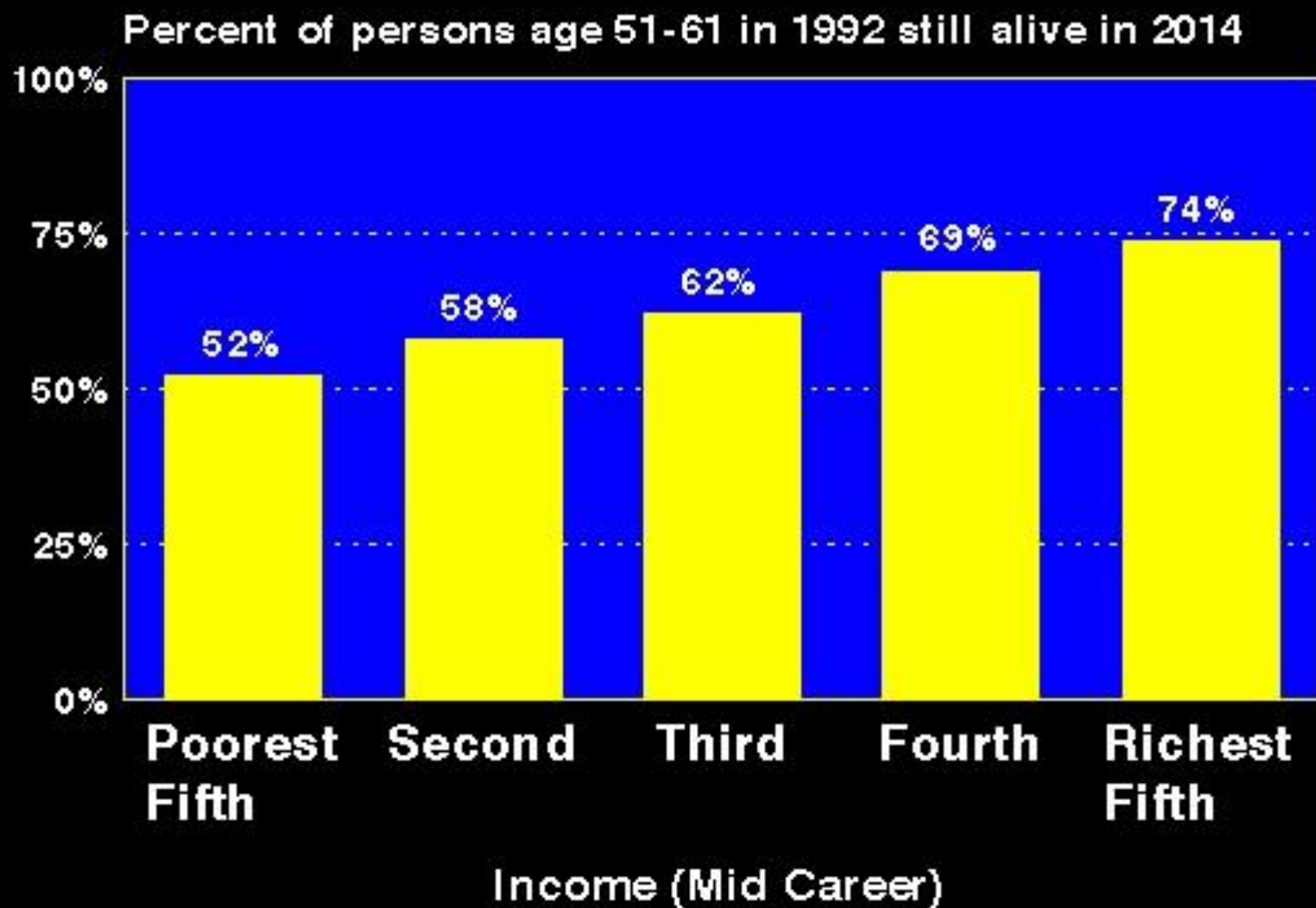
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Percent unable to isolate/quarantine at home



Source: Sehgal, Himmelstein & Woolhandler - Ann Intern Med - published online July 21, 2020  
Data are from analysis of 2017 American Housing Survey

# Lower Income, Shorter Lives





# Widening Gap In Life Expectancy Between High and Low Earners

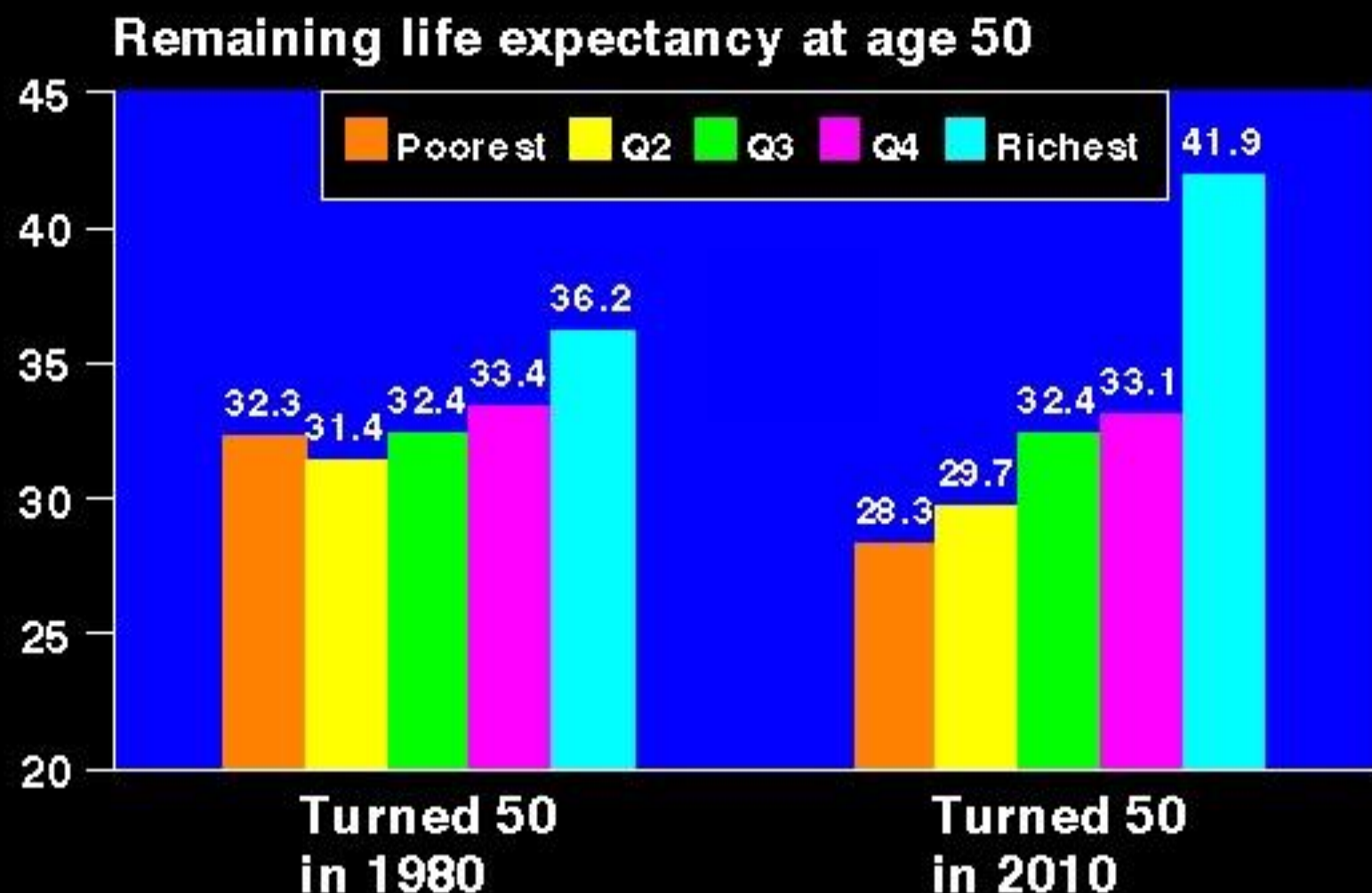
Remaining Life Expectancy for Men Turning 60





# Growing Gap in Life Expectancy by Income

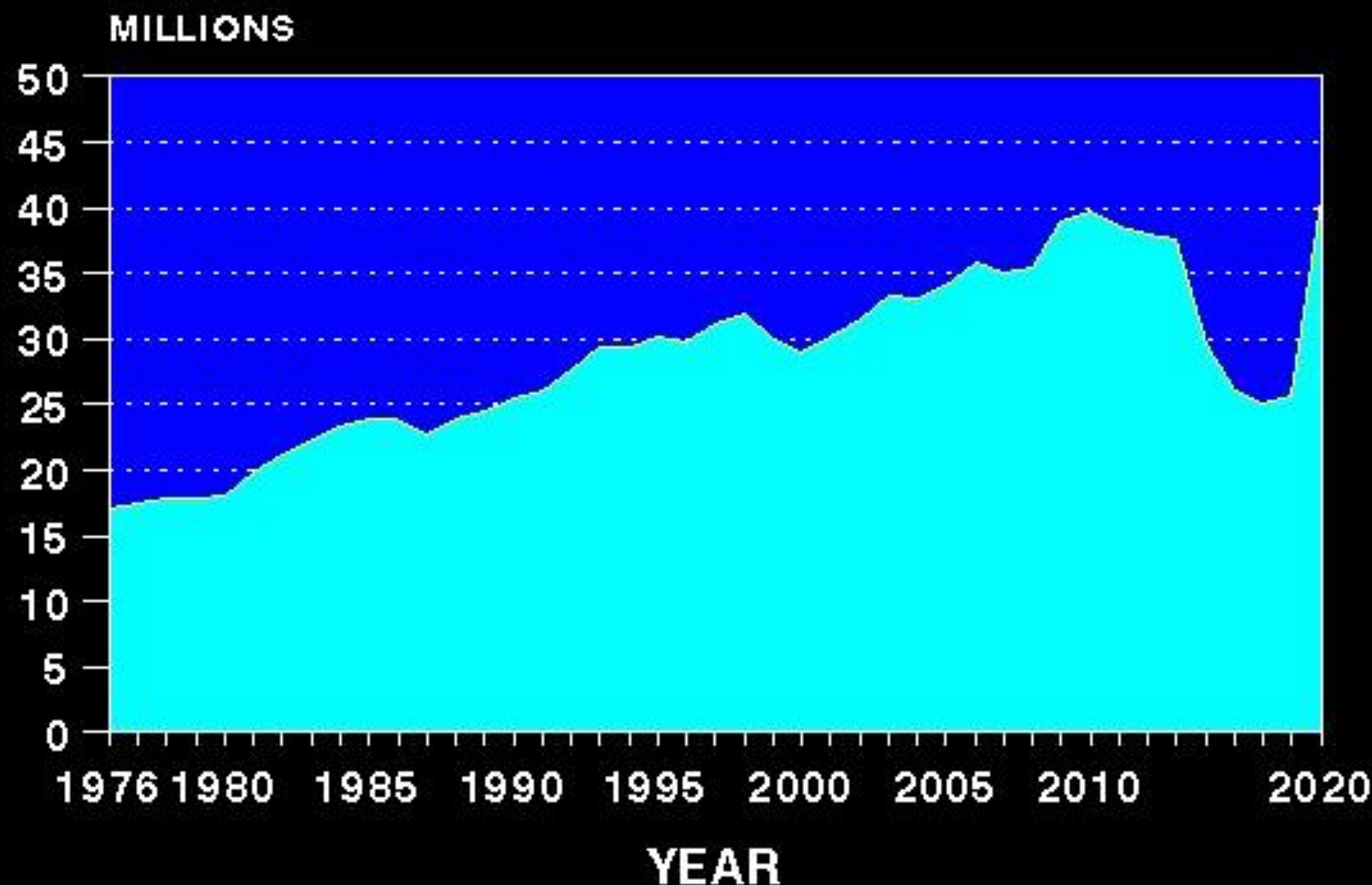
Dramatic Gains for the Wealthy, Losses for Lower Income



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

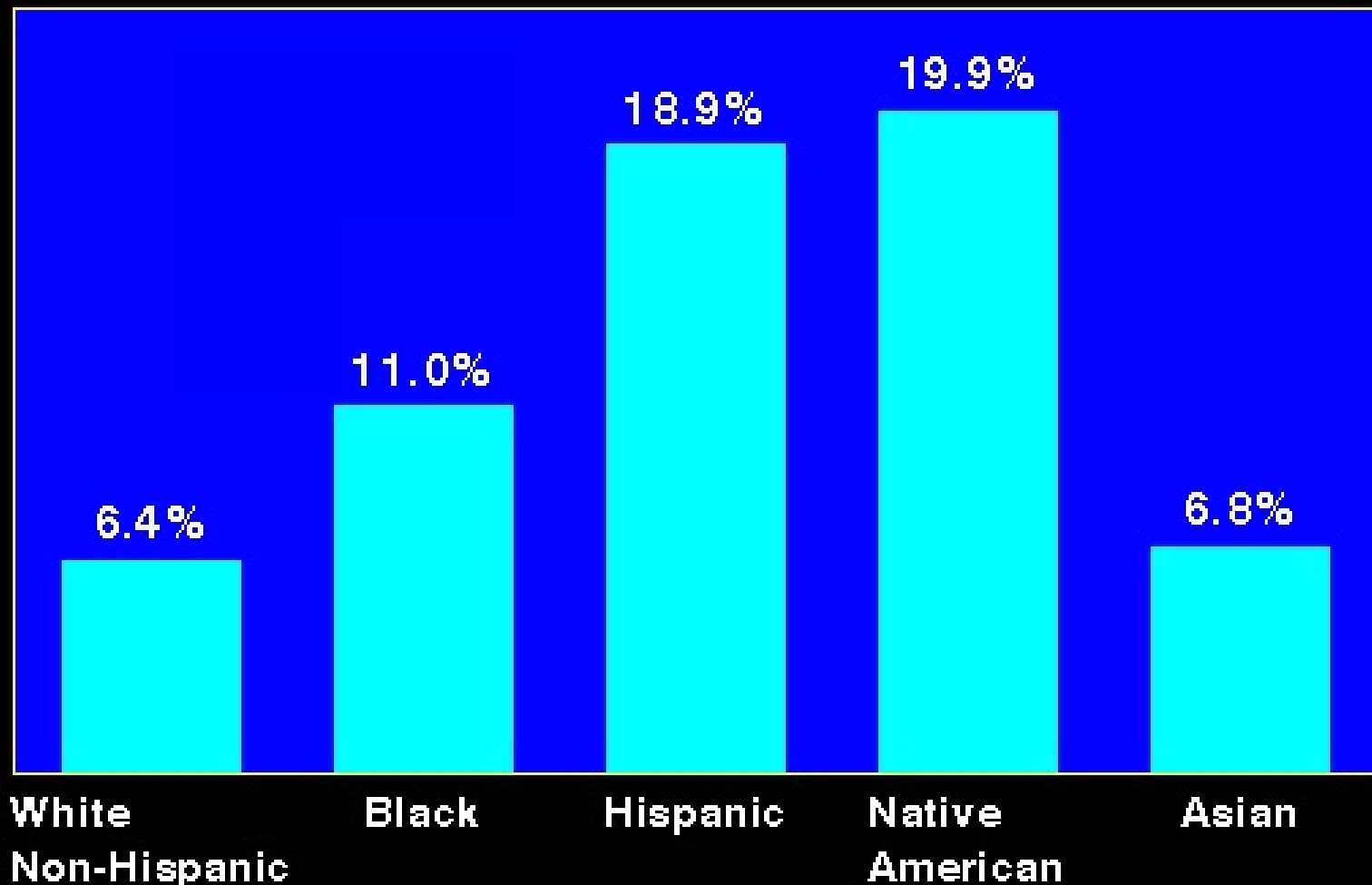
# The Uninsured

# Number Uninsured, 1976-June, 2020



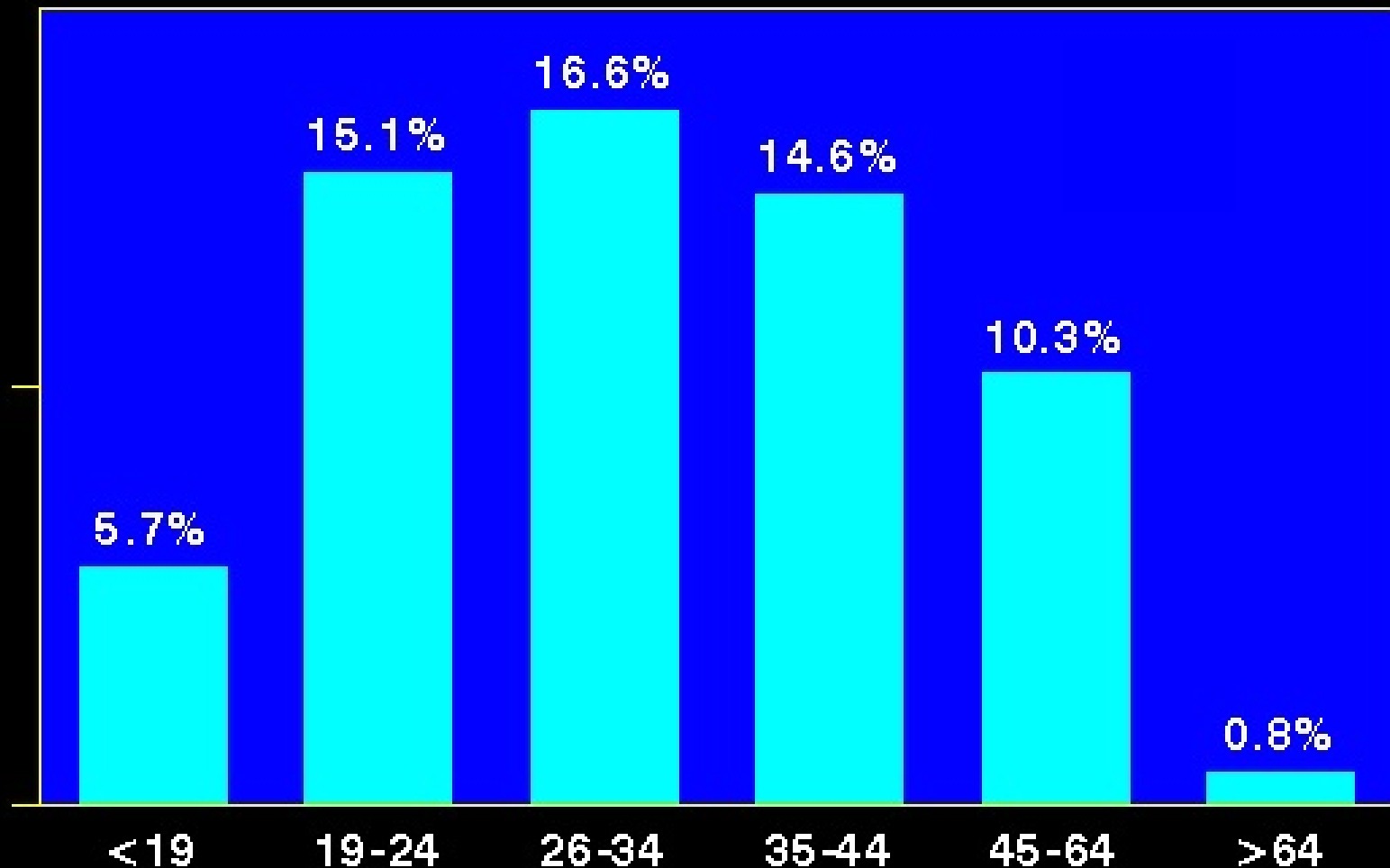
Source: Himmelstein & Woolhandler - Tabulation from CPS, ACS & NHIS Data  
Figure for 2020 is estimated based on increase in unemployment

# Percent Uninsured by Race/Ethnicity, 2019



Source: American Community Survey

# Percent Uninsured by Age Groups, 2019



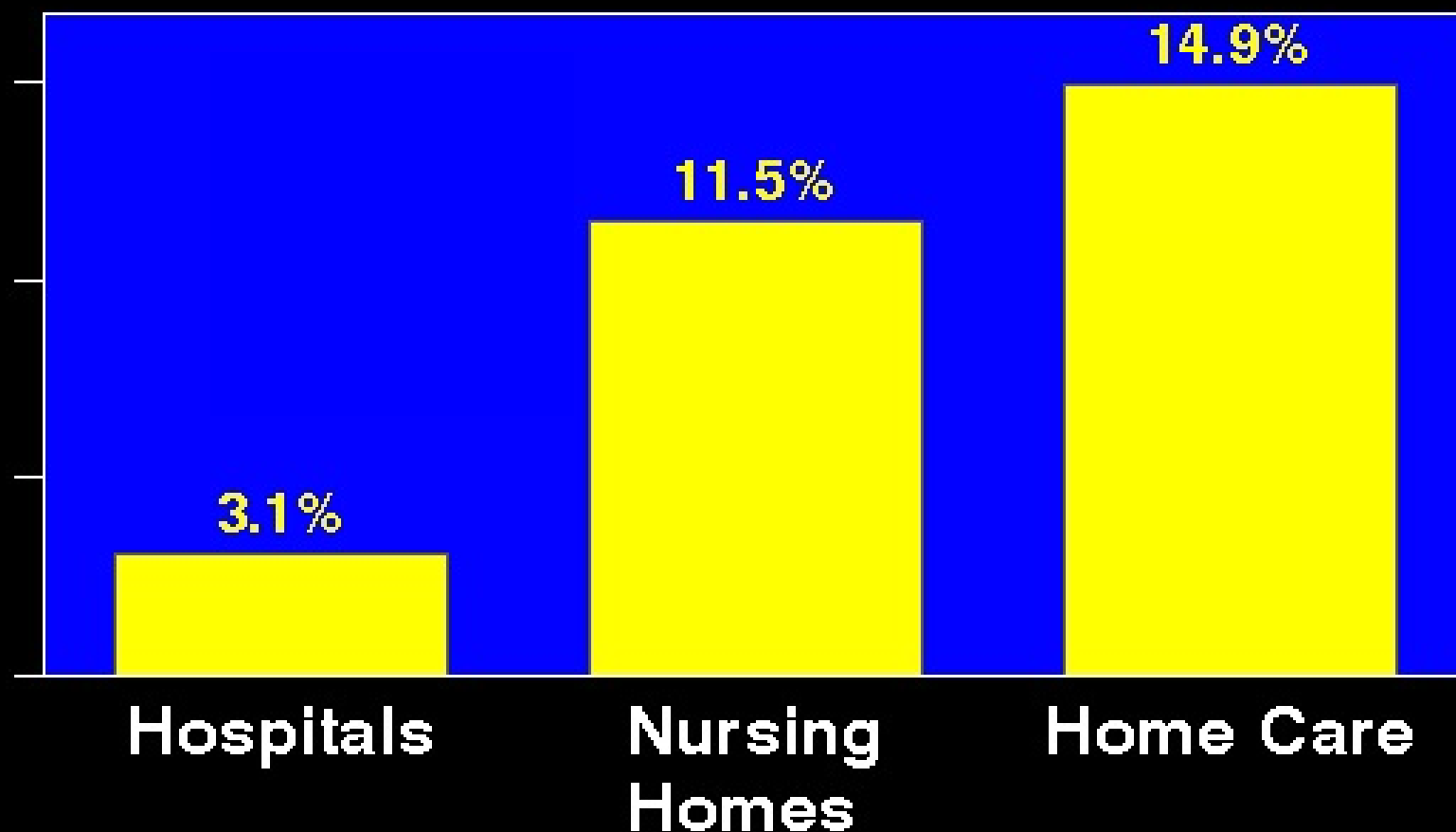
Source: American Community Survey



# Many Frontline Health Workers Are Uninsured

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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

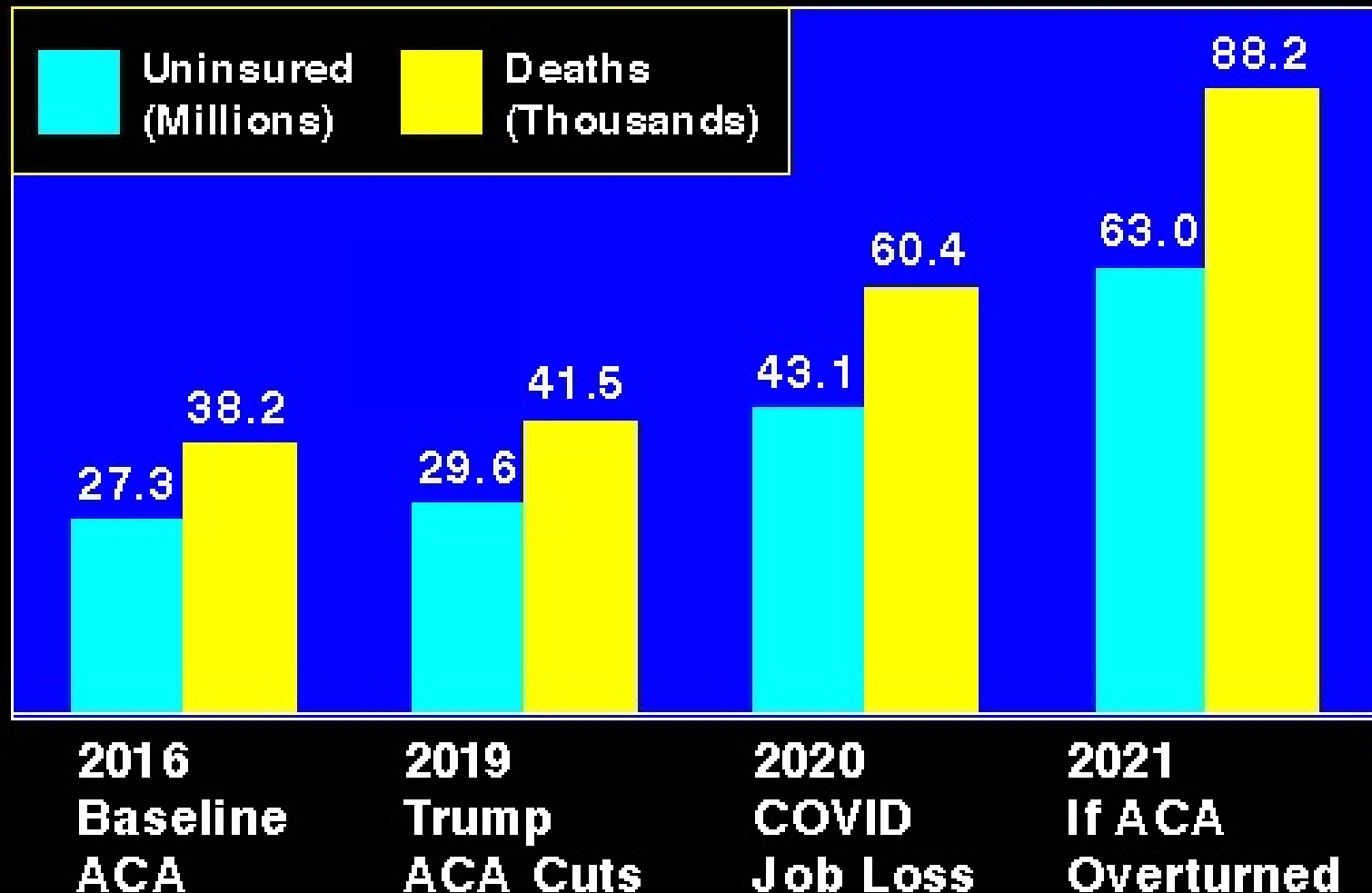
State	% Uninsured	Excess Deaths
Texas	18.4	6,804
California	7.7	3,903
Florida	13.2	3,619
Georgia	13.4	1,817
Noth Carolina	13.4	1,504
New York	5.2	1,309
U.S.	9.2%	38,531

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

# Rising Uninsurance Already Causing Many Deaths: More Likely if Court Overturns ACA

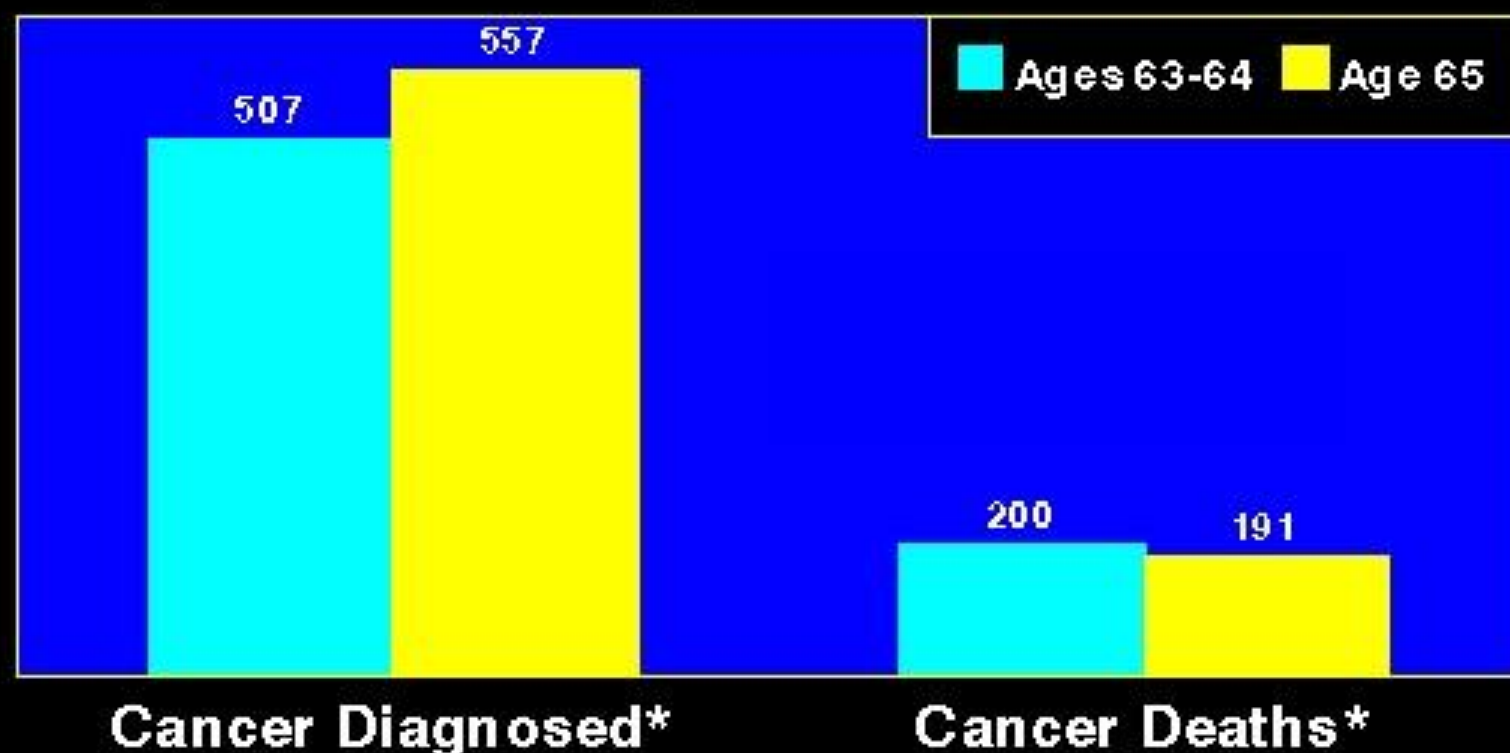
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# Medicare Coverage Improves Cancer Detection and Outcomes

Diagnoses Rise, Deaths Fall at Age 65

Rate per 100,000 women/year



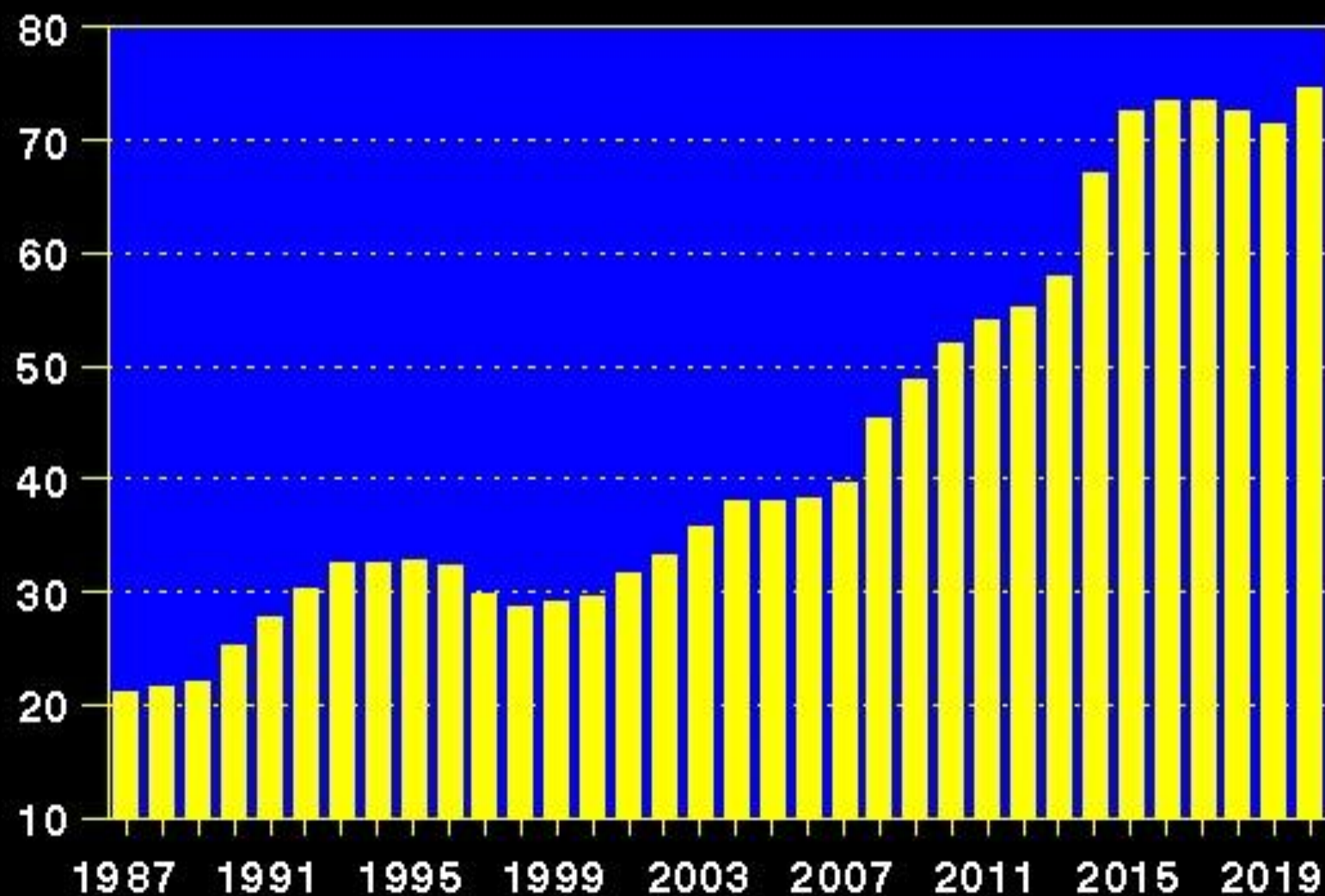
Source: NBER Working Paper 26292, September, 2019

\* Breast, colorectal or lung cancer

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

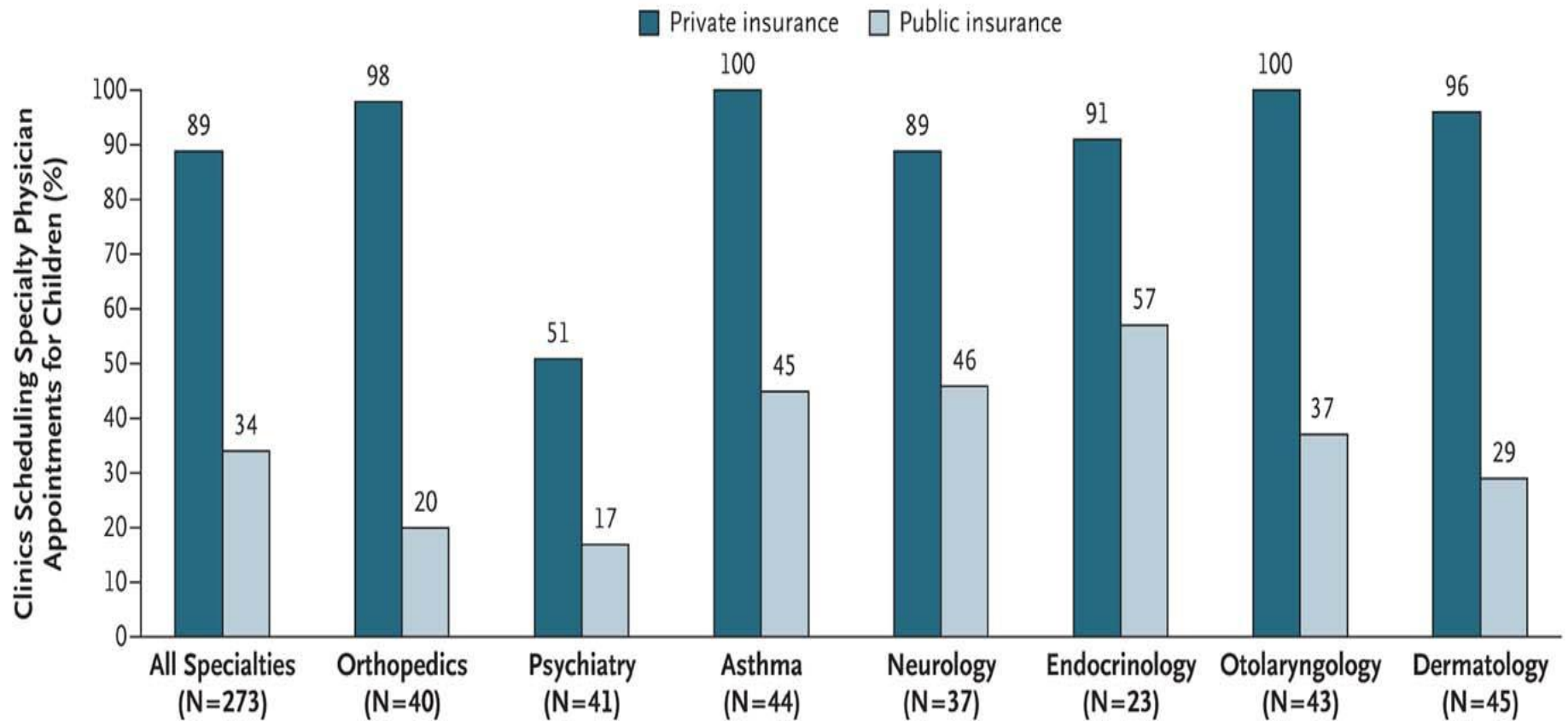


# Medicaid Enrollment, 1987-2020



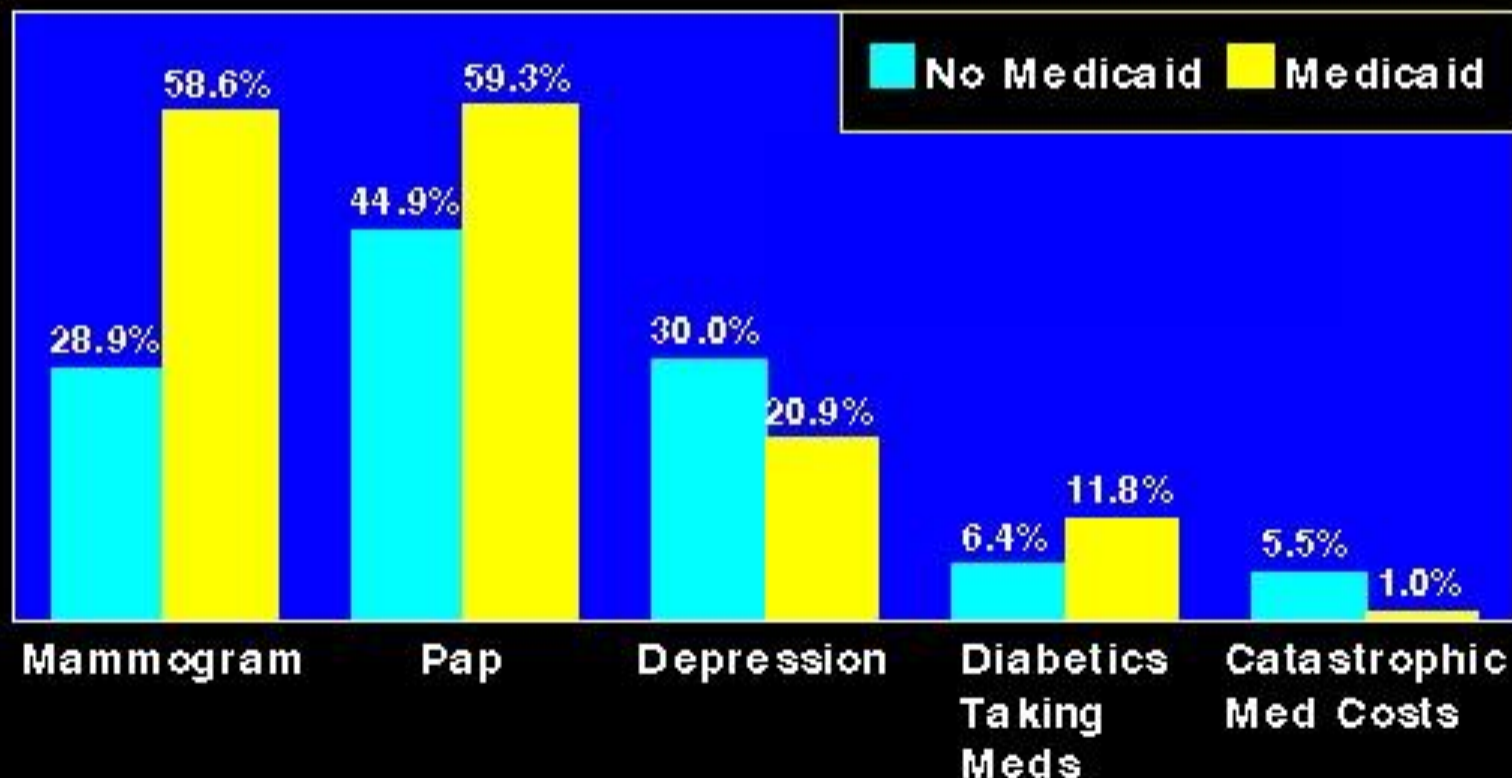
Source: Kaiser Foundation - Figures are for mid year

# Many Specialists Won't See Kids With Medicaid



# Medicaid Helps

## An RCT in Oregon



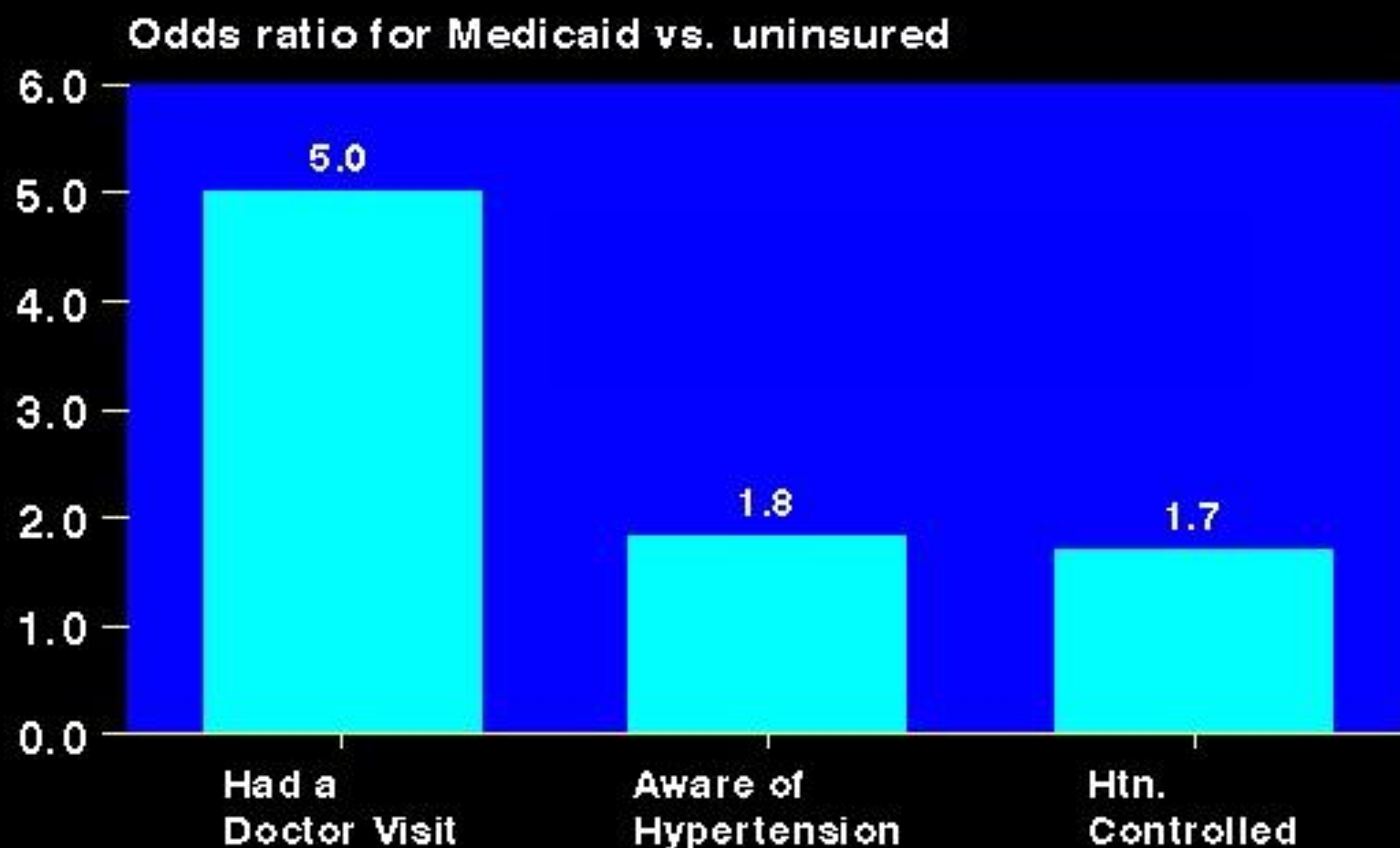
Source: NEJM May 2, 2013

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

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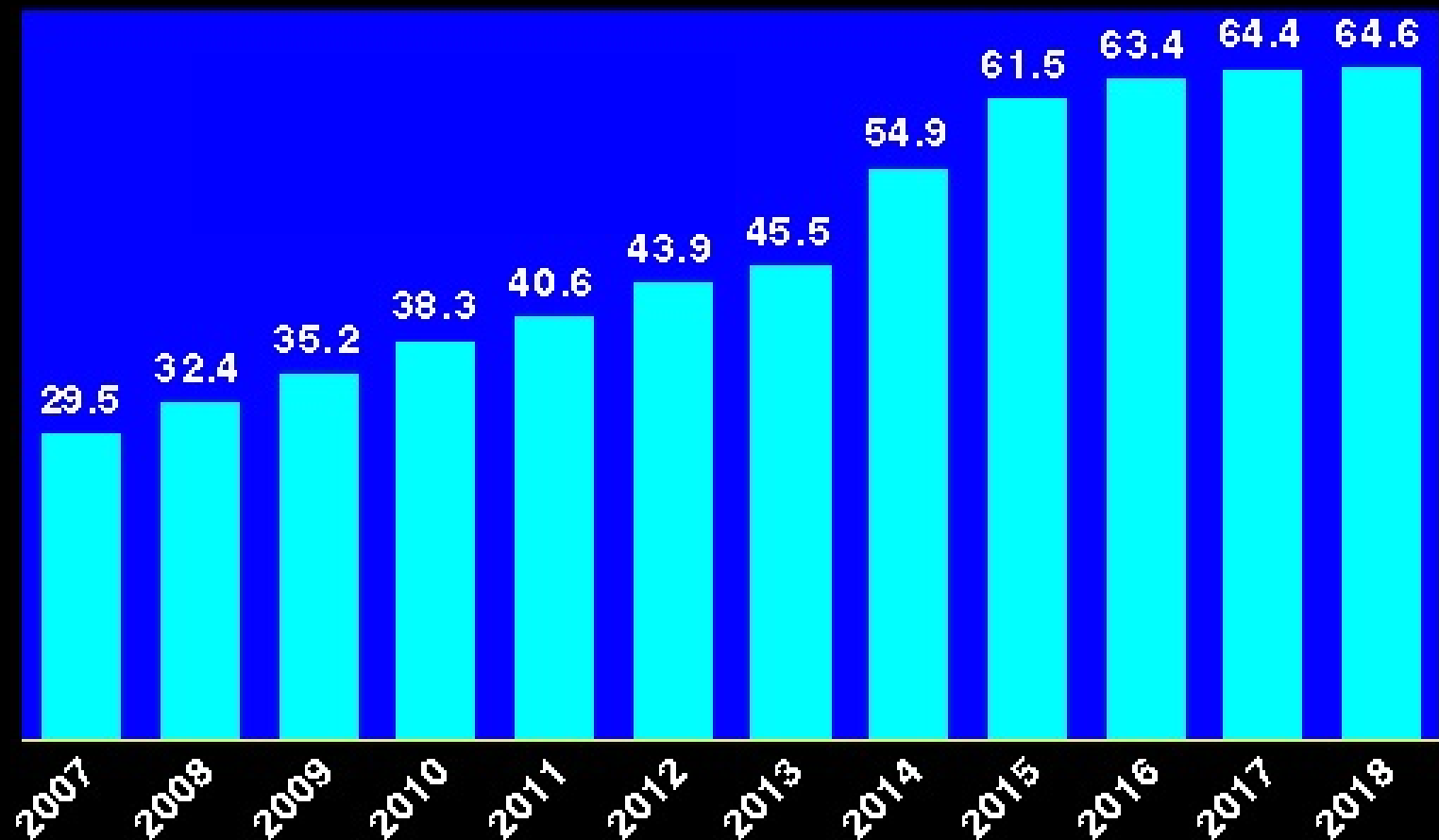


Source: Christopher, Wilper, Himmelstein, Woolhandler, McCormick - AJPH 2015  
Odds ratios are adjusted for sex, age, race/ethnicity, presence of chronic condition, disability

# Medicaid Managed Care Enrollment Soaring

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Millions of Enrollees



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

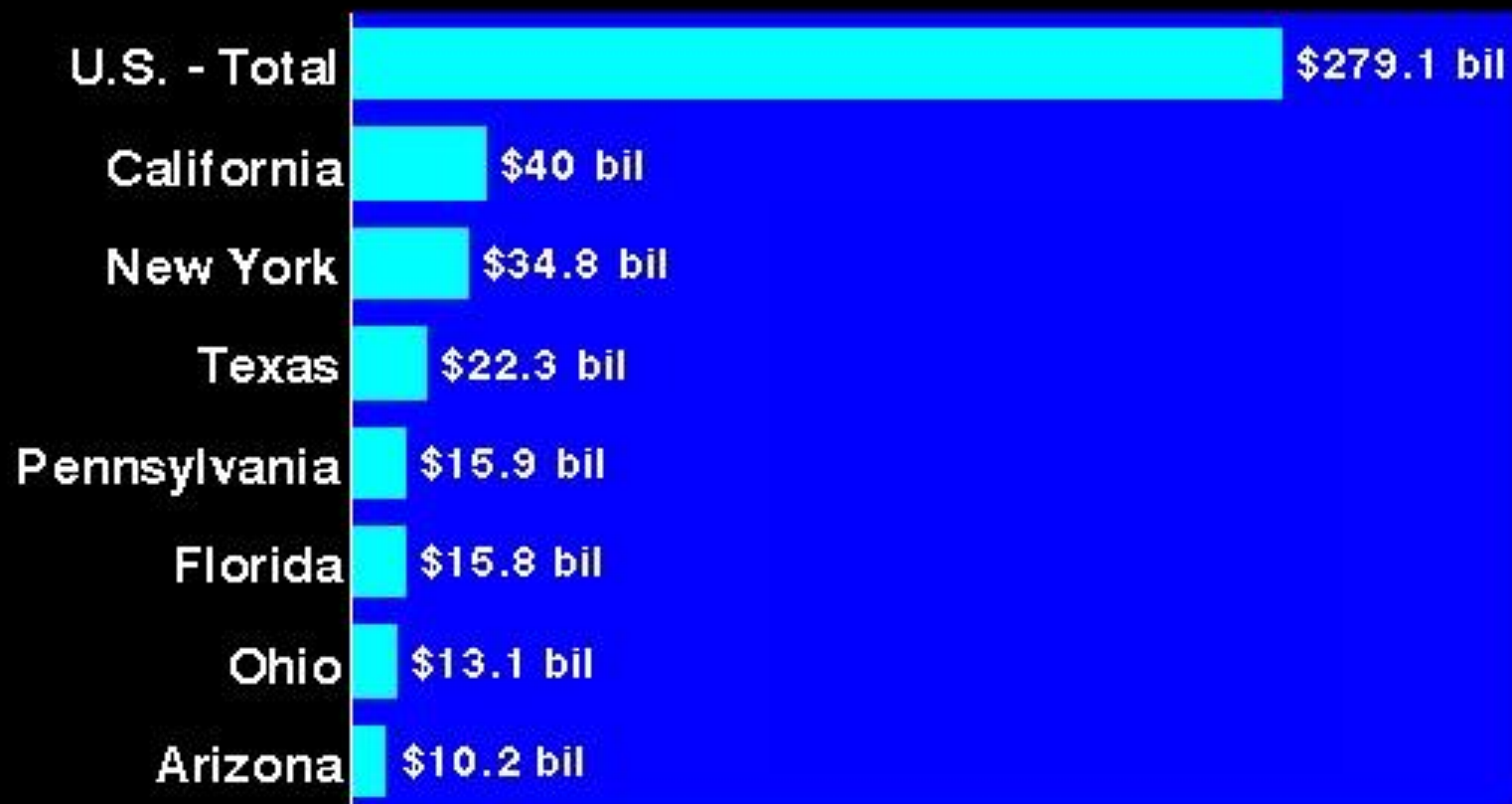
Note: Medicaid payments to mgt. care firms, 2019 = \$279.1 bil., MLR = 88.6 (overhead = \$9 bil.)

No evidence of cost savings, some evidence of worse quality



# Medicaid Managed Care: A Major Revenue Source for Insurers

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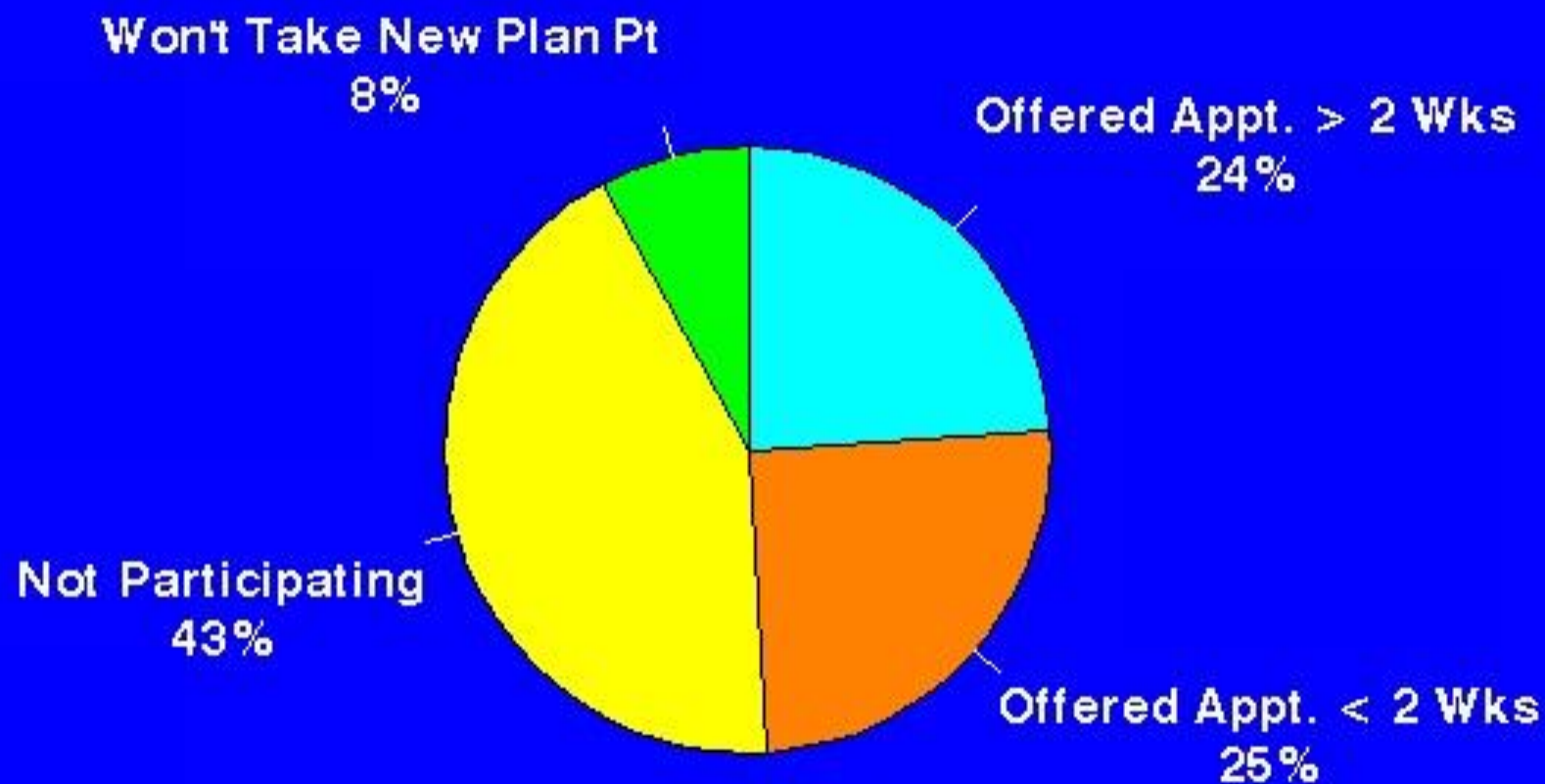
**Medicaid Managed Care Spending, 2019**

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

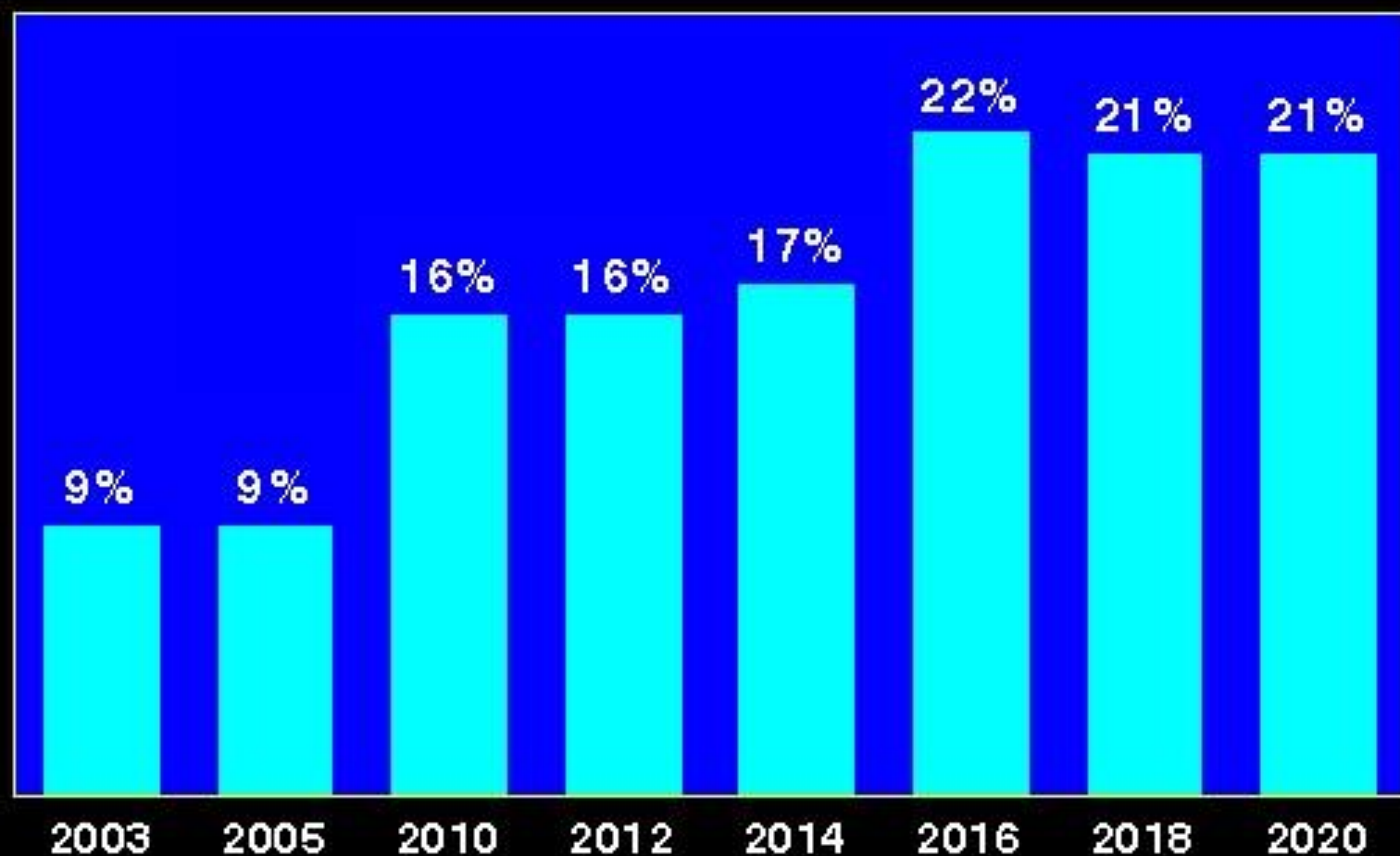


## Appointment Availability

# Under-Insurance On the Rise

# Under-Insurance Increased After ACA

Percent of adults 19-64 under-insured\*



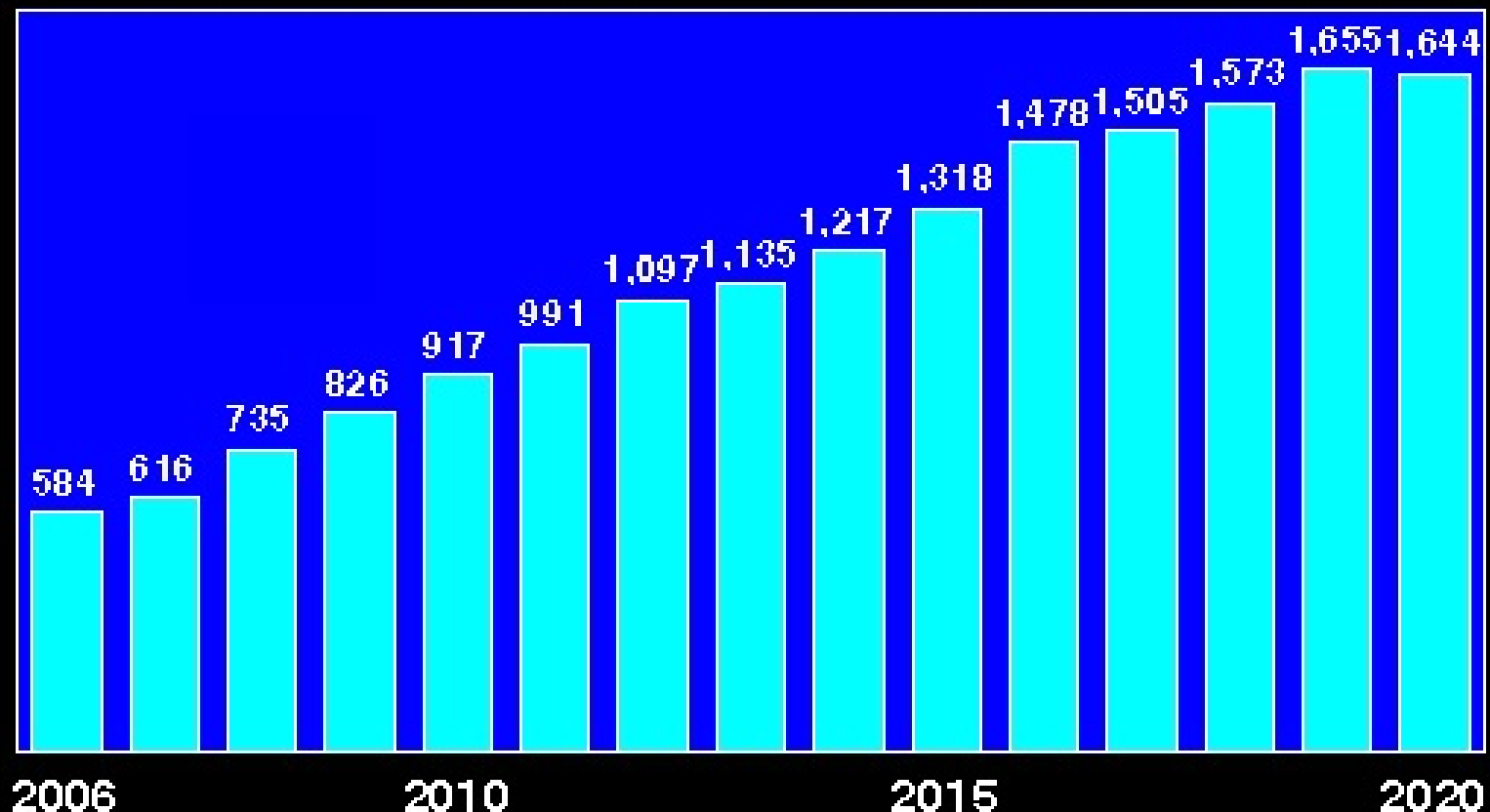
Source: Commonwealth Fund Health Insurance Surveys 2003-2020

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

# Average Deductible Rising

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



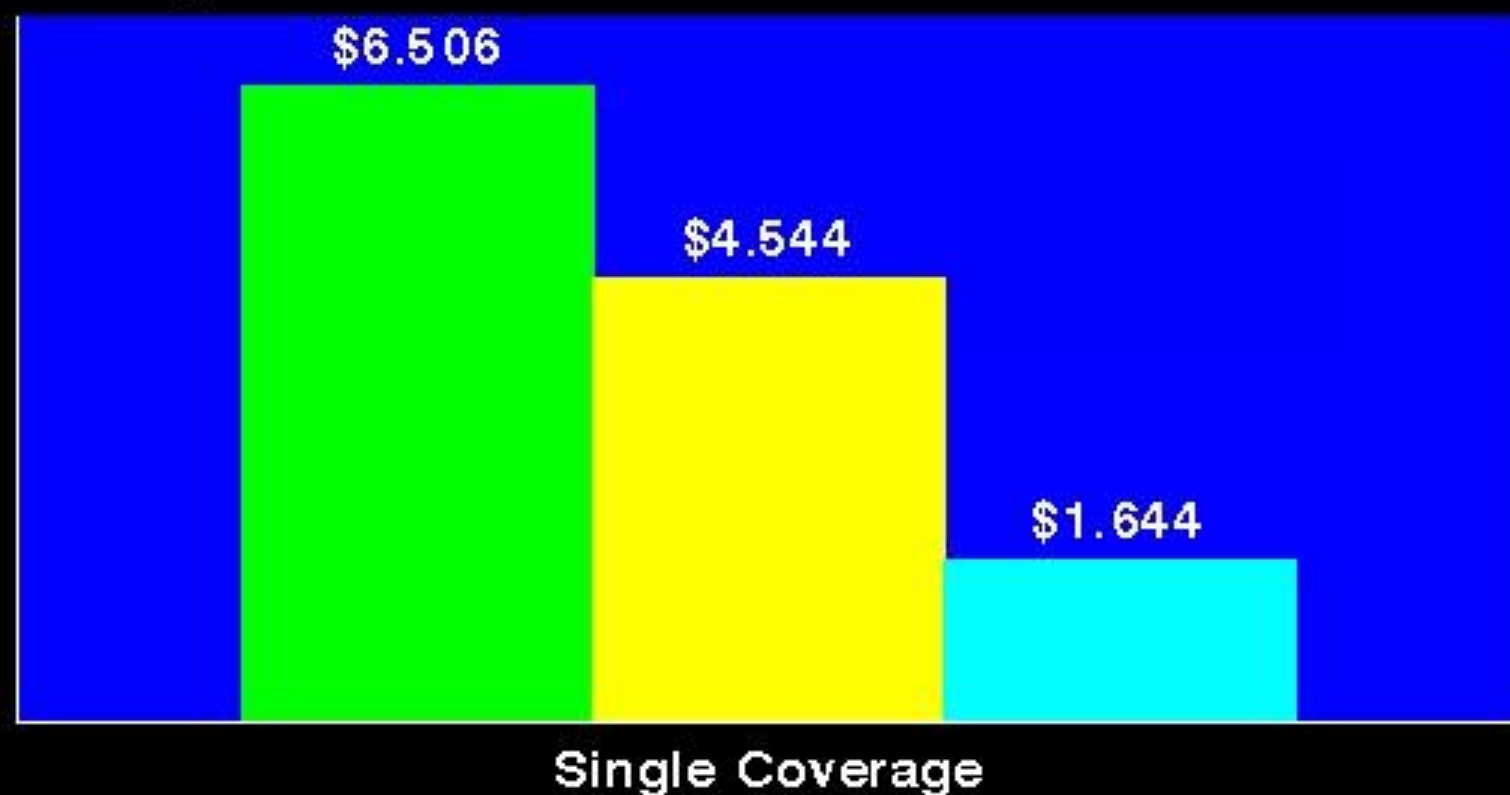
**Source: Kaiser/HRET Survey of Employer-Sponsored Benefits**



# ACA Exchange Plans' Deductibles

Higher Than Average Job-Based Plan

Average deductible



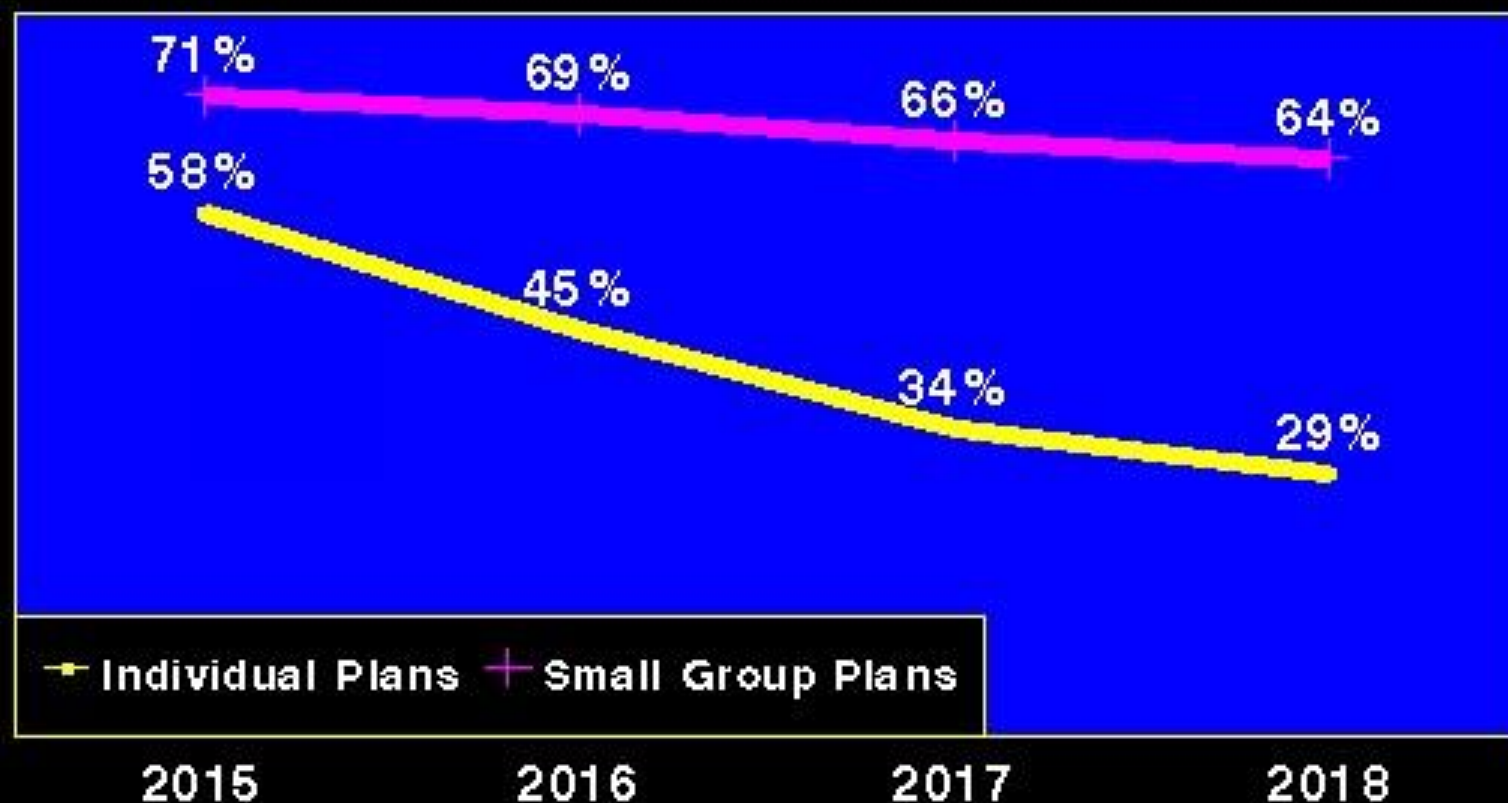
Exchange Bronze Exchange Silver Average Employer Plan

Source: KFF and Kaiser Foundation 2020 Employer Health Benefits Survey

# Many Plans Now Pay NOTHING for Out Of Network Care

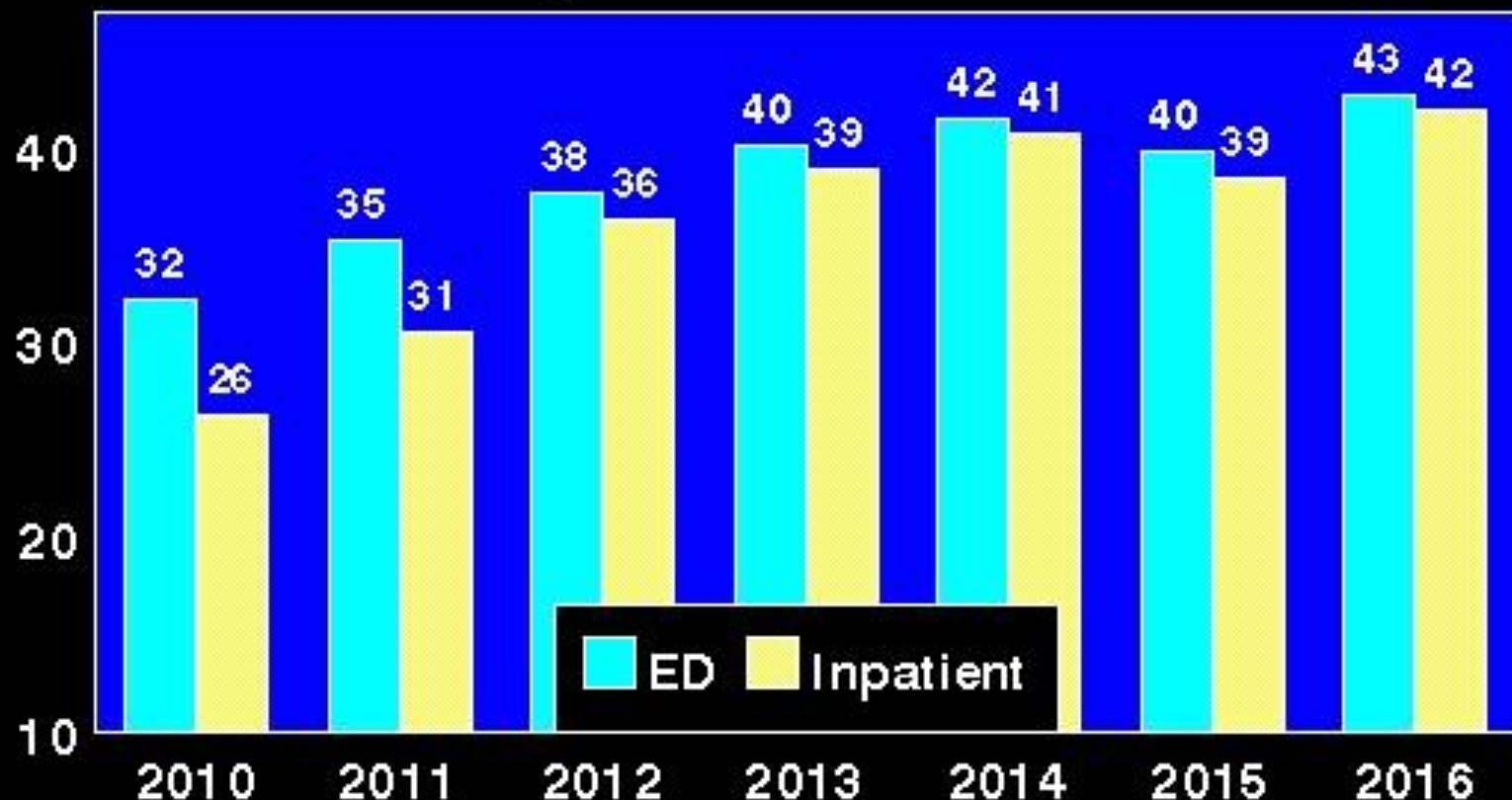
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Percent with ANY out of network benefit



# Out of Network Bills Rising

Percent receiving out of network bill



Source: JAMA IM 2019;179:1543

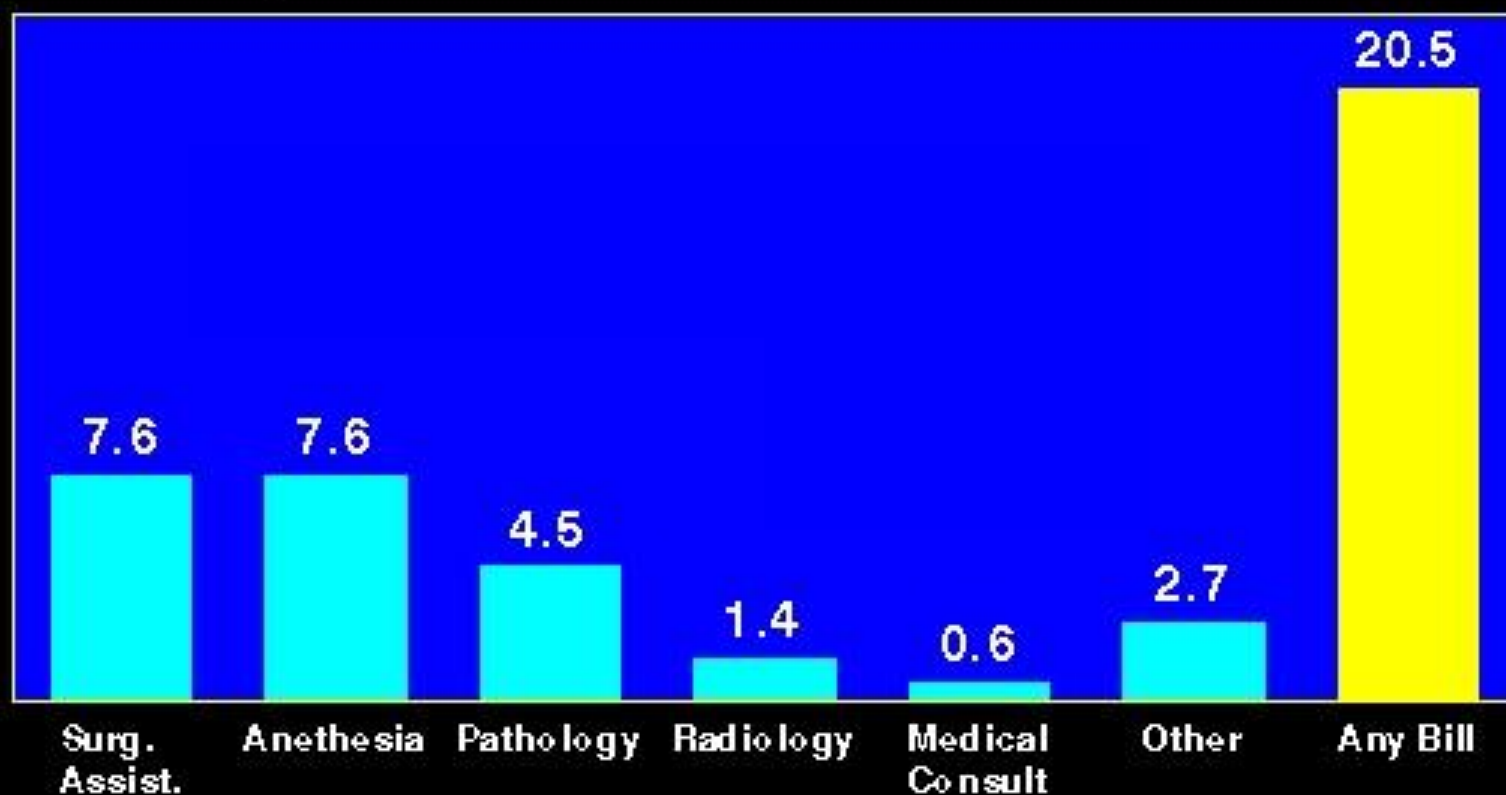
Mean out of network bill for ED care rose from \$220 to \$628

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

# One Fifth of Privately Insured Surgical Patients Get a Surprise Bill

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Percent of procedures with out of network bills



Source: JAMA 2020;323:538

Note: All patients had surgery at in-network hospital with in-network primary surgeon

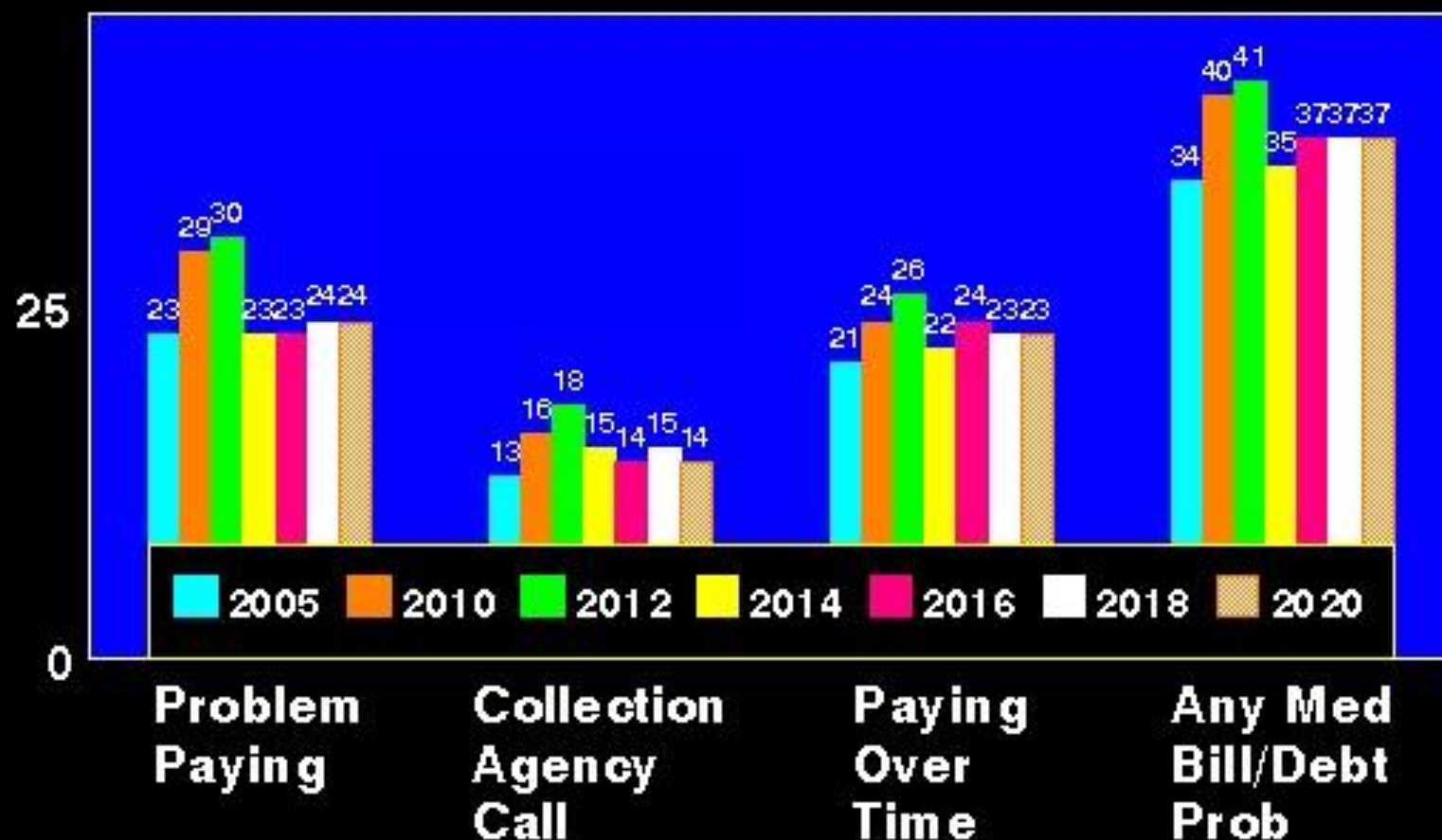
Average surprise bill = \$2,011



# Medical Bill and Debt Problems, 2005-2020

## No Better than in 2005

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

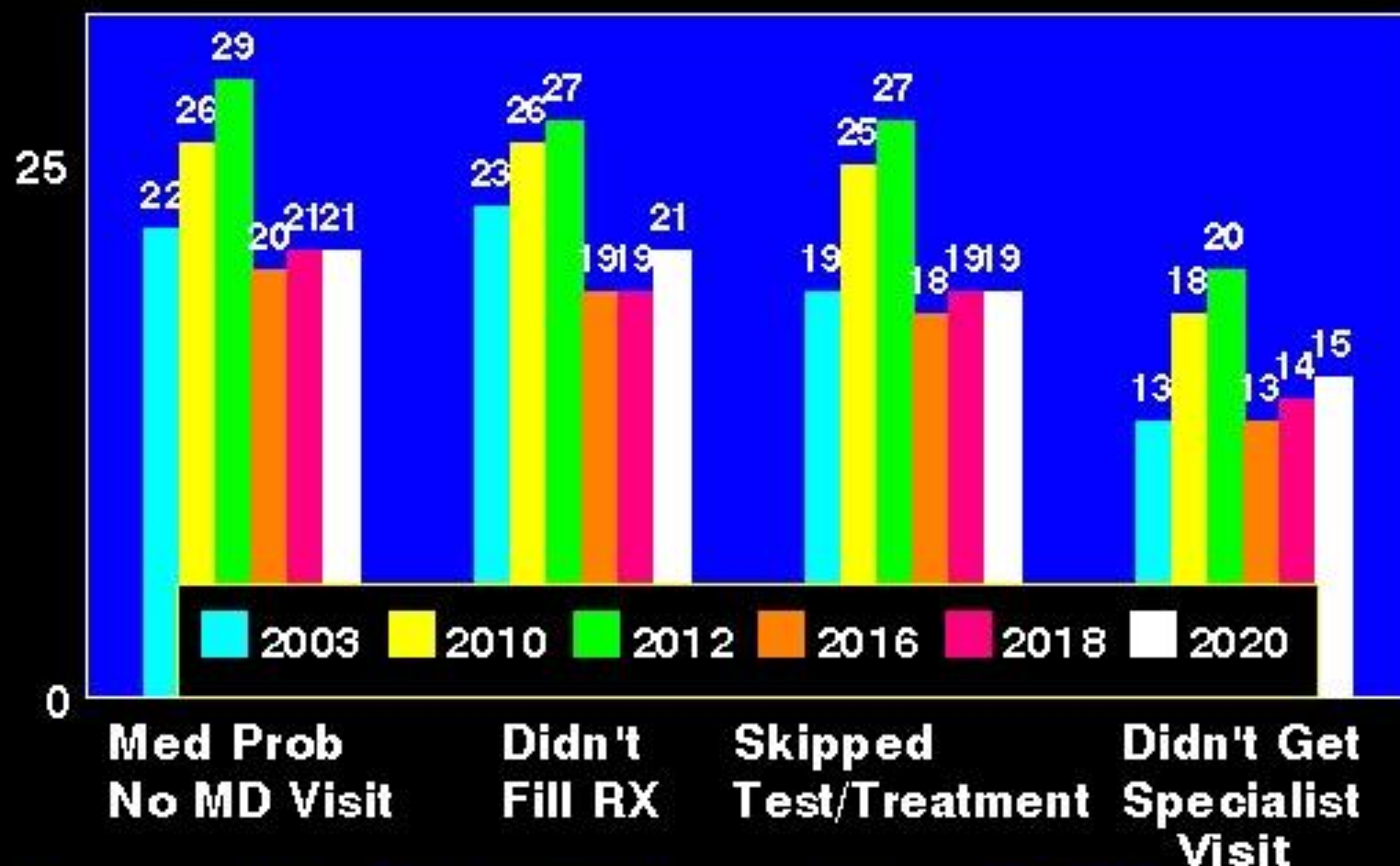




# Access to Care Problems, 2003-2020

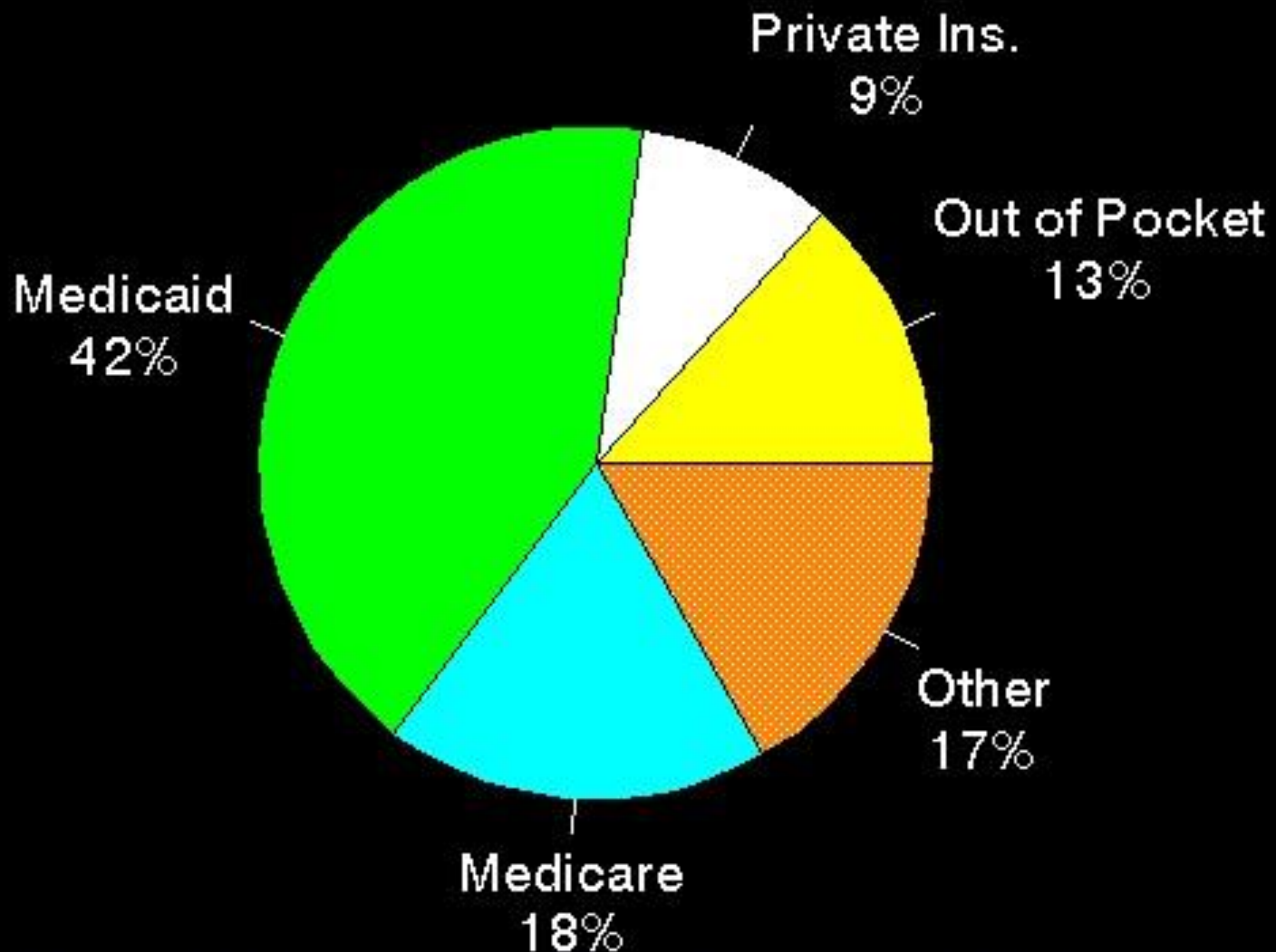
## Little Progress Since 2003

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 2019

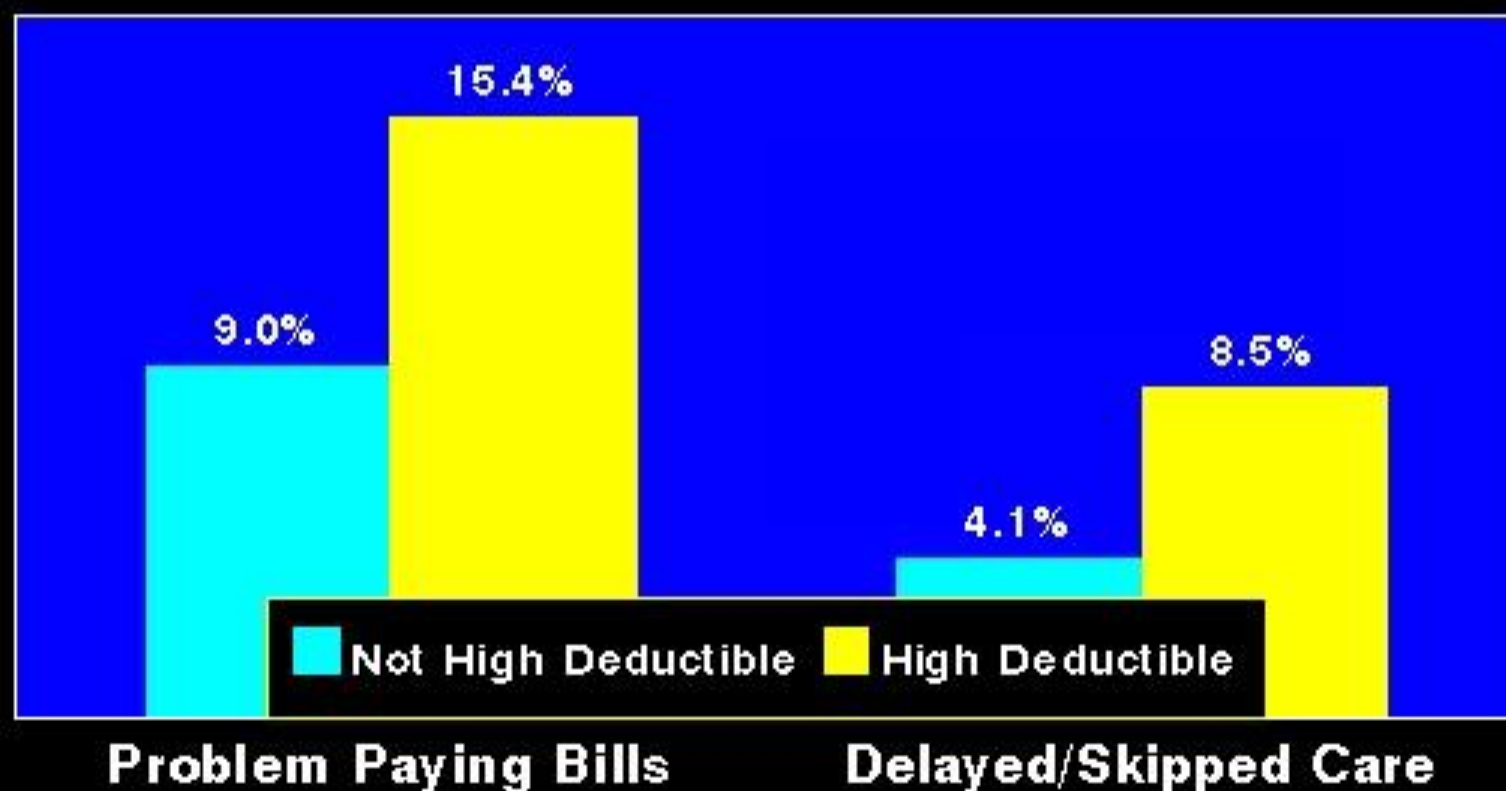
Note - Includes spending for NHs + Home care + "other residential and personal care"

