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

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

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.
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>247k</td>
</tr>
<tr>
<td>2016</td>
<td>197k</td>
</tr>
</tbody>
</table>

Source: Am J Preventive Med 2018;54:334
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
Median Family Income for Blacks and Whites: 1947-2018 (Inflation Adjusted)

Source: Bureau of the Census
Prisoners in Pre-Trial Detention

Pre-trial detainees per 100,000 population

- U.S. 148
- Russia 67
- Iran 72
- Canada 42
- Italy 31
- France 30
- U.K. 16
- Germany 16
- Japan 5

Increasing Economic Inequality Harms Health
“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)
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
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>Georgia</td>
<td>13.4</td>
<td>1,817</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.
Medicaid: Poor Access, But Better Than Nothing
Many Specialists Won’t See Kids With Medicaid

Medicaid Helps
An RCT in Oregon

Source: NEJM May 2, 2013
Note: Catastrophic medical costs = out-of-pocket spending >30% of income
Depression = screened positive for depression using PHQ8
Under-Insurance 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
One Fifth of Privately Insured Surgical Patients Get a Surprise Bill

Percent of procedures with out of network bills

Surg. Assist. 7.6
Anesthesia 7.6
Pathology 4.5
Radiology 1.4
Medical Consult 0.6
Other 2.7
Any Bill 20.5

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

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
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

Income Quintile or Decile

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

Source: Health Aff 2014:33:863
High Deductible Plans Delayed Breast Cancer Care

Extra delay (months) high vs. low deductible

Income Group:
- Low
- Middle
- High

Source: Health Affairs 2019;38:408
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

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

Change in visit rates after copay added

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

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%
- Bills + Work Loss: 36%
- No Medical Cause: 33%


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

Insurance at Illness Onset:

- Private: 60%
- Medicare: 22%
- Medicaid: 10%
- Uninsured: 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
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
Racism Harms Health
Black and Native Americans Die Younger
But Life Expectancy for Every Group is Shorter Than Other G7 Nations

<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>

G6 Average

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%
- Septicemia: 7%
- Homicide: 14%
- Renal Disease: 11%
- Stroke: 12%
- Other*: 6%

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

Value of buildings and equipment, $s per bed day

<table>
<thead>
<tr>
<th></th>
<th>Existing Assets</th>
<th>New Purchases, 2013-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainly White</td>
<td>$8.325</td>
<td>$3.092</td>
</tr>
<tr>
<td>Latinx-Serving</td>
<td>$5.763</td>
<td>$1.738</td>
</tr>
<tr>
<td>Black-Serving</td>
<td>$5.197</td>
<td>$1.242</td>
</tr>
</tbody>
</table>

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
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

Percent following prevention advise (or recommending the doctor)

- White Doctor
- Black Doctor

<table>
<thead>
<tr>
<th>Procedure</th>
<th>White Doctor</th>
<th>Black Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Screening</td>
<td>42</td>
<td>83</td>
</tr>
<tr>
<td>BP Check</td>
<td>62</td>
<td>72</td>
</tr>
<tr>
<td>Cholesterol Test</td>
<td>36</td>
<td>62</td>
</tr>
<tr>
<td>Flu Shot</td>
<td>18</td>
<td>28</td>
</tr>
<tr>
<td>BMI Check</td>
<td>60</td>
<td>76</td>
</tr>
<tr>
<td>Liked* Doctor</td>
<td>99</td>
<td>99</td>
</tr>
</tbody>
</table>

Authors estimate that universal availability of Black doctors could cut B:W CV mortality gap by 19%
* Liked = would recommend doctor to others
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 Psychiatrist 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
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
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: 1.00 Before Raid, 0.95 After Raid
Latina, US-Born: 1.13 Before Raid, 1.29 After Raid
Latina, Foreign-Born: 0.97 Before Raid, 1.32 After Raid

Source: Int J Epidemiol 2017;839
Note: 2008 Postville, Iowa raid was largest single-site immigration raid in history. 900 agents handcuffed and chained all Latinos at meatpacking plant.
Immigrants Get Little Care

Health care costs, $ per capita

- Total Health Care: $2546
- ED Care: $1582
- Children: $1059

* U.S. Born
* 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)

<table>
<thead>
<tr>
<th>Category</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Born</td>
<td>-$24.7 billion</td>
</tr>
<tr>
<td>Documented Immigrants</td>
<td>$17.0 billion</td>
</tr>
<tr>
<td>Undocumented Persons</td>
<td>$7.7 billion</td>
</tr>
</tbody>
</table>

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%
- Clin. Trial Leaders: 18.5%
- Academic Physicians: 18.3%

Source: Ann Int Med 2017;157:584
Administrative
Overhead Rising
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
Investor-Owned Care: Inflated Costs, Inferior Quality
Extent of For-Profit Ownership

