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

Source: J. Bor based on OECD 2020
Progress on Mortality Halted

Age adjusted mortality/100,000

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
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

Note: public health's share in Canada = 6.2%
Public Health Workforce Declined 20% Frontline Personnel to Fight Epidemics

Number of personnel employed by state/local health departments

2008: 247k
2016: 197k

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

$ billions

Promised in ACA
Actual Funding


APHA fact sheet
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

Source: Saez and Zucman (Saez's website, 2020)
Tax Rate Has Fallen for the Super-Rich, Risen for Others

Taxes as share of income

<table>
<thead>
<tr>
<th>Income Percentile or Group</th>
<th>1950</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest 10%</td>
<td>16</td>
<td>26</td>
</tr>
<tr>
<td>50-60 Percentile</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>90-95 Percentile</td>
<td>23</td>
<td>29</td>
</tr>
<tr>
<td>99.99 - 99.9999</td>
<td>68</td>
<td>30</td>
</tr>
<tr>
<td>Richest 400</td>
<td>70</td>
<td>23</td>
</tr>
</tbody>
</table>

Source: Saez and Zucman (Saez's website, 2020)
Women Health Workers' Low Pay
1.7 Million of Them and Their Children Live in Poverty

Percent

<table>
<thead>
<tr>
<th>Category</th>
<th>Black</th>
<th>Latina</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below Poverty</td>
<td>10.6</td>
<td>8.8</td>
<td>2.8</td>
</tr>
<tr>
<td>&lt;200% Poverty</td>
<td>31.0</td>
<td>29.7</td>
<td>11.4</td>
</tr>
<tr>
<td>Uninsured</td>
<td>10.2</td>
<td>10.2</td>
<td>5.9</td>
</tr>
<tr>
<td>Medicaid Coverage</td>
<td>15.1</td>
<td>16.0</td>
<td>7.2</td>
</tr>
</tbody>
</table>

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

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

Difference between union and non-union facilities

- Deaths: -30%
- Infections: -42%
- N95 Masks Available: 14%

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.

Top 1% Income Share

U.S. 20.2%
Canada 13.6%
Switzerland 11.9%
U.K. 11.7%
France 10.8%
Japan 10.4%
Australia 9.1%
Denmark 8.6%
Sweden 8.3%
Netherlands 6.7%

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Before Taxes/Transfers</th>
<th>After Taxes/Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>37</td>
<td>8</td>
</tr>
<tr>
<td>Finland</td>
<td>34</td>
<td>6</td>
</tr>
<tr>
<td>Italy</td>
<td>34</td>
<td>14</td>
</tr>
<tr>
<td>Germany</td>
<td>33</td>
<td>10</td>
</tr>
<tr>
<td>U.K.</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>U.S.</td>
<td>27</td>
<td>18</td>
</tr>
<tr>
<td>Australia</td>
<td>25</td>
<td>12</td>
</tr>
<tr>
<td>Canada</td>
<td>25</td>
<td>12</td>
</tr>
</tbody>
</table>

Source: OECD Poverty Statistics, 2019
Prisoners in Pre-Trial Detention

Pre-trial detainees per 100,000 population

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.
Increasing Economic Inequality Harms Health
Many Live in Homes Unsuitable for Quarantine/Isolation
Too Many People, Too Few Bedrooms or Bathrooms

Percent unable to isolate/quarantine at home

Whites: 19.8%
Asians: 28.3%
Blacks: 31.8%
Native Americans: 33.2%
Hispanics: 46.2%

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

Percent of persons age 51-61 in 1992 still alive in 2014

Poorest Fifth: 52%
Second: 58%
Third: 62%
Fourth: 69%
Richest Fifth: 74%

Source: GAO - Income and Wealth Disparities Continue Through Old Age, August, 2019 (data from HRS)
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

Remaining life expectancy at age 50

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

- White Non-Hispanic: 6.4%
- Black: 11.0%
- Hispanic: 18.9%
- Native American: 19.9%
- Asian: 6.8%

Source: American Community Survey
Many Frontline Health Workers Are Uninsured

Percent uninsured, 2019

- Hospitals: 3.1%
- Nursing Homes: 11.5%
- Home Care: 14.9%

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

<table>
<thead>
<tr>
<th>State</th>
<th>% Uninsured</th>
<th>Excess Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>18.4</td>
<td>6,804</td>
</tr>
<tr>
<td>California</td>
<td>7.7</td>
<td>3,903</td>
</tr>
<tr>
<td>Florida</td>
<td>13.2</td>
<td>3,619</td>
</tr>
<tr>
<td>North Carolina</td>
<td>13.4</td>
<td>1,504</td>
</tr>
<tr>
<td>New York</td>
<td>5.2</td>
<td>1,309</td>
</tr>
<tr>
<td><strong>U.S.</strong></td>
<td><strong>9.2%</strong></td>
<td><strong>38,531</strong></td>
</tr>
</tbody>
</table>

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

Medicare Coverage Improves Cancer Detection and Outcomes
Diagnoses Rise, Deaths Fall at Age 65

Rate per 100,000 women/year

Cancer Diagnosed:
- Ages 63-64: 507
- Age 65: 557

Cancer Deaths:
- Ages 63-64: 200
- Age 65: 191

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

![Bar chart showing the percentage of clinics scheduling specialty physician appointments for children with private and public insurance across various specialties.]

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

Odds ratio for Medicaid vs. uninsured

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

Millions of Enrollees

2007: 29.5
2008: 32.4
2009: 35.2
2010: 38.3
2011: 40.6
2012: 43.9
2013: 45.5
2014: 54.9
2015: 61.5
2016: 63.4
2017: 64.4
2018: 64.6

Source: Sanofi Public Payer Digest, 2016 and 2020
Note: Medicaid payments to mgd. 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

U.S. - Total: $279.1 bil
California: $40 bil
New York: $34.8 bil
Texas: $22.3 bil
Pennsylvania: $15.9 bil
Florida: $15.8 bil
Ohio: $13.1 bil
Arizona: $10.2 bil

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

- Won't Take New Plan Pt: 8%
- Not Participating: 43%
- Offered Appt. > 2 Wks: 24%
- Offered Appt. < 2 Wks: 25%

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

Average Deductible for Covered Workers, Single Coverage ($s)

Source: Kaiser/HRET Survey of Employer-Sponsored Benefits
ACA Exchange Plans' Deductibles
Higher Than Average Job-Based Plan

Average deductible

$6.506
$4.544
$1.644

Single Coverage

- 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

Percent with ANY out of network benefit

<table>
<thead>
<tr>
<th>Year</th>
<th>Individual Plans</th>
<th>Small Group Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>29%</td>
<td></td>
</tr>
</tbody>
</table>

Source: RWJF 10/4/2018
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

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?