Under-Insurance  
Impedes Care,  
Worsens Health

# High Deductible Coverage (HDHP) Compromises Finances and Access

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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

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Median Financial Assets (Thousands)



Source: Federal Reserve Survey of Consumer Finance 2019

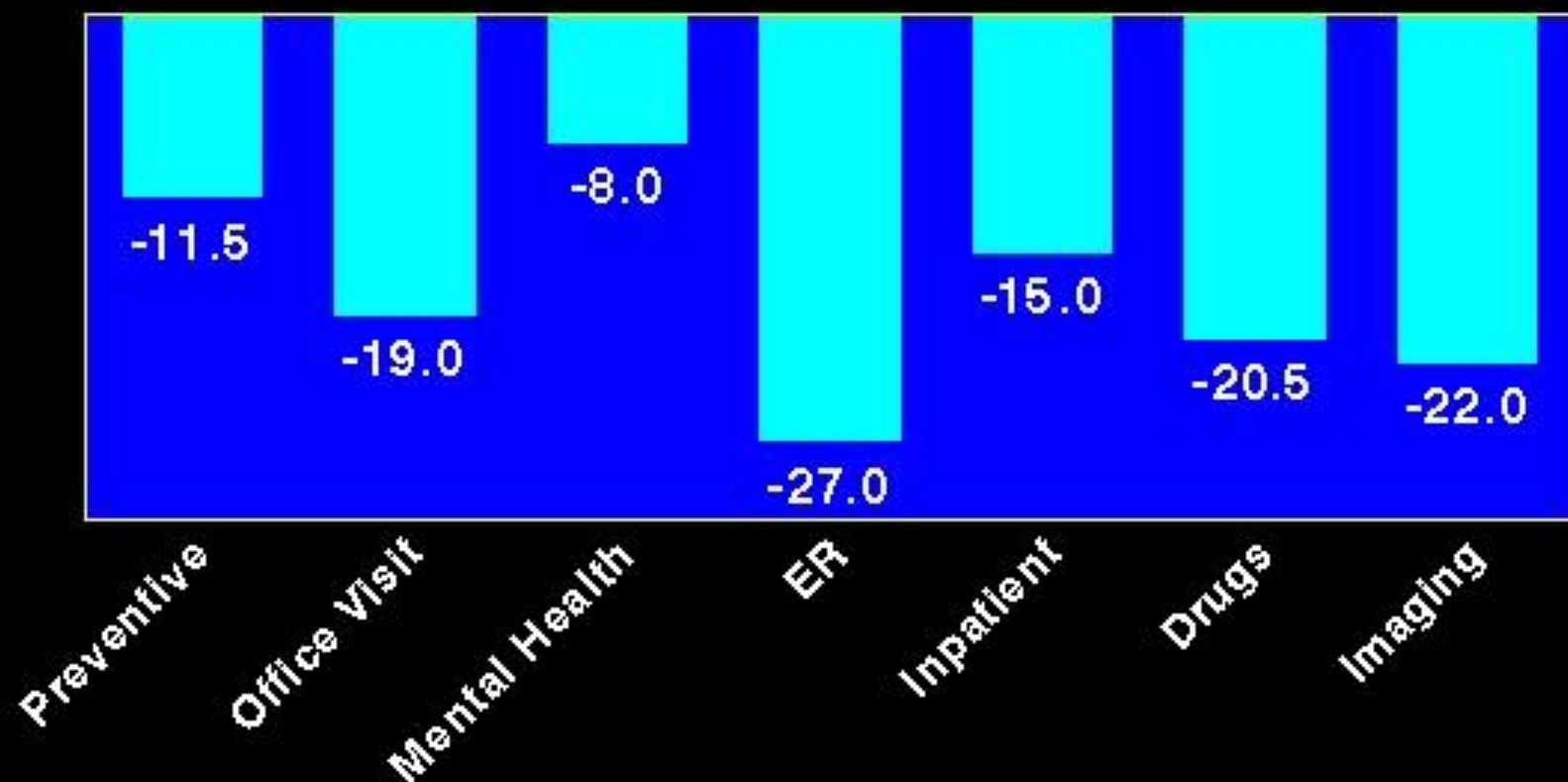


# High Deductibles Cut All Kinds of Care

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>

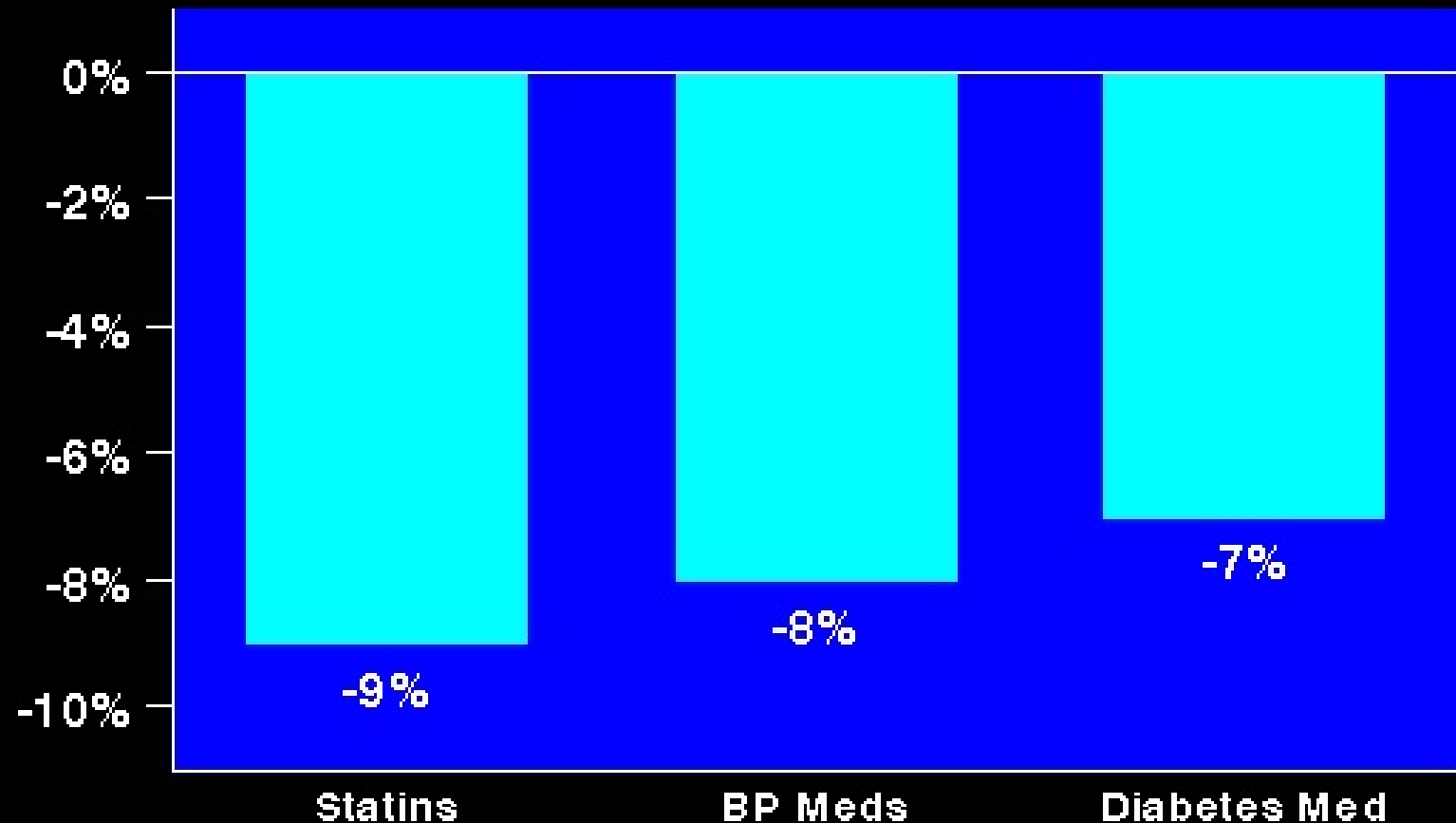
Note: Findings closely resemble those of Rand Health Insurance Experiment

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

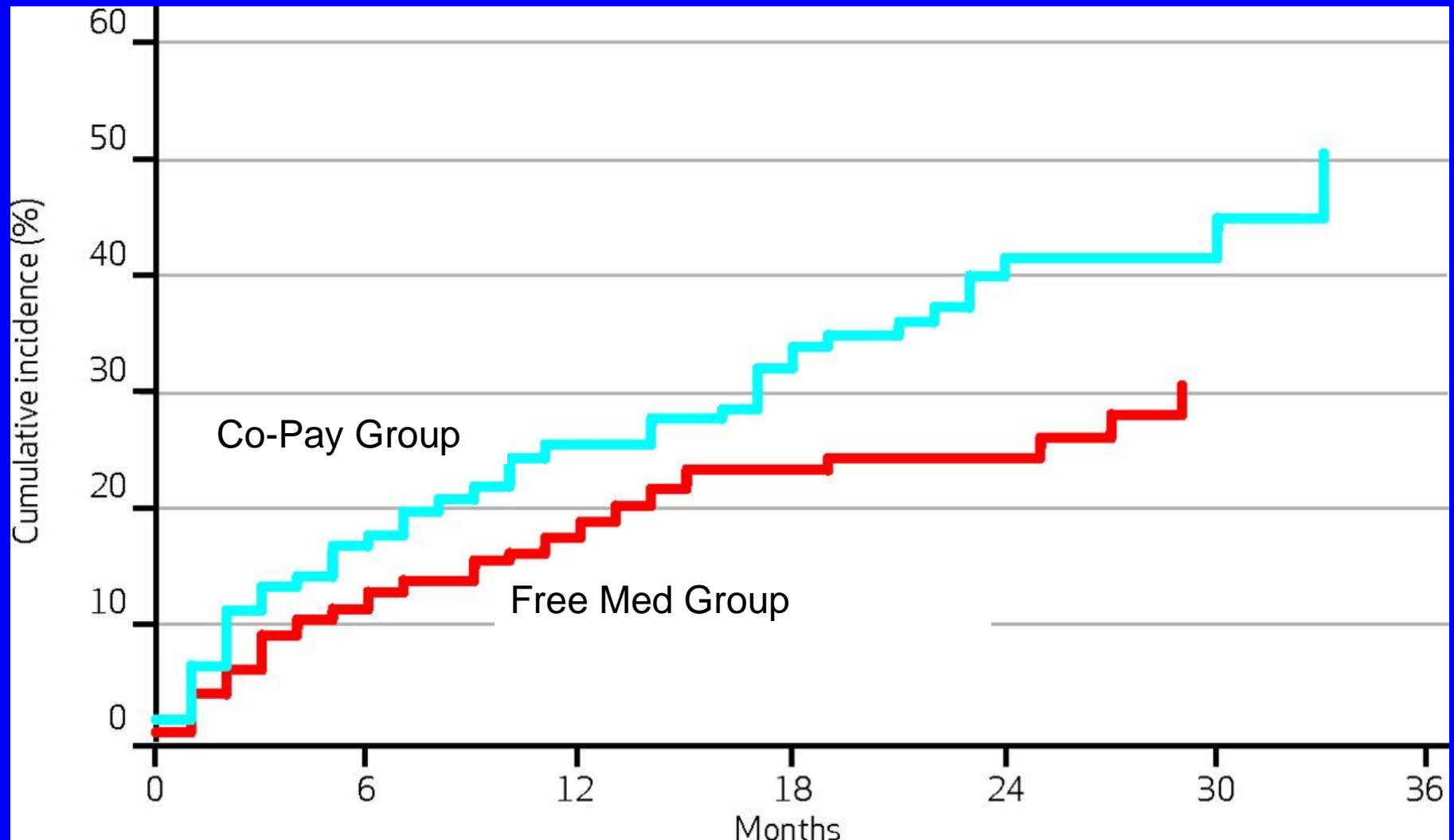
# Drug Deductible Reduced Needed Medication Use

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

Percent Change in Days of Medication Use After Drug Deductible Implemented



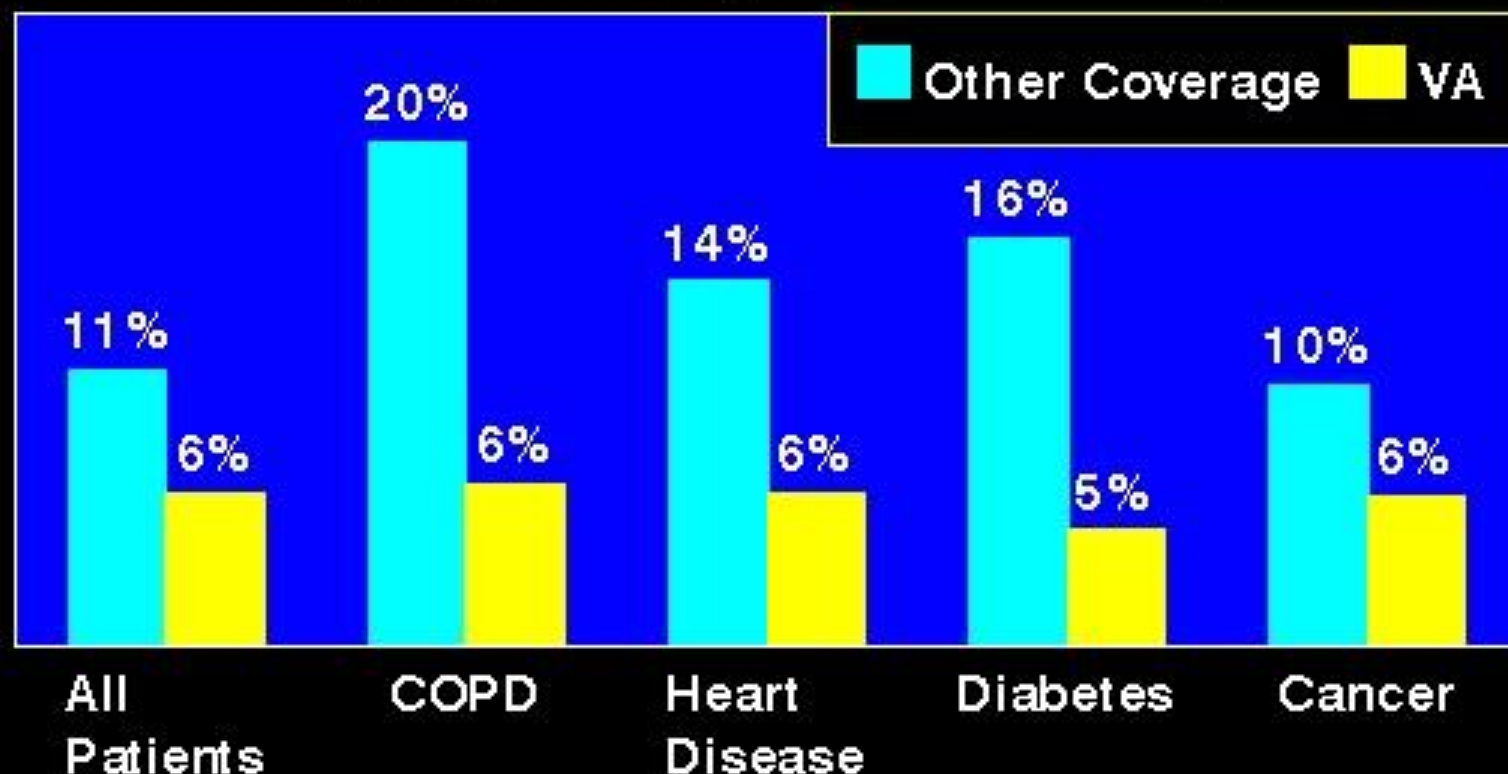
# Medication Co-pays Increased Post-MI Vascular Events in Minorities – An RCT



Source: Health Aff 2014;33:863

# VA Drug Coverage Cuts Cost-related Non-Adherence

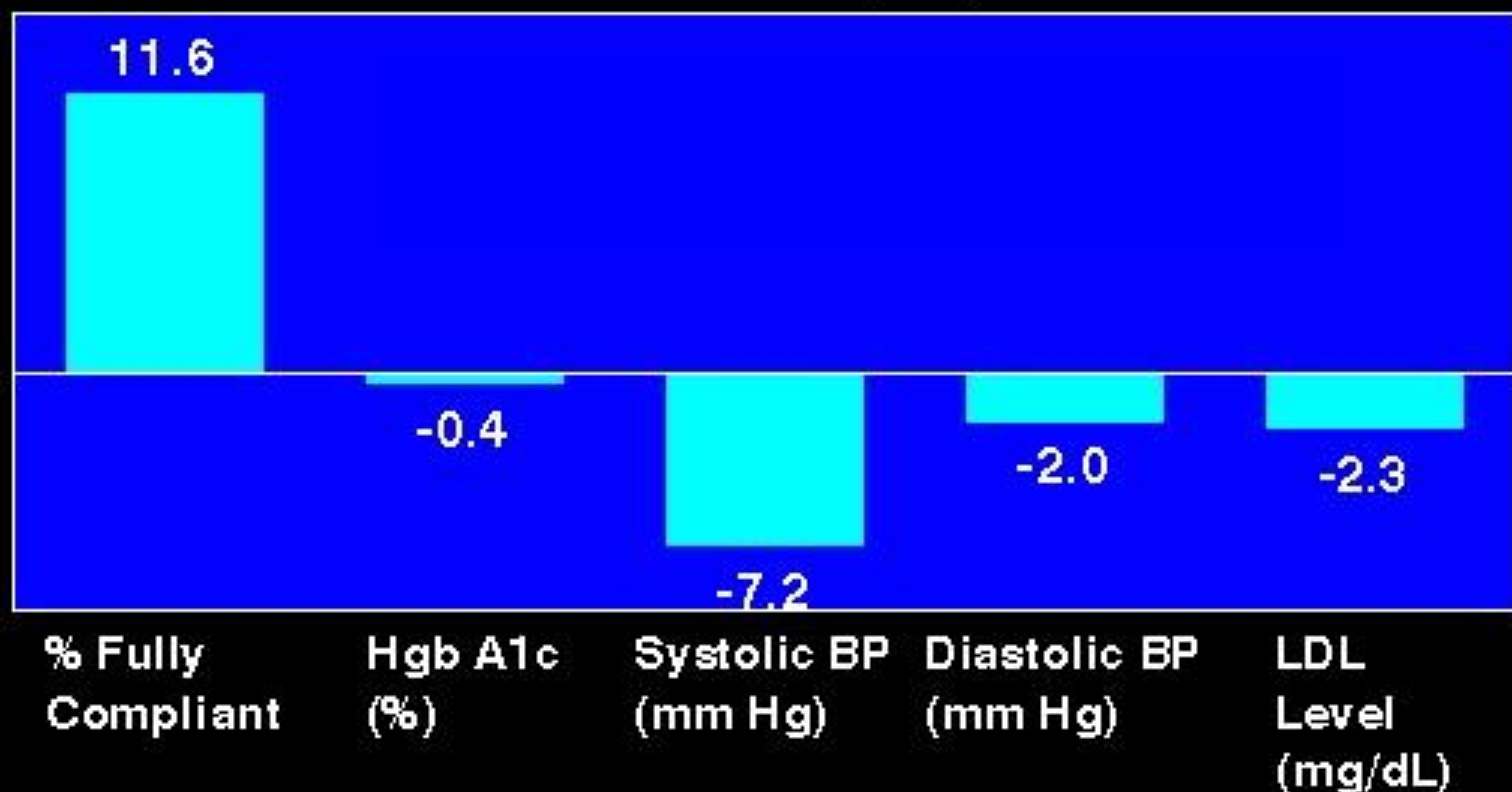
Percent skipping/delaying meds to save \$s



# RCT: Free Meds Improved Compliance and Outcomes

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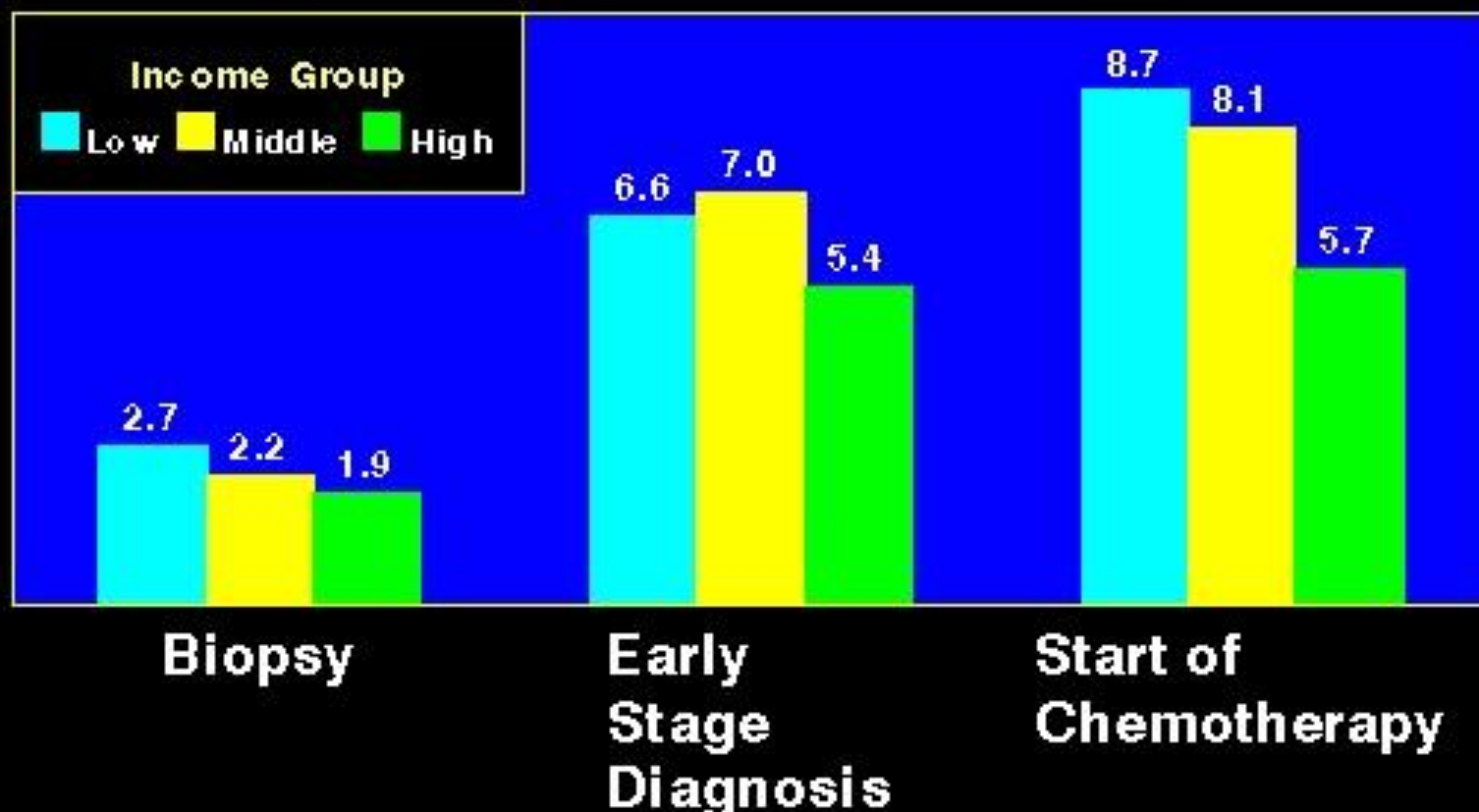
Difference: free meds vs. control group





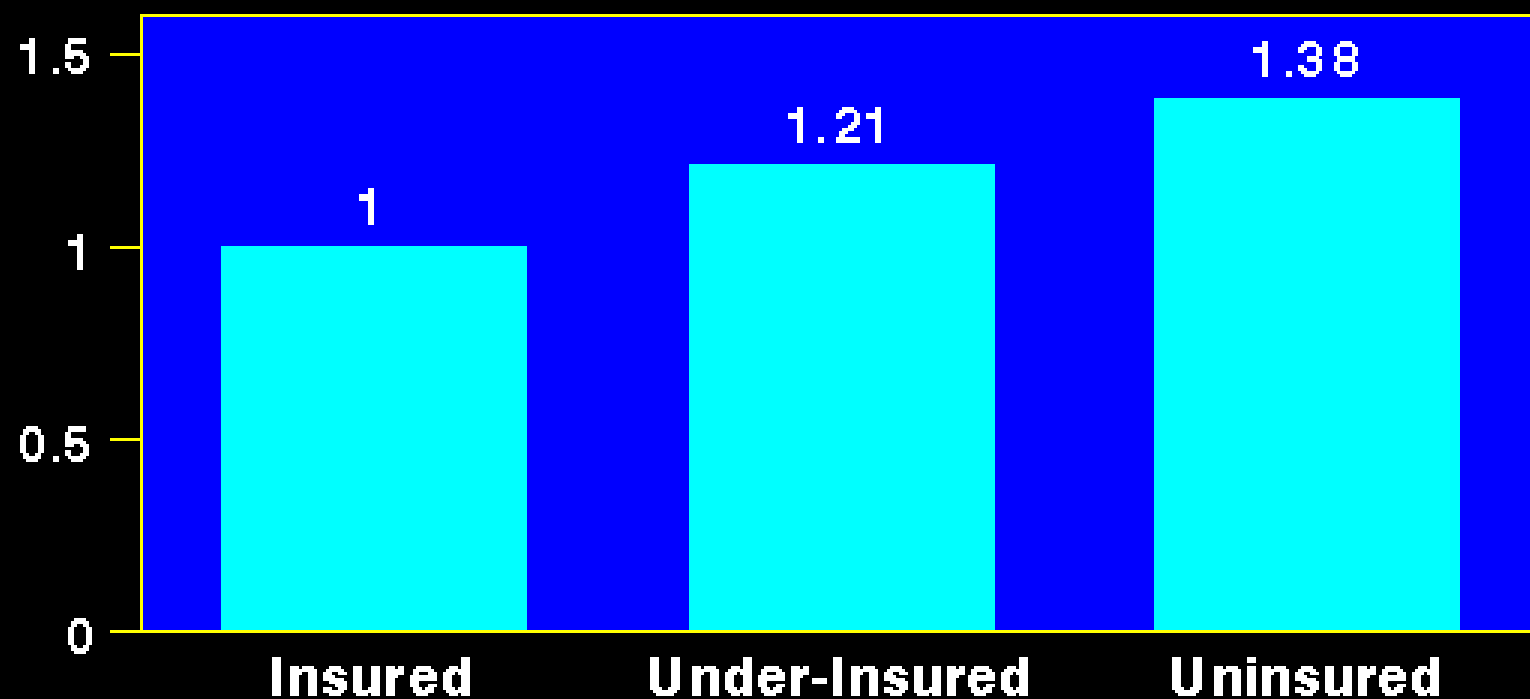
# High Deductible Plans Delayed Breast Cancer Care

Extra delay (months) high vs. low deductible



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

Odds ratio for delayed care\*



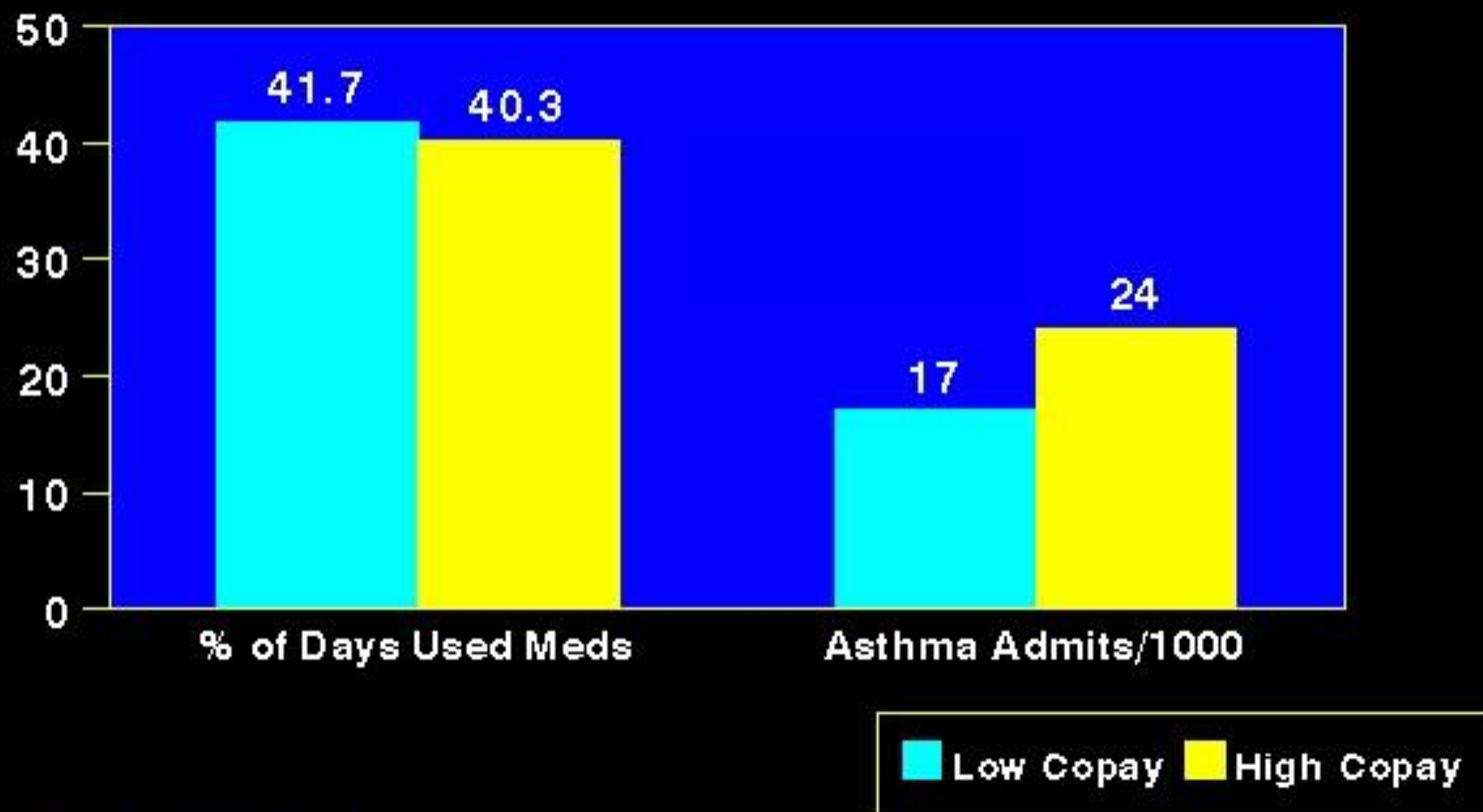
Source: JAMA April 15, 2010;303:1392

\*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

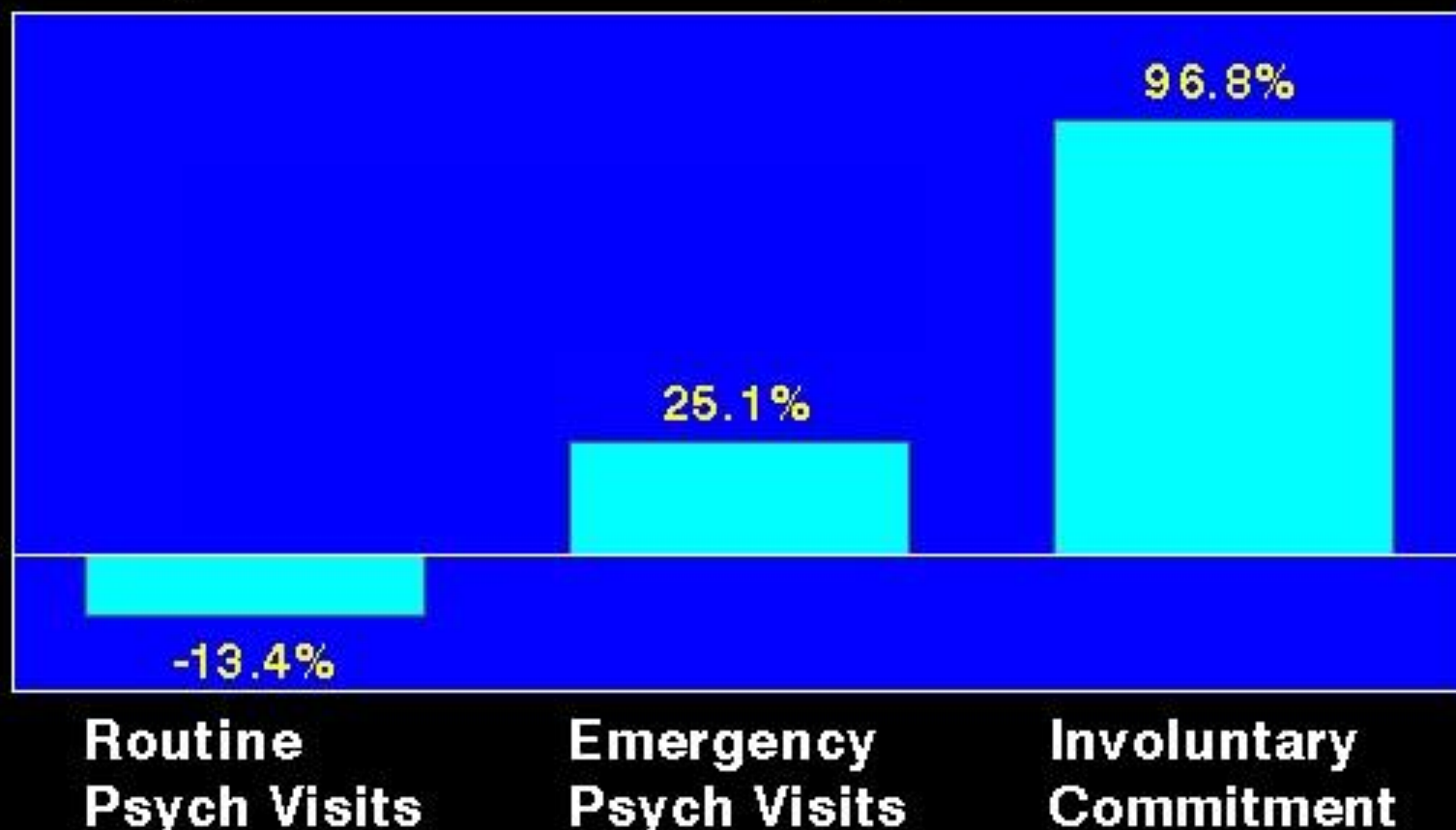
Children Age 5-18



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

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Change in visit rates after copay added



Source: JAMA Psychiatry 2017;74:932

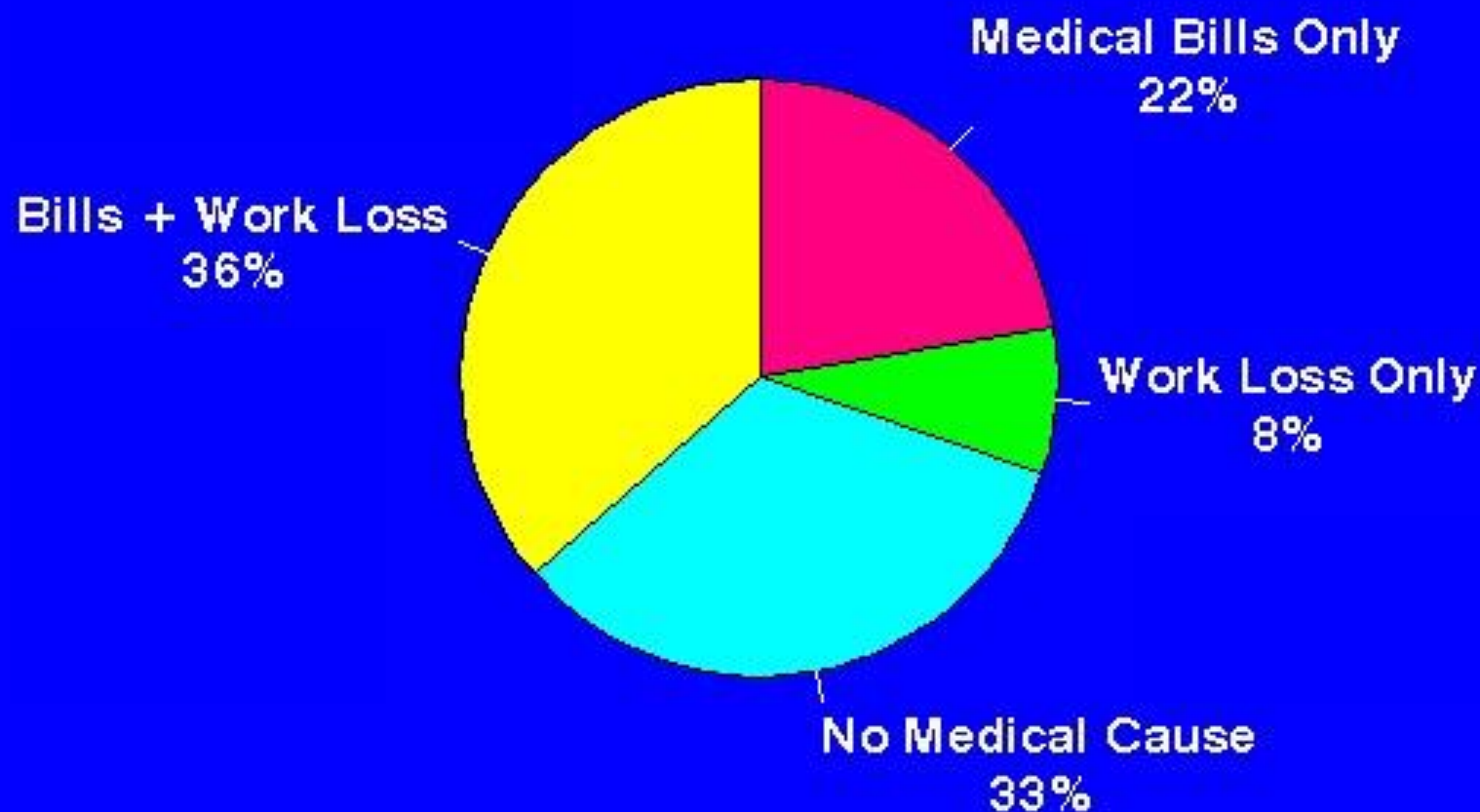
Note: Copay was not applied to children, whose use rates remained stable

# 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

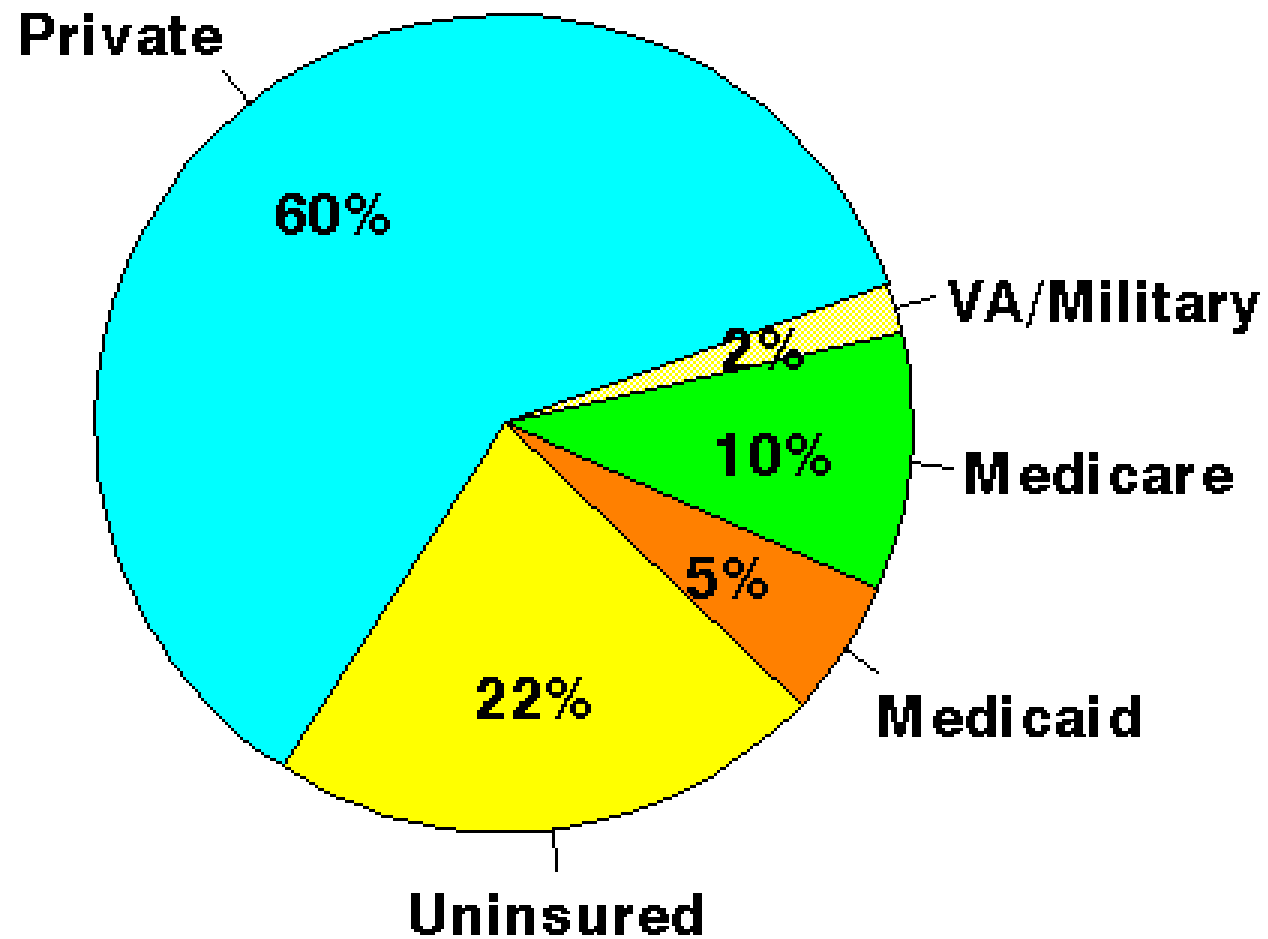
National Survey of Debtors, 2013-2016



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

Work loss = "work loss due to illness"

# Most of the Medically Bankrupt Had Coverage

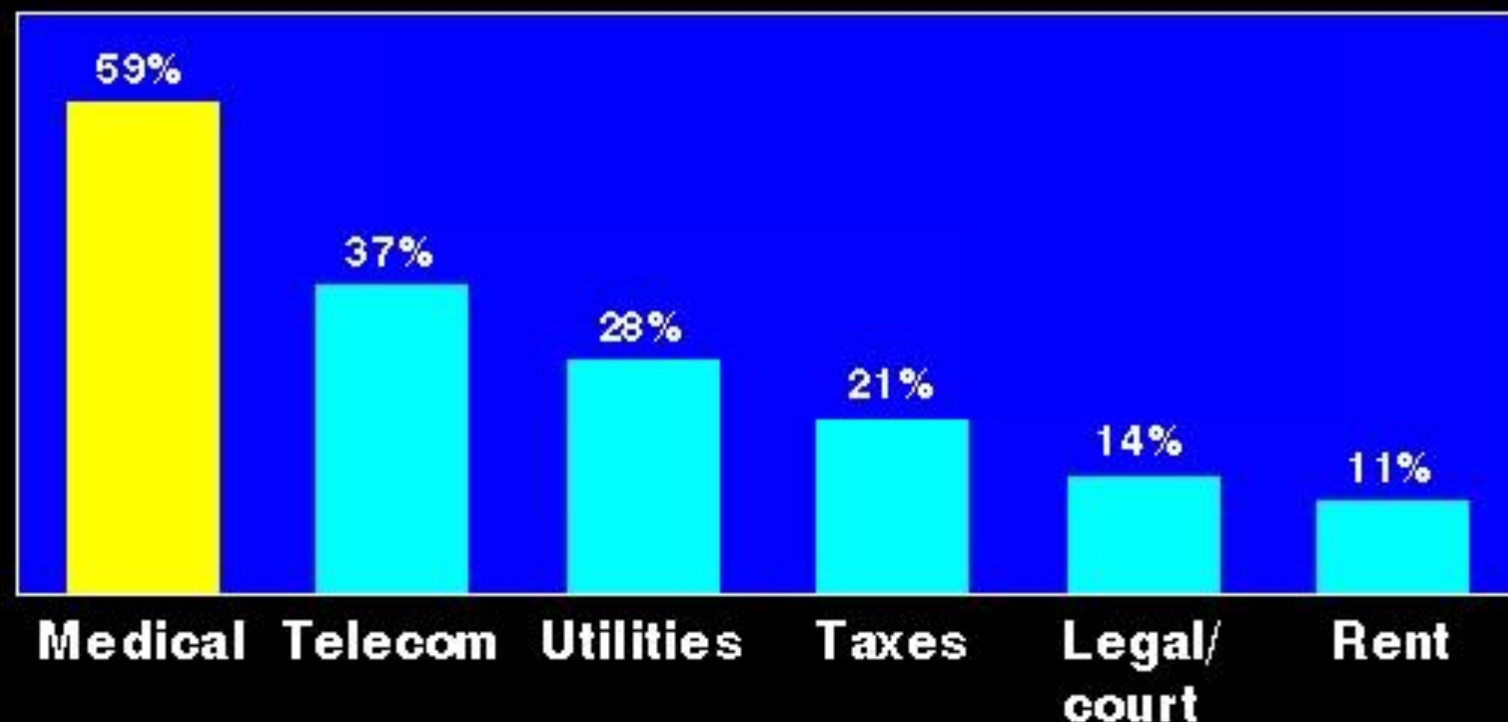


Insurance at Illness Onset

# Medical Bills are Most Common Reason for Collection Calls

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Percent of consumers receiving collection calls with specific type of debt



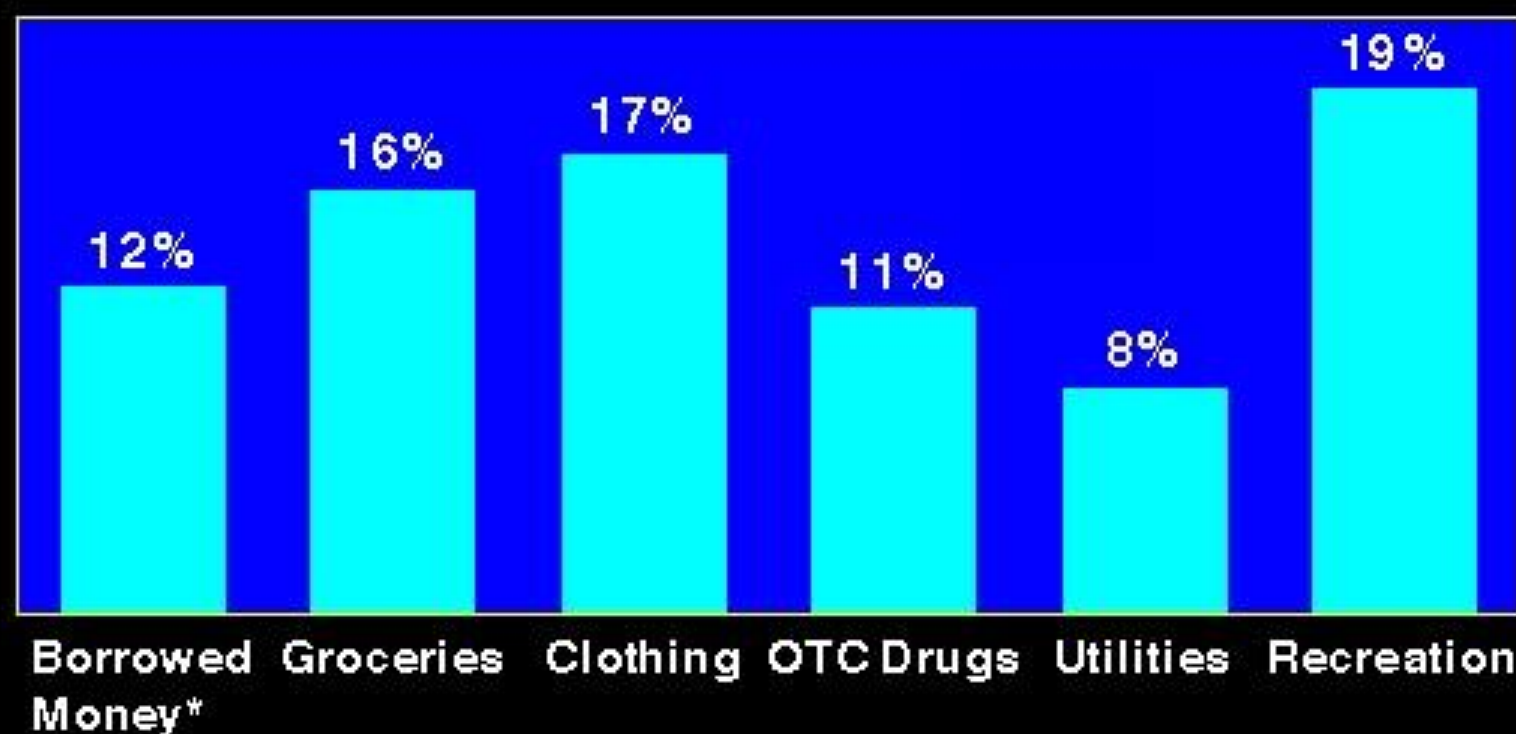
Source: Consumer Financial Protection Bureau, January, 2017

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

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



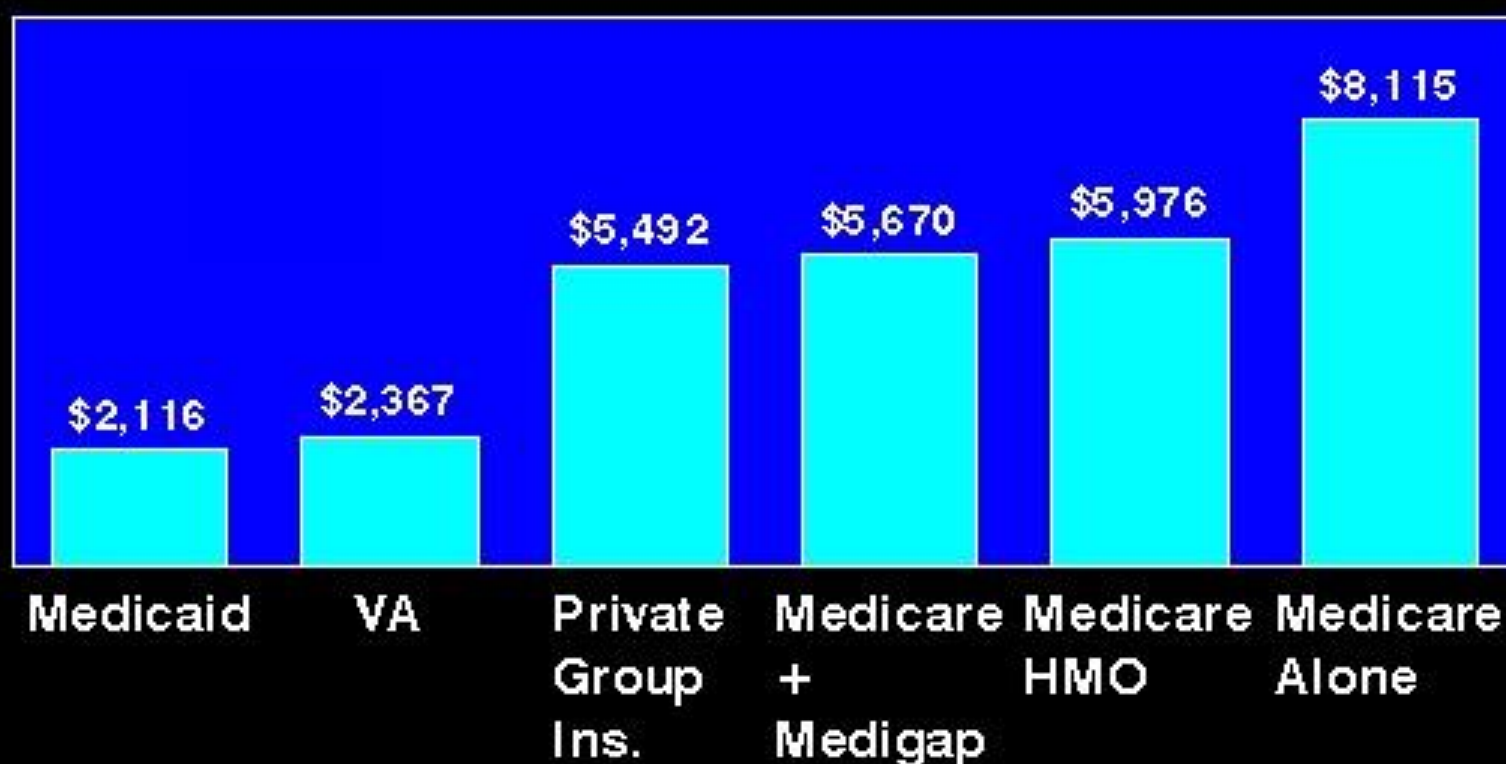
Source: Westhealth/Gallup - Public Perceptions of the U.S. Healthcare System - 2019

\* 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



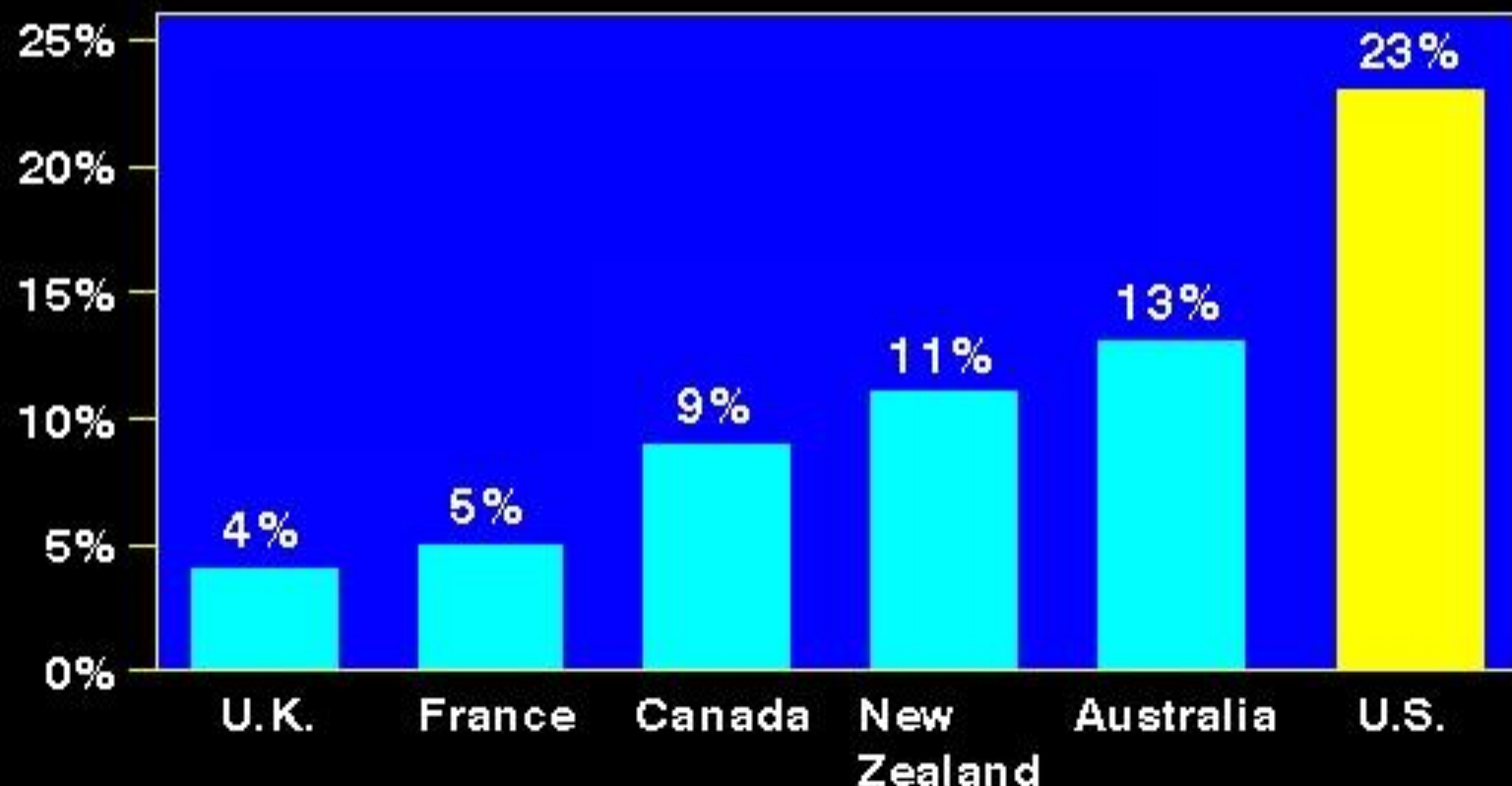
Source: JAMA Oncology 2017;3:753 - Based on analysis of data from Health and Retirement Study  
Note - Median household income was \$51,371



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

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

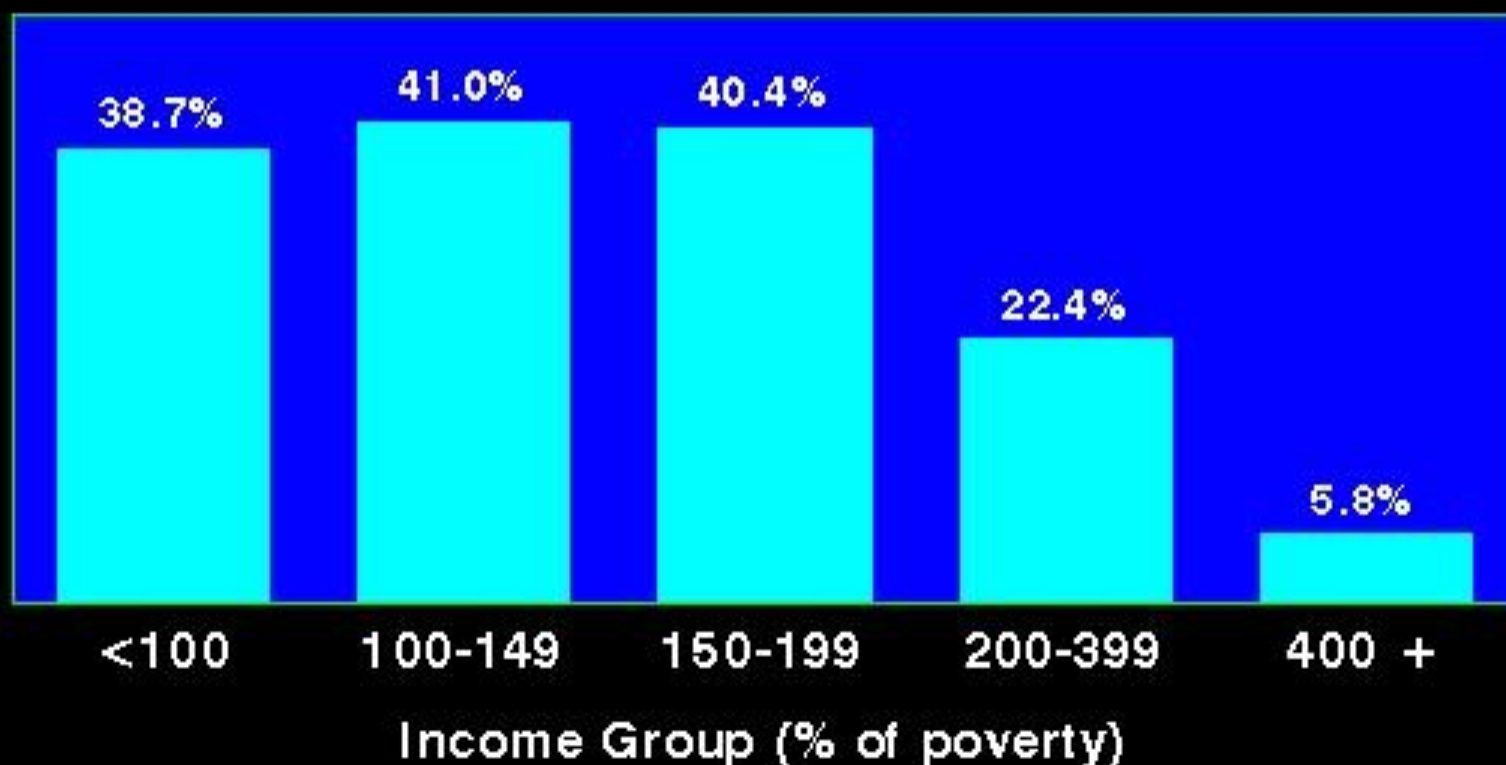


# Medicare Needs Improvement

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

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

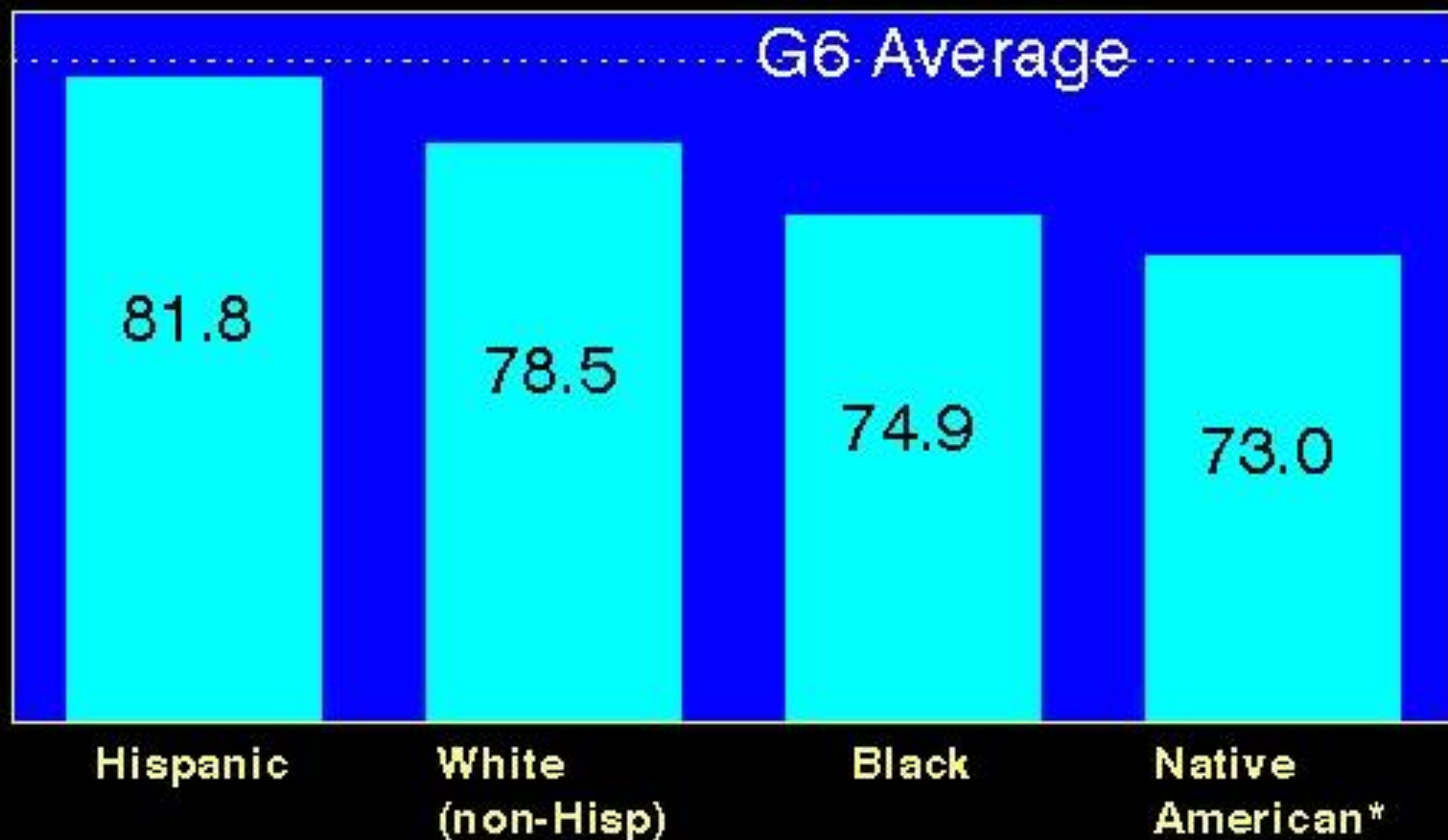


# Racism Harms Health

# Black and Native Americans Die Younger

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

Life expectancy, years

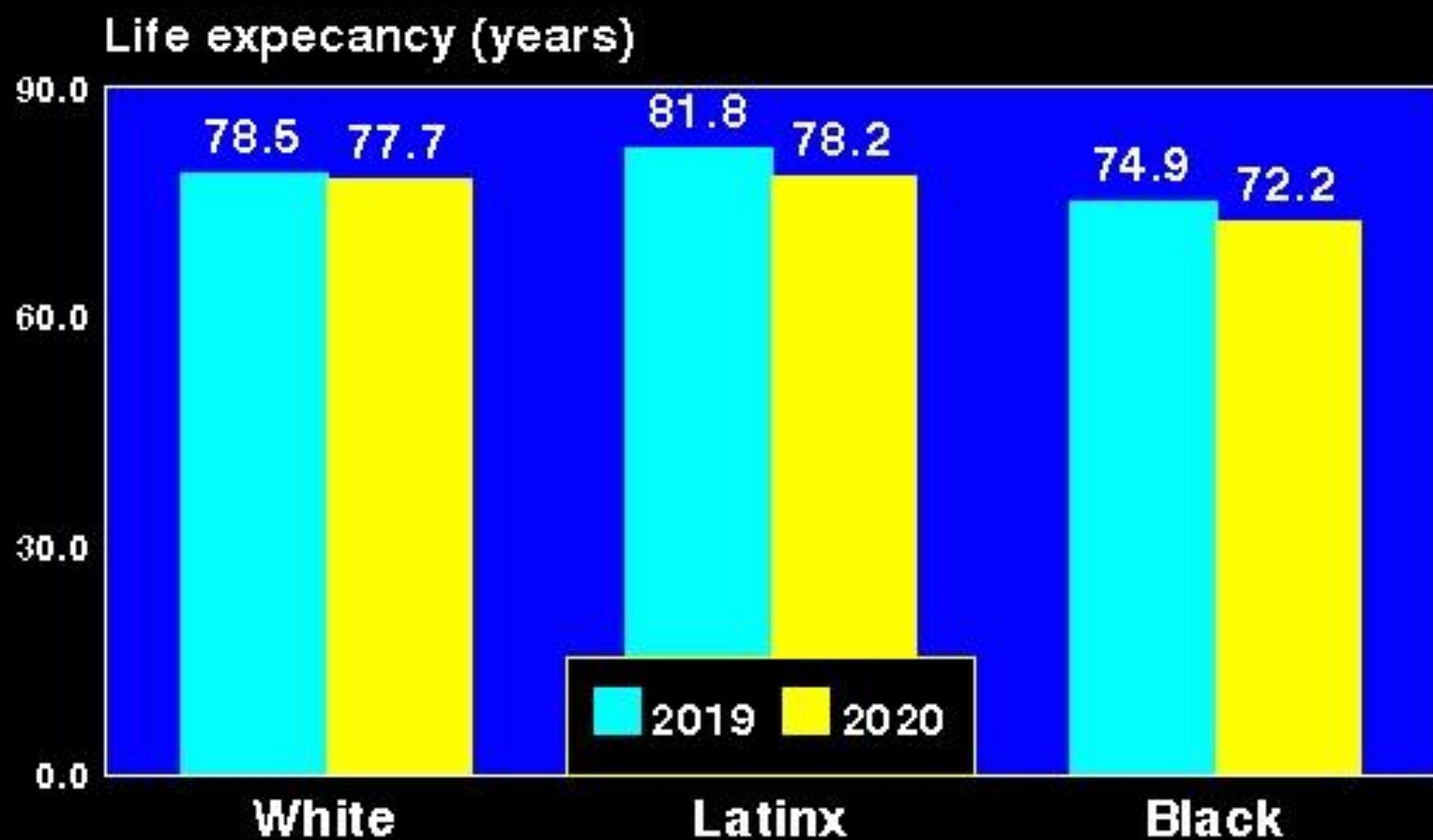


Source: NCHS, IHS, OECD

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

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

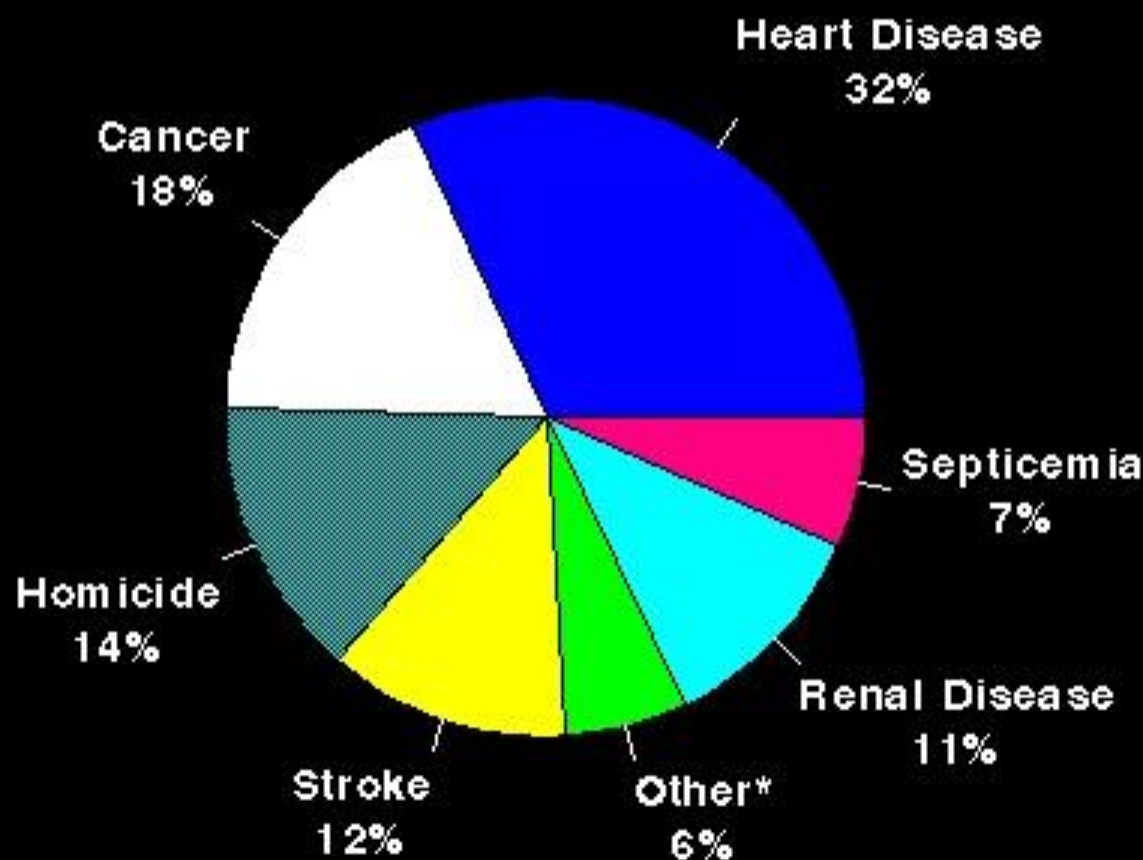
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Source: Andrasfay and Goldman MedRxiv preprint 9/15/2020



# Causes of Black/White Disparity in Adult Mortality

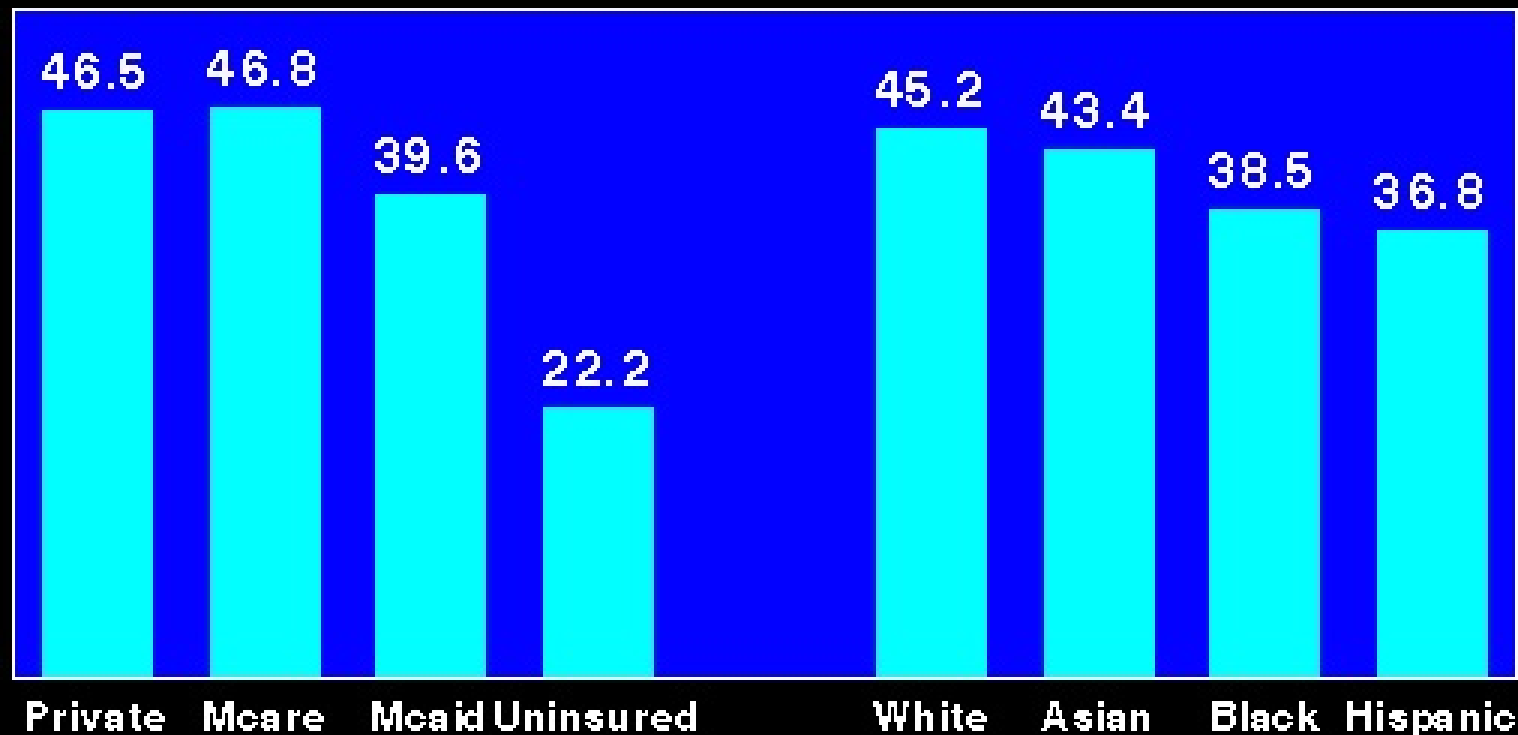


Source: MMWR May 2, 2017

\* 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

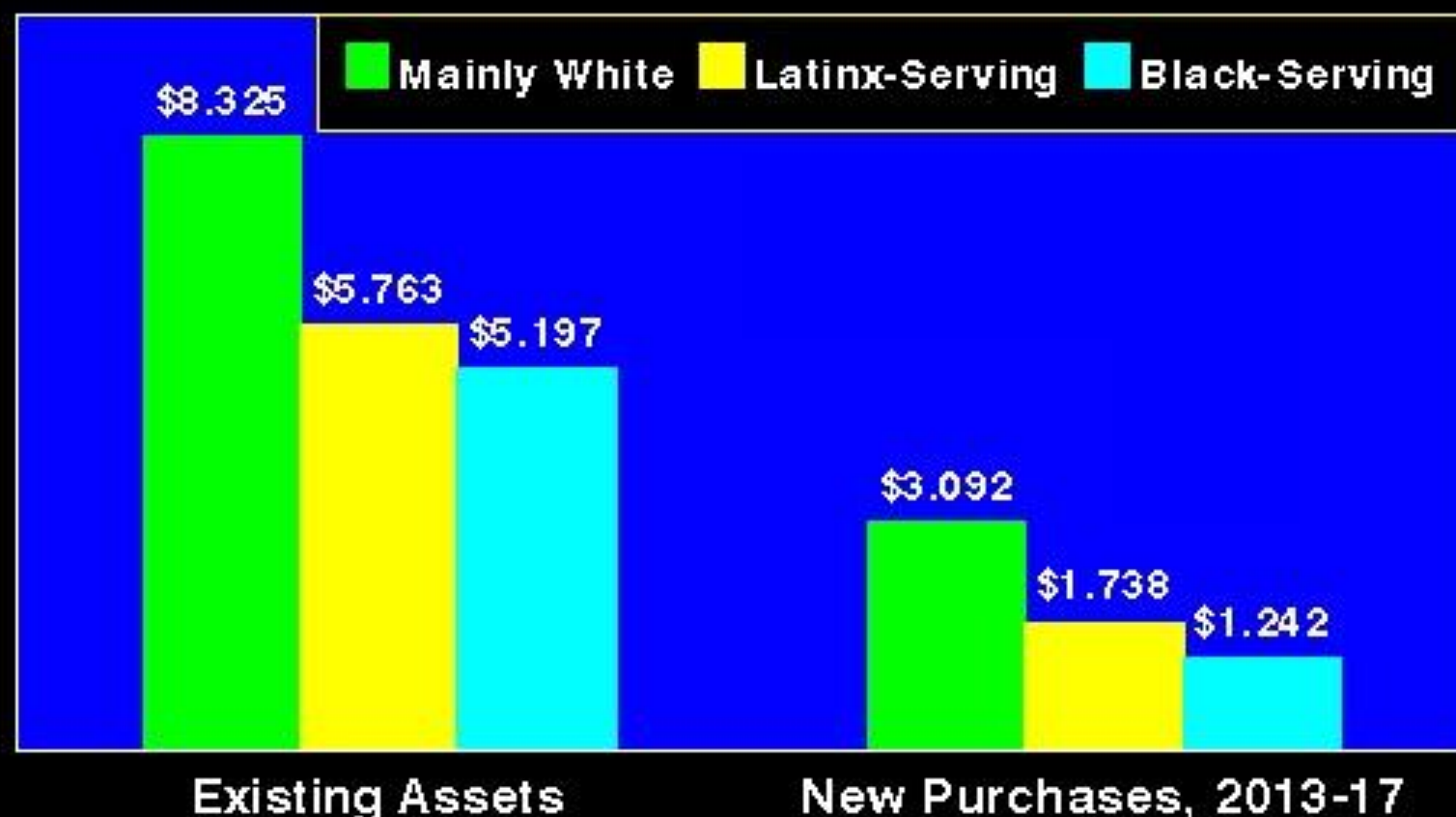
# Uninsured and People of Color Have Worse Blood Pressure Control

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



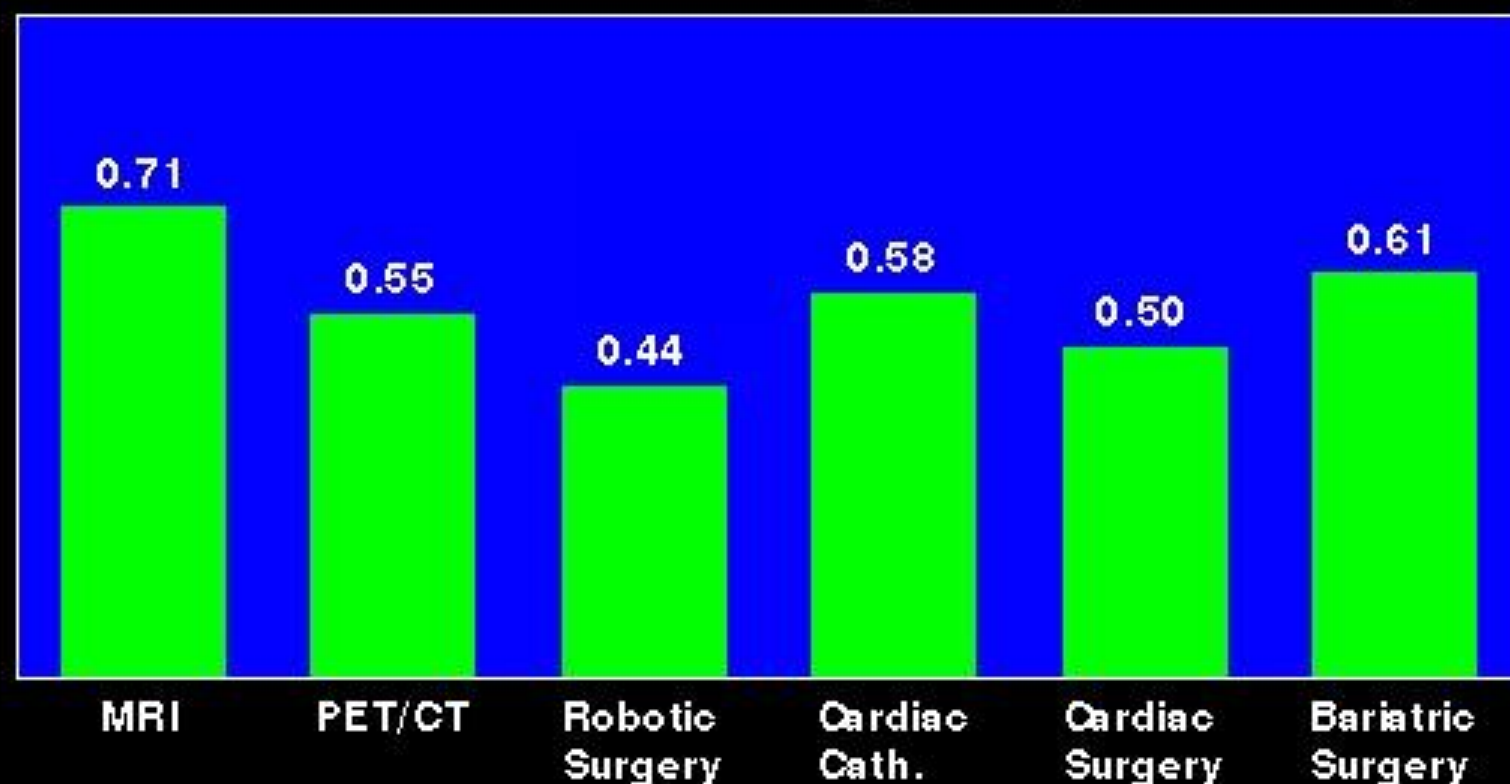
Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020