<table>
<thead>
<tr>
<th>Service Type</th>
<th>For-Profit Firms' Share of Total Revenues</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
<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
<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>$86.6 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, Duke</td>
<td>J &amp; J</td>
<td>$284,893</td>
<td>$2.3 mil</td>
</tr>
<tr>
<td>John Noseworthy</td>
<td>CEO, Mayo</td>
<td>Merck</td>
<td>$234,167</td>
<td>$0.3 mil</td>
</tr>
<tr>
<td>Charles Sawyer</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 T x 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

Fig. 2: Relative payments for care at private for-profit (PFP) and private not-for-profit (PNFP) hospitals. Note: CI = confidence interval.
The studies are in chronological order by midpoint of the data collection period. †Approximation from investigator.
For-Profit Hospitals' Administrative Costs are Higher

% spent on administration

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

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

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

<table>
<thead>
<tr>
<th>Source</th>
<th>RR (95% CI)</th>
<th>Favors Private For-Profit Facilities</th>
<th>Favors Private Not-For-Profit Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plough et al(^{16})</td>
<td>0.71 (0.49-1.02)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Farley(^{17})</td>
<td>1.11 (1.04-1.18)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Garg et al(^{18})</td>
<td>1.18 (1.02-1.37)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Irvin(^{19})</td>
<td>1.09 (1.07-1.12)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Irvin(^{20})</td>
<td>1.16 (1.09-1.23)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>McClellan et al(^{21})</td>
<td>1.09 (0.83-1.44)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Port et al(^{22})</td>
<td>1.06 (1.01-1.12)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Irvin(^{23})</td>
<td>1.05 (1.03-1.07)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Random-Effects Pooled Estimate for All 8 Studies</td>
<td>1.09 (1.05-1.12)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Random-Effects Pooled Estimate for 4 Selected Studies(^{16,17,19,22})</td>
<td>1.08 (1.04-1.13)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

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
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), $4,075 (Non-Profit)
- Administration: $1,279 (For-Profit), $681 (Non-Profit)
- Profit: $724 (For-Profit), $261 (Non-Profit)

Source: Cabin, Siman, Himmelstein & Woolhandler, Health Affairs 8/2014
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
Drug and Device Firms’ Inflated Prices
U.S. Drug Spending, 1990-2020

Outpatient Prescription Drug Spending - $ billions

Source: CMS, Office of the Actuary - Note: 2019 & 2020 estimated
Medicare Part D Drug Prices are Several-Fold Higher than in Other Nations

Average price of 79 single source drugs

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$466</td>
<td>$388</td>
<td>$111</td>
<td>$133</td>
<td>$93</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
Drug Company Profits, 1995-2019

Return on Revenues (%)

Source: Fortune 500 rankings for 1995-2020
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
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

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

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
COVID-19 Boosted Insurers' Profits

Overhead + Profits (% of Premiums)

<table>
<thead>
<tr>
<th>Company</th>
<th>Q2, 2019</th>
<th>Q2, 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centene</td>
<td>13.3</td>
<td>17.9</td>
</tr>
<tr>
<td>Anthem</td>
<td>13.3</td>
<td>22.1</td>
</tr>
<tr>
<td>Humana</td>
<td>15.6</td>
<td>23.6</td>
</tr>
<tr>
<td>Cigna</td>
<td>18.4</td>
<td>29.5</td>
</tr>
<tr>
<td>Aetna</td>
<td>16.0</td>
<td>29.7</td>
</tr>
<tr>
<td>United Healthcare</td>
<td>16.9</td>
<td>29.8</td>
</tr>
</tbody>
</table>

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

Source: AM Best 8/13/2018
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.
Medicare Advantage: The Only Working Model of a Public Option (Traditional Medicare) Competing With Private Plans
Medicare Advantage Plans' High Overhead

Traditional Medicare
Medical Services 97.8%

Overhead 2.2%

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

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

Source: CMS & Kaiser Foundation
How do Medicare Advantage Plans Outcompete Traditional Medicare?

• Cherry-picking + Lemon-dropping
  o Exclude hospitals/doctors attractive to high-cost patients
  o Benefit/formulary design
  o Hassle factor

• Upcode + over-diagnose to game risk adjustment

• Outright cheating
Medicare Advantage Plans’ Strategies: 1- Cherry Picking

Marketing, network manipulation, benefit design
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 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
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%
- Heart Failure: -2.4%
- Stroke: -4.1%

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

Source: JGIM 2019;34:1119
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.
Upcoding Boosts Advantage Plans’ CMS-Paid Premiums