- Medicaid: 42%
- Medicare: 18%
- Out of Pocket: 13%
- Other: 17%
- Private Ins.: 9%

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

Percent of adults 18-64

- Problem Paying Bills
  - Not High Deductible: 9.0%
  - High Deductible: 15.4%

- Delayed/Skipped Care
  - Not High Deductible: 4.1%
  - High Deductible: 8.5%

Source: Cohen & Zammitti, NCHS, June, 2017 - Based on 2016 NHIS data
Note: Of people with job-based coverage, 26.9% had HDHP in 2011, rising to 39.6% in 2016
Note: HDHP = ≥$1200/$2400 single/family deductible in 2011, $1300/$2600 in 2016
Many Families Lack Assets to Pay High Deductibles

Median Financial Assets (Thousands)

Bottom Fifth: $1.200  
20-40: $5.750  
40-60: $20.920  
60-80: $65.500  
80-90: $169.500  
Top 10%: $800.500

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

Preventive: -11.5%
Office Visit: -19.0%
Mental Health: -8.0%
ER: -27.0%
Inpatient: -15.0%
Drugs: -20.5%
Imaging: -22.0%

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

Statins: -9%
BP Meds: -8%
Diabetes Med: -7%

Source: Huckfeldt et al. NBER W20927 - 2/2015
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

- All Patients: 11% Other Coverage, 6% VA
- COPD: 20% Other Coverage, 6% VA
- Heart Disease: 14% Other Coverage, 6% VA
- Diabetes: 16% Other Coverage, 5% VA
- Cancer: 10% Other Coverage, 6% VA

Source: Gaffney, Bor, Himmelstein, Woolhandler & McCormick, Health Aff 2020; 39:33
RCT: Free Meds Improved Compliance and Outcomes

Difference: free meds vs. control group

- % Fully Compliant: 11.6
- Hgb A1c (%): -0.4
- Systolic BP (mm Hg): -7.2
- Diastolic BP (mm Hg): -2.0
- LDL Level (mg/dL): -2.3

Source: JAMA IM 2020;180:27
High Deductible Plans Delayed Breast Cancer Care

Extra delay (months) high vs. low deductible

Income Group: Low, Middle, High

- Biopsy: Low 2.7, Middle 2.2, High 1.9
- Early Stage Diagnosis: Low 6.6, Middle 7.0, High 5.4
- Start of Chemotherapy: Low 8.7, Middle 8.1, High 5.7

Source: Health Affairs 2019:38:408
Uninsured and Under-Insured Delay Seeking Care for Heart Attacks

Odds ratio for delayed care*

1.5
1.21

1.38

Insured
Under-Insured
Uninsured

Source: JAMA April 15, 2010:303:1392
*Adjusted for age, sex, race, clinical characteristics, health 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

Source: JAMA 2012;307:1284
200 Euro Copayment Cut Routine Psych Visits, Increased Crisis Care in Holland

Change in visit rates after copay added

-13.4% for Routine Psych Visits
25.1% for Emergency Psych Visits
96.8% for Involuntary Commitment

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

- Medical Bills Only: 22%
- Work Loss Only: 8%
- No Medical Cause: 33%

Bills + Work Loss: 36%


Work loss = "work loss due to illness"
Most of the Medically Bankrupt Had Coverage

Insurance at Illness Onset

- Private: 60%
- Uninsured: 22%
- Medicare: 10%
- Medicaid: 5%
- VA/Military: 2%

Medical Bills are Most Common Reason for Collection Calls

Percent of consumers receiving collection calls with specific type of debt

- Medical: 59%
- Telecom: 37%
- Utilities: 28%
- Taxes: 21%
- Legal/court: 14%
- Rent: 11%

Source: Consumer Financial Protection Bureau, January, 2017
Note: Medical collection calls were the only category which did not differ by income.
Health Costs Force Millions into Debt and to Forego Other Essentials

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

- Borrowed Money: 12%
- Groceries: 16%
- Clothing: 17%
- OTC Drugs: 11%
- Utilities: 8%
- Recreation: 19%

* 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

- Medicaid: $2,116
- VA: $2,367
- Private Group Ins.: $5,492
- Medicare + Medigap: $5,670
- Medicare HMO: $5,976
- Medicare Alone: $8,115

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

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

Source: Health Affairs 2017; 36:2123
Medicare Needs Improvement
For Many Seniors, Medical Costs Consume More Than 1/5th of Income

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

- <100: 38.7%
- 100-149: 41.0%
- 150-199: 40.4%
- 200-399: 22.4%
- 400+: 5.8%

Income Group (% of poverty)

Source: Commonwealth Fund May 12, 2017
Racism Harms Health
Black and Native Americans Die Younger
But Life Expectancy for Every Group is Shorter Than Other G7 Nations

Life expectancy, years

<table>
<thead>
<tr>
<th>Group</th>
<th>Life Expectancy, years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>81.8</td>
</tr>
<tr>
<td>White (non-Hisp)</td>
<td>78.5</td>
</tr>
<tr>
<td>Black</td>
<td>74.9</td>
</tr>
<tr>
<td>Native American*</td>
<td>73.0</td>
</tr>
</tbody>
</table>

Source: NCHS, IHS, OECD
Other G7 nations = Canada, France, Germany, Italy, Japan, UK
COVID-19 Has Sharply Reduced Black and Latinx Life Expectancy

Source: Andrasfay and Goldman MedRxiv preprint 9/15/2020
Causes of Black/White Disparity in Adult Mortality

- Heart Disease: 32%
- Cancer: 18%
- Homicide: 14%
- Stroke: 12%
- Septicemia: 7%
- Renal Disease: 11%
- Other*: 6%

* 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

Source: MMWR May 2, 2017
Uninsured and People of Color Have Worse Blood Pressure Control

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

Source: JAMA 2020;324:1190
Black- and Latinx-Serving Hospitals Have Less Funding for Buildings and Equipment

Value of buildings and equipment, $s per bed day

Existing Assets
- Mainly White: $8.325
- Latinx-Serving: $5.763
- Black-Serving: $5.197

New Purchases, 2013-17
- Mainly White: $3.092
- Latinx-Serving: $1.738
- Black-Serving: $1.242

Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020
Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts.
Black- and Latinx-Serving Hospitals Offer Fewer High Tech Services

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

Source: Gracie and Kathryn Himmelstein, Int J Health Services 2020
Black- and Latinx-serving = 10% of US hospitals with highest percent of Black/Latinx pts. Odds ratios are adjusted for size, location, teaching status and ownership.
Indian Health Service, Grossly Underfunded

Medical spending, 2017 per **user**

- Indian Health Service: $3.332
- Medicaid: $7.789
- VA: $8.759
- National Average: $9.207

Source: National Tribal Budget Formulation Workgroup, April, 2018
Note: Estimated spending shortfall, including facility upgrades = $36.83 billion
Poorer Regions, Fewer ICU Beds

Share of hospital service areas with NO ICU

Median Household Income of Service Area

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 Men More Often Followed a Black Doctor's Advise: An RCT
Even Though They Gave Black and White Doctors Same Ratings

Percent following prevention advise (or recommending the doctor)

- Diabetes Screening: 42% (White), 62% (Black)
- BP Check: 72% (White), 83% (Black)
- Cholesterol Test: 36% (White), 62% (Black)
- Flu Shot: 18% (White), 28% (Black)
- BMI Check: 60% (White), 76% (Black)
- Liked* Doctor: 99% (White), 99% (Black)

* 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

- U.S. Workforce Avg.: 16.1%
- Adv. Pract. RNs: 4.5%
- RNs: 5.7%
- Dentists: 6.1%
- MDs: 6.3%
- LPNs: 9.4%
- Aides: 13.7%
- Medical Assts.: 26.1%

Source: HRSA based on data from American Community Survey 2011-2015
Physician/Population Ratio by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Physicians/1000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, Non-Hispanic</td>
<td>2.64</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>0.89</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.01</td>
</tr>
</tbody>
</table>

Source: AMA and Census Bureau
Note: Data are for 2008
Black and Female Physicians Earn Less

Annual Income

$253,042
White Males

$188,230
Black Males

$163,234
White Females

$152,784
Black Females

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

- Black: 40.8
- Native American: 29.7
- Asian: 13.5
- White, Non-Hisp.: 12.7
- Hispanic: 11.5
- Canada: 6.3