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

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



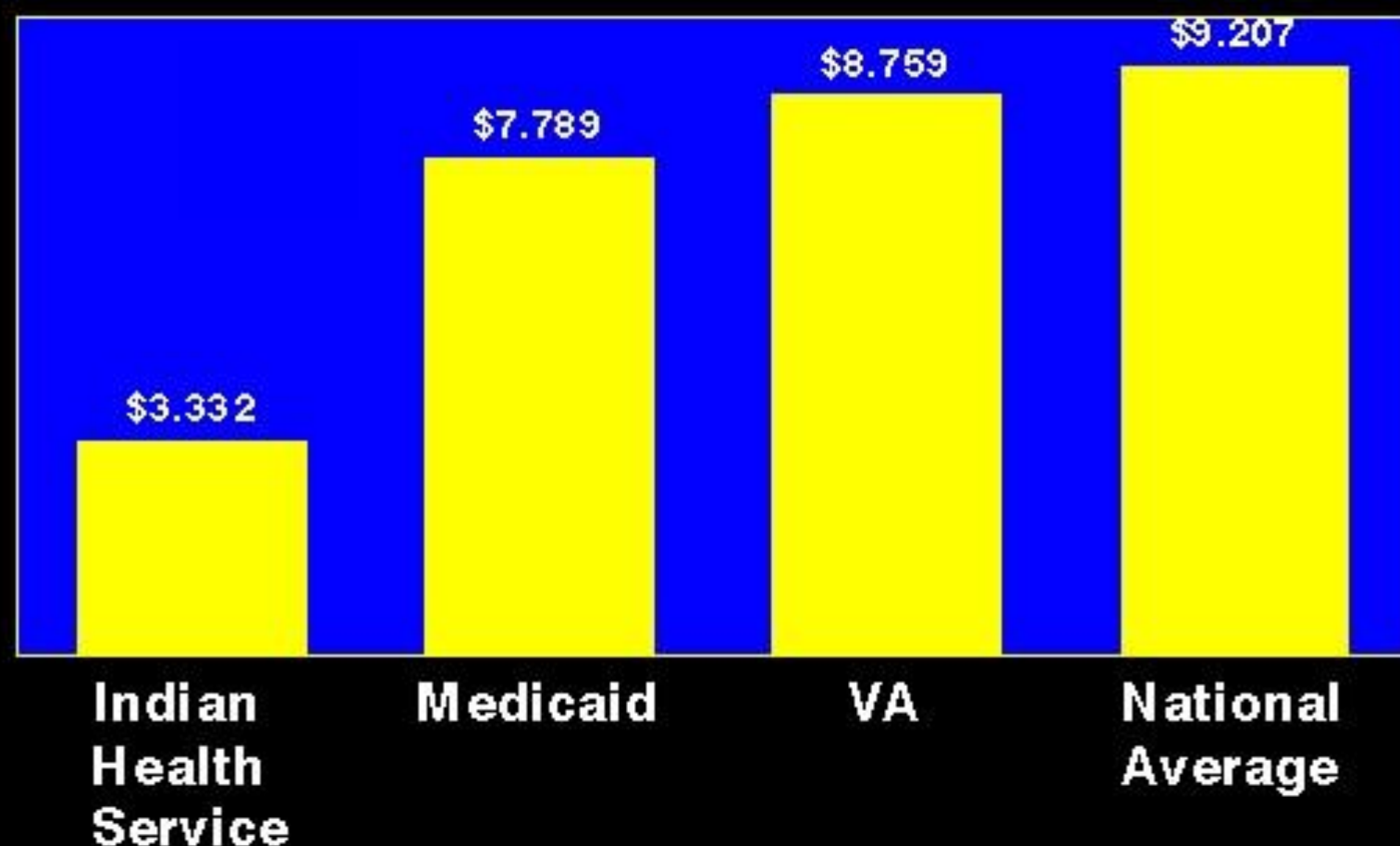
Source: Gracie and Kathryn Himmelstein, *Int J Health Services* 2020

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

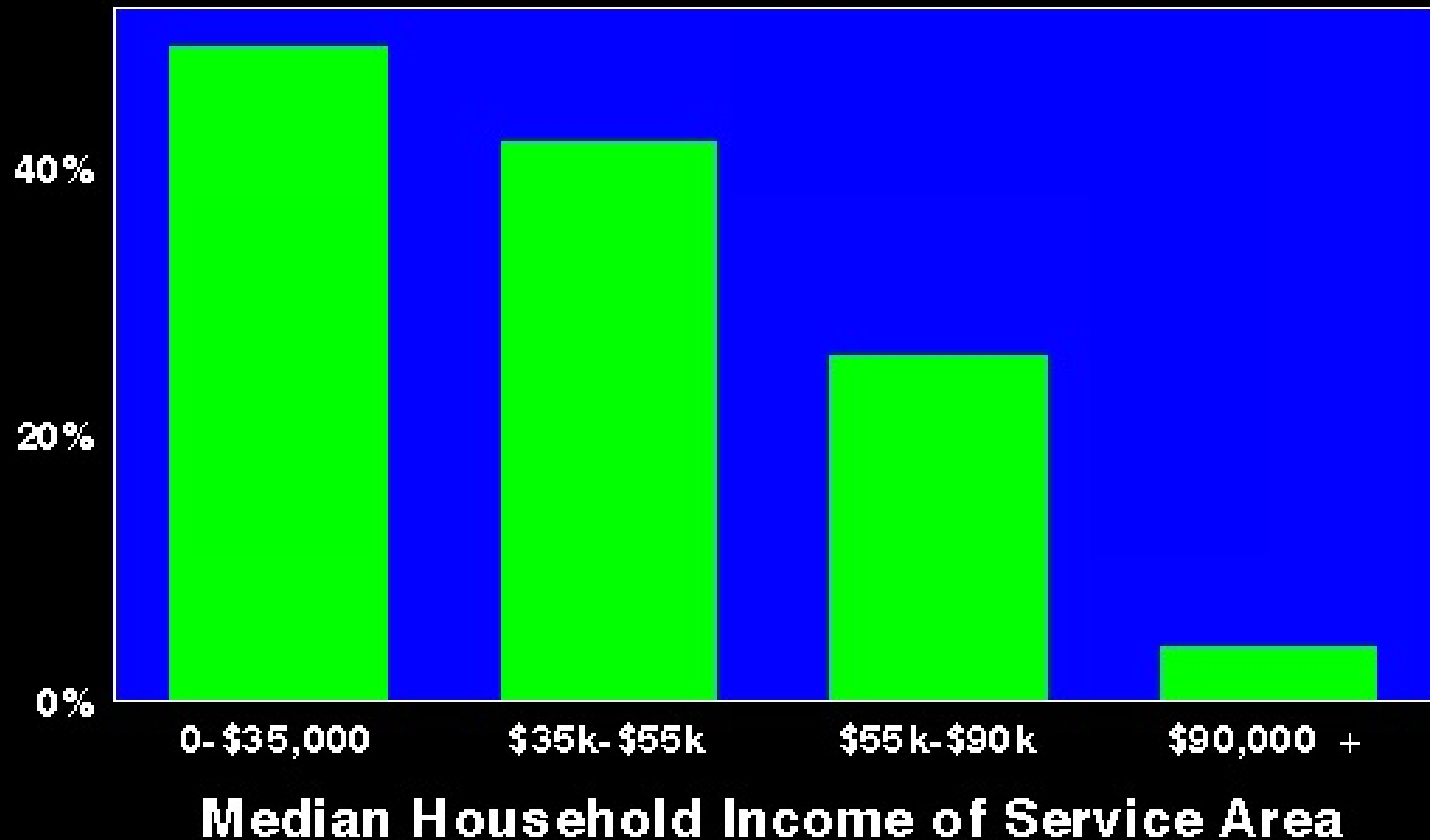
Note: Estimated spending shortfall, including facility upgrades = \$36.83 billion



# Poorer Regions, Fewer ICU Beds

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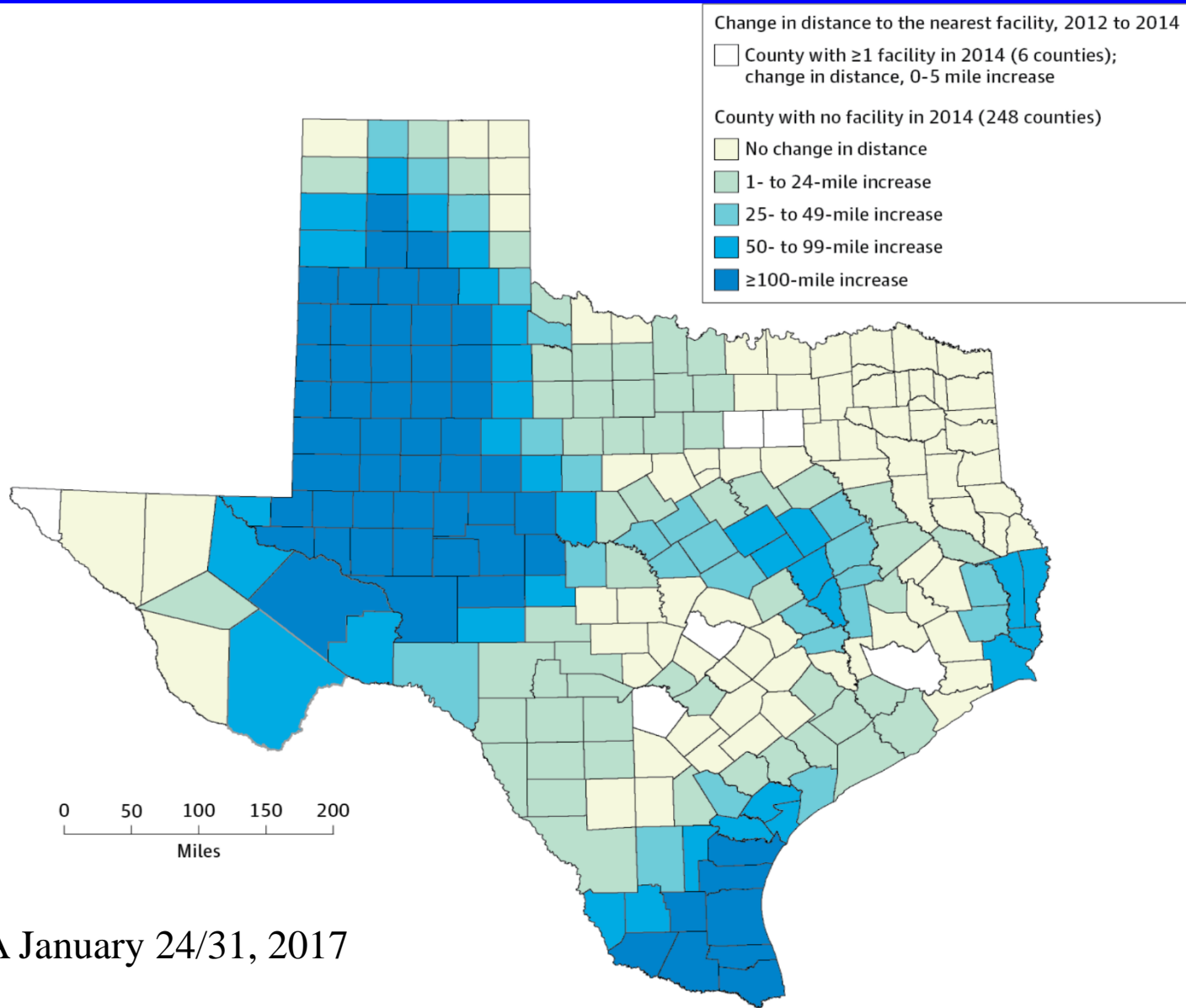
Share of hospital service areas with NO ICU



Source: Health Aff 2020;39:1362

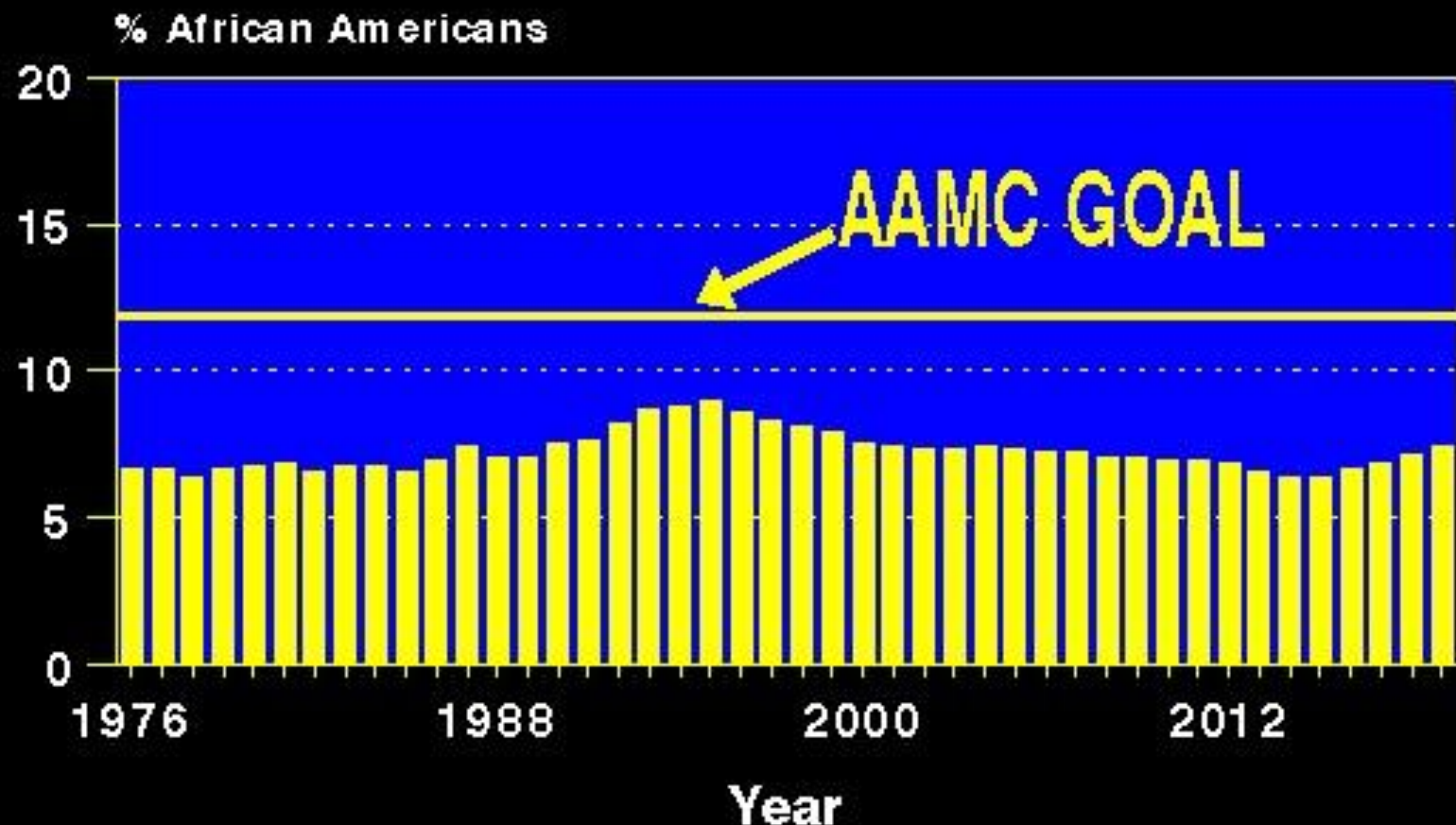
Note: A \$10,000 increase in median income was associated with a 11.8% increase in ICU beds

# Texas is Putting Abortion Facilities Out of Reach, Forcing Women to Travel Further



Source: JAMA January 24/31, 2017

# Black Enrollment in U.S. Medical Schools, 1976-2019/20



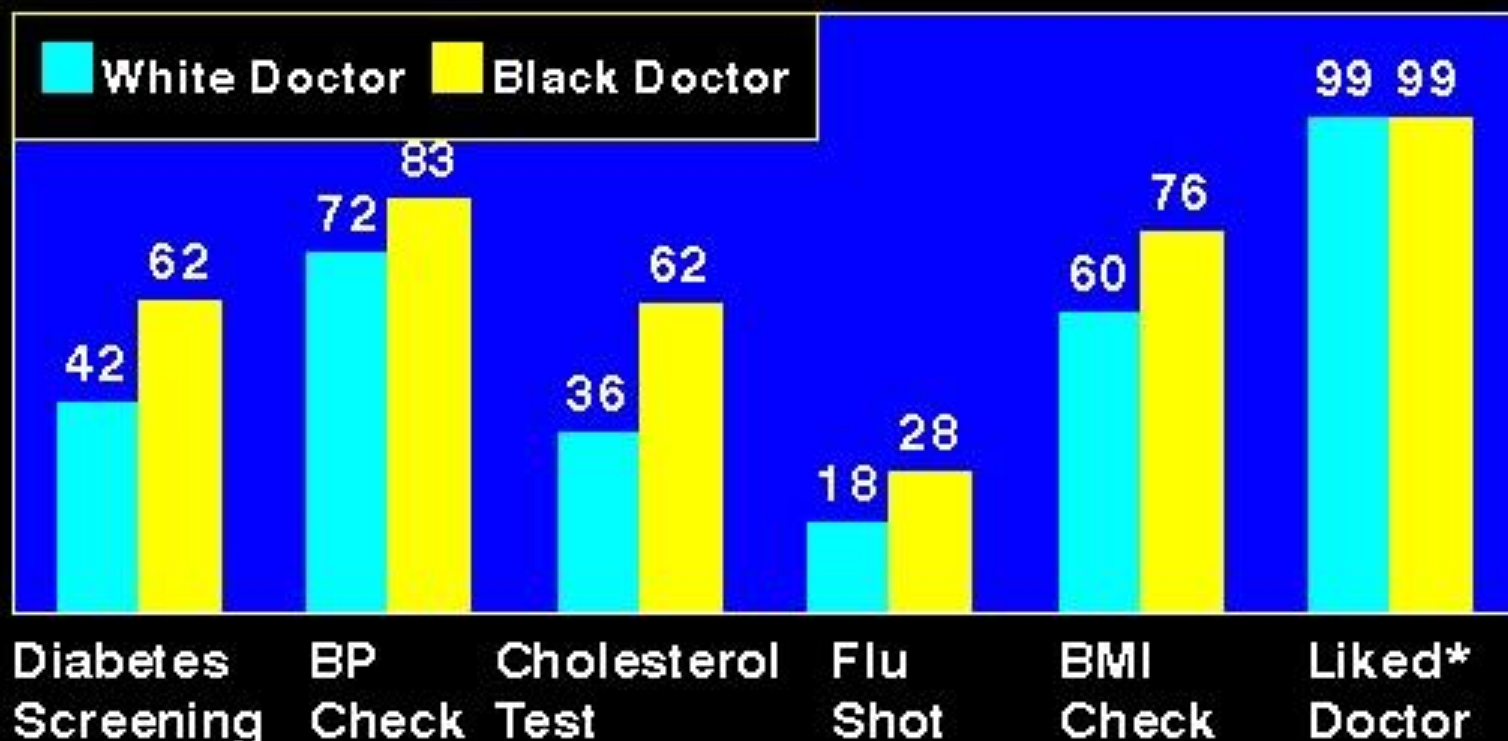
Source: RWJ Fdn. 1987; AAMC; & JAMA Annual Medical Education Special Issue

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

## Even Though They Gave Black and White Doctors Same Ratings

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Percent following prevention advise (or recommending the doctor)



Source: American Economic Rev 2019;109:4071

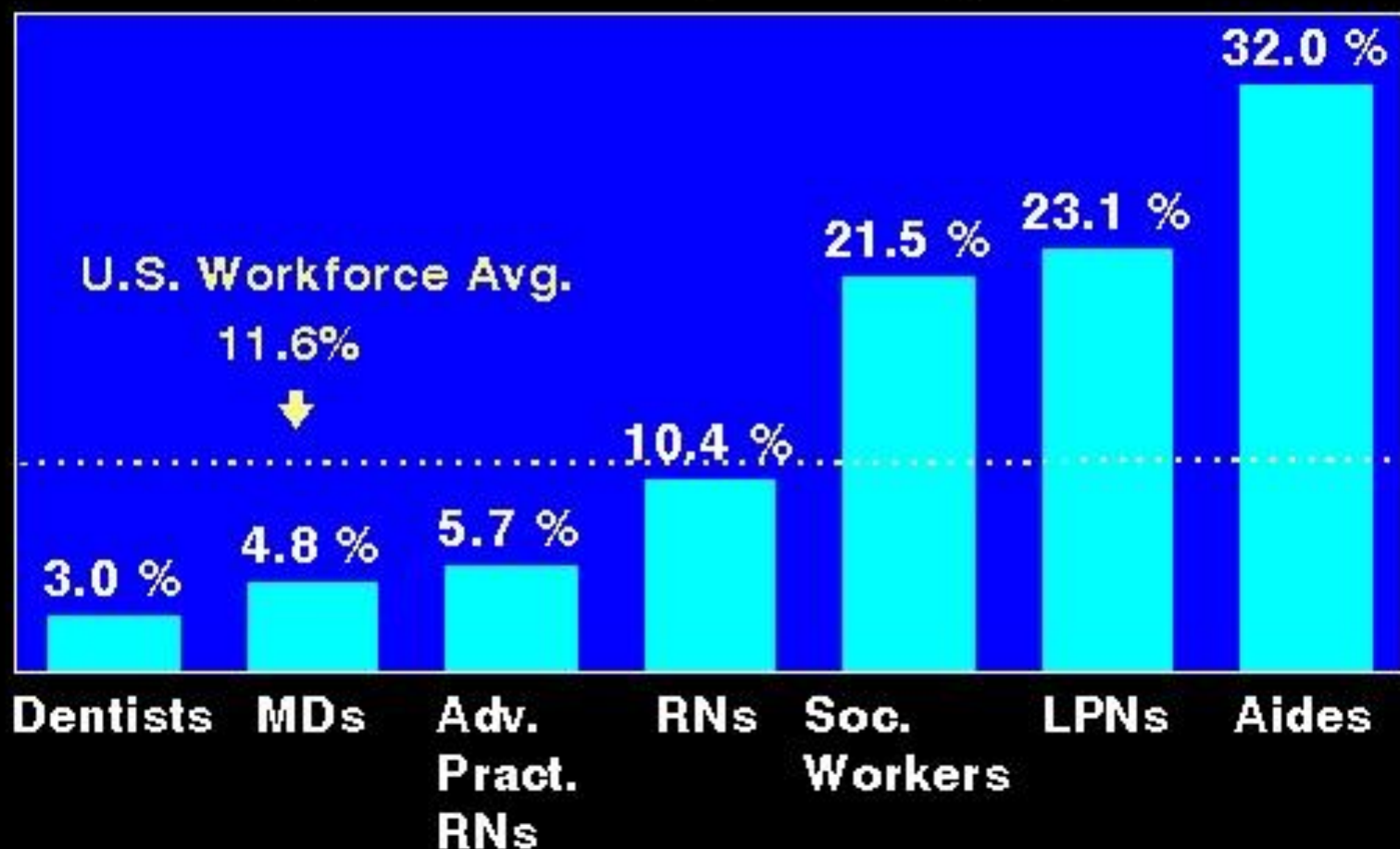
Authors estimate that universal availability of Black doctors could cut B:W CV mortality gap by 19%

\* Liked = would recommend doctor to others



# Blacks in Health Occupations

Blacks as percent of occupational group

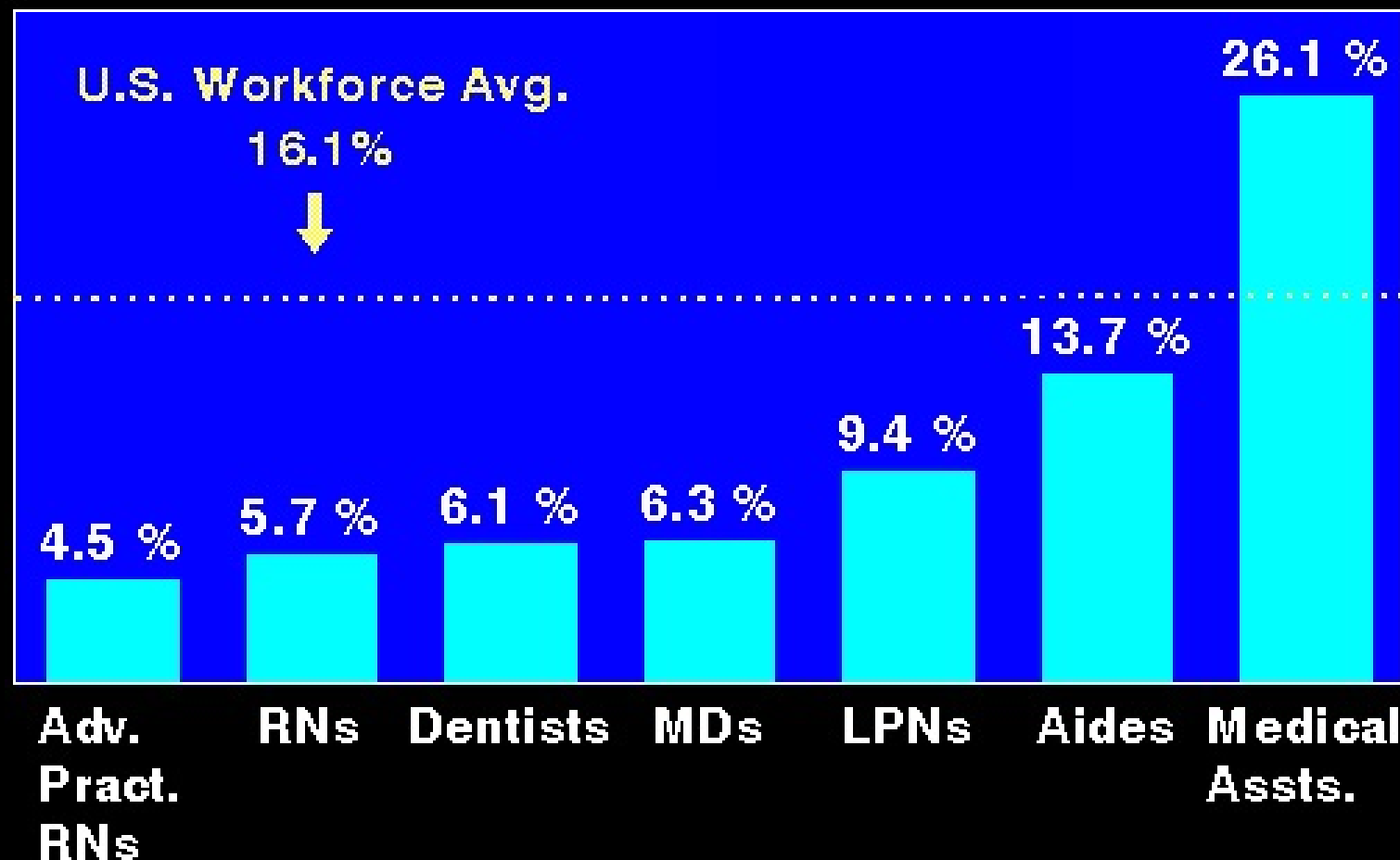


Source: HRSA based on data from American Community Survey 2011-2015



# Hispanics in Health Occupations

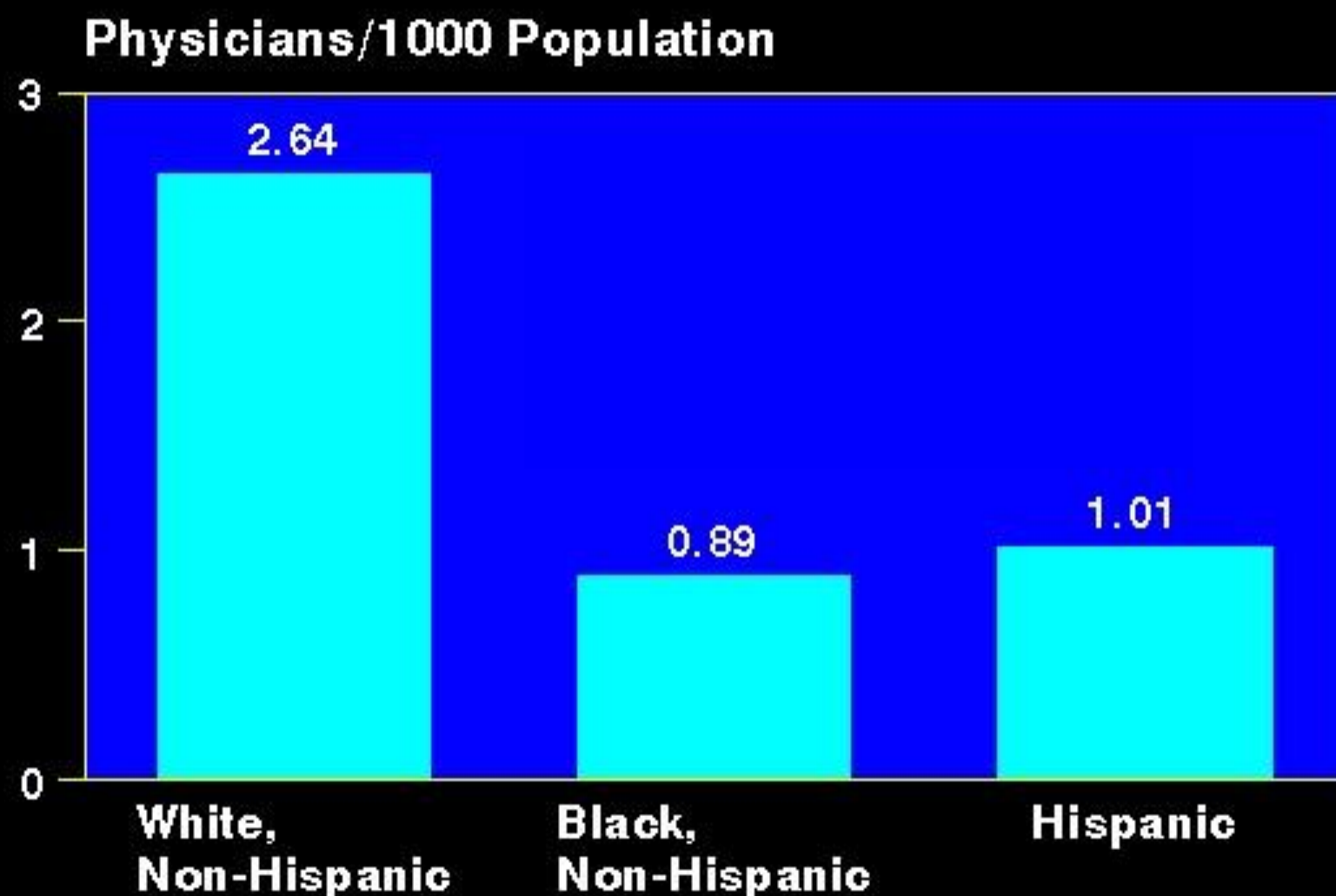
Hispanics as percent of occupational group



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

# Physician/Population Ratio by Race/Ethnicity

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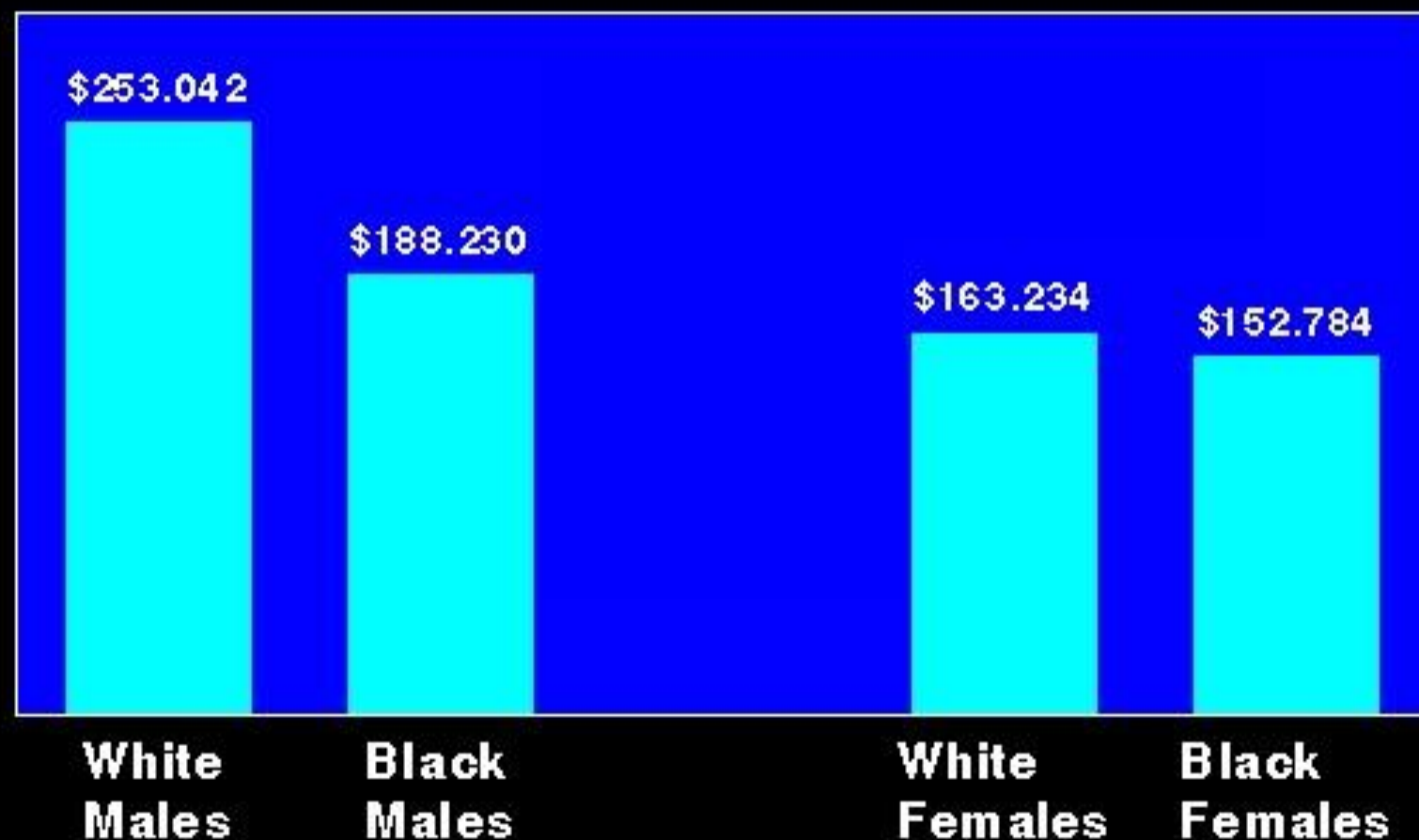


Source: AMA and Census Bureau

Note: Data are for 2008

# Black and Female Physicians Earn Less

Annual Income



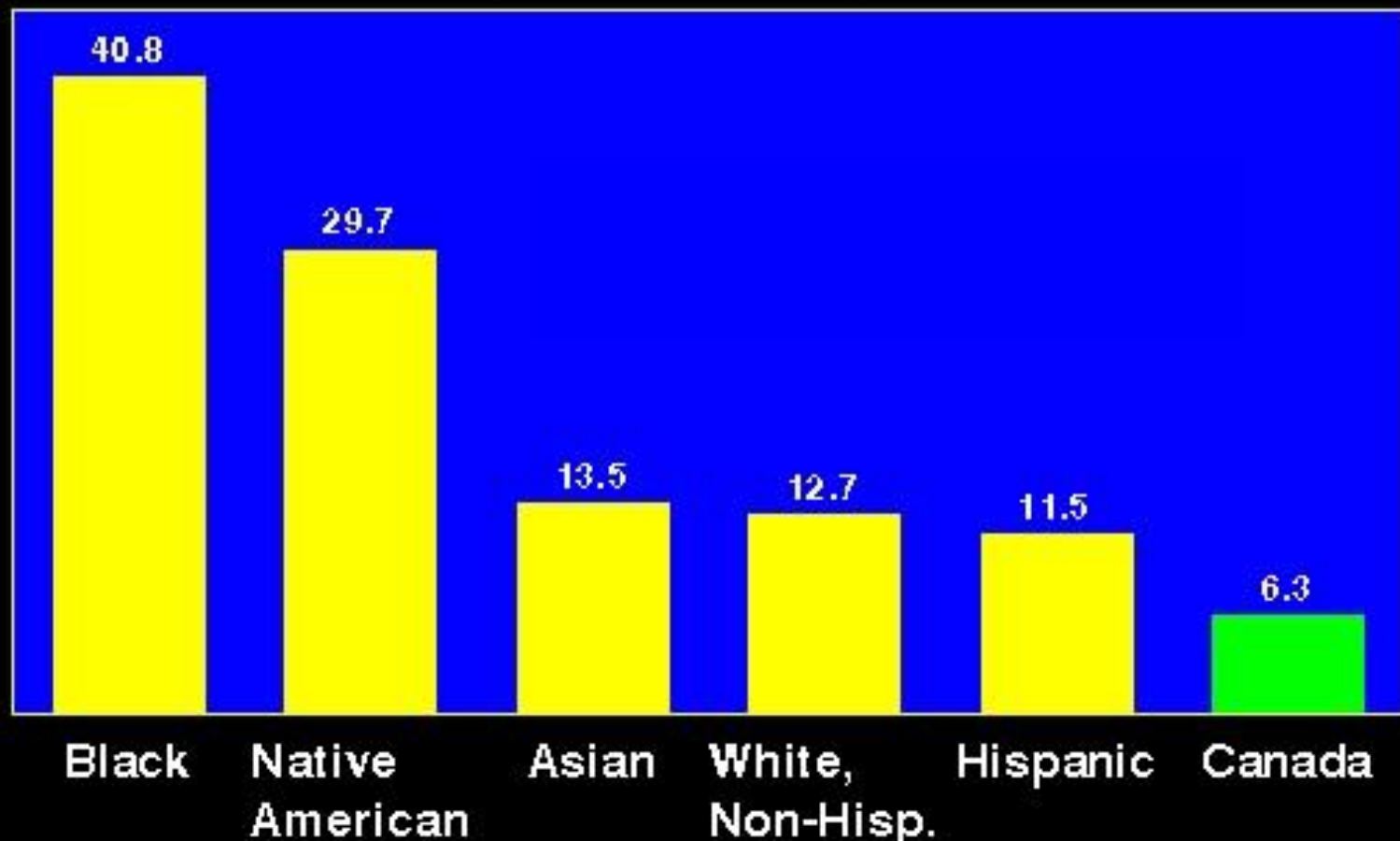
Source: Ly et al. BMJ 2016;353:2923

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

# Race/Ethnicity and Maternal Mortality

Every Group in the US Does Worse than Canadians

Maternal deaths/100,000 live births, 2016

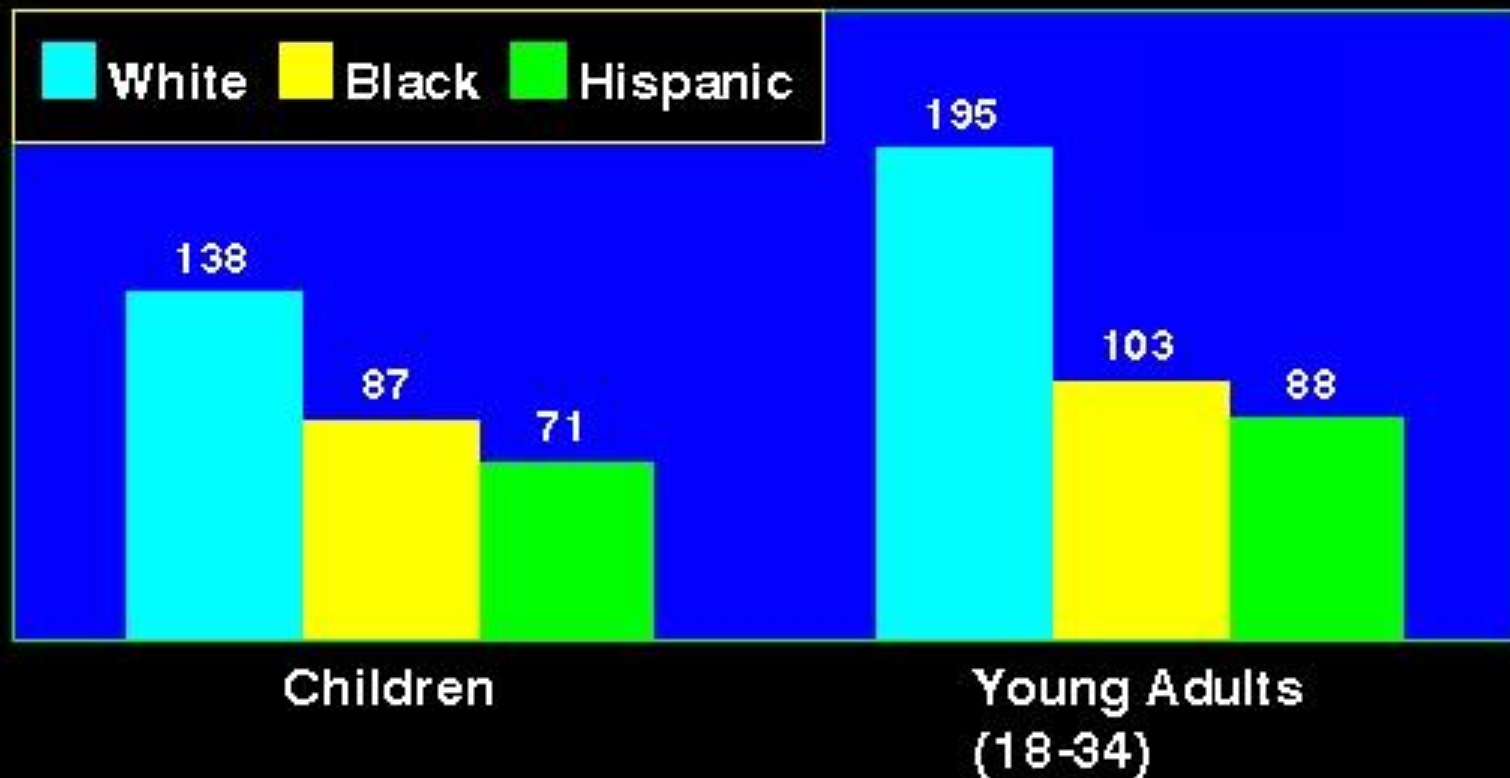


Source: MMWR September, 2019 and OECD

# Minority Children & Youth Get Few Psychiatrist Visits

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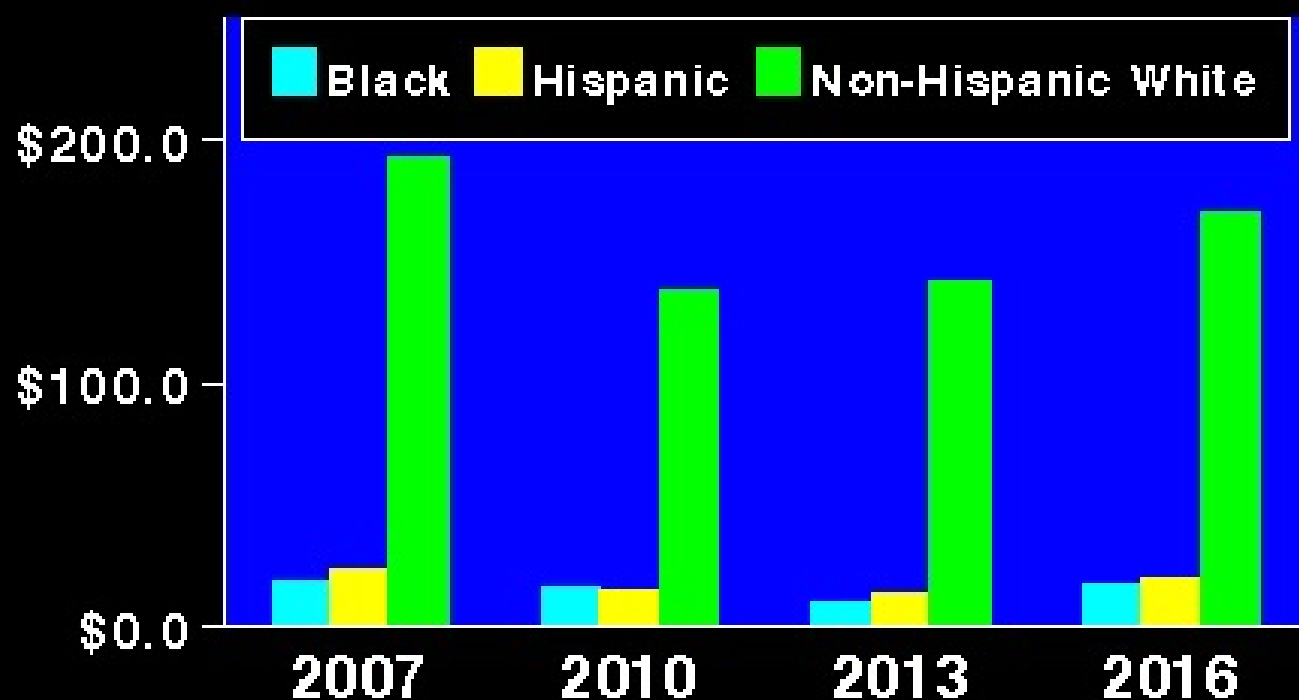
Psychiatrist visits/year/1000 population





# Growing Wealth Gap for Minorities

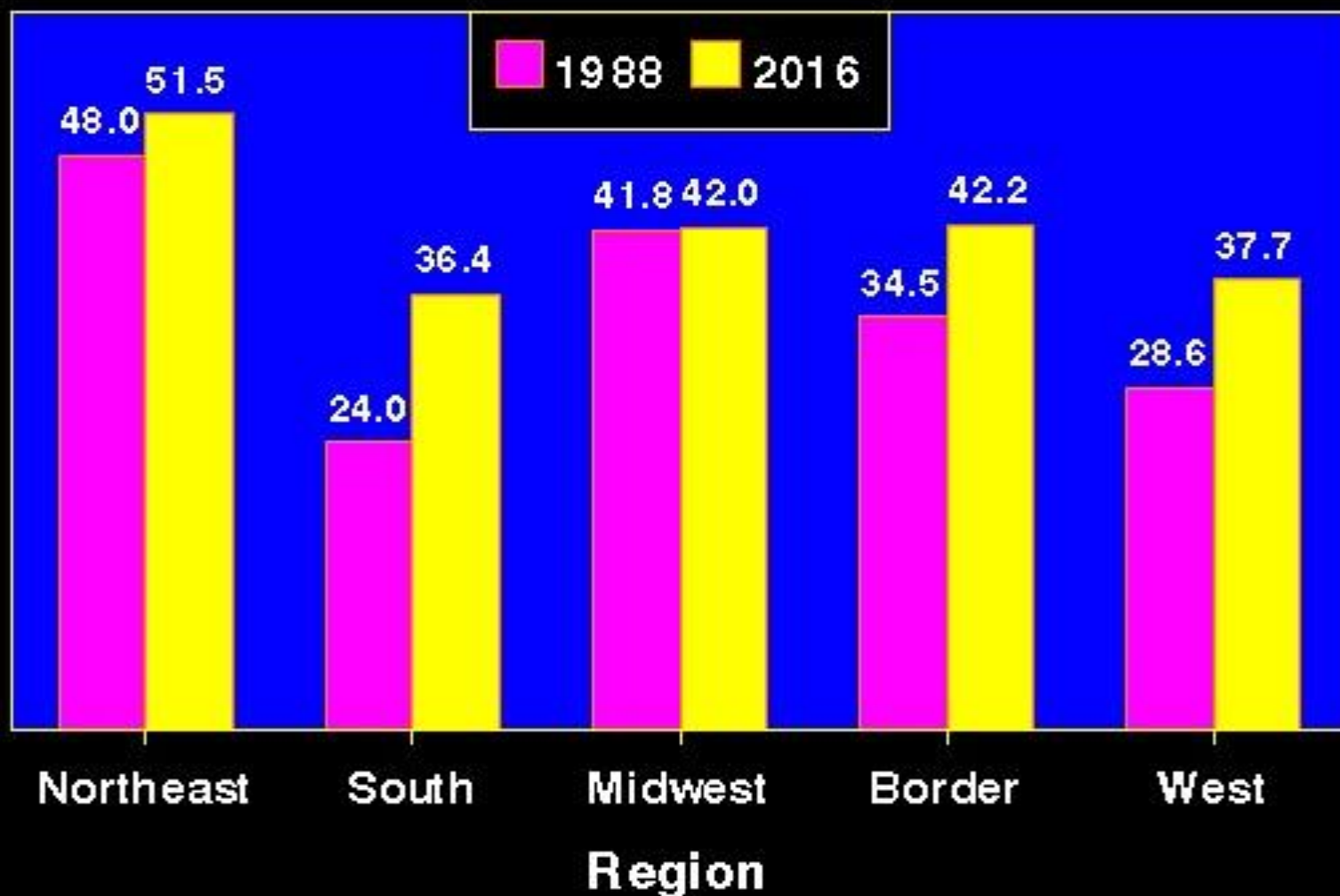
Median household net worth (2013 \$1000s)



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

# School Segregation Increased 1988-2016

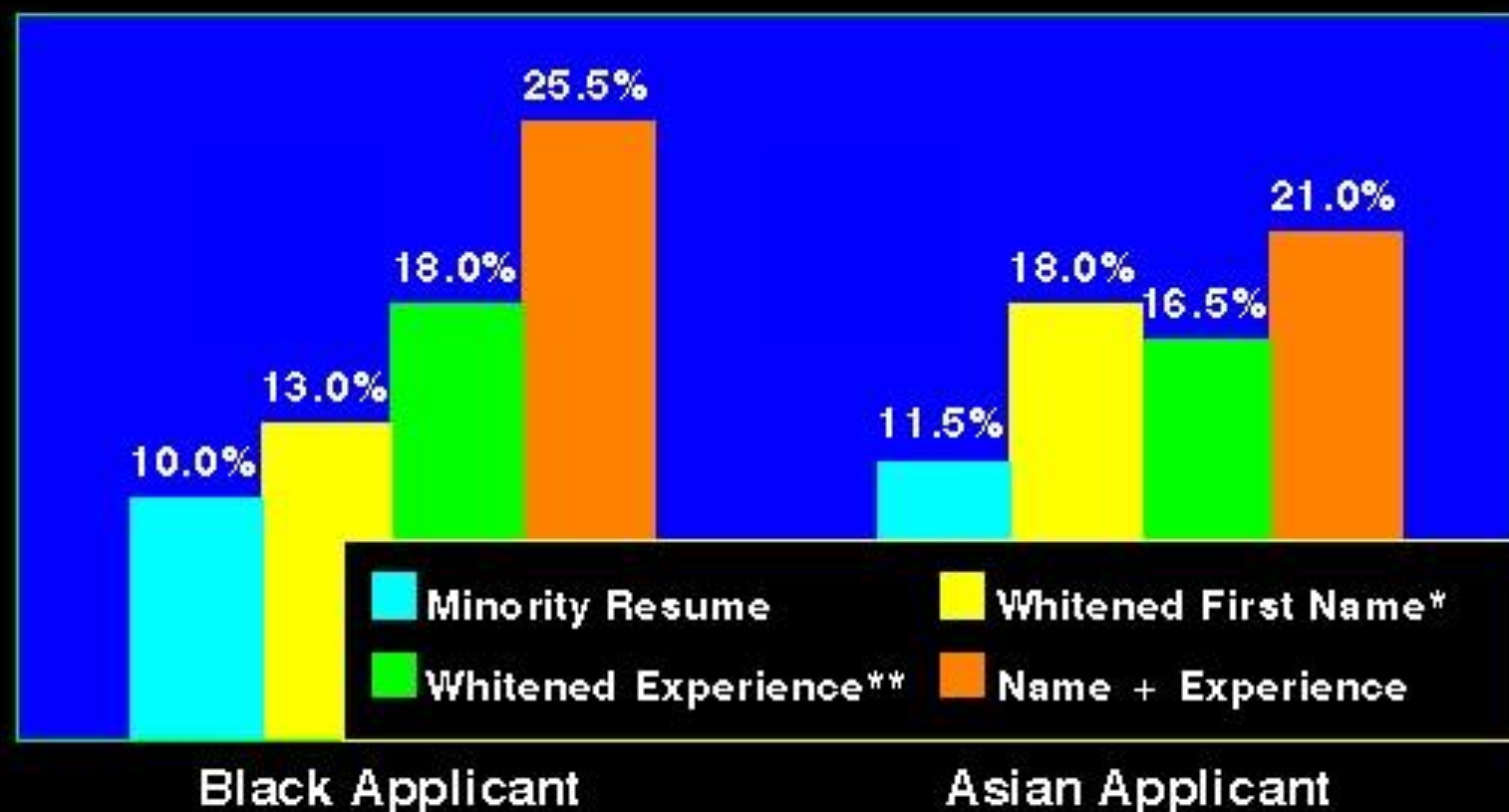
Share of Black students in schools with < 10% White students



# Job Discrimination Persists

## Experimental Study of the Impact of "Whitening" Resumes

Callback rate after resume submitted



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

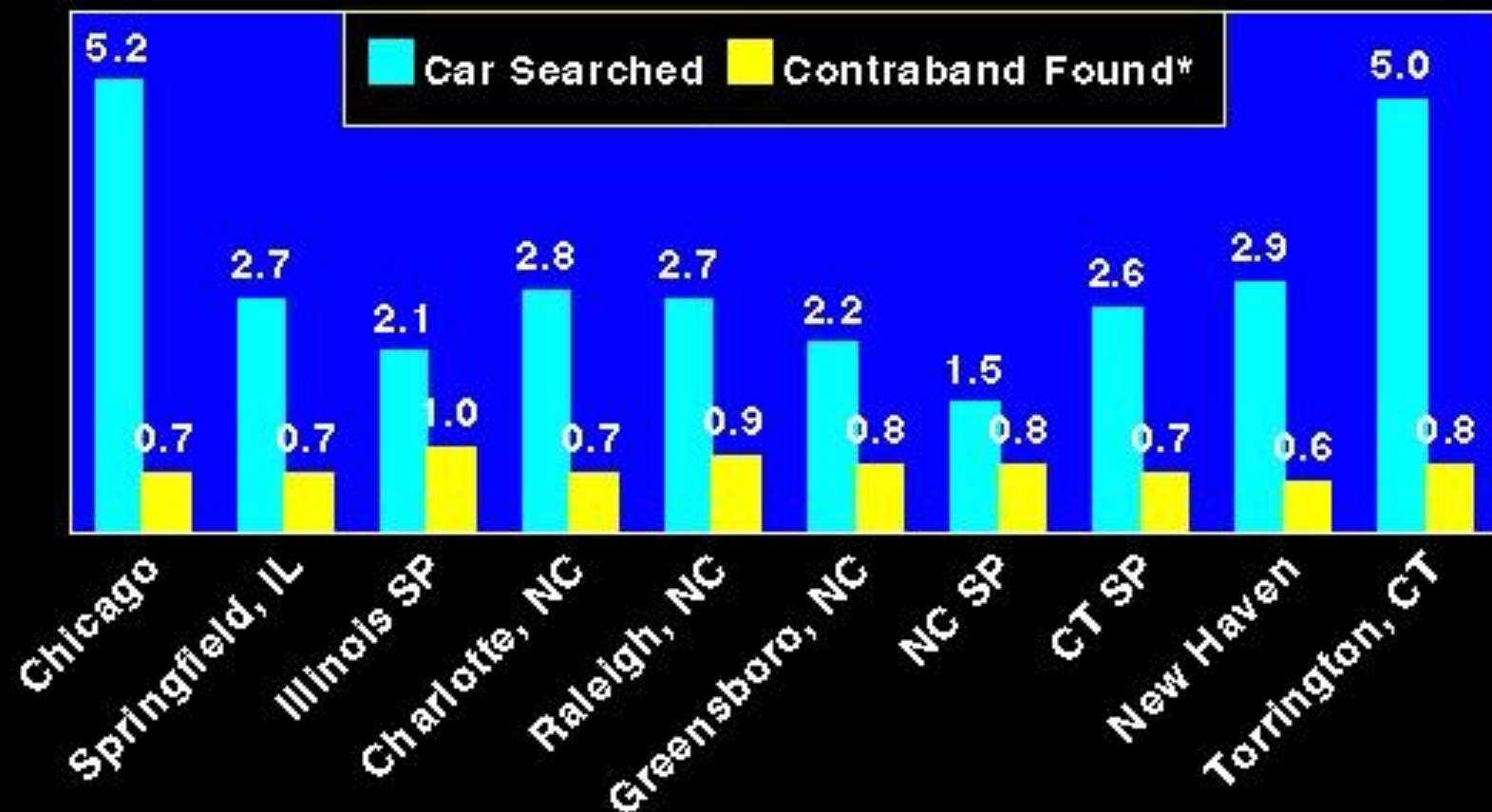
\* e.g. change "Lamar J. Smith" to "L. James Smith" or "Lei Zhang" to "Luke Zhang"

\*\* 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)



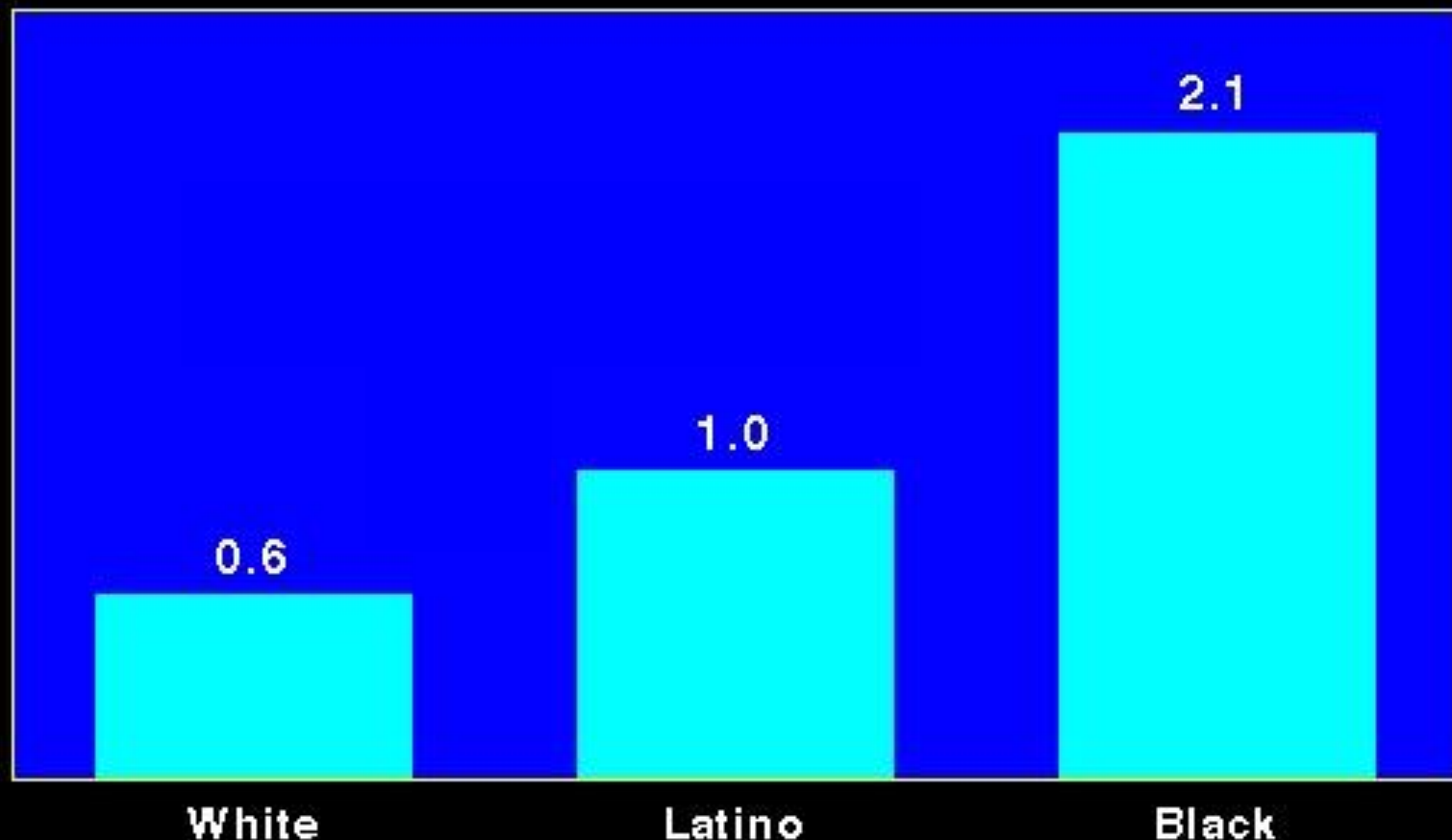
Source: NY Times 10/25/15

\* Contraband found among those searched

# Police More Likely to Kill Minority Men

2.8 Police Killings/Day in U.S.

Police killings per 100,000 men



Source: AJPH 2018;108:1241

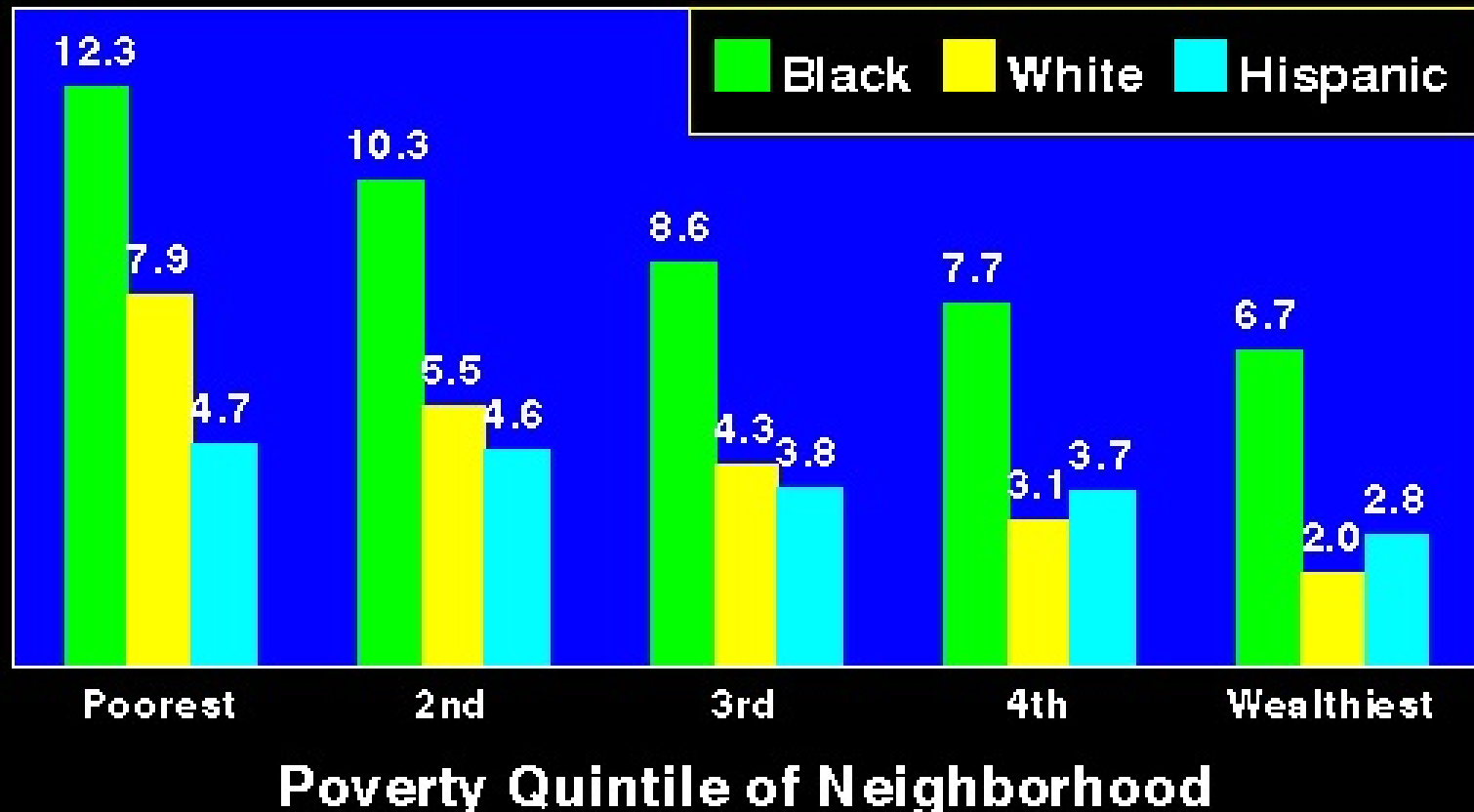
Police killings account for 8% of all homicides



# Police Killings: Higher in Poor Neighborhoods, Highest for Blacks

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Number killed by police/million population

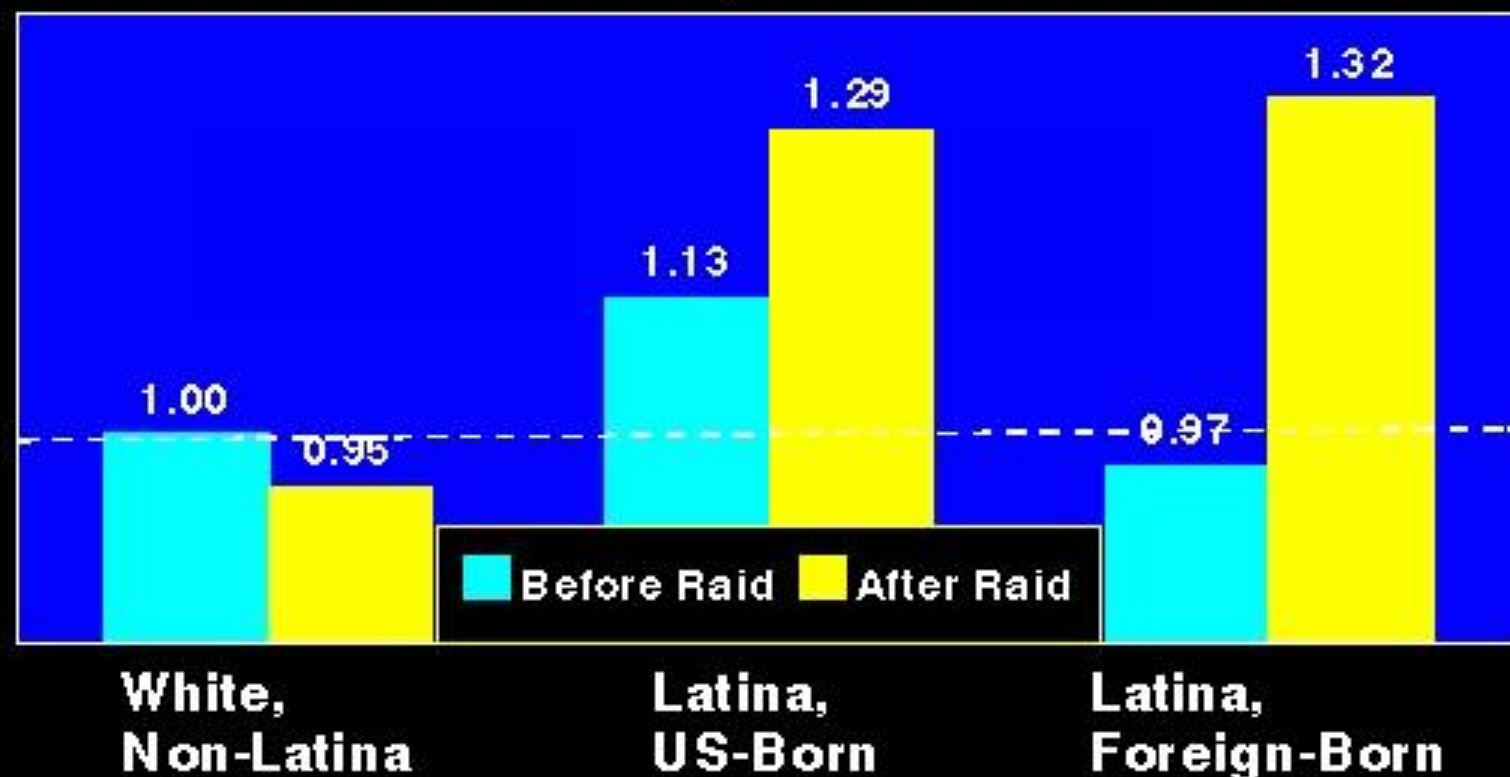


Source: J. Feldman: Police Killings in the US. People's Policy Project, 2020

# Protecting Immigrants' Right to Health Care

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

Relative risk of Low Birth Weight

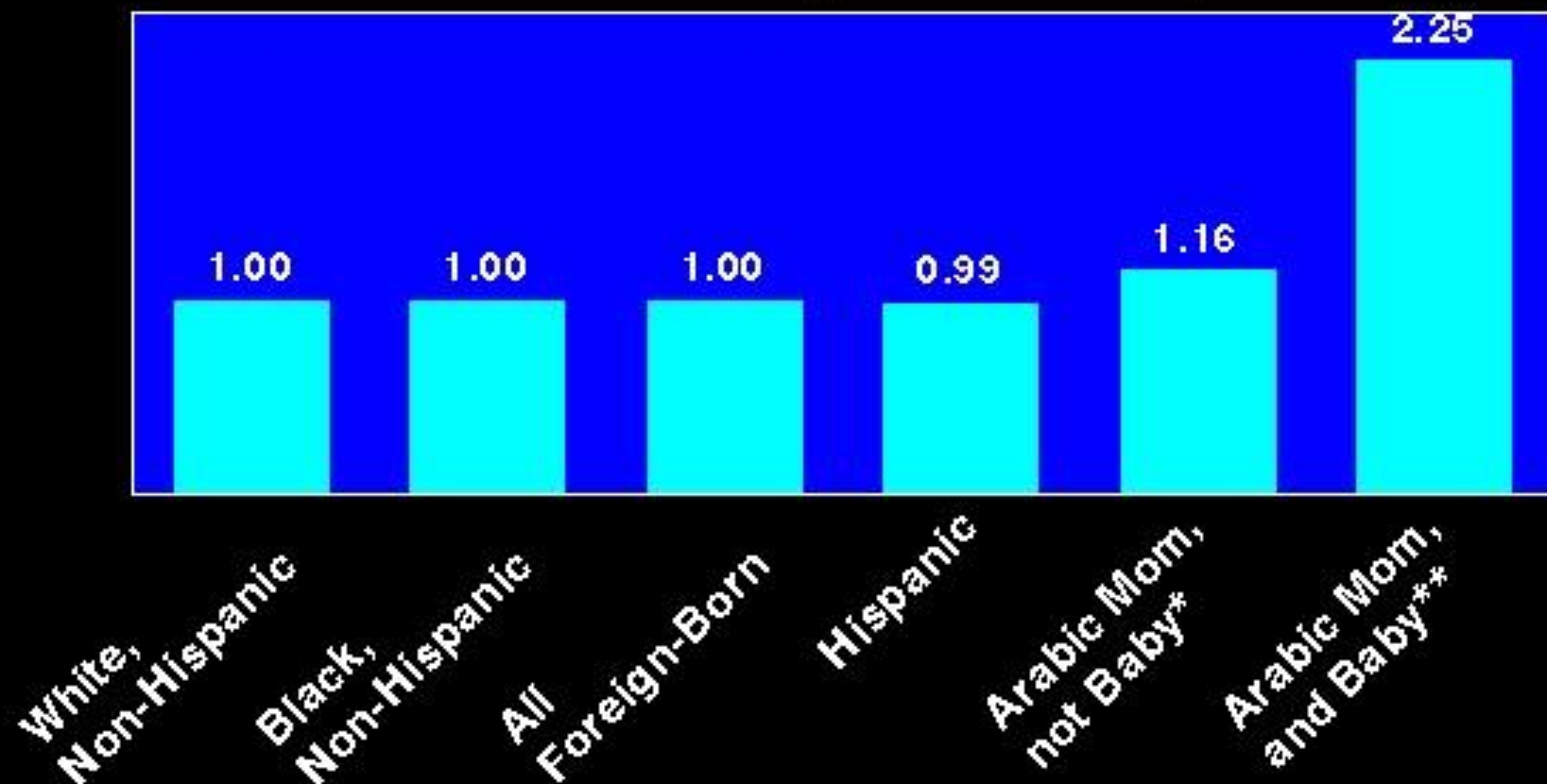


Source: Int J Epidemiol 2017;839

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

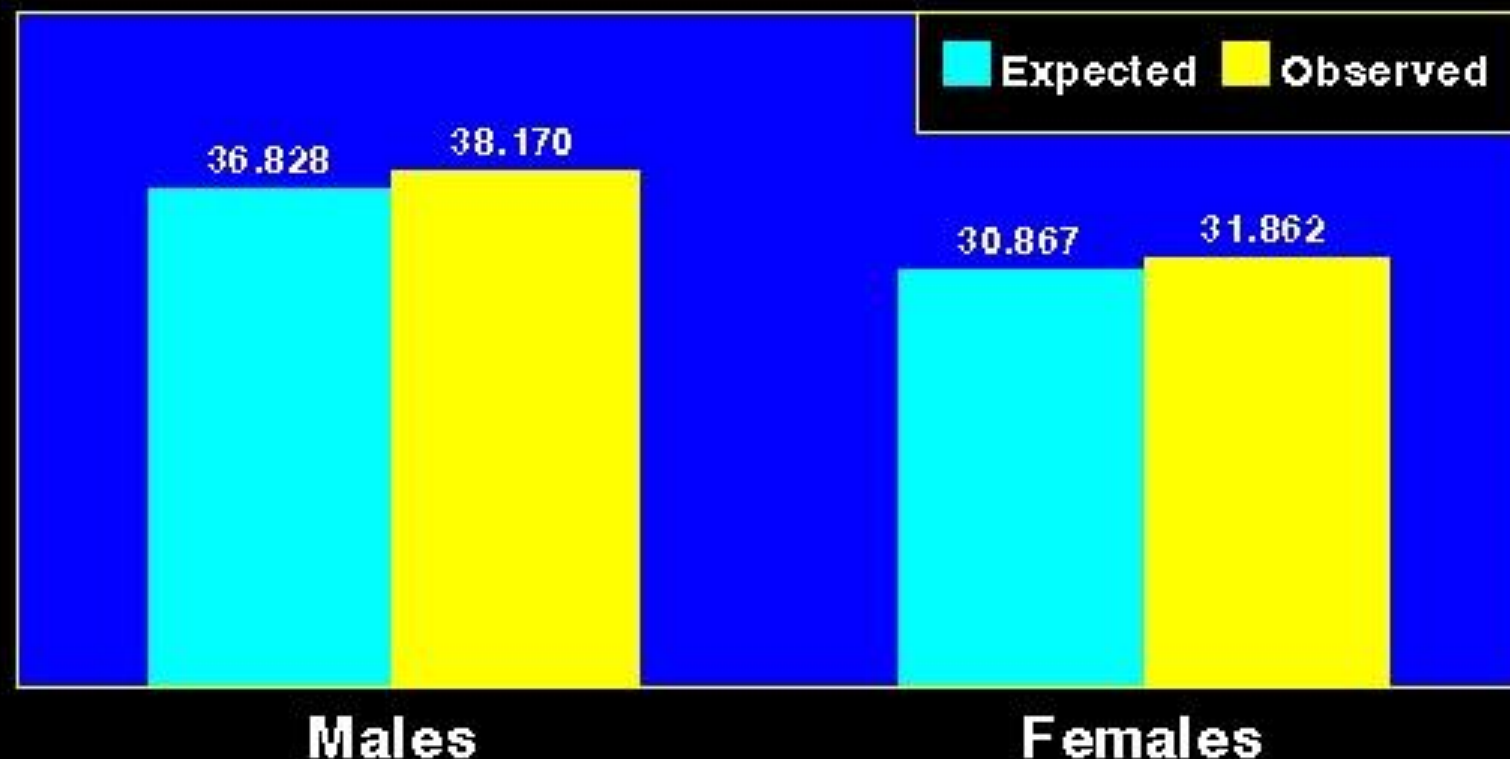
\*\* Mother's name Arabic, infant's name ethnically distinctive

# Preterm Latinx Births Increased After Trump's Election

**2337 Excess Preterm Births During 9 Months Post-Election**

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

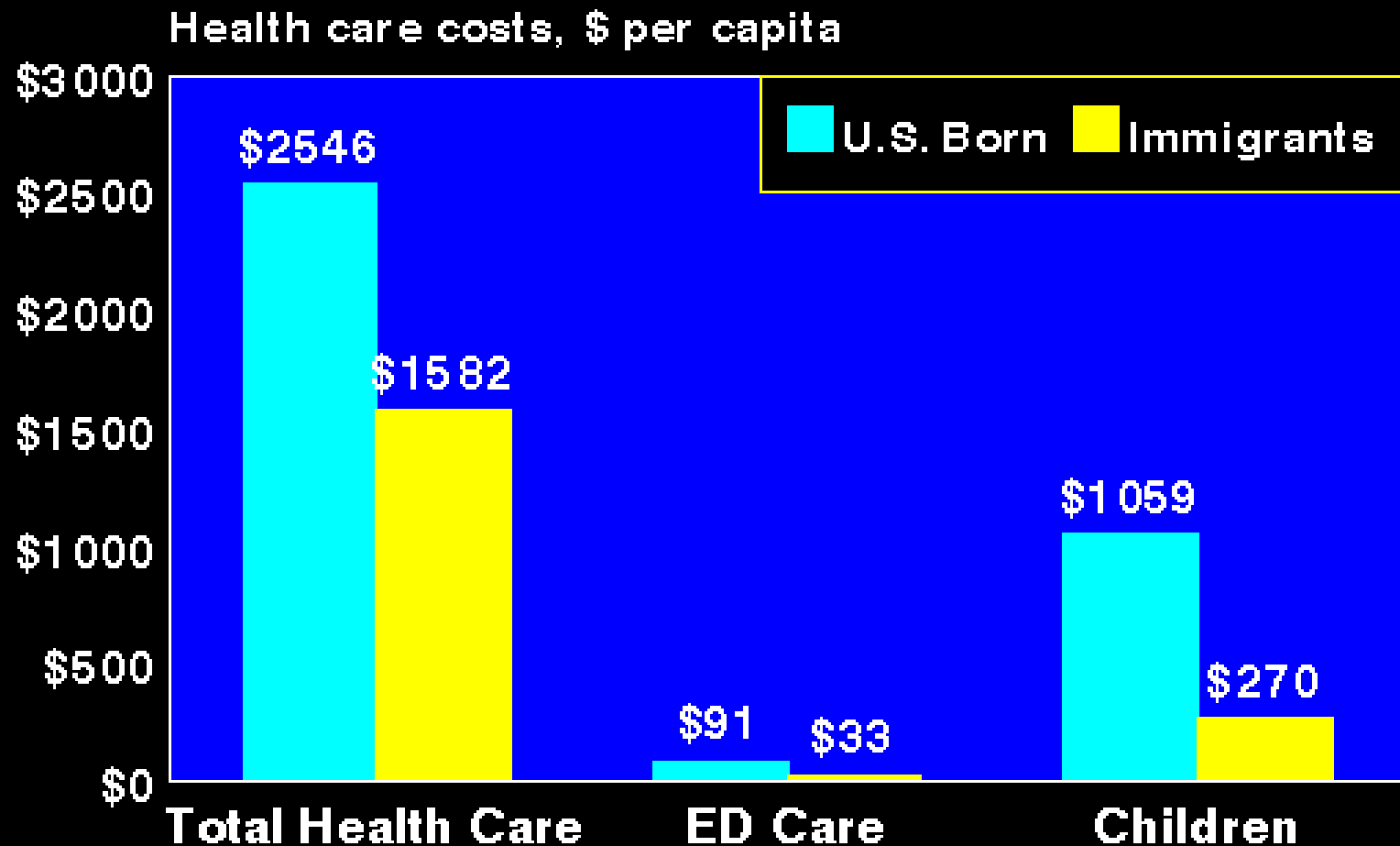


Source: Gemmill et al, JAMA Network Open July 19, 2019

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



# Immigrants Get Little Care

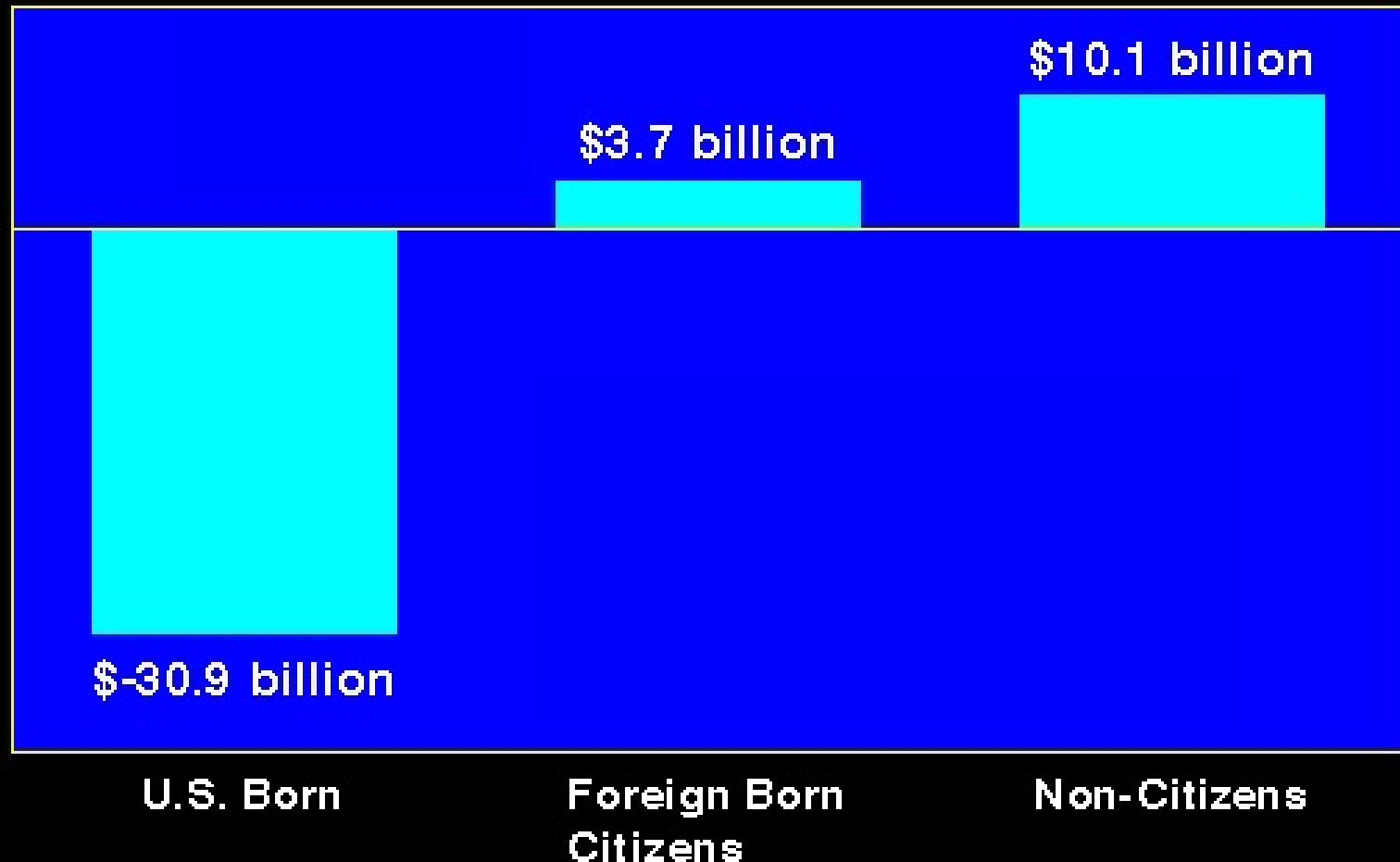


Source: Mohanty et al Am J Public Health 2005;95:1431

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

# Immigrants Keep Medicare Afloat

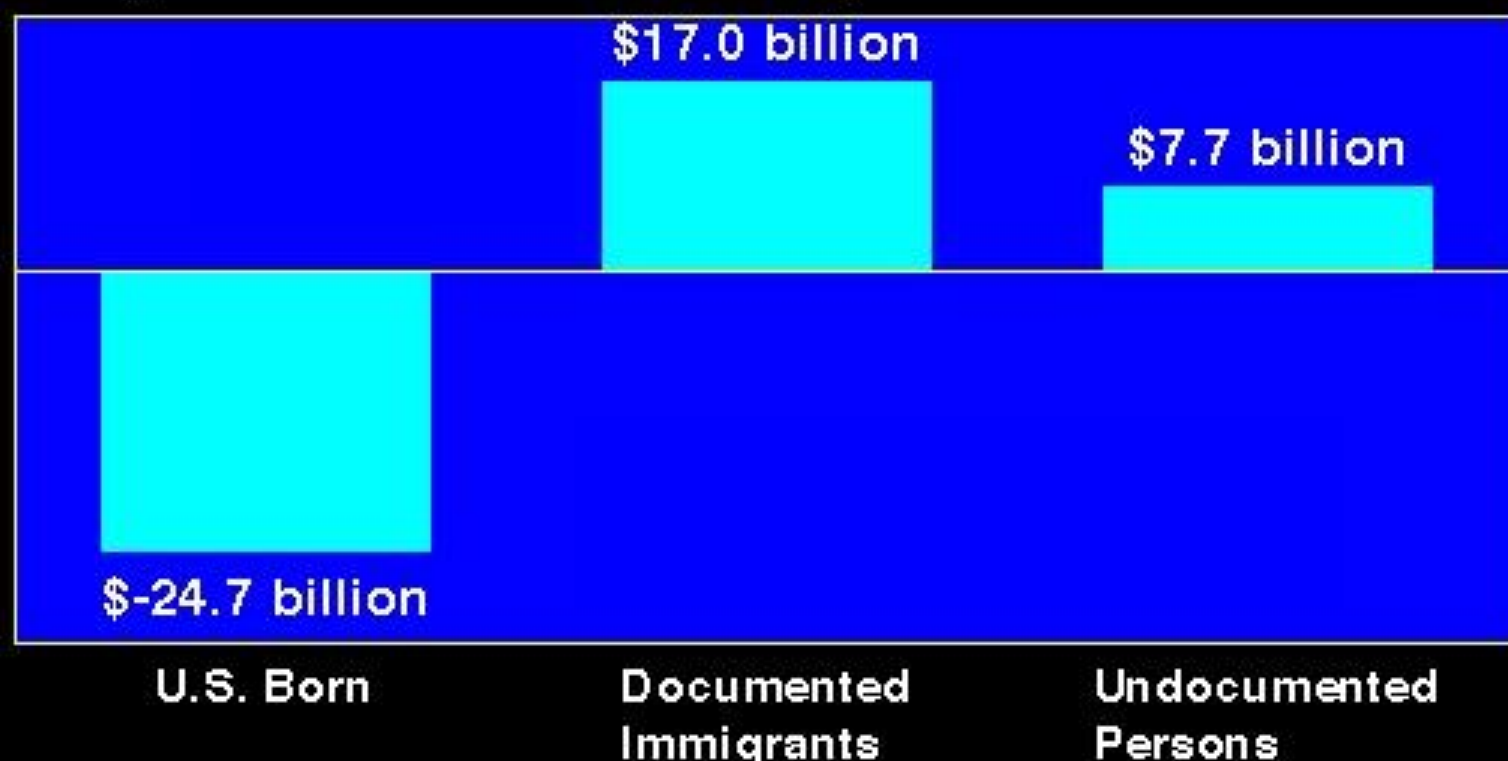
Net Contribution to Medicare Trust Fund, 2009



# Immigrants Subsidize Native-Born in Private Insurance

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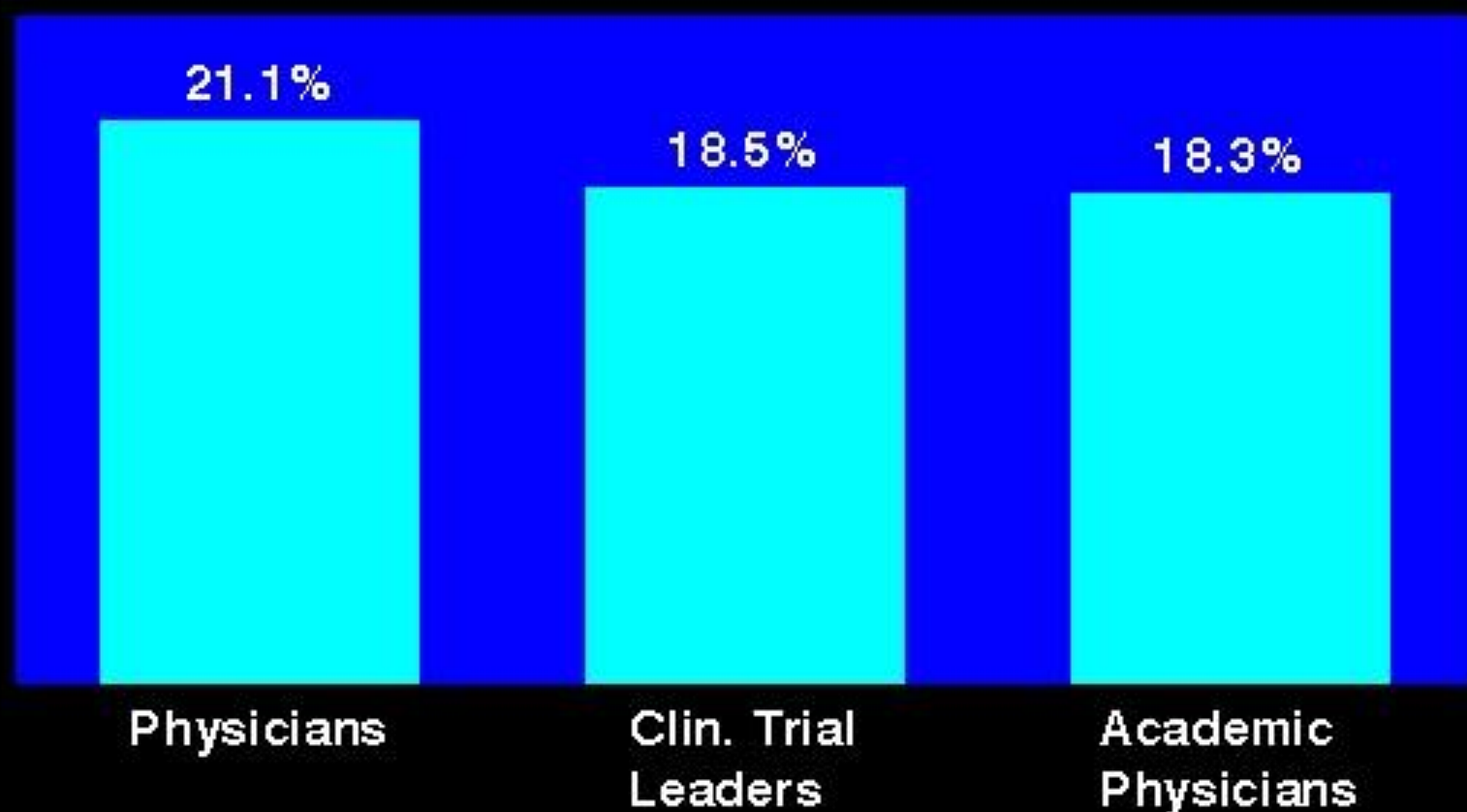
Net contribution to private insurance, 2014  
(premiums minus benefits)