Same Patient, Different Coding

<table>
<thead>
<tr>
<th>Condition</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base rate</td>
<td>$3950</td>
</tr>
<tr>
<td>Uncompl. DM</td>
<td>$1040</td>
</tr>
<tr>
<td>CKD</td>
<td>$0</td>
</tr>
<tr>
<td>Obesity</td>
<td>$0</td>
</tr>
<tr>
<td>Depression</td>
<td>$0</td>
</tr>
<tr>
<td>Chronic CAD</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$4990</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base rate</td>
<td>$3950</td>
</tr>
<tr>
<td>DM II with diab. CKD</td>
<td>$3180</td>
</tr>
<tr>
<td>CKD stage 4</td>
<td>$2370</td>
</tr>
<tr>
<td>Morbid Obesity</td>
<td>$2730</td>
</tr>
<tr>
<td>Major depression</td>
<td>$3950</td>
</tr>
<tr>
<td>CAD with angina</td>
<td>$1400</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$17580</strong></td>
</tr>
</tbody>
</table>

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

Monthly cost per beneficiary, adjusted*

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

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

Source: Am. Econ. J. Applied Econ 2019;11:302 - Data are for 2010
* Health status adjustment based on diagnoses + mortality risk
ACOs
Warmed Over Managed Care

"It's like deja vu all over again."
Yogi Berra
High Risk HMO Patients Fared Poorly in the Rand Experiment

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 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
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)

- Claimed "Savings": -$4.407
- Bonus Payment: $3.737
- Actual Savings: $0.670

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, 18 Control

The Toxicity of Pay for Performance (P4P)
Medicare Quality Scores Penalize Doctors Caring for Poor Seniors
Score Difference = $15,000 Lower Medicare Payments

Share of Poor Patients in Practice

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

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Top</th>
<th>Bottom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minority</td>
<td>14%</td>
<td>26%</td>
</tr>
<tr>
<td>Non-English Speakers</td>
<td>3%</td>
<td>10%</td>
</tr>
<tr>
<td>Uninsured/Medicaid</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>Infrequent Visits</td>
<td>29%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Source: JAMA 9/8/2010:1107
Performance Monitoring Increased Documentation of Alcohol Counseling, But Not Real Counseling Rate

Alcohol counseling rate among patients screening positive for unhealthy ETOH use

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2012</th>
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<tbody>
<tr>
<td>Documented</td>
<td>59.4%</td>
<td>83.0%</td>
</tr>
<tr>
<td>Patient Reported</td>
<td>66.1%</td>
<td>70.1%</td>
</tr>
</tbody>
</table>

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

Change from baseline (% opening bottles or mg/dL)

<table>
<thead>
<tr>
<th></th>
<th>Controls</th>
<th>Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opened Pill Bottles*</td>
<td>59</td>
<td>81</td>
</tr>
<tr>
<td>Fall in LDL @6 mo.</td>
<td>37</td>
<td>35</td>
</tr>
<tr>
<td>Fall in LDL @12 mo.</td>
<td>34</td>
<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
Veterans Health Administration: Better and Fairer Care
VA Hospitals Have Lower Mortality and Readmissions than Other Hospitals

30 day mortality or readmissions/100 patients

<table>
<thead>
<tr>
<th>Condition</th>
<th>Mortality</th>
<th>Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNA</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>CHF</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>AMI</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>COPD</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>PNA</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>CHF</td>
<td>19</td>
<td>22</td>
</tr>
<tr>
<td>AMI</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>COPD</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: JAMA IM 2017;177:882
Note: PNA=pneumonia; All rates are risk adjusted
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

THE SIMPLE GOP PLAN FOR THE UNINSURED

SINGLE RAVENHOOD

MARRIED

SINGLE

WOULDN'T YOU LIKE FRIES WITH THAT?

SMOKER BOWL

DENTIST

ERROR MESSAGE

MARCH

DIE HARD

CONGRATULATIONS!
YOU ARE INSURED

PREMIUMS

$1,000

$500

$250

PREMIUMS

GET IN BY METER

HEALTH PLANS

GET SICK

DIE PENNIESLESS

HELP CENTER

SUBSIDY

GO ONLINE

MEDICARE

MAD

MAD MAN

DECATHLON

DIEHARD

RETURN TO TARDIS

BACK TO THE FUTURE

ATTACK!

LOSE 15

INDIAN PRINCE

NAGAN

BLEEP

ERROR MESSAGE

MAD MUSICAL

ATTACK!

MAD

YOU ARE INSURED

PREMIUMS

CONGRATULATIONS!

YOU ARE INSURED

MARRIED
Medicare’s “Software”
18.9 Million Seniors Enrolled Within 11 Months

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

PLEASE READ THE ENCLOSED LEAFLET

Harry S Truman
Independence, Missouri

TO GET MEDICAL INSURANCE

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

IF YOU DO NOT WANT THIS MEDICAL INSURANCE

SIGN HERE

Signature by mark (X) must be witnessed below.