Source: MMWR September, 2019 and OECD
Minority Children & Youth Get Few Psychiatric Visits

Psychiatrist visits/year/1000 population

- White
- Black
- Hispanic

Children:
- White: 138
- Black: 87
- Hispanic: 71

Young Adults (18-34):
- White: 195
- Black: 103
- Hispanic: 88

Source: Marrast, Himelstein & Woolhandler - Int J Hlth Serv 2016
Growing Wealth Gap for Minorities

Median household net worth (2013 $1000s)

<table>
<thead>
<tr>
<th>Year</th>
<th>Black</th>
<th>Hispanic</th>
<th>Non-Hispanic White</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$19.2</td>
<td>$23.6</td>
<td>$192.5</td>
</tr>
<tr>
<td>2010</td>
<td>$16.6</td>
<td>$16.0</td>
<td>$138.6</td>
</tr>
<tr>
<td>2013</td>
<td>$11.0</td>
<td>$13.7</td>
<td>$141.9</td>
</tr>
<tr>
<td>2016</td>
<td>$17.6</td>
<td>$20.7</td>
<td>$171.0</td>
</tr>
</tbody>
</table>

Source: Kochhar - Pew Research Center, 12/12/14 - Based on Federal Reserve Data
School Segregation Increased 1988-2016

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

<table>
<thead>
<tr>
<th>Region</th>
<th>1988</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northeast</td>
<td>48.0</td>
<td>51.5</td>
</tr>
<tr>
<td>South</td>
<td>24.0</td>
<td>36.4</td>
</tr>
<tr>
<td>Midwest</td>
<td>41.8</td>
<td>42.0</td>
</tr>
<tr>
<td>Border</td>
<td>34.5</td>
<td>42.2</td>
</tr>
<tr>
<td>West</td>
<td>28.6</td>
<td>37.7</td>
</tr>
</tbody>
</table>

Source: Harming Our Common Future - Civil Right Project, May 10, 2019
Job Discrimination Persists
Experimental Study of the Impact of "Whitening" Resumes

Calback rate after resume submitted

Source: Kang SK, et al. Admin Sci Q, 2016 - Job ads with pro-diversity language yielded same result
* e.g. change "Lamar J. Smith" to "L. James Smith" or "Lei Zhang" to "Luke Zhang"
** e.g. change "Aspiring Asian Business Leaders" to "Aspiring 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)

Car Searched  Contraband Found*

Chicago  5.2  0.7
Springfield, IL  2.7  0.7
Illinois SP  2.1  1.0
Charlotte, NC  2.8  0.7
Raleigh, NC  2.7  0.9
Greensboro, NC  2.2  0.8
NC SP  1.5  0.8
CT SP  2.6  0.7
New Haven  2.9  0.6
Torrington, CT  5.0  0.8

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

- White: 0.6
- Latino: 1.0
- Black: 2.1

Source: AJPH 2018;108:1241
Police killings account for 8% of all homicides
Police Killings: Higher in Poor Neighborhoods, Highest for Blacks

Number killed by police/million population

Source: J. Feldman: Police Killings in the U.S. 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

- White, Non-Latina: Before Raid 1.00, After Raid 0.95
- Latina, Foreign-Born: Before Raid 0.97, After Raid 1.32

Source: Int J Epidemiol 2017;839
Note: 2008 Postville, Iowa raid was largest single-site immigration raid in history. 900 agents handcuffed and chained all Latinos at meatpacking plant.
Low Birth Weight Rose Among Arabic-Named Women in California After 9/11

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

Source: Demography 2006;43:185
* Mother's name Arabic, infant's name not ethnically distinctive
** Mother's name Arabic, infant's name ethnically distinctive
Preterm Latinx Births Increased After Trump's Election
2337 Excess Preterm Births During 9 Months Post-Election

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

Source: Gemmill et al, JAMA Network Open July 19, 2019
Note: Expected number calculated based on trends, 2009-October, 2016
Immigrants Get Little Care

Health care costs, $ per capita

- Total Health Care: $2546 (U.S. Born) vs. $1582 (Immigrants)
- ED Care: $91 (U.S. Born) vs. $33 (Immigrants)
- Children: $1059 (U.S. Born) vs. $270 (Immigrants)


* Adjusted for ethnicity, poverty, age, insurance status, patient/parent-reported health status
Immigrants Keep Medicare Afloat

Net Contribution to Medicare Trust Fund, 2009

U.S. Born: -$30.9 billion
Foreign Born Citizens: $3.7 billion
Non-Citizens: $10.1 billion

Source: Zallman et al, Health Affairs 2013; 32:1153
Immigrants Subsidize Native-Born in Private Insurance

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

- U.S. Born: -$24.7 billion
- Documented Immigrants: $17.0 billion
- Undocumented Persons: $7.7 billion

Source: Zallman et al, Health Affairs October, 2018
Immigrants Play Vital Roles in U.S. Care, Science and Education

Foreign medical graduates' share of total

- Physicians: 21.1%
- Clinical Trial Leaders: 18.5%
- Academic Physicians: 18.3%

Source: Ann Int Med 2017;157:584
While Many Go Without Vital Services, Others Get Low- or No-Value Care
Many Elective PCIs Are Inappropriate

- Appropriate: 33.9%
- Uncertain: 41.3%
- Inappropriate: 22%

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

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

- ED: 2008: 89, 2015: 57
- Urgent Care Centers: 2008: 47, 2015: 103
- Retail Clinics: 2008: 7, 2015: 22
- Telemedicine: 2008: 0, 2015: 6
- Total Visits: 2008: 143, 2015: 188
- Cost Per Member: 2008: 70, 2015: 80

Source: JAMA IM 2018;178:1342
Free Standing ERs in Texas Avoid Areas of Greatest Need

Mean family income in service area

$91,563

$66,825

Urgicenter  No Urgicenter

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

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

- EHR/Desk Work: 48%
- With Patients: 26%
- With Staff: 6%
- Other Tasks: 19%
- Other Admin: 1%

Note: Figures are percent of office hours - exclude the 1-2 hrs/night of home EHR DESK work
EPIC EHR Notes 4x Longer in US Documentation Driven by Payment Complexity

Source: Ann Intern Med 2018; 169:51
Investor-Owned Care: Inflated Costs, Inferior Quality
Extent of For-Profit Ownership

<table>
<thead>
<tr>
<th>Service Type</th>
<th>For-Profit Share</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Hospitals</td>
<td>10%</td>
</tr>
<tr>
<td>Inpt. Psych/Substance*</td>
<td>29%</td>
</tr>
<tr>
<td>Specialty Hospitals*</td>
<td>35%</td>
</tr>
<tr>
<td>Hospice**</td>
<td>70%</td>
</tr>
<tr>
<td>Home Care</td>
<td>77%</td>
</tr>
<tr>
<td>Skilled Nursing Fac.</td>
<td>82%</td>
</tr>
<tr>
<td>Surg/Urgent Care Ctrs</td>
<td>89%</td>
</tr>
<tr>
<td>Dialysis</td>
<td>94%</td>
</tr>
<tr>
<td>Free-Stand. Lab/Image</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceuticals</td>
<td>$83.6 bil</td>
</tr>
<tr>
<td>Insurers</td>
<td>$23.5 bil</td>
</tr>
<tr>
<td>Equipment/Supplies</td>
<td>$16.9 bil</td>
</tr>
<tr>
<td>Pharmacy/Lab/Benefit Mgr.</td>
<td>$14.1 bil</td>
</tr>
<tr>
<td>Providers</td>
<td>$4.2 bil</td>
</tr>
<tr>
<td>Distributors/Wholesalers</td>
<td>$2.9 bil</td>
</tr>
</tbody>
</table>