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

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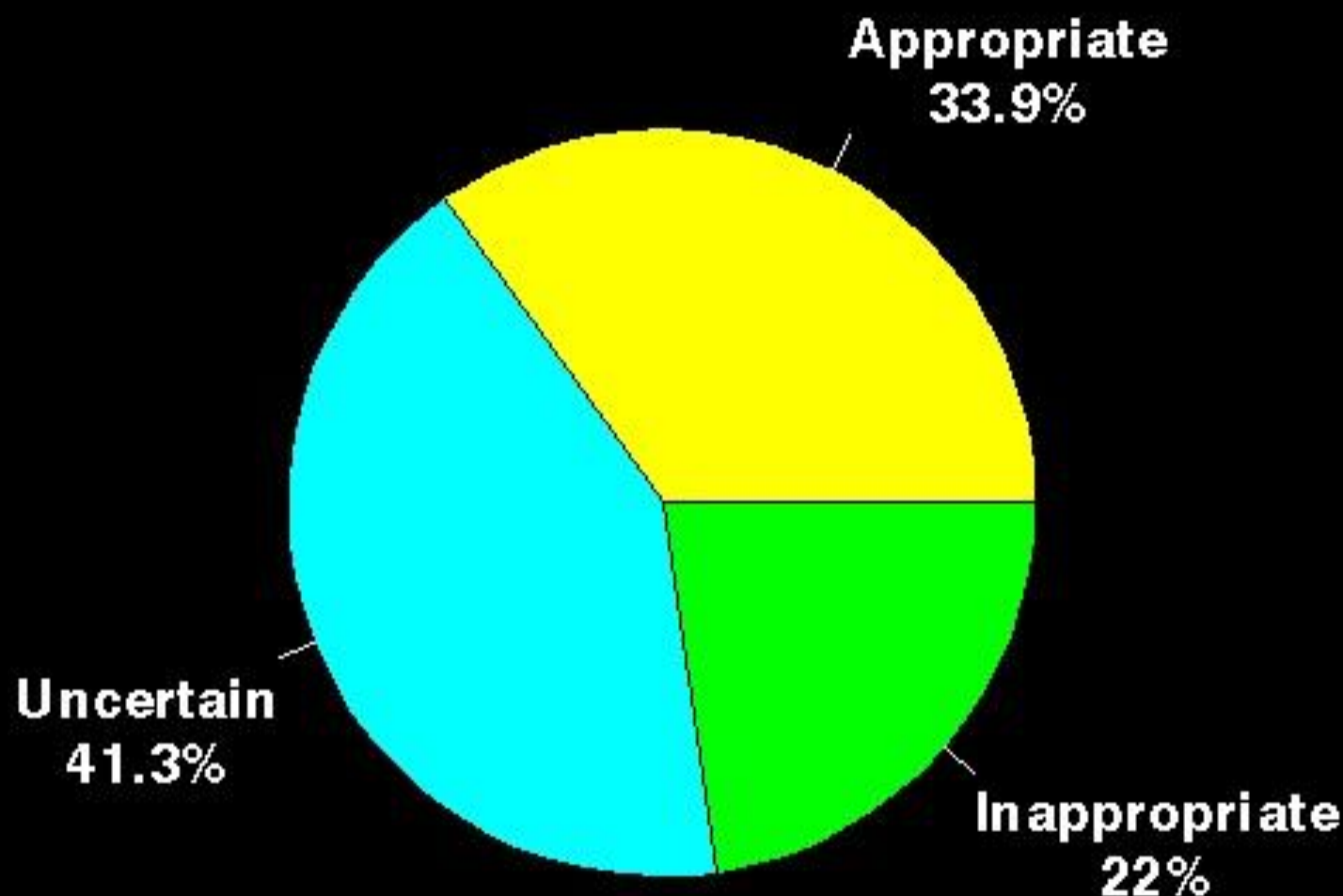
Foreign medical graduates' share of total



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



# Many Elective PCIs Are Inappropriate

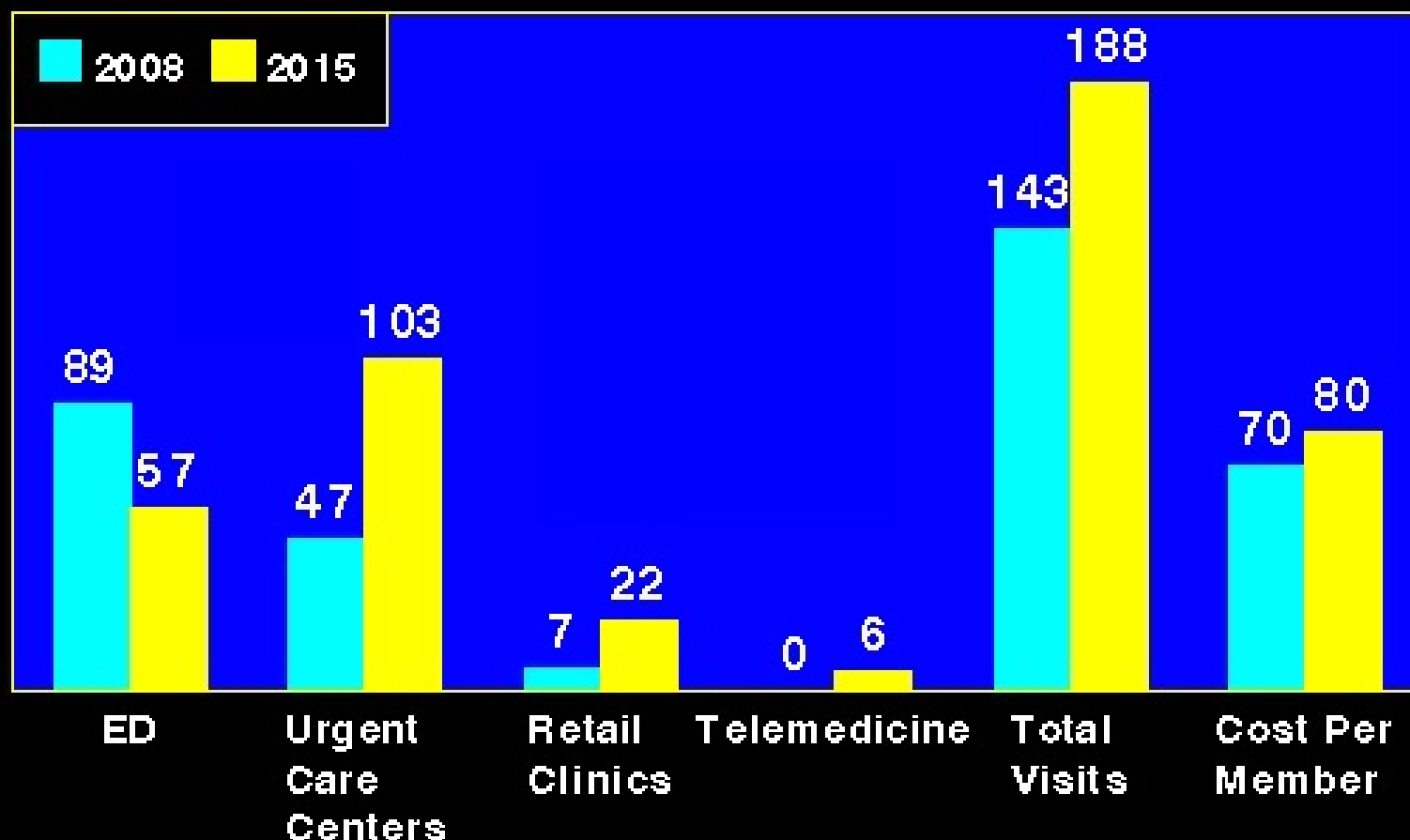


Source: JAMA IM 2014;174:1630 - Based on 1,225,562 patients in PCI Cath registry

# Urgent Care Centers and Retail Clinics Increase Use and Costs for Low Acuity Conditions

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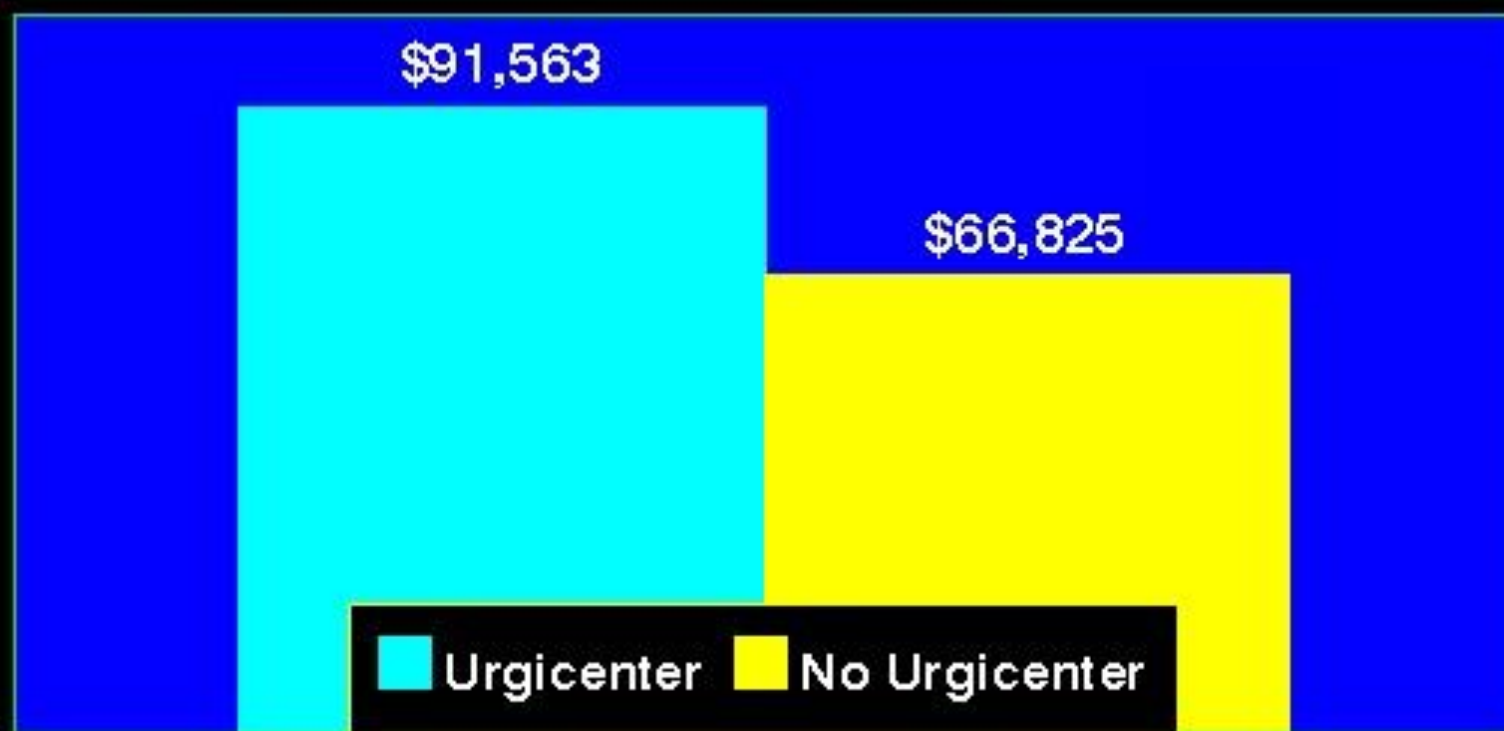
Visits/1000 or \$s/member for low acuity conditions



# Free Standing ERs in Texas Avoid Areas of Greatest Need

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Mean family income in service area



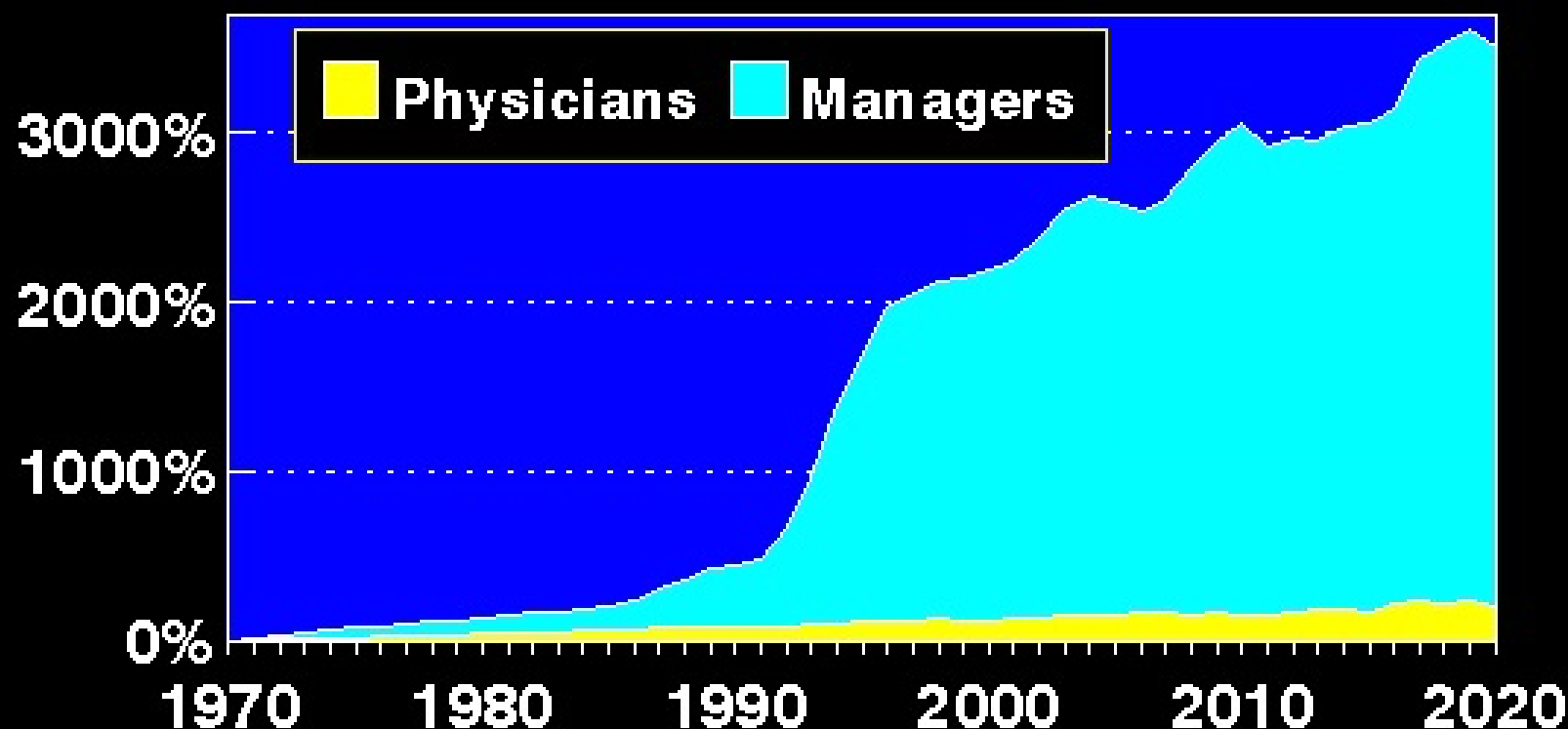
Source: Health Affairs 2017;36:1712 -

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 1970-2020

## Growth Since 1970

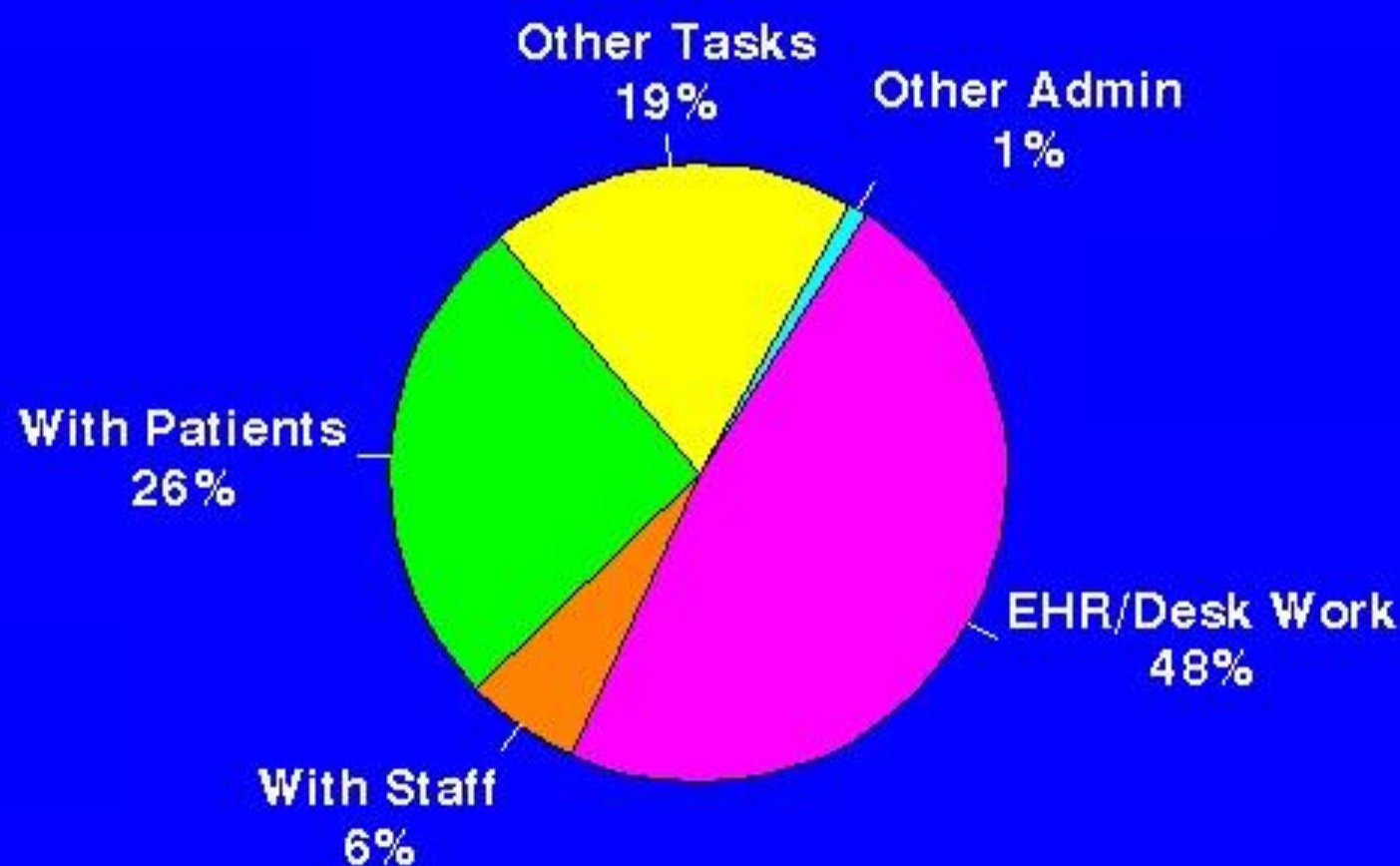


Source: Bureau of Labor Statistics; NCHS; and Himmelstein/Woolhandler analysis of CPS

Note - Managers shown 3 year moving average - 2020 figure distorted by data collection difficulties



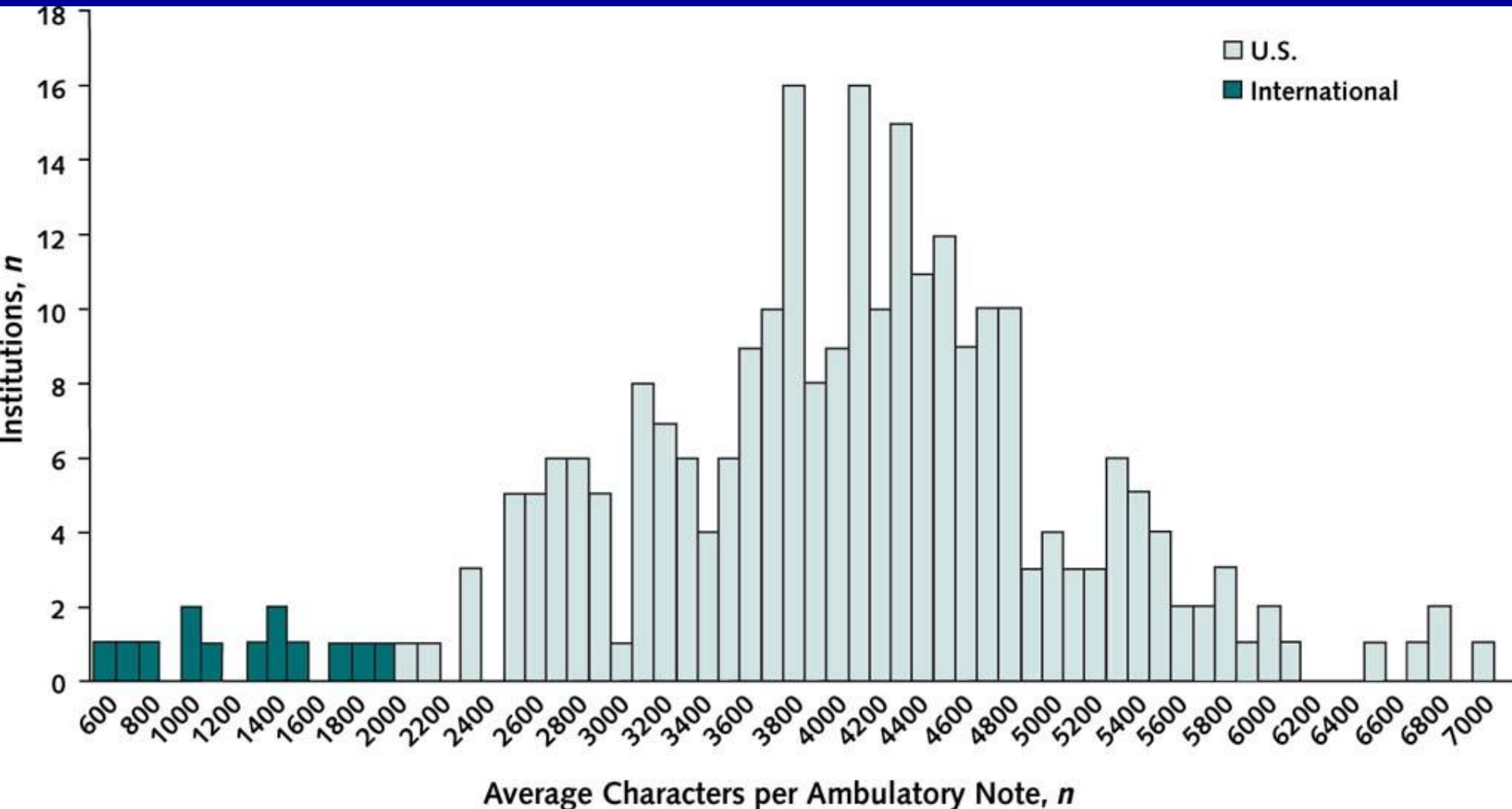
# Doctors Spend Twice as Much Time on EHR/Desk Work as With Patients



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

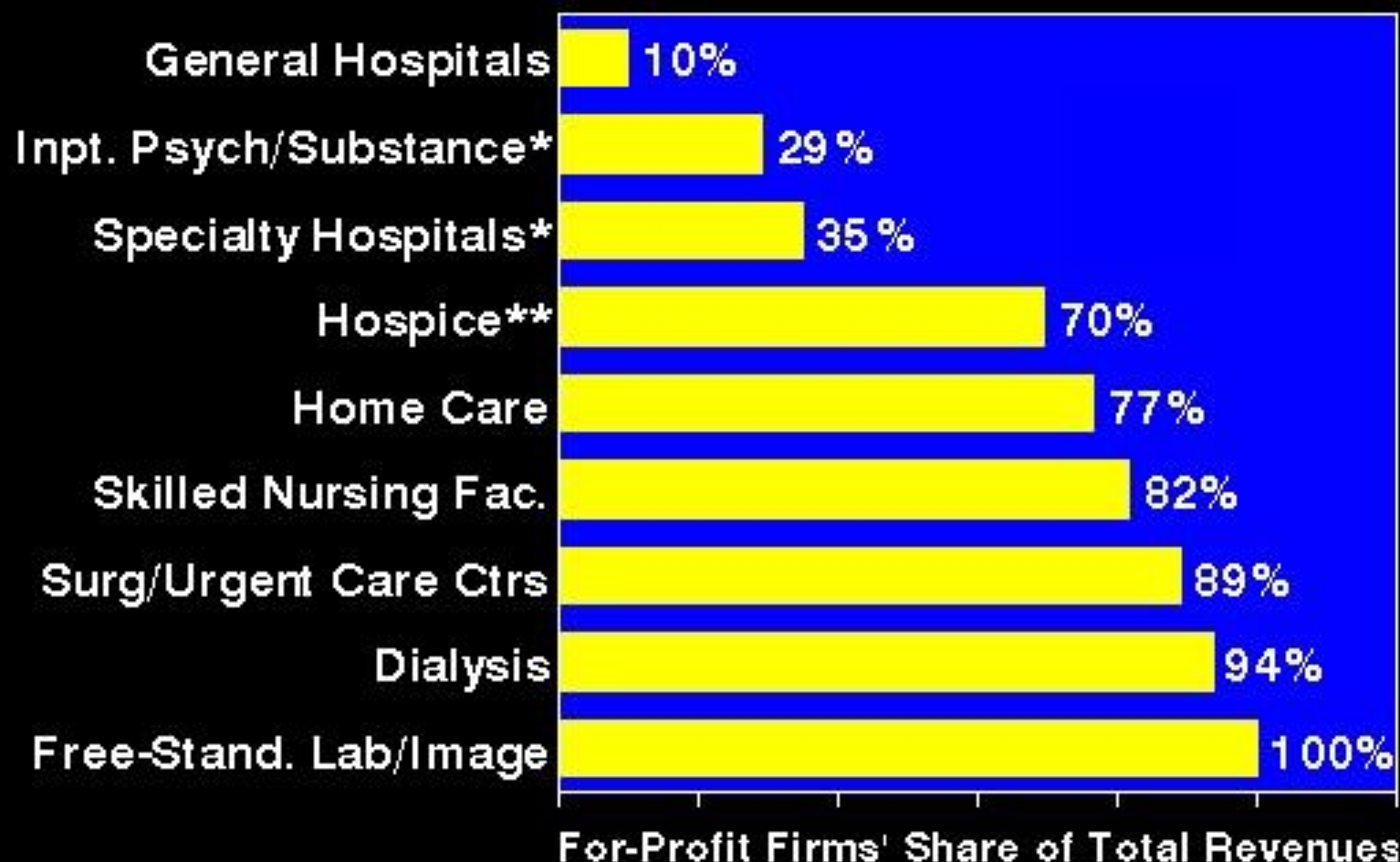
# EPIC EHR Notes 4x Longer in US

## Documentation Driven by Payment Complexity



# 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, 2019

Pharmaceuticals	\$83.6 bil
Insurers	\$23.5 bil
Equipment/Supplies	\$16.9 bil
Pharmacy/Lab/Benefit Mgr.	\$14.1 bil
Providers	\$4.2 bil
Distributors/Wholesalers	\$2.9 bil

Source: Fortune 500, 2020

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



# Health Care CEO's Pay, 2019

CEO	Firm	Total Pay
Martine Rothblatt	United Therapeutics	\$45.6 mil
Larry Merlo	CVS/Aetna	\$36.5 mil
Miles White	Abbott	\$27.8 mil
Kenneth Frazier	Merck	\$27.6 mil
Samuel Hazen	HCA	\$26.8 mil
Michael Neidorff	Centene	\$26.4 mil
Alex Gorsky	J&J	\$25.4 mil
Alan Miller	Universal Hlth. Serv.	\$24.5 mil
Ronald Rittenmeyer	Tenet	\$24.3 mil

# The Profits of "Non-Profit" Health Systems

Health System	2018 Profit	2019 Profit
Kaiser	\$1,891 mil.	\$2,732 mil.
Mayo	\$706 mil.	\$1,063 mil.
AdventHealth	\$784 mil.	\$829 mil.
Baylor Scott & White	\$582 mil.	\$725 mil.
Indiana U. Health	\$612 mil.	\$679 mil.
U. Colorado Health	\$526 mil.	\$657 mil.
Houston Methodist	\$473 mil.	\$651 mil.
NYU Langone	\$198 mil.	\$606 mil.
Mass General Brigham	\$310 mil.	\$485 mil.



# "Non-Profit" Health Systems Becoming Speculative Investors

Organization	Hedge Fund Investments	Private Equity	Total Investments
Kaiser	2.272 bil.	6.624 bil.	42.284 bil.
Ascension	1.839 bil.	2.769 bil.	20.774 bil.
MGH/Brigham	NA	0.764 bil.	11.523 bil.
Mayo	2.706 bil.	2.954 bil.	11.135 bil.
Cleveland Clinic	2.071 bil.	1.259 bil.	11.200 bil.
Providence St. Jos.	0.743 bil.	0.579 bil.	10.954 bil.
Advocate Aurora	2.800 bil.	1.300 bil.	9.697 bil.
Indiana U. Health	1.575 bil.	0.632 bil.	7.091 bil.
Sutter	1.251 bil.	0.313 bil.	6.354 bil.
Baylor/Scott & White	0.580 bil.	0.249 bil.	6.036 bil.
Northwell	0.553 bil.	NA	3.322 bil.

Source: Modern Healthcare 5/11 and 7/27, 2020

# 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

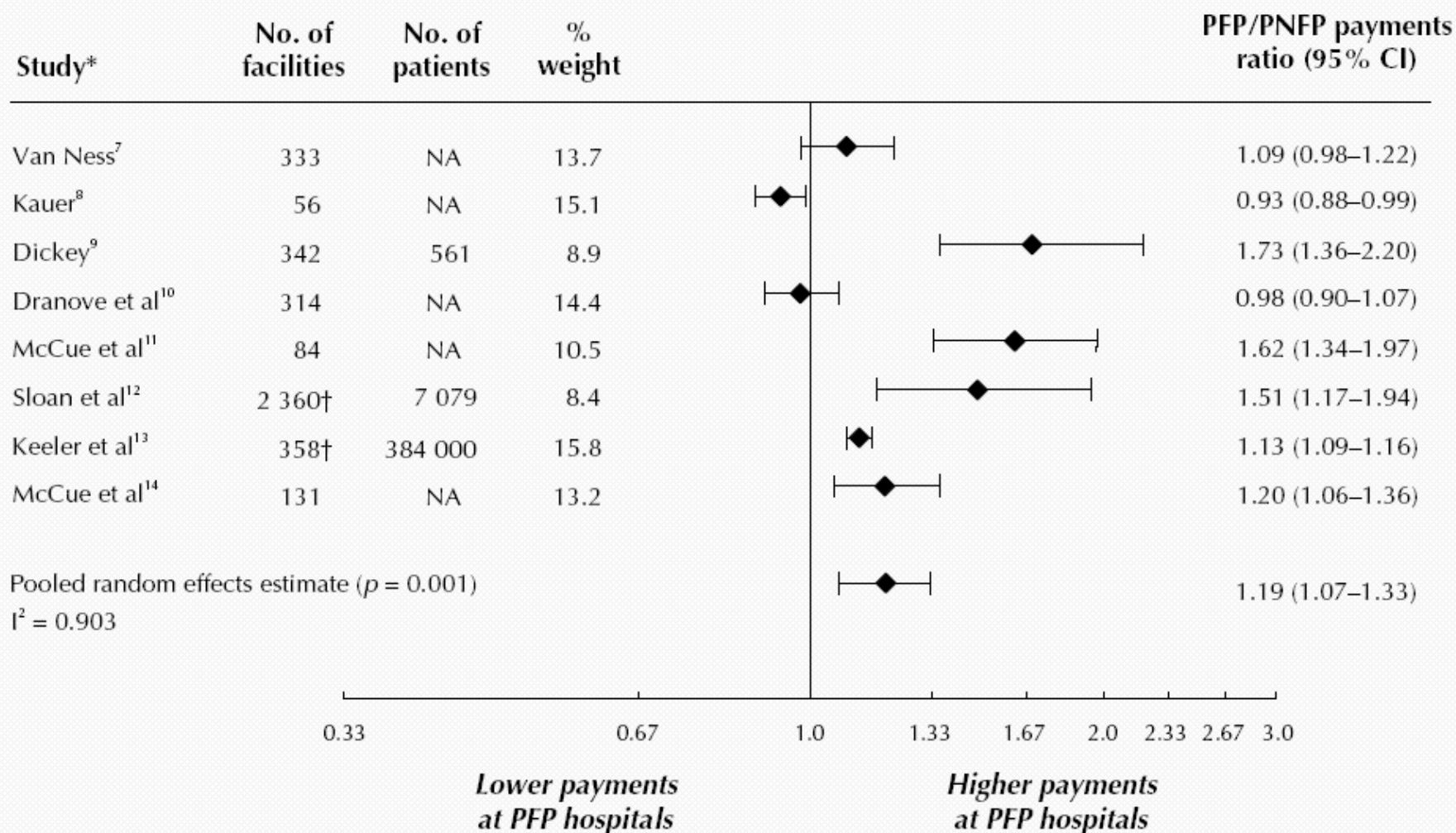


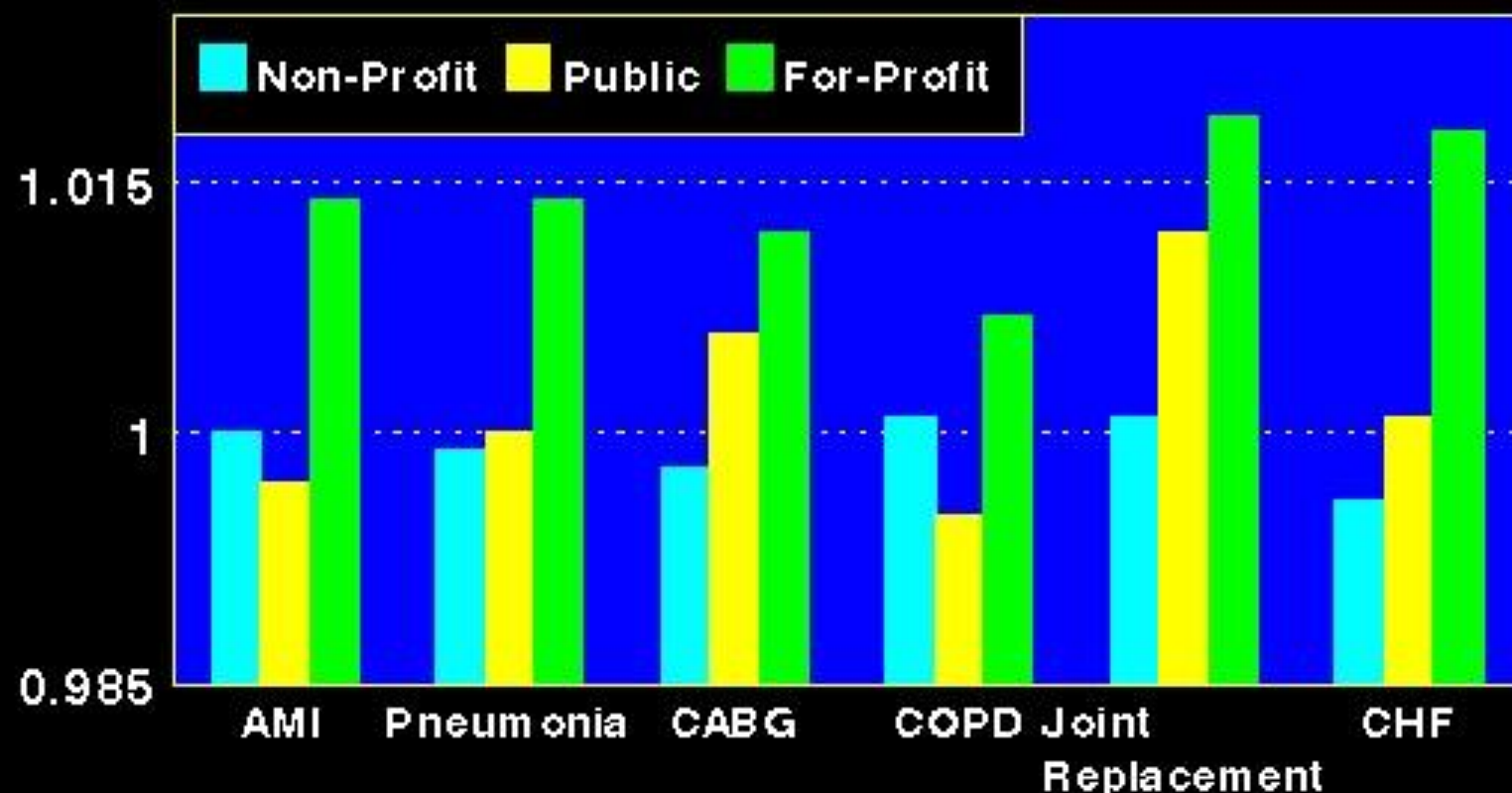
Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.

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



# For Profit Hospitals Have Highest Readmission Rates for EVERY Condition

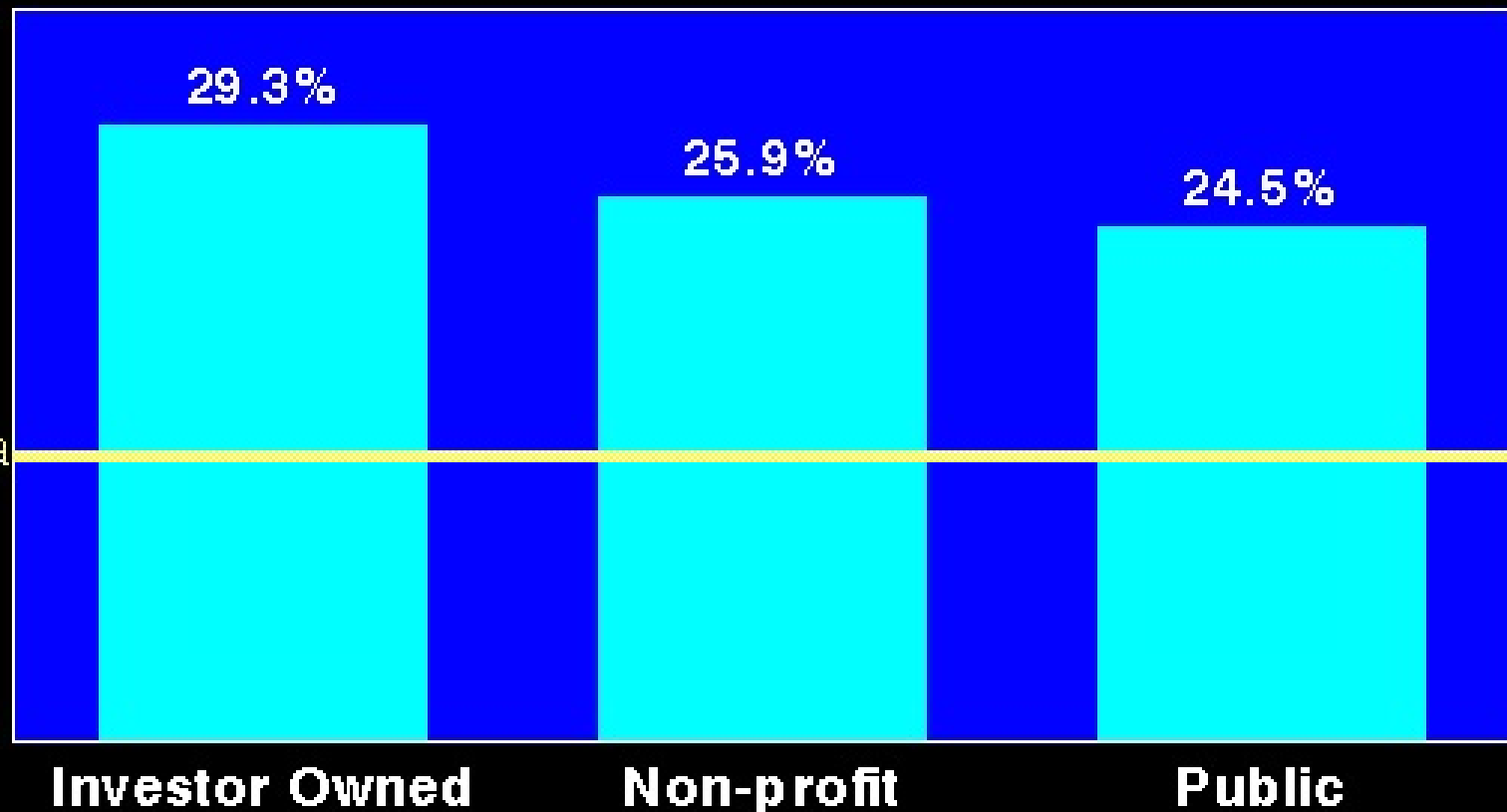
Readmission rate adjusted for severity  
(1.00 = expected rate)



# For-Profit Hospitals' Administrative Costs are Higher

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% spent on administration



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

# Doctors at For-Profits Take More Pharma Money

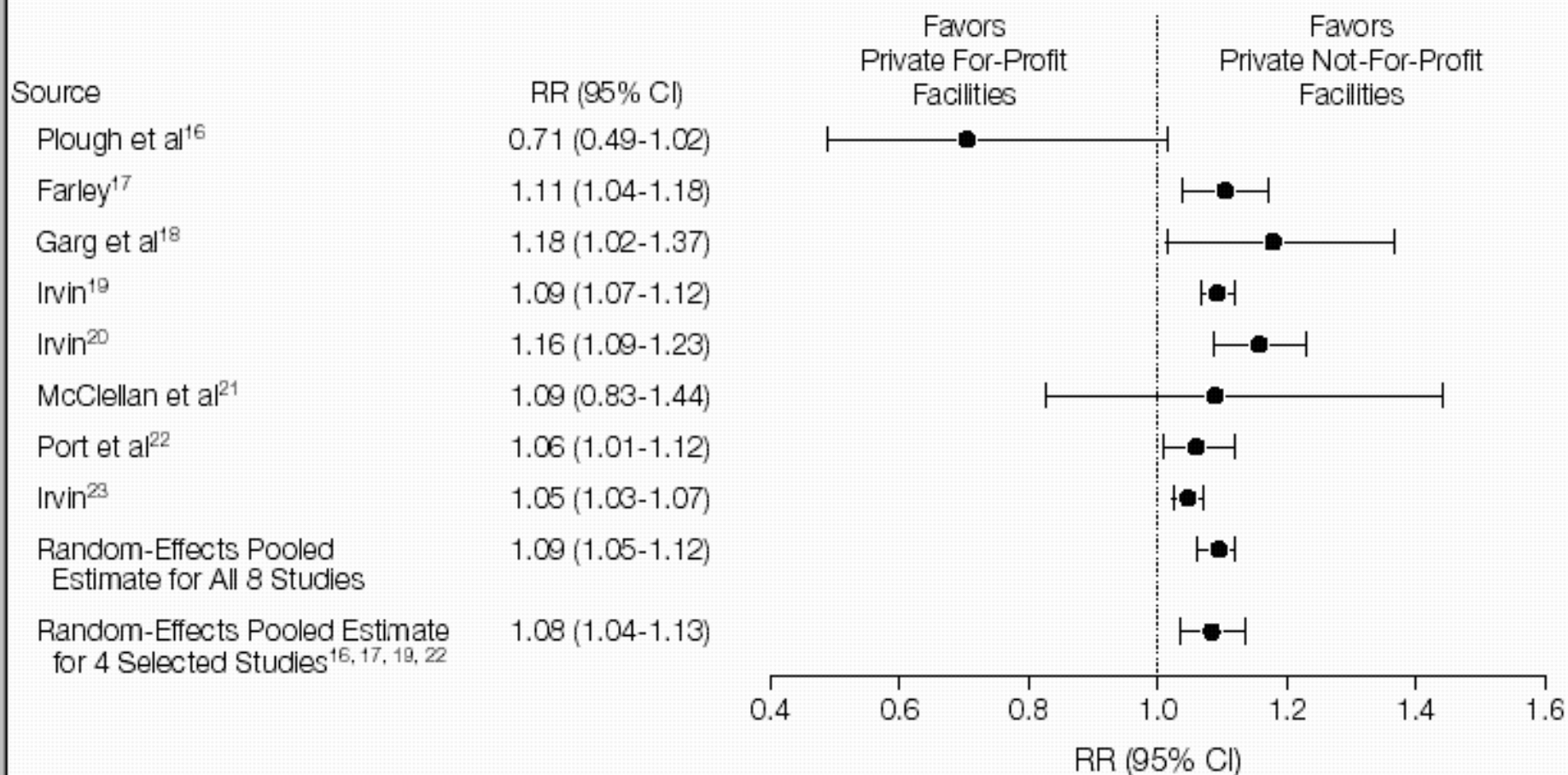
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Proportion of doctors receiving drug company payments



# For-Profit Dialysis Clinics' Death Rates are 9% Higher

**Figure 2.** Relative Risk (RR) of Mortality in Hemodialysis Patients



# Investor-Owned Dialysis Clinics Discourage Transplants

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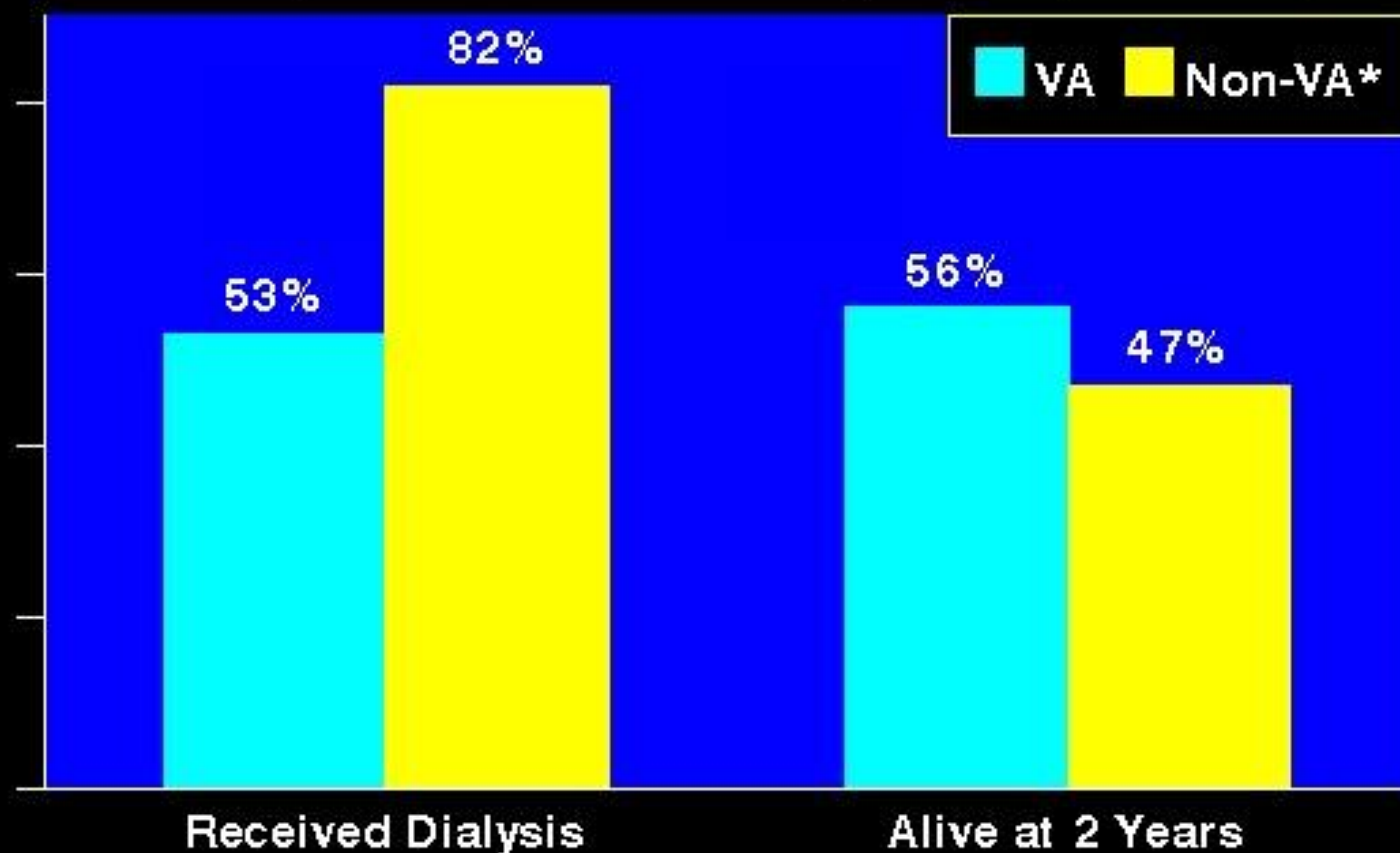
Percent of dialysis patients placed on transplant list





# VA Kidney Care: Less Dialysis, Better Survival

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

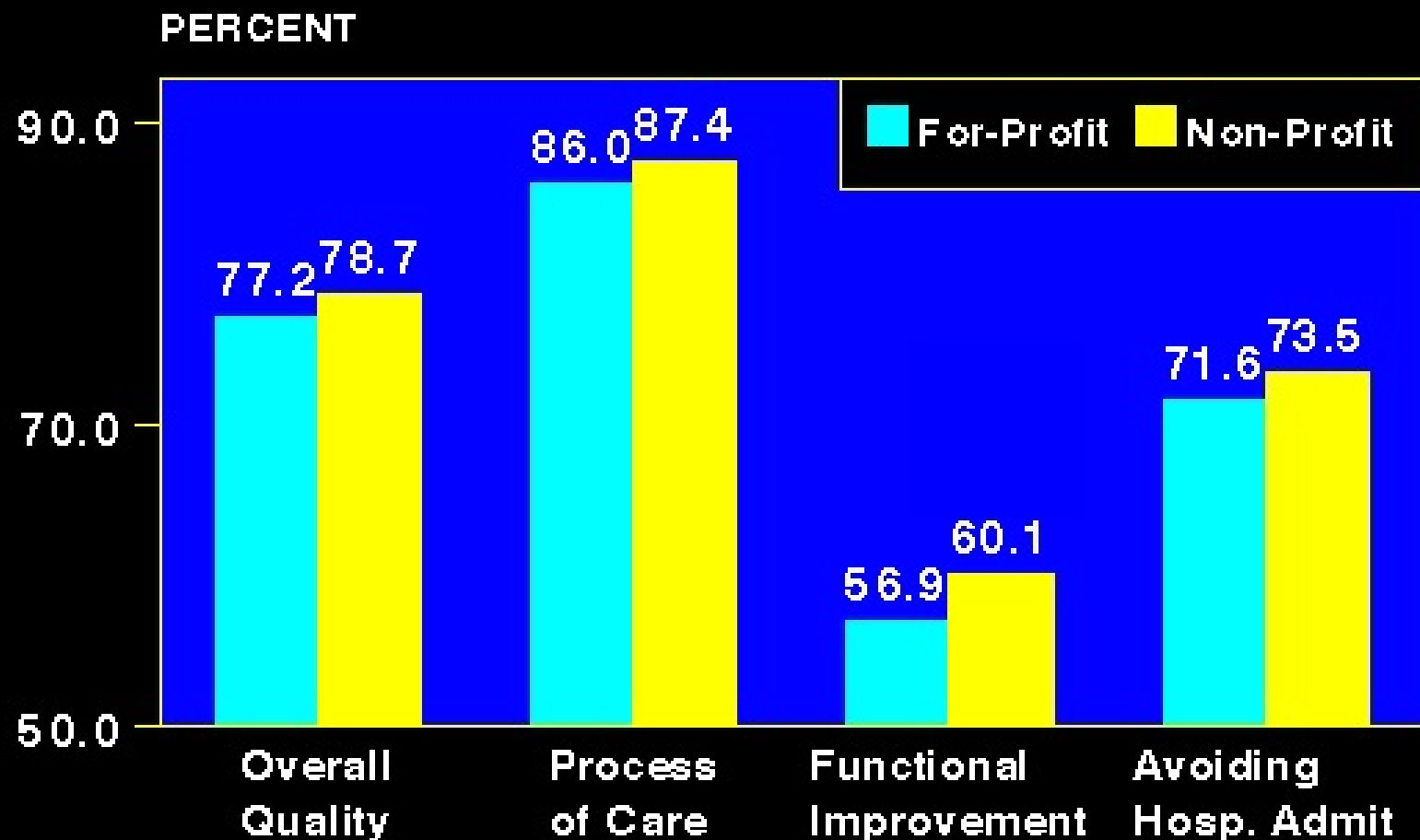


Source: JAMA IM 2018;178:657

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

# For Profit Home Care: Lower Quality

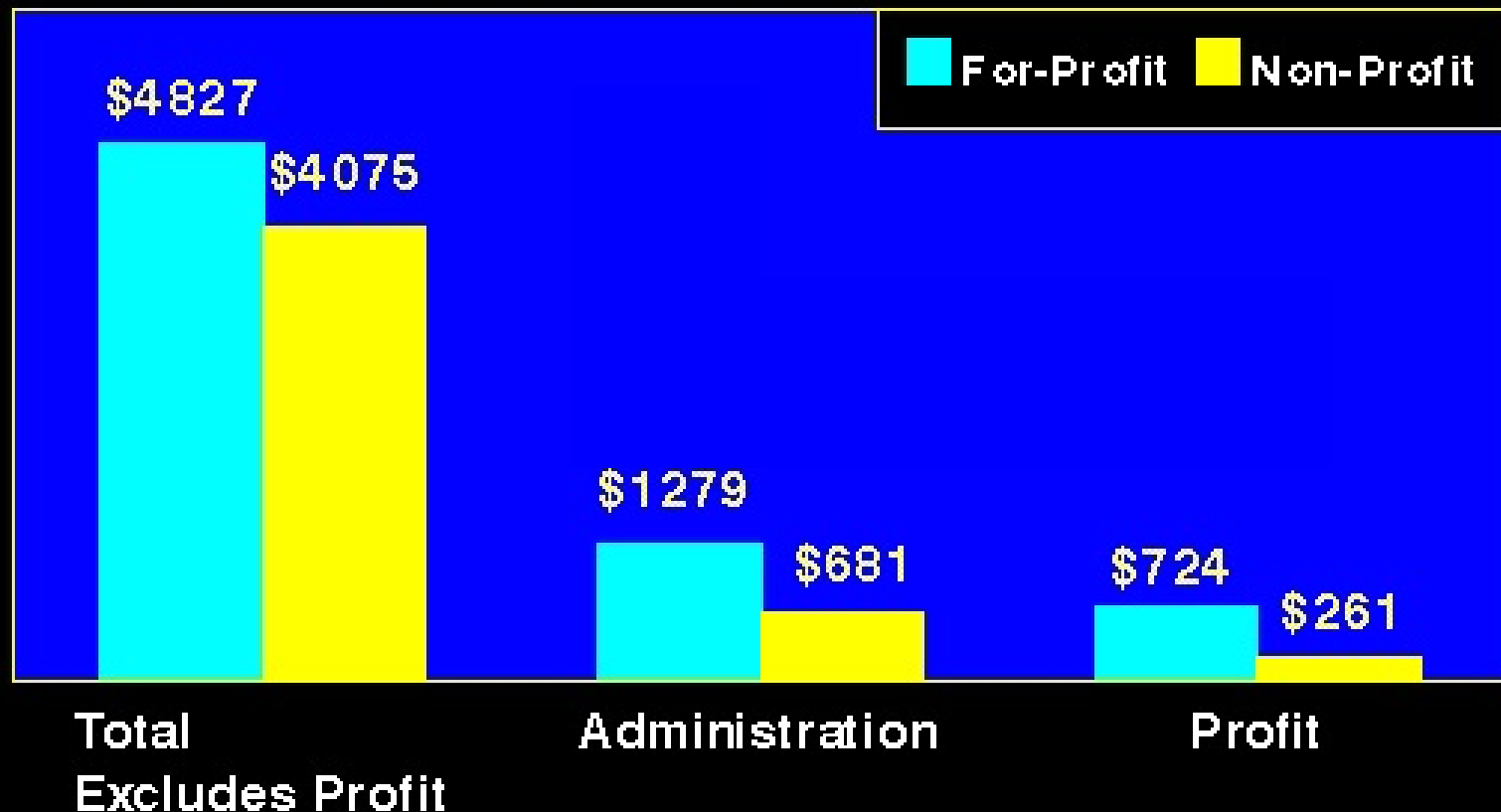
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# For Profit Home Care: Higher Cost

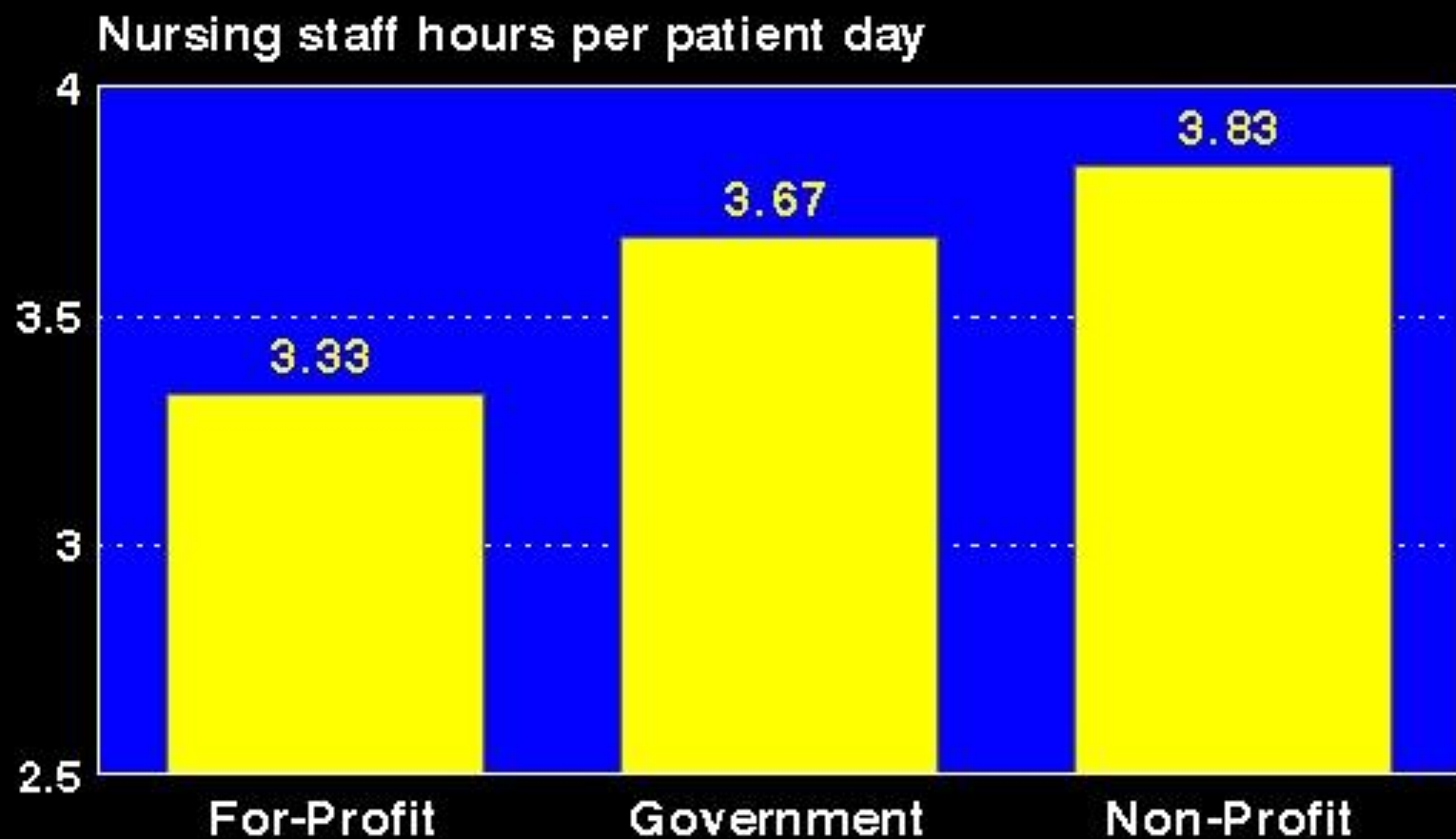
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## Annual Cost Per Patient



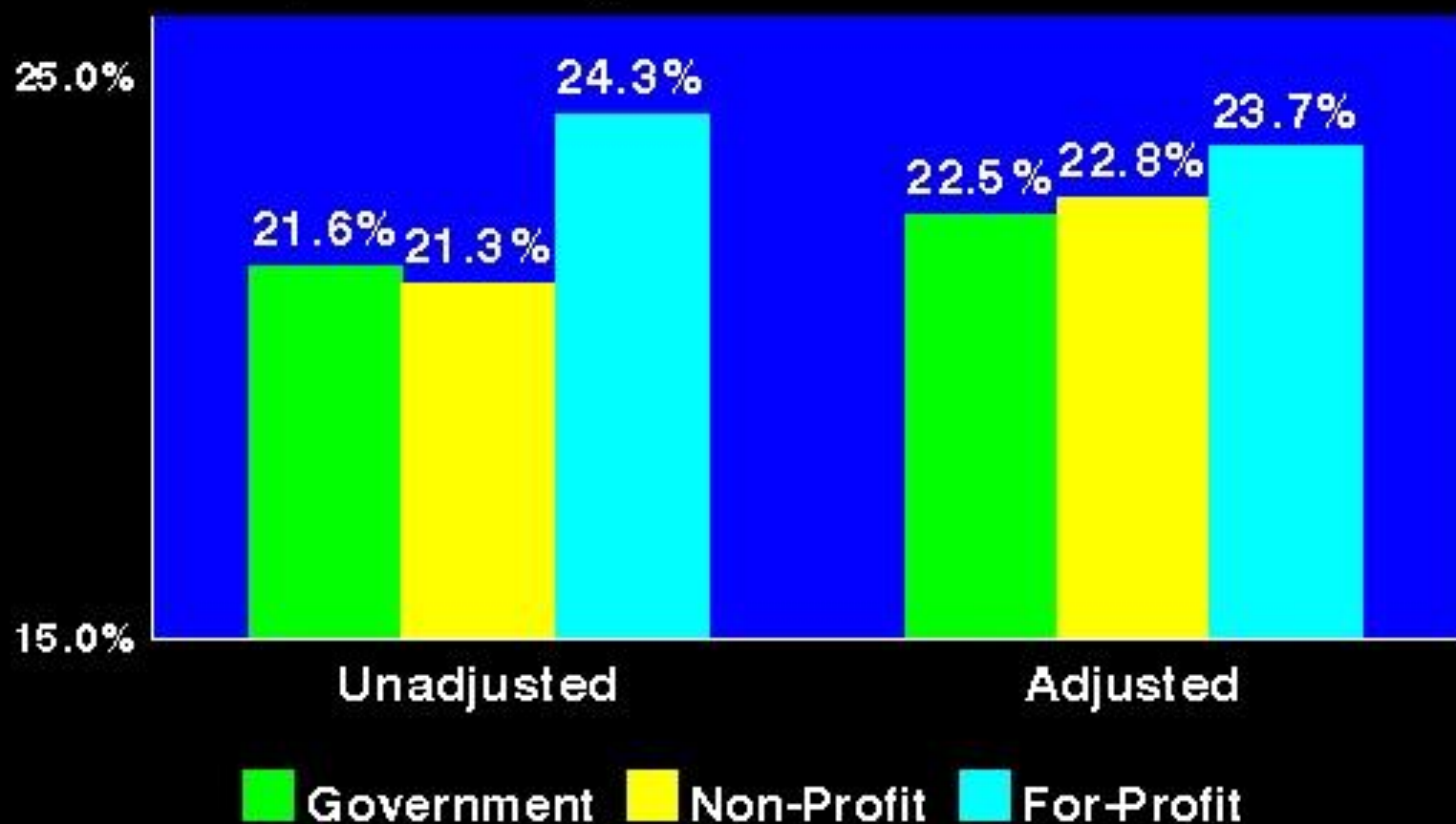
# For-Profit Nursing Homes: Less Nursing Care

A National Study



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

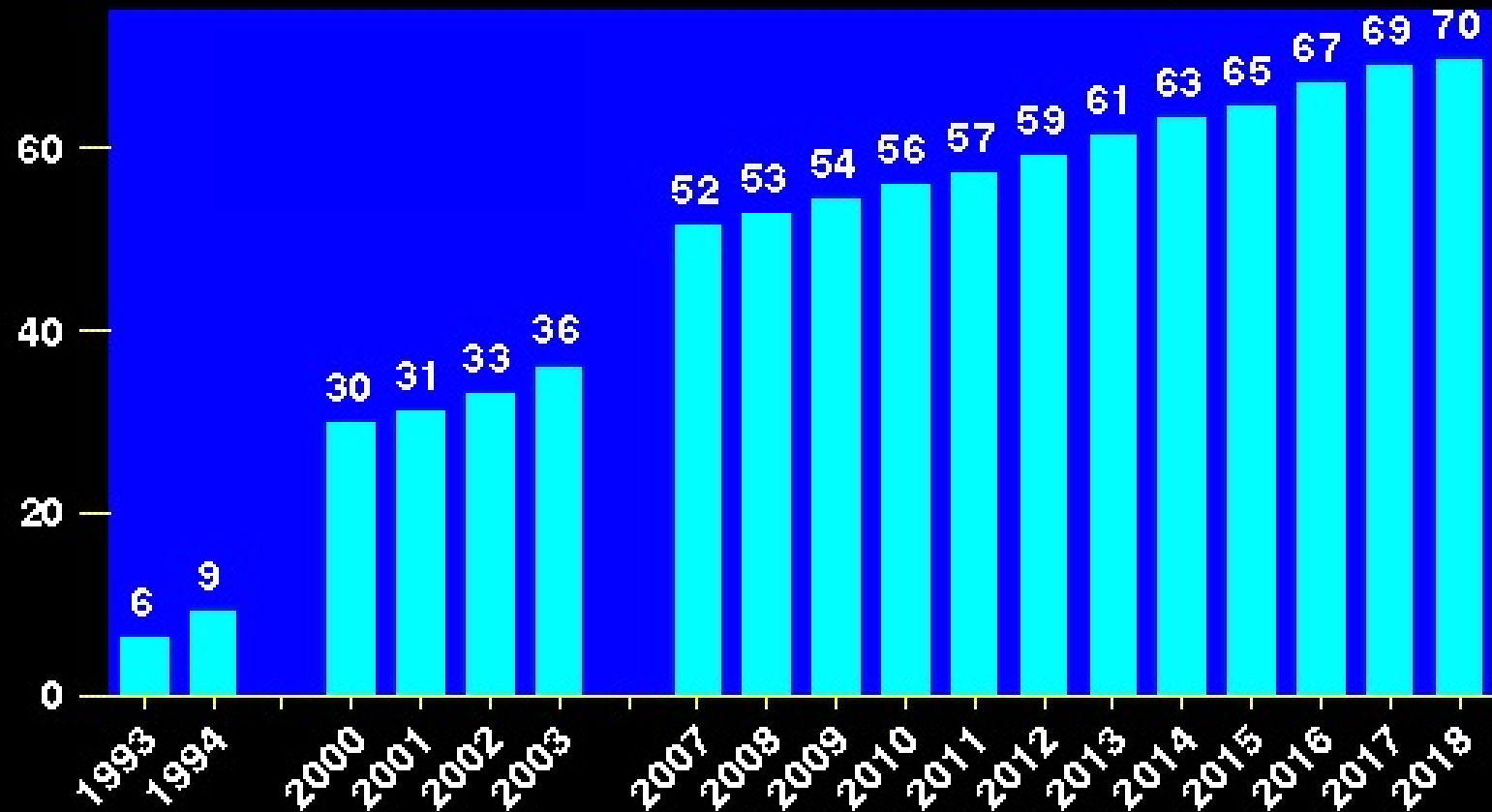
Percent of patients dying or readmitted within 30 days  
of hospital discharge





# Hospice Goes For-Profit

Percent of hospices under for-profit ownership



Source: MedPac Annual Report, 2020 and previous

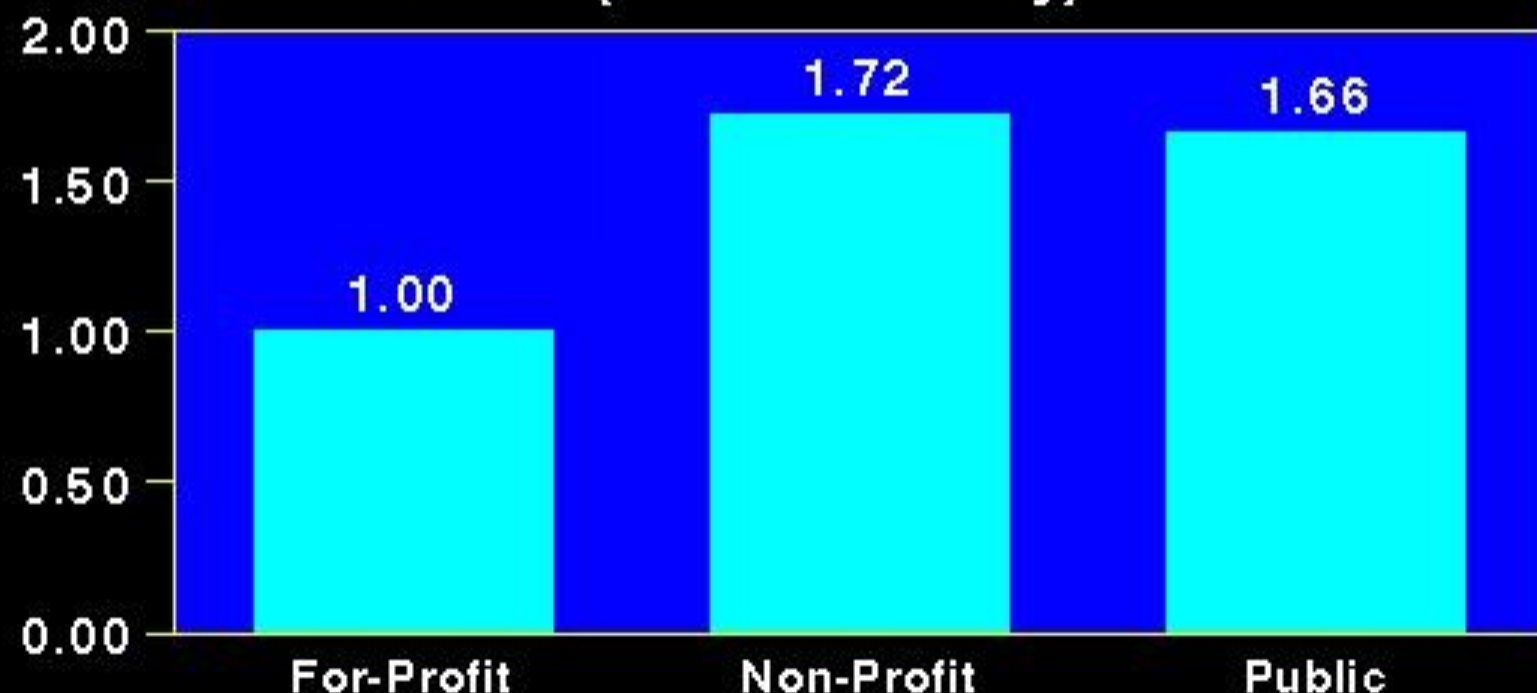
Note: Profit rate: for-profits = 20.2%; non-profits = 2.5%

Mean LOS: for-profits = 110 days; non-profits = 68 days

# For-Profit Hospices Avoid Unprofitable Patients

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

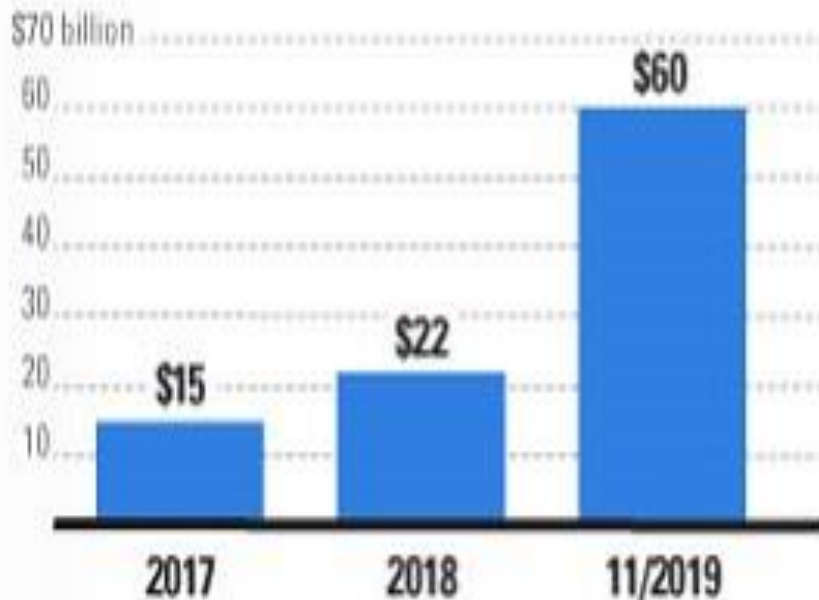


Source: Health Affairs 2012;31:2690

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



## Private equity and venture investment in physician practices

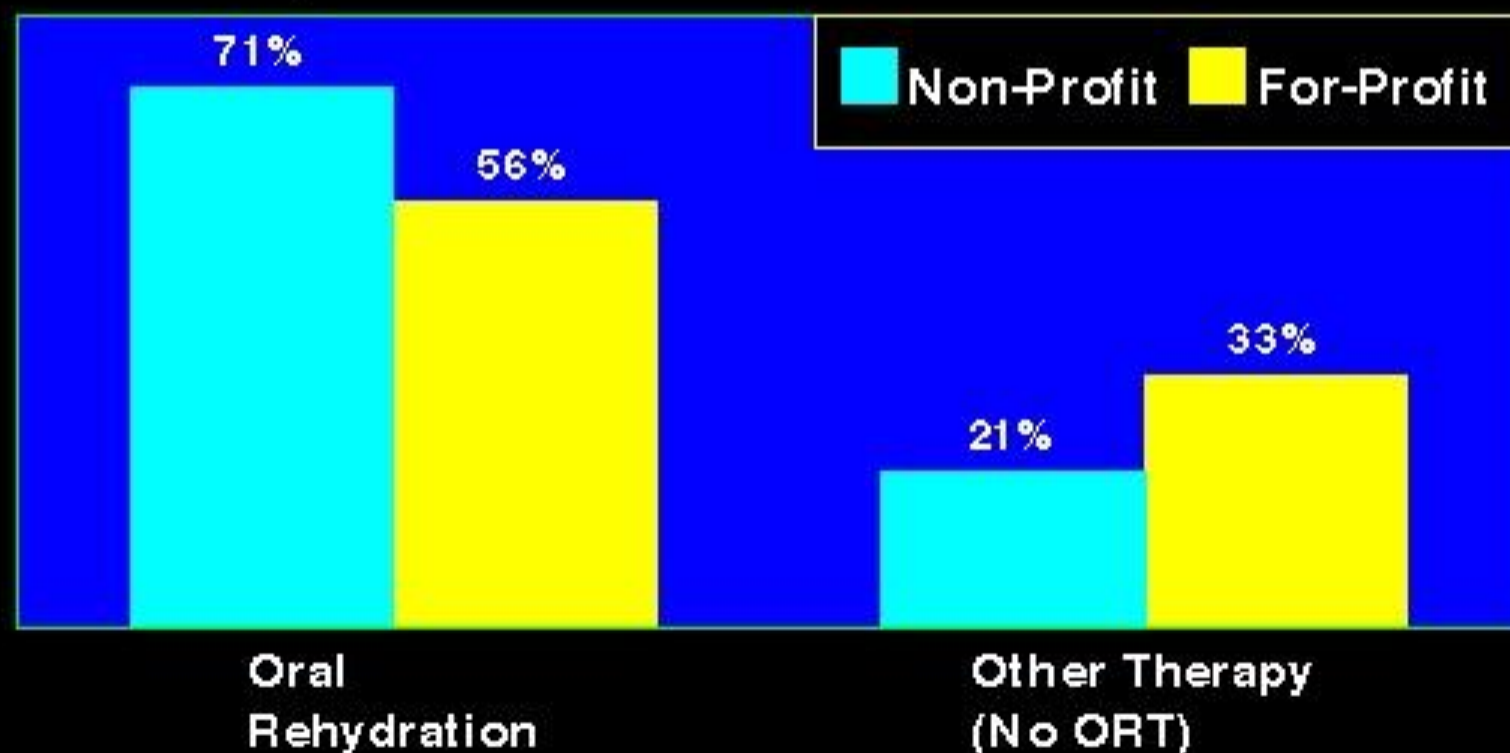


Source: "Private equity in healthcare," Medical Economics, Nov. 12, 2019

# 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

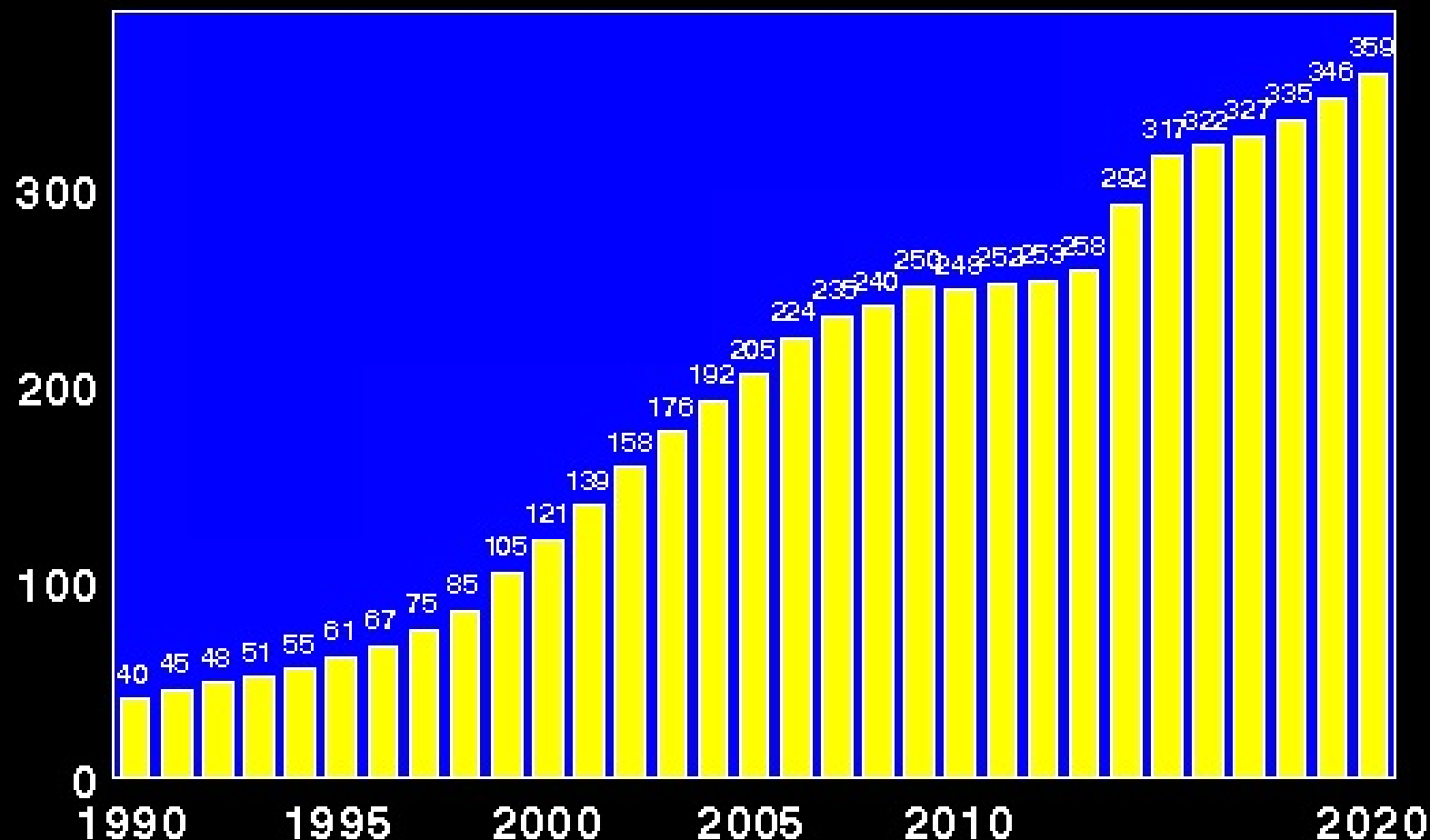
Note: Over 700,000 children die from diarrhea annually, ORT is life-saving

Drug and Device Firms  
Inflate Prices,  
Distort Priorities



# U.S. Drug Spending, 1990-2020

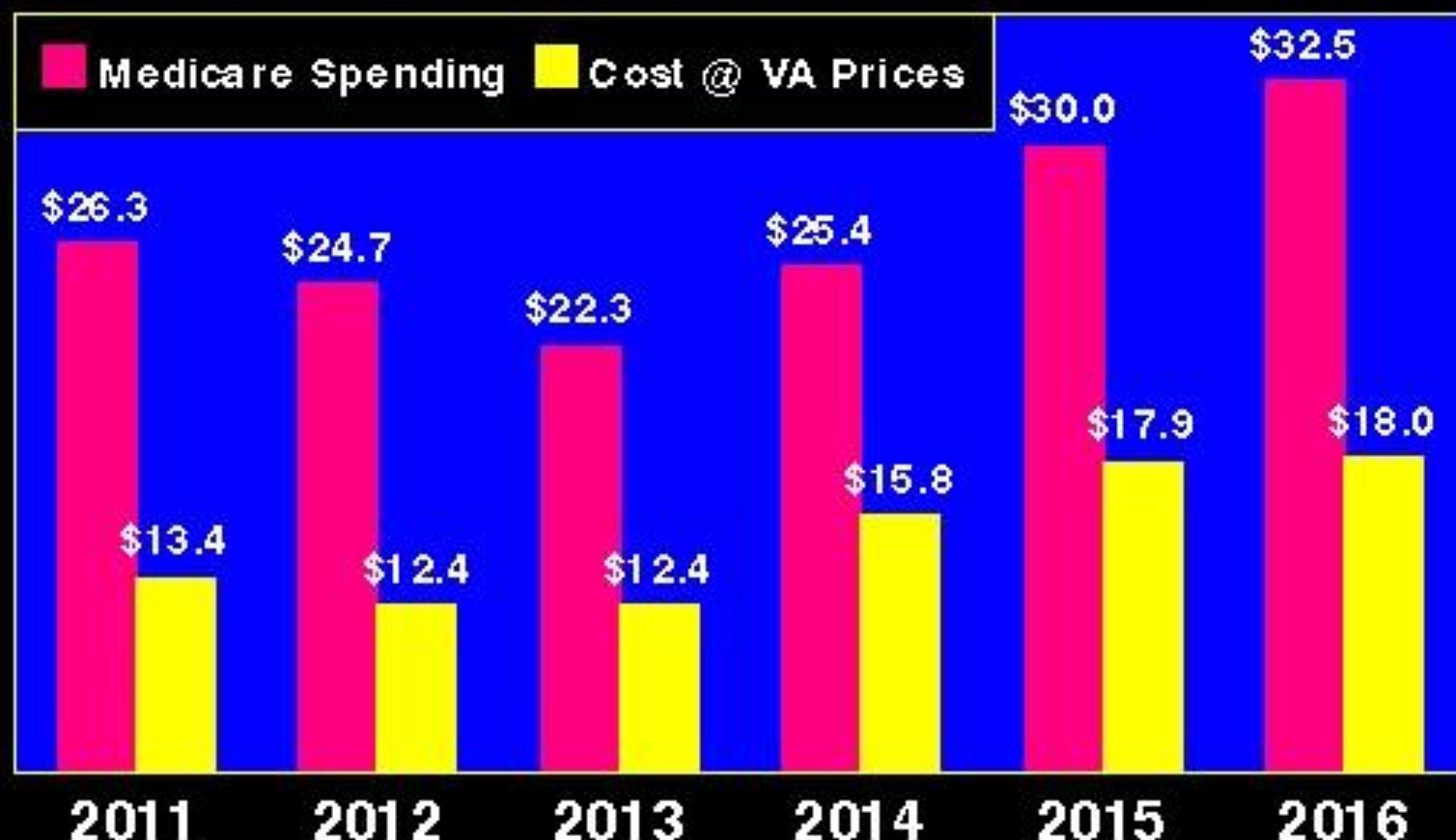
Outpatient Prescription Drug Spending - \$ billions



Source: CMS, Office of the Actuary - Note: 2019 & 2020 estimated

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

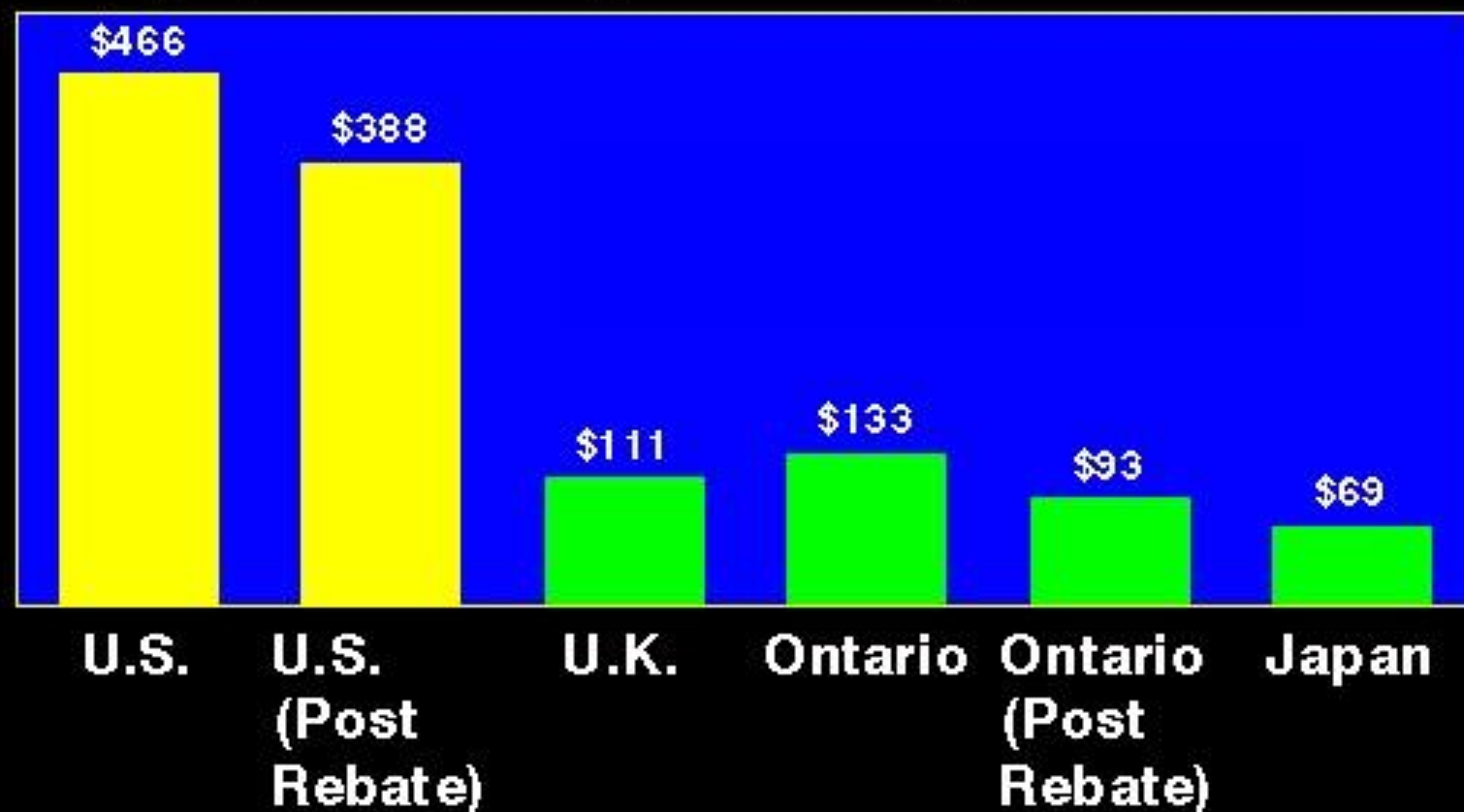
Spending for top 50 drugs (\$s billions)



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

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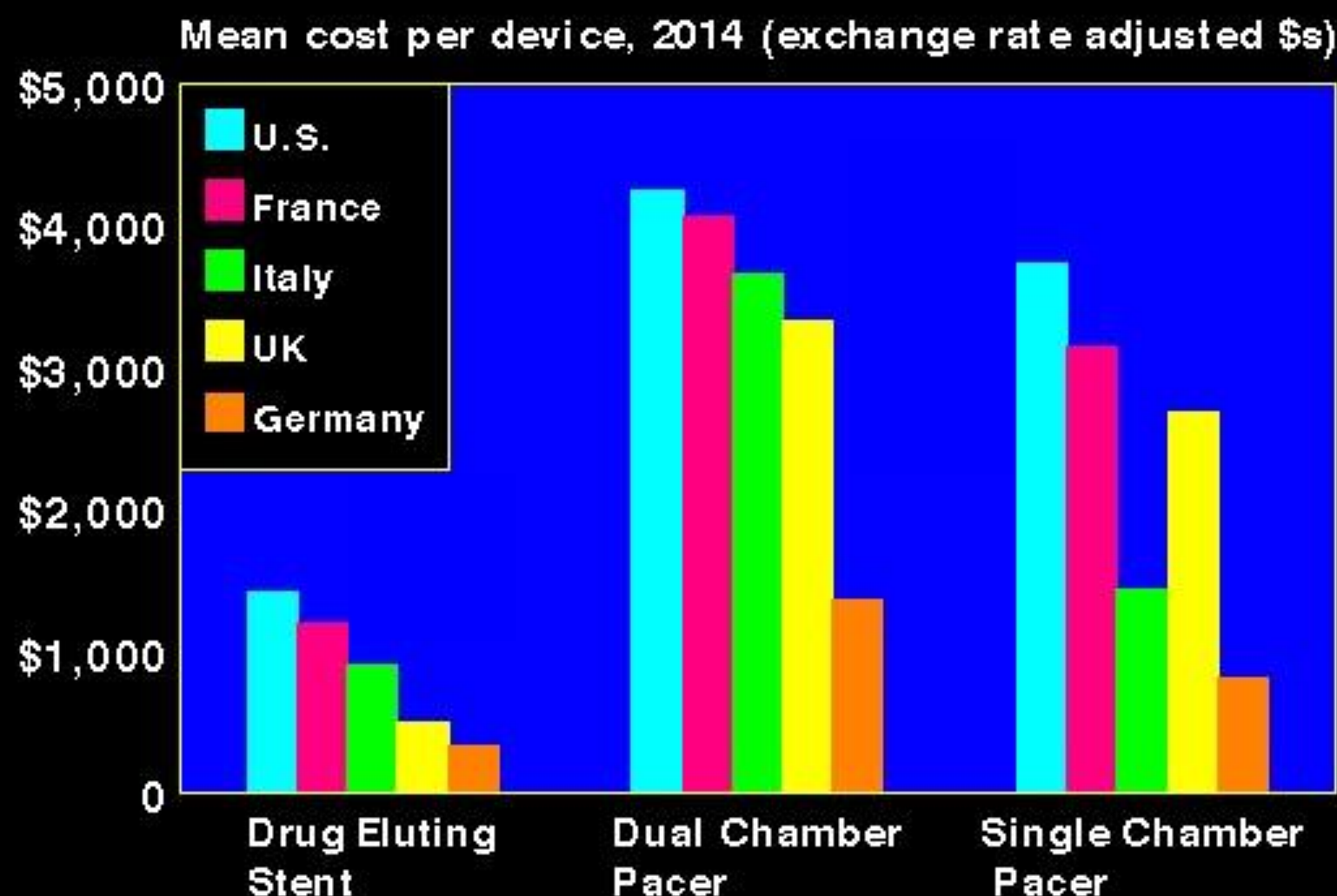
Average price of 79 single source drugs



Source: Health Affairs 2019;38:804

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

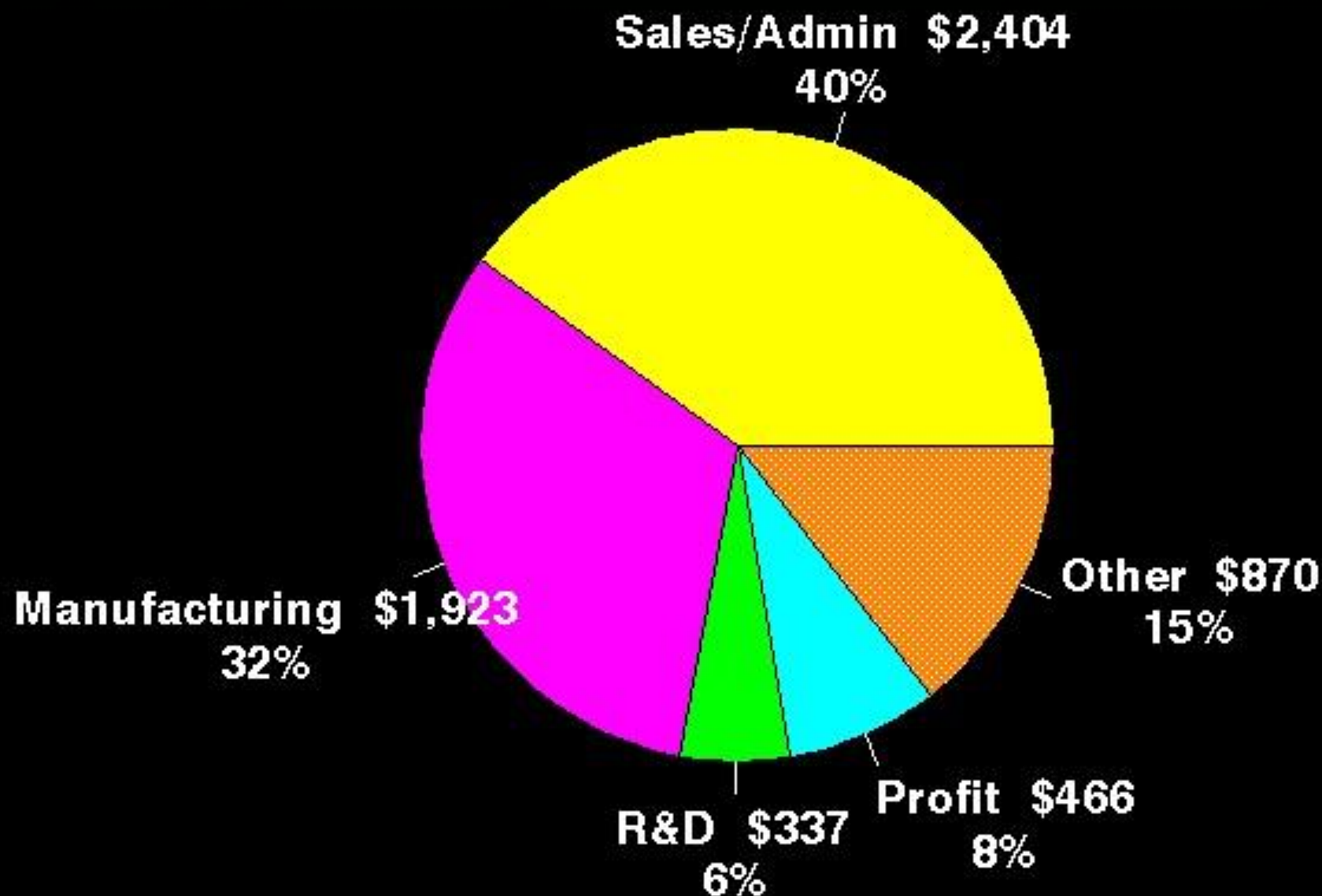
# As With Drugs, Devices Price are Highest in U.S.