SIGNATURE OF WITNESS

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

Source: Himmelstein & Woolhandler - Analysis of NCHS data
U.S. Public Spending Per Capita for Health Exceeds Total Spending in Other Nations

<table>
<thead>
<tr>
<th>Country</th>
<th>Total Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.K.</td>
<td>$4650</td>
</tr>
<tr>
<td>Japan</td>
<td>$4820</td>
</tr>
<tr>
<td>France</td>
<td>$5380</td>
</tr>
<tr>
<td>Canada</td>
<td>$5420</td>
</tr>
<tr>
<td>Holland</td>
<td>$5770</td>
</tr>
<tr>
<td>Sweden</td>
<td>$5780</td>
</tr>
<tr>
<td>Germany</td>
<td>$6650</td>
</tr>
<tr>
<td>Switzerland</td>
<td>$7730</td>
</tr>
</tbody>
</table>

U.S. | $7,619 | $11,600

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
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

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

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

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

Nurses/1000 Population

Source: OECD, 2020
Note: Data are for 2019 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%
- Switz.: 4.1%

Source: OECD, 2019
Note: Data are for 2017 or most recent year available
Insurance Overhead

$/Capita

U.S.: 965
Canada: 167
Holland: 213
Switzerland: 284
France: 289
Germany: 293

Source: OECD, 2020; NCHS; CIHI

Note: Figures adjusted for Purchasing Power Parity; data are for 2019 or most recent available
Canada’s Single Payer National Health Insurance Program
MINIMUM STANDARDS FOR CANADA'S PROVINCIAL PROGRAMS

1. UNIVERSAL COVERAGE THAT DOES NOT IMPED E, EITHER DIRECTLY OR INDIRECTLY, WHETHER BY CHARGES OR OTHERWISE, REASONABLE ACCESS.
2. PORTABILITY OF BENEFITS FROM PROVINCE TO PROVINCE
3. COVERAGE FOR ALL MEDICALLY NECESSARY SERVICES
4. PUBLICLY ADMINISTERED, NON-PROFIT PROGRAM
Free Care in Quebec
Improved Maternal/Infant Care

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

Deaths/1000 Live Births


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

<table>
<thead>
<tr>
<th>Income Group</th>
<th>Before NHI</th>
<th>After NHI</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$3000</td>
<td>45%</td>
<td>75%</td>
</tr>
<tr>
<td>$3000-4999</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>$5000-8999</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>$9000-14999</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>$15000+</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

All Incomes: 75%

Source: NEJM 1973;289:1174
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
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)

U.S. $1015

Canada $206

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
Physicians' Billing-Related Expenses
United States & Canada, 2019

$ per capita (PPP adjusted)

U.S.  $502
Canada  $96

Source: Woolhandler/Campbell/Himmelstein Ann Int Med 2020 (Updated)
Note: Excludes dentists and other non-physician, office-based practitioners.
Note: Excludes non-billing-related costs for documentation compliance etc.
Overall Administrative Costs Per Capita
United States & Canada, 2019

U.S. $3,966
Canada $1,196

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
## Canadian Physicians' Incomes, 2017/2018

### Average Clinical Payments Per Physician

<table>
<thead>
<tr>
<th>Specialization</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><strong>All Physicians</strong></td>
<td><strong>$344,978</strong></td>
</tr>
</tbody>
</table>

Source: Canadian Institute for Health Information - figures are in Canadian $s
What's OK in Canada?
Compared to the U.S.

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

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

Percent supporting Medicare for All with...

- **53%** Support
- **36%** Oppose
- **11%** Don't Know

- **46%** Support
- **35%** Oppose
- **18%** Don't Know

- **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

<table>
<thead>
<tr>
<th>Period</th>
<th>Favor</th>
<th>Oppose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998-2000</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>2002-2004</td>
<td></td>
<td>39%</td>
</tr>
<tr>
<td>2008-2009</td>
<td>46%</td>
<td>49%</td>
</tr>
<tr>
<td>2016-2017</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>2018-2019</td>
<td>57%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation Polls
Most Doctors Favor Single Payer Support Has Sharply Increased

2008
Support 42%
Oppose 58%

2017
Support 56%
Oppose 41%
No Opinion 3%

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
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 some 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.
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 vs. Medicare for More (e.g. Public Option)
Single Payer and Private Coverage

- **Allowed:** Supplemental non-competiting – 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)

- 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

Source: Bruenig - Jacobin Blog Post July, 2019

Other reasons for involuntary switch: Employer stopped offering coverage; coverage too expensive; policy holder died; hours dropped
Public Option = High Costs

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

Total health expenditures/year

$3.005 trillion  $3.636 trillion

Single Payer  Multi-Payer

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.
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

Source: http://museum.hackney.gov.uk/object9232