Source: Fortune 500, 2020  
Note: Excludes firms not in Fortune 500 which account for substantial pharma profits.
<table>
<thead>
<tr>
<th>CEO</th>
<th>Firm</th>
<th>Total Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martine Rothblatt</td>
<td>United Therapeutics</td>
<td>$45.6 mil</td>
</tr>
<tr>
<td>Larry Merlo</td>
<td>CVS/Aetna</td>
<td>$36.5 mil</td>
</tr>
<tr>
<td>Miles White</td>
<td>Abbott</td>
<td>$27.8 mil</td>
</tr>
<tr>
<td>Kenneth Frazier</td>
<td>Merck</td>
<td>$27.6 mil</td>
</tr>
<tr>
<td>Samuel Hazen</td>
<td>HCA</td>
<td>$26.8 mil</td>
</tr>
<tr>
<td>Michael Neidorff</td>
<td>Centene</td>
<td>$26.4 mil</td>
</tr>
<tr>
<td>Alex Gorsky</td>
<td>J&amp;J</td>
<td>$25.4 mil</td>
</tr>
<tr>
<td>Alan Miller</td>
<td>Universal HLth. Serv.</td>
<td>$24.5 mil</td>
</tr>
<tr>
<td>Ronald Rittenmeyer</td>
<td>Tenet</td>
<td>$24.3 mil</td>
</tr>
</tbody>
</table>

Source: AFL-CIO
### The Profits of "Non-Profit" Health Systems

<table>
<thead>
<tr>
<th>Health System</th>
<th>2018 Profit</th>
<th>2019 Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaiser</td>
<td>$1,891 mil.</td>
<td>$2,732 mil.</td>
</tr>
<tr>
<td>Mayo</td>
<td>$706 mil.</td>
<td>$1,063 mil.</td>
</tr>
<tr>
<td>AdventHealth</td>
<td>$784 mil.</td>
<td>$829 mil.</td>
</tr>
<tr>
<td>Baylor Scott &amp; White</td>
<td>$582 mil.</td>
<td>$725 mil.</td>
</tr>
<tr>
<td>Indiana U. Health</td>
<td>$612 mil.</td>
<td>$679 mil.</td>
</tr>
<tr>
<td>U. Colorado Health</td>
<td>$526 mil.</td>
<td>$657 mil.</td>
</tr>
<tr>
<td>Houston Methodist</td>
<td>$473 mil.</td>
<td>$651 mil.</td>
</tr>
<tr>
<td>NYU Langone</td>
<td>$198 mil.</td>
<td>$606 mil.</td>
</tr>
<tr>
<td>Mass General Brigham</td>
<td>$310 mil.</td>
<td>$485 mil.</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare October 19, 2020:34
## Non-Profit Health Systems Becoming Speculative Investors

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

Source: Modern Healthcare 5/11 and 7/27, 2020
## Non-Profit Leaders Collecting Big Paydays From Pharma

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

Source: BioPharma Dive - "Directors who hold board seats and lead non-profits"
For-Profit Hospitals Cost 19% More
Source: CMAJ 2004;170:1817

<table>
<thead>
<tr>
<th>Study*</th>
<th>No. of facilities</th>
<th>No. of patients</th>
<th>% weight</th>
<th>PFP/PNFP payments ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Ness(^7)</td>
<td>333</td>
<td>NA</td>
<td>13.7</td>
<td>1.09 (0.98–1.22)</td>
</tr>
<tr>
<td>Kauer(^8)</td>
<td>56</td>
<td>NA</td>
<td>15.1</td>
<td>0.93 (0.88–0.99)</td>
</tr>
<tr>
<td>Dickey(^9)</td>
<td>342</td>
<td>561</td>
<td>8.9</td>
<td>1.73 (1.36–2.20)</td>
</tr>
<tr>
<td>Dranove et al(^10)</td>
<td>314</td>
<td>NA</td>
<td>14.4</td>
<td>0.98 (0.90–1.07)</td>
</tr>
<tr>
<td>McCue et al(^11)</td>
<td>84</td>
<td>NA</td>
<td>10.5</td>
<td>1.62 (1.34–1.97)</td>
</tr>
<tr>
<td>Sloan et al(^12)</td>
<td>2 360†</td>
<td>7 079</td>
<td>8.4</td>
<td>1.51 (1.17–1.94)</td>
</tr>
<tr>
<td>Keeler et al(^13)</td>
<td>358†</td>
<td>384 000</td>
<td>15.8</td>
<td>1.13 (1.09–1.16)</td>
</tr>
<tr>
<td>McCue et al(^14)</td>
<td>131</td>
<td>NA</td>
<td>13.2</td>
<td>1.20 (1.06–1.36)</td>
</tr>
</tbody>
</table>

Pooled random effects estimate (\(p = 0.001\))
\(I^2 = 0.903\)

Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval. \(†\)Approximation from investigator.
For Profit Hospitals Have Highest Readmission Rates for EVERY Condition

Readmission rate adjusted for severity (1.00 = expected rate)

Source: PLOS One 9/18/2018 - based on Medicare data 2012-2015
For-Profit Hospitals' Administrative Costs are Higher

% spent on administration

Investor Owned: 29.3%
Non-profit: 25.9%
Public: 24.5%

Doctors at For-Profits Take More Pharma Money

Proportion of doctors receiving drug company payments

- Investor-Owned: 74.7%
- Non-Profit: 65.5%
- State/Local Government: 61.4%
- Federal (Non-VA): 29.0%

For-Profit Dialysis Clinics’ Death Rates are 9% Higher

Source: JAMA 2002;288:2449
Investor-Owned Dialysis Clinics Discourage Transplants

Percent of dialysis patients placed on transplant list:

- Big Chain 1: 7%
- Big Chain 2: 6.2%
- Small Chain: 6.6%
- Chain: 11.9%
- Non-Chain: 29.8%

Source: JAMA 2019;322:957
VA Kidney Care: Less Dialysis, Better Survival

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

- Received Dialysis: 53% (VA) vs. 82% (Non-VA)
- Alive at 2 Years: 56% (VA) vs. 47% (Non-VA)

Source: JAMA IM 2018;178:657
*Non-VA = Medicare-paid, mostly delivered by investor-owned facilities
For Profit Home Care: Lower Quality

Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014
For Profit Home Care: Higher Cost

Annual Cost Per Patient

- Total Excludes Profit: $4,827 (For-Profit) vs. $4,075 (Non-Profit)
- Administration: $1,279 (For-Profit) vs. $681 (Non-Profit)
- Profit: $724 (For-Profit) vs. $261 (Non-Profit)

Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014
For-Profit Nursing Homes: Less Nursing Care
A National Study

Nursing staff hours per patient day

Source: Health Affairs 2019;38:1095
For-Profit Nursing Homes (SNFs): More Deaths and Hospital Readmissions

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

Unadjusted
- Government: 21.6%
- Non-Profit: 21.3%
- For-Profit: 24.3%

Adjusted
- Government: 22.5%
- Non-Profit: 22.8%
- For-Profit: 23.7%

Source: JAMA 2014;312:1552
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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Investment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>$15</td>
</tr>
<tr>
<td>2018</td>
<td>$22</td>
</tr>
<tr>
<td>11/2019</td>
<td>$60</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Non-Profit</th>
<th>For-Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Rehydration</td>
<td>71%</td>
<td>56%</td>
</tr>
<tr>
<td>Other Therapy (No ORT)</td>
<td>21%</td>
<td>33%</td>
</tr>
</tbody>
</table>