Source: Health Affairs 2018;37:1570

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

# What Goes Into a \$6000 Orthopedic Implant

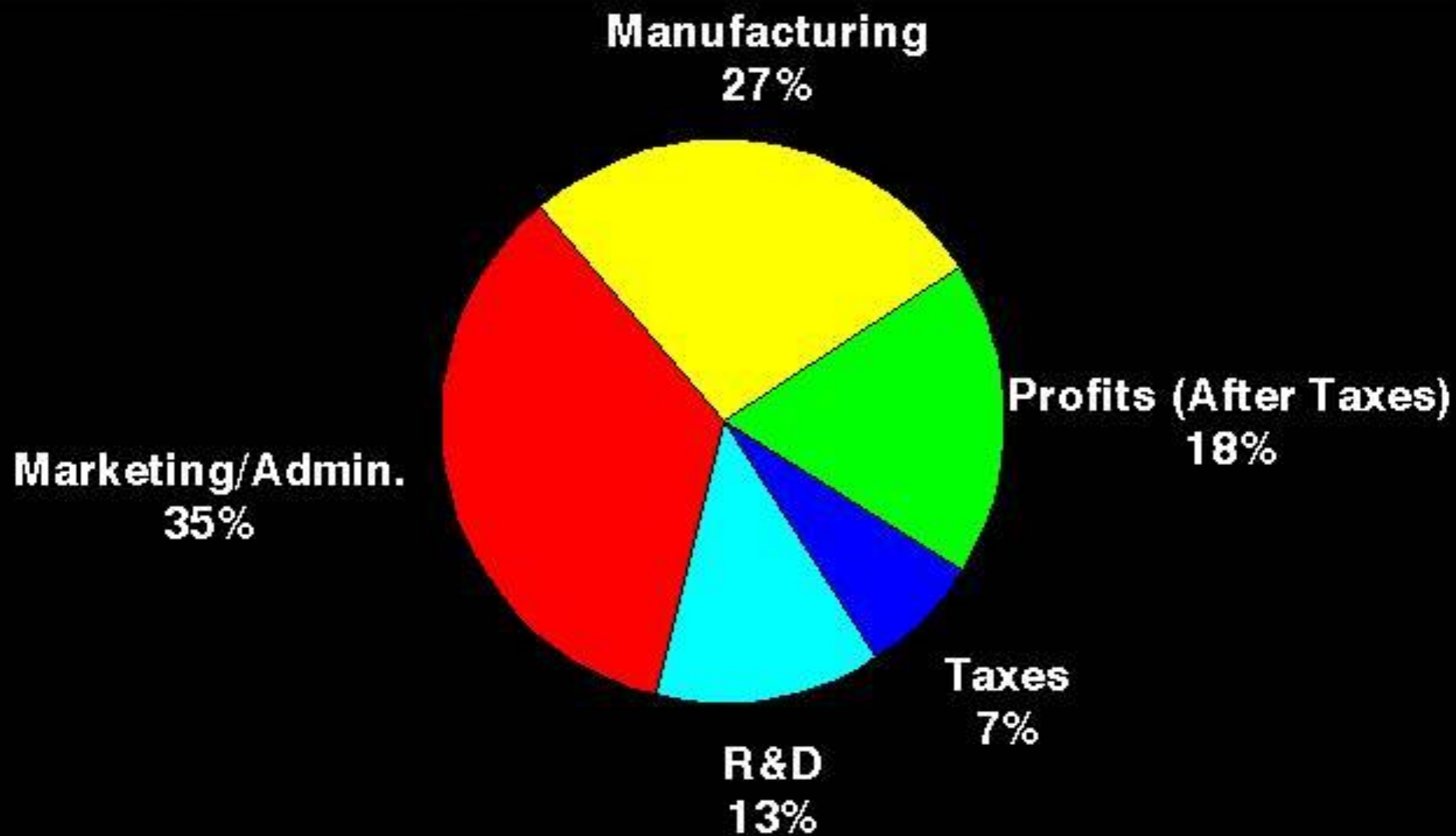


Source: Modern Healthcare 2/5/2018



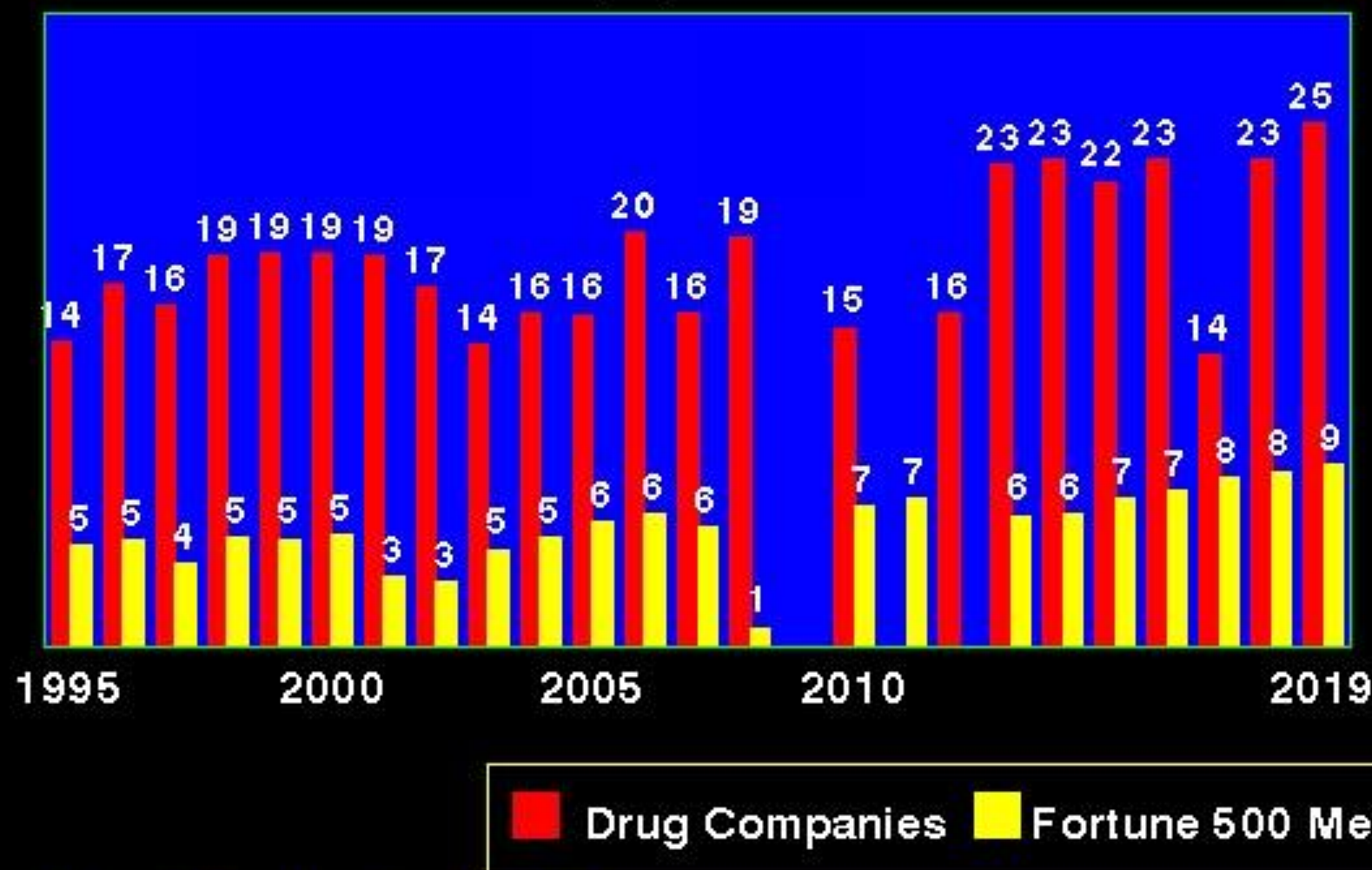
# Drug Companies' Cost Structure

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# Drug Company Profits, 1995-2019

Return on Revenues (%)

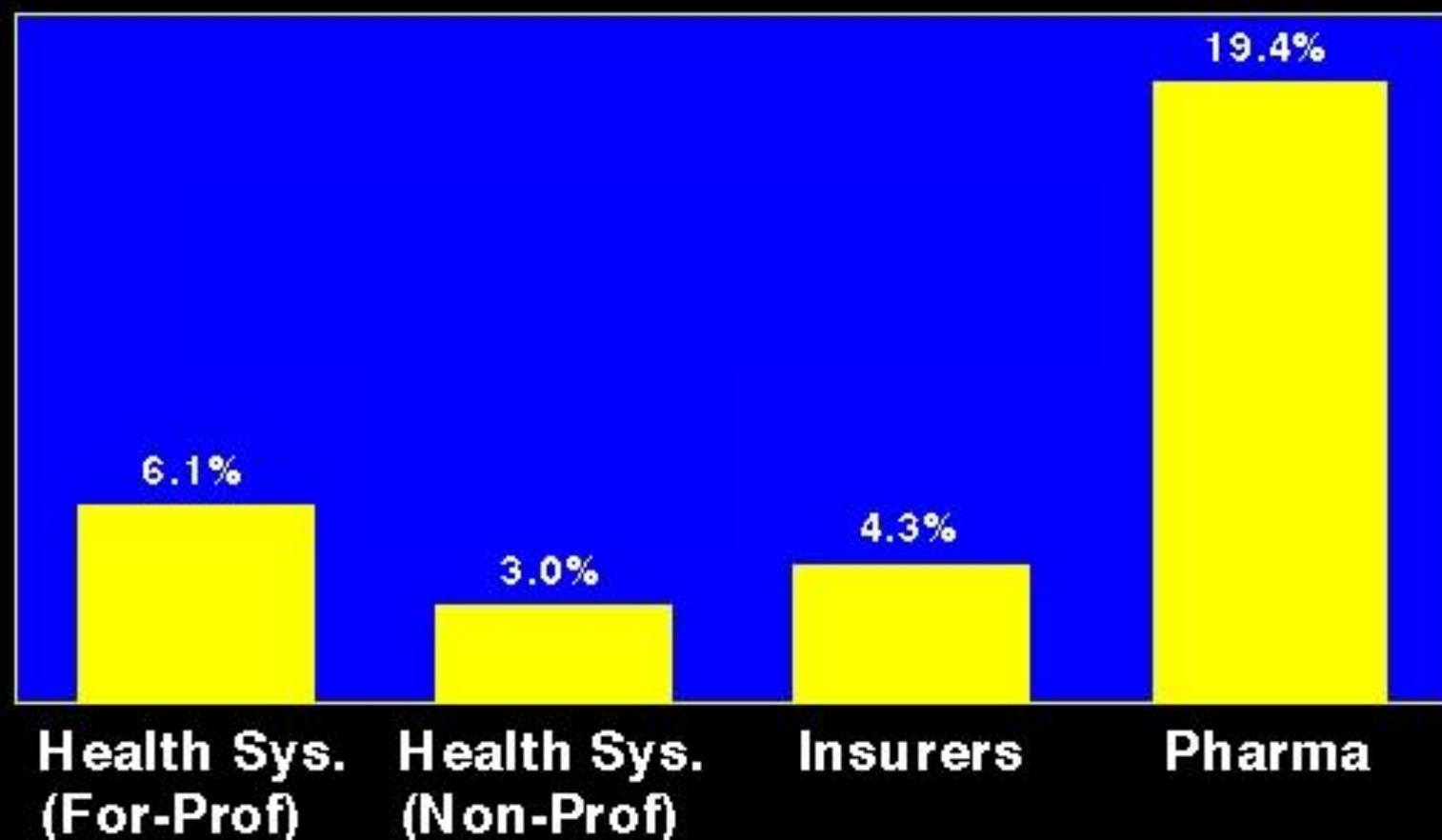


Source: Fortune 500 rankings for 1995-2020

# Health Industry Profit Rates

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Profits as % of revenues



Source: Modern Healthcare August 5, 2019:14

Note: Figures are for 5 largest firms in each sector

# Drug Firms' Strategy: Pay the Ticket, Keep on Speeding

- 85% of drug firms paid fines for illegal activities, 2003-2016.
- Most common violations: kickbacks, illegal marketing, overcharging.
- Fines over 14 years = \$33 billion ( $< \frac{1}{2}$  of single year profits).
- 21/26 firms engaged in illegal activities for at least 4 years.

Source: JAMA IM 2020;3324:1995

## 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



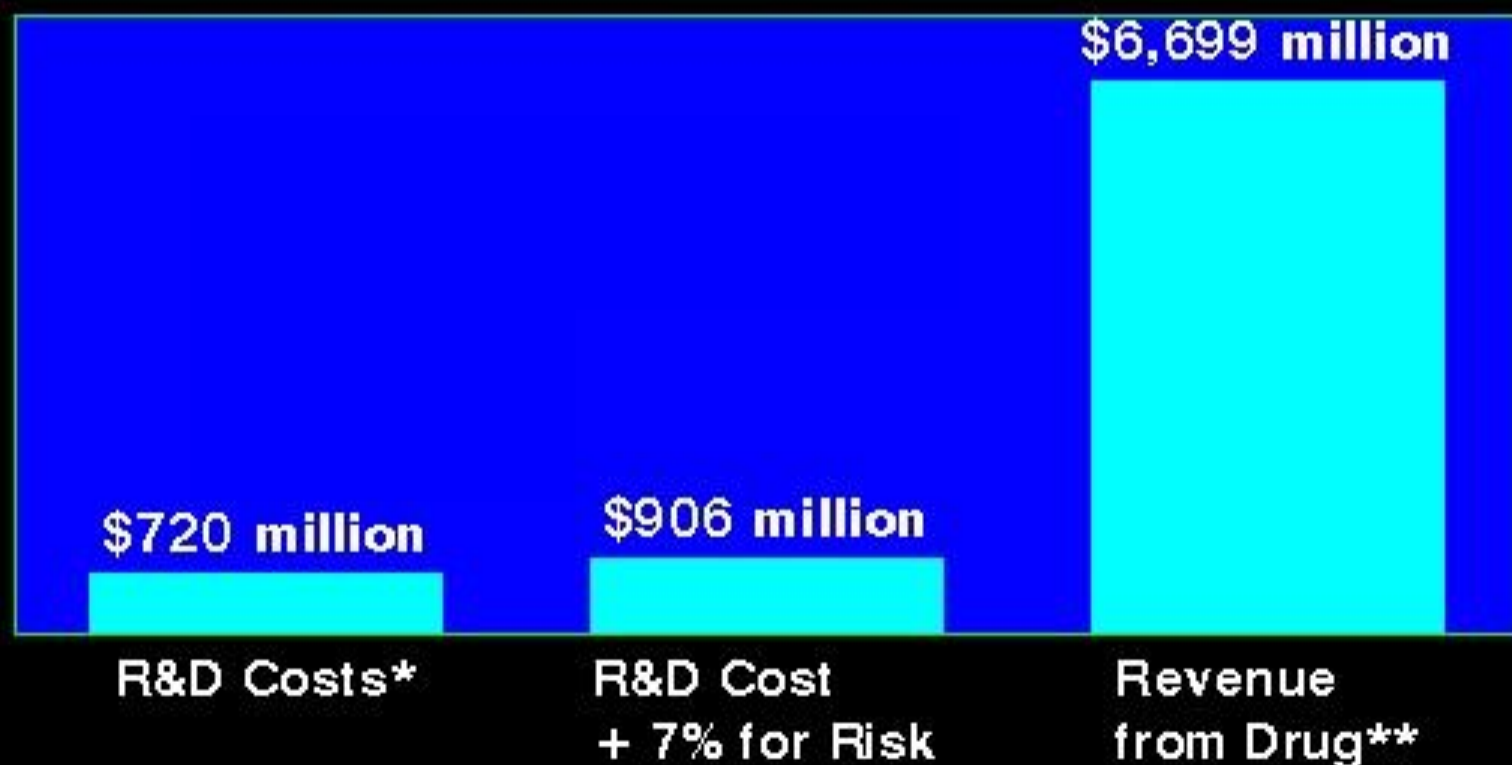
“The success of its [Gilead’s] hepatitis C franchise has gradually exhausted the available pool of treatable patients. . . In the case of infectious diseases such as hepatitis C, curing existing patients also decreases the number of carriers able to transmit the virus to new patients.”



# 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

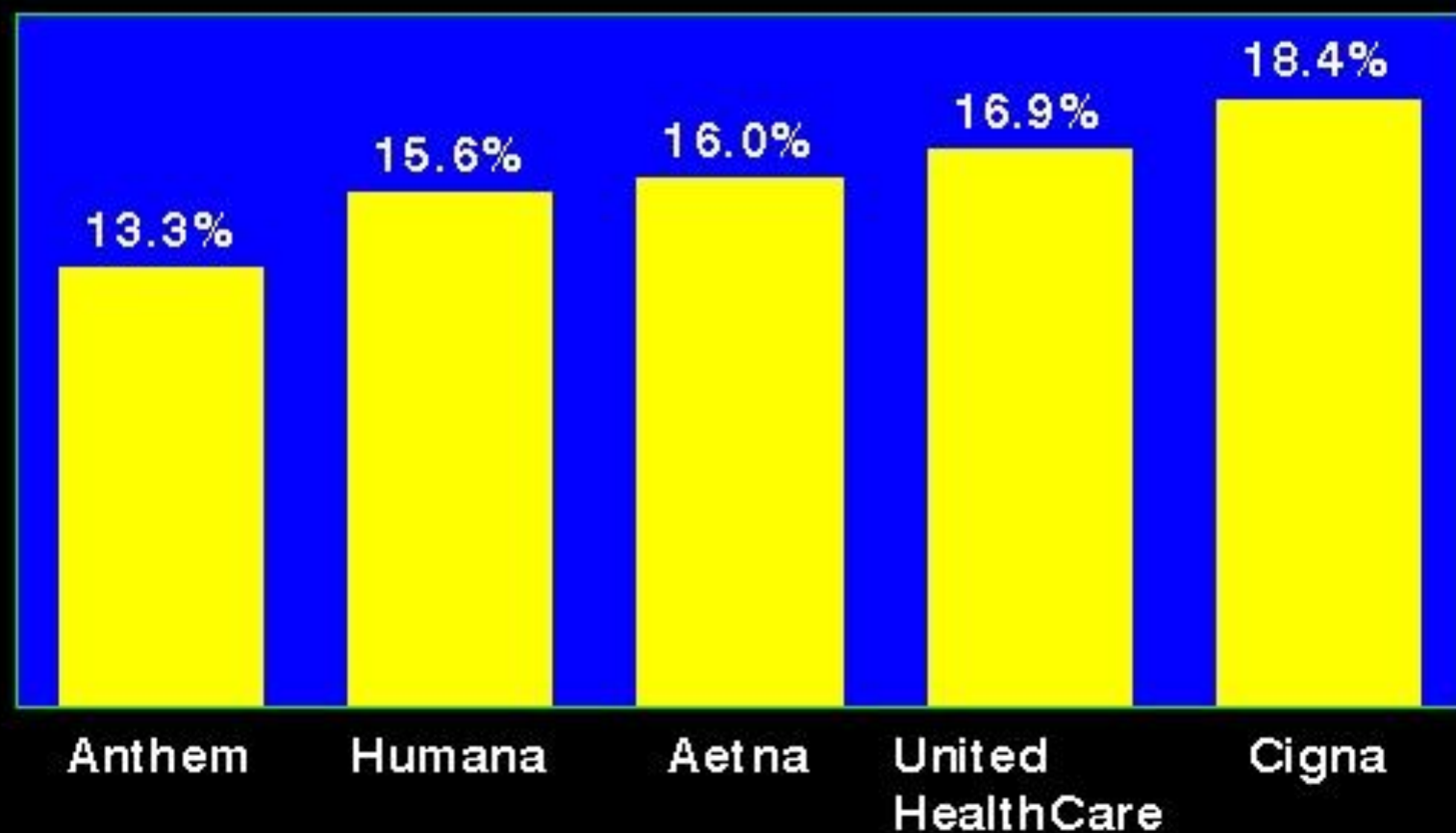
\*\* Total revenue from sales since approval - mean of 3.8 years

Private Insurers:  
Middlemen Who Add  
Costs But Not Value

# Insurance Overhead, 2019

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Medical loss ratio

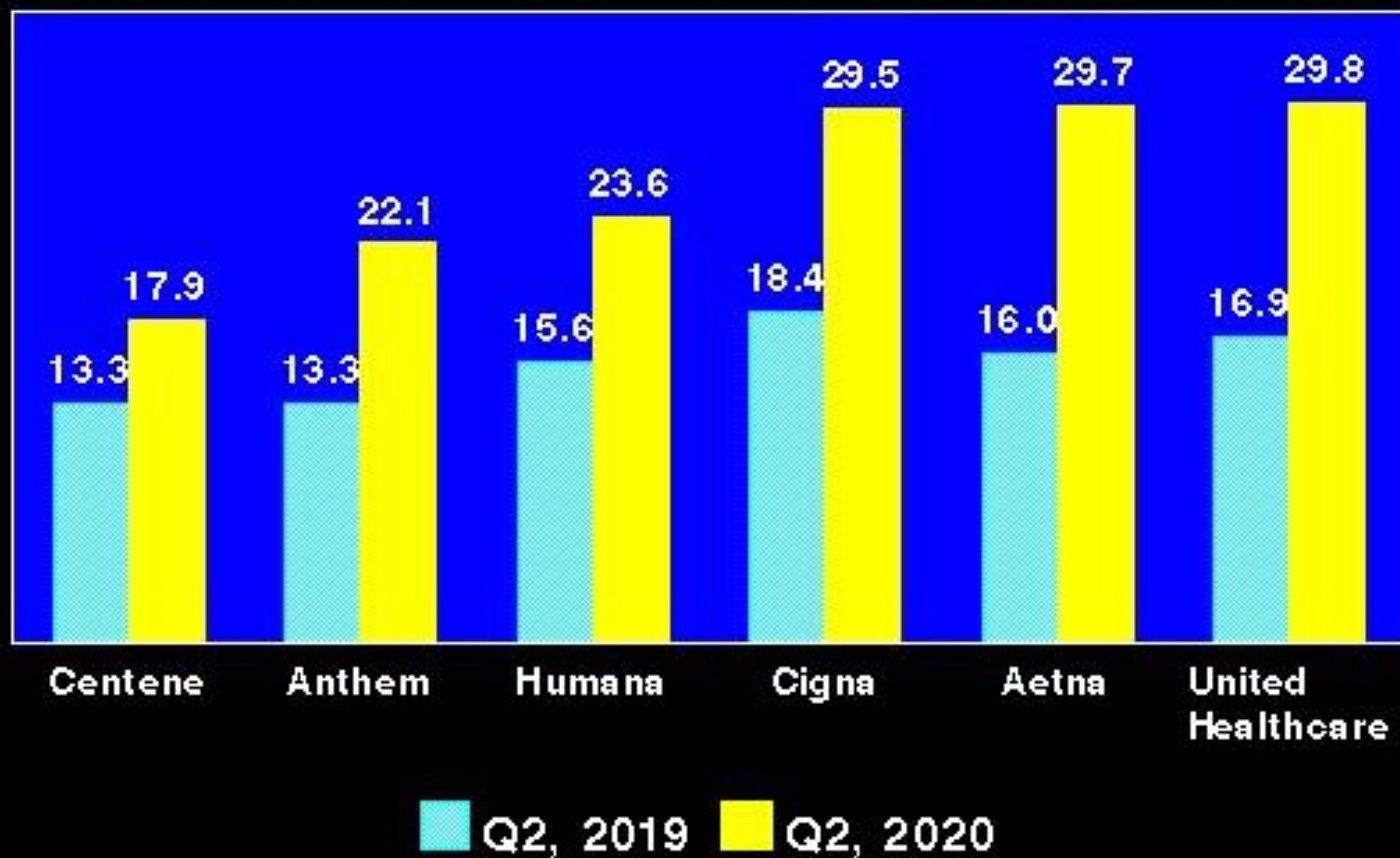


Source: SEC filings for first or second quarters, 2019

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

# COVID-19 Boosted Insurers' Profits

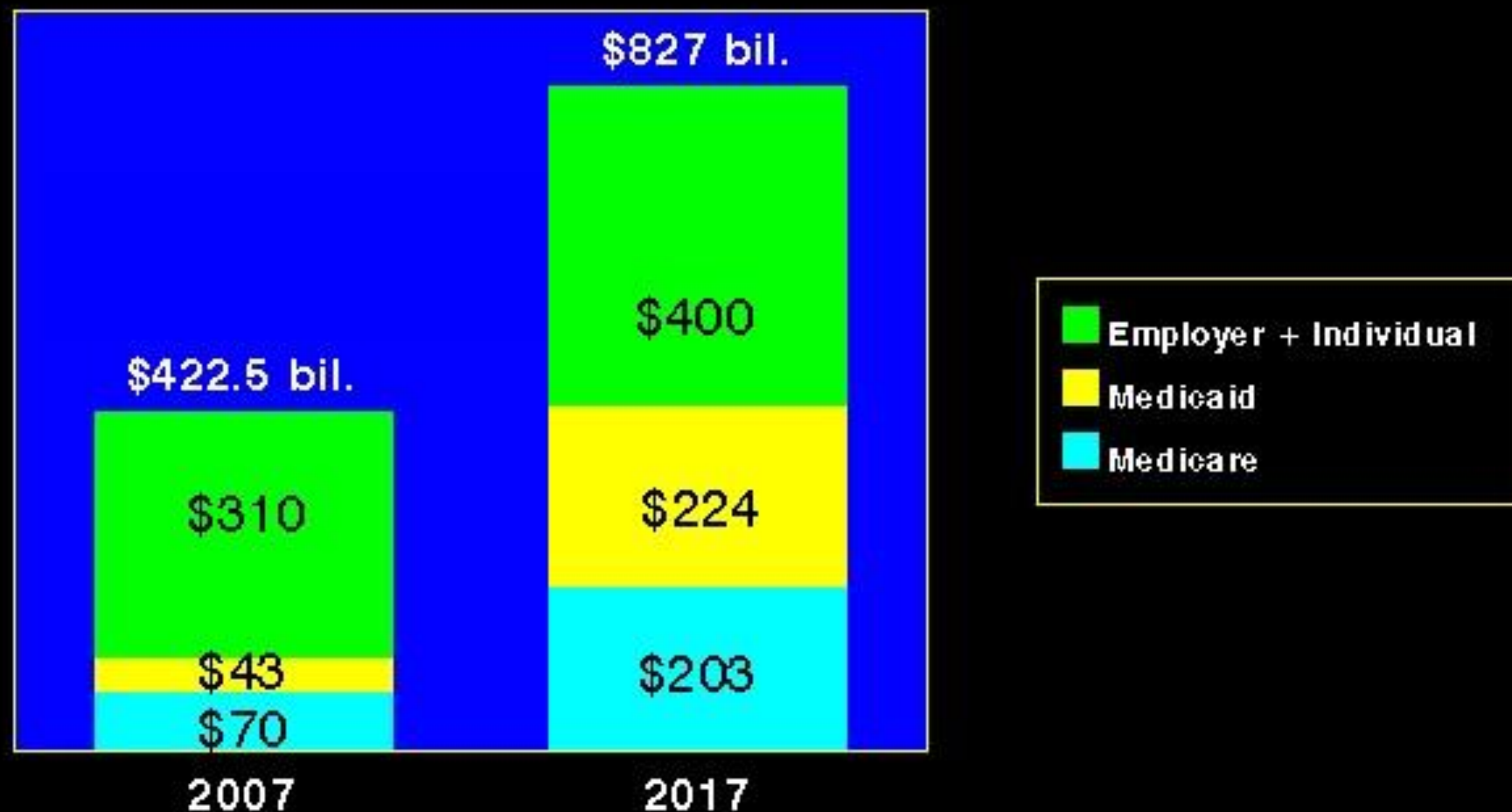
Overhead + Profits (% of Premiums)



Source: SEC Filings

# 52% of Private Insurers' Revenues Come From Medicare and Medicaid

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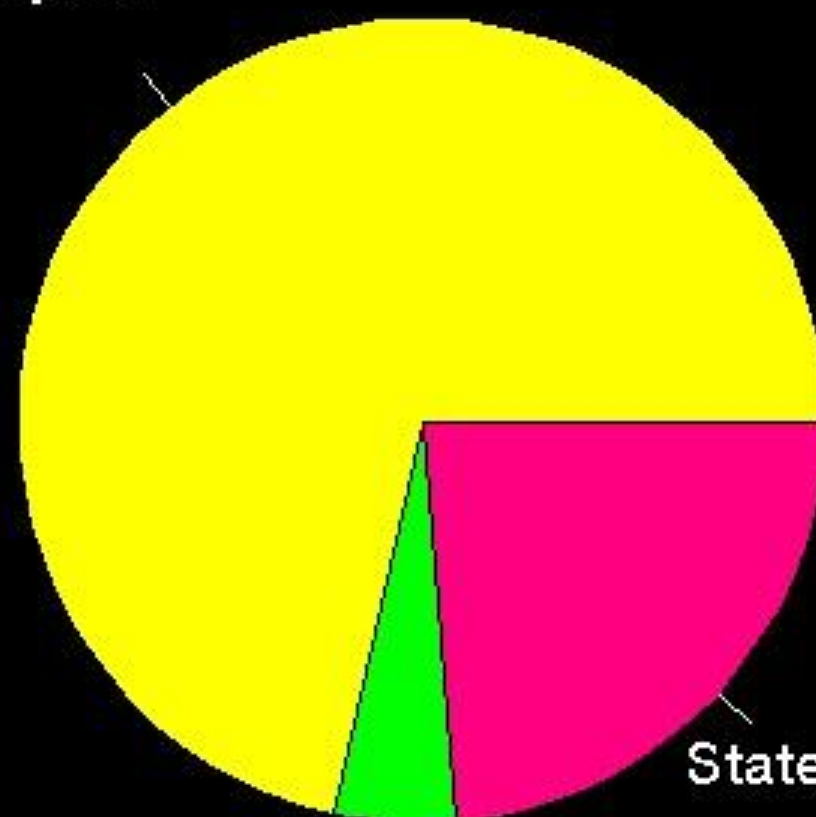




# Employer Payments for Private Insurance, 2020

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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

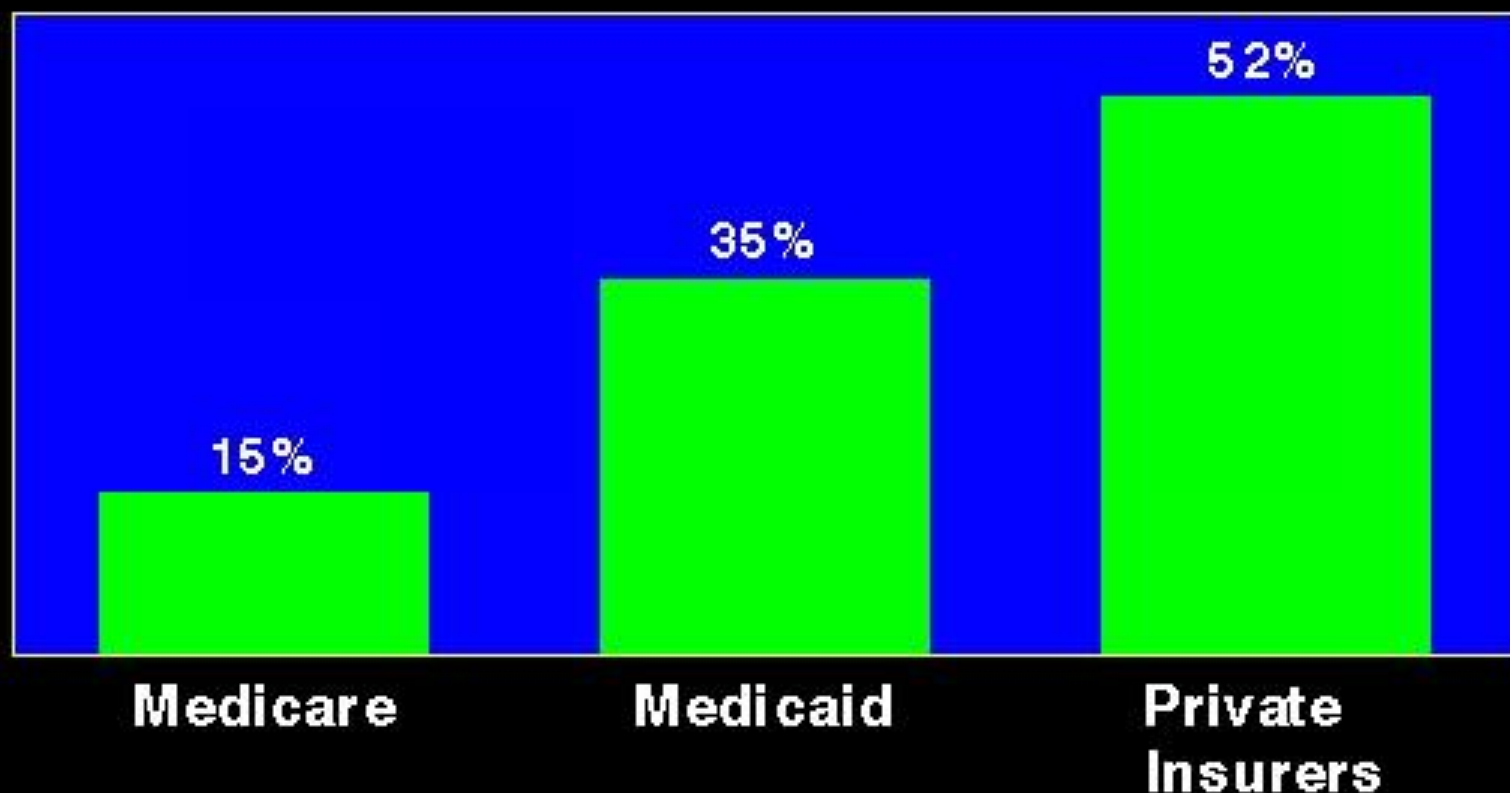
\* Harvard Pilgrim

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

# Private Insurers More Frequently Deny Hepatitis C Drugs

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Denial rate for prescriptions for Hep C DAA\* agents



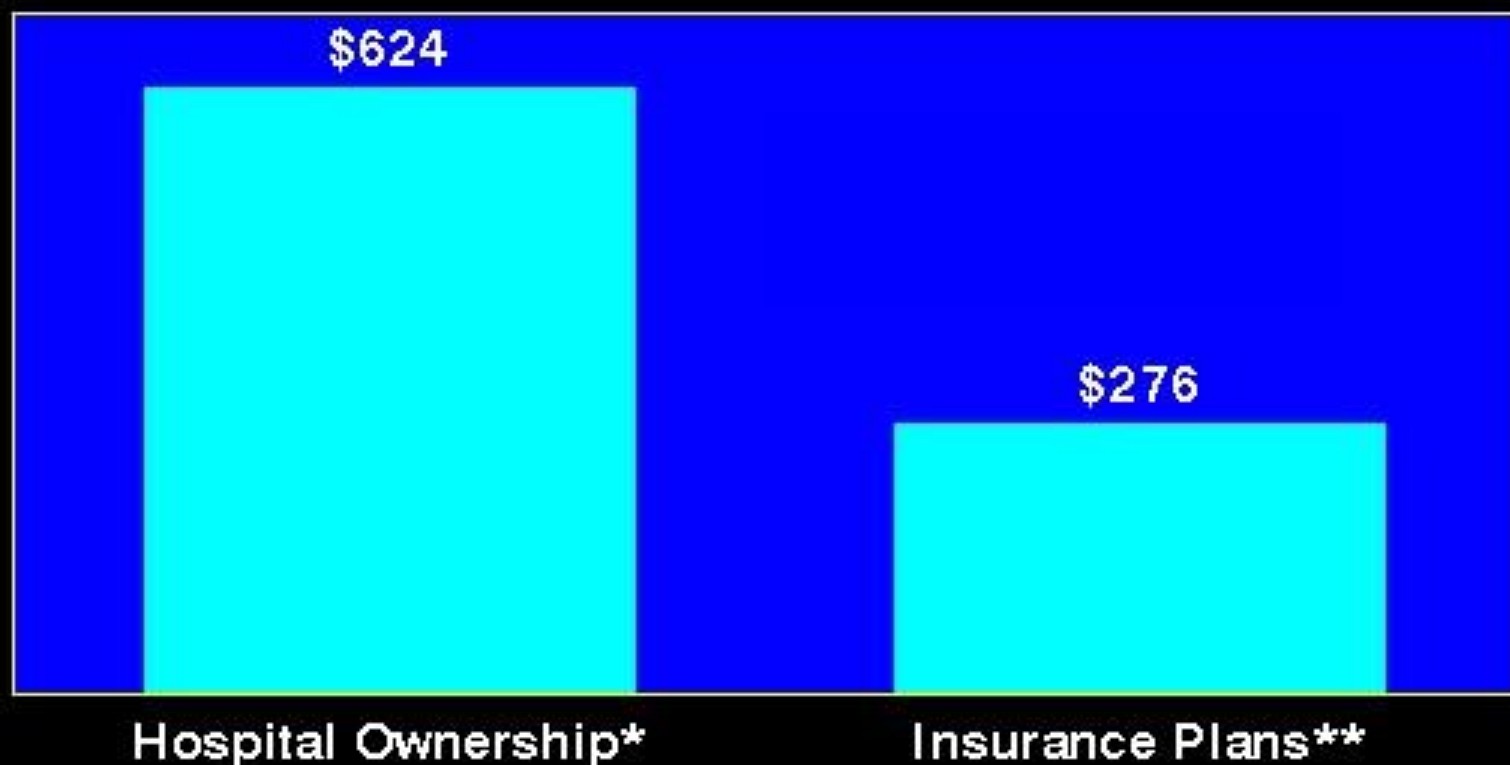
Source: Gawda et al., Open Forum Infectious Diseases, 2018

\*DAA = direct acting antivirals, such as sofosbuvir (Harvoni)

# Both Hospital and Insurer Consolidation Raise Premiums

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Annual premium boost



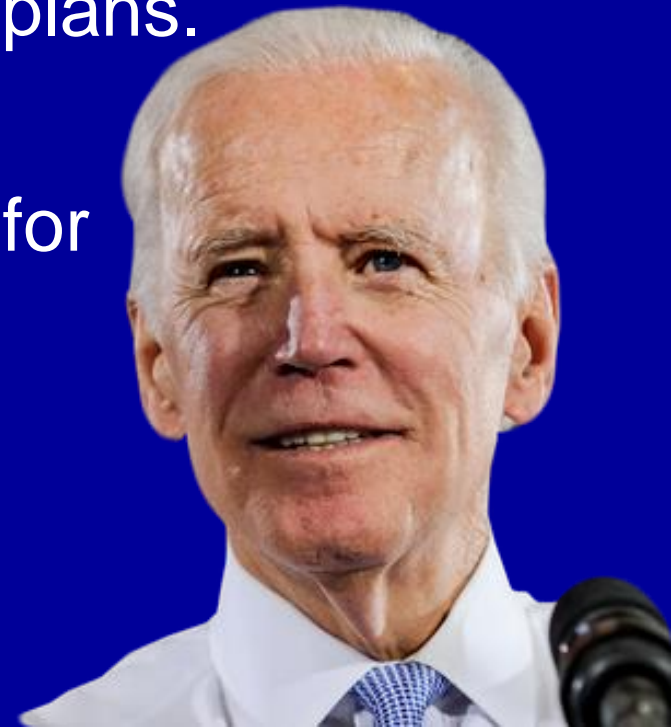
Source: Health Affairs 2019;34:668

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

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

# Biden's Health Reform Proposals

- **New “Medicare-like” Public Option.**
- Increase exchange subsidies to cap premiums at 8.5% of income.
- Subsidy amount based on Gold plans.
- Lower Medicare age to 60.
- Free enrollment in public option for persons <138% of FPL in non-expansion state.



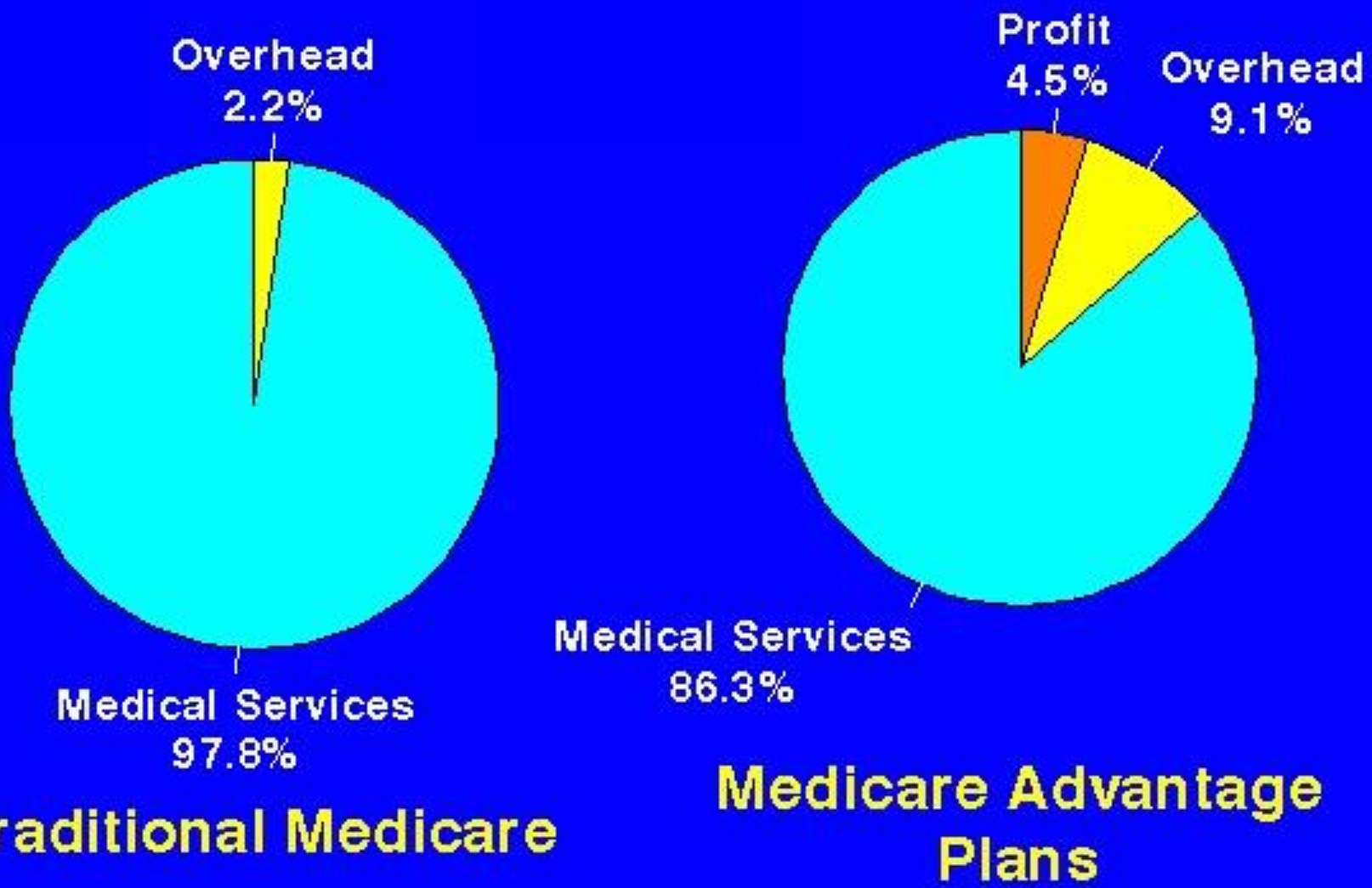


# ACA Non-Profit Insurance Co-Ops: A Failed Public Option

- 24 co-ops got federal start-up loans from ACA
- 4 remain, covering ~150,000.
- Attracted costliest enrollees e.g.:
  - 98 percent of all HIV patients [on Iowa exchange] chose the co-op because it offered low HIV drug copays.
  - A flood of cancer patients enrolled in the NY co-op - the only exchange plan covering care at Memorial Sloan Kettering Cancer Center.

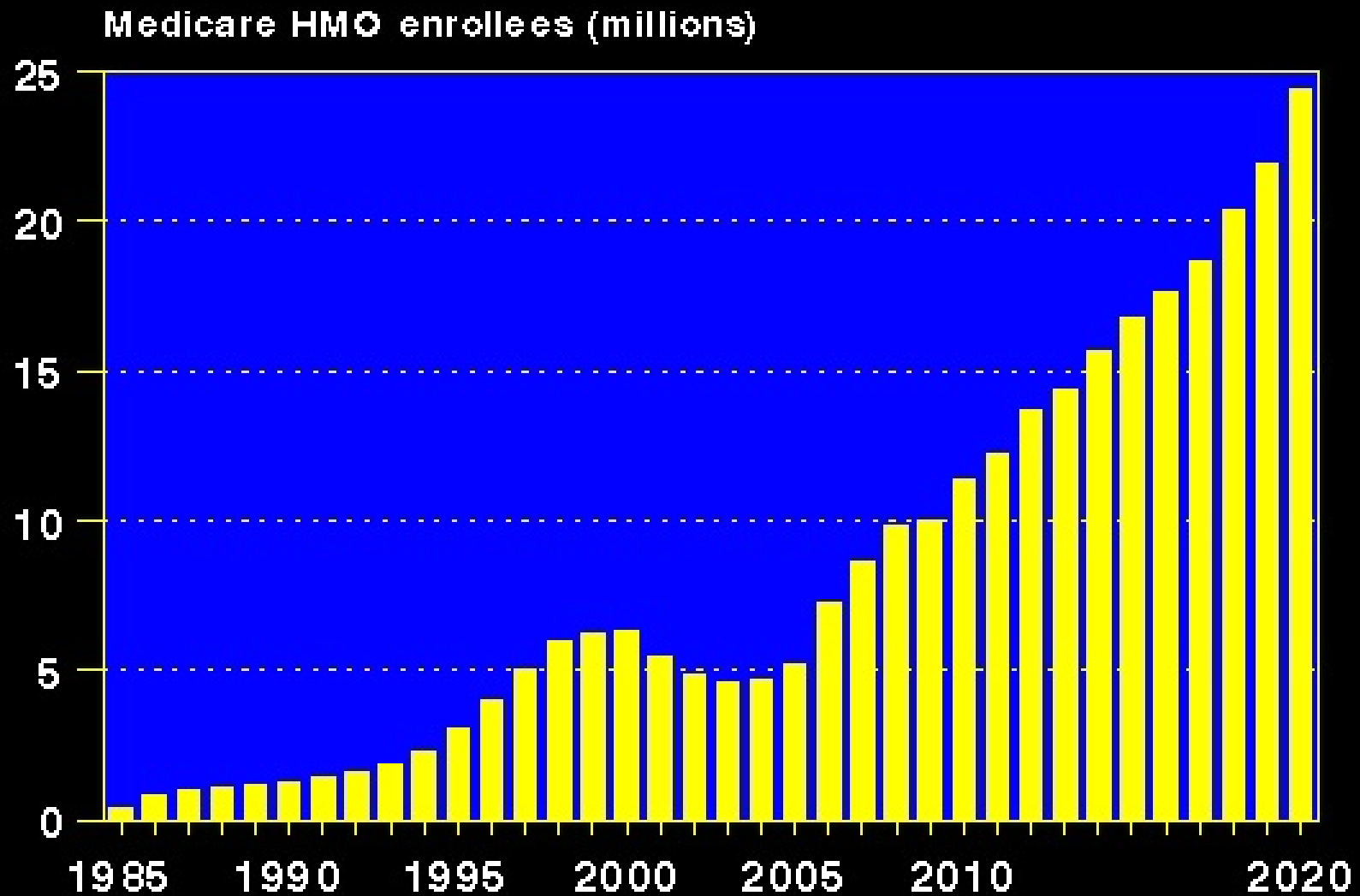
Medicare Advantage:  
The Only Working Model of  
Competing Private Plans  
and a Public Option  
(Traditional, FFS Medicare)

# Medicare Advantage Plans' High Overhead

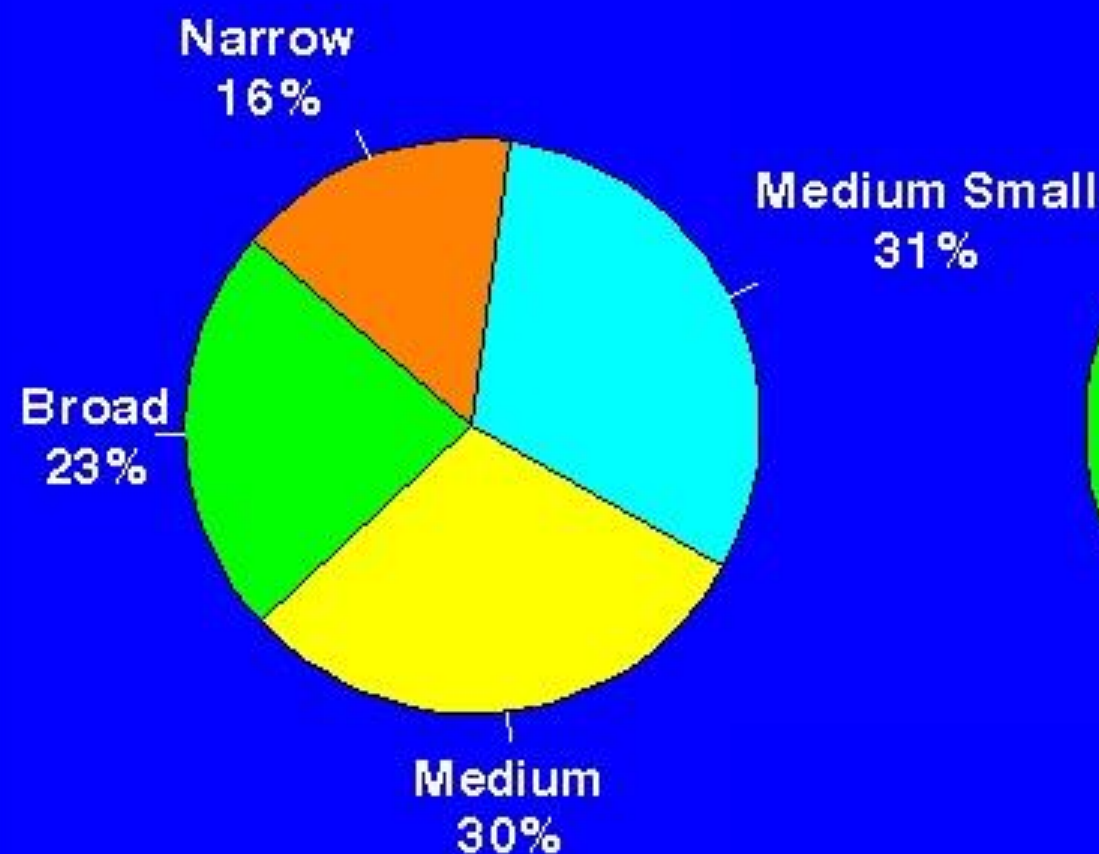


Source: GAO 12/2013 and Medicare Trustees report 2012 - Figures are for 2011  
Note: MA overhead = \$905/enrollee; profit = \$447/enrollee; total profit = \$3.3 billion

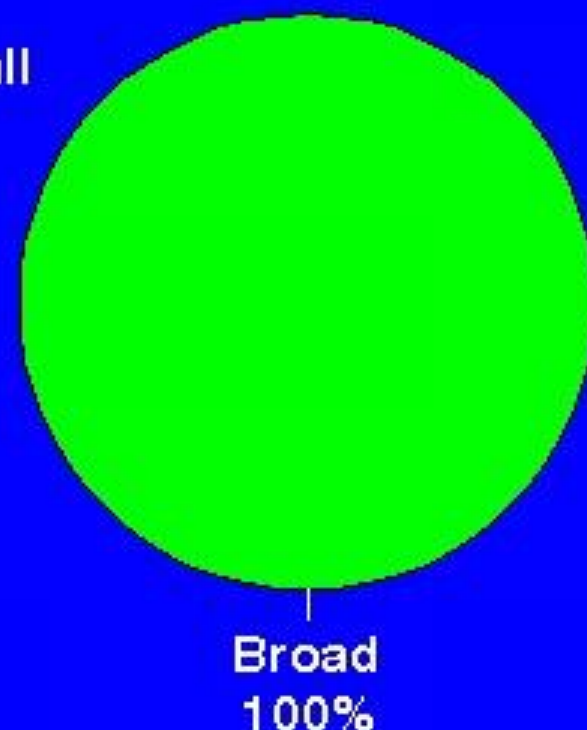
# Medicare HMO Enrollment, 1985-2020



# 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?

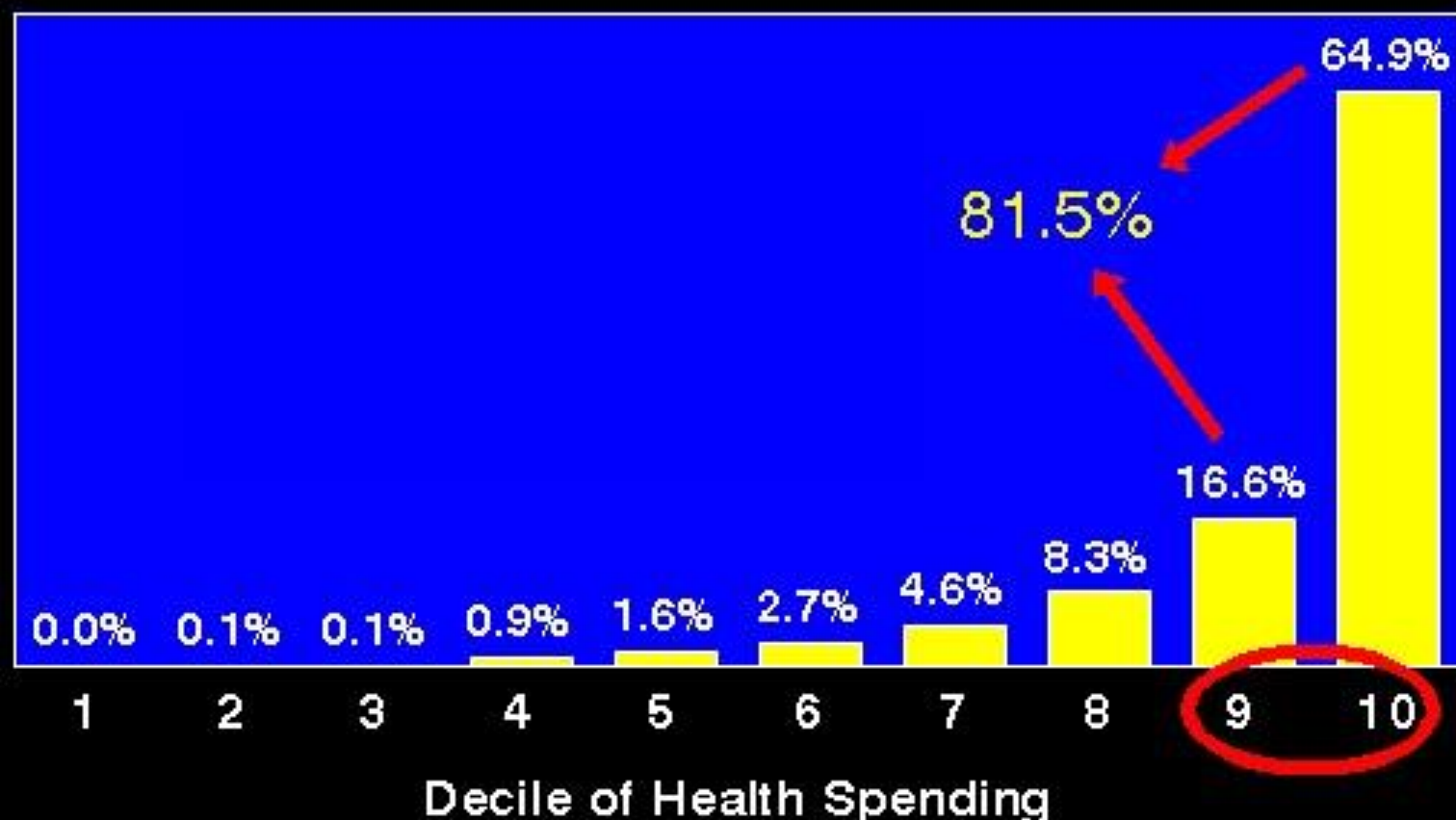
- Cherry-picking + Lemon-dropping
  - Exclude hospitals/doctors attractive to high-cost patients
  - Benefit/formulary design
  - Hassle factor
- Upcode + over-diagnose to game risk adjustment
- Outright cheating

# 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

# *When Apps Get Your Medical Data, Your Privacy May Go With It*



Source: NY Times 9/3/2019

- Insurers can use info on web searches, purchases etc. to medically profile potential enrollees and target marketing. **Makes ban on cherry picking unenforceable**

## **Worse Lies Ahead**

- Proposed federal rules require doctors/hospitals to let patients download their medical records to any App
- Apps are exempt from HIPAA so data can be used, shared or sold
- Google has bought 21% of “Oscar”, health insurer founded by Josh Kushner.



# Medicare Advantage Plans' Strategies: 2 - Lemon Dropping

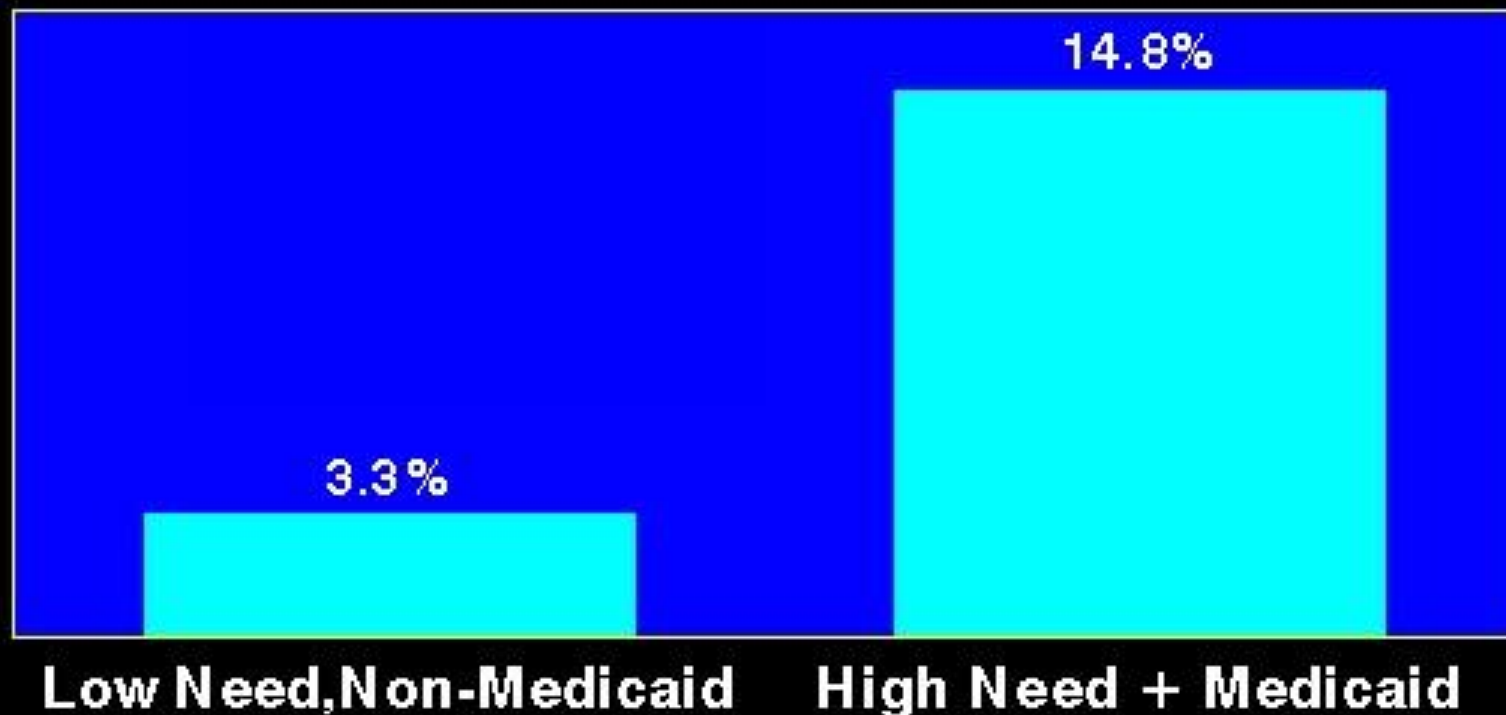


Network manipulation, benefit design, hassle factor

# High Needs Patients Frequently Disenroll From Medicare Advantage Plans

Another Example of "Lemon Dropping"

Percent switching from Medicare Advantage to FFS Medicare annually



Source: JAMA IM 2019;179:524

Note: High need = 2 or more chronic conditions; Medicaid = Medicare + Medicaid "dual eligible"

# Medicare Advantage Plans Skimp on Rehabilitation and Home Care

Decreased use relative to traditional Medicare\*



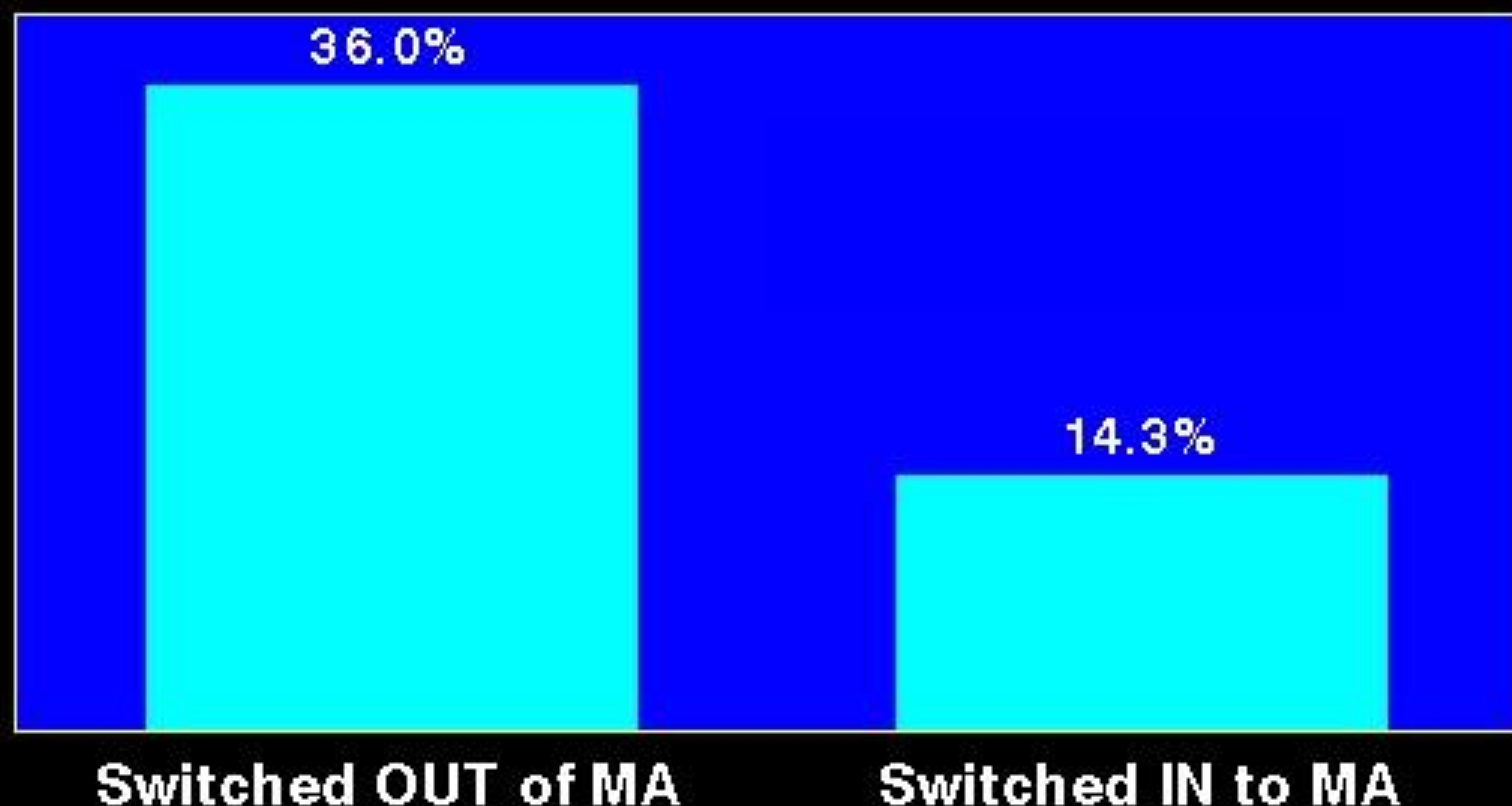
Source: Health Aff 2020;39:837

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

# Patients Acquiring New Disabilities Switch Out of Medicare Advantage

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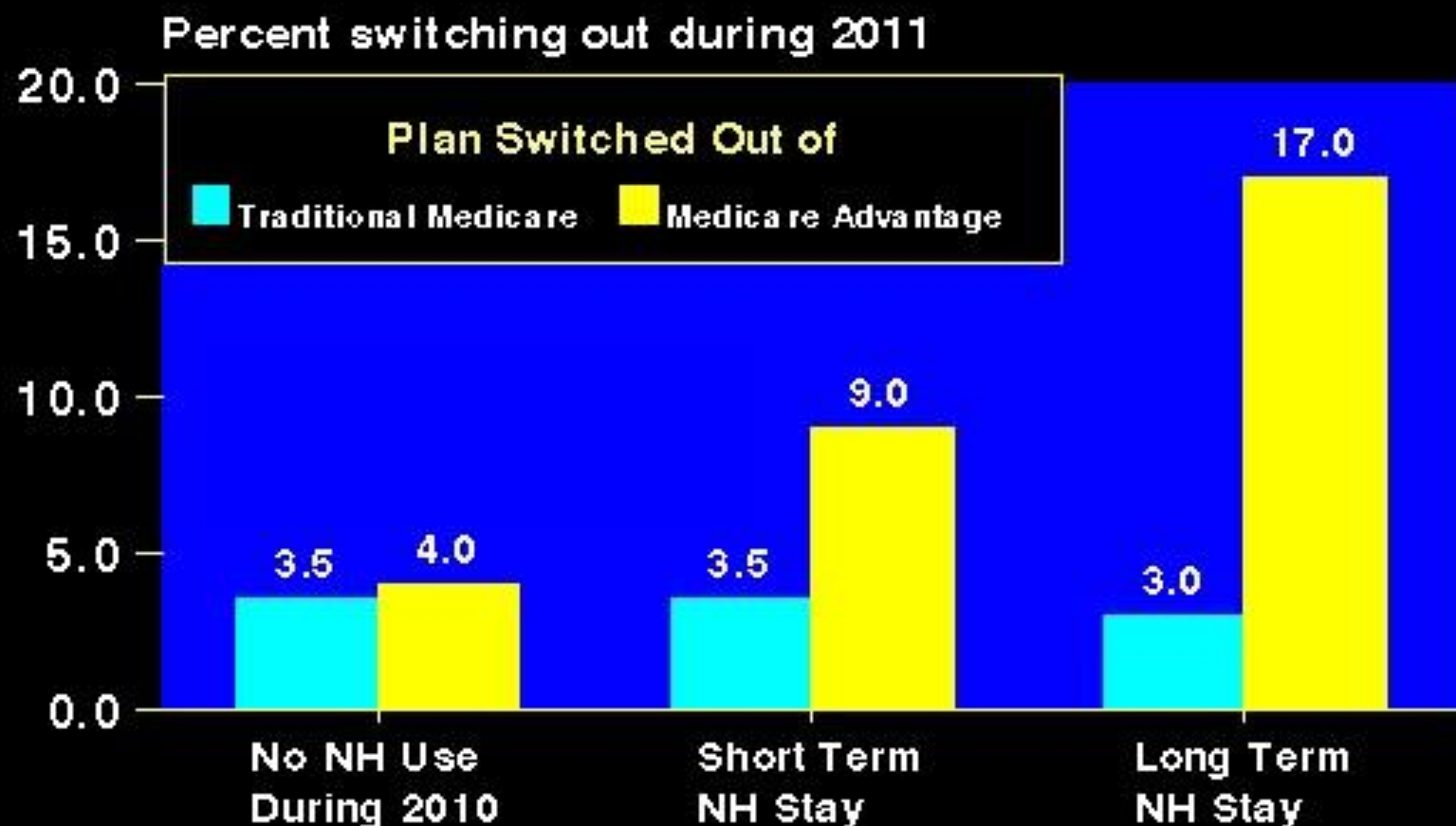
Percent of newly disabled who switched



Source: Health Aff 2020;39:809

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

# Sickest Patients Switch Out of Medicare Advantage



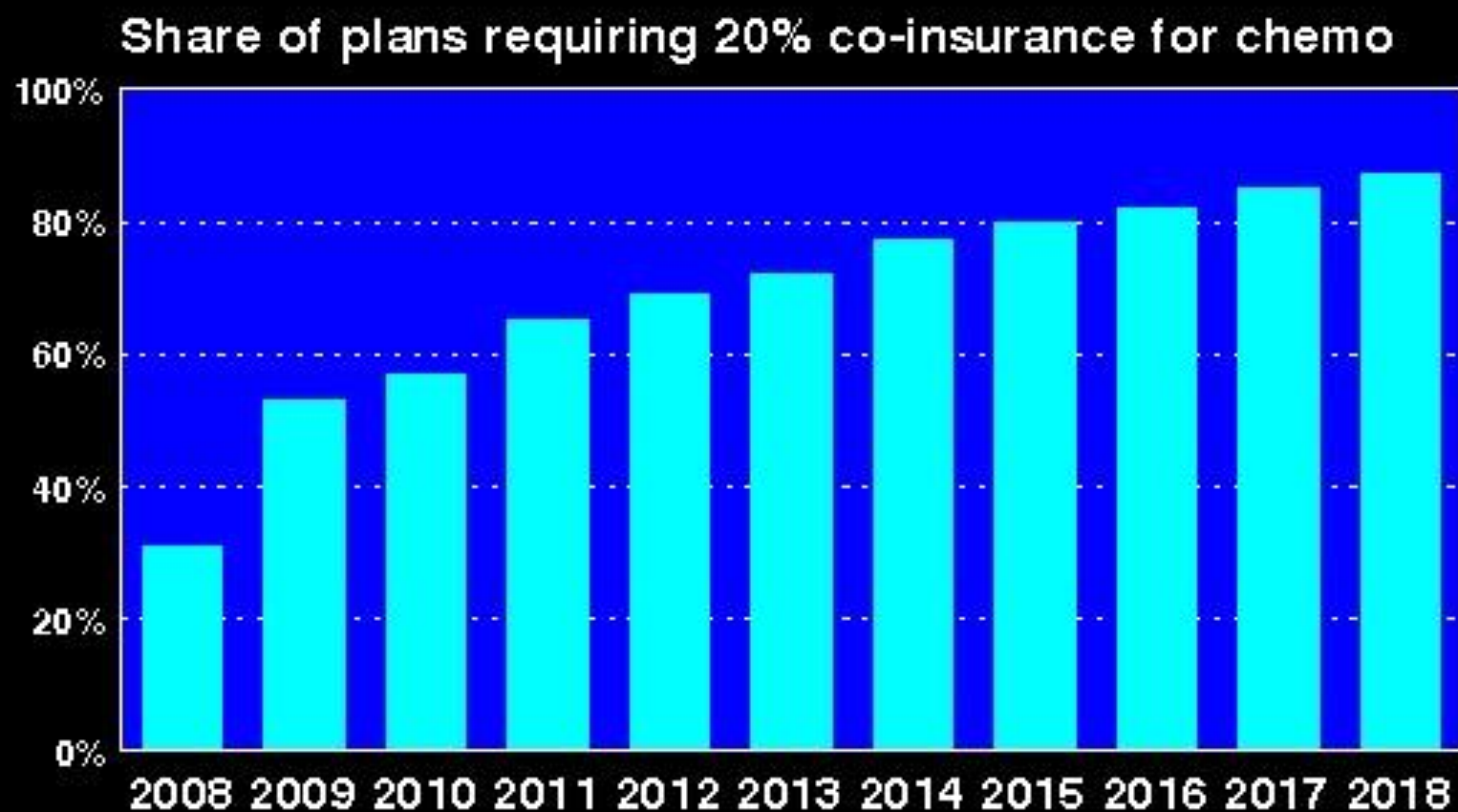
Source: Health Affairs 2015;34;1675

Note: Similar results for patients with hospital or home care use, more marked among dual eligibles



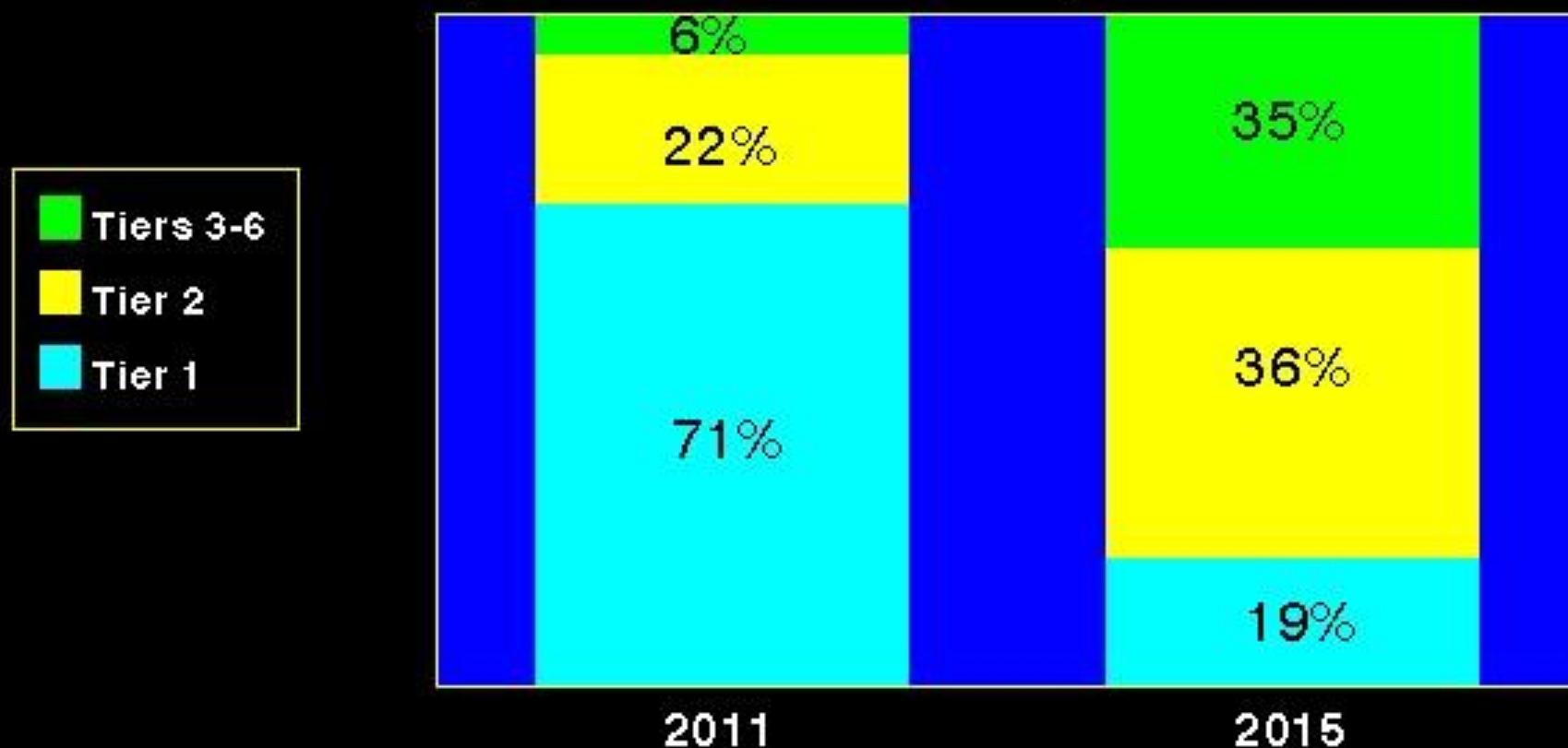
# Medicare Advantage Plans Push Cancer Patients Out by Imposing 20% Co-Insurance for Chemotherapy

---



# 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' Strategies: 3 - Cheating

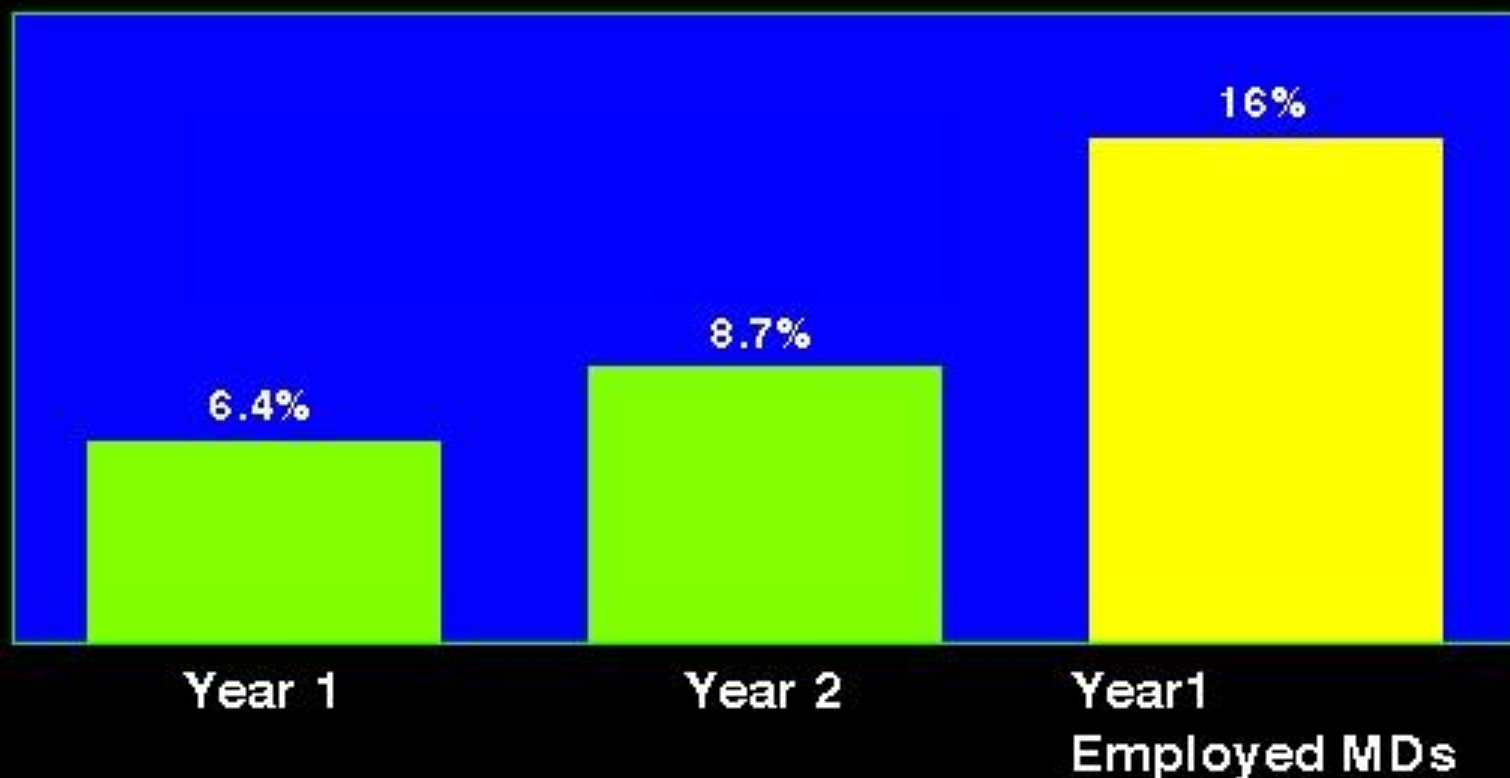


# Medicare Advantage Plans "Upcode"

**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.

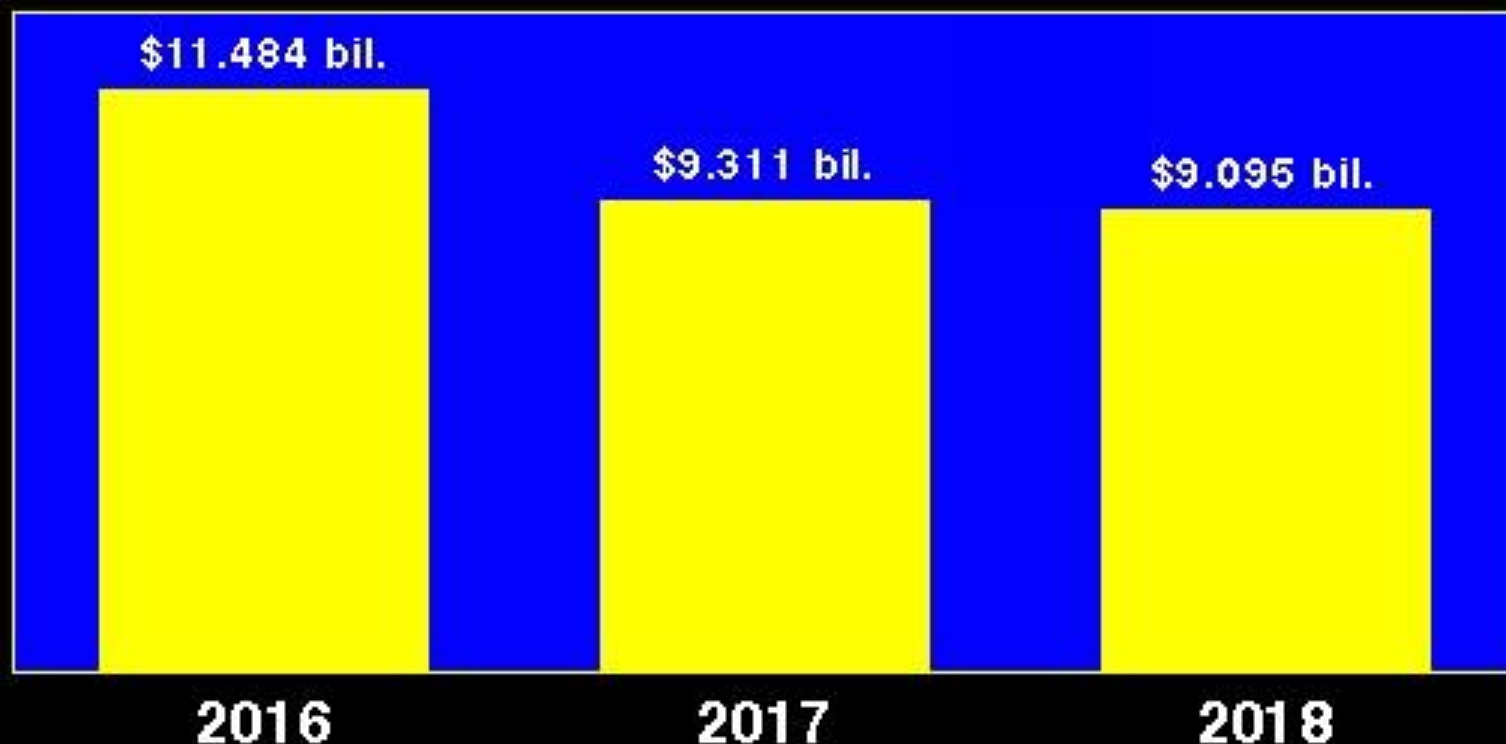


# Medicare Advantage Plans' Claims for Unsupported Diagnoses

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

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

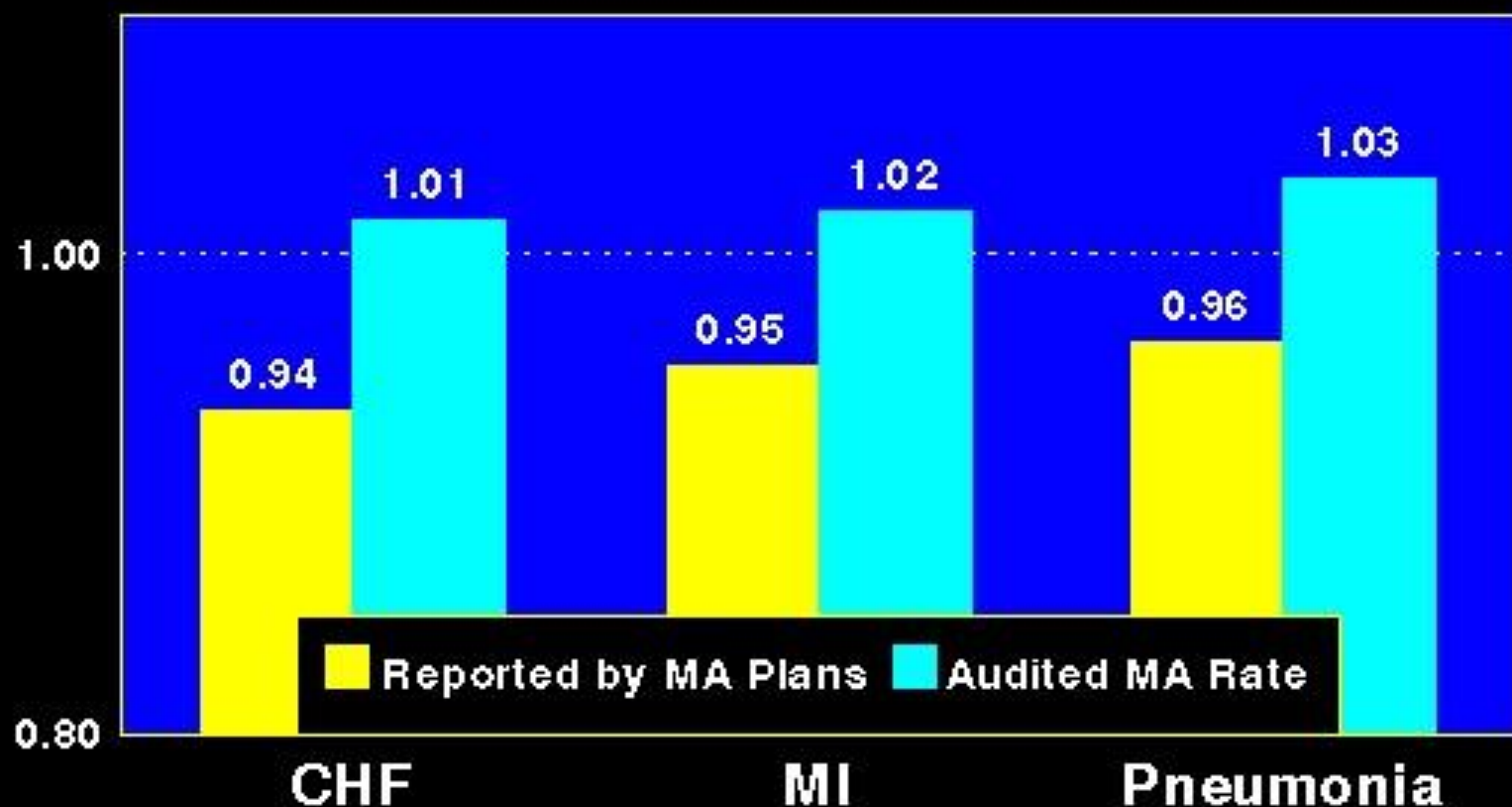




# M.A. Plans Lie About Quality

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

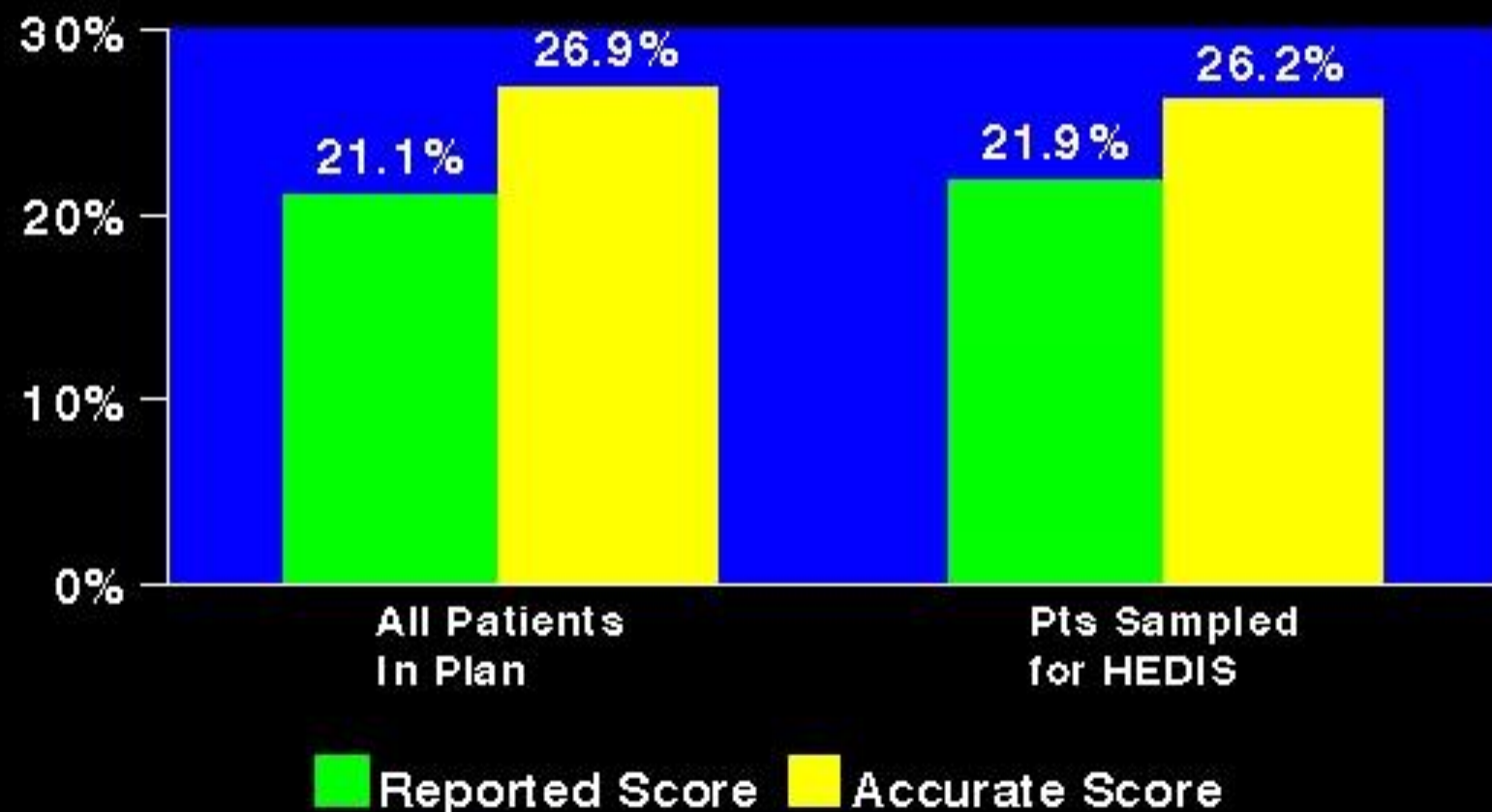
30 day readmission rate relative to Traditional Medicare