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 Spending
- Cost @ VA Prices

2011: $26.3 (13.4), 2012: $24.7 (12.4), 2013: $22.3 (12.4), 2014: $25.4 (15.8), 2015: $30.0 (17.9), 2016: $32.5 (18.0)

Source: JAMA IM 2019;179:431
Medicare Part D Drug Prices are Several-Fold Higher than in Other Nations

Average price of 79 single source drugs

<table>
<thead>
<tr>
<th>Country</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>$466</td>
</tr>
<tr>
<td>U.S. (Post Rebate)</td>
<td>$388</td>
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<tr>
<td>U.K.</td>
<td>$111</td>
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<tr>
<td>Ontario</td>
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<tr>
<td>Ontario (Post Rebate)</td>
<td>$93</td>
</tr>
<tr>
<td>Japan</td>
<td>$69</td>
</tr>
</tbody>
</table>

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.

Mean cost per device, 2014 (exchange rate adjusted $s)

Source: Health Affairs 2018;37:1570
Note: Devices account for 6% of U.S. health expenditures
What Goes Into a $6000 Orthopedic Implant

- Sales/Admin: $2,404 (40%)
- Manufacturing: $1,923 (32%)
- R&D: $337 (6%)
- Other: $870 (15%)
- Profit: $466 (8%)

Source: Modern Healthcare 2/5/2018
Drug Companies' Cost Structure

- Manufacturing: 27%
- Marketing/Admin.: 35%
- Profits (After Taxes): 18%
- Taxes: 7%
- R&D: 13%

Source: Health Affairs 2001; 20(5):136
Drug Company Profits, 1995-2019

Return on Revenues (%)

Source: Fortune 500 rankings for 1995-2020
Health Industry Profit Rates

Profits as % of revenues

- Health Sys. (For-Prof): 6.1%
- Health Sys. (Non-Prof): 3.0%
- Insurers: 4.3%
- Pharma: 19.4%

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

- Most common violations: kickbacks, illegal marketing, overcharging.
- Fines over 14 years = $33 billion (< ½ 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

$720 million  $906 million  $6,699 million
R&D Costs*  R&D Cost + 7% for Risk  Revenue from 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

Medical loss ratio

Anthem: 13.3%
Humana: 15.6%
Aetna: 16.0%
United HealthCare: 16.9%
Cigna: 18.4%

Source: SEC filings for first or second quarters, 2019
Note: Medical loss ratio = (medical benefits/premiums)
COVID-19 Boosted Insurers' Profits

Overhead + Profits (% of Premiums)

- Centene: 13.3% (Q2, 2019), 17.9% (Q2, 2020)
- Anthem: 13.3% (Q2, 2019), 22.1% (Q2, 2020)
- Humana: 15.6% (Q2, 2019), 23.6% (Q2, 2020)
- Cigna: 18.4% (Q2, 2019), 29.5% (Q2, 2020)
- Aetna: 16.0% (Q2, 2019), 29.7% (Q2, 2020)
- United Healthcare: 16.9% (Q2, 2019), 29.8% (Q2, 2020)

Source: SEC Filings
52% of Private Insurers' Revenues Come From Medicare and Medicaid

Source: AM Best 8/13/2018
Employer Payments for Private Insurance, 2020

Private Employers: 72%
Federal Government: 5%
State/Local Government: 24%

Source: NCHS 2020
<table>
<thead>
<tr>
<th>Drugs of Choice</th>
<th>Illness</th>
<th>Plan 1</th>
<th>Plan 2</th>
<th>Plan 3*</th>
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<tbody>
<tr>
<td>Anti-Retrovirals</td>
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<td>Migraine</td>
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<tr>
<td>Anti-Psychotics</td>
<td>Schizophrenia</td>
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<tr>
<td>Macrolides</td>
<td>Pneumonia</td>
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<td>L-Dopa</td>
<td>Parkinson's</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Anti-Convulsants</td>
<td>Seizure</td>
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<td>No</td>
<td>No</td>
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<tr>
<td>ACE Inhibitors</td>
<td>Hypertension</td>
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<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Metformin</td>
<td>Diabetes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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

Denial rate for prescriptions for Hep C DAA* agents

- Medicare: 15%
- Medicaid: 35%
- Private Insurers: 52%

Source: Gawda et al., Open Forum Infectious Diseases, 2018
*DAA = direct acting antivirals, such as sofosbuvir (Harvoni)
Both Hospital and Insurer Consolidation Raise Premiums

Annual premium boost

$624
Hospital Ownership*

$276
Insurance Plans**

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

Traditional Medicare
- Medical Services: 97.8%
- Overhead: 2.2%

Medicare Advantage Plans
- Medical Services: 86.3%
- Overhead: 9.1%
- Profit: 4.5%

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 Advantage Plans' Narrow Networks

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

Source: JAMA 2016;316:1348
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

Stayed in Public Mcare
$9,362

Switched to Mcare Adv.
$8,109

Source: Kaiser Foundation May, 2019
Note: For example, difference for pts. with asthma = $1410; depression = $1198; arthritis = $1371
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.

Source: NY Times 9/3/2019
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

- Low Need, Non-Medicaid: 3.3%
- High Need + Medicaid: 14.8%

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*

- Hip/Knee Replacement: -4.9%, -7.0%
- Heart Failure: -2.4%, -7.0%
- Stroke: -4.1%, -8.2%

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

Percent of newly disabled who switched

Switched OUT of MA: 36.0%
Switched IN to MA: 14.3%

Source: Health Aff 2020;39:809
Note: New functional disability = needs assistance with >1 ADL
Sickest Patients Switch Out of Medicare Advantage

Percent switching out during 2011

- No NH Use During 2010: 3.5% (Traditional Medicare), 4.0% (Medicare Advantage)
- Short Term NH Stay: 3.5% (Traditional Medicare), 9.0% (Medicare Advantage)
- Long Term NH Stay: 3.0% (Traditional Medicare), 17.0% (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

Share of plans requiring 20% co-insurance for chemo

Source: JGIM 2019;34:1119
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

- Tiers 3-6
- Tier 2
- Tier 1

2011:
- 6% Tier 3-6
- 22% Tier 2
- 71% Tier 1

2015:
- 35% Tier 3-6
- 36% Tier 2
- 19% Tier 1

Source: Avalere 5/22/2018
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

Year 1: 6.4%
Year 2: 8.7%
Year 1 Employed MDs: 16%

Source: NBER Working Paper # 21222
The 6.4% coding increase ups MA plans' payments from Medicare by $10 billion/yr, ~$650/enrollee. It is equivalent to 6% of all enrollees becoming paraplegic or 39% becoming diabetic.
Medicare Advantage Plans' Claims for Unsupported Diagnoses
CMS Chart Audit (But CMS Only Pursued Recovery for 0.2% of Projected Overcharges)

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

- **2016**: $11.484 bil.
- **2017**: $9.311 bil.
- **2018**: $9.095 bil.

Source: Kaiser Health News 7/16/2019
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

Source: Annals of Internal Medicine 2019; 171:99
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

- All Patients In Plan: Reported Score 21.1% vs. Accurate Score 26.9%
- Pts Sampled for HEDIS: Reported Score 21.9% vs. Accurate Score 26.2%

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

Source: Schulte, Center for Public Integrity, 2014
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
- Uncompl. DM: $1040
- CKD: $0
- Obesity: $0
- Depression: $0
- Chronic CAD: $0
- Total: $4990

- Base rate: $3950
- DM II with diab. CKD: $3180
- CKD stage 4: $2370
- Morbid Obesity: $2730
- Major depression: $3950
- CAD with angina: $1400
- Total: $17580

SOURCE: SGIM FORUM, 2017
Medicare Advantage Plans Raise Costs
Less Spending on Care, More on Overhead

Monthly cost per beneficiary, adjusted*

Traditional Medicare:
- $706
- $720
- Payments for Care: $706
- Overhead: $14

Medicare Advantage:
- $642
- $767
- Payments for Care: $642
- Overhead: $125

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

Difference in rate: traditional Medicare - Medicare Advantage

DX Tests: -24.4%
Flu Shot: -38.0%
Colon CA Screening: -14.9%
Mammo.: 3.3%
Non-emergent ED Visit: -15.8%
Needed ED Visit: -16.6%

Medicare Needs Improvement
Financial Problems of Seriously Ill Enrollees

Source: Health Aff 2019;38:1801
Note: "Necessity" = Food, heat, housing
ACOs
Warmed Over Managed Care

“IT’S LIKE DEJA VU ALL OVER AGAIN.”
YOGI BERRA
ACOs' Explosive Growth Since 2010

Number of ACOs

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

Relative Risk of Dying

Diastolic BP

Source: Rand Health Insurance Experiment, Lancet 1986; 1:1017

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")

- Dropped from ACO: 8.2%
- Stayed in ACO: 3.3%
- Never in ACO: 3.7%

Source: Health Affairs 2019;38:253
ACOs Got Rid of High Cost Patients

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

Total annual spending per patient

- Dropped from ACO: $8.437
- Stayed in ACO: $7.133

Source: Health Affairs 2019;38:253
ACOs Get Rid of High Cost Patients By Ejecting Their Doctors

Percent of doctors leaving ACO

- Highest Cost 1%: 30.4%
- Highest Cost 5%: 22.3%
- Median Cost: 13.8%

Doctors Rank According to Cost of Their Patients

Source: Ann Intern Med 2019;171:27
ACOs: No Savings, No Quality Improvement After Control for Selective Enrollment

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

Cost Savings ($s) | Diabetes Quality Score
---|---
118.0 | 2.2
-6.0 | -1.9

Type of Statistical Adjustment
- Risk Score Alone
- Selective Enrollment

Source: Ann Intern Med 2019;171:27
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)

Source: Himmelstein & Woolhandler analysis of CMS ACO Public Use Files, 8/2020 + MEDPAC staff est.
McKinsey: “The Math of ACOs”

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

Hotspotting Didn't Work - RCT
Much Touted Camden Model Failed

180 day post-discharge outcomes

- Any Readmission: 62% (Intervention), 62% (Control)
- 2 or More Readmits: 36% (Intervention), 36% (Control)
- Hospital Days: 9 (Intervention), 10 (Control)
- Hosp Costs ($1000s): 18 (Intervention), 16 (Control)

Physician-Leadership of ACOs Waning

share of ACOs led by physicians

- 2012: 47%
- 2013: 44%
- 2014: 45%
- 2015: 40%
- 2016: 39%
- 2017: 38%

Source: Modern Healthcare 2/5/18
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

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

Patient characteristics in panels of high/low scoring MDs

- Top Scoring MDs
- Bottom Scoring MDs

- Minority: 14% (Top) vs. 26% (Bottom)
- Non-English Speakers: 3% (Top) vs. 10% (Bottom)
- Uninsured/Medicaid: 10% (Top) vs. 17% (Bottom)
- Infrequent Visits: 29% (Top) vs. 38% (Bottom)

Source: JAMA 9/8/2010:1107
Medicare's Value-Based Payment Program Penalizes Doctors Caring for High-Needs Patients

Percent of practices penalized:
- Not Sick, Not Poor: 3.1%
- Poorer: 9.8%
- Sicker: 18.0%
- Sicker + Poorer: 13.1%

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 it’s true that the way to get better doctoring and better nursing is to put money on the table in front of doctors and nurses. I think that’s a fundamental misunderstanding of human motivation. I think people respond to joy and work and love and achievement and learning and appreciation and gratitude—and a sense of a job well done. I think that it feels good to be a doctor and better to be a better doctor. When we begin to attach dollar amounts to throughputs and to individual pay we are playing with fire. The first and most important effect of that may be to begin to dissociate people from their work.”

Don Berwick, M.D.

Source: Health Affairs 1/12/2005
Performance Monitoring Increased Documentation of Alcohol Counseling, But Not Real Counseling Rate

Alcohol counseling rate among patients screening positive for unhealthy ETOH use

Source: JGIM 2017;33:268
$450 Incentive to Take Statins Improved Pill Bottle Openings But Not LDL-C Levels

<table>
<thead>
<tr>
<th></th>
<th>Controls</th>
<th>Incentives</th>
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</thead>
<tbody>
<tr>
<td>Opened Pill Bottles*</td>
<td>59</td>
<td>81</td>
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<tr>
<td>Fall in LDL @6 mo.</td>
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<tr>
<td>Fall in LDL @12 mo.</td>
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<td>34</td>
</tr>
</tbody>
</table>

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)

Source: JAMA 2018;320:2542
P4P Didn't Improve Mortality in England

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

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

- Ischemic Heart Disease: -2.21
- Cancer: 0.28
- Other Incentivized: -1.75
- Non-Incentivized: 11.60

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

30 day mortality or readmissions/100 patients

- PNA: VA 9, Non-VA 16
- CHF: VA 12, Non-VA 8
- AMI: VA 14, Non-VA 9
- COPD: VA 6, Non-VA 8

- PNA: VA 15, Non-VA 17
- CHF: VA 22, Non-VA 19
- AMI: VA 16, Non-VA 17
- COPD: VA 16, Non-VA 20

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 (%)

Source: Ann Intern Med 2019;170:426
Blacks in VA: No Health Disadvantage
A Longitudinal Study of 3,072,966 Vets Cared for at VAs

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

Total Mortality Rate: 0.78
New CAD Event: 0.63
Stroke: 0.99

Source: Kovesdy et al. Circulation 9/18/2015
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
OBAMACARE
HEALTH EXCHANGES
PLATINUM
BRONZE PLAN
SILVER PLAN
GOLD PLAN
SUBSIDY
HELP CENTER
GO ONLINE
EMAIL OFFER FROM MAJORIAN PRINCE
CAT VIDEOS
MARCH
TIC TIC
DEADLINE
BACK TO THE TARDIS
PREMIUMS
ERROR MESSAGE
WOUULD YOU LIKE FRIES WITH THAT?
SINGLE SEX
PUT A RING ON IT
KIDS? WHY?
ANIMAL MINERAL DEDUCTIBLE
MARCH
TIC TIC
DIE HARD
GET IN BY METER
CONGRATULATIONS!
YOU ARE INSURED
THE SIMPLE GOP PLAN FOR THE UNINSURED
GET SICK
DIE PENNILESS
CONGRATULATIONS!
YOU ARE INSURED
SINGLE PARENT
Medicare’s “Software”
18.9 Million Seniors Enrolled Within 11 Months
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)

Income as % of Poverty Level

Source: Health Affairs 2017:36:1656
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