# 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
• <b>Total</b>	<b>\$4990</b>	• <b>Total</b>	<b>\$17580</b>

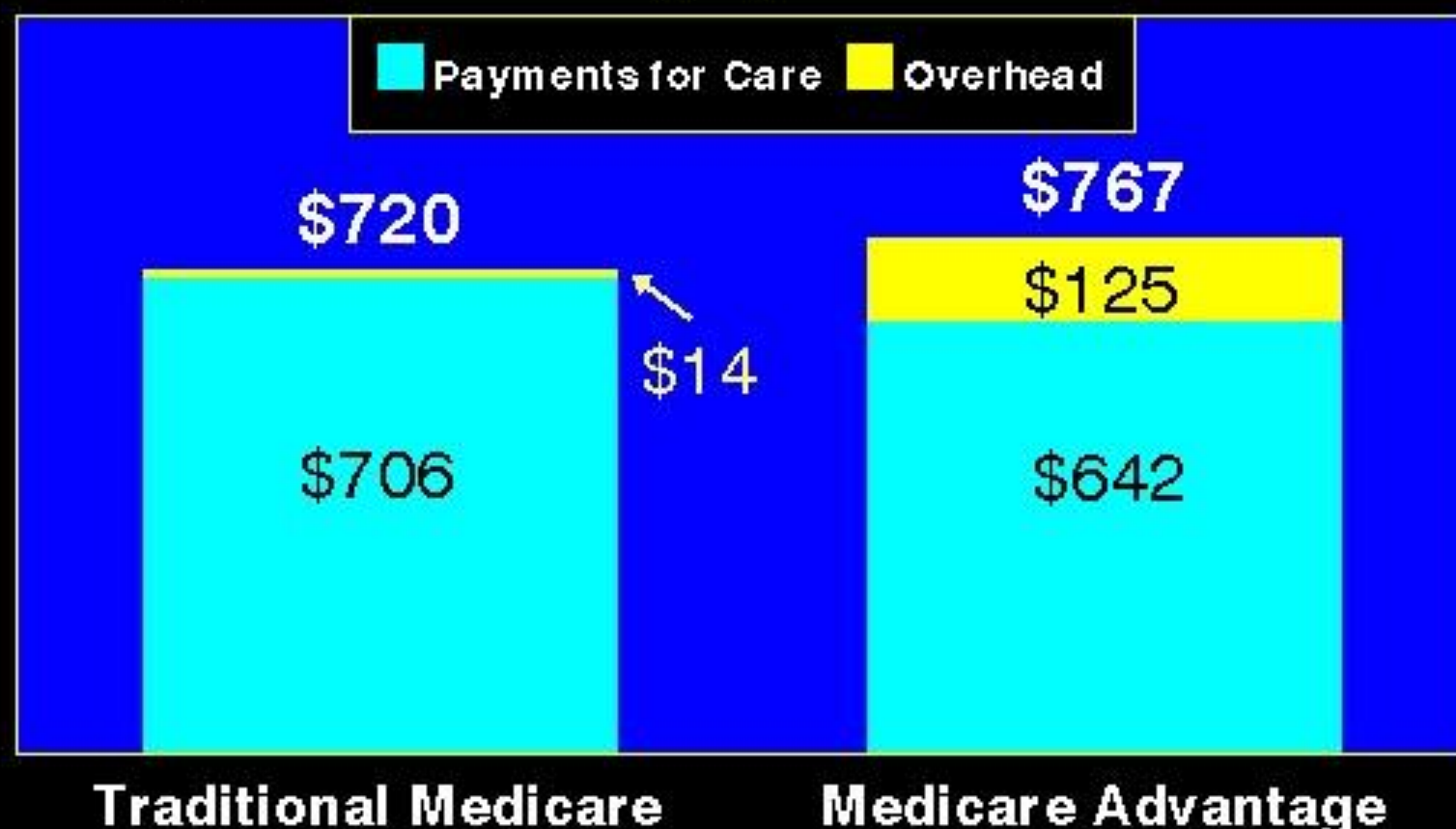
SOURCE: SGIM FORUM, 2017



# Medicare Advantage Plans Raise Costs

## Less Spending on Care, More on Overhead

Monthly cost per beneficiary, adjusted\*



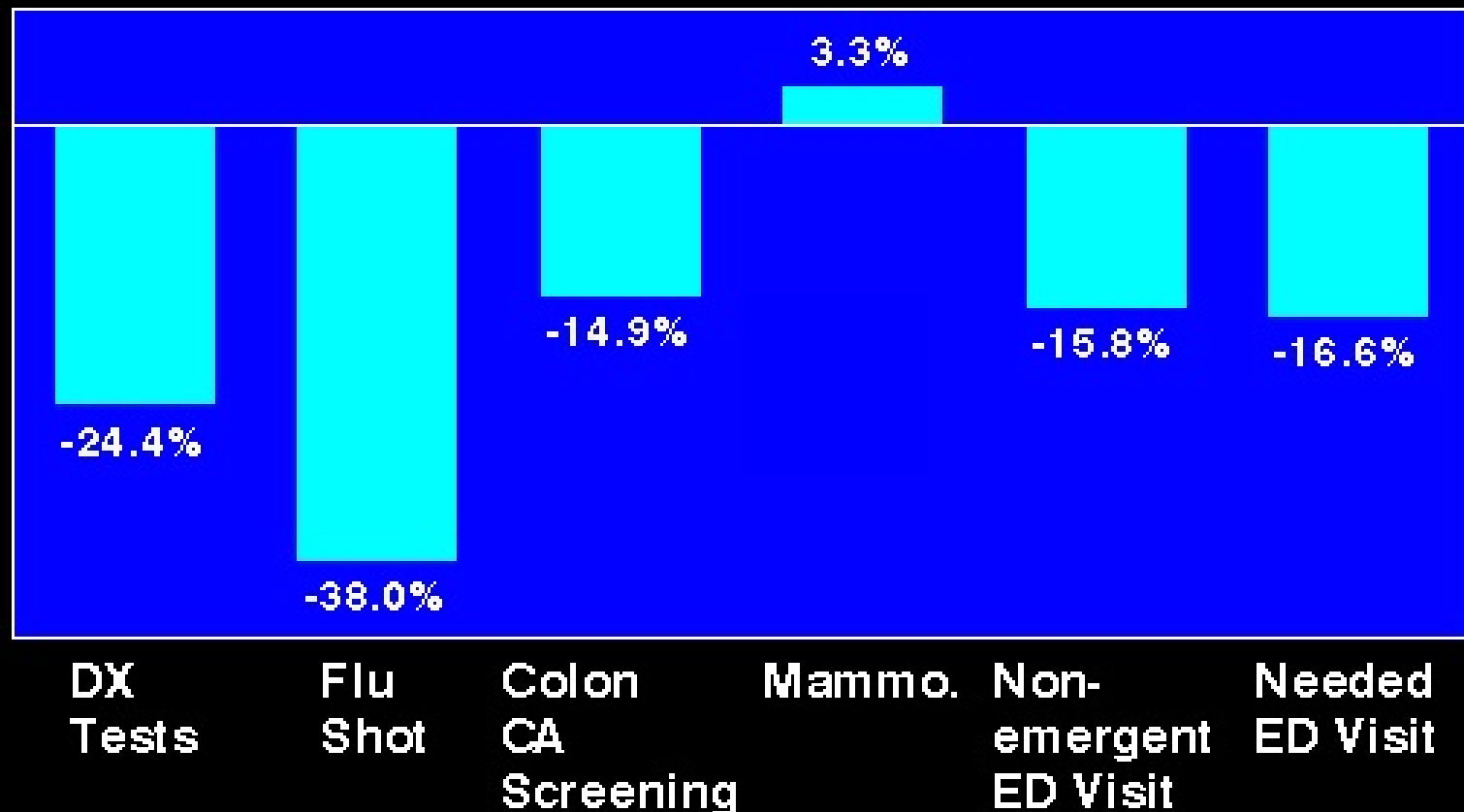
Source: Am. Econ. J. Applied Econ 2019;11:302 - Data are for 2010

\* Health status adjustment based on diagnoses + mortality risk

# Medicare Advantage Plans Cut Both Needed and Unneeded Care

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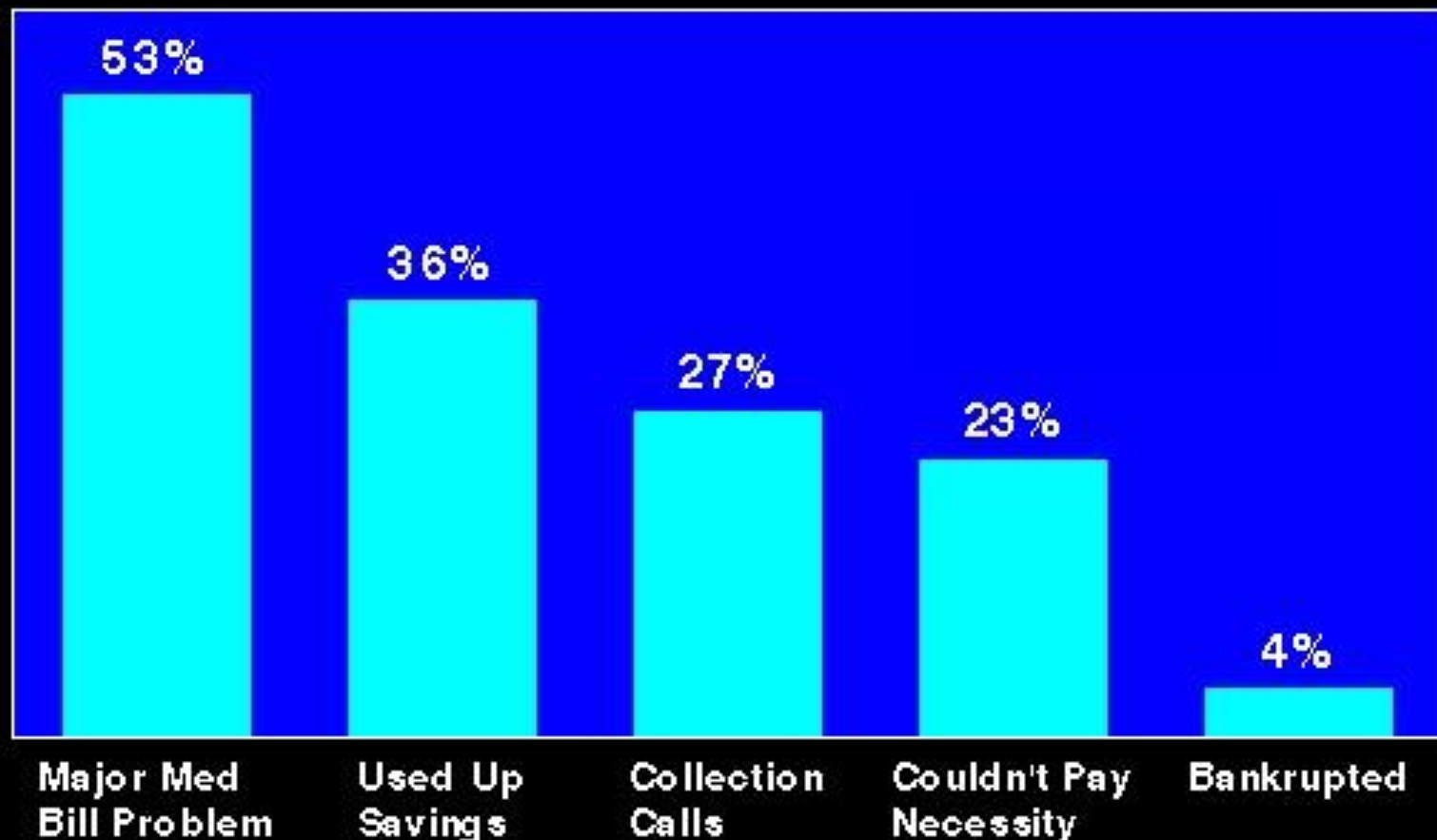
Difference in rate: traditional Medicare - Medicare Advantage



# Medicare Needs Improvement

## Financial Problems of Seriously Ill Enrollees

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Source: Health Aff 2019;38:1801

Note: "Necessity" = Food, heat, housing

# ACOs

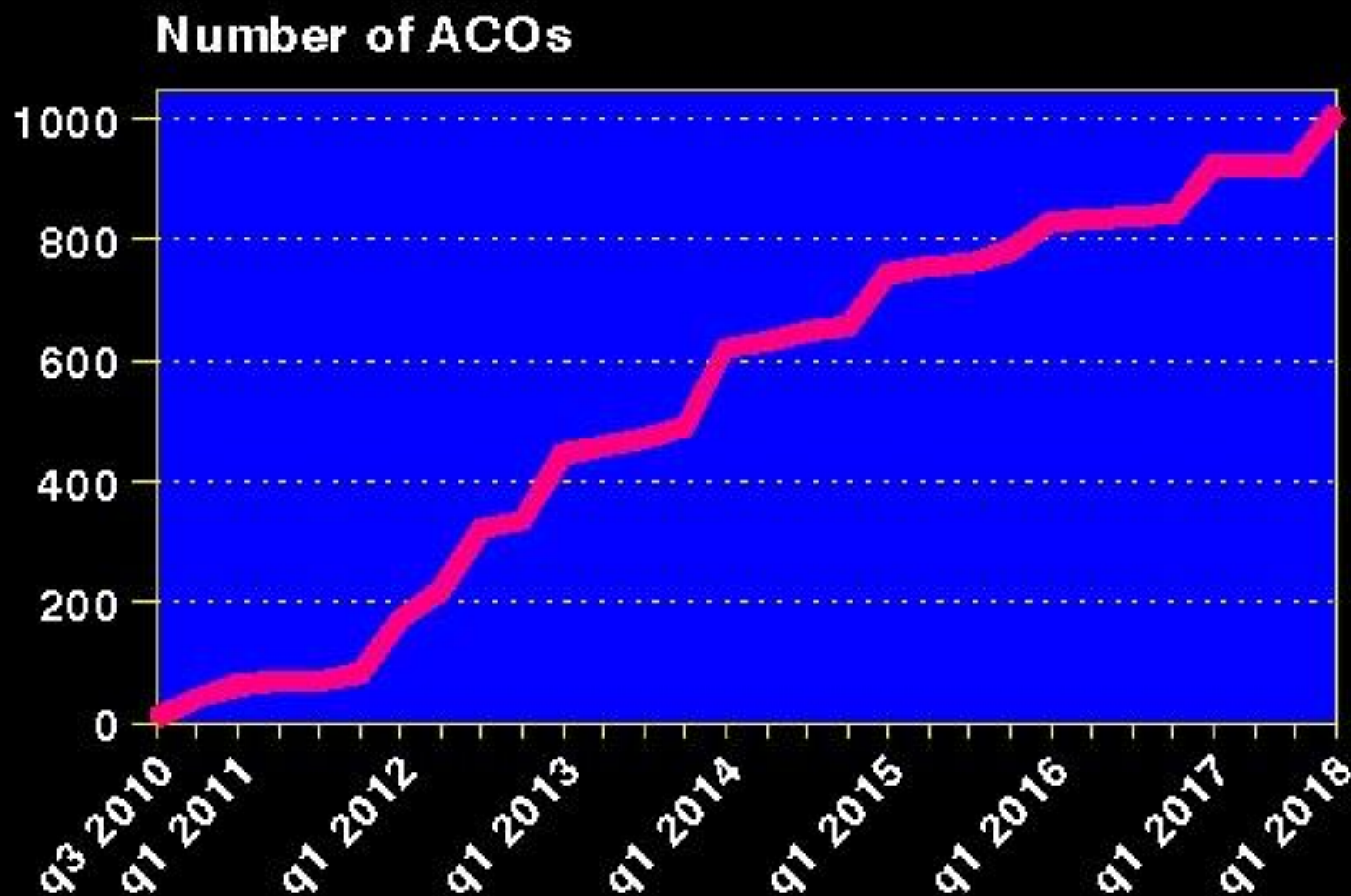
## Warmed Over Managed Care



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

YOGI BERRA

# ACOs' Explosive Growth Since 2010

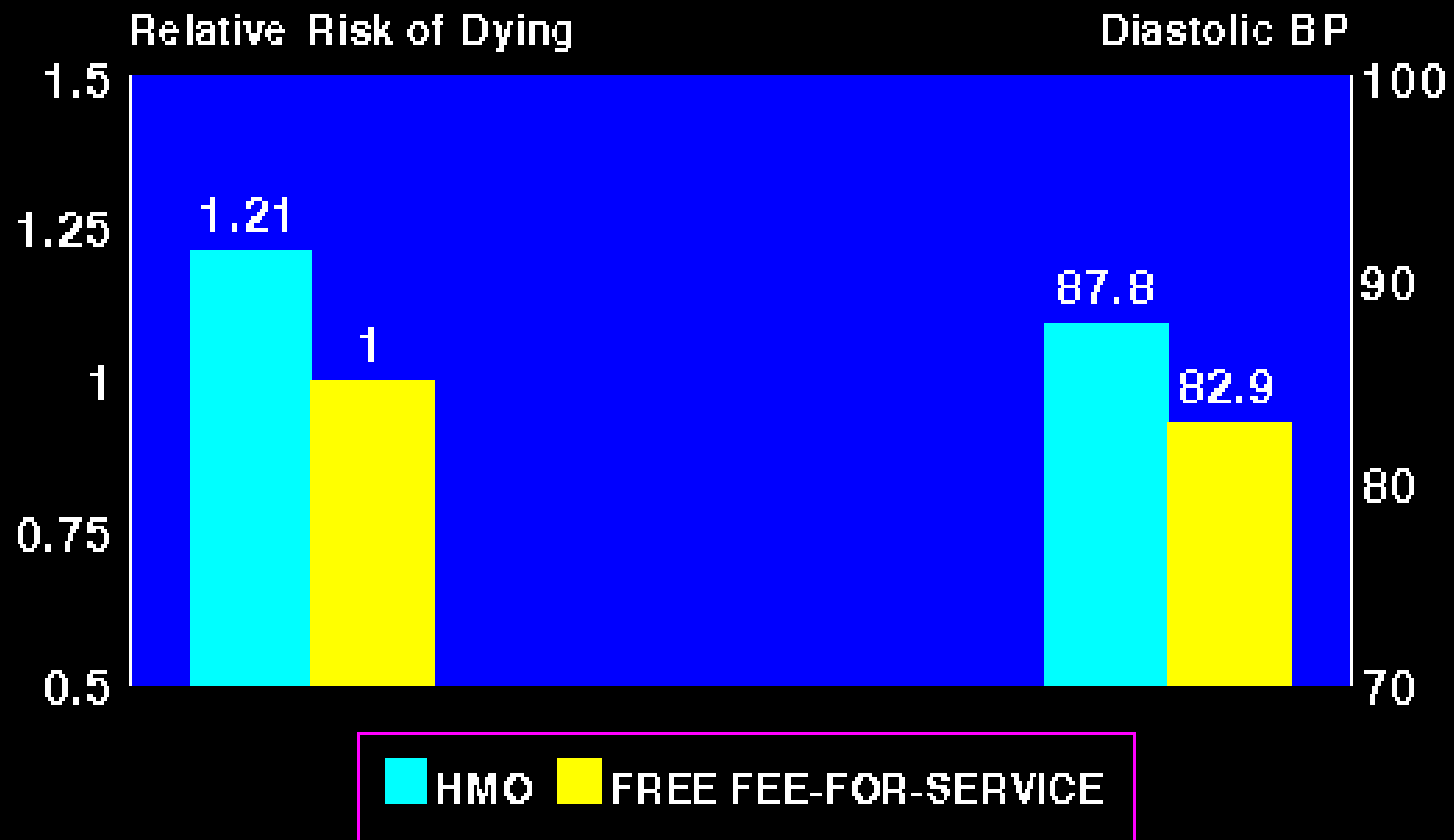


Source: Health Affairs Blog 10/31/13 & 3/31/15, 8/14/19; Leavitt Partners 6/28/17



# High Risk HMO Patients Fared Poorly in the Rand Experiment

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

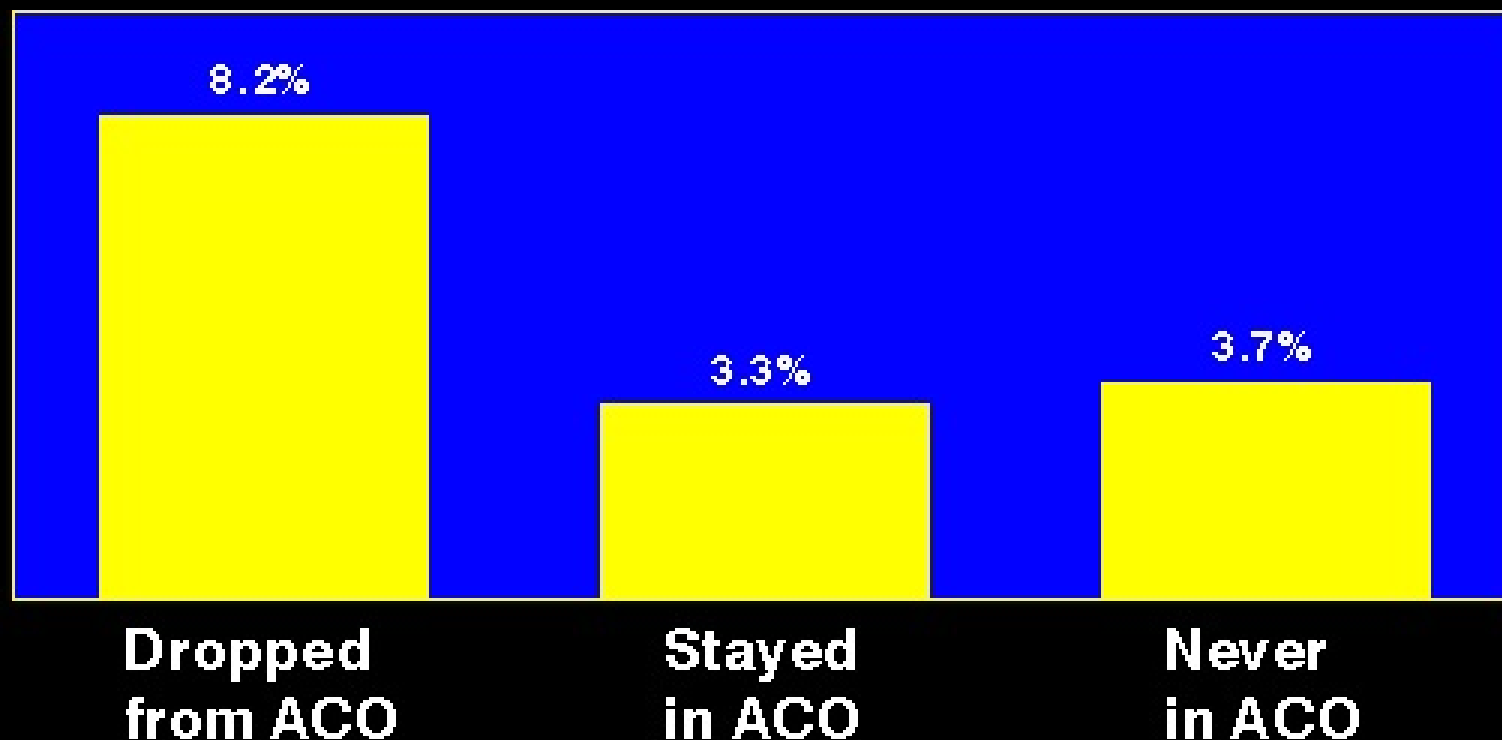
Note: High Risk = 20% of population with lowest income + highest medical risk

# 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

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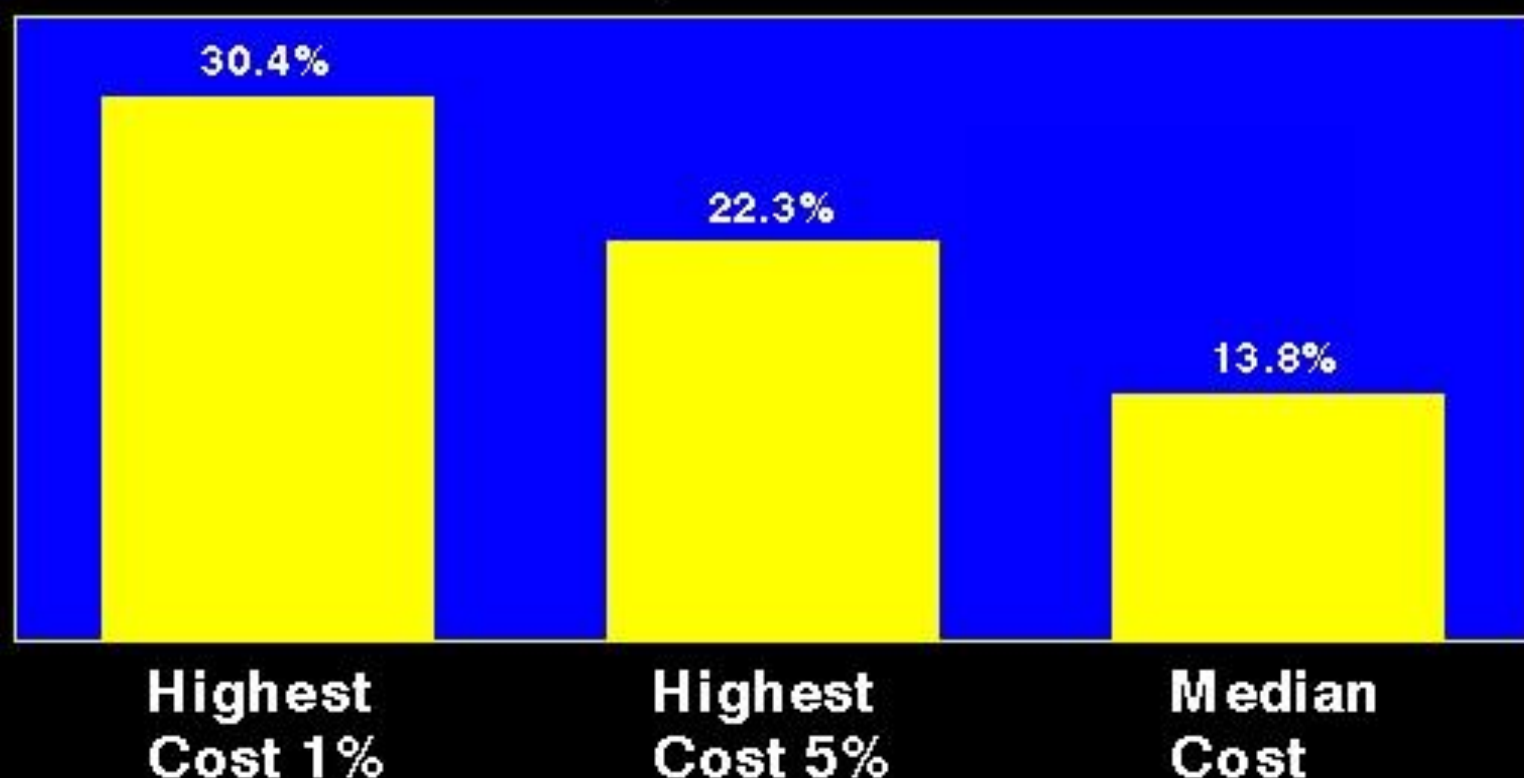
Total annual spending per patient



# ACOs Get Rid of High Cost Patients By Ejecting Their Doctors

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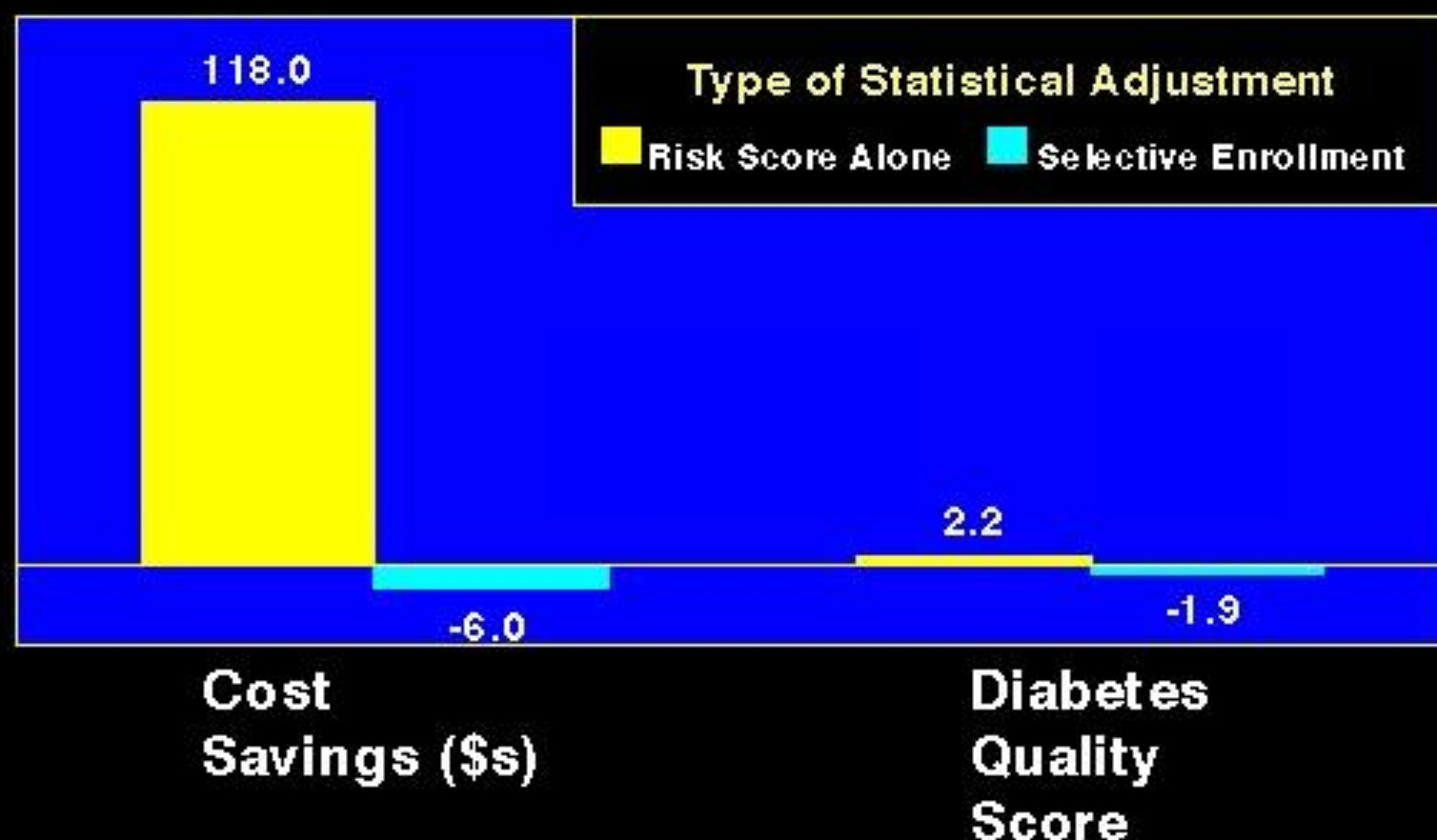
Percent of doctors leaving ACO



**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

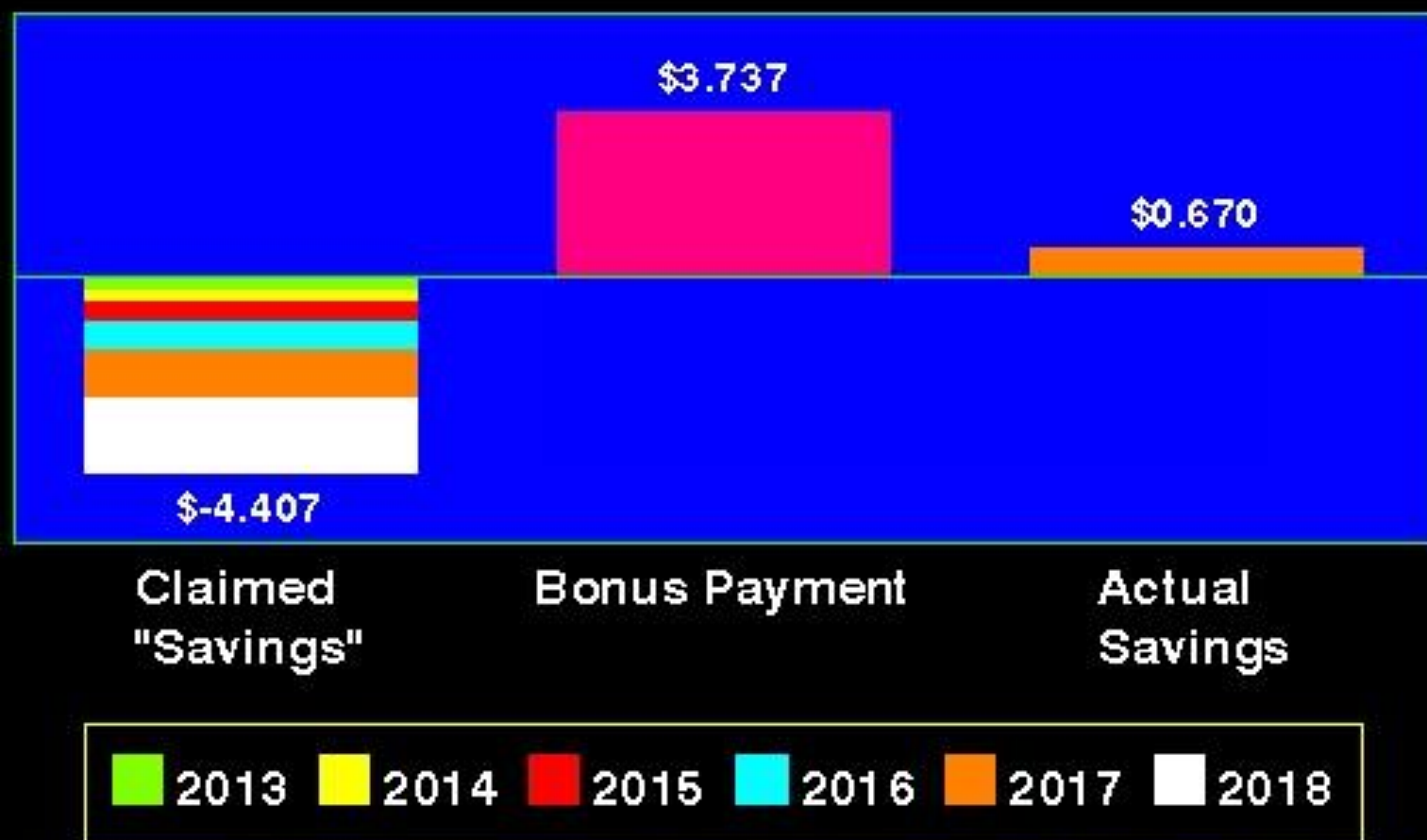




# ACO Savings = \$0.67 bil. Over 6 Years = 0.15% of Spending

MEDPAC Estimate: ACOs Increased Administrative Costs by \$8.52 bil.

Medicare payments to ACOs, 2013-2017 (\$ billions)



# McKinsey:

## “The Math of ACOs”

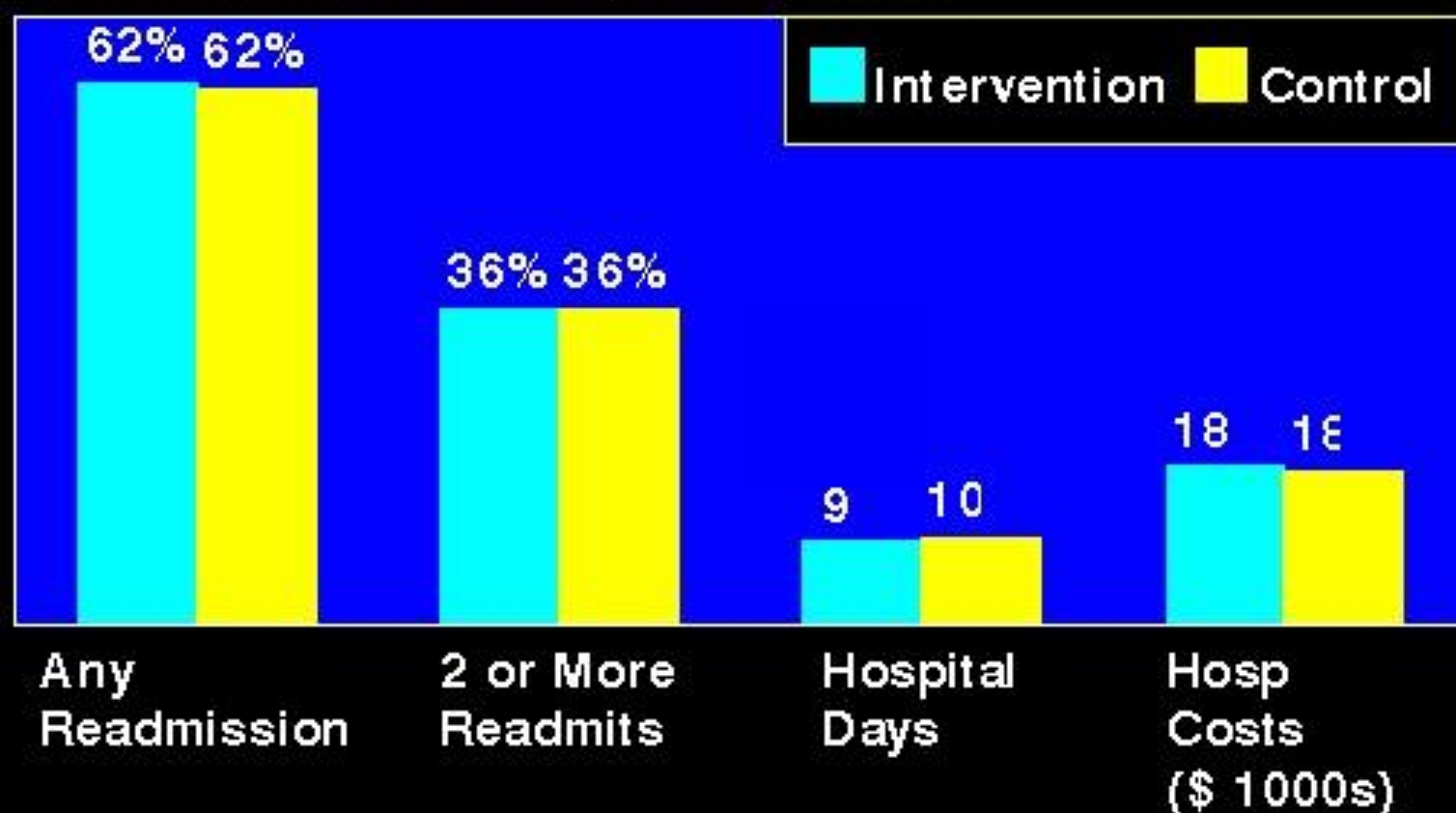
- ~\$9 million/year/ACA spent on new data/analytics
- ~1.25% of total revenues for care management:  
Success depends on curtailing patients' use of care and steering enrollees to lower-price providers, NOT managing chronic conditions.
- Additional costs for “executive director, head of real estate,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

# Hotspotting Didn't Work - RCT

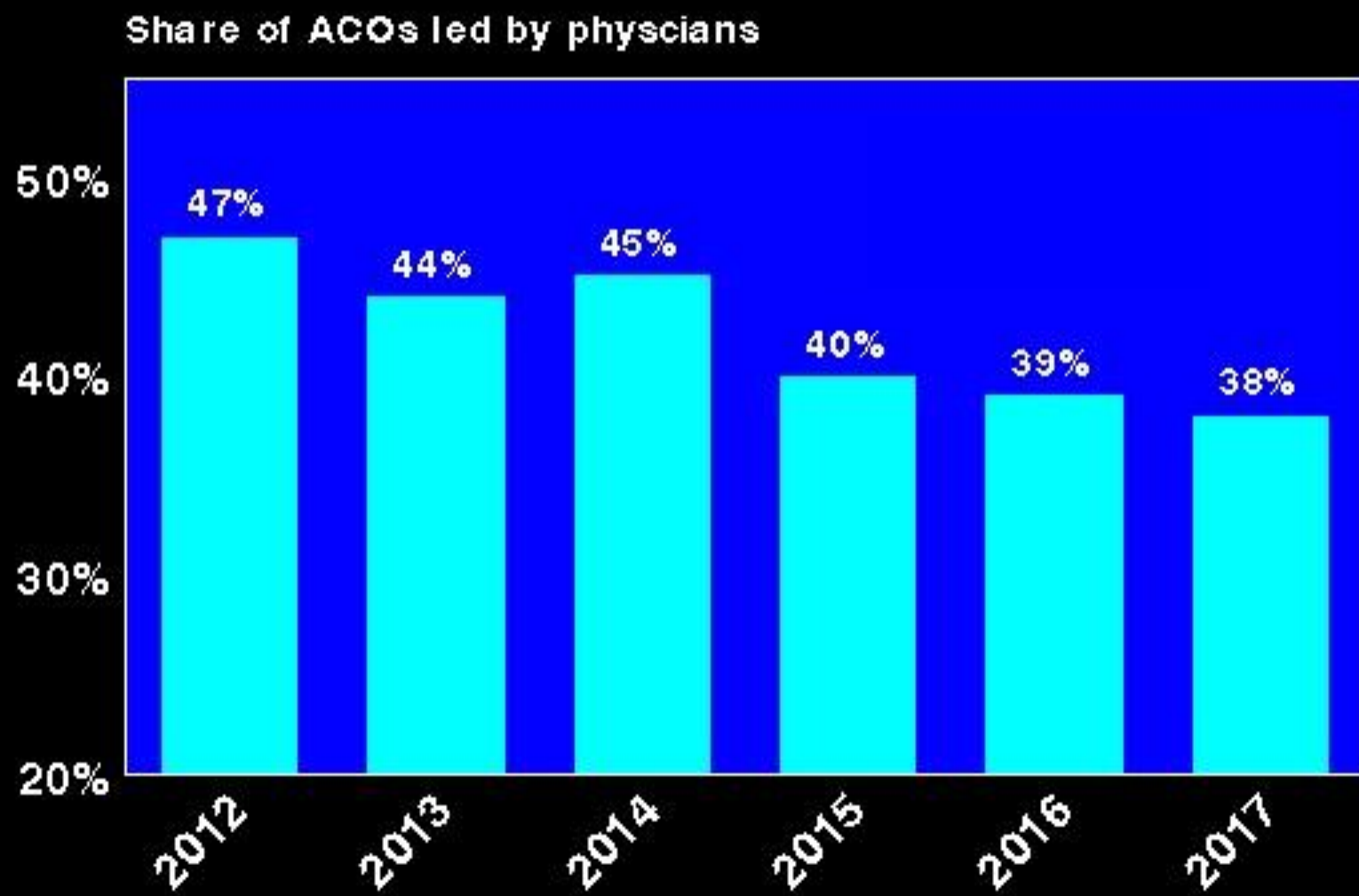
## Much Touted Camden Model Failed

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180 day post-discharge outcomes



# Physician-Leadership of ACOs Waning



Source: Modern Healthcare 2/5/18:18

Physician-led = no formal affiliation with a hospital

# 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)**

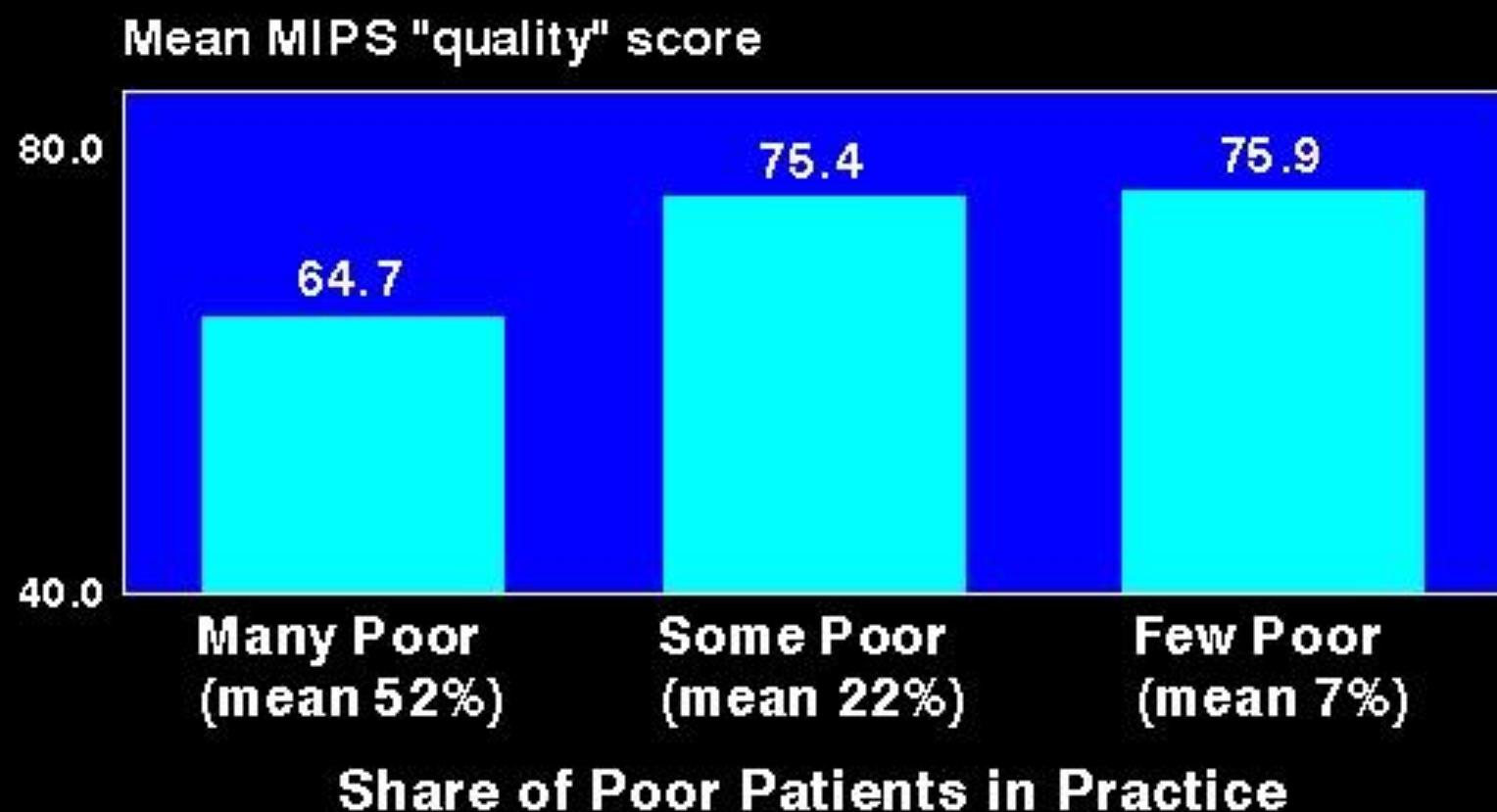
# Assumptions Implicit in P-4-P

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

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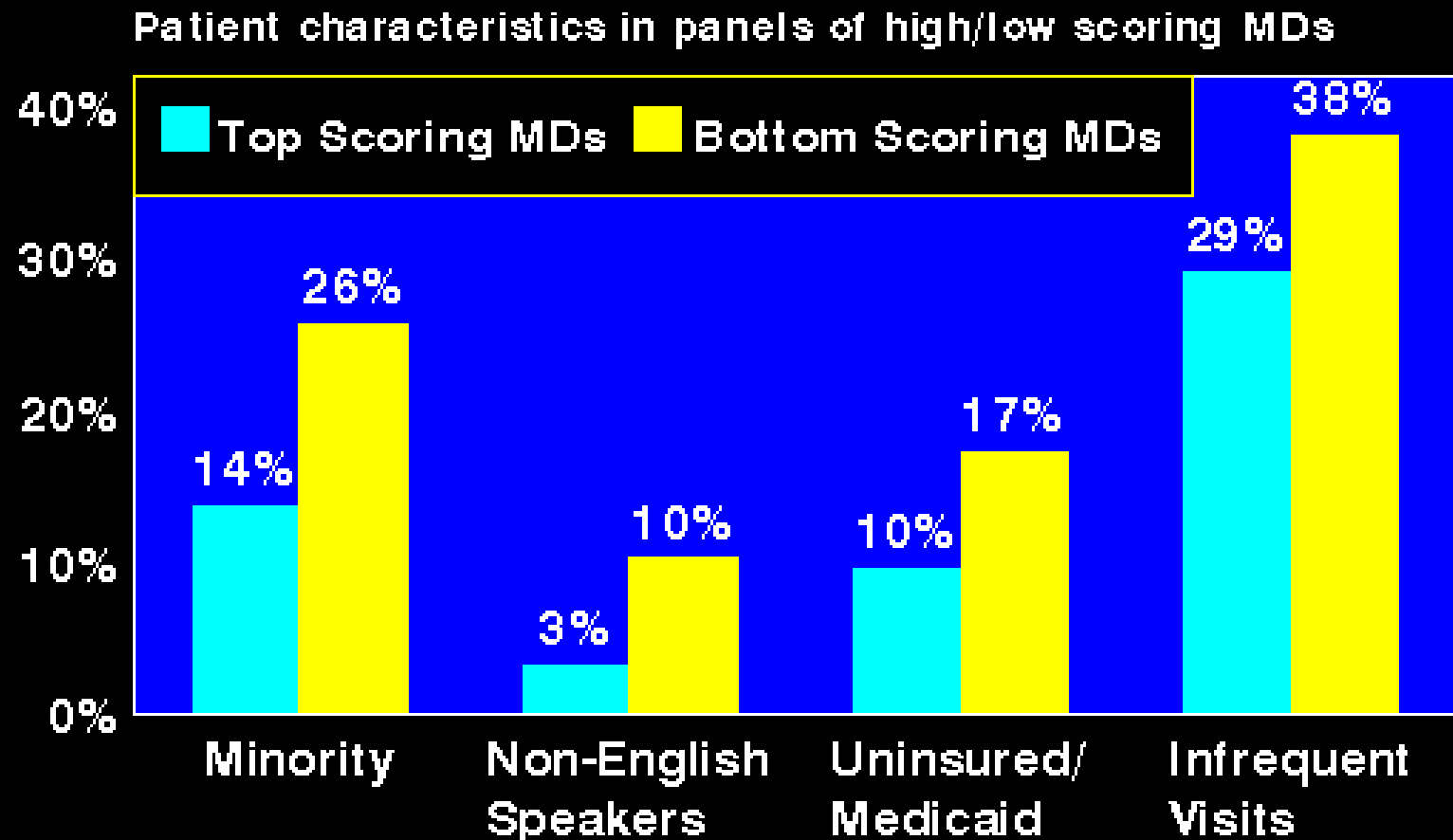


Source: JAMA 2020;324:975

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

# Quality Scores Tell More About Patients Than Doctors

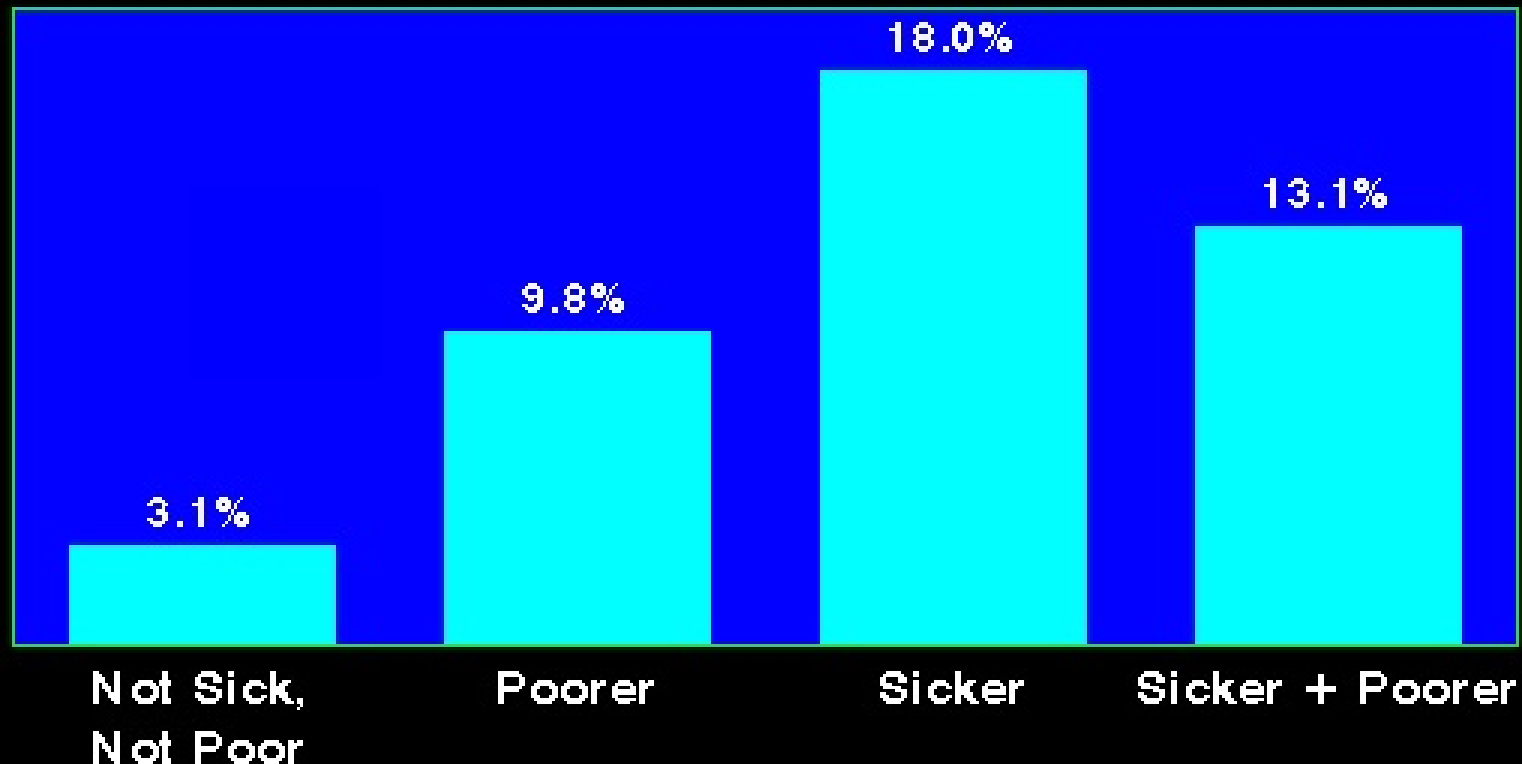
Harvard Docs with Poorer/Minority Patients Score Low



# 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."

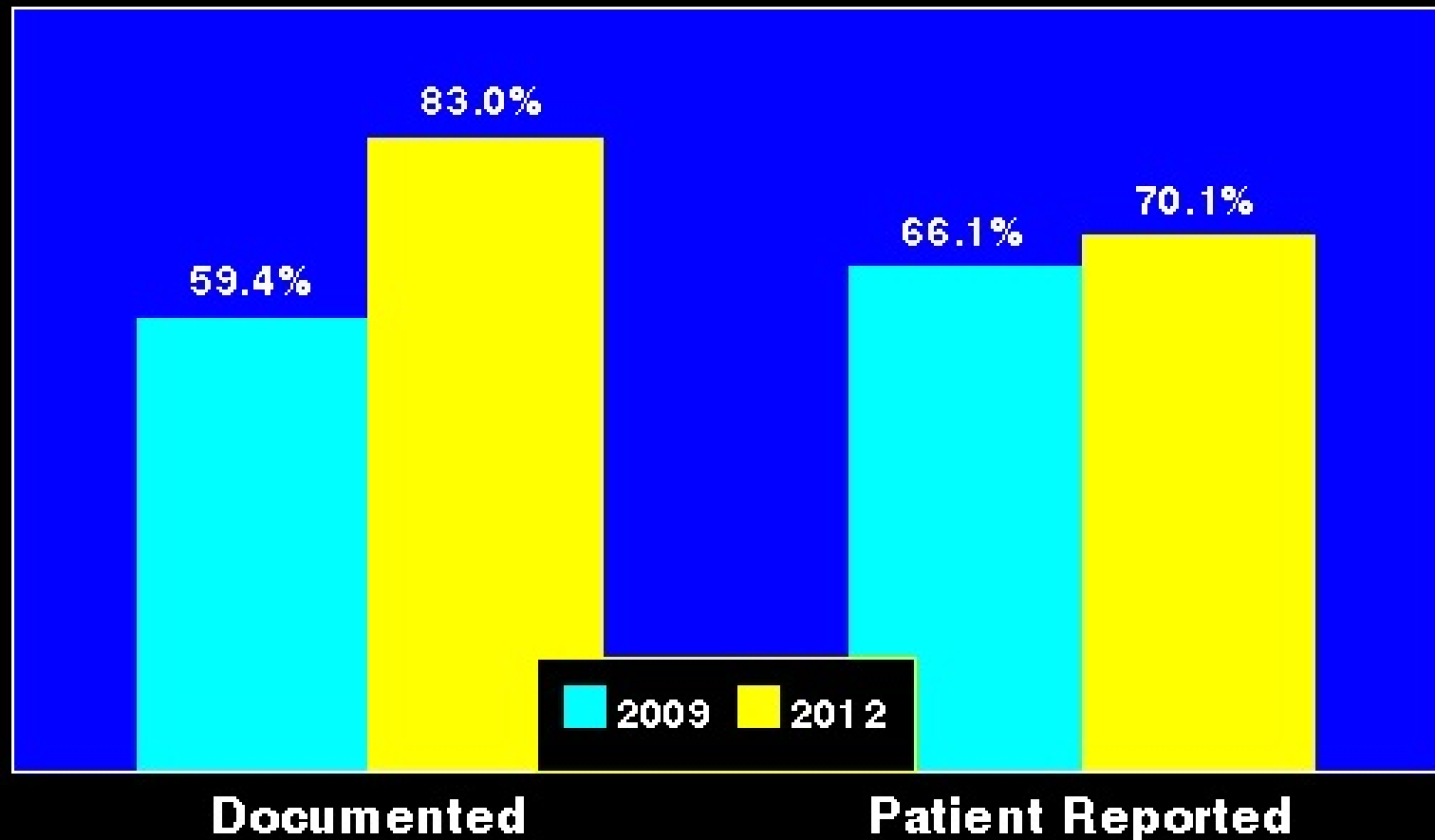
*Don Berwick, M.D,*

Source: Health Affairs 1/12/2005

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

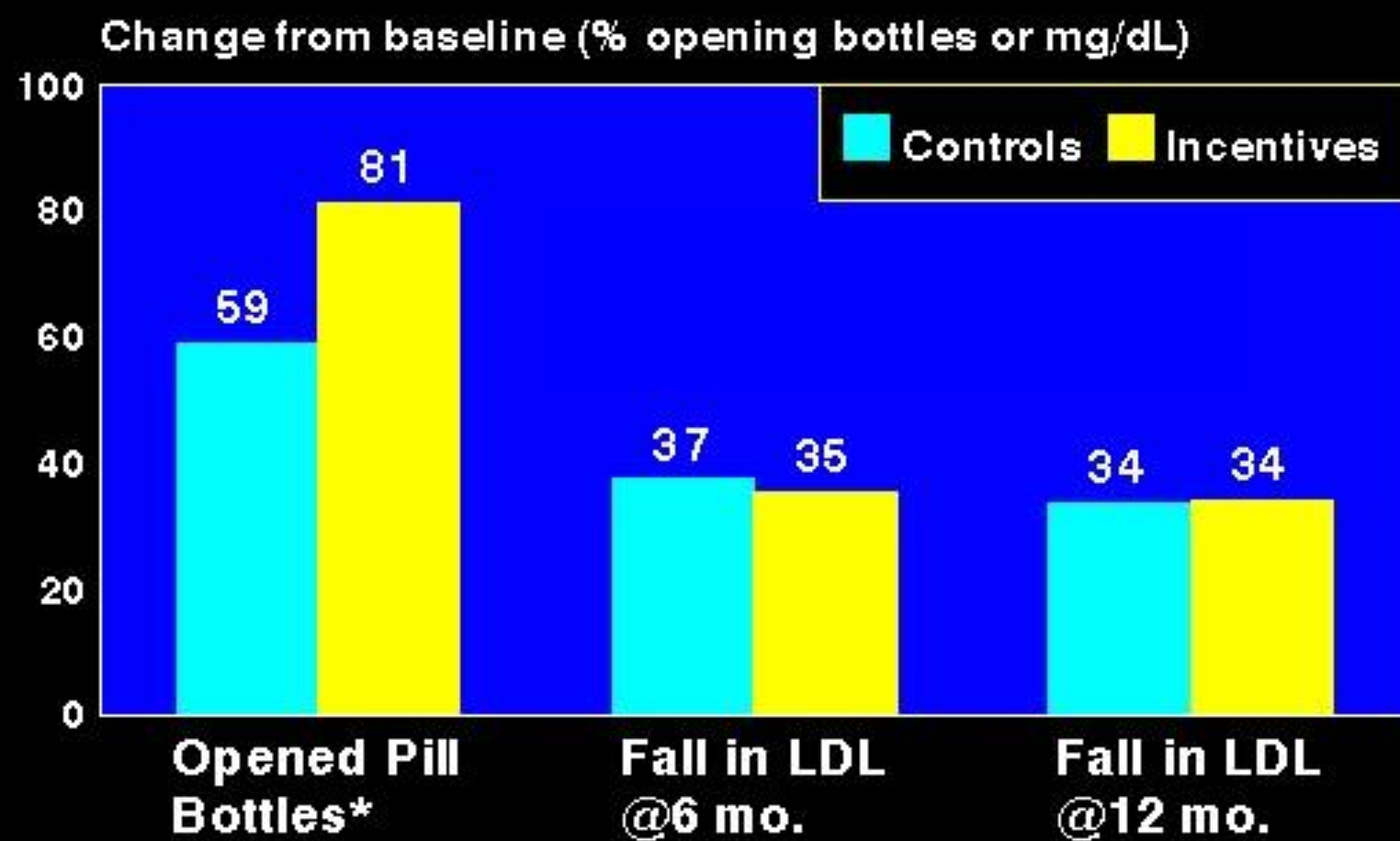
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Alcohol counseling rate among patients screening positive for unhealthy ETOH use



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

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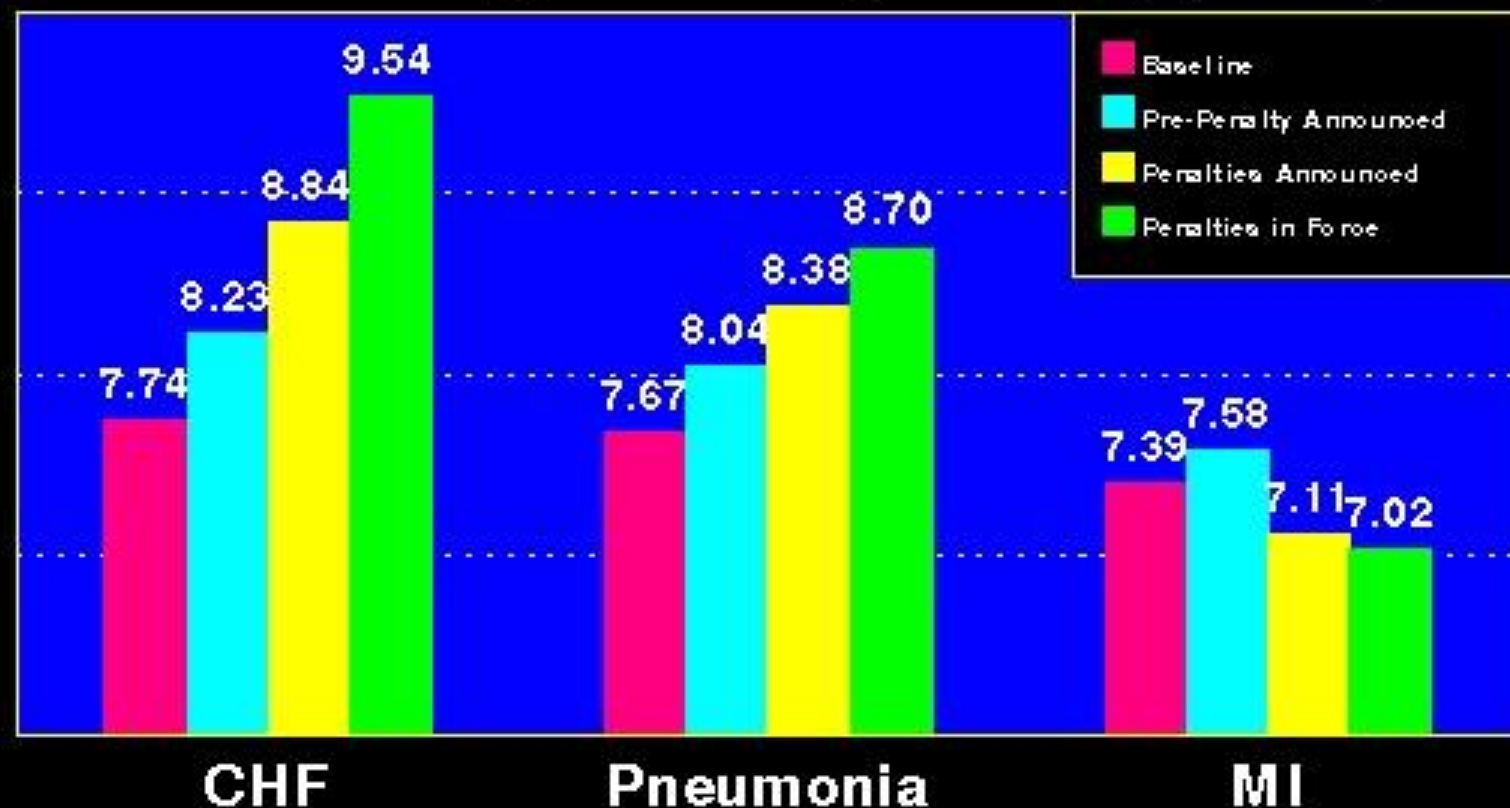
Source: JAMA Network Open 2020;3(10):e2019429 (RCT with 805 patients)

\*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)

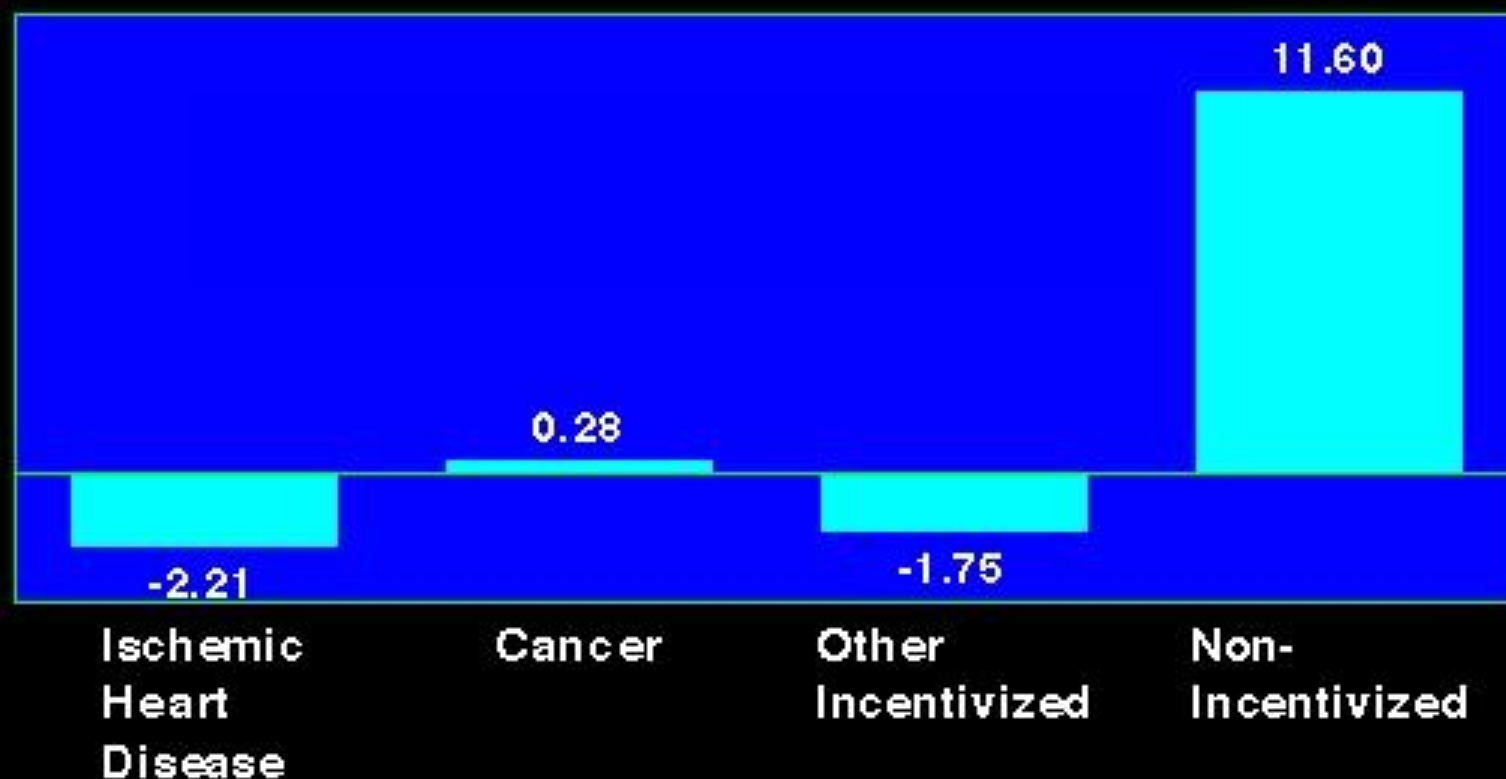


# P4P Didn't Improve Mortality in England

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

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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



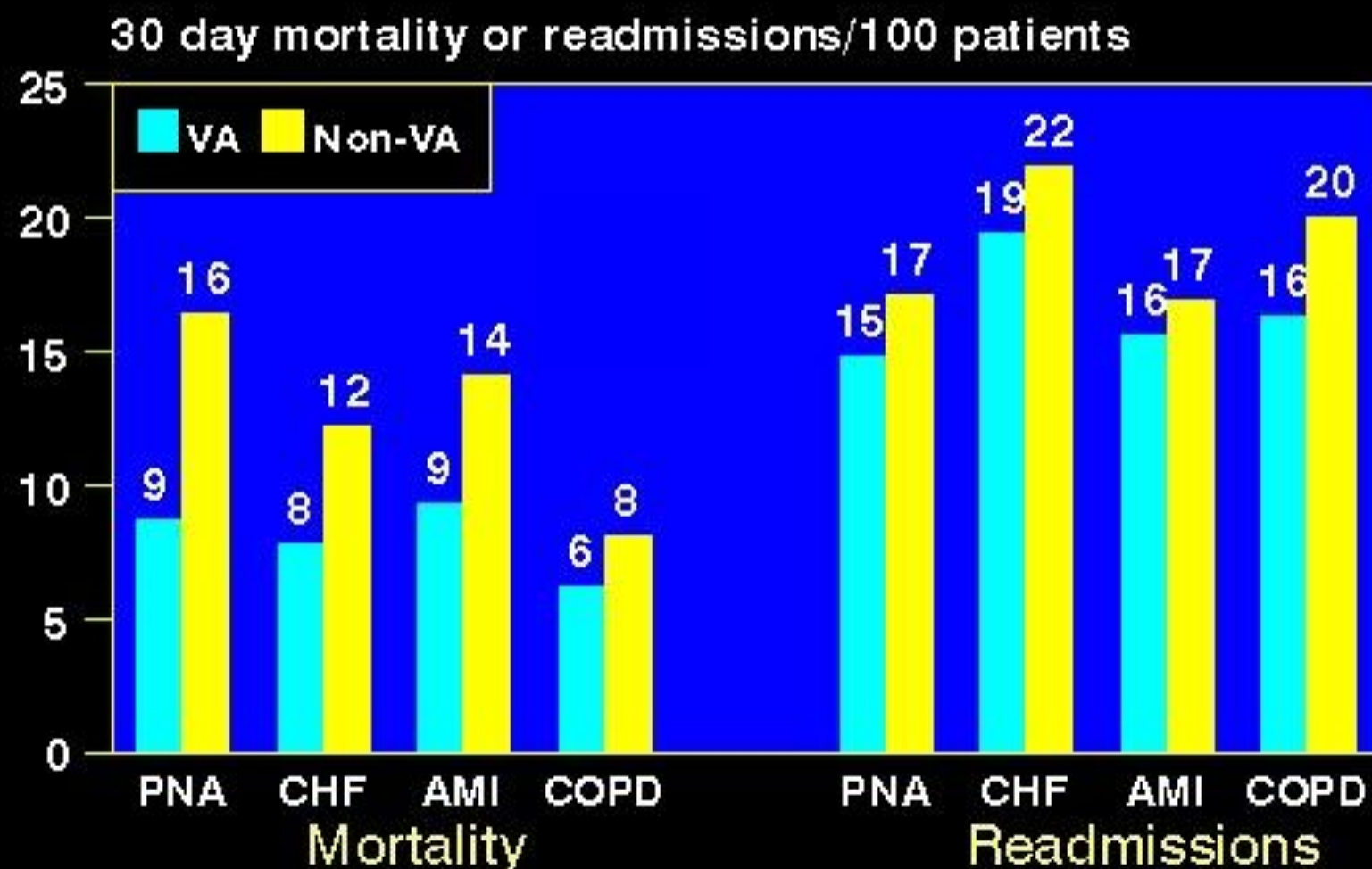
# ACOs and P4P: Implementation Without Evidence

- 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

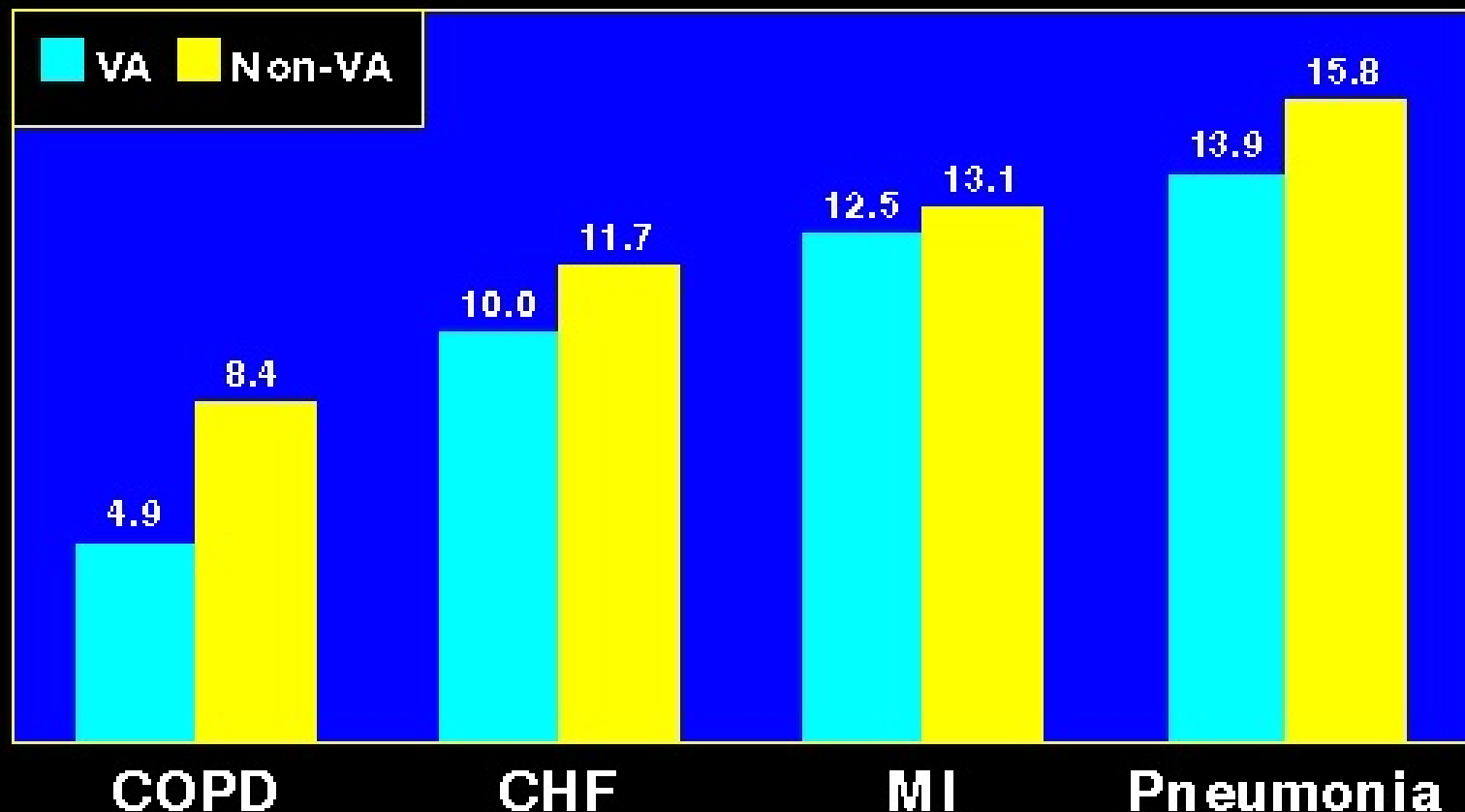
Note: PNA=pneumonia; All rates are risk adjusted

# VA Hospitals Have Lower Mortality Than Nearby Hospitals

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

---

30 day mortality rate (%)

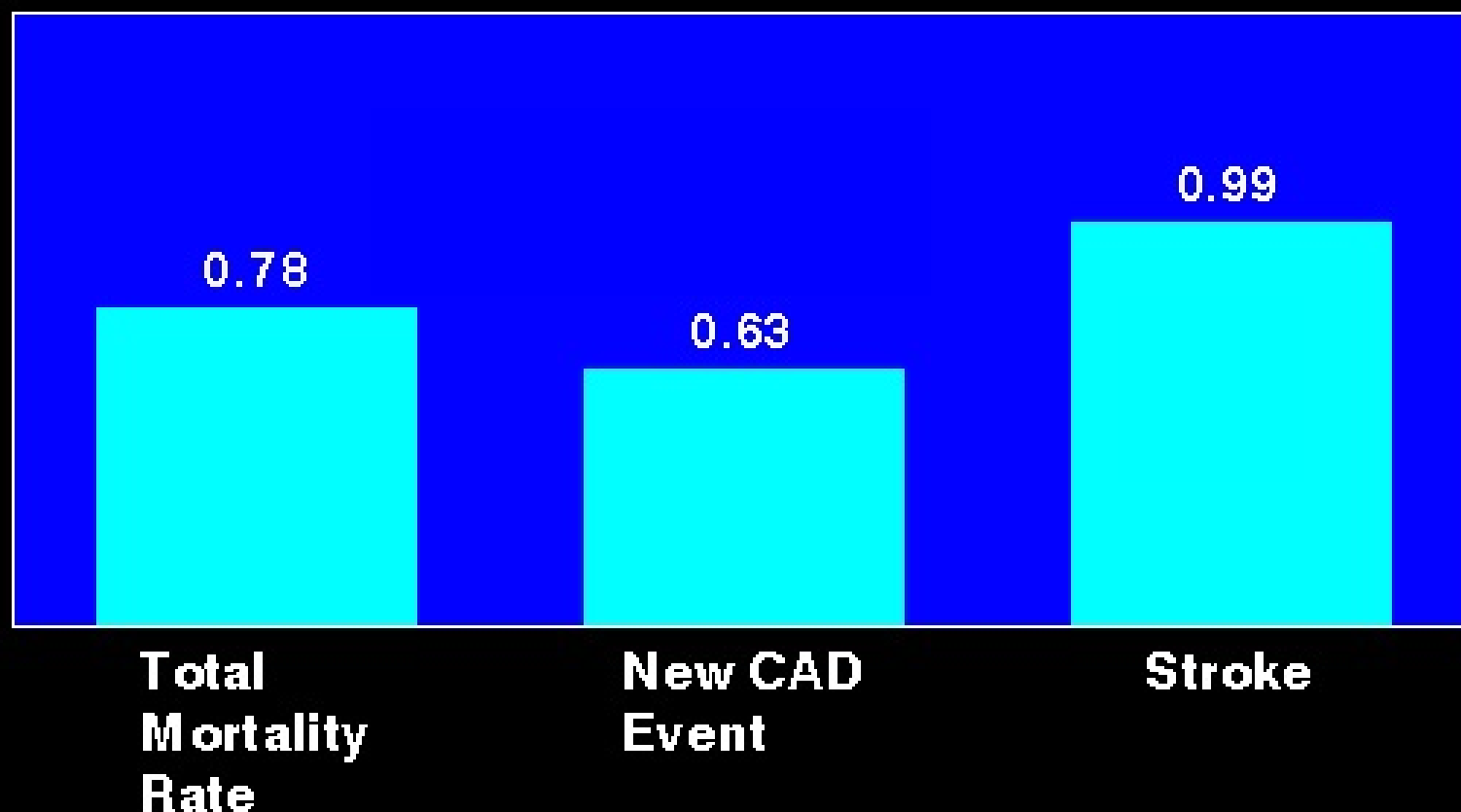


# Blacks in VA: No Health Disadvantage

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

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





# Mandate Model Reform: Keeping Private Insurers In Charge

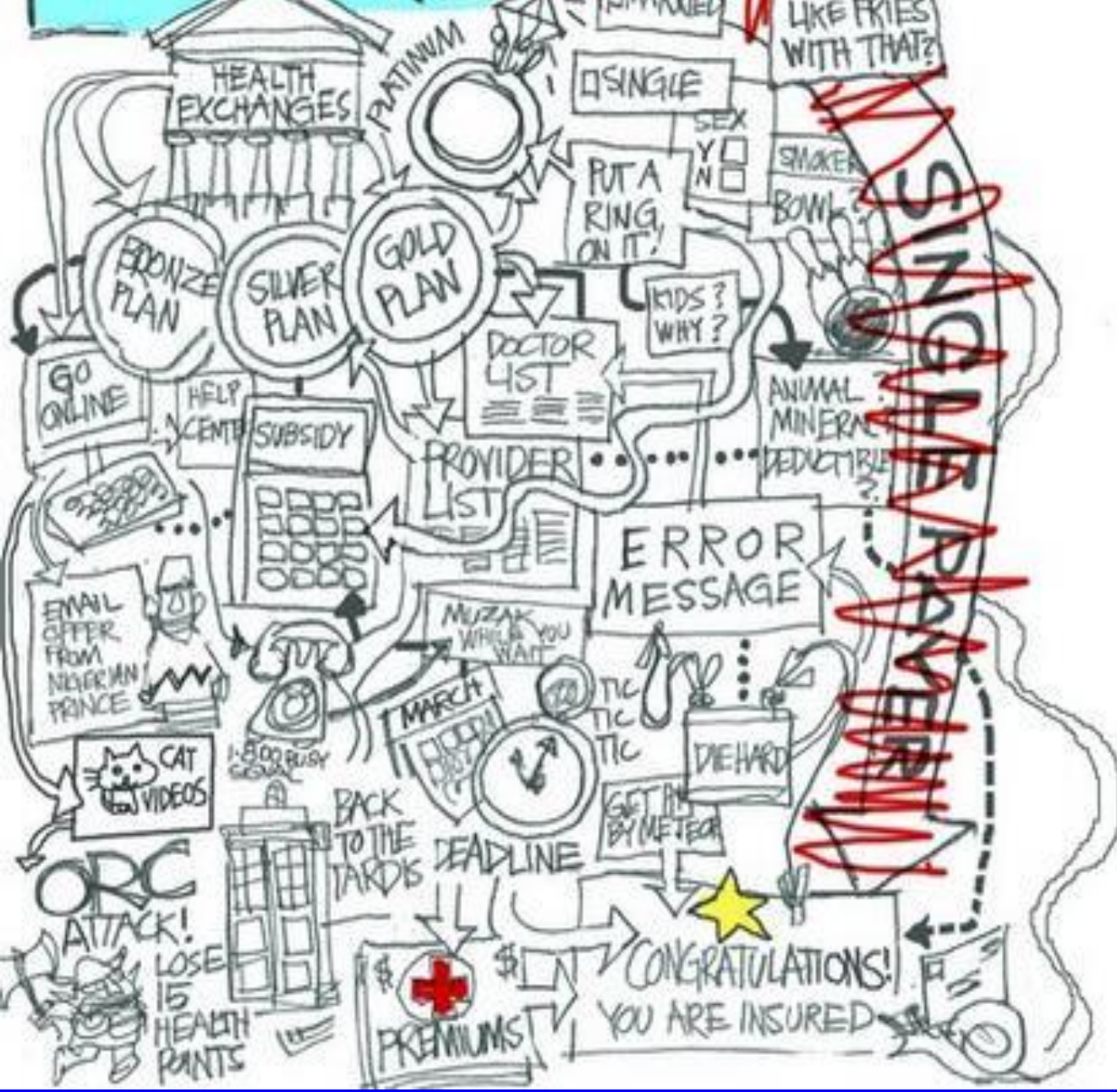
# “Mandate” Model for Reform



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

TO GET MEDICAL INSURANCE



YES

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



NO

SIGN  
HERE

Signature by mark (X) must be witnessed below.