Overhead as percent of premiums

<table>
<thead>
<tr>
<th>Company</th>
<th>Overhead %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambia</td>
<td>90.7%</td>
</tr>
<tr>
<td>United Health</td>
<td>62.7%</td>
</tr>
<tr>
<td>Mutual of Ohio</td>
<td>60.0%</td>
</tr>
<tr>
<td>Blue Cross S. Carolina</td>
<td>55.8%</td>
</tr>
<tr>
<td>Blue Cross Idaho</td>
<td>45.1%</td>
</tr>
<tr>
<td>National General</td>
<td>41.9%</td>
</tr>
</tbody>
</table>

Source: Modern Healthcare August 12, 2019:10
Medicaid Work Requirement: Trivial Savings Unless Exempt Groups are Also Disenrolled

- Insitutionalized: 69.3%
- Student: 1.8%
- Disabled/Frail: 11.2%
- Pregnant/Caregiver: 0.7%
- Employed-seeking work: 5.9%
- Senior/Child: 11.5%
- Non-Exempt Adults: 0.7%

Percent of Medicaid Spending

Source: Goldman, Woolhandler, Himmelstein et al. Forthcoming, JAMA IM & CP, May 23, 2018
Note: Spending on enrollees with multiple exemptions appear in only one category
Note: Estimated bureaucratic costs of administering requirement: $165 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

Private: 35%
Medicare: 20%
Medicaid: 17%

Tax Subsidies: 10%
Govt. Workers Benefits: 6%
VA, Public Health Etc.: 11%

Source: Himmelstein & Woolhandler - Analysis of NCHS data
Tax-Financed Share of Total Health Spending, 1965-2020

Tax-financed share as % of NHE

1965: 30.7
1970: 44.4
1975: 51.0
1980: 55.4
1985: 54.6
1990: 55.1
1995: 61.2
1999: 59.8
2013: 64.3
2015: 65.0
2020: 66.3

Source: Woolhandler & Himmelstein - Health Af 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

- U.K.: $4650
- Japan: $4820
- France: $5380
- Canada: $5420
- Holland: $5770
- Sweden: $5780
- Germany: $6650
- Switzerland: $7730

U.S.: $7,619 (Total), $11,600 (Private)

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

- U.S.: 33%
- Switz.: 22%
- France: 17%
- Canada: 16%
- Sweden: 8%
- Germany: 7%
- U.K.: 7%

Source: Commonwealth Fund Survey 2016
Life Expectancy

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>78.7</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>80.4</td>
</tr>
<tr>
<td>Germany</td>
<td>81.0</td>
</tr>
<tr>
<td>U.K.</td>
<td>81.3</td>
</tr>
<tr>
<td>Canada</td>
<td>82.0</td>
</tr>
<tr>
<td>Sweden</td>
<td>82.6</td>
</tr>
<tr>
<td>France</td>
<td>82.8</td>
</tr>
<tr>
<td>Italy</td>
<td>83.4</td>
</tr>
</tbody>
</table>

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

- Black (US): 37.1
- White, Non-Hisp. (US): 14.7
- Hispanic (US): 11.8
- Canada: 8.7
- U.K: 6.5
- Australia: 4.8
- Germany: 3.2

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

- U.S.: 16.5
- Canada: 17.5
- U.K.: 18.4
- Sweden: 19.9
- France: 20.1
- Germany: 21.5
- Italy: 22.8
- Japan: 28.4

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

Days/person/year

- U.S. 0.6
- Canada 0.6
- Australia 0.7
- U.K. 0.8
- France 0.9
- Switz. 1.1
- Germany 1.8
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

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

Australia: 1.2%
U.S.: 1.4%
Holland: 2.2%
Canada: 2.6%
Germany: 3.2%
Sweden: 3.4%
Switzerland: 4.1%

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

# of clinical medicine articles 1992-2002 per thousand population

Source: Lancet 2004; 363:250
Out-Of-Pocket Payments

$/Capita

Switzerland: 2165
U.S.: 1150
Australia: 845
Germany: 800
Canada: 795
Holland: 602
France: 477

Source: OECD, 2020 & NCHS
Note: Data are for 2019 or most recent year available; figures adjusted for Purchasing Power Parity
Insurance Overhead

$/Capita

<table>
<thead>
<tr>
<th>Country</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>965</td>
</tr>
<tr>
<td>Canada</td>
<td>167</td>
</tr>
<tr>
<td>Holland</td>
<td>213</td>
</tr>
<tr>
<td>Switzerland</td>
<td>284</td>
</tr>
<tr>
<td>France</td>
<td>289</td>
</tr>
<tr>
<td>Germany</td>
<td>293</td>
</tr>
</tbody>
</table>

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

Percent of serious Sx for which MD was seen

Income Group

Source: NEJM 1973;289:1174
Free Care in Quebec
Improved Maternal/Infant Care

Percent with visit

- Early Prenatal Care: Before NHI 40.9%, After NHI 54.9%
- Postpartum Visit: Before NHI 66.0%, After NHI 79.5%
- Newborn Checkup: Before NHI 79.2%, After NHI 85.0%

Source: NEJM 1974;291:649
A meta-analysis of patients treated for the same illnesses found that the quality of care is slightly better in Canada than in the U.S., with studies in the U.S. mostly involving insured patients.

**Table 1: Summary of findings**

<table>
<thead>
<tr>
<th>Findings</th>
<th>High-quality studies</th>
<th>Low-quality studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results favoured United States</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Results favoured Canada</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Mixed or equivocal results</td>
<td>3</td>
<td>16</td>
</tr>
</tbody>
</table>

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)

- Overall: 1.52
- Privately Insured: 1.18
- Medicare/Medicaid: 1.79
- Uninsured: 4.35

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

Deaths/1000 Live Births

Source: Statistics Canada, Canadian Institute for Health Information, Natl Ctr for Health Statistics
Infant Deaths by Income, Canada 2011
Even the Poor Do as Well as the U.S. Average

Infant mortality per thousand

Income Quintiles, Canada

Source: CDC and StatCan
Life Expectancy Falling for Lower-Income Americans, Rising for All Canadians

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

Canada

U.S.

Poorest 20% Q2 Q3 Q4 Richest 20%

2.9 4.4 5.0 3.9 4.2 6.4

-2.3 2.2 -0.3

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

Percent of Seniors' Total Medical Expenses Covered

- U.S. Medicare: 51%
- Canada Medicare: 79%

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

Source: Statistics Canada, Canadian Inst. for Health Info., & NCHS/Commerce Dept.
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

Source: Himmelstein & Woolhandler, Arch Intern Med, December, 2012
Insurance Overhead
United States & Canada, 2019

Source: NCHS and CIHI (projected)
Hospital Billing & Administration
United States & Canada, 2019

$ per capita (PPP adjusted)

$1015
U.S.

$206
CANADA

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
“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
Duke Medical Center: 957 beds, 1600 billing clerks

Source: JAMA 2018;319:691
Physicians' Billing-Related Expenses
United States & Canada, 2019

$ per capita (PPP adjusted)

$502

U.S.

$96

Canada

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

$3,966
U.S.