SIGNATURE  
OF WITNESS

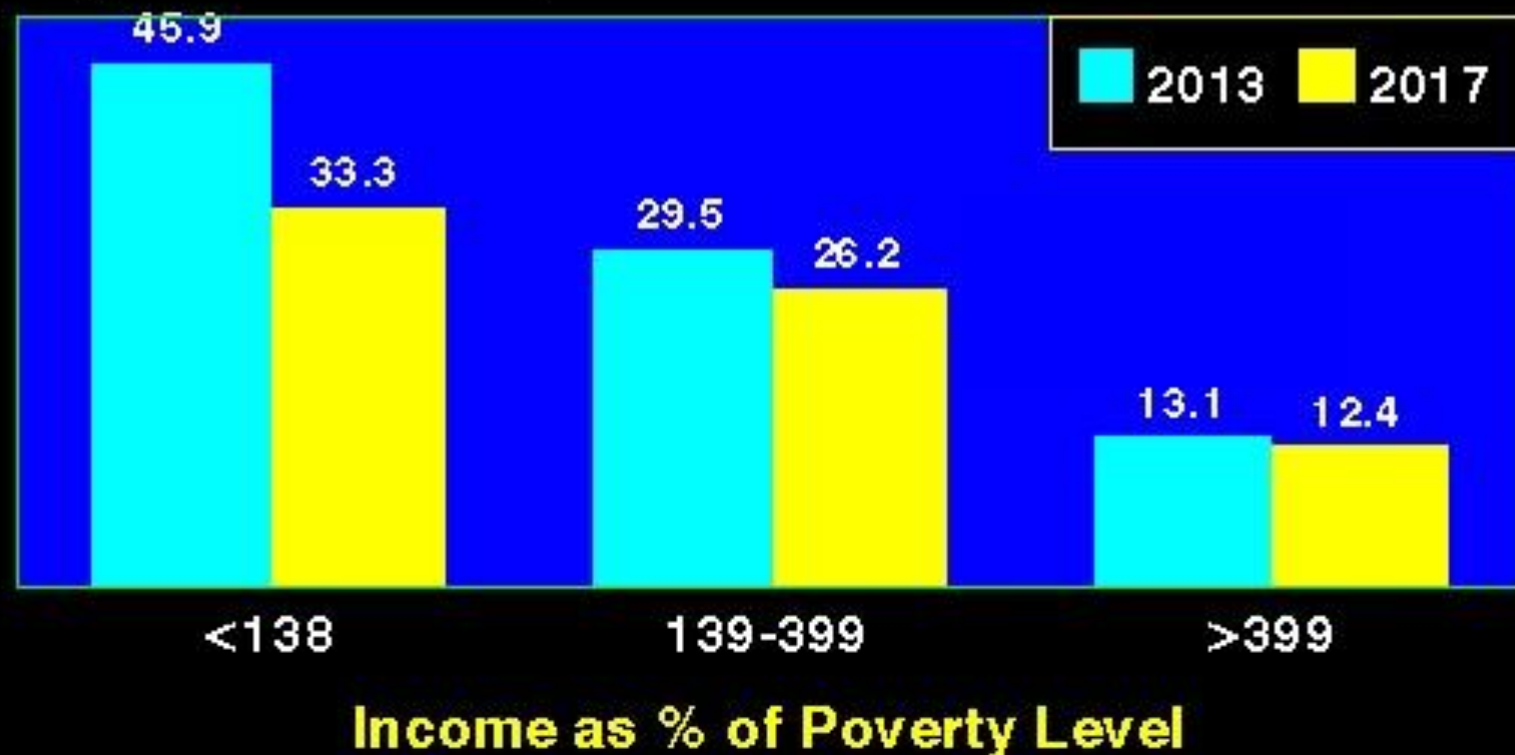
ADDRESS  
OF WITNESS

*Do not write in the space above*

# ACA Decreased Incidence of Unmet Medical Needs Due to Cost

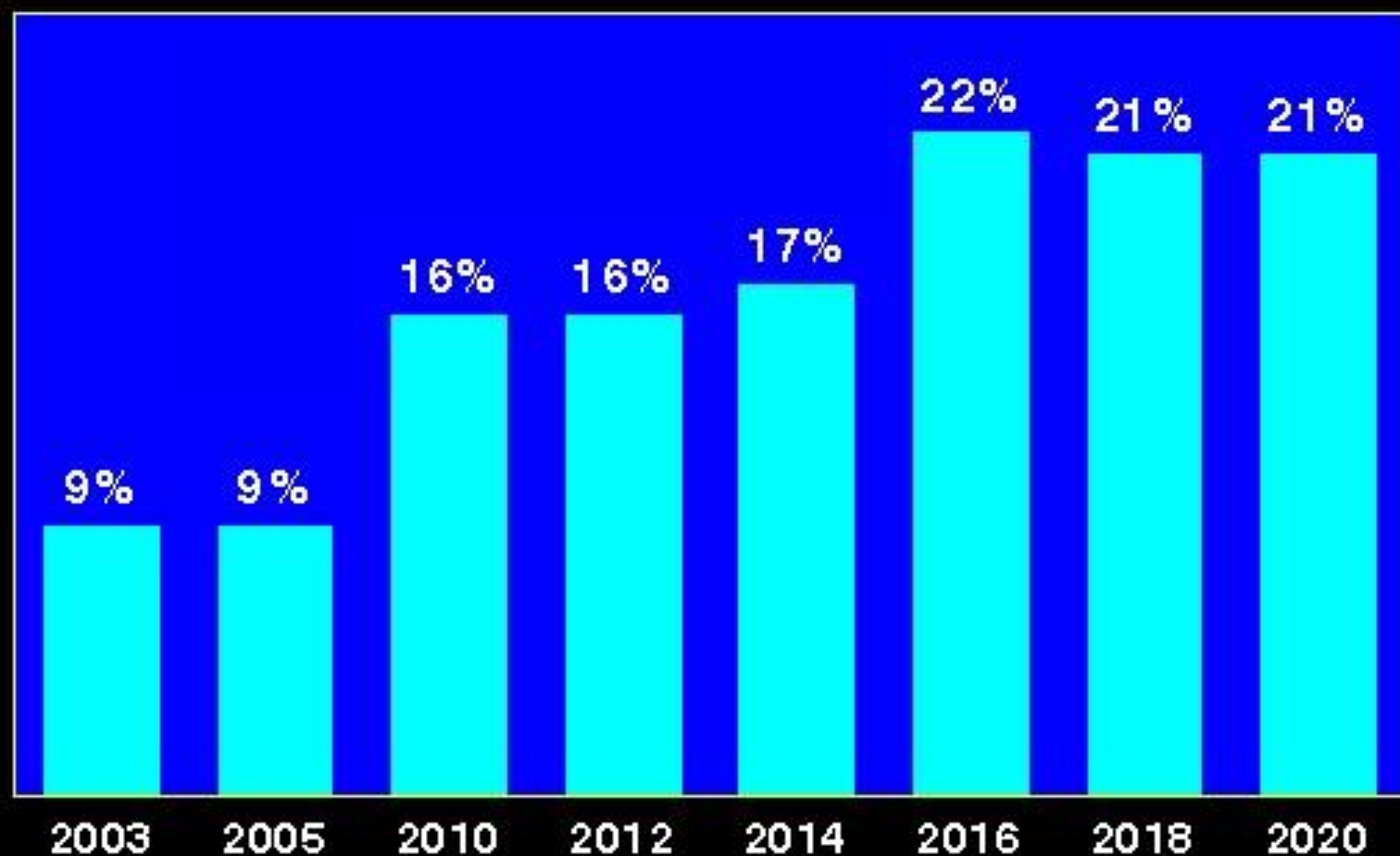
Better, But Still Not Good

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



# Under-Insurance Increased After ACA

Percent of adults 19-64 under-insured\*



Source: Commonwealth Fund Health Insurance Surveys 2003-2020

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



# Trump's Health Financing Actions

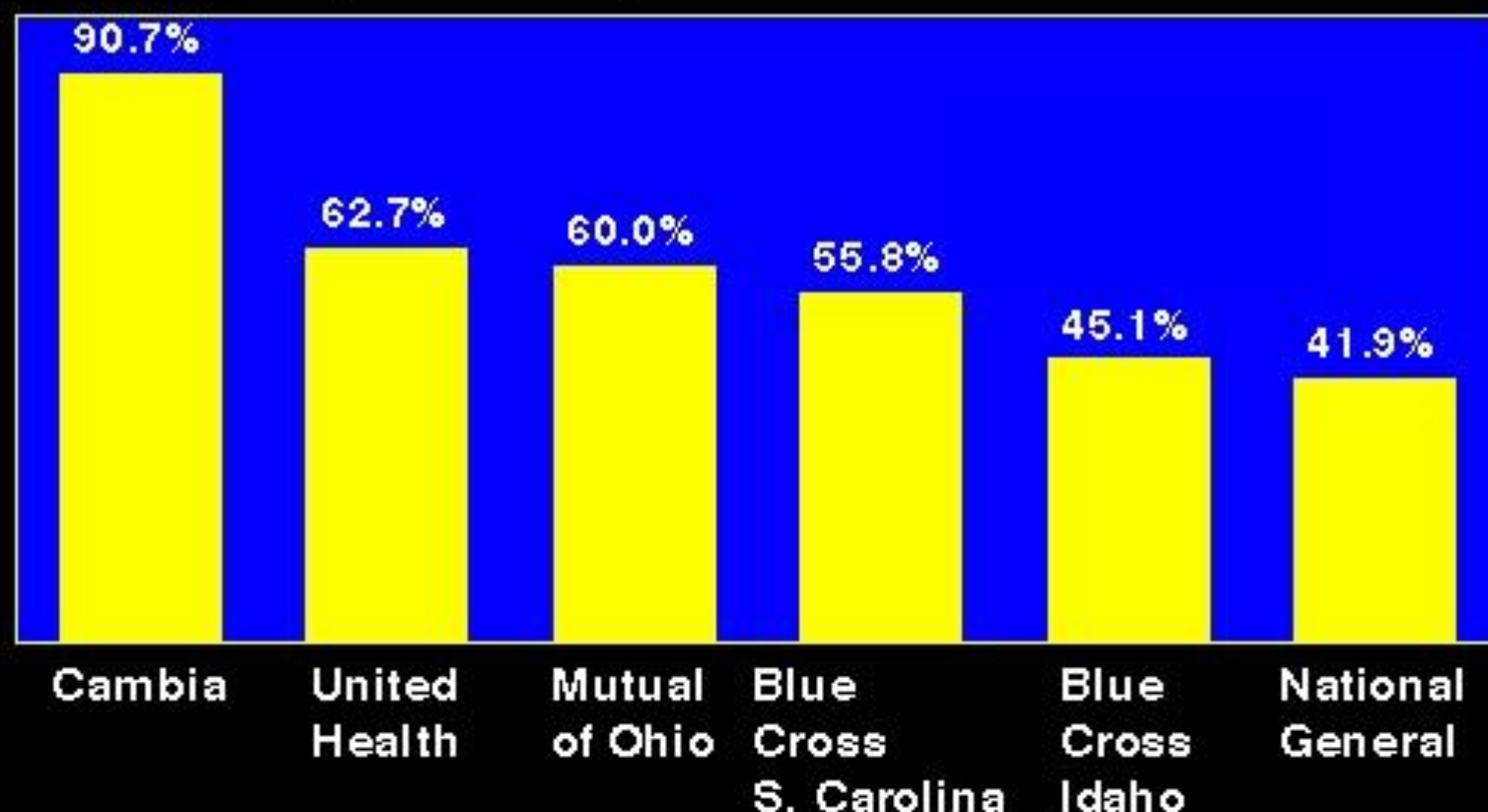
- Expand “association” and “short term” junk insurance – Increase under-insurance, undermine ACA risk pool raising cost for sicker people.
- Let employers deny coverage for birth control.
- Obstruct ACA enrollment.
- Allow states to implement punitive Medicaid changes.
- “Public charge” rule threatens documented immigrants if anyone in family uses Medicaid or nutrition services.
- Promoting Medicare Advantage.



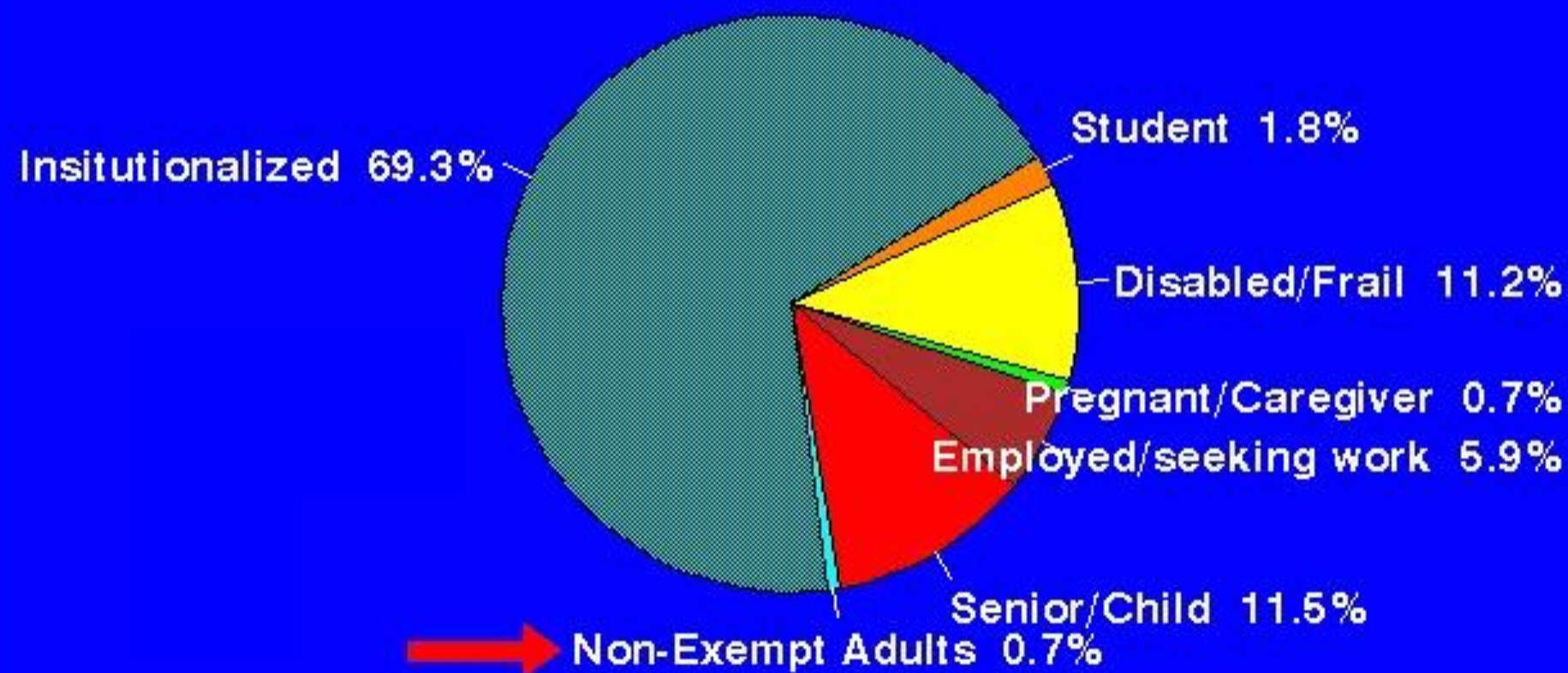
# Trump's Short Term Health Plans' Outrageously High Overhead

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Overhead as percent of premiums



# Medicaid Work Requirement: Trivial Savings Unless Exempt Groups are Also Disenrolled



**Percent of Medicaid Spending**

Source: Goldman, Woolhandler, Himmelstein et al. Forthcoming, JAMA IM & CBPP, May 23, 2018

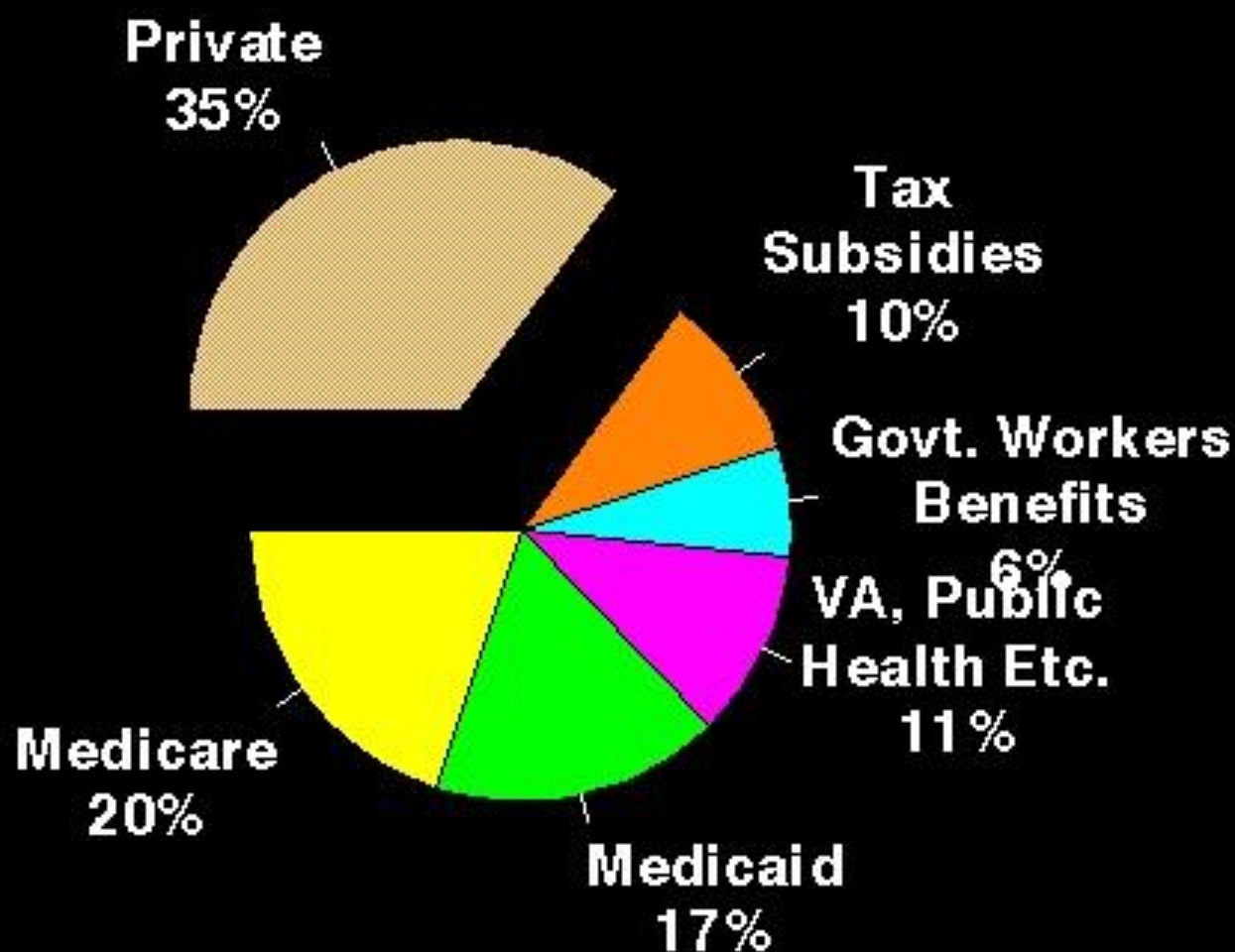
Note: Spending on enrollees with multiple exemptions appear in only one category

Note: Estimated bureaucratic costs of administering requirement: \$185 mil/yr in KY, \$600 mil in PA,

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

# Taxes Fund 2/3 of Health Spending

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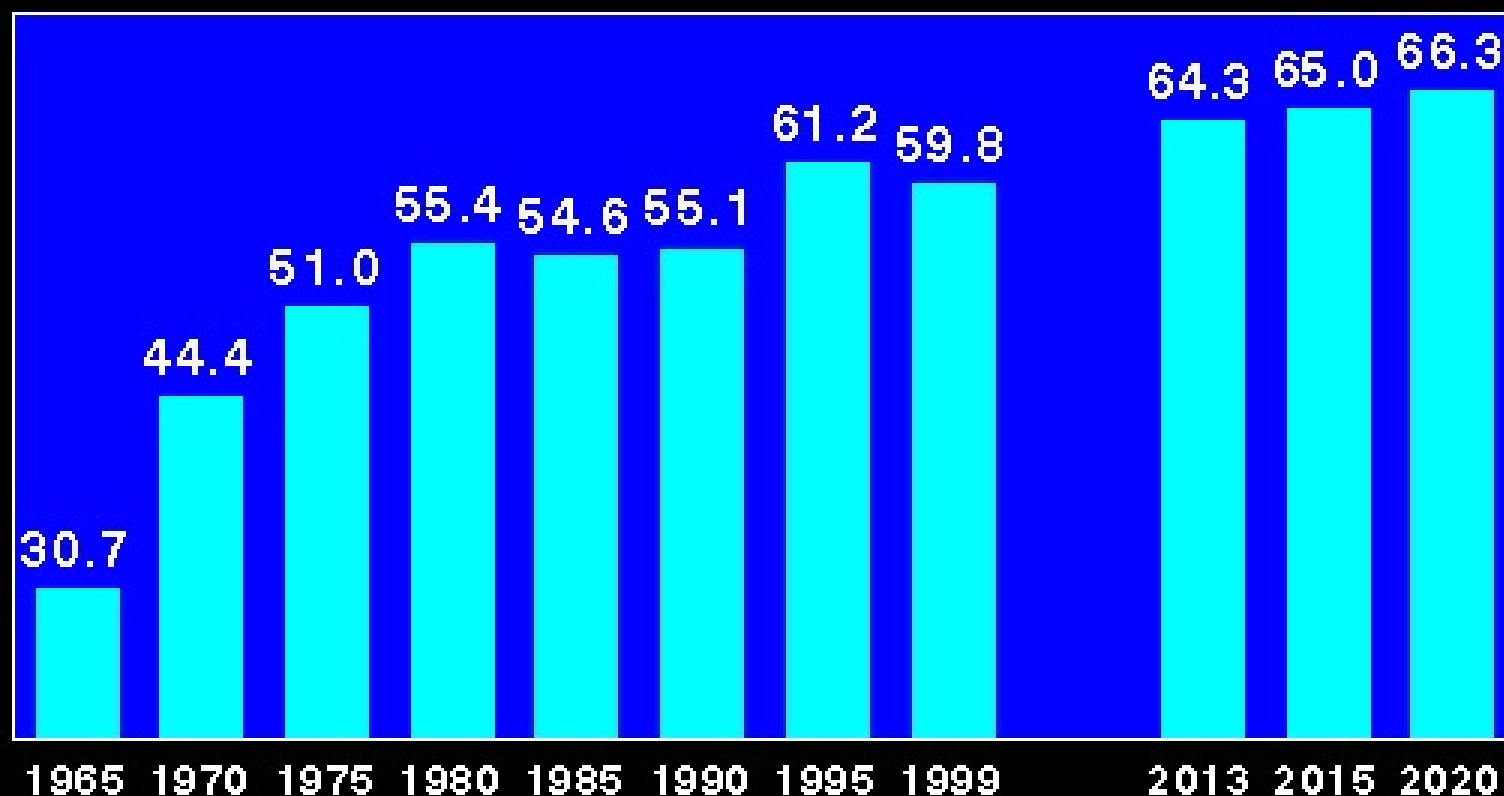
Source: Himmelstein & Woolhandler - Analysis of NCHS data



# 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



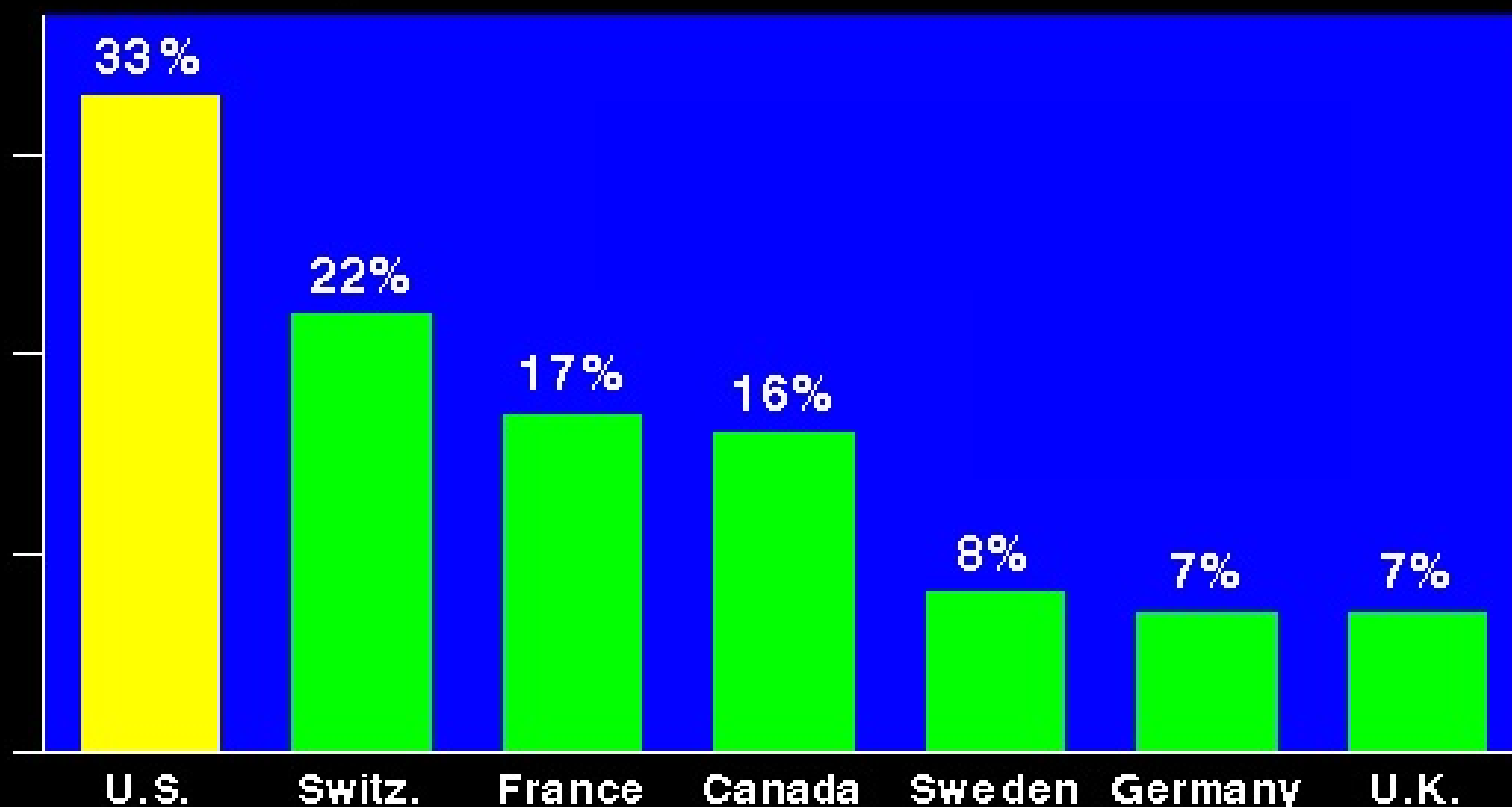
**Note: Public includes benefit costs for govt. employees & tax subsidy for private insurance**

**Source: OECD 2020; NCHS; AJPH 2016;106:449 (updated) - Data are for 2019**

# The U.S. Trails Other Nations on Health

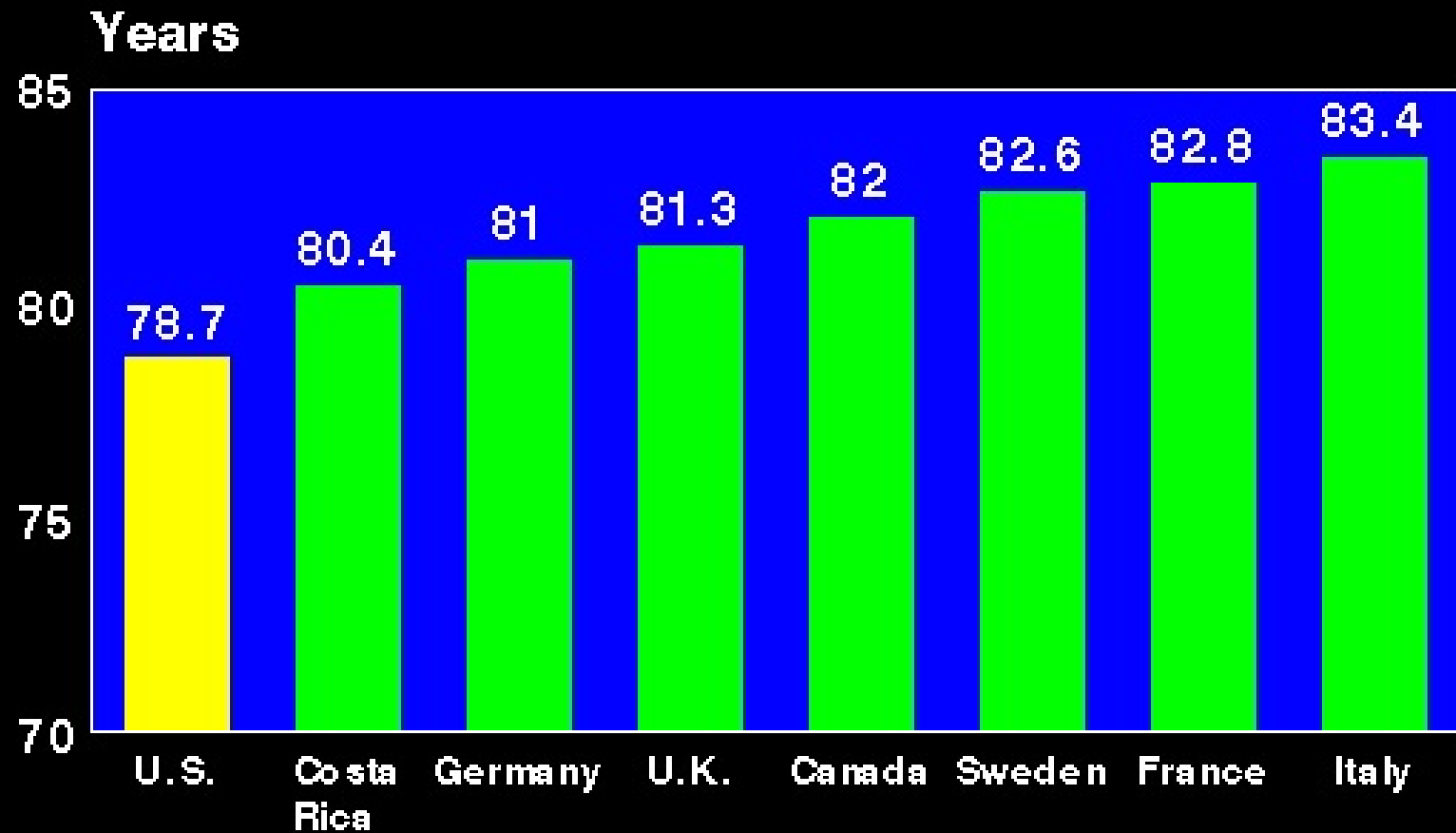
# U.S. Patients Skip Care More Often

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, 2020

Note: Data are for 2019 or most recent year available



# Infant Mortality

## Deaths in First Year of Life/1000 Live Births



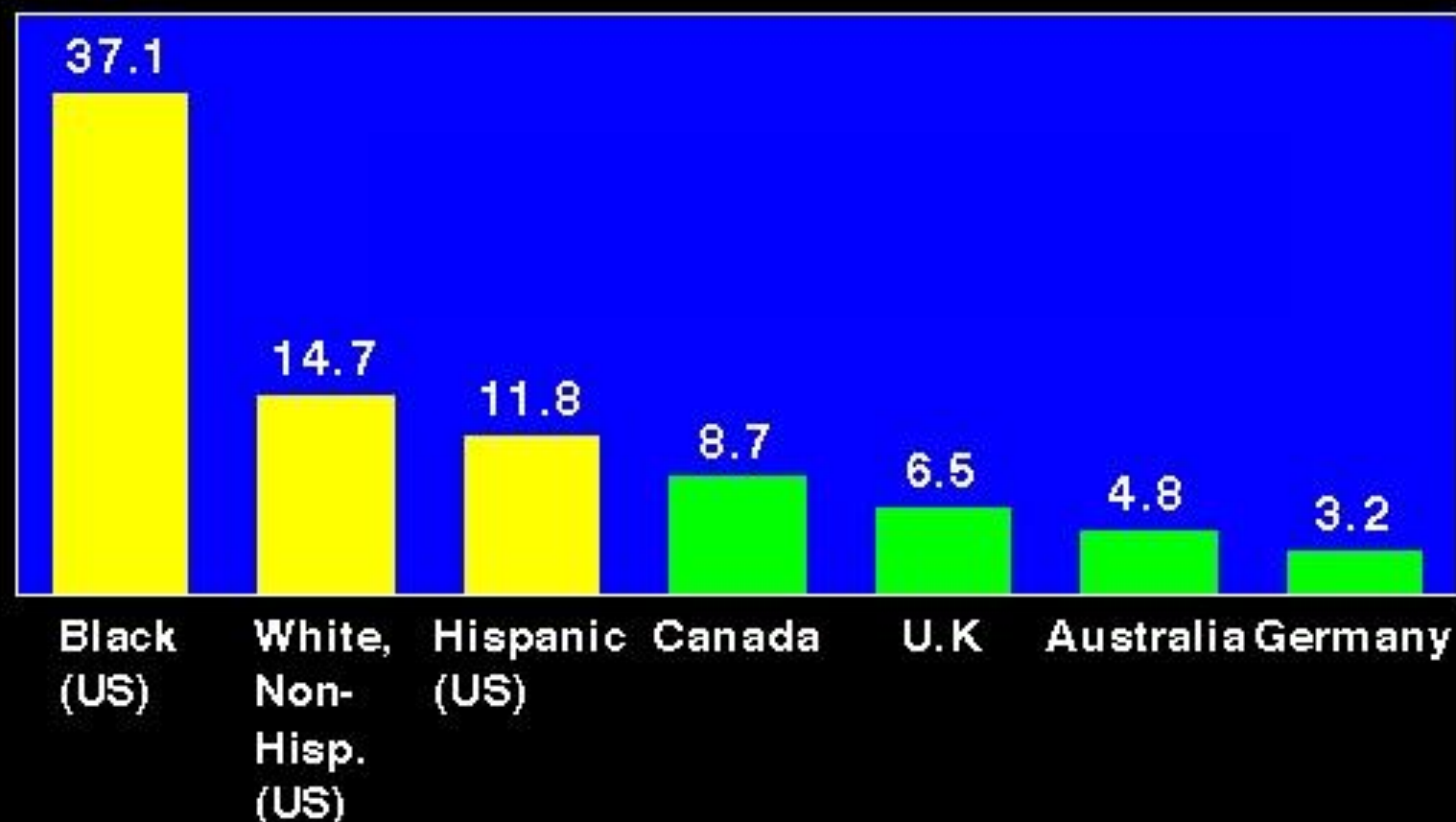
Source: OECD, 2020

Note: Data are for 2019 or most recent year available

# U.S. Mothers at Risk

## Black Women at Highest Risk, But All Fare Poorly

Maternal deaths per 100,000 live births, 2018

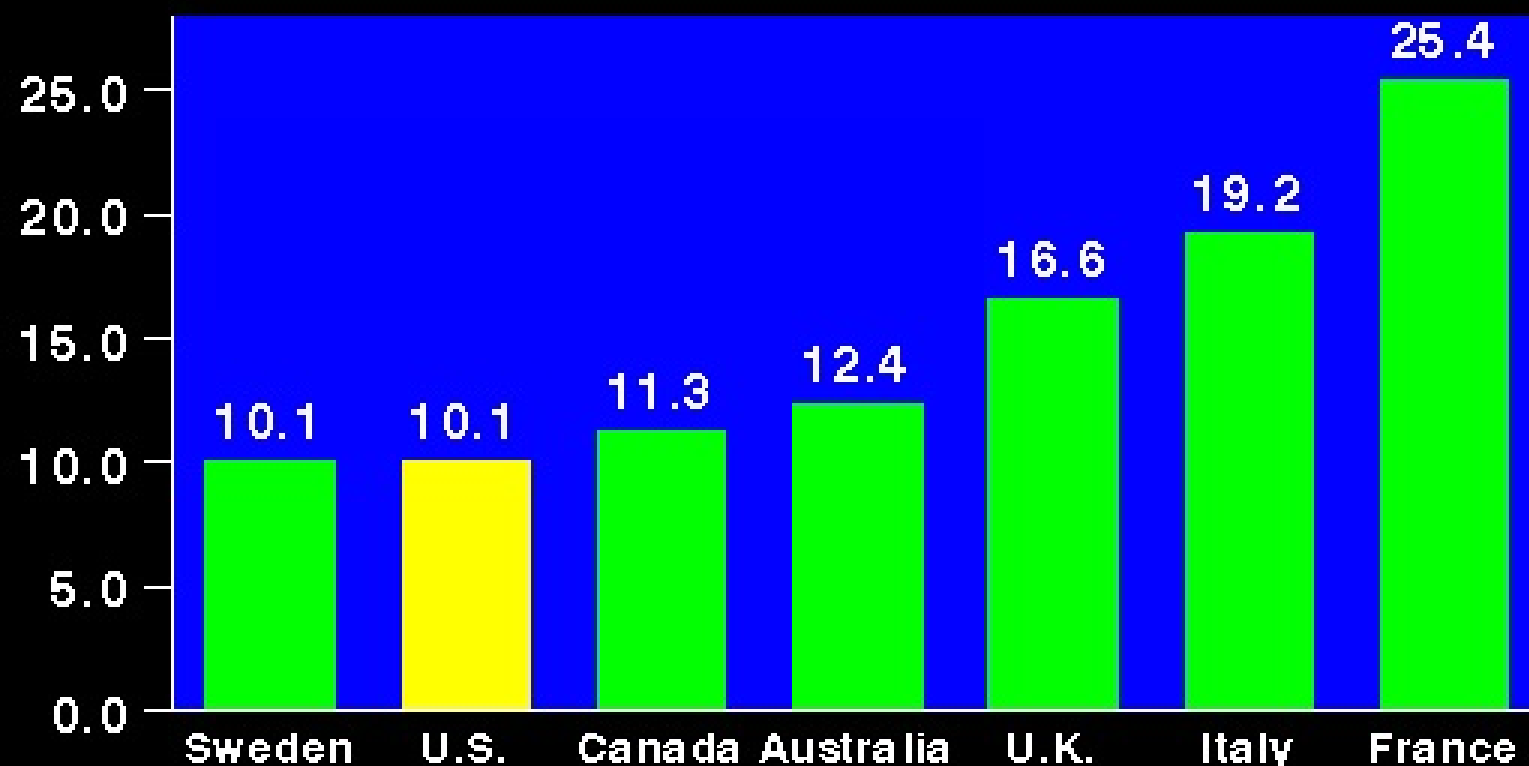


Source: CDC, January 30, 2020 and OECD 2020

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

# Smoking Prevalence

% of population >15 who smoke daily

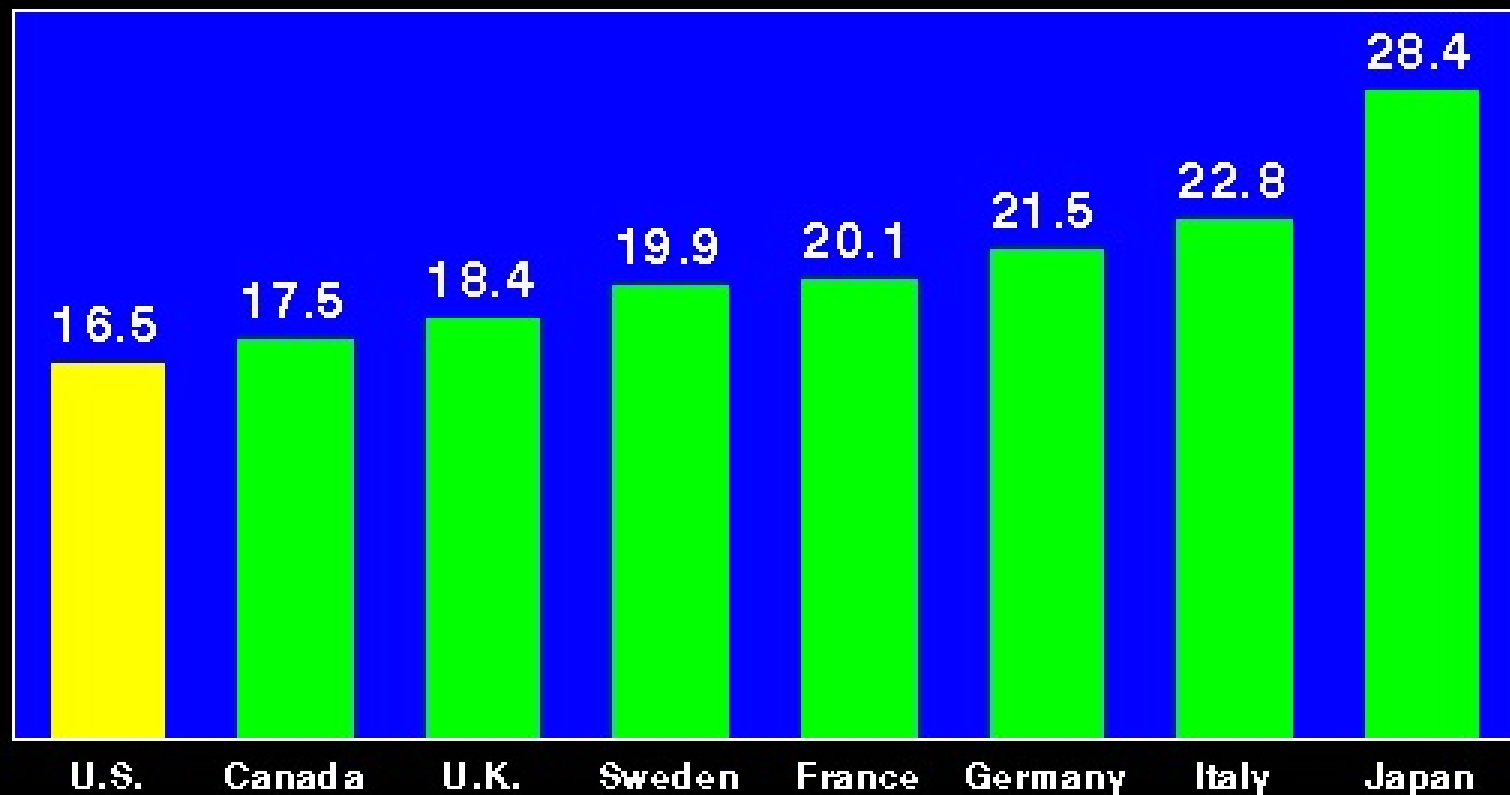


Source: OECD, 2020

Note: Data are for 2019, or most recent year available

# Percent Elderly

% of Population > 64

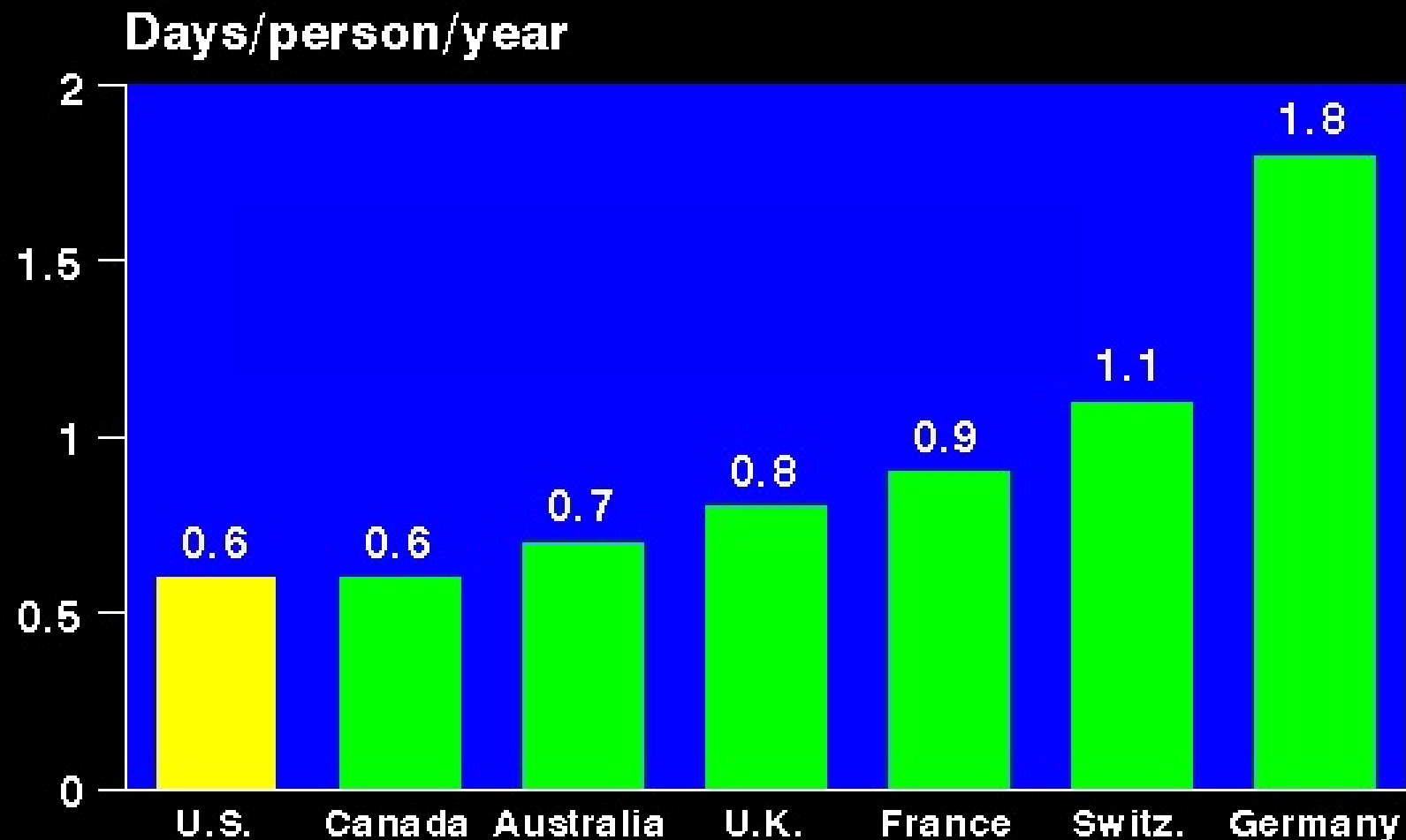


Source: OECD, 2020

Note: Data are for 2019 or most recent year available

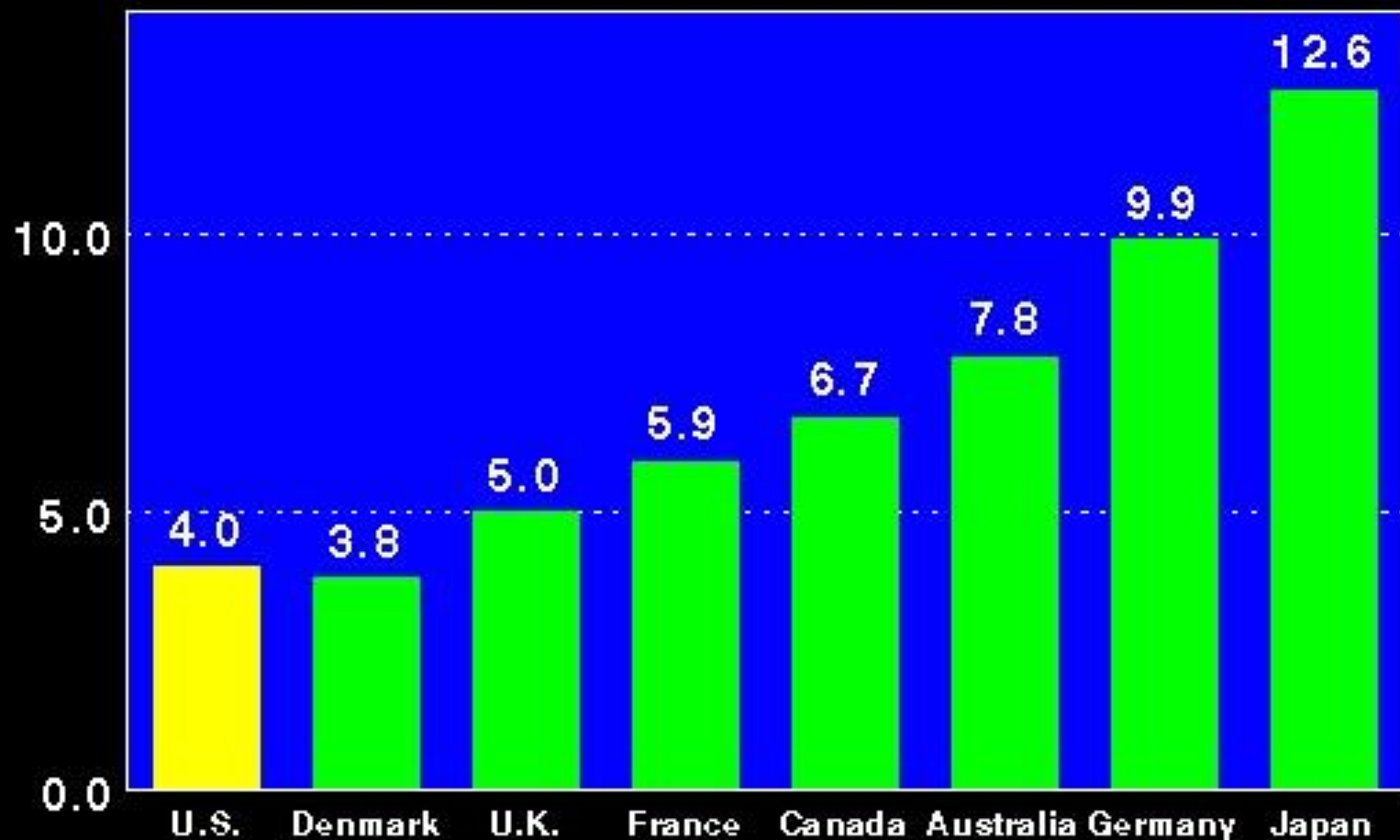


# Hospital Inpatient Days Per Capita



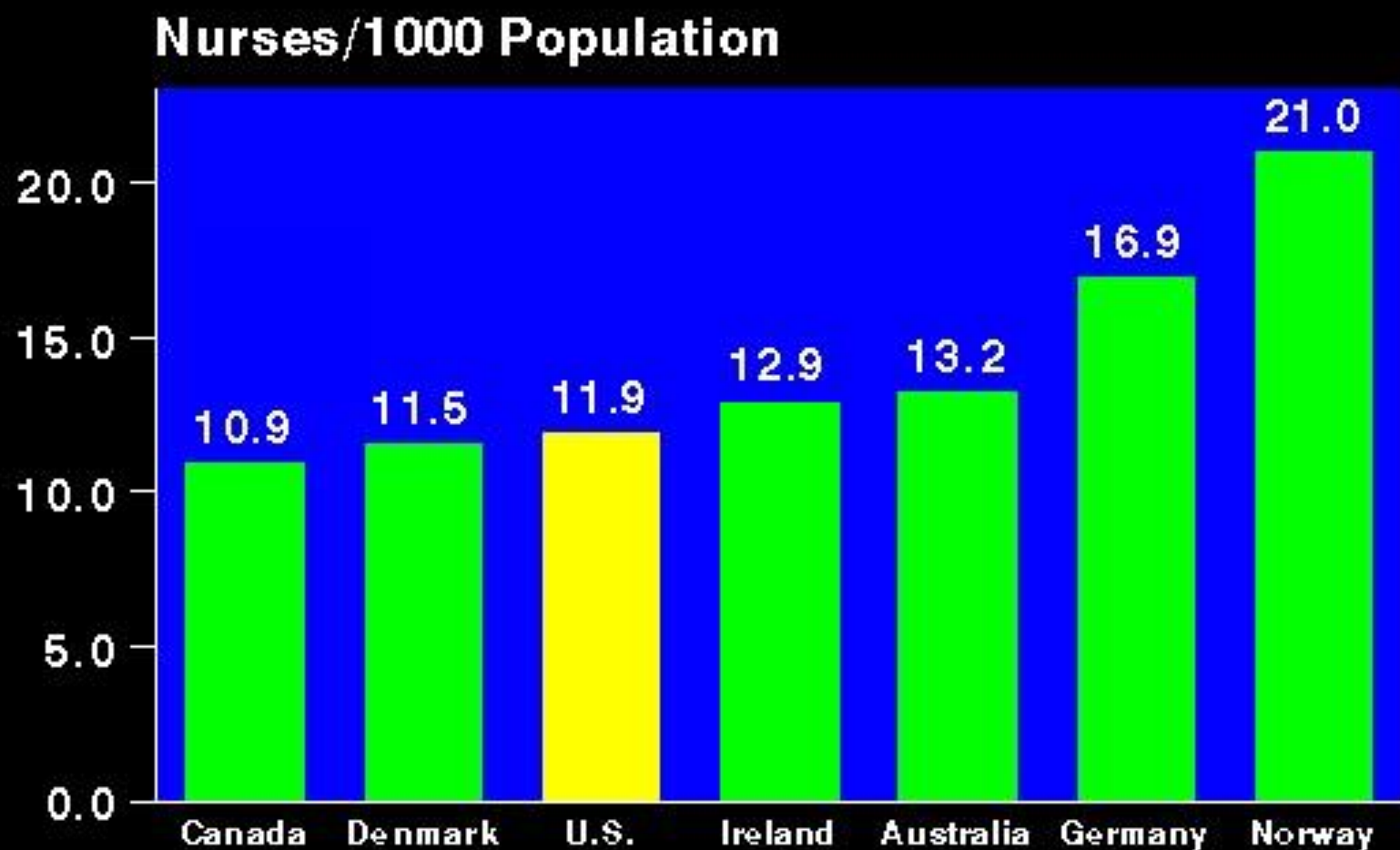
Source: OECD, 2020 & Kaiser Fdn. - Figures are for 2019 or most recent available

# Physician Visits Per Capita



Source: OECD, 2020 - Data are for 2019 or most recent available year

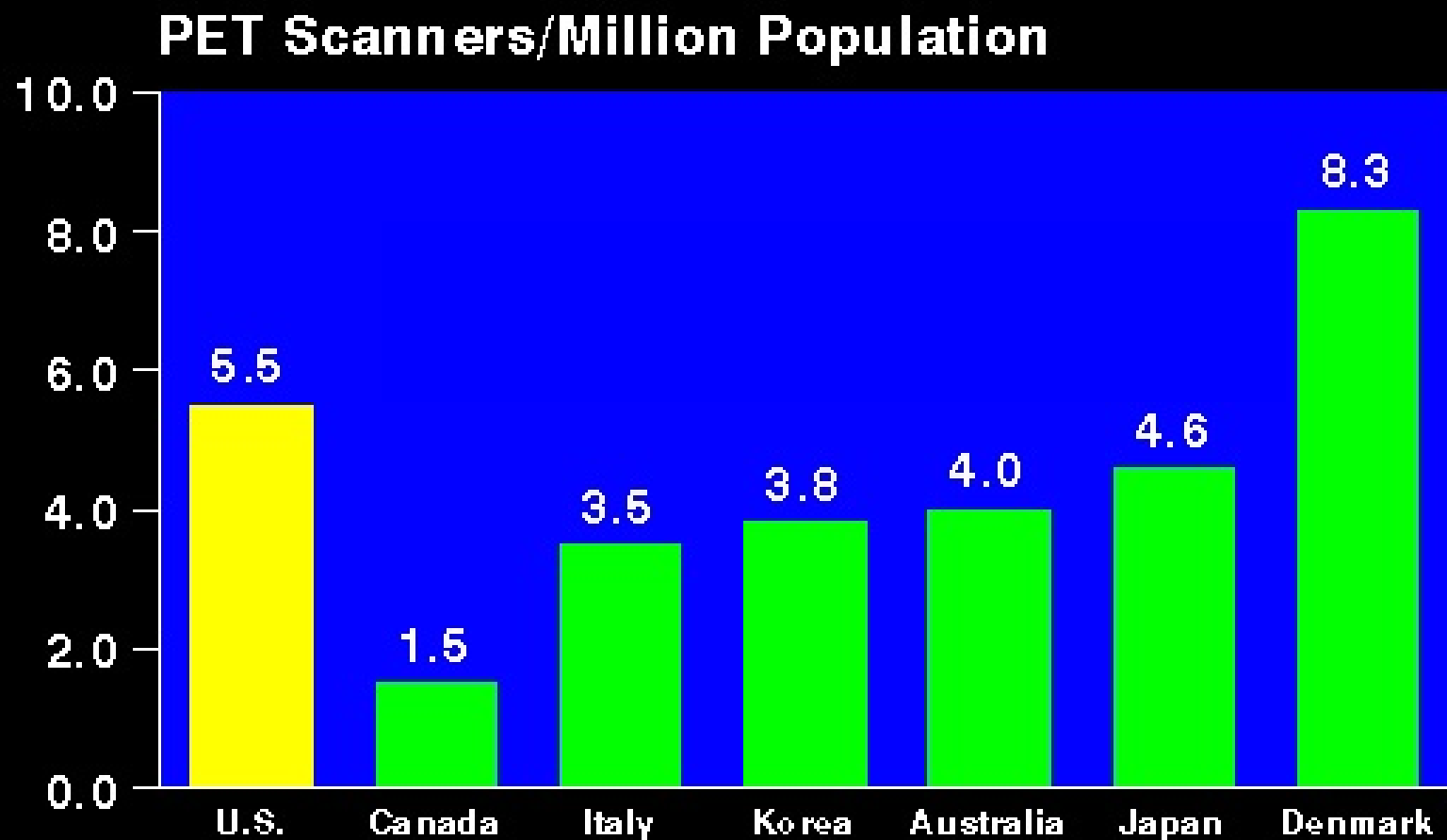
# Number of Nurses Per 1000 Population



Source: OECD, 2020

Note: Data are for 2019 or most recent year available

# PET Scan Units/Million Population

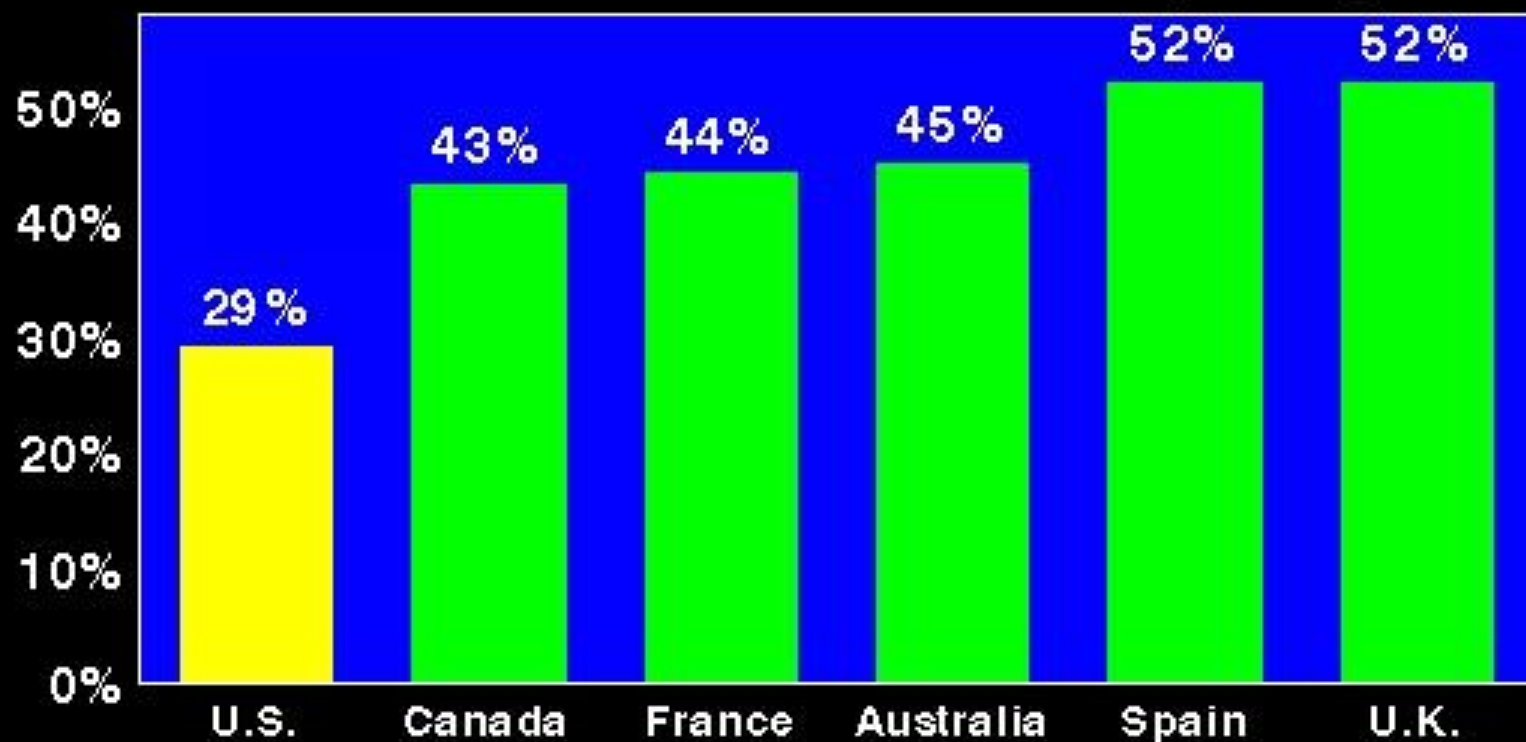


Source: OECD, 2020

Note: Data are for 2019, or most recent year available

# U.S. Renal Failure Patients are Less Likely to Get Transplants

Percent of ESRD Patients with Functioning Transplant

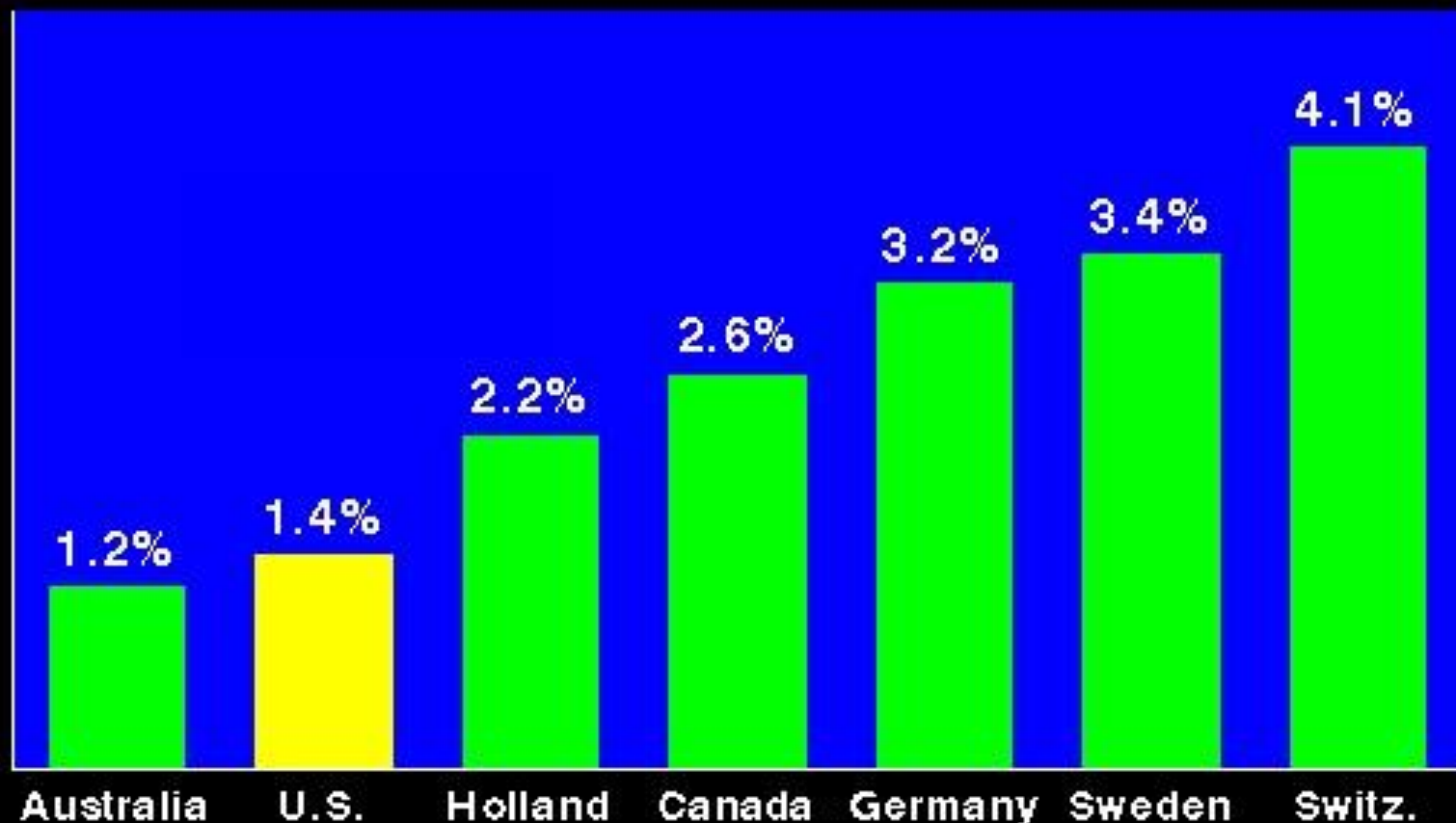


Source: OECD, 2015

Note: Data are for 2013 or most recent year available

## Other Countries Provide More Long Term Care

Percent of total population receiving LTC



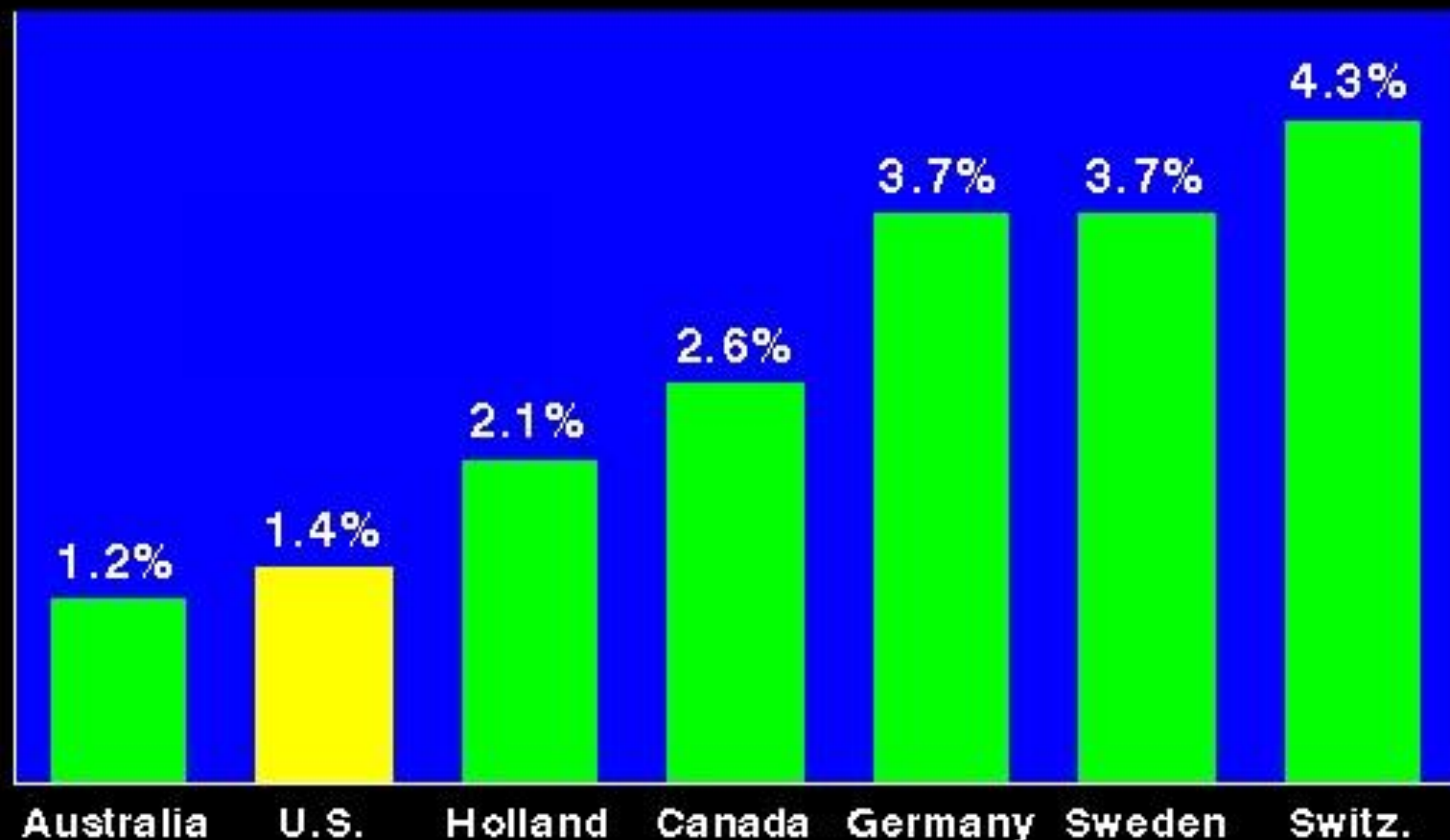
Source: OECD, 2019

Note: Data are for 2017 or most recent year available



## Other Countries Provide More Long Term Care at Home

Percent of total population receiving home care

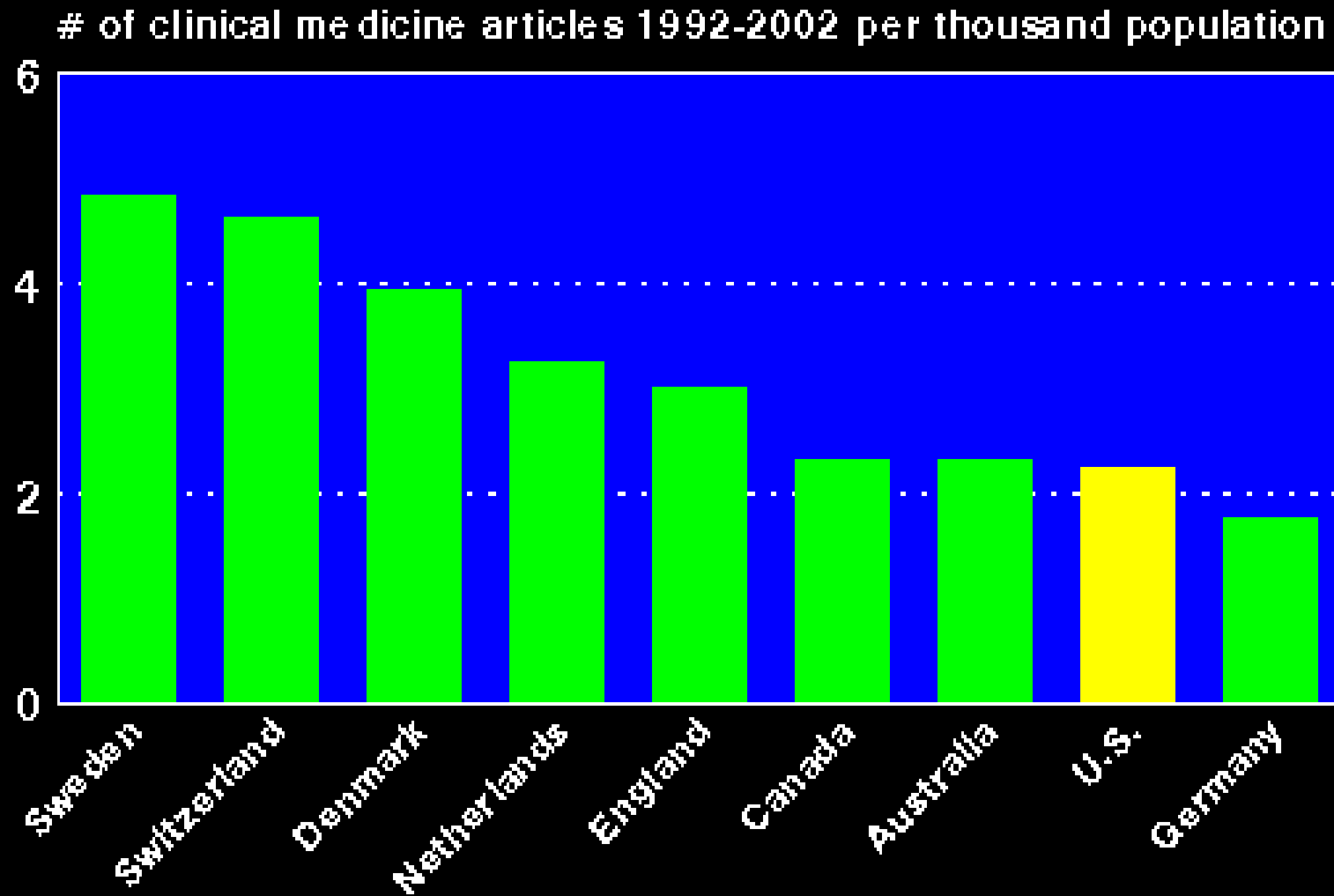


Source: OECD, 2020

Note: Data are for 2018 or most recent year available

# Medical Journals Articles Per Capita

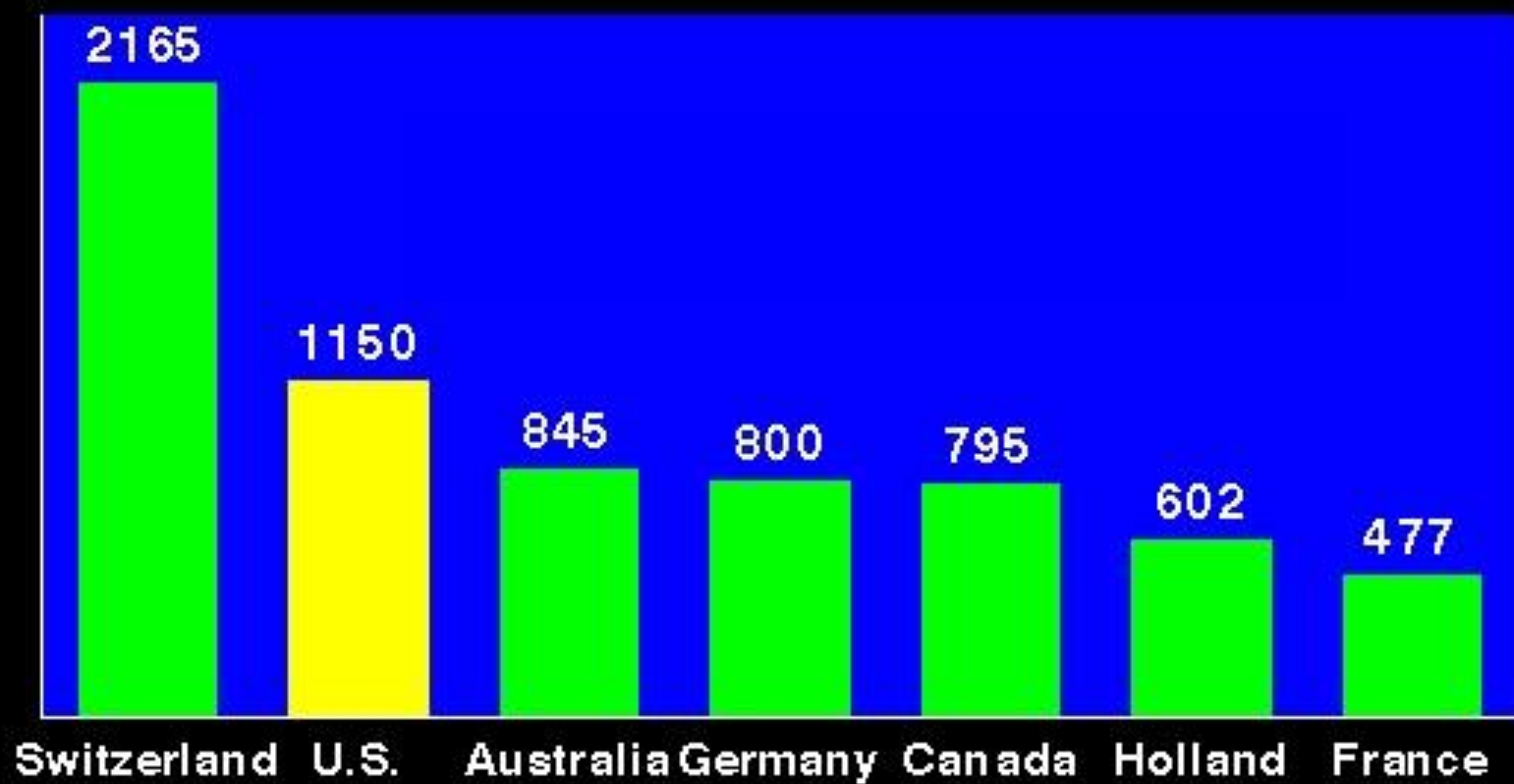
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Source: Lancet 2004; 363:250

# Out-Of-Pocket Payments

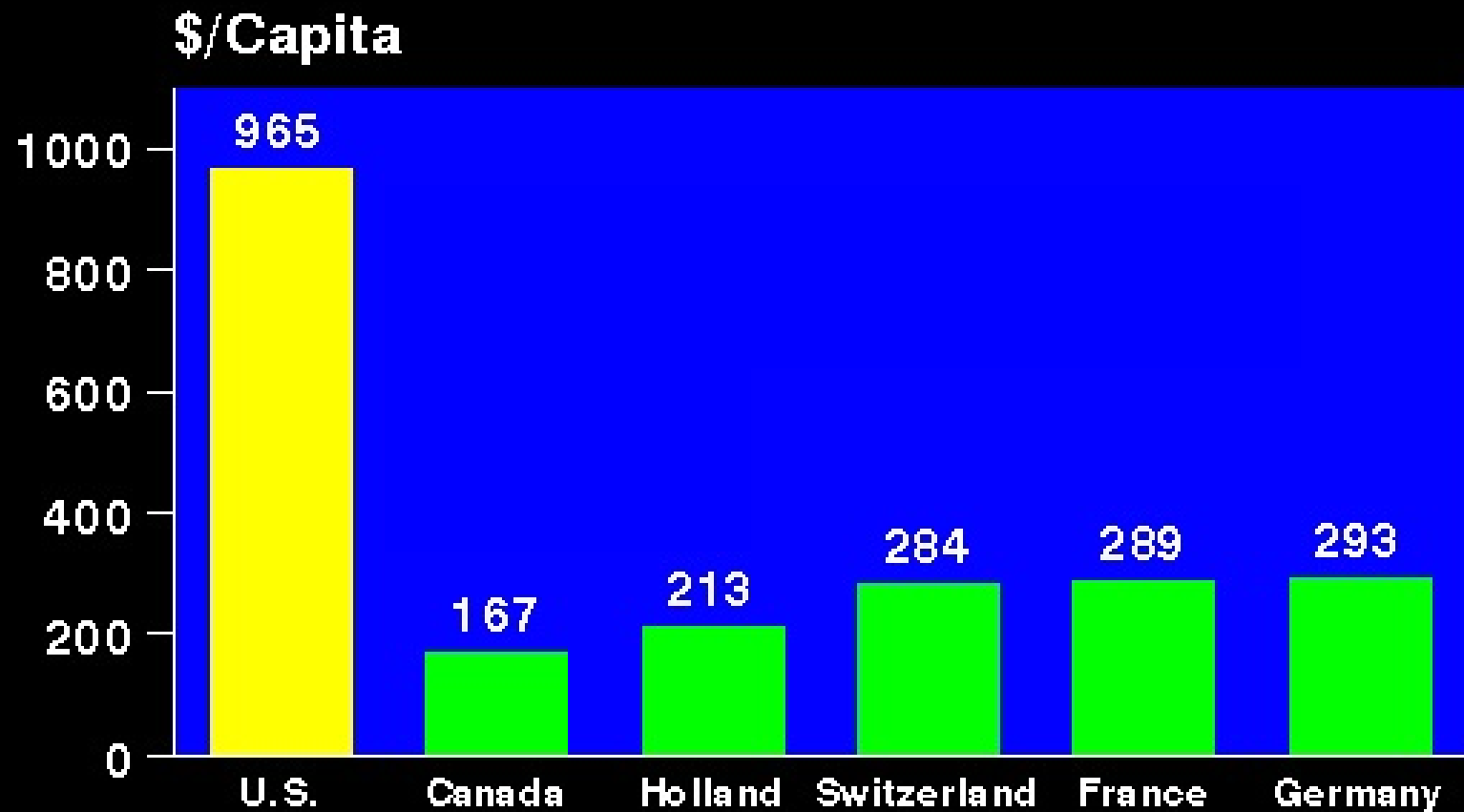
**\$/Capita**



**Source: OECD, 2020 & NCHS**

**Note: Data are for 2019 or most recent year available; figures adjusted for Purchasing Power Parity**

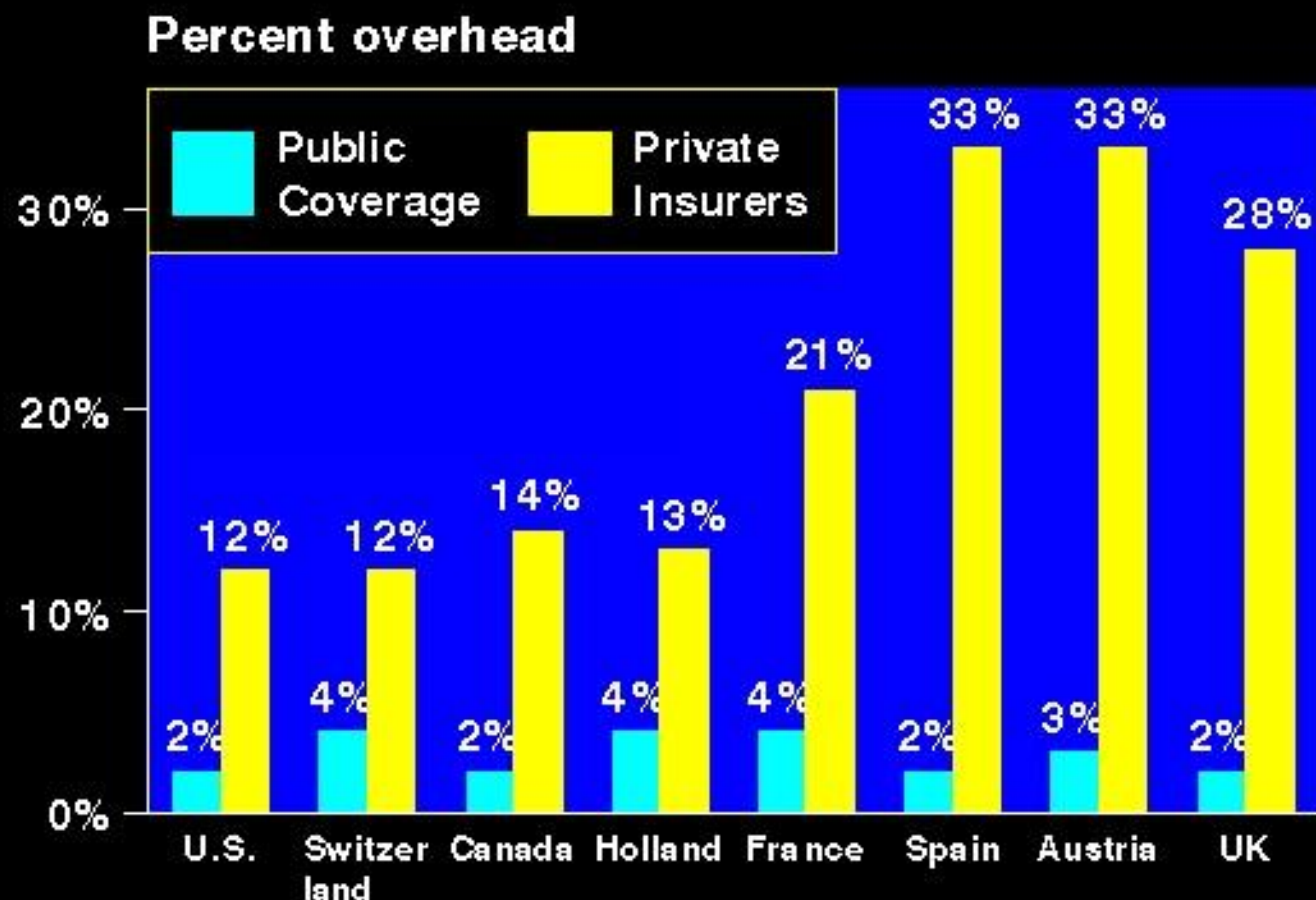
# Insurance Overhead



**Source: OECD, 2020; NCHS; CIHI**

**Note: Figures adjusted for Purchasing Power Parity; data are for 2019 or most recent available**

# Private Insurance: High Overhead Everywhere



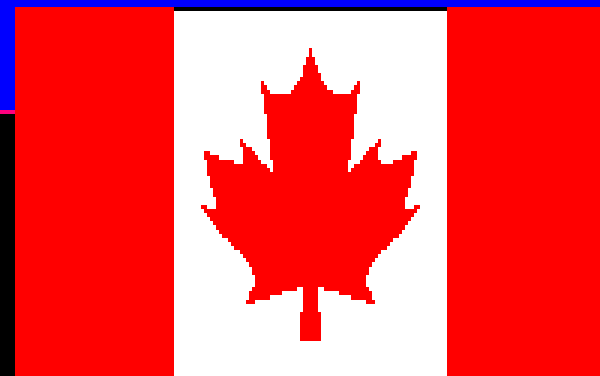
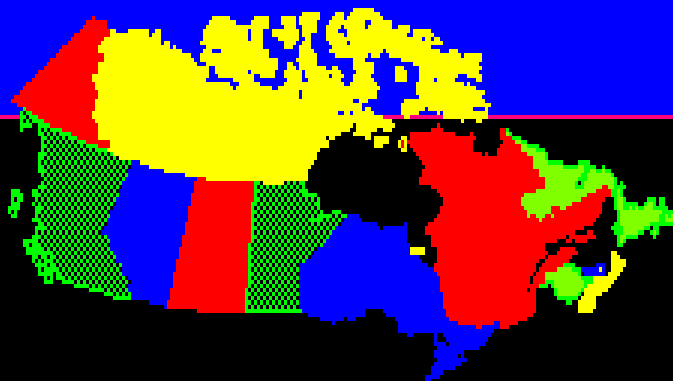
Source: Int J Health Planning and Management 2018;e:263 and NCHS

# Canada's Single Payer National Health Insurance Program



# MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

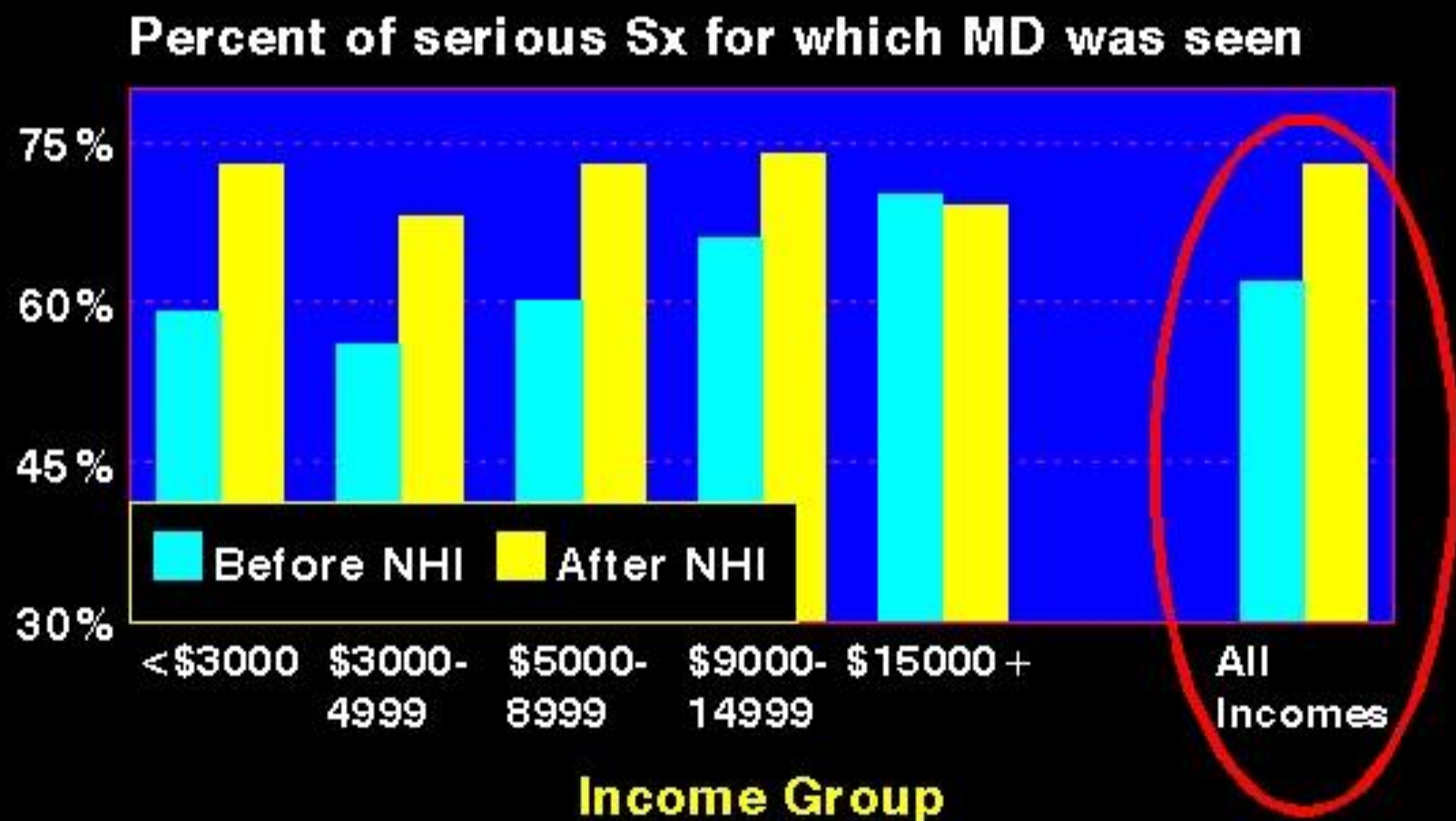
1. UNIVERSAL COVERAGE THAT DOES NOT IMPEDE, EITHER DIRECTLY OR INDIRECTLY, WHETHER BY CHARGES OR OTHERWISE, REASONABLE ACCESS.
2. PORTABILITY OF BENEFITS FROM PROVINCE TO PROVINCE
3. COVERAGE FOR ALL MEDICALLY NECESSARY SERVICES
4. PUBLICLY ADMINISTERED, NON-PROFIT PROGRAM



# Free Care in Quebec Increased Physician Care for Serious Symptoms

## Biggest Impact on Poor and Middle Class

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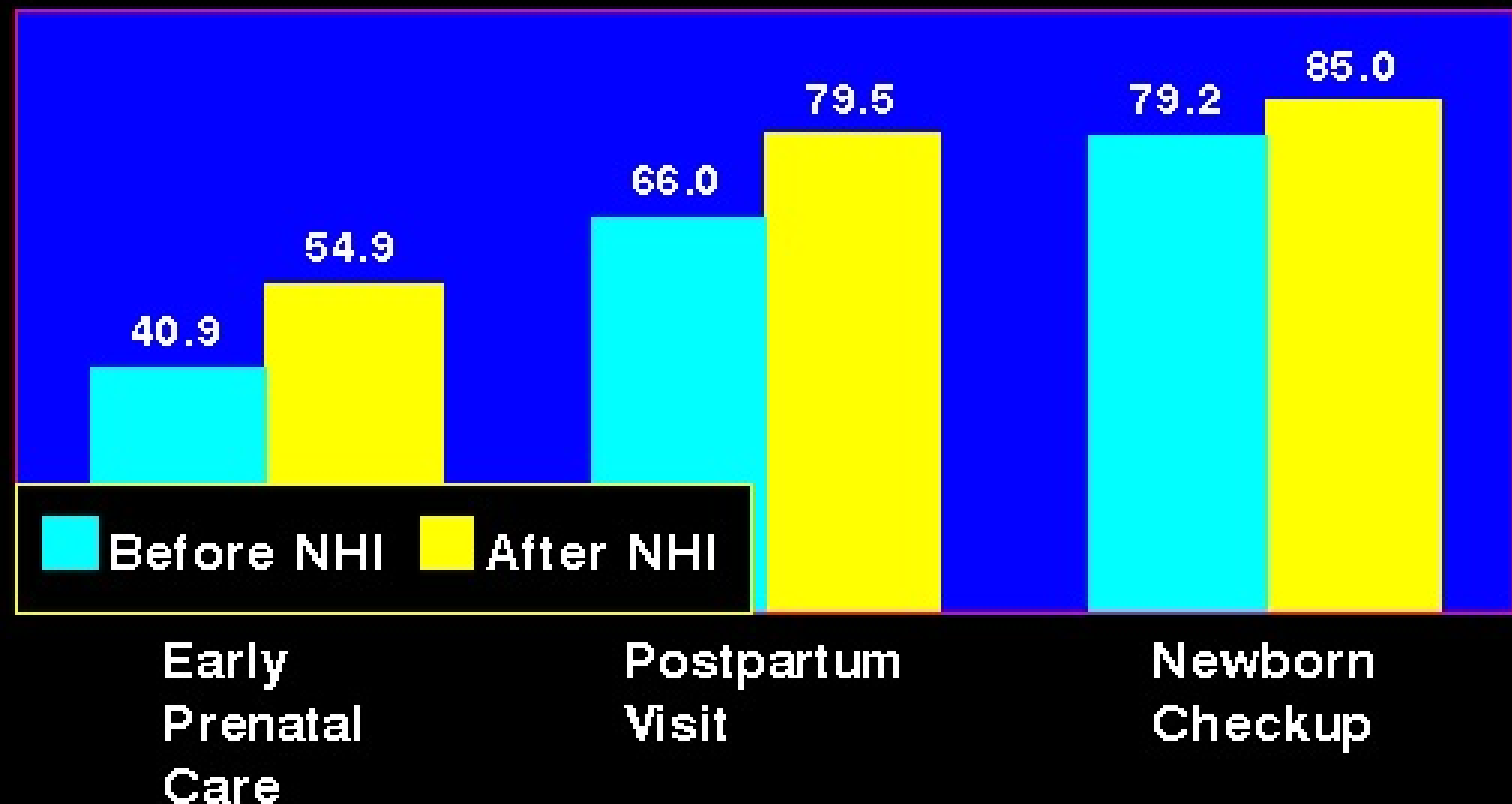


# Free Care in Quebec

## 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**

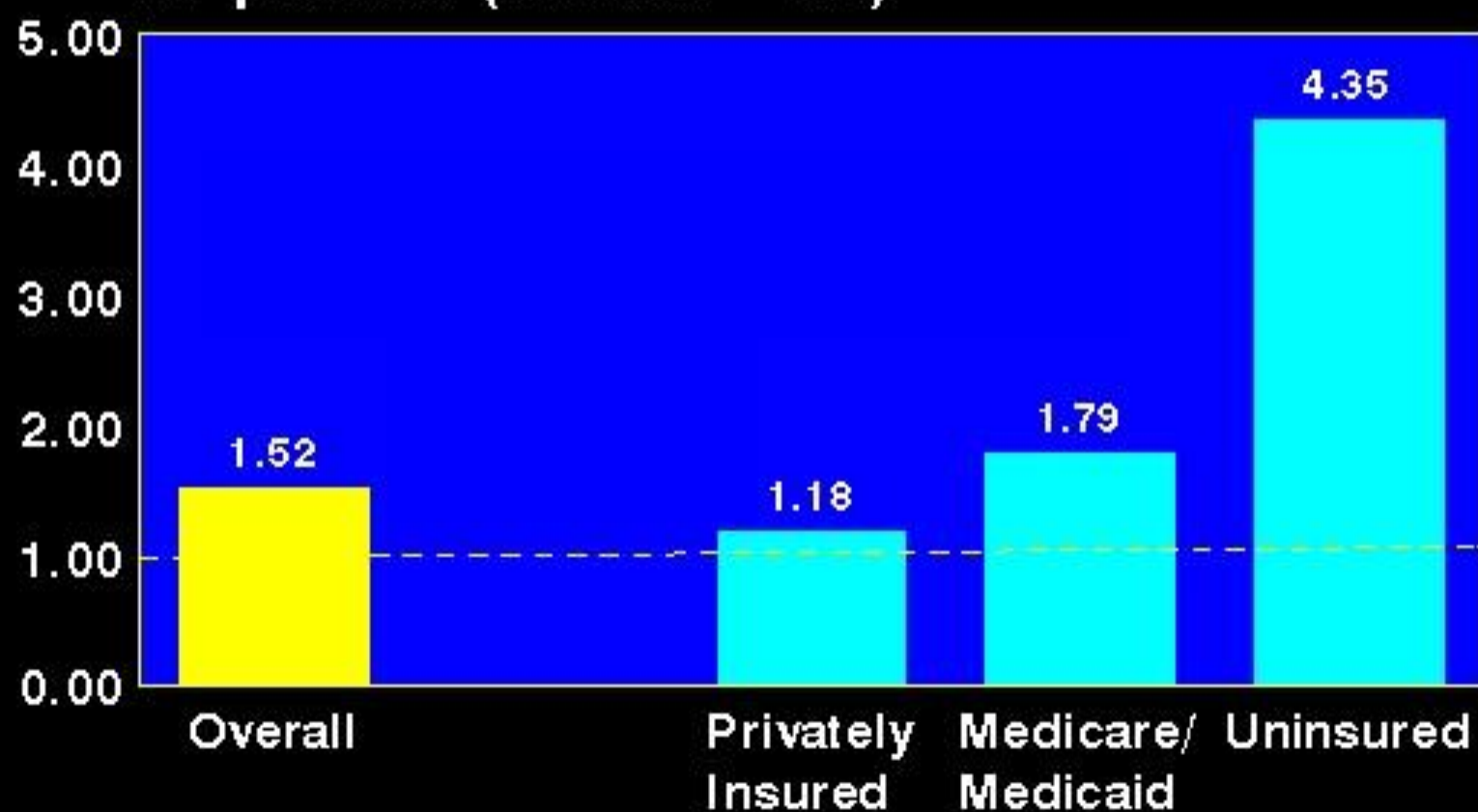
	High-quality studies	Low-quality studies
Results favoured United States	2	3
Results favoured Canada	5	9
Mixed or equivocal results	3	16

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

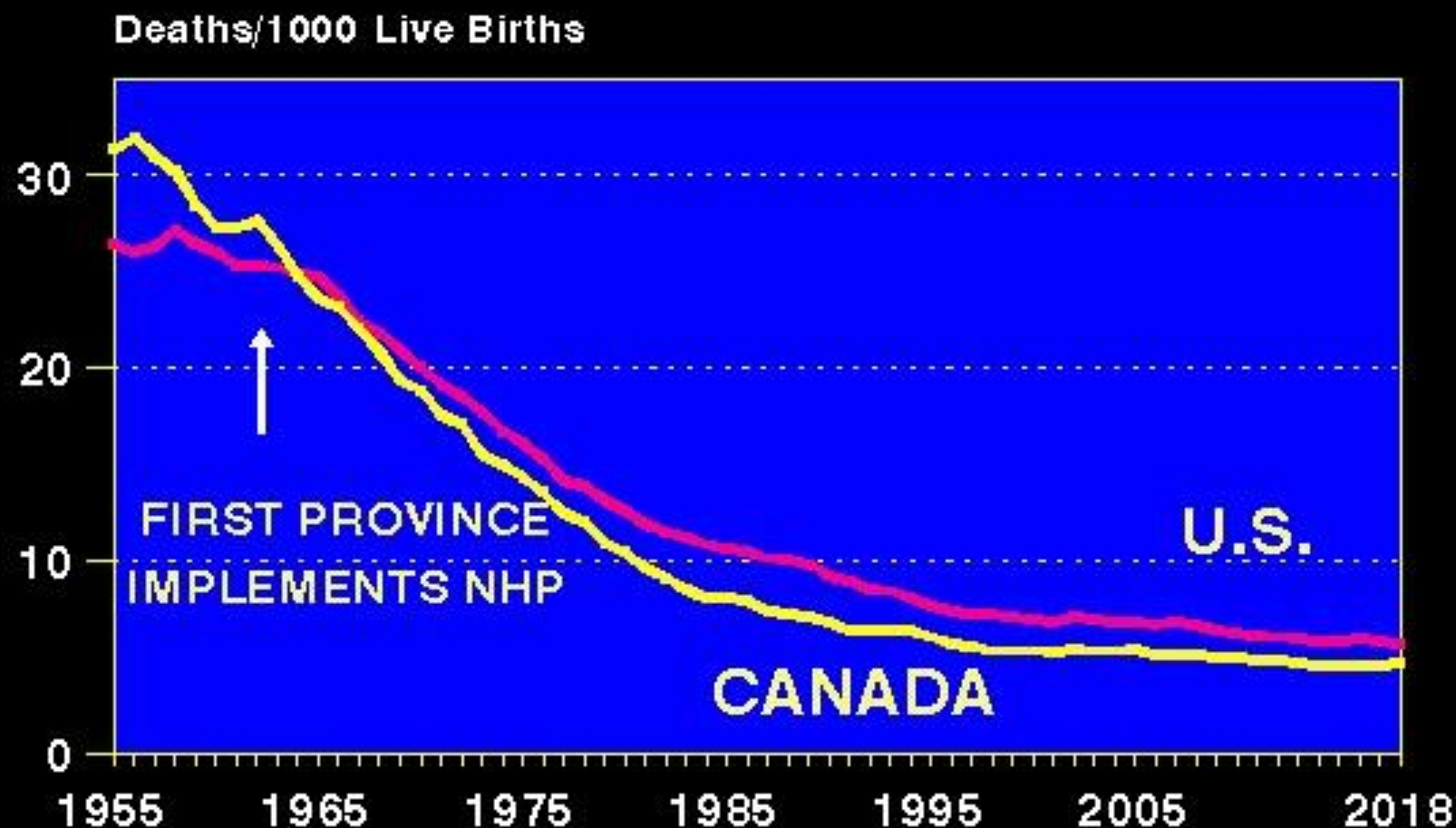
Hazard ratio for death, U.S. vs. Canadian  
CF patients (Canada = 1.0)



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

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

# Infant Mortality U.S. & Canada, 1955-2018

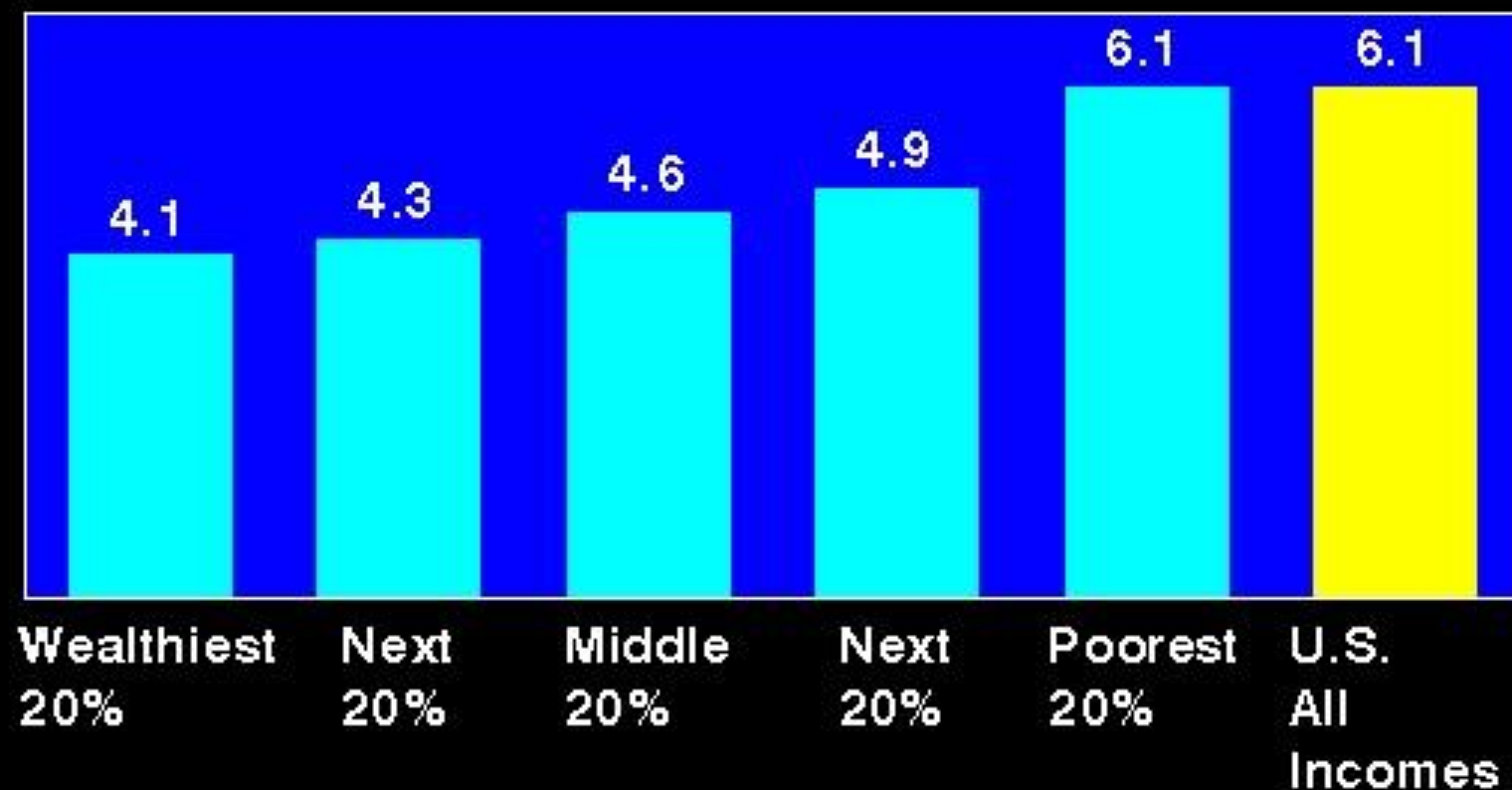




# Infant Deaths by Income, Canada 2011

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

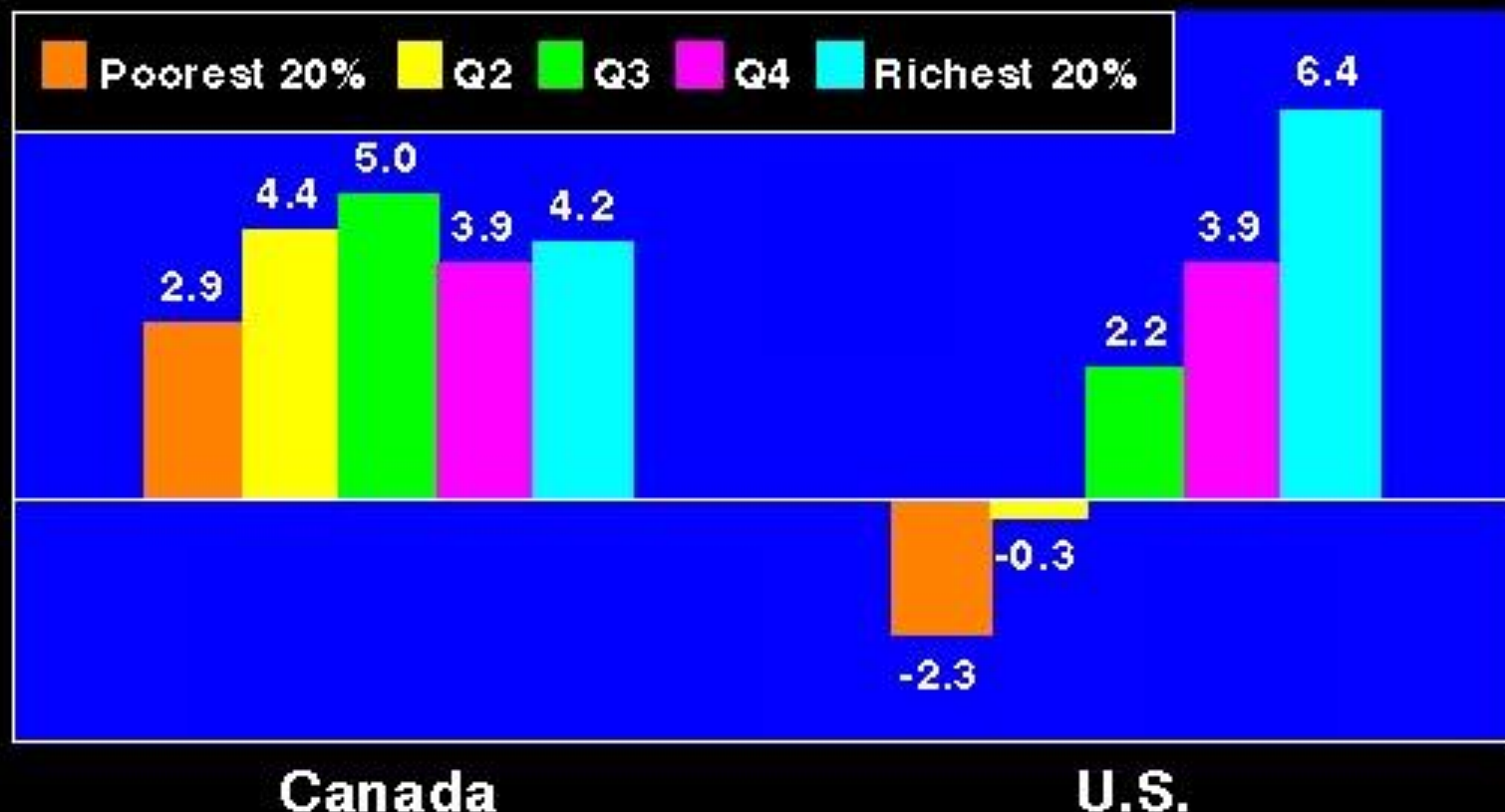
Infant mortality per thousand



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.



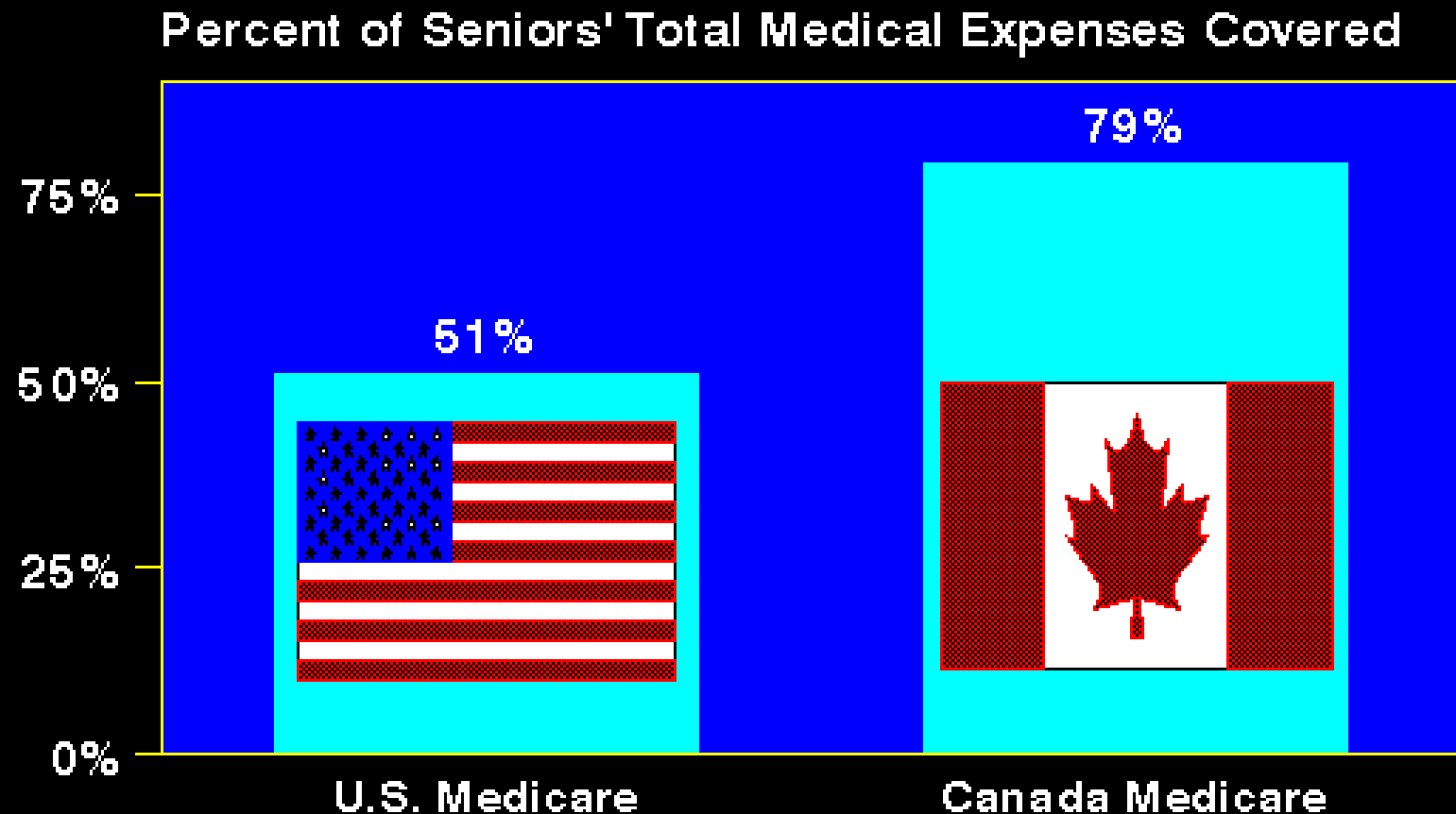
Source: Growing Gap in Life Expectancy by Income, NAS; Rich Man Poor Man, CD Howe Institute

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

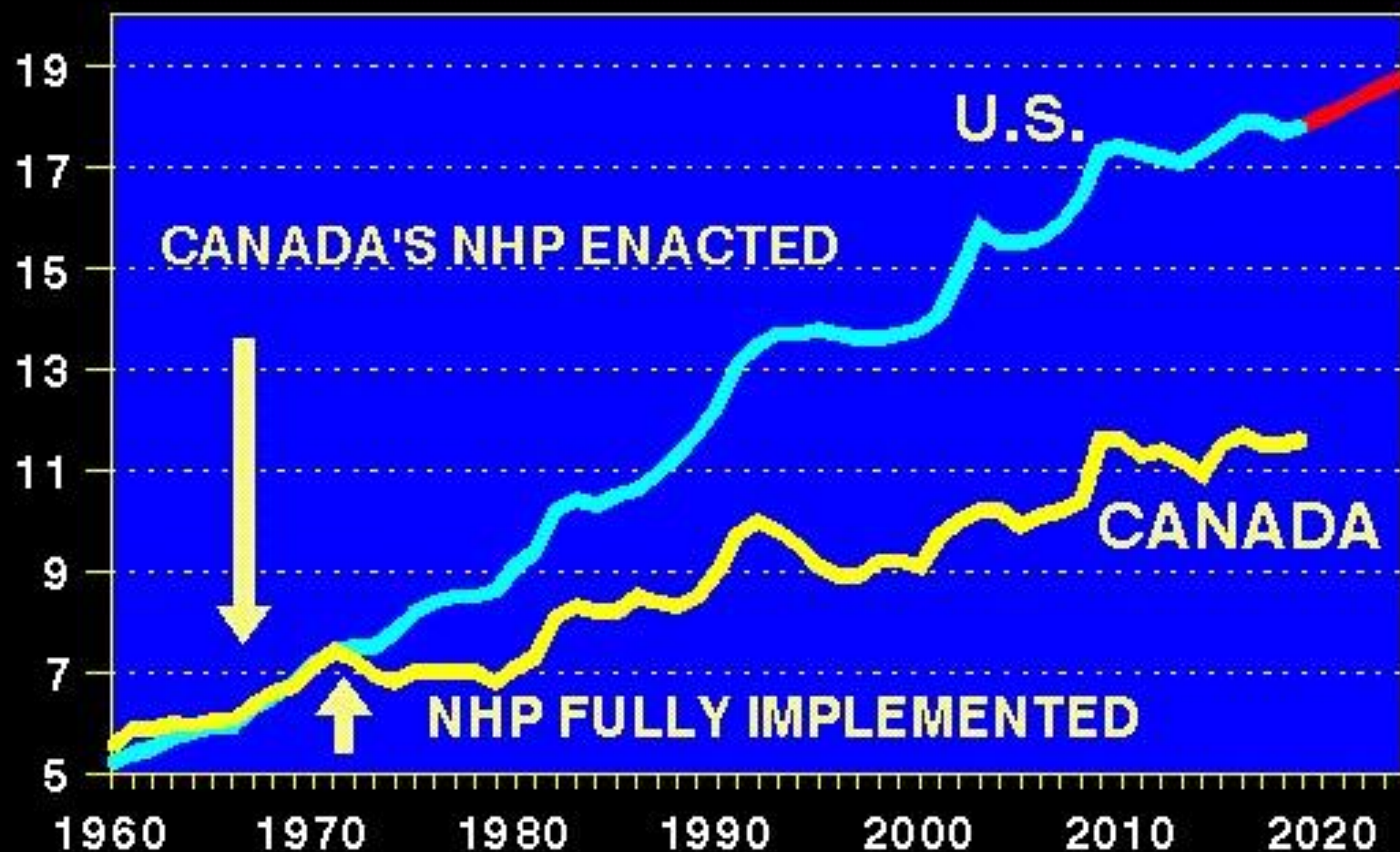
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Source: EBRI and Himmelstein/Woolhandler analysis of Health Canada data

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

# Health Costs as % of GDP: U.S. & Canada, 1960-2024



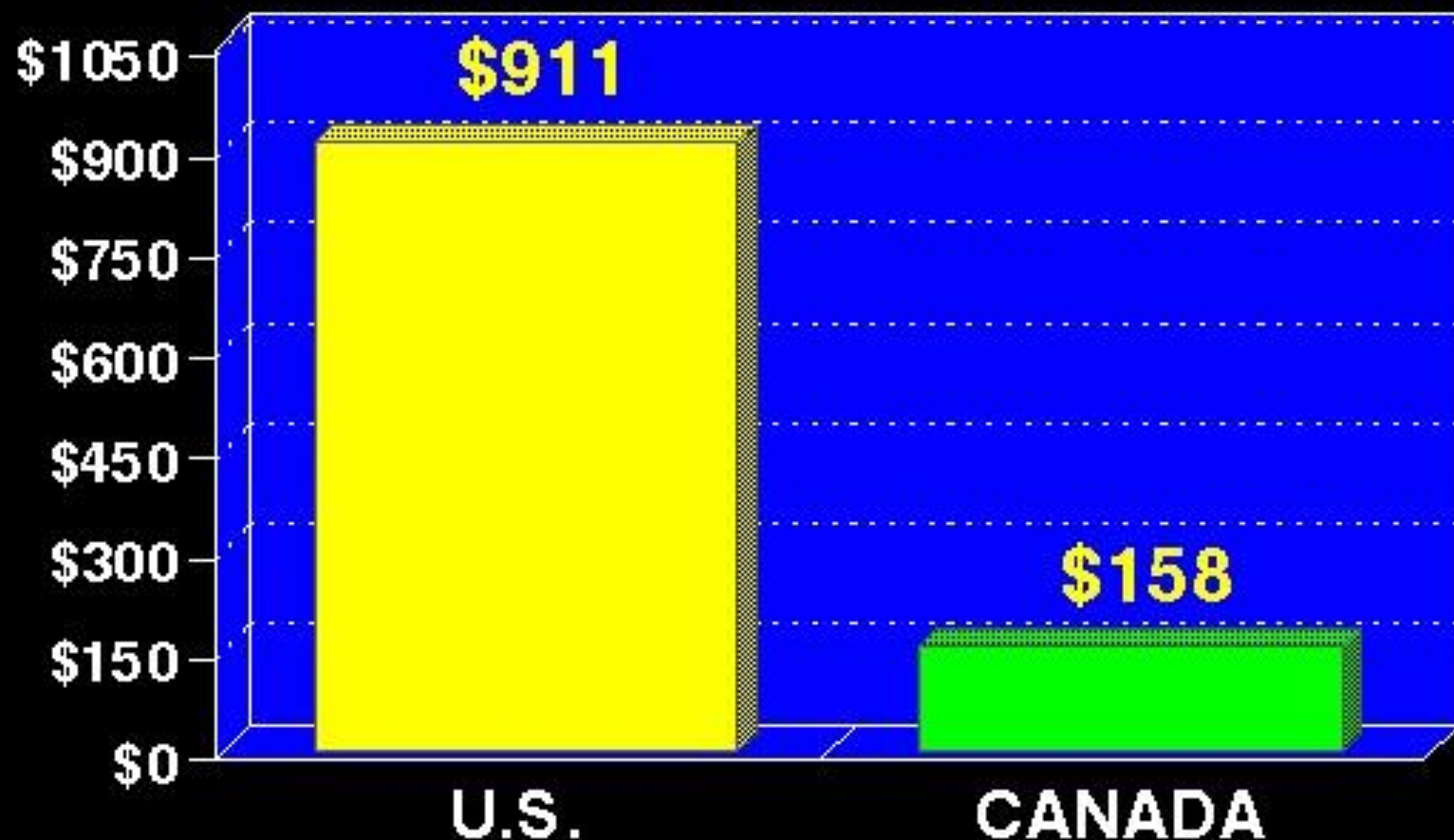
# How Canada Controls Costs

- 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, 2019

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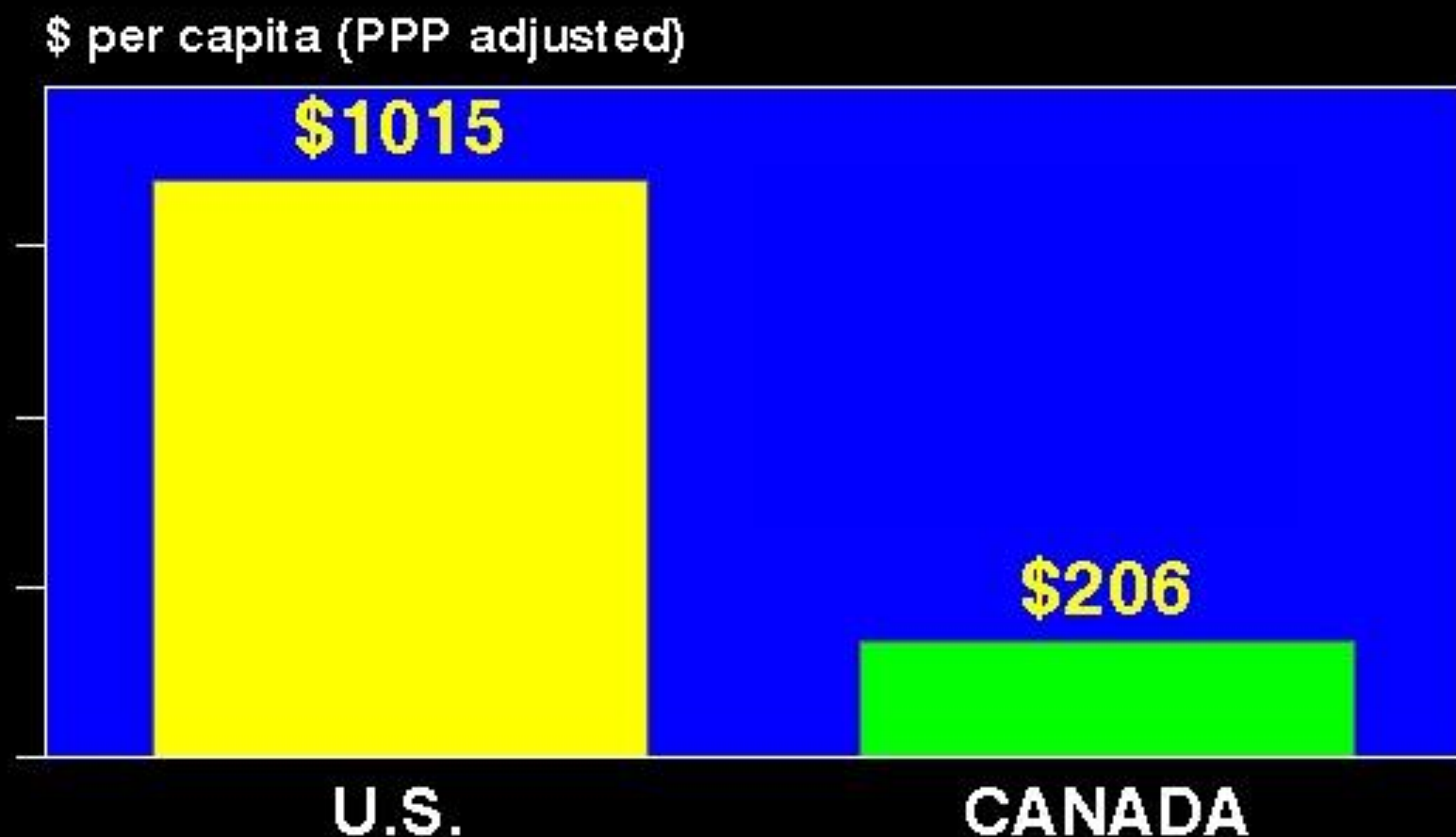


Source: NCHS and CIHI (projected)



# Hospital Billing & Administration United States & Canada, 2019

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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

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# Cleveland Clinic: 210 Million Prices

“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, 2019

---



**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.



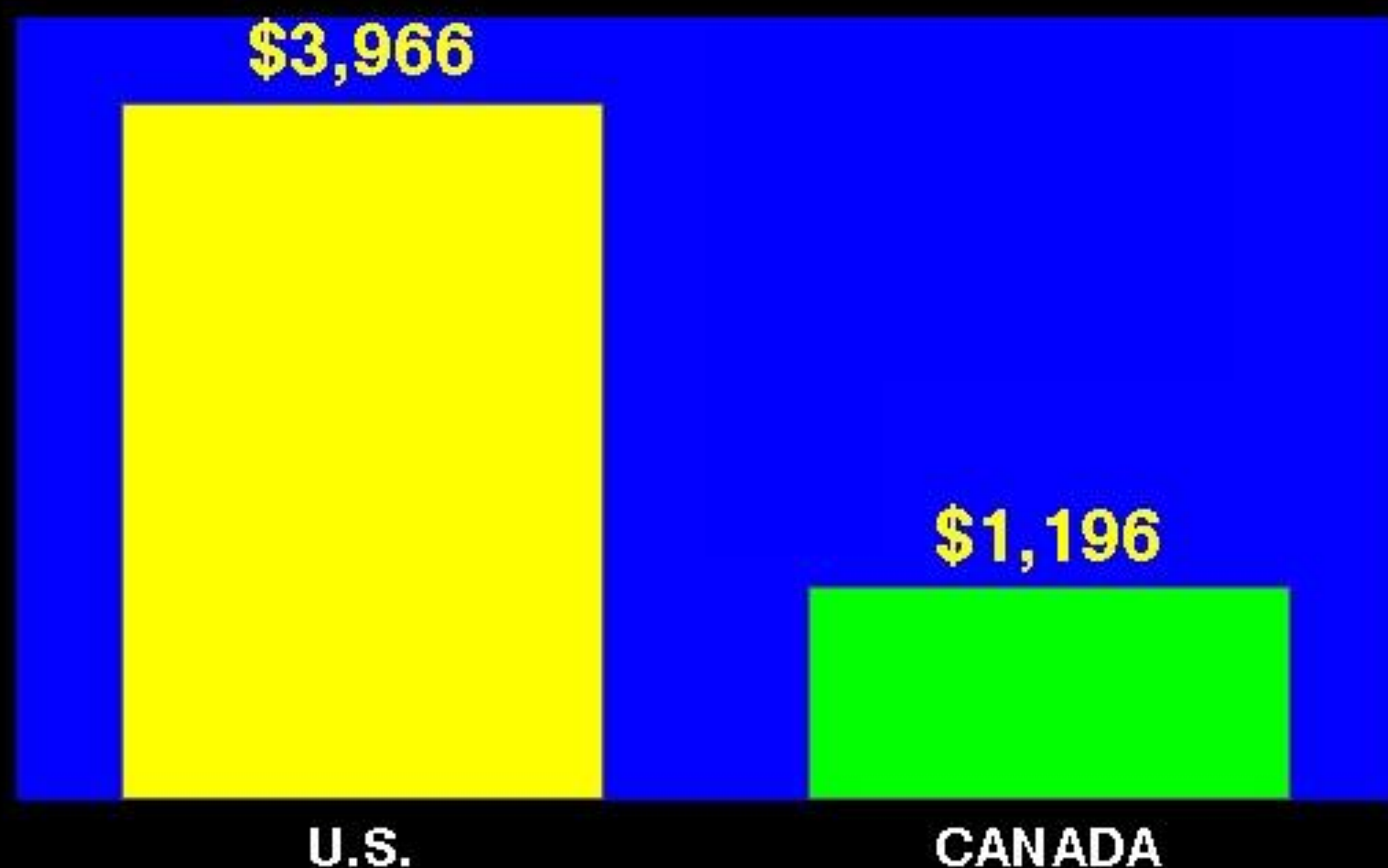


• Duke's costs to send  
bills for one PCP:  
\$99,000 annually

*Source: JAMA 2018;319:691*

# Overall Administrative Costs Per Capita United States & Canada, 2019

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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, 2017/2018

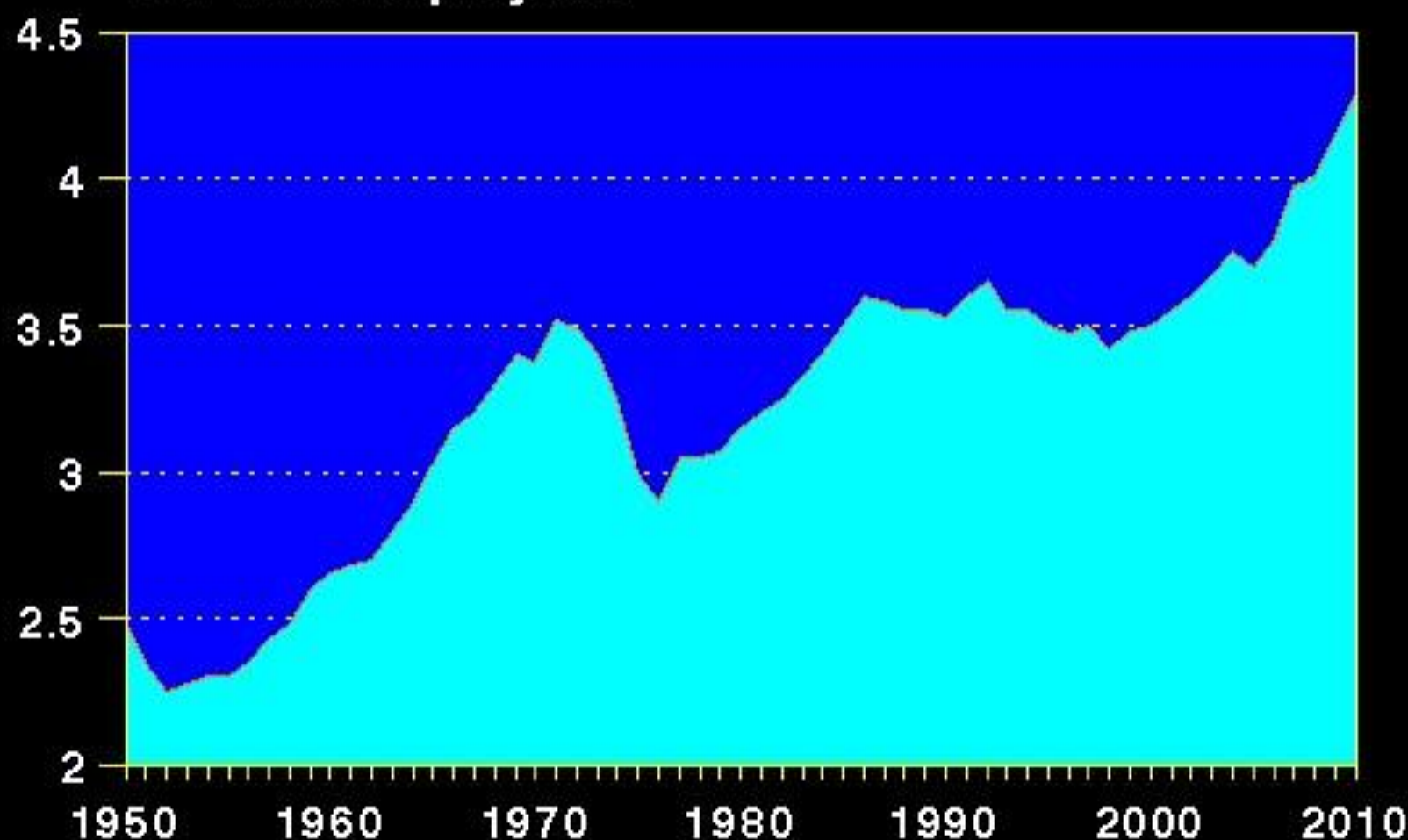
## Average Clinical Payments Per Physician

Family Medicine	\$280,763
Int. Medicine	\$403,942
Pediatrics	\$298,814
Psychiatry	\$278,069
Dermatology	\$384,786
Ob/GYN	\$391,743
General Surg.	\$452,283
Thoracic Surg.	\$599,910
Ophthalmology	\$768,958
All Physicians	\$344,978

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

# Trend In Canadian Physicians' Incomes, 1950-2010

**Mean Physician Income As Multiple All Canadian Full Time Employees**





# Malpractice Insurance Costs in Canada, 2019

All Figures in Canadian \$s

Specialty	Ontario*	Quebec	BC & Alberta
Family Med	\$4,908	\$1,583	\$3,420
Psychiatry	\$4,908	\$1,583	\$3,420
Cardiology	\$8,448	\$2,248	\$5,028
Anesthesia	\$12,948	\$3,139	\$8,472
Neurosurgery	\$38,980	\$7,312	\$26,424
Obstetrics	\$73,924	\$18,050	\$48,588

Source: Canadian Medical Protective Association - [www.cmpa-acpm.ca](http://www.cmpa-acpm.ca)

\* Government reimburses MDs for premiums above 1986 level





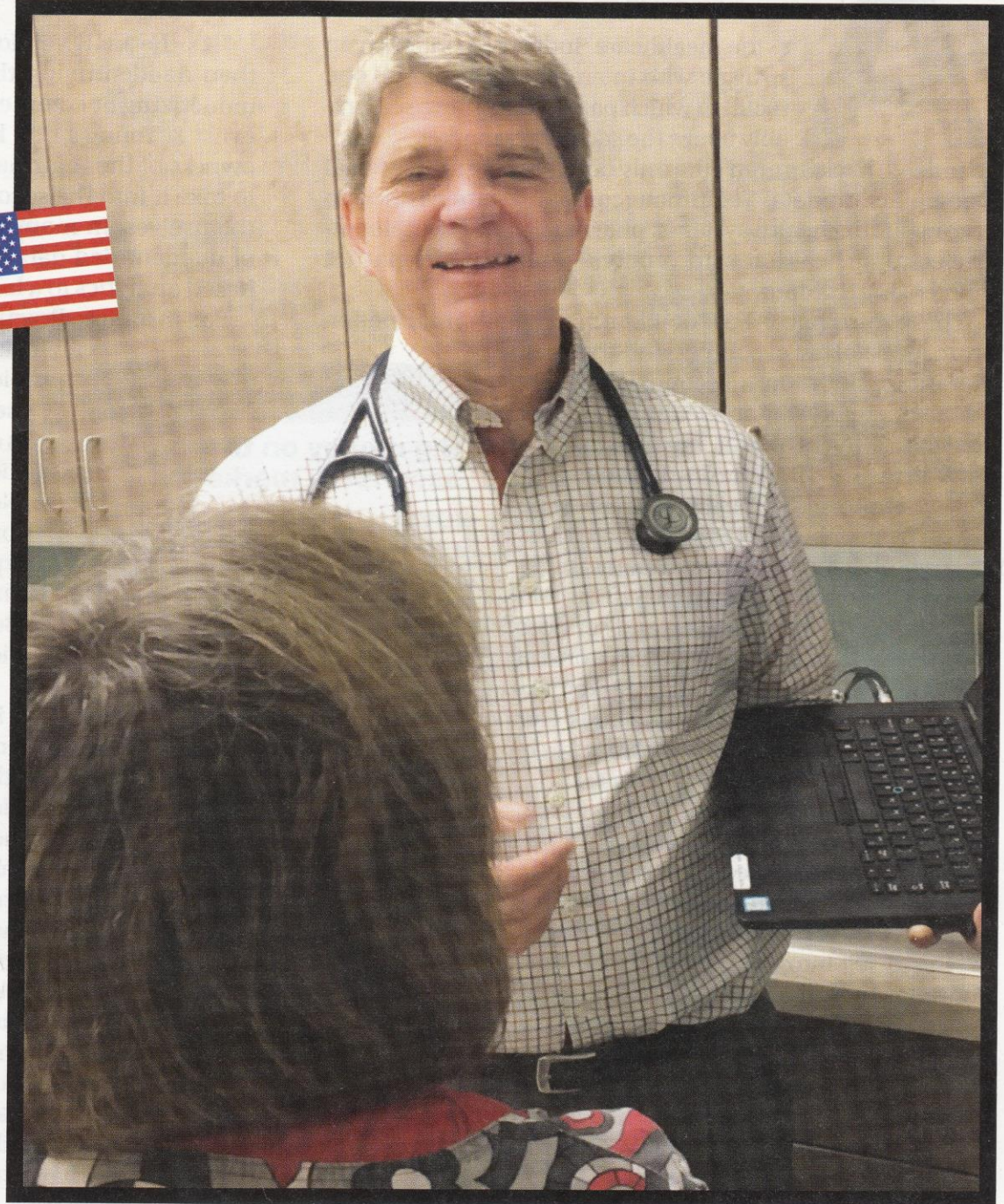
**“It’s not a big hassle. I can focus on patient issues, not administrative issues.”**

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?

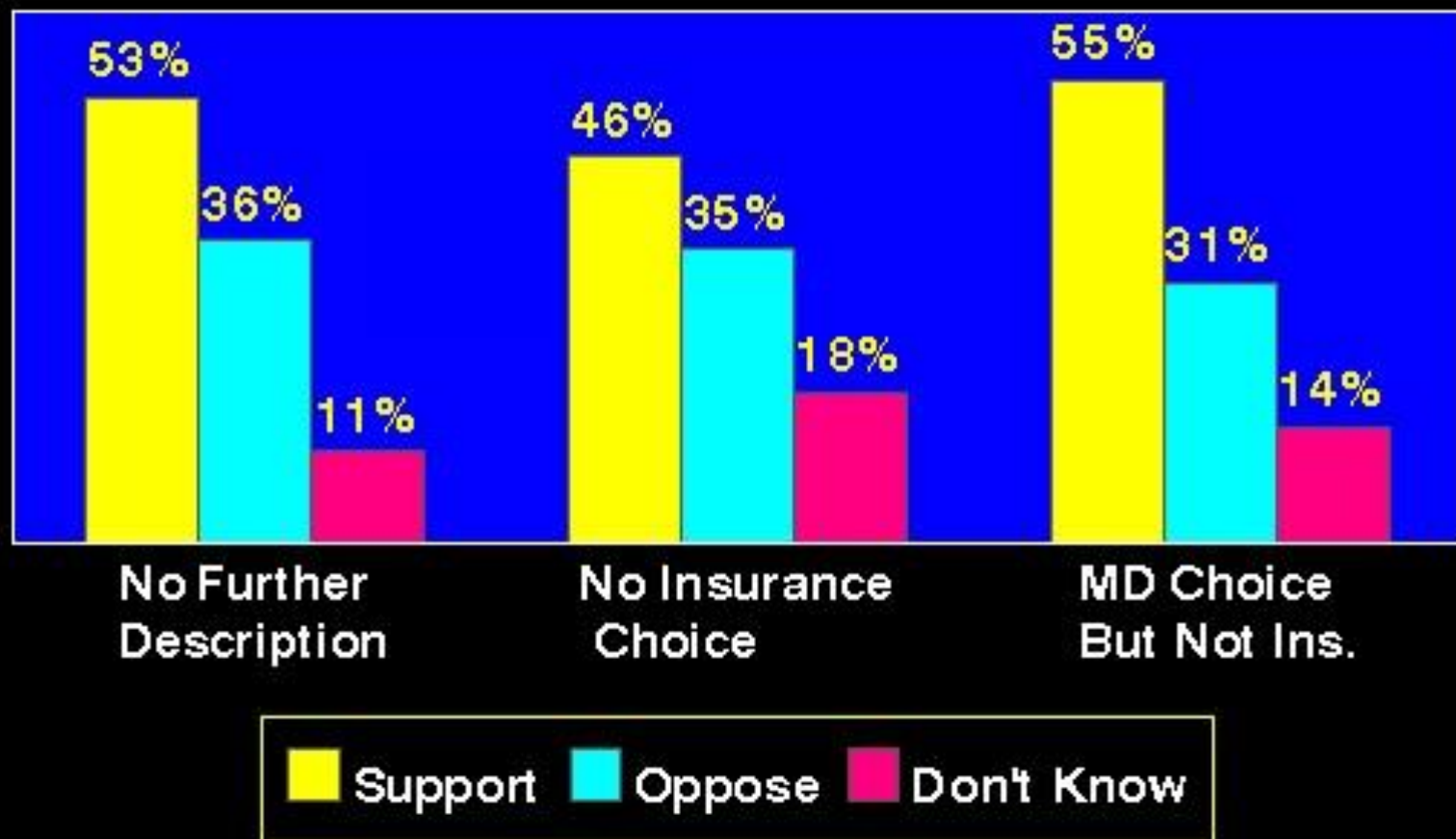
- The wealthy lobby for private funding and tax cuts; they resent subsidizing care for others
- Result: government funding cuts (e.g. 30% of hospital beds closed during 90s) causing dissatisfaction and waits for care
- U.S. and Canadian firms seek profit opportunities in health care privatization
- Conservative 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 . . .

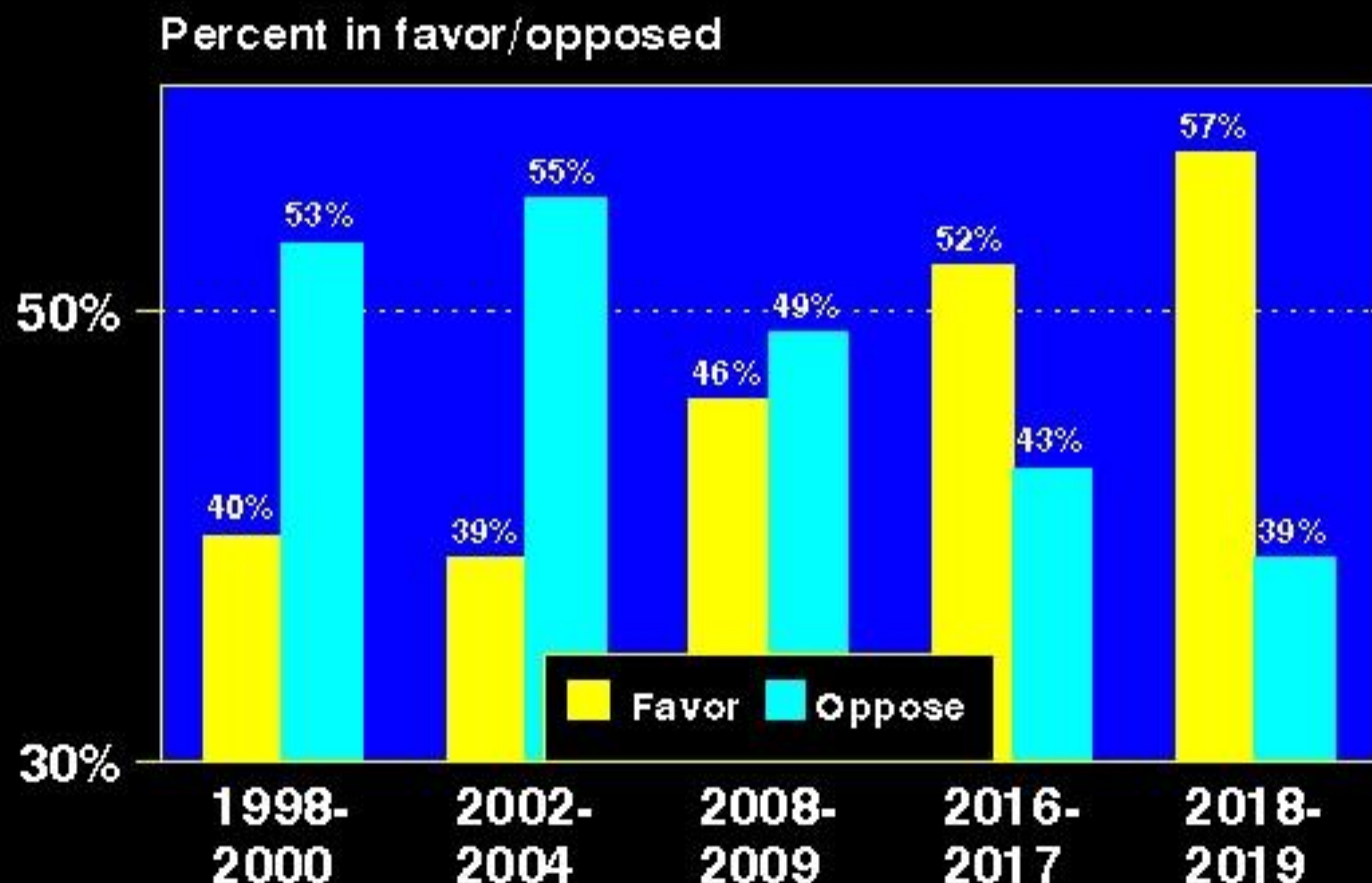


Source: Morning Consult July, 2019

Note: Question asked about choice of doctor AND hospital

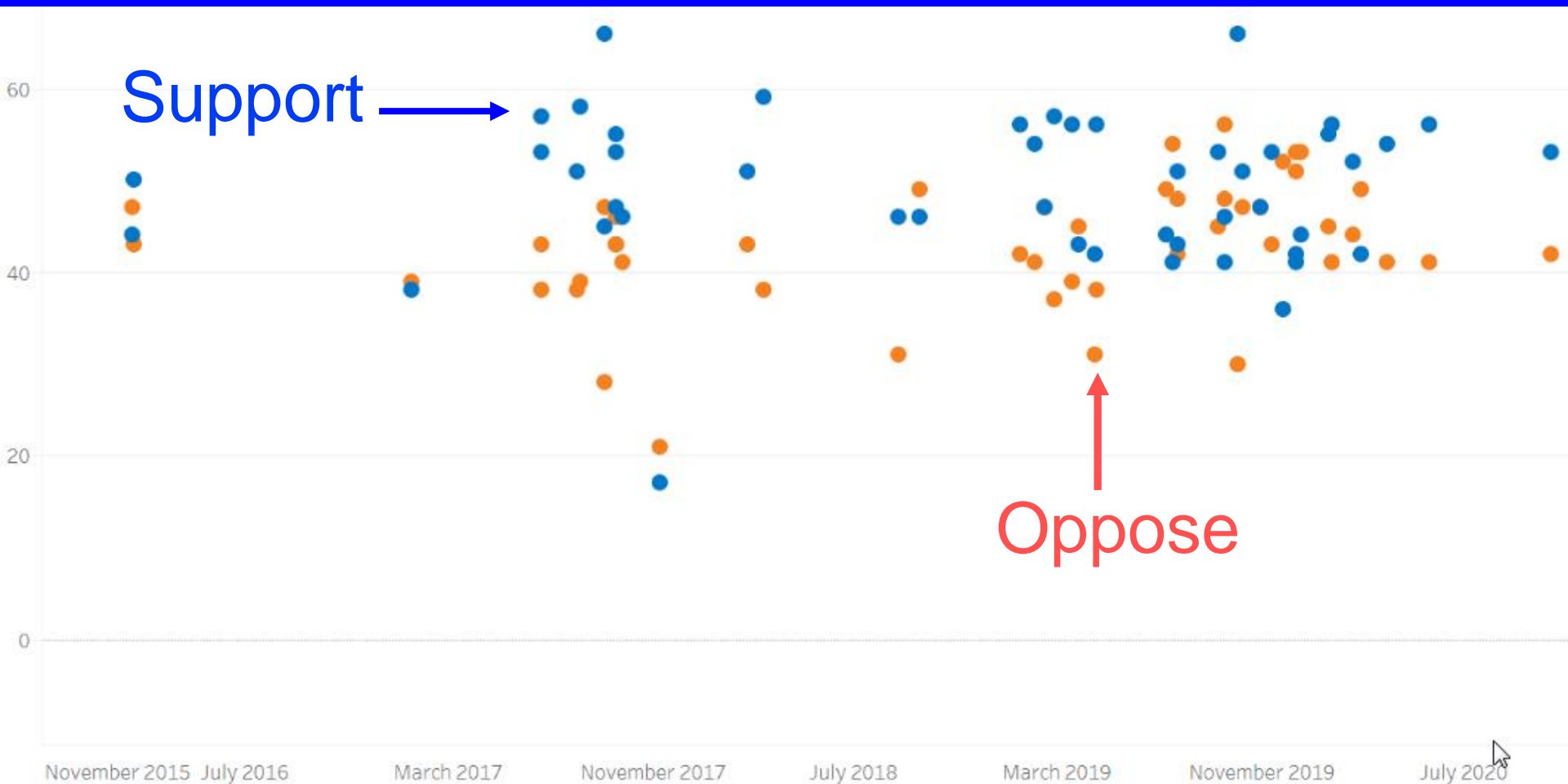
# Increasing Support for Single Payer

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



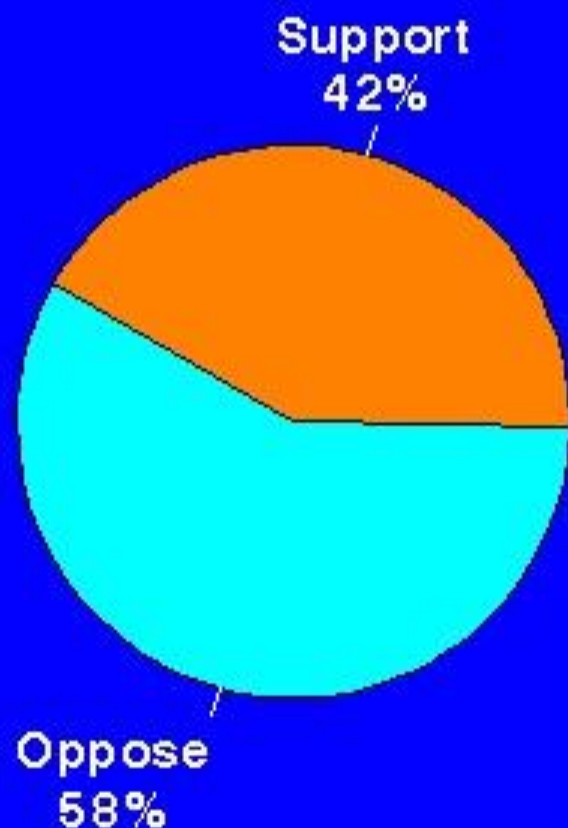
Source: Kaiser Family Foundation Polls

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

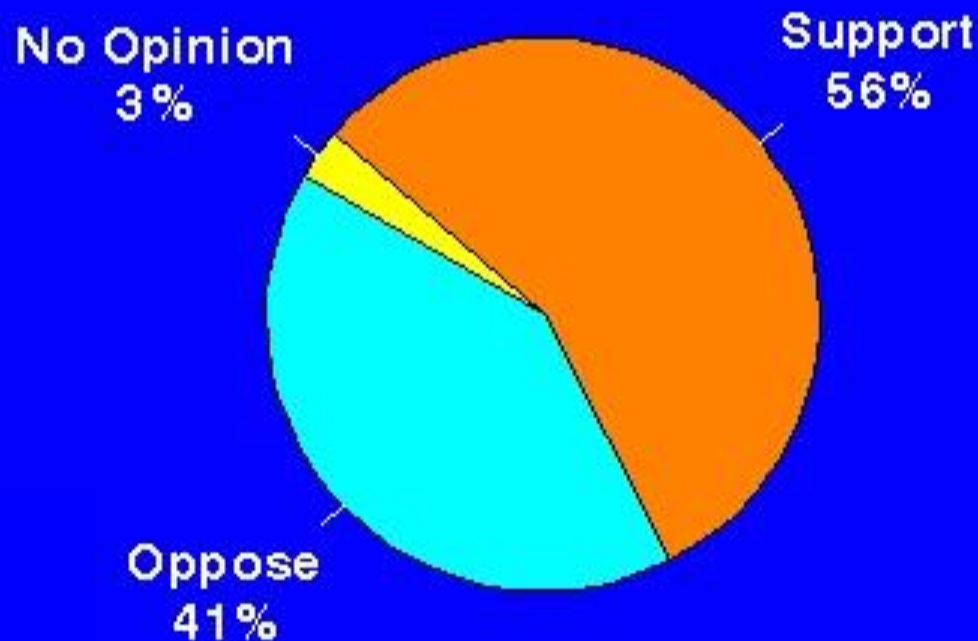


# Most Doctors Favor Single Payer

## 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 →

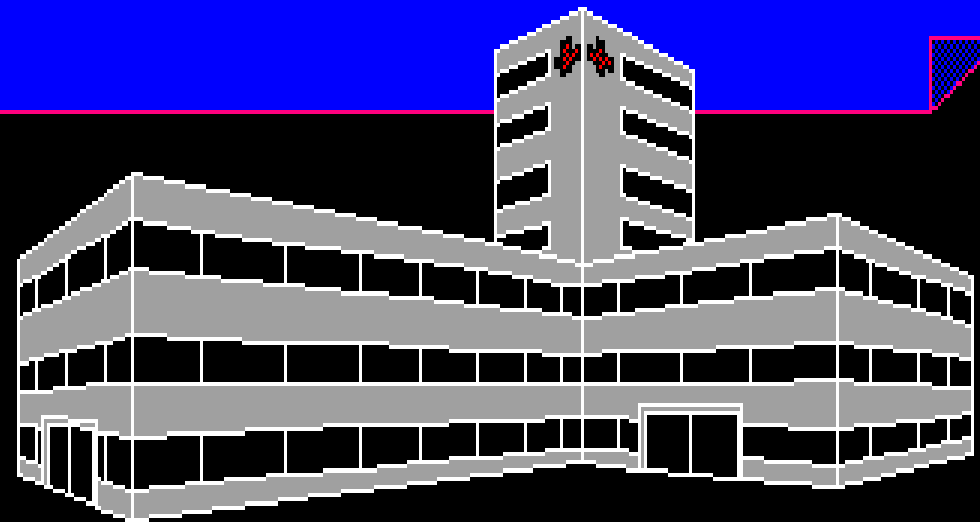
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## RECIPIENTS OF MONEY

→ 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

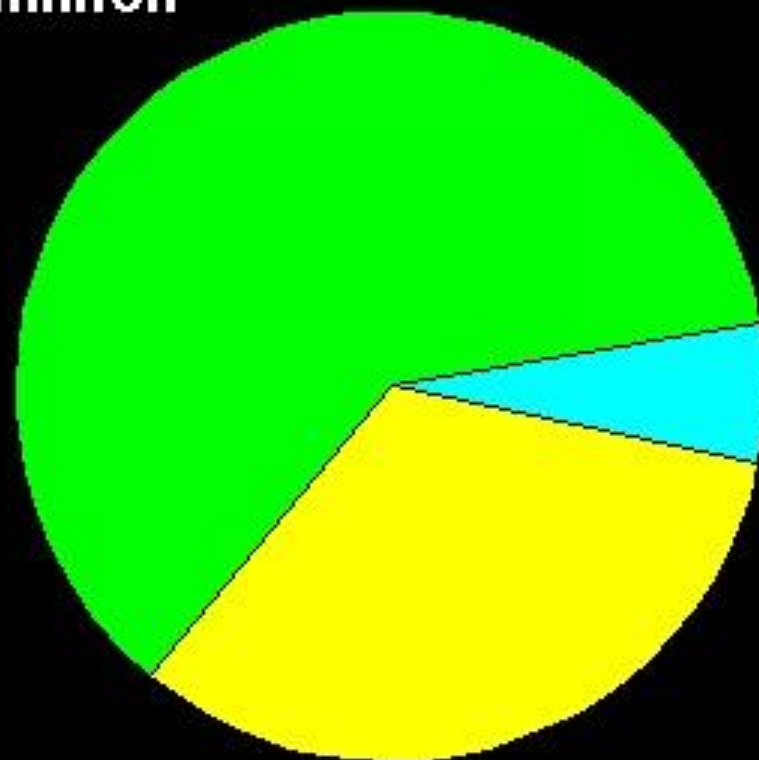
- All 400,000 health insurance workers and about ½ of the 2.6 mil. clerical/administrative employees in healthcare providers likely to be displaced – total 1.7 million.
- Many likely to be redeployed in expanded clinical workforce.
- Funding for income support and job retraining modeled on WWII GI Bill.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

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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

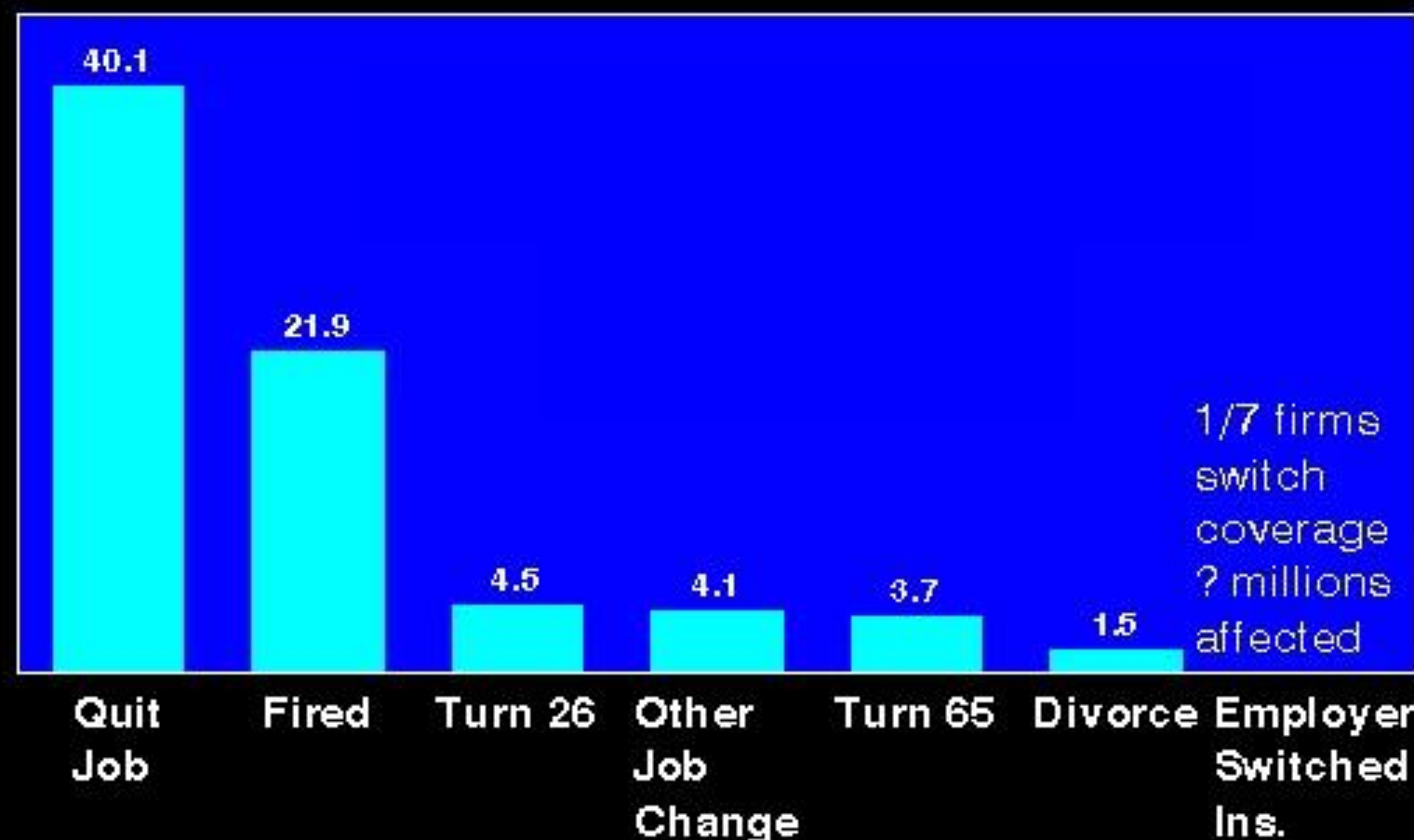
- **Allowed:** Supplemental non-competing – but can only cover benefits NOT covered by the public plan.
- **Banned:** Private insurance (including Medicare Advantage) duplicating public plan benefits – Key to administrative savings.

# 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 2<sup>nd</sup> 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

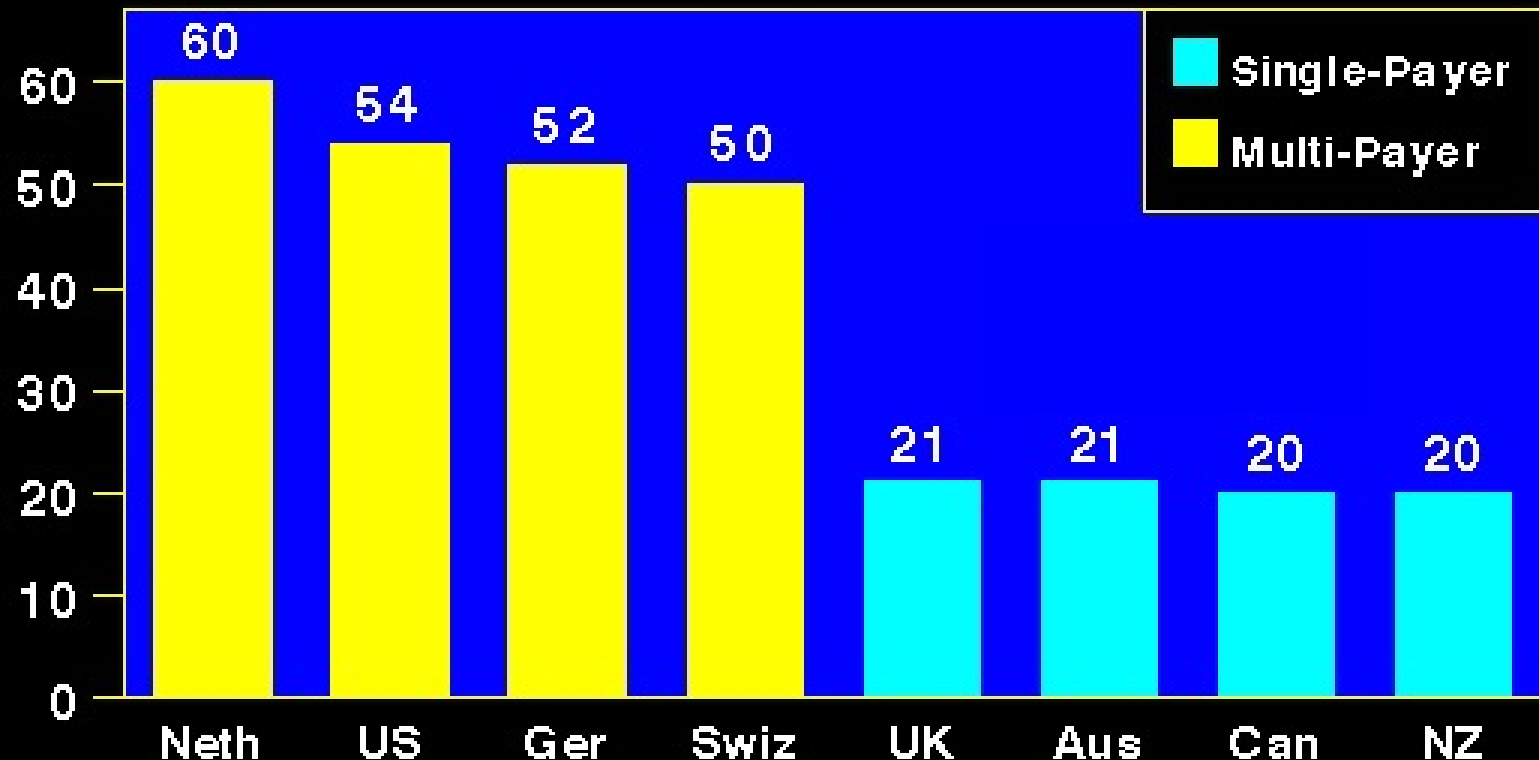
“Insurers in the Netherlands and Switzerland are not as a matter of public policy conceived of as private businesses and in important respects they are not allowed to function as private businesses. The Dutch and Swiss models--built on a uniform mandated benefit package, a limited menu of cost sharing, 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

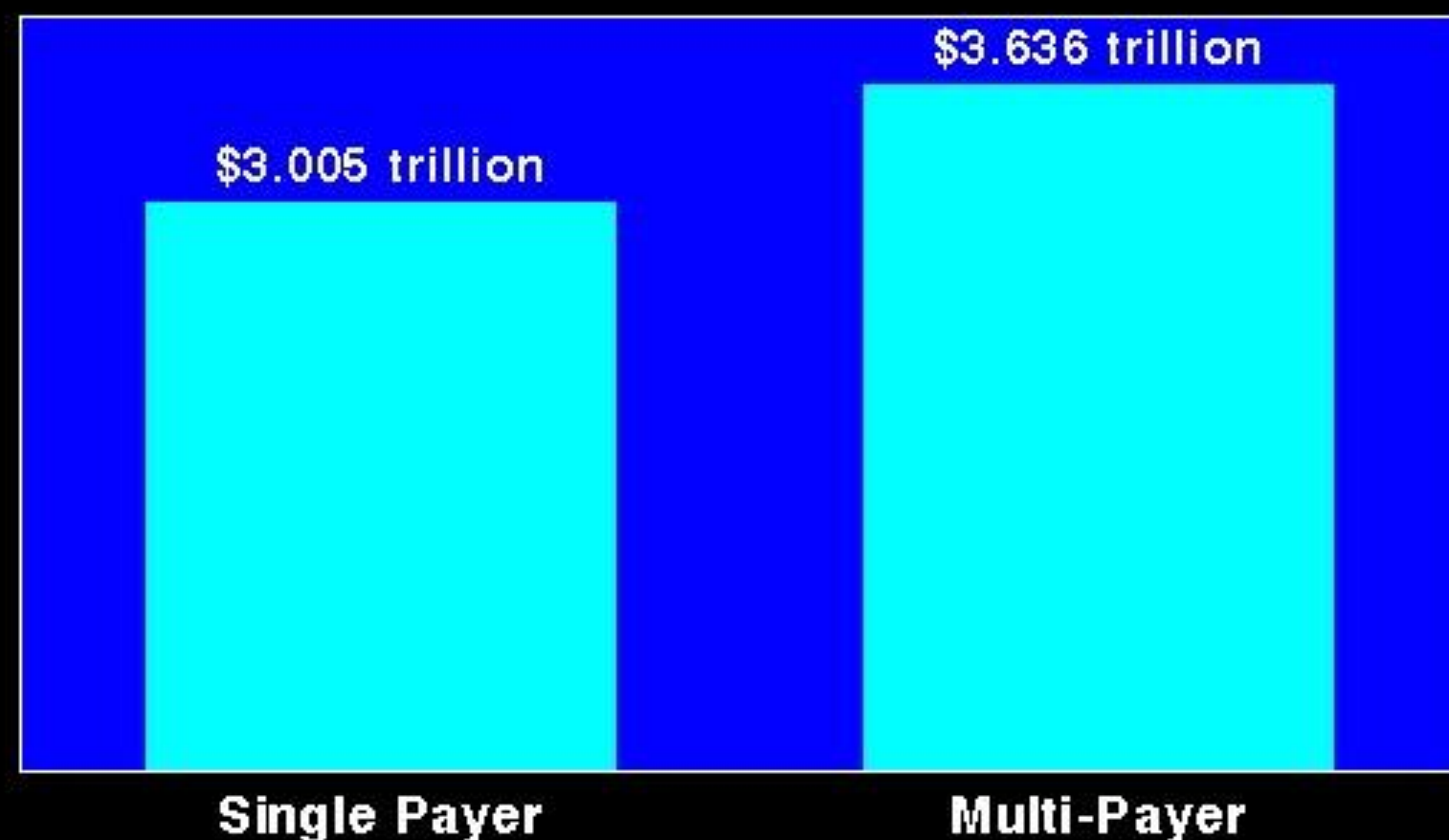
- Less savings than single payer on insurers' overhead
- Multiple payers = no savings on doctor/hospital billing and administration.
- Private insurers will tilt the playing field (as under Medicare Advantage) raising system-wide costs and perpetuating network restrictions, cherry-picking, lemon dropping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

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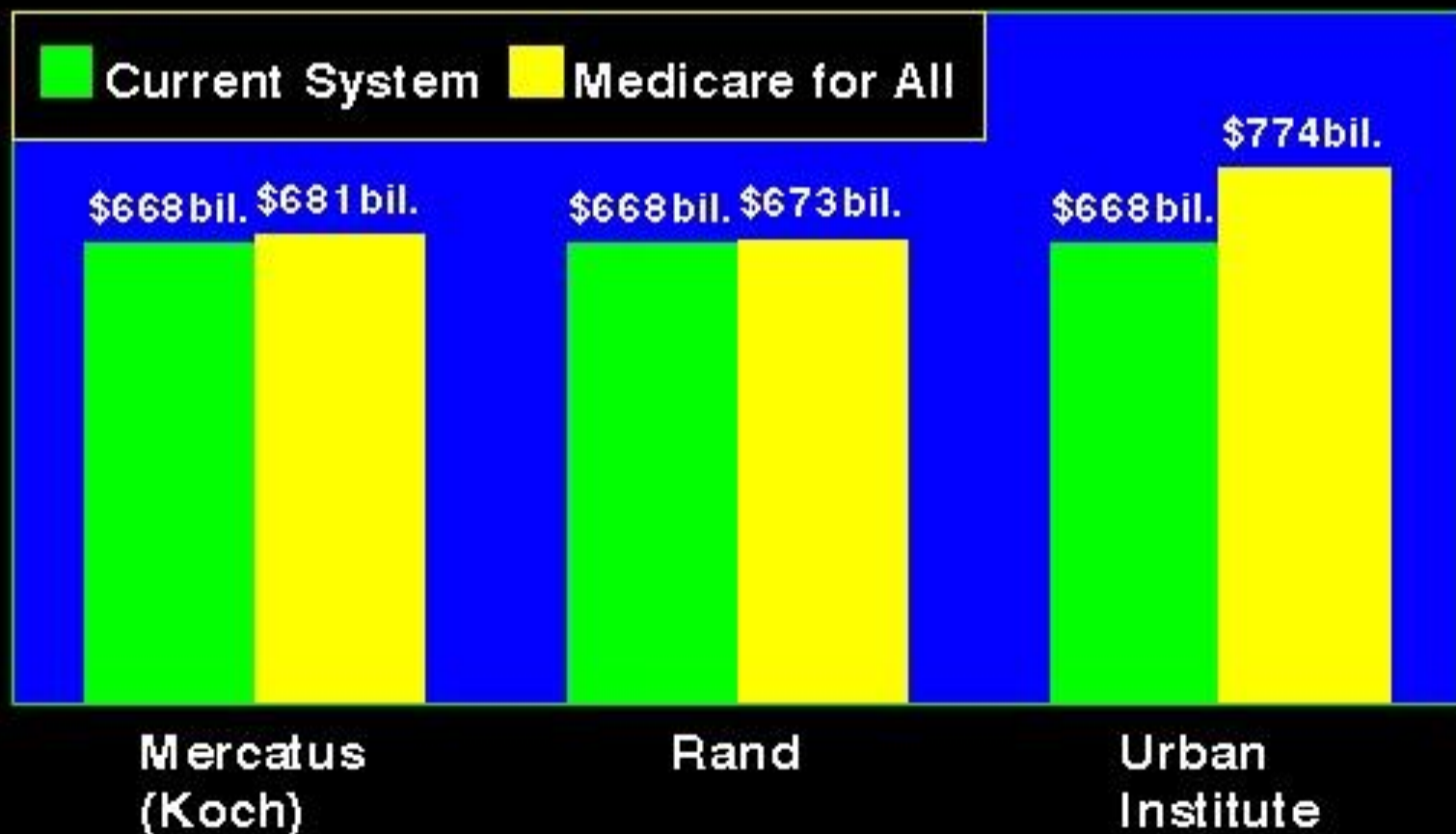
Total health expenditures/year



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)

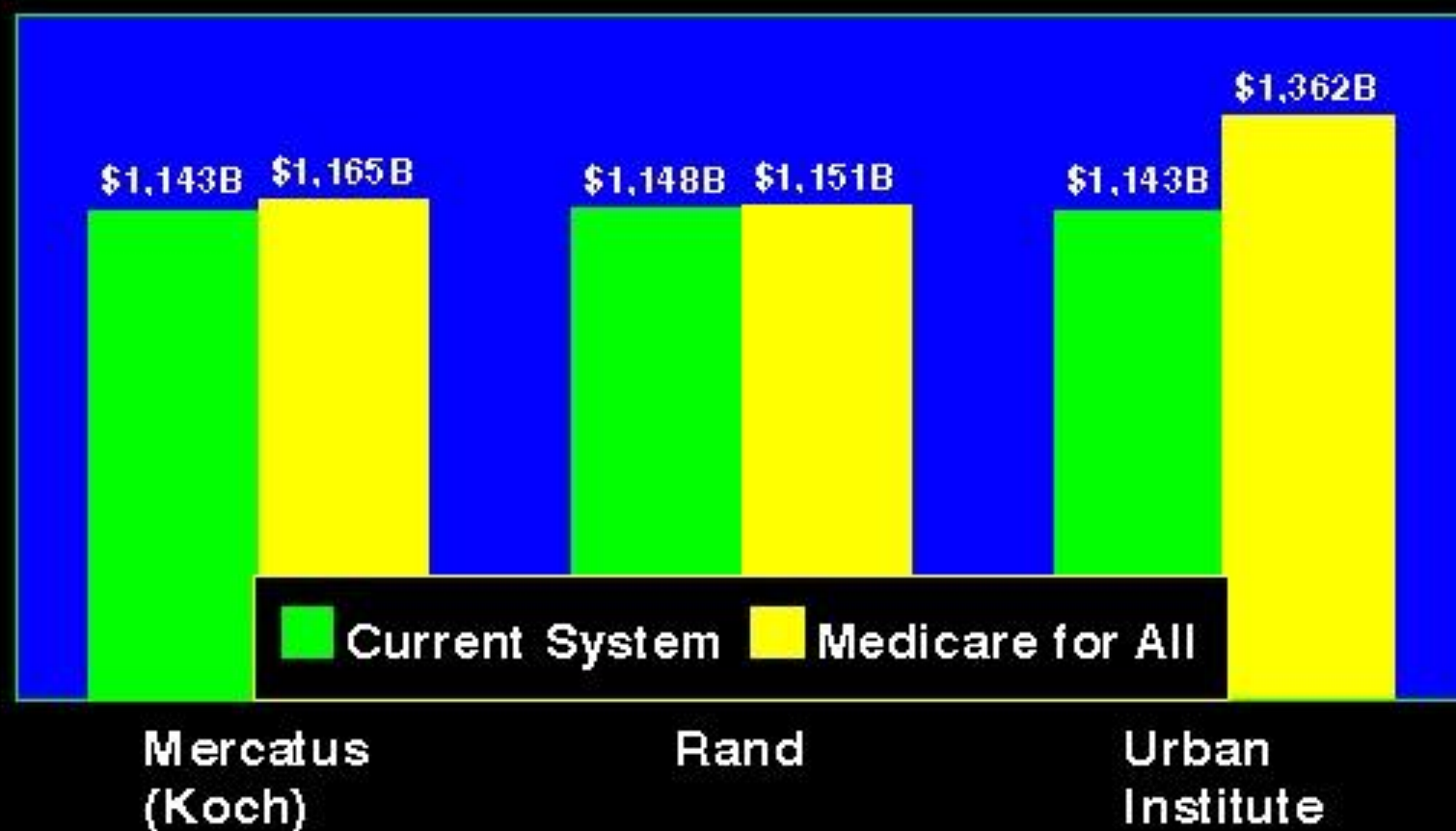
Note: Percentage estimates from original studies, applied to 2019 total physician expenditures

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

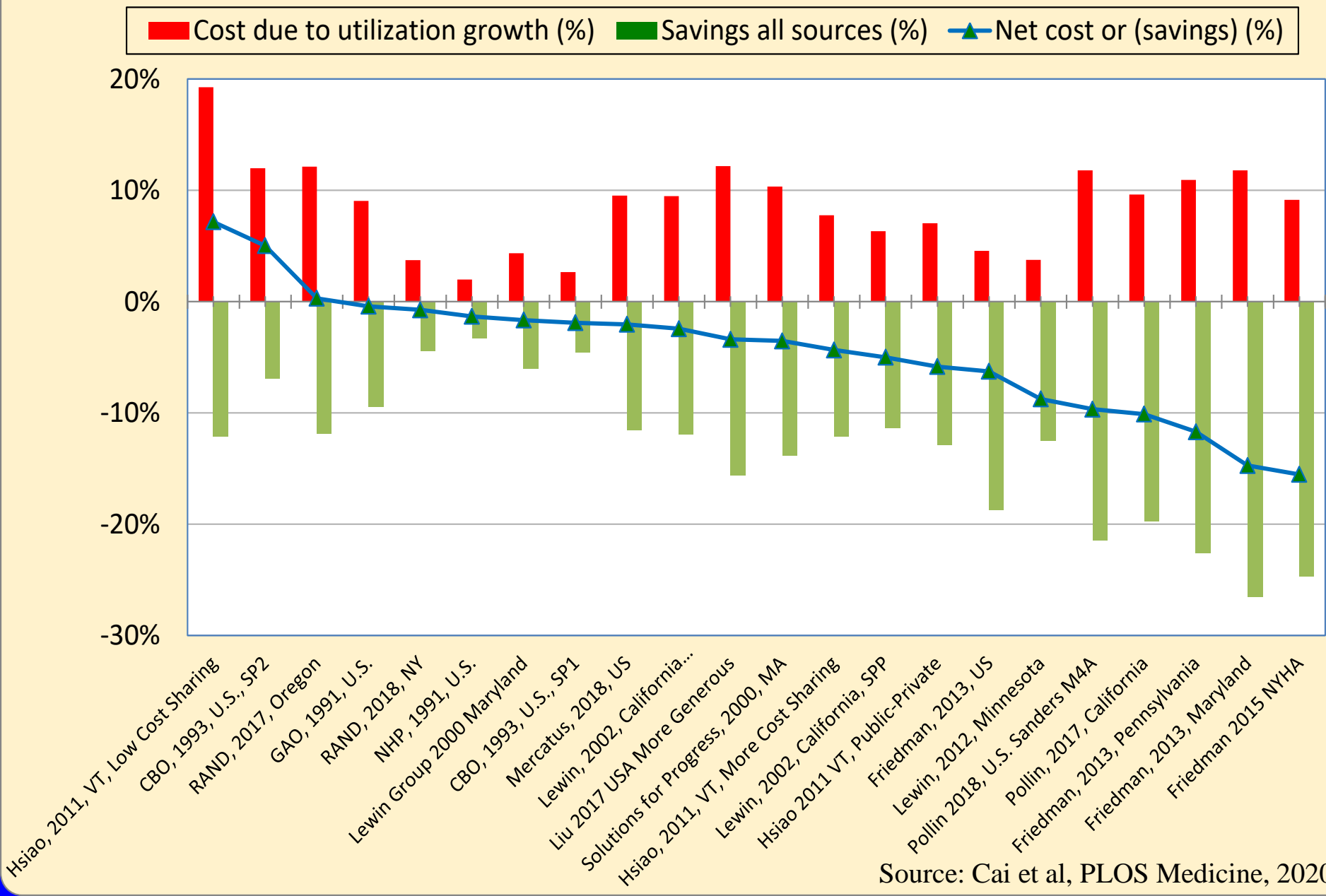


Sources: Rand Corporation (2019), Urban Institute (2016), Mercatus Center (2018)

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*