$1,196
CANADA

Source: Himmelstein/Campbell/Woolhandler - Ann Int Med 2020 (Updated)
Few Canadian Physicians Emigrate

Net Loss (# moving abroad minus # returning)

Source: Canadian Institute for Health Information
Note: A negative number indicates that more physicians returned from abroad than moved abroad.
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Average Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>$280,763</td>
</tr>
<tr>
<td>Int. Medicine</td>
<td>$403,942</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>$298,814</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$278,069</td>
</tr>
<tr>
<td>Dermatology</td>
<td>$384,786</td>
</tr>
<tr>
<td>Ob/GYN</td>
<td>$391,743</td>
</tr>
<tr>
<td>General Surg.</td>
<td>$452,283</td>
</tr>
<tr>
<td>Thoracic Surg.</td>
<td>$599,910</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>$768,958</td>
</tr>
<tr>
<td>All Physicians</td>
<td>$344,978</td>
</tr>
</tbody>
</table>
Trend In Canadian Physicians' Incomes, 1950-2010

Mean Physician Income As Multiple All Canadian Full Time Employees

Source: Grant and Hurley, U of Calgary School of Public Pol. Research Papers - 7/2013, Vol6, Issue 22
## Malpractice Insurance Costs in Canada, 2019

All Figures in Canadian $s

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Ontario*</th>
<th>Quebec</th>
<th>BC &amp; Alberta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Med</td>
<td>$4,908</td>
<td>$1,583</td>
<td>$3,420</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>$4,908</td>
<td>$1,583</td>
<td>$3,420</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$8,448</td>
<td>$2,248</td>
<td>$5,028</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$12,948</td>
<td>$3,139</td>
<td>$8,472</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>$38,980</td>
<td>$7,312</td>
<td>$26,424</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>$73,924</td>
<td>$18,050</td>
<td>$48,588</td>
</tr>
</tbody>
</table>

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

* Government reimburses MDs for premiums above 1986 level
“It’s not a big hassle. I can focus on patient issues, not administrative issues.”

Dr. Trina Larsen Soles, president of Doctors of BC, which represents physicians in British Columbia.
“It’s an incredible bureaucratic mess to get anything done for patients.”

Dr. John Cullen, president-elect of the American Academy of Family Physicians
What's OK in Canada?
Compared to the U.S.

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

- The wealthy lobby for private funding and tax cuts; they resent subsidizing care for others
- Result: government funding cuts (e.g. 30% of hospital beds closed during 90s) causing dissatisfaction and waits for care
- U.S. and Canadian firms seek profit opportunities in health care privatization
- Conservative foes of public services own many Canadian newspapers
- Misleading waiting list surveys by right wing Fraser Institute
Medicare for All Enjoys Wide Support
Most Favor Phasing Out Private Plans if They Can Keep Their Doctor/Hospital

Percent supporting Medicare for All with...

- No Further Description: 53% Support, 36% Oppose, 11% Don't Know
- No Insurance Choice: 46% Support, 35% Oppose, 18% Don't Know
- MD Choice But Not Ins.: 55% Support, 31% Oppose, 14% Don't Know

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"

Percent in favor/opposed

Source: Kaiser Family Foundation Polls
Polls: Consistent Support For M4A, Nov. 2015 – July 2020

Source: Kaiser Family Foundation, October, 2020
Most Doctors Favor Single Payer Support Has Sharply Increased

Source: Merritt Hawkins surveys of physicians
A National Health Program for the U.S.
National Health Insurance

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

Source: Proposal of the Physicians Working Group for Single Payer NHI. JAMA 2003;290:798
FUNDING FOR THE NHP

**SOURCES OF REVENUE**
- Medicare & Medicaid
- State, local government
- Employers
- Private insurance revenues
- New Taxes

**RECIPIENTS OF MONEY**
- Hospitals, operating
- Hospitals, capital
- Fee-for-service MDs
- Home Care Agencies
- Long Term Care

SOURCE: NEJM 1989; 320:102
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.

Source: Gaffney, Lexchin, Angell, Carome et al. BMJ 2018;361:k1039
Current Senate and House Bills

Strengths

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

Concerns

• Both allow for-profit providers, with constraints

• Senate bill: Adopts Medicare’s needlessly complex payment strategies, raising administrative burdens/costs and perpetuating incentives for upcoding etc., focusing on profitable services, etc.
Single Payer Transition: For Displaced Clerical and Administrative Workers

- All 400,000 health insurance workers and about ½ of the 2.6 mil. clerical/administrative employees in healthcare providers likely to be displaced – total 1.7 million.
- Many likely to be redeployed in expanded clinical workforce.
- Funding for income support and job retraining modeled on WWII GI Bill.
- Job displacement is common in the US – 60 million/year, including 20 million who are fired: 1.7 million = number who are fired every 31 days. (source: People’s Policy Report)
66.1 Million U.S. Workers Separated from Jobs in 2018
Putting Job Displacement Due to Single Payer Into Perspective

Quit - 41 million
Laid off/fired - 21.9 million
Other* - 4.1 million

* 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

- Quit Job: 40.1
- Fired: 21.9
- Turn 26: 4.5
- Other Job Change: 4.1
- Turn 65: 3.7
- Divorce: 1.5
- Employer Switched Ins: 1/7 firms switch coverage, millions affected

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 ½ union, ½ employer.
- All insurers pay same rates and include every doctor, every hospital.
- States fund most hospital capital investment.
- Single payer for long term care.
Transitioning to Switzerland

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

- Developed as German-style universal coverage.
- Private insurers introduced 2006.
- Doctors now complain of unbearable administrative burdens, and rupture of cooperation.
- Hospital administrative costs 2nd only to US.
- Single payer for long term care.
65% of Dutch GPs Sign Manifesto: “Everything Must Change”

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

*Act forces each GPs to negotiate individual contract with insurers

Source: “Competition Hurts Healthcare: Doctors” NL Times 4/17/15
“Insurers in the Netherlands and Switzerland are not as a matter of public policy conceived of as private businesses and in important respects they are not allowed to function as private businesses. The Dutch and Swiss models--built on a uniform mandated benefit package, a limited menu of cost sharing, and provider rate regulation-- are not the models that private insurers in the United States are in fact advocating, but rather represent a quite different tradition based on social solidarity and not on market competition.”

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

The Experience of Switzerland and the Netherlands with Individual Health Insurance Mandates: A Model for the United States? Timothy Stoltzfus Jost
Doctors in Multi-Payer Systems Have More Insurance Hassles

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

<table>
<thead>
<tr>
<th>Country</th>
<th>Single-Payer</th>
<th>Multi-Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neth</td>
<td>21</td>
<td>60</td>
</tr>
<tr>
<td>US</td>
<td>21</td>
<td>54</td>
</tr>
<tr>
<td>Ger</td>
<td>21</td>
<td>52</td>
</tr>
<tr>
<td>Swiz</td>
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<td>UK</td>
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<td>Aus</td>
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<td>20</td>
</tr>
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<td>Can</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>NZ</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Commonwealth Fund Physician Survey, 2015
Public Option = High Costs

- Less savings than single payer on insurers’ overhead
- Multiple payers = no savings on doctor/hospital billing and administration.
- Private insurers will tilt the playing field (as under Medicare Advantage) raising system-wide costs and perpetuating network restrictions, cherry-picking, lemon dropping etc.
- Higher system-wide costs (compared to single payer) assure political pressure for benefit cuts.
For Any Level of Spending, Single Payer Would Purchase More Care and Less Administration Than Public Option
Single Payer Would Cost $631 Billion Less Than a Universal Multi-Payer Reform

Total health expenditures/year

Single Payer $3.005 trillion
Multi-Payer $3.636 trillion

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

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

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

Source: Cai et al, PLOS Medicine, 2020
…There are no charges, except for a few special items

…no insurance qualifications

An equal right to healthcare